THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

ACTION MEMO

FOR: ASSISTANT SECRETARY OF DEFENSE HEALTH AFFAIRS

FROM: MG Steve Jones, Acting Commander, Joint Task Force National Capital Region Medical

SUBJECT: Approval of JTF CapMed Clinical Quality Management Manual

Reference: DOD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011

- Cited reference directs that, "The Commander, JTF CapMed shall establish and implement procedures, approved by the ASD(HA), for ensuring the application of standards comparable to MQA standards to all healthcare provided in accordance with his or her authority as Commander, JTF CapMed."

- The attached JTF CapMed Clinical Quality Management Manual was approved by my predecessor on 29 March 2012. Change 1 of the Manual incorporates changes that allow for use of both Navy and Army Centralized Credentials Quality Assurance System within the National Capital Region Medical Integrated Delivery System.

- As required by the reference, I am submitting JTF CapMed Clinical Quality Management Manual incorporating Change 1 for your review and approval.

RECOMMENDATION: Respectfully request your approval of the JTF CapMed Clinical Quality Management Manual by initialing below.

Approve _____ Disapprove _____ Other _____

MAR 27 2013

Attachment:
As stated

Prepared by: Mr. William Bradley, (301) 319-8400

Joint Task Force
National Capital Region Medical
MANUAL

NUMBER 6025.01
MAR 29 2012
Incorporating Change 1, December 17, 2012

J-3B

SUBJECT: Clinical Quality Management Manual

References: See Enclosure 1

1. PURPOSE. This Manual, in accordance with References (a) through (f):

a. Implements the policy guidance, procedures, and responsibilities for the administration of a Clinical Quality Management *(CQM)* Program (CQMP) ~~in~~ *by* the Joint Task Force National Capital Region Medical (JTF CapMed) ~~Joint Operations Area (JOA)~~ *within the National Capital Region (NCR)* ~~established in Reference (a)~~ under the guidance of DoD Instruction 6025.13 (Reference (f)), and Army Regulation 40-68 (Reference (g)).

b. Describes the relationships between JTF CapMed and the Military Services for quality management and administration functions for issues related to personnel assigned to inpatient Medical Treatment Facilities *[*(MTFs)*, i.e., FBCH and WRNMMC*] in the NCR and the Joint Pathology Center (JPC).

2. APPLICABILITY. This Manual applies to JTF CapMed Headquarters, Fort Belvoir Community Hospital (FBCH), Walter Reed National Military Medical Center (WRNMMC) *[hereafter, FBCH and WRNMMC are referred to as Joint MTFs]*, and the JPC.

3. DEFINITIONS. See Glossary

4. RESPONSIBILITIES. See Enclosure 2

5. RELEASABILITY. UNLIMITED. This Manual is approved for public release and is available on the ~~Internet from the~~ JTF CapMed Website at: www.capmed.mil.

6. EFFECTIVE DATE. This Manual: ~~is effective May 1, 2012.~~

a. Is effective upon publishing to the JTF CapMed Website; and

b. Must be reissued, cancelled, or certified current within 5 years of its publication in accordance with JTF CapMed Instruction 5025.01 (Reference (h)). If not, it will expire effective 10 years from the publication date and be removed from the JTF CapMed Website.

Enclosures

1. References
2. Responsibilities
3. Medical Staff and Inpatient MTF and JPC Committee Structure and Functions
4. CQMP and Organizational Performance Improvement
5. Licensure, Certification, and/or Registration of Health Care Professionals
6. Competency Assessment, Delegation, and Supervision of Practice
7. Peer Review Process
8. Privileged Health Care Providers
9. Credentials Review
10. Privileging Process and Medical Staff Appointment
11. Adverse Clinical Privileging/Practice Actions
12. Managing Inpatient MTF and JPC Personnel with Impairments
13. Patient Safety in the Healthcare Setting
14. Risk Management
15. Reporting and Releasing Adverse Privileging/Practice or Malpractice Information
16. Forms
17. Quality Assurance Confidentiality Statute for the DoD
18. Joint Training File
19. Scope of Practice of Enlisted Providers in Inpatient MTFs and JPC
20. Provider Credentials File
21. Pre-Selection Procedures for Non-Military Healthcare Personnel
22. Provider Activity File
23. Inter-facility Credentials Transfer Brief Preparation Instructions
24. Reportable Acts of Misconduct/Unprofessional Conduct for DoD Health Care Personnel
25. Management Control Evaluation Checklist

Glossary

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REFERENCES

(a) JTF CapMed *Instruction* 6025.04, "Medical Quality Assurance (MQA) and Clinical Quality Management," ~~dated~~ October 5, 2011 *as amended*
(b) Deputy Secretary of Defense Memorandum, "~~Establishing~~ Authorit~~y~~*ies* for Joint Task Force National Capital Region Medical (JTF CapMed)*,"* ~~and JTF CapMed Transition Team (Unclassified)," September 12, 2007~~ *February 7, 2012*
(c) Deputy Secretary of Defense Action Memorandum, "Civilian and Military Personnel Management Structures for the Joint Task Force National Capital Region Medical," January 15, 2009
(d) Comprehensive Master Plan for the National Capital Region Medical, April 23, 2010
(e) Supplement to the Comprehensive Master Plan for the National Capital Region Medical, August 31, 2010
(f) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011
(g) Army Regulation 40-68, "Medical Services Clinical Quality Management," Rapid Action Revision, May 22, 2009
(h) JTF CapMed Instruction 5025.01, "Formats and Procedures for Development and Publication of Issuances," March 5, 2012
(~~h~~*i*) DoD 6025.13-R, "Military Health System Clinical Quality Assurance Program Regulation," June 11, 2004
(~~i~~*j*) DoD Instruction 6055.1, "DoD Safety and Occupational Health (SOH) Program," August 19, 1998
(k) National Defense Authorizations Act 2012 revisions to Subtitle A, Part II; Chapter 55 § 1102 of title 10, United States Code
(~~j~~*l*) DoD Instruction 6000.14, "Patient Bill of Rights and Responsibilities in the Military Health System," September 5, 2007
(~~k~~*m*) Sections 1094 and 1102 (The National Defense Authorization Act for fiscal year 1987) of title 10, United States Code
(~~l~~*n*) Part 900 of title 21, Code of Federal Regulations
(~~m~~*o*) Army Regulation 40-3, "Medical, Dental, and Veterinary Care," February 22, 2008
(~~n~~*p*) Air Force Instruction 44-119, "Medical Quality Operations," September 24, 2007
(~~o~~*q*) Health Affairs Memorandum, "Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB)," December 11, 1995[1]
(~~p~~*r*) Army Regulation 15-6, "Procedures for Investigating Officers and Boards of Officers," October 2, 2006
(~~q~~*s*) Army Regulation 600-106, "Flying Status for Nonrated Army Aviation Personnel," March 2, 1992
(~~r~~*t*) Section 315.804 and part 752 of title 5, Code of Federal Regulations
(~~s~~*u*) DoD Instruction 1402.5, "Criminal History Background Checks on Individuals in Child Care Services," January 19, 1993
(~~t~~*v*) DoD Directive 5154.24, "Armed Forces Institute of Pathology (AFIP)," October 3, 2001
(~~u~~*w*) DoD Directive 6465.3, "Organ and Tissue Donation," May 4, 2004

[1] Available at http://www.ha.osd.mil/policies/default.cfm.

(~~v~~*x*) ~~Department of the Army, "Commander's Policy Memo No.3 – Off-Duty Employment 13," May 13, 2009.~~ *JTF CapMed Instruction 1120.02, "Off-Duty Employment (ODE) By Healthcare Practitioners," July 27, 2011*

(~~w~~*y*) Army Regulation 600–85, "Army Substance Abuse Program," February 2, 2009

(~~x~~*z*) Bureau of Medicine and Surgery 6320.66E, "Credentials Review and Privileging Program – Announcement of Core and Supplemental Privileges for Adult Psychiatric Mental Health Nurse Practitioner (PMHNP)," June 11, 2007

(~~y~~*aa*) DoD Directive 6490.1, "Mental Health Evaluations of Members of the Armed Forces," October 1, 1997

(~~z~~*ab*) Operational Navy Instruction 5350.4, "Navy Alcohol and Drug Abuse Prevention and Control," June 4, 2009

(a~~a~~*ac*) Air Force Instruction 44-121, "Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program," April 11, 2011

(a~~b~~*ad*) Department of the Army Pamphlet 600-85, "Army Substance Abuse Program," October 15, 2001

(a~~c~~*ae*) Department of the Navy Civilian Human Resource Manual, Sub-chapter 792.3, "Drug Free Workplace," October 2005

(a~~d~~*af*) Air Force Instruction 36-810, "Substance Abuse Prevention and Control," July 22, 1994

(a~~e~~*ag*) Bureau of Medicine and Surgery 5353.3, "Use of Disulfiram (Antabuse)," July 23, 1990

(a~~f~~*ah*) DoD Instruction 6490.4, "Requirements for Mental Health Evaluations of Members of the Armed Forces," August 28, 1997

(a~~g~~*ai*) Military Personnel Manual 1910-232, "Pre-Separation Treatment for Drug/Alcohol Dependent Personnel," June 16, 2008

(a~~h~~*aj*) Public Law 104–191, "The Health Insurance Portability and Accountability Act of 1996"

(a~~i~~*ak*) Public Law 101–647, "Crime Control Act (CCA) of 1990"

(a~~j~~*al*) Army Regulation 25–400–2, "The Army Records Information Management System (ARIMS)," October 2, 2007

(am) JTF CapMed-D 3000.01 "Commander's Critical Information Requirements (CCIR) and Serious Incident Reporting (SIR)," April 13, 2012

(a~~k~~*an*) Public Law 99-660, "The Healthcare Quality Improvement Act"

(a~~l~~*ao*) Title 5, United States Code

(ap) US Army Medical Command Memorandum, "Occupational Standards and Competency of Enlisted Soldiers," November 29, 2010

(aq) Headquarters United States Air Force/Service Group I Memorandum, "Occupational Standards and Competency for Enlisted Airmen," December 21, 2010

(ar) DoD Instruction 4000.19, "Interservice and Intragovernmental Support," August 9, 1995

(as) DoD 6025.13-R, "Medical Quality Assurance in the Military Health Service," June 11, 2004

(at) JTF CapMed Action Memorandum, "Competency Based Orientation Program for Enlisted Medical Personnel," August 17, 2009

(au) Commander, Joint Task Force Decision Memo #0004, "Standardized Enlisted Medication Administration Course," July 20, 2009

(av) Hospital Corpsmen Manual Naval Education and Training 14295A, "Hospital Corpsmen," revised 2010

(aw) United States Air Force 4NOXI/B/C," Aerospace Medical Service," April 1, 2007

(a~~m~~*x*) Section 801 through 977 of title 21, United States Code

ENCLOSURE 2

RESPONSIBILITIES

1. COMMANDER, JTF CAPMED (CJTF). The CJTF, as the senior medical department officer in the JOA, shall:

a. Be responsible for the quality of health care delivered to all beneficiaries in the JOA.

b. Establish CQMP policy to implement DoD 6025.13–R (Reference (~~h~~*i*)), other applicable DoD issuances, and current accrediting/regulatory guidance.

c. Serve as the governing body (GB) for health care facilities

d. Be the sole authority for reporting adverse privileging/practice actions and malpractice claims against civilian and contract providers to State and other regulatory agencies and to the National Practitioner Data Bank (NPDB). Coordinate with Service Surgeons General in their responsibility for reporting AD providers to State and other regulatory agencies and to the NPDB.

e. Delegate privileging authority to inpatient MTF Commanders ~~*and Center Directors*~~, thus making them responsible and accountable for the quality of health care provided in their treatment facilities.

f. Hold inpatient MTF Commanders and Center Directors responsible and accountable for the quality of health care provided in their treatment facilities.

g. Develop policy on credentialing, performance-based privileging, outcomes management (OM), medical staff appointment, and accreditation processes.

h. Provide policy guidance and consultation to inpatient MTFs and JPC.

i. Monitor and review sentinel events (SEs) that occur within the JOA and ensure that inpatient MTFs have processes in place to prevent future occurrences.

j. Monitor trends in processes and outcomes of care and report the results to both internal and external sources, as appropriate.

k. Collect aggregate JOA CQM data, as required by Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA)), or other agencies.

l. Participate fully in the DoD Patient Safety Program (PSP), including initiatives to promote the objectives of the program, monitor for inappropriate use of information generated, and provide recommendations to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) for program improvements through the senior leadership council or other mechanisms.

m. Coordinate with the Agent of JTF CapMed to:

(1) Assist in providing oversight responsibility for implementation of the JOA CQMP as requested by CJTF.

(2) Assure CJTF is represented on various committees and working groups sponsored by the OASD/HA, DoD, and other health care quality agencies.

(3) Provide CQM guidance for inpatient MTFs and JPC.

(4) Provide corporate guidance, administrative and/or clinical advice, consultation, and education to define and/or clarify standards of care, practice, and policy.

(5) Provide administrative support to CJTF to administer the JOA Patient Safety (PS) and Risk Management (RM) Programs that include but are not be limited to: risk assessment, risk avoidance, safety practices, incident monitoring/management, adverse privileging/practice actions, SEs, and malpractice claims.

(6) Assure appropriate maintenance of records of medical malpractice claims data for inpatient MTFs and JPC.

(7) Implement the administrative procedures related to reporting providers to the NPDB according to established DoD guidance.

(8) Interface with accrediting and licensing agencies, for the purposes of maintaining and improving quality of care within the inpatient MTFs and JPC.

(9) Represent the interests of JTF CapMed at the DoD Patient Safety Planning and Coordination Committee (PSPCC) and confer with those designated to be an inpatient MTF or JPC Patient Safety Manager (PSM) and leadership to direct initiatives and resolve issues related to PS.

2. SERVICING LEGAL OFFICE. The Servicing Legal Office shall provide legal advice and counsel related to the contents and application of this Manual for the Command and staff of the inpatient MTFs or JPC.

3. JTF CAPMED IG. The JTF CapMed IG shall conduct independent assessments of the issues related to the quality of health care in the JOA.

4. INPATIENT MTF COMMANDERS. The inpatient MTF Commanders shall:

a. Meet the appropriate requirements related to health care quality management (QM) and quality assurance (QA) as delineated in current published regulations, statutes, accreditation standards, and DoD issuances.

b. Approve the award of medical appointments for qualified providers (any discipline), clinical privileges, alterations in privileges, adverse privileging actions, and written notification of same, to all military, civilian, contract, and volunteer health care providers.

c. Ensure that a comprehensive CQMP is established in compliance with this Manual.

d. Appoint one or more personnel qualified by education, training, and experience to manage the CQMP components as addressed in this Manual.

e. Ensure coordination of actions under appropriate regulations and the Uniform Code of Military Justice (UCMJ) when necessitated by findings under this Manual.

f. Employ or request from JTF CapMed qualified subject matter experts as necessary to conduct local quality-of-care investigations.

g. Designate a chairperson for the credentials committee/function.

h. Designate membership of the committee/function tasked to provide support and oversight of impaired health care personnel (IHCP) (previously the Impaired Healthcare Provider Program).

i. Ensure systematic credentials authentication and competency assessment for all health care personnel. This includes primary source verification (PSV) of all licensure, certification, registration, and/or other authorizing documents required for practice prior to employment.

j. Ensure that interactive collaboration is maintained with civilian agencies involved in external resource sharing agreements to communicate credentialing and privileging information.

k. Ensure the organization is in continuous compliance with current accrediting agency standards and/or other regulatory/accreditation requirements, as appropriate. For The Joint Commission (TJC) purposes, the medical commander is the delegated authority to represent the GB at the local level and acts as liaison with accrediting agencies

l. Ensure implementation of an integrated PSP throughout the inpatient MTF. The administration of the inpatient MTF PSP shall be through an MTF PS Office or QM Program. The inpatient MTF PSP, with its emphasis on process and system design, must be an integral part of the risk reduction and performance improvement efforts of the inpatient MTF and shall function as an integral part of the quality oversight of the MTF.

m. Designate an individual as the PSM to direct the inpatient MTF PSP. The PSM shall be an integral part of the Executive Administrative team and report PS issues to the Command and the appropriate medical operations agency as indicated by the respective Services. Where

resources permit, the inpatient MTF PSM and Risk Manager should not be the same person. The PSM will:

(1) Facilitate inpatient MTF reporting of SEs, adverse events/incidents, and near-miss events. The PS Officer will forward redacted (i.e., patient, individual provider, staff information) copies of all root cause analyses (RCAs) and PS safety related Proactive Risk Assessments (PRA) to the PS Data Analysis Center (formerly referred to as the DoD PS Center).

(2) Review PSP reports, and analyze the information in conjunction with the DoD PSP and other uniformed Services. Through the PSPCC, develop and execute for JTF CapMed-level action plans for addressing patterns of patient care errors, as well as review and integrate processes for reducing harm due to medical errors and enhancing PS.

n. Ensure the inpatient MTF PSMs and other designated personnel receive appropriate DoD PS training.

o. Ensure program activities receive interdisciplinary support at all levels of the organization.

p. Ensure that inpatient MTF clinical and administrative personnel are educated about the DoD PSP and MTF-related activities. Such activities should include reporting of near-miss, adverse and SEs/incidents, effective communication techniques (e.g., team events, support/backup behaviors, structured communication, conflict resolution, handoffs, and transitions), as well as updates on the DoD PSP procedures and activities.

q. Ensure robust reporting of all medication and non-medication related PS events/incidents, to include near-miss events. Reporting must be consistent with DoD PSP methods.

r. Award appropriate practice privileges to Reservist/National Guard providers upon the review of Inter-Facility Credentials Transfer Briefs (ICTBs) and required privileging documentation from civilian health care organizations. Current competency in the duty area of clinical specialty skill must be ensured before granting or renewing privileges for Reservist/National Guard providers who do not currently hold comparable privileges within their Reserve unit.

s. Ensure that an optimal professional relationship exists among all healthcare providers in the facility.

t. Render appropriate reports to JTF CapMed, including but not limited to specific information requirements, results of surveys of accrediting and licensing organizations.

u. Support the JPC in meeting the requirements for CQM.

v. Ensure that RM processes, as defined in writing in the CQM plan, are in place and that an individual is designated to serve as the organization's risk manager and as the clinical advisor.

w. Ensure that a mechanism is in place to conduct a comprehensive review of each malpractice claim, as well as cases involving healthcare related death or medical disability of a military member.

5. JPC DIRECTOR. JPC Director shall be responsible for adherence to the provisions of this Manual. However, because they are not privileging authorities, they must determine methods to best meet the requirements of this Manual.

6. ASSISTANT CHIEF OF STAFF, EXECUTIVE COMMITTEE OF THE MEDICAL STAFF (ACOSECOMS). The ACOSECOMS shall:

a. Be a privileged physician holding an active appointment to the medical staff and designated as Chief of the Medical Staff.

b. Be the principal executive staff advisor to the commander concerning matters of quality and scope of medical care and utilization of professional resources, medical policy, and planning.

c. Be responsible for and have oversight of the credentialing and privileging process.

d. Act as liaison between assigned members of the medical staff and the commander and, as such, advocate on behalf of the medical staff and executive leadership.

e. Be chairperson of the Executive Committee of the Medical Staff (ECOMS). (In the absence of the ACOSECOMS, this responsibility may be delegated by the inpatient MTF Commander to another appropriately qualified individual.)

f. Be chairperson of the credentials committee/function or, with approval of the commander, delegate this responsibility.

g. Delegate selected ACOSECOMS responsibilities to a physician with appropriate qualifications, with the approval of the Commander.

h. Intervene on behalf of the commander to immediately hold in abeyance or suspend privileges when a provider's conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this Manual (see Enclosure 11).

i. Orient all medical staff applicants concerning inpatient MTF and Center bylaws governing patient care, medical staff responsibilities, professional ethics, continuing education requirements, privileging, adverse privileging actions, and due process proceedings.

j. Be responsible for ensuring organizational performance improvement (PI) activities are in place and actively participate in these processes.

k. Ensure that an ongoing, proactive program for identifying risks to PS and for reducing medical/health care errors is implemented according JTF CapMed guidance.

l. Participate in the development and implementation of policies and procedures that guide and support the provision of services ensuring that such policies and procedures are integrated into the overall plan for patient care.

m. Ensure an effective Peer Review Program (see Glossary) is in place for the organization's health care professionals.

n. Represent the interest of the medical staff as a voting member of the Executive Committee of the Nursing staff (ECONS) (or comparably named committee).

o. Ensure coordination with Graduate Professional Health Education (GPHE) programs concerning the provision of clinical care.

7. DEPUTY COMMANDER FOR NURSING (DCN). The DCN (or comparable title) shall:

a. Be certified as a licensed professional registered nurse.

b. Be the principal executive staff advisor to the commander on matters concerning the scope of patient care services and clinical policy (specifically related to the provision of nursing care and services and nurse staffing standards), nursing policy, and the availability and utilization of department of nursing resources.

c. Act as liaison between members of the nursing staff and the commander and, as such, advocate for the provision of quality nursing care, treatment, and services.

d. Participate in the development, implementation, and integration into the organization's overall plan for patient care, policies, and procedures that guide and support the provision of quality patient care services.

e. Be chairperson of the ECONS. (This responsibility may be delegated by the DCN to another appropriately qualified individual.)

f. Represent the interest of non-privileged nurses as a voting member of the ECOMS (or comparably named committee).

g. Ensure PI activities are in place in all arenas in which nursing care, treatment, or services are rendered and actively participate in these processes.

h. Designate a privileged nurse to be a voting member of the inpatient MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel, if the DCN is not a privileged nurse.

i. Reduce or appropriately limit the non-privileged scope of practice of any nursing staff member whose competence, quality of care, behavior, and/or conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this Manual see Enclosure 11).

j. Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/ healthcare errors according to JTF CapMed guidance.

k. Be an active participant in the organization's Records Management program.

l. Ensure the presence of an effective nursing peer review program (see Glossary).

m. Be executive staff advisor to the commander for other non-nursing hospital personnel and services under his or her supervision and authority, with the associated QM responsibilities as noted above.

8. CHIEF, DEPARTMENT, SERVICE, OR CLINIC. In his or her area of responsibility, or technical oversight, the Chief, department, Service, or clinic shall:

a. Be responsible for all clinically related activities.

b. Perform ongoing surveillance of the clinical performance of individuals who are required to hold a license, certification, or registration for clinical practice.

c. Be responsible for ongoing functional CQM activities and their integration, as appropriate, into the organizational PI Program.

d. Provide oversight of and participate in the peer review process.

e. Recommend to the medical staff the clinical privileging criteria that are relevant to the care provided in the department/service/unit.

f. Recommend privileges for each provider in the department/service/unit, as authorized.

g. Make recommendations to the relevant hospital authority for needed patient care services not provided by the department/service/unit.

h. Integrate the services of the department/service/unit with the primary functions of the inpatient MTF or JPC.

i. Coordinate and integrate inter/intradepartmental services.

j. Participate in the development and implementation of policies and procedures that guide and support the provision of services. Ensure that such policies and procedures are integrated into the overall plan for patient care.

k. Determine the qualifications and competencies of department/service/unit health care personnel. Confirm job descriptions for personnel within department, service or clinic.

l. Establish objective, quantifiable methods to continually assess and improve the quality of care and service provided. Utilize ORYX™ data, or like data, as applicable.

m. Maintain quality control programs, as appropriate, and ensure that PS issues are given high priority and addressed when department/service/unit-level processes, functions, or services are designed or redesigned.

n. Provide and support orientation, in-service training, and continuing education of all personnel in the department/ service/unit.

o. Make recommendations for space and other resources required by the department/service/unit.

p. Recommend a sufficient number of qualified and competent persons to provide care.

q. Participate in outside source selection for needed services.

9. PRIVILEGED STAFF. The privileged staff shall:

a. Acknowledge, in writing, at the time clinical privileges and medical staff appointment (if applicable) are awarded, the intent to abide by applicable bylaws.

b. Make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers, when a member of the credentials committee/function is appointed.

c. Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the privileges requested and/or according to the Service-specific military specialty code awarded, accomplish required training, and ensure the currency of all documents and other information contained in his or her provider files.

d. Participate in PI, quality control, and peer review processes.

10. ALL OTHER ORGANIZATIONAL ASSIGNED PERSONNEL. All other organizational assigned personnel, other than privileged providers, shall:

a. Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the scope of practice of the assigned position, accomplish required training, and ensure the currency of all documents and other information contained in his or her Joint Training File.

b. Participate in PI, quality control, and peer review processes, as applicable.

c. Ensure knowledge of and responsibility for implementing all applicable organizational policies and procedures relevant to his or her job description and/or scope of practice.

11. CQM COORDINATOR. The CQM Coordinator, or similarly titled individual (for example, PI coordinator), is tasked with overall responsibility for the inpatient MTF CQMP. The individual in this role may be expected to exercise broad oversight and to collaborate with various key staff to ensure the integration of the quality functions performed by the organization. This requires the incumbent to be an active member of the executive leadership team who shall:

a. Ensure that inpatient MTF-wide PI is a dynamic process based on ongoing identification of opportunities for change.

b. Provide leadership and consultative services to departments and sections within the Inpatient MTF or the JPC, as appropriate, with regard to credentialing and privileging issues, accreditation requirements, CQM and QA regulatory compliance issues, PI, and RM/PS.

c. Participate in the development of policies for the organization, giving special consideration to the integration of and collaboration between internal administrative and clinical policies.

d. Participate in the identification of opportunities for PI, recommendation of solutions for facility issues and concerns, and implementation of plans and follow-up activities related to organizational PI.

e. Serve as subject matter expert in conjunction with patient administration and the Servicing Legal Office in areas such as accreditation standards for health care documentation and the medical-legal aspects of health care practice.

f. Direct the collection, analyses, and dissemination of PI data within the organization ensuring that basic statistical analyses and comparative processes are included.

g. Facilitate inpatient MTF and Center efforts to provide prevention, wellness, and specific medical condition-based management programs as well as other health management programs, as required, based on timely inpatient MTF and Center data and identified beneficiary need.

h. Ensure that inpatient MTF-and Center-specific CQM and PI Program changes are identified and implemented as data analyses dictate.

i. Keep inpatient MTF and Center leadership informed of public policies, DoD and JTF CapMed regulations and guidance, and legislative and health care trends that affect various CQM and other related health care initiatives.

j. Facilitate the development and implementation of PI education and training sessions for the inpatient MTF and Center staff at all levels

k. Oversee the preparation of inpatient MTF and Center PI reports that demonstrate evidence of collaborative, multi-Service/departmental input.

12. CHIEF, CREDENTIALS AND PRIVILEGING. The Chief, Credentials and Privileging, shall:

a. Provide technical advice and direction to the inpatient MTF Commander and Center Director on issues related to health care provider credentialing and/or privileging processes.

b. Serve as a subject matter expert to the inpatient MTF and Center staff for appropriate credentialing and privileging procedures, guidelines, and mandates according to JTF CapMed issuances, DoD and/or DoD Instructions, accrediting agency standards, and other regulatory agency requirements. Maintain a resource library of such references.

c. Provide technical oversight and management of the process for verification of all licensure, certification, registration, and/or other authorizing documents required for practice. At the discretion of the inpatient MTF Commander or JPC Director, responsibility for non-privileged providers may be assigned to another individual(s).

d. Provide technical oversight and management of all health care provider credentialing and privileging functions.

e. Manage all privileging and medical staff appointment processes. Serve as a point of contact (POC) to privileged staff during initial application for medical staff appointment and for biennial re-appointments.

f. Offer comprehensive guidance and support to providers during the initial and renewal privileging processes.

g. Ensure peer and supervisory clinical performance review of health care providers who hold initial medical staff appointment and clinical privileges.

h. Manage and update documents of evidence contained in the provider credentials file (PCF) relevant to education, experience, licensure, certification, registration, and training to ensure accuracy and currency of information.

i. Conduct NPDB and other relevant inquiries and Pre-Selection Verification to authenticate credentials of staff members for initial award/biennial renewal of clinical privileges and for initial appointment/biennial re-appointment to the medical staff. Requirements also apply for biennial update of the PCF for Reservist/National Guard practitioners who are not currently privileged.

j. Ensure that the credentials of all civil service civilian and contract health care providers have been primary source verified prior to initial employment when licensure, certification, or registration is required as a condition of employment.

k. Establish and maintain the inpatient MTF's and Center's Centralized Credentials and Quality Assurance System (CCQAS).

l. Ensure the CCQAS database is current and complete.

m. Research and respond as appropriate to inquiries regarding the status of medical staff membership.

n. Maintain all PCFs according to this Manual.

o. Prepare and forward PCFs and/or ICTBs for privileged providers to the gaining inpatient MTF or JPC within the specified time requirements (see Enclosure 10).

p. Ensure that ICTBs and mandatory attachments are integrated into the credentials committee/function review process for timely privileging of providers.

q. Facilitate the review of all active duty (AD)/Reservist/National Guard and other Federal Service PCFs or ICTBs in compliance with this Manual.

r. Forward all requests for adverse credentialing and privileging information on individuals previously assigned or employed as privileged Federal Service providers to JTF CapMed for action.

s. Ensure a process for communicating credentialing and privileging information to civilian agencies involved in external resource sharing agreements.

13. CHIEF, RM AND/OR PS. (This may be a single position with combined responsibilities or two separate positions with individually defined responsibilities. See Enclosures 13 and 14 for additional information.) The Chief, RM and/or PS shall:

a. Integrate and coordinate all RM/PS administrative and management activities within the inpatient MTF or JPC, as appropriate.

b. Collaborate with executive leadership to develop compliance programs for all regulatory and accrediting requirements associated with RM and PS.

c. Ensure that organizational RM/PS programs are supported at all levels.

d. Establish/maintain a dedicated program for avoiding adverse events or medical misadventures and improving PS.

e. Collaborate with executive leadership and the inpatient MTF or JPC safety and occupational health manager (comparable title) in accordance with DoD Instruction 6055.1 (Reference (~~i~~*j*)) to ensure a comprehensive safety program for all patients, employees, visitors, volunteers, and others.

f. Recommend, develop, monitor, and evaluate plans and programs to decrease facility and Government liability and/or financial loss associated with medical misadventures, accidents, and other untoward events.

g. Initiate actions and processes that will secure, preserve, and protect evidence related to a SE or Medical Malpractice Claim.

h. Oversee the investigation of all SEs to ensure coordination of all data collection activities, completion of a thorough and credible RCA, and reporting through appropriate channels.

i. Inform and coordinate all activities associated with adverse events and SEs with the Center/Claims/Command Judge Advocate (CJA).

j. Participate in structured organizational processes to identify potential risk, analyze trends, and implement PI initiatives to reduce risks.

k. Collaborate with the patient representative/advocate and the inpatient MTF or JPC safety and occupational health manager to identify trends related to customer concerns, complaints, or incidents and to manage problems/risks appropriately.

l. Present opportunities for improvement related to organizational risks (including recommended solutions, implementation plans, and follow-up activities) to the inpatient MTF or JPC executive committee for action in support of quality patient care.

m. Provide consultative information and risk assessment/PS reports to the executive leadership, various committees or individuals, and all levels of staff on general and specific medical RM issues and events.

ENCLOSURE 3

MEDICAL STAFF AND INPATIENT MTF AND JPC COMMITTEE STRUCTURE AND FUNCTIONS

1. GENERAL. The Joint Commission (TJC) requires an organized, self-governing medical staff to provide direction and oversight of the quality of care, treatment, and services delivered by privileged providers. The organized medical staff, referred to in this publication as the ECOMS, is also responsible for evaluating the competency of privileged providers on an ongoing basis, delineating the scope of privileges that will be granted, ensuring a uniform standard of care, and providing leadership in PI activities within the organization. The medical staff is accountable to the governing body as represented by the inpatient MTF Commander or JPC Director.

2. MEDICAL STAFF BYLAWS

a. The bylaws will be developed, adopted, and amended by the medical staff and approved by the Commander as representative of the governing body. The medical staff will enforce and comply with the bylaws.

b. The inpatient MTF or JPC medical staff bylaws must meet current requirements of TJC.

3. INPATIENT MTF OR JPC DEPARTMENTAL STRUCTURE AND LEADERSHIP. The bylaws will describe the qualifications, roles, and responsibilities of department chiefs.

a. Physicians or other privileged providers will be appointed as chiefs of medical departments/services by the commander. Selection will be based on qualifications including clinical and leadership experience and ability. In instances where a non-physician serves as the chief of a clinical department/service, a physician will be selected as the medical director. The medical director will advise the chief and be responsible for practice issues outside the clinical scope of the non-physician chief. The medical director will be responsible for peer review and the credentialing and privileging of physicians and other privileged providers. The chief will represent the department/service at the ECOMS and other required meetings.

b. Department Chiefs shall conduct performance evaluations on subordinates regardless of their Service or Corps (discipline) and will be managed through Service-specific administrative processes.

4. EXECUTIVE COMMITTEE OF THE MEDICAL STAFF. The ECOMS is authorized to carry out medical staff responsibilities and performs its work within the context of the functions of governance, leadership, and PI. The ECOMS has the primary authority for activities related to self-governance of the medical staff and for PI of the professional services provided by

privileged healthcare providers. This committee reports to the Board of Deputies of the inpatient MTF or the JPC.

a. The majority (at least 51 percent) of voting ECOMS members will be licensed physicians with current privileges and medical staff appointments.

b. Voting membership will include the ACOSECOMS (chairperson), the DCN, and chiefs of clinical departments. Other members, qualifications for membership, and the voting status of members (who are not members of the medical staff) will be as delineated in the medical staff bylaws. Ad Hoc members may include senior privileged providers from other clinical entities (i.e., DiLorenzo TRICARE Health Clinic) affiliated with JTF CapMed and chiefs of administrative divisions/services related to patient care (for example, patient administration division (PAD) and CQM).

c. The ECOMS acts upon reports of the inpatient MTF or JPC (as appropriate) committees/functions, clinical departments and subcommittees or workgroups designated by the ECOMS. In addition, this committee provides recommendations to the commander at a minimum on the following:

(1) The medical staff structure.

(2) The process for credentials review and delineation of individual clinical privileges.

(3) Medical staff membership and termination of membership.

(4) The delineation of privileges for each eligible provider. (If the ECOMS and the credentials committee are not the same body, the privileging recommendations of the credentials committee for each provider will be reviewed by the ECOMS and forwarded to the commander.)

(5) The mechanism for terminating medical staff membership.

(6) The mechanism for adverse actions fair hearing and appeal procedures.

(7) The participation of the medical staff in organizational PI activities.

5. MEDICAL STAFF PARTICIPATION IN PI ACTIVITIES

a. Leadership. TJC requires the medical staff to provide leadership in measuring, assessing, and improving processes that primarily depend on the activities of privileged providers. All committee minutes/reports regarding these activities will be routed through the ECOMS to the commander. As a minimum, the following functions will be evaluated, documented, tracked, and reported:

(1) Medical assessment and treatment of patients

(2) Use of medications

(3) Use of blood and blood components

(4) Operative and other procedures

(5) Appropriateness of clinical practice patterns

(6) Significant departures from established patterns of clinical practice

(7) Use of information about adverse privileging decisions

(8) Use of developed criteria for autopsies

(9) Sentinel event data

(10) PS data and

(11) Other PI functions that may be significant to the organization include: medical records review, tumor board/cancer conference, pain management processes, outcomes related to cardiopulmonary resuscitation, and services provided to high-risk populations.

b. Participation. The organized medical staff participates in inpatient MTF- or JPC- wide PI activities (as appropriate), such as:

(1) Education of patients and families

(2) Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment and services of an individual patient

(3) Accurate, timely, and legible completion of patients' medical records

(4) Review of findings of the assessment process that are relevant to an individual's performance. The organized medical staff is responsible for determining the use of this information in the on-going evaluations of a practitioner's competence

(5) Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body

6. OTHER INPATIENT MTF OR JPC ORGANIZATIONAL FUNCTIONS AND COMMITTEES. TJC requires an ECOMS (or committee with a similar function). In addition, TJC directs the performance of other select functions; however, a committee need not be dedicated to that purpose. These functions must be accomplished by the organization, on a recurring basis, with documentation forwarded to the ECOMS. The use of minutes or summary reports to document the function is a facility-level decision. Certain other committees (such as

RM) are required by agencies other than TJC, as noted below. The following committees/functions are required by this Manual:

a. QM Function. There shall be a mechanism or forum to monitor and address clinical quality issues throughout the inpatient MTF or JPC (as appropriate). Reports and recommendations shall be rendered to the Board of Deputies for action, adjudication, and resolution. Decisions of the Board of Deputies shall be appropriately disseminated throughout the inpatient MTF or JPC, and communicated to JTF CapMed.

b. PS Committee/Function. PS activities are designed to maintain and improve healthcare processes and practices, reduce the potential for harm to patients, and ensure the general safety and security of patients in all settings. Membership of this committee will be multidisciplinary (See Enclosure 13). The PS committee reports to the QM Function.

c. RM Committee/Function. Reference (~~h~~*i*) requires an RM committee. If these RM duties are not performed by a dedicated committee, the medical staff bylaws will specify how this function will be accomplished. See Enclosure 14 for RM and the committee/function.

d. Credentials Committee/Function. See Enclosures 9 through 11

e. IHPC. See Enclosure 2

f. Other Formal Committees. Various committees, boards, and councils may be established with the approval of the QM Function to perform the monitoring and evaluation required by this Manual and other relevant guidance (Reference (~~h~~*i*)).

g. Committee/Function Records and Reports. A written record of all CQM committees/functions will be maintained by the inpatient MTF or JPC. The QM office, or equivalent, is the recommended site. The CQM plan of the inpatient MTF or JPC (as appropriate) will define the process for communicating the results of CQM activities and associated recommendations/actions within the organization, and to JTF CapMed and/or outside organizations.

ENCLOSURE 4

*CLINICAL QUALITY MANAGEMENT PROGRAM (*CQMP*)* AND ORGANIZATIONAL PERFORMANCE IMPROVEMENT (PI)

1. CQMP

a. The purpose of the JTF CapMed CQMP is to continuously and objectively assess key aspects of individual and institutional performance with the intent to improve the health care and services provided to eligible DoD beneficiaries and others.

b. Inpatient MTF Commanders and the JPC Director will establish and resource a CQMP that coincides with any DoD programs, as appropriate, and meets the unique needs of the organization. When developing the facility-level CQMP, consideration must be given to all accreditation and regulatory requirements. A comprehensive program requires integration of these criteria that offer evidence of the quality, cost, availability, and appropriateness of care and services being provided to DoD beneficiaries of all ages. Critical to the success of the CQMP is the active involvement and participation of all staff members.

c. CQM will be integrated into the organization's vision and mission statements and guiding principles. Such integration affords the Inpatient MTFs and the JPC's leadership an opportunity to develop an effective strategic plan of action for the delivery and continuous improvement of quality care.

d. Each inpatient MTF and Center will maintain a single written plan that includes all departments/services/functions and will define how each of its established CQM processes and PI activities will be implemented.

e. Improving individual and organizational performance necessitates the use of various techniques, tools, and methodologies within a structured framework to measure and ultimately enhance the quality and cost efficiency of healthcare delivery. While all healthcare personnel are stakeholders in the PI process, an executive leadership committed to quality is crucial to linking organizational strategic priorities with QA efforts, thereby optimizing the impact of improvement activities on organizational performance as a whole.

2. PROCESSES AND FUNCTIONS REQUIRING MEASUREMENT. Effective PI requires the measurement, evaluation, and comparison over time of a variety of patient-focused functions, organizational functions, and other activities (Reference (g)). Standards addressing these activities are found in various TJC Comprehensive Accreditation Manuals including those for hospitals, ambulatory care, behavioral health, home care, long-term care, laboratory services, and others. The facility's review mechanisms designed to systematically measure and continuously evaluate these activities must be collaborative and multidisciplinary.

3. PI DATA SOURCES AND ANALYSES

a. Successful PI will be based on effective use of both clinical and administrative data from a variety of sources. The inpatient MTF or JPC will determine which data are appropriate to consider for the purpose of organizational improvement.

b. Various activities, programs, and processes, such as those in 3.b.(1) through (7) of this ~~e~~*E*nclosure, merit consideration as sources of information that may influence the PI Program within the organization.

(1) Beneficiary and health care professional education and feedback sessions;

(2) Clinical practice guideline (CPG)-based condition management programs;

(3) Putting Prevention into Practice, Healthy People 2010, and other illness prevention and health promotion activities;

(4) Utilization management (UM) activities such as demand and referral management, case management, and discharge planning;

(5) Provider, clinic, and clinic team profiling related to morbidity, mortality, length of stay, access, disease and prevention program and/or outcomes-related metrics, patient satisfaction, and cost;

(6) Discipline-specific standards of care for privileged providers; and

(7) American Nurses Association (ANA) Standards of Nursing Practice or other nursing specialty organization's standards of practice (for example, the Association of Perioperative Registered Nurses or the American Association of Critical Care Nursing, as appropriate) for the delivery of nursing care and recognized practice standards for other healthcare specialties.

c. An expected consequence of effective data analyses related to Outcomes Management (OM)/UM activities is the identification of those clinical practices with significant positive outcomes that are successfully contributing to the organization's PI objectives. At the same time, practices that are ineffective in promoting PI objectives (that is, result in negative outcomes) may be noted. Careful analysis of the data will facilitate determination of both best and least effective practices for the organization. Organizational personnel, working in small focus groups, may be tasked to address processes that result in statistically significant positive or negative outcomes. These personnel should carefully evaluate the circumstances resulting in negative patient/organizational outcomes with specific emphasis on recommendations for PI. Those circumstances with notably positive outcomes may warrant promulgation throughout the organization, the JOA, or the Department of Defense.

d. The Commander/Director is responsible for analyzing the results of inpatient MTF or JPC studies conducted by external accrediting agencies as well as DoD or JOA-level organizations. In addition, the results from TJC and the National Committee on QA metrics monitoring, Centers

for Medicare and Medicaid Services (CMS) and Health Plan Employer and Data Information Set standards/metrics provide useful data. The National QM Program contract reports, as applicable, and the contractor CQM monitoring of the civilian health care provider network as stipulated in the TRICARE regional contract should be carefully considered. Actions to improve performance outcomes based on the various data available should be taken.

4. PI ACTIVITIES IN THE FACILITY WRITTEN PLAN

a. The inpatient MTF- or, as appropriate, JPC-specific approach to process improvement will be articulated in a plan that clearly defines how all levels of the organization will address improvement issues. Emphasis on quantifiable improvements relative to the processes and outcomes of care is essential. The PI plan will provide a systematic approach to PI and will contain:

(1) An identified scope and focus for measurement (that is, what data elements will be assessed).

(2) Structured processes to assess performance (that is, how the data will be assessed).

(3) Clearly established priorities for improvement.

(4) Application of OM/UM/utilization review information to prioritize management and use of limited organizational resources.

(5) Implementation of PI activities based on assessment conclusions.

(6) Identified processes to maintain achieved improvements.

b. The PI plan will describe all processes, procedures, and criteria used to evaluate care as well as the functions of the staff responsible for implementation and evaluation of the various UM/OM activities. A systematic process for considering and acting on recommendations for organizational improvement will be clearly identified in the plan.

5. FACILITY ACCREDITATION. Accreditation of inpatient MTFs, JPC, and designated health care programs/functions by recognized national organizations, as required by law and DoD guidance, is an integral part of JTF CapMed QM efforts, specifically in support of organizational PI.

a. Facilities Requiring Accreditation. It is DoD policy that all fixed hospitals, hospital-sponsored substance abuse rehabilitation programs, and free standing ambulatory care clinics will maintain accreditation by the TJC or other external accrediting organizations approved by the OASD(HA).

b. Accreditation Requirements. All facilities will maintain accreditation under the TJC standards or other nationally recognized accreditation organization standards, as approved by OASD(HA), that apply to the services and delivery systems that describe their care.

c. Accreditation Guidance. Information related to accreditation standard is contained in various references listed in Enclosure 1 and will not be duplicated in this issuance. On occasion, the CJTF may direct policies and procedures that exceed the standards of recognized accrediting agencies; in these cases, appropriate implementing instructions will be issued. If a conflict exists between accrediting agency standards and JTF CapMed policy, the most stringent standard will prevail.

d. Accreditation Funding. The TJC Accreditation Program is centrally funded and administered by JTF CapMed.

e. JOA Equivalencies for TJC Survey. The TJC recognizes the following equivalencies when applying TJC standards to inpatient MTFs:

(1) CJTF serves as the GB for inpatient MTFs.

(2) Federal law, DoD Directives, and JTF CapMed issuances serve as the reference documents for the Medical Staff Bylaws. In addition, inpatient MTF Commanders may require local policy for issues/activities not prescribed by guidance from other sources. Such local policies complement higher headquarters' requirements and are also part of the inpatient MTF formal bylaws.

(3) The inpatient MTF's mission statement describes its purpose and responsibilities.

(4) The inpatient MTF Commander serves as the chief executive officer and is responsible to the GB.

(5) The Deputy Commander *f*or Administration (DCA) or equivalent serves as the chief operating officer.

(6) The ACOSECOMS or equivalent serves as the chief or president of the medical staff.

(7) The DCN or equivalent serves as the nurse executive.

(8) The inpatient MTF Board of Deputies formally links the functions of the GB representative, the chief operating officer, and the medical and other professional staff, with other important aspects of the organization's operation.

f. Submission of Reports of Surveys from External Accrediting, Licensing, and/or Inspecting Organizations. The inpatient MTF will submit a copy of the preliminary report provided by external accrediting, licensing, and/or inspecting agencies to JTF CapMed at the completion of the survey. The survey will be submitted regardless of the survey results or disagreement on the

part of staff with the survey results. This requirement applies to all surveys by external accrediting, licensing, and/or inspecting agencies.

g. Inpatient MTF After-Action Reports. Within 30 days of completion of any survey by a nationally recognized external accrediting and/or inspecting agencies (triennial, unannounced, surveys for cause, or focused), the inpatient MTF Commander will submit to JTF CapMed an after-action report detailing the survey preparation process (planned surveys) and any lessons learned as a result of the survey process. Likewise, the inpatient MTF Commander ~~*director*~~ *or Center Director* will submit After Action Reports of any survey or site visit of other nationally recognized external accrediting and/or inspecting agencies to JTF CapMed.

6. PATIENT RIGHTS AND RESPONSIBILITIES

a. The health care beneficiary is the central focus of all CQM activities. This focus recognizes the patient as a partner, optimizes patient rights within the health care system, and capitalizes on the value of consumer feedback to effectively improve the processes of care.

b. Implementation of patient rights as defined in DoD Directive 6000.14 (Reference (~~j~~*l*)), current TJC standards, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an important component of the CQMP. These rights include but are not limited to:

(1) Information disclosure and access and amendment rights.

(2) Choice of providers and health plans.

(3) Access to emergency services (military or civilian).

(4) Participation in treatment decisions.

(5) Respect and nondiscrimination.

(6) Confidentiality of patient-specific health information.

(7) Complaints and appeals.

c. All health care personnel share in the professional responsibility of ensuring that beneficiaries understand not only their rights but also their responsibility to participate in their own health care decisions. Patients will be provided information as to their rights as beneficiaries of the DoD military health system (MHS), according to local policy.

d. Written and verbal beneficiary perceptions of care and services, both positive and negative, will be incorporated into inpatient MTF CQMP processes as appropriate.

e. As needed to provide care, treatment, and services, the medical record must contain any Advanced Directives. Upon admission, all adult patients will be informed in writing of their

right to participate in their health care decisions, including the right to accept or refuse medical or surgical treatment, and of their right to prepare advance directives. The inpatient MTF policy will prescribe when Advanced Directives must be available in the record.

f. Treatment will not be rendered until informed consent is properly executed. Such informed consent will be documented, and contain evidence of a patient's mutual understanding of, and agreement for, care, treatment, or services through written signature, electronic signature, or when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision maker. Inpatient MTF policy will prescribe when informed consent is required.

g. The inpatient MTF will develop guidelines for the use, withdrawal, and withholding of resuscitative measures, and assist the patient and/or surrogate in making ethically supportable end-of-life decisions.

7. CONFIDENTIALITY OF QA DOCUMENTS AND RECORDS. Section 1102 of title 10, United States Code (also known as The National Defense Authorization Act for fiscal year 1987 (Public Law (PL) No. 99-661)) (Reference (~~k~~*m*)) *and NDAA 2012 revisions to "TITLE 10 - Subtitle A; PART II; CHAPTER 55 § 1102 (Reference (k))* mandate that records created by or for the Department of Defense in a medical QA program are confidential and privileged. Reference (~~k~~*m*) and subsequent guidance predicated on Reference (~~k~~*m*) preclude disclosure of, or testimony about, any records or findings, recommendations, evaluations, opinions, or actions taken as part of a QA program except in limited situations. Under the provisions of Reference (~~l~~*n*), this information is exempt from release in accordance with Exemption 3 of the Freedom of Information Act (FOIA). Additional detailed information regarding the confidentiality of QA documents and records is contained in Enclosure 17.

ENCLOSURE 5

LICENSURE, CERTIFICATION, AND/OR REGISTRATION OF HEALTH CARE PROFESSIONALS

1. POLICY. To promote the highest quality health care for its beneficiaries, it is the policy of JTF CapMed that it's employed and contracted health care professionals meet established standards relative to educational preparation, professional standing, and technical ability. These standards are met, in part, by the application for and maintenance in good standing of a license, certificate, and/or registration (as mandated by State law, Federal statute, and Office of Personnel Management (OPM), JTF CapMed, or DoD Health Affairs policy) to practice within the individual's health care specialty. The requirements of this ~~e~~*E*nclosure also apply to those who are not classified as employees of the inpatient MTFs or the JPC, but are providing patient care services, for example, volunteers providing services under the auspices of a military memorandum of understanding/memorandum of agreement.

2. SCOPE OF LICENSURE REQUIREMENT

a. Military, civil service, and contract personnel, who require a license, certification, and/or registration to perform their duties must maintain a current, active, valid, and unrestricted license or other authorizing document such as certification or registration from any U.S. jurisdiction according to Reference (~~h~~*i*).

b. Licensure, certification, and/or registration requirements apply to professionals performing both clinical and/or administrative duties.

3. BASIC LICENSURE, CERTIFICATION, REGISTRATION CRITERIA

a. A license is a grant of permission to a health care professional by a recognized licensing agency of a State; the District of Columbia; the Commonwealth of Puerto Rico, Guam, or the U.S. Virgin Islands; or other territory or possession of the U.S. to provide health care within the scope of practice for a specific health care discipline.

(1) In lieu of a license when such is not available/offered for certain occupations, another mechanism such as State certification or registration serves as evidence to support practice within a specified discipline.

(2) In specialties that are not licensed by the State, and the requirements of the granting authority for State registration or certification are highly variable, there must be validation by a national organization that the individual is professionally qualified to provide health care in a specified discipline. Examples of this are the National Commission on the Certification of Physicians Assistants (NCCPA) for physician assistants (PAs) and the National Registry of Emergency Medical Technicians (NREMT) for emergency medical technicians.

(a) Service members (AD/Reservist/National Guard) possessing certain military occupational specialties are required to obtain and maintain certification by the NREMT. Certification will be, at a minimum, at the basic level (emergency medical technician-basic). If a Service member requires NREMT certification, Service-specific guidance will govern re-certification. Recertification as established by the NREMT is mandatory. Service members who fail to recertify according to NREMT guidance will immediately be suspended from all duties requiring NREMT-basic certification.

(b) Service members who fail to recertify according to NREMT guidance will be released to their Service for management according to Service-specific regulations.

b. The license, certification, and/or registration will be current (not revoked, suspended, or lapsed); active (characterized by present activity, participation, practice, or use); valid (the issuing authority accepts and considers professional performance and conduct in determining continued licensure); and unrestricted (not subject to restriction pertaining to the scope, location, or type of practice ordinarily granted to all other applicants for similar licensure in the granting jurisdiction).

c. If a State elects to eliminate the licensure requirement for a particular discipline, those health care professionals employed by the DoD (and who are licensed only in that State) must obtain licensure in another State.

d. Health care professionals who are attending licensure-qualifying educational programs must apply for licensure at the earliest available opportunity after having successfully met the qualifying prerequisites.

e. Licensed, certified, and/or registered health care personnel (privileged/non-privileged) must immediately notify their supervisor, and the appropriate inpatient MTF or JPC office responsible for authentication of practice credentials, that their license no longer meets the requirements noted elsewhere in this enclosure. Likewise, notification will be provided when an authorizing agency has imposed a restriction on their license, certification, and/or registration. Failure of an individual to obtain or maintain the appropriate current, active, valid, and unrestricted credentials (license, certification, registration) required by this Manual is the basis for immediate suspension of privileges/practice and/or other adverse personnel action as referenced in sections 4–10 of this enclosure. Such personnel will be reported to the Commander, JTF CapMed and released to their Service for management according to Service-specific regulations. Inpatient MTFs will support the Center in this regard.

4. PROFESSIONAL DISCIPLINES REQUIRING LICENSE, CERTIFICATION, AND/OR REGISTRATION

a. License. Licensure in one's respective discipline is required for all providers/professionals.

(1) The following health care providers/professionals must possess and maintain a

current, active, valid, and unrestricted license from a U.S. jurisdiction before practicing independently within the defined scope of practice for their specialty (list not all-inclusive): Advanced Practice Registered Nurses (APRNs), audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, counseling psychologists, dental hygienists, dentists, dietitians, occupational therapists (OTs), optometrists, physical therapists (PTs), non-personal services PAs, physicians, podiatrists, practical/vocational nurses, Licensed Practical Nurse/Licensed Vocational Nurse (LPN/LVN), psychological associates, registered nurses (RNs), substance abuse counselors, speech pathologists, and veterinarians. The basic qualifications for award of a medically related military enlisted specialty code are contained in Service-specific guidance. The OPM has established the minimum qualification requirements for comparable civilian positions by employee classification series and grade level in its Qualification Standards Handbook for General Schedule positions. The information presented in this chapter regarding licensure (or other authorizing document) of personnel providing direct/indirect health services or patient care may change over time as regulatory requirements at the State level evolve. Requirements related to licensure/certification/registration of JOA health care personnel (military/civilian) will, at all times, comply with current OASD(HA) guidance.

(2) Health care personnel (military/civilian) employed by the Federal Government will abide by the practice requirements imposed by their State of licensure/certification/registration to the fullest extent possible. Compliance with State requirements shall not interfere with the individual's performance of assigned duties/responsibilities in the specified discipline within the Federal sector. Individuals who provide ancillary health services and who hold licensure/certification/registration (national/State) in their individual specialty must reveal this authorizing documentation and are subject to the adverse practice action reporting requirements outlined in Enclosure 14. Professional conduct, behavior, or performance that, based on peer review, warrants an adverse practice action will be reported to the appropriate authorizing agency, according to current DoD guidance.

b. Certification and/or Registration for Select Disciplines

(1) All PAs must possess NCCPA (or its successor organization) certification as a condition of employment (civil service/contract employees) and before being granted clinical privileges (military, civil service, personal services contact, and volunteer).

(2) Dietitians must possess and maintain current registration by the Commission on Dietetic Registration of the American Dietetic Association (ADA) in addition to a current, active, valid, and unrestricted State license.

(3) Substance abuse counselors are required to possess and maintain a current, active, valid, and unrestricted license as a social worker or psychologist, or if the counselor is prepared at the master's degree level and is in the General Schedule (GS) 180 series, the license may be as a licensed professional counselor, with State or national certification in substance abuse rehabilitation.

(4) See Enclosure 8 for additional guidance related to scope of practice and other specific professional requirements for privileged providers.

(5) Although national certification of health care personnel (enlisted, civilian) who provide ancillary health services is not mandated, except mammography technicians (Federal Drug Administration, "Quality Mammography Standards") and emergency medical technicians each Service provides specific guidance. Nevertheless, it is highly encouraged in any specialty for which it may be available. Certification and/or registration requirements for JOA health care personnel (military/civilian) will, at all times, comply with DoD guidance. State licensure as a qualified radiology technician and continuing education in mammography may substitute for the certification specified according to part 900 of title 21, Code of Federal Regulations (Reference (~~l~~*n*)).

5. PROFESSIONAL RESPONSIBILITY REGARDING LICENSURE. It is the professional and individual responsibility of military and civilian health care professionals, and other health care personnel as may be required, to obtain and maintain the license, certification, and/or registration required to practice in a particular health care discipline. Deployment or other extended training does not exempt the military member from this requirement. This responsibility includes payment of requisite fees and knowledge of and compliance with all requirements for continuing education and other mandates of the licensing, certification, and/or registration authority. When in the best interest of the Government and the employee, civilian employees may be given brief excused absences from duty and official time off for required licensing and certification purposes. Permissive temporary duty (TDY) is authorized for military health care personnel taking licensure examinations.

6. GUIDANCE ON LICENSURE REQUIREMENTS

a. Professionals directly accessed from a training program who require a license, certification, and/or registration to practice must obtain such authorizing documents within 1 year of the date when all required didactic and clinical requirements are met; within 1 year of completion of postgraduate year 1 for physicians; and within 2 years after award of the doctoral degree for clinical psychologists. The civil service RN who is appointed to a position pending State licensure may not be extended beyond 6 months, or promoted, if licensure has not been attained.

b. AD health care providers who are eligible for privileges but have not acquired the appropriate license, certification, and/or registration will be released to their Service for management according to Service-specific regulations. Civilian and contract health care providers must possess appropriate license, certification and/or registration as a condition of employment.

c. For RNs and LPNs/LVNs, both military and civilian, the following stipulations apply in addition to the requirement for a current, active, valid, and unrestricted license from a State, U.S. Commonwealth, or territory:

(1) Nurse Officer. The Nurse Officer who graduated after December 31, 1997 must be a graduate of a nursing program accredited by the American Association of Colleges of Nursing or the National League for Nursing. Effective October 1, 2012, all Nursing Officers personnel must have taken and passed the National Council Licensure Examination - Registered Nurses (NCLEX–RN), an examination developed and administered by the National Council of State Boards of Nursing (NCSBN) (in accordance with Service-specific recruiting guidance). Those individuals who passed an RN licensing examination other than the NCLEX–RN prior to December 12, 1986 are granted an exception to this requirement. Before working without supervision within his or her designated scope of practice, the Nurse Officer must pass the NCLEX–RN.

(2) Enlisted practical nurse. The enlisted practical nurses who graduated after December 31, 1997 must be a graduate of a nationally accredited or State-approved practical nursing program. Effective October 1, 2012, the enlisted practical nurses must have taken and passed the NCSBN's National Council Licensure Examination-Practical Nurses (NCLEX–PN) according to Service-specific recruiting guidance). Those individuals who have passed an LPN/LVN licensing examination other than the NCLEX–PN prior to December 12, 1986 are granted an exception to this requirement. Before working without supervision within his or her designated scope of practice, the enlisted practical nurses must pass the NCLEX–PN.

(3) Civilian RN. The civilian RN must be a graduate of an approved professional nursing program, as noted in elsewhere in this enclosure. Current OPM Qualification Standards (civilian RN employment standards) do not include the requirement for the NCLEX-RN. Thus, the civilian RN is exempt from this requirement.

(4) Civilian LPN. The civilian LPN must be a graduate of an approved practical nursing program, as noted elsewhere in this enclosure. To qualify for the grade GS–4 and above, the civilian LPN/LVN is required to possess a minimum of 12 months of nursing assistant experience or have successfully completed a program in practical nursing of at least 9 months duration. Current OPM qualification requires state licensure.

(5) Individuals with both RN and LPN/LVN licenses. In instances where an individual maintains both an RN and an LPN/LVN license, he or she will be held accountable to the scope of practice of the position for which he or she was hired. LPNs/LVNs who, through advanced education, qualify for and obtain an RN license must maintain an LPN/LVN license when employed in an LPN/LVN position. Likewise, the RN who has accepted a position as an LPN/LVN must maintain a current, active, valid and unrestricted license as an LPN/LVN. The RN license is not a substitute for a license as an LPN/LVN.

d. Reservist/National Guard enlisted practical nurses must be in compliance with the above stated licensure requirement. Those individuals who have been unsuccessful in documented attempts to obtain licensure will be released to their Service for management according to Service-specific regulations.

e. Dentists, new dental accessions, health professions scholarship program graduates, and advanced general dentistry (AGD) 12-month residents must hold a current, active, valid, and unrestricted license to practice dentistry in a State or U.S. jurisdiction except as noted below.

(1) Recent dental graduates (up to 90 days after graduation) and AGD 12-month selectees must show proof of having passed both Part 1 and Part 2 of the National Board Dental Examination and of having taken a licensure examination in a State or U.S. jurisdiction prior to reporting for AD. Recent graduates must obtain a license within 1 year of graduation from dental school.

(2) Dental officers with unusual or extenuating circumstances will be released to their Service for management according to Service-specific regulations.

f. Unrestricted license specifications for the military are defined below:

(1) An individual with an unrestricted license has met all clinical, financial, professional, and administrative requirements of the issuing State; such license does not differ from the active license of the civilian counterpart. The requirement to possess a current, unrestricted license was established by law in accordance with section 1094 of Reference (~~k~~*m*), as amended.

(2) For AD members, physicians, surgeons, dentists, nurses, veterinarians, and other providers, an unrestricted license (or authorizing document) is not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

(a) The unrestricted license must allow the professional unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on his or her license.

(b) The requirement to hold an unrestricted license also applies to physicians in residency programs who are eligible for licensure as described in this section.

7. EXCEPTIONS ON THE REQUIREMENT FOR UNRESTRICTED LICENSE. Legislation does permit waiver of the requirement for providers to possess an unrestricted license in "unusual circumstances." The payment of a State's license renewal fee is not considered an "unusual circumstance" and is not subject to waiver. AD providers who require waiver will be referred to their Service for management according to Service-specific regulations.

8. CONTRACT PRIVILEGED PROVIDERS. All contract employees must maintain a current, active, valid, and unrestricted license or authorizing document as outlined above. In addition, U.S.-based non-personal services contracted providers, in all disciplines, will be licensed by the State or jurisdiction in which they are providing services.

9. INTERNATIONAL HEALTH CARE GRADUATES. Health care professionals trained in foreign countries are eligible to practice in the JOA in their respective disciplines if the appropriate requirements are met.

a. International Medical Graduates. Graduates of foreign medical schools practicing in the U.S. are required to possess both a medical license and certification by the Educational Commission for Foreign Medical Graduates (ECFMG) or Fifth Pathway.

b. International Nurse Graduates. Nurses who are graduates from jurisdictions other than the U.S. must possess a current, active, valid, and unrestricted license and certification, the Full Education Course-by-Course Report, by the Commission on Graduates of Foreign Nursing Schools. This certification validates the educational credentials of graduates of international nursing schools and verifies that these individuals are qualified to practice in the U.S.

