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Report to Congressional Requesters

December 2011

DOD HEALTH CARE

Actions Needed to Help Ensure Full Compliance and Complete Documentation for Physician Credentialing and Privileging

GAO-12-31

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GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-31, a report to congressional requesters

Why GAO Did This Study

The process of credentialing and privileging is central to ensuring that physicians who work in DOD military treatment facilities (MTF) have the appropriate credentials and clinical competence. After an Army physician allegedly shot and killed 13 people at Fort Hood in November 2009, GAO was asked to examine DOD's physician credentialing and privileging requirements and whether MTFs are fully complying with those requirements. GAO examined the extent to which: (1) DOD ensures that physician credentialing and privileging requirements are consistent across the Military Health System (MHS), (2) Army MTFs are complying with Army's physician credentialing and privileging requirements, and (3) Army's existing oversight and physician credentialing and privileging requirements are sufficient to assure compliance and complete documentation. GAO reviewed DOD and service-level requirements and interviewed DOD and military service officials. Because Army has the largest staff of medical personnel, GAO reviewed a nongeneralizable sample of 150 physician credentials files—selected to include a variety of specialties—and interviewed staff at five Army MTFs selected based on size and location.

What GAO Recommends

GAO is making recommendations to ensure consistency across MHS requirements; to better ensure that performance data and other relevant information are documented; and to improve oversight across the MHS. DOD agreed overall, but DOD's response lacks sufficient detail to determine how fully its planned actions will address the recommendations.

View GAO-12-31. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

DOD and the military services—Army, Navy, and Air Force—each establish requirements for reviewing physician credentials and competence, but the military services' requirements are in some cases inconsistent with DOD's requirements and each other's. For example, DOD requires disclosure and primary source verification of all state medical licenses a physician has ever held; Navy only requires these steps for licenses held during the previous 10 years. Inconsistencies also exist between DOD's and the services' requirements for the use of and primary source verification of certain clinical competence and practice history documents. Such differences may result in MTF noncompliance with requirements that DOD deems important. They may also create challenges for ensuring that all requirements are met for physicians from one military service who are working at an MTF managed by another service. Furthermore, DOD lacks a systematic process to address inconsistencies across requirements, to coordinate revisions to the requirements, and to achieve its goal of standardizing physician credentialing and privileging requirements across the MHS.

The five Army MTFs GAO examined did not fully comply with certain Army physician credentialing and privileging requirements. For 34 of the 150 credentials files GAO reviewed, the MTF had not documented proper verification of every state medical license the physician ever held at the time the MTF granted privileges; 7 of these 34 credentials files lacked this documentation for the physician's only current medical license. In addition, credentials files did not consistently contain documents required to support the physician's clinical competence, including peer recommendations and performance assessments; 14 files were missing required peer recommendations and 21 files were missing required performance assessments. Further, MTFs were not consistently documenting follow-up conducted on peer recommendations, as required. When required documents were present, they sometimes lacked required information. For example, performance assessments did not consistently contain data to support the assessment, even when an MTF's form specifically prompted for it. MTFs also lacked a systematic process for compiling and analyzing performance data. Finally, while MTFs usually complied with Army's requirement to search physicians' malpractice history, files often lacked information needed to determine if the MTF had documented a complete practice history, as required.

Army oversight processes and requirements were insufficient to assure that its MTFs fully complied with requirements and documented complete information to support credentialing and privileging decisions. Army oversight of individual MTFs' privileging decisions was insufficient to identify the instances of noncompliance and incomplete documentation that GAO observed during its review of credentials files at five selected Army MTFs. In particular, Army lacks a process for reviewing individual MTFs' credentials files to identify these issues, as do Navy and Air Force. Moreover, weaknesses in Army requirements contributed to noncompliance and incomplete documentation. For example, MTFs did not consistently document follow-up on peer recommendations, in part because existing requirements do not clearly delineate responsibilities for documenting follow-up. Further, Army lacks requirements for documenting certain types of information—such as information on significant MTF deliberations—needed to support credentialing and privileging decisions.

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Abbreviations

AFMOA	Air Force Medical Operations Agency
BUMED	Bureau of Medicine and Surgery
CCQAS	Centralized Credentials Quality Assurance System
CV	curriculum vitae
DOD	Department of Defense
DPDB	Defense Practitioner Data Bank
ICTB	inter-facility credentials transfer brief
MHS	Military Health System
MTF	military treatment facility
NPDB	National Practitioner Data Bank
PAF	provider activity file
PSV	primary source verification
VA	Department of Veterans Affairs

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

December 15, 2011

The Honorable Jason Chaffetz
Chairman
The Honorable John Tierney
Ranking Member
Subcommittee on National Security, Homeland Defense
and Foreign Operations
Committee on Oversight and Government Reform
House of Representatives

The Honorable Jeff Flake
House of Representatives

The Department of Defense (DOD) requires each of the military services—the Departments of the Army, Navy, and Air Force—to take specific steps to determine whether physicians have the appropriate professional qualifications and clinical abilities to care for the servicemembers and their families treated in the Military Health System (MHS). These steps begin with the process of credentialing and privileging each physician before the physician is allowed to treat patients at a DOD military treatment facility (MTF).[1] During the credentialing process, the MTF staff collects and reviews information such as a physician's professional training, malpractice history, peer recommendations, and other documents regarding their professional background to determine whether the physician has suitable clinical abilities and experience to practice at the MTF. During the privileging process, the MTF staff determines which specific health care services—known as clinical privileges—the physician should be allowed to provide, based on the physicians' clinical competence to provide the service and the specific capabilities of the MTF. After the physician is granted privileges, the credentialing and privileging processes are repeated at least every 2 years. During these 2 years, or in between privileging dates, DOD also requires MTFs to conduct ongoing monitoring of physicians' clinical performance to help ensure physicians' clinical competence.

[1]An MTF is a military treatment facility owned and operated by DOD that is established for the purpose of furnishing medical and/or dental care to eligible individuals.

The events at Fort Hood in November 2009, where an active duty Army physician allegedly shot and killed 13 people, have led to questions about how well DOD and the military services are monitoring, evaluating, and documenting the competence of their physicians. An independent investigation of the events at Fort Hood focused mainly on evaluating DOD's and the military services' policies and procedures for identifying potential safety threats, but it also included a review of the alleged perpetrator's medical training records.[2] The investigation identified discrepancies between the alleged perpetrator's performance as documented in official records and his actual performance during his medical training, residency, and fellowship in an Army MTF. The investigation also identified gaps in processes for ensuring that all relevant information about physician performance is included in the formal evaluation process and made available to supervisors.

The events at Fort Hood and the findings of the subsequent investigation raise questions about whether the military services' individual networks of MTFs are fully complying with DOD's physician credentialing and privileging requirements and appropriately implementing credentialing and privileging processes. To implement DOD's credentialing and privileging processes at their MTFs, each military service has established its own specific credentialing and privileging requirements that its MTFs must follow.[3] Each military service, under a surgeon general, has a central oversight agency—sometimes referred to as a medical command—with the delegated responsibility to lead the development and implementation of these service-specific requirements. However, as we have previously reported, there have been long-standing concerns about management challenges and potential inefficiencies related to the current MHS structure.[4] In both 2010 and 2011, defense authorization bills passed by the House contained provisions relating to the establishment of

[2]U.S. Department of Defense Independent Review, *Protecting the Force: Lessons from Fort Hood* (Washington, D.C.: Jan.15, 2010).

[3]Most MTFs are managed by a specific military service; Army, Navy, or Air Force, with Navy providing health care to the Marine Corps. However, some MTFs—such as the Walter Reed National Military Medical Center in the National Capital Region—are jointly managed by more than one service, and some facilities are jointly managed by DOD and the Department of Veterans Affairs (VA).

[4]GAO, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure*, GAO-08-122 (Washington, D.C.: Oct. 12, 2007).

a unified medical command system within the MHS.[5] Further, DOD has established goals for the MHS to standardize processes across the military services, including physician credentialing and privileging processes.[6] Standardizing these processes is intended to improve the ability of the military services to share information, particularly as it relates to MTFs' ability to obtain and review credentialing and privileging documents for all DOD health professionals.

In this context, you asked us to review the military services' policies and procedures for verifying physician credentials and clinical competence. In this report we examine the extent to which: (1) DOD ensures that the military services' physician credentialing and privileging requirements are consistent across the MHS, (2) Army MTFs are complying with Army's physician credentialing and privileging requirements, and (3) Army's existing oversight and physician credentialing and privileging requirements are sufficient to assure compliance and complete documentation.

To examine the extent to which DOD ensures that the military services' physician credentialing and privileging requirements are consistent with DOD's, we reviewed written policies issued by DOD, Army, Navy, and Air Force.[7] We also reviewed applicable standards published by The Joint Commission (a nonprofit organization that evaluates and accredits more than 16,000 health care organizations in the United States, including MTFs).[8] We compared DOD's and the military services' requirements related to primary source verification of physician credentials, evaluation

[5]H.R. 5136, 111th Cong. § 903 (as passed by House, May 28, 2010); H.R. 1540, 112th Cong. § 711 (as passed by House, May 26, 2011). Neither provision has become law.

[6]U.S. Department of Defense, *MHS Human Capital Strategic Plan 2008-2013* (Washington, D.C.: November 2007).

[7]Written policies used for analysis include *DOD Instruction 6025.13* (which replaced *DOD Directive 6025.13* on February 17, 2011), *DOD Regulation 6025.13-R*, *Army Regulation 40-68*, *Navy Bureau of Medicine and Surgery Instruction 6320.66E*, and *Air Force Instruction 44-119*. Throughout this report, we refer to these policies as "requirements." When we use the term "regulations," we are referring to specific written policy documents labeled as such by the issuer.

[8]DOD requires that all MTFs shall meet or exceed the standards of appropriate external accrediting bodies, including accreditation of all hospitals by The Joint Commission. In order to be accredited by The Joint Commission, each MTF is subject to on-site review once every 3 years.

of physician performance and clinical competence, and documentation of physician practice history. Specifically, we compared requirements regarding state medical licenses, peer recommendations, ongoing performance monitoring and assessment, malpractice and adverse action history, and practice experience. We selected these five credentialing and privileging requirements because they—unlike other requirements—address information about physicians that can change or be updated with new information periodically. To gain further understanding of efforts to standardize physician credentialing and privileging processes across the MHS, we also reviewed DOD strategy documents, including the *MHS Human Capital Strategic Plan 2008-2013*. To obtain further information regarding interpretation of requirements, the processes in place to help ensure consistency between DOD and the military services and among the military services themselves, and efforts to standardize processes, we interviewed officials from DOD and from each military service's oversight agency.[9]

To determine the extent to which Army MTFs are complying with the Army's requirements for credentialing and privileging of physicians, we conducted site visits to five Army MTFs in the United States. We limited our compliance review to Army MTFs because it is the military service with the largest staff of medical personnel.[10] We selected the MTFs in our sample to ensure variation in terms of the size of the MTFs and that each MTF had a sufficient number of physicians within each of six selected

[9]We interviewed senior officials who are responsible for developing and overseeing DOD's and the military services' physician credentialing and privileging requirements. These officials included the Deputy Assistant Secretary of Defense for Clinical and Program Policy; the Chief of Quality Management Division for the U.S. Army Medical Command; the Deputy Department Head of Clinical Operations Quality and Risk Management for the Navy Bureau of Medicine and Surgery; and the Chief of Professional Staff Management for the Air Force Medical Operations Agency. During most interviews more than one official was present; however, in some follow-up interviews, only the senior official was present.

[10]The number of fixed MTFs managed by each military service varies, and each service's MTFs may be located either in the United States or overseas. The Army operates 35 MTFs, including 9 medical centers. The Navy operates 31 MTFs, including 3 medical centers. The Air Force operates 72 MTFs, including 3 medical centers. We did not evaluate compliance at MTFs located overseas. At the time we began our review, the National Naval Audit Service was conducting a review of Navy's credentialing and privileging process and was using a similar file review methodology.

medical specialties.[11] We found the Army data we used to make this selection to be sufficiently reliable for our purposes. During our site visits to each of the five Army MTFs, we selected and reviewed a nongeneralizable sample of 30 physician credentials files (5 in each of the selected medical specialties), for a total of 150 files. However, results for some of the credentialing and privileging requirements do not total 150 because not all credentials files were required to comply with every requirement we examined. We also reviewed MTF-specific forms, such as peer recommendation forms and official performance assessment templates and minutes from meetings of the MTF committee responsible for reviewing physician credentials files, for the 2 years prior to our site visit. During our site visits, we interviewed MTF staff responsible for maintaining credentials files, MTF department chiefs, and other MTF staff responsible for reviewing credentials files and recommending privileges for physicians. We reviewed with MTF staff at the end of each visit all instances of documentation we were unable to locate. The results of our site visits to selected Army MTFs cannot be generalized to all Army MTFs, or MTFs managed by the Navy or the Air Force.

To determine the extent to which Army's existing oversight and physician credentialing and privileging requirements are sufficient, we reviewed information collected during our site visits to selected Army MTFs, reviewed relevant internal controls standards, and interviewed MTF staff and officials from Army Medical Command. Specifically, we considered Army's oversight, including the provision of policy and guidance, against relevant standards described in the *Standards for Internal Control in the Federal Government and the Internal Control Management and Evaluation Tool*.[12] We also reviewed information obtained during our site

[11]We selected the medical specialties of Family Practice, Obstetrics-Gynecology, Pediatrics, Psychiatry, Radiology, and Surgery. We selected these medical specialties in order to ensure that we had a sufficient number of physicians within each medical specialty to have a consistent sample of specialties across the five MTFs, and also to ensure that our sample could not be used to identify specific individuals at each MTF.

