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**United States Government Accountability Office**
**Washington, DC 20548**

October 28, 2011

The Honorable Bob Filner
Ranking Member
Committee on Veterans' Affairs
House of Representatives

The Honorable Michael H. Michaud
Ranking Member
Subcommittee on Health
Committee on Veterans' Affairs
House of Representatives

Subject: *VA Health Care: VA Uses Medical Injury Tort Claims Data to Assess Veterans' Care, but Should Take Action to Ensure That These Data Are Complete*

The Department of Veterans Affairs (VA) operates one of the largest health care delivery systems in the nation—providing health care services to more than 5 million veterans each year in over 1,000 facilities.[1] These health care services are delivered by physicians, nurses, and other types of practitioners and range from routine examinations to complex surgical procedures. As in any health care setting, veterans receiving health care services at VA facilities may be at risk of incurring medical injury as a result of substandard care.[2] Recent incidents have heightened concern about the quality of care provided to veterans by VA facilities.[3] For example, in 2010 we reported that one VA facility discovered in 2009 that medical equipment had been improperly cleaned, thus posing safety risks to 2,526 veterans.[4]

[1]As of November 2010, VA's health care system included 153 VA medical centers (VAMC), 773 community-based outpatient clinics, 135 community living centers (nursing homes), 260 Vet Centers, 47 residential rehabilitation treatment programs, and 121 comprehensive home care programs.

[2]When we refer to medical injuries, these injuries include death. We use the term substandard care to refer to an episode of care for which VA determined that a licensed medical practitioner rendered care that was below established medical practice standards. See Veterans Health Administration (VHA) Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports* (Dec. 28, 2009).

[3]According to VA, quality care is patient-centered care delivered competently at the appropriate time and in a safe environment.

[4]This VAMC discovered that equipment in use was not being properly cleaned, thus potentially exposing 2,526 veterans to infectious diseases, such as Human Immunodeficiency Virus, Hepatitis B, and Hepatitis C. See GAO, *VA Health Care: Preliminary Observations on the Purchasing and Tracking of Supplies and Medical Equipment and the Potential Impact on Veterans' Safety*, GAO-10-1038T (Washington, D.C.: Sept. 23, 2010). See also GAO, *VA Health Care: Weaknesses in Policies and Oversight Governing Medical Supplies and Equipment Pose Risks to Veterans' Safety*, GAO-11-391 (Washington, D.C.: May 3, 2011).

In the event that an injury occurs as a result of care rendered by a VA practitioner, a veteran alleging medical malpractice may seek compensation by filing a tort claim with one of VA's 22 regional counsel offices.[5,6] The offices, which operate under VA's Office of General Counsel (OGC), are responsible for initially investigating and, to the extent possible, resolving the tort claims through administrative review.[7] After undergoing administrative review, claims may proceed to litigation in federal court, in which the Department of Justice (DOJ) defends the United States. During either VA's administrative review or litigation, the government may resolve tort claims by making payments to veterans. When such payments are made to veterans, VA's Office of Medical-Legal Affairs (OMLA) uses medical information from these paid tort claims, as well as related medical records and other relevant information, to assess the quality of care provided to veterans.[8]

In 1995, we reported that data on tort claims provided opportunities for VA to identify concerns with individual providers and decrease the risk of future tort claims. Specifically, we recommended that VA use available data on tort claims to help identify problem-prone areas in VA's delivery of care and initiate programs that could help prevent the types of incidents that generate tort claims for medical injuries.[9] VA generally concurred with our 1995 recommendation and implemented a process to analyze and use available tort claims data to assess the quality of veterans' care.

In light of recent concerns about the quality of veterans' care provided in some VA facilities, you asked us to examine the resolution of tort claims filed against VA in the context of VA's efforts to improve the quality of veterans' care at its facilities. In this report, we (1) describe the number of tort claims that were resolved through VA's administrative review and through litigation from fiscal years 2005 through 2010 and (2) examine how OMLA uses paid tort claims data to assess the quality of veterans' care.

To describe the number of tort claims that are resolved through VA's administrative review and through litigation, we reviewed VA policies related to the submission and

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[5]See 28 U.S.C. §§ 1346(b), 2671-2680; 38 U.S.C. § 7316; 28 C.F.R. pt. 14 (2010); 38 C.F.R. §§ 14.600-14.605 (2010). Tort claims can also be filed for property damage or losses; however, this report only addresses claims filed as a result of a medical injury, including death. A veteran, or a veteran's agent or legal representative, may file a tort claim on the veteran's behalf. Additionally, if a veteran dies from care provided by VA, the veteran's personal representative, or any other legally qualified person, may file a tort claim as well. When referring to filing tort claims, we use the term veteran to include those who may file such claims on behalf of a veteran.

[6]In addition to tort claims, veterans or their representatives may also file claims for monthly compensation under 38 U.S.C. § 1151 for medical injuries incurred while receiving VA medical care. These claims are processed by the Veterans Benefits Administration. This report only addresses tort claims and does not include claims filed under 38 U.S.C. § 1151, which, according to a VA official, represented less than 1 percent of all disability compensation claims processed by the Veterans Benefits Administration as of March 2011.

[7]Certain small claims may be resolved by VA network and facility directors, and other claims may be resolved by OGC.

[8]OMLA is under the Office of Quality and Safety within VA headquarters, which is responsible for patient safety and risk management. OMLA receives paid tort claims information from VA's OGC and uses this information to initiate its review of these claims.

[9]See GAO, *VA Health Care: Trends in Malpractice Claims Can Aid in Addressing Quality of Care Problems*, GAO/HEHS-96-24 (Washington, D.C.: Dec. 21, 1995).

resolution of tort claims and interviewed VA headquarters officials on these processes. We reviewed summary data provided by VA's OGC on tort claims from fiscal years 2005 through 2010, including data on the number of claims filed and resolved, the amount paid, and the length of time to resolve claims. We examined trends in the number of tort claims and payments resulting from claims that were resolved through administrative review compared to those resolved through litigation over this 6-year period. We found the data VA provided on the number and resolution of tort claims to be sufficiently reliable for the purposes of this report after reviewing them for obvious errors and interviewing VA officials responsible for collecting and recording data and maintaining the data systems.

