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VA HEALTH CARE

Patient Safety Could be Enhanced by Improvements in Employment Screening and Physician Privileging Practices

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June 15, 2006

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Highlights

Highlights of GAO-06-760T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

In its March 2004 report, *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans*, GAO-04-566, GAO made recommendations to improve VA's employment screening of practitioners. GAO was asked to testify today on steps VA has taken to improve its employment screening requirements and VA's physician credentialing and privileging processes because of their importance to patient safety. This testimony is based on two GAO reports released today that determined the extent to which (1) VA has taken steps to improve employment screening for practitioners by implementing GAO's 2004 recommendations, (2) VA facilities are in compliance with selected credentialing and privileging requirements for physicians, and (3) VA has internal controls to help ensure the accuracy of privileging information.

What GAO Recommends

In its reports released today, GAO recommends that VA expand its employment screening oversight program to include all practitioners, provide guidance on collecting physician performance information, enforce the time frame to submit information on paid VA malpractice claims involving VA practitioners, and instruct facilities to establish internal controls for physician privileging information. VA agreed with the findings and conclusions and concurred with the recommendations in both reports.

www.gao.gov/cgi-bin/getrpt?GAO-06-760T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie E. Ekstrand at (202) 512-7101 or ekstrandl@gao.gov.

What GAO Found

In its report released today, *VA Health Care: Steps Taken to Improve Practitioner Screening, but Facility Compliance with Screening Requirements Is Poor*, GAO-06-544, GAO found that VA has taken steps to improve employment screening for practitioners, such as physicians, nurses, and pharmacists, by partially implementing each of four recommendations GAO made in March 2004. However, gaps still remain in VA's requirements. For example, for the recommendation that VA check all state licenses and national certificates held by all practitioners, such as nurses and pharmacists, VA implemented the recommendation for practitioners it intends to hire, but has not expanded this screening requirement to include those currently employed by VA. In addition, VA's implementation of another recommendation—to conduct oversight to help facilities comply with employment screening requirements—did not include all screening requirements, as recommended by GAO.

In another report released today, *VA Health Care: Selected Credentialing Requirements at Seven Medical Facilities Met, but an Aspect of Privileging Process Needs Improvement*, GAO-06-648, GAO found at seven VA facilities it visited compliance with almost all selected credentialing and privileging requirements for physicians. Credentialing is verifying that a physician's credentials are valid. Privileging is determining which health care services—clinical privileges—a physician is allowed to provide. Clinical privileges must be renewed at least every 2 years. One privileging requirement—to use information on a physician's performance in making privileging decisions—was problematic because officials used performance information when renewing clinical privileges, but collected all or most of this information through their facility's quality assurance program. This is prohibited under VA policy. Further, three of the seven facilities did not submit medical malpractice claim information to VA's Office of Medical-Legal Affairs within 60 days after being notified that a claim was paid, as required by VA. This office uses such information to determine whether VA practitioners have delivered substandard care and provides these determinations to facility officials. When VA medical facilities do not submit all relevant information in a timely manner, facility officials make privileging decisions without the advantage of such determinations.

VA has not required its facilities to establish internal controls to help ensure that physician privileging information managed by medical staff specialists—employees who are responsible for obtaining and verifying information used in credentialing and privileging—is accurate. One facility GAO visited did not identify 106 physicians whose privileging processes had not been completed by facility officials for at least 2 years because of inaccurate information provided by the facility's medical staff specialist. As a result, these physicians were practicing at the facility without current clinical privileges.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss efforts by the Department of Veterans Affairs (VA) to ensure that its health care practitioners provide safe care to veterans. Specifically, I want to discuss findings related to patient safety in two reports that we are releasing today. The first report focuses on employment screening requirements that VA medical facility officials must follow. Under these requirements, VA facility officials check the professional credentials and personal backgrounds for all practitioners their facilities employ.[1] VA practitioners include physicians, nurses, and pharmacists, among others. Part of the screening process includes credentialing, which is the process of checking that a practitioner's professional credentials, such as licensure, education, and training, are valid and meet VA's requirements for employment. Our second report specifically examines credentialing and privileging processes intended to ensure the safe delivery of care by VA physicians.[2] Physician privileging is the process for determining which health care services or clinical privileges, such as surgical procedures or administering anesthesia, a physician can provide to VA patients without supervision. These clinical privileges must be renewed at least every 2 years. While VA's requirements cannot guarantee patient safety in health care settings, they are intended to minimize the chance of patients receiving care from someone who is incompetent or who may intentionally harm them.

