



Report to the Chairman, Committee on
Veterans' Affairs, House of
Representatives

November 2017

VA HEALTH CARE

Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns

GAO Highlights

Highlights of [GAO-18-63](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Nearly 40,000 providers hold privileges in VHA's 170 VAMCs. VAMCs must identify and review any concerns that arise about the clinical care their providers deliver. Depending on the findings from the review, VAMC officials may take an adverse privileging action against a provider that either limits the care a provider is allowed to deliver at the VAMC or prevents the provider from delivering care altogether.

GAO was asked to review VHA processes for reviewing concerns about providers' clinical care. This report examines, among other things, selected VAMCs' (1) reviews of providers' clinical care after concerns are raised and VHA's oversight of these reviews, and (2) VAMCs' reporting of providers to the NPDB and SLBs and VHA's oversight of reporting. GAO visited a non-generalizable selection of five VAMCs selected for the complexity of services offered and variation in location. GAO reviewed VHA policies and files from the five selected VAMCs, and interviewed VHA, VISN, and VAMC officials. GAO also evaluated VHA's practices using federal internal control standards.

What GAO Recommends

GAO is making four recommendations, including for VA to direct VHA to require VAMCs to document reviews of providers' clinical care after concerns are raised, develop timeliness requirements for these reviews, and ensure proper VISN oversight of such reviews as well as timely VAMC reporting of providers to the NPDB and SLBs. VA concurred with GAO's recommendations and described steps it will take to implement them.

View [GAO-18-63](#). For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov or Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov

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VA HEALTH CARE

Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns

What GAO Found

Department of Veterans Affairs (VA) medical center (VAMC) officials are responsible for reviewing the clinical care delivered by their privileged providers—physicians and dentists who are approved to independently perform specific services—after concerns are raised. The five VAMCs GAO selected for review collectively required review of 148 providers from October 2013 through March 2017 after concerns were raised about their clinical care. GAO found that these reviews were not always documented or conducted in a timely manner. GAO identified these providers by reviewing meeting minutes from the committee responsible for requiring these types of reviews at the respective VAMCs, and through interviews with VAMC officials. The selected VAMCs were unable to provide documentation of these reviews for almost half of the 148 providers. Additionally, the VAMCs did not start the reviews of 16 providers for 3 months to multiple years after the concerns were identified. GAO found that VHA policies do not require documentation of all types of clinical care reviews and do not establish timeliness requirements. GAO also found that the Veterans Health Administration (VHA) does not adequately oversee these reviews at VAMCs through its Veterans Integrated Service Networks (VISN), which are responsible for overseeing the VAMCs. Without documentation and timely reviews of providers' clinical care, VAMC officials may lack information needed to reasonably ensure that VA providers are competent to provide safe, high quality care to veterans and to make appropriate decisions about these providers' privileges.

GAO also found that from October 2013 through March 2017, the five selected VAMCs did not report most of the providers who should have been reported to the National Practitioner Data Bank (NPDB) or state licensing boards (SLB) in accordance with VHA policy. The NPDB is an electronic repository for critical information about the professional conduct and competence of providers. GAO found that

- selected VAMCs did not report to the NPDB eight of nine providers who had adverse privileging actions taken against them or who resigned during an investigation related to professional competence or conduct, as required by VHA policy, and
- none of these nine providers had been reported to SLBs.

GAO found that officials at the selected VAMCs misinterpreted or were not aware of VHA policies and guidance related to NPDB and SLB reporting processes resulting in providers not being reported. GAO also found that VHA and the VISNs do not conduct adequate oversight of NPDB and SLB reporting practices and cannot reasonably ensure appropriate reporting of providers. As a result, VHA's ability to provide safe, high quality care to veterans is hindered because other VAMCs, as well as non-VA health care entities, will be unaware of serious concerns raised about a provider's care. For example, GAO found that after one VAMC failed to report to the NPDB or SLBs a provider who resigned to avoid an adverse privileging action, a non-VA hospital in the same city took an adverse privileging action against that same provider for the same reason 2 years later.

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Abbreviations

FPPE	focused professional practice evaluation
NPDB	National Practitioner Data Bank
SLB	state licensing board
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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November 15, 2017

The Honorable David P. Roe
Chairman
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health care systems in the nation, and nearly 40,000 providers hold privileges at its 170 VA medical centers (VAMC).¹ As in all health care delivery settings, VAMCs are responsible for ensuring that their providers deliver safe care to patients. If a concern about a provider's clinical care arises at any point, it is the VAMC's responsibility to review the provider's clinical care.² Depending on the nature of the concern and the findings from their review, VAMC leadership officials may take adverse privileging actions against providers that either limit the care they are allowed to deliver at the facility or prevent the providers from delivering care altogether. VAMC officials are also required to report the providers they take adverse privileging actions against to the National Practitioner Data Bank (NPDB), which is used by other VAMCs, non-VA hospitals, and other health care entities to obtain information on providers with a history of substandard care and misconduct.³ VAMC officials are also required to report providers to state

¹Privileges are the specific set of clinical services that a provider is approved to perform independently at a medical facility, based on an assessment of the provider's professional performance, judgement, clinical competence, and skills. For the purposes of this report, we use the term "provider" to refer to physicians and dentists.

²Examples of concerns about a provider's clinical care range from a provider not adequately documenting information about a patient visit to a provider practicing in a manner that is unsafe or inconsistent with industry standards of care. Such concerns may arise, for example, as part of VAMCs' routine performance monitoring or from patient complaints.

³The NPDB is an electronic repository administered by the U.S. Department of Health and Human Services that collects and releases information on providers who either have been disciplined by a state licensing board, professional society, or health care entity, such as a hospital, or have been named in a medical malpractice settlement or judgment. Industry standards call for health care entities to query the NPDB and verify with the appropriate state licensing board that a provider's medical licenses are current and in good standing before appointing a provider to the entity's medical staff and when renewing clinical privileges.

licensing boards (SLB) when there are serious concerns about a provider's clinical practice. The SLB can then investigate and determine if the provider's license to practice medicine should be suspended, restricted, or revoked.

