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VA HEALTH CARE

Veterans at Risk from Inconsistent Screening of Practitioners

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March 31, 2004

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Highlights

Highlights of GAO-04-625T, a testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VA employs about 190,000 individuals including physicians, nurses, and therapists at its facilities. It supplements these practitioners with contract staff and medical residents. Cases of practitioners causing intentional harm to patients have raised concerns about VA's screening of practitioners' professional credentials and personal backgrounds. This testimony is based on GAO's report *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans*, GAO-04-566 (Mar. 31, 2004). GAO was asked to (1) identify and assess the extent to which selected VA facilities comply with existing key VA screening requirements and (2) determine the adequacy of these requirements for its practitioners.

What GAO Recommends

GAO recommended that VA expand its existing verification process to require that all state licenses and national certificates be verified by contacting state 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 recommended that VA conduct oversight of its facilities to ensure their compliance with all screening requirements. VA generally agreed with the report's findings and plans to develop a detailed action plan to implement GAO's recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-04-625T.

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.

What GAO Found

GAO identified key VA screening requirements that include verifying state licenses and national certificates; completing background investigations, including fingerprinting to check for criminal histories; and checking national databases for reports of practitioners who have been professionally disciplined or excluded from federal health care programs. GAO reviewed 100 practitioners' personnel files at each of four facilities it visited and found mixed compliance with the existing key VA screening requirements. GAO also found that VA has not conducted oversight of its facilities' compliance with the key screening requirements.

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 verified for practitioners VA intends to hire	○	●	○	○
Credentials verified for practitioners currently employed in VA	●	●	●	●
List of Excluded Individuals and Entities queried for practitioners VA intends to hire	●	○	○	○
Background investigation completed or requested for practitioners currently employed in VA	●	○	○	●
Declaration for Federal Employment form completed for practitioners currently employed in VA	●	●	●	●

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.

GAO found adequate screening requirements for certain practitioners, such as physicians and dentists, for whom all licenses are verified by contacting state licensing boards. However, existing screening requirements for others, such as nurses and respiratory therapists currently employed in VA, are less stringent because they do not require verifying all state licenses and national certificates. Moreover, they require only physical inspection of these credentials rather than contacting licensing boards or 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 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 histories. This pattern of gaps and mixed compliance with key VA key screening requirements create vulnerabilities to the extent that VA remains unaware of practitioners who could place patients at risk.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the findings and recommendations in our report, which you are releasing today, on the Department of Veterans Affairs (VA) policies and practices for screening health care practitioners.[1] 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. VA has screening requirements intended to help ensure that its health care practitioners' professional credentials are verified and their personal backgrounds are checked for evidence of incompetence or criminal behavior.

While such requirements cannot guarantee safety in health care settings, they are intended to minimize the chance of patients receiving care from someone who is incompetent or who may intentionally harm them. According to medical forensic experts, however, the deliberate harm of patients by health care practitioners is a problem in the health care sector in general. The well-publicized case of Dr. Michael Swango, who pleaded guilty to murdering three veterans while a medical resident training at the VA facility in Northport, New York, and was sentenced to three consecutive life terms without the possibility of parole, illustrates the potentially disastrous effect of inadequate screening of health care practitioners.

You asked us to 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 safe care to veterans. Specifically, we (1) identified key VA screening requirements and assessed the extent to which selected VA facilities complied with these screening requirements for its health care practitioners and (2) determined the adequacy of the key VA screening requirements for health care practitioners.

To do our work, we selected 43 occupations in which practitioners have direct patient care access or have an impact on patient care and identified

[1]U.S. General Accounting Office, *VA Health Care: Improved Screening of Practitioners Would Reduce Risk to Veterans*, GAO-04-566 (Washington, D.C.: Mar. 31, 2004).

the key screening requirements that applied to these occupations.[2] To identify the key screening requirements, we reviewed VA employment screening policies and interviewed VA headquarters and facility officials and practitioners. To assess the extent to which VA facilities complied with the key screening requirements, we visited four VA facilities and reviewed a statistically random sample of about 100 practitioners' personnel files at each site. We selected facilities to visit based on geographic variation, affiliations with medical schools to train residents, and types of health care services provided. Additionally, we obtained documentation on how quickly facilities took action after obtaining the results of background investigations. Our results cannot be generalized to other facilities. To determine the adequacy of the key screening requirements, we examined whether these screening requirements were complete, and whether VA applied them to all practitioners it intended to hire, practitioners currently employed in VA, contract health care staff, medical residents, and volunteers. We also interviewed 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 did our work from August 2003 through March 2004 in accordance with generally accepted government auditing standards.

