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VA HEALTH CARE

Actions Needed to Ensure Provider Qualifications and Competence

Statement of Sharon M. Silas, Director
Health Care

October 16, 2019

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GAO Highlights

Highlights of GAO-20-152T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Nearly 165,000 licensed health care providers, such as physicians and nurses, provide care in VHA's VA medical centers and outpatient facilities. Medical center staff must determine whether to hire and retain health care providers by reviewing and verifying information about their qualifications and practice history. The NPDB is a key source of information about a provider's clinical practice history.

Medical center staff must also investigate any concerns that arise about the clinical care their providers deliver. Depending on the findings from these reviews, medical centers may take an adverse privileging action against a provider. VA medical centers are required to report providers to the NPDB and state licensing boards under certain circumstances. Failing to adhere to these requirements can negatively affect patient safety.

This testimony is primarily based on GAO's 2019 and 2017 reports on VHA processes for reviewing and reporting quality and safety concerns about VA providers. It addresses VA medical centers' implementation and VHA's oversight of (1) reviews of adverse information about providers in the NPDB; (2) reviews of providers' clinical care after concerns are raised; and (3) reporting of providers to the NPDB and state licensing boards. For the 2019 report, GAO reviewed a nongeneralizable sample of 57 VA providers who had an NPDB report. For the 2017 report, GAO reviewed providers whose clinical care was reviewed after a concern was raised about that care at a nongeneralizable selection of five VA medical centers.

View GAO-20-152T. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov

What GAO Found

The Department of Veterans Affairs (VA) needs to take action to ensure its health care providers have the appropriate qualifications and clinical abilities to deliver high quality, safe care to veterans, as GAO recommended in its February 2019 and November 2017 reports. Specifically, GAO found the following:

- **VA medical centers took action against some providers who did not meet VA licensure requirements, but overlooked others**. In its 2019 report, GAO found that some VA medical centers took administrative or disciplinary actions against these providers, such as removing them from employment, after becoming aware of disqualifying information in the National Practitioner Data Bank (NPDB). The NPDB is an electronic repository that contains information on providers who have been disciplined by a state licensing board, among other information. However, in some cases VA medical centers overlooked or were unaware of disqualifying information in the NPDB. For example, officials told GAO they inadvertently overlooked a disqualifying adverse action and hired a provider whose license had been revoked for patient neglect. GAO found three reasons for this inconsistency: lack of mandatory training for key staff, gaps in Veterans Health Administration (VHA) policies, and inadequate oversight.

- **Selected VA medical centers' reviews of providers' clinical care were not always documented**. The five selected VA medical centers that GAO included in its 2017 report were required to review 148 providers' clinical care after concerns were raised about their care from October 2013 through March 2017. However, officials at these medical centers could not provide documentation to show that almost half of these reviews had been conducted. GAO found two reasons for inadequate documentation of these reviews: gaps in VHA policies and inadequate oversight of the reviews.

- **Selected VA medical centers did not report providers to the NPDB or to state licensing boards as required**. The five selected VA medical centers that GAO included in its 2017 report had reported one of nine providers to the NPDB that they were required to report from October 2013 through March 2017. None of these providers were reported to state licensing boards, as required by VHA policy. These nine providers either had adverse privileging actions taken against them—actions that limit the care providers can deliver at a facility or prevent the providers from delivering care altogether—or resigned or retired while under investigation before such an action could be taken. GAO found two reasons providers were not reported: lack of awareness or understanding of VHA policies and inadequate oversight of this reporting.

GAO made 11 recommendations in its 2019 and 2017 reports to address the deficiencies identified. VA implemented two of these 11 recommendations, and provided action plans to address the other nine recommendations.

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent body of work on provider qualifications and competence at the Department of Veterans Affairs (VA). VA's Veterans Health Administration (VHA) operates one of the largest health care systems in the nation, and has approximately 165,000 licensed health care providers, such as physicians and nurses, across its 172 VA medical centers and over 1,000 outpatient facilities.[1] Like other health care facilities, VA medical centers are responsible for ensuring that their providers deliver safe care to patients. As part of this responsibility, VA medical centers are required to determine whether each provider has the appropriate professional qualifications and clinical abilities to care for patients. During this process, known as credentialing, VA medical center officials review and verify information about the provider's qualifications and practice history. Such information can include the provider's application for employment at VA, education, and state licenses. VA providers are required to hold at least one active and unrestricted medical license. If a provider has ever had a license revoked for cause, or has voluntarily surrendered a license after being notified in writing by the state of potential revocation of the license for cause, the provider is not eligible for VA employment, unless the license is restored to a full and unrestricted status.[2]

As part of credentialing, VHA policy also requires VA medical centers to review the National Practitioner Data Bank (NPDB) for any adverse information about a provider. The NPDB is an electronic repository administered by the U.S. Department of Health and Human Services that collects and releases information on providers who either have been disciplined by a state licensing board, professional society, or health care entity, such as a hospital, or have been named in a medical malpractice settlement or judgment. Consistent with industry standards, VHA policy

[1]For the purposes of this testimony, we use the term "provider" to refer to both licensed independent health care providers, such as physicians and dentists, and licensed dependent providers, such as nurses.

