



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

# Evaluation of Physician Credentialing and Privileging in Veterans Health Administration Facilities

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## **Executive Summary**

### **Introduction**

The Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections (OHI) completed an evaluation of Physician Credentialing and Privileging (C&P) in Veterans Health Administration (VHA) facilities. The purpose of this evaluation was to determine whether VHA facilities complied with selected requirements for physician C&P.

We performed the review at 35 VHA medical facilities during Combined Assessment Program reviews conducted from July 1, 2009, through March 31, 2010.

### **Results and Recommendations**

OHI has reviewed various components of C&P over the past several years and has observed considerable improvement. VHA facilities generally met the VHA credentialing requirements reviewed. They made copies of privileges available in key areas, had defined processes to address physicians who develop health conditions that might affect their performance, and granted privileges that were facility-specific, service-specific, and provider-specific. However, privileging practices could be strengthened if more efforts were made to verify privileges held at other institutions, if facilities' Medical Staff Executive Committees (MSECs) more thoroughly discussed and documented individual physicians' competence to perform the requested privileges, and if MSECs and service chiefs more clearly defined and met the parameters for Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation.

We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure compliance with VHA privileging requirements. The Under Secretary for Health concurred with the findings and recommendation. The implementation plan is acceptable, and we will follow up until all actions are complete.



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

**TO:** Under Secretary for Health (10)

**SUBJECT:** Healthcare Inspection – Evaluation of Physician Credentialing and Privileging in Veterans Health Administration Facilities

## **Purpose**

The purpose of this evaluation was to determine whether Veterans Health Administration (VHA) facilities complied with selected requirements for credentialing and privileging (C&P) physicians.

## **Background**

The Office of Healthcare Inspections (OHI)<sup>1</sup> and the Government Accountability Office (GAO)<sup>2</sup> have both reviewed C&P processes in VHA facilities and identified opportunities for improvement. Findings included that VHA staff did not consistently follow C&P requirements or consistently collect sufficient physician performance information in order to adequately gauge performance.

Two sets of reference documents describe requirements for these processes. The first is VHA's C&P handbook (the handbook), which was originally issued in 2001 and was most recently reissued on November 14, 2008.<sup>3</sup> The second document is The Joint Commission's (TJC's) Hospital Accreditation Standards manual. These documents are used throughout this report for definitions and requirements.

## **Scope and Methodology**

We performed the review at 35 VHA medical facilities during Combined Assessment Program (CAP) reviews conducted from July 1, 2009, through March 31, 2010. We

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<sup>1</sup> *Healthcare Inspection – Quality of Care Issues, VA Medical Center, Marion, Illinois*; Report No. 07-03386-65; January 28, 2008.

<sup>2</sup> *VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes*, GAO-10-26, January 6, 2010.

<sup>3</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

analyzed results and reported deficiencies in each facility's CAP report. The facilities we visited represented a mix of facility size, affiliation, geographic location, and Veterans Integrated Service Networks (VISNs). Our review focused on compliance with selected requirements from the handbook and TJC.

We reviewed documents, including the medical staff by-laws and policies related to C&P and minutes for the past 12 months from the committee(s) that reviews C&P. We selected at least 10 physicians from each facility and reviewed the C&P files and separate profiles (files that contain ongoing performance information for each physician). We selected physicians across services (such as Medicine, Surgery, and Radiology). We included physicians hired within the past 12 months and physicians who performed procedures such as colonoscopies and bronchoscopies. We discussed review results with facility Chiefs of Staff, their administrative officers, and/or medical staff coordinators. We reviewed a total of 401 physicians' documents and noted differing denominators depending on the number of physicians hired within the previous 12 months and the number of physicians expected to have performance information in their profiles.

We used 95 percent as the general level of expectation for performance in the areas discussed above. For those areas not mentioned further in this report, we found neither any noteworthy positive elements to recognize nor any reportable deficiencies.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## **Inspection Results**

### **Issue 1: Physician Credentialing**

Credentialing is the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status. The handbook requires each facility to verify, through the appropriate primary sources, a number of items, including professional education, training, and licensure. We found evidence of compliance with primary source verification of active medical licenses, medical degrees, medical residencies, and board certifications for nearly all physicians reviewed. Therefore, we made no recommendations regarding credentialing.

### **Issue 2: Physician Privileging**

Clinical privileging is the process by which a licensed independent practitioner is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific and based on the individual's clinical competence. Privileges are requested by the physician and reviewed by the responsible service chief who makes a recommendation to the credentialing committee. Privileges are then reviewed by the Medical Staff Executive Committee (MSEC). The

MSEC evaluates the evidence to determine whether clinical competence is adequately demonstrated to support the granting of the requested privileges. A final recommendation is then submitted to the facility Director for action.