Congress and VA have taken recent steps to make the adverse privileging action process more efficient and more transparent. For example, the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 shortens the appeals process timeframe when a VAMC proposes taking an adverse privileging action.⁴ While these actions may shorten the time period for reviewing and rendering a decision on taking an adverse privileging action, questions remain about the extent to which VAMC leadership officials review providers' clinical care after concerns are raised and, when appropriate, take adverse privileging actions against these providers and report them to the NPDB or SLBs. For example, there have been recent whistleblower complaints from VAMC providers to the U.S. Office of Special Counsel alleging that VAMC leadership officials have not adequately reviewed and addressed issues regarding providers' clinical care after concerns have been raised.⁵ According to the whistleblowers, specific providers have delivered care in a manner that is unsafe and inconsistent with industry standards of care, such as performing unnecessary procedures on veterans, without adequate reviews and actions taken by VAMC leadership.

Questions have also been raised about the extent to which VHA gives performance pay—a component of VA provider compensation—to providers who have had an adverse privileging action taken against them. Performance pay is an annual lump sum payment given to providers based on the extent to which the provider achieves specific goals in a given fiscal year. In July 2013, we reported that providers who were the

⁴Pub. L. No. 115-41, § 208, 131 Stat. 862, 878 (2017), codified, as amended, at 38 U.S.C. § 7462.

⁵The Office of Special Counsel is charged with protecting federal employees from prohibited personnel practices, such as retaliation against whistleblowing, discrimination, and nepotism. The Office of Special Counsel also handles other claims of wrongdoing from current employees, former employees, and applicants for federal employment including wrongdoing that presents a substantial and specific danger to public health or safety.

subject of adverse actions, including adverse privileging actions, received performance pay for the same year the actions were taken.⁶

You asked us to review the processes VHA has in place to review providers' clinical care after concerns arise and the extent to which providers receive performance pay when concerns are confirmed. In this report, we examine

1. VAMCs' reviews of providers' clinical care after concerns are raised and VHA's oversight of these reviews;
2. VAMCs' reporting of providers to the NPDB and SLBs and VHA's oversight of these processes; and
3. the extent to which VAMCs give performance pay to providers who have had an adverse privileging action taken against them.

To examine VAMCs' reviews of providers' clinical care after concerns are raised, we reviewed VHA policies and guidance and interviewed relevant VHA officials to obtain an understanding of VHA processes for these reviews.⁷ In addition, we identified providers whose clinical care required a review after concerns were raised at a non-generalizable selection of five VAMCs from October 2013 through the time we completed our site visits in March 2017. For these selected providers, we reviewed VAMC documentation of their reviews. We selected the five VAMCs based on the complexity of services offered and their geographic distribution. We identified providers at each VAMC by reviewing documentation of each VAMC's credentialing committee meetings from fiscal year 2014 through fiscal year 2016.⁸ During our visits, we interviewed VAMC officials,

⁶Our 2013 report focused on disciplinary and adverse actions beyond adverse privileging actions, such as letters of reprimand and suspension without pay. One of the five providers identified in the 2013 report had been the subject of an adverse privileging action; the other four providers had other types of actions taken against them. See *VA Health Care: Actions Needed to Improve Administration of the Provider Performance Pay and Award Systems*, [GAO-13-536](#) (Washington, D.C.: July 24, 2013).

⁷Veterans Health Administration, *Credentialing and Privileging*, VHA Handbook 1100.19 (Washington, D.C.: Oct. 15, 2012) and *Provider Competency and Clinical Care Concerns Including Focused Clinical Care Review and FPPE for Cause Guidance*, v.2 (Washington, D.C.: Jul. 2016).

⁸VAMCs generally have a committee responsible for making recommendations to VAMC leadership on matters related to credentialing and privileging, referred to in this report as the credentialing committee. Credentialing is the process of collecting and reviewing information—such as a provider's professional training, malpractice history, peer references, and other components of professional background—to determine whether the provider has suitable abilities and experience to provide medical services at a VAMC.

including chiefs of staff, clinical supervisors known as service chiefs, and other officials involved in these reviews. We asked the officials to clarify information about the documentation we received and confirm the completeness of the list of providers we identified. Based on the documentation and interviews, we determined the type of reviews the selected VAMCs conducted and the extent to which the VAMCs took adverse privileging actions against any of the identified providers.⁹ We assessed the extent to which the selected VAMCs adhered to VHA policy requirements for clinical care reviews and we compared these VHA policies and the selected VAMCs' reviews to federal internal control standards related to monitoring and documentation.¹⁰ To review VHA's oversight of VAMCs' clinical care reviews and adverse privileging actions, we reviewed VHA policy for oversight responsibilities and requirements. We also interviewed relevant VHA officials, as well as officials in VA's Veterans Integrated Service Networks (VISN) responsible for each of the five selected VAMCs, about their oversight activities.¹¹ We also compared VHA's policy and the selected VISNs' oversight activities with federal internal control standards related to monitoring.¹²

To examine VAMCs' reporting of providers to the NPDB and SLBs, we reviewed VHA's related policies and evaluated the extent to which the selected VAMCs adhered to these policies.¹³ Specifically, we evaluated the extent to which providers whose clinical care required a review or resulted in the VAMC taking adverse privileging actions against them from October 2013 through the time we completed our site visits in March 2017 were reported to the NPDB and the SLBs when appropriate. Our

⁹We limited our review of adverse privileging actions to final actions—that is, when all applicable internal VAMC due process procedures have been completed.

¹⁰GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014) and *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1, 1999). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹¹VISNs are regional systems of care that oversee the day-to-day functions of VAMCs that are within their network. Each VAMC is assigned to one of VA's 18 VISNs.

¹²[GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

¹³Veterans Health Administration, *National Practitioner Data Bank (NPDB) Reports*, VHA Handbook 1100.17 (Washington, D.C.: Dec. 28, 2009); Veterans Health Administration, *Reporting and Responding to State Licensing Boards*, VHA Handbook 1100.18 (Washington, D.C.: Dec. 22, 2005); and VHA, *Credentialing and Privileging*, VHA Handbook 1100.19.

review of NPDB reporting is limited to NPDB adverse action reports, which are reports of the adverse privileging actions VAMCs took against providers and any providers who resigned or retired while under investigation for a clinical care concern. Our review does not include VHA reporting of providers for paid medical malpractice settlements or judgements (tort claims). We reviewed VAMC documentation related to its reporting of specific providers and interviewed VAMC officials, including both clinical and administrative officials involved in these reporting processes. To examine VHA's oversight of VAMC reporting, we reviewed VHA policies for overseeing NPDB and SLB reporting and interviewed relevant VHA officials as well as officials in the VISNs responsible for each of the five selected VAMCs about VISN oversight activities. We also compared VHA's policy for oversight responsibilities and the selected VISNs' oversight activities with federal internal control standards related to monitoring.¹⁴

To determine the extent to which VAMCs give performance pay to providers who have had an adverse privileging action taken against them, we reviewed documentation of performance pay given to providers we identified with adverse privileging actions at the five selected VAMCs. Specifically, for each of the providers with an adverse privileging action who were eligible for performance pay, we reviewed documentation of performance pay for the fiscal year in which the action was taken and for the fiscal year prior to the action. Our performance pay analysis does not include contract providers, because only employed providers are eligible to receive performance pay.¹⁵ We also reviewed VA policy on performance pay and interviewed relevant VHA officials, as well as VAMC officials, about performance pay.

