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VA HEALTH CARE

Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes

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Highlights

Highlights of GAO-10-26, a report to congressional addressees

VA HEALTH CARE

Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes

Why GAO Did This Study

VA has policies to ensure that physicians have appropriate qualifications and clinical abilities through the processes of credentialing, privileging, and continuous monitoring of performance. Results of a VA investigatory report in 2008 cited deficiencies in the Marion, Illinois, VA medical center's (VAMC) credentialing and privileging processes and oversight of its surgical program. This report examines VA's policies and guidance to help ensure that information about physician qualifications and performance is accurate and complete, VAMCs' compliance with selected VA credentialing and privileging policies, and their implementation of VA policies to continuously monitor performance. GAO reviewed VA's policies, interviewed VA officials, and reviewed a judgmental sample of 30 credentialing and privileging files at each of six VAMCs that GAO visited. GAO selected the files to ensure inclusion of highly paid specialties, newly hired physicians, and other physician characteristics. GAO selected the judgmental sample of six VAMCs based on geographic balance and other factors.

What GAO Recommends

GAO recommends that VA develop a formal mechanism to systematically review VAMC credentialing and privileging files and performance monitoring for compliance with VA policies. VA agreed with GAO's findings and recommendations.

View GAO-10-26 or key components.
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What GAO Found

VA's policies and guidance on credentialing, privileging, and continuous monitoring help ensure the collection of accurate and complete information about physician professional qualifications, clinical abilities, and clinical performance. These policies and guidance address or exceed relevant accreditation standards. Following events at the Marion VAMC, VA made policy changes to allow VAMCs to collect more complete and timely information on physician licensure, malpractice, and disciplinary actions.

GAO did not find problems at the six VAMCs visited that mirrored the extent of those reported by investigators at the Marion VAMC. However, GAO found that VAMC staff did not consistently follow VA's credentialing and privileging policy requirements selected for review. GAO selected requirements that must be verified each time a physician goes through the credentialing process and must be recorded in VA's Web-based credentialing database. For example, 29 of the 180 credentialing and privileging files reviewed lacked proper verification of state medical licensure. In addition, the VAMCs did not identify instances when physicians appeared to have omitted required information on their applications. For example, GAO identified 21 files where required malpractice information was not disclosed by physicians and was not detected by VAMCs. GAO identified several of these cases in an external database of malpractice settlements and judgments that VAMCs should review. Finally, VA policies lacked sufficient internal controls, such as specifying how compliance should be assessed, to identify and correct problems with VAMCs' noncompliance with credentialing and privileging policies.

Compliance with Credentialing and Privileging Requirements at Six VAMCs

Proper verification of information provided by physicians

Type of information	Files with proper verification	Files lacking proper verification	Total files reviewed
State medical licenses	151	29	180
Malpractice	52	38	90

Identification of nondisclosures on physician applications

Type of information	Apparent disclosure	Evidence of nondisclosure	Total files reviewed
State medical licenses	168	12	180
Malpractice	159	21	180

Source: GAO analysis of documentation in VAMCs' credentialing and privileging files.

Note: Only 90 of 180 physicians reported a malpractice allegation or claim.

The six VAMCs GAO visited also exhibited gaps in implementing VA policies and guidance to continuously monitor physician performance. All six VAMCs either failed to document the collection of physician performance information or collected data that were insufficient to adequately gauge performance. In addition, despite VA guidance, confusion over the proper usage of protected physician performance information persisted at the VAMCs GAO visited. Four of the six VAMCs inappropriately used protected information in privileging decisions—a violation of VA policy that may result in public disclosure and render some privileging decisions subject to challenge.

United States Government Accountability Office

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Abbreviations

ACOS	associate chief of staff
CMO	chief medical officer
FPPE	Focused Professional Practice Evaluation
FSMB	Federation of State Medical Boards
NPDB	National Practitioner Data Bank
NSQIP	National Surgical Quality Improvement Program
OIG	Office of Inspector General
OPPE	On-Going Professional Practice Evaluation
VA	Department of Veterans Affairs
VAMC	Department of Veterans Affairs medical center
VISN	Veterans Integrated Service Network

January 6, 2010

Congressional Addressees

To help ensure the quality of care provided by its approximately 36,000 physicians, the Department of Veterans Affairs (VA) requires each VA medical center (VAMC) to take specific steps to determine whether physicians have the appropriate professional qualifications and clinical abilities to care for VA's patients. This begins with the processes of credentialing and privileging before physicians are appointed to a VAMC's medical staff. During the credentialing process, VAMC staff collect and review information such as a physician's professional training, malpractice history, peer references, and other components of professional background to determine whether physicians have suitable abilities and experience for appointment to a VAMC's medical staff. During the privileging process, VAMCs determine which health care services—known as clinical privileges—the physician should be allowed to provide. After a physician is hired, the credentialing and privileging processes are repeated at least every 2 years.[1] VA also requires that VAMCs monitor physicians' clinical performance through the collection and analysis of physician-specific clinical performance information. VA requires that VAMCs assess this clinical performance information to evaluate physicians' clinical competence as they reevaluate physicians' lists of privileges during the reprivileging process.

Patient deaths between October 2006 and March 2007 at the VAMC in Marion, Illinois, prompted an investigation by the VA Office of Inspector General (OIG) into the VAMC's processes for monitoring physician quality. The Marion VAMC had experienced a number of deaths after surgical procedures; specifically, VA's surgical quality monitoring program reported that seven patients died out of 180 surgical cases between October and December 2006. This mortality rate was more than four times greater than expected when considering the patients' physical conditions prior to surgery. The VA OIG issued a report in January 2008 that identified deficiencies at the facility related to credentialing and privileging of

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[1]Physicians must reapply for a position on a facility's medical staff at least every 2 years, a process known as reappointment. After the initial privileging process, each successive episode is known as "reprivileging."

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physicians and the process of monitoring surgical care.[2] For example, the VA OIG found multiple instances where physicians had privileges to perform procedures without evidence of competence to perform the procedures, and that the surgical program was expanded to include complex surgical procedures even though sufficient clinical support services, such as 24-hour respiratory therapy, pharmacy, and radiology, were not available at the VAMC. Marion VAMC officials also failed to adequately address information that a surgeon entered into a voluntary agreement with one state medical board to stop practicing medicine in that state.[3] The VA OIG recommended that VA make several improvements to its credentialing and privileging processes, and implement an oversight mechanism to ensure that appropriate clinical support services are available for all surgical procedures performed at VAMCs.

We have also reported on problems with VA's process for evaluating physician performance. In May 2006, we found that six of seven VAMCs we visited had problems complying with a privileging requirement[4] because officials inappropriately used protected physician performance information collected through the facility's quality management program when renewing clinical privileges.[5] This is prohibited under VA policy because information collected as part of a facility's quality management program is protected to encourage physicians to report and discuss adverse events without fear of punitive action. We recommended that VA provide guidance to its VAMCs on how to collect physician performance

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[2]Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection: Quality of Care Issues VA Medical Center, Marion, Illinois*, 07-03386-65 (Washington, D.C., Jan. 28, 2008).

[3]VA policy requires physicians to possess at least one full, active, current, and unrestricted license.

[4]GAO, *VA Health Care: Selected Credentialing Requirements at Seven Medical Facilities Met, but an Aspect of Privileging Process Needs Improvement*, GAO-06-648 (Washington, D.C.: May 25, 2006). The other four privileging requirements we reviewed were: (1) verify that physicians' state medical licenses are valid; (2) verify physicians' training and experience; (3) assess physicians' clinical competence and health status; and (4) consider any information provided by a physician related to malpractice allegations or paid claims, loss of medical staff membership, loss or reduction of privileges, or any challenges to state medical licenses.

[5]While VA requires that VAMCs collect and analyze physician performance information for use in the reprivileging process, this performance information must be collected outside of a VAMC's quality management program. VAMCs' quality management programs consist of specified systematic health care reviews carried out in order to improve the quality of medical care or the utilization of health care resources at VAMCs.

information that can be used to renew clinical privileges in accordance with VA's policy. In November 2007, we testified that VA had implemented our recommendation to provide VAMCs with additional guidance on how to collect performance information, but that we did not know the extent of compliance at VAMCs.[6]

Based on events at the Marion VAMC, questions have been raised about physician credentialing and privileging processes at VAMCs and whether VAMCs are performing surgical procedures that are adequately supported by the capabilities of the clinical support services. Explanatory material accompanying the fiscal year 2008 appropriation directed that we assess VA facilities' compliance with credentialing and privileging standards.[7] In this report we assess (1) the policies and guidance VA has in place to help ensure that information about physician professional qualifications, clinical abilities, and clinical performance is accurate and complete; (2) the extent to which selected VAMCs comply with selected VA credentialing and privileging policies for physicians, and the extent to which VA helps ensure compliance; (3) the extent to which selected VAMCs have implemented VA policies and guidance to continuously monitor physician performance; and (4) the extent to which VA has oversight mechanisms in place to track that VAMCs are performing surgical procedures that match their capabilities.

To determine the policies and guidance VA has in place to help ensure that information about physician professional qualifications, clinical abilities, and clinical performance is accurate and complete, we reviewed VA policies and guidance on credentialing and privileging and monitoring of physician performance, and interviewed VA headquarters officials, including the Director, Credentialing and Privileging, who is responsible for VA credentialing and privileging policy. We reviewed 2008 credentialing and privileging accreditation standards issued by The Joint Commission ("Joint Commission"), a nonprofit organization that evaluates and accredits more than 16,000 health care organizations in the United

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[6]GAO, *VA Health Care: Improvements Made in Physician Privileging Policies, but Medical Facility Compliance Has Not Been Assessed*, GAO-08-271T (Washington, D.C.: Nov. 6, 2007).

[7]H. Committee on Appropriations, 110th Cong., Committee Print on H.R. 2764 / Public Law 110-161, Division I, p. 1956 (2008) (Pub. L. No. 110-161, § 4, directed that the explanatory statement printed in the Congressional Record on or about December 17, 2007 shall have the same effect as if it were a joint explanatory statement of a committee of conference. *See* 153 Cong. Rec. H15479 (daily ed. Dec. 17, 2007)).

States, including hospitals. Because state medical boards are responsible for the licensure and discipline of physicians, we also conducted a Web-based survey of medical boards in all 50 states and the District of Columbia in order to obtain information on the policy of each medical board related to the disclosure of physician licensure information.[8] We opened the survey on March 19, 2009, and closed it on April 9, 2009, with a final response rate of 76 percent.

To determine the extent to which selected VAMCs comply with selected VA credentialing and privileging policies, we visited six VAMCs and reviewed credentialing and privileging files for a judgmental sample of 30 physicians at each VAMC, a total of 180 physician files. For each physician file, we examined credentialing and privileging documentation for compliance with selected VA policies. We reviewed four credentialing and privileging requirements about proper documentation: verification of all state medical licenses ever held by a physician, verification of malpractice claims, receipt of the minimum number of references, and queries to an external database about disciplinary actions taken against physician licenses. We also reviewed whether VAMCs reprivileged physicians within 2 years of the previous privileging process, as required by VA policy. We looked for evidence of omissions by physician applicants related to medical licenses and malpractice, as well as gaps in background greater than 30 days. We also looked for documentation by physician service chiefs—officials responsible for physicians providing particular clinical services—of the rationale for credentialing and privileging recommendations for physicians as is required by VA policy. In addition, we interviewed staff responsible for verifying physician-supplied information and staff responsible for recommending physician appointments or privileges.

