

**Medical Services**

# **Clinical Quality Management**

**Rapid Action Revision (RAR) Issue Date: 22 May 2009**

**Headquarters  
Department of the Army  
Washington, DC  
26 February 2004**

**UNCLASSIFIED**

# ***SUMMARY of CHANGE***

AR 40-68

Clinical Quality Management

This rapid action revision, dated 22 May 2009--

- o Establishes specific responsibilities for credentialing functions by Army Reserve Clinical Credentialing Affairs, Human Resources Command-St.Louis, and Active Army units (para 1-4h).
- o Replaces all content in chapter 2 with new guidance regarding the Executive Committee of the Medical Staff; medical staff bylaws; military treatment facility committees and functions; and departmental/service organization, structure, and leadership (chap 2).
- o Eliminates the requirement to submit the annual military treatment facility Quality Management Program Summary Report to the U.S. Army Medical Command (previously covered in chap 2).
- o Identifies the American Nurses Association Standards of Nursing Practice or other national professional organizations' standards as the source of practice expectations (para 3-3b(7)).
- o Relocates information regarding confidentiality of quality assurance documents from paragraph 2-5 to chapter 3 (para 3-7).
- o Requires veterinarians to maintain a current, active, valid, and unrestricted license to practice independently within their defined scope of practice (para 4-4a(1)).
- o Specifies the educational preparation by an accredited institution for military and civilian registered nurses and licensed practical nurses and requires the National Council Licensure Examination- Registered Nurses/ Practical Nurses for the military Army Nurse Corps and 68WM6/M3 (para 4-6c).
- o Restates the requirement for an unrestricted license (all Corps) and explains the process for limited waiver/exception (paras 4-6g and 4-7).
- o Clarifies the licensure requirement for personal services versus non-personal services contract healthcare personnel (para 4-8a).
- o Specifies the use of DA Forms 7653 and 7654 for competency verification of Army Nurses Corps personnel with skill identifier 8A (Critical Care) and M5 (Emergency Nursing) (para 5-1a(1)(b)).
- o Requires currency of emergency life support training at all times (para 5-1e).
- o Deletes the requirement for the advanced practice registered nurse, other than the non-personal services advanced practice registered nurse, to possess and maintain advanced practice licensure (para 7-4b(2)).

- o Restates the collaborative interaction required between the certified registered nurse anesthetist and anesthesiologist or operating surgeon (para 7-4e(4)(a)-(c)).
- o Authorizes selected prescription writing by occupational therapists (para 7-13c(2)(a)(6)).
- o Updates professional credentials requirements for physician assistants (para 7-16b).
- o Clarifies Category I and II privileges for physical therapists (para 7-17c).
- o Provides 10 USC 1102 protection to all documents in the provider credential file and the provider activity file (paras 8-3b(2)(c) and 8-9a).
- o Stipulates that the chairperson of the credentials committee will be a physician and that he/she will vote only in event of a tie (paras 8-5b and 8-5c(5)).
- o Indicates that the responsibility for credentials verification for contracted personnel will be specified in the contract (para 8-6d).
- o Allows use of the American Board of Medical Specialties Web site to verify board certification (para 8-7d).
- o Exempts providers outside the continental United States from the requirement of a current Drug Enforcement Agency certificate (para 8-7k).
- o Directs that qualified healthcare providers obtain a National Provider Identifier (para 8-7r).
- o Provides detailed information related to telemedicine procedures (para 9-2c(7)(a)).
- o Directs the military treatment facility credentials office to maintain the provider credential file for any assigned provider not currently involved in clinical practice (para 9-6b).
- o Provides new instruction for U.S. Army Reserve/Army National Guard deployment privileging (para 9-8c(4)(d)).
- o Clarifies that peer review for an adverse privileging/practice action be performed by a panel (para 10-6e(2)(c)).
- o Requires that a physician chair the adverse actions hearing board (para 10-8a) and that he/she will vote only in the event of a tie (para 10-8g).
- o Eliminates the requirement for verbatim transcript of the adverse actions hearing board (para 10-8e(3)).
- o States that the voluntary modification of privileges/practice as a result of a medical or behavioral condition is not an adverse privileging/practice action (para 11-4c).

- o Revises the risk management content entirety and omits reference to the now disbanded Consultation Case Review Branch (paras 13-1 through 13-5).
- o Specifies that any death/disability of a military member as a result of medical care will be treated as a potentially compensable event (para 13-5b).
- o Revises the layout and contents of the competency assessment file (app C).
- o Make additional rapid action revision changes (chaps 6, 7, 8, 9, 10, 11, 13,14, and apps E, F, G, H, I, J).

Effective 26 March 2004


**Medical Services**

**Clinical Quality Management**

By Order of the Secretary of the Army:

GEORGE W. CASEY, JR.  
*General, United States Army*  
*Chief of Staff*

Official:

  
JOYCE E. MORROW  
*Administrative Assistant to the*  
*Secretary of the Army*

**History.** This publication is a rapid action revision (RAR). This RAR is effective 29 June 2009. The portions affected by this RAR are listed in the summary of change.

**Summary.** This consolidated regulation prescribes policies, procedures, and responsibilities for the administration of the Clinical Quality Management Program. It includes DOD and statutory policies addressing medical services quality management requirements. In addition, it implements DOD 6025.13–R, DODD 6000.14, and other DOD guidance.

**Applicability.** This regulation applies to the Active Army, the Army National Guard of the United States, including periods when operating in an Army National Guard capacity, and U.S. Army Reserve. This document applies in both the table of distribution and allowances and table of

organization and equipment environments. It applies to all personnel (Active Army, Army National Guard of the United States, the U.S. Army Reserve, civilian employees, contract personnel, and foreign national local hires) who work within medical department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the responsible official. This publication is applicable during mobilization.

**Proponent and exception authority.** The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or a direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

**Army management control process.**

This regulation contains management control provisions and identifies key management controls that must be evaluated. (See appendix J.)

**Supplementation.** Supplementation of this regulation and establishment of command and local forms are prohibited without prior approval from The Surgeon General (DASG–HSZ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

**Suggested improvements.** Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Office of The Surgeon General (DASG–HSZ), 5109 Leesburg Pike, Falls Church, VA 22041–3258.

**Distribution.** This publication is available in electronic media only and is intended for command levels B, C, D, and E for the Active Army; C, D, and E for the Army National Guard of the United States; and B, C, D, and E for the U. S. Army Reserve.

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## Glossary



## Chapter 1 Introduction

### 1–1. Purpose

This regulation establishes policies, procedures, and responsibilities for the administration of the Army Medical Department (AMEDD) Clinical Quality Management Program (CQMP).

### 1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

### 1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

### 1–4. Responsibilities

*a. The Surgeon General.* The Surgeon General (TSG), as the senior medical officer in the Department of Army (DA), is/will—

- (1) Responsible for the quality of health care delivered to all categories of beneficiaries.
- (2) Establish CQMP policy to implement Department of Defense (DOD) 6025.13–R, other applicable DODD/Department of Defense Instructions (DODIs), and current accrediting/regulatory guidance.
- (3) Responsible for the quality of care provided in all military treatment facilities (MTFs) within the AMEDD. Serves as the governing body (GB) for health care facilities worldwide.
- (4) The sole authority for reporting adverse privileging/practice actions and malpractice claims against providers to State and other regulatory agencies and to the National Practitioner Data Bank (NPDB).
- (5) Delegate GB authority to MTF commanders, thus, making them responsible and accountable for the quality of health care provided in their treatment facilities.

*b. Commander, United States Army Recruiting Command.* The Commander, United States Army Recruiting Command (USAREC) is/will—

- (1) Ensure adherence to requirements for selection, commissioning, and accession of health care professionals.
- (2) Responsible for primary source verification (PSV) of licensure, or other authorizing documents for the AMEDD new accession, as well as collecting and forwarding these documents to the appropriate unit of assignment.

*c. U.S. Army Medical Command (USAMEDCOM) Staff Judge Advocate.* The U.S. Army Medical Command (USAMEDCOM) Staff Judge Advocate (SJA) will provide legal interpretation of and guidance related to the contents and application of this regulation.

*d. USAMEDCOM Inspector General.* The USAMEDCOM Inspector General (IG) will conduct independent assessments of the issues related to the quality of health care in the AMEDD.

*e. USAMEDCOM Quality Management Division staff.* The USAMEDCOM Quality Management Division (QMD) staff will—

- (1) Exercise broad oversight responsibility for implementation of the AMEDD CQMP as delegated by TSG.
- (2) Represent TSG as a member of various committees and working groups sponsored by the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), Department of Defense (DOD), and other health care quality agencies.
- (3) Provide corporate-level clinical quality management (CQM) guidance within the AMEDD to include policy on credentialing, performance-based privileging, outcomes management (OM), medical staff appointment, and accreditation processes.
- (4) Provide corporate guidance, administrative and/or clinical advice, consultation, and education to define and/or clarify standards of care, practice, and policy.
- (5) Administer the corporate AMEDD 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, sentinel events (SEs), and malpractice claims.
- (6) Provide policy guidance, consultation, monitoring, and review of SEs that occur within the AMEDD.
- (7) Monitor trends in processes and outcomes of care and report the results to both internal and external sources, as appropriate.
- (8) Collect aggregate AMEDD CQM data, as required by TSG, OASD/HA, or other agencies.
- (9) Serve as the corporate repository for select CQMP data.
- (10) Implement the administrative procedures related to reporting adverse privileging/practice actions to appropriate national, professional, and State licensure, certification, and registration agencies according to DOD guidance.
- (11) Implement the administrative procedures related to reporting providers to the NPDB according to established DOD guidance.

(12) Maintain the AMEDD corporate contract with The Joint Commission (TJC), or other accrediting agency as approved by the OASD(HA), and provide guidance on the accreditation processes.

(13) Responsible for PSV of selected documents as well as collecting and forwarding to their gaining MTF (see chap 8) initial credentials documents for deferred medical officers entering active duty (AD).

*f. Commanders of major subordinate commands.* Commanders of major subordinate commands (except Veterinary Command), 18th Medical Command, and Command Surgeons of the Training and Doctrine Command, Forces Command, U.S. Army Reserve Command (USARC), and National Guard Bureau are/will—

(1) Responsible for administration of this regulation; the effectiveness of the CQM, Performance Improvement (PI), and RM Programs in their subordinate units; and for tables of distribution and allowances (TDA), table of organization and equipment (TOE), and modified TOE units under their command.

(2) Control the extent of patient care services in those TDA and TOE treatment facilities in their areas of responsibility.

(3) Employ qualified IG assets or subject matter experts as necessary to conduct local quality-of-care investigations.

(4) Ensure integration of the U.S. Army Reserve and Army National Guard of the United States (USAR/ARNG) provider/professional issues/actions into all aspects of the organization's CQMP.

(5) Regional Medical Command (RMC) commanders will provide input to and recommend modifications or corrections to the support plan as submitted by the TOE commander for field patient care exercises within the RMC command area (see para *i*(3) below), as required. The RMC commander may delegate approval authority to the director of health services (DHS).

*g. MTF commanders.* MTF commanders will—

(1) Meet the appropriate requirements related to health care quality management and quality assurance as delineated in current published regulations, statutes, accreditation standards, and DODDs/DODIs.

(2) Approve the award of medical and dental staff 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.

(3) Ensure that a comprehensive, integrated CQMP is established in compliance with this regulation.

(4) Appoint one or more personnel qualified by education, training, and experience to manage the CQMP components as addressed in this regulation.

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

(6) Employ or request from the RMC/regional dental command (RDC) qualified subject matter experts as necessary to conduct local quality-of-care investigations.

(7) Designate a chairperson for the credentials committee/function.

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

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

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

(11) Ensure the organization is in continuous compliance with current TJC standards and other regulatory/accreditation requirements, as appropriate. For TJC purposes, the medical commander is the delegated authority to represent the GB at the local level.

(12) Ensure implementation of an integrated Patient Safety Program (PSP) throughout the organization.

(13) Provide opportunities for integration of USAR/ARNG TDA caretaker hospital health care personnel into all aspects of the facility-specific CQM processes/functions.

(14) Award appropriate practice privileges to USAR/ARNG 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 concentration (AOC) and/or specialty skill must be ensured before granting or renewing privileges for USAR/ARNG providers who do not currently hold comparable privileges within their Reserve unit.

(15) As DHS, coordinate with the TOE commander for the provision of health care and services during training exercises.

(16) Ensure that an optimal professional relationship exists among all healthcare providers in the facility.

*h. USAR and ARNG State Surgeons.* For the USAR, Army Reserve Clinical Credentialing Affairs (ARCCA) performs the CQMP procedures noted below for providers in TPUs; HRC-St. Louis is responsible for these activities for IRR Soldiers; and, for IMA providers assigned to AA units, the AA medical/dental unit performs these functions. For the ARNG, State Surgeons are responsible for the administration of the policies contained in this regulation. The above named authorities are required to establish PI programs within their respective commands and will—

(1) Designate a CQMP manager.

(2) Establish a credentials committee/function and ensure systematic credentials verification and competency assessment for all health care professionals. This includes authentication of all licensure, certification, registration, and/or other authorizing documents required for practice.

(3) Establish and maintain provider credentials files (PCFs).

(4) Provide complete and current ICTBs for review by the serviced MTF.

(5) Award privileges (USAR medical unit commanders/ARNG State Surgeons) to assigned healthcare providers involved in delivering health care to eligible beneficiaries during unit-controlled inactive duty training (IDT) and annual training (AT) activities. Examples of these activities include physical examinations, immunizations, dental examinations, Soldier readiness processing, field exercises, and medical support missions. Clinical privileging for medical treatment provided during IDT is limited to acute and emergent care only. NOTE: USAR providers who perform IDT or AT at an AA MTF will be privileged by that MTF.

*i. Commanders of TOE and modified TOE units.* Commanders of TOE and modified TOE units will—

(1) During training exercises, establish an open dialogue for coordination of health care and services with the DHS for the area of operations.

(2) Propose a scope of service/practice for the unit to the DHS, specifying, as a minimum, the following elements:

(a) Types and ages of patients served.

(b) The appropriateness, clinical necessity, and timeliness of support services to be provided directly by the hospital or through referral contracts.

(c) The availability of necessary staff to provide care.

(d) The extent to which the level of care or service provided meets patients' needs.

(e) Practice based on recognized standards of medical care or clinical practice guidelines, where these are in use.

(f) The extent to which the facility will be operational and proposed staffing while operational.

(3) In coordination with the DHS, establish a plan that includes both the TOE unit's scope of services and the professional support and backup to be provided by the co-located TDA unit.

(4) Forward the plan in (3) above for approval to the RMC commander.

*j. Other MTF personnel.*

(1) *Deputy commander for clinical services (DCCS).* The DCCS is/will—

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

(b) 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) Responsible for and has 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) Chairperson of the executive committee of the medical staff (ECMS). (In the absence of the DCCS, this responsibility may be delegated by the MTF commander to another appropriately qualified individual.)

(f) Chairperson of the credentials committee/function or, with approval of the commander, this responsibility may be delegated.

(g) With the approval of the commander, delegate selected DCCS responsibilities to a physician with appropriate qualifications.

(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 regulation. (See chap 9.)

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

(j) Responsible for ensuring organizational PI activities are in place and actively participates 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 to DODI 6025.17 and USAMEDCOM 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.

(2) *Deputy commander for nursing (DCN) (or comparable title).* The DCN is/will—

(a) A licensed professional registered nurse.

(b) 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 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) A voting member of the ECMS (or comparably named committee).
- (f) Ensure PI activities are in place in all arenas in which nursing care, treatment, or services are rendered and actively participate in these processes.
- (g) A voting member of the MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel.
- (h) Reduce or appropriately limit the scope of practice of any nursing staff member whose competence, quality of care, behavior/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 regulation. (See chap 9.)
- (i) Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/healthcare errors according to DOD 6025.13-R and USAMEDCOM guidance.
- (j) An active participant in the organization's RM program.
- (k) Ensure the presence of an effective nursing peer review program (see glossary).
- (l) Executive staff advisor to the commander for other non-nursing hospital personnel and services under his/her supervision and authority, with the associated quality management responsibilities as noted above.
- (3) *Chief, department, service, or clinic and TOE command surgeons.* (References to departments and services include alternate organizational structures such as product line teams or multidisciplinary care teams in facilities with these alternative structures.) For clinical department/services/clinics with chiefs who are not physicians, also see paragraph 2-3. In his/her area of responsibility, or technical oversight, the chief/command surgeon is/will—
  - (a) 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) 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 recommendation to the relevant hospital authority for needed patient care services not provided by the department/service/unit or the MTF.
  - (h) Integrate the services of the department/service/unit with the primary functions of the MTF.
  - (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.
  - (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.
- (4) *Privileged staff.* The privileged provider will—
  - (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) When appointed a member of the credentials committee/function, make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers.
  - (c) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the privileges requested and/or according to the AOCs and additional skill identifiers (ASIs) awarded, accomplish required training, and ensure the currency of all documents and other information contained in his/her provider files.
  - (d) Participate in PI, quality control, and peer review processes.
- (5) *All other organizational assigned personnel.* Personnel, other than privileged providers, will—

(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/her competency assessment file (CAF).

(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/her job description and/or scope of practice.

(6) *CQM coordinator.* The CQM coordinator, or similarly titled individual (for example, PI coordinator), is tasked with overall responsibility for the organization's 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. He/she will—

(a) Ensure that organization-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 organization 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 followup activities related to organizational PI.

(e) Serve as subject-matter expert in conjunction with patient administration and the servicing Staff Judge Advocate/legal advisor 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 organizational efforts to provide prevention, wellness, and specific medical condition-based management programs as well as other health management programs, as required, based on timely MTF data and identified beneficiary need.

(h) Ensure that facility-specific CQM and PI Program changes are identified and implemented as data analyses dictate.

(i) Keep organizational leadership informed of public policies, DOD and DA 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 MTF staff at all levels.

(k) Oversee the preparation of intra- and inter-organizational PI reports that demonstrate evidence of collaborative, multi-service/departmental input.

(7) *Credentials manager.* The individual in this role will—

(a) Provide technical advice and direction to the MTF commander on issues related to health care provider credentialing and/or privileging processes.

(b) Serve as a subject matter expert to the MTF staff for appropriate credentialing and privileging procedures, guidelines, and mandates according to Army regulations (ARs), DODDs and/or DODIs, TJC standards, and other regulatory agency requirements. Maintain a resource library of such reference materials.

(c) Provide technical oversight and management of the process for verification of all licensure, certification, registration, and/or other authorizing documents required for practice.

*Note.* At the discretion of the MTF commander, responsibility for nonprivileged 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 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 PSV 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.

*Note.* Requirements also apply for biennial update of the PCF for USAR/ARNG practitioners who are not currently privileged.

(j) When licensure, certification, or registration is required as a condition of employment, ensure that the credentials of all general schedule (GS) civilian and contract health care providers have been primary source verified prior to initial employment.

- (k) Establish and maintain the organization'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 regulation.
- (o) Prepare and forward PCFs and/or ICTBs for privileged providers to the gaining MTF within the specified time requirements. (See chap 8.)
- (p) In collaboration with the ARCCA and ARNG unit credentials manager, maintain the PCFs and CCQAS input for privileged providers in those TDA caretaker hospitals for which the MTF is responsible.
- (q) Ensure that ICTBs and mandatory attachments (see paras 8–10c (AA) and 8–11b (USAR/ARNG)) are integrated into the credentials committee/function review process for timely privileging of providers.
- (r) Facilitate the review of all AA/USAR/ARNG and other Federal Service PCFs or ICTBs in compliance with this regulation.
- (s) Forward all requests for adverse credentialing and privileging information on individuals previously assigned or employed as privileged Federal Service providers to the USAMEDCOM QMD for action.
- (t) Ensure a process for communicating credentialing and privileging information to civilian agencies involved in external resource sharing agreements.
- (8) *Chief, RM and/or PS.*

*Note.* This may be a single position with combined responsibilities or two separate positions with individually defined responsibilities. See chap 12 and 13 for additional information.

The person performing these duties will—

- (a) Integrate and coordinate all RM/PS administrative and management activities within the medical/dental facility.
- (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 MTF safety and occupational health manager (comparable title) (DODI 6055.1) 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 an SE.
- (h) Oversee the investigation of all SEs to ensure coordination of all data collection activities, completion of a thorough and credible root cause analysis (RCA), and reporting through appropriate channels. (See para 12–5 for more detailed information regarding SEs.)
- (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 MTF 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 followup activities) to the MTF 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.
- k. *AMEDD Center and School course directors.* AMEDD Center and School course directors for all academic programs under the auspices of the AMEDD Center and School will ensure that their program of instruction contains content relevant to current AMEDD CQM policy and processes, health care facility accreditation standards, and professional practice standards. Curriculum instruction will highlight each AMEDD member's responsibility to participate in organizational CQM activities.

## Chapter 2

### Medical Staff and Military Treatment Facility Committee Structure and Functions

#### 2–1. General

The Joint Commission 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 ECMS, or equivalent title—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 (TSG) as represented by the MTF commander.

## **2-2. 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. Many of TJC requirements for the medical staff bylaws are contained in this regulation and need not be repeated in MTF medical staff bylaws.

c. The MTF medical staff bylaws must meet current requirements of TJC. Those developed by the MTF should expand the partial listing provided in this chapter. TJC requires that bylaws include–

- (1) The qualifications, roles, and responsibilities of department chiefs. (See para 1-4 j(3).)
- (2) The structure, function, size, and composition of the ECMS (or equivalent committee) and of the methods for selecting and removing its members and the organized medical staff officers.
- (3) The empowerment of the ECMS to act on behalf of the medical staff.
- (4) The processes for credentialing, privileging, and medical staff appointment. (See chaps 8 and 9.)
- (5) The indications for automatic suspension or summary suspension of medical staff membership or clinical privileges and when these procedures are implemented. (See chap 10.)
- (6) The mechanism for a fair hearing and the appeal process for an adverse privileging action. (See chap 10.)

## **2-3. Military treatment facility 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 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 ECMS and other required meetings.

b. Rating schemes will reflect the administrative command and control regardless of the Corps (discipline) of the department/service chief.

## **2-4. Executive committee of the medical staff**

The ECMS is authorized to carry out medical staff responsibilities and performs its work within the context of the functions of governance, leadership, and PI. The ECMS 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 executive committee. Note: There is currently no requirement for an executive committee of the dental staff (ECDS). Where this regulation requires information/action to route through the ECMS to the commander, it may go directly to the dental commander.

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

b. Voting membership will include the DCCS (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. Other members may include senior privileged providers from garrison-level units and chiefs of administrative divisions/services related to patient care (for example, patient administration division (PAD) and CQM).

c. The ECMS functions may be conducted by the entire medical staff (committee of the whole) concurrently with those of another MTF committee (for example, the credentials committee) or by a separate committee.

d. The ECMS acts upon reports of MTF committees/functions, clinical departments, and subcommittees or workgroups designated by the ECMS. 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 ECMS and the credentials committee are not the same body, the privileging recommendations of the credentials committee for each provider will be reviewed by the ECMS and forwarded to the commander.)
- (5) The mechanism for terminating medical/dental staff membership.
- (6) The mechanism for adverse actions fair hearing and appeal procedures.
- (7) The participation of the medical staff in organizational PI activities.

## **2-5. Medical staff participation in performance improvement activities**

*a. Required functions.* The Joint Commission requires the medical staff to provide leadership in measuring, assessing, and improving processes that primarily depend on the activities of privileged providers, as well as participating in organization-wide PI activities. All committee minutes/reports regarding these activities will be routed through the ECMS 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) Patient safety data.

*b. Suggested functions.* 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.

## **2-6. Other military treatment facility organizational functions and committees**

The Joint Commission requires an ECMS (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 ECMS. The use of minutes or summary reports to document the function is a facility-level decision. Certain other committees (such as risk management) are required by agencies other than TJC, as noted below. The following committees/functions are required by this regulation:

*a. Executive committee.* Membership will include the commander (chairperson), DCCS, deputy commander for administration (DCA), deputy commander for nursing (DCN), or equivalents, the Command Sergeant Major, and those CQM staff/other staff designated by the commander. This committee is the conduit for channeling MTF CQM information to the commander who executes oversight authority.

*b. Patient safety 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 multidisciplinary committee will be according to guidance from USAMEDCOM (MCHO-CL-Q). The PS committee reports through the ECMS to the executive committee.

*c. Risk management committee/function.* DOD 6025.13-R requires an RM committee. If these risk management duties are not performed by a dedicated committee, the medical staff bylaws will specify how this function will be accomplished. See chapter 13 for RM and the committee/function.

*d. Credentials committee/function.* See chapters 8-10.

*e. Impaired healthcare personnel committee.* See chapter 11.

*f. Healthcare consortium.* This forum offers an opportunity for beneficiaries to provide input into healthcare delivery policy and to promote communication between the MTF and its beneficiaries. Participants will include the commander or designee (as chairperson); MTF leadership; and representation from officer, enlisted, Family member, and retiree beneficiaries. Local policy will define additional parameters of this committee (frequency of meetings, etc.). In settings like Europe where DoD beneficiaries are dispersed over a wide geographical area, commanders may delegate authority for holding local meetings. To satisfy this requirement, MTF commanders may attend installation town hall meetings.

*g. Other formal committees.* Various committees, boards, and councils may be established with the approval of the executive committee to perform the monitoring and evaluation required in paragraph 2-5 of this regulation and other relevant guidance (DOD 6025.13-R) as well as the PI functions as described in the MTF CQM plan.

*h. Committee/function records and reports.* A written record of all CQM committees/functions will be maintained by the MTF. The quality management (QM) office, or equivalent, is the recommended site. The MTF CQM plan will define the process for communicating the results of CQM activities and associated recommendations/actions within the organization and to other outside organizations.

## Chapter 3

# The Clinical Quality Management Program and Organizational Performance Improvement

### 3–1. The Clinical Quality Management Program

a. The purpose of the AMEDD medical and dental 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. Military treatment facility/dental activity (DENTAC) commanders will establish and resource a CQMP that coincides with any RMC/regional dental command (RDC) and/or 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. Clinical quality management will be integrated into the organization's vision and mission statements and guiding principles. Such integration affords MTF/DENTAC leadership an opportunity to develop an effective strategic plan of action for the delivery and continuous improvement of quality care.

d. Each MTF/DENTAC 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. When devising such a plan, various CQM models are available including the Find-Plan-Do-Study-Act/Plan-Do-Check-Act (that is, FOCUS/PDCA) framework (see glossary and app A).

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 QI efforts, thereby optimizing the impact of improvement activities on organizational performance as a whole.

### 3–2. 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. 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.

### 3–3. Performance improvement 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 MTF/DENTAC, in coordination with the RMC/RDC and USAMEDCOM, will determine which data are appropriate to consider for the purpose of organizational improvement.

b. Various activities, programs, and processes such as those in (1) through (7), below, 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) CPG-based condition management programs;
- (3) Putting Prevention into Practice, Healthy People 2010, and other illness prevention and health promotion activities;
- (4) 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 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 risk-adjusted outcomes 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 AMEDD, or the DOD.

d. The commander is responsible for analyzing the results of MTF studies conducted by external accrediting agencies as well as DOD or AMEDD-level organizations. In addition, the results from TJC and the National Committee on Quality Assurance metrics monitoring, CMS and Health Plan Employer and Data Information Set standards/metrics provide useful data. The National Quality Management 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.

### **3-4. Performance improvement activities in the facility's written plan**

a. The MTF-specific approach to process improvement will be articulated in a plan (see para 2-2b) 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/UR 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.

### **3-5. Facility accreditation**

Accreditation of AMEDD MTFs and designated health care programs/functions by recognized national organizations, as required by law and DOD guidance, is an integral part of the AMEDD CQMP, specifically in support of organizational PI.

a. *Facilities requiring accreditation.* It is DOD policy that all fixed hospitals, troop medical clinics, hospital-sponsored substance abuse rehabilitation programs, and free standing ambulatory care clinics (medical only) will maintain accreditation by the TJC or other accreditation source 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. (See para 3-2.)

c. *Accreditation guidance.* Information related to accreditation standards is contained in various references listed in appendix A and will not be duplicated in this regulation. On occasion, TSG 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 U.S. Army policy, current Army policy will prevail. The USAMEDCOM QMD will pursue resolution of any recognized inconsistency in guidance with the accrediting agency.

d. *Accreditation funding.* The TJC Accreditation Program for the AMEDD is centrally funded and administered by the USAMEDCOM QMD. Facilities will complete applications for survey in accordance with current requirements of TJC. The USAMEDCOM QMD will review the application in consultation with the facility and RMC personnel and provide authorization for the MTF to electronically forward the application to the TJC. The USAMEDCOM QMD is responsible for reimbursement of the triennial TJC surveys. A copy of each MTF's application for survey will be maintained on file in conjunction with survey-related expenditures. To ensure correct Government payment to TJC, requests for survey date changes or changes in the scope of a scheduled TJC survey will be made only by the USAMEDCOM QMD.

e. *AMEDD equivalencies for TJC survey.* The TJC recognizes the following equivalencies when applying TJC standards to AMEDD MTFs.

- (1) TSG serves as the GB for all MTFs worldwide.
- (2) Federal law, DODDs, ARs, TSG policies, and USAMEDCOM directives/policies serve as the hospital bylaws. These need not be rewritten to be included in facility-level documents. In addition, 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 MTF formal bylaws.
- (3) The MTF's mission statement describes its purpose and community responsibilities.
- (4) The MTF commander serves as the chief executive officer and represents the GB.
- (5) The deputy commander for administration (DCA) or equivalent serves as the chief operating officer.
- (6) The DCCS or equivalent serves as the chief or president of the medical staff.
- (7) The deputy commander for nursing (DCN) or equivalent serves as the nurse executive.

(8) The MTF executive committee 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. TJC survey report submission.* The MTF commander (medical units only) will submit to the USAMEDCOM QMD a copy of the preliminary report provided by TJC surveyors at the completion of the survey regardless of the survey results or disagreement on the part of MTF staff with the survey results. This requirement applies to all surveys by TJC.

*g. MTF after-action reports.* Within 30 days of completion of any TJC survey (triennial, unannounced, surveys for cause, or focused), the MTF commander will submit, through the next higher headquarters, to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, an after-action report detailing the survey preparation process (planned surveys) and any lessons learned as a result of the survey process. The USAMEDCOM QMD will disseminate lessons learned, as appropriate.

### **3-6. 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 DODD 6000.14, current TJC standards, and the Health Insurance Portability and Accountability Act of 1996 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 MTF CQMP processes as appropriate.

### **3-7. Confidentiality of quality assurance documents and records**

The National Defense Authorization Act for fiscal year 1987 (Public Law (PL) No. 99-661), section 1102, Title 10, (10 USC 1102) mandates that records created by or for the DOD in a medical or dental QA program are confidential and privileged. PL 99-661 and subsequent guidance predicated on this law (10 USC 1102) 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 10 USC 1102, this information is exempt from release in accordance with Exemption 3 of the FOIA. Additional detailed information regarding the confidentiality of QA documents and records is contained in appendix B.

## **Chapter 4**

### **Licensure, Certification, and/or Registration of Health Care Professionals**

#### **4-1. Policy**

To promote the highest quality health care for its beneficiaries, it is the policy of the U.S. Army that its 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, Office of Personnel Management (OPM), Army, or DOD (HA) policy) to practice within the individual's health care specialty. The requirements of this chapter also apply to those who are not classified as employees of the U.S. Army but are providing patient care services (for example, volunteers, members of other Services) under the auspices of the military or based on U.S./foreign country memorandum of understanding (MOU)/memorandum of agreement (MOA)) guidelines (for example, non-U.S. health care personnel in a deployed theater of operations).

#### **4-2. Scope of licensure requirement**

*a.* Military, civil service, 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 (DOD 6025.13-R).

*b.* Licensure, certification, and/or registration requirements apply to professionals performing both clinical and/or administrative duties. Individuals not assigned to or privileged by an MTF or Armed Forces Institute of Pathology (AFIP) (for example, Medical Research and Materiel Command (MRMC)) will provide evidence of a current, active, valid, and unrestricted license, certification, and/or registration to the appropriate next higher command that has professional or technical control.

#### **4-3. 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 United States (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)* Soldiers (AA/USAR/ARNG) possessing the 68W military occupational specialty (MOS) are required to obtain and maintain certification by the NREMT. Certification will be, at a minimum, at the basic level (emergency medical technician-basic). AA 68Ws will be NREMT certified and meet all other requirements for the MOS by 30 September 2007 (USAR/ARNG Soldiers by 30 September 2009). Periodic recertification as established by the NREMT is mandatory. Soldiers who fail to recertify according to NREMT guidance will immediately be suspended from all duties requiring NREMT-basic certification.

*(b)* Soldiers who fail to recertify according to NREMT guidance will be granted an additional 90 calendar days (for AA) and 180 calendar days (for USAR/ARNG) to obtain NREMT-basic certification; Soldiers will be deemed MOS qualified during this period. A Soldier's failure to obtain NREMT certification immediately following the respective 90- or 180-day period will result in his/her classification as non-MOS qualified and the initiation of an appropriate personnel action (that is, mandatory reclassification, separation) according to governing regulations.

(3) In the case of health care provided in a foreign country by a provider/professional who is not a U.S. citizen or national, a grant of permission from an official agency of that foreign country will suffice. This authorizes the individual to provide health care within the specified discipline to DOD beneficiaries in nondeployed settings and in deployed theaters of operation, in accordance with established U.S./foreign country MOU/MOA guidelines.

*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 U.S. Army (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/nonprivileged) must immediately notify their supervisor, and the appropriate MTF office responsible for authentication of practice credentials, that their license no longer meets the requirements noted in paragraph *b*, above. Notification will likewise 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 regulation is the basis for immediate suspension of privileges/practice and/or other adverse personnel action as referenced in paragraph 4-10. Such personnel will be reported to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

#### **4-4. Professional disciplines requiring license, certification, and/or registration**

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

*Note.* Advanced practice registered nurses (APRNs) are given until 1 July 2009 to meet the requirement for State licensure. If a license is not provided by the individual's State or U.S. jurisdiction, the official authorizing document issued in lieu of a license will be maintained.

