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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities

HEALTHCARE INSPECTION | REPORT #20-00827-126 | APRIL 7, 2022

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to assess VA medical facilities' compliance and processes regarding Veterans Health Administration (VHA) policies for reporting healthcare professionals to state licensing boards (SLBs) and the National Practitioner Data Bank (NPDB).[1] This project arose after two healthcare inspections involving two terminated physicians revealed concerns about facility directors' noncompliance with VHA's SLB and NPDB reporting policies, suggesting potential systemic failures.[2] While assessing VA medical facilities' compliance, the OIG identified a related concern regarding VHA programmatic oversight of facility SLB and NPDB reporting processes. Additionally, the OIG conducted a separate inspection reviewing the disciplinary appeals board (DAB) process afforded to physicians employed by VHA to determine if the process promotes fair and accurate decisions while ensuring safe patient care.[3] The OIG will publish these findings in a separate report.

Inspection Findings

The OIG found widespread noncompliance with SLB and NPDB reporting processes applied by facilities to healthcare professionals whose conduct or competence led to separation from employment. Failure to comply with these reporting processes leaves SLBs and recipients of NPDB information unaware of a healthcare professional's practice deficiencies and ultimately violates an important VA commitment to protect the health of veterans and the public. Moreover,

[1] In this report, healthcare professionals are licensed, registered, or certified by a state to practice a healthcare discipline. VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards,* December 22, 2005, was rescinded and replaced by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards,* January 28, 2021. The 2021 directive contains the same or similar language related to the topics discussed in this report unless otherwise noted. 42 U.S. Code § 11151. SLBs are state-regulated entities responsible for authorizing healthcare professionals to practice within a state. VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports,* December 28, 2009. U.S. Department of Health and Human Services, Health Resources and Services Administration Bureau of Health Workforce, *NPDB Guidebook,* October 2018, chap. A. The NPDB serves as a mechanism to "improve health care quality, protect the public, and combat health care fraud and abuse in the United States" by collecting and disseminating information regarding malpractice payments and certain adverse actions affecting healthcare professionals as well as healthcare professionals who surrender privileges during an investigation. Information provided by the NPDB may alert eligible entities that a more comprehensive review of the qualifications and background of a healthcare professional is warranted.

[2] VA OIG, *Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center Ohio*, Report No. 18-01275-89, February 20, 2020; VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia*, Report No. 19-07600-215, July 29, 2020.

[3] 38 U.S.C. § 7462(a). The DAB process involves an appeal of a major adverse personnel action that includes a question of professional conduct or competence against physicians and other healthcare professionals who are appointed under 38 U.S.C. § 7401(1).

the OIG found that there was a lack of programmatic oversight of compliance with SLB and NPDB reporting processes.

Noncompliance with the SLB Reporting Process

VHA requires facility directors to submit SLB reports regarding healthcare professionals when substantial evidence supports a reasonable conclusion that the professional's clinical practice raises a reasonable concern for the safety of patients or the community.[4] According to VHA policy, when information suggests that a healthcare professional's conduct or competence may meet the reporting standard, facility directors are required to follow a five-step process to determine whether an SLB report is required.[5] The report to an SLB serves as a notice of the facility's concern and SLBs determine what, if any, action to take based on the notification.

The OIG found that, for a majority of cases involving separated healthcare professionals, VA medical facility directors failed to follow VHA's mandatory processes for reporting healthcare professionals to SLBs.[6] The OIG analysis assessed overall compliance with the facility-controlled steps of the SLB reporting process and found that only 44 of the 107 (41 percent) cases reviewed were fully compliant. For the remaining 63 cases, the OIG found widespread noncompliance with the individual facility-controlled steps of the SLB reporting process—initial review, comprehensive review, director decision memorandum, and report submission to the appropriate SLB.[7] VA medical facility staff failed to complete an initial review on nearly one-fourth of the healthcare professionals who had filed an appeal of a separation from employment related to professional conduct or competence. Additionally, nearly half of the cases did not lead to a comprehensive review to determine whether a report to an SLB was necessary. Of the cases that did have a comprehensive review, facility directors failed to complete a required decision memorandum in nearly 25 percent of the cases. Further, although facility directors decided to report 46 clinicians to an SLB, only 41 healthcare professionals were actually reported.

Factors Contributing to SLB Reporting Noncompliance

Through analysis of questionnaire responses and interviews, the OIG identified SLB reporting noncompliance was related to facility staff misunderstanding the VHA SLB reporting policy and poor facility processes.

Examples of facility staffs' misunderstanding of policy included staff explaining to the OIG the initiation of the SLB reporting process was not started due to pending personnel action, which was contrary to policy. Another facility staff described a facility director not completing decision

[4] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.
[5] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.
[6] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.
[7] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

memorandums regarding SLB reporting because the healthcare professional was under the "auspices" of nursing.

The OIG learned that facilities processed a relatively low volume of cases involving a potential concern for the safety of patients based on a healthcare professional's conduct or competence, which contributed to some facility staff not having extensive experience conducting these reviews. While facility staff reported receiving training regarding SLB reporting processes, training methods varied and included self-learning and accessing SharePoint resources.

Poor facility processes were also a common theme found in facilities that demonstrated noncompliance. Examples of facility staff explanations that suggest poor processes included not having documentation to explain the failure to complete an initial SLB review and lack of facility oversight.

As a result of facility noncompliance, healthcare professionals whose conduct or practice was deficient enough to merit separation from employment were not reported to SLBs, resulting in SLBs not receiving information that could be used for licensing decisions to ensure safe practice.

Noncompliance with the NPDB Reporting Process

The OIG found that, in 15 of 35 physician or dentist cases appealing a separation from employment, facility directors failed to submit NPDB reports, as required by federal regulation and VHA's NPDB reporting policy.[8] The OIG found that this was a result of conflicting language in VHA policies and facility staff failures.

Federal regulation and VHA policy require facility directors to file an NPDB report regarding physicians and dentists whose privileges were impacted by an adverse action for more than 30 days based on a review related to professional competence or conduct, or who resigned during an investigation.[9] Federal regulation specifies that NPDB reports are intended to be filed within 15 days after a facility director's privileging action.[10] The VHA NPDB policy specifies, consistent with the federal regulation, NPDB reports must be submitted within 15 calendar days of the facility director finalizing the action.[11] The VHA NPDB reporting policy also states, however, that physicians or dentists must be offered "appropriate internal VA medical center due process procedures" as outlined in the VHA credentialing and privileging policy.[12]

[8] 38 CFR § 46.4 – Clinical privileges actions reporting.; VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports,* December 28, 2009; VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012.

[9] 38 CFR § 46.4 – Clinical privileges actions reporting. Adverse clinical privileging actions include privileging actions that result in a reduction, restriction, suspension, revocation, or failure to renew privileges.

[10] 38 CFR § 46.4(c).

[11] VHA Handbook 1100.17.

[12] VHA Handbook 1100.19.

The credentialing and privileging policy contradicts federal regulation and the VHA NPDB policy, instructing that NPDB reports be submitted after all appeals have been exhausted, rather than within 15 days of the facility director's privileging action.[13] The credentialing and privileging policy also states that, in revocation of privileges cases, physicians and dentists receive due process "including the Disciplinary Appeals Board (DAB) process. There is no due process proceeding or appeal at the facility level."[14] VA medical facilities, applying the credentialing and privileging policy instructions, might not submit reports prior to the conclusion of DAB proceedings, which can take several months.

