S. HRG. 110–377

OVERSIGHT HEARING: HIRING PRACTICES AND QUALITY CONTROL IN VA MEDICAL FACILITIES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

NOVEMBER 6, 2007

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OVERSIGHT HEARING: HIRING PRACTICES AND QUALITY CONTROL IN VA MEDICAL FACILITIES

TUESDAY, NOVEMBER 6, 2007

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to notice, at 9:34 a.m., in room SD–562, Dirksen Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Durbin and Burr

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Senator AKAKA. This hearing will come to order. This morning's hearing will focus on hiring practices and quality controls in VA hospitals and clinics. Among the issues we will address are the recent events at the Marion, Illinois, VA Medical Center. VA's internal tracking found a sharp and disturbing increase in the number of deaths at that hospital. In addition, they found cases of serious and unexpected complications from routine surgeries performed there.

As Chairman of the Senate Committee on Veterans' Affairs, it is very important to me that all veterans get the best possible care from the best possible health care practitioners. To achieve that goal, we must ensure that all providers are appropriately checked for their credentials and privileges.

I note that the Inspector General's office is in the midst of an investigation about the personnel involved in those events at the Marion VA, and because of this the IG will not be testifying today.

Knowing of Senator Durbin's interest, and with Senator Burr's concurrence, I have asked Senator Durbin to join us on the dais for this hearing. While this issue was brought to my attention due to the troubling situation at the Marion VA, it may indeed have implications for the entire VA health care system and the more than 140,000 providers employed by VA.

When the IG's investigation is complete, the Committee will review that report to ensure that no structural problems exist in VA's process to appropriately screen its employees. If systemic problems are found, we will work to address them.

I want to thank you all for being here, and we look forward to the testimony of our witnesses.

At this time I would like to call on our Ranking Member for his comments, and then we will turn to Senator Durbin.

STATEMENT OF HON. RICHARD M. BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Mr. Chairman. I appreciate you calling this hearing to look into what I think are extremely important matters. I would like the record to note that I know that there is interest on the part of Senator Durbin and Senator Obama, and were this North Carolina, I would have the same interest, and I am sure Senator Murray would for Washington. And as Committee Members, it is our responsibility to look into this. I asked the Chairman, though, not to hold this hearing because I think it is premature and inappropriate when there is a current investigation going on to believe that we can get to the bottom of the problem and that, in fact, we might—and I stress the word "might"—encumber the IG's investigation by what might be said, what might be reported, or what might be asked.

So, I reluctantly am here today. I understand the need of the State's Senators to be in front of this issue, and I respect the fact that both of them have been very vocal on it. And it is my understanding that the VA is currently in the process of sending a team in to look at multidisciplinary assessments of the entire Marion facility.

We do owe our veterans not only the very best medical care but also the highest quality professionals that we can put there to deliver that care. One way to show our commitment to our veterans is to ensure that the VA's hiring practices conform to the highest standards possible. However, these recent allegations of substandard care at the Marion VA Medical Center have called into question the VA's current system for credentialing and privileging health care professionals.

Everyone in the veterans community—including those who care for veterans professionally, concerned family members, and veterans themselves—was alarmed when they learned of the sharp rise in deaths at Marion. These deaths have raised many questions about whether substandard care and poor hiring practices are to blame.

As you pointed out, Mr. Chairman, the VA Inspector General is in the midst of an investigation into the deaths at the Marion VA facility, which is why he declined to testify at today's hearing, and I am glad he did decline. I have spoken to the Inspector General. He has assured me this is an active, ongoing investigation, and that when that investigation is complete, he intends to fully brief this Committee and to make himself available for any requests for hearings.

Mr. Chairman, I would suggest today, rather than jump to conclusions about what did or did not happen, or what may or may not be wrong with VA credentialing, that we wait until the IG has done his work. Let him investigate these issues and report back his findings. At that time, we will be better able to answer questions such as: Was the VA credentialing or privileging process itself at fault? Was the Marion facility negligent in following the estab-

lished VA process? And what exactly happened at Marion and, more importantly, who is responsible?

Mr. Chairman, we owe it to the surviving families to get to the bottom of the Marion case. We also owe it to our veterans to find out whether the rise in deaths at Marion is a warning sign of a system-wide credentialing and privileging problem within the VA.

Mr. Chairman, I know we both share a desire to see that these issues are thoroughly investigated. Once the IG's work is complete, I hope you will be calling a hearing, one where we can call the appropriate witnesses—not that those who are here today are not welcomed, but that we can look at the facts and ask the hard questions but, more importantly, get the right answers as it relates to the Marion VA facility.

So, Mr. Chairman, again, I thank you for the opportunity to be here. I welcome my colleagues, Senator Durbin and Senator Murray, and I am sure that if, in fact, there is some information to glean today, we will glean that.

Senator AKAKA. Thank you, Senator Burr.

Senator Durbin?

STATEMENT OF HON. RICHARD J. DURBIN,
U.S. SENATOR FROM ILLINOIS

Senator DURBIN. Mr. Chairman, thank you very much, and, Senator Burr, thank you for agreeing to this hearing. And I would like to say at the outset that Senator Obama and I have been involved in this from the start. Although he is not here this morning, he certainly shares my concern about what has happened at the Marion VA Hospital.

Let me say at the outset that the Marion VA Medical Center has served veterans in our region for generations, with extraordinarily good professional care. It enjoys a great reputation in southern Illinois, Indiana, and Kentucky for providing that care for veterans who have served us so honorably in many places around the world. And that is why this current situation is so troubling.

Let me concur with Senator Burr. We will not know the details on what happened here until the inspection is complete. There are, in fact, two inspections underway—one by the Inspector General's office and the other, I am told, by the quality assurance team at the Veterans Administration. And I welcome their conclusions, and I hope they are presented thoroughly and very soon.

But there are some things that we do know that are indisputable, and the information I am about to relate has been related directly to me by the Veterans Administration and I think is the reason why we can meet today and talk about some of the larger issues that this presents.

We know that in August of this year, it came to the attention of the Veterans Administration that there was a dramatic increase in surgical deaths at the Marion VA Medical Center, so much so that investigative teams were sent quickly and determined to give administrative leave to four of the top administrators at this Marion hospital. Shortly thereafter, a surgeon resigned—Dr. Mendez—and surgical activities were severely curtailed at the Marion hospital. That continues to this day while the investigation is underway.

There have been serious questions raised about the credentialing of the doctor who resigned, and I think that is what has given rise to our need for this hearing. This doctor was licensed in the State of Massachusetts and in the State of Illinois when he came on the staff of the Marion VA Medical Center. And it was after that time, about a year after, maybe a year and a half after he came on at the Marion VA Medical Center, that he surrendered his license in the State of Massachusetts to practice medicine, and it was characterized as for "nondisciplinary reasons." When he was asked why he would surrender his license to practice, he indicated he did not plan on returning to Massachusetts and he did not want to continue to pay the fees that were involved. I think those facts are basic and not much dispute about them.

We have come to learn that before he was hired by the Marion VA Hospital, he had two malpractice cases filed against him in the State of Massachusetts and one disciplinary action by a hospital. The question that I think this raises is: What is due diligence? What should the VA use as their standard to determine whether a doctor is fit and competent to practice at a Marion VA medical facility or any VA medical facility?

There are serious questions that have been raised here about the level of communication, for example, between the State of Massachusetts and the VA medical system in general and Marion VA in particular. As I understand it, a person can practice at a VA facility without being licensed in the State where that VA facility exists. And so, obviously, there is a need for communication with other States and other licensure boards to find out whether anything extraordinary has happened.

Since this investigation is underway, it has been publicly reported that another doctor has been suspended at the Marion VA Medical Center for his failure to disclose that he was licensed in another State. The reason that is important, of course, is that we want to keep on top of that situation to see if there have been any problems with that licensure in the other State.

Well, under the circumstances here, there are a lot of questions that need to be asked and answered about the policies of credentialing medical professionals who come into the VA medical system. I have been told that there are some 15,000 to 18,000 doctors in the system at this time. So, clearly, this is a major responsibility and undertaking by the VA.

The one point I would like to make to Senator Burr—and I hope he will understand and appreciate—is that I asked Members of my staff to go down to Marion and to talk to some of the people who were there. They have established a line of communication with a number of people who are participating in the investigation, as they should, and I encourage them to. But the sad reality is that at least three or four people with significant information in important positions at the Marion VA Medical Center have communicated to my office that they are unwilling to come forward, and they do not want to give this information for fear of reprisal and for fear of being terminated.

Now, let me say in conclusion here a word about Acting VA Secretary Gordon Mansfield. I did not know the man until we got involved in this issue. He has come by my office, and we have spoken

on the phone several times. I do not think we could ask for a better person to be head of the Veterans Administration. Mr. Mansfield is a veteran of Vietnam. He still carries the wounds from those battles. And I am convinced, I am personally convinced, that he is dedicated to the veterans in our country above everything else. His responses to me throughout have been clear and unequivocal. He wants to know what happened here. He wants to get to the truth, and he wants to protect those who will come forward in an honest fashion to tell what happened. He has said that to me repeatedly and said it again this morning. He told me that he is sending a special team now from the Veterans Administration to Marion to try to establish a better line of communication here.

We really need to get all the information and facts in, and, Senator Burr, I hope that this hearing, which will be reported, I am sure, back in Illinois, will be an indication to those employees to cooperate in good faith with the investigation, to feel that they can come forward and tell what happened honestly in this circumstance and get to the truth of it.

In the meantime, I hope this hearing will help us understand the process that is being followed to make certain that this never happens again and that we do everything we can to make sure that people in the VA medical system, the medical professionals, are skilled and competent.

Thank you.

Senator AKAKA. Thank you.

Senator Murray?

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Thank you very much, Mr. Chairman and Senator Burr, for holding today's important hearing on the tragic events that happened in Marion. Even with all of the controversy that is going on with the Department of Veterans Affairs within the context of this conflict, I know and I believe that overall our physicians and our clinical staff at the VA provide excellent care for our veterans. We hear it everywhere we go. The VA health care system has been an innovator in clinical care, in research in areas like PTSD and trauma care and electronic medical records, and they boast some of the most talented, knowledgeable physicians and staff in the country. So it was for that reason that I was deeply concerned when I heard about the physician at the Marion VA that was responsible apparently for providing care to our veterans that may have put them in danger.

So I hope that today's hearing, Mr. Chairman, is an opportunity to look at the procedures that are in place in the VA in terms of screening physicians and clinical staff so that we know the best procedures are in place so that an incident like this will not occur. And I think it is important that we ask the question of whether or not this was an isolated event or whether we have a system-wide issue. We want to know how common these problems are or possibly could be within the system. And I would like to know what the process is that the VA does have for screening health care providers as we are in the process right now of hiring a number of new physicians as we are putting a lot more resources, importantly, as

we should be—into the VA today and, importantly, how we can prevent a tragedy like this from ever occurring again.

So I think today's hearing is extremely important. I think the men and women in uniform who serve us very proudly have a right to know that we are doing due diligence to make sure that the care that they get is the best possible, that we have safe and effective care for them. That is the highest quality care available.

So I appreciate the opportunity to have this hearing today, and I look forward to hearing from all of our witnesses so that we can learn from the tragedy that has occurred.

Thank you.

Senator AKAKA. Thank you. Thank you very much, Senator Murray.

I want to welcome the first panel, from the Department of Veterans Affairs, Dr. Gerald M. Cross, Principal Deputy Under Secretary for Health. He is accompanied by Dr. Peter Almenoff, Director of the VA Heartland Network; and Dr. George O. Maish, Jr., Chief of Surgery at the Lebanon, Pennsylvania, VA Medical Center; and Kate Enchelmayer, Director of Quality Standards for the Veterans Health Administration. I want to thank you all for being here today, and as I mentioned in my opening statement, we are focusing on hiring practice as well as quality controls in VA hospitals and clinics. And, of course, what has happened in the Marion event also plays in this, and we are looking at credentials of the medical professionals.

And, with that, Dr. Cross, will you please begin?

STATEMENT OF GERALD M. CROSS, M.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PETER ALMENOFF, M.D., DIRECTOR, VETERANS INTEGRATED SERVICE NETWORK 15; GEORGE O. MAISH, JR., M.D., CHIEF OF SURGERY, LEBANON, PENNSYLVANIA, VA MEDICAL CENTER; AND KATHRYN ENCHELMAYER, DIRECTOR, QUALITY STANDARDS, VETERANS HEALTH ADMINISTRATION

Dr. CROSS. Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to come here today to discuss VA's Credentialing and Privileging and its impact on current events at the Marion VA health care facility. I am accompanied by Ms. Kate Enchelmayer, our Director of Quality Standards, to my right; Dr. Peter Almenoff, at the end of the desk, the Director of Veterans Integrated Service Network 15; and Dr. George Maish, Jr., Chief of Surgery, Lebanon, Pennsylvania, VA Medical Center.

My testimony will summarize our extensive credentialing and privileging process. I will also describe the National Surgery Quality Improvement Program, now famously known as NSQIP, that prompted our investigation at Marion.

Before I begin, please be assured that my foremost priority, VA's foremost priority, is the care and well-being of our patients, our veterans. That priority is what led us to take swift action at the Marion VA facility.Credentialing: Credentials are a person's educational, training, experience, current competence, health status, certification, and licensure documents. VA's standardized electronic

credentialing program, called "VetPro," is used system-wide to document the credentials of health care providers. VA realizes that accurate credentialing is a cornerstone to ensuring qualified health care providers are hired and, in addition to the credentialing done on every licensed provider, the process of privileging that provider to administer care within the scope of his license and clinical competence and within the medical center's supporting capability remains an essential part of the initial processing that must be completed before the provider begins his duties within the VA. This process is completed on initial appointment and at a minimum of every 2 years thereafter, before transfer from another medical facility, or whenever the provider requests an addition to his or her privileges.

The credentialing officer at a medical center obtains primary source information on all credentials. This is accomplished by direct contact with the source providing the education, training, certification, licensure, or registration. Information submitted by an individual health care practitioner is verified at that source. This includes confirming the practitioner's answers to 17supplemental—sometimes called "attestation"—questions specific to denial, surrender, revocation, and termination of a credential, privileges, and medical society affiliation, as well as any convictions. If a provider's license required for the position within VHA has ever been revoked or surrendered for cause—that is, for reasons of substandard care, professional misconduct, or professional incompetence—that provider is not eligible for employment in VHA unless that license has been fully restored. All practitioners must possess at least one full, active, current, and unrestricted license to practice.