To examine how OMLA uses paid tort claims data to assess the quality of veterans' care, we reviewed VA policies and OMLA's process for reviewing these claims. We also reviewed guidelines regarding internal controls for federal agencies.[10] We examined VA OGC's summary data on the number of tort claims paid during fiscal years 2005 through 2010 and OMLA data on its reviews of paid tort claims during this period. Additionally, we interviewed VA OGC officials about the tort claims data, and interviewed VA headquarters leadership and management officials responsible for VA's quality improvement efforts. We also interviewed officials from six VA networks that varied by geographic location.[11] We found the data on paid tort claims to be sufficiently reliable for the purposes of this report after reviewing them for obvious errors and interviewing VA officials responsible for collecting and recording the data and maintaining the data systems.

We conducted this performance audit from April 2011 through October 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## Results in Brief

From fiscal years 2005 to 2010, the number of tort claims filed against VA rose by 33 percent, from 1,251 to 1,670. Most tort claims filed against VA in fiscal years 2005 through 2010 were resolved through VA's administrative review, rather than through litigation. Specifically, VA resolved more than 80 percent of tort claims through administrative review during this 6-year period, and the remainder were resolved through litigation. Additionally, the amount paid for tort claims during fiscal years 2005 through 2010 was lower for claims resolved through administrative review than for claims resolved through litigation. For example, in fiscal year 2010, about $30 million was paid for the 277 tort claims that were resolved through VA's administrative review, while about $49 million was paid for the 114 claims that were resolved through litigation. Further, in fiscal year 2010 the average number of days

[10]See GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

[11]The management of medical facilities is decentralized to 21 VA networks, which are organized by region. Each VA network is responsible for the day-to-day management of medical facilities located within its network.

to resolve tort claims administratively was considerably less than the average number of days it took to resolve claims through litigation.

VA policy requires OMLA to review tort claims that result in payments to veterans in order to determine whether VA practitioners provided substandard care. For each medical injury–related tort claim paid, OMLA is required to collect medical records related to the incident that prompted the claim and convene a review panel of medical practitioners to determine whether the claim was associated with substandard care. If the panel determines that a practitioner rendered substandard care, OMLA notifies the director of the VAMC involved in the claim of the panel's conclusion and the director must report the practitioner to the National Practitioner Data Bank (NPDB).[12] VAMCs and VA networks utilize NPDB data in overseeing the practitioners who deliver services in their facilities. Although VA's regional counsel offices are required to notify OMLA about all paid tort claims to initiate OMLA's review of VA practitioners involved in the claims, we found that this notification does not always occur because VA lacks an internal control to help ensure that regional counsel offices comply with this requirement. Specifically, we found that the regional counsel offices did not report to OMLA 16 percent of the total number of paid tort claims involving VA practitioners from fiscal years 2005 through 2010. VA OGC officials told us that this occurred for several reasons, such as lack of administrative oversight and staff turnover. As a result, OMLA did not have the opportunity to review all paid tort claims for this time period to determine whether VA practitioners associated with these claims rendered substandard care, thus limiting the number of practitioners who should have been reported to the NPDB.

## Background

VA employs a number of health professionals, such as physicians, physician assistants, and other types of practitioners, to deliver care to veterans in VA facilities throughout the country.[13] These practitioners provide a range of services—from preventive health care services to surgical procedures—in various types of VA facilities, such as VAMCs, and may provide services in non-VA facilities as well.

One of the ways that VA seeks to ensure the quality of care provided to veterans is by overseeing practitioners who render care in its facilities through credentialing and privileging.[14] During VA's credentialing process, VAMCs collect and review NPDB information about practitioners as part of the process to determine whether they have suitable abilities and experience for appointment to a VAMC's medical staff. During the privileging process, VAMCs also use NPDB information to determine whether a practitioner was involved in a tort claim, and then can obtain information

[12]The NPDB is administered by the Department of Health and Human Services (HHS) and includes information on practitioners who either have been disciplined by a state medical board, professional society, or health care provider, or have been named in a medical malpractice settlement. Under the provisions of the Health Care Quality Improvement Act of 1986, which established the NPDB, and a Memorandum of Understanding between VA and HHS, VA must submit certain information on paid tort claims and on any actions taken against practitioners to the NPDB and appropriate state licensing boards. See 42 U.S.C. § 11152(b); 38 C.F.R. pt. 46 (2010).

[13]A physician assistant is a midlevel medical practitioner who works under the supervision of a licensed physician.

[14]See VHA Handbook 1100.19, *Credentialing and Privileging* (Nov. 14, 2008).

from the practitioner about the claim. With this claim information, as well as other information gathered during the privileging process, VAMCs determine which health care services—known as clinical privileges—the practitioner should be allowed to provide. After a VA practitioner is hired, the credentialing and privileging processes are repeated at least every 2 years. NPDB information may also affect the clinical privileges of VA practitioners who provide services in non-VA facilities because such facilities may also use NPDB information in their credentialing and privileging processes.

Veterans who believe they were injured as a result of care delivered by a VA practitioner may seek redress by filing a claim against VA under the Federal Tort Claims Act.[15,16] A veteran may initiate such a claim by submitting a Standard Form 95 (Claim for Damage, Injury, or Death) to VA within 2 years of when the medical injury was alleged to have occurred or when the veteran became aware of the injury. Tort claims against VA are filed with one of VA's 22 regional counsel offices, under VA's OGC, depending on where the incident that prompted the claim occurred. Regional counsel offices are responsible for conducting administrative reviews of tort claims. This review involves examining the claim, interviewing the VA health care practitioners involved, and obtaining, if necessary, an independent medical opinion on the circumstances of the claim. On the basis of this information, the regional counsel offices can resolve a claim administratively by denying the veteran's claim or by awarding the veteran a monetary settlement.[17] Although tort claims are generally handled by VA's regional counsel offices, any settlements over $150,000 must be approved by VA's OGC,[18] and settlements over $300,000 must also be approved by the United States Attorney General or his or her designee.[19]

If VA denies the tort claim, or if the veteran does not accept VA's settlement award amount, or if VA fails to make a final determination on the claim within 6 months of

[15]See 28 U.S.C. §§ 1346(b), 2671-2680; 38 U.S.C. § 7316; 28 C.F.R. pt. 14 (2010); 38 C.F.R. §§ 14.600-14.605 (2010).