10. FAILURE TO OBTAIN OR MAINTAIN A LICENSE, CERTIFICATION, AND/OR REGISTRATION. All health care personnel must be in full compliance with the stipulations of this ~~e~~*E*nclosure. An individual who is required to possess a current, active, valid, and unrestricted license, or other authorizing document, and fails to obtain the license or other authorizing document within the time frame specified is prohibited from practicing. In the event the license or other authorizing document is not obtained by the privileged (privileges-eligible) individual within the time frame specified, he or she must request a formal extension from CJTF. Said request will include an explanation of why the license or authorizing document was not obtained in accordance with this guidance, and will address the individual's specific plan for obtaining the license or authorizing document. Only the Commander, JTF CapMed is authorized to grant the privileged or privileges-eligible provider an extension to obtain the license or other authorizing document. Failure on the part of the individual to request an extension may result in the actions outlined elsewhere in this enclosure. If an individual fails to maintain the license or other authorizing document in good standing, or allows it to lapse for any reason, he or she will be prohibited from practicing. Health care personnel not subject to UCMJ who provide care in violation of this Manual are subject to a civil monetary penalty of not more than $5000.00 in accordance with section 1094 of Reference (~~k~~*m*). Military personnel, both officer and enlisted, who fail to maintain the proper credentials to practice in their clinical specialties will be released to their Service for management according to Service-specific regulations.

ENCLOSURE 6

COMPETENCY ASSESSMENT, DELEGATION, AND SUPERVISION OF PRACTICE

1. COMPETENCY ASSESSMENT

a. General. Competence is the ability of a staff member to apply decision-making, psychomotor, and interpersonal skills at the level of knowledge expected for his or her current duty position. Highly competent performance by members of the organization is predicated on a variety of factors to include: a carefully structured new employee orientation, ongoing education and training opportunities, and formalized evaluation processes. In this Manual, the word, "staff" refers to all inpatient MTF or JPC employees, those with patient care, administrative, or other support services responsibilities within the organization (for example, housekeeping, maintenance, supply, and so forth) including both military (AD/Reservist/National Guard) and civilian, contracted, and volunteer personnel. The term "health care personnel" includes all categories of individuals involved in the provision of health care and services (for example, laboratory technicians, nurses, physicians, respiratory therapists).

(1) Competency assessment is required of all members of the staff and is demonstrated by one's performance in a designated setting. Performance must meet established standards that are determined, in part, by the work setting and the employee's designated role in that setting. Thus, the leaders of an organization must have clearly defined the qualifications and competencies that staff must possess to accomplish the organization's mission.

(2) Each inpatient MTF or the JPC will have in place a mechanism to collect and analyze individual and group aggregate data, from a variety of sources, to assess the competence of staff and to identify training needs.

b. Responsibilities

(1) Organizational. Immediate supervisors (officer, enlisted, civilian) are responsible for assessing, maintaining, and improving staff competency through an ongoing series of activities. The organization will:

(a) Ensure all newly assigned/employed staff receives an orientation to organization and job-specific policies, procedures, and responsibilities. This orientation is accomplished within 45 days of arrival (military)/employment start date (civilian). If military deployment or other select mission requirements necessitate extension of this time frame, an annotation to this effect will be made in the individual's Joint Training File.

(b) Identify the competencies, to include age-specific knowledge or skills (for health care personnel), that staff must demonstrate to perform in their assigned duty positions. The ANA Standards of Nursing Practice and recognized national nursing specialty organization practice standards provide the professional framework upon which nursing competency

assessment is based. Likewise, for other healthcare disciplines, professional specialty-endorsed practice standards will apply.

(c) Conduct initial and periodic competency assessment of staff and document these results. Aggregate data from these assessments should be used to identify competency needs, patterns, and trends for a given unit or the organization. Specific training plans and activities at the unit, department, or organizational level will address the staff's identified learning needs.

(d) Inform staff of the expectations and objective criteria used to evaluate individual performance and any specific actions required to improve or enhance job performance. This includes reviewing job descriptions and performance standards.

(e) Design and implement various educational and training programs and an improvement plan, as needed, to enable staff to successfully meet the competency and performance standards established by the organization.

(f) Monitor and evaluate, at least annually, the formal educational and training programs in place and the response of staff members to these programs. The evaluation performed will assess the overall value of the organization's programs and the degree to which staff competence has been achieved and maintained relative to these programs.

(2) Individual health care personnel. Health care personnel, both privileged and non-privileged, must maintain the requisite competencies associated with the job position to which they are assigned within the organization. For licensed, certified, or registered health care personnel, failure to maintain current competency may result in formal evaluation of one's performance through the peer review process. This may include a standard of care (SOC) determination and, if applicable, recommendation to the commander for adverse action against one's privileges/scope of practice or for appropriate disciplinary action. Health care personnel will:

(a) Complete department and unit competency-based assessment and orientation, as appropriate, prior to independently performing duties required of the position.

(b) Perform those duties based on individual licensure/certification/registration for which they are competent and those for which competency has been validated or privileges have been awarded, as determined by organizational/unit policy or requirements.

(c) Request and participate in various training and educational programs as needed to enhance performance skills.

(d) Notify the appropriate supervisor of assigned duties they are not competent to perform.

c. Orientation. All staff is required to orient to and be proficient in the performance of the duties, responsibilities, expectations, and components of their job position. Throughout their employment with the organization, staff members will receive information and training on

confidentiality, new equipment, new procedures or processes, new or revised policies, and new performance expectations (that is, age-specific, population-related skills, as appropriate). This training is in addition to that for which an annual update is currently required, for example, fire and safety, infection control, basic life support (BLS), and so forth.

d. Education and Training Activities. In-~~s~~*S*ervice education, as well as formal continuing health professional education and training activities, will be made available to assist all staff in acquiring, maintaining, and improving job-related competence.

e. Emergency Life Support Training

(1) All health care personnel (civilian or military) assigned, or subject to reassignment, to duties involving the provision of patient care will possess and maintain BLS certificate of training. Deployment or other extended absence does not exempt the military member from this requirement. Others, such as part-time civilian consultants, faculty members, and so forth, may be excluded from this requirement on a case-by-case basis at the discretion of the inpatient MTF Commander or the JPC Director. Said exceptions will be documented.

(2) As a minimum, the anesthesiologists and certified registered nurse anesthetists (CRNAs) assigned to the anesthesia department/service will possess and maintain advanced cardiac life support (ACLS) certification. The physicians, PAs, nurse practitioners (NPs), and RNs assigned to the emergency department/service will possess and maintain advanced emergency life support training (for example, ACLS, advanced trauma life support (ATLS), and pediatric advanced life support (PALS)/advanced pediatric life support (APLS)). Other health care personnel (medical/dental) requiring ACLS, ATLS, or other advanced life support training, are at the discretion of the inpatient MTF Commander or the JPC Director. ATLS certification may be required if the hospital acts as a trauma receiving center. APLS certification may be required if the hospital serves a large pediatric population. ACLS or other advanced life support training is not a substitute for BLS training. The demonstrated mastery of life support skills is essential. Online BLS, ACLS, PALS, or ATLS courses do not satisfy the requirement for this training. Emergency life support training sponsored or endorsed by the American Heart Association is the only training recognized as acceptable.

f. Performance Evaluation. Each staff member's performance is evaluated according to Service-specific and OPM (civil services) regulatory guidance, both periodically (for example, quarterly counseling or as needed) and at regularly scheduled intervals. Performance evaluation is usually conducted by the person who directly supervises the individual's day-to-day work performance. These evaluations are analyzed by the supervisor for patterns or trends related to specific performance issues for which additional training, education, or more formal corrective action may be required. Both individual and aggregate employee data should be considered when determining how best to improve and sustain the skills of assigned personnel. In selected circumstances, written tests may be appropriate to determine the employee's competency and ability to fulfill specific job-related responsibilities (for example, dosage calculations related to potentially high-risk medications).

g. Competency Factors. The skills and abilities that are essential to every staff member's successful job performance fall into three distinct categories: cognitive, psychomotor, and interpersonal. These factors directly correlate to performance standards and are the basis for employee competency assessment and evaluation.

(1) Cognitive or critical thinking skills. Identifying subjective and objective data that are relevant to one's clinical practice and assessing their significance to determine what action, if any, is warranted.

(2) Psychomotor or knowledge-based physical task skills. Performing selected patient care or support functions that require manual dexterity/ability and an understanding of what series of steps are required and in what specific order.

(3) Interpersonal skills. Various interactions that take place when meeting, establishing rapport, interviewing, and providing care or service to patients, family members, and visitors, as well as working with other staff. Such interactions occur in any and all settings both within the organization and outside the organization and reflect the individual's ability to function effectively within an assigned team or work group.

h. Competency Documentation

(1) Non-privileged health care personnel. A Joint Training File will be maintained by the first line supervisor for all non-privileged health care personnel working within JTF CapMed. (In the context of this ~~e~~*E*nclosure, the terms "Joint Training File" and "credentials file" are interchangeable.) The Joint Training File will be readily available to the employee for updates, but protected from general view or public access. For non-privileged Reservist/National Guard personnel routinely scheduled to deliver patient care in an inpatient MTF or the JPC, a Joint Training File will be maintained at the inpatient MTF or JPC, as appropriate. The credentials file maintained by Service Reserve Unit contains the documents typically included in the Joint Training File.

(a) The Joint Training File is the repository for a variety of relevant professionally oriented data and information that are accumulated throughout the individual's tenure with the organization. The Joint Training File should contain information that relates to or may influence clinical performance; it is not a personnel or counseling folder. Counseling/disciplinary records, performance appraisals, and similar documents will not be retained in the Joint Training File.

(b) The Joint Training File is a chronological record that is utilized throughout the individual's employment, contract, assignment, or agreement with the member's branch of service during deployment, any temporary duty in support of health care/service mission, and permanent change of station (PCS)/transfer. It will be hand-carried by the non-privileged professional (military/civilian) from one place of duty to the next. The Joint Training File should accompany members during all assigned periods of duty in inpatient MTFs or the JPC. Upon separation from Federal employment, the contents of the Joint Training File will be turned over to the individual in question or destroyed.

(c) Photocopying of the nursing diploma and nursing license, certification, or registration is permissible and should be maintained within the PCF/provider activity file (PAF) by the Credentials office. These copies will be protected and secured as specified for PCF/PAF contents. Neither the original nor a copy of the individual's license (other authorizing document) will be maintained in the Joint Training File. Instead, an annotation to indicate that the document was verified with the primary source will be made in the Joint Training File or other location as specified in local policy. This annotation will include: date, method of verification, the POC contacted, and the name of the individual doing the verification. To prevent identity theft, Social Security numbers (SSNs), home addresses or other personal identifying information - other than the employee's name - will not be recorded in the Joint Training File.

(d) The non-privileged professional has a right to review, make comment on, and receive copies of all materials in his or her Joint Training File. He or she is responsible for ensuring that all information in the Joint Training File is current.

(e) Adverse information will be maintained according to local policy (that is, in a unit-level personnel file maintained by the first-line supervisor) and not in the Joint Training File. The individual in question will be provided a copy of any material of an adverse nature (that which reflects negatively on the professional's conduct, condition, clinical competence, or clinical performance) and offered the opportunity to comment or reclama before it is placed in his or her personnel file (not Joint Training File). Statements by the individual in response to this adverse information will also be included. Unprofessional conduct or performance that may be grounds to suspend, revoke, or restrict a staff member's license, certification, and/or registration will require a formal peer review as defined in Enclosure 7.

(f) Removal of any adverse information contained in the unit-level personnel file will be accomplished only if authorized by the commander (or designee).

(g) Documents that reflect the individual's employment history, education, and assessment of competence will be maintained in the Joint Training File for a minimum of 3 years and may be purged according to local policy. For Reservist/National Guard members, the contents of the Joint Training File that reflect past practice/competency assessment will be maintained for 5 years. The specific forms to be included in the Joint Training File, in keeping with the general guidance in Enclosure 18, will be at the discretion of the local command.

(h) Local policy will address security of the Joint Training File and identify responsibilities for updating its contents. For Reservist/ National Guard members, the Joint Training File will be available during all inactive duty training, active duty for training, and AT periods. Additions and modifications to the Reservist/National Guard Joint Training File contents are a joint responsibility of both the Reserve unit and the inpatient MTF or the JPC.

(i) See Enclosure 18 for additional information regarding the recommended structure and contents of the employee Joint Training File.

(2) Privileged health care providers. Initial competency assessment is based on documented academic education, letters of reference and/or supervised practice, and

standardized credentials data contained either in the PCF or the PAF. This same information serves as the basis for initial medical staff appointment and clinical practice privileges. The biennial renewal process, as described in Enclosure 10, integrates findings from a variety of performance-based determinants and substantiates privileged provider competency.

(3) Unlicensed enlisted providers

(a) Unlicensed enlisted providers differ from Unlicensed Assistive Personnel (UAPs). Unlicensed enlisted provides responsibility for the health care of unit members in operational situations worldwide where there may be demands that compassion, comfort, and care be provided to the utmost of a person's ability even though the situation may well require skills far beyond those of an UAP. In order to maintain and improve the operational readiness of this medical resource, the unlicensed enlisted provider is authorized to perform specific clinical tasks, procedures, and interventions, as approved by the inpatient MTF Commander or JPC Director, under the direct supervision of a privileged provider.

(b) Some unlicensed enlisted providers perform military-unique function requiring extensive education and training in advanced and/or life-sustaining skills. These individuals provide health care and support to operational units in remote or isolated environments in the absence of a medical officer. These include the Air Force Critical Care Technician (CCT) (4N0XX SEI487), Aerospace Medical Service Independent Duty Medical Technician (IDMT) (4N0X1C), the Army Special Forces Medical Sergeant (18D), and the Navy Independent Duty Corpsman (IDC) (HN-8402, -8403, -8425, -8494).

1. The unlicensed enlisted provider assigned to an inpatient MTF or the JPC for sustainment training will participate in a structured training program with integrated components of direct, hands-on patient care sufficient to ensure competency in the advanced scope of practice as addressed in Enclosure 19. It is expected that the unlicensed enlisted provider, in consultation with the supervising privileged provider, will participate in the delivery of routine health care, perform patient assessments, provide initial stabilization of acute illnesses and injuries, and manage a variety of health care needs to include complex and/or chronic conditions, according to the individual's academic preparation and prior clinical experience.

2. The specific guidelines and parameters related to unlicensed enlisted providers' medical proficiency training will be based on the inpatient MTF's or JPC's scope of services and the availability of appropriate supervisory support. At the conclusion of the sustainment training, a performance evaluation will be conducted to evaluate the unlicensed enlisted provider's competence and to determine if the identified training objectives were achieved.

2. DELEGATION

a. Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity that is within his or her own scope of

practice to be performed by UAPs, unlicensed enlisted providers, RNs/ LPNs, or other non-nursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual. In structured training situations, a provider may delegate a privileged task, function, or process to a competent non-privileged professional (for example, a medical student). The privileged provider is responsible and accountable for the task, function, or process that has been delegated, and for the patient outcomes. A specific, written plan for supervision of the non-privileged individual, as determined by the assessed level of his or her competence, is required.

b. UAPs, military, civilian or contractor, may be considered and utilized to perform delegated tasks in the delivery of patient care if the individual is competent to perform those tasks. The unlicensed enlisted provider is authorized to perform an extensive variety of clinical tasks in order to sustain and improve wartime readiness. Enclosure 19 provides an overview (not all-inclusive) of unlicensed enlisted providers' advanced scope of practice and outlines the types of clinical experiences that are critical to his or her medical skills proficiency. The specific guidelines and parameters related to unlicensed enlisted providers' medical skills sustainment training will be based on the inpatient MTF's or JPC's scope of services and the availability of appropriate supervisory support.

c. Professional judgment on the part of the privileged provider or the licensed, certified, and/or registered individual is required to determine which patient care activities are appropriate to delegate. The determination must take into consideration the safety/protection of the patient, any patient-unique needs, the level of care required by the patient, the education and training of the individual to whom the task is delegated, and the extent of supervision required. Any intervention that requires independent, specialized professional knowledge or skill and/or requires assessment, evaluation, and clinical judgment will not be delegated. Activities appropriate for delegation are those which meet all of the following criteria:

(1) Frequently or routinely re-occur in the daily care of a patient or group of patients (that is, vital signs, intake and output, select exercises/activity routines, preparation for or conducting certain diagnostic procedures or tests, and so forth).

(2) Do not require the individual to exercise independent judgment.

(3) Do not require complex and/or multi-dimensional application of the clinical or nursing process.

(4) Have predictable results and minimal potential risk to the patient.

(5) Use an established and unchanging procedure (that is, protocol, CPG, or standing operating procedure).

d. Selected invasive and high-risk tasks/procedures may be performed by UAPs and others who have received documented, formal training; such training may include a certification process. Local policy will direct which high-risk tasks/procedures may be delegated and to

whom and what level of supervision is required. The privileged provider/ professional who is responsible for direct/indirect supervision of the UAP, unlicensed enlisted provider, or other individual performing a given task/procedure is also responsible for the immediate post-procedure evaluation and disposition of the patient.

e. It is the responsibility of local leadership to ensure, for all health care personnel to whom patient care tasks/procedures have been delegated, that individual competency is assessed; competency-based orientation is provided; and utilization of personnel is based upon demonstrated knowledge, skills, and technical proficiency.

3. SUPERVISION OF PRACTICE. To ensure the competence and skill of those providing health care and services to every category of DoD beneficiaries, all health care personnel are provided supervision of their clinical performance, as appropriate. This requirement, based on a concern for public protection and PS, is predicated on public law and reinforced by various State authorizing agencies. In addition, the supervision of clinical practice is fundamental to both the inpatient MTF's or JPC's provider privileging and individual performance evaluation processes, and it is scrutinized by the external bodies/organizations that accredit or certify institutional performance.

a. Activities. Supervisory activities are performed in the context of the relationship that exists between supervisor (senior staff member) and employee (subordinate staff member). The assessment and ongoing validation of the employee's ability to perform various privileged tasks or patient care activities, as applicable, substantiates the competency of both privileged and non-privileged health care personnel.

b. Types of Supervision

(1) The performance of all health care personnel is supervised, indirectly or directly, and evaluated according to established JTF CapMed and OPM guidance. Specific requirements related to individuals requiring direct supervision will be locally determined based on the unique circumstances necessitating this level of supervision.

(a) Indirect. The supervisor performs retrospective review of selected records and/or observes the results of the care provided. Criteria used for this review relate to quality of care, quality of documentation, and the staff member's authorized scope of practice.

(b) Direct. During the delivery of health care and services, the supervisor is involved in the decision-making process. This may be further subdivided:

1. Verbal. The supervisor is contacted by telephone or by informal consultation before the supervised individual implements or changes a regimen or plan of care.

2. Physically present. The supervisor is physically present through all or a portion of care. "Physically present" will be locally defined and determined on a case-by-case

basis given the unique needs of the individual being supervised. This will be addressed in his or her personalized plan of supervision.

(2) In select circumstances (that is, for professionals not yet licensed, for novices or those returning to patient care responsibilities who must develop/refine skill and competence, or for those staff whose performance is less than acceptable), supervision is a formal requirement. The type of supervision that is warranted will be clearly identified and the plan for supervision articulated in writing.

(a) Inpatient MTFs or JPC with graduate professional health education (GPHE) programs will have a mechanism(s) in place and approved by the medical staff for supervision of program participants in the performance of their patient care responsibilities. Supervision will be rendered by an appropriately privileged provider, ideally in the same discipline that is familiar with the role, responsibilities, and patient care activities of the GPHE program participant. This requirement applies to members of all disciplines who are not yet licensed/privileged, but are involved in the provision of patient care. In the context of this Manual, GPHE applies to graduate level clinical training for all health-related disciplines.

(b) Individuals without clinical privileges must function within the written guidance of a job description specific to the level of care being provided. Job descriptions may be based on the role and need not be trainee-specific. (See Glossary for detailed definitions of supervised privileges for providers and enhanced supervision.)

c. Plan of Supervision. The intent of providing appropriate oversight of practice, in the context of this Manual, is to evaluate and enhance performance of health care personnel in delivering patient care services. Given that objective, a planned and organized approach to supervision is appropriate. The written plan of supervision, maintained in the PAF (privilege-eligible provider) or Joint Training File (non-privileged professional), as appropriate, will include:

(1) The type of supervision to be provided. The type of supervision will be based upon the assessed needs of individually privileged providers/non-privileged personnel.

(2) The name of the supervisor. The commander will appoint — in writing — a primary and alternate supervisor. This individual (same or similar discipline) will possess the professional experience and competence to provide appropriate oversight of the supervised provider's/professional's practice. The supervisor will ensure that care and/or services provided are consistent with the authorized scope of practice or privileges and all approved policies, procedures, and practice guidelines, as applicable.

(3) Performance evaluations. The specific intervals at which performance evaluations will be conducted during the period of supervision will be noted.

(a) Privileged providers. Supervisors of privileged providers will complete periodic clinical performance evaluations based on the individual's experience and competency. These are filed initially in the PAF and transferred to the PCF at the time of clinical privileges renewal,

PCS, or release from service/employment. A variety of parameters allow for review of the appropriateness of care and the privileged provider's current competence. Organizations must consider, and integrate into the plan for supervision and the evaluation of privileged provider performance, current TRICARE and other managed care performance assessment variables/outcomes. These address such factors as diagnostic techniques and procedures and associated costs, therapeutic practice patterns and outcomes of care.

(b) Non-privileged personnel. Supervisors of non-privileged health care personnel will complete periodic clinical performance evaluations, as specified in the plan of supervision, (narrative format or other locally devised format) that address the individual's demonstrated abilities and competency to perform the duties, responsibilities, expectations, and components of his or her job position. The individual's improvement or lack of improvement related to his or her documented performance limitations/inadequacies will be assessed and addressed in each written evaluation.

d. Unlicensed Health Care Personnel

(1) Both privileged providers and non-privileged professionals who require an authorizing document for practice and who are not licensed, certified, and/or registered (for example, enlisted providers, students in health professions' training, graduates awaiting licensure examination results) will practice only under the supervision of a properly licensed, certified, and/or registered (and privileged, if required) professional of the same or similar discipline. Foreign military health care personnel or others involved in official exchange student capacity are included in this category.

(2) The level of supervision will be more comprehensive than that provided a licensed individual of the same discipline. At pre-determined intervals, as stipulated in local policy, the professional's performance, competence, and capabilities in his or her assigned military or civilian position will be assessed and documented.

(3) Traditionally, the Services recognize the competencies of individual enlisted medical personnel, but have not actively coordinated cross-Service utilization of baseline skill sets. The individual's scope of practice in inpatient MTFs or JPC is granted to a health care provider based on credentials, clinical competence, and the mission and requirements of the inpatient MTF or JPC. Enlisted providers include, but are not limited to:

(a) USA Special Forces Medical Sergeants (18D) (see Enclosure 19)

(b) USAF Critical Care Technicians 4N0XXSEI 487 (see Enclosure 19)

(c) USAF Independent Duty Medical Technician 4N0X1C (see Enclosure 19)

(d) USN Independent Duty Corpsmen (see Enclosure 19)

(4) Enlisted Providers:

(a) Will be granted password access to electronic record keeping systems only upon review and certification of required training, professional certifications, national provider identifier number, and assignment of privileged physician supervisor.

(b) Deliver patient care for AD personnel under indirect supervision, allowing for the evaluation, diagnosis, and treatment of patients without being approved by a medical officer.

(c) Work within limits of specially developed formularies.

(d) Serve only AD members within their scope of practice without direct supervision.

(e) May provide care to other beneficiaries under direct supervision of a physician supervisor, and only with the beneficiary's consent (or in the case of a minor with the sponsor's consent).

(f) Will be subject to review within the MTF or, as appropriate, the JPC health care QA program.

(g) Will be supervised by a physician supervisor to assure compliance with Service-specific oversight, program management, and monitoring of healthcare delivery.

(h) Will be subject to a quarterly review of a minimum of 30 health records to assess clinical performance; enlisted providers who have 30 or less patient contacts per quarter will have 100 percent of their records retrospectively as part of the QA program. Where direct supervision is required all notes will be co-signed. Notes of enlisted providers under indirect supervision do not require co-signature.

(i) Will be supervised by facility training officials and are subject to and required to abide by all facility rules and applicable regulations, except where compliance world be inconsistent with Federal statute, regulation, or any other law binding members of the Services.

(j) Will be precepted by a privileged provider who co-signs all notes.

(k) Will work with physician supervisors and nurses who are knowledgeable of the competencies of enlisted providers.

e. Privileged Providers

(1) Privileged providers are responsible to their discipline-specific department chief or supervisor for the ongoing assessment of the quality of care they provide within their discipline-specific scope of practice and defined privileges. The discipline-specific chief/supervisor will:

(a) Review and recommend approval of the application for privileges and the PCF prior to submission to the credentials committee/function.

(b) Monitor and evaluate the discipline-specific scope of practice.

(c) Conduct routine peer review of individual practice according to local policy.

(2) Physician supervision of members of another discipline (for example, OTs, PTs, nurses, pharmacists) is not required for functions performed that are within the scope of practice authorized by the individual's license, registration, certification, or privileges.

f. Other Considerations Related to Supervision and Evaluation of Health Care Personnel

(1) Service-specific policy and/or State licensing laws require physician supervision of PAs privileged to provide patient care and services. Said physician supervisor (and an alternate) will be named in writing by the inpatient MTF Commander or, as appropriate, the JPC Director.

(2) Significant variation exists among States relative to physician supervision of nonphysician providers. Likewise, variation among States may exist regarding supervision and/or the scope of practice of the RN, LPN, or other licensed/ certified/registered professional. The individual nonphysician privileged provider/professional is responsible for informing his or her immediate supervisor of any specific State-directed requirements for supervision of clinical practice. Ideally, this information should be elicited from the employee during orientation and will be documented in his or her Joint Training File. The immediate supervisor will ensure appropriate coordination to facilitate organizational compliance, wherever feasible.

(3) Regardless of the oversight and/or supervisory relationship that exist, provider collaboration and collegial interchange in support of high quality patient care is the standard in all settings and circumstances.

(4) Individuals responsible for clinical oversight of privileged or non-privileged health care personnel need not be responsible for the overall performance evaluation of the officer, enlisted Service Member, or civilian employee.

(5) A copy of the privileged provider's clinical performance evaluation (not the official military performance appraisal or its civilian evaluation equivalent) will be forwarded to the inpatient MTF or, as appropriate, the JPC credentials committee/function. These documents will be maintained in Section II of the PCF and are the basis for biennial renewal or revision, as needed, of clinical privileges.

g. Supervision of Screening Personnel. Screening personnel (enlisted or civilian) assigned for duty in various clinic settings are permitted to utilize an algorithm-directed medical care (ADMC) system to screen AD Service members during daily sick call activities. Use of an algorithm-based system is mandatory when screening personnel provide evaluation, treatment, and/ or disposition of AD Military patients. Inpatient MTF Commanders who use ADMC systems will:

(1) Establish a local training program in the appropriate use of ADMC. Screeners must complete the formal training program prior to being assigned to evaluate, treat, and/or make disposition of Service members who present for care. This training will be documented in the individual's Joint Training File.

(2) Ensure that screeners are provided adequate supervision and performance evaluation by a physician, PA, or other qualified provider specifically assigned this responsibility. Documentation of the care provided by ADMC screeners will be reviewed on a daily basis. Screener evaluation will be documented in the individual's Joint Training File.

(3) Ensure that the screener's scope of practice with regard to evaluating, treating, and/or determining the disposition of AD sick call patients is delineated in writing and that it is reviewed and revised at least annually.

(4) Approve the list of self-care medications, as recommended by the pharmacy and therapeutics (Pharmacy and Therapeutics) committee in accordance with Army Regulation 40-3 (Reference (~~m~~*o*)), to be dispensed by screeners. Screeners may be approved to dispense the over-the-counter medications addressed in the screening Manual. Additions requested for use at the local level are authorized only if formal, documented training related to the safe and appropriate use of these medications has occurred.

(5) Require monthly visits by the appropriate department/service chief to all clinics utilizing ADMC to ensure compliance with the above requirements. This oversight responsibility may not be delegated.

ENCLOSURE 7

FORMAL PEER REVIEW PROCESS

1. GENERAL. This *eE*nclosure presents the basic framework for a formal peer review. Peer review of day-to-day performance is integral to the PI and competency assessment processes for all licensed, certified, and/or registered health care personnel both privileged and non-privileged. This routine review typically focuses on medical records' contents and direct observation of performance. However, in the context of a possible adverse privileging/practice action, the process takes on a greater degree of formality and involves fact finding, study, and analysis of a single incident that resulted in significant harm to a patient or a series of events involving a professional's performance, conduct, or condition. It is conducted in a collegial climate and is focused on obtaining all relevant information about the situation. Prior to any adverse action related to privileges/scope of practice, peer review is required for individuals who are licensed, certified, and/or registered. Likewise, in the event that an action against an individual's license (other authorizing document) may be contemplated, a formal peer review will be conducted. Additional specifics associated with peer review and adverse privileging/practice actions are contained in Enclosure 11. Peer review in relation to an SOC determination for a medical malpractice claim is discussed in Enclosure 14.

2. PEER REVIEW FUNCTION

a. A peer is one who is from the same professional discipline/specialty as the individual undergoing review. During a peer review, selected health care personnel (that is, peers) evaluate the quality of the patient care rendered by another professional. These selected health care personnel, who are qualified by education and experience, will identify opportunities for clinical PI and, as appropriate, determine whether or not, given an adverse event or malpractice claim, recognized standards of practice were followed or the SOC was met by the individual in question. Professional qualifications; adherence to established professional standards for the discipline; the merits of any allegations of substandard skill, abilities, or performance; and recommendations for adverse privileging/practice or administrative action to be taken concerning these complaints are also considered.

b. Each inpatient MTF and the JPC will establish peer review processes that are non-adversarial. Ideally, the peer review should be conducted as soon as possible after identification of the incident, circumstance, or behavior for which a peer review is warranted. The results of the peer review shall be made known to the individual in question as soon as possible following the conclusion of the peer review activities. See Enclosure 11 for specific time frames related to notification. The department/service chief is responsible for initiating and coordinating the peer review activities for non-privileged personnel. For a privileged provider, the peer review is typically coordinated by the credentials committee. Peer review subjects are entitled to due process which includes, but is not limited to, the right to a hearing and the right to appeal the decision of the inpatient MTF or the JPC Director to the Deputy Commander, JTF CapMed.

3. COMPOSITION OF PEER REVIEW BOARD. Peer review activities may be accomplished either by an established committee/subcommittee or by an ad hoc peer review panel/committee constituted on an as-needed basis. The formal committee/subcommittee structure may perform the peer review function for all categories of personnel, or for only privileged staff; the ad hoc committee may be responsible for the non-privileged personnel.

4. INTENT OF PEER REVIEW. Structured feedback from an individual's peers (that is, a performance assessment (as discussed in Enclosures 6 and 10)) may be used at any time an unbiased, external review of a staff member's day-to-day performance is appropriate. This is considered an informal peer review. However, peer review as presented in this enclosure is in the context of an adverse privileging/practice action and is a formal process. A formal peer review is required whenever an SOC determination must be made, or when the staff member's performance is such that an adverse practice action (for example, limitation of duty or removal from the clinical setting) is considered. The purpose of this review is to examine information obtained from the structured, unbiased investigation/inquiry and any other relevant materials. Following the review, recommendations are presented to the commander regarding the clinical performance, competence, and liability (medical malpractice case) of the individual. The peer review mechanism is intended to:

a. Protect the rights of the individual (afford due process).

b. Identify systemic issues and refer to appropriate CQM channels for resolution.

c. Separate professional actions and considerations from administrative or legal considerations.

d. Provide timely reporting to JTF CapMed when the need is identified to report a health care privileged provider or non-privileged professional to a regulatory body.

5. CONDUCTING THE PEER REVIEW

a. When a privileged or non-privileged staff member is removed from all or a portion of his or her patient care duties, the peer review function must be initiated to determine the extent of the problem and to make recommendations for further action on the professional issues in the case (for example, retraining, supervised practice, a licensing action). The focus of the peer review is on how the action under review impacts the individual's ability to practice clinically.

b. All procedures related to peer review (notification, withdrawal of permission for off-duty employment, hearing rights, the appeal process) are the same for both privileged and non-privileged personnel. See Enclosure 11 for additional guidance associated with peer review.

6. RECOMMENDATIONS AND FOLLOWUP REPORTING

a. In all cases, the recommendations resulting from peer review and subsequent action by the commander will be forwarded to the supervisor of the staff member whose practice/conduct was the subject of the peer review proceedings. It is the responsibility of the supervisor to ensure that the recommendations from the peer review function, and actions taken by the commander, are implemented.

b. The peer review function may recommend reporting the staff member to a licensing/regulatory agency. Local policy will establish who is responsible for preparation of the DoD (DD) Form 2499, "Health Care Practitioner Action Report." The inpatient MTF Commander or JPC Director will forward this document to Commander JTF CapMed. The recommendations of the peer review panel, and all other information related to the case, will accompany the DD 2499 when reporting of a privileged provider or non-privileged professional to a licensing or other regulatory body is required.

ENCLOSURE 8

PRIVILEGED HEATH CARE PROVIDERS

1. GENERAL

a. This Enclosure includes general information and specific professional requirements related to each category of privileged provider (military or civilian) listed below. The information presented is intended to be a broad overview, rather than all-inclusive, and will change over time as health care requirements evolve. The privileged practitioners at the inpatient MTF or JPC constitute the medical staff. A medical staff appointment may not be granted in the absence of the granting of clinical privileges. The privileged providers addressed include, but are not limited to:

(1) Advanced Practice Registered Nurse (APRN)

(a) Certified nurse midwife (CNM)

(b) Certified Registered Nurse Anesthetist (CRNA)

(c) Clinical nurse specialist (CNS)

(d) NP to include family, adult, pediatric, women's health care, acute care, geriatric, emergency, and so forth

(2) Audiologist

(3) Behavioral health practitioner

(4) Chiropractor

(5) Clinical pharmacist

(6) Clinical psychologist

(7) Clinical social worker

(8) Dentist

(9) Dietitian

(10) Dispensing Pharmacists

(11) Occupational Therapist (OT)

(12) Optometrist

(13) Physician

(14) PA and specialty physician assistant

(15) Physical Therapist (PT)

(16) Podiatrist

(17) Psychological associate

(18) Speech pathologist

(19) Substance abuse counselor

b. Clinical privileges, which define the individual's scope of practice in a specific institution, are granted to health care providers based on their credentials, clinical competence, and the mission and requirements of the organization.

(1) The privileged provider is authorized to make independent decisions related to beneficiary health care management based on his or her recognized scope of practice. He or she may supervise, coordinate, and direct, as appropriate, the care provided by other members of the health care team. A representative scope of practice, by discipline, is provided in the pages that follow. Changes to the scope of practice for any of the privileged providers presented in this enclosure are at the discretion of the Privileging Authority.

(2) The specific and individual privileges granted to each provider are delineated within CCQAS and should be contained in his or her PCF. ~~Army "Modified Privileged Lists"~~ *The Master Privilege List* within CCQAS will be used. The individual's category of privileges, appointment status, and authority to admit patients are reflected in CCQAS documentation.

2. CLINICAL PRACTICE

a. Decision Making. Clinical care decisions and specific therapeutic interventions on the part of the provider are based, in part, on CPGs; nationally recognized standards of care/practice; current professional clinical references; and other relevant regimens, guidelines, or policies, as appropriate. These serve as a framework for practice and are the basis for the specific clinical privileges requested by the individual provider and for periodic performance review and evaluation activities. CPGs may be superseded in situations where evidence-based medicine or current practice standards dictate deviation from these guidelines.

b. Collaboration. For privileged providers other than physicians and dentists, a designated physician will always be available for consultation and collaboration in person, telephonically, or by any other means that allows person-to-person exchange of information. Collaboration reflects

both independent and cooperative decision making based on the professional preparation and ability of each provider. Collaborative practice implies an open exchange of patient data and information and includes such activities as consultation, referral, coordination, and co-management of patient care.

c. Pharmaceuticals. Privileged providers are authorized to prescribe pharmaceuticals contained in the inpatient MTF formulary according to the guidance established by the local Pharmacy and Therapeutics committee. For providers other than physicians and dentists, the drugs approved for prescription writing will be based on the provider's scope of practice and the beneficiary group(s) served. An open formulary is not authorized. Facility-specific exceptions, either by category of drug or itemized by name of drug, will be noted in writing.

d. Procedures and Diagnostic Testing. Privileged providers are authorized to perform those procedures for which they have been appropriately trained, are properly qualified, and are privileged.

e. Continuing Education Requirements. Professional competency is maintained, in part, by the ongoing accumulation of advanced knowledge in one's practice discipline. For all privileged providers, the annual requirement for continuing professional education and development is according to Service-specific guidance or as determined by the provider's State of licensure, whichever is more stringent.

f. Readiness Training. This is of paramount importance to prepare AD-privileged providers for mobilization in support of the military's global mission and is according to Service-specific guidance.

3. CLINICAL PERFORMANCE REVIEW

a. Ongoing professional competency assessment and periodic formal evaluation of performance, to include both quantitative and qualitative data, are required for all privileged providers. This is accomplished at least biennially as part of the privilege reappraisal/privilege renewal processes and is documented in CCQAS. An example of professional competency assessment is the periodic peer review, in the context of PI, of a representative sample of medical records. Competency assessment also includes analyses by one's peers and supervisor of specific outcomes-related data, RM data, and patient letters of appreciation or complaints, as well as direct observation of performance and verbal/written assessment of clinical knowledge/skills. Other performance review criteria, as recommended by accrediting agencies, as approved by the OSD(HA, may also apply. Performance-based peer review will be according to inpatient MTF or, as appropriate, JPC policy. Performance review in this context applies to providers with current clinical privileges, and other professionals, who are actively engaged in the provision of patient care and services.

b. Additional requirements for enhanced supervision of the licensed novice, entry-level provider, or the experienced provider who has returned to clinical practice after a lapse in patient

care duties must be individually determined. This supervision will be provided by a designated individual of the same discipline or by a medical officer with more recent clinical experience.

4. APRN

a. Description

(1) The APRN, as a result of master's or doctoral level education and in-depth clinical experience, possesses the advanced knowledge and clinical competency to provide health care in a defined area of specialization. The APRN demonstrates expertise in the assessment, diagnosis, and treatment of actual or potential health problems; the prevention of illness and injury; maintenance of wellness; and the provision of comfort to individuals, families, or communities. The APRN group includes:

(a) Certified Nurse Midwives

(b) Certified Registered Nurse Anesthetists

(c) Clinical Nurse Specialists

(d) NPs. This includes family, adult, pediatric, women's health care, and others.

(2) Community Health Nurses (CHNs) function in an expanded role using CPGs approved by the ECOMS and the DCN. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he or she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the Privileging Authority.

b. Professional Credentials

(1) Education. APRNs who complete their respective specialty programs after December 31, 2001 must be graduates of an accredited master's level or doctoral program acceptable to the Service that prepares RNs with additional knowledge and skills to practice in their clinical specialty.

(2) Licensure. APRNs will maintain a current, active, valid, unrestricted RN license in at least one U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Certification. Within 12 months of graduation, the APRN will achieve certification by a nationally recognized certifying body appropriate to the specialty area of practice. Certification will be maintained for the duration of the individual's advanced clinical practice.

(4) Residency. New graduate APRNs, and those returning to clinical practice after a lapse, may be in an intern status with enhanced supervision for a period of time based upon their governing organization. Those APRNs who are returning to clinical practice after a lapse will follow the guidelines for FPPE outlined in paragraph 10-4(e) in this Manual. The supervision associated with the period of residency is not considered an adverse status.

c. Scope of Practice

(1) The APRN is a licensed and privileged practitioner and, as such, co-signature by a physician or other privileged provider of APRN entries in the patient's medical record, prescriptions, and so forth, is not required.

(2) As designated by his or her delineated privileges or scope of practice, demonstrated competence, and experience, the APRN (independently and collaboratively with other health care professionals) performs a wide variety of tasks or duties based on organizational requirements and according to local policy. The APRN may, among other tasks, perform medical examinations and document findings; screen health records for individuals participating in overseas deployments or other military duties; assist in weekly inspections of confinement facilities; examine and treat prisoners in confinement; recommend temporary limited-duty profiles for AD members to include those on flight status in accordance with Service-specific guidance; place patients under his or her care on quarters status in accordance Service-specific guidance, and perform other duties, as authorized by the commander.

(3) The APRN may authenticate temporary limited-duty profiles for pregnancy and other conditions according to Service-specific guidance.

d. Certified Nurse Midwife

(1) Description. CNMs are RNs with advanced, specialized training in midwifery. Nurse-midwifery practice is the independent management of women's health care, focusing particularly on pregnancy, childbirth, postpartum, and newborn care, as well as the family planning, well-woman care, and the gynecological needs of women. The CNM practices within a health care system that provides consultation, collaborative management, or referral as indicated by the health status of the beneficiary.

(2) Additional professional credentials. CNMs will demonstrate continued competency through active participation in the Continuing Competency Assessment Program of the American College of Nurse-Midwives. All CNMs will achieve and maintain current Continuing Competency Assessment Program certification.

(3) Scope of practice. The CNM:

(a) Provides routine prenatal care, labor and delivery management, immediate newborn care, and postpartum care. In addition, they provide well-woman gynecological services including yearly physical exams, breast exams, pap smears, family planning services, preventive health screening, and health education. With the appropriate training and experience, the CNM

may also be privileged to perform such procedures as colposcopy, ultrasound, and birth control implant insertions/removals and to provide primary care services to adult female beneficiaries.

(b) Practices according to the Standards for the Practice of Nurse-Midwifery, as defined by the American College of Nurse-Midwives, the ANA Standards of Clinical Nursing Practice for Nurse Midwifery, and local nurse midwifery service guidelines. The inpatient MTF-or, as appropriate, JPC-specific guidelines, define conditions for which referral or collaborative care (co-management) is appropriate.

(c) May provide obstetrical care within his or her scope of practice and expertise using physician consultation and/or co-management to provide comprehensive care for other than low-risk patients according to inpatient MTF guidelines. The CNM may perform outpatient care and be privileged to admit and discharge patients when an obstetrician is on call and are available by telephone to provide medical consultation, collaborative management, and/or referral when indicated.

e. Certified Registered Nurse Anesthetist (CRNA)

(1) Description. CRNAs are RNs with advanced, specialized training in the administration of anesthesia. Nurse anesthesia practice includes the independent administration and management of patient anesthesia to include preoperative evaluation and preparation, perioperative management, and postoperative follow-up and evaluation. The CRNA may provide consultation, collaborative management, or referral to other health care providers as indicated by the health status of the patient.

(2) Additional professional credentials. CRNAs will maintain current certification by the Council on Certification of Nurse Anesthetists.

(3) Scope of practice. The CRNAs will be responsible and privileged for the entire anesthetic process. The CRNA will

(a) Perform and document a pre-anesthetic assessment and evaluation of the patient to include requesting consultations and diagnostic studies.

(b) Establish an anesthesia plan and, based on the pre-anesthetic assessment, determine that the patient is an appropriate candidate to undergo the planned anesthetic.

(c) Obtain informed consent for anesthetic services.

(d) Select, prescribe, or administer medications and treatment modalities related to the peri-anesthetic care of patients.

(e) Conduct the pre-induction assessment to determine the patient's readiness to enter the surgical environment immediately prior to administering the selected anesthetic.

(f) Select, obtain, and administer anesthetics, adjunct drugs, accessory drugs, and

fluids necessary to manage the patient in the peri-anesthetic period, to maintain the patient's physiologic homeostasis, and to correct responses to the anesthesia or surgery consistent with the spectrum of anesthesia privileges.

(g) Ensure that the patient's postoperative status is assessed on admission to and discharge from (or bypass of) the post-anesthesia recovery area.

(h) Release or discharge patients from the post-anesthesia recovery area.

(i) Order and initiate perioperative pain relief therapy.

(4) Collaboration and anesthesia-related decisions

(a) CRNAs routinely provide independent anesthesia care for American Society of Anesthesiologists (ASA) physical status classification 1 and 2 patients. They are responsible and accountable for determining when a physician (anesthesiologist, if available) will be consulted for the delivery of anesthesia care to ASA 1 and 2 patients. Consultation will be requested, as necessary, regardless of the patient's ASA classification.

(b) Collaboration, and subsequent implementation of the specific recommendations provided by the physician, does not relieve the CRNA of his or her overall responsibility to ensure the utmost safety of the patient. At all times, the CRNA remains accountable for his or her decisions and all professional actions associated with the anesthesia care rendered. The consulted physician is accountable for his or her anesthesia-related decisions.

(c) For patients in ASA physical status classification 3, 4, 5, or 6, CRNAs will collaborate with a physician (anesthesiologist, if available) or oral surgeon before induction of anesthesia. This collaboration may be face-to-face or by telephone.

(5) Graduate nurse anesthetists. Graduate nurse anesthetists (GNAs) are individuals who have successfully completed a nurse anesthesia program but have not achieved CRNA certification.

(a) Prior to CRNA certification, the GNA will be granted supervised clinical privileges. A CRNA or anesthesiologist will supervise the GNA.

(b) The GNA will not be assigned to unsupervised on-call duties or emergency procedures nor will he or she teach/supervise anesthesia nursing students or other anesthesia providers in training.

f. Clinical Nurse Specialists

(1) Description. CNSs are RNs who have obtained advanced, specialized education and certification to practice collaboratively as APRNs for the purpose of providing specialty care (for example, oncology, psychiatric, cardiovascular, pulmonary). CNSs participate in the care of both inpatients and outpatients and have primary responsibility for providing clinical expertise;

consultation; case management; disease management; patient/family education; and research application in primary, secondary, or tertiary health care settings.

(2) Additional professional credentials

(a) Certification. CNSs must be certified in their specialty by the American Nurses Credentialing Center or the recognized national nursing certification organization for the specialty (for example, Oncology Nursing Society, American Association for Critical Care Nursing, Emergency Nurses Association, and so forth).

(b) Other. CNSs desiring prescriptive authority must meet the criteria specified by the ANA as well as the privileging requirements as described in Enclosure 10 of this Manual. A CNS requesting prescriptive authority, or authorization to function beyond the routine CNS scope of practice, may be privileged to provide expanded services to designated beneficiaries (for example, patients requiring comprehensive pain management).

(3) Scope of practice. CNSs practice independently and collaboratively with other members of the health care team to ensure a comprehensive plan of care for the patient. They function in a variety of practice environments ranging from primary care (as disease manager) to the intensive care setting (as acute care CNSs). Health care activities of the CNS may include taking initial and interval histories; performing developmental assessments and screenings; conducting diagnostic and screening tests; teaching and counseling patients/family members regarding identified problems, health maintenance, and disease prevention; and initiating and evaluating treatment regimens that may include prescribing and dispensing medication appropriate to the privileged scope of care.

g. NP

(1) Description. NPs are RNs with advanced, specialized education and clinical competency to provide medical/health care for diverse populations in a variety of primary, acute, and long-term care settings according to their practice specialty. NPs provide nursing and medical services to individuals, families, and groups. NP specialties include, but are not limited to, acute care, adult, emergency, family, geriatric, pediatric, psychiatric, and women's health.

(2) Additional professional credentials. NPs will maintain current certification by a national certifying body (for example, American Nurses Credentialing Center; American Academy of Nurse Practitioners; National Certification Board of Pediatric Nurse Practitioners and Nurses, ANA, National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties), as appropriate, for their specialty area of practice.

(3) Scope of practice

(a) The NP practices independently and collaboratively with other health care professionals to provide primary care and to diagnose, treat, and manage the patient's preventive, acute, and chronic health problems. Services include but are not limited to ordering, conducting, and interpreting diagnostic and laboratory tests; prescribing pharmacologic agents and

nonpharmacologic therapies; and teaching and counseling individuals, families, and groups.

(b) The NP practices according to his or her specialty, the ANA Standards of Clinical Nursing Practice for Nurse Practitioners, and as determined by the organizational mission and scope of care and services. Inpatient MTF-specific guidelines and the individual's privileges define conditions for which referral or collaborative care is appropriate.

5. AUDIOLOGIST

a. Description

(1) Audiologists provide hearing health care through audiological services including prevention, medical surveillance, treatment, education, and research.

(2) Audiologists implement a Hearing Conservation Program designed to prevent noise-induced hearing loss to enhance auditory performance in operational environments for AD Service members. Audiologists prevent hearing loss through the provision and fitting of hearing protective devices, consultation on the effects of noise on hearing, management of hearing conservation programs, and presentation of educational programs. Audiologists diagnose and treat hearing deficits of authorized beneficiaries by selecting, fitting, and dispensing amplification/hearing aids and other devices; providing aural rehabilitation; and, when necessary, referring patients for medical intervention.

b. Professional Credentials

(1) Education. Audiologists must have a master's or doctoral degree in audiology from an accredited institution acceptable to the Service with which the provider is affiliated.

(2) Licensure. Audiologists must maintain a current, active, valid, and unrestricted audiology license, registration, and certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of Practice. Audiologists follow the guidelines published by the American Speech-Language-Hearing Association, American Academy of Audiology, and the National Hearing Conservation Association. Audiologists are privileged to provide comprehensive diagnostic and rehabilitative services for all areas of auditory, vestibular, and related disorders. Those with advanced training and current competence may be privileged to perform special procedures such as intraoperative monitoring of the cranial nerves, cerumen removal, cochlear implant assessments and management, posturography, and other advanced balance mechanism evaluations. Audiologists will manage hearing conservation programs. Once certified as a course director by the Council for Accreditation in Occupational Hearing Conservation, audiologists will provide certification training for personnel conducting audiometry for hearing conservation programs.

6. BEHAVIORAL HEALTH PRACTITIONER

a. Description. Behavioral health practitioners are trained in behavioral science, counseling theories, and practical applications of behavior change principles. They may manage numerous behavioral and emotional problems, in both general and particular specialty practice levels, providing a variety of behavioral health services, including screening, treatment, and consultation. The behavioral health practitioner may develop additional expertise in psychometrics, industrial psychology, substance abuse rehabilitation, geriatric care, school or health psychology, neuropsychology, pediatric or adolescent psychology, aeromedical psychology, and combat stress reactions. The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State licensure requirements as a doctoral-level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this Manual, using the title of behavioral health practitioner or psychological associate.

b. Professional Credentials. Behavioral health practitioners must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for *C*ategory I–III level of privileges include:

(1) Category I. The individual has earned a master's degree in counseling psychology, fulfilling the requirements of a 2-year academic program, including a minimum of 12 supervised practicum hours in the major specialty. The graduate program must be offered by a college/university fully accredited by a U.S. regional accrediting body. The practitioner performs specialty counseling services and works under the supervision of a psychologist, psychiatrist, or clinical social worker licensed in his or her discipline. The individual must possess either the Licensed Professional Counselor (LPC) license or a master's level psychology license, such as psychological associate license, from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(2) Category II. The individual has completed a 2-year master's degree program in counseling psychology at a fully accredited college/university, including a minimum of 12 semester hours of supervised practicum. The individual possesses the LPC/LPC-equivalent licensure, or a psychological associate (or other master's level psychology license) available in some states. He or she has a minimum of 2 years' full-time experience in the specialty in which services are performed under the supervision of a higher level privileged provider with a license in social work, psychology, or psychiatry from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Category III. The individual has completed a post-master's specialty degree from an accredited university and passed a comprehensive examination in that specialty. The individual has a LPC/LPC-equivalent license, or a license as a master's level psychologist, from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction licensing body. He or she provides a wide range of services in the designated specialty and may supervise category II or I counselors in their provision of services in the specialty. The individual will be supervised by a psychologist, psychiatrist, or a social worker who is licensed in their respective disciplines and privileged at a higher level (category). Incumbent Army Substance Abuse Program (ASAP)

counselors who are already clinically licensed but do not possess the educational qualifications as noted above are permitted to continue in their present positions (current grade and GS-series). However, they are not eligible for lateral transfer to another position or promotion to a higher grade.

c. Scope of Practice. Individuals will practice within the guidelines of their respective State licensing boards as LPCs (or equivalent) or, if offered by their State, a license for master's-level psychology graduates such as psychological associate or licensed mental health provider. Behavioral health practitioners adhere to the State LPC or psychology licensing board's code of ethics and conduct. Specific clinical privileges are granted based upon training, experience, and competency. In general, behavioral health practitioners will:

(1) Conduct screening evaluations, utilizing information from clinical interviews, nonpsychometric tests, and collateral sources, as appropriate.

(2) Determine a provisional diagnosis according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(3) Provide individual and group behavioral health treatment within the scope of practice/privileges granted.

(4) Manage the behavioral health care of patients and refer those having needs beyond their scope of practice.

(5) Serve as collaborator in human behavioral issues with, and consultant to, community agencies, health care providers, and organizational leaders.

d. Supervision

(1) Master's level graduates who have recently (within the past year) obtained a master's level license such as an LPC or psychological associate license will be fully supervised during their first year of employment as a behavioral health practitioner.

(2) LPCs or psychological associates with 2 or more years' experience (after attaining licensure), will receive general supervision, according to the individual's level of competence, as assessed by his or her supervisor.

(3) LPCs or psychological associates with more than 2 years' experience and with post-master's work leading to a specialty degree, will require supervision in their specialty with difficult, high-risk cases, or for cases in which one or more of the patient's problems fall outside the scope of the counselor's specialty.

7. CHIROPRACTOR

a. Description. Chiropractors provide treatment and care of spine-related

neuromusculoskeletal conditions to eligible beneficiaries. The chiropractor utilizes chiropractic manipulation - also called chiropractic adjustment - to restore joint and related soft tissue function. This treatment may be used with other supporting forms of treatment (physical modalities) depending on the patient's specific needs. The chiropractic approach to health care is holistic, stressing the patient's overall well-being. The natural, drugless, nonsurgical methods of chiropractic treatment rely on the body's inherent recuperative abilities to promote healing.

b. Professional Credentials

(1) Education. The individual must be a graduate of a chiropractic college accredited by the Council on Chiropractic Education or its successor organization.

(2) Licensure. A current, active, valid, and unrestricted license to practice chiropractic in a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction is required.

(3) Experience. To qualify for clinical privileges, the chiropractor must have 2 years' minimum full-time active post-graduate chiropractic experience involving the delivery of both diagnostic and treatment services.

(4) Optional credentials. Optional credentials include postgraduate credits approved or accredited by an appropriate State licensing board, recognized diplomat status, formal hospital staff privileges (or evidence of actively seeking hospital privileges) at a nationally accredited health care facility.

c. Scope of practice. At the discretion of the Privileging Authority, clinical privileges may be granted based on the individual's documented education, competence, and experience. The minimum practice privileges for which the chiropractor is authorized include

(1) Performing patient history and chiropractic physical examination, excluding vaginal examination.

(2) Ordering radiologic examinations such as spine/four views (anterior-posterior, lateral, oblique, spot) and pelvic series.

(3) Ordering standard diagnostic laboratory tests (for example, electrolytes, glucose, urinalysis, urine culture and sensitivity, complete blood count, occult blood, and erythrocyte sedimentation rate).

(4) Performing standard osseous and soft tissue procedures consistent with chiropractic care as commonly contained in the core curriculum of Council on Chiropractic Education-accredited chiropractic colleges.

(5) Utilizing heat and cold modalities, electrical stimulation, hydrotherapy, and ultrasound therapy in patient treatment.

(6) Providing patient instruction and recommendations pertaining to hygiene, nutrition,

exercise, sanitary measures, lifestyle changes, stress reduction, and modifications of ergonomic factors.

(7) Placing Service members on limited duty profiles not to exceed 30 days according to local policy and on quarters for a maximum of 72 hours.

d. Supervision. The chiropractor functions under the indirect medical supervision of a physician assigned by the inpatient MTF. Both clinical supervision and professional evaluation of the individual are integrated into the organization's current evaluation structure.

8. CLINICAL PSYCHOLOGIST

a. Description. Clinical psychologists are specialists in the areas of behavioral science, psychological processes, and behavioral health. Clinical psychologists provide comprehensive behavioral health services as independently privileged health care providers. Behavioral health services include a variety of evaluation, treatment, and consultation activities that address behavioral and emotional problems at both the general practice and specialty practice levels. Clinical psychologists may develop additional expertise in neuropsychology, health psychology, child/pediatric psychology, personnel assessment and selection, aeromedical psychology, survival/evasion/resistance/escape (SERE) psychology, and combat stress control. The provisions of this section are applicable to GS 180-series counseling psychologists prepared at the doctoral degree level.

b. Professional Credentials. Clinical psychologists must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. Minimum requirements for category I–IV level of privileges are:

(1) Category I. The practitioner has completed predoctoral internship but has not yet completed degree requirements for a Doctor of Philosophy (Ph.D.) or Psy.D. in clinical or counseling psychology. The practitioner assists in performance of psychological and other services and works under the supervision of a licensed psychologist.

(2) Category II. The practitioner has a Ph.D. or Psy.D. in clinical or counseling psychology but is not yet licensed. The practitioner provides a full range of psychological services as qualified to deliver by virtue of training. He or she participates in team delivery of services, research, and teaching and receives qualified supervision (per licensing criteria) from a licensed psychologist.

(3) Category III. The practitioner has Ph.D. or Psy.D. in clinical or counseling psychology and is licensed. The practitioner is recognized as possessing a high level of skill in psychological assessment, intervention, and administration of services. He or she delivers psychological services to individuals and treatment teams and may be appointed as supervising psychologist for category I and II practitioners.

(4) Category IV. The practitioner has a Ph.D. or Psy.D. in clinical or counseling

psychology and is licensed and board certified by the American Board of Professional Psychology. The practitioner is recognized as possessing the highest level of skill in psychological assessment, intervention, and administration. He or she may be appointed as a supervising psychologist for category I and II practitioners.

c. Scope of Practice. Clinical psychologists practice within the guidelines of their respective State licensing boards and within the guidelines for providers of psychological services published by the American Psychological Association (APA). Psychologists adhere to the APA's Ethical Principles of Psychologists and Code of Conduct. Specific clinical privileges are granted based on training, experience, and competency.

(1) In general, clinical psychologists:

(a) Conduct psychological evaluations utilizing information from clinical interviews, psychological testing, and collateral sources, as appropriate.

(b) Establish psychiatric diagnoses according to the APA Diagnostic and Statistical Manual of Mental Disorders.

(c) Provide individual and group behavioral health treatments for which the provider holds privileges.

(d) Independently and collaboratively manage the behavioral health care of patients and refer patients to appropriate providers for health care which falls outside their scope of practice.

(e) Serve as expert consultants in human behavior to community agencies, health care providers, and organizational leaders.

(f) Provide operational psychological services to include combat stress control, aeromedical psychology, and SERE psychology.

(g) Conduct behavioral research in diverse settings to address the full range of psychological issues that impact individuals, groups, and military organizations.

(h) Conduct personnel assessment and selection for specialized military occupations.

(2) Clinical psychologists are authorized to admit, independently and collaboratively treat, and collaborate on the discharge of patients from inpatient care to include psychiatric units staffed by psychiatrists.

(a) Clinical psychologists may admit patients to the inpatient MTF only if a physician member of the medical staff, to include a psychiatrist in cases requiring admission to a psychiatric unit, assumes responsibility for performing the admission history and physical (H&P) examination. The physician must also be responsible for the patient's medical problems that exist at the time of admission, or may arise during hospitalization, and are outside the

psychologist's scope of practice.

(b) Coordination will occur between the admitting clinical psychologist and physician for patient discharge. The clinical psychologist's discharge recommendation will be documented in the medical record.

(c) The Medical Staff Bylaws will clearly specify the wards/units to which the clinical psychologist may admit and discharge patients.

d. Supervision

(1) Psychology officers who are recent graduates of military psychology residencies and are waiting award of their Ph.D. or Psy.D. will receive supervision of their clinical activities, based on individual needs, from a licensed psychologist.

(2) Unlicensed military clinical psychologists who hold a Ph.D. or Psy.D. in clinical or counseling psychology but have not yet obtained a State license to practice psychology will be supervised by a licensed psychologist until licensed, as specified in the written plan for supervision.

(3) Licensed clinical psychologists who are privileged in the independent practice of psychology do not require supervision except when engaging in new areas of practice. Psychologists will adhere to guidelines of the APA which require psychologists to receive appropriate training and supervision before engaging in new practice areas.

9. CLINICAL SOCIAL WORKER

a. Description. The primary mission of social work is to provide comprehensive professional services through a broad range of individual, family, command level and community interventions, programs, and services to sustain, restore, or enhance the social well-being and functioning of individuals, families, units, and the DoD community. Social workers are members of the health care team, most frequently working in social work service, Family Advocacy Programs (FAP), outpatient mental health clinics, substance abuse treatment services, division mental health services, combat stress control detachments, and correctional facilities.

b. Professional Credentials

(1) Education and experience. Clinical social workers must have a Masters of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education. Social workers practicing in the JOA must be qualified in clinical social work through the master's level educational program and post-MSW experience.

(a) In order to engage in independent practice, clinical social workers must have completed an MSW, have a minimum of 2 years' post-MSW clinical social work experience, and possess the appropriate State license/certification. (If the State offers a license for independent

clinical practice, this will be the level of license required. Otherwise, the license must be at the level appropriate for an MSW social worker with 2 years' experience.) These individuals may be awarded regular clinical privileges.

(b) Entry-level clinical social workers may be granted regular privileges with enhanced supervision as described in paragraph 4.e. of Enclosure 10. A written plan of supervision will be documented. This applies to the licensed entry-level clinical social workers possessing an MSW and less than 2 years' post-MSW experience and to clinical social workers with greater than 2 years' post-MSW experience that hold a license which does not authorize independent practice in their State of licensure.

(c) Social workers who are practicing clinical social work but have only an entry-level license from a State that offers a higher level of license, as described above will be awarded regular privileges with enhanced supervision until they obtain the necessary level of license.

(2) Licensure. Active Duty Clinical Social Workers will meet Service-specific licensure requirements. Civilian Clinical Social Workers will maintain a current, active, valid, and unrestricted MSW license as an independent provider from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of Practice. Clinical social worker privileges may include but are not limited to:

(1) Interviewing and evaluating patients.

(2) Diagnosing mental disorders and formulating appropriate treatment plans.

(3) Recommending administrative and medical dispositions.

(4) Providing individual, couple, family, and group psychotherapy.

d. Supervision. Clinical social workers with regular privileges will supervise entry-level social workers. A psychologist or psychiatrist may supervise a social worker qualifying for an advanced clinical license if a privileged, independent clinical practice social worker is unavailable, and if the supervisor meets the individual's State licensing authority requirements for supervision.

10. DENTIST

a. Description. Dentists ensure the optimal oral health of the Service members through preservation, restoration, and replacement dental services and they provide dental health care to eligible DoD beneficiaries according to Service-specific guidance. Dentists examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from defects, diseases, injuries, or disorders of the teeth, jaws, oral cavity, and supporting maxillofacial structures. In addition, dentists support casualty identification through dental forensic identification operations. Dental services are classified as general dentistry or specialty dentistry to include comprehensive

dentistry, pediatric dentistry, periodontics, endodontics, prosthodontics, orthodontics, oral and maxillofacial surgery, oral pathology, and public health dentistry.

b. Professional Credentials

(1) Education

(a) General dentist. To qualify as a general dentist, an individual must be a graduate of a dental school that is accredited by the American Dental Association, or an accepted equivalent program, and have passed all parts of the National Board Dental Examination.

(b) Specialty dentist. To qualify as a specialty dentist, an individual must meet all qualifications as a general dentist and be a graduate of a dental specialty training program that is accredited by the American Dental Association or an accepted equivalent program.

