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Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

March 2004

VA HEALTH CARE

Improved Screening of Practitioners Would Reduce Risk to Veterans

GAO-04-566

Highlights of GAO-04-566, a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

Cases of practitioners causing intentional harm to patients have raised concerns about VA's screening of practitioners' professional credentials and personal backgrounds. GAO was asked to (1) identify key VA screening requirements, (2) evaluate their adequacy, and (3) assess compliance with these screening requirements. GAO reviewed VA's policies and identified key VA screening requirements for 43 health care occupations; interviewed officials from VA, licensing boards, and certifying organizations; and randomly sampled about 100 practitioners' personnel files at each of four VA facilities we visited.

What GAO Recommends

GAO recommends that VA expand its existing verification process to require that all state licenses and national certificates held by all practitioners be verified by contacting the appropriate licensing boards and national certifying organizations, expand the query of a national database to include all licensed practitioners, and fingerprint all practitioners who have direct patient care access. GAO also recommends that VA conduct oversight of its facilities to ensure their compliance with all key screening requirements. VA generally agreed with GAO's findings and will develop a detailed action plan to implement the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-04-566.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

March 2004

VA HEALTH CARE

Improved Screening of Practitioners Would Reduce Risk to Veterans

What GAO Found

GAO identified key screening requirements that VA uses to verify the professional credentials and personal backgrounds of its health care practitioners. These requirements include verifying professional credentials; completing background investigations for certain practitioners, including fingerprinting to check for criminal histories; and checking national databases that contain reports of practitioners who have been professionally disciplined or excluded from federal health care programs.

GAO found adequate screening requirements for certain practitioners, such as physicians, for whom all licenses are verified by contacting state licensing boards. However, screening requirements for others, such as currently employed nurses and respiratory therapists, are less stringent because they do not require verification of all licenses and national certificates. Moreover, they require only physical inspection of the credential rather than contacting state licensing boards and national certifying organizations. Physical inspection alone can be misleading; not all credentials indicate whether they are restricted, and credentials can be forged. VA also does not require facility officials to query, for other than physicians and dentists, a national database that includes reports of disciplinary actions involving all licensed practitioners. In addition, many practitioners with direct patient care access, such as medical residents, are not required to undergo background investigations, including fingerprinting to check for criminal histories.

Four Facilities' Compliance with Existing Key VA Screening Requirements

	Compliance with key screening requirements			
Key screening requirements	**Facility A**	**Facility B**	**Facility C**	**Facility D**
Credentials of applicants verified	○	●	○	○
Credentials of employed practitioners verified	●	●	●	●
List of Excluded Individuals and Entities queried for applicants	●	○	○	○
Background investigation completed or requested for employed practitioners	●	○	○	●
Declaration for Federal Employment form completed for employed practitioners	●	●	●	●

Source: GAO analysis of VA facility files.

● Indicates a compliance rate of 90 percent or greater.

○ Indicates a compliance rate of less than 90 percent.

VA has not conducted oversight of its facilities' compliance with the key screening requirements. This pattern of mixed compliance and the gaps in key VA screening requirements creates vulnerabilities to the extent that VA remains unaware of practitioners who could place patients at risk.

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Abbreviations

FSMB	Federation of State Medical Boards
HIPDB	Healthcare Integrity and Protection Data Bank
LEIE	List of Excluded Individuals and Entities
NPDB	National Practitioner Data Bank
OPM	Office of Personnel Management
SLB	state licensing board
VA	Department of Veterans Affairs

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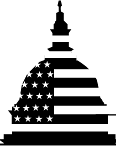


G A O

Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

March 31, 2004

The Honorable Steven Buyer
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

The Department of Veterans Affairs (VA) is responsible for safeguarding veterans receiving health care in its facilities by ensuring that its health care practitioners are qualified to provide care to their patients. VA employs about 190,000 individuals including physicians, nurses, pharmacists, and therapists at its facilities, and it supplements these practitioners with contract staff, medical consultants, and medical residents.[1] VA has screening requirements intended to help ensure that its health care practitioners' professional credentials are verified and their personal backgrounds checked for evidence of incompetence or criminal behavior. According to medical forensic experts, the deliberate harm of patients by health care practitioners is a problem in the health care sector, and VA's requirements are intended to minimize the chance of veterans receiving care from someone who is incompetent or may intentionally harm them.

Events at VA facilities have raised concerns about VA's screening of the professional credentials and personal backgrounds of health care practitioners at its facilities. In 1993, Dr. Michael Joseph Swango entered the VA health care system as a medical resident, although before entering the residency program he had been convicted and imprisoned for 2 years for aggravated battery against his fellow employees. Dr. Swango had admitted to medical school officials that he had a prior arrest and conviction, but lied about the nature of the crime. In 2000, he pleaded guilty to murdering three veterans at the VA facility located in Northport, New York, and received a sentence of three consecutive life terms without the possibility of parole. In another case, in 2000, events at the VA facility

[1]Contract staff may include intensive care nurses, emergency room physicians, or respiratory therapists. These staff have access to and provide care to patients.

in Albany, New York, raised concerns about VA's process for checking the credentials of individuals employed at its facilities. VA hired a research assistant to help administer several cancer studies. The research assistant had lost his medical license because he had forged his medical credentials. Once at VA, the research assistant allegedly falsified data that were used to qualify veterans for cancer studies, and this may have resulted in the untimely deaths of several veterans. In 2003, the researcher was indicted in federal court on charges including manslaughter, criminally negligent homicide, and fraud.

You asked that we examine VA's policies and practices intended to ensure that health care practitioners at its facilities have appropriate professional credentials and personal backgrounds to provide care to veterans. Specifically, we (1) identified key VA screening requirements for its health care practitioners, (2) determined the adequacy of these screening requirements, and (3) assessed the extent to which selected VA facilities complied with these screening requirements.

We reviewed health care occupations in VA and selected 43 occupations in which practitioners have direct patient care access or have an impact on patient care. See appendix I for a list of the 43 health care occupations included in our study. We reviewed VA employment screening policies and practices to identify those requirements that applied to the selected occupations and were key requirements for safeguarding veterans receiving health care in VA facilities.[2] To determine the adequacy of the key screening requirements, we examined whether they were complete, and whether VA applied them to all applicants, current employees, contract staff, medical residents, and volunteers. We also interviewed VA human resource officials, VA headquarters and VA facility officials, and facility practitioners; representatives of state licensing boards and national certifying organizations; and officials and representatives of organizations that operate national databases containing information on state licenses and national certificates. We also reviewed VA's policy on background investigations to determine its criteria for conducting background investigations. To assess the extent to which VA facilities complied with the key screening requirements, we visited four VA facilities and reviewed personnel files for practitioners at each site. From VA's automated pay

[2]Although VA has many employment screening requirements, such as whether the applicant is a United States citizen, we selected only those requirements that pertain to patient safety, such as verification of credentials and background investigations.

system, we selected a statistically random sample of 100 current practitioners in the 43 occupations for each facility we visited. We reviewed these practitioners' files to determine whether the facilities had documentation that demonstrated compliance with key VA screening requirements. We visited facilities located in Big Spring, Texas; New Orleans, Louisiana; Seattle, Washington; and the District of Columbia, based on geographic variation, affiliations with medical schools to train residents, and types of health care services provided. Of the four facilities we visited, three are large facilities located in major metropolitan areas and are affiliated with at least one medical school. The remaining facility is small, providing mainly primary care and long-term care services to veterans and is located in a rural area. Additionally, from the four facilities we visited and from six other facilities we selected based on geographic variation, we obtained documentation on how quickly facilities took action after obtaining the results of background investigations. Our results cannot be generalized to other facilities. For a complete description of our scope and methodology, see appendix I. Our work was conducted from August 2003 through March 2004 in accordance with generally accepted government auditing standards.