[16]Regardless of whether a tort claim is filed, VAMCs may, at any time, initiate reviews of veterans' injuries that occurred while receiving VA care. For example, VAMCs may conduct quality management reviews, such as peer reviews that are confidential and nonpunitive processes that assess the quality of care delivered, or may initiate management reviews to determine if a personnel action against a practitioner should be taken. See VHA Directive 2010-025, *Peer Review for Quality Management* (June 3, 2010), and VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents* (Nov. 7, 2008).

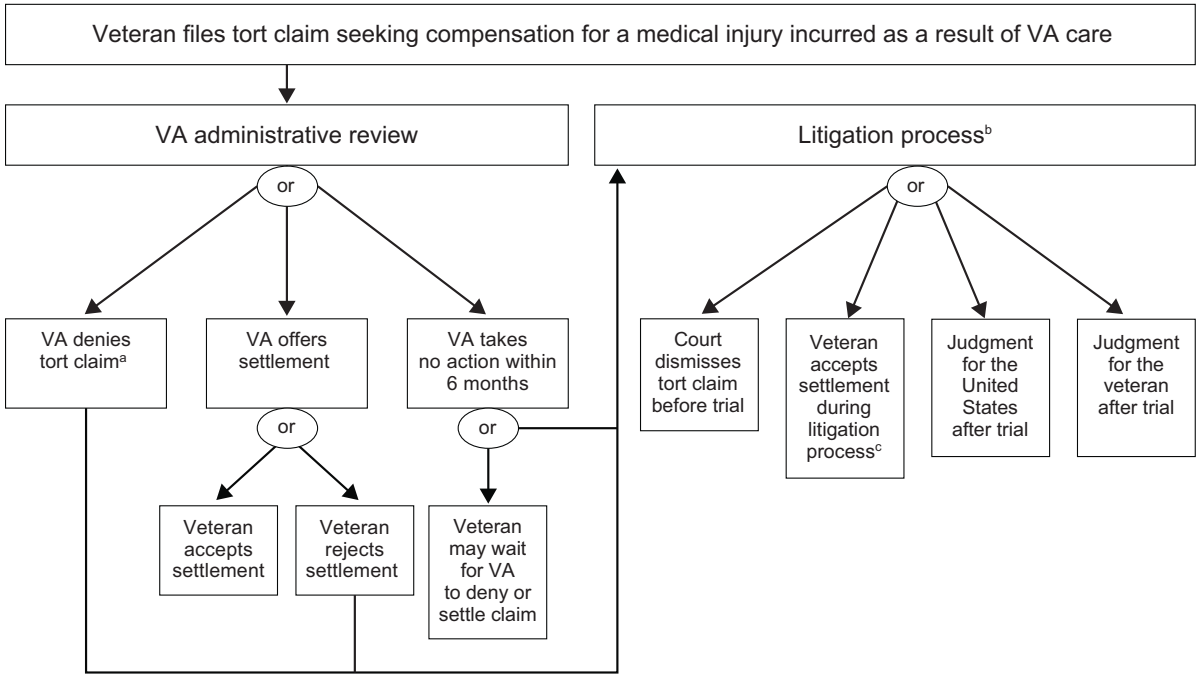
[17]A number of VA entities have the authority to settle tort claims depending on the dollar amount indicated in the claim. See 38 C.F.R. § 14.600 (2010). VA administrative tort claim settlements of $2,500 or less are paid out of VA appropriations. All other tort claim payments, through both the administrative and the litigation processes, are paid out of the Judgment Fund, a permanent appropriation administered by the Department of the Treasury. See 28 U.S.C. § 2672; 31 U.S.C. § 1304.

[18]A group of attorneys within VA's OGC is responsible for settling claims valued over $150,000, but according to a VA headquarters official, may delegate such settlement authority to regional counsel offices. VA's OGC may also be involved in settling claims valued under $150,000, depending on the circumstances of the claim.

[19]38 C.F.R. §§ 14.600-14.605 (2010).

when the claim is filed, the veteran may file the tort claim in federal court.[20,21] The United States Attorneys' Offices of DOJ defend the United States in all such litigation. If a veteran pursues litigation, the court can dismiss the tort claim prior to trial, can rule in favor of the veteran, or can rule in favor of the United States. The claim may also be settled during the litigation process. (See fig. 1 for a depiction of VA's administrative review and litigation processes.) Regardless of whether claims are resolved through VA's administrative review or through litigation, regional counsel offices and OGC are responsible for recording the status and resolution of tort claims into OGC's data system, which is used to generate summary data on the number of filed claims, how claims are resolved, payments to veterans, and length of time to resolve claims.[22]

**Figure 1: Department of Veterans Affairs' (VA) Tort Claim Processes**




Source: GAO analysis of VA documents and GAO interviews with VA officials.

[a]Once VA has denied a claim, the veteran may choose not to pursue the claim further, seek reconsideration of VA's denial, or proceed to litigation. VA may deny a veteran's claim a second time upon reconsideration, after which the veteran may choose to proceed to litigation or not to pursue the claim further. If VA offers a settlement upon reconsideration, a veteran may choose to accept the settlement or proceed to litigation.

[b]Veterans may proceed to litigation in federal court within 6 months of VA's denial or settlement offer or after 6 months of VA's failure to make a final determination on the tort claim. The United States Attorneys' Offices of the Department of Justice defend the United States in all such litigation.

[c]A VA headquarters official told us that a settlement can occur prior to and during a trial—and on rare occasions, after the court has rendered a verdict either against or favorable to the government. The VA headquarters official said that such a settlement can preserve a favorable court ruling that the government could lose on appeal and prevent possible future losses for tort claims that are likely to be filed.

[20]If VA denies the veteran's claim, the veteran may file a request with VA for reconsideration of the denial before proceeding to litigation. OGC is generally responsible for reconsidering denied claims. See 38 C.F.R. § 14.600(d) (2010).