We conducted this performance audit from August 2016 to November 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹⁴[GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

¹⁵Department of Veterans Affairs, *Pay Administration*, VA Handbook 5007, v.52 (Washington, D.C.: Mar. 4, 2016).

Background

Identifying Concerns about Providers' Clinical Care

As part of the credentialing and privileging process, VAMC officials are responsible for monitoring each provider's performance on an ongoing basis and identifying any concerns about clinical care that may warrant further review. VAMCs can identify concerns about providers' clinical care in a variety of ways, including the following:

- **Ongoing monitoring.** VHA requires VAMCs to conduct and document ongoing monitoring of each provider's performance at least twice a year through an ongoing professional practice evaluation. During this evaluation, a provider's performance is evaluated against benchmarks established by VAMC leadership that define acceptable performance, such as documenting patient visits appropriately and achieving specific patient outcomes.
- **Peer review triggers.** VHA has a separate process, called peer review, that VAMCs may use to review adverse events.¹⁶ While information collected as part of peer review is protected for quality improvement purposes and may not be used to take action against a provider, VAMCs can identify concerns about a provider's clinical care based on a trend of certain peer review outcomes over a specified period of time, referred to as triggers. VHA requires VAMCs to establish peer review triggers. An example of a peer review trigger is when a provider has two or more episodes of patient care within a 12-month period for which a peer determined that most experienced, competent providers would have managed the episodes differently.

¹⁶Peer review is a VHA process for determining 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. Adverse events are clinical incidents that may pose a risk of injury to a patient and result from a medical intervention or lack of an appropriate intervention, such as a missed or delayed diagnosis, rather than from the patient's underlying medical condition.

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- **Complaints or incident reports.** Concerns about a provider's clinical care can also be identified through complaints and incident reports.¹⁷ These can come from any individual with a concern, including patients, providers, or VAMC leadership.
 - **Tort claims.** Filed or settled tort claims or malpractice claims can raise a concern about a provider not identified through ongoing monitoring or peer review.

Reviewing Concerns about Providers' Clinical Care and Taking Adverse Privileging Actions

Once a concern about a provider's clinical care is identified, VHA policy and guidance establish processes for VAMC officials to use to review the concern and determine whether an action should be taken against the provider's clinical privileges. VHA policy states that if allowing a provider under review to continue delivering patient care could result in imminent danger to veterans, VAMC officials should remove the provider from delivering patient care through a summary suspension of privileges. VAMC officials have flexibility to determine the most appropriate process to use to review a provider's clinical care depending on the specific concerns and the situation. These processes include the following:

- **Focused professional practice evaluation (FPPE) for cause.** This is a prospective review of the provider's care over a specified period of time, during which the provider has the opportunity to demonstrate improvement in the specific area of concern. Failure to improve could result in further review or action.
- **Retrospective review.** This is a review of the provider's delivery of patient care focused on a specific period of time in the past, a specific area of practice, or both, based on an identified concern.
- **Comprehensive review.** This is a more extensive retrospective review, generally performed by a panel of experts to ensure fairness and objectivity. In addition to reviewing the provider's past patient care, these reviews may also include interviews with the provider, patients, and staff. These reviews generally result in conclusions

¹⁷Each VAMC maintains its own incident reporting system, which is used by VAMC staff to report adverse events. Adverse events also include nonclinical incidents, such as reported thefts or conflicts between employees; such incidences would not likely result in a concern being raised about a provider's clinical care. In addition to reviewing providers' clinical care, VAMCs have other processes available to them for responding to an adverse event or incident report. For more information about these other processes, see GAO, *Veterans Health Care: Veterans Health Administration Processes for Responding to Reported Adverse Events*, [GAO-12-827R](#) (Washington, D.C.: Aug. 24, 2012).

about whether care delivered by the provider met the standard of care and may include recommendations about the provider's privileges.

Once a review is completed, VAMC leadership officials and the VAMC credentialing committee make decisions about next steps, which could include the following:

- do nothing, if the review did not substantiate the concerns;
- conduct further review (such as an FPPE for cause to allow the provider an opportunity for improvement or a comprehensive review if more information is needed); or
- take an adverse privileging action, including limiting one or more privileges (such as prescribing medication or performing a certain procedure) or revoking all of the provider's privileges.

If the VAMC's credentialing committee recommends an adverse privileging action, it is the VAMC director's responsibility to weigh all available information, including recommendations, and take an action. After a permanent provider is notified of the director's decision, the provider can appeal the decision to the Disciplinary Appeals Board as part of their due process rights.¹⁸ The adverse privileging action is considered final once the Disciplinary Appeals Board reaches a decision and the Deputy Under Secretary for Health executes the Board's decision.¹⁹ If a permanent provider does not make use of the offered due process procedures within 7 days, the provider waives his or her right to due process and the adverse privileging action is considered final.

Reporting Providers to the NPDB and SLBs

VHA policy requires VAMCs to alert certain entities if there are serious concerns with regard to a provider's clinical performance. VHA policy assigns reporting responsibility and authority to the VAMC director, who generally delegates the task of reporting to other VAMC officials. VHA makes this information available to other health care entities through two distinct reporting processes:

¹⁸Due process varies by appointment type, with non-permanent providers having access to a limited fair hearing to determine if the reason for the adverse privileging action was related to substandard care, professional misconduct, or professional incompetence. Non-permanent providers cannot internally appeal the adverse privileging action itself.

¹⁹A provider adversely affected by a decision of the Disciplinary Appeals Board (as reviewed by the Secretary) may obtain judicial review of the decision. 38 U.S.C. § 7462(f)(1).

