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VA'S CURRENT PROCEDURES FOR BACKGROUND CHECKS AND CREDENTIALING

HEARING

BEFORE THE

SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

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VA'S CURRENT PROCEDURES FOR BACKGROUND CHECKS AND CREDENTIALING

WEDNESDAY, MARCH 31, 2004

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

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 334, Cannon House Office Building, Hon. Steve Buyer (chairman of the subcommittee) presiding.

Present: Representatives Buyer, Hooley, Evans, Boozman, and Udall.

OPENING STATEMENT OF CHAIRMAN BUYER

Mr. BUYER. The Subcommittee on Oversight and Investigations of the Committee on Veterans' Affairs will come to order. Today is March 31, 2004.

Good morning to everyone. The purpose of today's hearing is to review the Department of Veterans Affairs' current employment practices with regard to its procedures for personal background checks and credentialing of its health care practitioners.

In the past, the oversight subcommittee has touched upon this subject in several hearings. However, because there have been repeated serious lapses in the system over the years, we believe this issue warrants further scrutiny by this hearing today. In fact, there are several high profile cases which illustrate why it's so important to ensure that the VA has an effective policy in place.

One of the most compelling examples is the 1993 case of Dr. Michael Joseph Swango. In 1993, even though this doctor had a criminal record, he was able to secure a medical residency at a VA facility in Northport, NY. This doctor is currently in prison serving three consecutive life sentences for murdering three veterans at the Northport facility. The question is, at the present time could someone such as this doctor avoid detection and be successful in gaining employment with the VA today under credentialing procedures?

I believe we all recognize that such lapses do not happen solely in the VA. But it is my role and this subcommittee's in providing the oversight of the Department of Veterans Affairs to examine these issues that affect the safety of veterans, and that's the focus of this subcommittee.

Let's look at what the VA's Office of Inspector General was able to detect through its fugitive felon program that was initiated in 2001. Using the VA benefit system files, the IG was able to identify 9,700 matches for referrals to law enforcement agencies. In addi-

tion, over 6,500 fugitive felons identified in these matches have been referred to the Department for benefit suspension. Due to these identifications, 35 VA employees were arrested. Twenty-nine other employees were identified as fugitive felons but were not arrested because they were non-extraditable. They have been referred to the Veterans Health Administration for possible administrative action.

If any of us here today find ourselves in a position of having to seek medical care, we deserve to be treated by health care practitioners who have completed the necessary educational requirements, have passed their boards, and are licensed to practice medicine. Veterans deserve to have the very same level of confidence when they enter a VA medical facility.

Today's hearing will show that the VA has been working diligently to improve its credentialing and background checks of applicants seeking employment with the VA. However, there are several issues that need some clarification.

One such issue involves the VA's credentialing program, called VetPro. For instance, I wonder if VetPro is working as envisioned. I also wonder why the Federal Credentialing Program initiated by the VA and HHS, under whose auspices VetPro was developed and maintained, was dismantled last fall. While representatives of the VA have stated publicly that VetPro is an excellent tool for verifying credentials, I also wonder why the GAO was silent on VetPro in its report. I find it perplexing that such an omission would be made since this is one of the chief mechanisms used by the VA to verify credentials of physicians and dentists. Hopefully both the VA and HHS will shed some light on this.

The VA has several key screening requirements in place for verification of credentials and to investigate personal backgrounds of health care practitioners. These checks include the query of the Federation of State Medical Boards (FSMB), the National Practitioner Data Bank (NPDB), the List of Excluded Individuals and Entities (LEIE), and, on a limited basis require fingerprinting and background check which is performed by the Office of Personnel Management.

Today's witnesses are the Department of Veterans Affairs, the Department of Health and Human Services, and the General Accounting Office. When I spoke with the American Medical Association yesterday, I was assured by the AMA that they will have a representative here in the room. They will listen to this hearing, and I've asked them to provide a written statement with regard to their impressions of this hearing, and if they can get that statement to me within 10 days, we'll make it an official part of this record. It's hard to do a hearing I believe on credentialing and not hear from the perspective of doctors, in particular the AMA. I believe it will be very beneficial to this subcommittee.

And at this point, I will yield to the ranking member for comments that she may have.

OPENING STATEMENT OF HON. DARLENE HOOLEY

Ms. HOOLEY. Thank you, Mr. Chair, and I really appreciate you bringing up the AMA. I think that's important, and I'm glad you've done that.

For the VA to provide adequate health care for veterans, a number of things must come together. There must be an adequate budget to support an infrastructure, including state of the art equipment and practices. Additionally, VA employees must be dedicated to their jobs so as to maximize the care veterans receive. In overwhelming numbers, this is the case today.

When vacancies are filled at the VA, they are usually filled with clinicians and staff with the same high levels of dedication and interest. These newcomers are dedicated to providing excellent care for our veterans. It would nice if we could accept every applicant at their word, to accept the credentials they present at face value. But America's duty to veterans requires a higher standard and greater rigor in evaluating potential VA health care employees. Most who apply do so with the hope of finding employment in a clinical setting where they can put their training to its intended use.

History tells us that very few will apply with intent to do harm to those in their charge, but even one would be too many. Agencies with health care oversight sometimes chronicle and substantiate instances of abuse, malpractice and neglect in a broad spectrum of health care agencies across America. Every so often we read a story about a nurse's aide intentionally administering a fatal dose of medication or an intentional abuse of a patient.

The VA is not immune from those problems. Even with the best screening, problems of this type may sometimes occur. This is a key reason why effective and continuing oversight is so important. Once individuals are accepted into the VA system to provide patient care, continuous monitoring of performance and behavior is important. One sound remedy involves fostering a culture that is proactive in its self-policing actions in the current system.

We can, however, also minimize and eliminate known problems through effective screening during the hiring process. The GAO recently reported on gaps discovered in their review of the VA screening process for clinicians and others with direct patient access. These gaps deserve our full attention.

In addition to hearing comments on the screening process, I would like to expand the scope of this hearing and inquire about the screening process for all individuals with access to clinical or research laboratories, especially Level 3 labs where select biological, chemical and radiological agents are used or stored. Both the GAO and IG have reported problems regarding screening for laboratory personnel in the past. I'm interested to hear about the VA's progress in making those environments more secure.

And I yield back to my chair.

Mr. BUYER. Oh, I'm sorry. Thank you for joining us. I should have looked to the right. Do you have any opening comment you'd like to make? Thank you, Mr. Udall.

OPENING STATEMENT OF HON. TOM UDALL

Mr. UDALL. Thank you, Mr. Chairman, very much. And I appreciate you, Mr. Chairman, and Ranking Member Hooley for putting this hearing together.

I think most of us understand the seriousness of this issue when we look at the most well known cases of VA health care providers

with criminal records or fake credentials that have somehow slipped into the system. One of these cases involved a Dr. Michael Joseph Swango. Despite the fact that Dr. Michael Joseph Swango had a criminal record, he was able to secure a medical residency at the VA facility in Northport, NY. Dr. Swango is currently in prison serving three consecutive life sentences for murdering three veterans at the Northport facility during 1993 to 1995.

This is one of the more notorious examples, but it is not the only instance. Never should our veterans be subject to such despicable behavior. I hope that this hearing, Mr. Chairman, is a step in the direction of making sure that something like this never happens again.

In reading over the testimony we'll hear today, I am disturbed by what seems to be a very avoidable problem. Not only will we hear about gaps in the VA's current screening requirements, but also a lack of follow-up in some cases on background investigation results. It is incumbent upon us to figure out if this is a matter of VA culture, lack of funds, disorganization, or none of the above.

The VA is no doubt a complex system, but the health of our veterans is at stake.

I thank our witnesses who will be testifying for coming today and look forward to hearing their testimony, and, Mr. Chairman, at this point, yield back. Thank you.

Mr. BUYER. Thank you, Mr. Udall. We have one panel today, and I recognize Ms. Cynthia Grubbs. She's the Director of the Office of Policy and Planning, Bureau of Health Professions, Health Resources and Services Administration, Department of Health and Human Services. I'd ask that you recognize individuals that you've brought with you, please.

Ms. GRUBBS. Thank you, Chairman. I have Mr. Maurice Huguley, Mr. Mark Pincus.

Mr. BUYER. Would you let me know what they also do?

Ms. GRUBBS. Sure. Mr. Maurice Huguley works in the Office of Legislation at HRSA. Mr. Mark Pincus is a Senior Policy Analyst and the Associate Director for Policy at the National Practitioner Data Banks. And Ms. Pat Stroup also is the Director of the Office of Legislation at HRSA.

Mr. BUYER. Thank you. Also recognize Ms. Cynthia Bascetta, Director of the Health Care, Veterans' Health and Benefits Issues, General Accounting Office. And did you bring staff with you? If so, please recognize them.

Ms. BASCETTA. Yes, I did. Behind me is Marcia Mann, the Assistant Director who led this review, and Mary Ann Curran, the analyst in charge of the review.

Mr. BUYER. Thank you. Also recognize Dr. Frances Murphy, Deputy Under Secretary for Health Policy Coordination, Veterans Health Administration, Department of Veterans Affairs. Dr. Murphy, if you could introduce who is also here with you and what they do.

Dr. MURPHY. Accompanying me today are medical center directors from Seattle, Washington, DC, Big Spring, TX, and New Orleans here today. In addition, we have the DAS for Human Resources, Mr. Tom Hogan, his staff member, Ms. Barbara Panther, Bob Swanson from our Office of Management Support, and Kate

Enchelmayer, who is from the Office of Quality and Performance and is in charge of VetPro and credentialing for licensed independent practitioners.

Mr. BUYER. All right. Thank you very much. Let's go ahead, and we're going to open up. And instead of going left to right, we're going to go right to left. Is that all right with you, Dr. Murphy?

Dr. MURPHY. Fine.

Mr. BUYER. All right. Ms. Grubbs, before I yield to you, I want to—by process, I'll ask that witnesses limit their oral testimony to 5 minutes. Your complete written statements will be part of the official record, and I will now yield to Ms. Grubbs for her testimony.

STATEMENTS OF CYNTHIA GRUBBS, DIRECTOR, OFFICE OF POLICY AND PLANNING, BUREAU OF HEALTH PROFESSIONS, HEALTH RESOURCES AND SERVICES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY: MARK PINCUS, ACTING ASSOCIATE DIRECTOR OF POLICY, DIVISION OF PRACTITIONER DATA BANKS, BUREAU OF HEALTH PROFESSIONS; PAT STROUP, DIRECTOR, OFFICE OF LEGISLATION; MAURY HUGULEY, LEGISLATIVE COORDINATOR, OFFICE OF LEGISLATION; AND ROGER McCLUNG, OFFICE OF ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES; FRANCES M. MURPHY, M.D., DEPUTY UNDER SECRETARY FOR HEALTH FOR HEALTH POLICY COORDINATION, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY: THOMAS J. HOGAN, DEPUTY ASSISTANT SECRETARY FOR HUMAN RESOURCES MANAGEMENT; KATHRYN W. ENCHELMAYER, DIRECTOR, CREDENTIALING AND PRIVILEGING; BARBARA PANTHER, DIRECTOR, RECRUITMENT AND PLACEMENT POLICY, OFFICE OF HUMAN RESOURCES MANAGEMENT; ROBERT W. SWANSON, MANAGEMENT ANALYST, OFFICE OF MANAGEMENT SUPPORT; PAUL S. ROSENFELD, M.D., CHIEF OF STAFF, VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, NEW ORLEANS, LA; SANFORD M. GARFUNKEL, DIRECTOR, WASHINGTON VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, DISTRICT OF COLUMBIA; WILLIAM E. COX, ACTING DIRECTOR, VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, BIG SPRING, TX; AND TIMOTHY B. WILLIAMS, DIRECTOR, VA PUGET SOUND HEALTH CARE SYSTEM, VETERANS HEALTH ADMINISTRATION, SEATTLE, WA; CYNTHA A. BASCETTA, DIRECTOR, HEALTH CARE—VETERANS' HEALTH AND BENEFITS ISSUES, U.S. GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY: MARCIA MANN, ASSISTANT DIRECTOR; AND MARY ANN CURRAN, SENIOR ANALYST

STATEMENT OF CYNTHIA GRUBBS

Ms. GRUBBS. Thank you, and good morning. I'm here to speak with you today on the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and the Federal Credentialing Program.

The National Practitioner Data Bank (NPDB) was created in response to the requirements of the Health Care Quality Improvement Act of 1986 and plays a vital role in the process of health care

practitioner credentialing. Authorized users of the NPDB include state licensing boards, hospitals, managed care organizations, other health care entities and professional societies.

Hospitals are required to submit queries regarding staff practitioners every 2 years and/or each time they higher, affiliate, or grant privileges to a practitioner. The NPDB receives adverse information on licensure, clinical privileges and professional society actions taken against physicians and dentists. The NPDB also receives information on medical malpractice payments, Drug Enforcement Administration actions and Medicare/Medicaid exclusions taken against physicians, dentists, nurses and other health care practitioners.

NPDB data is intended to supplement a comprehensive and careful professional peer review. The data bank is used by entities to verify information the practitioner submits in his or her application for privileges, licensure or affiliation.

The NPDB is not funded by taxpayer dollars but entirely by user fees. It has successfully covered its costs for nearly 14 years. The current $4.25 query fee is substantially lower than fees charged for databases of similar though much less complete information. The NPDB is able to provide information within hours to requesters using the latest technology.

The Healthcare Integrity and Protection Data Bank, or HIPDB, commenced operations in late 1999. The purpose of the HIPDB is to combat fraud and abuse in health insurance and health care delivery, and to promote quality care. Like the NPDB, HIPDB information is intended to be used in combination with other sources.

Health plans and federal and state agencies are required to report adverse actions taken against health care providers, suppliers and practitioners. The HIPDB collects health care-related criminal convictions and civil judgments, federal or state licensing and certification actions, exclusions from participation in federal or state health care programs, and other adjudicated actions, including contract terminations taken by health plans. These same organizations, federal and state agencies and health plans, have access to the HIPDB information.

The HIPDB operations are funded through user fees also that are charged to health plans and state agencies. These fees have not generated sufficient revenue to fully fund its operations. Therefore, it has received supplemental funding from the Health Care Fraud and Abuse Control Act.

In terms of the use of the data banks by the Department of Veterans Affairs, the VA facilities use both the NPDB and the HIPDB. VA facilities submitted 31,750 queries and 119 reports to the NPDB in 2003. In 2003, the VA submitted 30,836 queries and one report to the HIPDB. VA facilities query the HIPDB for free.

The Federal Credentialing Program was developed to replace the paper-based credentialing processes with electronic storage techniques for easier retrieval of credentials and faster communication of credentialing information.

In 1997, the Veterans Health Administration and the Health Resources and Service Administration signed an interagency agreement establishing a formal partnership to develop this electronic, web-based credentialing data base. The resulting software applica-

tion, VetPro, allows providers to enter credentialing information, and a credentialer, through primary source verification, authenticates the data. The system shares an interface with the NPDB and HIPDB to allow for seamless querying of the databanks.

By 2001, the FCP was used by all 172 VA facilities. By 2003, the U.S. Public Health Service Office of Emergency Preparedness, Immigration and Naturalization Service, National Aeronautics and Space Administration and the National Health Service Corps had entered into 1-year interagency agreements to participate in the FCP.

However, by 2003, the landscape of the federal government had changed. The Office of Emergency Preparedness and the Immigration and Naturalization Services were transferred to the U.S. Department of Homeland Security. The Division of Commissioned Personnel's internal business process changed, which eliminated their need of the FCP. Therefore, in October of 2003, HRSA transferred responsibility for the management of all FCP-related activities, including the VetPro software, to the VA, where we understand the system continues to operate effectively.

Thank you for this opportunity to inform you about the National Practitioner Data Bank, the Health Care Integrity and Protection Data Bank, and the FCP.

[The prepared statement of Ms. Grubbs appears on p. 45.]

Mr. BUYER. Thank you, Ms. Grubbs. Dr. Murphy.

STATEMENT OF FRANCES M. MURPHY

Dr. MURPHY. Mr. Chairman and members of the subcommittee, I'm pleased to be here today to discuss VA's procedures for background checks and credentialing of its health care providers. We take very seriously our responsibility to ensure that these individuals are properly qualified and trained to provide care for our Nation's veterans.

Therefore, we appreciated the opportunity to review the recent draft GAO report which has just been published on the improved screening of practitioners. I have submitted a full statement that responds to many of the GAO preliminary findings that we reviewed.

At this time I'd like to briefly discuss some of the important points made in that statement. Credentialing is a systematic process of screening and evaluating qualifications and other credentials, including competence and health status. It must be completed prior to a practitioner's initial medical staff appointments and must be brought up to date before reappointment, which occurs at a minimum of every 2 years.

Since 1990, VA has performed primary source verification on physicians and dentists. In 1997, full primary source verified credentialing was expanded to all licensed independent practitioners.

In March of 2001, VA launched VetPro, its web-based credentialing data bank. VetPro ensures the consistency of the credentialing process for independent practitioners across VA's health care system. Through VetPro, VA is able to maintain a valid, reliable electronic databank of over 39,000 health care providers' credentials that are accurate and easily accessible.

