BROKEN PROMISES: ASSESSING VA'S SYSTEMS FOR PROTECTING VETERANS FROM CLINICAL HARM

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BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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C O N T E N T S

WEDNESDAY, OCTOBER 16, 2019

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U.S. HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
Washington, DC.

The subcommittee met, pursuant to notice, at 2:48 p.m., in room 210, House Visitors Center, Hon. Chris Pappas (chairman of the subcommittee) presiding.

Present: Representatives Pappas, Rose, Cisneros, Peterson, Wexton, Peters, Cunningham, Takano, Bergman, Radewagen, Bost, Roy and Miller.

OPENING STATEMENT OF CHRIS PAPPAS, CHAIRMAN

Mr. PAPPAS. Good afternoon. I call this hearing to order. Without objection, the chair is authorized to declare a recess at any time.

Before we begin, I would like to ask unanimous consent for our colleagues, Representatives Cunningham, Lewis, Miller, Peters and Wexton to participate in today's hearing should they all be able to attend.

Without objection, so ordered.

I would like to also welcome our full committee chair, Mark Takano. Thank you for being here, Mr. Chair.

Approximately 8 weeks ago the media began reporting on a string of concerning incidents of patient harm and professional misconduct in VA medical facilities. In August, a former VA pathologist in Fayetteville, Arkansas was charged with involuntary manslaughter, fraud and making false statements in an attempt to conceal years of substance abuse. Over his 11-year tenure with VA he is believed to have botched diagnoses for an estimated 3,000 veterans, some of whom died.

Authorities are also investigating at least a dozen suspicious deaths at the VA hospital in Clarksburg, West Virginia. Medical examiners have now determined that 3 of these veterans died of homicide by insulin injection.

Early in September a veteran receiving end of life care at a VA nursing home in Atlanta was bitten by ants more than 100 times before facility staff finally moved him to a new room and took action to address this infestation. These reports are sickening.

Over the last 2 months we have also received a steady stream of reports from VA's Inspector General (IG) identifying appalling VA quality management failures in several other locations.

For example, last month the IG reported on multiple leadership failures at a VA facility in Veterans Integrated Services Network (VISN) 10 in the Midwest which allowed an opthalmologist to perform substandard surgery and laser procedures for 2 years. This doctor regularly took hours to complete cataract surgeries that should have taken less than 30 minutes. The facility director and chief of staff repeatedly dismissed concerns that were raised by other staff members.

Although these 2 facility level leaders had the responsibility and the authority to remove the provider, they instead chose to disregard the patient safety risks. The reason, according to the IG the ophthalmologist's spouse was also a surgeon at the facility and leaders worried that terminating one would entice the other to resign, leaving several veterans—leaving the facility with 2 physician vacancies.

In the end, as a result, several veterans were referred to community care for further treatment to resolve complications arising from this surgeon's care.

It would be easy to dismiss any one of these cases as just an isolated incident or just one bad apple. Collectively, these cases speak to wider problems with VA's ability to identify clinicians who are negligent, abusive or committing criminal acts and prevent them from practicing. The VA has got to do better.

Today's hearing will explore several critical questions: What red flags are VA facilities missing, overlooking or choosing to ignore when they hire and employ clinicians; when concerns arise, why are not medical center officials investigating in a timely manner; and when concerns are substantiated, why isn't VA reporting them to the National Practitioner Data Bank, the NPDB, and to State licensing boards in a timely fashion.

As today's hearing will make clear, far too much responsibility and authority has been placed at the local level. The Veterans Health Administration and its VISNs are doing far too little oversight to ensure that facility level leaders understand and are complying with policies for ensuring proper patient care and safety.

Instead, VA's pervasive lack of accountability is leading to patient harm. That is why we have convened today's hearing. Veterans and their families deserve answers. They need to know that the VA is upholding its moral and ethical obligation to deliver world class health care. This is the promise our Nation made to those who have served, and our heroes deserve nothing less than that.

This is not new territory for VA or for this subcommittee. In fact, 2 years ago General Bergman shared a subcommittee hearing on this very topic. One of our witnesses. Dr. Gerard Cox, testified at that hearing. Among other things, Dr. Cox promised that the VA would update its policies related to credentialing and privileging, improve the timeliness and reporting to the NPDB and State licensing boards, expand NPDB reporting to nurses and other types of clinicians instead of just physicians and dentists, and establish a new VISN level compliance process.

As you will hear today, none of these actions have been made since our subcommittee's last hearing on this topic. I will say that again. The VA has not taken any of the actions that it promised during that hearing in 2017. The string of incidents over the last 8 weeks should serve as a wake up call. No one here would deny veterans deserve any less than that, but we must do better for VA employees who are brave enough to speak up when they are concerned that a colleague's clinical incompetence, their impairment, negligence or misconduct is putting veterans' lives at risk.

As the IG found in the case of the ophthalmologist in VISN 10, facility leaders repeatedly ignored concerns raised by other clinicians at the facility. The indictment of the VA pathologist in Arkansas states that colleagues complained to facility leaders repeatedly that the doctor appeared to be intoxicated while on duty, both before and after he completed an inpatient treatment program.

In both cases it took years for facility leaders to remove these providers, and in the meantime our veterans suffered. It is not enough for VA leaders to sit here today and pledge policy changes. They have done that before. We need to see that VA is as outraged as we are and that leaders at all levels will be willing to walk the walk. We must see a fundamental cultural transformation. Something must be done to make VA a place where employees at all levels feel they have psychological safety and to be able to sound the alarm.

Employees need to know that their concerns will be taken seriously, that there is a sense of urgency to address these concerns as soon as they arise and that VA is acting swiftly to guarantee these issues do not occur again in the future. Their lives depend on it.

With that I would like to recognize our ranking member, General Bergman, for 5 minutes for any opening remarks he may have.

OPENING STATEMENT OF JACK BERGMAN, RANKING MEMBER

Mr. BERGMAN. Thank you, Mr. Chairman. As you stated on the front end, in 2017 as chair of this subcommittee I held a hearing on VA provider competency, which focused on VA's handling of providers who were found to deliver substandard care.

Sadly, we are holding another hearing on this vitally important topic in the wake of several new reports of serious patient harm involving VA providers. Our veterans deserve better and we collectively must give them our best effort because they have given us their best effort through their service.

When problems arise, we must take a long, hard look at what went wrong, why it went wrong, and what we can do to mitigate the risk of future failures.

The unfortunate reality is that this is a retrospective process. No congressional hearing or legislation can change what happened. It has been said that there are 3 things that you can never get back in this world: The spent arrow, the spoken word, and the missed opportunity.

Mr. Chairman, we have before us an opportunity to significantly improve the department for veterans and their loved ones. The committee has received several reports recently from the VA Inspector General and the Government Accountability Office (GAO)

that identified failures in credentialing, privileging and quality management. It appears to me that there are polices in place that, if followed, could mitigate and/or avoid many of these issues.

However, an organization's policies and procedures alone do not make for success. It is the leadership of the organization that establishes the culture, empowers individuals to think and act autonomously, and drives the organization toward a more improved version of itself. It appears that many of these problems are, in a large part, leadership failures.

For example, one of the glaring issues following a recent GAO report was the lack of consistent and standard credentialing, privileging and quality management oversight from VISN Chief Medical Officers. The report found that the VISN CMOs assessments of credentialing, privileging and quality of care were often incomplete with inconsistent use of the "standardized assessment tool." In fact, some VISN officials stated that they were not using the standardized tool, but rather developing their own auditing tool.

You cannot manage what you do not measure. It seems that there is little about the VISN's oversight of credentialing and privileging that is actually measured.

Another area of concern that the inspector general has raised is the lack of direct observation of providers on Focused Professional Practice Evaluations or FPPEs. Instead, VA facilities rely on documents to evaluate the provider's performance.

Though documents may show performance to be within acceptable ranges, they may not capture a practitioner's behavior while operating, responding during a crisis or confidence with a procedure. I am interested in hearing more about this issue from our witnesses.

As a military commander, I know that there is always the 10 percent who are not with the program and can sully the reputation of the rest of the organization. While hundreds of thousands of veterans receive quality health care from tens of thousands of VA providers every day, VA is not immune to this 10 percent problem.

When issues are identified, VA must act swiftly to address them. Therefore, I want to know what VA is doing to correct the identified failures and most importantly what it has learned from these failures and what systems and people have been put in place to ensure that VA avoids similar failures in the future.

To kind of sum up, the observation is no clear chain of command, no structured review process and no requirement for direct observation.

I thank all of our witnesses for being here today and I look forward to a productive hearing.

With that, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you, Ranking Member Bergman.

I will now recognize our first witness. First we have Ms. Sharon Silas, a director of the U.S. Government Accountability's Office Health Care Team.

Thank you for appearing with us today, and you are recognized for 5 minutes.

STATEMENT OF SHARON SILAS

Ms. SILAS. Thank you.

Chairman Pappas, Ranking Member Bergman, and members of the subcommittee, I am pleased to be here today to discuss our recent body of work on provider qualifications and competence in VA's health care system.

My testimony today is summarized as findings and recommendations from 2 recent reports on VA's response to adverse information when credentialing providers, and the reviews and reporting of VA providers when concerns are raised about the quality of their clinical care.

Based on our findings from these 2 reports, we made 11 recommendations, 9 of which remain open.

Like other health care facilities, VA medical centers are responsible for ensuring that their providers deliver safe care to patients. VA has processes and policies in place to help ensure that providers have the qualifications and competence to deliver quality care to veterans.

First, as part of credentialing and renewing clinical privileges for a provider, Veterans Health Administration (VHA) policy requires VA medical centers to review the NPDB which is a data base that collects and releases information on providers who, for example, have been disciplined by a State licensing board or other health care entity.

Review of NPDB reports are used to verify that the provider's medical licenses are current and in good standing. However, in our 2019 report we found inconsistent adherence to VHA policies that disqualified providers from employment at VA medical centers.

Specifically, we found that some VA medical center officials were not aware of key policies that govern credentialing reviews and that gaps exist in VHA policy that allow for inconsistent interpretation.

For example, VHA did not have policies in place regarding Drug Enforcement Agency (DEA) registrations and the circumstances in which waivers may be required.

Last, VHA's oversight of VA medical centers' reviews of adverse information was inadequate.

Second, VA medical center officials are also required to review and, if warranted, address any concerns that may arise about a privileged provider's clinical care. Depending on the nature of the concern and the review's findings, take appropriate actions including limiting or preventing the provider from delivering care to veterans.

VA medical center officials are also required to report the providers against whom they take adverse privileging actions to the NPDB and State licensing boards. If VA medical centers fail to properly review, address and report concerns that have been raised about the provider's performance, they may be exposing veterans, and potentially the public, to unsafe care.

In our 2017 review, we found that for 148 providers that required clinical reviews at 5 VA medical centers, VA officials were unable to provide any documentation for about half of them. In fact, officials acknowledged that in some cases the required reviews were not conducted at all.

Furthermore, VA medical centers did not always conduct reviews of providers' clinical care in a timely manner, some taking longer

than 3 months and in some cases years to initiate reviews of a provider's performance.

We also found that the 5 VA medical centers did not alert the NPDB or State licensing boards if there were serious concerns with regard to a provider's clinical performance as required by VHA policy.

Specifically, we found that only 1 of 9 providers was appropriately reported to the NPDB and none of these providers were reported to the State licensing boards. We found that 1 of these providers was later fired and reported to the State licensing board by a non-VA facility for the same reason several years later.

The causes of these deficiencies that we identified in this review can again be attributed to gaps in policy and inadequate oversight. For example, we found that VHA policy does not require VA medical centers to document all types of reviews of providers' clinical care. We also found that while VISN officials are responsible for overseeing the credentialing and privileging processes of the respective VA medical centers, none of the VISN officials we spoke with describe any routine oversight.

In the last few months a number of high profile incidents involving quality and safety concerns with VA providers have been covered in the media. While these cases each have their own specific circumstances, many appear to illustrate the potential impact of the deficiencies we identified in our reviews and highlight the importance of VA implementing GAOs recommendations.

Strengthening policies and oversight of VA medical center's credentialing and reviews of provider clinical care when concerns are raised are key to decreasing the risks that our veterans and the general public will be exposed to unsafe care.

This concludes my prepared statement. I would be happy to answer any questions that you may have.

[THE PREPARED STATEMENT OF SHARON SILAS APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much, Ms. Silas.

Our second witness is Dr. John Daigh. He is the Assistant Inspector General for Health Care Inspections at the VA Office of Inspector General.

Dr. Daigh, thanks for joining us, and you are recognized for 5 minutes.

STATEMENT OF DR. JOHN DAIGH

Dr. DAIGH. Chairman Pappas, Ranking Member Bergman, members of the subcommittee, I thank you for the opportunity to testify regarding Office of Inspector Generals (OIG's) work on the important topic of credentialing and privileging of licensed and independent practitioners.

I am privileged to represent the OIG's Office of Health Care Inspections and the staff that prepared the reports discussed in our written testimony.

I would like to begin by affirming that our work supports the fact that VHA usually provides quality health care to veterans, and that the overwhelming majority of clinical administrative staff at VA hospitals are committed to their mission.

However, it is clear that credentialing and privileging processes along with the patient safety program and quality assurance must be improved to provide appropriate assurance that veterans will continue to receive high quality medical care.

In numerous reports over the last few years my office has detailed incidents where physician care did not meet VHA standards and episodes where veterans were placed at risk or harmed as a result of too many months of unchecked substandard care.

We have made recommendations to VHA to address the lapses in provider credentialing and privileging practice evaluations and a to ready acceptance by VHA privileging committees that a provider has the clinical skills and thought processes required to provide high quality care.

We are also concerned that it takes too long for the leadership at a hospital to act to address poor performing providers.

In particular, an August 2019 report highlights many of these failures with the VISN 10 medical center's decision to hire an opthalmologist. The individual that was hired was not board eligible in ophthalmology. The submitted clinical references did not provide comfort that the physician could perform cataract surgery, a surgery for which the physician was subsequently given privileges by the facility leadership. He was not adequately assessed through the FPPE process with respect to the ability to perform cataract surgeries. When concerns about the quality of this provider's surgical care were raised by nurses and other members of the staff, hospital leadership was far too slow to respond.

Simply put, it should not be a challenge to determine there is a problem when cataract surgery that should take less than 30 minutes takes hours, and it should not be a challenge to remedy that problem.

While VHA needs to improve their efforts to collect and review all required documents for the credentialing process, more emphasis should be given to understanding the quality of the provider's prior practice through interviews and references from appropriate sources.

VHA needs to look for opportunities to adopt a show me attitude when granting privileges. For example, observing a colonoscopy or reviewing the interpretation of scans and pathology slides should be comprehensively adopted in early stages of a provider's employment.

Direct observation of clinical procedure performance and increased use of simulation centers could better demonstrate that a clinician will be more likely to provide high quality medical care.

More concerning to me than the credentialing and privileging issues we uncover is the finding that substandard care was provided for months without VHA leadership action. Technicians and nurses tell my staff that they have no reason to speak up about poor provider care when they see inaction from providers themselves or from facility leadership.

I am unsure if providers and staff are not making themselves heard or if leadership is not listening. This problem speaks to the need to consider changes to the patient's safety and quality assurance programs. They must work together to ensure that veterans receive quality medical care.

While we generally believe VHA policies are reasonable, it is time for VHA to conduct a serious review of how it implements these policies. Our recent reports should not be discounted as isolated events that would be expected to occur across a large system.

In addition to challenging how providers are evaluated in order to reduce variance across the system, VHA should consider appointing a national leader for each speciality whose primary responsibility is to ensure that the quality practice of that speciality across VA is at an outstanding level.

A change in how local, regional and national leaders conduct evaluations and communicate about practitioners who should not be providing care to veterans is paramount given these missteps and delays. Many of the failures we identify can be traced to what is, at best, ineffective oversight from regional and national leaders.

Mr. Chairman, that concludes my statement and I will be pleased to answer any questions.

[THE PREPARED STATEMENT OF DR. JOHN DAIGH APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you very much, Dr. Daigh.

Finally, I will recognize our VA witnesses, Dr. Steven Lieberman, the Acting Principal Deputy Under Secretary for Health at the Veterans Health Administration or VHA. He is accompanied by Dr. Gerard Cox, VHA's Deputy Under Secretary For Health For Organizational Excellence. Finally we have Ms. Jessica Bonjorni who is VHA's Acting Assistant Deputy Under Secretary For Health For Work Force Services.

Thank you all for joining us today and, Dr. Lieberman, you are recognized for 5 minutes.

STATEMENT OF DR. STEVEN LIEBERMAN

Dr. LIEBERMAN. Good afternoon, Chairman Pappas, Ranking Member Bergman and members of the subcommittee.

I appreciate the opportunity to discuss the Veterans Health Administration's process for credentialing, privileging and quality management. I am joined today by Dr. Gerard Cox, Deputy Under Secretary For Health For Organizational Excellence, and Ms. Jessica Bonjorni, Acting Assistant Deputy Under Secretary For Health For Work Force Services.