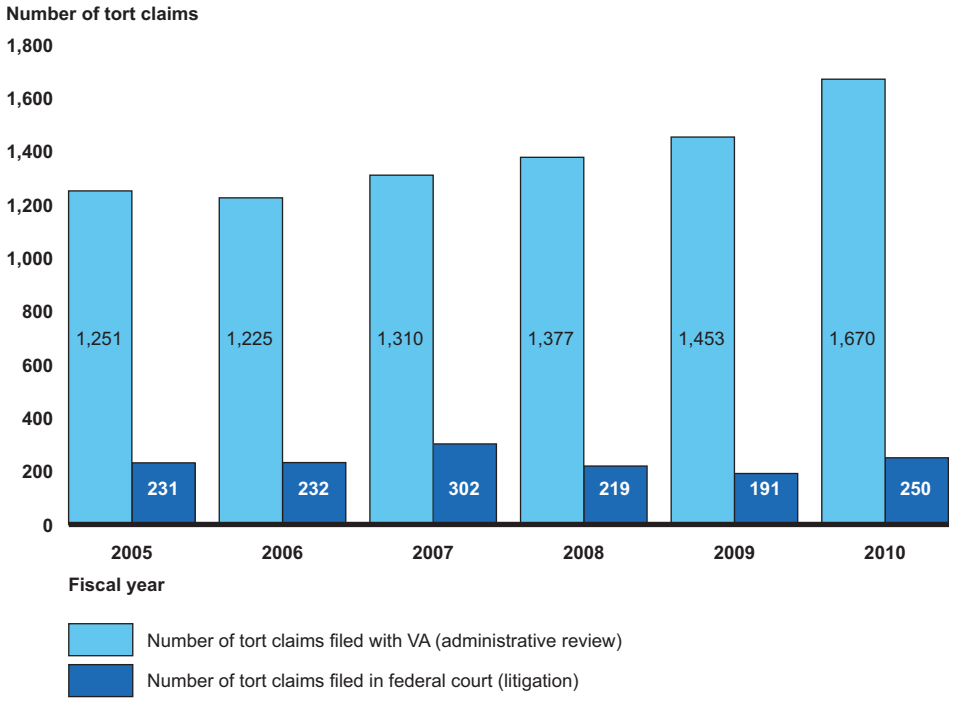
[21]Throughout this report, we use the term claims to refer to claims in administrative review and civil actions on claims litigated in federal court.

[22]Regional counsel offices and OGC record this information in a data system called the Tort Claims Information System.

## Tort Claims Are Largely Resolved through VA's Administrative Review Rather Than Litigation

From fiscal year 2005 to fiscal year 2010, the number of tort claims filed against VA rose by 33 percent, from 1,251 to 1,670 claims, while the number of tort claims filed in federal court has fluctuated but increased only slightly since 2005. (See fig. 2.)

**Figure 2: Number of Tort Claims Filed through the Department of Veterans Affairs' (VA) Administrative Review and through Litigation, Fiscal Years 2005 through 2010**



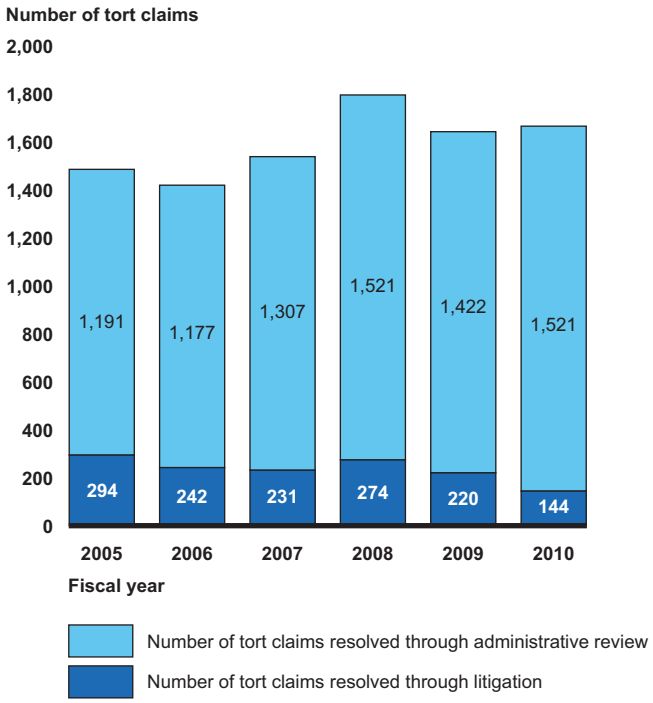

Source: GAO analysis of VA data.

Notes: All tort claims must first go through administrative review by VA. Veterans can proceed with litigation of tort claims in federal court if they do not accept VA's claim denial or settlement award amount or if VA fails to make a final determination on a claim within 6 months of when the tort claim was filed.

Over the last 6 years, VA has resolved a majority of the tort claims filed by veterans through administrative review of these claims, either by denying the claims or providing veterans with payments to settle the claims. During fiscal years 2005 through 2010, VA regional counsel offices or OGC denied or settled 8,139 tort claims (about 85 percent) through administrative review, while 1,405 tort claims were resolved through litigation where the claims were dismissed, settled, or resulted in judgments after trial.[23] (See fig. 3 for a breakdown of these claims by year.) According to a VA headquarters official, VA attempts to resolve tort claims, where there is exposure to liability, through administrative review because meritorious claims should be settled rather than litigated in federal court, which is both more expensive and time-consuming.

[23]Because tort claims generally take longer than 1 year to resolve, tort claims that were resolved through VA's administrative review or through litigation in one fiscal year may not have been filed in that same fiscal year.

**Figure 3: Number of Tort Claims Resolved through the Department of Veterans Affairs' (VA) Administrative Review and through Litigation, Fiscal Years 2005 through 2010**




Source: GAO analysis of VA data.

Notes: Although all tort claims begin with administrative review by VA, veterans can proceed with litigation of tort claims in federal court if they do not accept VA's claim denial or settlement award amount or if VA fails to make a final determination on a claim within 6 months of when the tort claim was filed. Because tort claims generally take longer than 1 year to resolve, tort claims that were resolved through VA's administrative review or through litigation in one fiscal year may not have been filed in that same fiscal year.

Tort claims that were administratively denied or settled are included in the number of tort claims resolved through VA's administrative review. The number of tort claims that were resolved through litigation includes claims that were dismissed before going to trial; claims that were settled before, during, or after trial; judgments for the United States after trial; and judgments for the veteran after trial.

