STATEMENT OF
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Good morning, Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee. I appreciate the opportunity to discuss VA's processes for ensuring the competency and quality administration of care by the health care professionals we employ. I am accompanied today by Dr. Gerard Cox, Deputy Under Secretary for Health for Organizational Excellence (VHA) and Ms. Jessica Bonjorni, Acting Assistant Deputy Under Secretary for Health for Workforce Services.

Introduction

VA is committed to ensuring that Veterans receive safe, high-quality health care. VA serves over 320,000 Veterans every day. The vast majority of VA employees are committed to doing the right thing while serving America's Veterans. In fact, as VA recently testified, many of VA's providers are called to serve in our medical facilities not because of money or acclaim, but because of their commitment to VA's mission to care for Veterans.

As in any large health care system, we must also face the unfortunate reality that some individual employees have not upheld that commitment. The actions of those few are deeply troubling. It is also deeply troubling that those actions might taint the reputations and undermine the good work of the nearly 348,000 VHA employees who run our medical facilities and take care of Veterans every day. These few people do not represent VA's values, and we will continue to hold accountable those who would commit crimes or provide poor care in our facilities.

VA takes great care to screen employees for their character and suitability and for their eligibility for a personal identity verification credential before bringing them on duty, including conducting criminal background checks. We also conduct extensive

scrutiny of prospective health care providers' medical credentials, and after hiring, we monitor those providers to ensure they are clinically competent and are providing safe, high-quality care. While we must do everything we can to make sure our employees are well-qualified and suitable for their jobs, we also recognize that we cannot guarantee that VA will never hire another person who fails to uphold VA's commitment to Veterans. What we have done in the face of that reality is establish a system in which wrongdoing can be identified quickly and swift action can be taken to minimize the harm to Veterans. We will learn everything we can from the problems that have given rise to this hearing to strengthen our system. We have also found in our reviews of recently-publicized cases that the monitoring and reporting systems we have in place typically work well in identifying potential inappropriate behavior or inadequate care earlier than before, and that VA's leaders do, in fact, take quick action to ensure that patients are safe.

Screening: Background Checks

VA requires that all individuals working directly with Veterans are thoroughly and properly vetted. For all potential employees, this starts with a background screening before entering on duty. The background screening process applies to all applicants, appointees, employees, contractors, affiliates, and other individuals who require physical or electronic access to VA information or information systems to perform their jobs.

VA conducts different levels of background checks on employees based on their position description, function, and scope of practice, as required by Office of Personnel Management (OPM) rules. Most front-line facility-level positions, including direct patient care positions, require a Low-Risk/Non-Sensitive Investigation. Upon receiving a conditional offer of employment, selected applicants undergo pre-screening for an interim suitability and personal identity verification (PIV) credentialing determination consisting of a review of their FBI criminal check results and employment history. If this review is favorable, the applicant is given a firm offer of employment. If derogatory information exists and cannot be mitigated, the subject's job offer is normally rescinded.

Following the pre-screening and interim suitability and credentialing determination, a full background investigation, that includes work and criminal history, ,

etc., is initiated. DoD's Defense Counterintelligence and Security Agency (DCSA) conducts these background investigations and returns them to the local VA facility for adjudication. An OPM-trained suitability adjudicator in the facility Human Resources Office reviews all investigative information and must establish a reasonable expectation that the person's employment or continued employment either would or would not protect the integrity and promote the efficiency of the Department. When there is a reasonable expectation that a person's employment would not do so, the person is found unsuitable. The process to remove an unsuitable VA employee varies depending on the length of the subject's employment (probationary vs. non-probationary).

Credentialing and Privileging

The next step in hiring a health care professional is the credentialing process. VHA's medical credentialing and privileging policies apply to all licensed health care professionals, including physicians, dentists, advanced practice nurses, physician assistants, and clinical pharmacists who work in any VA health care facility, as well as those in Veterans Integrated System Network (VISN) offices and the VHA Central Office.

- **Medical Credentialing** is the process of obtaining and verifying documents related to the applicant's professional education, licensure, and certification, (such as copies of medical licenses, medical or nursing school diplomas, board certification certificates, etc.). The medical credentialing process also includes a review of the applicant's health status; previous experience, including any gaps in training and employment longer than 30 days; professional references; malpractice history and adverse actions; and/or criminal violations, as appropriate. These requirements are established by The Joint Commission, which accredits most health care facilities across the U.S., including all VA Medical Centers (VAMC). VA does not make firm employment offers to health care professionals until the medical credentialing process is completed.

- **Privileging** is the process by which the authorized official at an individual VAMC (generally the Medical Center Director) determines whether to grant clinical

privileges to permit a licensed independent practitioner to provide medical care services within the scope of his or her licensure, training, and experience. According to The Joint Commission's standards, the decision whether to grant clinical privileges to an applicant to the medical facility's medical staff must be made at the local facility level.