[12]GAO, *Standards for Internal Control in the Federal Government* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives. The *Internal Control Management and Evaluation Tool* is based on the *Standards for Internal Control in the Federal Government*, and is intended to provide a systematic approach to assessing an agency's internal control structure. See GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

visits, including our reviews of select physician credentials files, MTF-specific forms, and relevant minutes from MTF meetings pertaining to credentialing and privileging. Lastly, we interviewed MTF staff, officials from DOD, and officials from each military service's oversight agency to gain insight into current oversight processes for physician credentialing and privileging.

Further details on our scope and methodology can be found in appendix I. We conducted this performance audit from May 2010 to December 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.

Background

Structure for Physician Credentialing and Privileging in the Military Health System

Within the MHS, the military services each have a network of MTFs. These MTFs are located both in the United States and abroad, and they vary in size from small clinics to large medical centers. The physician population at the MTFs within the MHS is diverse—including active duty, Reserve, and National Guard servicemembers, as well as civilians, contractors, VA staff, and volunteers. MHS physicians are assigned to a specific MTF, which is referred to as their duty station. However, physicians within the MHS frequently move among MTFs. Military physicians can be reassigned to a new duty station as frequently as every 2 to 3 years, and most physicians working at an MTF can be temporarily assigned to work at another MTF to assist DOD's mission needs.[13] Furthermore, individual MTFs can be staffed by physicians from more than one military service.

In order to care for servicemembers and their families at an MTF, a physician must have the required credentials and be granted the appropriate, specific privileges for their medical specialty. Credentialing is the process of inspecting and authenticating the documents that

[13]Military physicians can also be deployed for service overseas.

constitute evidence of appropriate education, training, licensure, and experience. Privileging is the process that defines the scope and limits of practice for a physician based on their relevant training and experience, current competence, peer recommendations, and the capabilities of the facility where the physician is practicing.

The Assistant Secretary of Defense for Health Affairs within DOD is responsible for developing and overseeing DOD's physician credentialing and privileging requirements to ensure their consistent application across the MHS.[14] To implement DOD's requirements, the military services' Surgeons General—who are delegated the responsibility by the Secretary of their respective service—establish specific physician credentialing and privileging requirements, with which their MTFs are required to comply. Each military service has a central oversight agency that is responsible for developing and implementing service-specific requirements. Moving forward, DOD strategy documents have established broad goals for standardizing processes and improving information-sharing across the MHS. For example, the *MHS Human Capital Strategic Plan for 2008-2013* established the goal to define and deploy a common credentialing and privileging system across the military services. These strategic plans also established goals for ensuring that information is accessible to MHS leaders at all levels to promote informed decision making.

Generally, DOD delegates oversight of physician credentialing and privileging at MTFs to each of the military services' Surgeons General, who then further delegate oversight to each of the services' responsible oversight agencies: U.S. Army Medical Command, Navy's Bureau of Medicine and Surgery (BUMED), and the Air Force Medical Operations Agency (AFMOA). Army and Navy also have a regional command structure, which has some responsibilities for overseeing credentialing and privileging at their MTFs. Within each MTF, the MTF commander—who is the final "privileging authority"—is responsible for ensuring that the MTF complies with all applicable DOD and service physician credentialing and privileging requirements. In addition, MTF staff such as members of

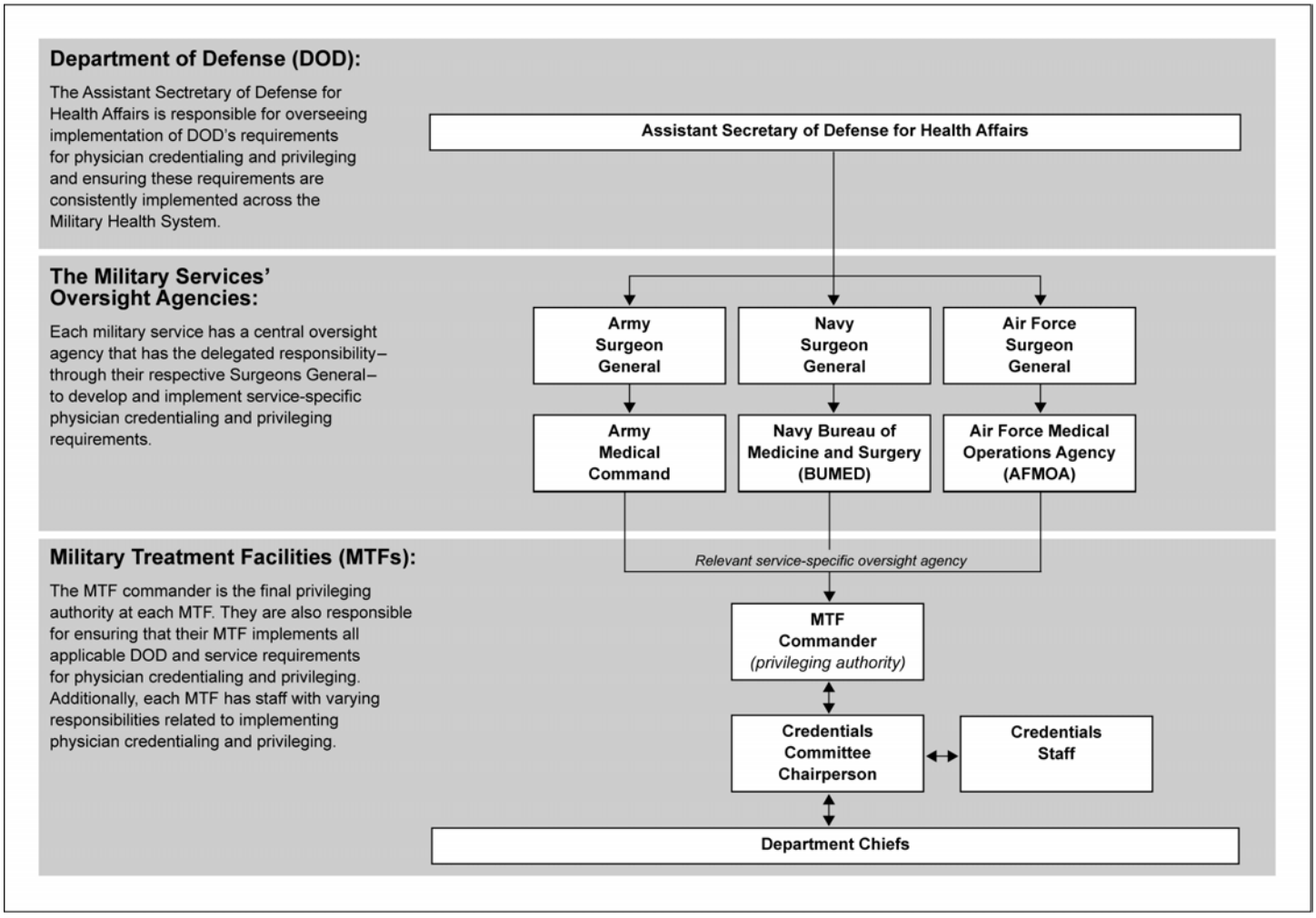
[14] *DOD Instruction 6025.13* and the associated *DOD Regulation 6025.13-R*—both of which contain procedures for physician credentialing and privileging—require the Assistant Secretary of Defense for Health Affairs to ensure their consistent implementation across the MHS. *DOD Regulation 6025.13-R* is mandatory for use by all DOD components. DOD also requires that each MTF comply with applicable hospital accreditation standards of The Joint Commission.

the credentials committee,[15] department chiefs,[16] and credentials staff—staff at each MTF dedicated to the credentialing and privileging process—have varying responsibilities for implementing physician credentialing and privileging processes. (See fig. 1.)

[15]The credentials committee is a group of MTF staff—typically made up of department chiefs and other appointed staff—that is responsible for reviewing each physician's application for privileges and making recommendations to the MTF commander on whether to grant privileges.

[16]In many cases, the department chief is the physician's clinical supervisor. However, in larger MTFs, this may not be the case. In all MTFs, the department chief is responsible for reviewing the physician's application for privileges prior to the credentials committee's review, so for the purposes of this report we focused on department chiefs' responsibilities in the credentialing and privileging processes.

Figure 1: Organization of Physician Credentialing and Privileging within the Military Health System



Source: GAO.

Physician Credentialing and Privileging Processes in the Military Health System

During the credentialing process, credentials staff collect and review each physician's medical credentials, such as state medical licenses and medical education, to determine whether the physician has the qualifications required by DOD to provide care at an MTF. During this process, some of the medical credentials must be primary source verified, which involves collecting documentation from the original source for each credential to confirm the factual accuracy and authenticity of the physician-provided documentation.

During the privileging process, MTF staff—typically department chiefs, members of the credentials committee, and the MTF commander—review available performance information on each physician to determine which specific health care services the physician is clinically competent to practice. Initial privileges are usually granted for 1 year, after which a physician must submit a request for the renewal of their clinical privileges. This renewal process is then repeated at least every 2 years.

The steps in the credentialing and privileging processes are essentially the same across the military services. The general processes include the following steps:

- A physician completes an application for privileges, in which the physician requests specific clinical privileges and provides all the required information on their medical credentials to the MTF's credentials staff.

- The MTF's credentials staff then conducts any required primary source verification of information, such as the physician's state medical licenses, and collects other required documents such as peer recommendations. For a physician who already holds privileges at the MTF, the credentials staff will obtain an assessment of current performance from the department chief.[17] The credentials staff then compiles the required documents and the physician's application for privileges into a credentials file and submits them to the department chief.

- The department chief is responsible for reviewing the physician's credentials file, including practice history, peer recommendations, and performance assessments. Based on this information, the department chief makes a recommendation to the committee designated to review the credentials file—usually the credentials committee—on whether to grant the requested privileges.

- The credentials committee reviews the department chief's recommendation and the physician's credentials file, along with any other input during the committee meeting. The credentials committee,

[17]Performance assessments should cover the time period since the MTF last granted privileges to the physician.

or the chairperson, then makes a recommendation regarding privileges to the MTF commander.

- The MTF commander reviews the credentials committee's recommendation and makes the final determination on whether to grant the requested privileges to the physician.

To facilitate the credentialing and privileging processes, MTFs are required to maintain a credentials file for any physician practicing within the MHS. The credentials file contains information relevant to both credentialing and privileging a physician, and includes information on a physician's credentials, clinical competence, and practice history. Types of information contained in the credentials file may include:

- *Credentials Verification Information*: documentation of required primary source verification of a physician's medical education, training, state medical licenses,[18] and certifications such as life support training.[19]

- *Clinical Competence Information*: documentation includes information such as peer recommendations and performance assessments to support a physician's current clinical competence to perform the requested clinical privileges.

- *Practice History Information*: documentation of a physician's prior practice, including:

    - any paid malpractice claims that were reported to the National Practitioner Data Bank (NPDB),[20]

[18]A physician may hold a medical license in more than one state. A medical license can have one of several different statuses, including active, expired, inactive, restricted, suspended, or revoked.

[19]Examples of these certifications include Basic Life Support, Advanced Cardiac Life Support, Advanced Trauma Life Support, Pediatric Advanced Life Support, and Neonatal Advanced Life Support.

[20]The NPDB is administered by the U.S. Department of Health and Human Services and includes information on physicians 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 or judgment.

- any relevant information in DOD's Defense Practitioner Data Bank (DPDB)[21] such as disability or other payment made due to the death or injury of an active duty member of the military services, and

- any additional information related to the physician's prior practice experience.

A credentials file within the MHS is a combination of paper and electronic files. In 2000, DOD introduced its Centralized Credentials Quality Assurance System (CCQAS), an on-line data system for use by all three of the military services' oversight agencies. CCQAS allows MTFs to electronically manage information related to a physician's credentialing and privileging. When a physician is reassigned to a new duty station, the paper credentials file transfers with the physician to their new duty station, which also gains access to and control of the physician's electronic credentials file in CCQAS. CCQAS consists of four modules:

- The credentials module of CCQAS, considered the electronic credentials file, contains information related to a physician's medical education and training, clinical competence, and practice history.

- The privileging module allows a physician to request privileges electronically. It also allows the MTF to review a physician's application and grant privileges electronically.

- The risk management module contains any information maintained by the MTF on malpractice settlements, claims, and potentially compensable events.[22]

- The adverse actions module contains information maintained by the MTF on any actions taken to limit a physician's privileges, including suspension, restriction, revocation, or denial.

[21]In addition to including information that DOD has reported to the NPDB, the DPDB includes information on instances where medical care contributed to the death or disability of an active duty service member.

[22]A potentially compensable event is an adverse event in which a patient experiences an unintended or unexpected negative result which may result in a medical malpractice claim or settlement.

Together, the risk management and adverse action modules in CCQAS comprise the DPDB.[23] However, unlike information in the privileging module, which is transferred when a physician is reassigned to a new duty station, information in the risk management and adverse action modules can only be accessed by the MTF that recorded it.

In addition to the general credentialing and privileging processes described above, DOD and the military services have developed an abbreviated process to facilitate the movement of physicians across MTFs. This process, predicated upon the use of a single document known as the inter-facility credentials transfer brief (ICTB), allows a "receiving" MTF to privilege a physician without duplicating efforts already taken by the physician's assigned duty station. For example, the receiving MTF would not need to obtain new peer recommendations for a physician who is being granted privileges based on an ICTB.[24] To initiate the ICTB process, the "sending" MTF will send a summary—the ICTB—of information regarding the physician's credentials, along with a statement attesting to the physician's clinical competence to the receiving MTF. The ICTB then serves in place of the physician's credentials file at the receiving MTF, and may be used both between MTFs managed by a single military service and between MTFs managed by more than one military service. In addition to the paper ICTB, the receiving MTF also can view any electronic information on the physician in CCQAS, although in general the receiving MTF cannot edit any of the information on a physician in CCQAS.

[23]For each malpractice claim or potentially compensable event that occurs at an MTF, the MTF is required to review the care provided by each involved physician and make a formal determination of whether the physician met or did not meet the applicable standard of care, or if the case was indeterminate.

[24]Reliance on the ICTB may result in the receiving MTF applying different credentialing and privileging requirements for physicians granted privileges based on an ICTB.