[2]Individuals 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. "For cause" refers to actions taken on the basis of professional misconduct, professional incompetence, or substandard care.

requires VA medical centers to query the NPDB and verify with the appropriate state licensing boards that a provider's medical licenses are current and in good standing—unrestricted—before appointing a provider to its medical staff. VHA policy also requires VA medical centers to query the NPDB when licensed independent providers such as physicians—those who can independently provide medical care—renew their clinical privileges.[3] Additionally, VHA enrolls these licensed independent providers in the NPDB continuous query, which alerts VHA if any entity reports information on a provider to the NPDB.[4] (See appendix I for additional details on VHA's credentialing, privileging, and monitoring processes.)

The presence of information in the NPDB does not automatically disqualify a provider from working at VA medical centers. Each VA medical center has broad discretion in hiring providers, within parameters. For example, a provider listed in the NPDB for a revoked license can be employed by VA if the license has been restored. If the NPDB indicates that a provider has had other state licensing board action, such as a reprimand, VA medical center officials must review the information on a case-by-case basis and document their review.

After a provider is hired, VA medical centers are also required to investigate and, if warranted, address any concerns that may arise about the provider's clinical care.[5] Concerns about a provider's clinical care can be raised for many reasons, ranging from a provider not adequately documenting information about a patient's visit to practicing in a manner that is unsafe or inconsistent with industry standards of care. VA medical centers may also become aware of a potential concern if the NPDB includes new adverse information about an existing provider. If VA

[3]Privileges are the specific set of clinical services that a provider is approved to perform independently at a medical facility, based on an assessment of the provider's professional performance, judgement, clinical competence, and skills. VA medical centers are required to review and approve each licensed independent provider's privileges at least every 2 years.

[4]VHA plans to begin requiring medical centers to enroll licensed dependent providers in the NPDB continuous query by the end of 2019.

[5]VA medical centers can identify concerns about a provider's clinical care in a variety of ways, including 1) ongoing monitoring of a provider's performance, 2) a trend of certain outcomes from quality reviews conducted by the provider's peers; 3) complaints or incident reports from any individual with a concern, and 4) filed or settled tort claims or malpractice claims.

medical centers fail to properly review and address concerns that have been raised about a provider, veterans may be exposed to unsafe care and potential harm.

Depending on the nature of the concern and the findings from their review, VA medical center officials may take adverse privileging actions against a provider that either limits the care the provider is allowed to deliver at the facility or prevent the provider from delivering care altogether. VA medical center officials are required to report independent providers against whom they take adverse privileging actions to the NPDB so that this information is available to other VA medical centers, non-VA hospitals, and other health care facilities. VA medical center officials are also required to report providers—both independent and dependent—to state licensing boards when there are serious concerns about providers' clinical care. State licensing boards can then investigate and determine if a provider's conduct or ability to deliver care warrants action against the provider's medical license.

Over the past few months, the VA Office of Inspector General and the media have reported on multiple cases of quality and safety concerns regarding specific VA providers. The issues reported range from providers lacking appropriate qualifications to poor performance and provider misconduct. For example, the VA Office of Inspector General reported in September 2019 that a VA medical center did not comply with several VHA credentialing and privileging activities in hiring and reviewing a surgeon. The Inspector General substantiated that the VA medical center staff did not appropriately verify the provider's credentials. Additionally, despite ongoing concerns about the provider's productivity, competency, and technical skills, medical center leadership reappointed the provider to the medical staff, which the VA Inspector General said allowed the provider to continue performing surgical procedures without the required training or competency to do so.[6]

My testimony today summarizes key findings from our February 2019 and November 2017 reports on the implementation and oversight of VHA

[6]Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility*, Report #19-06429-227 (Washington, D.C.: Sept. 24, 2019).

processes for reviewing and reporting quality and safety concerns about VA providers.[7] Accordingly, this testimony addresses

1. VA medical centers' reviews of adverse information about providers in the NPDB and VHA's oversight of these reviews;
2. selected VA medical centers' reviews of providers' clinical care after concerns are raised and VHA's oversight of these reviews; and
3. selected VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA's oversight of these processes.