VA is committed to ensuring that veterans receive safe, high quality health care. We know that some staff do not uphold VA's values and we will hold accountable anyone that provides poor care or commits crimes in our facilities.

Some recent events are deeply disturbing. It is extremely troubling that the actions of a few flawed staff might overshadow the great work of the nearly 348,000 employees who provide quality care every day to veterans and their families.

During Fiscal Year 2019, VA clinical staff engaged patients more than 121 million times, completed 1.7 million more outpatient appointments at VA facilities over Fiscal Year 2018, and saw an additional 73,000 more veterans over Fiscal Year 2018. We are proud that veterans are continuing to choose VA for their health care as the quality of care and access in VA continues to improve.

Research studies highlight that the quality of care in VA is better than care in the private sector. The public does not often hear

about the overwhelming majority of our patient encounters where VA staff works hard every day to optimize care. Our internal surveys from veterans who receive VA care show that their trust in our system continues to improve, most recently at 88 percent.

As we grow, we are undergoing a transformation into a high reliability organization. This new initiative to eliminate harm to patients includes remedying the culture in which mistakes may happen. Research confirms that most errors in health care are unintentional. Our goal is to embrace a just culture where staff feel comfortable speaking up if something has gone wrong or could go wrong if a concern is not addressed. This creates a system that reduces mistakes and prevents errors from harming the patient.

It is important to note that a just culture still ensures accountability, immediate discipline and prosecution, when appropriate, for those who act with maliciousness, willful negligence or intent to cause harm. VA demonstrated our commitment to that accountability with the recent incidents when staff did not live up to VA's high standards.

VA removes people who willfully cause harm from patient care immediately.

We learn from the mistakes that cause harm and we welcome investigations to ensure that we are doing everything we can to create a safe health care environment. We have not found a common thread between the recent incidents. Instead, there are a small number of people whom acted inappropriately.

VA has a robust set of processes to screen all applicants before they join VA that includes background screening. For health care providers we follow the joint commission standards for credentialing and privileging, including checking with the provider's State licensing board and the National Practitioner Data Bank to determine if an applicant has been reported due to substandard care, professional misconduct or professional incompetence.

VA continues to monitor provider's performance and the external reporting bodies to ensure they remain fit for service, and we react quickly when a new issue is found.

Unfortunately, there is no way in health care to predict every human failing. We establish strong systems in the way industry standards to respond quickly and comprehensively whenever a patient's safety might be in jeopardy.

In conclusion, I want to emphasize that I am sorry for any pain that any veteran or their families have experienced as a result of our employees acting inappropriately. When something goes wrong we learn from those experiences. As a result of that, we get stronger. We get stronger because of the nearly 348,000 employees who come to work every day to provide excellent care to veterans.

That completes my opening statement and we are prepared to answer your questions.

[THE PREPARED STATEMENT OF DR. STEVEN LIEBERMAN APPEARS IN THE APPENDIX]

Mr. PAPPAS. Thank you, Dr. Lieberman.

We will now turn to questions and I will begin by recognizing Chairman Takano for 5 minutes.

Mr. TAKANO. Thank you, Chairman Pappas.

About a month ago the full committee held a member day hearing where colleagues presented their veterans policy priorities and I was alarmed to hear from Representative Womack that VA either failed to provide or was slow to provide relevant information to his office and to other members of the Arkansas delegation after firing the pathologist whose botched diagnoses allegedly contributed to the death or harm of numerous veterans.

Representative Westerman submitted a statement for the record for today's hearing that echos those concerns. According to Mr. Westerman, the VA for months ignored his request to convene an administrative investigation board to examine possible medical center leadership failures. The investigation was convened only after several of the facilities senior leaders, including the director, had retired or quit.

I have also heard from members of the Arkansas delegation that VA originally only proposed reviewing the final year of cases handled by this individual. That is right. VA did not plan to fully review all 11 years of this pathologist's diagnoses until after Members of Congress and the IG applied pressure to do so.

Dr. Lieberman, has VA now finished reviewing all 11 years of this provider's practice?

Dr. LIEBERMAN. Yes, they have, sir.

Mr. TAKANO. Great. How has VA gone about informing veterans whose health may have been affected who might have been misdiagnosed by this doctor?

Dr. LIEBERMAN. They have reached out to every veteran or their family, if the veteran was no longer available, to disclose to them what had happened with their loved one.

Mr. TAKANO. Approximately how many veterans have been contacted, veteran families?

Dr. LIEBERMAN. Approximately 30.

Mr. TAKANO. 30. Are there more to be contacted because we are talking about 11 years worth of cases.

Dr. LIEBERMAN. Those are the cases where harm may have occurred as a result of the provider.

Mr. TAKANO. All right. I will be interested to hear more from your office about how you arrived at those 30 and how you could eliminate all of the other cases.

Dr. LIEBERMAN. We would be happy to meet with you to discuss that further.

Mr. TAKANO. Thank you.

Dr. Lieberman, when and how did the VA medical center, the VISN and VA headquarters become aware that at least a dozen—I am turning now to the question of Clarksburg, West Virginia, at least a dozen veterans died under suspicious circumstances over the course of about a year and a half. How did you become aware? How and when did the VA medical center, the VISN, the VA headquarters become aware that at least a dozen veterans died under suspicious circumstances?

Dr. LIEBERMAN. As you know this is still under criminal investigation and we have not had confirmed the numbers. We have not been informed on any specific numbers. We certainly were informed of what had trans—that there was a concern——

Mr. TAKANO. I just want to know how you all became aware. How did any of the medical centers, the VISN, how did you become aware?

Dr. LIEBERMAN. The facility had concerns that this was going on and did a review over a year ago and they informed their facility leadership who, once they became aware, immediately called leadership at the time in VA headquarters and then the OIG was immediately notified also.

Mr. TAKANO. My question is, is it true that they only became aware after the IG brought it to their attention or are you saying that they became aware before that—the IG got involved?

Dr. LIEBERMAN. Right before the IG became involved. The IG was notified very soon after leadership in VA headquarters was made aware.

Mr. TAKANO. How did you become aware of these deaths?

Dr. LIEBERMAN. Personally, I heard about it without any details, just that there was a concern at the facility from the OIG.

Mr. TAKANO. This is after the OIG was brought into this?

Dr. LIEBERMAN. I was not the leadership at the time when the concerns were first brought forward. When I assumed my leadership role is when I was notified about this.

Mr. TAKANO. Okay. What actions, if any, has VA taken to inform veterans or their next of kin who may have suffered unexplained hypoglycemic events or even death at the Clarksburg Veterans Affairs Medical Center (VAMC)?

Dr. LIEBERMAN. We have not reached out to anyone as this is an active investigation.

Mr. TAKANO. Fair enough.

Are veterans and their families expected to rely on the news media for this information?

Dr. LIEBERMAN. They certainly have the OIG available to answer any of their questions.

Mr. TAKANO. All right. VA is not—because of the ongoing investigation, you have not pro-actively made any notifications of the families?

Dr. LIEBERMAN. That is correct.

Mr. TAKANO. Mr. Chairman, my time is out and I yield back.

Mr. PAPPAS. Thank you, Chairman Takano.

I would now like to recognize Ranking Member Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman.

Dr. Lieberman, according to the VHA handbook, 1100.19, the Principal Deputy Under Secretary for Health or designee is responsible for ensuring oversight of VHA's credentialing and privileging for licensed providers.

However, the handbook also says, "The ultimate responsibility for credentialing and privileging resides with the facility director."

Can you please help me reconcile who has the ultimate responsibility because you are higher in the chain, the chain of command that is, than a medical center director, correct?

Dr. LIEBERMAN. Correct, sir.

Mr. BERGMAN. Okay. Who is at the top?

Dr. LIEBERMAN. Ultimately the Principal Deputy Under Secretary and the Under Secretary for Health have the ultimate responsibility for the organization to ensure that it is done correctly.

Mr. BERGMAN. Okay. Let me ask you a question. If you are at the top, you know, what are your expectations as they related to credentialing, and privileging, and when was the last time that you personally laid out your expectations?

Dr. LIEBERMAN. Credentialing and privileging is a critical aspect of screening to ensure we get the right candidates for our positions, although there is no perfect way to predict when an employee is going to be problematic. There are many checks and balances in this process. It starts with the H.R. department actually, takes a look at suitability, looks for—every employee undergoes a background check, gets fingerprinted.

Then the credentialing office begins their part of the review, which is what is called primary source verification where they double check that whatever the applicant says in their application is correct. They will check directly to make sure that they got the correct diploma, the correct training, the——

Mr. BERGMAN. Okay. Well, you know, you could talk for a lot because there is a lot to do there. To use the example of the cataract surgery taking 2 hours when we know it should take somewhere between 15 and 30 minutes, depending on what type of procedure, whether it is a temporal incision or wherever it is.

But the point is, you know, the ASCRS, the American Society for Cataract and Refractive Surgery, as well as other medical disciplines have, you know, have criteria for performance.

Does the VA look to these speciality groups like the cataract surgeons to make sure that in the end you are doing—I hear you are doing the paperwork, but who is doing truly the hands on to make sure that the surgeon can hold the phacoemulsification, you know, hand piece correctly so that it does not suck the iris out as opposed to the lens?

Dr. LIEBERMAN. Dr. Cox, do you want to just talk about that issue?

Dr. COX. Sure. Thank you very much for the opportunity to be here today.

Each clinical community establishes its own standards for quality. Ultimately, to answer your question, sir; it is the immediate supervisor, that surgeon, the service chief in ophthalmology or general surgery or dermatology or whatever service it is that is responsible for assuring the competency and the quality of the practice of the people providing that care in that medical center.

As you heard, there are processes in place for ongoing professional performance evaluation and for peer review to conduct that assurance.

Mr. BERGMAN. When is the last time that somebody got called before a board of their peers for review and was, shall we say, given a thumb's down based on performance?

Dr. COX. Well, in the surgery community, the idea of having a sort of peer review or local review of one another's care is commonplace. Morbidity and mortality conferences are routine in every medical facility, including VA medical facilities, to review cases where there is an unexpected outcome or something that could

have been done differently. That has helped providers learn from one another and assure the higher quality of care.

Dr. LIEBERMAN. Yes, just to respond, peer reviews get a thumb's down. Everyone has the responsibility to do these objectively. If the standard of care was not met, that is pointed out.

Mr. BERGMAN. Is there, I hate to say, re-mediation or retraining?

Again, in my time as a commercial pilot, if you could not pass your check ride you did not fly the line. You were not certified safe to operate that aircraft. You had to go back through training and you got a couple of chances before you lost your job.

Is there such, if you will, an exact set of re-qualification training or standards that will allow people who are good folks, but maybe their skill sets are not up to where they need—they must be to, again, to handle surgical instruments, is there a process?

Dr. COX. Well, you are exactly right, sir. It is a requirement that everybody be monitored in this way and the process depends on the specifics of each case. Each one is handled individually.

It may be determined that additional training or retraining is the remedy. It may be something like a lesser remedy, more close scrutiny or more frequent oversight. As Chairman Pappas suggested earlier, having another surgeon directly observe the care of that surgeon under scrutiny in the operating room.

Then in egregious cases where the provider's performance can not be improved after additional training or scrutiny of that type, then that is when we get into the question of taking action against the person's privileges to suspend them, limit them, or even to revoke them.

Mr. BERGMAN. Well, again, what this committee looks for, subcommittee looks for is examples of oversight on your part. These are tough decisions and tough things to have to tell professionals, you did not make the cut. There is no pun intended in that at all. I mean, the idea is that you need to get better before we let you into an operating room or into whatever level of care you are providing.

Dr. Daigh, you have raised to my staff that there is a lack of direct observation of providers when they are under a focus professional practice evaluation, the FPPE. What could be missed if a provider's documents are reviewed, but they are not directly observed?

Dr. DAIGH. Thank you, sir, for the question.

I think in the ophthalmologist's case I think it is pretty clear that if at the beginning of this individual's practice one had simply gone to the OR, if they were already a competent ophthalmologist, and observed this individual provide surgery for a day or 2, you would probably come to the conclusion that this person should not be privileged to practice medicine at the hospital that they practiced.

I think it is a missed opportunity, whether we are talking about colonoscopies or surgical procedures or the interpretation of slides or images to not test whether an individual new to your hospital with the prior practice coming in to test how well they actually can perform, as opposed to saying, you have wonderful degrees, you have been to great places, we are going to assume you can do this procedure.

Thank you, sir.

Mr. BERGMAN. Okay. I know my time is up.

To relate it to a check ride, you just do not welcome a new pilot into your squadron without giving him a check ride first.

Thank you, Mr. Chairman. I yield back.

Mr. PAPPAS. Thank you.

I will now recognize myself for 5 minutes of questioning.

I would like to start with Ms. Silas. One of the things that I hope we can address today at this hearing is the status of the corrective actions that VA promised it would take in our last subcommittee hearing on this 2 years ago.

I just want to reflect a little bit on your testimony. You indicated that the GAO made 11 recommendations. Among these recommendations include updating credentialing policies to establish a timeliness requirement reviewing quality of care concerns and to make clear that facilities must document these reviews.

GAO also recommended that VHA direct its VISNs to audit facilities' compliance with requirements for preparing credentialing files, initiating and completing timely reviews, documenting those reviews and reporting adverse actions to NPDB and State licensing boards.

Is it true that almost all of these recommendations remain unimplemented? If so, what are the status in getting VA where they need to be?

Ms. SILAS. Thank you for that question.

Yes. Out of the 11 recommendations that we have made between the 2 reports, 9 of those recommendations remain open. The 2 recommendations that have been closed is the recommendation that the VISN chief medical officer document evidence that the VISNs are overseeing compliance with policies.

When we did a recommendation follow up with the Veterans Health Administration in August 2019 they let us know that Vet Pro was modified to allow for documentation of the VISN chief medical officer reviews.

The other recommendation that has been closed is the recommendation that QSV office should compile and disseminate best practices to the facilities. The Veterans Health Administration let us know that they had compiled best practices and codified some of those best practices at the time.

Mr. PAPPAS. Well, thank you for that.

It is my understanding that VHA's credentialing and privileging policies, the directive and handbook, were due for re-certification at the end of October 2017.

Dr. Cox, I am wondering if I can ask you, you testified before the subcommittee almost 2 years ago pledging to update these policies and establish a VISN level oversight process.

Can you reflect on those comments and where things stand today and why we have not gotten to implementation?

Dr. COX. Thank you, Mr. Chairman. I would be happy to.

Since 2 years ago when I sat before this committee, there have been a number of steps that we have taken to strengthen and improve our credentialing and privileging and quality oversight.

First of all, as you read in the GAO report, we completed a review; a focused review of over 70,000 providers in our system who

had been improperly—to identify any who had been improperly hired because they had previously had a license that was revoked. That is a prohibition that we corrected. We removed 11 out of the 70,000 as a result of that review, and we reinforced the prohibition by providing additional training for our chiefs of staff and our credentialing officials at medical centers.

We developed and piloted that standard auditing tool for VISN Chief Medical Officers (CMOs). This is now an automated tool that will be fully implemented before the end of this calendar year. It will not only provide a standard for all CMOs to use, but also automatically provide information about the summary of those reviews to the VHA Central Office Medical Staff Affairs office that is responsible for these policies.

We strengthened the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) monitoring practices by mandating that only a specialist from within the same specialty community can review the work of another provider. That had not been standard prior to 2016. Now it is the standard. Those specialty-specific criteria must be used at each facility, rather than having a boiler plate set of criteria for those reviews.

We also, in cases where there is only one type of specialist, a solo physician, let us say the only general surgeon or the only anesthesiologist, in those cases we have put policy in place to make sure that their work is reviewed by somebody who is a true peer, somebody in the same specialty from a different facility rather than having a non-peer from within the same facility, even a clinical supervisor such as the chief of staff, for example, conduct those reviews.

Mr. PAPPAS. I appreciate these steps. When do you expect that these policy updates will be completed?

Dr. COX. Well, the policy updates are in progress and one of the reasons that they have not been completed is because we are rewriting and expanding them to incorporate some of these strengths and strengthening activities.

For example, we are separating the credentialing policy from the privileging policy and in the privileging policy adding additional information and guidance on how to conduct FPPE and OPPE.

In the case of the credentialing policy, we are incorporating requirements now for telemedicine which add another level of complexity for assessing the credentials of somebody who might practice in one State, but via telehealth be taking care of veterans in another State.

I expect both of these would be published by next summer.

Mr. PAPPAS. By next summer of 2020?

Dr. COX. Yes, sir.

Mr. PAPPAS. Okay. That is well beyond the date that you had indicated in the 2017 hearing, and I understand that these things can take months of review to actually get to the implementation stage. So——

Dr. Cox. That is correct.

Mr. PAPPAS.—we are going to continue to do follow up on that. I think this continues to be a critical area that requires our attention.

My time is expired, so I would like to recognize the next member for questioning.

Ms. Radewagen, you are recognized for 5 minutes.

Ms. RADEWAGEN. Hello for Mr. Chairman and Ranking Member. Thank you for holding this hearing. Thank you also to the panel for being here today.