Results in Brief

We identified key screening requirements in VA's policies for checking the professional credentials and personal backgrounds of health care practitioners in its facilities. These requirements are in place to verify state licenses and national certificates for applicants VA intends to hire and for continued employment of practitioners; to check health care practitioners against national databases that contain reports of professional disciplinary actions and criminal convictions; and to investigate the personal backgrounds of health care practitioners, including checking fingerprints against a fingerprint-based criminal history database.

We found adequate screening requirements for certain practitioners, such as physicians and dentists. These screening requirements include having facility officials verify all physicians' and dentists' licenses by contacting state licensing boards for applicants VA intends to hire and periodically for their continued employment. Screening requirements for other practitioners, such as currently employed nurses, are less stringent because they do not require that VA facility officials check all licenses. Moreover, they do not require contacting state licensing boards, but instead require physical inspection of the license only. VA does not require verifying national certificates—the credentials held by other health care practitioners, such as respiratory therapists—by contacting the national certifying organizations for applicants VA intends to hire and periodically

for their continued employment. Physical inspection of credentials alone can be misleading; not all state licenses and national certificates indicate whether they are restricted, and licenses and certificates can be forged. Also, other than for physicians and dentists, VA does not require facility officials to query a national database that contains reports of disciplinary actions and criminal convictions involving all licensed practitioners. In addition, many practitioners with direct patient care access, such as medical residents, are not required to undergo background investigations, including fingerprinting to check for criminal records. These gaps create vulnerabilities because VA may remain unaware of health care practitioners who could place patients at risk.

In the four facilities we visited, we found mixed compliance with the existing key VA screening requirements. All facilities generally checked the professional credentials of practitioners periodically for continued employment. However, they were less compliant in checking the professional credentials of applicants that they intended to hire. Furthermore, VA facilities varied in how quickly they took action after obtaining the results of background investigations. During the site visit at one facility, we discovered returned background investigation results that were over a year old but had not been reviewed. We brought them to the attention of facility officials, who reviewed the reports and then terminated a nursing assistant who had been fired by a previous employer for patient abuse. Although VA established an office more than a year ago to perform oversight of human resources functions, including whether its facilities comply with these key screening requirements, it has not started these reviews. There is no VA policy outlining the human resources program evaluations to be performed by this office, and the resources have not been provided to support the functions of this office.

To better ensure the safety of veterans receiving health care at VA facilities, we recommend that VA conduct more thorough screening of both applicants it intends to hire and current employees by expanding the verification requirement that facility officials contact state licensing boards and national certifying organizations to include all state licenses and national certificates held by practitioners; expanding the query of a national database to include all licensed practitioners that VA intends to hire and periodically for continued employment; and requiring fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct patient care access. Furthermore, VA should conduct oversight to help ensure that facilities comply with all key screening requirements for applicants and current employees. In commenting on a draft of this report, VA generally agreed

with our findings and conclusions and stated that it would provide details on how it plans to address our recommendations when the final report is issued.

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 are issued by state licensing boards, which generally establish state licensing requirements governing their licensed practitioners.[3] Current and unrestricted licenses are licenses that are in good standing in the states that issued them, and licensed practitioners may hold licenses from more than one state. To keep a license current, practitioners must renew their licenses before they expire and meet renewal requirements established by state licensing boards, such as continuing education. Renewal procedures and requirements vary by state and occupation. When licensing boards discover violations of licensing practices, such as the abuse of prescription drugs or the provision of poor quality of care that results in adverse health effects, they may place restrictions on licenses or revoke them. Restrictions from a state licensing board can limit or prohibit a practitioner from practicing in that particular state. Some, but not all, issued state licenses are marked in such a way as to indicate that the licenses have had restrictions placed on them. Generally, state licensing boards maintain 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.

National certificates are issued by national certifying organizations, which are separate and independent from state licensing boards.[4] These organizations establish professional standards that are national in scope for certain occupations, such as respiratory and occupational therapists.

[3]State licenses are issued by offices in states, territories, commonwealths, or the District of Columbia, collectively referred to as state licensing boards.

[4]Some practitioners may hold both a national certificate and a state license.

Practitioners who are required to have a national certificate to practice in VA may renew these credentials periodically by paying a fee and verifying that they obtained required educational credit hours. National certifying organizations can place restrictions on a certification or revoke certification for violations of the organization's professional standards. Like state licensing boards, national certifying organizations maintain a database of information on disciplinary actions taken against practitioners with national certificates and many can be accessed at no cost.

VA Policy Requires Its Facilities to Check Many Practitioners' Professional Credentials and Personal Backgrounds

We identified key VA screening requirements that are intended to ensure that VA facilities employ health care practitioners who have valid professional credentials and personal backgrounds appropriate to deliver safe health care to veterans. Officials at VA facilities are required to verify whether credentials—state licenses and national certificates—held by applicants and employees are current and unrestricted.[5] VA also requires its facilities to check the names of all applicants VA intends to hire against a federal list of individuals who have been excluded from participation in any federal health care programs and to compare applicants' educational institutions against lists of fraudulent institutions.[6] Additionally, VA requires that individuals in certain positions undergo a background investigation, which includes checking their fingerprints against a fingerprint-based criminal history database.

[5]Professional credentials held by practitioners may include licenses, registrations, and certifications. We refer to these credentials as state licenses or national certificates.

[6]The term applicants refers to those practitioners that VA facility officials plan to hire.

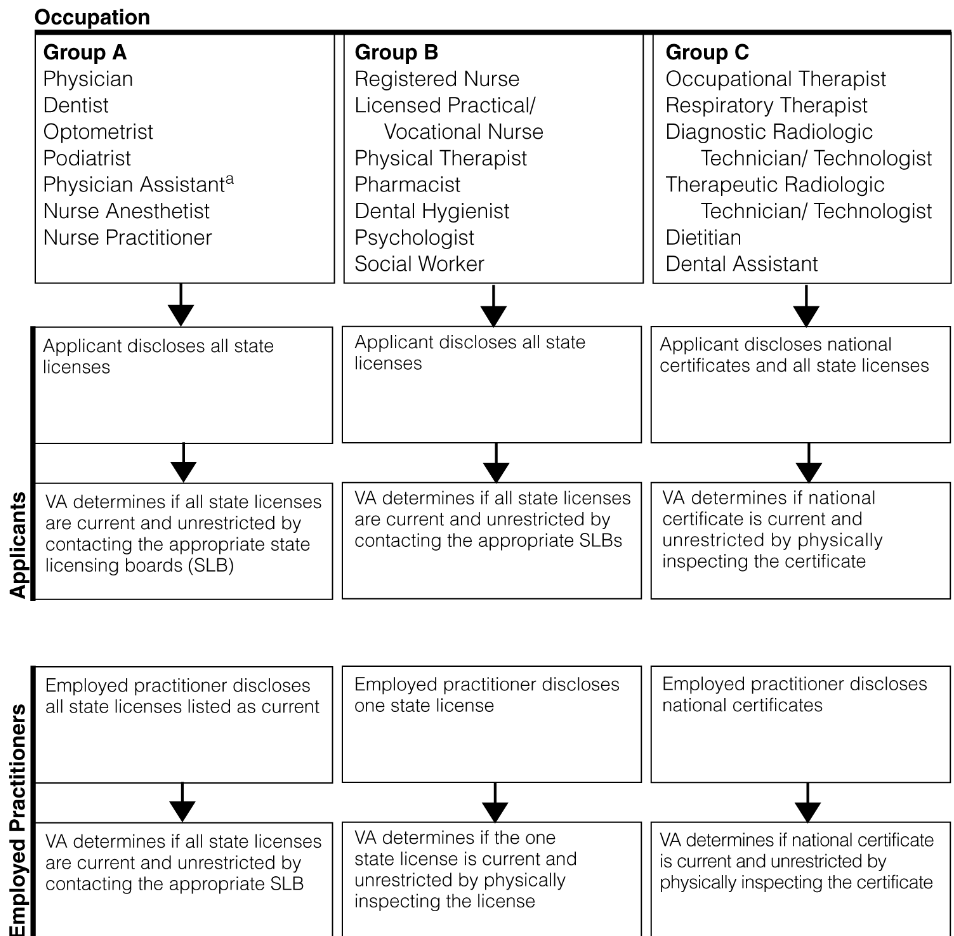
VA Policy Requires Verification of the Status of State Licenses and National Certificates

