GAO Highlights

VETERANS HEALTH CARE

Training and Improved Oversight Needed for Reviewing and Reporting Providers with Clinical Care Concerns

GAO-26-107528 May 2026

A report to the Ranking Member, Committee on Veterans' Affairs, House of Representatives

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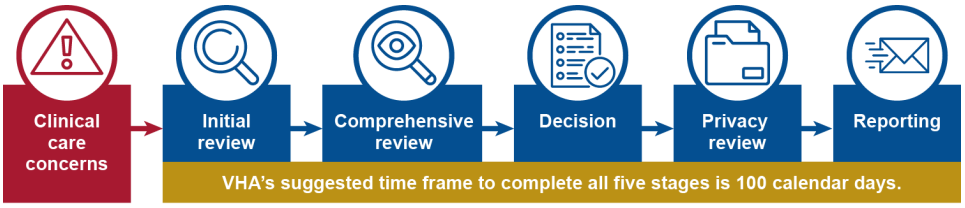
What GAO Found

Veterans Health Administration (VHA) medical facility officials are responsible for reviewing the clinical care delivered by their providers when concerns arise. GAO identified 104 providers with clinical care concerns (such as practicing in a manner that is unsafe or inconsistent with industry standards of care) at five selected VHA medical facilities between January 2020 and July 2024. GAO found these facilities did not consistently adhere to VHA policy when conducting quality reviews, or reporting providers to state licensing boards or the National Practitioner Data Bank. All five facilities also had missing or incomplete review documentation. As of March 2026, VHA has developed some mandatory training for facility staff related to credentialing providers, but not any on quality review and reporting processes. By failing to follow VHA policy, facilities increase the risk that these processes are conducted incorrectly and that these providers may continue to provide unsafe care to veterans.

State Licensing Board Reporting Process for VHA Providers, as of July 2024



Source: GAO analysis of Veterans Health Administration (VHA) information (text); Shelly/stock.adobe.com (icons). | GAO-26-107528

Related to reporting, GAO also found these five facilities did not initiate processes to determine whether seven providers should have been reported to state licensing boards or the National Practitioner Data Bank. Completing the review process for these providers will provide VHA assurance that any identified quality concerns will be properly assessed and that the providers who should be reported are reported. Timely reporting helps reduce the risk that other VHA facilities or community hospitals and clinics hire providers with unreported clinical care issues, thereby potentially putting patients at risk.

In addition, GAO found that VHA oversight of review and reporting processes at medical facilities was limited in ensuring adherence to VHA policy requirements. Specifically, VHA's oversight methods—which include a tracking tool and an annual facility self-assessment and audit—are not designed to assess adherence with all timeliness and documentation requirements. These limitations prevent VHA from comprehensively and consistently overseeing processes for monitoring provider clinical performance and ensuring safe, quality health care for veterans.

Why GAO Did This Study

VHA is responsible for ensuring providers deliver safe care to veterans at its more than 170 medical facilities. However, VHA has faced challenges ensuring providers with clinical care concerns undergo timely and documented reviews, and are reported to external entities when appropriate.

GAO was asked to examine VHA processes for reviewing concerns about providers' clinical care. This report assesses (1) selected VHA medical facilities' adherence to VHA policies for reviewing and reporting providers with clinical care concerns; and (2) VHA's oversight of quality review and reporting processes for providers with clinical care concerns.

GAO reviewed VHA policy documents and interviewed VHA officials. GAO also selected a non-generalizable sample of five VHA medical facilities (based on factors such as facility complexity) and identified providers with clinical care concerns from January 2020 through July 2024. This time frame included the most recent facility meeting minutes and allowed for reviews and reporting to be completed. For each provider, GAO reviewed available documentation and interviewed local and regional VHA officials.

What GAO Recommends

GAO is making seven recommendations to VHA, including developing training, completing the reporting process for certain providers, and ensuring that oversight methods assess compliance with VHA's review and documentation requirements. VA concurred or concurred in principle with GAO's seven recommendations and identified steps it plans to take.