



Report to the Ranking Member,
Subcommittee on Oversight and
Investigations, Committee on Veterans'
Affairs, House of Representatives

February 2019

VETERANS HEALTH ADMINISTRATION

Greater Focus on
Credentialing Needed
to Prevent
Disqualified Providers
from Delivering
Patient Care

GAO Highlights

Highlights of [GAO-19-6](#), a report to the Ranking Member, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VHA provides health services to almost 9 million veterans at medical facilities nationwide. Through the credentialing process, VHA facilities determine whether providers have the appropriate professional qualifications to provide care. The NPDB is one information source VHA uses to determine whether providers have been disciplined by a state licensing board or a health-care facility. Such discipline results in "adverse actions," that may disqualify providers from practicing at VHA.

GAO was asked to review how allegations of provider misconduct are resolved. GAO examined (1) how officials at VHA facilities responded to adverse-action information received through NPDB, (2) how VHA facilities adhered to policies regarding providers with adverse actions, and (3) steps VHA has recently taken to ensure that providers meet licensure requirements. GAO analyzed a nonprobability sample of 57 health-care providers—including physicians, nurses, and dentists—working at VHA as of September 2016 who had an NPDB record. GAO considered factors such as the seriousness of the offense reported to NPDB. GAO reviewed state licensing-board documents. GAO also examined VHA policies, and interviewed VHA officials.

What GAO Recommends

GAO is making seven recommendations, including that VHA ensure that facility officials responsible for credentialing and hiring receive periodic mandatory training, and periodically review providers who have an adverse action reported in NPDB. The agency concurred with GAO's recommendations.

View [GAO-19-6](#). For more information, contact Kathy Larin at (202) 512-5045 or larink@gao.gov.

February 2019

VETERANS HEALTH ADMINISTRATION

Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care

What GAO Found

GAO found that Veterans Health Administration (VHA) facilities responded in various ways to adverse-action information from the National Practitioner Data Bank (NPDB) for the 57 providers reviewed, and in some cases overlooked or were not aware of adverse action.

- In some cases, providers had administrative or other nondisqualifying adverse actions reported in the NPDB, but VHA facilities determined they could be hired. For example, VHA hired a physician who had surrendered his physical-therapy license for not completing physical-therapy continuing education. Although his license surrender resulted in an adverse action in NPDB, VHA determined that there were no concerns about the provider's ability to perform as a physician.
- VHA facilities disciplined or removed providers when they learned about adverse actions reported in NPDB. In addition, after GAO raised questions about certain providers' eligibility, based on GAO's examination of adverse-action information, VHA facilities removed five providers that it determined did not meet licensure requirements.
- In some instances, VHA facilities overlooked or were unaware of the disqualifying adverse-action information in NPDB. In these cases, VHA facilities inappropriately hired providers, but some providers were no longer working at VHA at the time of GAO's review. For example, VHA officials told GAO that in one case, they inadvertently overlooked a disqualifying adverse action and hired a nurse whose license had been revoked for patient neglect. This nurse resigned in May 2017.

VHA facilities did not consistently adhere to policies regarding providers with adverse actions. Among other issues, GAO found that some facility officials were not aware of VHA employment policies. Specifically, GAO found that officials in at least five facilities who were involved in verifying providers' credentials and hiring them were unaware of the policy regarding hiring a provider whose license has been revoked or surrendered for professional misconduct or incompetence, or for providing substandard care. As a result, these five VHA facilities hired or retained some providers who were ineligible. VHA provides mandatory onetime training for certain VHA staff, but not for staff responsible for credentialing. The absence of periodic mandatory training may result in facility officials who are involved in credentialing and hiring not understanding the policies and hiring potentially ineligible providers.

VHA officials described steps they have taken to better ensure that providers meet licensure requirements. For example, VHA completed a onetime review of all licensed providers beginning in December 2017 and removed 11 providers who did not meet the licensure requirements as a result of this review. VHA officials said these types of reviews are not routinely conducted, and noted the review was labor intensive. Without periodically reviewing those providers who have an adverse action reported in NPDB, VHA may be missing an opportunity to better ensure that facilities do not hire or retain providers who do not meet the licensure requirements.

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Abbreviations

DEA	Drug Enforcement Administration
NPDB	National Practitioner Data Bank
PAID	Personnel and Accounting Integrated Data
QSV	Office of Quality, Safety and Value
SSN	Social Security number
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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February 28, 2019

The Honorable Jack Bergman
Ranking Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Bergman:

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health-care systems in the nation, serving almost 9 million veterans annually in recent years. To care for these veterans at its more than 1,200 medical facilities, VHA officials said that the agency has approximately 165,000 licensed health-care providers, such as physicians and nurses.¹ Oversight for these facilities is the responsibility of 18 regional offices, referred to as Veterans Integrated Service Networks (VISN).

VHA has stated that it seeks to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and patient experience.² VHA policy also states that one standard of care must be guaranteed regardless of provider, service, or location.³ To help ensure the quality of care provided by its staff, VHA requires each of its medical facilities to determine whether providers have the appropriate professional qualifications and clinical abilities to care for patients. This begins with the process of credentialing providers before they are hired. VHA hiring officials are to examine information derived from the provider's application, state licensing boards, professional

¹VHA officials told us that the approximately 165,000 licensed health-care providers include full-time and part-time employees, as well as volunteers and contractors. VHA has about 170 medical centers and over 1,000 outpatient sites. In this report, we refer to medical centers and outpatient sites collectively as "facilities."

²Department of Veterans Affairs, Veterans Health Administration, *Blueprint for Excellence* (September 2014).

³Veterans Health Administration, *Credentialing and Privileging*, VHA Handbook 1100.19 (Washington, D.C.: Oct. 15, 2012).

references, and the National Practitioner Data Bank (NPDB), among other information.⁴

The NPDB is available to help public and private health-care facilities identify health-care providers who may have a record of misconduct or substandard care. The Health Resources and Services Administration—an agency within the Department of Health and Human Services—maintains the NPDB. The NPDB is an electronic repository that includes information on health-care providers who have been disciplined by a state licensing board, professional society, or health-care entity (such as a hospital), have been named in a health care–related judgment or criminal conviction, or have been identified in some other adverse action.⁵ We refer to these actions collectively as “adverse actions.” The NPDB receives information from state licensing boards, as well as hospitals, health plans, and federal and state agencies, among other entities.⁶ VHA facilities utilize NPDB data in overseeing the providers who deliver services.

The presence of an NPDB report does not automatically disqualify a provider from working at VHA. Each VHA facility has broad discretion in hiring providers. Nevertheless, VHA facility medical staff leadership is required to review the information referenced in the report—such as state licensing-board documents—to determine the provider’s ability to practice, and to document its review.

⁴The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health-care practitioners, providers, and suppliers. Created by Congress, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance. See, 42 U.S.C. §§ 11111–11152.

⁵The NPDB also contains information on medical malpractice payments. Not all malpractice payments are a result of substandard care by specific providers. The NPDB contains malpractice-payment information made on behalf of a provider; however, a payment made as a result of a claim filed solely against an entity (such as a hospital) that does not identify a provider is not reportable to the NPDB.

⁶Although the NPDB contains information on health-care providers who have been disciplined, not all NPDB reports are adverse. For example, if a license is reinstated, that information would also be in the NPDB.

You asked us to examine how allegations of VA employee misconduct are investigated and resolved, among other items.⁷ As the NPDB is a key source of data that are available for VHA to identify potential misconduct and improve health-care quality, this report discusses (1) how officials at VHA facilities responded to adverse-action information received through the NPDB about selected providers, (2) how VHA facilities adhered to policies regarding providers with adverse-action information, and (3) steps VHA has recently taken to ensure that providers meet licensure requirements.

To determine how officials at VHA facilities responded to adverse-action information received through the NPDB about selected providers, we identified a nonprobability sample of 57 health-care providers for an in-depth analysis. Health-care providers in our sample include physicians, nurses, dentists, physical therapists, and social workers who have an NPDB report and who were working at VHA as of September 30, 2016.⁸ We considered factors such as the seriousness of the offense and total number of offenses when selecting our sample. We selected providers with a health care–related conviction or an adverse action, such as a revoked or surrendered license. For each of the individuals in our sample, we reviewed the VHA personnel and credentialing files. We accessed the VHA credentialing system, VetPro, to review information that VHA credentialing staff verified and considered as part of the hiring process. The information in VetPro included NPDB reports, licensure data uploaded by the provider, notes made by hiring officials, and material that demonstrated when VHA became aware of the adverse action reported in the NPDB. We accessed employee personnel actions through the Office of Personnel Management’s Electronic Official Personnel Folder system, and reviewed information related to hire, separation, and disciplinary actions. When applicable, we also reviewed employee misconduct files

⁷In response to your request, we also issued a report about VA employee misconduct and disciplinary actions. See GAO, *Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability*, [GAO-18-137](#) (Washington, D.C.: July 19, 2018).

⁸VA provided us with an extract of year-end rosters for fiscal years 2010 to 2016, the most-current data available at the time of our request. There were approximately 1,600 individuals working at VA in September 2016 who had an NPDB report. Not all individuals with NPDB reports are working at VA in a health-care position that requires a license, and not all NPDB reports are adverse. We started with 59 cases, but dropped two cases because when we reviewed the employee personnel files, we determined that the employees were not employed at VHA as of September 30, 2016. For details on our sample-selection methodology and data sets used in our analysis, see app. I.

and privileging files that document the types of procedures providers are permitted to perform at each facility.

Additionally, we obtained and reviewed state licensing-board documents for all providers in our sample, and performed follow-up research with licensing-board officials to clarify the meaning of the documentation. We conducted interviews with VHA facility officials to obtain information about how they assessed the NPDB adverse-action reports with regard to VHA policy.

We asked VHA facility and Central Office officials about how certain policies were applied to providers in our case-study sample, but we do not make conclusions about the correctness of VHA's interpretations or decisions.

Although we have examples of cases from each of the 18 VISNs, the results of the case-study analysis are illustrative and nongeneralizable. We also conducted interviews with Health Resources and Services Administration officials to discuss the NPDB and the quality of the data. For more information on the specific data sources used to generate our sample, and additional steps taken as part of the case-study review, see appendix I.

To determine how VHA facilities adhered to policies regarding providers with adverse actions, we reviewed applicable federal law and regulations as well as VHA directives and handbooks. We also reviewed VA Office of Inspector General reports and prior GAO work. In addition, as part of our case-study review, we examined how VHA policies were applied in hiring and retention decisions for the 57 selected providers.

To identify steps that VHA has recently taken to ensure that providers meet licensure requirements, we reviewed VHA reports, guidance provided to VHA credentialing staff, and other related documentation that outlines the implementation of these initiatives. We also interviewed VHA headquarters officials to discuss initiatives undertaken to identify providers who do not meet the licensure requirements and the outcome of those initiatives.

To address all of our objectives, we interviewed senior officials from VHA's Office of Quality, Safety and Value (QSV), and Office of Workforce Management and Consulting, as well as medical-facility officials responsible for verifying credentialing information and for human resources, and officials with the Office of VA Pharmacy Benefits

Management Services. We also interviewed officials with the Drug Enforcement Administration (DEA) about DEA registration certificates and waivers.⁹ Further details about our scope and methodology can be found in appendix I.

We conducted this performance audit from October 2015 to February 2019 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.

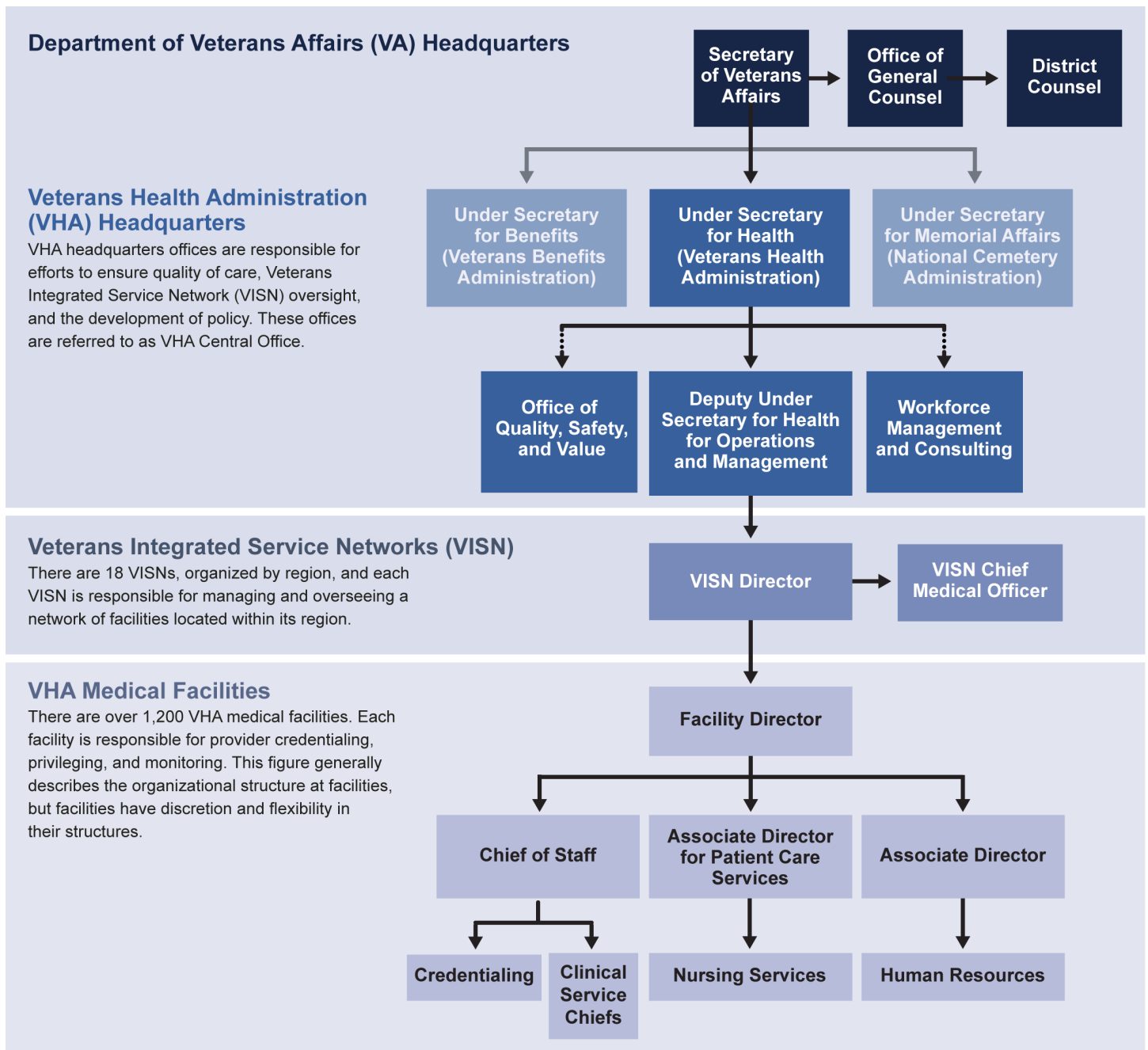
Background

VA Organization, Roles, and Responsibilities

VA has three major administrations: VHA, the Veterans Benefits Administration, and the National Cemetery Administration. Our work is focused on VHA. Figure 1 below highlights key aspects of VHA's organizational structure.

⁹DEA was not audited as part of our work. We interviewed subject-matter experts at DEA to learn about DEA registration requirements and waivers.

Figure 1: Key Aspects of VHA's Organizational Structure



Source: GAO analysis of VA information. | GAO-19-6

Note: District Counsel serves as VHA's in-house counsel, advising VHA medical facilities and VISN officials.

The Secretary of Veterans Affairs is the head of VA and is responsible for the proper execution of all laws by VA, and for the control, direction, and management of the agency. District Counsel serves as VHA's in-house counsel, advising local facilities and VISN officials. The Under Secretary for Health is responsible for the leadership and direction of VHA, and is responsible for maintaining and operating a national health-care delivery system for eligible veterans. The Office of Quality, Safety and Value (QSV) is responsible for overseeing VHA-wide credentialing and privileging policy, which includes requirements for the continuous monitoring of physician performance.¹⁰ Workforce Management and Consulting provides VHA-wide leadership for workforce operations and administration management, including providing VHA staffing, recruitment, and training support. The Deputy Under Secretary for Health for Operations and Management is responsible for, among other things, assuring that all 18 VISNs implement a credentialing and privileging process at each facility consistent with VHA policy.¹¹

VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to veterans. VHA specifically decentralized its decision-making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations. Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to the Deputy Under Secretary for Health for Operations and Management within VHA's Central Office. Each VISN has a VISN Director, who reports to the Deputy Under Secretary for Health for Operations and Management, and a VISN Chief Medical Officer, who reports to the VISN Director. The VISN Chief Medical Officer is responsible for the oversight of the credentialing and privileging process of facilities in the VISN's area of responsibility.

VHA policy provides each facility with broad discretion over hiring decisions. Within each facility, the facility Director has the ultimate

¹⁰Examples of continuous monitoring of physician performance include (1) Ongoing Professional Practice Evaluations, in which the facility evaluates and documents physician performance using available data, and (2) Focused Professional Practice Evaluations, in which the facility evaluates the privilege-specific competence of a physician who does not have documented evidence of competently performing the privilege requested.

¹¹In October 2015, VHA began realigning its VISN network, which included merging several VISNs. This realignment decreased the number of VISNs from 21 to 18. See [GAO-16-803](#). VISNs are not numbered sequentially.



responsibility for credentialing and privileging. Credentialers employed by each facility verify elements of the provider's application, including licensure, education, work history, and clinical references, as well as malpractice history and NPDB reports, if applicable. VHA Central Office officials told us that generally the credentialing staff who focus on the licensed independent practitioners are aligned under the Chief of Staff, and the credentialing staff who focus on the dependent providers are aligned under Human Resources offices.¹²

Credentialing, Privileging, and Monitoring

According to VHA policies, all licensed health-care providers must be credentialed before they are permitted to work. Examples of health-care provider occupations that require credentialing are shown in figure 2 below.

¹²Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Dependent providers, such as registered nurses, provide patient care under the supervision or direction of a licensed independent practitioner.

Figure 2: Examples of Health-Care Provider Occupations That Require Credentialing

Occupation	Description
 Physician	A doctor of medicine or osteopathy who is legally authorized by a state to practice medicine or surgery.
 Dentist	A doctor of dental surgery, a doctor of dental medicine, or the equivalent who is legally authorized by a state to practice dentistry.
 Nurse Practitioner	Practices in a variety of settings, including hospital outpatient clinic, nursing home, domiciliary, and home care. Responsibilities include delivering essential and preventive care, providing patient and family education, and coordinating all care services.
 Registered Nurse	Assesses and provides care to patients. Responsibilities include administering patient medication, documenting patients' medical conditions, analyzing test results, and operating medical equipment.
 Licensed Practical Nurse^a	Takes patient vital signs, provides basic care, and administers medications, but generally does not provide certain complex patient-care services such as patient assessments or administration of intravenous medications.
 Physical Therapist	Assists patients with improving their movement and manages their pain, as part of rehabilitation, treatment, and prevention efforts.
 Social Worker	Assists patients with solving and coping with problems. Clinical social workers also diagnose and treat mental, behavioral, and emotional issues.

Source: Analysis of Department of Veterans Affairs, Department of Health and Human Services, Department of Labor, and GAO data. | GAO-19-6

^aLicensed practical nurses and licensed vocational nurses have the same level of education and patient-care responsibilities. We use "licensed practical nurse" to refer to both licensed practical nurses and licensed vocational nurses.

Credentialing refers to the process of screening and evaluating qualifications and other credentials—including licensure, education, and relevant training—which is the first step in the process of determining whether the provider has appropriate clinical abilities and qualifications to

provide medical services. VHA policy requires facilities to use VetPro, a web-based credentialing database that is meant to facilitate completion of a uniform, accurate, and complete credentials file.¹³

Once the provider submits his or her required credentialing information, a facility employee—usually the credentialer—collects documentation from the original source for each credential, in order to confirm the factual accuracy of the information. For example, the credentialer would typically contact educational institutions to confirm dates of participation and program completion. This is referred to as primary-source verification. The credentials file contains information that the credentialer primary-source verified, including the provider’s licensure status, any adverse actions reported to the NPDB, education, and experience.

Health-care providers fall into two categories, which affect the process by which they are credentialed and monitored:


- Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Examples of licensed independent practitioners are doctors and dentists. VHA policy states that only licensed independent practitioners may be granted clinical privileges. Privileging is a process through which a provider is permitted by a facility to independently provide medical or patient care that is in alignment with the provider’s clinical competence, based on the provider’s clinical competence as determined by peer references, professional experience, education, training, and licensure, among other items. Licensed independent practitioners are privileged for a maximum of a 2-year term, and VHA facility officials must reevaluate their credentials before their contract is renewed or appointment extended.
- Dependent providers, such as registered nurses, provide patient care under the supervision or direction of a licensed independent practitioner. VHA policies do not place a time limit on a dependent provider’s term. According to VHA Central Office officials, dependent providers are typically appointed for an indefinite term. VHA facility officials evaluate the dependent provider’s credentials prior to the provider’s appointment.

¹³VHA Handbook 1100.19 and Veterans Health Administration, *Credentialing of Health Care Professionals*, VHA Directive 2012-030 (Washington, D.C.: Oct. 11, 2012).

Facilities generally have committees responsible for reviewing provider credentials, referred to in this report as “credentialing committees.” While the credentialing processes for licensed independent practitioners and dependent providers follow a similar (but not identical) path, the monitoring processes after appointment differ.¹⁴ Figure 3 below describes the credentialing processes for licensed independent practitioners and dependent providers.

¹⁴According to VHA Central Office officials, the members of the credentialing committees for licensed independent practitioners and dependent providers are generally different.

Figure 3: VHA's Credentialing and Privileging Process

		Licensed independent practitioners	Dependent providers
 <p>Credentialing The process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training, and experience.</p> <p>Privileging A process through which a provider is permitted by a facility to independently provide medical or patient care that is in alignment with the provider's clinical competence.</p>	<p>1 A provider submits an application for a position at a Veterans Health Administration (VHA) facility.</p>	✓	✓
	<p>2 Facility credentialing officials verify information.^a Credentialers verify elements of the provider's application, including licensure, education, work history, and clinical references, as well as malpractice history and National Practitioner Data Bank (NDPB) reports, if applicable.</p>	✓	✓
	<p>3 Facility Service Chief reviews information and decides whether or not to recommend appointment. The cognizant Service Chief—the manager responsible for a particular clinical service area such as surgery or medicine—reviews the information collected by credentialing officials and Human Resources offices and makes a recommendation about whether or not to appoint the provider.</p>	✓	✓
	<p>For licensed independent practitioners, the Service Chief also reviews the clinical privileges requested by the provider.</p>	✓	N/A
	<p>4 Facility credentialing committees review information and decide whether or not to recommend appointment to the facility Director.^b The cognizant credentialing committee reviews the provider's verified credentialing file and the Service Chief's recommendation and makes a recommendation to the facility Director about whether or not to appoint the provider.</p>	✓	✓
<p>For licensed independent practitioners, the credentialing committee also determines whether clinical privileges should be granted as requested by the provider, and makes a recommendation to the facility Director.</p>	✓	N/A	
<p>5 The facility Director makes the final decision as to whether to appoint the provider.^c The facility Director reviews the Service Chief and credentialing committee recommendations and decides whether or not to appoint a provider.</p>	✓	✓	
<p>For licensed independent practitioners, the facility Director also determines whether clinical privileges should be granted as requested by the provider.</p>	✓	N/A	

✓ Applicable

N/A Not applicable

Source: GAO analysis of Department of Veterans Affairs information. | GAO-19-6

Note: Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Examples of licensed

independent practitioners are doctors and dentists. Dependent providers, such as registered nurses, are individuals who provide patient care under the supervision or direction of a licensed independent practitioner.

