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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
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BROKEN PROMISES: ASSESSING VA'S SYSTEMS FOR PROTECTING VETERANS FROM CLINICAL HARM
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Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of Veterans Health Administration (VHA) efforts to ensure its medical facilities are effectively implementing their provider credentialing and privileging (C&P) processes. The mission of the OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, reviews, and investigations. For many years, the OIG has conducted reviews and investigations that have identified concerns with VHA's C&P operations.

This statement focuses on barriers and challenges to VHA's efforts to implement programs that ensure licensed independent healthcare practitioners have the appropriate qualifications to provide medical care services within the scope of their license. The need for VHA to properly manage and oversee these programs cannot be understated, as they are key to ensuring veterans receive health care from highly-qualified providers. Although VHA has national policies governing the C&P process, the decentralized structure of VHA puts significant responsibility on local leaders and physicians to actually execute the C&P process. The OIG has completed several reports recently in response to allegations of inappropriate or incomplete C&P processes. While the OIG has found general compliance with C&P processes during the course of recurring comprehensive healthcare inspections,[1] other focused OIG healthcare reviews related to specific incidents have identified concerning lapses in protocols that could have or have led to patient harm.

After providing some context for the discussion of C&P deficiencies, several reports are highlighted to provide examples of failures the OIG has identified in the C&P process.

[1] The OIG's Comprehensive Healthcare Inspection Program and the Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018 are discussed in the background section of this statement.

BACKGROUND ON CREDENTIALING, PRIVILEGING, AND SKILL ASSESSMENT

VHA has defined procedures for credentialing and privileging "all health care professionals who are permitted by law and the facility to practice independently…—without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[2] These healthcare professionals are also referred to as licensed independent practitioners (LIPs).

Credentialing "refers to the systematic process of screening and evaluating qualifications."[3] Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges are specific to the medical procedure performed. They are based on the individual's clinical competence, recommendations by service chiefs (typically the LIP's supervisor) and the Medical Staff Executive Committee, and with approval by the facility director. Peer references, professional experience, health status, education, training, and licensure inform decisions about a provider's clinical competence and ability to successfully accomplish clinical privileges. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo reprivileging prior to expiration.[4]

VHA also mandates processes to check the skills of providers during their term of employment. A Focused Professional Practice Evaluation (FPPE) is a time-limited process conducted in three instances: (1) for all new LIPs who are requesting initial privileges or scope of practice; (2) when a provider requests a new clinical privilege or scope of practice; and (3) when issues affecting the provision of safe, high-quality patient care are identified. VHA requires that all LIPs new to the facility have FPPEs completed, documented in the provider's electronic profile, and reported to an appropriate committee of the medical staff.[5] The process involves evaluating the provider's privilege-specific competencies. This may include periodic chart review, direct observation, monitoring diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[6]

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[2] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012 (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.) Healthcare professionals such as clinical pharmacists, nurses, and technologists are evaluated on their competency to perform core and specific skills and techniques, often using objective assessments, such as test-taking and completing simulations. These processes are entirely separate from the C&P process and are not addressed in this statement.

[3] VHA Handbook 1100.19.

[4] VHA Handbook 1100.19.

[5] VHA Handbook 1100.19.

[6] VHA Handbook 1100.19.

To monitor an LIP's performance during his or her service and help assist in determining whether a provider will be reprivileged, VHA uses the Ongoing Professional Practice Evaluation (OPPE). This oversight process involves the service chief's evaluation of the provider's professional performance and includes data specific to the provider's practice, such as reviews of surgical cases, electronic health records, infection control, and drug usage evaluation. Data must be provider-specific, reliable, easily retrievable, timely, justifiable, and comparable. The OPPE includes data from direct observation and reviews and confirms the quality of care delivered by privileged providers. OPPEs allow the facility to identify professional practice trends affecting patient safety and quality of care. The service chief is responsible for establishing whether a provider does or does not meet established criteria.

The OIG's Comprehensive Healthcare Inspection Program Focus on Evaluating Credentialing and Privileging Processes

The OIG uses its Comprehensive Healthcare Inspection Program (CHIP) to provide cyclical, focused evaluation of the quality of care delivered in the inpatient and outpatient settings of VHA facilities. Each inspection covers a consistent and predetermined set of key clinical and administrative processes that are associated with promoting quality care across facilities. These inspections are one element of the overall efforts of the OIG to ensure that the nation's veterans receive high-quality and timely VA healthcare services.