In addition, VA uses other flagging systems during the credentialing process and the determination of suitability for employment. These include, but are not limited to, the National Practitioner Data Bank-Health Integrity and Protection Data Bank, and the Disciplinary Alerts Service of the Federation of State Medical Boards. Moreover, VA continuously monitors physician licensure for any disciplinary or untoward activity with the FSMB. VA also queries a database maintained by the Office of the Inspector General at the Department of Health and Human Services that lists all individuals and entities that are currently excluded from participation in Medicare, Medicaid, and all other Federal health care programs.

VA also uses the background investigation that is generally required on all new Federal employees. It consists of a National Agency Check, the Defense Clearance and Investigations Index, the FBI Identification Division's name and fingerprint files; as well as written inquiries and searches of records covering specific areas of a person's background during the past 5 years. Those inquiries are sent to current and past employers, schools attended, references, and local law enforcement authorities.

Now to clinical privileging. In VA, health care providers licensed for independent practice are given "privileges" that cover the breadth of their area of clinical practice. Specifically, these privileges are permissions to perform the individual procedure(s). These requested procedures are recommended by the executive committee of the medical staff and approved by the medical center director in

accordance with medical center bylaws. Clinical privileges are focused on provider clinical practice and are medical center-specific, provider-specific, and within the scope of the provider's licensure, training, experience and competency, medical/clinical knowledge, and the provider's health. Consideration is also given to any information related to medical malpractice allegations or judgments, loss of medical staff membership, and loss of clinical privileges.

Clinical privileges are granted for a period not to exceed 2 years at which time they must be re-evaluated and reissued. The service chief assesses updated information that mirrors items reviewed at the provider's initial appointment. The service chief then recommends which privileges should be granted or re-granted to the executive committee of the medical staff which is chaired by the medical center chief of staff. The executive committee evaluates the materials to determine if medical and clinical knowledge and clinical competence are adequately demonstrated to support recredentialing and the granting of the requested privileges. A final recommendation is then submitted to the medical center director who is the authority to grant privileges.

Now I want to mention NSQIP. NSQIP is that program that gathers aggregate data from surgical outcomes to determine whether there are significant deviations in mortality or morbidity rates for major surgical procedures. Since the beginning of fiscal year 2007, this information is reported on a quarterly basis. Prior to that time, the information had been gathered yearly. It was decided that NSQIP would be a better tool if the data were gathered more frequently. This was reinforced when our NSQIP data was evaluated after the onset of the new timing.

In response to an elevated ratio of expected surgical deaths during the first two quarters of fiscal year 2007, we, the VA, sent a NSQIP team to conduct an onsite visit at the Marion, Illinois, VA Medical Center. This was conducted as part——

Senator AKAKA. Dr. Cross, will you please summarize your statement?

Dr. CROSS. In conclusion, Mr. Chairman, VA has multiple tools in place for assessing and evaluating health care, and they are working, as in this case, to identify any irregularities and to correct them. These tools are part of the ongoing processes that are used to not only reveal the positive but also the vulnerabilities and deficiencies. We acknowledge these findings and seek to actively address the challenges they present. Moreover, the lessons learned are disseminated to health care providers throughout our health care system.

Thank you, sir.

[The prepared statement of Dr. Cross follows:]

PREPARED STATEMENT OF DR. GERALD CROSS, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman and Members of the Committee. Thank you for the opportunity to come here today to discuss VA's Credentialing and Privileging and its impact on current events at the Marion VA health care facility. I am accompanied by Ms. Kate Enchelmayer, our Director of Quality Standards, Dr. Peter Almenoff, Director of Veterans Integrated Service Network 15, and Dr. George Maish, Chief of Surgery, Lebanon, Pennsylvania, VA Medical Center.

CREDENTIALING

Credentials are a person's educational, training, experience, current competence, health status, certification and licensure documents. The Department of Veterans Affairs' (VA) standardized electronic credentialing program, VetPro, is used systemwide to document the credentials of health care providers. VA realizes that accurate credentialing is a cornerstone to ensuring qualified health care providers come into the system. In addition to the credentialing done on every licensed provider, the process of privileging that provider to administer care within the scope of his license and clinical competence and within the medical center's supporting capability remains an essential part of the initial processing that must be completed before the provider begins his duties within the Veterans Health Administration (VHA). This process is completed on initial appointment and at a minimum of every 2 years thereafter, before transfer from another medical facility, or whenever the provider requests an addition to his privileges.

The Credentialing Officer at a medical center obtains primary source information on all credentials. This is accomplished by direct contact with the entity providing the education, training, certification, licensure or registration. Information submitted by an individual health care practitioner is verified with that entity. This includes confirming the practitioner's answers to 17 supplemental/attestation questions specific to denial, surrender, revocation and termination of a credential, privileges, and medical society affiliation, as well as felony charges and any convictions. If a provider's license required for the position within VHA has ever been revoked or surrendered for cause (i.e., for reasons of substandard care, professional misconduct, or professional incompetence), that provider is not eligible for employment in VHA unless that license has been fully restored. The practitioner also is required to possess at least one full, active, current, and unrestricted license to practice.

In addition, VA uses other flagging systems during the credentialing process and the determination of suitability for employment. These include the National Practitioner Data Bank—Health Integrity and Protection Bank (NPDB–HIPDB), the Disciplinary Alerts Service of the Federation of State Medical Board (FSMB), the Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE), the National Agency Check and Inquiry (NACI), and the Special Agreement Check (SAC) (fingerprint check). The NPDB is queried for reports of malpractice payments or adverse actions against clinical privileges by another entity. The HIPDB, which is a national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers, is queried. Moreover, VA continuously monitors physician licensure for any disciplinary or untoward activity with the FSMB. VA also queries the LEIE, which is a database maintained by the Office of the Inspector General at the Department of Health and Human Services that lists all individuals and entities that are currently excluded from participation in Medicare, Medicaid and all other Federal health care programs.

The NACI is the basic and minimum background investigation generally required on all new Federal employees. It consists of a National Agency Check (NAC) of OPM's Security/Suitability Investigations Index (SII); the Defense Clearance and Investigations Index (DCII); the FBI Identification Division's name and fingerprint files; as well as written inquiries and searches of records covering specific areas of a person's background during the past 5 years. Those inquiries are sent to current and past employers, schools attended, references, and local law enforcement authorities.

Providers as well as all applicants are subject to a pre-employment background investigation. The SAC, an OPM investigation tool is a fingerprint based criminal history check that is processed through the FBI.

CLINICAL PRIVILEGING (PRIVILEGES)

In VA, a health care provider licensed for independent practice is given "privileges" that cover the breadth of their area of clinical practice. Specifically, these privileges are permissions to perform the individual procedure(s). These requested procedures are recommended by the executive committee of the medical staff and approved by the medical center director in accordance with medical center bylaws. Clinical privileges are focused on provider clinical practice and are medical center-specific, provider-specific, and within the scope of the provider's licensure, training, experience and competency, medical/clinical knowledge and provider health status (as it relates to the individual's ability to perform the requested clinical privileges). Consideration is also given to any information related to medical malpractice allega-

tions or judgments, loss of medical staff membership, and loss or reduction in clinical privileges.

Clinical privileges are granted for a period not to exceed 2 years at which time they must be re-evaluated and reissued. Re-privileging begins with the licensed health care provider applying through VetPro, updating all credentials/certification information, provision of peer references, and, again, answering the 17 supplemental/attestation questions. The service chief assesses updated information that mirrors items reviewed for the provider's initial appointment. The service chief, along with the credentialing officer, then recommends which privileges should be granted/re-granted to the executive committee of the medical staff which is chaired by the medical center Chief of Staff. The executive committee evaluates the materials to determine if medical/clinical knowledge and clinical competence are adequately demonstrated to support re-credentialing and the granting of the requested privileges. A final recommendation is then submitted to the medical center director who is the authority to grant privileges.

NATIONAL SURGICAL QUALITY IMPROVEMENT PROGRAM (NSQIP)

NSQIP gathers aggregate data from surgical outcomes to determine whether there are significant deviations in mortality and morbidity rates for surgical procedures. Since the beginning of Fiscal Year 2007, this information is assembled on a quarterly basis. Prior to that time, the information had been gathered yearly. It was decided that NSQIP would be a better tool if the data were gathered more frequently. This was reinforced when our NSQIP data was evaluated after the onset of this new timing.

In response to an elevated ratio of observed to expected surgical deaths during the first two quarters of Fiscal Year 2007, a NSQIP team conducted an onsite visit at the Marion, IL VAMC. This was conducted as part of the NSQIP ongoing program of surveillance of surgical mortality. The site visit was conducted in August 2007.

Following a full and comprehensive investigation of the elevated ratio of mortality at the Marion VAMC, the Director took immediate action to ensure the safety of patients until the completion of the investigation. All in-patient surgery at the Marion VAMC requiring general anesthesia was discontinued immediately. Veterans requiring surgery with general anesthesia were referred to other VAMCs or, if necessary, to non-VA hospitals. VA's Under Secretary of Health (USH) directed the VA Office of Medical Inspector (OMI) to conduct an onsite visit. On September 5–6, 2007, the OMI conducted a visit at the Marion VAMC and confirmed significant issues regarding surgical quality and operation and raised issues regarding the management environment at the medical center in general. That report is anticipated to be completed in the near future. The USH requested the VA Office of the Inspector General (OIG) to conduct an onsite visit. Those findings are not final at this time. To date, five members of the Marion VAMC staff have been reassigned to non-clinical areas away from the medical center or placed on administrative leave.

VA promptly notified Congress of the initial finding identified by VA's ongoing assessment and review processes. VA continues to be responsive to Congressional inquiries, to the extent possible, considering ongoing investigations.

CONCLUSION

Mr. Chairman, VA has multiple tools in place for assessing and evaluating health care and they are working, as in this case, to identify irregularities and correct them. These tools are part of the ongoing processes that are used in not only revealing the positive but also the vulnerabilities and deficiencies in VA's health care system. VA acknowledges these findings and seeks to actively address the challenges they present. Moreover, the lessons learned are disseminated to health care providers throughout our health care system.

Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.

Senator AKAKA. Dr. Cross, there are two issues at the heart of the situation at Marion. One, did VA do all it could to ensure that physicians practicing there were appropriate hires? And, two, when deaths and botched surgeries started to arise, did hospital management take appropriate action? Are you confident that VA did everything possible to verify the credentials of physicians? And are you

at this point able to say with certainty that hospital management responded appropriately when they were told about problems with the surgeon?

Dr. CROSS. Sir, what I can assure you of is that we have taken dramatic, swift, definitive action based on the information we have at this time and that we had in August. I am not going to be confident to tell you that I have the complete picture until the investigations are complete. That does include the medical inspector investigation and the IG investigation. But we have found that we have enough concerns—we had enough concerns early on in August that we took rather definitive action in removing by detailing out the medical center director. We detailed out the medical center chief of staff and subsequently detailed out the chief of surgery and an anesthesiologist.

As our investigation has continued, we have taken further action, which I have listed in my oral statement elsewhere, and some of that just occurring within the past few days.

Senator AKAKA. Your full statement will be included in the record, Dr. Cross.

Dr. Cross and Ms. Enchelmayer, timing clearly poses a problem in the process of background checks. Because medical administrators cannot discuss open disciplinary investigations, prospective employees may not be aware of serious issues surrounding potential hires.

The question is: How can the background check process be improved to ensure timely and accurate reporting?

Ms. ENCHELMAYER. I think that I can honestly say that we have a credentialing system in VA that is the envy of most of the health care industry. We collect a great deal of information on our health care practitioners at this time. The application process using the VetPro system is an electronic system that actually requires practitioners to answer the questions that Dr. Cross alluded to in the opening statement about actions in their past—voluntary surrenders because they have moved from States, as well as disciplinary actions. And they attest to the accuracy of that information as they submit their information to us.

We also ask them for a complete application electronically, which includes not only their education and training, but also they are requested to provide us information on all current and previously held licenses and registrations that they did hold. They must also account for all gaps greater than 30 days from the time that they graduated from their professional program, which gives us a full background history, and we can compare that work history to the information that they have provided to us so that is available to the medical staff leadership and the staff at the facilities to review.

We use the secondary flagging systems of the National Practitioner Data Bank and Health Integrity and Protection Data Bank, and we actually also use the Disciplinary Alert Service at the Federation of State Medical Boards, which is not an industry standard. We exceed that when we do query the FSMB for information on disciplinary actions on physician licensure. And that database has been in existence for many, many years. It precedes the National Practitioner Data Bank by a significant number of years. So that we do get the disciplinary information as well.

When practitioners submit their information, they actually attest to the completeness and accuracy of that information, so it is a legal attestation and a legal signature that can be used later if the information is not complete.

And then as Dr. Cross said, all information is primary-source verified, and we receive all the information that we can possibly receive.

You asked how we could be helped. The health care industry as a whole could be helped because we get the same information every other hospital and health care entity gets, and that is public information. So we would have to go beyond what all of health care industry gets at this time.

Senator AKAKA. Dr. Cross and Ms. Enchelmayer, it is my understanding that doctors' credentials are updated every 2 years when reappointment decisions are made. Is there a process in place to ensure that credentials are rechecked as soon as new information becomes available in national databases regarding disciplinary actions, malpractice payments, or license suspensions?

Dr. CROSS. I will ask Ms. Enchelmayer to expand on this, but I want to say yes, and we have involved ourselves with that, taken advantage of that, because one of the key credentials is the license itself. And if action is taken against a license, we do have a system, wherever that action was taken, to notify us.

Kate, can you expand?

Ms. ENCHELMAYER. I am happy to, sir.

VA does subscribe through a contract with the Federation of State Medical Boards to the Disciplinary Alert Service. So if a State Medical Board takes an action against a license, they report that action to their parent organization, the FSMB, and they in turn alert all of the member boards, which are 70 osteopathic and medical boards, as well as anybody who subscribes to that Alert Service, within 24 hours. I personally receive those alerts, and we turn them around to the medical centers for immediate processing, and they are to bring the information to the attention of medical staff leadership for review and action, as well as primary-source verify the information with the State Medical Board that led to that action.

