



December 2013

# VA HEALTH CARE

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

# GAO Highlights

Highlights of [GAO-14-55](#), a report to congressional requesters

## Why GAO Did This Study

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

## What GAO Recommends

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

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

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

## What GAO Found

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

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

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Figure 2: VA and Veterans Health Administration (VHA)  
Organizational Components Involved in Monitoring VA  
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Processes

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**Abbreviations**

ADUSH	Assistant Deputy Under Secretary for Health
AIB	administrative investigation board
DUSHOM	Deputy Under Secretary for Health for Operations and Management
FPPE	focused professional practice evaluation
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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December 3, 2013

The Honorable Patty Murray  
Chairman  
Committee on the Budget  
United States Senate

The Honorable Bernard Sanders  
Chairman  
Committee on Veterans' Affairs  
United States Senate

The Honorable Michael Michaud  
Ranking Member  
Committee on Veterans' Affairs  
House of Representatives

The Honorable Eddie Bernice Johnson  
House of Representatives

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the largest health care delivery systems in the United States. VHA's health care system includes 152 VA medical centers (VAMC) that offer a variety of inpatient and outpatient services, ranging from routine examinations to complex surgical procedures. According to VHA officials, these services are provided by a variety of health care professionals, including over 39,000 physicians and dentists. As in all health care delivery settings like VAMCs, adverse events—clinical incidents that may pose the risk of injury to a patient as the result of a medical intervention or the lack of an appropriate intervention, such as a missed or delayed diagnosis, rather than that patient's underlying medical condition—may occur, resulting in potential or actual harm to patients.<sup>1</sup> In an analysis of VHA data published in 2011, for example, researchers found that there were 101 reported surgical adverse events—events pertaining to incorrect surgical procedures, such as a

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<sup>1</sup>Adverse events may not always be attributable to an error made by a provider; for example a patient fall occurring while under medical care may be considered an adverse event, but be unrelated to patient care.

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procedure performed on the wrong patient or with the wrong implant—across VAMCs from mid-2006 to 2009.<sup>2</sup>

VHA requires that VAMCs take appropriate action to report and evaluate adverse events.<sup>3</sup> VHA generally gives VAMCs discretion in choosing which process to use in responding to reported adverse events. VAMCs generally use one or more of the following three processes to evaluate the role of individual providers in adverse events: peer review for quality management, focused professional practice evaluation (FPPE), and administrative investigation board (AIB).<sup>4</sup> Peer review for quality management is used when there is a need to determine whether a provider's actions associated with an adverse event were clinically appropriate—that is, whether another provider with similar expertise would have taken similar action. An FPPE is a process whereby the VAMC evaluates a provider's competence in a specific area of clinical expertise, such as a surgical procedure, when a question arises regarding the provider's ability to provide safe, quality patient care.<sup>5</sup> An AIB can be used to investigate whether an adverse event was the result of a

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<sup>2</sup>Julia Neily et al., "Incorrect Surgical Procedures within and Outside of the Operating Room, A Follow-up Report," *Archives of Surgery*, vol. 146, no. 11 (2011).

<sup>3</sup>According to VHA officials, VHA requires adverse events to be reported to appropriate VAMC officials through each VAMC's incident reporting system, or through other methods such as a phone call or email to the applicable medical center's patient safety manager or risk manager. In addition to identifying and reporting adverse events, VAMCs have a quality management program that enables them to identify and respond to other quality-of-care issues that may not rise to the level of an adverse event. VHA uses the terms quality management, quality improvement, and quality assurance interchangeably.

<sup>4</sup>See GAO, *Veterans Health Care: Veterans Health Administration Processes for Responding to Reported Adverse Events*, [GAO-12-827R](#) (Washington, D.C.: Aug. 24, 2012). In this report we found that VAMCs may also use root cause analysis to evaluate the systems or process causes for an adverse event; we did not include root cause analysis in this report because we focused on the processes used to evaluate actions of individual providers, not processes used to address systems or process issues.

<sup>5</sup>FPPEs are also conducted at the time of a provider's initial appointment to the VAMC's medical staff, or when a provider applies for new or additional privileges; we excluded these types of FPPEs from the scope of our review. Privileges are the authority granted to a physician or dentist by the VAMC to provide patient care in the facility. Privileges are limited by the VAMC's capabilities and the individual's professional license, education, training, experience, and competence. Hereafter, we use the term FPPE to refer to an FPPE conducted for cause, such as when questions arise about a privileged provider's ability to deliver safe, quality care.

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provider's professional misconduct or from potential system deficiencies related to VHA policies or procedures.<sup>6</sup>

In evaluating the role of providers in adverse events, VHA emphasizes the use of protected processes that are confidential and nonpunitive, which they believe better facilitate quality management efforts at the individual provider level. The peer review for quality management is a protected process.<sup>7</sup> The information collected is confidential and protected under federal law, and therefore cannot be used to inform adverse actions against providers, such as limiting a provider's clinical privileges.<sup>8</sup> However, according to VHA officials, if a provider's ability to provide safe, quality patient care is in question, then VAMCs may use a nonprotected process to address such concerns.<sup>9</sup> FPPEs and AIBs are nonprotected processes, and, therefore, the information collected through these processes can be used to inform adverse actions against providers. When warranted on the basis of the outcome of these types of processes, VAMC officials may take a variety of actions, such as training and

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<sup>6</sup>An example of a system deficiency would be a failure of a VAMC's pharmacy to ensure patients receive the prescribed medication.

<sup>7</sup>Hereafter, we refer to peer review for quality management as protected peer review.

<sup>8</sup>Under federal law, records and documents created as part of VHA's medical quality assurance program are confidential and privileged and may only be disclosed under limited circumstances. See 38 U.S.C. § 5705; 38 C.F.R. §§ 17.500-17.511. VHA's medical quality assurance program consists of systematic health care reviews carried out by or for VHA for the purposes of improving the quality of medical care or improving the utilization of health care resources in VHA medical facilities. The protected peer review process is part of VHA's medical quality assurance program, and, as such, documents generated through these processes are confidential and privileged.

<sup>9</sup>VHA policy refers to nonprotected processes generally as management reviews.

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proctoring a provider, major adverse actions, disciplinary actions, or privileging actions.<sup>10</sup>

Adverse events raise questions about the quality of care VAMCs provide to veterans. You asked us to review any gaps in the processes that VAMCs use for responding to adverse events and the extent to which the processes are carried out across VHA's health care system. In this report, we examined

1. VAMCs' adherence to VHA's protected peer review process and the extent to which VHA monitors this process, and
2. VAMCs' adherence to VHA's nonprotected processes and the extent to which VHA monitors these processes.

To examine VAMCs' adherence to protected and nonprotected processes, we reviewed VHA's policies on protected peer review and FPPEs, and VA's policy on AIBs.<sup>11</sup> Additionally, we reviewed these processes in the context of federal internal control standards for risk assessment, information and communications, control activities, and monitoring.<sup>12</sup> We also visited four VAMCs, which were selected on the basis of geographic variation using the location in one of VA's 21 Veterans Integrated Service Networks (VISN) as a proxy, VAMC size

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<sup>10</sup>According to VA policy, major adverse actions include suspension, transfer, reduction in grade, reduction in basic pay, and termination. Disciplinary actions include admonishments, which are official letters of censure for minor deficiencies in competence or conduct; and reprimands, which are more severe letters of censure for deficiencies in competence or conduct. Department of Veterans Affairs, *Employee/Management Relations*, VA Directive 5021, v.3 (Washington, D.C.: Aug. 28, 2007) and *Employee/Management Relations*, VA Handbook 5021, v.10 (Washington, D.C.: Nov. 8, 2012), accessed April 17, 2013, [http://www.va.gov/vapubs/search\\_action.cfm?dType=2](http://www.va.gov/vapubs/search_action.cfm?dType=2). Privileging actions include reducing, revoking, suspending, denying, or failing to renew a provider's privileges. Veterans Health Administration, *Credentialing and Privileging*, VHA Handbook 1100.19 (Washington, D.C.: Nov. 14, 2008).

<sup>11</sup>According to VHA officials, protected peer review and FPPE processes are specific to VHA. In contrast, the AIB process is used across VA, by VHA as well as VA's other administrations—the Veterans Benefits Administration and the National Cemetery Administration.

<sup>12</sup>GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, [GAO-01-1008G](#) (Washington, D.C.: Aug. 2001).



based on the number of unique patients served, and level of surgical complexity (see table 1).<sup>13</sup>

**Table 1: VA Site Visit Locations and Characteristics**

VA medical center (VAMC) location	Veterans Integrated Service Network (VISN)	VAMC size <sup>a</sup>	Surgical complexity rating <sup>b</sup>
Dallas, Texas	17	112,000	Complex
Nashville, Tennessee	9	84,000	Complex
Seattle, Washington	20	87,000	Complex
Augusta, Maine	1	40,000	Intermediate

Source: GAO analysis of Veterans Health Administration (VHA) information.

<sup>a</sup>Number of unique patients rounded to the nearest thousand.

<sup>b</sup>VHA assigns each VAMC a surgical complexity rating of standard, intermediate, or complex. This classification system uses multiple variables to measure surgical complexity arrayed along four categories: facilities, equipment, workload, and staffing. These ratings were implemented May 7, 2010.

We also requested data from each VAMC on protected peer reviews, FPPEs, and AIBs from fiscal years 2009 through 2011 in order to review the four VAMCs' adherence to the applicable policies and within the context of relevant federal internal control standards.<sup>14</sup> Specifically, we reviewed VAMCs' adherence to several elements of VHA's protected peer review policy for which VAMCs are required to collect data;<sup>15</sup> these selected elements include timeliness of peer review completion and committee review of select peer review results. VHA requires VAMCs to establish peer review or professional activity triggers that signal the need to conduct a detailed assessment of a provider's care, which can then

<sup>13</sup>VISNs are regional systems of care that oversee the day-to-day functions of VAMCs that are within their network. Each VAMC is assigned to a single VISN. VHA assigns each VAMC a surgical complexity rating of standard, intermediate, or complex. This classification system uses multiple variables to measure surgical complexity arrayed along four categories, namely facilities, equipment, workload, and staffing load. For example, a hospital assigned a complex rating requires special facilities, equipment, and staff for difficult operations, such as cardiac surgery and organ transplants. We chose three sites with a complex rating and one with an intermediate rating, for variation.

