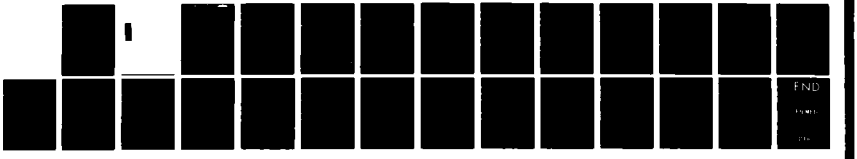
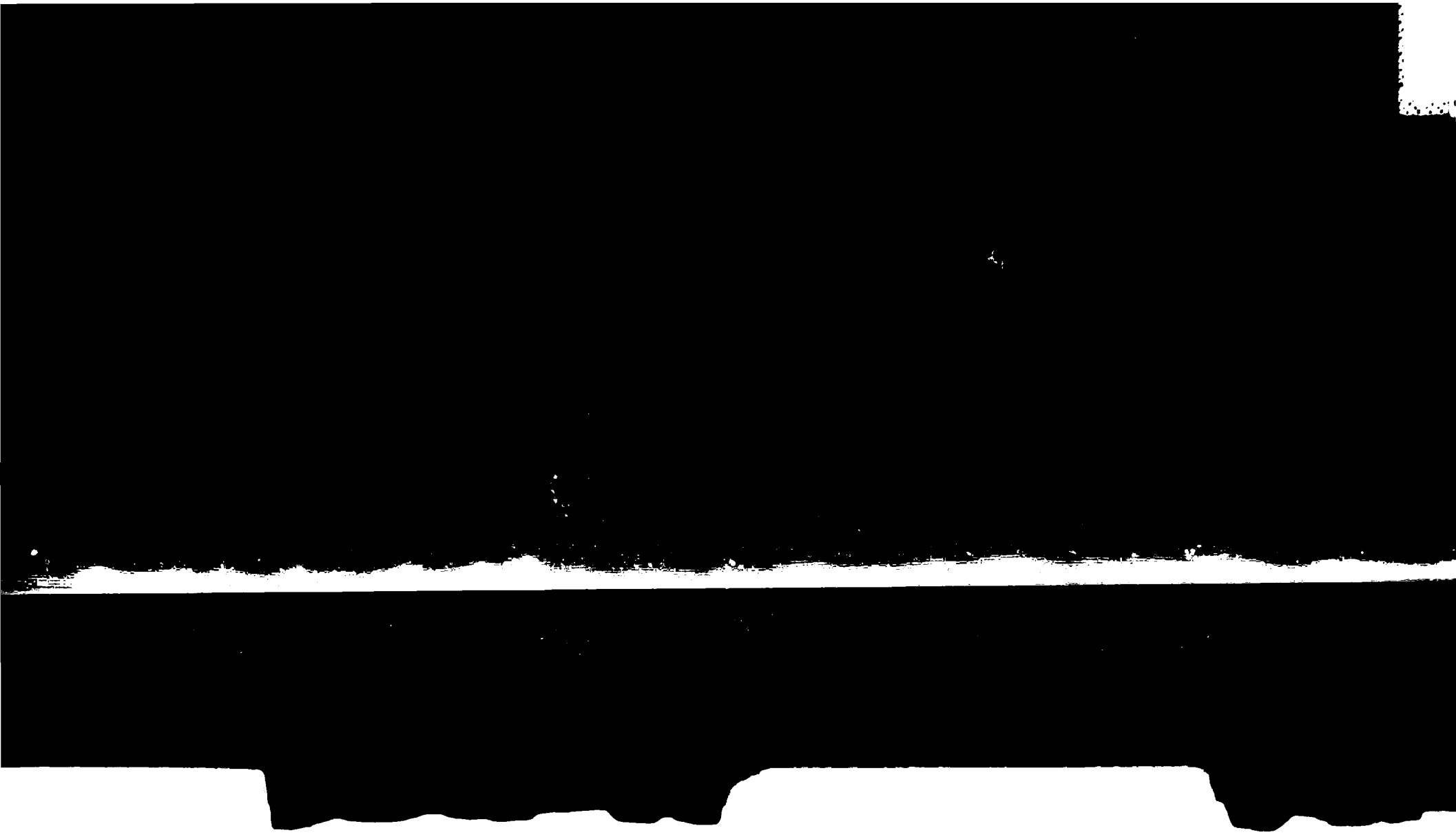
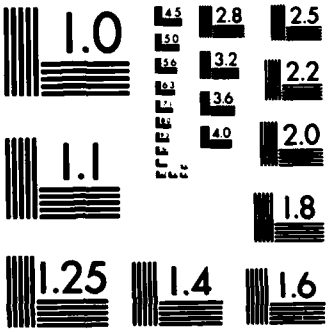
AD-A149 090 CREDENTIALING OF PHYSICIANS IN THE ARMY(U) ARMY WAR COLL CARLISLE BARRACKS PA F N BUSSEY 21 MAY 84 1/1