Senator AKAKA. Thank you very much.

Senator BURR?

Senator BURR. Thank you, Mr. Chairman.

Dr. Cross, I will direct my questions to you, but if you would like others to answer them, please feel free. I notice that you did not mention in your testimony as to whether or not you believe the VA credentialing or privileging problems might have led to any of the fatalities at the Marion VA facility. Do you believe that the VA credentialing or privileging process is at fault?

Dr. CROSS. I think it is too early for me to assign fault, and I think that is where the responsibility will be assigned in the IG and the MI investigation. But I do have some concerns. I have concerns that we follow through, and that once privileges are granted, that we make sure that those privileges remain what is appropriate for that individual and that facility.

Senator BURR. When you say "appropriate for that individual," the scope of their——

Dr. CROSS. The scope.

Senator BURR [continuing]. Surgical or physician practice?

Dr. CROSS. Correct.

Senator BURR. Thank you. Was the VA policy adequately followed at the Marion VA facility?

Dr. CROSS. Based on the knowledge that I have at this time, understanding the investigation is continuing, it appears that they checked all of the things that I have listed off here, which were the appropriate things to do.

Senator BURR. Do you care to share with the Committee your thoughts as to what happened or who might be responsible?

Dr. CROSS. Sir, I am respectfully not going to try and assign responsibility, but I think the focus of our concerns relate to the privileging aspect and the monitoring of the privileging and to make sure that the staff onsite are well aware of exactly how performance is carried out.

Senator BURR. The Chairman asked a question relative to one's privileging and how that might be affected if something new was gleaned in that 2-year period. Let me ask a slightly different question.

The process you go through for credentialing and privileging is a very in-depth process that you explained. I would like to hear more about how a medical professional already employed by the VA would go about maintaining their privileges.

Dr. CROSS. I will ask Kate Enchelmayer to respond.

Ms. ENCHELMAYER. I am happy to answer that question, sir. Actually, the privileges are granted for a period not to exceed 2 years, but throughout that 2-year period, we have many ongoing monitoring activities at the local facility level, and that information should be being routinely analyzed by the service chiefs who are supervising the practitioners on that service and by the executive committee of the medical staff and the various committees of the hospital, looking for any questions that might arise on a practitioner's clinical practice during that period.

At a minimum, though, every 2 years all the practitioner performance data is to be reviewed and is to be analyzed as that practitioner renews his or her privileges.

Senator BURR. Dr. Cross, let me go to that timeline, if I can. I am not sure that any of us know exactly what every line means, but let me just ask you a question. Given where you start on that timeline, which is recognizing in some of the outliers there might be a problem here—I take for granted here that is what the first arrow is—and ending with the November 1, a general surgeon, an orthopedic surgeon, and another surgeon had privileges limited, meaning there has been a review not just of a doctor-implicated but the entire medical staff. Do you think that the amount of time that it was taking to reach each one of those steps is consistent with what we would find in any other medical center in the country?

Dr. CROSS. Sir, I would be very impressed if anyone could have ever done it faster. This is a quick response, getting three teams assembled, three teams conducting the investigations, and we took actions, not waiting for all the teams to come back and report. We took actions based on the information that we got early on. That action that we took was pretty dramatic in terms of removing from

the facility key leadership individuals. And we did that early on in that cycle, before the IG report came back, before the MI report had been finished. We thought that we had enough concern—and we did—to take action to make sure that our patients were protected, and we did that early on in the cycle.

I want to emphasize one thing that you asked about. Our investigation is not limited to just one individual. We are taking the broader picture, checking the entire situation, institution, others, taking the broadest possible look to make sure that our patients can be reassured.

Senator BURR. Do you have any concern as the Principal Deputy Under Secretary of Health, your title, that the Inspector General is looking at this investigation with all the powers his office brings?

Dr. CROSS. I know the Inspector General and his staff quite well on the medical side, and they are focused on detail, and they have remarkable determination to get to every one of those details. So, yes, I have absolute confidence in them.

Senator BURR. Thank you, Dr. Cross.

Dr. CROSS. I also have great confidence in their independence.

Senator AKAKA. Thank you, Senator Burr.

Senator DURBIN?

Senator DURBIN. Dr. Cross, I listened to your description of the process that is followed to credential doctors into the VA medical system. How much of that decisionmaking and investigation is done at the local level by the Marion hospital, for example?

Dr. CROSS. There are elements of credentialing and privileging that are both done at the local level, but privileging is the second phase of that, which is almost purely a local process. I will ask Kate to correct me if I am wrong.

Ms. ENCHELMAYER. That is a correct statement. Privileging actually has to be facility-based because the privileging process starts with what is available at the medical center, and what resources are available. And then you start to look at determining what will be performed at that facility, which is then followed by matching that with the practitioners who will be delivering the care.

Senator DURBIN. The lengthy and elaborate process that you described for credentialing and recredentialing physicians, I am trying to understand if that is being done at each of the 150 or so different VA medical centers or is being done in some central location?

Ms. ENCHELMAYER. It is being done at each independent—each individual facility because of the fact that the privileging process must be done at the local facility level. And the credentials are what feed to granting to those privileges to the individual practitioners.

We implemented in 2001 a standardized electronic credentialing system, which does standardize the credentialing process across the agency so that the credentialing done in one facility is the exact mirror of what is done in every other facility.

Senator DURBIN. So assuming there is a vacancy for a surgeon in a veterans medical center, do I understand then that the local people at that medical center get into this process of finding out who is available and then determining their qualifications to serve at that medical center?

Ms. ENCHELMAYER. Yes, sir.

Senator DURBIN. Do I understand that you are promulgating a new policy as of October 2nd this year relative to credentialing?

Ms. ENCHELMAYER. The credentialing and privileging policy is a very dynamic policy, and it has been republished numerous times, and, yes, the most recent publication was October 2nd.

Senator DURBIN. What is the most significant change in this new approach of October 2nd?

Ms. ENCHELMAYER. The October 2nd policy actually incorporated a number of other directives that we had put in place concerning the query to the Federation of State Medical Boards, which was mandated back in 2002; expedited credentialing to facilitate the credentialing process at the facility level slightly in accordance with the Joint Commission standards. It also incorporated some policy on telemedicine and teleconsultation, which had been a separate policy. It was a unification policy as well as also clarifying a number of issues over questions that have been raised for a number of years.

Senator DURBIN. There is obviously some element of self-reporting going on here by the applicants. For example, you have one physician, a surgeon, who was put on administrative leave due to failure to disclose that he was licensed in a particular State. So I take it that, at least at some stage in the process, you depend on the applicant to tell you which States he is licensed in.

Ms. ENCHELMAYER. That is a true statement, sir. We also do have, though, in policy a requirement to analyze the work history and to determine where somebody practiced and if there was potential for them to have a license in a State.

Senator DURBIN. How long did that particular surgeon practice before you discovered that he was licensed in a State he had not disclosed?

Ms. ENCHELMAYER. I did not do the immediate credentialing, sir. I cannot answer that.

Senator DURBIN. Dr. Cross, do you know?

Dr. CROSS. I will have to get that for the record, sir.

Senator DURBIN. All right. Let me ask you this: As I read the timeline here, I was surprised at a new entry I was not aware of: November 1st, a general surgeon, an orthopedic surgeon, and a genitourinary surgeon had privileges limited at Marion. So I would like to ask you at this point, with the resignation of Dr. Mendez, with the administrative leave given to another surgeon for failure to disclose his licensure in another State, and now with privileges limited, can you give me some kind of a feeling about how many of the surgeons in the surgical team at Marion have either resigned, been suspended, or have had their privileges limited?

Dr. CROSS. Sir, to date, five members of the medical center—five members of the Marion VAMC staff have been reassigned to nonclinical areas away from the medical center or admin leave. Also, a surgeon resigned, the original, upon notice of the pending investigation, and the VA notified the Illinois Medical Board, as we should have done. We did that. And subsequent to the initiation of the investigation, the privileges of three other surgeons at the Marion facility have been limited, and that is recent.

Senator DURBIN. What does this tell us about what seems to be a comprehensive credentialing and licensing process and the quality assurance process that, at a facility like Marion, questions would be raised about the disclosures made or practices followed by so many surgeons?

Dr. CROSS. I will start the answer, and I will ask Dr. Almenoff to support me on this. But right now, in our reviews, the multiple reviews that are being done, they did not dot the "i" and cross the "t" and, you know, we are taking action.

I will ask Dr. Almenoff to be more specific.

Dr. ALMENOFF. In total, there were three physicians that were on administration leave, and then there are three physicians that are also on limited privileges at this point.

The privileging process at the facility is the heart of what we are looking at, at this point. Privileging is really determined at the local site, and it is based on the capabilities of the facility, it is based on the capabilities of the provider, and it is based on the training that they have had in that specific area.

Senator DURBIN. How many doctors are there in the VA medical system?

Ms. ENCHELMAYER. Thirty-six thousand.

Senator DURBIN. Is it my understanding that there is some review underway for the credentialing of all of these doctors?

Ms. ENCHELMAYER. Yes, sir. What we did, as soon as this came to light, was since we do have an electronic system, we actually looked through the system at 56,000 licensed independent practitioners, so that goes beyond just the physicians but to anybody practicing independently. And we have retrieved 17,000 names that are under review right now. These are people who answered the supplemental questions yes, and I will tell you my name is in that list because I allowed a license to lapse in good standing when I moved from a State, so I answered yes to that question, just like a number of other people did, and anybody who has a positive answer to a previous disciplinary action by a licensing board and anybody who has a report from the National Practitioner Data Bank.

We actually brought in seven field staff to help us initiate the analysis, and right now the data is being reviewed at each individual facility. We expect to have an initial preliminary review of that data by early December with a final report to the Under Secretary by the end of December.

Senator DURBIN. Was this all brought on by the situation in Marion?

Ms. ENCHELMAYER. Yes, sir.

Senator DURBIN. So is it fair to say that the Marion situation, as tragic as it was, is that the canary in the cage that gave some indication to the VA that something needed to be looked into here more closely to protect the veterans who were coming in for medical care across America?

Dr. CROSS. Sir, I do not know that the situation in Marion, the concerns that we have about the individuals involved, necessarily relate to other medical centers, but we are cautious people, and out of that caution and care and concern for the patients, we chose to go do this very broad review.

Senator DURBIN. I see my time is up, but I just want to close with a comment. It is an interesting system where 150 different hospitals are going through this credentialing process, privilege process. I can understand that, as it was explained. But it also means it has been diffused into a lot of different places and a lot of different people. And now that you are doing the review, it is a central review where questionnaires are being sent, which leads me to ask whether or not the initial credentialing process should have had more central force in it, more central involvement so that there are certain standards that we can be sure of, whether we are dealing with a rural VA hospital, an urban VA hospital, or some particular challenge.

Thank you.

Senator AKAKA. Senator Murray?

Senator MURRAY. Thank you, Mr. Chairman. I was going to ask you what assurances we can give our servicemembers that this is not more of a systemic failure. I assume your answer would be that you are doing this broad review now as a result of what happened at Marion, correct? You have 17,000 physicians that you are now going back through and looking at.

Dr. CROSS. Seventeen thousand independently licensed providers, I believe, Senator. But there is also one more thing to say. We discovered this. It was our internal processes that picked this up. It was not some external source that brought this to our attention. And I think that should provide at least some reassurance as well.

Senator MURRAY. I am not sure I understand that. I thought that——

Dr. CROSS. The internal systems that we have in place.

Senator MURRAY. But I thought that this came about as a result of deaths that occurred at Marion VA.

Dr. CROSS. Our ability nationwide to pick up those and monitor those in terms of national standards is what caused us to trigger the investigation.

Senator MURRAY. Well, can you tell me what some of the reasons are that the screening process that was used by the VA could have missed the problems that were documented at the other facilities that physician worked at?

Dr. CROSS. I will ask Kate to assist me on this, but my understanding—is that the steps that we described here were done. Also, we obtained from his State and from his associates and from his supervisor letters of recommendation. I believe those letters will be part of the ultimate record that is released.

I should tell you that I can characterize them as being very positive, often seeing, you know, the best surgeons, highly technically competent; we would hire them back in a minute. And so it was with those kinds of references, a full, unrestricted license, 30 years of practice, that were factors that came into being at that time.

Senator MURRAY. So how can we assure that this does not happen again?

Dr. CROSS. Again, responsibility will be assigned, but my focus lies with the staff onsite who monitor day to day and who know their surgeons, know the cases that they are doing and make judgments about the scope of surgery that should be done by that surgeon at that location.

Senator MURRAY. Dr. Cross, can you share with this Committee the rate of fatal and non-fatal patient safety events that have occurred at the Marion VA since the beginning of 2006 compared with some of our other VA hospitals across the Nation?

Dr. CROSS. I do not think I have that with me, Senator. I can get that for the record.

Senator MURRAY. Does anybody at the table have that? No idea at all? If you could share that with the Committee, then, I would appreciate it as soon as possible.

Can I ask you, after the first couple of incidents occurred at the Marion VA, why was this physician allowed to continue performing surgery?

Dr. CROSS. I think that is a good question that the IG and the medical inspector's reports will shed more light on. One possible explanation is that at the time and at the place where they reviewed those cases, they thought there were good explanations that explained what had happened.

Senator MURRAY. OK. Is there anything systematically to review a physician after incidences occur? Or is it just kind of haphazard?

Dr. CROSS. Well, unlike our colleagues in the civilian world, we do have an additional safeguard, and that is the NSQIP system. And so even if the local safeguards do not work out well, we have a national system unlike any others that helps us as an additional safety net.

Senator MURRAY. How many deaths does it take to activate that?

Dr. CROSS. It is a statistical—it is not an absolute number. It is a statistical technique that is based on comparison to a national standard.

Senator MURRAY. Were the procedures that were being performed particularly complex, or were they routine?

Dr. CROSS. I think some were routine and some were more complex than I would have expected.

Senator MURRAY. I am certain that we will want to review the IG's report when it comes out. Let me ask you a more broad question because it is one that I think we all need to be aware of, and that is that we are really trying to hire more physicians to deal with the high number of incoming veterans, both from the current war as well as previous wars, and Congress has allocated funds over the last year to do that.