DOD Lacks a Process to Ensure Physician Credentialing and Privileging Requirements Are Consistent Across the MHS

DOD and the military services have each established requirements for the review of physician credentials and the granting of privileges, but the military services have established requirements that are in some cases inconsistent with DOD's requirements and each other's. DOD does not have a process in place to identify and address these inconsistencies across the MHS.

Physician Credentialing and Privileging Requirements Are Not Always Consistent Across the MHS

All the military services require their MTFs to comply with DOD's requirements. However, we found some inconsistencies between the military services' requirements for credentialing and privileging and DOD's requirements in four of the five categories we reviewed, specifically, state medical licensure; peer recommendations; malpractice history; and practice experience. We also identified some potential consequences of these inconsistencies. (See table 1.) For example, DOD requires MTFs to verify peer recommendations with the primary source. While Army and Navy have incorporated this into their requirements, Air Force requires that peer recommendations be verified but does not specify that this verification must be with the primary source. Air Force MTFs may therefore lack assurance that the peer recommendations they have received for a physician are authentic documents.

Table 1: Extent that Military Services' Physician Credentialing and Privileging Requirements Are Consistent with DOD's Requirements, and Potential Consequences of Inconsistent Requirements, as of September 2011

DOD requirement	Army	Navy	Air Force	Details of inconsistent requirements	Potential consequences of inconsistent requirements
State medical licensure					
Physician maintenance of current, valid, unrestricted license	Yes	Yes	Yes		
Physician disclosure of all licenses ever held	Yes	No[a]	Yes	**Navy** requires disclosure of licenses held in the past 10 years.	Military treatment facilities (MTF) may not have information on actions taken against an undisclosed previous license from more than 10 years prior.
Primary source verification (PSV) of all licenses ever held	Yes	No[a]	Yes	**Navy** requires PSV of licenses held in the past 10 years.	MTFs may lack assurance on the authenticity of any license from more than 10 years prior and on the accuracy of information on actions taken against a previous license from more than 10 years prior.
Peer recommendations					
Required for all physicians	Yes	No	No	**Navy** requires peer recommendations for physicians new to the Navy. *Performance Appraisal Report* allowed for physicians coming from a Navy MTF. **Air Force** requires peer recommendations for physicians new to the specific MTF. Performance assessment *Air Force Form 22* allowed for physicians renewing privileges.	In substituting performance assessments for peer recommendations, MTFs may not have consistent information regarding physicians' clinical competence.
Two recommendations required for a physician	Yes	Yes[b]	Yes		
PSV of required peer recommendations	Yes	Yes	No	**Air Force** required to "verify" but no further clarification as to whether that verification must be with the primary source.	MTFs may lack assurance that peer recommendations are authentic documents.
Ongoing performance monitoring					
Periodic reviews of performance	Yes	Yes	Yes		

DOD requirement	Army	Navy	Air Force	Details of inconsistent requirements	Potential consequences of inconsistent requirements
Malpractice history					
National Practitioner Data Bank (NPDB) query required at privileging	Yes	Yes	Yes		
Defense Practitioner Data Bank (DPDB) query required at renewal of privileges	No	No	Yes	**Army** has no specific requirement. **Navy** has no specific requirement.	MTFs may not have the complete malpractice history information needed to make privileging decisions.
Document any malpractice claims, settlements, judicial or administrative adjudications, and adverse or disciplinary actions	Yes	Yes	Yes		
PSV malpractice history—other than NPDB	Yes	No	No	**Navy** required to "verify" but no further clarification as to whether that verification must be with the primary source. **Air Force** required to "verify" but no further clarification as to whether that verification must be with the primary source.	MTFs may lack assurance that physician-provided information is accurate.
Practice experience					
Chronological documentation of practice experience accounting for all periods of time is required at privileging	Yes	Yes	Yes		
PSV of documentation of practice history	No	No	No	**Army** has no specific requirement. **Navy** required to "verify" but no further clarification as to whether that verification must be with the primary source. **Air Force** required to "verify" but no further clarification as to whether that verification must be with the primary source.	MTFs may lack assurance that physician-provided information is accurate.

Source: GAO analysis.

Note: Written policies used for analysis include *DOD Instruction 6025.13* (which replaced *DOD Directive 6025.13* on February 17, 2011), *DOD Regulation 6025.13-R*, *Army Regulation 40-68*, Navy *Bureau of Medicine and Surgery* (*BUMED*) *Instruction 6320.66E*, and *Air Force Instruction 44-119*.

[a]Navy officials informed us that the Navy's current revisions process includes plans to revise Navy *BUMED Instruction 6320.66E* to require that physicians disclose, and Navy MTFs primary source verify, all licenses ever held.

[b]Navy (to the extent it requires recommendations) does not specify a number beyond "letters."

Since the military services require their MTFs to comply with DOD's requirements, the inconsistencies we identified between DOD's and the military services' requirements could result in one or more of the military services not complying with credentialing and privileging processes that DOD deems to be important. For example, DOD requires MTFs to query the DPDB at renewal of privileges, but Army requirements are silent on this requirement. Because Army does not have a specific requirement for MTFs to query the DPDB at renewal of privileges, Army MTFs may not be performing these queries. Additionally, DOD, Army, Navy, and Air Force officials told us that it is currently not possible for MTFs to query the DPDB for results from other MTFs.[25] Without obtaining all relevant information from the DPDB, MTFs may be missing information DOD deems important to the credentialing and privileging process.

The inconsistencies in physician credentialing and privileging requirements across the military services themselves also have potential consequences. First, the inconsistencies conflict with DOD's stated goal of standardizing these processes across the military services and improving the ability of the military services to share credentialing and privileging information. Second, these inconsistencies may create challenges related to ensuring that all applicable requirements have been met for physicians from one service who are granted privileges at another service's MTF on the basis of an ICTB in place of a full credentials file. For example, a Navy MTF may only have the disclosure and primary source verification of a physician's licenses from the past 10 years, which meets Navy's requirements. If that physician is later temporarily transferred to an Army MTF using an ICTB, the receiving Army MTF, which requires the disclosure and primary source verification of all licenses ever held, would risk making privileging decisions on information that would be insufficient to meet Army requirements. The responsible DOD official acknowledged that inconsistencies across the military services' requirements could be a problem and noted that DOD would like to move towards standardizing physician credentialing and privileging requirements.

[25]MTFs can only query the DPDB for results from incidents that happened at that MTF. MTFs can request that their oversight agency query the DPDB for relevant information on a physician related to incidents at other MTFs. However, due to current design limitations within CCQAS, each service can only query the DPDB for its own service-specific information.

DOD Lacks a Process to Address Inconsistencies among DOD's and the Military Services' Physician Credentialing and Privileging Requirements

DOD lacks a process to address inconsistencies in credentialing and privileging requirements and achieve its stated goal of standardizing physician credentialing and privileging processes across the MHS. The Assistant Secretary of Defense for Health Affairs has the responsibility to oversee the military services' implementation of physician credentialing and privileging requirements and to ensure consistent application of those requirements across the MHS. Moreover, the senior DOD official responsible for credentialing and privileging told us that DOD expects the military services' requirements to be consistent with DOD's and confirmed that, moving forward, DOD's goal is to standardize credentialing and privileging across the MHS.

However, the senior DOD official responsible for credentialing and privileging also told us that DOD relies on the military services to ensure that their requirements are consistent with DOD's requirements. The official acknowledged that DOD does not have a DOD-wide process to identify and address inconsistencies in requirements, either between DOD and the services, or among the services themselves. Without a DOD-level process, DOD cannot adequately assure that its requirements are being consistently applied across the MHS and that the military services are moving towards DOD's stated goals and expectations for standardizing credentialing and privileging processes.

As of September 2011, DOD and two of the military services were revising their credentialing and privileging requirements, but there is no assurance that the inconsistencies we found among the military services will be brought in line with DOD's requirements during this revision process.[26] In our discussions about ongoing efforts to revise credentialing and privileging requirements, the responsible DOD official told us that DOD has a process for coordinating revisions to DOD's requirements with the military services' central oversight agencies. The oversight agencies each have the opportunity to review and make comments on any changes to DOD requirements. However, there is no similar process for DOD to review and comment on any changes the military services make when revising their requirements. Additionally, DOD lacks a process to assure that the military services coordinate revisions to their physician credentialing and privileging requirements with each other. An official

[26]Army and Navy are currently revising their credentialing and privileging requirements. Air Force published its revised requirements in August 2011.

from one military service's oversight agency told us that they have discussed some specific military-service-level revisions with the other oversight agencies. However, there is no systematic, DOD-established process to coordinate all of their revisions. Absent a process for coordinating revisions to the military services' requirements, DOD cannot ensure that credentialing and privileging requirements are consistent across the MHS.

Selected Army MTFs Did Not Fully Comply with Certain Army Physician Credentialing and Privileging Requirements

Based on our review of 150 credentials files at the five Army MTFs we selected for our review, we found that none of the five Army MTFs fully complied with certain Army physician credentialing and privileging requirements. Specifically, we found that the selected MTFs did not fully comply with the Army's requirement to primary source verify all state medical licenses at the time of privileging and at renewal. Also, we found that documentation intended to support a physician's clinical competence often did not include the information required by the Army to document a physician's competence. Finally, while selected MTFs complied with Army's requirement to query the NPDB, it was not possible to tell if they complied with the Army's requirement to account for all periods of time since the physician's medical degree was obtained.

Selected MTFs Did Not Fully Comply with Army Requirements to Document Primary Source Verification of All State Medical Licenses

The Army requires that credentials staff at MTFs primary source verify all state medical licenses ever held by a physician, even those which are no longer active or have expired, at the time of privileging.[27] Furthermore, the Army requires that MTFs primary source verify any state medical license that a physician holds at the time of renewal of the license—at such time the physician may elect to either renew the license or allow it to expire.

During our review of credentials files we found that credentials staff at the five selected Army MTFs were not consistently documenting primary source verification of all state medical licenses as required by the Army regulation. For 34 of 150 credentials files we reviewed, we found that the MTFs' credentials staff had not documented primary source verification of all state medical licenses a physician ever held at the time of privileging.

[27]State medical licenses can have one of several different statuses, including active, expired, valid, and unrestricted. During our review we did not see any licenses with a status other than active, inactive, or expired. We reported licenses that were either inactive or expired as "expired."

Further, for 7 of these 34 credentials files, MTFs' credentials staff had not documented primary source verification of the physician's only active state medical license at the time of privileging. However, after the physician was granted privileges—but before our site visit—the MTFs' credentials staff had discovered the error and performed and documented the primary source verification for 5 of these 7 credentials files.

In addition, we found examples of credentials files in which the MTFs' credentials staff had not documented primary source verification of each state medical license at the time that the physician either renewed the license or allowed it to expire, as required by the Army. Specifically, we found 28 credentials files in which the MTFs' credentials staff had not promptly documented primary source verification at the time a physician's license was scheduled to be renewed. For example, during our review of credentials files we found that a physician—last privileged in January 2009—had a medical license that was scheduled to be renewed in December 2009.[28] At the time we conducted our site visit in September 2010—10 months after the license's expiration date—the credentials file did not contain documentation that the MTF's credentials staff had verified with the primary source whether the physician had renewed that medical license or allowed it to expire.

Without fully complying with Army's requirement to primary source verify all state medical licenses a physician has ever held, MTF staff who approve physician's credentials and privileges cannot ensure that they are aware of all restrictions on, actions taken against, or changes in status of a physician's medical licenses for practice-related reasons. Full compliance with this requirement, both at the time of privileging and at the time that medical licenses are renewed, is important because physicians may have not disclosed all changes in the status of their licenses to the MTF. For example, we reviewed one credentials file in which the MTF's credentials staff identified, in the process of primary source verifying the physician's medical licenses, pending actions against the physician's licenses that the physician had not disclosed.

[28]This was not the physician's only state medical license, and this physician did have one current, active primary source verified license in their credentials file at the time we conducted our review.

Selected MTFs Did Not Fully Comply with Army Requirements to Document Physician Clinical Competence

We found that most of the 150 credentials files we reviewed at the five MTFs we selected contained required clinical competence documents—two peer recommendations, performance assessments, and the associated provider activity file (PAF).[29] However, during our review we found that these documents did not consistently contain information required by the Army regulation to fully document a physician's clinical competence. We found that peer recommendations did not consistently contain required information to document they were from a peer with current, first-hand knowledge of the physician's clinical competence, and that MTFs did not consistently document any follow-up conducted on peer recommendations as required. Also, we found that performance assessments did not consistently contain required data to support the assessment of the physician. Finally, we found that physicians' PAFs did not consistently contain required data to evaluate performance and support the renewal of privileges.

Peer Recommendations Lacked Sufficient Information and MTFs Did Not Consistently Document Follow-up

Peer recommendations provide evidence of competence based on the documented assessment of a peer who has current, first-hand knowledge of the physician's clinical competence. In 111 of 125 credentials files[30] we found that MTFs' credentials staff had filed the two required peer recommendations in the physician's credentials file.[31] However, peer recommendations we reviewed often did not contain sufficient information for us to determine if the recommendation met the Army's requirement to be from an individual with current, first-hand knowledge of the physician's clinical competence. Of the 111 credentials files that contained the required number of peer recommendations, 51 included at least one recommendation that did not contain sufficient information for us to determine if the individual who wrote the recommendation was a peer with current, first-hand knowledge of the physician's clinical

[29]MTFs maintain a PAF for each physician that should include information related to their ongoing performance. The PAF is a paper file, and information contained within it is not routinely shared with other MTFs, even if the physician is changing permanent duty stations.

[30]Because 25 of the 150 credentials files we reviewed were for physicians who were on ICTB, and therefore were not required to have peer recommendations, only 125 credentials files required peer recommendations.

[31]The credentials files we reviewed did not contain sufficient documentation for us to determine if MTFs were routinely primary source verifying peer recommendations.

competence.[32] Furthermore, we found 4 credentials files where one or more of the individuals completing one of the two required peer recommendations clearly indicated they did not have current, first-hand knowledge of the physician's clinical competence.

