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Statement for the Congressional Record

National Council of State Boards of Nursing

United States House of Representatives

Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations

Broken Promises: Assessing VA's System for Protecting Veterans from Clinical Harm

October 16, 2019

Thank you for the opportunity to provide input on the House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations hearing: *Broken Promises: Assessing VA's System for Protecting Veterans from Clinical Harm*. The National Council of State Boards of Nursing (NCSBN) commends the Subcommittee for holding this hearing and addressing provider accountability issues within the Veterans Health Administration (VHA).

NCSBN is an independent, non-profit association comprising 59 boards of nursing (BONs) from across the U.S., the District of Columbia and four U.S. territories. BONs are responsible for protecting the public through regulation of licensure, nursing practice, and discipline of the 4.9 million registered nurses (RNs), licensed practical/vocational (LPN/VNs), and advanced practice registered nurses (APRNs) in the U.S. with active licenses.

NCSBN has a longstanding relationship with the VA, including working extensively with the Office of Nursing Services and Telehealth Services in support of regulatory changes that improve veterans' access to providers and the care they deliver. We strongly support VA as they endeavor to care for our nation's veteran population and seek to serve as a partner and resource in the Department's efforts to improve quality of care and patient safety. With those goals in mind, our comments focus on two issues that we believe are critical to improving patient safety in the VA.

Reporting to State Licensing Boards (SLBs) and the National Practitioner Data Bank (NPDB)

In November 2017, the Government Accountability Office (GAO) released a study entitled, "*Improved Policies and Oversight Needed for Reviewing and Reporting Providers for*

Quality and Safety Concerns."[1] The report found that between October 2013 and March 2017, the five VA Medical Centers under review had taken adverse privileging actions against nine providers that should have been reported to SLBs and NPDB. Of those nine providers, only one was reported to NPDB and none of them were reported to SLBs. The report exposed a major gap in public protection that exposes veterans and other patients to potentially risky care providers. GAO made four recommendations in the report, which included making sure that proper VISN oversight was in place to ensure timely reporting of providers to NPDB and SLBs.

VA concurred with GAO's recommendations, and set September 2018 as a targeted completion date for the first two recommendations and October 2018 for the second two recommendations. NCSBN is pleased that VA concurred with GAO's recommendations and developed plans to address them. However, we were disappointed to learn, according to testimony before this Subcommittee by Comptroller General Gene L. Dodaro on May 22, 2019, that all of GAO's recommendations remain open and that VA revised completion dates to August 2019 and August 2020, respectively. We encourage the VA to provide additional updates related to implementing these recommendations.

As a means to further address these ongoing patient safety issues, NCSBN encourages the passage of the Department of Veterans Affairs Provider Accountability Act (S. 221), which would require VHA facilities to report any covered major adverse action taken against a VHA provider, particularly those that affect patient safety, to the NPDB and the appropriate SLBs. The Senate Committee on Veterans Affairs has already held a hearing on the bill and introduction of a House companion is likely in the coming months.

Additionally, NCSBN strongly encourages VHA, in consultation with SLBs, to revise and update *VHA Handbook 1100.18 – Reporting and Responding to SLBs*, which outlines procedures that VHA facilities must follow when reporting providers to and interacting with SLBs. This section of the Handbook was originally drafted in 2005 and was scheduled for recertification in 2010, however no action has been taken. The current handbook language is both antiquated and complex, leading to VHA employee confusion about reporting responsibilities and limiting communication between SLBs and VHA facility staff.

[1] GAO, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, GAO-18-63 (Washington, D.C.: Nov. 15, 2017). https://www.gao.gov/assets/690/688378.pdf.

Ongoing Monitoring of Provider Credentials

In February 2019, GAO released a report entitled, "*Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*."[2] The report identified several issues with how VHA reviews provider credentials, and highlighted a need for ongoing monitoring of provider licensure. In response, GAO made the following recommendation and VA concurred.

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

NCSBN supports ongoing verification of VHA provider licensure to ensure that our nation's veterans are being treated by safe, competent providers. Over the past two years, NCSBN has had a tremendous partnership with the VA Office of Nursing Services, helping them better monitor the license status of VA nurses in real-time by offering direct assistance to several VHA facilities in implementing Nursys e-Notify, a free service for institutions who want to receive automated nurse license status updates. Nursys e-Notify informs a VHA facility if one of its employed RNs or LPN/VNs receives public discipline or alerts from their licensing jurisdiction(s). It also notifies the facility if licenses are expiring. Pilot sites for implementing Nursys e-Notify include: Baltimore, Maryland VAHCS, Beckley, WV VAMC, Dallas (North), TX VHCS, and Marion, IL VAMC. Nearly 20 VHA facilities have implemented Nursys e-Notify to date.

NCSBN is pleased with ongoing efforts to implement Nursys e-Notify at all VHA facilities and encourages VA to require its implementation at every VHA facility nationwide. This will enable nurse leaders at every facility across the country to have real-time information regarding the license and discipline status of their entire nursing workforce.

Conclusion

NCSBN and state boards of nursing look forward to continued partnership with the VHA, Congressional VA Committees, VA providers, and our nation's veterans. We aim to help

[2] GAO, Broken Promises: Assessing VA's System for Protecting Veterans from Clinical Harm, GAO 19-6, (Washington, D.C.: February 28, 2019). https://www.gao.gov/assets/700/697173.pdf.

ensure that veterans seeking care from the VHA enjoy the same patient safety protections as patients in the private sector.

NCSBN appreciates the opportunity to share our perspective and expertise with the Subcommittee on this important matter. If you have any questions or would like any additional information, please do not hesitate to contact us. Elliot Vice, NCSBN's Director of Government Affairs, can be reached at evice@ncsbn.org and 202-624-7781. We look forward to continuing the dialogue on these important issues.