For fiscal years 2005 through 2010, about one-quarter of the tort claims that were resolved through litigation were dismissed before proceeding to trial, and about 62 percent were settled during litigation. Of the remaining claims that were resolved through judgments, the vast majority were resolved in favor of the United States. (See table 1 for a breakdown of these claims by year.)

**Table 1: Breakdown of the Number of Tort Claims Resolved through the Department of Veterans Affairs' (VA) Administrative Review and through Litigation, Fiscal Years 2005 through 2010**

| Fiscal year | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|
| **Number of tort claims resolved through VA administrative review** | | | | | | |
| Claims denied | 963 | 952 | 1,094 | 1,220 | 1,158 | 1,244 |
| Claims settled | 228 | 225 | 213 | 301 | 264 | 277 |
| **Total claims resolved through administrative review** | **1,191** | **1,177** | **1,307** | **1,521** | **1,422** | **1,521** |
| **Number of tort claims resolved through litigation** | | | | | | |
| Claims dismissed before proceeding to trial[a] | 78 | 68 | 57 | 66 | 44 | 20 |
| Claims settled during the litigation process[b] | 152 | 138 | 140 | 169 | 155 | 111 |
| Judgments for the United States after trial | 47 | 28 | 30 | 36 | 15 | 10 |
| Judgments for the veteran after trial | 17 | 8 | 4 | 3 | 6 | 3 |
| **Total claims resolved through litigation** | **294** | **242** | **231** | **274** | **220** | **144** |

Source: GAO analysis of VA data.

Notes: Because tort claims generally take longer than 1 year to resolve, tort claims that were resolved in one fiscal year may have been filed in a prior fiscal year.

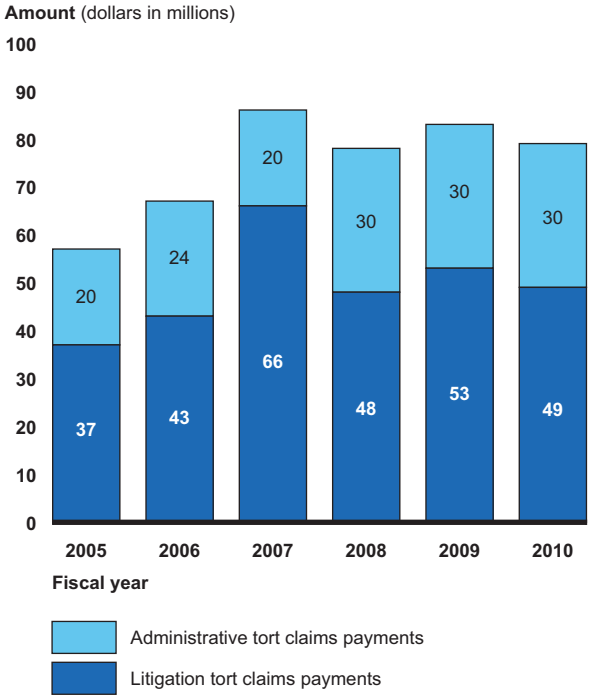
According to a VA headquarters official, this information was collected using the "status" of each tort claim at the end of each fiscal year. Although the official said that the status of claims may change within a fiscal year as claims move through administrative review and litigation, the claims are represented by their final end-of-year status. If the status of a claim changes in a subsequent fiscal year, that claim would be included in each fiscal year for which a change in status occurred. For example, a tort claim that was denied but settled on reconsideration by VA in the same fiscal year is included in the table once—as a claim that was settled. However, a tort claim that was denied in one fiscal year but settled on reconsideration by VA in a subsequent fiscal year would be included twice—once in the fiscal year it was denied and once in the fiscal year it was settled. Likewise, if a claim dismissed before trial in one fiscal year was appealed and settled in the same fiscal year, it would be included once under "claims settled during the litigation process." If a claim dismissed before trial in one fiscal year was appealed and settled in a subsequent fiscal year, that claim would be included twice—once in the fiscal year in which it was dismissed and once in the fiscal year in which it was settled. However, if the claim was dismissed and appealed in the same fiscal year and settled in a subsequent fiscal year, that claim would be included once—in the fiscal year in which it was settled—because a claim whose appeal is pending at the end of a fiscal year would not appear as a closed case in VA's annual report.

[a]A VA headquarters official told us that cases may be dismissed prior to trial for various reasons, such as untimely filing or filing with the wrong court.

[b]A VA headquarters official told us that a settlement can occur prior to and during a trial—and on rare occasions, after the court has rendered a verdict either against or favorable to the government. The VA headquarters official said that such a settlement can preserve a favorable court ruling that the government could lose on appeal and prevent possible future losses for tort claims that are likely to be filed.

Over the past 6 years, the total amount paid to veterans for tort claims that were resolved through litigation—through both settlements and judgments—was considerably higher than the total amount paid to veterans for tort claims settled through VA's administrative review. (See fig. 4.) Although the majority of tort claims were resolved through VA's administrative review, the amount awarded through litigation was higher because tort claims payments resulting from litigation are, on average, higher on a per-case basis than claim settlement awards made through VA's administrative review. For example, in fiscal year 2010 the average VA administrative settlement was $109,720, the average settlement for a tort claim that was settled during litigation was $403,978, and the average judgment for a claim that was litigated in federal court was $1,321,713.

**Figure 4: Total Amount of Payments for Tort Claims Resolved through the Department of Veterans Affairs' (VA) Administrative Review and through Litigation, Fiscal Years 2005 through 2010**




Source: GAO analysis of VA data.

Notes: Payment amounts were rounded to the nearest whole number. Administrative tort claims payments include only those claims that were settled through VA's administrative review. Litigation tort claims payments include claims that were settled before, during, or after trial and judgments awarded in favor of veterans. The tort claims payments made each fiscal year through VA's administrative review and the litigation process may not have resulted in payment during the same year the claims were filed.

According to VA, it can take several years to resolve a tort claim, although it generally takes considerably less time to resolve claims administratively than to resolve claims that proceed through administrative review and then to litigation. For example, in fiscal year 2010, for VA's administrative review, tort claims settled by regional counsel offices were resolved in an average of 447 days from the time they were filed, and claims settled by OGC were resolved in an average of 758 days from the time they were filed. In contrast, in that same year, tort claims that proceeded to trial but were settled during litigation took an average of 1,023 days from the time they were filed with VA. On average, claims resolved by a court judgment take longer; for example, in fiscal year 2010, judgments awarded by the court—whether in favor of the United States or the veteran—took over 1,600 days from the time the claims were filed with VA.