In addition, I will highlight key actions that we recommended VA take, including VA's responses and the current status of those recommendations.

For our 2019 report, we reviewed a nongeneralizable sample of 57 VA providers, including physicians, nurses, dentists, physical therapists, and social workers across all 18 Veterans Integrated Service Networks (VISN).[8] These 57 providers were listed in the NPDB for an adverse action, such as a revoked or surrendered license, and were working at VHA as of September 30, 2016.[9] For each of the individuals in our sample, we reviewed the VHA personnel and credentialing files, as well as state licensing board documents. Further details on our scope and methodology are included in our February 2019 report on credentialing VA providers.[10] For our 2017 report, we reviewed documentation and interviewed medical center staff at a nongeneralizable selection of five VA medical centers (across five different VISNs) to identify any independent providers whose clinical care was reviewed after a concern was raised

[7]GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6 (Washington, D.C.: Feb. 28, 2019) and *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).

[8]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA.

[9]We judgmentally selected 57 providers for in-depth review from 1,664 individuals employed by VA as of September 30, 2016 who had an NPDB report. 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. Our February 2019 report included both independent and dependent providers.

[10]GAO-19-6, 55.

about that care.[11] For each identified provider, we reviewed documentation and interviewed staff to determine whether the VA medical center took an adverse privileging action against any of these identified providers from October 2013 through the time we completed our site visits in March 2017. Further details on our scope and methodology are included in our November 2017 report.[12] Finally, we obtained information from VA officials in October 2019 on the status of their efforts to implement the recommendations that we made in our 2019 and 2017 reports.

We conducted the work on which this statement is based 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.

[11]We selected the five VA medical centers based on the complexity of services offered and their geographic distribution. We identified providers at each medical center by reviewing facility documentation of credentialing meetings from fiscal year 2014 through fiscal year 2016. During our visits, we conducted interviews with facility leadership and asked them to confirm the completeness of our list of providers. Our November 2017 report included independent providers only.

[12]GAO-18-63, 3.

VA Medical Centers Took Action against Some Selected Providers with Disqualifying Information in the NPDB but Overlooked Others

In our review of 57 providers selected for our February 2019 report, we found that the responsible VA medical centers took action against some providers with disqualifying information in the NPDB but overlooked others.[13] We found that VA medical centers took administrative or disciplinary actions against some providers, such as removing them from patient care, after becoming aware of adverse information in the NPDB. However, many of these actions were taken following our review and a VHA-wide licensure review, both of which occurred in 2018, rather than at the time of the NPDB report. Specifically, the responsible VA medical centers removed five providers who they determined did not meet VA licensure requirements following our inquiries. For example, one of these five providers had surrendered a license in 2014, while employed at VA, but was not removed by the VA medical center until after our inquiries in 2018. Additionally, another provider was reported to the Drug Enforcement Administration (DEA) by a VA medical center after we inquired about the provider prescribing controlled substances without appropriate registration.

We also found that VA medical centers hired or retained some of the 57 providers who they acknowledged had disqualifying adverse information in the NPDB, which is inconsistent with VHA policy. Specifically, these providers had licenses that were revoked or surrendered for cause, but VA medical center officials overlooked or were unaware of this information. However, none of these providers still worked at VHA at the time we completed our review. For example, one VA medical center hired a provider who had a state license revoked for patient neglect and substandard care.[14] VA medical center officials stated that they received the NPDB report about the revoked license at the time the provider was hired in 2014 but it was inadvertently overlooked by multiple staff. This provider voluntarily resigned in 2017.

In our February 2019 report, we found that three factors were largely responsible for inconsistent adherence to VHA policies that disqualify providers from employment.

[13]Cases evolve over time and can span multiple categories, which is why we did not enumerate the number of cases we found that fit into these various categories. We found that in some of the 57 cases, VA medical centers determined that providers had administrative or other nondisqualifying adverse actions reported in the NPDB, and concluded that the providers could be hired or retained.

[14]This provider had an active license in another state.