Dr. Lieberman or Dr. Cox, VHA Handbook 1100.19 states that the VISN CMO is responsible for oversight of the credentialing and privileging process of the facilities within the VISN using standardized assessment tool.

Would you please explain what this tool is, and what data does this tool provide, and how are these data points utilized in oversight?

Dr. COX. The auditing tool is basically an electronic form that has standard criteria that will be used across all 18 VISNs by each of the Chief Medical Officers. They will use it to review any clinical or competency reviews that are conducted at the facilities within that VISN.

Just to put this in perspective, Dr. Lieberman mentioned there were 348,000 or so VA employees. 180,000 of them are licensed providers. We have 180,000 providers in our credentials data base. Of those, 65,000 of them are independent providers such as physicians and dentists and advanced practice nurses.

One of the reasons that you do not hear about the 64,990-plus providers that are not getting into trouble that are not providing substandard care is because they are caring, and they are competent, and they are committed to the care of veterans.

Ms. RADEWAGEN. Ms. Silas, in your written testimony you referenced a standardized audit tool that VA developed to help VISNs oversee reviews of clinical concerns. It appears to me that many of the problems are a result of facilities not appropriately using the tools that VHA has provided.

I would like to hear your opinion as to what VHA needs to do to make sure that the tool is employed properly.

Ms. SILAS. That is correct. There is an audit tool that has been developed for the VISNs to oversee or at least conduct audits of the VA facilities.

What we found was that during our review from 2017 that none of the VISN officials that we spoke with described any type of routine oversight. They were not using the audit tool consistently.

We did make a recommendation that the Veterans Health Administration ensure that the VISNs were consistently using that tool to conduct their audits because currently right now the VISN or the VHA policy does not require VISNs to oversee the directors reporting to the National Practitioner Data Base or to the State licensing boards. This could also be incorporated into the tool and help to better ensure that there is oversight of the VA medical centers.

Ms. RADEWAGEN. Thank you, Mr. Chairman. I yield back.

Mr. PAPPAS. Thank you.

I would like to recognize Mr. Cisneros for 5 minutes.

Mr. CISNEROS. Thank you, Mr. Chairman. Thank you all for being here today.

Dr. Lieberman, in your testimony you State that the VA has an obligation to notify State licensing boards of any substantial findings in substandard care performed at the VA by current or former licensed health care professionals. However, in instances in which faulty clinicians are still able to practice to the detriment of veterans still occurs.

In your opinion what are the barriers in place that prevent the VA from reporting a clinician to the State licensing board?

Dr. LIEBERMAN. I will start and then perhaps Dr. Cox will have items to add.

First of all, when we fail to do something in a timely manner, if we do not—any issues with any of the cases we are discussing, we study what went wrong and we identify the problems and we look in the given facility. But then we also look nationally at what we can do to improve it.

Often, issues involved with failure for this would have to do with training of our staff and making sure that they are aware of the right way to proceed, and the timeliness and how they are supposed to proceed. Dr. Cox.

Dr. COX. First of all, let me clarify that reporting to the State licensing board is a separate process from reporting to the National Practitioner Data Bank (NPDB) and with different thresholds.

Reporting to the licensing board is done whenever we have enough evidence that a provider may have failed to meet the acceptable standard of care and could have put patients at risk.

The VA has no authority to take action against any provider's license. That authority resides with the licensing board. We provide them the evidence that we collect and then it is up to the board to determine whether to open their own investigation and whether to use that evidence to take actions such as restricting, removing or suspending a provider's license.

The standard for National Practitioner Data Bank reporting is much higher. That can only be done after a complete investigation as well as all the due process that providers do, including a fair hearing where they can present their own evidence and call their own witnesses to defend themselves.

At that point the National Practitioner Data Bank report is submitted by the Medical Center Director. To answer a question that came up earlier, it is the Medical Center Director who is the privileging authority and who has the sole and ultimate responsibility for making these decisions.

In fact, VA does a pretty good job of policing itself. The basis for that statement is that over the last 3 and a half years, from January 2016 until June of this year we reported over 1,000 of those 65,000 licensed independent providers to the NPDB. We have reported over 1,000 people in that 3 and a half year span.

These actions are taken all the time. They are difficult and complex cases. They require judicious decision-making on the part of that Medical Center Director. But that is what we need to do to protect the safety of Veterans.

Mr. CISNEROS. In the 2017 GAO report found that the VA medical center selected for their investigation did not report any of the providers with adverse privileges actions taken against them to State licensing boards despite it being required by VHA policy.

Therefore, GAO recommended it be required that the VISN officials establish a process for oversight in ensuring the VA medical centers were reporting providers to the State licensing board and to the National Practitioner Data Banks.

My understanding, to this date, the recommendation has still not been taken up even 2 years later. Why is this the case and why are there obstacles that prevent the VA from implementing this necessary oversight?

Dr. COX. Well, we agreed with the recommendation that it is the responsibility of the VISN to conduct that oversight. One of the reasons is, as I mentioned, 65,000 providers, 170 or so medical centers, so it is just not feasible to expect that any one person or office in Washington, DC. can do that. We have regional governance for that reason.

Regarding the open GAO recommendations that Ms. Silas talked about, I just wanted to indicate that, you know, across the 2 GAO reports in question, the 2017 report had 4 recommendations. It is true they are all still open. But it would not be fair to say that they have not been acted upon. That report was published in November 2017 and within 2 months, by January 2018 we had issued additional interim guidance to the field in lieu of a formal policy change, which is still in the works, and took the recommended actions.

Two of those 4 open recommendations have to do with putting this in policy, so they can not be closed until we have published that formal policy as Chairman Pappas asked me about. The other 2 have to do with finalizing this automated auditing tool for chief medical officers which we will be rolling——

Mr. CISNEROS. Yes. I am running out of time here, but I would like to, if you could, Mr. Lieberman, or Dr. Lieberman, sorry, submit for the record, one of the things that you said was training. There was a lack of training as to why this was not happening.

If you could submit for the record what that training program is and how are we going about training these directors of the medical centers to make sure that these requirements are met, that they do need to report these to the licensing boards and to the National Practitioner Data Bank, I would appreciate that.

Dr. LIEBERMAN. I would be happy to do that. I can just want to reemphasize what Dr. Cox was speaking about. Our VISN chief medical officers take this responsibility incredibly seriously and they have been going into the facilities and doing direct reviews and auditing, and we see this as really making a difference.

Mr. CISNEROS. All right. Thank you. I yield back my time.

Mr. PAPPAS. Thank you.

I would like to recognize Ms. Miller for 5 minutes.

Ms. MILLER. Thank you, Chairman Pappas, and Ranking Member Bergman, and thank you all for being here today.

It is of utmost importance that we continue to provide and maintain the highest quality of care for the men and women who have served our country so bravely. The deaths at Lewis A. Johnson VA Medical Center in Clarksburg, West Virginia, and the sexual assault allegations in Beckley, West Virginia VA Medical Center are not only troubling, but they are unacceptable.

As Members of Congress, it is our job to support swift and proper investigations to ensure that such instances never happen again. There have been considerable progress that has been made with the quality of care that our veterans are receiving following the enactment of the MISSION Act and efforts to address the veterans' suicide epidemic.

Our service members should feel safe and comfortable seeking care at the VA and these events show that there needs to be additional oversight of clinicians, proper removal of bad actor and monitoring of care.

The tragic deaths of our veterans at the Lewis A. Johnson VA Medical Center in Clarksburg and the sexual assault allegations at the Beckley VA Medical Center, once again, are unacceptable. We must work together to ensure the families of our Nation's heroes get the answers that they deserve and that we can work to prevent these tragic events in the future.

I fully support the investigation into this matter and I appreciate the committee's interest and oversight.

Dr. Lieberman, many of the veterans in my district are extremely faithful to the VA and the quality of care that they receive there. Do you have any suggestions on how we can take VA policies that are made here in D.C. and ensure that they make it down through the leadership ladder to guarantee that the individuals are aware of the policies and are implementing them correctly?

Dr. LIEBERMAN. Thank you for that question, a very important question.

We take this very seriously when we implement policies. We are in the process of modernizing and that is a big part of our modernization is to ensure that we are adequately communicating to all levels of the organization. We start at the top and have national meetings, but ultimately it is spread through the VISNs and then down to the facilities.

We also have through our clinical leadership, we expect them to communicate. We expect the communication to be 2 way. We have national calls by specialty, by different parts of the organization, nursing, clinical areas, and we talk about what are the challenges that the field is facing, what are their concerns if we are implementing a policy, making sure we get their input.

We do not want everything to be, decisions to be made always at the top. We want to make sure that we get input from front line staff so that our policies can be most effective.

Ms. MILLER. I am glad to hear that.

Dr. Daigh, what are the concerns and/or benefits of incorporating a direct observation policy?

Dr. DAIGH. Thank you for that question.

I think that the direct observation in many instances allows an expert, for example, going back to the eye surgeon, to observe whether or not it is a go, no go using the airline language as to whether a surgeon could actually do that job or not.

If you have an individual that you are going to give privileges to do a colonoscopy to, and you watch that person do the colonoscopy, and you see the same images that that person doing the colonoscopy is seeing, you can have a conversation, are they recognizing the right landmarks, are they seeing pathology and

biopsying it appropriately or marking it appropriately, did they get to where they want to go to the cecum to call it a complete colonoscopy.

I think that by observing and watching an individual do the skills they are being hired to do, you can learn a great deal.

There are other areas where it is much more difficult. It is an expensive process, but I think it is one that should be considered and applied much more freely than it is currently in the VA.

Ms. MILLER. If we were to incorporate this policy, what would it look like in terms of staffing, timeliness and quality of care?

Dr. DAIGH. I do not have an answer to that. I think that that would require work I have not done to try to figure out what the staffing requirements be or what the actual implementation strategy would be.

But by observing and reporting on the cases that we have seen recently, we are seeing evidence now that physicians are making errors that we did not used to see in terms of making it through the system and impacting a large number of veterans.

I think it is time to consider that we start to look at the quality of care provided at the beginning when we hire someone and do a more forceful job there observing their practice in addition to monitoring them with not just paperwork, but with a data collection system that is relevant to the care they provide.

For example, monitoring how much blood loss a surgeon has during a surgery is important, but that may not really inform as to whether they can do their surgery well.

Ms. MILLER. But it also is not just the physicians.

Dr. DAIGH. I agree. There are many providers in the hospital who—well, let me answer it this way. Nurses in general are required to show me that they—prove that they can do a skill. You are asked to suction here, suction this. You are asked to put a piece of equipment together to start an IV or to set up an IV bag.

Physicians are often given credit for their training and education and experience, and I think there should be more of a show me attitude as they are granted the privileges to do skills as other people who work in the hospital are often required to do.

Ms. MILLER. Because there are many other people that work in the hospitals.

Dr. DAIGH Absolutely.

Ms. MILLER. Thank you. I yield back my time.

Mr. PAPPAS. Thank you, Ms. Miller.

I would like to recognize Mr. Cunningham for 5 minutes.

Mr. CUNNINGHAM. Thank you, Mr. Chair, and thank you to each and every one of you all for coming here today. I appreciate it.

Dr. Lieberman, in 2017 a constituent of South Carolina's first congressional district who was also a VA patient with a service-related mental health disability died by asphyxiation while under supervision of the Doran VA Medical Center. Are you familiar with that case?

Dr. LIEBERMAN. I have heard about it. Yes.

Mr. CUNNINGHAM. Okay. I mean, speaking more generally here I want to use my time to discuss the VA's approach toward ensuring patient safety in a mental health setting, particularly for those patients who have been diagnosed with a serious mental illness.

Can you speak briefly about the policies or safeguards that the VA has in place to protect mental health patients from harm by hospital staff?

Dr. LIEBERMAN. We take this very seriously, patient safety. We talk about this. If there is any events that go wrong, we are going to take a look at it and see what happened in these situations. Certainly, if there is a suicide, but in this case it was not a suicide. It was——

Mr. CUNNINGHAM. Physical restraint.

Dr. LIEBERMAN.—physical restraint. Correct. We look at physical restraints. We monitor for that also with—under the recommendation of the joint commission we are supposed to take a look at that. We are supposed to minimize use of physical restraint. When something goes wrong, we have to take a look at it. Our mental health leadership take this very seriously, and do look at this, and do talk about this in national forums about how we can do better when something goes wrong.

Mr. CUNNINGHAM. Are you familiar with how personnel are trained under these circumstances when they have an encounter with someone with a serious mental health issue as was in this case?

Dr. LIEBERMAN. I would like to take that for the record and get back to you and make sure I get you an accurate answer of all the details. But we do extensive training in this area.

Mr. CUNNINGHAM. Yes. I would like to know some more details about the training and also who or what department in particular is charged with making sure that the restraint protocols meet certain standards. You do not have that information either handy I do not suppose, do you?

Dr. LIEBERMAN. Not today, no. We will be happy to get you that.

Mr. CUNNINGHAM. Okay. As far as the personnel thing, you touched on this briefly before, but what processes are in place to ensure the personnel are screened, they are credentialed, and they are retrained periodically to certify that they are aware of VHA policy requirements relating to the safe use of such techniques?

Dr. LIEBERMAN. When we first hire people we certainly do extensive background checking, doing fingerprinting, making sure that no one has a criminal background. Depending on the level of the staff, if it is licensed staff we are going to validate that they have the correct licenses.

We are certainly going to check their references, important things like that, to make sure that they do not have any history in the workplace showing any concern. Then we go very deep for our providers, making sure that everything they put on their application is accurate. If there is a lapse in time that they work, why did that have that lapse, are they physically and mentally healthy. We ask for—to have a medical recommendation about that.

Mr. CUNNINGHAM. Okay. I appreciate it. You will supplement the record and provide that information as far as who is tasked with training them and what that protocol is and how often it is reviewed, correct?

Dr. LIEBERMAN. Absolutely.

Mr. CUNNINGHAM. You know, obviously as we are seeing when our men and women return home from service, so many of their

scars we can not see. This is becoming, you know, a difficult issue to deal with. But they deserve the best care that we can give them. I applaud the VA for what they have done, and we are just seeking the areas in which they can improve upon. I appreciate your service.

My question to you is, what else can we as Members of Congress, specifically this committee, do to ensure that this growing area of concern, men and women with mental health issues, Post Traumatic Stress Disorder (PTSD), after coming back from doing so much for our country are awarded the care that they deserve and the care that they need? Are there any other tools from us that you would request?

Dr. LIEBERMAN. I really want to emphasize how dedicated, how well trained most of our staff are that do the right thing every day.

I have a concern when we just focus on the negative that it actually harms the veteran who is on the fence about whether they should come to the VA. We have to tell both sides. We have to tell the good stories because we hear that veterans hear about these issues, which are certainly concerning, and we certainly have to learn from them and improve. But we also have to talk about the quality of care that VA has to offer and especially for mental healthcare. I apologize for what happened at Doran. That is a very upsetting issue there for that particular case.

But we have to get our veterans to be willing to come to us, and I just get worried when we just focus on negative in forums that it is harming the veteran.

Mr. CUNNINGHAM. Yes. I would say in Charleston we have a 5-star facility and——

Dr. LIEBERMAN. Uh-huh.

Mr. CUNNINGHAM.—are very proud of that facility there in Charleston. I think overall that that is the impression there. Unfortunately, though, we do have to focus on some of the terrible situations we are confronted with and how to make things better and to ensure that they do not become a pattern. I think that is the purpose of being here today.

Again, I thank you for your service, each and every one of you all, and I would yield back.

Mr. PAPPAS. Thank you.

Mr. Peters, you are recognized for 5 minutes.

Mr. PETERS. Thank you, Mr. Chairman, and Ranking Member Bergman. Also, thank you for letting me waive on this committee. I was pleased to serve on it in the last Congress. As a San Diegan I really want to say how much I appreciate the work you all do and appreciate your commitment to our veterans.

I also want to acknowledge that there is a lot of fine work going on at the VA and that the nature of our business is that as oversight we are going to look at some of the things that are not going as well.

I wanted to come today just to get into a little bit of a troubling story from the San Diego VA. I recently detailed this story at the VA committee member day last month, but wanted to summarize the story here.

The San Diego VA participated in a study examining alcoholic liver disease, which was one site among other institutions of a larg-

er National Institutes of Health (NIH) funded study led by the Pittsburgh Liver Research Center at University of North Carolina (UNC) Chapel Hill.

Nine patients diagnosed with alcoholic hepatitis received transjugular biopsies, and according to whistleblower's disclosures this was not the standard of care and reported this to the VA's Office of Medical Inspector or OMI.

Following OMI's report the Office of the Special Counsel, or OSC, conducted an independent investigation and found that the VA's internal report was unsatisfactory.

The Special Counsel report alleges that these samples were collected improperly, sometimes without patient consent, and could have put patients in harm's way, not that there was evidence that anyone was harmed, but that was their conclusion. The Special Counsel urged the VA to revisit its findings in the matter and take a truly critical look at the research being conducted at the San Diego VA.

