

# EXAMINING VA'S FAILURE TO ADDRESS PROVIDER QUALITY AND SAFETY CONCERNS

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## HEARING

BEFORE THE

## SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

## COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS

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## **EXAMINING VA'S FAILURE TO ADDRESS PROVIDER QUALITY AND SAFETY CONCERNS**

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**Wednesday, November 29, 2017**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON VETERANS' AFFAIRS,  
SUBCOMMITTEE ON DISABILITY ASSISTANCE  
AND MEMORIAL AFFAIRS,  
*Washington, D.C.*

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Jack Bergman, [Chairman of the Subcommittee] presiding.

Present: Representatives Bergman, Bost, Poliquin, Dunn, Arrington, Gonzalez-Colon, Kuster, and Peters.

Also Present: Representatives Roe, McMorris Rodgers, and Takano.

### **OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN**

Mr. BERGMAN. I want to welcome everyone to today's hearing.

Before we begin, I would like to ask unanimous consent for our colleagues Representative Cathy McMorris from Washington and Representative Mark Takano from California to join us on the dais this morning and participate in the hearing, should they both be able to attend. I know that Ms. McMorris Rodgers is probably finishing up a meeting and I am guessing Mr. Takano is too.

So, without objection, so ordered.

Approximately 40,000 providers are privileged to deliver care at VA's 170 medical centers for the roughly 9 million veterans who receive medical care through the VA. Ensuring that these clinicians deliver safe, quality care is a vital piece of fulfilling VA's mission to provide our Nation's veterans with the services they have earned. That same mission obligates VA to hold providers who deliver substandard care accountable.

An important part of ensuring that accountability is the accurate and timely documentation of problems and communications with outside entities such as the National Practitioner Data Bank and state licensing boards. Refusing or failing to adhere to reporting requirements puts not just veterans, but all patients across the country at risk of receiving substandard health care. Today's hearing will explore how VA fulfills its obligation to hold privileged providers accountable by communicating with these entities and ensuring the timeliness and accuracy of such communications.

This week, the Government Accountability Office released a report requested by this Subcommittee that explores tremendous deficiencies across VHA in this particular area. The report found that

among the sample sites VA officials at the local, regional, and national level consistently failed to ensure that the facilities were adhering to reporting standards and requirements. This resulted in repeated failures to appropriately report incompetent providers, who in turn were free to continue giving care within VA or out in the community.

The burden of ensuring that these providers provide safe, quality care to veterans naturally rests with the medical center's administrators who are responsible for overseeing the delivery of health care services. However, GAO found that the sampled facilities frequently failed to maintain and provide sufficient documentation when reviewing or reporting providers. Moreover, some reviews and reports were initiated months or even years after problems were identified. Even worse, GAO found that facilities fail to report offending providers to the National Practitioner Data Bank and appropriate state licensing boards in almost all reviewed cases, leaving these providers free to continue practicing unchecked, sometimes in another VA or in the local community. These findings show a disappointing lack of commitment to the veterans receiving care from the agency and facilities charged with their well-being.

Further, GAO found that VISNs and VHA have failed to provide the oversight needed to ensure that VA medical centers are addressing these issues and reporting providers when appropriate.

While it makes sense that medical center officials are directly responsible for the integrity of the providers they employ, the VISNs and VHAs should and do have an obligation to exercise strong oversight over these competency and privileging processes. Unfortunately, GAO found that VISNs failed to audit facilities' provider reviews and did not consistently utilize the standardized tool designed for these oversight activities.

Having any underperforming provider continue to deliver care within the VA and to veterans is not only troubling, it is absolutely unsatisfactory. However, according to GAO, VA failures in reporting quality concerns allows subpar providers to not only continue administering care, but also to continue to be eligible for bonuses related to personal performance. Unfortunately, this news is not new to the VA.

A 2013 GAO report highlighted that VHA lacks information about how performance pay decisions were made and whether these decisions actually reflect a provider's performance. Clearly, VHA's oversight efforts continue to fall short. That these issues have persisted unaddressed for four years after being identified by an outside entity indicates a worrying lack of urgency on VA's part.

I look forward to discussing potential solutions to these persistent problems with today's witnesses.

Mr. BERGMAN. With that, I now yield to Ranking Member Kuster for her opening remarks.

#### **OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER**

Ms. KUSTER. Thank you, Mr. Chairman, and thank you to our witnesses and to all of you who are joining us today.

Reporting and documentation protects patients from harm and in some cases will save lives. You may remember at the very hearing that we held this Congress we discussed a case where a technician

at a New Hampshire hospital infected up to 50 patients with hepatitis C, because he was injecting himself with fentanyl intended for patients. Before being arrested in New Hampshire, he had been fired from medical facilities in half a dozen states, including the Baltimore VA Medical Center.

The doctor who was fired from the Tomah VA Medical Center in Wisconsin for over-prescribing opioids and retaliating against employees was immediately hired by a VA Choice Program provider and started treating veterans again.

A podiatrist who had been fired from the Togus VA Medical Center in Maine for harming veterans by performing surgeries below the clinically acceptable standard of care was hired by private providers. This same podiatrist harmed other patients after leaving the VA.

And GAO found in its report that a provider under contract to provide care at a VA medical facility was fired for patient abuse after 2 weeks on the job. The VA facility terminated the contract, but did not report the provider to the National Practitioner Data Bank or the appropriate state licensing board.

In all of these cases, the VA should have reported these providers to the National Practitioner Data Bank and to state licensing boards. VA and medical facilities all across the country are failing to protect patients by not reporting providers who do not meet clinically accepted standards of care. GAO found that providers who should have been reported were able to continue practicing at the VA during professional practice evaluations and reviews, and even after being fired from VA or forced to resign.

I would like this hearing to examine what the VA can immediately do to ensure incompetent and unprofessional providers are reported, and whether legislation is needed to ensure that this reporting happens and that patients are protected.

Additionally, GAO's report raises two issues that we continue to observe in our Subcommittee hearings: unclear and confusing VA policies and lack of oversight from the VISNs. The GAO found both unclear policies and lack of VISN oversight contributed to VA's failure to report providers to state licensing boards and National Practitioner Data Bank.

This week, Congresswoman Brownley and I asked the GAO to study the role of VISNs and to help us determine whether VA policy appropriately outlines the VISNs' oversight responsibilities. We have heard countless times on this Subcommittee that VISNs are not conducting appropriate oversight. When the GAO completes its work, I would like our Subcommittee to hold a hearing to determine what action should be taken to ensure that VISNs are enforcing VA policies and performing their oversight duties.

I also remain concerned about unclear VA policies and directives. This is one issue that has contributed to VHA's placement on the GAO high-risk list and confusion over VA policies on reporting providers to state licensing boards and the National Practitioner Data Bank was a major cause of VA's failure to report.

VA employees should not have to read multiple policies and outdated directives to figure out which policy should be followed. Policies and directives should be clear, easy to follow, and policies

should be clearly communicated to medical facilities. Employees who fail to follow policy should be held accountable.

Finally, providers who are fired from VA for failing to provide quality care to veterans should not be treating patients as a Choice Program provider or receiving taxpayer dollars.

Now, Senator Tammy Baldwin has a bill that has passed out of the Senate called the Access Act. It would prevent fired or suspended providers from treating veterans. It passed recently in the Senate and I am hoping that our VA Committee will quickly bring this bill to the floor and send it to the President's desk, and I look forward to working with the chair and Chairman Bergman to that effect.

Thank you, and I yield back.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

I ask that all Members waive their opening remarks, as per this Committee's custom.

With that, I invite the first and only panel to the witness table. As I see, you are already comfortably seated. And I think you know that you have to turn your mike on; other than that, nothing else has change since the last time you were here.

On our panel we have Dr. Gerard Cox, Acting Deputy—Acting Deputy Under Secretary—you know, we need to shorten up some of these titles—for Health for Organizational Excellence for the Department of Veterans Affairs. He is accompanied by Dr. Shereef Elnahal, VA's Assistant Deputy Under Secretary for Health, Quality, Safety, and Value.

We also have Mr. Randy Williamson, Director of Health Care Issues for the Government Accountability Office; and Dr. Hank Chaudhry, President and CEO for the Federation of State Medical Boards.

I ask the witnesses to please stand and raise your right hand.  
[Witnesses sworn.]

Mr. BERGMAN. Thank you. Please be seated.

Dr. Cox, you are recognized for 5 minutes.

#### **STATEMENT OF GERARD R. COX**

Dr. COX. Thank you. Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee. Thank you for the opportunity to discuss our medical centers' clinical competency reviews, compliance with reporting to state licensing boards and the National Practitioner Data Bank, and the related GAO report.

I am accompanied today, as you noted, by Dr. Shereef Elnahal, the Assistant Deputy Under Secretary for Health, for Quality, Safety, and Value.

Prior to joining the Veterans Health Administration a little less than 4 years ago, I served for more than 30 years in uniform as a U.S. Navy Medical Officer. I am a proud veteran of the 1990-'91 Gulf War and the ongoing conflict in Afghanistan. I dealt firsthand with issues surrounding clinical competency and adverse privileging actions as the Commander of the Naval Hospital at Camp Lejeune, as the Second in Command of the U.S. Naval Hospital in Okinawa, Japan, and as the Deputy to the Medical Officer of the



Marine Corps. During my last year on Active duty, I served as the Assistant Inspector General of the Navy for Medical Matters.

In my capacity at VHA, I am responsible for strengthening our compliance, ethics, and oversight functions, and I assumed broader responsibility as the Acting Deputy Under Secretary for Health last month. Therefore, I know well how important the issues we will address at today's hearing are to VA and to my fellow veterans.

VA has an ethical and moral obligation to our veterans, our agency, and our community to report certain providers to the National Practitioner Data Bank and state licensing boards.

We are taking three major steps to improve clinical competency and reporting: number one, we are improving our oversight to ensure that no settlement agreement waives VA's ability to report providers to the data bank or the licensing boards. Second, we are reporting more clinical occupations to the National Practitioner Data Bank instead of just physicians and dentists. And, thirdly, we are improving the timeliness of that reporting. We are also rewriting and updating our policies in response to the GAO's report. We are constantly striving for improvement in these areas to make sure our veterans receive the highest quality of care, which they have earned and deserve.

If the clinical practice of a privileged provider raises concerns about the quality of care, VA conducts a review to assess the provider's performance in that area. This is to substantiate if there is a concern related to the provider's clinical practice and to determine the appropriate next steps. If that information that caused the trigger raises a concern of imminent danger to patients, the provider may be removed from patient care by the medical center director until that review is complete.

If the review results in an adverse privileging action, such as reduction or revocation of privileges to practice in that facility, the medical center director is the final authority on that decision, in accordance with the accreditation standards of the Joint Commission, the entity that accredits all VA hospitals, as well as many hospitals in the private sector across the Nation.

Once the medical center director decides to take a final privileging action, the clinician is afforded a fair hearing opportunity. Clinicians who resign or retire while under investigation must still go through a limited hearing process.

Although the National Practitioner Data Bank only requires the health care industry to report physicians and dentists when an adverse privileging action is taken, or when they resign or relinquish privileges while under investigation, VA is voluntarily expanding the range of clinical occupations that we will report. We are doing this because we feel it is the right thing to do for veterans. This means that we will report to the National Practitioner Data Bank all privileged providers for adverse privileging action, all privileged providers who resign or relinquish privileges while under investigation, and any licensed provider who was terminated from a VA facility for substandard care, professional incompetence or professional misconduct, thus excluding them from future participation in the VA's community care programs.

In addition, at the direction of the Secretary, VA now requires that any employment dispute settlement involving payments of

more than \$5,000 must be approved by top VA officials here in Washington rather than officials at the local or regional level. We will expand this review process to confirm the requirement to report the provider to the National Practitioner Data Bank or state licensing boards. Any VA employee who is found to have proposed withholding that reporting will be subject to investigation and disciplined.

In addition to expanding the types of providers that can be reported, VA will improve the timeliness of both the decision-making on whether to report providers and the process of reporting providers, shortening the timeframe of that process.

GAO recently released report made four recommendations and VA has concurred with all of them. In response to these recommendations, VA will rewrite policy to formalize guidance on focused management review and will include timeline expectations for those reviews. We will update the standardized auditing tool to include monitoring of appropriate action taken when clinical care concerns are identified, and to include monitoring of timely reporting to the National Practitioner Data Bank, specifically for privileging actions and resignation while under investigation.

Mr. Chairman, as I have described, VA is taking three major steps to improve clinical competency and reporting, reporting more clinical occupations, improving the timeliness of reporting, and enhancing oversight to ensure that no settlement agreement waives VA's ability to report to the data bank and the licensing boards of states.

I am proud of the health care our facilities provide to our veterans and VA is committed to upholding that high level of care.

Thank you for the opportunity to testify today and I look forward to your questions.

[THE PREPARED STATEMENT OF DR. COX APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Cox.

Mr. Williamson, you are now recognized for 5 minutes.

#### **STATEMENT OF RANDALL WILLIAMSON**

Mr. WILLIAMSON. Good morning, Chairman Bergman and Ranking Member Kuster.

VA medical centers are responsible for ensuring that their providers deliver safe, high-quality care to veterans. If concerns arise about the VA provider's clinical care, VAMCs are required to undertake actions to review that provider's care and determine whether an adverse privileging action should be taken that restrict or curtail care the provider is allowed to deliver.

VAMCs are required to report VA providers for whom adverse actions have been taken to the National Practitioner Data Bank and state medical licensing boards. At the behest of Chairman Roe and this Subcommittee, GAO evaluated VA's processes for reviewing providers' competency at five VAMCs across the country and consistently found a variety of disturbing problems with how these processes are being carried out.

Specifically, we found that after concerns were raised about the providers, required reviews of their clinical care was frequently not

done or not conducted in a timely manner. Moreover, where adverse actions were taken against providers, VAMCs did not report providers to the data bank or to state medical licensing board, as required, or did so in a timely way.

We found that during the four-year period ending March, 2017, the five VAMCs we reviewed collectively required clinical reviews of 148 providers after concerns were raised about their care. For almost half these cases, VAMC officials could not provide documentation that the reviews were actually conducted. We also found that reviews were not always timely. We found 16 cases where reviews were delayed more than 3 months and in some cases years after concerns were raised. For two providers, reviews were initiated 3 and a half years after concern was raised and then only after we requested documentation on those cases.

The bottom line, VAMCs have been lax in conducting these reviews and VHA has no policy governing how soon reviews should occur after clinical care concerns have been raised. That needs to change.

We also found that for providers who had adverse actions taken against them, or who had resigned or retired during the adverse-action process, VAMCs failed to report them to the data bank and state medical license board, as VA policy requires. From our sample of 148 providers, we found that VAMCs should have reported 13 providers to the data bank and the state medical licensing boards. They reported only one of the 13 providers to the data bank and none to the state licensing boards.

VAMC staff told us they were oft confused about their reporting responsibilities, even though VA policies are clear in this regard. At one facility that accounted for six unreported providers, VAMC staff that were responsible for reporting were not even aware of those responsibilities, even though those responsibilities were actually in the local medical center policy.

VA's failure to report providers to the data bank or state licensing boards makes it possible for providers to obtain privileges at other VAMCs or non-VA health care entities that serve veterans. For example, for two providers in our sample whose services were terminated and whose adverse actions were not reported, one subsequently held privileges at another VAMC while the other belongs to a provider network that provides care to veterans in the community.

Even in the one case where we found the VAMC had reported the provider, it took 136 days from the time the appeals process was completed to the actual report, far beyond the current 15-day VA reporting requirement.

VA has no similar policy specifying how soon a provider should be reported to the state licensing boards after the adverse-action process is completed.

Generally speaking, the situations I have described were allowed to happen largely because of poor oversight and accountability from top to bottom in the VHA hierarchy. For example, neither the VISN nor the VA central office officials routinely perform any oversight to ensure that reviews are conducted in a timely way. Moreover, VA policy does not require that VISNs oversee reporting to

the data bank or state licensing boards; because of that, none of the VISNs we reviewed did so.

While VA has agreed with our recommendations and promised to make needed improvements, we believe that immediate, decisive actions are needed to remedy the serious problems we identified. Otherwise, VAMCs are potentially putting veterans in harm's way by exposing them to substandard and unsafe care.

That concludes my opening remarks.

[THE PREPARED STATEMENT OF MR. WILLIAMSON APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Williamson.

Dr. Chaudhry, you are now recognized for 5 minutes.

#### **STATEMENT OF HUMAYUN J. CHAUDHRY**

Dr. CHAUDHRY. Thank you. Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Committee. Thank you for this opportunity to discuss the important role that state medical boards play in the protection of the public and how working together we may be able to better protect our veterans.

I am pleased to mention that I served 14 years in the Air Force Reserves, trained to be a flight surgeon, and have more than a passing familiarity with issues related to health care needs of military personnel and veterans.

My organization, the Federation of State Medical Boards, was founded in 1912 and represents all 70 of the state medical and osteopathic regulatory boards in the United States and its territories, including Puerto Rico, Guam, the Northern Mariana Islands, the U.S. Virgin Islands, and the District of Columbia.

The mission of the FSMB is to support its member boards as they fulfill their statutory mandate to protect the public's health, safety, and welfare through the proper licensing, disciplining, and regulation of physicians and other health care professionals.

In addition to licensing physicians, state and territorial medical boards are empowered to investigate complaints or reports about physicians who may be incompetent or acting unprofessionally; to discipline those who violate the law; to work with local and Federal law enforcement where appropriate; to conduct physician evaluations; and to facilitate rehabilitation of physicians when appropriate. All of our member boards engage in an ongoing cooperative effort to share medical licensure and disciplinary information with one another by regularly contributing data to the FSMB's Physician Data Center, a comprehensive data repository that contains information about more than 950,000 actively licensed physicians in the U.S. including those who work for the VA.

The FSMB applauds the noble mission and dedication of the VA and its many personnel in serving the Nation's 9 million veterans and we believe strongly that veterans deserve the same level of quality health care and regulatory oversight and accountability that is available to the general public, if not better.

We have read with great concern the October 11 investigative story in USA Today. While we are pleased that the VA through FSMB's Physician Data Center has had access over a number of years to comprehensive licensure and disciplinary information

about physicians who work for the VA, more needs to be done to improve the sharing of information from the VA to the state medical boards that would expediently and efficiently identify unsafe providers operating within the VA system.

While the dearth of timely information sharing from the VA is not unique to the VA - civilian hospitals, health systems, medical directors, employers, and all physicians and health care providers can and should do more and do a better job of sharing concerns about incompetent or unprofessional doctors - we know that the VA has had policy in place for more than a decade specifically requiring such sharing.

In consultation with several state medical boards, we have confirmed what has been reported by the GAO that the VA does not always alert state boards in a timely fashion about violations, disciplinary actions, or suspected violations of a state's medical practice act. While the VHA handbook outlines notification requirements, in practice, the state boards tell us, many VA sites have not adhered to these standards.

