Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Quality of Care Issues
Captain James A. Lovell
Federal Health Care Center,
North Chicago, Illinois

Report No. 11-00163-109 **March 2, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations made by a confidential complainant regarding graduate medical education physician trainee (trainee) supervision and the quality of care provided by a physician at the Captain James A. Lovell Federal Health Care Center (the facility) in North Chicago, IL.

The complainant alleged that the physician did not review patient imaging tests prior to co-signing physician trainee report documentation and that the physician co-signed a misinterpreted imaging report. Additional allegations included the physician neglects patient care duties by not carrying a pager and not returning calls or electronic mail in a timely manner, trainees worked prior to the contract start date, the physician is not clinically competent to perform or supervise a specific procedure (the procedure), and the physician creates an intimidating work environment. We did not address the allegation of an intimidating work environment due to an ongoing Equal Employment Opportunity investigation.

We did not substantiate that the physician failed to review patient imaging tests prior to co-signing trainee documentation. We did not substantiate that the physician co-signed a misinterpreted imaging report. A Veterans Health Administration (VHA) consultant who reviewed the image that was allegedly misinterpreted stated the interpretation was not a misdiagnosis. We did not substantiate that the physician neglected patient care duties due to lack of a pager and rarely responding to electronic mail and telephone calls. The physician carries an encrypted BlackBerry® that receives both telephone calls and electronic mail.

We substantiated that a trainee worked prior to the contract start date. However, there was no harm to patients, and senior managers took appropriate actions to ensure trainees are scheduled according to their contract. We could neither confirm nor refute that the physician was competent to perform or supervise the procedure because the physician had not performed the procedure in the past 2 years. However, we found that senior mangers did not grant privileges based on documented clinical competence. We also found that the Executive Committee of the Medical Staff meeting minutes did not reflect the rationale used to support the physician's reprivileging.

We recommend that the facility's senior managers ensure compliance with VHA physician credentialing and privileging requirements as given in VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations. We will follow up to assure managers grant privileges based on documented clinical competence.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Great Lakes Health Care System (10N12)

SUBJECT: Healthcare Inspection – Alleged Quality of Care Issues James A. Lovell Federal Health Care Center, North Chicago, Illinois

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to determine the validity of allegations made by a confidential complainant regarding graduate medical education physician trainee (trainee) supervision and the quality of care provided by a physician at the Captain James A. Lovell Federal Health Care Center (the facility) [1] in North Chicago, IL.

Background

The facility provides care to all eligible veterans, and to active duty service members and their dependents. It consists of 199 hospital beds, 195 community living center beds, 149 Mental Health Residential Rehabilitation Treatment Program beds, and 3 community based outpatient clinics. Trainees work and receive training at the facility, which is part of Veterans Integrated Service Network (VISN) 12.

The complainant alleged the physician:

- Did not review patient imaging results prior to co-signing a physician trainee report documentation, which resulted in the co-signing of a report that contained an incorrect interpretation.
- Neglected patient care duties by not carrying a pager and having a delayed response to electronic mail or telephone calls

During interviews, the complainant additionally alleged:

- A trainee worked prior to the contract start date.
- The physician was not clinically competent to perform or to supervise trainees performing a specific procedure (the procedure).

[1] In October 2010, the North Chicago VA System and Great Lakes Naval Training Center integrated health care services and became the Captain James A. Lovell Federal Health Care Center, North Chicago, IL.

- The physician created an intimidating work environment.

We did not address the allegation of an intimidating work environment because of an ongoing Equal Employment Opportunity investigation.

Scope and Methodology

We interviewed the complainant by telephone and in person. We conducted a site visit on October 27–28. We interviewed senior managers, physician managers and other physicians familiar with the physician, and physician trainees. We also interviewed general counsel, Human Resources (HR) staff, the physician trainee program director, and a Veterans Health Administration (VHA) physician consultant.

We reviewed patient medical records, physician trainee supervision policies, Executive Committee of the Medical Staff (ECOMS) reprivileging meeting minutes, time and attendance records, and available administrative data. We also reviewed physician trainee program information, and quality management and physician credentialing and privileging data. Additionally, we consulted with a VA specialist who reviewed an imaging test result.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Trainee Supervision

We did not substantiate that the physician failed to review imaging test results prior to co-signing physician trainee report documentation, or that the physician co-signed an imaging test report that contained an incorrect interpretation.