- First, some medical center officials are not aware of key VHA policies, such as 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 the case of the provider who surrendered a license in 2014, documentation shows that the medical center staff became aware of the surrendered license in 2015, but VHA staff stated that the removal was stalled due to confusion about policies. This lack of awareness of key policies may be linked to a lack of mandatory training for credentialing staff.
- Second, gaps in VHA policy allow for inconsistent interpretation. For example, VHA has not issued policies pertaining to employing providers who have had their DEA registration for prescribing controlled substances revoked or surrendered for cause. While the DEA requires registrants, like VHA, to obtain a waiver before employing such providers, VHA policy is silent on the requirement to obtain a waiver; we found that VA medical center officials were unclear on the DEA requirement and had hired providers without obtaining the required DEA employment waiver. Further, we found that two providers inappropriately prescribed controlled substances without a DEA waiver.[15]
- Third, VHA's oversight of VA medical centers' reviews of adverse information is inadequate. Under VHA policy, VISN officials are responsible for reviewing providers with certain adverse licensure actions. However, we found that this review was not always conducted or documented. Further, although VHA-wide reviews of provider licenses have been completed and have identified providers with licensure issues, VHA officials indicated that these types of reviews are not routinely conducted because they are labor intensive.

In our February 2019 report, we also found that some VA medical centers had taken steps to improve the credentialing process and identify providers who do not meet the licensure requirements. For example, one medical center completed a periodic review of all licensed providers to identify providers who may have had an expired licensure issue. Another VA medical center updated its policies to require providers with adverse actions to be reviewed by management. However, we found that VHA does not routinely assemble and disseminate information about initiatives

[15]The DEA enforces the controlled-substances laws and regulations of the United States. According to DEA regulation, registrants—including VHA facilities—must obtain a waiver of federal regulations from DEA before employing a provider who has (1) been convicted of a drug-related felony, (2) had a DEA registration revoked or denied, or (3) surrendered a DEA registration for cause.

that medical centers have undertaken to improve the oversight of providers.

In our February 2019 report, we concluded that without consistent adherence to VHA employment policies and adequate oversight, VHA lacks assurance that all VA providers have the appropriate professional qualifications and clinical abilities to care for patients. To address these shortcomings, in our February 2019 report we made seven recommendations to VA. VA concurred with these recommendations. Table 1 summarizes these recommendations and the steps VA has taken to address them.

Table 1: GAO's February 2019 Recommendations for Improving Department of Veterans Affairs (VA) Provider Credentialing and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should ensure that facility officials who are responsible for credentialing, reviewing credentials, and hiring receive periodic mandatory training.	**Status: Not addressed** VA concurred with this recommendation and reported in August 2019 that this training has been implemented. When VA provides documentation of the training and additional information about the training requirements, such as who is required to take the training and how often, we will review this information and make an assessment on whether this recommendation has been fully addressed.
The Under Secretary for Health should develop policies and guidance regarding Drug Enforcement Administration (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.[a]	**Status: Not addressed** VA concurred with this recommendation in principle. VA indicated in August 2019 it has requested DEA's interpretation of the waiver requirement.
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.	**Status: Not addressed** VA concurred with this recommendation and said it will reinforce processes for taking appropriate administrative actions with respect to providers whose DEA registrations have been revoked or surrendered for cause. In August 2019, VA reported that it conducted a review of providers with National Practitioner Data Bank (NPDB) reports related to DEA registration since 2009. VA identified 10 providers and determined that 9 of the 10 had full, unrestricted DEA registration. However, VA may need to obtain a DEA waiver for one provider, even though VA reported that the provider is no longer prescribing controlled substances.
The Under Secretary for Health should confirm that Veterans Integrated Service Network (VISN) level Chief Medical Officer reviews are being appropriately documented so that Veterans Health Administration (VHA) Central Office officials are able to ensure that facilities and VISNs are complying with oversight policies.[b]	**Status: Addressed** VA concurred with this recommendation and reported in August 2019 that its electronic credentialing system, VetPro, was modified in November 2018 to allow for documentation of VISN Chief Medical Officer reviews.

GAO recommendation	Implementation status
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.	**Status: Not addressed** VA concurred with this recommendation. As of October 2019, VA anticipates being able to run reports to verify that VISN Chief Medical Officer reviews have been completed later in October 2019.
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.	**Status: Not addressed** VA concurred with this recommendation in principle. VA indicated that it requires enrollment of all independent VA providers in the NPDB continuous query so that VA medical centers and VHA receive alerts if licensure actions have been taken. VA stated that this process allows for proactive, immediate reviews, rather than periodically running retrospective reviews of NPDB adverse action reports. Additionally, as of January 2019, VA implemented new requirements for documenting these reviews. As of October 2019, VA plans to require medical centers to enroll dependent VA providers in the NPDB continuous query by the end of 2019.
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.[c]	**Status: Addressed** VA concurred with this recommendation and reported in August 2019 that it has codified best practices in standard practice in a variety of ways, including developing a standard form for reviewing NPDB reports and implementing training on the NPDB for credentialers.