OIG CHIP teams evaluate areas of clinical and administrative operations that reflect quality patient care, with focused review areas changing every fiscal year.[7] C&P processes were evaluated in fiscal year (FY) 2018, whereas FY 2019 and FY 2020 have focused on privileging.

Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018.

In FY 2018, OIG staff completed 51 CHIP reports, which are rolled-up in an FY 2018 Summary Report. Those reports were based, in part, on OIG staff interviews with facility leaders and reviews of C&P documentation for LIPs initially hired within 18 months before site visits and LIPs reprivileged within 12 months before the visits.[8] The OIG evaluated

- performance indicators for credentialing processes, such as current licensure and verification of primary source information;

[7] The eight areas for FY 2018 were quality, safety, and value; credentialing and privileging; environment of care; medication management; mental health; long-term care; women's health; and high-risk processes. The nine areas for FY 2019 were leadership and organizational risks; quality, safety, and value; medical staff privileging; environment of care; medication management; mental health; long-term care; women's health; and high-risk processes. The ten areas for FY 2020 are leadership and organizational risks; quality, safety, and value; medical staff privileging; environment of care; medication management; care coordination; mental health; women's health; high risk processes; and veterans integrated service networks.

[8] Comprehensive Healthcare Inspection Summary Report Fiscal Year 2018, October 10, 2019.

- privileging processes, such as verifying existing privileges and the details of the recommendations and approvals for requested privileges;
- FPPEs; and
- OPPEs.

The FY 2018 CHIP Summary Report generally found compliance with requirements for C&P processes but identified concerns with the FPPE and OPPE processes.

The Summary Report made four recommendations to the Under Secretary for Health to improve the C&P process nationally, based upon aggregate data collected during the FY 2018 CHIP site visits. The first recommends that VHA ensure that the FPPEs are reported properly to committees for review. The second recommends that the FPPEs clearly delineate time frames for review in compliance with VHA policy. The third recommends that VHA verify that clinical managers include service-specific data in ongoing professional practice evaluations and monitor clinical managers' compliance. The fourth recommends VHA verify that clinical managers include specialty-specific elements in gastroenterology, pathology, nuclear medicine, and radiation oncology providers' OPPEs and monitor clinical managers' compliance. The Executive in Charge for VHA concurred with the first, third, and fourth recommendations and in principle with the second recommendation.[9] The Executive in Charge projected that these recommendations would be fully implemented by June 2020. OIG staff will monitor VA's progress.

CREDENTIALING & PRIVILEGING PROCESS BREAKDOWNS

Ensuring that VHA providers have the training and education to care for the veterans they serve is imperative in the delivery of high-quality health care. Without effective implementation of the credentialing process, veterans are at risk of receiving care from providers who are not appropriately licensed, adequately skilled, or trained. Despite the importance of credentialing, OIG reports, such as the following, have documented breakdowns when VHA staff have not actually verified and obtained the required documentation or confirmed the accounts of job applicants' references.

Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility.

In December 2018, the OIG became aware of allegations of mismanagement, waste of funds, and safety risks at a Veterans Integrated Service Network (VISN) 10 medical facility.[10] A complainant alleged an ophthalmologist lacked training, provided substandard care, and failed to meet productivity

[9] VHA concurred in principle to our recommendation that FPPEs have clearly delineated time frames, noting that the Joint Commission describes FPPEs as focusing on either a period of time or a certain number of procedures for infrequent activities.

[10] *Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility*, September 24, 2019.

expectations. In spite of these reported concerns, the facility's chief of staff intended to reappoint the surgeon following the probationary period.

The OIG substantiated the surgeon lacked adequate training to perform cataract and laser surgery as the surgeon did not satisfactorily complete an approved residency training program, was ineligible for board certification in ophthalmology, and did not meet the facility's ophthalmologist hiring requirements. Additionally, the OIG found several C&P activities that did not comply with VHA policy. Facility staff could not explain to the OIG why primary source verification was not obtained from all foreign educational institutions the surgeon listed in the credentialing paperwork, and staff did not document when attempts to do so were unsuccessful. In addition to documentation to support claims of education and training, VHA requires physician applicants to provide the names of references with knowledge of the applicant's ability to perform the work for which they are being hired. Specifically, information is sought about the individual's level of performance, number and type of procedures performed, appropriateness, and outcomes of care provided. The four references the surgeon at issue provided were all flawed. Two non-VHA references had no direct knowledge of the surgeon's ability to perform cataract surgeries. The third could not provide actual numbers of surgeries or describe outcome quality. And, the fourth could not describe the surgeon's technical performance.