UNCLASSIFIED F/G 5/9 NL







REPORT DOCUMENTATION PAGE

READ INSTRUCTIONS BEFORE COMPLETING FORM

1. REPORT NUMBER	2. GOVT ACCESSION NO. / 3. RECIPIENT'S CATALOG NUMBER
4. TITLE (and Subtitle): Credentialing of Physicians in the Army	5. TYPE OF REPORT & PERIOD COVERED: STUDENT ESSAY
	6. PERFORMING ORG. REPORT NUMBER
7. AUTHOR(s): Colonel Frederick N. Bussey	8. CONTRACT OR GRANT NUMBER(s)
9. PERFORMING ORGANIZATION NAME AND ADDRESS: US Army War College, Carlisle Barracks, PA 17013	10. PROGRAM ELEMENT, PROJECT, TASK AREA & WORK UNIT NUMBERS
11. CONTROLLING OFFICE NAME AND ADDRESS: Same	12. REPORT DATE: 21 May 1984
	13. NUMBER OF PAGES: 22
14. MONITORING AGENCY NAME & ADDRESS(if different from Controlling Office)	15. SECURITY CLASS. (of this report): Unclassified
	15a. DECLASSIFICATION/DOWNGRADING SCHEDULE

16. DISTRIBUTION STATEMENT (of this Report)

DISTRIBUTION STATEMENT A; Approved for public release; distribution is unlimited.

17. DISTRIBUTION STATEMENT (of the abstract entered in Block 20, if different from Report)

18. SUPPLEMENTARY NOTES

19. KEY WORDS (Continue on reverse side if necessary and identify by block number)

20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

Credentialing of physicians is a process to specifically define areas of medical practice to include specific modalities of care which a medical treatment facility (MTF) grants to a physician who applies for practice privileges in that facility. This practice, in some form, has always been carried out in both military and civilian hospitals but has come under closer scrutiny by the public as well as Federal and state governmental agencies as part of the overall concern for quality assurance in medical care. Recently the Defense Health Council studied the status of the credentialing process in the military and made

Item 20 continued.

several recommendations for improvement. Although not specifically mentioned in the report, the credentialing process for the Reserve Components is an area of concern to the Army Surgeon General. This paper reflects the current process of credentialing physicians in military MTFs with emphasis on the Army, to include the Reserve Components, and recommended improvements which have been incorporated in the change to Chapter 9, AR 40-66, "Quality Assurance Program," which is presently being staffed prior to final approval by the Department of the Army.

USAWC MILITARY STUDIES PROGRAM PAPER

CREDENTIALING OF PHYSICIANS IN THE ARMY

by

Colonel Frederick N. Bussey, MC

Colonel Paul Kirkegaard, Inf
Study Adviser

US Army War College
Carlisle Barracks, Pennsylvania 17013
21 May 1984

ABSTRACT

AUTHOR: Frederick N. Bussey, COL, MC

TITLE: Credentialing of Physicians in the Army

FORMAT: Individual Essay

DATE: 21 May 1984 PAGES: 20 CLASSIFICATION: Unclassified

Credentialing of physicians is a process to specifically define areas of medical practice to include specific modalities of care which a medical treatment facility (MTF) grants to a physician who applies for practice privileges in that facility. This practice, in some form, has always been carried out in both military and civilian hospitals but has come under closer scrutiny by the public as well as federal and state governmental agencies as part of the overall concern for quality assurance in medical care. Recently the Defense Health Council studied the status of the Credentialing process in the military and made several recommendations for improvement. Although not specifically mentioned in the report, the credentialing process for the Reserve Components is an area of concern to the Army Surgeon General. This paper reflects the current process of credentialing physicians in military MTFs with emphasis on the Army to include the Reserve Components and recommended improvements which have been incorporated in the change to Chapter 9, AR 40-66 "Quality Assurance Program," which is presently being staffed prior to final approval by the Department of the Army.