At most facilities, we found evidence of processes to make copies of privileges available to facility staff in the operating room, intensive care units, emergency departments, and procedure areas, as required. Most facilities had a defined process for addressing physicians who develop a health condition that might affect their performance subsequent to the renewal of privileges. Also, at most facilities, privileges granted were facility-specific, service-specific, and provider-specific, as required. However, we found that the following areas needed improvement.

Verification of Privileges at Other Facilities. The handbook requires that facilities make a minimum of two efforts to obtain verification of clinical privileges currently, or most recently, held at other institutions. This process is required at the time of initial hiring and every 2 years the physician continues to request re-appointment to the facility's medical staff. Verification of privileges provides useful information about the types of medical services the physician provides elsewhere. Although privileges must be facility-specific, privileges for the same physician at different facilities should be congruent with that physician's skills and competence. We found evidence that at least two such efforts were made for 288 (90 percent) of 319 physicians (82 physicians reviewed for the most recent re-appointment had privileges only at their VHA facilities).

MSEC Documentation. The MSEC needs to make a determination about clinical competence at the time of initial hiring and every 2 years at re-appointment. We found that the MSEC documented its determination about whether clinical competence was adequately demonstrated to support the granting of the requested privileges for 256 (64 percent) of the 401 physicians. In many facilities, we found a standard statement for all physicians indicating that various documents had been reviewed rather than an individualized statement pertaining to the specific physician's competence to perform the specific privileges requested.

Focused Professional Practice Evaluation. Introduced in 2007 by TJC, Focused Professional Practice Evaluation (FPPE) is a process whereby the facility evaluates the competence of the physician at several key points: (1) when his or her practice is unfamiliar to the facility, (2) when he or she has learned a new skill, or (3) when his or her practice has raised concerns. FPPE is a time-limited period during which the medical staff leadership evaluates and determines the physician's ability to perform the privileges requested. Of the 35 facilities, we found that the criteria for FPPE were clearly defined in advance, as required, for:

- New hires' initial privileges at 26 (74 percent) facilities
- New privileges requested by currently privileged physicians at 27 (77 percent) facilities
- Quality of care concerns at 30 (86 percent) facilities

From our sample of 401 physicians, 85 were either newly hired or were already privileged and requested to add new privileges. FPPE applies to these physicians. Of the 85 physicians:

- The timeframe for the FPPE was clearly documented for 63 (74 percent) physicians. Timeframes may vary depending on the physician's experience and the frequency with which he or she performs the privileges. For example, a full-time physician might have a shorter FPPE timeframe than a physician who only works at the VHA facility part-time.
- Criteria were developed to determine the type of monitoring to be conducted for 74 (87 percent) physicians. For example, monitoring the number and type of procedures for a general surgeon would differ from a surgical specialist.
- Results of the FPPE were documented in the profiles of 66 (78 percent) physicians.
- Results were reported to the MSEC for 53 (62 percent) physicians.

Ongoing Professional Practice Evaluation. Since 2007, TJC has required that Ongoing Professional Practice Evaluations (OPPEs) be initiated to allow the facility to identify trends that impact on quality of care and patient safety. Clearly defined processes for OPPE were in place at 27 (77 percent) of the 35 facilities. Of the 35 facilities:

- Service chiefs had determined the type of information to be collected at 26 (74 percent) facilities.
- The MSEC approved the OPPE criteria at 24 (69 percent) facilities.
- The frequency of review was defined at 28 (80 percent) facilities.
- Similar qualifications were defined for privileges that are the same but exercised in multiple services at 27 (77 percent) facilities. For example, colonoscopies are performed by both gastroenterologists and general surgeons.

The determination to continue current privileges was based in part on results of physician-specific OPPE activities for 205 (70 percent) of 294 physicians, as required (107 physicians were too new for OPPE to apply). The criteria used in OPPE may include such items as those in the list below. Although it is not required that all of the following items be used, it is required that sufficient practice information be used to recommend continuing each physician's privileges. Of the 205 profiles that contained results of OPPE, we found the following items in decreasing order of use:

- Medical record quality reviews (94 percent)
- The number of procedures performed (56 percent)
- Adverse results indicating patterns or trends in a provider's clinical practice (45 percent)
- The number of major diagnoses treated (44 percent)
- Drug usage reviews (37 percent)
- Rates of complications compared with those of others doing similar procedures (33 percent)
- Infection control reviews (30 percent)

Extensive information sources and databases exist in VHA that could be used to evaluate physicians' ability to perform the requested privileges. Although confidentiality regulations prevent the use of protected quality assurance data, useful guidance has been provided to the field to assist with determining how to use the available information and data for OPPE.<sup>4</sup> The program officer stated that a training program for clinical leaders has been implemented to improve compliance.