Facility leaders continued to employ the surgeon despite substandard performance and staff in associated specialties expressing concerns about the surgeon's quality within months of hire. The surgeon did not consistently demonstrate the skills to assure good outcomes, was unable to meet surgical productivity expectations, and surgery times exceeded norms. For example, the chief of staff was told that the surgeon was taking one-to-two hours to complete a cataract surgery, as compared with VHA's average of 26 minutes. Retrospective clinical reviews by two other ophthalmologists within the same VISN reflected these deficits.

Despite these ongoing concerns, the chief of staff endorsed the surgeon's reappointment as the facility's sole ophthalmologist. At the time of the interviews, facility staff told the OIG that they believed the surgeon would be reappointed because facility leaders needed the services of the surgeon's spouse, who was also a surgeon, and facility leaders described them as a "package set," admitting that relationship was a consideration. As a result, for two years before the surgeon was terminated, patients were placed at unnecessary risk for potential surgical complications. The OIG made five recommendations related to C&P processes, professional practice evaluations, management of performance deficits, and the chief of staff's actions. OIG staff continue to monitor VA's progress until all proposed actions are complete.

Professional Practice Evaluation Breakdowns

In addition to being credentialed, before rendering services, the facility's medical leaders must determine if a provider meets the specific criteria for conducting procedures. Importantly, the facility considers the provider to be privileged only for particular medical procedures and must repeat the privileging process if the provider wishes to conduct different patient care services. Therefore, VHA

policy dictates that providers are privileged using identified provider-, service-, and facility-specific privileges. A critical feature of ensuring that providers are delivering high-quality care is the focused evaluation (FPPE) and the ongoing evaluation (OPPE). Once a provider begins rendering care to veterans, proper use of the FPPE to monitor performance at the start of employment or if a question of the provider's skills is raised can mitigate risks. A properly executed OPPE is critical for VHA's determination whether it wishes to retain the services of a current provider. However, numerous OIG reports have identified a lack of diligence across VHA facilities in executing FPPEs and OPPEs as the following examples demonstrate.

Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns at the Samuel S. Stratton VA Medical Center in Albany, New York.

The OIG conducted a healthcare inspection in response to confidential allegations regarding lack of quality oversight of the facility's Surgery Service, including communications to patients about surgery complications; the peer review process; and surgery outcomes for a surgical oncologist.[11] OIG's inspection revealed the facility did not meet VHA's C&P requirements. A lack of documentation regarding the surgical oncologist's supervision and competencies during the initial FPPE period may have contributed to the facility later not recognizing that the surgeon had missed diagnosing and removing tumors from veterans. The OIG could not determine if the surgeon was supervised when conducting the intraoperative radiofrequency ablation procedures, and there were no written evaluations of the procedures. The surgery manager's use of the FPPE was ineffective for practice evaluation.

Additionally, the surgeon's OPPE was flawed. The forms contained incomplete data and did not address specific competencies related to the surgical specialty. Further complicating matters, the chief of surgery failed to collect sufficient data to evaluate the surgeon's practice and surgical outcomes. The quarterly data used by the chief of surgery to evaluate the surgeon's competency also contained errors over a two-year period, thus failing to trigger a focused review of the surgeon. OIG staff could not determine if healthcare quality data or patient safety trends were affected by poor FPPE/OPPE processes because of the unreliable data. The OIG also found failures related to the facility's quality management. Patients were not timely notified that the surgeon did not completely remove tumors. Nine recommendations were made, and one recommendation related to establishing a process to track, monitor, and report on intraoperative radiofrequency ablation outcomes remains open.