I am particularly interested in our rural VA facilities where we know in the general health care system they already have a hard time accessing physicians.

Should we be concerned that with trying to reach out and hire as many physicians as possible, particularly in our rural facilities, that we may run into more problems like this?

Dr. CROSS. Whether the facility is rural or urban, the same standards have to apply. I think what changes at a rural facility is the scope of surgery that we might do.

Senator MURRAY. Have the smaller rural VA facilities like the one in Marion seen an increasing number of veterans from this current conflict?

Dr. CROSS. They certainly see more, and we have with us today Dr. George Maish, from a similar facility in Lebanon, Pennsylvania. Dr. Maish?

Senator MURRAY. Perhaps you could answer what you are seeing at your facility.

Dr. MAISH. Senator, our facility has grown from 1999 to the present from taking care of 19,000 individuals to taking care of almost 41,000 individuals. So we have had to recruit personnel—doctor, nurse, PA, nurse practitioner—to care for these people. We are very busy in the recruiting business because of the rapid growth in the demand for services.

Senator MURRAY. And you come from a fairly rural facility; is that correct?

Dr. MAISH. I think I would be considered rural. I am in a town of about 20,000 in the farming country of Pennsylvania. I am 35 miles from Harrisburg, 90 miles to Philadelphia.

Senator MURRAY. And you have gone from 19,000 in what year?

Dr. MAISH. 1999.

Senator MURRAY. More than double today.

Dr. MAISH. Yes, in an 8-year period, yes.

Senator MURRAY. I assume, Mr. Chairman, that this is fairly similar to what a lot of our rural facilities are facing today. And what has been your experience in trying to hire physicians and medical personnel?

Dr. MAISH. It is a difficult job. I run a general surgical residency program, and I am integrated into the College of Medicine at Hershey Medical Center. Thus, the personnel that I seek to hire, I have to be able to present to the College of Medicine to hold an assistant professorship. So, I have to look at standards. I have needs. People have issues. If you look at my chronology, I graduated high school in 1960; I graduated from college in 1964; I graduated from medical school in 1968; I finished my surgical residency in 1973.

When I have breaks in that process, I have to ask the practitioner, "Where were you that year? What did you do?" There are often good explanations, and there have been some that were in jail. I dropped that process immediately.

People do not disclose adverse rulings from licensure boards. They are instructed by their personal attorney not to, unless they are directly asked. I engage this process. I believe the process is excellent to screen, but I have to execute my responsibilities in the recruiting of new physicians.

Dr. CROSS. I think, Senator—and Hershey is a growing area, so a lot of people have, in fact, turned up in that environment. And to complete my answer on one of your other questions, the NSQIP does cover all of our hospitals where we do surgery, including rural.

Senator MURRAY. OK. Well, I think, Mr. Chairman, my point is that we are seeing an increased intensity and need in our VA facilities across the country. In our rural and in our urban, but in our rural hospital facilities in particular, they are trying to recruit very fast. That means we have to be even more diligent in checking credentials because, as we all know, that is when people start slipping through the cracks. And I look forward to the hearing that I hope we will have once the IG report is complete, and I hope that the VA can come to us and really talk to us about what they are doing, particularly in these communities, to make sure that we get the

best, the brightest, and those who are credentialed and safe to perform surgery.

Thank you very much.

Senator AKAKA. Thank you, Senator Murray.

I want to thank the first panel. Dr. Cross, what you said is something that is of paramount importance for us—the well-being of our patients. That is why we are here—the VA patients. I primarily wanted to focus today on the hiring practices and quality control as well as the credentials of those who serve in those areas. And we want to fix any problems. And so I hope what is happening today will result in that.

May I call on Senator Durbin?

Senator DURBIN. Dr. Maish, I am not sure if this question is for you or for Ms. Enchelmayer or Dr. Cross, or perhaps all of you. In this particular case, this doctor surrendered his license in the State of Massachusetts and was characterized by the State as having done so for a non-disciplinary reason. And the explanation, I understand, I gave earlier, that he was no longer going to practice there and so forth.

I would like to ask you: Is that the kind of thing that would raise a question in your mind even if it were characterized as non-disciplinary?

Dr. CROSS. Sir, it raised the question in our minds as well and in the staff there. I do have to be precise. He did not relinquish his license. It is a technicality, but he agreed to not practice in the State. He still had a license. And the response by our staff, as I understand from the preliminary medical inspector's report, is that they thought that was of concern as well and actually called to the State of Massachusetts to get more information.

Senator DURBIN. And did they get more information?

Dr. CROSS. The only information they got was the words "it was a non-disciplinary action."

Senator DURBIN. Well, the first time you explained that to me all the red flags started to wave. I know as a lawyer, it looks like there was an agreement reached here: We are not going to take your license away, but we do not want you practicing in this State. We will put it down as non-disciplinary and that will be the end of it, but don't come around here anymore. And the lawyer may have said, "Let's get out of here. You can still practice at the VA facility in Marion. You still have an Illinois license. Let's move on."

Now, maybe that is a cynical view, but with the limited information which you have, it could also be an accurate view. And I would say, Dr. Maish, as you went through step-by-step and day-by-day, this was a suspicious thing that occurred, and had action been taken at that point, it would have been taken before many of these fatal surgeries.

Senator AKAKA. Well, again, I want to thank our first panel for your testimony and for your responses.

Senator AKAKA. I will now introduce the second panel. I want to extend my warm welcome and my warm aloha to the second panel. I appreciate each of you being here today and look forward to your testimony.

First, I welcome Randall Williamson, who is Director of Health Care for the GAO.

I also welcome Tammy Duckworth, Director of the Illinois Department of Veterans' Affairs. Ms. Duckworth has testified before this Committee twice before, most recently during our hearing last March, which examined health care services for returning servicemembers. I am happy to see you again, Tammy.

I also welcome Steven McCarty, a veteran from Bedford, Texas. Mr. McCarty served in Iraq in 2006 and 2007, and thank you for making the trip to testify today.

Each of your statements will appear in the record of today's hearing, and I ask that you each limit your direct testimony to no more than 5 minutes so that we have time for questions.

Mr. Williamson, will you please begin with your testimony?

STATEMENT OF RANDALL B. WILLIAMSON, ACTING DIRECTOR, HEALTH CARE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Mr. WILLIAMSON. Thank you, Mr. Chairman and Members of the Committee. I am pleased to be here today to discuss our May 2006 report on VA's processes for credentialing and privilegingVA physicians. Since Dr. Cross has already given you a fairly detailed overview of VA's credentialing and privileging process, I am going to limit my remarks today to the findings of our 2006 report on compliance with these processes at VA facilities we visited. I will also discuss the action VA has taken on the recommendations we made to improve the privileging process. For this work, we visited seven VA facilities, reviewed physician files, and interviewed VA officials as these facilities and at VA headquarters.

At the facilities we visited in 2006, we found that all seven facilities were complying with the key credentialing requirements that we examined, including requirements to verify physicians' State medical licenses, to verify information provided by physicians on their involvement in malpractice claims, and to query available databases to determine physicians' involvement in disciplinary actions and malpractice claims. We also looked at compliance with privileging requirements, including whether facilities were verifying physicians' training and experience, assessing physicians' clinical competence and health status, and considering a physician's performance while at VA when renewing his or her clinical privileges. While the seven facilities were complying with most of the privileging requirements we examined, we noted compliance problems with certain aspects of privileging.

First, we found that six facilities were not using or obtaining appropriate data to evaluate physicians' performance while at VA. The seventh facility was not using any physician performance data in making its privileging decisions for reappointment of physicians.

Second, three of the seven facilities were not forwarding information within the required 60 days on paid VA medical malpractice claims to a VA office that makes determinations on whether substandard care has occurred. Delays in providing this information could prevent determinations of substandard care by physicians from being considered as part of the facility's privileging process.

Finally, we found that one facility we visited lacked internal controls that would have helped identify that the privileging process had not been completed for 106 of its physicians within the 2 years required. As a result, these physicians were practicing at the facil-

ity with expired clinical privileges. None of the other six facilities we visited had internal controls in place that would have prevented a similar situation from occurring.

We made recommendations to improve VA's physician privileging process and to remedy each of the three problem areas that we found. VA concurred with our findings and recommendations and reported that it has implemented measures to improve its privileging process. However, we have not visited or examined records at VA facilities since 2006 to determine whether these improvements are in place and whether VA facilities are complying with the current credentialing and privileging processes.

VA's privileging improvements include:

(1) a policy issued last month elaborating on the appropriate types and sources of physician performance information that could be used by its medical facilities during the privileging process.

(2) stricter procedures to enforce prompt reporting of information about paid malpractice claims, including notification to medical facility directors and VA headquarters about delinquencies.

(3) establishment of internal controls to ensure that privileging information is kept accurate and current at its facilities.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or other Members may have.

[The prepared statement of Mr. Williamson follows:]

PREPARED STATEMENT OF RANDALL B. WILLIAMSON,
ACTING DIRECTOR, VA HEALTH CARE

GAO Accountability · Integrity · Reliability

Highlights

Highlights of GAO-08-271T, a testimony before the Committee on Veterans' Affairs, U.S. Senate

November 6, 2007

VA HEALTH CARE

Improvements Made in Physician Privileging Policies, but Medical Facility Compliance Has Not Been Assessed

Why GAO Did This Study

In a report issued in May 2006, GAO examined compliance with the Department of Veterans Affairs' (VA) physician credentialing and privileging requirements at seven VA medical facilities GAO visited. VA's credentialing process is used to determine whether a physician's professional credentials, such as licensure, are valid and meet VA's requirements for employment. VA's privileging process is used to determine which health care services or clinical privileges, such as surgical procedures, a VA physician is qualified to provide to veterans without supervision. Although GAO cannot generalize from its findings, GAO found that the seven facilities were complying with credentialing requirements. However, the facilities were not complying with aspects of certain privileging requirements. To better ensure that VA physicians are qualified to deliver care safely to veterans, GAO made three recommendations to improve VA's privileging of physicians. GAO was asked to testify today on (1) how VA credentials and privileges physicians working in its medical facilities and (2) the extent to which VA has implemented the three recommendations made in GAO's May 2006 report that address VA's privileging requirements. To update its issued work, GAO reviewed VA's policies, procedures, and correspondence related to physician privileging and interviewed VA central office officials to determine if the recommendations made in GAO's May 2006 report were implemented.

To view the full product, including the scope and methodology, click on GAO-08-271T. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

VA has specific requirements that medical facility officials must follow to credential and privilege physicians. VA requires its medical facility officials to credential and privilege facility physicians periodically so that they can continue to work at VA. Facility officials verify the information used in the credentialing process and query certain databases that contain information on disciplinary actions that have been taken against a physician's state medical license and have information about a physician's professional competence. Each physician also must complete a written request for clinical privileges that is reviewed by the physician's supervisor who considers whether the physician has the appropriate professional credentials, training, and work experience. In addition, every 2 years, the supervisor is to consider information on a physician's performance, such as a physician's surgical complication rate, when deciding whether to renew a physician's clinical privileges.

In a May 2006, GAO examined compliance with VA's physician credentialing and privileging requirements at seven VA medical facilities it visited and made three recommendations designed to improve aspects of privileging and oversight of the process. The three recommendations were to

- provide guidance to medical facilities on how to collect individual physician performance information in accordance with VA's credentialing and privileging policy to use in medical facilities' privileging process,
- enforce the requirement that medical facilities submit information on paid VA medical malpractice claims to VA within 60 days after being notified that the claim is paid, and
- instruct medical facilities to establish internal controls to ensure the accuracy of their privileging information.

VA reports that it has implemented all three recommendations by establishing policy and guidance for its medical facilities. However, GAO does not know the extent of compliance with these requirements at VA medical facilities.

Mr. Chairman and Members of the Committee:

I am pleased to be here today as you discuss physician hiring practices at medical facilities operated by the Department of Veterans Affairs (VA). VA has over 36,000 physicians working at more than 1,300 facilities in its health care system. To help ensure the quality of the health care these physicians deliver and the safety of veterans, VA is responsible for determining that its physicians have the appropriate professional credentials and clinical experience to provide health care to VA's patients. To do this, VA requires physicians to undergo credentialing and privileging. VA's credentialing process is used to determine whether a physician's professional credentials, such as licensure, education, and training, are valid and meet VA's requirements for employment. VA's privileging process is used to determine which health care services or clinical privileges, such as surgical procedures or administering anesthesia, a VA physician is qualified to provide to veterans without supervision. VA physicians must be credentialed and privileged when they apply to work in VA—which is known as initial appointment—and at least once every 2 years thereafter when they must reapply for a position on the facility's medical staff. These subsequent reviews are known as the process of reappointment.

In a report we issued in May 2006, we examined compliance with select credentialing and privileging requirements at seven VA medical facilities we visited and made three recommendations designed to improve aspects of privileging and oversight of the process. Although we cannot generalize from our findings, we found that these facilities were complying with credentialing requirements. However, they were not complying with aspects of certain privileging requirements.[1] For example, VA medical facilities were not submitting information on paid medical malpractice claims within the 60-day required time frame to VA's office that reviews the claims information and makes a determination about whether physicians involved in the claims delivered substandard care to veterans. VA generally agreed with our findings, conclusions, and recommendations.

[1]GAO, *VA Health Care: Selected Credentialing Requirements at Seven Medical Facilities Met, but an Aspect of Privileging Process Needs Improvement*, GAO-06-648 (Washington, D.C.: May 25, 2006), and *VA Health Care: Patient Safety Could be Enhanced by Improvements in Employment Screening and Physician Privileging Practices*, GAO-06-760T (Washington, D.C.: June 15, 2006).

Today, I will discuss the progress VA has made in implementing our May 2006 recommendations to address noncompliance with VA's privileging requirements. Specifically, I will discuss (1) how VA credentials and privileges physicians working in its medical facilities and (2) the extent to which VA has implemented the three recommendations made in our May 2006 report that address VA's privileging requirements.

