VA HEALTH CARE

Improvements Needed in Processes Used to Address Providers’ Actions That Contribute to Adverse Events

Why GAO Did This Study
Adverse events—clinical incidents that may pose the risk of injury to a patient as the result of a medical intervention, rather than the patient’s underlying health condition—can occur in all health care delivery settings. VAMCs can use one or more of the protected (confidential and nonpunitive) and nonprotected processes to evaluate the role of individual providers in adverse events. GAO was asked to review the extent to which processes used to respond to adverse events are carried out across VAMCs. In this report, GAO examined (1) VAMCs’ adherence to VHA’s protected peer review process, and the extent to which VHA monitors this process, and (2) VAMCs’ adherence to VHA’s nonprotected processes and the extent to which VHA monitors these processes. To conduct this work, GAO visited four VAMCs selected for variation in size, complexity of surgeries typically performed, and location. GAO reviewed VHA policies and federal internal control standards and analyzed data from the four selected VAMCs. GAO also interviewed VHA and VA OIG officials, as well as officials from VISNs of the four selected VAMCs.

What GAO Found
The Department of Veterans Affairs (VA) medical centers GAO visited did not adhere to certain policy elements of the protected peer review process, and monitoring by VA’s Veterans Health Administration (VHA) is limited. According to policy issued by VHA, protected peer review may be used by VA medical centers (VAMC) when there is a need to determine whether a provider’s actions associated with an adverse event were clinically appropriate—that is, whether another provider with similar expertise would have taken similar action. Despite VAMC officials’ general understanding of the protected peer review process, none of the VAMCs GAO visited adhered to all four protected peer review policy elements selected for review, including the timely completion of reviews, and the timely development of peer review triggers that signal the need for further review of a provider’s care. Failure of VAMCs to adhere to the protected peer review policy elements may result in missed opportunities to identify providers who pose a risk to patient safety. Veterans Integrated Service Networks (VISN), responsible for oversight of VAMCs, monitor VAMCs’ protected peer review processes through quarterly data submissions and annual site visits. A VHA official said that VHA monitors the process by reviewing and analyzing the aggregated quarterly data submitted by VAMCs through the VISNs. The VA Office of the Inspector General (OIG) also conducts oversight of the protected peer review process as part of a larger review of VAMCs’ operations. While the VISNs and VA OIG have reviewed VAMCs establishment of peer review triggers to prompt further review of a provider’s care, neither they nor VHA has monitored their implementation. As such, VHA cannot provide reasonable assurance that VAMCs are using the peer review triggers as intended, as a risk assessment tool. This weakens VAMCs’ ability to ensure they are identifying providers that are unable to deliver safe, quality patient care.

VAMCs’ adherence to the nonprotected focused professional practice evaluation (FPPE) process is unclear due to gaps in VHA’s policy on documentation requirements, and VHA does not routinely monitor nonprotected processes. An FPPE for cause is a time-limited evaluation during which the VAMC assesses the provider’s professional competence when a question arises regarding the provider’s ability to provide safe, quality patient care. Information collected through the FPPE can be used to inform adverse actions, such as limiting the provider’s scope of care. Although VAMC officials were generally aware of the FPPE process, there are gaps in VHA’s policy regarding how these evaluations should be documented and what information should be included, which limited GAO’s ability to assess VAMCs’ adherence to the process. For example, one VAMC provided GAO with documentation labeled as an FPPE and identified by the service chief as an FPPE; however, the quality manager said a formal FPPE was not conducted and that the documentation was actually part of a protected peer review. These differing views illustrate that, even within the same facility, gaps in VHA’s policy on documenting FPPEs create a lack of clarity and opportunities for misinterpretation and inappropriate use. Moreover, the gaps in VHA’s policy may hinder VAMCs’ ability to appropriately document the evaluation of a provider’s skills, support any actions initiated, and track provider-specific incidents over time. There is no routine monitoring of FPPEs for cause by VHA, VISNs, or VA OIG.

What GAO Recommends
GAO recommends that VA take action to ensure VAMCs adhere to certain elements of the peer review policy, require VAMCs to report data on implementation of peer review triggers, and develop more specific policy to help guide the FPPE process, including documentation requirements. In its written comments, VA generally concurred with GAO’s conclusions and recommendations.

View GAO-14-55. For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.