According to facility staff responses to the OIG questionnaire, of the 35 cases that required an NPDB report, only 20 cases were reported. The OIG found only one of the 20 cases reported to the NPDB was submitted in under 15 days following a facility director's privileging action. The OIG found that facility directors failed to file NPDB reports in the remaining 15 cases.

Factors Contributing to NPDB Reporting Noncompliance

Aside from the inconsistent and inaccurate instructions in the VHA NPDB and credentialing and privileging policies, the OIG learned that reasons for facility directors' low compliance with NPDB reporting also included misunderstanding these policies and poor facility processes.

Facility staff's misunderstanding of the VHA NPDB reporting policy led to failures and delays in reporting physicians and dentists. For example, one staff reported awaiting the conclusion of a federal district court proceeding to decide whether to report a physician. Another staff misstated policy by saying that physicians are only reported for paid tort claims. Other staff reported that poor communication and poor facility oversight contributed to the failure to file NPDB reports.

As with SLB reporting, one facility staff explained that the difficulty in being proficient in NPDB reporting processes was due to the infrequency of an adverse action requiring NPDB reporting. Some staff reported less than one year of experience in NPDB reporting or having made two or fewer NPDB adverse action reports.

The OIG found that facility directors failed to consistently report physicians or dentists to the NPDB. The failure of this important safeguard could lead to current and future employers not being aware of concerns regarding competence or conduct of physicians and dentists who should have been reported. As a result, these physicians and dentists are enabled to continue to practice without the heightened level of scrutiny intended to be triggered by an NPDB report.

[13] VHA Handbook 1100.19.

[14] VHA Handbook 1100.19, 14l. (5)(a)3(b).

Lack of Oversight of SLB and NPDB Reporting Compliance

The OIG found that the VHA SLB and NPDB reporting policies did not assign programmatic oversight to ensure facility leaders' compliance with the mandated SLB and NPDB reporting processes. The lack of programmatic oversight contributed to the failure of VHA leaders to detect and intervene upon facility noncompliance.

The OIG made four recommendations to the Under Secretary for Health to review SLB reporting processes at the facility level to ensure compliance with VHA policy, to align NPDB facility reporting practices with federal regulations and VHA policy, to instruct facility directors to submit NPDB reports regarding physicians and dentists consistent with VHA policy, and to ensure programmatic oversight of facility SLB and NPDB reporting processes.

VA Comments and OIG Response

The Deputy Under Secretary for Health Performing the Delegable Duties of the Under Secretary for Health concurred with the recommendations and provided acceptable action plans. (See appendix B.) The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
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Contents

Abbreviations

DAB	Disciplinary Appeals Board
NPDB	National Practitioner Data Bank
OIG	Office of Inspector General
SLB	State Licensing Board
U.S.C.	United States Code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to assess VA medical facilities' compliance and processes regarding Veterans Health Administration (VHA) policies for reporting healthcare professionals to state licensing boards (SLBs) and the National Practitioner Data Bank (NPDB).[1] The inspection was initiated after a number of OIG reports raised concerns about facility directors' noncompliance with VHA's SLB and NPDB reporting policies suggesting potential systemic failures.[2] During the assessment of VA medical facilities' compliance and processes, the OIG identified a related concern regarding VHA programmatic oversight of facility SLB and NPDB reporting processes. Additionally, the OIG conducted a separate inspection reviewing the disciplinary appeals board (DAB) process afforded to physicians employed by VHA to determine if the process promotes fair and accurate decisions while ensuring safe patient care.[3] The OIG will publish these findings in a separate report.

Background

State Licensing Boards

SLBs are state regulated entities responsible for authorizing healthcare professionals to practice within a state by granting licenses, registrations, or certifications.[4] As law enforcement entities, SLBs may have the authority to restrict a healthcare professional's permission to practice in a state based on concerns for public health.[5] VHA requires facility directors to report licensed,

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[1] VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards,* December 22, 2005. This handbook was rescinded and replaced by VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. The 2021 directive contains the same or similar language related to the topics discussed in this report unless otherwise noted. VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports,* December 28, 2009. 42 U.S. Code § 11151. U.S. Department of Health and Human Services, Health Resources and Services Administration Bureau of Health Workforce, *NPDB Guidebook,* October 2018.

[2] VA OIG, *Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center Ohio*, Report No. 18-01275-89, February 20, 2020. VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia*, Report No. 19-07600-215, July 29, 2020.

[3] 38 U.S.C. § 7462(a). The DAB process involves an appeal of a major adverse personnel action that includes a question of professional conduct or competence against physicians and other health care providers appointed under 38 U.S.C. § 7401(1), which includes physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries. Government Accountability Office, *GAO-18-63, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*, November 2017. The Government Accountability Office found noncompliance with VHA's SLB and NPDB policies among reviewed VA medical facilities as well as inadequate oversight of SLB and NPDB report practices by VHA and VISNs. The OIG will publish findings from the review of the DAB process in a separate report.

[4] *NPDB Guidebook*.

[5] VHA Handbook 1100.18.

registered, or certified healthcare professionals for whom there is a concern for the safety of patients to each SLB in which the individual is licensed.[6]

National Practitioner Data Bank

The NPDB was established by Congress in 1986 and is a workforce tool intended to prevent practitioners from moving from state to state without SLBs or potential employers being aware of previous unprofessional performance. The NPDB serves as a mechanism to "improve health care quality, protect the public, and combat health care fraud and abuse in the United States."[7] Eligible entities, including VA medical facilities, must report information regarding healthcare professionals'

- medical malpractice payments,[8]
- adverse actions that affect privileges for more than 30 days, and
- surrender of privileges during an investigation.[9]

By law, certain eligible entities, including VA medical facilities, are required to query NPDB for information regarding healthcare professionals when making initial and ongoing privileging decisions.[10] The information provided by the NPDB may alert eligible entities that a more comprehensive review of the qualifications and background of a healthcare professional is warranted.[11]

Although NPDB accepts reports regarding any healthcare professional, VHA policy only requires facilities to report adverse action information regarding physicians and dentists.[12] Physicians and dentists who are subjects of these reports have access to their information. The reports are confidential, and not available to the public.[13]

Prior OIG Reports

Between October 1, 2018, and December 31, 2021, the OIG published eight healthcare inspection reports involving seven VA medical facilities that included recommendations

[6] VHA Handbook 1100.18. In this report, healthcare professionals are licensed, registered, or certified by a state to practice a healthcare discipline.

[7] *NPDB Guidebook*.

[8] Reporting malpractice payments to the NPDB is a different process and not discussed in this report.

[9] *NPDB Guidebook*.

[10] *NPDB Guidebook*; VHA Handbook 1100.19, *Credentialing and Privileging*, December 15, 2012.

[11] *NPDB Guidebook*.

[12] VHA Handbook 1100.17.

[13] U.S. Department of Health and Human Services, *NPDB About Us,* accessed on August 24, 2021, The NPDB - About Us (hrsa.gov).

addressing concerns with SLB or NPDB reporting.[14] All recommendations related to SLB or NPDB reporting, except for two, were closed as of December 31, 2021.