Source: GAO-19-6 and GAO analysis of VA information. I GAO-20-152T

[a]DEA registrations allow providers to prescribe controlled substances.

[b]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA. The VISN Chief Medical Officer is responsible for oversight of the credentialing and privileging process.

[c]QSV is the office within VHA responsible for overseeing VHA-wide credentialing and privileging policy.

Selected VA Medical Centers' Reviews of Providers' Clinical Care Were Not Always Documented or Timely

As we reported in November 2017, we found that from October 2013 through March 2017, the five selected VA medical centers required reviews of a total of 148 providers' clinical care after concerns were raised about their care. However, for almost half of these reviews, officials at these medical centers could not provide documentation to show that the reviews had been conducted.[16] We found that all five VA medical centers lacked at least some documentation of the reviews they told us they conducted, and in some cases, we found that the required reviews were not conducted at all. For example, we found that the medical centers lacked documentation showing they conducted a prospective review of 26 providers. Additionally, VA medical center officials confirmed that they failed to conduct this required review for an additional 21 providers.

We also found that the five selected VA medical centers did not always conduct reviews of providers' clinical care in a timely manner. Specifically, of the 148 providers, the VA medical centers did not initiate reviews of 16 providers for 3 or more months, and in some cases, for multiple years, after concerns had been raised about the providers' care. For three of these 16 providers, additional concerns about the providers' clinical care were raised before the reviews began.

In our November 2017 report, we found that two factors were largely responsible for the inadequate documentation and untimely provider reviews.

- First, VHA policy does not require VA medical centers to document all types of reviews of providers' clinical care, including retrospective reviews, and VHA has not established a timeliness requirement for initiating reviews of providers' clinical care.
- Second, VHA's oversight of the reviews of providers' clinical care is inadequate. Under VHA policy, VISN officials are responsible for

[16]VA medical center officials have flexibility to determine the most appropriate process to use to review a provider's clinical care depending on the specific concerns and the situation. These processes include 1) focused professional practice evaluation for cause, which is a prospective review of a provider's care, during which the provider has the opportunity to demonstrate improvement; 2) retrospective review, which is a review of the provider's past patient care; and 3) comprehensive review, which is a more extensive retrospective review that is generally performed by a panel of experts and typically results in conclusions and recommendations. VHA policy states that if allowing a provider to continue delivering patient care could result in imminent danger to veterans, officials should remove the provider from delivering patient care during the review.

overseeing the credentialing and privileging processes at their respective VA medical centers. While reviews of providers' clinical care after concerns are raised are a component of credentialing and privileging, we found that none of the VISN officials we spoke with described any routine oversight of such reviews.[17] This may be in part because the standardized tool that VHA requires the VISNs to use during their routine audits does not direct VISN officials to ensure that all reviews of providers' clinical care have been conducted and documented. Further, some of the VISN officials we interviewed told us they were not using the standardized audit tool as required.

In our November 2017 report, we concluded that without adequate documentation and timely completion of reviews of providers' clinical care, VA medical center officials lack the information they need to make decisions about providers' privileges, including whether or not to take adverse privileging actions against providers. Furthermore, because of its inadequate oversight, VHA lacks reasonable assurance that VA medical center officials are reviewing all providers about whom clinical care concerns have been raised and are taking adverse privileging actions against the providers when appropriate. To address these shortcomings and improve VA medical center reviews of provider quality and safety concerns, we made three recommendations to VA in our November 2017 report. VA concurred with these recommendations. Table 2 summarizes these recommendations and the steps VA has taken to address them.

[17]When asked about their routine audits, VISN officials we interviewed generally described selecting a sample of providers from different specialties to review compliance with VHA requirements related to credentialing and privileging. For example, VISN officials may check that medical centers have appropriately verified their providers' medical licensure. Some officials said they may also look at documentation of a VA medical center's review of a provider's clinical care after a concern had been raised if any of the providers in their sample happened to have documentation of such concerns in their files.