Now we know this is not the first time that OMI has investigated wrongdoing and has come up short in answers according to the Special Counsel. According to data provided by inewsource, which is a San Diego news outlet who has broke the story, when the Office of Special Counsel reviews OMI report, 16 percent of them are found unreasonable, which is more often than other executive agencies.

My colleagues here will remember the clinical neglect at the Manchester VA which has been mentioned. The Special Counsel also find OMI's reports in that instance to be unsatisfactory.

Again, no recorded cases of risking patient safety in this instance. This story presents a case, though, that could have consequences in other settings, especially for VA medical centers that conduct research onsite. We want them to do that. We want them to pair with academic institutions. My goal is to strengthen the investigatory bodies that handle these types of allegations so that these things do not come up.

Dr. Cox, maybe I will ask you, since you served as the director of the Office of Medical Inspector, how often does OMI review and report on medical research issues like these?

Dr. COX. Thank you, Congressman. I would be happy to answer your question.

First of all, it is not often that the Office of the Medical Inspector is involved with research oversight. VA is unique in having a separate and independent Office of Research Oversight (ORO) which participated with the Office of the Medical Inspector in that San Diego review.

If I may, I just would like to clarify the sequence of events that you described about the liver research case.

The 2 whistleblowers at the San Diego VA Medical Center, to whom we are very grateful for bringing these concerns forward, went to the Office of the Special Counsel (OSC). They asserted themselves as whistleblowers with OSC. Through the standard statutorily guided process, the Special Counsel of the United States referred the matter to the Secretary of the VA, who had then assigned it to the Office of the Medical Inspector (OMI) for Investigation.

OMI completes dozens of these whistleblower investigations every year. They are part of our independent internal assurance and oversight capability. They are the entity that can go into any VA medical center and conduct an investigation and collect evidence to determine whether the whistleblower's allegations are substantiated or not.

As you indicated, when OMI did the initial investigation, and wrote a report of that investigation at San Diego, they failed to substantiate the whistleblowers' concerns. The reason for that, it later became apparent, is that at least 1 key witness was not truthful—

Mr. PETERS. Okay.

Dr. COX.—was not forthcoming with information. When we later found out about that ourselves, we took it upon ourselves to go back, conduct a second visit, a second investigation. This is after OSC had closed the initial case and said it was not reasonable. On the second occasion we substantiated those findings, substantiated that there was egregious research misconduct, and voluntarily submitted that second report to the Special Counsel of the United States, and they are now considering it.

Mr. PETERS. Great. I appreciate that.

In general, do you think that OMI has enough resources to thoroughly handle whistleblower complaints?

Dr. COX. I do. You mentioned the inewsource article and we were able to answer questions from the investigative reporter before she published the article. We conducted our own analysis of the rate at which the Special Counsel of the United States finds OMI's reports not reasonable and we came up with a very different number.

She asserted 16 percent. Our number is about 5 percent. That track record actually has substantially improved from 2014 when the Office of the Medical Inspector was restructured, and we have added additional staff since then. I believe that the staffing levels are now at—

Mr. PETERS. I am out of time, but to the extent you would like to supplement your answers in writing, I would certainly appreciate that. Again, I appreciate you all being here.

Thank you.

Dr. COX. I would be very happy to. Thank you.

Mr. PETERS. I yield back.

Mr. PAPPAS. Thank you.

I would now like to recognize Ms. Wexton for 5 minutes.

Ms. WEXTON. Thank you, Mr. Chairman, and thank you to Mr. Chairman and Ranking Member for allowing me to participate in today's hearing.

I represent Northern Virginia here in Congress and my district begins just outside of Washington D.C. and goes about 100 miles west all the way to West Virginia. Veterans in my district, because we do not have a VA facility of our own, they have the option of either going east into the D.C. VA or west to Martinsburg. Both of these facilities are in VISN 5 and so obviously the allegations or the substantiated issues at VISN 5 are very important to me and to my constituents.

I was really troubled to learn about the deaths at the Johnson Medical Center in Clarksburg, West Virginia, and the sexual as-

sault allegations at Beckley, West Virginia's VA medical center. I am very concerned about the serious allegations of wrongdoing by medical personnel at the VA facilities in Arkansas and Georgia.

Our veterans have sacrificed so much for our country and they deserve the highest quality of care, and at a minimum they should feel safe in our VA facilities. I think we can all agree about that. Unfortunately, these facilities have failed on both counts.

With the benefit of hindsight we are able to see some of the things that went wrong, but what I am hoping we are able to do with today's hearing is make sure that we have the protections and protocols in place to make sure that these things do not happen again.

I would like to focus for a moment on the role of VISNs in oversight of wrongdoing at these VISN 5 facilities. There have been reports, Dr. Lieberman, that VA employees are hesitant to report suspected wrongdoing in these and other incidents. I was pleased to hear you talk a little bit about, you know, from top down, but also from bottom up to make sure that the reports are made.

Are VA employees trained on the appropriate chain of command in reporting suspected wrongdoing at the VA medical center level?

Dr. LIEBERMAN. Thank you for that question, Congresswoman.

This is a really critical issue and that is why we are undertaking this high reliability organization journey where, as a part of being a just culture staff feel comfortable coming forward. They are not concerned that they are going to get in trouble for this, and so we are working on this.

At the Atlanta facility, one of the biggest failures with that unfortunate case was the culture there was such that it did not come up the chain of command of what was going wrong there. As a response to that, we really emphasized in a variety of different forums, including Dr. Stone, our executive in charge, sent out a letter to every employee talking to them about the importance, that they have an obligation, a responsibility to speak up when they see an unsafe situation, that we will protect them if they come forward.

Certainly, if some employees will never trust their leadership, and so we always have the backup, there are hotlines, OIG. We have the compliance hotline, OSC. There is always that. But, really, we want to get to the point in our own organization where everybody feels comfortable in speaking up.

Ms. WEXTON. It would also be good for them to feel comfortable that their complaints will make it up the chain of command and be acted upon, and they will find out what the results of the investigation——

Dr. LIEBERMAN. Absolutely. We have to lead by example and show them that they are making a difference in the workplace when they speak up.

Ms. WEXTON. Thank you.

Ms. Silas, I was pleased to hear you talk about the GAOs 11 recommendations and ones that are being implemented, and particularly with regard to the standardized audit tool.

Now am I to understand from your answer to an earlier question that there are issues with the tool that is being rolled out right now? Is it lacking in some way?

Ms. SILAS. No. I was not commenting that there was an issue with the audit tool. We are still waiting for validation that the tool has been rolled out.

Ms. WEXTON. Have you had an opportunity to see how this tool works?

Ms. SILAS. I have not personally had an opportunity to see how the tool works.

Ms. WEXTON. Has someone with GAO had an opportunity to see how this tool works?

Ms. SILAS. Yes. The team that conducted the review had opportunity.

Ms. WEXTON. Is it your understanding from that team that the tool that is going to be implemented will address the oversight concerns that were announced in the report?

Ms. SILAS. Yes. That is correct.

Ms. WEXTON. Okay.

Dr. Cox, I guess you were talking about the fact that this tool is going to be rolled out before the end of the year; is that correct?

Dr. COX. Yes, ma'am.

Ms. WEXTON. What kind of training do you have for staff in order to ensure that they are properly using the oversight tool and that it will be a part of any sort of initial intake?

Dr. COX. Training of both the Chief Medical Officers at the VISNs who are going to be the primary ones to use this tool, and of the credentialing officials at every VA medical center, is a part of the implementation strategy. That is built into the roll out process.

The tool was developed and has been piloted. There were, as with many new electronic things, some IT glitches. We had to step back a little bit and fix those bugs, and that is the reason that it has not already been implemented. But it is on track to be rolled out this year.

Ms. WEXTON. You expect that for the year 2020 it will be fully operational and be used in the entire facility all throughout the VISN?

Dr. COX. We do.

Ms. WEXTON. Okay. Thank you very much.

I see my time has expired. I appreciate it. I yield back.

Mr. PAPPAS. Thank you very much.

I just have a few additional questions before we close and I am wondering, Dr. Daigh, if I can ask one of you.

In your testimony you talk a little bit about the decentralized nature of VHA and how this places significant responsibility, if not all the responsibility, in the hands of local leaders to ensure they are employing highly qualified, highly competent professionals.

But time and again your teams have discovered that leaders have failed to carry out certain responsibilities related to reviewing the quality of care concerns and taking action to limit or revoke privileges and reporting clinicians to licensing boards and the NPDB.

In your opinion should all of these responsibilities inherently reside at the local level? Do we have that balance right, or is there an opportunity here to get VISNs and VHA more involved in the process?

Dr. DAIGH. I think that VISNs and VHA should be more involved in the process. I think that sometimes there is a lack of knowledge as to what an evaluation would be that is proper. If you hire a medical specialist who is the only person in the hospital who does that specialty, the chief of staff may, in fact, know very little about the technical aspects of that job.

I think getting larger involvement or more specific involvement by national leaders would be important.

Mr. PAPPAS. Thank you.

Dr. Lieberman or the VA, would you like to comment on that at all?

Dr. LIEBERMAN. I think we are, or we are moving in that direction. As we mentioned before, the chief medical officers are having much more involvement with oversight and auditing of the process as well as our national offices are. Certainly a lot of the suggestions that Dr. Daigh has mentioned we are taking under serious consideration and taking a look at.

Mr. PAPPAS. Okay. Dr. Lieberman, one more thing before we close, and this has to do with the situation with the pathologist in Arkansas.

One of the things that really does not sit well with me is that this individual completed a 3-month inpatient rehab program and then was returned to his position as the chief of pathology. He went on not only to conceal his continued impairment, but was also changing, you know, recommendations and he was believed to have falsified veterans' medical records in that process.

I am wondering if you could talk broadly about the acceptability of an individual returning to a supervisory position. Shouldn't we have individuals watching this person's work as opposed to this individual being tasked with watching the work of other folks?

Dr. LIEBERMAN. Thank you for that question.

In this country about 10 to 15 percent of American citizens will have a problem with alcohol or other forms of substance abuse during their lifetimes, and that is no different than health care providers. It is an unfortunate fact, but that is part of our society.

It has been shown that for physicians that they actually have a very high long-term success rate with rehabilitation, upwards of 80 to 90 percent abstain from alcohol. It is thought that those individuals truly love what they do in their careers, and they are committed to this and they are successful.

In health care, in society, individuals are given a chance. This individual went through rehab. Most people who go through rehab will not—if the allegations are true about what the OIG has said about this individual, this person was very trained and skilled and found a substance that most people in health care have not even heard of, and knew that this could cause intoxication and also would not be detectable on screening.

I was not there or not involved with the decision, but certainly one could look at the decision to immediately put this individual back as the service chief. You might have decided to observe them in a non-leadership position for a while just to confirm.

Again, this individual was getting repeated alcohol tests and they were turning out to be negative. There were no obvious warning signs about that initially.

Mr. PAPPAS. Well, I certainly believe in second chances and supporting an individual's recovery is crucial, especially in the workplace. But I think that additional steps should have been taken in this case.

I am wondering, Dr. Daigh, if you have any thoughts on that particular case.

Dr. DAIGH. I would like not to talk about the case at hand, but talk more generally. I certainly do believe in second chances. I do think, though, when someone has a physical impairment or a mental impairment, be it Hepatitis or drug abuse or substance abuse, and they are brought back on to practice medicine that there should be close oversight of the quality of the work they do. Whether or not they are a manager or not, I think that is more of a local decision. But I think that the care they provide post-whatever the event was ought to be critical and be focused.

Mr. PAPPAS. Well, thank you. Thank you to our panel.

I would like to see if General Bergman has any additional questions or if he would like to close.

Mr. BERGMAN. The answer is both.

Mr. PAPPAS. Okay.

Mr. BERGMAN. One quick question. Ms. Bonjorni, you have been sitting there very quiet and patient for this entire time. I noticed that in your bio that you are certified both in human resource and project management.

It is my understanding that there are organizations that certify credentialing specialists. Does VHA require credentialing personnel to be certified and, if not, has VA explored the benefits of requiring certification and, if so, what did it find?

Ms. BONJORNI. Well, thank you for your question, sir.

I do not believe that we have explored that, but we are actually in the beginning stages of a process to look at the organizational structure and the position and career paths for people who do credentialing work within VHA. That is absolutely a concept that we could explore to determine whether that would make a significant positive impact.

Mr. BERGMAN. Well, you know, we are all here. You know, several of us have used the word just recently within the last minute or so we believe in second chances. We also believe that if—we have to look inside ourselves as an organization and what is it we are trying to achieve, and are our tactics, techniques and procedures or processes that we would use for ensuring that, number 1, the best quality outcome for the veterans, and that starts with providers who are credentialed, certified, re-certified from time to time to ensure that they are up to standard.

I would just like to, if I can just incorporate my closing into this, Mr. Chairman.

Mr. PAPPAS. Sure.

Mr. BERGMAN. You know, again, thanks for the hearing. You know, it has been about 2 years since I chaired the subcommittee hearing on this topic. I guess to say I am not troubled would not be true. I am troubled that we continue to have the same conversations about leadership and policy implementation. We can and we must do better.

I intend to work with all of you and all our other witnesses to leverage your experience, because you are where the rubber meets the road, to leverage your experiences, your responsibilities, to improve VA's processes for credentialing, privileging and quality management.

That said, I am encouraged by the fact that several of the incidents referenced today reached OIG through VA employees who were willing to stand up and call out what they believed to be substandard care, substandard practitioning, if you will.

We have had a series of hearings on the process for VA staff to report serious concerns, and with another one on the horizon I wanted to take a moment just to thank these individuals who have utilized the system to bring attention to these serious, serious issues.

With that, Mr. Chairman, I yield back.

Mr. PAPPAS. Thank you very much, General Bergman.

Thank you as well to our panel for being here today.

I think it is critical that we understand that we are all looking out for the veteran, the end-user of the care offered by the VA to ensure that it is top notch and to ensure that their health safety is always protected.

Veterans need to trust that the VA is fulfilling its responsibilities for credentialing and privileging. They also need to know that this department is taking appropriate action to investigate concerns that arise about clinical care and remove clinicians who deliver substandard care or engage in misconduct.

We as a subcommittee have a duty to ensure that VA fulfills all of its responsibilities and, unfortunately, I think today's testimony means that we have some more work to do. I am committed to working alongside General Bergman and to the members of this subcommittee as well as our congressional colleagues on both sides of the aisle to continue our oversight work and to continue to encourage the VA to be moving in the right direction.

I thank you for all of your efforts. I thank the workforce at the VA and its providers for the care that they offer for our veterans day in and day out. I just hope we can continue this conversation and continue to understand that there is a sense of urgency that is there for our veterans to make sure that the steps that have been outlined today are implemented as quickly as possible.

Members have 5 legislative days to revise and extend their remarks, and include any extraneous material.

Again, thank you all for joining us today. Without objection, the subcommittee stands adjourned.

[Whereupon, at 4:16 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

PREPARED STATEMENT OF MS. SHARON SILAS

United States Government Accountability Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
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VA HEALTH CARE

Actions Needed to Ensure Provider Qualifications and Competence

Statement of Sharon M. Silas, Director
Health Care

GAO-20-152T

Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee:

I am pleased to be here today to discuss our recent body of work on provider qualifications and competence at the Department of Veterans Affairs (VA). VA's Veterans Health Administration (VHA) operates one of the largest health care systems in the nation, and has approximately 165,000 licensed health care providers, such as physicians and nurses, across its 172 VA medical centers and over 1,000 outpatient facilities.[1] 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 determine whether each provider has the appropriate professional qualifications and clinical abilities to care for patients. During this process, known as credentialing, VA medical center officials review and verify information about the provider's qualifications and practice history. Such information can include the provider's application for employment at VA, education, and state licenses. VA providers are required to hold at least one active and unrestricted medical license. If a provider has ever had a license revoked for cause, or has voluntarily surrendered a license after being notified in writing by the state of potential revocation of the license for cause, the provider is not eligible for VA employment, unless the license is restored to a full and unrestricted status.[2]

As part of credentialing, VHA policy also requires VA medical centers to review the National Practitioner Data Bank (NPDB) for any adverse information about a provider. 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. Consistent with industry standards, VHA policy requires VA medical centers to query the NPDB and verify with the

[1]For the purposes of this testimony, we use the term "provider" to refer to both licensed independent health care providers, such as physicians and dentists, and licensed dependent providers, such as nurses.

[2]Individuals who were appointed prior to November 30, 1999, and have been on continuous appointment since that date are not disqualified for employment by any license, registration, or certification revocations or voluntary surrenders that predate November 30, 1999, provided they possess one full and unrestricted license as applicable to the position. "For cause" refers to actions taken on the basis of professional misconduct, professional incompetence, or substandard care.

appropriate state licensing boards that a provider's medical licenses are current and in good standing—unrestricted—before appointing a provider to its medical staff. VHA policy also requires VA medical centers to query the NPDB when licensed independent providers such as physicians—those who can independently provide medical care—renew their clinical privileges.[3] Additionally, VHA enrolls these licensed independent providers in the NPDB continuous query, which alerts VHA if any entity reports information on a provider to the NPDB.[4] (See appendix I for additional details on VHA's credentialing, privileging, and monitoring processes.)