(2) Licensure. All dentists will maintain a current, active, valid, and unrestricted license to practice dentistry from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of Practice. The general dentist is required and privileged to perform procedures appropriate their individual military specialty code. The specialty dentist is privileged to perform the same procedures as the general dentist in addition to those appropriate to his or her military occupational specialty. Dentists in residency training programs will perform specialty procedures as assigned and supervised by their program mentors.

11. DIETITIAN

a. Description. Dietitians provide nutrition services to include providing medical nutrition therapy (MNT); procuring, managing, and safeguarding all nutrition care division resources; supervising food production and service operations; educating patients, health care providers, and staff; managing the nutrition component of health promotion programs; and serving as nutrition consultants to the military community. Dietitians who provide MNT must be privileged to perform this therapy.

b. Professional Credentials. The minimum criteria for determining an applicant's ability to provide MNT within his or her defined scope of clinical privileges are

(1) Education. A baccalaureate degree from a U.S. regionally accredited college or university (or foreign equivalent) and completion of specific course work approved by the Commission on Accreditation for Dietetics Education is required. This course work must be validated by a verification statement from the Commission on Accreditation for Dietetics Education.

(2) Registration. Active Duty Dietitians will meet Service-specific registration requirements. Civilian dietitians must successfully meet the Commission on Accreditation for

Dietetics Education-accredited supervised practice requirements for registration by the Commission on Dietetic Registration of the ADA is required. Registration eligibility must be achieved through one of the following pathways:

(a) Dietetic internship.

(b) Approval of Pre-professional Practice Program.

(c) A coordinated undergraduate program in dietetics.

(3) Licensure. Active Duty Dietitians will meet Service-specific registration requirements. Civilian dietitians will maintain a current, active, valid, and unrestricted dietetics license or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) Scope of Practice. Dietitians may be granted clinical privileges to provide MNT that include nutrition assessment/evaluation, counseling, ordering laboratory tests and other assessment procedures, as well as implementing MNTs such as enteral/parenteral feedings for inpatients and outpatients and writing prescriptions for nutrition-related pharmaceuticals as described in paragraph 8-2c in this Manual.

(a) Nutrition assessment/evaluation includes analyses of nutrient intake; activity level; appetite; intake of vitamins, minerals, nutritional supplements, and other complimentary alternative medicine usage; weight history; taste changes; feeding problems; food intolerance; food-drug interactions; unhealthy diet behaviors; socioeconomic and ethnic background; documented medical history; current diagnoses and medical treatment modalities; current drug therapy; and clinical signs and symptoms of nutritional deficiencies. Physiological symptoms that may accompany nutrient intake problems may be part of the analyses (for example, nausea, vomiting, diarrhea, and constipation). Nutrition assessment/evaluation may also include anthropometric measures (height; weight; skinfold measurements; mid-arm and mid-arm muscle circumferences; elbow breadth; wrist, waist, hip, and neck circumferences).

(b) Nutrition counseling includes identifying nutritional inadequacies; planning and implementing dietary modifications and interventions; evaluating and documenting clients' progress toward desired outcomes and goals; initiating health maintenance nutrition education; monitoring and evaluation (M&E) and documenting individualized MNT plans; and initiating nutrition counseling follow up at defined intervals to ensure nutrition goals are met or redefined as appropriate.

(c) Advanced specialists with additional certifications may be privileged to order tube feedings, parenteral formulas, transitional feedings, and additional laboratory tests to support nutrition therapy decisions.

(d) To support MNT, dietitians may refer to other health care providers as needed such as to the diabetes educator; Women, Infants, and Children Program; hospice; home health care; and other community support programs.

12. ~~OT~~ *OCCUPATIONAL THERAPIST*

a. Description. OT is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health; prevent injury or disability; and which develop, improve, sustain or restore the highest possible level of independence of any individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical disability, or other disorder or condition. It includes assessment by means of skilled observation or evaluation through the administration and interpretation of standardized or non-standardized tests and measurements. OTs evaluate, treat, and consult with individuals whose abilities to cope with the tasks of everyday living are threatened or impaired by physical illness or injury, psychosocial disability, or developmental deficits. The OT uses goal-directed activities - appropriate to each person's age and social role - to restore, develop, or maintain the ability for independent, productive, and satisfying lives.

b. Professional Credentials

(1) Education and internship. The OT registered must be a graduate of an occupational therapy program that is accredited by The Accreditation Council for Occupational Therapy Education leading to a degree in occupational therapy. Completion of a clinical internship of not less than 6-months' duration is required. (This is an occupational therapy certification examination prerequisite that is usually accomplished prior to graduation from an accredited program.)

(2) Certification. Active Duty OTs will meet the Service-specific certification requirements. For civilian OTs, current certification from the National Board for Certification in Occupational Therapy (NBCOT) is required.

(3) Licensure. Active Duty OTs will meet the Service-specific licensure requirements. Civilian OTs will maintain a current, active, valid, unrestricted occupational therapy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) Other. To be considered an advanced OT registered clinical specialist in the treatment of upper extremity neuromusculoskeletal conditions, the AD Service Member must meet the Service-specific requirements. For civilian and contractor OTs, the Certified Hand Therapist (CHT) credential will indicate advanced training and competency in Upper Extremity Rehabilitation. However, the CHT credential alone does not indicate proficiency in the same supplemental privilege areas as obtained by the Army 7H Additional Skill Identifier (ASI) or Navy 6LJ AQD. At the discretion of their department chair, civilian and contractor OTs with military service may retain the Service-specific privileges earned for treatment of upper extremity neuromusculoskeletal conditions.

c. Scope of Practice

(1) Category I. Category I clinical privileges are appropriate for the OT whose activities are limited to the standard scope of practice as defined by his or her license or certification. The OT with Category I level of practice will:

(a) Use guidelines published by the American Occupational Therapy Association and the NBCOT.

(b) Provide occupational therapy evaluation and diagnostic and treatment services for patients seen by providers in the MHS as well as those referred by civilian providers.

(c) Evaluate and treat deficits in occupational performance components that include motor, neuromusculoskeletal, cognitive, social, and psychological dysfunction. Treatment includes individual and group-based purposeful activity, exercise, physical agent modalities (used as adjuncts to purposeful activity), fabrication and training in the use of temporary functional orthotics, splints and adaptive devices, counseling, and education.

(d) Conduct ergonomic evaluations and training, work capacity evaluations, and work site analyses.

(e) Provide assessment, education, and training to Service members/beneficiaries in the areas of health promotion and disease/injury prevention, to include prevention of psychosocial dysfunction and stress management.

(f) Perform combat neuropsychiatric triage.

(g) Provide command consultation on the prevention and management of combat stress casualties.

(h) Conduct unit stress and morale surveys and provide consultation and recommendations to command staff.

(i) Provide interventions that enhance communication, team building, motivation, and prevent suicide and misconduct stress behaviors.

(j) Serve as occupational therapy consultant to both inpatient MTF/Center and troop commanders.

(2) Category II. Category II clinical privileges are appropriate for the OT who demonstrates advanced education, training, and/or board certification, as appropriate.

(a) The OT skilled in the management of upper extremity neuromusculoskeletal conditions may be privileged to:

1. Provide direct access (that is, no referral required) upper extremity neuromusculoskeletal evaluation for acute musculoskeletal and neuromuscular conditions.

2. Request appropriate radiographs and laboratory tests for patients with neuromusculoskeletal conditions for whom they are performing primary evaluation and treatment.

3. Assign patients to quarters not to exceed 72 hours.

4. Refer patients to appropriate specialty clinics.

5. Authenticate temporary limited-duty profiles according to Service-specific guidance

6. Write prescriptions for selected medications as described in paragraph 8-2c in this Manual.

(b) The OT skilled in the management of patients with occupational performance deficits resulting from psychosocial conditions may be privileged to:

1. Conduct critical incident stress debriefings and other crisis intervention or critical incident stress management activities.

2. Assist doctoral-level mental health care providers in the assessment of patients referred for mental health evaluations by performing psychiatric diagnostic screening interviews and mental status examinations.

(c) The OT with advanced training in pediatrics may be privileged to:

1. Conduct infant and pediatric developmental evaluations and treatment.

2. Assist the radiologist and pediatrician in evaluation of pediatric modified barium swallow studies.

d. Supervision. The OT with either category I or II privileges will be provided supervision/oversight of his or her clinical practice by a more experienced OT. In the absence of a more experienced OT, a physician may provide supervision/oversight.

13. OPTOMETRIST

a. Description. Doctors of Optometry (ODs) are primary health care providers who examine, diagnose, and treat (or prescribe courses of treatment) for beneficiaries suffering from diseases, injuries, or disorders of the visual system, the eye, and associated structures as well as diagnosis-related systemic conditions. As primary eye care providers, optometrists are part of the health care team and provide an entry point into the health care system. They are skilled in the co-management of conditions that affect their patients' eye health and vision and are sources of referral and consultation for other health care professionals.

b. Professional Credentials

(1) Education. ODs must have a 4-year OD degree from an accredited 4-year college of optometry acceptable to DA.

(2) Licensure. Optometrists will maintain a current, active, valid, and unrestricted optometry license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of Practice. Optometrists may have privileges that include, but are not limited to:

(1) Examining, diagnosing, and treating or prescribing courses of treatment for eligible beneficiaries suffering from diseases, injuries, or disorders of the visual system, the eye, and associated structures as well as diagnosing related systemic conditions.

(2) Co-managing post-surgical eye cases and ocular complications of systemic illness in the inpatient and outpatient setting.

(3) Serving as consultant in optometry (primary eye care) for other health care professionals in the MHS.

(4) Promoting prevention and wellness, vision conservation, education and training activities, vision screenings, and positive eye and vision health behaviors.

(5) Prescribing drugs appropriate for ocular therapy. Prescriptive authority is based on the optometrist's education and experience. Graduates from U.S. schools of optometry (1985 and following) are deemed to possess the appropriate education.

d. Supervision. Optometrists are licensed independent practitioners and have no requirements for physician supervision.

14. PHARMACIST

a. Clinical Pharmacist

(1) Description. Clinical pharmacists are licensed pharmacists with complex clinical skills and capabilities acquired through advanced education and practical experience. Clinical pharmacists practice collaboratively in the area of pharmacoeconomics and with patients requiring therapy (for example, anticoagulant, asthma, hypertension, diabetes, hyperlipidemia, immunization, and oncology nuclear). Clinical pharmacists practice in primary care, medicine, pediatrics, geriatrics, infectious disease, nutrition, and pharmacotherapy settings. They provide medication refills. In many cases, the clinical pharmacist works directly for a physician or group of physicians in a particular specialty or primary care clinic. The pharmacist functions under CPGs developed in coordination with the medical staff, recommended by the Pharmacy and Therapeutics committee, and approved by the ECOMS. Clinical pharmacists provide pharmacokinetic consultation, enteral and parenteral nutrition consultation, and perform drug therapy management activities on inpatient units and in outpatient clinics. In all cases, communication between pharmacists and physicians is essential for quality patient care.

(2) Professional Credentials. Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include:

(a) Education/certification. Pharmacists must have

1. A post-baccalaureate or entry level doctor of pharmacy (PharmD) degree, or

2. A Master of Science degree in pharmacy from a clinically oriented program, or

3. Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmaceutical Specialties, or

4. Completed a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy, or

5. A Bachelor of Science degree in pharmacy with documentation of appropriate education, training, and/or continuing education in the practice of clinical pharmacy. (The didactic content of current Bachelor of Science programs is nearly identical to entry-level PharmD programs. The difference is that PharmD programs have 1 additional year of clinical experience.)

6. Appropriate formal education and clinical training to perform limited physical assessment (that is, assessment focused on the specific system under examination). This is included in PharmD programs but may not be for bachelor's and master's programs. Other sources of this training may include the Physical Assessment Education Program and/or a formal certification process.

(b) Licensure. Clinical pharmacists will maintain a current, active, valid, unrestricted pharmacy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Scope of practice. Pharmacists may be granted clinical privileges to provide clinical treatment protocol/CPG-based direct patient care. Communication with the patient's physician, through documentation of clinical activities in the patient's medical record and other verbal/written means, is essential to ensure continuity of care. Pharmacist privileges may include, but are not limited to:

(a) Assessing patient's response to drug therapy and planning drug therapy, based on physician-established diagnoses.

(b) Ordering and assessing laboratory tests necessary to evaluate drug therapy effects and therapeutic outcomes.

(c) Initiating, modifying, or discontinuing medications for ongoing therapy of chronic disease states (for example, hypertension, hyperlipidemia, diabetes, asthma, and so forth) in cooperation with the medical staff.

(d) Monitoring and managing pharmacotherapy requiring periodic adjustment due to specific or changing pharmacokinetic characteristics (for example, aminoglycosides, phenytoin, antithrombotics).

(e) Initiating or modifying drug therapy for minor acute conditions such as colds, rashes, and allergies.

(f) Administering prescription or nonprescription drugs according to established treatment protocols or practice guidelines.

(g) Assessing metabolic needs and ordering therapeutic enteral or parenteral nutrition products in inpatient and outpatient settings.

(h) Evaluating medical and medication histories for drug-related problems and adjusting drug therapy accordingly.

(i) Consulting with other health care providers (for example, physicians, dietitians, nurses, PTs, and so forth) regarding patient pharmacologic treatment needs or options.

(j) Consulting to therapeutically evaluate, recommend, or modify medication therapy for patients with complex medical conditions or difficult-to-manage disease states.

(k) Conducting and coordinating clinical investigation and research (consistent with other health care professionals) approved by a local or regional investigational review board and participating in outcome studies generated by the department of pharmacy and approved by the Pharmacy and Therapeutics committee.

(l) Providing patient education/counseling services to enhance compliance and reduce the occurrence of medication-related problems and adverse drug events.

(m) Applying advanced knowledge of drug therapy to provider and patient education, inpatient MTF drug formulary analysis and recommendations, and serving as preceptor for pharmacy students.

(4) Supervision

(a) Clinical pharmacists granted inpatient MTF privileges must have a physician available for consultation, either in person or by phone, when they are performing direct patient care activities.

(b) All clinical pharmacists must work via protocols recommended for approval by the ECOMS and practice with the supervision of a physician preceptor, identified in writing. The physician preceptor must provide consultation, clinical feedback, and general oversight of the clinical pharmacist's practice.

b. Dispensing Pharmacist

(1) Description. Dispensing pharmacists review new and renewing prescriptions, monitoring them for drug interactions, overlaps and allergies, and ensuring appropriateness of drug therapy; review non-formulary requests for proper justification; and manage formularies. They support requests for information from patients and providers, review patient profiles and clinical laboratory values, record pharmaceutical information in patient records, and are alert to potential drug-related problem for each patient. Dispensing pharmacists participate in quality improvement by performing drug storage inspection, culling expired supplies, and producing error and workload reports and documentation. They are active attendees at board, committee meetings, and pharmacy staff meetings. In the execution of duties, they utilize hospital instructions; professional journals; accrediting agency standards, and professional society literature. They use judgment to adapt and apply the established guidelines to the scope of services provided by the pharmacy department.

(2) Professional Credentials. Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include

(a) Education/certification. Pharmacists must have

1. A post-baccalaureate or entry level doctor of PharmD, or

2. A Master of Science degree in pharmacy from a clinically oriented program, or

3. Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmaceutical Specialties, or

4. Completed a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy, or

5. A Bachelor of Science degree in pharmacy with documentation of appropriate education, training, and/or continuing education for dispensing pharmacists. (The didactic content of current Bachelor of Science programs is nearly identical to entry-level PharmD programs. The difference is that PharmD programs have 1 additional year of clinical experience.)

6. Appropriate formal education and clinical training to perform limited physical assessment (that is, assessment focused on the specific system under examination). This is included in PharmD programs but may not be for bachelor's and master's programs. Other sources of this training may include the Physical Assessment Education Program and/or a formal certification process.

(b) Licensure. Dispensing pharmacists will maintain a current, active, valid, unrestricted pharmacy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Supervision

(a) Dispensing pharmacists granted inpatient MTF must have a physician available for consultation, either in person or by phone, when they are performing direct patient care activities.

(b) All clinical pharmacists must work via protocols recommended for approval by the ECOMS and practice with the supervision of a physician preceptor, identified in writing. The physician preceptor must provide consultation, clinical feedback, and general oversight of the clinical pharmacist's practice

15. PHYSICIAN

a. Description. Physicians are primary or specialty health care providers who examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from diseases, injuries, or disorders of any or all of the body's systems. As either primary or specialty care providers, physicians are an integral member of the health care team and participate in most clinical pathways in the health care system. They are skilled in the management of acute and chronic conditions that affect their patients and are primary sources of consultation for other health care professionals.

b. Professional Credentials

(1) Education. Physicians must have completed an accredited medical degree program acceptable to the Service with which they are affiliated.

(2) Licensure. Physicians will maintain a current, active, valid, and unrestricted (OSD(HA) authorized waiver) medical or osteopathic medical license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Board certification. Physicians who have completed requirements for training and experience meeting the standards of various member boards of the American Board of Medical Specialties (ABMS) are encouraged to attain board certification in their respective specialties. However, board certification is not required to practice independently.

c. Scope of Practice. Physician privileges may include, but are not limited to:

(1) Examining, diagnosing, and treating or prescribing courses of treatment within the scope of their training and experience for eligible beneficiaries suffering from diseases, injuries, or disorders.

(2) Serving as consultants for other health care professionals in the MHS.

(3) Promoting prevention and wellness, health and safety education and training activities, disease screenings, and positive health behaviors.

d. Supervision. Physicians are licensed independent practitioners and have no requirement

for direct supervision. They will act independently in areas of medical and surgical care when they have demonstrated competency within their delineated privileges. Physicians in post-graduate clinical training (interns, residents, and fellows) are required to function under the supervision of experienced physicians participating in the Graduate Medical Education (GME) system. A physician returning to practice after a lapse in providing patient care may be required to function for a specified period under the supervision of another more experienced physician (that is, enhanced supervision, as described in Enclosure 10 (4e)) if recommended by the credentials committee and approved by the Privileging Authority.

16. PA AND SPECIALTY PA

a. Description. PAs are health care providers who deliver primary or specialty medical care with physician supervision. Within that physician-PA relationship, PAs exercise significant professional autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services to all DoD beneficiaries. The clinical role of the PA includes but is not limited to primary care, family practice, and specialty areas such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational medicine, and orthopedics. PAs deploy to provide medical support during mobilization, humanitarian assistance, and peacekeeping missions. PA practice is centered on the management of illness and injury, disease prevention, and health promotion and may include - in addition to patient care responsibilities - didactic instruction in a formal setting, patient education, research, and administrative activities.

b. Professional Credentials

(1) Education. Military PAs must meet the educational criteria for commissioning stipulated by the Service with which they are affiliated. All PAs must be graduates of a PA training program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or previously recognized accrediting body) and acceptable to the DA.

(2) Certification. All PAs (AD/Reservist/National Guard and civilian) are required to possess current certification by the NCCPA before regular clinical privileges are granted/renewed.

(a) Initial certification. PAs who received their training from the Interservice Physician Assistant Training Program (IPAP) must take the NCCPA Physician Assistant National Certifying Examination (PANCE) at the first available testing period following Phase II of training. The IPAP graduate must pass the PANCE within 12 months following completion of the IPAP Phase 2. Individuals who, due to circumstances beyond their control, are unable to take the PANCE within the 12-month interval noted above must request deferment prior to the scheduled examination date by following Service-specific guidance. Any approved deferment will delay the 12-month mandatory period to pass the PANCE. The Service member will retain any unused portion of his or her 12 months for use upon termination of the deferment. IPAP graduates who are unsuccessful in passing the PANCE within the allotted 12 months will have their privileges revoked. This is considered an administrative action, not an adverse privileging action. PAs with an existing AD service obligation for training, who fail to complete the

PANCE within 12 months, will be processed for involuntary branch transfer according to Service-specific guidance.

(b) Certification renewal. All PAs will continuously maintain NCCPA certification while employed by the Federal Government. Biennial renewal is mandatory.

(c) Recertification. The PA National Recertification Examination/Pathway II is required every 6 years. PAs who are unsuccessful in passing this examination after two attempts will have their privileges revoked and are prohibited from practicing in their military occupational specialty. The PA with an existing AD service obligation for training will be processed for involuntary branch transfer according to Service-specific guidance. Individuals with no AD service obligation may be eliminated from service according to Service-specific guidance. .

(3) Licensure. Non-personal services contract PAs employed by the Federal Government must be licensed in the particular State in which they are working. All other PAs (AD, civil service, and personal services contract) are granted a waiver to the licensure requirement by the Department of Defense.

c. Scope of Practice. The PAs provide medical care for Service members and eligible beneficiaries in all age groups, including children under the age of 2, according to the clinical privileges awarded by the Privileging Authority.

(1) Outpatient duties. The PA outpatient duties include, but are not limited to:

(a) General medical care. Within the limits of their training and privileges, PAs provide primary and specialty medical care for the sick and injured.

(b) Diagnosis, treatment, and prescription. PAs may diagnose, prescribe for, and treat diseases, disorders, and injuries.

(c) Minor surgery and wound management. PAs may perform minor surgery and wound management that require completion of a JEO Optional Form (OF) 522, "Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures."

(d) Patients returning with the same complaint. PAs must consult with a physician when a patient presents with the same unresolved complaint twice in a single episode of care. Physician consultation will be documented on either a standard form (SF) 600, "Health Record-Chronological Record of Medical Care" or an SF 513, "Medical Record-Consultation Sheet." (See Air Force Instruction 44-119 (Reference (~~np~~*p*)) for instructions on the use of these forms.) This does not apply to patients who are returning for routine follow up as directed or for treatment of chronic illnesses previously documented in their medical record.

(e) Referral and evacuation. Situations requiring higher levels of medical diagnosis and treatment will be referred or evacuated. In the absence of a physician, the PA will be the

primary source of advice to determine the medical necessity, priority, and requirements for patient evacuation.

(f) Authentication of medical record entries. PAs will sign all entries made in the patient's inpatient treatment record or outpatient treatment record. Documentation in the inpatient treatment record (ITR) of the patient's medical history, physical examination, and narrative summary, as well as entries on a Doctor's Orders form, requires physician countersignature. Countersignature will be within 24 hours. Entries made by a PA in the health record or the outpatient treatment record do not require a physician's countersignature.

(2) Inpatient duties. The attending physician is responsible for the health care delivered by the PA. A PA may assist the physician in performing a variety of inpatient-related duties that may include, but is not limited to the following:

(a) Admit patients to an inpatient service, in consultation with the on-call/attending physician. All patients admitted to an inpatient service will have an attending physician.

(b) Write orders for inpatient care.

(c) Complete the medical histories and perform physical examinations.

(d) Prepare and dictate narrative summaries.

(e) Discharge patients but only at the direction of the attending physician.

(f) Specific pre-operative counseling is the responsibility of the attending surgeon. PAs may not perform a presurgical anesthesia evaluation that requires completion of the appropriate record of anesthesia.

(g) PAs may not sign or verify forms that constitute an Inpatient Treatment Record Cover Sheet.

(3) Pharmaceutical usage. PAs may be privileged to write prescriptions for a wide variety of pharmaceuticals as described in paragraph 8-2c in this Manual.

(a) PAs are authorized to prescribe controlled substances (Schedule II–V).

(b) When the PA is providing primary field medical support during a field training exercise or deployment, he or she may administer or prescribe any pharmaceutical stocked in the Service field medical set, kit, or assemblage authorized at that level of assignment. This is in addition to the pharmaceuticals authorized by addendum to the PA's delineation of clinical privileges.

(4) Medical examinations. PAs may:

(a) Conduct medical examinations, following the guidance in the ICTB (Reference (~~o~~*q*)), and as deemed appropriate by the supervising physician.

(b) Perform medical screening for overseas movement and sign the appropriate Service-specific forms.

(5) Profiles. PAs may authenticate temporary limited-duty profiles according to the guidance outlined in Service-specific guidance.

(6) Personnel on flight status. All PAs may assign duty limitations and recommend to an aviation unit commander that an aircrew member be medically restricted from flight duty. Only a flight surgeon (FS) may remove duty limitations on flight personnel.

(7) Additional duties. PAs will not be used in lieu of the professional officer-of-the-day or for administrative duties for which they have not been trained. Duties such as staff duty officer, report of survey officer, or investigation officer in accordance with Army Regulation 15–6 (Reference (~~p~~*r*)) are not appropriate for the PA whose primary responsibility involves day-to-day delivery of health care and services.

(8) Expanded roles. PAs with advanced education, training, experience and the appropriate privileges may be used in specialty practice settings such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational health, and orthopedics. Additions and deletions of PA specialties will be under the purview of the Services. A specialty-trained PA may perform the initial patient work-up or consultation. The consultation prepared by the PA will be reviewed and countersigned by a physician according to established procedures and/or locally developed scopes of practice.

(a) Aviation medicine. An AD Army PA who successfully completes the U.S. Army Flight Surgeon Primary Course will be designated as aeromedical PA, ASI M3, and may be assigned to assist the FS in the practice of aviation medicine. Aeromedical PAs:

1. Perform his or her aviation medicine duties under the supervision of a designated aviation-medicine-trained physician (61N) or resident in aerospace medicine.

2. Contribute to aviation medicine in the areas of medical examination for flight duty and primary health care for aviation personnel and their family members.

3. Participate in the Aviation Safety Program and may supervise the fitting and use of crew member personal safety equipment. The aeromedical PA will not be a substitute for an FS in these activities.

4. Assist in aircraft accident investigations. The aeromedical PA will neither substitute for the FS in aircraft accident investigations or flight evaluation boards nor will the aeromedical PA sign reports for these investigations or boards.

5. Sign the DA Form 4186, "Medical Recommendation for Flying Duty" in accordance with Reference (~~q~~*s*) recommending an air crew member's return to flight duty only after consultation with an FS. The name of the consulted FS will be annotated on the DA Form 4186 according to Army Regulation 600–106 (Reference (~~q~~*s*)) and on SF 600, "Health Record—Chronological Record of Medical" filed in the patient's health record.

6. Be placed on non-crewmember flight status by Headquarters, DA, under the provisions of section 315.804 and Part 752 of Title 5, Code of Federal Regulations (Reference (~~r~~*t*)).

(b) Cardiovascular perfusion. A PA who successfully completes an accredited cardiovascular perfusion training program may be designated as a cardiothoracic perfusion PA. Cardiothoracic perfusion PAs:

1. Function under the supervision of a board-eligible or board-certified cardiothoracic surgeon when assigned duties as a cardiothoracic perfusion PA.

2. Obtain certification (highly encouraged but not required) as a certified cardiovascular perfusionist through the American Board of Cardiovascular Perfusion.

3. Operate extracorporeal circulation and autologous blood recovery equipment during any situation where it is necessary to support or replace a patient's circulatory or respiratory function.

4. Administer blood products, anesthetic agents, and other medication through the extracorporeal circuit according to training guidelines and established protocols.

5. Use ancillary techniques such as hypothermia, hemoconcentration, intra-aortic balloon counterpulsation, ventricular assist devices, and hemodilution.

6. Assist with a variety of surgical or invasive procedures to include saphaneous vein harvesting, sternotomy and thoracostomy, chest tube insertion/removal, and cannulation of major vessels.

(c) Emergency medicine. A PA who successfully completes an approved graduate PA emergency medicine training program may be designated as an emergency medicine PA (EMPA). EMPAs:

1. Function under the supervision of a board-certified/-eligible emergency medicine physician when working in an emergency department/service.

2. Identify, evaluate, and initiate appropriate treatment to stabilize patients presenting to an emergency department/service with life-threatening or medically urgent injuries, illnesses, or conditions.

3. Perform all diagnostic and therapeutic emergency medicine procedures for which he or she has been properly trained and privileged.

4. Maintain/sustain those skills and certifications (ACLS, ATLS, PALS, etc.) which are required as part of the EMPA scope of practice and are necessary in the performance of duties within an emergency department/service.

(d) Occupational health. A PA who receives a graduate level degree in occupational health/public health may be designated as an occupational health PA (OHPA). The OHPA assists the occupational medicine physician or preventive medicine physician in occupational and preventive medicine duties for the inpatient MTF OHPAs.

1. Conduct job-related, fitness-for-duty, and health-maintenance examinations for military and civilian personnel.

2. Conduct occupational and non-occupational disease and injury prevention and treatment of military and civilian personnel.

3. Conduct illness and injury monitoring and investigations.

4. Supervise chronic disease surveillance to include tuberculosis and sexually transmitted diseases.

5. Provide occupational and environmental health education to Service members and DoD civilian employees.

(e) Orthopedics. A PA who successfully completes an approved graduate PA orthopedic training program may be designated an orthopedic PA. Orthopedic PAs:

1. Diagnose, treat, and appropriately manage musculoskeletal trauma and/or disease.

2. Perform minor orthopedic-related surgical procedures.

3. Perform orthopedic procedures to include traction pin placement and removal and adjustment of external fixation devices.

4. Function as first assistant in the operating room and emergency center/service/department for patients with orthopedic injuries or problems.

5. Directly assist the physician with reductions of all complex fractures and dislocations.

6. Perform all diagnostic and therapeutic orthopedic procedures for which he or she has been properly trained and privileged. Outpatient procedures by an orthopedic PA should

not include any manipulation, minor surgery, or wound management requiring other than local or peripheral nerve block anesthesia.

d. Privileges

(1) PAs will be awarded privileges commensurate with their education, experience, competence, and the operational needs of the unit to which they are assigned.

(2) New graduates of the Interservice Physician Assistant Training Program may be granted and maintained in a supervised privilege status until they have successfully passed the PANCE and are licensed (effective July 1, 2009).

e. Supervision. Inpatient MTF Commanders must exercise the utmost care when selecting physicians to be designated as supervisors for military and civilian PAs. These physicians (appointed by name and in writing) must demonstrate the ability to provide the required professional supervision, guidance, and support that is of vital importance in all patient treatment settings. The supervising physician must, when needed, prescribe standards of good medical practice. The supervisor must be available for consultation in person, telephonically, by radio, or by any other means that allows person-to-person exchange of information. An alternate physician supervisor must be available during temporary absences of the primary physician supervisor.

(1) Qualifications and duties. The physician supervisor will:

(a) Be qualified by education, training, and privileges to perform any treatment or procedure that he or she directs a PA to perform.

(b) Be responsible for the PA's medical practice and the quality of care rendered.

(c) Ensure that the PA's practice remains within the scope of his or her clinical privileges.

(d) Monitor the PA's performance using established outcome criteria for treatment, referral, and follow-up care.

(e) Ensure that performance evaluations are conducted according to established policies. These evaluations may be delayed for PAs working at geographically remote or inaccessible locations, with operationally deployed forces, or in units on field training exercises. Delayed evaluations will be conducted at the first opportunity and should not be delayed for a period greater than 6 months. (The 6-month maximum delay period may be waived for deployed forces only if compliance would jeopardize the operational mission of the unit. In this case, the review will be completed at the earliest available opportunity.)

(f) Review medical treatment records for patients managed by PAs according to current policies.

(g) Participate in the rating of the PA for whom supervision is provided. In all cases, the physician supervisor will be included as either the PA's rater or senior rater according to Service-specific guidance.

(2) Nonpersonal services contract PA supervision. A PA in this status may have supervision requirements imposed by his or her State of licensure that exceed JTF CapMed requirements. (Given the variation among States regarding supervision of PAs under non-personal services contract to the Government, inpatient MTFs are encouraged to hire contracted PAs via personal services contract.) For PAs who require additional supervision, the following two options, listed in order of preference, may apply.

(a) The contractor is responsible for providing the additional supervision. In this case, the inpatient MTF will cooperate by providing copies of medical records for external review. The number of medical records will be locally determined.

(b) The inpatient MTF must petition the State board of licensure to honor physician license portability in accordance with section 1094 of Reference (~~k~~*m*) in order for the inpatient MTF-appointed physician to provide the necessary supervision. In this case, the inpatient MTF is obliged to meet the other established supervision requirements of the State of licensure.

f. Continuing Medical Education (CME) and training. CME is critical for sustainment of clinical skills necessary for the PA to perform his or her duties.

(1) PAs are required to obtain 100 hours of CME every 2 years in order to maintain current NCCPA certification. Commanders are encouraged to provide the time and the necessary funding, as appropriate, to ensure that all assigned PAs remain current in their clinical skills.

(2) Readiness training is of paramount importance to prepare AD Service Member PAs for their wartime mission. Recommended training for AD/Reservist/National Guard PAs includes:

(a) ATLS or an equivalent. This training helps ensure that military PAs are qualified in advanced trauma management to meet the doctrinal mission to care for the wounded/injured on the battlefield. Advanced trauma management sustainment training is required for military PAs once every 4 years.

(b) Medical Management of Chemical and Biological Casualties Course. The increased risk that weapons of mass destruction will be employed in a battlefield scenario requires that military PAs be able to recognize and treat the injuries or diseases that will result from the use of chemical or biological agents. PAs should attend this training as soon as possible following graduation.

(c) Tropical/global medicine. The increasing likelihood of deployments and missions in the tropical and subtropical regions of the world requires familiarity with diseases

and conditions that are endemic to those areas and which pose a threat to the health and well-being of Service members.

17. PHYSICAL THERAPIST (PT)

a. Description. PTs examine, diagnose, and treat individuals of all ages with impairments, functional limitation, disabilities, or changes in physical function and health status resulting from injury, disease, and other causes. They consult with other health practitioners, and refer patients to other practitioners as appropriate. Physical therapy interventions include patient education; therapeutic exercise; functional training; manual therapy techniques; prescription, application, and fabrication of devices and equipment; airway clearance techniques; integumentary repair and protective techniques, electrotherapeutic modalities; and physical agents and mechanical modalities.

b. Professional Credentials

(1) Education. PTs must be graduates of a physical therapy program accredited by the Commission on Accreditation in Physical Therapy Education or its equivalent.

(2) Licensure. PTs will maintain a current, active, valid, and unrestricted physical therapy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

c. Scope of Practice

(1) Category I. Category I clinical privileges are appropriate for the PT whose activities are limited to the standard scope of practice as defined by his or her State license:

(a) Perform functions in support of physical therapy evaluation and treatment.

(b) Provide physical therapy examination, evaluation, diagnosis, prognosis, and intervention services for patients seen by providers within the MHS as well as those referred by civilian providers.

(c) Serve as PT clinical consultant for other health care professionals in MHS, DoD, and/or Department of Veterans Affairs (VA) facilities concerning patient-specific treatment approaches.

(d) Perform prevention and wellness activities, education, screening, and promote positive health behaviors.

(2) Category II. Category II clinical privileges are awarded to PTs who demonstrate appropriate education, training, and/or board certification. These authorize the PT to.

(a) Perform functions in support of physical therapy evaluation and treatment as follows:

1. Request appropriate imaging studies for patients with neuromuscular disorders for whom they are performing primary evaluation and treatment.

2. Assign patients to quarters for intervals not to exceed 72 hours.

3. Refer patients to specialty clinics.

4. Authenticate temporary limited-duty profiles according to the guidance outlined in Reference (~~o~~*q*).

5. Write prescriptions for selected medications for musculoskeletal conditions as described in elsewhere in this document.

(b) Perform and interpret electrophysiologic tests to include nerve conduction studies, needle electromyography, and somatosensory-evoked potentials. These privileges should only be granted if the PT has met the most recently published guidelines of American Board of Physical Therapy Specialties for the practice of clinical electrophysiologic physical therapy.

1. Documentation in support of the PT's request for such privileges includes a summary of post-graduate professional education, qualifying clinical experience, and a formal statement by the clinical preceptor and the medical officer attesting the proficiency of the candidate.

2. A qualified electrophysiologic supervisor, as elsewhere in this enclosure, will be designated by the inpatient MTF Commander to be a direct liaison with the PT performing electrophysiologic tests and will serve as the PT's clinical preceptor for problem cases, review of cases, ascertaining the quality of practice, and to answer questions concerning new equipment or special techniques.

3. An ongoing peer review process between the electrophysiologic supervisor and the practicing PT will be established. This should include a quarterly review of at least a 10 percent sample of patient medical records and reports and a yearly on-site review of the clinical electrophysiologic testing procedures. A qualified military or civilian electrophysiologic supervisor shall be a physician certified by the American Board of Electrodiagnostic Medicine, a physician holding a Certificate of Added Qualification in Clinical Neurophysiology of the American Board of Psychiatry and Neurology, or a PT certified by the American Board of Physical Therapy Specialties as an electrophysiologic certified specialist.

(c) Provide early intervention (i.e., physical therapy care for high-risk infants) in the neonatal intensive care unit.

d. Supervision. The PT with category I privileges will be provided supervision/oversight of his or her clinical practice, as required, by a PT with category II privileges, or in the absence of a category II privileged PT, by a physician.

18. PODIATRIST

a. Description. Doctors of podiatric medicine (DPM) provide comprehensive medical and surgical management of disorders of the foot and ankle. This includes examination, diagnosis, medical and surgical treatment, prevention, and care of conditions/functions of the foot and related structures. Podiatrists are members of the orthopedic/surgery service.

b. Professional Credentials

(1) Education. Podiatrists will have a DPM degree (4-year DPM degree) from an accredited college or university of podiatric medicine. While completion of a 24-month podiatric surgical residency is preferred, completion of a 12-month podiatric surgical residency plus a 12-month podiatric orthopedic/primary podiatric medical residency is accepted.

(2) Licensure. Podiatrists will maintain a current, active, valid, and unrestricted podiatry license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Certification. Board certification (not required but encouraged) is via one of two certifying boards recognized by the American Podiatric Medical Association's Council on Podiatric Medical Education.

(a) American Board of Podiatric Surgery.

(b) American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

c. Scope of Practice. A DPM may be privileged as any other member of the medical staff in the surgical service. The national standard for DPMs with the appropriate post-graduate education, as stated elsewhere in this enclosure, is the management of all disorders of the anatomic region of the foot and ankle and related structures affecting the foot and ankle. Podiatrists for whom residency training included medical history taking and physical examination may be privileged to perform the complete H&P for ASA patient classification status 1 and 2 patients in both the inpatient and outpatient settings. The DPM will perform and record the H&P on the appropriate medical form(s), for example, SF 504, "Clinical Record - History Part I," SF 505, "Clinical Record - History Part II, III," and SF 506, "Medical Record - Physical Examination" for the inpatient, or SF 600 (outpatient). Patients classified as ASA patient classification status 3 and greater will require an H&P, either all or part of which is performed by a qualified physician. The podiatric portion of the H&P may be performed, recorded, and signed by the DPM; the remaining medical portion of the H&P is the responsibility of the consulting physician. Findings, conclusions, and assessment of risk will be confirmed or endorsed by a qualified physician prior to initiation of any major high-risk diagnostic or therapeutic intervention. The DPM may be privileged to admit patients only if he or she is

educationally prepared to perform the H&P. Otherwise, a privileged physician must admit the patient, perform the H&P, and assume responsibility for the patient's inpatient medical care during hospitalization.

d. Supervision. Podiatrists are licensed independent practitioners and have no requirement for physician supervision.

19. PSYCHOLOGICAL ASSOCIATE

a. Description. Psychological associates are trained in general psychology, psychometric theory, psychological testing, behavioral science, counseling theories, and practical applications of psychological principles. The psychological associate may develop additional expertise in industrial psychology, school or health psychology, neuropsychology, and pediatric or adolescent psychology. The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State requirements as a doctoral level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this Manual, using the title psychological associate or behavioral health practitioner.

b. Professional Credentials. Psychology associates must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for *C*ategory I–III level of privileges include:

(1) Category I. The individual has earned a master's degree in psychology, fulfilling the requirements of an academic program, including a minimum of 6 semester hours of supervised practicum in the major specialty. The graduate program must be offered by a college/university fully accredited by a U.S. regional accrediting body.

(2) Category II. The individual has completed a master's degree program in psychology, at a fully accredited college/university, including a minimum of 6 semester hours of supervised practicum. The individual possesses licensure as a psychological associate, or the LPC/LPC-equivalent licensure (or other master's level psychology license) available in some States. The individual has a minimum of 2 years' full-time experience in the specialty in which services are performed under the supervision of a higher-level privileged provider with a license in psychology. Not all States offer licenses to master's level psychologists, but all offer the LPC, though some States use a different title for the LPC-equivalent license. The education and experience requirements for licensure are the basis for determining equivalency.

(3) Category III. The individual has completed a post-master's specialty degree from an accredited college/university and passed a comprehensive examination in that specialty. The individual is a master's level psychologist, or has an LPC/LPC-equivalent license from a State licensing body. The individual provides a wide range of services in the designated specialty and may supervise *C*ategory II or I counselors in the provision of services in the specialty.

c. Scope of Practice. Individuals will practice within the guidelines of their respective State licensing boards as a licensed psychological associate (if offered by their State), or LPC (or

equivalent), or "licensed mental health provider." Psychological associates adhere to the State licensing board's Code of Ethics and Conduct for psychologists or LPCs. Specific clinical privileges are granted based upon training, experience, and competency. In general, psychological associates will:

(1) Conduct an intake interview of assigned patients to include the history of the presenting problem, a psychosocial history, as well as a mental status evaluation, and any relevant behavioral observations.

(2) Conduct screening evaluations, utilizing information from clinical interviews, nonpsychometric tests, and collateral sources, as appropriate.

(3) Recommend an assessment strategy sufficient to answer the diagnostic question presented.

(4) Administer and score all psychological tests used in the assessment and present the data in a format to facilitate evaluation of the data.

(5) Determine a provisional diagnosis according to the Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

(6) Prepare, under the general supervision of a licensed psychologist, a report or evaluation that includes the presenting problem, all pertinent historical data, information from collateral sources, and psychological testing. Integrate all data to facilitate conclusions and recommendations.

(7) Provide feedback to patients on the results of the psychological evaluation.

d. Supervision

(1) Master's level graduates will be fully supervised during their first year of employment and will work under the direct supervision of a licensed psychologist. Thereafter, the work product will be fully reviewed and general supervision provided by a licensed psychologist according to the individual's level of competence, as assessed by his or her supervisor.

(2) Licensed psychology associates (or LPCs) with 2 or more years' experience (after attaining licensure) will receive general supervision by a licensed psychologist according to the individual's level of competence, as assessed by his or her supervisor.

(3) Licensed psychology associates (or LPCs) with more than 2 years' experience and with a post-master's specialty degree - such as the Ed.S. - require supervision in their specialty only with difficult, high-risk cases, or for cases in which one or more of the patient's problems fall outside the scope of the associate's training.

20. SPEECH PATHOLOGIST

a. Description. Speech pathologists diagnose and treat speech, voice, and communication deficits of Service members and other beneficiaries by prescribing appropriate treatment and, when necessary, providing referral for medical intervention.

b. Professional Credentials

(1) Education. Speech pathologists are required to have a master's or doctoral degree in speech pathology from an accredited institution.

(2) Licensure. Speech pathologists will maintain a current, active, valid, and unrestricted license, registration, or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) Certification. A Certificate of Clinical Competence from the American Speech-Language-Hearing Association is required.

c. Scope of Practice. Speech pathologists follow the guidelines published by the American Speech-Language-Hearing Association. They are privileged to provide comprehensive diagnostic and therapeutic procedures of the speech and voice mechanism. Those with advanced training and current competence may be privileged to perform advanced procedures such as electrophysiological measures of speech functions, acoustic analyses of voice production, fiber optic endoscopic evaluation of swallowing, modified barium swallow study, dysphagia therapy, stuttering treatments, and voice therapy.

d. Supervision. The speech pathologist will be supervised/provided oversight of his or her clinical practice by a more senior or experienced speech pathologist, as determined by the inpatient MTF Commander.

ENCLOSURE 9

CREDENTIALS REVIEW

1. GENERAL. Credentials are those documents presented by the health care professional, regardless of the nature of his or her practice or duty position, that constitute evidence of current licensure, certification, registration, or other authorizing document, as appropriate. In addition, professional credentials substantiate relevant education, training, and experience; current competence and judgment; and the ability to carry out the duties and responsibilities of the assigned position or, for the privileged provider, to perform the privileges requested.

2. INPATIENT MTF AND JPC AUTHENTICATION OF PROFESSIONAL CREDENTIALS

a. Review and Primary Source Verification (PSV) of the authenticity of credentials for all professional health care personnel is mandatory. In no instance will an individual be assigned or privileged to perform professional duties unless appropriately qualified by education, training, and experience.

b. Verification of credentials, as stipulated in this enclosure, will be accomplished for all categories of privileged and non-privileged Federal employees: AD military, civil service, consultant status, contract, or volunteer health care practitioners (includes new medical school graduates and trainees completing GME in civilian deferred status). For all privileged providers, inquiry will also be made to the NPDB prior to the initial granting of clinical privileges when expanding or adding new clinical privileges, and at each biennial renewal.

(1) Non-privileged staff. Verification of non-privileged professional credentials for RNs and LPNs is managed by the inpatient MTF Credentials Office. Verification of all other non-privileged professional credentials is managed by the department with which they are affiliated. The professional credentials that will be primary source verified and annotated in the individual's Joint Training File or other locally prescribed training file will include but not be limited to:

(a) Academic. Pre-existing academic achievement is verified prior to military accession. Pre-employment verification of academic credentials for civilians (civil service, personal services contract, and volunteer) is the responsibility of the inpatient MTF or, as appropriate, the JPC. Health-care-related professional degrees attained while employed by the Federal Government will be verified by the inpatient MTF or, as appropriate, the JPC. The inpatient MTF Credentials Office will assure a copy is maintained in the Joint Training File.

(b) Licensure/certification/registration or other authorizing documentation. For new military accessions, PSV of an existing license(s) prior to entry into Federal service will be accomplished by the member's Service Headquarters. The inpatient MTF Credentials Office is responsible for PSV of license for recently assigned non-privileged RNs and LPNs; departments are responsible for all other non-privileged providers. The contracting agency will verify licensure with the primary source for non-personal services contract personnel prior to the

employee being assigned to the inpatient MTF or JPC for duty. For military and civilian employees, periodic license renewal, as determined by the issuing State/national agency, will likewise be authenticated with the primary source by the responsible inpatient MTF or JPC authority. The contracting agency is responsible for PSV of licensure/certification/registration renewal for non-personal services contracted employees. This requirement applies to all non-privileged personnel who possess a license, certification, or registration as a professional credential.

(c) State or national specialty skills certification. This includes those offered by the ANA or other professional organization, mammography skills certification for radiology technicians, and so forth.

(d) Authentication of other discipline-specific skill or technical training to include DoD-sponsored training. This excludes in-service education and other locally established training requirements.

(2) Privileged staff. Privileged provider credentials are verified, updated, and maintained during the individual's tenure within the JOA by the inpatient MTF credentials manager. Professional information about the privileged provider is contained in both the Provider Credentials file (PCF) and the Provider Activity file (PAF).

(a) The PCF is the primary repository of permanent information related to provider credentials and performance. The contents must remain intact and the security of the information ensured at all times. Any request by the subject provider for amendment of information contained in the PCF (for example, correction of erroneous or inaccurate information, or the removal of improperly filed documents) must be considered under the provisions of the Privacy Act and Service-specific guidance. The PCF will be released only to the inpatient MTF Commander, Center Director, the credentials committee, department/service chiefs, recognized reviewing authorities, or officially appointed inspectors. The provider may authorize, in writing, release of his or her PCF to others, but the PCF should be retained in the credentials office with authorized access in that secure location. See Enclosure 20 for additional information regarding the PCF.

(b) The PAF is considered a working file that contains a variety of clinical data that are used to profile the provider's practice, to periodically reevaluate performance, and to reappraise privileges. Selected contents of this file (see Enclosure 20 for specific information regarding the contents and organization of the PCF) are transferred to the PCF, according to local procedures, for permanent inclusion in the PCF. Other contents should be maintained for a minimum of 2 years to allow tracking and trending of provider clinical performance data and other information considered significant to the organization from a business or clinical perspective.

(c) Both the PCF and the PAF contain sensitive, confidential information. The documents contained in these files qualify for protection under Reference (~~l~~*n*). (See Enclosure 20 for specific information regarding the contents and organization of the PCF.) To protect these files and to maintain the integrity of the contents, the PCF and the PAF must be stored in a secure location (for example, in a file cabinet, desk drawer, and so forth that can be locked). Access to either file is limited to authorized individuals only. The PAF can be retained in the

credentials office or by the department chief, with authorized access only in a secure location. If either the PCF or the PAF is required outside this area, personal delivery by the credentials coordinator (or designated individual) is recommended. The integrity of these files and security of the contents must be maintained at all times.

(d) A provider may, on request and in the presence of the credentials manager or other command representative, be allowed to review the contents of his or her PAF and PCF.

3. PRIVILEGED PROVIDER CREDENTIALING

a. The credentialing process includes a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment and reappointment to the medical staff, as well as delineation of individual clinical privileges. This information may also be the basis for subsequent action to expand or limit a provider's privileges.

b. Recommendations for the award of clinical privileges and medical staff appointment (if applicable) will be made by the department/service chief, acted upon by the credentials committee/function, and forwarded through the ECOMS to the commander for approval or disapproval. Recommendations from peers, who have firsthand knowledge of the applicant's competence, skill, and ability in the professional discipline, may be requested by the department chief *(See Figures 1-3 as samples)*. Peer recommendations may include written feedback from:

(1) The PI committee/function, the majority of whose members are the provider's peers.

(2) A department or clinical service chief who is a peer.

(3) The ECOMS, the majority of whose members are the provider's peers.

(4) A reference letter or documented telephone conversation about the provider from a peer who is a member of the inpatient MTF's or JPC's medical staff or who is from outside the organization. Peer recommendations will be maintained in the PCF and are filed with the recommendations by the provider's department or service chief.

4. INPATIENT MTF AND JPC CREDENTIALS COMMITTEE/FUNCTION. Central to the responsibility of assuring quality care and improving the performance of services rendered by privileged providers are the requirements for credentials review, delineation of individual clinical privileges for professional staff members, appointment/reappointment to the medical staff, and adverse privileging action hearing/appeals processes, as appropriate. These functions may be executed by the ECOMS or other group properly constituted to perform this series of activities, for example, the credentials committee. If the credentials committee is charged with these responsibilities, the ECOMS must review and concur with all recommendations for actions

associated with provider privileging and medical staff appointment/reappointment prior to their consideration by the commander.

a. Purpose

(1) The credentials committee/function reviews the credentials and the performance of each provider requesting clinical privileges and appointment to the medical staff. Subsequent to this review, recommendations for provider privileging/appointment actions, to include those for Reservist/National Guard providers for whom the committee has privileging responsibility, are made through the ECOMS to the commander. The committee's recommendations relevant to a provider's request for privileges are based upon his or her credentials, performance data, departmental peer recommendations, and the needs and capabilities of the institution.

(2) The credentials committee/function will also consider and recommend to the commander whether providers in a less-than-fully privileged status should be allowed to function under clearly defined supervision, or released to their Service/civilian employment.

(3) No action recommended by the credentials committee/function is final until it has been reviewed by the ECOMS and approved/signed by the commander.

b. Membership and Duties. The inpatient MTF Commander will designate the Assistant Chief of Staff (or other senior physician) as ECOMS chairperson and will name the permanent members and a designated alternate for each member of the committee. Alternates will exercise all the duties and responsibilities of the permanent voting member whom they represent.

(1) The chairperson will ensure that all assigned members receive appropriate orientation to assume the duties and responsibilities of this committee.

(2) Membership will reflect the diversity of privileged providers practicing within the inpatient MTF and JPC. Every effort should be made to ensure each Service is represented. The majority (51 percent or greater) will be privileged physicians.

(3) No action on a provider will be taken without the presence of a majority (51 percent or greater) of the voting membership.

(4) The chairperson may request the presence of a legal advisor (nonvoting).

(5) The senior nurse executive (that is, the Chief Nurse/DCN) is a voting member.

(6) At least one voting member of the same discipline, if available, will be present when clinical privileges for a nonphysician provider are considered.

(7) Members in the same discipline as the provider being evaluated should be present when the committee acts on the credentials of such providers. This is not mandatory for actions on temporary or supervised privileges.

(8) When the credentials of any member of the group are being considered, that member

will be excused from that portion of the meeting. This will be reflected in the minutes/reports.

(9) The review of credentials and privileges for the inpatient MTF Commander or, as appropriate, JPC Director will be performed as described below.

(10) Each inpatient MTF and Center should consider including a member from each Service to be represented on the Credentials committee where possible.

c. Meetings and Reports. The credentials committee will meet, or the function initiated, as often as necessary to ensure the timely appraisal of credentials and to prevent the expiration of privileges. The chairperson will ensure there are written records of all actions recommended/taken by this group.

(1) Reports and recommendations of the committee are provided through the ECOMS to the commander.

(2) Those providers to be considered will receive 90-days' notice to review and update their credentials, as appropriate, and to submit a current request for privileges.

(3) The chairperson may schedule an on-call meeting, as directed by the commander, or as needed to:

(a) Evaluate provider requests for modification (augmentation or reduction) of individual clinical privileges.

(b) Evaluate the credentials of newly assigned providers (initial DoD assignment, following PCS/transfer, or temporary duty).

(c) Reevaluate providers who are in initial or restricted categories of professional activities.

(d) Consider or make recommendations to the commander that a provider's privileges be suspended, restricted, revoked, reduced, or denied.

(4) Voting is by a show of hands, or by written or electronic ballot, with either a "yes" or "no" vote; no abstentions are allowed. The chairperson will vote only in the event of a tie. Voting related to routine reprivileging actions may be accomplished by electronic means rather than paper ballot. Local policy will prescribe the application of, and any restrictions associated with, this method of credentials committee information dissemination and balloting. In the case of an adverse privileging action against a provider, or a controversial issue involving a particular provider, the voting may be by secret ballot. If a member believes he or she should be disqualified from voting for (or against) a given individual, a request with justification is submitted to the chairperson. If the request is granted, the minutes will reflect, by name, the member who has recused himself or herself from the vote.

(5) The minutes will reflect the total "yes" and "no" votes cast for each action. Voting by nonpermanent members of the committee is restricted to actions or privileges for members of

their respective discipline. Disqualified members will not vote.

5. PROVIDER CREDENTIALS VERIFICATION. Prior to being privileged and awarded appointment to the medical staff, PSV of those provider's credentials that require such verification will be accomplished. Other credentials, as noted below, will be verified as true and authentic:

a. Credentials for which renewal is not appropriate (diploma, certificate of internship, and so forth) need only be primary source verified once if the individual maintains continual employment within the Department of Defense. Credentials that require periodic renewal will be verified upon renewal. The privileged health care provider's license is the only exception, as described below.

b. For civil service, consultant status, personal services contract, or volunteer health care privileged providers, credentials verification by the inpatient MTF or JPC, as appropriate, is required. Verification of the applicant's education, training, experience; licensure; certification and/or registration; current competence; and ability to perform the requested privileges or scope of practice is required. The inpatient MTF credentials manager (or other, as designated by the commander) will ensure that PSV of all credentials has been accomplished prior to position appointment/placement of the nonmilitary employee/volunteer. See Enclosure 21 for Civilian Personnel Operations Center (CPOC)/ Civilian Personnel Advisory Center (CPAC) duties/responsibilities associated with prospective employee credentials.

c. For the non-personal services contract privileged provider, the contract will specify who is responsible for PSV of the provider credentials.

d. The primary source for verification of a credential is the original source of the specific document. The primary source attests to the accuracy of a qualification. A reasonable effort must be made to verify, with the primary issuing authority, all documents that require PSV. These documents become part of the PCF. Unsuccessful attempts made to obtain verification of a credential from the primary source will be documented.

e. Documents may be primary source verified by one of the following methods (listed in order of preference):

(1) Written confirmation directly from the issuing authority.

(2) Verbal telephone confirmation from the issuing authority. A detailed record of the telephone interaction will be made in the PCF to include the name of the individual contacted, the date/time, and the signature of the person responsible for verification.

(3) American Medical Association (AMA) master file verification of U.S. medical school graduation and U.S. residency program completion. The American Osteopathic Association (AOA) provides a similar service for osteopathic physicians. Profile entries in either the AMA or AOA master files are only valid if they have been annotated as "Verified."

(4) For World Wide Web PSV, such verification is acceptable if the information is obtained directly from the professional organization's Web site. The identification of the individual making the Web site contact and the date will be annotated on the Web page printout and this will be entered in the PCF. Any discrepancy between information provided by the applicant and that on the Web site should be pursued by personal contact with the professional organization.

(5) For touch-tone telephone PSV, electronic access by telephone of a database is acceptable only if the other methods listed above are not available. The individual responsible for telephone verification will annotate in the PCF the date, time, his or her signature, and why this was the only verification method available.

f. When certificates (for example, BLS, ACLS, specialty board) are renewed, the credentials manager (or other individual as designated by the commander) must view the original renewal certificate and annotate on a photocopy of the document, "I certify this is a true and valid copy of the original." The photocopy will be signed, dated, and entered in the PCF. If verification documentation from the primary source is available for inclusion in the PCF, or other appropriate file (non-privileged professional), the requirement to photocopy the official document(s) does not apply.

6. PCF. The credentials information that originates during the pre-employment/accession application period serves as the basis of a comprehensive record (the PCF) that originates at the first unit of assignment/employment and is maintained and routinely updated throughout the provider's entire period of employment with the Federal Government. The contents of this record are permanent; however, data determined to be either erroneous or inaccurate will be removed. See Enclosure 20 for additional information regarding the PCF. The credentials contained in the PCF include the following:

a. Qualifying degrees, diplomas, ECFMG, Fifth Pathway, or other discipline-specific certificate, as appropriate. Those credentials will be primary source verified

(1) If the ECFMG certificate is dated prior to 1986, medical school graduation must be verified. (Prior to this date, the ECFMG did not verify graduation from medical school before issue of the certificate.)

(2) The inpatient MTF or JPC, as appropriate, will notify JTF CapMed who will telephonically contact JTF CapMed for guidance and assistance when:

(a) The medical/dental diploma was issued by a school in a foreign country that has no diplomatic relations with the U.S. and direct communication to primary source verify the diploma or other credentials is not possible.

(b) There are other concerns regarding the diploma or the foreign medical/dental school.

(c) PSV of credentials by a source outside the U.S. in a reasonable period of time is

not forthcoming.

b. State licenses, registrations, certifications, other authorizing documents, and current renewal certificates.

(1) A list of all licenses ever held will be provided along with an explanation of any that are not current or those have ever been subjected to disciplinary action. The provider's signature on this form indicates that the list and any related explanation are complete and accurate.

(2) Licensure of providers will be verified with the primary source at the time of:

(a) Staff appointment and initial granting of clinical privileges,

(b) Reappointment or renewal/revision of clinical privileges, and

(c) Renewal of an expired license.

c. Postgraduate training certificates (for example, residency, fellowship, nurse midwifery, nurse anesthesia school).

d. Specialty board certificates and certificates of renewal will be subject to PSV with the issuing board, or by referencing the AMA or AOA master files. The publication, "Official ABMS Directory of Board Certified Medical Specialties" (at http://www.abms.org), is now a recognized site for PVS and may also be used. The ABS directory only includes those specialty boards that are members of this organization. It is not necessary to delay the award of regular privileges pending verification of board certification if all other credentials are in order.

e. A dated curriculum vitae to account for all periods of time subsequent to obtaining the initial qualifying degree.

f. Proof of current (within 2-year) competence. This may include letters of reference/peer recommendations from a program or department director, or peer, describing the scope of practice and/or clinical privileges in the department/service/setting in which the applicant is currently practicing. A copy of the most recent list of privileges with evaluation of the provider's performance related to assigned privileges from the current or previous place of employment/assignment may be included, if available. The extent and description of recent clinical privileges will be verified.

g. Malpractice insurance history as requested on "Malpractice History and Clinical Privileges Questionnaire" with narrative comments, as appropriate.

(1) Explanation of any malpractice claims, settlements, or judicial or administrative adjudication with a brief description of the facts of each claim settled on the behalf of the provider.

(2) Dates of malpractice coverage and history of suits and claims verified for the 10 years prior to initial application.

(3) Verification with the insurance carrier of all self-reported suits and claims.

h. Detailed explanation of adverse clinical privileging and/or disciplinary action by institutions, State licensure boards, or other governing or regulatory agencies and those by any civilian medical or dental facility where the privileged provider is employed or practicing. This will include voluntary or involuntary termination of professional and/or medical staff membership or voluntary or involuntary suspension, restriction, reduction, or revocation of clinical privileges at a hospital or other healthcare delivery setting and any resolved or open charges of misconduct, unethical practice, or substandard care. The "yes" and "no" questions on Malpractice History and Clinical Privileges Questionnaire with appropriate explanation capture this provider-specific information. A lapse between periods of clinical privileges that is less than 180 days, due to PCS, hospitalization, mobilization, and so forth, is not considered an adverse circumstance or voluntary termination and does not require explanation as described here.

i. A statement by the applicant of his or her health status (physical, mental, and emotional health) relative to his or her ability to provide healthcare and to perform the privileges requested. Such a statement is required on page 2 (block 9) of Malpractice History and Clinical Privileges Questionnaire. Validation by another privileged provider familiar with the individual and his or her health status will be noted in separate memorandum to the credentials committee or as a comment in Section II, Delineation of Clinical Privileges, by the provider's supervisor.

j. The letters of reference/peer recommendations submitted with the application for Federal service are referred to in this document as letters of reference. These same letters of reference may be used for initial application for privileges/staff appointment; thereafter, for renewal of privileges/staff appointment written input in the form of peer recommendations may be required. The individuals providing the letters of reference or peer recommendations should be personally familiar with the subject provider's clinical, professional, and ethical performance. This written input will address the provider's medical knowledge, clinical judgment, and technical skills as well as his or her interpersonal skills, communication skills, and professionalism.

(1) Letters of reference. For initial privileges and staff appointment, a minimum of 2 current letters of reference from appropriate sources are required for verification of experience and current competence. To best represent the applicant being considered, these letters of reference should be dated within 12 months of submission.

(a) A letter from either the chief of the hospital medical staff, the clinic administrator, the professional supervisor, or the department head, where the appointee has current clinical privileges or is professionally associated.

(b) A letter from the director or a faculty member of the appointee's training program, if the appointee was in a training program within the last year.

(c) A letter from a provider (in the appointee's discipline, if possible) who is in a position to evaluate the appointee's professional standing, character, and ability (for example, a peer or a president or secretary of the local professional society). A letter of reference from both

a peer and a professional association or society is mandatory if the appointee is self-employed.

(d) The non-board certified physician who alleges to be a specialist requires 2 letters of reference attesting to his or her clinical competence by physicians certified in the specialty in which the non-board certified physician is practicing. For the physician who has not completed his or her initial period of qualification for board certification, 2 letters attesting to the applicant's clinical competence are required from board certified specialists who have current knowledge of his or her clinical practice.

(2) Peer recommendations. For providers (AD, Reservist/National Guard, civilian, volunteer, and contracted personnel) with current privileges, peer recommendations will be submitted every 2 years as part of the clinical privileges/staff appointment renewal process.

k. A copy of the provider's Federal narcotics license with current and prior Drug Enforcement Agency (DEA) or Controlled Drug Substance (CDS) numbers, as appropriate.

l. A current NPDB report on each provider. Conducting an NPDB query within 24 months of the previous query is permissible. However, under no circumstances will a provider's query interval exceed 24 months. Query of the NPDB will occur:

(1) By the appropriate recruiting agency at the time of application for employment or appointment (military accessions). This report may be used at the initial duty station if dated within 1 year.