Table 2: GAO's November 2017 Recommendations for Improving Department of Veterans Affairs (VA) Reviews of Provider Quality and Safety Concerns and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should specify in Veterans Health Administration (VHA) policy that reviews of providers' clinical care after concerns have been raised should be documented, including retrospective and comprehensive reviews.	**Status: Not addressed** VA concurred with this recommendation and indicated plans to revise policy to codify requirements for documenting reviews. As of October 2019, VA estimates completing these and other revisions to the VHA policy in August 2020.[a]
The Under Secretary for Health should specify in VHA policy a timeliness requirement for initiating reviews of providers' clinical care after a concern has been raised.	**Status: Not addressed** VA concurred with this recommendation and indicated plans to revise policy to incorporate timeline expectations for initiating reviews after clinical care concerns have been raised. As of October 2019, VA estimates completing these and other revisions to the VHA policy in August 2020.[a]
The Under Secretary for Health should require Veterans Integrated Service Network (VISN) officials to oversee VA medical center reviews of providers' clinical care after concerns have been raised, including retrospective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool.[b] This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner.[c]	**Status: Not addressed** VA concurred with this recommendation and indicated plans to update the standardized audit tool so that it directs the VISNs to oversee reviews of providers' clinical care after concerns have been raised. As of October 2019, VA reported that it had developed and piloted a new standardized audit tool. VA stated that it needs about 6 months to implement and assess the tool. VA estimated completion in November 2019.

Source: GAO-18-63 and GAO analysis of VA information. I GAO-20-152T

[a]VA officials indicated that the delay in issuing the revised policy is due to revisions unrelated to these recommendations.

[b]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA.

[c]Since April 2018, this recommendation has been designated a priority recommendation. We began issuing letters to the Secretary of VA in 2017 identifying open recommendations that we consider to be the highest priority (i.e., priority recommendations) for VA to implement in order to significantly improve VA operations. See GAO, Priority Recommendations: Department of Veterans Affairs, GAO-19-358SP (Washington, D.C.: Mar. 28, 2019).

Selected VA Medical Centers Did Not Report All Providers to the NPDB or to State Licensing Boards as Required

In our November 2017 report, we found that from October 2013 through March 2017, the five VA medical centers we reviewed had only reported one of nine providers that should have been reported to the NPDB as required by VHA policy. Furthermore, none of these nine providers were reported to state licensing boards as required by VHA policy.[18] These nine providers either had adverse privileging actions taken against them or resigned or retired while under investigation before an adverse privileging action could be taken.

The VA medical centers documented that these nine providers had significant clinical deficiencies that sometimes resulted in adverse outcomes for veterans. For example, the documentation shows that one provider's surgical incompetence resulted in numerous repeat surgeries for veterans. Similarly, the documentation shows that another provider's opportunity to improve had to be halted and the provider was removed from providing care after only a week due to concerns that continuing the review would potentially harm patients.

In addition to these nine providers, one VA medical center terminated the services of four contract providers based on deficiencies in the providers' clinical performance, but the facility did not follow any of the required steps for reporting providers to the NPDB or relevant state licensing boards. This is concerning, given that the VA medical center documented that one of these providers was terminated for cause related to patient abuse after only 2 weeks of work at the facility.

At the time of our review, two of the five VA medical centers we reviewed each reported one provider to the state licensing boards for failing to meet generally accepted standards of clinical practice to the point that it raised concerns for the safety of veterans.[19] However, we found that the medical centers' reporting to the state licensing boards took over 500 days to

[18]As a result of our audit work, VHA officials told us in April 2019 that the five selected VA medical centers completed NPDB reporting for eight of the nine providers and state licensing board reporting for seven of the nine providers. VHA officials stated that one provider was not reported to the state licensing board because the provider had self-reported before the VA medical center had an opportunity to do so. VHA officials stated that the other provider was not reported to the NPDB or state licensing board because the VA medical center director, at the time, had made the decision not to do so.

[19]These two providers were not among the nine providers who had an adverse privileging action taken against them, or who resigned or retired while under investigation but before an adverse privileging action could be taken. They were also not among the four contractors whose services were terminated.

complete in both cases, which was significantly longer than the 100 days suggested in VHA policy.

Across the five VA medical centers, we found that providers were not reported to the NPDB and state licensing boards as required for two reasons.

- First, VA medical center officials were generally not familiar with or misinterpreted VHA policies related to NPDB and state licensing board reporting. For example, at one VA medical center, we found that officials failed to report six providers to the NPDB because they were unaware that they were responsible for NPDB reporting. Officials at two other VA medical centers incorrectly told us that VHA cannot report contract providers to the NPDB.
- Second, VHA policy does not require the VISNs to oversee whether VA medical centers are reporting providers to the NPDB or state licensing boards when warranted. We found, for example, that VISN officials were unaware of situations in which VA medical center officials failed to report providers to the NPDB.