Four of the five MTFs we selected had a standard peer recommendation form that prompted the individual writing the recommendation to provide information detailing that individual's relationship with the physician and what period of time the individual had known the physician. The remaining MTF's peer recommendation form did not specifically ask for this information. Regardless of the peer recommendation form an MTF used, we found that individuals who submitted the recommendations were not consistently providing information related to the nature and length of their relationship with the physician. Credentials staff at some of the selected MTFs told us that it is the credentials staff responsibility to review the peer recommendations to determine if they are from someone with current, first-hand knowledge of the physician.

Credentials staff told us that for physicians renewing their privileges, they often rely on their knowledge of the MTFs' medical staff to determine if the recommendation was written by a peer. For physicians who are being privileged for the first time at the MTF, credentials staff told us they look for information in the recommendation, such as the person's title or signature line, to determine if the recommendation was written by a peer. Without this information clearly documented in the credentials file, an MTF official responsible for reviewing a physician's application for privileges would not have reasonable assurance that a peer recommendation was written by an individual qualified to attest to the physician's clinical competence.

While Army regulation does not require MTF staff to follow up on a peer recommendation, it does require that any follow-up conducted on a peer recommendation be documented. Specifically, Army regulation states that, "[a]nnotated records of each contact made with all personal and professional references will be maintained, to include names of all parties

[32]We found some examples among these 51 files in which one or more recommendations was written by a physician who appeared to be practicing at the same MTF as the physician whose file we were reviewing. However, this was not always indicated in the recommendation itself, and we did not systematically check to see if recommendations were written by a physician working at the MTF we selected or another MTF.

to the call, the date, and a summary of the conversation."[33] Department chiefs, who were conducting most of the follow-up on peer recommendations at MTFs, told us that under various circumstances they would contact an individual to follow up on a peer recommendation. For example, some told us they would only follow up for physicians who were contractors or civilians who were new to the MTF. Others said they would follow up only if something in the recommendation raised questions about a physician. Department chiefs often said that reviewing a recommendation requires reading "between the lines" to determine whether follow-up is required because people are hesitant to include negative information in peer recommendations.

Even when MTF staff told us that they had conducted follow-up on peer recommendations, they did not consistently document that follow-up in the credentials files we reviewed. Specifically, we found five instances where MTF staff confirmed that they had conducted follow-up on a peer recommendation that raised questions about a physician, but the credentials file did not contain documentation of that follow-up. We found other examples of recommendations that included the types of comments that department chiefs told us they would follow up on—such as "might do well in supervised group setting. Call me"—but did not always find follow-up documented in those credentials files. Some chiefs acknowledged that when something prompted them to follow up on a peer recommendation they would not routinely document these conversations in the credentials file because they thought credentials staff were including this detail in the credentials committee meeting minutes. Some department chiefs told us that they discuss follow-up on peer recommendations with the MTF's credentials committee prior to making a decision on whether or not to recommend a physician for privileges. As a result, they told us the documentation of follow-up on peer recommendations would be captured in the meeting minutes of the MTF's credentials committee. However, when we spoke with credentials staff responsible for creating meeting minutes, they told us the minutes would not usually include that level of detail on a physician, unless the physician's privileges were adversely affected. This was generally consistent with what we observed when we reviewed the credentials committee meeting minutes for the MTFs we selected. (See Fig. 2 which illustrates an example of the type of peer recommendation that department chiefs told us would prompt them to

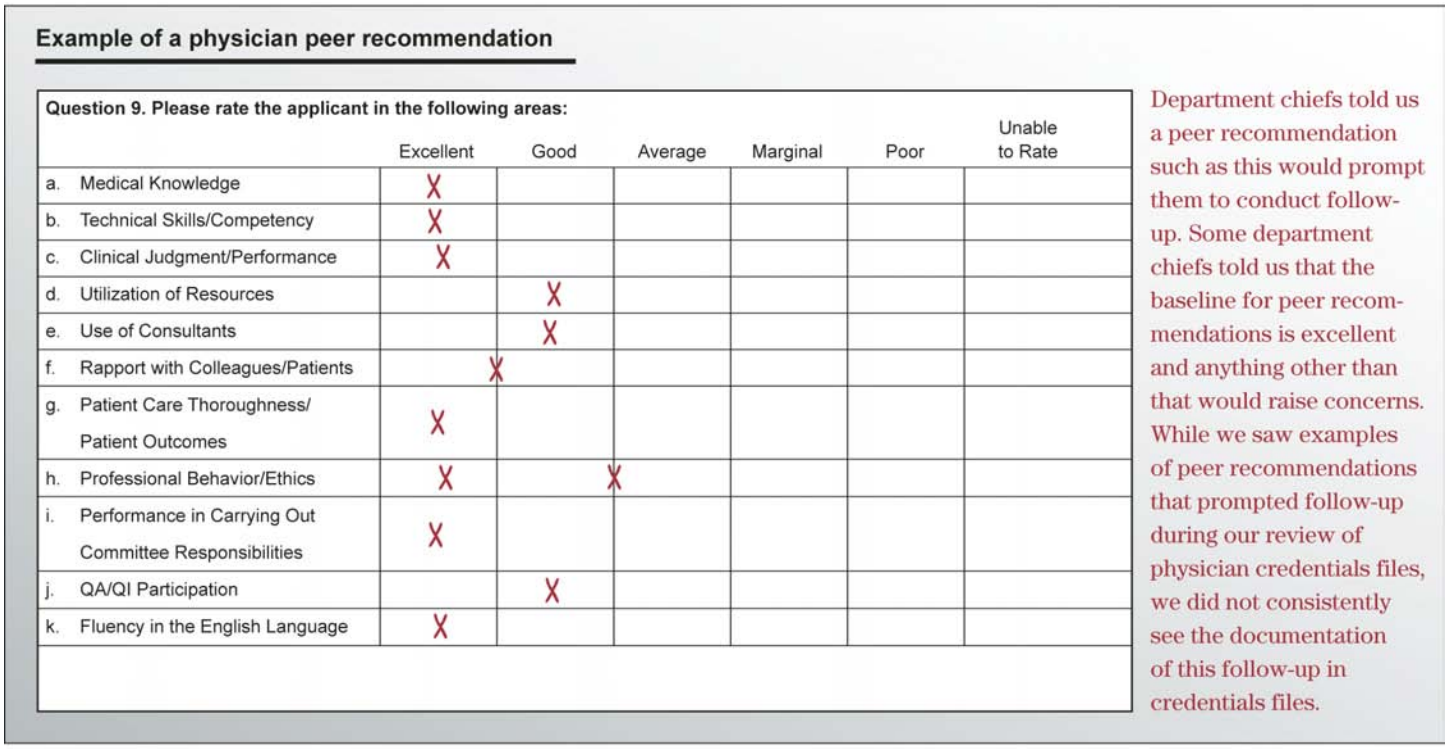
Army MTF Credentials File Review: Lack of Documentation of Peer Recommendation Follow-Up

In one file we reviewed, both peer recommendations were from individuals who indicated that they had limited knowledge of the physician's clinical competence. One individual rated the physician as average in several areas, including clinical judgment and professional behavior. The physician's department chief told us that they conducted follow-up with this physician's peers. However, because this follow-up alleviated concerns regarding competence and professionalism, the department chief did not document it in the credentials file or discuss it at the credentials committee meeting. The department chief later told us that this physician was terminated within the first 3 months due to issues with the physician's competence and professionalism.

[33]Army Regulation 40-68, 8-8, b., p.52.

follow up because the baseline for recommendations is excellent and anything else would raise concerns.)

Figure 2: Example of a Peer Recommendation that Could Raise Concern



Example of a physician peer recommendation

Question 9. Please rate the applicant in the following areas:	Excellent	Good	Average	Marginal	Poor	Unable to Rate
a. Medical Knowledge	X					
b. Technical Skills/Competency	X					
c. Clinical Judgment/Performance	X					
d. Utilization of Resources		X				
e. Use of Consultants		X				
f. Rapport with Colleagues/Patients		X				
g. Patient Care Thoroughness/ Patient Outcomes	X					
h. Professional Behavior/Ethics	X		X			
i. Performance in Carrying Out Committee Responsibilities	X					
j. QA/QI Participation		X				
k. Fluency in the English Language	X					

Department chiefs told us a peer recommendation such as this would prompt them to conduct follow-up. Some department chiefs told us that the baseline for peer recommendations is excellent and anything other than that would raise concerns. While we saw examples of peer recommendations that prompted follow-up during our review of physician credentials files, we did not consistently see the documentation of this follow-up in credentials files.

Source: GAO analysis of peer recommendations at selected MTFs.

Note: Three of the five MTFs we selected for our review used an MTF-specific peer recommendation form that included this table.

Data Were Not Consistently Available to Support Physician Performance Assessments

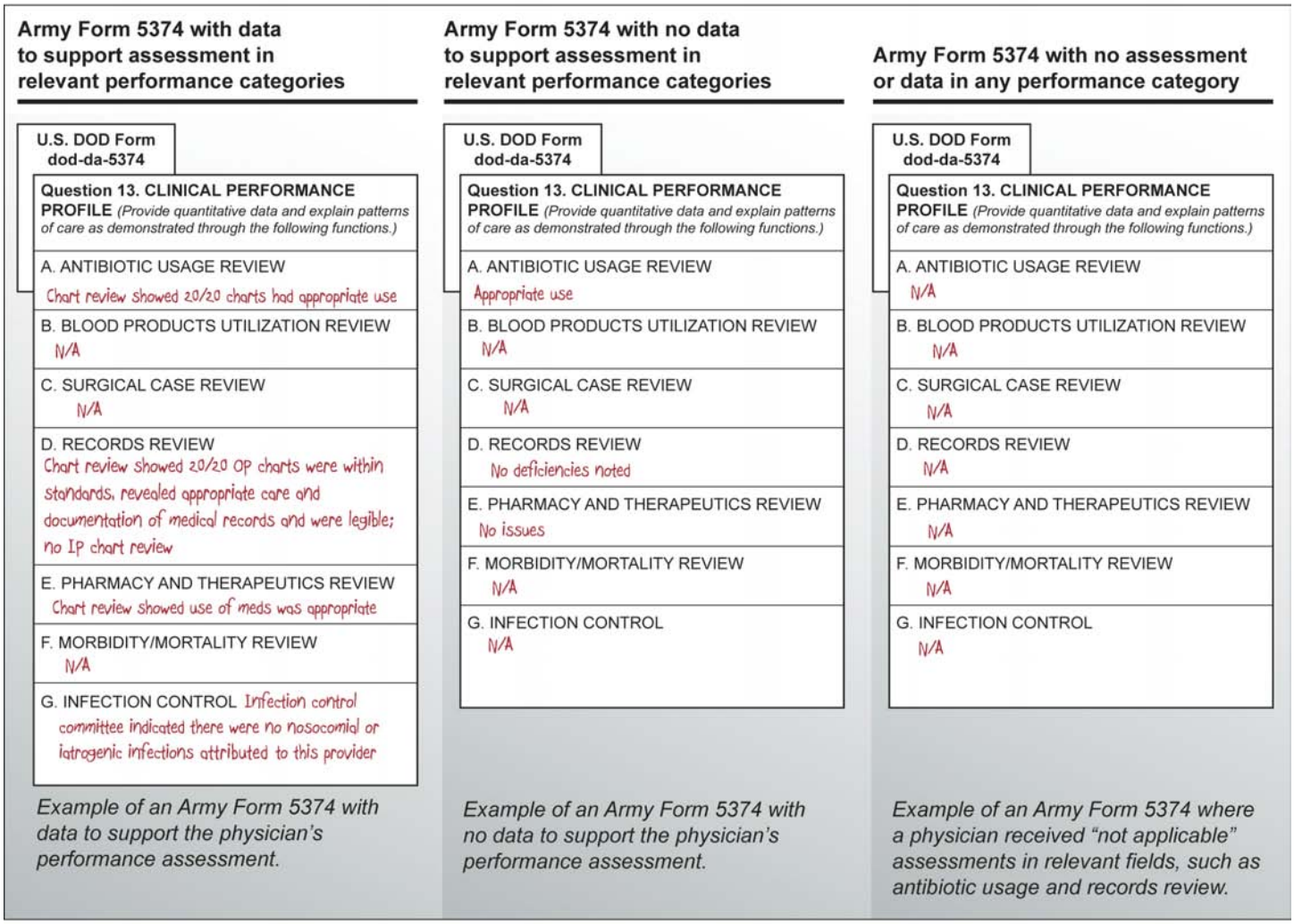
The Army requires a physician's department chief to complete two performance assessments—*Army Form 5374 Performance Assessment and Army Form 5441 Evaluation of Clinical Privileges*—at the time a physician renews their privileges in order to document the physician's clinical competence. Eighty-three of 104 credentials files[34] we reviewed contained both required performance assessments at the time of privileging, but 21 were missing documentation of either one or both of the performance assessments.[35] When asked about missing performance assessments, MTFs' credentials staff told us that it was sometimes challenging to obtain performance assessments for physicians who had been deployed or had been temporarily assigned to work at another MTF, although we found credentials files missing performance assessments where the physician was neither deployed nor returning from a temporary assignment.

During our review of completed *Form 5374s* we found that MTFs' department chiefs did not consistently include data to support performance assessments of physicians as required by the Army regulation. The *Form 5374* provides for a department chief to assess a physician in various performance categories. While not all categories are relevant for each physician; for example, a family practice physician would not usually be assessed under "surgical case review;" there are other performance categories included on the *Form 5374*, such as "records review" that are applicable to all physicians. However, during our review we found that assessments were sometimes missing from relevant performance categories, such as "surgical case review" for a surgeon or another physician who has performed surgeries during the review period. Figure 3 shows a range of examples that illustrate the types of assessments we found in the *Form 5374s* during our file review. The first example illustrates a *Form 5374* with data to support the assessment for relevant performance categories, while the second example demonstrates a *Form 5374* that has no data to support the assessment for relevant performance categories. The third example shows a *Form 5374* that has no assessments or data for any performance categories.

