October 16, 2019

VA HEALTH CARE

Actions Needed to Ensure Provider Qualifications and Competence

GAO Highlights

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

Why GAO Did This Study

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

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

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

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

What GAO Found

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

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

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

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

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