In March 2004, we reported and testified before this subcommittee on gaps in VA's practitioner screening requirements.[3] We found that VA did not require that all of its health care practitioners with access to patients be thoroughly screened. In addition, we found mixed compliance with VA screening requirements at the medical facilities we visited. We concluded that the gaps in and mixed compliance with VA's screening requirements created vulnerabilities that could allow VA to employ health care

[1]GAO, *VA Health Care: Steps Taken to Improve Practitioner Screening, but Facility Compliance with Screening Requirements Is Poor*, GAO-06-544 (Washington: D.C.: May 25, 2006).

[2]GAO, *VA Health Care: Selected Credentialing Requirements at Seven Medical Facilities Met, but an Aspect of Privileging Process Needs Improvement*, GAO-06-648 (Washington, D.C.: May 25, 2006).

[3]GAO, *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans*, GAO-04-566 (Washington, D.C.: Mar. 31, 2004), and *VA Health Care: Veterans at Risk from Inconsistent Screening of Practitioners*, GAO-04-625T (Washington, D.C.: Mar. 31, 2004).

practitioners who could place patients at risk. In our 2004 report, we made four recommendations to address the gaps we identified in VA's screening requirements and the noncompliance we found at the VA medical facilities we visited. VA generally agreed with our findings and conclusions and stated it would develop a detailed action plan to implement our recommendations.

The subcommittee is interested in the progress VA has made in implementing our March 2004 recommendations and in efforts by VA to ensure that its health care practitioners are qualified and have appropriate backgrounds to safely deliver care to veterans. My remarks today focus on the extent to which (1) VA has taken steps to improve employment screening for practitioners by implementing the four recommendations made in our March 2004 report, (2) VA medical facilities are in compliance with VA's employment screening requirements for health care practitioners, (3) VA medical facilities are in compliance with selected credentialing and privileging requirements for physicians, and (4) VA has internal controls to help ensure the accuracy of information medical facilities use to renew physicians' clinical privileges.

In carrying out this work, we reviewed VA's policies and procedures for employment screening and interviewed VA headquarters officials to determine if the recommendations we made in March 2004 were implemented. We also reviewed VA policies outlining the processes for credentialing and privileging physicians. In addition, we visited seven VA medical facilities for each report.[4] At each facility we visited, we reviewed a sample of practitioner files to determine if documentation in the files demonstrated compliance with the requirements in our reviews. For the employment screening report, we selected five employment screening requirements, and for the physician credentialing and privileging report, we selected four credentialing and five privileging requirements for physicians. See appendix I for the four recommendations we made in March 2004 and the VA screening, credentialing, and privileging requirements we used in our reports to measure VA medical facility compliance. We also identified the internal controls VA has in place for its privileging process and, using GAO's standards for internal controls in the

[4]For the employment screening report, we visited VA facilities in Fargo, North Dakota; Kansas City, Missouri; Miami, Florida; New Orleans, Louisiana; Salt Lake City, Utah; San Antonio, Texas; and Washington, D.C. For the physician credentialing and privileging report, we visited VA facilities in Boise, Idaho; Kansas City, Missouri; Las Vegas, Nevada; Lexington, Kentucky; Martinsburg, West Virginia; Miami, Florida; and San Antonio, Texas.

federal government, determined whether these controls are adequate.[5] We performed our work from April 2005 to May 2006 in accordance with generally accepted government auditing standards.

In summary, VA has taken steps to improve employment screening of its health care practitioners by partially implementing each of the four recommendations made in our March 2004 report; however, gaps still remain in VA's health care practitioner screening requirements. For example, for our recommendation that VA check all state licenses and national certificates held by all practitioners, VA implemented the recommendation for practitioners it intends to hire, but has not expanded this screening requirement to include those currently employed by VA. In addition, VA's implementation of another recommendation—to conduct oversight to help facilities comply with employment screening requirements—did not include all types of practitioners and screening requirements, as we recommended.