## VA Requires Review of Paid Tort Claims to Identify Practitioners Who Rendered Substandard Care, but Does Not Ensure That All Paid Claims Are Sent for Review

VA policy requires OMLA to review tort claims that result in payments to veterans in order to determine whether VA practitioners provided substandard care and, if so, to notify the director of the VAMC involved in the tort claim that the practitioner must be reported to the NPDB. Although VA's regional counsel offices are required to notify OMLA about settled tort claims or claims paid through litigation, we found that

regional counsel offices did not report a significant number of paid tort claims—for reasons such as lack of administrative oversight and staff turnover—and VA's OGC lacks an internal control to identify the extent to which the offices comply with this requirement.[24] As a result, OMLA did not have the opportunity to review all paid tort claims for fiscal years 2005 through 2010 to determine whether VA practitioners rendered substandard care.

VA's OMLA Reviews Information on Paid Tort Claims to Determine Whether VA Practitioners Delivered Substandard Care to Veterans

VA's 22 regional counsel offices are required to notify OMLA about all paid tort claims—that is, any monetary award for claims that are resolved through VA's administrative review or through litigation—resulting from care rendered by VA medical practitioners, as part of OGC's process for closing out the claims.[25,26] Once notified about a paid tort claim, OMLA oversees a paid tort claim review panel that reviews the claim—regardless of the payment amount—as part of VA's responsibility to determine whether a VA practitioner rendered substandard care and should be reported to the NPDB.[27] If the OMLA paid tort claim review panel makes this determination, OMLA notifies the involved VAMCs of their requirement to report the involved practitioner or practitioners to the NPDB.

For every paid tort claim involving VA practitioners, OMLA receives from the involved VAMC the medical records pertinent to the injury—which may have occurred years prior to the tort claim payment—as well as statements from the involved practitioners. OMLA then convenes a review panel consisting of a minimum of three medical practitioners to review the medical records and determine whether the claim was associated with substandard medical care.[28] If the OMLA review panel

[24]Although regional counsel offices resolve a majority of paid tort claims and are responsible for notifying OMLA about these claims as well as those resolved through litigation, VA network and facility directors have authority to settle small claims for $2,500 or less. See 38 C.F.R. § 14.600(c)(1) (2010). In such cases, VA network and facility directors are required to notify the appropriate regional counsel office and OMLA of any settlements. However, OGC officials indicated that only 1 of the 82 small claims paid during fiscal years 2005 through 2010 was coded in the Tort Claims Information System as having been settled by a facility director. Therefore, given the small number of claims settled at the facility or network level, we did not examine whether the network or facility directors notified OMLA about such claims. See VHA Directive 2010-004, *Delegation of Authority to Settle Tort Claims* (Jan. 14, 2010).

[25]See VA, *General Counsel Handbook*, ch. 17 (Oct. 3, 2002), and VHA Handbook 1100.17, *National Practitioner Data Bank (NDPB) Reports* (Dec. 28, 2009).

[26]The notification includes a copy of the Standard Form 95 that veterans use to file the claim, information on how the claim was resolved, and the payment awarded to the veteran.

[27]Under the provisions of the Health Care Quality Improvement Act of 1986, which established the NPDB, and a Memorandum of Understanding between VA and HHS, VA must submit certain information on paid tort claims and on any actions taken against practitioners' clinical privileges to the NPDB and appropriate state licensing boards. See 42 U.S.C. § 11152(b); 38 C.F.R. pt. 46 (2010). For example, in addition to reporting VA practitioners for paid tort claims, if a review initiated by a VAMC determines that a VA practitioner rendered substandard care or was involved in improper professional conduct resulting in a change or restriction to the practitioner's clinical privileges, the relevant VAMC director must report the change in clinical privileges to the NPDB. See VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports* (Dec. 28, 2009).

[28]OMLA officials told us that panel reviewers are primarily non-VA practitioners with at least one reviewer of the same medical profession and specialty as the involved practitioner or practitioners.

determines that a licensed practitioner rendered substandard care, OMLA notifies the director of the VAMC involved in the tort claim that the practitioner must be reported to the NPDB.[29,30] VAMCs, as well as non-VA medical facilities, use NPDB information, in part, to inform their credentialing and privileging processes for the practitioners who deliver care in their facilities. When a NPDB report is required, OMLA sends the relevant VAMC and VA network a letter containing information about the substandard care and the involved practitioner or practitioners' names. During fiscal years 2005 through 2010, OMLA reviewed 2,109 paid tort claims, determined that about half of these claims were associated with substandard care, and identified 785 practitioners for reporting to the NPDB.[31]

OMLA also analyzes the paid tort claims to identify the types of errors and types of practitioners most frequently associated with substandard care. OMLA's analysis showed that the types of errors most often associated with substandard care during fiscal years 2005 through 2010 related to diagnoses—such as wrong or delayed diagnoses that resulted in veteran injury. OMLA data also show that during this time period, physicians were the type of VA practitioners most frequently identified for reporting to the NPDB, followed by nurses and physician assistants. In addition, primary care was the most frequently identified clinical specialty associated with substandard care.[32]

VA headquarters officials told us that in addition to assessing the delivery of care related to paid tort claims and reporting practitioners to the NPDB as required, they also use OMLA data, in part, to help inform initiatives to improve the quality of care provided in VA facilities.[33] For example, VA headquarters officials indicated that OMLA's findings regarding diagnostic errors prompted the development of the Diagnostic Error Task Force to explore ways to reduce these errors.

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[29]Within 30 calendar days of notification by OMLA that a practitioner had delivered substandard care, the appropriate VAMC director, or designee, is required to report the practitioner and the amount of the paid tort claim to the NPDB, and send a copy of the report to the OMLA Director. See VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*.

[30]In addition to OMLA reviews of paid tort claims, VA headquarters and VA network officials told us that VAMCs frequently conducted their own reviews of the medical incidents that precipitated tort claims—often soon after the incident occurred—as another check to improve the quality of care they provide to veterans.