[34]Forty-six of the 150 files we reviewed were either for a physician on ICTB from another MTF or for a physician who was new to the military, and therefore were not required to have the *Army Forms 5374* and *5441*.

[35]Of the 21 files that were missing performance assessments, 14 were missing both assessments, and 7 were missing either the *Form 5374* or the *Form 5441*.

Figure 3: Examples of Data Provided in *Form 5374*s at Army MTFs GAO Selected for its Review



Source: GAO analysis of DOD Form dod-da-5374.

Note: Text in the figure represents information from performance assessments we reviewed during our site visits to the five Army MTFs we selected for our review. Text reflects the actual information included in performance assessments, and has not been edited by GAO. Not all categories are relevant for each physician, for example a family practice physician would not usually be assessed under "surgical case review." Other performance categories included on the *Form 5374*, such as "records review," are applicable to all physicians.

Further, even when MTFs included specific text in their *Form 5374* to prompt the department chief to include data, department chiefs did not consistently provide data to support their assessments. Four of the five MTFs we selected had included standardized text in the *Form 5374* to prompt for performance data or yes/no checkmarks. Two MTFs modified their *Form 5374* to prompt for data to support the assessment (for example, X records reviewed, Y met the standard); however, we found that department chiefs did not consistently provide this information. In instances where the form had been modified to prompt for yes/no check marks or was not modified with standardized text, we found that department chiefs did not consistently provide data to support their assessment of a physician.

Army regulation also requires that each MTF have a mechanism in place to collect and analyze individual performance data, from a variety of sources, to assess a physician's competence. Department chiefs we interviewed consistently told us that they were collecting data on a physician's performance, but they were not always compiling and analyzing the available data when completing the *Form 5374*. In addition, several department chiefs at MTFs we selected told us that their MTF lacked a systematic process—such as a software system or personnel resources—for collecting and analyzing performance data. Absent such a process, department chiefs told us that they often based performance assessments on their personal knowledge of a physician's clinical competence. As a result, several department chiefs described the process of filling out the performance evaluation forms as a "pencil-pushing exercise."

Provider Activity Files Lacked Documentation of Ongoing Performance

Army requires MTFs to maintain a PAF that should contain various types of clinical data, including metric performance data to be used to profile a physician's clinical practice, to periodically reevaluate performance, and assist with the renewal of privileges. At the five Army MTFs we selected, we found that 134 of 150 credentials files[36] had an associated PAF. However, we found limited data in PAFs that related to the physician's performance. Specifically, in 103 of 150 credentials files we reviewed, we found that the MTF had not documented data in an associated PAF to support physician performance assessments.

[36]Ten of the 16 credentials files that did not have an associated PAF were for physicians on ICTB. The Army requires that a PAF be maintained for all privileged physicians, but does not specify that a "receiving" MTF for a physician on ICTB do so.

Army MTF Credentials File Review: Inconsistent Information in a Physician *Form 5374*

In one file we reviewed, the physician's PAF included data indicating that the physician's prescription error rate was above the MTF's established threshold. However, these data were not reflected in the physician's *Form 5374* that covered the relevant period of time. The physician's department chief—who was not the department chief at the time the assessment was completed—was not aware of the negative prescription data but was "not at all surprised" because there were current concerns about this physician.

Credentials staff at most MTFs we selected told us that performance data were maintained by individual departments, but acknowledged that data were not being consistently submitted to credentials staff to be included in the PAF. We did see some instances where MTFs had stored some practice data on the physician in the PAF such as results from departmental reviews of a physician's medical charts. Some PAFs contained other information about a physician's practice such as the number of patients a physician treated, letters from patients, or results from patient satisfaction surveys. Within the PAFs we found that did not contain data to support the physician's performance assessment, we saw examples where the PAF was empty or the MTF had used the PAF to store nonperformance-related information such as administrative documents (i.e., email exchanges between credentials staff and the physician, or copies of the physician's performance assessments).

Without required information in the peer recommendations and the PAF, as well as information in the *Form 5374* to support performance assessments, MTFs lack assurance that they are granting privileges based on complete evidence of a physician's clinical competence. Furthermore, absent a systematic process for compiling and analyzing performance data, MTFs lack assurance that they are granting privileges to physicians based on documented and analyzed performance data as opposed to anecdotal information about physician performance.

Selected Army MTFs Did Not Fully Comply with Requirements to Document Physician Practice History

We found that credentials staff at the five Army MTFs we selected for our review were usually documenting information related to a physician's practice history found in the NPDB. However, we found that credentials staff were not complying with Army's requirement that the physician's curriculum vitae (CV) account for all periods of time since the physician graduated from medical school.[37]

We found that credentials staff at the Army MTFs we selected documented their queries of the NPDB at the time of privileging—as required by the Army regulation—in 147 of 150 credentials files. One of the 3 credentials files we reviewed that did not contain documentation of current NPDB queries at the time of privileging was for a physician on

[37]A curriculum vitae provides a short account of an individual's career and qualifications, similar to a resume.

ICTB to an MTF in our sample. While the receiving MTF we selected usually queried the NPDB before privileging physicians on ICTB, Army regulation does not specify that they do so.[38]

The Army requires that a physician's credentials file contain a CV to account for all periods of time subsequent to obtaining their medical degree, in order to document the physician's complete practice history. At the five Army MTFs we selected, we found that 115 of 125 credentials files had the required CV.[39] When asked about credentials files that were missing CVs, credentials staff sometimes said they had requested them but had not received them. Credentials staff at two MTFs said that they would not necessarily hold a physician's application back from credentials committee review because it was missing a CV.

We were unable to determine how well the five selected MTFs were complying with the requirement to account for all periods of time since obtaining a medical degree in the CV because of insufficient information in the credentials files we reviewed. In 63 of the 115 credentials files that included the required CVs, the CV did not include both the months and the years a physician had worked at a previous location. While the Army does not specifically require CVs to contain both months and years, credentials staff acknowledged that they would need start and end dates—including both month and year—to identify if all periods of time were accounted for since the medical degree was obtained. Furthermore, even when CVs contained both months and years, they did not always account for all periods of time. Although not specified in Army regulation, the responsible Army Medical Command official said that if there were periods of time that were not accounted for in the CV, they would expect explanations for those periods of time to be documented in the credentials files. However, we found that credentials files did not consistently contain documents explaining unaccounted for periods of time. Without this information clearly documented in the credentials file, an MTF official responsible for reviewing a physician's application for

[38]The ICTB sent by the permanent duty station includes a section on relevant information found in the NPDB which the receiving MTF can refer to when making a decision to privilege a physician.

[39]Twenty-five of the 150 credentials files we reviewed were for physicians who were on ICTB and therefore were not required to have a CV.

privileges would not have reasonable assurance that all unaccounted for periods of time had been identified and explained.

Army Oversight and Physician Credentialing and Privileging Requirements Were Insufficient to Assure that MTFs Fully Complied and Documented Complete Information

Army oversight and physician credentialing and privileging requirements were not sufficient to assure that MTFs fully complied with existing requirements or completely documented information needed to support credentialing and privileging decisions. Specifically, Army Medical Command's oversight of individual MTFs' reviews of physicians' applications for privileges was insufficient to identify the instances of noncompliance and incomplete documentation that we observed during our review of credentials files at five selected Army MTFs. In particular, Army Medical Command's oversight did not include a process for conducting reviews of individual MTFs' credentials files. In addition, Army physician credentialing and privileging requirements were insufficient in some respects. Certain requirements do not clearly delineate responsibilities and procedures for documenting complete information in order to comply with the requirement. Additionally, Army has not established requirements for documenting certain types of information that are needed to support credentialing and privileging decisions.

Army Medical Command Oversight Was Insufficient to Assure that MTFs Fully Complied and Documented Complete Information

Army Medical Command oversight was not sufficient to assure that individual MTFs fully complied with Army physician credentialing and privileging requirements and documented complete information needed to support credentialing and privileging decisions. Under Army regulation, Army Medical Command is responsible for conducting broad oversight of the implementation of credentialing and privileging requirements at MTFs. In addition to Army regulation, the *Standards for Internal Control in the Federal Government* states that an organization should provide reasonable assurance of compliance with applicable laws and regulations.[40] These standards, along with the *Internal Control Management and Evaluation Tool*, also state that an organization should record information and communicate it to management and others who need it in a form and within a time frame that enables them to carry out their responsibilities efficiently and effectively.[41] However, we found that Army Medical Command's oversight lacked a process for reviewing

[40]See GAO/AIMD-00-21.3.1, p. 6.

[41]See GAO/AIMD-00-21.3.1, p.20, and GAO-01-1008G, p. 53.

individual MTFs' credentials files to identify instances of noncompliance or incomplete documentation.

As noted earlier in this report, the five Army MTFs we selected for our review did not fully comply with established Army physician credentialing and privileging requirements or document complete information in the following areas:

Documentation of primary source verification of state medical licenses. Credentials files did not consistently document primary source verification of all physician state medical licenses at the time of privileging or at the time the licenses were scheduled to be renewed.

Documentation of clinical competence. Credentials files did not consistently include required peer recommendations or performance assessments, or associated PAFs, to support clinical competence. Additionally peer recommendations, performance assessments, and PAFs did not consistently include required information and credentials files did not consistently include required documentation of any follow-up conducted on peer recommendations. Further, MTFs lacked a mechanism for collecting and analyzing performance data.

Documentation of practice history. Credentials files did not consistently include a CV to account for all periods of time subsequent to the medical degree. When included, physician CVs did not consistently include sufficient information to determine if they met Army's requirement to account for all periods of time since obtaining the medical degree.

At the five MTFs we selected, the credentials committee chairperson and the MTF commander had reviewed the application for privileges for each physician in our sample; but those reviews did not prevent the instances of noncompliance and incomplete documentation discussed above. Credentials committee chairpersons we interviewed said they often focus their reviews on looking for potentially negative information in the file, such as negative peer recommendations. Credentials committee chairpersons also said they often rely on credentials staff to ensure that files contain all required documents before they reach the credentials committee and they rely on department chiefs to raise any concerns that surfaced during their review of the application. Ultimately, Army regulation assigns MTF commanders the final responsibility for ensuring systematic review of credentials and competence for all physicians at their respective MTFs and ensuring compliance with applicable requirements. However,

MTF commanders had granted privileges based on credentials files that did not fully comply with Army physician credentialing and privileging requirements or contain complete documentation of information needed to support credentialing and privileging decisions.

Although we identified these instances of noncompliance and incomplete documentation through reviews of credentials files, we found that Army Medical Command's oversight of physician credentialing and privileging did not include a routine process for conducting reviews of individual MTFs' credentials files. The responsible Army Medical Command official told us that Army's regional medical commands began conducting some visits to individual MTFs at the beginning of fiscal year 2011.[42] However, these visits—which may include reviews of the MTFs' credentials files in preparation for the MTFs' triennial review by The Joint Commission[43]—are not focused on credentialing and privileging. In addition, the regional commands do not currently have a process for routinely reporting the results of any reviews of credentials files they may perform to Army Medical Command. However, the Army Medical Command official told us that they hold regular teleconferences with MTF staff and said that staff would discuss any issues found during regional command reviews on these teleconferences.

The responsible Army Medical Command official said that Army Medical Command's oversight consisted mainly of running CCQAS data reports, which we found was not sufficient to assure that MTFs fully complied with Army physician credentialing and privileging requirements or completely documented information needed to support credentialing and privileging decisions. These reports focused primarily on identifying potential lapses in MTFs' credentials verification processes and on the completeness of information MTFs enter into CCQAS. Specifically, the Army Medical Command official reported running periodic CCQAS reports on metrics such as the number of unlicensed providers or the number of electronic applications at an MTF. However, these CCQAS reports did not provide complete information about MTFs' compliance with physician

[42]Previously, the Army Medical Command Inspector General conducted quality inspections at a sample of individual MTFs. These inspections sometimes included reviews of MTF's credentials files, but were not specific to credentialing and privileging.

[43]Credentialing and privileging requirements may be one element of the accreditation reviews conducted by The Joint Commission, though not all reviews include this element.

credentialing and privileging requirements, as evidenced by the instances of noncompliance that we observed, and are discussed above. Additionally, CCQAS reports did not provide Army Medical Command information about whether MTFs were documenting complete information needed to support credentialing and privileging decisions. For example, Army Medical Command lacked information about the following types of incomplete documentation in credentials files, which we noted earlier in this report:

Documenting the source of peer recommendations. Peer recommendations we reviewed did not always include sufficient information to determine if they met Army's requirement to be from someone with current, first-hand knowledge of the physician's competence. Army Medical Command officials said they thought most MTFs' peer recommendation forms would prompt for information about the peer's relationship with the physician—such as how long they have known them and for what period of time. However, Army Medical Command was not aware that even when MTFs' forms prompted for this information, the source of peer recommendations was not always documented.

Documenting data in performance assessments. Performance assessments we reviewed did not consistently contain performance data needed to support the assessments. The responsible Army Medical Command official told us that Army expects performance assessments to include supporting data, as stated in Army regulation. This official also said that the use of yes/no checkmarks alone in these assessments would not be sufficient. However, Army Medical Command was not aware that some MTFs (including two of the five MTFs we selected) have modified the *Form 5374* with standardized text which prompted only for checkmarks. They were also unaware that even when MTFs' forms prompted for data, they were not always included.

A mechanism for collecting and analyzing performance data. MTF staff expressed a need for a mechanism to collect and analyze performance data to better support performance assessments. We found that four of the five MTFs we selected were taking steps to develop, or invest in, software to help address this need. These MTFs—and in one case, two different departments within one MTF—

were each investing resources in systems that collect similar information.[44] While the responsible Army Medical Command official acknowledged that Army MTFs face challenges meeting the requirement and that some had developed "home grown" systems, this official said that Army Medical Command was not coordinating these efforts.[45] Army Medical Command's current oversight process did not facilitate an evaluation of the potential benefits of a more systematic process to help MTFs meet Army's performance data requirement and avoid potential duplication and inefficient use of resources resulting from these MTFs' efforts.