We visited the following VAMCs: Alexandria VAMC (Pineville, Louisiana); Edward Hines, Jr. VA Hospital (Hines, Illinois); Lebanon VAMC (Lebanon, Pennsylvania); Hunter Holmes McGuire VAMC (Richmond, Virginia); Togus VAMC (Augusta, Maine); and VA Montana Health Care System (Fort Harrison, Montana). We chose these VAMCs based on a variety of factors, including location in metropolitan and nonmetropolitan areas and geographic balance. We conducted the site visits between August 2008 and February 2009. On the basis of the sample of credentialing and privileging files we reviewed at each of the six VAMCs, we can discuss a facility's

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[8]We did not survey state boards of osteopathic medicine.

documented compliance for the physician files we reviewed; we cannot draw conclusions about the remaining physician files at the VAMCs we visited or about the compliance of other VAMCs.

To determine the extent to which VA helps ensure compliance with its credentialing and privileging policies, we reviewed VA policies and GAO internal control standards to determine criteria for management oversight.[9] To obtain information about the processes in place to oversee compliance, we interviewed officials at each of the six Veterans Integrated Service Networks (VISN) where we conducted a VAMC site visit.[10] We also reviewed documents describing the criteria VISNs use to evaluate facilities' credentialing and privileging processes. We analyzed how VetPro, VA's Web-based credentialing database, displays information for users and analyzed the information that physicians are asked to input directly into VetPro. The information from our site visits cannot be used to make generalizations about practices at all VAMCs, and the information from our interviews with VISN officials cannot be used to generalize about VISN-level oversight. Because our credentialing and privileging file review included reviewing information in VetPro, we also assessed the database's reliability. To do this, we examined relevant documentation and interviewed VA headquarters officials about measures VA takes to ensure the reliability of information in VetPro. On the basis of our review, we determined that the information in VetPro was sufficiently reliable for the purposes of our report.

To determine the extent to which selected VAMCs implemented VA policies and guidance to continuously monitor physician performance, we reviewed VA policies and guidance relating to credentialing and privileging. We interviewed VA headquarters officials and officials in the six VISNs that include the VAMCs we visited. To evaluate VAMC implementation of VA policies and guidance pertaining to physician performance monitoring, we interviewed physician service chiefs at each VAMC we visited about efforts to monitor physician performance. Finally, at each VAMC we collected documents demonstrating how continuous monitoring of physician performance was conducted. To determine the

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[9]GAO, *Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[10]VA's health care system is organized into 21 geographically defined regions, or VISNs, which have budget and management responsibilities for VA facilities located within their region.

possible effects of the inappropriate use of physician performance information, we reviewed federal law and interviewed VA general counsel staff. The information from our site visits cannot be used to generalize about all monitoring practices at the selected VAMCs, or about the practices at all VAMCs.

To examine the extent to which VA has oversight mechanisms in place to track that VAMCs are performing surgical procedures that match their capabilities, we reviewed VA policies. To obtain information on VA's plans for implementing an oversight mechanism for VAMCs' surgical programs, we reviewed the work of VA's Operative Complexity and Infrastructure Standards Workgroup and conducted a series of interviews with VA headquarters officials. While on site visits at the selected VAMCs, we conducted interviews with chiefs of surgery, and after the site visits, we conducted follow-up interviews to obtain information on the facility-level implementation of the National Surgical Quality Improvement Program (NSQIP)—which is VA's noncardiac surgical quality monitoring program—and other VAMC reviews of surgical program quality. We also reviewed copies of facility-level NSQIP reports, NSQIP training materials, and articles on NSQIP in peer-reviewed journals. The information we obtained through our site visits and interviews with chiefs of surgery cannot be generalized to all VAMCs.

Further details on our scope and methodology can be found in appendix I. We conducted this performance audit from July 2008 through January 2010 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

VA Organization, Roles, and Responsibilities

VA provides health care services at 153 VAMCs, which are grouped by region into 21 VISNs. Responsibilities for physician credentialing, privileging, and continuous monitoring of physician performance exist in all three levels of VA: VA headquarters, VISNs, and VAMCs. (See fig. 1.)

Figure 1: Select VA Organization, Roles, and Responsibilities

VA headquarters

Headquarters offices are responsible for efforts to ensure quality of care, for Veterans Integrated Service Network (VISN) oversight, and for the creation of policy.

Under Secretary for Health

Deputy Under Secretary for Health for Operations and Management

Office of Quality and Performance

Veterans Integrated Service Networks (VISN)

There are 21 VISNs, organized by region, and each VISN is responsible for managing and overseeing facilities located within its region.

VISN Director

VISN Chief Medical Officer

VA medical centers (VAMC)

Each VAMC is responsible for implementing the credentialing, privileging, and physician monitoring processes consistent with VA policy. This figure generally describes the organization of the six VAMCs we visited.

VAMC Director

Chief of Staff

Credentialer

Chief of Medicine

Chief of Mental Health

Chief of Surgery

Other Physician Service Chiefs

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

VA headquarters develops VA-wide policies and oversight approaches for the VISNs to execute. The Office of Quality and Performance is responsible, at the direction of the Under Secretary for Health, for overseeing VA-wide credentialing and privileging policy, which includes requirements for the continuous monitoring of physician performance. The Deputy Under Secretary for Health for Operations and Management is responsible for assuring that all 21 VISNs implement a credentialing and privileging process at each VAMC consistent with VA policy. Each VISN has a VISN director, who reports to the Deputy Under Secretary for Health

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for Operations and Management, and a VISN chief medical officer (CMO), who reports to the VISN director. The VISN CMO is responsible for the oversight of the credentialing and privileging process of VAMCs in the VISN. Within each VAMC, the VAMC director has the ultimate responsibility for physician credentialing and privileging at the facility. The chief of staff is the highest ranking medical officer in the VAMC, and is responsible for the quality of clinical care provided at the facility, including maintaining the credentialing and privileging process. VAMCs are generally organized by clinical service. The six VAMCs that we visited were divided into services—such as medicine, mental health, and surgery—which provide specialized health care services.[11] Services are led by physician service chiefs, who are responsible for the physicians within the service, including monitoring the quality of care being delivered to patients by physicians in the service. Generally, service chiefs report to the chief of staff.

Credentialing and Privileging Processes

Initial credentialing and privileging for physicians occurs before physicians are permitted to practice medicine at a VAMC. VA policy requires physician applicants to enter information about medical licensure, board certification, and other relevant credentials into VetPro. Applicants also complete requests for privileges which describe the specific health care services that they would like to provide. Once the required credentialing information is provided by the physician, an employee of the VAMC—usually a credentialer—collects documentation from the original source for each credential, in order to confirm the factual accuracy of the physician-provided information. For example, the credentialer would typically contact medical schools and medical residency programs to confirm dates of participation and program completion by the physician. This is referred to as primary source verification. New physician applicants must also provide three professional references. These references must provide specific information about physicians' scope of practice and clinical performance.[12]

Service chiefs must review this information about a physician's professional training and experience, as well as input from references, before determining whether to recommend both the physician's

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[11]Examples of other services at VAMCs we visited included primary care, geriatrics, and radiology.

[12]Physicians applying for reprivileging are expected to provide two references.

appointment to the VAMC medical staff and the appropriate clinical privileges. VA requires its physicians to possess at least one full, active, current, and unrestricted license to practice medicine. VA also prohibits the employment of physicians who have or have had more than one license and had any license terminated, or voluntarily relinquished any license after written notification by the state of possible termination, for reasons of substandard care, professional misconduct, or professional incompetence, unless such license is fully restored. Service chiefs are expected to review applicants' files to identify inconsistencies or omissions in information and then require physicians to enter the omitted information. For physicians going through the reappointment and reprivileging processes, service chiefs also must review and consider physician-specific clinical information collected at the VAMC that is related to professional performance, judgment, or clinical or technical competence.

Service chiefs' recommendations for both new applicants and reappointments are considered by a committee of VAMC physicians who forward medical staff appointment and privileging recommendations to the VAMC director, who is the final approving official. Appointments and privileges are typically granted for 2 years, and VAMCs must reappoint physicians and renew their privileges at least every 2 years.

Continuous Monitoring of Physician Performance

VA requires VAMCs to continuously monitor the performance of physicians providing care at VAMCs. Continuous monitoring allows VAMCs to identify professional practice trends that impact the provision of high-quality patient care. While continuous monitoring can take many forms, VA requires that during the reprivileging process, service chiefs consider such factors as procedure volume, complication rates, and comparison of physician-specific data with aggregate data of physicians holding comparable privileges when available. Service documentation of continuous monitoring is kept in individual physician-specific performance profiles. A physician's performance profile can be used by the service chief to assess the physician's performance at the time of reprivileging. Monitoring of physician performance includes On-Going Professional Practice Evaluations (OPPE), which are a way to document and evaluate physician performance using available data.

One other specific type of continuous monitoring is Focused Professional Practice Evaluations (FPPE). The FPPE is a process where the VAMC evaluates the privilege-specific competence of a physician who does not have documented evidence of competently performing the privilege

requested at the VAMC. VAMCs must consider performing FPPEs at initial appointment or when granting new privileges. FPPEs may also be used if a question arises about a physician's ability to provide safe, high-quality patient care. FPPEs can take a number of forms, including direct observation of physician skills or periodic chart reviews. VAMC officials must specify the evaluation criteria to be used prior to performing the FPPE.

National Surgical Quality Improvement Program (NSQIP)

NSQIP collects data on selected surgical procedures performed by each VA facility and the outcomes within 30 days of those procedures.[13] The NSQIP analysis uses risk adjustment to control for patient risk factors that might affect surgical outcomes by estimating the expected number of deaths and complications. By comparing these estimates to the actual number of deaths and complications the facilities experienced, VA can assess the quality of surgical care at each VAMC. NSQIP uses statistical estimates to determine if facilities are outliers when they have higher than expected numbers of deaths and complications within 30 days of a sample of surgeries, given known patient risk factors. These outlier VAMCs must evaluate all deaths that occurred during the reporting period.[14] If the VAMC is an outlier for two consecutive reporting periods, a VA surgical site visit team is sent to evaluate the VAMC's surgical program. Between 1991 and the end of fiscal year 2004, deaths within 30 days of major surgery in the VA decreased by 37 percent, and complications decreased by 42 percent.[15]

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[13]In 1991, VA began a study in 44 VAMCs to validate the methodology of NSQIP. In 1994, VA established NSQIP as a monitoring mechanism in all VAMCs.

[14]VHA Directive 2007-008, *Quality Reviews of Surgical Programs and Outcomes*, states that any facility that is an outlier during the 6-month reporting period must perform a written assessment of all mortalities, and that two consecutive 6-month periods would prompt a site visit. A VA headquarters official told us that this directive is currently under revision, and that the current practice includes a quarterly reporting period.

[15]Shukri F. Khuri, "The NSQIP: A New Frontier in Surgery," *Surgery* 138(5) (2005): 839.