This report underscores the need for adherence to VHA policy that ongoing assessments of a provider's competence must focus on the specific provider and examine his or her particular skills and judgment as

[11] *Intraoperative Radiofrequency Ablation and Other Surgical Service Concerns at the Samuel S. Stratton VA Medical Center Albany, New York*, August 29, 2018.

they relate to the requested privilege. To ensure thorough and accurate evaluations, VHA policy has appropriately mandated that reviews be conducted by a physician with similar training and privileges.

Quality of Care Concerns in Thoracic Surgery, Bay Pines VA Healthcare System in Florida.

This healthcare inspection focused on anonymous allegations regarding the quality of care provided by a thoracic surgeon at the Bay Pines VA Healthcare System.[12] While the review did not substantiate that the thoracic surgeon was incompetent, the OIG identified a deficiency in the system's process for evaluating a surgeon's competency. Contrary to policy, the criteria used in the surgeon's initial FPPE were not privilege-specific and was inadequate to fully assess a practitioner's skills. The OIG recommended that the system's director ensure that FPPE review criteria are sufficient to evaluate the privilege-specific competence for thoracic surgeons.

The surgeon had been employed with VA long enough to have undergone a routine recredentialing OPPE, which was conducted by an administrative psychiatrist. New VHA guidance had been issued, but was not yet in force, mandating OPPEs be conducted by a provider with similar training and privileges. Based on the OIG's recommendation made during the site visit, the system arranged for the surgeon to be proctored in order to confirm whether the surgeon had the ability and skills. A thoracic surgeon from another VA facility directly observed the thoracic surgeon's operative skills and did not have concerns regarding his surgical technique. VHA has satisfactorily completed action on OIG recommendations. This report highlights the benefit of having performance determinations made with specificity and by an independent peer.

Credentialing and Privileging Process Failures Have Patient Care Impacts

Additional reports from the OIG further demonstrate that failures to execute C&P processes properly occur across the VHA system and affect its provision of patient care and quality management.

Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi.

The OIG conducted a healthcare inspection to examine the C&P process, as well as the facility's understanding of quality management practices, in response to multiple allegations of another thoracic surgeon's poor quality of care.[13] A review of the surgeon's C&P files revealed that before hiring the surgeon in August 2013, facility leaders knew of malpractice issues as well as the surgeon having

[12] *Quality of Care Concerns in Thoracic Surgery Bay Pines VA Healthcare System Bay Pines, Florida*, August 16, 2017.

[13] *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System*, August 28, 2019. Two other allegations received were addressed in the OIG report, *Inadequate Intensivist Coverage and Surgery Service Concerns, VA Gulf Coast Healthcare System Biloxi, Mississippi*, March 29, 2018.

relinquished a state medical license in October 2006 to prevent prosecution in a disciplinary case. Still, the facility director hired the surgeon after the Credentialing Committee recommended the appointment.

Process failures continued after the surgeon's hiring. Facility leaders did not complete components of the surgeon's focused and ongoing evaluations. In addition, the OIG team found that facility leaders were deficient in granting and continuing the surgeon's clinical privileges without required evidence of competency. During the OIG's April 2018 site visit, the OIG team found that although the surgeon resigned from VHA in December 2017, the chief of surgery did not provide C&P staff with details regarding an exit-interview statement about the surgeon's failure to meet standards of practice until June 2018. This information was needed to inactivate the surgeon's C&P file.

Facility leaders removed the surgeon in October 2017 from clinical care without following required processes, including notifications to external reporting agencies. As a result, facility leaders were unable to report the surgeon to the National Practitioner Data Bank and were delayed in reporting to state licensing boards.

The failures to follow C&P processes with the surgeon led the OIG to review service file documentation for 50 other facility care providers who were newly appointed to the medical staff from October 2016 through December 2017. The following table reflects deficiencies in facility oversight responsibilities.

VHA and Facility Requirements	OIG Findings
New facility providers undergo FPPE as defined at the time of privilege approval.	Fourteen of the 50 provider service files did not contain documentation of a defined or completed FPPE.
Providers undergo FPPE when there is a change or request for a new privilege.	Three of four providers who requested a change or new privilege did not have an FPPE.
The Executive Committee of the Medical Service must consider all information, including reasons for renewal when criteria have not been met, such as a "for cause" FPPE and document deliberations in the meeting minutes.	Three of seven "for cause" FPPEs were not presented to the committee for consideration in making recommendations on clinical privileges.
OPPE reviews conducted by service chiefs must include activities with defined criteria that emphasize appropriateness of care, patient safety, and desired outcomes.	Six of 18 provider service files that contained an OPPE did not contain a review for appropriateness of care, patient safety, and/or desired outcomes.