(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): 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 (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 MOS/ASI are contained in DA Pam 611–21. 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.

*Note.* 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 AMEDD 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.

*Note.* 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 chapter 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) certification as a condition of employment (GS/contract employees) and before being granted clinical privileges (military, GS, personal services contract, 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 GS 180-series, the license may be as a licensed professional counselor, with State or national certification in substance abuse rehabilitation. The deadline for substance abuse counselors to obtain this license was 31 May 2003.

(4) See chapter 7 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 (AR 40–3), it is highly encouraged in any specialty for which it may be available. Certification and/or registration requirements for AMEDD health care personnel (military/civilian) will, at all times, comply with DOD guidance.

*Note.* State licensure as a qualified radiology technician and continuing education in mammography may substitute for the certification specified (21 CFR Part 900 - Mammography).

#### **4–5. 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.

*a. Use of appropriated funds for payment of fees.* Appropriated funds may be used to pay professional licensure expenses for military health care personnel who are required to be licensed in their State of practice in order to participate in a resource sharing agreement with a civilian institution. This entails performance of officially assigned professional duties at an authorized location outside the MTF and any military installation. Federal statute, 10 USC 1096, allows the Secretary of Defense to reimburse the military member for up to \$500.00 of the amount of the license fee. This applies only to situations in which the host State or civilian facility refuses to recognize the individual's professional license/authorizing document despite the licensure portability statute as described in 10 USC 1094 and DODI 6025.16.

*b. Civilian employee time off.* 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 TDY is authorized for military health care personnel taking licensure examinations.

#### 4-6. 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 (PGY-1) for physicians; and within 2 years after award of the doctoral degree for clinical psychologists. The GS civilian 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.

(1) *AA/USAR/ARNG physicians.* To be eligible for licensure, physicians must successfully complete Step III of the United States Medical Licensing Examination (USMLE) or Comprehensive Osteopathic Medical Licensing Examination (COMPLEX), as appropriate, and complete 1 year of postgraduate training. Physicians who choose to be licensed in a State that requires more than 1 year of postgraduate training must first obtain a license from a State that requires only 1 year of postgraduate training.

(2) *Other military physicians.* Military in deferred status or USAR/ARNG physicians in civilian graduate medical education (GME) training programs—including those receiving financial benefits (Special Training Assistance Program or Financial Assistance Program (FAP))—must meet the applicable licensure standards of their civilian training programs. These physicians must possess a current, active, valid, and unrestricted license in a State or other U.S. jurisdiction upon successful completion of the training program or upon entering the FAP at the PGY3 level.

b. Health care providers who are eligible for privileges but have not acquired the appropriate license, certification, and/or registration will be awarded supervised privileges and may practice only under a written plan of supervision. The supervision will be more comprehensive than that afforded a licensed privileged provider of that same discipline. The supervision provided must be from a licensed, fully qualified, independently practicing, and, if appropriate, privileged provider of the same or similar specialty.

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) *AN officer.* The AN officer who graduated after 31 December 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 1 October 2012, all AN 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 USAREC guidance). Those individuals who passed an RN licensing examination other than the NCLEX-RN prior to 12 December 1986 are granted an exception to this requirement. Before working without supervision within his/her designated scope of practice, the AN officer must pass the NCLEX-RN.

(2) *Enlisted practical nurse.* The 68WM6 or 68WM3 who graduated after 31 December 1997 must be a graduate of a nationally accredited or State approved practical nursing program. Effective 1 October 2012, the 68WM6/M3 must have taken and passed the NCSBN's National Council Licensure Examination-Practical Nurses (NCLEX-PN) according to USAREC guidance). Those individuals who have passed an LPN/LVN licensing examination other than the NCLEX-PN prior to 12 December 1986 are granted an exception to this requirement. Before working without supervision within his/her designated scope of practice, the 68WM6/M3 must pass the NCLEX-PN.

(3) *Civilian RN.* The civilian RN must be a graduate of an approved professional nursing program, as noted above in paragraph (1). 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. The foreign national local hire (FNLH) RN practicing outside the continental U.S. (OCONUS) must maintain the appropriate written authorization from the country in which he/she is employed (see para 4-9d).

(4) *Civilian LPN.* The civilian LPN must be a graduate of an approved practical nursing program, as noted in paragraph (2), above. To qualify for the grade GS-4 and above, the civilian LPN/LVN is required to possess a minimum of 6 months of practical nursing experience or have successfully completed a program in practical nursing of at least 9 months duration. Current OPM Qualification Standards (civilian LPN employment standards) do not include the requirement for the NCLEX-PN. Thus, the civilian LPN/LVN is exempt from this requirement.

(5) *Individuals with both RN and LPN/LVN licenses.* In instances where an individual maintains both an RN and an LPN/LVN license, he/she will be held accountable to the scope of practice of the position for which he/she was hired. LPNs/LVNs employed by the U.S. Army 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. USAR/ARNG enlisted practical nurses (68WM6/M3) must be in compliance with the above stated licensure requirement. Individuals accessed into the USAR/ARNG for whom an RN license was considered an acceptable substitute for the LPN/LVN license, or others who, through advanced education, now hold the RN license, must obtain an LPN/LVN license from their State of licensure (or other State). Those individuals who have been unsuccessful in documented attempts to obtain dual State licensure will forward a request for assistance through Headquarters, USARC (AFRC-MD), 1401 Deshler Street SW, Fort McPherson, GA 30330-2000, to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

e. Clinical psychologists who have not been awarded their doctoral degree are required to make continual progress

toward completing the doctoral dissertation and meeting State licensure requirements throughout the period of their initial contract with the U.S. Army. Due to differences in dissertation requirements, no specific guidelines can be established for all clinical psychologists. The majority of States require 1 year of postdoctoral supervision before a clinical psychologist is eligible for testing and provisional licensure. Direct accession clinical psychologists must possess a current, active, valid, and unrestricted license upon commissioning (military) or when hired (civilian).

*f.* 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 may request a waiver of the 1-year timeline to meet licensure requirements. Requests should be submitted through the chain of command to TSG.

*g.* 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 (10 USC 1094, as amended by section 734 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, Public Law 105-261).

(2) For members of the Medical Corps (MC), Dental Corps (DC), Army Nurse Corps (AN), Medical Service Corps (MS), Army Medical Specialist Corps (SP), and Veterinary Corps (VC), 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/her license.

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

#### **4-7. Exceptions to the requirement for unrestricted license**

*a.* Legislation does permit waiver of the requirement for providers to possess an unrestricted license in “unusual circumstances.” Note: The payment of a State’s license renewal fee is not considered an “unusual circumstance” and is not subject to waiver.

(1) TSG has delegated licensure waiver authority through the USAMEDCOM to the MTF commander. The commander may not exercise independent judgment or decision making in this activity. In order to qualify for approval, the OASD(HA) must first have identified that the specific requirement is eligible for waiver.

(2) Waiver of licensure requirements is not automatic. The provider must submit an application for waiver (obtained from the credentials manager). The waiver is valid only for the licensure period for which it was requested. A new application for waiver must be submitted for each licensure renewal period. Submission of subsequent application for license waiver is the responsibility of the provider.

(3) If a State presents an unusual and substantial licensure requirement that has yet to be identified, this requirement and any supporting documentation will be submitted with the waiver application. The waiver request packet is forwarded through the RMC to the Commander, USAMEDCOM, who will submit the request to the OASD(HA) for consideration. The approval/disapproval from the OASD(HA) will be forwarded by USAMEDCOM through the RMC to the MTF of origination.

(4) Approved licensure waivers will be placed in Section VI of the PCF next to the copy of the provider’s license.

*b.* For military, GS, and personal services contract PAs, the requirement to possess and maintain a current, active, valid, and unrestricted license is waived. Current NCCPA certification is the recognized authorizing document in lieu of license.

*c.* The complexity of licensure, certification, and/or registration requirements and the changing environment of State licensure policies renders this a dynamic process. Up-to-date guidance will be provided as necessary via conventional and electronic mail and will be posted to the USAMEDCOM QMD homepage, <http://www.qmo.amedd.army.mil/home.htm>.

#### **4-8. Contract privileged providers**

All contract employees must maintain a current, active, valid, and unrestricted license or authorizing document in accordance with paragraphs 4-3, 4-4, 4-7, and *a* and *b*, below.

*a.* Personal services contractors, and non-personal services contracted providers with duty in non-U.S. locations, may practice under a current, active, valid, and unrestricted license from any State or U.S. jurisdiction. 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.

*b.* In OCONUS locations, the host country must grant a waiver to permit an American citizen (civilian) to be hired under a non-personal services contract. This waiver must stipulate that the individual will provide services only on the U.S. Federal enclave and will be licensed in any U.S. jurisdiction, not the host nation. The contracted employee may also obtain a license, or other authorizing document, from the host nation via endorsement or reciprocity. Personal service contract personnel must be determined to be acting within the scope of employment to be covered.

#### **4–9. International health care graduates**

Health care professionals trained in foreign countries are eligible to practice in the AMEDD in their respective disciplines if the appropriate requirements are met. (The term, “international” replaces the previously used term, “foreign.”)

*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. International medical graduates participating in U.S. Army-sponsored GME who have more restrictive requirements for GME or who encounter administrative obstacles related to meeting licensure requirements will not be flagged nor subject to other adverse privileging/personnel action. Their status will be equal to that mandated by the State’s requirement for individuals of that category. (See the glossary for additional details regarding Fifth Pathway.) International medical school graduates (including U.S. citizens) who desire FAP entry must additionally be enrolled full time in, or accepted to attend, an accredited program in the U.S. or Puerto Rico for the designated specialized training. They must have completed an accredited PGY–1 program for FAP entry at the PGY–2 level. The specialized training program must be accredited by the Accreditation Council for Graduate Medical Education (ACGME) for residents. The GME programs must meet the requirements of the GME Directory published by the American Medical Association or Yearbook and Directory of Osteopathic Physicians published by the American Osteopathic Association, as applicable.

*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.

*c. International dental graduates.* Dentists who are graduates from jurisdictions other than the U.S. and Canada are expected to meet the criteria of paragraph *d* below and will be managed by the DC on a case-by-case basis.

*d. International Health Care Graduates and DOD OCONUS.* To fulfill the requirements for licensure, FNLH health care professionals from jurisdictions other than the U.S. who are providing care to DOD beneficiaries OCONUS require written authorization (grant of permission of an official agency) from the country in which they are practicing or where they were trained. Newly employed FNLH health care personnel shall practice with supervision for 1 year. M&E of the FNLH’s practice provides evidence of current competence and serves as the basis for continuation of practice. The commander (or designee) will delegate responsibility for conducting and documenting the necessary locally established M&E activities. (See glossary for the definition of M&E.) For purposes of hiring the FNLH, and during the period of M&E data collection, initial authorization for the FNLH to provide care to DOD beneficiaries, and to subsequently continue practice, must be determined based on the following:

(1) Comprehension of and proficiency in oral and written use of the English language as demonstrated by external agency evaluation, if available, or a personal interview by the selecting official.

(2) Documented clinical competency assessed by objective performance measures.

(3) Possession of a current, active, valid, and unrestricted license; certification; registration; or other authorizing document to practice in the country of employment (host nation) or a license, certification, and/or registration accepted by the U.S. as a basis for employment and practice in that country.

#### **4–10. 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 chapter. 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/she must request a formal extension from the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. 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, USAMEDCOM, is authorized to grant the privileged (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 in paragraph *a* or *b*, below. If an individual fails to maintain the license or other authorizing document in good standing, or allows it to lapse for any reason, he/she will be prohibited from practicing. Health care personnel not subject to UCMJ who provide care in violation of this regulation are subject to a civil monetary penalty of not more than \$5000.00 (10 USC 1094).

*a.* The following applies to military personnel, both officer and enlisted, who fail to maintain the proper credentials to practice in their clinical AOC/MOS/ASI.

(1) Individuals who are not in compliance with this chapter may have all favorable actions suspended under AR 600–8–2. Unfavorable personnel action (a nontransferable flag) is initiated pending involuntary separation/elimination due to lack of Soldier qualification.

(2) The Soldier’s obligated status does not exempt him/her from adverse administrative actions, to include early separation from service for loss of professional qualifications, should this be in the best interest of the U.S. Army.

(3) Individuals separated prior to completion of obligated service may be subject to recoupment of educational subsidies.

(4) Soldiers (AA/USAR/ARNG) with MOS 68WM6/M3 who fail to maintain a current, active, valid, and unrestricted LPN/LVN license do not meet the established requirements for the M6/M3 ASI (Military Personnel Message Number 01–212). At the discretion of the unit commander, AA Soldiers may be authorized 90 calendar days (180 calendar days for the USAR/ARNG) to renew their State licensure. However, during this period of nonlicensure, the Soldier will not be permitted to function as an LPN/LVN. While the Soldier is considered nonqualified in the ASI M6/M3, he/she will remain qualified in the primary MOS 68W. A Soldier’s failure to renew State licensure immediately following the 90- or 180-day interval will result in the unit commander initiating action for removal of M6/M3 ASI according to governing regulations.

(5) Subject to the needs of the U.S. Army, the Soldier may be cross-trained into another military career field or may revert to a previously held AOC/MOS.

(6) Regular Army/USAR officers and enlisted Soldiers who are not in compliance with this regulation may be involuntarily separated from the Service under the provisions of AR 600–8–24, AR 635–200, AR 135–175, or AR 135–178. The local military personnel office (MILPO) will be consulted for assistance in processing the individual for separation/discharge from service.

(7) Service obligations resulting from receipt of special incentive pays, military education (advanced course, long-term civilian schooling), acceptance of promotion, or resulting from the 3-year initial AD obligation incurred upon accession without Service-sponsored education will be handled as noted above in paragraphs (2) and (4). The appropriate finance office will determine recoupment of any incentive pays or other remuneration.

b. If OPM, Army, or DOD requires a specific license, certification, and/or registration to qualify for certain occupations, maintenance of that license, certification, and/or registration is considered a condition of employment. Failure to meet this condition of employment may result in administrative action to reassign, suspend, or remove the employee from their civil service position. GS civilian personnel may be subject to adverse personnel action according to Title 5, USC, and Title 5, Part 752, Code of Federal Regulations (CFRs), as implemented by appropriate DOD policies, ARs, and applicable labor agreements. The servicing civilian personnel advisory center (CPAC) and SJA should be consulted for guidance throughout all phases of depriving, disciplinary, or adverse personnel actions against the civilian employee.

c. The status of individual professional licensure, certification, and/or registration for all health care personnel will be tracked at the facility level on a regular basis. This information will be kept up to date in the CCQAS or the AMEDD-identified database equivalent.

## **Chapter 5**

### **Competency Assessment, Delegation, and Supervision of Practice**

#### **5–1. 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/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 regulation, the word, “staff” refers to all MTF 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 (AA/USAR/ARNG) 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.

(a) To standardize criteria for competency skills verification throughout the Army, forms implemented at the DA level must be used.

(b) Two forms currently required for this purpose are DA Form 7653, Verification of Clinical Competencies for

Critical Care Skill Identifier (SI 8A) and DA Form 7654, Verification of Clinical Competencies for Emergency Nursing Skill Identifier (SI M5).

(2) Each MTF 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.

(a) An annual report to the MTF executive committee, as required by the TJC, will elaborate levels of competence, patterns and trends, and competency maintenance activities for all staff. The responsibility for data collection from all departments/services and the preparation of the consolidated MTF report to the executive committee will be according to local policy. This report should include such data as—

1. Total number of personnel (entire organization).
2. Percentage of new employees who received new employee orientation.
3. Percentage of total staff who have met AT requirements.
4. Percentage of total staff who are competent, based on organizational criteria, to perform the specific requirements of their positions.
5. Of those staff for whom licensure, certification, and/or registration is appropriate, the percentage of total for whom these credentials are current.
6. Specific education or training needs as identified for all levels of staff.

(b) While all staff must be considered in the preparation of this report, those who have clinical contact with patients should receive special focus related to identification of training needs and staff development opportunities. Local policy will direct who in the organization is responsible for data collection and preparation of this report.

*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 receive 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 CAF.

(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 nonprivileged, 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 are 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-service 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 MTF commander. 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 so forth) according to AR 40–3. Other health care personnel (medical/dental) requiring ACLS, ATLS, or other advanced life support training, are at the discretion of the MTF commander. 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, pediatric advanced life support (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.

(3) In support of a deployed force that will include Soldiers with a broad spectrum of health care needs, DA or DOD civilians, and Government contractors, PAs assigned to all TOE units are encouraged to obtain and maintain ACLS certification. Coordination of ACLS training for divisional assets is a joint responsibility between the Division Surgeon and the DHS.

*f. Performance evaluation.* Each staff member's performance is evaluated according to Army and OPM (GS civilians) regulatory guidance, both periodically (for example, quarterly counseling or as needed) and at regularly scheduled intervals (for example, midpoint or annual performance appraisal counseling, as required by the Army Performance Appraisal System). 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 (that is, the RMC, USAMEDCOM, TRICARE lead agent) and reflect the individual's ability to function effectively within an assigned team or work group.

*h. Competency documentation.*

(1) *Nonprivileged health care personnel.* A CAF will be maintained by the first line supervisor for all nonprivileged health care personnel working within the AMEDD. The CAF will be readily available to the employee for updates but protected from general view or public access. For non-privileged USAR/ARNG personnel, the credentials file maintained by ARCCA contains the documents typically included in the CAF. In the context of this chapter, the terms, "CAF" and "credentials file" are interchangeable.

(a) The CAF 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 CAF 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 CAF.

(b) The CAF is a chronological record that is utilized throughout the individual's employment, contract, assignment, or agreement with the AMEDD during deployment, any TDY in support of health care/service mission, and permanent change of station (PCS)/transfer. It will be hand carried by the nonprivileged professional (military/civilian) from one

place of duty to the next. For RC, the CAF should accompany members during all assigned periods of duty with AA MTFs. Upon separation from Federal employment, the contents of the CAF will be turned over to the individual in question or destroyed.

(c) Xerographic copying of the nursing license, certification, or registration is permissible. These copies will be protected and secured as specified for PCF/PAF contents (see para 8–3b(2)(c)). Neither the original nor a copy of the individual's license (other authorizing document) will be maintained in the CAF. Instead, an annotation to indicate that the document was verified with the primary source will be made in the CAF 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 CAF.

(d) The nonprivileged professional has a right to review, make comment on, and receive copies of all materials in his/her CAF. He/she is responsible for ensuring that all information in the CAF 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 CAF. 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/her personnel file (not CAF). 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 chapter 6.

(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 CAF for a minimum of 3 years and may be purged according to local policy. For USAR/ARNG members, the contents of the CAF that reflect past practice/competency assessment will be maintained for 5 years. The specific forms to be included in the CAF, in keeping with the general guidance in appendix C, will be at the discretion of the local command.

(h) Local policy will address security of the CAF and identify responsibilities for updating its contents. For USAR/ARNG members, the CAF will be available during all IDT, active duty for training (ADT), and AT periods. Additions and modifications to the USAR/ARNG CAF contents are a joint responsibility of both the Reserve unit and the AA facility staff.

(i) See appendix C for additional information regarding the recommended structure and contents of the employee CAF.

(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 provider activity file (PAF). This same information serves as the basis for initial medical staff appointment and clinical practice privileges. The biennial renewal process, as described in chapter 9, integrates findings from a variety of performance-based determinants and substantiates privileged provider competency.

(3) *Special forces medical sergeants.* The special forces medical sergeant, MOS 18D, is a combat arms Soldier with extensive medical education and training in life sustaining skills. This individual performs the military-unique function of providing primary care medical support to operational units in remote or isolated environments in the absence of a medical officer.

(a) The 18D's responsibility for health care of special forces unit members in operational situations worldwide 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 unlicensed health care giver. In order to maintain and improve the operational readiness of this Army medical resource, the 18D is authorized to perform specific clinical tasks, procedures, and interventions, as approved by the MTF commander, under the direct supervision of a privileged provider.

(b) The 18D assigned to an MTF 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 appendix D. It is expected that the 18D, 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, chronic conditions, according to the individual's academic preparation and prior clinical experience.

(c) The specific guidelines and parameters related to 18D medical proficiency training will be based on the MTF'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 18D's competence and to determine if the identified training objectives were achieved.

(d) Because the 18D is a nonmedical MOS, this brief discussion has been provided to acquaint the reader with the

nontypical medical proficiency training requirements these individuals place on a TDA MTF. For additional information on career management field 68-series clinical competencies (scope of practice), contact the Commander, USAMEDCOM, ATTN: MCHO-CL-C, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

## **5-2. 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/her own scope of practice, to be performed by unlicensed assistive personnel (UAPs), an RN/LPN, or other nonnursing 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.

*Note.* In structured training situations, a provider may delegate a privileged task, function, or process to a competent nonprivileged professional (for example, a medical student, or 18D. 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 nonprivileged individual, as determined by the assessed level of his/her competence, is required. (See para 5-3 for additional detail regarding types of supervision.)

*b.* Various health care personnel—to include 68-series career management field Soldiers, nursing assistants, and others—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 18D is authorized to perform an extensive variety of clinical tasks in order to sustain and improve wartime readiness. Appendix D provides an overview (not all inclusive) of the 18D's advanced scope of practice and outlines the types of clinical experiences that are critical to his medical skills proficiency. The specific guidelines and parameters related to 18D medical skills sustainment training will be based on the MTF'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 reoccur 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, the 18D, 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.

## **5-3. Supervision of practice**

To ensure the competence and skill of those providing health care and services to every category of AMEDD 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 PL and reinforced by various State authorizing agencies. In addition, the supervision of clinical practice is fundamental to both the MTF'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 nonprivileged 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 AR 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.

*Note.* "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/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) MTFs 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, who 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.

*Note.* In the context of this regulation, GPHE applies to graduate level clinical training for all health-related disciplines (all corps).

(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. *The plan of supervision.* The intent of providing appropriate oversight of practice, in the context of this regulation, 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 CAF (nonprivileged professional), as appropriate, will include—

(1) *The type of supervision to be provided.* (See para b above.) The type of supervision will be based upon the assessed needs of individually privileged providers/nonprivileged 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 utilizing DA Form 5441 (Evaluation of Clinical Privileges – Anesthesia) and DA Form 5374 (Performance Assessment). 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—

1. Diagnostic techniques and procedures and associated costs.
2. Therapeutic practice patterns and outcomes of care.
3. Consultation and referral patterns.
4. Availability and productivity.
5. Documentation of patient care and services.

(b) *Nonprivileged personnel.* Supervisors of nonprivileged 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/her job position. The individual's improvement or lack of improvement related to his/her documented performance limitations/inadequacies will be assessed and addressed in each written evaluation.

d. *Unlicensed health care personnel.*

(1) Both privileged providers and nonprivileged professionals who require an authorizing document for practice and who are not licensed, certified, and/or registered (for example, students in health professions' training, graduates

awaiting licensure examination results, and so forth) 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.

*Note.* 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/her assigned military or civilian position will be assessed and documented.

*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) In instances of a sole privileged provider in a given setting, or the provider is the senior member of his/her discipline (that is, the chief of the department), the provider is responsible to an assigned clinical authority, as appropriate to the organization. This individual (from within the MTF or the RMC) will perform appropriate supervisory functions and provide oversight of the care and services delivered to authorized beneficiaries.

(a) The individual tasked with oversight authority may be of the same discipline, a similar discipline, or a physician.

(b) The individual selected must be qualified by education and experience to provide the appropriate level of supervision and oversight of practice that is required.

(3) 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) Army 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 MTF commander.

(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/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/her CAF. The immediate supervisor will ensure appropriate coordination to facilitate organizational compliance, wherever feasible.

(3) Regardless of the oversight and/or supervisory relationship that exists, 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 nonprivileged health care personnel need not be responsible for the overall performance evaluation (OER/Enlisted Evaluation Report/civilian performance appraisal). Decisions regarding nonclinical rating schemes must be based on the structure of the organization and other variables that are individual provider and facility specific.

(5) A copy of the privileged provider's clinical performance evaluation (not the OER or its civilian evaluation equivalent) will be forwarded to the MTF 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 the algorithm-directed troop medical care (ADTMC) system (or comparable system) to screen AD Soldiers during daily sick call activities. (Contact USAMEDCOM ATTN: MCHO-CL-C for use of this system.) Use of an algorithm-based system is mandatory when screening personnel provide evaluation, treatment, and/or disposition of AD sick call patients. MTF commanders will—

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

(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 ADTMC screeners, DA Form 5181 (Screening Note of Acute Medical Care), or like form, will be reviewed on a daily basis. Screener evaluation will be documented according to instructions from the USAMEDCOM ATTN: MCHO-CL-C.

(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 (P&T) committee (see AR 40-3), 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 ADTMC to ensure compliance with the above requirements. This oversight responsibility may not be delegated.

## **Chapter 6**

### **The Peer Review Process**

#### **6–1. General**

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 nonprivileged. 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. This chapter presents the basic framework for a formal peer review. Additional specifics associated with peer review and adverse privileging/practice actions are contained in chapter 10. Peer review in relation to an SOC determination for a medical malpractice claim is discussed in chapter 13.

#### **6–2. The 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.

*Note.* In circumstances where nursing practice is subject to scrutiny, in order to determine quality, efficacy, or appropriateness, the specialty-specific ANA Standards of Clinical Nursing Practice will apply.

*b.* Each MTF will establish peer review processes that are nonadversarial. Ideally, the peer review should be conducted as soon as possible (within 30 calendar days) 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 chapter 10 for specific time frames related to notification. The department/service chief is responsible for initiating and coordinating the peer review activities for nonprivileged personnel. For a privileged provider, the peer review is typically coordinated by the credentials or the RM 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 MTF commander to the next higher level of command. (See para 10–6f for additional detail.)

#### **6–3. Composition of peer review board**

Peer review activities may be accomplished either by an established committee/subcommittee (that is, credentials/RM) 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 nonprivileged personnel. The peer review mechanism that is most appropriate for the organization will be addressed in local policy. The size of the MTF and the number and variety of health care personnel for whom peer review is appropriate will determine whether one, or more than one, peer review mechanism is established. One option is a single peer review panel with selective membership of an odd number of participants, the majority of whom are peers of the staff member whose practice is being reviewed. This is a more flexible alternative than each department/service assuming responsibility for its own ad hoc peer review panel. In circumstances, such as outlying health clinics, where sufficient staff are not available to conduct peer review, the process will be performed at the next level in the chain of command.

#### **6–4. The intent of peer review**

Structured feedback from an individual's peers (that is, a performance assessment (chaps 5 and 9)) 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 chapter 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 the USAMEDCOM QMD, utilizing Department of Defense Form (DD) 2499 (Health Care Provider Action Report) (see chap 10) or DD Form 2526 (Case Abstract for Malpractice Claims) (see chap 13), when the need is identified to report a health care privileged provider or nonprivileged professional to a regulatory body.

## **6–5. Conducting the peer review**

- a.* When a privileged or nonprivileged staff member is removed from all or a portion of his/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 nonprivileged personnel. See chapter 10 for additional guidance associated with peer review.

## **6–6. 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 DD Form 2499. The MTF commander will forward this document to Commander, USAMEDCOM, MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, Texas 78234–6010, with copy furnished to the RMC or other higher headquarters, as appropriate. 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 nonprivileged professional to a licensing or other regulatory body is required. TSG is the sole reporting authority (para 14–3).

# **Chapter 7 Privileged Health Care Providers**

## **7–1. General**

*a.* This chapter 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 providers addressed include, but are not limited to—

- (1) APRN.
  - (a)* Certified nurse midwife (CNM).
  - (b)* 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) OT.
- (11) Optometrist.
- (12) Physician.
- (13) PA and specialty physician assistant.
- (14) PT.
- (15) Podiatrist.
- (16) Psychological associate.
- (17) Speech pathologist.
- (18) 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/her recognized scope of practice. He/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 chapter are at the discretion of the MTF commander, who is the privilege-granting authority.

*Note.* While the specialist in blood banking (SBB) may be awarded clinical privileges in the specialty, he/she does not function independently to diagnose, initiate, alter or terminate health care treatment regimens. The term "provider," as defined in this regulation, does not apply to the SBB. (See paras 9-1 and 9-2 for additional information regarding the granting of clinical privileges.)

(2) The specific and individual privileges of each provider are delineated on the appropriate DA Form 5440, Delineation of Clinical Privileges, contained in his/her PCF.

*Note.* See app A for a complete listing of the DA Forms 5440 series.

Providers with admitting privileges and all physicians will be appointed to the medical staff. For health care providers who are not authorized to admit patients, medical staff appointment is optional. The individual's category of privileges, appointment status, and authority to admit patients are reflected on DA Form 5440A, Approval of Clinical Privileges/Staff Appointment.

## **7-2. 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.

*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 MTF formulary according to the guidance established by the local P&T 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 authorized. Facility-specific exceptions, either by category of drug or itemized by name of drug, will be noted in writing. Prescription writing authorization—as recommended by the P&T committee, reviewed by the credentials committee, and approved by the MTF commander—will be annotated in the PCF as an addendum to the provider's delineation of clinical privileges.

*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. Nonphysician privileged providers may be authorized to perform, and document in the medical record, minimally complex or selected moderately complex diagnostic procedures classified as provider-performed microscopy by the DOD Clinical Laboratory Improvement Program. (See AFIP Pam 40-24.) Other radiological studies, diagnostic testing, and procedures authorized according to local guidance will be addressed on the discipline-specific DA Form 5440.

*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 AR 351-3, or as determined by the provider's State of licensure, whichever is more stringent.

*f. Readiness training.* This is of paramount importance to prepare U.S. Army privileged providers for mobilization in support of the Army's global mission. Local command decisions will govern the training of assigned personnel. Suggested training includes—

(1) *ACLS and ATLS or an equivalent.* This training ensures that military providers are qualified in advanced cardiac and trauma management to care for the wounded/injured on the battlefield or other mission-related settings.

(2) *Medical management of chemical, biological, nuclear, radiological illness/injury.* The increased risk that weapons of mass destruction will be employed on the battlefield or in terrorist activity worldwide requires that privileged providers, as appropriate, be prepared to diagnose and appropriately manage the injuries or diseases that will result from the use of these unconventional agents.

### **7-3. 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 on DA Forms 5374 and 5441. (See app A for a complete listing of DA Forms 5441 series.) 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 the TJC or other accrediting agencies, as approved by the Office of the Secretary of Defense (Health Affairs) (OSD(HA)), may also apply. Performance-based peer review will be according to local policy.

*Note.* 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 or entry-level provider (or the experienced provider who has returned to clinical practice after a lapse (see glossary) 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.

### **7-4. Advanced practice registered nurse**

#### *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) CNMs.

(b) CRNAs.

(c) CNSs.

(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 ECMS and the DCN. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/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 MTF commander.

#### *b. Professional credentials.*

(1) *Education.* APRNs who complete their respective specialty programs after 31 December 2001 must be graduates of an accredited master's level or doctoral program acceptable to DA 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 (para 4-4).

(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 (see para 9-4e) for a period of 12-24 weeks. The supervision associated with the period of residency is not considered an adverse status. For specific guidance related to APRN residency requirements, contact MCHO-CL.

#### *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/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 (HRECs) 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 on DA Form 3349 (Physical Profile) for AD Soldiers to include those on flight status (AR 40–501); place patients under his/her care on quarters status (AR 40–66); 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 the guidance outlined in AR 40–501.

*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. (See para (c) below.) 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 MTF-specific guidelines define conditions for which referral or collaborative care (co-management) is appropriate.

(c) May provide obstetrical care within his/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 MTF guidelines. The CNM may perform outpatient care and be privileged to admit and discharge patients when an obstetrician is on call and is available by telephone to provide medical consultation, collaborative management, and/or referral when indicated.

*e. Certified registered nurse anesthetist.*

(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 followup 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 preanesthetic assessment and evaluation of the patient to include requesting consultations and diagnostic studies.

(b) Establish an anesthesia plan and, based on the preanesthetic 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 perianesthetic 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 perianesthetic 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/her overall responsibility to ensure the utmost safety of the patient. At all times, the CRNA remains accountable for his/her decisions and all professional actions associated with the anesthesia care rendered. The consulted physician is accountable for his/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. In an MTF without an assigned or available anesthesiologist, this collaboration will be with the operating surgeon. The CRNA will document the results of this interaction in the medical record prior to the start of the case. There is no requirement for the collaborating physician or oral surgeon to be privileged in the administration or management of anesthetics.

(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/she teach/supervise anesthesia nursing students or other anesthesia providers in training.

*f. Clinical nurse specialist.*

(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 chapter 9 of this regulation. 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. Nurse practitioner.*

(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/her specialty, the ANA Standards of Clinical Nursing Practice for Nurse Practitioners, and his/her individual DA Form 5440 as determined by the organizational mission and scope of care and

services. MTF-specific guidelines and the individual's privileges define conditions for which referral or collaborative care is appropriate.

## **7-5. Audiologist**

### *a. Description.*

(1) Audiologists contribute to the operational readiness and quality of life of the fighting force and other eligible beneficiaries by providing cost-effective hearing health care through audiological services including prevention, medical surveillance, treatment, education, and research.

(2) Audiologists support the missions of DOD personnel by implementing the Army Hearing Conservation Program and preventing noise-induced hearing loss to enhance auditory performance in operational environments. 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 DA.

(2) *Licensure.* Audiologists will maintain a current, active, valid, and unrestricted audiology license, registration, or 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.

## **7-6. 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.

*Note.* 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 regulation, using the title of behavioral health practitioner or psychological associate. (See para 7-19.)

*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 category 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/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 State licensing board.

*Note.* Not all States offer licenses to master's level psychologists, but all offer the LPC, though some States use a different title for their LPC-equivalent license. The education and experience requirements for licensure are the basis for determining equivalency.

(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/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.

(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 State licensing body. He/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).

*Note.* 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/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.

## **7-7. 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.
- (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 MTF commander, 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 AD Soldiers 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 MTF. Both clinical supervision and professional evaluation of the individual are integrated into the organization's current evaluation structure.