CREDENTIALING OF PHYSICIANS IN THE ARMY NATIONAL GUARD

Credentialing of physicians is a process to specifically define areas of medical practice to include specific modalities of care which a medical treatment facility (MTF) grants to a physician who applies for practice privileges in that facility. This process, in some form, has always been carried out in both military and civilian hospitals, to limit the scope of a physician's practice to those areas in which he has gained competence through formal education, training, and experience. As recently as 15 years ago, this procedure consisted of a physician's demonstration of successful completion of medical school, internship, state licensure, post graduate training such as residencies or fellowships in specialized medical or surgical fields and some letters of recommendation attesting to his experience, ability and character. Based on a review of these "credentials" and an interview with a medical staff committee from a hospital or other MTF, an agreement or contract was consummated stating the general area of medical care privileges which the hospital would grant the physician within their facility. These areas were frequently broadly stated such as "internal medicine," "general surgery," "pediatrics," or "obstetrics and gynecology." These credentials or citizenship, if you will, remained in effect until such time as there was reason to limit or expand the privileges granted based on observed performance or specialized training. This process was utilized to insure an adequate "mix" of medical care specialties were available at the hospital and the practitioners had been trained in their area of medical care.

This credentialing process came under attack for two reasons. First, the rapid advances in medical knowledge and technology made it impossible for a physician to keep current in all aspects of the broad areas of medicine for which they were being credentialed. This led to subspecialization training

and the eventual credentialing by specific procedures (i.e. heart catheterization) or treatment modalities (i.e. treatment of diabetic ketoacidosis). Second, as these medical advances were taking place, and the cost of medical care was escalating, there has been an increasing public and governmental concern over the quality of medical care provided which have lead to Quality Assurance Programs in both the civilian and military medical systems. Quality Assurance Programs are comprised of two parts. The first part insures that the practitioner who provides the care is trained and competent to provide the service required. The second, of course, deals with the quality of the care provided including the results obtained. Both are obviously important and inseparable for quality patient care, but this paper will confine itself to the credentialing portion of the Quality Assurance Program.

THE CREDENTIALING PROCESS AND THE LAW

The traditional credentially process was based on an assumption by the hospital that their responsibilities were confined to providing a facility equipped with specialized medical equipment and services where a patient could come to seek medical care from a trained practitioner. This belief was held until 1965 when in a landmark case of Darling versus Charleston Community Memorial Hospital,[1] the court developed the principle that the hospital is responsible for assuring that the physicians it grants clinical privileges to are qualified to perform those privileges and furthermore if the hospital fails in this responsibility, it can be held corporately liable for damages that result from that failure. This was the first time that a hospital was held responsible for not only providing custodial care to a patient, but also for the quality of the care provided.

A second landmark case, Joiner versus Mitchell Country Hospital in 1972 held that a hospital can be liable for injuries caused to a patient if it is negligent in granting medical privileges to an unskilled physician. The court specifically noted that a "Hospital Authority operating a public hospital has authority to examine the qualifications of any physician seeking staff privileges and to limit his practice to those areas in which he is deemed qualified to practice or to completely bar him from such practice if he is incompetent, unqualified, inexperienced or reckless."[2] There are many other legal decisions which have impacted on medical credentials, but their impact is clear that the Governing Body of the hospital as well as the medical staff are responsible for the competence of its practitioners.

THE CREDENTIALING PROCESS AND THE JCAH

Long before there were legal precedents to adjudicate hospitals' responsibilities, the medical profession itself organized and set forth standards of care. In 1918 the American College of Surgeons (ACS) established the Hospital Standardization Program initially "to encourage adoption of a uniform medical record format that would facilitate the accurate recording of the patient's clinical course."[3] This effort expanded during the years until in 1951 a separate organization was established as an outgrowth of the ACS Hospital Standardization Program called the Joint Commission on the Accreditation of Hospitals (JCAH). This organization, through constant review and revision, established standards for hospitals which are "optional within available resources, reflecting the highest state of the art; they are achievable, meaning that compliance with them has been demonstrated in an existing facility; and, compliance with them is measurable."[4] Surveys of civilian hospitals are voluntary but accreditation by the JCAH is generally sought after to establish credibility for conducting post graduate training

programs, meeting care requirements of governmental programs (i.e. Medicare) and to develop confidence by patients and medical providers as a referral hospital. An integral part of the JCAH standards are the requirements accepted for medical staff appointment, granting of initial clinical privileges, and staff reappointment/reappraisal. In general the requirements not only include verification of medical degree and specialized training (completion or certification) but also state licensure, letters of recommendation on demonstrated abilities, experience, and character; copies of credentialing actions by hospitals where he/she has previously worked; a request by the physician for specific clinical privileges to be granted (or limited); the physician's pledge to maintain an ethical practice; a statement by the physician of any information relating to involvement in any adverse malpractice action, challenges to licensure or loss of medical organization membership. Of interest it also recommends that specific privileges be granted only when the hospital can insure adequate facilities, support services, and additional staff members with the applicant's skills and training.[5]

The reappraisal process in accordance with JCAH criteria includes information relative to the physician's professional performance, judgment, and, when appropriate, technical skill. Along with the reappraisal request should be a statement of further training, experience, continuing medical education efforts, and present health status.