In summary, we identified key VA screening requirements and found mixed compliance with these requirements in the four facilities we visited. The key screening requirements are those that are intended to ensure that VA facilities employ health care practitioners who have valid professional credentials and personal backgrounds to safely deliver health care to veterans. While we found that all facilities generally checked, on a periodic basis, the professional credentials of practitioners currently employed in VA, they did not verify all of the credentials of all of the practitioners 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 non-VA employer for patient abuse. Although VA established an

[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.

office more than a year ago to perform oversight of human resources functions, including whether its facilities comply with these key screening requirements, that office has not conducted any compliance reviews at facilities. Furthermore, VA has not implemented a policy for the human resources program evaluation to be performed by this office and has not provided funds to support this office. This pattern of mixed compliance creates vulnerabilities to the extent that VA remains unaware of practitioners it employs who could place patients at risk.

We also found gaps in the key VA screening requirements that VA officials used to verify the professional credentials and personal backgrounds of health care practitioners. We found adequate screening requirements for certain practitioners, such as physicians and dentists, for whom facilities are required to verify all licenses by contacting state licensing boards. However, existing screening requirements for others, such as nurses currently employed in VA, are less stringent because they do not require that facilities verify all state licenses that a nurse may hold—only one must be checked—and they require only physical inspection of the license rather than contacting the state licensing board to verify the status of the license. VA also 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 practitioners VA intends to hire and periodically for those employed in VA. Physical inspection alone can be misleading; not all professional credentials indicate whether they have had disciplinary actions taken against them, and credentials can be forged. VA also does not require facility officials to query a national database, for other than physicians and dentists, that contains reports of professional 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 histories.

To better ensure the safety of veterans receiving health care at VA facilities, in our report we recommend that VA conduct more thorough screening of practitioners VA intends to hire and practitioners currently employed in VA by expanding its verification requirement that facility officials contact state licensing boards and national certifying organizations for all state licenses and national certificates; expanding the query of a national database to include all licensed practitioners that VA intends to hire and periodically for practitioners currently employed in VA; and requiring fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct

patient care access. Furthermore, we recommend that VA conduct oversight to help ensure that facilities comply with all screening requirements. In commenting on a draft of our report, VA generally agreed with our findings and conclusions and stated that it will develop a detailed action plan to implement our recommendations.

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 licensing requirements, and licensed practitioners may be licensed in more than one state.[3] "Current and unrestricted licenses" are licenses that are in good standing in the state where they are issued. To keep a license current, practitioners must renew their licenses before they expire and meet renewal requirements established by state licensing boards. Renewal requirements include criteria, such as continuing education, but renewal procedures and requirements vary by state and occupation. When a licensing board discovers a licensee is in violation of licensing requirements or established law, for example, abusing prescription drugs or intentionally or negligently providing poor quality care that results in adverse health effects, it may place restrictions on or revoke a license. Restrictions imposed by a state licensing board can limit or prohibit a practitioner from practicing in that particular state. Some, but not all, state licenses are marked to indicate that the licenses have had restrictions placed on them. Generally, state licensing boards maintain a database of information on restrictions, which employers can 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

[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 national certificates and state licenses.

organizations establish professional standards that are national in scope for certain occupations, such as respiratory and occupational therapists. Practitioners who are required to have national certificates to work at VA must have current and unrestricted certificates. Practitioners may renew these credentials periodically by paying a fee and verifying that they obtained required educational credit hours. A national certifying organization can restrict or revoke a certificate for violations of the organization's professional standards. Like state licensing boards, national certifying organizations maintain databases of information on disciplinary actions taken against practitioners with national certificates, and many can be accessed at no cost.