By April of 2004, VA will require that all physicians assistants and advance practice registered nurses are also credentialed through VetPro. We are pleased that the GAO found that our reviews of the credentials of licensed independent practitioners was complete and thorough. Similarly, the Joint Commission on Accreditation of Healthcare Organizations has stated that VetPro represents a state-of-the-art system for consistent, high quality, safe and effective credentialing.

VA has learned important lessons from this success and will use this best practice to improve its other credentialing and suitability programs.

Two nationwide flagging systems under the auspices of the Department of Health and Human Services are available to VA for query as supplements to the other information obtained during the credentialing process. One is the National Practitioner Data Bank or the NPDB. As previously discussed, this databank permits discreet inquiry into specific areas of practitioners' licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges.

VA requires that all practitioners who are privileged and are practicing independently be queried against the NPDB before privileges are granted, changed or renewed.

The second database is the Health Integrity and Protection Data Bank, or HIPDB. This is a flagging system to alert users that a more comprehensive review of the practitioners', providers', or suppliers' past actions may be prudent.

VA currently performs a joint query of both the HIPDB and the NPDB for all licensed independent practitioners. However, we agree that we must go further in the future. Therefore, VA plans to issue a policy requiring a query of the HIPDB on all new hires by May of 2004. We also intend to begin querying the HIPDB on current employees prior to their reappointment. This will occur following appropriate notification to employee bargaining units of our intent, and is expected to be in place by August of 2004.

VA takes seriously the completion of appropriate adjudication of background investigations on its employees, and we expect full compliance with established policies and procedures. Nonetheless, GAO found inconsistent implementation and compliance with VA's key screening requirements. GAO recommended that we conduct oversight to help ensure that VA facilities consistently apply existing policies. In light of this recommendation, we are establishing mechanisms and long-range goals for improving compliance with applicable federal regulations and VA policies.

We are providing facilities electronic lists of completed investigations upon which they must take immediate action. We're instructing our facilities to report on the status of all overdue investigations by April of 2004, and are requiring weekly reports until all actions have been completed and all investigations have been submitted. Network coordinators will monitor submission of the required reports.

GAO also recommended that VA require fingerprints for all health care practitioners who were previously exempted from background investigations and who have direct patient access.

On March 11, 2004, VA's National Leadership Board approved a requirement that electronic fingerprint checks be extended to all VHA paid without-compensation employees, trainees, volunteers and contractors. We expect full implementation of the recommendation during the first quarter of calendar year 2005.

VA employment policy requires that all selectees for positions funded by VA's health care programs be screened against the list of excluded individuals and entities. VA also matches current VHA employees in VHA's employment database with individuals on this list on a monthly basis. When current employees are identified from the list, facilities must initiate action to separate them or clear the exclusion.

GAO identified concerns in the pre-employment and post-employment credentialing reviews of such health care providers as nurses, dieticians and respiratory therapists. GAO recommended expanding the verification requirement for contacting state licensing boards and national certifying organizations to include verification checks of all applicants and employed practitioners with state licenses and national certificates.

We agree that this must be an integral part of the credentialing review process and will implement these procedures in the near future, possibly modeled on the credentialing process used for VA's independent providers.

Mr. Chairman, VA is already in compliance with the standard in the community for background checks and credentialing procedures for independent providers. However, we acknowledge that we must further improve our overall credentialing system.

Meeting industry standards is not enough. We intend to establish a higher standard for veterans health care system. We intend to create a systematic credentialing and oversight process to ensure overall exemplary performance in the future.

This completes my statement, and my colleagues and I will be happy to answer any questions that you or other members of the subcommittee may have.

[The prepared statement of Dr. Murphy appears on p. 52.]

Mr. BUYER. Thank you, Dr. Murphy.

Ms. Bascetta, you are now recognized.

STATEMENT OF CYNTHA A. BASCETTA

Ms. BASCETTA. Mr. Chairman and members of the subcommittee, thank you for inviting us to discuss our report on VA's screening of its health care practitioners.

Let me tell you about the findings that VA has responded to in its testimony. You asked us to review compliance with VA's screening requirements and to determine if the requirements are adequate. To address your concerns, we visited four facilities, and at each one we reviewed the personnel files of about 100 practitioners who have direct patient care access. We also interviewed VA officials in headquarters and the field and discussed verification procedures with state licensing boards and national certifying organizations.

I'd like to highlight two problems. First, we found mixed compliance with VA's key screening requirements. And second, some of the requirements are inadequate because they do not result in com-

plete and thorough screening. These two problems have created vulnerabilities that could allow incompetent practitioners or practitioners who might deliberately harm patients into VA's health care system.

Based on our discussions with medical forensic experts, similar risk to patient safety is a problem in the general health care sector as well. In commenting on our draft, and as you just heard, VA generally agreed with our findings and conclusions and stated its intent to provide a detailed action plan to implement our recommendations when our final report is issued.

Mr. Chairman, to keep problem practitioners away from patients, VA expects 100 percent compliance with its screening requirements to screen out practitioners who may have restricted or fraudulent credentials, criminal backgrounds or questionable work histories.

While some facilities in our review were doing a good job in some areas, we were frankly disappointed by the degree of compliance we found. We identified failures to verify credentials, failures to query national databases that contained reports about practitioners who have had disciplinary actions taken against their licenses, failures to check for practitioners whose credentials may be from diploma mills, and failures to respond to the results of background investigations in time to prevent practitioners with prior criminal records from caring for veterans.

Equally disturbing was the lack of oversight by headquarters to monitor compliance of its facilities with key screening requirements.

In spite of the clear risk of inadequate screening, we note that VA has conducted no oversight to date. VA did establish an oversight office in January 2003 but has yet to approve either the resources to support this function or the proposed program evaluation to be used in assessing facility compliance.

Mr. Chairman, even if compliance were perfect, we found gaps in VA's requirements that could allow some practitioners access to patients without adequate checking of their professional credentials. To VA's credit, this is not the case for all occupations. In fact, the complete and thorough requirements for physicians and other licensed independent practitioners serve as a model. They require verifying all licenses a practitioner holds and doing so by directly contacting state licensing boards.

In contrast, for some practitioners already employed by VA, such as nurses and pharmacists, the screening requirement for periodic verification of their credentials is not complete, because they can present only one license for verification, even if they hold multiple licenses. As a result, they could conceal licenses that may have disciplinary actions taken against them.

Moreover, the requirement calls for simply viewing the license. But this practice is not as thorough as contacting state licensing boards, which is the only sure way to identify restricted licenses or forged credentials.

Besides verifying credentials, VA requires querying national databases that flag problems with physicians and dentists, but it overlooks querying HIPDB, which could provide similar warning flags for all other licensed practitioners.

Finally, VA has not implemented consistent background checks for all practitioners, including fingerprinting to look for criminal histories. OPM began to offer a fingerprint only check in 2001, which can be done within 3 weeks at a cost of less than $25. In commenting on our draft report last week, VA told us it plans to fingerprint volunteers, contract health care practitioners, medical residents, and practitioners who work without direct VA compensation, but it has not issued guidance to implement its plan except for volunteers.

In 1996, the FSMB recommended that to better ensure patient safety, states should check the criminal histories of medical residents who have varying degrees of unsupervised care. For the same reason, one of the VA facilities we visited has already implemented fingerprint-only checks of its medical residents and contract health care practitioners.

In summary, these are serious weaknesses with profound implications for patient safety. VA's intent to provide an action plan to comply with our recommendations should be an immediate priority, and it apparently is.

This concludes my remarks, and I'd be happy to answer any questions you might have.

[The prepared statement of Ms. Bascetta appears on p. 59.]

Mr. BUYER. We have been joined by Mr. Lane Evans, Ranking Member of the full committee, and also Mr. Boozman. If any of you have any opening statements, we will submit them for the record. Mr. Evans?

Mr. EVANS. I echo your request. I'd like them entered into the record.

Mr. BUYER. Yes. It will be so granted. Mr. Evans, your written statement shall be entered into the record.

[The prepared statement of Congressman Evans appears on p. 44.]

Mr. BUYER. Mr. Boozman? Thank you. I yield myself at this time 5 minutes. Ms. Bascetta, when was the last time the GAO looked at this credentialing issue for the VA?

Ms. BASCETTA. Mr. Chairman, not in my tenure. I believe we have not looked at this issue in the last 10 years.

Mr. BUYER. And your tenure would be defined by what period of time?

Ms. BASCETTA. Six years.

Mr. BUYER. Six years. Not in your tenure, and to your knowledge, not in 10 years?

Ms. BASCETTA. Right.

Mr. BUYER. Are you able to tell us whether or not DOD, the Department of Defense, has similar problems with regard to credentialing?

Ms. BASCETTA. We haven't looked at the credentialing process at DOD.

Mr. BUYER. At DOD? All right. In your testimony, you can grab it if you've got it there in front of you, on your opening page, you have a chart with regard to the four facilities.

Ms. BASCETTA. Right.

Mr. BUYER. You lay them out, Facility A, Facility B, Facility C and Facility D. It's a very simple chart but at the same time will you please identify the facilities for me, Facility A, B, C and D?

Ms. BASCETTA. Yes, sir. Facility A is Big Spring, TX. Facility B is Washington, DC. Facility C is New Orleans, and Facility D is Seattle.

Mr. BUYER. All right. On page 7 of your testimony you state that during one of your facility reviews you found a case that exceeded the 90-day timeframe involving a nurse assistant who was hired to work in a VA nursing home in June of 2002. In August of 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 your review, you found this case among a stack of OPM results of background investigations that were stored in a clerk's office on a pile on a desk in some work spaces.

When you brought this to the attention of the facility officials in December 2003, they terminated the nursing assistant who had worked at the VA facility for more than one year. In which facility did this travesty occur?

Ms. BASCETTA. Mr. Chairman, that was at the Washington, DC facility.

Mr. BUYER. Who heads up the Washington, DC facility? Would you please scoot up to the microphone?

Mr. GARFUNKEL. Yes, sir.

Mr. BUYER. Please identify yourself.

Mr. GARFUNKEL. Sanford Garfunkel. I'm the director of the facility.

Mr. BUYER. And how long have you been the director of the DC facility?

Mr. GARFUNKEL. Approximately eight years.

Mr. BUYER. For eight years?

Mr. GARFUNKEL. Yes, sir.

Mr. BUYER. Would you please tell the subcommittee how this was allowed to happen under your watch and what happened to the people who were responsible to ensure that the personnel action was fulfilled?

Mr. GARFUNKEL. Sir, first of all, I need to say that in our effort to identify this nursing assistant, we could not do so. The only nursing assistant that we could identify that would come close to this scenario is a nursing assistant who we understand was found guilty at one point of spousal abuse or abuse at home and subsequently resigned. So I honestly could not identify this individual.

I will tell you that, without making excuses, that we had issues in our HR service subsequent to this review. We have a new team in our HR service, a new chief, very conscientious, who is taking appropriate actions to assure that we have systems in place that make sure that we have adequate follow-up on issues like this.

Mr. BUYER. Let me ask this. Where did the system fail us?

Mr. GARFUNKEL. I think the system failed perhaps, without making excuses, Congressman.

Mr. BUYER. I'm not asking for any.

Mr. GARFUNKEL. I understand.

Mr. BUYER. Let's go right at it.

Mr. GARFUNKEL. I think perhaps not enough emphasis was put on the importance of making sure that we had adequate follow-up. I'm told that when any result did come back from these reviews, background checks that did show a significant issue, that immediate action was taken, and in other cases there were delays in follow-up.

In this case, and I'll tell you very honestly, in the next case, which is ours as well, we found very different results than what this report would indicate, and so as forceful action as might be indicated from this report was not taken.

Mr. BUYER. And for whom would you be referring? Yourself?

Mr. GARFUNKEL. I'm sorry?

Mr. BUYER. You said forceful action was not taken.

Mr. GARFUNKEL. No. I'm talking about forceful action was not taken to the employee because the results of the background check that we got was different than the results that are shown in this report.

Mr. BUYER. Who's responsible for compliance?

Mr. GARFUNKEL. I am ultimately, sir.

Mr. BUYER. That's correct. There is no sinister design by the way we've set out this panel here today. We want the subcommittee to explore this. Health and Human Services do it a particular way. You try to coordinate with the VA. For whatever reason, we're going discover why some things were dismantled.

We bring in the Government Accounting Office to do an examination. They can be openly critical with regard to the VA headquarters with regard to oversight, but their criticism is the oversight of the compliance with regard to what the hospital directors have done or not done, correct?

Mr. GARFUNKEL. Yes, sir.

Mr. BUYER. All right. So that's what we're sort of laying out here today for open discussion. And we're not going after anybody here. We're trying to figure out how we can improve our system, and that's what our goal is.

I now yield to Ms. Hooley for any questions she may have.

Ms. HOOLEY. Yes. Ms. Bascetta, thank you very much. I think you did an excellent job on your report. GAO previously reviewed the issue of VA research lab vulnerabilities. There were two basic components to the review: physical security and a variety of procedural and accounting mechanisms, and the human element. What can you tell us about the screening process for those individuals with access to select biological, chemical, or radiological agents in the VA lab, especially their Level 3 research labs?

Ms. BASCETTA. Let me give you a little background on what we did. At the request of the chairman and Congressman Evans, who were the lead requesters on our work—there were several other requesters involved who had jurisdiction over other federal labs—we looked, as you said, at the issue of security in those labs, and we found what I would characterize as a similar lax mindset with regard to the issue of security, particularly with regard to concern about individuals who might have malicious intent.

And the focus of our review was actually on CDC's administration of the select agent program, but at the same time, the VA inspector general as well as the IGs in the other departments with

federal laboratories were doing extensive work on security with regard to personnel policies. They've been working on this since right after the anthrax event in October 2001, and I believe they are still working on it. Their work is classified, so I can't discuss it. But I know they made a number of recommendations and are following up with all of the agencies to determine their compliance with those regulations.

CDC published guidance I believe in December 2002, and their guidance covered everything from physical security to revised and tightened personnel regulations that recommended background checks for anybody with access to a federal laboratory, including visitors.

Ms. HOOLEY. Let me just follow up on that. You said you are following up on your recommendations. And what's been the result of your follow-up?

Ms. BASCETTA. Well, our recommendations were directed at CDC's management of the select agent program which governs the transfer of these agents between laboratories. That was the major focus of our work. And CDC has issued much tighter regulations and guidance to its laboratories.

Under the Patriot Act, the IGs were looking at compliance with the security of personnel access to those laboratories, and that work is classified.

Ms. HOOLEY. Okay. So are we complying—are they complying with your recommendations now?

Ms. BASCETTA. CDC is, yes.

Ms. HOOLEY. Okay. Just very quickly, you wanted to reduce vulnerabilities in patient care and you had all the oversight. My question is, on your recommendations, how can the VA accomplish these actions? And what will it take, other than your recommendations for VA to act to close their credentialing gap?

Ms. BASCETTA. Well, I think Dr. Murphy's testimony reflects the first and most important step, which is to acknowledge that they have problems that they are committed to correcting.

I think from the credentialers' standpoint, the most important thing that the Department can do is simplify the process. Now they have a rather confusing mix of requirements that vary by type of practitioner and by a point in the process, that is, for applicants or those already employed. If they have one standard, that is, if they check all licenses for everybody and that they do so by directly contacting the state licensing boards, that will simplify the guidance to the field as to what they should be doing.

But in a situation like this, the other most important cultural piece I think I'd call it is the mindset, the vigilance to ensure that this is always a top priority, and that 100 percent compliance is expected, no deviation is allowed.

Ms. HOOLEY. And will you follow-up—being oversight—and look at what their compliance is?

Ms. BASCETTA. We always follow up with our recommendations, yes.

Ms. HOOLEY. And do you know how the VA's performance compares to the private sector regarding screening and credentialing?

Ms. BASCETTA. No. We have not looked at the private sector, but as I mentioned briefly in my statement, we did speak with experts who believe that similar problems exist in the private sector.

Ms. HOOLEY. Thank you. I yield back.

Mr. BUYER. Mr. Boozman, you are now recognized.

Mr. BOOZMAN. Yes. When there is a vacancy, say a hospital needs a gastroenterologist or whatever, what is the process? I guess you go for the interview. At that time, you know, if the interview goes well and they decide whatever, who actually does the credentialing? What kicks in?

Dr. MURPHY. I'm going to ask our technical expert to——

Mr. BUYER. Dr. Boozman, would you yield for just a second?

Mr. BOOZMAN. Yes.

Mr. BUYER. That is a wonderful question. And rather than—to Dr. Murphy, I'll just propose this to you. Let's ask one of the directors of one of the hospitals what they actually do now, and then we can get comment, and I'll be more than happy to yield additional time, with no objection. I think it would be interesting to find out. Do you concur?

Mr. BOOZMAN. Sure.

Mr. BUYER. Thank you. I'll let you select one of the four.

Mr. BOOZMAN. Just whoever.

Dr. MURPHY. Do we have a volunteer? Tim?

