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VA HEALTH CARE

Improved Oversight and Compliance Needed for Physician Credentialing and Privileging Processes

GAO Accountability·Integrity·Reliability

Highlights

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

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.