Comparing physician-specific data to the aggregate data of physicians who hold the same or comparable privileges can supply valuable information about the consistency of practice patterns at the facility. Although not required, we found evidence of such comparisons for 72 (25 percent) of 287 physicians (114 physicians were either too new to have OPPE data or no other physicians had the same or comparable privileges).

## Conclusions

OHI has reviewed various components of C&P over the past several years and has observed considerable improvement. VHA facilities generally met the VHA credentialing requirements reviewed. They made copies of privileges available in key areas, had defined processes to address physicians who develop health conditions that might affect their performance, and granted privileges that were facility-specific, service-specific, and provider-specific. However, privileging practices could be strengthened if more efforts were made to verify privileges held at other institutions, if facilities' MSECs more thoroughly discussed and documented individual physicians' competence to perform the requested privileges, and if MSECs and service chiefs more clearly defined and met the parameters for FPPE and OPPE.

## Recommendation

**Recommendation 1.** We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure compliance with VHA privileging requirements.

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<sup>4</sup> Deputy Under Secretary for Health for Operations and Management, "Guidance on the Privileging Process," memorandum, December 17, 2008.

## Comments

The Under Secretary for Health concurred with the recommendation and provided implementation plans with target completion dates. VHA's Office of Quality and Performance will: (1) continue to train new service chiefs both online through the Learning Management System and through new service chief orientation, (2) work with the Deputy Under Secretary for Health for Operations and Management (DUSHOM) to clarify VISN oversight of the C&P process using a standardized assessment tool, and (3) continue to work with the DUSHOM to conduct ongoing outreach with VISNs on the medical staff process. The full text of the comments is shown in Appendix A (beginning on page 7). The Under Secretary for Health's comments and implementation plans are responsive to the recommendations. We will continue to follow up until all actions are complete.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## Under Secretary for Health Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** June 11, 2010

**From:** Under Secretary for Health (10)

**Subject: Evaluation of Physician Credentialing and Privileging in  
Veterans Health Administration Facilities**

**To:** Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the recommendation. Attached is the Veterans Health Administration (VHA) corrective action plan for the report's recommendation.
2. VHA concurs with the report's recommendation that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network (VISN) and facility senior managers, ensure compliance with VHA privileging requirements.
3. VHA's Office of Quality and Performance will (1) continue to train new service chiefs both online through Learning Management System and through New Service Chief Orientation; (2) work with Deputy Under Secretary for Health for Operations and Management (DUSHOM) to clarify VISN oversight of the credentialing and privileging process using a standardized assessment tool; and (3) continue to work with DUSHOM to conduct ongoing outreach with VISNs on the medical staff process including facility Chiefs of Staff, Service Chiefs, and medical staff professionals.
4. Thank you for the opportunity to review the draft report. A complete action plan to address the report's recommendation is attached. If you have any questions, please contact Linda H. Lutes, Director, Management Review Service (10B5) at (202) 461-7014.

*(original signed by:)*

Robert A. Petzel, M.D.

Attachment

## **Under Secretary for Health Comments to Office of Inspector General's Report**

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

**Recommendation 1. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensure compliance with VHA privileging requirements.**

Concur

The Office of Quality and Performance (OQP) will:

- Train new service chiefs both online through the Learning Management System (modules-Medical Staff Leadership; Provider Profiles Part I and Part II), and through the New Service Chief Orientation scheduled three times a year. New Service Chief Orientation was held on May 27, 2010.

Status: Completed

Completion Date: May 27, 2010

- Present on aspects related to credentialing and the roles and responsibilities of all medical staff involved in the process at the National Credentialing and Medical Staff Conference. The conference will take place August 17-20, 2010.

Status: In Process

Target Date: August 17–20, 2010

- Conduct credentialing boot camp for new credentialers with less than 12 months experience. The training will focus on credentialing and privileging basics and the importance of the integration of the credentialing process into the medical staff appointment process. This took place May 25–27, 2010.

Status: Completed

Completion Date: May 25–27, 2010

- Conduct monthly conference calls with medical staff professionals on topics important to the credentialing and privileging process.

Status: In Process

Ongoing Activity

- Present the importance of the medical staff process and working across the facility at the National Quality Management (QM) Conference on June 22–24, 2010.

Status: In process

Target Date: June 22–24, 2010

Additional OQP activities

- OQP will work with Deputy Under Secretary for Health for Operations and Management (DUSHOM) to clarify VISN oversight of the credentialing and privileging process using a standardized assessment tool. The assessment tool is going through the concurrence process.

Status: In process

Target Date: January 2011

- OQP will also continue to work with DUSHOM to conduct ongoing outreach with VISNs on the medical staff process including facility Chiefs of Staff, service chiefs, and medical staff professionals. This is an ongoing activity.

Status: In process

Ongoing Activity

## OIG Contact and Staff Acknowledgments

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OIG Contact	Julie Watrous, CAP Director Office of Healthcare Inspections 310-729-9466
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