VA Facilities Demonstrated Mixed Compliance with Key VA Screening Requirements

We identified key VA screening requirements and found mixed compliance with these requirements in the four facilities we visited. The key screening requirements are those that are intended to ensure that VA facilities employ health care practitioners who 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 screening requirements. In addition, VA does not currently conduct oversight of its facilities to determine if they comply with the key screening requirements.

Key VA screening requirements include:

- verifying the professional credentials of practitioners VA intends to hire;
- verifying periodically the professional credentials of practitioners currently employed in VA facilities;
- querying, prior to hiring, the Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals and Entities (LEIE) to identify practitioners who have been excluded from participation in all federal health care programs;[5]
- ensuring that background investigations are requested or completed for practitioners currently employed in VA facilities;
- ensuring that the Declaration for Federal Employment form (Form 306) is completed by practitioners currently employed in VA facilities; and

[5]LEIE, a database maintained by the Department of Health and Human Services' Office of Inspector General, provides information to the public, health care providers, patients, and others relating to parties excluded from participation in Medicare, Medicaid, and all federal health care programs.

- verifying that the educational institutions listed by a practitioner VA intends to hire are checked against lists of diploma mills that sell fictitious college degrees and other fraudulent professional credentials.

To show the variability in the level of compliance among the four VA facilities we visited, we measured their performance in five of the six screening requirements, against a compliance rate of at least 90 percent for each requirement, even though VA policy allows no deviation from these requirements. Table 1 summarizes the compliance results we found for the five requirements among the four VA facilities we visited. For the sixth requirement to match 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 1: 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 verified for practitioners VA intends to hire	○	●	○	○
Credentials verified for practitioners currently employed in VA	●	●	●	●
LEIE queried for practitioners VA intends to hire	●	○	○	○
Background investigation requested or completed for practitioners currently employed in VA	●	○	○	●
Declaration for Federal Employment form completed for practitioners currently employed in VA	●	●	●	●

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 practitioners currently employed in VA facilities, either by contacting the state licensing boards for

practitioners such as physicians or physically inspecting the licenses or national certificates for practitioners such as nurses and respiratory therapists. They also generally ensured that practitioners VA intended to hire had completed the Declaration for Federal Employment form, which requires the practitioner to disclose, among others things, criminal convictions, employment terminations, and delinquencies on federal loans. However, three of the facilities did not follow VA's policies for verifying the professional credentials of practitioners VA intends to hire, and three did not compare practitioners' names to LEIE prior to hiring them. Two of the four facilities conducted background investigations on practitioners currently employed in their facilities 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 a practitioner VA intended to hire against a list of diploma mills to verify that the practitioner's degree was not obtained from a fraudulent institution. An official at one of the four facilities told us he consistently performed this check. Officials at the other three facilities stated that they did not perform the check because they did not have lists 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. The Office of Personnel Management (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, through August 23, 2003, at the 4 facilities we visited and 6 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.

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 in a clerk's office on a cart and in piles on the desk and on other workspaces. After we brought this case to the attention of facility officials in December 2003, they reviewed the report and then terminated the nursing assistant, who had worked at the VA facility for more than 1 year, for not disclosing this information on the Declaration for Federal Employment form.

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. In addition, VA has not implemented a policy for the human resources program evaluation to be performed by this office and has not provided the resources necessary to support this office.

Gaps in Key VA Screening Requirements Create Vulnerabilities

Gaps in VA's requirements for screening the professional credentials and personal backgrounds of practitioners create vulnerabilities in its screening processes that could place patients at risk by allowing health care practitioners who might harm patients to work in VA facilities. For certain VA practitioners, screening requirements include the verification of all state licenses by contacting the state licensing boards to verify that licenses are current and unrestricted. For example, all state licenses for physicians and dentists are verified by contacting state licensing boards to ensure the licenses are in good standing when VA intends to hire them and periodically during employment. Similarly, all licenses for nurses and pharmacists VA intends to hire are verified by contacting the state licensing boards. However, once hired, periodic screening for nurses and pharmacists simply involves a VA official's physical inspection of one state license, even if the practitioner has multiple state licenses, creating a gap in the verification process.

