



Testimony

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and Investigations, Committee on
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Representatives

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VA HEALTH CARE

Improved Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns

Statement of Randall B. Williamson, Director,
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Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent report on provider quality and safety concerns at the Department of Veterans Affairs (VA).¹ VA's Veterans Health Administration (VHA) operates one of the largest health care systems in the nation, and nearly 40,000 providers hold privileges at its 170 VA medical centers.² Like other health care facilities, VA medical centers are responsible for ensuring that their providers deliver safe care to patients. As part of this responsibility, VA medical centers are required to investigate and, if warranted, address any concerns that may arise about the clinical care their providers deliver. Concerns about a provider's clinical care can be raised for many reasons, ranging from providers not adequately documenting information about a patient's visit to practicing in a manner that is unsafe or inconsistent with industry standards of care. If VA medical centers fail to properly review and address concerns that have been raised about their providers, they may be exposing veterans to unsafe care.

Depending on the nature of the concern and the findings from their review, VA medical center officials may take adverse privileging actions against providers that either limit the care the providers are allowed to deliver at the facility or prevent the providers from delivering care altogether. VA medical center officials are required to report the providers against whom they take adverse privileging actions to the National Practitioner Data Bank (NPDB). The NPDB is used by other VA medical centers, non-VA hospitals, and other health care entities to obtain

¹GAO, *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).

²Privileges are the specific set of clinical services that a provider is approved to perform independently at a medical facility, based on an assessment of the provider's professional performance, judgement, clinical competence, and skills. For the purposes of this testimony, we use the term "provider" to refer to physicians and dentists.

information on a provider's history of substandard care and misconduct.³ VA medical center officials are also required to report providers to state licensing boards when there are serious concerns about the providers' clinical care. State licensing boards can then investigate and determine if the providers' conduct or ability to deliver care warrants action against the providers' medical license.

My testimony today summarizes the findings from the report, which analyzed the implementation and oversight of VHA processes for reviewing and reporting providers after quality and safety concerns have been raised at selected VA medical centers. Accordingly, this testimony addresses:

1. VA medical centers' reviews of providers' clinical care after concerns are raised and VHA's oversight of these reviews, and
2. VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA's oversight of these processes.

To conduct our work, we reviewed VHA policies and guidance related to reviewing and reporting clinical care concerns about providers and interviewed relevant VHA officials. We also visited a nongeneralizable selection of five VA medical centers, selected based on the complexity of the medical services they offer veterans and to achieve variation in geography. At each VA medical center we reviewed documentation and interviewed medical center staff to 1) identify providers whose clinical care was reviewed after a concern was raised about that care and 2) determine whether the VA medical center took an adverse privileging action against any of these identified providers. In addition, we evaluated the extent to which each medical center adhered to applicable VHA policies from October 2013 through the time we completed our site visits in March 2017. We also interviewed officials from the five Veterans Integrated Service Networks (networks) that oversee the five selected medical centers. We compared VHA and the networks' oversight of the VA medical centers' reviewing and reporting of providers to VHA's related

³The NPDB is an electronic repository administered by the U.S. Department of Health and Human Services that collects and releases information on providers who either have been disciplined by a state licensing board, professional society, or health care entity, such as a hospital, or have been named in a medical malpractice settlement or judgment. Industry standards call for health care entities to query the NPDB and verify with the appropriate state licensing board that a provider's medical licenses are current and in good standing before appointing a provider to its medical staff and when renewing the provider's clinical privileges.

policy requirements and to federal standards for internal control related to monitoring.⁴ Further details on our scope and methodology are included in our report.⁵ The work this statement is based on was performed in accordance with generally accepted government auditing standards.