VA policy requires officials at its facilities to screen applicants to determine whether they possess at least one current and unrestricted state license or an appropriate national certificate, whichever is applicable for the position they seek. We classified VA's practitioners into three groups, depending upon the credentials and the verification process VA requires for employment. Figure 1 illustrates VA's process for credentials verification with state licensing boards and national certifying organizations for these groups for applicants VA intends to hire and for employed practitioners, whose credentials are checked periodically.[7] [8] Groups A and B represent practitioners who must be licensed to work in VA. However, the requirements and process VA uses to verify professional credentials is different for each of these groups. Group C represents practitioners who must have a national certificate to work in VA and may also have a state license.

[7]The frequency of when practitioners' credentials are checked depends on their occupation and the requirements of the state or national organization that issued the credential.

[8]We use the term employed practitioners to refer to practitioners who have been hired by VA and to distinguish them from practitioners who have applied for VA employment, but have not been hired.

Figure 1: VA's Process for Credentials Verification with State Licensing Boards and National Certifying Organizations



Source: GAO analysis of Department of Veterans Affairs, *VA Handbook 5005* (Washington, D.C.: 2002).

Note: Groups A and B represent practitioners who must be licensed to work in VA. Some group B psychologists and social workers may undergo the same credentials verification process as practitioners in group A. Group C represents practitioners who must have a national certificate to work in VA and may also have a state license.

[a]Physician assistants are not required to have a license to work in VA, but their credentials are verified using a process that is similar to other group A practitioners.

The process used to screen applicants in all three groups has two stages. First, applicants are required to disclose, if applicable, their state licenses and national certificates. Second, VA facility officials are required to verify whether applicants' state licenses or national certificates are current and unrestricted. To verify applicants' credentials, VA officials are required to

either contact state licensing boards or to physically inspect an applicant's national certificate. Officials are also required to document that they verified the status of the professional credentials.

VA also has requirements for verifying the credentials of its employed practitioners. Like the verification process for applicants, this process involves employed practitioners' disclosures and VA verification of that information. VA employed practitioners in group A are required to disclose all of their current licenses, while those in group B must disclose only one license. For employed practitioners in group A, facility officials are also required to determine if any expired licenses disclosed as current and unrestricted at the beginning of employment had restrictions placed on them prior to their expiration. VA depends on its employed practitioners in group B to inform facility officials of any change in the status of their license, including any that have expired. Employed practitioners in group C must disclose a national certificate. VA officials must confirm that the disclosed licenses and certificates are current and unrestricted. For group A practitioners, VA facility officials contact the appropriate state licensing boards directly; for groups B and C they physically inspect the state license or national certificate. VA officials verify these credentials periodically depending on the occupation and the requirements of the state or national organization that issued the license or certificate. For example, a registered nurse with a state license from Virginia must renew the license every 3 years, while a respiratory therapist must renew the national certificate every 5 years.[9] VA officials are required to document these verifications.

If VA's verification process identifies that a state licensing board or national certifying organization took disciplinary action against a practitioner, facility officials are required to determine the circumstances of the disciplinary action. Licensing boards and certifying organizations have various options for disciplining practitioners. For example, a nurse who is abusing drugs and voluntarily enters a drug abuse program may retain a license to practice with supervision when administering drugs. In contrast, a physician whose treatment results in the death or the permanent disability of a patient may have a license revoked. On the basis of a review of the action taken by the state licensing board or national

[9] The requirement for respiratory therapists to renew their national certificate every 5 years became effective in July 2002 and affects those national certificates obtained after June 30, 2002.

certifying organization, VA officials are to determine whether an applicant should be hired or an employed practitioner should be retained or terminated.

To supplement its checks with state licensing boards, VA has requirements for searching for disciplinary actions taken against licensed practitioners that might not have been disclosed by physician and dentist applicants and employed practitioners. VA requires its facilities to check national databases for information on disciplinary actions taken against these practitioners. Specifically, VA requires that facility officials query the Federation of State Medical Boards (FSMB) database, which includes records of disciplinary actions taken against physicians by all state licensing boards.[10] Similarly, VA requires facility officials to query the National Practitioner Data Bank (NPDB), which contains information including disciplinary actions taken against physicians and dentists.[11] Facility officials must document the results of these queries.

VA Policy Requires Checks of Applicants and Their Credentials against Lists Designed to Prevent Fraud and Abuse

VA policy requires its facilities to check the names of all applicants VA intends to hire against a federal list of individuals who have been excluded from participation in any federal health care program.[12] The list, referred to as the List of Excluded Individuals and Entities (LEIE), is maintained by the Department of Health and Human Services' Office of Inspector General. Since March 1999, VA facilities are to electronically query the LEIE Web site on all applicants prior to employment.

VA also requires its facilities to make sure that an applicant's educational degrees are authentic. VA requires that applicants for some positions, such as social workers, have degrees from accredited institutions. To prevent

[10]FSMB represents state medical licensing boards and establishes standards for physician licensure and practice. FSMB operates a national database to collect, record, and distribute to state medical boards and other appropriate agencies data on disciplinary actions taken against physicians by the boards and other governmental authorities.

[11]The Health Resources and Services Administration of the Department of Health and Human Services is responsible for the management of NPDB.

[12]The Balanced Budget Act significantly expanded the authority of the Department of Health and Human Services to exclude certain individuals and entities from participation in federal health care programs. Exclusion is mandatory for those convicted of Medicare-related crimes, patient abuse, and certain health care fraud and controlled substance crimes. Exclusion is permissive for other offenses, including professional health care license revocation. *See* Pub. L. No. 105-33 § 4331(c), 111 Stat. 251, 396; 42 U.S.C. § 1320a-7.

the use of fraudulent degrees to obtain employment, VA requires that its facilities compare the educational institutions listed by an applicant against existing lists of "diploma mills" that sell fictitious college degrees and other professional credentials.

VA Policy Requires Background Investigations and Disclosures for Certain Employed Practitioners

VA's employed practitioners are required to undergo a background investigation that verifies their personal histories.[13] A background investigation verifies, for instance, an individual's history of employment, education, and residence. It also includes a fingerprint check that searches for evidence of criminal activity by comparing fingerprints against a database of criminal records. The Office of Personnel Management (OPM) conducts the investigations for VA and reports its results back to the facility that requested the investigation.