As a result of VHA staff misinterpretation of VHA policy and insufficient oversight, we concluded that VHA lacks reasonable assurance that all providers who should be reported to the NPDB and state licensing boards are reported. Consequently, the NPDB and state licensing boards in other states where the providers we identified held licenses were not alerted to concerns about the providers' clinical practice. We reported that this could allow a provider who delivered substandard care at one VA medical center to obtain privileges at another VA medical center or at hospitals outside of VA's health care system. In our November 2017 report, we noted several cases of this occurring among the providers who were not reported to the NPDB or state licensing boards by the five VA medical centers we reviewed. For example,

- We found that two of the four contract providers whose contracts were terminated for clinical deficiencies remained eligible to provide care to veterans outside of that VA medical center. At the time of our review, one of these providers held privileges at another VA medical center, and another participated in the network of providers that can provide care for veterans in the community.
- We also found that a provider who was not reported as required to the NPDB during the period we reviewed had their privileges revoked 2 years later by a non-VA hospital in the same city for the same reason the provider was under investigation at the VA medical center.

Officials at this VA medical center did not report this provider following a settlement agreement under which the provider agreed to resign. A committee within the VA medical center had recommended that the provider's privileges be revoked prior to the agreement. There was no documentation of the reasons why this provider was not reported to the NPDB.

To improve VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA oversight of these processes, we made one recommendation in our November 2017 report. VA concurred with this recommendation. Table 3 summarizes the recommendation and the steps VA has taken to address it.

Table 3: GAO's November 2017 Recommendation for Improving Department of Veterans Affairs (VA) Reporting of Provider Quality and Safety Concerns and the Implementation Status of This Recommendation

GAO recommendation	Implementation status
The Under Secretary for Health should require Veterans Integrated Service Network (VISN) officials to establish a process for overseeing VA medical centers to ensure that they are reporting providers to the National Practitioner Data Bank (NPDB) and state licensing boards, and are reporting in a timely manner.	**Status: Not addressed** VA concurred with the recommendation and indicated plans to update the standardized audit tool so that it directs the VISNs to ensure timely reporting to the NPDB and state licensing boards, in accordance with Veterans Health Administration (VHA) policy. As of October 2019, VA reported that it had developed and piloted a new standardized audit tool. VA stated that it needs about 6 months to implement and assess the tool. VA estimated completion in November 2019. In addition to completing the tool, VA needs to demonstrate that the providers we identified in our review have been reported to the NPDB and state licensing boards, or document its decision not to report these providers.

Source: GAO-18-63 and GAO analysis of VA information. I GAO-20-152T

Notes: Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA. Since April 2018, this recommendation has been on our high priority list. We began issuing letters to the Secretary of VA in 2017 identifying open recommendations that we consider to be the highest priority (i.e., priority recommendations) for VA to implement in order to significantly improve VA operations. See GAO, Priority Recommendations: Department of Veterans Affairs, GAO-19-358SP (Washington, D.C.: Mar. 28, 2019).

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 (silass@gao.gov). Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Marcia A. Mann

(Assistant Director), Kaitlin M. McConnell (Analyst-in-Charge), Summar C. Corley, Cathy Hamann, Jacquelyn Hamilton, and Vikki Porter. Other contributors include David Bruno, Julia DiPonio, Ranya Elias, Kathryn A. Larin, and Joy Myers.

Appendix I: Veterans Health Administration Credentialing, Privileging, and Monitoring Processes

According to Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) policies, all licensed health care providers must be credentialed before they are permitted to work.[1] Credentialing is the process of screening and evaluating qualifications and other credentials—including licensure, education, and relevant training—that is the first step in the process of determining whether the provider has appropriate clinical abilities and qualifications to provide medical services. Credentialing processes and requirements differ for independent licensed providers, such as doctors—who are permitted by law and the facility to deliver patient care services independently, without supervision—and dependent providers, such as nurses—who deliver patient care under the supervision or direction of an independent provider. Additionally, VHA policy states that only licensed independent providers 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. Figure 1 provides a summary of the VHA credentialing and privileging processes for independent and dependent providers.

[1]VHA policy allows for temporary medical staff appointments for urgent patient care needs before full credentialing information has been received.

Figure 1: VHA's Credentialing and Privileging Process

Credentialing
The process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training, and experience.

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.

	Licensed independent practitioners	Dependent providers
1 A provider submits an application for a position at a Veterans Health Administration (VHA) facility.	✔	✔
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.	✔	✔
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.	✔	✔
For licensed independent practitioners, the Service Chief also reviews the clinical privileges requested by the provider.	✔	N/A
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.	✔	✔
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.	✔	N/A
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.	✔	✔
For licensed independent practitioners, the facility Director also determines whether clinical privileges should be granted as requested by the provider.	✔	N/A

✔ Applicable

N/A Not applicable

Source: GAO analysis of Department of Veterans Affairs information. | GAO-20-152T

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.