VA's Policies and Guidance Help Ensure Accurate Information on Physician Qualifications, but One Policy May Not Be an Effective Use of Resources

VA's policies and guidance on credentialing, privileging, and continuous monitoring help ensure the collection of accurate and complete information about physician professional qualifications, clinical abilities, and clinical performance. Following events at the Marion VAMC, VA made several policy changes to allow VAMCs to collect more complete and timely information on physician licensure, malpractice, and disciplinary actions. However, VA's new policy requiring facilities to obtain written verification of licensure information from state medical boards—which previously could be obtained by telephone or through a state medical board's Web site—may not be an effective use of VA resources.

VA Policies and Guidance on Credentialing, Privileging, and Continuous Monitoring Address or Exceed Joint Commission's Accreditation Standards

VA's policies on credentialing address relevant Joint Commission standards. (See table 1.) For example, the Joint Commission requires that facilities verify a physician's education and relevant training. Correspondingly, VA's policy states that each VAMC must verify information about medical school graduation, residencies, and fellowships.

Table 1: Selected Joint Commission Standards, and Corresponding VA Policies, for Physician Credentialing

Joint Commission standard[a]	VA policy
Licensure	
Verify current physician licensure with the relevant state medical board(s) at specified times, including when the license expires.	Verify with the state medical board(s) all licenses currently or previously held that are disclosed by the physician at appointment, reappointment, and upon lapsing.
Education, training, and experience	
Verify education and relevant training.	Verify information about medical school graduation, residencies, fellowships, and board certification. Physician must disclose information on all education, training, and employment experience, including all gaps greater than 30 days.
Malpractice history and adverse actions against licensure, medical staff membership, and clinical privileges	
Evaluate any evidence of an unusual pattern or number of malpractice judgments.	Efforts must be made to obtain primary source verification of the issues and facts related to physician involvement in any administrative, professional, or judicial proceedings in which malpractice is or was alleged. Documentation must include a statement of adjudication by an insurance company, court of jurisdiction, or attorney's statement of claim status. Unsuccessful good faith efforts to obtain this information must be documented. The facility must document evaluation of the facts of malpractice case resolution. VA policy sets specific thresholds for additional review. A VA chief medical officer, who is responsible for oversight of the credentialing and privileging processes of the facilities within the region, must review, to ensure the appointment is appropriate, of each physician with (1) three payments made, (2) two payments totaling $1 million or more, or (3) one payment of at least $550,000.
Query the National Practitioner Data Bank (NPDB)[b] at specified times, including before granting new privileges.	Enroll the physician in NPDB's Proactive Disclosure Service through VetPro, VA's Web-based credentialing database, before initial appointment, and renew enrollment annually. This service provides alerts to the facility any time new information about a physician is entered into NPDB. Reports from the service are to be verified, and VA medical centers (VAMC) must document evaluation of the facts of the report.
Evaluate challenges to, and voluntary and involuntary relinquishment of, licensure.	Obtain disciplinary information prior to initial appointment through screening the physician, using VetPro, through the Federation of State Medical Boards (FSMB)[c] Disciplinary Alerts Service that provides alerts to VA headquarters when a state medical board reports an action against a license. Within 30 days after receiving notice of an alert from VA headquarters, VAMC officials must document primary source verification of the action and review of this information to determine the impact on the physician's continued ability to practice within the scope of granted clinical privileges.
Evaluate voluntary or involuntary termination of medical staff membership and reductions, limitations, or loss of privileges.	Verify any voluntary or involuntary termination of medical staff membership and loss of, or adverse action against, privileges.

Sources: GAO analysis of 2008 Joint Commission standards and 2008 VA policy.

[a]Joint Commission standards related to malpractice history and adverse actions against licensure, medical staff membership, and clinical privileges are privileging standards. VA policy, however, classifies them as credentialing standards.

[b]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.

In addition, VA's credentialing policies include requirements that are not included in the Joint Commission's standards. For example, Joint Commission standards require verification of a physician's current state medical licenses, while VA policy requires verification of both current and past licenses. VA also requires physicians to disclose and explain gaps in education, training, and employment greater than 30 days, while the Joint Commission standards contain no such requirement.

VA's privileging policies and guidance also address Joint Commission's standards. The Joint Commission requires facilities to consider, during the privileging process, a physician's credentials, such as licensure and training. The standards also require consideration of peer references that include information related to clinical performance, as well as information, when available, on a physician's clinical performance compared to aggregate data. Correspondingly, for privileging, VA policy states that VAMCs must consider physician credentials, attempt to obtain verification of the privileges the physician currently holds or most recently held at other institutions, and review three professional references. References need to contain information about the applicant's medical knowledge, technical skills, and clinical judgment. For reprivileging, VA requires that VAMCs review two peer references and consider the physician's clinical performance at the VAMC, using data such as complication rates. Each physician's performance must be compared to aggregate data for physicians with the same or comparable privileges, if available. In December 2008, VA provided guidance to VAMCs that included specific types of information that may be used in reprivileging, such as infection rates.

Finally, VA's policies and guidance on continuous monitoring of clinical performance also address the Joint Commission's standards, as described in table 2. In particular, the Joint Commission described in its 2008 standards how facilities should collect data for OPPEs and FPPEs. VA's 2008 guidance described how VAMCs should implement these processes.

Table 2: Selected Joint Commission Standards and Corresponding VA Policy and Guidance for Continuous Monitoring of Physician Performance

Joint Commission standard	VA policy and guidance
On-going Professional Practice Evaluations (OPPE)	
Facilities must have a clearly defined process in place for OPPEs. Facilities may evaluate performance using data such as procedures, outcomes, and length of patient stay in the facility.	VA guidance states that OPPEs should be conducted twice a year to comply with Joint Commission standards.
Focused Professional Practice Evaluations (FPPE)	
Facilities must implement a process to evaluate the privilege-specific competence of physicians who do not have documented evidence of competently performing a requested privilege at the facility. This process may also be used when a question arises regarding a currently privileged physician's ability to provide safe, high-quality, patient care. Facilities must develop criteria, such as evidence of a clinical performance trend that would trigger an FPPE of a physician.	VA policy states that VA medical centers must have a process in place to evaluate the privilege-specific competence of a physician who does not have documented evidence of competently performing a requested privilege. Consideration for FPPEs is to occur at the time of initial appointment or when granting new privileges. FPPEs may also be used if a question arises regarding a physician's ability to provide safe, high-quality patient care.

Sources: GAO analysis of 2008 Joint Commission standards and 2008 VA policy and guidance.

When implemented by VAMCs, VA policies for credentialing, privileging, and continuous monitoring help ensure that facilities can identify physicians with insufficient or falsified credentials or questionable clinical performance. The VA OIG report on the events at the Marion VAMC identified several deficiencies in the facility's credentialing and privileging processes that were related to failures—largely on the part of the VAMC's medical leadership—to comply with VA policies for credentialing and privileging physicians.

VA Has Changed Policies to Obtain More Complete and Timely Information about Physician Licensure, Malpractice, and Disciplinary Actions

Since events at the Marion VAMC, VA has made two changes to its policies for verifying information about physician credentials. First, for licensure, VA began using a new service from FSMB that reports all states where a physician has ever held a license.[16] When VAMCs screen a physician through FSMB, the VAMCs will receive this report, which they can use to identify state medical licenses not disclosed by the physician. VA began receiving this service in summer 2008, according to a VA official. VA told us that it has verbally instructed facilities to verify any discrepancies between the FSMB report and what the physician has disclosed, and VA policy requires follow up of any discrepancies found during the verification process. Second, also included in VA's 2008 policy is a requirement for facilities to enroll physicians, through VetPro, at initial

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[16]This information is provided to FSMB by state medical boards.

appointment in the National Practitioner Data Bank's (NPDB) Proactive Disclosure Service, and renew enrollment annually.[17] This service provides alerts to VA headquarters any time new information about a physician is entered into NPDB. Previously, VAMCs obtained new information from NPDB only when the database was queried every 2 years after initial appointment or when a physician requested new privileges. This policy allows VAMCs to obtain more timely information about malpractice and disciplinary actions than under the previous policy.

According to VA headquarters officials, in response to events at Marion VAMC, the November 2008 policy included a new requirement for VISN oversight of physicians who have unusually high numbers or amounts of malpractice payments. In cases where a physician has three malpractice payments, two payments that total $1 million or more, or one payment equal to or over $550,000, the VISN CMO must review the physician's appointment to ensure that the appointment is appropriate.

VA Issued a New Requirement for Written Licensure Verification, but It May Not Be an Effective Use of Resources

VA's November 2008 policy included a new requirement for VAMCs to request written verification of state medical licensure, but we found that this may not be an effective use of facility resources. Previously, other means of verification—such as telephone verification or using a state medical board's Web site—were permitted without a requirement for written verification.[18] According to VA's Director, Credentialing and Privileging, the policy change is intended to enhance VA's ability to obtain information from state medical boards about pending board actions against a physician's license, disciplinary actions under consideration, or open investigations. VA has implemented this policy to require that VAMCs' requests to the state medical boards include a waiver, signed by the physician as a condition of appointment, authorizing the boards to release this information about pending or ongoing actions. However, FSMB officials told us that state medical boards, citing state laws or policies, may not disclose this information even with a waiver.

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[17]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.

[18]Under the new policy, VAMCs may initially obtain licensure verification by Web site or telephone, but must request written verification within 5 days.

The results of our state medical board survey confirmed that state medical boards frequently will not provide information on pending or ongoing actions, even with a signed waiver. Of the 50 states and District of Columbia that received the survey, 39 responded (76 percent). Twenty-six states (66 percent of those that responded) reported that they would not provide information about pending board actions against a physician's license, disciplinary actions under investigation, or open investigations. Of the 26 states that said that they would not provide this information, most (22) cited state law as the reason. While 13 of the 26 states would provide written verification of licensure and final actions against licensure, they would charge a fee for VA to obtain this information. Of the 12 states that listed a specific fee, the average fee was $20, with 1 state charging $50. Thirteen of the 39 states responded that they would provide information about pending board actions against a physician's license, disciplinary actions under investigation, or open investigations. However, 2 of these states reported that they would provide only information that is already publicly available, and 1 state's response was not clear as to whether it would actually disclose the relevant information. Therefore, VA's current policy may require VAMCs to expend resources to obtain information about final actions taken against licensure that is not likely to exceed what is currently available at no cost. A VA headquarters official told us that VA is aware that state medical boards may not disclose this information. VA planned in October 2009 to send each board a letter asking them whether they will release the information if provided a signed waiver by the physician.

Credentialing and Privileging at Selected VAMCs Lacks Consistent Compliance with VA Policy, Clear Documentation in VetPro, and Comprehensive Oversight by VISN Officials

At the six VAMCs we visited, we found that VAMC staff did not consistently follow VA's credentialing and privileging policies. Credentialers sometimes did not comply with requirements to verify physician information such as state medical licenses and prior malpractice claims. Service chiefs did not always adequately review the information submitted by physicians in order to identify whether required information had been omitted by physicians. In addition, we found weaknesses in VetPro's display of summary information and the wording of questions for physicians, which could inhibit service chiefs' ability to evaluate physician qualifications. Finally, VA policies lacked specificity in describing the monitoring activities that are expected to oversee VAMCs' compliance with credentialing and privileging policies.