## **7–8. Clinical pharmacist**

*a. 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 clinical treatment protocols or CPGs developed in coordination with the medical staff, recommended by the P&T committee, and approved by the ECMS, or DOD/USAMEDCOM-developed and approved CPGs. 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.

*b. Professional credentials.* Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include—

(1) *Education/certification.* Pharmacists must have—

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

(b) A master of science degree in pharmacy from a clinically oriented program, or

(c) Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmaceutical Specialties, or

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

(e) A bachelor of science degree in pharmacy with documentation of appropriate education, training, and/or continuing education in the practice of clinical pharmacy.

*Note.* 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.

(f) 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.

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

*c. Scope of practice.* Pharmacists may be granted clinical privileges to provide clinical treatment protocol/CPG-based direct patient care. (See para *a* above.) 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—

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

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

(3) 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.

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

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

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

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

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

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

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

(11) 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 P&T committee.

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

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

*d. Supervision.*

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

(2) All clinical pharmacists must work via protocols recommended for approval by the ECMS 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.

## **7–9. 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, and escape (SERE) psychology, and combat stress control.

*Note.* 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 graduate program and internship must meet requirements of DA Pam 611–21. 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 graduate program and internship must meet requirements of DA Pam 611–21. The practitioner provides a full range of psychological services as qualified to deliver by virtue of training. He/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. Graduate programs and internships must meet requirements of DA Pam 611–21. The practitioner is recognized as possessing a high level of skill in psychological assessment, intervention, and administration of services. He/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. Graduate programs and internships must meet requirements of DA Pam 611–21. The practitioner is recognized as possessing the highest level of skill in psychological assessment, intervention, and administration. He/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 American Psychiatric Association 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 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 appropriate DA Form 5440 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 awaiting 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 who have not engaged in clinical practice for a period of 12 months or more will require assignment to a 12-month period of general supervision. Psychologists will adhere to guidelines of the APA which require psychologists to receive appropriate training and supervision before engaging in new practice areas.

(4) If another psychologist is not available to provide the required supervision, the MTF will coordinate with the RMC senior psychologist before establishing the plan of supervision.

## **7-10. Clinical social worker**

*a. Description.* The primary mission of Army 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 Army community. Social workers are members of the health care team, most frequently working in social work service, outpatient mental health clinics, Family Advocacy Programs (AR 608-18), 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 master of social work (MSW) degree from a school of social work accredited by the Council on Social Work Education. Social workers practicing in the AMEDD 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.

*Note.* Incumbent 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.

(b) Entry-level clinical social workers may be granted regular privileges with enhanced supervision as described in paragraph 9-4e. 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. Individuals will be given until 1 October 2004 to meet this independent practice licensure requirement. (This allows 2 years to meet State clinical experience/supervision requirements plus an

additional year to obtain the appropriate license. Individuals who have already completed the experience and supervision requirements will be given up to 1 year to complete the examination and licensure/certification process.)

(2) *Licensure.* A current, active, valid, and unrestricted MSW license at any level from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction is required and must be maintained.

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.

## **7-11. Dentist**

a. *Description.* Dentists ensure the optimal oral health of the Soldier through preservation, restoration, and replacement dental services and they provide dental health care to eligible DOD beneficiaries (AR 40-400). 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 to AOC 63A. The specialty dentist is privileged to perform the same procedures as the general dentist in addition to those appropriate to his/her specialty AOC. Dentists in residency training programs will perform specialty procedures as assigned and supervised by their program mentors.

## **7-12. 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.

*Note.* 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/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.* Successful completion of the Commission on Accreditation for Dietetics Education-accredited supervised practice requirements for registration by the Commission on Dietetic Registration of the ADA is required. (If the applicant entered the Army as a "fully qualified" dietitian, current registration by the Commission on Dietetic Registration of the ADA is required. If the applicant is a graduate of the Military Dietetic Internship Consortium, registration must be obtained no later than October of the graduating year.) Registration eligibility must be achieved through one of the following pathways:

- (a) Dietetic internship.
- (b) Approval of Preprofessional Practice Program.
- (c) A coordinated undergraduate program in dietetics.

(3) *Licensure.* 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 7–2c.

(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; 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.

(5) *Supervision.* If a dietitian is assigned where no other dietitian is available to provide supervision or assessment of the individual's performance, this responsibility is delegated to the senior RMC dietitian or the MTF DCCS. The competency assessment may include periodic review of a representative sample of medical records, direct observation of performance, or verbal/written assessment of clinical knowledge/skills according to the ADA Manual of Clinical Dietetics. Competency assessment will be documented and maintained in the dietitian's CAF.

### **7–13. Occupational therapist**

a. *Description.* OTs contribute to operational readiness and quality of life by providing cost-effective occupational therapy care to the fighting force and eligible beneficiaries. Occupational therapy 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 nonstandardized 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.* Current certification from the National Board for Certification in Occupational Therapy (NBCOT) is required.

(3) *Licensure.* OT registered will maintain a current, active, valid, unrestricted occupational therapy license from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) *Other.* The advanced OT registered clinical specialist in the treatment of upper extremity neuromusculoskeletal conditions must—

(a) Attend the U.S. Army Occupational Therapy Evaluation and Treatment of Upper Extremity Conditions course.

(b) Complete a 6-month preceptorship under the supervision of an orthopedic physician and be awarded the 7H designator.

#### *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/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 Soldiers/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 MTF 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 (NMSE) 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 the guidance outlined in AR 40–501.

6. Write prescriptions for selected medications as described in paragraph 7–2c.

(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/her clinical practice by a more experienced OT. In the absence of a more experienced OT, a physician may provide supervision/oversight.

## 7–14. 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 requirement for physician supervision.

## **7–15. 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 DA.

(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 acceptable to DA.

(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 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 para 9–4e) if recommended by the credentials committee and approved by the MTF commander.

## **7–16. Physician assistant and specialty physician assistant**

*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.

*Note.* The majority of Army PAs are assigned to TOE combat and combat service support units. More detailed explanation (for example, regarding training requirements, continuing education, and so forth) is offered about PAs so that non-AMEDD personnel will better understand the duties and responsibilities of these providers both in garrison and in the field.

*b. Professional credentials.*

(1) *Education.* Military PAs must meet the educational criteria for commissioning as a 65D according to AR 135–101 which stipulates a baccalaureate or master's degree. 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 (AA/USAR/ARNG 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) (see AR 601–20) 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, in writing, from the Chief, Army

Medical Specialist Corps, prior to the scheduled examination date. Any approved deferment will delay the 12-month mandatory period to pass the PANCE. The Soldier will retain any unused portion of his/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 AR 614-100.

(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 AOC/ASI. The PA with an existing AD service obligation for training will be processed for involuntary branch transfer according to AR 614-100. Individuals with no AD service obligation may be eliminated from service according to AR 600-8-24. See MEDCOM guidance for additional NCCPA certification requirements.

(3) *Licensure.* Non-personal services contract PAs employed by the Federal Government must be licensed in the particular State in which they are working (see para 4-8a). All other PAs (AD, GS, and personal services contract) are granted a waiver to the licensure requirement by DOD.

c. *Scope of practice.* The PAs provide medical care for Soldiers and eligible beneficiaries in all age groups, including children under the age of 2, according to the clinical privileges awarded by the MTF commander.

(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 Optional Form (OF) 522 (Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures). (See AR 40-66 for instructions on the use of this form.)

(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 AR 40-66 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 (ITR) or outpatient treatment record (OTR). Documentation in the ITR of the patient's medical history, physical examination, and narrative summary, as well as entries on DA Form 4256 (Doctor's Orders) (see AR 40-66) require physician countersignature. Countersignature will be within 24 hours. Entries made by a PA in the HREC or the OTR 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 using DA Form 4256.

(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 pre-surgical anesthesia evaluation that requires completion of a DA Form 7389 (Medical Record-Anesthesia). (See AR 40-66.)

(g) PAs may not sign the DA Form 3647 (Inpatient Treatment Record Cover Sheet). (See AR 40-400.)

(3) *Pharmaceutical usage.* PAs may be privileged to write prescriptions for a wide variety of pharmaceuticals as described in paragraph 7-2c.

(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/she may administer or prescribe any pharmaceutical stocked in the U.S Army 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 AR 40–501, and as deemed appropriate by the supervising physician.

(b) Perform medical screening for overseas movement and sign the DA Form 4036 (Medical and Dental Preparation for Overseas Movement). (See AR 600–8–11.)

(5) *Profiles.* PAs may authenticate temporary limited-duty profiles according to the guidance outlined in AR 40–501.

(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 AR 15–6 investigation officer 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 approved by the Commander, USAMED-COM (MCHO–CL–C), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. 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 CQM procedures and/or locally developed scopes of practice. Guidance for each PA specialty is as follows—

(a) *Aviation medicine.* A 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/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) (see AR 40–501) 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 AR 600–106 and on SF 600 filed in the patient's HREC.

6. Be placed on noncrewmember flight status by Headquarters, DA, under the provisions of AR 600–106.

(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 a TSG-approved graduate PA emergency medicine training program may be designated as an emergency medicine PA (EMPA), (ASI M2). 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/she has been properly trained and privileged.

4. Maintain/sustain those skills and certifications (that is, ACLS, ATLS, pediatric advanced life support (PALS))

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 (60C) or preventive medicine physician (60D) in occupational and preventive medicine duties for the medical center (MED-CEN), medical department activity (MEDDAC), or TOE unit areas of responsibility. 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 Soldiers and DOD civilian employees.

(e) *Orthopedics.* A PA who successfully completes a TSG-approved graduate PA orthopedic training program may be designated an orthopedic PA (ASI M1). 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/she has been properly trained and privileged.

*Note.* 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 1 July 2009).

(3) The appropriate TOE surgeon will participate in the privileging process for PAs assigned to TOE units.

*e. Supervision.* 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/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/her clinical privileges.

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

(e) Ensure that performance evaluations are conducted according to established CQM 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 unit CQM 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 AR 623-3.

(2) *Nonpersonal services contract PA supervision.* A PA in this status may have supervision requirements imposed by his/her State of licensure that exceed U.S. Army requirements. (Given the variation among States regarding supervision of PAs under non-personal services contract to the Government, 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 MTF will cooperate by providing copies of medical records for external review. The number of medical records will be locally determined.

(b) The MTF must petition the State board of licensure to honor physician license portability (10 USC 1094) in order for the MTF-appointed physician to provide the necessary supervision. In this case, the MTF is obliged to meet the other established supervision requirements of the State of licensure.

f. *CME and training.* CME is critical for sustainment of clinical skills necessary for the PA to perform his/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 U.S. Army PAs for their wartime mission. Recommended training for AA/USAR/ARNG 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 Soldiers.

## **7–17. Physical therapist**

a. *Description.* PTs ensure operational readiness and quality of life to the fighting force and other eligible beneficiaries by providing appropriate physical therapy care. This is achieved through physical therapy services that include examination, evaluation, diagnosis, prognosis, intervention, prevention, health promotion, education, and research.

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/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 the MHS, the DOD, and/or Department of Veteran's 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 AR 40–501.

5. Write prescriptions for selected medications as described in paragraph 7–2c, for musculoskeletal conditions.

(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 American Board of Physical Therapy Specialties guidelines for the practice of clinical electrophysiologic physical therapy published in *Clinical Electrophysiologic Physical Therapy: Description of Advanced Clinical Practice* (1995).

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 defined below, will be designated by the 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 (that is, 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/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.

## **7–18. 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 acceptable to DA. 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 in *b* above, 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/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.

## **7–19. 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.

*Note.* 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 regulation, using the title psychological associate or behavioral health practitioner. (See para 7–6.)

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 category 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.

*Note.* 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 category 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/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/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.

## **7–20. Speech pathologist**

*a. Description.* Speech pathologists help ensure operational readiness and quality-of-life to the fighting force and other eligible beneficiaries by providing cost-effective speech communication health care. Speech, language, voice, and swallowing services are offered to include prevention, medical surveillance, education, and research. The goal of speech pathology is to support the DOD mission and DOD personnel through implementation of communication enhancement and voice conservation. Speech pathologists diagnose and treat speech, voice, and communication deficits of Soldiers 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 acceptable to DA.

(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, fiberoptic 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/her clinical practice by a more senior or experienced speech pathologist, as determined by the MTF commander. In the absence of a senior speech pathologist, a physician or other qualified privileged provider, as designated by the DCCS, may provide supervision/oversight.

## **Chapter 8**

### **Credentials Review**

#### **8–1. General**

Credentials are those documents presented by the health care professional, regardless of the nature of his/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.

#### **8–2. Credentials authentication for military accessions**

*a.* Prior to selection for military service, the appropriate personnel from the respective AMEDD Recruiting Detachments will complete PSV of selected military provider/professional credentials and these are forwarded to the appropriate branch at USAREC, (Health Services Directorate (HSD)), Fort Knox, KY.

(1) The PSV performed by USAREC need not be repeated by the MTF credentials manager if appropriately authenticated provider credentials are available. The methods used to primary source verify credentials are those outlined in paragraph 8–6f.

(2) The documents and forms required by USAREC to apply for military service vary by AMEDD program type. For privileged provider applicants (direct accessions) the documents that may subsequently become part of the PCF include but are not limited to—

- (a) Personnel Data Sheet.
- (b) Professional license and PSV (copy).
- (c) Curriculum vitae (CV) or resume (copy).
- (d) Diploma (copy).
- (e) Qualifying degree official transcripts (copy).
- (f) Continuing medical or health education (copy).
- (g) Malpractice insurance coverage and PSV (copy).
- (h) Additional documents: board certification(s); NPDB query results; ECFMG/Fifth Pathway certificate (if applicable); and internship, residency, fellowship certification or verification, as appropriate.

*b.* In addition to the various documents noted above, USAREC requires an Electronic Personnel Security Questionnaire from all individuals who do not currently hold a secret clearance.

*Note.* An NPDB query is placed for all privileged providers, unless a verified copy of the response from a recent query (less than 1 year old) is available from a civilian organization.

*c.* Once military appointment is accepted, all primary source verified documents and other credentials, as noted in paragraph *a* above, submitted as part of the application for military appointment will be forwarded by USAREC (HSD) as follows—

(1) *AA providers/practitioners.* USAREC (HSD) will forward credentials to the first MTF of assignment, as applicable, upon receipt of written request (see fig 8–1) from the MTF credentials office. These documents will be forwarded by Federal Express (FedEx), or comparable mail service, to the MTF credentials manager.

(a) USAREC (HSD) will process credentials requests for the following categories of AA accessions:

1. *Fully qualified direct accession applicants in all AMEDD corps.* Credentials will be forwarded upon request as noted above.

2. *Army Medical Specialists Corps.* Credentials for student accessions into the U.S. Army/Baylor Program in Physical Therapy, the AMEDD Dietetic Internship, and Occupational Therapy Fieldwork Programs will be forwarded to the appropriate program directors (no formal request required).

3. *Medical Service Corps.* Credentials for participants of the Clinical Psychology and Podiatry Residency Programs will be forwarded to the appropriate program directors (no formal request required).

4. *Dental AGD 12-month applicants.* Documents will be forwarded to the individual program directors at each training site following the AGD selection board (no formal request required).

(b) USAREC (HSD) is not responsible for forwarding credentials on the following categories of AA accessions:

1. *Retiree recalls.* The retiree's PCF must be requested from the U.S. Army Human Resources Command (HRC), AHRC-RSA-Q, 1 Reserve Way, St. Louis, MO 63132-5200. Credentials acquired since retirement will be appropriately verified (PSV) by the credentials office at the unit of assignment.

2. *Reserve Officer Training Corps (ROTC) cadets.* The Army ROTC Program is an accessions source for generic (nonspecialized) officers, primarily AN and MS. A baccalaureate degree, verified by ROTC Cadet Command, from a DA-approved college or university is the single credential required of all ROTC officers. Prior to being assigned to an Officer Basic Course class, the ROTC-commissioned AN officer must have successfully passed the National Council for Licensure Examinations Registered Nurse and hold a valid, unrestricted RN license as confirmed by ROTC Cadet Command with the respective State board of nursing.

3. *ROTC educational delay participants.* These individuals are involved in an advanced degree program (most often self-funded) in a health care specialty (for example, OT, PT, and so forth). If the individual is accessed into the military in a health care AOC, credentials from the appropriate source must be requested and PSV conducted by the credentials manager at the first unit of assignment.

4. *Health Professions Scholarship Program participants.* Upon graduation from medical school or other professional education program, certified true copies of official academic credentials (that is, diploma, final transcripts, and so forth) will be hand carried by the individual to his/her first year unit of assignment.

*Note.* Official sealed copies of academic credentials are the only credentials that may be hand carried by the individual in question.

5. *Financial Assistance Program participants (same as para 6 below).*

6. *Military/civilian residency, fellowships, or training program participants.* Credentials for military trainees in any of these programs will be forwarded in accordance with paragraph 9-4d(1). For students participating in GPHE in civilian deferred status (includes FAP), credentials must be requested from the training site. PSV will be conducted by the credentials office at the individual's first MTF of assignment.

(2) *USAR providers/practitioners.* Forwarding instructions will be determined by assignment/attachment as follows:

(a) For providers assigned to troop program units (TPUs), forward to the designated unit of assignment.

(b) For providers assigned to a unit but attached to the National AMEDD Augmentation Detachment (NAAD), forward to Commander, NAAD (AFRC-NAD-QA), 1401 Deshler Street SW, Fort McPherson, GA 30330-2000.

(c) For providers assigned to the Individual Ready Reserve (IRR) (excludes GME participants in civilian-deferred status) or the Individual Mobilization Augmentation Program, documents will be forwarded to Commander, HRC, (AHRC-RSA-Q), 1 Reserve Way, St. Louis, MO 63132-5200.

(3) *National Guard providers.* Forward documents to Strength Maintenance Division (NGB-ASM-S) (AMEDD), Suite 3400, 1411 Jefferson Davis Highway, Arlington, VA 22202-3231. Strength Maintenance Division will forward documents to the appropriate State Surgeon/Deputy State Surgeon who will forward the documents to the designated credentials manager.

### **8-3. Military treatment facility authentication of professional credentials**

a. Review and 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 chapter, will be accomplished for all categories of privileged and nonprivileged Federal employees: AA/USAR/ARNG military, civil service, consultant status, FNLH, 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 (see para 8-7f) prior to the initial granting of clinical privileges when expanding or adding new clinical privileges, and at each biennial renewal.

(1) *Nonprivileged staff.* Verification of nonprivileged professional credentials is managed by the MTF readiness, education, and training department/service (or other service) according to local policy. The professional credentials that will be primary source verified and annotated in the individual's CAF (see chap 5 and app C) or other locally prescribed training file include but are not limited to—

(a) *Academic.* Pre-existing academic achievement is verified prior to military accession. Pre-employment verification of academic credentials for civilians (GS, personal services contract, and volunteer) is the responsibility of the MTF. Health-care-related professional degrees attained while employed by the Federal Government will be verified by the MTF.

(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 USAREC. Local policy will direct who at the MTF is responsible for PSV of license for recently assigned nonprivileged military accessions and for pre-employment licensure verification for civilians (GS, personal services contract, and volunteer). The contracting agency will verify licensure with the primary source for non-personal services contract personnel prior to the employee being assigned to the MTF 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 MTF authority.

The contracting agency is responsible for PSV of licensure/certification/registration renewal for non-personal services contracted employees. This requirement applies to all nonprivileged personnel who possess a license, certification, or registration as a professional credential. (See paras 8–6e and f for more information on PSV.)

(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 with the U.S. Army by the MTF credentials manager, or other responsible authority, as designated by the commander. Professional information about the privileged provider is contained in both the PCF and the 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 AR 340–21. The PCF will be released only to the MTF commander, the credentials committee, department/service chiefs, recognized reviewing authorities, or officially appointed inspectors. The provider may authorize, in writing, release of his/her PCF to others, but the PCF should be retained in the credentials office with authorized access in that secure location. See appendix E 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 app E 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. (See additional PAF information in para 8–9 and app F.)

(c) Both the PCF and the PAF contain sensitive, confidential information. The documents contained in these files qualify for protection under 10 USC 1102. (See app E 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 should be retained in the credentials office with authorized access only in that 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/her PAF and PCF.

#### **8–4. 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/dental 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 ECMS (AA facilities and USAR/ARNG units wherever feasible) 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 are essential to the medical/dental staff appointment/reappointment process, as well as to the granting, renewing, or revising of clinical privileges. 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 ECMS, 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 MTF'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.

#### **8–5. Military treatment facility 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 ECMS/ECDS (see glossary) 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 ECMC 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/dental staff. Subsequent to this review, recommendations for provider privileging/appointment actions, to include those for USAR/ARNG providers for whom the committee has privileging responsibility, are made through the ECMS/ECDS to the commander. The committee's recommendations relevant to a provider's request for privileges are based upon his/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, involuntarily separated, or released from AD or civilian employment.

(3) No action recommended by the credentials committee/function is final until it has been reviewed by the ECMS/ECDS and approved/signed by the commander.

*b. Membership and duties.* The MTF commander will designate the DCCS (or other senior physician) as 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 facility, in outlying patient care settings under the command and control of the MTF, and in garrison-level TOE units, where present. The majority (51 percent or greater) will be fully appointed members of the medical/dental staff.

(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.

*Note.* 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 MTF commander and deputy commander will be performed according to paragraph 9-2c.

*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 ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the commander.

(2) Announcements of meetings, with the exception of on-call meetings, will be made no later than 5 days (no later than 30 days for USAR/ARNG committee meetings) prior to the planned meeting date.

(3) Those providers to be considered will receive 30-days' notice (60 days for USAR/ARNG providers) to review and update their credentials, as appropriate, and to submit a current request for privileges.

(4) 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 providers newly assigned (initial DOD assignment, following PCS/transfer, or TDY).

(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.

(5) 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.

*Note.* Voting related to routine reprivilaging 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/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 him/herself from the vote.

(6) 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.

*d. USAR/ARNG credentials management and credentials committee/function.* ARCCA manages credentials for the USAR—except for those managed by HRC-St. Louis (IRR providers) and those managed by the AA MTF (IMA providers). For the ARNG, a credentials manager will be appointed on orders. He/she will maintain a complete credentials file, and CCQAS data file, for all ARNG privileged providers within the State.

(1) State Surgeons will establish a credentials committee (or ensure the function is performed by one of the mechanisms described below) to perform the various credentialing and privileging activities as outlined in this regulation. The State Surgeon will not serve as chairman of the credentials committee. He/she will serve as the approval authority for all privileging actions and will sign in block 9a, DA Form 5440A for both initial privileges/staff appointment and for renewal of privileges/staff appointment.

(2) A variety of ARNG unit-specific circumstances exist that influence credentials committee structure and function.

(a) The State Surgeon’s credentials committee serves as the centralized credentialing authority for all ARNG healthcare providers in the State. The State Surgeon may delegate this function to another activity, if performance is comparable to that of the State Surgeon’s credentials committee.

(b) ARNG medical units with a minimum of three privileged providers may form a credentials committee.

(c) Units unable to form a credentials committee, due to insufficient providers or other reasons, may coordinate to convene a regional credentials committee. An MOU between the participating States serves as the charter for this committee.

(3) The credentials committee will—

(a) Make recommendations to the ARNG State Surgeon/MTF commander on privileging a unit provider for IDT/AD activities such as those identified in paragraph 1–4h(5).

(b) Review each provider’s education, training, and current competencies against regular duty/mobilization AOC requirements. All ARNG providers will be credentialed in both their duty AOC and their civilian-equivalent AOC. However, privileges will be granted in accordance with the ARNG provider’s duty AOC.

(c) Consider, and make recommendations to the State Surgeon, as appropriate, that an ARNG provider’s privileges be denied, suspended, restricted, reduced, or revoked.

## **8–6. Provider credentials verification**

Prior to being privileged and awarded appointment to the medical/dental 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 DOD. Credentials that require periodic renewal will be verified upon renewal. The privileged health care provider’s license is the only exception, as described in paragraph 8–7b(2).

*b.* For military (AA/USAR/ARNG), credentials verification occurs during pre-selection processing prior to military commissioning. (See para 8–2 for more information.)

*c.* For civil service, consultant status, FNLH, personal services contract, or volunteer health care privileged providers, credentials verification by the MTF 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 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 appendix F for Civilian Personnel Operations Center (CPOC)/CPAC duties/responsibilities associated with prospective employee credentials.

*d.* For the non-personal services contract privileged provider, the contract will specify who is responsible for PSV of the provider credentials as noted in paragraph *c*, above.

*e.* 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.

*f.* 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 masterfile 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) *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) *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/her signature, and why this was the only verification method available.

g. 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 (nonprivileged professional), the requirement to photocopy the official document(s) does not apply.

## **8–7. Provider credentials file**

The credentials information that originates during the pre-employment/accesion 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 in accordance with AR 340–21 and local policy. See appendix E for additional information regarding the PCF. The credentials contained in the PCF include the following:

*Note.* Those credentials specified in paragraphs a through d and paragraph j ,below, will be primary source verified.

a. *Qualifying degrees, diplomas, ECFMG, Fifth Pathway, or other discipline-specific certificate, as appropriate.*

(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 MTF will notify the RMC/RDC who will telephonically contact the Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010 or the Commander, U.S. Army Dental Command (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234–6004 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 (on DA Form 4691 (Initial Application for Clinical Privileges and Staff Appointment)) along with an explanation of any that are not current or that 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, by one of the methods described in paragraph 8–6f, 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 and fellowship certificates.* 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 American Board of Medical Specialties (ABMS) Directory of Board Certified Medical Specialties” (at Web site <http://www.abms.org>), is now a recognized site for PVS and may also be used. The ABMS directory only includes those specialty boards that are members of this organization.

*Note.* 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 1 year or most recent clinical practice if in an administrative role) 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. (See para j, below, for additional detail.) 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 DA Form 5754 (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 DA Form 5754 with appropriate explanation capture this provider-specific information.

*Note.* 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/her health status (physical, mental, and emotional health) relative to his/her ability to provide healthcare and to perform the privileges requested.* Such a statement is required on page 2 (block 9) of DA Form 5754. Validation by another privileged provider familiar with the individual and his/her health status will be noted in separate memorandum to the credentials committee or as a comment in Section II, DA Form 5440-series, by the provider’s supervisor.

*j. Letters of reference/peer recommendations.* The letters 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 is 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/her interpersonal skills, communication skills, and professionalism.

(1) *Letters of reference.* A minimum of two current letters of reference from appropriate sources in (paras *a*) through (*c*) below are required for verification of experience and current competence. To best represent the applicant being considered for initial privileges and staff appointment, 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 are mandatory if the appointee is self-employed.

(*d*) The non-board certified physician who alleges to be a specialist requires two letters of reference attesting to his/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/her initial period of qualification for board certification, two letters attesting to the applicant’s clinical competence are required from board certified specialists who have current knowledge of his/her clinical practice.

(2) *Peer recommendations.* For providers (AA, USAR/ARNG, 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.*

The requirement of a current DEA certificate does not apply to providers credentialed by OCONUS MTFs located in Germany, Korea, and other non-territories of the U.S.

*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 MTF at the time a provider initially applies for clinical privileges (initial duty station or place of

employment unless para (1) above applies), 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 by the provider's first MTF 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 USAR/ARNG 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 advanced pediatric life support (APLS), and/or the Neonatal Resuscitation Program may be additional performance requirements, but these are not a substitute for the BLS requirement. (See para 5-1e for more specific guidance regarding emergency life support training requirements.)

*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 AR 351-3 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 (AA, USAR/ARNG, 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 MTF. As addressed in local policy, the MTF 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 MTF 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 DODI 1402.5 or Assistant Secretary of Defense (Force Management (ASD(FM))) policy, subject: Criminal History Background Checks on Healthcare Personnel, dated 20 April 1992, 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 Department of Health and Human Services, Food and Drug Administration, 21 CFR, Part 900, Quality Mammography Standards, Final Rule, published in the Federal Register, Vol. 62, No. 208, Tuesday, 28 October 1997, effective 28 April 1999.) 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/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. National provider identifier.* 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, who meet established eligibility criteria (HA Policy: 05-002). It is used 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 23 May 2007. The credentials manager will ensure that the NPI is entered into CCQAS and that a copy is maintained in the PCF.

## **8-8. 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/dental 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.

## **8-9. Provider activity file**

The PAF is the repository for supporting information and data to validate privileging of the provider by the MTF. See appendix G 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 paragraph B-9 of this regulation. It is a working file with contents considered confidential quality assurance (QA) documents protected by 10 USC 1102.

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 available for review and evaluation by designated staff (peer level performance assessment) and by the department or service chief for biennial provider repriviling/reappointment to the medical/dental 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 AR 340-21 and 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).

#### **8-10. The inter-facility credentials transfer brief**

a. The ICTB is a computer-generated summary of information contained in the PCF. It is a standardized format (see app H) for transmittal of privileged provider credentials information across the MHS (Health Affairs Policy 94-004 and Health Affairs memorandum, subject: Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB), 11 December 1995). The ICTB may be used for all categories of privileged providers to include uniformed military (AA/USAR/ARNG); civilian (GS, 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 MTF for clinical practice, the sending MTF must convey all relevant credentials and privileging information to the gaining MTF. 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 MTF. Assignment for duty is only as stipulated in their contract. Use of an ICTB is not authorized.

(2) Providers (AA/USAR/ARNG) 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 TDY in this capacity, his/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. Required attachments to the ICTB for AA providers include—

- (1) Discipline-specific DA Form 5440-series for privileges being requested.
- (2) DA Form 5440A, with top portion completed.
- (3) A copy of the current DA Form 5440-series for clinical privileges held at the sending facility.
- (4) DA Form 5754.
- (5) Two peer recommendations, dated within 24 months of submission, for providers who do not hold current military clinical privileges. (See para H-3a(10) for additional detail.)
- (6) Authorization for release of information signed by the provider (may be specific to the gaining MTF, 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 DA or local privileging 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 paragraph 9-6c and in appendix H.

#### **8-11. The inter-facility credentials transfer brief and USAR/ARNG training**

a. The ICTB with appropriate supporting documents will be made available to the facility (training site) by the USAR/ARNG credentials manager at least 45 days before the scheduled arrival of the USAR/ARNG provider. The USAR/ARNG privileged provider's ICTB will be forwarded electronically or by mail; it will not be hand carried by the privileged provider. If the 45-day time frame cannot be met, direct coordination between the AA and USAR/ARNG units is required.

b. Required attachments to the ICTB for USAR/ARNG providers include—

- (1) Discipline-specific DA Form 5440-series for privileges being requested.
- (2) DA Form 5440A, with top portion completed.
- (3) A copy of the clinical privileges currently held (civilian facility and military).
- (4) DA Form 5754 signed within 60 days of ICTB submission.

(5) Two peer recommendations, dated within 24 months of submission, for providers who do not hold current military clinical privileges. (See para H-3b(10) for additional detail.)

(6) Authorization for release of information signed by the provider (may be specific to the gaining MTF, if provided).

c. USAR/ARNG providers will not be accepted for IDT, ADT, AD for special work, or AT as privileged providers until the AA MTF notifies the provider's parent unit that privileges have been awarded.

d. AA MTF commanders will ensure that USAR/ARNG privileged provider ICTBs are reviewed expeditiously and that prompt notice of this review is provided to the USAR/ARNG credentials manager. This will allow timely processing of personnel actions related to provider training by the unit. Delays in reviewing the ICTB and notifying the USAR/ARNG credentials manager that the documentation is in order could delay the provider's availability for duty.

e. Upon completion of the required training by USAR/ARNG providers, the AA MTF will forward a DA Form 5374, and any other specific privileged provider activity data to ARCCA, the appropriate unit commander, the administrative headquarters, or the credentials manager responsible for custody of the PCF. This information will be forwarded electronically or by mail; it will not be hand carried by the USAR/ARNG provider.

## **8-12. USAR/ARNG credentials and privileging for activation/mobilization**

a. Privileged providers who are activated on individual orders for a period that is less than 30 days will have an ICTB generated and forwarded with attachments to the gaining facility. The gaining facility is responsible for granting privileges, as appropriate, based on the ICTB.

b. For USAR/ARNG Soldiers mobilized for 30 days or more, the PCF manager will ensure that the PCF is current and complete and will initiate privileging actions by transmitting an ICTB with attachments to the gaining facility or by preparing the PCF for review by the local credentials committee.

c. Commanders of units that are mobilized either as a derivative unit or as a total medical asset, and designated (typically in a field environment) to function independently of a fixed-facility MTF, are authorized to grant clinical privileges for their assigned providers. The privileging process as described in paragraph 9-6a will be followed.

d. Mobilized providers that are assigned to, or within the area of operations of, a fixed-facility MTF (AA) will be granted privileges by the commander of that MTF.

e. USAR/ARNG providers participating in clinical training (prior to arrival in theater) for which privileges are required will be granted privileges for these activities by the facility conducting the training. An ICTB with appropriate attachments will be prepared and transmitted to the gaining/training MTF. The commander of the gaining/training MTF will grant privileges, as appropriate, based on the ICTB.

f. Medical personnel assigned to nonmedical units will request guidance from their higher headquarters as to the privilege granting authority in their given situation. If patient care activities are included in the provider's description of duties, the prescribed credentialing and privileging processes will be followed regardless of the unit of assignment or the mobilization assignment. Privileges should be granted prior to the provider's arrival in theater.

g. For mobilized USAR privileged providers in TPUs, ARCCA will retain control of the PCF during the period of mobilization; HRC-St. Louis will do this for IRR members; and, the AA unit credentials manager will perform this function for IMA providers. The ARNG unit PCF managers are responsible for the PCF during periods of ARNG provider mobilization. Transfer of the PCF to the Soldier's unit of assignment within the theatre of operations is not authorized.

h. During the period of mobilization, credentialing actions that can reasonably be completed by the PCF manager should continue. This includes, but is not limited to, PSV of license and certification renewals.

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OFFICE SYMBOL

Date

MEMORANDUM FOR Commander, United States Army Recruiting Command,  
ATTN: RCHS-OPS (Credentials), 1307 Third Avenue, Ft Knox, KY 40121-2726

SUBJECT: Request for Credential Documents

1. Request credential documents according to AR 40-68 for the following individual:
  - a. Name: (provide first and last name and middle initial)
  - b. Social security number (SSN): (provide full SSN)
  - c. Corps:                      AOC:
  - d. Date assigned to your organization:
2. Request documents be forwarded to: (provide complete mailing address to include room number and name of person receiving credentials).
3. POC is (provide POC name) at telephone (DSN and commercial), or e-mail (provide e-mail address).