While it is important to note that each state board's relationship with their local VA facilities tends to vary and some are better than others in terms of information sharing, we have found it rare for a board to receive up-front or helpful information from the VA in a timely manner. When information is shared with a state medical board, we have learned it is often well past the 100-day notification requirement designated by the VA.

These gaps in communication between state medical boards and the VA are of significant concern to the FSMB and we sincerely hope that we can work with our boards, the VA, and Congress to address this issue and overcome any perceived impediments.

Providers who are unqualified or unsafe to practice medicine in the VA should not be allowed to practice outside of or elsewhere in the VA, nor should such providers be able to conceal their disciplinary actions with secret settlement arrangements. Proper notification of provider disciplinary proceedings within the VA to the appropriate state medical boards and the National Practitioner Data Bank will help ensure that unsafe and dangerous physicians are identified and prevented from also treating patients outside of the VA.

The FSMB commends Congress for recognizing these deficiencies and for moving swiftly to rectify them with legislative solutions. The FSMB has endorsed H.R. 4059, introduced by Chairman Roe, House Republican Conference Chair Cathy McMorris Rodgers, and Congressman Bruce Poliquin; as well as S. 2107, introduced by Senators Dean Heller and Joe Manchin.

Chairman Bergman, thank you for the opportunity to testify before the Committee today. I look forward to responding to any questions you and the other Members of the Committee may have.

[THE PREPARED STATEMENT OF DR. CHAUDHRY APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Chaudhry.

The written statements of those who have just provided oral testimony will be entered into the hearing record.

We will now proceed to questioning. And just know that when Ms. McMorris Rodgers comes, we are going to recognize her without objection, because she has a real tight schedule and if everybody is okay with that, you know.

But anyway, so we will now proceed with the questioning, and I would like to recognize Ranking Member Kuster for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman, and thank you to you all for your testimony today.

I want to turn my attention to Mr. Williamson from the GAO, and I just want to say for the record that Mr. Williamson is coming up on his retirement after 50 years of public service—50, 5–0.

Mr. WILLIAMSON. Thank you.

[Applause.]

Ms. KUSTER. We thank you. On behalf of Americans everywhere, thank you for your service to your country. We are very grateful.

Mr. WILLIAMSON. Thank you.

Ms. KUSTER. In your report, you recommended that the VHA establish timeliness standards for reviewing providers after concerns are raised about their clinical care, and I first want to clarify and then ask what your recommendations are.

Between your testimony and Dr. Chaudhry, I heard 15 days to report and then I heard 100 days to report. So these may be reporting different things, but if you could just give us an overview of what the current rules as you understand them are and what your recommendations are for timeliness of reporting.

Mr. WILLIAMSON. Once a concern is raised, there is no time period for when that review of the provider's care should start, but once that process is started and it is completed, let's say it is completed with an adverse action, then VA has 15 days by their own standard to report to the National Practitioner Data Bank. For state licensing board reporting, the process is different, and it is a lower bar, because the state licensing board does their own investigation, VA doesn't have to go through the rigor that they do with an adverse action. So—and there is no reporting requirement at all there.

So what we are thinking is that, first of all, there should be a time period or a requirement for how soon after the care is questioned to when the actual review starts, and I see no reason why that shouldn't be 30 to 60 days. We saw nothing in our discussions with VAMC staff that would indicate there were any problems with that.

Once reporting—and the 100 days, the 100-day requirement, or it is not really a requirement, it is something that VA officials suggest that the state licensing board process should take, but that is not a requirement right now. So I think basically 30 to 60 days to start the review for the state licensing board, 100 days perhaps to do the review, and then it should be immediately reported.

Ms. KUSTER. All right, that is very helpful. Thank you.

And in your report you mention that VHA has established a required timeframe for completing reports the National Practitioner Data Bank—okay, this is what you have just reviewed, but not to the state licensing boards. Would you suggest to us that these timelines that you have recommended should be by statute or should we be working with VHA? It sounds from Dr. Cox that they

are making some progress in this regard. Do you have a preference that—

Mr. WILLIAMSON. Well, if VA established that in policy and was specific enough along the lines I just talked about, that would probably be sufficient. My question would be whether VA is willing to do that.

Ms. KUSTER. So then I will turn to Dr. Cox.

Can you clarify for this Committee whether new guidelines with timeliness standards are underway or whether our Committee should follow-up with statutory guidelines, so that after your good works are done future people at the VA would comply?

Dr. COX. Yes, thanks, Congresswoman. They are underway and our new procedures are being written. In our response to the GAO, which they accepted, in response to their recommendations we committed to giving interim guidance to our field facilities next month, in December. And then the process of writing the formal policy and getting that approved and signed will take a little bit longer, but it will be completed this year, this fiscal year.

Ms. KUSTER. And my time is shortly up, but can you just briefly say the timelines that you are suggesting?

Dr. COX. The timelines are, as Mr. Williamson said, a recommendation for 100 days to complete the entire state licensing board reporting process. The National Practitioner Data Bank reports generally take much longer because, as was suggested, they require a more thorough investigation and a final decision about whether an adverse privileging action should be taken. So that will be longer.

Ms. KUSTER. My time is up, but hopefully one of my colleagues will follow-up. Thank you.

I yield back.

Mr. BERGMAN. Thanks, Ranking Member Kuster.

Ms. McMorris Rodgers, thanks for joining us this morning. You are recognized for 5 minutes. We know you have an extremely tight schedule.

Mrs. MCMORRIS RODGERS. Well, thank you, Chairman. I appreciate the opportunity to join the Veterans Affairs' Committee on this important issue.

I wanted to ask Dr. Cox, that you testified that the VA is implementing new policies in light of concerns raised about the VA's processes for reporting safety and quality concerns. I remain worried that VHA's central office remains too disconnected from the field to effectively enforce policies.

The question is, what specific actions will VHA take moving forward to improve communication with and oversight of the field offices in regards to reporting safety and quality concerns?

Dr. COX. Well, thank you. The key to your question is in fact oversight and as Mr. Williamson has pointed out, as GAO has pointed out to us before, as Representative Kuster mentioned in her opening remarks, the VA has come under criticism for not providing adequate oversight and accountability of its facilities. And I share that concern; that is one of the reasons that we are on the GAO high-risk list.

So we need to do much better. I mean, I can't excuse the fact that in the past that adequate oversight by VISNs and by the central office has not been provided.

So among the steps that we are taking are developing a new electronic auditing tool that we will be able to use and will require the VISNs to use to monitor the timeliness and the compliance with reporting requirements within the facilities in their regions. And then we will be able to compile that information at the national level beginning in 2018 and be able to generate a report at the end of the year, so we will have a much better handle on how things are going out there.

Mrs. MCMORRIS RODGERS. So that is part of the solution, but I think, as we know, reaching agreements to exchange refraining from reporting a provider for their resignation or retirement are against VHA policy and concerns persist that these agreements are still taking place. So what will make oversight of these policies change the outcome?

Dr. COX. You are absolutely correct. Any agreement that involves negotiating a decision not to report somebody who should otherwise be reported is not only a violation of VA policy, it is illegal and is unethical. And when we find that any facility director or other leader in the field has engaged in such a negotiation, we will provide appropriate investigation and take disciplinary action as warranted.

Mrs. MCMORRIS RODGERS. What are you doing with the current cases that we have been made aware of?

Dr. COX. Each of those cases has been provided to us. The GAO was able to give us the names of the individual providers who were not reported in a timely fashion and that they cited in their report. And so we now have that information and have begun the work of contacting each of the facilities that are in question, determining why what happened did not happen, and have already begun the process in all of those cases, nine out of nine now, to conducting reporting both to the data bank and to the state licensing boards.

Mrs. MCMORRIS RODGERS. How long do you anticipate that taking?

Dr. COX. Well, four of those nine have already been made, four of those nine reports have already been made. Those were the simpler ones where the individual left VA's employment while under investigation, so it is a fairly easy decision. In the other five cases where there was an adverse privileging action taken there is a little bit more process to make sure that the individual has a chance to rebut the claims and so forth, but once that process is over the reports will be made very quickly.

Mrs. MCMORRIS RODGERS. So can you just share with me what will be the role of the VISNs in this implementation?

Dr. COX. The VISNs need to do a better job of overseeing these practices within their regions. My view is a longstanding lack of clarity about the roles and responsibilities of VISN officials vis-a-vis their facilities and also vis-a-vis the central office.

So great discussion is going on now across VA and in the parts of the organization that I work about clarifying those roles and responsibilities. You may have heard that Secretary Shulkin is committed to modernizing the VA and this is one of the key elements



of the VA modernization effort, to clarify the decision-making authorities, the roles and responsibilities, and then to hold people accountable for maintaining those responsibilities.

Mrs. MCMORRIS RODGERS. Well, I greatly appreciate your attention to this issue. I appreciate so many that work at the VA all across the country, but unfortunately we have also had some incidences at the medical centers that I represent where doctors were let go, but then it wasn't reported anywhere and then they went into the private sector. So it is very important that this accountability take place.

So, thank you, and thank you, Mr. Chairman, for giving me the chance to join you today.

Mr. BERGMAN. Thanks for joining us.

I am now going to recognize Mr. Takano for 5 minutes. Thank you for joining us.

Mr. TAKANO. Chairman Bergman, I want to thank you and Ranking Member Kuster for letting me join the Subcommittee this morning. I really appreciate what you have done.

Dr. CHAUDHRY, VA has a policy of requiring the reporting of providers; do other hospitals and medical directors, physicians, and health systems have policies requiring the reporting of incompetent or unprofessional providers?

Dr. CHAUDHRY. Congressman, you are referring to outside the VA system?

Mr. TAKANO. Outside the VA.

Dr. CHAUDHRY. There is a requirement understood, but not always followed, by hospitals and others to—medical centers and facilities to share information as well.

I made it a point in my remarks to mention that this issue is not unique to the VA. The state medical boards can do more for the Nation in protecting the public if they had access to more timely information from all sorts of sources. And I agree with Dr. Cox, it is an ethical matter ultimately for physicians and others to do that as well.

Mr. TAKANO. So, but these policies vary from state to state and I am trying to get a sense—the line of my question is to try and get a sense of VA and non-VA providers and the accountability that we expect and the reporting of these incidents.

Do you have any data that could be used to compare the rate at which VA providers are reported compared to the rate at which private providers are reported to the state licensing boards and the National Practitioner Data Bank?

Dr. CHAUDHRY. Yes, I can provide you—my staff can provide you that information afterwards.

Mr. TAKANO. Okay. I would be very much interested in seeing that.

What review mechanisms are afforded to providers before they are licensed or practicing privileges are suspended or revoked?

Dr. CHAUDHRY. Just as in the VA system, Congressman, there is a due process that the state boards adhere to as part of their medical practice acts. So any physician for whom there is a complaint, there is a process to determine if it warrants investigation, number one, and, if it does, there is ample opportunity for the physician to

be represented by counsel, if necessary, and to be able to rebut or explain the circumstances.

These processes are not new, they have been around for the state boards for decades, and they ultimately serve the public in the right way, we believe.

Mr. TAKANO. How could the VA makes it provider reviews and professional performance evaluation processes more transparent to veterans, state licensing boards, and to the public?

Dr. CHAUDHRY. Well, one of the things we have heard, Congressman, is that the information that the state boards do get sometimes has significant pieces of information that is redacted for privacy purposes and sometimes even the names of the providers. It is very difficult to do the right thing at the state board level if information that is relevant to the complaint and the individual is not made available.

So while we are talking about sharing of information, I would hope that that information is actionable information.

Mr. TAKANO. Getting back to the question about the comparative data, are there any generalizations you can just sort of tell me? I mean, is the VA on par with the non-VA providers in terms of its reporting practice or is the private sector ahead? How do they compare? Or is it just too complicated to explain in a short answer?

Dr. CHAUDHRY. I couldn't tell you that, but what I can tell you is the VA has a benefit of being a centralized system, it is a closed system, so that in theory, when something goes wrong, it should be able to be traveled up and to be addressed in the right way.

The Nation's hospitals are all under different management, some are for-profits and non-profit, it becomes a little bit more complicated, but there is a benefit to the VA to be able to do this in the right way.

Mr. TAKANO. I am generally interested in the question as to—I mean, the VA is certainly subject to the oversight of the Congress, of this Subcommittee, and I think it is important for the public to understand how transparent the private systems are too. I kind of get the sense that they are less transparent, because they don't report to Congress and they are not subject to the kind of oversight that we can lend, and if there is comparable kinds of oversight at the state level.

Dr. CHAUDHRY. I couldn't tell you if they are less compliant or less forthcoming. What I can tell you is the FSMB last year through our House of Delegates, which is made up of all the state licensing boards, passed a resolution about the duty to report, which speaks to what Dr. Cox was referring to, the ethics of this. It is important for everyone, not just providers, but members of the public, Members of Congress, and others, that if they are aware of an issue, whether it is individuals or an entity or a site that they need to speak up.

Mr. TAKANO. Dr. Cox, how will the VHA hold VISNs accountable for performing routine oversight over medical facilities and ensure reporting to state licensing boards and National Practitioner Data Bank?

Dr. COX. Well, as these policies are revised and the requirements strengthened, we will be able to hold VISN officials more accountable. I think the importance of reinforcing our expectations of them

has to come first and then, as soon as those expectations are made clear, we will be able to address it.

Mr. TAKANO. All right. Thank you very much. My time is up.

And I want to thank the Chairman and Ranking Member again for allowing me to participate today. Thank you.

Mr. BERGMAN. Thanks, Mr. Takano.

Mr. Bost, you are recognized for 5 minutes.

Mr. BOST. Thank you, Mr. Chairman.

A lot of the questions that I had have been answered, but I wanted—and I know we are moving forward with a different policy, but, Dr. Cox, can you explain to me, because I would like to know, how in the world anyone ever in the VA process thought it was okay to make a deal to send somebody on to a different location and/or just not report them, have them leave? Whenever I have my constituents out there, all of a sudden they go into the private sector or whatever and then we have endangered them as well. How did that come about?

Dr. COX. Well, Congressman, I agree, that is a very troubling situation, and I can't explain how that comes about. As you know, each of these negotiations is conducted on a case-by-case basis and there are different facts that pertain.

I will point out that when we are talking about settlements of employment disputes, that is separate from the credentialing and privileging actions taken by medical staffs to police themselves. So these are negotiations that occur because our VA providers happen also to be Federal employees and subject to all of the processes and responsibilities that go along with that.

So those settlement agreements are generally undertaken by people outside the medical staff, but that is certainly no excuse. And as I said before, once we determine that any such agreement has been made that is not only a violation of policy, but illegal and unethical, then we will take action to investigate those individuals.

Mr. BOST. Let me tell you a story and many of my colleagues have heard this. Prior to being elected, I actually—because I have a VA close to my home, I actually asked many people online to give me any information. A very good friend of mine actually responded back that actually we had a physician at the VA hospital in Marion, he said that she did a great job of his exam and everything like that; however, if she didn't have religious beliefs where she couldn't look below the waist, they would have found his hernia.

It took us almost 3 years to get rid of that physician, 3 years. Now, when she took her medical courses, she didn't have that religious belief, okay? This was picked up afterwards.

Do we have things in place now that allow the administrators of VA when a situation like this comes up that they can actually remove them from their positions, so that someone who can do their job adequately can be put in place, or are we bound by certain rules that they are protected where you can't let them go?

Dr. COX. Congressman Bost, I am going to defer to my colleague Dr. Elnahal to help me answer that question.

Dr. ELNAHAL. Congressman, I think it is a great question, and in that particular case we do have a process within the VA that allows us to evaluate the clinical behavior and practices of physicians, that is called a focused professional practice evaluation. So

if there is a clinical concern raised or if somebody notices that something was missed for a reason like that, there is a process by which we evaluate through a peer who also practices in that specialty and people who know how to—the standard of care and the scope of practice to evaluate that practice.

And in that situation, if that was caught in such an evaluation, something would have been done about it. The concern would have been raised to the chief of staff and potentially a privileging action—

Mr. BOST. Has that policy been in place a long time?

Dr. ELNAHAL. We have been doing focused professional practice evaluations for a very long time.

Mr. BOST. Okay.

Dr. ELNAHAL. Every time we on-board a new physician that is done, just for our due diligence, and then it can also be done if a clinical concern is raised.

Mr. BOST. More on a personal note before my time runs out, specifically with Marion—and, Dr. Cox, you may have to look this up and get back with me later on, but we actually—the OMI did a report and found out that many of our radiologists were either over or under-reading reports and it was then turned over, and I just need to know if the review has been done on that and has that problem been corrected.

Dr. COX. The Office of the Medical Inspector, which I oversee, has actually been to Marion twice in the last few months, the first time for the radiology service evaluation that you mentioned and the second time to look at broader issues of patient safety and leadership and so forth.

So the findings of the review of the radiology department have been—made complete recommendations for corrective action and the facility has provided its corrective action plan to us, which we are monitoring to completion.

Mr. BOST. Okay. Thank you very much.

I yield back.

Mr. BERGMAN. Mr. Poliquin, you are recognized for 5 minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much, I appreciate it. Thank you all for being here.

Dr. Cox, first of all, thank you very much for your service to our country, and everybody else on the panel, I really appreciate it.

Dr. Cox, you are a physician?

Dr. COX. Yes.

Mr. POLIQUIN. Okay. Is the standard of care at the VA the same standard of care that you should receive or a patient should receive at a non-VA hospital?

Dr. COX. Absolutely.

Mr. POLIQUIN. Okay. You know, I am really troubled by what I am hearing today and by some of the news reports that I will get into in a little bit here. We hear from Dr. Chaudhry that folks in the non-VA medical center community, whether it be a for-profit or non-profit, seem to report on a more timely basis when we have accusations or allegations or investigations about malpractice, but they are not as forthcoming at the VA. Didn't I hear you say that, Dr. Chaudhry?

Dr. CHAUDHRY. Part of the problem, Congressman, is that the state medical boards are complaint-based, so that we don't know what we don't know. So I couldn't make comparisons, but it is an issue of reporting everywhere.

Mr. POLIQUIN. Okay. So let's take a look—Mr. Williamson, you have been around for a long time.

Mr. WILLIAMSON. Yes.

Mr. POLIQUIN. Congratulations on your forthcoming retirement, sir. You looked at five out of the 170, roughly, medical centers in the VA during this study of yours and you identified about 148 doctors and nurses, and what have you, and practitioners that the concerns rose to the level of being investigated and only one of those, one of those, if I am not mistaken, was reported to the National Data Base, is that correct, but not to the state—

Mr. WILLIAMSON. correct.

Mr. POLIQUIN [continued]. —at the state level? Okay. And it took 4 and a half months to do this, roughly?

Mr. WILLIAMSON. It took what?

Mr. POLIQUIN. Four and a half months to do this, roughly, about 136 days. Okay, do you find that unusual?

Mr. WILLIAMSON. Yes.

Mr. POLIQUIN. Okay. If you were to do the same evaluation of five out of the thousands of hospitals in the non-VA space, do you think you would find that sort of mismanagement?