Some VAMC Credentialing and Privileging Files Were Missing Information Necessary to Determine Whether Physicians Were Adequately Qualified

Across the six VAMCs we visited, we found inconsistent compliance by credentialers with verifying required credentialing and privileging information we selected for review.[19] This credentialing information is necessary to evaluate the qualifications and credentials of physicians, and the privileging information is necessary to determine which health care services physicians should be permitted to independently practice within the facility. The four credentialing and privileging documentation requirements we reviewed for compliance were: (1) verification of all state medical licenses ever held by a physician; (2) verification of malpractice claims; (3) queries to FSMB about disciplinary actions taken against a physician's license; and (4) receipt of the required number of references. Noncompliance with documentation of medical license verification and malpractice verification accounted for most of the instances where VA policy was not followed. Table 3 summarizes compliance with VA policies of the 30 physician files we reviewed at each VAMC.

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[19]We based this review on VA's 2007 credentialing and privileging policies, which were the policies in place when we began visiting the six VAMCs.

Table 3: Compliance with Selected VA Documentation Requirements Used for Physician Credentialing and Privileging at Six VA Medical Centers (VAMC)

VAMC	State medical licenses		Malpractice		Federation of State Medical Boards database query		Physician references	
	Complied with VA policy	Did not comply with VA policy	Complied with VA policy	Did not comply with VA policy	Complied with VA policy	Did not comply with VA policy	Complied with VA policy	Did not comply with VA policy
A	28	2	8	8	30	0	30	0
B	24	6	12	8	30	0	29	1
C	28	2	10	2	30	0	29	1
D	21	9	6	10	25	5	28	2
E	30	0	13	0	30	0	29	1
F	20	10	3	10	30	0	29	1
Total	**151**	**29**	**52**	**38**	**175**	**5**	**174**	**6**

Sources: GAO analysis of documentation in VAMCs' credentialing and privileging files.

Notes: We reviewed 30 files at each VAMC. However, results for one category do not total 30 at each facility because the requirement did not apply to all physician files. Site visits to these six VAMCs were conducted from August 2008 through February 2009.

At the six VAMCs, medical licenses were properly verified in 151 out of 180 files, with five of six VAMCs having 2 or more physician files that lacked proper verification of medical licenses.

VAMC staff at the six VAMCs properly verified malpractice allegations or claims for 52 of 90 files in which physicians reported at least one past allegation of malpractice. However, at three VAMCs malpractice verification was not completed properly at least half of the time.

We found that VA documentation requirements were followed for querying the FSMB and collecting physician references in all but a limited number of instances. Specifically, we found:

- documentation that the FSMB had been queried in 175 out of 180 physician files, and

- documentation that the required number of references had been obtained in 174 out of 180 physician files.

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In addition to the four credentialing and privileging requirements, we also examined whether credentialers ensured that reprivileging took place no more than 2 years after the previous privileging process. Reprivileging took place no more than 2 years after the previous privileging process in 123 out of 128 files that had reprivileging data.

Medical Staff Leadership Did Not Adequately Scrutinize Information or Document Credentialing and Privileging Decisions at Selected VAMCs

Although credentialers are generally responsible for collecting primary-source documentation at the VAMCs we visited, it is service chiefs who are responsible for reviewing physicians' credentials to recommend medical staff appointments and privileges and, therefore, best positioned to identify instances where physicians did not provide required information. However, some service chiefs at the VAMCs we visited did not identify those instances when physicians omitted required information in the 180 files we reviewed—even when evidence of the omissions was available elsewhere in the physician file.[20] An example would be if a physician disclosed employment in Pennsylvania but did not list a Pennsylvania medical license.

As part of our review of the 180 physician files at the six VAMCs, we looked for evidence of omissions by physician applicants related to medical licenses, malpractice, and gaps in background greater than 30 days. (See table 4 for a summary of our findings related to instances when service chiefs did not identify omissions made by physicians in submitted credentialing and privileging information at the six VAMCs we visited.)

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[20]We cannot be certain our review reflects all instances in which omissions by physicians occurred. The data we collected during physician file reviews captures detail about instances in which evidence elsewhere in the physician file demonstrated that required information was missing.

Table 4: Identification of Compliance with VA Policy Regarding Physician Disclosure of Information Prior to Service Chief Recommendation at Six VA Medical Centers (VAMC)

VAMC	State medical licenses		Malpractice		Background	
	Evidence of unreported licenses	No evidence of unreported licenses	Evidence of unreported or underreported malpractice	No evidence of unreported or underreported malpractice	Unexplained gaps greater than 30 days	No unexplained gaps greater than 30 days
A	2	28	2	28	3	27
B	4	26	5	25	1	29
C	2	28	5	25	0	30
D	2	28	4	26	1	29
E	0	30	1	29	—	—
F	2	28	4	26	1	29
Total	**12**	**168**	**21**	**159**	**6**	**144**

Sources: GAO analysis of documentation in VAMCs' credentialing and privileging files.

Notes: Site visits to these six VAMCs were conducted from August 2008 through February 2009. We did not analyze the background requirement at VAMC E.

VAMC File Review: Inadequate review of licensure and an inadequate reference

An experienced primary care physician at one VAMC we visited was hired in 2007. The physician's file showed that the only medical license he reported holding was issued 6 years after he started in private practice. The VAMC never documented investigating this. Further, records from one hospital where the physician worked show the physician held privileges at that facility for just 3 months in the 1990s—not the 31 years he disclosed to the VAMC. Finally, one of the three required references was an attorney who answered "no information" to questions about the applying physician's clinical competency and medical practice.

During our file review at the six VAMCs, we found that 168 of 180 physician files showed no evidence that physicians had omitted any state medical licenses currently or previously held. However, 12 of the 180 files contained evidence that not all medical licenses were disclosed by the physician. Without full disclosure of medical licenses, credentialers would not know which states need to be contacted to obtain primary source verification that would indicate whether disciplinary action had been taken against a physician's license. The VA OIG found weakness in the disclosure of medical licenses by physicians at the Marion VAMC. Its review uncovered evidence that one physician did not disclose a medical license in which disciplinary action had been taken. As a result of the VA OIG's scrutiny, the provider was placed on authorized absence pending an investigation.

We also found during our review that 159 of 180 physician credentialing files contained detailed written information about all malpractice complaints made against physicians as required by VA policy.[21] Several of the 21 cases where the malpractice disclosure policy was not followed

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[21]VA policy states: "VA application forms, or supplemental forms, require applicants to give detailed written explanations of any involvement in administrative, professional, or judicial proceedings, including Federal tort claims proceedings, in which malpractice is, or was, alleged."

were identified through NPDB reports in the physician file. These NPDB reports—which VAMCs are required to collect on each physician during each appointment or reappointment process—showed malpractice payments had been made on claims that physicians never disclosed. For example, a surgeon at one VAMC disclosed no malpractice allegations against him, yet NPDB showed that two claims, totaling $160,000, had been paid based on care provided by the physician. This physician's credentialing file documented that the physician was reappointed in part based on "no pending or actual malpractice judgments."

VA policy requires that physicians with gaps of greater than 30 days in their backgrounds and experience document the reasons for these gaps because this information can be compared with licensure data to make sure physicians reported all licenses held. We found that 144 of 150 physician files either documented no gaps or contained explanations for the gaps of greater than 30 days. In the remaining 6 files, gaps were found with no documentation that an explanation was provided.

Although VA policy requires physician service chiefs—officials responsible for physicians providing particular clinical services—to document their rationale for credentialing and privileging recommendations for physicians, we found such documentation only about one-third of the time. VA requires service chiefs to document in VetPro what quality-of-care information they reviewed during the reprivileging process. Service chiefs must then explain their rationale for recommending the physicians' privileges. Of the 130 physicians who went through the reprivileging process at least once, we found that only 45 files—about a third—contained required service chief documentation in their most recent reprivileging cycle. (See table 5 for a breakdown of our findings by VAMC visited.)

Table 5: Service Chief Compliance with VA Documentation Policies for Reprivileging Recommendations at Six VA Medical Centers (VAMC)

| VAMC | Rationale for reprivileging documented by service chief | |
	Complied with VA policy	Did not comply with VA policy
A	6	12
B	2	21
C	17	5
D	6	17
E	8	11
F	6	19
Total	**45**	**85**

Sources: GAO analysis of documentation in VAMCs' credentialing and privileging files.

Notes: We reviewed 30 files at each VAMC. However, results do not total 30 at each facility because the requirement did not apply to all physician files. Site visits to these six VAMCs were conducted from August 2008 through February 2009.

Of the 85 files that did not contain required documentation, some contained no service chief comments at all. Others contained comments that did not meet VA requirements for service chiefs to explain the rationale for their decisions and the quality-of-care activities that were considered. For example, one service chief wrote "outstanding surgeon," but did not explain what quality data, if any, were used to reach that conclusion.

Display of VetPro Information May Inhibit VAMCs' Ability to Accurately Collect and Scrutinize Data

We identified two VetPro weaknesses—in the display of summary information and in the wording of questions for physicians—that could inhibit service chief review of physician qualifications during the credentialing and privileging process.

VetPro's Information Display May Limit Identification of Inaccurate Information

We found weaknesses in the way VetPro displayed credentialers' corrections to physician-supplied information. VetPro displays information by category, and each category of information—such as medical training, medical licensure, and references—is available on separate VetPro screens. Some of the screens have a table with summary information at the top of the screen and detailed information about a single entry at the lower portion of the screen. However, when information has been corrected by credentialers based on primary source verification, the corrections do not appear in these summary tables and there is no notification within these summary tables that alerts service chiefs that

physicians' self-reported information was found by credentialers to be inaccurate. This corrected information was available in VetPro, but accessing it required an extra step. In one instance, we found a discrepancy of 14 months between the dates when the physician reported obtaining privileges at one hospital and the privileging information provided directly by the hospital. (See fig. 2, which illustrates a hypothetical example of VetPro's display of summary information.)

Figure 2: Illustration of How VetPro Displays Summary Information

1 The "Status" box on the summary table receives a label "V," for verified, once credentialers enter information into the "Verified Data" section. However, other information in the summary table is based on what the physician applicant enters, not the information collected by credentialers—even when there are discrepancies with the primary source information that credentialers collect.

2 Detail information is only visible for one record at a time. Those reviewing the VetPro file must click on the other state names to view details of the primary source information for medical licenses in those states.

3 There is a discrepancy between the Maine license expiration reported by the physician and primary source information collected by the VAMC credentialer. Information from the credentialer shows a 7 month gap between the expiration of the Maine license and the start of the Idaho license. However, no gap is observable from the summary table. VA policy requires VAMCs to follow up when discrepancies are found during the verification process.

4 This area contains links to electronic copies of the primary source documents collected by the credentialer. Reviewers such as service chiefs can examine these images to obtain additional detail about the circumstances of when and why the physician surrendered a medical license.

Source: GAO analysis of VetPro Web-based credentialing database.