<sup>14</sup>Data from fiscal years 2009 through 2011 were the most recent data available at the time we initiated our review.

<sup>15</sup>Department of Veterans Affairs, Veterans Health Administration, *Peer Review for Quality Management*, VHA Directive 2010-025 (Washington, D.C.: June 3, 2010).

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lead to an FPPE.<sup>16</sup> We reviewed only whether VAMCs established peer review triggers, since VAMCs collect peer review data.<sup>17</sup> To assess the reliability of the protected peer review data we analyzed, we reviewed VHA's protected peer review policy on data reporting requirements, interviewed VHA and VAMC officials familiar with the data, and conducted checks on the data, looking for missing values, outliers, or other anomalies. We found some records that contained missing, incomplete, or inaccurate data and excluded those data from our analysis. We determined that the deletions had no material effect on our analysis and that the data, as analyzed, were sufficiently reliable for our purposes.

We examined VAMCs' adherence to VHA's FPPE process by reviewing VAMCs' available FPPE documentation for clarity and ease of tracking what steps the VAMC had taken to conduct the FPPEs from initiation to completion. We reviewed VA's policy on AIBs and interviewed VAMC officials about their use of AIBs to investigate providers involved in adverse events. We also reviewed previous GAO work on VA's AIB process, including the extent to which VA collected data on AIBs and how VA used the results of AIB investigations.<sup>18</sup> We were unable to analyze VAMCs' implementation of certain elements of VA's AIB policy because at the time of our review VAMCs had not retained all of the documentation necessary for us to conduct a review for processes conducted from fiscal years 2009 through 2011. According to the AIB policy,<sup>19</sup> the investigation files need to be retained in accordance with applicable records retention schedules and, at a minimum, until any corrective action is completed and the time frame for any claims or

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<sup>16</sup>VHA Directive 2010-025. VHA refers to the detailed assessment as a focused review.

<sup>17</sup>A peer review trigger typically is a threshold that is determined by the number and results of protected peer reviews within a specified time frame, usually 12 months, for a particular provider that indicates the need for further review of the provider's patient care. While VHA's protected peer review policy mentions professional activity triggers, it does not provide a definition or illustrative example of such triggers. According to a VHA official, a professional activity trigger is based on clinical actions or professional clinical decisions made by the practitioner in the episode of care under review.

<sup>18</sup>GAO, *VA Administrative Investigations: Improvements Needed in Collecting and Sharing Information*, [GAO-12-483](#) (Washington, D.C.: Apr. 30, 2012).

<sup>19</sup>Department of Veterans Affairs, *Administrative Investigations*, VA Handbook 0700 (Washington, D.C.: undated).

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appeals has passed; we did not assess how long VAMCs should have kept each of the investigation files.<sup>20</sup>

To examine the extent to which VHA monitors VAMCs' use of protected and nonprotected processes to respond to adverse events, we interviewed VHA officials from the Office of the Assistant Deputy Under Secretary for Health (ADUSH) for Quality, Safety and Value, including the Director of Risk Management and the Director of Credentialing and Privileging; the Office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM); and the Office of the Medical Inspector. We also interviewed officials from the VA Office of Inspector General (OIG) Office of Healthcare Inspections, as well as the chief medical officers of the four VISNs for the VAMCs we visited.

We limited our review to describing VHA's protected and nonprotected processes for responding to adverse events that involve individual providers, excluding from our scope processes, such as root cause analysis,<sup>21</sup> that focus primarily on events that involve systems or processes issues. We focused our review on VHA physicians and dentists, hereafter referred to as providers, because these are the primary types of licensed independent providers at VAMCs. The findings of our four site visits cannot be generalized to other VAMCs.

We conducted this performance audit from July 2012 to December 2013 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.

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<sup>20</sup>Since this report covers fiscal years 2009 through 2011, the period of time covered by the applicable records retention schedule for AIB documentation might have passed by the time we requested the documentation.

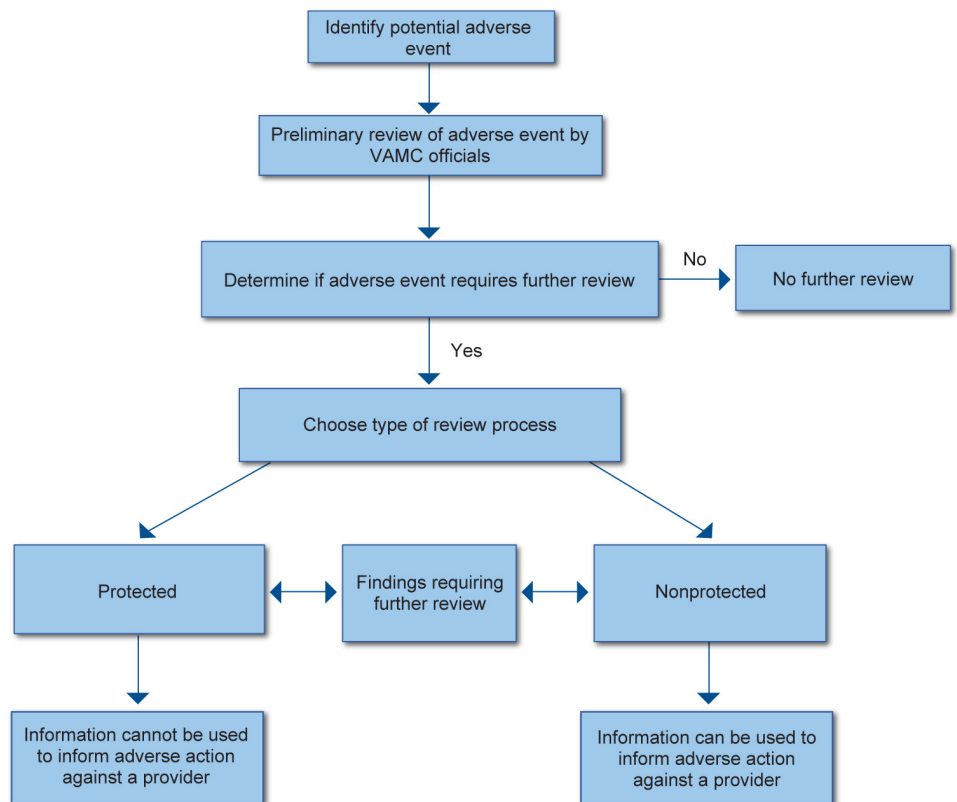
<sup>21</sup>A root cause analysis is a process for identifying the basic or contributing factors that underlie variations in the performance of systems and processes.

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## Background

VAMCs conduct an initial review of cases that are identified as possible adverse events to determine how best to respond and which process to use to determine the facts of the case, such as protected peer review, FPPE, or AIB. Because VAMCs generally have discretion in which of these processes they choose to use to respond to an adverse event, different VAMCs may choose different processes in response to experiencing similar adverse events. Based on the nature of the adverse event and the information gleaned through a particular review process, a VAMC may decide to conduct multiple types of reviews, both protected and nonprotected processes, as appropriate. Information collected through protected review processes, including protected peer review, cannot be used to inform adverse actions against a provider; information collected through nonprotected processes, including FPPEs and AIBs, can be used to support a VAMC's decision to take adverse action against a provider. According to VHA policy, VAMCs can use both protected and nonprotected processes concurrently or consecutively as long as protected and nonprotected processes and data collection are kept separate. According to VHA officials, if a VAMC is using a protected process to review an event and realizes that a nonprotected review may be necessary, the protected process should be stopped and the VAMC should start a nonprotected review. See figure 1 for an illustration of the decision process a VAMC official might use when deciding how to respond to an adverse event.

**Figure 1: Example of Decision Process Used by VA Medical Center (VAMC) Officials When Responding to an Adverse Event**



Source: GAO.

## Protected Process

According to VHA's protected peer review policy, peer review is required under certain circumstances, such as a death that appears related to a hospital-incurred incident or a complication from treatment and a suicide within 30 days of a clinical encounter with a VA health care professional.<sup>22</sup> Peer review may be considered in other circumstances, such as when there is an unexpected or negative outcome. Once VAMC officials decide to conduct a protected peer review, a peer reviewer is assigned to

<sup>22</sup>VHA Directive 2010-025.

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evaluate the care delivered and the actions taken by the provider.<sup>23</sup> The peer reviewer makes an initial determination of whether the provider should have taken different action when providing patient care and preliminarily assigns one of the following three levels of care:

- Level of care 1 – the most experienced, competent providers would have managed the case in a similar manner;
- Level of care 2 – the most experienced, competent providers might have managed the case differently; or
- Level of care 3 – the most experienced, competent providers would have managed the case differently.

According to VHA's peer review policy, the initial peer review should be completed within 45 calendar days from determination of the need for peer review.<sup>24</sup> If the peer-reviewed case is assigned a level of care 2 or 3, it must be referred to the VAMC's peer review committee for further review.<sup>25</sup> After conducting a further review of the facts of the case, and receiving further input from the provider under review, the peer review committee either validates the initial level of care or assigns a higher or lower level of care. The peer review committee's level of care rating is final and must be completed within 120 calendar days from determination of the need for peer review. The peer review committee can also make recommendations for nonpunitive, nondisciplinary actions, as appropriate,

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<sup>23</sup>The peer reviewer is a provider who has relevant expertise necessary to make accurate judgments about the clinical event being reviewed, is able to make a fair and credible assessment, and has knowledge of relevant standards of care. According to VHA and VAMC officials, generally, a provider is peer-reviewed by another provider at the same VAMC and, if possible, within the same specialty.

<sup>24</sup>Language referring to this 45 calendar day requirement was changed in the 2010 version of VHA's peer review policy from must to should be completed in 45 calendar days. According to the VHA Director of Risk Management, despite this change in policy language, VAMCs are still expected to complete initial peer reviews around the 45 day time frame. VHA's protected peer review policy was updated in June 2010, which was during the time period we studied— fiscal years 2009 through 2011. For the previous version of VHA's protected peer review policy, see Department of Veterans Affairs, Veterans Health Administration, *Peer Review for Quality Management*, VHA Directive 2008-004 (Washington, D.C.: Jan. 28, 2008).