Given our findings that Army Medical Command lacks a routine process for conducting reviews of individual MTFs' credentials files to identify noncompliance and incomplete documentation, we interviewed Navy and Air Force officials about their oversight of physician credentialing and privileging. Navy and Air Force officials told us that their oversight agencies also do not conduct their own routine reviews of individual MTFs' credentials files. Both services reported regional or MTF-level reviews similar to Army's but acknowledged that these reviews do not focus on credentialing and privileging, may not occur on a regular basis, and the results are not formally reported to BUMED and AFMOA. Additionally, Navy and Air Force officials told us that, like Army, they use CCQAS data reports as their primary oversight mechanism.[46] The responsible Navy official acknowledged that they would not be able to identify MTF-level compliance issues without conducting reviews of credentials files.

[44]In June 2011, staff at one MTF told us that they had been working to replace the system they had developed locally by implementing a software program recommended by their regional medical command. However, in September 2011, staff at this MTF told us that the MTF had decided not to implement the new system because they lacked the resources and support needed. They also told us that they had not found any other MTFs in the region who had successfully implemented the system.

[45]The responsible Navy and Air Force officials told us that some Navy and Air Force MTFs have developed their own data systems as well. The responsible Navy official told us that there is a need for a system to compile performance data across the MHS and it would be helpful if DOD were to implement an MHS-wide solution. The responsible DOD official said that they were not aware of individual MTFs' efforts to develop data systems, but acknowledged that there may be a role for DOD to coordinate MTFs' efforts.

[46]Navy and Air Force officials also reported that they conduct oversight through training, regular teleconferences, and their daily interactions with MTF staff to address questions that arise.

Army Physician Credentialing and Privileging Requirements Were Insufficient to Assure MTFs Fully Complied and Documented Complete Information

We found that Army physician credentialing and privileging requirements were insufficient to assure that MTFs fully complied and documented complete information needed to support credentialing and privileging decisions. As noted, internal control standards state that an organization should provide reasonable assurance of compliance and should record information and communicate it efficiently and effectively.[47] However, we found that unclear requirements contributed to the instances of noncompliance and incomplete documentation we observed at the five MTFs we selected. Additionally, Army has not established requirements for documenting certain types of information needed to support credentialing and privileging decisions. Army Medical Command officials acknowledged that, in some cases, their expectations for documenting this information were not explicit in existing Army regulation.

Certain Army Requirements Unclear

Certain Army requirements do not clearly delineate responsibilities and procedures for documenting complete information in order to comply with the requirement. Specifically, a lack of clarity in the following Army requirements contributed to noncompliance:

Documenting follow-up on peer recommendations. Army regulation requires documentation of any follow-up conducted on peer recommendations, but does not specify who is responsible for documenting follow-up or where it should be documented. As a result, MTFs did not consistently meet Army's requirement to document follow-up. As noted earlier in this report, department chiefs we interviewed routinely told us that discussion of follow-up on peer recommendations that occurred during a credentials committee meeting would be documented in the meeting minutes. However, credentials staff told us those minutes would not usually contain that level of detail. The responsible Army Medical Command official told us that they expect MTFs to document follow-up on peer recommendations. However, when asked who should document this information and where it should be documented, this official did not have clear expectations.

[47]See GAO/AIMD-00-21.3.1, p.6 and p.20, and GAO-01-1008G, p.53.

Accounting for all periods of time in physician CVs. Army regulation requires physician CVs to account for all periods of time subsequent to the medical degree in order to document the physician's complete practice history, but does not specify what information needs to be documented to meet this requirement. Specifically, Army regulation does not require CVs to include both months and years for previously held positions, though the responsible Army Medical Command official said this would be necessary to identify any gaps in practice history. While credentials staff agreed that they would need months and years in order to identify gaps, they acknowledged they were not routinely looking for this information in the CV. Army regulation also does not specifically require MTFs to document explanations of any gaps in the CV, though the Army official said they should. Credentials staff at some MTFs said that gaps should be explained somewhere in the credentials file; however, we did not consistently see this in credentials files we reviewed.

Army Has Not Established Requirements for Documenting Certain Types of Information

Army has not established requirements for documenting certain types of information that are needed to support credentialing and privileging decisions; specifically, significant events that occurred during an MTF's review of a physician's application for privileges or information that may be relevant from the DPDB.

Documenting significant events. Current Army regulation does not specifically require MTFs to document significant events—such as the MTF's consideration of concerns about a physician raised in performance assessments, NPDB queries, and other clinical competence and practice history documents—that occurred during their review of a physician's application for privileges.[48] Nevertheless, Army Medical Command officials said that they expect MTFs to document follow-up on some issues raised in the credentials file. For example, Army Medical Command officials said that they would expect documentation of an MTF's consideration of concerns raised in a physician's CV, but would not necessarily expect documentation of

[48]The internal control standards specifically identify significant events as a type of information that should be clearly documented and readily available for examination (GAO/AIMD-00-21.3.1, p.17).

Army MTF Credentials File Review: Significant Events Not Documented

In one credentials file we reviewed, the physician's performance assessment lacked information because the physician had been unable to practice during the initial appointment. The department chief told us that when the MTF renewed this physician's privileges, the MTF placed the physician under increased supervision for certain privileges, reduced the physician's patient load, and held regularly scheduled check-ins for several weeks. However, none of this was documented in the physician's credentials file.

In another credentials file we reviewed, the physician expressed certainty about being currently clinically competent to practice a specific privilege that the physician had disclosed voluntarily relinquishing during a previous position. When we reviewed the physician's privileges we noted that the physician had been granted the privilege in question. The department chief told us that the physician was only granted the privilege because it was rarely practiced at that MTF, and if there were an opportunity, the physician would only be allowed to conduct it under the supervision of another physician. However, none of this was documented in the physician's credentials file.

an MTF's consideration of NPDB query results.[49] The responsible Army Medical Command official acknowledged that their expectations may not be consistent with what MTFs are doing.[50] Despite Army Medical Command's expectations, the MTFs we selected were not always documenting this information.

Documenting relevant information from the DPDB. Unlike DOD, Army regulation does not specifically require MTFs to query the DPDB for each physician. As a result, the Army MTFs we selected were consistently not querying the DPDB. Additionally, Army has not established requirements for documenting risk management information—such as reviews of malpractice claims and potentially compensable events—from the DPDB or specified which types of information should be considered relevant. However, the responsible Army Medical Command official said they expect MTFs to document risk management information from the DPDB that may be relevant to credentialing and privileging in the credentials file. For example, the Army official said MTFs are expected to document information from the DPDB in a physician's credentials file if the MTF determines that the physician did not meet the standard of care. These officials acknowledged that this expectation is not explicit in Army regulation.[51]

In addition to the lack of requirements that MTFs query the DPDB and document relevant risk management information in credentials files, Army has not addressed access limitations to information in the DPDB. The responsible Army Medical Command official stated that the DPDB does not allow MTFs to

[49]The responsible Navy, Air Force, and DOD officials all said that they would expect MTFs to document their consideration of NPDB query results.

[50]Although the DOD regulation does not specifically require documentation of significant events, the responsible DOD official expressed concern that this may not be happening routinely. The responsible Navy and Air Force officials agreed that MTFs should document follow-up on concerns raised in the credentials file. The responsible Air Force official acknowledged that this expectation is not explicit in Air Force regulation.

[51]The responsible Navy officials said that they only expect MTFs to document risk management information from the DPDB if it indicates a concern. These officials said this might occur if the MTF determines that the physician did not meet the standard of care, or if there is a concerning pattern of incidents. The responsible Air Force official said they expect MTFs to document risk management information in the credentials file, regardless of the MTF's standard of care determination.

query for information entered by another MTF.[52] Moreover, most credentials staff we interviewed said that they did not have access to the DPDB itself and would have to request available information from risk management staff. However, credentials staff acknowledged that they were not requesting this information.

The lack of an Army requirement to query the DPDB, or obtain and document relevant information from risk management staff in the credentials file, combined with DPDB access limitations, contributed to MTFs not routinely obtaining relevant information from the DPDB. As a result some credentials files we reviewed lacked documentation of key information that DOD and Army have deemed important for MTF staff to make fully informed decisions on physicians' competence. Specifically, during our review of the DPDB for physicians in our sample, we identified nine physicians with risk management information in the DPDB that was not documented in the physicians' credentials files; for example, this information may be documented in physician disclosure forms, NPDB query results, or performance assessments. For eight of the nine physicians, the DPDB indicated that either the MTF's review determined that the physician had met the standard of care or the MTF's review was still pending at the time the physician was privileged. For one physician, the MTF had determined that the physician did not meet the standard of care. When we interviewed the credentials committee chairperson at that MTF, the chairperson told us that they were not aware of the review and that it should have been documented in the credentials file.

[52]The responsible Navy official said that Navy MTFs do not query the DPDB due to access limitations. These officials said that Navy has developed a form that can be used to document information from the DPDB that is considered relevant and cannot be found elsewhere in the credentials file. The responsible Air Force official said that Air Force MTFs are required to routinely submit requests for DPDB queries to AFMOA as part of the reprivileging process. This official also said that some Air Force MTFs are routing the performance assessment form to the MTF's risk management staff at the time of privileging and asking them to include any relevant information from the DPDB. The responsible Army, Navy, Air Force, and DOD officials told us that planned updates to CCQAS by 2013 should help address MTF staffs' access to information in the DPDB; however, their expectations for how the new feature would operate, including what information would be available and under what circumstances, varied.

Conclusions

Physician credentialing and privileging requirements are central to DOD's efforts to ensure that all physicians who work in the MHS are competent to provide care to servicemembers and their families. To achieve this, DOD and the military services have established requirements for how their MTFs validate and review each physician's credentials, clinical competence, and practice history. However, the inconsistencies that we identified between the military services' and DOD's requirements create implementation and compliance challenges for MTFs, and make it inherently more difficult for DOD to ensure that the requirements are implemented consistently across the MHS. In addition, inconsistencies across the military services themselves create challenges for ensuring that all requirements are met for physicians from one service who are working at an MTF managed by another service and thus subject to different requirements. Without a DOD-wide process to identify and address such inconsistencies across DOD's and the military services' physician credentialing and privileging requirements and to coordinate all revisions to those requirements, DOD cannot ensure that the military services' requirements are consistent across the MHS. As DOD moves towards a more standardized credentialing and privileging process, and MTFs are staffed with physicians from multiple military services, it is increasingly important that DOD ensure that physician credentialing and privileging requirements are consistent across the MHS.

At individual Army MTFs, complying with established credentialing and privileging requirements is integral to ensuring that physicians practicing at those MTFs are clinically competent and qualified in their areas of specialty. The findings from our review of a sample of credentials files at the five Army MTFs we selected for our review raise concerns about whether Army MTFs are systematically compiling, reviewing, and verifying all necessary information before granting a physician privileges. For example, some credentials files we reviewed lacked complete documentation to show that MTFs had primary source verified all of the physician's state medical licenses, including seven instances involving a physician's only active medical license. Additionally, documenting a physician's clinical competence is a critical part of the credentialing and privileging processes, but some credentials files we reviewed did not include required peer recommendations, performance assessments, or PAFs. Even when credentials files contained these documents, the documents did not consistently contain required information, such as performance data to support assessments of a physician's clinical competence. Finally, while MTFs routinely documented required NPDB queries, physician CVs often lacked sufficient information needed to document a complete physician practice history. Allowing these types of

lapses to continue at MTFs raises the risk that physicians who may not be fully qualified or competent to practice in some areas are deemed fit to do so through flawed credentialing and privileging processes.

Our findings show that Army Medical Command's oversight is not sufficient to ensure that individual MTFs fully comply with physician credentialing and privileging requirements, and that weaknesses in those requirements contribute to the types of noncompliance and incomplete documentation that we observed at five selected Army MTFs. Because Army Medical Command does not have an oversight process to review credentials files at individual MTFs, it does not have the information about noncompliance that it needs to hold MTF staff and commanders accountable to Army requirements, or to assess whether MTFs are documenting complete information needed to support credentialing and privileging decisions. Further, Army Medical Command had not assessed the potential to avoid duplication resulting from MTFs' independent efforts to develop "home grown" systems to collect and analyze performance data to better support performance assessments. Our findings also identify weaknesses in existing Army physician credentialing and privileging requirements. For example, because Army requirements do not clearly delineate who is responsible for documenting follow-up on peer recommendations and where that documentation should be filed, MTFs were not consistently documenting follow-up. Additionally, Army has not established requirements for documenting certain types of information that are needed to support credentialing and privileging decisions. Although Army Medical Command expects MTFs to document some types of significant events—such as the MTF's consideration of concerns raised in a physician's CV—as well as relevant information from the DPDB, this is not explicitly required in current Army regulation. Without clear requirements to do so, MTFs were not consistently documenting these important types of information. Because of the frequent movement of physicians among Army MTFs and across the MHS, ensuring that MTFs completely document all information needed to support credentialing and privileging decisions is particularly important. The patterns of noncompliance and incomplete documentation we observed may also exist, beyond the Army MTFs we selected, at other services' MTFs. Officials from Navy and Air Force oversight agencies acknowledged that, like the Army, they lack a process for reviewing individual MTFs' credentials files, and that some of their documentation requirements are unclear. Consequently, weaknesses exist across the Army, Navy, and Air Force oversight agencies' physician credentialing and privileging processes. If the weaknesses in these processes are not corrected, DOD and the military services cannot be certain that every

physician treating patients in the MHS is fully qualified and competent to practice the specific privileges they have been granted.