At the seven VA medical facilities we visited for our review of VA's health care practitioner screening, we found poor compliance with four of the five VA screening requirements we selected for review. Based on the practitioner files we reviewed, we found that none of the facilities we visited had a compliance rate of 90 percent or more for all screening requirements, and VA policy requires 100 percent compliance with these requirements.[6]

At the seven VA medical facilities we visited for our review of VA's physician credentialing and privileging requirements, we found compliance with almost all selected credentialing and privileging requirements. Specifically, the physician files we reviewed demonstrated compliance with the four selected credentialing requirements and four of the five privileging requirements. Compliance with a fifth privileging requirement—to use information on a physician's performance in making privileging decisions—was problematic at six of the VA medical facilities. At these six, officials obtained this information from their facilities' quality

[5]GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

[6]A 90 percent compliance rate means that 90 percent of the health care practitioner files we examined at each facility provided documentation that the screening requirement had been met in accordance with VA policy.

assurance programs.[7] Use of such information in connection with privileging is prohibited by VA policy, and according to VA officials, this prohibition exists to protect the confidentiality of quality assurance information and to encourage physicians to participate in quality assurance programs. VA has not provided guidance to help medical facilities find alternative ways to efficiently collect performance information, outside of a facility's quality assurance program, that could be used in the renewal of clinical privileges. At the seventh medical facility, officials did not use performance information to renew physicians' clinical privileges, as required. Further, three of the seven facilities did not submit medical malpractice claim information to VA's Office of Medical-Legal Affairs within 60 days after being notified that a claim was paid, as required by VA. This office is responsible for forming panels of practitioners to determine whether VA practitioners have delivered substandard care. When VA medical facilities do not submit all relevant information in a timely manner, facility officials make privileging decisions without the advantage of such determinations.

VA has not required its medical facilities to establish internal controls to help ensure that physician privileging information managed by medical staff specialists—employees who are responsible for obtaining and verifying the information used in credentialing and privileging—is accurate. One facility we visited did not identify 106 physicians whose privileging processes had not been completed by facility officials for at least 2 years because of inaccurate information provided by the facility's medical staff specialist. As a result, these physicians were practicing at the facility without current clinical privileges. This facility has since implemented internal controls to reduce the risk of a similar situation occurring in the future. During our visits to other VA facilities for the physicians' credentialing and privileging report, we did not identify any facilities that had established internal controls to help ensure the accuracy of physician privileging information.

[7]VA requires each of its medical facilities to have a quality assurance program. In general, the VA quality assurance program consists of specified systematic health care reviews carried out by or for VA for the purpose of improving the quality of medical care or the utilization of health care resources in VA facilities. See 38 C.F.R. § 17.500 (2005). These programs collect data on various clinical process and outcome measures involving physicians and other types of practitioners. The measures may include a surgeon's complication rate or a physician's prescribing of medications. Medical facility officials use these measures to look for undesirable patterns and trends in performance.

To better ensure the safety of veterans receiving health care at VA facilities, in our reports we recommended that VA expand its oversight to include a review of VA facilities' compliance with screening requirements for all types of health care practitioners, provide guidance to medical facilities on how to collect individual physician performance information in accordance with VA's credentialing and privileging policy to use in the renewal of physicians' clinical privileges, and enforce the requirement that medical facilities submit information on paid VA medical malpractice claims in a timely manner to VA's Office of Medical-Legal Affairs. Additionally, we recommended that VA instruct its medical facilities to establish internal controls to ensure the accuracy of their physician privileging information. In commenting on drafts of these reports, VA agreed with our findings and conclusions and concurred with our recommendations. VA provided an action plan to address the three recommendations in the report on VA's physician credentialing and privileging requirements, and stated that it will provide an action plan to implement the recommendations in the practitioner screening report after issuance of the report.

Background

VA operates the largest integrated health care system in the United States, providing care to nearly 5 million veterans per year. The VA health care system consists of hospitals, ambulatory clinics, nursing homes, residential rehabilitation treatment programs, and readjustment counseling centers. In addition to providing medical care, VA is the largest educator of health care professionals, training more than 28,000 medical residents annually, as well as other types of trainees.