^aVHA officials told us that, concurrent to the credentialing process, Human Resources officials at the facilities complete preemployment checks, including drug testing, suitability review, and criminal-background checks.

^bWe refer to committees that review the provider's credentials as "credentialing committees." VHA officials told us that the facility's Executive Committee of the Medical Staff—comprising the facility's medical staff leadership—is responsible for reviewing credentials and privilege requests for licensed independent practitioners. They said that the facility's Professional Standards Board—comprising peers from the provider's occupation—is responsible for reviewing credentials for dependent providers. If there is no Professional Standards Board for the occupation that the provider is applying for, they told us that the credentialing file is reviewed by a second credentialing professional to ensure that credentialing is completed in accordance with policy.

^cVHA officials told us that for dependent providers, the approving official may be someone other than the facility Director.

According to VHA policy, in addition to the steps outlined above, facility officials must consult with the VISN Chief Medical Officer in certain instances, and must document VISN Chief Medical Officer consultation in VetPro. Specifically, VISN Chief Medical Officer review is required if a licensed independent practitioner


- enters into an agreement with a state licensing board (disciplinary or nondisciplinary) to not practice the occupation in a state;
- has or has ever had a license restricted, suspended, limited, placed on probation, or denied upon application; or
- has malpractice payments in excess of certain thresholds.¹⁵

Facilities are also to query the NPDB before the licensed independent practitioner or dependent provider is appointed. In addition, facilities enroll licensed independent practitioners in NPDB continuous query, and are reenrolled annually. NPDB continuous query automatically alerts VHA

¹⁵VHA Handbook 1100.19. VA policy specifies that the VISN Chief Medical Officer would review a provider if the payments met one of these thresholds: (1) three or more medical malpractice payments in the provider's payment history, (2) a single malpractice payment of \$550,000 or more, or (3) two medical malpractice payments totaling \$1,000,000 or more.

when there is a new NPDB report.¹⁶ Figure 4 below describes the facility's monitoring process after a provider is hired.

Figure 4: VHA's Process to Monitor Provider Licenses

		Licensed independent practitioners	Dependent providers
 <p>Monitoring Veterans Health Administration (VHA) facilities monitor the provider's licenses to identify adverse actions and to verify that licenses are renewed.</p>	<ul style="list-style-type: none"> VHA facilities review licensed independent practitioners' clinical privileges at least every 2 years. Among other items, facility officials confirm licensure status, professional competency, and malpractice history, when deciding whether or not to renew licensed independent practitioners' privileges. 	✓	N/A
	<ul style="list-style-type: none"> VHA facilities enroll licensed independent practitioners in the National Practitioner Data Bank (NPDB) continuous query. Through an electronic interface, NPDB continuous query alerts VHA if any entity files a report on one of VHA's licensed independent practitioners. Facilities reenroll licensed independent practitioners in NPDB continuous query annually. 	✓	N/A
	<ul style="list-style-type: none"> VHA facilities verify the provider's license by contacting the state licensing board when it is up for renewal—typically every 1 to 2 years, depending on the state and type of license—to ensure that the license is in good standing. 	✓	✓

✓ Applicable
N/A Not applicable

Source: GAO analysis of Department of Veterans Affairs information. | GAO-19-6

Note: Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Examples of licensed independent practitioners are doctors and dentists. Dependent providers, such as registered nurses, are individuals that provide patient care under the supervision or direction of a licensed independent practitioner.

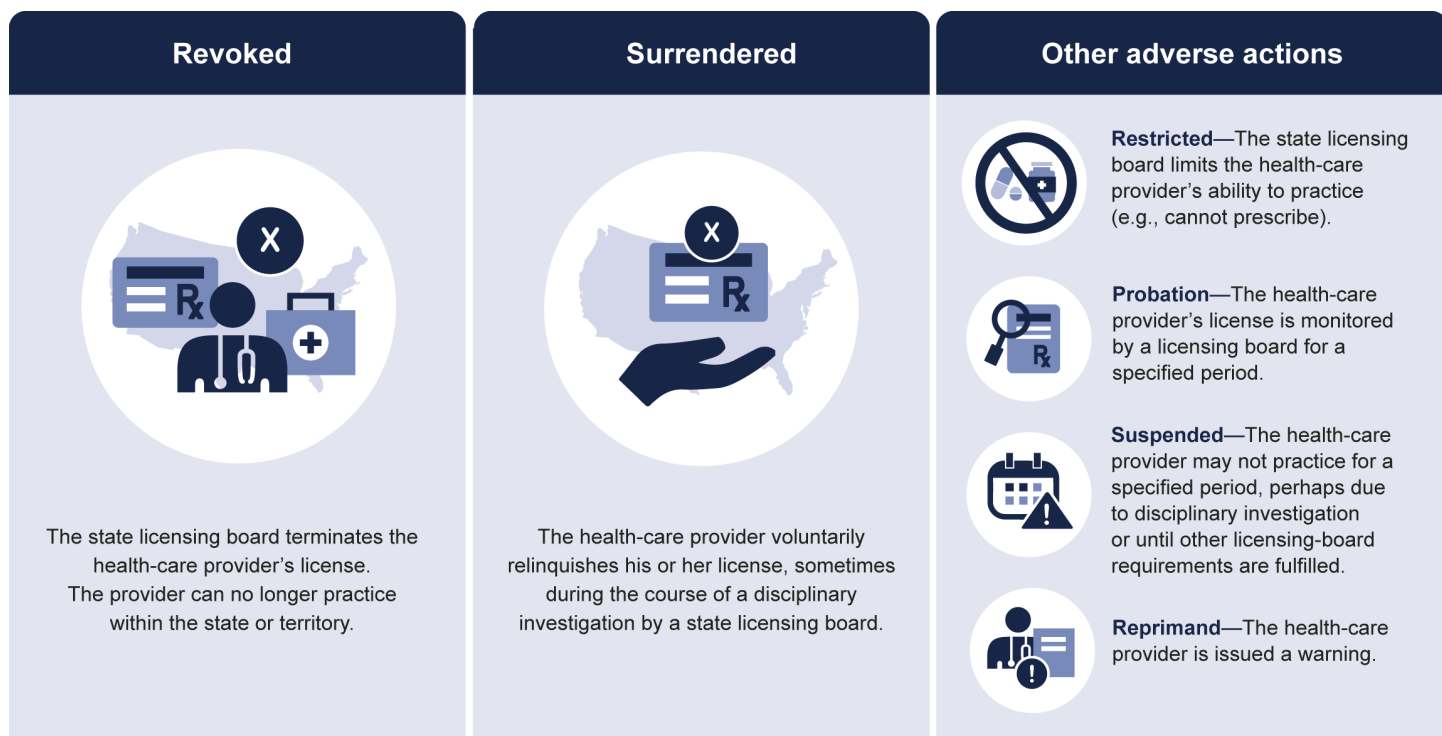
State Licensing Boards

State licensing boards issue licenses for health-care providers, including physicians, dentists, social workers, and nurses. According to officials from the Health Resources and Services Administration—the agency that

¹⁶VHA Central Office officials noted that VHA's enrollment in NPDB continuous query exceeds The Joint Commission standards. The Joint Commission is a nonprofit organization that evaluates and accredits more than 16,000 health-care organizations in the United States, including hospitals. The Joint Commission standard is to query the NPDB at specified times, including before granting new privileges. As noted in [GAO-10-26](#), VA policies on credentialing, privileging, and monitoring address or exceed the Joint Commission's accreditation standards.

maintains the NPDB—there are approximately 700 state licensing-board entities registered with the NPDB.¹⁷ Licensing boards are also responsible for regulating the profession, investigating complaints, and disciplining providers who violate the law or regulations. Licensing boards can take a number of adverse actions, some of which are highlighted in figure 5 below.

Figure 5: Examples of State Licensing-Board Adverse Actions



Source: Federation of State Medical Boards. | GAO-19-6

¹⁷Health Resources and Services Administration officials noted that not all 700 entities license health-care providers; some license health-care entities, such as hospitals, and medical suppliers. They also noted that some entities are made up of several licensing boards that interact with the NPDB administratively as a single entity, even though within the state's structure the boards are separate.

VHA Licensure and Controlled-Substances Registration Policies and Requirements

According to statute and VHA policy, applicants or employees in certain health-care occupations must have at least one full, active, current, and unrestricted license.¹⁸ For licensed independent practitioners, the license must authorize the provider to practice outside of VHA. VHA providers may be licensed in more than one state, and they are permitted to practice both at VHA and non-VHA facilities simultaneously. VHA providers are not required to be licensed by the state where the VHA facility is located because of the supremacy of federal laws over state laws. As long as they have an active license issued by a state, territory, or district of the United States, providers can work at any VHA facility.

According to statute and VHA policy, applicants or employees who have been licensed in more than one state and who

- have had a license revoked for professional misconduct, professional incompetence, or substandard care;¹⁹ or
- voluntarily surrender a license after being notified in writing by that state of potential revocation of the license for professional misconduct, professional incompetence, or substandard care,

are not eligible for appointment or continued employment, unless the revoked or surrendered license is restored to a full and unrestricted status.²⁰ In this report, we refer to actions taken on the basis of professional misconduct, professional incompetence, or substandard care, as “for cause.”

Providers are responsible for maintaining their licenses in good standing, and must inform VHA of any changes in the status of their credentials. VHA policy requires applicants and providers to notify VHA within 15 days

¹⁸38 U.S.C. § 7402; Department of Veterans Affairs, *Staffing*, VA Directive 5005 (Washington, D.C.: Apr. 15, 2002); VHA Handbook 1100.19; and VHA Directive 2012-030.

¹⁹See 38 U.S.C. § 7402(f). VHA policy provides examples of substandard actions that raise concern for patient safety; see Veterans Health Administration, *Reporting and Responding to State Licensing Boards*, VHA Handbook 1100.18 (Washington, D.C.: Dec. 22, 2005).

²⁰Individuals who were appointed prior to November 30, 1999, and have been on continuous appointment since that date are not disqualified for employment by any license, registration, or certification revocations or voluntary surrenders that predate November 30, 1999, provided they possess one full and unrestricted license as applicable to the position.

after receiving notification of proposed or final actions that would adversely affect or limit their credentials or clinical privileges.²¹

VHA considers the necessity of providers holding DEA registrations—which allows providers to prescribe controlled substances—on a case-by-case basis. If providers are in a position that requires them to prescribe controlled substances, they would need to have an individual DEA registration.²² According to DEA officials, 22 states require providers to obtain state-level controlled-substances licenses. DEA requires providers to meet the state’s controlled-substances requirements before they are granted a federal DEA registration. DEA is required to report providers with controlled-substances registration adverse actions to the NPDB. VHA Central Office officials told us that if a provider has a DEA registration, that information would be verified by the credentialer. However, if the position does not require the provider to prescribe controlled substances, a DEA registration is not necessary to work at VHA.

Prior GAO work

We previously reported on issues related to oversight of VHA health-care providers. For example, we examined VHA facilities’ reporting of providers to the NPDB; adherence to performance pay policies; response to clinical incidents that may pose the risk of injury to a patient; and oversight of the physician credentialing and privileging process. We issued pertinent recommendations, such as having VHA require VISN-level officials oversee facility reviews of provider’s clinical care after concerns have been raised, and VA concurred with most of them. See appendix II for a detailed description of our previous work and the status of the recommendations.

²¹VHA Handbook 1100.19 § 12(c) and (d). VHA Directive 2012-030 § 4(i).

²²Starting in January 2017, VA required providers who prescribe controlled substances to obtain their own DEA registration. Prior to January 2017, they were permitted to use the facility DEA registration. Some states also require a state-level registration to prescribe controlled substances. VHA policy requires providers who are licensed in states that require a state-level registration and who prescribe controlled substances to obtain a state-level registration.

VHA Facilities Responded in Various Ways to Adverse-Action Information from NPDB and in Some Cases Overlooked Disqualifying Actions and Hired the Provider

Our review of 57 case studies found that VHA facilities responded to adverse-action information they received through the NPDB about providers in various ways.²³ In some cases, some facilities evaluated adverse-action information and determined that providers had administrative or other nondisqualifying adverse actions reported in NPDB, and concluded that the providers could be hired or retained. In other cases, VHA facilities disciplined, removed or reported providers to appropriate authorities as a result of their adverse actions. However, we also identified cases where VHA facilities did not respond to adverse-action information from NPDB because they were unaware of or overlooked disqualifying information. In these cases, VHA facilities inappropriately hired providers whose actions were reported in NPDB, although these providers no longer work at VHA.

Cases evolve over time and can span multiple categories, which is why we do not enumerate the number of cases we found that fit into these various categories.²⁴ For example, in some of the cases we reviewed, a VHA facility hired a provider who had a disqualifying adverse action, and later removed that provider. In some cases, the facility retained a provider with an adverse action, but also took disciplinary or administrative action, such as removing the provider from patient care.

VHA policy provides each facility with broad discretion over hiring decisions. As discussed above, while we asked VHA facility and Central Office officials about how certain policies were applied to providers in our case studies, we did not evaluate VHA's interpretations or decisions.

²³For a high-level summary of the 57 cases we reviewed, see app. III. The results of our case-study analysis are illustrative and nongeneralizable.

²⁴To avoid revealing the identities of providers mentioned in the report, we removed names and use "he" and "his" throughout the report regardless of the gender of the provider. We also removed the state names as well as VHA VISN- and facility-identifying information.

Some Providers Had Administrative or Other Nondisqualifying Adverse Actions Reported in NPDB, and VHA Facilities Determined They Could Be Hired or Retained

VHA policy allows providers with adverse actions reported in the NPDB to work at VHA, if the provider has at least one full, active, current, and unrestricted license, and does not have a license that is revoked or surrendered for cause.²⁵ In some cases, the facility—in accordance with VHA policies—hired a provider with an adverse action reported in the NPDB, as it determined that the issue was administrative (unrelated to patient care), or the license with the adverse action was not required for the position. For example:

- Case 6—The provider was hired as a practical nurse in January 2003, and continues to work at VHA. The NPDB indicates that, in June 2015, one state revoked the provider’s license after the provider did not complete a required course. VHA facility officials determined that the provider had an active license in another state or territory and retained the provider.
- Case 35—The provider was appointed as a physician in November 2013, and continues to work at VHA. The NPDB indicates that the provider surrendered his physical-therapist license in March 2003, after failing to complete the continuing-education requirements for physical therapy. VHA facility officials concluded that because the license surrender was administrative, and because the provider has an active and unrestricted physician license, the provider met the licensure requirements for working at VHA. VHA facility officials documented in their hiring justification that the provider had surrendered his physical therapist’s license, but VHA had no concerns about the provider’s ability to perform as a physician.

In addition to the cases highlighted above, we found other instances in which the adverse action reported in the NPDB was administrative, or the license with the adverse action was not required for the position. For other examples, see appendix III, Cases 5, 13, 15, 17, 24, 29, and 57.

In some cases, although the licensing-board documents cite adverse actions related to patient care, public safety, or unprofessional conduct, VHA determined that the adverse actions were nondisqualifying, and hired or retained the provider. For example:

- Case 18—The provider was hired by a VHA facility as a physician in January 2016 and continues to work at the facility. The NPDB

²⁵We refer to actions taken on the basis of professional misconduct, professional incompetence, or substandard care as “for cause.”

indicates that, among other items, the provider surrendered one license in August 2004. The licensing-board document states that a former patient filed a complaint alleging that the provider engaged in “unprofessional conduct,” and that “probable cause exists to substantiate charges of disqualification from the practice of medicine.” Furthermore, the licensing-board documents state that the provider “agrees not to apply for a medical license again in [that state] at any time in the future” and the provider understood if he did so, “the request for medical licensure would be denied.” According to VHA policy, applicants are ineligible for appointment if they have voluntarily surrendered a license after being notified in writing by the state that issued the license of potential revocation for cause, unless the surrendered license is restored to a full and unrestricted status. However, facility officials told us that because the provider surrendered his license before the licensing board could file formal charges, he met the licensure qualifications to work at VHA. This provider had an active and unrestricted license in another state when he was hired.

- Case 31—The provider was hired as a registered nurse by a VHA facility in March 2013 and continues to work at the facility. The NPDB indicates that, among other items, the provider surrendered his license in one state in 1998, after the licensing board informed him that it would investigate him due to concerns that the provider “may not be safe and competent to practice nursing.” An official from the licensing board confirmed to VHA facility officials that the provider “voluntarily surrendered” his nursing license “due to abandonment of patients.” According to VHA policy, applicants are ineligible for appointment if they have voluntarily surrendered a license after being notified in writing by the state that issued the license of potential revocation for cause, unless the surrendered license is restored to a full and unrestricted status. VHA facility officials said that the provider was eligible for employment because the disciplinary notice did not specifically state that the provider’s license could be revoked. VHA Central Office officials explained that a licensing board may investigate an issue and decide not to discipline a provider, so an investigation alone is not grounds for denying an appointment. They further stated that the policy is written to disqualify providers who would have had their license revoked, so, absent clear evidence that the license would have been revoked, a voluntarily surrendered license would not disqualify a provider from working at VHA.
- Case 54—The provider was hired by a VHA facility as a registered nurse in March 2002, and continues to work at VHA. The NPDB indicates that, in February 2008, one licensing board placed a

reprimand on the provider's license. The licensing-board document cited concerns about the provider's ability to safely practice, noting that "the Board finds that there exists serious risks to public health and safety as a result of impaired nursing care due to intemperate use of controlled substances or chemical dependency." The board also listed three convictions related to Driving Under the Influence arrests between August 1984 and January 1999, one Assault conviction in 1998, and one Disorderly Conduct–Fighting in Public conviction in 2006. According to VHA policy, as long as a provider has at least one full, active, current, and unrestricted license, a reprimand on a license does not automatically disqualify a provider from employment. VHA policy also requires providers to notify VA within 15 days after receiving notification of proposed or final actions that would adversely affect or limit their credentials. VHA did not learn about the license reprimand until the registered nurse disclosed the board action in September 2008. VHA facility officials told us that the provider was not disciplined for failing to disclose the prior convictions. They said that they determined that the licensure issue was an ethical concern, rather than a patient-care concern. VHA Central Office officials told us that there are no separate credentialing policies or guidance related specifically to substance use; instead these are treated as suitability issues. VHA Central Office officials said that this provider would have undergone a background check when he was hired to ensure that he was suitable for employment.²⁶ VHA Central office officials also noted that the facts and circumstances surrounding substance use can vary from case to case and that each instance would need to be considered individually.

In addition to the cases highlighted above, we found other instances in which VHA hired or retained providers who it determined had other nondisqualifying adverse actions related to patient care, public safety, or unprofessional conduct reported in the NPDB. For other examples, see appendix III, Cases 7, 12, 22, 23, 30, 32, 38, 45, 48, 53, and 56.

VHA Central Office officials said that it is possible for one facility to determine that a provider is eligible for employment, while another facility

²⁶Central Office officials said that as part of the background check, prior convictions would have been flagged and considered towards the suitability determination for employment. They said that suitability determinations are based on careful, objective analysis of information about a person's character and conduct that is relevant to the criteria set forth in 5 C.F.R. Part 731. Central Office officials also said that VA's Office of Human Resources Management has guidance about how to appropriately assess an employee who may be impaired while at work.

determines that the same provider is ineligible. We found one case in which different VHA facilities came to different conclusions about a provider's qualifications; one VHA facility denied employment to a provider based on adverse actions reported in the NPDB, but a separate VHA facility hired this provider. Specifically:

- Case 33—The provider was hired as a physician in one VISN in October 2010 and continues to work at a VHA facility. The NPDB indicates that in September 2006 one licensing board (State 1) issued a reprimand citing failure to review an X-ray and to discuss the results with the patient. The patient was later diagnosed with Stage 4 cancer that had metastasized. In September 2007, the provider surrendered his license in another state (State 2) after the State 2 licensing board determined that disciplinary action had been taken against the provider by a licensing board (State 1). According to VHA policy, applicants who voluntarily surrender a license after being notified in writing by the state that issued the license of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status.

This physician applied for an appointment at a VHA facility in August 2010 and officials there chose not to appoint the provider because they determined that this physician surrendered his State 2 license for cause and was disqualified from working at VHA.²⁷ However, VHA facility officials at a different facility and in another VISN hired the provider in October 2010. Facility officials where the provider was hired told us that District Counsel reviewed board documents and determined that the license was surrendered voluntarily for administrative reasons, making him eligible for employment.

VHA Central Office officials told us that facilities make their own hiring decisions and are responsible for ensuring that providers meet the licensure requirements. They said that VHA hires a high volume of employees, and that the Central Office does not have visibility into each case. When asked about Case 33, VHA Central Office officials said that they cannot comment on how the two facilities came to different conclusions, as they do not know what the discussions were with their respective District Counsel. They said that when there are questions

²⁷Specifically, the facility that did not hire the provider determined that the provider had surrendered his State 2 license after being notified of potential termination of his license for professional misconduct, professional incompetence, or substandard care, and therefore did not meet the licensure qualifications for employment at VA.

about a provider's qualifications, they refer facility officials to District Counsel, and that the facilities could have come to different conclusions if the information presented to their District Counsel differed.

VHA Facilities Disciplined, Removed, or Reported to Appropriate Authorities Providers Who Had Adverse Actions

In some cases, we found that when a VHA facility learned about adverse actions against a provider in an NPDB report, it took administrative or disciplinary action, such as placing the provider on nonduty status or removing the provider from employment. For example:

- Case 8—The provider was hired as a registered nurse by a VHA facility in November 2013 and was removed from employment in March 2018, as a result of a VHA-wide license review. The NPDB indicates that, in June 2014, a licensing board revoked the provider's license due to alleged drug diversion. In November 2014 the provider's license was restored, when the board found that there was insufficient evidence to support the allegations. According to VHA policy, employees who have had a license revoked for professional misconduct, professional incompetence, or substandard care are not eligible for continued employment, unless the revoked license is restored to a full and unrestricted status. When the facility learned about the revoked license, it placed this provider on paid nonduty status to give him time to get his license restored. Facility officials told us that this provider was on paid nonduty status for about 7 months—from August 2014 to March 2015—when he returned to work.²⁸ In March 2018, the facility removed the provider as part of a VHA-wide license review, when the facility determined that this provider did not meet the licensure qualifications. Officials from the licensing board confirmed that the provider's license was restored in November 2014. VHA facility officials did not dispute that this provider's license was restored in 2014, but said that District Counsel instructed them to remove the provider from employment. VHA Central Office officials told us that his removal was appropriate because his license was revoked for cause in June 2014.
- Case 46—The provider was hired as a physician by a VHA facility in February 2016 and was removed from employment in October 2016

²⁸On the basis of VHA policy, the provider should have been immediately separated from VHA when he no longer met the licensure requirements, and then allowed to reapply if his license was reinstated. Facility officials said that they did not remove the provider because they did not think that the provider received the disciplinary notice from the licensing board because the provider moved.

when the VHA facility determined that a state licensing board restricted the provider's license. The NPDB indicates that, in September 2016, the licensing board entered into an agreement with the provider because of concerns that the provider "may have misdiagnosed children with bipolar I disorder and used excessive dosages and inappropriate medication to treat children." Under the terms of the licensing-board agreement, the provider is not permitted to treat children. According to VHA policy, providers must have at least one full, active, current, and unrestricted license. VHA Central Office officials told us that they rely on their counsel to determine whether or not a license is restricted, taking into account the duties of the position. Even though this provider was not treating children at VHA, VHA facility officials determined that the provider's license was restricted because the agreement prohibits him from seeing children, and this provider was removed from VHA.