The presence of information in the NPDB does not automatically disqualify a provider from working at VA medical centers. Each VA medical center has broad discretion in hiring providers, within parameters. For example, a provider listed in the NPDB for a revoked license can be employed by VA if the license has been restored. If the NPDB indicates that a provider has had other state licensing board action, such as a reprimand, VA medical center officials must review the information on a case-by-case basis and document their review.

After a provider is hired, VA medical centers are also required to investigate and, if warranted, address any concerns that may arise about the provider's clinical care.[5] Concerns about a provider's clinical care can be raised for many reasons, ranging from a provider not adequately documenting information about a patient's visit to practicing in a manner that is unsafe or inconsistent with industry standards of care. VA medical centers may also become aware of a potential concern if the NPDB includes new adverse information about an existing provider. If VA medical centers fail to properly review and address concerns that have

[3]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. VA medical centers are required to review and approve each licensed independent provider's privileges at least every 2 years.

[4]VHA plans to begin requiring medical centers to enroll licensed dependent providers in the NPDB continuous query by the end of 2019.

[5]VA medical centers can identify concerns about a provider's clinical care in a variety of ways, including 1) ongoing monitoring of a provider's performance, 2) a trend of certain outcomes from quality reviews conducted by the provider's peers; 3) complaints or incident reports from any individual with a concern, and 4) filed or settled tort claims or malpractice claims.

been raised about a provider, veterans may be exposed to unsafe care and potential harm.

Depending on the nature of the concern and the findings from their review, VA medical center officials may take adverse privileging actions against a provider that either limits the care the provider is allowed to deliver at the facility or prevent the provider from delivering care altogether. VA medical center officials are required to report independent providers against whom they take adverse privileging actions to the NPDB so that this information is available to other VA medical centers, non-VA hospitals, and other health care facilities. VA medical center officials are also required to report providers—both independent and dependent—to state licensing boards when there are serious concerns about providers' clinical care. State licensing boards can then investigate and determine if a provider's conduct or ability to deliver care warrants action against the provider's medical license.

Over the past few months, the VA Office of Inspector General and the media have reported on multiple cases of quality and safety concerns regarding specific VA providers. The issues reported range from providers lacking appropriate qualifications to poor performance and provider misconduct. For example, the VA Office of Inspector General reported in September 2019 that a VA medical center did not comply with several VHA credentialing and privileging activities in hiring and reviewing a surgeon. The Inspector General substantiated that the VA medical center staff did not appropriately verify the provider's credentials. Additionally, despite ongoing concerns about the provider's productivity, competency, and technical skills, medical center leadership reappointed the provider to the medical staff, which the VA Inspector General said allowed the provider to continue performing surgical procedures without the required training or competency to do so.[6]

My testimony today summarizes key findings from our February 2019 and November 2017 reports on the implementation and oversight of VHA

[6]Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Leadership Failures Related to Training, Performance, and Productivity Deficits of a Provider at a Veterans Integrated Service Network 10 Medical Facility*, Report #19-06429-227 (Washington, D.C.: Sept. 24, 2019).

processes for reviewing and reporting quality and safety concerns about VA providers.[7] Accordingly, this testimony addresses

1. VA medical centers' reviews of adverse information about providers in the NPDB and VHA's oversight of these reviews;
2. selected VA medical centers' reviews of providers' clinical care after concerns are raised and VHA's oversight of these reviews; and
3. selected VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA's oversight of these processes.

In addition, I will highlight key actions that we recommended VA take, including VA's responses and the current status of those recommendations.

For our 2019 report, we reviewed a nongeneralizable sample of 57 VA providers, including physicians, nurses, dentists, physical therapists, and social workers across all 18 Veterans Integrated Service Networks (VISN).[8] These 57 providers were listed in the NPDB for an adverse action, such as a revoked or surrendered license, and were working at VHA as of September 30, 2016.[9] For each of the individuals in our sample, we reviewed the VHA personnel and credentialing files, as well as state licensing board documents. Further details on our scope and methodology are included in our February 2019 report on credentialing VA providers.[10] For our 2017 report, we reviewed documentation and interviewed medical center staff at a nongeneralizable selection of five VA medical centers (across five different VISNs) to identify any independent providers whose clinical care was reviewed after a concern was raised

[7]GAO, *Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*, GAO-19-6 (Washington, D.C.: Feb. 28, 2019) and *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).

[8]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA.

[9]We judgmentally selected 57 providers for in-depth review from 1,664 individuals employed by VA as of September 30, 2016 who had an NPDB report. We selected providers with a health care conviction or an adverse action, such as a revoked or surrendered license. We considered factors such as the seriousness of the offense, total number of offenses, and whether the provider had any VHA disciplinary records. Our February 2019 report included both independent and dependent providers.

[10]GAO-19-6, 55.

about that care.[11] For each identified provider, we reviewed documentation and interviewed staff to determine whether the VA medical center took an adverse privileging action against any of these identified providers from October 2013 through the time we completed our site visits in March 2017. Further details on our scope and methodology are included in our November 2017 report.[12] Finally, we obtained information from VA officials in October 2019 on the status of their efforts to implement the recommendations that we made in our 2019 and 2017 reports.

We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

VA Medical Centers Took Action against Some Selected Providers with Disqualifying Information in the NPDB but Overlooked Others

In our review of 57 providers selected for our February 2019 report, we found that the responsible VA medical centers took action against some providers with disqualifying information in the NPDB but overlooked

[11]We selected the five VA medical centers based on the complexity of services offered and their geographic distribution. We identified providers at each medical center by reviewing facility documentation of credentialing meetings from fiscal year 2014 through fiscal year 2016. During our visits, we conducted interviews with facility leadership and asked them to confirm the completeness of our list of providers. Our November 2017 report included independent providers only.

[12]GAO-18-63, 3.

others.[13] We found that VA medical centers took administrative or disciplinary actions against some providers, such as removing them from patient care, after becoming aware of adverse information in the NPDB. However, many of these actions were taken following our review and a VHA-wide licensure review, both of which occurred in 2018, rather than at the time of the NPDB report. Specifically, the responsible VA medical centers removed five providers who they determined did not meet VA licensure requirements following our inquiries. For example, one of these five providers had surrendered a license in 2014, while employed at VA, but was not removed by the VA medical center until after our inquiries in 2018. Additionally, another provider was reported to the Drug Enforcement Administration (DEA) by a VA medical center after we inquired about the provider prescribing controlled substances without appropriate registration.

We also found that VA medical centers hired or retained some of the 57 providers who they acknowledged had disqualifying adverse information in the NPDB, which is inconsistent with VHA policy. Specifically, these providers had licenses that were revoked or surrendered for cause, but VA medical center officials overlooked or were unaware of this information. However, none of these providers still worked at VHA at the time we completed our review. For example, one VA medical center hired a provider who had a state license revoked for patient neglect and substandard care.[14] VA medical center officials stated that they received the NPDB report about the revoked license at the time the provider was hired in 2014 but it was inadvertently overlooked by multiple staff. This provider voluntarily resigned in 2017.

In our February 2019 report, we found that three factors were largely responsible for inconsistent adherence to VHA policies that disqualify providers from employment.

- First, some medical center officials are not aware of key VHA policies, such as the requirement that a provider who has had a license revoked or surrendered for cause is ineligible for employment unless the license is reinstated. For example, in the case of the provider who

[13]Cases evolve over time and can span multiple categories, which is why we did not enumerate the number of cases we found that fit into these various categories. We found that in some of the 57 cases, VA medical centers determined that providers had administrative or other nondisqualifying adverse actions reported in the NPDB, and concluded that the providers could be hired or retained.

[14]This provider had an active license in another state.

surrendered a license in 2014, documentation shows that the medical center staff became aware of the surrendered license in 2015, but VHA staff stated that the removal was stalled due to confusion about policies. This lack of awareness of key policies may be linked to a lack of mandatory training for credentialing staff.

- Second, gaps in VHA policy allow for inconsistent interpretation. For example, VHA has not issued policies pertaining to employing providers who have had their DEA registration for prescribing controlled substances revoked or surrendered for cause. While the DEA requires registrants, like VHA, to obtain a waiver before employing such providers, VHA policy is silent on the requirement to obtain a waiver; we found that VA medical center officials were unclear on the DEA requirement and had hired providers without obtaining the required DEA employment waiver. Further, we found that two providers inappropriately prescribed controlled substances without a DEA waiver.[15]
- Third, VHA's oversight of VA medical centers' reviews of adverse information is inadequate. Under VHA policy, VISN officials are responsible for reviewing providers with certain adverse licensure actions. However, we found that this review was not always conducted or documented. Further, although VHA-wide reviews of provider licenses have been completed and have identified providers with licensure issues, VHA officials indicated that these types of reviews are not routinely conducted because they are labor intensive.

In our February 2019 report, we also found that some VA medical centers had taken steps to improve the credentialing process and identify providers who do not meet the licensure requirements. For example, one medical center completed a periodic review of all licensed providers to identify providers who may have had an expired licensure issue. Another VA medical center updated its policies to require providers with adverse actions to be reviewed by management. However, we found that VHA does not routinely assemble and disseminate information about initiatives that medical centers have undertaken to improve the oversight of providers.

[15]The DEA enforces the controlled-substances laws and regulations of the United States. According to DEA regulation, registrants—including VHA facilities—must obtain a waiver of federal regulations from DEA before employing a provider who has (1) been convicted of a drug-related felony, (2) had a DEA registration revoked or denied, or (3) surrendered a DEA registration for cause.

In our February 2019 report, we concluded that without consistent adherence to VHA employment policies and adequate oversight, VHA lacks assurance that all VA providers have the appropriate professional qualifications and clinical abilities to care for patients. To address these shortcomings, in our February 2019 report we made seven recommendations to VA. VA concurred with these recommendations. Table 1 summarizes these recommendations and the steps VA has taken to address them.

Table 1: GAO's February 2019 Recommendations for Improving Department of Veterans Affairs (VA) Provider Credentialing and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should ensure that facility officials who are responsible for credentialing, reviewing credentials, and hiring receive periodic mandatory training.	**Status: Not addressed** VA concurred with this recommendation and reported in August 2019 that this training has been implemented. When VA provides documentation of the training and additional information about the training requirements, such as who is required to take the training and how often, we will review this information and make an assessment on whether this recommendation has been fully addressed.
The Under Secretary for Health should develop policies and guidance regarding Drug Enforcement Administration (DEA) registrations, including the circumstances in which DEA waivers may be required, the process for requesting them, and a mechanism to ensure that facilities follow these policies.[a]	**Status: Not addressed** VA concurred with this recommendation in principle. VA indicated in August 2019 it has requested DEA's interpretation of the waiver requirement.
The Under Secretary for Health should identify and review providers whose DEA registrations were revoked or surrendered for cause and determine whether an employment waiver may be needed from DEA.	**Status: Not addressed** VA concurred with this recommendation and said it will reinforce processes for taking appropriate administrative actions with respect to providers whose DEA registrations have been revoked or surrendered for cause. In August 2019, VA reported that it conducted a review of providers with National Practitioner Data Bank (NPDB) reports related to DEA registration since 2009. VA identified 10 providers and determined that 9 of the 10 had full, unrestricted DEA registration. However, VA may need to obtain a DEA waiver for one provider, even though VA reported that the provider is no longer prescribing controlled substances.
The Under Secretary for Health should confirm that Veterans Integrated Service Network (VISN) level Chief Medical Officer reviews are being appropriately documented so that Veterans Health Administration (VHA) Central Office officials are able to ensure that facilities and VISNs are complying with oversight policies.[b]	**Status: Addressed** VA concurred with this recommendation and reported in August 2019 that its electronic credentialing system, VetPro, was modified in November 2018 to allow for documentation of VISN Chief Medical Officer reviews.
The Under Secretary for Health should confirm that the appropriate VHA Central Office is conducting monitoring to ensure that required VISN-level Chief Medical Officer reviews of licensed independent practitioner credentialing files are conducted.	**Status: Not addressed** VA concurred with this recommendation. As of October 2019, VA anticipates being able to run reports to verify that VISN Chief Medical Officer reviews have been completed later in October 2019.

GAO recommendation	Implementation status
The Under Secretary for Health should direct the VHA facilities to periodically review provider licenses using NPDB adverse-action reports, similar to recent VHA-wide reviews. Facility officials should take appropriate action on providers who do not meet the licensure requirements, and report the findings to VHA, VISN and Central Office officials for review.	**Status: Not addressed** VA concurred with this recommendation in principle. VA indicated that it requires enrollment of all independent VA providers in the NPDB continuous query so that VA medical centers and VHA receive alerts if licensure actions have been taken. VA stated that this process allows for proactive, immediate reviews, rather than periodically running retrospective reviews of NPDB adverse action reports. Additionally, as of January 2019, VA implemented new requirements for documenting these reviews. As of October 2019, VA plans to require medical centers to enroll dependent VA providers in the NPDB continuous query by the end of 2019.
The Under Secretary for Health should direct the Office of Quality, Safety and Value (QSV) to compile and disseminate to all facilities best practices employed by facilities that have proactively identified and addressed provider adverse-action licensure issues.[c]	**Status: Addressed** VA concurred with this recommendation and reported in August 2019 that it has codified best practices in standard practice in a variety of ways, including developing a standard form for reviewing NPDB reports and implementing training on the NPDB for credentialers.

Source: GAO-19-6 and GAO analysis of VA information. | GAO-20-152T

[a]DEA registrations allow providers to prescribe controlled substances.

[b]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA. The VISN Chief Medical Officer is responsible for oversight of the credentialing and privileging process.

[c]QSV is the office within VHA responsible for overseeing VHA-wide credentialing and privileging policy.

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

As we reported in November 2017, 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. However, for almost half of these reviews, officials at these medical centers could not provide documentation to show that the reviews had been conducted.[16] 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. For example, we found that the medical centers lacked documentation showing they conducted a prospective review of 26 providers. Additionally, VA medical center officials confirmed

[16]VA medical center officials have flexibility to determine the most appropriate process to use to review a provider's clinical care depending on the specific concerns and the situation. These processes include 1) focused professional practice evaluation for cause, which is a prospective review of a provider's care, during which the provider has the opportunity to demonstrate improvement; 2) retrospective review, which is a review of the provider's past patient care; and 3) comprehensive review, which is a more extensive retrospective review that is generally performed by a panel of experts and typically results in conclusions and recommendations. VHA policy states that if allowing a provider to continue delivering patient care could result in imminent danger to veterans, officials should remove the provider from delivering patient care during the review.

that they failed to conduct this required review for an additional 21 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 or more months, and in some cases, for multiple years, after concerns had been raised about the providers' care. For three of these 16 providers, additional concerns about the providers' clinical care were raised before the reviews began.

In our November 2017 report, we found that two factors were largely responsible for the inadequate documentation and untimely provider reviews.

- 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, VISN officials 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 VISN officials we spoke with described any routine oversight of such reviews.[17] This may be in part because the standardized tool that VHA requires the VISNs to use during their routine audits does not direct VISN 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.

In our November 2017 report, we concluded that 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

[17]When asked about their routine audits, VISN officials we interviewed generally described selecting a sample of providers from different specialties to review compliance with VHA requirements related to credentialing and privileging. For example, VISN 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.

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 and improve VA medical center reviews of provider quality and safety concerns, we made three recommendations to VA in our November 2017 report. VA concurred with these recommendations. Table 2 summarizes these recommendations and the steps VA has taken to address them.

Table 2: GAO's November 2017 Recommendations for Improving Department of Veterans Affairs (VA) Reviews of Provider Quality and Safety Concerns and the Implementation Status of These Recommendations

GAO recommendation	Implementation status
The Under Secretary for Health should specify in Veterans Health Administration (VHA) policy that reviews of providers' clinical care after concerns have been raised should be documented, including retrospective and comprehensive reviews.	**Status: Not addressed** VA concurred with this recommendation and indicated plans to revise policy to codify requirements for documenting reviews. As of October 2019, VA estimates completing these and other revisions to the VHA policy in August 2020.[a]
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.	**Status: Not addressed** VA concurred with this recommendation and indicated plans to revise policy to incorporate timeline expectations for initiating reviews after clinical care concerns have been raised. As of October 2019, VA estimates completing these and other revisions to the VHA policy in August 2020.[a]
The Under Secretary for Health should require Veterans Integrated Service Network (VISN) officials to oversee VA medical center reviews of providers' clinical care after concerns have been raised, including retrospective and comprehensive reviews, and ensure that VISN officials are conducting such oversight with the required standardized audit tool.[b] This oversight should include reviewing documentation in order to ensure that these reviews are documented appropriately and conducted in a timely manner.[c]	**Status: Not addressed** VA concurred with this recommendation and indicated plans to update the standardized audit tool so that it directs the VISNs to oversee reviews of providers' clinical care after concerns have been raised. As of October 2019, VA reported that it had developed and piloted a new standardized audit tool. VA stated that it needs about 6 months to implement and assess the tool. VA estimated completion in November 2019.

