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MILITARY HEALTH CARE

Preliminary Observations on DOD's Monitoring of Provider Qualifications and Competence

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Statement of Sharon M. Silas, Director, Health Care

GAO-22-105890

GAO Highlights

Highlights of GAO-22-105890, a testimony before the Subcommittee on Military Personnel, Committee on Armed Services, House of Representatives

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Why GAO Did This Study

Since 2014, Congress and the Department of Defense (DOD) have taken steps intended to strengthen patient safety in the Military Health System. As part of those efforts, Congress required DHA, an agency within DOD, to assume the military departments' administrative responsibilities for medical facilities, including ensuring individual providers are qualified and competent to deliver safe, high quality care to patients. This includes verifying providers' qualifications before hiring them, as well as reviewing any concerns that may arise about a provider as a result of routine performance monitoring or patient safety events.

This statement describes preliminary observations on selected medical facilities' adherence to DHA's clinical quality management procedures and DHA's efforts to monitor their implementation.

For the ongoing work on which this statement is based, GAO selected four medical facilities that varied by military department, geographical location, and number of patient safety events. Additionally, GAO reviewed relevant DHA procedures for clinical quality management and interviewed relevant officials from DHA and each of the military departments (Air Force, Army, and Navy) about these procedures and related monitoring efforts.

GAO plans to complete this work in summer 2022 and will make recommendations as appropriate.

What GAO Found

The Defense Health Agency (DHA) must ensure the quality and safety of health care delivered by individual providers at its medical facilities. However, GAO's preliminary observations from its ongoing work indicate that four selected medical facilities and DHA did not always adhere to DHA's clinical quality management procedures for credentialing and privileging of providers, focused evaluations of providers, and reviews of patient safety events that could have caused or did cause harm to patients.

- **Credentialing and privileging.** GAO reviewed credentialing and privileging procedures for 100 selected providers from four selected medical facilities. For about one-sixth of providers, the facilities did not adhere to the DHA requirement to verify all medical licenses before granting privileges. For three-quarters of the providers GAO reviewed, the facilities did not adhere to the requirement to conduct ongoing performance monitoring every 6 months.
- **Focused evaluations.** GAO reviewed all 20 focused evaluations conducted by the four selected medical facilities during the period of GAO's analysis. Selected facilities did not document the metrics for evaluating concerns that arise about the quality and safety of an individual provider's care under a focused evaluation, as required, for about half of these evaluations. This raises questions about whether facilities ensured concerns were adequately addressed before returning providers to regular performance monitoring.
- **Patient safety events.** Selected medical facilities did not always adhere to procedures for reviewing patient safety events that may result in compensation to patients or their families. Specifically, for 19 cases from four facilities that had not resulted in compensation, the facilities never documented their consideration of whether such events warranted adverse action against a provider. Also, over four-fifths of selected facilities' reviews of these events exceeded required time frames.

  GAO also found that DHA did not always adhere to its own requirements for reviewing the 12 patient safety events from four selected facilities that resulted in compensation to patients or their families. Specifically, about half of DHA's reviews of these events exceeded the required time frames and DHA did not report providers to a national database when those reviews exceeded the required time frames, as required.

In addition, GAO's ongoing work also indicates that DHA does not sufficiently monitor medical facilities' adherence to its clinical quality management procedures. As of March 2022, DHA's monitored credentialing and privileging by running reports on expired credentials, but did not monitor adherence to requirements not uploaded into DHA's database. DHA officials also told GAO they have not yet monitored facilities' documentation of focused evaluations, but are developing an approach to do so. Finally, DHA monitors medical facilities' reviews of patient safety events that have resulted in compensation, but DHA stated they are not yet monitoring the reviews of events that have not.

View GAO-22-105890. For more information, contact Sharon Silas at (202) 512-7114 or silass@gao.gov.

Chair Speier, Ranking Member Gallagher, and Members of the Subcommittee:

I am pleased to be here today to discuss preliminary observations from our ongoing work examining the Defense Health Agency's (DHA) monitoring of the qualifications and competence of health care providers within the Military Health System. Within the Department of Defense (DOD), DHA supports the delivery of health care to beneficiaries, including service members and their families, at military medical treatment facilities. These health care services are delivered by physicians, dentists, and other providers and range from routine examinations to complex surgical procedures. In 2014, news articles highlighted concerns about medical errors and lapses in patient safety at military medical treatment facilities, including failures to review serious patient safety events, such as the misdiagnosis of a life-threatening condition.[1] In August 2014, DOD released a review of the Military Health System that addressed patient safety, among other issues.[2] DOD's review concluded that the Military Health System generally provided safe, quality, and timely care, but noted considerable variation.