## SIGNATURE BLOCK

Figure 8–1. Sample format for request of new accessions credentials from USAREC (HSD)

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## Chapter 9 The Privileging Process and Medical Staff Appointment

### 9–1. 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 (MTF/USAR/ARNG unit commander/State Surgeon). 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 chapter 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 chapter 10.

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. DA Form 5440-series 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 MTF's scope of services, the provider's experience, and the DOD beneficiary healthcare requirements.

*Note.* While the criteria for award of privileges and the specific privileges pertinent to each department are the responsibility of the department/service chief, the MTF commander is the clinical privileges approval authority within the MHS.

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 the MTF and in MTF controlled outlying locations.

f. Where full performance in a given GS civilian position requires the incumbent to be privileged, obtaining and maintaining clinical privileges in good standing is deemed a condition of employment.

(1) In this regulation, "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 MTF commander 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 are not required (may be voluntary or involuntary).

*Note.* 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. (See paras 9-4d(2) and 9-4e.) For USAR/ARNG providers, see para 9-8d(1).) 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 (for example, commander, USAREC or Office of TSG staff officer, or AMEDD Center and School instructor) 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.

## **9-2. 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 regulation, 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 therapists, 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 chap 7) and SBBs.

b. 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.

c. Special privileging considerations are as follows.

(1) *Commander and deputy commander privileges.* Approval of privileges (to include periodic privilege renewal) and appointment to the medical staff for the DCCS and the commander (and comparable dental positions) will be as follows.

(a) The commander/DCCS will submit his/her application for privileges and request for medical/dental staff appointment (DA Form 4691-1 (Application for Renewal of Clinical Privileges and Staff Appointment)) through the appropriate department chief.

(b) The DCCS is excused from the credentials committee meeting (if he/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/dental staff appointment for the DCCS (or like DC position) will be submitted through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the local MTF commander for approval/disapproval.

(d) For commanders, the credentials committee recommendations regarding clinical privileges and medical/dental staff appointment and all supporting provider documentation will be forwarded by certified return receipt requested mail as noted below (by healthcare facility type)—

1. *Freestanding ambulatory/health clinic, MEDDAC, and DENTAC.* Documents will be forwarded to the responsible RMC/RDC commander.

2. *121 General Hospital.* Documents will be forwarded to Commander, 18th Medical Command, Unit 15281, APO AP 96205-0054.

3. *MEDCEN, RMC/RDC, and major subordinate command.* Documents will be forwarded to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or the Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004.

4. *18th Medical Command.* Documents will be forwarded to TSG, 5109 Leesburg Pike, Skyline 6, Room 684, Falls Church, VA, 22041-3258.

(2) *Emergency or disaster situations.* Scope of practice limitations as defined by the clinical privileges granted by the MTF 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 DODD 5154.24, authorizes medico-legal death investigations for all DOD MTFs. The range of support includes onsite autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners hold privileges granted by the AFIP. 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 and the Armed Services Medical Regulating System.* Organ donation and transplant conducted by organ and tissue procurement teams, and the related treatment provided within MTFs by personnel assigned to the Armed Forces Medical Regulating System, is addressed in DODD 6465.3. 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 MTF commander 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 providers—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 manual 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 MTF 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 MTF, 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 that 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.* MTF commanders will ensure that new technology (for example, excimer lasers) does not

surpass the staff's abilities. MTF commanders 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 nonprivileged support staff. Adverse patient outcomes involving equipment malfunction will be reported according to MTF policy and will include notification of the PS manager/risk manager. (See para 12–10.)

(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/dental 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 Health Insurance Portability and Accountability Act (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 MTF; 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-conference 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 MTF. In such cases, the MTF must obtain and maintain a copy of the ICTB and delineation of privileges from the provider's MTF 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 between MTFs and/or other military organizations, for example, AFIP. When the telemedicine service is provided via contracted services, regardless of the type of service in question, the providers must be privileged by the receiving MTF. In instances where the contract for services described in paragraph 3 is with a civilian hospital accredited by TJC, the receiving MTF need not privilege the providers if provider information equivalent to that on an ICTB and his/her delineation of current privileges from the hospital are obtained and maintained on file at the 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/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/her clinical privileges, as appropriate. For further information, see chapters 10 and 11.

(c) *Providers assigned to a geographically separated unit.* The host unit with privileging authority is responsible for maintaining the provider's PCF and for awarding clinical privileges and a medical staff appointment if requested by the provider.

(d) *Oral surgeons.* The organization (AA/USAR/ARNG) to which a dental officer is assigned has primary responsibility for managing the oral surgeon's PCF, verifying credentials, and awarding clinical privileges and dental staff appointment, as appropriate. For the oral surgeon with duty at a facility other than the dental unit of assignment (that is, a MEDDAC or MEDCEN), an ICTB and all appropriate attachments (see para 8–10b (AA) or 8–11b (USAR/ARNG)) will be provided for use by that organization in awarding clinical privileges/staff appointment.

(e) *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.

(f) *Complementary and alternative medicine.* Application and/or use of these techniques and therapies (acupuncture, homeopathy, massage therapy, and so forth) are gaining acceptance within the MHS. 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 relative to new procedures detailed in paragraph (6)(a) above.

### **9–3. 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. Privileges may be granted with or without an accompanying appointment to the medical/dental staff. 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 MTF 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 in paragraph 9-5d.

*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 MTF 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. See paragraph 5-3 for additional information regarding supervision of practice.

(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. (See para 9-4e for additional information regarding enhanced supervision.)

(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 chapter 4. These providers may request regular privileges and a medical/dental staff appointment once a license is obtained.

## **9-4. The clinical privileging process**

*a. Forms required for award of privileges.* Performance data and other information (appropriate DA forms) 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 (see para 9-4c(6)), PCS, or separation from service/employment. The original will be placed in the PCF with a copy furnished to the provider.

*Note.* Providers will transition to use of the revised privileging documents addressed below at their next reappraisal/reprivileging opportunity.

(1) *DA Form 4691.* DA Form 4691 provides a synopsis of the provider's education and experience at the time of initial application for clinical privileges and medical staff appointment (if applicable). It includes professional education, postgraduate training, previous clinical assignments, specialty board certification, professional society membership, and credentials action history. For the provider with continuous Federal service, DA Form 4691 is completed only once, at the provider's first military duty station or place of DOD employment. For all categories of providers with noncontinuous Federal service (that is, there is a lapse in clinical privileges/staff appointment within the DOD), this form must be completed if the interval between periods of service is greater than 180 days. Initial clinical privileges

and medical staff membership are valid for a period of 1 year. During this 12-month period, regularly scheduled evaluation of the provider's performance is required.

(2) *DA Form 4691-1 (new)*. DA Form 4691-1 is used by providers with continuous Federal service, or a lapse in periods of service of less than 180 days, to request renewal of clinical privileges and medical staff reappointment. Information entered on this form relates to the provider's professional activities (for example, education, experience, professional recognition, and so forth) since the previous application for clinical privileges and medical staff appointment.

(3) *DA Form 5374*. This form contains provider-specific performance data, both qualitative and quantitative. It is used to evaluate the provider's demonstrated clinical performance according to established standards and compared to that of his/her peers. In conjunction with DA Form 5441-series, this two-page assessment contains evidence of the individual's competence, skills, and abilities, and provides objective and subjective data upon which to base award/renewal of clinical privileges and appointment/reappointment to the medical staff.

(4) *DA Form 5440*. The appropriate discipline-specific DA Form 5440 (as delineated in app A) will be used to document the request by the provider for clinical privileges and the recommendation for approval by the department/service chief and the credentials committee. Any variance between the privileges requested by the provider and the privileges recommended for approval by the supervisor should be discussed prior to submission of the DA Form 5440. Any unresolved discrepancies must be explained in Section II, Comments, for consideration by the credentials committee. These forms may contain categorical (patient risk and provider training requirements) and itemized disease and procedure-based privileging information by discipline. The disease-related and procedural content of this form will be individualized to address the current competency of the provider requesting privileges as well as the needs and capabilities of the MTF. The requirements for residency training and board certification as stated on the DA Form 5440 cannot be changed at the local level. The entire DA Form 5440-series is available in the AMEDD Electronic Forms Support System and at [http://www.apd.army.mil/USAPA\\_formsPUBformrange\\_f.asp](http://www.apd.army.mil/USAPA_formsPUBformrange_f.asp) for printing and/or local reproduction on 8½- by 11-inch paper.

(5) *DA Form 5440-22 (Delineation of Clinical Privileges)*. This blank form is used as a continuation sheet for those providers completing their discipline-specific DA Form 5440 and for expanded role functions or practice specialties not otherwise included in the DA Form 5440 series (for example, endocrinology, adolescent psychiatry). This form is available for customized use, as needed.

(6) *DA Form 5440A*. DA Form 5440A is used to record executive-level medical staff recommendations and decisions by the commander concerning the clinical privileges and medical/dental staff appointment (if applicable) of all privileged providers.

(7) *DA Form 5441*. The discipline-specific DA Form 5441 will be used to evaluate the provider's competence and skill in the performance of his/her clinical privileges. Appendix A contains a listing of forms in the 5441-series. The content of this document corresponds to the privileges of the specialty as outlined on the DA Form 5440.

(8) *DA Form 5753 (USAR or ARNG Application for Clinical Privileges to Perform Active or Inactive Duty Training)*. This form is obsolete and is replaced by revised DA Form 4691 (for initial privileges) or DA Form 4691-1 (for privilege renewal) which are used for clinical privileging by both AA/USAR/ARNG.

(9) *DA Form 5754*. All privileged providers will complete a DA Form 5754. DA Form 5754 provides information on licensure, malpractice, clinical privileges, and conditions that may impact the individual's ability to deliver care. The form is completed as part of the initial application for clinical privileges and at each subsequent renewal of privileges.

*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 following:

(a) DA Form 4691.

(b) The appropriate DA Form 5440 with the provider completing the column on the left side of the form by properly coding the specific category of privileges requested, if applicable, and each individually listed privilege.

(c) For the newly graduated provider requesting privileges for the first time, DA Forms 5440, 5441, and 5374, if available, (prepared by the clinical director/faculty) document his/her competence, skill, and ability in the training setting. (See para *h(3)* below.) For providers currently involved in civilian practice or those with a lapse in privileges/staff appointment in the DOD of greater than 180 days, the most current evaluation of clinical performance (DA Forms 5441 and 5374) and peer recommendations contained in the PCF will substitute.

(d) DA Form 5754 completed and signed by the provider.

(e) All verified/validated credentials and other documents, as required in paragraph 8-7.

(f) Evidence that a CHBC has been initiated as per the Crime Control Act of 1990 (42 USC 13041) and AR 608-10 for individuals (contract/volunteer) who provide healthcare or other services for children under the age of 18 years. (Also see para 8-7o.)

(2) The request will be reviewed by the department or service chief who will properly code each category, if applicable, and privilege in the appropriate column of the DA Form 5440. 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 MTF credentials committee/function for review.

(3) The provider’s validated credentials (para 8–7) and the completed DA Forms 4691 and 5440-series serve as the basis for the granting of clinical privileges. The credentials committee/function will forward its recommendation for clinical privileges and medical/dental staff appointment (if applicable) through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the facility commander.

(4) The commander is the approving authority for the award of clinical privileges and medical/dental staff appointment. The commander’s signature on DA Form 5440A authorizes clinical privileges and staff appointment, if appropriate, based on the individual provider’s licensure, education and training, experience, and his/her demonstrated professional competence.

(a) DA Form 5440A will be used to record the executive level medical staff recommendations and the commander’s decision concerning the clinical privileges and medical/dental 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) The type of medical/dental staff appointment, if applicable, will be recorded in Block 6b, DA Form 5440A.

(c) Block 6c of DA Form 5440A will reflect the current recognized privileging category. Block 6d notes admitting privileges.

(d) Signature by the department/service chief and the chairperson of the credentials committee affirms that a review was made of the provider’s primary-source-verified licensure, education and training, experience, capability to perform the requested privileges, and documented current competence. Age groups for whom the provider will render healthcare services are indicated in block 6g. Any age or patient population-specific comments will be included in block 7.

(e) For providers who are assigned to one department/service/clinic and request privileges in another, the discipline-specific DA Form 5440s will be submitted; the appropriate chiefs in both departments/services/clinics will be named and will sign the DA Form 5440A. Block 7 may be used for the additional signatures.

(f) 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 the AMEDD, lack of provider credentials, lack of demonstrated competency, or lack of professional performance.)

(5) The authenticated copies of DA Forms 5440 and 5440A serve as notification to the provider of the award/renewal of his/her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared. (See fig 9–1.) The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager. (See fig 9–2.) The original DA Forms 5440, 5440A, 4691, and 5754 will be maintained in the provider’s PCF with copies returned to the provider.

*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/her clinical privileges and medical/dental staff appointment (if applicable) every 2 years. The request for renewal will be submitted far enough 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, DA 4691–1 will be submitted. Appropriate attachments include a new DA Form 5440 and 5754 completed and signed by the provider and DA Forms 5441 and 5374 prepared by the individual’s department/service chief.

(4) DA Form 5441 documents the assessment of the provider’s performance of currently assigned privileges and his/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. (See app A for a complete listing of the DA Forms 5440 and 5441 series.)

(a) The “privileges performed” and evaluated on DA Form 5441 must be identical to the “privileges delineated” as requested on DA Form 5440.

(b) When privileges are to be modified because of the performance reappraisal, the reason will be stated under “Comments” on DA Form 5441.

(c) DA Form 5374 will be used to 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. The comparative analysis that is performed should contain both intra- and inter-facility data.

(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 (see para *e*, below), or remedial training may be warranted (para *f*, below).

(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 DA Forms 5440 and 5440A serve as notification to the provider of the renewal of his/her clinical privileges and medical staff appointment. A cover memorandum to the provider may also be prepared. (See fig 9-1.) The provider must acknowledge receipt of these documents by signed memorandum returned to the PCF manager. (See fig 9-2.) The original DA Forms 5440, 5440A, 5441, 4691-1, and 5754 will be maintained in the provider's PCF with copies returned to the provider.

*d. Application for renewal of privileges following PCS or permanent transfer.*

(1) Upon notification of the provider's impending PCS/transfer to another MTF, the losing unit will complete new DA Forms 5441 and 5374. The biennial appraisal will be considered current if it was completed within 6 months of departure. The credentials manager of the losing MTF 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 MTF will use this documentation as the basis for initiating clinical privileging and medical/dental staff appointment actions. The PCF will include the most recent clinical performance appraisals (DA Forms 5441 and 5374), even if the provider transfers to a leadership or administrative position involving no clinical practice or to student status (see para 9-5).

(3) With the release of CCQAS version 2.6, the data contained in this restricted-access data base—in conjunction with DA Forms 5374 and 5441—will facilitate the privileging of newly assigned providers. Preliminary review of credentials for privileging and medical staff appointment can begin in advance of the provider's actual arrival or the facility's receipt of his/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/dental staff appointment. The request will include the documents noted above. Transfer between AMEDD facilities is considered continuous DOD service under the same GB (TSG) and, provided the stipulations of paragraph *a*(1), above, are met, renewal of provider privileges and professional staff reappointment are appropriate.

(6) The provider (AA/USAR/ARNG) will apply for privileges immediately but in no case later than 5 duty days (10 duty days for OCONUS providers) following arrival. The USAR/ARNG privileged provider will meet with the unit credentials manager as soon as possible to submit his/her credentials for review and to apply for unit-level privileges, if appropriate. 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/dental 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 TDY 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/her clinical practice skills.

(3) Although only the initial category of medical/dental privileges/staff appointment specifically requires review of the medical/dental staff member's performance, this does not preclude enhanced supervision or performance review of providers in an active, affiliate, or temporary appointment status or providers who do not have a medical/dental staff appointment.

(4) Routine, ongoing performance assessment is the basis for all PI activities and is essential for providers with all types of medical/dental 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 block 6e of DA Form 5440A. 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 10-6f(5).

*f. Formal remedial training program.*

(1) When a provider with clinical privileges fails to maintain required proficiency levels to practice in his/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. (See para 10-6f(5).) 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 TDY.

(5) Requests for remedial training will be initiated by the provider's current MTF commander and forwarded through the next higher headquarters to Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Requests concerning dentists will be forwarded to the Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234-6004. 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 TSG by the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or the Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234-6004 in consultation with the appropriate specialty consultant to TSG.

(a) The decision will be coordinated with the MTF commander or designee, the MTF commander or designee at the training site, and, if necessary, the Health Services Division, HRC (TAPC-MSR), 200 Stovall Street, Alexandria, VA 22332-0002.

(b) The respective corps chief or designee has final approval of the remedial training plan.

(c) The Chief, QMD, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 will be kept informed of the privileged provider's progress in the remedial program and the ultimate outcome.

(7) Generally, an individual identified as needing remedial training will be assigned to an MTF that is at 85 percent or higher fill against the authorizations in his/her specific AOC or as determined by the TSG consultant in the AOC/ASI. At the time the provider in remedial training returns to full practice, he/she may be slotted against a valid authorization. The provider may be retained at the facility that provided the training, returned to his/her original unit, or reassigned to a new duty station. Coordination for reassignment will be accomplished by HRC in conjunction with the appropriate TSG specialty consultant.

(8) Providers who do not successfully complete remedial training may be processed for separation under the provisions of AR 600-8-24 or AR 135-175, as appropriate.

(9) 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. The USAR/ARNG provider who wishes to re-establish clinical competency may request, through his/her chain of command, an AT opportunity for skills enhancement purposes.

*g. Modification of privileges at the request of the provider.*

(1) If a provider requests modification of his/her clinical privileges for the upcoming period, a new DA Form 5440 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 members of their specialty AOC or skill identifier (SI) 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 DA Form 5440. 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 AOC or SI 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 to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Such actions may require subsequent reporting to the NPDB according to paragraph 10-12a(1).

*h. GPHE participants.*

(1) *Supervision.*

(a) Physician and dental providers with regular privileges in the same AOC or SI and an active appointment on the medical/dental staff will supervise MC/DC 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 AOC/SI 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 para 5-3b(2)(a) for 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. (See AR 40-66 for instructions on the use of these forms.) 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 will also be filed in his/her PAF.

(4) *Clinical performance evaluation.* Prior to completion of the clinical training program, trainees will submit the appropriate discipline-specific DA Form 5440 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/her current level of competence related to privileges appropriate to his/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, DA Forms 5441 and 5374. 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/her performance during training. DA Forms 5440, 5441, and 5374 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 MTF GPHE committee does not exist, a comparable line of academic authority must be locally established based on the availability of professional resources. The MTF commander 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 DA Forms 5440, 5441, and 5374 will be forwarded by the supervisor through the credentials committee/function to the trainee's next unit of assignment.

(c) DA Forms 5440, 5441, and 5374 are available at Web site <http://www.apd.army.mil/>. Each corps will ensure that instructions for proper completion, authentication, and transmittal to the first unit of assignment are provided to military and GS civilian trainees enrolled in civilian GPHE/long-term health education and training clinical programs. The trainee will ensure that the completed documents are mailed by the authorized supervisor (program director/faculty member/preceptor) to the trainee's first unit of assignment (ATTN: MTF Credentials Office). These documents will not be relinquished to the trainee. The performance data contained on the DA Forms 5441 and 5374 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 AR 623-3.

(5) *Failure to complete.* In the case of a provider's failure to complete his/her training program or he/she is removed from a program for lack of competence or for disciplinary reasons, the details will be documented in the individual's TCF.

(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 paragraphs 9-7, 10-13, and 10-15.

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 AOC or SI 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 AOC or SI 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 DA Forms 5441 and 5374 which will reflect those clinical privileges warranted at the individual's MTF 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.

## **9-5. Medical/dental staff appointment**

a. Appointment to the medical/dental 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. DA Form 4691 or DA Form 4691-1, signed by the privileged provider and submitted to the credentials committee, is utilized to request clinical privileges and medical/dental staff appointment, if desired.

b. A medical/dental staff appointment reflects the provider's relationship with the medical/dental staff and the degree to which the provider participates in medical/dental staff surveillance and review as well as quality improvement activities related to the governance of the medical/dental staff.

(1) An appointment to the medical/dental 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) Medical staff membership is not required of individually privileged nonphysician providers who do not admit patients, but they may request membership, if desired.

(4) No provider with regular or temporary privileges is precluded from membership on the medical staff solely because of his/her professional discipline or specialty.

c. The applicant for medical staff appointment with accompanying privileges will be oriented to pertinent U.S. Army and MTF procedures, policies, and regulations governing patient care and medical/dental staff responsibilities and expectations. The applicant will acknowledge in writing his/her intention (an attestation) to abide by these standards. The MTF is responsible for providing each privileged provider, who is a member of the medical/dental 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 MTF. There are five categories of medical staff appointment.

(1) *Initial appointment.*

(a) An initial medical/dental staff appointment is granted to a provider when he/she is first assigned or employed in a DOD MTF. Or, if the provider (AA/USAR/ARNG) has not held a medical staff appointment in a DOD MTF 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/dental 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/her type of employment or relationship with the medical/dental 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/dental 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/dental staff, according to the needs of the Government, after successfully completing the initial appointment period. A provider who has completed an initial appointment period at another 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/dental staff members with active appointments will participate fully in appropriate activities of the medical/dental 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/dental staff, according to the needs of the Government, 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/dental staff nor expected to be a full participant in activities of the medical/dental staff. Affiliate appointments will not exceed a 24-month period without renewal.

(b) The category of affiliate member was created to relieve certain medical/dental staff members of the requirement to serve on medical/dental staff committees, including the ECMS/ECDS. Affiliate members may, therefore, be precluded from membership on the ECMS/ECDS and may be relieved of the requirement to participate in other medical/dental staff committees and activities. Affiliate members, however, will be encouraged to participate in department/service/clinic and medical/dental staff meetings and PI activities. Affiliate members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical/dental staff and are responsible for being knowledgeable of the same. The MTF will keep affiliate members informed of changes to the bylaws, rules, regulations, policies, and procedures of the medical/dental staff.

(c) Affiliate status may be considered for contracted staff, consultants, experts, staff in a TDY status, resource sharing personnel, part-time staff, USAR/ARNG providers performing individual duty for training (for example, monthly drills) at the MTF, and individual mobilization augmentees (IMAs). Also included are providers who are not nationals of the U.S. but are rendering care to DOD beneficiaries under an established U.S./foreign country MOU/MOA.

(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/dental staff. These providers do not share medical/dental staff responsibility to the GB for medical/dental staff surveillance, review, and quality improvement activities within the MTF; they are not authorized admitting privileges.

e. When a provider is privileged and appointed to the medical/dental staff, if applicable, the commander will advise the provider—in writing—of their defined privileges and the medical staff appointment that has been granted. DA Form 5440A will be utilized for this purpose, with or without a cover memorandum (see fig 9–1). The provider will acknowledge receipt of the privileges and professional staff appointment, if applicable, by signed memorandum.

## **9-6. Provider privileging for temporary duty and other actions involving the provider credentials file**

### *a. Provider temporary duty.*

(1) For providers on TDY for clinical practice to another MTF/unit, the information conveyed in the ICTB is the basis for making appropriate medical staff appointment and privileging decisions in an expeditious manner. The sending MTF commander, or designee, will ensure that all information communicated in the ICTB is accurate and will sign the document. The commander's signature imparts their recommendation for subsequent privileges. However, the gaining institution retains full responsibility and authority for making privileging decisions.

(2) The ICTB, which serves in place of documents contained in the PCF, is joined with the formal application for privileges (DA 4691 or DA Form 4691-1) 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 app H for guidance on the preparation of the ICTB.)

(3) 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.

(4) After customary departmental/service/clinic and credentials committee review and recommendation, and consideration of the facility's capability, the gaining MTF commander may grant privileges, with or without modifications, based on the approved privilege list from the sending MTF/unit. The gaining facility will use DA Form 5440A 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.

(5) 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/dental staff appointment (if applicable) at the sending MTF 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 to which an ICTB is sent to ensure updates on provider status are forwarded as required. The sending MTF will provide a new ICTB whenever the provider's privileges change (for example, renewal of privileges, adverse privileging actions, and so forth).

(6) Performance appraisals received by the provider while practicing under the authority of an ICTB will be maintained in the PAF and incorporated into his/her clinical privileges reappraisal process. The MTF (sending facility) credentials committee/function will accept provider performance appraisals/evaluations submitted on the other Services' forms.

*b. Administrative assignment.* If the privileged provider is assigned to a position outside an MTF involving no clinical practice (for example, USAMEDCOM, MRMCMC, AMEDD Center and School) or attends a civilian or military school (other than GPHE or other graduate level training for which clinical privileges are required), the PCF and CCQAS provider file will be forwarded to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 for other than DC providers. Dental officer files will be sent to Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234-6004. These files will be held until requested. If the provider applies for privileges at a local MTF while in an academic or administrative position, the facility credentials manager will request the PCF for clinical privileging and medical staff appointment, if appropriate. The PCF for the individual assigned to an MTF who is currently not involved in clinical practice will be retained in the local credentials office, and the CCQAS file will be maintained in active status at the MTF.

*c. 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 in paragraph *a*, above.

## **9-7. Separation of privileged providers**

*a. Military.* AA officers who experience a loss of professional qualifications will be processed for elimination in accordance with the provisions of AR 600-8-24.

*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/she may be separated under the provisions of Section 315.804, Title 5, CFR. 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 Title 5, Part 752, CFR. 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/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.

## **9-8. USAR/ARNG privileging procedures**

*a. Privileging at the unit-level.* The clinical privileging process for USAR/ARNG privileged providers will meet all the requirements addressed in this chapter. Privileging of USAR/ARNG commanders will be coordinated with the next higher medical headquarters or the State Surgeon's office, as appropriate.

(1) USAR/ARNG providers will complete DA Form 4691 at the time of initial application for unit-level privileges and submit it to their unit's credentials committee or other appropriate credentials committee. (See para 8-5d(1).) Members of the IRR will submit DA Form 4691 at the time of initial application to Commander, HRC, ATTN: AHRC-RSA-Q, 1 Reserve Way, St. Louis, MO 63132-5200.

(2) Other appropriate privileging documents as outlined in paragraphs 9-4a through c, will be used to request privileges at the unit level. Unit-level privileges will be based on mission and/or medical taskings from higher headquarters. The extent to which privileges are granted may differ based upon type and length of duty performed. For privileged providers assigned to the IRR who request duty at an AA MTF, HRC Quality Management Directorate will coordinate completion of the appropriate privileging documents with the AA MTF. (See para b, below.)

(3) The originals of each privileging forms (DA Form 4691, 4691-1, 5440, 5440A, and 5754) are maintained in the PCF with a copy furnished to the USAR/ARNG provider.

*b. Privileging for USAR/ARNG training or duty at AA MTFs.*

(1) The provider documentation that will be forwarded to the AA MTF includes an ICTB generated by the unit and the attachments as specified in paragraph 8-11b. The USAR/ARNG unit commander/State Surgeon will recommend privileges to be granted by the AA MTF based on recommendations by the unit's credentials committee. The AA credentials committee/function will integrate the ICTB with attachments provided by the USAR/ARNG unit into its routine privileging process.

(2) Given the organizational structure and mission of HRC and the NAAD, traditional credentials committee function is not practical. Thus the Director, Quality Management Directorate, HRC Health Services and the Commander, NAAD may recommend that privileges be granted based upon direct review of the PCF without the preliminary action (review and recommendations) by a credentials committee.

(3) USAR/ARNG providers who cannot supply documentation to support current clinical competence may be subject to an evaluative AT period of duty. This is not considered an adverse privileging action. There will be coordination between the unit of assignment/attachment and higher headquarters to identify the facility that will accommodate the healthcare provider for the evaluative period. At no time will this period of evaluation be less than 14 days.

(4) A current ICTB and other supporting documentation are required for each period of AT, ADT, or IDT except in situations where USAR/ARNG provider training occurs at the same AA facility, and his/her clinical scope of practice remains the same. In these situations, the period of clinical privileges may be up to 12 months if no professional staff appointment has been granted and up to 24 months if the provider holds a professional staff appointment.

(5) If the USAR/ARNG provider's scope of privileges is limited due to the inability of the AA MTF to support specific practices, the limitations will be annotated in the "Comments" section of DA Form 5440A. This is not considered an adverse privileging action and does not require reporting.

(6) If an USAR/ARNG provider's privileges are denied, or if in the performance of duty his/her privileges are restricted due to professional incompetence or misconduct, the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 will be notified according to paragraph 10-16b. The USAMEDCOM will then notify the following as appropriate:

(a) *IRR and IMA members.* Commander, HRC (AHRC-RSA-Q), 1 Reserve Way, St. Louis, MO 63132-5200.

(b) *USAR TPU members.* Through Commander, USARC (AFRC-MD), 1401 Deshler Street SW, Fort McPherson, GA 30330-2000 to the commander, unit of assignment/attachment.

(c) *ARNG.* Through the ARNG Readiness Center (NGB-ARS), 111 South George Mason Drive, Arlington, VA 22204-1382, to The Adjutant General, ATTN: State Surgeon and MILPO of the applicable State.

(7) USAR/ARNG providers with recurrent duty at the same AA MTF are eligible and may request an appointment to the professional staff as described in paragraph 9-5.

*c. Remote site training, medical site support, and tactical exercise support.*

(1) Remote sites are defined as USAR/ARNG training sites with troop medical clinics, physical examination sites, Army Materiel Command depots, semi-active Federal sites, medical readiness and training exercises, and field sites when conducting unit training.

(2) For remote sites that are under the command and control of an AA MTF, the MTF commander, as the DHS, is the privileging authority for all assigned providers. At sites located away from an AA MTF, USAR/ARNG providers may be granted privileges by the USAR/ARNG unit commander or State Surgeon to perform unit integrity requirements as identified in paragraph 1-4h(5). These USAR/ARNG providers are subject to credentials review and privileging according to chapters 8 and 9.

(3) The standard scope of practice for providers at these sites will be based on the appropriate DA Form 5440.

(4) Privileges may be granted by the appropriate GB (or designee) based upon the recommendation of the credentials committee. For RC, this responsibility is delegated to the unit medical or dental commander. There are four possible scenarios—

(a) The State Surgeon's credentials committee provides centralized credentialing for all healthcare providers in the State and recommends approval of privileges to the State Surgeon. The State Surgeon is the privileging authority.

(b) The participating USAR/ARNG medical unit has sufficient MC staff to form its own credentials committee. The committee reviews the provider's PCF and makes recommendations to the unit commander who is the granting authority for clinical privileges.

(c) The credentials committee of the medical unit at the next level in the USAR/ARNG chain of command (if the unit does not have its own committee) reviews the provider's PCF and makes recommendations for privileges to the unit commander who is the granting authority for clinical privileges.

(d) For deployment to a theatre of operation, USAR/ARNG providers will be privileged by the AA MTF privileging authority at, or responsible for, the deployment site. This will be accomplished using the ICTB with required attachments provided by the ARCCA or the individual State Surgeon's office. A copy of the ICTB and delineation of privileges granted by the MTF will be presented to the commander of the medical unit to which the individual is assigned.

(e) If the USAR/ARNG provider will be delivering healthcare at, or under the supervision of, an AA MTF, the MTF credentials committee will review the individual's ICTB and make recommendations to the MTF commander who is the privilege granting authority.

(5) For informational purposes, copies of the USAR/ARNG provider's privileges granted by the USAR/ARNG commander, any other relevant clinical privileging documentation, and the ICTB will be forwarded to the DHS within whose area the site is located or the exercise takes place.

*d. Evaluation of USAR/ARNG providers/activities.*

(1) Reappraisal and renewal or modification (augmentation or restriction) of clinical privileges will follow the guidance in this chapter. Evaluations will normally be performed during AT or following each AD period of 5 or more days.

(2) The appropriate DA Form 5441 will be used to evaluate each AD training period. For USAR/ARNG providers who participate in an inactive duty status, evaluation will be conducted following the completion of a minimum of 24 nonconsecutive inactive duty days. DA Form 5374 will be used to evaluate periods of IDT. This process allows the evaluation of performance to be completed, giving consideration to current policies regarding fragmented training or excused absences from training. The original copy of DA Forms 5441 or 5374 will be included in the PCF. If the PCF is maintained by the USAR/ARNG unit, these forms will be forwarded by the AA MTF credentials manager as soon after completion as possible. A copy may be attached to the ICTB maintained by the AA MTF. A copy will also be furnished to the USAR/ARNG privileged provider.

(3) Except for evaluations following each AD period of five or more consecutive days, evaluation of providers is required only once annually.

(4) For evaluation of medical or dental care providers at remote sites, the DHS may defer to the USAR/ARNG "on-site" medical unit commander. The medical unit commander may be required to certify by letter, at the completion of AT, that healthcare (as assessed by current, established, objective criteria) met the required standards. In other training units where the medical unit commander is unable to personally verify the quality of care being provided, the DHS has the following options:

(a) Conduct site visits using various staff representatives from the MTF.

(b) Accept certification by the on-site clinical officer in charge that the quality of care provided by his/her USAR/ARNG unit or privileged providers meets established performance requirements mandated by provider credentials, scope of practice, and current professional standards of care. This certification requires a medical or dental staff of three or more officers to conduct a quality-of-care review at the USAR/ARNG treatment facility.

(c) Require a retrospective medical record review by the DHS representative. A representative sample of medical records will be reviewed for quality, medical necessity, and appropriateness of care.

(5) DA Form 5374 and the appropriate DA Form 5441 will be used to record individual clinical performance evaluations based on type of duty as discussed above.

(6) State-owned and State-operated ARNG facilities will undergo periodic site evaluation visits from the area DHS (or representative) to enable the RMC commander to fulfill his/her technical oversight responsibility (AR 10-87).