In addition to the cases highlighted above, we found other instances in which VHA took disciplinary or administrative action on a provider when it learned of the adverse-action information reported in NPDB. For other examples, see appendix III, Cases 11, 25, 41, 43, 44, 45, 50, 51, and 55.

On the basis of our inquiries, VHA facilities also removed five providers who they determined after further review did not meet the licensure requirements. Specifically, VHA determined that these providers had a license that was revoked or surrendered for cause, or that the license was restricted. For example:

- Case 16—The provider was hired by a VHA facility as a physician in September 2012 and retired in lieu of involuntarily action in December 2017.²⁹ The NPDB indicates that, among other items, the provider surrendered his license in one state in August 2015, after the licensing board determined that this provider failed to disclose on his renewal application several arrests and convictions for driving while under the influence. In its notification letter, the licensing board stated that it would determine the appropriate discipline, which could include revocation of the provider's license. According to VHA policy, employees who surrender a license after being notified in writing by

²⁹An employee who is eligible for retirement under 5 U.S.C. § 8336 may, in some circumstances, retire before the agency separates or takes other involuntary action against the employee. The Office of Personnel Management, which issues the SF-50 and which advises agencies on various aspects of benefits administration, instructs agencies to mark such retirements as Retirement—ILIA (In Lieu of Involuntary Action), rather than as Voluntary.

the state that issued the license of potential termination of their license for professional misconduct, professional incompetence, or substandard care are not eligible for continued employment unless the surrendered license is restored to a full and unrestricted status. Initially, facility officials told us that when this provider was hired, facility officials reviewed the circumstances surrounding the surrendered license and determined that the provider was eligible because the issues were unrelated to patient care and the provider had one active, unrestricted license. However, after our inquiries, VHA facility officials reviewed this license again and determined the provider was not eligible for continued employment because the surrendered license disqualified him from VHA employment.

- Case 19—The provider was hired by a VHA facility as a physician in August 2002 and retired in lieu of involuntarily action in December 2017. The NPDB indicates that the provider surrendered his Drug Enforcement Administration (DEA) registration in June 2015, among other items.³⁰ In January 2015 one licensing board (State 1) suspended this provider’s license for 30 days, followed by indefinite probation for a minimum of 2 years. The State 1 licensing board found that the provider prescribed controlled substances to patients without conducting a complete examination; failed to consistently address “red flags” of abuse and dependence exhibited by patients; and failed to take steps to prevent and detect substance abuse. The State 1 licensing-board documents state that the provider engaged in these prescribing practices outside of VHA.

Although the physician surrendered his individual DEA registration in June 2015, according to VHA facility documents, he prescribed controlled substances on two occasions in July and August 2015 using the facility’s DEA registration.³¹ In late August 2015, VHA facility officials completed a review of the provider’s prescribing actions for

³⁰VA considers the necessity of a DEA registration on a case-by-case basis. Facility officials told us that the provider did not need a DEA registration, as the provider’s position did not require the provider to prescribe controlled substances.

³¹According to DEA’s manual for practitioners, providers who are employees of a hospital or other institution may dispense, administer, or prescribe controlled substances under the DEA registration of the hospital or other institution provided: dispensing, administering, or prescribing is in the usual course of the provider’s professional practice; the hospital or other institution has verified that the provider is permitted within the state to dispense, administer, or prescribe controlled substances; and the provider acts only within the scope of his employment. When authorizing the provider to dispense or prescribe under its registration, the hospital or other institution must also assign a unique internal code number to the provider.

the preceding year and said they did not identify any issues. VHA facility officials also reviewed the physician's privileges and decided that the physician would no longer be allowed to prescribe controlled substances. According to VHA facility officials, there was no need for the provider to prescribe controlled substances as part of his role.

DEA officials said that the facility would need to obtain a waiver to employ the provider, and that the employment waiver would not necessarily permit the provider to prescribe controlled substances.³² DEA officials said that if they grant a waiver, it is limited to a specific provider and a specific facility, and the conditions are spelled out in the waiver.

Drug Enforcement Administration (DEA) Waiver Requirements

DEA enforces the controlled-substances laws and regulations of the United States.

According to DEA regulation, registrants—including Veterans Health Administration facilities—must obtain a waiver of federal regulations from DEA before employing a provider who has

- been convicted of a drug-related felony, or
- had a DEA registration revoked or denied, or
- surrendered a DEA registration for cause.

Source: GAO analysis of DEA requirements. | GAO-19-6

VHA facility officials said they were unaware that a waiver from DEA was needed to continue to employ the physician, and therefore did not request one.³³ VHA facility officials told us that they do not plan to report the provider to DEA because the provider used the facility's DEA registration when prescribing controlled substances. However, according to a DEA official, the VHA facility should have reported the provider to DEA because he prescribed controlled substances without the proper authority. VHA Central Office officials told us that VHA's policy does not cover DEA waivers, and as of December 2018, they were unable to provide VHA's policy regarding providers using facility DEA registrations whose individual DEA registrations have been revoked or surrendered for cause. (This is discussed in greater detail later in the report.)

With regard to the provider's medical licenses, in June 2017—in response to the State 1 licensing-board disciplinary action—a second state (State 2) licensing board placed the provider's license on probation for a period of no less than 2 years and limited the provider's practice to the VA Medical Facility. According to VHA policy, licensed independent practitioners must hold a license that is unrestricted, meaning it allows them to practice both outside and at VA.³⁴ Initially, VHA facility officials told us that they reviewed the medical license actions and determined that the provider met the

³²Starting in January 2017, VA required providers that prescribe controlled substances to obtain their own DEA registration. Prior to January 2017, they were permitted to use the facility DEA registration.

³³VISN officials said that they have since consulted with the Office of General Counsel on the process to request a DEA waiver and will use this information to help inform facility staff.

³⁴VHA Handbook 1100.19.

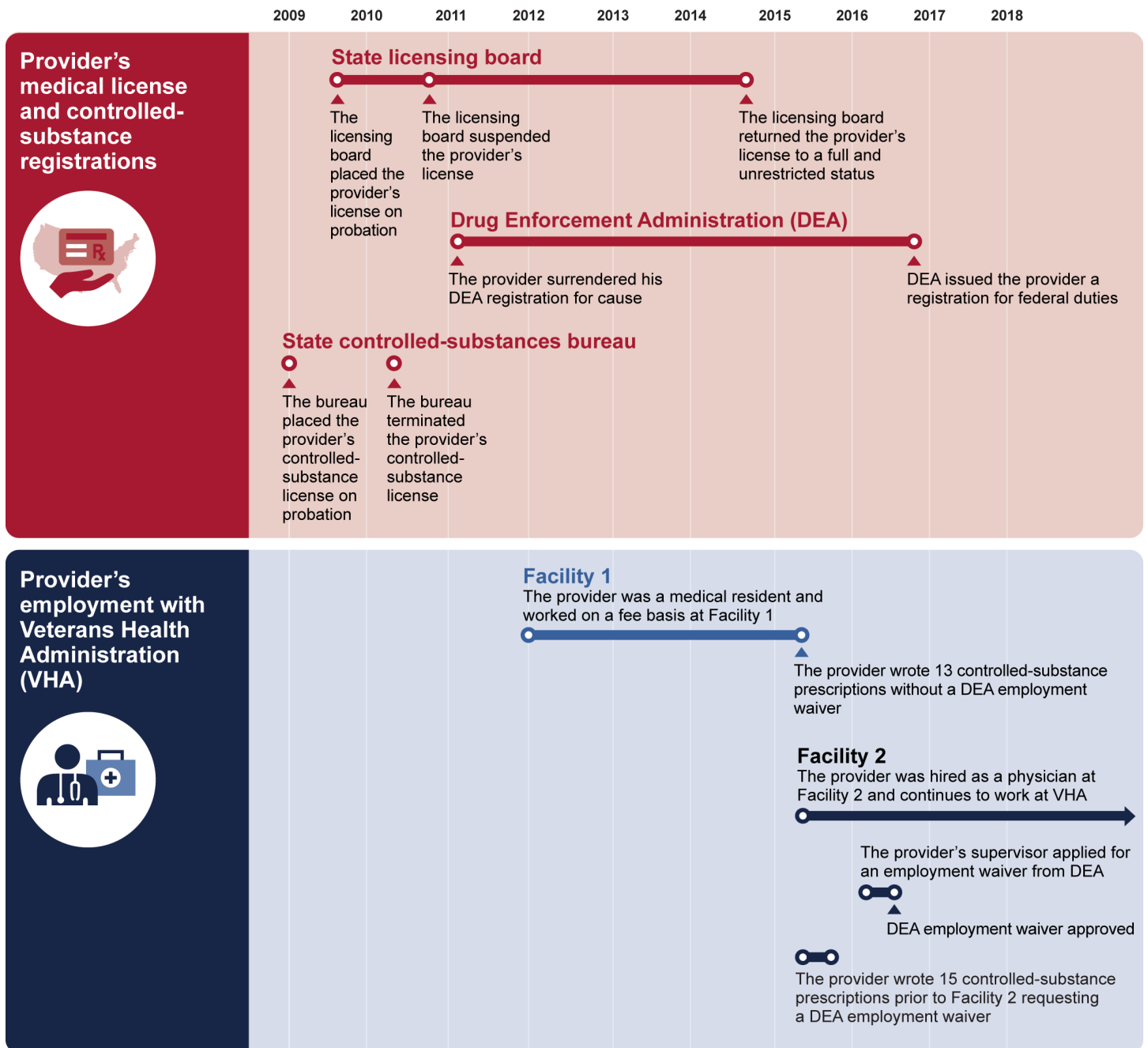
qualifications for continued appointment because they considered the provider's State 2 license as active and unrestricted. However, after our inquiries, VHA facility officials reviewed the provider's license and determined the provider was not eligible for continued employment.

For the other cases where VHA removed providers after a review based on our inquiries, see appendix III, Cases 20, 36, and 47.

In addition to the five providers VHA facilities removed after a review based on our inquiries, VHA facility officials told us that they reported one provider to DEA for prescribing controlled substances without an appropriate DEA registration. Specifically:

- Case 21—The provider was hired as a physician by a VHA facility in May 2015 and continues to work at the facility. VHA facility officials told us that prior to May 2015 the provider was a medical resident and worked on a fee basis at another facility in the same VISN from 2012 to 2015. The NPDB indicates that, among other things, prior to working at VHA, the provider surrendered his DEA registration in February 2011. The surrender came after a licensing board suspended the provider's medical license for 3 years. In addition, the state controlled-substances bureau placed the provider's state-level controlled-substances registration on probation for 3 years in January 2009. The probation action was taken because an investigation carried out by the state controlled-substances bureau found that, among other things, the provider had not documented all controlled substance-related activities in patients' charts and did not report the loss or diversion of controlled substances. Officials at both facilities told us that the provider was forthcoming about the DEA surrender when the provider was hired. Figure 6 below illustrates the timeline associated with this provider's employment at VHA, medical license status, and controlled-substances registrations.

Figure 6: Example of a Provider’s VHA Employment History, Medical License, and Controlled-Substances Registrations



Source: GAO analysis of VHA, National Practitioner Data Bank, state licensing board, and DEA information. | GAO-19-6

In September 2014, the licensing board lifted the provider's license from probation, and restored the provider's license to a full and unrestricted status. Officials at the VHA facility where the provider served as a resident and worked on a fee basis told us that because this provider's medical license became unencumbered in 2014, the provider was permitted to, and did, prescribe controlled substances under the facility's DEA registration in 2015. VHA facility officials said that although the state where the facility is located requires providers to have a state-level controlled-substance license, they did not believe this requirement applied to a federal facility. The facility granted the provider the ability to electronically prescribe controlled substances under the facility's DEA registration, even though the facility did not obtain a DEA waiver. According to VHA documents, the provider prescribed controlled substances on 13 occasions between April 2015 and May 2015.³⁵

Officials at the VHA facility where the provider was hired in May 2015 told us that, when the provider was appointed, the provider was not in a position that would need to prescribe controlled substances. However, when the provider was later assigned shifts in another department in the spring of 2016—where there was a need to prescribe controlled substances—facility officials said that the provider's supervising physician applied for a DEA waiver. VHA facility officials told us that they applied for a waiver in March 2016 and that DEA approved the waiver in July 2016. The DEA waiver allows VHA to employ the provider under the premise that the provider's access to controlled substances would be limited to electronic ordering for in-patients. VHA facility officials told us that the provider also prescribes in an out-patient setting and that, in retrospect, they should have requested a waiver from DEA that would allow the provider to do so. Officials from this VHA facility provided us with a list of controlled substances that this physician prescribed between May 2015 and October 2015, before the facility applied for the DEA waiver. These 15 prescriptions were written under the DEA registration of the facility where the provider was hired in May 2015.

Officials from the VHA facility that hired the provider in May 2015 told us that they were not aware that the provider had been prescribing controlled substances before they obtained the DEA waiver. The officials said they were unaware because both facilities where the

³⁵Some states also require a state-level registration to prescribe controlled substances. VHA policy requires providers who are licensed in states that require a state-level registration and who prescribe controlled substances to obtain a state-level registration.

physician worked share an information-technology system used to grant permissions and track prescriptions. Officials at the VHA facility said that because the provider did not have a DEA registration, they did not check the system to see whether the provider had been granted permission to prescribe controlled substances until the provider was assigned to a job where the prescription of controlled substances was necessary. The VHA facility was unaware that the facility where the provider was previously employed had granted the provider permission in the information-technology system to prescribe controlled substances. In November 2016, DEA issued the provider a registration that was limited to federal duties only. On the basis of our inquiries, in May 2018, officials at the VHA facility where the provider was hired in May 2015 reported the provider to DEA. They also told us that, after we brought this matter to their attention, they reviewed the medications that this physician prescribed before the waiver was obtained from DEA, and that they all seemed appropriate.

VHA Central Office officials told us that if a provider claims to have a DEA registration, the credentialer is responsible for verifying that information. VHA Central Office officials said that the credentialing policy does not specifically cover DEA waivers, but if the revoked or surrendered DEA registration restricts the provider's license or ability to perform in the position, policy requires that the provider be immediately removed from VHA.

VHA Facilities Inappropriately Hired Some Providers Because They Overlooked or Were Unaware of the Disqualifying Actions Reported in NPDB, but These Providers No Longer Work at VHA

We found that VHA facilities hired or retained providers who they acknowledged had disqualifying adverse actions reported in the NPDB. Specifically, VHA facilities hired or retained providers who had a license that was revoked or surrendered for cause. For example:

- Case 9—The provider was hired as a practical nurse in November 2014 and voluntarily resigned in May 2017. The NPDB indicates that, among other issues, in April 2013—before the provider was hired—one state revoked the provider's license, citing, among other items, patient neglect and substandard or inadequate care. According to VHA policy, applicants who have had a license revoked for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the revoked license is restored to a full and unrestricted status. VHA officials acknowledged that they had an NPDB report about the revoked license. They said

that the credentialer and hiring Service Chief had the information, but they inadvertently overlooked it when this provider was hired.³⁶

- Case 10—The provider was hired as a registered nurse in June 2015 and voluntarily resigned in November 2017. The NPDB indicates that, among other issues, one licensing board (State 1) revoked the provider’s license in November 2005. Before being hired, the provider disclosed to VHA that he surrendered his State 1 license, and that State 1 was going to charge him with working without a license because the state had no record of him successfully passing the registered-nurse exam. The VHA facility verified that the provider’s State 1 license had been revoked, but the provider had an active license in another state (State 2).³⁷ The VHA facility also obtained licensing-board documents from State 2 that provided further information about the State 1 licensing-board actions. The State 2 licensing-board document says that the “[State 1] Board of Nursing notified [the provider] of an opportunity for a hearing regarding allegations [the provider] had fraudulently represented [himself] as a registered nurse to employers, on medical examination reports, and submitted an altered [registered nurse] license to the [State 1] board.” VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. A facility official told us that this provider was part of the VHA-wide license review (discussed later in this report), and that in January 2018 the facility prepared a notice to remove the provider based on the revoked license. However, the facility later realized that the provider voluntarily resigned in November 2017, so no action could be taken. The facility official said that if the credentialer does not identify the revoked license, management executives are not likely to catch the problem. According to a VHA Central Office official, in this case, the credentialer did identify the revoked license, but other facility officials missed this information.

In addition to the cases highlighted above, we found other instances in which VHA hired a provider who did not meet the licensure requirements. For other examples, see appendix III, Cases 2, 14, and 28.

³⁶The VHA facility verified that the provider had an active license in another state at the time the provider was hired.

³⁷According to the licensing-board document, the State 1 license was revoked.

VHA policy requires providers to notify VHA within 15 days after receiving notification of proposed or final actions that would adversely affect their credentials. This includes not only final actions, but also pending or proposed actions. However, in a few cases, a provider did not meet this requirement. As a result, VHA retained a provider because VHA was not immediately aware of the adverse NPDB information when the licensure action happened because the provider did not disclose it. For example:

- Case 3—The provider was hired as a practical nurse in September 2014 and voluntarily resigned in August 2017. The NPDB indicates that a licensing board revoked the provider’s license in July 2016 due to misappropriation of patient property and a criminal conviction. According to the licensing-board documents, this practical nurse stole items and pawned them to support an addiction to pain medication. The board documents also state that this provider admitted to consuming prescriptions meant for patients and to faking a drug test by giving a substituted specimen.

VHA facility officials told us that they did not find out about the revoked license in a timely manner because dependent providers are not enrolled in NPDB continuous query and this provider did not self-disclose the revocation. Facility officials eventually found out about the revoked license because of the provider’s conversation with colleagues, but by that point the VHA facility was unable to take disciplinary action, as the provider had already submitted his resignation.³⁸ As a result, the provider worked for over a year—from July 2016 to August 2017—with a revoked license. Facility officials told us that they reported this provider to the licensing board, for practicing without a license. In December 2017, the state licensing board opened an investigation into this provider.

For another example in which the provider was retained when the provider did not disclose the adverse action, see appendix III, Case 1.

³⁸VHA facility officials told us that they became aware of the revoked license on August 9, 2017. This provider submitted a resignation on July 31, 2017, indicating that his last day would be August 11, 2017. VHA facility officials told us that this provider did not see patients after they discovered that he had been working with a revoked license.

Inconsistently Adhered to or Lack of VHA Policies Resulted in Providers with Adverse-Action Information Continuing to Deliver Patient Care

VHA Policies That Disqualify Providers Are Not Always Consistently Followed

We found that VHA policies that disqualify providers are not always consistently followed because some facility officials are unaware of VHA employment policies. Officials in at least five facilities, representing five cases we examined, were unaware of the requirement that a provider who has had a license revoked or surrendered for cause is ineligible for employment unless the license is reinstated. For example:

- In Case 2, the provider was hired as a nurse in June 2016 and voluntarily resigned in January 2017. The provider was reported to the NPDB because one licensing board revoked his license in September 2005. The provider disclosed to VHA that this license was revoked due to substance abuse. VHA facility officials stated that they were aware that the provider had one license that was revoked when the provider was hired. They noted that the facility hiring manager was not aware of the requirements laid out by VHA policy that this provider was ineligible for employment.
- In Case 28, the provider was hired as a nurse in November 2015 and removed in February 2018. The provider was reported to the NPDB because the provider surrendered his license in one state in April 2011, after the licensing board filed an accusation against him related to patient care. In September 2010, the provider received a notice from the licensing board indicating that it would hold a hearing to investigate claims of “incompetence” and “gross negligence” and that the provider’s license could be revoked. VHA became aware of the licensure action in August 2015, before the provider was hired by VHA.

VHA facility officials initially told us that, when working for the federal government, a provider only has to have an unrestricted license in one state. They were apparently unaware of the requirement that

licenses surrendered or revoked for cause must be reinstated for the provider to be eligible for VHA employment, even if a provider has an unrestricted license in another state. According to the provider's VHA misconduct file, the provider was included in a VHA-wide provider licensure review and, on the basis of the facility's findings that the surrendered license had not been restored to a full and unrestricted status, the provider was removed from employment.

- In Case 32, the provider was hired as a nurse in November 2006 and remains employed at VHA. This provider was reported to the NPDB in May 2011 when he surrendered his license in one state (State 1) during the course of a State 1 licensing-board investigation into action taken by another licensing board (State 2). According to the State 1 licensing board, the surrender "shall have the same effect as a revocation." The provider's State 2 license was suspended in March 2011 and was reinstated in December 2011. The NPDB report lists the basis for the license suspension as patient abuse, patient neglect, and exploiting a patient for financial gain, among other items. Thus from May 2011 through December 2011 the provider did not have an active, unrestricted license while employed at VHA.

The human-resources officials at the facility were unaware of the requirement that licenses revoked or surrendered for cause must be reinstated for the provider to be eligible for VHA employment, even if a provider has an unrestricted license in another state.³⁹ Human-resources officials at the VHA facility told us that the provider should have been immediately removed for failing to meet the conditions of employment when the provider's license in State 2 was suspended. However, they told us that they determined that the provider is currently eligible for employment because the provider has an active, unrestricted license in State 2 even though the provider's surrendered State 1 license has not been reinstated.

In addition to the cases highlighted above, we found other instances where facility officials were unaware of the requirement that a provider who has had a license revoked or surrendered for cause is ineligible for employment unless the license is reinstated. See appendix III, Cases 30 and 36.

³⁹VHA Central Office officials told us that facility officials determined there was no evidence that the nurse was notified in writing of a potential license revocation, therefore the provider's license surrender was not considered a revocation. However, VHA Central Office officials could not confirm or verify the accuracy of the facility's interpretation.

The lack of awareness we identified at the five facilities may be linked in part to the lack of mandatory training for credentialers. Specifically, mandatory training exists for certain VHA staff, but not for credentialers.⁴⁰ According to VHA policies and officials from QSV—the office responsible for overseeing VHA’s credentialing and privileging policies—there is a onetime, mandatory training for officials reviewing credentials and making hiring decisions—specifically, service chiefs, facility Directors, and credentialing committees. However, the QSV officials did not describe further periodic training for hiring officials and said that credentialers have no mandatory training requirements.⁴¹ A QSV official said that VHA-wide training for credentialers is not mandatory because of institutional concerns that there is too much required training overall, and facility Directors are ultimately responsible for implementing the credentialing process.