Congress and DOD have since taken steps intended to strengthen accountability, transparency, and standardization in the Military Health System. In particular, in the National Defense Authorization Act for Fiscal Year 2017, Congress mandated that DHA assume the military departments' administrative responsibilities for military medical treatment facilities.[3] In August 2019, DHA issued standardized clinical quality management procedures intended to ensure that individual providers are qualified and competent to deliver safe, high quality care to patients

[1]Sharon LaFraniere,"Military Hospital Care Is Questioned; Next, Reprisals," *The New York Times* (Dec. 20, 2014) accessed March 17, 2022, https://www.nytimes.com/2014/12/21/us/military-hospital-care-is-questioned-next-reprisals.html?_r=1 and Sharon LaFraniere and Andrew Lehren,"In Military Care, A Pattern of Errors but Not Scrutiny" *The New York Times* (June 28, 2014) accessed March 14, 2022, https://www.nytimes.com/2014/06/29/us/in-military-care-a-pattern-of-errors-but-not-scrutiny.html.

[2]Department of Defense, *Final Report to the Secretary of Defense MHS Review* (Washington, D.C.: Aug. 29, 2014).

[3]See 10 U.S.C. § 1073c.

across all military departments.[4] Under these procedures, for example, facilities are to review providers' credentials and any concerns about the care they deliver that may emerge from routine monitoring or the occurrence of patient safety events. Additionally, DHA reviews providers involved in patient safety events that result in compensation to patients or their families.

My testimony today is based on our ongoing examination of DHA's procedures for ensuring individual providers are qualified and competent to deliver health care in the Military Health System. This statement provides preliminary observations on

1. selected facilities' and DHA's adherence to its clinical quality management procedures, and
2. DHA's monitoring of selected facilities' adherence to these procedures.

To examine adherence to DHA procedures, we reviewed relevant DHA procedures for clinical quality management. Our review included procedures for credentialing and privileging providers; focused evaluations of providers when concerns arise; and reviews of patient safety events. We interviewed relevant officials from DHA and each of the military departments (Air Force, Army, and Navy) about these procedures and about DHA and the departments' monitoring of the procedures. We also reviewed documentation of facility implementation of these procedures from four selected facilities and assessed it for adherence to the DHA procedures. We selected the four facilities to include representation from each of the military departments; a range in the number of certain types of patient safety events at each facility, as reported by DHA and the military departments; and geographical

[4]See Department of Defense, Defense Health Agency, *Defense Health Agency Procedures Manual 6025.13: Clinical Quality Management in the Military Health System,* Volumes 3: Healthcare Risk Management and 4: Credentialing and Privileging (Falls Church, Va.: Aug. 29, 2019). In December 2020, we issued a report summarizing the August 2019 DHA procedures manual. See GAO, *Military Health Care: Defense Health Agency Processes for Responding to Provider Quality and Safety Concerns*, GAO-21-160R (Washington, D.C.: Dec. 1, 2020).

distribution.[5] These selected facilities also had at least 100 providers, such as physicians and dentists, who were privileged to deliver health care services.

For credentialing and privileging, we selected a nongeneralizable sample of 100 providers to include variation in appointment type (including military, civilian, and contract providers) and clinical specialties (such as family medicine and surgery). We reviewed all focused evaluations from the four selected facilities that were initiated between October 1, 2019, and March 1, 2021. We also reviewed all patient safety events that occurred at the four selected facilities between October 1, 2019, and March 1, 2021, and for which the facilities conducted potentially compensable event reviews, which are reviews to determine whether a provider's care caused or contributed to an event that is likely to result in a payment to the patient or their family. Additionally, for the patient safety events within our review that resulted in payments, we reviewed DHA documentation and assessed it for adherence to DHA's procedures.[6]

The ongoing work on which this statement is based is being conducted 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 preliminary findings and conclusions based on our audit objectives.

[5]According to DHA procedures, the term "patient safety event" includes adverse events, no-harm events, near miss events, and unsafe conditions. Adverse events are events that resulted in harm to the patient, and may occur by either the omission or commission of medical care. DHA defines no-harm events as events that "reach" (or involve) the patient, but did not cause harm. Near miss events are events that did not reach the patient. Unsafe conditions are conditions or circumstances other than a patient's own disease process or condition that increases the probability of an adverse event.