To perform our 2006 review, we selected four of VA's credentialing requirements for review because they are requirements that—unlike others—address information about physicians that can change or be updated with new information periodically. As a result, VA requires that this information be verified by medical facility officials when a physician initially applies for employment at VA and at least every 2 years thereafter. Under the four requirements we reviewed, VA medical facility officials must

1. verify that all state medical licenses held by physicians are valid;
2. query the Federation of State Medical Boards (FSMB) database to determine whether physicians had disciplinary action taken against any of their licenses, including expired licenses;
3. verify information provided by physicians on their involvement in medical malpractice claims at a VA or non-VA facility; and
4. query the National Practitioner Data Bank (NPDB) to determine whether a physician was reported to this data bank because of involvement in VA or non-VA paid medical malpractice claims, display of professional incompetence, or engagement in professional misconduct.

Of the privileging requirements in VA's credentialing and privileging policy, we selected four requirements that VA identifies as general privileging requirements. In addition, we selected another privileging requirement about the use of individual performance information because of its importance in the renewal of clinical privileges. The five VA privileging requirements we selected were as follows:

1. verify that all state medical licenses held by physicians are valid;
2. verify physicians' training and experience;
3. assess physicians' clinical competence and health status;

4. consider any information provided by a physician related to medical malpractice allegations or paid claims, loss of medical staff membership, loss or reduction of clinical privileges at a VA or non-VA facility, or any challenges to a physician's state medical license; and

5. use information on a physician's performance when making decisions about whether to renew the physician's clinical privileges.

Two of the five privileging requirements—verify all state medical licenses and consider medical malpractice information—are also VA credentialing requirements we reviewed.

To update our work, we reviewed VA's policies, procedures, and correspondence related to physician privileging and interviewed VA central office officials to determine if the recommendations we made in our May 2006 report were implemented. We updated our issued work in July 2007 and November 2007, and we performed all of our work in accordance with generally accepted government auditing standards.

In summary, VA has specific requirements that medical facility officials must follow to credential and privilege physicians. VA requires its medical facility officials to credential and privilege facility physicians periodically so that they can continue to work at VA. We reported in May 2006 that the seven VA medical facilities we visited complied with the four credentialing requirements we reviewed and all but one of the five privileging requirements we reviewed. However, during our review, we found that medical facility officials did not have all of the information they needed on physicians involved in paid VA medical malpractice claims, because the facilities had not submitted such information in a timely manner to VA's office that reviews the claims information and makes a determination about whether physicians involved in the claims delivered substandard care to veterans. We also found during our review that VA did not require its medical facilities to establish internal controls to help ensure the accuracy of their privileging information. Without internal controls VA medical facility officials did not know if they properly renewed clinical privileges, thereby allowing physicians to practice with expired clinical privileges. Since our 2006 review, VA reports that it has implemented all three of our recommendations to improve VA's physician privileging process. However, since our work in 2006 we have not visited or examined records at facilities to determine the extent of compliance.

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. VA delegates decision making regarding financing, health care service delivery, and medical facility operations to its 21 networks.

Physicians who work at VA medical facilities are required to hold at least one current and unrestricted state medical license. Current and unrestricted licenses are those in good standing in the states that issued them, and licensed physicians may hold licenses from more than one state. State medical licenses are issued by state licensing boards, which generally establish state licensing requirements governing their licensed practitioners.[2] To keep licenses current, physicians must renew their licenses before they expire and meet renewal requirements established by state licensing boards, such as continuing education. Renewal procedures and requirements vary by state. When state licensing boards discover violations of licensing practices, such as the abuse of prescription drugs or the provision of substandard care that results in adverse health effects, they may place restrictions on licenses or revoke them. Restrictions issued by a state licensing board can limit or prohibit a physician from practicing in that particular state. Generally, state licensing boards maintain a database that contains information on any restrictions or revocations of physicians' licenses.

VA's Credentialing and Privileging Processes

Credentialing Process

When physicians apply for initial appointment, they initiate the credentialing process by completing VA's application, which includes entering into VetPro—a Web-based credentialing system VA implemented in March 2001—information used by VA medical facility officials in the credentialing process. Among the credentialing information that VA requires physicians enter into VetPro is information on all the state

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

medical licenses they have ever held, including any licenses they have held that have expired. For their reappointments, physicians must update this credentialing information in VetPro.

Once physicians enter their credentialing information into VetPro, a facility's medical staff specialist—an employee who is responsible for obtaining and verifying the information used in the credentialing and privileging processes—performs a data check on the information to be sure that all required information has been entered. In general, the medical staff specialist at each VA medical facility manages the accuracy of VetPro's credentialing data. The medical staff specialist verifies, with the original source of the information, the accuracy of the credentialing information entered by the physicians. This type of check is known as primary source verification. For example, the medical staff specialist contacts state licensing boards in order to verify that physicians' state medical licenses are valid and unrestricted.

At initial appointment only, VA requires medical staff specialists to query FSMB, which contains information from state licensing boards. This query enables officials to determine all the state medical licenses a physician has ever held, including those not disclosed by a physician to VA, and whether a physician has had any disciplinary actions taken against these licenses. VA does not require this query at reappointment because VA headquarters regularly receives reports from FSMB on any VA physician whose name appears on FSMB's list, indicating that disciplinary action has been taken against the physician's state medical license. When VA headquarters receives a report from FSMB, it notifies the appropriate VA medical facility.

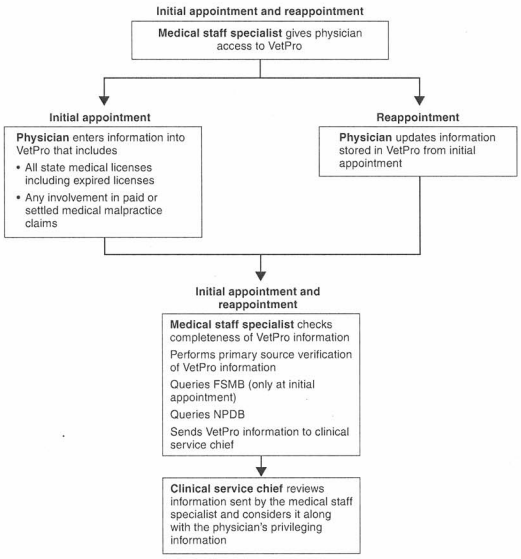
VA's credentialing process requires VA medical staff specialists to verify medical malpractice claims at initial appointment and at reappointment. These claims may be verified by contacting a court of jurisdiction or the insurance company involved in the medical malpractice claims, or by obtaining a statement of claims status from the attorney representing the physician in the medical malpractice claim. In addition, VA requires medical staff specialists to query NPDB, which contains reports by state licensing boards, hospitals, and other health care entities on unprofessional behavior on the part of physicians or adverse actions taken against them. This query enables officials to determine whether physicians fully disclosed to VA any involvement they might have had in paid medical

malpractice claims.[3] Once a physician's credentialing information has been verified, the medical staff specialist sends the information to the physician's supervisor, who is known as a clinical service chief.[4] The clinical service chief reviews this information along with the physician's privileging information. Figure 1 illustrates VA's credentialing process.

[3]NPDB includes information on medical malpractice claims that are paid, but does not include information on ongoing claims.

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

Figure 1: Steps Taken in VA's Physician Credentialing Process



Source: GAO analysis of VA credentialing policy.

Privileging Process

Physicians, in addition to entering credentialing information into VetPro, must complete a written request for clinical privileges. The facility medical staff specialist provides a physician's clinical service chief with the physician's requested clinical privileges and information needed to complete the privileging process, including information that indicates that the credentialing information entered by the physician into VetPro has been verified with the appropriate sources. For reappointment,

documentation is required by another physician stating that the physician is able to perform both physically and mentally the clinical privileges requested. In addition, the medical staff specialist provides the clinical service chief with information on medical malpractice allegations or paid claims, loss of medical staff membership, loss or reduction of clinical privileges, or any challenges to the physician's state medical licenses.

The requested clinical privileges are reviewed by a clinical service chief, who recommends whether a physician should be appointed or reappointed to the facility's medical staff and which clinical privileges should be granted. When deciding to recommend clinical privileges, a clinical service chief considers whether the physician has the appropriate professional credentials, training, and work experience to perform the privileges requested. For reappointment only, a clinical service chief is to consider observations of the physician's delivery of health care to veterans, and VA's policy requires that information on a physician's performance, such as a physician's surgical complication rate, be used when deciding whether to renew a physician's clinical privileges. Based on the clinical service chief's observations and the physician's performance information, the clinical service chief recommends that clinical privileges previously granted by the facility remain the same, be reduced, or be revoked, and whether newly requested privileges should be added.[5]

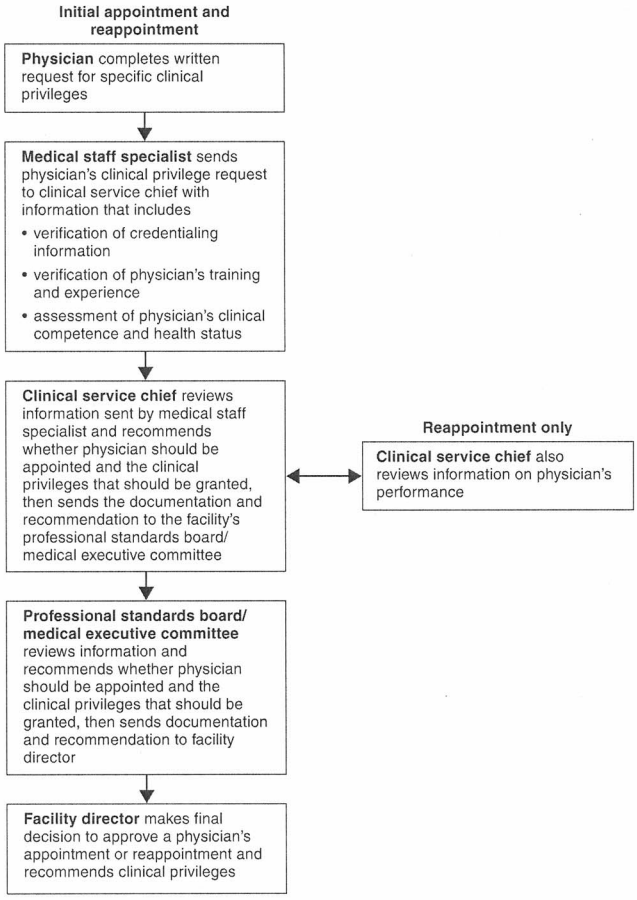
Clinical service chiefs forward their recommendations and the reasons for the recommendations to the next level of a medical facility's privileging review process, which may be a professional standards board or a medical executive committee.[6] A medical facility professional standards board or the medical executive committee reviews the recommendations of the clinical service chief and recommends to the facility director whether the physician should be appointed to the facility's medical staff and which clinical privileges should be granted to the physician. The 2-year time period for renewal of clinical privileges and reappointment to the medical staff begins on the date that the privileges are approved by the medical

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

[6]At some VA medical facilities, the professional standards board and the medical executive committee represent the medical staff, have the same members, and perform the same functions so are considered to be one committee. If the committees are separate, the professional standards board generally consists of three to five physician peers and the medical executive committee generally consists of all facility clinical service chiefs.

facility's director. The list of approved clinical privileges with the date of approval is maintained at VA medical facilities and the initial appointment or reappointment date is entered into VetPro. Figure 2 illustrates VA's privileging process.

Figure 2: Steps Taken in VA's Physician Privileging Process



Source: GAO analysis of VA privileging policy.

According to VA's policy and a VA memorandum, information concerning individual physician performance that is used as part of the privileging process to either reduce, revoke, or support[7] granting clinical privileges must be collected separately from a medical facility's quality assurance program.[8] VA's policy is based on a federal law that restricts the disclosure of documents produced in the course of VA's quality assurance program.[9] In general, documents created in connection with such a program are confidential and may not be disclosed except in limited circumstances.[10] Individuals who willfully disclose documents that they know are protected quality assurance documents are subject to fines up to $20,000. Although the law states that it is not intended to limit the use of documents within VA, VA's policy expressly prohibits the use of such documents in connection with the privileging process. VA's use of separate information sources for quality assurance and privileging decisions is intended to maintain the confidential status of documents produced in connection with quality assurance programs. According to VA, the confidentiality of individual performance information helps ensure provider participation, including physicians, in a medical facility's quality assurance program by encouraging providers to openly discuss opportunities for improvement in provider practice without fear of punitive action.

VA has another requirement that is related to the renewal of physicians' clinical privileges. Medical facility officials are required to submit to VA's Office of Medical-Legal Affairs information on paid VA malpractice claims. This information must be submitted within 60 days after the medical facility is notified about a paid malpractice claim. The Office of Medical-Legal Affairs is responsible for convening a panel of clinicians to determine whether a VA facility physician involved in the claim delivered

[7]Support granting clinical privileges means that the clinical privileges previously held by the physician will be maintained and newly requested clinical privileges will be added.

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

[9]38 U.S.C. § 5705 (2000).

[10]See Department of Veterans Affairs, *VHA Handbook*, 1100.19 (Washington, D.C.: Mar. 6, 2001).

substandard care. The Office of Medical-Legal Affairs notifies the medical facility director of the results of its review. If it is determined that the physician delivered substandard care to veterans, the medical facility must report the physician to NPDB within 30 days of being notified of the decision. VA medical facility officials also would use this determination to decide whether to grant clinical privileges to the physician involved in the VA medical malpractice claim.

VA Has Addressed All GAO Physician Privileging Recommendations, but Extent of Medical Facility Compliance Is Unknown

In our 2006 report, we found that the physician files at the seven facilities we visited demonstrated compliance with four VA credentialing and four privileging requirements we reviewed.[11] However, we found that there were problems complying with a fifth privileging requirement—to use information on a physician's performance in making privileging decisions. We also found during our review that three of the seven medical facilities we visited did not submit to VA's Office of Medical-Legal Affairs information on paid VA medical malpractice claims within 60 days after being notified that a claim was paid, as required by VA policy. Further, VA had not required its medical facilities to establish internal controls to help ensure that privileging information managed by medical staff specialists is accurate. Internal controls are important because at one facility we visited we found 106 physicians whose privileging process had not been completed by facility officials for at least 2 years because of inaccurate information. As a result, these physicians were practicing at the facility with expired clinical privileges. None of the VA medical facilities we visited for our 2006 report had internal controls in place that would prevent a similar situation from occurring. To better ensure that VA physicians are qualified to deliver care safely to veterans, we recommended that VA

- provide guidance to medical facilities on how to collect individual physician performance information in accordance with VA's credentialing and privileging policy to use in medical facilities' privileging process,
- enforce the requirement that medical facilities submit information on paid VA medical malpractice claims to VA's Office of Medical-Legal Affairs within 60 days after being notified that the claim is paid, and

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

- instruct medical facilities to establish internal controls to ensure the accuracy of their privileging information.