<sup>25</sup>The peer review committee is a multidisciplinary group that is chaired by the Chief of Staff and includes the Nurse Executive, senior members of key clinical disciplines, and nonphysician members.

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such as reviewing and revising local policy, to improve the quality of care delivered. The final level of care rating and any recommendations for improvement are reported to the provider's supervisor, who gives the provider feedback that is based on the peer review committee's findings. According to VHA officials, VAMCs conduct approximately 23,000 protected peer reviews systemwide annually.

VHA also has a contract with an external organization that is used to audit protected peer review.<sup>26</sup> VAMCs may request external protected peer review expertise if there are no qualified peers available at the VAMC. According to a VISN official, external review may also be requested if the VAMC needs to ensure an independent peer review, for example, if all the providers in the same clinical specialty were involved in the event. VHA also requires each VAMC to submit quarterly a sample of cases that were recently peer-reviewed, for a secondary peer review by this external organization.<sup>27</sup>

According to VHA's protected peer review policy, each VAMC is required to develop peer review or professional activity triggers to signal the need for further assessment of a provider's clinical care.<sup>28</sup> The triggers are specific to an individual VAMC. If, after a detailed assessment, concerns arise about a provider's ability to deliver safe, quality patient care, then an FPPE would be conducted.<sup>29</sup> For example, if a provider meets a VAMC's peer review triggers by receiving three peer review level of care ratings of 3—meaning that the most experienced, competent providers would have managed the cases differently—within a 12-month period, then VAMC officials would be prompted to conduct a detailed assessment of the

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<sup>26</sup>VHA contracted with Lumetra Healthcare Solutions to conduct external protected peer reviews of selected cases and to assess the accuracy of peer review conducted by VAMCs. According to VHA officials, the implementation of this contract started in fiscal year 2011. Lumetra Healthcare Solutions has a peer review network of over 250 physicians and other clinical professionals.

<sup>27</sup>VAMCs that offer more complex clinical services are required to send 15 cases per quarter, and VAMCs that offer less complex clinical services are required to send 10 cases per quarter, for this external audit.

<sup>28</sup>VHA Directive 2010-025.

<sup>29</sup>An FPPE can be initiated for reasons other than when a trigger is met or exceeded, such as when a VAMC official has a concern about the clinical actions or decisions made by a provider for the episode of care under review.

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provider's care, and address concerns about the provider's ability to deliver safe, quality patient care by conducting an FPPE.

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## Nonprotected Processes

According to VHA policy, an FPPE may be used when a question arises regarding a provider's ability to provide safe, quality patient care, such as whether documentation of patient encounters is late or insufficient, or whether diagnoses are accurate. An FPPE may also be used when a provider meets or exceeds a VAMC's peer review triggers and a detailed assessment indicates the need for further review. According to VHA and VAMC officials, an FPPE begins by providing an opportunity for a provider to improve his or her performance in area(s) of identified concern. The FPPE is a time-limited period during which medical staff leadership assesses the provider's professional performance and ability to improve. According to VAMC officials, if the provider's performance improves, VAMC officials may decide that the FPPE process is completed and the provider may be returned to routine monitoring. If a provider's performance does not improve, then medical staff leaders may decide to continue the FPPE for an additional period of time or determine if a privileging action should be taken, such as reducing or revoking a provider's privileges.<sup>30</sup> The FPPE may include a review of the provider's care, either through medical record review, direct observation, or discussions with other individuals involved in the care of patients. FPPEs conducted when a question arises regarding a provider's ability to provide safe, quality patient care are not conducted often, according to VHA and VAMC officials. According to a VHA official, about 100 FPPEs of this kind are conducted VHA-wide each year.<sup>31</sup>

VA typically uses AIBs to examine nonclinical issues for which the facts are in dispute, such as allegations of employee misconduct, according to VHA and VAMC officials. These officials also said VAMCs may use AIBs to investigate issues of an individual provider's clinical competence, but

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<sup>30</sup>A privileging action could include reduction, denial, nonrenewal, or revocation of privileges.

<sup>31</sup>These 100 FPPEs include only FPPEs conducted for cause and do not include FPPEs conducted for newly hired providers or for providers requesting new or additional privileges.



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this is not typical.<sup>32</sup> According to VA's AIB policy, the convening authority—typically the VAMC director—appoints members to an AIB and defines the scope and authority of the investigation.<sup>33</sup> The AIB collects and analyzes evidence and develops a report, including findings and conclusions. The VAMC director may use an AIB's findings to inform decisions of whether to take adverse action against a provider and, if so, what type of action to pursue. In our 2012 report on AIBs, we found that VAMCs and VISNs conducted a total of 1,136 investigations nationwide from fiscal year 2009 through 2011, but because VA does not track the types of matters investigated, it is unclear how many of these were related to clinical competence.<sup>34</sup>

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## VA and VHA Monitoring Responsibilities

There are several VA and VHA organizational components that are involved in monitoring VAMCs' adverse events and related processes. VHA's Office of the ADUSH for Quality, Safety and Value is responsible for establishing VHA policies for protected peer review and FPPEs and for providing guidance to VAMCs on using those processes. VHA's Office of the DUSHOM oversees the VISNs and provides the VISNs broad and general operational direction and guidance; VISN directors are tasked with oversight of the protected peer review process. The Office of the Medical Inspector addresses health care problems to monitor and improve the quality of care provided by VHA; veterans may report problems with medical care received at VAMCs directly to the Office of the Medical Inspector. The VA OIG Office of Healthcare Inspections inspects individual health care issues and performs quality program assistance reviews of VAMC operations. See figure 2 for a simplified organizational chart of the relationship among these entities.

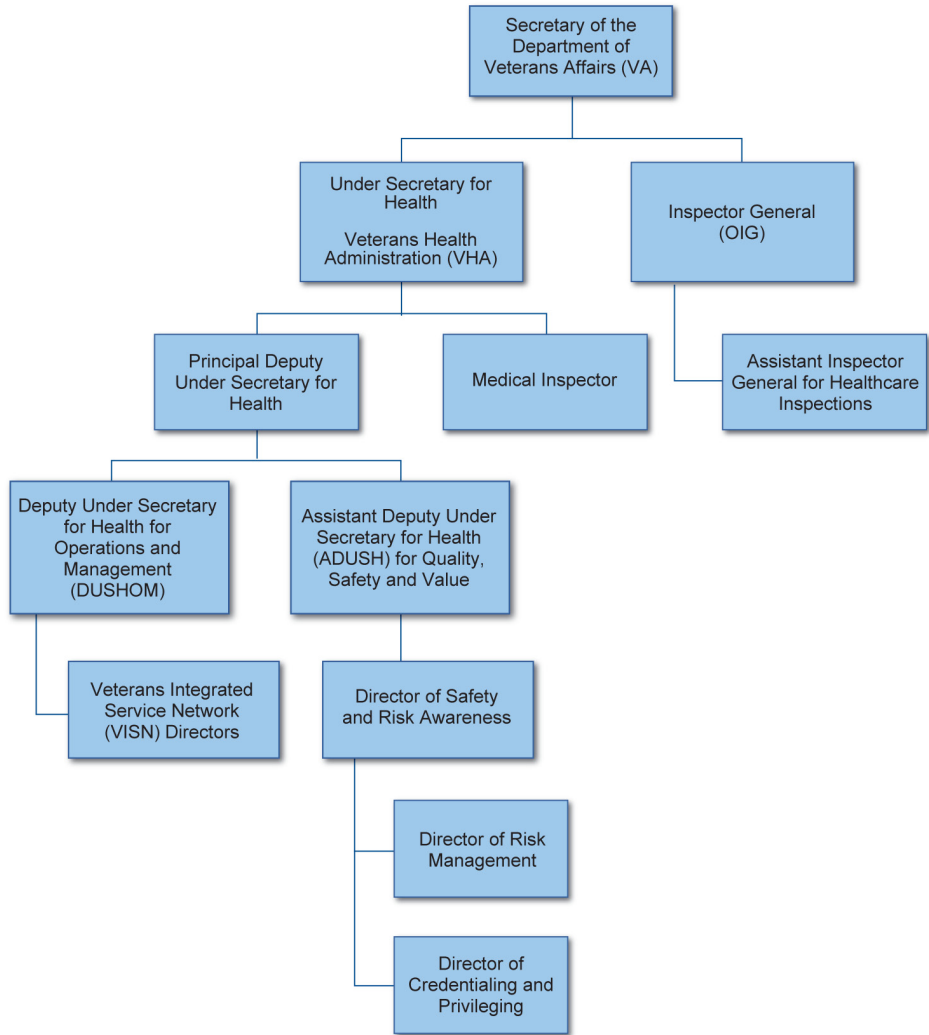
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<sup>32</sup>Clinical competence is the documented demonstration that an individual provider has the requisite or adequate abilities or qualities to perform up to a defined expectation in providing patient care.

<sup>33</sup>VA Handbook 0700.

<sup>34</sup>We recommended that VHA establish a process to collect and analyze aggregate data from AIB investigations, including the number of investigations conducted, the types of matters investigated, whether the matters were substantiated, and the systemic deficiencies identified. See [GAO-12-483](#).

**Figure 2: VA and Veterans Health Administration (VHA) Organizational Components Involved in Monitoring VA Medical Centers' (VAMC) Adverse Events and Related Processes**



Source: GAO analysis of VA data.

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## VAMCs Did Not Adhere to Certain Policy Elements of the Protected Peer Review Process, and Monitoring by VHA Is Limited

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### VAMCs Did Not Adhere to Certain Policy Elements of the Protected Peer Review Process

According to VHA's protected peer review policy, and supported by federal internal control standards for risk assessment and information and communications, VHA's protected peer review policy requirements should ensure that identified patient safety risks are mitigated and lead to organizational improvements and optimal patient outcomes. Additionally, federal internal control standards state that agencies should have reliable information relating to internal events to effectively run and control their operations; this information should be identified, captured, and communicated in sufficient detail and at the appropriate time to the right people.