One service chief told us that he looked at information in VetPro with his credentialer, who helped him navigate the process; another told us that the credentialer would identify any information in the physician's file that needed special attention. A third said that if the credentialer corrected physician-supplied information in VetPro he was not aware of it. Such a process—in which service chiefs rely on credentialers to identify information in the VetPro file that requires extra attention—requires credentialers, who typically do not have medical backgrounds, to conduct substantive review of physicians' credentialing information. One service chief suggested that an alert, or "flag," would make the review process more useful by drawing attention to places in VetPro where there were discrepancies between physician-reported information and verified documentation. Once discrepancies are identified, service chiefs would need to investigate further to determine whether these discrepancies should be taken into account when recommending medical staff appointment or privileges.

Wording of Questions in VetPro May Have Been Confusing to Physicians

In addition, some physicians may have been confused about the wording of VetPro questions related to medical licensure and experience with malpractice allegations. For example, physicians are asked a series of questions after the following introduction:

"For disciplinary reasons, have any of the following ever been, or are they in the process of being either on a voluntary or involuntary basis—conditional, denied, revoked, suspended, reduced, limited, placed on probation, not renewed, withdrawn, or relinquished while under investigation or after being notified that investigation would be conducted?"

What follows is a series of yes-or-no questions including, for licensure, "Medical License in any State?" and, for malpractice claims, "Have you ever been involved or notified that the quality of care you provided is being reviewed *as part of an administrative (e.g. Administrative Tort Claim)*, or judicial proceeding in which professional malpractice has been alleged?" (emphasis in original)[22]

During our file reviews, we noted that several physicians answered "yes" to the question about licensure even though some stated the licenses were voluntarily surrendered for nondisciplinary reasons. These cases suggest

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[22]VA does not provide a definition in VetPro. A claim against a federal agency under the Federal Tort Claims Act may be referred to as an administrative tort claim. See 28 C.F.R. Part 14. Such a claim could result from injury or death alleged to have been caused by a physician working for the VA or another federal agency.

physician confusion about the meaning of this question, since the loss of a medical license for disciplinary reasons could render the physician ineligible to work at a VAMC. Further, one physician, whose file was among the 21 instances where files contained evidence of either undisclosed or inadequate disclosure of malpractice allegations or claims, responded to the question about malpractice, in part, that the question was too vague and that more specificity was needed.[23] Confusion about the wording of the malpractice question may have been a factor in some of these 21 instances. This confusion with respect to VetPro questions related to licensure and malpractice suggests weaknesses in processes that are intended to help VAMCs collect complete and accurate credentialing information.

VA Oversight Policies Lack Detail Necessary to Implement Proper Controls over VAMCs' Credentialing and Privileging Processes

The oversight policies for credentialing and privileging processes that were issued by VA in 2008 assign responsibility for oversight to VISN chief medical officers (CMO) but lack specificity in describing the monitoring activities that are expected.[24] Internal control standards state that agencies should clearly define key areas of authority and responsibility, establish appropriate lines of reporting, assess the quality of performance over time, and include policies and procedures for ensuring that the findings of audits and other reviews are promptly resolved.[25] VA's 2008 oversight policies do not specify how CMOs should assess compliance with credentialing and privileging policies, nor do they specify how CMOs should follow up to ensure that identified weaknesses have been promptly resolved. VA also provided guidance in August 2009 that details specific oversight activities that can be used to evaluate a VAMC's credentialing and privileging processes; however, the guidance does not describe a process for follow up to ensure that findings are resolved.

VISN officials we spoke with described participating in oversight activities or planning oversight activities that addressed at least some elements of

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[23]We did not find documentation that the facility addressed the physician's confusion by following up to explain what information was required.

[24]CMOs were given responsibility for "ensuring a sound process for granting and renewing clinical privileges" in an October 2008 policy. They were assigned to oversee credentialing and privileging processes of VAMCs in their respective VISNs according to the November 2008 revision of VA's credentialing and privileging policy.

[25]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

internal control standards. We interviewed CMOs and other officials in the six VISNs that were responsible for oversight of the six VAMCs we visited. The VISN officials described past and current oversight practices, as well as changes that were planned as a result of VA's new oversight policies. Activities that VISN officials described included participating in credentialers' e-mail discussion groups to track questions that come up about recredentialing and reviewing three to five credentialing files per site visit for completeness. Officials at two VISNs said the VA oversight policies would lead to more frequent site visits. One of these officials also said the policies led him to become more hands-on during site visits, and making direct observation of processes and engaging in direct questioning of VAMC staff about credentialing and privileging.

Some of the practices VISN officials described were insufficient for identifying key areas of authority and responsibility, assessing the quality of performance over time, and conducting adequate follow-up to see that findings had been promptly resolved. For example, one VISN official we interviewed could not say whether the VISN had staff assigned to review VAMC credentialing and privileging files, and a second VISN reported that sometimes the credentialing and privileging file review process was not conducted if VISN officials determined it was not warranted. A third VISN official reported that he reviewed 20 to 30 credentialing and privileging files per hour—a pace, at 2 to 3 minutes per file, that provides only a limited ability to assess all aspects of compliance.[26] Officials at a fourth VISN reported using criteria from the Joint Commission and the VA OIG to review credentialing and privileging files in preparation for reviews by these entities. However, these criteria do not fully overlap with VA's credentialing and privileging policies.[27] Of the four VISNs that systematically conducted file reviews, only one described engaging in a follow-up process after reviewing credentialing and privileging files to ensure that findings were resolved.

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[26]The VA headquarters official responsible for credentialing and privileging estimated that a thorough review of a physician file should take at least 30 minutes.

[27]The Joint Commission standards do not include some VA policy requirements related to credentialing. For example, the Joint Commission does not require facilities to collect information about all medical licenses that have ever been held by a physician, as VA does. The VA OIG inspection protocol that was in place when we interviewed VISN officials did not include review of any elements of credentialing. The OIG revised its review protocol starting in July 2009, and this revised protocol contains some elements for reviewing credentialing information. However, the revised protocol does not ask inspectors to look for evidence of required information that physician applicants have not provided in their credentialing file.

VA provided guidance in August 2009—after our interviews were conducted—for evaluating a VAMC's credentialing and privileging process. The guidance includes provisions for reviewing verification of state medical licensure and malpractice, completion of an FSMB query, gaps in work history greater than 30 days, possible omissions of state medical licenses through reviewing discrepancies between physicians' work history and state medical licenses reported, and whether service chiefs documented physician competency and recommended privileges. However, VA's guidance does not include a process for ensuring that the findings of the review are promptly resolved by the VAMC.

Gaps in Continuous Monitoring of Physician Performance Existed at Selected VAMCs and Officials Continued to Use Performance Information Inappropriately

The six selected VAMCs we visited varied in their implementation of VA policies and guidance to continuously monitor physician performance. Some VAMCs exhibited gaps in this monitoring by either failing to document the collection of physician performance information, or by collecting data that were insufficient to adequately gauge performance. In addition, despite VA guidance issued after our 2006 report, confusion about the proper use of protected physician performance information persisted in the VAMCs we visited: four of the six used this information inappropriately in privileging decisions.

Selected VAMCs Varied in Their Implementation of VA Policies to Continuously Monitor Physician Performance and Gaps in Monitoring Processes Existed

VA policy requires service chiefs to continuously monitor physician performance. Continuous monitoring of physician performance is important because VA requires service chiefs to assess all available information addressing physician performance when recommending privileges for the physicians in their services. However, all of the VAMCs we visited exhibited gaps in their efforts to conduct this monitoring. We reviewed the surgery, mental health, and medicine services at all six VAMCs visited and found that 6 of these 18 services failed to document compliance with VA policy regarding continuous monitoring of physician performance. These 6 services could not provide us with any documentation of continuous monitoring, such as data collection spreadsheets, standardized forms for assessing performance, or checklists of performance criteria. Table 6 describes the documentation of compliance, by service and facility, with VA policy.

Table 6: Service Documentation of Compliance with Continuous Monitoring of Physician Performance at Six VA Medical Centers (VAMC)

VAMC	Service		
	Surgery	**Mental Health**	**Medicine**
A	●	●	●
B	●	●	●
C	●	○	○
D	●	○	○
E	●	●	○
F	●	○	●

Sources: GAO analysis of physician performance information obtained from VAMCs.

Legend:

● The service was able to provide us with documentation of continuous monitoring, such as data collection spreadsheets, standardized forms for assessing performance, or checklists of performance criteria.

○ The service was unable to provide us with any documentation of continuous monitoring of physician performance.

Note: Site visits to these six VAMCs were conducted from August 2008 through February 2009.

In the reprivileging process, VA requires consideration of such factors as the number of procedures performed and complication rates, when available. It also requires the comparison of physician-specific data to aggregate data of physicians with the same or comparable privileges, when available. The VA official responsible for credentialing and privileging policy told us that some mental health services may not have physicians that perform procedures. Consistent with this official's statement, one of the three mental health services that produced documentation of continuous monitoring did not have information on procedures in its documentation.

While 9 of the 12 services reviewed in surgery and medicine provided us with documentation of continuous monitoring, 1 of these 9 services did not include information on procedures or complication rates. Additionally, 4 of these 9 services did not compare physician-specific data to aggregate data as required by VA policy. Table 7 summarizes whether surgery and medicine service documentation of continuous monitoring included information on these three factors.

Table 7: Factors of Clinical Performance Included in Continuous Monitoring at Six VA Medical Centers (VAMC), by Service

	Service	
Factor of clinical performance	Surgery	Medicine
VAMC A		
Procedure volume data	●	●
Complication rates	●	●
Data are compared to aggregate data	❍	●[a]
VAMC B		
Procedure volume data	●	●
Complication rates	●	●
Data are compared to aggregate data	❍	❍
VAMC C		
Procedure volume data	●	❍
Complication rates	●	❍
Data are compared to aggregate data	●	❍
VAMC D		
Procedure volume data	●	❍
Complication rates	❍	❍
Data are compared to aggregate data	●[a]	❍
VAMC E		
Procedure volume data	●	❍
Complication rates	●	❍
Data are compared to aggregate data	●[a]	❍
VAMC F		
Procedure volume data	●	●
Complication rates	●	●
Data are compared to aggregate data	❍	●

Sources: GAO analysis of physician performance information obtained from VAMCs.

Legend:

● The service efforts to document continuous performance monitoring included this factor of clinical performance.

❍ The service efforts to document continuous performance monitoring did not include this factor of clinical performance.

Note: Site visits to these six VAMCs were conducted from August 2008 through February 2009.

[a]These services compared physician-specific data to benchmark criteria.

Continuous monitoring varied by service as well as by facility. Surgical services consistently exhibited efforts to conduct continuous monitoring of physician performance. All six surgical services produced documentation of continuous monitoring. Further, all six surgical services collected information on at least one of the three factors of clinical practice, with two of the six services collecting information on all three factors. VA's Acting Chief Quality and Performance Officer told us that there are areas of clinical practice that are procedure based, such as surgery, where the types of procedures performed allow for more opportunities to collect procedure based data on physician performance than those clinical care areas that are not procedure based. The variation also existed across facilities. At VAMC B both services we reviewed—surgery and medicine—produced documentation of efforts to conduct continuous monitoring of physician performance, and the documentation produced contained at least one of the three factors of clinical performance. In contrast, only one service reviewed at VAMC D provided us with documentation of continuous monitoring efforts.