(2) By the inpatient MTF or JPC at the time a provider initially applies for clinical privileges (initial duty station or place of employment), when expanding or adding new clinical privileges, and every 24 months thereafter as part of the clinical privileges reappraisal (renewal) process.

(3) If initial privileging occurs more than 1 year after the NPDB query for entry on AD. In this case, querying the NPDB will be required as part of the initial privileging process.

(4) By the facility providing training or serving as the site of assignment, if necessary, for Reservist/National Guard providers. If a valid NPDB query is present in the provider's PCF, re-query is not necessary.

m. Evidence of current BLS certification. ACLS or ATLS, PALS, or APLS, and/or the Neonatal Resuscitation Program may be additional performance requirements, but these are not a substitute for the BLS requirement.

n. Evidence of approved continuing medical/health education. Such evidence will be accumulated by the provider for intervals of not less than 2 years and made available to the credentials manager for initial privileges/appointment and for biennial renewal. The annual requirement for CME credits according to Service-specific guidance or as determined by the provider's State of licensure, whichever is more stringent.

o. Criminal history background checks (CHBCs) for all contract and volunteer providers

who care for patients under the age of 18. Other providers (AD, Reservist/National Guard, and civil service) do not require a CHBC as this security check is routinely performed as part of the new accession/employment process. Contracting agencies are responsible for performing the CHBC on their employees for whom this investigation is required.

(1) For non-personal service contract personnel, the contractor is responsible for completion of CHBCs and must forward results to the gaining inpatient MTF or JPC, as appropriate. As addressed in local policy, the inpatient MTF or JPC, as appropriate, must ensure the CHBC has been completed prior to allowing the contracted provider to care for patients under the age of 18. For personal services contract personnel, the inpatient MTF or, as appropriate, the JPC is responsible for CHBC completion.

(2) Pending completion of the CHBC, the provider's practice will be supervised. The commander will determine the level of supervision that is required. The plan for supervision, with designated supervisor noted, will be in writing.

(3) See DoD Instruction 1402.5 (Reference (~~s~~*u*)) for additional information.

p. Special requirements for radiologists providing mammography service. The Mammography Quality Standards Act imposes specific requirements on radiologists who are involved in providing mammography service. These providers will abide by Mammography Quality Standards Act requirements and submit the appropriate documentation for inclusion in the PCF. (Refer to Reference (~~j~~*l*)). The Mammography Quality Standards Act can be found on the Internet at http://www.fda.gov/cdrh/mammography/frmamcom2.html.

q. Special requirements for physicians providing nuclear medicine services. The radiopharmaceuticals used in nuclear medicine may only be prescribed by providers who are "authorized users" under the facility's nuclear regulatory commission license. For regular privileges in diagnostic nuclear medicine, the provider must submit documentation that he or she is an authorized user at the facility. For privileges in therapeutic nuclear medicine, there must be specific approval as an "authorized user" in this capacity as well. Approval by the commander may be for all or selected therapies.

r. The national provider identifier (NPI)-Type 1 is a 10-digit provider-unique number assigned by CMS to healthcare personnel, both privileged and non-privileged to identify providers on claims, prescriptions, referrals, and other healthcare related documents. MHS providers were required to obtain and begin using their NPI-Type 1 by May 23, 2007. The credentials manager will ensure that the NPI is entered into CCQAS and that a copy is maintained in the PCF.

7. PREVIOUS EXPERIENCE AND REFERENCE CHECKS. Every effort should be made to authenticate all provider credentials, stated experience, references, and other information contained in the PCF in a timely manner. Granting of clinical privileges and medical staff appointment, as appropriate, will be withheld until sufficient verified data to document training, experience, and current clinical competence are available.

a. In general, reference checks should not be limited to only those references noted by the provider on the application form. Providers will be notified that other individuals may be

contacted, as necessary.

b. Annotated records of each contact made with all personal and professional references will be maintained, to include names of all parties to the call, the date, and a summary of the conversation. Contacts will be advised that the providers may request and be provided this information.

8. PROVIDER ACTIVITY FILE (PAF). The PAF is the repository for supporting information and data to validate privileging of the provider by the inpatient MTF. See Enclosure 22 for suggested content of the PAF. Various PAF criteria definitions are contained in the Glossary.

a. A PAF will be established and maintained for each privileged provider. The cover of the PAF must bear the disclosure statement as noted in this Manual. It is a working file with contents considered confidential QA documents protected by Reference (~~k~~*m*).

b. Metric performance data, both qualitative and quantitative, and aggregate data from a representative peer group sample, are examples of the data contained in the PAF. The information and data contained are summarized and will be reviewed and evaluated by designated staff (peer level performance assessment) and by the department or service chief for biennial provider reprivileging/reappointment to the medical staff.

c. Any data included in the PAF that is not required for transfer to the PCF and is greater than 2 years old may be removed and destroyed according to local policy. (The provider will be given the opportunity to keep any productivity and computer-generated data prior to its destruction.) Data determined to be either erroneous or inaccurate will be removed from the PAF and in accordance with local policy.

d. The contents of the PAF may be used by supervisors for administrative purposes (for example, counseling, evaluation reports, preparation of GPHE documentation, and letters of reference or peer recommendations).

9. INTER-FACILITY CREDENTIALS TRANSFER BRIEF (ICTB)

a. The ICTB is a computer-generated summary of information contained in the PCF. It is a standardized format (see Enclosure 23) for transmittal of privileged provider credentials information across the MHS under Reference (~~o~~*q*). Reference (~~o~~*q*) may be used for all categories of privileged providers to include uniformed military (AD/Reservist/ National Guard); civilian (civil service employees, contractors (personal services only), resource sharing); VA; and nonmilitary uniformed providers (for example, Public Health Service). This document may be maintained in a temporary PCF created by the gaining facility.

b. When a DoD provider is temporarily assigned to another inpatient MTF or JPC for clinical practice, the sending inpatient MTF or, as appropriate, JPC must convey all relevant credentials and privileging information to the gaining inpatient MTF or JPC. The receiving

commander uses this information as the basis for assessing current clinical competence and making appropriate privileging and staff appointment decisions in a timely manner.

(1) Non-personal services contract personnel (that is, individuals working for the Government, yet employed by a non-Federal agency) are not authorized temporary assignment to another inpatient MTF or JPC. Assignment for duty is only as stipulated in their contract. Use of an ICTB is not authorized.

(2) Providers (AD/Reservist/National Guard) mobilized/activated in support of covert operations (that is, a command structure with privilege granting authority may not be known or available) do not require an ICTB. While the provider is temporary duty in this capacity, his or her PCF may be placed in an inactive status at the sending facility. The PCF will be closed out and archived. Credentials committee minutes will reflect those providers whose PCF is in an inactive status. Upon return from deployment, the PCF will be reactivated and updated, as necessary, prior to the provider resuming assigned patient care duties.

c. The ICTB must include:

(1) Discipline-specific Delineation of Clinical Privileges Form for privileges being requested.

(2) Approval of Clinical Privileges/Staff Appointment Form with top portion completed.

(3) A copy of the current Delineation of Clinical Privileges Form for clinical privileges held at the sending facility.

(4) Completed Malpractice History and Clinical Privileges Questionnaire.

(5) Two peer recommendations, dated within 24 months of submission, for providers who do not hold current military clinical privileges.

(6) Authorization for release of information signed by the provider (may be specific to the gaining inpatient MTF or, as appropriate, JPC, if provided).

d. The ICTB and required attachments accompany the formal application for privileges by the privileged provider. Information that appears in the ICTB need not be duplicated on any forms that contain essentially like information. An annotation will be made on these forms, as appropriate, to "See ICTB."

e. Additional information regarding the ICTB is contained in Enclosure 23.

Figure 1. Sample Cover Letter Requesting Peer Recommendation

Professional Peer Recommendation

Name of Applicant _____ Name of Evaluator _____

Sample Peer Recommendation

Date

Facility Name
Facility Address

Regarding applicant: John Doe, M.D.
Specialty: General Surgery

Dear _____:

We have received an application from the above-named provider for medical staff appointment and privileges. A copy of the privileges requested is attached. The applicant has listed you as a peer who will be willing to provide a recommendation. In order to process the application we require your evaluation of the applicant's experience, ability, and current competence in the areas of medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

Our policies require completion of the enclosed form. Your failure to return this form will delay consideration of the applicant's request for privileges. You may supplement the form with additional information, if you so desire. The applicant has authorized you to provide this information to our organization via signature on the attached Authorization and Release Form.

Sincerely,

Medical Staff Coordinator

Figure 2. Sample Professional Peer Recommendation

Professional Peer Recommendation

Name of Applicant _____ Name of Evaluator _____

Relationship of applicant to evaluator _____

How often do you observe this provider's clinical care abilities?	Never; applicant is a personal acquaintance ☐	Rarely ☐	Monthly ☐	Weekly ☐	Daily ☐

Do you (or would you) refer your patients to the applicant?	Yes ☐	No ☐
If no, please explain. _____		

PLEASE RATE THE PRACTITIONER IN THE FOLLOWING AREAS	Excellent	Good	Fair	Poor	Unable to evaluate
Professional knowledge – Awareness of established and emerging biomedical, clinical, and cognate science as applied to patient care. Evidence of professional knowledge includes completion of formal educational and training requirements, on-the-job experience, in-service training, and continuing education.					
Clinical judgment - Observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, and inferences used to reach decisions, individually and/or collectively with other providers, about patient diagnosis and treatment.					
Technical skills – Possesses knowledge and psychomotor skills required to perform all procedures routinely required in provider's specialty.					
Interpersonal skills – Works effectively with colleagues, patients and their family members to provide patient-focused care as a member of a healthcare team. Demonstrates caring, compassionate, and respectful behavior.					
Communication skills – Demonstrates effective listening skills, nonverbal communication, ability to elicit and provide information, and good writing skills. Creates and sustains a therapeutic and ethically sound relationship with other care givers, patients, and their families.					
Professionalism - Responsive and accountable to the needs of the patient, society, and the profession as demonstrated by respect, compassion, and integrity. Committed to providing high-quality patient care and continuous professional development. Subscribes to an ethical approach to clinical care, patient confidentiality, informed consent, and business practices.					

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Figure 2. Sample Professional Peer Recommendation (continued)

Professional Peer Recommendation

Name of Applicant _____ Name of Evaluator _____

Relationship of applicant to evaluator _____

How often you observe this provider's clinical care abilities?	Never; applicant is a personal acquaintance ☐	Rarely ☐	Monthly ☐	Weekly ☐	Daily ☐

Do you (or would you) refer your patients to the applicant?	☐ Yes	☐ No
If no, please explain. _____		

PLEASE RATE THE PRACTITIONER IN THE FOLLOWING AREAS	Excellent	Good	Fair	Poor	Unable to evaluate
Professional knowledge – Awareness of established and emerging biomedical, clinical, and cognate science as applied to patient care. Evidence of professional knowledge includes completion of formal educational and training requirements, on-the-job experience, in-service training, and continuing education.					
Clinical judgment - Observations, perceptions, impressions, recollections, intuitions, beliefs, feelings, and inferences used to reach decisions, individually and/or collectively with other providers, about patient diagnosis and treatment.					
Technical skills – Possesses knowledge and psychomotor skills required to perform all procedures routinely required in provider's specialty.					
Interpersonal skills – Works effectively with colleagues, patients and their family members to provide patient-focused care as a member of a healthcare team. Demonstrates caring, compassionate, and respectful behavior.					
Communication skills – Demonstrates effective listening skills, nonverbal communication, ability to elicit and provide information, and good writing skills. Creates and sustains a therapeutic and ethically sound relationship with other care givers, patients, and their families.					
Professionalism - Responsive and accountable to the needs of the patient, society, and the profession as demonstrated by respect, compassion, and integrity. Committed to providing high-quality patient care and continuous professional development. Subscribes to an ethical approach to clinical care, patient confidentiality, informed consent, and business practices.					

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ENCLOSURE 10

PRIVILEGING PROCESS AND MEDICAL STAFF APPOINTMENT

1. GENERAL. Privileging is the process whereby a specific scope and content of patient care services (delineated clinical privileges) are authorized for a healthcare provider by the Privileging Authority. Such authority is based on an evaluation of the individual's credentials, performance, and the specific needs of the organization.

a. The privileging process is directed solely and specifically to the provision of quality patient care and is not a disciplinary or personnel management mechanism. Privileging actions may, however, accompany actions of an administrative or judicial nature or may engender such actions.

b. A number of privileging actions, both routine and adverse, are available to the commander at the recommendation of the credentials committee. The routine privileging actions that are addressed in this enclosure include privilege approval (with or without restrictions), privilege reappraisal, and privilege renewal. Adverse privileging actions include privilege restriction, reduction, suspension, revocation, and denial. These, and the non-adverse privileging action of placing a provider's privileges in abeyance and summary suspension, are discussed in Enclosure 11.

c. Privileges are facility-specific. As such, the facility's characteristics, supportive resources, and staff are considered in the privileging decisions.

d. Each department or service chief will develop criteria relevant to the award of clinical privileges for the department or service and will identify what privileges are appropriate for the scope of work in the given setting. Delineation of Clinical Privileges Forms provides basic privileging criteria and other information that are applicable to the practice discipline. The form provides space for comments and privileges to be added, as needed, based on the inpatient MTF's or JPC's scope of services, the provider's experience, and the DoD beneficiary healthcare requirements. While the criteria for award of privileges and the specific privileges pertinent to each department are the responsibility of the department/service chief, the Privileging Authority grants clinical privileges.

e. Providers will be granted clinical privileges appropriate to the settings in which they practice. This includes various departments, services, clinics, and the emergency center/service/department, both within and outside the inpatient MTF or JPC.

f. Where full performance in a given civil service position requires the incumbent to be privileged, obtaining and maintaining clinical privileges in good standing is deemed a condition of employment.

(1) In this Manual, "good standing" requires that the employee is:

(a) Not in a remedial training program.

(b) Able to practice independently.

(c) Functioning with privileges that have not been reduced, restricted, suspended, revoked, or denied.

(2) For civilian employees whose privileges are not in good standing, the inpatient MTF Commander or JPC Director may elect to:

(a) Terminate the employee.

(b) Change the employee to a position at a lower grade (may be voluntary or involuntary).

(c) Reassign the employee to a position for which privileges is not required (may be voluntary or involuntary). Any financial incentives associated with the previously held position shall be terminated.

g. Reappraisal of defined clinical privileges will take place at least every 24 months (prior to the renewal of privileges) and when a provider is reassigned to a new duty station. Renewal of clinical privileges is based on the provider's professional qualifications and demonstrated competence to perform the privileges requested. Providers who are assigned to nonclinical duty positions who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges. These individuals will only be privileged if they are expressly engaged in patient care activities appropriate to the discipline in which they are requesting privileges. The medical staff bylaws will address how the current competence of providers in administrative positions will be assessed for reappointment and clinical reprivileging. Examples of criteria that may be considered include, but are not limited to, department/service chief interview; documented continuing education/training; the acceptable interval between performance of procedures that are identified as complex, high-risk, or problem-prone; available patient outcomes assessment data; and clinical practice hours per month/year.

2. PRACTITIONERS WHO MAY BE PRIVILEGED

a. Healthcare practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged. In this Manual, practitioners who are granted privileges are referred to as providers. Providers include audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, dentists, dietitians, nurse anesthetists, nurse midwives, NPs, OTs, optometrists, PTs, physicians, PAs, podiatrists, psychological associates, speech pathologists, and substance abuse rehabilitation counselors. Also included are CNSs, CHNs, and OHNs who, in selected circumstances and at the discretion of the commander, may be granted clinical privileges (see Enclosure 8) and specialists in Blood Banking.

g. Members of the healthcare staff who function under a standard job description in the performance of their duties - utilizing practice guidelines or standing policies and/or procedures - do not require clinical privileges. Department/service chiefs are responsible for the ongoing assessment of the competence of personnel to safely perform assigned duties. For those who are not privileged, an internal certification process may be used to designate selected personnel who have achieved the competence needed to perform specific complex, high-risk, or problem-prone clinical functions.

h. Special privileging considerations are as follows:

(1) Commander/ACOSECOMS. Approval of privileges (to include periodic privilege renewal) and appointment to the medical staff for the ACOSECOMS and the commander will be as follows:

(a) The Commander/ACOSECOMS will submit his or her application for privileges and request for medical staff appointment through the appropriate department chief.

(b) The ACOSECOMS is excused from the credentials committee meeting (if he or she is being reviewed), and the remaining senior member of the credentials committee will act as chairperson.

(c) The credentials committee recommendations regarding clinical privileges and medical staff appointment for the ACOSECOMS will be submitted through the ECOMS (inpatient MTFs or, as appropriate, the JPC) to the Privileging Authority.

(d) For commanders, the credentials committee recommendations regarding clinical privileges and medical staff appointment and all supporting provider documentation will be forwarded to the Commander, JTF CapMed.

(2) Emergency or disaster situations. Scope of practice limitations as defined by the clinical privileges granted by the inpatient MTF or JPC may be ignored only in bona fide emergency circumstances (see Glossary) or disaster situations. In such cases, providers are expected to intervene and to do everything possible to save the patient's life or to prevent injury, or to effectively respond to a significant increase in demand for medical treatment. This includes requesting consultation with available medical resources and coordinating care and services as appropriate.

(3) The Armed Forces Medical Examiner System. This system, as addressed in DoD Directive 5154.24 (Reference (~~t~~*v*)), authorizes medico-legal death investigations for all DoD inpatient MTFs or JPC. The range of support includes onsite autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their Armed Forces Medical Examiner credentials to the commanding officer. An application for medical staff appointment with clinical privileges is not required for this service.

(4) The Organ and Tissue Procurement Program. Organ donation and transplant

conducted by organ and tissue procurement teams, and the related treatment provided within inpatient MTFs or JPC is addressed in DoD Directive 6465.3 (Reference (~~u~~*w*)). These personnel are authorized to perform their duties in Federal facilities without formal credentials review and privileging. However, the individuals assigned to support these programs will present sufficient documentation (for example, official orders, assignment letter, or identification card) to the inpatient MTF Commander or, as appropriate, the JPC Director to establish their authorization to perform these services.

(5) Musculoskeletal Manipulations. Musculoskeletal manipulations involve palpation and other manual techniques used to evaluate and correct somatic dysfunction that impairs or alters function of the somatic systems. These include the skeletal, arthrodial, myofascial, vascular, lymphatic, and neural systems. This does not refer to the spinal or peripheral joint manipulations commonly used by PTs that are included in their accepted standard scope of practice as defined by the American Physical Therapy Association. The following policy guidance applies to the performance of musculoskeletal manipulation procedures.

(a) Privileged provider - other than doctors of osteopathy, PTs, and chiropractors for whom manipulation is considered part of their routine scope of practice - with evidence of appropriate education, training, and experience acceptable to the credentials committee may be granted specific privileges to perform musculoskeletal manipulations.

(b) Only specifically privileged physicians (Doctor of Medicine or Osteopathy) may perform manipulation procedures using general anesthesia or intravenous medications. An appropriately privileged anesthesiologist or nurse anesthetist will administer the required anesthesia or sedation for these procedures.

(6) Privileging for New Medical Procedures and Technology. The privileging process remains the same. Particular attention will be focused on provider training, experience, and competence and inpatient MTF or JPC capabilities in granting privileges for use of recently developed or approved technologies and equipment.

(a) New procedure. Prior to the introduction of a substantially new and innovative procedure into an inpatient MTF or the JPC, the commander will ensure that privileging criteria are developed at the departmental level and endorsed by the credentials committee. The criteria will include the specific preparatory training providers must complete prior to being granted the privilege to perform the new procedure. The privileging process for providers will be accomplished prior to the procedure being performed on eligible beneficiaries.

(b) New technology. Inpatient MTF Commanders or JPC Director will ensure that new technology (for example, robotics) does not surpass the staff's abilities. Inpatient MTF Commanders or JPC Director will establish safety protocols for an instrument's use and provide for proper privileging procedures prior to the application or use of the new technology. The plan for implementation of new technology must include training of non-privileged support staff. Adverse patient outcomes involving equipment malfunction will be reported according to inpatient MTF or, as appropriate, JPC policy and will include notification of the PS manager/risk manager.

(7) Miscellaneous Privileging Issues

(a) Telemedicine. Telemedicine involves electronic communication or other communication technologies to provide or support clinical care at a distance.

1. The medical staff will determine which clinical services are appropriately delivered via telemedicine link. Telemedicine encounters require written informed patient consent before the use of said technology. All medical information generated in the delivery of telemedicine will be properly documented and archived in the medical record. Any patient information associated with telemedicine, in either electronic or paper format, is subject to current HIPAA standards.

2. Providers who write orders or direct care/treatment/services via telemedicine must be privileged by the facility receiving this service. The ICTB and a copy of the delineation of privileges will be submitted to the privileging inpatient MTF or JPC; privileges will be granted for only the services to be rendered via telemedicine. Types of services that require privileges include, but are not limited to, those which involve video-teleconference or other direct interactions between patient and provider.

3. Providers who render official readings of images, tracings, or specimens or who provide only consultative advice do not require privileges at the receiving inpatient MTF or JPC. In such cases, the inpatient MTF or JPC must obtain and maintain a copy of the ICTB and delineation of privileges from the provider's MTF or JPC of assignment, but need not privilege the provider. Examples of these types of services include, but are not limited to, teleradiology (except mammography for which there are additional requirements), teleechocardiography, telepathology, and store-forward teledermatology.

4. The above paragraphs apply to telemedicine services among inpatient MTFs, JPC, and/or other military organizations, or the telemedicine programs within the JOA. When the telemedicine service is provided via contracted services, regardless of the type of service in question, the providers must be privileged before practicing in the receiving inpatient MTF or JPC. In instances where the contract for services described above is with a civilian hospital accredited by a nationally recognized external accrediting, licensing, and/or inspecting agency, the receiving inpatient MTF or JPC need not privilege the providers if provider information equivalent to that on an ICTB and his or her delineation of current privileges from the hospital are obtained and maintained on file at the inpatient MTF.

(b) Management of impaired providers. A physical or psychological condition that adversely affects (or has the potential to adversely affect) or limits an individual's ability to safely execute his or her responsibilities in providing healthcare can be considered an impairment. This includes alcohol or other drug dependency/abuse or mental health disorders. Typically, acute or chronic medical conditions will require a limited-duty profile or medical evaluation board (MEB) to decide fitness for duty of the military member. Comparable processes exist for the civilian employee with duty restrictions related to health problems. Such circumstances are managed as medical problems (short or long term) and are not considered impairments. The credentials committee/function will review the performance of privileged

providers who are impaired to determine to what extent their impairment hampers their ability to safely practice the privileges they have been granted. The provider's condition or impairment may require modification of his or her clinical privileges, as appropriate. For further information, see Enclosures 11 and 12.

(c) Dentists administering conscious sedation. As with all procedures, the award of specific privileges to a dentist to perform conscious sedation is based upon appropriate education, training, and experience. Because this skill is not part of basic dental education, specific training in this procedure must be obtained and documented before dentists can be authorized to administer conscious sedation.

(d) Complementary and alternative medicine. With the approval of the commander, these may be integrated into the broad array of healthcare and services offered to DoD beneficiaries by qualified providers. Privileges may be granted following the guidance in Enclosure 6 in this Manual.

(e) AD Navy providers must request the broadest scope of privileges commensurate with their professional qualifications, level of current competence, and the facilities' ability to support them. CCQAS will house the credentials files for all providers primarily privileged at WRNMMC and FBCH.

3. CATEGORIES OF CLINICAL PRIVILEGES. Clinical privileges define the scope and limits of independent patient care services that a provider may render within the granting healthcare organization. The three categories of clinical privileges that may be awarded are:

a. Regular Privileges

(1) Regular privileges grant the provider permission to independently provide medical, dental, and other patient care services in the facility within defined limits. Regular privileges are granted to providers only after full verification and review of credentials. Regular privileges will not exceed a 24-month period without renewal.

(2) In granting regular privileges, the commander will define the limits of those privileges to include whether or not enhanced supervision is required. The nature and extent of enhanced supervision will be delineated in writing. The commander will also specify limits on regular privileges based upon the inpatient MTF or JPC mission requirements and the ability to support the requested privileges.

(3) A provider granted regular privileges may be considered for any type of medical staff appointment as discussed elsewhere in this document.

b. Temporary Privileges

(1) Temporary privileges authorize a provider to independently provide medical, dental, and other patient care services on a time-limited basis to meet pressing patient care needs when

time constraints will not allow full credentials review. The use of temporary privileges should be rare. This category of privileges is appropriate in bona fide patient emergency situations or a declared disaster and is not intended for the administrative convenience of the department/ service. Temporary privileges will not exceed a period of 30 days and are not subject to renewal. Any subsequent request for consecutive privileges should be assessed to determine if regular privileges are more appropriate.

(2) Because the inpatient MTF or JPC has not conducted a thorough credentials review prior to granting temporary privileges, there is an added degree of risk relevant to the competency of the provider. In order to minimize the risk associated with granting temporary privileges, the following actions, as a minimum, will occur:

(a) A copy of the provider's license will be obtained and verified with the issuing agency.

(b) Telephonic contact will be made with the facility where the provider has regular privileges to verify that the individual is clinically competent, fully qualified, and that the requested privileges are within the individual's current scope of practice and privileges. The chief of the medical staff, department chair, or other appropriate authority may provide this information. Or, if available, the ICTB may be used for the purpose of granting temporary privileges.

(3) A complete, thorough credentials review will occur during the period of the temporary privileges.

(4) Temporary privileges may be granted with or without a temporary appointment to the medical staff.

(5) The use of temporary privileges is authorized for all categories of providers.

c. Supervised Privileges

(1) Supervised privileges are granted to providers who do not meet the requirements for independent practice because they lack the necessary license, certification, or other authorizing document. These providers are not eligible for a medical staff appointment and are unable to practice independently. Providers working under supervised privileges can practice only under a written plan of supervision with a licensed person of the same or a similar discipline.

(2) This category of privileges will not be granted to licensed providers, or providers holding other authorizing documents, even though the defined limits of their privileges include supervision.

(3) Supervised privileges should not be confused with enhanced supervision of practice offered to those privileged providers who, for a defined period of time, require oversight of their clinical practice.

(4) Supervised privileges will be granted for periods not to exceed 24 months. Providers who are required to have a license will obtain that license within the time frame specified in Enclosure 5. These providers may request regular privileges and a medical staff appointment once a license is obtained.

4. CLINICAL PRIVILEGING PROCESS

a. Forms Required for Award of Privileges. Performance data and other information to be considered in the privileging process are maintained in the PAF. These documents are transferred to the PCF, as appropriate, upon biennial renewal of the provider's clinical privileges, PCS, or separation from service/employment. The original will be placed in the PCF with a copy furnished to the provider. Providers will transition to use of the revised privileging documents addressed below at their next reappraisal/reprivileging opportunity. Providers will complete and submit all required privileging related information on electronic forms in CCQAS. If CCQAS is not available, equivalent paper forms will be used.

b. Initial Application for Privileges

(1) Upon arrival at the first duty station or place of DoD employment, the provider must submit a request for initial clinical privileges. The request will include the required CCQAS electronic forms.

(2) The request will be reviewed by the department or service chief, who will properly code each privilege requested according to the appropriate category. The recommendation by the department or service chief for the award or the limitation of privileges requested will include specific rationale or justification of same in the "Comments" area (Section II). The request will then be forwarded to the inpatient MTF credentials committee/function for review.

(3) The provider's validated credentials and the completed forms serve as the basis for the granting of clinical privileges. The credentials committee/function will forward its recommendation for clinical privileges and medical staff appointment (if applicable) through the ECOMS to the facility commander.

(4) The commander is the approving authority for the award of clinical privileges and medical staff appointment. The commander's signature authorizes clinical privileges and staff appointment, if appropriate, based on the individual provider's licensure, education and training, experience and his or her demonstrated professional competence.

(a) Approval of the Clinical Privileges and Staff Appointment Form (in CCQAS) will be the record of the executive level medical staff recommendations and the commander's decision concerning the clinical privileges and medical staff appointment of providers. Credentials committee/function minutes/reports will reflect deliberations made by this committee regarding both privileging and appointment status for each provider.

(b) When privileges are modified from those requested, the reason will be stated in block 7. (Examples of such reasons include lack of technological resources, lack of support staff, privileges unauthorized by JTF CapMed, lack of provider credentials, lack of demonstrated competency, or lack of professional performance.)

(5) The authenticated copies of CCQAS Delineation of Clinical Privileges and Approval of Clinical Privileges/Staff Appointment serve as notification to the provider of the award/renewal of his or her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared. (See Figure ~~1~~*3*) The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager (See Figure 2).

Figure ~~1~~*3*. Sample Format for Memorandum Notifying Provider of Clinical Privileges and Medical Staff Appointment Status

(MTF Letterhead)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Applicant's name, Department/Service)

SUBJECT: Clinical Privileges and Medical Staff Appointment Status

1. Your application for clinical privileges and medical staff appointment at (MTF NAME)was reviewed by the credentials committee at the (date) meeting. Based on review and recommendations of that committee, and the executive committee of the medical staff, and approval by the Privileging Authority (MTF name), clinical privileges are granted as specified at enclosure.

2. You are granted (specified category) privileges for the period (date) through (date) as specified on the enclosure.

3. You are granted a/an (specify status) appointment to the medical staff for the period (date) through (date) as indicated on the enclosure.

4. Two copies of the memorandum and attachment are provided. Please acknowledge receipt on the attached memorandum and return the original to the credentials office. The second copy of the memorandum, a copy of your delineated privileges, a copy of the approval of clinical privileges/medical staff appointment, and a copy of the plan of supervision, if applicable, are provided for your files.

ENCL: as

Signature Block
Credentials Manager

Figure ~~2~~4. Sample Format for Provider Acknowledging Receipt of Notification of Clinical Privileges and Medical Staff Status

S: (Suspense date)

PROVIDER'S OFFICE SYMBOL Date

MEMORANDUM FOR: Commander, MTF

SUBJECT: Receipt of Notification of Clinical Privileges and Medical Staff Status

I hereby acknowledge receipt of a copy of the letter granting me clinical privileges (to include/but not to include admitting privileges) and (appointment to the medical staff.) A listing of my approved clinical privileges (and plan of supervision) as addressed in the memorandum from the commander has also been provided. I understand that I am granted 10 duty days from receipt of this memorandum to appeal the commander's decision, should I disagree.

(Signature of Provider)

(Typed Name)
(Grade, Corps)

c. Periodic Reappraisal and Renewal of Privileges

(1) Provider performance will be continuously monitored through facility-specific ongoing performance assessment activities to ensure that quality patient care is rendered. Providers are responsible for submitting CME, continuing dental education, or documentation of other discipline-specific professional education, licensure renewals, BLS certification renewals, and other certification renewals or credential updates to the PCF manager in a timely manner.

(2) Clinical privileges are in effect for a period not to exceed 24 months from the date granted. It is the responsibility of each provider to request the renewal of his or her clinical privileges and medical staff appointment (if applicable) every 2 years. The request for renewal will be submitted no later than 120 days in advance to permit an evaluation of current clinical privileges and performance. Failure to request renewal in a timely fashion may result in the expiration of the provider's privileges.

(3) For clinical privileges renewal, CCQAS applications will be forwarded by email from the credentials office.

(4) The CCQAS form "Evaluation of Clinical Privileges" documents the assessment of the provider's performance of currently assigned privileges and his or her professional

performance according to established standards. Reappraisal and renewal of clinical privileges are based on provider performance, facility capabilities, and the needs of the beneficiaries.

(a) The "privileges performed" and evaluated must be identical to the requested "privileges delineated."

(b) When privileges are to be modified because of the performance reappraisal, the reason will be stated under "Comments" on the CCQAS form "Evaluation of Clinical Privileges."

(c) A performance assessment will evaluate professional clinical and interpersonal skills. It will be completed by the department/service/clinic chief and will include both qualitative and quantitative performance data. The assessment will address the individual's clinical and technical skills based on locally determined performance criteria, as well as a comparative analysis of the provider's performance in relation to aggregate data from a representative peer group sample.

(5) A review of provider credentials will be conducted. Privilege reappraisal and subsequent renewal will be based on education, training, experience, clinical performance evaluations, provider activity profile data, professional conduct, PI activities, and the provider's capability to perform the requested privileges (formerly called health status).

(6) If the provider's performance is deemed to be substandard, or not current, enhanced supervision may be required for a period of time as specified by the commander or remedial training may be warranted.

(7) At the time of privilege reappraisal/renewal, other than current data may be removed from the PAF and destroyed (or given to the provider). This will take place only after it has been determined, based on credentials committee criteria, that this information is reflected accurately and completely in the current performance appraisal and other privilege delineation information contained in the PCF.

(8) The authenticated CCQAS forms "Delineation of Clinical Privileges" and "Approval of Clinical Privileges/Staff Appointment" serve as notification to the provider of the renewal of his or her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared (See Figure 1). The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager. (See Figure ~~24~~)

d. Application for Renewal of Privileges Following PCS or Permanent Transfer

(1) Upon notification of the provider's impending PCS/transfer to another inpatient MTF or JPC, the losing unit will complete new CCQAS forms "Evaluation of Clinical Privileges" and "Performance Assessment." The biennial appraisal completed within 6 months of departure may be used if there is no new information to include. The credentials manager of the losing inpatient MTF (or the manager servicing the JPC) will forward these forms together with the PCF and the provider's CCQAS file, by certified return receipt requested mail, to the receiving unit. The files

will be forwarded far enough in advance to ensure arrival at the receiving facility at least 15 days prior to the provider's reporting date. Any documents that have not been included in the PCF, prior to its release, will be forwarded at the earliest possible opportunity. If the gaining facility has not received these documents upon the provider's arrival, immediate action should be taken to locate these sensitive files.

(2) The gaining inpatient MTF or JPC will use this documentation as the basis for initiating clinical privileging and medical staff appointment actions. The PCF will include the most recent clinical performance appraisals even if the provider transfers to a leadership or administrative position involving no clinical practice or to student status.

(3) CCQAS will allow preliminary review of credentials for privileging and medical staff appointment in advance of the provider's actual arrival or the facility's receipt of his or her PCF.

(4) Electronic/telephonic communication between facility credentials managers regarding providers in transit is likewise encouraged. The information documented as a result of these interactions may serve in place of the actual forms in the privileging process. Any credentialing/privileging action taken by the credentials committee based on other than actual documents in the PCF will be annotated in meeting minutes/reports. Verification of receipt of the document(s) in question, and that it is in order, will be noted in subsequent meeting minutes/reports.

(5) Upon arrival at the new duty station or place of employment, the provider will submit a request for renewal of clinical privileges and, if applicable, medical staff appointment. The request will include the documents noted above.

(6) The provider (AD/Reservist/National Guard) will apply for privileges immediately but in no case later than 5 duty days following arrival. All providers must be privileged prior to being involved in or assigned to patient care activities.

e. Enhanced Supervision for Providers

(1) Enhanced supervision is not an adverse privileging action against a provider. It does not alter the individual's medical staff appointment status nor does it reduce the provider's category of privileges as awarded by the institution.

(2) Enhanced supervision for up to 6 months (with extension granted on an individual basis) may be required when, in the best interest of quality patient care, the privileged provider's performance warrants closer attention or scrutiny. Some examples include:

(a) Following a PCS move or during a temporary duty to ensure full clinical competence.

(b) When privileges for a new procedure or technology are considered.

(c) For providers returning to clinical practice following an extended absence from patient care responsibilities.

(d) For the novice provider who is developing his or her clinical practice skills.

(3) Although only the initial category of medical/dental privileges/staff appointment specifically requires review of the medical staff member's performance, this does not preclude enhanced supervision or performance review of providers in an active, affiliate, or temporary appointment status.

(4) Routine, ongoing performance assessment is the basis for all PI activities and is essential for providers with all types of medical staff appointments and all categories of privileges. The credentials committee/function will recommend, for the commander's approval, the specific enhanced supervision requirements based upon the provider's needs.

(a) The requirement for enhanced supervision will be indicated in CCQAS form "Approval of Clinical Privileges/Staff Appointment." The provider's performance will be reviewed by the credentials committee upon completion of the specified time period for the supervision. If it is determined that the supervision is no longer required, a new annotation will be made in block 7. The appropriate credential committee/function minutes/report will reflect this decision. The provider's privileging period will not change.

(b) The requirement for supervision to determine or monitor the clinical competence of newly assigned providers, those who practice infrequently, or those requesting new privileges is not considered adverse and does not require reporting.

(c) If the period required for enhanced supervision is greater than 12 months, remedial training for the privileged provider should be considered.

(d) In contrast to the above, requirements for supervision resulting from an adverse privileging action (for example, restriction of privileges) will be reported as adverse according to the procedures outlined in paragraph 11-6f(5) in this Manual.

f. Formal Remedial Training Program

(1) When a provider with clinical privileges fails to maintain required proficiency levels to practice in his or her specialty, at the discretion of the commander, a remedial training plan designed to enhance proficiency levels may be implemented. The decision to implement a formal remedial training program must be based on the individual circumstances of the provider and any additional unit-related considerations.

(2) The formal remedial training program, as addressed here, is appropriate for AD service-obligated providers who have had their privileges either suspended or restricted by the facility commander. Providers who have had their privileges reduced or revoked are not eligible for remedial training.

(3) The unique nature of each situation necessitates an individualized approach to determining the length of the formal training, the location, and other specifics.

(4) In the interest of the privileged provider, this training is best accomplished after PCS to a new assignment or during a period of temporary duty.

(5) Requests for remedial training will be initiated by the provider's current inpatient MTF Commander or JPC Director and forwarded through the Commander, JTF CapMed. Specific criteria defining the expected trainee outcomes will be included as part of the request.

(6) The goals, duration, and location of remedial training will be addressed in recommendations to the Appellate Authority. The decision will be coordinated with the inpatient MTF Commander or, as appropriate, the JPC Director, JTF CapMed, and Service Headquarters of the AD Member. Services will maintain administrative control of Service members and therefore determine the best site for remedial training.

(7) In contrast to formal remedial training, informal training may be utilized for any category/discipline of provider/professional at any time. This is coordinated at the local level by the individual's chain of command. A provider who wishes to re-establish clinical competency may request, through his or her chain of command, an opportunity for skills enhancement purposes.

g. Modification of Privileges at the Request of the Provider

(1) If a provider requests modification of his or her clinical privileges for the upcoming period, a new CCQAS form "Delineation of Clinical Privileges" will be prepared with the specific privileges to be modified appropriately coded. The requested modification may be for augmentation or reduction of privileges. If the request is for an augmentation of privileges, documentation of appropriate education, training, and experience to support the additional privileges is required. Providers who request privileges substantially less than those of other members of their Service-specific military specialty code will require careful evaluation and subsequent action by the credentials committee.

(2) If the modification reduces the provider's privileges, written justification will be submitted with the CCQAS form "Delineation of Clinical Privileges." The credentials committee will determine if:

(a) The request is warranted and what accommodations are appropriate considering the individual's special needs associated with a medical condition or other documented situation related to performance deficit(s).

(b) The privileged provider will undergo a period of structured training. If the training is approved (does not include the formal remedial training described above), the temporary modification of privileges, if 30 days or less, will not result in an adverse privileging action.

(c) A recommendation should be made to change the provider's Service-specific military specialty code and terminate any special pay.

(d) Separation in a less-than-fully-privileged status should be recommended.

(3) A privileged provider cannot voluntarily request a modification of privileges in order to avoid an adverse privileging action. A voluntary surrender or restriction of privileges while under investigation for possible professional incompetence or unprofessional conduct, or as part of an agreement with the organization for not conducting an investigation or professional review action, will be reported through the Commanders to CJTF. Such actions may require subsequent reporting to the NPDB.

h. GPHE Participants

(1) Supervision

(a) Physician and dental providers with regular privileges in the same occupational specialty or skill and an active appointment on the medical staff will supervise Medical Corps/Dental Corps graduate level clinical residency and fellowship program participants. Nonphysician privileged providers in graduate clinical training programs will be supervised by a provider with the same or similar AD military skill identifier code and regular privileges or by a physician.

(b) The degree of supervision (direct or indirect) afforded the provider in student status will be appropriate to the individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. (See subparagraph 3.b.(2)(a) of Enclosure 6 of this Manual; see additional information regarding supervision of GPHE trainees.) Concurrent consultation will be obtained for any patient for whom a substantial risk is implied or the diagnosis is obscure. This consultation will be documented on SF 509, "Medical Record-Progress Notes," on SF 513, or on SF 600. Situations that require mandatory direct supervision will be identified by the program director - in writing - and documentation of such will be provided to all those involved.

(2) Privileges/staff appointment for eligible trainees. Fellows and other privileged providers involved in a second residency may apply for regular privileges in their primary specialty (for example, fellows in plastic surgery who are eligible for regular privileges in otolaryngology may apply for otolaryngology privileges; eligible pediatricians in endocrinology fellowships may apply for pediatric privileges). These providers may be granted either an active or affiliate appointment according to their expected participation in medical staff activities or an initial appointment if they have not held a medical staff appointment in a DoD facility during the past 180 days.

(3) Training credentials files (TCFs). A TCF and a PAF will be developed and maintained during GPHE for interns, residents, and other trainees (all disciplines), in military training programs, for whom a PCF has not yet been established. The TCF will be initiated during the first year of training and will contain verified copies of diplomas, licenses, clearing house reports, training certificates, practice experience documents, curriculum vitae, and other

documents, as appropriate. TCFs and PAFs will be maintained by the GME director or as indicated by the commander. Performance assessments will be conducted at least every 6 months; on an annual basis the department chief will provide a written recommendation to approve/disapprove matriculation to the next year's training level. All such assessments will be filed in the PAF. Other documentation such as letters of appreciation, patient complaints, and other reports that may lend themselves to trending or profiling the trainee's performance also will be filed in his or her PAF.

(4) Clinical performance evaluation. Prior to completion of the clinical training program, trainees will submit the appropriate discipline-specific CCQAS form "Delineation of Clinical Privileges" through their service and department chiefs to the GPHE committee (military setting) or to their faculty advisor/preceptor (civilian setting). The trainee, based on a self-appraisal, is attesting to his or her current level of competence related to privileges appropriate to his or her specialty.

(a) One month prior to completion of the training, the trainee's clinical supervisor will complete, and the GPHE committee (or committee with comparable professional oversight authority) will authenticate, CCQAS forms "Evaluation of Clinical Privileges" and "Performance Assessment." These documents address the trainee's professional skills, abilities, and competence and reflect recommendations for clinical privileges at the provider's subsequent duty assignment based on his or her performance during training. CCQAS form "Delineation of Clinical Privileges," "Evaluation of Clinical Privileges," and "Performance Assessment" will become a permanent part of the TCF. The information contained in the TCF becomes the basis for the PCF.

(b) The GPHE committee will decide which, if any, of the interval performance assessments and other data accumulated during the training period will remain in the TCF. In instances where an inpatient MTF or JPC GPHE committee does not exist, a comparable line of academic authority must be locally established based on the availability of professional resources. The inpatient MTF Commander or JPC Director will delegate responsibility for the duties performed by the GPHE office/committee, for academic/clinical oversight, and for documentation of the trainee's clinical competence, as appropriate. The TCF will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. In the absence of GPHE committee, as a minimum CCQAS forms "Delineation of Clinical Privileges," "Evaluation of Clinical Privileges," and "Performance Assessment" will be forwarded by the supervisor through the credentials committee/function to the trainee's next unit of assignment.

(c) CCQAS forms "Delineation of Clinical Privileges," "Evaluation of Clinical Privileges," and "Performance Assessment" ~~*are available at www.apd.army.mil/. Each corps will ensure that instructions for proper completion, authentication, and transmittal*~~ are sent to the first unit of assignment ~~*are provided to*~~ for military and civil service trainees enrolled in civilian GPHE/long-term health education and training clinical programs. The trainee should ensure that ~~*the completed*~~ required documents are mailed by the authorized supervisor (program director/faculty member/preceptor) to the trainee's first unit of assignment (ATTN: [Inpatient MTF] Credentials Office). These documents will not be relinquished to the trainee. The

performance data contained on the CCQAS forms "Evaluation of Clinical Privileges" and "Performance Assessment" serve as the basis for award of initial clinical privileges and professional staff appointment. Clinical performance evaluation is in addition to, and does not substitute for, the academic evaluation report that is required in accordance with Service-specific guidance.

(5) Failure to complete. In the case of a provider's failure to complete his or her training program or he or she will be processed according to Service-specific guidelines.

(6) Reporting. The administrative management and reporting of providers who fail to complete or are removed from a training program for substandard performance or unprofessional conduct will be made according to provisions of this Manual.

i. Formal on-the-job training (OJT). OJT programs involve formal, structured training designed to provide knowledge and technical expertise to providers who are expected to receive privileges in a given Service-specific military specialty code or for augmentation of clinical privileges associated with new technology or a new procedure(s). The commander will require a written program of instruction, specific learning objectives, and clearly identified training outcomes for the OJT program.

(1) Providers with defined privileges in the same Service-specific military specialty code will supervise OJT trainees. The degree of supervision will be appropriate to each trainee's level of progress, the risk of the procedure, and the seriousness of the patient's illness. The trainee will obtain concurrent consultation for any patient for whom a substantial risk is implied or the diagnosis is obscure. Situations requiring mandatory direct supervision will be identified in writing by the OJT program director/coordinator, and documentation of this requirement will be provided to all those involved.

(2) Individuals progressing unsatisfactorily in a formal OJT program will be managed according to established training program procedures.

(3) One month prior to completion of training, the preceptor will complete CCQAS forms "Evaluation of Clinical Privileges" and "Performance Assessment" which will reflect those clinical privileges warranted at the individual's inpatient MTF or JPC of assignment based on performance during training. These forms will be forwarded through the GPHE committee, if one exists, otherwise through the credentials committee, to the gaining facility. They will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. The gaining facility will use this information as the basis for granting clinical privileges. These forms become a permanent part of the individual's PCF.

5. MEDICAL STAFF APPOINTMENT

a. Appointment to the medical staff is a process distinct from that of granting clinical privileges. While similar data are considered for these concurrent procedures, they are separate recommendations to the commander by the credentials committee and must be reflected as such

in the credentials committee minutes. CCQAS forms "Initial Application for Clinical Privileges" and "Application for Renewal of Clinical Privileges and Staff Appointment," signed by the privileged provider and submitted to the credentials committee, is utilized to request clinical privileges and medical staff appointment, if desired.

b. A medical staff appointment reflects the provider's relationship with the medical staff and the degree to which the provider participates in medical staff surveillance and review as well as quality improvement activities related to the governance of the medical staff.

(1) An appointment to the medical staff can be granted only to licensed, certified, or registered providers and it must be accompanied by the granting of clinical privileges.

(2) A medical staff appointment is required for privileged providers to admit patients to inpatient services.

(3) All individually privileged nonphysician providers are appointed members of the medical staff. Their categories of appointment may vary.

c. The applicant for medical staff appointment with accompanying privileges will be oriented to pertinent JTF CapMed and inpatient MTF or JPC procedures, policies, and regulations governing patient care and medical staff responsibilities and expectations. The applicant will acknowledge in writing his or her intention (an attestation) to abide by these standards. The inpatient MTF or JPC is responsible for providing each privileged provider, who is a member of the medical staff, copies of any significant revisions to the rules and regulations governing their practice.

d. The type of appointment will vary depending upon the clinical privileges granted, the availability of the provider to the facility, and the defined role of the provider in the delivery of healthcare by the inpatient MTF or JPC. There are five categories of medical staff appointment.

(1) Initial appointment

(a) An initial medical staff appointment is granted to a provider when he or she is first assigned or employed in a DoD MTF or JPC. Or, if the provider (AD/Reservist/National Guard) has not held a medical staff appointment in a DoD MTF or JPC during the previous 180 days, an initial appointment is the only appointment that will be granted. This is in the best interest of quality patient care and is not intended to reflect negatively on the individually privileged provider. The initial appointment will not exceed a 12-month period.

(b) During the initial appointment period, the privileged staff member's performance will be under review by the responsible department/service/clinic chief(s) to determine clinical competence and to evaluate the provider's knowledge and conduct with respect to the medical staff bylaws, policies, procedures, regulations, and code of professional conduct. The commander will determine specific supervisory requirements for the provider when an initial appointment is granted.

(c) A provider may subsequently be granted either an active or an affiliate medical staff membership depending upon his or her type of employment or relationship with the medical staff. Advancement from initial to active or affiliate appointment status is discretionary and is not a right of the appointee. Advancement will depend upon the appointee's qualifications, performance, and the needs of the facility. When an appointee is not advanced because of changing needs of the facility, the medical staff appointment will expire; this is not considered an adverse occurrence.

(2) Active appointment

(a) An active appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical staff after successfully completing the initial appointment period. A provider who has completed an initial appointment period at another inpatient MTF, and has not had a lapse of greater than 180 days, may be granted an active appointment upon arrival at the new duty station. Active appointments will not exceed a 24-month period without renewal.

(b) Medical staff members with active appointments will participate fully in appropriate activities of the medical staff. Active members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical staff and are responsible for being knowledgeable of the same.

(3) Affiliate appointment

(a) An affiliate appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical staff after successfully completing the initial appointment period. A provider with an affiliate appointment, due to conditions of employment, is neither assigned organizational responsibilities of the medical staff nor expected to be a full participant in activities of the medical staff. Affiliate appointments will not exceed a 24-month period without renewal.

(b) The category of affiliate member was created to relieve certain medical staff members of the requirement to serve on medical staff committees, including the ECOMS. Affiliate members may, therefore, be precluded from membership on the ECOMS and may be relieved of the requirement to participate in other medical staff committees and activities. Affiliate members, however, will be encouraged to participate in department/service/clinic and medical staff meetings and PI activities. Affiliate members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical staff and are responsible for being knowledgeable of the same. The inpatient MTF or, as appropriate, the JPC will keep affiliate members informed of changes to the bylaws, rules, regulations, policies, and procedures of the medical staff.

(c) Affiliate status may be considered for contracted staff, consultants, experts, staff in a temporary duty status, resource sharing personnel, part-time staff, Reserve providers performing individual duty for training (for example, monthly drills) at the inpatient MTF or JPC, and individual mobilization augmentees (IMAs).

(4) Temporary appointment. A temporary appointment is granted in emergency or disaster situations when time constraints will not allow full credentials review but when there are pressing patient care needs and a temporarily privileged provider will be admitting patients. The use of temporary appointments should be rare. The temporary appointment will be time limited and will not exceed 30 days. A complete, thorough credentials review will occur during the period of the temporary appointment.

(5) No appointment. Providers without a license or other authorizing document, or who have not been granted clinical privileges, will not be appointed to the medical staff. These providers do not share medical staff responsibility to the GB for medical staff surveillance, review, and quality improvement activities within the inpatient MTF or JPC; they are not authorized admitting privileges.

e. When a provider is privileged and appointed to the medical staff, if applicable, the commander will advise the provider - in writing - of their defined privileges and the medical staff appointment that has been granted. CCQAS form, "Approval of Clinical Privileges/Staff Appointment" will be utilized for this purpose, with or without a cover memorandum (see Figures 1-2). The provider will acknowledge receipt of the privileges and professional staff appointment, if applicable, by signed memorandum.

6. PROVIDER PRIVILEGING FOR TEMPORARY DUTY AND OTHER ACTIONS INVOLVING THE PCF

a. For providers on temporary duty for clinical practice to another inpatient MTF/unit or JPC, the information conveyed in the ICTB is the basis for making appropriate medical staff appointment and privileging decisions in an expeditious manner. The sending Privileging Authority will ensure that all information communicated in the ICTB is accurate and will sign the document. The Commander's or Director's signature imparts their recommendation for subsequent privileges. However, the gaining institution retains full responsibility and authority for making privileging decisions.

b. The ICTB, which serves in place of documents contained in the PCF, is joined with the formal application for privileges and supplants sections of these forms containing essentially like information. Every effort must be made to avoid unnecessary duplication of information in the privileging of temporarily assigned providers. (See Enclosure 23 for guidance on the preparation of the ICTB.)

c. When privileges are requested other than those granted at the sending facility, additional documentation will be provided supporting these new privileges (for example, training documentation or privileging and evaluation documentation from another hospital). The gaining facility will review this documentation, in addition to the ICTB, to evaluate the provider's competencies and to determine what privileges will be granted.

d. After customary departmental/service/clinic and credentials committee review and recommendation, and consideration of the facility's capability, the gaining Privileging Authority

may grant privileges, with or without modifications, based on the approved privilege list from the sending inpatient MTF/unit. The gaining facility will use CCQAS form "Approval of Clinical Privileges/Staff Appointment" for notifying providers of their clinical appointments and for documenting the same. Privileges applied for but not granted, due to facility-based limitations, are not adverse privileging actions.

e. The ICTB becomes invalid upon expiration of the clinical privileges and professional staff appointment (sending facility) on which it is based. If the provider is assigned temporarily for several brief periods to the same location, the ICTB remains valid over the duration of the combined periods, provided the clinical privileges and medical staff appointment (if applicable) at the sending inpatient MTF or JPC remain active. If other credentials have expired in the interim, telephonic or message confirmation of the renewal of the credential(s) with the facility holding the PCF will suffice. A new ICTB is not required. A record of the telephone call or the message confirmation will be maintained in the PCF at the gaining facility. The sending facility will keep an accurate record of each MTF/unit to which an ICTB is sent to ensure updates on provider status are forwarded as required. The sending inpatient MTF or, as appropriate, the JPC will provide a new ICTB whenever the provider's privileges change (for example, renewal of privileges, adverse privileging actions, and so forth).

f. Performance appraisals received by the provider while practicing under the authority of an ICTB will be maintained in the PAF and incorporated into his or her clinical privileges reappraisal process. The inpatient MTF (sending facility) credentials committee/function will accept provider performance appraisals/evaluations submitted on the other Services' forms.

(1) Administrative assignment. If the privileged provider is assigned to a position outside an inpatient MTF or JPC involving no clinical practice or attends a civilian or military school (other than GPHE or other graduate level training for which clinical privileges are required), the disposition of the PCF will follow Service-specific guidelines.

(2) Academic assignment. For those attending military graduate medical/dental education, or other graduate level professional health education, the PCF and CCQAS provider file will be forwarded to the military facility conducting the internship, residency, or fellowship training. For those attending civilian graduate medical or dental education, the losing facility will send a copy of the PCF, by certified return receipt requested mail, to the civilian institution and the original, along with the provider's CCQAS file, to the appropriate command as identified elsewhere in this enclosure.

7. SEPARATION OF PRIVILEGED PROVIDERS

a. Military. AD officers who experience a loss of licensure or privileges will be processed for elimination in accordance with Service provisions.

b. Civilian. A civilian provider's failure to attain or to maintain the required proficiency may be the basis for separation from Federal service. Commanders will consider separation

under one of the following three options, each of which requires close coordination and consultation with the servicing CPOC/CPAC, as appropriate:

(1) Separation during probation. If the GS provider is serving as a new DoD employee under a probationary appointment (initial competitive appointment, typically a 365-day period), he or she may be separated under the provisions of section 315.804 of Reference (~~f~~). Such an action should be completed before the end of the last duty day prior to the provider's 365th day following appointment. For providers who are in a probationary status, this is the preferred course of action. Close scrutiny of employees during their first year of employment is encouraged to identify potential clinical practice problems.

(2) Separation based on performance. This option is based on poor performance of one or more critical elements in a provider's performance plan and need not include a loss of privileges. This action is taken under the provisions of Part 752 of Reference (~~f~~). Organizational leadership must be aware of significant employee rights to include rights to notice, opportunity to improve, and opportunity to seek external review.

(3) Separation based on loss of qualifications. This alternative is based on the fact that the provider is no longer qualified to perform the duties of the position to which he or she was appointed or when misconduct or malfeasance is the issue. This option may also be exercised if provider misconduct or malfeasance is the issue. (The misconduct must be related to the individual's ability to perform the duties of the position, that is, the "nexus" requirement.) In this instance, there are significant employee rights to notice, hearing, representation, and appeal beyond the agency.

ENCLOSURE 11

Adverse Clinical Privileging/Practice Actions

1. GENERAL. This ~~e~~*E*nclosure describes the management of adverse privileging/practice actions for privileged providers and other professionals. The process has four steps: investigation, professional peer review, hearing, and appeal. The term "provider" is used for individuals granted clinical privileges. In select instances, information contained in this enclosure may also apply to the non-privileged professional. In those instances, the term, "professional" will be used. (See Enclosure 5 for adverse practice action and peer review information regarding non-privileged personnel.)

2. COMMAND RESPONSIBILITY

a. Action taken on the part of the inpatient MTF Commander against a provider's privileges (professional's scope of practice) may be warranted based on performance suspected or deemed not to be in the best interest of quality patient care. These actions include holding in abeyance, denying, suspending, restricting, reducing, or revoking clinical privileges/practice. The action taken may be immediate (summary) in the event of a critical incident or as a result of the credential committee's deliberation (routine) on information made available through CQM reporting channels.

b. The Commander's prerogative to hold in abeyance, to deny, or to summarily suspend clinical privileges/practice is exercised when there is reasonable cause to doubt the individual's competence to practice or for any other cause affecting the safety of patients or others. Reasonable cause includes but is not limited to:

(1) A single incident of gross negligence

(2) A pattern of inappropriate prescribing

(3) A pattern of substandard care

(4) An act of incompetence or negligence causing death or serious bodily injury

(5) Abuse of legal or illegal drugs or diagnosis of alcohol dependence (see Enclosure 12)

(6) Documented alcohol or other drug impairment and the individual refuses/fails rehabilitation or a psychiatric disorder that is not responsive to treatment

(7) Unprofessional conduct

c. The specific goal of all those involved in any adverse action against a provider's privileges (adverse practice action for the professional) should be:

(1) To protect the safety and well-being of all patients for whom healthcare is provided.

(2) To safeguard the quality and efficiency of care

(3) To protect the rights of the individual(s) in question (afford due process)

(4) To ensure timely resolution of the issues related to provider/professional performance

(5) To separate professional actions and considerations from any associated administrative or legal considerations

(6) To allow timely reporting of individuals to professional regulatory agencies, if warranted.

3. CONSULTATION AND COORDINATION REGARDING ADVERSE PRIVILEGING/PRACTICE ACTIONS

a. With Legal Counsel. Prior to proceeding with any adverse privileging/practice action addressed in this enclosure, coordination should occur with the inpatient MTF servicing legal office. This includes actions of abeyance, summary suspension of clinical privileges, investigations/inquiries, removal of the provider/professional from patient care, and any notification letters. Legal office coordination will help ensure that appropriate due process and legal rights are afforded from the outset of any action that may be taken. Prompt coordination with the servicing legal office is also encouraged to help ensure that the manual guidance regarding the action(s) underway is followed throughout.

b. With WRNMMC, FBCH and the JPC

(1) All categories of employees. CJTF will be notified early in the adverse privileging/practice action process. As the primary POC for subordinate units on policies and procedures related to an adverse privileging/practice action, JTF CapMed is responsible for oversight of the process. JTF CapMed will provide a second level review. The Surgeon General of the AD member is the appeal authority of the inpatient MTF commander's decision regarding an adverse privileging/practice action. For civilian and contract providers, CJTF is the appeal authority.

(2) Civil service employees. After consultation with the servicing Legal Office, coordination should occur with the contracting officer in any adverse privileging action related to a contract employee. This consultation will help ensure that all established civil service employee policies and regulations are met.

(3) Contract employees. After consultation with the Servicing Legal Office,

coordination with the contracting officer is required prior to any adverse privileging action involving a contract employee.

c. JTF CapMed Review. All adverse privileging/practice actions will be reviewed by JTF CapMed for legal sufficiency prior to final action.

4. APPROPRIATE USE OF ADVERSE PRIVILEGING/PRACTICE ACTIONS

a. Adverse privileging/practice actions addressed in this enclosure and any related administrative or legal actions must be handled separately. Inpatient MTF Commanders and Center Directors must ensure that, when appropriate, adverse privileging/practice action is taken and that the associated procedures are managed in a timely manner.

b. An adverse privileging/practice action is considered appropriate when there is evidence of incompetence, unprofessional conduct, or impairment. For example, evidence may include deficits in medical knowledge, expertise, or judgment (competence); unprofessional, unethical, or criminal conduct (serious misdemeanor or felony) (conduct); or mental health disorders or alcohol/drug impairment (condition) that reduce or prevent the individual from safely executing his or her responsibilities in providing healthcare.

c. If an acute or chronic medical problem, mental health condition, or alcohol/drug impairment interferes with the provider's/professional's performance of clinical duties, the individual will submit a request to appropriately modify his or her privileges or scope of practice. This is considered an administrative action not an adverse privileging/practice action. The request with supporting evidence/information will be documented reflecting the modified privileges will be submitted according to manual privileging procedures. The request will be processed in the same manner as any other request for change of clinical privileges. See Enclosure 12 for further information regarding privileging actions and impairments. A request for modification of privileges is not permissible to avoid an adverse privileging/practice action.

d. Actions that do not meet these stated criteria may require command and legal attention and action, as appropriate.

e. If warranted, adverse privileging/practice action must be taken regardless of the individual's affiliation with the organization (for example, contracted employee, volunteer) or duty status within the inpatient MTF or JPC.

f. Severing the employment relationship (to include PCS, separation, or retirement) in lieu of taking the adverse privileging/practice action that is indicated is not appropriate.

g. In situations involving illegal activity (for example, narcotics pilfering, physical/sexual abuse of a patient, and so forth) the inpatient MTF or JPC *S*ervicing Legal Office will be notified and an adverse privileging/practice action initiated as soon as possible following initiation of a criminal investigation. Concurrent with the investigation the inpatient MTF or JPC will facilitate

timely notification to outside agencies of those individuals for whom such notice is warranted. No reporting to regulatory agencies will occur until final resolution of the investigation and all relevant information concerning the incident is available to CJTF.

5. OTHER CONSIDERATIONS RELATED TO ADVERSE PRIVILEGING/PRACTICE ACTIONS DEFINED

a. Individuals Providing Implicating Information. All reasonable efforts will be taken to protect the identity of persons who offer information that may result in an adverse privileging/practice action against another provider or professional. For example, the name of the individual providing information will be protected unless the due process rights of the provider/professional who is the subject of the action require disclosure or if disclosure is deemed appropriate pursuant to a request under the FOIA or Privacy Act. No disciplinary action, punishment, or any form of retaliatory action will be taken against a person who submits information concerning a provider/professional unless it is later determined that the information was false and the person providing the information acted maliciously.

b. Allegations Involving Providers/Professionals Separated from Service. Any allegations of substandard performance or misconduct reported to have occurred prior to an individual's separation from Federal service must be investigated, even though the individual in question is no longer on AD or employed by the Federal Government. The responsibility for investigating these situations, which may result in a provider/professional adverse privileging/practice action, will remain with the inpatient MTF or the JPC in which the alleged substandard performance or misconduct occurred, with assistance as necessary from JTF CapMed. The inpatient MTF or JPC will notify the provider/professional of the allegations under review and will afford the individual the opportunity to supply information on his or her behalf.

c. Allegations Involving the Inpatient MTF Commander and Center Director. When information arises on a privileged commander's clinical performance, conduct, or condition that may bear on his or her suitability for professional practice, the ACOSECOMS will notify JTF CapMed. JTF CapMed is responsible for any adverse privileging/practice action involving an inpatient MTF Commander or JPC Director.

d. Use of Time Lines. Time lines will be specified both in calendar days for actions required of the command and in duty days (that is, actual working days) for the individual involved when corresponding actions are required of the provider/professional. The time lines are established to allow the individual in question adequate time to prepare for and sufficiently participate in the proceedings and to facilitate timely resolution of the adverse privileging/practice action. While it is important that the time limits reflected in this Manual are met, no rights will accrue to the benefit of an affected provider/professional, in an otherwise proper action, based solely on the organization's failure to meet such time limits.

e. Withdrawal of Permission to Engage in Off-Duty Employment

(1) The commander or director (or designee) must withdraw any permission for the

military provider/professional to engage in clinically related off-duty civilian employment until the privilege/practice action under review is resolved according to ~~Commander's Policy Memo No.3 – Off-Duty Employment 13~~ Reference (~~x~~*v*). The ~~c~~*C*ommander or ~~d~~*D*irector must also notify the inpatient MTF or JPC (or civilian treatment facility) where the individual (military or civilian) is employed of a summary suspension of clinical privileges/practice. Coordination with the inpatient MTF or JPC servicing legal office is encouraged to ensure the Privacy Act rights of the provider/professional are not violated in the notification of off-duty employers.