VAMC officials from all four sites we visited demonstrated a general understanding of the process as described in the protected peer review policy. For example, officials from each of the four VAMCs knew that peer review was a protected nonpunitive process and officials from three of the four VAMCs were able to describe the steps of the process. However, our analysis of peer review data for fiscal years 2009 through 2011 provided by the four VAMCs showed that none of the VAMCs adhered to all four VHA protected peer review policy elements selected for review: (1) completing the initial peer review within 45 calendar days, (2) completing the final peer review within 120 calendar days, (3) sending all initial level of care 2 and 3 peer reviews to the peer review committee, and (4) developing peer review triggers. Additionally, these peer review data included varying amounts of missing and inaccurate data, which affected our ability to fully analyze these data. See table 2 for a summary of the four VAMCs' adherence to selected protected peer review policy elements.

**Table 2: Adherence to Selected Protected Peer Review Policy Elements at Four VA Medical Centers (VAMC) GAO Visited, Fiscal Years 2009 through 2011**

VAMC	Total number of protected peer reviews <sup>a</sup>	Percentage of initial peer reviews completed within 45 calendar days	Percentage of final peer reviews completed within 120 calendar days	Percentage of initial peer reviews rated level of care 2 and 3 sent to peer review committee
A	262	77	89	100
B	354 <sup>b</sup>	100	97 <sup>c</sup>	99
C	1,000	Cannot determine <sup>d</sup>	Cannot determine <sup>d</sup>	79 <sup>e</sup>
D	307	79	89	96

Source: GAO analysis of Veterans Health Administration (VHA) data.

Note: Peer review level of care 2 means that the most experienced, competent provider might have managed the case differently; peer review level of care 3 means that the most experienced, competent provider would have managed the case differently.

<sup>a</sup>These totals do not include peer-reviewed cases for which the date the case was initially sent to the peer reviewer was missing from VHA's data. The total number of protected peer reviews for each facility does not reflect the numbers that were used to determine adherence for the three policy elements listed in this table. Each percentage calculation used a different denominator because of variations in the quality of the data sets across each of the policy elements and fiscal years.

<sup>b</sup>Includes the number of protected peer reviews conducted in fiscal years 2010 and 2011 only, because the data for fiscal year 2009 were missing the date the peer review was sent and received by the peer reviewer.

<sup>c</sup>Includes data from fiscal years 2010 and 2011 only. We could not determine adherence to this policy element because the data provided by this VAMC for fiscal year 2009 were missing the date the peer review was sent and received by the peer reviewer.

<sup>d</sup>The peer review data provided by this VAMC for fiscal years 2009 through 2011 did not include the date the case was sent for initial peer review; it only included the date of the initial review. As a result, we could not determine whether initial peer reviews were completed within 45 calendar days or whether final peer reviews were completed within 120 calendar days for fiscal years 2009 through 2011.

<sup>e</sup>To determine the percentage of initial peer reviews rated level of care 2 and 3 sent to the peer review committee, we used evidence of a final peer review level as a proxy that a case was sent to the peer review committee for further review.

**Completing initial peer reviews within 45 calendar days.** In our analysis of the timeliness policy elements for fiscal years 2009 through 2011, we found that VAMCs A and D completed 77 to 79 percent of initial peer reviews within 45 calendar days. VAMC B completed 100 percent of initial peer reviews within 45 calendar days for the 2 fiscal years for which data were available—2010 and 2011. We could not determine the completion percentage for VAMC C because the data provided by the facility did not contain all of the information needed. According to a VAMC C official, the peer review data provided to us was compiled just before our site visit and was based on a review of past records; the missing data elements could not be located during that review. Officials from VAMCs A

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and D told us that it was difficult to get peer reviewers to abide by the 45-day rule, and, according to officials from VAMC D, the heavy workload of those in charge of peer review tracking during our study period affected their ability to ensure peer reviewers' timely completion. According to the official in charge of peer review tracking at VAMC D, a routine process is now in place at this facility to remind peer reviewers to complete their reviews after 30 of the 45 calendar days allotted have elapsed.

**Completing the final peer reviews within 120 calendar days.** VAMCs A and D each completed 89 percent of final peer reviews within 120 calendar days for fiscal years 2009 through 2011; VAMC B completed 97 percent for fiscal years 2010 through 2011.<sup>35</sup> As previously noted, we were unable to determine the completion percentage for VAMC C. An official at VAMC A told us that, in addition to the delays in completing the initial peer reviews within 45 calendar days, the peer review committee might not have always been able to review all peer-reviewed cases at its monthly meeting if there had been a particularly large number of cases sent to the committee that month.

**Sending level of care 2 and 3 peer reviews to the peer review committee.** We found that VAMCs A and D sent 96 to 100 percent of their initial level of care 2 and 3 peer reviews to the peer review committee for fiscal years 2009 through 2011; VAMC B sent 99 percent for fiscal years 2010 through 2011.<sup>36</sup> VAMC C sent 79 percent of its initial level of care 2 and 3 peer reviews to the peer review committee. Officials from VAMC C told us that a possible reason for the low adherence rate could be that the peer review committee and one of the VAMC's service line committees tasked with sending level of care 2 and 3 cases to the peer review committee for further review did not communicate well during this time period. According to these officials, communication and coordination between these two committees has recently improved.

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<sup>35</sup>The VA Office of Inspector General (OIG) found in its report focusing on one of the sites we visited that 2 percent of final peer reviews exceeded the 120 calendar day time frame and extensions had not been requested or approved. This was a repeat finding from the VA OIG's previous review.

<sup>36</sup>This requirement did not change from the 2008 to the 2010 version of VHA's peer review policy.

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**Developing peer review triggers.** We found that some VAMCs did not develop peer review triggers in a timely way. VHA’s protected peer review policy issued in January 2008 required that VAMCs develop criteria that may define the need for further review or action.<sup>37</sup> VHA’s 2010 update of this policy specified that VAMCs were required to establish peer review or professional activity triggers. The 2010 policy update provides one example of what these triggers could include—three peer review level of care 3 ratings for a provider within 12 consecutive months. Further, federal internal control standards for risk assessment state that management should identify internal risks and undertake a thorough and complete analysis of the possible effects. Additionally, the standards state that risk assessment should include establishment of criteria for determining low, medium, and high risk levels.

We found that while all four VAMCs we visited developed peer review triggers, two of the four VAMCs developed peer review triggers approximately two years after the updated policy was issued. (See table 3.)

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**Table 3: Date Established and Description of Peer Review Triggers at Four VA Medical Centers (VAMC) GAO Visited**

VAMC	Date trigger established	Description of trigger
A	May 2012	Three level of care 3s within 12 consecutive months
B	July 2008	Two level of care 3s or four level of care 2s within 12 consecutive months
C	August 2012	Two level of care 3s or three level of care 2s within 12 consecutive months
D	December 2010	Two level of care 3s or three level of care 2s within 6 consecutive months

Source: GAO analysis of VHA data.

Note: Peer review level of care 2 indicates that the most experienced, competent provider might have managed the case differently. Peer review level of care 3 indicates that the most experienced, competent provider would have managed the case differently.

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<sup>37</sup>VHA Directive 2008-004.

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According to some VAMC officials we spoke with, the delay in developing peer review triggers was the result, at least in part, of a lack of guidance from VHA. When asked about peer review triggers, officials from VAMCs B and C told us they did not receive any assistance from VHA in developing triggers and that the guidance provided by VHA was vague. Officials from VAMCs A and C, the two VAMCs that did not initially develop peer review triggers, told us that while they had informal triggers that could prompt the need for a nonprotected review, such as an FPPE, they had not formally documented the triggers.

When VAMCs fail to complete peer reviews in a timely manner and send all level of care 2 and 3 initial peer reviews to the peer review committee, they put patients' safety at risk through potential exposure to substandard care. VAMCs may fail to identify problematic providers in a timely manner and take the appropriate actions. Additionally, by not submitting initial level of care 2 and 3 peer reviews to the peer review committee for further evaluation, VAMCs are not ensuring that the initial ratings assigned were appropriate. Moreover, the delayed establishment of the peer review triggers by some VAMCs may have resulted in missed opportunities to identify providers who posed a risk to patient safety and to conduct an FPPE, which would have allowed any warranted action to be taken against the provider.

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## VHA and VA OIG Monitor VAMCs' Protected Peer Review Process

Within VHA, the VISNs and the Office of Risk Management monitor VAMCs' protected peer review processes. Officials from the VISNs that oversee the four VAMCs we visited told us they monitor VAMCs' protected peer review processes through quarterly data monitoring and annual site visits, as required by VHA's protected peer review policy.<sup>38</sup> Officials from these VISNs said they monitor peer review data that VAMCs are required to submit quarterly.<sup>39</sup> Data elements that are to be submitted by VAMCs and reviewed by the VISN include, but are not limited to, the number of peer reviews completed, the assigned level of care ratings by the initial peer reviewer and by the peer review committee,

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<sup>38</sup>VHA's peer review policy requires that VISNs conduct and complete annual and ad hoc site visits, ensure peer review data are collected, analyzed, and acted upon, and ensure peer review data are loaded quarterly into a shared database. See VHA Directive 2010-025.

<sup>39</sup>VHA Directive 2010-025.

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the number of assigned level of care ratings changed to a higher or lower level by the peer review committee, and the timeliness of the reviews. After completing their review of VAMCs' quarterly data, VISN officials are to send aggregated peer review data to VHA's office of the ADUSH for Quality, Safety and Value through a shared electronic database.

In addition to quarterly review of the data, officials from all four VISNs said they conduct annual site visits to the VAMCs within the VISN; these site visits include a multifaceted review of VAMCs' quality management operations. However, we did not review documentation from the VISNs' site visits; one VISN official told us that the VISN does not keep formal records and that it is required only to attest to their completion. The scope of VISNs' annual site visits covers a broad variety of topics, including VAMCs' protected peer review processes, according to VISN officials. All VISN officials we spoke with told us they typically chose which elements of the peer review process to review based on the focus of recent inspections by other entities, such as The Joint Commission and the VA OIG.<sup>40</sup> For example, officials we spoke with from one of the four VISNs said they reviewed in a 2012 site visit whether the VAMCs implemented the protected peer review policy elements for timeliness—specifically, completing final peer reviews within 120 calendar days; VA OIG reported in January 2011 that a VAMC within the VISN was not compliant with this timeliness requirement.