Source: GAO-18-63 and GAO analysis of VA information. I GAO-20-152T

[a]VA officials indicated that the delay in issuing the revised policy is due to revisions unrelated to these recommendations.

[b]Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA.

[c]Since April 2018, this recommendation has been designated a priority recommendation. We began issuing letters to the Secretary of VA in 2017 identifying open recommendations that we consider to be the highest priority (i.e., priority recommendations) for VA to implement in order to significantly improve VA operations. See GAO, Priority Recommendations: Department of Veterans Affairs, GAO-19-358SP (Washington, D.C.: Mar. 28, 2019).

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

In our November 2017 report, we found that from October 2013 through March 2017, the five VA medical centers we reviewed had only reported one of nine providers that should have been reported to the NPDB as required by VHA policy. Furthermore, none of these nine providers were reported to state licensing boards as required by VHA policy.[18] 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.

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. Similarly, the documentation shows that another provider's opportunity to improve had to be halted and the provider was removed from providing care after only a week due to concerns that continuing the review would potentially harm patients.

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

At the time of our review, 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

[18]As a result of our audit work, VHA officials told us in April 2019 that the five selected VA medical centers completed NPDB reporting for eight of the nine providers and state licensing board reporting for seven of the nine providers. VHA officials stated that one provider was not reported to the state licensing board because the provider had self-reported before the VA medical center had an opportunity to do so. VHA officials stated that the other provider was not reported to the NPDB or state licensing board because the VA medical center director, at the time, had made the decision not to do so.

concerns for the safety of veterans.[19] However, we found that the medical centers' reporting to the state licensing boards 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 were responsible for NPDB reporting. Officials at two other VA medical centers incorrectly told us that VHA cannot report contract providers to the NPDB.
- Second, VHA policy does not require the VISNs to oversee whether VA medical centers are reporting providers to the NPDB or state licensing boards when warranted. We found, for example, that VISN officials were unaware of situations in which VA medical center officials failed to report providers to the NPDB.

As a result of VHA staff misinterpretation of VHA policy and insufficient oversight, we concluded that VHA lacks reasonable assurance that all providers who should be reported to the NPDB and state licensing boards are reported. Consequently, the NPDB and state licensing boards in other states where the providers we identified held licenses were not alerted to concerns about the providers' clinical practice. We reported that this could allow a provider who delivered substandard care at one VA medical center to obtain privileges at another VA medical center or at hospitals outside of VA's health care system. In our November 2017 report, we noted 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,

[19]These two providers were not among the nine providers who had an adverse privileging action taken against them, or who 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.

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.

To improve VA medical centers' reporting of providers to the NPDB and state licensing boards and VHA oversight of these processes, we made one recommendation in our November 2017 report. VA concurred with this recommendation. Table 3 summarizes the recommendation and the steps VA has taken to address it.

Table 3: GAO's November 2017 Recommendation for Improving Department of Veterans Affairs (VA) Reporting of Provider Quality and Safety Concerns and the Implementation Status of This Recommendation

GAO recommendation	Implementation status
The Under Secretary for Health should require Veterans Integrated Service Network (VISN) officials to establish a process for overseeing VA medical centers to ensure that they are reporting providers to the National Practitioner Data Bank (NPDB) and state licensing boards, and are reporting in a timely manner.	**Status: Not addressed** VA concurred with the recommendation and indicated plans to update the standardized audit tool so that it directs the VISNs to ensure timely reporting to the NPDB and state licensing boards, in accordance with Veterans Health Administration (VHA) policy. As of October 2019, VA reported that it had developed and piloted a new standardized audit tool. VA stated that it needs about 6 months to implement and assess the tool. VA estimated completion in November 2019. In addition to completing the tool, VA needs to demonstrate that the providers we identified in our review have been reported to the NPDB and state licensing boards, or document its decision not to report these providers.

Source: GAO-18-63 and GAO analysis of VA information. I GAO-20-152T

Notes: Each VISN is responsible for managing and overseeing VHA facilities within a defined geographic area and for reporting to VHA. Since April 2018, this recommendation has been on our high priority list. We began issuing letters to the Secretary of VA in 2017 identifying open recommendations that we consider to be the highest priority (i.e., priority recommendations) for VA to implement in order to significantly improve VA operations. See GAO, Priority Recommendations: Department of Veterans Affairs, GAO-19-358SP (Washington, D.C.: Mar. 28, 2019).

Chairman Pappas, Ranking Member Bergman, 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 (silass@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, Cathy Hamann, Jacquelyn Hamilton, and Vikki Porter. Other contributors include David Bruno, Julia DiPonio, Ranya Elias, Kathryn A. Larin, and Joy Myers.

Appendix I: Veterans Health Administration Credentialing, Privileging, and Monitoring Processes

According to Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) policies, all licensed health care providers must be credentialed before they are permitted to work.[1] Credentialing is the process of screening and evaluating qualifications and other credentials—including licensure, education, and relevant training—that is the first step in the process of determining whether the provider has appropriate clinical abilities and qualifications to provide medical services. Credentialing processes and requirements differ for independent licensed providers, such as doctors—who are permitted by law and the facility to deliver patient care services independently, without supervision—and dependent providers, such as nurses—who deliver patient care under the supervision or direction of an independent provider. Additionally, VHA policy states that only licensed independent providers may be granted clinical privileges. Privileging is a process through which a provider is permitted by a facility to independently provide medical or patient care that is in alignment with the provider's clinical competence. Figure 1 provides a summary of the VHA credentialing and privileging processes for independent and dependent providers.

[1]VHA policy allows for temporary medical staff appointments for urgent patient care needs before full credentialing information has been received.

Figure 1: VHA's Credentialing and Privileging Process

Credentialing
The process of screening and evaluating qualifications and other credentials, including, but not limited to: licensure, required education, relevant training, and experience.

Privileging
A process through which a provider is permitted by a facility to independently provide medical or patient care that is in alignment with the provider's clinical competence.

	Licensed independent practitioners	Dependent providers
1 A provider submits an application for a position at a Veterans Health Administration (VHA) facility.	✔	✔
2 Facility credentialing officials verify information.[a] Credentialers verify elements of the provider's application, including licensure, education, work history, and clinical references, as well as malpractice history and National Practitioner Data Bank (NDPB) reports, if applicable.	✔	✔
3 Facility Service Chief reviews information and decides whether or not to recommend appointment. The cognizant Service Chief—the manager responsible for a particular clinical service area such as surgery or medicine—reviews the information collected by credentialing officials and Human Resources offices and makes a recommendation about whether or not to appoint the provider.	✔	✔
For licensed independent practitioners, the Service Chief also reviews the clinical privileges requested by the provider.	✔	N/A
4 Facility credentialing committees review information and decide whether or not to recommend appointment to the facility Director.[b] The cognizant credentialing committee reviews the provider's verified credentialing file and the Service Chief's recommendation and makes a recommendation to the facility Director about whether or not to appoint the provider.	✔	✔
For licensed independent practitioners, the credentialing committee also determines whether clinical privileges should be granted as requested by the provider, and makes a recommendation to the facility Director.	✔	N/A
5 The facility Director makes the final decision as to whether to appoint the provider.[c] The facility Director reviews the Service Chief and credentialing committee recommendations and decides whether or not to appoint a provider.	✔	✔
For licensed independent practitioners, the facility Director also determines whether clinical privileges should be granted as requested by the provider.	✔	N/A

✔ Applicable
N/A Not applicable

Source: GAO analysis of Department of Veterans Affairs information. | GAO-20-152T

Note: Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Examples of licensed

independent practitioners are doctors and dentists. Dependent providers, such as registered nurses, are individuals who provide patient care under the supervision or direction of a licensed independent practitioner.

[a]VHA officials told us that, concurrent to the credentialing process, Human Resources officials at the facilities complete preemployment checks, including drug testing, suitability review, and criminal-background checks.

[b]We refer to committees that review the provider's credentials as "credentialing committees." VHA officials told us that the facility's Executive Committee of the Medical Staff—comprising the facility's medical staff leadership—is responsible for reviewing credentials and privilege requests for licensed independent practitioners. They said that the facility's Professional Standards Board—comprising peers from the provider's occupation—is responsible for reviewing credentials for dependent providers. If there is no Professional Standards Board for the occupation that the provider is applying for, they told us that the credentialing file is reviewed by a second credentialing professional to ensure that credentialing is completed in accordance with policy.

[c]VHA officials told us that for dependent providers, the approving official may be someone other than the facility Director.

VHA facilities are also required to monitor providers' licenses after they are hired to ensure the licenses are current and review any licensure actions, in accordance with VHA policy. Figure 2 provides a summary of VHA's processes for monitoring independent and dependent providers' licenses.

Figure 2: VHA's Process to Monitor Provider Licenses

Monitoring

Veterans Health Administration (VHA) facilities monitor the provider's licenses to identify adverse actions and to verify that licenses are renewed.

	Licensed independent practitioners	Dependent providers
▶ VHA facilities review licensed independent practitioners' clinical privileges at least every 2 years. Among other items, facility officials confirm licensure status, professional competency, and malpractice history, when deciding whether or not to renew licensed independent practitioners' privileges.	✔	N/A
▶ VHA facilities enroll licensed independent practitioners in the National Practitioner Data Bank (NPDB) continuous query. Through an electronic interface, NPDB continuous query alerts VHA if any entity files a report on one of VHA's licensed independent practitioners. Facilities reenroll licensed independent practitioners in NPDB continuous query annually.	✔	N/A
▶ VHA facilities verify the provider's license by contacting the state licensing board when it is up for renewal—typically every 1 to 2 years, depending on the state and type of license—to ensure that the license is in good standing.	✔	✔

✔ Applicable

N/A Not applicable

Source: GAO analysis of Department of Veterans Affairs information. | GAO-20-152T

Note: Licensed independent practitioners are providers who are permitted by law and the facility to provide patient-care services independently, without supervision or direction. Examples of licensed

independent practitioners are doctors and dentists. Dependent providers, such as registered nurses, are individuals that provide patient care under the supervision or direction of a licensed independent practitioner.

Related GAO Reports

Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care. GAO-19-6. Washington, D.C.: February 28, 2019.

Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability. GAO-18-137. Washington, D.C.: July 19, 2018.

VA Health Care: Improved Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns. GAO-18-260T. Washington, D.C.: November 29, 2017.

VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns. GAO-18-63. Washington, D.C.: November 15, 2017.

Veterans Health Care: Improved Oversight of Community Care Physicians' Credentials Needed. GAO-16-795. Washington, D.C.: September 19, 2016.

VA Health Care: Improvements Needed in Processes Used to Address Providers' Actions That Contribute to Adverse Events. GAO-14-55. Washington, D.C.: December 3, 2013.

Veterans Health Care: Veterans Health Administration Processes for Responding to Reported Adverse Events, GAO-12-827R. Washington, D.C.: August 24, 2012.

VA Health Care: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes. GAO-10-26. Washington, D.C.: January 6, 2010.

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October 16, 2019

VA HEALTH CARE

Actions Needed to Ensure Provider Qualifications and Competence

GAO Highlights

Highlights of GAO-20-152T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Nearly 165,000 licensed health care providers, such as physicians and nurses, provide care in VHA's VA medical centers and outpatient facilities. Medical center staff must determine whether to hire and retain health care providers by reviewing and verifying information about their qualifications and practice history. The NPDB is a key source of information about a provider's clinical practice history.

Medical center staff must also investigate any concerns that arise about the clinical care their providers deliver. Depending on the findings from these reviews, medical centers may take an adverse privileging action against a provider. VA medical centers are required to report providers to the NPDB and state licensing boards under certain circumstances. Failing to adhere to these requirements can negatively affect patient safety.

This testimony is primarily based on GAO's 2019 and 2017 reports on VHA processes for reviewing and reporting quality and safety concerns about VA providers. It addresses VA medical centers' implementation and VHA's oversight of (1) reviews of adverse information about providers in the NPDB; (2) reviews of providers' clinical care after concerns are raised; and (3) reporting of providers to the NPDB and state licensing boards. For the 2019 report, GAO reviewed a nongeneralizable sample of 57 VA providers who had an NPDB report. For the 2017 report, GAO reviewed providers whose clinical care was reviewed after a concern was raised about that care at a nongeneralizable selection of five VA medical centers.

View GAO-20-152T. For more information, contact Sharon M. Silas at (202) 512-7114 or silass@gao.gov

What GAO Found

The Department of Veterans Affairs (VA) needs to take action to ensure its health care providers have the appropriate qualifications and clinical abilities to deliver high quality, safe care to veterans, as GAO recommended in its February 2019 and November 2017 reports. Specifically, GAO found the following:

- **VA medical centers took action against some providers who did not meet VA licensure requirements, but overlooked others**. In its 2019 report, GAO found that some VA medical centers took administrative or disciplinary actions against these providers, such as removing them from employment, after becoming aware of disqualifying information in the National Practitioner Data Bank (NPDB). The NPDB is an electronic repository that contains information on providers who have been disciplined by a state licensing board, among other information. However, in some cases VA medical centers overlooked or were unaware of disqualifying information in the NPDB. For example, officials told GAO they inadvertently overlooked a disqualifying adverse action and hired a provider whose license had been revoked for patient neglect. GAO found three reasons for this inconsistency: lack of mandatory training for key staff, gaps in Veterans Health Administration (VHA) policies, and inadequate oversight.

- **Selected VA medical centers' reviews of providers' clinical care were not always documented**. The five selected VA medical centers that GAO included in its 2017 report were required to review 148 providers' clinical care after concerns were raised about their care from October 2013 through March 2017. However, officials at these medical centers could not provide documentation to show that almost half of these reviews had been conducted. GAO found two reasons for inadequate documentation of these reviews: gaps in VHA policies and inadequate oversight of the reviews.

- **Selected VA medical centers did not report providers to the NPDB or to state licensing boards as required**. The five selected VA medical centers that GAO included in its 2017 report had reported one of nine providers to the NPDB that they were required to report from October 2013 through March 2017. None of these providers were reported to state licensing boards, as required by VHA policy. These nine providers either had adverse privileging actions taken against them—actions that limit the care providers can deliver at a facility or prevent the providers from delivering care altogether—or resigned or retired while under investigation before such an action could be taken. GAO found two reasons providers were not reported: lack of awareness or understanding of VHA policies and inadequate oversight of this reporting.

GAO made 11 recommendations in its 2019 and 2017 reports to address the deficiencies identified. VA implemented two of these 11 recommendations, and provided action plans to address the other nine recommendations.

PREPARED STATEMENT OF DR. JOHN D. DAIGH

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of Veterans Health Administration (VHA) efforts to ensure its medical facilities are effectively implementing their provider credentialing and privileging (C&P) processes. The mission of the OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, reviews, and investigations. For many years, the OIG has conducted reviews and investigations that have identified concerns with VHA's C&P operations.

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

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

BACKGROUND ON CREDENTIALING, PRIVILEGING, AND SKILL ASSESSMENT

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

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

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges are specific to the medical procedure performed. They are based on the individual's clinical competence, recommendations by service chiefs (typically the LIP's supervisor) and the Medical Staff Executive Committee, and with approval by the facility director. Peer references, professional experience, health status, education, training, and licensure inform decisions about a provider's clinical competence and ability to successfully accomplish clinical privileges. Clinical privileges are granted for a period not to exceed 2 years, and LIPs must undergo reprivileging prior to expiration.[4]

VHA also mandates processes to check the skills of providers during their term of employment. A Focused Professional Practice Evaluation (FPPE) is a time-limited process conducted in three instances: (1) for all new LIPs who are requesting initial privileges or scope of practice; (2) when a provider requests a new clinical privilege or scope of practice; and (3) when issues affecting the provision of safe, high-quality patient care are identified. VHA requires that all LIPs new to the facility have FPPEs completed, documented in the provider's electronic profile, and reported to

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

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

[3] VHA Handbook 1100.19.

[4] VHA Handbook 1100.19.

an appropriate committee of the medical staff.[5] The process involves evaluating the provider's privilege-specific competencies. This may include periodic chart review, direct observation, monitoring diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[6]

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

THE OIG'S COMPREHENSIVE HEALTHCARE INSPECTION PROGRAM FOCUS ON EVALUATING CREDENTIALING AND PRIVILEGING PROCESSES

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

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

COMPREHENSIVE HEALTHCARE INSPECTION SUMMARY REPORT FISCAL YEAR 2018.

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

- performance indicators for credentialing processes, such as current licensure and verification of primary source information;
- privileging processes, such as verifying existing privileges and the details of the recommendations and approvals for requested privileges;
- FPPEs; and
- OPPEs.

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

The Summary Report made four recommendations to the Under Secretary for Health to improve the C&P process nationally, based upon aggregate data collected during the Fiscal Year 2018 CHIP site visits. The first recommends that VHA ensure that the FPPEs are reported properly to committees for review. The second recommends that the FPPEs clearly delineate timeframes for review in compliance with VHA policy. The third recommends that VHA verify that clinical managers include service-specific data in ongoing professional practice evaluations and monitor clinical managers' compliance. The fourth recommends VHA verify that clinical managers include specialty-specific elements in gastroenterology, pathology, nuclear

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[5] VHA Handbook 1100.19.