NPDB. Under VHA policy, VAMC directors must report to the NPDB any adverse privileging action the facility takes that 1) affects the clinical privileges of a provider for a period longer than 30 days and 2) is related to professional incompetence or professional misconduct.²⁰ VHA policy requires VAMCs to submit these NPDB adverse action reports within 15 calendar days of the date the adverse privileging action is made final—that is, when all applicable internal due process procedures have been completed and the VAMC director has signed off on the action. VAMC directors are also required to report to the NPDB providers who resign or retire while under investigation or in return for the VAMC not conducting such an investigation or proceeding.²¹ To avoid any errors in the facts of the report, the VAMC director must notify any provider who is about to be reported to the NPDB and give the provider an opportunity to discuss the content of the report before it is submitted.

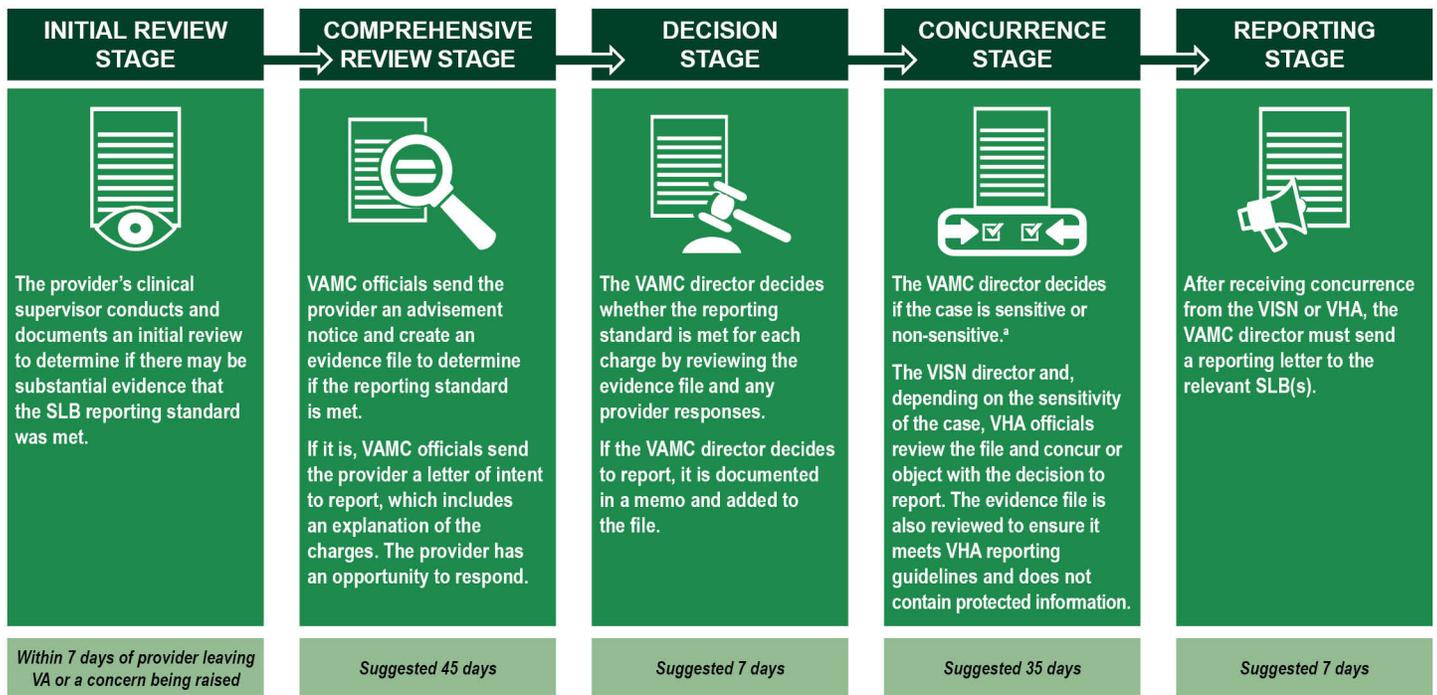
SLBs. VHA policy requires VAMC directors to report providers—both current and former employees—when there are serious concerns about the providers’ clinical care to any SLB where the providers hold an active medical license. Specifically, VHA policy requires VAMCs to report providers who so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. According to VHA policy and guidance, the SLB reporting process should be initiated as soon as it appears that a provider’s behavior or clinical practice fails to meet accepted standards. VAMC

²⁰VHA policy also requires VAMCs to forward a copy of the NPDB report to the SLB(s) where the provider holds an active medical license and to the SLB where the VAMC is located if the provider does not hold a license in that state. VA policy requires that providers hold one active unrestricted state medical license and does not require the provider to be licensed in the state where the VAMC is located. The Health Care Quality Improvement Act of 1986, which called for the establishment of the NPDB and requires the reporting of certain information, including information on professional review actions taken by health care entities, also required VA and the Department of Health and Human Services to enter into a memorandum of understanding regarding VA’s reporting of such information. In 1990 the two agencies entered into such an understanding, and VHA policy lays out these agreed upon reporting procedures for VAMCs. See Pub. L. No. 99-600, Tit. IV, 100 Stat. 3743, 3784 (1986), codified, as amended, at 42 U.S.C. §§ 11101-11152). VA’s updated reporting procedures are found at 38 C.F.R. Part 46.

²¹The NPDB defines an investigation broadly, running from the start of an inquiry until a final decision on an adverse privileging action is reached. An investigation must be focused on the provider in question, must concern the professional conduct or professional competence of the provider in question, and generally should be a precursor to a final action. According to VHA guidance, FPPEs for cause are not considered an investigation or a clinical privileging action and thus a provider would not be reported for resigning or retiring during an FPPE for cause.

officials are directed not to wait to report to SLBs until adverse privileging actions are taken because an SLB conducts its own investigation of the provider to determine whether licensure action is warranted. This reporting process comprises five stages as established in VHA policy, and VHA policy states that the process should be completed in around 100 days (see figure 1).

Figure 1: An Overview of the Stages of the Veterans Health Administration’s (VHA) State Licensing Board Reporting Process



Legend: SLB=state licensing board; VAMC=Department of Veterans Affairs medical center; VISN=Veterans Integrated Service Network.

Source: GAO review of VHA policy. | GAO-18-63

^aA case is considered sensitive if (a) it includes a previous history of licensure action against the provider; (b) it includes the death of a patient; (c) the provider has retained legal counsel in anticipation of litigation; (d) there has been media attention related to some aspect of the case; or (e) the provider has a clinical diagnosis, or is under the care of a physician, and that information is part of the review or provider response includes the provider's personal health information.

