Evaluation Report

DOD IMPLEMENTATION OF THE
NATIONAL PRACTITIONER DATA BANK GUIDELINES

Report Number 98-168 June 26, 1998

Office of the Inspector General
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Acronyms

AFIP	Armed Forces Institute of Pathology
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CCQAS	Centralized Credentials Quality Assurance System
DHHS	Department of Health and Human Services
DPDB	Defense Practitioner Data Bank
JAG	Judge Advocate General
MTF	Military Treatment Facility
NPDB	National Practitioner Data Bank
QPRAC	Query for Practitioners

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June 26, 1998

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE
(HEALTH AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY
(FINANCIAL MANAGEMENT AND COMPTROLLER)
ASSISTANT SECRETARY OF THE AIR FORCE
(FINANCIAL MANAGEMENT AND COMPTROLLER)
AUDITOR GENERAL, DEPARTMENT OF THE ARMY

SUBJECT: Evaluation Report on DoD Implementation of the National Practitioner Data Bank Guidelines (Report No. 98-168)

We are providing this report for review and comment. We considered management comments on a draft of this report in preparing the final report.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. As a result of management comments, we revised Recommendation A.2.a. We request that the Assistant Secretary of Defense (Health Affairs) reconsider her position on Recommendations A.1.a.(2), A.1.b.(1), and A.1.b.(2). In addition, we request that the Army and the Navy provide implementation plans and dates for Recommendations C.1. and C.2. Management should provide comments by August 26, 1998.

We appreciate the courtesies extended to the evaluation staff. Questions on the evaluation should be directed to Mr. Michael A. Joseph at (757) 766-9108 (email mjoseph@dodig.osd.mil), or Ms. Betsy Brilliant at (703) 604-8875 (DSN 664-8875) (email bbrilliant@dodig.osd.mil). See Appendix H for the report distribution. The evaluation team members are listed on the inside back cover.

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Office of the Inspector General, DoD

Report No. 98-168 **June 26, 1998**
(Project No. 7LH-0009)

DoD Implementation of the National Practitioner Data Bank Guidelines

Executive Summary

Introduction. This evaluation was requested by the Assistant Secretary of Defense (Health Affairs) (ASD[HA]). The National Practitioner Data Bank (NPDB) is a Federal database that collects and releases information relating to the professional competence and conduct of physicians, dentists, and other healthcare practitioners and providers. It is intended to improve the quality of healthcare by restricting the ability of incompetent healthcare practitioners and providers to move from State to State without disclosure or discovery of their previous damaging or incompetent performance.

Evaluation Objectives. The primary evaluation objective was to determine the Military Departments' overall effectiveness in implementing the NPDB program guidelines. In addition, we assessed the DoD programs, policies, procedures, and practices for identifying, processing, and reporting to the NPDB those healthcare practitioners and providers associated with malpractice payments or subjected to adverse privileging actions. We reviewed the management control program as it applied to the implementation of NPDB guidelines in DoD.

Evaluation Results. DoD has made progress in implementing the NPDB guidelines. Initiatives by all three Military Departments resulted in improvements in the processing time for reporting adverse privileging actions. In addition, the communication between the Air Force medical and legal communities is commendable. However, improvements were still needed in reporting malpractice payments and adverse privileging actions to the NPDB, and in reporting to the Defense Practitioner Data Bank (DPDB).

o Although DoD reporting of malpractice payments to the NPDB needs improvement, it conforms to DoD policy, which mandates only partial reporting. Of the 124 malpractice payment records reviewed, 87 (70 percent) had not been reported to the NPDB. In addition, those reported had not been submitted in a timely manner. As a result, the NPDB had incomplete and untimely information and, when the NPDB was queried, healthcare entities did not have all relevant information available for making credentialing and privileging decisions (Finding A).

o Although the Military Departments were reporting physicians and dentists, the specific adverse privileging actions reported varied widely. In addition, the Military Departments did not report the actions taken in a timely manner. As a result, healthcare entities querying the NPDB did not have all relevant information available when making credentialing or privileging decisions (Finding B).

o The DPDB did not contain records that had been reported to the NPDB. Of 1,150 malpractice payments in our sample database, 88 (8 percent) were found only in the NPDB, and 90 of the 220 (41 percent) adverse privileging actions in the sample database were found only in the NPDB. When reports were sent to both data banks, key information was different. As a result, there was no complete, accurate, automated database within DoD for conducting clinical and malpractice analyses (Finding C).

See Appendix A for details on the management control program.

Summary of Recommendations. We recommend that the ASD(HA) enter into a memorandum of understanding with the Department of Justice to obtain more timely and complete information on malpractice payments and to reconcile outstanding claims on a quarterly basis. In addition, we recommend that the ASD(HA) revise the policy regarding NPDB reporting on malpractice payments and adverse privileging actions. We recommend the Military Departments' Surgeons General identify the information needed from the Department of Justice and the Military Departments' Judge Advocates General. We further recommend that the Surgeons General reconcile the DPDB and the NPDB and implement procedures to ensure that reports are submitted to the DPDB concurrent with NPDB reporting.

Management Comments. The ASD(HA) concurred with the recommendation to enter into a memorandum of understanding with the Department of Justice. The Assistant Secretary stated that the memorandum of understanding will specify the type of malpractice information the Military Departments require to efficiently process paid malpractice claims. The ASD(HA) nonconcurred with the recommendation to change DoD policy to report all malpractice payments or to report those payments within 30 days of notification. To facilitate NPDB reporting, the ASD(HA) has implemented policy whereby all paid [malpractice] cases determined to meet the standard of care or are attributable to a systems problem will be peer reviewed by an external civilian agency. The ASD(HA) stated that the DoD reporting policy was established in an effort to level the playing field between DoD healthcare practitioners and practitioners in the civilian community. Further, the civilian community protects healthcare practitioners by using a "corporate shield" whereby the practitioner's name is deleted from the claim and instead the claim is filed against the corporation. Finally, the ASD(HA) stated that 120 days rather than 30 days is necessary to allow adequate time to report malpractice payments. The ASD(HA) concurred with the recommendations for status reporting by the Surgeons General, NPDB reporting in its management control plan, and revising adverse privileging actions reporting policy. The Assistant Secretary stated that the DoD Risk Management Committee will be responsible for monitoring and tracking NPDB reporting.

The Military Departments concurred with all the recommendations except the recommendations to report all malpractice payments within 30 days. The Army stated that the small number of reports submitted was related to administrative problems, not current policy. The Navy and the Air Force stated that reporting the involved practitioners when the standard of care was not met complies with NPDB policy of reporting malpractice payments made on behalf of a practitioner. The Military Departments also requested that the malpractice payments reporting deadline be extended to 90 to 120 days. The Navy and the Air Force partially concurred with the recommendation on reporting payment information by the Judge Advocates General to the Surgeons General; but requested that the deadline be extended to 45 days. Further,

the Air Force agreed to reconcile data differences between the NPDB and the DPDB by hiring a full-time database manager to be responsible for malpractice and adverse action databases. See Part I for a discussion of management comments and Part III for the complete text of those comments.

Evaluation Response. Comments from the ASD(HA), the Army, the Navy, and the Air Force were partially responsive. We recognize the ASD(HA) and Military Departments' position that DoD should report only malpractice payments made on behalf of the practitioner. However, we believe that implementation of our recommendation to report all malpractice payments is necessary to bring DoD into compliance with the intent of the public law. In addition, the original memorandum of understanding between DoD and the Department of Health and Human Services stated that DoD would report all malpractice payments. We see no need to revise the deadline for reporting malpractice payments from 30 days to 120 days because the additional time is needed only if limited reporting continues. If all malpractice payments are reported, 30 days from notification of payment is sufficient. Based on management comments, we revised the recommendation for reporting by the Judge Advocates General to the Surgeons General by extending the reporting period to 45 days. We request that the ASD(HA) reconsider her position and provide additional comments and that the Army and the Navy provide implementation plans and dates in response to the final report by August 26, 1998.

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Part I - Evaluation Results

Evaluation Background

This evaluation was requested by the Assistant Secretary of Defense (Health Affairs) (ASD[HA]).

Creation of the National Practitioner Data Bank. The Health Care Quality Improvement Act of 1986, November 14, 1986, authorized the Secretary of the Department of Health and Human Services (DHHS) to establish a data bank to collect and release information relating to the professional competence and conduct of physicians, dentists, and other healthcare practitioners and providers.[1] The Act also authorized the Secretary of the DHHS to enter into a memorandum of understanding with the Secretary of Defense. Congress intended to improve the quality of healthcare by restricting the ability of incompetent healthcare practitioners and providers to move from State to State without disclosure or discovery of their previous damaging or incompetent performance.

The DHHS established the National Practitioner Data Bank (NPDB) on September 1, 1990. The NPDB is a system of computerized records maintained for DHHS by a contractor. It is not intended to be the primary source of practitioner information; rather, it supplements information available from other sources so healthcare entities can make credentialing and privileging decisions. Healthcare entities use the NPDB for reporting actions in accordance with guidelines and for querying.

NPDB Reporting. Three general categories of information are reportable to the NPDB.

o **Adverse Privileging Actions.** Healthcare entities are required to report any adverse privileging action taken against a physician or dentist lasting more than 30 days.

o **Licensure Actions.** State licensing boards are required to report any revocation, suspension, or other restriction of a practitioner's license.

o **Medical Malpractice Payments.** Insurance carriers are required to report within 30 days any payment they make on the behalf of a healthcare practitioner.

NPDB Querying. Healthcare entities query the NPDB to obtain any relevant adverse information regarding a particular practitioner's professional competence or conduct.

DoD Policy about the NPDB. On September 21, 1987, prior to the issuance of any implementing NPDB guidance, DoD and DHHS signed a memorandum of understanding outlining DoD participation in a national reporting system. After

[1] "Healthcare practitioner" refers to any healthcare professional required to be licensed to practice. "Healthcare provider" refers to any licensed healthcare professional required to be privileged by a facility to practice at the facility. See Appendix F for definitions of healthcare terms used in this report.

DHHS issued the NPDB guidelines, DoD released DoD Directive 6025.14, "Department of Defense Participation in the National Practitioner Data Bank," November 1, 1990, which requires DoD healthcare entities to participate in the NPDB. DoD Instruction 6025.15, "Implementation of Department of Defense Participation in the National Practitioner Data Bank," November 9, 1992, provides additional policy, procedures, and informational requirements.

NPDB reporting is the responsibility of the Military Departments' Surgeons General. Although malpractice claims and adverse privileging actions originate at a military treatment facility (MTF), when a final reporting decision is made, that decision is reviewed and approved by the appropriate Surgeon General before being reported to the NPDB.

Defense Practitioner Data Bank. DoD established the Defense Practitioner Data Bank (DPDB) in 1982 for risk management. The DPDB is operated by the Department of Legal Medicine, Armed Forces Institute of Pathology (AFIP), Office of the ASD(HA). The DPDB is composed of two databases, one for malpractice payments and the other for adverse privileging actions. AFIP performs risk management analyses of the databases to assist the ASD(HA) in implementing policy changes designed to improve the quality of healthcare. The DPDB operates independent of the NPDB.

ASD(HA) Proposals for Congress. On November 6, 1997, the ASD(HA) testified before the National Security Subcommittee, House Appropriations Committee, U.S. House of Representatives, regarding trust in military physicians and the DoD healthcare system. One issue addressed in the testimony was DoD implementation of the NPDB. Specifically, the ASD(HA) stated that he had requested the Office of the Inspector General, DoD, to audit compliance of NPDB reporting and that he had taken actions to improve reporting. The first improvement was to require the Military Departments to eliminate their backlogs of malpractice payment cases as soon as possible. Second, he proposed an external civilian panel to review all malpractice payments for which the Military Departments indicated the standard of care was met or was attributable to a system problem. Whenever the civilian panel disagrees with the Military Department, the Surgeon General will make the final disposition.

Evaluation Objectives

The objectives of the evaluation were to:

o determine the Military Departments' overall effectiveness in implementing the NPDB guidelines;

o assess DoD programs, policies, procedures, and practices for identifying, processing, and reporting to the NPDB those practitioners and providers associated with malpractice payments or subjected to adverse privileging actions; and

o assess the management control program as it applies to the implementation of NPDB guidelines in DoD.

See Appendix A for details on the evaluation scope and methodology, review of the management control program, and summary of prior coverage. Appendix B contains the details of an Inspector General, DoD, nonconcurrence to a draft revision of the DoD policies and procedures for reporting to the NPDB.

Finding A. DoD Reporting of Malpractice Payments

DoD reporting of malpractice payments to the NPDB needs improvement. Of 124 malpractice payment records reviewed, 87 (70 percent) had not been reported to the NPDB. In addition, those reported had not been submitted in a timely manner. The limited reporting occurred because DoD policy requires reports for malpractice payments only when the Surgeon General determines a specific practitioner deviated from an accepted standard of care. The timeliness problem resulted from a lack of definitive policy on time frames for reporting and weaknesses in the reporting process. As a result, the NPDB had incomplete and untimely information and, when the NPDB was queried, healthcare entities did not have all relevant information available for making credentialing and privileging decisions.

Malpractice Payment Reporting Policies

DHHS Policy. The primary policy outlining DHHS requirements for reporting malpractice payments to the NPDB is Title 45, Code of Federal Regulations, Part 60, "National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners," October 17, 1989. It specifies that a report is to be sent to the NPDB whenever a malpractice payment is made on behalf of a healthcare practitioner. Reports to the NPDB must be submitted within 30 days from the date of payment. Reports are sent regardless of how the matter was settled (arbitration, court judgment, or settlement). However, healthcare practitioners are not required to report any payment personally made to settle a malpractice claim. Claims paid on behalf of a clinic, group, or hospital are also not reported to the NPDB. We have been informed by DHHS staff members that they are in the process of revising the procedures for the private sector to require all malpractice payments to be reported, even those on behalf of clinics, groups, hospitals, and other corporations. In addition, the specific practitioner associated with the payment will still be identified.

Title 45, Code of Federal Regulations, Part 60, is based on the Health Care Quality Improvement Act of 1986 (Public Law 99-660). The legislative history of the public law clearly shows the congressional committee creating the law understood that malpractice data is to be viewed with caution and that malpractice payments are only clues to a practitioner's history. But, understanding those limitations, the committee felt malpractice data would prove extremely useful. The committee also understood that there are claims that have little merit with respect to medical services that meet or exceed acceptable standards of medical care, but because they can be resolved economically, it makes sense to settle rather than litigate them. However, the committee still chose not to except those "nuisance" claims from reporting. Finally, the committee was very clear that they wanted DHHS to enter into a memorandum of understanding with DoD to implement the reporting provisions of the public law so physicians identified and traced under the law would not "disappear" into DoD.

DoD Policy. Two key DoD policies outline the requirements for reporting malpractice payments to the NPDB: DoD Directive 6025.14 and DoD Instruction 6025.15. In addition, each Military Department has implementing policies based on the DoD Directive and Instruction. Appendix C contains additional information regarding the Military Department policies.

In addition to DoD policy on NPDB reporting, three Federal laws and one Supreme Court decision specifically prescribe who can submit a malpractice claim, who is liable, and the process for submitting a claim against the Federal Government and DoD. Those are the Federal Tort Claims Act, the Gonzales Act, the Military Claims Act, and the Feres Doctrine. As a result of those laws and doctrine, all malpractice payments are made on behalf of the U.S. Government and a specific practitioner cannot be named in the claim or the lawsuit. Therefore, senior staff within the Office of the ASD(HA) concluded that since malpractice payments are not made on behalf of any practitioners, no reporting is required. However, by reporting those practitioners who fail to meet an acceptable standard of care, DoD believes it is meeting the intent of the law. We believe that the congressional requirement for a memorandum of understanding between DHHS and DoD to implement the section of the law addressing NPDB reporting demonstrates that Congress intended for DoD to report all malpractice payments. Appendix D contains additional details about the laws and the Supreme Court decision.

Malpractice Payment Processing Procedures

Military Department Procedures. The Military Departments have established procedures to process malpractice claim payments and submit reports to the NPDB. The procedures were based on the organizational structures of their legal and medical departments, as well as circumstances that were unique to the Military Department. Although the specific procedures were different for each Military Department, the procedures were based on DoD policies for processing malpractice payments and reporting to the NPDB. The procedures required, at a minimum:

- o submission of a Standard Form 95, "Claims for Damages, Injury, or Death";
- o investigation of the circumstances regarding the claim by MTF staff;
- o reviews of the allegations of the claim by medical and legal personnel;
- o determinations of standard of care;[2]

[2]See Appendix F for a definition.

o notification to the practitioners involved requesting their input on the care related to the claim; and

o reporting to the NPDB, as appropriate, after payment is made, based on the review and recommendation of the Surgeon General review panel and the final determination by the Surgeon General.

Appendix C provides additional information about the procedures used by the Military Departments for processing malpractice claims and reporting malpractice payments to the NPDB.

Private Sector Procedures. Reporting in the private sector is usually done by the insurance company that made the malpractice payment on behalf of a practitioner. Because all payments are reported, standard of care determinations are not a factor in the reporting decision.

DoD-Unique Procedures. Unlike the private sector, malpractice claims and lawsuits against DoD are handled by two organizationally separate entities; submissions to the NPDB are handled by a third separate entity. The Military Departments' Judge Advocates General (JAGs) can independently handle malpractice claims of up to $200,000. Claims exceeding $200,000 are handled by the Military Departments' JAGs with approval from the Department of Justice. Lawsuits are handled within the Department of Justice by U.S. Attorneys with the support of the Military Departments' JAGs. Neither is involved in NPDB reporting. If any payments result, reporting to the NPDB is done by the Military Departments' Surgeons General. However, the Surgeons General are not involved in malpractice claims processing or payment.

Malpractice Payments. AFIP estimated that between 800 and 1,000 malpractice cases are closed each year and about half result in payments. During the period 1992 through 1996, an average of 354 malpractice payments (172 Army, 71 Navy, and 111 Air Force) were made through the Judgment Group Fund, Department of Treasury.[3] During that same period, an average of 52[4] malpractice payment reports (6 Army, 9 Navy, and 38 Air Force) were sent to the NPDB.

[3]The Judgment Group Fund includes all payments made under the Federal Tort Claims Act exceeding $2,500. It does not include the small number of payments under $2,500 or payments made under the Military Claims Act.

[4]The difference between the sum of the individual Military Department averages and the overall average is due to rounding.

Reporting to the NPDB

As of December 31, 1997, the NPDB contained 136,624 malpractice payment reports. Of those, 321 were reported by DoD. Table 1, based on data from the NPDB, shows malpractice payments reported by calendar year and Military Department.