Concerns

This project arose after two healthcare inspections involving two terminated physicians revealed concerns about facility directors' noncompliance with VHA directives regarding reporting physicians with professional conduct or competency issues to SLBs and the NPDB, which may have represented systemic failures.[15] Therefore, the OIG initiated this healthcare inspection of VHA medical facilities' compliance with SLB and NPDB reporting policies. During the inspection, the OIG identified an additional concern regarding VHA programmatic oversight of facility SLB and NPDB reporting practices.

[14] VA OIG, *Medication Management, Dispensing, and Administration Deficiencies at the VA Maryland Health Care System, Perry Point, Maryland*, Report No. 17-05742-66, February 6, 2019; VA OIG, *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System in Biloxi, Mississippi*, Report No. 17-03399-200, August 28, 2019; VA OIG, *Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina*, Report No. 18-05316-234, September 30, 2019; VA OIG, *Inadequate Emergency Department Care and Physician Misconduct at the Washington DC VA Medical Center*, Report No. 19-07507-214, July 28, 2020; VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia*, Report No. 19-07600-215, July 29, 2020; VA OIG, *Deficiencies in Provider Oversight and Privileging Processes at the Carl Vinson VA Medical Center in Dublin, Georgia*, Report No. 19-07828-265, September 28, 2020; VA OIG, *Misconduct by a Gynecological Provider at the Gulf Coast Veterans Health Care System in Biloxi, Mississippi*, Report No. 20-01036-70, February 10, 2021; VA OIG, *Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma VA Health Care System in Muskogee*, Report No. 20-04341-182, July 21, 2021. Two recommendations remain open from the Audiology Leader' report.

[15] VA OIG, *Quality of Care Issues in the Community Living Center and Emergency Department at the Dayton VA Medical Center Ohio*, Report No. 18-01275-89, February 20, 2020; VA OIG, *Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia*, Report No. 19-07600-215, July 29, 2020.

Scope and Methodology

The OIG initiated the inspection in November 2019 to assess VA facility director and staff compliance and processes regarding SLB and NPDB reporting policies. The OIG reviewed relevant federal regulations and VHA policies regarding SLB and NPDB reporting as well as credentialing and privileging.

To gain an understanding of VA medical facilities' SLB and NPDB reporting compliance and practices, the OIG conducted an analysis of

- data obtained from the Office of the Chief Human Capital Officer regarding all DAB cases filed by healthcare professionals from October 1, 2017, through September 30, 2019;
- facility staff responses to a June 2020 OIG questionnaire regarding facility SLB and NPDB reporting practices received; and
- facility subject matter experts' responses during OIG interviews regarding facility processes.[16]

Data regarding DAB cases indicated that 154 cases appealing a major adverse action were filed by physicians, dentists, nurses, and other healthcare professionals involving 83 facilities from October 1, 2017, through September 30, 2019. The OIG conducted a preliminary analysis of the 83 facilities' responses to the OIG questionnaire regarding SLB and NPDB reporting practices.[17] The review indicated that the reasons for appeals included suspension (38 cases), reduction in pay or grade (6 cases), separation during probation or appointment (3 cases), and discharge or removal (107 cases).[18]

To understand facility SLB reporting practices, the OIG focused further analysis on the 64 facilities involved in the 107 cases filed by permanent healthcare professionals that shared a common element—appeal of a separation from employment. To gain insight on facility NPDB reporting practices, the OIG narrowed the analysis to the 50 physician or dentist cases of the 107 cases appealing a discharge or removal from employment.

[16] The Office of the Chief Human Capital Officer is responsible for administrative oversight of the DAB process, provides policies and guidance regarding staffing, recruitment, classification, pay and leave administration, performance management and recognition, and work-life and employee benefits. VA Handbook 5021/1, *Employee/Management Relations*, March 5, 2004. A DAB is a three-member board designated to hear an employee's appeal of an adverse action that is based in whole or in part on a question of professional conduct or competence.

[17] Facility directors were instructed to complete the OIG questionnaire or to delegate knowledgeable staff to complete the form.

[18] Data from the Office of the Chief Human Capital Officer identified "discharge," and "removal" as reasons for appeals that the OIG categorized as separation or termination from employment in this report. Some healthcare professionals filed appeals of separation from employment after having resigned positions.

Additionally, to clarify responses to the OIG questionnaire and gain additional insight into facility SLB and NPDB reporting processes, the OIG interviewed facility staff from a sample of nine of the 64 VA medical facilities that were involved in an appeal of a discharge or removal. Interviewees represented facilities that did and did not demonstrate compliance with reporting directives based on questionnaire responses. The OIG conducted an in-depth analysis of the responses.

In addition, the OIG interviewed National Medical Staff Affairs office leaders regarding VHA SLB and NPDB reporting policies and oversight processes.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

1. Noncompliance with the SLB Reporting Process

The OIG found that, for a majority of cases involving separated healthcare professionals, facility directors failed to follow VHA's mandatory processes for reporting healthcare professionals to SLBs.[19] Specifically, the OIG identified noncompliance among facility directors regarding commencing initial and comprehensive SLB reviews, decision-making documentation, and reporting to SLBs.[20] Lapses in SLB reporting processes can result in delays or failures in reporting healthcare professionals whose conduct or practice raised patient safety concerns.

VHA requires facility directors to report any healthcare professionals to the respective SLB(s) when clinical practice or behavior so substantially failed to meet generally accepted standards of clinical practice as to raise a reasonable concern for the safety of patients.[21] Any healthcare professional, regardless of employment status, who meets the reporting standard must be reported.[22] Additionally, any healthcare professional must be reported to SLBs who

- was fired or who resigned following the completion of a disciplinary action relating to clinical competence,
- resigned after having clinical privileges restricted or revoked, or
- resigned after serious concerns about clinical competence were raised, but not resolved.[23]

When a facility director decides to initiate SLB reporting regarding a currently employed healthcare professional, a determination may also be made to initiate a disciplinary proceeding or

[19] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[20] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021. An initial review is conducted to determine if there is substantial evidence that an employee so substantially failed to meet standards of clinical practice as to raise reasonable concern for the safety of patients. A comprehensive review is to determine whether there is substantial evidence that the reporting standard has been met; in addition, this stage of a review involves preparation of an SLB reporting file.

[21] VHA Handbook 1100.18. A "healthcare professional is an individual appointed…under 5 U.S.C. or 38 U.S.C. on a full-time, part-time, intermittent, off-station or on-station, fee basis; contract basis, or sharing agreement basis; either permanent or temporary, whether paid or without compensation, who is licensed, certified or registered in a healthcare profession (such as a physician, dentist, podiatrist, optometrist, chiropractor, nurse, physician assistant, expanded-function dental auxiliary, physical therapist, practical or vocational nurse, pharmacist, social worker, occupational therapist, or certified or registered respiratory therapist)."

[22] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021. This directive does not apply to community physicians under a Community Care Network or a Veterans Care Agreement.

[23] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

place the professional in a non-clinical environment.[24] VHA policy does not permit facility directors to delay the SLB reporting process pending completion of disciplinary actions.[25]

VHA policy dictates procedures to determine whether a clinician has met the reporting standard and, if indicated, to report the clinician to SLBs with jurisdiction over the professional.[26] Although the policy does not provide an all-inclusive list of occurrences that trigger SLB reporting procedures, the policy lists examples of actions that represent a "reasonable basis for a concern for the safety of patients" ranging from direct patient care deficiencies to unethical conduct (see appendix A).[27]

Submitting a report to an SLB is the last step in the reporting process and serves as a notice to the SLB that a concern exists based on substantial evidence.[28] The SLB decides what, if any, actions to take based on the facility director's report.[29]

The facility-controlled SLB review process steps include initial review, comprehensive review, director decision, and submission of report to the relevant SLB.[30] The process also includes a privacy review conducted by a Veterans Integrated Service Network (VISN) assigned privacy officer.[31] During the period of the OIG's review, the VHA policy suggested time frame for the entire process was 101 days.[32] The steps of the SLB reporting process are highlighted below in Figure 1.