VA states that it has implemented all three recommendations we made in our May 2006 report to address compliance with VA's physician privileging requirements by establishing policy and guidance for its medical facilities. However, we do not know the extent of compliance with these requirements at VA medical facilities.

VA implemented our recommendation that VA provide guidance to VA medical facilities on how to appropriately collect information on individual physician performance and use that information in VA's privileging process. Physician performance information is to be used to assist VA medical facility clinical service chiefs in determining the appropriate clinical privileges that should be granted based on a physician's clinical competence. VA implemented our recommendation by issuing a policy on October 2, 2007, that elaborated on the sources of physician performance information and the types of information that could be collected outside of VA medical facilities' quality assurance programs. In addition, in July 2007, VA officials told us that they were in the process of implementing online training programs on physician performance information to help implement our recommendation. The training will be mandatory for all VA medical facility clinical service chiefs and medical staff leaders responsible for the assessment and oversight of the privileging process and must be completed by January 31, 2008.

VA also implemented our recommendation that it enforce its requirement that VA medical facilities report information on any paid VA malpractice claims involving their physicians to VA's Office of Medical-Legal Affairs within 60 days after being notified of a paid claim. In June 2006, VA's Office of Medical-Legal Affairs began notifying network and VA medical facility directors of delinquencies in reporting this information by the medical facilities. If a medical facility's delinquency in reporting extends longer than 90 days, VA requires the Office of Medical-Legal Affairs to inform not only network and VA medical facility directors but also VA's central office of the delinquency. Because VA's Office of Medical-Legal Affairs reviews information on paid malpractice claims involving VA physicians to determine whether the physicians delivered substandard care, when VA medical facilities do not submit relevant malpractice claim information to this office, medical facility clinical service chiefs may make privileging decisions without complete information about substandard care provided by physicians.

Further, VA implemented our recommendation that it instruct VA medical facilities to establish internal controls to ensure the accuracy of their privileging information. Internal controls help ensure that VA medical facility officials have accurate clinical privileging information and that physicians are not practicing at the facility with expired clinical privileges. To address our recommendation, VA first asked network directors to report on how they tracked the privileging status of VA physicians. In response to a VA memorandum sent on May 16, 2006, network directors provided a report indicating that their medical facilities had one or more mechanisms in place to identify physicians who were currently privileged at their facilities and to track whether their privileges have expired. In addition, VA instructed its network directors to monitor the internal controls at their facilities that ensure that VA medical facilities have accurate clinical privileging information and that physicians are not practicing with expired clinical privileges.

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

Contacts and Acknowledgments

For further information regarding this testimony, please contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this testimony. Marcia Mann, Assistant Director; Mary Ann Curran; Christina Enders; Krister Friday; Lori Fritz; Rebecca Hendrickson; and Jason Vassilicos also contributed to this statement.

Senator DURBIN [Presiding]. Secretary Duckworth, you are next to testify. Glad to see you here.

STATEMENT OF TAMMY DUCKWORTH, DIRECTOR, ILLINOIS DEPARTMENT OF VETERANS' AFFAIRS

Ms. DUCKWORTH. Well, I would like to thank my Senators, Senator Durbin and Senator Obama, for their aggressive actions leading to the examination that we are now seeing at the Marion VA Medical Center. Senator Durbin and Senator Obama have long been advocates of veterans here in Illinois.

I would like to have my additional comments added to the record from the written statement.

Senator DURBIN. Without objection.

Ms. DUCKWORTH. My biggest concern, sir, is that there is a lack of consistency across the Nation when it comes to the local level for implementing many of the VA's national programs, and I am seeing this in our rural communities especially, specifically Danville VA and Marion VA. Both are in rural central and southern Illinois.

The problem that we have is that whether it is a policy of allowing veterans to access outside physicians or whether it is this credentialing issue, there is a national policy, but it is selectively enforced at the individual medical center level. I will give you an example with Danville VA.

Many of the patients at Danville VA actually have to travel upwards of 3 to 4 days just to get a simple chest x-ray, while there are doctors and physicians near their home towns where they can actually get these procedures completed without having to spend multiple overnights. The Danville VA is very reluctant to allow the patients in its community to access their outside health care, even though a procedure already exists for them to do so in the Federal VA system. So while there is great national policy and procedures written someplace in a manual, oftentimes it is the local administrators, the local hospital administrators, who interpret those policies who do not actually administer them.

The timeline that we saw earlier today gives me great concern because we are so focused on what happened after the ten deaths occurred, we are not looking at what happened up to that point. Did the local facilities actually implement those processes, those wonderful processes that actually lead the Nation in terms of credentialing? I am also additionally concerned with the fact that a doctor in the Marion VA does not have to hold a license in Illinois to practice in Illinois. That is a great concern to me. I know that in our four nursing homes that we operate by the State of Illinois for veterans, our doctors that operate there hold licenses in Illinois and also have privileges at the local hospitals outside of our own system. So that there is some sort of a cross-check, not only of we verifying them but they also hold privileges at the local community hospitals as well, who also go through their own process of verifying the credentials of the physician.

Throughout this, I think it is important to say that I do not ask for any shutdowns of any rural VAs. In fact, we need more VA hospitals and clinics, especially in our rural communities. In Illinois alone, over 50 percent of our recruits come from areas outside Chicago's Cook and collar counties, and we are seeing an increased

rise in veterans' needs, not just from the young veterans coming home from Iraq and Afghanistan. The Federal VA estimates that there are approximately 8,122,000 Vietnam veterans who are now entering their mid-60's, at a point when their medical needs increase. Many of the illnesses, such as those caused by Agent Orange, are just now appearing in their system—leukemia, cancers, those types of things. There is going to be a greater demand for more complex procedures for older veterans, and this is happening across the Nation.

As a percentage of that 8 million veteran number, I am estimating that Illinois alone has approximately 389,000 Vietnam veterans. Many of these veterans have not accessed VA care up until this point. Many of these veterans live a long way away from the nearest VA clinic or hospital.

So I would like to just summarize my testimony by saying that some of the suggested solutions are that the USDVA needs to either open more VA clinics and Vet Centers, or they need to start certifying private practitioners to provide medical services and give the veteran this option to access care outside of the VA clinic or the VA hospital themselves. We need to ensure, however, that there is no drop in standard of care for our veterans. We also need to identify major civilian medical facilities, such as university teaching hospitals or other large networks, where the physicians who have privileges at the VA hospital should be required to also have privileges, surgical privileges, practice privileges as these outside facilities to provide a cross-check, as it were. Not only is there a VA system that is being implemented by the local VA hospital administrator, but if that physician is required to have a licensing requirements in the State where he is practicing, as well as privileges at an outside hospital, I hope that will help to reinforce and provide a back-up.

There simply is just not enough time for the USDVA to try to recruit enough physicians to meet the current need, and I think that it is time to think a little outside the box. And I thank you for calling this hearing, even at this early stage, because I think it will allow us to move forward in terms of future questions that need to be raised.

I want to say, Senator Akaka, that it is great to see you in that chair, sir. Thank you.

[The prepared statement of Ms. Duckworth follows:]

PREPARED STATEMENT OF TAMMY DUCKWORTH, DIRECTOR,
ILLINOIS DEPARTMENT OF VETERANS' AFFAIRS

Mr. Chairman, Members of the Committee. It is a pleasure to be asked to testify before you today on behalf of Illinois Governor Rod Blagojevich and the Illinois Department of Veterans' Affairs. This Committee is to be commended for drawing attention to the very important issue of quality of care for our returning Veterans and servicemembers.

I want to thank my Senator, Senator Durbin, for his aggressive action which led to the examination we are now seeing at the Marion VA Medical Center. Sen. Durbin has long been an advocate for Veterans and their care.

The Illinois Department of Veterans' Affairs assists Illinois' Veterans in obtaining their State of Illinois Veterans' benefits as well as their Federal Veterans' benefits. We have 74 Veterans Service Officers on staff who are certified by the U.S. Dept. of Veterans' Affairs (USDVA) to process, represent and make appeals on behalf of the Veteran in their claims for compensation from the USDVA. State of Illinois benefits for Veterans are in addition to Federal benefits and range from generous edu-

cational, mortgage loan, and other financial assistance to our four Veterans' Homes where Illinois' Veterans may live out their remaining days with the dignity and care they deserve. As the Director of this agency, I want to be clear that we do not have any jurisdiction over the USDVA's operations, to include the various USDVA Veterans' clinics, hospitals and Vet Centers.

While we may not have the responsibility of licensing and overseeing the actual hiring of doctors for the Federal facilities in Illinois, we do work closely with all our Veterans and try to find the most reasonable and highest quality health care accommodations available.

As the Director of IDVA, I see every day the struggles of families as they prepare to drive long distances to a health care facility. These struggles impact spouses, parents, and children. And when in a rural area, these drives and travels take a further toll on our servicemembers and Veterans. We cannot afford to have doctors who are not suited for license practicing medicine in any of our facilities. And we cannot have disparities in the quality of care that is provided at our rural and urban facilities.

Statistics vary on the actual number of U.S. military recruits from rural communities, but they all indicate that a disproportionate percentage of our all-volunteer military are from rural areas, and thus a disproportionate share of deaths and injuries are occurring within our rural recruit population. In Illinois, over 50 percent of our military recruits entered the service from a county outside the city of Chicago's Cook and collar counties. As such, maintaining facilities such as Marion, yet improving the quality of care provided, is essential to DOD's and the VA's ability to care for our Soldiers once they return home from their service to our Nation.

In Illinois we have a significant rural population who live a long distance away from the nearest metropolitan area where the USDVA typically locates its Veterans servicecenters, clinics and hospitals. This poses a significant access issue for our Veterans. Accordingly, the IDVA has responded by opening 51 offices throughout the state to provide Veterans with a location to obtain assistance in applying for their USDVA benefits. Once approved, however, Veterans still often have to travel a long distance in order to obtain care, often involving multiple overnights away from home as they wait for the various once-a-day shuttle bus services. It is normal for a Veteran in central Illinois to have to travel fours days away from home roundtrip, for a single doctor's visit, sometimes for a procedure as simple as an x-ray.

More personally, as an injured Veteran I've seen first hand what it is like to receive care in our VA system. In particular, I want to highlight the stresses of traveling to get care as well as the impacts that these stresses have on the families of Veterans. I can attest to the hardship on my family and employer. I live in suburban Chicago. To access my VA hospital basically takes an entire day off from work because of the long drive times as well as the common experience of long waiting times to see medical professionals, obtain pharmacy services, etc. Now, I'm the Director of a state Veteran's agency. I would not be surprised if I routinely receive more conscientious service than most. If I find some of these things challenging or difficult, imagine how a 20-year-old Soldier who has never interacted with the system feels. Not to mention, how does a 70-year-old Veteran who can no longer drive obtain the services that he earned and now needs?

The VA system faces new challenges as a result of the wars in Iraq and Afghanistan. The patient profile in the VA is changing. More wounded Soldiers are surviving very serious injuries. We face new types of injuries, such as Traumatic Brain Injury and an increase in poly trauma cases as well as servicemembers facing Post Traumatic Stress Disorder. With the all-volunteer military, we are now seeing a much larger patient load that is geographically disbursed around our country.

With these new demands, the VA hospitals will be under increased pressure to find more doctors to deliver quality care. I repeat, QUALITY care. The VA must ensure that its hiring procedures do not allow anyone to cut corners and compromise excellence as hiring is ramped up. That pressure is likely to be most acute in hospitals located in rural and underserved areas. The VA must put procedures in place to ensure that only qualified doctors are hired and that these medical professionals are given the cultural training that comes with the unique culture of the military. At the end of his life my father could be a difficult patient. However, if a doctor called him by his military rank and told him there were lower ranking Vets who were ill and needed to have priority over him, my dad would have gladly slept in the hallway to make sure that the lower ranking Soldier was cared for.

Our VA medical system must meet the challenge our young Veterans' have as they return with new needs and at the same time it must expand its services to meet the demand of the boom in Vietnam Veterans re-entering the VA system. Many of these Vietnam Vets have not used VA services previously, but are now entering their mid-60's with all the associated diseases and illnesses that comes with

their age. We are also dealing with injuries that have taken over 30 years to develop, such as cancers, diabetes and other conditions that result from exposure to Agent Orange. According to the State of Aging and Health in America 2007 Report, the cost of providing health care for an older American is three to five times greater than the cost for someone younger than 65.

So the USDVA is now faced with our young servicemembers returning home and entering the VA medical system at the exact same time that the medical needs of our Vietnam Veterans will be increasing. The amount of money this is going to cost the Nation and each individual state is tremendous. In addition, we don't have enough room at our facilities—state or Federal—to take care of both eras at once. The dedicated staff at the USDVA medical hospitals is already overworked and understaffed. Let me give you an example: The USDVA estimates that there are 8,122,000 Vietnam era Veterans in this country. I estimate, based on percentage of Veterans in Illinois that we are home to 389,856 Vietnam Veterans. The Illinois Department of Veterans' Affairs operates four state Veteran homes, which are long-term care facilities. Our 1,000 beds are almost at full capacity and already house 100 Vietnam Veterans. The number of Vietnam Veterans seeking to enter our Veterans' homes will only increase as will the number on the waiting list. In response, we are in the planning stages to build another new Veterans' home. The fact is that right now most VA systems, at the state or the Federal level, are not ready to handle both eras' Veterans entering the VA system at the same time. Illinois is working to be ready with the first of the expansions to our Veterans Homes opening next summer and by investing over $50 million in new programs aimed at young Veterans in just 2007 alone.