Table 1. Malpractice Payments Reported to the NPDB
(data as of December 31, 1997)

Year	Army	Navy	Air Force	Total
1990-1991[1]	3	0	9	12
1992	12	0	16	28
1993	13	10	56	79
1994	1	19	23	43
1995	0	4	43	47
1996	4	10	50	64
1997	3	9	36	48
Total	**36**	**52**	**233[2]**	**321**

[1]Period covers September 1, 1990, when NPDB reporting began, through December 31, 1991.

[2]The higher reporting by the Air Force does not reflect the quality of care provided, but instead reflects a better malpractice payments reporting process.

Reporting by the Military Departments

Military Department Reporting. DoD reporting of malpractice payments needs improvement. We sampled malpractice payments made after September 1, 1990.[5] Of 124 malpractice payment records reviewed, only 37 (30 percent) resulted in reports to the NPDB. For the remaining 87 records, most were not reported because, consistent with DoD policy, the Surgeons General determined that either the standard of care was met or there was a system error.[6]

[5]Appendix A contains details on the sample selection.

[6]A system error, according to current Military Department procedures, occurs when the death or injury is not caused by a practitioner or is the result of a failure in a standard operating procedure within a facility, such as mislabeled supplies or failure by the pharmacy to follow procedures for dosage verification.

Army Reporting Results. Of the 47 Army malpractice payments reviewed, only 9 (19 percent) had been reported to the NPDB. Of the 38 not reported, 26 showed the standard of care was met, 10 were identified as a system error, 1 had incomplete information and a reason for not reporting could not be identified, and 1 involved a partnership provider and was not reportable. Generally, the Surgeon General agreed with the determinations made by the various review panels. One claim in the sample was unique because three reviews, completed prior to the Surgeon General's decision, indicated the standard of care was not met; however, the Surgeon General determination was not to report.

Navy Reporting Results. Of the 30 Navy malpractice payments reviewed, 15 (50 percent) resulted in a report to the NPDB. Of the 15 payments not reported, 6 had no explanation in the files, 3 indicated the standard of care was met, 3 resulted from a system error, 2 were not reportable practitioners per Navy policy, and 1 was based on the Surgeon General's decision not to report even though the review panel recommended reporting to the NPDB.

Air Force Reporting Results. Of the 47 Air Force malpractice payments reviewed, 13 (28 percent) had been reported to the NPDB. Of the remaining 34 malpractice payments, 30 had not been reported because the standard of care was met, 2 were the result of system errors, and 2 were not reportable practitioners (resident and intern).

DoD Policy on What to Report. DoD policy does not require reporting when the standard of care is met or if the incident was the result of a system error. In the memorandum of understanding between DoD and DHHS, the ASD(HA) agreed to report all malpractice payments, even when the standard of care was met. However, when DoD implementing policy was issued, reporting malpractice payments was required only when the standard of care was not met and the incident was not the result of a system error. The ASD(HA) notified the Secretary of the DHHS on November 9, 1992, of the deletion of the provisions in the memorandum of understanding that were inconsistent with the DoD Instruction.

Current DoD policy requires a report be submitted to the NPDB when the malpractice payment is considered to be made for the benefit of a healthcare practitioner. That occurs if the practitioner was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment and one of the following circumstances was found to exist:

o the practitioner deviated from the standard of care in the act or omission, as determined by the Surgeon General;

o the payment was the result of a judicial determination of negligence and the Surgeon General supported the court's decision; or

o the payment was the result of an administrative or litigation settlement and the Surgeon General determined a report was required.

DoD does not send reports to the NPDB for administrative or litigation settlements that were due to circumstances outside the control of the practitioners, such as drugs mislabeled by the supplier, equipment or power failure, and accidents unrelated to patient care. Reports are also not sent to the NPDB if the settlement was based on administrative or litigation considerations rather than clear evidence that a practitioner was negligent.

Complying With NPDB Guidelines Would Result in More Reports. DoD policy restricts NPDB reporting to those malpractice payments occurring when standard of care was not met by a practitioner. The DoD policy does not comply with the NPDB policy of reporting all malpractice payments, whether the standard of care was met or not.

We agree that there are valid exceptions to reporting all malpractice payments to the NPDB. It would not be fair to report a practitioner when the payment was the result of circumstances outside the control of any practitioner. However, whenever any practitioner is involved, DoD should report the malpractice payment, even if the standard of care was met. Reports on malpractice payments made when the standard of care was met should include that information.

Timeliness of Reporting Malpractice Payments

DoD reporting of malpractice payments to the NPDB needs improvement. None of the Military Departments reported malpractice payments in a timely manner. However, because of the differences in the Military Department procedures, we did not compare the Military Departments to each other. Untimely reporting was the result of inadequate policy regarding time standards for reporting, plus delays due to three procedural problems. First, the offices of the Army and the Navy Surgeons General did not receive complete and timely information on malpractice payments. Second, the processes within the offices of the Surgeons General increased the processing time. Third, there was no oversight by the Office of the ASD(HA) to ensure reporting was being done in a reasonable time frame.

Overall Reporting by the Military Departments. The average time to process 31 malpractice payments varied by Military Department from 10.7 months to 26.3 months. Of 37 malpractice payments reported[7] to the NPDB, 31 had sufficient documentation to determine processing time.

Army Processing Time. For seven malpractice payments reviewed, the average time from payment date to report date was 10.7 months. The Army sample included nine malpractice payment reports sent to the NPDB. For two of those nine payments, the report submission date was not available, leaving seven for analysis. However, eight of the nine reports occurred prior to 1993. As a result, we concluded that the data did not adequately reflect recent Army processing time for malpractice payments. Therefore, we reviewed 39 records for which we had closure dates, whether the payment was reported to the NPDB

[7]Appendix A contains details on the sample selection.

or not. For those records, we calculated the period of time from the date of malpractice payment until the Surgeon General made a final reporting decision. The average processing time was 17.2 months.

The Army informed us that receiving complete and timely information from the agencies making the payments was a major problem. Unfortunately, one key date in the process not obtained was the date the U.S. Army Medical Command (Army Medical Command) received written notification of the malpractice payment from the Army JAG offices or the Department of Justice.

Navy Processing Time. For 11 malpractice payment records reviewed, the average processing time from payment until a report was sent to the NPDB was 26.3 months. The Navy sample included 15 malpractice payment reports sent to the NPDB; however, only 11 contained sufficient data for analysis. In a separate analysis of 17 malpractice payments that were complete, 7 of which had been reported to the NPDB, we identified the period of time from date of payment until the Navy Bureau of Medicine and Surgery (BUMED) was notified of the payment by the Navy JAG. The average time for notification, with all required payment information, was 8.1 months. Therefore, most of the time required to submit a report to the NPDB was within the BUMED purview to control.

Air Force Processing Time. For the 13 Air Force malpractice payment records reviewed, the average processing time from malpractice payment until NPDB reporting was 11.8 months. The majority of the sample records reviewed were reported prior to 1996, when the Air Force reengineered its malpractice payment reporting process. Therefore, we judgmentally selected nine malpractice payments in 1996 and 1997; three of the practitioners were reported to the NPDB. The average reporting time was 5.8 months. Since March 1996, receipt of complete payment information from the Air Force JAG has not been a significant problem.

DoD Policy on When to Report. DoD policies do not stipulate a time frame for reporting malpractice payments to the NPDB. In the private sector, reporting is required within 30 days of payment. However, since DoD malpractice payments are handled by agencies organizationally separate from the one responsible for reporting, 30 days is not a realistic policy for DoD. Two time frame standards are needed. First, a standard is needed from the time of payment, that is the date closed by the Military Department JAGs or the Department of Justice, until notification of payment is provided to the offices of the Surgeons General. Second, a standard is needed for the offices of the Surgeons General from the time they receive notification of the malpractice payment until they report to the NPDB.

Obtaining Complete Information. Obtaining incomplete information was one cause for the delay in reporting by the Army Medical Command and Navy BUMED. The Army indicated that it did not always receive sufficient information from the JAG to identify on whose behalf the payment was made. As a result, additional information was needed before any reporting could be completed. The Navy indicated that the JAG provided only minimal information about the malpractice payment. Detailed information supporting

the payment was needed by BUMED prior to completing the review package for the Surgeon General. The Army and the Navy indicated they needed more detailed information regarding payment, reasons for the outcome, and the practitioners associated with the payment.

The Air Force legal and medical organizations, at the base level, had internal processes to identify any practitioners associated with a potential malpractice claim. The Air Force Office of the Surgeon General did not rely on payment information to identify the practitioner associated with the malpractice payment made.

Obtaining Timely Information. Delay in obtaining timely information about malpractice payments from the Military Department JAGs and the Department of Justice was another reason for the lengthy amount of time the Army and the Navy took to submit reports to the NPDB. The Army Medical Command and Navy BUMED stated they are receiving malpractice payment information in a more timely manner. However, payment information should be provided to the Army Medical Command and Navy BUMED more frequently to further improve timeliness. For the Army and the Navy Surgeons General to report to the NPDB in a more timely manner, the Army and the Navy JAGs and the Department of Justice need to provide more timely support.

The Army Claims Service[8] within the Army JAG indicated it provides copies of letters concerning malpractice payments to the Army Medical Command at the same time as it notifies the claimant. The Army Medical Command indicated that it does not get the information that quickly. The Litigations Branch[9] in the Army JAG, which is separate from the Army Claims Service, also did not always provide timely payment information to the Army Medical Command. We examined a set of Litigations Branch memorandums providing malpractice payment information to the Army Medical Command. The memorandum dates ranged from 1.5 months to 7.5 months after the payment date.

The Navy JAG was notifying BUMED bimonthly instead of annually, which helped improve the process. However, even receiving reports every other month is not adequate to ensure timely processing of reports to the NPDB.

The Air Force Office of the Surgeon General had not experienced the timeliness problem because it had established strong communications with the Air Force JAG. This occurred, in part, because the Air Force JAG had a legal representative assigned to the Air Force Office of the Surgeon General. In addition, the JAG communicated regularly with the U.S. Attorneys working Air Force lawsuits. The JAG recognized the importance of timely payment information to the NPDB reporting process and, since March 1996, has reported malpractice payment information on a monthly basis. For malpractice payments made in calendar years 1996 and 1997, the average time from the date of payment to the date of notification of payment to the Office of the Surgeon General was 3.9 months and 1.8 months, respectively.

[8]The Army Claims Service is responsible for malpractice claims submitted to the Army.

[9]The Army Litigations Branch is responsible for lawsuits filed against the United States for Army malpractice incidents.

The ASD(HA) needs to increase dialog with the Department of Justice to improve the timely provision of payment information. The U.S. Attorneys were last officially notified of the requirement to report malpractice payments to the Military Departments in a July 1, 1992, memorandum, which referred to another memorandum dated November 1989. The November 1989 memorandum identified the information needed by the Military Departments and the addresses to send the information. That notification has been insufficient in ensuring the Military Departments receive payment information in a timely manner. Only the Air Force received timely information, and that was the result of regular communication by the Air Force JAG with the U.S. Attorneys.

Processing Within the Office of the Surgeon General. Processing within the Military Departments' offices of the Surgeons General added to the timeliness problem. Each Military Department had several reviews as part of the reporting determination process, as shown in Table 2. Those reviews were in addition to the Surgeon General reviews and any reviews done by the JAGs in support of the legal case. The Army had up to three reviews: an MTF review; a Consultant Case Review Branch review; and a review by a specialty panel at the Surgeon General level, as needed. The Navy had up to three reviews: a specialty review (previously completed at BUMED, now at the MTF level); a Surgeon General consultant review, as needed; and a review by the Professional Case Review Panel at the Surgeon General level. The Air Force had up to three reviews: a specialty review; the Surgeon General medical consultant review; and, as needed, a review by the Surgeon General Medical Practice Review Panel. Reporting all malpractice payments within 30 days of notification of payment, whether standard of care was met or not, may not eliminate the processes required by the Surgeons General.

Table 2. Military Department Standard of Care Reviews

Reviews	Army	Navy	Air Force
MTF	X	X	
Medical/Legal consultant	X		X
Surgeon General consultant		As Needed	X
Surgeon General review panel	As Needed	X	As Needed

Oversight. Another reason for untimely reporting was the lack of oversight by the Office of the ASD(HA). DoD Instruction 6025.15 states the ASD(HA) "shall ensure that the policy established . . . is implemented." DoD Directive 6025.13, "Clinical Quality Management Program in the Military Health Services System," July 20, 1995, states the ASD(HA) shall monitor the implementation of "this Directive," which includes the requirement to query and report to the NPDB in accordance with DoD Directive 6025.14 and DoD Instruction 6025.15.

The ASD(HA) did not ensure malpractice payments were reported to the NPDB in a timely manner. One of the mechanisms used in the past for overseeing the entire reporting process was the Risk Management Committee of the Tri-Service Quality Council. The Council included representatives from the Military Departments, AFIP, and the Office of the ASD(HA). NPDB reporting was discussed by the Committee. The Council stopped meeting in 1994. Shortly after the Council was disbanded, there was a noticeable drop in the number of reports submitted by the Army and Navy, as shown in Table 1.

DoD succeeded the Council with two other groups that were used to share information. Representatives of the Military Departments and the Office of the ASD(HA) met in early 1997 to revise the current DoD Directive on NPDB reporting. In addition, in 1996, the Centralized Credentials Quality Assurance System (CCQAS) Working Group was established. It is composed of risk managers and credentials personnel from each Military Department, and it meets monthly to discuss issues relating to CCQAS, which can include NPDB reporting. However, the Military Departments had no formal process to report NPDB activities or problems. That changed in February 1998, when the Risk Management Committee was reestablished under the TRICARE Quality Council. The reestablished Committee's first meeting was held on February 19, 1998. Reestablishing the Committee was an excellent step for ensuring the ongoing exchange of information among the Office of the ASD(HA) and the Military Departments. In addition, we believe regular reporting to the Office of the ASD(HA) by the Military Departments on malpractice payments reported to the NPDB should help manage the reporting process and assist in identifying problem areas in the future.

Completeness of the NPDB

As a result of the limited number of malpractice payment reports sent and the lengthy amount of time taken to send those reports, the NPDB did not have complete and timely information regarding DoD practitioners when healthcare entities queried the NPDB. The NPDB is one of the key sources of information used by the Military Departments and the private sector when making credentialing and privileging decisions. Incomplete data in the NPDB could result in healthcare entities making uninformed decisions about a practitioner.

Concerns Identified by DHHS

On August 7, 1996, the Associate Director for Policy, Division of Quality Assurance, Health Resources and Services Administration, Public Health Service, submitted the report, "Improving the Coverage of the National Practitioner Data Bank and Streamlining Department of Defense Participation," to the Deputy Assistant Secretary of Defense for Clinical Services, Office of the ASD(HA). The report states that there was variance between the agreements in the memorandum of understanding between DoD and DHHS and how the Military Departments were reporting to the NPDB. The variances occurred in what to report, terminology, time frames, and wording that appears on the forms. The report recommended reporting all malpractice payments and

adverse privileging actions as defined in the law and within the period specified, thereby reducing the reporting burden and duplication of effort through greater efficiency. It also recommended rewriting the DoD Directive to provide clearer guidance to the Military Departments, which would bring them closer to full compliance with the Health Care Quality Improvement Act of 1986. The report suggested that DoD send malpractice payment and adverse privileging action reports directly to the NPDB and the NPDB would forward the reports to AFIP. DoD did not respond to the report.

Recommendations, Management Comments, and Evaluation Response

Revised Recommendation. As a result of management comments, we revised draft Recommendation A.2.a. to allow 45 days, instead of 30 days, for the Military Departments' Judge Advocates General to provide malpractice information to the Military Departments' Surgeons General.

A.1. We recommend that the Assistant Secretary of Defense (Health Affairs):

a. Enter into a memorandum of understanding with the Assistant Attorney General, Civil Division, Department of Justice, to:

(1) Require the U.S. Attorneys to provide malpractice information within 30 days of payment or denial and include, at a minimum:

- **patient name, case number, and date of incident;**
- **outcome;**
- **payment or denial date and amount (if any);**
- **the basis for the disposition;**
- **the names of practitioners associated with the incident, and whether those practitioners breached standard of care based on Department of Justice medical reviews; and**
- **copies of any medical reviews done in support of the malpractice payment.**

(2) Include an agreement for the Department of Justice to provide a quarterly (or more frequent) reconciliation of outstanding claims from the previous quarter.

Assistant Secretary of Defense (Health Affairs) Comments. The ASD(HA) concurred with the recommendation, stating that the memorandum of understanding will specify what type of information the Military Departments require in order to efficiently process paid malpractice claims and will include

an agreement for the Department of Justice to send a monthly report on new claims that are outstanding. Cases pending litigation will not be included in the report.

Department of the Army Comments. Although not required to comment, the Army agreed with the recommendations.

Department of the Navy Comments. Although not required to comment, the Navy agreed with the recommendation and requested that the patient's social security number be included in the list of required information.

Evaluation Response. The ASD(HA) comments were fully responsive to the requirement that the Department of Justice provide malpractice information to the Military Departments, and partially responsive to requiring a quarterly reconciliation between the Military Departments and the Department of Justice. Receiving reports on only the new cases filed will not solve the problem of timeliness identified in the report. Therefore, we request that the ASD(HA) reconsider including a list of cases pending litigation on each Department of Justice report so the Military Departments are made aware of all outstanding cases. We suggest that the Navy provide the request for additional malpractice information (patient's social security number) to the Risk Management Committee for possible inclusion in the memorandum of understanding with the Department of Justice.

A.1. We recommend that the Assistant Secretary of Defense (Health Affairs):

b. Revise current policy to:

(1) Require the Military Departments to report all malpractice payments whether standard of care was met or not, except for those cases due to circumstances outside the control of any practitioner, such as drugs mislabeled by the supplier, equipment or power failure, or accidents unrelated to patient care.

(2) Require that National Practitioner Data Bank (NPDB) reports be sent within 30 calendar days of receipt of written notification of malpractice payment.

(3) Direct the Surgeons General to provide, at least annually, management information outlining the number of malpractice payments, the number of reports submitted to the NPDB, timeliness of reports, any backlog, and any problems with NPDB reporting.

Assistant Secretary of Defense (Health Affairs) Comments. The ASD(HA) nonconcurred with the recommendation to modify DoD policy to require the Military Departments to report all malpractice payments to the NPDB. She stated that amending the memorandum of understanding between DoD and DHHS was done in an effort to level the playing field between DoD healthcare practitioners and practitioners in the civilian community. The ASD(HA) further stated that the civilian community protects healthcare practitioners by using a "corporate shield" whereby the practitioner's name is deleted from the claim and instead the claim is filed against the corporation. The ASD(HA) realizes

that DHHS is trying to remove the corporate shield loophole from the law, but believes that elimination of the corporate shield should be accomplished before allowing reporting of all malpractice payments on DoD practitioners. To facilitate NPDB reporting, DoD has contracted with an external civilian agency to review all malpractice payments for which the Military Departments determined that the standard of care was met or the payment was attributable to a systems error. The results will be provided to the Surgeons General as additional information in making final reporting decisions. The ASD(HA) stated that a large number of paid malpractice claims are settled for the convenience of the Government and not on the basis of the merits of the claim. The ASD(HA) further stated that DoD practitioners have no say in whether a claim is settled, because the claim is against the Government. For DoD policy to mandate reporting of all malpractice payments to the NPDB would be a devastating blow to the morale of its practitioners.