Additionally, the OIG noted weaknesses in quality management, documentation of basic and advanced cardiac life support certification, administrative closure of electronic health record notes, posting of confidential data to the facility's internal website, adverse event reporting, completion of institutional disclosures, and administrative investigation board timeliness.

The OIG made 18 recommendations related to professional practice evaluation processes, National Practitioner Data Bank and state licensing board reporting, documenting sufficient detail in committee meeting minutes to reflect decision-making, and protecting certain confidential information. Recommendations also centered on reporting events to the Patient Safety Committee, reporting surgery patients' deaths as required, completing proactive risk assessments, and institutional disclosure and administrative investigation board review processes. OIG staff will monitor VA's progress until all proposed actions are complete.

Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center in Asheville, North Carolina.

An OIG healthcare inspection team evaluated concerns regarding deficiencies identified in the practice and oversight of a fee-basis radiologist during a six-month tenure in 2014.[14] The concerns were identified during the facility's 2018 CHIP review in response to questions related to the radiologist's initial C&P, the radiologist's deficient delivery of care, and the facility's delayed evaluation of the deficient care.[15]

The OIG determined that facility leaders did not complete the C&P of the radiologist in line with VHA and facility requirements. First, the references used to approve the radiologist's request for privileges did not include a reference from peers and a most recent employer. In fact, the references were from three non-radiologist physicians and a non-physician radiology technician. These are individuals who are not "qualified to provide authoritative information regarding training/experience, competence, [and] health status." The failure to secure a reference from the radiologist's last employer is notable given the radiologist had been working at a VA medical center in Altoona, Pennsylvania (Altoona VAMC). Second, in June 2014, the radiologist denied having been notified of any malpractice-related judicial proceedings. However, the radiologist was sent notification by the Altoona VAMC in January 2014 that they were named in a tort claim, with a separate notice sent a later in June. VHA Central Office and Asheville VAMC leaders explained to the OIG that they were unaware of these tort claims and would not have known before final adjudication of the claims unless the radiologist disclosed them.

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[14] *Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center Asheville, North Carolina*, September 30, 2019.

[15] *Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina*, October 16, 2018.

As the radiologist began providing medical services in 2014, there was inadequate oversight of the radiologist, most vividly demonstrated by the facility's failure to complete an FPPE within VHA-established timelines. The chief of imaging, the radiologist's supervisor, did not complete the FPPE for 174 days, well past the 90-day deadline. This failure was undetected because facility managers did not have a tracking system to monitor such action items. When the chief of imaging did finally review the radiologist's work, it was noted as "unsatisfactory" with concerns about diagnostic interpretations. The facility also did not complete a review of the radiologist's work until after 2016 and did not submit an issue brief to VISN 6 leaders alerting them to the clinical failures until 2018, after the OIG identified the concerns in the CHIP review. If the facility had conducted the FPPE within required timelines, the radiologist could have been removed from service more quickly. As it happened, two patients received disclosures resulting from the radiologist's deficient practices. The facility also received help from VHA's National Teleradiology Program to assist with reviews of the radiologist's work, identifying dozens of other images that were not read to standard.

Facility leaders failed to take proper actions to curtail the radiologist's practice after not renewing the radiologist's contract in December 2014 and did not promptly complete the subject radiologist's exit memorandum within seven days as required by VHA to comply with state licensing boards' reporting requirements. The results were not made to the facility professional standards board until August 2018, three years after the required date. Due to the failure to complete the exit memorandum, the patient safety manager was not promptly notified to trigger mandated administrative reviews. After the OIG review commenced, the facility director issued notices in January 2019 to eight state licensing boards stating that the radiologist failed to meet generally accepted standards of clinical practice. The OIG subsequently made four recommendations to the facility and VISN related to C&P requirements, state licensing board reporting, reporting of adverse events, and potential administrative actions. OIG staff will monitor VA's progress until all proposed actions are complete.

Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VAMC in Altoona, Pennsylvania.