[6]As of March 2022, the military departments are continuing to support implementation of certain clinical quality management procedures in their respective military medical treatment facilities, including performing some of the DHA responsibilities for patient safety events that result in payment. However, because DHA ultimately has the authority and responsibility for implementation of the procedures, we generally refer to DHA in this testimony statement.

Background

In October 2019, DOD established a timeline to implement DHA's administrative authority over all domestic military medical treatment facilities. Between October 2019 and March 2021, all three of the military departments continued to support DHA by administering facilities' implementation of the DHA procedures for clinical quality management. Army and Air Force provided such support until March 2021 and October 2021, respectively. As of March 2022, Navy continues to provide support until DHA is ready to assume responsibility, which is expected no later than October 2022.

DHA's clinical quality management procedures include (1) credentialing and privileging, (2) focused professional practice evaluations for cause, and (3) reviews of patient safety events.

Credentialing and privileging. Credentialing and privileging is an important means by which health care organizations gain assurance that providers deliver competent and safe care. During credentialing, facility staff verify that a provider's professional credentials—such as medical licenses—are valid and appropriate for their requested clinical privileges. During privileging, facility staff grant permission and responsibility to a health care provider to perform specified health care services at a medical facility, such as performing moderate or deep sedation.

As part of credentialing and privileging, facility staff must verify that providers' medical licenses are in good standing, review information about their past performance, and query national databases that may contain potentially adverse information, including malpractice claims history, before granting providers privileges, among other things.

Focused professional practice evaluations for cause (focused evaluation). When concerns about a provider's clinical abilities arise, such as from a patient complaint or involvement in a patient safety event, facility staff may place them on a focused evaluation for a period of enhanced monitoring. These evaluations are intended to help providers improve their skills in response to such concerns. Providers who improve their performance during the focused evaluation may return to the routine, ongoing performance monitoring cycle. However, if the providers fail to meet performance criteria, the focused evaluations may be extended or, if concerns are significant, may result in adverse privileging actions, such as restriction or removal of privileges.

Reviews of patient safety events. DHA requires that facility staff review patient safety events—regardless of whether the patient was harmed—for which there is a likelihood of financial loss to the government, such as with an active-duty disability or death payment to a service member or their family, or with a potential or filed malpractice claim.[7] In such reviews of these potentially compensable events, facility staff identify providers who were significantly involved in the event and determine whether each of these providers delivered care that was consistent with standards.[8] DHA requires facility staff to consider actions against the significantly involved providers at two points in the review.

- First, at the initiation of the review, facility staff must document consideration of whether the event was so egregious that it warrants an investigation for adverse privileging action, which involves removing the provider from care and potentially reducing or revoking the provider's privileges to deliver health care.
- Second, if the completed review determines that the provider did not meet the standard of care, a committee of providers at the facility—referred to as the credentials committee—must consider additional actions, such as an adverse privileging action or placing the provider on a focused evaluation.

[7]Active-duty service members who become retired or separated from service for physical disability may receive a disability payment as compensation. Similarly, when active-duty service members die, their beneficiaries may receive death benefit payments as compensation. A medical malpractice claim could be filed, for example, if during the course of treatment, a provider deviates from accepted norms of practice and causes or contributes to an injury or death to the patient. Although any beneficiary could file a medical malpractice claim, prior to enactment of the National Defense Authorization Act of Fiscal Year 2020, DOD could only settle and pay such claims filed by or on behalf of non-active-duty service member patients, such as family members. The law was changed to allow DOD to settle and pay such claims filed by or on behalf of active-duty service members on or after January 1, 2020. Pub. L. No. 116-92, § 731, 133 Stat. 1198, 1457-1460 (2019).

[8]Standard of care determinations are based on the established standards of healthcare delivery at the time of the event, and may be based on professional literature, professional organization or society publications, facility policies and processes, and applicable healthcare laws.

DHA requires facilities to document information about the potentially compensable event review in a centralized database and complete the review within 180 days.[9]

In the event that a patient safety event results in a payment for medical malpractice or an active-duty service member's death or disability, information from the potentially compensable event review is used to inform whether DHA reports a significantly involved provider to the National Practitioner Data Bank.[10] With events resulting in payment, DHA must conduct additional steps to inform this reporting decision, and must do so within 270 days of payment or notification of payment.[11] These steps depend on the facility's standard of care determination.

- If the facility determined that the provider met the standard of care, DHA must obtain an external review by a contractor to provide a second opinion. If the external reviewer also finds that the provider met the standard of care, the case may be closed.
- If either the facility or external review determines that the provider did not meet the standard of care, then a DHA panel of clinicians reviews the case and recommends whether to report the provider to the National Practitioner Data Bank.