Selected VA Medical Centers' Reviews of Providers' Clinical Care Were Not Always Documented or Timely

We found that from October 2013 through March 2017, the five selected VA medical centers required reviews of a total of 148 providers' clinical care after concerns were raised about their care, but officials at these medical centers could not provide documentation to show that almost half of these reviews were conducted. We found that all five VA medical centers lacked at least some documentation of the reviews they told us they conducted, and in some cases, we found that the required reviews were not conducted at all. Specifically, across the five VA medical centers, we found the following:

- The medical centers lacked documentation showing that one type of review—focused professional practice evaluations (FPPE) for cause—had been conducted for 26 providers after concerns had been raised about their care. FPPEs for cause are reviews of providers' care over a specified period of time, during which the provider continues to see patients and has the opportunity to demonstrate improvement. Documentation of these reviews is explicitly required under VHA policy. Additionally, VA medical center officials confirmed that FPPEs for cause that were required for another 21 providers were never conducted.
- The medical centers lacked documentation showing that retrospective reviews—which assess the care previously delivered by a provider during a specific period of time— had been conducted for 8 providers after concerns had been raised about their clinical care.
- One medical center lacked documentation showing that reviews had been conducted for another 12 providers after concerns had been raised about their care. In the absence of any documentation, we

⁴GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014) and *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: Nov. 1, 1999). Internal control is a process effected by an entity's management, oversight body, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

⁵See [GAO-18-63](#).

were unable to identify the types of reviews, if any, that were conducted for these 12 providers.

We also found that the five selected VA medical centers did not always conduct reviews of providers' clinical care in a timely manner. Specifically, of the 148 providers, the VA medical centers did not initiate reviews of 16 providers for 3 months, and in some cases, for multiple years, after concerns had been raised about the providers' care. In a few of these cases, additional concerns about the providers' clinical care were raised before the reviews began.

We found that two factors were largely responsible for the inadequate documentation and untimely reviews of providers' clinical care we identified at the selected VA medical centers.

- First, VHA policy does not require VA medical centers to document all types of reviews of providers' clinical care, including retrospective reviews, and VHA has not established a timeliness requirement for initiating reviews of providers' clinical care.
- Second, VHA's oversight of the reviews of providers' clinical care is inadequate. Under VHA policy, networks are responsible for overseeing the credentialing and privileging processes at their respective VA medical centers. While reviews of providers' clinical care after concerns are raised are a component of credentialing and privileging, we found that none of the network officials we spoke with described any routine oversight of such reviews.⁶ This may be in part because the standardized tool that VHA requires the networks to use during their routine audits does not direct network officials to ensure that all reviews of providers' clinical care have been conducted and documented. Further, some of the VISN officials we interviewed told us they were not using the standardized audit tool as required.

Without adequate documentation and timely completion of reviews of providers' clinical care, VA medical center officials lack the information they need to make decisions about providers' privileges, including

⁶When asked about their routine audits, network officials we interviewed generally described selecting a sample of providers from different specialties to review their compliance with VHA requirements related to credentialing and privileging. For example, network officials may check that medical centers have appropriately verified their providers' medical licensure. Some officials said they may also look at documentation of a VA medical center's review of a provider's clinical care after a concern had been raised if any of the providers in their sample happened to have documentation of such concerns in their files.

whether or not to take adverse privileging actions against providers. Furthermore, because of its inadequate oversight, VHA lacks reasonable assurance that VA medical center officials are reviewing all providers about whom clinical care concerns have been raised and are taking adverse privileging actions against the providers when appropriate. To address these shortcomings, we recommended that VHA 1) require documentation of all reviews of providers' clinical care after concerns have been raised, 2) establish a timeliness requirement for initiating such reviews, and 3) strengthen its oversight by requiring networks to oversee VA medical centers to ensure that such reviews are documented and initiated in a timely manner. VA concurred with these recommendations and described plans for VHA to revise existing policy and update the standardized audit tool used by the networks to include more comprehensive oversight of VA medical centers' reviews of providers' clinical care after concerns have been raised.

Selected VA Medical Centers Did Not Report All Providers to the NPDB or to State Licensing Boards as Required

We found that from October 2013 through March 2017, the five VA medical centers we reviewed had only reported one of nine providers required to be reported to the NPDB under VHA policy. These nine providers either had adverse privileging actions taken against them or resigned or retired while under investigation before an adverse privileging action could be taken. None of these nine providers were reported to state licensing boards as required by VHA policy.