Mr. WILLIAMS. Okay. I'm Tim Williams from the VA Puget Sound Health Care System in Seattle. And just to go through the process, we would receive a request from either one of our contractors if we got this individual through a contract, or if it came from one of our service lines, somebody who applied directly for a position at the facility. That would then—we would do a background check after that, once we have the name. They're considering this individual for a position, and then we would do the background check relative to the professional credentials, medical school, licensing and all of that, and then we would look at——

Mr. BOOZMAN. So somebody at that facility would do the——

Mr. WILLIAMS. That's correct. I have a medical staff officer who is responsible for this, does it on an ongoing basis, uses VetPro, uses Priv Plus, uses a variety of sources to be able to do that including, you know, telephone calls to the state licensing boards and to the universities along the way. So, yes, it would be done at the facility.

Mr. BOOZMAN. Okay. How does that differ? Were you ever in the private sector in hospital management?

Mr. WILLIAMS. A really long time ago. But I can tell you that what the physicians that we hire tell us is that we are much more thorough, that we ask for more information, we ask for more documentation than what they get from other private sector facilities.

Mr. BOOZMAN. Do many of the private sector facilities hire people that—firms, that that's all they do is do the background checks to vet the people?

Mr. WILLIAMS. I don't know that. I presume so, but I can't speak definitively to that.

Mr. BOOZMAN. Okay. I guess the other question I'd have, when, the case that you had when the—the very notorious case that's doc-

umented here—when those sort of things happen, what broke down in your investigation in the process?

Dr. MURPHY. If you're referring to the Swango case that's been talked about this morning——

Mr. BOOZMAN. Yes. He and whoever else. It doesn't really matter.

Dr. MURPHY. I think there are several important and key components to the credentialing process and the background security checks, and I'll use those terms very specifically.

It's important for us to query the available public databases, the HIPDB, the National Practitioner Data Bank, and the Federation of State Medical Boards. We also do primary verification of all other credentials for education and certification that are provided.

In addition, in the Swango case, if he had been fingerprinted, we would have been able to pick up his previous convictions, and that's why VA is implementing electronic fingerprinting for all of our employees, our volunteers, our without-compensation staff and trainees.

Electronic fingerprinting has an advantage over the ink- and-paper fingerprinting, because we can get the results back very quickly. In 48 hours, we can get the fingerprint match results. And I think that those additional steps that we have committed to will avert problems in the future.

Another key feature is to provide the oversight to make sure that we are consistently applying those policies throughout the country.

Mr. BOOZMAN. Thank you.

Mr. BUYER. Mr. Udall, you're now recognized.

Mr. UDALL. Thank you very much, Mr. Chairman. Thank you, Dr. Murphy, for that issue that you just took up on Dr. Swango. Because I think that he shows—if you follow this history, and that's what I want to ask both of you about. If you follow this history of what happened to him and how he ended up killing and injuring so many people, I want you to highlight for me what, Dr. Murphy, what you've changed and ask the GAO representative, Ms. Bascetta, what is it that you saw that were the faults.

Because I look here. Here's this guy—talking about Swango—he hires on in Ohio in 1984 and he assaults a patient there and then moves on from there to Adams County, Illinois, in 1985. And in that particular place, he poisons co-workers with arsenic and he gets a felony conviction in 1985 for aggravated battery for poisoning these folks.

And then what happens after that, you've got a whole series of hirings all over the country and all over the world. I mean, look at this. Here in 1992 he was hired in South Dakota to work at a VA facility. He lied about his criminal conviction. Then you go to 1993, he's hired over at Stony Brook Medical Center in the VAMC at Northport, which is where he killed the people and was actually convicted for that. But he told everybody in that instance that it was a barroom brawl, and so he made it in the facility. He lied about his background.

He then goes overseas and is hired in 1995 at a hospital in Zimbabwe and ends up giving patients there toxic substances, and then in Saudi Arabia in 1997, he's hired through an employment agency located in Portland, Oregon and assigned as a physician in

Saudi Arabia, and that's where he's arrested for the false statements.

But if you'd look at this very early on, he has a felony conviction for poisoning patients with arsenic. And yet a number of medical centers and VA facilities hire him and they never detect what's going on. And so my first question to Ms. Bascetta is, and it sounds like you said that many of the things, the mistakes that were made here, are still things that could have caused problems. So you might have the possibility of this same kind of thing occurring. And I'd like to know, based on this history of Dr. Swango, what is it that you see that are problems that would let a doctor that has these evil intentions get into the system?

Ms. BASCETTA. You make several very good points by laying out this unbelievable history. First and most important, as you pointed out, he had a criminal conviction that was in his record that would have been picked up on fingerprinting before not only the VA hired him but some private sector hospitals that were in the mix, as well. Nobody checked him against a criminal record database. So he's definitely not the problem of the VA alone.

And I might also point out that the reason that he was ultimately convicted was because the IG would not let it go, and they wanted him behind bars.

Another point is that the databases that VA and the other hospitals check are only as good as the reports that are in them. And my understanding in the Swango case is that despite many, many people having deep misgivings about his behavior, he was pretty much passed from place to place.

The Institute of Medicine talks about this briefly in one of their reports on licensing and databases and how people with problems, problem practitioners can fall between the cracks. Sometimes it's because a facility is worried about liability if they admit that somebody that has been working within their facility could have potentially caused harm, either from incompetence or deliberately.

And finally, we have to be sure that when people get information that indicates that somebody could be a bad actor that they use the appropriate judgment in taking action to keep that person out of the facility. And that's closing the loop and assuring that VA officials and others act appropriately when they're armed with information about a practitioner's past.

Mr. UDALL. And, Dr. Murphy, have we closed some of those loopholes today so that a doctor like Dr. Swango wouldn't get into the VA today? You talked about fingerprinting. I mean, talk about some of the other things that she's laid out there.

Dr. MURPHY. There are actually several different ways that this individual could have been picked up if he applied to VA today. The Health Integrity and Protection Data Bank from HHS includes some corrections information, and it should have indicated a problem with this individual's past history.

Currently we have put in place a policy to do electronic fingerprinting for all VA staff. The fingerprinting would have picked this up. In addition, VA staff who are undergoing background checks would be screened for past convictions, and the adjudication process would avert our hiring full time staff with these kinds of problems in their backgrounds.

So I think there are a number of ways that our current policies and the improvements that we're making on the basis of the GAO recommendations will allow us to make sure that we have high quality health care providers and practitioners in the VA system.

Mr. UDALL. Thank you. And thank you for allowing us to go a little bit over, Mr. Chairman.

Mr. BOOZMAN (presiding). Ms. Grubbs, how many people are employed in the Bureau of Health Professions?

Ms. GRUBBS. In the Bureau of Health Professions?

Mr. BOOZMAN. Yes, ma'am.

Ms. GRUBBS. I'm not sure of the exact number, but there are six different divisions and two offices, so the Bureau has somewhere around 300 people. The Division of Practitioner Data Banks, which runs the National Practitioner Data Bank and the Health Care and Integrity Protection Data Bank has a staff of around 22.

Mr. BOOZMAN. Okay. And Health Resources and Services Administration?

Ms. GRUBBS. How many are employed there?

Mr. BOOZMAN. Yes, ma'am.

Ms. GRUBBS. I'm sorry, sir. I would have to get back to you with that answer.

(The information follows:)

The Health Resources and Services Administration employs 1,852 people, in partnership with States and local communities, to perform the varied tasks necessary to provided medical care and social services to millions of low-income Americans, many of whom lack health insurance and live in remote rural communities and inner-city areas where health care services are scarce.

Mr. BOOZMAN. The National Practitioner Data Bank has been in place since I think 1986. Hospitals are required to submit queries regarding staff practitioners every 2 years. Does that make the VA compliant on the biannual requirement?

Ms. GRUBBS. The legislation that authorized the National Practitioner Data Bank was in 1986. It actually opened in 1990, and the VA is compliant. They do query, based on the numbers, they have queried from all of their facilities.

Mr. BOOZMAN. VA, can you comment on that?

Dr. MURPHY. We comply with query to the National Practitioner Data Bank on all physicians and dentists.

Mr. BOOZMAN. Okay. The Health Care Integrity and Protection Data Bank created as part of the HIPPA of 1996 commenced operations in late 1999. I'm curious as to why both these important databanks aren't combined.

Dr. GRUBBS. They basically are combined. It is one electronic system. So if a private hospital or the VA facilities submit a query and choose to query both databanks, it's done at one time and they receive the reports electronically from both databanks at the same time. And it generally takes about 45 minutes to receive a response.

Mr. BOOZMAN. Okay. So how does it work with the fugitive felon program?

Dr. GRUBBS. We have nothing to do with the fugitive felon program.

Mr. BOOZMAN. So there's no interface of the databanks?

Dr. GRUBBS. No, sir.

Mr. BOOZMAN. Okay. Ms. Bascetta, we've heard your testimony. I've heard the VA's testimony and I've heard the HHS testimony. My question to you is, could another Dr. Swango situation occur today in light of the VA's current credentialing procedures? Do you feel like the measures that have been enacted in the last several months would prevent another incident like this from happening?

Ms. BASCETTA. The most important way to have prevented him would have been to have fingerprinted residents, which they're not doing yet, but they indicate that they are planning to do. That would have caught him.

I might point out also that applicants simply knowing that they'll have to undergo a background investigation or fingerprinting could be deterred from trying to enter VA or another health care system.

Mr. BOOZMAN. Okay.

Mr. BUYER. Mr. Udall.

Mr. UDALL. Thank you, Mr. Chairman. Ms. Bascetta, you say they aren't currently fingerprinting residents. And my understanding of why that's a problem, at least from the way I understand my teaching hospital in Albuquerque, New Mexico, is when you have residents—and interrupt me if I'm not explaining this, this relationship between VAs and teaching hospitals. But in a teaching hospital, they frequently have their residents serve over in the Veterans Administration hospital. So the residents are moving back and forth. They're doing duty at the VA hospital. They're also over at the teaching hospital and doing their residency over there.

And when you're saying the way you pick this up is you have to have fingerprinting for residents, then it's because the large volume of people moving back and forth, the health care people and the docs that are doing that. Is that what you're—that's how you pick up this kind of situation?

Ms. BASCETTA. Yes. that's certainly part of it. Let me add some information that wasn't discussed in our report but that we have in our workpapers.

Several states require fingerprinting of residents, and your state, New Mexico, does. They require a state-only check, which means they would basically check with the police in your state, and they also require federal background checks for selected residents. I don't know what their criteria are.

But basically, 19 states do require background checks for medical residents. Seven of those states require a state-only check, and 12 require a state or federal check. But one of the reasons that we feel so strongly that VA implement this check within their own system is that they wouldn't necessarily have access to the results of these background investigations in the states. It's so inexpensive to do a fingerprint check only, and as I've said, they're already planning to do that.

But it is very complicated, and the fact that these states already have this requirement indicates to us that there is acknowledgement of this problem in the health care system at large.

Mr. UDALL. Dr. Murphy, you aren't currently doing fingerprinting now, but you intend to?

Dr. MURPHY. The issue of fingerprinting residents is actually a broader problem than in VA. As Ms. Bascetta has indicated, there

are some states that currently require fingerprinting of residents, and we have actually been fingerprinting residents in Network 20 at the Seattle facility and in Network 3 in New York/New Jersey.

We've also addressed that issue from a national policy standpoint. And as previously noted at our March meeting of the National Leadership Board, we approved a policy that we will begin electronic fingerprinting, and we've funded that program.

We will get that program up and running as quickly as we can, purchasing the equipment and putting the policies and staff in place to actually accomplish that. So we believe the VA has acted on this proactively.

We've also been working with our colleagues in the AAMC to make sure that they're aware of what VA is doing, because it will have an impact on the universities that don't universally implement fingerprinting of all residents across the country.

Mr. UDALL. So you named a couple of facilities. I assume all the rest of the facilities you're not doing fingerprinting in?

Dr. MURPHY. We've not been routinely fingerprinting in all VA facilities, but we've changed our policy and will begin to do that. We're also compliant in the states where the universities are required to do that.

Mr. UDALL. And when you say you're going to begin, how soon are we talking about?

Dr. MURPHY. We believe that we'll be able to get the program in place in 2005.

Mr. UDALL. Ms. Bascetta, is the reason fingerprinting is so important is that you have an individual who has a felony conviction, let's assume, like Dr. Swango, and you get the fingerprint as a part of that process. And then if that individual tries to move anyplace in the system, if you have fingerprinting, the individual that comes in, that applies, submits a fingerprint in their application, and you're able then to make a comparison with the databases and determine that here is an individual that has in fact had a conviction. Is that what we're talking about?

Ms. BASCETTA. Yes. That's exactly right.

Mr. UDALL. My time has run out here, so I'll go ahead and yield back, Mr. Chairman.

Mr. BOOZMAN. Ms. Bascetta, can we get a copy of the OPM background check on the nursing assistant that was allegedly fired a year previously for patient abuse? The GAO in DC seem to disagree on the facts.

Ms. BASCETTA. I don't know if we have that in our possession. I know that we would have part of her paperwork, but background investigations are considered private documents. They're not allowed to keep them in their official personnel files. They're also allowed to, by OPM regulations, actually encouraged to destroy those documents.

I can tell you that we, for our own quality assurance purposes, have two analysts review every personnel file that we look at, and that all of the workpapers have been signed off, of course, by a supervisor. I will get you what documentation we do have on that particular case.

When we followed up with the facility, we didn't have documentation that they terminated this person. This was what they told us based on our initial concerns about her employment.

Mr. BOOZMAN. Ms. Murphy, how many VA employees and VA contractors have been matched with individuals on the Department of Health and Human Services Office of Inspector General's list of excluded individuals and entities since 1999, the year that this became available?

Dr. MURPHY. I don't know that I have the exclusions list data back that far. What I do have is that since November of 2002, 24 individuals were identified as potential matches with individuals on that list, and of these, 15 have been terminated. Two were not confirmed to be VA employees. Two resigned. Three were reinstated. That is, they resolved the issue with HHS and were taken off the list. And two are in the process of being terminated by the employing facility.

Mr. BOOZMAN. Okay. So is that when the VA started to query the list? 2003? Is that when they started to query the list? When did they start to——

Dr. MURPHY. It was, Barbara, in 1999?

Ms. PANTHER. Yes. Ninety-nine.

Dr. MURPHY. We began the query in 1999, but unfortunately, the information I have with me today only goes back to 2002. We'd be happy to provide the data back to 1999 for the record.

Mr. BOOZMAN. How often do we query the list? How does that work?

Dr. MURPHY. On a monthly basis.

Mr. BOOZMAN. Monthly? Okay. When will the VA have a plan developed to address the four recommendations in the GAO's report?

Dr. MURPHY. For some of the recommendations we will implement changes within the next month. Others are more complex and will require us to set up a task force to make sure that we've got the most effective solution in place, and that we've identified the appropriate resources to implement a standardized system that will give us the consistent reporting and policy that we want to put in place.

We believe that one of the key features is to have a systematic approach that allows people to do the right thing and keeps them from not doing the right thing. And that's really what our web-based program, VetPro, allows us to do. It's a standardized, systematic approach that gives staff the tools to do the job and does not allow them to appoint a person if they've not gotten all the appropriate information prior to the appointment.

We'd like to have that kind of standardized approach for employees in Categories B and C, and for the excluded employees who have direct patient care responsibilities.

Mr. BOOZMAN. How many staff are assigned to the VA's Office of Human Resources, Oversight and Effectiveness?

Dr. MURPHY. Seven.

Mr. BOOZMAN. Seven. What does the—what has that particular office accomplished? Have they done any investigations or?

Dr. MURPHY. We have individuals here from that office. They have not done any for cause investigations at this point.

Mr. BOOZMAN. Okay. In regard to the other question, you know, you said that you'd have some of the four implemented almost immediately. Could you give us, you know, maybe in writing, kind of a timeframe as to how as you discuss, you know, the process, could you give us some sort of a timeframe as to when you think the entire thing will get done?

Dr. MURPHY. Let me point out some of the key pieces that we believe we need to put in place. We've agreed that we need to check all of the Category B and C employees against the HIPDB database. We believe that we'll be able to do that for applicants next month. As of May of 2004, that should be in place. And we should be able, after notification to the employee bargaining units, to put that same process in place for reappointment of our current employees.

In addition, we will purchase and begin fingerprinting employees—without-compensation staff and volunteers and trainees—we believe by the first quarter of 2005.

We've asked for the background checks, the security checks and suitability adjudications to be looked at immediately and a report on the status at each medical center to be forwarded to us by April 15. We will require periodic reporting until all of those adjudications have been cleared.

Going forward, prospectively, we expect that facilities will be timely in complying with OPM policy, which is to do background checks within 14 days; upon receiving the results, to review the results of the background check within 10 working days; and to adjudicate and respond to OPM within 90 days.

Mr. BOOZMAN. Okay. Thank you. Mr. Udall?

Mr. UDALL. Thank you, Mr. Chairman. Is one of the issues—for any of the panelists here—one of the issues with fingerprinting, because I seem to get that in the last question is that—do you all have the authority at the federal level to require the fingerprinting, or is that normally done at the state level through the states?