Preliminary Observations Suggest Selected Facilities and DHA Do Not Always Adhere to Clinical Quality Management Procedures

Our preliminary observations from ongoing work indicate that the four selected military treatment facilities and DHA do not always adhere to the

[9]Facilities are required to complete the potentially compensable event review within 180 days of notification of the event.

[10]The National Practitioner Data Bank is an electronic repository administered by the U.S. Department of Health and Human Services that collects and releases information on providers, including having been named in a medical malpractice payment.

[11]The DHA procedures manual requires DHA to report all significantly involved providers to the National Practitioner Data Bank, within 180 days of payment notification, unless DHA has made a final determination that the outcome was not caused or contributed to by the failure of the provider to meet the standard of care. However, for cases that would have reached the 180-day threshold between October 1, 2020, and March 31, 2022, DOD issued a waiver extending the deadline to 270 days from the date of payment or notification of payment.

DHA procedures for clinical quality management, related to (1) credentialing and privileging, (2) focused evaluations, and (3) patient safety events that may, or did, result in payment to patients or their families.

Credentialing and Privileging

Our ongoing review of documentation for a sample of 100 providers across the four selected facilities shows that these facilities did not always adhere to DHA procedures for credentialing and privileging, which are necessary to verify provider qualifications and clinical competency. For example:

Active licenses. The documentation we reviewed for our sample of providers shows that for about one-sixth of the selected providers, the selected facilities did not adhere to the DHA requirement to verify all medical licenses before granting privileges. For example, in one instance, a provider had ten medical licenses but the facility only verified eight of those licenses before granting privileges. In other instances, the facilities could not provide documentation that they verified any licenses before granting privileges to a provider.

Ongoing performance monitoring. The documentation we reviewed also shows the selected facilities did not adhere to the DHA requirement to conduct and document ongoing performance monitoring every 6 months for three quarters of the applicable providers we reviewed.

Without conducting required credentialing and privileging procedures, such as verifying all medical licenses and reviewing performance information, medical facilities run the risk of granting privileges to a provider who is unqualified to provide competent care.

Focused Evaluations

Our ongoing review of 20 focused evaluations that were initiated between October 1, 2019 and March 1, 2021 at the four selected facilities shows that these facilities did not consistently adhere to DHA procedures. For example, the selected facilities inconsistently documented two required elements in their written plans for evaluating concerns about providers: metrics and criteria. These two elements are intended to make clear what skills the provider and supervisor must focus on in order for the provider to be deemed successful in completing the focused evaluation. However,

the selected facilities in our review included metrics about half the time and criteria in roughly one third of cases. If the provider and supervisor do not understand the criteria for success, providers may be returned to regular performance monitoring before they have adequately addressed the areas in which concerns were raised.

Patient Safety Events

Our ongoing work indicates that the four selected facilities did not always adhere to procedures for reviewing 19 patient safety events. These 19 events, which occurred between October 1, 2019 and March 1, 2021, were those that facilities determined may result in future payments to patients or their families (i.e., a potentially compensable event) but had not resulted in payments at the time of our review. Further, our ongoing work also indicates that DHA did not adhere to certain required procedures for reviewing an additional 12 patient safety events that occurred at the four facilities during the same time frame and did result in payments.

Specifically, we found the selected facilities did not adhere to DHA requirements for these 19 potentially compensable event reviews in two key areas. First, at the initiation of the reviews, the selected facilities did not document their consideration of whether to remove the provider from care and take adverse privileging action against any of the providers in our review. While such actions may be limited to rare instances of egregious patient safety events, the procedures manual specifies that the decision for or against such action must be documented, which helps to ensure that this option is being considered. Second, the selected facilities did not always complete the reviews within 180 days of notification, as required by DHA procedures.[12] Our preliminary analysis indicates that the number of days to completion ranged from 91 to 546, with over 80 percent of the reviews exceeding 180 days. Without considering actions against providers or conducting these reviews in a timely manner, facilities are neither gleaning important information about the quality and safety of care delivered by individual providers within the military health system nor conducting required procedures intended to help prevent these events from occurring in the future.

[12]DHA requires facilities to complete the potentially compensable event review within 180 days of notification of the event.