(2) Notification in response to abeyance of privileges/practice is at the commander's discretion.

(3) The commander must revoke permission for off-duty health-care-related employment if an individual has been indicted or titled for any of the acts of unprofessional conduct listed in Enclosure 24.

(4) The Contract Officer Representative (COR) will be notified for contract employees. The COR will notify the contractor if the provider is unable to fulfill contract requirements.

(5) Any new application for off-duty employment submitted during an adverse privileging/practice action review will not be approved until the privileges/practice duties of the individual have been restored.

f. Information to State and Other Regulatory Agencies. Every effort must be made at the inpatient MTF or JPC to assist in the investigation of the incident(s) by State boards or other regulatory agencies. Information made available to licensing/regulatory bodies will only be provided only by JTF CapMed.

6. INVOKING AN ADVERSE PRIVILEGING/PRACTICE ACTION. When a provider's conduct, condition, or performance requires action to protect the health or safety of patients, his or her clinical privileges/practice will be placed in abeyance or suspended while a thorough and impartial investigation is conducted. The fact-finding period allows time to gather and carefully evaluate additional information regarding the situation prior to initiation of an adverse privileging/practice action, if deemed appropriate.

a. Abeyance

(1) An abeyance is not an adverse privileging/practice action. The individual is formally placed "on notice" that scrutiny of his or her practice has begun which may result in an adverse privileging action or other administrative action. The inpatient MTF Commander or JPC Director may take this action against a provider/professional.

(2) An abeyance action is taken by the privileging authority when an evaluation of performance appears warranted, but information is insufficient to suspend privileges/practice or the potential hazard to patients or patient care is not well defined. In any case, prudence dictates that the individual not be permitted to render patient care. During the period of abeyance the

provider is assigned to nonclinical duties until the investigation is complete. Appropriate documentation will be initiated and forwarded (for informational purposes only) to JTF CapMed.

(3) An abeyance is valid for 30 calendar days. On the 31st day, if the abeyance is not closed, the action automatically becomes a summary suspension of clinical privileges/practice. This is a temporary action. Once the case is closed, all documentation associated with an unfounded abeyance action will be destroyed.

(4) An abeyance that is not resolved when the individual terminates his or her relationship with the inpatient MTF or JPC (that is, resigns his or her position or is released from AD) automatically becomes a suspension of privileges. This is considered a final action and the suspension of the provider's privileges/practice will be reported as outlined in Enclosure 15.

b. Suspension. There are two types of suspension associated with clinical privileges; summary suspension (a temporary action) and suspension (a final privileging action).

(1) Summary suspension of clinical privileges/practice is a temporary removal of privileges (full or partial) that is used to limit a provider's/professional's practice while the investigation and due process procedures are conducted or while performance reevaluation, targeted training, or rehabilitation is completed.

(a) As noted elsewhere in this Enclosure, a summary suspension is automatically in effect following 30 calendar days of abeyance, if the fact-finding procedures and related actions have not been completed. Every effort must be made to conclude the investigation in a timely manner in order to reinstate the individual's privileges/practice, if warranted, or to proceed with other appropriate interventions or an adverse privileging/practice action.

(b) In cases where the individual's misconduct, professional incompetence, or negligence is obvious, poses a clear and evident threat to the safety of patients, or the well-being of others, instead of an abeyance, a summary suspension of clinical privileges/practice should be the initial course of action.

(2) When the inpatient MTF Commander or, as appropriate, the JPC Director invokes summary suspension of clinical privileges/practice, this effectively details the individual in question to nonclinical duties. Specific instructions to the provider/professional related to his or her duty will be included in the written notification of suspension. A summary suspension of privileges/practice will last only as long as needed for other definitive adverse privileging/practice action (that is, restriction, reduction, suspension, denial, or revocation) to be taken. While these actions, if longer than 30 days in duration, are reportable to the NPDB, summary suspension of clinical privileges within the Department of Defense is not reported to the NPDB. DD Form 2499 will be initiated (informational purposes) and forwarded to the CJTF. At the conclusion of the period of summary suspension, if the case is unsubstantiated or unfounded, all documentation associated with this action will be placed in the provider's PAF as part of their performance evaluation documents

(3) A suspension of privileges (final determination) is an adverse privileging action and must be identified as such. Suspensions must be disclosed when applying for future privileges, licensure/certification/registration, or malpractice insurance. The suspension must be disclosed even if subsequent action results in reinstatement. Explanation of the reasons for the suspension and its final outcome may be offered by the provider/professional at the time of disclosure.

c. Notification Procedures

(1) Privileged provider or professional:

(a) The individual will be notified in writing on the day that his or her clinical privileges/practice has been placed in abeyance/summary suspension. The memorandum (see Figure ~~35~~), delivered in person or by certified return receipt requested mail, will state the basis for the abeyance/summary suspension, the duration of the action, that a QA investigation will be conducted, and that the results of the process will be reviewed by the credentials committee.

(b) If only a portion of the provider's clinical privileges or professional's scope of practice is being placed in abeyance/summary suspension, the notification letter must state this.

(c) In addition, the notification must state that an abeyance not resolved within 30 calendar days will become a summary suspension.

(d) The notification letter should also explain the implications of leaving military service or Federal employment while a privilege/practice action is underway. The provider will acknowledge receipt of this notification by signed memorandum. (See Figure ~~34~~) If the provider refuses to sign the memorandum, a responsible official may indicate "refused to sign" where the signature would normally appear.

(2) JTF CapMed notification:

(a) The Privileging Authority will notify the JTF CapMed when a provider's privileges/professional scope of practice have been either placed in abeyance or summarily suspended. Notification utilizing DD Form 2499 will be made within 3 working days.

(b) CJTF will be immediately notified of any egregious situation of a sensitive or a potentially notorious nature, any incident of gross negligence, and any act of incompetence or negligence causing death or serious bodily injury (an SE), or allegations thereof.

(c) The JTF CapMed is responsible for relaying information as appropriate. Follow up documentation on DD Form 2499 will be according to the requirements outlined in section 14 of this Manual.

d. CQM QA Investigation

(1) In cases of abeyance or summary suspension of clinical privileges/practice, there will be an immediate and rigorous investigation to collect the relevant facts and information. Every

Figure ~~3~~5. Sample Format for Memorandum Notifying Provider of an Abeyance or Summary Suspension

(MTF Letterhead)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Name, Grade, Address of Provide/Professionals)

SUBJECT: Notice of Abeyance (Summary Suspension) of Clinical Privileges/Practice

1. Effective immediately, (all/a portion) of your clinical privileges/practice at (include MTF name and location) have been (placed in abeyance/summarily suspended). This action is being taken as a result of (state the specific/alleged deficiencies involved, and the scope of the action being taken. Include the specific privileges/scope of practice that is are/is effected and what is expected of the provider/professional in terms of his/her clinical duties and responsibilities.)

2. The period of (abeyance is for a period of [specify number up to 30] days/summary suspension is indefinite, pending conclusion of due process, as appropriate, associated with this action). Action related to your clinical privileges/practice and staff appointment, if warranted, will be initiated by the credentials committee at its meeting scheduled for (date). Every effort will be made to conclude the proceeding related to this matter in a timely manner.

3. An abeyance that is not closed within 30 calendar days will automatically become a summary suspension of clinical privileges. Summary suspension will be in effect while due processes proceedings are underway. Summary suspension in the DoD is not reportable.

4. You are hereby notified that a clinical quality management (CQM) quality assurance (QA) investigation will be conducted concerning the allegation specified above in paragraph 1. If, based on this investigation, there is substantial cause to proceed, a peer review under the auspices of the credentials committee (other committee) will be conducted to collect the necessary facts bearing on this matter. Should a peer review be warranted, you will receive written notification of such and instructions as to your rights and responsibilities related to the review process as detailed in the enclosure.

5. Should you elect to terminate your (military/Federal) service prior to resolution of the matters, you (abeyance/summary suspension) will become a suspension of privileges/practice. This is considered a final action and a report to the NPDB and/or other State or regulatory agencies will be filed.

For the Commander (if authorized) Signature

Typed Name
Grade, Corps
Chairperson, Credentials Committee

effort must be made to ensure a thorough, fair, honest, and unbiased review of the matter(s) under investigation.

(a) The Privileging Authority (or designee) will appoint a disinterested AD Military Officer pursuant to the authority of this Manual, to conduct the investigation and to report the results to the credentials committee or for non-privileged individuals to the department/service chief.

(b) The investigating officer may testify at any hearing conducted following the investigation and may be required to provide clarifying information or respond to questions from the credentials committee, as appropriate. If the individual is a member of the credentials committee, he or she is disqualified from any formal committee vote on this matter.

(c) To ensure a comprehensive, independent review of the event, the Privileging Authority may request that a provider/professional with the appropriate specialty background and credentials be made available to conduct the investigation.

(d) To maximize the objectivity of the process, a recognized, unaffiliated civilian specialist may be requested, if practical, to actively participate in the investigation.

(2) The investigation may include voluntary consultation with the individual in question, review of any relevant documents, or discussions with other individuals having knowledge of the situation.

(a) When the investigation is complete, the report submitted by the investigating officer will present the factual findings with appropriate justification or details and may include the investigating officer's conclusions or recommendations.

(b) In some cases, the inpatient MTF commander need not wait until the conclusion of the investigation to return the provider to clinical duties. If the early phases of the investigation clearly indicate the absence of substandard performance or other problems, the credentials committee should meet, review the preliminary details of the investigation, and advise the commander of such without delay. In situations where provider misconduct or malfeasance may be apparent or suspected, the Privileging Authority will be notified immediately. Other action (for example, Article 32 investigation) on the part of the commander may be appropriate. The inpatient MTF or JPC *S*ervicing Legal Office shall be consulted. For non-privileged professionals, information regarding the CQM QA investigation is returned to the department/service chief. The credentials committee is involved in direct management of privileged providers only. See Enclosure 7 for information regarding non-privileged professional peer review mechanisms

e. Credentials Committee Action

(1) At the conclusion of the investigation, the credentials committee will review and carefully consider the investigative officer's report. The report, along with other information

collected, is the basis of the peer review that may be warranted and subsequent recommendations to the inpatient MTF commander for adverse privileging action against the provider.

(2) After reviewing the CQM QA investigation report and/or other pertinent information, the credentials committee chairperson may recommend to the commander that:

(a) No further action be taken (that is, the evidence available did not warrant a privileging action) and the provider's clinical privileges in abeyance be fully reinstated.

(b) The provider's clinical privileges currently held in abeyance be summarily suspended pending a formal peer review.

(c) A peer review panel be convened to evaluate the available information and to determine if the SOC was met. This function may be conducted under the auspices of the credentials committee or other committee as is customary for the organization and according to manual policy. The appropriate authority, according to manual policy, will ensure that the provider receives written notification of the forthcoming peer review (see Figure *46*) and is advised of his or her rights to due process.

(d) Other actions (administrative, personnel, civil, or criminal) be taken.

f. Privileged Provider Peer Review Process. See Enclosure 7 for peer review information pertinent to non-privileged professionals.

(1) Intent. When a provider's privileges have been summarily suspended (or otherwise adversely affected), a peer review panel (internal or external) will be conducted to evaluate the provider's performance, conduct, or condition to determine the extent of the problem(s) and to make recommendations through the credentials committee to the commander.

(a) To avoid the possibility of bias, those individuals who are involved in the peer review (for SOC determination or evaluation of the provider's conduct, condition, or competence) should not participate as voting members for subsequent credentials or RM committee actions involving the named provider.

(b) The professional review by a committee of the provider's peers must focus on how the action under review impacts the provider's ability to practice clinically.

(c) The provider in question does not have the right to be present during the proceedings; however, he or she shall have the opportunity to provide a written statement regarding the events under review, to appear before the committee and make a verbal statement, to clarify issues in the case as needed, to ask questions, and to respond to questions from the committee.

(d) The provider is encouraged to consult with legal counsel either at their own expense or as authorized under military Service regulations for AD or RC personnel at any step in an adverse privileging action; however, the peer review is not a legal proceeding.

Figure 6. Sample Format for Memorandum Notifying Provider/Professional of a Forthcoming Peer Review

(MTF Letterhead)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Name, Grade, Address of Provide/Professionals)

SUBJECT: Provider/Professional Notification of Peer Review

1. This is to inform you that on (date), (the credentials committee/a credentials hearing board/other committee) will conduct a peer review to evaluate your performance, conduct, or condition that was the subject of a recent CQM QA investigation. This committee will review the nature of the circumstances surrounding the events in question, determine the validity of any allegations, and make recommendations to the commander, as appropriate. The peer review may adversely affect your clinical privileges/practice. Your staff appointment, as appropriate, may likewise be affected.

2. The allegations to be reviewed are (state the nature of the allegations constituting the grounds for the peer review in sufficient detail. Include the date, identity, and location of the record(s) of all activities or the cases that are involved in the allegations, so that the individual will be fully apprised of the matters to be considered during the peer review.)

3. The peer review will be conducted at (hour) on (date) at (locations) (within 14 calendar days of notice to individual.) While you do not have the right to be present during the proceedings, you may present a written statement regarding the events under review. In addition, you may be required to appear before the peer review panel to make a verbal statement, to clarify issues as needed, to ask questions, and to respond to questions of the panel.

4. You are encouraged to seek legal counsel at any step in the adverse privileging/practice action process. However, the peer review is not a legal proceeding, and a lawyer is not permitted to actively participate during the peer review. (As a civilian employee, you may be entitled to bargaining unit representation.)

5. A point of contact for you as you prepare for the peer review process is (state POC name, address, telephone, and facsimile numbers). He/she is available to assist you and to accept any forthcoming written correspondence from third party sources or any information that you may wish to provide.

6. Should you have any questions, or need further guidance, you may access the JTF CapMed Quality Manual in the office of the Credentials Manager.

7. Based on the CQM QA investigation, the peer review results, and the (credentials committee/other committee) recommendations, the commander will determine what adverse action, if any, against your clinical privileges/practice is warranted. You will receive separate notification from the commander of proposed action against your clinical privileges (and staff appointment/practice.)

For the Commander (if authorized) Signature

Typed Name
Grade, Corps
Chairperson, Credentials Committee

(2) Provider notification of a scheduled peer review. The individual in question will acknowledge receipt of notification of forthcoming peer review, using a format similar to the memorandum acknowledging notification of abeyance/summary action (See Figure 48). The written notification to the provider, within 14 calendar days of the decision to conduct the peer review, will contain:

(a) The date, time, and location of the peer review.

(b) A statement of the alleged facts, events, conduct, or omissions subject to review. To maintain the confidentiality of any patients who may be associated with the evaluation of the individual's conduct or performance, the patient's hospital admission number or initials will be used.

(c) His or her rights regarding participation in the peer review proceedings, as noted elsewhere in this enclosure.

(d) A POC (name, address, telephone, and facsimile numbers) to receive any written correspondence or provider-supplied information.

(e) Reference to the inpatient MTF or JPC peer review policy for additional guidance.

(3) Peer review panel composition. The provider peer review panel must be comprised of an odd number of members, except as noted elsewhere in this ~~e~~*E*nclosure.

(a) One person will be designated as the chairperson/facilitator.

(b) The members will be of similar background, whenever possible, and in the same professional discipline/specialty as the provider in question. Panel members may be brought in from any other inpatient MTF or JPC to meet this requirement (that is, to conduct an internal peer review). Manual policy stipulates the circumstances under which an external peer review is required. The peer review panel may also be convened by audio/video-teleconference if there are insufficient qualified providers in a given location to perform the peer review.

(c) Except in cases of an unfounded or unsubstantiated abeyance action or summary suspension of a provider's privileges, the credentials manager will maintain an administrative file containing the peer review documentation associated with an adverse privileging. JTF CapMed Secretariat will prescribe the period of time this record will be kept at the inpatient MTF or, as appropriate, the JPC, but no less than 2 years. Documents retained in this file may include: list of references used; list of documents reviewed; list of personnel interviewed; inventory of documents reviewed and returned; a confidentiality statement to be signed by each of the panel participants; or the commander's letter of appointment to the peer review for each member. All documentation associated with an unfounded abeyance action or summary suspension will be destroyed.

(4) Impartiality of the peer review participants. This review process is a function of the provider's peers. Personnel participating in this process must be able to impartially review the case and render an objective decision at the conclusion of deliberation. The following individuals should not be voting participants in the peer review of the provider in question:

(a) The individual's direct supervisor.

(b) Providers for whom the individual is the supervisor, to include immediate or senior rater for performance appraisals for military or civilians.

(c) The individual who suspended the provider's privileges or who recommended administrative or legal action against the provider in this case or previous cases.

(d) Any person who investigated the case.

(e) Any person whose testimony is part of the case.

(f) Any member who is participating, or has participated, in other administrative proceedings (courts-martial board or administrative review board) involving the provider in question.

(g) Any member who is reviewing, or has reviewed, the provider's actions under consideration by the credentials committee.

(h) The credentials/RM committee chairperson.

(5) Recommendations regarding clinical privileges. The conclusions reached should be readily supported by rationale that specifically addresses the issues for which the peer review was conducted. Minority opinions and views of the peer review panel will be considered and appropriately entered into the record of the panel's activities. If additional information is required, the case may be referred back for further action to the individual(s) who conducted the inquiry. The peer review panel considers the information from the CQM QA investigation and any other relevant facts and makes recommendations to the credentials committee regarding the provider's clinical privileges. One of the following recommendations may be made:

(a) Reinstatement. The return of privileges to the original privilege state. Reinstatement may include provisions for provider monitoring and evaluation (M&E) with stipulations as to the nature and duration of the M&E. This is not an adverse privileging action; it is not reportable to regulatory agencies, and no hearing or appeal is offered. If M&E exceeds 30 days, this is deemed a conditional reinstatement of privileges and will be reported by JTF CapMed to the appropriate State/regulatory agencies.

(b) Suspension. The temporary removal of all or a portion of a provider's privileges resulting from incompetence, negligence, or unprofessional conduct.

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

(d) Reduction. The permanent removal of a portion of the provider's clinical privileges. The reduction of privileges may be based on misconduct, physical impairment, or other factors limiting a provider's capability.

(e) Revocation. The permanent removal of all clinical privileges and termination of the provider's patient care duties. In most cases, this action will be followed by administrative procedures to terminate the individual's DoD services. This action can only be taken after the provider has been afforded hearing rights. Prior to the hearing, the inpatient MTF or JPC may decide/notify/refer to action only with the intent to revoke clinical privileges/practice.

(f) Denial. Refusal of a request for privileges due to substandard performance, professional misconduct, or impairment. This may occur at the time of initial application for privileges or when renewal of privileges is requested.

(6) Credentials committee recommendations to the commander. Within 7 calendar days of completing the peer review process, the panel's recommendation(s), along with the case evidence, will be forwarded to the credentials committee. Following any additional review of the facts of the case, the credentials committee will include its recommendation(s), which may or may not coincide with those of the peer review panel, and the entire case file with recommendations is forwarded to the Privileging Authority.

(7) Action by Privileging Authority

(a) The Privileging Authority has 14 calendar days from receipt of the recommendation(s) to review and to decide what privileging action to take based on the facts provided. The Privileging Authority is not bound by the recommendations of the credentials committee or the peer review panel.

(b) The Privileging Authority will provide written notification to the provider of the privileging action to be taken and the justification for this action addressing all specified allegations (see Figure ~~5~~7). If the provider is a contractor, a copy of the notification is forwarded to the responsible contracting office (through the COR if designated), and a letter documenting these actions is provided to the contractor at the address of record.

(c) If the proposed action is to deny, suspend, restrict, reduce, or revoke the provider's privileges, the Privileging Authority must advise the provider in writing of his or her hearing and appeal rights. The Privileging Authority must address in the notice to the provider the specific allegations that constitute grounds for the hearing and will include relevant dates and copies of patient records that are pertinent to the hearing.

Figure ~~5~~7. Sample Format for Notifying Provider of Proposed Adverse Clinical Privileging/Practice Action

(MTF Letterhead)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Name, Grade, Address of Provide/Professionals)

SUBJECT: Notice of Proposed Adverse Clinical Privileging/Practice Action by the Privileging Authority

1. You are hereby notified of my decision to (state adverse privileging/practice action) your clinical privileges/practice at (MTF name and location). Effective (date your clinical privileges/practice will be (state limitation) for improper (state specifically the performance, conduct, behavior under review and the rationale for the actions addressing all allegations.) The period of this adverse privileging/action action is to be (indefinite/temporary for a period of [state number of days], from (date) to (date)).

2. My decision is based upon recommendations from the (credentials/other committee) that met (date) to review all the facts and evidence pertinent to the CQM QA investigation and peer review that were conducted. As a result, (specify which privilege(s)/practice(s) are affected and what is expected as far as the providers' clinical duties and responsibilities.)

3. In addition to this proposed adverse action related to your clinical privileges, your staff appointment to this facility (will/will not be affected). Note proposed change to appointment status, as appropriate.

4. You are advised that you have the right, upon request, to have the credentials hearing board conduct a hearing to review this action concerning your privileges. The hearing procedures and your hearing rights are detailed in the JTF CapMed Quality Manual, Enclosure 11.

5. For this hearing to be conducted, you must make a written request for such to the chairperson of the credentials committee within 10 duty days of the date you receive this notice. If you fail to make the request within that time frame, or if you fail to appear at the scheduled hearing, you waive your right to the hearing and also waive your right to appeal to higher medical authority.

Signature of Privileging Authority

Typed Name
Grade, Corps
Privileging Authority

(d) For providers whose privileges have been restricted to the extent that they are no longer performing the full range of normal duties in their specialty practice, follow-on administrative action may be required.

1. The Privileging Authority may recommend separation from service in a less-than-fully privileged status (military) or take appropriate action through the civil service system for employees, or the contracting officer for contract employees.

2. Any Military Provider recommended for separation will be referred to their Service Surgeon General for final determination and disposition.

g. Other Credentials Committee Actions

(1) In the case of suspected drug or alcohol involvement, a member of the impaired healthcare personnel committee (IHCPC) will be appointed to the ad hoc group that will conduct the peer review (see Enclosure 11).

(2) The credentials committee will ensure that peer review findings are considered when provider-specific credentialing and privileging decisions are rendered and, as appropriate, in the organization's PI processes. Summary peer review conclusions will be tracked over time and any PI actions based on these conclusions will be monitored for effectiveness.

(3) The credentials committee is responsible for executive oversight and analysis of aggregate data related to all adverse privileging/scope of practice actions within the organization. Privileged provider data are contained in credentials committee minutes. For the non-privileged healthcare professional, a copy of the CQM QA investigation, peer review activity, and the subsequent recommendations for action provided to the Privileging Authority, will be forwarded by the appropriate department chief to the credentials committee.

7. PROVIDER HEARING RIGHTS

a. Written Notice of Hearing Rights. Notification of the Privileging Authority's decision for action against a provider's privileges will be delivered to the provider either in person or by certified return receipt requested mail (see Figure ~~5~~*7*). The notification will be made as soon as is practical but in no case later than 14 calendar days after the recommendations are made by the credentials committee to the Privileging Authority. The same written notification requirement and time line exist when the CQM QA investigation finds reasonable cause. When the Privileging Authority's proposed action is to deny, suspend, restrict, reduce, or revoke the provider's privileges, the following requirements apply.

(1) The written notice to the provider will specify the deficiencies substantiated by the peer review process, the proposed adverse privileging action to be taken by the Privileging Authority, and the right of the provider to request and to be present at a formal hearing.

(2) By signed memorandum, the provider acknowledges his or her receipt of this notification (see Figure ~~6~~*8*). Should the provider refuse to acknowledge receipt of written notice,

a memorandum for record to make note of the refusal will be prepared.

Figure ~~6~~8. Sample Format for Provider Memorandum Acknowledging Notification of Proposed Adverse Privileging/Practice Action

PROVIDER'S OFFICE SYMBOL Date

MEMORANDUM FOR: (Commander, MTF, Address, ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Proposed Clinical Privileging/Practice Action by the Privileging Authority

I hereby acknowledge receipt on (date) of the memorandum notifying me of the Privileging Authority's action against my clinical privileges (and staff appointment/practice). I understand that I have 10 duty days to request a hearing, if I elect to do so, according to JTF CapMed Quality Manual. Further, I understand that should I elect not to request a hearing, or if I fail to appear at the scheduled hearing, I waive my right to appeal to a higher medical authority.

(Signature of Provider)

(Typed Name)
(Grade, Corps)

b. Provider Participation. If the provider wishes to request a hearing, he or she will have 10 duty days, from date of receipt of the notification of recommended adverse privileging action, to respond in writing to the credentials committee chairperson.

(1) Prior to the hearing, the provider will have access to all information that will be presented for consideration at the hearing.

(2) The provider may voluntarily waive his or her right to a hearing. This decision is final and not subject to appeal.

(3) If the provider waives his or her right to a hearing, recommendations from the credentials committee (and peer review panel if this review was conducted) will be forwarded to the Privileging Authority for review and decision. A copy of the Privileging Authority's decision regarding the adverse privileging action and the provider's notice of said action will be filed in the PCF.

(4) Waiver of hearing and appeal rights in and adverse privileging case will result in a report to the NPDB.

(5) Failure on the part of the provider to request a hearing, or failure to appear at the

scheduled hearing (absent good cause), constitutes waiver of hearing and appeal rights. At the request of the provider, the Privileging Authority will determine the existence of good cause.

(6) If the provider is unable to appear in person at the hearing due to unusual or urgent circumstances, alternate means of obtaining his or her personal participation will be offered (for example, written deposition, telephone conference call or video teleconference (VTC)).

8. HEARING BOARD PROCEDURES

a. The ACOSECOMS (or other physician designated by the Privileging Authority) will chair the hearing board. Members of the hearing board shall be individuals who were not involved in the peer review of the provider in question.

(1) The hearing is administrative in nature. The rules of evidence prescribed for trials by courts-martial or for proceedings in a court of law are not applicable. If criminal misconduct is suspected, the president of the board will seek the advice of the servicing Legal Office before proceeding.

(2) The committee will be fully informed of the facts to allow an intelligent, reasonable, good faith judgment. The committee may question witnesses and examine documents, as necessary, to collect pertinent information.

(3) For procedural guidance on how to conduct the hearing, Service-specific guidance may be consulted, but their provisions are not mandatory.

b. The chairperson of the hearing board will advise the provider in writing (Figure ~~7~~*9*), delivered in person, with provider receipt acknowledged by signed memorandum (Figure ~~8~~*10*), or by certified return receipt requested mail, of the following:

(1) The adverse privileging action under consideration that is the grounds for the hearing; any specific dates, facts; and all pertinent documents applicable to the case.

(2) The time and location of the hearing. The hearing should convene within 10 duty days (not less than 5 days but not more than 10 days) from the provider's receipt of the hearing notification unless extended for good cause by the hearing board chairperson (e.g., provider request). For Reserve Component providers, the hearing will be convened within 30 calendar days of provider notification.

(3) The names of the witnesses who will be called to testify at the hearing.

(4) His or her right to be present, to submit evidence, to question witnesses called, and to call witnesses on his or her behalf. The provider should be advised that he or she is responsible for arranging the presence of his or her witnesses and that failure of such witnesses to appear will not constitute a procedural error or basis for delay of the proceedings.

(5) The right to consult legal counsel. Providers whose personnel status entitles them to receive legal assistance may contact the servicing Legal Office if desired. Legal representation

in this matter is not an entitlement but may be provided subject to resources available and applicable Service's regulations to individual legal service at Government expense. Providers may obtain advice or representation from civilian counsel at no expense to the Government.

Figure ~~79~~. Sample Format for Memorandum Notifying Provider/Professional of Credentials/Other Board Hearing

(MTF Letterhead)

S: (Suspense date)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Name, Grade, Address of Provide/Professionals)

SUBJECT: Provider/Professional Notification of Credentials Committee/Other Committee Hearing

1. (The credentials committee /other committee) will conduct a (credentials hearing/hearing), at your request, concerning allegations that may adversely affect your clinical privileges/practice. Your staff appointment, as appropriate, may likewise be affected.

2. The allegations to be reviewed are (state the nature of the allegations constituting the grounds for the peer review in sufficient detail. Include the date, identity, and location of the record(s) of all activities or the cases that are involved in the allegations, so that the individual will be fully apprised of the matters to be considered during the peer review.)

3. The committee will hold the hearing at (hour) on (date) at (location) You have the right to be present, to present evidence and call witnesses in your behalf, to cross-examine witnesses called by the committee, to consult legal counsel and to be advised by legal counsel; at the hearing. It is your responsibility to arrange for the presence of any witnesses you desire. You may contact the local Legal Office for legal advice, Legal representation in this matter is not an entitlement, but may be provided subject to resource limitations as determined by the local Legal office. You may retain a civilian attorney at your own expense.

a. Failure to appear at the hearing will constitute a waiver of the rights listed here and our right to appeal

b. Upon your written request, the time and place of the hearing may be changed by the chairperson of the hearing board before the indicated suspense date, if your request is based on good cause.

c. The hearing board will call the following witnesses: (list or witnesses, if any.)

4. Any closed (not pending reconsideration or appeal) adverse clinical privileging/practice action will be reported to the NPDB and to other State or regulatory agencies, as appropriate.

For the Commander (if authorized) Signature

Typed Name
Grade, Corps
Chairperson, Credentials Committee

Figure ~~8~~*10*. Sample Format for Provider Memorandum Acknowledging Receipt of Hearing

PROVIDER'S OFFICE SYMBOL Date

MEMORANDUM FOR: (Commander, MTF, Address, ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Credentials/Other Committee Hearing

I hereby acknowledge receipt of the subject memorandum, Notification of a Credential/Other Committee Hearing. The memorandum is dated (date) and I receive it on (date).

(Signature of Provider)

(Typed Name)
(Grade, Corps)

c. The provider is encouraged to consult with legal counsel or any other representative. Civilian counsel obtained by the provider will be at no expense to the Government. Such representatives may attend the hearing but their participation is limited to advising the provider only. They will not be permitted to ask questions, respond to questions on behalf of the provider, call or question witnesses, or seek to or enter material into the record.

d. During a hearing involving a civilian provider, the exclusive representative of the appropriate bargaining unit (union or contract agency) has the right to be present, if requested by the provider, under the following conditions:

(1) When a civilian provider as a member of the bargaining unit is the subject of the proceedings or a requested and participating witness.

(2) When the civilian provider reasonably believes that the investigation could lead to disciplinary action. Unless specifically required by the collective bargaining agreement, there is no requirement to advise the employee that the representative could be present under these circumstances.

(a) If the civilian provider requests the presence of the exclusive representative, a reasonable amount of time will be allowed for this to be accomplished. The servicing CPOC/CPAC, as appropriate, and labor law counselor will be consulted before denying such a request.

(b) The role of the exclusive representative is not wholly passive, although he or she will not be permitted to make the proceedings adversarial.

(c) Subject to the discretion of the hearing board chairperson, the exclusive representative may be permitted to explain the employee's position in this matter (if the employee agrees) or to persuade the employee to cooperate in the proceedings.

e. The hearing board will review all the material presented, including that submitted by the provider. The chairperson will arrange for the orderly presentation of information and will rule on any objections made by the provider.

(1) If criminal misconduct, including dereliction of duty, is known or suspected, the chairperson of the hearing board will certify the provider has received the appropriate rights warnings to ensure the provider is waiving those rights prior to the start of the proceedings.

(2) If an investigating officer was designated, he or she may be called before the hearing committee to answer questions or to provide additional information. The investigating officer will not participate in the hearing board deliberations and he or she may not vote.

(3) The hearing will be documented in summarized minutes that reflect all the salient details of the proceedings. The hearing is considered a QA activity covered by Reference (~~l~~*n*) and, as such, no recording devices, other than that used by the designated recorder to prepare the record, will be permitted in the hearing room.

f. Following the presentation of all evidence and relevant information, the provider being examined will be excused, and the hearing board will determine its findings and recommendations. Each of the board's findings must be supported by a preponderance of the evidence. Each finding must be supported by a greater weight of evidence than supports a contrary conclusion, that is, evidence which, considering all evidence presented, points to a particular conclusion as being more credible and probable than any other conclusion. Recommendations may include, but are not limited to:

(1) Reinstatement of privileges.

(2) Identification of specific provider deficiencies that require improvement and the establishment of requirements such as consultation with other providers or specialists related to patient care management. (The board should not make recommendations involving the reassignment of a provider.)

(3) Suspension, reduction, or restriction of clinical privileges for a specified length of time. The hearing board may recommend that a provider be released from AD or Federal employment.

(4) Revocation of clinical privileges.

(5) To reconvene the hearing, after appropriate notice to the provider, to consider additional relevant evidence.

g. Decision of the hearing board is by majority vote. The chairperson of the board will vote only in the event of a tie. Members of the hearing board will cast a vote either "yes" or "no." No abstentions are permitted. Voting will be by secret ballot.

h. The hearing board must be aware of the gravity of its responsibilities and the need to clearly document its findings and recommendations. Specifically identified incidents or situations will support general statements by the board. Copies of pertinent medical/dental records or specific case histories, to substantiate the findings of the board, will be included in the record of the proceedings. These, and any other attachments, will be tabbed as exhibits to the record.

i. Selected members of the credentials committee may serve as the hearing board, or the entire credentials committee may perform this function, as determined locally. Any credentials committee member, who has acted as investigating officer or member of the peer review panel, should recuse themselves from any subsequent proceedings in which a vote is required. A privileged provider from the same discipline as the provider in question should be a voting member of the hearing board.

j. The hearing will be closed to the public; however, the provider may request that observers be permitted. The chairperson will normally grant the request but may limit the number of observers and may exclude anyone who is disruptive.

k. The hearing board may obtain advice and counsel concerning legal questions from the servicing Legal Office. The provider should be advised of any legal questions as they arise and the answers that were provided by legal counsel.

9. ACTION ON HEARING RECOMMENDATIONS

a. The record of the hearing - including findings and recommendations - will be reviewed by the ECOMS prior to being forwarded to the Privileging Authority and, if appropriate, the Center Director.

(1) The hearing board record - to include findings and recommendations - shall be available for review by all qualified members of the ECOMS prior to the case file being forwarded to the Privileging Authority.

(2) All qualified members of the ECOMS (excluding any hearing board members or any member that acted as the investigation officer) may either concur by endorsement with their recommendations or submit separate recommendations to the Privileging Authority.

(3) If a member of the ECOMS is absent (for example, through temporary duty or illness) when the hearing board report is forwarded, such absence will be noted and the case forwarded to the Privileging Authority without action by the absent member.

b. The Servicing Legal Office will review the record, including credentials committee/peer review panel findings and recommendations and any input from the provider in question, for legal sufficiency prior to action by the Privileging Authority.

c. The Privileging Authority will review the hearing record (including credentials committee/peer review panel findings and recommendations and any input from the provider in question) and make a decision regarding the provider's privileges.

(1) The findings and recommendations contained in the hearing record are advisory only and not binding on the Privileging Authority.

(2) Written notice of the Privileging Authority's decision, with the date of delivery annotated on it, will be furnished to the provider either in person or by certified return receipt requested mail. The signed receipt acknowledges the provider's receipt of the Privileging Authority's decision. If the decision includes denial, suspension, restriction, reduction, or revocation of the individual's privileges, the notice should advise the provider of his or her right of appeal. The notice should also advise the provider that, upon request, he or she will be provided a copy of the hearing record.

(3) A copy of this notice will be placed in the individual's PCF. The appropriate department, service, or clinic chiefs will also be advised of the decision.

10. APPEALS PROCESS

a. When the Privileging Authority decides to suspend, restrict, reduce, revoke, or deny clinical privileges, the provider will be granted 10 duty days (extendable in writing by the Privileging Authority for good cause) to submit a request for reconsideration to the Privileging Authority.

(1) If the provider does not request reconsideration, the adverse privileging action and all information pertaining to the case will be submitted to JTF CapMed. For Military Providers, the case will be forwarded to the provider's Service Headquarters, for reporting to the NPDB; for civilian and contract providers, the case will be forwarded to the NPDB by JTF CapMed. (See Enclosure 14)

(2) If the provider elects to appeal the Privileging Authority's decision, he or she will submit a formal request for appeal that identifies the errors of fact or procedure that form the basis of the request. The burden is on the provider to specify the grounds for reconsideration/appeal.

b. The Privileging Authority is granted 14 calendar days to consider the request. If he or she denies the request in whole or in part, the action will automatically be referred to the military provider's SG as an appeal. The SG is the final appellate authority for denying, suspending, restricting, reducing, or revoking clinical privileges of Military Providers. Civilian and

contractors who appeal will be referred to CJTF as the Appellate Authority for final determinations.

c. The Appellate Authority will convene the appeals board as soon as possible following receipt of all materials related to the adverse privileging action.

d. The appeals board will review all information furnished by the provider, as well as the hearing record, and all findings and recommendations, in light of the provider's alleged basis for appeal. After considering the information and evaluating the merit of the appellant's appeal, the appeals board will advise the Appellate Authority of its findings and recommendations for disposition, and whether it finds substantial evidence to support the Privileging Authority's adverse privileging action. The findings and recommendations of the appeals board are advisory in nature and do not bind the appellate authority. The Appellate Authority is the sole authority responsible for provider notification of the final decision associated with an appeal. To remove any potential conflict, no other parties will have input into the final decision by the appellate authority. There will be no deviation from this Manual in the review process.

e. The Appellate Authority will notify the provider by certified return receipt requested mail, as soon as possible, following adjournment of the appeals board, of the decision concerning the appeal. The Privileging Authority will also be notified in writing. Where appropriate, the Privileging Authority will notify the Center Director. The appellate authority will provide clear guidance as to what actions the inpatient MTF or JPC is expected to take regarding the future utilization of the provider.

f. Only adverse privileging actions may be appealed under these procedures. Denial of a request for privileges for reasons unrelated to the abilities, qualifications, health, or skills of the provider is not considered an adverse privileging action.

g. Administrative action to separate the provider as a result of an adverse privileging action will be deferred pending appeal resolution. Providers who voluntarily separate prior to resolution of their appeal will be informed in writing that the process will be completed as though they were still on AD or employed in a civilian capacity. Special considerations, such as extensions of time for appeal, will not be granted.

11. CIVILIAN TRAINING. If subsequent to an adverse privileging action the provider is not separated from Federal service and he or she seeks remedial training at a civilian institution, that institution will be notified of the adverse privileging action. Any remedial training to support continued employment in the inpatient MTF or JPC must be approved by the inpatient MTF Commander or JPC Director.

12. SEPARATION FROM FEDERAL SERVICE. A provider's loss of license or clinical privileges, or a professional's loss of license, may be the basis for separation from military or civilian service. When the clinical privileges of a military or civilian provider are denied, suspended, restricted, reduced, or revoked, a local command administrative review will be held to determine whether personnel action to separate the provider from Federal service should be

initiated. Military Providers will be referred to their Service headquarters for final determination; civilian and contract providers will be referred to JTF CapMed for appropriate action and determination by CJTF (or designee).

a. For a provider/professional who separates from Federal service (military or civilian) in a less-than-fully privileged status or with less-than-full scope of practice, information relative to the adverse privileging/practice action will be reported. Only CJTF is authorized to report Civilian and Contract Providers to the appropriate professional regulating authorities. Only the Service SG is authorized to report Military Providers to the appropriate professional regulating authorities. The provider/professional will be informed of the consequences of leaving Federal service in a less-than-fully-privileged status/full scope of practice (that is, that a report will be filed with the NPDB, the Federation of State Medical Boards, State licensing board, and other regulatory agencies).

b. For a provider/professional with a service obligation, consideration must then be given to branch transfer or reclassification action or, as an exception to policy, elimination from the Service. These cases will be referred to their Service Headquarters.

13. SEPARATION OF A CRIMINALLY CHARGED PROVIDER. Service-specific guidelines will be followed for completion of investigation or privilege/licensing action. All investigations or privilege/licensing actions must be completed prior to reassignment.

14. REPORTING ADVERSE PRIVILEGING/PRACTICE ACTION ACTIVITIES

a. The DD Form 2499 is used to report actions taken against a provider's privileges or the licensed/certified/ registered professional's scope of practice.

(1) At the conclusion of the adverse privileging/practice action proceedings, documentation supporting the DD Form 2499 to include credentials committee minutes, hearing board record of proceedings, results of investigation, appeal response letter, and any other pertinent information will be forwarded, if the Privileging Authority has not already done so, with the DD Form 2499 to CJTF.

(2) The Privileging Authority will sign and date the DD Form 2499 in the bottom right hand corner of the "remarks section," (block 12) below any annotations contained in this section of the form.

(3) The date the DD Form 2499 is transmitted to JTF CapMed will be annotated in the top right corner of the form.

b. The following activities will be reported through the chain of command, as indicated:

(1) CQM QA investigations. Provider/professional CQM QA investigations being conducted will be reported to JTF CapMed J-3B (for informational purposes) within 7 calendar days of initiation. Appropriate documentation (that is, DD Form 2499 and other supporting materials) will follow, as stipulated below, if the evidence from the investigation supports an adverse privileging/practice action.

(2) Clinical privileges/practice actions. When the Privileging Authority suspends, restricts, reduces, revokes, or denies (for other than facility-specific reasons) a provider's privileges or a professional's practice, or the individual voluntarily surrenders all privileges/practice while under investigation or to avoid investigation, a DD Form 2499 will be submitted within 7 calendar days following the action.

(a) Privileging Authority will forward the DD Form 2499 to JTF CapMed.

(b) Copies of all supporting documentation related to the adverse privileging/practice action will accompany the DD Form 2499.

(3) Status reports. Provider/professional status changes, using DD Form 2499, will be reported to JTF CapMed. Reports will be submitted every 30 days until final action has been completed and so indicated on the final DD Form 2499.

(4) Reinstatement of clinical privileges/practice. When the Privileging Authority approves total or partial restoration of clinical privileges/practice that had previously been removed, DD Form 2499 will be submitted to JTF CapMed.

(5) Administrative or judicial action affecting privileges/practice. If an individual is the subject of an administrative or judicial action, for example, a court-martial, a DD Form 2499 will be submitted reflecting the modified status of the individual's privileges.

c. In the event of a suspension, restriction, reduction, revocation, or denial of clinical privileges for a military provider with permission to engage in remunerative professional employment at a civilian medical/dental healthcare institution, the civilian employer will be notified of adverse privileging actions, as they occur, by the Privileging Authority. The same requirement to report applies to nonmilitary providers working at civilian facilities. This is the only exception to CJTF as the information-releasing authority.

15. REPORTABLE ACTS OF UNPROFESSIONAL CONDUCT

a. Healthcare providers who are involved in any of the unprofessional acts/activities listed in Enclosure 24, or similarly unprofessional actions, will be evaluated by the credentials committee (by the peer review panel and department/service chief for non-privileged) and appropriate adverse privileging or practice recommendations will be made to the Privileging Authority. Although the credentials committee is not a criminal investigative body, it can and will consider all evidence from such investigations in its deliberations. Whenever a reportable activity is identified, a DD Form 2499 will be submitted noting any adverse privileging/practice actions that have been taken.

b. An unprofessional act is deemed to have "occurred" when the individual is indicted or titled for an offense (if applicable) or after completion of applicable investigative proceedings and command action. The Privileging Authority will notify any civilian facilities in which the individual is engaged in off-duty health-care-related employment of the aforementioned.

c. A DD Form 2499 will be submitted on privileged providers and other non-privileged healthcare personnel, whether licensed or pending licensure, who are convicted, plead guilty, plead nolo contendere, receive a discharge in lieu of courts-martial, receive a discharge in lieu of criminal investigation, or a less than honorable discharge for unprofessional conduct. Reporting will occur within 7 days of the date that formal charges were filed or the date of discharge, whichever comes first.

16. RESERVIST/NATIONAL GUARD PROVIDER/PROFESSIONAL ADVERSE PRIVILEGING/PRACTICE ACTIONS

a. Reservist/National Guard providers/professionals are subject to denial, suspension, restriction, reduction, or revocation of clinical privileges/practice.

b. If a military agency initiated the adverse privileging/practice action, that agency will process the action according to Service-specific guidance, with copy furnished to JTF CapMed. The Service HQ will notify the appropriate regulatory authorities, medical commands, and the major commands to which the individual is assigned. Initiation of adverse privileging/practice actions will be based on individual unit assignment/attachment and type of training as follows:

(1) For all Reservist/National Guard members performing duty (regardless of type) in an inpatient MTF or JPC, the Privileging Authority of that facility will initiate the actions.

(2) Hearing rights and the appeals process is as described elsewhere in this enclosure.

Figure ~~9~~*11*. Sample Format for Provider Memorandum Acknowledging Notification of Abeyance/Summary Suspension

S: (Suspense date)

PROVIDER'S OFFICE SYMBOL Date

MEMORANDUM FOR: Commander, MTF

SUBJECT: Receipt of Notification of Clinical Privileges and Medical Staff Status

I hereby acknowledge receipt of a copy of the letter granting me clinical privileges (to include/but not to include admitting privileges) and (appointment to the medical staff.) A listing of my approved clinical privileges (and plan of supervision) as addressed in the memorandum from the commander has also been provided. I understand that I am granted 10 duty days from receipt of this memorandum to appeal the commander's decision, should I disagree.

(Signature of Provider)

(Typed Name)
(Grade, Corps)

Figure ~~10~~12. Sample Format for Memorandum Notifying Provider/Professional of Hearing Board Results

(MTF Letterhead)

S: (Suspense date)

OFFICE SYMBOL Date

MEMORANDUM FOR: (Name, Grade, Address of Provide/Professionals)

SUBJECT: Provider/Professional Notification of Hearing Board Results

1. You are hereby notified that the hearing board has concluded its activities related to the proposed adverse action against your clinical privileges/practice. A copy of the hearing board findings and recommendations is attached. A copy of the hearing transcript is available to you, upon request.

2. You are granted 10 duty days following receipt of the hearing board findings and recommendations to submit a written statement of corrections, additions, or other matters that you wish to present for my consideration related to the hearing. You must clearly and convincingly specify the grounds for reconsideration.

3. If my final decision is to deny your request, in whole or in part, the action will be endorsed to (your Surgeon General[for a military provider]/CJTF[for a civilian/contract provider]), as an appeal. This is the final appellate authority for adverse action against your clinical privileges/practice.

Signature of Privileging Authority

ENCL: as

Typed Name
Grade, Corps
Privileging Authority

Figure ~~11~~*13*. Sample Format for Provider Memorandum Acknowledging Receipt of Hearing Board Results

PROVIDER'S OFFICE SYMBOL Date

MEMORANDUM FOR: (Commander, MTF, Address, ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Hearing Board Results

I hereby acknowledge receipt of the subject memorandum, Notification of a Credential/Other Committee Hearing. The memorandum is dated (date) and I receive it on (date). I understand that I have 10 duty days in which to submit a written statement to the privileging authority of corrections, additions, or other matters for his/her reconsideration in this matter.

(Signature of Provider)

(Typed Name)
(Grade, Corps)

ENCLOSURE 12

MANAGING INPATIENT MTF OR JPC PERSONNEL WITH IMPAIRMENTS

1. GENERAL. To include the physical and emotional well-being of individuals providing care and other services to patients is an important consideration in the ongoing assessment of professional competence and performance. This enclosure establishes policies and procedures for health-focused assessment and support activities provided by the inpatient MTFs and JPC for its assigned personnel. The following guidance applies to inpatient MTF and Center employees, both military and civilian (GS and personal services contract) employees, or volunteers who function in an administrative or ancillary services support capacity.

2. IMPAIRED HEALTH CARE PERSONNEL PROGRAM (IHCPP)

a. Each Privileging Authority will establish an IHCPP, or comparably titled program, to address the multidisciplinary needs of its military and civilian healthcare personnel with physical limitations, emotional or psychiatric conditions, or alcohol/other drug abuse problems/dependency. These limitations or conditions result in social or occupational dysfunction of the provider in question or place the patient or others at risk. The program will meet all the provisions of Reference (g), Reference (~~n~~*p*), Army Regulation 600–85 (Reference (~~w~~*y*)), and Bureau of Medicine and Surgery 6320.66 E (Reference (~~x~~*z*)) for applicable personnel.

b. The IHCPP is designed to provide support, assistance, and rehabilitation to those healthcare personnel who suffer from a condition that negatively influences, or has the potential to negatively influence, optimal performance. For purposes of this enclosure, the term "impairment" applies to the manifestations of emotional or psychological conditions and alcohol or other drug use/abuse problems/dependency. Physical limitations are considered impairments when the provider's physical condition places the safety of patients or others in jeopardy. These medical problems may be associated with alcohol or other drug use/abuse, a co-existing emotional/psychological disorder, infectious disease or seropositivity or physical conditions that the provider is unwilling to acknowledge or for which treatment is refused.

c. The objectives of the IHCPP are to:

(1) Promote the well-being of healthcare personnel through education and minimize factors that contribute to impairment associated with alcohol and other drug use/abuse.

(2) Identify impairment of healthcare personnel as early as possible in order to promote recovery and ensure PS.

(3) Provide a mechanism for appropriately limiting the clinical practice of privileged or non-privileged healthcare personnel with an identified impairment.

(4) Provide a mechanism for treatment, or other appropriate remedial actions, and subsequent return to clinical practice (when feasible) for impaired personnel who have been

successfully rehabilitated.

(5) Provide a mechanism for ongoing monitoring of rehabilitated personnel.

(6) Provide a mechanism for ensuring compliance with DoD Directives 6490.1 (Reference (~~y~~*aa*)), Operational Navy Instruction 5350.4D (Reference (~~z~~*ab*)), and Air Force Instruction 44-121 (Reference (a~~a~~*ac*)) when a mental status evaluation is recommended for applicable personnel.

d. Key participants in the process of identification, treatment, and the successful rehabilitation of healthcare personnel with an impairment include the Privileging Authority, the IHCPP members, alcohol and other drug rehabilitation counselors, medical resource personnel, supportive family/friends, and the provider confronting and attempting to effectively deal with his or her impairment.

3. COMPOSITION, ROLE, AND FUNCTION OF THE IMPAIRED HEALTHCARE PERSONNEL AD HOC COMMITTEE. The IHCPC, or comparably titled committee, as a formal committee or subcommittee of another body (for example, credentials committee), serves to ensure effective assistance and rehabilitation, and to aid the employee in retaining or regaining optimal professional functioning. In addition, the IHCPC facilitates implementation of the guidelines set forth in DA Pamphlet 600-85 (Reference (a~~b~~*d*)), Department of the Navy Civilian Human Resource Manual (Reference (a~~e~~*e*)), and Air Force Instruction 36-810 (Reference (a~~d~~*f*)) in a healthcare setting. This committee is charged with the identification, treatment, and return to service of healthcare personnel with alcohol/other drug problems/dependency and medical, psychiatric, or emotional conditions.

a. The committee members will be designated by the Privileging Authority and should, when possible, include at least:

(1) The alcohol/other drug abuse clinical director and/or the clinical consultant.

(2) Representatives from the departments of psychiatry and nursing (a CNS, if available).

(3) A recovering impaired staff member of comparable position with at least 2 years in recovery, if available.

b. The IHCPC chairperson will ensure that all assigned members receive an orientation to the duties and responsibilities of this committee.

c. The IHCPC will meet as needed to accomplish the following functions:

(1) Recommend to the Privileging Authority director a plan for management of healthcare personnel impaired by alcohol/other drug abuse/dependence, medical problems, and/or psychiatric problems, including emotional and behavioral disorders.

(2) Design a staff development plan that incorporates elements of impairment prevention, education about healthcare personnel impairment, and well-being issues.

(3) Recommend facility-specific procedures for management of IHCPs. Recommendations will be consistent with all requirements contained in both Bureau of Medicine and Surgery 5353.3 (Reference (a~~e~~*g*)) and DoD Instruction 6490.4 (Reference (a~~f~~*h*)) when a mental status evaluation is considered for a healthcare provider, regardless of the reason for the evaluation.

(4) Evaluate any healthcare staff member reported, or self-referred, for alcohol/other drug abuse/dependence for evidence of impairment.

(5) Recommend restrictions on the clinical privileges/practice of IHCPs. Recommendations for privileged providers will be forwarded through the credentials committee, and the ECOMS, to the Privileging Authority. Recommendations for all others will be provided through the provider's Department Chief to the Privileging Authority, with copy furnished to the Credentials Committee. For trainees, a report will be furnished to the NCC executive committee. Recommendations are routed through/to the credentials committee to ensure the committee is aware of all staff members with an identified impairment. Periodic status reports on inpatient MTF or JPC staff being followed by the IHCPP may be submitted to the Privileging Authority.

(6) Monitor the progress of impaired providers during treatment, through aftercare, until the completion of the ongoing monitoring phase.

(7) Recommend an individualized plan for the gradual return to full clinical practice for each impaired staff member who has completed treatment. For privileged providers who are retiring or separating from Federal service while still enrolled in an IHCPP, the IHCPC will address whether to recommend full reinstatement of privileges or continuation of the monitored status by the State licensing board.

(8) When an impaired staff member from a particular department is discussed, the department chief may be requested to attend the meeting, if this direct participation is deemed beneficial to the provider in question. One-on-one coordination, as required, may also occur between IHCPC chairperson or committee member and the appropriate department chief.

(9) When impairment is due to alcohol or other drugs, the IHCPC will review input from the alcohol/other drug abuse clinical staff, the duty supervisor, and the involved healthcare staff member's department chief, as appropriate.

(10) In cases of medical or psychiatric impairment, the IHCPC will review statements of progress and recommendations from the impaired provider's physician and duty supervisor and recommend appropriate actions. If, as the result of a physical condition/disorder/problem, an MEB recommendation results in a duty limitation or recommendation for separation from service, the MEB ruling will be reviewed for its impact on the provider's privileges or scope of practice. If the provider is unable to fully perform his or her granted privileges or scope of practice, appropriate modification of the provider's privileges/scope of practice will be recommended to the Privileging Authority.

4. MANAGEMENT OF HEALTHCARE PERSONNEL IMPAIRED BY MEDICAL, PSYCHIATRIC, OR EMOTIONAL PROBLEMS. Any staff member involved in the delivery of healthcare (medical or dental) who is known or suspected of having an acute or chronic medical, psychiatric, or emotional problem that impairs (or could potentially impair) clinical performance will be reported to the IHCPC. Likewise, any staff member who recognizes that a potential/actual problem exists may self-report.

a. The Command-directed mental health evaluation is an evaluation directed by a Service member's Commander as an exercise of the Commander's discretionary authority, IAW applicable law and regulations.

(1) The requirements, restrictions, and specific procedures associated with this type of evaluation are addressed in References (~~y~~*aa*) and (a~~f~~*h*).

(2) The Privileging Authority ensures that fully trained personnel and the necessary safeguards and performance review processes in support of the above mentioned guidance are in place within his or her organization.

b. The IHCPC will request the following:

(1) A statement of diagnosis, prognosis, and implications for clinical performance from a physician (preferably the primary physician treating the provider/professional). A mental health evaluation should be included in the assessment of the health status of IHCP, as appropriate.

(2) Recommendations from the department/service chief or program director regarding the impaired staff member's scope of clinical privileges/practice. These may be provided directly to the IHCPC, or through other locally established channels (for example, via the credentials committee). The provider/professional in question may be actively involved in the process of review and recommendations for modification, if warranted, of his or her clinical privileges/scope of practice. Department/service chief recommendations must take into consideration the best interest of quality care and PS.

c. The IHCPC will review the information in subparagraphs 4.b.(1)-(2) of this enclosure, and recommend modifications to clinical privileges or practice, as necessary. If the impaired staff member has privileges, these recommendations will be submitted through the credentials committee and ECOMS to the Privileging Authority. Otherwise, the recommendations will be made through the department chief to the Privileging Authority. The voluntary modification of clinical privileges or practice as a result of medical or behavioral health-related problems is not to be construed as an adverse privileging/ practice action. If, due to other extenuating circumstances, the Privileging Authority decides to invoke an adverse privileging/practice action, notification of this action will be made according to the provisions of this Manual.

d. Current status reports from the provider's attending physician and his or her clinical supervisor (or a designated professional peer) will be required for the provider with a chronic or debilitating disease. These reports are required at the time of privilege reappraisal and renewal/performance evaluation or if a change occurs in the health of the impaired staff member. For privileged providers, these reports will be maintained in the PAF. Otherwise, the reports will

be maintained in a confidential, temporary QA file (see Enclosure 17) that will be destroyed when the staff member is successfully returned to full clinical practice. If a PCS occurs prior to the return to full practice, this QA file and all supporting documentation will be forwarded to the gaining facility in the same manner as the PCF (by certified return receipt requested mail). In addition, the credentials coordinator at the gaining facility will be notified telephonically or electronically via a signed/encrypted email that an impaired healthcare provider is being transferred to the facility.

e. Upon report of the staff member's recovery, separation, or retirement from Federal service, the IHCPC will again request and review statements from the attending physician, at least one immediate supervisor or a professional peer, and the department/service chief.

(1) Based on the above feedback, the committee will make recommendations through the credentials committee and ECOMS to the Privileging Authority regarding the removal of limitations on clinical practice. If the recommendation is to remove the limitation(s), the committee may recommend an appropriate follow up period of monitoring.

(2) For those IHCPs separating or retiring from service due to a medical or psychological condition, the committee will make a recommendation regarding the need to continue in a monitored status versus a return to full privileges/practice without monitoring. If continued monitoring is recommended, the staff member will be reported on DD Form 2499 to JTF CapMed.

(3) JTF CapMed will report these IHCPs to appropriate licensing authorities. Any privileged provider who fails to complete the rehabilitation program in which he or she is enrolled will be reported to the NPDB using DD Form 2499.

5. MANAGEMENT OF HEALTHCARE PERSONNEL IMPAIRED BY ALCOHOL/OTHER DRUG ABUSE/DEPENDENCE

a. Abuse and Dependence. Alcohol/other drug abuse/dependence as described in the current Diagnostic and Statistical Manual of Mental Disorders may lead to impairment and the subsequent need for rehabilitation.

b. Reporting of Impaired Personnel. All healthcare personnel (military and civilian) known or suspected of having an alcohol/other drug abuse/dependence problem will be reported, or may self-report, to the IHCPC.

c. Drug and Alcohol Rehabilitation Program Components. The provisions of References (~~w~~*y*), (a~~b~~*d*), (a~~e~~*g*), and Military Personnel Manual 1910-232 (References (a~~g~~*i*)) and Public Law 104–191 (Reference (a~~h~~*j*)) apply fully to healthcare personnel impaired by alcohol/other drug abuse/dependence. The eight program components related to management of the provider with this type of impairment include: prevention, case-finding, intervention, treatment, aftercare, re-entry, ongoing monitoring, and program termination.

(1) Prevention

(a) Because healthcare personnel work in a milieu that is often highly stressful, overuse of alcohol by some may be problematic. Likewise, ready access to habit-forming drugs presents an enticement that may lead to misuse/abuse. All inpatient MTFs and the JPC will develop a prevention and identification plan in conjunction with the alcohol/other drug abuse clinical director. The plan will incorporate elements of alcohol and drug de-glamorization, widespread publicity, education, and various QA activities to identify staff member performance or behavior that is substandard or that has deteriorated over time.

1. Educational programs will place special emphasis on the susceptibility to drug abuse for those working with pharmaceuticals of addictive potential. In addition, all inpatient MTFs and the JPC will have in place standardized policies and procedures for storing, handling, dispensing, and accounting for controlled drugs throughout the organization (that is, parent unit and outlying clinics). These policies and procedures will be reviewed periodically and will comply with all applicable Service-specific and nationally recognized external accrediting, licensing, and/or inspecting agenciy standards.

2. When drug diverting or illegal use has occurred, it will be addressed immediately within the inpatient MTF or the JPC CQM structure. Lessons learned that may benefit others will be forwarded to JTF CapMed. It should be noted that drug diversion and abuse is criminal misconduct and law enforcement involvement is required.

(b) All healthcare providers - especially those in Psychiatry, Family Practice, Primary Healthcare, and Emergency Medicine - will be educated in all aspects of alcohol/other drug abuse/dependence as part of an ongoing educational program. All personnel with patient care contact should, when feasible, participate in a didactic and experiential orientation at a residential treatment facility (RTF).

(c) Formal educational programs for inpatient MTF or JPC healthcare personnel will emphasize:

1. The vulnerability of healthcare personnel to alcohol/other drug abuse/dependence, despite their backgrounds, education, training, and experience.

2. The importance of healthy coping mechanisms in dealing with the stresses that often contribute to the development of alcohol/other drug abuse/dependence among healthcare personnel.

3. The RM and PS implications of providing or supervising patient care while impaired.

4. The impact on decision-making skills and the risks associated with the use and misuse of alcohol and/or other drugs.

5. The impact of denial relative to alcohol/other drug abuse/dependence and that this is compounded by the silence of colleagues, supervisors, and even patients.

a. The early behavioral and job-related performance indicators of alcohol/other drug abuse/dependence.

b. The principles of effective intervention and the various treatment programs available to IHCP and their families.

6. The responsibility of peers and supervisors to report any provider who abuses or is dependent on alcohol or other drugs to the IHCPC.

a. The specific procedures for self-referral according to established policy.

b. The threat to the career, health, and life if the impairment is allowed to continue unreported and untreated. The statistics related to effective treatment and successful return to full clinical practice, especially when abuse/dependence is identified and treated early.

(d) Encourage IHCPs who have been through treatment and have been in recovery for at least 1 year to volunteer as resource personnel to assist in teaching or conducting alcohol and drug abuse educational programs.

(e) Mechanisms to solicit employee feedback concerning recognized/perceived staff problems with alcohol or other drugs should be considered. Review of specific unit policies or stressful work environments that may be contributing to the use of alcohol or other drugs by inpatient MTF or JPC staff is appropriate.

(2) Case-finding. Techniques such as anonymous employee surveys and IG sensing sessions may help identify personnel with real or potential problems. Management must be sensitive to the signs and symptoms of alcohol/other drug abuse/dependence in order to facilitate early recognition and treatment of such problems. A change in a staff member's clinical performance and behavior as noted by the clinical supervisor may be among the first signs of an impending problem.