In conjunction with the background investigation, VA employed practitioners are required to disclose information about their professional and personal backgrounds by filling out the Declaration for Federal Employment form—also known as form 306. Employed practitioners are asked to disclose, among other things, information about criminal convictions, employment terminations, military court-martials, and delinquencies on federal loans. Failure to disclose information requested on form 306 is grounds for dismissal. Facility officials compare the information obtained from form 306 with the results obtained through the background investigation to determine whether employed practitioners have been forthcoming in their disclosures. If the background investigation results include questionable issues, such as discrepancies in work or criminal histories, the facility has 90 days to take action.

[13]Executive Order 10450, April 27, 1953, requires all persons employed by federal departments and agencies to undergo a background investigation to ensure that their employment is consistent with national security interests. It is administered by the Office of Personnel Management (OPM), which has issued implementing regulations in part 732 of Title 5 of the Code of Federal Regulations. OPM may grant exemptions to the executive order and, with regard to VA, background investigations are not required for employees appointed for 6 months or less. Related regulations regarding determinations of an individual's suitability for federal employment, based on their character, conduct, knowledge, and ability, are contained in part 732 of the Code of Federal Regulations.

Gaps in Key VA Screening Requirements Create Vulnerabilities

Gaps in key VA screening requirements result in vulnerabilities when screening certain health care practitioners. Although the screening requirements for some occupations, such as physicians, are adequate because they require verifying all licenses by contacting state licensing boards, screening requirements for other occupations are less stringent. These less stringent requirements do not require checking all licenses, and they require physical inspection of one license only rather than contacting the state licensing board. Similarly, VA does not require contacting national certifying organizations to verify national certificates—the credentials held by health care practitioners, such as respiratory therapists. Physical inspection of credentials alone can be misleading; not all state licenses and national certificates indicate whether they are restricted, and licenses and certificates can be forged. While VA requires checking a national database for physicians and dentists, it does not require that facility officials query a national database that contains reports of disciplinary actions and criminal convictions involving all licensed practitioners. In addition, VA does not require that all practitioners undergo background investigations, including fingerprinting, to check for criminal records. These gaps create vulnerabilities because VA may remain unaware of health care practitioners who could place patients at risk.

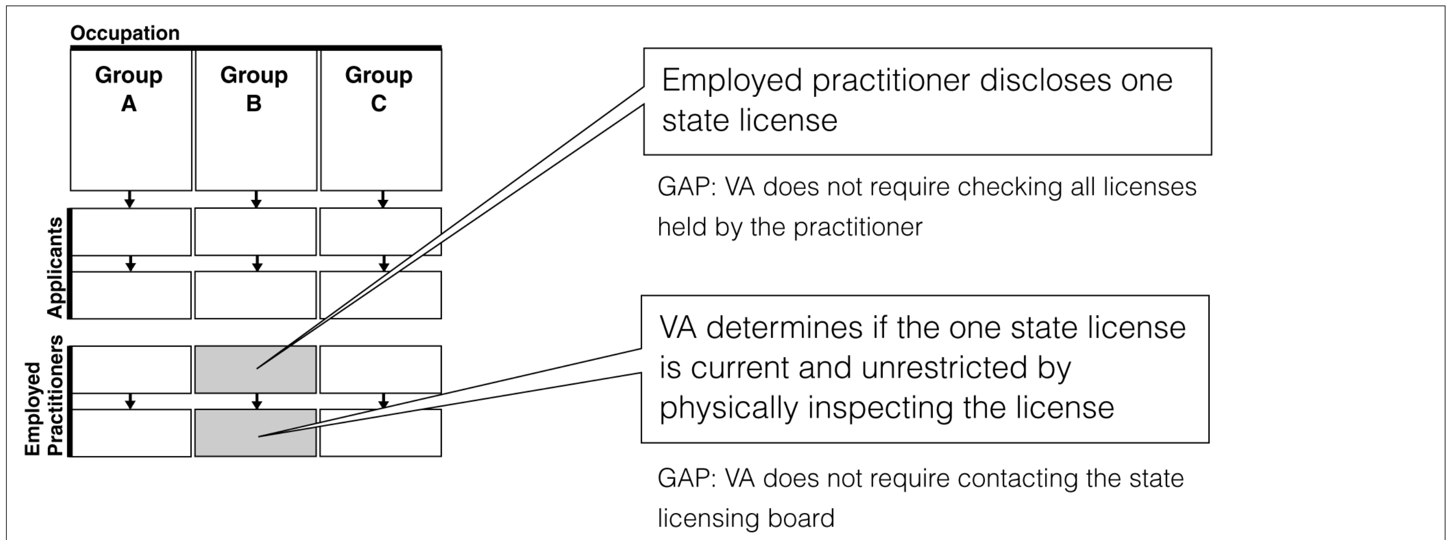
VA Has Adequate Requirements for Verifying Professional Credentials of Certain Practitioners

VA's requirements for verifying the professional credentials of applicants it intends to hire and employed practitioners in group A, such as physicians and dentists, are complete and thorough. This is also the case for applicants VA intends to hire in group B, such as nurses and pharmacists. VA requires facility officials to verify all state licenses by contacting the appropriate state licensing boards. To supplement these requirements for physicians and dentists, VA officials also must query FSMB and NPDB to identify reports of any disciplinary actions involving these practitioners.

Gaps Exist in VA's Requirements for Verifying Professional Credentials of Other Practitioners

In contrast to all practitioners in group A, the process for verification of licenses for group B practitioners has gaps, as illustrated in figure 2. VA's verification process for group B practitioners that it intends to hire is as stringent as the process used for group A practitioners. However, the process used to verify licenses for continued employment of group B practitioners is less stringent, because facility officials are required to check only one state license, which is selected by the practitioner. Furthermore, officials are not required to contact the state licensing board directly, but instead may simply physically inspect the one state license to check its status.

Figure 2: Gaps in Group B Employed Practitioners' Credentials Verification with State Licensing Boards



Source: GAO analysis of Department of Veterans Affairs, *VA Handbook 5005* (Washington, D.C.: 2002).

Employed practitioners in group B with multiple state licenses select the one state license under which they will continue to practice in VA. The license selected does not have to be from the state where the VA facility is located. VA officials check only that single license. As a result, these employed practitioners could have a restricted license in one state, or several restricted state licenses, but offer VA officials an unrestricted license from another state for verification.