The mechanism by which this is accomplished is the Credentials Committee. The committee is composed of members of the medical staff representing the various medical disciplines present in the hospital and consists of physicians when a physician is the applicant under consideration. Dentists, podiatrists, or optomotrists will be present when the applicant is of that discipline although only physicians and dentists may be members of the medical staff.

Established criteria for acceptance into the medical staff and/or granting of clinical privileges should be delineated in the medical staff bylaws and each applicant should be evaluated on an equal basis without regard for sex, race, creed, or national origin. The recommendations of the Credentials Committee are then approved by the medical staff (or its Executive Committee) and the Governing Body.

THE CREDENTIALING PROCESS IN THE MILITARY

The credentialing process for military physicians essentially mirrors that used by civilian hospitals. Although each service differs somewhat in the mechanics of the credentialing process, they all are required to meet the standards for credentialing established by the JCAH. Official U.S. Army policy is set forth in Army Regulation 40-66 (AR 40-66) paragraph 9-1 which states:

> The goal of an MTF's quality assurance plan is the maintenance of high quality patient care, the correction of identified problems, and the effective use of MTF services. Such a plan must conform to the guidelines set for Federal hospitals by the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals (JCAH). A quality assurance plan involves: a. Patient care auditing; b. Credentialing; c. Utilization review; d. Risk management."[6]

This regulation applies to the Total Army including the Active and Reserve Components.[7] There are some differences between civilian and military hospitals when interpreting the requirements of the JCAH standards. For example, military hospitals don't have a Governing Body per se for each hospital. In the Army The Surgeon General and the MTF commander act jointly as the Governing Body. The Surgeon General (TSG) sets general policy by directives and regulations and is the final approval authority for Army physician accessions and to a great extent eliminations (Department of the Army is the actual authority but generally follows the recommendations of

TSG). The MTF commander is responsible for setting policy for his facility within the scope of policies set by Department of the Army and acts as the "onsite" Governing Body to include approval authority for the MTF's Credentials Committee and therefore grants all clinical privileges awarded within his MTF (or several MTFs if he is also a Medical Activity (MEDDAC) commander). There is also no requirement for each MTF to have its own medical staff bylaws, as the physician's commissioning oath as an Army physician and the various regulations, directives, and standard operating procedures (SOP) meet this standard.

The initial accession of physicians for the Army Medical Department (AMEDD) is handled by the AMEDD Officer Procurement Division of the U.S. Army Medical Department Personnel Support Agency (AMEDDPERSA) a Field Operating Agency of the Office of the Surgeon General (OTSG). Both Active Army or Reserve Component (U.S. Army Reserve (USAR) and Army National Guard (ARNG)) applications are processed through AMEDDPERSA and have similar requirements. These requirements include both the eligibility standards for commissioning in the Army and the credentials of a physician in good standing. The professional qualifications require: (1) a medical degree (either a Doctor of Medicine (MD) or a Doctor of Osteopathy (D.O.) for U.S. or Canadian medical graduates or an MD and the Education Council for Foreign Medical Graduates (ECFMG) Certificate for foreign medical graduates); (2) certificate of successful completion of one year of American Medical Association approved Graduate Medical Education (GME); and (3) an unrestricted state license. The second requirement may be waived by the Surgeon General if the applicant is presently in an approved GME program or will complete one within 15 months of appointment. The licensure requirement may be waived if the applicant is employed by a Federal Government agency which does not require a license (e.g. the Public Health Service and

the National Institutes of Health), he/she is in an approved GME program which does not require a license, or a license will be secured within 15 months of the appointment date. The ECFMG Certificate for foreign medical graduates may be waived by TSG if the applicant has an unrestricted state medical license and can show proof of successful completion of the FLEX exam.

In addition to the basic requirements, verified copies of all advanced (adjunctive) degrees, certificates of Graduate Medical Training (Intern Resident, fellowship), specialty board certification, letters of recommendation, Curriculum Vitae, statements of current clinical privileges and any pending or past adverse judgments in malpractice suits, and results of interview with Active Army physician preferrably in same specialty.