Recommendations for Executive Action

To help ensure that the military services' requirements for physician credentialing and privileging are consistent across the MHS, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the Surgeons General of the military services to establish a DOD-wide process to:

- Identify and address existing inconsistencies between DOD's and the military services' physician credentialing and privileging requirements, including those inconsistencies we identified in this report, and
- Coordinate all current and future efforts to revise physician credentialing and privileging requirements.

To assure that information on a physician's clinical competence and practice history is documented and available to support credentialing and privileging decisions by Army MTFs, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the Army Surgeon General to take the following five actions:

- Coordinate individual MTFs' efforts to establish mechanisms to collect and analyze data to evaluate physician performance and support performance assessments.
- Clarify requirements for how MTFs document follow-up on peer recommendations, including who is responsible for documenting follow-up and where that documentation should be filed.
- Clarify requirements for the information that physicians need to provide in their CV so that MTFs can identify unaccounted for periods in practice history, as well as how MTFs should document explanations of any unaccounted for periods.
- Establish requirements for MTFs to document significant events that occur during the review of a credentials file, including which types of significant events should be documented, who is responsible for documenting significant events, and where that documentation should be filed.

- Establish a process to ensure that relevant information from the DPDB is documented in the credentials file.

To assure that MTFs are fully complying with DOD's and the military services' requirements for physician credentialing and privileging and implementing these requirements appropriately, we recommend that the Secretary of Defense direct the Surgeons General of the military services to establish and implement an oversight process to conduct reviews of a sample of credentials files to identify and address areas of noncompliance and incomplete documentation.

Agency Comments and Our Evaluation

We provided a draft of this report to DOD for comment and received a written response on November 30, 2011, which is reproduced in appendix II. DOD also provided technical comments which we have incorporated as appropriate. In its written comments, DOD concurred overall with our findings and conclusions and provided comments on our recommendations. While DOD's comments suggested that DOD agreed with our recommendations, the comments do not provide sufficient detail for us to determine how fully the agency's planned actions will address the intent of the recommendations. Additionally, in its comments, DOD did not establish time frames for any of the actions it identified to address our recommendations. The following discussion summarizes DOD's response to our recommendations and our evaluation of the agency's response.

DOD agreed to our first and second recommendations—to address inconsistencies across DOD's and the military services' requirements for physician credentialing and privileging and coordinate all efforts to revise requirements—and stated that it is updating its policies to establish "a single business process" for physician credentialing and privileging in the MHS and cited its ongoing revision to *DOD Regulation 6025.13-R* and/or planned updates to DOD's CCQAS program. DOD noted that it will apply best practices that it has identified across the MHS to standardize physician credentialing and privileging requirements, eliminate inconsistencies, and clarify some aspects of the requirements. We agree that revising the DOD regulation and updating CCQAS may help promote a single business process for credentialing and privileging in the MHS. However, because DOD did not provide any detail on which inconsistencies it has identified and plans to address, it is not clear whether the revisions will fully address our recommendations. Moreover, DOD noted challenges in obtaining funding to support the redesign of CCQAS and did not establish any time frames for the redesign. Taken together this raises serious questions about when DOD will undertake this

effort, which is an integral part of the actions DOD described to address our recommendations. Addressing the inconsistencies that we identified in this report will require not only that DOD update its regulations and move forward with its redesign of CCQAS, but also that DOD establish a robust, DOD-wide process to ensure that each of the military services' regulations are consistent with DOD's. As part of this process DOD must ensure that any future revisions to DOD's or the military services' regulations do not create new inconsistencies. As long as there are inconsistencies between DOD's written requirements and those of each military service, DOD will be constrained in its ability to ensure that each service is consistently applying DOD's physician credentialing and privileging requirements.

In its response to our recommendation on coordinating the efforts of individual MTFs to establish mechanisms to collect and analyze physician performance data, DOD stated that requirements for "peer review"—a reference to departmental reviews of a physician's medical charts—should be standardized. That is not what we recommended. Instead, we recommended that DOD work to coordinate the efforts of individual MTFs to establish systems to collect and analyze performance data as part of the performance assessment process. In our review, we found that department chiefs were not always compiling and analyzing performance data that had already been collected when developing performance assessments. We also found that performance assessments often lacked supporting data. Four of the five MTFs we visited had undertaken "home grown" efforts to either develop, or invest in, software systems to help address the need to compile and analyze performance data to better inform performance assessments. Our recommendation is intended to help better ensure that performance data that MTFs are already collecting is both analyzed and completely documented in physician performance assessments, and also to reduce the potential for duplication of efforts and inefficient use of resources across multiple MTFs that are working individually to establish systems to meet similar needs.

DOD agreed to address our other recommendations to assure that information on clinical competence and practice history is documented and available to support privileging decisions—including clarifying requirements for how MTFs should document follow-up on peer recommendations; clarifying the information needed in CVs to identify unaccounted for periods in practice history; establishing requirements for the types of significant events that MTFs should document and report, including where that documentation should be filed; and establishing a process to ensure that all relevant information from the DPDB is

documented in the credentials file—as part of its revisions to *DOD Regulation 6025.13-R* and planned updates to CCQAS. However, DOD did not specify how the requirements would be revised or when it would complete the revisions. Without this information it is not possible for us to determine if the planned revisions will fully address the issues we identified in this report. For example, DOD noted that planned revisions to CCQAS will address current limitations on MTFs' and the services' ability to query the DPDB by making relevant information from the DPDB available in individual credentials files. However, without additional detail about the planned CCQAS revisions it is not possible for us to determine if the information that will be visible in the credentials file will fully ensure that all relevant information from the DPDB is documented in the credentials file.

In DOD's response to our final recommendation—for DOD and the military services to implement an oversight process to conduct reviews of a sample of credentials files to identify and address areas of noncompliance and incomplete documentation—DOD acknowledged the need to measure compliance and noted that, until CCQAS revisions have been completed, more service-level reviews at the MTF level will be required. However, DOD did not provide sufficient detail about its planned oversight processes for us to determine if it will fully address the compliance and documentation issues we identified in this report. For example, DOD stated that compliance will be measured through accreditation visits and service reviews, but did not clarify how often these reviews will be conducted, how many credentials files will be reviewed, or the extent to which the reviews will be focused on credentialing and privileging issues, as opposed to accreditation standards more broadly. In addition, DOD noted that CCQAS will be the prime repository for all credentialing and privileging data moving forward. However, as we noted in our report, CCQAS does not provide the complete information necessary to determine whether MTFs are fully complying with credentialing and privileging requirements and completely documenting information needed to support credentialing and privileging decisions.

To fulfill their responsibilities to ensure that physicians who practice in DOD MTFs are qualified and clinically competent to care for servicemembers and their families, DOD and the military services must take the necessary steps to ensure that the weaknesses that we identified in their current physician credentialing and privileging processes are not allowed to persist. To date, DOD has not established time frames for the planned regulation updates, a redesign of CCQAS, clarifications and updates to existing requirements, and increased oversight that DOD

outlined in its comments. In addition, because DOD provided only limited detail on the specific actions it will take to address our recommendations, we cannot determine whether DOD has identified the steps needed to ensure that it addresses the weaknesses in its credentialing and privileging processes. Addressing these weaknesses will be important to ensuring that servicemembers and their families receive care from physicians who are fully qualified.

We are sending copies of this report to the Secretary of Defense, appropriate congressional committees, and other interested parties. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at 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 major contributions to this report are listed in appendix III.

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Director, Health Care

Appendix I: Scope and Methodology

This appendix describes the information and methods we used to examine the extent to which: (1) the Department of Defense (DOD) ensures that the military services' physician credentialing and privileging requirements are consistent across the Military Health System (MHS), (2) Army military treatment facilities (MTFs) are complying with the Army's physician credentialing and privileging requirements, and (3) Army's existing oversight and physician credentialing and privileging requirements are sufficient to assure compliance and complete documentation.

Specifically, we discuss our methods for reviewing DOD, Army, Navy, and Air Force requirements for physician credentialing and privileging; selecting Army MTFs for site visits; selecting a sample of medical specialties and credentials files to review; assessing selected MTFs' compliance with Army requirements; and assessing the Army's current oversight of the credentialing and privileging process. In addition to the methods described below, we also reviewed applicable standards published by The Joint Commission (a nonprofit organization that evaluates and accredits more than 16,000 health care organizations in the United States, including MTFs).[1]

Review of DOD, Army, Navy, and Air Force Written Policies on Physician Credentialing and Privileging

To examine the extent to which DOD ensures the military services' policies on physician credentialing and privileging are consistent across the MHS, we reviewed written policies issued by DOD, Army, Navy, and Air Force. We reviewed copies of the services' written policies on credentialing and privileging—including *DOD Instruction 6025.13 Medical Quality Assurance and Clinical Quality Management in the Military Health System* (which replaced *DOD Directive 6025.13* on February 17, 2011), *DOD 6025.13-R Military Health System Clinical Quality Assurance Program Regulation*, *Army Regulation 40-68 Clinical Quality Management*, *Navy Bureau of Medicine and Surgery Instruction*

[1]DOD's Quality Assurance regulations require that all MTFs shall meet or exceed the standards of appropriate external accrediting bodies, including accreditation of all hospitals by The Joint Commission.

6320.66E, and *Air Force Instruction 44-119 Medical Quality Operations*.[2] We compared DOD and the military services' requirements related to the primary source verification of a physician's credentials, the process for evaluating a physician's performance and determining their clinical competence, and the process for obtaining information related to a physician's practice history.[3] Specifically, we compared requirements regarding state medical licenses, peer recommendations, ongoing performance monitoring, malpractice and adverse action history, and practice experience. We selected these five credentialing and privileging requirements because they—unlike other requirements—address information about physicians that can change or be updated with new information periodically.

To obtain additional detail on inconsistencies we identified between DOD and the military services' regulations, we interviewed officials from the offices responsible for developing physician credentialing and privileging requirements—including the Deputy Assistant Secretary of Defense for Clinical and Program Policy, the Chief of Quality Management for the U.S. Army Medical Command, the Deputy Department Head of Clinical Operations Quality and Risk Management for the Navy Bureau of Medicine and Surgery, and the Chief of Professional Staff Management for the Air Force Medical Operations Agency. We interviewed officials from DOD and the military services to obtain additional information on their processes for ensuring that physician credentialing and privileging requirements are consistent across the MHS, and to discuss potential challenges that the services and their MTFs face as the result of inconsistent requirements.

[2]In order to be clear and consistent throughout this report, we refer to these policies as "requirements." When we use the term "regulations," we are referring to specific written policy documents labeled as such by the issuer. We limited the scope of our review to physician credentialing and privileging. Other types of medical providers, such as nurse practitioners and physician assistants, are also subject to specific credentialing and privileging requirements.

[3]We limited our review to the primary source verification of state medical licenses because MTFs are required to primary source verify these credentials both at the time of privileging and at the time of license renewal.

Site and Sample Selection Methodology

To determine the extent to which Army MTFs are complying with the Army's requirements for credentialing and privileging of physicians, we selected a sample of five Army MTFs for our review. We limited our compliance review to Army MTFs in the United States because the Army has the largest staff of medical personnel, with active duty Army medical personnel accounting for more than 40 percent of DOD's active duty medical workforce.[4] During our site visits we reviewed a nongeneralizable sample of 150 credentials files (30 files at each MTF we selected) and interviewed MTF staff responsible for physician credentialing and privileging. Based on the sample of physician credentials files we reviewed at the five selected Army MTFs, we can discuss the selected MTF's compliance for the credentials file we reviewed; we cannot generalize our findings to the remaining credentials files at the Army MTFs we selected, other Army MTFs, or MTFs managed by Navy or Air Force.

Site Visit Selection

To identify Army MTFs for our site visits, we examined relevant and available Army data. We selected our sample of site visit locations based on several factors, including the following:

- The size of the MTF, based on data provided by Army Medical Command on the size of Army medical centers, community hospitals, and outpatient clinics, including estimated numbers of medical providers (including physicians) that held privileges at each Army MTF as of May 2010.
- The number of physicians holding privileges at each MTF within each of six selected medical specialties to allow us to select a sufficient number of credentials files for our sample (discussed below).
- Other considerations such as the feasibility and costs associated with travel to potential site visit locations.

[4]We eliminated from consideration MTFs that operate overseas or in a combat area. We also limited our compliance review to Army facilities because at the time we initiated our review the Naval Audit Service was conducting a review of Navy's credentialing and privileging processes and was using a similar file review methodology.

Using these criteria, we selected the following five Army MTFs: DeWitt Army Community Hospital, Fort Belvoir, Virginia; Martin Army Community Hospital, Fort Benning, Georgia; Womack Army Medical Center, Fort Bragg, North Carolina; Ireland Army Community Hospital, Fort Knox, Kentucky; and Madigan Army Medical Center, Fort Lewis, Washington. We conducted our site visits from July 2010 through October 2010.

Medical Specialty and Credentials File Selection

At each of the five Army MTFs we selected for our review we selected a nongeneralizable sample of 30 physician credentials files from the MTF's physician population for a total of 150 credentials files across our sample. Our sample included credentials files for physicians serving in a variety of capacities, including active duty, reserve, or National Guard servicemembers;[5] civilians; contractors; and volunteers. At each MTF we selected 5 physicians from each of the following six medical specialties; family practice, obstetrics and gynecology, surgery, pediatrics, radiology, and psychiatry. We selected these medical specialties to ensure that we had a sufficient number of physicians at each MTF to select 5 credential files from each specialty at each MTF. We used Army data on the number of physicians within each medical specialty at each MTF to select the six medical specialties that consistently had a sufficient number of privileged physicians for us to select at least 5 credentials files for each specialty. Additionally, we needed to ensure that each MTF had a sufficient number of physicians in each specialty that our sample could not be identified with specific individuals.

For each credentials file in our sample, we examined both paper and electronic documentation in the file to assess compliance with selected Army credentialing and privileging requirements. Specifically, we focused our review on assessing documentation in the credentials file that addressed the following requirements:[6]

- Primary source verification of all physician state medical licenses ever held;

[5]Our sample included physicians from Army, Navy, and Air Force (we did not limit our sample to Army physicians).