In the absence of documentation of continuous monitoring processes, it is unclear what specific criteria services use to monitor physician performance on an ongoing basis. Further, if services' continuous monitoring efforts do not include collection of physician volume and complication rate data, and comparison of these data with aggregated data from comparably privileged physicians, service chiefs are less able to make a meaningful assessment of a physician's clinical competence and identify negative trends in a physician's care. As a result, VAMCs and VA cannot ensure that these services are adequately monitoring the performance of their physicians.

VA has recently issued new policies and guidance on physician performance monitoring processes in an effort to clarify how services can monitor physician performance. In December 2008, VA issued guidance to VAMCs on how to perform On-Going Professional Practice Evaluations (OPPE), a type of continuous monitoring that involves formally documenting and evaluating physician performance using available data.[28] The guidance provides suggestions on how facilities should conduct

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[28]The OPPE process allows clinical leadership to identify professional practice trends that affect the quality of care and patient safety. Because this December 2008 guidance was issued in the middle of our site visits, which occurred from August 2008 to February 2009, we did not evaluate the extent to which the six VAMCs we visited had implemented the OPPE process.

OPPEs, how often OPPEs should be conducted, and suggests specific criteria service chiefs can use in assessing physician performance.

Selected Facilities Continued to Use Protected Physician Performance Information Inappropriately Despite VA Guidance

Four of the six VAMCs visited used protected peer review information in privileging decisions, despite VA guidance and training about the legal protections granted to certain types of performance information and appropriate ways to use this information.[29] In 2006 we found that six of seven VAMCs visited used protected quality management program information in reprivileging, which is prohibited under VA policy. We recommended that VA issue guidance to facilities about this topic.[30] In October 2007, VA issued additional guidance, and subsequently provided training to facilities, including two presentations addressing the proper usage of protected information. VA requires that during reprivileging, service chiefs use information on a physician's performance to support, reduce, or revoke the clinical privileges the physician requested. The performance information a service chief uses cannot be collected as part of a VAMC's quality management program. Protected peer review is a quality management process and information contained in documents created in the course of a quality management process is protected under VA policy. The policy explicitly states that information generated by these peer reviews cannot be used to take personnel actions, such as changes in privileges. Despite this guidance, our physician file reviews showed four of the six VAMCs we visited used protected peer review information in privileging decisions. In one such case, the physician's VetPro file included a document with brief notes relating to a protected peer review along with the final outcome of this peer review. Similar information was found in physician performance profiles used by service chiefs in their reprivileging decisions.

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[29] Peer review is a nonpunitive, critical review of a physician's clinical interventions performed by a peer or group of peers. The purpose of peer review is to improve the quality of care or utilization of resources at a VAMC. A peer is a practitioner of similar education, training, licensure, and privileges or scope of practice. A typical peer review involves a single reviewer making a judgment about the quality of decisions associated with another physician's clinical intervention. Peer reviews ultimately result in the case receiving a rating based on whether other experienced, competent practitioners would have managed the case in a similar manner.

[30] See GAO-06-648.

VAMC officials we interviewed expressed and demonstrated confusion as to the appropriate use of protected peer review information. At one VAMC one official told us he thought it was permissible to aggregate physician-specific peer review information and use this information in privileging, while another attested to directly using this type of information in privileging. However, the VA official responsible for credentialing and privileging policy confirmed that aggregate physician-specific peer review information was protected and should not be used in privileging. Another VAMC had policies which clearly outlined processes generating protected and unprotected physician performance information and stated that protected information was not to be used in privileging. However, we found protected peer review information in materials used for privileging at this facility.

VA officials confirmed that the use of protected information in the privileging process in violation of VA policy may result in the information becoming public or in legal challenges to privileging decisions. According to VA's Director, Credentialing and Privileging, privileging is considered a human resources function, and therefore the information used in the privileging process is subject to less stringent legal protections than information generated as part of a VAMC quality management program. If protected physician performance information generated by a VAMC quality management program serves as the basis for a privileging decision, the decision itself could be subject to challenge. Further, a physician making such a challenge may be able to obtain the release of inappropriately used information, thereby raising the possibility that the information could become public.

VA Has Begun to Implement Its Plan to Improve Oversight for VAMC Surgical Programs by Creating Resource Standards for Surgical Procedures

In response to a recommendation to improve oversight of VAMC surgical programs made by the VA OIG in its report on events at Marion VAMC, VA has created a plan to set resource standards for surgical procedures and has taken steps towards the implementation of this plan. In addition to these new oversight plans, VA also uses surgical quality data to monitor the quality of its surgical programs through NSQIP, which is an oversight mechanism used to monitor noncardiac surgical program quality.

VA Has Developed Surgical Resource Standards for VAMCs and Created a Plan for Implementing These Standards

In response to the VA OIG recommendation from the report on the Marion VAMC that VA develop a mechanism to ensure that diagnostic and therapeutic interventions are appropriate to the capabilities of each facility, VA chartered an Operative Complexity and Infrastructure Standards Workgroup in December 2007.[31] The Workgroup took several steps. First, it determined, based on a literature review, that there were no existing surgical resource standards.[32] Second, it identified the clinical support services and resources needed before, during, and after the surgeries and procedures performed at VAMCs and classified each support service as standard, intermediate, or complex. Third, the Workgroup classified surgeries or procedures as requiring standard, intermediate, or complex clinical support services or resources.

A VA headquarters official said that when VA's resource standards are implemented, each VA facility will be classified as having standard, intermediate, or complex operative complexity—that is, the ability to perform standard, intermediate, or complex surgeries and procedures based on the availability of clinical support services or resources at the facility. VA conducted a survey of all VAMCs on the clinical support services and resources available at each facility, and the VISNs used the results to determine VAMCs' initial operative complexity designation in February 2009. VA also used the survey to identify any VAMC that needed additional resources. Facilities with resource deficiencies were instructed to establish an action plan to resolve deficiencies and to provide VA with status reports by September 1, 2009, and December 1, 2009. According to VA headquarters officials, VA plans to issue the final policy containing these standards in January 2010.

The Workgroup's final report, signed by the Under Secretary for Health in October 2008, describes the resource standards and the Workgroup's recommended steps to implement the standards, including the release of the policy containing the standards. The steps and VA's anticipated completion dates are outlined in table 8 below.

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[31]The Workgroup included clinicians from VA headquarters, VISN, and VAMC levels.

[32]According to a 2008 Joint Commission standard on determination of organizational resource ability (MS.4.00), medical staff must determine before granting privileges that the resources necessary to support the privileges granted are currently available or available within a specified time frame. The standard does not specify the resources needed for specific procedures.

Table 8: Steps in VA's Plan to Implement the Operative Complexity and Infrastructure Standards Workgroup's Recommendations Regarding Surgical Resource Standards

Steps	Status
Identification of Veterans Integrated Service Network (VISN) chief surgical consultant: The Workgroup recommended that each VISN develop an identified Lead Network Director of Surgical Service, responsible to the VISN chief medical officer, to facilitate communication. According to VA officials, a chief surgical consultant for each VISN was established in February 2009 to help facilities analyze their capabilities.	Complete
Monitoring of compliance through the National Surgical Quality Improvement Program (NSQIP): The Workgroup recommended the development of a monitoring method through NSQIP. According to VA officials, in order to monitor compliance, a facility will be flagged through NSQIP software if it records a procedure that is more complex than those procedures in the facility's operative complexity designation.	Complete
Response to facility designation: The Workgroup recommended that VA permit the development of a plan to achieve compliance with an initial operative complexity designation, and that the VISN address funding for all facilities that need to achieve compliance. Each facility was given an initial classification of standard, intermediate, or complex. VISNs were instructed to develop a plan for each VAMC to either concur with the designation or identify and justify an alternative designation. According to VA officials, this should include the procurement of additional resources if necessary to fill any resource gaps. All VISNs have submitted an action plan.	Complete
Creation of VISN model for surgical services: The Workgroup recommended that VA facilitate a VISN model for the delivery of surgical services within the VISN, including an inventory of available surgical services at each facility within each VISN. According to VA officials, this model will be finished before the release of the policy.	Completion anticipated before January 1, 2010
Creation of VISN plan to address transfer of patients: The Workgroup recommended that VA require each VISN to develop a plan for the transfer of patients to another facility when the initial treating facility does not have the appropriate resources to handle the surgical condition. According to VA officials, this is a part of the VISN model for surgical services, and will be finalized before the release of the policy.	Completion anticipated before January 1, 2010
Release of policy: The Workgroup recommended that VA accept the resource standards and mandate their use by policy. According to VA officials, this policy will be effective January 1, 2010.	Completion anticipated before January 1, 2010

Sources: GAO analysis of VA documents and interviews with VA headquarters officials.

According to VA headquarters officials, as of July 2009, three of the six steps in VA's plan to implement resource standards have been completed. First, in February 2009, a chief surgical consultant was identified for each VISN. According to these officials, each chief surgical consultant is responsible for helping facilities analyze their capabilities, and will receive facility-level information from within the VISN. Second, these officials said that NSQIP software can also be used to track VAMC procedures and identify VAMCs that are performing procedures outside their classification

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level through codes recorded in NSQIP. Third, VISNs have responded to the operative complexity designations. VA headquarters officials told us that the VISN models for surgical services and patient transfer plans would be completed by the time the policy is issued, in January 2010.

To further improve surgical program oversight, VA issued a policy in January 2009 on future restructuring, reduction or augmentation of VAMCs' clinical programs. The policy would require that a VAMC obtain approval from the VISN and the Under Secretary for Health before undertaking any major expansion of a surgical program.[33] When requesting an expansion, the VAMC's chief of staff and VISN CMO must ensure that a thorough clinical evaluation has been conducted at the facility to ensure that providers have the required competency and that an assessment of clinical support services and resources has been made. The chief of staff and VISN CMO must also ensure that a site visit, which may include experts in the relevant surgical specialty, is conducted when applicable by the responsible VA headquarters program staff.[34] Finally, the chief of staff must ensure processes are in place to provide ongoing review and evaluation of the quality of care provided for all clinical services. The facility director must submit a formal business plan to the VISN director for approval. VA's new policy also provides a mechanism for facilities to change their operative complexity designation. VA headquarters officials told us that a facility's formal business plan will also be used to approve a change in designation. For example, these officials told us that if a facility is designated as intermediate, but wants to expand to perform complex surgeries, VA must approve a formal business plan describing planned clinical and support services.

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[33]Major expansion includes the introduction of a new surgical procedure which would significantly increase the complexity of procedures done at the facility, or the introduction of thoracic or vascular surgery, transplant services, cardiac surgery, bariatric surgery, neurosurgery, or total joint replacement. This policy also prohibits any elimination of major clinical programs without approval.

[34]A panel of experts is specifically required when new programs are desired in robotic surgery, bariatric surgery, transplant surgery, cardiac surgery, or neurosurgery.

VA Monitors Surgical Outcome Data and Has Policies Related to Oversight of VAMC Surgical Programs

In addition to the oversight activities under development related to facility capabilities, VA and VAMCs conduct other activities for oversight of surgical program quality. VA uses NSQIP to monitor surgical program quality.[35] While NSQIP does not directly consider facility capabilities, VA uses NSQIP to detect problems within surgical programs and further investigate the potential causes of those problems, as it did at Marion VAMC when NSQIP identified a mortality rate over four times higher than the expected rate.