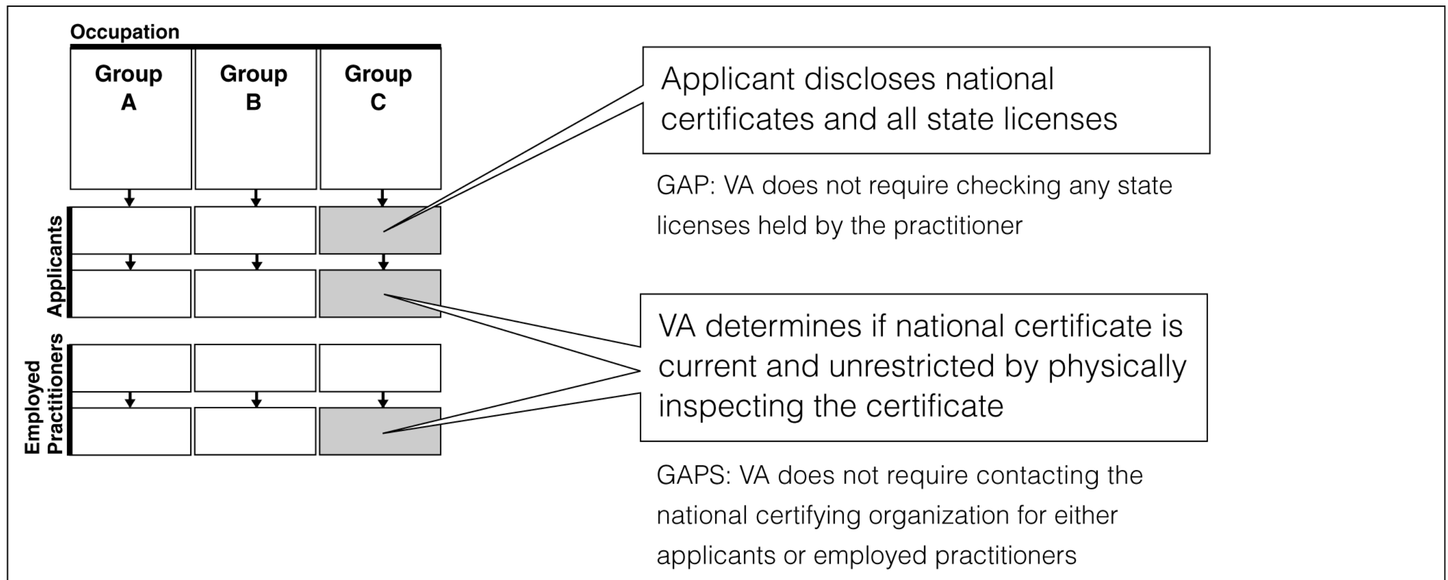
Moreover, the method required to periodically verify the status of licenses for continued employment of practitioners in group B is not thorough. VA facility officials are only required to physically inspect the license—instead of contacting the state licensing board. VA facility officials we interviewed were unaware of the inherent vulnerabilities in relying on a physical inspection. According to licensing board officials, one cannot determine with certainty that a license is valid and unrestricted unless the state licensing board is contacted directly. These officials explained that state licensing boards do not always exchange information. Furthermore, physical inspection of licenses alone can be misleading because not all state licensing boards mark a license to indicate that it is restricted, and licenses can be forged, even though licensing boards have taken steps to minimize this problem. Licensing board officials also pointed out that many state boards do not charge a fee to verify licenses.

Unlike the national database queries of FSMB for physicians and NPDB for physicians and dentists, VA does not require facility officials to query the Healthcare Integrity and Protection Data Bank (HIPDB), a national database that contains information on disciplinary actions and criminal convictions involving all licensed practitioners.[14] All government agencies, including state licensing boards, are required to report to HIPDB. VA accesses HIPDB when it queries the NPDB for physicians and dentists because the databases share information. However, VA does not require its facilities to query HIPDB for all licensed practitioners even though VA is authorized by statute to query this database at no charge.

VA's requirements for verifying the professional credentials of both applicants and employed practitioners in group C also have gaps, as illustrated in figure 3. For both applicants and employed practitioners in group C, which include respiratory therapists and dietitians for example, facility officials are only required to physically inspect the national certificate to check its status. The physical inspection is required when these practitioners apply for employment and periodically for continued employment. Additionally, VA requires applicants in group C to disclose all of the state licenses they have ever held, but does not require facility officials to verify any of these state licenses.

[14]HIPDB was developed after the Health Insurance Portability and Accountability Act of 1996 was enacted, which added new section 1128E to the Social Security Act, requiring development of the database. *See* Pub. L. No. 104-191, § 221(a), 110 Stat. 1936, 2009 (codified at 42 U.S.C. § 1320a-7e(2000)). The applicable regulations are contained in Part 61 of Title 45 of the Code of Federal Regulations. HIPDB is maintained and operated by the Health Resources and Services Administration in the Department of Health and Human Services.

Figure 3: Gaps in Group C Applicants' and Employed Practitioners' Credentials Verification with State Licensing Boards and National Certifying Organizations



Source: GAO analysis of Department of Veterans Affairs, *VA Handbook 5005* (Washington, D.C.: 2002).

However, according to officials from national certifying organizations, the authenticity and status of a national certificate can only be assured by contacting the national certifying organizations directly. For example, an official from the National Board for Respiratory Care told us that practitioners that were certified prior to July 2002 are not required to renew their certificates—they can voluntarily choose to recertify. Thus, physical inspection of a certificate will not ensure that there has been no disciplinary action taken by the board since the certificate was issued.

VA Has Not Implemented Consistent Background Screening Requirements

VA has not implemented consistent background screening requirements, which include fingerprint checks, for all practitioners. Although VA requires background investigations for newly hired employed practitioners, it does not require background investigations for certain contract health care practitioners, practitioners who work without compensation from VA, medical consultants, and medical residents. VA, with prior approval from OPM, has the authority to determine which positions in VA require a background investigation. VA requested and received permission from OPM to exempt certain categories of health care practitioners from background investigations, based on VA's assessment

that these types of practitioners do not need a background investigation. Table 1 lists the types of practitioners that VA exempts from background investigations.

Table 1: Types of Practitioners VA Exempts from Background Investigations

Types of practitioners VA exempts	Length of appointment
Contract health care practitioners or practitioners that work without direct compensation from VA	• 6 months or less in a single continuous appointment or series of appointments
Medical consultants	• 1 year or less and not reappointed • 1 year or more but less than 30 days in a calendar year and not reappointed
Medical residents	• 1 year or less of continuous service at a VA facility

Source: Department of Veterans Affairs, *VA Manual MP-1, Part I, Chapter 5, Change 1* (Washington, D.C.: 1979).

VA requested and received permission from OPM, in 2001 and 2003, to perform fingerprint-only checks for contract health care practitioners, who work in a facility for 6 months or less and are currently exempt from background investigations, and for all volunteers who have access to patients, patient information, or pharmaceuticals.[15] OPM began to offer a fingerprint-only check—a new screening option—for use by federal agencies in 2001. Compared to background investigations, which typically take several months to complete, fingerprint-only checks can be obtained within 3 weeks or less and cost less than $25, about a quarter of the cost of a background investigation.[16] In commenting on a draft of this report, VA said that it planned to implement fingerprint-only checks for all contract health care practitioners, medical residents, medical consultants, and practitioners that work without direct compensation from VA, as well as certain volunteers. However, VA has not issued guidance to its facilities instructing them to implement fingerprint-only checks on all these practitioners. VA did issue guidance to its facilities to implement fingerprint-only checks for volunteers who have access to patients, patient information, or pharmaceuticals.

[15] VA's volunteer program is the largest in the federal government, providing volunteers to assist veterans by augmenting staff in such settings as hospitals and nursing homes.

[16] Departments and agencies may obtain fingerprints in two ways: either using paper or using computerized technology, which became available in 1999. Computerized technology typically produces fingerprint match results in 2 days.

Implementing fingerprint-only checks for practitioners who are currently exempt from background investigations would detect practitioners with a criminal history. According to the lead VA Office of Inspector General investigator in the Dr. Swango case, if Dr. Swango had undergone a fingerprint check at the VA facility where he trained, VA facility officials would have identified his criminal history and could have taken appropriate action. Additionally, one of the facilities we visited had implemented fingerprint-only checks of medical residents training in the facility and contract health care practitioners. An official at this facility stated that at a minimum, fingerprint-only checks of medical residents and contract practitioners were necessary to help ensure the safety of veterans in the facility. FSMB in 1996 recommended that states perform background investigations, including criminal history checks, on medical residents in order to better protect patients because residents have varying levels of unsupervised patient care. This recommendation, in part, resulted from reports that over a 4-year period more than 500 residents had performance, behavioral, or criminal problems during their training.