State Licenses and National Certificates

VA requires its health care practitioners to have professional credentials in their specific professions through either state licenses or national certificates.[8] VA policy requires officials at its medical facilities to screen each applicant for positions at VA to determine whether the applicant possesses at least one current and unrestricted state license or an appropriate national certificate, whichever is applicable for the position sought by the applicant. VA also requires officials at its medical facilities to periodically verify licenses or national certificates held by health care

[8]Not all VA practitioners, such as nursing assistants, are required to have a state license or a national certificate. Some practitioners, such as occupational therapists, may hold both national certificates and state licenses.

practitioners already employed at VA. In general, for both applicants and employed health care practitioners, VA's employment screening process proceeds in two stages. First, applicants and employed health care practitioners are required to disclose to VA, if applicable, their state licenses and national certificates. Applicants disclose their credentials to VA during the application process, and employed health care practitioners disclose credentials to VA as they expire and are renewed with the state licensing board or certifying organization. Second, VA facility officials are required to check whether the disclosed credentials are valid.

State licenses are issued by state licensing boards, whereas national certificates are issued by national certifying organizations, which are separate and independent from state licensing boards. Both state licensing boards and national certifying organizations establish requirements that practitioners must meet to be licensed or certified. Licensed practitioners may be licensed in more than one state. "Current and unrestricted licenses" are licenses that are valid and in good standing in the state where issued. To keep a license current, practitioners must renew their licenses before they expire. When licensing boards discover a licensee is in violation of licensing requirements or established law, for example, abusing prescription drugs or intentionally or negligently providing poor quality care that results in adverse health effects, they may place restrictions on or revoke a license. Restrictions from a state licensing board can limit or prohibit a practitioner from practicing in that particular state. Some, but not all, state licenses are marked to indicate whether the licenses have had restrictions placed on them. Practitioners, such as respiratory and occupational therapists, who are required to have national certificates to work at VA, must have current and unrestricted certificates. National certifying organizations can restrict or revoke certificates for violations of the organizations' professional standards. Generally, each state licensing board and national certifying organization maintains a database of information on restrictions, which employers can often obtain at no cost either by accessing the information on a board's Web site or by contacting the board directly.

Background Investigations

In addition to holding valid professional credentials, when hired, health care practitioners are required to undergo background investigations that verify their personal and professional histories.[9] Depending on the position, the extent of the background investigations for health care practitioners varies. For example, the minimum background investigation is a fingerprint-only investigation, which compares a practitioner's fingerprints to those stored in criminal history databases. A traditional background investigation, which covers a health care practitioner's personal and professional background for up to 10 years, is the most common type of background investigation conducted by VA on its health care practitioners. The traditional background investigation verifies an individual's history of employment, education, and residence, and includes a fingerprint check against a criminal-history database. The Office of Personnel Management conducts background investigations for VA. To determine the level of background investigation required for employment, VA facility officials are required to complete VA Form 2280, which documents the level of risk posed by a particular position.

Physician Credentialing and Privileging

For physicians, VA has specific requirements that facility officials must follow to credential and privilege physicians. Officials must follow these requirements when physicians initially apply to work in VA—which is known as initial appointment—and then again at least every 2 years when physicians must apply for reappointment in order to renew their clinical privileges. Prior to working at VA, physicians enter into VetPro, a Web-based credentialing system VA implemented in March 2001, information used by VA medical facility officials in the credentialing process. For example, physicians enter information on their involvement in VA and non-VA medical malpractice claims and their medical education and training. For their reappointments, physicians must update this credentialing information in VetPro. A facility's medical staff specialist then performs a data check to be sure that all required information has been entered into VetPro. In general, the medical staff specialist at each VA medical facility manages the accuracy of VetPro's credentialing data. The medical staff specialist verifies, with the original source of the information, the accuracy of the credentialing information entered by the physicians. Once a physician's credentialing information has been verified,

[9]Executive Order 10450, April 27, 1953, requires all persons employed by federal departments and agencies to undergo background investigations to ensure that their employment is consistent with national security interests.

the medical staff specialist sends the information to the physician's supervisor, known as a clinical service chief.[10]

In addition to entering credentialing information into VetPro, physicians complete written requests for clinical privileges. The facility medical staff specialist provides a physician's clinical service chief with the requested clinical privileges and information needed to complete the privileging process, including information that indicates that the credentialing information entered by the physician into VetPro has been verified with the appropriate sources. The requested clinical privileges are reviewed by the clinical service chief, who recommends whether a physician should be appointed or reappointed to the facility's medical staff and which clinical privileges should be granted. For reappointment only, VA's policy requires that information on a physician's performance, such as a physician's surgical complication rate, be used when deciding whether to renew a physician's clinical privileges. Based on the physician's performance information, the clinical service chief recommends that clinical privileges previously granted by the facility remain the same, be reduced, or be revoked, and whether newly requested privileges should be added.[11] The 2-year period for renewal of clinical privileges and reappointment to the medical staff begins on the date that the privileges are approved by the medical facility's director.