Dr. MURPHY. We believe that we have the authority and have made it our policy and a requirement from this time forward.

Mr. UDALL. So even states that don't have—my state and several others that she's mentioned actually have it right now in place. Even if those states don't have it in their teaching hospitals and that kind of thing, you're still able to require it, Dr. Murphy, is that right?

Dr. MURPHY. Yes. We will have a national VHA policy.

Mr. UDALL. A national policy? Okay. Ms. Bascetta, on the issue of databases, you said one of the things that is important is the database is only as good as the information that's in them. Why is that a problem vis-á-vis the kind of Dr. Swango situation?

Ms. BASCETTA. Well, it wouldn't have been with Swango because of the criminal conviction which would have been in the database. But in other cases that aren't as black and white, where perhaps something is under investigation—and a lot of these things take a long time to investigate—if there's reluctance on the part of the facility that is to do the reporting to admit that they've had a problem with a practitioner in one of their facilities, these people can fall through the cracks. They can move from jurisdiction to jurisdiction, for example, while something is being investigated. And un-

less someone is willing to tell a prospective employer about a problem, they may not know.

That's why, in addition to checking the databases, the primary source verification, the contacting of the state licensing boards or the national certifying organizations is so important. Because that's really your first line of defense. These databases are double checks. There are other ways to find out about incidents that may not have been disclosed. But your first line of defense is that primary source verification.

Mr. UDALL. And the primary source verification, that institution is allowed to give that information out? So if a VA hospital contacts the New Mexico licensing board and says we have this particular doctor by this name, and he claims to have these certificates from you, can you verify that this is in fact true?

Dr. MURPHY. Yes, we can and we will.

Mr. UDALL. Now that doesn't deal with the issue of is it the identical person that there's in front of you, I guess? You'd do away with that with fingerprinting, but you could always have a situation I guess where somebody is representing to be someone that's there. How do you all deal with that in your whole screening effort?

Dr. MURPHY. For VA employees, we currently require not only the credentials check, but a background check. And in the process of doing the background check, fingerprinting will be done so identity can be verified.

Mr. UDALL. Through the fingerprinting?

Dr. MURPHY. Yes.

Mr. UDALL. Dr. Murphy, are you familiar with an individual by the name of Christine Gilbert? This is a nurse that was at the VA facility, VA Medical Center, 1989 to 1996, and she has 63 deaths I think as a result of—from patients occurring on the ward. Are you familiar with that or heard——

Dr. MURPHY. Sir, I recognize——

Mr. UDALL. This is Northampton, Massachusetts. It's the medical center up there.

Dr. MURPHY. I recognize the name, but I don't have the details of that case.

Mr. UDALL. Okay. One of the things that I think is—that we need to talk about in this hearing, is this is a nurse that—I thought you might be familiar with it—but walked into the system, had no problems in her background, was a legitimate registered nurse. And then because of these bizarre situations with her boyfriend and faking emergencies to put people in an emergency situation and to show that she could save them, and in fact many of them died, you had this tragedy.

How do you pick up those kinds of individuals that make it—they don't have problems, but they make it into the system, and then they go bad within the system? I mean, how do you pick that up? What's your approach to that?

Dr. MURPHY. One of the approaches that we take in VA involves our very robust patient safety system, and we do a root cause analysis on either near misses or adverse events. In doing a root cause analysis on either a single case or a series of cases, we believe that we have the ability to at least begin to question whether any wrongdoing or pattern of wrongdoing has occurred.

It's a system that is relatively unique to VA and really has been viewed as a best practice in an area where VA leads the country.

Mr. UDALL. And so the kinds of things that you look at are if you start having a series of incidents in a particular ward that seem unusual, you immediately get into that and investigate it? Is that what you're talking about?

Dr. MURPHY. The way the patient safety system is set up, even if a near miss or an adverse event almost occurs, it can trigger a patient safety root cause analysis. And a team would be put together to analyze that single near miss or adverse event, and try to determine what the cause was.

By providing that level of scrutiny and oversight for serious events, we have an ability to pick up some of these cases.

There is no way to be 100 percent sure that you are going to identify people who have ill intent or who are not following what we consider appropriate standards of care. But within VA, our patient safety system certainly gives us a greater ability to address these issues than many medical centers in this country, whether the public or the private sector. It is one of the aspects of VA's health care system that has been identified as a model to be adopted by other medical facilities in this country.

Mr. UDALL. Thank you, Dr. Murphy. Thank you, Mr. Chairman.

Mr. BOOZMAN. Dr. Murphy, what's the rationale for only checking one state license for some practitioners, such as nurses who currently work in the VA, and not verifying all of the licenses held by the practitioner?

Dr. MURPHY. Having a single state license or certification is a condition of employment, and because that was the condition of employment we had in the past only required verification of that single credential.

We agree that this is a potential problem, and we have already made a commitment to set up a system so that we will verify all licenses or certificates for the Categories B and C non-independent providers in our system, and that we will contact the issuing organization directly in the future. It is a change based on the recommendations from the GAO.

Mr. BOOZMAN. Good. Again, that does seem like that makes sense. Have all the VA facilities, do they have a database of the diploma mills?

Dr. MURPHY. It's very difficult to keep a diploma mill list up to date, and what's recommended at this time is that we check to make sure that the degrees and the educational credentials of our applicants and our employees are from awarded by accredited institutions. So we check a list of accredited programs and make sure that we only hire individuals who have degrees that are required for their position that are from accredited institutions.

Mr. BOOZMAN. Going back to the other question, it does seem like, you know, we do have situations where an individual is in good standing with the current state, but because they didn't do a good job of looking back, that, you know, that you might have an individual that had problems, you know, in another state, moved, you got—you see what I'm saying? I mean, that does seem like that that really is very important to get fixed.

Dr. MURPHY. We check with the Federation of State Medical Boards for licensed providers and therefore can check all state licenses that way. In the future, we will also do that for individuals who are not in the independent provider category—nurses, therapists, et cetera. We will check all licenses and we will check all certificates.

Mr. BOOZMAN. Very good. Okay.

Mr. BUYER. Mr. Udall?

Mr. UDALL. Thank you. Dr. Murphy, VA Directive 2002-075 involves security and access requirements for VA's research laboratories. Could you explain the approval and vetting process for individuals granted access to Level 3 laboratories?

Dr. MURPHY. I can't give you a complete explanation of that, but we do have individuals from the Research Service here who would be happy to explain the process to you.

Mr. UDALL. Would you like to start, or would you just want to defer to them?

Dr. MURPHY. We require credentials checks and background checks for VA employees who are in those positions. We comply with the CDC recommendations in those areas, and we have recently done a verification of compliance in the VA's the BSL–3. This was done to ensure that they were aware of the regulation that they had been appropriately trained, that the credentials checks were in place, and that the required security procedures were being complied with.

Our VA IG's office has done an audit of those lab facilities. I understand that that report is still a draft at this point, so I don't have results for you.

Mr. UDALL. What I'm trying to focus in on is some of the labs grant access to research assistants who may be attending an affiliated university, and some of these research assistants may not be U.S. citizens. So how does the VA screen non-citizens for access to the labs? And if you want to have the individual come up, that would be fine.

Dr. MURPHY. We will provide that information for the record. There is a process in place, and that was a specific focus of the IG audit. The credentials and the background checks are being done. Again, we believe we are in compliance with the CDC recommendations for the BLS labs.

Mr. UDALL. Do you see this as a possible weak point in terms of having somebody that isn't a citizen that may be at a university that has access to the lab, or is that taken into consideration in your recent regulation or directive?

Dr. MURPHY. I believe the directive addresses the issue of background checks and credentials checks for not only VA full time and part time staff, but for WOC employees. Again, that's not a program that's in my area of either expertise or in my current portfolio, so I'd like to provide more detailed information to you for the record. I don't want to give you an inaccurate answer, sir.

Mr. UDALL. Thank you very much, Dr. Murphy. Ms. Bascetta, do you have any comment on access to these labs?

Ms. BASCETTA. Only that as I mentioned earlier, I am aware that the IG in VA as well as their counterparts in other federal agencies

are reviewing both the requirements as well as compliance with those requirements.

Mr. UDALL. Thank you. Ms. Bascetta, you outlined a couple of the reasons or a couple of the areas that you thought should be looked into—the fingerprinting, the database is only as good as the info in it.

And I think you said, your third one is with you have to get the right information to the people that are making the judgments and making the decisions. Could you explain that a little more of exactly what you mean there and what's the possible problem with the system?

Ms. BASCETTA. I was simply making the point that it's conceivable that a hiring official even when faced with information about a problem in a person's work history, you know, could for whatever reason decide to hire the person anyway. So that even having the requirement doesn't preclude that somebody uses poor judgment.

Mr. UDALL. And so what you're talking about there may be a situation where they so desperately need an employee, a doctor or a nurse or someone along that line, they feel an urgency to get the hire done, and they may have an indication that there's something wrong, but they don't further check it out, they just hire the individual.

So the message you're really sending is, if there's anything out there that looks like that it's a problem, it should be thoroughly investigated and put to rest before you put the employee on, the health care professional on, and have them have contacts with patients and veterans in that kind of situation?

Ms. BASCETTA. That's correct.

Mr. UDALL. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. Thank you, Mr. Udall. Dr. Murphy, on page 9 of the GAO's testimony, it states that VA facility officials are not required to check state licenses disclosed by a practitioner such as respiratory therapists, and are only required to physically inspect the national certificate.

Is that a written policy?

Dr. MURPHY. I believe the personnel policies at this time require that we check the licenses as a condition of employment, and it's a single license or certificate for reappointments they're currently looking at. But as I said in my testimony, we will begin to check all state licenses, certifications and to do verification with the issuing organization.

Mr. BUYER. So with what you have just outlined, is proper authentication possible?

Dr. MURPHY. Please clarify; I don't want to give you an incorrect answer. Are you talking about the current policy?

Mr. BUYER. I'll let you answer the question.

Dr. MURPHY. All right. We believe that our current policy allows us to verify that an individual has the appropriate credentials and state licensure or certificate to practice under that state license or certificate.

However, we do agree with GAO that, in some circumstances, it might not allow us to have a complete verification. There may be a state licensure in another state that has been restricted, and we agree that we want to know that information so that we can appro-

priately make judgments about the quality of that provider and whether they should be hired or continue to practice in the VA.

Mr. BUYER. The approximate effective date of the policies for which you've just expressed—when?

Dr. MURPHY. We've already established a task force. They are to give us their recommendations no later than October 2004. We hope that they will be able to quickly give us recommendations that we can implement in 2005 or as early as possible.

Mr. BUYER. So your testimony is prospective?

Dr. MURPHY. Pardon me?

Mr. BUYER. Your testimony is prospective. It's over the horizon as opposed to what it is today?

Dr. MURPHY. Absolutely. The solutions are prospective solutions that will improve the VA health care system in the future.

Mr. BUYER. Under the current policy, if a health care practitioner has a license in any state, that individual may work in any VA facility in the Nation. Is that a good policy or not?

Dr. MURPHY. I think it is a good policy. We require that physicians and other providers have a valid state license and they practice under the scope of practice of that license.

Our physicians often move from facility to facility, and we believe that such a state license allows them to have the credentials to provide the level of quality care that our veterans deserve.

Mr. BUYER. What's the rationale for asking medical practitioners who are not required to have a license to work in the VA to disclose all state licenses held but then not verifying that all are in good standing?

Dr. MURPHY. We've already responded, Mr. Chairman, that we believe that that is a gap in our current practices, and we intend to correct that by verifying all state licenses, certificates, and national certificates.

Mr. BUYER. How do the facilities know which databases to query? How do they know which ones to go to? I'm going to go to the directors here in just a second, but I just wanted to ask you.

Dr. MURPHY. For independent providers, the process is actually standardized through the VetPro and credentialing process. There are VA policies that prescribe the process for the other provider categories. As has been previously mentioned, those are not as standardized, and we don't have computerized tools to ensure that that process is uniformly and consistently implemented across the country at this point. And that is one of the issues that the task force has been asked to address and to provide us recommendations on how we can improve the tools that we give our give our facilities so that they can actually accomplish the work that's prescribed in VA policy.

Mr. BUYER. Why—and I'm going to open this up to all three of you—why was the Federal Credentialing Program dismantled?

Dr. MURPHY. I think probably HHS is best able to answer that.

Ms. GRUBBS. One of the reasons was, or the most prevalent reason is because the participants that we did have were consumed by the Homeland Security, Department of Homeland Security. And once they went over to that new department, those groups were basically dismantled and put into new groups. And because they had

a different focus and a different priority at that time, we couldn't keep the Federal Credentialing Program alive economically.

Dr. MURPHY. Could I add to that?

Mr. BUYER. Sure.

Dr. MURPHY. From a VA perspective, the important components to our system have not been dismantled. We have adopted the VetPro software. We continue to use that in exactly the same way that we did under the Federal Credentialing Program.

That benefit, however, is not being applied to the other partners who were previously using the credentialing program. And so if you're concerned that the dismantling of the Federal Credentialing Program has had a negative impact on VA, it has not. We have continued just as strong a commitment and have continued to use the software in exactly the same way.

Mr. BUYER. All right. I'd like to receive testimony from the directors of the four hospitals. Have you had an opportunity to review the GAO report, all four of you? All four nod their head in the affirmative.

With regard to the GAO's criticisms, constructive, and with regard to how they've charted to indicate compliance and noncompliance, I would like to give each of you the opportunity to discuss the findings of the GAO report and what actions, if any, have you taken subsequent at their visit. This is your opportunity to, I view, rehabilitate yourself. So we'll start with Seattle first.

We'll slide the chair up one at a time.

Mr. WILLIAMS. Excuse me. Tim Williams from Seattle. The criticisms from the GAO, one of the areas that they identified that we were lacking in was looking at applicants for—doing a thorough review of applicants. What we think is that if you look at the definition of that, I think it's a definitional issue. But as we have serious applicants for positions, we are doing complete background checks on that.

If we were to go to doing security checks on and full background checks on all applicants, we hire one out of every 30 applicants. For instance, police officers. We may get 100 applicants for a single job. So I think that by doing the full background check on those people prior to—those that are serious applicants—prior to the hiring, we're actually in compliance with the intent of the screening all applicants. So I think that we're there for that.

The other area on the table that we didn't come up to the 90 percent on had to do with looking at the license problems. And my human resources, along with my people in the medical service office have created that hole as a result of that and are filing those more rapidly. So.

Mr. BUYER. You should, in the area of transparency, sir, you should know that GAO felt that you were very responsive at the Seattle facility. So I want to thank you for that.

Mr. WILLIAMS. Thank you.

Mr. BUYER. Next? DC?

Mr. WILLIAMS. Dr. Murphy has asked that I just say a few words about our fingerprinting program that we have.

Mr. BUYER. All right.

Mr. WILLIAMS. Because we are fingerprinting everyone —all of the residents, all of the medical students, all of the volunteers, ev-

erybody that comes into our facility that isn't a patient, to do the $21 background check that gives us a criminal background check on all of those people.

Because the digital equipment is portable, we're able to take it over to the university, and that's what we do is take it over to the university. And a question came earlier about the number of residents that we do have rotating through the facility, and on an annual basis, I have 500 medical residents that rotate through the facility, and we go over to the university and get them prior to their rotations through our facility and do the background checks in advance of their coming to our facility.

Mr. BUYER. How long have you been doing that?

Mr. WILLIAMS. I beg your pardon?

Mr. BUYER. How long have you been doing this?

Mr. WILLIAMS. We've been doing that for about a year. It has now been adopted for our VISN, our complete Veterans Integrated Service Network, has embraced this, and we have bought the equipment. And by October, all of the facilities in the VISN will be fully utilizing this program.

Mr. BUYER. All right. Thank you.

Mr. WILLIAMS. You're welcome.

Mr. BUYER. DC, please reidentify yourself and your facility.

Mr. GARFUNKEL. Sorry, sir? Reidentify myself? I'm Sandy Garfunkel, Director of the VA hospital here in DC. I think—I guess in answer to your first question, I think the recommendations in the report are good recommendations that will help us.

I've already, I think—I hope—mentioned that we had fallen behind in our background investigations. I want to tell you as of now, we have fingerprinted all of our employees and begun background investigations. So we're in complete compliance there.

We have not yet started to do our medical residents, and we've discussed how we will go about that. We have three medical schools. We're the only VA affiliated with three medical schools, so it's a complex issue for us, but we're going to find a way to do that. We do have the electronic equipment, and we'll probably need more of it to begin to do that.

The list of exclusionary individuals, I sent an individual yesterday into HR to take a look at the last 30 hires we had, and we were in 100 percent compliance at this point with the list of excluded individuals. So corrective action has been taken on both of the deficiencies that were found.

Mr. BUYER. Did you find any employees working at the VA who should not be there employed because of your background checks?

Mr. GARFUNKEL. We did. I did in fact terminate an employee recently because of a problem that was found on the background check, but surprisingly few——

Mr. BUYER. What was it?

Mr. GARFUNKEL. I honestly can't recall exactly what it was, sir. I can get you that information if you'd like. But surprisingly few.