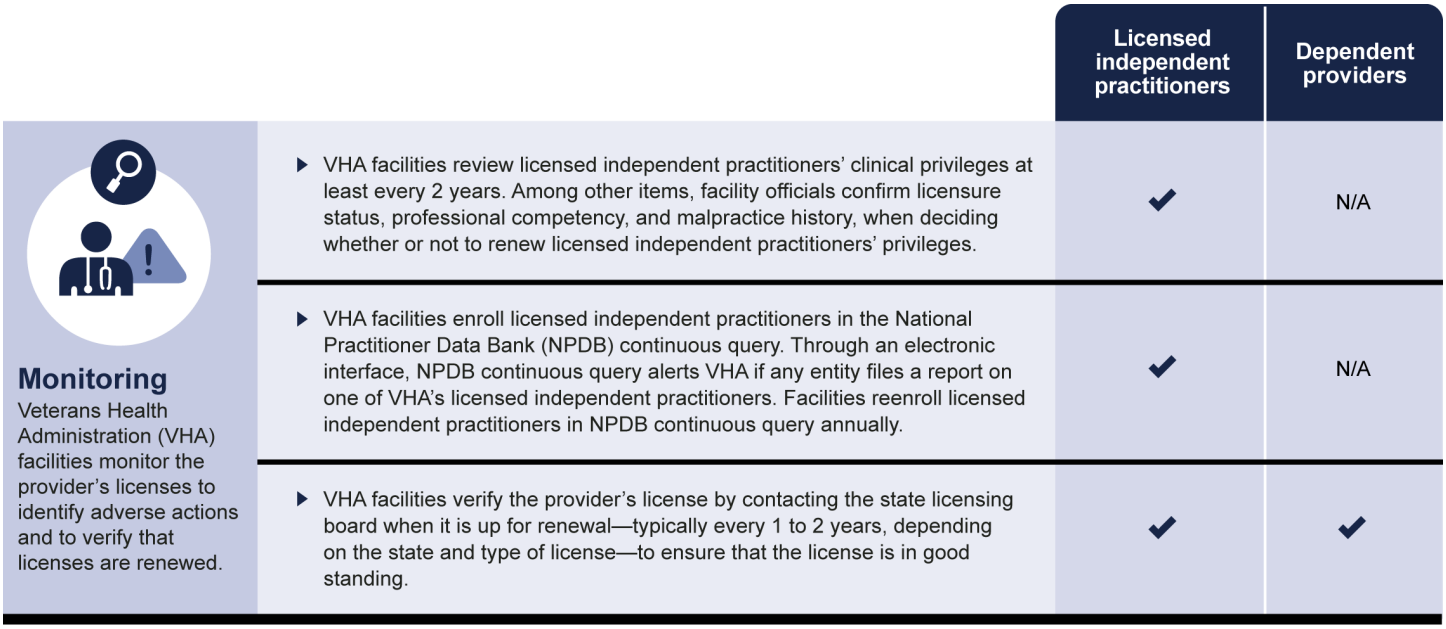
[a]VHA officials told us that, concurrent to the credentialing process, Human Resources officials at the facilities complete preemployment checks, including drug testing, suitability review, and criminal-background checks.

[b]We 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.

[c]VHA officials told us that for dependent providers, the approving official may be someone other than the facility Director.

VHA facilities are also required to monitor providers' licenses after they are hired to ensure the licenses are current and review any licensure actions, in accordance with VHA policy. Figure 2 provides a summary of VHA's processes for monitoring independent and dependent providers' licenses.

Figure 2: VHA's Process to Monitor Provider Licenses



Source: GAO analysis of Department of Veterans Affairs information. | GAO-20-152T

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.

Related GAO Reports

Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care. GAO-19-6. Washington, D.C.: February 28, 2019.

Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability. GAO-18-137. Washington, D.C.: July 19, 2018.

VA Health Care: Improved Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns. GAO-18-260T. Washington, D.C.: November 29, 2017.

VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns. GAO-18-63. Washington, D.C.: November 15, 2017.

Veterans Health Care: Improved Oversight of Community Care Physicians' Credentials Needed. GAO-16-795. Washington, D.C.: September 19, 2016.

VA Health Care: Improvements Needed in Processes Used to Address Providers' Actions That Contribute to Adverse Events. GAO-14-55. Washington, D.C.: December 3, 2013.

Veterans Health Care: Veterans Health Administration Processes for Responding to Reported Adverse Events, GAO-12-827R. Washington, D.C.: August 24, 2012.

VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes. GAO-10-26. Washington, D.C.: January 6, 2010.