[24] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[25] VHA Handbook 1100.18, 2005; VHA Notice 2018-05 Amendment to VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*. SLB Reporting Program reviews may be delayed due to "rare extenuating circumstances such as an ongoing VA Office of Inspector General (OIG) criminal investigation."

[26] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[27] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[28] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[29] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[30] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021.

[31] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021. Due to the facility director having the final decision on whether to report or not to report, the OIG did not evaluate the VISN review stage of the SLB reporting process.

[32] VHA Handbook 1100.18, 2005. VHA Directive 1100.18, 2021. The 2021 directive states that the five SLB steps should be completed in less than 100 calendar days.

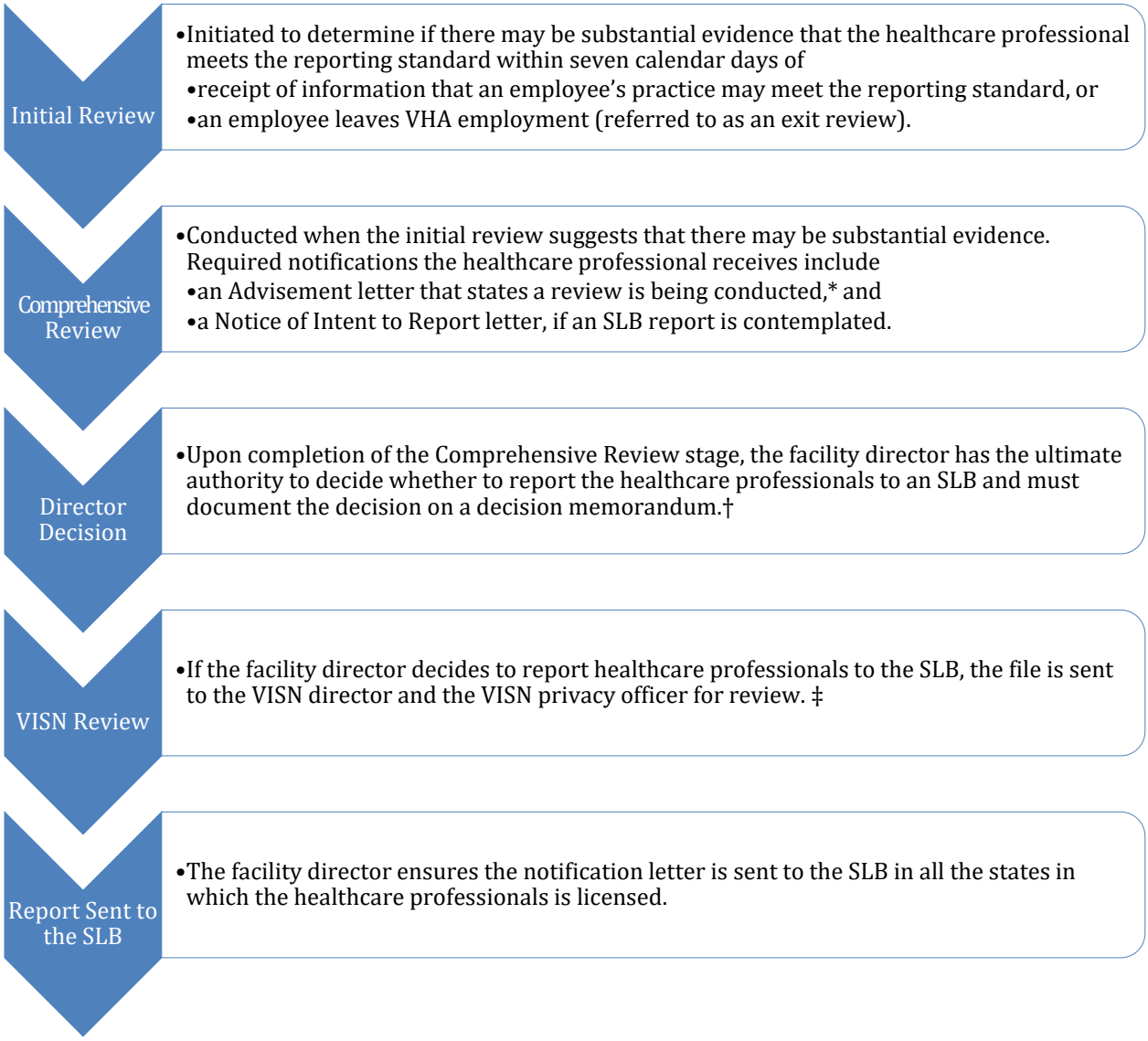

Figure 1. *VHA SLB Reporting Process.*
Source: Based on the OIG review of VHA Handbook 1100.18
** VHA Handbook 1100.18, 2005. VHA Directive 1100.18, 2021. The 2021 directive removed the requirement to send an Advisement letter to healthcare professionals under review and required the facility director to complete a decision memorandum regardless of the reporting decision.*
VHA Notice 2018-05, Amendment to VHA Handbook 1100.18, Reporting and Responding to State Licensing Boards, February 5, 2018. The amendment clarified that the facility director had the ultimate responsibility to decide whether to report a healthcare professional.
‡ The 2018 amendment removed a requirement for sensitive cases to be reviewed by the Office of General Counsel. The amendment also changed a requirement for obtaining VISN concurrence to VISNs being required to review the file for adherence to privacy rules.

SLB Reporting Process Review Results

The OIG analysis focused on compliance with the facility-controlled steps of the SLB process.[33] Specifically, the OIG calculated the overall facility compliance rate based on whether

- an initial review was completed;
- either a comprehensive SLB review was initiated or a comprehensive review was not initiated for a valid reason;
- a comprehensive review included required notifications made to the healthcare professional;
- a decision memorandum was completed by the facility director when required; and
- an SLB reporting letter was submitted to the relevant SLB, if required.

The OIG analysis indicated only 44 of the 107 (41 percent) cases reviewed were fully compliant with all facility-controlled steps of the SLB reporting process. In the following sections, facility compliance with individual steps of the SLB reporting process are discussed.

Initial Review of Current or Separated Healthcare Professionals

Facility staff reported that an initial review was completed in 82 of the 107 (77 percent) cases in which a healthcare professional appealed an adverse action of discharge or removal. In 25 of the 107 (23 percent) cases, an initial review was not completed, indicating that these healthcare professionals were not subjected to the required initial review to determine the need for SLB reporting.

The OIG analyzed responses to the OIG questionnaire regarding the reasons an initial review was not completed. The reasons provided by facility staff suggested deficiencies in understanding the SLB reporting policy and facility processes. Some examples were

- the healthcare professional was not terminated,
- the healthcare professional was terminated by the VA Central Office, not by the facility director,
- the healthcare professional did not provide clinical care,
- the facility director made the decision not to pursue,
- due process error and action was rescinded, and
- the charges were not sufficient to warrant reporting.