Mr. BUYER. Go ahead and remain in your seat. With regard to Seattle, when you went back—you were in compliance weren't you?

Now when you went back and looked in Seattle, did you find anyone that was noncompliant or should not be employed in the VA?

Mr. WILLIAMS. No, we did not. We found some volunteers, but we did not find employees.

Mr. BUYER. Some volunteers?

Mr. WILLIAMS. Yes.

Mr. COX. I'm William Cox, Acting Director of Big Spring VA Medical Center.

Mr. BUYER. Wait. Time out. Volunteers. What were these individuals doing at the VA who are volunteers of whom you found should not have been there with regard to your background check?

Mr. WILLIAMS. These are volunteers who escort patients from one clinic to another or, you know, move—read to patients, provide coffee, that sort of thing.

Mr. BUYER. All right.

Mr. WILLIAMS. They're not providing medical care.

Mr. BUYER. Right.

Mr. WILLIAMS. Nobody who was providing medical care.

Mr. BUYER. But these individuals, I mean, you're not going to shock me here all of a sudden? These were individuals who were abusive to people or had been arrested for battery and are now caring for our veterans?

Mr. WILLIAMS. No. No, they're not.

Mr. BUYER. All right. Thank you. I don't need to get into the details of it. I just don't want to be shocked. Thank you, sir.

Mr. COX. William Cox, Acting Director of the Big Spring VA Medical Center. With regards to the audit and study itself, I think it was positive in the fact that it has identified some gaps and opportunities for us to improve our processes.

At Big Spring, I know we've taken the information and have looked at opportunities on how we can improve from this. One area is in the area is staying current with the background checks and looking at fingerprinting of volunteers that have access to patient care information.

So we're looking at the study as an opportunity to improve our processes.

Mr. BUYER. Now you've not been in this position all that long, correct?

Mr. COX. That's correct. I've been there 3½ months.

Mr. BUYER. I will exercise self-restraint because of the—well, I'm going to exercise self-restraint. You're a new medical director. My criticisms would be lobbed at those of whom came before you, and some of these individuals of whom are still there, which means you have to exercise some pretty stern leadership, and for that, we give you the opportunity.

Mr. COX. Thank you.

Mr. BUYER. All right. Next?

Dr. ROSENFELD. Mr. Chairman, I'm Dr. Paul Rosenfeld. I'm the Chief of Staff at the VA Medical Center in New Orleans. I'm here for my Medical Center director, who is ill.

At the New Orleans Medical Center, we actively use the list of exclusionary individuals for all our licensed independent practitioners, and that was pointed out to us as a best practice by the GAO.

We did have problems in the audit with background checks being completed on time. I can now report to you that all those back-

ground checks have been done and have been completed and are up to date at this time.

Mr. BUYER. Did you find anything shocking?

Dr. ROSENFELD. No we did not, sir. We found a few things, but nothing that would be—nothing in any practitioners.

Mr. BUYER. Good. Not to be redundant, it's very unusual that this subcommittee bring the medical directors, or you in particular, sir, the chief of staff here to Washington, DC to testify.

Too often in this subcommittee what we find is, is we bring in the hierarchy of the VA and we question them and they answer. They're very responsive. We turn to the GAO, they jump into the high weeds, come back and give us the reports. But here in particular, while the criticisms are easy to say that there's been lack of oversight at the headquarters of the VA, it all goes back—it goes down to somebody, and it is the medical directors.

We're not picking on you here today. We've invited you here because the GAO found some of these noncompliant issues for we take very seriously, and I know you do, too, and there's a lot of things that you're working on, and you've got a pretty broad—the waterfront is very broad.

But I want you to know, these are very important to us. And the fact that we've brought you here, we also recognize will send a tremendous signal across the spectrum of the VA facilities.

So I don't want it to be that you were brought here for us to beat up on you. You were brought here for an opportunity to respond to the GAO's findings, to tell us what you're doing to bring yourself into compliance, at the same time sending the signal across the VA system.

We won't hesitate to bring in the medical directors, even to go to that particular level, not that we micromanage, but this subcommittee, being the oversight subcommittee, I think we're tasked to do that, okay? And that's the reason we brought you in here.

So, Dr. Murphy, I don't mean to go around you here today. I have tremendous respect for you over the years. But that's the reason you're here.

Did any of the four of you—I know you talked about your compliance—any of the four of you have disagreements with regard to the analysis or findings from the GAO? None of you? All right. Very good.

Mr. Udall, did you have any follow-up? Let me yield to Mr. Udall for any follow-up he may have.

Mr. UDALL. On the GAO report, I'm first going to go to Ms. Bascetta and then to the directors here. If you look at your graph on I guess this is page 1 of your report where you have the chart and the black dots and the clear dots, it's very, very clear that three out of four of these facilities verified credentials for practitioners they intended to hire, and three out of four of them did not, did not verify for people they intended to hire, and yet when you get to credentials verified for practitioners currently employed at the VA, you have 100 percent.

And I'm wondering, what's the difference there? Why are they able to verify 100 percent and do well for the people they have, and yet they fall down on the people they're going to hire, that are going to be brought into the system?

Ms. BASCETTA. First let me just clarify that the black dots don't mean 100 percent. They mean 90 percent or better.

Mr. UDALL. Thank you. Thank you for that correction. Ninety percent or greater.

Ms. BASCETTA. But part of the reason is that remember that our finding about this requirement is that it's less stringent. They are not going back to the state licensing boards or the national certifying organizations. They are doing a visual inspection of the credential. So it's an easier requirement to meet.

Mr. UDALL. And then that's the sole explanation of why these facilities all except for one don't get a very good ranking here?

Ms. BASCETTA. Well, that would be my explanation. I would be interested to hear what their views are about the difference between those two processes.

Mr. UDALL. Could you tell us—the only facility that was able to verify for practitioners it intends to hire was the DC facility. Texas, New Orleans, Seattle, you're listed as less than 90 percent. And I'd first ask Ms. Bascetta, you have—it's less than 90 percent. Are there some of them that are down at 50 percent or 30 percent? I mean, is there a difference here? Are we talking about just below 90? Is there a difference in these three facilities?

Ms. BASCETTA. No, there was a pretty broad range, and many were well below the 90. In fact because of the way we did the statistical test, those who were close to 90 were bumped up into the compliant range.

Mr. UDALL. Okay. Could Texas and New Orleans and Seattle tell me what the problem is there?

Dr. ROSENFELD. Sir, I think again, the distinction between a licensed——

Mr. UDALL. Sir, you're going to have to reidentify yourself so we can get the record clear.

Dr. ROSENFELD. I'm sorry. Paul Rosenfeld, Chief of Staff in New Orleans. There is difference between licensed independent practitioners and other practitioners, the distinction between the various groups in the chart.

For the Group A practitioners, the licensed independent practitioners, we do primary source verification on all people that we intend to bring on.

For other practitioners, for the Group C practitioners, following the VA regulations, we only view the license. We agree that that's a problem, and as Dr. Murphy has testified, in the future the plan is that we will do primary source on everyone.

Mr. UDALL. And how soon are you going to do that in your facility?

Dr. ROSENFELD. As soon as we can make it happen. So I can't give you a time, but as soon as we can make it happen.

Mr. UDALL. Okay. Thank you.

Mr. WILLIAMS. Tim Williams, VA Puget Sound Health Care System. And I think that we've got two things. One is definitional. And we believe that for those that become selectees that we are doing greater than 90 percent. In fact, my human resources people tell me 100 percent of background checks on those people who get to the point where we are going to hire them.

But earlier in the process, we do not do a complete background check.

Mr. UDALL. So you wouldn't agree with how the GAO has listed you here?

Mr. WILLIAMS. As I say, I think it's a definition. The way they did it, it's correct. We think that before they get to actually see patients, we have gotten 100 percent verification on that.

Mr. UDALL. Ms. Bascetta, do you have any comment on that?

Ms. BASCETTA. Well, we know that the requirement is not to do the background investigation until the employee is hired. I think that the open dot here for Seattle is actually in verifying the credential, not doing the background investigation.

Mr. WILLIAMS. We do—well, we do check all of the—we use VetPro to verify credentials. We go back to the source, the universities. I'm not sure why it fell below 90 percent, but we believe we've got the processes in place and have as a result of the visit from the GAO, tightened the procedures that we have in place.

I have three people in a credentialing office that this is their full time position. We actually have a police officer now, because that individual is able to look at issues a little differently and has stopped the hiring of some folks just because of the additional skills.

So I think that we've got the personnel in place and the processes in place such that this will not happen.

Mr. UDALL. Thank you. As of today?

Mr. WILLIAMS. That's correct.

Mr. UDALL. Yes. Okay. And just to finish the last one.

Mr. COX. William Cox, Acting Director of Big Spring VA Medical Center. It looked like we were about 75 percent compliant, which is not good enough, and we should be making improvements.

I would like to take this data back and review the areas where we fell short. Like Mr. Williams, we have full time staff that are dedicated to this area, and obviously, we need to do a better job. So I will take the information, go back and verify where we fell short.

Mr. UDALL. Thank you. Thank you, Mr. Chairman.

Mr. BUYER. Thank you, Mr. Udall, for your contributions. Ms. Grubbs, thank you for coming, and your staff and helping you also prepare for today's testimony.

Dr. Murphy, as always, appreciate it, along with the medical directors for coming. I extend my appreciate to your staff, Ms. Bascetta, as always. Please extend also to your staff good job. Another well written report and a tremendous contribution.

I note, Dr. Murphy, that you've extended some promises here in the April and May timeframe. What I will do, though, is I'd like to ask GAO to continue to monitor all of the remedies and these hard milestones to make sure that the VA fixes this problem.

And obviously the bottom line here is no one, none of us I know in this endeavor want to re-live the hideous example with regard to Dr. Swango. And that is awful, that is cruel. And somewhere the system failed us, and we never want that to happen again.

So thank you very much. This hearing is now concluded.

[Whereupon, at 12:06 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN BUYER

Good Morning. The purpose of today's hearing is to review the Department of Veterans Affairs' current employment practices with regard to its procedures for personal background checks and credentialing of its health care practitioners.

In the past the Oversight Subcommittee has touched upon this subject in several hearings, however because there have been repeated serious lapses in the system over the years, we believe this issue warrants further scrutiny. In fact, there are several high profile cases which illustrate why it's so important to insure that VA has an effective policy in place. One of the most compelling examples involves a Dr. Michael Joseph Swango. In 1993, even though he had a criminal record, Dr. Swango was able to secure a medical residency at the VA facility in Northport, New York. Dr. Swango is currently in prison serving three consecutive life sentences for murdering three veterans at the Northport facility. The question is: At the present time, could someone like Dr. Swango avoid detection and be successful in gaining employment with the VA?

I believe we all recognize that such lapses do not happen solely in the VA, but in my role of providing oversight over the Department of Veterans Affairs, issues affecting the safety of veterans are my major focus.

Let's look at what the VA's Office of Inspector General was able to detect through its fugitive felon program that was initiated in 2001. Using the VA benefit system files, the IG was able to identify 9,700 matches for referrals to law enforcement agencies. In addition, over 6,500 fugitive felons identified in these matches have been referred to the Department for benefit suspension. Due to these identifications, 35 VA employees were arrested. Twenty nine other employees were identified as fugitive felons, but were not arrested because they were non-extraditable. They have been referred to the Veterans Health Administration for possible administrative action.

If any of us here today find ourselves in the position of having to seek medical care, we deserve to be treated by health care practitioners who have completed the necessary educational requirements, have passed the boards and are licensed to practice. Veterans deserve to have this same level of confidence when they enter a VA medical facility.

Today's hearing will show that the VA has been working diligently to improve its credentialing and background checks of applicants seeking employment with the VA.

However, there are several issues that need some clarification. One such issue involves VA's credentialing program called VetPro. For instance, I wonder if VetPro is working as envisioned. I also wonder why the Federal Credentialing Program initiated by VA and HHS, under whose auspices VetPro was developed and maintained, was dismantled last fall. While representatives of the VA have stated publicly that VetPro is an excellent tool for verifying credentials, I also wonder why the GAO was silent on VetPro in its report. I find it perplexing that such an omission would be made since this is one of chief mechanism used by VA to verify credentials of physicians and dentists. Hopefully, both VA and HHS will shed some light on this.

The VA has several key screening requirements in place for verification of credentials and to investigate personal backgrounds of health care practitioners. These checks include querying the Federation of State Medical Boards (FSMB), the National Practitioner Data Bank (NPDB), the List of Excluded Individuals and Entities (LEIE), and, on a limited basis require finger printing and a background check, which is performed by the Office Personnel Management.

Today's witnesses include the Department of Veterans, the Department of Health and Human Services and the General Accounting Office. When I spoke with the

American Medical Association yesterday about its decision not to testify, I was assured that the AMA will send a representative to hear our concerns. I have also asked them to provide a written statement and respond to post hearing questions, which will be made part of the official record. It would have benefited this Subcommittee to hear AMA's position on physician credentialing and its interaction with the federal and private health care sectors during the hearing.

INSPECTOR
GENERAL

VA OIG
CASE OF 2000

For 7 years, VA OIG agents and healthcare inspectors, along with the Office of the U.S. Attorney and the FBI worked to put Dr. Michael J. Swango permanently behind bars. On September 7, 2000, Swango pleaded guilty to the murder of three veterans in his care at VA Medical Center (VAMC) Northport, NY. He was sentenced to three consecutive life terms without the possibility of parole for the VAMC murders.

From a book, "Torture Doctor," Swango copied:
'He could look himself in a mirror and tell himself that he was one of the most powerful and dangerous men in the world . . . he could feel that he was like a god in disguise.'

Doctor Who Killed

Sentenced to life after guilty plea in 3 VA deaths

The Ohio Murder and Assault

Michael Swango graduated from the Southern Illinois University Medical School in 1983 and began the internship program at Ohio State University Hospital upon his graduation. As spelled out in the indictment, while working as an intern at Ohio State University Hospital in January 1984, Dr. Swango murdered Cynthia McGee by injecting her with a lethal dose of potassium. In February 1984, he assaulted his patient, Rena Cooper, by injecting her with a poisonous substance. She survived the attack. After that assault, Ohio State University Hospital removed

Dr. Swango from the residency program, and in 1985 Ohio authorities commenced a murder investigation into his activities. Although that investigation did not result in the filing of charges against Swango, he did learn of the investigation and concealed the fact that he was investigated for murdering patients from the other hospitals that subsequently hired him.

Adams County Ambulance Service

In 1985, Swango began employment at the Adams County, Illinois, Ambulance Service as an emergency medical technician. According to the indictment, he poisoned several of his co-workers there with arsenic. They later recovered and he was tried and convicted of aggravated battery. He was sentenced to a 5-year term of imprisonment.

Northport Murders and Assault

Several years after his release from an Illinois prison, Swango sought admission to several medical residency programs. In 1992, he was hired by the University of South Dakota and assigned to work as a resident at the VAMC Sioux Falls, South Dakota, after he falsified facts about his prior criminal conviction. Swango was discharged from the program after hospital administrators became aware of the facts surrounding his conviction and his activities at Ohio State University Hospital.

In 1993, Swango applied for and obtained a position as a medical resident at the State University of Stony Brook Medical School, which ran a residency program at VAMC Northport. During the application process, he misrepresented that his criminal conviction in Illinois stemmed from a barroom brawl; a false statement that ultimately led to his conviction and incarceration on Federal charges.

Thereafter, Swango murdered George Siano, Aldo Serini and Thomas Sammarco, while all three were patients at VAMC Northport. Swango killed all three patients by administering injections of toxic substances. In addition, Swango also injected a poison into another patient at the hospital, Barron Harris. Mr. Harris survived the incident.

In October 1993 Swango was discharged from his residency at VAMC Northport, and was later charged with making a false statement to Federal officials and improper use of controlled substances in connection with his employment there. Before those charges were filed however, he fled the United States and was hired as a physician at the Zimbabwe Association of Church Hospitals.

VA OIG, FBI and Federal Prosecutors speak to the press outside the U.S. District Court House in Central Islip, NY following the conviction of Dr. Michael Swango for the murder of three veteran patients at the Northport VA Medical Center.

The Zimbabwe Assaults

On May 14, 1995 and July 7, 1995, respectively, Swango administered injections of toxic substances into his patients Kenias Mueaza and Virginia Sibanda, both of whom were under his care at Mnene Hospital in Zimbabwe, Africa. Both survived Swango's attacks. Swango was suspended from practice at Mnene Hospital in July 1995.

Saudi Arabia

In 1997, as a result of false statements, Swango obtained employment as a physician through KAMA Enterprises, Inc., an employment agency in Portland, Oregon, and was assigned to work as a physician at the Royal Hospital in Dharan, Saudi Arabia. In June 1997, Swango was arrested in a Chicago airport on his way from Africa to Saudi Arabia, to begin his employment there. He was arrested for the false statement and controlled substance charges that had been filed in the Eastern Judicial District of New York.

