

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.