Although there is no mandatory training for credentialers, QSV officials said they offer optional virtual training sessions, called “boot camps,” on the credentialing process. Additionally, QSV officials said that QSV staff hold conference calls on a monthly basis for credentialers in each VISN. QSV officials said that the topics covered during conference calls include issues related to continuing education, emerging issues, and questions from facility officials. In addition, the QSV Director holds monthly nationwide conference calls for credentialers.⁴² The purpose of the calls is to discuss ongoing areas of focus and upcoming changes, and to provide an opportunity for facility staff to ask questions. QSV officials also post

⁴⁰According to VHA Central Office officials, credentialers across VHA do not have a dedicated occupational series, resulting in different grades in different parts of the country for similar work. They told us that, to increase consistency and reduce disparities across VHA facilities, they are looking into developing a standardized position description and classification for credentialers across VHA facilities. They said that such stability will improve retention and enhance management of the workforce. According to the Office of Personnel Management, position classification standards encourage uniformity and equity in the classification of positions by providing a common reference across organizations, locations, and agencies. Classification standards usually include a description of the work performed, official titles, and criteria for determining grades. The General Schedule classification and pay system covers the majority of the 1.5 million civilian, white-collar federal employees.

⁴¹To access VetPro, a QSV official said that credentialers are required to complete annual privacy training.

⁴²According to a QSV official, the monthly conference call for credentialers who handle licensed independent practitioners has occurred for years. The conference call for credentialers who handle dependent providers began in 2018.

guides for how to review a provider’s credentials on VHA’s intranet, as well as “tips of the week” that discuss a policy issue.

According to federal internal control standards, training—enabling individuals to develop competencies appropriate for key roles—is a factor managers should consider as part of efforts to ensure the recruitment, development, and retention of qualified individuals.⁴³ Requiring periodic training could provide VHA with greater assurance that credentialers and hiring officials understand requirements and appropriately determine the eligibility of providers.

Flexibility in VHA Policies Regarding Substandard Care and Lack of Policies Regarding DEA Waivers Have Resulted in Facilities Taking Various Actions

Although VHA policy disqualifies providers whose license has been revoked or surrendered due to professional misconduct, professional incompetence, or substandard care and has not been reinstated, VHA policy does not define what constitutes professional misconduct, professional incompetence, or substandard care. According to VHA Central Office officials, professional misconduct, professional incompetence, and substandard care are terms that have been used to define “for cause” as it relates to the statute.⁴⁴ They said that District Counsel interprets statutes, and that the facilities are instructed to contact District Counsel offices if they have questions.⁴⁵ VHA policy does, however, provide examples of “substandard actions” that raise “a reasonable concern for the safety of patients” and are reportable to the state licensing board, including

- multiple errors in transcribing, administering, or documenting medications;
- an inability to perform clinical procedures considered basic to the performance of a provider’s occupation;
- a provider performing, in nonemergency situations, procedures not included in the provider’s clinical privileges;

⁴³GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#), (Washington, D.C.: September 2014).

⁴⁴38 U.S.C. § 7402(f).

⁴⁵Additionally, VHA policy requires District Counsel to review a provider’s credential files if the provider has a current, full and unrestricted license in more than one state, but has or ever had a license, registration, or certification restricted, suspended, limited, issued or placed on probation status, or denied upon application.

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- substance abuse when it affects a provider's ability to perform appropriately as a health-care provider or in the patient-care environment; or
 - patient abuse, including mental, physical, sexual, or verbal abuse.

Though VHA strives for consistent, quality care, varied interpretation or a misinterpretation of policies may result in inconsistent quality of care. For example, officials at the same facility made a different determination about a provider's employment eligibility upon further review.

- As highlighted previously in Case 16, the provider was hired as a physician in September 2012 and retired in lieu of involuntary action in December 2017. The provider was reported to the NPDB in 2015 when the provider surrendered three licenses from three states in April, August, and December, as well as his DEA registration for issues related to professional misconduct stemming from convictions for driving while under the influence of alcohol. Initially, facility officials told us that they and District Counsel reviewed the circumstances surrounding the license surrender and determined the physician was eligible for employment because the issues were unrelated to quality of patient care and the physician had one active, unrestricted license. However, after our inquiries, VHA officials reviewed the provider's license again and determined the physician was not eligible for continued employment.

For another example where officials at the same facility made a different determination about a provider upon further review, see appendix III, Case 19.

In another instance, officials from one VISN and facility and officials from another VISN and facility made different determinations about the same provider.

- As mentioned in Case 33 above, the provider was hired as a physician in October 2010 and remains employed at VHA. The provider was reported to the NPDB when he surrendered his license in one state in September 2007, after the state licensing board determined that disciplinary action—a reprimand—had been taken against the provider by another state's licensing board. Officials from one facility in another VISN reviewed an adverse action reported in the NPDB and determined the physician was not eligible for appointment because the physician voluntarily relinquished his license in one state after being notified in writing of potential termination for professional misconduct, professional incompetence, or substandard

care. However, officials in a separate VISN and facility reviewed the adverse action reported in the NPDB and determined that the license was surrendered voluntarily, and the physician was hired.

VHA Central Office officials told us that they cannot comment on how the two facilities came to different conclusions because each facility is responsible for reviewing the circumstances and consulting with District Counsel as needed. VHA Central Office officials said that they provide facilities with policies and rely on facility officials to understand and adhere to policy, and follow up with District Counsel if there are questions about a provider's license. According to VHA policies, the ultimate responsibility for credentialing resides with facility Directors, and VISN Chief Medical Officers are responsible for oversight of facilities' credentialing processes using a standardized File Assessment Tool. Information on VHA Central Office and VISN-level oversight of the facilities is discussed below.

In addition, VHA has not issued policies pertaining to waivers from DEA to employ providers that have had registrations revoked or surrendered for cause.⁴⁶ VHA Central Office officials told us that providers are not always required to have a DEA registration; it depends on their roles and responsibilities. VHA Central Office officials from QSV and the Office of Workforce Management and Consulting said they were unaware of any policies having been issued to facilities about how to handle providers who have had a DEA registration revoked or surrendered for cause. Under the Controlled Substances Act, DEA requires entities and individuals, such as hospitals and physicians that distribute or dispense controlled substances, to obtain a DEA registration. Further, according to DEA officials, 22 states require providers to obtain state-level controlled-substance licenses. Additionally, per DEA regulations, registrants—including VHA facilities—must obtain a waiver from DEA before employing a provider who has had a DEA registration revoked or surrendered for cause, among other things.⁴⁷ VHA Central Office officials

⁴⁶VHA has also not issued credentialing policies on provider substance abuse. VHA Central Office officials said that each case is considered individually. As previously mentioned, they also said that the Office of Human Resources Management publishes a checklist on how to appropriately assess an employee who may be impaired while at work. The checklist is a tool to aid supervisors in determining whether to refer the employee to a rehabilitation program or to conduct drug testing. For cases that we reviewed that relate to substance use, see app. III, Cases 2, 3, 4, 7, 11, 13, 14, 16, 21, 22, 25, 27, 30, 31, 37, 45, 47, 50, 53, 54, and 57.

⁴⁷Pub. L. No. 91-513, Title II, 84 Stat. 1236, 1242–1284 (codified as amended at 21 U.S.C. §§ 801–904).

said that VHA policies do not specifically cover DEA waivers, but if a DEA registration that has been revoked or surrendered for cause restricts the provider's only license or leads to the revocation of a provider's clinical privileges, policy requires that the provider be immediately removed from VHA.

However, as demonstrated by two cases we reviewed, VHA facility officials appeared to have an inconsistent understanding of DEA policies regarding situations when a provider's DEA registration has been revoked or surrendered for cause. As a result, there is a risk that state and DEA controlled-substance requirements may not be followed. For example, as described above in Case 21, the VHA facility where the physician worked on a fee basis is located in a state that requires providers to obtain a state-level controlled-substance license. According to DEA regulations, registrants—in this case a VHA facility—must obtain a waiver of federal regulations from DEA before employing a provider who has previously surrendered a DEA registration for cause.⁴⁸ However, facility officials told us the physician did not need a state-level controlled-substances license because the physician was working on federal property. Additionally, a facility official said that she had been doing credentialing for 15 years, and the issue of a DEA waiver had never come up. Although the physician prescribed controlled substances at the facility 13 times between mid-April 2015 and the beginning of May 2015, the physician was not granted a waiver from DEA until July 2016, after the provider moved to another VHA facility.

In another instance, as discussed above in Case 19, a physician working at a VHA facility who surrendered a DEA individual registration for cause in June 2015 prescribed controlled substances in July and August 2015 on two occasions using the facility DEA registration. VHA facility officials were aware that the physician had surrendered the individual DEA registration and said they decided in August 2015 to no longer allow the provider to prescribe controlled substances. However, facility officials said they were not aware that a waiver from DEA may be needed to continue to employ the physician, and did not request one. VISN officials said that they have since consulted with the VA Office of General Counsel on the

⁴⁸According to 21 C.F.R. § 1301.76(a), a registrant shall not employ, as an agent or employee who has access to controlled substances, any person who has been convicted of a felony offense related to controlled substances or who, at any time, had an application registration with DEA denied, had a DEA registration revoked, or has surrendered a DEA registration for cause.

process to request a DEA waiver and will use this information to help inform facility staff. Facility officials said they were not obligated to report the physician to DEA for prescribing controlled substances after the physician had surrendered the DEA registration because the physician used the facility DEA registration. VHA Central Office officials were unable to provide us with policies regarding providers using facility DEA registrations if providers' individual DEA registration have been revoked or surrendered for cause. Without such policies regarding DEA registrations, facilities risk having providers prescribe controlled substances inappropriately, and potentially unlawfully.

It is unclear whether VHA knows how many of its providers may need an employment waiver to prescribe controlled substances. According to DEA officials, an employment waiver is needed if a provider has access to controlled substances and has not subsequently obtained another DEA registration after surrendering such a registration. DEA officials said that access, among other things, means controlled substances are located on-site, even in locked cabinets. According to DEA officials, from 2016 to 2017, VHA requested one waiver, and it was for the provider discussed above in Case 21. We followed up with a QSV senior-level official to see whether VHA has conducted a system-wide review of providers to identify those for whom an employment waiver may be needed from DEA. The QSV official was unaware of any review of DEA employment waivers. Conducting a review of providers who have had their DEA registration revoked or surrendered for cause and not reinstated would provide VHA with greater assurance that it has identified providers for whom a DEA waiver is necessary.

Some VHA Credentialing Policies and Oversight Mechanisms Are Not Consistently Followed or Have Gaps

Although VHA policies require the VISN Chief Medical Officer to review the credentialing file for certain providers who have adverse licensure actions, we found that this review was not always completed. VHA policy requires the VISN Chief Medical Officer to review credentialing files for licensed independent practitioners in certain situations related to state licensing-board actions or medical malpractice. Specifically, VISN Chief Medical Officer review of credentialing files is required if

- a provider has an agreement with a licensing board not to practice in a state;
- the provider has or ever has had a license that was restricted, limited, suspended, placed on probation, or denied; or

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- the provider has malpractice payments exceeding certain thresholds.⁴⁹

A QSV official said that, for licensing board actions, there is no specific time frame when the VISN Chief Medical Officer review should occur, but it should occur before the provider is appointed. If the triggering event occurs after the initial appointment, the VISN Chief Medical Officer review must occur before the provider is reappointed—typically every 2 years. According to the QSV official, the policy does not indicate a time frame or time limit for the VISN Chief Medical Officer review because reviewing credentials and licensing actions can be a lengthy process.

According to VHA policy, VISN Chief Medical Officer review is to occur within 90 days for licensed independent providers with NPDB action reports related to malpractice payments. VHA policy says that reviews by the VISN Chief Medical Officer should include documentation collected through the credentialing process and the provider’s explanation of the circumstances, and should be documented in VetPro. Furthermore, reviews by the VISN Chief Medical Officer are conducted to ensure “appropriate review is completed in the credentialing process” and are to be completed prior to the provider being presented to the facility credentialing committee for review.

We reviewed the credentialing files for licensed independent practitioners included in our sample and identified 20 that appeared to meet at least one of the situations that would prompt review by a VISN Chief Medical Officer. Of these providers, at least 17 did not have VISN Chief Medical Officer review documented in VetPro.⁵⁰ A QSV official told us that they do not oversee or track compliance with VISN Chief Medical Officer reviews. QSV officials do not know when a facility hires a provider, including providers for whom VISN Chief Medical Officer review is required, the

⁴⁹VHA Handbook 1100.19. VA policy specifies that the VISN Chief Medical Officer would review a provider if the payments met one of these thresholds: (1) three or more medical malpractice payments in the provider’s payment history, (2) a single malpractice payment of \$550,000 or more, or (3) two medical malpractice payments totaling \$1,000,000 or more. According to the NPDB, a settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence of the provider.

⁵⁰According to a QSV official, VISN Chief Medical Officer review is documented in the “Service Chief Approval” screen in VetPro. We reviewed this screen for documentation of VISN Chief Medical Officer review—signature with job title or notes stating that VISN Chief Medical Officer review occurred—for each provider in our sample who appeared to meet at least one of the situations that would prompt review by a VISN Chief Medical Officer.

official said. The QSV official also said such review would have to be manually performed and would require knowing a provider should have undergone VISN Chief Medical Officer review.

Annual facility audits performed by the VISNs are another oversight mechanism. However, QSV officials do not currently receive the results of these audits, leaving a gap in the oversight approach. QSV officials said that as part of annual audits of facilities, VISN officials are to ensure compliance with credentialing and privileging policies. VISN officials do so by reviewing a sample of licensed independent practitioner credentialing files using a standardized assessment tool (audit tool). Among other things, the audit tool includes items such as determining whether education, training, and licenses have been appropriately verified and whether the facility Service Chief appropriately documented the decision to appoint the provider. In response to one of our previous recommendations, senior VHA officials said they plan to update the auditing tool by 2019 to include monitoring of facilities' timeliness in reporting to NPDB adverse privilege actions taken by facilities.⁵¹ QSV officials said that they do not currently receive the results of audits that VISNs conduct but are working to automate the auditing tool so that VHA Central Office officials can track trends and aggregate data.

Other oversight mechanisms provide the VHA Central Office information on the implementation of credentialing policies. For example, QSV officials receive copies of continuous-query reports from the NPDB when they are sent to facilities. QSV officials said that when they receive a continuous-query report, they send officials at the pertinent facility an NPDB Report Review Checklist that contains actions that should be taken to review the information reported by the NPDB. A QSV official said the NPDB Report Review Checklists are used to ensure that facilities appropriately review and respond to the adverse action. Among other things, the NPDB Report Review Checklist includes reminders for facilities to verify primary source documents, such as state licensing-board actions. A QSV official said facilities have 90 days to complete the checklist. However, this is an internal deadline, as use or completion of the NPDB Report Review Checklists are not mandated or required by policy. QSV officials said that they receive documentation from facilities to

⁵¹GAO, *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*, [GAO-18-63](#) (Washington, D.C.: Nov. 15, 2017).

show that the NPDB report was considered by management, such as credentialing-committee meeting minutes.

The findings of our case studies indicate that, without adequate controls, credentialing policies could be inconsistently or inappropriately applied across the system. Such risks are not new. For example, in May 2018 the VA Inspector General noted that the Inspector General's past work has shown that VHA did not have adequate data to monitor VISN operations, which led to inadequate oversight of VISN operations, a lack of accountability, and noncompliance with policies.⁵² In a similar vein, on the basis of a review of provider files from October 2013 through March 2017, we found in November 2017 that the VHA Central Office and VISNs did not conduct adequate oversight and could not ensure that facilities appropriately reported providers to the NPDB and state licensing board when required to do so by VHA policy.⁵³

Federal internal control standards state that agency managers should design and implement control activities that enforce management's directives to achieve organizational objectives and address related risks.⁵⁴ Requiring VISN Chief Medical Officer review for providers affords VHA a mechanism to help ensure that additional review occurs for providers with potentially problematic licensure or malpractice issues. Taking action to ensure that VISN Chief Medical Officer reviews are conducted and are appropriately documented, in accordance with VHA policy, would help provide assurances that VHA is providing one standard of care to veterans by ensuring timely and appropriate credentialing of providers.

⁵²Michael J. Missal, Inspector General, Department of Veterans Affairs, *The Curious Case of the VISN Takeover: Assessing VA's Governance Structure*, testimony before the House Committee on Veterans' Affairs, 115th Cong., 2nd sess., May 22, 2018.

⁵³[GAO-18-63](#).

⁵⁴[GAO-14-704G](#).

VHA Has Recently Taken Steps to Better Ensure That Providers Meet Licensure Requirements

VHA officials at the Central Office and facility level described efforts to better ensure that providers meet licensure requirements, such as reviewing provider licenses and expanding monitoring efforts. In addition, facility officials highlighted initiatives at their facilities to improve oversight of provider licenses.

VHA Completed Reviews of Licenses and Removed Providers Who Did Not Meet Qualifications, but Reviews May Have Missed Some Providers

In December 2017, the Deputy Under Secretary for Health for Operations and Management directed the VISNs to complete an agency-wide review of licensure actions for all health-care providers. VHA Central Office officials told us that this review was prompted after a December 2017 news article reported that a facility hired a provider who was not eligible for employment because the provider had a revoked license that was not reinstated to a full and active status.

VHA Central Office officials told us that the licensure review included all licensed providers who were employees at VHA as of December 2017, as well as contractors and volunteers. They said that of the approximately 165,000 licensed providers, the VHA Central Office identified about 77,000 that required further follow-up by facility officials, and that 11 providers were removed because they did not meet the license qualifications. They said that they identified the providers who required follow-up based on information contained in the VetPro credentialing system, and who met one or both of the following criteria:

- provider's self-disclosure of a potential licensure issue; or
- the credentialer's identification of a potential licensure issue; for example, if the credentialer indicated that there was a past or pending adverse action on the provider's license, the provider was selected for the VHA review.

For those providers who required follow-up, the VHA Central Office instructed facility officials to review the providers' information to determine whether they had a licensure action that would disqualify them from appointment. Specifically, facilities were asked to identify providers who had a license that was

- revoked and not fully restored, or

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- surrendered in lieu of revocation and not fully restored.

VHA Central Office officials said that credentialers at the facility were asked to review the provider's entire case file for each provider VHA Central Office officials flagged. This included reviewing licensure status information as well as any NPDB reports in VetPro. Central Office officials told us that they instructed facilities to consult with their District Counsel when they had questions, and that District Counsel worked with facility human-resources officials to determine whether a provider met the licensure qualifications. Central Office officials asked the facilities to provide a written response with the resolution for each of the flagged providers. VHA Central Office officials told us that the license review was comprehensive and required about 20,000 hours to complete.

However, on the basis of our case studies, we identified potential shortcomings with VHA's licensure review that could have resulted in disqualified providers not being identified. Specifically:

- A provider did not list in VetPro every license that he ever had held. Officials at one VHA facility told us that providers are instructed to list every license ever held, and that the credentialer is to verify that information as a matter of routine practice. However, if a provider did not disclose a license and if the licensure action of the license in question is not included in VetPro, the provider would not necessarily have been included in VHA's review. For example, in Case 14, the provider did not self-disclose his revoked license, and this license was not listed in VetPro's licenses screen for the credentialer to verify. VHA Central Office officials confirmed that had the employee in Case 14 been at VHA as of December 2017, this provider would have been missed in the licensure review.⁵⁵
- The VHA review could have missed disqualified providers who had an adverse action on an expired license if the provider did not self-disclose the information. During our review, we found that a state licensing board can take disciplinary action on an expired license. For example, in Case 50, the licensing board in one state placed the nurse's expired license on probation. VHA facility officials told us that credentialers verify all licenses ever held, including expired ones, when a provider is first appointed. After appointment, however, the

⁵⁵This nurse had a revoked license in one state, and facility officials told us that the provider did not meet the licensure requirements. For further details about this case, see app. III.

credentialer only verifies current licenses to make sure they were renewed. Consequently, the VHA license review could have missed providers who had a disqualifying licensure action taken on an expired license.

- A VHA Central Office official said it did not undertake quality-control procedures to ensure that the information was accurately compiled and policies were consistently applied across facilities. For example, the provider in Case 47 was part of VHA's license review, and facility officials said they initially determined that the provider met the qualifications.⁵⁶ However, after we met with facility officials and identified a license that was surrendered for cause, they determined that the provider was not qualified for employment and removed him from VHA. VHA Central Office officials told us that they provided facilities with guidance on employment qualification standards, but they did not complete any type of reviews or spot checks to verify that the information was compiled correctly.

In addition, because VHA facilities were instructed to review 77,000 providers in a span of about 1 month, it may not have been sufficient time for VHA facilities to evaluate the providers' licenses. As mentioned above, VHA Central Office officials told us that the license review required about 20,000 hours to complete, which equates to an average of about 15 minutes per provider. During the course of our case-study analysis, we found that evaluating provider licenses can take significant time and effort, especially when the provider has multiple licenses and if there are disciplinary actions on the license.

In April 2018, we met with VHA Central Office officials to discuss the results of the license review. VHA subsequently identified 11 providers—6

⁵⁶Among other items, the NPDB indicates that in August 2004, one licensing board placed the provider's license on an indefinite restriction due to substance abuse and prescription forgery. Under the terms of the licensing-board agreement, the provider was not permitted to practice medicine. As a result of this licensing-board action, other licensing boards took disciplinary action, which are noted in the NPDB. In September 2010, the licensing board that placed the license on an indefinite restriction restored the provider's license to a full and unrestricted status. Before the provider was hired in July 2014, the provider disclosed that he surrendered a license in another state.

who were in our sample—who do not meet the license requirements, and those providers were removed.⁵⁷ They said that

- for nine of the 11 providers, the adverse licensure action occurred before the appointment; and
- for two of the 11 providers, the adverse licensure action occurred after appointment; in both cases, the providers were dependent providers who are not enrolled in NPDB continuous query.

VHA Central Office officials told us that they subsequently completed two additional VHA-wide licensure reviews that were more limited in scope. However, these reviews did not yield additional provider follow-ups, as we discuss below.

- The first review, started and completed in January 2018, focused on the approximately 39,000 physicians across VHA and used licensure-action information from the Federation of State Medical Boards.⁵⁸ A QSV official told us that QSV staff reviewed the licensure-action reports in Federation of State Medical Boards information to ensure that all providers with a Federation of State Medical Boards report were flagged in the initial license review.
- Due to shortcomings we identified with the initial license review, VHA Central Office officials told us that they conducted a second review. Completed in July 2018, the second review focused on the approximately 67,000 licensed independent practitioners across VHA, and used NPDB reports. VHA facilities were instructed to review licensed independent practitioners who had an NPDB report and who were not identified in the first license review.

No additional providers were identified in these additional VHA-wide reviews because all of the providers with Federation of State Medical Boards or NPDB reports were flagged in the initial review.