(a) All JTF *CapMed* MTF and Center personnel are required to notify the Privileging Authority of providers (including contract personnel) whose clinical practice is impaired. This notification may be either verbal or in writing. An open-door policy on the part of the IHCPC encourages self-referral as well as identification of suspected or potential impairment. Non-personal services contract personnel will be brought to the attention of the contracting agency for management and appropriate follow up according to State licensing board requirements. All who are involved with healthcare personnel who are either being evaluated for or who have been determined to have impairment must be mindful of the confidentiality of information shared in the context of the IHCPP and the provider in question's right to privacy. No disciplinary action, punishment, or any form of retaliatory action will be taken against a person who submits information concerning an impaired provider/professional unless it is later determined that the information was false and the provider providing the information acted maliciously.

(b) The department chief will review the report and inform the committee whether monitoring or confrontation will be employed. In either case, the alcohol, and drug abuse clinical director will be notified and he or she will be involved in the process.

(c) For civilian staff, in addition to the employee assistance program, the management-employee relations representative from the servicing CPOC/CPAC, and the bargaining unit (union) representative will be informed. Coordination to ensure the appropriate management of this sensitive situation is essential to ensure compliance with References (a~~b~~*d*), (a~~c~~*e*), and (a~~d~~*f*)).

(d) One of the following courses of action will be taken if performance does not meet the supervisor's expectations or performance standards as a result of actual (or suspected) alcohol/other drug abuse/dependence:

1. Monitoring or enhanced supervision. This action is used only when there is no clear evidence with which to confront potential impairment. If monitoring or enhanced supervision is the course of action selected, a memorandum for the record describing the circumstances and specifying the type of monitoring to be conducted will be forwarded to the IHCPC.

2. Confrontation. This course of action is recommended if evidence of impairment exists. The supervisor will present the objective; documented evidence of the staff member's job performance issues. The supervisor will not discuss any suspicion of alcohol/other drug abuse but will focus only on the job performance. The supervisor should offer assistance for any problem that may be contributing to the job performance issues. It is also appropriate to advise the staff member that he or she will be referred to another professional (for example, a Behavioral Health professional, an Addiction Specialist, or an employee assistance specialist) for support/assistance, in accordance with References (~~w~~*y*), (~~z~~*ab*), (a~~a~~*c*), (a~~b~~*d*), (a~~e~~*g*), and (a~~d~~*f*), or other appropriate service for a full evaluation. The supervisor must not attempt to diagnose the problem but should outline his or her expectations relative to acceptable future employee performance. The potential consequences to the employee if he or she fails to meet these expectations should be stressed. A memorandum for record will be forwarded to the IHCPC describing the evidence presented in the confrontation, the stated future expectations, and the staff member's response. Under no circumstance will a staff member be questioned about his or her impairment, or the cause thereof, without appropriate legal advice concerning the staff member's Article 31 UCMJ, and/or other employee rights, as appropriate.

(3) Intervention

(a) Intervention involves confrontation as a first step toward the IHCP entering treatment. Intervention is used when the behavior that impairs (or potentially impairs) clinical performance is clearly related to alcohol/other drug abuse/ dependence. When intervention is elected:

1. The alcohol/other drug abuse clinical director will be notified so that the therapist can provide consultation and assistance. The alcohol/other drug abuse clinical staff will process enrollment and admission to an appropriate treatment program, if appropriate.

2. A medical evaluation is necessary prior to admission to any inpatient or partial treatment program or for referral to outpatient and all other treatment programs.

3. The Privileging Authority may initiate command-directed enrollment of a Service member into a treatment program if participation on the part of the involved provider is not voluntary. If the impaired staff member is a civilian employee, when a civilian employee receives a confirmed positive test for illicit drugs, the employee's supervisor will consult with the CPAC and his or her service legal office and suspend the employee from the TDP and access to classified information pending a determination of administrative action. If the employee is in a Personnel Reliability Program position, the supervisor will promptly notify the certifying official and suspend the employee from their position in accordance with Service-specific guidance pending a final determination of administrative action. The civilian program coordinator of the alcohol/other drug abuse clinical program, the management-employee relations representative from the servicing CPOC/CPAC, and the bargaining unit (union) representative will be notified prior to the intervention. Coordination to ensure the appropriate management of this sensitive situation is essential. Consequences to the civilian or military member for refusal to enter treatment will be determined in advance and the employee or Service Member so advised. Reserve healthcare personnel identified by virtue of urinalysis, blood alcohol level, direct observation, alcohol breath analysis device, or job performance issues will be counseled according to Service-specific regulations: References (~~w~~*y*), (~~z~~*ab*), and (a~~a~~*ac*). A counseling statement which includes the following:

> "Pursuant to AR 340–21, chapter 3, AR 600–85, OPNAVINST 5350. 4D, Air Force instruction 44-121 depending on the service affiliation of the person identified by urinalysis, blood alcohol level, direct observation or deteriorating job performance. I hereby consent to release of information by the Military Branch concerning my alcohol/drug abuse to the State-certified, Military Branch-approved substance abuse counseling and treatment center of my choice. I further consent, under applicable State and Federal law, to the release of information concerning my treatment and rehabilitation by the substance counseling and treatment center to my commander."

This statement will be signed by the Service member involved. Should the provider elect not to sign the statement, he or she is subject to immediate suspension from duty and initiation of separation proceedings.

(b) The clinical practice parameters of the impaired provider will be reviewed by the IHCPC in coordination with the credentials committee, when appropriate. The impaired staff member will be removed from direct patient contact if deemed necessary. In an effort to be supportive of the impaired provider and to protect the safety of patients and the quality of care provided, decisions regarding professional privileges/practice must be made on a case-by-case basis. If a privileged provider is involved, his or her privileges may require immediate suspension until the credentials committee determines that the problem has been resolved. IHCPs requiring inpatient treatment will have their clinical privileges/practice reevaluated upon return to duty.

(c) Care will be taken to ensure that healthcare personnel who have been confronted have an adequate support system regardless of whether the provider remains at home and receives treatment as an outpatient or is hospitalized.

(4) Treatment

(a) Need for treatment. The need for treatment is based both on the type of drug and how it is being abused. Apart from the legal ramifications, drug abuse can range from simple experimentation to psychological or physical dependence. All identified AD abusers will immediately be referred for evaluation and treatment of substance abuse or other appropriate intervention and management, per References (~~w~~*y*), (~~z~~*ab*), (a~~a~~*c*), (a~~b~~*d*), (a~~c~~*e*), and (a~~d~~*f*), or other Service-specific regulations. Reservists will seek assistance from area civilian agencies, or if eligible, through the VA. Assessment of the need for treatment and the level of treatment will be made in accordance with References (~~w~~*y*), (~~z~~*ab*), (a~~a~~*c*), (a~~b~~*d*), (a~~c~~*e*), and (a~~d~~*f*), or other Service-specific regulations.

(b) Types of treatment

1. Inpatient (residential) treatment of AD Military healthcare personnel will be offered in an RTF if the provider has potential for retention on AD. Treatment may be offered through the VA if the Service member is separated from military service.

2. If detoxification is necessary, it will be accomplished per established local medical detoxification protocols.

3. Outpatient treatment and education will be available from the alcohol/other drug abuse clinical staff to all military and civilian IHCPs.

4. Civilians may elect to be treated in civilian outpatient or residential programs through the Federal Employee's Health Benefits Program, other commercial insurance programs, or State board of licensing rehabilitation programs.

5. Reservists may elect to enroll, or may be directed by their State board of licensure to participate, in a State IHCP treatment program. The program may be inpatient, outpatient, or residential. The State board will stipulate the parameters of the impaired provider's practice. The Navy authorizes Reservists to use MTFs; however, treatment at inpatient MTFs will be under individually prepared permissive letter-type orders. Orders will clearly set forth the fact that pay, allowances, and retirement points are not authorized (Reference (~~z~~*ab*)).

(c) Coordination of treatment

1. Treatment will be coordinated by the alcohol/other drug abuse clinical staff for Service members and civilian personnel. Reservists will comply with the treatment plan established by their State's IHCPP. Activities will be monitored and supported by a physician or other clinical staff members participating in the treatment plan. Every effort will be made to ensure that the families of IHCPs are included in the development and implementation of treatment plans.

2. Adverse administrative or disciplinary actions that may interfere with treatment should be resolved prior to admission to an RTF. For those who do not enter an RTF and those awaiting the decision of adverse administrative or disciplinary action, a binding outpatient treatment plan will be developed according to the requirements in subparagraph 5.c.(5) of this enclosure.

(5) Aftercare. Aftercare for Service members is the program of activities that takes place during the remainder of the 1-year enrollment following residential or outpatient treatment. The program is designed to promote long-term recovery. The aftercare plan will be developed prior to discharge from the RTF or completion of an outpatient treatment program. The alcohol/other drug abuse therapist will coordinate a rehabilitation team meeting as soon as the staff member returns to duty. The inpatient MTF Commander, Center director, supervisor, involved staff member, and IHCPC will be provided a copy of the plan. The aftercare plan will be binding and the consequences to the impaired staff member of not following the plan will be clearly documented.

(a) The aftercare plan will include the provision that the impaired staff member demonstrates evidence of:

1. Attendance at Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, or other approved support group at least 3 times weekly.

2. Appropriate use of anti-relapse medication, if prescribed in accordance with Reference (a~~a~~*c*), Reference (a~~d~~*f*), and Reference (a~~g~~*i*).

3. Participation in the groups, educational classes, and individual sessions as described in the aftercare of the following Service-specific documents: Reference (~~z~~*ab*), Reference (a~~a~~*c*), Reference (a~~b~~*d*), Reference (ad), and Reference (a~~e~~*e*).

4. Compliance with random testing for illegal drug use. IHCPs with problems involving illegal drug use will submit to urine testing conducted by the installation biochemical testing coordinator. The samples will be tested for the specific drug of abuse, if possible. Such testing will be performed weekly for the first 6 months and twice a month for the next 6 months. In the second year of aftercare, the inpatient MTF Commander or JPC Director, in coordination with the alcohol/other drug abuse staff, will ensure that monthly drug testing is accomplished. The test results will be reported to the IHCPC.

(b) Evidence of compliance with the above requirements will be submitted to the IHCPC monthly for the first year following entry into treatment and at least quarterly for the second year.

(c) In the event of a relapse (return to alcohol or other drug abuse), the impaired staff member will have his or her clinical duties suspended immediately. The report of assessment will contain a recommendation for processing the staff member for release from Federal service or for continued treatment. If a second admission to an RTF is recommended, approval must be granted by the Privileging Authority according to established managed care criteria and policies.

(d) Tours of duty for AD IHCPs will be stabilized for at least 12 months from the date of admission to the RTF or initiation of outpatient treatment, according to Service-specific guidelines. Other Service-specific guidelines regarding the management of Service members during aftercare include Reference (a~~b~~*d*), Reference (a~~g~~*i*), and Public Law 104-191 (Reference (a~~h~~*j*)). Major leadership positions and solo practices are to be avoided. In these cases, a request

for exception to policy will be initiated to ensure the impaired professional is appropriately reassigned.

(e) Routine requests by IHCPs for leave generally will not be approved until 60 days after discharge from an RTF to allow time for transition into the aftercare phase of rehabilitation.

(6) Re-entry. Re-entry refers to the return to duty and re-entry into clinical practice of recovering IHCPs. Reinstatement to full clinical practice will normally be a gradual process. Return to full practice depends upon the circumstances of the individual case and the staff member's response to treatment and aftercare. The Privileging Authority makes re-entry-into practice determinations based on recommendations from the IHCPC in coordination with the credentials committee, when appropriate. Reservists will be transferred to their parent command.

(a) The privileged healthcare provider who has abused controlled drugs is generally restricted from prescribing or administering controlled drugs upon initial return to duty after any treatment.

(b) If progress is satisfactory, the healthcare staff member should eventually be returned to full clinical practice in the role previously held. The provider's return to practice, the capacity in which practice will resume, and the specifics of the ongoing monitoring of practice, must be determined on a case-by-case basis.

(c) If, in the opinion of the Department Chief, the IHCPC, credentials committees, the involved therapists, and the provider concerned, a return to the previously held practice specialty is not appropriate, the parent Service will be notified for disposition determination. For civilian healthcare personnel, coordination for a change in duty position will occur among the inpatient MTF or JPC leadership, the CPOC/CPAC representative, the bargaining unit, and the individual employee.

(d) In no case will the recovering staff member participate as a speaker for an inpatient MTF or JPC in-service or other presentation on alcohol/other drug abuse/dependence during the first 12 months following the onset of treatment.

(e) Reservists will be allowed to perform duty within inpatient MTFs or JPC while participating in or following completion of an IHCPP, unless their practice has been restricted. The State impaired-personnel program in which the provider has participated (either voluntarily or by order/stipulation) establishes criteria related to return to practice. A copy of all State orders/stipulations should be obtained and reviewed by the parent unit to facilitate a clear understanding of the Reservist's probation and any limitations or restrictions to practice that may have been imposed. Contact with the State board for clarification of terms, definitions, or other expectations is warranted. State treatment program requirements must be followed to facilitate and support the impaired Reservists' return to his or her clinical environment. The Reserve providers will furnish proof of employer notification to his or her parent unit of assignment/attachment. Documentation related to current delineation of privileges from each civilian agency where the impaired Reservist provider is privileged will be submitted to the Privileging Authority at the time of request for privileges.

(7) Ongoing monitoring. Ongoing monitoring for Service members includes the observations, reports, and meetings required over a 2-year period to assess the progress of IHCPs who have returned to duty. This 2-year period begins from the day the provider completes treatment as an outpatient or is discharged from a residential setting. The clinic is involved in monitoring during the first year of aftercare. The supervisor, department chief, and IHCPC will continue monitoring for the second year. The committee will review the progress of each impaired staff member monthly for the first 3 months of treatment and at least quarterly thereafter until 2 years from the last date of treatment. Requirements related to ongoing monitoring of Reservists who are participating in State treatment programs vary dramatically. State-impaired personnel programs are inconsistent in monitoring requirements, and the period of monitoring may be anywhere from 5–10 years in length. Direct coordination with the State treatment program or organization providing monitoring is necessary. State programs or agencies that will not support impaired personnel reporting requirements will be identified to JTF CapMed for coordination efforts.

(a) Information pertinent to required reports is as follows:

1. The Substance abuse program clinic staff will submit monthly written reports to the IHCPC for the first 3 months and quarterly thereafter while IHCPs are in aftercare according to Reference (~~w~~*y*), Reference (~~z~~*ab*), and Reference (a~~a~~*c*). These reports will state for each case, as a minimum, the status of compliance with the aftercare plan, current progress, and prognosis. The reports will be forwarded to the credentials committee for privileged HCPs.

2. The immediate supervisor or designated peer will submit monthly reports to the ASAP regarding the staff member's duty competence during the first 3 months and quarterly thereafter until completion of aftercare monitoring.

3. Reports forwarded to the credentials committee will be maintained in the PAF. Reports on non-privileged staff members will be maintained in a confidential, protected QA file which will be destroyed when the staff member is successfully returned to full practice. If a PCS occurs prior to the provider's return to full practice, these files will be transferred to the gaining facility following the guidelines for transfer of a PCF.

(b) Providers involved in monitoring the impaired staff member will notify the appropriate supervisor and therapist immediately upon signs of relapse or failure to follow the aftercare plan. Prompt intervention will be initiated for the good of the staff member as well as the safety of his or her patients.

(c) The confidentiality requirements of References (~~w~~*y*), (~~z~~*ab*), and (a~~a~~*c*) apply to all reports, committee minutes, and discussions pertaining to IHCPs in the U.S. Army's ASAP, U.S. Navy Drug and Alcohol Program Advisor (DAPA), and U.S. Air Force Alcohol and Drug Abuse Prevention and Treatment (ADAPT) program. Civil penalties apply for unauthorized disclosure.

(8) Program termination

(a) Professional involvement. Reference (~~u~~*w*), DAPA, Reference (~~w~~*y*), and the ADAPT program in accordance with Reference (a~~a~~*c*), specify the staff member's recovery

program. These programs generally end 1-2 years after the date treatment was completed. At this time the IHCPC will recommend termination of monitoring unless findings based on review of the case or relapse necessitate further involvement.

(b) Processing for separation. In accordance with References (~~w~~*y*), (~~z~~*ab*), (a~~a~~*c*), and (Reference (a~~g~~*i*)), all Service members and Reservists who are identified as drug abusers will be processed for administrative separation.

6. NOTIFICATION REQUIREMENTS

a. Notification to JTF CapMed will be made regarding all healthcare personnel (officer, enlisted, civilian, and contracted) who are involved in the IHCPP. DD Form 2499 will be utilized for this purpose. Each Privileging Authority will provide a copy of the DD Form 2499 to their appropriate Service organization. Notification requirement may be found in References (~~w~~*y*), (~~z~~*ab*), and (a~~a~~*c*).

b. While JTF CapMed is notified of all healthcare personnel involved in the IHCPP, only those meeting any of the criteria in subparagraphs 6.b.(1)-(5) of this ~~e~~*E*nclosure are reported to professional regulating authorities. The provider/professional:

(1) Has his or her clinical privileges/practice denied, suspended, restricted, reduced, or revoked. Reserve units are not responsible for reporting clinical privileges/practice actions taken against Reservists by civilian agencies/facilities; this is the responsibility of the civilian employer. Privileges denied, suspended, restricted, reduced, or revoked by the Reserve unit of assignment/attachment will be reported.

(2) Possesses, prescribes, sells, administers, gives, or uses any drug legally classified as a controlled substance for other than medically acceptable therapeutic purposes.

(3) Separates from AD or Federal service with less-than-full privileges or less-than-full scope of clinical practice for non-privileged personnel.

(4) Has an unauthorized absence at any time, for any reason, during the 2-year monitoring period following alcohol or other drug rehabilitation.

(5) Has been enrolled in the IHCPP. Reporting by JTF CapMed (for civilian and contract providers) or the member‘s Service headquarters (for Military Providers) to the NPDB will occur only if the impaired provider fails to successfully complete the 2 year program.

c. For reporting to professional regulating authorities, CJTF is the reporting authority for civilian and contract IHCPs; for Military Providers, the Service SG is the reporting authority according to References (~~u~~*w*), (~~u~~*x*), and (a~~a~~*c*).

7. REVIEW OF NPDB QUERY AND LICENSING INFORMATION

a. Reserve IHCPs are reported to the NPDB by both the civilian healthcare facility and by the State licensing board when an adverse privileging/practice action associated with impairment has been taken against the provider's license. Reporting of the impaired Reservist member occurs despite the provider being actively engaged in and complying with all the requirements of a rehabilitation program.

b. Because an adverse privileging/practice action report to the NPDB is filed by the facility and licensing board, it is not unusual for more than one adverse privileging/practice action to be noted on a Reservist member's report from the NPDB. This is in contrast to the AD provider's NPDB report which will not reflect an adverse privileging/practice action related to an impairment unless one of the conditions in paragraph 6.b. of this enclosure is met.

c. All adverse reports from the NPDB require review by the credentials committee. However, if multiple reports of the same impairment are on record, this should be taken into consideration when recommendations for initial privileges or renewal of privileges are made.

d. A Reservist member who is involved in a civilian IHCPP may have an unfavorable action taken by the State licensing board that places the license on probation but does not restrict the provider's practice. The probation period is for a specified length of time that varies from State to State.

ENCLOSURE 13

PATIENT SAFETY (PS) IN THE HEALTHCARE SETTING

1. GENERAL

a. PS in the healthcare setting involves a variety of clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the potential for harm to beneficiaries and to improve healthcare quality. Effective PS initiatives seek to control untoward events before they occur and, as such, elements of risk assessment, risk identification, and risk reduction or containment are involved. In the past, this frame of reference has been associated almost exclusively with Risk Management (RM) at the facility level.

b. The inpatient MTF or JPC leadership plays a critical role in the facility-based Patient Safety Program (PSP) given the influence that leaders exert on activities directly associated with this program such as PI, environmental safety, and RM. Although the beneficiary is the central focus of PS, it is difficult to create an organization-wide PS initiative that excludes staff, family members, and others. Many of the activities implemented to improve PS (for example, security, fire safety, equipment safety, infection control, falls prevention) encompass staff and others, as well as patients. PS is a critical component of a comprehensive safety effort. As such, PS activities and processes must be effectively integrated with those of the existing inpatient MTF or, as appropriate, the JPC Safety Program, *and similar initiatives*.

2. SAFETY ASSOCIATED WITH PATIENT CARE

a. PS activities are proactive and focus on reducing or avoiding misadventures during the delivery of medical/ healthcare. Deliberate attention is required to improve medical systems and processes in order to prevent harm related to medical/healthcare interventions and to modify, reduce, or eliminate beneficiary exposure wherever possible.

b. In order to sustain a culture of safety throughout the JOA, enhanced responsibility and accountability for PS at all levels is essential. Leadership must establish an atmosphere of trust and confidence that encourages all staff to report actual and potential medical/healthcare errors in order to protect patients, to learn from the hazardous situations identified, and, wherever possible, to prevent future recurrences.

c. Active participation is required on the part of all command and staff members to avoid untoward medical care outcomes and to improve PS. As a minimum, organizations will:

(1) Appropriately report adverse events (including SEs) and near misses according to DoD PSP requirements and accrediting agency guidance.

(2) Focus on system and process factors rather than the performance of the individual(s) involved when analyzing a PS event to determine its cause.

(3) Identify the underlying cause(s) and the associated process changes that may reduce the potential for recurrence.

(4) Implement healthcare service delivery system redesigns that will reduce the likelihood of harm and promote PS.

(5) Document PS issues and lessons learned for dissemination internally and throughout the JOA, as appropriate.

3. PATIENT SAFETY PROGRAM (PSP)

a. Each inpatient MTF Commander and Center Director will establish and implement a PSP. The PSP will seek to improve the safety of care delivered to beneficiaries across the JOA. The PSP is a comprehensive program which provides products, services, educational and training resources to help ensure the safe delivery of healthcare to patients.

(1) The guiding principles include: encouraging a systems approach across the Services to create a safer patient environment; promoting innovation and creativity while engaging leadership; fostering a culture of trust and transparency through communication, coordination and teamwork; and embracing of national initiatives deemed beneficial to the MHS.

(2) The goals of the DoD PSP are to: promote safe care environments for a healthy military work structure; support efforts to equip beneficiaries to partner with their health care providers to ensure safe care; reduce overall healthcare costs through delivery of safe care; develop processes and products to improve PS practices; promote a culture that optimizes the use of resources; and demonstrate PS impact. Ultimately, the DoD PSP, in collaboration with the Clinical Quality Division, is leading the MHS to a culture of safety and quality.

b. The DoD PSP will be implemented in the inpatient MTFs and, as appropriate, the JPC as a dedicated program for reducing harm due to medical errors and improving PS that is focused on prevention, not punishment, and on improving medical systems and processes to overcome preventable errors.

4. REPORTS AND INTERVENTION TECHNIQUES FOR MONITORING PROBLEM-PRONE AREAS

a. Patient Safety Reports (PSR)

(1) PS Reports will be submitted through JTF CapMed to the PS Data Analysis Center. The data, information, and format will be in accordance with DoD PSP guidance.

(2) In order to facilitate timely and accurate reports and analysis, information submitted to the PS Data Analysis Center shall include identification of the reporting facility. If unique identifiers are used during transmission, the corresponding master decoder document will be

provided by the Service Headquarters to the PS Data Analysis Center. All personal patient and individual provider information will be redacted before being sent to the PS Data Analysis Center.

(3) All Patient Safety reports required by entities outside the MTF shall be routed through JTF CapMed Quality Division prior to final submission to such entities.

b. PSR System

(1) The goal of the DoD PSP is to deploy an automated PSR system. Once deployed, the automated DoD PSR System will allow users to report, aggregate, and analyze patient safety events/incidents.

(2) When available, inpatient MTF and Center staff shall use the automated PSR system to report patient safety events.

c. Proactive Risk Assessment (PRA)

(1) Requirement to Complete a PRA. PRA is a process for the analysis and improvement of any at-risk system process. All inpatient MTFs and, as appropriate, the JPC will complete a PRA on a high-risk process in accordance with requirements established by their accrediting organization and/or individual Service guidance. PRAs may be conducted at any time and are appropriate for all processes. Medical facilities accredited by accrediting organizations other than TJC may be exempt from a PRA requirement, as determined by JTF CapMed.

(2) PRA Submission

(a) All facilities shall submit each PRA to JTF CapMed within 30 days of completion. JTF CapMed staff shall forward all completed PRAs to the Patient Safety Data Analysis Center within 45 calendar days of receipt from the inpatient MTF or, as appropriate, the JPC. The reporting facility will be fully identified and included on the PRA. Any requests for additional or clarifying information required from the inpatient MTF or JPC by the PS Data Analysis Center will be requested through JTF CapMed.

(b) PRA materials are not intended for public release and shall be maintained as confidential QA records.

d. Root Cause Analysis (RCA)

(1) A RCA is used to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a SE. A RCA focuses on systems and processes, not individual performance.

(2) PS RCA data is used within the DoD for improving healthcare systems and processes that impact quality and PS. At all levels of the DoD, information obtained through a PS RCA, to the greatest extent possible, will not be used in adverse administrative, privileging, or other

personnel actions, including disciplinary action. In cases where possible disciplinary action could result, the command will conduct two separate and independent investigations.

(3) An RCA shall be completed by the inpatient MTF or, as appropriate, the JPC on all TJC reviewable SEs within the time period specified in the current TJC standards.

(4) RCA Submission

(a) Inpatient MTFs or the JPC will submit completed RCAs to JTF CapMed.

(b) Electronic and/or hard copies of RCA from reviewable SEs should reach the PS Data Analysis Center not later than 45 days after reviewed and approved by TJC. The data provided shall remove all identifying information concerning patients and individual health care providers. RCA with extensions granted by TJC will be annotated accordingly. The reporting facility identification will be included on the RCA. These copies shall be maintained as confidential QA records.

(c) Copies of additional updates or changes to the RCA (such as those required by TJC, intermediary, or Service headquarters) will be forwarded through JTF CapMed to the PS Safety Data Analysis Center within 30 days of the RCA final approval. Any requests for additional or clarifying information required from the inpatient MTF or JPC by the PS Data Analysis Center will be coordinated through the Service headquarters staff.

5. MANAGEMENT OF AN ADVERSE EVENT OR NEAR MISS

a. Types of Incidents. In the context of PS, incidents involving patients are classified as either adverse events or near miss. (See Glossary)

(1) The person in charge of the activity where the adverse event/near miss has occurred will ensure that the PS manager (or designee) is notified within 24 hours of its detection.

(2) The PS manager is responsible for review of the facts associated with either type of event and for ensuring that an appropriate evaluation is performed as required by DoD guidance.

(3) The servicing legal office will be informed and appropriate coordination will occur throughout the management of adverse events that are identified as Potentially Compensable Events (PCEs) and SEs.

b. Assessment of the Adverse Event

(1) The adverse event assessment and weighted scoring (that is, Agency for Healthcare Research and Quality (AHRQ) Harm Scale or comparable DoD-sanctioned methodology) may be used by a designated individual (for example, the PS manager) or by an interdisciplinary group. A multidisciplinary approach ensures that a broad, objective perspective is maintained in the review process. Both clinical and nonclinical experts provide valuable input to the decisions

that result and the subsequent actions taken regarding adverse events/near miss. The harm scale categories are defined as follows:

(a) Death. Death at the time of the assessment.

(b) Severe Permanent Harm. Severe lifelong bodily or psychological injury or disfigurement that interferes significantly with the functional ability or quality of life. Prognosis at the time of assessment.

(c) Permanent Harm. Lifelong bodily or psychological injury or increased susceptibility to disease. Prognosis at the time of assessment.

(d) Temporary Harm. Bodily or psychological injury, but likely not permanent. Prognosis at the time of assessment.

(e) Additional Treatment. Injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery, and/or expected treatment in future as a direct result of event.

(f) Emotional Distress or Inconvenience. Mild and transient anxiety or pain or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies). Distress/inconvenience since discovery, and/or expected in the future as a direct result of event.

(g) No Harm. Event reached patient, but no harm was evident.

(h) Near Miss. Event that did not reach the patient.

(i) Unsafe Condition. Potential event. Any circumstance that increases the probability of a patient safety event.

(2) A Potentially Compensable Event (PCE) is identified as any adverse event that resulted in harm to the patient and presents a possible financial loss to the Federal Government (a malpractice claim or death/disability payment). PCE determination is based on the evidence of harm as described previously. Any event that is determined by the risk manager to meet the harm scale categories of: (a) Death, (b) Severe Permanent Harm, (c) Permanent Harm, (d) Temporary Harm, and (e) Additional Treatment is to be identified and reported as a PCE.

(3) If there is a low priority accorded the event based on the standardized PS severity assessment performed (that is, AHRQ Harm Scale), the decision may be to take no action, other than tracking, trending, and subsequent aggregate review analysis of the adverse event according to DoD guidance. The action may include reporting the event to Joint JTF CapMed, and/or the TJC. If warranted, an RCA will be performed and a corrective action plan developed in accordance with DoD PSP guidance. Adverse events or incidents involving physical safety issues or hazardous conditions will be reviewed and referred for corrective action to the

individual(s) responsible for managing the inpatient MTF or, as appropriate, the JPC Safety Program or other appropriate facility personnel. Incidents classified as PCEs will be referred to RM for appropriate action.

(4) If, in the course of investigation, the evidence suggests that the incident presumed to be an adverse event is the result of an intentional unsafe act, the incident will immediately be referred to the inpatient MTF Commander or, as appropriate, the JPC Director for appropriate action. Intentional unsafe acts are not within the defined scope of the PSP. RM is responsible for notifying the servicing Legal Office of such alleged incidents as well as all coordination and follow-up action. Findings of intentional unsafe acts that result from gross negligence or possible criminal activity shall be included in the investigation. Given the implications of these acts, they will be addressed, with all due attention, through appropriate legal, administrative, and disciplinary actions.

(5) For incidents that appear to be both an adverse event and an intentional unsafe act, that is, deliberate administration of a potentially lethal dose of a medication, primary authority and responsibility are outside the PSP. The PS manager may proceed with a review of the incident to include an RCA, if applicable, of any facility systems and processes implicated in the actual/potential intentional safe act. Given the medical malpractice implications, a separate RM investigation/SOC determination will be conducted on the matter of culpability of the individual(s) involved in the act. This is in addition to any criminal investigation that may ensue.

(6) Unintentional human error will occur despite the most diligent efforts on the part of healthcare personnel. These must be dealt with in an atmosphere of supportive concern. However, criminal actions and errors due to gross negligence/reckless behavior, substance abuse, and/or patient abuse will not be tolerated. Individuals implicated in such actions will be referred for action, to the fullest extent possible, through established RM provider action channels, or administrative channels for the non-privileged healthcare professional.

c. Investigating and Tracking

(1) In order to maintain an accurate accounting of occurrences with potential PS implications, all adverse events (including near misses), will be entered into the organization's registry of adverse events. Requirements for reporting the data that are collected will be according to current DoD guidance.

(2) For events with minimal harm to the patient and near misses, an aggregate review and analysis of data may be appropriate. Falls and medication errors are two examples of events for which an aggregate review is authorized.

(3) An RCA is mandatory for all SEs and for other adverse events as designated by DoD policy.

(4) Any adverse event that is classified as a PCE will also be entered into *CCQAS*. Given the potential medical malpractice implications, a peer review/SOC determination will be conducted on the matter of culpability of the individual(s) significantly involved in the PCE.

When scrutinizing professional behavior and competence, the medical malpractice peer review that is conducted will rely, to the maximum extent possible, on other review systems and processes outside the PSP.

d. Reporting. Adverse events that, according to DoD guidance, require QM division (QMD) notification will be reported as a Commander's Critical Information Report to JTF CapMed within 72 hours of identification. Inpatient MTFs or JPC will also inform JTF CapMed of any situation in which the news media is involved, or may be involved, and the coverage may reflect negatively on the JOA. Facility-level PSP aggregate data will be electronically submitted quarterly to JTF CapMed.

6. MANAGEMENT OF A SE. A SE is an unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Such adverse events are called "sentinel" because they signal the need for immediate, impartial investigation, and response by the organization. Within the context of this general definition, each organization may further define, for its own purposes, the specific parameters of the term, "sentinel event." JTF CapMed adopts TJC list of reviewable SEs. As a minimum, the organization's written SE policy will include those events that are subject to review according to TJC and JTF CapMed guidance.

a. DoD and TJC Reviewable SEs

(1) Inpatient MTFs and JPC will report all SEs to JTF CapMed within 24 hours.

(2) Sentinel Events will be forwarded to Health Affairs within 24 hours after the recognition that an SE has occurred.

(3) JTF CapMed will notify the TMA OCMO within 72 hours of discovery of a SE. The JTF CapMed will report all TJC reviewable SEs occurring in inpatient MTFs and JPC. Reports will be sent by email. The report will include the event type or category, inpatient MTF or JPC identification, date of event discovery, brief summary of the event, date the RCA was chartered, the Service point of contact and any unique identifiers or codes for the report.

b. Intentional Unsafe Acts

(1) The investigation of and consideration of corrective actions on intentional unsafe acts are not within the primary authority or responsibility of the DoD PSP. If in the course of the activities of the PSP, information about intentional unsafe acts is revealed, the original report shall be referred to applicable command authorities for criminal investigation and action as appropriate. Primary authority to investigate and consider corrective actions on the matter shall be outside the DoD PSP.

(2) Some events meet the definitions of both "adverse events" and "intentional unsafe acts." When an event appears to be both an "adverse event" and an "intentional unsafe act," primary authority and responsibility is outside the DoD PSP. The DoD PSP shall proceed with a review, including an RCA, if applicable, of the systems and processes of the facility implicated

in the actual or potential intentional unsafe act, but shall defer to the separate investigation and consideration on any matter of culpability of any person involved in the act.

c. Facility-Level Follow-up Actions. The PS/RM will notify the Servicing Legal Office of an SE as soon after identification as possible. As an integral part of its established process for PS analysis, each inpatient MTF or JPC will have in place, and in writing, a mechanism for performing an RCA, reporting, and other appropriate follow-up activities related to SEs that are consistent with current TJC, and DoD, guidance.

(1) An RCA must be conducted using thorough and credible processes to determine the basic or causal factor(s) that contributed to, or may have contributed to, an SE/possible occurrence of an SE. In an attempt to be impartial and fully accountable, the RCA will focus primarily on organizational systems or processes not individual performance.

(2) A detailed RCA action plan must be developed that enumerates the risk reduction strategies that the organization intends to implement, as a result of the RCA, to prevent the recurrence of similar events in the future. The specific content of the inpatient MTF or, as appropriate, the JPC action plan with follow-up evaluation of the effectiveness of the RCA action plan will be according to DoD guidance.

d. RCA and Action Plan Review

(1) By the TJC. Review by the TJC of the inpatient MTF or JPC RCA and action plan will be according to current TJC guidance. Timelines established by the TJC for submission of the RCA and action plan will be followed. See the TJC Web site for additional information.

(2) By JTF CapMed. A copy of the RCA and action plan for all SEs will be provided through the chain of command to the JTF CapMed according to the guidance and timelines established for reporting to the TJC.

e. Media Requests. Any and all communication with the media concerning an SE, an adverse event, or significant PS issues will be forwarded to JTF CapMed for action.

f. Requests for Medical/Dental Information. Reference (a~~g~~*i*) requires that release of health records will be in compliance with appropriate statutory and regulatory authority to protect, within the guidelines of those laws and regulations, the sanctity of the records. Requests from claimants or potential claimants (or their attorneys or representatives) for medical or dental information related to an SE, or any adverse event, will be referred to the chief, PAD for either medical or dental records. In these cases, PAD will coordinate with the PS/risk manager who will follow the legal guidance provided by the Servicing Legal Office. Inpatient MTF or JPC personnel will not deal directly with claimants or potential claimants (or their attorneys or representatives) without prior coordination with the PS/risk manager.

7. PS COMMITTEE/FUNCTION

a. Integration of all organizational PS and risk-related issues and processes under the auspices of the inpatient MTF or, as appropriate, the JPC safety committee/function reduces duplication of effort and enhances overall program efficiency. The inpatient MTF or as appropriate, the JPC review process for PS-related issues will be multidisciplinary to include representatives of the inpatient MTF or JPC executive leadership (for example, the ACOSECOMS, DCA, DCN); selected department chiefs; ancillary services representatives (for example, pharmacy, logistics, nutrition care); the QM/PI coordinator; the PS/risk manager; the inpatient MTF or as appropriate, the JPC safety and occupational health manager; the Servicing Legal Office; enlisted representatives; and others as deemed appropriate.

b. The PS committee/function minutes or reports will summarize activities to include, as a minimum, analysis of the results of adverse events/near misses/SE process measures, analysis of the results of inpatient MTF- or JPC-specific occurrence screens, and recommendations to the inpatient MTF or JPC leadership for improvements to specific PS processes, PS initiative(s), and other organizational changes, as appropriate. PS committee/function minutes/reports will be maintained according to JTF CapMed guidance.

8. PRODUCT LIABILITY AND THE SAFE MEDICAL DEVICE ACT OF 1990. The PS function will incorporate quality control procedures and processes for medical materiel complaints and Safe Medical Device Act (SMDA) (Public Law 101–647) (Reference (a~~i~~*k*)) identification and reporting.

a. The chief, logistics division (or comparable title) is responsible for dissemination of medical materiel quality control messages. The chief, logistics division will ensure that the PS/risk manager and appropriate department/service chiefs are promptly notified of all product liability complaints to include SMDA events. A follow-up mechanism to ensure that appropriate action is taken on a complaint and that PS is achieved will be established by the chief, logistics division.

b. In actual or potential product liability/SMDA cases, the PS/risk manager will ensure that evidence is carefully preserved. Representative cases include adverse events in which medical equipment or appliances are involved in unexpected injury, drug overdose, drug reaction, or an improper prescription. Every effort will be made to preserve the actual equipment (for example, needles, sponges), supplies, drugs, or any SMDA-listed items along with relevant maintenance and purchase records and manufacture's literature in accordance with JTF CapMed guidance. The list of documentary evidence that should be preserved in actual/potential product liability/SMDA cases includes all manufacturers, Food and Drug Administration, and other notices regarding the drug, product, medical equipment, or appliance and any documentation of remedial action taken by the inpatient MTF or JPC.

c. In situations that involve malfunctioning (actual or suspected) medical equipment (for example, respirator, suction equipment, or devices controlling the administration of intravenous fluids), the equipment in question will immediately be removed from service. A qualified Government employee will inspect the equipment to determine whether there has been a malfunction or a design flaw and to determine whether an independent appraisal is necessary.

d. JTF CapMed will specify procedures for reporting incidents that relate to medical materiel complaints/problems to include SMDA events. The supplier and manufacturer will be notified and provided an opportunity to inspect (under the observation of a qualified Government employee) the actual equipment and equipment parts involved. The Servicing Legal Office will be notified prior to any inspection by Government employees, contractors, or suppliers. The equipment will be repaired and returned to service, prior to contractor or supplier inspection, only when, in the opinion of the commander, medical necessity requires its immediate use. Any defective parts removed and replaced will be secured for possible evidentiary use by the chief, logistics division. All original maintenance and purchase records, as well as any photographs taken of the malfunctioning equipment, will also be maintained in a secure manner.

e. SMDA incident identification, tracking, and reporting procedures will be described in the facility safety plan. The plan will address those devices identified under SMDA which result in a reportable death or serious injury or illness. SF 380, "Reporting and Processing Medical Materiel Complaints/Quality Improvement Report" will be used to submit incidents.

f. In cases (SEs) involving death associated with or suspected to be the result of the use of a medical device or equipment, immediate attention will be given to determine whether an autopsy would aid in determining cause of death. The autopsy should attempt to consider all life shortening conditions present. Where necessary, consultation with the Department of Legal Medicine, TRICARE Management Activity is encouraged. These cases will be handled as SEs.

9. PATIENTS WHO LEAVE THE INPATIENT MTF ORTHE JPC PRIOR TO COMPLETION OF CARE

a. Termination of Healthcare. Patients/prospective patients being provided healthcare, or waiting for care, in either the inpatient or the outpatient setting, may, on occasion, elect to terminate the healthcare provider-beneficiary relationship before definitive care is complete. The decision to terminate inpatient/outpatient care by other than a privileged provider presents valid PS concerns. Three different scenarios are associated with the termination of healthcare in this context.

(1) The non-AD patient for whom diagnostic or definitive care has been initiated may refuse additional treatment and depart against medical advice.

(2) The patient for whom diagnostic or definitive care has been initiated may depart the care setting, without the prior knowledge/consent of the healthcare staff (that is, an elopement).

(3) The individual presenting for care and for whom diagnostic treatment by a privileged provider (or designee) has not yet begun may leave without being seen by the provider. In the context of this paragraph, privileged provider may include residents (referred to here as designee) as established in local policy.

b. Patient risk. The decision by other than a qualified privileged provider (or designee) to terminate care (that is, to leave against medical advice, leave without being seen, or elope) may

pose a real or potential risk to the safety of the patient and/or others. Thus, specific intervention on the part of the inpatient MTF staff is appropriate. Given any of the termination of care situations presented, both counseling Servicing Legal Office (patient/legal representative), if feasible, and documentation of the event in the medical record (ITR/outpatient treatment record (OTR)/health record/civilian employee medical record (CEMR)) is required.

c. Termination of Care Against Medical Advice

(1) The attending privileged provider (or designee) managing the patient's care is responsible for counseling the patient or his or her legal representative. This counseling will include as a minimum the nature/purpose of the treatment, the material risks associated with the treatment, the likelihood of success, alternatives to the proposed treatment, and the prognosis without the treatment or the medical or surgical intervention.

(2) If the mentally competent patient is intent on leaving against medical advice, despite efforts of the healthcare staff to convince him or her otherwise, a form documenting "Medical Record-Release Against Medical Advice" will be completed by the attending privileged provider (or designee). The patient/legal representative should be asked to sign the form to acknowledge that the counseling was performed and the risks associated with the decision to terminate care were presented. Should the patient/legal representative refuse to sign the form, this will be annotated on the form or in the patient's medical record on SF 509 (inpatient) or SF 600 (health record, OTR, CEMR).

(3) The attending privileged provider (or designee) will document in the ITR/OTR/CEMR a summary of the counseling that was provided to the patient/legal representative and an assessment of the patient at the time of this counseling. In addition, any specific instructions (for example, what to do in case of bleeding, continued/increased pain, fever, and so forth) and recommended follow-up outpatient care will also be noted.

(4) Incidents will be appropriately documented. Other documentation related to the inpatient/outpatient treatment will be completed, as appropriate, to close out the medical record for that episode of care.

(5) Service members are not authorized to refuse medical care except as noted in Service-specific guidance. Service members will not sign out against medical advice. Consult the local office of the Servicing Legal Office for additional guidance regarding Service members who refuse medical care.

d. Patient Elopement

(1) Unlike an against medical advice departure from the inpatient MTF, the patient who elopes has terminated the beneficiary/provider relationship without advance notice to the healthcare staff and without benefit of the counseling described elsewhere in this enclosure. Elopement is often discovered some time after the patient has departed the treatment setting.

(2) The incident will be documented in the ITR/OTR, as appropriate.

(3) Local policy will address appropriate actions for contacting the individual who has eloped (his or her legal representative) to determine the patient's health status at the time of contact and to provide instruction for further follow-up or emergency care/treatment, as required. A privileged provider (or designee) or other professionally qualified individual will initiate contact with the patient/legal representative. The contact made with the patient, any current symptoms or complaints he or she describes, and the instructions provided by the staff member will be documented in the ITR/OTR/health record.

e. Person Who Leaves Without Being Seen

(1) This individual (AD/Reservist/National Guard/family member) has presented for care in the outpatient setting but decides to leave without being seen by the privileged provider (or designee). This person may have been triaged and evaluated by nursing personnel but no definitive care has been initiated.

(2) Local policy will determine what follow-up actions are required for contacting this individual (his or her legal representative) and other procedures to ensure the well-being of the patient.

f. Cognitive Assessment of the Beneficiary

(1) If, in the opinion of the privileged provider or psychiatrist, the patient who has elected to depart the inpatient MTF against medical advice or to elope is mentally incompetent to fully understand the ramifications of such a decision, the medical record entry will clearly annotate the patient's inability to understand the potential consequences of his or her actions.

(2) Local policy will direct other actions to be taken by inpatient MTF staff. As a minimum, the Servicing Legal Office will be contacted as early in the situation as possible to provide legal guidance. Law enforcement authorities should be notified of the mentally incompetent patient's elopement if the family/significant other has no knowledge of his or her whereabouts.

g. Termination of Care by the Inpatient MTF. On rare occasion, medical care may be terminated by the healthcare provider for failure on the part of the patient/family member to comply with the established plan of care, established regulations, inpatient MTF policy, or as the result of other irregularities. In these instances, the stipulations noted in subparagraphs 9.c.(1)-(4) of this enclosure will apply. In accordance with current managed care policy, coordination of necessary follow-on care and any other arrangements will be made by inpatient MTF or staff with another appropriate healthcare facility. Termination of care under these circumstances will be according to the legal guidance provided by the servicing legal office.

10. CONFIDENTIALITY. As with other medical QA documents, any information, records, reports, minutes, and other documents directly associated with PS and RM activities are protected under Reference (~~l~~*n*) and Reference (~~h~~*i*). See Enclosure 17 for more information concerning the confidentiality of CQM QA documents.

ENCLOSURE 14

RISK MANAGEMENT (RM)

1. GENERAL. RM involves a variety of activities designed to prevent the loss of human, materiel, or financial resources and to limit the negative consequences of adverse or unanticipated events that occur in a healthcare setting. Comprehensive processes to effectively identify and reduce the occurrence of PCEs and to manage medical malpractice claims against the U.S. Government are critical to an organization's RM activities. The importance of collaboration among organizational staff members who are responsible for RM, PS, inpatient MTF or, as appropriate, the JPC safety, and occupational health cannot be overemphasized.

2. INPATIENT MTF OR JPC RM ACTIVITIES / RESPONSIBILITIES. Each inpatient MTF or, as appropriate, the JPC will demonstrate evidence of RM activities that meet current DoD guidance.

a. The inpatient MTF or, as appropriate, the JPC CQM plan for RM will include such facility-specific activities as:

(1) The responsibilities of inpatient MTF or JPC personnel relative to RM.

(2) Educational requirements for identified staff members regarding RM.

(3) Clearly defined processes related to risk reduction/risk mitigation activities.

(4) The management of all PCEs/medical malpractice claims. The term PCE refers to injury to all categories of MHS beneficiaries including injury with subsequent death or disability of a military member in accordance with DoD Instruction 6000.14 (Reference (~~j~~*l*)).

(5) How opportunities for change/improvement in healthcare and services that are identified during the malpractice claims review will be integrated into the organization's PI processes.

b. The inpatient MTF Commander or JPC Director will ensure that RM processes, as defined in writing in the CQM plan, are in place and that an individual is designated to serve as the organization's risk manager and as the clinical advisor, as appropriate.

c. The inpatient MTF or, as appropriate, the JPC's Risk Manager will:

(1) Identify and quantify healthcare-related risk.

(2) Participate in the risk analysis process.

(3) Coordinate the PCE and malpractice claims management processes.

(4) Develop and revise RM policies and procedures.

(5) Educate staff (all levels, all disciplines) concerning risk reduction/mitigation.

(6) Provide data on a periodic basis to inpatient MTF or JPC senior leadership concerning RM issues and trends. To avoid redundancies due to the comparable processes related to risk and PS, the information reported to the inpatient MTF or, as appropriate, the JPC executive committee or ECOMS at defined intervals should reflect an integration of effort wherever possible.

d. The RM clinical advisor is a senior physician or dentist appointed to provide oversight of the RM program in healthcare settings where the designated RM is other than a physician or a dentist. He or she is responsible for providing professional medical/dental consultation to key PS/RM staff and the medical Servicing Legal Office. Among other RM duties, the clinical advisor will:

(1) Assist in the review and analysis of all patient-related adverse events with particular attention to those identified as PCEs.

(2) Ensure that coordination is made for participation, as required, by qualified military or civilian medical/dental/other specialists in any peer review activities related to a PCE.

(3) Ensure that medical/dental malpractice claims information is collected, collated, and reported in a timely manner.

e. The JTF CapMed is responsible for collecting inpatient MTF- or JPC-level data associated with medical malpractice claims and healthcare related death or injury to military members for quarterly reporting to the DoD RM committee. Said data are likewise reviewed and analyzed for trends and opportunities for improvement. In addition, JTF CapMed conducts a senior review of paid malpractice claims for JTF CapMed and provides recommendations for reporting of licensed, certified, or registered healthcare personnel to the NPDB.

3. INPATIENT MTF OR THE JPC RM COMMITTEE

a. The inpatient MTF or, as appropriate, the JPC RM committee provides impartial oversight and review of all PCEs and medical malpractice/disability claims management activities as described in this enclosure.

(1) This group is multidisciplinary, with representation from each clinical department/service, the risk manager, the medical Servicing Legal Office, and other designated (ad hoc) participants, as needed.

(2) The risk manager and Servicing Legal Office are non-voting members.

(3) The chairperson will vote only in the event of a tie.

b. The RM committee will review the facts of the case (PCE or claim), consider any department/service level peer review findings and recommendations concerning the events in question, and categorize the care related to the PCE/ claim as: SOC "Met," "Not Met," or "Indeterminate."

(1) All significantly involved healthcare providers (any discipline) associated with the care deemed to have caused patient harm/injury will be considered and SOC determination made for each healthcare provider. This information must be entered in the "Standard of Care" and "Attribution of Cause" fields of CCQAS, which are required fields for both a PCE and a claim.

(2) The specific rationale for an SOC determination of "Not Met" and "Indeterminate" will be addressed. SOC may be deemed "Indeterminate" for any number of reasons, for example, unavailability of the medical record contents, or the provider's involvement in the medical care in question is not clear.

c. The RM committee minutes will summarize the committee's activities, to include: the SOC vote for each involved provider; specific follow-up actions related to systems or process issues; any apparent trends with recommendations for improvement; and the status of any pending claims and PCEs. Recommendations to the credentials committee for privilege/professional practice related actions will be clearly stated.

(1) Minutes/reports will be forwarded through the appropriate QM channels to the commander. For accurate identification of the individual(s) involved in an adverse event (PCE, claim), the significantly involved providers (any discipline) will be identified, by name.

(2) Practitioner-specific findings will be reported to the credentials committee and/or department chief (non-privileged professional) according to local policy.

(3) The RM minutes/reports are confidential QA-protected documents. Every effort must be made to ensure that the privacy of the contents is maintained at all times.

(4) Sensitive information not included in the minutes/reports will be maintained in the risk manager's office.

4. MANAGING THE POTENTIALLY COMPENSIBLE EVENT (PCE). Every healthcare adverse event involving an MHS patient (active duty member or other (TRICARE) beneficiary) shall be reviewed regardless of whether or not it resulted in harm to the patient. The risk manager, patient safety officer, senior clinical staff, and the inpatient MTF attorney (or Military Department legal office representatives), will collaborate to determine the appropriate investigative process(es) for the adverse event. any adverse event (to include those involving military members) that meets the definition of a PCE, as contained in this Manual, will be documented, tracked, reviewed and analyzed to determine if the adverse event could have been avoided. Any identified trends will be reported through established QM channels and organizational changes which may be warranted to prevent the reoccurrence of an event must be openly addressed. Close coordination will occur among the inpatient MTF or, as appropriate,

the JPC risk manager, the clinical advisor, and the Servicing Legal Office throughout the PCE identification and management process.

a. Any adverse event that meets the definition of a PCE shall be documented in the PCE module of CCQAS within 180 days of identification of the occurrence.

(1) PCEs are to be documented within the PCE module following the definitions and taxonomy based on the following types of events: (1) Accident, (2) Behavior, (3) Blood/Blood Products, (4) Clinical Process/Procedure, (5) Fall, (6) Healthcare Associated Infection, (7) Lab Nonconformance, (8) Maternity Care, (9) Medical Device/Equipment/Product, (10) Medication/IV Fluid/Biologic (includes vaccine), (11) Neonatal Care, (12) Nutrition, (13) Oxygen/Gas/Vapor, (14) Resources/Organizational Management, and (15) Vascular Access Lines as defined in Enclosure 19.

(2) Both the type of event, according the PCE taxonomy and the level of harm associated with the event, will be documented in CCQAS.

(3) Information concerning the description of the PCE, shall be in enough detail to facilitate data tracking and trending at the inpatient MTF, Service, Joint, and DoD levels. Documentation in CCQAS shall include the SOC assessment and determination.

b. All PCEs will be promptly prioritized and investigated by the risk manager in accordance with Reference (~~j~~*l*). All PCEs will be peer reviewed and information related to the event will be entered into CCQAS.

c. Copies of documents in PCE files maintained by the risk manager will be forwarded to the Servicing Legal Office for review. The PCE case files contain Privacy Act data and will be secured and maintained in accordance with JTF CapMed guidance.

d. Use of module.

(1) CCQAS electronic data entry will be initiated for every identified PCE.

(2) These electronic data document descriptive information regarding the incident, the healthcare personnel involved, all relevant patient information, the clinical details of the incident, and the department/RM committee professional peer review assessments.

(3) During the early phases of information gathering related to the PCE, partially completed CCQAS data entries at the facility level are acceptable. Incremental submission by the RM staff of information associated with the PCE is as follows:

(a) Initial CCQAS data entry within 7 days of PCE identification.

(b) Interim data entry with supporting documentation of facility-level action such as the department/service peer review results, RM committee activity/decisions, or referral to credentials committee for an adverse privileging action, as these are available.

(c) Should a medical malpractice claim against the U.S. Government be filed, the data contained in the PCE module will be electronically imported into the CCQAS claims management module.

(4) Information contained in CCQAS and other supporting documentation associated with the PCE or claim help to establish a factual and accurate data base for future reference. CCQAS data are password-protected as "controlled access only" information. Paper case files (PCE and claim) will be secured and maintained by the risk manager according to local policy for Reference (~~k~~*m*)-protected information.

e. PCE Analysis. An analysis of the causes of the PCE provides an opportunity for organizational improvement to prevent the reoccurrence of the same, or like, event. Organizational changes that might follow a PCE investigation include, but are not limited to: simplifying and standardizing processes; reducing reliance on memory; introducing checklists, constraints or forcing functions; eliminating "look alike" and "sound alike" medications; encouraging teamwork and better communication; and providing training programs.

(1) For every PCE, every claim for liability compensation shall be reported. The receiving claims office shall report the claim to the CJTF, who shall forward it to their agent. Unless a SOC review was previously completed, the inpatient MTF involved shall review the healthcare provided and assess whether the SOC was met. An SOC review will be completed for all cases in which there is sufficient information within the claim to allow identification of the patient and healthcare involved.

(2) The PCE review process shall commence within 30 days of PCE identification and be completed within 180 days. If the PCE involves an ADSM death, the 180-day process will include a final determination, by the respective SG stating whether SOC was met. Upon completion of the review process, each PCE, and the determination regarding whether SOC was met/not met, shall be entered into the DoD PCE module of CCQAS to provide for review by the ASD (HA).

(3) Significantly involved providers shall be identified and informed that a review of the PCE will be completed.

(4) Significantly involved providers shall be afforded the opportunity to provide input and to reasonably participate in the PCE review process.

(5) A SOC review shall be conducted on each of the significantly involved providers. The SOC investigation shall include a professional review of the care and an opinion rendered as to whether the SOC was "met" or "not met" for each significantly involved provider. In select circumstances SOC may be "indeterminate" due to such factors as a lack of information, or incomplete medical records. For SOC "not met" or "indeterminate" opinion, the rationale for the decision will be documented.

(a) The SOC review considers any system issues, as well as the clinical judgment, skills, knowledge, and experience of the providers in question. For performance improvement purposes significantly involved providers should receive feedback regarding the SOC

determination and the rationale for a "not met" or indeterminate decision.

(b) Recommendations for further action will be forwarded to the provider's clinical supervisor/department chair or to the QA department, as appropriate, for system and process improvement consideration.

(c) Other processes and factors which may have contributed to the adverse event should be addressed.

(6) The DoD PCE module of CCQAS will be utilized to document and track all PCEs. The details of the PCE, the specifics of the investigation, all significantly involved providers, and a SOC determination for each shall be documented in CCQAS. The receiving claims office shall report the claim to the JTF CapMed, who shall forward it to their agent. Unless a SOC review was previously completed, the inpatient MTF involved shall review the healthcare provided and assess whether the SOC was met. An SOC review will be completed for all cases in which there is sufficient information within the claim to allow identification of the patient and healthcare involved.

e. Disclosure of an Adverse Event

(1) Patients are entitled to factual, complete information about the outcomes of diagnostic testing, medical procedures, and other healthcare interventions. This is true whether the results are expected or unanticipated. Prompt, compassionate, and honest communication with the patient and family following an adverse event or an unanticipated outcome is an essential component of quality healthcare. Communication about the event should revolve around the known facts taken from the medical record and should avoid speculation or personal opinion. Proper disclosure does not suggest that the involved provider(s) have been negligent. Rather, it informs the patient/family that an unanticipated outcome has occurred, confirms the patient's current status, and identifies the ongoing plan of treatment. At a minimum the disclosure should include:

(a) Explanation of the effect of the incident on the patient's condition and prognosis.

(b) Provision of reliable information and facts associated with the event avoiding all conjecture or opinions.

(c) Identification of the person designated to provide the patient/family with additional information and how and when that communication will occur.

(d) Recommendations for further diagnostic and therapeutic interventions

(2) Full disclosure should address the issues, concerns, and emotional responses on the part of the patient or family. If the patient has been harmed full disclosure includes expressions of empathy or sorrow with the situation. The providers should verify that the patient/family understand the facts and ensure timely and accurate documentation of those facts in the medical record. At a minimum, disclosure should include:

(a) Explanation of the effect of the incident on the patient's condition and prognosis.

(b) Provision of reliable information and facts associated with the event avoiding all conjecture or opinions.

(c) Identification of the person designated to provide the patient/family with additional information, and how/when such communication will occur.

(d) Recommendations for further diagnostic and therapeutic interventions.

(3) An adverse events or unanticipated outcome will be documented in the medical record.

(4) RM subject matter experts will provide periodic training to healthcare providers regarding appropriate means and methods to disclose and document adverse events.

5. STANDARD OF CARE REVIEW OF A PCE. Every alleged malpractice claim and every death or disability of a military member as a result of healthcare services shall include a SOC determination for each significantly involved provider. The SOC determination shall be documented in CCQAS.

a. Initial Peer Review. The initial peer review of a PCE is most often conducted at the department/service level. It is performed by an individual (a peer, as defined by this Manual) who has not been involved with the case in question. The primary reason for the RM peer review is to render an SOC determination which is forwarded to the RM committee for action. The clinical facts and circumstances surrounding the adverse event are examined to determine if practice was, or was not, according to accepted practice standards (medical, nursing, etc). In addition, responsibility (attribution) for the event is assigned based on the investigation of the circumstances and an unbiased review of the evidence available. Local policy will dictate the work flow related to PCE review and analysis and the degree of involvement by the RM committee with identified PCEs.

b. Peer Review Scope. A peer review (internal to the inpatient MTF or JPC, or external) will be initiated as soon as possible (ideally within 30 days) after the PCE is identified. The peer review process for a PCE and for a malpractice claim is identical and will include every case involving death or disability of a military member as a result of medical or dental care.

(1) An immediate investigation of the PCE ensures timely access to the healthcare personnel involved and the availability of all medical record documentation. In addition, involved personnel can provide accurate detail concerning the PCE which enhances the validity of the peer review findings.

(2) In instances where the inpatient MTF or JPC lacks sufficient personnel to conduct an impartial and unbiased peer review and/or RM committee functional oversight, JTF CapMed will assist in coordinating for these external peer review services with another inpatient MTF or JPC.

(3) Significantly involved healthcare providers (all disciplines) - including those no

longer assigned to the inpatient MTF or JPC - will be notified of the forthcoming RM peer review and afforded the opportunity to participate or to waive participation in the peer review process.

(a) The notice to the individual(s) involved will be in person or by certified return receipt requested mail.

(b) Medical records and redacted copies of other documents associated with the case will be made available to the healthcare provider(s) in question, prior to the peer review.

(c) Participation by significantly involved personnel in the peer review process is typically by written statement. However, local policy may allow in-person presentation of information by the provider. Significantly involved personnel will not be present for, nor participate in, the RM committee deliberations related to the PCE being considered.

(d) Unlike the adverse privileging/practice action process, RM peer review is not a formal proceeding, therefore, due process procedures in this context do not apply.

(4) The department/service-specific peer review process must include/consider all significantly involved providers and professionals, as defined by this Manual, and will:

(a) Identify each individual by name.

(b) Consider all information pertinent to the PCE to include any written statements regarding the provider/professional's involvement in the case and the rationale for his or her clinical interventions and decisions associated with the care in question.

(c) Render an SOC determination for the case as a whole and for each of the healthcare providers/professionals significantly involved.

(5) The peer review documentation will include the review of care findings, with SOC determination, assignment of responsibility and the rationale in support of this decision, and any input from each provider involved unless he or she has elected to waive this opportunity.

(6) All healthcare personnel who were significantly involved in the case will be documented in CCQAS according to Reference (~~h~~*i*):

(a) Regardless of SOC determination (that is, met, not met, or indeterminate).

(b) Regardless of the professional discipline or duty status of the healthcare provider (that is, regular staff (full/part-time), attending, supervising, or trainee).

(c) Regardless of the peer review determination that a system, management, facility, or equipment failure was the cause of the harm.

(7) If the peer review identifies a non-licensed, non-registered, or non-certified individual (not required to be licensed, registered, or certified, and not a trainee) as responsible, the individual involved will also be documented in CCQAS. While said individuals are not

reportable to the NPDB, their names will be noted in CCQAS to complete the data entry

(8) A peer review may also be warranted, for PI purposes, as a proactive response to any adverse event or series of events regardless of the apparent severity. This is at the discretion of the risk manager, in consultation with the PS manager, and the clinical advisor. A peer review should not be construed as an adverse or punitive action against a provider/professional. Rather, it is an opportunity for fact finding, data collection, and clarification of the circumstances related to the event.

c. Coordination with the Servicing Legal Office. Coordination is required among the PS manager, Risk manager, inpatient MTF or, as appropriate, the JPC safety and occupational health manager, and the Servicing Legal Office to ensure effective communication exists regarding all adverse incidents involving beneficiaries, family members, visitors, volunteers, inpatient MTF or JPC personnel, and others.

d. PCE File Maintenance. CCQAS data related to a PCE are maintained permanently. Paper or electronic (non-CCQAS) case files associated with a PCE should be retained in accordance with Army Regulation 25–400–2 (Reference (aj)) for 7 years beyond the date that the beneficiary was made aware of the incident (adult), or for a PCE involving a minor, following the individual's age of majority or the date the malpractice claim was resolved, whichever is greater.

e. JTF CapMed Oversight of the PCE. JTF CapMed is responsible for tracking and trend analysis of all PCE related data covered by this Manual.