VA Has Taken Steps to Improve Employment Screening Requirements, but Gaps Remain

VA has taken steps to improve employment screening of its health care practitioners by partially implementing each of the four recommendations made in our March 2004 report; however, gaps still remain in VA's health care practitioner screening requirements. To address our recommendation that VA facility officials contact state licensing boards and national certifying organizations to verify all licenses and certificates held by all VA health care practitioners, VA expanded its verification requirement to include licenses and certificates for all prospective hires but did not extend this requirement to include all practitioners currently employed by VA. For those currently employed, such as nurses and pharmacists, VA only required facility officials to physically inspect one license of a

[10]Clinical services may include surgery, medicine, and radiology.

[11]Reduction of privileges may include restricting or prohibiting a physician from performing certain procedures or prescribing certain medications. Revocation of privileges refers to the permanent loss of all clinical privileges at that facility.

practitioner's choosing.[12] Physical inspection of a license cannot ensure that it is valid and without restriction, nor can it ensure that there are not other licenses from other states that may have restrictions. Checking all licenses against state records is the only way to identify practitioners with restricted licenses. We reviewed a draft of a VA policy that if issued in its current form would fully address our recommendation to require medical facility officials to verify all state licenses and national certificates of currently employed health care practitioners. According to a VA official, this policy is expected to be issued in June 2006.

To address our second recommendation that VA query the Department of Health and Human Services' (HHS) Healthcare Integrity and Protection Data Bank (HIPDB) for all licensed health care practitioners that VA intends to hire and periodically query it for those already employed, VA in July 2004 directed facility officials to query HIPDB for all applicants for VA employment. However, officials were not directed to periodically query HIPDB for health care practitioners currently employed by VA. Officials told us that VA is working with HHS to develop a process whereby VA can electronically query HIPDB for current VA employees. Once this process is in place, and VA is using it to periodically query HIPDB for those currently employed at VA, the department will have fully implemented our recommendation. However, VA did not provide a time frame for implementing this electronic query of HIPDB.

To address our third recommendation that VA expand the use of fingerprint-only background investigations for all practitioners with direct access to patients, VA issued a policy that required all VA medical facilities to begin using electronic fingerprint machines by September 1, 2005. By February 1, 2006, all but two facilities had obtained the equipment necessary to implement this requirement.

To address our fourth recommendation concerning oversight of the screening requirements, VA formalized an oversight program within its Office of Human Resource Management to include a review of some aspects of the screening process for applicants and current employees. However, the oversight program does not ensure that facilities are complying with all of VA's key screening requirements, as we recommended. For example, officials from the oversight program are not required to check personnel files to ensure that facility officials query

[12]*VA Handbook 5005*, pt. II, ch. 3, para. 17a(1).

HIPDB and verify all health care practitioners' licenses and certifications with the relevant issuing organizations.

VA Facilities Did Not Comply with Employment Screening Requirements for Practitioners

For the seven VA facilities we visited to determine compliance with employment screening requirements for practitioners, we found poor compliance with four of the five requirements we selected for review. Two of these five requirements VA implemented since our March 2004 report—for individuals VA intends to hire, query HIPDB and use an employment checklist to document the completion of employment screening requirements. Three other employment screening requirements were long-standing—verify health care practitioners' state licenses and national certificates; complete VA Form 2280, which is used to determine the appropriate type of background investigation needed for each health care practitioner job category; and conduct background investigations. In order to show the variability in the level of compliance among the facilities, we measured their performance against a compliance rate of at least 90 percent for each of the screening requirements, even though VA policy requires 100 percent compliance with these requirements. None of the facilities had a compliance rate of 90 percent or more for all screening requirements we reviewed. Table 1 summarizes the rate of compliance among the seven facilities.