If all parts of the application packet are complete and meet the criteria for commissioning in the Army and acceptance as an Army physician, the application is reviewed by a board of Medical Corps Officers and if favorably considered is approved by TSG. Upon his initial assignment for the Active Duty physician the MTF Credentials Committee will require him/her to complete DA Form 4691-R Initial Application for Clinical Privileges which is reviewed with the applicant by the department or service chief of that particular specialty. The department or service chief then recommends specific clinical privileges on DA Form 4692-R Clinical Privileges Annual Evaluation that should be granted to the applicant on a provisional basis to the Credentials Committee. The Credentials Committee may or may not interview the applicant in person. If these clinical privileges are approved as requested by the Credentials Committee, a recommendation to grant the clinical privileges on a provisional basis usually for six months is sent to the MTF commander for approval. Only after approval by the MTF commander (acting as the Governing Body) is the applicant awarded clinical privileges and allowed to practice his

specialty. During the initial six month period the department or ser chief will assign a member of his staff to observe and supervise the physician's care practices to insure they meet "state of the art" sta After the six months provisional period, the DA Form 4691-R and DA Fo will be resubmitted by the department or service chief with his/her recommendations to the Credentials Committee. The recommendations of committee are then forwarded to the MTF commander for approval. If a the applicant will gain active status on the medical staff. Hencefor clinical privileges will be evaluated annually based on demonstrated performance, technical ability, further training including continued m education, board certification, health status and character/ethical tr His clinical privileges may then be continued, modified or limited. T also provisions to evaluate the clinical privileges of a staff member time it appears warranted, usually on the recommendation of the depart service chief.

If the Credentials Committee recommends that the clinical privile should be limited, suspended or revoked, a letter of this intent is se the applicant. The physician may then reply in writing or in person t specific allegations made which would cause curtailment of his/her pri The Credentials Committee may also form a subcommittee to fully invest the matter, the members of which would then be excluded from voting on recommendation. The results of the investigation are made known to th concerned physician who may answer the charges in writing or in person without legal counsel. The final recommendations of the Credentials C are forwarded to the MTF commander for approval. The commander may co his own investigation or interview the physician. If he approves the recommendation of the Credentials Committee the physician's clinical

privileges are immediately limited, suspended or revoked as the case may be. The concerned physician may appeal the commander's decision to the next higher headquarters where an independent evaluation (and possibly another investigation) is made. If the MTF commander's decision is upheld by the next higher headquarters, a final appeal may be made by the concerned physician to the Office of the Surgeon General. The Surgeon General is the final appeal authority. All physicians whose clinical privileges have been revoked will be evaluated for termination of service. If a physician leaves the service in a "decredentialed" state--that is his/her clinical privileges have been permanently limited or revoked the MTF commander must notify the Quality Assurance Branch of the OTSG who will report the credentialing status of the physician to DOD and the Federation of State Medical Boards where further action may be taken concerning his/her state licensure.

DEPARTMENT OF DEFENSE CONCERNS

Alarmed by the increasing number and escalating costs of malpractice litigation and based on the findings of a report by the Armed Forces Institute of Pathology, "Malpractice Claims in the Military Health Care System; Contributing Factors," the Defense Health Council identified credentialing of health care providers as a quality assurance issue requiring immediate study.[8] The main problem in credentialing noted by the AFIP was there was "little evidence that vigorous performance standards had been adopted at most MTFs i.e., clinical privileges given based on a provider's demonstrated performance against standardized criteria."[9] Instead the provider's rank, position and/or past or present affiliations rather than performance criteria were the determining factors. In response the working group developed a working definition of the credentialing and privileges granting process, evaluated the three Services credentialing programs to see what was being done and

identified the best portions of each program without trying to standardize the credentialing programs among the Services. One of the findings revealed that while the Navy and Air Force had highly specified standardized lists of privileges in each specialty, the Army requirements were more general and left largely to the discretion of the respective MTF. In addition only the Air Force had an expeditious release from active duty policy for providers who during their one year "conditional" credentialing period fail to meet professional requirements. Other issues concerned an absence of any policies that tie Special Pay provisions to a provider's ability to function in his/her specialty and the absence of formalized proctoring programs whereby new providers have their skills evaluated during the provisional privileges period.

The recommendations included a definition of the credentialing and clinical privilege-granting process and a generic description of the health care providers who should be credentialed. The accepted definition for Tri-Service use states that:

> Credentialing is the process whereby the Commander of the Medical Treatment Facility (MTF), upon recommendations by the MTF Credentials Committee, grants to individual health care providers the privilege and responsibility of providing specified medical and dental care within the MTF. All health care providers who will be allowed to make independent decisions to initiate or alter the regimen of medical or dental care being provided to a patient should be individually credentialed.[10]

In accordance with this definition the following health care providers must be individually credentialed: physicians, dentists, nurse practitioners, nurse midwives, physician assistants, podiatrists, nurse anesthetists, clinical psychologists and optometrists. Individual credentialing is optional (depending on whether they may initiate or alter a regimen) for the following categories of provides: clinical social workers, clinical dieticians,

clinical pharmacists, dental hygienists, physical therapists, occupational therapists, audiologists, speech pathologists, independent duty technicians, and submarine corpsman.