Performance Pay

Performance pay—a component of VA provider compensation—is an annual lump sum payment based on the extent to which an individual provider achieves specific goals. The goals may vary for providers across VA, at the same VAMC, or within a particular specialty. VA policy establishes minimum performance pay eligibility criteria, including being employed by VA from July 1 through September 30 of the fiscal year being reviewed.

Selected VAMCs' Reviews of Providers' Clinical Care Are Not Always Documented or Timely, and VHA Does Not Adequately Oversee These Reviews

Documentation frequently lacking. We found that the five selected VAMCs collectively required reviews of 148 providers' clinical care after concerns were raised from October 2013 through March 2017, but VAMC officials were unable to provide documentation that almost half of these reviews were conducted. We found that all five VAMCs lacked at least some documentation of the reviews they told us they conducted, and in some cases the required reviews were not conducted at all. We also found VHA does not adequately oversee these reviews, as discussed later in this report.

- **FPPEs for cause.** FPPEs for cause accounted for most of the missing documentation of clinical care reviews, despite VHA policy requiring VAMCs to document FPPEs for cause in the providers' files. Specifically, of the 112 providers for whom the selected VAMCs required FPPEs for cause from October 2013 through March 2017, the VAMCs were unable to provide documentation of the FPPEs for nearly a quarter (26) of the providers. Additionally, VAMC officials confirmed that FPPEs for cause that were required for another 21 providers were never conducted.
- **Other reviews.** The selected VAMCs were also unable to provide documentation of some retrospective reviews. Specifically, of the 27 providers for whom the selected VAMCs conducted a retrospective review, 8 were missing documentation. While VHA guidance recommends that VAMCs document these reviews, VHA policy does not require that VAMCs document retrospective or comprehensive reviews. VHA officials told us that they expected VAMCs to document these types of reviews so that the information could be used to support adverse privileging actions, if necessary. Without clearly stated documentation requirements in VHA policy, VAMC officials inconsistently document their results, preventing VAMC directors and VISNs from properly evaluating the effectiveness of its retrospective and comprehensive reviews, which are used to, among other things, ensure patient safety. Additionally, we found that key officials from two VAMCs were not aware of the VHA guidance and that 5 of the 8 missing retrospective reviews were from these two VAMCs.

We also found that one VAMC was missing documentation of clinical care reviews for 12 providers who met the VAMC's peer review trigger. In the absence of this documentation, we were unable to identify the type of reviews that were missing for these 12 providers.

The selected VAMCs' failure to document reviews of providers' clinical care after concerns were raised is inconsistent with federal internal

control standards for monitoring and documentation, which state that management should conduct and document separate evaluations, when necessary.²² In the absence of VAMC documentation of such separate evaluations of providers, VAMC leadership officials lack key information needed to make decisions about whether providers' privileges are appropriate, and they also lack reasonable assurance that appropriate reviews are conducted.

Reviews not always timely. We found that the five selected VAMCs' reviews of providers' clinical care were not always conducted in a timely manner after concerns were raised. Specifically, of the 148 providers, the VAMCs' initiation of reviews of 16 providers' clinical care was delayed by more than 3 months, and in some cases for multiple years, after the concern was raised.²³ At one VAMC, service chiefs were not instructed to conduct reviews of 14 providers until 4 to 13 months after these providers met the VAMC's peer review trigger.²⁴ Before the service chiefs were notified of the concerns, 3 of these providers had at least one additional concerning episode of care—that peer reviewers judged would have been handled differently by most experienced providers—identified through the peer review process.²⁵ As pointed out in VHA guidance, earlier intervention could prevent additional patients from receiving substandard care. Officials from another VAMC did not conduct retrospective reviews on 2 providers until we requested documentation of the reviews, approximately 3 and a half years after the credentialing committee had initially requested a review.²⁶

While VHA officials told us that clinical care reviews should be conducted as expeditiously as reasonably possible, VHA policy does not specify a timeliness requirement. Allowing more time to elapse before a clinical care review is initiated weakens the intended purpose behind clinical care

²²[GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

²³VHA policy and guidance do not specify how quickly a clinical care review should be initiated after a concern is identified. We define a delay as longer than 3 months because FPPEs for cause are generally completed within this timeframe.

²⁴For 1 of the 14 providers, the service chief became aware that the provider met a peer review trigger and conducted a review before the notification letter was sent.

²⁵One provider had two additional concerning episodes of care before the service chief was notified that the provider met the peer review trigger.

²⁶The reviews did not identify any additional clinical care concerns.

reviews and further increases risk to patient safety. Federal internal control standards for monitoring state that management should evaluate issues and remediate identified deficiencies in a timely manner.²⁷ A clinical care concern could represent a potential deficiency in providing medical care, and as a result, VHA increases its risk further without establishing a policy that sets timeframes for conducting clinical care reviews.

VHA oversight is inadequate. We also found that VHA does not adequately oversee VAMC reviews of providers' clinical care after concerns have been raised, including ensuring that these reviews are completed and documented in a timely manner. Under VHA policy, VISNs are responsible for overseeing the credentialing and privileging processes at their respective VAMCs. While reviews of providers' clinical care after concerns are raised are a component of credentialing and privileging, we found that the VISNs with responsibility for overseeing the selected VAMCs through routine audits do not include these reviews in their audits. While the standardized tool VHA requires the VISNs to use for these audits instructs the VISNs to identify and review providers who were on an FPPE for cause, none of the VISN officials we spoke with described any routine oversight of FPPEs or any other reviews of identified clinical care concerns.²⁸ This may be in part because some VISN officials are not using VHA's standardized audit tool as required. Officials from one VISN said they had developed their own audit tool and officials from another VISN said that they were not conducting the audits due to multiple instances of turnover in a key position at the VISN. Further, VHA's standardized audit tool does not direct the VISN to oversee any other types of reviews of clinical care concerns, such as retrospective or comprehensive reviews. The tool also does not require VISN officials to look at documentation of the FPPEs for cause; instead, it calls for reviewing credentialing committee meeting minutes. Without reviewing documentation, VISN officials would be unable to identify the incomplete documentation that we identified in our review. Both VHA and VISN officials described instances of assisting VAMC officials with

²⁷ [GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

²⁸ Regarding their audits of VAMCs, VISN officials we interviewed generally described selecting a sample of providers from different specialties to review VAMC compliance with other, more routine credentialing and privileging requirements, such as appropriate verification of licensure. Some officials said they would look at documentation of a VAMC's review of a provider's clinical care after a concern had been raised if any of the providers in their sample happened to have a documented review in their files.

reviews of providers' clinical care after concerns had been raised, but VHA and VISN officials told us that their involvement in these reviews is typically consultative and not routine. (For example, the VISN may assist by identifying providers outside of the VAMC to conduct the review.) As a result, VHA and the VISNs are not conducting routine oversight to ensure that VAMC reviews of providers' clinical care after concerns are raised are conducted appropriately, including adequately ensuring that the reviews are completed and documented in a timely manner, in accordance with VHA policy.