VA's requirements allow a practitioner to select the license under which he or she will work in VA, and this license can be from any state, not necessarily the one in which the VA facility is located. A practitioner may have a restricted state license as a result of a disciplinary action, yet show a facility official a license from another state that is unrestricted. VA facility officials informed us that checking one state license was sufficient because state licensing boards share information on disciplinary actions

and licenses are marked when restricted. However, according to state licensing board officials, one cannot determine with certainty that a license is valid and unrestricted unless the licensing board is contacted directly. These officials explained that state licensing boards do not always exchange information about disciplinary actions taken against a practitioners and not all states mark licenses that are restricted. Moreover, licenses can be forged, even though state licensing boards have taken steps to minimize this problem. Therefore, physical inspection of a license alone can be misleading.

To supplement the screening of the state licenses of physicians and dentists, VA requires facilities to query two national databases—the National Practitioner Data Bank (NPDB) and the Federation of State Medical Boards (FSMB) database—which contain information about disciplinary actions taken against practitioners. Another available national database, the Healthcare Integrity and Protection Data Bank (HIPDB), contains information on professional disciplinary actions and criminal convictions involving all licensed health care practitioners, not just physicians and dentists. VA is currently accessing HIPDB automatically when it queries NPDB for physicians and dentists because the databases share information. However, VA does not require its facilities to do so for all licensed practitioners even though it is authorized to query HIPDB without a fee.

VA also requires that practitioners it intends to hire and who must have national certificates to work in VA facilities, such as respiratory therapists, disclose the national certificates and any state licenses they have ever held. However, VA facility officials are not required to check state licenses disclosed by these practitioners and are only required to physically inspect the national certificates. As with physical inspection of state licenses, physical inspection of national certificates alone can be misleading; not all certificates are marked if restricted, and they can be forged. The only way to know with certainty if a national certificate is current and unrestricted is to contact the issuing national certifying organization.

In addition to gaps in VA's verification of professional credentials, VA has not implemented consistent background screening requirements, which would include fingerprint checks, for all practitioners. Although VA requires background investigations for some practitioners currently employed in VA, it does not require these investigations for all types of practitioners. VA requested and received OPM's permission to exempt certain categories of health care practitioners from background investigations based on VA's assessment that these types of practitioners

do not need to be investigated. Table 2 lists the practitioners that VA exempts from background investigations.

Table 2: Types of Practitioners VA Exempts from Background Investigations

Types of practitioners VA exempts	Length of appointment
Contract health care practitioners or practitioners who 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).

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 check results can be obtained within 3 weeks at a cost of less than $25.[6] In commenting on a draft of our report, VA said that it planned to implement fingerprint-only checks for all contract health care practitioners, medical residents, medical consultants, and practitioners who 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.

Implementing fingerprint-only checks for practitioners who are currently exempt from background investigations would detect practitioners with criminal histories. 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

[6]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.

facility and contract health care practitioners. An official at this facility stated that fingerprint-only checks of medical residents and contract practitioners were a necessary component of ensuring the safety of veterans in the facility. FSMB in 1996 recommended that states perform background investigations, including criminal history checks, on medical residents to better protect patients because residents have varying levels of unsupervised patient care.

Concluding Observations

VA's screening requirements are intended to ensure the safety of veterans by identifying practitioners with restricted or fraudulent credentials, criminal backgrounds, or questionable work histories. However, 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 carry out its oversight function. 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.

Even if VA facilities had complied with all key screening requirements, 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. Similarly, while VA relies on two national databases to identify physicians and dentists who have disciplinary actions taken against them, VA does not require facility officials to query HIPDB. This national database provides information on reports of professional disciplinary actions and criminal convictions that may involve currently employed licensed practitioners and those VA intends to hire. As part of its query of another database, VA accesses HIPDB automatically for physicians and dentists, but practitioners such as nurses, pharmacists, and physical therapists do not have their state licenses checked against this 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 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.

In our report, we recommend that VA 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 practitioners VA intends to hire and currently 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 practitioners currently employed in VA,
- 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 practitioners VA intends to hire and practitioners currently employed by VA.

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

Contact and Acknowledgments

For further information regarding this testimony, please contact Cynthia A. Bascetta at (202) 512-7101. Mary Ann Curran and Marcia Mann also contributed to this statement.

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