[6]The results from our compliance review for some of the credentialing and privileging requirements do not total 150 because not all credentials files were required to comply with all of the requirements we examined for.

- Peer recommendations, including documentation of any follow-up contacts that were made;
- Ongoing performance monitoring, including physician's performance assessments, and documentation in the provider activity file (PAF);
- Malpractice and adverse action history, including queries of the National Practitioner Data Bank (NPDB) and the Defense Practitioner Data Bank (DPDB); and
- Physician's practice history including information in the curriculum vitae (CV).[7]

Because our site selection process and our credentials file reviews included reviewing both paper files and electronic information contained in DOD's Centralized Credentials Quality Assurance System (CCQAS), we assessed the reliability of this database. To do this, we examined relevant documentation and interviewed officials from the military services' oversight agencies and DOD about measures taken to ensure reliability of information in CCQAS. We also reviewed the information in CCQAS for all 150 of the credentials files in our sample. Based on our review, we determined that the information in CCQAS was sufficiently reliable for the purposes of our report.

In addition to reviewing credentials files during our site visits, we reviewed meeting minutes from each MTF's credentials committee for the 2 years prior to our site visit. For example, if we visited a site in July 2010, we requested meeting minutes from July 2008 through July 2010. We also reviewed any Army forms used during the credentialing and privileging process—such as peer recommendation forms and *Army Form 5374 Performance Assessment*—including forms which the MTF had modified to include standardized text.

Finally, we interviewed staff responsible for recommending or granting physician privileges—including department chiefs and the credentials committee chairperson—and credentials staff responsible for maintaining a physician's credentials file. We discussed with MTF staff at the end of each site visit all instances of documentation that we were unable to

[7]A curriculum vitae provides a short account of an individual's career and qualifications, similar to a resume.

locate during our credentials file review in order to ensure that we had accurately captured the documentation present in the files we reviewed.

Review of Sufficiency of Army Oversight and Requirements

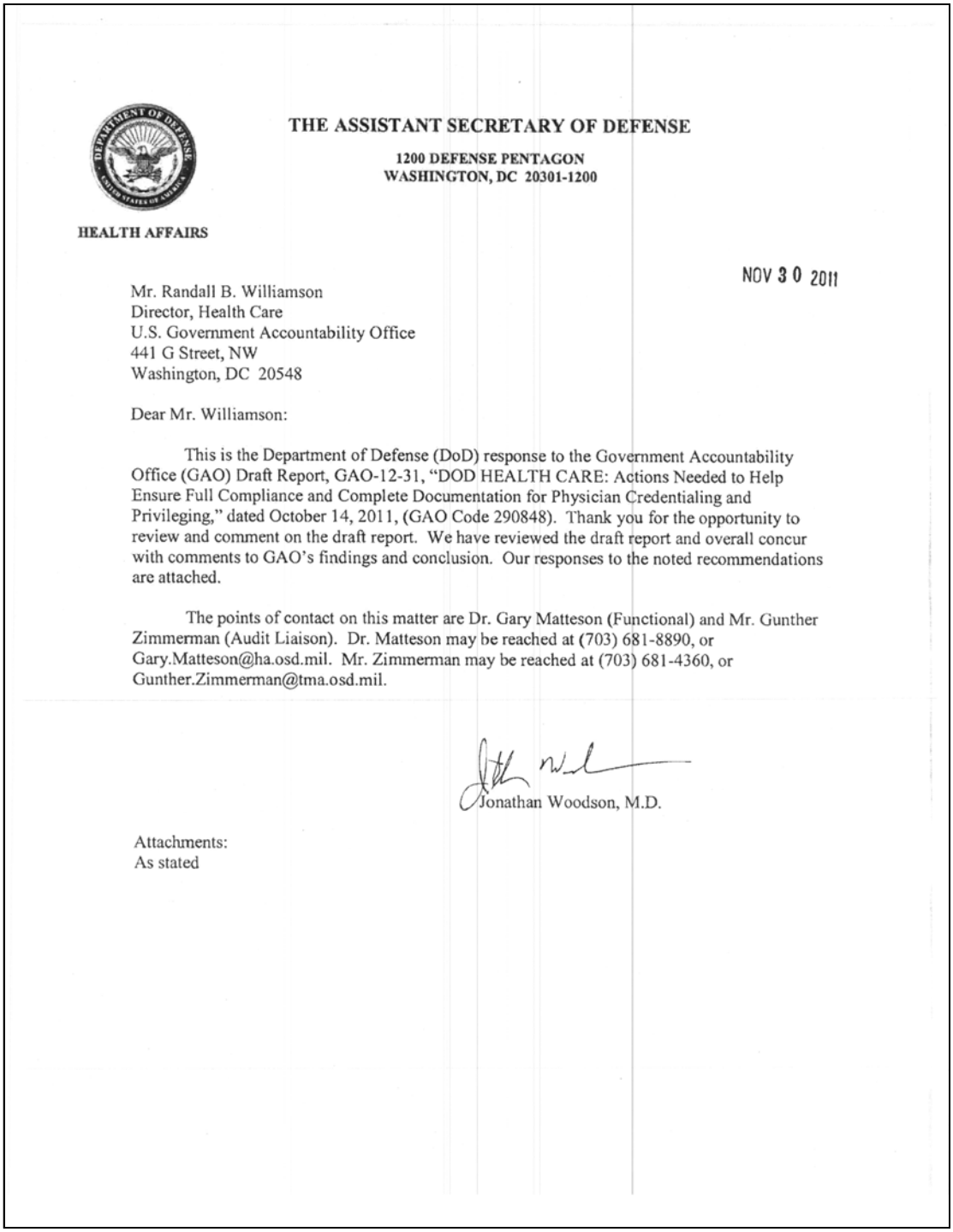
To determine the extent to which Army's existing oversight and physician credentialing and privileging requirements are sufficient to assure compliance and complete documentation, we used information collected during our site visits to selected Army MTFs, reviewed applicable internal controls standards, and interviewed MTF staff and Army Medical Command officials. Regarding internal controls, we considered Army's oversight, including the provision of policy and guidance, against the standards described in the *Standards for Internal Control in the Federal Government and the Internal Control Management and Evaluation Tool*, particularly relevant internal control standards on information, monitoring, and communication.[8] We interviewed Army officials to determine Army's current processes for oversight of physician credentialing and privileging at Army MTFs. During our site visits, we also assessed the completeness of documentation to determine if relevant information was documented in credentials files. For example, for physicians in our sample, we compared documentation of relevant information from the DPDB in the credentials file to information we collected through our own searches of the DPDB to determine if all potentially relevant information was documented. In addition, we examined each credentials file to identify any significant events—such as an MTF's consideration of potential concerns raised in performance assessments, NPDB queries, and other clinical competence and practice history documents—that may have occurred during an MTF's review of the credentials file during the most recent privileging cycle. We searched for any documentation in the credentials files related to such events. We also interviewed MTF staff to discuss the examples of noncompliance with Army requirements and incomplete documentation that we identified in our review of credentials files. Lastly, to gain

[8]GAO, *Standards for Internal Control in the Federal Government* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). These standards provide the overall framework for establishing guidelines for internal control. Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives. Internal control is not one event, but a series of actions and activities that occur throughout an entity's operations and on an ongoing basis. The *Internal Control Management and Evaluation Tool* is based on the *Standards for Internal Control in the Federal Government*, and it is intended to provide a systematic approach to assessing an agency's internal control structure. See GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

additional insight into oversight of the credentialing and privileging process across the MHS, we interviewed officials from DOD, as well as Navy and Air Force oversight agencies.

We conducted this performance audit from May 2010 through December 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.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

NOV 30 2011

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

Dear Mr. Williamson:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-12-31, "DOD HEALTH CARE: Actions Needed to Help Ensure Full Compliance and Complete Documentation for Physician Credentialing and Privileging," dated October 14, 2011, (GAO Code 290848). Thank you for the opportunity to review and comment on the draft report. We have reviewed the draft report and overall concur with comments to GAO's findings and conclusion. Our responses to the noted recommendations are attached.

The points of contact on this matter are Dr. Gary Matteson (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Dr. Matteson may be reached at (703) 681-8890, or Gary.Matteson@ha.osd.mil. Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.Zimmerman@tma.osd.mil.

Jonathan Woodson, M.D.

Attachments:
As stated

GAO DRAFT REPORT – DATED OCTOBER 14, 2011
GAO CODE 290848/GAO-12-31

"DOD HEALTH CARE: Actions Needed to Help Ensure Full Compliance and Complete Documentation for Physician Credentialing and Privileging"

DEPARTMENT OF DEFENSE COMMENTS TO THE RECOMMENDATIONS

To help ensure that the military services' requirements for physician credentialing and privileging are consistent across the MHS, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the surgeons General of the military services to establish a DoD-wide process to:

RECOMMENDATION 1: Identify and address existing inconsistencies between DoD's and the military services physician credentialing and privileging requirements, including those inconsistences we identified in this this report.

DOD RESPONSE: The Assistant Secretary of Defense for Health Affairs (ASD(HA)) is preparing an updated policy to establish a single business process for Risk Management and credentialing and privileging. This common approach is being codified in the revision to DoD Regulation 6025.13R and The Centralized Credentialing and Quality Assurance System (CCQAS). All three Services and the Joint Task Force National Capital Region Medical (JTF CapMed) fully support the development of a single business process for Military Health System (MHS) credentialing and privileging. Included with the redesign, we have identified best practices and will apply them across the MHS in order to standardize the credentialing and privileging process and eliminate inconsistencies. CCQAS was developed with a limit of 3 Services and with separate processes for each and with differing data fields. Funding was available for maintenance of the program but with the redesign, we have had to obtain additional funding to enable the changes. We are right now in the midst of developing common Master Privileging lists that will be shared by all Services and the JTF CapMed.

RECOMMENDATION 2: Coordinate all current and future efforts to revise physician credentialing and privileging requirements.

DOD RESPONSE: There is already significant coordination between the office of the ASD(HA) and the Services. Our Hospitals are all accredited by The Joint Commission, receive focused reviews by Service IGs and we report our patient care outcomes to others such as The National Surgical Quality Improvement Program. We agree that pre-selection criteria for Healthcare Practitioners should be revised to more clearly address all aspects of credentialing and privileging and not just initial privileging. CCQAS was not developed with the capability for a comprehensive central review either at the Service or DoD level. This was originally done to limit access to identifiable Personnel Health Information, but as a result, it serves also to limit top-down review by the Services and DoD. With the planned changes to CCQAS, we will have the ability to review all information contained in CCQAS (credentials, privileging, risk management, and adverse action). This information will be made available to DoD and the Services on a need-to-know basis.

To assure that information on a physician's clinical competence and practice history is documented and available to support credentialing and privileging decisions by Army MTFs, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs and the Army Surgeon General to take the following five actions:

RECOMMENDATION 3: Coordinate individual MTFs' efforts to establish mechanisms to collect and analyze data to evaluate physician performance and support performance assessments.

DOD RESPONSE: DoD and the Services' oversight process is ongoing. The credentialing and privileging process including peer review standards are reviewed during all Joint Commission surveys. We agree that the requirements should be standardized.

RECOMMENDATION 4: Clarify requirements for how MTFs document follow-up on peer recommendations, including who is responsible for documenting follow-up and where that documentation should be filed.

DOD RESPONSE: Service peer review criteria are very similar for both initial privileging and for renewal of privileges. DoD will ensure DoD 6025.13R incorporates clarification of the requirement and CCQAS will be changed when funding is available to clarify the single MHS business process for initial privileging and renewal of privileges. Delayed funding will require increased Service inspection to ensure compliance at the military treatment facility (MTF) level.

RECOMMENDATION 5: Clarify requirements for the information that physicians need to provide in the CV so that MTFs can identify unaccounted for periods in practice history, as well as how MTFs should document explanations of any unaccounted for periods.

DOD RESPONSE: Both DoD 6025.13R and CCQAS will be modified to implement a single business process for privileging and renewal of privileges. This will include clarifying the requirements for documenting unaccounted for periods in practice history and a standard format for CVs.

RECOMMENDATION 6: Establish requirements for MTFs to document significant events that occur during the review of a credentials file, including which types of significant events should be documented, who is responsible for documenting significant events and where that documentation should be filed.

DOD RESPONSE: Both DoD 6025.13R and CCQAS will be modified to implement the single business process for privileging and renewal of privileges. This will include clarification of what type of significant events should be documented, reported, and where the documentation is to be filed. We will remain compliant with accreditation standards of the Centers for Medicare and Medicaid Services and The Joint Commission.

RECOMMENDATION 7: Establish a process to ensure that relevant information from the Defense Practitioner Data Bank (DPDB) is documented in the credentials file.

DOD RESPONSE: There is no current way to query the DPDB across all 3 services but the system containing the DPDB, CCQAS, is undergoing modification and the needed items from the DPBD will soon be visible in the individual credentials file. This will eliminate the need for a separate query.

RECOMMENDATION 8: The Secretary of Defense direct the Surgeons General of the military services to establish and implement an oversight process to conduct review of a sample of credentials files to identify and address areas of non-compliance and incomplete documentation.

DOD RESPONSE: ASD(HA) will address the need for Service and JTF CapMed efforts to collect, store and analyze practitioner performance data in a standardized manner in policy guidance. Compliance will be measured by accreditation visits and Service review. CCQAS will be the prime repository for all credentialing and privileging data but additional revisions to the program will be required. Without

adequate funding, changes to CCQAS will be delayed and we will require increased Service review at the MTF level to ensure compliance.

Appendix III: 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, Marcia A. Mann, Assistant Director; Chad Davenport; Cynthia Forbes; Janida Grima; Hannah Marston Minter; and Kaitlin M. McConnell made key contributions to this report. George Bogart provided legal support and Laurie L. Pachter assisted in message and report development.