The minimum elements in the application package for prospective Active Duty, Civil Service or Contract Providers include: (1) Application form (includes personal history and Curriculum Vitae); (2) Letters of Recommendation from a. Chief of Staff/Training Program Director, b. Hospital Administrator, c. Professional Supervisor/Department Chairman, and d. professional peer. (3) Letter of Personal Interview (from officer of same corps and preferrably of same specialty); (4) Statement of professional privileges; (5) Malpractice Statement; (6) Statement attesting to drug/alcohol abuse, (7) Physical examination; (8) Inquiry with State Board of Examiner, Federation of State Medical Boards, etc. as appropriate for current status; (9) Qualifying Degree; (10) Specialty Program Certificate or GME Certification; (11) Board Eligibility or Certification if applicable, (12) Continuing Education for those not coming from a training program; (13) ECFMG Certification for foreign medical graduates; (14) Registration/ Licensure; (15) Prior service records; and (16) Conditional Release form to procure the above information.

Other recommendations included: eliminating "blanket" privileges in favor of <u>specific</u> clinical privileges, developing an expeditious "release from active duty" or from Service employ within one year of their initial entry or employment date if a provider fails to attain or retain the required credentialed status; each service develop a specified clinical privileges request form; policy guidance for MTF commanders on the use of Incentive Special Pay and Additional Special Pay as performance management took to reward excellence and automatic "discontinuation of such discretionary

incentive/special pays when a provider's full clinical privileges are permanently revoked;"[11] increasing the 90-day provisional clinical privileges to insure adequate time to assess the provide's capabilities and performance; and additional study be given to developing a more formal proctoring system for newly acquired providers.

A review of the Army's credentialing process for initial procurement of physicians already contains most of the criteria recommended by the Tri Service Working Group. The main problem appears to be the policies for granting and renewing clinical privileges at the MTF. Some facilities have excellent policies which are well documented, comprehensive and in accordance with OTSG and JCAH standards. Other MTF lack specification, compliance with stated policies or lack of resources to maintain a comprehensive. Examples of the problems found in the MTF's of all three services have been reported by a Defense Department Audit Team as a result of preliminary study which took place between May and September 1983.[12]

In order to insure that Quality Assurance Programs in the Army are keeping abreast of the ever-changing standards of the JCAH, Defense Department Directives and to provide policy guidance to MTF commanders, the Surgeon General established a new Quality Assurance Branch in the Directorate of Professional Services last summer. The Chief of the Branch, Colonel Robert Zone, and his staff, are presently in the process of completing the final draft of a complete revision of Chapter 9, AR 40-66, "Quality Assurance." As noted above there are several aspects to a comprehensive quality assurance program but credentialing is a major portion and the changes in the regulation are most comprehensive in this area. During the revision of the credentialing program, considerable interest was taken to be sure the Civil Service physicians and Reserve Components had viable credentialing procedures. The

revisions are not, so much, drastic changes in policy but expand on the existing procedures for more comprehensive guidance to MTF commanders. Each commander still has the prerogative to establish a credentialing procedure to fit the facility, its operations and the personnel resources he has. The regulation does specify the process by which a physician becomes credentialed and the requirements necessary to insure the clinical privileges granted are commensurate with the provider's capabilities. Emphasis is placed on verification of an applicant's training and licensure, the awarding and renewal of clinical privileges based on continuing clinical competence as demonstrated by performance and CME. The procedure for limiting, suspending or revoking clinical privileges is described in detail, to include the appeal process to insure the physician in question has every opportunity to improve his performance if required or to have the circumstances which initiated the action fully described in writing and an opportunity to answer the allegations in writing and/or in person. Further he/she has the right of legal counsel and appeal in accordance with due process. Department of the Army civilian physicians will be required to have a current unrestricted state license in all cases and the credentialing process and granting of clinical privileges is the same as for Active Duty physicians except that the provisional status requirements and termination of employment, (if indicated) come under Civil Service regulations.

CREDENTIALING IN THE RESERVE COMPONENTS

Although the requirements of AR 40-66 are applicable to the Reserve Components-U.S. Army Reserve and the Army National Guard, there are unique problems in credentialing physicians who are on Active Duty for Training (ADT) status for 15 only days per year. There appears to be few problems in the initial procurement of physicians for the Reserve Components as the screening

process for professional qualification requires the same documentation and is reviewed at AMEDDPERSA by the same process as Active Duty physician applicants to include a determination of acceptability by a board of Active Duty medical officers. The major problems occur in the granting and updating clinical privileges by the MTFs.