In addition to NSQIP reports, surgery chiefs at all six VAMCs we visited told us that they also monitor their surgical programs using other types of facility-level surgical quality oversight. Specifically, five of six surgery chiefs identified morbidity and mortality reviews as a mechanism for monitoring their surgical programs.[36] VA policy requires that VAMCs ensure the trending of mortality data by location, time, and provider[37] is implemented, and that VAMCs conduct a review of the data to identify and address any problematic trends. These data are to be discussed in a regular forum, such as within quality management or morbidity and mortality committee meetings. Furthermore, all major complications and deaths that are related to a surgical procedure at a VA facility must be peer reviewed within 30 days of the original surgical procedure.[38]

VA policy also provides for VISN and headquarters oversight for all peer reviews, including those related to patient morbidity and mortality.[39] The VISN director must ensure an annual inspection of all VAMCs to ensure compliance with peer review requirements, adequate review of peer review results, and implementation of follow-up actions. VA policy also requires that facilities collect and report quarterly to the VISN certain data related to peer review such as the number and results of reviews. The VISN must analyze these data and identify any difference in facility data

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[35]NSQIP oversees the quality of certain noncardiac surgeries; the Continuous Improvement in Cardiac Surgery Program similarly oversees cardiac surgical programs, and the Neurologic Surgery Consultants Work Group oversees neurosurgical programs.

[36]Other types of quality monitoring mechanisms mentioned include infection control reviews and surgical and other invasive procedure review.

[37]The policy requires trending data by provider when the provider can be linked to the care of a specific patient.

[38]VHA Directive 2005-056, *Mortality Assessment* (Dec. 1, 2005).

[39]VHA Directive 2008-004, *Peer Review for Quality Management* (Jan. 28, 2008).

resulting from the peer review process. The VISN must report on a quarterly basis its data and analysis to VA headquarters.

Conclusions

Following events at the VAMC in Marion, Illinois, which identified weaknesses in the monitoring of physician quality of care, VA has strengthened several of its credentialing and privileging policies and guidance and has taken steps to implement a mechanism to help ensure that VAMCs are not performing surgical procedures beyond their capabilities. With the exception of the new policy requiring written verification of licensure—which potentially wastes VA resources—these policies, if implemented correctly by VAMCs, appear sufficient to help facilities identify physicians who should not be providing care to veterans, as well as surgical programs that may be endangering veterans by authorizing the performance of complex procedures that are not adequately supported.

We did not find problems at the six VAMCs we visited that mirrored the extent of those reported by the VA OIG in 2008 at the Marion VAMC. However, we identified deficiencies in credentialing, privileging, and continuous monitoring of physicians that suggest a lack of scrutiny in critical areas, such as awareness of physicians' experience with malpractice and experience in all states where physicians have practiced. Activities such as these are the responsibility of VAMCs' service chiefs, who are the individuals best positioned to scrutinize the background information provided by physicians seeking appointment and to identify inconsistencies or missing information. However, the lack of compliance we found related to service chiefs' responsibilities suggests that service chief attention to these activities needs to be made a higher priority. We also found weaknesses in VetPro which, if corrected, would make it easier for service chiefs to scrutinize the backgrounds of physicians and allow them to make decisions based on complete and accurate information. Absent complete and accurate information, service chiefs may recommend physicians with inappropriate backgrounds for appointment to VAMC medical staffs.

The lack of compliance we found at the six VAMCs indicates that oversight of these activities needs heightened scrutiny at all levels—VA, VISN, and VAMC. Because credentialing, privileging, and continuous monitoring are facility-level processes, vigorous VISN oversight is needed for VA to have reasonable assurance that VAMCs are implementing these processes adequately. However, oversight of VAMCs' credentialing and privileging activities was insufficient. VISN officials described cursory activities, such

as spending just 2 to 3 minutes per credentialing and privileging file. Further, VA's policy for oversight lacks internal controls, such as a follow-up mechanism to confirm that identified problems have been properly addressed. In addition, while VA has provided guidance on continuous monitoring that may be helpful to facilities, we found gaps in monitoring efforts and that some facilities continued to use protected information to make privileging decisions.

Recommendations for Executive Action

In order to improve oversight of credentialing, privileging, and continuous monitoring processes at VAMCs, we are making three recommendations. We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following 3 actions:

- Require VISN directors to develop a formal oversight process to systematically review credentialing and privileging files and the information used to support reprivileging of physicians for compliance with VA policies and document results of reviews and corrective actions at least annually. The oversight process should include feedback to VAMC officials about the proper use of legally protected performance information, if necessary. In order to close the feedback loop, the oversight process should describe a method of follow up to measure whether VAMCs corrected identified weaknesses.

- Update VetPro to more effectively display physician credentialing information. Specifically, VA should improve the display of verified information on VetPro's summary tables and simplify and clarify questions related to malpractice and licensure.

- Collect more information about state medical boards' policies on the release of information, and consider amending VA policy to not require written verification for states that do not provide additional information in addition to what is available by phone or on the state boards' Web sites.

Agency Comments

VA provided us with comments on a draft of this report, which we have reprinted in appendix II. In its comments, VA agreed with our recommendations and described the agency's planned actions to implement them. Specifically, VA said that a workgroup representing VISN and VAMC leadership would develop a system of formal oversight for the credentialing and privileging process. The system will include documentation of results and corrective actions, with follow up at least annually. The oversight framework is to be incorporated into a revision to VA's credentialing and privileging policy, which will be completed by June

2010. VA also plans revisions to VetPro which are scheduled to be completed by September 2012. VA noted that these revisions will include easier VetPro usage and will clarify VetPro's display. Finally, VA said that its survey of state medical boards to seek their willingness to provide additional information, initiated in October 2009, will be analyzed and results considered for inclusion into the current revision of VA's credentialing and privileging policy. VA also provided technical comments, which we have incorporated as appropriate.

We are sending copies of this report to the Secretary of Veterans Affairs, 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 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.

Randall B. Williamson
Director, Health Care

List of Congressional Addressees

The Honorable Tim Johnson
Chairman
The Honorable Kay Bailey Hutchison
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
  and Related Agencies
Committee on Appropriations
United States Senate

The Honorable Chet Edwards
Chair
The Honorable Zach Wamp
Ranking Member
Subcommittee on Military Construction, Veterans Affairs,
 and Related Agencies
Committee on Appropriations
House of Representatives

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

The Honorable Richard J. Durbin
United States Senate

Appendix I: Scope and Methodology

To determine what policies and guidance the Department of Veterans Affairs (VA) has in place to help ensure that information about physician professional qualifications, clinical abilities, and clinical performance is accurate and complete, we reviewed VA policies and guidance on credentialing and privileging and monitoring of physician performance. To obtain more information about these policies and guidance, we interviewed VA headquarters officials, including VA's Director, Credentialing and Privileging. We reviewed 2008 credentialing and privileging accreditation standards issued by The Joint Commission ("Joint Commission"), a nonprofit organization that evaluates and accredits more than 16,000 health care organizations in the United States, including hospitals. We also interviewed officials from Joint Commission, including the Senior Vice President for Healthcare Improvement and the Vice President, Standards and Survey Methods.

To obtain information about the potential effects of VA's policy requiring written verification of licensure, we interviewed VA's Director of Quality Standards and two officials from the Federation of State Medical Boards (FSMB)—the Senior Director of the Federation Credentials Verification Services and Federation Physician Data Center and Credentials Verification Service and the Manager of the FSMB Physician Data Center. To obtain information on medical board policy related to the disclosure of physician licensure information, we conducted a Web-based survey of medical boards in all 50 states and the District of Columbia.[1] We opened the survey on March 19, 2009, and closed it on April 9, 2009, with a final response rate of 76 percent.

To determine the extent to which selected VA medical centers (VAMC) comply with selected VA credentialing and privileging policies, we conducted site visits to six VAMCs and reviewed credentialing and privileging files for a judgmental sample of 30 physicians at each VAMC, a total of 180 physician records. For each physician, we examined credentialing and privileging documentation for compliance with VA policies. The four credentialing and privileging requirements we selected for review included

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[1]We did not survey state boards of osteopathic medicine. The New York State Education Department, Office of the Professions, is responsible for updating physician licensure information, while the Department of Health Office of Professional Medical Conduct maintains information related to physician discipline. We surveyed each organization separately and combined their responses into one response for New York.

- verification of all state medical licenses ever held by the physician;

- verification of malpractice claims by contacting a court of jurisdiction or the insurance company involved in the medical malpractice claim, or by obtaining a statement of claim status from the attorney representing the physician in the malpractice claim;

- receipt of the minimum number of references; VA requires that physicians provide three references prior to their initial appointment at a VAMC and two references prior to medical staff reappointment; and

- query the FSMB about disciplinary actions that state medical boards have taken against physician licenses.

In addition to the four credentialing and privileging requirements, we also examined whether credentialers ensured that reprivileging took place within 2 years after the previous privileging process. We looked for evidence of omissions by physician applicants related to medical licenses, malpractice, and at five of six VAMCs visited, gaps in background greater than 30 days. We also looked for documentation by physician service chiefs—officials responsible for physicians providing particular clinical services—of the rationale for credentialing and privileging recommendations for physicians as is required by VA policy. We interviewed staff responsible for recommending or granting physician appointment or privileges—including service chiefs, chiefs of staff, and facility directors—about their decision-making processes. We also interviewed credentialers who collect documentation to verify physician-supplied information about their processes for verifying credentialing and privileging information.

At each site we identified a judgmental sample of 30 physicians' files. In selecting the files, we attempted to maximize the number of physician medical specialties while also having consistency in the specialties that were reviewed at each site. To identify which medical specialties were likely to be represented at each site, we identified a list of "core specialties" using descriptions of hospital services and lists of designated service chiefs at VAMCs. From this core, we identified the three highest paying surgical and medicine specialties as well as the highest paying specialty from imaging services—since pay is a challenge where VA competes with the private sector to hire qualified physicians—and chose

two physicians from each of these specialties.[2] We reviewed the files of at least five newly hired physicians at each site to identify whether the facility was complying with VA's October 2007 credentialing and privileging policy, which was in effect when we began our work. In addition, at each site we reviewed the files of at least two psychiatrists—because of VA's initiative to hire more mental health providers—and all physicians who were the only specialist in their discipline on the medical staff.[3] In addition, we reviewed the files of at least two general surgeons, since problems at the Marion VAMC focused on issues related specifically to the clinical skills of a general surgeon at that facility. When the VAMC had more than two physicians in each medical specialty we designated, or more than five newly hired physicians, we chose files randomly from within the whole group of specialists or new physicians. On the basis of the sample of physician files we reviewed at each of the six VAMCs, we can discuss a facility's documented compliance for the physician files we reviewed; we cannot draw conclusions about the remaining physician files at the VAMCs we visited or about the compliance of other VAMCs.

Because our file review included reviewing information in VetPro, we assessed the database's reliability. To do this, we examined relevant documentation and interviewed VA headquarters officials about measures VA takes to ensure the reliability of information in VetPro. On the basis of our review, we determined that the information in VetPro was sufficiently reliable for the purposes of our report.