We found that the subsequent license reviews also had potential shortcomings. Specifically, VHA may have missed a disqualified provider

⁵⁷The six providers who were in our sample are Cases 8, 20, 28, 36, 47, and 50. As noted above, facility officials reviewed Case 47 and initially determined that the provider met the licensure requirements. However, after our inquiries, facility officials determined that the provider did not meet the licensure requirements.

⁵⁸The Federation of State Medical Boards represents the 70 state medical boards within the United States, its territories, and the District of Columbia. We considered using federation data on adverse licensure actions, but found it mostly duplicated NPDB data.

in the subsequent reviews. For example, as noted in Case 47 above, the provider was part of the initial license review, and facility officials said they determined that he was eligible for continued employment. However, after we inquired about a license that was surrendered for cause, facility officials reviewed the provider's licenses and determined that he was not eligible for employment. A QSV official confirmed that this provider was identified in the Federation of State Medical Boards query, but since the provider was flagged in the initial review, he was not re-reviewed. Had we not inquired about this provider's employment eligibility, the provider would not have been subject to re-review because he was included in the initial license review. In addition, as in the first license review, VHA Central Office officials did not undertake quality-control procedures to verify the accuracy of the work. They said that facilities verify licenses and are in the best position to determine whether a provider meets licensure qualifications.

Although VHA-wide reviews of provider licenses have been completed, VHA officials told us these types of reviews are not routinely conducted. VHA Central Office officials stated that the initial review was labor intensive. Having the facilities conduct ongoing periodic reviews of adverse actions reported in the NPDB, VHA-wide, could offer a more-targeted approach than using VetPro information to identify providers who do not meet the licensure requirements because fewer providers would be flagged for review.⁵⁹ Taking appropriate action and reporting the findings to VHA VISN and Central Office officials will also provide greater opportunities to monitor facilities' compliance with credentialing policies.

VHA Plans to Expand Monitoring Efforts of Dependent Providers by Receiving NPDB Alerts

VHA Central Office officials told us that they will be enrolling dependent providers in NPDB continuous query by December 2018. As previously discussed, currently only licensed independent practitioners—such as physicians—are enrolled in NPDB continuous query, while dependent providers—such as nurses—are not. This means that VHA may not know about an adverse action for a dependent provider in a timely manner, unless the provider self-discloses the information. When a provider is enrolled in NPDB continuous query, a VHA Central Office official said that VHA Central Office and facility officials receive a notification when there is a new NPDB report about the provider, which enables VHA to better

⁵⁹There were approximately 1,600 employees at VA as of September 30, 2016, who had an NPDB report. Not all of these individuals are employed in a health-care position at VHA. See app. I for further details.

monitor license status. For example, if a state licensing board places a license on probation after a licensed independent practitioner is appointed, VHA would learn about it through the NPDB continuous query. Enrolling dependent providers in NPDB continuous query will help VHA identify providers who are not qualified or may have potential licensure problems. For example, it could have identified Case 3—the nurse whose license was revoked after the provider was hired. It would also identify instances where a state licensing board takes disciplinary action on an expired license.

Certain VHA Facilities Have Initiated Actions to Improve Oversight of Provider Licensing

Officials at certain facilities told us they have taken actions to identify employees who do not meet the licensure requirements or to improve the credentialing process. Although these actions are limited to certain facilities, they are positive steps that have the potential to improve the quality of providers. Examples of actions taken by individual VHA facilities include the following:

- Completed a periodic review of all licensed providers to identify providers who may have an expired licensure issue. Specifically, officials from one facility told us that, in January 2013, they identified that the nurse in Case 43 had been working with a lapsed license when they completed a periodic review of all licensed providers in their facility. Facility officials explained that they complete reviews of all licenses to identify ways to improve their internal process. VHA Central Office officials noted that periodic reviews are completed through NPDB continuous query and at the time of the provider's license renewal.
- Conducting a review of prior cases when officials found that a nurse was working with a lapsed license to determine whether there were any quality-of-care concerns. Facility officials told us that after they identified that the nurse in Case 43 had been working with a lapsed license in January 2013, they conducted a retroactive review of the provider's notes and did not find any issues with the care provided to patients.
- After our inquiries, one facility updated its standard operating procedures to require providers with adverse actions to be reviewed by management. Specifically, facility officials told us that they updated their standard operating procedures after our inquiries about Case 36 revealed that the provider did not meet licensure qualifications. These officials said that the facility will now require all licensure actions to be escalated to management and will require sign-offs from the Chief of

Staff, Professional Standards Board, Human Resources Officer, and District Counsel. Facility officials also told us that they conducted training for all human-resources specialists in response to our findings.

As previously noted, a QSV official said facilities make their own hiring decisions, and facility Directors are ultimately responsible for ensuring that the facility adheres to VHA policy. VISNs and VHA medical facilities do not routinely share information about best practices that they employ to improve the licensure review process. Furthermore, QSV, which is responsible for VHA-wide credentialing and privileging, does not routinely assemble and disseminate information about initiatives that facilities have undertaken to improve the oversight of providers. In our report about streamlining government, we note that key practices to improve efficiency should be shared more broadly.⁶⁰ Standards for Internal Control in the Federal Government also describe how managers should design a process to identify the information requirements needed to achieve the entity's objectives and address risks. The practices that certain facilities adopt could, if disseminated more broadly, help disparate facilities improve their oversight of providers, as it would provide examples for conducting, for example, license reviews, or developing new procedures.

Conclusions

VHA is responsible for ensuring appropriate credentialing and privileging of providers throughout its system of more than 1,200 facilities. According to VHA Central Office officials, they provide facilities with policies and rely on facility officials to understand the policies and to consult with District Counsel when they have questions about a provider's license. This approach allows for flexibility and decision making at the local level but may bring with it an increased risk that VHA policies may be inappropriately and inconsistently applied across facilities and VISNs.

Our case studies show that facilities vary in their responses to adverse actions reported in the NPDB. Training is a key component in cultivating professional competency, and it helps ensure consistent application of policies, but there is no mandatory training for credentialers or periodic training for officials responsible for reviewing credentials and making hiring decisions. This is problematic because nuanced analysis and professional judgment are necessary to determine whether a provider

⁶⁰GAO, *Streamlining Government: Key Practices from Select Efficiency Initiatives Should Be Shared Governmentwide*, [GAO-11-908](#) (Washington, D.C.: Sept. 30, 2011).

meets licensure requirements. Additionally, because credentialers and hiring officials play a key role in the process of determining providers' qualifications to work at VHA, mandatory periodic training could help ensure that both credentialers and hiring officials appropriately vet providers. Until VHA strengthens its training processes, it lacks assurance that credentialing staff and officials responsible for reviewing credentials and making hiring decisions will be able to accurately identify providers who do not meet eligibility requirements.

In addition to ensuring that providers have the appropriate medical licensing, the credentialing process also helps ensure that providers whose duties require that they handle controlled substances have the appropriate authority to do so. DEA regulations require that VHA facilities obtain a waiver from DEA before employing a provider who has had a DEA registration revoked or surrendered for cause. However, VHA has issued no policies on DEA waivers. Without such policies, there is a risk that state and DEA controlled-substance requirements may not be followed and that providers whose DEA registrations have been revoked or surrendered for cause are inappropriately prescribing controlled substances.

VHA's layered organizational structure affords opportunities for increased oversight of credentialing policies and discussion and review of potentially problematic providers—those with certain state licensing-board actions and malpractice issues. VHA policies require the VISN Chief Medical Officer to review credentialing files for licensed independent practitioners in certain situations related to licensing-board actions or medical malpractice, but some reviews have not been documented in VetPro, as required. Taking action to ensure that VISN Chief Medical Officer review occurs could provide assurances that those providers serving veterans have been subject to timely, appropriate credentialing.

VHA has identified providers who did not meet eligibility requirements through three VHA-wide reviews, VHA officials told us that these types of reviews are not routinely conducted. Conducting periodic reviews could provide the VHA Central Office with greater visibility to identify facilities that may be hiring or retaining providers who do not meet licensure requirements. Certain VHA facilities are taking independent action to improve credentialing processes, and VHA has taken action to foster information sharing via conference calls, but these best practices are not being disseminated to all facilities. Disseminating best practices could help disparate facilities improve the license review process by providing examples for how to execute the detail-driven and case-specific process.

Recommendations for Executive Action

We are making the following seven recommendations to VA.

The Under Secretary for Health should ensure that facility officials who are responsible for credentialing, reviewing credentials, and hiring receive periodic mandatory training. (Recommendation 1)

The Under Secretary for Health should develop policies and guidance regarding DEA registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies. (Recommendation 2)

The Under Secretary for Health should identify and review providers whose DEA registrations were revoked or surrendered for cause and determine whether an employment waiver may be needed from DEA. (Recommendation 3)

The Under Secretary for Health should confirm that VISN-level Chief Medical Officer reviews are being appropriately documented so that VHA Central Office officials are able to ensure that facilities and VISNs are complying with oversight policies. (Recommendation 4)

The Under Secretary for Health should confirm that the appropriate VHA Central Office is conducting monitoring to ensure that required VISN-level Chief Medical Officer reviews of licensed independent practitioner credentialing files are conducted. (Recommendation 5)

The Under Secretary for Health should direct the VHA facilities to periodically review provider licenses using NPDB adverse-action reports, similar to recent VHA-wide reviews. Facility officials should take appropriate action on providers who do not meet the licensure requirements, and report the findings to VHA VISN and Central Office officials for review. (Recommendation 6)

The Under Secretary for Health should direct the Office of Quality, Safety and Value (QSV) to compile and disseminate to all facilities best practices employed by facilities that have proactively identified and addressed provider adverse-action licensure issues. (Recommendation 7)

Agency Comments

We provided a draft of this report to the Health Resources and Services Administration, DEA, and VA for review and comment. The Health Resources and Services Administration and DEA did not have comments.

In its written comments, reproduced in appendix IV, VA said that it concurred with the findings and the intent of the recommendations. It directly addressed three of the seven recommendations.

VA concurred with our first recommendation that the Under Secretary for Health should ensure that facility officials who are responsible for credentialing and hiring are aware of licensure requirements, and said that it will implement annual training on relevant requirements.

VA concurred with our second recommendation that the Under Secretary for Health should develop policies and guidance regarding DEA registrations—including the circumstances when DEA waivers may be required. VA said that it would collaborate with DEA and will update national policies to reflect employment requirements.

VA also concurred with our third recommendation that the Under Secretary for Health should identify and review providers whose DEA registrations were revoked or surrendered for cause and determine whether an employment waiver may be needed from DEA. VA said that it will reinforce processes for taking appropriate administrative actions with respect to providers whose DEA registrations have been revoked or surrendered for cause.

In its reply, VA did not directly respond to our fourth, fifth, sixth, or seventh recommendations.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Veterans Affairs, the Under Secretary for Health, and other interested parties. In addition, the report is 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 me at (202) 512-5045 or larink@gao.gov. Contact points for our Offices of

Congressional Relations and Public Affairs may be found on the last page of this report. For the GAO contact, see appendix V.

Sincerely yours,

A handwritten signature in black ink that reads "Kathryn Larin". The signature is written in a cursive style with a large, looping initial 'K' and a long, sweeping tail.

Kathy Larin
Director, Forensic Audits and Investigative Service

Appendix I: Objectives, Scope, and Methodology

Our objectives were to determine (1) how officials at Veterans Health Administration (VHA) facilities responded to adverse-action information received through the National Practitioner Data Bank (NPDB) about selected providers, (2) how VHA facilities adhered to policies regarding providers with adverse-action information, and (3) steps VHA has taken to ensure that providers meet licensure requirements.

For the first objective, we selected a nonprobability sample of 57 health-care providers—including physicians, nurses, dentists, physical therapists, and social workers—who have an NPDB report, for an in-depth analysis.¹ The NPDB is a federal electronic repository that collects and releases information on health-care providers who have been disciplined by a state licensing board, professional society, or health-care entity, have been named in a medical malpractice settlement or judgment, or identified in some other adverse action.² We used three primary databases to identify the population of VHA health-care providers with potential misconduct or disciplinary issues:

- Department of Veterans Affairs (VA) employee rosters,
- VA employee disciplinary actions (misconduct files), and
- NPDB reports.

To determine how officials at VHA facilities responded to adverse-action information received about selected providers, we judgmentally selected cases for in-depth review. We narrowed the population to select our sample by only including individuals that were employed at VA as of September 30, 2016. There were 1,664 individuals employed as of September 30, 2016, who had an NPDB report. We judgmentally selected 57 providers for in-depth review from this population. We selected providers with a health-care conviction or an adverse action, such as a revoked or surrendered license. We considered factors such as the seriousness of the offense, total number of offenses, and whether the provider had any VHA disciplinary records in the VA Personnel and Accounting Integrated (PAID) misconduct file when selecting our sample.

¹The original sample contained 59 cases; however, we dropped two cases because the individuals were not employed at the VHA as of September 30, 2016.

²The NPDB also contains information on medical malpractice payments. Not all malpractice payments are a result of substandard care by specific providers. The NPDB contains malpractice-payment information made on behalf of a provider; however, a payment made as a result of a claim filed solely against an entity (such as a hospital) that does not identify a provider is not reportable to the NPDB.

VA employee roster and misconduct data were extracted from VA's PAID system, which was developed to track payroll actions and contains information about adverse disciplinary actions that affect employee salaries department-wide. VA provided us with an extract of year-end rosters from the PAID system, as well as PAID misconduct data (such as removals, suspensions, and demotions) for fiscal years 2010 through 2016, the most-current data available at the time of our request.³ The PAID system was not designed to track all misconduct cases, but it does contain information about adverse disciplinary actions that affect employee status or salary, or result in a Notification of Personnel Action form (Standard Form 50). The PAID roster data only include VA employees. As such, the extracts we received did not include health-care providers who are not employees, such as providers who fill positions on a temporary basis, fee basis, or contract basis. We limited our in-depth review to appointed providers. However, a few providers selected in our sample were contract-based employees at some point in their tenure with VA.

We compiled all of the roster extracts into one file, retaining one record for each unique provider, for a combined roster of all VA-wide employees (including employees who are not health-care providers) containing approximately 546,000 records. This file was used to match to the NPDB Adverse Action and Judgments and Convictions files to create the population from which we selected our sample of 57 VA health-care providers. The PAID misconduct file was not used to outline the total universe our sample was drawn from, but was used to augment our analysis of the cases selected.

The Health Resources and Services Administration—an agency within the Department of Health and Human Services—maintains the NPDB. The NPDB receives information from state licensing-board entities, as well as hospitals, health plans, and federal and state agencies, to help these entities identify health-care providers who may have a record of misconduct or substandard care. By law, certain entities—including hospitals and other health-care entities—report to the NPDB, query the NPDB, or both. The NPDB collects information on medical malpractice payments and certain adverse actions, and discloses that information to eligible entities to facilitate comprehensive reviews of the credentials of

³Some of the roster data we used were also requested for another GAO report ([GAO-18-137](#)). In addition to fiscal-year data, we used an additional extract of the other report's PAID roster data from May 2015.

health-care providers, entities, and suppliers. Facilities utilize NPDB data in overseeing the providers who deliver services. Importantly, according to VHA Central Office officials, the presence of an NPDB report does not automatically disqualify a provider from working at VHA, but medical staff leadership is required to review the associated information—such as state licensing-board documents—to determine the provider’s ability to practice safely, and to document its review. Although the NPDB contains information on health-care providers who have been disciplined, not all NPDB reports are adverse. For example, if a license is reinstated or restored, that information would also be in the NPDB.

We provided the Health Resources and Services Administration with the combined VA roster we compiled, and it matched the roster to the NPDB using both Social Security number (SSN) and provider name as matching criteria. The Health Resources and Services Administration furnished only those matches that were an exact match on SSN, or were exact matches using both SSN and provider first and last name. The match did not include medical malpractice payments or adverse clinical-privileges actions. On the basis of the matching methodology, Health Resources and Services Administration officials estimate that approximately 10 percent of the potential matches may be missed, and that less than 5 percent of the matched data may contain false positives.⁴ The Health Resources and Services Administration performed the match and provided us with two matched files: (1) NPDB Adverse Action and (2) NPDB Judgments and Convictions files. Actions reportable to the NPDB Adverse Action file are taken against a health-care provider and often relate to professional competence or professional conduct, among other items.⁵ The NPDB Adverse Action file contains information about revoked or surrendered licenses, and other adverse actions. It is possible that

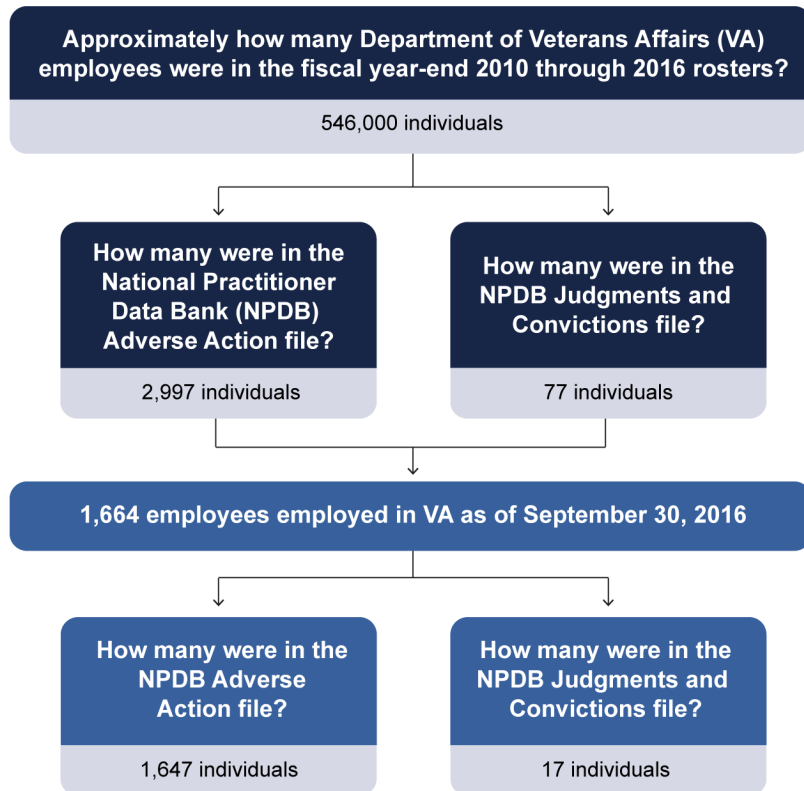
⁴The potential for error with our matches does not affect our work. For each case selected, we verified the adverse action listed in the NPDB. Further, the results of our work are nongeneralizable. According to Health Resources and Services Administration officials’ estimates, using only exact matches we may potentially miss 10 percent of providers in the NPDB because the VA roster provided limited identifying information. Further, we did not perform a “fuzzy match” using name, address, and birth date as additional matching fields.

⁵Reportability for the NPDB stems from the following three statutes: Title IV of Pub. L. No. 99-660, Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act (Section 5(b) of Pub. L. No. 100-93, the Medicare and Medicaid Patient and Program Protection Act of 1987, as amended); and Section 1128E of the Social Security Act (Pub. L. No. 104-101, the Health Insurance Portability and Accountability Act of 1996).

individuals in the NPDB Adverse Action file can have more than one NPDB report, and not all actions listed are adverse. For example, when a state licensing board reinstates a license or removes the probation, the reinstatement would also appear in the data as a separate report. The NPDB Judgments or Convictions file includes health care–related federal or state criminal convictions.⁶ The Health Resources and Services Administration provided us with a match of the two files, current as of February 2017. Not all individuals in the NPDB are working at VA in a health-care position that requires a license. Figure 7 below illustrates the NPDB matches we received, as well as the number of employees that were listed in the September 30, 2016, roster, the most-recent file received for our analysis.

⁶Reporting of criminal convictions is authorized under Section 1128E of the Social Security Act (Pub. L. No. 104-191, the Health Insurance Portability and Accountability Act of 1996), 45 C.F.R. § 60.13. Examples of health care–related federal or state criminal convictions include drug diversion, patient abuse, or fraudulent billing.

Figure 7: Match of VA Employees to the NPDB



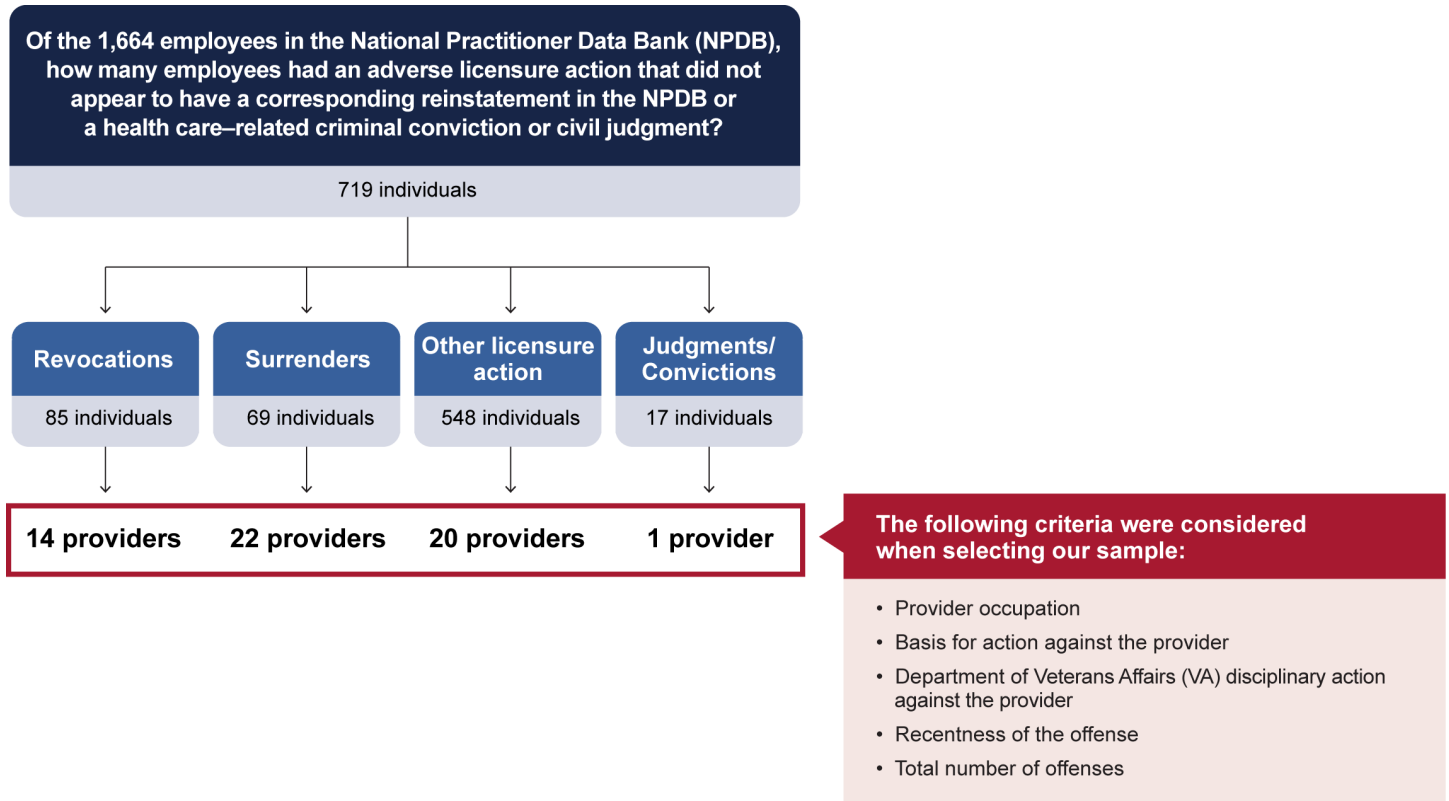
Source: GAO analysis of NPDB and VA information. | GAO-19-6

Note: As of September 30, 2016, seven individuals were in both the Adverse Action file and the Judgments and Convictions file.