[31]The number of paid tort claims associated with substandard care may differ from the number of practitioners identified for reporting to the NPDB for several reasons, including that more than one practitioner was involved in a paid tort claim, a practitioner involved in a paid tort claim is now deceased, or a practitioner was not involved, but rather VA system errors—such as insufficient diagnostic equipment available—contributed to substandard care. According to an OMLA official, in fiscal year 2010, VA submitted 165 NPDB reports. For comparison, this official told us that in 2010 there were a total of 13,277 public and private sector NPDB reports associated with public and private sector tort claim payments. This official indicated that while NPDB data are available by calendar year, it was not possible to obtain annual NPDB data corresponding to VA's fiscal year.

[32]VA defines primary care as care provided by internal medicine and family practice physicians, as well as nurse practitioners and physician assistants, functioning in the role of primary care providers.

[33]VA headquarters officials told us that they review other information as part of these broader quality improvement efforts. Also, see VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook* (May 23, 2008), and VHA Directive 2008-077, *Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents* (Nov. 7, 2008).

## VA Does Not Ensure That All Paid Tort Claims Are Sent for Review

Although VA requires its 22 regional counsel offices to notify OMLA regarding paid tort claims to initiate OMLA's review of VA practitioners involved in the claims, we found that the regional counsel offices did not comply with VA policy to notify OMLA about all tort claims that resulted in payments to veterans. While a majority of paid tort claims were reported, an OGC official told us that some of the reasons given by regional counsel offices for not reporting the remaining paid tort claims included lack of administrative oversight, turnover in staff, and uncertainty as to which office was responsible for notifying OMLA that a claim had been paid. Specifically, we found that there were 386 more paid tort claims in OGC's summary data from its regional counsel offices than appeared in OMLA's data on paid tort claims to be reviewed for fiscal years 2005 through 2010—and VA's OGC was unaware of this discrepancy. These claims represented 16 percent of the total number of paid tort claims during this time period. We identified these claims by comparing the number of paid tort claims in OGC's summary data for fiscal years 2005 through 2010 with the number of paid tort claims during this same time period that OMLA's data indicated the office had received from the regional counsel offices.

VA OGC officials acknowledged that the paid tort claims had not been sent to OMLA and that VA lacks an internal control to identify this problem.[34] Specifically, VA's OGC has not established a check or any other procedure to ensure that OGC's regional counsel offices send information on paid tort claims to OMLA. This should involve a process to regularly reconcile OGC and OMLA data, which would verify the accuracy and completeness of the notifications on which OMLA relies to initiate its reviews. However, in the absence of such an internal control, VA does not know whether, or to what extent, the paid claims data OMLA reviews are complete.

OGC and OMLA officials told us that the 386 claims that had not been reported to OMLA are likely to be similar to the claims that had been reported and reviewed by OMLA during fiscal years 2005 through 2010 in terms of the types of providers or errors associated with substandard care.[35] Therefore, since OMLA's review of paid tort claims from fiscal years 2005 through 2010 resulted in about 37 practitioners being required to be reported to the NPDB for every 100 paid tort claims reviewed, a similar pattern of reporting may be expected for the 386 paid tort claims that were not sent to OMLA for review. Assuming a similar rate of reporting based on these projections, we estimate, and an OMLA official agrees, that for these 386 claims, approximately 140 practitioners would likely have been required to be reported to the NPDB for rendering substandard care.

[34]Regional counsel offices and OGC record the resolution of tort claims into OGC's Tort Claims Information System; however, OGC officials told us that the system does not include information on whether the offices notified OMLA about the claim.

[35]According to OGC officials, the paid tort claims that were not reported to OMLA as required came from different regional counsel offices and were not reported for a variety of reasons. These officials added that there was no indication that the unreported paid tort claims would differ from those that were sent to OMLA for review.

It will be a challenge for OMLA to review the 386 new paid tort claims that we identified from the prior 6 fiscal years—in addition to its regular workload—given that OMLA typically reviews this number of claims in 1 year. OMLA officials told us that they intend to develop a plan to review the newly identified paid tort claims from prior fiscal years that they receive from OGC.

## Conclusions

VA's analysis of paid tort claims is one of several important components of the agency's efforts to assess and improve the quality of care veterans receive at VA facilities. VA reviews data from paid claims and related medical records in order to determine whether VA practitioners rendered substandard medical care and to identify the types of errors and types of practitioners most frequently associated with substandard care. Given the importance of these data for VA and the care it provides veterans, VA needs reasonable assurance that the tort claims data it reviews are complete.

In the course of our review, however, we found that 386 paid tort claims that were resolved through VA's administrative review or litigation did not appear in OMLA's data on paid tort claims to be reviewed. In light of this discrepancy, OGC officials indicated that regional counsel offices did not notify OMLA about these claims as required under VA policy. We also found that OGC did not have an internal control in place to determine whether regional counsel offices had reported all paid tort claims to OMLA for review. As a result, OMLA reviewed incomplete tort claims data and therefore did not have the opportunity to examine the care rendered to veterans by a number of VA practitioners involved in paid tort claims. An OMLA official agreed with our estimate that some of these practitioners likely delivered substandard care, and that VA likely would have reported some of them to the NPDB. While OMLA's review of paid tort claims is a part of VA's broader quality improvement efforts, the absence of steps needed to ensure that the tort claims data reported to OMLA are complete creates a gap in VA's ability to better ensure the quality of care provided to veterans. Additionally, the underreporting of practitioners to the NPDB has broader implications for care delivered in non-VA facilities since these facilities may use NPDB information in the credentialing and privileging processes for their practitioners as well.

## Recommendations for Executive Action

To help ensure the quality of care provided to veterans by VA practitioners, including that information about all paid tort claims is reported and used appropriately to improve patient care, we recommend that the Secretary of Veterans Affairs direct the General Counsel to take the following three actions:

- Ensure that regional counsel offices notify OMLA about all paid tort claims resolved through VA's administrative review and through litigation.
- Develop and implement an internal control process to verify the completeness of the notifications of paid tort claims that regional counsel offices provide to OMLA.
- Review all paid tort claims related to medical injuries at VA facilities in prior years to ensure that all of these claims are reported to OMLA.