The ASD(HA) also nonconcurred with the 30-day reporting deadline and stated that 120 days is required. The additional time would allow adequate time to collect patient records and other documentation, obtain input from involved practitioners, perform internal and external peer reviews of the case, and make the standard of care determination.

The ASD(HA) concurred with directing the Surgeons General to provide management information regarding NPDB reporting and stated the DoD Risk Management Committee will be responsible for monitoring the metrics each quarter.

Department of the Army Comments. Although not required to comment, the Army disagreed to reporting all malpractice payments to the NPDB within 30 days of notification of payment. It stated that the premise underlying the recommendation was a Service-imposed requirement that a standard of care determination be made before issuance of any report. The Army believed other administrative breakdowns were the primary cause for the low report rate. The Army also stated that the 30-day standard for submission of reports was not workable. It believed the standard should be 90 to 120 days. The Army agreed with reporting NPDB reporting management information.

Department of the Navy Comments. Although not required to comment, the Navy disagreed with the recommendation to report all malpractice payments to the NPDB. It stated that the NPDB does not require reporting all malpractice payments, only those made on behalf of a practitioner. The involved practitioner may have knowledge of the action, but unlike civilian practitioners, has no control over the Government's decision to settle or litigate the claim. In the Navy, the Surgeon General carefully screens cases in which a payment has been made and reports the involved practitioner when the standard of care was not met. Those are the cases that the payment is deemed to be made on behalf of a practitioner. This is a fair and reasonable process that complies with the NPDB requirements and protects practitioners. Implementation of the proposed recommendation would place military practitioners on an unfair and unequal playing field, with potential adverse impacts on morale and readiness.

Department of the Air Force Comments. Although not required to comment, the Air Force Surgeon General and the Air Force Legal Services Agency disagreed with reporting all malpractice payments to the NPDB within 30 days

of payment notification. The Surgeon General stated that the recommendation was inappropriate because all malpractice payments do not have to be reported, only those made on behalf of individual practitioners. Also, unlike civilian practitioners, Air Force practitioners are not notified of their involvement in a claim until after payment has been made, providing no opportunity to respond to the claim. Further, decisions on litigation and payment are outside the control (or knowledge) of the individual practitioner. Accordingly, the Air Force consistently identified significantly involved practitioners and reported individuals to the NPDB when the Air Force determined it paid the claim on behalf of the practitioner. The Air Force Legal Services Agency stated the NPDB would be better served by reporting only confirmed malpractice. In addition, the Air Force Surgeon General nonconcurred with the 30-day reporting deadline, recommending 120 days.

Evaluation Response. The ASD(HA) comments were partially responsive. We disagree that reports should be sent to the NPDB only for malpractice payments in which standard of care was not met. The legislative history of the public law that created the NPDB clearly demonstrates that Congress wanted all malpractice payments reported, including nuisance claims. The "corporate shield" concept is a loophole in the law that DHHS is working to eliminate. The fact that DHHS is working to eliminate the loophole is further evidence that the intent of the program is to report all payments. DoD should take action now to be consistent with the intent of the program, rather than waiting for a known loophole to be closed. In addition, the original memorandum of understanding between DoD and DHHS stated that DoD would report all malpractice payments. We also see no need to revise the deadline for reporting malpractice payments from 30 days to 120 days, because the additional time is needed only if limited reporting continues. If all malpractice payments are reported, 30 days from notification of payment is sufficient.

The Army comment that the premise of the recommendation is a "Service-imposed" requirement is incorrect. The premise of the recommendation is that DoD policy requires only limited reporting. The Air Force comment regarding practitioner notification of claims is not consistent with the information it provided us when explaining its malpractice payment processing procedures (See Appendix C). We request that the ASD(HA) reconsider her position regarding reporting all malpractice payments within 30 days and provide additional comments in response to the final report. The ASD(HA) comments regarding management information reporting by the Surgeons General were fully responsive.

A.1. We recommend that the Assistant Secretary of Defense (Health Affairs):

c. Review the information provided by the Surgeons General regarding NPDB reporting and take corrective action to resolve any reporting problems and provide assistance in eliminating any backlog.

d. Provide coverage of NPDB reporting as part of its management control program. Appendix A provides details on the adequacy of management's self-assessment.

Assistant Secretary of Defense (Health Affairs) Comments. The ASD(HA) concurred with the recommendations. The Assistant Secretary stated that review of the Surgeons General reports will be done at the quarterly Risk Management Committee meeting, which will be the oversight body for the management control plan.

Department of the Army and Department of the Navy Comments. Although not required to respond, the Army and the Navy agreed with the recommendations.

A.2. We recommend the Judge Advocates General of the Military Departments:

a. Provide malpractice information to the offices of the Surgeons General within 45 days of the payment or denial. At a minimum, the report should include the:

- **patient name, case number, and date of incident;**
- **outcome;**
- **payment or denial date and amount (if any);**
- **basis for the disposition;**
- **names of practitioners associated with the incident, and whether those practitioners breached standard of care based on Judge Advocate General medical reviews; and**
- **copies of any medical reviews done in support of the malpractice payment.**

b. Provide at least a quarterly reconciliation of outstanding claims from the previous quarter.

Department of the Army Comments. The Army concurred with the draft report recommendation to report malpractice information within 30 days and to provide a quarterly reconciliation.

Department of the Navy Comments. The Navy partially concurred, stating that information will be provided within 45 days rather than the 30-day reporting deadline outlined in the recommendation. The Navy concurred with providing a quarterly reconciliation of outstanding claims.

Department of the Air Force Comments. The Air Force Surgeon General and the Air Force Legal Services Agency partially concurred, requesting the reporting deadline be extended from 30 days to 45 days to allow for current operational procedures to continue. The Air Force Legal Services Agency also stated that a monthly report is provided on all closed claims and litigated cases. It further stated that while it does not include all the information in the recommendation, the report and other information has been or will be provided

to the Surgeon General to comply with the recommended reporting requirement. The Air Force concurred with the recommendation to provide quarterly reconciliation, stating procedures are already in place to meet the requirements.

Evaluation Response. The Military Departments comments were responsive. As a result of management comments, we revised the number of days in which to report malpractice information by increasing it to 45 days.

A.3. We recommend the Surgeons General of the Military Departments:

a. Identify the specific information and documents required from the Department of Justice and the appropriate Military Department Judge Advocate General in order to identify practitioners to report to the NPDB. A minimum list is provided in Recommendations A.1. and A.2.

Department of the Army Comments. The Army concurred.

Department of the Navy Comments. The Navy concurred.

Department of the Air Force Comments. The Air Force Surgeon General concurred and requested a point of contact and phone number be added to the malpractice information list.

Evaluation Response. The Military Departments comments were responsive. We suggest that the Air Force present its request for additional malpractice information (points of contact and phone number) through the Risk Management Committee for possible inclusion in the Department of Justice memorandum of understanding and in the JAG requirements.

A.3. We recommend the Surgeons General of the Military Departments:

b. Provide coverage of NPDB reporting as part of their management control programs. Appendix A provides details on the adequacy of managements' self-assessments.

Department of the Army Comments. The Army concurred.

Department of the Navy Comments. The Navy concurred.

Department of the Air Force Comments. The Air Force Surgeon General concurred and stated that NPDB reporting is tracked monthly and reported to the Commander, Air Force Medical Operations Agency, and the Air Force Surgeon General.

Finding B. DoD Reporting of Adverse Privileging Actions

Although the Military Departments were reporting physicians and dentists, the specific adverse privileging actions reported to the NPDB varied widely. In addition, the Military Departments did not report the actions taken in a timely manner, although processing time was improving. The variation in reporting occurred because DoD and Military Department policies inconsistently define the various types of adverse privileging actions and which actions to report. The timeliness problem occurred because DoD lacked policy establishing a time frame for reporting adverse privileging actions and because the Office of the ASD(HA) did not provide adequate oversight to ensure reporting was completed in a timely manner. As a result, healthcare entities querying the NPDB did not have all relevant information available when making credentialing or privileging decisions.

Adverse Privileging Actions Reporting Policies

DHHS Policy. The DHHS implementing policy, Title 45, Code of Federal Regulations, Part 60, defines an adverse privileging action as any professional review action that adversely affects the clinical privileges of a physician or dentist. "Adversely affects" is further defined as a denial, reduction, restriction, revocation, or suspension of clinical privileges.[10]

What and Who to Report. DHHS requires a civilian hospital or other eligible healthcare entity to report physicians and dentists when the healthcare entity:

- o takes a professional review action that adversely affect the provider's clinical privileges for a period of more than 30 days; or

- o accepts the provider's surrender or restriction of clinical privileges while under investigation for professional incompetence or improper professional conduct, or in return for not conducting an investigation or professional review action.

In addition, revisions to reported adverse privileging actions, such as full or partial reinstatement, are reportable to the NPDB.

When to Report and to Which Agency. DHHS policy requires healthcare entities to report adverse privileging actions within 15 days of the date the adverse action is taken or clinical privileges are voluntarily surrendered

[10]See Appendix F for definitions.

or restricted. Healthcare entities report to the appropriate licensing authority, which forwards the report to the NPDB within 15 days of receipt. Reporting time, therefore, should not exceed 30 days from the date that any reportable adverse privileging action is taken.

DoD Policies. Three key DoD policies define what, when, and which healthcare providers to report regarding adverse privileging actions. Those policies are DoD Directive 6025.13, DoD Directive 6025.14, and DoD Instruction 6025.15. In addition, each Military Department issued implementing instructions based on the DoD Directives and Instruction. Appendix E contains additional details regarding Military Department policies for processing adverse privileging actions.

Adverse Privileging Actions Processing Procedures

Military Department Procedures. For the Military Departments, an adverse privileging action begins at an MTF when a questionable action occurs regarding a provider's ability to provide patient care. The questionable action could be the result of negligence, a pattern of substandard care, impairment, or misconduct. Initially, the provider's privileges are placed in abeyance,[11] which is not an adverse privileging action. However, a DD Form 2499, "Health Care Provider Actions Report," may be generated, identifying a possible adverse privileging action. After the possible adverse privileging action is identified, the processing through various levels to the Office of the Surgeon General differs among the Military Departments. However, all the Military Departments require the completion of due process procedures, including any hearing or appeal requested by the provider, before an action is deemed final for reporting purposes. Although an MTF commander may make a decision to take an adverse privileging action, for purposes of this evaluation report, we did not consider an adverse action final until the NPDB reporting decision was made.

Private Sector Procedures. The private sector is required by NPDB guidelines to report all adverse privileging actions that exceed 30 days. Although not a statistically valid sample, we contacted several small and large civilian hospitals regarding NPDB reporting and found that three of the five hospitals contacted reported[12] only after final action was taken, regardless of the length of time taken for due process procedures. Two indicated they submitted interim reports if the adverse action exceeded 30 days. Three State medical boards contacted indicated that they did receive some interim reports, but most of the reports they received were final actions.

[11]See Appendix F for a definition.

[12]Hospitals report to State medical boards, which forward the report to the NPDB.

Reporting to the NPDB

As of December 31, 1997, the NPDB contained 32,148 adverse privileging action reports. Of those, 326 were reported by DoD. Table 3, based on data from the NPDB, shows adverse privileging actions reported to the NPDB by calendar year and Military Department.

Table 3. Adverse Privileging Actions Reported to the NPDB
(data as of December 31, 1997)

Year	Army	Navy	Air Force	Total
1990-1991*	21	0	0	21
1992	22	12	17	51
1993	17	3	24	44
1994	24	13	8	45
1995	13	33	5	51
1996	21	17	15	53
1997	25	14	22	61
Total	**143**	**92**	**91**	**326**

*Period covers September 1, 1990, when NPDB reporting began, through December 31, 1991.

Reporting by the Military Departments

Although the Military Departments were reporting adverse privileging actions for physicians and dentists, the specific adverse privileging actions reported varied widely. We sampled adverse privileging actions that occurred after September 1, 1990.[13] Of the 94 reportable provider records reviewed, 84 (89 percent) had been reported to the NPDB. However, when the final action was a reportable adverse privileging action, the Navy and the Air Force did not consistently report the associated adverse actions, such as suspensions. Reporting alcohol-impaired providers varied among the Military Departments. Those variations were the result of inconsistent definitions of reportable actions and inconsistent Military Department policies on what to report.

[13]Appendix A contains details on the sample selection.

Overall Reporting of Adverse Privileging Actions. Of the 39 reportable Army provider records reviewed, 32 (82 percent) had been reported to the NPDB. Of the remaining seven, four were unique cases for which no pattern applied and three involved alcohol-impaired providers who should have been reported but were not. The Army cases not reported had occurred prior to May 1995, that is, before the process was transferred to the Army Medical Command.

Of the 30 reportable Navy provider records reviewed, 29 (97 percent) had been reported. For the one not reported, BUMED personnel discovered that a report had not been sent when they pulled the record as part of our sample. Since the case was several years old, a decision was made not to submit a report to the NPDB at such a late date. However, a report had been submitted to the Federation of State Medical Boards when the action occurred. As discussed in more detail later, our review also indicated that when the final action was a reportable adverse privileging action, the Navy did not always report the associated adverse privileging actions.

Of the 25 reportable Air Force provider records reviewed, 23 (92 percent) had been reported. For the two not reported, one was a denial of privileges that had been handled incorrectly. The other involved associated actions, limitation followed by reinstatement, neither of which had been reported.

Reporting Associated Actions. The Navy and the Air Force generally reported only final adverse privileging actions, not the associated actions, such as limitations, restrictions, or suspensions. As a result, if a provider's privileges had been initially limited or suspended before being revoked, the Navy and the Air Force reported only the revocation. By not reporting all associated actions, the Navy and the Air Force did not fully disclose the actions taken against the physician or dentist. However, the Navy and the Air Force reported suspensions, as required, if the provider left the Military while under investigation. The Army reported associated actions, including limitations and suspensions, consistent with NPDB policy.

In an Air Force case, a provider's privileges had been limited and then conditionally reinstated; however, the Air Force reported only the conditional reinstatement. NPDB policy allows for two actions to appear on one report if the report clearly and fully identifies both actions. However, the report must reflect the adverse privileging action taken. In the Air Force example, the report should have indicated privileges had been limited and the length of time of the limitation. If multiple adverse privileging actions apply, more than one report may be sent, each identifying the individual action taken. Regardless of the number of actions taken, if the final action is a reportable action, then all adverse actions related to the incident should be reported to the NPDB.

Reporting Alcohol-Impaired Providers. The Military Departments varied in their reporting of alcohol-impaired providers. Army policy is to not report providers who successfully complete an alcohol rehabilitation program. The Army allows providers to enter a 2-year post-rehabilitation program; if they successfully complete the program, they are not reported to the NPDB. If a provider leaves the program before completion, he or she is reported to the NPDB. The policy does not differentiate between those providers who self-refer for the rehabilitation program and those involuntarily enrolled. The Navy

treats adverse privileging actions against providers impaired by alcohol the same as any other adverse privileging actions. The actions are reportable if a final adverse action is taken. The Air Force did not have a written policy regarding providers impaired by alcohol. Typically, the provider was placed under suspension while in rehabilitation, which was not reported. In addition, the Air Force views providers who self-refer as seeking help and generally takes no punitive action. The Office of the ASD(HA) supports the policy to "help, not hurt" the provider.

The private sector also appears to support the position of not reporting some alcohol-impaired providers. The Federation of State Medical Boards recommends that State boards encourage treatment of impaired providers by waiving reporting requirements for those who successfully complete treatment programs. At least 21 States have alcohol-impaired provider programs administered by the State medical boards, medical societies, or by some other agency for the State. Physicians who self-refer into an alcohol rehabilitation program are less likely to be reported to the NPDB. Although State boards are involved with licensing issues and DoD is involved with privileging issues, we believe the waiving of reporting by the State boards for physicians who self-refer was significant. In addition, the NPDB guidelines have conflicting policy. One section of the guidebook states that when a physician surrenders medical staff privileges because of personal reasons or infirmity, the surrender is not reportable. An infirmity can include alcoholism. However, another section of the guidebook states that if an impaired provider enters a rehabilitation program and relinquishes clinical privileges, then the action is reportable.

Given the conflicting guidance from the NPDB and the approach in the private sector to encourage self-referral, we support not reporting those providers who self-refer into an alcohol rehabilitation program even if an adverse privileging action was taken. While the provider may not be reported to the NPDB, the provider's privileges will be impacted appropriately to ensure patient safety. However, if the provider does not successfully complete the rehabilitation program, including all after-care requirements, then the provider should be reported to the NPDB. Providers who enter alcohol rehabilitation, but not through self-referral, should also be reported.

Consistency of Terms and Reportable Actions

The variations in reporting by the Military Departments occurred because the DoD and Military Departments differed in the definitions of reportable actions and the types of actions to report. The NPDB guidelines specify which actions are reportable by healthcare entities. Those actions include denial, reduction, restriction, revocation, and suspension of privileges, including the decision to deny the renewal of privileges, if the decision is based on a provider's professional incompetence or misconduct. In addition, reportable actions include revisions to previous actions, such as reinstatement. The list of codes for categories of reportable actions to the NPDB on the DD Form 2499 includes the same terms as the NPDB guidelines. However, the Military Department policies describe different types of adverse privileging actions when outlining the procedures to follow and, as a result, reporting was not consistent among the Military Departments or with NPDB guidelines.

Differences in Terms. The DoD policies and the memorandum of understanding do not use the specific terms in the NPDB guidelines when identifying reportable adverse privileging actions. The following highlight the inconsistencies in the DoD policies and the memorandum of understanding regarding adverse privileging actions.

o The memorandum of understanding between DoD and the DHHS defines reportable actions as denials, limitations (restrictions), and revocations.

o DoD Directive 6025.13 defines adverse privileging actions as denials, revocations, and suspensions of clinical privileges.

o DoD Instruction 6025.15 identifies denials, limitations (restrictions), and revocations of clinical privileges as reportable actions.

o Army Regulation 40-68, "Medical Services Quality Assurance Administration," December 20, 1989, and Interim Change I03 to Army Regulation 40-68, dated June 30, 1995,[14] identify denials, restrictions, revocations, and suspensions of clinical privileges as reportable actions.

o Navy BUMED Instruction 6010.18, "Participation in the National Practitioner Data Bank," May 18, 1993, includes denials, limitations, and revocations of clinical privileges as potentially reportable adverse privileging actions.

o Air Force Instruction 44-119, "Medical Service Clinical Quality Management," October 1, 1995, identifies denials, limitations, and revocations of clinical privileges as reportable actions.