The Director of Risk Management told us the Office of Risk Management monitors protected peer review processes by reviewing and analyzing aggregated data submitted quarterly by VAMCs through the VISNs, as required by VHA's protected peer review policy.<sup>41</sup> The Director of Risk Management told us a staff member in that office reviews the data at the VISN and VAMC levels, including the total number of peer reviews; initial peer review level of care 1, 2, or 3 ratings; total number of peer reviews sent to the peer review committee; and number of peer reviews with the

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<sup>40</sup>The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States, including VAMCs. According to VHA's policy on protected peer review, VAMCs' protected peer review processes must comply with accreditation requirements of The Joint Commission.

<sup>41</sup>VHA's protected peer review policy requires VHA to conduct analysis of peer review data findings submitted by each VISN and to disseminate those findings to the Under Secretary for Health, VISNs, and other leadership. See VHA Directive 2010-025.



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rating level of care changed by the peer review committee. The Director of Risk Management said that if an outlier is identified in the aggregated data, it is brought to the attention of the relevant VISN officials. An official from the Office of Risk Management reported that the office produces quarterly reports from analysis of the VHA systemwide aggregated protected peer review data and that these quarterly reports are shared with each VISN. According to VHA's fourth quarter report for fiscal year 2012, ratings for 22 percent of peer-reviewed cases were changed by the VAMCs' peer review committees. VHA's analysis found that the peer review committees were more likely to improve the peer review rating by decreasing the assigned rating level, such as decreasing a level of care 3 to a level of care 1 or 2, or a level of care 2 to a level of care 1.

In addition to monitoring VISNs' aggregated protected peer review data, VHA's Director of Risk Management said the office communicates regularly with the Office of the DUSHOM, as required by VHA's protected peer review policy and supported by federal internal control standards for information and communications. According to VHA's protected peer review policy, the DUSHOM's responsibilities include establishing and maintaining the peer review program in coordination with the ADUSH for Quality, Safety and Value, and providing direction and guidance on data elements that VAMCs must report through VISNs to VHA.<sup>42</sup> Federal internal control standards state that mechanisms should exist to allow the easy flow of information down, across, and up through the organization, and easy communications should exist between functional activities. These standards also state that responsibility for decision-making should be clearly linked to the assignment of authority, and individuals should be held accountable accordingly.<sup>43</sup> The Director of Risk Management said that the office periodically gives brief overviews of the office's work, including protected peer review findings, to the Under Secretary for Health and to the DUSHOM.

Beyond VHA monitoring of VAMCs' protected peer review process, the VA OIG also routinely reviews certain policy elements of the process through its Combined Assessment Program, which reviews each VAMC

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<sup>42</sup>VHA Directive 2010-025.

<sup>43</sup>[GAO-01-1008G](#).

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every 2 to 3 years.<sup>44</sup> In the last 5 years, the VA OIG has reviewed VAMCs' compliance with several requirements, including (1) peer review committee must submit quarterly reports to the medical executive committee,<sup>45</sup> (2) peer review committee must analyze protected peer reviews for trends in follow-up items and recommendations, and (3) protected peer reviews by the initial reviewer and the peer review committee must be completed timely. The VA OIG has conducted at least one Combined Assessment Program review since 2011 at each of the four VAMCs we visited.<sup>46</sup> See table 4 for a summary of protected peer review monitoring activities conducted by VISNs, VHA's Office of Risk Management, and VA OIG.

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<sup>44</sup>VA OIG conducts Combined Assessment Program reviews that provide cyclical oversight of VAMCs and are used to review selected clinical and administrative operations.

<sup>45</sup>The medical executive committee is the primary governance committee for the medical staff at the VAMC. The medical executive committee, with input from the medical staff, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. According to VHA's protected peer review policy, the medical executive committee is responsible for utilizing data from the peer review committee to determine the need for further action.

<sup>46</sup>For examples of VA OIG Combined Assessment Program reports for the four sites, see Department of Veterans Affairs, Office of Inspector General Office of Healthcare Inspections, *Combined Assessment Program Review of the VA Puget Sound Health Care System, Seattle, Washington*, Report No. 11-04569-141 (Washington, D.C.: Apr. 3, 2012); Department of Veterans Affairs, Office of Inspector General Office of Healthcare Inspections, *Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee*, Report No. 12-02185-288 (Washington, D.C.: Sept. 27, 2012); Department of Veterans Affairs, Office of Inspector General Office of Healthcare Inspections, *Combined Assessment Program Review of the VA North Texas Health Care System, Dallas, Texas*, Report No. 12-01875-245 (Washington, D.C.: Aug. 13, 2012); and Department of Veterans Affairs, Office of Inspector General Office of Healthcare Inspections, *Combined Assessment Program Review of the VA Maine Healthcare System, Augusta, Maine*, Report No. 12-03741-61 (Washington, D.C.: Dec. 12, 2012).

**Table 4: Protected Peer Review Process Monitoring Activities by Selected VA and Veterans Health Administration (VHA) Organizational Components**

VA/VHA organizational component	Data monitoring	Site visits
VHA Office of Quality, Safety and Value, Office of Risk Management	X	
Veterans Integrated Service Networks (VISN)	X	X
VA Office of Inspector General Office of Healthcare Inspections		X

Source: GAO.

According to officials from the Office of Risk Management, routine monitoring of certain policy elements of VAMCs' protected peer review processes has enabled VHA to make changes in policy and improve protected peer review monitoring activities. VHA's Director of Risk Management said that her office is responsible for making changes to policy in response to VA OIG findings related to the protected peer review process. For example, in a 2008 report on VISNs' oversight of the protected peer review process, the VA OIG found that VISNs failed to substantially comply with the requirement to conduct periodic inspections; the VA OIG recommended that VHA clarify its peer review policy to define periodic site visits required of VISNs.<sup>47</sup> VHA's 2008 revision of the protected peer review policy redefined site visits as annual to result in more frequent monitoring by VISNs.<sup>48</sup> VHA also improved peer review data monitoring activities. According to the Director of Risk Management, a national survey of VAMC risk managers was conducted in 2011 to better understand how protected peer review data are used. Based on survey data and a literature review, VHA officials said they determined that VAMCs and VISNs needed additional data on the specific areas of care that were being peer-reviewed as well as information about significant problems identified and frequently cited issues. VHA officials said that in fiscal year 2012, they expanded the required quarterly protected peer review data set that VAMCs report to the VISN to include the commonly peer-reviewed aspects of care, such as the choice of a

<sup>47</sup>Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection: Veterans Integrated Service Network Oversight of Peer Review Processes*, Report No. 08-00338-115 (Washington, D.C.: Apr. 22, 2008).

<sup>48</sup>VHA Directive 2008-004.

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diagnostic test, performance of a procedure or treatment, and addressing abnormal results of diagnostic tests.

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### VHA and VA OIG Monitoring of Peer Review Triggers Is Limited

According to VHA's protected peer review policy, VISNs and the Office of Risk Management play a role in monitoring VAMCs' implementation of protected peer review processes, which include peer review triggers. In addition, federal internal control standards state that management needs to comprehensively identify risks and analyze the possible effects; these peer review triggers serve as part of VHA's risk assessment tool to help identify issues of risk to patient safety and improve the organization.<sup>49</sup>

Officials of the VISNs for the four VAMCs we visited and the VA OIG told us they have reviewed the establishment of peer review triggers by VAMCs. However, VISNs, VHA, and VA OIG have not monitored whether the triggers have actually been implemented. Officials we interviewed from two of the four VISNs said their VISNs reviewed VAMCs' peer review triggers during the required annual site visits; an official from a third VISN said that the VISN has confirmed that most VAMCs have established peer review triggers. Officials from the fourth VISN told us they have reviewed types of triggers in place at VAMCs, but they have not confirmed that VAMCs have established peer review triggers. Officials from all four VISNs told us they typically do not monitor whether VAMCs have implemented the established peer review triggers, including monitoring how many FPPEs for cause have been triggered. One VISN official explained that the VISN cannot monitor every aspect of every policy and regulation that govern VAMCs' operations; therefore, they choose to focus their monitoring efforts on the elements of particular importance where other entities—such as the VA OIG and The Joint Commission—have found evidence of noncompliance.

VHA's Director of Risk Management told us that the office does not monitor whether VAMCs have established peer review triggers. Further, the official told us the office has not monitored how VAMCs have implemented peer review triggers or tracked how many providers may be exceeding the triggers and are subject to FPPEs for cause. The official also noted that VHA has not asked VAMCs to document their peer review triggers and has not asked the VA OIG to look specifically, during

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<sup>49</sup> [GAO-01-1008G](#).

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Combined Assessment Program reviews, at whether VAMCs have established triggers.

Officials from the VA OIG told us they did monitor VAMCs' establishment of peer review triggers as part of Combined Assessment Program reviews conducted in fiscal year 2009. The OIG review found 97 percent compliance with establishing peer review triggers across the 44 VAMCs OIG officials visited; the four VAMCs we visited were not among the 44 VAMCs included in this review.<sup>50</sup> According to VA OIG officials, they decided not to review the establishment of peer review triggers in subsequent Combined Assessment Program reviews because of the high compliance rate in 2009; instead, subsequent Combined Assessment Program reviews focused on requirements with which VAMCs had not been in compliance, such as requiring the peer review committee to submit quarterly reports on protected peer review to the medical executive committee.<sup>51,52</sup> VA OIG officials told us they have not reviewed whether VAMCs have implemented the triggers.

Because neither VHA's Office of Risk Management nor VA OIG review whether peer review triggers have been implemented, VHA cannot provide reasonable assurance that VAMCs are using the triggers as a risk assessment tool as intended. Failure to do so weakens VAMCs' ability to ensure patient safety, and officials cannot be assured that the use of these triggers meets the intended goal of identifying providers that are not delivering safe, quality patient care.

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<sup>50</sup>Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection: Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2009*, Report No. 09-00069-161 (Washington, D.C.: June 2, 2010). OIG officials confirmed that none of the four VAMCs included in our site visits were part of their sample of 44 VAMCs in the fiscal year 2009 Combined Assessment Program reviews.

<sup>51</sup>The VA OIG found that 35 of the 44 VAMC peer review committees submitted quarterly reports to their medical executive committees as required. See VA OIG Report No. 09-00069-161.

<sup>52</sup>Department of Veterans Affairs, Office of Inspector General, *Combined Assessment Program Summary Report, Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2011*, Report No. 11-00104-186 (Washington, D.C.: May 17, 2012). See also Department of Veterans Affairs, Office of Inspector General, *Combined Assessment Program Summary Report, Evaluation of Quality Management in Veterans Health Administration Facilities, Fiscal Year 2012*, Report No. 12-01480-183 (Washington, D.C.: Apr. 25, 2013).