Local policy requires that qualified, privileged physicians supervise all physician trainees and document concurrence with their assessments and observations. There are varying levels of supervision, which range from being physically present with the physician trainee to being available for telephone consultation, and co-signing their documented assessments. The level of supervisory involvement is dependent upon the experience and skill of the physician trainee. In the case of the imaging results, the supervising physician must review the images prior to co-signing physician trainee documentation.

We found no evidence that the physician did not review patient imaging test results prior to co-signing physician trainee documentation. We reviewed attendance records and identified 2 days when the physician was the only supervisor on duty. The physician co-signed all imaging reports written on those days, and physician trainees told us the physician reviewed the images prior to co-signing their documentation.

We did not find that the imaging test report, co-signed by the physician, contained an incorrect diagnosis. Another facility physician documented that the physician trainee's interpretation, which was based on a patient's test images, was incorrect. The other physician also documented a different diagnosis. Therefore, we requested a VHA consultant to review the images. In November, the consultant reviewed the patient's medical history and the imaging test results. The consultant did not believe the physician trainee's documented imaging report was a misdiagnosis. The consultant noted either diagnosis would not pose a significant risk for the patient's long-term prognosis.

Issue 2: Communication

We did not substantiate that the physician neglected patient care duties due to lack of a pager and rarely responding to electronic mail and telephone calls.

To assure continuity of care, physicians must be available by telephone, electronic mail, or pager unless they are on leave and have assigned another physician to care for patients in their place. The physician carries an encrypted BlackBerry® that receives both telephone calls and electronic mail. We learned of one instance where the physician responded 3 days after another physician's electronic mail request to change a patient's medication. The patient had a 2-week supply of the required medication, and we determined an immediate response was not necessary to assure quality care.

We interviewed supervisors, staff, and physician trainees regarding the physician's response to electronic mail and telephone calls. All told us that when an immediate response was necessary, the physician responded either in person or by telephone in a timely manner.

Issue 3: Physician Trainee Start Date

We substantiated that a physician trainee worked prior to the contract start date.

The physician trainee affiliation agreement was between the facility and another medical center, which was associated with the physician trainees' medical school.

Two new physician trainees began work in the facility a few days before their contract date. One of the physician trainees observed patient testing and did not provide patient care. The second physician trainee provided night call coverage[2] and responded to one call. The physician trainee's supervising physician reviewed and agreed with the physician trainee's response to the call.

On June 29, staff alerted managers when they learned human resources (HR) staff had not cleared the physician trainees to begin before their contract date. Managers then

[2] Night call refers to a health care provider who is readily available to respond to patient medical needs during the evening and night hours, either in person or by telephone.

immediately removed the physician trainees from duty. Because there was no harm to patients, and senior managers took appropriate actions to ensure the physician trainees' program manager schedules physician trainees according to their contract, we made no recommendations.

Issue 4: Clinical Competence

We could not confirm or refute whether the physician was competent to perform the procedure. Interviews and record reviews revealed the physician had not performed the procedure at the facility during the prior 2-year period; however, facility senior managers granted the physician privileges to perform the procedure in 2010. We found the senior managers did not evaluate clinical competency data prior to granting privileges to perform the procedure. We also found the ECOMS minutes did not reflect the rationale used to support granting of the physician's requested privileges.

VHA Handbook 1100.19[3] requires that the physician's service chief reviews the requested privileges and recommends continuing the privileges after evaluating the physician's demonstrated clinical competence. The ECOMS then determines whether clinical competence is adequately demonstrated to support granting the requested privileges. The ECOMS meeting minutes must reflect the rationale used to support granting requested privileges. We found senior managers did not grant privileges based on documented clinical competence and documentation was not included in the ECOMS minutes.

Conclusions

We did not substantiate that the physician failed to review patient imaging tests prior to co-signing physician trainee documentation. A VHA physician consultant reviewed the imaging test results that contained an alleged misdiagnosis. The consultant stated the documented diagnosis would not be considered a misdiagnosis.