Although denials and revocations are included in all five DoD policies and the memorandum of understanding, most of the other terms are not: suspension is in two; limitation in four; and restriction in one. Reduction of privileges is not mentioned in any DoD or Military Department policy. In addition, none of the terms are defined in the DoD Directive or DoD Instruction; therefore, the Military Departments had to develop their own definitions, which differed. Finally, while not an adverse privileging action, reinstatement is a reportable revision to an action and should be included in the DoD policies.

Limitation of Privileges. The Army did not report or define limitations. The Navy defined limitation as the permanent removal of a portion of a provider's privileges. The Air Force definition was similar, but was expanded to include the permanent reduction of privileges or a restriction placed on all or part of the provider's privileges. Limitation, to the Air Force, included proctoring and supervision of the provider.

Restriction of Privileges. Restriction was used only by the Army. It was defined the same way the Navy defined limitation: the permanent removal of a portion of a provider's clinical privileges.

[14]Change I03 was extended until June 30, 1999, by the Army Surgeon General.

Suspension of Privileges. Suspension was defined by the Army and the Navy as the temporary removal of all or part of the provider's clinical privileges. The Air Force expanded the definition to include restriction of all or part of the provider's clinical privileges. The Air Force also included in its definition that suspensions were normally not reportable to the NPDB.

Appendix F contains our proposed definitions for adverse privileging actions for any future DoD policy.

Differences in Types of Reportable Adverse Privileging Actions. Reportable actions in DoD policy were not consistent with reportable actions outlined in the NPDB guidelines. The terms in the DoD policies did not match the codes used by the NPDB for reporting adverse privileging actions. The problem was further complicated by the use of "limitation" in the policies; limitation is not a valid action in the NPDB guidelines or on DD Form 2499, which is used by DoD for reporting.

The impact of the inconsistency between DoD policies and the NPDB guidelines is demonstrated by the Navy and the Air Force failing to report suspensions. In addition, the Navy and the Air Force use limitation as a reportable action, which has to be converted to a valid NPDB code before it can be reported. None of the Military Department policies include reduction in privileges as a reportable action.

DoD and Military Department policies need to be revised to match the reportable actions required by the NPDB guidelines and included on the DD Form 2499. The DoD Instruction needs to clearly define all terms related to adverse privileging actions and identify all reportable actions to ensure consistent implementation of NPDB processing and reporting by the Military Departments.

Timeliness of Reporting Adverse Privileging Actions

For the 94 provider records reviewed,[15] processing time for reporting adverse privileging actions varied by Military Department from an average 6.7 to 10.6 months from the date of final action until the date the report was submitted to the NPDB. Untimely reporting occurred because DoD did not require reporting within a specified time frame. In addition, the Office of the ASD(HA) provided inadequate oversight to ensure the reports were submitted in a timely manner.

Overall Reporting by the Military Departments. We reviewed a sample of 94 Army, Navy, and Air Force provider records with adverse privileging actions to determine whether reports were sent to the NPDB within a reasonable time frame. In addition to the variations discussed previously regarding how the Military Departments defined adverse privileging actions, the Military Departments also varied in how and when an adverse privileging action was considered final. For the Army and the Navy, the final date was after the

[15]Appendix A contains details on the sample selection.

appeal was completed, if one was requested. For the Air Force, the final date was based on the date of the MTF commander's decision, prior to completion of the appeal process. That difference made it difficult to fairly compare timeliness of adverse privileging action reporting among the Military Departments.

Army Processing Time. For the 39 Army records reviewed, the Army averaged 6.7 months for reporting final reports. Based on the sample records involving cases completed in the past 2 years, the Army Medical Command improved the timeliness of reporting adverse privileging actions, with final actions reported in an average of slightly more than 4 months.

Navy Processing Time. For the 30 Navy records reviewed, the Navy took an average of 7.8 months from the time of final action to submission of a report to the NPDB. That was not consistent with Navy policy, which states reports are to be sent within 15 days. However, the Navy showed substantial improvement. Based on an analysis of nine adverse privileging actions processed from May 1997 through December 1997, the average processing time from the date of final action to the date of the report to the NPDB was 1 month.

Air Force Processing Time. For the 25 Air Force records reviewed, the average processing time was 10.6 months from final action by the MTF commander to the submission of a report to the NPDB. An analysis of nine adverse privileging actions completed in 1997 showed slight improvement, with an average of 9.2 months from the date of final action by the MTF commander until a report was sent. However, key dates not obtained for our analysis were the dates the appeal process was completed and the Surgeon General made a final reporting decision. As a result, for the Air Force analysis, we were unable to calculate the average time from the date of final action for reporting purposes until the date a report was sent to the NPDB.

DoD Policy on When to Report. Only the Navy specified a time frame for reporting adverse privileging actions. The Navy policy states that reports will be sent within 15 days of the final action. No other DoD policies outline a time frame for reporting adverse privileging actions to the NPDB. In the private sector, reporting is required within 30 days of taking an adverse privileging action. However, even the private sector does not generally report any actions taken until the final action is determined, after due process procedures are completed. Any DoD standard for reporting to the NPDB should be based on the date of final action, after all due process procedures have been completed. At the time of a final action, the appropriate Office of the Surgeon General has available all information for reporting to the NPDB.

Oversight. The Office of the ASD(HA) did not ensure adverse privileging actions taken against physicians and dentists were reported to the NPDB in a timely manner. The reestablishment of the Risk Management Committee of the TRICARE Quality Council should improve oversight by the Office of the ASD(HA) for adverse privileging action processing and reporting, as it should for malpractice payments. In addition, we believe regular reporting to the Office of the ASD(HA) by the Military Departments on adverse privileging actions reported to the NPDB will help manage the reporting process and assist in identifying problem areas in the future.

Completeness of the NPDB

Because of the variations in and untimely reporting of adverse privileging actions by the Military Departments, the NPDB did not have complete information regarding DoD physicians and dentists for healthcare entities querying the NPDB. The NPDB is one of the key sources of information used by the Military Departments and the private sector when making credentialing and privileging decisions. Incomplete data in the NPDB could result in healthcare entities making uninformed decisions about a provider.

Recommendations, Management Comments, and Evaluation Response

B. We recommend that the Assistant Secretary of Defense (Health Affairs):

1. Revise policy to:

a. Clearly define all terms related to adverse privileging actions. At a minimum the policy should delete any reference to limitation and clearly define abeyance, denial, reduction, reinstatement, restriction, revocation, and suspension, as proposed in Appendix F.

b. Require the Surgeons General to report all associated adverse privileging actions taken when the final action results in an adverse action, consistent with National Practitioner Data Bank (NPDB) reporting.

c. Require reporting adverse privileging actions taken against providers with alcohol-related impairments who do not self-refer into a rehabilitation program, or those who self-refer but do not complete the rehabilitation program.

d. Require reporting within 30 calendar days of the date of Surgeon General approval of the adverse privileging action.

e. Direct the Surgeons General to provide, at least annually, management information outlining the number of adverse privileging actions taken, the number reported to the NPDB, the timeliness of the reports, any backlog, and any problems with NPDB reporting.

2. Review the information provided by the Surgeons General regarding NPDB reporting and take corrective action to resolve any reporting problems and provide assistance in eliminating any backlog.

Assistant Secretary of Defense (Health Affairs) Comments. The ASD(HA) concurred, stating that it will direct the Risk Management Committee to review the "Proposed Definitions of Key Terms for Future DoD Policy" outlined in this report and come to a consensus on standardizing key terms for describing adverse privileging actions. The Assistant Secretary also stated that the Military Departments not currently reporting adverse actions taken against providers with alcohol-related impairments who do not self refer into rehabilitation will modify their policy to comply with the requirement. The ASD(HA) will direct the

Surgeons General to comply with the 30-day reporting policy. In addition, the Risk Management Committee will be responsible for monitoring compliance with the revised policy and tracking adverse privileging actions.

Military Department Comments. Although not required to comment, the Military Departments agreed with both recommendations.

Finding C. Completeness of DoD Automated Files

The DPDB did not contain all records that had been reported to the NPDB. From the merged database used for our sample, 88 of the 1,150 (8 percent) malpractice payments and 90 of the 220 (41 percent) adverse privileging actions were in the NPDB but not the DPDB. In addition, when reports were in both data banks, effective and final action dates were incorrect for 50 percent of a sample of records reviewed. The variation in the records reported to the databases and the differences in data within the records occurred because management controls were not adequate to ensure the Military Departments reported complete and accurate information to the DPDB and the NPDB. As a result, AFIP did not have a complete, accurate, automated database for conducting analysis related to clinical and malpractice issues.

Data for Analysis

Our analysis of the completeness of the automated files was based on merged records used to provide a universe of records for sample selection.[16] To develop a sampling database, we combined the records from the DPDB with those in the NPDB, matching records as much as possible to eliminate duplication. Merging the two databases and eliminating duplicates resulted in 1,150 malpractice payments and 220 adverse privileging actions reports.[17] Of the 1,150 malpractice payments records, 219 were Army, 216 were Navy, and 715 were Air Force. Of the 220 adverse privileging action records, 91 were Army, 55 were Navy, and 74 were Air Force.

Our analysis of the accuracy of the automated files was based on the samples selected for the evaluation. We reviewed 47 Army, 30 Navy, and 47 Air Force malpractice payment records and 39 Army, 30 Navy, and 25 Air Force adverse privileging actions to identify those records in both databases. From those records, we identified 10 Army, 2 Navy, and 13 Air Force malpractice payment records and 14 Army, 5 Navy, and 15 Air Force adverse privileging actions in both data banks. Table 4 summarizes the number of records reviewed for accuracy by type of report and Military Department.

[16]Additional records from the Army and the Air Force were used in the sample selection, but were not used in the comparison of the DPDB and the NPDB.

[17]Appendix A contains details on the sample selection.

Table 4. Records Reviewed for Accuracy Analysis

	Malpractice Payments		Adverse Privileging Actions	
	Total Sample Records	Sample Records in Both DPDB and NPDB	Total Sample Records	Sample Records in Both DPDB and NPDB
Army	47	10	39	14
Navy	30	2	30	5
Air Force	47	13	25	15
Total	**124**	**25**	**94**	**34**

Automated Systems

National Practitioner Data Bank. Military Department reports are sent to the NPDB through the Query for Practitioners (QPRAC). QPRAC is the software provided by the NPDB that allows eligible healthcare entities to electronically query and report issues related to healthcare practitioners.

Subsystems of the Defense Practitioner Data Bank. DoD collection of adverse privileging actions began in 1982 through the subsystem of the DPDB called CLIN2. Collection of data regarding malpractice payments began in 1988 through the subsystem of the DPDB called TORT2. The Military Departments' offices of the Surgeons General enter the data into the two subsystems.

Dual Entry Required. The Military Departments have to separately enter data into the DPDB and the NPDB. DoD intended to include in the DPDB reporting system the capability to extract data for reports to the NPDB, eliminating the need for dual entry. However, the implemented system lacked that feature. It could not produce either the hard copy NPDB reports or the automated records required for NPDB reporting through QPRAC. In the future, CLIN2 and TORT2 will no longer be required; data for both the DPDB and the NPDB will be collected through CCQAS Version 2.0, thus eliminating the need for dual entry.

Centralized Credentials Quality Assurance System. CCQAS is a world-wide, tri-Service credentialing information system designed to assist MTF staff in collecting, tracking, and reporting required provider data for credentialing. It tracks and stores information on provider adverse privileging actions, affiliations, certifications, demographics, education, licenses, malpractice, and medical readiness training. CCQAS Version 2.0 adds the CLIN2 and TORT2 databases to the system. Data entered into CCQAS

Version 2.0 will be sufficient to automatically generate NPDB reports for both malpractice payments and adverse privileging actions. The reports will originate in CCQAS but will be automatically transferred to QPRAC, where they will be completed and sent to the NPDB. According to Office of the ASD(HA) staff, CCQAS is scheduled to be deployed worldwide by September 30, 1998.

CCQAS and Year 2000 Compliance. CCQAS Version 2.0 appears to comply with Year 2000 requirements. All date fields in CCQAS Version 2.0 are four-digit years, all data will be entered manually, and there will not be any automated input sources to the system. Because CCQAS Version 2.0 is scheduled to be implemented prior to March 1999, the implementation deadline set by the U.S. Office of Management and Budget for system conversions and implementations, we did not evaluate the legacy systems, CLIN2 and TORT2, for Year 2000 compliance.

Completeness and Accuracy of the DPDB

Completeness of the DPDB. The DPDB did not have complete information. For malpractice payments, 88 of the 1,150 merged records (8 percent), were reported only to the NPDB and were not in the DPDB. The 88 records should also have been reported to the DPDB. Of the 1,150 records, 192 were reported to the DPDB and the NPDB. For adverse privileging actions, 90 of the 220 total merged records (about 41 percent) were reported only to the NPDB. Again, the 90 records should also have been reported to the DPDB. Of the 220 records, 74 were reported to the DPDB and the NPDB. Appendix G provides details comparing the two databases by Military Department and DoD total.

Accuracy of the DPDB. Although the information reported for malpractice payments did not appear to have inconsistencies, the information on adverse privileging actions did, including different names on two Army records and, for many records, differences in effective and final action dates, as well as differences in the action codes reported. Some records were different in only one area, but there were records where both the dates and the action codes were different.

Effective and Final Action Dates. Half of the 34 adverse privileging action records we reviewed that were in both the DPDB and the NPDB had different effective or final action dates. Of the 14 Army adverse privileging action records, 9 had different dates. Of the 5 Navy records, 2 had different dates. Of the 15 Air Force records, 6 had different dates.

Action Codes. For 3 of the 14 Army, 2 of the 5 Navy, and 5 of the 15 Air Force records from our sample, the adverse privileging action code in the DPDB was different from the code in the NPDB. Therefore, about 29 percent of the sample records found in both databases had different action code information.

Differences Should Not Occur in the Future. With the implementation of CCQAS Version 2.0, dual entry will not be required. Therefore, problems associated with incomplete or differing data between the two databases should not occur once CCQAS Version 2.0 is in use.

Management Controls

Although DoD policy requires the Military Departments to provide AFIP with the information used to complete malpractice payment and adverse privileging action reports, the offices of the Surgeons General did not have adequate management controls to ensure the required reporting occurred. The requirement to report all malpractice payments and adverse privileging actions to the DPDB was in addition to the requirement to submit selected reports to the NPDB.

The lack of management controls to ensure full reporting was evident in an analysis done by AFIP in 1995. For each Military Department, AFIP compared malpractice payment data contained in TORT2 to closed malpractice claims[18] from the Military Department JAGs. The comparison information was provided to the Military Department Deputy Surgeons General on October 4, 1995. While AFIP expected about 450 malpractice payment records each year, in 1994 they only received 81 Army, no Navy, and 12 Air Force records. In 1995, AFIP received 102 Army records, but none from either the Navy or the Air Force. Each of the Military Departments responded to the AFIP analysis with either explanations or areas of improvement that would help resolve the problems. Two Military Departments recommended a tri-Service meeting. But inaccurate reporting has continued, as evidenced by the number of reports still found only in the NPDB.

Information Needed for Analysis

The analysis of data from the DPDB is used to highlight clinical areas for potential risks, to educate practitioners about past mistakes, and to identify areas of clinical practice with the greatest exposure to error. Evaluation of malpractice and adverse action trends is an integral part of the Office of the ASD(HA) risk management program for measuring performance improvement. Although CCQAS will eliminate the problem in the future, differences in the current databases need to be reconciled to ensure AFIP has complete and accurate data with which to conduct those risk management and trending analyses. Incorrect information, such as incorrect effective dates of actions taken or incorrect adverse privileging action codes, impacts the ability to do trending analyses over periods of time. Incomplete automated information compromises the usefulness of the reports produced by AFIP for the ASD(HA). Therefore, until CCQAS Version 2.0 is fully implemented, the offices of the Surgeons General need to implement management controls to ensure that all reports submitted to the NPDB are also submitted to the DPDB.

[18]Closed claims from the JAGs can include both malpractice payments and denials.

Recommendations, Management Comments, and Evaluation Response

C. We recommend that the Surgeons General of the Military Departments:

1. Reconcile the Defense Practitioner Data Bank (DPDB) and National Practitioner Data Bank (NPDB) databases by submitting to the DPDB all records found only in the NPDB and correcting the inconsistencies in the data.

Department of the Army Comments. The Army concurred.

Department of the Navy Comments. The Navy concurred, stating it has contracted with a private sector company to eliminate its backlog. It also stated that management controls were already in place.

Department of the Air Force Comments. The Air Force concurred, stating it plans to hire a full-time database manager to be responsible for malpractice and adverse action databases. The individual will be tasked with reconciling the databases. The estimated date for hiring the database manager was June 15, 1998.

Assistant Secretary of Defense (Health Affairs) Comments. Although not required to comment, the ASD(HA) agreed with the recommendation.

Evaluation Response. The Air Force comments were responsive. The Army and the Navy comments were partially responsive. The Army did not provide an implementation plan or estimated dates for reconciling the databases. The Navy discussed its method for reducing backlog, but did not address its plan for reconciling the databases. We request that the Army and the Navy provide implementation plans for reconciling the DPDB and the NPDB and the estimated completion dates in response to the final report.

C. We recommend that the Surgeons General of the Military Departments:

2. Implement procedures so that reports are submitted to the DPDB at the same time as data is submitted to the NPDB until the Centralized Credentials Quality Assurance System Version 2.0 is fully implemented.

Department of the Army Comments. The Army concurred.

Department of the Navy Comments. The Navy concurred, stating that management controls were already in place.

Department of the Air Force Comments. The Air Force concurred, stating it plans to hire a full-time database manager to be responsible for malpractice and adverse action databases. The individual will be tasked with submitting quarterly data reports to AFIP. The estimated date for hiring the database manager was June 15, 1998.

Assistant Secretary of Defense (Health Affairs) Comments. Although not required to comment, the ASD(HA) agreed with the recommendation.

Evaluation Response. The Air Force comments were responsive. The Army and the Navy comments were partially responsive. The Army did not provide an implementation plan or estimated completion dates for ensuring reports are submitted to both the NPDB and the DPDB. The Navy did not explain how existing controls will resolve the DPDB reporting issues identified in the report. We request that the Army and the Navy provide implementation plans and the estimated completion dates for ensuring reports are sent to both the NPDB and the DPDB in response to the final report.