[33] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021. Facility-controlled steps are initial SLB review, comprehensive SLB review, director decision, and reporting to the appropriate SLB.

Failure to conduct an initial review of healthcare professionals whose performance or conduct merited a removal from employment signals that facilities did not take required steps to decide whether to report these professionals to SLBs. The OIG is concerned that this noncompliance leads to SLBs not receiving information that could be used to make licensing decisions.

Comprehensive Review Initiated

Facility staff reported data revealed a comprehensive SLB review was initiated in 56 of 107 (52 percent) cases. A comprehensive SLB review was not initiated in 51 (48 percent) of the cases.

The OIG analyzed questionnaire responses regarding reasons comprehensive reviews were not performed. In 13 cases, facility responses provided a valid reason for not initiating a comprehensive review, such as the initial review indicated the healthcare professional met generally accepted standards for clinical practice and there were no concerns for patient safety. In the remaining 38 of the 51 cases, facility staff did not identify valid reasons to justify not initiating a comprehensive SLB review. For example, invalid reasons included facility staff reporting comprehensive reviews were not initiated due to pending disciplinary appeals and deficiencies in facility oversight.

Due to invalid reasons, 38 healthcare professionals whose performance or conduct merited termination were not subjected to a comprehensive review to determine whether an SLB report was required.

Decision Memorandum

Based on facility staff responses to the OIG questionnaire, the OIG determined that in 40 of the 56 cases (71 percent) with a comprehensive SLB review, facility directors either completed a required decision memorandum or were not required to complete one.[34] Facility directors failed to complete a required decision memorandum in 13 of the 56 (23 percent) cases.[35]

Analysis of facility staff responses to the OIG questionnaire revealed that facility directors failed to complete decision memorandums related to a misunderstanding of policy and poor facility processes. Examples of facility staff responses included

[34] VHA Notice 2018-05, Amendment to VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards*, February 5, 2018. A decision memorandum is a means for a facility director to document decisions on SLB reporting. The memorandum either prompts progression to the next SLB reporting step or serves as evidence of a final decision not to report. A VHA policy amendment, effective in February 2018, mandated facility directors to document all SLB decisions on a decision memorandum Previously, facility directors were required to only document decisions to report healthcare professionals to SLBs.

[35] The OIG was unable to determine if three cases required a decision memorandum because of incomplete data provided by facility staff.

- nurses fall under the "auspices" of the Associate Director of Patient Care Services,
- the process was halted pending DAB decision and human resources charges, and
- the process was delayed due to a lack of knowledge, staffing shortages, consolidation, and COVID-19.

Documentation of SLB reporting decisions either prompts progression to the next SLB reporting step or serves as evidence of a final decision not to report. The documentation removes ambiguity when deciding whether to send a report to SLBs and the NPDB regarding a healthcare professional who resigns during an SLB review.[36]

SLB Report Submissions

The OIG analysis of questionnaire data revealed that of the 56 comprehensive SLB reviews initiated, facility directors decided to report 46 clinicians to an SLB; however, only 41 of the 46 (89 percent) healthcare professionals were ultimately reported.

Two of the five unreported cases were pending VISN review, despite the healthcare professionals being separated from employment for more than 10 months prior to submitting the OIG questionnaire responses, long after the suggested 101-day time frame for completing the SLB reporting process. The remaining justifications for not reporting healthcare professionals to SLBs were inconsistent with VHA policy or represented poor facility processes. Specifically, one respondent reported the facility director's decision was pending a decision from the DAB; another respondent attributed the failure to report the facility director's decision to outstanding legal issues. The OIG found another respondent indicated the failure to report was due to poor facility processes, specifically, "communication failure among key constituents in the process."

The OIG is concerned that facility directors missed an important opportunity to alert SLBs to identified problems with a healthcare professional's practice by failing to send reporting letters as required.

Factors Contributing to SLB Reporting Noncompliance

Through survey responses and interviews, the OIG identified two contributors to low SLB reporting compliance—misunderstanding of VHA policy and poor facility processes.

[36] VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports,* December 28, 2009. *NPDB Guidebook.* Physicians and dentist who surrender privileges during an investigation must be reported to the NPDB. "An investigation begins as soon as the healthcare entity begins an inquiry and does not end until the healthcare entity's decision-making authority takes a final action or makes a decision to not further pursue the matter."

Misunderstanding VHA Policy

When required actions were not taken, the OIG identified that a misunderstanding of VHA policy often was the reason. For instance, facility staff reported that an initial SLB review was not conducted because the clinician was reinstated, the termination was related to conduct as opposed to practice, or facility leaders decided not to conduct the review. Similarly, facility staff reported that SLB reviews were not initiated due to other pending personnel actions or a particular state was not interested in professional conduct issues that did not affect patients.

Based on questionnaire responses, facility leaders' misunderstanding of policies contributed to 5 of the 13 comprehensive SLB reviews not resulting in a required decision memorandum. For instance, one facility staff reported that the employee fell under the "auspices" of nursing. Another facility staff reported that the decision memorandum was not completed due to outstanding legal issues. Similarly, some facility staff provided reasons for not reporting a clinician to an SLB following a director's decision to report that suggested a misunderstanding of policy, such as the SLB report was pending an appeal decision.

The OIG found that staff experience and training were potentially the basis for the misinterpretation of policy. During interviews with facility staff, the OIG learned that, because of the low volume of cases requiring an SLB review, some facility staff did not have extensive experience conducting these reviews. Specifically, some facility staff reported having one year or less experience or completion of one or no cases. While facility staff reported receiving training from facility and VISN levels, training methods varied and included self-learning and accessing SharePoint resources.

Poor Facility Processes

The OIG found that poor facility processes contributed to the failure to complete required SLB reporting steps. For instance, facility staff reported through questionnaire responses that an initial SLB review was not completed because of facility process deficiencies, such as poor communication. Other examples included not having documentation to explain the failure to complete an initial SLB review or lack of facility oversight.

During OIG interviews, several staff described recent changes in facility's management of the SLB reporting process to improve compliance. Facility staff reported process changes to ensure initial SLB reviews were completed within seven days as required by VHA policy, including: implementation of a process to document when clinicians separate, consolidation of

responsibility for licensed independent practitioners and dependent practitioners under one credentialing office, and assignment of designated staff to coordinate the process.[37]

In conclusion, for the majority of reviewed cases, VHA medical facility directors failed to follow VHA's mandatory processes for reporting healthcare professionals to SLBs due to noncompliance with initiating initial and comprehensive SLB reviews and decision-making documentation. The OIG found that the noncompliance was linked to facility staff misunderstanding of VHA policy and poor facility processes. The noncompliance led to lapses in SLB reporting practices that resulted in delays or failures in reporting healthcare professionals whose clinical practice or behavior so substantially failed to meet generally accepted standards of clinical practice as to raise a reasonable concern for the safety of patients.

2. Noncompliance with the NPDB Reporting Process

The OIG found that facility directors failed to submit NPDB reports regarding physicians and dentists whose clinical privileges were adversely affected for more than 30 days, as required by federal regulation and VHA's NPDB reporting policy. The OIG found that this was a result of conflicting language in VHA policies and facility staff failures. Specifically, for practitioners who appealed a discharge or removal, the OIG determined that VHA's credentialing and privileging policy expanded the time frame for reporting physicians and dentists to the NPDB by several months over the 15-day time frame intended by federal regulation.[38] Additionally, the OIG found that even after following the credentialing and privileging policy regarding when to submit NPDB reports, facility directors failed to report 43 percent of reviewed cases to the NPDB as required.