Mr. WILLIAMSON. Probably, I don't know. But, you know, I can tell you that if we looked—I am confident I could take my audit team in almost any VA medical center and find similar to things that we—

Mr. POLIQUIN. Okay, I am talking about if you were auditing non-VA hospitals.

Mr. WILLIAMSON. Non-VA hospitals, I have no idea on that.

Mr. POLIQUIN. Okay. Here's one of the problems that I have, fellas—folks. There is a terrific veteran from Maine, his name is Jake Myrick. Jake was an infantryman in the Army for 15 years and discharged in 2003. In 2004, he goes up to Togus, which is our only VA hospital in the State of Maine. The first in the country, by the way, we are very proud of and, for the most part, they do a good job. In 2004, he meets with a fellow named Tom Franchini, Dr. Thomas Franchini, who is a foot surgeon at Togus. He has having a lot of problems with his foot. And, in 2005, Franchini operates on him and botches the operation.

For the next 5 years, the pain is excruciating, it doesn't fix the problem. They say, well, you need some orthotics or you need some ankle braces. He stops running, stops biking, stops coaching his kids in athletics because he just can't take the pain. He is depressed, he is at home, he quits his job.

Now, during the ensuing 5 years while all this is happening, from roughly 2005 to 2010, there are 87 other veterans that are operated on by Mr. Franchini up at Togus, 87 other, all botched over this 5-year period. One of them, April Wood, had multiple operations on a problem ankle that were botched. The pain was so excruciating, the only way to relieve it was to amputate her leg. Amputate her leg.

Now, in 2010, the folks up at Togus and confirmed by the headquarters of the VA, wherever in the heck that is dealing with this issue, recognizes, you know, absolutely there was a problem here. In 2010, 5 years after. It took them 3 and a half years to get back to those 88 folks who suffered under Mr. Franchini to even notify them that, yes, he was a problem, and it exceeded the statute of limitations.

You know what I think? I think we got a culture here at the VA, no one wants to be responsible. You are not reporting on time to make sure no other people are hurt. I think you all are protecting your butts. what I think is happening.

This mismanagement is breathtaking. How do you fix it? I don't know how to fix it. I've got a great idea, though, Mr. Chairman, and I don't know if there is a way to do this, but I am going to talk to David Shulkin about that this afternoon. Maybe there is a way we can withhold funding from VA central to some of the hospitals out in the field who don't report on time what they should report so this doesn't happen in the future. Maybe we can do something like that; I don't know if we can, but I am going to find out.

Secondly—and thank you for the indulgence, Mr. Chairman—H.R. 4059 I have cosponsored with Chairman Phil Roe and Conference Chairman Cathy McMorris Rodgers, who was just here, it requires the VA to do what they are supposed to do, why in the heck do we have to write a new law to force the VA to abide by their own rules? And we wonder why the American people are losing confidence in Government?

These are people who fought for our country, these are veterans. We have got a problem at the VA where people are providing service to our veterans with botched operations, one after another, and we are not reporting it on time and they go out and they do it to someone else? Yeah, I am all for withholding money from these folks that don't report this.

But it is a shame, Mr. Chairman, we have to pass legislation to have the VA follow their own guidelines.

I yield back my time.

Mr. BERGMAN. Thank you.

Dr. Dunn, you are recognized for 5 minutes.

Mr. DUNN. Thank you very much, Mr. Chairman.

Gentlemen, when physicians usually come up here to testify, it is usually a happy occasion for me. We get to—you know, I think we—I am a surgeon myself, we view the world through the same prism and so we are often, you know, able to agree on many things. I think today we are faced with a problem, though, that is a disturbing pattern of bureaucratic ineptitude and cover-ups.

And I should note here at this point to Dr. Cox, I think you are new to the VA, am I right, you are brand new?

Dr. COX. Relatively new, yes, sir.

Mr. DUNN. Yeah, okay. So Deputy Under Secretary for Organizational Excellence, as I understand?

Dr. COX. Well, that is a role I assumed in an acting capacity last month.

Mr. DUNN. Okay. So that is the role that I see, you know, when you Google you under. So you are sort of the new sheriff in town, supposed to come here and drain the swamp, is that right?

Dr. COX. I suppose you could characterize it that way.

[Laughter.]

Mr. DUNN. Well, that is the most charitable way I think I can.

So, you know, we have some hard questions we have to face and I am going to refer to a specific VA medical center that is just outside my district in Florida. The Bay Pines VA Center has indefinitely suspended thoracic surgeries after being notified by the Joint Commission of issues within that department with at least three veterans dying from complications following surgery. So in August of this year, the VA Office of Inspector General found deficiencies in the process of evaluating the competency of the thoracic surgeons at Bay Pines.

How did those problems within the thoracic surgery department persist after the VA claimed to have corrected those problems?

Dr. COX. Congressman, I am going to have to admit I am not familiar with this situation at Bay Pines specifically, but I will certainly review the OIG report, and I would like to take your question and get an answer back to you, if I may.

Mr. DUNN. We have a report that there is another entity doing an external review; do you know anything about who that entity is?

Dr. COX. No, I am not sure.

Mr. DUNN. So you can't tell me whether or not that is somebody from within the VA or outside the VA all together?

Dr. COX. I can tell you that I am not familiar with any internal investigation going on at Bay Pines.

Mr. DUNN. In your testimony, you said that the VA's clinical reviews consist of providers from the same specialty objectively reviewing patients that the provider had seen previously. However, from Bay Pines we have an administrative psychiatrist conducting an ongoing professional evaluation of a thoracic surgeon. Can you tell me how that would happen or if you think that that has any basis in occurring even?

Dr. COX. I can tell you that that certainly wouldn't represent a peer by my definition, a psychiatrist reviewing the clinical care of a thoracic surgeon, and so I am not sure how that would have happened. Now, you said administrative review—

Mr. DUNN. Yeah, that was disturbing for me as a surgeon to see that, honestly. I think that that is clearly, you know, below the standard of medical practice.

Are the professional evaluations, these focused professional evaluations ongoing, are they standardized throughout the VA system?

Dr. COX. No. Focused professional performance evaluations are conducted and customized at each facility, in fact within each service to the particular needs of that specialty. So these are—first of all, these are not unique to the VA. FPPEs are part of the Joint Commission's accreditation standards for monitoring clinical care and they are prospective in nature. So these are put into place when a provider has an issue that is not egregious, where there is no imminent threat to patient safety, but where monitoring, closer monitoring was required to ensure that they are practicing high-quality care.

So the particular criteria for that individual in that specialty and the concern about their care goes into crafting an FPPE that is addressing that situation.

Mr. DUNN. So I have been party to a number of these over the years, I have been chief of surgery at several hospitals over the years, and I can tell you that we would always have specialists of the same specialty participating in those ongoing reviews. And so I have some familiarity with that and I found that appalling the way this one was carried out.

What do you do, what does the VA do when there is only one provider of a specific specialty, a urologist, thoracic surgeon, whatever, how does that center handle that problem?

Dr. COX. And that is a great question because, as you know, there are many smaller VA medical centers, some located in rural areas where there is only a sole provider.

Mr. DUNN. And shortages throughout the system.

Dr. COX. Indeed. So, ordinarily, if you need to have a peer of the same specialty review the clinical practice of a sole provider at a facility, then the VISN will arrange for another member of that same specialty from another nearby medical center to conduct the review.

Mr. DUNN. So our time is drawing short here. I just want to say that I think you have a very hard job, I don't envy you your job, but we will help you here on this Committee. We want the VA to improve, we need it to improve; you know, failure is not an option. You know, we are going to give you the help you need to do this, but, you know, we have to have a better VA medical system when we come out the other end of this.

Thank you very much, Mr. Chairman. I yield back.

Mr. BERGMAN. Thank you, Dr. Dunn.

Mr. Arrington, you are recognized for 5 minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman. Thank you, panelists.

Just when I think I can't be more depressed about the VA's lack of oversight and accountability and their fundamentally flawed organizational management, then I have this hearing and so I sink to new lows, because it is just shameful. This is why I am for choice and competition and, quite frankly, we could do well just to outsource the whole thing, because we have trapped our veterans in this system, trapped them. They don't have any way out.

My colleague Mr. Takano asked a really good question about the difference between private performance, non-profit, and the VA. The difference is, when they find out—and, Dr. Chaudhry, you know this and you interact with all sorts of hospital systems—when they find out at a private or non-profit hospital that somebody has been sanctioned or disciplined and not reported and continues to practice, they lose patients, which means they lose revenue, which means they will be insolvent. But the VA keeps getting paid, they get their paychecks regardless of how they treat the veterans, because they have a monopoly over them. It is a single-payer system and they are trapped, and it is shameful.

Now, Mr. Cox, you said it is a moral and ethical obligation to make sure there is an environment where the veterans, our veterans are being cared for by the best of standards, professionalism,



competency, et cetera. I agree with that, but clearly that doesn't exist. How long has it not existed, Mr. Cox, that VA has fulfilled its moral and ethical obligation to care for our veterans, how long has that existed?

Dr. COX. Well, I would like to respond by saying that even though our salaried physicians and other providers in the VA are part of this closed system that you talked about, it is still our obligation to ensure that the same quality standards apply as we apply in the private sector, in the military health system, and everywhere in America—

Mr. ARRINGTON. But eight out of nine, this is the majority of clinicians in the GAO report, eight out of nine were not reported when they had problems, when they had adverse action taken, eight out of nine. You are almost 100 percent at not reporting. That is not an ethical—meeting your ethical or moral obligation, so it is devoid of that right now.

You were the medical, what do you call it, the Medical Inspector? Like the Inspector General, but for the VHA?

Dr. COX. Yes.

Mr. ARRINGTON. How many years were you in that role?

Dr. COX. I was the interim Medical Inspector for a little over 2 years.

Mr. ARRINGTON. Two years. When did you first learn that this was a problem, this lack of oversight and accountability and just almost no management of this process of making sure we had the good guys still practicing, the bad guys weren't, and that we communicated with others to make sure the bad guys didn't practice somewhere else and hurt other patients, how long have we known about this?

Dr. COX. Well, I became specifically aware of the issues with reporting to the state licensing boards and the National Practitioner Data Bank when the GAO did its audit.

Mr. ARRINGTON. What about your own internal, though, controls and knowing that this wasn't happening? Was it the GAO report that revealed this to you or did you know this? Did you ever conduct an investigation or some review or audit as the Inspector General for the VHA?

Dr. COX. No, this was not something that was the subject of an internal investigation or audit. But that points out the need for us to strengthen our internal audit capabilities and we are in the process of doing that.

Mr. ARRINGTON. Do you have family members, a spouse, children?

Dr. COX. I do.

Mr. ARRINGTON. Would you allow your wife or your children to go to a health care system knowing what you know about this process and how flawed it is in this area?

Dr. COX. I would feel confident with my family members going to a health care system that has solid policies in place and that enforces them.

Mr. ARRINGTON. Well, but we are not enforcing them, right? Correct?

Dr. COX. That is correct.

Mr. ARRINGTON. And we are not creating—we are not fulfilling our moral and ethical obligation. So the question is, in a situation like that, would you allow your family member to go into a health care system like that?

Dr. COX. I would want to feel confident that the health care system not only—

Mr. ARRINGTON. I don't mean to put words in your mouth, but you wouldn't do it, okay? You wouldn't do it, because it is not happening.

And, Chaudhry, you wouldn't do it. I don't even know your family, I know you wouldn't do it. Nobody on this panel would allow their family members to be trapped in a situation like this when we are talking about their very lives at risk. These are people that deserve the very best and we are giving them the very worst in our efforts to make sure they are taken care of.

Has anybody, Mr. Cox, been fired for these—or disciplined for this problem as it has been revealed in the GAO report?

Dr. COX. Well, as was mentioned before, we now know the sites—

Mr. ARRINGTON. Yep.

Dr. COX [continued]. —and we now know the providers who were uncovered in the GAO's audit, and so we are undertaking appropriate review of their work, investigation of their decision-making, and disciplinary action as necessary.

Mr. ARRINGTON. Mr. Chairman, I am going to yield back because out of respect for my colleagues' time. I would love to have some follow-up questions, if there is time at the end of this.

But I would ask that you all, the VA submit for the record any disciplinary action that has occurred over the last several years with respect to the medical center directors involving this sort of practice of reviewing and reporting adverse actions. So if you would please get that information to the Chairman, I would like to see that.

Dr. COX. We will be happy to.

Mr. ARRINGTON. Okay.

Mr. BERGMAN. Thank you, Mr. Arrington. We are going to do a second round here for anybody who has a second question.

So, Miss Gonzalez-Colon, you are recognized for 5 minutes.

Miss GONZALEZ-COLON. Thank you, Mr. Chairman. And thank you, Chairman Roe, for coming here and sitting here. So I am between two Chairman's, I am happy today.

First of all, thank you for all the Members of the panel for being here. Just a note that the five centers that were evaluated, Puerto Rico and the territories were not part of that study that was conducted by the GAO.

One of the issues that I do want to ask is regarding Dr. Cox. I do understand the responsibility to report to the medical—to the National Practitioner Data Bank is from the medical director of the VA, correct?

Dr. COX. The responsibility lies with the medical center director, so the hospital director.

Miss GONZALEZ-COLON. And in the absence of that medical director, it should be on the staff, correct?

Dr. COX. Well, there will always be somebody performing the role of the medical center director, perhaps in an acting capacity, of which we have many, but it is—according to the accreditations—

Miss GONZALEZ-COLON. The responsibility can be delegated to somebody there?

Dr. COX. Actually, the decision to report I believe cannot be delegated beyond the—below the level of the medical center director or the person performing those duties.

Now, there are certainly clinical experts, right, the chief of staff, the executive committee of the medical staff, the providers who advise the medical center director about when a report may be necessary, but it is the director's responsibility under the Joint Commission's accreditation standards to do so.

Miss GONZALEZ-COLON. But the problems and the report we have here establish that the main issue we have got is the misinformation, miscommunication, and even their own staff is unaware of their responsibility to make these reports. And some of the regulations said that they are not—maybe did not understand the policy and regulations that comes with that appointment. How are you facing that problem?

Dr. COX. Yeah, it is very troubling that there are apparently medical center directors and chiefs of staff who don't understand the policy or perhaps don't even know to turn to the central office where the policy originates to ask for help.

I will tell you that there is lots of information made available both by direct consultation and published on our internal Web site, so that everybody knows where to look and find it. And, fortunately, these instances are relatively rare, all right? So a particular medical center director in the course of his or her tenure may only face these kinds of situations once or twice. Those that perform best are the ones that seek help, that seek consultation with the program office that oversees this where the true experts reside. And others that don't seek consultation or who try to do it on their own and may misinterpret what are sometimes confusing policies are the ones that tend to make errors.

Miss GONZALEZ-COLON. I do have a problem here and I do share my colleagues' concerns with this situation in the VA. And what is the consequence for those staff that are not reporting or are not taking their duty as they should, they are not properly carrying out that responsibility, what is the consequence for them directly?

Dr. COX. Well, fortunately, under the new Accountability and Whistleblower Protection Act, the Secretary has wider latitude—

Miss GONZALEZ-COLON. But that is now. Before that it was nothing?

Dr. COX. I can't speak to any particular instance, but, no, there wasn't nothing. I think, though, that the ability to hold VA employees accountable is greater now and the Secretary certainly has vowed to do that to uphold our highest standards.

Miss GONZALEZ-COLON. What should we do in terms of improving that communication, improving that knowledge to the staffers in terms of their responsibility to notify those elements, to even the state or the National Practitioner Data Base?

Dr. COX. I agree we do need to do a better job of communicating these requirements and of educating those that we put into leader-

ship positions. As you know, we have many new medical center directors and new chiefs of staff, some of them, quite a few of them are acting. And so our pledge is to do more outreach to inform them of these policies and to make available help for them when they face this, again, fortunately, not common situation.

Miss GONZALEZ-COLON. You know that many of our VA medical centers are understaffed and that is happening in Puerto Rico too in our only medical VA center. How are you going to have all those personnel be reeducated and know what they are going to face in terms of reporting this in a properly timed manner?

Dr. COX. That is a great question. I think the focus should be on targeting the people in positions that really need to know this.

Miss GONZALEZ-COLON. Are you doing that right now?

Dr. COX. Yes, yes. We are improving our education efforts, as I said earlier, revising and strengthening our policies, and those revised policies will be communicated and we will make sure that everybody knows what they need to know.

Miss GONZALEZ-COLON. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. BERGMAN. Thank you.

Dr. Roe, you are recognized for 5 minutes, sir.

Mr. ROE. Thank you, Mr. Chairman. And I apologize for being late, I had another Committee I had to go to.

As a physician and veteran myself, I was really alarmed by the GAO findings. And during my medical career, my colleagues and I took great pride in meeting and exceeding quality standards.

And for those of you all who haven't served on a medical staff, what I am hearing here now is really—Dr. Cox, is a Ned in the First Reader. I mean, this is something that every hospital does. You apply for credentials to the hospital staff, they vet your credentials very clearly, and then you are on the staff and you start taking care of patients. And if there are issues that come up, we have an executive committee or a credentials committee that looks at those things and puts a plan out. I mean, any hospital administrator in the world knows that, any chief of staff knows that. I find it astonishing that we have to educate somebody who is a medical center director that that would be something they needed to know about.

Would you please, please answer that, because I found your statement just amazing to me that you would have a medical center director somewhere that wouldn't know something as simple as that.

Dr. COX. Well, Chairman Roe, thank you for the question. I didn't mean to imply that medical center directors don't know about the procedures for applying to medical staffs, being granted privileges, the vetting that goes on at every VA medical center, just as in every other hospital that hires physicians. So, I mean, those are basic and ongoing processes.

What I meant to say is that for the less common, the much less common situations where there are concerns about a provider's clinical practice, where there is contemplation of a need to perhaps report them to the data bank or to their state licensing board, that those processes are less familiar. And so we need to do a better job of making sure are familiar with them.

Mr. ROE. Well, I would think that, and this surprised and shocked me also when I read this, that in five medical centers—this is on five medical centers, the VA has over 150—that 148 providers were looked at and then when only one was actually—do you know how many in the VA—and this is maybe a question you couldn't answer today, but in the entire system have been either reported to the state licensure boards or to the national data bank?

Dr. COX. Well, that is a question that I can't answer completely. Regarding the National Practitioner Data Bank, there are three circumstances when a provider—

Mr. ROE. No, I know those things, but my question—that is not the question, I know those. The question is how many have been, from the VA system have actually been reported, because it looked like that—and my concern is this, look, our hospitals at home, here is a VA and right next door is the hospital that I practiced. What happens if VA doesn't do that and someone then comes to our credentials committee, we don't have this information and we put this doctor on the staff that should not—this provider on the staff that shouldn't have been put on there if we would have had that information? That is the scary part. And that doesn't happen the other way around, that information does go and every doctor that practices medicine now is concerned about that, their name being in the data bank.

Dr. COX. Well, you are absolutely right, that is the core issue here to make sure that providers who are not competent or safe to practice are reported properly.