Part II - Additional Information

Appendix A. Evaluation Process

Scope

Work Performed. The evaluation focused on the programs, policies, procedures, and practices used by the Office of the ASD(HA) and the Military Departments for identifying, processing, and reporting malpractice payments and adverse privileging actions in accordance with the DoD Directives and Instruction. We focused on the implementation of the program for licensed and privileged healthcare personnel in MTFs, whether they were on active duty, in the Reserves, employed as a civilian in the MTF, or under contract with the MTF.

Limitations to Evaluation Scope. We did not include providers under a TRICARE contract who were not privileged by the MTF. In addition, although querying the NPDB is outlined in DoD policies as part of the total process, it is separate from reporting and, therefore, was not included in our evaluation.

DoD-wide Corporate Level Government Performance and Results Act Goals. In response to the Government Performance and Results Act, the DoD has established 6 DoD-wide corporate level performance objectives and 14 goals for meeting those objectives. This report pertains to achievement of the following objective and goal.

> **Objective:** Maintain highly ready joint forces to perform the full spectrum of military activities. **Goal:** Maintain highly ready joint forces to perform the full spectrum of military activities by improving force management procedures throughout DoD. **(DoD-5.3)**

DoD Functional Area Reform Goals. Most major DoD functional areas have also established performance improvement reform objectives and goals. This report pertains to the achievement of the following functional area objective and goal.

> **Health Care Functional Area. Objective:** Exercise strategic leadership of the Military Health System. **Goal:** Use a strategic, systematic approach to overall management of the Military Health System, incorporating performance measures, customer involvement, feedback, and corrective action. **(MHS-2.2)**

General Accounting Office High Risk Area. The General Accounting Office has identified several high risk areas in DoD. This report provides coverage of the Defense Infrastructure high risk area.

Methodology

We reviewed DHHS laws and regulations, the memorandum of understanding between DHHS and DoD, and DoD and Military Department directives, instructions, regulations, and other published reports pertaining to NPDB reporting, dated from November 1986 through July 1996. We interviewed key personnel within DoD who were involved in the oversight and processing of malpractice payments and adverse privileging actions. In addition, we interviewed key personnel from DHHS and the Department of Justice concerning their roles in supporting NPDB reporting by the DoD.

We reviewed malpractice payments and adverse privileging action cases that occurred from September 1, 1990, through October 15, 1997. Six samples were selected by the Quantitative Analysis Division; Analysis, Planning, and Technical Support Directorate; Office of the Inspector General, DoD. The samples were used to identify problems and successes regarding identifying, tracking, and reporting malpractice payments and adverse privileging actions. We did not question the determinations made by the Military Departments as to whether the standard of care was met or not, or whether there was a system error. In addition to the samples, we looked at nine malpractice payments completed from October 1996 through December 1997 for the Air Force, nine adverse privileging action cases closed by the Navy from May through December 1997, and nine adverse privileging action cases closed by the Air Force from January through December 1997 to determine the impact of recent procedural changes by the Navy and the Air Force.

Use of Computer-Processed Data. To achieve the evaluation objectives, we relied on computer-processed data contained in the DPDB, the NPDB, and the Army database, Medical Quality Assurance System. Although we did not test the general and application controls of the DPDB, the NPDB, and the Medical Quality Assurance System, we did validate the sample data produced by those systems, which revealed inaccuracies in the data (Finding C). However, when the data are reviewed in context with other available evidence, we believe that the opinions, conclusions, and recommendations in this report are valid.

Sample Selection Methodology. Six samples were used for the evaluation. A separate sample was provided for malpractice payments made and adverse privileging actions taken for each of the Military Departments. The samples were drawn from three automated files: the DPDB, maintained by AFIP; the NPDB, maintained by DHHS; and the Medical Quality Assurance System, maintained by the Army. In addition, the files were supplemented with internal tracking information provided by the Office of the Air Force Surgeon General, and combined to develop two databases from which the samples were drawn.

There were substantial problems with the databases. Names were entered inconsistently and dates and action codes differed between the DPDB and the NPDB files. In addition, there were duplicate records. Because of the inconsistencies in data across systems, it was not always possible to determine

whether reports in different systems were the same or not. We manually reviewed the data files and determined when only one action was taken even though the names, award amounts, effective dates, or final dates reported in the DPDB and NPDB records differed.

The samples were based on records meeting the following criteria:

o effective dates of malpractice payments and adverse privileging actions from September 1, 1990, through October 15, 1997;

o status action codes indicating the case was completed; and

o for malpractice payments, the payment amount was greater than zero; for adverse actions, the case involved a physician.

Malpractice Payments. To develop a database for sampling malpractice payments, we restructured the DPDB to include only one practitioner name per record. For example, if the record identified two practitioners, two records were created. This allowed matching with records in the NPDB, which name only one practitioner per record. A match was performed based on the date of the incident, practitioner name, and settlement amount. Any records that did not specifically identify a name or adjudication number were deleted because they could not be traced to a specific malpractice payment. Finally, we reviewed the complete list and identified duplicates. The result was 1,933 total records, merging into 1,291[1] clearly identifiable records (299 Army, 216 Navy, and 776 Air Force). The sample for each Military Department was drawn using simple random sample selection methodology. The resultant samples included 53 Army, 46 Navy, and 59 Air Force unique malpractice payments.

Of the 53 Army records in the sample, 2 were not found and 4 were not applicable, resulting in 47 records for analysis. Of the 46 Navy records included in the sample, 1 was not identifiable, 11 were not found or had been destroyed,[2] and 4 were still pending decisions. Therefore, 30 Navy records were used in our analysis. Of the 59 Air Force records, 12 could not be found, leaving 47 for review.

Adverse Privileging Actions. We developed a database for sampling adverse privileging actions by matching the provider name, type of action taken, and effective date of the action. Additionally, we reviewed the complete list after the merge was completed and identified duplicates, combining records found in multiple sources. The result was 390 total records, merging into 223[3] clearly identifiable provider records (94 Army, 55 Navy, and 74 Air Force). The sample for each Military Department was drawn using simple

[1]That number includes 80 records found only in the Army files and 61 records found only in the Air Force files. Removing those records leaves 1,150 records that were in the DPDB and NPDB.

[2]The Navy destroys claim files after 2 years if no practitioner associated with the claim was reported to the NPDB.

[3]Of the 223 records, 3 were found only in Army files, leaving 220 records that were in the DPDB and NPDB.

random sample selection methodology. The resultant samples included 40 Army, 31 Navy, and 36 Air Force provider records. In the Army, one provider had two reports. In the Air Force, one record was not available for review. As a result, 41 Army, 31 Navy, and 35 Air Force provider records were available for review. However, of the 41 Army provider records initially reviewed, 2 were not applicable, leaving 39 for analysis. Of the 31 Navy provider records initially reviewed, 1 was not applicable, leaving 30 for analysis. For the Air Force, 10 provider records were not applicable, leaving 25 for analysis.

Limitations to Analysis. Although dentists were included in adverse privileging action reporting, none were sampled because of the inability to clearly identify them in the various databases. Because of the inconsistencies found in the various databases and the fact that many records were found only in the NPDB, neither the DPDB nor the NPDB can be taken as the "true" population. Because there was no clearly defined universe on which to project the sample results, no projections were made. Instead, review of the samples was the basis for our analysis. Despite the limitations, the sampling methodology demonstrated the sample selection was not biased.

Evaluation Type, Dates, and Standards. We performed this program evaluation from October 1996 through January 1997, and September 1997 through February 1998, in accordance with standards implemented by the Inspector General, DoD. We included tests of management controls considered necessary.

Contacts During the Evaluation. We visited or contacted individuals and organizations from the offices of the ASD(HA), Military Departments' Surgeons General, and Military Departments' JAGs within DoD. We also visited or contacted individuals from the offices of DHHS, Department of Justice, and the civilian community. Further details are available upon request.

Management Control Program

DoD Directive 5010.38, "Management Control Program," August 26, 1996, requires DoD organizations to implement a comprehensive system of management controls that provides reasonable assurance that programs are operating as intended and to evaluate the adequacy of the controls.

Scope of Review of the Management Control Program. We reviewed the adequacy of management controls over the DoD implementation of the NPDB guidelines in the offices of the ASD(HA) and the Surgeons General. Specifically, we reviewed management controls over reporting malpractice payments and adverse privileging actions in a complete and timely manner. We also reviewed management's self-evaluation applicable to those controls.

Adequacy of Management Controls. We identified material management control weaknesses for the offices of the ASD(HA) and Surgeons General as defined by DoD Directive 5010.38. In the offices of the Surgeons General, management controls for NPDB reporting were not adequate to ensure that malpractice payments and adverse privileging actions were reported to the

DPDB and the NPDB completely and in a timely manner. In addition, the Office of the ASD(HA) did not provide adequate oversight of the program. Recommendations A.1., A.2., A.3.b., B.1., B.2., C.1., and C.2., will improve reporting. A copy of the report will be provided to the senior official responsible for management controls in the offices of the ASD(HA) and Surgeons General.

Adequacy of Management's Self-Evaluation. Management at the Office of the ASD(HA) and the Military Departments did not identify implementation of NPDB reporting as an assessable unit and, therefore, did not identify or report any related management control weaknesses.

Summary of Prior Coverage

There were no related DoD reports in the last 5 years; however, the DHHS Inspector General and the Public Health Service issued related reports. The DHHS Inspector General report is summarized below and the Public Health Service report is discussed on page 14.

DHHS Office of the Inspector General Report No. OEI-01-94-00050, "Hospital Reporting to the National Practitioner Data Bank," February 1995. The report states that there were large variations in NPDB reporting from State to State and that about 75 percent of all hospitals in the United States had never reported an adverse privileging action. The report recommended that the Public Health Service further inquire through the DHHS Health Resources Services Administration to get a better understanding of factors affecting hospital reporting, set up a conference to focus on issues influencing reporting, and work with the Health Care Financing Administration to ensure that the Joint Commission on Accreditation of Healthcare Organizations assesses more fully hospitals' compliance with NPDB law.

Appendix B. Other Matters of Interest

Draft DoD Directive 6025.14. On January 22, 1998, the ASD(HA) requested comments on a draft revision of DoD Directive 6025.14. On March 11, 1998, the Inspector General, DoD, nonconcurred with the draft policy. Key reasons for the nonconcurrence were as follows.

o The Directive does not provide time frames for reporting malpractice payments or adverse privileging actions.

o The Directive continues a policy that results in limited reporting of malpractice payments by the Military Departments.

o The Directive does not provide clear definitions of reportable adverse privileging actions, and it is not consistent with the reportable actions required by the NPDB.

o The Directive does not include sufficient oversight by the Office of the ASD(HA) to ensure consistent application of reporting malpractice payments and adverse privileging actions.

The revised Directive will consolidate DoD Directive 6025.14 and DoD Instruction 6025.15, canceling the Instruction. Because the Instruction provides most of the implementing guidance, it is critical that the revised DoD Directive contain as much detail as possible to ensure accurate, consistent, and timely reporting to the NPDB. The proposed revision does not contain sufficient detail.

Appendix C. Malpractice Payment Policies and Procedures

Policies

Army Policy. Army policy for reporting malpractice payments to the NPDB is outlined in Army Regulation 40-68. Since DoD policy was not finalized until November 1990, after the Regulation was published, details concerning the processing of malpractice payments were included in Interim Change I03. Change I03 states that the Surgeon General will send reports to the NPDB when standard of care is not met and a specific practitioner is identified as having not met the standard of care. If the healthcare practitioner is not licensed or the malpractice payment is attributable to a system or management problem, that is, outside the control of the healthcare practitioner, a report is not sent to the NPDB. Although there are time frames for elements of malpractice payment processing prior to reporting to the NPDB, there are no specific time frames for submitting reports to the NPDB.

Navy Policy. The primary Navy policy for reporting malpractice payments is BUMED Instruction 6010.18. It states that reports are sent by the Surgeon General to the NPDB if two conditions occur. First, monetary payment must be made in response to a claim, either as a settlement or court action. Second, the healthcare practitioner or trainee must have been responsible for an act or omission that was the cause (or a major contributing cause) of harm that resulted in the malpractice payment. The policy does not include any time frames for reporting malpractice payments to the NPDB.

Air Force Policy. Air Force policy for reporting malpractice payments is outlined in Air Force Instruction 44-119. The Air Force policy states that reports "are made to the NPDB in cases of malpractice claim payment according to the guidelines specified in DoDD [sic] 6025.15." Therefore, reports are sent by the Surgeon General only if standard of care is not met for a specific practitioner. The policy does not include any time frame standard for reporting.

Procedures

Army Procedures. After a claim is filed, the process begins with the base-level JAG, who is responsible for initiating a DD Form 2526, "Case Abstract for Malpractice Claims." The form is then forwarded to the MTF risk manager, who is responsible for completing any missing information and forwarding the information through the Regional Medical Command to the Army Medical Command. A standard of care determination is made at the MTF. The Army Claims Service contacts the Consultant Case Review Branch

for another standard of care determination. No further action is taken at the MTF until notification that the claim is settled or denied. The MTF forwards the final payment information to the Army Medical Command through the Regional Medical Command.

The Army Medical Command requires a completed DD Form 2526; the standard of care determinations by the MTF and the Consultant Case Review Branch; and information from the Army Claims Service that the claim is closed. If a malpractice payment is made, supporting documentation concerning the payment is provided by the Army Claims Service to the Army Medical Command. For lawsuits involving the Litigations Branch within the Army JAG and the Department of Justice, the process is similar. Once the claim is closed, if a malpractice payment is made, documentation supporting the payment is sent by the Litigations Branch or U.S. Attorneys to the Army Medical Command.

After all the information is received at the Army Medical Command, a final decision regarding reporting to the NPDB is made. If each review panel determines that the standard of care was met, then no report is sent to the NPDB. If there is a difference in opinion between the MTF and Consultant Case Review Branch, the Surgeon General convenes another panel for a final standard of care determination. A report is sent to the NPDB only when the Surgeon General makes a final determination that there was a breach in the standard of care and that the breach was caused by a specific practitioner. All final information is entered into the appropriate automated systems.

Navy Procedures. The Navy malpractice process begins when a potentially compensatory event is investigated for potential claims and litigations. This could occur before any claim is filed. The information is provided to BUMED, which summarizes the investigation for potential risk management and quality assurance action and determines whether the MTF staff took all necessary corrective actions. Prior to October 1997, BUMED obtained a specialty review; after October 1997, that responsibility was delegated to the MTF.

When a claim is filed, the MTF staff works on the investigation with the Navy Legal Services Office, within the Navy JAG. The MTF makes a standard of care determination and forwards that information to the legal staff. The JAG handles the claim and BUMED receives a courtesy copy of the reviews supporting the claim. BUMED waits to be notified by the JAG, including Department of Justice cases, that the claim is settled or denied.

After notification of the malpractice payment, the risk management office within BUMED reviews the claim and determines if reviews indicate the standard of care was met. If the standard of care was met, no reports are sent to the NPDB, appropriate files are updated, and the claim is closed. If the standard of care was not met, BUMED determines which practitioners were associated with the claim and identifies those who might be reported to the NPDB. The practitioners are notified for their input for consideration by the Professional Case Review Panel (the Panel).

All paid claims are reviewed by the Panel. A package is prepared for the Panel that includes all review decisions, the legal documents, and any input from the practitioner associated with the claim. The Panel is permanent and convenes monthly. It is tasked with offering recommendations to the Surgeon General on

whether or not to report a practitioner to the NPDB. If the recommendation is not to report, then BUMED sends a letter to the practitioner that his or her name will not be reported to the NPDB. If the recommendation is to report, then that recommendation goes to the Surgeon General. The final decision for reporting to the NPDB resides with the Surgeon General. When the Surgeon General approves reporting to the NPDB, a report is sent and the appropriate automated files are updated.

Air Force Procedures. The malpractice process in the Air Force begins when a potentially compensable event occurs at the MTF. When such an event occurs, MTF staff initiate a quality assurance review of the care provided, during which the risk manager identifies all practitioners associated with the event and obtains written statements from them.

The claim process begins when the Standard Form 95, "Claims for Damages, Injury, or Death," is sent to the base claims officer, who is responsible for investigating the claim. During the investigation, the base claims officer obtains a copy of the medical records and quality assurance review from the risk manager, identifies the practitioner(s) associated with the claim and other witnesses that could provide information about the incident, interviews the witnesses, documents the interviews, and prepares a review of the applicable law. A memorandum that describes the claim, with supporting documentation, is then sent to an Air Force regional medical law consultant.

The medical law consultant continues the development of the case file by having specialty reviewers review the claim and provide a written summary of fact, including a standard of care determination. All memorandums and supporting documentation are forwarded to the appropriate legal and medical offices. The Office of the Surgeon General reviews the file. If the standard of care determination indicated that it was met and the legal office reported that the claim is closed (payment or denial), the file is closed, the appropriate systems are updated, and no report is sent to the NPDB.

If, however, the standard of care determination was not met, the MTF commander is responsible for notifying the practitioners of that decision and their right to appeal the determination. If practitioners appeal, a Surgeon General medical consultant reviews the claim and makes another standard of care determination. The Medical Practice Review Board, the recommending body to the Surgeon General, reviews the entire claim, makes a final standard of care determination, and provides the Surgeon General with a recommendation about reporting the practitioner to the NPDB. The final decision for reporting to the NPDB is made by the Surgeon General. This could occur prior to any malpractice payment. When the Surgeon General is notified that the claim was paid by the JAG or the Department of Justice through the JAG, NPDB reporting is completed, if authorized.

Appendix D. Laws Applicable to DoD for Malpractice Claims

Following are summaries of the three Federal laws and the Supreme Court decision that define the policies for submitting malpractice claims to the DoD.

Federal Tort Claims Act. The Federal Tort Claims Act, August 2, 1946, is the basic law prescribing the policies and procedures for submitting a monetary claim against the U.S. Government for personal injury or death caused by the negligence or wrongful act of an employee of the U.S. Government. Medical malpractice claims are included under the Act. The Act excludes any claim arising in a foreign country. As a result, claims are limited to injuries or deaths that occurred in the 50 states, the District of Columbia, or U.S. territories. The Act does not include any limit on the dollar amount of a claim. If the claim is not settled within 6 months after filing, the claimant has the right to sue the U.S. Government in Federal Court.

Gonzales Act. The Gonzales Act, also called the Medical Malpractice Immunity Act, October 8, 1976, states that military healthcare practitioners are protected from malpractice liability while acting within the scope of their responsibility. Thus, a military healthcare practitioner cannot be sued directly for malpractice. Individuals injured in an MTF would file a claim against the U.S. Government under the Federal Tort Claims Act or the Military Claims Act.