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OFFICE SYMBOL (640-10e)

(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/dental staff, and approval by the commander, (MTF name), clinical privileges are granted as specified at enclosure (DA Form 5440-XX, Delineation of Clinical Privileges).

2. You are granted (specify category) privileges for the period (date) through (date) as specified on DA Form 5440-XX.

3. You are granted a/an (specify status) appointment to the medical staff for the period (date) through (date), as indicated on DA Form 5440A.

4. Two copies of this memorandum and attachments 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 (DA Form 5440-XX), a copy of the approval of clinical privileges/medical staff appointment (DA Form 5440A), and a copy of the plan of supervision, if applicable, are provided for your files.

Encls

1. DA Form 5440-XX

2. DA Form 5440A

3. Plan of supervision (if applicable)

Signature Block

Credentials Manager

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Figure 9-1. Sample format for memorandum notifying provider of clinical privileges and medical staff appointment status

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S: (Suspense date)

PROVIDER'S OFFICE SYMBOL (640-10e)

date

MEMORANDUM FOR Commander, MEDCEN, MEDDAC, or DENTAC and  
Address

SUBJECT: Receipt of Notification of Clinical Privileges and Medical Staff Status

I hereby acknowledge receipt of a copy of DA Form 5440A 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 (DA Form 5440-XX) (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)

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Figure 9–2. Sample format for provider memorandum acknowledging clinical privileges and staff appointment status

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## Chapter 10 Adverse Clinical Privileging/Practice Actions

### 10–1. General

This chapter 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 chapter may also apply to the nonprivileged professional. In those instances, the term, “professional” will be used. (See chap 6 for adverse practice action and peer review information regarding nonprivileged personnel.)

### 10–2. Command responsibility

*a.* Action taken on the part of the 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—

- (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 chap 11.)
  - (6) Documented alcohol or other drug impairment and the individual refuses/fails rehabilitation or a psychiatric disorder that is not responsive to treatment.
  - (7) Significant unprofessional conduct.
- c. The specific intent 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 delivered within the AMEDD.
  - (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 the professional actions and considerations from any associated administrative or legal considerations.
  - (6) To allow timely reporting of individuals to professional regulatory agencies, if required.
- d. When an MTF closes, careful attention will be given to the disposition of adverse privileging/practice action information. Records will not be destroyed. The credentials manager at the closing facility will forward all files, reports, and adverse privileging/practice actions information (archived and active) to the RMC/RDC. The RMC/RDC assumes responsibility for the resolution of any pending adverse action cases (privileging/practice or administrative) and the maintenance of all records, files, and reports.

### 10-3. Consultation and coordination regarding adverse privileging/practice actions

a. *With legal counsel.* Prior to proceeding with any adverse privileging/practice action addressed in this chapter, coordination should occur with the servicing SJA. This includes actions of abeyance, summary suspension of clinical privileges, investigations/inquiries, removal of the provider/professional from patient care, and any letters of notification. SJA 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 local SJA is also encouraged to help ensure that the legal guidance regarding the action(s) underway is followed throughout.

b. *With the RMC/RDC and others.*

(1) *All categories of employees.* The RMC/RDC will be notified early in the adverse privileging/practice action process for guidance on procedures and to discuss a plan of action. As the primary POC for subordinate units on policies and procedures related to an adverse privileging/practice action, the RMC/RDC is responsible for oversight of the process. For providers/professionals assigned to MTFs within the region, the RMC/RDC will conduct the appeal of the commander's decision regarding an adverse privileging/practice action unless the MTF is a MEDCEN. For MEDCEN and RMC/RDC staff, the USAMEDCOM/USADENCOM will provide oversight and will conduct the appeal.

(2) *Civil service (GS) employees.* Consultation with the appropriate CPOC/CPAC employee relations specialist should occur prior to any adverse privileging/practice action (nonprivileged professional) being considered related to civil service employees. This consultation will help ensure that all established GS civilian employee guidelines are met.

(3) *Contract employees.* If an adverse privileging/practice action is being considered on a contract employee, the contract officer must be contacted before proceeding according to the provisions of the contract in place.

c. All adverse privileging/practice actions will be reviewed by the USAMEDCOM, Office of the SJA for legal sufficiency prior to final action by TSG.

### 10-4. Appropriate use of adverse privileging/practice actions

a. Adverse privileging/practice actions addressed in this chapter and any related administrative or legal actions must be handled separately. MTF and RMC/RDC commanders 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 and the provider/professional refuses to voluntarily modify or relinquish his/her privileges/scope of practice. 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/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/her privileges or scope of practice. This is considered an administrative action **not an adverse privileging/practice action**. The request with supporting evidence/information and the appropriate DA Form 5440 reflecting the modified privileges will be submitted according to local privileging procedures. The DA Forms 5441 and 5374 will be processed in the same manner as any other request for change of clinical privileges. See chapter 11 for further information regarding privileging actions and impairments.

d. Actions that do not meet these stated criteria may warrant authorized administrative or 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 MTF.

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 CJA will be notified and an adverse privileging/practice action initiated as soon as possible following initiation of the Criminal Investigation Division (CID) investigation. Concurrent action by the CID and the MTF will facilitate timely notification to outside agencies of those individuals for whom such notice is warranted. No reporting to regulatory agencies by the USAMEDCOM will occur until final resolution of the CID investigation and all relevant information concerning the incident is available to TSG.

#### **10-5. Other considerations related to adverse privileging/practice actions**

a. *Individuals providing implicating information.* The AMEDD will make all reasonable efforts 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. 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 MTF in which the alleged substandard performance or misconduct occurred, with assistance as necessary from the RMC/RDC. The MTF will notify the provider/professional of the allegations under review and will afford the individual the opportunity to supply information on his/her behalf. If the MTF is no longer operational, the RMC/RDC will assume these responsibilities.

c. *Allegations involving the MTF commander.* When information arises on a privileged commander's clinical performance, conduct, or condition that may bear on his/her suitability for professional practice, the DCCS (or dental equivalent) will notify the RMC/RDC who, in turn, will notify the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004. The RMC/RDC is responsible for any adverse privileging/practice actions involving its subordinate MTF commanders except MEDCEN commanders. The USAMEDCOM QMD or USADENCOM is responsible for any adverse privileging/practice action involving RMC/RDC or MEDCEN commanders.

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 regulation 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 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. The commander must also notify any MTF (or civilian treatment facility) where the individual (military or civilian) is employed of a summary suspension of clinical privileges/practice. Coordination with the CJA is encouraged to ensure the Privacy Act rights of the provider/professional are not violated in the notification of off-duty employers. (See AR 40-1, para 1-8, for guidance regarding off-duty civilian employment.)

(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 appendix I.

(4) The contractor will be notified for contract employees.

(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 local level, and by appropriate USAMEDCOM QMD staff, to assist in the investigation of the incident(s) by State boards or other

regulatory agencies. Information made available to licensing/regulatory bodies will be provided only by the USAMEDCOM QMD.

## **10-6. 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/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. However, the individual is formally placed "on notice" that scrutiny of his/her practice has begun which may result in an adverse privileging action or other administrative action. The commander, DCCS, or department chief may take this action against a provider/professional.

(2) An abeyance action is taken by the appropriate 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. DD Form 2499 will be initiated and forwarded (for informational purposes only) to the USAMEDCOM QMD, with copy furnished to the RMC or other higher headquarters, as appropriate.

(3) An abeyance is valid for 15 calendar days and may be extended by the commander, if required, provided the total period of abeyance does not exceed 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/her relationship with the MTF (that is, resigns his/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 chapter 14.

*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 in paragraph *a*(3), above, a summary suspension is automatically imposed 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 and this 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) The commander will invoke the summary suspension of clinical privileges/practice. This immediately details the individual in question to nonclinical duties. Specific instructions to the provider/professional related to his/her duty will be included in the commander's 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 (see para 14-3b), summary suspension of clinical privileges within the DOD is not reported to the NPDB. DD Form 2499 will be initiated (informational purposes) and forwarded to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with copy furnished to the RMC or other higher headquarters, as appropriate. At the conclusion of the period of summary suspension, if the case is unsubstantiated or unfounded, all documentation associated with this action will be destroyed. No information concerning this incident will be entered into the PCF.

(3) A suspension of privileges (final determination) is an adverse privileging action and, therefore, 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 within 14 calendar days that his/her clinical privileges/practice have been placed in abeyance/summary suspension. The memorandum (see fig 10-1)—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 are 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. (See para a(4), above.) The provider will acknowledge receipt of this notification by signed memorandum. (See fig 10-2.) If the provider refuses to sign the memorandum, a responsible official may indicate "refused to sign" where the signature would normally appear.

(2) RMC/RDC and USAMEDCOM/USADENCOM notification.

(a) The MTF commander will notify the USAMEDCOM and the next higher headquarters 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) Other available information regarding 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, will be transmitted electronically to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with copy furnished to the RMC or other higher headquarters, as appropriate.

(c) The USAMEDCOM QMD is responsible for relaying information to TSG, as appropriate. Followup documentation on DD Form 2499 will be according to the requirements of paragraph 10-14.

*d. The 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 effort must be made to ensure a thorough, fair, honest, and unbiased review of the matter(s) under investigation.

(a) The MTF commander (designee) will appoint an officer (a disinterested third party), pursuant to the authority of this regulation, to conduct the investigation and to report the results to the credentials committee or for nonprivileged 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. However, if the individual is a member of the credentials committee, he/she is disqualified from any formal committee vote on this matter.

(c) To ensure a comprehensive, independent review of the event, the MTF commander may request that a provider/professional with the appropriate specialty background and credentials be made available from the next higher headquarters, or from another Service, 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 select circumstances, the 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 commander will be notified immediately. Other action (for example, Article 32 or AR 15-6 investigation) on the part of the commander may be appropriate. The servicing Judge Advocate shall be consulted.

*Note.* For nonprivileged 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 chapter 6 for information regarding nonprivileged 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 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 local policy. The appropriate authority, according to local policy, will ensure that the provider receives written notification of the forthcoming peer review (see fig 10–3) and is advised of his/her rights to due process.

(d) Other actions (administrative, personnel, civil, or criminal) be taken.

f. *The privileged provider peer review process.* (See chap 6 for peer review information pertinent to nonprivileged professionals.)

(1) *The 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/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 at any step in an adverse privileging action; however, the peer review is not a legal proceeding.

(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 fig 10–2.) 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/her rights regarding participation in the peer review proceedings, as noted in paragraph (1)(c), above.

(d) A POC (name, address, telephone, and facsimile numbers) to receive any written correspondence or provider-supplied information.

(e) Reference to the MTF 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 in paragraph (4) below.

(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 other MTFs to meet this requirement (that is, to conduct an internal peer review) or the case file and all supporting documentation may be forwarded to another MTF (military or civilian) for an external peer review to be performed. Local policy will stipulate 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 this function.

(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 action for possible future reference. The Army Records Information Management System (ARIMS) retention schedule at <https://www.arims.army.mil/specifies> the period of time this record may be kept at the MTF. 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 OERs or endorsing official for civilian performance appraisals.

(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 plays a significant part in 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 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 the USAMEDCOM QMD 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. (See para b(3), above.)

(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/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. (See para 10-7.) Prior to the hearing, the MTF may decide/notify/refer to this only as an 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 commander.

(7) *Action by the commander.*

(a) The commander 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 commander is not bound by the recommendations of the credentials committee or the peer review panel.

(b) The commander 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 fig 10-4). If the provider is a contractor, a copy of the notification is forwarded to the responsible contracting office, 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 commander must advise the provider in writing of his/her hearing and appeal rights. The commander 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.

(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 MTF commander may consider separation from service in a less-than-fully privileged status (military) or take appropriate action through the civil service system or the employee's contracting agency for failure to maintain conditions of employment (civilian/contract).

2. If the provider is to be retained on AD, appropriate personnel or administrative action will be taken to change his/her AOC or SI and discontinue specialty pay. The MTF commander will make his/her recommendation through the RMC, through the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 to HRC (TAPC-OPH) appropriate career branch), 200 Stovall Street, Alexandria, VA 22322-0417. The

DTF commander will make his/her recommendations through the RDC, through Commander, USADENCOM (MCDS), 2050 Worth Road, Fort Sam Houston, TX 78234-6004 through the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 to HRC (TAPC-OPH) appropriate career branch), 200 Stovall Street, Alexandria, VA 22322-0417. See paragraph 10-16e for guidance regarding USAR/ARNG personnel.

*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 chap 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 nonprivileged healthcare professional, a copy of the CQM QA investigation, peer review activity, and the subsequent recommendations for action provided to the commander, will be forwarded by the appropriate department chief to the credentials committee.

## **10-7. Provider hearing rights**

*a. Written notice of hearing rights.* Notification of the commander'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 fig 10-4). 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 commander. The same written notification requirement and time line exist when the CQM QA investigation suggests reasonable cause. When the commander'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 commander, and the right of the provider to request and to be present at a formal hearing.

(2) By signed memorandum, the provider acknowledges his/her receipt of this notification. (See fig 10-5.) Should the provider refuse to acknowledge receipt of written notice, a memorandum for record to make note of the refusal will be prepared.

*b. Provider participation.* If the provider wishes to request a hearing, he/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/her right to a hearing. This decision is final and not subject to appeal.

(3) If the provider waives his/her right to a hearing, recommendations from the credentials committee (and peer review panel if this review was conducted) will be forwarded to the MTF commander for review and decision. A copy of the commander'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 will result in a report to the NPDB according to paragraph 14-3b.

(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 commander 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/her personal participation will be offered (for example, written deposition, telephone conference call).

## **10-8. Hearing board procedures**

*a. The DCCS (or other physician designated by the commander) 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. Therefore, the rules of evidence prescribed for trials by courts-martial or for proceedings in a court of law are not applicable. For further guidance, see AR 15-6, paragraph 3-6. If criminal misconduct is suspected, the president of the board will seek the advice of the servicing judge advocate 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, AR 15-6 may be consulted, but its provisions are not mandatory.

*b. The chairperson of the hearing board will advise the provider in writing (fig 10-6), delivered in person, with*

provider receipt acknowledged by signed memorandum (fig 10–7), 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. For USAR/ARNG 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/her right to be present, to submit evidence, to question witnesses called, and to call witnesses on his/her behalf. The provider should be advised that he/she is responsible for arranging the presence of his/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 their servicing office of the SJA for legal advice if desired. Legal representation in this matter is not an entitlement but may be provided subject to resource limitations as determined by the supervisory judge advocate in the office of the SJA or Trial Defense Service. Providers may obtain advice or representation from civilian counsel at no expense to the Government. To determine if a provider is eligible to receive legal assistance, consult AR 27–3.

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 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 union counselor will be consulted before denying such a request.

(b) The role of the exclusive representative is not wholly passive, although he/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 advise the provider of his/her rights, using DA Form 3881 (Rights Warning Procedure/Waiver Certificate). (See AR 190–30 for instructions on the use of this form.)

(2) If an investigating officer was designated (see para 10–6d(1)), he/she may be called before the hearing committee to answer questions or to provide additional information. However, the investigating officer will not participate in the hearing board deliberations and he/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 10 USC 1102 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.

*Note.* 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 concerning legal questions from the servicing SJA office. The provider should be advised of any legal questions as they arise and the answers that were provided by legal counsel.

#### **10–9. Action on hearing recommendations**

a. The record of the hearing—including findings and recommendations—will be reviewed by the ECMS prior to being forwarded to the MTF commander.

(1) The hearing board record—to include findings and recommendations—shall be available for review by all qualified members of the ECMS prior to the case file being forwarded to the commander.

(2) All qualified members of the ECMS (excluding any hearing board members or any member that acted as the investigation officer) may either concur by endorsement with the recommendations or submit separate recommendations.

(3) If a member of the ECMS is absent (for example, through TDY or illness) when the hearing board report is forwarded, such absence will be noted and the case forwarded to the commander without action by the absent member.

b. The servicing SJA (or DA civilian attorney) 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 commander.

c. The commander 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 commander.

(2) Written notice of the commander’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 commander’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/her right of appeal. The notice should also advise the provider that, upon request, he/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.

#### **10–10. The appeals process**

a. When the MTF commander decides to suspend, restrict, reduce, revoke, or deny clinical privileges, the provider will be granted 10 duty days (extendable in writing by the commander for good cause) to submit a request for reconsideration to the MTF commander.

(1) If the provider does not request reconsideration, the adverse privileging action and all information pertaining to the case will be submitted to the USAMEDCOM QMD, with copy furnished to the next higher headquarters, for reporting to the NPDB. (See chap 14.)

(2) If the provider elects to appeal the commander’s decision, he/she will submit a formal request for reconsideration 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 MTF commander is granted 14 calendar days to consider the request. If he/she denies the request in whole or in part, the action will automatically be endorsed to TSG as an appeal. TSG is the final appellate authority for denying, suspending, restricting, reducing, or revoking clinical privileges.

c. The written appeal and all information pertaining to the case will be submitted through the appropriate RMC/

RDC commander using certified return receipt requested mail. The RMC/RDC commander will review the packet to ensure that all necessary information is included prior to forwarding the case to the appropriate staff office that will conduct the appeal.

*d.* The USAMEDCOM QMD will convene the appeals board for those appeals involving MEDCEN/RMC/RDC providers or commanders; the RMC/RDC is responsible for any adverse privileging action appeal from its subordinate MTFs. In either case, the appeals board will convene as soon as possible following receipt of all materials related to the adverse privileging action.

*e.* The appeals board will consist of a minimum of three privileged providers, one of whom will serve as the chairperson. The chairperson of the appeals board is a voting member. This may be the DCCS at the RMC level (comparable RDC position), or the Director, QMD at the USAMEDCOM level or other senior officer as deemed appropriate. It is recommended that at least one member be of the same discipline and specialty as the provider whose appeal is being considered.

(1) If the provider is a dentist with no medical facility privileges, the appeals board will consist of three dental officers.

(2) If the dentist has medical facility privileges and these privileges are subject to review, the committee will include one privileged physician and two dental officers. Ideally, one of these DC officers shall hold medical facility privileges. If action is being considered against a dental officer with hospital privileges, yet the action involves only the provider's dental privileges, the composition of the appeals board will be as described in paragraph (1) above. The dental provider will be afforded the same opportunity to submit written input for consideration by the appeals board.

*f.* 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 commander (USAMEDCOM/USADENCOM or RMC/RDC) of its findings and recommendations for disposition, and whether it finds substantial evidence to support the MTF commander's adverse privileging action. For RMC-level appeals, the findings and recommendations of the board will be endorsed by the RMC commander and all documents considered by the board will be forwarded by certified return receipt requested mail to the USAMEDCOM for review and approval by the appellate authority (TSG). The findings and recommendations of the appeals board are advisory in nature and do not bind the appellate authority. TSG 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 regulation in the review process.

*g.* 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 RMC or MTF commander, as appropriate, will also be notified in writing. The appellate authority will provide clear guidance as to what actions the MTF is expected to take regarding the future utilization of the provider.

*h.* 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.

*i.* Administrative action to separate the provider as a result of an adverse privileging action under paragraph 10-12 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.

## **10-11. Civilian training**

If subsequent to an adverse privileging action the provider is not separated from Federal service and he/she seeks remedial training at a civilian institution, that institution will be notified of the adverse privileging action. Any remedial training must be approved by the MTF commander.

## **10-12. Separation from Federal service**

*a.* An AMEDD provider's loss of license or clinical privileges, or a professional's loss of license, is the basis for separation from military or civilian service. (See AR 600-8-24 and AR 135-175 (for officers) or AR 635-200 and AR 135-178 (for enlisted).) 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.

(1) 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 TSG is authorized to report AMEDD healthcare personnel 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).

(2) 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.

b. The facility that initiated the adverse privileging/practice action will be responsible for finalizing all details associated with the action. This includes followup administrative procedures for a provider/professional who has been detailed to another facility for evaluation and found unfit for duty. In this instance, the individual will also be advised of his/her rights of due process.

### **10-13. Separation of a criminally charged provider**

In accordance with AR 600-8-2, flags will be submitted when an unfavorable action or investigation (formal or informal) is started against a Soldier by military or civilian authorities. Soldiers will not automatically be held beyond their expiration term of service (ETS), expiration of service agreement (ESA), or mandatory release date (MRD) pending completion of an investigation or privilege/licensing action, even if they are flagged. All investigations or privilege/licensing actions must be completed prior to ETS/ESA/MRD, or authority must be obtained from the General Court-Martial Convening Authority or Headquarters, Department of the Army (HQDA) to extend the ETS/ESA/MRD. In accordance with AR 600-8-24, paragraph 1-16, an officer under investigation or pending court-martial will not be separated without HQDA approval. In the case of civilian personnel, the management employee relations specialist at the servicing CPAC should be contacted for guidance.

### **10-14. 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 MTF has not already done so, with the DD Form 2499 to the USAMEDCOM/USADENCOM. A copy of these documents will also be furnished by the MTF to the next higher headquarters.

(2) The MTF commander 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 mailed to the USAMEDCOM 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 the next higher headquarters (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 commander 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) MTF commanders will forward the DD Form 2499 to Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with copy furnished to the next higher headquarters.

(b) DTF commanders will forward the DD Form 2499 through the Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004, with copy furnished to the next higher headquarters. USADENCOM subsequently forwards the report to USAMEDCOM (MCHO-CL-Q).

(c) The RMCs and RDCs are responsible for administrative review to ensure completeness of the DD Form 2499 and all enclosures and other guidance as appropriate.

(d) 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 the USAMEDCOM (MCHO-CL-Q)/USADENCOM (MCDS) with copy furnished to the next higher headquarters. 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 MTF commander approves total or partial restoration of clinical privileges/practice that had previously been removed, DD Form 2499 will be submitted to USAMEDCOM (MCHO-CL-Q), with copy furnished to the next higher headquarters.

(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 MTF commander.

The same requirement to report applies to nonmilitary providers working at civilian facilities. This is the only exception to TSG as the information-releasing authority.

#### **10–15. Reportable acts of unprofessional conduct**

a. Healthcare providers who are involved in any of the unprofessional acts/activities listed in appendix I, or similarly unprofessional actions, will be evaluated by the credentials committee (by the peer review panel and department/service chief for nonprivileged) and appropriate adverse privileging or practice recommendations will be made to the commander. 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 (see para 10–14b), 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 commander will notify any civilian facilities in which the individual is engaged in off-duty health-care-related employment of the aforementioned. (See para 10–5e.)

c. A DD Form 2499 will be submitted on privileged providers and other nonprivileged 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.

#### **10–16. USAR/ARNG provider/professional adverse privileging/practice actions**

a. USAR/ARNG providers/professionals are subject to denial, suspension, restriction, reduction, or revocation of clinical privileges/practice according to paragraph 10–4b.

b. If a military agency initiated the adverse privileging/practice action, that agency will forward the DD Form 2499 to Commander, USAMEDCOM, ATTN: MCHO–CL–Q, 2050 Worth Road, Fort Sam Houston, TX 78234–6010 or Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234–6004, with copy furnished to the RMC or next higher headquarters, as appropriate. The USAMEDCOM will notify the appropriate regulatory authorities, medical commands, and the major Army 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 USAR/ARNG members performing duty (regardless of type) in an MTF, the commander of that facility will initiate the actions.

(2) For Active Guard Reserve members not assigned to a TPU, the actions will be initiated by the commander of the unit to which they are assigned or attached. Other Active Guard Reserve members are covered by the provisions of subparagraph (6) or (7) below.

(3) For IMA members, the commander of the unit to which they are assigned will initiate the actions.

(4) For IRR members not attached to a unit and assigned to the HRC (not performing duty), the HRC commander will initiate the actions.

(5) For IRR members attached to or performing duty at a TPU, if the individual is in a medical unit, the actions will be initiated by the unit commander. If the individual is not in a medical unit, the next higher medical command or the command having medical authority will initiate the actions.

(6) For ARNG members assigned to a medical unit, the unit commander will initiate the action. If the individual is not assigned to a medical unit, the State Surgeon or next higher command having a medical authority will initiate the action.

(7) For USAR members assigned or attached to a medical TPU, the unit commander will initiate the actions. If the individual is not assigned to a medical TPU, the next higher command having medical authority will initiate the actions.

c. For purposes of initiating adverse privileging/practice actions, processing appeals, and other appropriate followup action, if the next level of command is not a medical unit (or is a medical unit without sufficient medical assets assigned to convene the required committees), the higher commander having a medical authority will direct the appropriate assets from within his/her command to provide the necessary support.

d. When the USAMEDCOM is notified by a regulatory authority, to include the Federation of State Medical Boards or other sources, that an action was taken against an USAR/ARNG member, the USAMEDCOM (MCHO–CL–Q) will automatically notify the individual’s unit of assignment/attachment. Additionally, the National Guard Bureau, USARC, and/or HRC will be notified of adverse privileging/practice information relevant to their assigned personnel. Information from the regulatory authorities will be provided to the appropriate commands for review and action according to chapter 14 of this regulation and/or AR 135–175, if appropriate.

e. A USAR/ARNG provider/professional will be considered for reclassification, branch transfer, or separation if an adverse privileging/practice action was taken which resulted in a permanent restriction or revocation of clinical

privileges/scope of practice. USAR/ARNG commanders will review such assigned members and recommend disposition according to appropriate regulations, dependent upon the nature and merit of each case.

*f.* Hearing rights and the appeals process will be as described in paragraphs 10–8 and 10–10. TSG is the final appeal authority.

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(HEALTH CARE FACILITY Letterhead)

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Name, Grade, and Address of Provider/ Professional)

SUBJECT: Notice of Abeyance (Summary Suspension) of Clinical Privileges/Practice

1. Effective immediately (all) (a portion) of your clinical privileges/practice at (include facility 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 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) days (may not exceed 30) (summary suspension is indefinite, pending conclusion of due process proceedings, 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 proceedings related to this matter in a timely manner.
3. An abeyance that is not closed within 30 days will automatically become a summary suspension of clinical privileges. Summary suspension will be in effect while due process 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 allegations 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 peer review process as detailed in AR 40-68, chapter 10.
5. Should you elect to terminate your (military) (Federal) service prior to resolution of these matters, your (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.

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Figure 10-1 (PAGE 1). Sample format for memorandum notifying provider of an abeyance or summary suspension

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FOR THE COMMANDER (if authorized):

(Signature)

(Typed Name)

(Grade, Corps)

Chairperson, Credentials Committee

Figure 10-1 (PAGE 2). Sample format for memorandum notifying provider of an abeyance or summary suspension—  
Continued

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PROVIDER'S OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR: (Commander, Health Care Facility and Address,  
ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Abeyance (Summary Suspension) of Clinical  
Privileges/Practice

Receipt acknowledged. I understand that a CQM QA investigation will ensue  
and a peer review of my performance, conduct, or condition may be required. I  
also understand that I will be notified in writing should a peer review be  
scheduled so that I may attend and participate, as required.

(Signature of individual)

(Typed Name)

(Grade, Corps)

Figure 10-2. Sample format for provider memorandum acknowledging notification of abeyance/summary suspension

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(HEALTH CARE FACILITY Letterhead)

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR: (Name, Grade, and Address of Provider)

SUBJECT: Provider/Professional Notification of Peer Review

1. This is to inform you that on (date), the (credentials committee) (a credentials hearing board or 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 recommendation 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 (location) (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 additional information that you may wish to provide.
6. Should you have any questions, or need further guidance, you may access AR 40-68, Clinical Quality Management, in the (office of the Credentials Manager) (other location). (Note any other local references that may be useful to the provider.)

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Figure 10-3 (PAGE 1). Sample format for memorandum notifying provider/professional of a forthcoming peer review

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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

Figure 10-3 (PAGE 2). Sample format for memorandum notifying provider/professional of a forthcoming peer review—  
Continued

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(HEALTH CARE FACILITY Letterhead)

S: (Suspense date)

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Name, Grade, and Address of Individual)

SUBJECT: Notice of Proposed Adverse Clinical Privileging/ Practice Action by the Commander

1. You are hereby notified of my decision to (state adverse privileging/practice action proposed) your clinical privileges/practice at (FACILITY: State 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 action addressing all allegations). The period of this adverse privileging/practice 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, (must specify what privileges/practice are affected and what is expected as far as the provider's 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 AR 40-68, chapter 10.

5. In order 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 from 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 or dental authority.

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Figure 10-4 (PAGE 1). Sample format for memorandum notifying provider of a proposed adverse privileging/practice action

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(Signature of Commander)  
(Typed Name)  
(Grade, Corps)  
Commander

Figure 10–4 (PAGE 2). Sample format for memorandum notifying provider of a proposed adverse privileging/practice action—  
Continued

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OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Commander, Health Care Facility and Address, ATTN:  
Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Proposed Adverse Clinical Privileging/Practice  
Action by the Commander

Receipt acknowledged. The memorandum notifying me of the commander's proposed adverse action against my clinical privileges (and staff appointment)/practice is dated (date), and I received it on (date). I understand that I have 10 duty days to request a hearing, if I elect to do so, according to AR 40-68. 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 or dental authority.

(Signature of individual)

(Typed Name)  
(Grade, Corps)

Figure 10–5. Sample format for provider memorandum acknowledging notification of proposed adverse privileging/practice  
action

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(HEALTH CARE FACILITY Letterhead)

S: (Suspense date)

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Name, Grade, and Address of Individual)

SUBJECT: Provider/ Professional Notification of Credentials Committee/Other Committee Hearing

1. (The credentials committee) (a credentials hearing/other committee) will conduct a 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 hearing in sufficient detail. Include the date, identity, and location of the record of activities or the cases that are involved in the allegations, so that the provider/professional will be fully apprised of the matters under investigation.)
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 Office of the Staff Judge Advocate for legal advice. Legal representation in this matter is not an entitlement, but may be provided subject to resource limitations as determined by the appropriate supervisory Judge Advocate. 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 your 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 of 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.

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Figure 10-6 (PAGE 1). Sample format for memorandum notifying provider/professional of credentials/other board hearing

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FOR THE COMMANDER (if authorized):

(Signature)

(Typed Name)

(Grade, Corps)

Chairperson, Credentials Committee

Figure 10-6 (PAGE 2). Sample format for memorandum notifying provider/professional of credentials/other board hearing—  
Continued

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PROVIDER'S OFFICE SYMBOL(640-10e)

(Date)

MEMORANDUM FOR (Commander, MEDDAC, MEDCEN, or DENTAC and  
Address, ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notification of Credentials/Other Committee Hearing

I hereby acknowledge receipt of the subject memorandum, Notification of a  
Credentials/Other Committee hearing. The memorandum is dated (date) and I  
received it on (date).

(Signature of individual)

(Typed Name)

(Grade, Corps)

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Figure 10-7. Sample format for provider memorandum acknowledging notification of credentials/other board hearing

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(HEALTH CARE FACILITY Letterhead)

S: (Suspense date)

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR: (Name, Grade, and Address of Individual)

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 The Surgeon General (TSG) as an appeal. TSG is the final appellate authority for adverse action against your clinical privileges/practice.

(Signature of Commander)

Encls as

(Typed Name)  
(Grade, Corps)  
Commander

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Figure 10–8. Sample format for memorandum notifying provider of hearing board findings/recommendations

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PROVIDER'S OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Commander, Health Care Facility and Address,  
ATTN: Chairperson, Credentials Committee)

SUBJECT: Receipt of Notice of Hearing Board Results

Receipt acknowledged. The memorandum notifying me of the hearing board's actions/recommendations is dated (date), and I received it on (date). I understand that I have 10 duty days in which to submit a written statement to the commander of corrections, additions, or other matters for his/her reconsideration in this matter.

(Signature of provider)

(Typed Name)  
(Grade, Corps)

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Figure 10–9. Sample format for provider memorandum acknowledging receipt of hearing board findings/recommendations

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## **Chapter 11**

### **Managing Military Treatment Facility Personnel with Impairments**

#### **11–1. General**

Health status—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 chapter establishes policies and procedures for health-focused assessment and support activities provided by the MTF for its assigned personnel. The following guidance applies to MTF employees—both military and civilian (GS and personal services contract)—or employees who function in an administrative or ancillary services support capacity.

#### **11–2. The Impaired Healthcare Personnel Program**

*a.* Each facility will establish an Impaired healthcare Personnel Program (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 individual in question or place the patient or others at risk. The program will meet all the provisions of AR 600–85. (See DA Pam 600–85 for additional instruction and procedural guidance.) Medical and dental facilities that are co-located are encouraged to develop a single program that includes all eligible MTF participants.

*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 chapter, 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 individual’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, or there may be physical conditions that the individual 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 nonprivileged 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 DODD 6490.1 when a mental status evaluation is recommended.

*d.* Key participants in the process of identification, treatment, and the successful rehabilitation of healthcare personnel with an impairment include the RMC/MTF commander, the IHCPP members, alcohol and other drug rehabilitation counselors, medical resource personnel, supportive Family/friends, and the individual confronting and attempting to effectively deal with his/her impairment.

### **11–3. The composition, role, and function of the impaired healthcare personnel ad hoc committee**

The IHCP, 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 IHCP facilitates implementation of the guidelines set forth in AR 600–85 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 commander 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 IHCP chairperson will ensure that all assigned members receive an orientation to the duties and responsibilities of this committee.

*c.* The IHCP will meet as needed to accomplish the following functions:

(1) Recommend to the MTF commander a plan for management of healthcare personnel impaired by alcohol/other drug abuse/dependence, as well as psychiatric problems including emotional and behavioral disorders.

*(a)* Design a staff development plan that incorporates elements of impairment prevention, education about healthcare personnel impairment, and well-being issues.

*(b)* Recommend facility-specific procedures for management of IHCPs. Recommendations will be consistent with all requirements contained in both DODD 6490.1 and DODI 6490.4 when a mental status evaluation is considered for a healthcare provider, regardless of the reason for the evaluation.

*(c)* Evaluate any healthcare staff member reported, or self referred, for alcohol/other drug abuse/dependence for evidence of impairment.

*(d)* Recommend restrictions on the clinical privileges/practice of IHCPs. Recommendations for privileged providers will be forwarded through the credentials committee, and the ECMS/ECDS, to the commander. Recommendations for all others will be provided through the individual's department chief to the commander, with copy furnished to the credentials 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 MTF staff being followed by the IHCPP may be submitted to the commander.