We assessed the reliability of the VA PAID data for the purposes of generating a judgmental sample of providers with adverse actions and found it reliable for our purposes. To do this, we performed electronic tests on each PAID database to determine the completeness and accuracy of the fields contained in the data files. We also spoke with VA officials knowledgeable about the PAID system, and reviewed related documentation about the data. On the basis of this information, we found the VA PAID employee roster and misconduct data to be sufficiently reliable for our purposes. We also assessed the reliability of the NPDB data by interviewing Health Resources and Services Administration officials knowledgeable about the NPDB, reviewing the data for completeness, and comparing records in the NPDB files we received to primary source information, such as state licensing-board documents. On

the basis of this information, we found the NPDB data to be sufficiently reliable for our purposes. The results of the case-study analysis are illustrative and nongeneralizable. Although we may be able to extract themes of how there may be gaps in the VHA credentialing process, we are not able to assess the extent to which these problems are prevalent at VHA. See figure 8 below.

Figure 8: Process to Identify Case Studies for Review



Source: GAO analysis of NPDB and VA information. | GAO-19-6

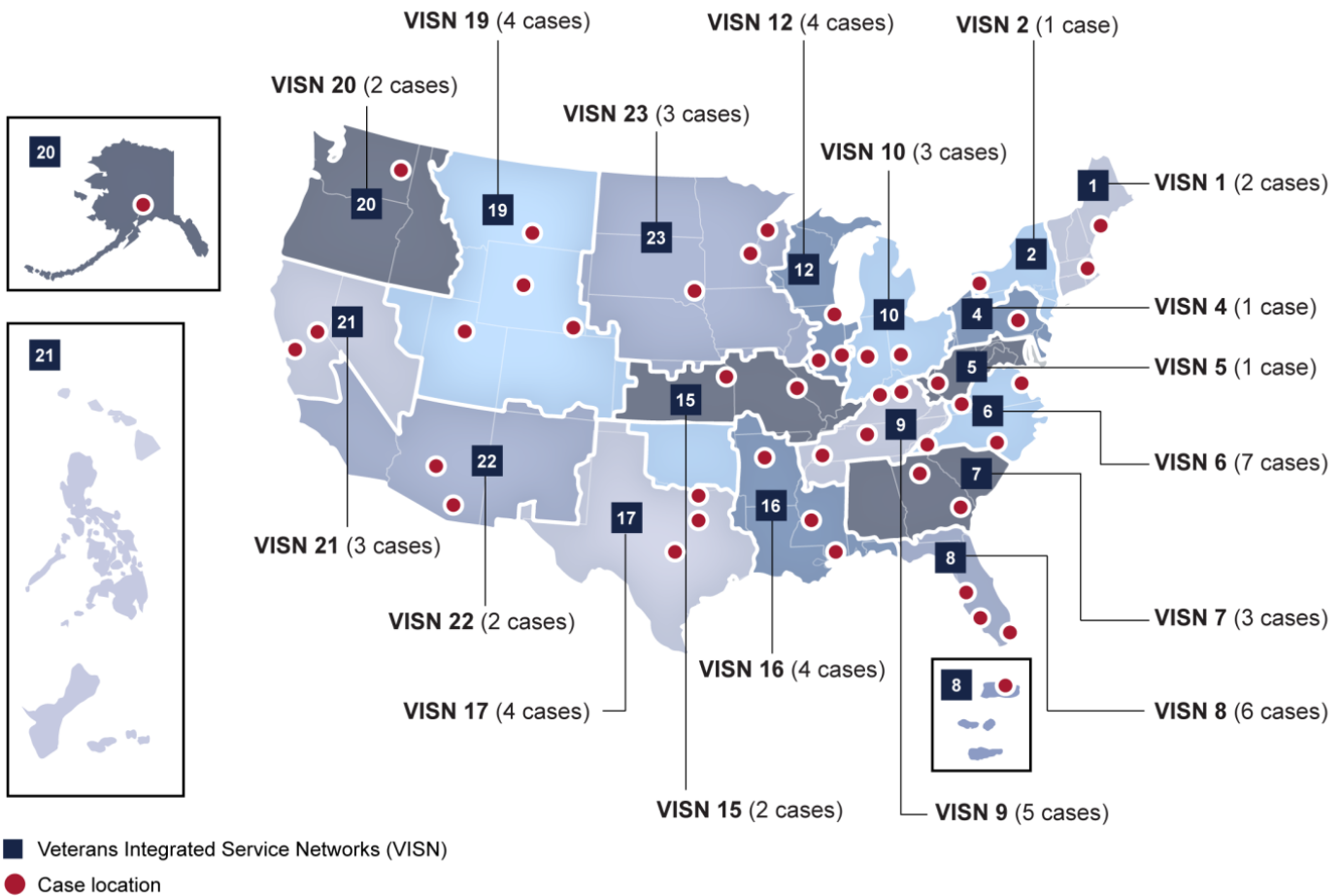
Note: Individuals may have multiple NPDB reports that span various types of actions. We omitted individuals who are in nonlicensed positions from our analysis. For example, if an employee’s nursing license was revoked, but the employee was working at the Veterans Health Administration as a benefits coordinator—a position that does not require a nursing license—we omitted this individual from further analysis.

We did not consider location when selecting our cases for review. Hence, our cases are not limited to a particular facility or Veterans Integrated

Service Network (VISN).⁷ However, as shown in figure 9 below, facilities in all 18 VISNs were included in our review. The results of the case-study analysis are illustrative and nongeneralizable.

⁷VHA organizes its system of care into regional networks called Veterans Integrated Service Networks (VISN). Each VISN is responsible for managing and overseeing facilities within a defined geographic area and reporting to the Deputy Under Secretary for Health for Operations and Management within VHA's Central Office. Beginning in 2002, VHA began realigning VISNs, which included merging several VISNs. This realignment decreased the number of VISNs from 21 to 18. In 2002, VISNs 13 and 14 were merged to create VISN 23. In 2015, three sets of VISNs merged: VISNs 2 and 3; 10 and 11; and 18 and 22. Additionally, some facilities were moved from one VISN to another VISN. See [GAO-16-803](#).

Figure 9: Geographic Dispersion of Selected Cases



Source: GAO analysis of Department of Veterans Affairs (VA) information (data); Map Resources and VA (map). | GAO-19-6

Note: The Veterans Health Administration (VHA) organizes its system of care into regional networks called Veterans Integrated Service Networks (VISN). Each VISN is responsible for managing and overseeing facilities within a defined geographic area and reporting to the Deputy Under Secretary for Health for Operations and Management within VHA's Central Office. Beginning in 2002, VHA began realigning VISNs, which included merging several VISNs. This realignment decreased the number of VISNs from 21 to 18. In 2002, VISNs 13 and 14 were merged to create VISN 23. In 2015, three sets of VISNs merged: VISNs 2 and 3; 10 and 11; and 18 and 22. Additionally, some facilities were moved from one VISN to another VISN.

For each of the providers in our sample, we consulted several data sources to document the details and circumstances of their employment at VHA. We examined the VHA personnel and credentialing files and privileging and misconduct files, when applicable. We accessed the VHA electronic credentialing system, VetPro, to review information that VHA staff verified and considered as part of the hiring process, including:

NPDB reports that VHA received about providers, licensure information the provider updated into the system, information the providers self-disclosed about their licensure status, notes made by the Service Chief when making a hiring determination, and information that demonstrated when VHA became aware of the NPDB adverse-action report. We accessed employee personnel actions through the Office of Personnel Management's Electronic Official Personnel Folder system, and reviewed information related to hire, separation, and disciplinary actions. When available, we also reviewed the employment application to determine whether the employee disclosed any adverse action. We also reviewed privileging files for providers who are required to have privileges. Additionally, we reviewed individual employee misconduct files for providers against whom VHA had taken action.

We also conducted interviews with VHA facility officials from the applicable facility and VISN, when necessary, to obtain information about how they assessed the NPDB adverse-action reports when making hiring or retention decisions. We asked VHA facility and Central Office officials about how certain policies were applied to our case-study sample, but we do not make conclusions about the correctness of VHA's interpretations or decisions. We obtained and reviewed state licensing-board documents for all licenses for all providers in our sample, and performed follow-up research with state licensing-board officials, when necessary, to clarify the meaning of the documentation.

To address how VHA facilities adhered to policies regarding providers with adverse actions, we reviewed the applicable federal law and regulations as well as VHA directives and handbooks. We also reviewed VA Office of the Inspector General reports and prior GAO work. In addition, as part of our case-study review, we examined how VHA policies were applied in hiring and retention decisions.

To identify steps VHA has taken to ensure that providers meet licensure requirements, we interviewed VHA Central Office officials to discuss initiatives undertaken to identify providers who do not meet the licensure requirements and the outcome of those initiatives. We also reviewed VHA reports, guidance provided to VHA credentialing staff, and other related documentation that outlines the implementation of these initiatives.

To address all objectives, we interviewed senior officials from VHA's Central Office, specifically, the Office of Quality, Safety, and Value, and the Office of Workforce Management and Consulting; as well as officials at facilities responsible for verifying credentialing information and for

human resources, and officials with the Office of VA Pharmacy Benefits Management Services. We also interviewed officials with the Drug Enforcement Administration about its registration certificates and waivers.⁸

We conducted this performance audit from October 2015 to February 2019 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.

⁸The Drug Enforcement Administration was not audited as part of our work. We spoke with subject-matter experts at the agency only to learn about the agency's registration requirements and waivers.

Appendix II: Prior GAO Work

We previously reported on issues related to oversight of Veterans Health Administration (VHA) health-care providers. For example, we examined VHA facilities' reporting of providers to the National Practitioner Data Bank (NPDB); adherence to performance pay policies; response to clinical incidents that may pose the risk of injury to a patient; and oversight of the physician credentialing and privileging process. We issued pertinent recommendations, and the Department of Veterans Administration (VA) concurred with most of them, as follows.

In November 2017, we found that when there were concerns about a provider's clinical performance, the five selected facilities in our review did not report most providers who should have been reported to the NPDB or state licensing board in accordance with VHA policy.¹ We also found that officials at these facilities misinterpreted or were not aware of VHA policies and guidance related to NPDB and licensing-board reporting processes. Additionally, we found that VHA and the Veterans Integrated Service Networks (VISN) did not conduct adequate oversight of the NPDB and licensing-board reporting practices and could not reasonably ensure appropriate reporting of providers. As a result, we concluded that VHA's ability to provide safe, high-quality care to veterans was hindered because other VHA facilities, as well as non-VHA health-care entities, were unaware of serious concerns raised about a provider's care. We recommended that VHA require VISN-level officials to oversee facility reviews of providers' clinical care after concerns have been raised. VHA agreed with the recommendation and indicated that it had plans to improve the tool that VISNs use to oversee reviews of providers' clinical care after concerns have been raised. VHA's estimated completion date for improvements to the tool is 2019.

In 2013, we reported on VHA's performance pay and award systems.² We found that among the four facilities we visited, all eligible providers received performance pay incentives, including all five providers who had an action taken against them related to clinical performance. We also found that VHA's oversight was inadequate to ensure that facilities comply with performance pay and award requirements. VHA's annual consultative reviews, initiated in 2011, help facilities comply with human-

¹GAO, *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*, [GAO-18-63](#) (Washington, D.C.: Nov. 15, 2017).

²GAO, *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).

resources requirements, including performance-award requirements. We found that reviewers did not have the authority to require facilities to resolve compliance problems they identify, and VHA had not formally assigned specific organizational responsibility to ensure medical centers resolve identified problems. As a result, we concluded that VHA was unable to ensure that reviews consistently identified problems, and that these problems were corrected and do not recur. We recommended that VA assign responsibility to a VHA organizational component to ensure correction of facilities' noncompliance with VA's performance pay and award policy requirements. VA agreed and has since implemented this recommendation.

In a 2012 report, in response to questions raised about the quality of care provided to veterans by facilities, and whether lessons learned at one facility are being translated into system-wide improvements, we found that VHA had given facilities discretion in the process they choose to respond to reported adverse events.³ Specifically, we found that each facility maintained its own incident-reporting system, which was used by facility staff to report adverse events. In addition to reviewing providers' clinical care, facilities had other processes available to them for responding to an adverse event or incident report. We did not make any recommendations in this report.

In a 2010 report we examined VHA's policies and guidance that help ensure that information about physician qualifications and performance is accurate and complete.⁴ We also examined facilities' compliance with selected VHA credentialing and privileging policies and their implementation of policies to continuously monitor performance. We found that VHA's policies and guidance on credentialing, privileging, and continuous monitoring helped ensure the collection of accurate and complete information about physician professional qualifications, clinical abilities, and clinical performance. We also found that these policies and guidance addressed or exceeded relevant accreditation standards. However, we found that facility staff did not consistently follow VHA's credentialing and privileging policy requirements selected for review. For example, 29 of the 180 credentialing and privileging files reviewed lacked

³GAO, *Veterans Health Care: Veterans Health Administration Processes for Responding to Reported Adverse Events*, [GAO-12-827R](#) (Washington, D.C.: Aug. 24, 2012).

⁴GAO, *VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes*, [GAO-10-26](#) (Washington, D.C.: Jan. 6, 2010).

proper verification of state medical licensure. In addition, the facilities did not identify instances when physicians appeared to have omitted required information on their applications. Finally, we found that VHA policies lacked sufficient internal controls, such as specifying how compliance should be assessed, to identify and correct problems in a facility's noncompliance with credentialing and privileging policies.

In the 2010 report, we made three recommendations. First, we recommended that VHA should require VISN Directors to develop a formal oversight process to systematically review credentialing and privileging files and the information used to support reprivileging of physicians for compliance with VHA policies and to document results of reviews and corrective actions at least annually. To close the feedback loop, the oversight process should describe a method of follow-up to measure whether facilities corrected identified weaknesses. VA agreed and has since implemented this recommendation. Second, we recommended that VHA should collect more information about state licensing-board policies on the release of information, and consider amending VHA policy to not require written verification for states that do not provide additional information beyond what is available by phone or on the state licensing boards' websites. VA agreed and since has implemented this recommendation. Last, we recommended that VHA update VetPro to more effectively display physician credentialing information. Specifically, VHA should improve the display of verified information on VetPro's summary tables and simplify and clarify questions related to malpractice and licensure. VA agreed; however, it did not implement this recommendation because VHA officials said they were moving to a new system. At the time of our current work, VHA was using VetPro. However, VHA Central Office officials told us that they are moving to a new credentialing system in 2019.

Appendix III: Summary of Case-Study Work for Selected Providers

We analyzed the National Practitioner Data Bank (NPDB) data to identify health-care providers who had a revoked or suspended license or other adverse action taken on their licenses and who were working at the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) as of September 30, 2016, and selected a nonprobability sample of 57 health-care providers. For each provider, we reviewed various data sources, including VA employee files, state licensing-board documentation, and NPDB data. We also interviewed VHA facility officials, when necessary, to better understand how the NPDB data were considered when hiring or retaining the providers. Table 1 provides a summary of information we compiled for each of the 57 provider case studies. All case information is current as of the time of our review.

The results of our case-study analysis are illustrative and nongeneralizable. For each provider, we identified the position he held at VHA, the date he was hired, and his current employment status at VHA. We also identified the date and action that was reported to the NPDB and how VHA became aware of the action. We summarized the applicable VHA policy on how this action should affect the provider’s employment status. Finally, we documented how VHA responded to the action. To avoid revealing the identities of individuals mentioned in the appendix and report, we use “he” and “his” throughout the appendix and report, regardless of the actual gender of the individual. For more information on how we generated our sample, and the steps taken as part of the case-study review, see appendix I.

Table 1: Summary of 57 Provider Case Studies

Case	Position	Summary
1	Physician	<ul style="list-style-type: none"> • Employment at the Veterans Health Administration (VHA): The provider was hired as a physician in April 2007 and voluntarily retired from VHA in January 2017. • National Practitioner Data Bank (NPDB) Reporting: The provider was reported to the NPDB because the state licensing board revoked the provider’s license to practice medicine in January 2017 for failing to practice medicine with an acceptable level of care or skill. • VHA Policy on Licensure Action: VHA policy states that providers with a license revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA officials told us that they received a letter from the state licensing board stating that the revocation was impending, but they could not remember when they received the letter, nor could they locate the letter. The provider disclosed that his license was under investigation, but did not disclose that his license was going to be revoked. • VHA Response: Before VHA could take any action, the provider voluntarily retired.

**Appendix III: Summary of Case-Study Work for
Selected Providers**

Case	Position	Summary
2	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in June 2016 and voluntarily resigned in January 2017. • NPDB Reporting: The provider was reported to the NPDB because a state licensing board revoked the provider's registered-nurse license in September 2005. The provider's license was not reinstated prior to the provider's appointment at VHA. The provider disclosed to VHA that his license was revoked due to substance abuse. VHA verified that the provider held an active license in another state that had an expiration date of June 2017. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: VHA became aware of the revoked license in April 2016, before the provider was hired, from an NPDB report. • VHA Response: VHA facility officials stated that they were aware that the provider's state license was revoked, but that the revocation was based on a felony that was later expunged. However, they also noted that the facility hiring manager was not aware of the requirements laid out by VHA policy.
3	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in September 2014 and voluntarily resigned in August 2017. • NPDB Reporting: The provider was reported to the NPDB in July 2016 by the state licensing board. The provider's license was revoked due to misappropriation of patient property and a criminal conviction. According to the state licensing-board documents, the provider stole items and pawned them to support the provider's addiction to pain medication. The provider also admitted to faking a drug test by giving a "substituted specimen." • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA did not learn about the revoked license until August 2017 when a staff member reported the provider for working without a license. The provider worked for over a year at VHA with a revoked license and no other active licenses. • VHA Response: VHA facility officials told us that the provider resigned before disciplinary action could be taken. VHA facility officials told us that in November 2017, they reported the provider to the state licensing board.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
4	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in November 2006 and voluntarily resigned from VHA in February 2018. • NPDB Reporting: The provider was reported to the NPDB as the provider's license in one state was revoked in December 2007 for failure to comply with the licensing-board orders by not completing required courses. Prior to and during the provider's employment at VHA, two state licensing boards acted on the provider's licenses due to alcohol dependency and a history of alcohol-related arrests. • VHA Policy on Licensure Action: VHA policy does not disqualify health-care providers with a revoked license from employment if the revocation was due to administrative reasons. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: VHA became aware of the licensing issue in May 2009 when staff ran an NPDB query. In the provider's VetPro disclosure, the provider told officials the license was encumbered but did not mention it was revoked. • VHA Response: VHA facility officials told us the provider voluntarily resigned in February 2018. They were in the process of removing the provider, but as there was no official proposed disciplinary action, the resignation is treated as voluntary.
5	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in February 2013 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because the provider had a state license revoked in December 2015 for failing to complete a required ethics course. During this time, the provider had an active license in another state. • VHA Policy on Licensure Action: VHA policy does not disqualify health-care providers with a revoked license from employment, if the revocation was due to administrative reasons. • How VHA Became Aware of Action: VHA was unaware of the action because the provider was not required to notify the agency. • VHA Response: The VHA facility did not take action because the provider was not required to notify the agency.
6	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in January 2003 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because the provider's license in one state was revoked in June 2015 for failing to complete a state licensing board–required course on state laws and rules. During this time, the provider had an active license with another state licensing board. • VHA Policy on Licensure Action: VHA policy does not disqualify health-care providers with a revoked license from employment, if the revocation was due to administrative reasons. • How VHA Became Aware of Action: VHA was unaware of the action until we contacted the facility as part of this inquiry. • VHA Response: The provider was not required to notify VHA about this issue. Hence, the VHA facility did not take action.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
7	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 2015 and remains employed at VHA. • NPDB Reporting: The provider was in the NPDB because he surrendered a state training certificate for failing to abstain from drugs and alcohol and to submit to random drug and alcohol screenings. The Surrender Agreement stated that the provider is not permitted to practice any profession regulated by the state licensing board, including medicine and surgery. During this time, the provider held an active license in another state. • VHA Policy on Licensure Action: VHA policy does not disqualify health-care providers with a revoked license from employment, if the revocation was due to administrative reasons. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis • How VHA Became Aware of Action: The provider disclosed the surrender of the state training certificate before being hired in July 2015. • VHA Response: When documenting the hiring recommendation, the Service Chief noted that the provider demonstrated required compliance to all monitoring requests and has an excellent professional record.
8	Registered Nurse	<ul style="list-style-type: none"> • Employment at the VHA: The provider was hired as a nurse in November 2013 and was removed in March 2018 as a result of the VHA-wide provider licensure review. • NPDB Reporting: The provider was reported to the NPDB because in June 2014 the provider's state license was revoked due to alleged drug diversion. The provider's license was reinstated in November 2014 after the state licensing board determined there was insufficient evidence to support the allegations. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA was made aware of the licensure action in August 2014, as part of an Employee Relations investigation. The investigation file states that the provider falsified information concerning his professional registration and licensure. • VHA Response: When the VHA facility learned about the revoked license, it placed the provider on paid nonduty status to give the provider time to get his license reinstated. Facility officials told us that the provider was on paid nonduty status for about 7 months—from August 2014 to March 2015. During this time he did not report for work. The provider was included in the VHA-wide provider licensure review and, on the basis of its findings, the provider was removed in March 2018.
9	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in November 2014 and voluntarily resigned in May 2017. • NPDB Reporting: The provider was reported to the NPDB in April 2013 because a state licensing board revoked the provider's multistate license for patient neglect and substandard care. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How VHA Became Aware of Action: Officials at the VHA facility told us that they received the NPDB report in October 2014, but the license revocation was inadvertently overlooked by multiple VHA personnel who were reviewing several NPDB reports for this provider. At the time of application, the provider failed to enter the license as required. • VHA Response: VHA hired the provider with a revoked state license.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
10	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in June 2015 and voluntarily resigned in November 2017. • NPDB Reporting: The provider was reported to the NPDB because a state revoked the provider's license in November 2005 because he fraudulently represented himself as a registered nurse to employers by submitting an altered registered-nurse license. During this time, the provider had an active license in another state. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How VHA Became Aware of Action: The provider disclosed that he surrendered his license because the state licensing board was going to charge him with working without a license. VHA facility officials confirmed that the state licensing board revoked the provider's license. • VHA Response: The Service Chief reviewed the provider's file and recommended the provider for appointment. VHA officials stated that the provider was included in the VHA-wide provider licensure review, and VHA facility officials began action to remove the provider in January 2018. However, the provider had voluntarily resigned in November 2017.
11	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in July 2005 and was removed in February 2009. The provider was reappointed in October 2010 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because the provider's state license was revoked in April 2002 due to substance-abuse issues. During this time the provider had an active license in another state. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: VHA became aware of the state license revocation in January 2009 as part of a mandate to ensure all department providers were credentialed. • VHA Response: VHA officials told us that the provider's revoked license was discovered as a result of a 2007 VHA mandate requiring all nurses to be credentialed. The VHA facility removed the provider due to the revoked state license and rehired him after that license was reinstated in April 2010.