VHA Policy Inconsistent with Federal Regulation Regarding When to Submit an NPDB Report

Federal regulation requires facility directors to file an NPDB report regarding physicians and dentists whose privileges were impacted by an adverse action for more than 30 days or who resigned during the course of an investigation.[39] The regulation specifies that a reportable adverse action is based on a review related to professional competence or conduct.[40] As stated in

[37] VHA Handbook 1100.18, 2005; VHA Directive 1100.18, 2021. VHA Handbook 1100.19, *Credentialing and Privileging,* October 15, 2012. Licensed independent practitioners are granted privileges by a facility director to practice independently. Dependent practitioners do not have privileges to practice independently. VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. The 2021 "directive supersedes the Credentialing portion of VHA Handbook 1100.19…but does not impact the Privileging portion of Handbook 1100.19."

[38] VHA Handbook 1100.17; VHA Handbook 1100.19; 38 CFR § 46.4—Clinical privileges actions reporting.

[39] 38 CFR § 46.4—Clinical privileges actions reporting. Adverse clinical privileging actions include privileging actions that result in a reduction, restriction, suspension, revocation, or failure to renew privileges.

[40] 38 CFR § 46.4(a).

the regulation, "[i]t is intended that the [NPDB] report be filed within 15 days of the date the action is made final, that is, subsequent to any internal (to the facility) appeal."[41] Consistent with the regulation, VHA policy for reporting to the NPDB states that facility directors must report to the NPDB "within 15 calendar days of the date the action is made final by signature of the Medical Center Director."[42] However, the VHA NPDB policy also instructs that physicians and dentists must be offered "appropriate internal VA medical center due process procedures" outlined in VHA Handbook 1100.19.[43]

Although the VHA NPDB policy instructs facility directors to file a report to the NPDB within 15 calendar days of a facility director's final signed action, VHA Handbook 1100.19 provides contradictory instructions by noting:

> It is only after the due process is completed, a final action taken by the facility director, and all appeals have been exhausted that the summary suspension and subsequent reduction or revocation of clinical privileges of a physician or dentist is reported to the NPDB.[44]

VHA Handbook 1100.19 further states that, in revocation of privileges cases, physicians and dentists receive due process "including the Disciplinary Appeals Board (DAB) process. There is no due process proceeding or appeal at the facility level."[45]

Despite the note quoted above, VHA Handbook 1100.19 further states

> Dismissal constitutes a revocation of privileges, whether or not there was a separate and distinct privileging action, and must be reported if the practitioner is a physician or dentist without further review or due process to the NPDB.[46]

Several months may elapse between a facility director's final action and the exhaustion of all appeals, which includes an appeal to the DAB. DABs are required to render a recommendation on the appeal within 45 days of the hearing or, if there is no hearing, within 120 days of the appeal being filed.[47] Within 90 days of the DAB's recommendation, the Deputy Under Secretary for Health is required to finalize the DAB case with a final administrative action.[48] Therefore, a report to the NPDB of a physician who appeals an adverse action to the DAB may not be submitted for several months, rather than 15 days as intended by federal regulation.

[41] 38 CFR § 46.4(c).
[42] VHA Handbook 1100.17, 9c(1).
[43] VHA Handbook 1100.17, 9b(1)(a).
[44] VHA Handbook 1100.19, 14l(3)(c)1a.
[45] VHA Handbook 1100.19, 14l. (5)(a)3(b).
[46] VHA Handbook 1100.19, 14l. (5)(a)2.
[47] VA Handbook 5021/1, *Employee/Management Relations,* March 5, 2004.
[48] VA Handbook/1 5021.

The VHA Medical Staff Affairs Director explained that the inconsistency of when to report is found in the definition of a final action and stated that, according to the NPDB, a final action occurs after a fair hearing is completed. The VHA Medical Staff Affairs Director stated that, for full-time, permanent Title 38 physicians and dentists, the DAB is the fair hearing. However, the OIG did not identify an NPDB requirement to delay reporting until after a fair hearing for an adverse action that affects privileges for more than 30 days. Rather, according to the NPDB Guidebook and an NPDB senior policy analyst, the NPDB requires reporting of an adverse action restricting privileges of a physician or dentist for more than 30 days as a result of professional review based on "the date the action was taken."[49]

Indeed, the NPDB contemplates subsequent appeals of a final decision. Specifically, if an NPDB report is made, but subsequent appeals negate the basis of the report, the facility director must submit a void report to the NPDB.[50] The NPDB then sends a notification to recipients of the initial NPDB report, including SLBs.[51] Additionally, voided reports must be removed from the individual's credentialing and privileging file.[52]

Facility Noncompliance with NPDB Adverse Action Reporting

The OIG reviewed facility director practices consistent with the perspective that physicians or dentists who appealed revocation of privileges were not to be reported to the NPDB until DAB appeals were completed. The OIG found that many facility directors failed to report physicians and dentists to the NPDB even after DAB proceedings were completed.

VHA policy requires facility directors to follow prescribed procedures regarding NPDB reporting.[53] NPDB reporting processes are highlighted below in Figure 2.

[49] *NPDB Guidebook*, chap E.
[50] VHA Handbook 1100.17.
[51] *NPDB Guidebook*, chap E.
[52] VHA Handbook 1100.17.
[53] VHA Handbook 1100.17.

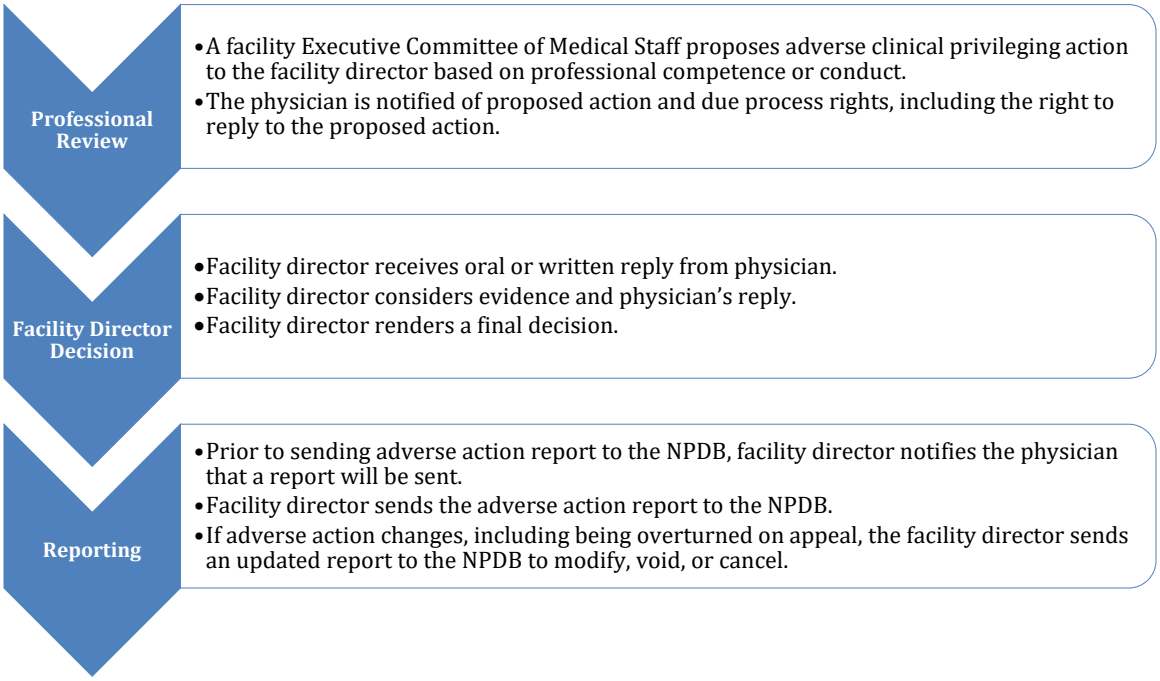

Figure 2. *VHA NPDB reporting process.*
Source: VA OIG analysis of VHA Handbook 1100.17. VHA Handbook 1100.19. VA Directive 5021, Employee/Management Relations, April 15, 2002.