*(e)* Monitor the progress of impaired individuals during treatment, through aftercare, until the completion of the ongoing monitoring phase.

*(f)* 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 IHCP will address whether to recommend full reinstatement of privileges or continuation of the monitored status by the State licensing board.

(2) 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 individual in question. One-on-one coordination, as required, may also occur between IHCP chairperson or committee member and the appropriate department chief.

(3) When impairment is due to alcohol or other drugs, the IHCP 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.

(4) In cases of medical or psychiatric impairment, the IHCP will review statements of progress and recommendations from the impaired individual's physician and duty supervisor and recommend appropriate actions.

(5) 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 individual's

privileges or scope of practice. If the provider is unable to fully perform his/her granted privileges or scope of practice, appropriate modification of the individual's privileges/scope of practice will be recommended to the commander.

#### **11-4. 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 IHCP. 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 Soldier's commander as an exercise of the commander's discretionary authority.

(1) The requirements, restrictions, and specific procedures associated with this type of evaluation are addressed in DODD 6490.1, DODI 6490.4, and current USAMEDCOM (MCHO-CL-H) guidance.

(2) The MTF commander will ensure that fully trained personnel and the necessary safeguards and performance review processes in support of the above mentioned guidance are in place within his/her organization.

*b.* The IHCP 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) A statement concerning current clinical performance from at least one immediate supervisor or professional peer. The statement must focus on how the medical or psychological condition reduces or prevents the individual's ability to safely execute his/her responsibilities in providing or supervising the delivery of healthcare. Any recognized deficits in medical knowledge, technical ability, performance, or judgment associated with the identified medical or psychological condition should also be addressed.

(3) Recommendations from the department/service chief regarding the impaired staff member's scope of clinical privileges/practice. These may be provided directly to the IHCP, 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/her clinical privileges/scope of practice. Department/service chief recommendations must take into consideration the best interest of quality care and PS.

*c.* The IHCP will review the information in paragraph *b*, above, and recommend modifications to clinical privileges or practice, as necessary. If the impaired staff member has privileges, these recommendations will be submitted through the MTF credentials committee and ECMS/ECDS to the commander. Otherwise, the recommendations will be made through the department chief to the commander. 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 commander decides to invoke an adverse privileging/practice action, notification of this action will be made according to paragraph 10-6/(7).

*d.* Current status reports from the individual's attending physician and his/her clinical supervisor (or a designated professional peer) will be required for the individual 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 app B) 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 MTF will be telephonically notified that an impaired healthcare individual is being transferred to the facility.

*e.* Upon report of the staff member's recovery, separation, or retirement from Federal service, the IHCP 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 ECMS/ECDS to the commander regarding the removal of limitations on clinical practice. If the recommendation is to remove the limitation(s), the committee may recommend an appropriate followup 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 USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

(3) The USAMEDCOM QMD will report these IHCPs to appropriate licensing authorities. Any privileged provider who fails to complete the rehabilitation program in which he/she is enrolled will be reported to the NPDB.

#### **11-5. 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 IHCP.

*c. Drug and alcohol rehabilitation program components.* The provisions of AR 600–85 apply fully to healthcare personnel impaired by alcohol/other drug abuse/dependence. The eight program components related to management of the individual with this type 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 MTFs 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 deglamorization, 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 MTFs 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 U.S. Army and TJC standards.

2. When drug diverting or illegal use has occurred, this general problem will be addressed within the MTF CQM structure. Lessons learned that may benefit others will be forwarded through the next higher headquarters to USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. (It should be noted that drug diversion and abuse is criminal misconduct and law enforcement involvement is appropriate.)

(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 MTF 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 role of denial relative to alcohol/other drug abuse/dependence and that this is compounded by the silence of colleagues, supervisors, and even patients.

6. The early behavioral and job-related performance indicators of alcohol/other drug abuse/dependence.

7. The principles of effective intervention and the various treatment programs available to IHCP and their Families.

8. The responsibility of peers and supervisors to report the individual who abuses or is dependent on alcohol or other drugs to the IHCP.

9. The specific procedures for self-referral according to local policy.

10. The threat to the career, health, and life if the impairment is allowed to continue.

11. The statistics related to effective treatment and successful return to full clinical practice, especially when abuse/dependence is identified 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 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 MTF 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 ultimate treatment of such problems. A change in a staff members' clinical performance and behavior as noted by the clinical supervisor may be among the first signs of an impending problem.

(a) All MTF personnel are required to notify the IHCP (or the DCCS, if this is more practical) of individuals (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 IHCP will encourage 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 followup 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 an impairment must be mindful of the confidentiality of information shared in the context of the IHCPP and the individual 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 individual 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/she will be involved in the process.

(c) For civilian staff, in addition to the ASAP clinic civilian program coordinator, 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.

(d) One of the following courses of action will be taken if performance does not meet the supervisor's expectations 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 record describing the circumstances and specifying the type of monitoring to be conducted will be forwarded to the IHCP.

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 deteriorating job performance. The supervisor will not discuss any suspicion of alcohol/other drug abuse but will focus only on the deteriorating job performance. The supervisor should offer assistance for any problem that may be contributing to the deteriorating job performance. It is also appropriate to advise the staff member that he/she will be referred to another professional (for example, a mental health professional, an addiction specialist, or an employee assistance specialist) for support/assistance and to the ASAP clinic or other appropriate service for a full evaluation. The supervisor must not attempt to diagnose the problem but should outline his/her expectations relative to acceptable future employee performance. The potential consequences to the employee if he/she fails to meet these expectations should be stressed. A memorandum for record will be forwarded to the IHCP 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/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. The medical staff will develop criteria and include these criteria in their bylaws for determining when a medical evaluation is required for referral to outpatient and all other treatment programs.

3. The MTF commander will initiate direct enrollment of an AA Soldier into a treatment program if participation on the part of the involved individual is not voluntary. If the impaired staff member is a civilian employee, 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 so advised.

4. USAR/ARNG healthcare personnel identified by virtue of urinalysis, blood alcohol level, direct observation, alcohol breath analysis device, or job performance will be counseled according to AR 600-85. A counseling statement which includes the following: "Pursuant to AR 340-21, chapter 3, I hereby consent to release of information by the Army concerning my alcohol/drug abuse to the State-certified, Army-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." will be signed by the Soldier involved. Should the individual elect not to sign the statement, he/she is subject to immediate separation.

(b) The clinical practice parameters of the impaired individual will be reviewed by the IHCP 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 individual 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/her privileges may require summary suspension (see para 10-6b) 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 individual 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 used. Apart from the legal ramifications, drug abuse can range from simple experimentation to psychological or physical dependence. All identified abusers will immediately be referred to the ASAP clinic for evaluation. USAR/ARNG personnel 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 by the ASAP clinic staff independent of any administrative or legal concerns.

(b) *Types of treatment.*

1. Inpatient (residential) treatment of AA healthcare personnel will be offered in an Army RTF if the individual has potential for retention on AD. Treatment may be offered through the VA if Soldiers are 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. USAR/ARNG personnel 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 individual's practice.

(c) *Coordination of treatment.*

1. Treatment will be coordinated by the alcohol/other drug abuse clinical staff for AA and civilian personnel. USAR/ARNG personnel 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. Administrative or legal charges 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 administrative or legal charges, a binding outpatient treatment plan will be developed according to the requirements in (5) below.

(5) *Aftercare.* Aftercare for AA personnel 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 MTF commander, supervisor, involved staff member, and IHCP 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 three times weekly.

2. Appropriate use of Antabuse, if prescribed.

3. Participation in the ASAP groups, educational classes, and individual sessions as described in the aftercare plan.

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 MTF commander, 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 IHCP.

(b) Evidence of compliance with the above requirements will be submitted to the IHCP 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 use), the impaired staff member will have his/her clinical duties suspended immediately. A full reevaluation will be made to include an assessment of progress to this point and the circumstances surrounding the individual's relapse (that is, precipitating factors and the staff member's use of recovery coping skills). 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 commander 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 AR 614-5. Exceptions may be made by RMC commanders in cases where the community is lacking sufficient aftercare resources, or levels of staffing are insufficient and replacement of

the recovering provider is necessary to support the patient care mission. 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.

(f) Aftercare for USAR/ARNG IHCPs participating in State treatment programs will be according to established guidelines of the specific State treatment program. State programs vary significantly, and USAR/ARNG unit contact with the individual agency will be necessary to facilitate achievement of all associated program requirements. Most States require that a contract of agreement to participate be signed by the impaired individual. This contract describes the sanctions that will be imposed if the IHCP is not compliant with aftercare treatment expectations.

1. The RC provider is required to notify his/her employer(s) of enrollment in a treatment program. This requirement includes notification of his/her RC unit of assignment/attachment.

2. A copy of the signed contract between the impaired USAR/ARNG member and the civilian treatment facility will be provided to the USAR/ARNG unit of assignment/attachment. A POC will be identified on this document to facilitate future coordination between the USAR/ARNG unit and the civilian agency.

3. Specific contractual requirements will be noted and supported by the USAR/ARNG unit.

4. Copies of progress reports from the coordinator of the treatment program will be obtained and included in the PCF/case file for nonprivileged personnel.

5. Most contracts include as a minimum: attendance at, or participation in, ASAP groups or meetings; random unannounced urinalysis, if applicable; restriction of healthcare personnel to the State in which treatment is being monitored unless prior State approval is granted.

(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 commander makes re-entry-into-practice determinations based on recommendations from the IHCP in coordination with the credentials committee, when appropriate. The USAR/ARNG unit commander may designate a qualified unit member who is familiar with the State's requirements related to healthcare personnel with impairments to determine the appropriate level of return to practice of the impaired USAR/ARNG provider/professional. These recommendations are forwarded to the USAR/ARNG commander for his/her decision.

(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 treatment.

(b) If progress is satisfactory, the healthcare staff member should eventually be returned to full clinical practice in the role previously held. The individual'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 IHCP, credentials committees, the involved therapists, and the individual concerned, a return to the previously held practice specialty is not appropriate, a recommendation for change of AOC/MOS/duty position will be initiated. The appropriate corps chief is the final approval authority. For civilian healthcare personnel, coordination for a change in duty position will occur among the MTF 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 MTF in-service or other presentation on alcohol/other drug abuse/dependence during the first 12 months following the onset of treatment.

(e) USAR/ARNG members will be allowed to perform duty within AA MTFs while participating in or following completion of an IHCPP, unless their practice has been restricted. The State impaired personnel program in which the individual 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 USAR/ARNG unit to facilitate a clear understanding of the USAR/ARNG member'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 USAR/ARNG member's return to his/her clinical environment. The USAR/ARNG provider will furnish proof of employer notification to his/her USAR/ARNG unit of assignment/attachment. Documentation related to current delineation of privileges from each civilian agency where the impaired USAR/ARNG provider is privileged will be submitted to the AA MTF at the time of request for privileges.

(7) *Ongoing monitoring.* Ongoing monitoring for AA personnel 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 individual completes treatment as an outpatient or is discharged from a residential setting. The ASAP clinic is involved in monitoring during the first year of aftercare. The supervisor, department chief, and IHCP 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 USAR/ARNG members 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 U.S. Army's impaired personnel reporting requirements will be identified to the USAMEDCOM QMD for coordination efforts.

(a) Information pertinent to required reports is contained in paragraphs 1 through 3, below.

1. The ASAP clinic staff will submit monthly written reports to the IHCP for the first 3 months and quarterly thereafter while IHCPs are in aftercare. 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 nonprivileged staff members will be maintained in a confidential, protected QA file (see app B) which will be destroyed when the staff member is successfully returned to full practice. If a PCS occurs prior to the individual's return to full practice, these files will be transferred to the gaining facility following the guidelines for transfer of a PCF. (See para 9–4d(1).)

(b) Individuals 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/her patients.

(c) The confidentiality requirements of AR 600–85 apply to all reports, committee minutes, and discussions pertaining to IHCPs in the U.S. Army's ASAP. Civil penalties apply for unauthorized disclosure. (See app B.)

(8) *Program termination.*

(a) *Professional involvement.* The ASAP's role in the staff member's recovery program ends 1 year after the date treatment was completed. The role of all others generally ends after the second year. At this time the IHCP 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 AR 600–85, all AA and USAR/ARNG Soldiers who are identified as illegal drug abusers will be processed for administrative separation.

## **11–6. Notification requirements**

a. Notification to the USAMEDCOM will be made regarding all healthcare personnel (officer, enlisted, civilian, and contracted) who are involved in the IHCP. DD Form 2499 will be utilized for this purpose. Reports will be sent through the next higher headquarters to Commander, USAMEDCOM (MCHO–CL–Q), 2050 Worth Road, Fort Sam Houston, TX 78234–6010. Each AA MTF will provide a copy of the DD Form 2499 to their ASAP clinical offices. USAR/ARNG units will forward a copy of the DD 2499 to their respective Regional Support Command or State Army USAR/ARNG Headquarters, Surgeon's Offices.

b. While the USAMEDCOM is notified of all healthcare personnel involved in the IHCP, only those meeting any of the criteria in (1) through (5), below are reported to professional regulating authorities. The provider/professional who—

(1) Has his/her clinical privileges/practice denied, suspended, restricted, reduced, or revoked. USAR/ARNG units are not responsible for reporting clinical privileges/practice actions taken against USAR/ARNG personnel by civilian agencies/facilities; this is the responsibility of the civilian employer. However, privileges denied, suspended, restricted, reduced, or revoked by the USAR/ARNG 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 nonprivileged personnel.

(4) Has an unauthorized absence at any time, for any reason, during the 2-year monitoring period (AA only) following alcohol or other drug rehabilitation.

(5) Has been enrolled in the IHCP. Reporting by the USAMEDCOM to the NPDB will occur only if the impaired individual fails to successfully complete the program.

c. TSG is the reporting authority for IHCPs (AA/USAR/ARNG) to all professional regulating authorities.

## **11–7. Review of National Practitioner Data Bank query and licensing information**

a. USAR/ARNG 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 individual's license. Reporting of the impaired USAR/ARNG member occurs despite the individual 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 an USAR/ARNG member's report from the NPDB. This is in contrast to the AA provider's NPDB report which will not reflect an adverse privileging/practice action related to an impairment unless one of the conditions in paragraph 11–6b 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 USAR/ARNG 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 individual's practice. The probation period is for a specified length of time that varies from State to State.

## **Chapter 12**

### **Patient Safety in the Healthcare Setting**

#### **12-1. 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 RM at the facility level.

b. The MTF leadership plays a critical role in the facility-based 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 TDA organization's comprehensive safety efforts. As such, PS activities and processes must be effectively integrated with those of the existing MTF Safety Program.

c. PS and the reporting of adverse events, especially SEs, are likewise important in the TOE environment. Wherever practical, efforts must be made by TOE leadership to emphasize PS and to minimize patient harm associated with the provision of healthcare to Soldiers.

#### **12-2. 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 within the AMEDD, enhanced responsibility and accountability for PS at all levels of the organization 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 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 close calls/near misses according to DOD and USAMEDCOM PSP requirements and TJC 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 AMEDD and the MHS, as appropriate.

#### **12-3. The Patient Safety Program**

a. Each MTF commander will establish and implement a PSP according to USAMEDCOM guidance as an integral part of the QA/PI processes of the organization according to DOD policy (DODI 6025.17). The specific components of PS include the assessment, identification, classification, management, analysis, and reporting, as appropriate, of medical/health-care-associated adverse events (to include SEs). PS addresses incidents involving both potential harm (close call) to patients as well as those in which actual injury occurred (adverse event).

b. Each MTF will demonstrate evidence of PSP activities that meet current DOD and USAMEDCOM guidance as well as applicable TJC standards.

c. The MTF commander will ensure integration of the various PS functions—as defined in writing—into both the MTF Safety Program and the organization's CQMP. He/she will designate a qualified individual as PS manager to effectively coordinate the organization's interdisciplinary PS activities and initiatives.

d. The facility-level PSP will be based on current DOD and USAMEDCOM guidance and will include as a minimum—

- (1) The roles and responsibilities of all personnel, to include the medical/dental staff, relative to PS.
- (2) Education of staff and patients regarding PS, emphasizing opportunities to reduce risk and minimize harm to patients.
- (3) Clearly defined, standardized processes for reporting, reviewing, and analyzing risk and other PS data and initiating corrective measures to reduce and prevent future occurrences.
- (4) Standardized methods for identifying, classifying, tracking, trending, and evaluating all near miss and adverse events (to include SEs).
- (5) A standardized method for conducting an RCA of SEs and other adverse events.
- (6) Identified process metrics relative to PS (see USAMEDCOM guidance for required and recommended metrics).
- (7) A mechanism for providing prompt feedback to staff who report adverse events including close calls. Feedback of a nonconfidential nature that addresses actions taken/actions projected as a result of the staff member's report is appropriate. This communication acknowledges the importance of the staff member's efforts to participate actively in organizational PI.
- (8) The requirement for reporting PSP data to the USAMEDCOM and other agencies as required by OASD(HA) and an annual evaluation of the overall effectiveness of the integrated PS/RM activities.
- (9) An evaluation (utilizing the standardized survey tool provided by USAMEDCOM) of the organization's corporate culture as it affects the reporting of adverse events and close calls.
- (10) Establishment of an interdisciplinary PS review function.

e. The annual CQMP report that is submitted to the MTF Executive Committee will summarize the organization's significant PS issues and activities (for example, reportable adverse events, SEs, system issues and steps taken to rectify problems, and any lessons learned). These data are extracted from the MTF annual PSP report. Reporting requirements associated with the PSP are dynamic and may vary from year to year based on DOD guidance. The USAMEDCOM QMD will provide current, up-to-date guidance as requirements change. A copy of the MTF's annual PSP report will be provided to USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

#### **12-4. Management of an adverse event or close call**

a. *Types of incidents.* In the context of patient safety, incidents involving patients are classified as either adverse events or close calls. (See glossary definitions.)

- (1) The person in charge of the activity where the adverse event/close call has occurred will ensure that the PS manager (or designee) is notified within 48 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 and USAMEDCOM guidance.
- (3) The CJA 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. Documentation.*

(1) DA Form 4106 (Incident Report), or equivalent report, will be completed. DA Form 4106 is used to document all types of incidents or unanticipated events, to include patient safety events, that occur in the MTF. This document provides the initial report of a situation that, based on Army or USAMEDCOM guidance or local policy, may require more detailed documentation. Upon review by the designated authority (PS manager, risk manager, MTF safety and environmental health manager, and so forth), if it is determined that the incident has QA/RM implications, this document is considered protected under 10 USC 1102. The specific type of incident (hospital safety, PS, RM, and so forth) will determine what additional documentation, if any, is necessary and who is responsible for followup action. DA Form 4106 contains concise, factual, objective, and complete details about the event. While an explanation of the situation is appropriate, to include precipitating circumstances or reasons, speculation about the cause of the incident should be avoided.

(2) The completed DA Form 4106 will be forwarded through appropriate supervisory channels to the designated authority as soon as possible but not later than 48 hours after the occurrence. Reports of adverse events/close calls or other incidents occurring on the weekend or holidays will be submitted on the first duty day following the incident.

(3) Upon submission, DA Form 4106, or electronic equivalent, will be maintained in a central location (for example, the PS/RM office) as determined by local policy. In accordance with the ARIMS record retention schedule, information relating to involvement of a patient in an unusual occurrence or accident in an MTF is destroyed after 7 years. Information relating to medical incidents for which a claim and/or suit has been filed, have the following disposition schedule: cutoff: after final resolution of the case; transfer: to the Federal Records Center 3 years after cutoff. DA Form 4106 will not be included in the beneficiary medical/dental record; it will not be duplicated and maintained at the department or service level.

(4) All factual data related to a PS adverse event will be entered in the patient's medical/dental record on SF 509 or other appropriate medical records form (for example, SF 600, SF603/603A (Dental Health Record)). The entry should

describe—in detail—exactly what occurred, any evidence of injury to the beneficiary, and the immediate action(s) initiated in response to the event. In addition, all the facts surrounding the adverse event must be fully disclosed to the patient/Family member by the provider. A statement by the primary care provider or attending physician documenting the circumstances surrounding the adverse event as relayed to the beneficiary or Family member will be entered (DODI 6025.17) in the patient's medical/dental record. The annotation in the medical/dental record will not conclude that an adverse event or accident occurred, using those specific terms, nor will it indicate that a DA Form 4106 was completed. Questions related to disclosure and documentation of information associated with an unanticipated patient outcome or adverse event should be referred to the MTF CJA.

*c. Assessment of the adverse event.*

(1) The adverse event assessment and weighted scoring (that is, safety assessment code (SAC) or comparable DOD-sanctioned methodology) may be 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/close calls.

(2) If there is a low priority accorded the event based on the standardized PS severity assessment performed (that is, SAC score (see USAMEDCOM PSP guidance for event scoring directions)), the decision may be to take no action, other than tracking, trending, and subsequent aggregate review analysis of the adverse event according to DOD and USAMEDCOM guidance. The action may include reporting the event to USAMEDCOM, AFIP, and/or the TJC. If warranted, an RCA will be performed and a corrective action plan developed in accordance with USAMEDCOM 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 MTF Safety Program or other appropriate facility personnel. Incidents classified as PCEs will be referred to RM for appropriate action.

(3) 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 MTF commander for appropriate action. Intentional unsafe acts are not within the defined scope of the PSP. RM is responsible for notifying the CJA of such alleged incidents as well as all coordination and followup action. Findings of intentional unsafe acts that result from gross negligence or possible criminal activity shall be reported to the CID. Given the implications of these acts, they will be addressed, with all due attention, through legal, administrative, and disciplinary channels.

(4) 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. However, 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.

(5) 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 nonprivileged healthcare professional.

*d. Investigating and tracking.*

(1) In order to maintain an accurate accounting of occurrences with potential PS implications, all adverse events (including close calls), 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 and USAMEDCOM guidance.

(2) For events with minimal harm to the patient and close calls, 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 and USAMEDCOM policy.

(4) Any adverse event that is classified as a PCE will also be entered into the RM M&E database (that is, CCQAS or replacement system). 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. (See para 13-4b for additional guidance.) 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.

*e. Reporting to the USAMEDCOM.* Adverse events that, according to USAMEDCOM guidance, require QMD notification will be reported to the USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010, within 72 hours of identification. MTFs will also inform the USAMEDCOM of any situation in which the news media is involved, or may be involved, and the coverage may reflect negatively on the MHS. Facility-level PSP aggregate data will be electronically submitted to the USAMEDCOM QMD on a regularly scheduled basis (that is, quarterly) according to current USAMEDCOM guidance.

## 12-5. Management of a sentinel event

An 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.” As a minimum, the organization’s written SE policy will include those events that are subject to review according to TJC and USAMEDCOM guidance.

### *a. Reporting of an SE.*

(1) *To the TJC.* Any incident that meets the current TJC definition of a reviewable SE must be reported directly to the TJC within 5 days of its identification. See Web site [www.TJC.org](http://www.TJC.org) for specific reporting criteria and other guidelines. Neither beneficiary nor caregiver identifiers may be used when reporting SEs to the TJC.

(2) *To USAMEDCOM.* All SEs reported to the TJC must also be reported, through the RMC (or through the RDC and the USADENCOM) to the USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 within 72 hours of identification. (See para 12-4d.)

*b. Facility-level followup actions.* The PS/RM will notify the CJA of an SE as soon after identification as possible. As an integral part of its established process for PS analysis, each MTF will have in place, and in writing, a mechanism for performing an RCA, reporting, and other appropriate followup activities related to SEs that are consistent with current TJC, DOD, and USAMEDCOM 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 MTF action plan with followup evaluation of the effectiveness of the RCA action plan will be according to USAMEDCOM guidance.

### *c. RCA and action plan review.*

(1) *By the TJC.* Review by the TJC of the MTF 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, as noted in paragraph 12-5a(1), for additional information.

(2) *By USAMEDCOM.* A copy of the RCA and action plan for all SEs will be provided through the chain of command to the USAMEDCOM, QMD according to the guidance and timelines established for reporting to the TJC. These documents will be forwarded to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Commercial overnight delivery service is authorized for this purpose.

*d. Media requests.* Any and all communication with the media concerning an SE, an adverse event, or significant PS issues will be coordinated by the local public affairs office (PAO) with the CJA. Press inquiries and other media-related issues will be referred by the local PAO, as appropriate, to the USAMEDCOM PAO, USAMEDCOM (MCPA), 2050 Worth Road, Fort Sam Houston, TX 78234-6000. (See AR 27-40.)

*e. Requests for medical/dental information.* The Health Insurance Portability and Accountability Act of 1996 (PL 104-191) requires that release of HREC’s 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, patient administration division (PAD) for medical records or the DTF commander for dental records. In these cases, PAD or the DTF commander will coordinate with the PS/risk manager who will follow the legal guidance provided by the CJA. MTF personnel will not deal directly with claimants or potential claimants (or their attorneys or representatives) without prior coordination with the PS/risk manager.

## 12-6. The PS committee/function

*a.* Integration of all organizational PS and risk-related issues and processes under the auspices of the MTF safety committee/function reduces duplication of effort and enhances overall program efficiency. The MTF review process for PS-related issues will be multidisciplinary to include representatives of the MTF executive leadership (for example, the DCCS, DCA, DCN); selected department chiefs; ancillary services representatives (for example, pharmacy, logistics, nutrition care); the QM/PI coordinator; the PS/risk manager; the MTF safety and occupational health manager; the CJA; enlisted representatives; and others as deemed appropriate.

*b.* For dental clinics, the PS committee membership will be at the discretion of the dental commander. It will be multispecialty composed of general and specialty dentists and others as appropriate.

*c.* The PS committee/function minutes or reports will summarize activities to include, as a minimum, analysis of the results of adverse events/close calls/SE process measures, analysis of the results of MTF-specific occurrence screens, and recommendations to the MTF 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 AR 25-400-2.

## **12-7. 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) identification and reporting.

a. The chief, logistics division (or comparable title) in both TDA and TOE healthcare facilities is responsible for dissemination of medical materiel quality control messages under the provisions of AR 40-61. 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 followup 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 manufacturer's literature. (See AR 27-20.) The list of documentary evidence that should be preserved in actual/potential product liability/SMDA cases includes all manufacturer, Food and Drug Administration (FDA), and U.S. Army MPMC notices regarding the drug, product, medical equipment, or appliance and any documentation of remedial action taken by the MTF.

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. AR 40-61 outlines 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 CJA 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 according to AR 40-61 guidelines.

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, AFIP, is encouraged. These cases will be handled as SEs according to paragraph 12-5.

## **12-8. Patients who leave the military treatment facility setting 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 (AMA).

(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.

*Note.* 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 AMA, 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 MTF staff is appropriate. Given any of the termination of care situations presented, both counseling (patient/legal representative), if feasible, and documentation of the event in the medical record (ITR/OTR/HREC/civilian employee medical record (CEMR)) is required.

c. *Termination of care AMA.*

(1) The attending privileged provider (or designee) who is managing the patient's care is responsible for counseling the patient or his/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 AMA, despite efforts of the healthcare staff to convince him/her otherwise, DA Form 5009 (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 DA Form 5009 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 DA Form 5009, this will be annotated on the form or in the patient's medical record on SF 509 (inpatient) or SF 600 (HREC, 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 followup outpatient care will also be noted.

(4) DA Form 4106 will be completed, according to paragraph 12-4a of this regulation, to document this incident. 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) AD Soldiers are not authorized to refuse medical care except as noted in AR 600-20. AD Soldiers will not sign out AMA. See AR 600-20 and consult the local office of the SJA for additional guidance regarding Soldiers who refuse medical care.

*d. Patient elopement.*

(1) Unlike an AMA departure from the 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 in paragraph c(1), above. 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, to close out the medical record for that episode of care and a DA Form 4106 will be completed.

(3) Local policy will address appropriate actions for contacting the individual who has eloped (his/her legal representative) to determine the patient's health status at the time of contact and to provide instruction for further followup 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/she describes, and the instructions provided by the staff member will be documented in the ITR/OTR/HREC.

*e. The person who leaves without being seen.*

(1) This individual (AA/USAR/ARNG/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 followup actions are required for contacting this individual (his/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 MTF AMA 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/her actions.

(2) Local policy will direct other actions to be taken by MTF staff. As a minimum, the SJA 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/her whereabouts.

*g. Termination of care by the 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, MTF policy, or as the result of other irregularities. In these instances, the stipulations noted above in paragraphs c(1) through (4), will apply. In accordance with current managed care policy, coordination of necessary follow-on care and any other arrangements will be made by MTF staff with another appropriate healthcare facility. Termination of care under these circumstances will be according to the legal guidance provided by the servicing SJA.

## **12-9. Role of USAMEDCOM Quality Management Division**

The role of the USAMEDCOM QMD in facilitating effective PS processes is consultative, educational, and supportive. The QMD staff will provide policy guidance and education; gather, maintain, and disseminate U.S. Army-wide clinically focused PS data; and provide consultation and support about SE analysis; provide feedback on best practices; and report information, as appropriate, to outside agencies as directed by OASD(HA).

## **12-10. Confidentiality**

As with other medical QA documents, any information, records, reports, minutes, and other documents directly

associated with PS activities are protected under 10 USC 1102 and DOD 6025.13–R. See appendix B for more information concerning the confidentiality of CQM QA documents.

## **Chapter 13**

### **Risk Management**

#### **13–1. General**

Risk management 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 potentially compensable events (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, MTF safety, and occupational health cannot be overemphasized.

#### **13–2. Military treatment facility and U.S. Army Medical Command risk management activities/responsibilities**

Each MTF will demonstrate evidence of RM activities that meet current DOD and USAMEDCOM guidance.

- a. The MTF CQM plan for RM will include such facility-specific activities as—
  - (1) The responsibilities of MTF 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. Note: The term PCE refers to injury to all categories of MHS beneficiary including injury with subsequent death or disability of a military member (see DOD 6025.13-R).
  - (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 MTF commander 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 MTF 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 risk management policies and procedures.
  - (5) Educate staff (all levels, all disciplines) concerning risk reduction/mitigation.
  - (6) Provide data on a periodic basis to MTF senior leadership concerning RM issues and trends. To avoid redundancies due to the comparable processes related to risk and patient safety, the information reported to the MTF executive committee or ECMS at defined intervals should reflect an integration of effort wherever possible (see para 12-6).
- 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/she is responsible for providing professional medical/dental consultation to key PS/RM staff and the medical CJA/SJA. 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 USAMEDCOM QMD is responsible for collecting MTF-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 AMEDD-wide trends and opportunities for improvement. In addition, MEDCOM conducts the senior AMEDD review of paid malpractice claims and provides recommendations to TSG for reporting of licensed, certified, or registered healthcare personnel to the NPDB.

#### **13–3. The military treatment facility risk management committee**

- a. The MTF RM committee provides impartial oversight and review of all PCEs and medical malpractice/disability claims management activities as described in this chapter.
  - (1) This group is multidisciplinary, with representation from each clinical department/service, the risk manager, the medical CJA/SJA, and other designated (ad hoc) participants, as needed.

(2) The risk manager and CJA/SJA 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.

*Note.* 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.

*Note.* 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.

#### **13–4. Managing the potentially compensable event**

Any adverse event (to include those involving military members) that meets the definition of a PCE, as contained in this regulation, 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 MTF risk manager, the clinical advisor, and the CJA/SJA throughout the PCE identification and management process.

a. DA Form 4106, Incident Report, or equivalent, will be used to document all RM events that occur in the MTF. Typically, this document originates at the point of care (adverse event) and is the initial report of the situation. However, information related to a PCE may come to light via written or verbal statements from the patient, a Family member, or healthcare staff. Additional documentation, investigation, and follow-up action by the risk manager and others is required. (See para 12-4 for instructions on the use of DA Form 4106.)

b. All PCEs will be promptly prioritized and investigated by the risk manager (DOD 6025.13-R). All PCEs will be peer reviewed and information related to the event will be entered into the RM module of CCQAS.

c. Copies of documents in PCE files maintained by the risk manager will be forwarded to the CJA/SJA for review as mandated by AR 27–20. The PCE case files contain Privacy Act data and will be secured and maintained in accordance with AR 340–21 and AR 25–400–2.

d. Use of the CCQAS RM 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 10 USC 1102 protected information.

### **13–5. Peer review of a potentially compensable event**

Peer review in the context of risk management is different than that which is conducted when an adverse privileging/practice action is being considered.

*a.* 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 regulation) 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, and so forth.). In addition, responsibility (attribution) for the event is assigned based on the investigation of the circumstances and an unbiased review of the evidence available.

*Note.* 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.* A peer review (internal to the MTF 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 MTF lacks sufficient personnel to conduct an impartial and unbiased peer review and/or RM committee functional oversight, the RMC will assist in coordinating for these external peer review services with another MTF.

(3) Significantly involved healthcare providers (all disciplines)—including those no longer assigned to the MTF—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.

*Note.* 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 regulation, 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/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/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 DOD 6025.13–R—

(*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.

*Note.* 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 CJA/SJA.* Coordination is required among the PS manager, risk manager, MTF safety and occupational health manager, and the CJA/SJA to ensure effective communication exists regarding all adverse incidents involving beneficiaries, Family members, visitors, volunteers, MTF 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 (AR 25-400-2) for 3 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. USAMEDCOM oversight of the PCE.* The USAMEDCOM QMD is responsible for corporate tracking and trending, as directed by TSG, of all PCE related data.

### **13-6. 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 U.S. Army Claims Service (USARCS), or the Office of the CJA/SJA 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 MTF commander of the facility against which the claim has been filed, with a copy furnished to the USAMEDCOM QMD. To maintain a high level of awareness regarding all active malpractice claims, the MTF risk manager will reconcile the status of all claims with the servicing CJA/SJA on a monthly basis.

*b. Responsibilities of the MTF commander.* The commander 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 MTF commander will—

(1) Notify the next higher headquarters (RMC, other) according to current guidance particularly for cases of command or media interest.

(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 MTF notification of the claim to the USAMEDCOM. 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 local CJA/SJA that a claim alleging negligence or substandard care has been filed.

(b) The risk manager is notified by the local CJA/SJA that a monetary award has been granted. In this instance, the claim was settled either by the USARCS or the host nation (International Claims Settlement Act claims), or was a litigation case settled or adjudicated by the Department of Justice.