[6] VHA Handbook 1100.19.

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

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

medicine, and radiation oncology providers' OPPEs and monitor clinical managers' compliance. The Executive in Charge for VHA concurred with the first, third, and fourth recommendations and in principle with the second recommendation.[9] The Executive in Charge projected that these recommendations would be fully implemented by June 2020. OIG staff will monitor VA's progress.

CREDENTIALING & PRIVILEGING PROCESS BREAKDOWNS

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

LEADERSHIP FAILURES RELATED TO TRAINING, PERFORMANCE, AND PRODUCTIVITY DEFICITS OF A PROVIDER AT A VETERANS INTEGRATED SERVICE NETWORK 10 MEDICAL FACILITY.

In December 2018, the OIG became aware of allegations of mismanagement, waste of funds, and safety risks at a Veterans Integrated Service Network (VISN) 10 medical facility.[10] A complainant alleged an ophthalmologist lacked training, provided substandard care, and failed to meet productivity expectations. In spite of these reported concerns, the facility's chief of staff intended to reappoint the surgeon following the probationary period.

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

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

Despite these ongoing concerns, the chief of staff endorsed the surgeon's reappointment as the facility's sole ophthalmologist. At the time of the interviews, facility staff told the OIG that they believed the surgeon would be reappointed because facility leaders needed the services of the surgeon's spouse, who was also a surgeon, and facility leaders described them as a "package set," admitting that relationship was a consideration. As a result, for 2 years before the surgeon was terminated, patients were placed at unnecessary risk for potential surgical complications. The OIG made five recommendations related to C&P processes, professional practice evaluations, management of performance deficits, and the chief of staff's actions. OIG staff continue to monitor VA's progress until all proposed actions are complete.

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

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

PROFESSIONAL PRACTICE EVALUATION BREAKDOWNS

In addition to being credentialed, before rendering services, the facility's medical leaders must determine if a provider meets the specific criteria for conducting procedures. Importantly, the facility considers the provider to be privileged only for particular medical procedures and must repeat the privileging process if the provider wishes to conduct different patient care services. Therefore, VHA policy dictates that providers are privileged using identified provider-, service-, and facility-specific privileges. A critical feature of ensuring that providers are delivering high-quality care is the focused evaluation (FPPE) and the ongoing evaluation (OPPE). Once a provider begins rendering care to veterans, proper use of the FPPE to monitor performance at the start of employment or if a question of the provider's skills is raised can mitigate risks. A properly executed OPPE is critical for VHA's determination whether it wishes to retain the services of a current provider. However, numerous OIG reports have identified a lack of diligence across VHA facilities in executing FPPEs and OPPEs as the following examples demonstrate.

INTRAOPERATIVE RADIOFREQUENCY ABLATION AND OTHER SURGICAL SERVICE CONCERNS AT THE SAMUEL S. STRATTON VA MEDICAL CENTER IN ALBANY, NEW YORK.

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

Additionally, the surgeon's OPPE was flawed. The forms contained incomplete data and did not address specific competencies related to the surgical specialty. Further complicating matters, the chief of surgery failed to collect sufficient data to evaluate the surgeon's practice and surgical outcomes. The quarterly data used by the chief of surgery to evaluate the surgeon's competency also contained errors over a 2-year period, thus failing to trigger a focused review of the surgeon. OIG staff could not determine if healthcare quality data or patient safety trends were affected by poor FPPE/OPPE processes because of the unreliable data. The OIG also found failures related to the facility's quality management. Patients were not timely notified that the surgeon did not completely remove tumors. Nine recommendations were made, and one recommendation related to establishing a process to track, monitor, and report on intraoperative radiofrequency ablation outcomes remains open.

This report underscores the need for adherence to VHA policy that ongoing assessments of a provider's competence must focus on the specific provider and examine his or her particular skills and judgment as they relate to the requested privilege. To ensure thorough and accurate evaluations, VHA policy has appropriately mandated that reviews be conducted by a physician with similar training and privileges.

QUALITY OF CARE CONCERNS IN THORACIC SURGERY, BAY PINES VA HEALTHCARE SYSTEM IN FLORIDA.

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

The surgeon had been employed with VA long enough to have undergone a routine recredentialing OPPE, which was conducted by an administrative psychiatrist. New VHA guidance had been issued, but was not yet in force, mandating OPPEs

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

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

be conducted by a provider with similar training and privileges. Based on the OIG's recommendation made during the site visit, the system arranged for the surgeon to be proctored in order to confirm whether the surgeon had the ability and skills. A thoracic surgeon from another VA facility directly observed the thoracic surgeon's operative skills and did not have concerns regarding his surgical technique. VHA has satisfactorily completed action on OIG recommendations. This report highlights the benefit of having performance determinations made with specificity and by an independent peer.

CREDENTIALING AND PRIVILEGING PROCESS FAILURES HAVE PATIENT CARE IMPACTS

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

FACILITY LEADERS' OVERSIGHT AND QUALITY MANAGEMENT PROCESSES AT THE GULF COAST VA HEALTH CARE SYSTEM IN BILOXI, MISSISSIPPI.

The OIG conducted a healthcare inspection to examine the C&P process, as well as the facility's understanding of quality management practices, in response to multiple allegations of another thoracic surgeon's poor quality of care.[13] A review of the surgeon's C&P files revealed that before hiring the surgeon in August 2013, facility leaders knew of malpractice issues as well as the surgeon having relinquished a State medical license in October 2006 to prevent prosecution in a disciplinary case. Still, the facility director hired the surgeon after the Credentialing Committee recommended the appointment.

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

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

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

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

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

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

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

FACILITY HIRING PROCESSES AND LEADERS' RESPONSES RELATED TO THE DEFICIENT PRACTICE OF A RADIOLOGIST AT THE CHARLES GEORGE VA MEDICAL CENTER IN ASHEVILLE, NORTH CAROLINA.

An OIG healthcare inspection team evaluated concerns regarding deficiencies identified in the practice and oversight of a fee-basis radiologist during a 6-month tenure in 2014.[14] The concerns were identified during the facility's 2018 CHIP review in response to questions related to the radiologist's initial C&P, the radiologist's deficient delivery of care, and the facility's delayed evaluation of the deficient care.[15]

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

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

Facility leaders failed to take proper actions to curtail the radiologist's practice after not renewing the radiologist's contract in December 2014 and did not promptly complete the subject radiologist's exit memorandum within 7 days as required by VHA to comply with State licensing boards' reporting requirements. The results were not made to the facility professional standards board until August 2018, 3 years after the required date. Due to the failure to complete the exit memorandum, the patient safety manager was not promptly notified to trigger mandated administrative reviews. After the OIG review commenced, the facility director issued notices

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

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

in January 2019 to eight State licensing boards stating that the radiologist failed to meet generally accepted standards of clinical practice. The OIG subsequently made four recommendations to the facility and VISN related to C&P requirements, State licensing board reporting, reporting of adverse events, and potential administrative actions. OIG staff will monitor VA's progress until all proposed actions are complete.

ALLEGED INAPPROPRIATE ANESTHESIA PRACTICES AT THE JAMES E. VAN ZANDT VAMC IN ALTOONA, PENNSYLVANIA.

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

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

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

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

NATIONAL AND LOCAL OVERSIGHT WEAKNESSES

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

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

The C&P issues reported by OIG should not be discounted as isolated events expected across a large system. Rather, changes should be considered to the C&P processes by requiring LIPs to demonstrate the skills required to perform specific clin-

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

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

CONCLUSION

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

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

PREPARED STATEMENT OF DR. STEVEN LIEBERMAN

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

INTRODUCTION

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

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

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

SCREENING: BACKGROUND CHECKS

VA requires that all individuals working directly with Veterans are thoroughly and properly vetted. For all potential employees, this starts with a background

screening before entering on duty. The background screening process applies to all applicants, appointees, employees, contractors, affiliates, and other individuals who require physical or electronic access to VA information or information systems to perform their jobs.

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

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

CREDENTIALING AND PRIVILEGING

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

- Medical Credentialing is the process of obtaining and verifying documents related to the applicant's professional education, licensure, and certification, (such as copies of medical licenses, medical or nursing school diplomas, board certification certificates, etc.). The medical credentialing process also includes a review of the applicant's health status; previous experience, including any gaps in training and employment longer than 30 days; professional references; malpractice history and adverse actions; and/or criminal violations, as appropriate. These requirements are established by The Joint Commission, which accredits most health care facilities across the U.S., including all VA Medical Centers (VAMC). VA does not make firm employment offers to health care professionals until the medical credentialing process is completed.
- Privileging is the process by which the authorized official at an individual VAMC (generally the Medical Center Director) determines whether to grant clinical privileges to permit a licensed independent practitioner to provide medical care services within the scope of his or her licensure, training, and experience. According to The Joint Commission's standards, the decision whether to grant clinical privileges to an applicant to the medical facility's medical staff must be made at the local facility level.

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

All information obtained through the medical credentialing process must be carefully considered before appointment and privileging decision actions are made. Hiring officials take this process very seriously when considering a potential employee. The local Medical Center Director has the ultimate decision authority about wheth-

er an employee should be hired and whether clinical privileges should be granted, based on the outcome of the medical credentialing process.

MONITORING AND INVESTIGATIONS

VA has an obligation to reasonably ensure that its health care staff meet or exceed generally accepted professional standards for patient care and has the obligation to alert those entities charged with licensing health care professionals when there is serious concern about a licensed health care professional's clinical practice.

This obligation includes monitoring the care that our providers deliver in medical facilities. It also includes notifying SLBs of any substantiated findings of substandard care performed at VA by current or former licensed health care professionals and responding to inquiries from SLBs concerning the clinical practice of those professionals.

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

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

NPDB SCREENING AND ONGOING MONITORING

As described above, all applicants are thoroughly screened, including a review of any reports made to NPDB. Each report is individually reviewed in detail and primary source information is obtained from the reporting entity to outline the circumstances that led to the report. If information obtained through this process calls into question the professional competence or conduct of an individual applying to VA, the selecting official and facility leadership review the facts and circumstances to determine what action would be appropriate, possibly including non-selection.

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

We note that VA is like all other health care systems in this area. All accredited VAMCs and systems adhere to Joint Commission standards for medical credentialing and monitoring care. If there were some way of entirely avoiding misconduct or poor clinical care, there would be no need for the industry to use an NPDB, or for SLBs to have review procedures. We are, unfortunately, unable to pre-

dict and account for every issue that may arise, which is why we must respond quickly and comprehensively whenever Veterans' safety might be in jeopardy.

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

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

CONCLUSION

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

Additional Submissions for the Record

SUBMISSIONS FOR THE RECORD

PREPARED STATEMENT OF THE HONORABLE RICK CRAWFORD (AR-1)

Chairman Pappas and Ranking Member Bergman, thank you for holding this hearing regarding the Veterans Affairs health system.

I would like to thank the committee for its attention to the disturbing matter that occurred in the Fayetteville VA Hospital from 2015 to 2018.

Due to the failure of leadership within the Veterans Health Care System of the Ozark (VHSO), Dr. Robert Morris Levy's irresponsible actions have resulted in over 3,000 misdiagnoses and 15 deaths.

Our great Veterans deserve the best care and should have never been exposed to the personal tragedies that resulted from Mr. Levy's malpractice.

We should all use this terrible situation as an opportunity to review and amend rules and regulations within the Department of Veterans Affairs to ensure that our Veterans receive quality healthcare and accurate diagnoses.

While I am not a member of the Committee on Veterans Affairs, I am committed to providing support for any proposals that will help the Department of Veterans Affairs avoid similar tragic situations in the future.

One important change to consider would be to prohibit individuals from taking supervisory roles immediately after being rehabilitated from substance abuse.

I believe that many common-sense changes can be made to ensure that this never happens again.

I would especially like to thank the Department of Veterans Affairs Office of Inspector General for its extensive investigation that resulted in Federal charges.

Again, thank you Chairman Pappas and Ranking Member Bergman for your time and attention to this matter.

PREPARED STATEMENT OF THE HONORABLE FRENCH HILL (AR-2)

Chairman Pappas, Ranking Member Bergman, and Members of the Committee:

I appreciate the opportunity to submit this statement in support of this critical hearing today examining patient harm at U.S. Department of Veterans Affairs (VA) medical facilities.

As you may be aware, in my home State, Dr. Robert Morris Levy was chief pathologist at the VA Medical Center of the Ozarks in Fayetteville, Arkansas, and was recently indicted for allegedly botching diagnoses for an estimated 3,000 veterans between 2005 to 2017, and responsible for at least 15 deaths.

This alleged gross negligence by a physician charged with caring for our veterans is a disturbing revelation and a clear failure to uphold the VA's mission to the men and women who served our Nation in uniform.

Congress has provided the VA with the necessary tools to remove bad actors, such as Dr. Levy. Failing to dismiss physicians and any other employees whose work is unsatisfactory does a disservice to our veterans.

Dr. Levy's case is especially troubling, as his history of issues with substance abuse and run ins with the law were evident for years.

Nine years before VA even hired him in 2005, he was arrested and convicted of drunken driving. He hid his abuse at VA for a decade until an employee reported him to supervisors as intoxicated in 2015, but Dr. Levy denied the allegation and no further action was taken.

In 2016, Dr. Levy was found to be intoxicated when he was called to the radiology department to assist with a biopsy. His blood alcohol level was at 0.4, five times the legal limit in Arkansas of 0.08. He was suspended and entered a 3-month inpatient treatment program, at taxpayer expense.

After completing treatment, Dr. Levy returned to his work at VA, as if nothing happened.

In 2017, Dr. Levy was sent home after appearing drowsy and "speaking nonsense phrases" when he arrived to chair an October 2017 meeting of the hospital's tumor board. The hospital was forced to cancel multiple surgeries and medical procedures that required a pathologist.

His clinical privileges were suspended but he was allowed to return to nonclinical work. Again, allowing this reckless behavior to continue.

It would be almost an entire year before VA began a deeper dive of his work, finding a number of misdiagnoses.

In March 2018, Dr. Levy was arrested for driving under the influence after local police spotted him driving erratically in a post office parking lot. He was finally fired by VA the next month.

I was proud to support the VA Accountability and Whistleblower Protection Act of 2017, which was signed into law on June 23, 2017, and instituted necessary reforms at the VA by providing the Secretary with the authority to remove, demote, or suspend any VA employee, including Senior Executive Service (SES) employees, for performance or misconduct.

This would have proved vital to Dr. Levy's case, who had a staggering record of being impaired on the job and yet continued to evaluate patients even after numerous complaints against him.

My district is home to many of our brave veterans and service members at Little Rock Air Force Base and Camp Robinson, and they deserve to know that VA is giving them the best possible care.

I share your commitment to rigorous oversight to protect the men and women who sacrificed and served our country and will hold those who break the law and undermine the mission of the VA accountable.

Thank you again for holding this critical hearing and putting the care of our Nation's veterans above all else.

PREPARED STATEMENT OF THE HONORABLE JOHN LEWIS (GA-5)

Good afternoon, Chairman Pappas, Ranking Member Bergman, and Members of the Subcommittee.

Thank you for inviting me to testify on this important matter. I am grateful that the Subcommittee is holding this hearing. It is critical that safe, quality, consistent, compassionate patient care become a top priority at all VA Medical Centers. A United States Veteran should never experience what Airman Joel Marrable and his family endured.

The Atlanta Veterans Affairs Health Care System (VAMC) is one of the largest in the country. In Atlanta alone, there are more 18,000 Veterans, who may rely on the services provided at VA medical facilities. The Atlanta VAMC is one of eight Department of Veterans Affairs (VA) medical facilities that comprise the VA Southeast Network. This expansive network serves 1.4 million Veterans in Georgia, South Carolina, and Alabama. This is the third largest veteran population in the country.

Many Veterans throughout the region rely on the Atlanta VAMC to provide general and service-related health care. Located in Decatur, Georgia, the Atlanta VAMC oversees community-based clinics and health facilities throughout Metro Atlanta and surrounding areas. The Eagle's Nest Community Living Center is one of several facilities in the VA Southeast Network responsible for providing Veterans with long term care. Fulfilling their mission should require the highest level of attentive and empathetic care.

The importance of these facilities and the expectation of quality, safe care are the reasons that Air Force Veteran, and cancer patient, Joel Marrable's case is so horrific. When news broke last month detailing how Airman Marrable endured more than 100 ant bites while in care at the VAMC's Eagles Nest Community Living Center, a facility in my district, I was disgusted and heartbroken.

I want you to close your eyes. Imagine that after serving your nation around the world, you face the greatest battle of your life—the fight against cancer. It is a constant struggle, and the pain seems insurmountable. When you feel as if the suffering could not get any worse, you are attacked by an infestation of ants—covering your body and your room, biting you constantly— as you fight for your life.