The OIG found that out of the 107 reviewed cases appealing an action of discharge or removal, 50 cases involved a physician or dentist. The OIG found that 35 of the 50 (70 percent) cases identified from the Office of the Chief Human Capital Officer data were reportable to the NPDB following the completion of the DAB proceeding. The DAB reversed or mitigated penalties to non-reportable actions in 11 cases, which, based on VHA practices, did not require a report to the NPDB. The Office of the Chief Human Capital Officer data indicated that in four cases, the DAB did not make a decision due to lacking jurisdiction because appealed adverse actions did not relate to professional competency or conduct. The OIG did not consider these four cases to be reportable to the NPDB.

Based on OIG analysis of data supplied by the Office of the Chief Human Capital Officer and facility staff questionnaire responses, 20 of the 35 cases that required an NPDB report were submitted to NPDB. One of these 20 cases was reported in under 15 days of the facility director's final privileging action. In that case, a physician was reported to the NPDB prior to the date of termination. The maximum number of days from the facility director decision to NPDB reporting in the sample of cases reviewed was 611. The OIG found that facility directors failed to file required NPDB reports in 15 of 35 (43 percent) cases.

Factors Contributing to Facility Noncompliance with NPDB Reporting

Aside from the inconsistent and inaccurate instructions in the VHA NPDB and credentialing and privileging policies, based on facility staff responses, the OIG learned that reasons for facility directors' low compliance with NPDB reporting also included misunderstanding these policies and poor facility processes.

Misunderstanding Policy

Through analysis of facility responses to the OIG questionnaire and during OIG interviews, misunderstanding policy was a frequent reason for the failure to report physicians and dentists to the NPDB as required by federal regulation and VHA policy. Examples of noncompliance with NPDB reporting related to misunderstanding policy included responses stating

- physicians are only reported to NPDB for paid tort claims,[54]
- NPDB reporting decisions were at the discretion of the facility director,
- NPDB reporting had to be delayed when a DAB decision was on appeal to a federal district court, and
- being unclear that a 60-day suspension was reportable to the NPDB.

To further understand contributors to facility noncompliance due to misunderstanding policy, the OIG asked facility staff about training, experience, available resources, and oversight for NPDB reporting. Facility staff indicated receiving various levels of training related to the NPDB reporting ranging from self-learning of applicable VHA policy to formal training sessions conducted by VISN or VHA National Medical Staff Affairs personnel.

Some facility staff reported less than one year experience in NPDB reporting or having made two or fewer NPDB adverse action reports, while another staff member explained that the difficulty in being proficient in the NPDB reporting process was due to the infrequency of an adverse action requiring NPDB reporting.

During interviews, facility staff reported that consultative resources regarding NPDB reporting was available through the facility, VISN, or VHA National Medical Staff Affairs office. In addition, facility staff reported receiving guidance from the Office of General Counsel and Employee Relations/Labor Relations staff. The OIG found that despite the availability of consultative resources, facility staff may not recognize when to use the resources.

[54] *Merriam-Webster.com Dictionary*, *"tort,"* accessed March 22, 2021, https://www.merriam-webster.com/dictionary/tort. A tort is a civil wrong, other than breach of contract, for which a remedy may be obtained, usually in the form of damages.

Poor Facility Processes

Based on facility responses to the OIG questionnaire, the OIG found that poor facility processes also contributed to noncompliance with the NPDB reporting policy. For example, one facility response acknowledged that the failure to report was related to a lack of facility oversight and another indicated that the failure to report was a communication failure. During an OIG interview with facility subject matter experts, one interviewee described that the retirement of a staff member responsible for credentialing contributed to the failure to report to the NPDB.

The OIG found that in 15 of 35 cases requiring an NPDB report, facility directors failed to do so. These failures could lead to SLBs and potential employers not being aware of concerns regarding competence or conduct of physicians or dentists who should have been reported. As a result, patient safety could be negatively affected.

3. Lack of Oversight of Facility SLB and NPDB Reporting

During the inspection, the OIG found an additional concern—a lack of oversight to ensure facility compliance with VHA reporting policies. The OIG identified that VHA SLB and NPDB reporting policies did not include provisions regarding programmatic oversight to ensure facility compliance. This lack of oversight contributed to the failure of VHA leaders to detect and correct reporting noncompliance at the facility level.

The versions of the SLB reporting policy, in effect during the period of the cases under review, did not assign programmatic oversight to ensure compliance. Specifically, the 2005 version directed that the facility director had overall responsibility for reporting healthcare professionals at the facility level but did not identify an entity to ensure facility director compliance with the policy requirements.[55] In 2018, the National Medical Staff Affairs office was assigned responsibility in providing guidance regarding implementation of an amendment to the SLB reporting policy but the version did not assign programmatic oversight.[56] Notably, in 2021, the SLB directive added oversight responsibility, instructing the "Under Secretary for Health is responsible for ensuring overall VHA compliance with this Directive."[57] Additionally, the 2021 directive instructed that "the Medical Staff Affairs Director is responsible for serving as the VHA subject matter expert for reporting and responding to SLBs."[58]

The VHA NPDB reporting policy, published in 2009, designated VA medical facility directors as responsible for submitting adverse action reports to the NPDB.[59] While the policy also

[55] VHA Handbook 1100.18, 2005.
[56] VHA Notice 2018-05 Amendment to VHA Handbook 1100.18.
[57] VHA Directive 1100.18, 2021.
[58] VHA Directive 1100.18.
[59] VHA Handbook 1100.17.

assigned responsibility for the content of the policy to multiple offices, the policy did not designate responsibility for programmatic oversight.[60]

During an OIG interview, the VHA Medical Staff Affairs Director acknowledged having policy oversight of SLB and NPDB reporting and serving as a subject matter expert for facilities. The VHA Medical Staff Affairs Director, while not having programmatic oversight of the reporting policies, acknowledged challenges related to the low frequency of adverse actions that required reporting. However, the Director described recent changes at facility and VISN levels to improve facility reporting compliance by instituting dedicated positions, additional training, and increased VISN oversight. In addition, the Director reported that credentialing and privileging activities have been consolidated under one office at the facility level. At the VISN level, a newly established credentialing and privileging officer position has oversight responsibility for facility credentialing and privileging staff within the VISN.