Table 1: Facilities' Rates of Compliance with Select VA Screening Requirements, 2005

	Facility compliance with screening requirements[a]						
Screening requirements	Facility A	Facility B	Facility C	Facility D	Facility E	Facility F	Facility G
Conducting background investigations	○	○	○	○	●	○	○
Position risk level determined (VA Form 2280)	○	○	○	●	●	○	○
Querying HIPDB[b]	○	○	○	●	●	○	○
Completing employment checklist[c]	○	○	○	○	○	○	○
Verifying license, certification, or both	●	●	●	●	○	●	○

○ Indicates a compliance rate of less than 90 percent

● Indicates a compliance rate of 90 percent or greater

Source: GAO analysis of VA facility files.

Notes: We considered facilities to be in compliance if they were able to provide documentation not available in the personnel file. Site visits to these seven VA facilities were conducted from April 2005 through August 2005. Only salaried practitioners are represented in this table.

[a]Tested for significance at the 95 percent confidence level.

[b]Applies only to health care practitioners hired on or after October 1, 2004, and certain health care practitioners hired prior to this date, such as physicians and dentists. Results for this screening requirement cannot be generalized to the facility being reviewed because of the sample size.

[c]Applies only to health care practitioners hired on or after October 1, 2004. Results for this screening requirement cannot be generalized to the facility being reviewed because of the sample size.

As shown in table 1, while two facilities performed HIPDB queries on individuals they intended to hire, one of these facilities completed the queries immediately prior to our visit and not at the time the individuals were hired. We also found that two facilities had created their own employment checklists, but had not included all of the screening requirements contained in the original checklist issued by VA. As a result, these facilities were not in compliance with VA's requirement.

Physician Files at Facilities Demonstrated Compliance with Almost All Selected Credentialing and Privileging Requirements; Not All Facilities Submitted Paid Malpractice Claim Information in a Timely Manner

We found that the physician files at the facilities we visited demonstrated compliance with four VA credentialing and four privileging requirements we reviewed.[13] However, we found that there were problems complying with a fifth privileging requirement—to use information on a physician's performance in making privileging decisions. In addition, we found that three of the seven medical facilities we visited did not submit to VA's Office of Medical-Legal Affairs information on paid VA medical malpractice claims within 60 days after being notified that a claim was paid, as required by VA policy.

Selected Physician Files at Facilities Demonstrated Compliance with Four VA Credentialing and Four Privileging Requirements; a Fifth Privileging Requirement Was Problematic

We found that the physician files at the facilities we visited demonstrated compliance with four VA credentialing and four privileging requirements we reviewed. For the physician files we reviewed, the VA facilities' medical staff specialists contacted state licensing boards to ascertain the status of the state medical licenses held and disclosed by their physicians.[14] They also queried the Federation of State Medical Boards (FSMB) database, as required, to obtain additional information on the status of physicians' medical licenses, including those that may not have been disclosed by physicians.[15] Medical staff specialists complied with the requirement to contact sources, such as courts of jurisdiction, to verify information on physicians' involvement in medical malpractice claims, including ongoing claims, disclosed by physicians. Additionally, in all cases medical staff specialists queried the National Practitioner Data Bank

[13]Findings for the credentialing and privileging requirements cannot be generalized to the facility being reviewed because of the sample size.

[14]VA medical facility officials may also verify physicians' licenses by querying a state licensing board's Web site for information on the licenses.

[15]VA requires facility officials to query FSMB at initial appointment only. Thereafter, VA headquarters regularly receives reports from FSMB on any currently employed VA physician whose name appears on FSMB's list, indicating that disciplinary action has been taken against the physician's state license.

(NPDB) to identify those physicians who have been involved in paid medical malpractice claims, including any physicians who failed to disclose involvement in such claims. The physician files also demonstrated compliance with four of VA's privileging requirements. Medical staff specialists verified physicians' state licenses and the information disclosed by physicians about their involvement in medical malpractice allegations or paid claims, which are both credentialing and privileging requirements. We also found that medical staff specialists verified that physicians had the necessary training and experience to deliver health care and perform the clinical privileges physicians requested. Additionally, after medical staff specialists performed their verification, clinical service chiefs reviewed this information, as required, along with information on physicians' health status.