6. MANAGING THE MEDICAL MALPRACTICE CLAIM. The management of medical malpractice claims is a multidisciplinary process involving legal, clinical, and QM administrative staff members who are responsible for RM and for the privileging of healthcare providers.

a. Notification of a Claim. The Claims Service supporting the inpatient MTF, Center, or the Office of the Servicing Legal Office at which the medical malpractice claim was submitted, will provide a copy of SF 95, "Claim for Damage, Injury or Death," (or any other writing constituting a claim) alleging substandard care to the inpatient MTF Commander or JPC Director of the facility against which the claim has been filed, with a copy furnished to the JTF CapMed. To maintain a high level of awareness regarding all active malpractice claims, the inpatient MTF or, as appropriate, the JPC risk manager will reconcile the status of all claims with the Servicing Legal Office on a monthly basis.

b. Responsibilities of the Inpatient MTF Commander or the JPC Director. The Commander or Director will ensure that a mechanism is in place to conduct a comprehensive review of each malpractice claim, as well as cases involving healthcare-related death or medical disability of a military member. The inpatient MTF Commander or, as appropriate, the JPC Director will:

(1) Notify the JTF CapMed according to current guidance particularly for cases of command or media interest *(Reference (al))*.

(2) Ensure electronic data entry into CCQAS (claim management module) within 7 days of notification of a claim having been filed. This CCQAS data entry serves as the inpatient MTF or JPC notification of the claim to JTF CapMed. Initial CCQAS claims data entry should include as much information as possible with follow-up data provided as it becomes available. If the event has already been entered in the "Incident Module" of CCQAS as a PCE, it can be readily linked to the newly received claim. The claim management module of CCQAS will be utilized when:

(a) The Risk Manager is notified by the Servicing Legal Office that a claim alleging negligence or substandard care has been filed.

(b) The Risk Manager is notified by the Servicing Legal Office that a monetary award has been granted.

(c) The case has been settled and a monetary payment was made, or payment was denied. Data entry to the CCQAS claim management module will occur for all malpractice claims regardless of the SOC determination associated with the case.

(d) New data is available to update the CCQAS file.

(3) Initiate the peer review process under the auspices of the RM committee, within 30 days of notice that a malpractice claim has been filed, to render both SOC and attribution determinations. Included in this requirement is every claim of alleged malpractice filed under the Federal Tort Claims Act, or the Military Claims Act relating to healthcare provided by a DoD facility or practitioner. If the event was previously peer-reviewed as a PCE and all requirements specified in this Manual were met, the process need not be repeated.

(a) For every malpractice claim, responsibility for the act or omission cited on the SF 95 (or any other writing constituting a claim), or implied based on the facts of the case, will be assigned for each provider/professional named (or otherwise determined to be involved).

(b) Prompt action is imperative to allow final SOC determination by CJTF, no later than 180 days following notification of the malpractice claim payment according to Reference (~~h~~*i*).

(4) Provide the Servicing Legal Office all clinically pertinent information relevant to a claim, to include a legible copy of medical records, within 20 working days of notification. The Servicing Legal Office is responsible for forwarding all required documentation to the servicing Claims Office.

(5) Ensure that all malpractice claims documentation is secured, as determined locally, and forwarded to JTF CapMed, upon request. Upon compilation of all claim-related documentation at JTF CapMed, the inpatient MTF or, as appropriate, the JPC may dispose of the medical malpractice case file according to Reference (a~~h~~*j*). At this point, JTF CapMed becomes the case file custodian. Case files are maintained for a period of 10 years following administrative closure.

c. Malpractice Claim Documentation. At a minimum, the inpatient MTF or JPC case file that is forwarded to JTF CapMed will include:

(1) An SF 95 (or any other writing constituting a claim).

(2) An electronically generated DD Form 2526, "Case Abstract for Malpractice Claims," from the CCQAS RM module. The DD Form 2526 (paper version) is no longer in use. It will not be substituted for CCQAS claim management data entry in its entirety.

(3) The department/service peer review minutes/report supporting the SOC/attribution determinations and associated RM committee meeting minutes/reports.

(4) Statements from the significantly involved healthcare personnel.

(5) A copy of pertinent patient medical records, as directed by JTF CapMed.

(6) Current addresses (mail, e-mail) for the involved personnel, if available.

(7) Notice of legal settlement or disposition, if available.

d. Follow-up Actions. Within 30 days of notification by the Servicing Legal Office that a claim has been settled (paid or denied), the Commander or Director will ensure that:

(1) All relevant information has been entered into CCQAS claim file and it is electronically transferred for access by JTF CapMed.

(2) The entire case file, as described above, is on file with JTF CapMed.

e. Responsibilities of JTF CapMed. JTF CapMed will assure appropriate maintenance of records of medical malpractice claims data for inpatient MTFs and JPC. Specific duties include coordination/oversight of the clinical expert review, external peer review, and special review panel (SRP).

7. MANAGEMENT OF MEDICAL/DENTAL RECORDS. Complete and accurate medical records are the best defense in the event of patient care-related litigation. Medical records management is a critical factor in loss prevention and medical malpractice claims resolution.

a. In all situations identified as PCEs or malpractice/disability claims, original medical/dental records will not be released directly to the beneficiary or his or her authorized representative. The CJA or USARCS, as appropriate, may release copies of the records. This does not apply to cases in which the claim is being filed with an individual or agency outside the U.S. Government. (See Reference (a~~i~~*k*) for additional medical/dental records management information.)

b. Original records and/or other documents will not be released unless requested by a U.S. Government attorney defending the U.S. in a malpractice lawsuit. The records/documents will be released only in accordance with JTF CapMed guidance. Any request for medical/dental

records must be in writing and must specify the treatment dates and the names of the involved inpatient MTFs or JPC. Release of medical/dental records is limited to records defined in Reference (a~~i~~*k*).

c. Other records, reports, and any specimens maintained by inpatient MTF or JPC departments, services, and clinics (for example, X-rays, wet tissue, paraffin blocks, microscopic slides, surgical and autopsy specimens, tumor and death reports, and fetal monitoring strips) will be released only upon request by the appropriate legal authority. Granting of requests for records by the beneficiary or his or her representative will be at the discretion of the Servicing Legal Office.

d. When medical/dental records are required by another healthcare facility for beneficiary treatment purposes, copies or appropriate extracts will be furnished. Legal advice will be sought prior to the disposition of these records.

e. Special handling will be provided to medical/dental records involved in litigation or adjudication to ensure accuracy and correlation of evidential documentation. There will be strict adherence to the following practices.

(1) Prior to any action (for example, photocopy; release to Servicing Legal Office; transmittal to appropriate legal authority; or response to subpoena), the original medical/dental record will be reviewed for completeness by PAD and assembled as prescribed in Reference (a~~i~~*k*).

(2) Medical/dental records involved in litigation or adjudication require special safeguarding by PAD. If practical, they will be maintained separately from other medical/dental records. For accountability purposes, portions of records (for example, reports of special examination) that may be in another location will be cross-referenced by an annotation in the basic record (for example, on SF 600 as prescribed in Reference (a~~i~~*k*)).

(3) PAD is the only location in the inpatient MTF where an authenticated photocopy of a medical/dental record will be made for purposes cited in this Manual. There will be a legible photocopy page to correspond to every original page in the medical/dental record. All pages of the medical/dental record will be numbered consecutively prior to photocopying.

(4) When medical/dental records are released to the Servicing Legal Office, PAD will append the appropriate staff signature/initial verification list to the record.

(5) Copies of all correspondence concerning the case will be appended to the record. Copies of this same correspondence will also be maintained by the Servicing Legal Office.

ENCLOSURE 15

REPORTING AND RELEASING ADVERSE PRIVILEGING/PRACTICE OR MALPRACTICE INFORMATION

1. GENERAL. A variety of national agencies and clearinghouses exist to which JTF CapMed must report information such as malpractice payments, licensure disciplinary actions, adverse clinical privileging actions, and unfavorable actions affecting professional society membership. Adverse professional peer review actions taken against any healthcare personnel must be reported. In addition, State regulatory agencies responsible for licensure, certification, or registration require notification of the following: substantiated unprofessional conduct or behavior, any actions taken to restrict or otherwise constrain the professional privileges/scope of practice of healthcare personnel, and malpractice settlements.

2. INPATIENT MTF OR JPC RESPONSIBILITIES FOR PROVIDING INFORMATION

a. Requests for Routine Information. Inpatient MTFs or the JPC often receive requests for information involving an application for employment and/or clinical privileges at a civilian facility by currently or previously assigned providers/professionals. The responsible Credentials Office may reply to non-DoD requests for information from a provider's/professional's records only if the individual in question has authorized disclosure of said information to the requesting civilian agency/institution by signed and dated release according to Service-specific guidance. If the responsible Credentials Office no longer has information on file regarding a provider or professional who has retired/separated from military service, the request and the individual's authorization for release of information may be forwarded consistent with Service-specific guidance.

b. Requests for Adverse Privileging/Practice Action or Malpractice History Information. Requests to the inpatient MTF or the JPC from outside agencies for release of adverse privileging information, including queries from GPHE programs or malpractice history information will be forwarded directly to JTF CapMed for response. Individuals who are the subject of any information released under this Manual are entitled to a copy of that same information. The provider/professional must authorize - in writing - the release of adverse privileging/practice action information or malpractice history by the QMD to prospective employers or insurers.

3. CJTF RESPONSIBILITIES IN REPORTABLE ACTIONS. For civilian and contract providers, CJTF is the sole reporting authority to the NPDB, State regulatory authorities, the Federation of State Medical Boards, and/or other appropriate central clearinghouses. For Military Providers, their Service Surgeon General is the sole reporting authority for those purposes. CJTF and/or the Military Member's SG is responsible for reporting malpractice history information and adverse privileging actions, unprofessional conduct or behavior, and any legal charges for which the provider/professional is found guilty, pleads guilty, pleads nolo

contendere, or requests discharge from the military in lieu of courts-martial. CJTF will not report to professional regulatory agencies, or to any other agencies, adverse privileging actions, malpractice payments, or any civilian court actions involving a Reservist/National Guard provider's behavior or conduct which occurs during other than his or her military duty. Privileging Authority documentation in support of reports to the NPDB, State regulatory agencies, the Federation of State Medical Boards, or other bodies will be forwarded JTF CapMed.

a. Malpractice Claims Reported to the NPDB

(1) The Public Law 99–660 (Reference (a~~k~~*n*)) provides for reporting to the NPDB malpractice claims resulting in monetary settlements and certain professional review actions. Healthcare providers/professionals will be reported whether licensed or pending licensure. Protection is ensured in accordance with Reference (~~k~~*m*) for those submitting information to a professional review body, the NPDB, or other regulatory agency unless such information is false and the person providing the information had knowledge that it was false.

(2) Malpractice claims considered reportable to the NPDB for Military Providers will be referred to their Service Surgeon General for determination and disposition. In a malpractice case, the following criteria will be used by JTF CapMed to support a determination to report a civilian or contract provider in question to the NPDB or to the Defense Practitioner Data Bank (DPDB) for events involving personal injury or death of a military member as a result of medical care.

(a) The provider/professional or trainee deviated from the SOC in the act of commission or omission.

(b) Monetary payment was made and the provider/professional or trainee was responsible for an act of commission or omission that was the cause of a harm that gave rise to payment.

(c) In instances involving a healthcare trainee, his or her act(s) of omission or commission were not reasonably foreseeable by the supervisor, or the trainee acted outside his or her established scope of practice.

(d) In instances involving a healthcare trainee, the supervising provider failed to meet reasonable standards of supervision.

(3) The SRP recommendation to CJTF, based on a majority vote, and any supporting comments, including the recommendations of the clinical expert participants, will be prepared by JTF CapMed. The Servicing Legal Office will be consulted for legal sufficiency before NPDB or DPDB reporting.

(4) The individual will be provided written notification that a report was, or was not, submitted to the NPDB or DPDB.

(5) The reporting of healthcare personnel (privileged or non-privileged) is an administrative process; therefore, full due process procedures are not applicable.

(6) A copy of the NPDB report will be:

(a) Forwarded to all States of known provider/professional licensure.

(b) Maintained on file by JTF CapMed.

(c) Forwarded by certified return receipt requested mail to the individual involved.

b. Adverse Privileging/Practice Actions Reported to the NPDB or to State Regulatory Agencies

(1) Privileged providers/professionals will be reported to the NPDB or to a State regulatory agency within 30 calendar days of approval when any of the following occur:

(a) Clinical privileges have been denied due to lack of qualifications, or a restriction, reduction, suspension or revocation for substandard performance, impairment with refusal to seek treatment, or unprofessional conduct has occurred. Any adverse privileging action longer than 30 days in duration will be reported. However, a report to the NPDB will not occur until the individual's appeal, if requested, is completed.

(b) The provider/professional voluntarily surrenders his or her clinical privileges or voluntarily requests a limitation of scope of practice while under investigation for issues of competence or conduct.

(c) The provider/professional with an adverse privileging action in effect or limited scope of practice elects to separate from military service, retire, or terminate his or her employment (GS or contract) or volunteer service rather than to contest the adverse privileging/practice action.

(d) The provider with suspended privileges or the professional with a limited scope of practice who is enrolled in rehabilitation for alcohol or other substance abuse fails to satisfactorily complete the program, or electively leaves Federal service prior to completing the rehabilitation program. (This does not preclude reporting to other professional regulating authorities as noted in paragraph 3.c. of this *E*nclosure.) Any adverse privileging/practice action taken against the provider/professional in rehabilitation for professional incompetence, patient endangerment, or unprofessional conduct will be reported.

(2) A copy of the NPDB report of an adverse privileging/practice action will be forwarded to:

(a) States of known provider/professional licensure.

(b) The individual involved at his or her last known address.

(3) Maintenance of the NPDB report of adverse privileging/practice action will be as follows:

(a) A copy of the report to the NPDB will be included in the PCF or, for the non-privileged individual, in the confidential counseling file maintained by the first line supervisor.

(b) Copies of DD Forms 2499 and 2526 associated with the NPDB report will also be included in the PCF or the non-privileged individual's confidential counseling file.

c. Administrative Actions Reported to State Regulatory Agencies. In addition to reporting adverse privileging/practice actions noted above, administrative actions may be reported by CJTF for civilian or contract providers to State regulatory agencies. For Military Providers, Service Surgeons General will report. A privileged provider/professional will be reported if he or she:

(1) Is separated under any administrative discharge authority.

(2) Is separated/removed from medical care responsibilities, following appropriate due process procedures, for physical or mental limitations that affect his or her ability to provide quality patient care.

(3) Has a medical condition that affects his or her ability to render safe patient care (includes individuals who voluntarily limit their practice for medical reasons).

(4) Is found guilty, pleads guilty or nolo contendere, separates from the Service in lieu of further administrative or legal action, or separates following a voluntary written confession or admission of any of the reportable acts of misconduct listed in Enclosure 24 or similar unprofessional actions.

(5) Commits any other act, not otherwise covered by the provisions of this Manual, which is reportable according to State licensing statutes or regulations.

4. HEALTHCARE INTEGRITY AND PROTECTION DATA BANK (HIPDB). The HIPAA of 1996 established the HIPDB as a fraud and abuse data collection program for the reporting and disclosure of certain final unfavorable actions taken against healthcare providers, suppliers, or practitioners. JTF CapMed is required to report to the HIPDB a broad range of "adverse privileging/practice actions" affecting DoD healthcare personnel, as well as members of the civilian provider community involved in TRICARE.

a. Reporting Responsibility. The following reporting responsibilities by CJTF:

(1) CJTF is responsible for reporting to the HIPDB adverse privileging/practice or administrative actions taken against civilian and contract providers, suppliers, or practitioners providing healthcare services to AD members or any other MHS beneficiaries in inpatient MTFs or JPC or as part of any military unit. For Military members, their Service Surgeon General will

determine HIPDB reporting. Clinical privileging actions against physicians and dentists are excluded from this reporting requirement. These actions are reportable to the NPDB. The following will be reported to the HIPDB:

(a) Adverse privileging/practice actions. Adverse privileging/practice actions against healthcare practitioners other than physicians and dentists.

(b) UCMJ actions. Adverse convictions under the UCMJ as approved by the courts-martial convening authority (or final nonjudicial punishment under the UCMJ) of a healthcare provider, supplier, or practitioner in a case in which the acts or omissions of the member convicted were related to the delivery of a healthcare item or service.

(c) Other adjudicated actions or decisions. The following actions are reportable if they are against a healthcare provider, supplier, or practitioner based on acts or omissions that affect the payment, provision, or delivery of a healthcare item or service:

1. Adverse personnel actions affecting military members. Any administrative action resulting in separation, reduction in grade, involuntary military occupational specialty classification, or other administrative action.

2. Adverse civilian personnel actions. Any adverse personnel action under Title 5, United States Code (Reference (a~~ł~~*o*)).

3. Contract termination for default. A contract termination for default taken by an inpatient MTF or the JPC against a personal services or non-personal services contractor.

(2) Reports to the HIPDB by CJTF will also be forwarded to the Department of Legal Medicine of the Armed Forces Institute of Pathology.

(3) Designated debarring officials of the military departments and the Defense Logistics Agency are required to report to the HIPDB any contract debarments or suspensions arising from any DoD healthcare program contracts with any healthcare provider, supplier, or practitioner.

b. Methods and Procedures for HIPDB Reports. In filing reports with the HIPDB, the methods and procedures will be according to those described on the following Web Site: www.bhpr.hrsa.gov/dqa.

ENCLOSURE 16

FORMS

1. PRESCRIBED FORMS. Except where otherwise indicated below, the following forms are available through the National Capital Region (NCR) Integrated Healthcare System Forms Management Committee.

a. DD Form 2499

s. DD Form 2526

2. REFERENCED FORMS

a. SF 95

b. SF 380, Reporting and Processing Medical Materiel Complaints/Quality Improvement Report

c. SF 504, Clinical Record - History Part I

d. SF 505, Clinical Record - History Part II and III

e. SF 506, Medical Record - Physical Examination

f. SF 509, Medical Record - Progress Notes

g. SF 513, Medical Record - -Consultation Sheet

h. SF 600, Health Record - Chronological Record of Medical Care

i. SF 603, Health Record - Dental

j. SF 603A, Health Record—Dental–Continuation

k. OF 522, Medical Record–Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

l. DA Form 4186, Medical Recommendation for Flying Duty

ENCLOSURE 17

QA CONFIDENTIALITY STATUTE FOR THE DEPARTMENT OF DEFENSE

1. STATUTE OVERVIEW. The National Defense Authorization Act for fiscal year 1987 (Reference (~~k~~*m*)), provides that records created by or for the Department of Defense in a medical or dental QA program are confidential and privileged. This law precludes disclosure of, or testimony about, any QA records or findings, recommendations, evaluations, opinions, or actions taken as part of a QA program except in limited situations. Further guidance is provided in Reference (~~h~~*i*). The statutory privilege addressed in these documents is designed to improve the quality of medical/dental care by encouraging thorough and candid QA evaluation, review, and reporting processes.

2. STATUTE PROVISIONS. The statute:

a. Establishes the confidential and privileged nature of QA information.

b. Prohibits disclosure of records and testimony concerning the records except in those circumstances as defined in Reference (~~h~~*i*) and Reference (~~k~~*m*) and implemented by this Manual.

c. Establishes penalties for unauthorized disclosure.

d. Provides immunity from civil liability for anyone who, in good faith, participates in or provides information to a person or body engaged in creating or reviewing medical/dental QA records. The law does not limit access to information in a record created and maintained outside a medical/dental QA program even though it may be presented to a peer review body and is subsequently incorporated into a QA record (for example, a patient's medical/dental record).

3. INCLUSION AS CONFIDENTIAL OR PRIVILEGED. To receive coverage under this statute, QA activities as well as those documents that qualify as QA records will be clearly identified.

4. DEFINITIONS SPECIFIC TO QA

a. A "medical QA program" is defined in Reference (~~l~~*n*) as "any peer review activity carried out before, on, or after 14 November 1986 by or for the DoD to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

b. A "medical QA record" is defined in Reference (~~l~~*n*) as "the proceedings, records, minutes,

and reports that emanate from QA program activities and are produced or compiled by the DoD as part of a medical QA program."

5. QA RECORD AS PART OF ANOTHER RECORD. QA records do not lose their protected status because they are included as part of other records or reports. For example, when QA records are included as part of IG, criminal investigation, or other reports, the QA records will not be released under the FOIA or other formal request for information except as specifically outlined in this Manual. QA records will be removed from the report(s) when IG, criminal investigation, or other reports are released if disclosure of said QA records is not authorized. The investigation record(s) or reports will be annotated that QA contents have been removed pursuant to Reference (~~l~~*n*).

6. AUTHORIZED DISCLOSURE OR TESTIMONY. The statute and DoD guidance allow for disclosure of a QA record or testimony in connection with such a record, only as follows:

a. A Federal executive agency, or private organization, if the medical QA record(s) or testimony is needed to perform licensing or accreditation functions related to DoD health care facilities or to perform monitoring, as required by law, of DoD health care facilities.

b. An administrative or judicial proceeding initiated by a present or former DoD health care provider concerning the termination, suspension, or limitation of his or her clinical privileges.

c. A Government board or agency or a professional health care society or organization, if the medical/dental QA records or testimony is needed to perform licensing, credentialing, or monitoring of professional standards of any health care provider/professional who is, or was, a member, contractor, contracted employee, or an employee of the Department of Defense.

d. An inpatient MTF, Center, or other institution that provides health care services, if the medical/dental QA records or testimony is needed to assess the professional qualifications of any health care provider who is, or was, a DoD member or employee and who has applied for or has been granted authority or employment to provide health care services in or on behalf of such institution.

e. DoD officer, employee, or contractor who has need for said records or testimony to perform official duties.

f. A criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health and safety, if a qualified representative of said agency or instrumentality makes a written request that the records or testimony be provided for a purpose authorized by law.

g. An administrative or judicial proceeding initiated by a criminal or civil law enforcement agency or instrumentality referred to in paragraph 6.f of this enclosure but only with respect to the subject of said proceeding.

7. SECONDARY DISCLOSURE. The records of the QA activity or testimony given concerning the QA process remain confidential and further disclosure may be made only as specifically provided. This extends to any person or entity having possession of, or access to, QA records or testimony.

8. RELEASE OF INFORMATION. In no instance will QA records or information be released to anyone other than JTF CapMed in the performance of their duties without the written approval of the inpatient MTF Commander or JPC Director or CJTF. Release of QA information outside the Department of Defense requires the approval of CJTF or his or her designee. CJTF has sole responsibility for reporting QA-specific information to the NPDB and national, professional, and State licensing, certification, and registration agencies. Inpatient MTF Commanders or JPC director should consult with the servicing Legal Office concerning questions of disclosure of information.

9. DISCLOSURE STATEMENT. The following will be included on all QA documents prior to transmittal: "Quality Assurance Document under Section 1102 of title 10, United States Code. Copies of this document, Enclosures thereto, and information wherefrom will not be further released under penalty of the law. Unauthorized disclosure carries a statutory penalty of not more than $3,000 in the case of a first offense and not more than $20,000 in the case of a subsequent offense. In addition to these statutory penalties, unauthorized disclosure may lead to unfavorable actions under the UCMJ and/or adverse administrative action, including separation from military or civilian service."

10. PENALTY PROVISIONS. The penalty provisions specified in the disclosure statement above apply to any person who willingly makes an unauthorized disclosure of protected QA information.

11. DELETION OF NAMES FROM THE RECORD. All names included in a QA record, except the name of the subject of a QA action, will be deleted from the record before disclosure outside the Department of Defense. The requirement to delete names does not apply to information released to the individual who is the subject of a QA action (Privacy Act, section 552a of Reference (a~~l~~*o*)). Formal minutes (except for the credentials committee) or other QA documents will not refer to a case in a way that will allow identification of the patient involved or any health care personnel attending to the patient (for example, SSN, registration number, provider's name). A reference number or code to allow for tracking will be used. QA records should not contain third-party SSNs or third-party home addresses. If such information is contained in a record, it must be expunged before release of the record to anyone, including the individual who is the subject of a QA action.

12. USE OF THE FOIA REQUEST. While QA records are specifically exempt from access under the FOIA, the processing of a FOIA request is required for authorized disclosure of information in any of the circumstances outlined in section 6 of this enclosure. The FOIA

request will be forwarded, with legible copies of the requested QA records, to the appropriate initial denial authority. The initial denial authority for QA records is CJTF.

ENCLOSURE 18

JOINT TRAINING FILE

1. DESCRIPTION. The Joint Training File is used as the repository for information related to individual competence for all non-privileged healthcare personnel.

2. CONTENTS AND ORGANIZATION. All information contained in the Joint Training File will be filed chronologically with the most recent on top. Due to the sensitive nature of such information as SSN, address, and so forth, this personal information should not be included in the Joint Training File. Any counseling or disciplinary records, performance appraisals, and the like should be maintained in the individual's personnel folder. The Joint Training File will be assembled as follows:

a. Section I. Job description, qualifications, and performance standards for all staff (military, GS, contract, and volunteer).

b. Section II. License verification and certifications.

(1) Evidence of verification of all State licenses, State or national certifications, and/or registrations. If said verification is maintained in a centralized location within the inpatient MTF or the JPC, a reliable and confidential mechanism to transmit these data to the Joint Training File manager will be addressed in local policy. Because of the potential for inappropriate use of this sensitive document, the individual's license/other authorizing document will not be xerographically copied for maintenance in the Joint Training File or comparable file.

(2) Evidence of mandatory certifications (for example, BLS, ACLS, ATLS, PALS), as required.

(3) Evidence of any national specialty certifications (for example, Certified Emergency Nurse), or facility-specific certifications (for example, chemotherapy administration, suturing).

c. Section III. Orientation and training.

(1) Evidence of facility-level orientation.

(2) Evidence of unit-level orientation.

(3) Evidence of initial and annual medical readiness training, as required, and other training according to Service-specific, accrediting agency, Occupational Safety and Health Administration (OSHA), and other local guidelines.

(4) Other professional achievements (for example, published articles and books, committee membership, community service).

d. Section IV. Initial and ongoing competency assessment.

(1) Evidence of initial competency assessment. A standardized format is not required for use at the inpatient MTF or the JPC.

(2) Evidence of ongoing competency assessment. A standardized format is not mandatory.

(3) Evidence of age-specific competency assessment, if indicated. A standardized format is not mandatory.

(4) Other institution-specific forms as specified in local policy.

e. Section V. Continuing education.

(1) Evidence of professional education, military and readiness training, in-service education related to clinical competence, or civilian continuing education unit producing programs/courses.

(2) For employees with patient care responsibilities, evidence of ongoing education related to such topics as: pain management, recognition of abuse and neglect, PS, and topics pertinent to the patient-specific care setting.

f. Section VI. Miscellaneous information. This section may be used for facility- or unit-specific requirements as specified in local policy. Examples include: the individual's curriculum vitae, letters of appreciation/recognition, professional publications, and so forth.

ENCLOSURE 19

SCOPE OF PRACTICE OF ENLISTED PROVIDERS WITHIN INPATIENT MTFs OR JPC

1. GENERAL. Enlisted providers are Medics (Army 68W), Hospital Corpsmen (HM XXXX), and Medical Technicians (Air Force 4NOs) who work alongside Primary Care Managers, medical doctors, nurse practitioners, physician assistants, nursing supervisors, registered nurses, and/or head nurses in the care of beneficiaries in all patient care settings. Enlisted providers assigned and/or attached to NCR facilities serve and practice to the full extent of their competencies within their particular Air Force Specialty Code (AFSC), Military Occupational Specialty (MOS), or Navy Enlisted Classification (NEC) identifier. Every effort is made to capitalize on all Service-specific competencies of enlisted providers listed in References (ap) through (aw). As part of their competency assessment and validation, enlisted providers complete the appropriate training, orientation, and the NCR Standardized Enlisted Medication Administration course, as appropriate based on area of assignment. They may prescribe within established specific formularies. Enlisted providers' orientation, training, skill set evaluation, competency assessment, validation, and oversight are managed in accordance with The Joint Commission guideline, applicable Service-specific guidance, this Manual, and MTF policies. Supervisors working with enlisted medical personnel are knowledgeable of the competencies for medics, corpsmen, and medical technicians. They work under the direct supervision of a member of the MTF staff who has been appointed to evaluate and document their competence in the Joint Training File.

~~1~~*2.* CCT (4N0XX SEI487). The Air Force Aerospace Medical Service CCT (4N0XX SEI487) works with the clear expectation that Aerospace Medical Service personnel will be utilized to the full extent of their knowledge/task certification within inpatient critical care units. In addition to their principal role of Aerospace Medical Service technician (4N0XX), the CCT must have the basic competencies reflecting skill as an Aerospace Medicine Service technician. They maintain their Special Experience Identifier through experience, training, and continuous learning directly tied to curriculums supporting training to provide health care in today's operational arena. During structured sustainment training in an inpatient MTF or the JPC, and under the supervision of a privileged provider, the IDMT is authorized to perform specific duties as follows:

a. Recognize hemodynamic values in adults, pediatric patients, and neonates.

b. Recognize pa wave forms: PA catheter insertion, Right Atrium, Right Ventricle (RV), Pulmonary Artery (PA), Pulmonary Capillary Wedge.

c. Monitor patients on telemetry: Monitor cardiac rhythm strips, perform initial interpretation of rhythm strip.

d. Document and record cardiac monitoring strips, alarm parameters, waveforms, trends.

e. Prepare/transport patient with special equipment for critical care transfer, assembles transport supplies/equipment, operate pediatric and neonatal transport isolettes, operate ventilator, transfer patient between stationary ventilator/portable ventilators.

f. Assist with medical examinations/special procedures: pericardiocentesis, percutaneous (bedside) tracheostomy placement, transurethral bladder placement, intubation/extubation, pronation/supination of intubated patient, positive end-expiratory pressure (PEEP)-saver valve.

g. Perform ventilator alarm/circuit troubleshooting: timed cycled, pressure cycled, volume cycled, principles of mechanical ventilation, controlled ventilation, assist/control, intermittent mandatory ventilation, high frequency ventilation, pressure regulated volume control, mandatory minute ventilation, synchronized intermittent mandatory ventilation, tidal volume, inspiratory pressure, inspiratory flow, inspiration to expiration ratio, peak airway pressure, mean airway pressure, minute volume, PEEP, continuous positive airway pressure, weaning parameters.

h. Monitor patient on mechanical ventilator: principles of arterial blood gas (ABG) values, normal values, analyze ABG results.

i. Setup and assist with cardiovascular procedures: pulmonary artery catheter insertion, RV ejection fraction/volumetric oximetry catheter, continuous cardiac output/PA catheter, continuous cardiac output/mixed venous/pulmonary artery catheter, Paceport catheter, transvenous pacing catheter placement, flow directed pacing catheter placement, monitoring intra-aortic balloon pump insertion, umbilical artery catheter placement.

j. Perform/obtain measurements and operations: PA pressure measurements, central venous pressure measurements, pulmonary capillary wedge pressure, cardiac output measurements, blood from central line, mixed venous blood sample, monitor SVO2 TR: Handbook of Noninvasive Diagnostic Techniques in Vascular Surgery, ankle brachial indexes.

k. Assist with special neurovascular procedures: Fiber optic sensor for intracranial pressure monitoring, ventriculostomy drain placement, cold calorics.

l. Perform/monitor special neurovascular procedures: intracranial pressures, cerebral perfusion pressure calculations.

m. Understand principles and management of hemodialysis: acute renal failure, fluid overload, acidosis/alkalosis, continuous renal-to-renal transfusion therapy, continuous ambulatory peritoneal dialysis, and continuous cyclic peritoneal dialysis.

~~2~~3. AIR FORCE AEROSPACE MEDICAL SERVICE IDMT (4N0X1C)

a. The Air Force IDMT (4N0X1C) must maintain a variety of medical skills for application in worldwide operational environments where no medical officer is available. In addition to their principal role of Aerospace Medical Service technician (4N0XX), the IDMT must have the basic competencies reflecting skill as an Aerospace Medicine Service technician. They maintain

their Special Experience Identifier through experience, training, and continuous learning directly tied to curricula supporting training to provide health care in today's operational arena.

b. During structured sustainment training in an inpatient MTF or the JPC, and under the supervision of a privileged provider, the Air Force IDMT is authorized to perform specific duties as follows:

(1) General tasks: infection control, asepsis, sterility of supplies/equipment, communicable disease management, infectious hazards reporting procedures.

(2) General procedures: perform hand-washing, don/doff sterile gloves, don/doff non-sterile gloves, don/doff sterile gown, don/doff non-sterile gown, set-up/maintain sterile field, prepare supplies/equipment for sterilization, perform sterilization procedures, dispose of contaminated materials, clean patient unit, perform isolation precautions, perform housekeeping duties.

(3) Measure and record patient parameters: temperature, pulse rate, respiratory rate, blood pressure, auscultation, palpation, pain scale, height (standing) and weight, buttocks-to-knee measurement, anthropometric measurement, orthostatic vital signs, neuro checks, pulse oximetry/oxygen saturation, intake and output, body/abdominal girth, pulmonary function tests, 12-lead electrocardiogram, peak expiratory flow, visual acuity test.

(4) Assist with specimen collection: cerebral spinal fluid, cytology, prepare requisitions for tests/procedures, collect and label, emesis, urine, sputum, stool, drainage, blood from venipuncture, throat culture, rapid strep test, strain urine for calculi, test urine for sugar and ketones, test urine for specific gravity, test urine for blood, perform finger stick for blood sampling, perform heel stick for blood sampling, use blood glucose meter.

(5) Medications and fluid therapy under supervision of nurse or physician: anesthetic-local, antacids/antiflatulents, anticholinergics, anticoagulants, antidiabetics, antidiarrheals, antidysrhythmics, antiemetics, anti-infectives, antifungals, antihistamines, antihypertensives, antimigraine agents, antineoplastics, antipsychotics, antitoxins and antivenins, antitussives/expectorants, antivirals, benzodiazepines, bronchodilators, cholinergics, corticosteroids, diuretics, hormonal contraceptives, immune serums, laxatives, nonopioid analgesics, nonsteriod antiinflammatories, opioid analgesics, opioid antagonists, salicylates, vaccines and toxoids, vitamins, and document medication administration and fluid therapy.

(6) Prepare and administer medication: oral medication, subcutaneous injection, intramuscular injection, intradermal injection, agents in prefilled or Tubex syringes (e.g., EpiPen), rectal suppository, vaginal suppository, vaginal douche for medication delivery, ophthalmic ointments and drops, otic drops, topical medication, inhaled medication, via updraft nebulizer, via prescribed inhaler, intravenous medication, sublingual medication, administer scheduled drugs.

(7) Prepare and administer Schedule II medications: oral administration (5/7/9 levels only), intramuscular (5/7/9 levels only), intravenous (7/9 levels only), prepare and administer

Schedule III medications: oral administration (5/7/9 levels only), intramuscular (5/7/9 levels only), intravenous (7/9 levels only), oral administration (5/7/9 levels only), intramuscular (5/7/9 levels only), intravenous (7/9 levels only), oral administration (5/7/9 levels only), intramuscular (5/7/9 levels only), intravenous (7/9 levels only).

(8) Intravenous fluid and blood administration: assist with blood administration, obtain blood/blood products from blood bank, set-up blood warmer and pump, monitor blood transfusion, intravenous therapy, set-up, regulate, and monitor intravenous fluid administration, initiate peripheral intravenous infusion/saline lock, monitor intraosseous infusion, apply armboard or restraints to secure infusion, set up and regulate infusion pumps/controllers, set up and regulate infusion pressure bag, change intravenous fluid bags/bottles, discontinue intravenous infusion/heparin lock, calculate dosages/drip rates.

(9) Patient transfer techniques: mechanical aids for lifting and moving, assist to and from, bed, wheelchair/chair, bathtub/commode, automobile, ambulance, stretcher/gurney, examining table, ambulate patients, move patients on/off elevators in wheelchair/stretcher/beds.

(10) Prepare patient transfer with: monitoring system, oxygen, drainage system, intravenous lines, immobilization devices, and ventilator.

(11) Assemble supplies and equipment/assist with medical examinations/special procedures: basic physical examination, chest tube insertion/water seal drainage, pelvic examination, paracentesis/thoracentesis, lumbar puncture, biopsy, tympanometry, incentive spirometer, sitz bath, minor surgery, sigmoidoscopy, proctoscopy, and colonoscopy, bronchoscopy, radial ABG sample percutaneously, endotracheal intubation.

(12) Perform specific procedures: diabetic foot exam, endotracheal care, tracheostomy care, contact lens removal, Fluorescein eye stain, ear irrigation, eye irrigation, pharnygotracheal lumen/combi-tube airway insertion, tepid/sponge-bath for fever.

(13) Wound management: soft tissue injuries, complicated wounds, perform wound evaluation, burns evaluation, wound irrigation/scrub, wound debridement, burn debridement, subungual hematoma evacuation, vacuum drainage system monitoring.

(14) Local anesthetic agents' administration: topical, local infiltration, digital block.

(15) Wound closure and care: sterile tape strips, stapling, suturing, suture and staple removal, sterile dressing application and change (dry, wet-to-dry, wet-to-wet), heat and cold treatments.

~~3~~*4*. SPECIAL FORCES MEDICAL SERGEANTS (18D). The Special Forces Medical Sergeant (18D, herein after "SF Medical SGT") must maintain a variety of medical skills for application in worldwide operational environments where no medical officer is available.

a. During structured sustainment training in an inpatient MTF or the JPC, the SF Medical

SGT is authorized to perform the following procedures under the supervision of a privileged provider:

~~a~~*(1)* Airway management including intubation and emergency airway procedures.

~~b~~*(2)* Bag-valve-mask or bag-valve-tube ventilatory support.

~~c~~ *(3)* Patient immobilization and transport.

~~d~~*(4)* Placement of urinary tract catheter.

~~e~~*(5)* Placement of nasogastric or orogastric tube.

~~f~~*(6)* Minor surgical procedures for wound debridement, abscess drainage, or hemorrhage control.

~~g~~*(7)* Wound suturing.

~~h~~*(8)* Emergency needle and tube thoracostomy.

~~i~~*(9)* Administration of topical, inhalation, oral, subcutaneous, intravenous, or intramuscular medications.

~~j~~*(10)* Administration of local, regional, and intravenous anesthesia for the primary purpose of providing sufficient analgesia/amnesia/sedation to allow completion of a required surgical or manipulative procedure.

4*b.* ~~PATIENT ASSESSMENT TRAINING AND MANAGEMENT SKILLS .~~–During structured sustainment training in an inpatient MTF or the JPC, the SF Medical SGT is authorized to perform the following patient assessment and management skills under the supervision of a privileged provider:

~~a~~*(1)* Perform assessment of patients and document H&P examination.

~~b~~*(2)* Triage patients and recommend disposition of patients.

~~c~~*(3)* Basic interpretation of plain radiographs of extremities, chest, abdomen, spine, and pelvis.

~~d~~*(4)* Perform basic interpretation of urinalysis, complete blood count, Gram's stain, blood smears, and KOH and saline slide preparations.

~~e~~*(5)* Assess and manage diseases of the mouth and teeth to include uncomplicated dental caries and emergency management of maxillofacial and dental trauma.

~~f~~*(6)* Initial management of:

~~1~~*(a)* Various types of wounds (lacerations, burns, blunt injury, crush injury, head trauma) and traumatic amputations.

~~2~~*(b)* Fractures and soft tissue injuries to include bandaging, splinting, and casting.

~~3~~*(c)* Shock (cardiogenic, hemorrhagic, septic) to include intravenous access and fluid management.

4*(d)* Various medical emergencies including cardiac, pulmonary, gastroenterologic, neurologic, toxicologic, metabolic, and ophthalmologic diseases, heat/cold injury, and altitude/decompression sickness.

~~g~~*(7)*. Initial assessment and management of:

(~~1~~*a*) Medical diseases including infectious disease, gastroenterology, cardiovascular, endocrine, pulmonary, neurology, otolaryngology, nephrology, musculoskeletal,and dermatology.

(~~2~~*b)* Uncomplicated emotional, psychological, and psychiatric conditions.

(~~3~~*c*) Acute, uncomplicated pediatric illness and infectious disease.

~~H~~*(8)*. Manage uncomplicated gynecological diseases and perform uncomplicated obstetrical care to include management of pregnancy, labor, delivery and care of the newborn and emergency childbirth with normal presentation.

5. IDC (HN-8402, -8403, -8425, -8494)

a. General. The IDC include Navy Enlisted Classification (NEC) codes: HM-8402 Submarine Force IDC, HM-8403 Special Operations IDC, HM-8425 Surface Force IDC, and HM-8494 Deep Sea Diving IDC. IDCs exercise independent clinical judgment and decision making augmented by protocols or best practices that are evidence-based. In addition to their principal role of diagnosing and treating routine minor illnesses and injuries, the IDC must be able to recognize the presence of urgent or emergent conditions, stabilize if necessary (using protocols established by Physician Supervisors), and initiate prompt referral to a higher level of care. These basic competencies reflect the skills an IDC must attain through experience, training, and continuous learning to provide health care in today's operational arena and are directly tied to curriculums supporting training to NEC.

b. Specific. During structured sustainment training in an inpatient MTF or the JPC, and under the supervision of a privileged provider, the IDC is authorized to perform preliminary assessment and initial treatment, stabilization, as follows:

(1) Patient assessment: complete medical history; physical exam with vital signs; accurate documentation in the subjective, objective, assessment, plan format; develop a diagnosis and treatment plan; patient interaction skills – professionalism, respect, empathy, sensitivity to psychosocial concerns, privacy awareness, discretion, confidentiality, etc.

(2) Emergency medical procedures: demonstrate knowledge and skill to safely remove a casualty from danger; demonstrate knowledge and skill in positioning a patient appropriate to an injury; demonstrate knowledge and skill in triaging of mass casualties; attain or maintain certification in ALS, BLS, and TCCP (to include: airway management/maintenance using oral, combi-tube, and endotracheal airways; assisted ventilation with oxygen therapy via nasal catheter or mask; control hemorrhage via direct pressure, pressure dressing, tourniquet, or hemostat; manage respiratory distress, including sucking chest wound).

(3) Internal medicine: chest pain differential; fluid and electrolyte disorders; heat or cold injuries; chemical and thermal burns; shock; headache; altered levels of consciousness; gastrointestinal disorders; respiratory distress; drug overdose or poisoning; uncomplicated hypertension; uncomplicated diabetes; communicable or infectious diseases (including antibiotic prescription); adverse drug reactions; acute pain; weakness and malaise.

(4) Orthopedics: simple uncomplicated fractures; strains and sprains; low back pain; minor musculoskeletal/sports medicine injuries.

(5) Surgery: abdominal pain to include surgical abdomen; inguinal hernia; triage of multiple trauma patients; penetrating wounds; animal and human bites.

(6) Psychiatry: psychosis and delusional thinking; suicidal ideation or attempt; depression; substance use and abuse.

(7) Urology: testicular torsion; renal calculi; sexually transmitted infection; acute cystitis (uncomplicated); prostatitis; epididymitis; genitourinary trauma; acute pyelonephritis (uncomplicated).

(8) Ophthalmology: penetrating eye injuries; acute ocular pain; acute vision change; conjunctivitis; corneal abrasion; conjunctival foreign body.

(9) Dermatology: psoriasis; acne; warts; herpes (simplex, zoster, etc.); scabies; lice; contact dermatitis; plantar warts; corns and calluses.

(10) OB/GYN: initial diagnosis of intrauterine pregnancy; pelvic inflammatory disease; abnormal vaginal bleeding; ectopic pregnancy and spontaneous abortion; vaginitis; sexually transmitted infection to include culture of cervix; family planning (using approved contraceptive methods); breast mass; sexual assault and legal requirements.

(11) Dental: Dental abscess; symptomatic caries; lost restoration; fractured tooth; lip or tongue laceration; jaw fracture; traumatically mobilized teeth.

(12) Ear, eyes, nose, and throat: Otitis media and externa; auricular hematoma; cerumen impaction; external auditory canal foreign body; acute pharyngitis and tonsillitis; epistaxis; rhinitis or upper respiratory infection; uncomplicated allergic conditions; acute sinusitis; acute nasal fractures; peritonsillar abscess/cellulitis; acute barotrauma; eustachian tube dysfunction; tympanic membrane rupture/puncture.

(13) Occupational Health and Preventive Medicine: Medical surveillance programs to include: noise exposure; asbestos exposure; heat exposure; immunization programs; sanitation inspections; diving-related disorders; radiation health program.

(14) Chemical, Biological, and Radiation Procedures: Apply chemical decontamination kit; administer antidotes and pre-treatments; assess, process, and decontaminate the contaminated wounded patient; IDCs must be fully competent to perform the following procedures:

(15) Medical and Surgical Procedures: Local anesthesia; digital block anesthesia; primary and secondary skin closure (using various techniques) and suture removal; wound care including débridement, wound irrigation, and applying and changing sterile dressings; inserting nasogastric tube; performing venipuncture; initiating, maintaining, discontinuing, and documenting intravenous fluid therapy to include intravenous piggy-back medications and medication drips as indicated; mental status examination; vision screening using Snellen chart or other appropriate methods; obtain and interpret basic audiograms; removal of foreign object by forceps or superficial incision; cast/splint application for non-displaced extremity fractures; perform urethral catheterization; incise and drain superficial abscesses; apply hot and cold therapy; vaginal speculum exam to visualize cervix and or to obtain appropriate lab sampling; bimanual pelvic exam; breast exam (before referral); administer medications (oral, sublingual, subcutaneous, intramuscular, topical, rectal, and intravenous); pack and prepare sterile packs.

(16) Emergency Treatment: Parenteral IV therapy; needle thoracostomy; gastric lavage; endotracheal intubation.

(17) Laboratory procedures: Dipstick urinalysis; microscopic urinalysis; white blood cell count and differential; hematocrit; gram stain; collection of culture specimen (pharyngeal, wound, rectal, urethral, vaginal, etc.); wet (saline) prep; potassium hydroxide (KOH) prep; Wright stain; mono-spot; urine pregnancy test (human chorionic gonadotropin).

ENCLOSURE 20

*PROVIDER CREDENTIALS FILE (*PCF*)*

1. INDIVIDUALS REQUIRING A PCF. A PCF will be established for all privileged providers. Either paper or electronic files (that is, CCQAS) may be maintained. Any request by the subject privileged provider for amendment of information contained in the PCF must be considered under the provisions of the Privacy Act.

2. DURATION OF USE. The PCF will be maintained for the entire service career of the military provider to include active and inactive service as a Reservist. For civilians (GS and contract), the PCF will be maintained for the entire period of employment with the Federal Government.

3. MAINTENANCE OF THE PCF. For the various categories of providers, the responsibility for PCF maintenance is as follows:

a. For AD military and civilian (GS and contract), the credentials office of the inpatient MTF or the JPC who exercises command or executive authority over the provider is responsible for the PCF.

b. National Guard, Reservist, transient personnel unit-privileged providers and individual ready reserve members and retired providers (Reservist/National Guard, retired and discharged/separated AD) will be handled according to Service-specific guidance.

4. SECURITY OF THE PCF. The PCF manager will maintain all PCFs in a secure manner (for example, cabinet/container that can be locked) in a limited access area. Providers may review the contents of their PCF in the presence of the credentials manager. At no time will the PCF be removed from the control of the PCF manager.

a. The contents of the PCF are protected by the Privacy Act of 1974. Thus, the cover of the PCF must contain the following statement: “Privacy Act of 1974 governs access to this file.”

b. All contents within the PCF are deemed confidential and privileged QA information. As such, the contents of the PCF are protected under Reference (~~k~~*m*). The cover of the PCF will bear the disclosure statement as required by this Manual.

c. The PCF will be released only to the inpatient MTF Commander or JPC Director, the credentials committee, department/service chiefs, and reviewing authorities or officially appointed inspectors. The contents must remain intact and the security of the information ensured at all times. The provider may authorize, in writing, release of his or her PCF to others.

The PCF will be retained in the credentials office with authorized access by others in that secure location.

5. DISPOSITION OF THE PCF

a. The PCF transfer from facility-to-facility will be by certified mail, return receipt requested. A PCF will never be hand-carried by the individual provider.

b. For AD providers who have separated in good standing with defined privileges, the original PCF will be forwarded according to Service-specific guidance. A copy of the PCF and a copy of the separation order will be held at the inpatient MTF or the JPC for 1 year and then destroyed.

c. Upon discharge or retirement, the PCF (all military providers) will be forwarded according to Service-specific guidance.

d. Disposition of the PCF after the provider ends his or her military service (separates, is discharged, or retires) will be according to Service-specific guidelines.

e. The PCF of civilian providers (GS and contract) will be retained for 5 years by the last inpatient MTF or the JPC of employment and then destroyed.

f. At the time of provider discharge or separation, a copy of both the PCF and the PAF that contain any permanent adverse privileging actions or information will be forwarded according to Service-specific guidance.

6. PCS, RETIREMENT, OR SEPARATION FROM SERVICE. When the provider PCSs, retires, or separates from the Service, the PCF will be updated prior to the file being forwarded, as required by this Manual.

7. CCQAS DATA ENTRY. Primary-source-verified-credentials information contained in the PCF will be entered and maintained in the DoD Tri-service CCQAS data base, or subsequent DoD-designated replacement system, by the credentials manager of the PCF. CCQAS data entry is required for all privileged providers regardless of discipline or category of employment (that is, military (AD, Reservist, National Guard) or civilian (GS, contract, volunteer)).

8. PCF CONTENTS AND ORGANIZATION. The PCF is a six-section folder (National Stock Number 7530–00–990–8884) with like documents grouped together, filed in reverse chronological order with the most current data on top. Information entered into the PCF will be permanently maintained.

ENCLOSURE 21

PRE-SELECTION PROCEDURES FOR NON-MILITARY HEALTH CARE PERSONNEL

1. GENERAL

a. Applicability and Health Care Personnel Addressed. This enclosure applies to servicing CPOCs/CPACs and inpatient MTF Commanders or the Director of the JPC. These provisions cover personnel who are making initial application for Federal service positions in the following occupations, including but not limited to medical officer, GS–0602; dentist, GS–0680; veterinarian, GS–0701; nurse, GS–0610; podiatrist, GS–0660; PA, GS–0603; clinical psychologist, GS–0180; optometrist, GS–0662; PT, GS–0633; OT, GS–0631; social worker, GS – 0185; dietician, GS-0630; pharmacist, GS-0660; speech pathologist, GS-0665; psychologist, GS-0180; audiologist, GS–0663; medical technologist, GS–0644; emergency medical technician, GS–0699; paramedic, GS–0699; LPN, GS–0620; and dental hygienist, GS–0682. The requirements contained in this enclosure are also relevant to applicants for volunteer and personal services contract positions, to include chiropractors.

b. PSV. PSVs of education, training, clinical experience, licensure, and certification or registration before appointment and/or placement into selected civil service, consultant and expert, and contracted positions is required. Only certified true copies of professional credentials will be accepted. For internal placement or transfer of in-service applicants, a thorough review of the individual's qualifications for the position in question shall be conducted. Current in-service Federal employees seeking to transfer into positions or functions identified above are addressed in Enclosure 9 and 10 of this Manual. With a release of information signed by the provider/professional in question, information as specified by the individual related to clinical performance (or other information) from the PCF/PAF/Joint Training File may be provided to prospective employers in either the Federal or civilian sectors. Exceptions to the release of adverse information are described in paragraph 15 (2) b in this Manual. The responsibility for procurement and appointment of highly qualified candidates for all health care positions is a responsibility shared jointly by the CPOC/CPAC and the inpatient MTF or the JPC.

2. PRE-SELECTION TASKS

a. The servicing CPOC/CPAC and employing inpatient MTF, Center, or health care facility will perform data collection, primary source verification of credentials, and authentication of civil service health-care-related-occupations applicants, consultants, and experts. The Commander will designate an individual(s) to perform these required pre-employment activities.

b. For personal services contracted employees, the inpatient MTF or, as appropriate, the JPC will perform the data collection, primary source verification of credentials, and authentication. For non-personal services contracted employees, the contracting office provides for data collection, review, and authentication.

c. The Privileging Authority (or designee) is responsible for the primary source verification of professional credentials, including resolution of any issues that bear on the employment of the individual in question. Appointment to any health-care-related position may be made only after receipt of the Privileging Authority's (or designee's) written approval of the candidate's acceptability.

3. PROCEDURES FOR CIVIL SERVICE, CONSULTANT, AND EXPERT HEALTHCARE PERSONNEL

a. Candidates Who Require Privileges. Upon selection, the new-to-Federal-service applicant will submit to the inpatient MTF or, as appropriate, the JPC credentials manager (or designee) the appropriate privileging documents. These documents and the required letters of reference supplement the professional credentials compiled by the servicing CPOC/CPAC and are necessary for initial clinical privileging and professional staff appointment, if applicable.

b. Candidates Not Requiring Privileges. New applicants for Federal service employment for whom privileges are not required will submit to the CPOC/CPAC, or the inpatient MTF or the JPC POC tasked with coordinating the hiring action, the appropriate documentation of professional credentials. Examples include official transcripts and diploma from an accredited institution of higher learning, required license/certification/registration, evidence of current continuing education/ experience, and BLS and other certification, if available.

c. Servicing CPOC/CPAC. The servicing CPOC/CPAC is responsible for determining the new applicant's basic qualifications according to the OPM qualification standards and for referring to the inpatient MTF or the JPC individuals who meet the established OPM qualifying criteria. If paperwork for a CHBC has not already been submitted for a newly hired employee (GS, personal services contract, volunteer), the security office will initiate this action. The servicing CPOC/CPAC performs data collection; the employing inpatient MTF or the JPC is responsible for assuring completion of a credentials review and authentication, as appropriate. A CPOC/CPAC official will:

(1) Obtain certified copies of the following from the applicant:

(a) Qualifying official transcripts (or equivalent documents) and diplomas to include post-graduate training, fellowships, and board certification, as applicable.

(b) Professional license(s), registration, certification, or other authorizing documents, as applicable. A list of all health care licenses ever held will be obtained along with an explanation of any licenses that are not current, have been voluntarily relinquished, or have been subjected to disciplinary action.

(c) ECFMG certificate for the physician trained in other than a U.S. territory or Canada.

(2) Establish an official civilian personnel file on all qualified applicants.

(3) Initiate a national agency check with inquiry.

d. Inpatient MTF or, as appropriate, the JPC. The appropriate inpatient MTF or, as appropriate, the JPC credentials office staff member will:

(1) Authenticate the educational and other credentials from medical facilities and/or institutions where the applicant was enrolled and/or employed.

(2) Secure at least two letters of reference on behalf of the new-to-Federal-service applicant who will be requesting initial privileges.

(3) Obtain ~~a~~current report*s* from the NPDB*, HIPDB, and DPDB* for all privileged providers unless a valid report less than 2 years old is available from another hospital/health care institution.

(4) Ensure that a CHBC has been initiated in compliance with the Reference (~~p~~*r*) and Reference (a~~*i*~~*k*) for staff who will be working with children under 18 years of age.

(5) Validate certificates of completed CME or other CE, as applicable, to include the category type. This information must cover 3 years or from the time the applicant obtained the qualifying degree if less than 3 years.

(6) Determine if any of the applicant's licenses/registrations/certifications have been or are currently being challenged.

(7) Determine if the applicant has been involved in any medical malpractice actions and whether the provider has had his or her medical organization membership cancelled or professional staff appointment terminated.

(8) Obtain and verify a history of clinical privileges, as applicable, and determine if any adverse action has been taken against the individual's privileges by any hospital/health care institution.

(9) Note currency of DEA or CDS status, as appropriate.

(10) Conduct PSV of the credentials requiring this authentication.

(11) Notify the CPOC/CPAC that credentials verification is complete on the selected candidate so that an employment start date can be established.

(12) Return any documentation regarding the applicant, as appropriate, either electronically or in the selected individual's file to the servicing CPOC/CPAC.

(13) Complete the privileging process as described in Enclosure 10.

4. PROCEDURES FOR CONTRACTED SERVICES. The contracting office will accomplish the pre-selection verification for non-personal services contract personnel and provide documentation of such upon request by the inpatient MTF or the JPC. The contracting office will ensure that a CHBC has been initiated as required by Reference (~~p~~*r*) and Reference (aj).

ENCLOSURE 22

*PROVIDER ACTIVITY FILE (*PAF*)*

1. DESCRIPTION OF THE PAF. The PAF contains various data, to include metric performance data, and other information to support the granting of provider clinical privileges. Maintenance and security of this working file is typically the responsibility of the credentials manager. The PAF will be kept in a locked cabinet in a locked room.

a. The contents of the PAF are protected by the Privacy Act of 1974. Thus, the cover of the PAF must contain the following statement: "Privacy Act of 1974 governs access to this file."

b. Documents maintained in the PAF are protected under Reference (~~k~~*m*). The cover of the PAF will bear a disclosure statement as noted previously in this Manual. Additional information regarding 1102 protection of individual documents can be obtained from the Servicing Legal Office.

2. CONTENTS OF THE PAF. A suggested listing (not all-inclusive) of data that may be contained in the PAF is provided below. There is no specific requirement for which items are to be filed; nor is there a set format for the organization of the PAF or how data are to be presented. Each clinical department/service must determine which parameters are most useful to assess the performance of its providers. Some performance parameters evaluated will have economic/utilization implications; others must be considered for their clinical performance implications. At least every 2 years, at the time of clinical privileges renewal, and at reassignment, information contained in the PAF will be reviewed for transfer to the PCF as permanent provider data. Information relevant to the provider's competence, performance, and conduct will be considered for inclusion in the PCF. Information not transferred to the PCF may be turned over to the provider or destroyed in accordance with local policy.

a. Baseline Information and Metric Data

(1) All providers. Provider identification number, required professional staff meeting attendance, number of duty days, clinical time (that is, percentage of time spent on clinical activities, administration, and so forth), percentage of time deployed.

(2) Outpatient providers. Average daily/monthly patient load, total annual visits, number of impaneled patient visits for emergency services.

(3) Inpatient providers. Number of admissions, discharges, procedures by category (for example, deliveries, surgeries, and so forth), special care admissions.

(4) Emergency providers. Number of visits, admissions/special care admissions, special procedures (for example, thoracotomies).

(5) Supervised providers. Periodic performance reports as required, name of clinical supervisor.

b. Outcomes Data. Provider-specific data on mortality, morbidity, and other clinical performance parameters (for example, surgical cases, transfusion therapy, and drug usage reviews that reflect notable variances) should be maintained. Include cases of superior care and cases of substantiated substandard care, each with appropriate documentation.

c. Utilization Review Data. These data reflect the medical necessity and appropriateness of care. Consider use/nonuse of approved CPGs and other relevant data for specific diagnoses (high volume, high risk, or high cost). Include appropriate data on usage of high-cost resources such as computerized tomography scan, magnetic resonance imaging, medications, durable and nondurable medical equipment/supplies, and blood product utilization. As computer-based UM data in support of current business practices become more readily available, information on lengths of stay by International Classification of Diseases Manual (current edition) code, and other meaningful utilization data should be identified and maintained.

d. RM Data. Synopses of negative incident reports, SEs, malpractice claims, and applicable peer review materials should be included.

e. Patient/Family-Generated Data. Commendations/complaints with relevant reviews attached.

f. Administrative Contents

(1) Provider profile reports highlighting expiration dates of current State license(s), BLS, ATLS, and ACLS training certificates; date of last clinical privileges reappraisal; and date(s) of recent professional training (courses/programs offering certificates of completion and number of hours or units of CE awarded by professional organizations, societies, or associations).

(2) Reports on medical/dental record deficiencies and delinquencies. As a minimum, the following medical/dental record deficiencies will be identified and recorded:

(a) H&P not performed within 24 hours of admission.

(b) Operative report not dictated within 24 hours of completion of surgery.

(c) Narrative summary not dictated within 4 working days of patient discharge.

g. Committee Actions. Ongoing peer review (that is, minutes, recommendations, counseling, and sanctioning documents for any case leading to investigation or adverse privileging actions of the provider).

h. Other Information. Letters of appointment to staff positions and committee duties, participation in activities of benefit to military medicine, teaching activities, and other information as deemed appropriate by the credentials committee or the department/service chief.

ENCLOSURE 23

*INTER-FACILITY CREDENTIALS TRANSFER BRIEF (*ICTB*)* PREPARATION INSTRUCTIONS

1. PURPOSE. The ICTB has been authorized by the Department of Defense for credentials transfer and privileging when DoD health care providers are temporarily assigned to medical or dental treatment facilities for clinical practice.

2. CCQAS. The CCQAS is a Web-based application that maintains and stores provider credentialing information on a central secure server. The ICTB is generated electronically from key data elements of information stored within CCQAS. For users with CCQAS access rights, basic information regarding the use of this real-time credentials data collection/management system is available at Web site https://ccqas.mont.disa.mil. Instructions for use of this system are located in the Help menu on the Credentials Provider Search Screen.

3. AD ICTB AND RESERVIST/NATIONAL GUARD ICTB. The CCQAS generates two different ICTBs: an AD ICTB or a Reservist/National Guard ICTB. The AD ICTB is to be used by military or full-time civilian providers assigned to fixed military facilities except nonpersonal services contract employees. The ICTB supports privileging requirements for temporary assignment of providers between the inpatient MTFs or the JPC and the units (AD/Reservists/National Guard). The Reservists/National Guard ICTB is used by the Reservists/National Guard providers when requesting privileges in a fixed facility. The ICTB may be prepared using the CCQAS (current version) or by typing the information as specified below. The screen content of the CCQAS ICTB will vary slightly from the manually prepared version.

a. The contents of the manually prepared ICTB for AD providers are as follows:

(1) Paragraph 1. Provider data. Complete name, grade (or rating if GS provider), corps, branch of service, SSN, date of birth, gender, and clinical specialty.

(2) Paragraph 2. Education/training. Note the school or facility name. List qualifying degree, internship, residency, fellowship, and other qualifying training as appropriate. Include the completion date of each level of training and indicate presence/absence of PSV in the credentials file. PSV of all documents associated with education/training is required.

(3) Paragraph 3. Licensure/registration/certification. List all currently held State licenses, registrations, and certifications; authorizing State and document number (for example, license number); status (for example, active, inactive); expiration date; and PSV status. PSV is required.

(4) Paragraph 4. Specialty or board certification/recertification. List all applicable

specialty/board certifications/recertifications; certification/recertification date(s); and expiration date(s). PSV is required.

(5) Paragraph 5. Contingency training. List all applicable life support training (BLS, ACLS, ATLS, and so forth), any readiness training as documented in CCQAS, and expiration dates. BLS certification is a requirement for all personnel who are involved in the provision of patient care.

(6) Paragraph 6. DEA/CDS authorizing document. Note document type, number, expiration date, and PSV status.

(7) Paragraph 7. Current staff appointment/clinical privileges. List the type of professional staff appointment currently held by the provider and the expiration date of the appointment. Identify the privilege category. Attach a copy of the current list(s) of privileges to the ICTB.

(8) Paragraph 8. NPDB/HIPDB*/DPDB* query. List the date of most recent NPDB/HIPDB/DPDB queries and include the information contained in these reports.

(9) Paragraph 9. Purpose of temporary duty. Include a statement of the nature or purpose of the temporary assignment and request performance appraisals, as appropriate, from the gaining facility. Specify the date that the evaluation/appraisal is due. Appropriate forms will be used for evaluation/appraisal of providers performing duty in an inpatient MTF or the JPC. However, any of the Services' clinical performance appraisal/evaluation forms will be accepted by the sending facility. Upon completion of provider's temporary assignment, the evaluation/appraisal forms should be forwarded by the gaining facility to the facility/unit initiating the ICTB.