Making the Case

While Swango was imprisoned on this charge, VA OIG investigators and healthcare inspectors, FBI agents, and U.S. Attorneys had limited time to find the evidence to make the case for the three deaths which happened in a federal facility. Extensive review of records, laboratory studies, and interviewing witnesses in the United States and Africa took thousands of hours. In that effort, the team received the full cooperation and support from the management and staff at VA Medical Center Northport, NY.

The Guilty Plea and Sentence

Faced with the possibility of a death sentence, Swango pleaded guilty to the murder of the three veterans in New York and was sentenced to three consecutive life terms without parole.

VA IG Richard Griffin and U.S. Attorney Loretta Lynch

"Through a web of lies and deception, Michael Swango inveigled his way into the confidence of hospital administrators across the country and the world. Once in their trust and employ, he utilized his skills to search for victims and take their lives. This case is the result of the hard work and diligent efforts of not just this office but of the Federal Bureau of Investigation and the Department of Veterans Affairs Office of Inspector General, who were determined that Swango be held accountable for his actions and not be allowed to victimize others. I thank both of those agencies for their dedication and determination in investigating this matter, across the years and the globe. We extend our deepest sympathies to the victims and their families."

Loretta E. Lynch
United States Attorney

U.S. Department of Justice

United States Attorney
Northern District of New York

445 Broadway
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October 30, 2003

PRESS RELEASE

United States Attorney Glenn T. Suddaby announces the return of an indictment by a federal grand jury for the Northern District of New York in Albany, New York, charging Paul H. Kornak with making false statements, mail fraud, wire fraud, involuntary manslaughter, and criminally negligent homicide.[1] Kornak, 52, resides in Cliffton Park.

The indictment charges that Kornak made a false statement in his application to work for Stratton Veterans Affairs Medical Center in Albany, and in the resume he submitted with that application; engaged in a scheme to defraud which involved the use of the mails and wire communications, as well as deprivation of his honest services; falsified documents in connection with the participation of patients in clinical trials for drugs and treatments; and caused the death of James J. DiGeorgio by causing him to be administered chemotherapeutic drugs as a part of a study when Mr. DiGeorgio did not meet the criteria for participating in the study and had impaired kidney and liver function.

The indictment charges:

[1] An indictment is merely an accusation and the defendant is presumed innocent until and unless proven guilty.

- Beginning in February of 1999, Kornak was employed by Albany Research Institute, Inc., initially as a Research Assistant and then as Study Director of VA Cooperative Studies. The Albany Research Institute, Inc., is a non-profit research and education corporation established to conduct research projects and education activities in connection with the Stratton VA Medical Center. Beginning in October of 2000, Kornak was employed by the Department of Veterans Affairs as a Program Specialist at Stratton VA Medical Center. His duties in this position included coordination of research protocols.

- In his application for federal employment (August 15, 2000), Kornak falsely said he had not been convicted or on probation, for he had been convicted of mail fraud, in United States District Court for the Middle District of Pennsylvania, case number 1:CR-92-278, on December 16, 1992, and, on April 23, 1993, placed on probation for 3 years (which continued until November 8, 1995). Kornak also submitted a false resume setting forth that he had attended the College of St. Rose 1970-1974; attended Ross University School of Medicine 1981-1985; and worked as an Anesthesiologist and Pharmocology Research Associate at Albert Einstein College of Medicine/Montefiore Medical Center 1993-1999, though the truth is that he had attended the College of St. Rose 1972-1974 and had falsified a transcript reflecting his performance there; attended Ross University School of Medicine 1984-1985 but attended St. George's University School of Medicine 1982-1984, when he was dismissed for falsifying transcripts; and resigned from his positions at Albert Einstein College of Medicine/Montefiore Medical Center in 1993 and worked elsewhere 1995-1999.

- The Stratton VA Medical Center has been designated as a Comprehensive Cancer Center, and has participated in several clinical studies of drugs for the treatment of cancer, including:

  - A study sponsored by Aventis Pharmaceuticals, Inc., for the treatment of gastric

cancer with docetaxel (brand name taxotere) in combination with cisplatin and/or 5-flourouracil, known as Tax 325;

- A study sponsored by Aventis for the treatment of prostate cancer with docetaxel and prednisone, known as Tax 327; and,
- A study co-sponsored by ILEX Oncology, Inc., and the National Cancer Institute, Division of Cancer Prevention into the use of difluoromethylornithine (DFMO) to treat bladder cancer.

- The Stratton VA Medical Center also participates in the Cooperative Studies Program of the Office of Research and Development of the Department of Veterans Affairs, including the Iron (Fe) and Atherosclerosis Study (AST), known as FeAST, a clinical trial testing a new procedure for controlling atherosclerosis, also known as hardening of the arteries, by reducing iron in the body through blood drawing.

- Kornak was the site coordinator at the Stratton VA Medical Center for Tax 325, Tax 327, the DFMO study, and FeAST.

- In connection with these studies, Kornak made and used, or caused to be made and used, false laboratory reports, radiology reports, electrocardiogram (ECG) reports, patient records, and forms, falsely reflecting the dates and results of analysis, including substituting the report pertaining to one patient for another, deleting or altering information that might disqualify a patient from participation in a study, and changing dates to come within prescribed time constraints.

- The Albany Research Institute and Stratton VA Medical Center were paid for patients participating in these studies. Documents reflecting patient participation and payment for that were sent through the mails and private interstate carriers or by wire, such as fax or electronic transfer.

- The inclusion criteria for Aventis' Tax 325 study protocol included requirements that each

patient had levels of creatinine, total bilirubin, AST (SGOT), and alkaline phosphatase within specified levels, and set a minimum calculated creatinine clearance. Kornak falsified a form and a report reflecting these levels for James J. DiGeorgio on May 25, 2001, substituting levels which met inclusion criteria for the actual levels, which did not. The actual levels showed impaired kidney and liver function which disqualified Mr. DiGeorgio from receiving the chemotherapeutic drugs docetaxel, cisplatin, and 5-FU in connection with Tax 325. Chemotherapy thus began on May 31, 2001, and Mr. DiGeorgio died on June 11, 2001.

Kornak's arraignment is scheduled for Monday, November 3, 2003, at 1:30 p.m., before Hon. Randolph F. Treece, United States Magistrate Judge.

The maximum potential penalties for each count principally are:

- False statements and documents – imprisonment for 5 years and a $250,000 fine;
- Mail fraud or wire fraud – imprisonment for 20 years and a $1,000,000 fine;
- Involuntary manslaughter – imprisonment for 6 years and a $250,000 fine; and,
- Criminally negligent homicide – imprisonment for 4 years and a $250,000 fine.

The investigation is being conducted by the Office of the Inspector General of the Department of Veterans Affairs and the Food and Drug Administration. The case is being prosecuted by Assistant U.S. Attorneys William C. Pericak and Grant C. Jaquith.

PREPARED STATEMENT OF CONGRESSMAN EVANS

Thank you, Mr. Chairman. Cases in the VA and in the private sector highlight what can go wrong when an individual's health care credentials are not checked carefully, and background checks are not performed with rigor.

Thorough background checks may have prohibited the harmful and criminal acts of Dr. Swango that are mentioned in the GAO testimony. Identifying "bad apples" and screening them out will help build a more responsible VA health care system. It will help keep veterans secure from harmful or careless actions.

Additionally, we must strengthen vigilance by those within the VA health care system with access to veteran patients. It is possible for those who enter the system with good credentials and clean backgrounds to just go bad. They try to inflict harm on those in their charge. The system must be responsive to detect such occurrences.

For example, effective screening may not have detected the problems Kristen Gilbert, RN was to cause in the Northhampton, Massachusetts, VA acute care medical unit. Ultimately, she was convicted of three counts of first degree murder, one count of second degree murder and a host of other charges. She was sentenced to four consecutive life sentences without the possibility of parole.

The point is that screening and credentialing are important, but solutions to the problem do not stop at that point. Thank you, Mr. Chairman, I look forward to hearing from the witnesses this morning.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services Administration

Rockville MD 20857

Cynthia Grubbs

Director

Office of Policy and Planning

Bureau of Health Professions

Health Resources and Services Administration

U.S. Department of Health and Human Services

before the

Subcommittee on Oversight and Investigations

Committee on Veterans' Affairs

U.S. House of Representatives

March 31, 2004

Good Morning. I am Cynthia Grubbs, the Director of the Office of Policy and Planning, Bureau of Health Professions, Health Resources and Services Administration, U.S. Department of Health and Human Services. I am here to speak with you today on the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank and the Federal Credentialing Program.

The Health Resources and Services Administration (HRSA) -- often referred to as the "access" agency -- provides medical care and social services to millions of low-income Americans, many of whom lack health insurance and live in remote rural communities and inner-city areas where health care services are scarce. We work in partnership with States and local communities. One of our operating bureaus, the Bureau of Health Professions, invests in programs to help make sure that all areas of the nation and all segments of the population have access to skilled health care professionals. In conjunction with these tasks, responsibility for the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank is assigned to that Bureau.

The National Practitioner Data Bank (NPDB) was created in response to the requirements of the Health Care Quality Improvement Act of 1986 and plays a vital role in the important process of health care practitioner credentialing. It provides verification of sensitive adverse information about health care practitioners in an efficient and reliable manner, while at the same time maintaining the security and confidentiality required by law. Authorized users of the NPDB include State licensing boards, hospitals, managed care organizations, other health care entities and professional societies. Hospitals are required to submit queries regarding staff practitioners every two years and/or each time they hire, affiliate or grant privileges to a practitioner. The NPDB receives adverse information on licensure, adverse clinical privilege, and professional society actions taken against physicians and dentists from the required reporting by licensing boards, hospitals, and other health related entities. The NPDB also receives information on medical malpractice payments, Drug Enforcement Administration actions and Medicare/Medicaid exclusions taken against physicians, dentists, nurses, and other health care practitioners. Let me be clear that the NPDB does not contain information on all health care practitioners, only those practitioners who have had an adverse action taken against them.

NPDB data is intended to supplement a comprehensive and careful professional peer review. The Data Bank is used by entities to verify information the practitioner submits in his or her application for privileges, licensure, or affiliation. Currently, for example, when a practitioner applies for employment or for admitting privileges, the hospital asks the practitioner for a complete practice history including any malpractice payments or adverse actions. A query of the NPDB then verifies the information about malpractice payments and adverse actions for the hospital, or it discloses information to the hospital that the practitioner may have failed to include in the application.

The NPDB is now considered essential to the process of privileging and credentialing. Its value has been documented by surveys of Data Bank customers. Additionally, the NPDB along with its companion system, the Healthcare Integrity and Protection Data Bank (HIPDB), was recognized this year as among the "Top 5" information technology achievements in the public service arena by *Excellence.gov*, an annual awards program that honors computer innovation in the Federal government. Major accrediting organizations, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee for Quality Assurance (NCQA), have endorsed the value of the NPDB by strongly encouraging, and in some cases requiring, organizations they accredit to access the NPDB in the credentialing process.

The NPDB is not funded by taxpayer dollars, but entirely by user fees. The NPDB currently covers its costs through fee collection and has done so successfully for nearly fourteen years. The current $4.25 query fee is substantially lower than fees charged for databases of similar, though much less complete, information. Through fee collection, the NPDB is able to provide information within hours to requesters using the latest technology to maximize speed, convenience, and security, while minimizing financial burden to its customers and not imposing any burden on the U.S. taxpayers.

NPDB Aggregate Data

At the end of calendar year 2003, the NPDB contained 344,708 reports on individuals. It received 3,256,295 requests for information in 2003. Of those requests, 445,004 matched information contained in the NPDB for a match rate of 13.7 percent.

HIPDB

The Healthcare Integrity and Protection Data Bank (HIPDB), created as part of HIPAA of 1996, commenced operations in late 1999. The purpose of the HIPDB is to combat fraud and abuse in health insurance and health care delivery and to promote quality care. The HIPDB is primarily a flagging system that may serve to alert users that a more comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. Like the NPDB, HIPDB information is intended to be used in combination with other sources (e.g., evidence of current competence through continuous quality improvement studies, peer recommendations, verification of training and experience, relationships with organizations) in making determinations in employment, affiliation, certification, or licensure decisions.

Health plans and Federal and State agencies are required under Section 1128E of the Social Security Act to report adverse actions taken against health care providers (HMO, PPO, Group Medical Practice), health care suppliers (Durable Medical Equipment, Manufacturers, Pharmaceutical, Insurance Producers) and health care practitioners (nurses, podiatrists, psychologists, etc.) to the HIPDB. The HIPDB collects healthcare-related criminal convictions and civil judgments entered in Federal or State court, Federal or State licensing and certification actions, exclusions from participation in Federal or State health care programs, and other adjudicated actions or decisions that the Secretary has established by regulation, such as certain contract terminations taken by health plans. These same organizations, Federal and State agencies and health plans, access the HIPDB for information.

The HIPDB provides another resource to assist Federal and State agencies, State licensing boards, and health plans in conducting extensive, independent investigations of the qualifications of the health care practitioners, providers, or suppliers whom they seek to license, hire, credential, or with whom they seek to contract or affiliate.

The information in the HIPDB serves only to alert Government agencies and health plans that there *may* be a problem with a particular practitioner's, provider's, or supplier's performance. HIPDB information is not used as the sole source of verification of a practitioner's, provider's or supplier's professional credentials.

HIPAA requires that the HIPDB's operation be funded through user fees charges to health plans and other private entities that are authorized to query the database. These fees have not

generated sufficient revenue to fully fund the database's operations. To meet the statutory mandate to operate the HIPDB, HHS has supplemented the user fee collections with funds from the Health Care Fraud and Abuse Control (HCFAC) account.

HIPDB aggregate data

At the end of calendar year 2003, the HIPDB contained 159,995 reports on individuals and 3,758 reports on organizations. Of the reports on individuals, 21,787 were on physicians and dentists, 21,731 were on registered nurses, and 15,031 were on licensed practical nurses or vocational nurses. Pharmacists constituted 4,785 of the reports, chiropractors were 3,532 of the reports, nurses' aides were 11,804 of the reports, and psychologists represented 1,203 of the reports. The HIPDB received 872,211 queries in calendar year 2003. Of those requests, 10,028 matched on information contained in the HIPDB for a match rate of 1.1 percent

VA and the Data Banks

In terms of the use of the Data Banks by the Department of Veterans Affairs, the VA facilities use both the NPDB and HIPDB. As mandated by the NPDB's implementing legislation, a Memorandum of Understanding (MOU) between the VA and HHS governs the VA's interactions with the NPDB. The provisions of the MOU are intended to mirror the requirements the legislation places on the private sector. VA facilities submitted 31,750 queries and 119 reports to the NPDB in 2003. Of those queries, 25,612 were submitted on physicians and 6,138 queries were submitted on other practitioners. The VA has submitted 349,223 queries and 940 reports since the NPDB commenced operations in 1990. For HIPDB, VA is specifically mentioned in the statute as a mandatory reporter and a voluntary requester of the information. In 2003, VA facilities submitted 30,836 queries and 1 report to the HIPDB. Of the queries submitted in 2003, 24,958 were submitted on physicians and 5,871 were submitted on other practitioners. Under the provisions of the HIPDB statute, VA facilities query the HIPDB for free.

DoD also uses the NPDB and the HIPDB as part of its credentialing process. DoD submits queries to the NPDB and HIPDB, as well as, reports adverse actions to the data banks on its health care practitioners.

Federal Credentialing Program

The Federal Credentialing Program (FCP) was developed to replace paper-based credentialing processes with electronic storage techniques for easier retrieval of credentials and faster communication of credentialing information in the Federal Government. In 1997, the Department of Veterans Affairs, Veterans Health Administration (VHA) and the Department of Health and Human Services (HHS)/Health Resources and Services Administration signed an inter-agency agreement establishing a formal partnership to develop an electronic credentialing database for the vetting of the VA's health care professionals.

In partnership, HHS and the VA determined that a certified, trusted electronic system would result in better credentialing and efficiency. The resulting software application, VetPro (i.e., to vet (evaluate) in a Peer Review Organization) allows providers to enter credentialing information such as education, licenses, and work history into an electronic, web-based system. A credentialer through primary source verification in accordance with appropriate accreditation standards authenticates the data. In addition, the system shares an interface with the NPDB/HIPDB to allow for seamless querying to the Data Banks. Once verified, the data may be stored electronically for subsequent retrieval. Information about health care professionals contained in these databases is very sensitive, and the Agencies administer the data consistent with all applicable security and privacy requirements.

By 2001, the FCP was used by the VA in all of the 172 facilities in its health care delivery network. By 2003, the U.S. Public Health Service, Office of Emergency Preparedness, Immigration and Naturalization Service, National Aeronautics and Space Administration, and the National Health Service Corps had entered into one-year interagency agreements to participate in the FCP.

However by 2003, the landscape of the Federal government had changed. The Office of Emergency Preparedness and the Immigration and Naturalization Service were transferred to the U. S. Department of Homeland Security. The Division of Commissioned Personnel's internal business processes changed, which eliminated their need of the FCP. These three Federal organizations no longer participate in the FCP.

For these reasons, in October 2003, HRSA transferred responsibility for management of all FCP-related activities, including the VetPro software, to the VA, where we understand the system continues to operate effectively.