## Agency Comments

VA provided written comments on a draft of this report, which are reprinted in enclosure I. In its comments, VA concurred with our recommendations, identified actions agency officials are taking to implement them, and provided a technical comment that we incorporated. VA also provided some additional comments about the actions the agency takes before the completion of the tort claims process, which was outside the scope of our review.

To address our recommendations, VA's OGC has reemphasized to the regional counsel offices the need to provide OMLA with notices of all paid tort claims, and plans to modify its data systems to better ensure that regional counsel offices comply with this requirement. OGC is also providing OMLA with a report of all tort claims payments to date for the fiscal year and will update this report monthly, thus enabling OMLA to determine whether it has received the required information on each paid claim from the regional counsel offices. Further, OGC plans to include information on paid claims in the Tort Claims Information System that OMLA will be able to access as needed. Additionally, OGC has begun to compare prior years' paid tort claims against the records of claims that OMLA has opened for review. OGC plans to provide OMLA with notices of all prior year paid claims when it is determined that such notices have not been provided. OGC expects to identify and provide supporting documentation on all paid claims to OMLA by the end of January 2012.

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We are sending a copy of this report to interested congressional committees and the Secretary of Veterans Affairs. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me 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 report. GAO staff who made key contributions to this report are listed in enclosure II.

Randall B. Williamson
Director, Health Care

Enclosures – 2

## Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

October 14, 2011

Mr. Randall Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA Health Care: VA Uses Medical Injury Tort Claims Data to Assess Veterans' Care, but Should Take Action to Ensure that These Data Are Complete"*** (GAO-12-6R) and is providing comments in the enclosure.

VA appreciates the opportunity to comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***"VA Health Care: VA Uses Medical Injury Tort Claim Data to Assess Veterans' Care, but Should Take Action to Ensure that These Data Are Complete"***
(GAO-12-6R)

**GAO Recommendation: To help ensure the quality of care provided to veterans by VA practitioners, including that information about all paid tort claims is reported and used appropriately to improve patient care, we recommend that the Secretary of Veterans Affairs direct the General Counsel to take the following three actions:**

**Recommendation 1:** Ensure that regional counsel offices notify OMLA about all paid tort claims resolved through VA's administrative review and through litigation.

**VA Comment:** Concur. VA's Office of General Counsel (OGC) has re-emphasized to the Regional Counsels the need to provide such notices and plan to modify its data systems to better ensure compliance. Currently, the Veterans Health Administration's Office of Medical-Legal Affairs (OMLA) is being given a spreadsheet each month showing the prior month's payments. The list is also being placed on an OGC Web site, and Regional Counsels are to note the date they provide the notification documents to OMLA.

**Recommendation 2:** Develop and implement an internal control process to verify the completeness of the notifications of paid tort claims that regional counsel offices provide to OMLA.

**VA Comment:** Concur. OGC is providing OMLA with a report of all tort claims payments to date for the fiscal year, and will update the report monthly. OMLA will be able to determine whether it has received from the Regional Counsel the required information on each paid claim.

**Recommendation 3:** Review all paid tort claims related to medical injuries at VA facilities in prior years to ensure that all of these claims are reported to OMLA.

**VA Comment:** Concur. OGC has begun this review and is comparing its paid claims reports against OMLA's records of cases it has opened for review. In those cases where it is determined that notices of payment have not been furnished to OMLA, such notices will be provided. OGC also plans to develop a report of paid claims that OMLA will be able to run at its convenience in the Tort Claims Information System, an OGC database containing information on VA malpractice claims to which OMLA has access. OGC anticipates identifying and providing supporting documentation to OMLA on all of the paid claims by the end of January 2012.

Enclosure

Department of Veterans Affairs (VA) Comments to
Government Accountability Office (GAO) Draft Report
***"VA Health Care: VA Uses Medical Injury Tort Claim Data to Assess Veterans' Care, but Should Take Action to Ensure that These Data Are Complete"***
(GAO-12-6R)

**Additional Comments**

It is important to note that the Veterans Health Administration (VHA) takes action before the completion of Regional Counsel, OGC, or United States Attorney settlement/litigation determinations, and subsequent VHA OMLA panel reviews to address quality of care issues related to tort claims. VA facilities normally address quality of care issues when an incident occurs; facilities do not wait for the filing of a tort claim to take action. All VA facilities have an incident reporting process that requires employees to notify their supervisor, quality management, patient safety, risk management, police and security, senior leadership, and others as appropriate, when an adverse event occurs. Providing treatment to the Veteran is always the immediate concern, and quality and safety officials review the information that was reported as being associated with the adverse event soon after the specific incident.

Based on the information provided about a specific incident, facility leadership may refer the case for a peer review for quality management, conduct a Root Cause Analysis (RCA) review, perform a fact-finding investigation, or initiate an Administrative Investigative Board (AIB). These reviews are typically completed within 45 days or less of being assigned to an individual staff member or team. The findings and data analyses from reviews of these types are referred to appropriate venues so that actions, e.g., revisions in policy and procedure, are taken to prevent recurrence of incidents in a timely manner. Clinical staff also discuss patient incidents in their service-specific morbidity/mortality conferences to identify opportunities to improve quality and safety. In addition, the National Center for Patient Safety (NCPS) maintains a comprehensive database of information that is reported through these local processes. NCPS recommends changes to policy and procedures based on their reviews of facility, regional, and national trends.

When allegations of substandard care are first brought to the attention of VHA management officials (either when the incident occurred or when the tort claim is filed), information obtained by the review processes can result in positive changes in provider practice patterns and VA policy/procedure modifications necessary to improve quality and safety at the facility and national level. VA has many ways to ensure the best quality of care; use of medical injury tort claims data is one method that almost always happens after VHA leadership and staff takes other steps to ensure lessons learned from a particular incident are appropriately applied.

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Enclosure II

## GAO Contact and Staff Acknowledgments

### GAO Contact

Randall B. Williamson, (202) 512-7114 or williamsonr@gao.gov

### Staff Acknowledgments

In addition to the contact named above, Mary Ann Curran, Assistant Director; Kye Briesath; Krister Friday; Martha R. W. Kelly; JoAnn Martinez-Shriver; Lisa Motley; Michelle Paluga; and Suzanne Worth made key contributions to this report.

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