The policy for appointment of physicians in the USAR is contained in AR 135-101, "Appointment of Reserve Commissioned Officers for Assignment to Army Medical Department Branches." USAR AMEDD personnel counselors insure that the physician applicant completes all portions of the application packet and arranges for a prescreen interview and medical examination by a Medical Corps officer of one of the Uniformed Services. The individual meets the standards for commissioning (similar to AD requirements), the complete packet is reviewed by AMEDDPERSA who then convenes a selection board. The recommendations of AMEDDPERSA are sent to the Commanding General, Reserve Components Personnel and Administration Center (RCPAC), who reviews the application and authorizes the procurement counselor to accomplish the oath of office and issue the letter of appointment. There is also a provision that if for any reason the applicant fails to provide documentation required--usually a completed physical exam or documents to complete a security clearance, within 60 days of signing the oath, the Commanding General, RCPAC is authorized to discharge the individual. The only problem in the initial procurement policy was the possibility of an Active Duty physician who leaves the Active Component and applies for transfer to the Reserves. In the change to AR 40-66 this is prevented in two ways. First, the Quality Assurance Branch, OTSG, notifies AMEDDPERSA of any physician who is in a discredentialed state, which will be evaluated prior to commissioning and second, there is a

requirement for the Practitioner's Credentials File (PCF) from the last MTF to be obtained by the gaining MTF or unit prior to granting clinical privileges.

Following a reorganization of RCPAC in October 1983, the administrative aspects of appointment and mobilization of the Reserves was transferred to the U.S. Army Reserve Personnel Center (ARPERCEN), a part of the Office of the Chief, Army Reserve (OCAR). For USAR physicians, this function is performed by the Special Officer Division, Officer Personnel Management Directorate, ARPERCEN located in St. Louis, Missouri. ARPERCEN is also the repository of the physicians credentials file which at present includes a Curriculum Vitae and a DA Form 4213 (Supplemental Data for Army Medical Service Reserve Officers) which is a credentials/performance statement that is supposed to be updated annually.

There are three categories of USAR physicians: Troop Program Unit (TPU) who are assigned to Reserve Units, Individual Mobilization Augmentee (IMA) formerly referred to as Mobilization Designees (MOBDES), and a Control Group Reinforcement (CGR). The latter two groups are in a general personnel pool for mobilization purposes and are not assigned to a specific unit (basically the old Individual Ready Reserve). For TPU physicians, the unit commander generally has a rather complete credentials file as well as knowledge of his professional reputation in the local community. The unit commander also completes the annual update of the DA Form 4213 and sends a copy to ARPERCEN. The IMA physicians are generally augmentees to Health Services Command (HSC) facilities and a board is held at HSC for nomination and assignment. ARPERCEN arranges for the Annual Duty for Training. The major problem with this group and even more so with the CGR physicians is a lack of documentation, from either their civilian medical practice or from their Annual Duty for Training, concerning current professional competence and CME. At present the Officer

Efficiency Report is the only document ARPERCEN receives on a physician following ADT which does not lend itself well to evaluate professional competence in more than a general way. Also in many cases, the physician may have been performing administrative or other duties during his ADT which would not measure his clinical competence in his specialty or his mobilization assignment. Forwarding a copy of the DA 4213 to ARPERCEN for IMA and CGR physicians is left to the physician himself and most files are not current. There is also the problem of the physician who reports to the HSC MTF without a credentials file for his/her ADT which makes complete evaluation of the individual's competence impossible. Many of these problems have been addressed in the change to AR 40-66 such as a standardized Practitioner's Credentials File, making ARPERCEN a repository for the Credentials File with copies to the practitioner and to the gaining unit at least 45 days prior to ADT. The problem of designating Credentials Committees to annually validate a physician's continuing competence particularly for reservists in the IMA and CGR is still being worked out.[13]

The policy for appointment in the Army National Guard for physicians is contained in National Guard Regulation 600-100. The application packet is similar to the one for AD and USAR physicians. The AD Senior Adviser to the state convenes a Federal Recognition Board consisting of two Regular Army and one National Guard Officer to grant temporary Federal recognition to qualified applicants. The completed application is then forwarded to the ARNG Personnel Center where it is reviewed for completeness. Questions of health problems are referred to the Chief Surgeon, National Guard Bureau. The packet is then reviewed by AMEDDPERSA where a selection board convenes similar to the process described for AD and USAR physicians. The National Guard Bureau and RCPAC are notified of the board's recommendations, which are in turn forwarded to the

state for final approval and appointment. Since all National Guard physicians are required to have a current unrestricted state license, the initial procurement process has few problems from an initial credentials standpoint.