(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 are 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, the Military Claims Act, the International Claims Settlement Act, or the Foreign Claims Act relating to healthcare provided by a DoD facility or practitioner. Note: If the event was previously peer reviewed as a PCE and all specifications of para 13-5 a-b above 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 TSG, no later than 180 days following notification of the malpractice claim payment (see DOD 6025.13-R).

(4) Provide the local CJA/SJA all clinically pertinent information relevant to a claim, to include a legible copy of medical records, within 20 working days of notification. The CJA/SJA is responsible for forwarding all required documentation to the USARCS.

(5) Ensure that all malpractice claims documentation is secured, as determined locally, and forwarded to the USAMEDCOM, upon request. Upon compilation of all claim related documentation at the USAMEDCOM, the MTF may dispose of the medical malpractice case file according to AR 25-400-2. At this point, the USAMEDCOM QMD

becomes the case file custodian. Case files are maintained by the USAMEDCOM QMD for a period of 10 years following administrative closure.

c. *Malpractice claim documentation.* At a minimum, the MTF case file that is forwarded to USAMEDCOM 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 risk management 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 USAMEDCOM QMD.
- (6) Current addresses (mail, e-mail) for the involved personnel, if available.
- (7) USARCS or Army Litigation Division notice of legal settlement or disposition, if available.

d. *Followup actions.* Within 30 days of notification by the CJA/SJA that a claim has been settled (paid or denied), the commander will ensure that—

- (1) All relevant information has been entered into CCQAS claim file and it is electronically transferred, that is, “Released to OTSG” for access by USAMEDCOM QMD.
- (2) The entire case file, as described above, is on file with the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.
- (3) Upon request, copies will be furnished to the RMC or other higher headquarters.

e. *RMC staff participation.* Participation by the RMC/RDC staff to facilitate speedy but thorough processing of medical malpractice cases in preparation for USAMEDCOM special review is essential. The level of involvement by the RMC/RDC with medical malpractice claims management, and duties appropriate to the respective staff members, will be coordinated with the USAMEDCOM and as directed by the RMC/RDC commander.

f. *Responsibilities of USAMEDCOM QMD.* The USAMEDCOM QMD serves as the office of record for medical malpractice claims data and is responsible for corporate oversight of the medical malpractice processes within the AMEDD. Specific duties include coordination/oversight of—

- (1) *The clinical expert review.* The discipline/specialty reviewer provides TSG expert clinical review related to the quality of care associated with a malpractice claim/death or disability of a military member. This review, which replaces the review previously performed by the Consultation Case Review Branch (CCRB), may be provided in a written report of findings or via participation as a member of the special review panel (SRP). If a written report is submitted, it will include an SOC determination for significantly involved providers of the same discipline. In instances where a provider is deemed to have “Not Met” SOC or “Indeterminate” is selected, the rationale for said determination will be explained.

*Note.* Due to the disbanding of the QMD CCRB, malpractice cases processed by the USAMEDCOM after 1 July 2006 do not require CCRB review.

- (2) *The external peer review.* The USAMEDCOM QMD ensures that the external review (DOD 6025.13-R) is conducted utilizing the peer review organization designated by the OASD(HA).

(3) *The SRP.* The USAMEDCOM SRP, comprised of senior military clinicians, is convened to review paid medical malpractice claims, as well as medically related disabilities and deaths involving military members.

g. *The USAMEDCOM SRP procedures and functions.*

(1) *Panel composition.* The SRP will consist of at least three privileged providers; a senior military physician will serve as the chairperson. The panel will include a minimum of one member of the same specialty (privileged healthcare provider under review) or discipline (non-privileged healthcare provider under review). All participants will vote unless, for some reason, an individual elects to recuse him/herself. In lieu of actual SRP participation, a written review by a clinical expert of the same specialty or discipline, as described in paragraph 13-5e(1), will suffice.

(2) *Review procedures.*

(a) The SRP activities are administrative in nature; therefore, rules of evidence prescribed for trials by courts-martial or for civil court proceedings are not applicable (see para 4-9b(3)(b)).

(b) A file that includes the investigative and/or fact finding report(s), the various peer reviews (MTF, clinical expert, DOD external), the summary of the administrative claim adjudication and/or litigation disposition documents, and any relevant clinical records is compiled for each SRP member.

(c) The significantly involved healthcare provider under review will be notified of the forthcoming SRP and afforded time (usually 15 duty days), to submit additional information on his/her behalf to Headquarters, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

(d) The SRP will review all documents presented and any written comments submitted for consideration by the involved provider and the results of all SOC reviews to date and render its determination.

(e) According to DOD 6025.13-R, TSG may delegate NPDB reporting authority to a senior USAMEDCOM

physician reviewer. In cases where there is consensus for reporting among lower level reviews (MTF, clinical expert, or other agency as designated by OASD(HA)), the SRP will render the final SOC determination. The report to the NPDB, in this instance, is made at the direction of the SRP.

(f) In cases for which there is disagreement for reporting among lower level reviews, the SRP will document its SOC determination and recommendation to TSG for provider reporting to the NPDB, as appropriate. The case will be evaluated by the USAMEDCOM SJA for legal sufficiency to support a report to the NPDB or other regulatory agencies. All relevant case documents are then forwarded for final review and decision by TSG.

### **13–7. 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/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 AR 40–66 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 per AR 340–21, AR 25–55, and AR 27–20. Any request for medical/dental records must be in writing and must specify the treatment dates and the names of the MTFs involved. Release of medical/dental records is limited to records defined in AR 40–66.

c. Other records, reports, and any specimens maintained by MTF 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 Litigation Division of the Office of the Judge Advocate General (OTJAG) or USARCS. Granting of requests for records by the beneficiary or his/her representative will be at the discretion of the CJA or USARCS.

d. When medical/dental records are required by another healthcare facility for beneficiary treatment purposes, copies or appropriate extracts will be furnished. The United States Army Legal Services Agency, Litigation Division (JALS–LTT), 901 North Stuart Street, Ballston Suite 400, Arlington, VA 22203–1821 will be consulted prior to the disposition of these records to the National Personnel Records Center, USARCS, or Litigation Division.

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 local CJA; transmittal to Litigation Division, OTJAG; or response to subpoena), the original medical/dental record will be reviewed for completeness by PAD or the DENTAC and assembled as prescribed in AR 40–66.

(2) Medical/dental records involved in litigation or adjudication require special safeguarding by PAD or by the DTF commander. 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 AR 40–66).

(3) PAD is the only location in the MTF (dental commanders will designate who has responsibility for this function) where an authenticated photocopy of a medical/dental record will be made for purposes cited in this regulation. 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 CJA or to USARCS, PAD or the DTF commander (designee) 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 CJA.

## **Chapter 14**

### **Reporting and Releasing Adverse Privileging/Practice or Malpractice Information**

#### **14–1. General**

A variety of national agencies and clearinghouses exist to which the AMEDD 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 (see app I), any actions taken to restrict or otherwise constrain the professional privileges/scope of practice of healthcare personnel, and malpractice settlements on behalf of healthcare personnel.

## 14-2. Military treatment facility responsibilities for providing information

*a. Requests for routine information.* MTFs 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 MTF 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 AR 25-55 and AR 340-21. If the MTF 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 to Commander, AHRC-St. Louis (Human Resources Command) (AHRC-RSA-Q), 1 Reserve Way, St. Louis, MO 63132-5200.

*b. Requests for adverse privileging/practice action or malpractice history information.* Requests to the MTF from outside agencies for release of adverse privileging information, including queries from GPHE programs or malpractice history information, will be forwarded directly to the Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010 for response. Individuals who are the subject of any information released under this regulation 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.

## 14-3. The Surgeon General responsibilities in reportable actions

The Surgeon General is the sole reporting authority to the NPDB, State regulatory authorities, the Federation of State Medical Boards, and/or other appropriate central clearinghouses. TSG 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. TSG will not report to professional regulatory agencies, or to any other agencies, adverse privileging actions, malpractice payments, or any civilian court actions involving a USAR/ARNG provider's behavior or conduct which occurs during other than his/her military duty. MTF documentation in support of reports to the NPDB, State regulatory agencies, the Federation of State Medical Boards, or other bodies will be forwarded directly to Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

### *a. Malpractice claims reported to the NPDB.*

(1) PL 99-660 (The Healthcare Quality Improvement Act of 1986) 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 (10 USC 1102) 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) In a malpractice case, the following criteria will be used by the USAMEDCOM QMD SRP to support a recommendation to TSG to report the 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.

*Note.* The DPDB is composed of the various data/reports released to DOD via the CCQAS risk management module.

(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/her act(s) of omission or commission were not reasonably foreseeable by the supervisor, or the trainee acted outside his/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 TSG, based on a majority vote, and any supporting comments, including the recommendations of the clinical expert participants, will be prepared by the USAMEDCOM QMD. The USAMEDCOM SJA 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 the USAMEDCOM QMD.

(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/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/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 para c below.) 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/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 nonprivileged 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 nonprivileged 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 TSG to State regulatory agencies. A privileged provider/professional will be reported if he/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/her ability to provide quality patient care.

(3) Has a medical condition that affects his/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 appendix I or similar unprofessional actions.

(5) Commits any other act, not otherwise covered by the provisions of this regulation, which is reportable according to State licensing statutes or regulations.

#### **14-4. The Healthcare Integrity and Protection Data Bank**

The Health Insurance Portability and Accountability Act 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. The AMEDD 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.* Health Affairs Memorandum, DOD Participation in the HIPDB, 31 October 2000, outlines the following reporting responsibilities by TSG and other Federal agencies.

(1) TSG is responsible for reporting to the HIPDB adverse privileging/practice or administrative actions taken against healthcare providers, suppliers, or practitioners providing healthcare services to AD members or any other MHS beneficiaries in MTFs or as part of any military unit. Clinical privileging actions against physicians and dentists are excluded from this reporting requirement. These actions are reportable to the NPDB as noted in paragraph 14-3b. 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 Chapter 75 or Title 5, USC.
3. *Contract termination for default.* A contract termination for default taken by an MTF or medical command against a personal services or non-personal services contractor.
  - (2) Reports to the HIPDB by TSG will also be forwarded to the Department of Legal Medicine of the AFIP.
  - (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 Web site: [www.bhpr.hrsa.gov/dqa](http://www.bhpr.hrsa.gov/dqa).

## **Appendix A References**

### **Section I**

#### **Required Publications**

Army regulations are available online from the APD Web site at <http://www.apd.army.mil>. Public laws may be accessed at <http://www.gpoaccess.gov/plaws/index.html>. DOD directives and instructions are available at <http://www.dtic.mil/whs/directives>. DOD Health Affairs policies are available at <http://www.ha.osd.mil/policies/default.cfm>.

#### **AR 15-6**

Procedures for Investigating Officers and Boards of Officers (Cited in paras 7-16c(7), 10-6d(2)(b), 10-8a(1), (3), and B-3.)

#### **AR 25-55**

The Department of the Army Freedom of Information Act Program (Cited in paras 13-6b 14-2a.)

#### **AR 25-400-2**

The Army Records Information Management System (ARIMS). (Cited in paras 12-6c 13-4a(2), -5b(5) and E-5d(1).)

#### **AR 40-66**

Medical Record Administration and Healthcare Documentation. (Cited in paras 7-4c(2), 7-16c(1)(c), 7-16c(1)(d), 7-16c(1)(f), 7-16c(2)(f), 9-4h(1)(b), 13-6a, 13-6b, 13-6e(1), and 13-6e(2).)

#### **AR 40-501**

Standards of Medical Fitness. (Cited in paras 7-4c(2), 7-4c(3), 7-13c(2)(a)5, 7-16c(4)(a), 7-16c(5), 7-16c(8)(a)5, and 7-17c(2)(a)4.)

#### **AR 135-175**

Separation of Officers. (Cited in paras 4-10a(6), 9-4f(8), 10-12a, and 10-16d.)

#### **AR 135-178**

Enlisted Administrative Separations. (Cited in para 4-10a(6) and 10-12a.)

#### **AR 340-21**

The Army Privacy Program. (Cited in paras 8-3b(2)(a), 8-7, 8-9c, 11-5c(3)(a)4, 13-4a(2), 13-6b, 14-2a, and E-1.)

#### **AR 351-3**

Professional Education and Training Programs of the Army Medical Department. (Cited in paras 7-2e and 8-7n.)

#### **AR 600-8-2**

Suspension of Favorable Personnel Actions (Flags). (Cited in paras 4-10a(1) and 10-13.)

#### **AR 600-8-24**

Officer Transfers and Discharges. (Cited in paras 4-10a(6), 7-16b(2)(c), 9-4f(8), 9-7a, 10-12a, and 10-13.)

#### **AR 600-85**

Army Substance Abuse Program. (Cited in paras 11-2a, 11-3, 11-5c, 11-5c(3)(a)4, 11-5c(7)(c), and 11-5c(8)(b).)

#### **AR 608-10**

Child Development Services. (Cited in para 9-4b(1)(f).)

#### **AR 614-100**

Officer Assignment Policies, Details, and Transfers. (Cited in paras 7-16b(2)(a) and 7-16b(2)(c).)

#### **AR 623-3**

Evaluation Reporting System. (Cited in para 7-16e(1)(g).)

#### **AR 635-200**

Active Duty Enlisted Administrative Separations. (Cited in paras 4-10a(6) and 10-12a.)

**DA Pam 600-85**

Army Substance Abuse Program Civilian Services. (Cited in para 11-2a.)

**DA Pam 611-21**

Military Occupational Classification and Structure. (Cited in paras 4-4a(1) and 7-9b(1) through (4).)

**DOD 6025.13-R**

Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS). (Cited in paras 1-4a(2), 1-4j(2)(i), 2-6candg, 4-2a, 12-10, 13-2a(4), 13-4b, 13-5b(6), 13-6b(3)(b), 13-6f(2), and 13-6g(2)(e).)

**DODI 1332.38**

Physical Disability Evaluation. (Cited in para 13-4b(1).)

**DODI 1402.5**

Criminal History Background Checks on Individuals in Child Care Services. (Cited in paras 8-7o(3), F-3d(4), and F-4.)

**DODI 6025.16**

Portability of State Licensure for Healthcare Professionals. (Cited in para 4-5a.)

**DODI 6055.1**

DoD Safety and Occupational Health (SOH) Program. (Cited in para 1-4j(7)(e).) )

**DODI 6490.4**

Requirements for Mental Health Evaluations of Members of the Armed Forces. (Cited in paras 11-3c(1)(b) and 11-4a(1).)

**Health Affairs Policy 05-002**

Health Insurance Portability and Accountability Act National Provider Enumeration Policy for Military Health System Individual (Type 1) Healthcare Providers, 26 January 2005. (Cited in para 8-7r.) (Available at <http://www.ha.osd.mil/policies/default.cfm>.)

**Health Affairs Policy 00-0009**

DoD Participation in the Health Integrity and Protection Data Bank. (Cited in para 14-4.) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Health Affairs Memorandum**

Additional Guidance Regarding DoD Policy on Physician Licensure, 28 September 1999. (Cited in para 4-6g.) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Health Affairs Memorandum**

Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB), 11 December 1995. (Cited in para 8-10a.) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Health Affairs Policy 94-004**

DoD Inter-Facility Credentials Transfer and Privileging. (Cited in para 8-10a.) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Health Affairs Policy 98-015**

Policy for Provider Directories. (Cited in para 2-4a(7).) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Health Affairs Policy 99-007**

DoD Policy on Physician Licensure. (Cited in paras 4-6g(1) and 4-7a.) Obtain online at <http://www.ha.osd.mil/policies/default.cfm>.

**Office of Personnel Management**

Qualification Standards; General Schedule Positions. (Cited in para 4-4a(1).) (Obtain at <http://www.opm.gov/qualifications/index.html>.)

## **The Joint Commission Manuals**

Comprehensive Accreditation Manual for Hospitals: Ambulatory Care Manual, Home Care Manual, Long Term Care Manual, Healthcare Networks Manual, Behavioral Health Manual, Pathology and Clinical Laboratory Manual. (Cited in paras 3-2, 3-6b(2), and J-4b.) (The current editions of the seven publications listed above may be obtained from TJC, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.)

## **Section II**

### **Related Publications**

A related publication is a source of additional information. The user does not have to read a related reference to understand this publication. The Public Laws and the U.S. Code are available at <http://www.gpoaccess.gov/index.html>. DOD directives are available online at <http://www.dtic.mil/whs/directives>.

### **Armed Forces Institute of Pathology (AFIP) Pamphlet 40-24**

Technical Instructions for the DoD Clinical Laboratory Improvement Program. (Obtain at <http://www.afip.org/OCLAB/forms/PAM40-242002.pdf>.)

#### **AR 15-1**

Committee Management

#### **AR 20-1**

Inspector General Activities and Procedures

#### **AR 27-3**

The Army Legal Assistance Program

#### **AR 27-20**

Claims

#### **AR 27-40**

Litigation

#### **AR 40-1**

Composition, Mission, and Functions of the Army Medical Department

#### **AR 40-3**

Medical, Dental, and Veterinary Care

#### **AR 40-61**

Medical Logistics Policies

#### **AR 40-400**

Patient Administration

#### **AR 135-101**

Appointment of Reserve Commissioned Officers for Assignment to Army Medical Department Branches

#### **AR 190-30**

Military Police Investigations

#### **AR 385-10**

The Army Safety Program

#### **AR 600-8-11**

Reassignment

#### **AR 600-20**

Army Command Policy

#### **AR 600-106**

Flying Status for Nonrated Army Aviation Personnel

**AR 601–20**

Interservice Physician Assistant Training Program

**AR 608–18**

The Army Family Advocacy Program

**Clinical Electrophysiologic Physical Therapy: Description of Advanced Practice**

Alexandria, VA: American Physical Therapy Association (1995). (Obtain at [http://www.apta.org/Education/specialist/ABPTSCert/dscpt\\_advanced\\_cln\\_prt](http://www.apta.org/Education/specialist/ABPTSCert/dscpt_advanced_cln_prt).)

**Diagnostic and Statistical Manual of Mental Disorders**

(This publication may be obtained from The American Psychiatric Association, 1700 18th Street, NW, Washington, DC 20009.)

**DODD 5154.24**

Armed Forces Institute of Pathology (AFIP)

**DODD 6000.14**

Patient Bill of Rights and Responsibilities in the Military Health System (MHS)

**DODD 6025.13**

Medical Quality Assurance (MQA) in the Military Health Service (MHS), 4 May 2004.

**DODD 6465.3**

Organ and Tissue Donation

**DODD 6490.1**

Mental Health Evaluations of Members of the Armed Forces

**ICD–9–CM**

International Classification of Diseases (ICD)-Ninth Revision-Clinical Modification. (Copies of this 3-volume set may be obtained from the Superintendent of Documents, Government Printing Office, Washington, DC 20402–9325.)

**Manual of Clinical Dietetics**

American Dietetic Association. (Obtain at <http://www.eatright.org>.)

**Out of the Crisis**

Deming, W.E. Cambridge, MA: Massachusetts Institute of Technology. (Obtain at <http://www.deming.edu>.)

**PL 99–660**

The Healthcare Quality Improvement Act of 1986

**PL 99–661**

The National Defense Authorization Act for Fiscal Year 1987

**PL 101–629**

Safe Medical Devices Act of 1990

**PL 101–647**

Crime Control Act (CCA) of 1990

**PL 104–191**

The Health Insurance Portability and Accountability Act of 1996

**Title 5, Code of Federal Regulations**

Administrative Personnel. (Obtain at <http://www.access.gpo.gov/nara/cfr/>.)

**Title 21, Code of Federal Regulations**

Food and Drugs. (Obtain at <http://www.access.gpo.gov/nara/cfr/>.)

### **Section III**

#### **Prescribed Forms**

Except where otherwise indicated below, the following forms are available as follows: DA forms are available on the Army Publishing Directorate's (APD) Web site (<http://www.apd.army.mil>); DD forms are available on the Office of the Secretary of Defense Web site (<http://web1.whi.osd.mil/icdhome/icdhome.htm>).

#### **DA Form 4106**

Incident Report. (Prescribed in paras 12-4b(1), (2), (3), (4); 12-8c(4); 12-8d(2); and 13-4a(2).)

#### **DA Form 4691**

Initial Application for Clinical Privileges and Staff Appointment. (Prescribed in paras 8-7b(1); 9-4a(1),(8); 9-4b(1)(a); 9-4b(3),(5); 9-5a; 9-8a(1),(3); E-8a(1); and G-3a.)

#### **DA Form 4691-1**

Application for Renewal of Clinical Privileges and Staff Appointment. (Prescribed in paras 9-2c(1)(a); 9-4a(2),(8); 9-4c(3),(8); 9-6a(2),(3); and E-8a(6).)

#### **DA Form 5009**

Medical Record—Release Against Medical Advice. (Prescribed in para 12-8c(2).)

#### **DA Form 5374**

Performance Assessment. (Prescribed in paras 3-6b(2)(e); 5-3c(3)(a); 7-3a; 8-11b; 9-4a(3); 9-4b(1)(c); 9-4c(3); 9-4c(3)(c); 9-4d(1),(2),(3); 9-4h(4)(a); 9-4i(3); 9-8d(2),(5); 10-4c; E-6(2),(3); E-8b(1); E-8e; H-3a(8))

#### **DA Form 5440 Series**

Delineation of Clinical Privileges— (Note: Forms included in this series begin with DA Form 5440 and end with DA Form 5440-58, as listed below.) (Prescribed in paras 7-1b(2); 7-2d; 7-4g(3)(b); 7-9c(2); 8-7i; 8-10c(1),(3),; 8-11b(1);9-1d; 9-4a(4),(5),(7);9-4b(1) through (5); 9-4c(3),(4),(8); 9-4g(1),(2); 9-4h(4); 9-8a(3); 9-8c(3); 10-4c; E-8a(2); E-8e; F-3a; G-3a; and H-3c(1). )

#### **DA Form 5440A**

Approval of Clinical Privileges/Staff Appointment. (Prescribed in paras 7-1b; 8-5d(1); 8-10c(2); 8-11b(4); 9-4a(6); 9-4b(4),(5); 9-4c(4),(8); 9-4e(4); 9-4h(4); 9-5e; 9-6a(3); 9-8b(5); 9-8a(3); E-8a(3); and H-3c(4).)

#### **DA Form 5440**

Delineation of Clinical Privileges—Anesthesia. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-1**

Delineation of Clinical Privileges—Dentistry. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-2**

Delineation of Clinical Privileges—Family Practice. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-3**

Delineation of Clinical Privileges—Internal Medicine. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-4**

Delineation of Clinical Privileges—Neurology. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-5**

Delineation of Clinical Privileges—Obstetrics and Gynecology. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-6**

Delineation of Clinical Privileges—Optometry. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-7**

Delineation of Clinical Privileges—Pathology. (Prescribed in para 9-4a(4).)

#### **DA Form 5440-8**

Delineation of Clinical Privileges—Pediatrics. (Prescribed in para 9-4a(4).)

**DA Form 5440-9**

Delineation of Clinical Privileges—Podiatry. (Prescribed in para 9-4a(4).)

**DA Form 5440-10**

Delineation of Clinical Privileges—Psychiatry. (Prescribed in para 9-4a(4).)

**DA Form 5440-11**

Delineation of Clinical Privileges—Psychology. (Prescribed in para 9-4a(4).)

**DA Form 5440-12**

Delineation of Clinical Privileges—Diagnostic Radiology. (Prescribed in para 9-4a(4).)

**DA Form 5440-13**

Delineation of Clinical Privileges—General Surgery. (Prescribed in para 9-4a(4).)

**DA Form 5440-14**

Delineation of Clinical Privileges—Nurse Anesthetist. (Prescribed in para 9-4a(4).)

**DA Form 5440-15**

Delineation of Clinical Privileges—Certified Nurse Midwife. (Prescribed in para 9-4a(4).)

**DA Form 5440-16**

Delineation of Clinical Privileges—Nurse Practitioner. (Prescribed in para 9-4a(4).)

**DA Form 5440-18**

Delineation of Clinical Privileges—Physician Assistant. (Prescribed in para 9-4a(4).)

**DA Form 5440-19**

Delineation of Clinical Privileges—Dietetics. (Prescribed in para 9-4a(4).)

**DA Form 5440-20**

Delineation of Clinical Privileges—Occupational Therapy. (Prescribed in para 9-4a(4).)

**DA Form 5440-21**

Delineation of Clinical Privileges—Physical Therapy. (Prescribed in para 9-4a(4).)

**DA Form 5440-22**

Delineation of Clinical Privileges. (Prescribed in para 9-4a(4).)

**DA Form 5440-23**

Delineation of Clinical Privileges—Emergency Medicine. (Prescribed in para 9-4a(4).)

**DA Form 5440-24**

Delineation of Clinical Privileges—Aerospace Medicine. (Prescribed in para 9-4a(4).)

**DA Form 5440-25**

Delineation of Clinical Privileges—General Medical Officer. (Prescribed in para 9-4a(4).)

**DA Form 5440-28**

Delineation of Clinical Privileges—Social Work. (Prescribed in para 9-4a(4).)

**DA Form 5440-29**

Delineation of Clinical Privileges—Allergy/Immunology. (Prescribed in para 9-4a(4).)

**DA Form 5440-30**

Delineation of Clinical Privileges—Nephrology. (Prescribed in para 9-4a(4).)

**DA Form 5440-31**

Delineation of Clinical Privileges—Chiropractic. (Prescribed in para 9-4a(4).)

**DA Form 5440-32**

Delineation of Clinical Privileges-Dermatology. (Prescribed in para 9-4a(4).)

**DA Form 5440-33**

Delineation of Clinical Privileges-Urology. (Prescribed in para 9-4a(4).)

**DA Form 5440-34**

Delineation of Clinical Privileges—Behavioral Health Practitioner. (Prescribed in para 9-4a(4).)

**DA Form 5440-35**

Delineation of Clinical Privileges—Psychological Associate. (Prescribed in para 9-4a(4).)

**DA Form 5440-36**

Delineation of Clinical Privileges-Audiology. (Prescribed in para 9-4a(4).)

**DA Form 5440-37**

Delineation of Clinical Privileges—Speech Pathology. (Prescribed in para 9-4a(4).)

**DA Form 5440-38**

Delineation of Clinical Privileges—Clinical Pharmacy. (Prescribed in para 9-4a(4).)

**DA Form 5440-39**

Delineation of Clinical Privileges—Nuclear Medicine. (Prescribed in para 9-4a(4).)

**DA Form 5440-40**

Delineation of Clinical Privileges—Therapeutic Radiology. (Prescribed in para 9-4a(4).)

**DA Form 5440-41**

Delineation of Clinical Privileges—Physical Medicine and Rehabilitation. (Prescribed in para 9-4a(4).)

**DA Form 5440-42**

Delineation of Clinical Privileges-Cardiology. (Prescribed in para 9-4a(4).)

**DA Form 5440-43**

Delineation of Clinical Privileges-Ophthalmology. (Prescribed in para 9-4a(4).)

**DA Form 5440-44**

Delineation of Clinical Privileges-Otolaryngology. (Prescribed in para 9-4a(4).)

**DA Form 5440-45**

Delineation of Clinical Privileges-Cardiovascular Surgery. (Prescribed in para 9-4a(4).)

**DA Form 5440-46**

Delineation of Clinical Privileges—Pulmonary Disease. (Prescribed in para 9-4a(4).)

**DA Form 5440-47**

Delineation of Clinical Privileges—Preventive Medicine. (Prescribed in para 9-4a(4).)

**DA Form 5440-48**

Delineation of Clinical Privileges— Oral & Maxillofacial Surgery. (Prescribed in para 9-4a(4).)

**DA Form 5440-49**

Delineation of Clinical Privileges—Plastic Surgery. (Prescribed in para 9-4a(4).)

**DA Form 5440-50**

Delineation of Clinical Privileges—Vascular Surgery. (Prescribed in para 9-4a(4).)

**DA Form 5440-51**

Delineation of Clinical Privileges-Neurosurgery. (Prescribed in para 9-4a(4).)

**DA Form 5440–52**

Delineation of Clinical Privileges—Critical Care Medicine. (Prescribed in para 9–4a(4).)

**DA Form 5440–53**

Delineation of Clinical Privileges—Occupational Medicine. (Prescribed in para 9–4a(4).)

**DA Form 5440–54**

Delineation of Clinical Privileges—Thoracic Surgery. (Prescribed in para 9–4a(4).)

**DA Form 5440–55**

Delineation of Clinical Privileges—Orthopaedic. (Prescribed in para 9–4a(4).)

**DA Form 5440–56**

Delineation of Clinical Privileges—Blood Services. (Prescribed in para 9–4a(4).)

**DA Form 5440–57**

Delineation of Clinical Privileges—Psychiatric Advanced Practice Nurse. (Prescribed in para 9–4a(4).)

**DA Form 5440–58**

Delineation of Clinical Privileges—Substance Abuse Rehabilitation. (Prescribed in para 9–4a(4).)

**DA Form 5441 Series**

Evaluation of Clinical Privileges—. (Note: Forms included in this series begin with DA Form 5441 and end with DA Form 5441–58 as noted below.)(Prescribed in paras 5–3c(3); 7–3a; 9–4a(3),(7); 9–4b(1); 9–4c(3),(4),(8); 9–4d(1),(2),(3); 9–4h(4); 9–4i(3); 9–8d(2),(5); 10–4c; E–6; E–8a(4); E–8e; H–3a(9); and H–3b(9).)

**DA Form 5441**

Evaluation of Clinical Privileges—Anesthesia. (Prescribed in para 9–4a(7).)

**DA Form 5441–1**

Evaluation of Clinical Privileges—Dentistry. (Prescribed in para 9–4a(7).)

**DA Form 5441–2**

Evaluation of Clinical Privileges—Family Practice. (Prescribed in para 9–4a(7).)

**DA Form 5441–3**

Evaluation of Clinical Privileges—Internal Medicine. (Prescribed in para 9–4a(7).)

**DA Form 5441–4**

Evaluation of Clinical Privileges—Neurology. (Prescribed in para 9–4a(7).)

**DA Form 5441–5**

Evaluation of Clinical Privileges—Obstetrics and Gynecology. (Prescribed in para 9–4a(7).)

**DA Form 5441–6**

Evaluation of Clinical Privileges—Optometry. (Prescribed in para 9–4a(7).)

**DA Form 5441–7**

Evaluation of Clinical Privileges—Pathology. (Prescribed in para 9–4a(7).)

**DA Form 5441–8**

Evaluation of Clinical Privileges—Pediatrics. (Prescribed in para 9–4a(7).)

**DA Form 5441–9**

Evaluation of Clinical Privileges—Podiatry. (Prescribed in para 9–4a(7).)

**DA Form 5441–10**

Evaluation of Clinical Privileges—Psychiatry. (Prescribed in para 9–4a(7).)

**DA Form 5441-11**

Evaluation of Clinical Privileges—Clinical Psychology. (Prescribed in para 9-4a(7).)

**DA Form 5441-12**

Evaluation of Clinical Privileges—Diagnostic Radiology. (Prescribed in para 9-4a(7).)

**DA Form 5441-13**

Evaluation of Clinical Privileges—General Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-14**

Evaluation of Clinical Privileges—Nurse Anesthetist. (Prescribed in para 9-4a(7).)

**DA Form 5441-15**

Evaluation of Clinical Privileges—Certified Nurse Midwife. (Prescribed in para 9-4a(7).)

**DA Form 5441-16**

Evaluation of Clinical Privileges—Nurse Practitioner. (Prescribed in para 9-4a(7).)

**DA Form 5441-18**

Evaluation of Clinical Privileges—Physician Assistant. (Prescribed in para 9-4a(7).)

**DA Form 5441-19**

Evaluation of Clinical Privileges—Dietetics. (Prescribed in para 9-4a(7).)

**DA Form 5441-20**

Evaluation of Clinical Privileges—Occupational Therapy. (Prescribed in para 9-4a(7).)

**DA Form 5441-21**

Evaluation of Clinical Privileges—Physical Therapy. (Prescribed in para 9-4a(7).)

**DA Form 5441-22**

Evaluation of Clinical Privileges. (Prescribed in para 9-4a(7).)

**DA Form 5441-23**

Evaluation of Clinical Privileges—Emergency Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-24**

Evaluation of Clinical Privileges—Aerospace Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-25**

Evaluation of Clinical Privileges—General Medical Officer. (Prescribed in para 9-4a(7).)

**DA Form 5441-28**

Evaluation of Clinical Privileges—Social Work. (Prescribed in para 9-4a(7).)

**DA Form 5441-29**

Evaluation of Clinical Privileges—Allergy/Immunology. (Prescribed in para 9-4a(7).)

**DA Form 5441-30**

Evaluation of Clinical Privileges—Nephrology. (Prescribed in para 9-4a(7).)

**DA Form 5441-31**

Evaluation of Clinical Privileges—Chiropractic. (Prescribed in para 9-4a(7).)

**DA Form 5441-32**

Evaluation of Clinical Privileges—Dermatology. (Prescribed in para 9-4a(7).)

**DA Form 5441-33**

Evaluation of Clinical Privileges—Urology. (Prescribed in para 9-4a(7).)

**DA Form 5441-34**

Evaluation of Clinical Privileges—Behavioral Health Practitioner. (Prescribed in para 9-4a(7).)

**DA Form 5441-35**

Evaluation of Clinical Privileges—Psychological Associate. (Prescribed in para 9-4a(7).)

**DA Form 5441-36**

Evaluation of Clinical Privileges—Audiology. (Prescribed in para 9-4a(7).)

**DA Form 5441-37**

Evaluation of Clinical Privileges—Speech Pathology. (Prescribed in para 9-4a(7).)

**DA Form 5441-38**

Evaluation of Clinical Privileges—Clinical Pharmacy. (Prescribed in para 9-4a(7).)

**DA Form 5441-39**

Evaluation of Clinical Privileges—Nuclear Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-40**

Evaluation of Clinical Privileges—Therapeutic Radiology. (Prescribed in para 9-4a(7).)