The lack of routine VHA oversight, through the VISNs, of VAMC reviews of providers' clinical care after concerns are raised is inconsistent with federal internal control standards for monitoring, which state that management should establish and operate monitoring activities.²⁹ In the absence of routine monitoring of VAMCs' evaluations of providers after concerns have been raised, VHA lacks reasonable assurance that VAMCs adequately review all identified concerns about providers' clinical care and take appropriate privileging actions to ensure that VA is providing safe, high quality care for veterans.

²⁹[GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

Selected VAMCs Did Not Always Report Providers to the NPDB and SLBs in Accordance with VHA Policy, and VHA Does Not Adequately Oversee This Reporting

NPDB and SLB reporting not completed. We found that the five selected VAMCs did not report the majority of providers who should have been reported to the NPDB or SLBs in accordance with VHA policy.³⁰ Our analysis shows that from October 2013 through March 2017, of the 148 providers whose clinical care required a review, the VAMCs took adverse privileging actions against 5 providers, and another 4 providers resigned or retired while under review but before an adverse privileging action could be taken. However, at the time of our review, we found that the five selected VAMCs had only reported 1 of these 9 providers to the NPDB and none of these providers to the SLBs.³¹ Furthermore, the 1 provider who was reported to the NPDB for an adverse privileging action was reported 136 days after all internal VA appeals were complete, far beyond the 15 day reporting requirement.

In addition to these nine providers, one of the selected VAMCs terminated the services of four contract providers based on deficiencies in the providers' clinical performance, effectively revoking their clinical privileges. For example, the VAMC documented that one contractor's services were terminated for cause related to patient abuse after only 2 weeks of work at the VAMC. A VAMC leadership official told us there was no further documentation of whether reporting was considered or whether any comprehensive review was conducted, despite the fact that the VAMC credentialing committee recommended both. While VHA policy identifies the requirements, steps, and limited fair hearing process for reporting contract providers, these required steps were not followed, and none of these providers were reported to the NPDB or SLB.

As a result of our audit work, in August 2017, one of the VAMCs reported to the NPDB three of the providers who resigned or retired while under investigation but before an adverse privileging action could be taken.

³⁰Statements about SLB reporting in this report refer to the requirement that VAMC directors report to SLBs those providers who so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, unless otherwise stated. This requirement is separate from the requirement that a copy of an NPDB report of an adverse privileging action be provided to any SLB where the provider holds an active medical license and to the SLB where the VAMC is located if the provider does not hold a license in that state. It is assumed that if a provider was not reported to the NPDB, a copy of such a report could not have been provided to the appropriate SLBs.

³¹Officials documented that these nine providers met the standard for reporting to the SLB after they separated from the VAMC.

These reports were completed between 11 months and over 3 and a half years after the providers resigned or retired. VAMC officials could not confirm that they sent the required copies of the NPDB reports to the appropriate SLBs.

The five selected VAMCs did report two providers to their respective SLBs for reasons other than adverse privileging actions. In accordance with VHA policy, these SLB reports were made after VAMC officials determined that the providers' behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients—the standard for SLB reporting. One of these providers could not have an adverse privileging action taken against them because VAMC officials unintentionally allowed the provider's privileges to expire during a comprehensive review of the provider's care. The other provider reported to the SLBs was considered for an adverse privileging action, but VAMC officials suspended the provider instead. The provider demonstrated improvement after the suspension.

SLB reporting not always timely. While two of the selected VAMCs had each reported a provider, we found that in these cases the SLB reporting process took significantly longer than the 100 day timeframe suggested in VHA policy. Specifically, it took over 500 days for each of the two completed reports to pass initial and comprehensive review at the VAMC, receive concurrence from the VISN, and be submitted to the SLB. For example, one of the two providers self-reported to the SLB the concerning episode of care at the VAMC. However, before the VAMC submitted its SLB report 328 days later, the SLB had completed its investigation of the provider's self-report and put in place an agreement that placed restrictions and requirements on the provider's medical license. Subsequently, the provider successfully met the requirements of the agreement and had all restrictions on the license removed. Officials at two VAMCs told us the SLB reporting is more tedious or cumbersome than the NPDB reporting process, making it difficult to complete in a timely manner. One VAMC official commented that while completing the process in less than a year seems reasonable, the typical timeframe for submitting a SLB report is at least 2 years.

At the five selected VAMCs, we found that providers were not reported to the NPDB and relevant SLBs as required because officials were generally not familiar with or misinterpreted related VHA policies. VHA officials commented that adverse privileging actions and clinical care concerns rising to the level of reporting are infrequent, with officials at two VISNs

estimating that only a few occur across the facilities within their network each year. Staff at three VAMCs commented that there has been turnover in positions that have been delegated tasks related to reporting and one VAMC official told us that turnover in these positions is a barrier to timely reporting. For example,

- at one facility, we found that officials failed to report six providers to the NPDB because the officials were unaware that they had been delegated responsibility for NPDB reporting.³²
- Officials at two of the selected VAMCs told us that VHA cannot report contract providers to the NPDB. This assertion is inconsistent with VHA policy.
- Officials at two of the selected VAMCs were waiting to start the SLB reporting process for providers until after all appeals had been exhausted. This approach is inconsistent with VHA policy, which states that the process should start within 7 days of when the reporting standard is met. For example, for one provider who was reported, VAMC officials unnecessarily waited 7 months for the completion of the appeals process before they resumed the reporting process, which ultimately took 547 days.
- Officials at one VAMC did not report a provider to the NPDB or SLB following an adverse privileging action because the SLB had found out about the issue independently. This is inconsistent with VHA policy for NPDB and SLB reporting, and the SLBs in other states where the provider held a license were not alerted of concerns about the provider's clinical practice.