While we found evidence demonstrating compliance with four of VA's privileging requirements, the files we reviewed showed that there were problems complying with a fifth privileging requirement that is used only in the renewal of privileges—to use information on a physician's performance in making privileging decisions. VA requires that during the renewal of a physician's clinical privileges, VA clinical service chiefs use information on a physician's performance to support, reduce, or revoke the clinical privileges the physician has requested. However, as stated in VA policy, physician performance information that is collected as part of a facility's quality assurance program cannot be used in a facility's privileging process. According to VA, the confidentiality of individual performance information helps ensure practitioner participation, including that of physicians, in a medical facility's quality assurance program by encouraging practitioners to openly discuss opportunities for improvement in practitioner practice without fear of punitive action. VA officials stated that quality assurance information if used outside of a facility's quality assurance program could be available for other purposes, including litigation. However, VA has not provided guidance on how facility officials can obtain such information in accordance with VA policy—that is, outside of a quality assurance program. Officials at six medical facilities told us that they used performance information to support the granting of clinical privileges requested by their physicians, but collected all or most of this information through facility quality assurance programs. At the seventh medical facility, officials did not use individual physician performance information to renew physicians' clinical privileges, as required by VA.

Not All Facilities Submitted Paid Malpractice Claim Information in a Timely Manner

We also included in our review a requirement that is related to the privileging process—medical facilities must submit to VA's Office of Medical-Legal Affairs information on paid VA medical malpractice claims within 60 days after being notified that a claim was paid. VA's Office of Medical-Legal Affairs is responsible for forming panels of practitioners to determine whether practitioners involved in any of these claims delivered substandard care to veterans and provides these determinations to facility officials. We found that three of the seven VA medical facilities we reviewed did not submit claim information to VA's Office of Medical-Legal Affairs within the 60-day time frame. For example, for one facility we visited, we found that from 2001 through 2005, information on 21 of the facility's 26 paid medical malpractice claims had not been submitted within the 60-day time frame to VA's Office of Medical-Legal Affairs.[16] Moreover, on average this medical facility took 30 months to submit information to VA's Office of Medical-Legal Affairs, whereas the other two facilities averaged about 5 months to submit information.

When VA medical facilities do not submit all relevant claim information to the Office of Medical-Legal Affairs, determinations on substandard care are not available to facility officials when they make privileging decisions. In addition, substandard care determinations are required to be reported by facility officials to NPDB. When VA medical facilities do not send claim information in a timely manner to the Office of Medical-Legal Affairs, these cases, if substandard care is found, go unreported or reporting to NPDB is delayed. This prevents other VA and non-VA facilities where the physician may also practice from having complete information on the physician's malpractice history.

[16]As of March 31, 2006, this medical facility had sent all delinquent medical malpractice claim information to VA's Office of Medical-Legal Affairs.

VA Has Not Established Internal Controls to Help Ensure the Accuracy of Facilities' Privileging Information

VA has not required its medical facilities to establish internal controls to help ensure that privileging information managed by medical staff specialists is accurate. One facility we visited did not identify 106 physicians whose privileging processes had not been completed by facility officials for at least 2 years because of inaccurate information provided by the facility's medical staff specialist. According to facility officials, the medical staff specialist changed reappointment dates for some physicians and for other physicians removed their names from VetPro, the facility's credentialing database. As a result, these physicians were practicing at the facility without current clinical privileges.

Once medical facility officials became aware of the problem, they reviewed the files of all physicians and identified 106 physicians for whom the privileging process had not been completed. Facility officials told us they did not find any problems that would have warranted the 106 physicians' removal from the facility's medical staff or that placed veterans at risk. This facility has since implemented internal controls to reduce the risk of a similar situation occurring in the future. During our site visits to other VA medical facilities for the physicians' credentialing and privileging report, we did not identify any facilities that had established internal controls to help ensure the accuracy of the information they use to renew physicians' clinical privileges. Without accurate information, VA medical facility officials will not know if they have failed to renew clinical privileges for any of their physicians.

Concluding Observations

VA's employment screening requirements are intended to ensure the safety of veterans receiving care by identifying practitioners who are incompetent or may intentionally harm veterans. In our practitioner screening report that we are releasing today, we continue to raise concerns about gaps in VA's employment screening requirements. Although VA concurred with our March 2004 recommendations and took steps to implement them, none were fully implemented as of March 2006. These recommendations should be fully implemented. We are also concerned that compliance with employment screening requirements for practitioners, including physicians, nurses, and pharmacists, among others, continues to be poor at the facilities we visited. Continuing gaps in VA's employment screening requirements and mixed compliance with these requirements continue to place veterans at risk.