Military Claims Act. The Military Claims Act, August 10, 1956, allows individuals to file malpractice claims for injuries or deaths caused by civilian employees or military members when the incident is not covered by the Federal Tort Claims Act. Therefore, any claims arising from personal injury or death in a foreign country are filed under the Military Claims Act. The Military Claims Act allows claims to be filed within 2 years of injury or death. Claim payments normally do not exceed $100,000. Individuals may file only malpractice claims, not lawsuits, under the Military Claims Act.

Feres Doctrine. The Feres Doctrine resulted from a December 4, 1950, Supreme Court decision that the Government was not liable under the Federal Tort Claims Act for injuries to Service members arising out of an activity incident to military service. As a result, Service members are prohibited from filing a malpractice claim or suing the U.S. Government. The Doctrine does not apply to their dependents, retired Service members, or other civilians receiving treatment in MTFs.

Appendix E. Adverse Privileging Action Policies and Procedures

Policies

Army Policy. Army Regulation 40-68 addresses the requirement to report adverse privileging actions to the NPDB, but it does not contain explicit procedures because the policy was issued prior to the implementation of the NPDB. Detailed procedures are included in Interim Change I03. Reportable privileging actions include denials, restrictions, revocations, and suspensions of privileges. The policy states that any closed adverse privileging action longer than 30 days in duration will be reported to the NPDB. It does not identify a time frame in which the report must be sent. The automatic suspension of privileges for providers enrolled in rehabilitation for substance abuse are not reported unless they fail to satisfactorily complete the program, or the adverse privileging action was taken for incompetence, endangerment, or unprofessional conduct.

Navy Policy. BUMED Instruction 6010.18, and BUMED Instruction 6320.67, "Adverse Privileging Actions, Peer Review Panel Procedures, and Healthcare Provider Reporting," April 23, 1990, are the primary policies for reporting adverse privileging actions to the NPDB. Navy policy includes denials, limitations, and revocations of clinical privileges as possible reportable adverse privileging actions. It does not state that the adverse privileging action has to exceed 30 days to be reportable. BUMED policy, which is to report adverse privileging actions on all privileged providers, exceeds DHHS policy which requires reports on only physicians and dentists. Navy policy states that a report will be sent to the NPDB within 15 days of completion of the appeal procedures or notification that the provider will not appeal the final action. The policy does not differentiate between adverse privileging actions related to substance abuse and other privileging actions.

Air Force Policy. Air Force Instruction 44-119 is the primary policy for adverse privileging action reporting. The policy states that after a final decision is made, national and State regulatory agencies, including the NPDB, are to be notified of reportable actions. Reportable privileging actions include denials, limitations, and revocations of privileges. The policy does not identify time frames for which the privileging action must occur or time frames in which reports are to be sent. The policy states that a DD Form 2499 will be generated when a provider enters a substance abuse program, regardless of whether or not an adverse privileging action occurred. The completion of the form is separate from NPDB reporting.

Procedures

Army Procedures. If a questionable action occurs regarding a provider's ability to provide patient care, the provider's privileges are put in abeyance.[1] While in abeyance, three actions occur. First, the provider is notified in writing of the action and signs a receipt acknowledging the notification. Second, a DD Form 2499 is prepared at the MTF and sent through the Regional Medical Command to the Army Medical Command. Last, an investigation is initiated to collect information about the questionable action. Abeyance can last up to 28 days. If the investigation reveals that cause did not exist to take an adverse privileging action, the case is closed. If further investigation is needed and the action extends beyond 28 days, the MTF credentials committee makes a decision as to the action necessary.

If the credentials committee believes that cause exists, and either (1) immediate action is needed to protect the safety of patients, employees, or others in the MTF or (2) the provider is involved in gross negligence, then a summary suspension[2] is taken. If cause exists, but neither of the two situations apply, then the credentials committee can recommend either limitation, restriction, or revocation of privileges. The provider is notified in writing of the action and given 10 days to request a hearing. If no hearing is requested, then the action is deemed final for reporting purposes and is reported through the Regional Medical Command to the Army Medical Command, which is responsible for reporting to the NPDB.

If the provider requests a hearing, all information is presented and the credentials committee makes a recommendation to the MTF commander. If no action is taken, the case is closed and a closeout DD Form 2499 is completed and sent to the Army Medical Command through the Regional Medical Command. If action is taken, the provider has the right to appeal the decision through the Regional Medical Command to the Army Medical Command. If no appeal is requested, the action is deemed final for reporting purposes and the information is sent through the Regional Medical Command to the Army Medical Command, which submits a report to the NPDB. If the provider appeals the decision, a panel of three providers, including one in the same specialty, reviews the documentation. If the decision is to restrict, revoke, or suspend clinical privileges after all due process procedures are completed, the case is deemed final and the provider is reported to the NPDB. Due process procedures, including the right to a hearing and appeal, also apply to providers denied privileges at an MTF.

Navy Procedures. If a questionable action occurs, privileges are initially placed in abeyance. The MTF commander could, however, take whatever action is necessary to ensure patient safety. The purpose of abeyance is to provide time to conduct an investigation and gather additional information to

[1]See Appendix F for a definition.

[2]A summary suspension of privileges is also known as a summary action of suspension. See Appendix F for a definition.

make a more definitive decision. Abeyance is for a maximum of 28 days, after which time the commander makes a decision to reinstate or suspend the provider's privileges. If the privileges are reinstated, no further action is taken and the case is closed.

If a provider's privileges are suspended, the action is reviewed by an MTF Peer Review Panel (the Review Panel). The Review Panel is composed of providers from the MTF appointed by the commander. The responsibility of the Review Panel is to review the provider's conduct or clinical practice and make a recommendation to the commander regarding the provider's privileges. The Review Panel will make a recommendation that the provider's privileges be denied, limited, reinstated, or revoked. Generally the commander accepts the recommendation of the Review Panel, but he or she is not bound by its recommendation and could render a different decision. When the commander makes a decision, the provider is notified in writing of the decision, the reasons for the decision, and the provider's right to appeal any adverse privileging action decision. If the decision is to reinstate, no further action is taken and the case is closed. For an adverse privileging action, a notification is sent to the provider that outlines the procedures and time frames for an appeal. If the provider chooses not to appeal the decision, the case is deemed final and the appropriate documents are forwarded to BUMED. Any reportable adverse privileging actions taken are reported to the NPDB by BUMED.

If the provider chooses to appeal the MTF commander's decision, the appeal is submitted to BUMED. An attorney at BUMED prepares an executive brief that summarizes the case. The executive brief is forwarded to Chief of the provider's Corps[3] for comment, who then forwards it to the Surgeon General. The Surgeon General reviews the provider's appeal, the executive brief, and the Corps Chief's comments, and either grants or denies the appeal. The provider is notified by letter of the Surgeon General's decision regarding the appeal.

The case is final for reporting purposes after completion of the appeal process. In most cases, if the final decision is a reportable adverse privileging action, BUMED reports the action to the NPDB. Although reportable according to NPDB guidelines, suspensions are not reported by the Navy. The Navy considers suspensions temporary actions and therefore only reports denials, limitations, reinstatements, or revocations of provider privileges. The exception is when a provider separates while privileges are suspended. In that case, BUMED submits a report to the NPDB, as appropriate.

Air Force Procedures. If a questionable action occurs regarding a provider's ability to provide patient care, the MTF credentials committee performs a review of the provider's performance and makes a recommendation to the MTF commander to either conduct an investigation to obtain additional information or take an adverse privileging action.

If an investigation is conducted, the provider is removed from any patient care duties and the provider's privileges are placed in abeyance. Abeyance in the Air Force can last up to 60 days. If the investigation is not completed within the 60-day period of abeyance, the provider's privileges are automatically suspended for up to 6 months. The provider's case is referred to an MTF

[3]In the Navy, the Corps include the Dental, Medical, Medical Service, and Nurse Corps.

investigating committee or credentials committee for completion of the investigation. The committee handling the case would make a recommendation to the MTF commander to deny, limit, reinstate, or revoke the provider's privileges.

Whether the commander decides to initially take an adverse privileging action or makes the decision as a result of the investigation, the provider is notified of the pending action and of the right to a hearing. If the provider does not request a hearing, the action is considered final for reporting purposes and the MTF sends the case file through its major command to the Office of the Surgeon General for approval and reporting to the NPDB. If the provider requests a hearing, it is conducted at the MTF level and the results are provided to the MTF commander. The provider is sent a copy of the hearing results and recommendations and is allowed to submit a letter of exception and correction to the MTF commander. The MTF commander then makes the decision to deny, limit, reinstate, or revoke the privileges. The provider is notified of the commander's decision and, if the decision is to deny, limit, or revoke the privileges, the provider can appeal to the Surgeon General. The adverse action case file is sent to the major command, which is responsible for making sure the file is complete. The major command then sends the file to the Office of the Surgeon General.

If the action is not appealed, the case is deemed final for reporting purposes and, if the action is a reportable action, a report is sent to the NPDB by the Office of the Surgeon General. If the action is appealed, a consultant for the Surgeon General's office performs a clinical review of the case that focuses on whether the action is supported by the evidence. The Surgeon General's legal counsel performs a legal review of the case for compliance with policy and due process procedures. When both reviews are completed, the Surgeon General's Medical Practice Review Board reviews the case and makes a recommendation to the Surgeon General to uphold the MTF commander's final decision, grant the appeal in part, or grant the appeal in total. The Surgeon General, after consulting with legal and medical staff, either concurs or nonconcurs with the recommendation. If the final decision is to take an adverse privileging action, the case is deemed final and a report is sent to the NPDB.

Although reportable according to NPDB guidelines, suspensions are not reported by the Air Force. The Air Force considers suspensions temporary actions. The Air Force policy is to report denials, limitations, reinstatements, or revocations of provider privileges. The exception is when a provider separates while privileges are suspended. In that case, the Air Force submits a report to the NPDB, as appropriate.

Appendix F. Proposed Definitions of Key Terms for Future DoD Policy

The following are proposed definitions for consideration in publishing future DoD policy regarding NPDB reporting. These definitions are based on DoD policies, Military Department policies, and NPDB guidelines.

Abeyance: The temporary assignment of a provider from clinical duties to nonclinical duties while an internal or external peer review or quality assurance investigation is conducted. Abeyances cannot exceed 30 days. Abeyance is not considered an adverse privileging action.

Adverse Privileging Action: The denial, reduction, restriction, revocation, or suspension of clinical privileges based on misconduct, professional impairment, or lack of professional competence. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership may also result in an adverse privileging action.

Clinical Privileging: The process whereby healthcare entities grant providers permission and responsibility to provide specified or delineated healthcare within the scope of his or her certification, license, or registration. Clinical privileges define the scope and limits of practice for individual providers and are based on the capability of the healthcare facility; the provider's current competence, health status, judgment, licensure, and relevant training and experience; and peer and department head recommendations.

Credentials: The documents that constitute evidence of certification, education, experience, expertise, health status, licensure, and training of a healthcare practitioner.

Denial of Privileges: Refusal to grant requested privileges to a provider. This could occur at initial application of privileges or when renewal of privileges is requested. Denial of privileges because of professional incompetence or misconduct is reportable to the NPDB.

Healthcare Practitioner: Any healthcare professional required to possess a professional license or other authorization. These include all healthcare providers, plus practical nurses, registered nurses, and any other person required to possess a license or other authorization as may be designated by the ASD(HA).

Healthcare Provider: Healthcare professionals, whether military (active or Reserve) or civilian (civil service or under contractual arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens. Privileges are granted within the scope of the provider's certification, license, or registration. Providers include physicians, dentists, nurse anesthetists, nurse midwives, nurse practitioners, audiologists, clinical dietitians, clinical pharmacists, clinical psychologists, occupational therapists, optometrists, physical therapists, physician assistants, podiatrists, social workers, speech pathologists, and other persons providing direct patient care as may be designated by the ASD(HA).

License: A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare within the scope of practice for a discipline. To be acceptable, the license must be:

a. Current: Active, not revoked, suspended, or lapsed in registration.

b. Valid: The issuing authority accepts, investigates, and acts upon assurance information, such as practitioner professional performance, conduct, and ethics of practice, regardless of the practitioner's military status or residency.

c. Unrestricted: Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

Limitation of Privileges: Limitation of privileges is not a valid adverse privileging action per the NPDB guidelines. See entries for reduction and restriction of privileges, which are reportable adverse privileging actions.

Malpractice Payment: Money paid as a result of a settlement or judgment of a written complaint or claim demanding payment based on a licensed healthcare practitioner's provision of or failure to provide healthcare services and may include, but is not limited to, the filing of a cause of action, based on the law of tort, brought in any State or Federal court or other adjudicative body.

NPDB: The database designated by the DHHS to receive and provide data on malpractice payments made on behalf of healthcare practitioners and data on adverse privileging actions against healthcare providers.

QPRAC: Software provided by the NPDB that allows eligible healthcare entities to electronically query and report on healthcare practitioners.

Reduction in Privileges: The permanent removal of a portion of a provider's clinical privileges. The reduction of privileges may be based on substandard performance, misconduct, physical impairment, or other factors limiting a provider's capability. Reduction in privileges is reportable to the NPDB.

Reinstatement of Privileges: A revision to an adverse privileging action taken that restores all or a portion of the provider's clinical privileges. Reinstatement of privileges is reportable to the NPDB.

Restriction of Privileges: A temporary or permanent limit placed on all or a portion of the provider's clinical privileges so the provider is required to obtain concurrence before providing all or some specified healthcare procedures within the scope of his or her certification, license, or registration. The restriction may require some type of supervision. Restriction of privileges is reportable to the NPDB.

Revocation of Privileges: The permanent removal of all clinical privileges of a healthcare provider. In most cases, such action should be followed by action to terminate the provider's DoD service. Revocation of privileges is reportable to the NPDB.

Significantly Involved Practitioner: A practitioner who, based on medical record entries, actively delivered care in either primary or consultative role during the episode(s) of care that gave rise to the malpractice allegation, regardless of the standard of care determination.

Standard of Care: Generally accepted or correctly considered actions of a provider or practitioner taken in order to arrive at a diagnosis or implement treatment of a given disease, disorder, or patient problem.

Summary Suspension (or Summary Action of Suspension) of Privileges: The temporary removal of all or part of a provider's privileges, taken prior to the completion of due process procedures, based on peer assessment or command decision that action is needed to protect patients or the integrity of the command resulting from cases involving possible incompetence, negligence, or unprofessional conduct. A summary suspension could continue until due process procedures are completed. Summary suspension of privileges within DoD are not reportable to the NPDB, unless the final action is reportable.

Suspension of Privileges: The temporary removal of all or part of a provider's privileges resulting from incompetence, negligence, or unprofessional conduct after due process procedures are completed. Suspension of privileges is reportable to the NPDB.

Appendix G. Comparison of Defense Practitioner Data Bank and National Practitioner Data Bank Records

The following two figures show the number and percent of records from the data sources used for the samples. Figure G-1 identifies the malpractice payment sources. Figure G-2 identifies the sources for the adverse privileging actions. All malpractice payments and adverse privileging actions included in the NPDB should have been included in the DPDB.

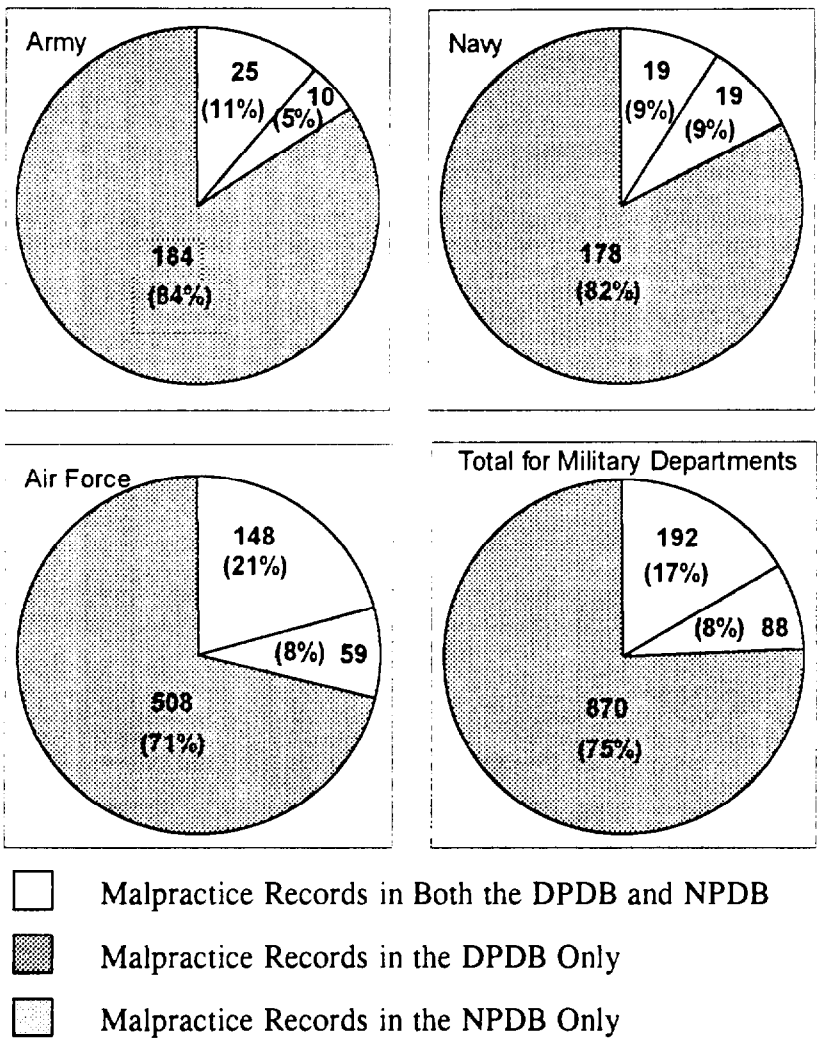

Figure G-1. Comparison of Malpractice Payment Record Sources

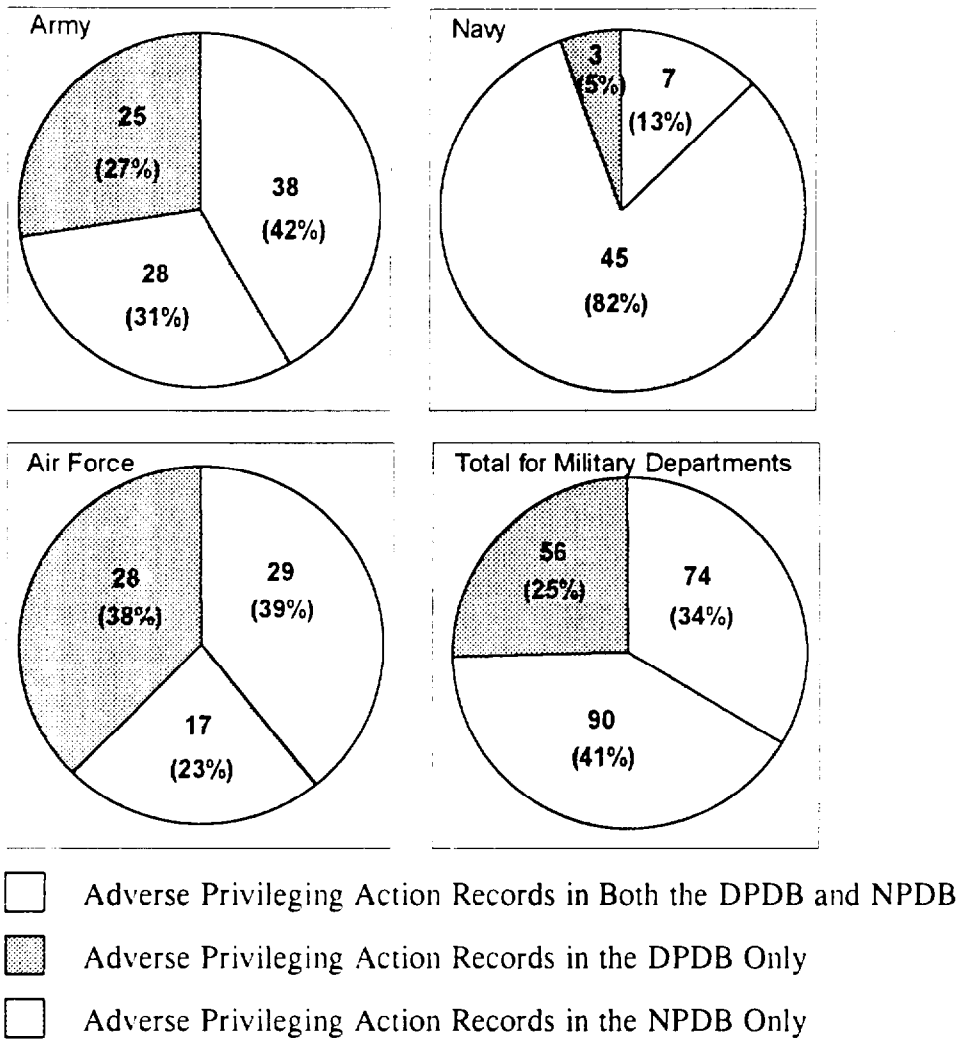

Figure G-2. Comparison of Adverse Privileging Action Record Sources

Appendix H. Report Distribution

Office of the Secretary of Defense

Under Secretary of Defense (Comptroller)
  Deputy Chief Financial Officer
  Deputy Comptroller (Program/Budget)
Assistant Secretary of Defense (Health Affairs)
Assistant Secretary of Defense (Public Affairs)
Director, Defense Logistics Studies Information Exchange