VA Facilities Did Not Comply with All of the Key VA Screening Requirements

In the four facilities we visited, we found mixed compliance with the existing key VA screening requirements which are intended to ensure that applicants and employed practitioners at VA facilities have valid professional credentials and personal backgrounds to deliver safe health care to veterans. None of the four VA facilities complied with all of the key requirements. Moreover, VA does not conduct oversight of its facilities to determine if they comply with these key screening requirements.

In order to show the variability in the level of compliance among the four VA facilities we visited, we measured their performance against a compliance rate of at least 90 percent for each of five of the six screening requirements, even though VA allows no deviation from these requirements. Table 2 summarizes the rate of compliance among the four VA facilities we visited. For detailed information about our analysis and each facility's compliance with a particular requirement, see appendixes I and II. For the sixth requirement—matching the educational institutions listed by a practitioner against lists of diploma mills—we asked facility officials if they did this check and then asked them to produce the lists of diploma mills they use.

Table 2: Facilities' Rate of Compliance with Existing Key VA Screening Requirements

	Compliance with key screening requirements[a]			
Key screening requirements	Facility A	Facility B	Facility C	Facility D
Credentials of applicants verified	○	●	○	○
Credentials of employed practitioners verified	●	●	●	●
List of Excluded Individuals and Entities queried for applicants	●	○	○	○
Background investigation completed or requested for employed practitioners	●	○	○	●
Declaration for Federal Employment form completed for employed practitioners (form 306)	●	●	●	●

Source: GAO analysis of VA facility files.

● Indicates a compliance rate of 90 percent or greater.

○ Indicates a compliance rate of less than 90 percent.

Note: Some screening requirements do not require verifying all licenses a practitioner might hold or verifying professional credentials by contacting state licensing boards or national certifying organizations.

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

All four facilities generally complied with VA's existing policies for verifying the professional credentials of employed practitioners, either by contacting the state licensing board for practitioners, such as physicians, or physically inspecting the license or national certificate for practitioners, such as nurses and respiratory therapists. They also generally ensured that applicants VA intended to hire had completed the Declaration for Federal Employment form, which requires the applicants to disclose, among other things, information about criminal convictions, employment terminations, and delinquencies on federal loans. However, three of the four facilities did not follow VA's policies for verifying all of the professional credentials of applicants and three facilities did not compare applicants' names to LEIE prior to hiring them. Two of the four facilities conducted background investigations on their employed practitioners at least 90 percent of the time, but the other two facilities did not.

We also asked officials whether their facilities checked the educational institutions listed by an applicant against a list of diploma mills to verify that the applicant's degree was not obtained from a fraudulent institution.

An official at one of the four facilities told us his staff consistently performed this check. Officials at the other three facilities stated they did not perform the check because they did not have a list of diploma mills.

In addition to assessing the rate of compliance with the key screening requirements, we found that VA facilities varied in how quickly they took action to deal with background investigations that returned questionable results, such as discrepancies in work or criminal histories. OPM gives a VA facility up to 90 days to take action after the facility receives investigation results with questionable findings. We reviewed the timeliness of actions taken by facility officials from August 1, 2002, to August 23, 2003, at the four facilities we visited and six additional facilities geographically spread across the VA health care system. We found that officials at 5 of the 10 facilities took action within the 90-day time frame, with the number of days ranging on average from 13 to 68. Officials at 3 facilities exceeded the 90-day time frame on average by 36 to 290 days. One facility took action on its cases prior to OPM closing the investigation, and another facility did not have the information available to report. For additional information on the average number of days it took each facility to report its actions, see appendix II.

One of the cases that exceeded the 90-day time frame involved a nursing assistant who was hired to work in a VA nursing home in June 2002. In August 2002, OPM sent the results of its background investigation to the VA facility, reporting that the nursing assistant had been fired from a non-VA nursing home for patient abuse. During our review, we found this case among stacks of OPM results of background investigations that were stored on a cart and in piles on the desk and on other work surfaces of a clerk's office. After we brought this case to the attention of facility officials in December 2003, they reviewed the report and then terminated the employee for not disclosing this information on the Declaration for Federal Employment form 306. The employee had worked at the VA facility for more than 1 year.

Another case at the same facility that exceeded the 90-day time frame involved an employee who had been convicted for possession of illegal drugs prior to being hired by VA. He had been hired at the facility in August 2002 and was to complete a background investigation form at that time. In June 2003, almost 1 year after being hired, a facility official realized the employee had not completed and returned this form and gave the employee the form to complete. The employee returned the completed form in the same month and it was sent to OPM, which returned the results of its investigation to the facility in July 2003, before the

employee’s probationary period of 1 year was completed. The OPM report revealed numerous arrests for possession of illegal drugs. During our December 2003 review and about 120 days after the investigation results were returned from OPM, we found this report and brought it to the attention of the facility director. Later, a facility official told us that VA’s regional counsel stated that since the employee’s 1-year probationary period had ended and the employee had disclosed this information on the Declaration for Federal Employment form 306, the facility could not take action to terminate the employee.

VA has not conducted oversight of its facilities’ compliance with the key screening requirements. Instead, VA has relied on OPM to do limited reviews of whether facilities were meeting certain human resources requirements, such as completion of background investigations. These reviews did not include determining whether the facilities were verifying professional credentials. Although VA established the Office of Human Resources Oversight and Effectiveness in January 2003 to conduct such oversight, the office has not conducted any facility compliance evaluations. There is no VA policy outlining the human resources program evaluations to be performed by this office, and the resources have not been provided to support the functions of this office.

Conclusions

VA’s screening requirements are intended to ensure the safety of veterans by identifying applicants and employed practitioners with restricted or fraudulent credentials, criminal backgrounds, or questionable work histories. However, gaps in VA’s existing screening requirements allow some practitioners access to patients without a thorough screening of their professional credentials and personal backgrounds. For example, although the screening requirements for verifying professional credentials for some occupations, such as physicians, are adequate, VA does not apply the same screening requirements for all occupations with direct patient care access. Specifically, VA does not require that all licenses be verified, or that licenses and national certificates be verified by contacting state licensing boards or national certifying organizations. VA relies on two national databases to identify physicians and dentists who have had disciplinary actions taken against them. In addition, VA accesses a third national database, HIPDB, for physicians and dentists, because HIPDB is linked to one of the two national databases VA currently accesses. HIPDB is a national database that contains reports of disciplinary actions and criminal convictions involving all licensed practitioners, not just physicians and dentists. However VA does not require facility officials to query HIPDB for all licensed practitioners. As a result, practitioners such

as nurses, pharmacists, and physical therapists do not have their state licenses checked against a national database. In addition, VA does not require all practitioners with direct patient care access, such as medical residents, to have their fingerprints checked against a criminal history database. These gaps create vulnerabilities that could allow incompetent practitioners or practitioners with the intent to harm patients into VA's health care system.