The main problems with the credentialing process of the Army National Guard physicians has to do with the granting and updating of clinical privileges. The difficulties are different than those faced by the USAR as the ARNG physicians all belong to a unit--generally in the local area where they are in practice and are well known in the local community. Since each state is unique in the method in which physicians are assigned and their credentials are monitored it is difficult to set specific policy and until recently there has been no central organization to establish and monitor the physician's credentialing program. The logical solution to this problem is for policy guidance to be developed by the Chief Surgeon, ARNG in conjunction with OTSG and the medical advisers to the National Guard Bureau. A recent reorganization in the Surgeon Office should give him the resources necessary to also monitor the program and act as consultant in credentialing matters. The actual credentialing process for each state will continue to vary since the medical assets are not the same in each state and may vary from a single Medical Detachment (Idaho) to several medical units such as a Medical Brigade, a Medical Battalion, a Combat Support Hospital, an Evacuation Hospital, an Air Ambulance Company, and a Medical Detachment (California). The State Surgeon should have the leeway to tailor the credentialing policies for his/her particular state to include the designation of the Credentials Committee(s) and the repository for the practitioners Credential File. There are three Medical Brigades in the ARNG. The medical units in states that are encompassed by the Sixth U.S. Army come under the 175th Medical Brigade in Sacramento, California, the units in the 4th and 5th U.S. Army come under the

112th Medical Brigade in Worthington, Ohio, and First and Second Army Areas under the 213th Medical Brigade in Jackson, Mississippi. These Medical Brigades may be the appropriate units to monitor the credentialing process in the states. If the medical resources available within the state are not sufficient or are geographically too dispersed to carry out the credentialing functions then the nearest military MTF may be tasked to provide these functions.

Since the USAR and ARNG physicians are best known in the civilian hospitals where they practice and are required to have an annual review of their credentials it seems obvious that a copy of any credentialing actions taken by civilian MTFs should become part of that physician's military Credentials File to be used along with his/her ADT evaluations in determining continued clinical privileges and/or assignment. This requirement is also part of the draft AR 40-66.

CONCLUSION

The procedures of credentialing physicians in both the civilian and military environments entail the same process. In civilian hospitals where physicians tend to remain in one area for much of their medical career the evaluation of continued competence is relatively easy. In the military with its constant turbulence and unique characteristics of the Reserve Components the process becomes more complicated to evaluate properly with a constant influx of new physicians. It becomes vitally important that the credentials process developed for the military insures that only physicians qualified by education, training and continued demonstrated competence in their particular field are allowed to practice in the military.

The guidelines for a successful credentialing process have been set forth in the JCAH accreditation standards. The process consists of six parts:

(1) the verification of successful completion of medical education and training in approved facilities; (2) granting of clinical privileges based on demonstrated competence during a provisional period where the physician is supervised by an appropriate member of the medical staff in the same specialty; (3) granting of clinical privileges by specific treatment areas and procedures to be performed; (4) annual renewal and/or modification of clinical privileges based on demonstrated competence, further training and CME; (5) provisions to limit, suspend or revoke clinical privileges under due process when competence has not been demonstrated or when the physician is physically, mentally or professionally impaired; and (6) the documentation of these credentialing efforts into a Practitioners Credentials File that is available to a gaining MTF commander. The credentialing process for physicians in the Army meets these requirements. The draft change to Chapter 9, AR 40-66, provides direction for a successful credentialing program at the MTF and should go far to standardize the process throughout the Army.

END NOTES

1. Darling versus Charleston Community Memorial Hospital, 33 I 11.2d 326, 211 N.E. 2d 253, (1965). Cert. den 383 U.S. 946, 86 S. (+1204).

2. Joiner versus Mitchell County Hospital 229 Ga. 140, 189 S.E. 2d 412 (1972).

3. Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals 1982 Edition, p. ix.

4. Ibid., p. xi.

5. Ibid., p. 94.

6. U.S. Department of the Army, Army Regulation 40-66, p. 9-1 (hereafter referred to as "AR 40-66").

7. Ibid., p. 1-1.

8. The Tri-Service Working Group on Credentialing Report to the Defense Health Council dated September 16, 1983, p. 1.

9. Ibid., p. 1.

10. Ibid., p. 17.

11. Ibid., p. 14.

12. Nancy Tomich, "DOD Auditors Uncover Credentialing Problems," U.S. Medicine, April 15, 1984, p. 1.

13. Interview with Douglas J. Silvernale, Colonel, MSC, Quality Assurance Branch, OTSG, Washington, 17 January 1984.

END

FILMED

2-85

DTIC

his ow

recomm