The other report that we are releasing today demonstrates that medical facilities we reviewed largely complied with VA's physician credentialing and privileging requirements. However, we identified problems with the

appropriate use of physician performance information in the privileging process and the timely submission of medical malpractice information to VA's Office of Medical-Legal Affairs. Additionally, VA's lack of internal controls for its facilities to ensure the accuracy of physician privileging information raises concerns that VA is at risk for allowing physicians to practice with expired clinical privileges.

Our reports include the following four recommendations that VA should implement to help ensure patient safety:

- expand the human resource management oversight program to include a review of VA facilities' compliance with employment screening requirements for all types of practitioners,
- provide guidance to medical facilities on how to collect individual physician performance information in accordance with VA's credentialing and privileging requirements to use in medical facilities' privileging processes,
- enforce the requirement that medical facilities submit information on paid VA medical malpractice claims to VA's Office of Medical-Legal Affairs within 60 days after being notified that the claim is paid, and
- instruct medical facilities to establish internal controls to ensure the accuracy of their physician privileging information.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions you or other members of the subcommittee may have.

Contacts and Acknowledgments

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Appendix I: March 2004 Report Recommendations and VA Screening, Credentialing, and Privileging Requirements

In our March 2004 report, *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans*, we made four recommendations to address the gaps we identified in VA's employment screening requirements and the noncompliance we found at the four medical facilities we visited.[1]

March 2004 Report Recommendations

- Expand verification of all state licenses and national certificates by contacting the appropriate licensing boards and national certifying organizations for all Department of Veterans Affairs' (VA) health care practitioners.
- Expand query of the Healthcare Integrity and Protection Data Bank (HIPDB)—a national data bank that contains information on health care practitioners involved in health care-related civil judgments and criminal convictions or who have had disciplinary actions taken against their licenses or national certificates—to include all licensed health care practitioners at VA facilities.
- Conduct fingerprint-only background investigations for all VA health care practitioners with direct patient care access.
- Conduct oversight of medical facilities to ensure compliance with all of VA's key screening requirements.

VA Employment Screening Requirements for Practitioners Selected for Review

To measure facility compliance with VA's employment screening requirements, we selected five requirements for our review.[2] We selected two of the five requirements because in our March 2004 report we found that VA facilities had problems complying with these two long-standing requirements. We selected two other requirements because VA implemented these since March 2004 to improve its employment screening of practitioners. The remaining requirement is long-standing, but is related to the performance of background investigations, which was a requirement we reviewed and found compliance with this requirement to be problematic in 2004.

- Complete VA Form 2280, which medical facility officials must do in order to determine the appropriate type of background investigation needed for each health care practitioner job category.
- Perform a background investigation.

[1]GAO-04-566.

[2]GAO-06-544.

- Query HIPDB.
- Complete an employment checklist, which VA officials are to use to document the completion of VA screening requirements for those practitioners VA intends to hire.
- Verify the status of state licenses and national certificates.

VA Physician Credentialing Requirements Selected for Review

We selected four of VA's credentialing requirements for review because they are requirements that—unlike other credentialing requirements—address information about physicians that can change or be updated with new information periodically.[3]

- Verify that all state medical licenses held by physicians are valid.
- Query the Federation of State Medical Boards database to determine whether physicians had disciplinary action taken against any of their licenses, including expired licenses.
- Verify information provided by physicians on their involvement in medical malpractice claims at VA or non-VA facilities.
- Query the National Practitioner Data Bank to determine whether a physician was reported to this data bank because of involvement in VA or non-VA paid medical malpractice claims, display of professional incompetence, or engagement in professional misconduct.

VA Physician Privileging Requirements Selected for Review

We selected four privileging requirements that VA identifies as general privileging requirements. In addition to the four general privileging requirements, we selected another privileging requirement because of its importance in the renewal of clinical privileges because it provides clinical service chiefs with information on the quality of care delivered by individual physicians.[4]

- Verify that all state medical licenses held by physicians are valid.
- Verify physicians' training and experience.
- Assess physicians' clinical competence and health status.
- Consider any information provided by physicians related to medical malpractice allegations or paid claims, loss of medical staff membership, loss or reduction of clinical privileges at VA or non-VA facilities, or any challenges to physicians' state medical licenses.

[3]GAO-06-648.

[4]GAO-06-648.

- Use information on physicians' performances when making decisions about whether to renew physicians' clinical privileges.

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