In addition to these gaps, compliance with the existing key screening requirements was mixed at the four facilities we visited. None of the four facilities complied with all of the key VA screening requirements. However, all four facilities generally complied with VA's requirement to periodically verify the credentials of practitioners for their continued employment. Although VA created the Office of Human Resources Oversight and Effectiveness in January 2003 expressly to provide oversight of VA's human resources practices at its facilities, it has not provided resources for this office to conduct oversight of VA facilities' compliance with these requirements. Without such oversight, VA cannot provide reasonable assurance that its facilities comply with requirements intended to ensure the safety of veterans receiving health care in VA facilities. In light of the gaps we found and mixed compliance with the key screening requirements by VA facilities, we believe effective oversight could reduce the potential risks to the safety of veterans receiving health care in VA facilities.

Recommendations for Executive Action

To better ensure the safety of veterans receiving health care at VA facilities, we recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following four actions:

- expand the verification requirement that facility officials contact state licensing boards and national certifying organizations to include all state licenses and national certificates held by applicants and employed practitioners,
- expand the query of the Healthcare Integrity and Protection Data Bank to include all licensed practitioners that VA intends to hire and periodically query this database for continued employment,
- require fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct patient care access, and
- conduct oversight to help ensure that facilities comply with all key screening requirements for applicants and current employees.

Agency Comments

In commenting on a draft of this report, VA generally agreed with our findings and conclusions. VA acknowledged that we identified gaps in its process for conducting background and credentialing checks and that we provided what appeared to be reasonable recommendations to close those gaps. VA stated that it would provide a detailed action plan to implement our recommendations when the final report was issued.

VA said that our draft report inaccurately omitted VA's querying HIPDB for practitioners who practice independently. We revised our report to clarify that NPDB queries performed by VA automatically check HIPDB for these practitioners because the databases are linked. However, VA does not perform queries of HIPDB for the majority of its licensed practitioners, which includes nurses, pharmacists, physical therapists, and dental hygienists. VA also incorrectly stated that the draft report did not include VA's requirement to query FSMB for physicians. In addition, VA said that it planned to implement fingerprint-only checks for all contract health care practitioners, medical residents, medical consultants, and practitioners that work without direct compensation from VA, as well as certain volunteers. However, VA has not issued guidance to its facilities instructing them to implement fingerprint-only checks for all these practitioners. Further, VA stated that the title of the report implied that veterans are receiving inadequate care on a broad basis. We disagree. The title reflects vulnerabilities created by the gaps in the screening of practitioners that could place veterans at risk by allowing incompetent practitioners or those with the intent to harm patients into VA's health care system. VA provided technical comments which we incorporated, as appropriate. VA's written comments are reprinted in appendix III.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. We will then send copies of this report to the Secretary of Veterans Affairs and other interested parties. We also will make copies available to others upon request. In addition, the report will be available at no charge at the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please call me at (202) 512-7101. Another contact and key contributors are listed in appendix IV.

Sincerely yours,

Cynthia A. Bascetta
Director, Health Care—Veterans'
Health and Benefits Issues

Appendix I: Scope and Methodology

We examined VA's policies and practices that are intended to ensure that health care practitioners at its facilities have appropriate credentials and backgrounds to provide care to veterans. Specifically, we (1) identified key VA screening requirements for its health care practitioners, (2) determined the adequacy of these screening requirements, and (3) assessed the extent to which selected VA facilities complied with these screening requirements.

To identify key VA screening requirements for its health care practitioners, we reviewed VA's policies and *VA Handbook 5005*, which explains how to implement the screening policies. We limited our review to 43 occupations in VA that have direct patient care access or have an impact on patient care. See table 3 for a list of the occupations included in our review. To identify the 43 occupations, we consulted with VA human resource officials. We interviewed human resource officials at VA headquarters and at each facility we visited. We classified the practitioners who are required to have professional credentials—a state license or a national certificate—into three groups according to VA's requirements for verifying these credentials. Groups A and B represent practitioners who must be licensed to work in VA. However, the requirements and process VA uses to verify professional credentials is different for each of these groups. Group C represents practitioners who must have a national certificate to work in VA and may also have a state license. Practitioners not included in the three groups are not required to have either a license or a national certificate to work in VA facilities.

Table 3: State Licensure and National Certification Requirements for the 43 VA Occupations

Occupation code	Occupation title	Occupations that require a state license to work in VA	Occupations that require a national certificate to work in VA	Occupations that do not require a state license or a national certificate to work in VA
101	Social Science			X
102	Social Science Aid and Technician			X
180	Psychology	X		
181	Psychology Aid and Technician			X
185	Social Work	X		
186	Social Services Aid and Assistant			X
187	Social Services			X
189	Recreation Aid and Assistant			X
413	Physiology			X
601	General Health Science			X
602	Medical Officer (Physician)	X		
603	Physician's Assistant		X	
605	Nurse Anesthetist	X	X	
610	Registered Nurse[a]	X		
620	Practical Nurse	X		
621	Nursing Assistant			X
622	Medical Supply Aide/Technician			X
630	Dietitian and Nutritionist		X	
631	Occupational Therapist		X	
633	Physical Therapist	X		
635	Corrective Therapist			X
636	Rehabilitation Therapy Assistant			X
638	Recreation/Creative Arts Therapist			X
640	Health Aid and Technician			X
644	Medical Technologist			X
645	Medical Technician			X
646	Pathology Technician			X
647	Diagnostic Radiologic Technologist		X	
648	Therapeutic Radiologic Technologist		X	
649	Medical Instrument Technician			X
651	Respiratory Therapist[b]		X	
660	Pharmacist	X		

Occupation code	Occupation title	Occupations that require a state license to work in VA	Occupations that require a national certificate to work in VA	Occupations that do not require a state license or a national certificate to work in VA
661	Pharmacy Technician			X
662	Optometrist	X		
665	Speech Pathology and Audiology			X
667	Orthotist and Prosthetist			X
668	Podiatrist	X		
672	Prosthetic Representative			X
680	Dental Officer (Dentist)	X		
681	Dental Assistant		X	
682	Dental Hygiene	X		
1320	Chemistry			X
1715	Vocational Rehabilitation			X

Source: *VA Handbook 5005*, April 15, 2002.

[a]Registered Nurse—includes nurse practitioners and clinical nurse specialists.

To determine the adequacy of the key VA screening requirements, we analyzed VA's policies and procedures to identify whether there were inconsistencies in how the requirements were applied among various types of practitioners. We interviewed VA headquarters and facility officials and practitioners at the facilities we visited to determine how VA's policies are implemented in facilities. In addition, we interviewed representatives from 13 state licensing boards and the District of Columbia Board of Nursing and 2 national certifying organizations to determine if VA's requirements for verifying professional credentials are adequate for identifying practitioners without valid and unrestricted state licenses and national certificates.[1]

To assess the extent to which VA facilities we visited complied with the key screening requirements, we chose a judgmental sample of four VA facilities that varied in size, location, and medical school affiliations to assess the extent to which these selected facilities complied with these

[1]The licensing boards contacted were Alabama, Arkansas, California, Delaware, District of Columbia, Florida, Indiana, Louisiana, Massachusetts, New Jersey, New Mexico, Oregon, Texas, and Washington. The national certifying organizations contacted were the National Board for Respiratory Care and the National Board for Certification in Occupational Therapy.

requirements. The four facilities are located in Big Spring, Texas; New Orleans, Louisiana; Seattle, Washington; and the District of Columbia. We chose these facilities based on geographic variation, affiliations with medical schools to train residents, and types of health care services provided. Of the four facilities we visited, three are large facilities located in major metropolitan areas and each are affiliated with at least one medical school. The remaining facility is small, providing mainly primary care and long-term care services to veterans and is located in a rural area. For each facility, VA provided, from its automated pay system, a list of current practitioners in the 43 occupations. As a result of using VA's automated pay system, our sample does not include those practitioners providing care through a contract or training agreement or without direct compensation from VA. For each of the four facilities, we selected a random sample of 100 practitioners either hired or assigned to their current position no earlier than January 1, 1993. We chose to limit our review to approximately the last 10 years because VA changed its process for credentials verification in the early 1990s. For each of these practitioners, we reviewed their personnel files to check that the facility had complied with the following key VA screening requirements:

- verify state licenses and national certificates for applicants;
- verify state licenses and national certificates for employed practitioners;
- query the List of Excluded Individuals and Entities (LEIE) prior to hire;
- ensure completion of background investigations, including fingerprints;
- ensure completion of the Declaration for Federal Employment form, also known as form 306; and
- verify that the educational institutions listed by a practitioner VA intends to hire are checked against lists of diploma mills.