The VA medical centers documented that these nine providers had significant clinical deficiencies that sometimes resulted in adverse outcomes for veterans. For example, the documentation shows that one provider's surgical incompetence resulted in numerous repeat surgeries for veterans. Another provider's opportunity to improve through an FPPE for cause had to be halted and the provider was removed from providing care after only a week due to concerns that continuing the review would potentially harm patients.

In addition to these nine providers, one VA medical center terminated the services of four contract providers based on deficiencies in the providers' clinical performance, but the facility did not follow any of the required steps for reporting providers to the NPDB or relevant state licensing boards. This is concerning, given that the VA medical center documented that one of these providers was terminated for cause related to patient abuse after only 2 weeks of work at the facility.

Two of the five VA medical centers we reviewed each reported one provider to the state licensing boards for failing to meet generally accepted standards of clinical practice to the point that it raised concerns for the safety of veterans.⁷ However, we found that the medical centers' reporting to the state licensing board took over 500 days to complete in both cases, which was significantly longer than the 100 days suggested in VHA policy.

Across the five VA medical centers, we found that providers were not reported to the NPDB and state licensing boards as required for two reasons.

- First, VA medical center officials were generally not familiar with or misinterpreted VHA policies related to NPDB and state licensing board reporting. For example, at one VA medical center, we found that officials failed to report six providers to the NPDB because they were unaware that they had been delegated responsibility for NPDB reporting.⁸ Officials at two other VA medical centers incorrectly told us that VHA cannot report contract providers to the NPDB. At another VA medical facility, officials did not report a provider to the NPDB or to any of the state licensing boards where the provider held a medical license because medical center officials learned that one state licensing board had already found out about the issue independently. Therefore, VA officials did not believe that they needed to report the provider. This misinterpretation of VHA policy meant that the NPDB and the state licensing boards in other states where the provider held licenses were not alerted to concerns about the provider's clinical practice.
- Second, VHA policy does not require the networks to oversee whether VA medical centers are reporting providers to the NPDB or state licensing boards when warranted. We found, for example, that network officials were unaware of situations in which VA medical center officials failed to report providers to the NPDB. We concluded that VHA lacks reasonable assurance that all providers who should be reported to these entities are reported.

⁷These two providers were not among the nine providers who had an adverse privileging action taken against them, resigned or retired while under investigation but before an adverse privileging action could be taken. They were also not among the four contractors whose services were terminated.

⁸As a result of our audit work, in August 2017, officials at this VA medical center reported three of these six providers to the NPDB.

VHA's failure to report providers to the NPDB and state licensing boards as required facilitates providers who provide substandard care at one facility obtaining privileges at another VA medical center or at hospitals outside of VA's health care system. We found several cases of this occurring among the providers who were not reported to the NPDB or state licensing boards by the five VA medical centers we reviewed. For example, we found that two of the four contract providers whose contracts were terminated for clinical deficiencies remained eligible to provide care to veterans outside of that VA medical center. At the time of our review, one of these providers held privileges at another VA medical center, and another participated in the network of providers that can provide care for veterans in the community. We also found that a provider who was not reported as required to the NPDB during the period we reviewed had their privileges revoked 2 years later by a non-VA hospital in the same city for the same reason the provider was under investigation at the VA medical center. Officials at this VA medical center did not report this provider following a settlement agreement under which the provider agreed to resign. A committee within the VA medical center had recommended that the provider's privileges be revoked prior to the agreement. There was no documentation of the reasons why this provider was not reported to the NPDB under VHA policy.

To improve VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA oversight of these processes, we recommended that VHA require its networks to establish a process for overseeing VA medical centers to ensure they are reporting to the NPDB and to state licensing boards and to ensure that this reporting is timely. VA concurred with this recommendation and told us that it plans to include oversight of timely reporting to the NPDB and state licensing boards as part of the standard audit tool used by the networks.

Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 (williamsonr@gao.gov). Contact points for our Office of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Marcia A. Mann (Assistant Director), Kaitlin M. McConnell (Analyst-in-Charge), Summar C. Corley, Krister Friday, and Jacquelyn Hamilton.

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