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## VAMC's Adherence to the FPPE Process Is Unclear Due to Gaps in Policy Addressing Documentation Requirements; VHA Does Not Routinely Monitor Nonprotected Processes

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Gaps in Policy Create Lack of Clarity as to How VAMCs Are to Document the FPPE Process; Requirements for AIBs Generally Are Clear

**FPPEs.** According to federal internal control standards for control activities, written documentation should exist for all significant events that occur within an agency; this documentation should be readily available for examination, and it should be complete and accurate in order to facilitate tracing the event from initiation through processing to completion. In documenting FPPEs, building strong and complete evidence on each case is important to support the outcome of the evaluation, as well as to track the identified area of concern over time.

VHA's FPPE policy provides a general definition of an FPPE, that it can be used for cause (when a question arises regarding a provider's ability to provide safe, quality patient care), that the criteria for the FPPE should be defined by the VAMC in advance, and that the results of the FPPE must be documented in the provider's profile.<sup>53</sup> However, there are gaps in VHA's policy regarding how these evaluations should be documented and what information should be included, which limited our ability to assess VAMCs' adherence to the FPPE policy. Officials from two of the VAMCs we visited told us there are no standardized guidelines on how the FPPE process should be structured. According to the Director of Credentialing and Privileging, VHA's policy on FPPEs was intended to allow VAMCs flexibility in the design of the evaluation to accommodate the variety of

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<sup>53</sup>Provider profiles consist of practitioner-specific data utilized to assist service chiefs and medical staff leadership in the privileging process. These profiles contain physician performance information collected through VAMC continuous monitoring efforts.

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ways that issues are identified and the types of issues that may be addressed (see box for example of an FPPE).

**Example of an FPPE at one VAMC we visited**

There are multiple ways that an FPPE may be prompted, including multiple patient complaints or exceeding a VAMC's peer review trigger. At one VAMC we visited, a provider exceeded a peer review trigger—receiving two or more level of care 3 peer review ratings within 6 months—which prompted a detailed assessment, including a retrospective evaluation of 25 percent of the provider's medical records over the previous 12 months. The medical records were evaluated specifically for patient evaluations, outcomes, and documentation. Upon completion of the assessment, VAMC officials determined that the provider's documentation, including patient discharge summaries, patient transfer, medication review, and disclosure notes, was inadequate. An FPPE was initiated, for which the provider was instructed on how to properly document these types of summaries and notes. The evaluator also recommended that the provider write the notes for each patient seen before moving to see other patients, instead of writing the notes for all patients at the end of the day. VAMC officials also initiated a performance improvement plan for the provider, which included monitoring his medical record documentation over a 6-month period. When officials determined that the provider had not improved after this period, the FPPE was extended to continue monitoring aspects of his clinical care. The provider retired 6 months later.

Officials from the VAMCs we visited were generally aware that FPPEs can be used to address concerns about the quality of a provider's care; are time limited; and are not disciplinary, but could ultimately be used to take adverse action against a provider, if necessary. While VAMC officials were generally aware of the FPPE process, we found that the four VAMCs we visited varied widely in their documentation of FPPEs, attributable at least in part to the lack of specificity in VHA's FPPE policy regarding documentation requirements. In reviewing FPPEs conducted between fiscal years 2009 and 2011 we found the following:

- One of the four VAMCs provided a completed template for each of its FPPEs, including the purpose of the FPPE, specifying what triggered the review, the time period for review, comments by the evaluator, an action plan based on the review, and evidence of concurrence with the review by the applicable service chief. (See app. I for an example of an FPPE template used at one of the VAMCs we visited.)
- Two other VAMCs provided various combinations of documents as evidence of their FPPEs, including professional standards board minutes and emails and letters from evaluators. These documents contained varying amounts of information detailing the circumstances prompting the FPPE, comments from evaluators, and follow-up actions, if any.<sup>54</sup>
- The fourth VAMC initially provided us with documentation of one FPPE, including a completed template identifying the clinical service involved, the method of evaluation, the evaluator's findings, and the service chief's conclusions; and several documents, each with focused professional practice evaluation labeled at the top, specifying the medical records evaluated for the FPPE and the evaluator's comments on each case. The VAMC's service chief told us that an FPPE had been conducted for cause for this provider, but the VAMC's quality manager said a formal FPPE had not been conducted and that the documentation we received was part of a protected peer review

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<sup>54</sup>From three of the four VAMCs, we received documentation for a total of 12 FPPEs from fiscal years 2009 through 2011 conducted in response to questions that arose regarding a provider's ability to provide safe, quality patient care.

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process. This disagreement illustrates that even within the same facility the interpretation of VHA's policy on FPPEs differs, which can lead to potentially inappropriate use.

Gaps in VHA's policy on FPPE documentation requirements create a lack of clarity and therefore may affect VAMCs' ability to appropriately document the evaluation of providers' skills, support any actions initiated, and track provider-specific FPPE-related incidents over time. For example, if FPPEs are not well documented, VAMC officials may have limited knowledge of the findings to proceed with any actions and limited ability to track that such evaluations were conducted. As a result, if another adverse event subsequently occurred involving the same provider, the VAMC may not be aware of any prior findings. One VAMC official stressed to us the importance of thorough documentation of an FPPE, even if the determination is made that the provider delivered safe, quality patient care and no adverse action is needed. Without adequate documentation, a VAMC may conduct an FPPE that complies with VHA's policy, and determine that adverse action is needed on the basis of the evaluation's findings, but ultimately may be unable to take the action because the documented evidence is insufficient. Officials at one VAMC said they did not believe that the evidence gathered from an FPPE was strong enough to hold up against a provider's appeal of an adverse action.

**AIBs.** Another type of nonprotected review that VAMC officials may choose to address an adverse event is an AIB.<sup>55</sup> In our review of VA's AIB policy, we found that the policy generally provides clear guidance on the requirements, including documentation. For example, the policy specifies steps on how VAMC officials determine the need for an AIB, select the board members, and write the charge letter that convenes the AIB, and also provides a number of templates and checklists, including templates for the charge letter and investigative report, and checklists for collecting evidence, conducting interviews, and writing the report.<sup>56</sup>

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<sup>55</sup>According to VAMC officials, although AIBs can be used to address issues of clinical competence, they are not usually used in these cases. They said a protected peer review or another nonprotected review process, such as an FPPE, would more likely be used to address clinical competence issues.

<sup>56</sup>We identified five AIBs used to investigate potential problems with a provider's patient care occurring during fiscal years 2009 through 2011 from two of the four VAMCs we visited.



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When asked about AIBs, VAMC officials told us an AIB could be used when (1) a case is egregious; (2) there is a previous incident involving the same provider; (3) the VAMC needs or wants to take privileging or disciplinary action; and (4) the facts of a case are in dispute or when there is a high level of complexity and ambiguity in the case. For example, at one VAMC we visited, an AIB was convened to investigate the facts and circumstances regarding the care and treatment immediately preceding a veteran's death. The AIB was charged with investigating allegations that a provider's care deviated from standard practice procedures, including prescribing inappropriate doses of medications, not ensuring appropriate monitoring or appropriate interval of physical assessments, and providing substandard documentation and communication.

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### VHA Does Not Routinely Monitor Nonprotected Processes

**FPPEs.** According to federal internal control standards for monitoring, agencies should assess the quality of performance over time and provide reasonable assurance that deficiencies are detected and promptly resolved. Further, VHA's credentialing and privileging policy states that the DUSHOM is responsible for ensuring that VISN directors maintain an appropriate credentialing and privileging process, which includes FPPEs, consistent with VHA policy.<sup>57</sup> The VISN Chief Medical Officer is responsible for oversight of the credentialing and privileging process of the VAMCs within the VISN.

Officials we interviewed from three of the four VISNs told us they do not monitor FPPEs conducted in response to questions about a provider's ability to deliver safe, quality patient care. Officials from two of those three VISNs said that they have examined a sample of FPPEs during annual site visit reviews of VAMC operations; however, the sample of FPPEs would include mostly FPPEs for newly hired providers, since there are very few FPPEs conducted in response to questions that have arisen about a provider's ability to deliver safe, quality patient care. An official from the fourth VISN said he monitors FPPEs during annual site visits to

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<sup>57</sup> According to VHA's credentialing and privileging policy, the DUSHOM's monitoring of credentialing and privileging must continue through periodic site visits by The Joint Commission and other reviews as applicable. See VHA Directive 1100.19. VHA's Director of Credentialing and Privileging told us that VHA policy does not specify a process or authority for monitoring FPPEs. However, although the policy does not mention monitoring of FPPEs specifically, FPPEs are part of the overall credentialing and privileging process.

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VAMCs, including FPPEs conducted in response to questions that have arisen about a provider's ability to deliver safe, quality patient care.

Officials from the office of the DUSHOM and the Office of Credentialing and Privileging said they do not monitor FPPEs conducted in response to questions about a provider's ability to deliver safe, quality patient care. The Office of Credentialing and Privileging does not monitor these FPPEs because there are so few of them that the cost of reviewing a process that occurs so infrequently would outweigh the benefit. According to VHA officials, if an FPPE leads to a proposed reduction or revocation of clinical privileges, the Director of Credentialing and Privileging is frequently consulted to ensure that appropriate due process is afforded the provider.<sup>58</sup>

Similar to the VISNs, VA OIG officials told us they do not monitor FPPEs conducted when a question arises regarding a provider's ability to deliver safe, quality patient care. However, VA OIG officials said that, during site visits for Combined Assessment Program reviews, they do review policy elements of the process for FPPEs for providers newly appointed to the VAMCs' medical staff or for providers requesting new privileges.<sup>59</sup> Because none of these entities monitor FPPEs conducted when a question arises regarding a provider's ability to deliver safe, quality patient care, VHA cannot be assured that the process is working as intended or whether VAMCs need additional guidance or training about the process.