In order to show the variability in the level of compliance among the four VA facilities we visited, we distinguished between facilities that had a compliance rate of at least 90 percent for each of five of the six screening requirements and those that did not. For each facility and key screening requirement, we compared the percentage of personnel files found in compliance to an acceptance level of 90 percent. In order to confirm that a requirement had a compliance rate less than 90 percent, we performed a one-sided significance test at the 95 percent confidence level. See appendix II for detailed information on the four VA facilities' compliance with each of the key VA screening requirements. Our results from these four facilities cannot be generalized to other facilities. In order to determine compliance with the key screening requirement to verify that the educational institutions listed by a practitioner are not fraudulent, we

asked facility human resources staff if they performed this screening and asked them to produce their lists of diploma mills.

Additionally, we reviewed VA facilities' response times to 214 background investigation results returned from OPM with questionable issues, from August 1, 2002, to August 23, 2003, at the four locations we visited and six other VA facilities selected based on geographic location. The six additional facilities were located in Boston, Massachusetts; East Orange, New Jersey; Indianapolis, Indiana; Palo Alto, California; Portland, Oregon; and San Diego, California. For these 10 facilities, we asked officials to provide the date they took action on cases returned from OPM, and from VA headquarters we obtained the dates when OPM returned the cases to the facility. We determined the average number of days it took each facility to take action after these cases were returned from OPM with questionable issues. Our results cannot be generalized to other VA facilities. See appendix II for detailed information on the results of our analysis.

Appendix II: Results of Our Compliance Reviews at VA Facilities

Tables 4 and 5 show the sample counts used to measure compliance and the results of our review for five of the requirements. Table 6 shows the average number of days it took each facility to take action after cases with questionable issues were returned from OPM.

Table 4: VA Facility Compliance with Key Screening Requirements—Professional Credentials Verification

	Credentials of applicants verified		Credentials of employed practitioners verified	
Facility	Number in sample	Number where verification followed VA policy	Number in sample	Number where verification followed VA policy
Facility A	81	61	74	74
Facility B	77	71	59	59
Facility C	74	43	67	67
Facility D	62	47	56	55

Source: GAO analysis of facility files.

Note: The number of practitioners in the sample may be less than the number of practitioner files reviewed at each facility because the requirement may not apply to all VA applicants or employed practitioners.

Table 5: Facility Compliance with Key Screening Requirements—Personal Background Screening

	List of Excluded Individuals and Entities (LEIE) queried for applicants prior to hiring		Background investigation completed or requested for employed practitioners		Declaration for Federal Employment form (form 306) completed for employed practitioners	
Facility	Number in sample	Number queried prior to hire	Number in sample	Number with a completed or requested background investigation	Number in sample	Number with completed form 306
Facility A	61	53	99[a]	93	94	92
Facility B	72	26	99[b]	27	93	80
Facility C	64	5	100	47	83	77
Facility D	66	39	100	98	92	86

Source: GAO analysis of facility files.

Note: The number of practitioners in the sample may be less than the number of practitioner files reviewed at each facility because the requirement may not apply to all VA applicants or employed practitioners.

[a]One personnel file was not available because the practitioner resigned and the file was sent to storage.

[b]Facility B was unable to locate one personnel file; therefore, we sampled 99 files at that location.

Table 6: Average Number of Days from Obtaining Background Investigation Results to VA Facility Action (August 1, 2002, to August 23, 2003)

Facility	Average number of days for facility action	Number of background investigation results reviewed
Facility A	13	14
Facility B	282	41
Facility C	21	15
Facility D	-14[a]	17
Facility E	26	11
Facility F	34	43
Facility G	68	39
Facility H	126	33
Facility I	380	1
Facility J	No data available	No data available

Source: GAO analysis of facility data.

[a]A negative number of days indicates that the facility took action on its cases before OPM returned the investigation results.

Appendix III: Comments from the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

March 26, 2004

Ms. Cynthia A. Bascetta
Director
Heath Care Team
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed your draft report, ***VA HEALTH CARE: Improved Screening of Practitioners Would Reduce Risk to Veterans*** (GAO-04-566) and generally agrees with your findings and conclusions. As the Department was provided a limited time to review the draft report, VA will provide the General Accounting Office (GAO) with a detailed action plan to implement the recommendations in its comments to the final report.

VA is committed to ensuring that the practitioners who are responsible for delivering quality health care to our Nations veterans and their beneficiaries are qualified to do so both in professional qualifications and personal ethical integrity. To this end, VA has developed a set of policies and procedures to ensure that its practitioners are of the caliber needed for such a high calling. VA recognizes the accuracy in the report's description of VA's policies and requirements for conducting background and credentialing checks. GAO identifies gaps in VA's process and provides what appear to be reasonable recommendations to close those gaps.

However, VA offers some suggestions for the overall accuracy of GAO's message. GAO acknowledges that VA's requirements for verifying professional credentials of practitioners in Group A, such as physicians and dentists, are complete and thorough.

Broad statements throughout the report, including the recommendations, do not differentiate between the fully credentialed licensed independent practitioners (i.e., all physicians, dentists, most optometrists and podiatrists and other credentialed professionals such as psychologists, pharmacists, advanced practice registered nurses and social workers who practice independently by law and facility approval) and the remaining licensed practitioners. For all individuals privileged to provide care without supervision, VA does query the National Practitioner Data Bank and the Health Integrity and Protection Data Bank. In addition, VA queries the Federation of State Medical Boards' Data Center on all

Page 2

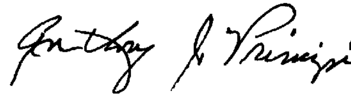
Ms. Cynthia A. Bascetta

physicians. VA believes that a clearer view of VA's credentialing process would be presented if GAO acknowledged these data queries.

In addition, the draft report title strongly implies that veterans are receiving inadequate care on a broad basis. VA suggests the title be revised to "Improved Screening of Practitioners Would Enhance Safety of Veterans."

The enclosure discusses technical corrections VA believes would improve the overall accuracy and clarity of GAO's report. The Department appreciates the opportunity to review and comment on your draft report.

Sincerely yours,



Anthony J. Principi

Enclosure

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Marcia A. Mann, (202) 512-9526

Acknowledgments

In addition to the contact named above, Jacquelyn T. Clinton, Jessica Cobert, Mary Ann Curran, Martha A. Fisher, Krister Friday, Lesia Mandzia, and Marie Stetser made key contributions to this report.

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