VHA oversight is inadequate. We also found that VHA and the VISNs do not adequately oversee NPDB and SLB reporting and they cannot ensure that VAMCs are reporting providers when required to do so by VHA policy. While the VISNs are responsible for overseeing the credentialing and privileging at their respective VAMCs under VHA policy, VHA policy does not require the VISNs to oversee whether VAMCs are reporting providers to the NPDB or SLB when warranted. As a result, VISN officials were unaware of situations in which VAMC directors failed to report providers to the NPDB, as evidenced by our review. In the case of reporting processes for SLBs, VISN officials told us that they review the evidence files to ensure, among other things, that the files are in compliance with privacy laws. However, officials told us that the VISNs do

³²After our review, VAMC officials reported three of these six providers to the NPDB.

not oversee the reporting process to ensure that VAMC directors are reporting all providers to the SLB who should be reported. Additionally, VHA officials told us that they are not aware of the number of cases that have been initiated for SLB reporting.

Further, by failing to report providers as required, VHA facilitates providers who provide substandard care obtaining privileges at another VAMC or a hospital outside of VA's health care system without an indication on their record that an adverse privileging action was taken against them or that they resigned or retired while under investigation. For example, we found that

- two of the four contract providers whose privileges were revoked and were not reported to the NPDB or SLBs by one VAMC continue to be able to provide care to veterans outside of that VAMC. Specifically, one provider whose services were terminated related to patient abuse subsequently held privileges at another VAMC, while the other provider belongs to a network of providers that provides care for veterans in the community.³³
- Seven of the 12 providers who were not reported to the NPDB or SLBs after their privileges were revoked—through adverse privileging actions or the termination of services on a contract—or who resigned or retired while under investigation have current Medicare enrollment records, indicating that they are likely practicing outside of VA and may still be receiving federal dollars by billing for services provided to Medicare beneficiaries.
- We also identified one case where a VAMC director did not report a provider to the NPDB or SLB after an agreement was reached that the provider would resign, though the VAMC credentialing committee recommended the provider's privileges be revoked. We found that the provider's privileges were also revoked from a non-VA hospital in the same city for the same reason 2 years later. The director's decision not to report the provider as required left patients in that community vulnerable to adverse outcomes because problems with the provider's

³³The Patient-Centered Community Care and Veterans Choice programs are two of VA's programs that allow eligible veterans to receive care in the community when generally (1) its medical facilities do not offer the services needed on site, (2) the veteran would have to travel a long distance to obtain care from a VHA medical facility, or (3) there are long wait times to obtain appointments at VHA medical facilities. Under both programs, VA's two third party administrators are responsible for developing regional networks of providers to deliver care to eligible veterans.

performance were not disclosed. There was no documentation of the reasons why the VAMC director did not report the provider to the NPDB or SLBs.³⁴

This lack of routine oversight from VHA through the VISNs of VAMCs' reporting of providers to the NPDB and SLBs is inconsistent with federal internal control standards for monitoring. The standards state that management should establish and operate monitoring activities to monitor the internal control system and appropriately remediate deficiencies on a timely basis.³⁵ Without routine monitoring of the reporting process, VHA lacks reasonable assurance that all providers who should be reported to the NPDB and SLBs are reported.

At Selected VAMCs, Providers with Adverse Privileging Actions Were Ineligible for Performance Pay the Year the Actions Were Taken

None of the five providers who had an adverse privileging action taken against them in the period we reviewed received performance pay for the fiscal year the action was taken because they were ineligible, per VA policy.³⁶ This is because VA policy requires providers to be employed through the end of the fiscal year to be eligible for performance pay, and none of the five providers we reviewed were still employed by the VAMCs at the end of the fiscal year in which the actions were taken.

All five of the adverse privileging actions resulted from concerns about the providers' clinical care in previous fiscal years. Among the five providers, two providers received performance pay in the fiscal year before their privileges were revoked, and three providers did not. For example, one provider's privileges were revoked in 2015 due to concerns raised in 2014 regarding the provider's failure to complete necessary documentation of patient care in a timely manner. This provider did not receive credit for the performance pay goal directly related to timely completion of documentation, and ultimately the provider received half of the maximum amount of performance pay for fiscal year 2014. In the case of another provider who did not receive any performance pay for the fiscal year before the adverse privileging action was taken, VAMC officials noted that the provider had been removed from practice for a portion of the fiscal

³⁴We were unable to interview the VAMC director because he had retired.

³⁵[GAO-14-704G](#) and [GAO/AIMD-00-21.3.1](#).

³⁶Since contract providers are not eligible for performance pay, our review of performance pay did not include the four providers that one VAMC released from their contracts based on substandard care.

year while they were reviewing the clinical care concern and thus was unable to meet performance pay goals.

Conclusions

VHA is responsible for ensuring that providers at its VAMCs deliver safe care to veterans and that concerns that may arise about providers' clinical care are reviewed and addressed at VHA's 170 VAMCs. However, our work shows that at our five selected VAMCs, reviews of concerns about providers' clinical care were not always documented or conducted in a timely manner and VAMCs had not reported the majority of providers they should have reported to the NPDB or SLBs. This is concerning for several reasons. First, without documentation of the reviews of these concerns about providers' clinical care, VAMC leadership officials may not have the information they need to make decisions about whether a provider's privileges at the VAMC are appropriate. Second, if VAMCs do not document that they have reviewed provider's clinical care after concerns have been raised, VHA lacks reasonable assurance that the VAMCs are adequately addressing such concerns or that VAMCs are limiting or revoking providers' privileges when necessary. Third, if these reviews are not conducted in a timely manner and providers continue to deliver potentially substandard care, VHA may be increasing the risk that veterans will receive unsafe care at VAMCs. Finally, VAMCs' failure to report providers to the NPDB and SLBs, as required under VHA policy, makes it possible for providers to obtain privileges at other VAMCs or non-VA health care entities without disclosing the problems with their past performance. In effect, this can help shield the providers from professional accountability outside of VA's health care system.

Further, VHA's inadequate oversight of these processes calls into question the extent to which VAMCs are held accountable for ensuring that veterans receive safe, high quality care. As our review shows, the VISNs responsible for overseeing the five selected VAMCs do not routinely oversee VAMC reviews of providers' clinical care after concerns are raised to ensure that these reviews are completed in accordance with VHA policies; nor do the VISNs oversee the VAMCs to ensure that all providers that should be reported are reported to the NPDB and SLBs. Until VHA strengthens its oversight of these processes, veterans may be at increased risk of receiving unsafe care through the VA health care system.