Thank you for the opportunity to inform you about the NPDB/HIPDB and the FCP.

Statement of
Frances M. Murphy, MD, MPH
Deputy Under Secretary for Health for Health Policy Coordination
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives
Hearing on
VA's Procedures for Background Checks and Credentialing

March 31, 2004

Mr. Chairman and members of the Subcommittee:

I am pleased to be here today to discuss Department of Veterans Affairs' (VA) procedures for background checks and credentialing of its health care providers. With me today are Thomas J. Hogan, Deputy Assistant Secretary for Human Resources Management; Kathryn Enchelmayer, VHA's Director of Credentialing and Privileging; Barbara Panther, Director, Recruitment and Placement Policy Service, Office of Human Resources Management (OHRM); and Robert Swanson from VHA's Office of Management Support.

We take seriously our responsibility to ensure that those charged with caring for the Nation's veterans are properly qualified and trained to provide that care. However, we are aware that opportunities exist to enhance and improve our credentialing and hiring processes. Therefore we appreciate the report prepared by the Government Accounting Office (GAO) on improved screening of practitioners. Although we have seen only a draft of that report, our testimony responds to many of their preliminary recommendations and findings.

Credentialing

The term "credentialing" refers to the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, current competence, and health status. Credentialing must be completed prior to the practitioner's initial medical staff appointment and must be brought up to date before reappointment to the medical staff, which occurs at a minimum of every two years.

Since 1990, VA has performed primary source verification of the education, training, licensure and certifications of physicians and dentists. In 1997, full primary source verified credentialing was expanded to all licensed independent practitioners (LIPs), which includes podiatrists, optometrists, and other independent practitioners who are permitted by law and the employing facility to provide direct patient care independently. These are practitioners who are recognized by the facility to practice without supervision or direction, within the scope of the individual's license and may also include psychologists, social

workers, and pharmacists.

In March 2001, VA launched VetPro, its web-based credentialing data bank. VetPro ensures the consistency of the credentialing process for independent practitioners in support of high quality medical care across VA. Through VetPro, VA is able to maintain a valid, reliable, electronic databank of health care provider credentials that is accurate and easily accessible. As of March 20, 2004, over 39,000 providers are currently appointed through VetPro.

We are pleased that, in its report, the GAO has concluded that our pre-appointment and regular reappointment reviews of the credentials of LIPs are complete and thorough. Moreover, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reviewed VetPro and stated that the program represents a state-of-the-art system for consistent, high-quality, safe, and effective credentialing, which meets JCAHO's accreditation requirements. We believe that the success of this program is due in large part to assigning all responsibilities to a dedicated staff of credentialers and providing them clear templates and tools to perform their duties in a systematic and thorough manner.

With the introduction of JCAHO's 2004 accreditation standards, VA has directed that all physician assistants and advanced practice registered nurses also be credentialed through VetPro. Implementation of this requirement will be completed in April 2004. VA is working with DoD to evaluate the merits of integration in the credentialing processes at facilities operated by both departments. We will be testing this approach at the pilot sites established pursuant to the 2002 NDAA. The pilot sites are in Las Vegas, North Chicago and Hines, and Louisville.

NPDB

The National Practitioner Data Bank (NPDB) became operational in 1990. It is intended to direct discreet inquiry into specific areas of practitioner's licensure, professional society memberships, medical malpractice payment history, and record of clinical privileges. The NPDB is intended to augment, not replace, traditional forms of credentials review. It is a nationwide flagging system, supplementing other information obtained during the credentialing process.

VA, like all Federal agencies, agreed to participate through a Memorandum of Understanding with the Department of Health and Human Services (HHS). The final rule and supporting policy for participation in the NPDB were published on October 28, 1991. Since then, VA has required that all practitioners who are privileged and practicing independently be queried against the NPDB before privileges are granted, changed, or renewed, which occurs at a minimum of every two years.

HIPDB

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Integrity and Protection Data Bank (HIPDB) as a tool to help counter fraud and abuse in health insurance and health care delivery. The HIPDB, like the NPDB, is a flagging system to alert users that a more comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. The HIPDB opened for querying in March 2000. Federal Government agencies are authorized to query the HIPDB at no charge, but there is no requirement for the Agencies to do so.

VA currently performs a joint query to the NPDB and HIPDB for all licensed independent practitioners. However, we believe we must go further in our efforts to enhance and improve our credentialing process. Therefore, VA plans to develop and issue a policy requirement to query the HIPDB on all new hires by May 2004. Selecting officials and human resources offices will assess any problematic results obtained from this query to determine whether there is a need for a more comprehensive review. The review will evaluate the issue and its relationship to the position being filled to determine whether the applicant should be appointed to the position.

Furthermore, VA intends to begin querying the HIPDB on current employees prior to their re-appointment. This will necessitate notification to employee bargaining units of our intent. Following appropriate notification, VA will begin to query the HIPDB at regular intervals and will evaluate the results obtained in relation to the position occupied and determine whether further action within VA's existing employee relations systems, including collective bargaining agreements, is necessary and appropriate. The implementation of requirements to query the HIPDB on current employees is expected to be in place by August 2004.

Post-Graduate Medical Education

In VA's role of training the future health care workers of this country, VA ensures that the qualifications and credentials of residents are documented as part of the appointment process. Annually, VA trains over 29,000 residents from 107 U.S. medical schools. Before a VA medical center (VAMC) Director approves the appointment of any resident, evidence of appropriate credentials is required. A Resident Credentials Verification Letter certifying that all documents for appointment to VA, as well as compliance with the appropriate training program accrediting body, must be in order, and those credentials requiring primary source verifications are documented. The Resident Credentials Verification Letter is signed by the responsible training official and then submitted for approval by the VAMC Director.

Verifying Education

VA's process for reviewing applications for qualifications and suitability includes ensuring that education used to qualify for appointment, advancement, or other employment purposes has been received from accredited educational institutions. This verification includes, at a minimum, a comparison of the educational institution(s) cited on the application against existing lists of accredited institutions and against lists of institutions or "diploma mills" that sell fictitious college degrees and other professional credentials. VA is enhancing the implementation of this program with training and tools that will be developed after OHRM staff attend OPM-sponsored training on this topic in April 2004.

Background Checks

VA takes seriously the completion and appropriate adjudication of background investigations on its employees. VA has, in fact, appointed a full-time individual to administer the employee suitability and adjudication program. Servicing human resources offices have responsibility for ensuring that employment background checks are conducted when required, and that background investigations are appropriately adjudicated, documented, and reported to the Office of Personnel Management on a timely basis. VA expects full compliance with these policies and procedures.

The GAO has found that none of the four facilities reviewed complied with all of the key VA screening requirements and recommended that we conduct oversight to help ensure that VA facilities comply with these requirements for applicants and current employees. In light of these findings and recommendations, we are establishing monitors and other mechanisms to ensure full compliance with these policies and procedures. By the end of May 2004, long-range goals will be in place for continuing and improving compliance with federal regulations and VA policies on suitability issues and providing comprehensive guidance and education to VA employees and managers.

Overdue Investigations

Beginning earlier this month, VA medical facilities received access to information on unadjudicated investigations. We are providing the facilities electronic lists of completed investigations upon which they must take immediate action. We are instructing our facilities to report to the Under Secretary for Health on the status of all overdue investigations by April 9, 2004. We have also issued them instructions to ensure that all involved HR staff understand their responsibilities, and that actions related to background checks and investigations are processed on a timely basis and appropriately documented. Additionally, we are requiring weekly reports until all actions have been completed and all

investigations have been submitted, and Network coordinators will continue to monitor submission of the required reports.

Fingerprint Checks

GAO also recommended that VA require fingerprint checks for all health care practitioners who were previously exempted from background investigations and who have direct patient care access. I am pleased to report, Mr. Chairman, that on March 11, 2004, VHA's National Leadership Board had approved a requirement that electronic fingerprint checks be extended to VHA paid and without-compensation employees, trainees, volunteers, and contractors. VA will begin fingerprinting trainees during the 2004-05 academic year and we expect full implementation of the recommendation during the first quarter of calendar year 2005.

Oversight and Effectiveness Service

VA is also establishing an Oversight and Effectiveness Service (OES) in the OHRM that will monitor the implementation of human resources policies and procedures. This oversight program will provide facilities the tools to conduct self-assessments of key human resources programs, which are then reviewed by OHRM. In addition, they will conduct reviews of specific cases when individual circumstances so warrant. We expect that the policy authorizing the OES to engage in activities and conduct reviews will be implemented by the end of April 2004.

List of Excluded Individuals and Entities

Public Law 105-33 authorizes the HHS Inspector General to exclude certain individuals and entities from all Federal healthcare programs by placing them on the List of Excluded Individuals and Entities (LEIE). VA employment policy requires that all selectees for positions funded by VA's healthcare program be screened against the LEIE. VA also matches current VHA employees in VA's employment database with individuals on the LEIE on a monthly basis. When current employees are identified as being on the LEIE, field facilities are instructed to initiate action to separate these employees. VHA is attempting to develop a comparable automated process to review contractors and vendors on an ongoing basis. Since November 2002, we have identified 24 individuals as "potential matches" with individuals on the LEIE. Of these, 15 have been terminated; two were not confirmed as VA employees; two resigned; three have been reinstated; and two are in the process of being terminated by the employing facility.

Gaps in the Credentialing Review Process

The GAO report mentioned earlier identified areas of concern in the pre-employment and post-employment credentialing reviews of other health care providers, such as nurses, dieticians and respiratory therapists. They recommended expanding the verification requirement for contacting state licensing boards and national certifying organizations to include verification checks on all applicants and employed practitioners with state licenses and national certificates. VHA agrees that it is important to verify all existing licenses and certificates with the issuing organization for both applicants and employee renewals. We will implement these procedures in the near future. We believe that the credentialing process used for VHA's independent providers serves as a good model for an improved process for other professional groups.

To develop this new program, VHA has formed a task force that will ensure the process for credentialing and background investigations of these individuals is logical, consistent, complete, and adequate to verify credentials and screen out individuals from positions where their backgrounds indicate they are not suitable. The process would be consistent with the security and privacy protections prescribed by applicable law. The task force will work within the Department to evaluate current credentialing procedures, verification of all licenses, certifications and registrations of all applicants and employees with the primary source, address compliance with policy requirements, and assess the potential for use of technology and other tools to improve effectiveness and integrate these changes into departmental policies and procedures as appropriate. The task force will provide completed findings and recommendations by October 1, 2004.

In 2003, VA initiated the System-wide Ongoing Assessment and Review Strategy (SOARS), a facility site visit process the goal of which is to improve external review results and promote continuous readiness. All VAMCs will undergo a SOARS review every three years. We are now developing criteria for the SOARS teams to use in reviewing the pre-employment and post-employment credentialing and background investigations processes. SOARS teams will incorporate these criteria into the site visit assessment tool effective with the site visits in April 2004. This new management process will give VA the means to do periodic reviews of the credentialing process and background checks. These reviews will be shared with the Office of Oversight and Effectiveness and will augment and complement their activities and responsibilities.

As a final point, VHA is in the final stages of preparing checklists that bring together in a single document all the required steps to screen, check credentials, verify personal information, and complete the detailed and complicated processes required to employ Federal employees, grant access to confidential

patient information, and ensure appropriate pre-employment screening. We will provide these checklists to employing facilities for use by May 2004.

Mr. Chairman, while VHA already exceeds many public and private sector health care systems in our credentialing procedures and background checks for independent providers, we agree that further improvement is required in our credentialing system. We intend to create systematic credentialing and oversight processes to ensure overall exemplary performance in the future. We are committed to do this because we believe that veterans deserve the highest quality healthcare available and quality healthcare is critically dependent on the quality of VA's staff. This completes my statement. My colleagues and I will be happy to answer any questions that you or other members of the Subcommittee might have.

United States General Accounting Office

GAO

Testimony

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

For Release on Delivery
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VA HEALTH CARE

Veterans at Risk from Inconsistent Screening of Practitioners

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

GAO-04-625T

March 31, 2004

GAO Accountability · Integrity · Reliability

Highlights

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

VA HEALTH CARE

Veterans at Risk from Inconsistent Screening of Practitioners

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

Key screening requirements	Compliance with 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*			
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.

*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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STATEMENT

for the Record

of the

American Medical Association

to the

Subcommittee on Oversight and Investigations
of the
Committee on Veterans' Affairs
United States House of Representatives

Hearing on

VA's PROCEDURES FOR BACKGROUND CHECKS AND CREDENTIALING

March 31, 2004

The American Medical Association (AMA) is pleased to submit this statement for the record regarding the important issue of screening requirements for verification of professional credentials. Medical staff credentialing is generally a standardized process, and is regulated by state and federal laws and regulations. It requires primary source verification of an applicant's background, such as medical education, state licensure, and certification to determine his or her eligibility for medical staff membership and/or obtaining hospital privileges. The credentialing process is applicable to all physicians and other independent practitioners seeking clinical privileges regardless of whether they also seek or hold medical staff membership.

Our statement focuses on the AMA's Physician Masterfile (also known as the AMA Physician Profile), a well-established, reliable and cost-effective credentialing system that is widely used by hospitals and institutions, as well as health plans, to check on the qualifications of physicians, osteopaths and physician assistants. A majority of Department of Veterans Affairs' (DVA) hospitals utilize the Masterfile for their credentialing checks. The AMA is very pleased that the General Accounting Office recently concluded that there were no major problems with the credentialing of physicians in DVA facilities.

The AMA's Physician Masterfile was established by the AMA in 1906, in response to the need for a comprehensive biographic record of all US physicians. From the beginning, except for current practice data provided by the physician, all information on the Masterfile has been obtained or verified through those institutional sources that confer

credentials. Appropriate use of the Masterfile meets selected credentialing standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Masterfile includes current and historical data on all physicians, including AMA members and nonmembers. The Masterfile data span the continuum from undergraduate medical education through practice and comprise databases of 125 medical schools accredited by the Liaison Committee on Medical Education (LCME); 7,900 graduate medical education programs and 1,600 teaching institutions accredited by the Accreditation Council for Graduate Medical Education (ACGME); 820,000 physicians; and 19,000 medical group practices.

Masterfile data are collected on all doctors of medicine (MDs) in the United States who have completed or are completing requirements to practice medicine and on U.S.-trained physicians who are temporarily located overseas. Doctors of osteopathic medicine (DOs) who are members of the AMA, have enrolled in or completed residency training programs accredited by the ACGME, have been licensed or have had disciplinary actions taken by state licensing agencies, or have specifically requested that they be listed also are included.

The Masterfile also includes data on graduates of foreign medical schools who reside in the United States and who have met the educational and credentialing requirements necessary for recognition as physicians. Data on international medical graduates (IMGs) are included in the Masterfile when IMGs enter residency programs accredited by ACGME. The Masterfile also includes data on IMGs who are licensed to practice medicine but who have not entered ACGME-accredited programs and on physicians licensed to practice medicine in the United States but who are temporarily located abroad.

Physician records are never removed from the AMA Physician Masterfile, even in the case of a physician's death. The AMA maintains information on more than 130,000 deceased physicians. These data are shared with other organizations and agencies that credential physicians and are used to identify individuals who attempt to fraudulently assume the credentials of deceased physicians.

The AMA Physician Profile Service provides computerized printouts (e.g., "profiles") of individual physician records derived from the AMA Physician Masterfile to state licensing agencies, hospitals, group practices, managed care organizations, physician recruiters, and other organizations for the purpose of facilitating the credentials verification process. All of the information contained in the Profile is obtained from or verified with primary sources and is continuously updated. A more detailed description of how these primary source data elements are collected, maintained and verified is provided below.

Medical Schools

A Masterfile record is created when individuals enter medical schools accredited by the LCME or, in the case of IMGs, upon entry into ACGME-accredited programs. The AMA Medical Student File is updated annually through freshman matriculation,

graduation and change of status reports. These data are provided and certified to the AMA by each medical school director, unless by exception, a student does not pass from years 1, 2, and 3 on schedule. The AMA receives the full name of each student, his or her school address, year and place of birth, gender, an indication if he or she has received a degree, did not receive a degree or is currently enrolled, and actual or expected year of graduation directly from each U.S. medical school.

Information received from LCME-accredited Canadian schools is stored electronically and is added to the file if the physician moves to the U.S. Graduation reports prepared by the osteopathic schools are supplied to the AMA by the American Osteopathic Association. This information is used to initiate a record on the AMA's medical student file. A unique record identifier, the medical education number (ME), is assigned to the record when the student enters medical school and can remain unchanged throughout that individual's career. Students are tracked for as long as it takes them to complete their undergraduate medical education.

Post Graduate Medical Training Programs

Each year the AMA conducts the Survey of Graduate Medical Education (GME) Programs. Approximately 7,900 ACGME-accredited programs receive the electronic survey. Also surveyed are some 239 programs that offer medical specialty board-approved "combined specialty" programs. The survey collects data on over 97,000 individual residents in graduate medical education programs and is used to update physician records in the AMA Physician Masterfile.