This is what Airman Marrable endured. This is how a daughter discovered her father. This was their lasting memory of Atlanta VAMC. The staff told his daughter, Ms. Laquana Ross, that they thought her father passed away because of the magnitude of ants covering his body. I cannot comprehend how a person could be so neglected that the staff could not tell if he was still alive.

The record should be clear—the Atlanta VAMC failed Airman Marrable in his final days. It was Ms. Ross who discovered that her father was still alive and still

fighting for his life. It was Ms. Ross who insisted that her father to receive the care and dignity that he deserved in his final hours. A clean room, a bathed body, a bed without biting bugs, and regular health checks are not extraordinary expectations. These are the basics, and the VAMC failed to provide them.

In Airman Marrable's last days, his family could not even comfort him without causing pain. Ms. Ross recalled that her father was in so much agony from the ant bites that he would flinch whenever she touched his swollen hands. Mr. Chairman, these were his final moments. This was the care that his government gave Airman Marrable as he transitioned from this world.

When something is not right, it is our duty as Members of Congress to speak up and speak out. We have a moral obligation to do what is just and what is fair. Mr. Chairman, I shared my concerns with Department of Veterans Affairs Secretary, Robert Wilkie, and Ms. Ann Brown, the Director of the Atlanta VA healthcare system in a letter, which I would like to submit for the record. I am here today, because I want to ensure that what Airman Marrable endured never occurs again. He deserved better, and his country failed him and his family in their time of need.

The men and women who serve and sacrifice for our country deserve exceptional care from an agency and their contractors whose sole purpose is to care for those who valiantly protected our Nation. I am grieved by the inept response and negligence surrounding Airman Marrable's care. It is appalling to know that in his last days, Airman Marrable and his family were left to resolve this crisis when they should have been afforded the opportunity to cherish their last precious moments together.

Throughout my congressional district, Veterans are an integral part of the fabric of our community. These patriots put their lives on the line and their family, friends, and personal ambition on the back burner as they serve our Nation. They work, live, and contribute to the vibrancy of our country and deserve the highest level of respect and care.

Mr. Chairman, similar to many congressional offices, the majority of my office's constituent casework concerns Servicemembers, Veterans, and their families.. Upon hearing of this horrific case, my District Office caseworkers began a desperate search to provide support and solace to Airman Marrable and his. family. We extended our deepest condolences and ensured that the Marrable family knew that our office was a resource in their darkest hour.

The challenge of timely, quality, consistent service at VA facilities remains constant and widespread. My caseworkers are constantly fielding stories from frustrated and distraught constituents and their families. There is a sense of disarray and a lack, of appreciation for the important work of VA patient advocates, who are key intermediaries between congressional offices, the VA, and the Veterans. Responses to congressional inquiries languish, and those caseworkers and advocates who dedicate their careers to serving United States' Veterans and Servicemembers increasingly feel hopeless.

I believe that the commitment to the health and well-being of our Veterans takes priority over politics and party lines. We must demonstrate that the sacrifices made by these brave men and women were not in vain. These women and men sacrificed selflessly, and their country's appreciation should be proudly displayed by the quality of care at every VA Medical Facility.

As a nation and as a people, we can do better, and we must do better. The care our Veterans receive is a direct reflection of how our Nation shows gratitude to those who fight bravely to preserve our freedoms. Compassion, empathy, and respect should be our compass, our mission, and our mandate. At every opportunity, we should work tirelessly to correct the errors and shortcomings of the systems upon which they rely and strengthen the agency to support future generations of Veterans and their families.

Again, I thank you, Mr. Chairman, for the opportunity to testify this afternoon.

JOHN LEWIS
5th District, Georgia

SENIOR CHIEF DEPUTY
DEMOCRATIC WHIP

COMMITTEE ON
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September 17, 2019

The Honorable Robert Wilkie
U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Secretary Wilkie,

I write to thank you for speaking with me regarding preliminary actions to ensure that what Mr. Joel Marrable, an Air Force Veteran, and his family experienced at Eagles' Nest Community Living Center in Decatur, Georgia, never occurs again.

As you know, reports surfaced last week that Airman Marrable's family discovered their beloved patriarch covered with ants and over 100 bites in his room at the Eagle's Nest Community Living Center, a part of Atlanta VA Medical Center in Decatur, Georgia. Sadly, Airman Marrable passed away from cancer shortly afterwards. It is unacceptable that in the days before his death, Airman Marrable endured preventable pain and suffering.

Family members should trust their government to care properly for their loved ones. The reported infestation, living conditions, and atrocious care are inexcusable. The abysmal care that he received in his final days did not reflect the significance of his life and our appreciation for his service to our nation.

The men and women who serve, protect, and sacrifice for our country deserve exceptional medical care. Veterans and their families should receive respect and exemplary care and services from an agency and their contractors whose sole purpose is to care for those who valiantly served our nation.

The negligence and inept response surrounding this incident are alarming and unacceptable. I look forward to a continued updates on this grave matter and information on plans to ensure that Veterans in Metro Atlanta receive the quality of care that they earned and merit.

Sincerely,

John Lewis
Member of Congress

cc: The Honorable Johnny Isakson, Chair, Senate Committee on Veterans' Affairs
The Honorable Mark Takano, Chair, House Committee on Veterans' Affairs

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PREPARED STATEMENT OF THE HONORABLE DAVID MCKINLEY (WV-1)

We cannot begin to understand the grief and anger the families of those killed at the Clarksburg VA Medical Center have felt this last year. To find out that your loved ones were killed while in the care of a hospital is unimaginable.

The investigation into the suspicious deaths at the Clarksburg VA Medical Center has now gone on for more than 16-months and has left families with more questions than answers. It is imperative that the authorities conclude this investigation as soon as possible and provide answers to the public, closure to the families and justice to those who lost loved ones.

While hindsight is 20/20, we now know that several red flags should have been raised soon after the deaths. At the time, many of these deaths did not raise suspicions, and family members trusted the VA hospital when they were told the deaths were natural.

While it is clear several missteps were made, we would be remiss if we did not give credit to the Clarksburg VA Medical Center, for self-reporting the suspicious deaths once a pattern was noticed.

This incident has damaged the trust veterans and their families' have in the VA, and we owe it to them to find out what happened. I hope the committee will use today's hearing to find solutions that will protect our veterans and restore their belief that they are receiving the best quality of care possible.

PREPARED STATEMENT OF THE HONORABLE CAROL MILLER (WV-3)

Thank you, Chairman Pappas and Ranking Member Bergman for holding this hearing today.

It is of utmost importance that we continue to provide and maintain the highest quality of care for the men and women who have bravely served our country.

The deaths at Louis A. Johnson VA Medical Center in Clarksburg, West Virginia and the sexual assault allegations at Beckley, West Virginia VA Medical Center are troubling and unacceptable. As Members of Congress, it is our job to support swift and proper investigations to ensure that such instances never happen again.

There has been considerable progress with the quality of care that our veterans receive following the enactment of the MISSION Act and efforts to address the veteran's suicide epidemic. Our service members should feel safe and comfortable seeking care at the VA, and these events show that there needs to be additional oversight of clinicians, proper removal of bad actors, and monitoring of care.

The tragic deaths of our veterans at the Louis A. Johnson VA Medical Center in Clarksburg and the sexual assault allegations at the Beckley VA Medical Center are unacceptable. We must work together to ensure the families of our Nation's heroes get the answers that they deserve, and that we can work to prevent these tragic events in the future. I fully support the investigation into this matter and appreciate the Committee's interest and oversight.

PREPARED STATEMENT OF THE HONORABLE BRUCE WESTERMAN (AR-4)

Chairman Pappas and Ranking Member Bergman, distinguished Members of the Committee, and today's witnesses, thank you for hosting today's hearing and allowing me to submit a statement for the record.

As many of you now know, the Veterans Health Care System of the Ozarks (VHSO) suffered a catastrophic failure to hold one of their highest-ranking providers accountable, Chief Pathologist Dr. Robert Morris Levy.

Since his firing in 2018, only after he was arrested for a DUI, it has been uncovered that his malpractice resulted in the death of 15 of our Nation's veterans and 15 others whose health was irreparably harmed.

An additional 3,007 errors and misdiagnosis date back to 2005. It's now been uncovered that Dr. Levy had a misdiagnosis rate of 9 percent. Over 12 times the average pathology error rate.

In total, Dr. Levy diagnosed over 21,000 individuals and viewed 33,902 total cases during his tenure.

We may never know the true extent of the damage he caused, but the systemic problems that allowed it to occur in the first place must be addressed, and that starts with leadership.

When I first learned of the issues with Dr. Levy in May 2018, I immediately requested more information on how veterans and their families would be notified of the lookback process, and what resources would be made available to those seeking more information.

The VA did set up a dedicated phone line for patients, but when my staff tested it, they sat on hold for over 22 minutes.

Imagine learning from a televised press conference that you may have had your cancer misdiagnosed, and you call a number to learn more about what you can do, only to wait almost half an hour before you can talk to anyone.

That's simply unacceptable, and the problems didn't end there.

We requested for months that the VHSO put together an Administrative Investigative Board (AIB) to internally review the processes and problems that enabled this to happen, but it wasn't completed until September 17, 2018, almost 4 months after first learning of the problems with Dr. Levy.

At that time, many of the senior leadership staff had retired or quit, limiting the ability for the Board to conduct a substantive investigation.

Furthermore, we were told that the AIB was limited to assessing the validity of the allegations against Dr. Levy related to quality of care, and that they could not investigate the quality of care and oversight because the Office of the Inspector General (OIG) was investigating these issues.

My staff inquired with the OIG's office to assess if this was in fact true, and we were told the OIG does not believe they would have directed the VHSO to avoid those topics.

I would like to know why the AIB took so long to be commenced and completed and why, or if, it was limited in scope per the VHSO's communication to my office?

I also have concerns regarding the VHSO's decision to first only conduct a short retrospective review of Dr. Levy's cases.

It took the VA Inspector General requesting a full, comprehensive review to be done instead of the VA making this decision on their own—potentially harming the health of veterans who received care from Dr. Levy at other stages of his career.

The lookback process seems as if it was made up as it went along without any proven and tested systems in place to ensure each and every case was reviewed in depth and in a timely manner.

Does the VA have a standard lookback or review process for cases involving medical malpractice, and if so, was it properly followed?

Additionally, why was Dr. Levy allowed to immediately return to a position of authority after rehabilitating from substance abuse?

This allowed Dr. Levy to conceal misdiagnosis that may have been caused by his substance abuse. He was able to remove and delete cases that may have shown evidence of misdiagnosing patients, and even falsely claim a second physician had reviewed his cases for quality control.

The VA must look at the processes and procedures for reinstating physicians after substance abuse issues to ensure they do not relapse or hide medical mistakes without proper oversight.

Another issue we discovered was the length of time it took for VISN Director Skye McDougall to put a permanent Medical Center Director in place following the retirement of Dr. Worley in June 2018, the previous Medical Center Director and supervisor to Dr. Levy.

From communications my staff had with Director McDougall, she stated that a replacement candidate had been submitted for approval in May 2018—yet this makes no sense because Dr. Worley was still there at the time.

That candidate, Mr. Kelvin Parks, was not formally approved until the end of November 2018.

Why did it take 6 months to hire a permanent director, one who had been serving as an Interim Medical Center Director the whole time, during a time when strong leadership was needed?

And was a proper interview process followed that included other candidates to assess who may serve the VHSO best?

Additionally, what processes are in place to ensure a timely and efficient hiring process is in place, and what can be done, whether administratively or legislatively, to ensure the hiring process can be improved?

Although more issues were uncovered, the examples I present here today show a pattern of leadership failures when problems arise, and we need to ensure these failures don't happen again.

The members of America's Armed Forces are promised care for life due to the sacrifice they make to serve our Nation. We owe it to them to ensure that promise is kept, and that the care they receive is of a high quality.

The men and women that work at the VA are honorable, hard-working and highly qualified medical personnel who provide our Nation's veterans with great care, but that care can always be improved.

And when malpractice like this happens, it's imperative we do everything we can to ensure it's made right and corrected so it may never happen again.

As Members of Congress, how can we support the VA, and are there legislative changes we need to make to help stem leadership and accountability failures and ensure our veterans get the best care possible?

Again, thank you Chairman Pappas and Ranking Member Bergman for allowing me this opportunity, and I trust that we will all work together to ensure this may never happen again.

PREPARED STATEMENT OF THE HONORABLE STEVE WOMACK (AR-3)

Chairman Pappas, Ranking Member Bergman, distinguished members of the subcommittee, thank you for holding this important hearing focused on the Veterans Affairs health system.

As many of you know, Robert Levy, a former employee of the Veterans Health System of the Ozarks (VHSO), was recently indicted in the Western District of Arkansas on three counts of involuntary manslaughter and 28 counts of mail fraud, wire fraud, and making false statements to law enforcement.

These charges stem from Mr. Levy's conduct while serving as Chief of Pathology and Laboratory Medical Services for the VHSO, which is located in my district in Fayetteville, Arkansas.

While he was serving as Chief of Pathology, Mr. Levy was responsible for diagnosing veterans after examining their fluid and tissue samples. He repeatedly showed up to work intoxicated, first from alcohol and then, in order to pass mandated alcohol tests, from a substance called 2M–2B. This compound produces a sensation like alcohol but cannot be detected on normal alcohol screenings. Mr. Levy was finally fired from the VA in April 2018 following 2M–2B being detected in a fluid sample.

This was not Mr. Levy's first time failing an alcohol test. He was required to pass mandatory alcohol screenings because in 2016 he was found to be intoxicated while on duty. His blood alcohol content was 0.396—almost 5 times the legal limit—during the time he was scheduled to consult on a biopsy for a patient.

I was given the opportunity to speak about this situation at your committee's Member Day Hearing last month. During my testimony, I asked your committee to investigate the circumstances surrounding Mr. Levy's reinstatement, specifically how he was allowed to return to duty as a supervisor. I want to thank each and every one of you for responding to my request by holding this hearing.

While I understand this hearing is intended to look broadly at the VA's credentialing system, I would ask you to pay special attention to the physician reinstatement process. Particularly, the process for determining whether a physician should be returned to a supervisory position.

As Mr. Levy's indictment clearly shows, he was able to conceal misdiagnoses that may have occurred because of his intoxication due to his supervisory position. This position allowed him to ensure any conflicting diagnoses were removed or deleted and, in some cases, he was able to falsely claim a second physician conducted a review when no review was completed.

As I previously stated, I do not understand why, at the very least, an independent review procedure was not put in place to ensure Mr. Levy's subordinates were able to submit their reviews without interference. I think this committee and the VA should look at the procedures for reinstating a physician following a substance abuse issue. Furthermore, I hope you will look at whether or not those physicians should be returned to supervisory positions.

I truly appreciate your attention to these matters. The people of Northwest Arkansas and across the country are well-served by your diligence and knowledge. I

look forward to any solutions that come from this hearing and stand ready to help you in any way.

Our veterans stepped forward to defend our country and our values. They answered the call of duty, and it is now up to us to support these patriots. This hearing is the first step to ensuring the VA's credentialing system is appropriate for that mission.

Thank you again for your time and attention.

PREPARED STATEMENT OF THE NATIONAL COUNCIL OF STATE BOARDS OF NURSING

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

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

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

REPORTING TO STATE LICENSING BOARDS (SLBS) AND THE NATIONAL PRACTITIONER DATA BANK (NPDB)

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

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

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

Additionally, NCSBN strongly encourages VHA, in consultation with SLBs, to revise and update VHA Handbook 1100.18-Reporting and Responding to SLBs, which outlines procedures that VHA facilities must follow when reporting providers to and

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

interacting with SLBs. This section of the Handbook was originally drafted in 2005 and was scheduled for recertification in 2010, however no action has been taken. The current handbook language is both antiquated and complex, leading to VHA employee confusion about reporting responsibilities and limiting communication between SLBs and VHA facility staff.

ONGOING MONITORING OF PROVIDER CREDENTIALS

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

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

NCSBN supports ongoing verification of VHA provider licensure to ensure that our Nation's veterans are being treated by safe, competent providers. Over the past 2 years, NCSBN has had a tremendous partnership with the VA Office of Nursing Services, helping them better monitor the license status of VA nurses in real-time by offering direct assistance to several VHA facilities in implementing Nursys e-Notify, a free service for institutions who want to receive automated nurse license status updates. Nursys e-Notify informs a VHA facility if one of its employed RNs or LPN/VNs receives public discipline or alerts from their licensing jurisdiction(s). It also notifies the facility if licenses are expiring. Pilot sites for implementing Nursys e-Notify include: Baltimore, Maryland VAHCS, Beckley, WV VAMC, Dallas (North), TX VHCS, and Marion, IL VAMC. Nearly 20 VHA facilities have implemented Nursys e-Notify to date.

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

CONCLUSION

NCSBN and State boards of nursing look forward to continued partnership with the VHA, Congressional VA Committees, VA providers, and our Nation's veterans. We aim to help ensure that veterans seeking care from the VHA enjoy the same patient safety protections as patients in the private sector.

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

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