Mr. ROE. And that didn't happen—

Dr. COX. That didn't happen—

Mr. ROE [continued]. —in this report.

Dr. COX [continued]. —in most of these cases.

Mr. ROE. And we don't know how pervasive it is because we just did a small sample of the physicians in the VA system, just five hospitals, medical centers.

Dr. COX. correct.

Mr. ROE. Well, my commitment to ensuring VA providers adhere to professional standards compelled me to introduce H.R. 4059, and Mrs. McMorris Rodgers may have already talked about this, the Ethical Patient Care for Veterans Act of 2017, along with Mr. Poliquin, and our bill would direct VA to ensure that each of its physicians is informed of the duty to report any impaired or incompetent provider unethical act that requires reporting.

I would think that just should be policy; we shouldn't need a law to do that, that should just be the policy of every VA medical center and we should have some confidence, as Mr. Arrington obviously does not, to carry that out. Would that be reasonable?

Dr. COX. It is entirely reasonable and it is already policy, the problem is we are not enforcing—

Mr. ROE. Not implementing that policy.

Dr. COX [continued]. —the policies the way that we need to.

Mr. ROE. Dr. Chaudhry, for the benefit of all of us gathered here today, would you explain the function of the state licensing board and the importance of VA's communication of privileging actions to state—to communicate those adverse things to a state board?

Dr. CHAUDHRY. Thank you very much, Chairman Roe. The state medical boards play an important function in this country in looking out for the public. Their primary mission by statute at the level of the state and the territory is to protect the public by not only licensing appropriately qualified and trained doctors, but also disciplining them when there is reason to do so.

As I mentioned earlier this morning, we don't know what we don't know. It is a complaint-based system and so it is important for the state licensing boards to have the information from facilities, from providers and others, so that they can investigate and allow due process for the physician, but follow through and do what is appropriate, whether it is a letter of reprimand, a fine, a suspension, a limitation, or ultimately a revocation of license, which they do as well.

Mr. ROE. And my time has expired, but just one last statement. One of the reasons we have such confidence in our medical system is because of our board system, it allows us to make sure that patients understand when they come in that they're going to get the highest quality of care and with no information, you are absolutely right, you can't do your job; am I correct?

Dr. CHAUDHRY. Yes, sir.

Mr. ROE. I am sorry, I exceeded my time. I yield back.

Mr. BERGMAN. Thank you, sir.

I will claim 5 minutes for my time as the Chairman.

Approximately one year ago, a veteran had his leg amputated due to a blockage. This blockage was later determined after the amputation to be caused by plastic packaging mistakenly left in an artery by his VA doctor.

We met with the medical center and the VISN director overseeing that facility recently and they informed us that while the provider is no longer allowed to practice in that VA facility, the doctor still practices in the community. The medical center and the VISN director stated that they could not report this provider's actions to the NPDB or relevant state licensing board because he worked for a contractor and it was the contractor's duty and responsibility to report that provider.

Dr. Cox, or anyone who would like to respond, what prohibits the VA from reporting a contract provider who administers substandard care inside a VA facility?

Mr. WILLIAMSON. Nothing. The contract providers are supposed to be reported just like anybody else.

Mr. BERGMAN. So you are telling us we were lied to, right?

Mr. WILLIAMSON. Yeah.

Mr. BERGMAN. Dr. Cox, GAO's report discusses the focused professional practice evaluation, the FPPE that we talked about earlier, this process which consists of a prospective review of a provider's care over a specified period of time during which the provider has the opportunity to demonstrate improvement in specific areas of concern. Explain to me how VA can take appropriate action against a provider when these reviews are not properly documented or conducted in a timely manner?

Dr. COX. Well, that is a very concerning question and the—I think what GAO found is that in many cases there was no documentation that the review had been done. It is not clear whether

that means that they hadn't been performed at all or whether the review hadn't been saved in the provider's file as it should have been.

So there is another gap there that we need to address and are addressing with our strengthen and revised policy to make sure that facilities understand what seems easily understandable, that when you have paperwork that relates to something as serious as a provider's clinical competence that it needs to be maintained as part of a system of records, kept in their file.

Mr. WILLIAMSON. We also found that not only was documentation missing for almost half, but in 21 cases the reviews weren't done at all. So it was a combination of both.

Mr. BERGMAN. Okay. So, Dr. Cox, you have been in the seat for a very short period of time. Mr. Williamson, you have been here for 40 years, you know, with the GAO. So in either case, is it fair to ask either of you, is what we are talking about here today new?

Mr. WILLIAMSON. Go ahead.

Dr. COX. I would be willing to bet and it is only speculation on my part that these things aren't new and that problems exist in many health systems, including the VA, and have existed for some time. So, periodically we need to reinforce what the rules are, what our expectations are, and that is the situation we find ourselves in.

Mr. BERGMAN. So how do you plan to do that?

Dr. COX. Well, as we have talked about this morning—

Mr. BERGMAN. No, you as an individual, as a naval officer, used to leadership roles, running a hospital, multiple hospitals, command, how do you plan to instill that based upon your position that you are in now?

Dr. COX. Well, I am now in a position to require improved oversight and strengthen our accountability measures. The offices that provide the policy and that perform the medical legal reviews belong to my part of the organization and to Dr. Elnahal, so we are both in a position to make sure that our strengthened policies and our approaches are carried out in a more satisfactory manner.

Mr. BERGMAN. But you are the man at the top of the pyramid right now, right?

Dr. COX. I guess this part of the pyramid, yes, sir.

Mr. BERGMAN. Okay, but the rest of that pyramid that is below you knows that there is a new sheriff in town?

Dr. COX. They do.

Mr. BERGMAN. Okay. Well, I would suggest to you that if they don't, they should get that word right away, because as Dr. Dunn said, failure is not an option, and it comes from the top on down.

And with that, I have just got a couple of seconds here, I am going to yield back the remaining 10 seconds and we are going to go to a second round for anyone else who would like to ask a question.

So, having said that, Ranking Member Kuster, you are good, right?

Ms. KUSTER. I most certainly am.

Mr. BERGMAN. Okay. Mr. Poliquin, you are recognized for 5 minutes.

Mr. POLIQUIN. Thank you, Mr. Chairman, very much.

Mr. Chairman, I would like to submit for the record the testimony from Jake Myrick, our terrific veteran of 15 years who suffered under the care of Dr. Thomas Franchini up at the Togus Medical Center in Maine.

Dr. Cox, I would like to ask you a couple questions, if I can. When you have a situation as I described where a medical center, in this case the Togus Medical Center in Augusta, Maine, knew and confirmed in April of 2010 that in fact Dr. Franchini had botched multiple surgeries on 87 of our veterans, one which resulted in a leg amputation just to relieve the pain. The VA knew about this, the local medical center knew about this in 2010, they did not inform the patients who had been harmed, these 88 patients, until 2013, 3 years later. The statute of limitations is two years.

Now, first of all, I don't think anybody in America would think that it is fair to deny these 88 men and women who served our country in uniform the opportunity to file a claim against the VA, against Dr. Franchini or whomever, they should have their day in court.

So my question to you, Dr. Cox, and possibly to Mr. Williamson, is do you have any evidence or any belief that the VA waited until after the statute of limitations expired deliberately to avoid liability? Mr. Cox?

Dr. COX. Congressman, I know of no such evidence that would suggest that anybody did anything deliberate of that sort.

Mr. POLIQUIN. Mr. Williamson?

Mr. WILLIAMSON. I can tell you that if the situation you described is accurate, that should have been something that would have been a subject of review and a process. I don't understand it either.

Mr. POLIQUIN. Okay. I am thinking, Dr. Cox, what the heck—not me, what you and the VA tells Jake Myrick. You can't give him back the years that he lost with his family while he was suffering depression, had to quit his job. What do you tell April Wood, who as one leg now? You can't return that. Is there a process whereby the statute of limitations language can be excepted? Is there an appeal process, is there something that not only these two warriors, but anybody else who has suffered under this sort of quackery can still file a claim even though the statute of limitations is expired, not because of any fault of theirs, but because of the fault of the VA? Dr. Cox?

Dr. COX. Well, first of all let me say, I am greatly troubled by the stories that you are telling and that I have read about regarding Mr. Myrick, Ms. Wood and the other veterans that were harmed by Dr. Franchini.

Mr. POLIQUIN. Thomas Franchini. Make sure everybody knows who he is.

Dr. COX. And there is no question in my mind from what I know of this case, which as you said is from several years ago, that the medical center didn't do the job that they should have done. They took far too long from the time of discovery around 2009, 2010 of Dr. Franchini's complications and problems of surgery to conduct the review and to eventually, over two years later, report him to



the five states where he was licensed, that is far too long a time and that is not acceptable.

Mr. POLIQUIN. Is there any way to adjust the law such that there is a process whereby they can still file a claim even though the statute of limitations has been exceeded?

Dr. COX. Well, Congressman, I am not a legal expert—

Mr. POLIQUIN. Who could answer that question for me, Mr. Cox?

Dr. COX [continued]. —or an attorney, but I know—

Mr. POLIQUIN. Who could answer that question for me, Mr. Cox?

Dr. COX. I know that there is a U.S. District Court action that is still open and the judge is considering that very question and will hopefully rule soon. I believe—

Mr. POLIQUIN. But there is nothing that can be done within the VA itself if I called Dr. Shulkin about this, no, it is in the hands of the courts now, is that correct?

Dr. COX. As I understand it, correct.

Mr. POLIQUIN. Okay. I yield back my time, Mr. Chairman. Thank you very much.

Mr. BERGMAN. Thank you.

Dr. Dunn?

Mr. DUNN. I just want to very briefly point out that we keep saying that this failure to report to the National Practitioner Data Bank is illegal, it is in fact a crime to not do that. So we have a number of criminals who are veteran's center's directors at this point. I mean, that actually is a Federal crime. You know, I certainly had to operate under that law for 35 years.

I just wanted to underscore, you know, said it is illegal, it is a crime, and I will bet the statute of limitations isn't up on that.

I yield back.

Mr. BERGMAN. Mr. Arrington, you are recognized.

Mr. ARRINGTON. Thank you, Mr. Chairman. Mr. Cox, I want to follow-up on my line of questioning earlier about when did we know, when were you guys aware, when was the VA aware, that this area, this very important area, was without management oversight accountability?

I mean, I don't expect perfection, and I don't think anybody up here does, I don't think the taxpayers, this is a large organization, and I certainly am not perfect, and my organization, even a small one like my office, but I expect consistent delivery on what we promise that we are going to do for people, and in this case, excellent care for our veterans.

So my question, again, is, when was the first time you were aware that in this very important area—and I don't think you would dispute this is critical to the care of our veterans—when did you know this sort of review and reporting was not taking place?

Mr. COX. Well, as I said before, we became aware of these specific cases when the GAO conducted its audit. The—

Mr. ARRINGTON. Did you do an audit prior to the GAO's audit, an internal audit?

Mr. COX. No, there was no internal audit done of this area. The thinking within VA for a long time has been that reporting is a responsibility at the local level and it is, indeed, the medical center director that bears that responsibility. And we—

Mr. ARRINGTON. What responsibility does the secretary and the central office have to make sure that these important controls are in place to make sure that veterans don't get hurt and they are not trapped in a health care system that is so fundamentally broken that they have people that have had adverse actions taken against them, have limited privileges still practicing it?

At what point does Central want to understand that that, in fact, is going on or not going on, and where to shore up where the gaps are? I mean, you were the inspector general for the VHA, why wouldn't that be a regular audit so that we know that we were taking care of our veterans and not putting them at risk?

Mr. COX. Well, I can tell you I certainly am interested in knowing that we are reporting providers appropriately, and now that this has become—

Mr. ARRINGTON. How could you care and not have an audit and wait for the GAO to come in and reveal to the world now how nonexistent the oversight is in this area? I mean, that is the problem. The message to me is, and I know that you do care as an individual, but the VA system doesn't care, the system is the enemy for me right now. The bureaucracy is the enemy to this—to our most precious commodity, our most treasured asset, our wounded warriors, and the system is the enemy. They don't care, or they would have had controls in place, right? So I know to every—

Mr. COX. Right.

Mr. ARRINGTON [continued]. —individual you would say that you care, and I believe you as an individual, but the organization doesn't. And—

Mr. COX [continued]. It does—

Mr. ARRINGTON. Yes, sir.

Mr. COX. I think as an organization, we have for too long entrusted that people are doing the right thing and we haven't checked. I mean, that is what oversight really is, right? Checking to make sure that—

Mr. ARRINGTON. But if it was your son, if it was your spouse, you wouldn't tolerate that. Treat these people like they are your children, treat them like they are your spouse, and we won't need policies, we won't need hearings. Would you agree with that?

Mr. COX. I would.

Mr. ARRINGTON. Okay. Dr. Chaudhry, you have seen a lot of health care systems, no doubt, in your tenure in the current role over these state licensing boards. With respect to the private sector and this particular area of reviewing complaints and then when there are findings reporting that out and taking action against physicians who are incompetent, or acting unprofessionally and unfit to practice, would you say, comparatively speaking, to the folks that you have interacted with on the outside of the VA, for profit or non-profit, that the VA is above the average, the average, or below average, in this area?

Dr. CHAUDHRY. Congressman, based upon the conversations that I have had over the years, and I have been in my role nine years, this is not a brand new issue, we never knew the extent of it—

Mr. ARRINGTON. Brand new issue for the VA or for life, in like all health care systems?

Dr. CHAUDHRY. In terms of the VA—

Mr. ARRINGTON. Okay.

Dr. CHAUDHRY [continued]. —system. So I have heard of anecdotal reports over the years, but my concern is, as what the GAO report suggests, that it may be below.

Mr. ARRINGTON. Okay. Mr. Elnahal, do you represent the central office, the secretary's office, who do you represent here today?

Mr. ELNAHAL. Congressman, I report to Dr. Cox says the head of quality, safety, and value for the VHA.

Mr. ARRINGTON. Okay. Well, I hope Central engages. I believe in this secretary, I really do. I have heard enough from him, engaged enough with him, and I know this President cares about our veterans, and I know he won't tolerate this sort of sub-par organizational management. And so I am hopeful. But it is going to take a lot of time.

And we are going to stay on you, and I am going to stay on you. And then I will help you any way that you tell me you need help. If you need tools you don't have, resources, I know our Chairman will do the same, and I know the Chairman of this Subcommittee feels the same. But we are going to be—we are going to stay on you until this thing is fixed, until you do right by our veterans. With that, I yield back, Mr. Chairman.

Mr. BERGMAN. Thank you. Ms. Gonzalez-Colon, you are recognized for five minutes.

Ms. GONZALEZ-COLON. Thank you, Mr. Chairman. I want to follow-up on my first round. And, Dr. Cox, I mean, what we are talking about, having those directors and those staff being capable and committed to submit that information through the data bank and to the state license. And I asked directly, what do they face if they are not doing their job? You told me directly that the new law provide direct actions from the secretary. Is there any other action?

Mr. COX. I am sorry, I missed the last part of your question.

Ms. GONZALEZ-COLON. Is there any other action that can be—that those employees can face after committing this crime?

Mr. COX. So, no actions have been taken against the medical center directors that were involved in the GAO's audit. We only, in that last few days, became aware of what those centers are. But that process of review and potential disciplinary action is now underway.

Ms. GONZALEZ-COLON. Okay. And we are talking—I mean, this is vague. This is not just only our veterans, which I—it is very disturbing, we are talking also about all patients in the outside community that are receiving the same treatments from the same providers that are actually treating badly our veterans. So this is a very big problem. It is outside the VA, it is (indiscernible) the whole community. And that is the reason we have a database that is the reason we got a state license, to prohibit this kind of conduct to happen.

One of the issues that I want to bring now, and to you. You, in your testimony, you said that you expand the range of the clinic or occupation that should be reported to the national practitioner's database, including other medical professionals aside from the physicians and dentists. How, if you are expanding those, if we can't even comply with the physicians and the dentists?

Mr. COX. Well, the decision to expand the range of health care professionals—

Ms. GONZALEZ-COLON. And I do agree on that.

Mr. COX. Yes, and I agree as well. That decision to expand the range of professionals who will report stems from concerns such as Representative Poliquin described it in Togus, Maine, where the individual involved was a podiatrist not a medical doctor, not a dentist. And so the requirements of the Department of Health and Human Services to report adverse privileging actions—

Ms. GONZALEZ-COLON. But how to comply? If you can't do it right now with the law, what the law provide, and you did this in an administrative sort of way voluntarily, how will you provide for that expansion when you can't do the one that is required by law?

Mr. COX. We certainly can pay greater attention to it enforce our policies, conduct the oversight, conduct the audits—

Ms. GONZALEZ-COLON. You just said—

Mr. COX [continued]. —to make sure that—

Ms. GONZALEZ-COLON. —this is enforcement. I mean, we can have all the policies, but if we can't enforce them, we will have the same problem one again and again. Mr. Williamson, I just want to know what are some of the reasons, if there are any, that the vast majority of providers in your study were not reported to the national practitioner's data bank when required.

Mr. WILLIAMSON. There are a couple reasons that you have mentioned already, some of them. A lot of the staff we talked to didn't know what the responsibilities were that they had responsibility for reporting. And even in the cases where they did, they were confused about what circumstances—under what circumstances they should report. For example, as Chairman mentioned a while ago, there was a misconception among center staff that they shouldn't report contract providers. That is totally false.

Ms. GONZALEZ-COLON. Is there guidelines?

Mr. WILLIAMSON. Yes, it is in their policy.

Ms. GONZALEZ-COLON. It is in their policy. So it is a written statement?

Mr. WILLIAMSON. Correct.

Ms. GONZALEZ-COLON. And they are instructed to do so?

Mr. WILLIAMSON. They asked Central Office and Central Office—somebody in Central Office told them they didn't have to. But it is in the policy, so, you know.

Ms. GONZALEZ-COLON. Just hearsay?

Mr. WILLIAMSON. Yeah. Also, one of the cases where VA didn't report, or one of the medical centers didn't report six people, the medical center director delegated it to the human relations department. That was in the medical center—in the local medical center policy, and when we talked to the human relations department, they were not aware they had that reporting responsibility. It is really outrageous that people are not being told about the responsibilities and don't know their job like they should.

Ms. GONZALEZ-COLON. Thank you, Mr. Williamson. And just to—last question to Mr. Cox. What is going to be happening to the employees from the VA that are having tailored reports with settlements to—reaching settlements that involves the impact of faulty

services? What is going to be happening with those Federal employees? And with that, I yield back the balance of my time.

Mr. COX. So, very briefly. And as mentioned before, any employee that is involved in negotiating an improper settlement will be appropriately disciplined.

Mr. BERGMAN. Thank you. Mr. Peters, you are recognized for five minutes, sir.

Mr. PETERS. Thank you, Mr. Chairman. First, I want to just apologize that the way things work around here is they schedule both your hearings at once, so I was at a energy Subcommittee hearing. And so I am going to ask—I have one question, and I apologize, also, if you have already addressed it, but it is a particular concern of mine, and maybe you will—if you answer it a second time, you will like your second answer better.