**AIBs.** Officials from two of the four VISNs we interviewed said they routinely monitor VAMCs' AIB activity, including confirming whether the AIBs were completed timely and what kinds of issues were addressed. Officials from the other two VISNs said they do not monitor AIBs. Because the AIB directive is a VA policy, there are no explicit

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<sup>58</sup>VA policy affords due process to providers prior to any privileging action. Providers are given the right to reply to a proposed privileging action prior to a final action. Once the VAMC director makes a final determination on a privileging action, the provider is entitled to a fair hearing by a panel of peers. If a privileging action is sustained following a fair hearing, providers have the right to appeal the decision to the VISN director, who may ultimately sustain or reverse the privileging action.

<sup>59</sup>According to a VA OIG official, these policy elements include whether there is evidence that FPPEs for new providers or new privileges are initiated, completed, and reported to the medical executive committee.

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requirements for VHA to monitor AIBs; however, federal internal control standards for information and communications state that relevant, reliable, and timely information is needed by an agency to achieve its objectives and to control its operations.<sup>60</sup> In our 2012 report on AIBs, we found that VA does not collect and analyze aggregated data on AIB investigations, and at that time, VHA officials told us that there were no plans to do so.<sup>61</sup> In our report, we recommended that VA establish a process to collect and analyze aggregated data from AIB investigations conducted within VHA. Having these types of data may provide VA with valuable information to systematically gauge the extent to which matters investigated by AIBs are occurring throughout VHA and to take corrective action, if needed, to reduce the likelihood of future occurrences. According to VHA officials, after our 2012 report was issued, VHA created a workgroup to examine our recommendation and concluded that monitoring AIBs was not necessary or warranted.

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## Conclusions

VAMCs' adherence to policies on protected and nonprotected processes for responding to providers' actions that contribute to adverse events helps ensure that quality care is provided to veterans and that safety risks are minimized. Having clear and detailed guidance in policy for these processes is critical to helping VAMC officials identify and address adverse events, including providers' contributing actions, in a timely and appropriate manner. Although officials at the four VAMCs we reviewed generally understood the protected peer review process, we found that none of these four VAMCs adhered to all four VHA protected peer review policy elements selected for review, such as completing peer reviews within required time frames and sending the required peer-reviewed cases to the peer review committee for further assessment. As such, VHA may be missing opportunities for improvements both in the practice of individual providers and organizationally. VHA also may be missing opportunities to identify and intervene early with providers whose care may pose a risk to patient safety if VAMC officials have not established or implemented peer review triggers that would initiate a detailed assessment of a provider's care. Assisting with and monitoring VAMCs' development and use of these peer review triggers will help VHA ensure that the protected peer review process contributes to organizational

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<sup>60</sup> [GAO-01-1008G](#).

<sup>61</sup> [GAO-12-483](#).

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improvements and favorable patient outcomes, as intended by VHA policy.

FPPEs and AIBs are nonprotected processes that VAMCs use to address adverse events involving individual providers. However, gaps in VHA's FPPE policy on documentation requirements have created a lack of clarity for VAMCs on how to appropriately document the process. Inadequate documentation of the FPPE process may result in VAMC officials being unable to take adverse action against a provider when necessary. Providing more specific policy guidance for FPPEs would better support VAMCs' use of this process, including when officials determine that they may need to take adverse action against a provider. Although VHA officials reiterated that they do not have plans to collect and analyze aggregated AIB data as we recommended in our 2012 report, we continue to believe that this is a potentially important quality improvement tool for use by VHA.

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## Recommendations for Executive Action

To improve VHA's use of the protected peer review and nonprotected processes to respond to individual providers involved in adverse events or when questions arise regarding providers' ability to deliver safe, quality patient care, we are making five recommendations.

To address protected peer review process requirements, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to

- ensure that VAMCs send all required initial peer reviews (level of care 2 and 3) to the peer review committee;
- ensure VAMCs' peer review committees complete final peer reviews within 120 calendar days;
- provide clear guidance and assistance on the purpose, development, and implementation of peer review triggers; and
- require VAMCs to periodically provide data on peer review triggers, including the number of providers that have exceeded the triggers as part of the protected peer review data VAMCs report to VISNs on a quarterly basis.

To address the nonprotected FPPE process, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to

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develop more specific policy on the FPPE process, including documentation requirements such as the FPPE's purpose, time period covered, evaluator's assessment, and the summary of actions to be taken.

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## Agency Comments and Our Evaluation

VA provided written comments on a draft of this report, which we have reprinted in appendix II. In its comments, VA generally concurred with our conclusions and our five recommendations, and described the agency's plans to implement each of our recommendations. VA also provided technical comments, which we have incorporated as appropriate.

In response to our first and second recommendations that VA ensure that all initial peer reviews (levels of care 2 and 3) be sent to the peer review committee for review and that the committee's reviews be completed within 120 days, VA stated that it will provide refresher education to key staff, such as chiefs of staff, risk managers, and VISN officials. VA anticipates that its planned actions will be completed by December 31, 2013.

In response to our third recommendation that VA provide clear guidance and assistance on the purpose, development, and implementation of peer review triggers, VA stated that refresher education on this policy requirement, which also encompasses professional activity triggers, was communicated to key staff, such as chiefs of staff, risk managers, and VISN officials, through a conference call. Additionally, VA stated that staff in the VHA Risk Management Program, Office of Quality, Safety and Value will be available to provide consultative assistance to facilities that are unclear on how to implement this requirement. VA anticipates completion of these activities by December 31, 2013.

In response to our fourth recommendation that VA require VAMCs to periodically provide data on peer review triggers, VA concurred. VA stated that VAMCs will be required to submit a deidentified, summary report discussing trends and analysis of aggregate data on peer review activity with their quarterly submission to the VISN. VA stated that this new requirement will be included in the fiscal year 2014 revision of VHA Directive 2010-025, Peer Review for Quality Management, which establishes that the VAMC's medical executive committee is responsible for determining peer review or professional activity trigger levels. VA anticipates completion of these activities by September 30, 2014. VA disagreed with the latter part of our recommendation that the data submitted should include the number of providers that have exceeded the

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triggers. VA stated that reviewing aggregate data for the number of providers who exceeded trigger thresholds would represent skewed data, which VA officials believe is not reflective of the quality of care provided by those providers submitted for triggered reviews. VA stated larger facilities may appear to have artificially higher levels of providers referred for detailed assessments than those of smaller facilities. We agree with VA that VAMC clinical leadership, with VISN oversight, input, and support, is the preferred means to handle trigger thresholds and data analysis; however, VA did not specify what data on protected peer review triggers that VAMCs would be required to report. We maintain that it is important for VAMCs and the VISNs to review whether the peer review triggers are implemented as intended. Part of this review should include monitoring how many providers have exceeded the trigger thresholds. Additionally, we believe that collecting and reporting such data will help the VISNs and VHA ensure that the protected peer review process contributes to organizational improvements and favorable patient outcomes.

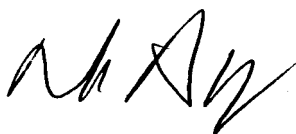
In response to our fifth recommendation that VA develop more specific policy on the FPPE process, including documentation requirements such as the FPPE's purpose, time period covered, evaluator's assessment, and the summary of actions to be taken, VA stated that it will develop guidance on the FPPE process that will begin with a description of the process for a detailed assessment and define the FPPE for cause process if an opportunity to improve is indicated. VA further noted that the guidance will end with an overview of the adverse action process to be initiated when the provider does not demonstrate adequate improvement and a reduction or revocation of clinical privileges appears to be indicated. VA anticipates completion of these activities by September 30, 2014. While we understand VA's intention of expediting dissemination of information about the FPPE process through guidance, we believe that it is important for the guidance to be included in the next formal iteration of VHA policy.

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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>.

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If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read 'Debra A. Draper'.

Debra A. Draper  
Director, Health Care

# Appendix I: Example of a VA Medical Center's (VAMC) Focused Professional Practice Evaluation (FPPE) Template

This FPPE form is a full recreation of a template used by one of the VAMCs we visited.

VA MEDICAL CENTER			
FOCUSED PROFESSIONAL PRACTICE EVALUATION			
PROVIDER NAME:			
DATE OF APPOINTMENT:			
<u>PURPOSE OF FOCUSED PROFESSIONAL PRACTICE EVALUATION</u>			
<input type="checkbox"/> New provider with clinical privileges has the credentials to suggest competency but a period of evaluation is needed to confirm the new provider's competence in this organization.			
<input type="checkbox"/> Provider has requested a new clinical privilege.			
<input type="checkbox"/> Provider requires supervision for a procedure(s) and/or treatment modality.			
<input type="checkbox"/> Service has concerns about a provider's competence in relation to:			
<input type="checkbox"/> Sentinel event			
<input type="checkbox"/> Provider-specific tort settlement			
<input type="checkbox"/> Substantiated provider-specific complaint			
<input type="checkbox"/> Significant safety violation			
<input type="checkbox"/> Repeated or egregious unprofessional behavior			
<input type="checkbox"/> Concerns raised by Medical Staff regarding provider's performance			
<input type="checkbox"/> Other Specify:			
TIME PERIOD FOR REVIEW From: To:			
COMPETENCY ASSESSMENT			
<u>1. PATIENT CARE</u>			
<i>Provides patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness and treatment of disease.</i>			
PROVIDER NAME:			
<b>Measures of Competency</b>			
<input type="checkbox"/> Medical Record Review			
<input type="checkbox"/> Clinical Inspection/Observation of Actual Treatment Procedures			
<input type="checkbox"/> Morbidity and Mortality Data			
<input type="checkbox"/> Other Specify:			
<b>Competency Rating</b>			
Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9
<b>Comments:</b>			
<u>2. MEDICAL/CLINICAL KNOWLEDGE</u>			
<i>Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and applies knowledge to patient care and the education of others.</i>			

Source: VHA.



Appendix I: Example of a VA Medical Center's  
(VAMC) Focused Professional Practice  
Evaluation (FPPE) Template

**Measures of Competency**

- ☐ Case Management
- ☐ Completion Orientation/Mandatory Training
- ☐ Current Licensure
- ☐ Current BLS
- ☐ Current ACLS
- ☐ Other Specify:

**Competency Rating**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

3. PRACTICE-BASED LEARNING AND IMPROVEMENT

*Uses scientific evidence and methods to investigate, evaluate, and improve patient care practices.*

**Measures of Competency**

- ☐ Compliant with Peer Review Recommendations
- ☐ Professional CME
- ☐ Conference/Journal/Study Club Presentations
- ☐ Other Specify:

**Competency Rating**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

4. INTERPERSONAL AND COMMUNICATION SKILLS

*Demonstrates interpersonal and communication skills to establish and maintain professional relationships with patients, families, and other members of the healthcare team*

**Measures of Competency**

- ☐ Discussion with other individuals involved in the care of provider's patients
- ☐ Staff/patient complaints
- ☐ Staff/patient compliments
- ☐ Other Specify:

**Competency Rating**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

5. PROFESSIONALISM

*Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward patients, the medical profession, and society.*

Source: VHA.