Department of the Army

Auditor General, Department of the Army

Department of the Navy

Assistant Secretary of the Navy (Financial Management and Comptroller)
Auditor General, Department of the Navy
Superintendent, Naval Post Graduate School

Department of the Air Force

Assistant Secretary of the Air Force (Financial Management and Comptroller)
Auditor General, Department of the Air Force

Other Defense Organizations

Director, Defense Contract Audit Agency
Director, Defense Logistics Agency
Director, National Security Agency
  Inspector General, National Security Agency
Inspector General, Defense Intelligence Agency

Non-Defense Federal Organizations and Individuals

Office of Management and Budget
Department of Health and Human Services
General Accounting Office
  National Security and International Affairs Division,
    Technical Information Center
  Health, Education and Human Services

Chairman and ranking minority member of each of the following congressional committees and subcommittees:

  Senate Committee on Appropriations
  Senate Subcommittee on Defense, Committee on Appropriations
  Senate Committee on Armed Services
  Senate Committee on Governmental Affairs
  Senate Special Committee on the Year 2000 Technology Problem
  House Committee on Appropriations
  House Subcommittee on National Security, Committee on Appropriations
  House Committee on Government Reform and Oversight
  House Subcommittee on Government Management, Information, and Technology,
    Committee on Government Reform and Oversight
  House Subcommittee on National Security, International Affairs, and Criminal Justice,
    Committee on Government Reform and Oversight
  House Committee on National Security

Part III - Management Comments

Assistant Secretary of Defense (Health Affairs) Comments

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

18 JUN 1998

MEMORANDUM FOR DIRECTOR, READINESS AND LOGISTICS SUPPORT DIRECTORATE

SUBJECT: Evaluation Report on DoD Implementation of the National Practitioner Data Bank (NPDB) Guidelines (Project No. 7LH-0009)

I am submitting this reply in response to your draft evaluation report on the DoD Implementation of the National Practitioner Data Bank Guidelines. The office of the Assistant Secretary of Defense (Health Affairs), and the Executive Director, TRICARE Management Activity thank your staff for their comprehensive review of the DoD systems for identifying, processing, and reporting providers to the NPDB who are associated with malpractice payments or subjected to adverse privileging actions. The Health Affairs response has been discussed with the Army, Navy and Air Force Surgeons General offices, the Service Judge Advocate General offices, the Armed Forces Institute of Pathology (AFIP) and the DoD General Counsel at the DoD Risk Management Committee Meeting.

I appreciate your exhaustive efforts on behalf of the Military Health System. Your staff made some excellent observations and offered many practical suggestions for effecting process improvement. DoD concurs with all but two of the IG recommendations. Our rationale for non-concurrence with the recommendations to: 1) report all malpractice payments, whether standard of care was met or not, and 2) submit the report to the NPDB within 30 days following written notification of a malpractice payment, is fully explained on pages 2-4 of the attached document.

My POC for questions related to this document are LtCol Jim Williamson or COL Christine Miller in the TRICARE Management Activity. They can be reached at (703) 681-3629 or email (Jim.Williamson@osd.tma.mil) (Christine.Miller@osd.tma.mil).

Dr. Sue Bailey

Dr. Sue Bailey

DoD IMPLEMENTATION OF THE NATIONAL PRACTITIONER DATA BANK GUIDELINES

DoD(HA)/TMA Response to DoD IG

General Comments

The Assistant Secretary of Defense for Health Affairs and the Executive Director of the TRICARE Management Activity wish to thank the DoD IG for their comprehensive review of DoD and Service implementation of the National Practitioner Data Bank guidelines and their recommendations for process improvements for NPDB reporting.

The DoD response to the IG was discussed with the Army, Navy and Air Force Surgeons General offices, Service Judge Advocate General offices, AFIP and DoD General Counsel at the DoD Risk Management Committee Meeting.

A. IG Findings related to DoD Reporting of Malpractice Payments:

1. DoD reporting of malpractice payments to the NPDB needs improvement. Of the 124 malpractice payment records reviewed, 70% had not been reported the NPDB. In the Memorandum of Understanding (MOU) between DoD and the Department of Health and Human Services (DHHS), the ASD(HA) agreed to report all malpractice payments, even when the standard of care was met. However, when DoD implementing policy was issued, reporting malpractice payments was required only when the standard of care was not met and the incident was not the result of a system error.

2. Those reports made to the NPDB had not been submitted in a timely manner. The timeliness problem resulted from a lack of definitive policy on time frames for reporting and weakness in the reporting process.

B. DoD IG Recommendations for the ASD(HA) and Comments from ASD(HA):

(A.1.a.) Enter into an MOU with the Assistant Attorney General, Civil Division, Department of Justice to:

(A.1.a.(1) Require the U.S. Attorneys to provide malpractice payment information within 30 days of payment or denial.

We concur with this recommendation. DoD(HA) will seek to enter into an MOU with the Assistant Attorney General, Civil Division, Department of Justice (DOJ). The MOU will specify what type of malpractice information the Services require in order to efficiently process paid malpractice claims.

- Case name and number, patient name and social security number
- Date of incident
- Outcome (claim paid or denied)
- Payment date, amount, and reason for payment
- Copies of any medical reviews done in support of the malpractice payment.
- Name of provider(s) on whose behalf payment was made and whether the Department of Justice medical reviews indicated that the provider(s) breached the standard of care.

The department of legal medicine of the AFIP will receive a monthly report of malpractice claims certified from the Judgment Fund for the three Defense agencies. (see attachment 1) The information will be provided to the Service risk managers monthly.

(A.1.a.(2) Include an agreement for the Department of Justice to provide a quarterly (or more frequent) reconciliation of outstanding claims from the previous quarter.

We concur with this recommendation. The MOU with the DOJ will include a requirement for DOJ to send monthly reports on new cases that are outstanding claims filed. Reports will be forwarded to: the Service Judge Advocate General Staff; the Armed Forces Institute of Pathology (AFIP) legal medicine department; the Service Surgeons General Offices (risk managers); and the risk management committee. Cases pending litigation will not be included in the report.

(A.1.b.) Revise current policy to:

(A.1.b.(1) Require the Military Departments to report all malpractice payments whether standard of care was met or not, except for those cases due to circumstances outside the control of any practitioner, such as drugs mislabeled by the supplier, equipment or power failure, or accidents unrelated to patient care.

We Non-Concur with this recommendation. The DoD implementation policy on NPDB reporting and the decision by the ASD(HA) to amend the provisions of the MOU between DoD(HA) and the DHHS, was done in an effort to level the playing field between DoD healthcare practitioners and practitioners in the civilian community. It is important to understand that, despite the philosophical intent of the NPDB, it is universally viewed by healthcare practitioners as a data base for "bad practitioners" and an entity to be avoided.

The civilian community currently employs several methods to protect healthcare practitioners from being reported to the NPDB. The most common is the use of a "corporate shield". Under this concept, the practitioner's name is deleted from the malpractice claim and the claim is filed against the corporation employing the practitioner (e.g., Kaiser). Even if a malpractice payment is made on behalf Kaiser, since a corporation cannot be reported to the NPDB, no report is filed. Practitioners who are not employed by a corporation have the ability

to hire an attorney to represent their interests in a malpractice claim. In some instances insurance companies will make malpractice payments directly to the provider and have the provider pay the claimant. There is no NPDB reporting requirement if a practitioner provides reimbursement directly to the claimant. Although the Health Resources and Services Administration is trying to eliminate corporate shield and feels close to doing so, Health Affairs believes the elimination of corporate shield should be accomplished first before allowing reporting of all malpractice payments on DoD providers.

Under the provisions of the Gonzales Act and Federal Tort Claims Act, a military healthcare practitioner cannot be sued directly for malpractice. All claims must be filed against the U.S. Government. While this could be viewed as a form of corporate shield, DoD(HA) policy does provide for the reporting of malpractice payments if the standard of care (SOC) was not met, or if the cause of the untoward incident is attributable to a systems problem Vs a practitioner problem. This determination is made by the Service Surgeon General only after a thorough peer review of the case.

In order to facilitate NPDB reporting IAW DoD policy, DoD has implemented a policy whereby all paid cases determined to meet the SOC or attributable to a systems problem will be peer reviewed by a external civilian agency. Beginning 1 June 1998, and retroactive to 1 January 1998, all "standard of care (SOC) met" and "systems" problem determinations on cases for which a payment was made will be sent to the National Quality Monitoring Contractor (KePRO) for review. The Services will send a copy of these cases to KePRO after the Surgeons General Office risk manager is notified of a payment and a SOC met or system problem determination has been made. KePRO shall complete its review within 30 days of receipt of the case. KePRO will forward their peer review report to the surgeon general for use as additional information in making his final determination. A report will also be forwarded to AFIP who will monitor the results of this process for the TRICARE Management Activity. (attachment 2) The Services will also provide a report to AFIP at the quarterly Risk Management Committee meeting for tracking and reconciliation purposes.

For DoD(HA) policy to mandate the reporting of all malpractice payments to the NPDB would be a devastating blow to the morale of its practitioners. A large number of paid malpractice claims are settled for the convenience of the Government and not on the basis of the merits of the claim. Reasons for administrative settlements might include: lost medical records; bias on the part of the judge in the jurisdiction; the aggressiveness of the plaintiff's law firm; the sympathy factor of the plaintiff and the quality of the government witnesses. DoD practitioners have no say in whether or not a claim is settled. DoD(HA) is aware that DHHS is trying to legislate NPDB reform; however, such action is highly unlikely to be successful. If, and when, that comes to fruition, we will review our current position to ensure we are in compliance with the law.

(A.1.b.(2) Require that National Practitioner Data Bank reports be sent within 30 calendar days of receipt of written notification of malpractice payment.

We non-concur with this recommendation. The Services will modify their current processes, as necessary, in order to send a copy of the case documents to KePRO after 90 days of receiving complete notification of a malpractice payment. KePRO turn around time to the Surgeons general offices is 30 days. NPDB reports will be filed 120 days after the Service's risk manager receives complete notification that a payment was made. (Complete notification meaning all the necessary information on the case from the JAG or DOJ (see para A.1.a.(1). The 120 days is required to allow adequate time to collect a copy of the patient record and other necessary documentation, obtain input from involved provider(s), perform internal (3 levels) and external peer review of the case, and make the SOC determination.

(A.1.b.(3) Direct the Surgeons General to provide, at least annually, quality management information outlining the number of malpractice payments, the number of reports submitted to the NPDB, timeliness of reports, any backlog, and any problems with NPDB reporting.

We concur with this recommendation. Services have developed metrics for tracking: the number of malpractice payments; the number of reports submitted to the NPDB; the timeliness of the reports; and any backlog and/or problems with NPDB reporting. The DoD Risk Management Committee will be responsible for monitoring the metrics each quarter.

(A.1.c) Review the information provided by the Surgeons General regarding NPDB reporting and take corrective action to resolve any reporting problems and provide assistance in eliminating any backlog.

We concur with this recommendation. Review will be done at the quarterly Risk Management Committee meeting.

(A.1.d) Provide coverage of NPDB reporting as part of its management control program.

We concur with this recommendation. NPDB reporting will become part of the management control program. The quarterly Risk Management Committee meeting will be the primary oversight body.

C. <u>IG Findings Related to the Reporting of Adverse Privileging Actions:</u>

1. Although the Military Departments were reporting physicians and dentists, the specific adverse privileging actions reported to the National Practitioner Data Bank (NPDB) varied widely. The variations in reporting occurred because DoD and the

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Military Department policies inconsistently defined the various types of adverse privileging actions and which actions to report.

2. The Military Departments did not report the actions taken in a timely manner.

D. DoD IG Recommendations for the ASD(HA) and Comments for ASD(HA):

(B) Recommend that the ASD(HA):

(B.1) Revise Policy to:

(B.1.a) Clearly define all terms related to adverse privileging actions. At a minimum the policy should delete any reference to limitation, and clearly define abeyance, denial, reduction, reinstatement, restriction, revocation and suspension.

We concur with this recommendation. DoD(HA) will direct the Risk Management Committee to review the "Proposed Definition of Key Terms for Future DoD Policy" outlined in the IG report and come to a consensus on standardizing key terms for describing adverse privileging actions across the Services. Services will modify their respective policies accordingly.

(B.1.b) Require the Surgeons General to report all associated adverse privileging actions taken when the final action results in an adverse action, consistent with NPDB reporting.

We concur with this recommendation. The DoD Risk Management Committee will Monitor compliance with the IG recommendation.

(B.1.c) Report adverse privileging actions taken against providers with alcohol-related impairments who do not self-refer into a rehabilitation program, or those who self-refer but do not complete the rehabilitation program.

We concur with this recommendation. Services not currently following this recommendation will modify their policies accordingly.

(B.1.d) Require reporting within 30 calendar days of the date of Surgeon General approval of the adverse privileging action.

We concur with this recommendation. Since the Surgeons General approval of the adverse privileging action occurs only after the practitioner involved has exhausted his/her "due process" rights and the action is deemed final, the requirement to report within 30 days is

reasonable. DoD(HA) will direct the Surgeons General to comply with the IG recommendation and modify their policy accordingly.

(B.1.e) Direct the Surgeons General to provide, at least annually, management information outlining the number of adverse privileging actions taken, the number reported to the NPDB, the timeliness of the reports, any backlog and any problems with NPDB reporting.

We concur with this recommendation. Services have developed metrics for tracking: the number of adverse actions taken; the number of reports submitted to the NPDB; the timeliness of the reports; and any backlog and/or problems with NPDB reporting. The DoD Risk Management Committee will be responsible for monitoring these metrics each quarter.

(B.2) Review the information provided by the Surgeons General regarding NPDB reporting and take corrective action to resolve any reporting problems and provide assistance in eliminating any backlog.

We concur with these recommendations. The DoD Risk Management Committee will provide a forum for monitoring the status of the Services' NPDB reporting of adverse privileging actions and to address problems with the reporting process. This information will be collected by the Surgeons General's offices and will be reported quarterly at the DoD Risk Management Meeting.

D. Completeness of Automated Files:

IG Findings:

1. The Defense Practitioner Data Bank (DPDB) did not contain all records that had been reported to the National Practitioner Data Bank (NPDB). A merged data base sample of reports reviewed for this survey demonstrated that eight percent of the malpractice payments and 41 percent of the adverse privileging actions were found in the NPDB but not in the DPDB.

2. When reports did appear in both data banks, effective and final action dates were incorrect for 50 percent of a sample of records reviewed.

3. The variation in data base records is attributable to inadequate management controls which do not ensure that Military Departments report complete and accurate information to the DPDB and the NPDB.

IG Recommendations for the ASD(HA) and Comments from ASD(HA):

(C) No recommendations were made to the ASD(HA). Recommendations were made to the Surgeons General to:

(C.1) Reconcile the DPDB and the NPDB databases by submitting to the DPDB all records currently only in the NPDB.

(C.2) Implement procedures so that reports are submitted to the DPDB at the same time as data is submitted to the NPDB until the Centralized Credentials Quality Assurance System, version 2.0 is fully implemented.

ASD(HA) concurs with these recommendation. We recommend that the DoD Risk Management Committee oversee the implementation of the IG recommendations.

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Department of the Army Comments

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH VA 22041-3258

REPLY TO ATTENTION OF

DASG-HSZ (40)

09 JUN 1998

JLS 11 June 98

MEMORANDUM THRU Assistant Secretary of the Army (Manpower and Reserve Affairs)

Jayson L. Spiegel
Acting Assistant Secretary of the Army
(Manpower and Reserve Affairs)

FOR Director, Readiness and Logistics Support Directorate Inspector General, Department of Defense, 400 Army Navy Drive, Arlington, VA 22202

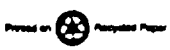
SUBJECT: Department of Defense Inspector General (DODIG) Draft Report on the DOD Implementation of the National Practitioner Data Bank Guidelines, 6 Apr 98

1. Reference memorandum, SAAG-PMO-L (36-2b), dated 20 April 1998, Subject: Evaluation Report on DOD Implementation of the National Practitioner Data Bank Guidelines (Project No. 7LH-0009). The following is the Army's position with respect to the findings, recommendations, and corrective actions of the subject report.