The annual method of collecting this data begins in mid-May when the AMA receives the names of approximately 13,000 graduating medical students and their placement in residency programs from the National Residency Matching Program (NRMP). Information on current residents received from the residency program director in prior years as well as the NRMP data is then used to create the data diskette used in the survey process. The survey is sent to the program directors through a secure, password protected online application. The data included is the most recent information the AMA has on the program itself and its respective residents. Program directors are asked to verify or update the data on each record as appropriate and add any residents in their program whose records are not included.

The data collected via the survey includes the following variables: demographic information to ensure a match; year in program; post-graduate year; successfully completed training in the specialty/did not successfully complete training in the specialty; and reason for leaving, if applicable. The AMA maintains the sponsoring institution name rather than the clinical site or participating site, and that is what appears on the profile. Training segments that have not been successfully completed at a particular institution will have an "incomplete" heading next to them on the AMA Physician Profile. The completed surveys generally start to return to the AMA in mid-July, and the required return date is September 30th. Approximately one week after the due date, the staff follows up with phone calls to those programs that have yet to respond. As the

surveys are returned, they are uploaded to the AMA Physician Masterfile. Ninety-five percent of the responses to the survey are completed by December.

Recently, several changes have been implemented to improve the currency and double-check the quality of the data collected through the survey. For example, changes to the actual processing mechanism of the annual GME Survey system have resulted in greatly improving how current the data is. A follow-up mailing process has also been developed to acquire information from non-respondent institutions to the survey, non-accredited training programs, and those physicians with no known current medical training.

Systems have been designed to ensure 100% resolution of all records received from the survey, including unidentified U.S. graduates and IMGs who are in unaccredited programs or have not been certified by the Educational Commission for Foreign Medical Graduates (ECFMG). Quality assurance programs have been developed to compare the survey response and the data already included in the Masterfile and resolve differences.

State Licensing Agencies

The state licensing agencies issue approximately 45,000 licenses per year. Each of the 67 state medical and osteopathic boards provides the AMA with data on an ongoing basis. Licensure data is obtained on a monthly basis for 60% of the boards while the other 40% provide data on a bi-monthly, quarterly, or semi-annual basis. Most of the state boards provide the degree (MD/DO); the date the license was initially granted; the expiration date (approximately 95% of all records have expiration dates); licensure status (active, inactive, denied or pending); and the licensure type (unlimited, limited or temporary). The "Last Reported" date is included on each profile to reflect the last time that data pertaining to that record was provided to the AMA from the individual licensing board.

State Disciplinary Actions/Federal Sanctions

The AMA processes disciplinary action reports received directly from the state medical boards and osteopathic boards, as well as from the U.S. Department of Health and Human Services in relation to Medicare and Medicaid sanctions. The AMA flags the physician's file with a star that appears on the physician's profile. A record is flagged if a license has been revoked, suspended, surrendered or has a stipulation of a disciplinary nature. For historical purposes, flags are never removed from the Masterfile. Over 300 physician records are flagged each month. The Profile refers the user to the state agency that took the action for further information.

Educational Commission for Foreign Medical Graduates (ECFMG)

Graduates of international medical schools (IMGs) who are residing in the United States generally are incorporated into the Masterfile upon entry into an ACGME-accredited program of graduate medical residency training. Background information is supplied to the AMA by the ACGME-accredited programs and by the ECFMG. ECFMG certification provides assurance to directors of ACGME-accredited residency and

fellowship programs that graduates of foreign medical schools have met minimum standards of eligibility required to enter such programs. ECFMG certification is also a prerequisite for licensure to practice medicine in most states and is one of the eligibility requirements to take Step 3 of the U.S. Medical Licensing Examination.

American Board of Medical Specialties

Physicians certified by member boards of the American Board of Medical Specialties (ABMS) are reported to the AMA by the ABMS. The ABMS File provided to the AMA includes the following information: the physician's name; the name of the certifying Board or Boards; the certification or subcertification awarded; the certificate type; the date of the original certification, subcertification and any recertification; the date of expiration or revocation of the certification and any recertification; and the last reported date. The AMA records carry only information on board certifications issued by boards that are recognized by the Liaison Committee for Specialty Boards (LCSB). The LCSB is comprised of members from the AMA Council on Medical Education and ABMS member boards.

Federal Drug Enforcement Administration

Federal Drug Enforcement Administration (DEA) Registration status information is updated quarterly. The information includes the DEA registration expiration date. Many states require their own controlled substances registration/license, and the AMA does not maintain this information.

Conclusion

The AMA appreciates this opportunity to provide the Subcommittee with information about how the Masterfile and Physician Profile system work. We would welcome the opportunity to be of further assistance to the Subcommittee as its examination of the VA's credentialing procedures continues.

Site Visit to San Diego, CA

April 19-22, 2004 staff from the Oversight and Investigations and Benefits Subcommittees conducted a site visit in the San Diego, CA area. Staff met with the VA Regional Office and received an update on its efforts in hiring veterans and disabled veterans. Staff also met with representatives involved in Operation Transition from the TAP program, organized labor, local businesses, SBA, One-Stop Career Center, non-profit organizations, and the San Diego Chamber of Commerce to review efforts to assist veterans with employment, and starting small businesses. Staff attended Transition Assistance classes and Disabled Transition Assistance Classes at Point Loma Naval Base, Miramar Marine Base, and Camp Pendleton Marine Base.

On April 22, 2004, staff met with Rear Admiral John Mateczun, Commander, Naval Medical Center San Diego and his staff to discuss VA-DOD sharing, separation physicals, VA-DOD coordination on transition matters, physician credentialing, and third party billing. Staff also learned that the Naval Medical Center is continuing to fill its prescriptions through Consolidated Mail Order Pharmacy, even though the pilot has finished; used VA as a business partner to develop their East County Clinic Project concept with VA Medical Center Outpatient Center in San Diego; and used VA's safety model as its prototype to develop their own safety protocols. In the afternoon staff met with VA Medical Center Director Gary Rossio and his staff to discuss part-time physicians time and attendance, its research program, third party collections, and pharmacy program.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CONGRESSMAN BOOZMAN TO DEPARTMENT OF VETERANS AFFAIRS

Items for the Record
March 31, 2004, Hearing on
VA's Procedures for Background Checks and Credentialing
Before the
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives

1. Cong. Boozman requested a complete record of all actions related to the LEIE since 1999.

Response: VHA initiated automated, nationally standardized reviews beginning in the fall of 2002. Prior to this date, local reviews were conducted by the individual medical centers. Attachment 1 provides (1) a consolidated list of all reviews completed and actions taken on "potential matches" between VA employees and vendor names that appeared on the exclusionary list for the time period 1999 through 2002; and (2) an exclusionary list report as of June 24, 2004, providing information since November 2002, when VHA began automated, nationally standardized reviews of the LEIE.

2. Cong. Boozman asked for a timeline related to VA's plans to address the GAO recommendations.

Response: VA is now reviewing the final GAO report and recommendations. The department will submit its response to GAO by July 2004. The response will include an action plan for each recommendation and estimated timeframes for implementation of the recommendations. However, we have committed already to several actions intended to assist in enhancing the credentialing and background review processes. These are outlined in Attachment 2.

3. Cong. Udall questioned whether VA gives access to BSL3 labs to non-U.S. citizens.

Response: Yes, if certain conditions are met and the individual has a need to participate in the research being performed. The current VHA Handbook 1200.6 "Control of Hazardous Agents in VA Research Laboratories" includes specific requirements that must be met before citizens and non-citizens can access a BSL-3 laboratory. Section 7c requires that all personnel obtain formal approval prior to beginning work in a VA research laboratory. Section 7c(1) of the Handbook requires that Human Resource Management Service (HRMS) verify the person's credentials. HRMS and/or the Police Service will submit the appropriate forms as determined by the individual's position risk and sensitivity level and fingerprints to the Office of Personnel Management for completion of a background check. The Associate Chief of Staff for Research and Development must ensure that this has been done. (§ 7c(1)). As a further safeguard, the status of all visas and of WOC employees must be reviewed annually. (§ 7c(7)). Non-US citizens who do not have a valid visa that allows for their

work as employees, WOC, contractors or students are NOT allowed into VA research laboratories or BSL-3 laboratories.

If the person will be working in a BSL-3 laboratory, he/she must obtain specific approval to do so from the Research and Development (R&D) committee (§ 4j). In making the determination to approve the individual to work in a BSL-3 laboratory, the Committee must consider the need for the person to work within the BSL-3, the person's qualification, their citizenship, and visa status (if applicable), and the findings of the suitability assessment.

If Select Agents, Biological Agents or Toxins, as defined in 42 CFR Part 73, 7 CFR Part 331, and 9 CFR Part 121, are stored or used in the research laboratory, all persons are required to have a Security Risk Assessment that has been approved by the Attorney General. They must also receive specific authorization from the R&D committee to work within the laboratory and their status must be reviewed semi-annually. In addition, in compliance with the US Patriot Act (Title 18 USC § 174b), and Federal Regulations 42 CFR Part 73, 7 CFR Part 331, and 9 CFR Part 121, follow-up with appropriate external agencies, such as the Immigration and Naturalization Service, may be necessary to clarify or validate a non-citizen's credentials.

For all VA research laboratories, HRMS is required to assist the research program in issues related to personnel and in reviewing application for citizenship and visa status and the Office of Security and Law Enforcement is responsible for conducting personnel security checks for controlled area access. (§§ 4b and 4c) Careful attention to these procedures is required to ensure that inappropriate or illegal non-citizens are not permitted in VA facilities. Discrepancies must be reported to the local federal Marshal through the VA Police Service and to VA Office of Inspector General. Section 7c(3)(c) states "An Alien (other than an alien lawfully admitted for permanent residence) who is a national of a country determined by the Secretary of State to have repeatedly provided support for acts of international terrorism may not be granted access to any sensitive areas in which select agents (as defined in Title 42 CFR 72) may be present. Individuals meeting any other criteria for identification as a "restricted person" are similarly prohibited from accessing sensitive areas and/or possessing select agents (18 U.S.C. §175b)."

For reference, we are enclosing a copy of VHA Handbook. 1200.6.

4. Cong. Udall asked about the role of research assistants and WOCs.

Response: Research assistants and WOCs may have access if they are participating in the research and they meet the requirements cited in our response above.

Attachment 1

Consolidated List Obtained from VISNs

- Number of VA employees confirmed to be on the LEIE – 41
- Number of separations – 11
- Number of resignations – 6
- Number of reinstatements* – 24
- Number of "potential names" on the LEIE that were confirmed not to be VA employees – 136

* Excluded individuals and entities wishing to again participate in Federal health care programs must apply to the Health and Human Services Office of the Inspector General (HHS OIG) for "reinstatement." An example of a "reinstatement" would be an employee who is originally on the LEIE because of student loan default, and who subsequently develops a repayment plan approved by the HHS OIG. Abiding by the repayment plan would allow the employee to be reinstated.

Exclusionary List Report as of 6/24/04

Number of HHS cases on Exclusionary List: 26 (since November 2002)

Status:

- 14 terminations
- 3 personnel no longer employed and taken off roles
- 3 personnel reinstated per HHS
- 2 personnel not VA employees
- 1 person retired
- 1 resigned
- 1 pending dismissal
- 1 not excluded from employment (placed on the list prior to 8/5/97)

Attachment 2

Actions that VA has committed to take in order to enhance its processes for credentialing and background checks on health care employees:

1. VA will credential physician assistants and advanced practice registered nurses through VetPro starting in April 2004.

   Status – Completed

2. VA will develop and issue a policy requirement to query the HIPDB for all new hires by May 2004 and will begin querying HIPDB on current employees prior to their re-appointment. Notification to employee bargaining units will be required prior to the start of this process with an expected start date of August 2004.

   Status – VHA drafted a memorandum to all VHA field facilities directing them to perform HIPDB screens on all prospective appointees. The memo was sent to Department of Health and Human Services (HHS) to ensure technical accuracy. On 6/2/04, HHS made VHA aware of an internal HHS problem that occasionally causes a delay in having individuals who have been placed on the List of Excluded Individuals and Entities (LEIE) also placed on the HIPDB. The draft memo originally provided that the HIPDB screen would be performed in lieu of the currently required LEIE screen. The problem noted by HHS will now require that both screens be performed. The memo is currently under revision and is scheduled for issue by 6/15/04. In addition, a process for periodically screening current employees against the HIPDB will be developed and implemented when collective bargaining obligations are met. The target date for this process to be in place is August 2004.

3. VA will put in place long-range goals for continuing and improving compliance with federal regulations and policies on suitability and providing comprehensive guidance to VA employees and managers by the end of May 2004.

   Status - VA policy on Human Resources Management Program Evaluation was put into effect on April 1, 2004. The Office of Human Resources Oversight and Effectiveness (O&E) began piloting evaluation site visits in June 2004. Full-scale evaluation visits will begin in FY 2005. O&E is working with Veteran Health Administration's (VHA) Office of Quality and Performance's Credentialing and Privileging staff and the Office of Human Resources Management Recruitment and Placement Policy Service in developing checklists and questions for use during evaluation site visits in order to gauge improved screening of practitioners.

4. VHA facilities are being provided electronic lists of completed investigations upon which they must take immediate action with a report of overdue investigations by April 9, 2004. Instructions have been issued to define responsibility and actions.

Weekly reports will be required until all actions are completed and all investigations are completed with Network coordinators monitoring these reports.

Status – Process is underway and ongoing

5. VHA National Leadership Board had approved a requirement for fingerprint checks to be extended to VHA paid and without compensation (WOC) employees, trainees, volunteer and contractors. VA will fully implement by first quarter of calendar year 2005.

   Status - The Management Support Office is currently working with the Credentialing and Suitability Task Force in developing functional specifications and statement of work, market research strategies, vendor evaluations, equipment needs assessment and deployment and training plans. More detailed planning direction will be provided when the task force provides recommendations to the National Leadership Board in September 2004. Target date for implementation is the first quarter of 2005.

6. VHA will verify all existing licenses and certifications with the issuing organizations for both applicants and employee renewals in the near future with VetPro as a possible model.

   Status – Feasibility study is underway by the VHA Credentialing and Suitability Task Force

7. VA will enhance verification against existing lists of accredited institutions to avoid accepting education from "diploma mills" after OHRM staff attend OPM-sponsored training in April 2004.

Status - The Department's Suitability and Adjudication Program Office is responsible for developing policy and issuing instruction regarding requirements for verifying the accreditation of educational institutions listed by applications and employees. Staff of that office attended OPM's Diploma Mill training on May 5, 2004, and subsequently issued instructions to Human Resources (HR) Practitioners in VA. Training is also being developed on background investigations, adjudications, and diploma mills that will be delivered to HR practitioners.

Policy in VA Handbook 5005, Part II, Chapter 3, Section B, paragraph 3, requires that the accreditation of educational institutions be verified. Revised and expanded language is being developed to formalize the most current guidance and instructions, and especially to focus on checking schools with accrediting agencies, rather than against lists of diploma mills. Guidance provided on May 28, 2004, provides this focus until the policy can be rewritten.

8. VA will implement policy authorizing the Oversight and Effectiveness Service in OHRM to engage in activities and conduct reviews to by end of April 2004.

Status - VA policy on Human Resources Management Program Evaluation was put into effect on April 1, 2004. The Office of Human Resources Oversight and Effectiveness (O&E) began piloting evaluation site visits in June 2004. Full-scale evaluation visits will begin in FY 2005. O&E is working with Veteran Health Administration's (VHA) Office of Quality and Performance's Credentialing and Privileging staff and the Office of Human Resources Management Recruitment and Placement Policy Service in developing checklists and questions for use during evaluation site visits in order to gauge improved screening of practitioners.

9. VA is attempting to develop an automated process to review the LEIE re contractors and vendors on an on-going basis.

   Status – This is an action item identified by the Credentialing and Suitability Task Force with a target completion date of January 2005.

10. VHA will develop criteria for SOARS teams to review pre-employment and post-employment credentialing and background investigation processes and incorporate criteria into site visit assessment tool with site visits in April 2004.

    Status – SOARS teams are currently reviewing pre-employment and post-employment credentialing and suitability processes.

11. VHA will prepare checklist for HR process related to background checks and pre-employment screening and provide checklists to employing facilities by May 2004.

    Status – Checklist has been drafted and is scheduled for distribution for field testing in June 2004.

12. VA has formed a task force to ensure process for credentialing and background investigations are logical, consistent, complete, and adequate. Task Force findings are to be presented by October 1, 2004, and implementation will occur in early 2005. Specifically, the task force will:
    a. evaluate current credentialing procedures;
    b. verify all licenses and certifications of all applicants and employees with the primary source;
    c. address compliance with policy; and
    d. assess potential of technology and tools.

    Status - The Task Force on Credentialing and Suitability, which has been divided into one subcommittee dealing with credentialing issues and another with suitability issues, has been meeting regularly via teleconference calls. Action plans have been developed by both subcommittees. The entire task force convened on May 17 through 18, 2004 to present preliminary action plans. Task force recommendations will be provided to the National Leadership Board by October 1, 2004, after which future direction will be finalized.

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