What the USDVA needs is to either open more VA clinics and Vet Centers or to certify private practitioners to provide medical services and give the Veteran this option. While there is already a system in place within the USDVA for Veterans to use private medical care facilities, this system is uneven across the Nation. In central Illinois, the Danville VA facility is so unyielding that it actually forces its Veterans to endure overnight travel to get a simple x-ray performed instead of using a local clinic minutes away from their home. By identifying major civilian medical facilities, such as University teaching hospitals or other large networks, the USDVA could ensure that our Veterans receive the needed quality care that they deserve. I must caution, however, that any privatization of VA care be conducted with extreme supervision to insure that there is no lowering of standards and quality of care for our Veterans.

An additional way that the USDVA is not ready to handle our Veterans' needs is in technology. The USDVA has superior expertise in many areas and can meet Veterans' needs if the Veteran can afford to travel to the appropriate VA facility. However, in other areas, the VA is far behind current developments and will be unlikely to catch up and adequately meet Veterans needs at the same time. For example, in the case of prosthetics, the VA is not ready and our Veterans cannot afford to wait for them to play catch-up. My VA hospital, Hines, is superior in blind and spinal cord rehabilitation, but the prosthetics department, while eager to meet my needs, is many decades behind in prosthetics technology. I now receive care at Hines for my primary medical care, but also continue to return to Walter Reed for prosthetics—paying for my own travel costs. I also travel to a specialist in Florida for state-of-the-art care. Recently, Hines sent a prosthetist with me to Florida to learn about the high-tech artificial legs that I obtain from the private practitioner there. He was overwhelmed by the technology and the civilian practitioner was appalled at the lack of current knowledge shown by the Hines representative. The USDVA is absolutely not ready to treat amputee patients at the high-tech levels set at the DOD medical facilities. Much of the technology is expensive and most of the VA personnel are not trained on equipment that has been on the market for several years, let alone the state-of-the-art innovations that occur almost monthly in this field. I recommend that the VA expand its existing program that allows patients to access private prosthetic practitioners. There is simply not enough time for USDVA to catch up in this field in time to adequately serve the new amputees from OIF/OEF during these critical first 2 years following amputation. Perhaps after the end of the current wars in Iraq and Afghanistan, the VA will have time to advance its prosthetics program.

I've appeared before both the U.S. Senate Committee on Veterans' Affairs and the House Subcommittee on Veterans' Affairs to testify on the seamless transition from DOD to VA health care and have presented several recommendations to improve the health care services for our Nation's Veterans. For instance, I recommended that any seamless transition program must also include comprehensive screening for Traumatic Brain Injury (TBI), Post Traumatic Stress Disorder (PTSD) and vision loss by both the DOD and the USDVA Health Care systems.

I want to highlight how Illinois is addressing TBI and PTSD. Over the past summer, Illinois announced the Nation's first-of-its-kind program to screen every Illinois National Guard member for Traumatic Brain Injury while offering free TBI screening to all other Illinois Veterans. As part of this program, Illinois is also establishing a24-hour, toll-free hotline to provide psychological assistance to Veterans suffering from Post Traumatic Stress Disorder. When a Veteran calls this hotline, a clinician performs an initial over-the-phone screening and determines the next steps to take. All staff will be trained in the area of combat-related PTSD and other mental issues faced by Veterans, and there is at least one psychiatrist on call at all times. The hotline format is important, as our Veterans often do not have the option or willingness to drive 100 miles for PTSD treatment. When one wakes up from a nightmare at 2 a.m. on a Friday night, one needs help immediately, not at 8 a.m. on the following Monday, which is the current case with the USDVA. I know that efforts are underway to strengthen these assessments by both the DOD and the USDVA. However, there is no standard procedure in place to insure that all returning servicemembers are screened nation-wide.

I commend this panel for its oversight of the U.S. Veterans Administration and the facilities that it operates. We should all demand that our Veterans have access to care that is commensurate to their dedication to our country.

I would be happy to take any questions.

Senator AKAKA [Presiding]. Thank you.

Mr. McCarty?

STATEMENT OF STEVEN MCCARTY, VETERAN, OPERATION IRAQI FREEDOM, BEDFORD, TEXAS

Mr. MCCARTY. Mr. Chairman, thank you for the opportunity to testify today before the Veterans' Affairs Committee. I look forward to sharing my story with the Senators here this morning.

My name is Steve McCarty, and I am a Lance Corporal with the United States Marine Corps Reserve with the 14th Marines Headquarters Battery out of Fort Worth, Texas. On June 1, 2006, I was part of a detachment that was activated with 1st Marines 24th Division. We were sent to Fallujah, Iraq, from September 24, 2006, to April 15, 2007. During this time I served as a member of a truck platoon.

In February of this year, while I was still in Iraq, I was concerned when I started experiencing diarrhea with blood in the stool. When I confronted my corpsman, he gave me the option to either keep going and do the missions or go to medical and receive treatment and possibly miss operations. I chose to keep going.

Upon returning from Iraq in April, the stress of demobilization and jubilation of getting reacquainted with family and civilian life overshadowed the discomfort of my symptoms, which seemed minor at the time. While driving home from visiting my grandmother in Indiana, my symptoms got to the state where they could no longer be ignored. I was in severe pain, had bad diarrhea, and was vomiting. My parents were now aware of my deteriorating health and convinced me to stop at the VA Hospital in Marion, Illinois.

Upon arriving at the emergency room, the doctor ran various tests, which included blood work and a CAT scan. The results of these tests were negative. At this time, the ER doctor, who was a surgeon, admitted me and diagnosed my symptoms as possibly being appendicitis. He recommended removing the appendix and doing exploratory surgery. After he consulted with other doctors, some of which did not agree with this diagnosis, he took the advice of a second surgeon who recommended doing the surgery laparoscopically. We were more comfortable with this technique

due to the shorter recovery time and lack of a large incision. The doctors thought I would be ready to leave the hospital in a few days.

I had surgery at the Marion VA on Friday, June 15th. After the operation, we were told that the appendix did not look as bad as what they anticipated. Although I had been suffering for 4 months, the surgeon thought I must have a virus since the antibiotics were not having any effect.

On Sunday, 2 days after the surgery, my symptoms were getting worse. However, the doctors continued to follow the timetable and release after having your appendix removed. At this point one of the nurses told my parents that she would get me out of there if I were her son. She said the doctors did not know what was wrong with me.

Seeing my deterioration, my parents began asking for specialists on Monday, June 18. They were told the specialists were part of the clinic and were not available to attend to hospital patients. After receiving outside advice, my parents spoke with the patient advocate at the hospital. We were told that there was not a gastroenterologist, but an infectious disease specialist was available.

Four days after my surgery, my stomach still swollen and the other symptoms still there, an infectious disease specialist finally came to see me. Within minutes, he diagnosed me with dysentery and changed my antibiotic, but he could not explain my swollen stomach. I honestly looked like I was 9 months pregnant. That night my mom asked a nurse about this, and she said she had never seen it last this long. Another nurse told us that she would never take her family to any doctors there. They go to doctors in St. Louis, Missouri—a 2-hour drive from Marion.

After 7 days at the Marion hospital, my condition had stabilized enough for me to attempt to travel, and my parents asked for assistance in getting me quickly and safely home. The only assistance given to us was the cost of one ticket for the shuttle that runs from Marion to the St. Louis airport. When I was discharged, I was supposed to take the new antibiotic, but they mistakenly gave me the old and less effective one.

Upon returning home to Texas, my close Marine buddy informed us that we still had TRICARE coverage. The morning after returning from Illinois, we went to the emergency room at Harris Methodist H-E-B Hospital. The doctor noticed the severity of my symptoms and did all the same tests I had received at Marion. Upon reviewing the test results, the ER doctor discovered that my colon was perforated and I had free air under my diaphragm. My waste was pouring into my abdominal cavity. The ER doctor immediately called in the specialists.

I was taken to surgery that afternoon. Two sections of my colon had to be removed. These two sections were in the same location as two of the laparoscopic incisions. Due to the severity of the infection, my wound had to be left open. After the surgery, the doctor told my parents I was lucky to be alive. If it had not been for the fact that I was in such good shape and young, I would be dead.

I spent the next 3 weeks in the hospital and was discharged on July 11, 2007. I was attached to a wound vac for 6 weeks. Now I have both a colostomy and ileostomy bag. The doctors at Harris

Methodist H-E-B Hospital finally diagnosed my symptoms I had been experiencing since my service in Iraq as ulcerative colitis—a condition that would have been seen earlier if a colonoscopy would have been performed.

This has affected the quality of life for me and my family. This has prevented me from drawing unemployment and working. It is also hindering my advancement in the military. I have no source of income, and I am told it will take 1 year for the VA to process my disability requests. I have applied for incapacity pay, but have not received anything to date.

In closing, I have a colostomy bag, an ileostomy bag, a large open wound, and multiple laparoscopic incisions. I will be unable to effectively serve in the Marines at home as well as unable to deploy. The actions of the VA hospital in Marion have removed this Marine and countless other veterans from the war on terror. These wounds are not a result of insurgents; they are a result of incompetence on American soil.

Thank you for allowing me to share my story today. I am happy to answer any questions about my experience.

[The prepared statement of Mr. McCarty follows:]

PREPARED STATEMENT OF STEVEN MCCARTY, VETERAN, OPERATION IRAQI FREEDOM

Mr. Chairman, thank you for the opportunity to testify today before the Veterans' Affairs Committee. I look forward to sharing my story with the Senators here this morning.

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In February of this year, while I was still in Iraq, I was concerned when I started experiencing diarrhea with blood in the stool. My symptoms were consistent with what has since been diagnosed as ulcerative colitis. When I confronted my corpsman, he gave me the option to either keep going and do the missions or go to medical and receive treatment and possibly miss operations. I chose to keep going.

Upon returning from Iraq in April, the stress of demobilization and jubilation of getting reacquainted with family and civilian life overshadowed the discomfort of my symptoms which seemed minor at the time. After being deactivated off of active duty on June 1, my family and I traveled to the Midwest. While driving home from visiting my grandmother in Indiana, my symptoms got to the state where they could no longer be ignored. I was in severe pain, had bad diarrhea, and was vomiting. My parents were now aware of my deteriorating health and convinced me to stop at the VA Hospital in Marion, Illinois.

Upon arriving at the emergency room, the doctor ran various tests which included blood work and a CAT scan. The results of these tests were negative. At this time, the ER doctor, who was a surgeon, admitted me and diagnosed my symptoms as possibly being appendicitis. He recommended removing the appendix and doing exploratory surgery. After he consulted with other doctors, some of which did not agree with the diagnosis, he took the advice of a second surgeon who recommended doing the surgery laparoscopically. We were more comfortable with this technique due to the shorter recovery time and lack of a large incision. The doctors thought I would be ready to leave the hospital in a few days.

I had surgery at the Marion VA on Friday, June 15. After the operation, we were told that the appendix did not look as bad as they had anticipated. Although I had been suffering for 4 months, the surgeon thought I must have a virus since the antibiotics were not having any effect.

On Sunday, 2 days after the surgery, my symptoms were getting worse. In addition, my stomach was now swollen. However, the doctors continued to follow the timetable for recovery and release after having appendicitis. At this point one of the nurses told my parents that she would get me out of there if I were her son. She said the doctors did not know what was wrong with me.

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Upon returning home to Texas, my close Marine buddy informed us that we still had TRICARE. The morning after returning from Illinois, we went to the emergency room (ER) at Harris Methodist H-E-B Hospital. The doctor noticed the severity of my symptoms and did the same tests I had received in Marion. Upon reviewing the test results, the ER doctor discovered that my colon was perforated and I had free air under my diaphragm. My waste was actually pouring into my abdominal cavity. The ER doctor immediately called the specialists.

I was taken to surgery that afternoon. Two sections of my colon had to be removed. Those two sections were in the same location as two of the laparoscopic incisions. Due to the severity of the infection, the wound had to be left open. After the surgery, the doctor told my parents I was lucky to be alive. If I hadn't been in such good shape and young, I would be dead.

I spent the next 3 weeks in the hospital and was discharged on July 11, 2007. I celebrated my birthday while still in the hospital. I was attached to a wound vac for 6 weeks. I now have both a colostomy bag and ileostomy bag. The doctors at Harris Methodist H-E-B Hospital finally diagnosed the symptoms I had been experiencing since my service in Iraq as ulcerative colitis. The part of my colon that remains is not functional at this time.

This has affected the quality of life for me and my family. This has prevented me from drawing unemployment and working. It is also hindering my advancement in the military. I have no source of income and I am told it will take 1 year for the VA to process my disability requests. I have also applied for incapacity pay but have not received anything to date.

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Thank you for allowing me to share my story today. I am happy to answer questions about my experience.

Senator AKAKA. Thank you, Mr. McCarty.

Senator Durbin?

Senator DURBIN. I would like to thank Chairman Akaka for allowing me to ask first. I have to go down to a Senate Judiciary Committee meeting. My thanks to the panel, each one of you.

First, to Lance Corporal McCarty, who came by my office yesterday with his family, this is a heart-breaking story of a young man with a medical problem whose treatment was inappropriate and which led to complications, pain, hospitalization, and your life has changed. That is the reality when serious mistakes are made. I am certain that your case will be investigated, as it should be, and I stand ready to help you in any way that I can. You served your country. Now we need to serve you. And thank you for being here today and telling your story. I know it was not easy, but it is im-

portant that it be heard. It is a reminder that a lot of things that we are talking about here involve real human lives, the lives and the futures of our veterans like Steven McCarty. So, thank you so much for being here.

To Tammy Duckworth, let me just say that there are probably very few people in America better qualified than you to talk about the treatment of soldiers and veterans after your experience serving in Iraq and coming back and facing rehabilitation since then. I am so happy that you are here today and that you continue to serve your Nation and my State of Illinois. I could not agree with you more on the basic premise that if we cannot provide the medical care promised to Steven McCarty and every other soldier, regardless of the war they served in or the time that they served, then we need to consider alternatives. And I have seen it repeatedly. This morning, as I came in here, I met Eric Edmondson on the sidewalk, a man that you know, Tammy, and I know well. It is a long and heroic story of his family fighting for his rights. This man, a victim of Traumatic Brain Injury in Iraq, has made dramatic strides because of the determination of his family.

When I think of what he went through and I hear Lance Corporal McCarty talk about waiting a year—a year?—to have his disability claim processed. What is wrong with this picture? We are telling recruits if you will show up in 6 weeks we will give you more money to go overseas. And now we tell them when they return wounded, wait a year before we can tell you what your Government is going to provide? This is totally unfair, and something has to be done about it.