We did not substantiate that the physician neglected patient care duties due to not carrying a pager and to delayed response to electronic mail or telephone calls. The physician responded to most communications in a timely manner. The one incident provided for our review did not affect patient care.

We substantiated that a physician trainee worked prior to the contract start date. There was no harm to patients and senior managers took appropriate actions to ensure physician trainees are scheduled according to their contract.

We could not confirm or refute that the physician was not competent to perform or supervise physician trainees performing the procedure because the physician had not performed the procedure in the past 2 years. We found senior mangers granted privileges

[3] VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

that were not based on documented clinical competence. We also found the ECOMS meeting minutes did not reflect the rationale used to support the physician's reprivileging for the procedure.

Recommendation

We recommend that facility senior managers ensure compliance with VHA physician credentialing and privileging requirements as given in VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Comments

The VISN and Facility Directors agreed with the findings and recommendation (see Appendixes A and B, pages 6–9, for the Director's comments). We will follow up to assure managers grant privileges based on documented clinical competence.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2011

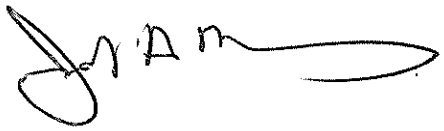
From: Director, VA Great Lakes Health Care System (10N12)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues at James A. Lovell Federal Health Care Center, North Chicago, Illinois**

To: Director, Denver Office of Healthcare Inspections (54DV)

Thru: Director, Management Review Service (10B5)

Attached please find the [Captain James A. Lovell Federal Health Care Center] FHCC response to the alleged quality of care issues. I have reviewed and concur with the response and request for closure.



Network Director, VA Great Lakes Health Care System (10N12)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 10, 2010

From: Director, James A. Lovell Federal Health Care Center (556/00)

Subject: **Healthcare Inspection – Alleged Quality of Care Issues at James A. Lovell Federal Health Care Center, North Chicago, Illinois**

To: Director, VISN

1. This is to acknowledge receipt and review of the findings and recommendation of the Office of the Inspector General Healthcare Inspection referenced above.

2. Attached is our response and request for closure.

(original signed by:)
Patrick Sullivan, Director
Captain James A. Lovell Federal Health Care Center (556/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendation

Recommendation 1. We recommend that the facility senior managers ensure compliance with VHA physician credentialing and privileging requirements as given in VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

Concur

Target Completion Date: Ongoing monitoring

Facility's Response: Although this facility cannot disagree that compliance with all handbooks is required, this recommendation seems to be based on the handbook requirement for renewal (vs. new) clinical privileges. In addition, the special and unique situation related to the merger with the Navy needs to be taken into consideration. The approach used for the medical staff privileging at the point of integration for the new Federal Health Care Facility (FHCC) is a new approach that was endorsed by the VHA Office of Quality and Performance and falls under the handbook for new credentialing and privileging.

Specifically, within 30–60 days prior to October 1, 2010, all 480 former North Chicago VA System (NCVAMC) and Naval Clinic Great Lakes providers had to apply for credentialing and privileging in the newly established Captain James A. Lovell FHCC, and for that purpose they were all considered and processed as new providers for the FHCC.

Given the above approach, all the providers whose privileges were in good standing in the "former" facilities as of September 1, 2010, were granted the same (facility specific) privileges, and their appropriate chiefs were required to have Focused Professional Practice Evaluation on all of them.

The [specialist] in question had privileges that were granted at NCVAMC to cover the period October 26, 2008 through October 25, 2010, and was in good standing. His privileges as a new provider to FHCC were then granted for September 22, 2010 through September 21, 2012. All providers, including this [specialist], will undergo Focused Professional

Practice Evaluation to demonstrate competencies of all the privileges requested. At that point, any competency that is not current will be re-evaluated and removed per VHA Handbook 1100.19 procedures. Closure of this recommendation is requested due to additional clarification provided.

OIG Contact and Staff Acknowledgments

OIG Contact	Virginia L. Solana, RN Director, Denver Office of Healthcare Inspections
Acknowledgments	Cheryl Walker, NP, Team Leader Laura Dulcie, BS Stephanie Hensel, RN, JD

Appendix C

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