We visited the following facilities: Alexandria VAMC (Pineville, Louisiana); Edward Hines, Jr. VA Hospital (Hines, Illinois); Lebanon VAMC (Lebanon, Pennsylvania); Hunter Holmes McGuire VAMC (Richmond, Virginia); Togus VAMC (Augusta, Maine); and VA Montana Health Care System (Fort Harrison, Montana). We chose these VAMCs based on a variety of factors,

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[2]Physician pay data came from the American Medical Group Association's 2007 Medical Group Compensation and Financial Survey. The surgical specialties selected were orthopedic surgery, urology, and anesthesiology. The medical specialties selected were cardiology, gastroenterology, and dermatology.

[3]We chose these sole specialists because for these physicians peer review often must be done using specialists from outside the facility.

including location in metropolitan and nonmetropolitan areas,[4] geographic balance,[5] and facilities' procedural complexity level.[6] We eliminated from consideration those facilities that did not perform inpatient surgery because the VA Office of Inspector General (OIG) report on the Marion VAMC identified weaknesses in the inpatient surgery unit. We also excluded the seven facilities we visited in our 2006 report on credentialing and privileging,[7] and facilities in Veterans Integrated Service Network (VISN) 15 because, during the time of our selection process, a VA official told us that the VISN was transitioning away from a centralized credentialing process.[8] We conducted our site visits between August 2008 and February 2009. The results from our site visits are not generalizable to all facilities.

To determine the extent to which VA helps ensure compliance with its credentialing and privileging policies, we reviewed VA policy changes in October and November 2008 which contained provisions delegating credentialing and privileging oversight responsibilities to VISN officials. We reviewed GAO internal control standards to determine criteria for management oversight.[9] We interviewed the chief medical officer (CMO) for each of the six VISNs where we conducted a VAMC site visit to capture

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[4]We considered area population in the selection process to ensure that we included VAMCs in regions that were similar to the Marion VAMC in terms of rurality or geographic isolation. To identify those VAMCs in rural and geographically isolated areas, we used the Rural-Urban Continuum Codes from the 2007 Area Resource File. We deemed a facility rural or geographically isolated if it was located in a nonmetropolitan county or the lowest population category for metropolitan counties in the continuum. Facilities that met this standard were located in counties in nonmetropolitan areas or in metropolitan areas of less than 250,000 people. Four of the six facilities we visited—Lebanon VAMC, VA Montana Health Care System, Togus VAMC, and Alexandria VAMC—met this standard.

[5]To address geographic balance, the selected VAMCs were from different VISNs and Census divisions.

[6]To consider facility complexity, we used VA's classification system that assigns VAMCs to one of three complexity levels. In descending order of complexity, they are complexity level 1 (further subdivided into levels 1a, 1c, and 1c), complexity level 2, and complexity level 3. We selected two hospitals at complexity level 1, two hospitals at level 2, and two hospitals at level 3. Alexandria VAMC, a complexity level 2 facility at the time of our site selection, had been reclassified as a complexity level 3 facility at the time of our site visit.

[7]The VAMCs were located in Boise, Idaho; Kansas City, Missouri; Las Vegas, Nevada; Lexington, Kentucky; Martinsburg, West Virginia; Miami, Florida; and San Antonio, Texas.

[8]Marion VAMC is part of VISN 15.

[9]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

information about the review processes in place to oversee the proper execution of credentialing and privileging activities. Our interviews with VISN CMOs were conducted between December 2008 and May 2009, after VA's policies had been released. We reviewed VA's August 2009 guidance for evaluating VAMCs' credentialing and privileging processes. Further, we analyzed how the VetPro database displays information for users and the information that physicians are asked to input into VetPro, and we interviewed service chiefs to understand their interpretation of information in VetPro. The analysis of the VetPro display included an examination of how corrections made by VAMC staff were displayed for VetPro users. The information from our site visits cannot be used to generalize about practices at all VAMCs, and the information from our interviews with VISN officials cannot be used to generalize about VA oversight at the VISN level.

To determine the extent to which selected VAMCs implemented VA policies and guidance to continuously monitor physician performance,[10] we reviewed relevant VA policies, including those for credentialing and privileging, and interviewed VA headquarters officials and the CMOs for six VISNs that included the VAMCs we visited. To clarify our understanding of accreditation standards relating to physician performance monitoring, we interviewed officials from The Joint Commission. Finally, we evaluated VAMC implementation of VA policies and guidance pertaining to physician performance monitoring on our site visits to six VAMCs. We interviewed service chiefs about efforts to monitor physician performance at each of the VAMCs we visited, and collected documents describing how the individual services conducted continuous monitoring of physician performance. We spoke with the service chiefs in charge of the surgery, mental health, and medicine services at each facility visited.[11] We also interviewed service chiefs in primary care, radiology, and

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[10]We conducted our site visits between August 2008 and February 2009. Evaluation of VAMC compliance with VA policies on continuous monitoring of physician performance is based on VA's October 2007 policy on credentialing and privileging. While VA issued a revised policy in November 2008, we had already conducted several site visits and therefore evaluated all six VAMCs based on VA's 2007 policy.

[11]We chose surgery because the VA OIG identified problems with the surgical program at the Marion VAMC, and mental health because of a recent VA initiative to hire more mental health physicians. At one VAMC we interviewed the associate chief of staff (ACOS) for acute care. At this facility, the acute care unit is organized to include physician staff positions in internal medicine. While the ACOS for acute care was not the direct supervisor for internal medicine physicians, the ACOS has ultimate responsibility for the internal medicine practices of the VAMC.

long-term care at some facilities. To determine the possible effects of the inappropriate use of protected physician performance information, we reviewed federal law and interviewed VA general counsel staff. On the basis of the information we gathered, we can discuss individual VAMC and service compliance with VA policies and guidance to continuously monitor physician performance. However, we cannot generalize about the other service practices at the selected VAMCs, or about the practices at all VAMCs.

To examine the extent to which VA has oversight mechanisms in place to track that VAMCs are performing surgical procedures that match their capabilities, we reviewed several VA policies, including policies on restructuring clinical programs, quality reviews of surgical programs and outcomes, mortality assessment, and peer review for quality management. We also reviewed the VA OIG report on the Marion VAMC to identify issues related to surgical program oversight, and reviewed and identified relevant accreditation standards from The Joint Commission. For background information on VA's National Surgical Quality Improvement Program (NSQIP), we reviewed copies of facility-level NSQIP reports, NSQIP training materials, and peer-reviewed journal articles on NSQIP. We reviewed the final report written by VA's Operative Complexity and Infrastructure Standards Workgroup to identify recommendations to VA in implementing its oversight mechanism. We also conducted a series of interviews with the VA headquarters officials to obtain additional information on implementation for VA's oversight mechanism. While on site visits at the selected VAMCs, we conducted interviews with chiefs of surgery, and after the site visits, we conducted follow-up interviews to obtain information on the facility-level use of NSQIP and other surgical program monitors. The information we obtained through our site visits and interviews with chiefs of surgery cannot be generalized to all VAMCs.

We conducted this performance audit from July 2008 through January 2010 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 Veterans Affairs

Department of Veterans Affairs
Office of the Secretary
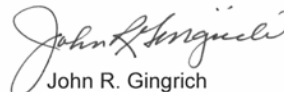
December 14, 2009

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

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, *VA HEALTH CARE: Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Process* (GAO-10-26) and agrees with the findings and concurs with GAO's recommendations.

The Veterans Health Administration (VHA) is already moving forward to enhance physician credentialing and privileging. The enclosure describes actions taken or that will occur to address each of GAO's recommendations. The enclosure also provides technical comments. VA appreciates the opportunity to review and comment on your draft report.

Sincerely,

John R. Gingrich
Chief of Staff

Enclosure

Enclosure

The Department of Veterans Affairs (VA) Comments To
Government Accountability Office (GAO) Draft Report,
*VA HEALTH CARE: Improved Oversight and Compliance Needed
for Physician Credentialing and Privileging Process*
(GAO-10-26)

GAO Recommendation: In order to improve oversight of credentialing, privileging, and continuous monitoring processes at VAMCs, GAO recommends that the Secretary of Veterans Affairs direct the Under Secretary for Health to:

Recommendation 1: Require VISN Directors to develop a formal oversight process to systematically review credentialing and privileging files and the information used to support reprivileging of physicians for compliance with VA policies and document results of reviews and corrective actions at least annually. The oversight process should include feedback to VAMC officials about the proper use of legally protected performance information, if necessary. In order to close the feedback loop the oversight process should describe a method of follow up to measure whether VAMCs corrected identified weaknesses.

VA comments to the draft report: Concur. The Office of the Deputy Under Secretary for Health for Operations and Management will collaborate with Veterans Health Administration's (VHA) Office of Quality and Safety, through the Office of Quality and Performance, to facilitate a work group representing VISN and facility leadership to develop a system of formal oversight of the credentialing and privileging process. This oversight process, to be determined by the Office of the Deputy Under Secretary for Health for Operations and Management, will provide a systematic approach to a programmatic review of compliance with VA policy, documenting results and corrective actions and follow-up at least annually. The framework will be incorporated into VA credentialing and privileging policy currently under revision to be completed by June 2010.

Recommendation 2: Update VetPro to more effectively display physician credentialing information. Specifically, VA should improve the display of verified information on VetPro's summary tables and simplify and clarify questions related to malpractice and licensure.

VA comments to the draft report: Concur. The Associate Deputy Under Secretary for Health for Quality and Safety, through the Office of Quality and Performance, has already initiated a new service request for the next generation of VetPro. Requirements for functionality and display will be developed by system users to enable easier VetPro usage and clarity of its display.

Depending on approval of the new service request and the extent of support from VA's Office of Information and Technology, the Office of Quality and Performance anticipates the completed assessment and plan for the next generation of VetPro system by

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Enclosure

The Department of Veterans Affairs (VA) Comments To
Government Accountability Office (GAO) Draft Report,
*VA HEALTH CARE: Improved Oversight and Compliance Needed
for Physician Credentialing and Privileging Process*
(GAO-10-26)

September 2010. The development and deployment of the new VetPro system is
estimated to be completed by September 2012.

Recommendation 3: Collect more information about state medical boards' policies
regarding the release of information, and consider amending VA policy to not require
written verification for states that do not provide additional information from what is
available by phone or on the state boards' Web sites.

VA comments to the draft report: Concur. The Associate Deputy Under Secretary for
Health for Quality and Safety, through the Office of Quality and Performance, initiated a
survey in October 2009 to the 70 state medical boards, 53 state nursing boards, and 53
state dental boards, to seek their willingness to provide additional information for
credentialing and privileging purposes. This survey will be analyzed when completed
and the results considered for inclusion into the current revision to VA's credentialing
and privileging policy. Any amendments to the current credentialing and privileging
policy will be in concurrence by March 31, 2010.

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Randall B. Williamson, (202) 512-7114

Staff Acknowledgments

In addition to the contact named above, Marcia A. Mann, Assistant Director; Susannah Bloch; Lori Fritz; Kaitlin McConnell; Kate Nast; Steve Robblee; Jessica Cobert Smith; and Rusty Walker made key contributions to this report.