Mr. Williamson, you heard some of the questions earlier that were asked about this situation between Massachusetts and the Marion VA, and from what we gathered, Massachusetts really did not want to tell the Marion VA much about this Dr. Mendez and his giving up his right to practice medicine in Massachusetts. During the course of your GAO investigation, did you come across anything like this?

Mr. WILLIAMSON. No, we did not, Senator. We looked at a sample of cases at each of the seven facilities we visited and we did not come across anything like this.

Senator DURBIN. It seems to me to make a mockery of recredentialing if the individual veterans facility cannot get straight and complete answers about the status of licensure of one of their medical staff. How could you possibly know whether that person should continue practicing? Did you make any recommendations about that in terms of your VA study?

Mr. WILLIAMSON. Well, our recommendations dealt with privileging, and really, I think from what I have heard today, that was what VA is focusing on. The credentialing process for the seven hospitals that we looked at, was following VA requirements. However, privileging, was an area we found that needed some improvements. We have not compared VA's credentialing and privileging process with that of the private sector. VA's got a good system. But the system is only as good as the people implementing it, and I really want to say that I think it is important to wait for the VA IG's report to come out to see whether it was the process or was it the implementation of that process.

Senator DURBIN. I completely agree with you on that. But I tell you, one thing that came out today is the fact that of the 34,000 medical professionals who are being reviewed—I think that number is correct—some 17,000 of them are requiring some follow-up, additional information, which is an indication to me that the system needs to be a lot more thorough and a lot more complete than it currently is. And I think your GAO study may have pointed some new directions for us to move in that regard.

Mr. Chairman, I am going to have to leave for the Judiciary Committee. I want to thank this panel. Steven, thank you and your family for the sacrifice you made to be here. And, Tammy, I am looking forward to continuing to work with you in Illinois and beyond. Mr. Williamson, thank you for your insight on this.

I hope, Mr. Chairman, when this investigation is completed at Marion, that we might schedule another hearing to see what lessons can be learned. Thank you very much.

Senator AKAKA. Thank you very much, Senator Durbin. We will look very closely at the results of the IG investigation. Thanks so much.

Mr. McCarty, again, I appreciate your coming forward as you have, and I want you to know how sorry we are about what happened to you. I hope that your claim for VA benefits will be resolved quickly. Please let me know if I can be of assistance in helping to resolve this effort.

At this time I just want to ask whether you have any other comments, besides the testimony you have made concerning your experiences, and especially what you hope for—what the VA can possibly do for you.

Mr. MCCARTY. At this time, Mr. Chairman, I want to thank you again for the opportunity to speak today. The only thing that I can see that I would like to come out of this is the doctors at the VA are held accountable for their performance. That is really the only thing that I would like to be done.

Senator AKAKA. Well, thank you for that. You know that the focus in this hearing has been to that end—to be sure that we can continue quality control.

Ms. Duckworth, talking about quality control—and as I mentioned, this is part of the reason for this hearing—what type of quality assurance does your office do working in conjunction with the Division of Professional Regulation to ensure that veterans in your State receive the highest standard of care?

Ms. DUCKWORTH. Well, sir, we have no say over the Federal VA facilities, in our case Hines, Marion, and Danville. All we can do is, as we get complaints into our office, refer them to the local hospital administrator and bring it to their attention. So, we actually—as a State agency—have no say over the Federal.

We are, however, as a State agency, inspected by the Federal VA as well as the State of Illinois Department of Public Health. So our four veterans' homes that we operate in the State of Illinois are double inspected, not only by the Federal VA when they come out and inspect our facilities, but also by our sister agency. And I think that double inspection process, while it can be onerous at times, it helps us to have a checks and balance as to the entire process. And

oftentimes we have found that our sister agency is much tougher on us in terms of their findings than the Federal VA has been.

I do want to say, sir, that I have had personally wonderful treatment through the VA system. I think that Hines VA, with its blind rehabilitation program, with its spinal cord injury program, really leads the Nation and that the VA has great expertise that we need to respect and maximize. However, I do think that there is opportunity here for us to look at some outside care and more participation of local communities, teaching hospitals, that sort of thing, to not supplant, but supplement the Federal VA. And I think that bringing in some outside—as I mentioned earlier, requiring doctors to have privileges at the local hospital where the VA hospital is also co-located—will help with that process.

So, as far as the State of Illinois is concerned, we are co-inspected by our sister agency in the State of Illinois. We are also inspected federally. We have no say whatsoever over the Federal VA other than getting complaints and letters and trying to advocate for our veterans the best that we can.

Senator AKAKA. Speaking about Marion, when was your office told by VA about the spike in deaths at Marion?

Ms. DUCKWORTH. I have never received official notice from the Federal VA, sir. We have a veterans' home in Anna, in far southern Illinois, which sends its patients to Marion VA. The only notice we received was that we could no longer send our patients there for surgeries, and we have never been informed as to what the reason was other than just through the media and me making some phone calls.

Senator AKAKA. I want to thank you for your remarks about VA having the best kind of providers.

Ms. DUCKWORTH. Yes, sir.

Senator AKAKA. Unfortunately, you know, there are many clinics, many hospitals, and our effort here is to try to maintain quality control throughout the system. And your testimony and your responses will help us do that, and I am sure will help the administration do it as well. We are looking forward to continuing this until the investigation is done.

Mr. Williamson, as may have been the situation in the case of the surgeon at Marion, timing clearly poses a problem in the process of background checks. Because medical administrators cannot discuss open disciplinary investigations, employers may not be aware of serious issues surrounding potential hires. My question to you is: How can the background-checking process be improved to avoid this problem?

Mr. WILLIAMSON. Well, as you may know, Mr. Chairman, we did work in 2004 and 2006 on screening of all health care practitioners in VA. We took issue with the background processes in the sense that in many cases they were not being done, and there was not adequate documentation to show, in some cases, that the results of the background investigation had been reviewed.

Since that time, VA has implemented some stricter background-checking procedures; whereby, they are now doing background checks on all their health care providers, and they now have a process in place to document that. So, I think with the fingerprint-only kinds of background checks that are going on, I think VA is

now doing those kind of things that we took issue with in earlier work.

Senator AKAKA. Mr. Williamson, what can be done to lessen the chances that Marion will be repeated?

Mr. WILLIAMSON. I am going to go back to what I said a minute ago, Mr. Chairman, and that is that the process can be a good one, but it really needs to be followed. And I really cannot comment on the Marion situation. I just do not know the facts and, pending the VA IG review, I think it would be remiss if I commented on that.

But I can tell you that I have worked for GAO for over 40 years, and in that time I have looked at hundreds—done hundreds and hundreds of audits, many of those something like this, where something has gone wrong. And in a general sense, without reflecting on Marion, I can tell you that there are always—almost always—danger signals that if in 20/20 hindsight people would have paid attention to, we could have prevented these kind of things.

So I would be, I think, as curious as this Committee is in terms of trying to find out what the causes of the Marion situation were.

Senator AKAKA. Yes. It is interesting. When you raise "dangerous signals," it is something that I hope we can deal with, because it is important and it is the beginning of something that we need to know more about. And with your 40 years of experience with GAO, I hope you can come up with a solution to that, so that we can do it here in our Government.

But all of this, of course, would be done for the purpose of keeping quality control throughout our system. As was mentioned, when you talk about 56,000 doctors, it is huge; and to keep control over the 56,000 is very difficult. But we have to do that, try our best to do that, and this is our effort today.

So thank you so much, all of you, for your testimonies and for your responses, and I want to wish you well. Remember, we are here to maintain that high quality of service to our veterans, and that is what we are doing.

Thank you very much, and this hearing is adjourned.

[Whereupon, at 11:10 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

On behalf of the nearly 65,000 clinically practicing physician assistants (PAs) in the United States, the American Academy of Physician Assistants (AAPA) is pleased to submit comments for the hearing record on Hiring Practices and Quality Control in VA Medical Facilities. The Academy's comments will focus on H.R. 2790, a bill introduced in the House by Representatives Phil Hare and Jerry Moran to amend title 38, United States Code, to establish the position of Director of Physician Assistant Services within the office of the Under Secretary of Veterans' Affairs for Health. AAPA believes that enactment of H.R. 2790 is essential to improving patient care for our Nation's Veterans, ensuring that the 1,600 PAs employed by the VA are fully utilized and removing unnecessary restrictions on the ability of PAs to provide medical care in VA facilities. The Academy believes that enactment of H.R. 2790 is necessary to advance recruitment and retention of PAs within the Department of Veterans' Affairs and requests that the Senate Committee on Veterans' Affairs supports this important legislation.

Physician assistants are licensed health professionals, or in the case of those employed by the Federal Government, credentialed health professionals, who—

- practice medicine as a team with their supervising physicians
- exercise autonomy in medical decisionmaking
- provide a comprehensive range of diagnostic and therapeutic services, including performing physical exams, taking patient histories, ordering and interpreting laboratory tests, diagnosing and treating illnesses, suturing lacerations, assisting in surgery, writing prescriptions, and providing patient education and counseling
- may also work in educational, research, and administrative settings.

Physician assistants' educational preparation is based on the medical model. PAs practice medicine as delegated by and with the supervision of a physician. Physicians may delegate to PAs those medical duties that are within the physician's scope of practice and the PA's training and experience, and are allowed by law. A physician assistant provides health care services that were traditionally only performed by a physician. All states, the District of Columbia, and Guam authorize physicians to delegate prescriptive privileges to the PAs they supervise. AAPA estimates that in 2006, approximately 231 million patient visits were made to PAs and approximately 286 million medications were prescribed or recommended by PAs.

The PA profession has a unique relationship with veterans. The first physician assistants to graduate from PA educational programs were veterans—former medical corpsmen who had served in Vietnam and wanted to use their medical knowledge and experience in civilian life. Dr. Eugene Stead of the Duke University Medical Center in North Carolina put together the first class of PAs in 1965, selecting Navy corpsmen who had considerable medical training during their military experience as his students. Dr. Stead based the curriculum of the PA program in part on his knowledge of the fast-track training of doctors during World War II. Today, there are 139 accredited PA educational programs across the United States. Approximately 1,600 PAs are employed by the Department of Veterans Affairs, making the VA the largest single employer of physician assistants. These PAs work in a wide variety of medical centers and outpatient clinics, providing medical care to thousands of veterans each year. Many are veterans themselves.

Physician assistants are fully integrated into the health care systems of the Armed Services and virtually all other public and private health care systems. PAs are on the front line in Iraq and Afghanistan, providing immediate medical care for wounded men and women of the Armed Forces. Within each branch of the Armed Services, a Chief Consultant for PAs is assigned to the Surgeon General. PAs are covered providers in TRICARE. In the civilian world, PAs work in virtually every area of medicine and surgery and are covered providers within the overwhelming

majority of public and private health insurance plans. PAs play a key role in providing medical care in medically underserved communities. In some rural communities, a PA is the only health care professional available.

AAPA is very appreciative of the leadership of many Members of the Senate Committee on Veterans' Affairs in creating the VA's Physician Assistant (PA) Advisor to the Under Secretary for Health. The current PA Advisor to the Under Secretary for Health was authorized through section 206 of P.L. 106–419 and has been filled as a part-time, field position. Prior to that time, the VA had never had a representative within the Veterans Health Administration with sufficient knowledge of the PA profession to advise the Administration on the optimal utilization of PAs. This lack of knowledge resulted in an inconsistent approach toward PA practice, unnecessary restrictions on the ability of VA physicians to effectively utilize PAs, and an underutilization of PA skills and abilities. The PA profession's scope of practice was not uniformly understood in all VA medical facilities and clinics, and unnecessary confusion existed regarding such issues as privileging, supervision, and physician countersignature.

Although the PAs who have served as the VA's part-time, field-based PA Advisor have made progress on the utilization of PAs within the agency, there continues to be inconsistency in the way that local medical facilities use PAs. In one case, a local facility decided that a PA could not write outpatient prescriptions, despite licensure in the state allowing prescriptive authority. In other facilities, PAs are told that the VA facility can not use PAs and will not hire PAs. These restrictions hinder PA employment within the VA, as well as deprive veterans of the skills and medical care PAs have to offer.

The AAPA believes that a full-time Director of PA Services within the VA Central Office is necessary to recruit and retain PAs in the Department of Veterans' Affairs. PAs are in high demand in the private market place.

- The US Bureau of Labor Statistics (BLS) projects that the number of PA jobs will increase by 50 percent between 2004 and 2014 and has ranked the profession as the fourth fastest growing profession in the country.
- US News and World Report named the PA profession within its 2007 list of 25 best careers.
- Money magazine ranked the PA profession No. 5 in its 2006 list of top careers; CNN listed the PA profession as No. 4 in its 2006 list of top US careers.

The growth in PA jobs is in the private sector, not the Federal Government. AAPA believes that the Federal Government, including the Department of Veterans' Affairs, will not be able to compete with the private market unless special efforts are made to recruit and retain PAs. According to the AAPA's 2006 Census Report, an estimated 3,545 PAs are employed by the Federal Government to provide medical care. Unfortunately, AAPA's Annual Census Reports of the PA Profession from 1997 to 2006 document an overall decline in the number of PAs who report Federal Government employment. In 1991, nearly 13.4 percent of the total profession was employed by the Federal Government. This percentage dropped to 6 percent in 2006.

The Academy also believes that the elevation of the PA Advisor to a full-time Director of Physician Assistant Services, located in the VA central office, is necessary to increase veterans' access to quality medical care by ensuring efficient utilization of the VA's PA workforce in the Veterans Health Administration's patient care programs and initiatives. PAs are key members of the Armed Services' medical teams but are an underutilized resource in the transition from active duty to veterans' health care. As health care professionals with a longstanding history of providing care in medically underserved communities, PAs may also provide an invaluable link in enabling veterans who live in underserved communities to receive timely access to quality medical care.

Thank you for the opportunity to submit a statement for the hearing record in support of legislation to elevate the VA's PA Advisor to a full-time position in the VA's central office. AAPA is eager to work with the Senate Committee on Veterans' Affairs to improve the availability and quality of medical care to our Nation's veteran population.

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