Every applicant for a position on the medical staff of a VA facility is required to disclose information about any history of malpractice claims, adverse actions taken against licensure or privileges held in a previous position, prior misdemeanor or felony convictions, etc. VA's mandatory screening procedures also require queries of the appropriate State Licensing Board (SLB), the Federation of State Medical Boards, and the National Practitioner Data Bank (NPDB) to determine whether an applicant has been reported to any of these entities due to substandard care, professional misconduct, or professional incompetence. VA verifies the information disclosed by the provider to ensure the hiring official has a full picture of the applicant from an objective source.

All information obtained through the medical credentialing process must be carefully considered before appointment and privileging decision actions are made. Hiring officials take this process very seriously when considering a potential employee. The local Medical Center Director has the ultimate decision authority about whether an employee should be hired and whether clinical privileges should be granted, based on the outcome of the medical credentialing process.

Monitoring and Investigations

VA has an obligation to reasonably ensure that its health care staff meet or exceed generally-accepted professional standards for patient care and has the obligation to alert those entities charged with licensing health care professionals when there is serious concern about a licensed health care professional's clinical practice. This obligation includes monitoring the care that our providers deliver in medical facilities. It also includes notifying SLBs of any substantiated findings of substandard care performed at VA by current or former licensed health care professionals and

responding to inquiries from SLBs concerning the clinical practice of those professionals.

Whenever concern arises about a privileged provider's ability to deliver safe, high-quality patient care, the first consideration is whether that provider presents an imminent danger to the health and safety of any individual based upon the knowledge at hand. If there is an imminent danger, the VAMC Director invokes a summary suspension of clinical privileges which immediately removes the provider from patient care to ensure patient safety. Summary suspension can range from suspending a single privilege to perform a specific procedure to suspension of all clinical privileges; however, the purpose of summary suspension is to afford time for a focused review of the clinical care concern or issue. This action can be taken by a facility Medical Center Director immediately, allowing VA to ensure Veterans' safety without delay to conduct an investigation. Providers receive a notice of suspension that includes their due process rights to respond.

The focused clinical care review generally takes the form of a retrospective review of the care that has been provided in the clinical care area of concern. Retrospective reviews are completed by independent health care professionals of the same specialty who hold privileges in the area being reviewed. These specialists provide an expert opinion regarding whether the provider under scrutiny has met the standard of care. The facility's clinical leaders then decide on whether action should be taken based on the findings of the review. If a review of the findings does not identify a risk to patients, appropriate action may involve intensive monitoring of the provider's practice for a defined period. In more serious cases, an adverse privileging action may be warranted, such as reducing, restricting, or denying privileges or, in the most egregious cases, revoking all privileges and terminating employment with VA.

NPDB Screening and Ongoing Monitoring

As described above, all applicants are thoroughly screened, including a review of any reports made to NPDB. Each report is individually reviewed in detail and primary source information is obtained from the reporting entity to outline the circumstances that led to the report. If information obtained through this process calls into question the

professional competence or conduct of an individual applying to VA, the selecting official and facility leadership review the facts and circumstances to determine what action would be appropriate, possibly including non-selection.

After being appointed to the medical staff of a VA facility, all privileged providers are enrolled in and monitored through the NPDB Continuous Query Program. VA mandated this voluntary, proactive measure so that we receive immediate alerts whenever any privileged provider is reported by any entity to the NPDB, including reports that arise from problems that occurred prior to VA employment. Once the alert is received, VA expeditiously obtains primary source information related to the report entered and takes immediate action as needed. For example, if an NPDB report is entered by an SLB, VA can review the information obtained from the reporting licensing board and determine if a licensure action has been taken which would immediately disqualify a provider from a VA appointment in accordance with section 7402(f) of title 38, United States Code. The review of licenses and determination of qualification for employment is made by the facility Human Resources Officer in consultation with the District Counsel Attorney. VA takes the matter of license revocation very seriously, as we continue to keep sight of the well-being of our Veterans in our care.

We note that VA is like all other health care systems in this area. All accredited VAMCs and systems adhere to Joint Commission standards for medical credentialing and monitoring care. If there were some way of entirely avoiding misconduct or poor clinical care, there would be no need for the industry to use an NPDB, or for SLBs to have review procedures. We are, unfortunately, unable to predict and account for every issue that may arise, which is why we must respond quickly and comprehensively whenever Veterans' safety might be in jeopardy.

In 1980, VA established the Office of the Medical Inspector (OMI) to assess and report on quality of care issues within VHA. In Public Law 100-322, Veterans' Benefits and Services Act of 1988, Congress expanded the functions of OMI and assigned the VA Inspector General an oversight role. This law addressed the Department's quality assurance activities, upgraded and expanded OMI, and increased its number of employees to ensure independence, objectivity, and accountability.

As an integral element of VHA's oversight and compliance program, OMI is responsible for assessing the quality of VA health care through independent, objective, and thorough health care investigations. In 2014, following the VA wait times crisis, the Acting Secretary of Veterans Affairs appointed Dr. Cox as the Interim Medical Inspector. Under his leadership, we restructured the policies, procedures, and human resources of OMI.

Conclusion

VA remains committed to earning Veterans' trust in our system and will continue to do everything we can to ensure that our patients receive appropriate and safe health care. Although VA cannot always foresee and prevent wrongdoing, we will continue to monitor patient care diligently and take quick action when Veterans' safety is at risk. Mr. Chairman this concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.