I guess to the GAO, I guess the question would be, about the IT system. I want to know if you have had a sense of how the VA's antiquated IT system or the data tracking methods have hindered efforts to provide good provider quality. And I am asking this as a way to suggest or to help the VA get the right kind of IT system that could help better care—achieve better care and more efficient service delivery. And just ask you that if you could respond to that, I appreciate it.

Mr. WILLIAMSON. Well, I have done—my teams have done a wide variety of audits looking at Choice, looking at claims, payments, and a number of other things, and IT is always at the top of the list as far as a root cause for not having good data, not being able to track things, and if you can't—if you don't have good data, and you don't have a system for tracking, oversight is pretty difficult, if not impossible. So, yes, IT on a whole—on a broad kind of scale is probably one of the biggest problems that VA faces.

Mr. PETERS. Are you familiar with what the VA, today, is doing to address that issue? And, do you offer any suggestions for them?

Mr. WILLIAMSON. Excuse me?

Mr. PETERS. Are you familiar with what the VA is, today, doing to address IT? And do you have any suggestions on that?

Mr. WILLIAMSON. Somewhat. That is not my area. And I know they are—have taken a number of actions in the past, some failed attempts to come up with large data systems, right now they are working on it. But I think we have issued a number of reports recently that is talked about some shortcomings, and I think Secretary Shulkin's decision to take an off-the-shelf IT system to remedy the electronic records problem and its operability with DoD, for example, is a good step.

Mr. PETERS. That is my sense, too. I think Secretary Shulkin has put the right emphasis on this, and we don't need to reinvent the wheel here, probably wheel inventing is not our strength, and so I am happy to see that. But just in the time I have remaining, you have particular instances or examples for how the failure of an IT system has affected provider care? More specific examples?

Mr. WILLIAMSON. I am not sure I do. Although in this case, in the case of the audit we are currently talking about, we found that, as far as tracking reviews, the reviews done when care concerns have been raised at the medical center level—

Mr. PETERS. Right.

Mr. WILLIAMSON. —it is very fragmented, you couldn't walk into a medical center and ask for a list of reviews underway when care concerns have been raised. We had great difficulty doing that when we identified our 148 cases. So there is no electronic tracking of that. I mean, if you had an up-to-date modern system, you would do that electronically, you would do it in a central repository in the VA MCs such that if you wanted a list at any time somebody could produce it for it.

Mr. PETERS. Well, thank you for that. Thank you for the work. We talk a lot about accountability in this Committee, we are committed to it. Obviously, you can't achieve accountability if you can't get a sense of whether we are moving in the right direction, you can't keep up with things. So, I appreciate that, look forward to working with the Committee on that. I yield back.

Mr. BERGMAN. Thank you. Dr. Roe, you are recognized for five minutes.

Mr. ROE. I thank you. I will respectfully disagree with Mr. Williamson. Maybe it makes your job a little easier, but I can assure you before there was ever one of these things anywhere near me, we knew how to evaluate our staff, and we know how to keep records, and we knew how to do this. Quality of care has been an issue for years, long before there was a computer chip. It will make it easier to trace, I admit. And, Mr. Peters, I want to—I just got back from Fairchild Air Force Base, and I think this implementation of the Cerner system is going to be a little harder than it thought after visiting out there.

But I guess my question to Dr. Cox, or anyone at the VA, is why would it take a GAO investigation to determine just simple, basic medical staff functions like this? That is what still baffles me is because I don't know why Mr. Williamson was ever needed to go out. This is such a basic function of a medical staff. Credentialing and quality of care in your facility. I mean, that is the thing that I focused on for over 30 years because if people lose confidence in your hospital, they will quit coming there, and they will quit coming to you as a physician if they find that out.

Mr. COX. Well, Mr. Chairman, I agree that it is indefensible, and I can only speculate. I just wanted to point out that these decisions about reporting somebody to the data bank, or potentially taking an action that will affect their license, are never taken lightly, you know. As you know, these are complex and serious matters. You are dealing with professionals who have had years and years of professional training; four years of college, four years of medical school, three to seven years of residency training, maybe more in certain specialties.

And so when the person who has the authority to make that report also has a very serious responsibility, both to the veterans and the rest of the community, but also to bear in mind that that decision could, in fact, impact that provider's livelihood. So that is not an excuse for anything, but it is to point out that when I had to wrestle with these decisions, I wanted to make sure we had all the facts, I wanted to make sure that they were all collected properly, and that my decision was based on sound evidence.

Mr. ROE. Look, I was going to say, I could not agree with you more. I mean, I have been on the credentials committee, and it is

a weighty decision when you have a professional that is there that is spent all these years. I totally get it, there is two sides to this equation.

Mr. COX. Yes, sir.

Mr. ROE. But at the end of the day, we still have, as medical staff people, the patient's safety and quality of care is upmost. And I agree with you, you have to do that. Well, one of the things that is bothered me since I have gotten here is, this bill that Ms. McMorris Rodgers, myself, and Mr. Poliquin have. We make laws because people are not doing their job, and their unnecessary. The bill that we have got it really ought to be unnecessary because if the medical staff had done its job, you wouldn't need to have a law that now complicates things even further, I think.

So I would encourage you, and one of the things I would encourage you to do when you go back, this is not only embarrassing to a great organization like the VA, to the medical profession, to me, it is embarrassing to me as a physician that this went on. But if I were you, I would go back and instruct every VISN director and every medical center director to be sure that that policy was totally understood by my medical staff and how it was carried out. And every hospital has this system set up.

So I would make sure that that every 150 plus those medical centers that checked that box and said we know how to do this, and are doing this—and that is the other thing I want to know is, how many providers have been reported to the national data bank or to the state agencies? I want to get that number and find out how many you have actually done, because it is a big step, I realize that, to do that.

Mr. COX. Well, I agree with you, Mr. Chairman. And that number is not easy to come by now because we haven't been tracking it centrally. We can track—and I can tell you the number and be happy to provide it afterwards—those providers that were subjects of a malpractice claim, right, there is a paid claim or a settlement, we actually do very well with compliance rates in the last three years of 95 to 98 percent in reporting providers who are named in a malpractice case.

But what we have not been tracking, and what we can't easily tell you at this moment is those individuals who were named because of concerns about the quality of care locally where there was an adverse privileging action but not a malpractice claim.

Mr. ROE. This is what I don't want to see happen, I don't want to see, whew, that is not my problem anymore, and then now it is somebody else's problem, because I have dealt with that. And, you know, once you get someone on a medical staff, as you just pointed out Dr. Cox, it is very hard to then dismiss that person from the staff, so you are better off doing your due diligence to start with. And Dr. Chaudhry, he's out there as a state licenser, if he doesn't have that information, he makes a bad decision. So I think it is bad decision, bad decision. And we need to—we have to do, we don't need to, we have to do better. I yield back.

Mr. BERGMAN. Thank you. Dr. Cox, VA has the option to provide orders from its providers, disciplinary boards, to the FSMB when they take action to preclude or limit a provider's ability to practice within the VA. According to Dr. Chaudhry's testimony from 2007

to present, VA has not sent any such reports to the FSMB. Why not?

Mr. COX. I am afraid I am not sure what the situation has been regarding FSMB. You know, regarding the individual state licensing boards, as the GAO pointed out and as we have been discussing, there is no question that we have not been making reports with the frequency that they should have been made.

Mr. BERGMAN. Okay. Dr. Chaudhry, in your testimony you state that many of your constituents, boards have found VA does not report providers in a timely fashion, and that the VA is often unable to adhere to reporting standards outlined in its own guidance. Why do you believe the VA is unable to adhere to its own guidance and standards?

Dr. CHAUDHRY. So I think that question is best answered by the VA, but, as Dr. Cox has indicated, I think it is a local issue, is the best that I can interpret, so all these discussions are helpful in terms of moving forward. If I can make a quick comment, Mr. Chairman, about the FSMB. We have a database of all physicians wherever they are licensed. Increasingly, physicians are licensed in more than one jurisdiction.

The value of the VA sharing that with the FSMB's database is we can share that with all the state boards where that physician who works in the VA is also licensed. So that is it is shared not just for the licensing entity where that physician is licensed but also additional licenses, so that everyone has information. And we have a data sharing agreement with the VA which encourages the VA to do that, and I would be interested in strengthening that recommendation as well.

Mr. BERGMAN. Okay. Mr. Williamson, as you know, it is against the VHA policy to enter into an agreement with a provider stipulating that the VA will not report the provider to the NPDB or state licensing board in return for their resignation, retirement, et cetera. Did you find any evidence of these types of agreements in your review?

Mr. WILLIAMSON. No, we did not. And we looked—we didn't look at the settlement process, per se, we came across two settlements that were in our sample of 148. And as you know, VA policy prohibits the not, you know, they must report even though the settled agreement is reached on some other (indiscernible). That is non-negotiable.

Mr. BERGMAN. Okay. Thank you. Ranking Member Kuster, do you have any?

Ms. KUSTER. I have nothing else.

Mr. BERGMAN. Okay. Well, I did a quick back-of-the-napkin math here, Mr. Williamson. You and I must be similar in age, and so my congratulations to you on the length of your career. Now, how is your health?

Mr. WILLIAMSON. What is that?

Mr. BERGMAN. How is your health?

Mr. WILLIAMSON. It is good. That is why I am retiring.

Mr. BERGMAN. Okay. So, the point is, I look forward to hearing of your relaxing, recharging your batteries, because given the longevity tables for someone in good health, you have at least one more career in front of you. I would suggest do something different



than you have been doing for the last 40 years, it will rejuvenate you.

Mr. WILLIAMSON. That is why my wife tells me, too.

Mr. BERGMAN. I mean, 50 years. I apologize, 50 years. I was doing my math in the Marine Corps and applied it to yours. Maybe 40 years in the Marine Corps seems like 50 years somewhere else. Congratulations to you—

Mr. WILLIAMSON. Thank you.

Mr. BERGMAN [continued]. —and job well done. Thank you, witnesses, for being with us today and sharing your testimony. The panel is now excused.

Today's discussion has illustrated the importance of proper management, of competency, and privileging processes, and the consequences of failed oversight. Healthcare organizations are responsible for validating the competency of their medical staffs through a credentialing and privileging process. These processes are important, essential, and closely tied to reimbursement, accreditation standards, and state and Federal laws. At VA facilities, these processes influence the quality of a facility's workforce which, at VA, determines the quality of the care that veterans receive.

The fact that VA is taking three months to, in some cases, years to review quality concerns is entirely unacceptable. But perhaps more outrageous are the cases where VA uses taxpayer dollars to settle cases with clinicians who have provided sub-standard care to veterans essentially to just make them go away. That is not what my fellow veterans and our constituents deserve.

Ensuring underperforming providers are held accountable is a burden shouldered by the entirety of the American health care system. But as the country's largest integrated health system, VA has a particular responsibility to hold themselves to the highest standards for managing quality and safety concerns.

The testimony presented today highlighted the lack of urgency and the VA's disregard for the domino effect a dysfunctional privileging and reporting process has on its patient population allowing the same concerns to persist year after year. Each of us gathered here today would agree that our Nation's veterans have earned high quality health care.

We would also agree that the VA's ability to deliver quality care in a timely manner depends largely on its actions it takes to review and report potentially questionable actions of the providers it privileges. Therefore, we will continue to track VA's progress closely in addressing the concerns brought forth today, both from the GAO and offered during today's discussion.

Now, I heard early on in the testimony today a phrase—there is a difference between incompetency and unprofessional behavior, and I would agree with you whole heartedly. I would suggest to you that leadership and culture will go a long way towards taking care of unprofessional behavior.

Incompetency is just that, and it is a leader's responsibility, and organization's responsibility at all levels, to self-report and to ensure that if a provider, or anyone, is deemed incompetent after given ample opportunity to bring their performance up to standards that they be dealt with immediately and not continued to be

led down a path that you know, as a leader, they cannot attain that level of competency.

You—I am going to call you Captain Cox here for a minute rather than Dr. Cox or, you know, Acting Assistant Deputy Secretary Cox—you know as a leader of a hospital, you had those—that staff, whether they be the nurses, the doctors, the PAs, the nurse practitioner, whoever was under your command, you knew as the leader at the top of that pyramid in that hospital, you didn't call D.C., you didn't call someone else, you took leadership action because as a captain, as a commissioned officer in the United States Navy, it was your responsibility to hold yourself accountable and, therefore, hold others accountable.

You are the new kid on the block here. You have an opportunity to show what it means to be a true leader to the entire Department of Veterans Affairs as it relates to physicians and providers. Don't miss the opportunity to be a leader. By the way, you may think that you heard a motion from our Committee Members here, that was not a motion that was passion. Passion for the veterans, passion for providing the best medical services possible, and taking no excuses for lack of performance.

And you also heard in several cases that this Committee should not have to create new laws to get the VA to enforce the current laws and policies. They exist, use them. This Committee, as a whole—the Subcommittee as a whole, the Committee as a whole, is so committed to giving the VA every tool necessary, you have to use the tools. If you don't, there will be consequences.

Again, I thank you for being here this morning. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and to include extraneous material. Without objection, so ordered.

Again, I would like to once again thank our witnesses and the audience members for joining us here today. This hearing is now adjourned.

[Whereupon, at 11:59 a.m., the Committee and Subcommittee were adjourned.]

## A P P E N D I X

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### **Prepared Statement of Dr. Gerard R. Cox**

Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee. Thank you for the opportunity to discuss our medical centers' clinical competency reviews, compliance with reporting to State Licensing Boards (SLBs) and the National Practitioner Data Bank (NPDB), and the related Government Accountability Office (GAO) report. I am accompanied today by Dr. Shereef M. Elnahal, Assistant Deputy Under Secretary for Health, Quality, Safety, and Value.

#### **Introduction**

VA has an ethical and moral obligation to our Veterans, agency, and community to report certain providers to the National Practitioner Data Bank and State Licensing Boards. We are taking three major steps to improve clinical competency and reporting: improving oversight to ensure that no settlement agreement waives VA's ability to report providers to NPDB or SLBs; reporting more clinical occupations to the NPDB, instead of just physicians and dentists; and improving the timeliness of reporting. We are also rewriting and updating policies in response to the GAO's report. We are constantly striving for improvement in these areas to make sure our Veterans receive the highest quality of care, which they have earned and deserve.

#### **Reliability of Medical Centers' Clinical Competency Reviews**

If a privileged provider delivers care that triggers concern (from sources including Quality Assurance reviews, patient complaints, coworker concerns, or outcome reviews), VA conducts a review to assess the provider's performance in the area of concern. The purpose of this review is for fact-finding to substantiate if there is a concern related to the provider's clinical practice and to determine any appropriate next steps, while ensuring patient safety throughout the process. Care providers of the same specialty provide an objective review of randomly selected patients that the provider has seen previously. Reviewers are often from other VA medical centers to ensure objectivity of the review. If the information that caused the trigger raises a concern of imminent danger for patients, the provider may be removed from patient care by the Director until the review is complete. The clinical service chief and the executive committee of the medical staff analyze the results of the review. Then, one of three outcomes occur: (1) The concern is not substantiated and no action is taken; (2) There is no egregious finding but the service chief will closely monitor the provider through a Focused Professional Practice Evaluation (FPPE) for Cause to ensure improvement in a noted area; or (3) Take a "privileging action" such as reduction or revocation of privileges to practice in the facility. If a privileging action is recommended, the Medical Center Director reviews and is the final authority on that decision. These reviews are filed in the provider's profile with their ongoing professional evaluation documents.

If the Medical Center Director takes a final privileging action, the clinician is afforded a fair hearing opportunity. There, a panel determines if privileging action was due to substandard care, professional misconduct, or professional incompetence. If the panel determines the privileging action was "for cause," the Director is responsible for ensuring the privileging action is entered into the NPDB reporting database. Clinicians who resign or retire while the investigation is ongoing must still go through a limited hearing process.

#### **VA's Compliance with Reporting clinicians to SLBs and NPDB**

VA currently reports providers to the NPDB in the following three circumstances:

1. Physicians and dentists, when a privileging action (as described above) has been taken due to substandard care, professional misconduct, or professional incompetence.

2. Physicians and dentists, when they resign or relinquish privileges while under investigation.

3. Any licensed provider (other types of clinicians that are licensed to see patients independently, such as psychologists or podiatrists, in addition to physicians and dentists) that is named during the review process for tort claims paid by the agency for any issue with clinical care that they provided.

NPDB only requires the health care industry to report physicians and dentists for adverse privileging actions and resignation while under investigation. VA is voluntarily expanding the range of clinical occupations that we will report. We are doing this because we feel it is the right thing to do for Veterans. Specifically, we will report:

1. All privileged providers to the NPDB for privileging actions resulting from substandard care, professional misconduct, or professional incompetence;

2. All privileged providers to the NPDB for resignation or relinquishing of privileges while under investigation for substandard care, professional misconduct, or professional incompetence.

3. Licensed providers who were terminated from a VA facility for substandard care, professional misconduct, or professional incompetence to the NPDB, thus excluding them from future participation in VA's Community Care programs.

It has always been against VA policy for any management official to negotiate or settle employee grievances such that an explicit decision is reached to not report a provider to NPDB or SLBs when their actions should be reported. VA will improve our management controls to the greatest extent possible to enforce this. At the direction of the Secretary, VA has already begun to require that all employment dispute settlements involving payments of more than \$5,000 be approved by top VA officials in Washington, rather than officials at the regional level. We will expand this review process by including confirmation that there is no negotiation of reporting the provider to NPDB or SLBs if they meet the requirements for reporting. Any VA employee who enters into a settlement agreement waiving VA's ability to report to NPDB or SLBs will be subject to discipline.

In addition to expanding the types of providers that can be reported, VA will improve the timeliness of both the decision-making on whether to report providers and the process of reporting providers to the SLBs, shortening the timeframe of the entire reporting process.

If a clinician is identified as being involved in care resulting in a paid or settled tort claim, they are may submit a written statement about that care. That care and the involvement of all respective licensed practitioners (defined above) are reviewed through the Office of Medical Legal Affairs' (OMLA) paid tort claim review process. The OMLA Review Panel identifies any licensed practitioner who provided substandard care, professional misconduct, or professional incompetence in that care. OMLA notifies the VA facility of the involved providers who must be reported to NPDB. The Medical Center Director is responsible for reporting the named providers to the NPDB within 30 days of the notification from OMLA. Below are statistics on the reports filed with NPDB since FY 2015:

FY	Number	Number Reversed	NPDB Reports required	NPDB Reports Filed	Still within 30 days of notification	Overdue
2015	260	33	227	223 (98%)		4
2016	254	17	237	230 (97%)	2	5

For the time period of October 1, 2016 through June 30, 2017, 236 NPDB reports were required. Of these, 200 reports (82%) have been filed, with the majority of the outstanding reports still within their 30 days for sending of the filed report to OMLA.