2. We concur with all findings and recommendations except A.1.b(1), which recommends a revision of the National Practitioner Data Bank (NPDB) reporting policy to require reports of all malpractice payments whether the standard of care was met or not; and, A.1.b(2), which recommends that reports be sent to the NPDB within 30 calendar days of receipt of written notification of claim payment.

3. The premise underlying recommendation A.1.b.(1) is that the reason why this agency has reported so few providers to the NPDB since its inception is because of the Service-imposed requirement that a standard of care deviation determination be made prior to the issuance of any report. Other administrative breakdowns, however, are thought to be the primary cause of the low report rate. Because this recommendation appears based on a finding of causative effect, the validity of which is questionable, it should not be adopted by this agency.

4. Regarding recommendation A.1.b.(2), a 30-day standard for submission of reports to the NPDB is inherently unworkable, given the necessity of obtaining documents from various sources and of notifying the provider for comment. By way of example, AR 40-68, Interim Change No. I03 allows seven (7) days for the Medical Treatment Facility to submit a completed DD Form 2526 to the US Army Medical Command (MEDCOM) upon notification of payment;



this can be extended, upon request, for up to twenty-one (21) days to allow for completion of the peer review process. Further, the notified provider is given thirty days to respond to any potential NPDB report. This agency's recommendation would be a 90- or 120-day standard.

5. The current reporting policy demonstrably works when both leadership and resources are focused on making it work. USAMEDCOM now has fifty-four (54) confirmed NPDB reports. Our current process now also supports the dual reporting requirement to the NPDB and the DPDB, and we will continue to collaborate with agents for the DPDB to align the data as necessary.

6. The Office of the Judge Advocate General concurred with this response. For additional information our point of contact is LTC Cannon, Provider Actions Staff Officer, at DSN 471-6195 or Commercial (210) 221-6195.

FOR THE SURGEON GENERAL:

JOHN J. CUDDY
Major General, DC
Deputy Surgeon General

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Department of the Navy Comments

Final Report Reference

DEPARTMENT OF THE NAVY
OFFICE OF THE ASSISTANT SECRETARY
(MANPOWER AND RESERVE AFFAIRS)
1000 NAVY PENTAGON
WASHINGTON, D.C. 20350-1000

JUN 16 1998

MEMORANDUM FOR THE DEPARTMENT OF DEFENSE INSPECTOR GENERAL

SUBJECT: Department of Defense Inspector General Draft Report on DoD Implementation of the National Practitioner Data Bank Guidelines

Navy has reviewed Attachment 1 and comments are provided as Attachment 2.

Department of Navy point of contact is CDR Frank Alamia, Bureau of Medicine and Surgery (MED-32RM), at (202) 762-3081.

KAREN S. HEATH
Principal Deputy

Attachments:
1. Draft Report
2. Navy Comments

Attachment Deleted

Final Report Reference

Navy Comments on the Evaluation Report of DoD Implementation of the National Practitioner Data Bank Guidelines

Finding A., page 5: *DoD Reporting of Malpractice Payments:* DoD reporting of Malpractice payments to the NPDB needs improvement. Of the 124 malpractice payment records reviewed, 87 (70 percent) had not been reported to the NPDB. In addition, those reported had not been submitted in a timely manner. The limited reporting occurred because DoD policy requires report for malpractice payments only when the Surgeon General determines a specific practitioner deviated from an accepted standard of care. The timeliness problem resulted from a lack of definitive policy on time frames for reporting a weaknesses in the reporting process. As a result, the NPDB was queried, healthcare entities did not have all relevant information available for making credentialing and privileging decisions.

Comment: Concur.

Recommendations for Corrective Action:

A.1.a., page 16: Enter into a memorandum of understanding with the Assistant Attorney General, Civil Division, Department of Justice to: Page 15

(1) Require the U.S. Attorneys to provide malpractice information within 30 days of payment or denial and include, at a minimum: patient name, case number, date of incident; outcome; payment or denial date and amount (if any); basis for the disposition; names of practitioners associated with the incident, and whether those practitioners breached standard of care based on Judge Advocate General medical reviews; and, copies of any medical reviews done in support of the malpractice payment.

Comment: Concur. Recommend adding patients social security number for better identification.

A.1.b., page 16: Revise current policy to:

(1) Require the Military Departments to report all malpractice payments whether standard of care was met or not, except for those cases due to circumstances outside the control of any practitioner, such as drugs mislabeled by the supplier, equipment or power failure, or accidents unrelated to patient care.

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Comment: Do Not Concur. The NPDB does not require reporting of all payments made in response to malpractice claims. Only payments made "on behalf" of a provider must be reported. In DoD, Federal Torts Claim Act (FTCA) litigation is always framed as against the Government. The involved provider may have knowledge of the action, but unlike civilian providers, has no control over the decision by the Office of the Judge Advocate General and the Justice Department to settle or litigate the claim. FTCA claims are handled according to what is in the best interest of the U.S. Government, not the individual provider. Claims are settled for a variety of reasons, such as the expense of litigation, even in cases where the standard of care has been met. In the private sector, many settlements are made in the name of the corporate healthcare entity vice the individual provider, thus, avoiding an otherwise reportable NPDB action. In the Navy, the Surgeon General carefully screens cases where a payment has been made, and reports the involved provider where the standard of care was not met. It is in those cases that the payment is deemed to be "on behalf" of the provider vice the U.S. Government. This is a fair and reasonable process that complies with NPDB requirements and protects providers. Implementation of the proposed recommendation would place military providers on an unfair and unequal playing field, with potential adverse impacts on morale and readiness.

Page 18

A.1.c., page 17: Review the information provided by the Surgeon General regarding NBDB reporting and take corrective action to resolve any reporting problems and provide assistance in eliminating any backlog.

Comment: Concur.

Page 19

A.2.a., page 17: Provide malpractice information to the offices of the Surgeons General within 30 days of the payment or denial. At a minimum, the report should include: patient name, case number, date of incident; outcome; payment or denial date and amount (if any); basis for disposition; names of practitioners associated with the incident, and whether those practitioners breached the standard of care based on Judge Advocate General medical reviews; and copies of any medical reviews done in support of the malpractice payment.

Comment: Qualified Concur. Office of Judge Advocate General (OJAG)(Code 35) will provide malpractice information to the office of the Navy Surgeon General in a report to include the items recommended by DoDIG. However, information will be

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provided within 45 versus 30 days of Code 35 being notified of a payment or final denial. Revised Page 19

A.2.b., page 17: Provide at least quarterly reconciliation of outstanding claims from the previous quarter. Page 19

Comment: Concur. OJAG (Code 35) will provide quarterly reports on open claims to the Navy Surgeon General

A.3.a., page 17: Identify the specific information and documents required from the Department of Justice and the appropriate Military Department Judge Advocate General in order to identify practitioners to report to the NPDB. A minimum list is provided in Recommendations A.1 and A.2. Page 20

Comment: Concur

A.3.b., page 17: Provide coverage of NPDB reporting as part of their management control programs. Appendix A provides detail on the adequacy of managements' self-assessments. Page 20

Comment: Concur.

Finding B., page 18: DoD Reporting of Adverse Privileging Actions: Although the Military Departments were reporting physicians and dentists, the specific adverse privileging actions reported to NPDB varied widely. In addition, the Military Departments did not report the actions taken in a timely manner, although processing time was improving. The variation in reporting occurred because DoD and Military Department polices inconsistently define the various types of adverse privileging actions and which actions to report. The timeliness problem occurred because DoD lacked policy establishing a time frame for reporting adverse privileging actions and because the Office of the ASD(HA) did not provide adequate oversight to ensure reporting was completed in a timely manner. As a result, healthcare entities querying the NPDB did not have all relevant information available when making credentialing or privileging decisions. Page 21

Comment: Concur.

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Recommendation for Corrective Action:

Page 29

B.1., page 27: We recommend the ASD(HA) revise policy to:

a. Clearly define all terms related to adverse privileging actions. At a minimum the policy should delete any reference to limitation and clearly define abeyance, denial, reduction, reinstatement, restriction, revocation, and suspension, as proposed in Appendix F.

b. Require the Surgeons General to report all associated adverse privileging actions taken when the final action results in an adverse action, consistent with NPDB reporting.

c. Require reporting adverse privileging actions against providers with alcohol-related impairments who do not self-refer into a rehabilitation program, or those who self-refer but do not complete the rehabilitation program.

d. Require reporting within 30 calendar days of the date of Surgeon General approval of the adverse privileging action.

e. Direct the Surgeons General to provide, at least annually, management information outlining the number reported to NPDB, the timeliness of the reports, any backlog, and any problems with NPDB reporting.

Comment: Concur.

Page 29

B.2., page 27: Review the information provided by the Surgeons General regarding NPBD reporting and take corrective actions to resolve any reporting problems and provide assistance in elimination of any backlog.

Comment: Concur.

Page 31

Finding C., page 28: Completeness of DoD Automated Files: The DPDB did not contain all records that had been reported to the NPDB. From the merged database used for our sample, 88 of the 1,150 (8 percent) malpractice payments and 90 of the 220 (41 percent) adverse privileging actions were in the NPDB but not the DPDB. In addition, when reports were in both data banks, effective and final action dates were incorrect for 50 percent of a sample of records reviewed. The variation in the records reported to the databases and the differences in data within the records occurred because management controls were not adequate to ensure the Military Departments reported complete and

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accurate information to the DPDB and the NPDB. As a result, AFIP did not have a complete, accurate, automated database for conducting analysis related to clinical and malpractice issues.

Comment: Concur.

Recommendation for Corrective Action:

C.1., page 32: Reconcile the Defense Practitioner Data Bank and National Practitioner Data Bank (NPDB) databases by submitting to the DPDB all records found only in the NPDB and correcting inconsistencies in the data. Page 35

Comment: Concur.

C.2., page 32. Implement procedures so that reports are submitted to the DPDB at the same time as data is submitted to the NPDB until the Centralized Credentials Quality Assurance System Version 2.0 is fully implemented. Page 35

Comment: Concur.

Additional Comments:

Navy has contracted with a private sector company to eliminate its backlog of NPDB cases. All backlogged cases have been reviewed and final action on each case is expected to take place by 30 July 1998. Management controls are already in place.

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Air Force Surgeon General Comments

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE

05 JUN 1998

MEMORANDUM FOR OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

FROM: HQ USAF/SG
110 Luke Avenue, Room 400
Bolling AFB, DC 20332-7050

SUBJECT: Response to Evaluation Report on DoD Implementation of the National Practitioner Data Bank (NPDB) Guidelines - Project No. 7LH-0009 (Your Draft Report, 6 April 1998)

Finding A: Reporting of Malpractice Payments

Concur: DoD policy lacks definitive time frames for reporting to the NPDB.

Recommendations for Corrective Action:

A.1. Assistant Secretary of Defense (Health Affairs):

A.1.b. Revise current policy to:

(1) Require the military departments to report all malpractice payments whether standard of care was met or not, except for those cases due to circumstances outside the control of any practitioner, such as drugs mislabeled by the supplier, equipment or power failure, and accidents unrelated to patient care

Nonconcur: Reporting of all malpractice payments is inappropriate for three reasons: 1) The NPDB does not mandate this; 2) The military departments are not private insurance companies, and 3) Decisions on litigation and payment are outside the control (or knowledge) of the individual provider

The NPDB reporting guidelines clearly direct that hospitals, insurance carriers, and reporting entities report when payment is made on behalf of a provider. The NPDB Guidebook, May 1996, page E-28 states "Employers who insure their employees must report medical malpractice payments they make for the benefit of their employees." These healthcare entities must make a determination on whether payment was made on behalf of the hospital or on behalf of individual providers.

The military departments are not private insurance companies and cannot report like a private insurance company. In the private sector, the provider gets notified that a claim is filed and then he or she notifies their insurance agent. The insurance agent is required to involve the provider in the deliberations resulting in payment or denial of the claim. Most of the Air Force providers are notified of their involvement in a claim after payment has been made, providing them no opportunity to respond to the claim.

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All malpractice claims and lawsuits are filed against the U.S. Government and paid on behalf of the U.S. Government. Litigation efforts tend to focus on the interests of the government and not on the individual providers. Decisions on whether to litigate or settle are often based on the judgement of a single reviewer, and the expertise of legal representatives may vary considerably. The provider is not involved in the process of adjudication of the claim.

The Surgeon General of each military department has the responsibility to make the discriminating decisions about whether payment was made on behalf of individual providers. The Air Force Surgeon General, who reviews each paid malpractice claim, the standard of care reviews, and individual provider's rebuttal, takes this responsibility very seriously before making a final decision. The Air Force has followed the Memorandum of Understanding with the NPDB, and DoD Policy on reporting of healthcare providers for malpractice. We have consistently identified significantly involved providers, made standard of care determinations and have reported individual providers to the NPDB when it was determined that the Air Force paid on their behalf. Within the unique framework of the military, this is the correct approach to take in reporting malpractice payments.

(2) Require NPDB reports be sent within 30 calendar days of receipt of written notification of malpractice payment.

Nonconcur: Timeline is too stringent to allow for quality of care review, provider notification of involvement in the claim, and Surgeon General approval of reporting. Would recommend 120 days.

A2. Judge Advocate General of the Military Departments:

a. Provide malpractice information to the offices of the Surgeons General within 30 days of payment or denial. At a minimum, the report should include the:

- Patient name, case number and date of incident

- Outcome

- Payment or denial date and amount (if any)

- the basis for the disposition

- the names of the practitioner associated with the incident, and whether those practitioners breached standard of care based on Department of Justice Medical reviews; and

- Copies of any medical reviews done in support of the malpractice payment

b. Provide at least quarterly reconciliation of outstanding claims from the previous quarter.

Partially Concur: Recommend 45 days to report final payments.

Revised Page 19

A3. Surgeon's General of the Military Departments:

a. Identify the specific information and documents required from the Department of Justice and the appropriate Military Department Judge Advocate General in order to identify practitioners to report to the NPDB.

Concur: Information cited in recommendation A2 is needed. In addition, a point of contact and phone number to request additional information on a paid claim is needed.

b. Provide coverage of NPDB reporting as part of their management control programs.

Concur: NPDB reporting is tracked monthly on both malpractice claims and adverse privileging actions. It is reported to the Commander, Air Force Medical Operations Agency and the Air Force Surgeon General.

Finding B: DoD Reporting of Adverse Privileging Actions.

Concur with both findings and recommendations proposed.

Finding C: Completeness of DoD Automated Files.

Recommendation for Corrective Action:

Surgeon's General of the Military Departments:

(1) Reconcile the Defense Practitioner Data Bank (DPDB) and the NPDB databases by submitting to the DPDB all records found only in the NPDB and correcting the inconsistencies in the data.

Concur: Action Planned: Hire a full time data base manager (interviews being conducted) to be responsible for malpractice and adverse action databases. This individual will be tasked with reconciling the databases, and for submitting quarterly data reports to Armed Forces Institute of Pathology. Estimated start date: 15 Jun 98.

(2) Implement procedures so that reports are submitted to the DPDB at the same time as data is submitted to the NPDB until the Centralized Credentials Quality Assurance System Version 2.0 is fully implemented.

Concur: See above.

My point of contact is Major Paula Lewis; Chief, Risk Management Operations, Air Force Medical Operations Agency, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050, DSN 297-4140.

Charles H. Roadman II

CHARLES H. ROADMAN II
Lieutenant General, USAF, MC
Surgeon General

Air Force Legal Services Agency Comments

Final Report Reference

DEPARTMENT OF THE AIR FORCE
AIR FORCE LEGAL SERVICES AGENCY (AFLSA)

03 JUN 1998

MEMORANDUM FOR OFFICE OF THE DoD INSPECTOR GENERAL
ATTN: MS. BETSY BRILLIANT

FROM: AFLSA/JACT
1501 Wilson Blvd, Room 835
Arlington VA 22209-2403

SUBJECT: DoD IG Report - DoD Implementation of the National Practitioner Data Bank (NPDB) Guidelines

Thank you for the opportunity to comment on your draft of Project No. 7LH-0009. Our comments are limited to the reporting requirements set out for the Judge Advocates General of the Military Departments, in section A.2.

- Paragraph A.2.a. (page 17). The Air Force Tort Claims and Litigation Division (AFLSA/JACT) has been providing the Office of the Surgeon General (SG) with a monthly report on all closed (settled and denied) claims and litigation cases since December 1993. The report includes the information set out in your draft section A.2.a. with the exception of (1) name(s) of practitioners associated with the incident, (2) whether those practitioners breached standard of care based on medical legal reviews and (3) copies of any medical reviews done during evaluation of malpractice allegations. We begin compiling our monthly report at the close of each calendar month. The report is not completed and forwarded to the SG before 7-10 days into the next month. As a result, claims that are closed early in the month are not reported to the SG until more than 30 days have elapsed. By extending this reporting deadline to 45 days, we can to continue to use an effective system already in place and comply with your amended recommended reporting requirement. Revised Page 19

The name(s) of practitioners associated with the incident, and whether those practitioners breached standard of care based on Judge Advocate General medical reviews, and copies of any medical reviews done during malpractice evaluation are already provided to the SG directly from the regional Medical Law Consultant. We will provide to the SG available information from subsequent medical reviews that may have been acquired during negotiations or litigation.

JACT will also report final actions on cases in litigation within 45 days from the time we receive that information from the Assistant United States Attorneys, as we cannot control the timeliness of reporting case closures by United States Attorneys' Offices.

- Paragraph A.2.b. (page 17). Outstanding claims information is already provided to the SG on a monthly basis. Page 19

While not directed toward the service Judge Advocates General, I must voice my non-concurrence with the DoD proposal under A.1.b. (2) to report all paid cases to the NPDB even if standard of care is met. Under DoD practice, providers are not afforded personal counsel to defend their actions. Further, unlike the civilian world, DoD providers cannot take advantage of the "corporate shield". Finally, the uniqueness of military medicine places providers in circumstances where the mission, i.e. "system", forces increased risk of liability exposure. These issues impact case disposition, and, without a separate peer determination of practice standards, providers' professional careers and reputations will be dependent upon claims officers or Assistant United States Attorneys with separate representational interests. The purpose of the NPDB is better served by reporting only confirmed malpractice.

Please contact this office if you need further information. My point of contact is Mr. Joseph A. Procaccino, Jr. who can be reached at 696-9055.

DANIEL P. HASS, Colonel, USAF
Chief, Tort Claims and Litigation Division
Air Force Legal Services Agency

Evaluation Team Members

The Readiness and Logistics Support Directorate, Office of the Assistant Inspector General for Auditing, DoD, produced this report.

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