The OIG found that due to a lack of programmatic oversight of facility SLB reporting processes and facility NPDB reporting practices, VHA leaders failed to detect and correct reporting noncompliance at the facility level. As a result of unaddressed facility noncompliance, SLBs and the NPDB did not receive required reports regarding healthcare professionals who were terminated related to professional conduct or competence concerns.

[60] VHA Handbook 1100.17.

Conclusion

The OIG found that, for a majority of cases involving a separated healthcare professional, facility directors failed to follow VHA's mandatory processes for reporting healthcare professionals to SLBs. Specifically, the OIG identified noncompliance among facility directors regarding commencing initial and comprehensive SLB reviews, decision-making documentation, and reporting to SLBs. The OIG identified two contributors to low SLB reporting compliance—misunderstanding of VHA policy and poor facility processes. Lapses in SLB reporting practices can result in delays or failures in reporting healthcare professionals whose conduct or practice raised patient safety concerns.

The OIG found VHA policies and facility processes contributed to facility directors not reporting physicians and dentists to the NPDB as required by federal regulation. For practitioners who appealed a discharge or removal from employment, the OIG determined that the VHA credentialing and privileging expanded the time frame for reporting physicians and dentists to the NPDB by several months over the 15-day time frame intended by federal regulation. The OIG found that in only one of the 20 cases reported to the NPDB, the facility director reported in under 15 days. Of the 20 cases reported to the NPDB, the maximum number of days from the facility director decision to NPDB reporting was 611. The OIG reviewed facility director practices consistent with the perspective that physicians and dentists who appealed revocation of privileges were not to be reported to the NPDB until DAB appeals were completed. Based on OIG analysis, the OIG found that facility directors failed to file required NPDB reports in 43 percent of reviewed cases.

The OIG found that, in addition to the delays created by the credentialing and privileging policy, reasons for facility directors' low compliance with NPDB reporting included misunderstanding VHA policy and poor facility processes.

During the inspection, the OIG found an additional concern—a lack of programmatic oversight to ensure facility compliance with VHA SLB and NPDB reporting policies. The OIG identified that the VHA SLB and NPDB reporting policies in effect at the time of the cases reviewed for this inspection did not include provisions regarding programmatic oversight to ensure facility compliance. This lack of oversight contributed to the failure of VHA leaders to detect and correct reporting noncompliance at the facility level.

Recommendations 1–4

1. The Under Secretary for Health reviews the State Licensing Board reporting processes at the facility level to ensure compliance with Veterans Health Administration policy, identifies noncompliance, and takes action as warranted.

2. The Under Secretary for Health ensures that the National Practitioner Data Bank facility reporting practices align with federal regulations and Veterans Health Administration policy.

3. The Under Secretary for Health instructs facility directors to submit National Practitioner Data Bank reports regarding physicians and dentists consistent with Veterans Health Administration policy.

4. The Under Secretary for Health ensures programmatic oversight of facility State Licensing Board and National Practitioner Data Bank reporting processes.

Appendix A

Table 1. Adverse Actions Reportable to an SLB

Examples
Significant deficiencies in clinical practice, for example: lack of diagnostic or treatment capability; multiple errors in transcribing, administering, or documenting medications; inability to perform clinical procedures considered basic to the performance of one's occupation; or performing procedures not included in one's clinical privileges in other than emergency situations.
Patient neglect or abandonment.
Physical and mental health impairment to cause the individual to make judgment errors affecting patient safety, behave inappropriately in the patient care environment, or provide unsafe patient care.
Substance abuse when it affects the individual's ability to perform as a healthcare provider or in the patient care environment.
Falsification of credentials, medical records, or prescriptions.
Inappropriate dispensing or theft of drugs.
Unethical behavior or moral turpitude (such as sexual misconduct toward any patient involved in VA health care).
Patient abuse, including mental, physical, sexual, and verbal abuse, and • any action or behavior that conflicts with a patient's rights identified in Title 38, Code of Federal Regulations; • intentional omission of care; • willful violations of a patient's privacy; or • willful physical injury, or intimidation, harassment, or ridicule of a patient.
Falsification of research findings, regardless of where the research was carried out or the funding source, as long as it was involved in some aspect of VA operations.

Source: VA OIG reproduction of VHA information.[61]

[61] VHA Handbook 1100.18.

Appendix B: Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 9, 2022

From: Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, VETERANS HEALTH ADMINISTRATION "Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities" (Project Number 2020-00827-HI-0982) (VIEWS # 6899280)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) subject draft report. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven Lieberman, M.D.

Attachment

Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report: Noncompliant and Deficient Processes and Oversight of State Licensing Board and National Practitioner Data Bank Reporting Policies by VA Medical Facilities (2020-00827-HI-0982)

Recommendation 1. The Under Secretary for Health reviews the State Licensing Board reporting processes at the facility level to ensure compliance with Veterans Health Administration policy, identifies noncompliance, and takes action as warranted.

VHA Comments: Concur. The VHA Office of Quality and Patient Safety will strengthen oversight of these processes at the facility level by incorporating responsibility for monitoring State Licensing Board (SLB) and National Practitioner Data Bank (NPDB) reporting actions into standardized position descriptions for VISN Credentialing and Privileging (C&P) Officers. As of February 2021, all VISN C&P Officers have been onboarded or are in the final selection process. Additionally, Medical Staff Affairs has developed a new tracking system for VISN C&P Officers to use to ensure timely reporting. Training will be provided on the new tracking system to C&P Officers and facility C&P Managers.

Additionally, to address executive leadership knowledge deficiencies regarding their role in state licensing board reporting, VHA Office of Quality Management will establish a task group to review OIG findings and recommend strategies to improve the awareness of the Executive Leadership Team (ELT) role and responsibilities in the SLB process.

Status: In Progress **Target Completion Date:** December 2022

Recommendation 2. The Under Secretary for Health ensures that the National Practitioner Data Bank facility reporting practices align with federal regulations and Veterans Health Administration policy.

VHA Comments: Concur. Federal regulations governing NPDB reporting are under revision. VHA's Office of Quality and Patient Safety is collaborating with the NPDB division of the Department of Health and Human Services to update the VHA Memorandum of Understanding for NPDB. Once completed, VHA policy will be revised to reflect updated processes and expanded reporting practices.

Status: In Progress **Target Completion Date:** December 2023

Recommendation 3. The Under Secretary for Health instructs facility directors to submit National Practitioner Data Bank reports regarding physicians and dentists consistent with Veterans Health Administration policy.

VHA Comments: Concur. VHA's Office of Quality and Patient Safety will issue a national memorandum reestablishing the requirement for facility directors to submit

physician and dentist NPDB reports. The memorandum will reinforce the processes and timeframes for reporting adverse actions and suspension of clinical privileges during an investigation.

Status: In Progress **Target Completion Date:** June 2022

Recommendation 4. The Under Secretary for Health ensures programmatic oversight of facility State Licensing Board and National Practitioner Data Bank reporting processes.

VHA Comments: Concur. Oversight of facility SLB and NPDB reporting processes will be accomplished using a new tracking system for NPDB and State Licensing Board reporting. Tracking will be conducted at the VISN level to monitor facility compliance. VHA Medical Staff Affairs will track and trend results quarterly to identify discrepancies in reporting at either the VISN or facility level. Medical Staff Affairs will report this data along with any actions taken at most annually to the VHA Quality, Safety, and Value Council. Training on the new tracking system will be provided to VISN C&P Officers and facility C&P Managers.

Status: In Progress **Target Completion Date:** December 2022

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