**Appendix III: Summary of Case-Study Work for
Selected Providers**

Case	Position	Summary
12	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in August 2013 and voluntarily resigned in October 2016. • NPDB Reporting: The provider was reported to the NPDB because the provider's license was suspended in October 2016 and revoked in December 2016 after the provider was convicted of health-care fraud and money laundering in June 2016. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. • How the VHA Became Aware of Action: The provider disclosed that he was the subject of an ongoing Medicare fraud investigation when he was appointed to VHA. In April 2015, the provider disclosed that he was indicted on Medicare fraud charges in September 2013 and was in the process of contesting those charges. In July 2015, after reviewing the provider's responses, the Service Chief noted that he "trusts that [the provider] will be found innocent." The provider worked at VHA for approximately 3 months after the conviction. Facility officials stated that they did not take immediate action because they were waiting for sentencing and state licensing-board action before making a decision. VHA facility officials stated that a criminal conviction alone does not disqualify a provider from employment at VHA. • VHA Response: VHA facility officials stated that the circumstances surrounding this case were examined by the appropriate staff prior to the appointment. The provider voluntarily resigned in October 2016, 1 day before the state licensing board suspended the provider's license and 3 months before the provider's license was revoked.
13	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in March 2014 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because the provider's pharmacy-technician license was revoked in October 2008 due to possession of marijuana. This action was taken on the provider's pharmacy-technician license, not his nursing license. At the time the provider was hired, the provider had an active state nursing license. • VHA Policy on Licensure Action: VHA policy states that for applicants who have been registered in a profession other than what is applicable to the position, and for whom termination for professional misconduct is documented, a complete review of the professional conduct of the applicant must be documented. • How VHA Became Aware of Action: The provider disclosed the issue with his pharmacy-technician license when he applied in December 2013. • VHA Response: The Service Chief reviewed the provider's responses to the supplemental attestation questions and recommended the provider for appointment.

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Case	Position	Summary
14	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in October 2006. The provider was removed from his position in October 2017 for administrative reasons. • NPDB Reporting: The provider was reported to the NPDB because the provider's state license was revoked in March 2003 after the provider was convicted of driving under the influence of alcohol and endangerment. • VHA Policy on Licensure Action: VHA policy states that providers whose license is revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is restored to a full and unrestricted status. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: In October 2006, a VHA human-resources specialist queried the NPDB and pulled a report detailing this licensure issue. However, officials stated that the human-resources specialist did not elevate the matter. Further, the provider did not disclose the license revocation to VHA. • VHA Response: VHA facility officials said that based on their understanding of VHA's policy, the provider did not meet the requirements to work at VHA because of the provider's revoked license, even though the provider has active licenses elsewhere.
15	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a practical nurse in August 2004 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in September 2016 when the provider surrendered his registered-nurse license. The NPDB data indicate the reason for the surrender was misrepresentation of credentials, fraud, and violation of federal or state statutes, regulations, or rules. According to NPDB data, the basis for the action was that the provider misrepresented his education to obtain a registered-nurse license. The provider currently holds a practical-nurse license and is employed as a licensed practical nurse at VHA. • VHA Policy on Licensure Action: VHA policy states that for applicants who have been registered in a profession other than what is applicable to the position, and for whom termination for professional misconduct is documented, a complete review of the professional conduct of the applicant must be documented. • How VHA Became Aware of Action: VHA facility officials told us they were unaware of the action until the provider applied at another VHA facility. • VHA Response: VHA Central Office officials told us that a revoked registered-nurse license would not disqualify the provider from working as a licensed practical nurse, as the licenses and the qualifications are distinct from one another. Further, the provider was never employed at VHA as a registered nurse.

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Case	Position	Summary
16	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in September 2012 and retired in lieu of involuntary action in December 2017. • NPDB Reporting: In 2015, the provider was reported to the NPDB when the provider surrendered three licenses from three states in April, August, and December, for issues related to professional misconduct stemming from convictions for driving while under the influence of alcohol. • VHA Policy on Licensure Action: VHA policy states that providers who have had a license surrendered for professional misconduct are not eligible for continued employment unless the surrendered license is restored to a full and unrestricted status. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis • How VHA Became Aware of Action: In April 2014, the provider self-disclosed to VHA that he had surrendered his Drug Enforcement Administration (DEA) registration. VHA also received NPDB reports on each of the license surrenders in 2015. • VHA Response: VHA facility officials, including the Professional Standards Board and District Counsel, reviewed the circumstances surrounding the surrender and determined the provider was eligible for employment because the issues were unrelated to patient care and the provider had one active, unrestricted license. A VHA official stated that, in December 2017, in response to our inquires, VHA officials reviewed the provider's license and issued a notice of termination after determining that the provider had licenses that were suspended and surrendered for cause and that the provider no longer met employment requirements. The provider retired from VHA in lieu of involuntary action.
17	Nurse Practitioner	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse practitioner in August 2006 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because the provider surrendered his DEA registration in December 2015. • VHA Policy on Licensure Action: VHA considers the necessity of a DEA registration on a case-by-case basis. VHA facility officials stated that the provider surrendered his DEA registration because it was not required for nurse practitioners in the state. As such, the surrender does not disqualify the provider from employment. • How VHA Became Aware of Action: VHA became aware of the surrender through an NPDB report in February 2016. The provider was recredentialed in 2016. • VHA Response: The Service Chief noted the surrender but did not indicate that the provider was ineligible for employment. Facility officials noted that the provider is in good standing.
18	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in January 2016 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in August 2004 when the provider surrendered his state license. This was in response to a patient complaint alleging unprofessional conduct. • VHA Policy on Licensure Action: VHA policy states that providers who have had a license surrendered for professional misconduct are not eligible for continued employment unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: In December 2015, prior to the provider's hire, the provider disclosed the surrendered license to VHA and stated that it was related to substance-abuse issues. During this time, the provider had an active license in another state. • VHA Response: VHA hired the provider. The VHA facility Chief of Staff stated that the state licensing board proceeded without filing of charges or a formal complaint and notice of hearing as the provider decided to surrender his license.

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Case	Position	Summary
19	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in August 2002 and retired in lieu of involuntary action in December 2017. • NPDB Reporting: The provider was reported to the NPDB in June 2015 when the provider surrendered his DEA registration as the result of an investigation. Further, the provider was reported to the NPDB when a state licensing board indefinitely suspended for a minimum of 1 year the provider's license in May 2015 for inappropriate prescribing of controlled substances. The provider was reported to the NPDB again in July 2015 when another state licensing board denied the provider's application for renewal. In June 2017, a third state licensing board placed the provider's license on indefinite probation for a period of no less than 2 years and limited the provider's practice to the VHA medical facility. This action was taken as a result of the actions of the other state licensing boards. • VHA Policy on Licensure Action: VHA policy states that a physician is not eligible to work at VHA if a state licensing board restricts the provider's license to a specified facility; the physician must hold a full, active, current and unrestricted license. • How VHA Became Aware of Action: VHA received an NPDB report in June 2015. VHA received an NPDB report in June 2017 regarding the licensure action in the third state. • VHA Response: VHA facility officials told us that they determined that the provider did not need a DEA registration to fulfill his occupational duties. We identified that the provider had prescribed controlled substances after surrendering the DEA registration in June 2015. Facility officials said they do not plan to report the provider to DEA because the provider used the facility's DEA registration when prescribing controlled substances. With regard to the provider's state medical licenses, facility officials initially told us that the provider met qualifications because the provider possessed a valid state medical license. However, after we inquired about the limitation that allows the provider to only work at VHA, VHA officials reviewed the provider's license and issued a notice of termination in December 2017. VHA facility officials determined that the provider did not meet licensure employment requirements. The provider retired from VHA in lieu of involuntary action.
20	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in July 2007 and was removed by VHA in January 2018. • NPDB Reporting: The provider was reported to the NPDB in October 2014 when the provider surrendered his state license. The order from the state licensing board states that the surrender should be treated as a license revocation. Another state licensing board suspended the provider's license in February 2015 for diverting narcotics for the provider's personal use. • VHA Policy on Licensure Action: VHA policy states that providers who have had a license surrendered for professional misconduct are not eligible for continued employment unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: Licensure documentation in the VetPro system shows that VHA became aware of the license surrender in March 2015. • VHA Response: In January 2018, VHA removed the provider for failing to maintain all qualifications required for appointment and provide evidence of qualifications in a timely manner. VHA staff stated that the removal of the provider was stalled because of confusion among VHA staff about human-resource and performance-management policies and procedures and complications presented by two state licensing boards. VHA facility staff received clarification that a surrender of one license would make the provider ineligible. Upon clarification of the policy and on the basis of our inquiries and the VHA-wide review of provider licenses, they removed the provider from employment.

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Case	Position	Summary
21	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in May 2015 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB because, in February 2011, the provider surrendered his DEA registration that allowed the provider to prescribe controlled substances. This action was taken after the provider was investigated by a state licensing board for drug possession and drug diversion. • VHA Policy on Licensure Action: VHA considers the necessity of a DEA registration on a case-by-case basis. VHA facility officials stated that they obtained a DEA waiver in July 2016, which permitted the provider to work at VHA and to prescribe controlled substances. • How VHA Became Aware of Action: VHA became aware of the action when it received an NPDB report in December 2014, before the provider was hired. • VHA Response: VHA facility officials told us that when the provider was hired, he was in a position that did not require him to prescribe controlled substances. However, DEA regulation states that a DEA waiver is required to employ the provider. According to the provider's supervisor, when the provider's role changed, and the provider needed to be able to prescribe controlled substances, VHA facility officials applied for and obtained a DEA waiver. After we identified that the provider had been prescribing controlled substances before the VHA facility obtained the waiver, facility officials reported the provider to DEA in May 2018.
22	Physical Therapist	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physical therapist in September 2013 and voluntarily resigned in October 2016. • NPDB Reporting: The provider was reported to the NPDB in January 2015 because the provider surrendered his physical-therapy license. The state licensing-board documents state that the provider surrendered his license after a stay of suspension because the provider tested positive for alcohol. • VHA Policy on Licensure Action: VHA policy does not disqualify health-care providers with a surrendered license from employment, if the surrender was unrelated to professional misconduct, professional incompetence, or substandard care. During this time, the provider had a valid physical-therapy license in another state. • How VHA Became Aware of Action: VHA became aware of the surrendered license in February 2015. However, according to a VHA facility official, there is limited information available on this licensure action. The VetPro file does not contain information on how VHA officials determined whether the surrender was administrative or related to professional competency. • VHA Response: VHA did not take action on the NPDB report. The provider had an active, valid license in another state during this time.

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Case	Position	Summary
23	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in March 2015 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in May 2012 when the provider surrendered his state license after the state licensing board alleged conduct by the provider that constituted professional misconduct, hazardous negligence, or incapacity in the practice of medicine. This action occurred after a patient died of alleged complications of a colonoscopy that the provider performed. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA received an NPDB report in January 2015 with information on the state-license surrender. This report was received 2 months before the provider's appointment. • VHA Response: VHA facility officials said a review was conducted surrounding the circumstances of the surrender, and officials decided that it would not affect patient care. The provider was included in the VHA-wide provider licensure review, and VA District Counsel determined that the provider is eligible for employment because the provider surrendered his license prior to receiving notification from the state licensing board of a possible license termination for cause.
24	Nurse Practitioner	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse practitioner in February 2016 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in November 2014 when the provider's DEA registration was surrendered. The provider had his registration reinstated in January 2015 prior to his hire at VHA. • VHA Policy on Licensure Action: VHA considers the necessity of a DEA registration on a case-by-case basis. • How VHA Became Aware of Action: VHA queried the provider in the NPDB in October 2015, prior to his appointment. The provider disclosed that a previous employer renewed all employee state and federal licenses en masse, and as part of this process an administrative error created issues with the provider's DEA registration. • VHA Response: Prior to hiring the provider, a VHA facility official confirmed with the provider's prior employer that his DEA registration surrender resulted from an error by the employer and the employer worked with DEA to correct the error.

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Case	Position	Summary
25	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was most recently hired as a physician in August 2017 and remains employed at VHA. The provider also had previously held fee-basis appointments, starting in May 2013. • NPDB Reporting: The provider was reported to the NPDB in March 2014 when the provider surrendered his DEA registration as a result of an investigation. The state licensing board suspended the provider’s license in February 2014 after he was convicted of a second drunk-driving offense. • VHA Policy on Licensure Action: VHA considers the necessity of a DEA registration on a case-by-case basis. VHA policy states that providers must have a full and unrestricted license to be eligible for employment at VHA. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: VHA received an NPDB report in March 2014 with information on the license suspension. • VHA Response: When the provider’s license was suspended, VHA terminated the provider’s fee-basis appointment. The provider’s license was reinstated with no restriction in June 2014, and the provider’s DEA registration was immediately reinstated. VHA officials stated that when deciding to rehire the provider, they considered that the provider did well in the state alcohol-rehabilitation program. The provider agreed as a condition of employment to perform a breathalyzer test prior to every clinical shift. If the provider had positive test results, he would immediately be terminated.
26	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in August 2013 and resigned in December 2017. • NPDB Reporting: The provider was reported to the NPDB in October 2006 when the provider surrendered his medical license in one state. The state licensing board investigated the provider for failing to notify the board within 30 days of an action that had been taken against the provider’s license by another state licensing board. As part of the surrender, the provider agreed never to apply for licensure as a physician in the state where he surrendered the license. The second state licensing board placed the provider’s license under an agreed order in 2005 for circumstances related to the provider’s privileges being summarily suspended at a non-VHA hospital because the standard of care he provided contributed to a patient’s death. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA became aware of the surrender in March 2013, before the provider was hired, when VHA received an NPDB report. • VHA Response: VHA facility officials said that they cannot answer how the provider met the minimum qualifications because the individuals who signed off on his appointment no longer work at VHA, and officials are unable to locate the provider’s files. The provider resigned after VHA sought to take action. VHA officials told us that they were working to remove the provider because of the provider’s treatment of other staff at the time of the resignation.

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Case	Position	Summary
27	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was most recently hired as a physician in October 2016 and left employment at VHA in October 2017 because the provider’s contract was not renewed. The provider also had previously worked at VHA on intermittent contracts from July 2007 through March 2011. • NPDB Reporting: The provider was reported to the NPDB in November 2011 when the provider surrendered his state license after he failed to comply with a state health-care provider assistance program. In July 2012, the provider was reported to the NPDB when the provider surrendered his DEA registration following an investigation. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA received NPDB reports regarding the surrenders in September 2016, prior to the provider’s appointment at VHA. The provider also disclosed this information in the VetPro system in September 2016. • VHA Response: VHA hired the provider. The provider’s state license was reinstated in August 2016, and VHA facility officials stated that the provider was not in a prescribing position until after the provider’s DEA registration was restored. VHA facility officials stated that the provider’s contract was not renewed for reasons unrelated to the provider’s licenses.
28	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in November 2015 and removed in February 2018. • NPDB Reporting: The provider was reported to the NPDB because the provider surrendered his state license in April 2011, during the course of an investigation. In September 2010, the provider received a notice from the state licensing board indicating that it would hold a hearing to investigate claims of “incompetence” and “gross negligence” and that the provider’s license could be revoked or suspended. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA became aware of the licensure action in August 2015, before the provider was hired by VHA. The provider disclosed the surrender, and VHA received an NPDB report on the surrender. • VHA Response: VHA facility officials were aware of the surrender and hired the provider. Initially, facility officials we spoke with stated that, when working for the federal government, a provider only has to have an unrestricted license in one state. However, according to the provider’s VHA misconduct file, the provider was included in the VHA-wide provider licensure review and, on the basis of the facility’s findings that the state license had not been restored to a full and unrestricted status, the provider was removed from employment.

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Case	Position	Summary
29	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in August 2016 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in June 2012 when the provider surrendered his DEA registration. • VHA Policy on Licensure Action: VHA considers the necessity of a DEA registration on a case-by-case basis. • How VHA Became Aware of Action: The provider disclosed the DEA surrender in the VetPro system in May 2016, approximately 3 months before he was hired by the facility. • VHA Response: VHA facility officials stated that the provider does not need a DEA registration for his current position. Prior to the provider’s appointment, the credentialing committee met and discussed the provider’s qualifications and experience with regard to the provider’s potential appointment. In particular, officials noted that the provider had voluntarily relinquished his DEA registration after a facility that the provider worked at was investigated for illegal distribution of controlled substances. The provider was not named in the investigation. VHA hired the provider.
30	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in October 2013 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in May 2012 when the provider voluntarily surrendered a medical license, after the provider received a notice of impending disciplinary action. The surrender was in response to a different state board monitoring his license after the provider disclosed that he was seeking treatment for substance abuse. The state licensing board order from the state where the license was surrendered does not state that the state licensing board would terminate the provider’s license, but it does state it would take disciplinary action. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: The provider disclosed the licensure surrender in the VetPro system in July 2013, approximately 3 months before the provider was hired by VHA. • VHA Response: VHA facility officials were aware of the license surrender and hired the provider. The Chief of Staff said that she took into consideration actions the provider had taken to address his substance-abuse issues, such as participating in rehabilitation, prior to hiring him. As part of his employment contract, the provider was required to submit to a breathalyzer before work and random drugs tests. VHA officials reported that the provider has not failed a breathalyzer test and that he is an excellent provider.

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Case	Position	Summary
31	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in March 2013 and continues to work at VHA. • NPDB Reporting: The provider is in the NPDB because the provider surrendered his state nursing license in June 1998 due to patient abandonment. At the time he was hired, the provider had an active license in another state. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: In November 2012, the provider disclosed his license surrender in the VetPro system and attributed his license surrender to substance abuse, for which the provider completed a 5-year monitoring program in 2011. • VHA Response: According to the Chief of Human Resources at the facility, the provider's license information was verified at the time of the appointment. However, due to an administrative oversight, officials did not review the provider's appointment with respect to the requirement that applicants or individuals who surrendered a license after being notified of the potential termination of a license are not eligible for appointment. In December 2017, A VHA attorney determined that the provider's license surrender was not problematic with respect to his appointment because the state licensing board's letter to the provider was too vague to establish that the provider had been notified of the potential termination of his license.
32	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in November 2006 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in May 2011 when the provider surrendered his state license during the course of a state licensing-board investigation into action taken in another state. The provider's other state license was suspended in March 2011 and was reinstated in December 2011. The NPDB report lists the basis for action as including patient abuse, patient neglect, and exploiting a patient for financial gain. Thus from May 2011 through December 2011 the provider did not have an active, unrestricted license to practice nursing while employed at VHA. • VHA Policy on Licensure Action: VHA policy requires providers to have a full, active, current and unrestricted license. Additionally, VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA became aware of the state license surrender in June 2014 when it ran an NPDB query. • VHA Response: The provider was indicted in 2013 on charges including vulnerable adult abuse and negligent homicide. VHA placed the provider on indefinite suspension during the 2013 criminal proceedings. VHA determined that the provider was eligible for continued employment because the criminal charges were dropped. The human-resources specialist determined that the provider is currently eligible for employment because he has an active, unrestricted license. However, the provider surrendered his license in another state in 2011 during the course of an investigation by another state licensing board and has not been reinstated. In a subsequent interview, a VHA official said that the provider should have been immediately removed for failing to meet the conditions of employment when one of his licenses was suspended and the other license was surrendered. The provider continues to work at VHA as a nurse.

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Case	Position	Summary
33	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in October 2010 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in September 2007 when the provider voluntarily surrendered his license in one state in response to a settlement agreement with another state’s licensing board. The settlement agreement with the other state licensing board was related to a patient-care issue. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: The provider disclosed his license surrender in May 2010, about 5 months before the provider was hired. • VHA Response: District Counsel reviewed board documents and determined that issues related to the surrendered license were administrative. VHA facility officials stated they performed a review and determined that the licensure surrender did not result from an adverse action based on competence or conduct. Further, District Counsel stated that neither state licensing board recommended a licensure revocation. The VHA facility hired the provider. In August 2010, another VHA facility—in another Veterans Integrate Service Network (VISN)—deemed the provider ineligible for appointment because of the license surrender. It determined that the provider had surrendered his state license after being notified in writing of the potential termination of the license for professional misconduct, professional incompetence, or substandard care.
34	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 2004 and was removed from VHA in September 2017. • NPDB Reporting: The provider was reported to the NPDB in January 1998 when the provider surrendered his state medical license for providing care that fell below the minimum standards of acceptable practice. The state licensing board reinstated the provider’s license in April 2001. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrendered a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA received an NPDB report in December 2002 detailing the provider’s licensure actions. On the basis of the information in the VetPro system, it is unclear whether the provider disclosed the full nature of the licensure actions. • VHA Response: VHA facility officials were aware of the surrendered license that had been reinstated prior to the provider’s employment. The Medical Center Director said it was his understanding that all state licensing-board restrictions against the provider were cleared prior to the provider starting at VHA; however, the Medical Center Director said that this is only speculation, because of limited facility documentation. The provider was removed in September 2017 for issues unrelated to his license surrender and restrictions. VHA officials said that the provider did not provide credentialing information as requested and that the provider had attested to voluntarily resigning from a faculty position whereas the provider had been involuntarily removed. In prior years, VHA had sought to take disciplinary actions against the provider due to concerns that the provider violated patient privacy policies.

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Case	Position	Summary
35	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in November 2013 and remains employed with VHA. • NPDB Reporting: The provider was reported to the NPDB in March 2003 when the provider surrendered his physical-therapist license after failing to meet continuing education credits. The action on the provider’s license was administrative in nature. Additionally, the licensure action was not on the provider’s medical license • VHA Policy on Licensure Action: VHA policy states that individuals who surrender a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA was made aware of the physical-therapy license surrender when the provider disclosed it in October 2013, prior to his appointment. • VHA Response: The facility Service Chief reviewed the provider’s credentialing file and recommended appointment.
36	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in November 2014 and was terminated from VHA in December 2017. • NPDB Reporting: The provider was reported to the NPDB for actions related to licenses in three states. One state licensing board revoked his license in December 1995 for actions related to inappropriate sexual conduct with patients who were minors. A second state licensing board revoked the provider’s license in July 1996 in response to actions taken by the first state. In September 1996 the provider was reported to the NPDB because he surrendered his license in a third state. The board documents do not detail the reason for this surrender. • VHA Policy on Licensure Action: VHA policy states that applicants who voluntarily surrender a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment, unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA became aware of the license surrender in October 2014 when it received an NPDB report. However, the licensure issue was not elevated, and higher-level officials were not made aware of the issue, until October 2017 when we asked questions about the surrender. • VHA Response: Officials said that the provider should never have been appointed to VHA because the provider’s surrendered license made the provider ineligible. VHA facility officials said they were unaware of actions against the nurse’s license until we began this review. Facility officials said the human-resources specialist who conducted the preemployment checks was aware of the actions against the nurse’s licenses but did not elevate it to officials who made the hiring decision. The provider was terminated in December 2017 for failing to disclose the license actions. Officials at the facility also said that they disciplined the human-resources specialist and implemented new standard operating procedures, created a verification form, and provided training to staff to ensure a similar process breakdown does not occur in the future. The provider was included in the VHA-wide provider licensure review.