### GAO Report

GAO's recently-released report, *VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*, made four recommendations and VA concurred with each of them.

In response to the first recommendation, VA's Office of Quality, Safety, and Value (QSV) will rewrite VA policy to formalize guidance on focused management reviews

and incorporate existing documents relating to the process of addressing clinical care concerns. This is in progress, with a target completion date of September 2018.

For the second recommendation, QSV will rewrite policy to include timeline expectations for the above-mentioned review. The Assistant Deputy Under Secretary for Clinical Operation will issue interim guidance by December 2017, with a target completion date of September 2018.

To respond to GAO's third recommendation, QSV will update the standardized auditing tool to include monitoring of appropriate action taken when clinical care concerns are identified. This update will include a reporting structure to facilitate aggregation of reports to identify trends. This response is in progress, with a target completion date of October 2018.

In response to the fourth recommendation, QSV will update the standardized auditing tool to include monitoring of timely reports to the NPDB, specifically for privileging actions and resignation while under investigation. The tool will also include monitoring of timely reporting of substantial evidence of a failure to meet the generally accepted standard of care. This update will include a reporting structure to facilitate aggregation of reports to identify trends. This response is in progress, with a target completion date of October 2018.

### **Conclusion**

Mr. Chairman, VA is taking three major steps to improve clinical competency and reporting: reporting more clinical occupations to the NPDB; improving the timeliness of reporting; and enhancing oversight to ensure that no settlement agreement waive VA's ability to report NDPB and SLBs. We are also rewriting and updating our related policies in response to the GAO's report. I am proud of the health care our facilities provide to our Veterans and we look forward to upholding that high level of care. Thank you for the opportunity to testify before this subcommittee, I look forward to your questions.

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## **Prepared Statement of Randall B. Williamson**

### **VA HEALTH CARE**

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

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). VA's<sup>1</sup> 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.<sup>2</sup> 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 informa-

<sup>1</sup> 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).

<sup>2</sup> Privileges 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.

tion on a provider's history of substandard care and misconduct.<sup>3</sup> 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 policy requirements and to federal standards for internal control related to monitoring.<sup>4</sup> Further details on our scope and methodology are included in our report.<sup>5</sup> 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

<sup>3</sup>The 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.

<sup>4</sup>GAO, 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.

<sup>5</sup>See GAO 18 63.

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 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.<sup>6</sup> 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 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

<sup>6</sup>When 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.

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.<sup>7</sup> 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.<sup>8</sup> 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.

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

<sup>7</sup>These 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.

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



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](mailto: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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### **Prepared Statement of Humayun J. Chaudhry, DO, MACP**

Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Committee. Thank you for this opportunity to discuss the important role that state medical boards play in the protection of the public and how, working together, we may be able to better protect our veterans and their families. I served 14 years in the U.S. Air Force Reserves as a flight surgeon and have more than a passing familiarity with issues related to the health care needs of military personnel and veterans. My statement today focuses on the Federation of State Medical Boards (FSMB) and how we, along with our 70 state medical and osteopathic member boards of the United States and its territories, are responsible for attesting that physicians, and in most states physician assistants, meet the qualifications necessary to safely practice medicine. I will then share some concerns raised by our member boards from several states and urge that the U.S. Department of Veterans Affairs improve its information sharing processes, especially in terms of alerting state licensing boards, in a timely fashion, of violations by a clinician in the treatment of a patient, or of the disciplinary actions taken by the VA against a clinician. Finally, I will address some legislative solutions introduced in the U.S. House of Representatives and U.S. Senate that will significantly help state medical boards protect patients, both within and outside of the VA system.

#### **About the FSMB**

The Federation of State Medical Boards (FSMB) represents the 70 state medical and osteopathic licensing and regulatory boards—commonly referred to as state medical boards—within the United States, its territories and the District of Columbia. The FSMB supports its member boards as they fulfill their statutory mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals. The FSMB serves as the voice for our nation's state medical boards, supporting them through education, assessment, research and advocacy while providing services and initiatives that promote patient safety, quality health care and regulatory best practices.

#### **About State Medical Boards**

To protect the public from the unprofessional, improper and incompetent practice of medicine, each of the 50 states, the District of Columbia and the U.S. territories have enacted laws and regulations that govern the practice of medicine and outline the responsibility of state medical boards to regulate that practice. This guidance is commonly outlined in a state statute, usually called a Medical Practice Act. Seventy state and territorial medical boards in the United States are currently authorized to regulate physicians.

All state medical boards issue licenses for the general practice of medicine. State licenses are undifferentiated, meaning physicians in the United States are not licensed based upon their particular medical or surgical specialty or practice focus, and certification in a medical specialty is not absolutely required in order to obtain a license to practice medicine. In many states, other health care professionals, such as physician assistants, are also licensed and regulated by medical boards in addition to physicians.

In addition to licensing physicians and other health care providers, state medical boards investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate the rehabilitation of physicians when appropriate. State medical boards also adopt policies and guidelines related to the practice of medicine that are designed to improve the overall quality of health care in the state.

The ongoing duty of a state medical board goes far beyond the licensing and re-registration of physicians. Boards also have the responsibility of determining when a physician's professional conduct or ability to practice medicine warrants modification, suspension or revocation of a license to practice medicine. Boards review and investigate complaints and/or reports received from patients, hospitals, other state medical boards, health professionals, government agencies and professional liability carriers about physicians who may be incompetent or acting unprofessionally, and take appropriate action against a physician's license if the person is found to have

violated the law. State laws require that boards assure fairness and due process to any physician under investigation.

Medical boards devote much time and attention to overseeing the practice of medicine by physicians. When a board receives a complaint about a physician, the board has the power to investigate, hold hearings and impose discipline, including restriction of practice, suspension, probation or revocation of a physician's license, public reprimands and fines.

While the overwhelming majority of patient-physician interactions that occur each day in the United States are conducted in an appropriate and professional manner, state medical boards recognize that issues such as physician negligence, incompetence, substance abuse, fraud and sexual misconduct exist. These issues are taken very seriously by state medical boards, which in recent years have advocated for strengthened reporting requirements to ensure individuals or organizations who are aware of, or witness, inappropriate behavior come forward to report the problem. Physicians, hospitals, law enforcement agencies and consumers all can help reduce future issues by reporting inappropriate behavior.

To help address the issue of under-reporting, the Federation of State Medical Boards House of Delegates unanimously adopted new policy in 2016 that urges physicians, hospitals and health organizations, insurers and the public to be proactive in reporting instances of unprofessional behavior to medical boards whenever it is suspected. Consumers must feel safe and secure in any medical interaction, and they should always speak up if they suspect inappropriate behavior.

#### **How State Medical Boards Share Information about Disciplined Physicians**

All of the state medical boards engage in an ongoing, cooperative effort to share licensure and disciplinary information with one another by regularly contributing data to the FSMB's Physician Data Center (PDC) - a comprehensive data repository that contains information about the more than 950,000 actively licensed physicians in the United States, as well as board disciplinary actions dating back to the early 1960s.

State medical boards use the Physician Data Center in several ways. Boards query the Data Center when new physician applicants apply for medical licensure in a state to identify any prior disciplinary actions. The Data Center also proactively alerts boards if an applicant has been disciplined in another jurisdiction via its Disciplinary Alert Service within 24 hours after a disciplinary action has been reported to the Data Center. This valuable service helps prevent disciplined doctors from practicing undetected across state lines.

#### **VA and FSMB Data Sharing Agreement**

The VA currently utilizes two related services provided through the FSMB's Physician Data Center (PDC), and enjoys a positive working relationship with both the department's IT and operational leadership at the FSMB.

The first service, a disciplinary alert service, utilizes a file of VA health practitioners to cross-reference against any sanctions provided by state medical boards and other PDC reporting entities. In the event an order is received by the PDC against any of the individuals contained in the VA practitioner file, an alert is sent to the VA notifying them of the action taken against their practitioner by another regulatory agency. The VA currently has 58,175 names (as of 11/15/2017) in their monitoring file. This file and this service is based on VA needs and may fluctuate based on the number of practitioners within the monitoring program.

In 2017, there were 219 disciplinary alerts sent to the VA under this arrangement, which we believe has been ultimately helpful to the VA in protecting veterans and their families.

The second service, FSMB's PDC Query Service, is a transactional query performed at the request of each of the VA's medical credentialing centers (142 including 1 in Puerto Rico) for the purpose of obtaining full PDC Profile Reports about individual health care practitioners. This PDC Profile Report is a comprehensive document identifying any previously recorded disciplinary actions taken by PDC reporting agencies in addition to a medical licensure history and a listing of currently active licenses held by the physician.

In 2016, the VA queried 10,233 practitioners and in 2017 thus far, they have queried 8,345.



### **The VA and State Medical Boards - Notification, Communication, and Reporting**

The FSMB applauds the noble mission and dedication of the VA in serving the nation's veterans, and we believe strongly that veterans and their dependents deserve the same level of quality care and appropriate regulatory oversight and accountability that is available to the general public.

The FSMB read with concern the October 11, 2017 USA Today investigative story, VA conceals shoddy care and health workers' mistakes. The goal of improving communication between the VA and state medical boards continues to be one of the utmost importance to the FSMB and our membership. While we are very pleased that the VA, through our Physician Data Center, has had access to comprehensive licensure and disciplinary information about physicians who work for the VA, I am afraid there is room for improvement with regard to the sharing of detailed information from the VA to the state medical boards that would expediently and efficiently identify unsafe providers operating within the VA system. The dearth of timely information sharing with state medical boards is certainly not unique to the VA - hospitals, health systems, medical directors and physicians themselves should do a better job of sharing concerns about incompetent or unprofessional doctors - we note that the VA has specific policy in place requiring such sharing.

According to a Government Accountability Office (GAO) report issued this month, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, "VHA policy requires VAMC (VA Medical Center) directors to report providers-both current and former employees-when there are serious concerns about the providers' clinical care to any SLB (state licensing board) where the providers hold an active medical license. Specifically, VHA policy requires VAMCs to report providers who so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. According to VHA policy and guidance, the SLB reporting process should be initiated as soon as it appears that a provider's behavior or clinical practice fails to meet accepted standards. VAMC officials are directed not to wait to report to SLBs until adverse privileging actions are taken because an SLB conducts its own investigation of the provider to determine whether licensure action is warranted. This reporting process comprises five stages as established in VHA policy, and VHA policy states that the process should be completed in 100 days."

In this report, the GAO "found that from October 2013 through March 2017, the five selected Department of Veterans Affairs (VA) medical centers (VAMCs) did not report most of the providers who should have been reported to the National Practitioner Data Bank (NPDB) or state licensing boards (SLB) in accordance with VHA policy. GAO found that:

- selected VAMCs did not report to the NPDB eight of nine providers who had adverse privileging actions taken against them or who resigned during an investigation related to professional competence or conduct, as required by VHA policy, and
- none of these nine providers had been reported to SLBs."

In consultation with several state medical boards over the past few years, we have found confirmation of our concerns that the VA often does not always alert state medical boards in a timely fashion of violations, disciplinary actions, or suspected violations of the state's Medical Practice Act. While the VHA Handbook speaks to certain notification requirements, in practice we have determined that the VA is often unable to adhere to these standards. It is important to note that each state's VA facilities and their relationships with their state medical boards vary but there are enough concerns, too often in too many states, to warrant a comprehensive solution.

One state medical board shared with us that "When we are alerted and attempt to investigate, we find it extremely difficult to gain any information from them (the VA) even if we follow their exact procedure to gain such information. Material received is so heavily redacted it is of little usefulness."

From several recent conversations with executive directors of state medical boards, it appears to be rare for a state medical board to receive "up front" information from the VA, and often this is well past the 100-day notification requirement. If any information is received, from what we have heard, it is often a vague notification which may or may not even have the name of the health care provider. Occasionally a state medical board may receive information through informal channels, but there typically is not a formal proactive information exchange as called for in VA policy. In some instances, a state medical board will send a request letter, and the VA facility will then provide what appears to be a portion of the disciplinary

file on the provider. In one state, the board only receives a copy of the final hospital disciplinary action without any of the details. Another state board said that it usually learns of improper medical care at a VA facility only after a patient complaint has been filed with it.

Such identified gaps in communication between state medical boards and the VA is of significant concern to the FSMB, and we sincerely hope that we can all work together - the state medical boards, the VA, and Congress - to address this issue and overcome any perceived impediments. Improved sharing with state medical boards of detailed disciplinary information that expediently identifies unsafe providers will significantly help the boards protect patients, both within and outside of the VA system. Providers who have been deemed unqualified or unsafe to practice by the VA should not be allowed to practice outside of the VA, nor be able to conceal their disciplinary actions with discreet settlement arrangements. Proper notification of provider disciplinary proceedings from the VA to the appropriate state medical board(s) and the National Practitioner Data Bank (NPDB) will help ensure that unsafe and dangerous physicians are not allowed to treat patients outside of the VA.

### **Federal Legislative and Regulatory Solutions**

The FSMB commends the U.S. House of Representatives and the U.S. Senate for recognizing deficiencies in information sharing and moving swiftly to rectify them with legislative solutions.

The FSMB would like to take this opportunity to formally endorse H.R. 4059, The Ethical Patient Care for Veterans Act of 2017, introduced by House Committee on Veterans' Affairs Chairman Phil Roe, M.D. (R-TN-1), House Republican Conference Chair Cathy McMorris Rodgers (R-WA-5) and Congressman Bruce Poliquin (R-ME-2). This important legislation directs the Department of Veterans Affairs to ensure that each VA physician is informed of the duty to report any covered activity committed by another physician that the physician witnesses, or otherwise directly discovers, to the applicable state licensing authority within five days.

This month, the FSMB also endorsed S. 2107, Department of Veterans Affairs Provider Accountability Act, introduced by Senators Dean Heller (R-NV) and Joe Manchin (D-WV), which would require the Under Secretary of Health to report major adverse personnel actions involving health care employees to the National Practitioner Data Bank and to applicable state licensing boards.

In recent years, the FSMB has also endorsed S. 1641, The Jason Simcakoski Memorial Opioid Act and then The Comprehensive Addiction and Recovery Act of 2016 (Public Law No: 114-198), specifically Sections 941 and 942.

Section 941 ensures that as part of the hiring process for each health care provider considered for a position at the Department of Veterans Affairs, the Secretary of Veterans Affairs shall require from the medical board of each State in which the health care provider has or had a medical license:

(1) information on any violation of the requirements of the medical license of the health care provider during the 20-year period preceding the consideration of the health care provider by the Department; and

(2) information on whether the health care provider has entered into any settlement agreement for a disciplinary charge relating to the practice of medicine by the health care provider.

Section 942 further requires that, with respect to each health care provider of the Department of Veterans Affairs who has violated a requirement of the medical license of the health care provider, the Secretary of Veterans Affairs shall provide to the medical board of each State in which the health care provider is licensed detailed information with respect to such violation, regardless of whether such board has formally requested such information.

Legislative approaches such as these, and others, will play a vital role in protecting the public, and providing state licensing boards with timely information that can be utilized to fulfill their regulatory duties.

The FSMB also offers its support for the four recommendations provided in the GAO report, including:

- The Under Secretary for Health should specify in VHA policy that reviews of providers' clinical care after concerns have been raised should be documented, including retrospective and comprehensive reviews. (Recommendation 1)
- The Under Secretary for Health should specify in VHA policy a timeliness requirement for initiating reviews of providers' clinical care after a concern has been raised. (Recommendation 2)
- The Under Secretary for Health should require VISN officials to oversee VAMC reviews of providers' clinical care after concerns have been raised, including ret-

respective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool. This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner. (Recommendation 3)

- The Under Secretary for Health should require VISN officials to establish a process for overseeing VAMCs to ensure that they are reporting providers to the NPDB and SLBs, and are reporting in a timely manner. (Recommendation 4)

The FSMB is pleased to learn that, in terms of Recommendation 4 specifically, that the “VHA will update the standardized audit tool used by the Veterans Integrated Service Networks (VISNs) so that it directs them to oversee reviews of providers’ clinical care after concerns have been raised and to ensure timely reporting to the NPDB and SLBs. According to VA, the revised tool will also facilitate aggregate reporting by VISNs to identify trends and issues. VA estimates that it will complete these actions by October 2018.”

### **Conclusion**

Mr. Chairman, thank you for the opportunity to testify before the Committee today. The Federation of State Medical Boards (FSMB) welcomes the opportunity to work with the Committee on this important issue, and commends the Committee for its bipartisan leadership. I look forward to responding to any questions you and Members of the Committee may have.

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## **Statements For The Record**

### **Kenneth (Jake) Myrick Statement**

Dear Chairman Roe, Ranking Member Walz, and members of the House Veterans’ Affairs Committee,

My name is Kenneth Myrick and I very much appreciate the opportunity to submit this statement to the House Veterans Affairs’ Committee. Thank you for holding this important hearing and letting me share my story with you. I hope it will lead to legislation that will prevent what happened to me and the 87 other Maine veterans from ever happening to any other veterans ever again. I would like to thank Congressman Bruce Poliquin for his work on this. This issue must be addressed and that is why I reached out to him about this. Maine veterans are fortunate to have him fighting for us in Congress.

Veterans like myself serve in the United States military out of a sense of duty and honor to our country that we love. When we return home from the battlefield, we place our trust and faith in the VA to help take care of our service connected injuries and ailments. Regretfully, this trust and faith have been shattered for myself and the 87 other Maine veterans who received substandard care from Dr. Thomas Franchini at Togus Medical Center in Augusta, Maine.

I would like to share my story with you. I enlisted in the United States Army in 1998 and was medically discharged in November 2003 after undergoing a high tibia osteotomy (HTO) to correct knee problems suffered while on active duty.

In 2004, I began to notice an increased pain, discomfort and instability with my left ankle. I was referred to Dr. Thomas Franchini, a foot surgeon at Togus from my VA primary care physician. After a thorough examination, Dr. Franchini determined that my left ankle had undergone structural changes in order to compensate for my left knee alteration and was also a contributing factor to my ongoing knee pain. He recommended that I have corrective surgery, which I did shortly after. Dr. Franchini performed the surgery in 2005.

Between 2005 and 2010, I continued to experience severe ankle pain, discomfort and instability. I continued seeing Dr. Franchini for this problem. During this time, he recommended orthotics, ankle braces, x-rays, and ultimately diagnoses the problem as a bone spur and recommended another surgery.

During this time, I also began experiencing severe pain in my left knee, left hip, and lower back. There were days when I could not get out of bed due to the pain. I had to leave my job as a corrections officer because I could not keep up with the physical requirements for the job. I could not teach my son football, basketball or any other sports because of the pain they would cause. I had to stop running and biking. I missed out on hunting trips with my son and brother because I could not carry my gear and pack through the weeks. I could not take my little girl to the playground. My quality of life became so limiting, and I became severely depressed.

In February of 2013, I received a phone call from Togus asking if I would participate in a reevaluation of my left ankle surgery. I agreed and was seen by Dr. Sang at Togus shortly thereafter.