For the 12 patient safety events that did result in payment, DHA did not always adhere to its own procedures. Specifically, DHA did not always 1) complete their reviews within required time frames or 2) report providers to the National Practitioner Data Bank when the reviews exceeded time frames, as required under DHA procedures.[13] For example, for about half of the cases from the four selected facilities, the DHA reviews were incomplete and had exceeded the requirement to complete the reviews within 270 days of payment notification. Specifically, the payments in these ongoing cases were made between 420 and 746 days before DHA provided us with information in February 2022. However, DHA officials told us they had not reported providers whose reviews exceeded 270 days, as required.

Moreover, our preliminary analysis indicates that the delay in completing these cases occurred between the completion of the facility-level standard of care review and the initiation of the DHA review. In half of the cases, DHA initiated its reviews after our inquiry about the status of these patient safety event reviews. DHA officials indicated that they are exploring the possibility of obtaining a waiver to retrospectively extend the amount of time that DHA is allowed before being required to report these providers to the National Practitioner Data Bank. Officials said they were seeking this waiver to avoid reporting providers to the National Practitioner Data Bank due to administrative delays that the providers cannot control. However, DHA's failure to report providers in a timely manner to the National Practitioner Data Bank may inappropriately shield them from professional accountability because other health care organizations that may consider granting privileges to such providers would lack complete information about the providers' professional history.

[13]The DHA procedures manual requires DHA to report all significantly involved providers to the National Practitioner Data Bank, within 180 days of payment notification, unless DHA has made a final determination that the outcome was not caused by or did not contribute to the failure of the provider to meet the standard of care. However, for cases that would have reached the 180-day threshold between October 1, 2020, and March 31, 2022, DOD issued a waiver extending the deadline to 270 days from the date of payment or notification of payment.

Preliminary Observations Suggest DHA Does Not Sufficiently Monitor Facilities' Adherence to Its Clinical Quality Management Procedures

Our preliminary observations based on our ongoing work indicate that DHA does not sufficiently monitor facilities' implementation of its procedures for credentialing and privileging, focused evaluations, and patient safety event reviews.

- **Credentialing and privileging.** As of March 2022, DHA officials said they run reports from the database on the number of certain types of credentials, such as licenses, that are expired. However, such reports would not allow DHA to identify some of the instances of nonadherence to procedures for which documentation is not stored in the centralized database, such as for ongoing performance monitoring.
- **Focused evaluations.** As of March 2022, DHA officials told us they do not currently review facilities' documentation to ensure that the facilities are adhering to these procedures. DHA officials said they are currently developing an approach to obtain information from facilities about focused evaluations, which are also not stored in the centralized database, and randomly audit a sample of them.
- **Potentially compensable event reviews.** DHA officials said they have not yet begun monitoring facilities' implementation of its procedures for reviews of cases that do not result in payments, such as whether facilities are considering actions against providers at required points or conducting their reviews in accordance with the timeliness requirements. As of March 2022, DHA officials said that their office is still ramping up capacity to monitor potentially compensable event reviews, and they are currently focusing their efforts on monitoring cases that resulted in payments.
- **Patient safety events that resulted in payments.** While DHA reviews facilities' documentation of patient safety events that result in payments, our preliminary observations indicate that DHA lacks complete information about the cases that require its review. DHA officials described challenges to obtaining information about all active-duty service members' death and disability payments, including difficulty obtaining access to this information from within DOD and

identifying the payments that were related to health care.[14] However, DHA officials also said that they are considering requesting access to this information from DOD, particularly now that DHA has the staff to conduct these reviews. In the meantime, DHA officials said they rely on information entered into the centralized database by facility staff, which we have found is not always complete.

In conclusion, DHA has procedures in place to help ensure that individual providers are qualified and competent to deliver health care services to service members and their families, as well as ensuring that concerns that arise about providers' clinical care are reviewed and addressed. However, our preliminary observations from our ongoing work show that facilities do not always adhere to these procedures and that DHA does not monitor for adherence. We plan to complete this work in summer 2022 and will make recommendations as appropriate.

Chair Speier, Ranking Member Gallagher, and Members of the Subcommittee, this completes my prepared statement. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Sharon M. Silas, Director, Health Care at (202) 512-7114 or silass@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are Ann Tynan (Assistant Director); Kaitlin M. McConnell (Analyst-in-Charge); Bianca Eugene; Jacquelyn Hamilton; Jeanne Murphy-Stone; Vikki Porter; Cathy Hamann Whitmore; and Zoe Ziliak Michel.

[14]DHA officials stated that most of active-duty service member death and disability payments are not related to health care and thus do not require facilities to conduct a potentially compensable event review or DHA review of the case. Officials explained that each case would need to be reviewed by a clinician to determine its relevance to these procedures.

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