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Case	Position	Summary
37	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in March 2008. The provider voluntarily resigned in May 2017. • NPDB Reporting: The provider was reported to the NPDB for a June 2008 conviction for unlawful possession of scheduled drugs. As a result, the provider’s state license was placed on probation; the provider was allowed to practice medicine under several conditions, including agreeing to abstain from prohibited substances and to undergo substance monitoring. • VHA Policy on Licensure Action: A criminal conviction does not automatically disqualify a provider from employment at VHA. • How VHA Became Aware of Action: The provider disclosed the conviction on his preemployment application. • VHA Response: VHA staff, in conjunction with VA General Counsel, evaluated the provider’s criminal conviction and license status and deemed the provider qualified for appointment. In April 2017, the provider tested positive for drug use, and the VHA facility subsequently issued a notice for Proposed Removal. However, officials said that the provider entered into an agreement that allowed the provider to voluntarily resign. VHA reported the provider to the state licensing board in March 2018.
38	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 2007 and was removed from his position in April 2012. The provider was rehired in July 2012 and remains employed by VHA. • NPDB Reporting: The provider was first reported to the NPDB in May 2007, after a non-VHA hospital suspended the provider’s clinical privileges. The provider also has multiple NPDB adverse-action reports from multiple states, stemming from an action taken in one state. Specifically, in June 2011 the state licensing board placed a reprimand on the provider’s license for failing to conform to the minimal standard practice of medicine in the treatment of eight patients under his care. In March 2012, another state licensing board placed a restriction on the provider’s license. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA was made aware of the reprimand in July 2011 and state license restriction in April 2012 from NPDB continuous-query reports. • VHA Response: As a result of the license restriction, the VHA facility determined that the provider no longer met the qualifications to work there and removed the provider from employment on the same day. The provider informed the VHA facility his license was reactivated in July 2012 and was rehired by VHA later that month when they confirmed his license was active. In the VetPro credentialing system, the Service Chief recommended approval of the provider’s initial appointment, but there is no discussion about how he came to that conclusion.

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Case	Position	Summary
39	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in January 2004 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in May 2016 because the provider entered into an agreement with a licensing board, as a condition of license renewal. The agreed order stems from an incident in which the provider ordered a prescription for one patient who was not eligible for VHA medical care under another patient’s name. In October 2016, the state licensing board determined that the provider met the requirements of the order and terminated the agreement. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA was aware of the licensure issue because it resulted from misconduct that occurred while the provider was employed at VHA. The misconduct occurred in June 2012. VHA facility leadership was made aware of the incident in June 2016, and the provider disclosed the incident to VHA leadership in July 2015. • VHA Response: According to the misconduct file, the VHA facility suspended the provider for 30 days; 7 days of this 30-day suspension were served without pay, and the remaining 23 days with pay. Additionally, VHA facility officials stated that they reported the provider to the state licensing board in January 2017 and that the provider had already self-reported to the state licensing board with which the provider had the original order in March 2016.
40	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 1988 and was removed from employment in November 2016. • NPDB Reporting: The provider was reported to the NPDB in August 2016 because the state licensing board restricted his license after a May 2015 incident in which the provider allegedly sexually assaulted a VHA colleague. The provider was indicted for Sexual Battery charges and pled guilty to a misdemeanor charge of Assault by Offensive Contact. • VHA Policy on Licensure Action: A criminal conviction does not automatically disqualify a provider from employment at VHA. VHA facility officials told us that they review the information and make a determination on a case-by-case basis. • How VHA Became Aware of Action: The VHA facility became aware of this licensure action because it was a response to an incident that occurred while the provider was employed there. • VHA Response: In April 2016, VHA indefinitely suspended the provider and, in November 2016, VHA removed him from employment for misconduct. A VHA official stated that the facility did not report the provider to the NPDB because he self-reported. Additionally, VHA facility officials were advised not to proceed with any actions, except for the administrative leave, while the criminal investigation was ongoing.

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Case	Position	Summary
41	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 2011 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in May 2015 when a state licensing board issued an Emergency Order of Suspension. This suspension was lifted in August 2015. The provider's license in this state was again suspended in April 2016, with the suspension lifted in October 2016. Although not mentioned in the board documents, in May 2015 the provider was indicted, along with 17 other individuals, on charges that he conspired with the intent to possess and distribute, and distributed, controlled substances. Additionally, in May 2016 the state licensing board prohibited the provider from practicing. During this time, the provider had active, unrestricted licenses in two other states. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA was made aware of the licensure action in June 2015 from an NPDB continuous query report. • VHA Response: VHA facility officials placed the provider on indefinite suspension in July 2015, pending the outcome of the trial. After the provider was found not guilty of all charges, VHA approved the provider to return in September 2016.
42	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a licensed practical nurse in October 2006 and is currently employed at a VHA medical facility in another VISN after the provider transferred to the facility in August 2016. • NPDB Reporting: The provider was reported to the NPDB in January 2011 when the state licensing board placed the provider's license on probation for 2 years after the provider was convicted of attempted endangering the welfare of a child. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA facility officials in the provider's original VISN stated that they were unaware of the licensure action while the provider was employed at their facility. VHA facility officials in the provider's current VISN received information detailing the licensure action in February 2016. The provider's current VHA facility officials stated they did not take action because the licensure action occurred prior to the provider's transfer. • VHA Response: VHA did not take any action related to the provider's licensure probation because the license was in an active and unrestricted status at the time of transfer.
43	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in January 2008 and remains employed by VHA. • NPDB Reporting: The provider was reported to the NPDB because, among other items, in April 2013 the state licensing board issued a reprimand stemming from practicing with an expired license for approximately 15 months. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: In January 2013, while performing a review of provider licenses, VHA facility officials discovered that the provider's license had expired, and that the provider had been practicing without an active license. • VHA Response: Because the provider had been working with an expired license, the VHA facility reported the provider to the state licensing board and suspended the provider for 10 days. VHA officials stated that the expired license was the result of administrative oversight and that the provider renewed the license as soon as VHA brought the expired license to his attention. The facility also conducted a peer review of the provider's cases while the nurse worked with an expired license and did not identify any issues.

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Case	Position	Summary
44	Social Worker	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a social worker in June 2009 and voluntarily resigned in May 2017. • NPDB Reporting: The provider was reported to the NPDB in April 2011 for a reprimand from a state licensing board because of concerns that the provider offered counseling services on the Internet without a license to practice in that state. During this time, the provider maintained a license in another state. In October 2012, the second state licensing board reprimanded the provider and placed his license on probation in response to the actions taken by the first state licensing board. • VHA Policy on Licensure Action: VHA policy requires social workers to be licensed to practice independently. Social workers are also subject to the VHA policy that providers who have had a license surrendered for professional misconduct are not eligible for continued employment unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: VHA was made aware of the state reprimand in April 2013, as part of the credentialing process. • VHA Response: In March 2014, the VHA facility issued a notice of Proposed Removal to the provider. The notice alleges that the provider’s documentation of work with high-risk suicide patients was significantly lacking. In December 2014, a decision was made to mitigate the proposed removal with a 14-day suspension. In April 2016, the provider and VHA entered into a Settlement Agreement, where the facility agreed to keep the provider on Leave without Pay status until May 2017, and to treat the provider’s separation as a voluntary resignation.
45	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in August 1991 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in November 2011, when the provider’s privileges at a non-VHA hospital were suspended because of patient-safety concerns. In July 2012, the provider was reported to the NPDB, when the provider’s state license was placed on probation because the state licensing board, citing alcohol or substance abuse, stated that the provider engaged “in the practice of medicine when mentally or physically unable to safely to so.” The provider’s license was placed on 5-year probation after the provider attempted to perform surgery while under the influence. The Professional Standards Board minutes note that although the provider’s license was on probation, the provider had an active and unrestricted license. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA was made aware of the issues in August 2012 after it received an NPDB report. • VHA Response: The VHA facility temporarily moved the physician to an administrative role and, in July 2012, the facility allowed the physician to see patients in the clinic, but the provider no longer performed surgeries. Further, VHA facility officials told us that the provider was not reported to the NPDB because the provider voluntarily requested a reduction in privileges.

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Case	Position	Summary
46	Physician	<ul style="list-style-type: none"> • Employment at the VHA: The provider was hired as a physician in February 2016 and was removed in October 2016. • NPDB Reporting: The provider was reported to the NPDB in September 2016 because the state licensing board placed a restriction on the provider's license for no less than 5 years that prohibited the physician from treating children. The order stated that the provider may have misdiagnosed children and used excessive dosages and inappropriate medication to treat children. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA became aware of the license restriction in October 2016, when VHA facility officials received an NPDB report. • VHA Response: The VHA facility removed the physician in October 2016, when VHA facility officials determined that, due to the provider's license restrictions, the provider no longer met the employment requirements.
47	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in July 2014 and was terminated by VHA in April 2018. • NPDB Reporting: The provider was reported to the NPDB in August 2004 when a state licensing board placed the provider's license under indefinite restriction for several issues, including substance abuse and prescription forgery. The restriction initially stated that the physician was not to practice medicine. In 2007, the board amended the restriction to permit the physician to practice medicine, and the restriction was terminated by the board in September 2010. As a result of the actions on the provider's license, two other state licensing boards took action. One state licensing board issued an indefinite suspension in May 2006. In June 2007, the provider surrendered his license in the other state after he received notice that the board would hold a hearing about whether to suspend or revoke his license. • VHA Policy on Licensure Action: VHA policy states that individuals who surrender a license after being notified in writing by a state of potential termination for professional misconduct, professional incompetence, or substandard care are not eligible for appointment unless the surrendered license is restored to a full and unrestricted status. • How VHA Became Aware of Action: Before the physician was hired, in August 2013 the provider disclosed to VHA the disciplinary actions taken on his licenses. However, the provider did not list his surrendered licenses in the appropriate screen in VetPro, and as a result VHA facility officials stated that the credentialing staff did not verify the surrendered licenses. • VHA Response: Facility officials stated that the provider was selected for the VHA-wide provider license review. An attorney with the VHA Office of General Counsel reviewed the provider's file and determined that the provider met the qualifications for appointment. However, the documentation that the attorney reviewed did not include information related to the surrendered license. Officials subsequently told us they reviewed the physician's file and determined the provider to be ineligible for VHA employment because the provider relinquished his license after being notified of the possibility that it could be revoked or suspended.

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Case	Position	Summary
48	Physician	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a physician in March 2003 and continues to work at VHA. • NPDB Reporting: The provider is in the NPDB due to actions taken by various state licensing boards in response to a 2005 incident. In June 2005, the provider submitted a false police report in connection with a child custody dispute. In December 2005, the provider was convicted of filing a false police report. As a result, in February 2007, one state licensing board suspended the provider's license for 6 months. This licensure action led to a series of other actions taken by other states. For example, one state licensing board issued a reprimand in December 2007, and, in March 2008, another state licensing board placed the physician's license on 5-year probation and suspended his license for 90 days. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: The provider disclosed issues related to the state suspension to VHA in February 2007. • VHA Response: The VHA facility chose to retain the provider because facility officials determined that the provider continued to meet the licensure requirements. After one state suspended the provider's license, in March 2008, VHA facility officials restricted the provider from seeing patients for 1 day, until a mental-health evaluation determined there were no concerns.
49	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a licensed practical nurse in February 2014 and retired in August 2017. • NPDB Reporting: The provider was reported to the NPDB in February 2006 when the state licensing board suspended his license for several issues including substandard or inadequate care and failure to comply with health and safety requirements. The suspension was lifted in May 2006, and his license was on probation until May 2008. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. The suspension and probation on the provider's license ended prior to his being hired by VHA. Additionally, the provider had a full, current, and unrestricted state license at the time of hire. • How VHA Became Aware of Action: The provider disclosed the issues with his license in the VetPro system in November 2013. • VHA Response: The Hospital Director said that the human-resources clerk who reviewed the file was aware that the provider had a past license suspension, but did not take further action because the provider had had an active unrestricted license for 8 years. Further, at the time the provider was appointed there was no mechanism for discussing an older license suspension.

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Case	Position	Summary
50	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in March 2014 and was terminated from employment at VHA in February 2018. • NPDB Reporting: The provider was reported to the NPDB in September 2007 because a state licensing board put the provider's license on probation for theft of controlled substances for personal consumption. In December 2007, another state licensing board revoked the provider's license in response to the actions taken by the first licensing board. In September 2009, a third state licensing board placed the provider's license on probation and revoked his multistate privilege to practice; this probation was lifted in January 2011. In May 2015, due to the licensure actions taken by the three licensing boards, a fourth state revoked the provider's license; however, the revocation was paused and the provider's license was put on probation for 3 years. • VHA Policy on Licensure Action: VHA policy states that providers whose license has been revoked for professional misconduct, professional incompetence, or substandard care are not eligible for employment unless the revoked license is reinstated. Further, VA policy states that providers must have an active, current, full, and unrestricted license, as determined by hiring officials for employment. • How VHA Became Aware of Action: The provider disclosed the issues with his license on his employment application in June 2013. • VHA Response: VHA facility officials decided to hire the provider in a position that does not require access to medications. VHA facility officials told us that they reviewed the provider's license as part of a review and determined that the provider did not meet the qualifications for employment because one of the provider's licenses was revoked. Further, officials stated that the provider was not qualified for employment at the time of hire, but that the hiring manager approved the hire despite the disqualifying licensure action. The provider was included in the VHA-wide provider licensure review and, on the basis of its findings, the provider was removed from employment.
51	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in September 2009 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in December 2014 because a state licensing board revoked the provider's license. The action was later stayed, and the provider's license was placed on probation for 3 years. The board action cited unprofessional conduct, gross negligence, and incompetence in response to an incident in which the provider failed to comply with a physician's orders, which contributed to the death of a patient. During this time, the provider also had an active license in another state. The provider did not disclose the issue with his revoked license to VHA. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: The facility became aware of the issue between December 2014 and January 2015. From our review, it is unclear exactly when in that period the VHA became aware of the licensure issue. On the basis of the misconduct file, VHA learned about the state board action sometime between December 2014, the effective date of the state board order, and January 2015, the date the provider was placed on Authorized Absence. • VHA Response: VHA facility officials took action to remove the provider from employment. In July 2016, an arbitrator found that the provider failed to notify VHA of the licensure action, but determined that the removal was too severe in relationship to the offense. Instead, the provider served a 45-day unpaid suspension.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
52	Licensed Practical Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a licensed practical nurse in August 2002 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in March 2005 when a state licensing board suspended the provider’s license for 6 months in March 2005, for failing to complete a required ethics course. During this time, the provider had an unrestricted license in another state. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA officials stated they became aware of this issue in November 2008 when the provider disclosed the suspension when use of the VetPro system was implemented. • VHA Response: VHA facility officials said that the provider was working at VHA with an unrestricted license from another state and that is how the provider met VHA employment requirements. Hence, VHA did not take disciplinary action against the provider.
53	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in January 2015 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in August 2011, when a state licensing board placed the provider’s license on probation for 12 months for conduct or practice that is or might be harmful or dangerous to the health of a patient. This stemmed from a prior driving under the influence of alcohol arrest and poor work performance. The provider’s probation ended prior to his appointment to VHA. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: In October 2014, the provider disclosed to VHA that his license had been on probation from August 2011 to November 2012 and that he had a driving under the influence of alcohol conviction. • VHA Response: The facility Service Chief recommended a temporary appointment, not to exceed 1 year, to evaluate the provider’s competence and conduct.
54	Registered Nurse	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a nurse in March 2002 and continues to be employed by VHA. • NPDB Reporting: The provider was reported to the NPDB in February 2008 when a state licensing board issued a reprimand on the provider’s license citing concerns about the provider’s ability to safely practice nursing due to substance abuse. The state licensing board cited three driving under the influence of alcohol arrests between August 1984 and January 1999, one assault conviction in 1998, and one disorderly conduct–fighting in public conviction in 2006 among its concerns. As part of the order, the provider was required to notify all employers of the reprimand, have a supervising nurse provide periodic reports to the board about his capability to practice nursing, refrain from using alcohol and drugs, and submit to random drug tests. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis • How VHA Became Aware of Action: VHA became aware of the reprimand in September 2008 when the provider disclosed this information in the VetPro system. • VHA Response: VHA facility officials stated that the provider’s licensure issue was an ethical concern rather than a patient-care concern; hence, they determined that the provider was qualified for employment. Further, they noted that the provider did not have any restrictions on his license. Additionally, VHA facility officials stated that they are able to take disciplinary action in cases where the applicant does not provide truthful answers in the application, but they did not take any action against the provider.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
55	Dentist	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a dentist in February 2014 and remains employed at VHA. • NPDB Reporting: The provider was reported to the NPDB in 2003 because the state licensing board placed the provider's license on probation for 2 years for failing to meet the minimum standard of care when the provider completed unnecessary dental work on patients. The provider's probation ended before his appointment to VHA and no additional actions had been taken against his license prior to 2014. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: The provider disclosed the licensure action in September 2013 on his application and in VetPro, and VHA was aware of it before the provider was appointed. • VHA Response: The facility Service Chief reviewed the NPDB report, and recommended appointment. Facility officials told us that in January 2017 the provider's clinical privileges were suspended, pending an investigation into the provider's practice. Facility officials stated that the proposal to remove the provider has been revoked and his suspension of privileges was rescinded.
56	Manager	<ul style="list-style-type: none"> • Employment at VHA: The provider was originally hired as a pharmacist in August 1987, and was promoted to a manager position in January 2016. The provider voluntarily retired in December 2016. • NPDB Reporting: The provider was first reported to the NPDB in July 2008 when he received a reprimand on his specialist certificate. Additionally, the provider was again reported to the NPDB when the state licensing board indefinitely suspended the provider's pharmacist license in September 2016 for knowingly filling prescriptions with no medicinal value, and using false patients to fill prescriptions for controlled substances. • VHA Policy on Licensure Action: VHA policy states that providers must have an active, current, full, and unrestricted license. • How VHA Became Aware of Action: VHA officials stated they were informed of the action by the facility's union president in July 2016. • VHA Response: The Chief of Pharmacy at the facility stated that a pharmacist with VHA, even in an administrative role, must have an active unrestricted license. The VHA facility Chief of Staff stated that he believed the action against the provider's license was related to employment activities outside VHA. There is no indication in the VetPro system documenting when the facility responded to the NPDB report related to the action on the provider's license. Officials we spoke with stated there may have been an entry error into VetPro. Additionally, the provider was not enrolled in the NPDB continuous query. VHA notified the provider that he was to be removed from employment effective December 2016 for failing to maintain a license. However, as a result of a March 2017 settlement agreement, the provider was allowed to voluntarily retire. The Chief of Pharmacy at the facility noted that the former Chief of Pharmacy advocated on behalf of the provider with the state licensing board.

Appendix III: Summary of Case-Study Work for Selected Providers

Case	Position	Summary
57	Social Worker	<ul style="list-style-type: none"> • Employment at VHA: The provider was hired as a social worker in May 2016 and resigned in September 2017. • NPDB Reporting: The provider was reported to the NPDB in March 2009, after the state licensing board indefinitely suspended the provider's nursing license because of concerns about substance abuse. • VHA Policy on Licensure Action: VHA policy states that for applicants who have been registered in a profession other than what is applicable to the position, and for whom termination for professional misconduct is documented, a complete review of the professional conduct of the applicant must be documented. According to VHA Central Office officials, VHA does not issue credentialing and privileging guidance about how to treat alcohol or substance-abuse issues; facilities make a determination on how to treat these incidents on a case-by-case basis. • How VHA Became Aware of Action: The provider disclosed the issue with his nursing license on the employment application at VHA. • VHA Response: VHA facility officials stated that the issue with the provider's nursing license was considered when making the hiring decision.

Source: GAO analysis of NPDB, VHA, and state licensing-board data. | GAO-19-6

Note: The following are VHA descriptions for the positions outlined above:

Physician: A doctor of medicine or osteopathy who is legally authorized by a state to practice medicine or surgery.

Physical Therapist: Assist patients improve their movement and manage their pain, as part of rehabilitation, treatment, and prevention efforts.

Social Worker: Assist patients with solving and coping with problems. Clinical social workers also diagnose and treat mental, behavioral, and emotional issues.

Dentist: A doctor of dental surgery, a doctor of dental medicine, or the equivalent who is legally authorized by a state to practice dentistry.

Registered Nurse: Assesses and provides care to patients. Responsibilities include administering patient medication, documenting patients' medical conditions, analyzing test results, and operating medical equipment.

Nurse Practitioner: Practice independently in a variety of settings to include hospital outpatient clinic, nursing home, domiciliary, and even home care. Responsibilities include delivering essential and preventive care, providing patient and family education, and coordinating all care services.

Licensed Practical Nurse: Takes patient vital signs, provides basic care, and administers medications, but generally does not provide certain complex patient-care services such as patient assessments or administration of intravenous medications.

Appendix IV: Comments from the Department of Veterans Affairs



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 11, 2019

Ms. Kathy Larin
Director
Forensic Audits and Investigative Service
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Larin:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office (GAO) draft report: ***"VETERANS HEALTH ADMINISTRATION: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care"*** (GAO-19-6).

The quality VA health care is linked to the quality of our health care providers. The Veterans Health Administration's (VHA) credentialing and privileging program ensures that our providers have the licensure, education, experience, training, and competence to deliver the care Veterans need. VA appreciates GAO's review of the credentialing program and concurs with the findings and intent of the recommendations. VA will provide GAO with detailed action plans to the recommendations in its response to the final report.

VHA is taking definitive actions to build excellence into our credentialing program. VHA will, in collaboration with the Drug Enforcement Agency (DEA), update national policies to reflect employment requirements. VHA will reinforce processes for taking appropriate administrative actions with respect to providers whose DEA registrations have been revoked or surrendered for cause. VHA will oversee facility and Veterans Integrated Service Network policy implementation and ensure credentialers and hiring officials receive annual training on relevant requirements.

VHA health care providers must meet and maintain license requirements at all times. VHA requires all licensed independent practitioners be enrolled in the National Practitioner Data Bank Continuous Query program so facilities and headquarters receive just-in-time alerts if a licensure action has been taken. This allows for proactive, immediate review. In January 2018, all VHA facilities completed an extensive review of appointed health care providers to ensure that they met licensure qualification requirements in accordance with law and policy¹, specifically that:

- a. They maintained a full and active license;
- b. They did not have a license revoked for cause (where the license was not fully reinstated); and

¹Title 38 U.S.C 7402 and VA Handbook 5005

Page 2.

Ms. Kathy Larin

- c. They did not have a history of relinquishing a license in lieu of a revocation for cause (where the license was not fully reinstated).

VA appreciates the opportunity to comment on your draft report.

Sincerely,



Robert L. Wilkie

Appendix V: GAO Contact

GAO Contact

Kathy Larin, (202) 512-5045 or larink@gao.gov

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