**Appendix I: Example of a VA Medical Center's  
(VAMC) Focused Professional Practice  
Evaluation (FPPE) Template**

**Measures of Competency**

- ☐ Professional Behavior
- ☐ Compliance with Bylaws, Directives, Policies
- ☐ Meets Administrative Responsibilities in Timely Manner
- ☐ Participates Medical Center Committees, Staff Meetings
- ☐ Other Specify:

**Competency Rating**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

**6. SYSTEM-BASED PRACTICE**

*Demonstrates an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize health care.*

**Measures of Competency**

- ☐ Compliant with Team Systems Design/Organization Processes
- ☐ Time-Out Procedure/Process Compliance
- ☐ Informed Consent Process Compliance
- ☐ Other Specify:

**Competency Rating**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

**OVERALL RATING**

Unsatisfactory/Marginal Performance	1	2	3
Fully Satisfactory Performance	4	5	6
Outstanding Performance	7	8	9

**Comments:**

PROVIDER NAME:

**ACTION**

- ☐ No concerns regarding competency; proceed with Ongoing Professional Practice Evaluation
- ☐ Extent time period for focused professional practice evaluation

Specified Time Period:                      From:                      To:

Source: VHA.

Appendix I: Example of a VA Medical Center's  
(VAMC) Focused Professional Practice  
Evaluation (FPPE) Template

Specified Clinical Privileges:

☐ All

☐ One or more

☐ Specify:

☐ Initiate plan for performance improvement.

Specify:

☐ It is recommended that this competence assessment be addressed with the provider.

☐ Findings of competency assessment discussed with the provider?

Yes

No

Print Reviewer's Name and Title

Date

Reviewer's Signature

Date

☐ Concur

☐ Do not Concur

Actions to be taken:

Signature of Service Chief

Date

Source: VHA.

# Appendix II: Comments from the Department of Veterans Affairs



DEPARTMENT OF VETERANS AFFAIRS  
Washington DC 20420

November 5, 2013

Ms. Debra A. Draper  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA HEALTH CARE: Improvements Needed in Processes Used to Address Providers' Actions That Contribute to Adverse Events"*** (GAO-14-55). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to  
Government Accountability Office (GAO) Draft Report  
***“VA HEALTH CARE: Improvements Needed in Processes Used to Address Providers’  
Actions That Contribute to Adverse Events”***  
(GAO-14-55)

**GAO Recommendation:** To improve VHA’s use of the protected peer review and nonprotected processes to respond to individual providers involved in adverse events or when questions arise regarding providers’ ability to deliver safe, quality care, we are making five recommendations.

To address the protected peer review process, we recommend that the Secretary of VA direct the Under Secretary for Health to:

**Recommendation 1:** Ensure that VAMCs send all required initial peer reviews (level of care 2 and 3) to the peer review committee.

**VA Comment:** Concur. The Veterans Health Administration (VHA) Directive 2010-025, Peer Review for Quality Management, dated June 3, 2010, requires the Peer Review Committee to reconsider all peer review for quality management cases within the facility completed by individual initial peer reviewers when the level of review is determined to be a Level 2 or Level 3. The involved provider will have an opportunity to submit written comments or appear before the Peer Review Committee prior to the committee’s determination of a final level assignment.

Refresher education on this policy requirement will be communicated to key constituent groups, e.g., Chiefs of Staff, Risk Managers, Veterans Integrated System Network (VISN) Chief Medical Officers, and VISN Quality Management Officers, to reinforce compliance with this directive. This information was communicated on the quarterly Risk Managers call held on September 24, 2013. Anticipated completion date is December 31, 2013.

**Recommendation 2:** Ensure VAMCs’ peer review committees complete final peer reviews within 120 calendar days.

**VA Comment:** Concur. VHA Directive 2010-025 states that the Peer Review Committee must complete a final review of each referred case within 120 days from the determination that a peer review is necessary. The exception for a delay, or an extension beyond 120 days, needs to be requested in writing and approved by the facility Director.

Medical centers are required to submit a quarterly update of their compliance to their VISN. The VISN does a roll-up of this peer review monitor, along with other peer review data, for submission to the VHA Risk Management Program for analysis. VISNs that have medical centers not meeting this requirement are contacted to ensure an action plan has been developed to maintain compliance.

Refresher education on this policy requirement was communicated to key constituent groups, e.g., Chiefs of Staff, Risk Managers, VISN Chief Medical Officers, and VISN Quality

Enclosure

Department of Veterans Affairs (VA) Response to  
Government Accountability Office (GAO) Draft Report  
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(GAO-14-55)

Management Officers, to reinforce compliance with this directive. This information was communicated on the quarterly Risk Manager call held on September 24, 2013. Anticipated completion date is December 31, 2013.

**Recommendation 3: Provide clear guidance and assistance on the purpose, development and implementation of peer review triggers.**

**VA Comment:** Concur. VHA Directive 2010-025 states that the Medical Executive Committee is responsible for establishing peer review or professional activity triggers, e.g., three Level 3 assignments to a provider in a rolling 12-month period, or professional actions that lead to a focused review of a provider's clinical care.

Refresher education on this policy requirement was communicated to key constituent groups, e.g., Chiefs of Staff, Risk Managers, VISN Chief Medical Officers, and VISN Quality Management Officers, to reinforce compliance with this directive. Staff in the VHA Risk Management Program, Office of Quality, Safety, and Value will be available to provide consultative assistance to facilities that are unclear on how to implement this requirement. This information was communicated on the quarterly Risk Manager call held on September 24, 2013. Anticipated completion date is December 31, 2013.

**Recommendation 4: Require VAMCs to periodically provide data on protected peer review triggers, including the number of providers that have exceeded the triggers as part of the protected peer review data VAMCs report to VISNs on a quarterly basis.**

**VA Comment:** Concur.

VA concurs that VA medical centers (VAMC) should be required to periodically provide data on protected peer review triggers to the VISNs but disagrees with including the number of providers that have exceeded the triggers.

The Peer Review program is a quality assurance activity. VHA Directive 2010-025, Peer Review for Quality Management, states that the Medical Executive Committee is responsible for determining the trigger levels. This is a locally driven decision-making process that allows the clinical leadership to provide appropriate oversight on potential problems in their facility and to understand how and why adverse events may occur within VA medical facilities.

Reviewing aggregate data for the number of providers who exceeded trigger thresholds would represent skewed data, which is not reflective of the quality of care provided by those providers submitted for triggered reviews. Facilities vary across the Nation by size and complexity. Very large facilities that see more critically ill patients and perform more high-risk procedures would have more opportunities for the provider's care to meet or exceed the

Enclosure

Department of Veterans Affairs (VA) Response to  
Government Accountability Office (GAO) Draft Report  
***“VA HEALTH CARE: Improvements Needed in Processes Used to Address Providers’  
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(GAO-14-55)

trigger thresholds. Conversely, smaller facilities that do not see critical patients and whose care is outpatient based, will have fewer opportunities for providers to meet or exceed the trigger thresholds. By comparing national aggregate data, larger facilities may appear to have artificially high levels of providers referred for focused reviews than those of smaller facilities. Higher facility complexity levels have a disproportionately higher number of providers in clinical sub-specialties (e.g., neurosurgery and cardiothoracic surgery), and this will also play a role in the probability of a provider being referred for a focused review due to activating a trigger. Further, while small facilities may be less likely to reach a threshold, they also have greater risk of severe variations in the numbers of events. Though the quality of care could remain constant, by chance alone a trigger may occur. It is important that facilities be able to assess the context in which events happen, not be bound by arbitrary triggers.

VISN and medical centers should determine and review their own triggers, which allows for consideration and analysis based on regional and local variations in the complexity of care provided at any given facility. Local clinical leadership, with VISN oversight, input and support is the preferred means to handle trigger thresholds and data analysis.

VHA Directive 2010-025, Peer Review for Quality Management establishes that the Medical Executive Committee is responsible for determining the trigger levels. The facility monitors this process and takes appropriate follow up action with involved providers. The directive is scheduled to be updated this fiscal year. The updated directive will include a provision that requires facilities to submit a de-identified, summary report discussing trends and analysis of aggregate data with their quarterly submission to the VISN of peer review activity.

Target completion date: September 30, 2014.

**GAO Recommendation:** To address the nonprotected FPPE process, we recommend that the Secretary of VA direct the Under Secretary for Health to:

**Recommendation 5:** develop more specific policy on the FPPE process, including documentation requirements such as the FPPE’s purpose, time period covered, evaluator’s assessment, and the summary of actions to be taken.

**VA Comment:** Concur. VHA concurs with this recommendation and will develop guidance on the Focused Professional Practice Evaluation (FPPE) process beginning with initial privileges through Ongoing Professional Practice Evaluation (OPPE) for ongoing monitoring of provider competency. This guidance will describe the processes to be used when OPPE identifies concerns with the care delivered by a provider. The guidance will begin with a description of the process for a focused review and define the FPPE for cause process if an opportunity to improve is indicated. The guidance will end with an overview of the adverse action process to be initiated when the provider does not demonstrate adequate improvement

Enclosure

Department of Veterans Affairs (VA) Response to  
Government Accountability Office (GAO) Draft Report  
***"VA HEALTH CARE: Improvements Needed in Processes Used to Address Providers'  
Actions That Contribute to Adverse Events"***  
(GAO-14-55)

and a reduction or revocation of clinical privileges appears indicated. Anticipated completion date is September 30, 2014.



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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Debra A. Draper, (202)512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Marcia Mann, Assistant Director; Ashley Dixon; Mariel Lifshitz; Katie McConnell; Elizabeth Morrison; Lisa Motley; Ann Tynan; and Michael Zose made key contributions to this report.

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