(10) Paragraph 10. Statement of qualifications. This paragraph contains a brief statement (may be extracted or summarized from an actual peer recommendation) from an individual personally acquainted with the provider's professional and clinical performance through direct observation or review. The individual providing this information may be a training program director for new providers, or a peer (military or civilian) from a present or prior duty assignment/employment. Specific reference should be made to current and projected practice. The statement should describe:

(a) The provider's actual clinical performance with respect to the privileges granted at the sending facility,

(b) The discharge of his or her professional obligations as a medical staff member, and

(c) His or her ethical performance.

(d) The direct contact with the person (peer) providing the statement of qualifications be required, include the name, title or position held, address and telephone

number(s), both office and facsimile, where this individual at the sending facility may be reached prior to the provider reporting for duty. The names and contact information of the two staff members who provided the peer recommendations, if required, may be noted. For AD providers not currently holding military privileges, 2 peer recommendations dated within 24 months of ICTB submission are required attachments to the ICTB. These supplement the contents of paragraph 10. PSV of peer recommendations is required.

(11) Paragraph 11. Verification of ICTB contents. Include a statement attesting to the fact that the PCF was reviewed that is accurately reflected in the brief, and the date the ICTB was prepared. This paragraph must contain a statement indicating the presence/absence of other relevant information in the PCF that is of particular importance, and is supplemental information accompanying PSV of training and licensure, unprofessional conduct during training or in previous practice settings, investigations conducted or limitations imposed by State licensing boards, adverse privileging actions, malpractice cases, and so forth. Three possible statements that may be applicable are as follows:

(a) The PCF contains no additional information relevant to the privileging of the provider.

(b) The PCF contains additional relevant information regarding status of the current license. Contact this command for further information before taking appointing and privileging action.

(c) The PCF contains additional relevant information that may reflect on the current competence of the provider. Contact this command for further information before taking appointing and privileging action.

(12) Paragraph 12. Other comments. Note any additional remarks pertinent to the provider's credentials and/or other privilege-related information.

(13) Paragraph 13. Credentials coordinator's signature. Note the name, telephone and facsimile numbers, and electronic mail address of the inpatient MTF credentials coordinator.

(14) Paragraph 14. Commander's signature. The signature of the privileging authority (that is, the Commander or designee) and date are required. By signing, he or she is attesting to the accuracy and the completeness of the information provided. An individual designated on an additional duty appointment may sign for the Commander if so authorized.

b. The following documents are mandatory attachments to the ICTB:

(1) A copy of all clinical privileges currently held, both military and civilian (that is, DoD and/or civilian privileging document(s)).

(2) In instances where the provider does not hold current military privileges, 2 professional peer recommendations dated within 24 months of submission.

(3) A Delineation of Clinical Privileges specific to individual's military occupational specialty.

(4) Documentation of the approval of clinical privileges/staff appointment the top portion only (blocks 1–5).

(5) A completed Malpractice History and Clinical Privileges Questionnaire (signed within 60 days of ICTB submission).

(6) An authorization document for release of information. This may be specific to the gaining facility, if available.

c. The ICTB should be sent to the gaining facility no later than 45 days prior to the start date of duty. This allows the inpatient MTF or JPC sufficient time to conduct the required privileging activities (for example, to process the privileging forms, conduct the NPDB/HIPDB/*DPDB* queries, and integrate the ICTB into the inpatient MTF's or JPC's regularly scheduled privileging process).

ENCLOSURE 24

REPORTABLE ACTS OF MISCONDUCT/UNPROFESSIONAL CONDUCT FOR DoD HEALTH CARE PERSONNEL

1. ACTS REQUIRING REPORTING FOLLOWING COMMAND ACTION. Acts of misconduct or unprofessional conduct, or similarly unprofessional actions, will be reported to the Federation of State Medical Boards (physicians and dentists), National Council for State Boards of Nursing (RN and LPN/LVN), and/or the appropriate State agency or national professional certifying body for all health care personnel, as appropriate, following command action and completion of applicable appeal procedures in compliance with Reference (aq). Military members will be reported to their Service SG. Civilian and contractors will be reported by CJTF. The following will be reported upon conviction by court-martial or civilian court or upon other final disposition, adjudication, or administrative action:

a. Fraud or misrepresentation involving application for enlistment, commission, employment, or affiliation with DoD services that results in removal from Service.

b. Fraud or misrepresentation involving renewal of contract for professional employment, application for or renewal of clinical privileges, or extension of a Service obligation.

c. Proof of cheating on a professional qualifying examination.

d. Entry of guilty, nolo contendere plea, or request for discharge in lieu of court-martial while charged with a serious misdemeanor or felony.

e. Abrogating professional responsibility through any of the following or similarly unprofessional actions:

(1) Deliberately making false or misleading statements to patients regarding clinical skills and/or clinical privileges/ practice.

(2) Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law.

(3) Being impaired by reason of alcohol/other drug abuse and refusing to participate in or failing to complete rehabilitation.

(4) Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

f. Commission of an act of sexual abuse, misconduct, or exploitation related to clinical activities or non-clinically related indications of sexual misconduct. Examples include promiscuity, bizarre sexual conduct, indecent exposure, rape, contributing to the delinquency of a minor, or child molestation. Such activities, in the Commander's judgment, impair the

individual's overall effectiveness and credibility within the health care system or within his or her professional and patient communities.

g. Prescribing, selling, administering, giving, or using any drug legally classified as a schedule II controlled substance, as defined by section 801–977 of title 21, United States Code (Reference (a~~v~~*x*)), intended for use by the practitioner or a family member of the practitioner without an exception to policy and the expressed written permission of the inpatient MTF Commander or JPC Director, or admitted misuse of such substances by the provider/professional.

h. Commission of any offense that is punishable in a civilian court of competent jurisdiction by a fine of more than $1,000 or confinement for over 30 days for offense(s) related to professional practice or which impairs the practitioner's credibility within the health care system or within his or her professional community.

i. Any violation of the UCMJ for which the individual was awarded nonjudicial punishment when the offense is related to the practitioner's ability to practice his or her profession or which impairs the practitioner's credibility within the health care system or within his or her professional community.

j. Fraud under dual compensation provisions of Federal statutes relating to directly or indirectly receiving a fee, commission, rebate, or other compensation for the treatment of patients eligible for care in a DoD MTF or facility.

k. Failure to report to the privileging authority:

(1) Any disciplinary action taken by professional or governmental organization reportable under this Manual.

(2) Malpractice awards, judgments, or settlements occurring outside DoD facilities.

(3) Any professional sanction taken by a civilian licensing agency or health care facility.

l. Request for administrative discharge in lieu of courts-martial or administrative discharge while charged with any of the offenses noted above.

2. ACTS REPORTED FOLLOWING COURTSMARTIAL OR INDICTMENT. The following will be reported upon referral for trial by courts martial or indictment in a civilian court and upon final verdict, adjudication, or administrative disposition:

a. Offenses punishable by a fine of more than $5,000 or confinement in excess of 1 year by the civilian jurisdiction in which the alleged offense occurred.

b. Offenses punishable by confinement or imprisonment for more than 365 days under the UCMJ.

c. Entry of a guilty or nolo contendere plea, or a request for discharge in lieu of courts-martial, while charged with an offense designated in paragraph 2.a. or 2.b. of this enclosure.

d. Committing an act of sexual abuse or exploitation in the practice of medicine, dentistry, nursing, or other practice of health care.

e. Inappropriately receiving compensation for treatment of patients eligible for care in any DoD MTFs or facility.

f. Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.

ENCLOSURE 25

MANAGEMENT CONTROL EVALUATION CHECKLIST

1. FUNCTION. The function covered by this checklist is CQM administration.

2. PURPOSE. The purpose of this checklist is to assist local Commanders and JTF CapMed in evaluating the key management controls listed below. It is not intended to address all controls.

3. INSTRUCTIONS. Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, interviewing, data sampling, or simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished and documented on the appropriate Management Control Evaluation Certification Statement form.

4. TEST QUESTIONS

a. Clinical QM Program. Each inpatient MTF or, as appropriate, the JPC has established a comprehensive, integrated CQMP that is in compliance with current accrediting/regulatory guidance.

(1) Is there a comprehensive, integrated CQMP in place in the inpatient MTF or, as appropriate, the JPC?

(2) Is the inpatient MTF or the JPC CQMP supported by a written CQM plan?

(3) How are providers/professionals being educated about the inpatient MTF's or JPC's quality issues and initiatives?

(4) How are quality or quality-process issues that are identified by staff or beneficiaries brought to the attention of the inpatient MTF or the JPC leaders?

(5) Are CQM data collected, analyzed, and utilized by inpatient MTF or the JPC leadership to improve organizational performance?

(6) Are CQMP summary reports prepared and submitted according to applicable regulatory guidance?

(7) Are QA documents and records maintained according to Federal applicable DoD guidance?

b. Accreditation Program. Compliance with TJC accreditation standards is evaluated during the triennial TJC survey process. The standards are outlined in the current TJC Manual as applicable to the site being surveyed. The survey results are submitted to JTF CapMed.

(1) Did the inpatient MTF Commander or JPC Director ensure compliance with TJC and other accreditation standards?

(2) Did the inpatient MTF or the JPC submit its TJC or other accrediting agency survey preliminary report and a survey after-action report to JTF CapMed?

c. Patient Rights and Responsibilities. Each inpatient MTF or, as appropriate, the JPC has established processes that ensure patient rights and responsibilities are addressed according to TJC or other accrediting agency standards and DoD requirements.

(1) Does the inpatient MTF or, as appropriate, the JPC review and incorporate the facility-specific information from DoD-sponsored beneficiary surveys into its programs and processes?

(2) Was the inpatient MTF or the JPC in compliance with current TJC or other accrediting agency patient rights standards during its latest accreditation survey?

(3) Did the inpatient MTF Commander or, as appropriate, the JPC Director designate at least one person to be responsible for explaining to beneficiaries their rights and responsibilities?

(4) Is a health care consumer council in place and functioning in the organization? Does the inpatient MTF or the JPC leaders participate in the activities of this council as appropriate? What has changed in the organization as a result of this council's actions?

(5) Did the inpatient MTF Commander or, as appropriate, the JPC Director include the status of patient rights implementation in the annual CQMP Summary Report?

(6) Is an inpatient MTF or, as appropriate, the JPC report card posted or visibly displayed? What data are provided and how often is this data updated?

d. Utilization Management/Outcomes Management. Each inpatient MTF or the JPC establishes UM/OM processes to meet TJC, other accrediting agency, DoD, and JTF CapMed requirements.

(1) Did the inpatient MTF or, as appropriate, the JPC UM/OM plan describe the functions of the staff responsible for UM/OM within the organization as well as all processes, procedures, and criteria used to evaluate health care and services?

(2) Did the inpatient MTF or, as appropriate, the JPC demonstrate quantifiable improvements in the processes and outcomes of care as reflected in the annual CQMP Summary Report to the Commander or Director?

(3) Did the inpatient MTF or, as appropriate, the JPC provide evidence of the use of CPGs and/or clinical pathways in the annual CQMP Summary Report to the Commander or Director?

e. RM/PS Program(s). Each inpatient MTF or the JPC establishes-either as an individual program or integrated into the inpatient MTF/Center Safety Program - an RM/PS Program(s) to meet accrediting agency, DoD, and JTF CapMed requirements.

(1) Was a comprehensive inpatient MTF or, as appropriate, the JPC Safety Program in place for all beneficiaries, employees, visitors, volunteers, and others?

(2) Did the inpatient MTF or, as appropriate, the JPC perform rigorous risk assessment, risk evaluation, and risk reduction/containment activities to reduce the potential for harm to beneficiaries and others?

(3) Did the inpatient MTF or, as appropriate, the JPC demonstrate process measures for identifying, evaluating, and reporting PS events that are according to regulatory and accrediting guidance?

(4) Did the inpatient MTF Commander or, as appropriate, JPC director report SEs according to current JTF CapMed guidance?

(5) Did the inpatient MTF Commander or, as appropriate, JPC director conduct an RCA for each SE reported?

(6) Did the ECOMS (or equivalent group) demonstrate oversight and review of the inpatient MTF or, as appropriate, the JPC RM/PS Program(s) according to regulatory guidance?

(7) Were PCEs and medical malpractice claims identified, tracked, and systematically managed according to regulatory guidance?

f. Licensure, Certification, or Registration. The Department of Defense has established requirements for the licensure, certification, or registration of health care personnel working within the MHS.

(1) Are all health care practitioners who are required to possess a license, certification, or registration in compliance with applicable DoD guidance?

(2) If a provider is unable to obtain the required license, certification, or registration in the time frame indicated by this Manual, is a formal request for extension submitted to the Commander, JTF CapMed?

(3) What action is taken when a provider's/professional's license has lapsed?

g. Competence Assessment, Supervision, and Peer Review

(1) Were organizational and unit-based orientation processes and procedures in place and required for all privileged and non-privileged health care personnel?

(2) Was there evidence of initial and ongoing competence assessment of all members of the organization's health care staff?

(3) For those individuals who require supervision of clinical practice, was a plan of supervision established and in writing?

(4) What process is in place for dealing with a physician for whom a health care quality or ethics issue arose? For a nonphysician provider/professional?

(5) Was there evidence of a viable peer review process for both privileged and non-privileged practitioners?

(6) Was peer review conducted prior to any adverse action against a privileged provider's privileges or a non-privileged professional's scope of practice?

h. Credentials Review, Clinical Privileging, and Proceedings

(1) Did the inpatient MTF or the JPC, TJC or other accrediting agency survey results document compliance with current TJC or other accrediting agency medical staff standards?

(2) Was there evidence of systematic credentials verification for all privileged providers and non-privileged professionals?

(3) Did the inpatient MTF or, as appropriate, the JPC demonstrate evidence of performance-based decision making relevant to clinical privileging and appointment to the medical staff?

(4) Was a PCF established for each privileged provider and were these PCFs maintained according to regulatory guidance?

(5) Is ~~the~~ CCQAS in place and utilized according to DoD guidance?

(6) Are provider privileging or professional scope of practice actions managed and reported to regulatory and State licensing agencies, as appropriate?

(7) Were adverse privileging/practice actions reported directly to the JTF CapMed?

i. Impaired Health Care Personnel Program.

(1) Was there evidence of an inpatient MTF or, as appropriate, the JPC IHCPP that is functional and incorporated into the CQMP processes, as appropriate?

(2) Were both privileged and non-privileged members of the staff with alcohol/other drug

impairments, or medical, psychiatric, or emotional conditions included in the inpatient MTF or the JPC IHCPP?

5. COMMENTS. To make this a better tool for evaluating the CQM processes, comments regarding this checklist should be addressed to: Commander, JTF CapMed.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ABG	Arterial Blood Gases
ABMS	American Board of Medical Specialties
ACOSECOMS	Assistant Chief of Staff, Executive Council of the Medical Staff
ACLS	Advanced Cardiac Life Support
AD	Active Duty
ADA	American Dietetic Association
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
ADMC	Algorithm-Directed Medical Care
AGD	Advanced General Dentistry (12 Month)
AHRQ	Agency for Healthcare Research and Quality
AMA	American Medical Association
ANA	American Nurses Association
AOA	American Osteopathic Association
APA	American Psychological Association
APLS	Advanced Pediatric Life Support
APRN	Advanced Practice Registered Nurse
ASA	American Society of Anesthesiologists
ASAP	Army Substance Abuse Program
ASI	Additional Skill Identifier
ATLS	Advanced Trauma Life Support
BLS	Basic Life Support
CCQAS	Centralized Credentials Quality Assurance System
CDS	Controlled Drug Substance
CEMR	Civilian Employee Medical Record
CHBC	Criminal History Background Checks
CHN	Community Health Nurse
CJTF	Commander, JTF CapMed
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
CPAC	Civilian Personnel Advisory Center
CPG	Clinical Practice Guideline
CPOC	Civilian Personnel Operations Center
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CRNA	Certified Registered Nurse Anesthetist
DA	Department of the Army

DAPA	Drug and Alcohol Program Advisor
DCA	Deputy Commander For Administration
DCN	Deputy Commander For Nursing
DD	Department of Defense Form
DEA	Drug Enforcement Agency
DPDB	Defense Practitioner Data Bank
DPM	Doctor of Podiatric Medicine
ECFMG	Educational Commission for Foreign Medical Graduates
ECOMS	Executive Committee of Medical Staff
EMPA	Emergency Medicine Physician Assistant
FBCH	Fort Belvoir Community Hospital
FOIA	Freedom of Information Act
FS	Flight Surgeon
GB	Governing Body
GME	Graduate Medical Education
GNA	Graduate Nurse Anesthetist
GPHE	Graduate Professional Health Education
GS	General Schedule
HIPDB	Healthcare Integrity and Protection Data Bank
HIPAA	Health Insurance Portability and Accountability Act
H&P	History and Physical
ICTB	Inter-Facility Credentials Transfer Brief
IDC	Independent Duty Corpsman
IDMT	Independent Duty Medical Technician
IG	Inspector General
IHCP	Impaired Health Care Personnel
IHCPC	Impaired Health Care Personnel Committee
IHCPP	Impaired Health Care Personnel Program
IPAP	Interservice Physician Assistant Training Program
ITR	Inpatient Treatment Record
JOA	Joint Operating Area, Joint Operations Area
LPC	Licensed Professional Counselor
LPN/LVN	Licensed Practical Nurse/Licensed Vocational Nurse
M&E	Monitoring and Evaluation
MEB	Medical Evaluation Board
MTF	Medical Treatment Facility
MHS	Military Health System
MNT	Medical Nutrition Therapy

MSW	Master of Social Work
NBCOT	National Board for Certification In Occupational Therapy
NCCPA	National Commission on Certification of Physician Assistants
NCLEX–PN	National Council Licensure Examination-Practical Nurse
NCLEX–RN	National Council Licensure Examination-Registered Nurse
NCSBN	National Council of State Boards of Nursing
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NREMT	National Registry of Emergency Medical Technicians
OASD/HA	Office of the Assistant Secretary of Defense for Health Affairs
OD	Doctor of Optometry
OHN	Occupational Health Nurse
OHPA	Occupational Health Physician Assistant
OJT	On-The-Job Training
OM	Outcomes Management
OPM	Office of Personnel Management
OSD(HA)	Office of the Secretary of Defense for Health Affairs
OT	Occupational Therapist
OTR	Outpatient Treatment Record
PA	Physician Assistant
PAD	Patient Administration Division
PAF	Provider Activity File
PALS	Pediatric Advanced Life Support
PANCE	Physician Assistant National Certifying Examination
PCE	Potentially Compensable Event
PCF	Provider Credentials File
PCS	Permanent Change of Station
PEEP	Positive End Expiratory Pressure
PharmD	Doctor of Pharmacy
PI	Performance Improvement
POC	Point of Contact
PS	Patient Safety
PSP	Patient Safety Program
PSV	Primary Source Verification
PT	Physical Therapist
QA	Quality Assurance
QM	Quality Management
QMD	Quality Management Division
RCA	Root Cause Analysis
RM	Risk Management

RN	Registered Nurse
RTF	Residential Treatment Facility
RV	right ventricle
SE	sentinel event
SERE	Survival, Evasion, Resistance, and Escape
SF	Standard Form
SMDA	Safe Medical Device Act
SRP	Special Review Panel
SSN	Social Security Number
SOC	Standard of Care
TDY	Permissive Temporary Duty
TCF	Training Credentials File
TJC	The Joint Commission
UAP	Unlicensed Assistive Personnel
UCMJ	Uniform Code of Military Justice
UM	Utilization Management
VA	Department of Veterans Affairs
WRNMMC	Walter Reed National Military Medical Center

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this Manual.

abeyance. The temporary assignment of a provider from clinical duties to nonclinical duties while an internal or external peer review or QA investigation is conducted. An abeyance is valid for 30 calendar days. It is not an adverse clinical privileging action and need not be reported.

ABMS. A nonprofit organization whose mission is to maintain and improve the quality of medical care by assisting member boards to develop and use professional and educational standards for the evaluation and certification of physician specialists.

accreditation. A formal process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined standards.

Accreditation Council for Graduate Medical Education. An agency that accredits GME programs. Membership is composed of national association, Federal Government, public sector, and resident physician representatives.

action plan. The end product of an RCA that identifies the risk reduction strategies the facility intends to implement to prevent the recurrence of similar adverse events in the future.

adverse event. An occurrence or condition associated with the provision of care or services that caused harm/injury to the beneficiary. Adverse events may be due to acts of commission or omission.

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

advocate. A person who represents the rights and interests of another individual as though they were the person's own, in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual's needs.

agent. The entity which acts on behalf of JTF CapMed to meet the requirements of clinical quality management as outlined in Reference (f) and other relevant guidance.

aggregate. To combine standardized data and information collected over time.

aggregate data. An accumulation of data that is used by the organization to measure performance.

aggregate review. The process of analyzing recurring incidents, events, or near misses for trends and patterns. This information is utilized by the organization for process improvement interventions.

alcohol dependence or alcoholism. Psychological and/or physiological reliance on alcohol as defined by the current Diagnostic and Statistical Manual.

Alcohol and Drug Abuse Prevention and Control Program. Now referred to as ASAP, the Army's official program for prevention, identification, treatment, and management of personnel with alcohol and drug-related problems.

ancillary services. Those services that participate in the care of patients principally by assisting and augmenting the talents of attending health care providers in diagnosing and treating human ills. Ancillary services generally do not have primary responsibility for the clinical management of patients.

appointment to the medical staff. A designation by the GB that stipulates the provider's relationship to the medical staff and the degree to which the provider participates in medical/dental activities related to the governance of said staff.

appropriate. The determination that the service being provided is suited for the condition that is present, and that it is suitable for a particular person, condition, occasion, and/or place.

appropriateness. The extent to which a particular procedure, treatment, test, or service is effective, is clearly indicated, is not excessive, is adequate in quantity, and is provided in inpatient, outpatient, home, or other settings best suited to the patient's need, given the current state of knowledge.

ASA physical status classification. A system used to classify the physical status of the patient prior to the administration of anesthesia. Patients are classified along a continuum P1 through P6 or as an emergency (e). The "PS" before each number refers to "physical status."

PS1 - A normal, healthy patient.

PS2 - A patient with mild systemic disease.

PS3 - A patient with severe systemic disease.

PS4 - A patient with severe systemic disease that is a constant threat to life.

PS5 - A moribund patient who is not expected to survive without the operation.

PS6 - A declared brain-dead patient whose organs are being removed for donor purposes.

E - A patient for whom an emergency operation is required.

assess. To transform data collected as part of the measurement activity into information through analysis.

assessment. The following applies:

The systematic collection and review of beneficiary-specific data, as it applies to PI activities.

For the purpose of beneficiary assessment, the process established by an organization for obtaining appropriate and necessary information about each individual seeking entry into a health care setting or service.

attending physician. The physician with defined clinical privileges having primary responsibility for diagnosis and treatment of the patient.

audiologist. An individual qualified by graduation from an accredited college or university with a master's or doctoral degree in audiology. He or she possesses national certification from either the American Board of Audiology or the American Speech Language Hearing Association and is licensed to practice audiology in a State, Commonwealth, territory, or jurisdiction.

augmentation. The addition of clinical privileges not previously held by the provider based upon additional professional training, sustained superior performance, or correction of previously demonstrated deficiencies.

authenticate. Authenticate is:

A method to denote authorship of an entry made in a patient's medical or dental record by means of a written signature, identifiable initials, a computer key, or a personally used rubber stamp.

The process of certifying machine-generated copies as genuine.

availability. The degree to which appropriate care/service is present to meet an individual's needs.

beneficiary. Anyone eligible to receive health promotion, illness prevention, inpatient and outpatient health care and services within the MHS.

board certified. A term applied to a physician or other health care professional who has passed an examination given by a professional specialty board and has been certified by that board as a specialist in that subject or discipline.

bylaws. A governance framework that establishes the roles and responsibilities of a body and its members.

care. The provision of accommodations, comfort, and treatment to an individual. In all services provided to include habilitation, rehabilitation, or other programs instituted by the organization for the individual, the responsibility for safety is implied.

CCQAS. A database for managing a provider's credentials and privileges or scope of practice. This includes information on adverse privileging/practice actions, malpractice claims, and PCEs.

certification. Official recognition of an individual by a national agency or association that is intended to assure the public that the health care professional has successfully completed an approved educational program and evaluation. This includes a formal examination designed to assess the knowledge, experience, and skills requisite to the provision of high quality patient care in that specialty.

certified nurse midwife. An RN who has graduated with a master's or doctoral degree from an accredited school of midwifery. He or she has passed the national certification examination by the Continuing Competency Assessment Program of the American College of Nurse-Midwives. The midwife is qualified to diagnose, determine, initiate, alter, or terminate defined regimens of midwifery care and/or nursing treatment provided to a patient on a routine or occasional basis.
certified registered nurse anesthetist. An RN who has graduated with a master's degree from an accredited school of nurse anesthesia and who has passed the national certification examination by the Council on Certification of Nurse Anesthetists. He or she is qualified to diagnose,

determine, initiate, alter, or terminate anesthesia care and/or nursing treatment provided to a patient on a routine or occasional basis.

chiropractor. An individual qualified by graduation from an accredited chiropractic college with a minimum of a baccalaureate degree and who possesses a current license to practice chiropractic in a U.S. State, Commonwealth, territory, or jurisdiction.

clinical competence. The knowledge, skills, and abilities of a health care provider/professional that contributes to effective intervention in illness or injury. The health care individual's demonstrated capability to perform in keeping with defined expectations.

clinical consultant (also known as "specialty leader"). A professional practitioner (who has interest and special knowledge, training, and expertise in a professional field of endeavor) appointed by a Service Surgeon General, CJTF, or in select instances by the inpatient MTF Commander or JPC director, to serve as the subject matter expert in support of the JOA/MTF/Center mission.

clinical practice guidelines. Systematically developed disease/diagnosis-based statements to assist provider and patient decisions about appropriate health care for specific clinical conditions or circumstances.

clinical pharmacist. An individual qualified by graduation from an accredited college or university pharmacy program with a baccalaureate, master's, or doctoral degree and clinical pharmacy experience/training. He or she may possess certification by the Board of Pharmaceutical Specialties and is licensed to practice pharmacy by a State, Commonwealth, territory, or jurisdiction.

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

clinical social worker. An individual qualified by graduation from an accredited college or university social work program with a master's in social work and appropriate license/certification to practice social work from a State, Commonwealth, territory, or jurisdiction.

close call. See "near miss."

CNS. An RN who has graduated with a master's degree, with emphasis as a CNS, from an accredited school of nursing and who has passed the national certification examination by the American Nurses Certification Corporation or the recognized national nursing certification for his or her particular specialty. In select circumstances, the CNS may be qualified to diagnose, determine, initiate, alter, or terminate health services management of identified populations of

patients, and/or the nursing treatment provided to patients on a routine or occasional basis. The CNS possesses a current license to practice in a State, Commonwealth, territory, or jurisdiction.

committee of the whole. In smaller, less complex hospitals, the entire medical staff comprises a committee that performs the activities and functions of the ECOMS.

community health nurse. An RN who possesses experience related to providing family-centered nursing services to individuals, families, and groups in the community to include epidemiological and health promotion support.

competence. The ability to perform the duties, functions, and requirements of a particular discipline, job or duty position, as measured by meeting the following conditions:

Authorized to practice a specified scope of care under a written plan of supervision at any time within the past 2 years; or, completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years, or, privileged to practice/authorized to provide a specified scope of care at any time within the past 2 years.

Actively pursued the practice of his or her discipline, job or duty position within the past 2 years by having encountered a sufficient number of clinical cases or variety of experiences to represent a broad spectrum of the privileges requested or scope of care authorized; and,

Satisfactorily practiced the discipline as determined by the results of professional staff M&E relative to the quality and appropriateness of patient care.

compliance. Behavior that is consistent with stated requirements, such as standards, laws, and regulations.

complication. A condition that arises following the initiation of inpatient or outpatient health care or treatment and alters the course of the patient's illness or the medical care required.

confidentiality. Confidentiality is:

Restriction of access to data and information to individuals who have a need, a reason, and permission for such access.

An individual's right, within the law, to personal and informational privacy, including his or her health care records.

continuing education. Education beyond initial academic or professional preparation that is relevant to the type of care or service delivered in an organization; courses of study that provide current knowledge relevant to an individual's field of practice or service responsibilities; and that update and enhance the knowledge, skills, and experience of health care personnel.

continuity of care. The process for providing the ongoing appropriate level of care as the patient moves through the health care continuum from the most acute and intensive to the least acute and

intensive.

credentialing. The process of obtaining, assessing, and verifying the qualifications of a health care provider to render beneficiary care/service in or for a health care organization.

credentials. The documents that constitute evidence of qualifying education, training, licensure, certification or registration, experience, current competence, health status, and other qualifications of health care personnel.

credentials review. The process by which the health care professional's credentials are determined to be appropriate for the position requested or held prior to being granted clinical privileges or assigned patient care responsibility. It is based on the following four core criteria: current licensure; relevant education, training or experience; current competence; and ability to perform the requested privileges or scope of practice (non-privileged personnel). Credentials review is conducted on health care personnel prior to selection and procurement for military service or civilian employment. It is repeated for licensed, certified, or registered health care personnel at the time of authorizing document renewal; and for health care providers prior to medical staff appointment and award of clinical privileges. Thereafter, the review is due at the time of biennial staff reappointment and renewal of privileges.

criteria. Expected levels of achievement or specifications against which performance or quality may be compared.

data. Material, facts, or clinical observations that have not been interpreted.

delegation. To entrust to another competent individual the authority to perform a selected task(s) in a selected situation(s).

Defense Practitioner Data Bank. A national data collection program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers, and suppliers. The HIPDB collects information regarding licensure and certification actions, exclusions from participation in Federal and State health care programs, health care-related criminal convictions and civil judgments, and other adjudicated actions or decisions as specified in regulation

denial of privileges. Refusal to grant requested privileges to a provider, at the time of initial application or renewal, due to professional or clinical concerns, or due to facility-specific limitations. Denial of privileges due to professional incompetence or misconduct is an adverse privileging action that is reportable to the NPDB. Denial of privileges due to facility-related constraints is not an adverse privileging action and is not reported to the NPDB.

dentist. An individual qualified by a degree in dental surgery or dental medicine and licensed by a State, Commonwealth, territory, or jurisdiction to practice dentistry.

dietitian. An individual qualified by graduation from a college or university with a major in foods or nutrition or institution management and possessing either a baccalaureate or a master's

degree and registered by the ADA.

direct supervision. See "supervision."

disaster. A natural or man-made event within the facility or in the nearby community that significantly disrupts the MTF's or JPC's environment of care or its ability to provide patient care and treatment. The event results in sudden, significantly changed, or increased demands on the organization's services and typically will require activation of the organization's Emergency Management/Preparedness Plan.

documentation. The process of recording information in the health care beneficiary's medical record or the recording of information in/on another source document.

drug abuse. The use or possession of illegal drugs or the nonmedical use of prescription or over-the-counter drugs.

drug dependence. Psychological and/or physiological reliance on a psychoactive drug as defined by the current Diagnostic and Statistical Manual American Psychiatric Association of Mental Disorders.

due process. The manner in which proceedings are conducted, according to established rules and procedures, in order to protect the individual's Fifth Amendment right to notice of a hearing and Fourteenth Amendment right to a fair hearing.

durable medical equipment. Medical equipment that is not disposable (that is, is used repeatedly) and is related only to care of a medical condition.

Educational Commission For Foreign Medical Graduates. A nonprofit organization that assesses the readiness of graduates of foreign medical schools to enter residency programs in the U.S. that are accredited by the Accreditation Council For Graduate Medical Education.

Executive Committee of the Medical Staff. A group, comprised of physicians and other members in leadership positions within the organization, that is responsible for activities related to self-governance of the medical staff and PI of the professional services provided by individuals with clinical privileges. A majority (at least 51 percent) of voting members of this committee must be fully licensed and privileged physician members of the medical staff actively practicing in the hospital.

effectiveness. The degree to which action(s) achieve the intended health or dental result under normal or usual circumstances.

efficacy. The degree to which the care of the individual has been shown to accomplish the desired or projected outcomes.

efficiency. Optimal allocation of goods or services. In health or dental care, it is maximizing the units of effective care delivered for a given unit of resources expended.

elopement. When a patient or resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired, wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge.

emergency. A condition in which life is in imminent danger and/or permanent injury may result if treatment is delayed. In a larger context, this may be a natural or man-made event that severely taxes the resources and capability of a health care organization requiring activation of the Emergency Management/Preparedness Plan. (See "disaster.")

ergonomics. The field of study that seeks to fit the job to the person, rather than the person to the job. Includes the evaluation and design of workplaces, environments, jobs, tasks, equipment, and processes in relationship to human capabilities and interactions in the workplace.

evaluation. Analysis of collected, compiled, and organized data pertaining to important aspects of care. Data are compared with predetermined, clinically valid criteria; variations from criteria are determined to be justified or unjustified; and problems or opportunities to improve care are identified.

facility. A designated unit, organization, institution, or physical structure either military or civilian. Facility infers and applies to entities engaged in the delivery of health care and services. (See definition of "MTF.")

Fifth Pathway. A program to facilitate entry into GME in the United States for individuals who obtain their undergraduate medical education abroad. The Fifth Pathway is a period of supervised clinical training for students who have:

Completed, in an accredited U.S. college or university, undergraduate premedical studies of a quality acceptable for matriculation into an accredited U.S. medical school;

Received undergraduate education abroad at a medical school listed in the World Health Organization World Directory of Medical Schools;

Completed all formal requirements of the foreign medical school except internship and/or social service, and passed Step 1 of the United States Medical Licensing Examination. (Those who have completed all the requirements of the foreign medical school are NOT eligible.) After successful completion of a year of clinical training, that is, post-graduate year one, sponsored by a U.S. medical school accredited by the Liaison Committee on Medical Education, and having passed United States Medical Licensing Examination Step 2, the candidate receives a Fifth Pathway certificate and is eligible to enter residency training as an international medical graduate.

focused review. Review that concentrates on a perceived problem area that may be a specific diagnosis, procedure, practitioner(s), patient(s), or other limited scope topic. It may be performed in place of or preliminary to a more comprehensive review, formal education, and training program. A planned program of instruction that is based on individually assessed

learning needs of the participants. Specific learning objectives provide a structure to the academic and/or technical content that is presented. A pre- and/or post-test may be administered to assess student comprehension and mastery of the material presented.

governing body. The individual, group, or agency that has ultimate authority and responsibility for the overall operation of the organization. For the inpatient MTFs and Centers, this is CJTF. Graduate professional health education structured, discipline-specific professional health care-related training that is accredited by a national body (for example, the Accreditation Council For Graduate Medical Education, National League for Nursing, and so forth), and obtained after the appropriate basic professional degree. Completion of the educational requirements associated with this training may lead to the award of a master's or doctoral-level academic degree.

hazard. Any real or potential condition that can cause injury, illness, or death to patients, personnel, or other individuals, or damage to or loss of equipment or property, mission degradation, or damage to the environment.

hazardous condition. Any set of circumstances which increases the likelihood of injury or harm.

Health Care Financing Administration. The Federal Agency that oversees all aspects of health care financing for Medicare and for the Office of Prepaid Health Care Operations and Oversight (now referred to as Centers for Medicare and Medicaid Services).

health care personnel. Individuals involved in the direct or indirect delivery of health services or patient care.

health care professional. Military (Active Duty/Reservist/National Guard) and civilian (GS and those working under contractual or similar arrangement) personnel who have received advanced education or training beyond the technical level in a recognized health care discipline and who are licensed, certified, or registered by a State, Government agency, or professional organization to provide specific health services in that field. This includes those involved in the provision of diagnostic, therapeutic, or preventive care, ancillary services, and administration.

health care provider. Military (Active Duty/Reservist/National Guard) civilian (GS and those working under contractual or similar arrangement) or volunteer granted privileges to diagnose, initiate, alter, or terminate health care treatment regimens within the scope of his or her license, certification, or registration.

health care services. The services intended to directly or indirectly contribute to the health and well-being of patients.

Health Integrity and Protection Data Bank - HIPDB is a tracking system managed by the Healthcare Resources and Services Administration (HRSA) of the Department of Health and Human Services. It alerts users that a comprehensive review of the practitioner, provider, or supplier's past actions may be prudent. The Health Insurance Portability and Accountability Act

of 1996 led to the creation of the HIPDB to combat fraud and abuse in health insurance and health care delivery.

impaired health care personnel. A privileged provider or non-privileged individual who by reason of alcohol or drug abuse or dependence, medical condition, or emotional disturbance has exhibited unprofessional conduct, substandard medical practice, or professional incompetence which is, or has the potential to be, detrimental to PS or to the proper delivery of quality patient care.

important aspects of care. Clinical activities that involve a high volume of patients, entail a high degree of risk for beneficiaries, or tend to produce problems for patients. Such activities are deemed important for the purpose of monitoring and evaluation.

indicator. A defined, measurable dimension (variable) of the quality or appropriateness of an important aspect of care. Indicators specify the patient care activities, events, occurrences, or outcomes that are to be monitored and evaluated over time in order to determine whether those aspects of patient care conform to current acceptable standards of practice.

indirect supervision. See "supervision."

infection control program or process. An organization-wide program or process, to include policies and procedures, for surveillance, prevention, and control of infection to minimize the risk of infection to patients and medical or dental treatment staff.

information. An interpreted set(s) of data that can assist in decision making.

in-service education. Organized educational opportunities designed to enhance staff member knowledge and skills or to teach new knowledge and skills relevant to their particular responsibilities and disciplines.

intentional unsafe act. Any alleged or suspected deliberate act or omission by a provider, staff member, contractor, trainee, or volunteer pertaining to a patient that involves a criminal act; a purposefully unsafe act; patient abuse; or an event caused or affected by drug or alcohol abuse. Intentional unsafe acts are matters for military and/or civilian law enforcement, the military or civil service disciplinary systems, or an administrative investigation and are significant RM issues. Said acts are not within the definition of adverse events for which the PSP has authority.

International Classification of Diseases. A manual that classifies medical/surgical diseases/disorders based on severity and complexity. This universally accepted three-volume publication is revised periodically. Each new revision is numbered sequentially. Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325.

international medical graduate. A physician whose basic medical degree or qualification was conferred by a medical school located outside the United States, Canada, or Puerto Rico.

Joint. Connotes activities, operations, organizations, etc., in which elements of two or more Military Departments participate.

lapse. A period of nonclinical duty that has diminished, or has the potential to diminish, the clinical skills/abilities of the provider. Typically, this is an interval of 12 months or more but must be determined on a case-by-case basis.

license. A grant of permission by an official agency of a State, the District of Columbia, or a Commonwealth, territory, or possession of the United States to provide health care within the scope of practice of a specified discipline.

current. Active, not revoked, suspended, or lapsed in registration.

active. Characterized by present activity, participation, practice, or use.

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

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. See "restriction."

LPN/LVN. An individual who is specifically prepared in the techniques of nursing, who is a graduate of an accredited school of practical/vocational nursing and whose qualifications have been examined by a State board of nursing, and who has been legally authorized to practice as an LPN/LVN.

M&E. Denotes actions taken to ensure a provider or non-privileged professional understands and renders appropriate care. This action is not reportable to the NPDB or regulatory agencies and may include:

Elements of indirect supervision such as retrospective or concurrent review of medical records.

Reviewing verbally with the provider/professional the diagnosis/assessment, treatment options, and decisions for care rendered by the provider/professional on a sample of cases or on particular types of cases.

Observing at least two significant demonstrations of technical skill, if appropriate.

malpractice. A dereliction of professional duty, incorrect or negligent treatment, failure of professional skill or learning, as well as illegal or immoral conduct by any provider/professional responsible for health care, that results in death, injury, loss, or damage to the health care beneficiary.

measure. To collect quantifiable data about a function or process.

measurement. The systematic process of data collection, repeated over time, or at a single point in time.

medical examination. A process of inspection or investigation performed by a qualified individual specifically as a means of diagnosing disease, illness, or dysfunction.

medical nutrition therapy. The assessment of patient nutritional status followed by therapy ranging from diet modification and counseling to the administration of specialized nutrition therapies such as enteral or parenteral feedings.

medical quality assurance program. any peer review activity carried out before, on, or after November 14, 1986 by, or for the Department of Defense to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

medical readiness training certification. A process that verifies the preparation of health care providers for operational requirements. The Commander's review and verification of individual, collective, and unit medical readiness training, education, and experiences is a critical element of the process.

medical staff. An organized body of fully licensed individuals (physician and others with the appropriate appointment) privileged by Privileging Authority and who are characterized by primary responsibility to the GB for the quality of patient care.

medical staff appointment. A status that reflects the relationship of a given privileged provider to the medical staff. At the time clinical privileges are granted or renewed, the provider may also be granted a medical staff appointment which runs concurrently with the privileges. While privileges may be granted with or without a staff appointment, a medical staff appointment may not be made in the absence of granting privileges. A medical staff appointment may be revoked without affecting the provider's clinical privileges. An appointment to the medical staff is required in order for a provider to admit patients. There are four medical staff appointment categories:

initial. Granted to a provider when he or she is first assigned/employed in a DoD MTF or the JPC, or if the provider has a lapse of greater than 180 days since holding a medical staff appointment in a DoD MTF or other facility, such as the JPC.

active. Granted to a provider exercising regular privileges and meeting all qualifications for medical staff membership after successful completion of the initial appointment period.

affiliate. Granted to a provider exercising regular privileges and meeting all qualifications

for medical staff membership. This applies after successful completion of the initial appointment period when, due to conditions of employment, the provider is neither assigned organizational responsibilities of the medical staff nor expected to fully participate in activities of the medical staff.

temporary. Granted to a provider in emergency or disaster situations when there are urgent beneficiary care needs, but the time constraints will not allow full credentials review.

Medicare. The Federal health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease.

MHS. The combination of military and civilian medical systems used to provide health care to DoD medical beneficiaries. The MHS incorporates all aspects of health services for the Department of Defense.

monitoring. The systematic and ongoing collection, compilation, and organization of data pertaining to indicators for the quality and appropriateness of important aspects of care in order that problems or opportunities to improve care can be identified.

MTF. Health Care Facilities, i.e., hospitals and Centers.

near miss. An event or situation that could have resulted in harm to the patient but did not, either by chance or through timely intervention. The event was identified and resolved before reaching the patient. Such events are also referred to as "close call" incidents. An example of a near miss is a surgical procedure almost performed on the wrong patient but caught before the surgery was initiated.

National Practitioner Data Bank. The agency designated by the Department of Health and Human Services to receive and provide data on substandard clinical performance and conduct of physicians, dentists, and other licensed health care practitioners, including data on malpractice claims payment made on behalf of those practitioners.

network. The combination of the MTF, Center, and other civilian preferred providers (for example, individual and group practitioners, other Federal and non-Federal hospitals, clinics, and so forth) who have agreed to accept DoD and uniformed Services beneficiaries enrolled in the MHS Managed Care (TRICARE) Program, provide care at negotiated rates, adhere to QA and UM procedures, and follow other requirements of the TRICARE Program.

nexus. A connection or link between individual events, circumstances, or facts. The fundamental core or center of a given situation (that is, the heart of the matter).

NP. An RN who has graduated with a master's degree, as an NP in a given specialty, from an accredited school of nursing and who has passed the national certification examination by the American Nurses Certification Corporation or the recognized national nursing certification for his or her particular specialty. The NP is qualified to diagnose, determine, initiate, alter, or terminate health services management of identified populations of patients and/or the nursing

treatment provided to patients on a routine or occasional basis. The NP possesses a current license to practice in a State, Commonwealth, territory, or jurisdiction.

NPI. A standard, provider-unique 10-digit number assigned by CMS to eligible healthcare personnel. The NPI is used throughout the United States healthcare system to identify providers who furnish billable healthcare services or those who may initiate and/or receive referrals.

nursing plan of care. Any written documentation of the nursing process as it applies to an individual patient.

nutritional care services. Those activities related to the provision of comprehensive nutritional care, to include nutritional assessment and MNT of beneficiaries, nutrition education and health promotion, administration and operation of a hospital food service, and applied research.

obligated status. Active duty service obligation(s) resulting from entry into the Military Service, participation in the various subsidized accession programs (for example, Health Professions Scholarship Program, Uniformed Services University of the Health Sciences, Reserve Officer Training Corps), or from participation in in-service or Service-sponsored professional education programs that include an active duty obligation.

occupational hazards. Hazards directly related to the work environment. occupational and environmental health nursing. The specialty practice that provides for and delivers health and safety programs and services to workers. The practice focuses on promotion of health, prevention of illness and injury, and protection from work-related and environmental hazards. Occupational and environmental health nurses have a combined knowledge of health and business that they blend with healthcare expertise to achieve the requirement for a safe and healthful work environment.

optometrist. A person qualified by graduation from an accredited school of optometry and licensed to provide independent primary eye care in a State, Commonwealth, territory, or jurisdiction.

ORYX ™. A TJC proprietary initiative that integrates health care organizational outcomes and other performance measurement data into the accreditation process.

OT. An individual qualified by graduation from an accredited school of occupational therapy with either a baccalaureate or master's degree who has passed a national certification examination given by the National Board for Certification in Occupational Therapy, Inc. A license to practice from a State, Commonwealth, territory, or jurisdiction is required.

other authorizing document.

A mechanism, such as registration and certification, by which a State; the District of Columbia; or a Commonwealth, territory, or possession of the United States grants authority to provide health care in a specified discipline; or

In specialties not licensed and where the requirements of the granting authority for registration or certification are highly variable, the validation by a national organization that a practitioner is professionally qualified to provide health care in a specified discipline

outcomes. The result of performance (or nonperformance) of a function, process, or series of processes; states, or conditions of individuals and populations attributed or attributable to antecedent health care. They can include adverse or beneficial results of care, short- or long-term results of care, complications, or occurrences, and are the product of the performance (or nonperformance) of one or more functions or processes.

PA. An individual who has graduated from an accredited PA education program, and is granted privileges to determine, initiate, alter, or terminate regimens of medical care under the supervision of a licensed physician.

patient care. Health care interventions or services provided to a designated beneficiary in a health care, home, or other setting that are diagnostic, preventive, or therapeutic in nature. Patient care may be classified as either direct or indirect.

direct patient care. Health care interventions, services, or activities that engage the provider/professional in face to face contact with the beneficiary and/or family member/significant other. Examples of direct care include assisting with activities of daily living; conducting a patient assessment; taking an X-ray; performing an H&P examination; patient teaching; and the collecting, reporting, and documenting data related to these activities.

indirect patient care. Health care-related activities that complement or augment direct care but typically do not involve immediate contact with the beneficiary and/or family member/significant other. Examples of indirect care include performing a procedure on a specimen in the laboratory; processing or interpreting radiological films; reviewing data contained in a medical record; preparing pharmaceuticals or intravenous solutions; and the collecting, reporting, and documenting data related to these activities.

patient care evaluation. Processes performed either concurrently or retrospectively, which assess in depth the quality and/or nature of the utilization of an aspect of health or dental care/service. This often is accomplished by observation or medical record review. Corrective action is taken where indicated and a subsequent analysis (follow-up) is made of the corrective action/effect.

patient harm. Personal injury or damage to a patient of a physical or psychological nature as a result of a patient safety event.

patient safety event. An incident or error that occurred (actual event), or almost occurred (close call/near miss) that caused, or had the potential to cause, harm to the patient.

peer. An individual from the same professional discipline/specialty to whom comparative reference is being made.

peer recommendation. Written feedback from an individual (a peer) who has firsthand knowledge of the professional performance of the provider in question. The document will be current (that is, for initial staff appointment/award of clinical privileges less than 12 months old; less than 24 months for appointment/privileges renewal). The content of the recommendation should address the provider's professional knowledge, clinical judgment and technical skills, interpersonal skills, communication skills, and professionalism. In instances where these documents are not available, or are not current, another method (for example, telephonic interview, with documentation included in the PCF) of obtaining peer recommendation will be employed. This course of action should be taken only in extreme circumstances (that is, emergency/disaster), and is valid for a temporary period of time according to local policy, pending receipt of written peer recommendations.

peer review. Any assessment of the quality of medical care carried out by a health care professional, including any such assessment of professional performance, any patient safety program root cause analysis or report, or any similar activity described in regulations prescribed by the Secretary under subsection (i) of NDAA 2012.

performance improvement. The continuous study and adaptation of a health care organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals, populations, and other users of services.
physician. An individual possessing a degree in medicine or osteopathy and licensed by a State, Commonwealth, territory, or jurisdiction to practice medicine.

plan of supervision. A command-approved arrangement to provide supervision, specific to a practitioner, which includes: the scope of care permitted, level of supervision, identity of supervisor, evaluation criteria, and frequency of evaluation.

podiatrist. An individual qualified by graduation from an accredited school of podiatric medicine and licensed to practice podiatry by a State, Commonwealth, territory, or jurisdiction.

PCE. An adverse event that resulted in harm to the patient and presents a possible financial loss to the Federal Government (a malpractice claim or death/disability payment). It includes any adverse event or outcome, with or without legal fault, in which the patient experiences any unintended or unexpected negative result. It pertains to all patients regardless of beneficiary status (for example, AD, retired, family member, civilian emergency).

practice or procedure variance. Any deviation from the accepted standards of care, practice, or performance.

prescriptive authority. Permission granted by an authorizing State agency to prescribe pharmacologic agents based on specific clinical indicators, including the results of diagnostic tests and laboratory results, and the patient's health status or needs.

PSV. The process utilized to authenticate the accuracy of a specific credential or qualification as reported by an individual health care provider or professional. The primary source is the institution, agency, or body that is the original source of the credential or qualification.

privileges (clinical). Permission to provide specified medical and other beneficiary health care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, competence, ability, health, and judgment. The three categories of clinical privileges include:

regular. Permission to independently provide medical and other beneficiary health care services as described above. Regular privileges shall be granted for periods not to exceed 24 months.

temporary. Granted in situations when time constraints will not allow full credentials review. Temporary privileges are valid for periods not to exceed 30 days. Granting of temporary privileges should occur infrequently and then only to fulfill pressing patient care needs. Temporary privileges may be granted with or without a temporary appointment to the medical staff.

supervised. Identifies the status of nonlicensed/noncertified providers who may neither be appointed to the medical staff nor practice independently. Supervised privileges may be granted for periods not to exceed 24 months. (See "supervised privileges" for more detail.)

privileging. The process whereby the privileging authority, upon recommendation from the credentials committee, grants to individuals the authority and responsibility for making independent decisions to diagnosis, initiate, alter, or terminate a regimen of medical or dental care.

process. A goal-directed, interrelated series of actions, events, mechanisms, or steps.

professional. See "health care professional."

professional impairment. A condition that may adversely affect the ability of health care personnel to render quality care. Professional impairment may include deficits in medical knowledge, expertise, or judgment; unprofessional, unethical, or criminal conduct; and any medical condition that reduces or prevents the individual from safely executing his or her responsibilities in the provision of health care.

professional review process. The process by which providers/personnel of a like or similar discipline conduct an investigation and peer review to evaluate the quality of patient care of another health care provider/professional. Recommendations are subsequently made to the Privileging Authority regarding adverse privileging action or limitation of practice. The credentials committee/function is involved in the evaluation of the privileged provider; a designated peer review panel evaluates the non-privileged health care professional.

professional staff appointment. See "medical staff appointment."

protocol. A written procedure providing basic guidelines for the management (diagnosis and treatment) of specific types of medical or dental patient care in specified circumstances.

provider. See "health care provider."

provider activity file. A file containing temporary provider-specific information and performance data used to support the privilege renewal process. It contains RM data to include pending adverse privileging/practice action information and potential data pending resolution. It is an extension of the PCF and contains active QA documents protected from disclosure by Reference (~~k~~*m*). PAF criteria include, but are not limited to:

Number of patients "discharged" identifies the total number by patients discharged and transferred to the responsibility of the attending practitioner (excluding administrative transfers when the patient was not admitted for treatment). This includes inpatient deaths but excludes patients for whom only medical records responsibility is assumed.

Number of patient "deaths (failed criteria)" identifies deaths that may have been contributed to by provider failure, delay, or inappropriate diagnosis or treatment.

Number of patients with "normal tissue (failed criteria)" identifies surgical cases with normal tissue found unacceptable by surgical cases review function. Number of medical record "deficiencies" is determined by the medical record review function.

Number of medical record "delinquencies" identifies documented instances of a provider's failure to complete records within prescribed time limits, that is, in no instance longer than 30 days from patient discharge for total record completion.

Number of "transfusion variations" identifies instances of inappropriate blood use as determined by transfusion review or other QA/quality improvement review function.

Number of "drug use variations" identifies instances of inappropriate drug use as determined by review of the Pharmacy and Therapeutics committee/function or other QA/quality improvement review.

Number of "validated complaints" identifies provider-directed beneficiary complaints reviewed and found justified.

Number of "validated occurrences" identifies occurrences that have been attributed to a provider's act of commission or omission.

provider credentials file. A file containing a variety of professional credentialing and privileging documents that substantiate the provider's licensure, education, training, experience, current competence, health status, and medical practice reviews. Information related to provider performance, permanent adverse privileging actions, and malpractice cases is contained. It is maintained in a secure manner and is protected from disclosure by Reference (~~k~~*m*).

PT. An individual qualified by graduation from an accredited school of physical therapy with either a baccalaureate or master's degree and licensed by a State, Commonwealth, territory, or jurisdiction to practice physical therapy.

QA. A formal and systematic monitoring and reviewing of medical care delivery and outcomes; designing activities to improve health care and overcome identified deficiencies in providers, facilities, or support systems; and carrying out follow-up steps or procedures to ensure that actions have been effective and no new problems have been introduced.

quality. The degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcome for a particular service, procedure, diagnosis, or clinical problem.

quality improvement. An approach to the continuous study and improvement of the processes of providing health care services to meet the needs of individuals and others. Synonyms include continuous quality improvement, continuous improvement, organization-wide PI, and total QM.

QM. A systematic, organized, multidisciplinary approach to the ongoing assessment, monitoring, evaluation, and modification of the processes of health care and services to enhance quality. These activities are associated with incremental and focused processes or PIs to meet the health care needs and expectations of eligible beneficiaries.

QM program. A structured series of coordinated activities and procedures that emphasizes leadership commitment to quality performance, regardless of the practice site (including operational platforms), a supportive organizational culture, and the evaluation of the effectiveness of clinical PI activities. These activities include structured processes that design, measure, assess, and improve the health care status and the quality of health care services provided to individuals and populations.

quality of care. The degree to which health care and services for individuals and populations increase the likelihood of achieving desired health outcomes and are consistent with current professional knowledge. Dimensions of performance relative to quality of care include: the perspective of the beneficiary; safety of the care environment; and accessibility, appropriateness, continuity, effectiveness, efficacy, efficiency, and timeliness of care.

reduction of privileges/practice. The permanent removal of a portion of a provider's clinical privileges or a non-privileged professional's scope of practice. The reduction may be based on misconduct, physical impairment, or other factors limiting the individual's capability. Reduction of privileges/scope of practice is reportable to the NPDB and to State and other regulatory agencies, as appropriate. An opportunity for a hearing will be afforded the individual.

referral. The practice of directing a patient to another program or practitioner for services or advice that the referring source is not prepared or qualified to provide.

reinstatement of privileges/practice. A revision to an adverse privileging action that restores all or a portion of the provider's/non-privileged professional's privileges or scope of practice. Reinstatement may include provisions for M&E of the individual involved; the nature and duration of M&E will be clearly established in writing. Reinstatement of privileges is reportable to the NPDB.

representative sample. A sample, inclusive of the personnel or procedures under review, in sufficient number to create statistically significant data.

restriction of privileges/practice. A temporary or permanent limit is placed on all or a portion of a provider's clinical privileges or the non-privileged professional's scope of practice based on incompetence, unprofessional conduct, or other factors affecting the activities restricted. The individual may be required to obtain concurrence before providing all or some specified care and/or may require some type of supervision. This action may be permanent or for a specified period of time. Restriction of privileges/scope of practice is reportable to the NPDB and to State and other regulatory agencies, as appropriate. An opportunity for a hearing will be afforded the individual.

revocation of privileges/practice. The termination of all clinical privileges/practice of a given provider/professional and permanent removal of the individual from all patient care duties. In most cases, such action is followed by action to terminate the provider's/non-privileged professional's DoD service. Revocation of privileges/scope of practice is reportable to the NPDB and to State and other regulatory agencies, as appropriate. An opportunity for a hearing will be afforded the individual.

risk. The chance of an adverse outcome or negative consequence such as injury, illness, or loss.

risk assessment. A structured process to proactively identify and evaluate safety and health-related hazards in order to minimize the likelihood of the event occurring.

RM. Clinical and administrative activities that organizations undertake to identify, evaluate, and reduce the risk of injury to patients, staff, and visitors and the risk of financial loss to the organization. It involves identifying risk potential, prevention of risk exposure, and the management of real or potential adverse incidents and medical malpractice claims.

RN. An individual who is specifically prepared in the scientific basis of nursing; is a graduate of an accredited school of nursing; has successfully completed the National Council Licensure Examination for Registered Nurses; and possesses a license to practice as an RN in a State, Commonwealth, territory, or jurisdiction.

root cause analysis. A systematic process for identifying the causal and contributory factors associated with adverse events and near misses which includes the development of corrective action plans and outcomes measures. The analysis focuses primarily on systems and processes rather than individual performance.
RTF. The inpatient rehabilitation element of the ASAP which provides an intensive structured treatment program for eligible MHS beneficiaries.

safety assessment code. A risk assessment score that is assigned to an adverse or near miss event based on the severity of the incident and the probability of its recurrence.

Servicing Legal Office. Military organizational entity providing legal assistance to MTFs, JPC, and JTF CapMed.

scope of care or services. The activities performed by governance, managerial, clinical, or support staff.

sentinel event. An unexpected occurrence involving death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Services. A Department of the United States Department of Defense, including the United States Army, the United States Navy, the United States Air Force, the United States Marine Corps, and the United States Coast Guard

significantly involved provider/staff member. Individuals who (based on medical record entries) actively delivered care in primary or consultative roles during the episode(s) of care that gave rise to the allegation(s) of malpractice, regardless of the SOC determination.

specialty leader. See "clinical consultant."

speech pathologist. An individual qualified by graduation from an accredited college or university with a master's or doctoral degree in speech pathology. He or she possesses a Certificate of Clinical Competence from the American Speech-Language-Hearing Association and license to practice speech pathology from a State, Commonwealth, territory, or jurisdiction.

standard of care. Health care diagnostic or treatment judgments and actions of a provider/professional generally accepted in the health care discipline or specialty involved as reasonable, prudent, and appropriate.

standard of performance. Expected level of performance based on education, level of experience, and criteria of current position requirements.

standard of practice. Identified levels of care that focus on health care personnel and serve as guidelines to assess their competence, experience, and education.

standards. Professionally developed expressions of the range of acceptable variation in quality of care, generally with respect to specific services.

substandard medical practice or care. Medical care rendered to a patient that fails to meet the SOC.

summary suspension of clinical privileges. The temporary removal of all or a portion of a provider's privileges. This action, taken prior to the completion of due process procedures, is based on peer assessment or command decision that the action is necessary to protect patients or the integrity of the command. Summary suspension results in the individual's temporary removal from patient care duties based on allegations of incompetence, negligence, unprofessional conduct, physical (alcohol or other drug related) or professional impairment, and

may continue until due process procedures are complete. This action may take place following a period of abeyance, or as an initial action in response to the performance, conduct, or behavior of the provider in question. Summary suspension of clinical privileges within the DoD is not reportable to the NPDB or to State or other regulatory agencies.

supervised privileges. Privileges granted to a provider who does not meet the requirements for independent practice because he or she lacks the necessary license or certification to practice independently. However, all minimal educational requirements must be met in order to qualify for supervised privileges.

The procedure for awarding supervised privileges is the same as for regular privileges except that a clinical supervisor must be named, in writing, at the time privileges are awarded. A written plan for supervision and a schedule for periodic reporting of the provider's progress must also be outlined. The supervisor must be a provider at an inpatient MTF or the JPC with regular privileges in a scope of practice that meets or exceeds that of the provider being supervised. The degree of supervision required is determined by the clinical supervisor and must be appropriate to the background, experience, and demonstrated skill of the provider being supervised.

Supervised privileges may be granted for periods not to exceed 24 months.

supervision. The process of reviewing, monitoring, observing, and accepting responsibility for assigned personnel. The three types of supervision are:

indirect. The supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of privileges/practice of the individual in question. Reviews may also include countersignature or authentication of medical entries, reports, or orders prescribed by another.

direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows: (1) Verbal–the supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care; and (2) Physically present–the supervisor is present physically through all or a portion of care.

enhanced supervision. Supervision afforded a provider with regular privileges for whom the need to assess competence and performance has been identified. This may be appropriate following a PCS move or a provider's return to patient care responsibility from an administrative/nonclinical assignment, during a period of temporary duty, or when privileges for a new procedure are granted. This is not an adverse privileging/practice action.

supervisor (clinical). One who provides professional oversight of the clinical activities of another. This may be the department/service chief, or a senior staff member of like specialty or service, who reviews and makes medical policy, and ensures that the medical staff review functions are performed within the service. For purposes of evaluating performance and recommending clinical privileges, the clinical supervisor is a peer (if possible) who is an appointed member of the medical staff and is the individual best qualified, on the basis of background and training, to judge the practice of the provider under review.

support services. Those activities in a health care facility which are required to sustain patient care and the environment in which care is provided. Examples include medical maintenance, housekeeping, medical supply and materiel activities, information management, resources management, and the medical library.

suspension of privileges/practice. The temporary removal of all or a portion of a provider's privileges or a non-privileged personnel's scope of practice based on incompetence, negligence, unprofessional conduct, or other factors that do or may affect the appropriateness of the provider's privileges/practice. Suspension of privileges/scope of practice is reportable to the NPDB and to State and other regulatory agencies, as appropriate. An opportunity for a hearing will be afforded the individual.

systems analysis. The analysis of a sequence of activities or management operations to determine which activities or operations are necessary, how they can best be accomplished, and how successful processes can be perpetuated.

telemedicine. The use of telecommunication and information technologies to provide health services. Typically, this involves live video-teleconference between a beneficiary and the primary care provider (at a remote site) and a consultant or specialist in another location. The consultant reviews relevant medical or other data before the session; conducts an actual, live assessment and consultation; and subsequently provides a written report to the provider requesting this service.

thresholds. Pre-established levels or points which, when reached, will trigger intensive evaluation.

unprofessional conduct. Conduct that is beyond, or outside of, professional requirements for rendering beneficiary care and which negatively affects, or has the potential to negatively affect, the professional relationship or contract with the beneficiary.

utilization management. A series of processes by an organization to examine, evaluate, and determine if utilization of its resources is appropriate. These processes include planning, organizing, directing, and controlling the delivery of medical or dental service in a manner that is cost-effective while maintaining acceptable performance and practice standards.

utilization review. The retrospective and concurrent evaluation of an individual provider's practice to determine the medical necessity and appropriateness of the care delivered.

verified credentials. Documents for which confirmation of authenticity has been obtained from the primary source.