Recommendations for Executive Action

We are making the following four recommendations to VA:

The Under Secretary for Health should specify in VHA policy that reviews of providers' clinical care after concerns have been raised should be documented, including retrospective and comprehensive reviews. (Recommendation 1)

The Under Secretary for Health should specify in VHA policy a timeliness requirement for initiating reviews of providers' clinical care after a concern has been raised. (Recommendation 2)

The Under Secretary for Health should require VISN officials to oversee VAMC reviews of providers' clinical care after concerns have been raised, including retrospective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool. This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner. (Recommendation 3)

The Under Secretary for Health should require VISN officials to establish a process for overseeing VAMCs to ensure that they are reporting providers to the NPDB and SLBs, and are reporting in a timely manner. (Recommendation 4)

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, which are reproduced in Appendix I, VA agreed with our conclusions and concurred with our recommendations. In its comments, VA stated that VHA plans to revise existing policy to require documentation of reviews of providers' clinical care after concerns have been raised and to establish expected timeframes for completing such reviews. VA estimates that it will complete these actions by September 2018. VA also stated that VHA will update the standardized audit tool used by the VISNs so that it directs them to oversee reviews of providers' clinical care after concerns have been raised and to ensure timely reporting to the NPDB and SLBs. According to VA, the revised tool will also facilitate aggregate reporting by VISNs to identify trends and issues. VA estimates that it will complete these actions by October 2018.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the appropriate congressional committees, the Secretary of Veterans Affairs, and the Under Secretary for Health. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov or Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs can be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.

Sincerely yours,



Sharon M. Silas
Acting Director, Health Care



Randall B. Williamson
Director, Health Care

Appendix I: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

October 20, 2017

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "**VA HEALTH CARE: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns**" (GAO-18-63). VA agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure provides information on actions taken to address the GAO draft report recommendations.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

A handwritten signature in black ink that reads "Gina S. Farrissee".

Gina S. Farrissee
Deputy Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Improved Policies and Oversight Needed for Reviewing and
Reporting Providers for Quality and Safety Concerns”***
(GAO-18-63)

Recommendation 1: The Under Secretary for Health should specify in VHA policy that reviews of providers’ clinical care after concerns are raised should be documented, including retrospective and comprehensive reviews.

VA Comment: Concur. The Veterans Health Administration’s (VHA) Office of Quality, Safety, and Value, Medical Staff Affairs, will rewrite policy to formalize guidance on focused management reviews that are to be conducted when a clinical care concern has been raised. Policy will codify maintenance of these reviews in the Provider Profile and in accordance with the System of Records Notice 77VA10A4, “Health Care Provider Credentialing and Privileging Records – VA.” Existing policy will be expanded to incorporate existing guidance documents related to the process of addressing clinical care concerns for privileged providers to facilitate standardization throughout the agency. The Assistant Deputy Under Secretary for Clinical Operations will review and facilitate the distribution of interim guidance by December 2017 related to addressing clinical care concerns for privileged providers which will include documentation and maintenance of focused management reviews. This process has a target completion date of September 2018.

Recommendation 2: The Under Secretary for Health should specify in VHA policy a timeliness requirement for initiating reviews of providers’ clinical care after a concern is raised.

VA Comment: Concur. VHA’s Office of Quality, Safety, and Value, Medical Staff Affairs will rewrite policy to include timeline expectations for initiating a focused management review when a clinical care concern has been triggered for a privileged provider. Existing policy will be expanded to incorporate existing guidance documents related to the process of addressing clinical care concerns for privileged providers to facilitate standardization throughout the agency. The Assistant Deputy Under Secretary for Clinical Operations will review and facilitate the distribution of interim guidance by December 2017 related to addressing clinical care concerns for privileged providers which will include documentation and maintenance of focused management reviews. This process has a target completion date of September 2018.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***“VA HEALTH CARE: Improved Policies and Oversight Needed for Reviewing and
Reporting Providers for Quality and Safety Concerns”***
(GAO-18-63)

Recommendation 3: The Under Secretary for Health should require VISN officials to oversee VAMC reviews of providers’ clinical care after concerns are raised, including retrospective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool. This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner.

VA Comment: Concur. VHA’s Office of Quality, Safety, and Value, Medical Staff Affairs will update the standardized auditing tool that is to be utilized by the Veterans Integrated Service Network (VISN) Chief Medical Officers to include monitoring of appropriate action taken when a facility identifies a clinical care concern with a privileged provider. The VISN auditing tool will be revised by the end of the first quarter of fiscal year (FY) 2018 and will have a reporting structure to facilitate aggregate reporting to identify trends and issues. Oversight will be demonstrated through the resulting aggregate report at the end of FY 2018, which will be produced by VHA’s Office of Quality, Safety, and Value, Medical Staff Affairs. This process has a target completion date of October 2018.

Recommendation 4: The Under Secretary for Health should require VISN officials to establish a process overseeing VAMCs to ensure that they are reporting providers to the NPDB and SLBs, and are reporting in a timely manner.

VA Comment: Concur. VHA’s Office of Quality, Safety, and Value, Medical Staff Affairs will update the standardized auditing tool that is to be utilized by the VISN Chief Medical Officers to include monitoring of timely reporting to National Practitioner Data Bank in accordance with VHA Handbook 1100.17, National Practitioner Data Bank, specifically for adverse privileging actions and resignation while under investigation. The tool will also incorporate monitoring of timely reporting to state licensing boards when a facility has substantial evidence that a licensed provider has failed to meet the generally accepted standard of care. The VISN auditing tool will be revised by the end of the first quarter of FY 2018 and will have a reporting structure to facilitate aggregate reporting to identify trends and issues. Oversight will be demonstrated through the resulting aggregate report at the end of FY 2018, which will be produced by VHA’s Office of Quality, Safety, and Value, Medical Staff Affairs. This process has a target completion date of October 2018.

Appendix II: GAO Contacts and Staff Acknowledgments

GAO Contacts

Sharon M. Silas, (202) 512-7114 or silass@gao.gov
Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann (Assistant Director), Kaitlin M. McConnell (Analyst-in-Charge), and Summar C. Corley made major contributions to this report. Also contributing were Krister Friday, Jacquelyn Hamilton, Vikki Porter, and Brienne Tierney.

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