Following the evaluation, I met with Togus Director Ryan Lilly, at his request, to discuss the outcome of the evaluation and care provided by Dr. Franchini. I met with Director Lilly on March 25, 2013. During this meeting, Director Lilly and his staff told me that the care I received from Dr. Franchini failed to meet the standard of care required, thus resulting in failed ankle reconstruction and the direct cause of my continuous pain and discomfort I had been experiencing for several years. It was also explained that the surgery is what led to the deterioration of my left knee, hip, and lower back. During this meeting, Director Lilly apologized and gave me two legal forms should I want to bring action against the VA- a 1151 claim form and a tort claim form.

As I would later learn, both of those forms would be useless to me because of the two-year statute of limitations for filing medical malpractice suits in the State of Maine. I also learned that the VA knew in 2010 about the substandard care I received by Dr. Franchini but chose to withhold that information from me for three years. I also have learned that the VA did this with the other 87 Maine veterans as well. I am attaching an internal VA memo that clearly shows that the VA knew about this in 2010 and did not tell me.

I lost with my family-with my children— because of the substandard care I received and because it was concealed from me. I can never get that back and it will haunt me for the rest of my life.

I have had several surgeries to repair the physical pain caused by Dr. Franchini. The pain will never fully go away-I will never be able to run again or lead a physically active life-but I have learned to live with it.

As a father, I will always carry the emotional pain with me and the time I missed out on with my children. It tears me apart to think that this all could have been prevented if Dr. Franchini had been held to the proper standard as a VA physician and if I had known about the botched surgeries rather than having them hid from me for years.

Thank you for your time. I hope you will do something to address this.

Sincerely,

Kenneth (Jake) Myrick

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## VHA ISSUE BRIEF

### VISN 1 - VA Maine HCS, Augusta, ME

**Issue Title:** Concern Regarding Staff Podiatrist with the potential for leading to Institutional Disclosure

**Date of Report:** April 16, 2010, updated April 12, 2012, updated April 16, 2012

**Brief Statement of Issue and Status:** On December 10, 2009, the Chief of Staff received a written communication from a staff Comp and Pen Examiner raising concerns regarding the clinical care provided by a Staff Podiatrist. These concerns were based upon the statements of several veterans during Comp and Pen exams who complained of “poor outcomes” following surgical interventions for ankle instability and who states that they were “refusing to see this podiatrist again.” The Comp and Pen Examiner states that a review of these Veterans’ records appeared to indicate that surgical intervention was occurring following minimal evaluation. The Chief of Staff communicated this concern to the Chief of Surgery in late December 2009 and requested that a focused review of the provider’s ankle and foot surgeries be undertaken.

#### **Actions, Progress, and Resolution Date:**

1. On March 29, 2010, the Chief of Surgery informed the Chief of Staff that he was nearing completion of a review of a random selection of 25 surgical cases, and that there appeared to be “significant documentation and quality of care issues in a number of these cases.” The final report of this review was provided to the Chief of Staff on April 13, 2010.

2. The Executive Leadership Team and Risk Manager were informed of this situation on March 29, 2010. The Director informed the Chief Medical Officer of the situation on this same date.



3. On March 29, 2010, the Chief of Staff requested the Podiatrist be asked to voluntarily suspend performance of all surgical procedures during a period of a more extensive review of the initial cases and other cases.

4. The Podiatrist agreed to this upon return from leave on April 1, 2010. A written statement to this effect was signed by the provider on April 16, 2010.

5. On March 29, 2010, the Chief of Staff, Chief of Surgery and Risk Manager met with the Chief of Podiatry and decided to request case reviews by the Chief of Orthopedic Surgery at the VA Boston Healthcare System and by a podiatrist recommended by the Director, Podiatric Services, VHA Services. This review is underway.

6. On April 15, 2010, the Chief of Orthopedics from VA Boston HCS completed a review of randomly selected charts that confirmed the preliminary findings of our Chief of Surgery including:

- Very poor documentation of clinical assessment or justification for surgical intervention
- Surgical intervention that appeared to be unjustified by the nature or severity of the clinical problem
- Cases in which it appeared that an improper or inadequate procedure was performed for the clinical problem

A written report of findings will be provided in the very near future.

7. On April 15, 2010, the Chief of Staff consulted with Regional Counsel to update him on the status of the focused reviews. It was agreed that all these reviews would be presented to the Professional Standard Board on April 27, 2010, for action. Consideration of formal reduction or revocation of clinical privileges will occur at that time, when all reviews have been completed.

8. At this time it is considered to be likely that a significant number of Veterans treated by the podiatrist will require re-evaluation and treatment by a foot and ankle specialist. It is also considered likely that institutional disclosure of unnecessary or inappropriate surgical interventions will be required.

**Indicate if Applicable:** place an "X" next to the response reflecting the facilities action

- **Institutional Disclosure** —X— Yes; —NO; —N/A  
(Final decision to disclose will be based on a case by case review)
- **Clinical Disclosure**—Yes; —NO; —N/A

#### **Updated April 12, 2012;**

9. On April 27, 2010, the Professional Standards Board reviewed the results of the focused reviews and made the decision to summarily suspend the podiatrist's privileges pending a comprehensive review of the allegations. The provider was placed on administrative leave during this process.

10. On April 28, 2010, the podiatrist received a letter letting him know his privileges had been summarily suspended and he was being placed on administrative leave pending completion of comprehension review.

11. On May 26, 2010, the Chief of Staff received the case review summary conducted by Podiatrist from VAMC, Palo Alto, California

12. On June 17, 2010, the podiatrist was notified of the proposed removal and revocation of clinical privileges in accordance with personnel management guidance on such matters.

13. On September 1, 2010, an Alert Notice was sent to the Physicians State Licensing Boards (SLB) Maine and New York notifying them of an issue of clinical competence with an unnamed provider. However, Rhode Island was not notified at that time. (additional information on this process reference in #31 and #34)

14. On September 28, 2010, letter received from NY SLB stating no further action to be taken on their part.

15. During the period from June 17 to November 1, 2010, the facility responded to several inquiries from the provider's legal counsel including providing de-identified case specific information in support of the allegations.

16. On November 8, 2010, the podiatrist resigned.

17. On November 19, 2010, podiatrist received an advisement notice that further review of this situation was in progress and could result in reports to applicable licensing boards.

18. On November 29, 2010, the Chief of Surgery was asked to begin institutional disclosure in a face-to-face discussion with each Veteran for the cases identified in the process of revocation of clinical privileges on this provider (the initial 25+ cases).

19. On December 9, 2010, the Chief of Surgery was provided a list of all the surgical cases performed by this podiatrist from the period of 2004 to 2010, to assist in a systematic review process.

20. On January 6, 2011, a letter was received from podiatrist's attorney suggesting defamatory comments were being made against him to outside hospitals in New York where he was attempting to obtain privileges. In fact, requests for previous employment history and assessment of standing related to privileges were responded to by the Chief of Staff factually, expressing provider had his privileges suspended pending investigation of substandard care. Medical Staff Coordinator was informed that all requests of this nature were to come to the Chief of Staff.

21. On January 20, 2011, the Chief of Surgery provided the Chief of Staff a more detailed summary of six cases from the original 25 that were the most egregious and were to be used in the report to the State Licensing Board. After review by the Chief of Staff, this summary was provided to HRM ER/LR Specialist to be utilized in the preparation of the appropriate notification to the Maine State Board of Licensure.

22. On February 22, 2011, a request was received from the podiatrist's attorney request copies of any reports to their hospitals, to state licensing boards and to NPDB. To this point, no formal reports to licensing boards or NPDB naming this provider had been submitted.

23. On September 23, 2011, Chief of Staff was informed by the Chief of Surgery that he had started the more formal review of all the surgical cases performed by this provider, including a sampling of non-operated patients (clinic visits only). He was asked to strictly focus on the surgical cases at this point.

24. On October 3, 2011, an Intent to Report notice was mailed to the podiatrist.

25. On October 12, 2011, reply received from the podiatrist requesting additional response time and a copy of the evidence file.

26. On October 26, 2011, the Chief of Surgery communicated with the Chief of Staff his desire to step down as Chief on January 1, 2012, pending his retirement to be effective February 29, 2012, and focus his attention on completing the review of cases. This did not occur as the Associate Chief, a general surgeon was unable to relinquish more of his clinical duties to take on the Acting Chief responsibilities.

27. As of March 13, 2012, The Chief of Surgery (Orthopedics specialty) continues his review of the surgical cases performed by the podiatrist spanning the years of 2004–2010. To date, all of the cases from 2009–2010 have been reviews; a total of 103 cases. Of the 103, approximately 30 of them are problematic, with 6 of the 30 being the most egregious. The review of 2008 cases is underway at this time. There are a total of 589 cases that will be reviewed.

28. At this time it is considered to be likely that a significant number of Veterans treated by the podiatrist will require re-evaluation and treatment by a foot and ankle specialist. It is also considered likely that institutional disclosure of unnecessary or inappropriate surgical interventions will be required. If the current review outcomes are maintained, approximately 30% of the 589, namely 175+ cases may require institutional disclosure under the following charges:

a. Repeated surgical cases in which non-operative alternatives were not employed resulting in inadequate informed consent for surgery and probably unnecessary surgical procedures.

b. Repeated surgical cases in which pre-operative evaluation was either missing, inadequate, or contradicted by studies performed; again making it probable that unnecessary surgery was performed.

c. Repeated surgical cases in which post-operative follow-up case was inadequate.

d. Repeated examples of inadequate surgical procedures leading to poor outcomes, and no evidence of patient disclosures when indicated.

29. On March 20, 2012, Chief of Surgery provided to the Acting Director and Chief of Staff a summary of this methodology used to conduct the review of surgical cases.

30. On March 21, 2012, the HRM ER/LR Specialist verified that Maine SLB received a copy of our September 1, 2010, Alert Notice.

31. On March 22, 2012, the HRM ER/LR Specialist received verification via e-mail that Rhode Island did not receive a copy of the September 1, 2010, Alert Notice.

32. On March 23, 2012, VA Maine HCS Acting Director, Chief of Staff, HR Employee Relations/Labor Relations Specialist, Medical Staff Coordinator, Risk Manager, and Staff Assistant to the Director held a conference call with Director of Credentialing, VA Central Office, to discuss our intent to submit Adverse Action Information to the National Practitioner Data Bank on this Podiatrist, at which time the Acting Director and Medical Staff Coordinator were informed that VHA Handbook 1100.17, page 2 states the VA is only required to report adverse actions regarding physicians and dentists. The Handbook states the Agency has a MOU on file with the NRDB that releases VA Hospitals from the requirement to report adverse actions regarding other health care providers.

33. On March 26, 2012, the HRM ER/LR Specialist received the request from Maine SLB requesting follow-up information regarding September 1, 2010, Alert Notice.

34. On March 28, 2012, the HM ER/LR Specialist contacted the Maine SLB explaining that the Alert Notice previously sent to them should have gone to the Board of Podiatric Medicine, not Physician Licensing Board. This has been corrected for all States involved (Maine, Rhode Island and New York) and new Alert Notices sent on March 29, 2012.

35. On March 20, 2012, meeting to brief Acting Medical Center Director on Practice issues related to this podiatrist and actions to date, included COS, Risk Manager, Regional Counsel, and HR ER/LR Specialist. Acting Medical Center Director concerned over delays in reviews and disclosures. We called Network Office - spoke with Chief Medical Officer to brief him on situation.

36. On March 21, 2012, Acting Director met with involved staff regarding out failure to report to NPDB. Met with HR Specialist regarding out error in sending Adversiment Notices to the Physician State Licensing Boards.

37. On March 22, 2012, briefed VISN 1 Chief Medical Officer on the status of this situation. Met with COS and HR to discuss further errors in State Licensing Board notification. Met with Chief of Surgery and Chief of Staff to discuss findings of case reviews

38. On March 23, 2012, met with involved staff regarding current status of NPDB and SLBs reporting process. Held a conference call with National Director of Credentialing to discuss NPDB and SLB reporting process

39. On March 28, 2012, met with Chief of Surgery to review findings of additional year of surgical cases reviewed.

40. On March 29, 2012, additional error found in original SLB notifications - Adversiment Notices redone and sent to appropriate Boards of Podiatric Medicine in three involved states.

41. On March 30, 2012, met with Patient A for disclosure and apology - current unassociated medical condition is terminal; COS and Regional Counsel involved in institutional disclosure meeting.

42. On April 2, 2012, Joint Commission arrived unannounced and onsite for five days. No findings regarding medical staff credentialing and privileging cited by Joint Commission.

43. On April 5, 2012, met with Regional Counsel, New England and Local Regional Counsel to discuss case specifics.

44. On April 9, 2012, met with involved staff regarding letter received from podiatrist's attorney to determine level of response needed.

45. On April 10, 2012, spoke with VISN 1 Chief Medical Officer indicating the plan to contact National Director of Risk Management for Guidance. Held conference call with National Director of Risk Management for guidance. Held conference call with National Director of Risk Management seeking new guidance on disclosure process. Held conference call with Acting Chief Medical Officer, VACO

Operations and Management and provided case specific information. They provided instructions Regarding next steps.

46. Action Plan as of April 12, 2012; in the discussion with the Acting Chief Medical Officer, Operations and Management in VA Central Office on April 10, 2012, the plan as

Of this date is as follows:

- summaries of all record reviews completed to date will be scanned and e-mailed to her attention no later than April 18, 2012
- a tentative date of April 20, 2012, has been set for the Subject Matter Expert Panel (SME) to convene
- the facility will await further guidance from the Acting Chief Medical Officer, Operations and Management
- for any activities regarding State Licensing Board reporting, the facility will seek guidance from the Director, Credentialing and Privileging, VA Central Office before taking any action.

47. In early March 2012, prior to this issue surfacing, VISN 1 revised their process for ensuring follow up of issue briefs with open items which should receive follow up. Whenever an open item for which follow up is expected, a task is created in our VISN Tasking system with the due date based on expected follow up. The task is then assigned to appropriate party for action. If response is not received by the due date, VISN staff now follows up with responsible party to ensure needed action is taken.

48. VISN 1 is in the process of reviewing all issue brief from the past three years to Ensure all expected follow up actions have in fact taken place.

**Updated - April 16, 2012:**

**What date was the Staff Podiatrist hired at Togus VAMC and on what date did he perform his first surgical Procedure?**

Response: April 18, 2004; first surgical procedure performed on May 21, 2004

**Did the Staff Podiatrist work at any other VAMC in the past?**

Response: His employment history does not indicate he has worked at another VA Medical Center.

**Is 589 the total number of surgical procedures performed by the Podiatrist between 2004–2010?**

Response: Yes

**To date, how many of the surgical procedures performed by the Podiatrist have been reviewed for indications and outcomes?**

Response: 173

**What is the current plan to review the remaining patient records and when is this anticipated to be completed?**

Response: The Orthopedist (former Chief of Surgery) who has been doing this review will return on Tuesday, April 17, 2012. He will be working for us two days per week on a fee basis (retired on 3/31/2012) with primary focus to be the completion of these case reviews. He is a foot and ankle specialist. It is difficult to judge the time frame for completion at this point. We will have a conversation with him upon his arrival on April 17 to get a better sense of time to completion.

**Has a master list been created (contact, date of procedure, whether seen in follow-up) of all Veterans who have received a surgical procedure?**

Response: We have been working with a master list and will be adding to it the contact information and dates of follow-up.

**Please confirm that only 1 institutional disclosure has been provided to date.**

Response: On March 30, 2012, one institutional disclosure was completed and has Been documented in the Veteran's medical record.

**Please confirm that the Chief of Surgery engaged in this review has retired and'**

**No longer active at Togus VA.**

Response: The Chief of Surgery did retire; however, as noted in #5 above, he will be returning on a fee appointment April 17, 2012, to continue the case reviews.

**As of today, who is actively engaged in reviewing the remaining cases?**

Response: Please refer to #5 above.

“The Handbook states the Agency has a MOU on file with the NPDB that releases VA Hospitals from the requirement to report adverse actions regarding other health care providers.”

**Question: Does this preclude VA from reporting such adverse actions? If not precluded, is the decision local? Or would it require national policy?**

Response: Please see response provided by Kate Enchelmayer -

In accordance with VHA policy and VA regulation for reporting to the NPDB. VA only reports adverse actions on physicians and dentists. This is national policy and regulation. The reason for this is that the Health Care Quality Improvement Act which established the NPDB requires the reporting of adverse actions on physicians and dentists and allows that the adverse actions on other health care providers MAY be reported. The HQIA requires the Secretary of HHS to enter into an MOU with VA (and other Federal health care entities) for participation in

VA. Back in 1990 when the MOU was being negotiated and the implementing Regulations were written (and subsequently revised) VA elected to follow the HCQI in requiring reporting of adverse actions on physicians and dentists only.

Since it is discretionary throughout the industry, VA did not want to require the reporting of adverse actions on other health care providers. Additionally, a national reporting standard had to be established which follows the required reporting requirements of the statute. It is not reasonable to allow discretion across the Agency since one facility might report all adverse actions, and another would only report those that are required.

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## Questions For The Record

### Letter From Chairman Jack Bergman to VA

Secretary  
U.S. Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Secretary Shulkin,

Please provide written responses to the attached questions for the record regarding the Subcommittee on Oversight and Investigations hearing entitled, “Examining VA’s Failure to Address Provider Quality and Safety Concerns” that took place on November 29, 2017. In responding to these questions for the record, please answer each question in order using single-spaced formatting. Please also restate each question in its entirety before each answer. Please provide your responses by the close of business on Friday, January 12, 2018. Answers to these questions for the record should be sent to Ms. Hillary Dickinson at [Hillary.Dickinson@mail.house.gov](mailto:Hillary.Dickinson@mail.house.gov) and to Ms. Grace Rodden at [Grace.Rodden@mail.house.gov](mailto:Grace.Rodden@mail.house.gov), copying Ms. Alissa Strawcutter at [Alissa.Strawcutter@mail.house.gov](mailto:Alissa.Strawcutter@mail.house.gov).

If you have any questions, please do not hesitate to have your staff contact Mr. Jon Hodnette, Majority Staff Director, Subcommittee on Oversight and Investigations, at 202-225-3569.

Sincerely,

Jack Bergman  
Chairman  
Subcommittee on Oversight and InvestigationsCJB/hd  
Cc: Ann McLane Kuster, Ranking Member  
Attachments

Questions from Chairman Jack Bergman

1. VA stated that medical center directors are ultimately responsible for ensuring that clinicians who receive adverse privileging actions are reported to the National Practitioner Data Bank (NPDB). The Government Accountability Office (GAO) found

that, in the facilities it reviewed, the majority of clinicians who should have been reported (eight out of nine) were in fact not reported. What accountability is being taken against the directors of these facilities for failing to report these eight providers?

2. VA testimony stated that the Department is “improving oversight to ensure that no settlement agreement waives VA’s ability to report providers to NPDB or [state licensing boards].” However, these agreements have always been against VA policy. Therefore, what accountability measures, to date, has VA taken against employees for flouting this longstanding policy?