In 2018, the OIG reported on C&P concerns also involving the Altoona VAMC in response to a complainant's allegations about the services provided by an anesthesiologist at the facility.[16] The anesthesiologist allegedly did not follow VHA and facility policies for controlling medication waste and did not individualize patient medication dosing and used more anesthetic/sedation medication than the recommended guidelines for outpatient procedures. The OIG found the anesthesiologist used more anesthetic/sedation medication for outpatient procedures than the FDA-approved manufacturer's instructions for 17 of 20 identified patients. This OIG-directed review was conducted by the chief of anesthesiology at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania.

[16] *Alleged Inappropriate Anesthesia Practices at the James E. Van Zandt VAMC, Altoona, Pennsylvania*, July 5, 2018.

While the OIG found issues with dosing above the recommended guidance, OIG staff did not find that the reviewed patients suffered related adverse outcomes.

The OIG examined the facility's adherence to VHA and facility-level privileging policies as well as reporting the provider's conduct to oversight bodies. Although the facility did not identify issues to report to the National Practitioner Data Bank or the anesthesiologist's pertinent state licensing board upon the anesthesiologist's discharge from employment, the OIG recommended that the facility should reevaluate if the provider should be reported for the practice of administering medications inconsistent with FDA-approved manufacturer's instructions.

Facility leaders did not provide oversight of the anesthesiologist according to VHA and facility privileging and ongoing monitoring policies. When facility leaders renewed the anesthesiologist's privileges in 2017, the privileges were not facility-specific, which is a key component of privileging. The anesthesiologist's privileges included management of patients under general anesthesia during surgical and certain other medical procedures and supervision of critically ill patients in special care units, which the facility does not have. Therefore, facility leaders should not have granted those privileges to the anesthesiologist.

Additionally, the anesthesiologist's OPPE did not include monitoring of drug usage, which is a relevant, provider-specific data element. The reason for this was unclear; however, a review of drug usage data may have identified a pattern of the anesthesiologist prescribing anesthesia medications inconsistent with FDA-approved manufacturer's instructions, which increased the patients' risks of respiratory and cardiac arrest and/or failure. The OIG made four recommendations, which are now closed. The facility subsequently reported the anesthesiologist to the National Practitioner Data Bank and state licensing board.

NATIONAL AND LOCAL OVERSIGHT WEAKNESSES

Many of the issues identified in the cited OIG reports are united with common themes of management and programmatic failures. Many of these failures are due to ineffective oversight from regional and national leaders. The OIG has not found evidence that national leaders are actively engaged in the determination, collection, and analysis of standardized quality-related data. The OIG has also found that local leaders do not always have tools to track and follow up on completion of provider evaluations. These gaps can lead to situations in which local leaders receive actionable information later than desired to promptly resolve problems.

Additionally, because VHA first uses a local peer to review a clinician's performance, smaller facilities that have few specialists can be at a disadvantage. The reviewing clinician may be placed in the awkward position of attempting to review medical decision-making without the requisite skills or education. When VHA medical facilities face physician staffing shortages, this problem intensifies as the clinician is required to devote time to conducting the review in addition to their daily tasks, such as accomplishing their patient care duties.

The C&P issues reported by OIG should not be discounted as isolated events expected across a large system. Rather, changes should be considered to the C&P processes by requiring LIPs to demonstrate the skills required to perform specific clinical activities. For example, during the FPPE process, the regular use of direct observation of clinical procedure performance and increased use of simulation centers would better demonstrate that a clinician will provide high-quality medical care. VHA should also consider appointing a national leader for each specialty whose primary responsibility is to ensure the highest quality practices across all facilities, with active involvement in overseeing the FPPE and OPPE processes. The need for changes in how local, regional, and national leaders conduct evaluations and communicate about practitioners who should not be providing care to veterans could not be more urgent given the missteps and delays the OIG has observed

CONCLUSION

VHA's goal is to deliver high-quality, timely health care to veterans. To achieve this objective, it is clear that VHA must improve its efforts to ensure physicians have the training, skills, and techniques they claim to possess. The OIG has repeatedly identified deficiencies in the management and execution of the C&P processes that inevitably lead to mistakes and failures in the delivery of health care to veterans. To more efficiently use its resources in delivering health care, VHA must continue to implement OIG and other oversight recommendations and properly staff clinical positions to provide the capacity needed for properly conducting the C&P processes.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.