3. What steps will VA take to prevent veterans from receiving care via Choice or another non-VA care program from poorly performing providers who left VA and are now working in the community?

4. A recent VA Office of Medical Inspector report about the Marion, Illinois VA found that radiologists were both over- and under-reading reports. Has the facility conducted any clinical reviews to determine if adverse privileging actions need to be taken against the providers in question?

5. Dr. Cox testified that nothing prohibits VA from reporting a contract provider to the NPDB and state licensing boards (SLBs) when that provider administers substandard care inside of a VA facility. However, Committee staff was told that VA was unable to report the doctor who conducted the amputation in Memphis I referred to at the hearing. As such, please explain what is precluding VA from reporting the contract doctor at issue, and if the answer is nothing, please explain why that doctor has not been reported.

6. Given VA’s failures to properly document and report quality and safety concerns, what steps is VA taking to address the deficiencies in reviewing and reporting providers when evaluating providers for performance pay?

7. VA has the option to provide orders from its provider disciplinary boards to the Federation of State Medical Boards when VA takes action to preclude or limit a provider’s ability to practice within one of its facilities. But according to the FSMB’s testimony, from 2007 to present, VA has not sent any such reports to the FSMB. Why has VA chosen to not forward these orders to the FSMB for at least the last 10 years?

8. The Bay Pines VAMC has indefinitely suspended thoracic surgeries after being notified by the Joint Commission of issues within that department and at least three veterans died from complications following surgery. Notably, in August 2017, the VA Office of Inspector General (OIG) found deficiencies in the process for evaluating the competency of thoracic surgeons at Bay Pines. How then did problems within the thoracic surgery department persist after VA claimed to have corrected the evaluation deficiencies identified by the OIG? Is any kind of formal review being conducted? If so, by whom?

9. The same OIG report from Bay Pines highlighted how an administrative psychiatrist conducted a thoracic surgeon’s Ongoing Professional Practice Evaluation (OPPE). How is an administrative psychiatrist competent to review the work of a thoracic surgeon?

10. GAO found that medical center staff did not always know the relevant policies regarding reporting problem providers. Therefore, what steps will VA take to improve medical center staff education?

11. Does VA’s duty to report SLBs differ from the duty borne by 1011-government hospitals? If so, what are the differences in when a report must be made?

12. VA’s testimony highlighted the hearing process following an adverse privileging action of a provider. In that process, are providers (or their attorneys) allowed discovery to access relevant documentation to assist in their defense?

13. In the event that a veteran patient who suffered harm as a result of a VA provider’s incompetence is not notified of the provider’s mistake until after any relevant statutes of limitation or repose have expired, what allowances are made in law or in VA policy to allow that veteran to pursue a claim for compensation?

14. In regards to the podiatrist from Tagus discussed during the hearing:

- a. Have each of this provider’s cases been reviewed?
- b. Have all of the affected veterans been contacted?
- c. How long did this process take?

d.Are any of the affected veterans within the timeframe to pursue a claim for compensation?

15.What position or program office at the local VAMC is responsible for reporting to SLBs and the NPDB? Is this standardized across the system?

## VA RESPONSE

### Chairman Bergman

**1. VA stated that medical center directors are ultimately responsible for ensuring that clinicians who receive adverse privileging actions are reported to the National Practitioner Data Bank (NPDB). The Government Accountability Office (GAO) found that, in the facilities it reviewed, the majority of clinicians who should have been reported (eight out of nine) were in fact not reported. What accountability is being taken against the directors of these facilities for failing to report these eight providers?**

Department of Veterans Affairs (VA) Response: The Deputy Under Secretary for Health for Operations and Management (DUSHOM) is reviewing the pertinent information provided by (GAO) and will, in coordination with the Office of Accountability and Whistleblower Protection and the Office of General Counsel, determine appropriate action(s), if any, for the facility directors that failed to report.

**2. VA testimony stated that the Department is “improving oversight to ensure that no settlement agreement waives VA’s ability to report providers to NPDB or [state licensing boards].” However, these agreements have always been against VA policy. Therefore, what accountability measures, to date, has VA taken against employees for flouting this longstanding policy?**

**VA Response:** To strengthen oversight of settlement agreements, Veterans Health Administration (VHA) issued specific guidance to settlement officials. All proposed settlement agreements over \$5,000 now require pre-clearance from the following: Medical Center Director, Veterans Integrated Services Network (VISN) Director, the Deputy Under Secretary Health Operations and Management (DUSHOM), and the Principal Deputy Under Secretary for Health.

Additionally, the Office of the DUSHOM has issued enhanced guidance to all VHA leadership of the requirements for reporting providers to the National Practitioner Data Bank. The DUSHOM is reviewing specific site information contained in the GAO report, and will determine appropriate action, if any, for employees that are non-compliant with the NPDB policy.

**3. What steps will VA take to prevent veterans from receiving care via Choice or another non-VA care program from poorly performing providers who left VA and are now working in the community?**

**VA Response:** VA has controls in place to help ensure high quality providers serve our Veterans under the Choice program. Providers are excluded from the Choice network if they are on the U.S. Department of Health and Human Services List of Excluded Individuals/Entities. This list provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. VA also requires that providers have current and unrestricted clinical licenses for the field in which they practice. Further, VA conducts random monthly and annual sampling audits to ensure that the Third Party Administrators are properly excluding poorly performing providers. However, VA cannot prevent Veterans from choosing to see such a provider if a veteran chooses to use other health insurance for their care.

**4. A recent VA Office of Medical Inspector report about the Marion, Illinois VA found that radiologists were both over- and under-reading reports. Has the facility conducted any clinical reviews to determine if adverse privileging actions need to be taken-against the providers in question?**

**VA Response:** Marion VA Medical Center (VAMC) has conducted clinical reviews of radiologic care. Based on recommendations made by both the Office of the Medical Inspector and the VHA National Radiology Program Office, a radiologist outside of the Marion VAMC is currently conducting a retrospective Focused Professional Practice Evolution (FPPE) review of 100 cases. The cases read by each radiologist at Marion are specific to each exam technique (i.e. plain radiography, computed to-

mography, magnetic resonance imaging, etc.). Until the reviews are finalized, adverse privileging actions would be premature.

Additionally, Marion VAMC has developed an Imaging Quality Improvement Committee which tracks metrics such as critical results, complication rates, and patient safety. Marion VAMC has also requested that the VHA National Radiology Program office conduct a follow-up visit.

**5. Dr. Cox testified that nothing prohibits VA from reporting a contract provider to the NPDB and state licensing boards (SLBs) when that provider administers substandard care inside of a VA facility. However, Committee staff was told that VA was unable to report the doctor who conducted the amputation in Memphis I referred to at the hearing. As such, please explain what is precluding VA from reporting the contract doctor at issue, and if the answer is nothing, please explain why that doctor has not been reported.**

**VA Response:** VA conducted peer review of the amputation performed by the surgeon in question. Upon completion of the peer review the facility Chief of Staff or Chief of Surgery would have met with the surgeon to discuss the results. Peer review is the process by which one or more physicians examines the work of a peer and determines whether the physician under review has met accepted standards of care in rendering medical services. Peer review is a quality improvement process and is not intended to be punitive. The Joint Commission on Accreditation requires hospitals to conduct peer review to retain accreditation.

Under Veterans Health Administration Handbook 1100.18, Reporting and Responding to State Licensing Boards (SLB), Paragraph 2.a., "VA has broad authority to report to SLBs those employed or separated health care professionals whose behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients." In this instance, VA did not find that it was required to report this provider to the SLB under this standard.

**6. Given VA's failures to properly document and report quality and safety concerns, what steps is VA taking to address the deficiencies in reviewing and reporting providers when evaluating providers for performance pay?**

**VA Response:** The purpose of physician performance pay is to improve the overall quality of care and health outcomes by achieving specific goals and objectives related to the clinical, academic and research missions of the Department of Veterans Affairs. Each VHA physician and dentist is assigned specific goals and objectives each year by his or her clinical supervisor. These are generally developed locally and the amount of performance pay that a physician or dentist receives may vary based on the degree of execution and individual achievement of specified goals and objectives. When evaluating performance pay, supervisors and managers must document to what extent a performance or conduct related disciplinary/adverse action impacted the individual's ability to achieve his or her established goals and objectives and what effect, if any, the action had on the performance pay decision.

**7. VA has the option to provide orders from its provider disciplinary boards to the Federation of State Medical Boards (FSMB) when VA takes action to preclude or limit a provider's ability to practice within one of its facilities. But according to the FSMB's testimony, from 2007 to present, VA has not sent any such reports to the FSMB. Why has VA chosen to not forward these orders to the FSMB for at least the last 10 years?**

**VA Response:** It is important to distinguish adverse privileging actions that a VA medical facility may take versus actions to restrict or revoke a provider's medical license. Only a state licensing board can determine whether to restrict or revoke a provider's medical license. When a VAMC takes a final privileging action, the action is reported to the NPDB with a copy of the report notifying the respective state licensing board(s). The state boards determine whether or not they want to open their own investigation and then, based upon that investigation, take a licensing action. If a licensing board takes an action on a physician's license, that information is then reported to the Federation of State Medical Boards.

**8. The Bay Pines VAMC has indefinitely suspended thoracic surgeries after being notified by the Joint Commission of issues within that department and at least three veterans died from complications following surgery. Notably, in August 2017, the VA Office of Inspector General (OIG) found deficiencies in the process for evaluating the competency of thoracic**



**surgeons at Bay Pines. How then did problems within the thoracic surgery department persist after VA claimed to have corrected the evaluation deficiencies identified by the OIG? Is any kind of formal review being conducted? If so, by whom?**

**VA Response:** The thoracic surgery program has been thoroughly reviewed by both internal and external entities. The thoracic surgeon at Bay Pines has been found to be competent with quality indicators within targets. During visits in November and December 2016, the Office of Inspector General did not find any quality of care concerns related to the thoracic surgeon's performance, but did make recommendations that a similarly trained provider should evaluate the thoracic surgeon's competency. This recommendation was implemented immediately, with a similarly trained thoracic surgeon from another VAMC reviewing the care provided.

After receiving a subsequent complaint from The Joint Commission, facility leadership decided to place a moratorium on thoracic surgery procedures pending an additional review. The VISN 8 Chief Surgical Consultant conducted an on-site review on December 5, 2017, and provided recommendations which the facility is currently implementing. As for The Joint Commission complaint, none of the allegations of complications related to thoracic surgery care were substantiated.

**9. The same OIG report from Bay Pines highlighted how an administrative psychiatrist conducted a thoracic surgeon's Ongoing Professional Practice Evaluation (OPPE). How is an administrative psychiatrist competent to review the work of a thoracic surgeon?**

**VA Response:** Prior to August 2016, it was the practice of VHA facilities for clinical service chiefs to submit Ongoing Professional Practice Evaluations (OPPE) to the Chief of Staff during the re-privileging process, once service level peers had finished their evaluation. In the case of Bay Pines, the referenced administrative psychiatrist is the Facility Chief of Staff who supervises the Chief of Surgery, who in this case was the thoracic surgeon.

In August 2016, the DUSHOM issued a memorandum which required that only providers with similar training and privileges conduct FPPE and OPPE. In December 2016, the facility arranged for a thoracic surgeon from another VAMC to directly observe the Bay Pines thoracic surgeon's operative skills and there were no concerns raised regarding his surgical technique. The facility is currently in compliance with the August 2016, DUSHOM memorandum.

**10. GAO found that medical center staff did not always know the relevant policies regarding reporting problem providers. Therefore, what steps will VA take to improve medical center staff education?**

**VA Response:** Tremendous effort is underway to provide education on the reporting process. Since the time of the testimony, training has been provided during the national call for Medical Center Directors and a special call was held for Chiefs of Staff. Additionally, training and discussion has been held on the national call for credentialing staff. The State Licensing Board (SLB) reporting policy is being revised. Once it is published, there will be extensive training on the new policy and reporting process including national webinars, reference material, and guidance on conducting adverse privileging actions.

**11. Does VA's duty to report SLBs differ from the duty borne by non-government hospitals? If so, what are the differences in when a report must be made?**

**VA Response:** VA follows the reporting procedures outlined in VHA Handbook 1100.18, "Responding and Reporting to State Licensing Boards." VA has broad authority to report to SLBs those employed or separated health care professionals whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

Private facilities have their own review and reporting policies and processes. VA is not an authority on those practices. However, the Federation of State Medical Boards (FSMB) House of Delegates unanimously adopted new policy in 2016 that urges physicians, hospitals and health organizations, insurers and the public to be proactive in reporting instances of unprofessional behavior to medical boards whenever it is suspected. Additionally, FSMB has noted that collaboration between public and private entities including VA, the Centers for Medicare and Medicaid Services, and the NPDB could enhance public safety by engaging more proactively with each

other. VHA has a representative on the FSMB and is well positioned to work in this collaborative environment.

**12. VA's testimony highlighted the hearing process following an adverse privileging action of a provider. In that process, are providers (or their attorneys) allowed discovery to access relevant documentation to assist in their defense?**

**VA Response:** Yes. A fair hearing process is afforded to the privileged provider which is an evidentiary review process. The provider may have a representative for the fair hearing, which is typically an attorney.

**13. In the event that a veteran patient who suffered harm as a result of a VA provider's incompetence is not notified of the provider's mistake until after any relevant statutes of limitation or repose have expired, what allowances are made in law or in VA policy to allow that veteran to pursue a claim for compensation?**

**VA Response:** Such a Veteran could file a claim for VA disability compensation under the provisions of 38 United States Code (U.S.C.) § 1151. Statutes of limitations and repose are not applicable to 1151 claims.

**14. In regards to the podiatrist from Togus discussed during the hearing:**

**a. Have each of this provider's cases been reviewed?**

**VA Response:** The concerns identified with this provider were concerns of surgical quality. Thus, his patients were segregated for the purpose of review into patients that received surgery and those that did not receive surgery. In total, 431 patients were identified that received surgery from Dr. Franchini. Each of these surgical cases was reviewed. Additionally, during the process, it was decided to expand the review to include a limited number of outpatients and wound care patients. In total, 37 outpatients and 12 wound care patients were also reviewed, for a total of 480 patients. All patients within these three groups were reviewed at least once and most at least twice (initial Togus review and external review) to determine if any experienced possible or probable harm from their treatment.

**b. Have all of the affected veterans been contacted?**

**VA Response:** In accordance with the VA's Institutional Disclosure process, the preliminary reviews served to determine which of the 480 patients who received care from Dr. Franchini were to be contacted about this matter. A total of 270 of the 480 identified patients that were determined from the review, discussed above, to have experienced potential or probable harm, were reviewed for institutional disclosure. Efforts were made to contact these 270 patients to determine if they wished to receive a new evaluation. All patients were contacted with the exception of 28 patients who are deceased and 10 patients who were unable to be contacted due to undeliverable letters, no address on file, or were unable to be reached by phone.

**c. How long did this' process take?**

**VA Response:** The initial facility level review of 25 cases took from (approximately) December 2009 to April 2010. The larger facility level review of all surgical cases took from April 2010 to May 2012. It was later determined to expand the review to include a subset of outpatients and wound care patients. Multiple external reviews of all of these identified cases and coordination with the National Clinical Review Board (CRB) process was conducted from May 2012 to January 2013. The large scale disclosure portion of the process was completed in January 2013 (via mail). Independent exams of affected patients were substantially completed from January through April 2013, though several patients waited months or even years more, at their own request, before receiving an exam.

**d. Are any of the affected veterans within the timeframe to pursue a claim for compensation?**

**VA Response:** The "affected" Veterans have the ability to pursue two types of claims. First, they can file a claim for VA disability compensation under the provisions of 38 U.S.C. § 1151, as mentioned above. This process has no time limits, so any veteran treated by Dr. Franchini still could pursue a § 1151 claim at this point. Such a claim would be considered a "claim for compensation" separate from the tort claim process described below.

Second, affected veterans can seek compensation through the tort claim process, set forth under the Federal Tort Claims Act ("FTCA"). The tort claim process in-

volves, potentially, multiple steps and implicates two separate time-periods in which a claim must be filed, both of which must be met.

With regard to the steps involved, under the FTCA, a Veteran seeking compensation for a tort, such as medical malpractice, would be required to file an administrative claim with the Department of Veterans Affairs, via a federal Standard Form 95. If the claim is denied or the Veteran believed that he or she deserved greater compensation than that offered, he or she then could file suit, within certain temporal limitations, in the United States District Court. A Veteran may not file suit in federal court unless and until his or her administrative claim has been exhausted.

With regard to the “timeframe to pursue a claim for compensation,” there are two limitations periods implicated by any affected Veterans’ claims against Dr. Franchini, and each veteran must file his or her claim within both periods in order to avoid being time-barred. The first time period is Maine’s statute of repose, 24 Maine Revised Statutes Annotated § 2902, which bars any claims filed more than three years from the date of the alleged negligent act (with a narrow exception for instances of fraudulent concealment - an issue that is currently pending with the United States District Court in the six current lawsuits filed in the District of Maine). Because Maine’s statute of repose is not subject to equitable tolling (which otherwise would toll application of the period until each Veteran discovered or should have discovered the alleged injury), the trigger for each Veteran’s three-year period is the date of allegedly negligent care by Dr. Franchini. It does not appear that any affected Veterans who filed administrative claims did so within three years of Dr. Franchini’s allegedly negligent care. Therefore, barring a finding of fraudulent concealment, none of Dr. Franchini’s patients at the VA, including those who currently are in active litigation against the United States, appear to be within the timeframe to pursue a tort claim against the United States.

The second time-period for pursuing a claim is the FTCA’s two-year statute of limitations, which does have an equitable tolling element, requiring submission of an administrative tort claim form within two years of when the patient knew or reasonably should have known about the alleged negligence. Because the issue of when a patient knows or should know about his or her injury is one of fact, that question can be answered only on a case-by-case basis. With regard to the six Veterans who are in active litigation against the United States, the United States Attorney’s Office for the District of Maine, which is defending the United States in those suits, has not fully evaluated whether any of those six plaintiffs met the FTCA’s two-year statute of limitations. In the event that the Court finds that any of the six plaintiffs’ claims are not barred by the Maine statute of repose, the parties will turn to the issue of whether the surviving claims are barred by the FTCA statute of limitations. At this point, however, it is premature to draw any conclusions in that regard.

Other than the six cases that are currently in litigation, there is one claim that has been denied based upon the two-year statute of limitations in which litigation may yet be filed.

**15. What position or program office at the local VAMC is responsible for reporting to SLBs and the NPDB? Is this standardized across the system?**

**VA Response:** The SLB reporting process is standardized through VHA policy. The Director is responsible for assigning an individual to be responsible for the SLB reporting at the facility. VHA does not prescribe what position is to be assigned the duty. Directors use their discretion based upon the resources, experience, and knowledge among their staff.

NPDB reporting is also standardized through VHA policy. An individual with administrative access to the NPDB reporting system, usually a credentialing staff member, is responsible for the data entry.