**DA Form 5441-41**

Evaluation of Clinical Privileges—Physical Medicine and Rehabilitation. (Prescribed in para 9-4a(7).)

**DA Form 5441-42**

Evaluation of Clinical Privileges—Cardiology. (Prescribed in para 9-4a(7).)

**DA Form 5441-43**

Evaluation of Clinical Privileges—Ophthalmology. (Prescribed in para 9-4a(7).)

**DA Form 5441-44**

Evaluation of Clinical Privileges—Otolaryngology. (Prescribed in para 9-4a(7).)

**DA Form 5441-45**

Evaluation of Clinical Privileges—Cardiovascular Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-46**

Evaluation of Clinical Privileges—Pulmonary Disease. (Prescribed in para 9-4a(7).)

**DA Form 5441-47**

Evaluation of Clinical Privileges—Preventive Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-48**

Evaluation of Clinical Privileges—Oral & Maxillofacial and Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-49**

Evaluation of Clinical Privileges—Plastic Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-50**

Evaluation of Clinical Privileges—Vascular Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-51**

Evaluation of Clinical Privileges—Neurosurgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-52**

Evaluation of Clinical Privileges—Critical Care Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-53**

Evaluation of Clinical Privileges—Occupational Medicine. (Prescribed in para 9-4a(7).)

**DA Form 5441-54**

Evaluation of Clinical Privileges—Thoracic Surgery. (Prescribed in para 9-4a(7).)

**DA Form 5441-55**

Evaluation of Clinical Privileges—Orthopedics. (Prescribed in para 9-4a(7).)

**DA Form 5441-56**

Evaluation of Clinical Privileges-Blood Services. (Prescribed in para 9-4a(7).)

**DA Form 5441-57**

Evaluation of Clinical Privileges-Psychiatric Advanced Practice Nurse. (Prescribed in para 9-4a(7).)

**DA Form 5441-58**

Evaluation of Clinical Privileges-Army Substance Abuse Rehabilitation. (Prescribed in para 9-4a(7).)

**DA Form 5754**

Malpractice History and Clinical Privileges Questionnaire. (Prescribed in paras 8-7g,h,i; 9-4a(9); 9-4b(1),(5); 9-4c(3),(8); 9-8a(3); E-8a(5); and G-3a.)

**DA Form 7653**

Verification of Clinical Competencies for Critical Care Skill Identifier (SA 8A). (Prescribed in para 5-1a (1).)

**DA Form 7654**

Verification of Clinical Competencies for Emergency Nursing Skill Identifier (SI M5). (Prescribed in para 5-1a (1).)

**DD Form 2499**

Health Care Provider Action Report. (Prescribed in paras 6-4d; 6-6b; 10-5f; 10-6a(2); 10-6b(2); 10-6c(2)(a),(c); 10-14a; 10-14b(1) through (5); 10-15a, 10-15c, 10-16b, 11-4e(2), 11-6a, and 14-3b(2) (b).)

**DD Form 2526**

Case Abstract for Malpractice Claims. (Prescribed in paras 6-4d, 13-4a(1), 13-4b(4), 13-4c, 13-4e, 13-5b(1),(3),(5), 13-5c(1),(2), 13-6c(2), and 14-3b(3))

**Section IV****Referenced Forms****DA Form 11-2-R**

Management Control Evaluation Certification Statement

**DA Form 200**

Transmittal Record

**DA Form 2028**

Recommended Changes to Publications and Blank Forms

**DA Form 3349**

Physical Profile

**DA Form 3647**

Inpatient Treatment Record Cover Sheet

**DA Form 3881**

Rights Warning Procedure/Waiver Certificate

**DA Form 4036**

Medical and Dental Preparation for Overseas Movement

**DA Form 4186**

Medical Recommendation for Flying Duty

**DA Form 4256**

Doctor's Orders

**DA Form 5181**

Screening Note of Acute Medical Care

**DA Form 5753**

USAR or ARNG Application for Clinical Privileges to Perform Active or Inactive Duty Training. (This form is obsolete but, if previously completed, it will be kept for historical purposes in individual files.)

**DA Form 7389**

Medical Record—Anesthesia

**DA Form 7653**

Verification of Clinical Competencies for Critical Care Nursing Skill Identifier (SI 8A)

**DA Form 7654**

Verification of Clinical Competencies for Critical Care Nursing Skill Identifier (SI M5)

**OF 522**

Medical Record—Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

**SF 95**

Claim for Damage, Injury, or Death

**SF 380**

Reporting and Processing Medical Materiel Complaints/Quality Improvement Report

**SF 504**

Clinical Record - History Part I

**SF 505**

Clinical Record - History Part II and III

**SF 506**

Medical Record - Physical Examination

**SF 509**

Medical Record—Progress Notes

**SF 513**

Medical Record—Consultation Sheet

**SF 600**

Health Record—Chronological Record of Medical Care

**SF 603**

Health Record—Dental

**SF 603A**

Health Record—Dental—Continuation

**Appendix B****Quality Assurance (QA) Confidentiality Statute for the DOD****B–1. Statute overview**

The National Defense Authorization Act for fiscal year 1987 (PL99–661), as contained in 10 USC 1102, provides that records created by or for the DOD 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. (See para B–6.) Further guidance is provided in DOD 6025.13–R. 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.

## **B–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 10 USC 1102 and DOD 6025.13–R and implemented by this regulation.
- 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).

## **B–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. For example, a commander’s investigation under AR 15–6 is not normally a QA function, while a QA investigation using the format for an AR 15–6 investigation would be a QA function. Similarly, an IG survey, inquiry, or investigation under AR 20–1 is not routinely a QA activity, while an IG survey, inquiry, or investigation designated by the commander as a QA survey, inquiry, or inspection would be protected as a QA activity.

## **B–4. Definitions specific to quality assurance**

a. A “medical QA program” is defined in 10 USC 1102 as “all activities carried out before, on, or after 14 November 1986 by or for the DOD to assess the quality of medical care.” The statute specifically includes any activity designed to assess the quality of medical care by individuals; MTF/DTF committees or other review bodies responsible for QA, credentials, infection control, patient care assessment outcomes (including treatment procedures, blood, drugs, and therapeutics); medical/dental records; health resource management review; and identification and prevention of medical/dental incidents and risks.

b. A “medical QA record” is defined in 10 USC 1102 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” (now considered a subset of the CQMP).

## **B–5. The 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, CID, 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 regulation. QA records will be removed from the report(s) when IG, CID, 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 10 USC 1102.

## **B–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/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 DOD.
- d. A hospital, MEDCEN, 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 member or employee of the DOD 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. An officer, employee, or contractor of the DOD 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 subparagraph *f* above but only with respect to the subject of said proceeding.

#### **B-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.

#### **B-8. Release of information**

In no instance will QA records or information be released to anyone other than AMEDD personnel in the performance of their duties without the written approval of the MTF commander or TSG. Release of QA information outside the DOD requires the approval of TSG or his designee. TSG has delegated to the USAMEDCOM QMD sole responsibility for reporting QA-specific information to the NPDB and national, professional, and State licensing, certification, and registration agencies. MTF commanders should consult with the SJA or civilian legal adviser concerning questions of disclosure of information.

#### **B-9. Disclosure statement**

The following will be included on all QA documents prior to transmittal: "Quality Assurance Document under 10 USC 1102. Copies of this document, enclosures thereto, and information therefrom 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."

#### **B-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.

#### **B-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 DOD. The requirement to delete names does not apply to information released to the individual who is the subject of a QA action (Privacy Act, 5 USC 552a). 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.

#### **B-12. Use of the FOIA request**

While QA records are specifically exempt from access under the FOIA (5 USC 552a), the processing of a FOIA request is required for authorized disclosure of information in any of the circumstances outlined in paragraph B-6. 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 TSG.

### **Appendix C Competency Assessment File**

#### **C-1. Description**

The CAF is used as the repository for information related to individual competence for all non-privileged healthcare personnel. See paragraph 5-1*h* for additional information related to competency documentation and use of the CAF.

#### **C-2. Contents and organization**

All information contained in the CAF 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 CAF. Any counseling or disciplinary records, performance appraisals and the like should be maintained in the individual's personnel folder. The CAF 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 MTF, a reliable and confidential mechanism to transmit these data to the CAF 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 CAF 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 USAMED-COM, TJC, Occupational Safety and Health Administration, 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 with multiple examples of competency assessment tools are available for local modification and use at <https://akm.amedd.army.mil/competency> or <http://akm.amedd.army.mil/competency>. While this format is recommended, it is not required for use at the MTF level.

(2) *Evidence of ongoing competency assessment.* A standardized format for this requirement is likewise available at the Web sites noted above. While this format is recommended, its use at the MTF level is not mandatory.

(3) *Evidence of age-specific competency assessment, if indicated.* Age-specific competency tools are available at the Web sites noted above. These should be used to complement the ongoing training documentation.

(4) *Other.* Other institution-specific forms as specified in local policy.

*e. Section V.* Continuing education.

(1) Evidence of professional education, military and readiness training, inservice 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, patient safety, 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.

## **Appendix D**

### **Special Forces Medical Sergeants' (18D) Scope of Practice in AMEDD MTFs**

#### **D-1. General**

The Special Forces Medical Sergeant (18D) must maintain a variety of medical skills for application in worldwide operational environments where no medical officer is available. During structured sustainment training in an AMEDD MTF, the 18D is authorized to perform the following procedures under the supervision of a privileged provider:

*a.* Airway management including intubation and emergency airway procedures.

*b.* Bag-valve-mask or bag-valve-tube ventilatory support.

*c.* Patient immobilization and transport.

*d.* Placement of urinary tract catheter.

*e.* Placement of nasogastric or orogastric tube.

*f.* Minor surgical procedures for wound debridement, to drain an abscess, or to control hemorrhage.

*g.* Wound suturing.

*h.* Emergency needle and tube thoracostomy.

*i.* Administration of topical, inhalation, oral, subcutaneous, intravenous, or intramuscular medications.

*j.* 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.

## **D-2. Patient assessment training and management skills**

During structured sustainment training in an AMEDD MTF, the 18D is authorized to perform the following patient assessment and management skills under the supervision of a privileged provider:

- a.* Perform assessment of patients and document H&P examination.
- b.* Triage patients and recommend disposition of patients.
- c.* Perform basic interpretation of plain radiographs of extremities, chest, abdomen, spine, and pelvis.
- d.* Perform basic interpretation of urinalysis, complete blood count, Gram's stain, blood smears, and KOH and saline slide preparations.
- e.* Assess and manage diseases of the mouth and teeth to include uncomplicated dental caries and emergency management of maxillofacial and dental trauma.
- f.* Initial management of—
  - (1) Various types of wounds (lacerations, burns, blunt injury, crush injuries, head trauma) and traumatic amputations.
  - (2) Fractures and soft tissue injuries to include bandaging, splinting, and casting.
  - (3) Shock (cardiogenic, hemorrhagic, septic) to include intravenous access and fluid management.
  - (4) Various medical emergencies including cardiac, pulmonary, gastroenterologic, neurologic, toxicologic, metabolic, and ophthalmologic diseases, heat/cold injury, and altitude/decompression sickness.
- g.* Initial assessment and management of—
  - (1) Medical diseases including infectious disease, gastroenterology, cardiovascular, endocrine, pulmonary, neurology, otolaryngology, nephrology, musculoskeletal, and dermatology.
  - (2) Uncomplicated emotional, psychological, and psychiatric conditions.
  - (3) Acute, uncomplicated pediatric illness and infectious disease.
- h.* 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.

## **Appendix E Provider Credentials File**

### **E-1. Individuals requiring a PCF**

A PCF will be established for all privileged providers per paragraph 8-3b(2)(a). 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 and AR 340-21.

### **E-2. Duration of use**

The PCF will be maintained for the entire service career of the military provider to include active and inactive service in the RC. For civilians (GS and contract), the PCF will be maintained for the entire period of employment with the Federal Government.

### **E-3. Maintenance of the PCF**

For the various categories of AMEDD providers, the responsibility for PCF maintenance is as follows:

- a.* For AA military and civilian (GS and contract), the credentials office of the MTF who exercises command or executive authority over the provider is responsible for the PCF. For AA privileged providers attending nonclinical postgraduate or specialty training, advanced military training, or changing duty stations to a nonclinical assignment, the PCF will be forwarded to Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.
- b.* For ARNG, the respective State Adjutant General or the ARNG State Surgeon who is the Adjutant General's designee for CQM will be responsible.
- c.* For USAR TPU privileged providers, ARCCA is responsible. Duplicate files will not be maintained by the unit of assignment/attachment.
- d.* For IRR members and retired providers (USAR/ARNG, retired and discharged/separated AA), the HRC is responsible.
- e.* For IMAs, the credentials office of the facility to which the provider is assigned is responsible.

*Note.* Any credentialing processes performed at other than AA medical or dental units will be to the same level of quality and detail as that of the AA MTF credentials committee.

### **E-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 10 USC 1102. The cover of the PCF will bear the disclosure statement as noted in paragraph B-9 of this regulation.

c. The PCF will be released only to the MTF commander, the credentials committee, department/service chiefs, and reviewing authorities or officially appointed inspectors. The contents must be intact and the security of the information ensured at all times. The provider may authorize, in writing, release of his/her PCF to others. The PCF will be retained in the credentials office with authorized access by others in that secure location.

#### **E-5. Disposition of the PCF**

a. The PCF transfer from facility-to-facility will be by certified mail, return receipt requested. Accompanying the PCF will be a DA Form 200 (Transmittal Record). A PCF will never be hand carried by the individual provider.

b. For AA providers who have separated in good standing with defined privileges, the original PCF will be forwarded immediately to Commander, HRC, ATTN: AHRC-RSA-Q, 1 Reserve Way, St. Louis, MO 63132-5200. A copy of the order of separation, discharge, or assignment to the IRR will be included with the PCF. A copy of the PCF and a copy of the separation order will be held at the MTF for 1 year and then destroyed.

c. Upon discharge or retirement from the Army, the PCF (all military providers) will be forwarded to HRC Quality Management Directorate for maintenance. For those AD providers transferring to the RC, the entire PCF will be forwarded to the unit of assignment/attachment or to Commander, HRC, ATTN: AHRC-RSA-Q, 1 Reserve Way, St. Louis, MO 63132-5200 for forwarding to the TPU of assignment.

d. Disposition of the PCF after the provider ends his/her military service (separates, is discharged, or retires) will be according to AR 25-400-2.

(1) HRC will store in a retired status the PCFs of all retired privileged providers as stipulated in AR 25-400-2.

(2) Pertinent data from the PCFs of all retired privileged providers will be entered into the CCQAS database; the PCFs are then catalogued and stored according to established tracking procedures.

(3) Retirees in USAMEDCOM-designated critically short AOCs will have their PCFs maintained by HRC for a period as specified in USAMEDCOM guidance.

(4) The PCFs of privileged providers separating from the military will be entered into the CCQAS database, identified by a tracking number, and forwarded to the designated QM holding area at HRC.

(5) The PCFs and credentials data of privileged providers discharged from AD roles and transferred to the IRR will be maintained by HRC until these individuals retire or separate from the IRR.

e. The PCF of civilian providers (GS and contract) will be retained for 5 years by the last MTF 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 directly to Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

#### **E-6. PCS, retirement, separation from Service**

When the provider PCSs, separates, or retires from the Service, an updated copy of DA Forms 5374 and 5441 will be included in the PCF prior to the file being forwarded, as indicated in paragraphs E-5b and c.

#### **E-7. CCQAS data entry**

Primary-source-verified-credentials information contained in the PCF will be entered and maintained in the DOD Triservice 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 (AA/USAR/ARNG, U.S./foreign national) or civilian (GS, contract, FNLH, volunteer)). USAMEDCOM instructions will direct the forwarding of CCQAS information, as required, to the USAMEDCOM and/or between MTFs.

#### **E-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 as follows—

a. *Section I.*

(1) DA Form 4691.

(2) DA Form 5440 (current).

(3) DA Form 5440A (current).

- (4) DA Form 5441 (current).
- (5) DA Form 5754.
- (6) DA Form 4691-1.
- (7) Release-of-information statement signed by the provider (local document). Renewal required every two years.
- (8) ICTB for the current period, if applicable.

*b. Section II.*

- (1) DA Form 5374 (current).
- (2) PAF data as determined by the credentials committee and commander (para 8-7).
- (3) Credentials and privileges granted (scope of practice) from civilian facilities where the member is employed or practicing (for USAR/ARNG practitioners).
- (4) For USAR/ARNG providers, two peer recommendations attesting to the competence and professional capabilities of the named provider. These letters must be renewed every 2 years.

*c. Section III. Documents of adverse privileging action by Army MTFs:*

- (1) Letters/memorandum of notification.
- (2) Letters/memorandum of acknowledgment.
- (3) Hearing summary or minutes.
- (4) Investigation results.
- (5) NPDB and/or HIPDB reports - current (within 2 years) and previous.
- (6) Letters of decision (SOC determination, final adverse privileging action).
- (7) Malpractice claims together with the peer review SOC determinations (MTF, CCRB, or USAMEDCOM, as appropriate).
- (8) Copies of any other unfavorable information. Such information will be placed in the PCF only after review by the credentials committee and at the direction of the MTF commander. (The USAR/ARNG PCF will include copies of any adverse privileging actions taken by civilian agencies, if available).
- (9) Copy of CHBC result (when applicable) (see para 8-7o).
- (10) Copy of the provider's current malpractice insurance policy for AA providers engaged in off-duty civilian employment and for USAR/ARNG providers.

*d. Section IV.*

- (1) Continuing education (CE) summary, which includes a 3-year history of courses, sponsors, locations (city and State), dates (start/end), and CE hours/units. Documented proof of attendance at approved CE offerings is required.
- (2) Lectures given, papers published, and special activities (for example, research).
- (3) Curriculum vitae or biographical summary that is revised, dated, and resubmitted every 2 years—ideally with other privilege renewal documents.

*e. Section V. All past and previous DA Forms 5440, 5441, and 5374; ICTBs from previous MTFs; privileges granted at civilian agencies, if applicable; and any historical data associated with clinical privileges.*

*f. Section VI.*

- (1) Copies of diplomas/certificates (for example, medical school, residencies, fellowships).
- (2) Copies of licenses, certifications, and other authorizing documents.

*Note.* Due to the security provided the PCF, copies of the provider's license (other authorizing documents) may be kept on file in the PCF according to local policy.

- (3) Specialty board certification.
- (4) Primary source verification of credentials documentation (para 8-6).
- (5) Emergency resuscitation training data (BLS, ACLS, ATLS, PALS/APLS, neonatal resuscitation program, and so forth).
- (6) DEA/CDS and NPI-Type 1 documentation.
- (7) Provider acknowledgement of DOD physician licensure policy requirements (MC only).

## **Appendix F**

### **Pre-Selection Procedures for Non-Military Health Care Personnel**

#### **F-1. General**

*a. Applicability and health care personnel addressed.* This appendix applies to servicing CPOCs/CPACs, procurement offices, and commanders or directors of AMEDD activities. These provisions cover personnel who are making initial application for Federal service positions in the following occupations and their FNLH equivalents (list not all inclusive)—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; dietitian, 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 appendix are also relevant to applicants for volunteer and personal services contract positions, to include chiropractors.

*b. Pre-selection verification.* Pre-selection PSV of education, training, clinical experience, licensure, and certification or registration before appointment and/or placement into selected civil service, consultant and expert, contracted, and FNLH 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 chapters 8 and 9 of this regulation. 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/CAF may be provided to prospective employers in either the Federal or civilian sectors. See paragraph 14-2*b* for exceptions to the release of adverse information. 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 MTF.

## **F-2. Pre-selection tasks**

*a.* For civilian (GS) health-care-related-occupations applicants (para F-1*a*), consultants and experts, and FNLHs, the servicing CPOC/CPAC and employing AMEDD activity will perform data collection, pre-selection credentials review, and authentication. The commander will designate an individual(s) to perform these required pre-employment activities.

*b.* For personal services contracted employees, the MTF will perform the data collection, pre-selection credentials review, and authentication. For non-personal services contracted employees, the contracting office provides for data collection, review, and authentication. (See para F-4.)

*c.* The AMEDD activity commander/director (or designee) is responsible for the pre-selection validation or verification of professional credentials, including resolution of any issues that bear on the employment of the individual in question. Appointment to any AMEDD health-care-related position may be made only after receipt of the AMEDD commander's/director's (or designee's) written approval of the candidate's acceptability.

## **F-3. Procedures for civil service, consultant and expert, and foreign national local hire health care personnel**

*a. Candidates who require privileges.* Upon selection, the new-to-Federal-service applicant will submit to the MTF credentials manager (or designee) the appropriate privileging documents (for example, DA Forms 4691, 5754, and the 5440 appropriate to his/her discipline). 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. (See para 8-7 for a listing of required credentials.)

*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 MTF 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 MTF 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 AMEDD MTF is responsible for 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. The AMEDD facility.* The appropriate MTF staff member/action officer 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. (See para 8-7.)

- (3) Obtain a current report from the NPDB 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 Crime Control Act of 1990 and DODI 1402.5 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/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 chapter 9.

#### **F-4. Procedures for contracted services**

The contracting office will accomplish the pre-selection verification (para F-1b) for non-personal services contract personnel and provide documentation of such upon request by the AMEDD activity. The contracting office will ensure that a CHBC has been initiated as required by the Crime Control Act of 1990 and DODI 1402.5.

## **Appendix G Provider Activity File**

### **G-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 secure location and filed with, but not part of, the PCF.

*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 10 USC 1102. The cover of the PAF will bear the disclosure statement as noted in paragraph B-9 of this regulation. For additional information regarding 1102 protection of individual documents, see paragraph E-8 and appendix B or consult the local SJA for more specific guidance.

### **G-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 PCS/ETS, 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, and so forth).

- (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 (ICD) manual (current edition) code, and other meaningful utilization data should be identified and maintained.
- d. Risk management 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.

## Appendix H

### Inter-Facility Credentials Transfer Brief Preparation Instructions

#### H-1. Purpose

The ICTB has been authorized by DOD for credentials transfer and privileging when DOD health care providers are temporarily assigned to medical or dental treatment facilities for clinical practice.

#### H-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>.

*Note.* Instructions for use of this system are located in the Help menu on the Credentials Provider Search Screen.

#### H-3. Active Army ICTB and USAR/ARNG ICTB

The CCQAS generates two different ICTBs: an AA ICTB or a USAR/ARNG ICTB. The AA ICTB is to be used by military or full-time civilian providers assigned to AA military facilities except nonpersonal services contract employees. The ICTB supports privileging requirements for temporary assignment of providers between MTFs/units (AA/USAR/ARNG). The USAR/ARNG ICTB is used by the USAR/ARNG providers when requesting privileges in an AA facility. The ICTB may be prepared using the CCQAS (current version) or by typing the information as specified below.

*Note.* The screen content of the CCQAS ICTB will vary slightly from the manually prepared version.

- a.* The contents of the manually prepared ICTB for AA 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 (AOC).
  - (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.

*Note.* 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.

*Note.* 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).

*Note.* 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. (See para 5–1e(1) for additional information.)

(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.

*Note.* Attach a copy of the current list(s) of privileges to the ICTB.

(8) *Paragraph 8.* NPDB/HIPDB query. List the date of most recent NPDB/HIPDB queries and include the information contained in these reports.

(9) *Paragraph 9.* Purpose of TDY. 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. DA Forms 5374 and the 5441 will be used for evaluation/appraisal of providers performing duty in an MTF. 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 the provider's—

(a) Actual clinical performance with respect to the privileges granted at the sending facility,

(b) The discharge of his/her professional obligations as a medical staff member, and

(c) His/her ethical performance.

(d) Should 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.

*Note.* For AA providers not currently holding military privileges, two 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 and is accurately reflected in the brief, as of the date the ICTB was prepared. This paragraph must contain a statement indicating the presence/absence of other relevant information in the PCF. Of particular importance, 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 MTF credentials coordinator.

(14) *Paragraph 14.* Commanders's signature. The signature of the privileging authority (that is, the commander or

designee) and date are required. By signing, he/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 contents of the manually prepared ICTB for USAR/ARNG 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 (AOC).

(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.

*Note.* 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.

*Note.* 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).

*Note.* 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. (See para 5-1e(1) for additional information.)

(6) *Paragraph 6.* DEA/CDS authorizing document. Note document type, number, expiration date, and PSV status.

*Note.* PSV is required.

(7) *Paragraph 7.* Current medical staff appointment/clinical privileges. List the type of professional staff appointment(s) currently held by the provider at the MTF/civilian institution(s) and the expiration date of the appointment(s). The provider who is privileged at the USAR/ARNG unit level normally will not have an MTF staff appointment. Identify the privilege category.

*Note.* Attach a copy of the current list(s) of privileges (civilian and military) to the ICTB.

(8) *Paragraph 8.* NPDB/HIPDB query. List the date of most recent NPDB/HIPDB queries and include the information contained in these reports. If no query has been made, so state.

(9) *Paragraph 9.* Purpose of TDY. 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. DA Forms 5374 and the 5441 will be used for evaluation/appraisal of providers performing duty in an MTF. However, any of the Services' clinical performance appraisal/evaluation forms will be accepted by the sending facility. Upon completion of a 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. This paragraph must contain a statement indicating the presence/absence of other relevant information relating to the provider's clinical competence. The statement should describe the provider's—

(a) Actual clinical performance with respect to the privileges granted at the sending facility,

(b) The discharge of his/her professional obligations as a medical staff member, and

(c) His/her ethical performance.

(d) Should direct contact with the person (peer) providing the statement of qualifications be required, include the name, address and telephone number(s), both business and facsimile, where this professional POC may be reached prior to the USAR/ARNG provider reporting for duty. The names and contact information of the two staff members who provided the peer recommendations, if required, may be noted.

*Note.* For USAR/ARNG providers not currently holding military privileges, two peer recommendations dated within 24 months of ICTB submission are required attachments. These supplement the contents of paragraph 10 of the ICTB.

(11) *Paragraph 11.* Privileging sites/activities and contact information.

(a) Include the provider's current civilian position, place(s) of employment or facility(ies) where privileges are held, and the specialty(ies) in which the individual is privileged. A POC at each facility (including name, title, address, telephone number, facsimile number, and so forth) should be included in the event there are questions related to current

civilian privileges. Civilian facilities should receive a release of information signed by the provider and should be advised that this information will be used for privileging the provider while he/she is on AD.

(b) If the provider is self-employed, provide the individual's office address, telephone number, and facsimile number.

(c) If privileges are held at several civilian facilities, provide the name and location of the place(s) where the majority of the provider's practice is conducted.

(12) *Paragraph 12.* Provider contact information. Include demographic information on how to reach the USAR/ARNG provider by mail or telephone prior to the individual reporting for TDY.

(13) *Paragraph 13.* USAR/ARNG training data. Include a listing of recent Reserve training dates, locations, and type of training performed.

(14) *Paragraph 14.* Verification of ICTB contents. Include a statement attesting to the fact that the USAR/ARNG provider's PCF was reviewed and is accurately reflected in the brief as of the date of the ICTB. A statement indicating the presence/absence of other relevant information in the PCF will also appear here. (This is a prompt by the computer at the time the ICTB is generated and is referring to "adverse information" that might be found within the PCF.) Include any additional information that is relevant to the privileging of the USAR/ARNG provider, as noted above in paragraph (11) for the ICTB.

(15) *Paragraph 15.* Other comments. Note any additional remarks pertinent to the provider's credentials and/or other privilege-related information.

(16) *Paragraph 16.* Unit credentials POC. Indicate a primary POC who has responsibility as the USAR/ARNG unit credentials manager and can address issues or concerns if a problem arises. Include both telephone and facsimile numbers, and electronic mail address, if available. If the credentials manager is not available on a full-time basis, note an alternate POC (that is, a full-time individual who is authorized access to CCQAS and can answer questions during weekday duty hours).

(17) *Paragraph 17.* Commander's signature. The privileging authority (that is, the USAR/ARNG hospital/unit commander or designee) will sign and date this document. By signing, he/she is attesting to the accuracy and the completeness of the information provided. The chief of professional services or an individual designated on an additional duty appointment may sign for the commander if so authorized. This signature serves as the Commander's recommendation that the provider be granted privileges.

c. The following documents are mandatory attachments to the ICTB for both AA and USAR/ARNG:

(1) A copy of all clinical privileges currently held, both military and civilian (that is, DA Form 5440-series and/or civilian privileging document(s)).

(2) In instances where the provider does not hold current military privileges, two professional peer recommendations dated within 24 months of submission.

(3) A completed DA Form 5440 (specific to individual's AOC).

(4) A completed DA Form 5440A, the top portion only (blocks 1–5).

(5) A completed DA Form 5754 (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.

*Note.* For the USAR/ARNG, contact is encouraged with the specific AA facility where the individual is to report for duty. The USAR/ARNG credentials manager may submit the forms noted above to the AA facility either prior to the ICTB being generated or with the ICTB once it is prepared. If previously submitted to the gaining facility, these forms are not mandatory attachments at the time the ICTB is forwarded.

d. The ICTB should be sent to the gaining facility no later than 45 days prior to the start date of duty. This allows the AA facility sufficient time to conduct the required privileging activities (for example, to process the privileging forms, conduct the NPDB/HIPDB queries, and integrate the ICTB into the AA facility's regularly scheduled privileging process).

## **Appendix I**

### **Reportable Acts of Misconduct/Unprofessional Conduct for DOD Health Care Personnel**

#### **I–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 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 DOD guidance (DOD 6025.13–R). 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 service 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 courts-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/her professional or patient communities.
- g.* Prescribing, selling, administering, giving, or using any drug legally classified as a schedule II controlled substance, as defined by 21 USC 801–977, 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 MTF commander, 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 an offense(s) related to professional practice or which impairs the practitioner's credibility within the health care system or within his/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/her profession or which impairs the practitioner's credibility within the health care system or within his/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.
- k.* Failure to report to the privileging authority—
  - (1) Any disciplinary action taken by professional or governmental organization reportable under this regulation.
  - (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.

## **I-2. Acts reported following courts-martial 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 *a* or *b* above.
- 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 DOD MTFs.
- f.* Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.

## **Appendix J**

### **Management Control Evaluation Checklist**

## J-1. Function

The function covered by this checklist is CQM administration.

## J-2. Purpose

The purpose of this checklist is to assist local commanders and the USAMEDCOM QMD in evaluating the key management controls listed below. It is not intended to address all controls.

## J-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 on DA Form 11-2-R (Management Control Evaluation Certification Statement).

## J-4. Test questions

*a. Clinical Quality Management Program.* Each MTF 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 MTF?
- (2) Is the MTF CQMP supported by a written CQM plan?
- (3) How are providers/professionals being educated about the MTF'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 MTF leaders?
- (5) Are CQM data collected, analyzed, and utilized by MTF 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 law and 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 the USAMEDCOM, QMD.

- (1) Did the MTF commander ensure compliance with TJC accreditation standards as evidenced by a score of 70 percent or better during its triennial accreditation survey?
- (2) Did the MTF submit its TJC survey preliminary report and a TJC survey after-action report to the USAMEDCOM, QMD?

*c. Patient rights and responsibilities.* Each MTF has established processes that ensure patient rights and responsibilities are addressed according to TJC standards and DOD requirements.

- (1) Does the MTF review and incorporate the facility-specific information from DOD-sponsored beneficiary surveys into its programs and processes?
- (2) Was the MTF in compliance with current TJC patient rights standards during its latest TJC survey?
- (3) Did the MTF commander 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? Do the MTF leaders participate in the activities of this council? What has changed in the organization as a result of this council's actions?
- (5) Did the MTF commander include the status of patient rights implementation in the annual CQMP Summary Report?

- (6) Is an MTF report card posted or visibly displayed? What data are provided and how often is this data updated?

*d. Utilization management/outcomes management.* Each MTF establishes UM/OM processes to meet TJC, DOD, and USAMEDCOM requirements.

- (1) Did the MTF 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 MTF demonstrate quantifiable improvements in the processes and outcomes of care as reflected in the annual CQMP Summary Report to the commander?
- (3) Did the MTF provide evidence of the use of CPGs and/or clinical pathways in the annual CQMP Summary Report to the commander?

*e. Risk Management/Patient Safety Program(s).* Each MTF establishes either as an individual program or integrated into the MTF Safety Program-an RM/PS Program(s) to meet TJC, DOD, and USAMEDCOM requirements.

- (1) Was a comprehensive MTF Safety Program in place for all beneficiaries, employees, visitors, volunteers, and others?
- (2) Did the MTF perform rigorous risk assessment, risk evaluation, and risk reduction/containment activities to reduce the potential for harm to beneficiaries and others?

(3) Did the MTF demonstrate process measures for identifying, evaluating, and reporting PS events that are according to regulatory and accrediting guidance?

(4) Did the MTF commander report SEs according to current USAMEDCOM guidance?

(5) Did the MTF commander conduct an RCA for each SE reported?

(6) Did the ECMS (or equivalent group) demonstrate oversight and review of the MTF 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.* DOD 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 regulation, is a formal request for extension submitted to the Commander, USAMEDCOM?

(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 nonprivileged 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 nonprivileged 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 MTF TJC survey results document compliance with current TJC medical staff standards?

(2) Was there evidence of systematic credentials verification for all privileged providers and nonprivileged professionals?

(3) Did the MTF 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 USAMEDCOM QMD?

*i. Impaired Health Care Personnel Program.*

(1) Was there evidence of an MTF IHCPP that is functional and incorporated into the CQMP processes, as appropriate?

(2) Were both privileged and nonprivileged members of the staff with alcohol/other drug impairments, or medical, psychiatric, or emotional conditions included in the MTF IHCPP?

## **J-5. Supersession**

There was no previous checklist on this subject.

## **J-6. Comments**

Help make this a better tool for evaluating the CQM processes. Comments regarding this checklist should be addressed to: Commander, USAMEDCOM (MCHO-CL-Q), 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

## **Glossary**

### **Section I Abbreviations**

#### **AA**

Active Army

#### **ABMS**

American Board of Medical Specialties

#### **ACGME**

Accreditation Council for Graduate Medical Education

#### **ACLS**

advanced cardiac life support

#### **AD**

active duty

#### **ADA**

American Dietetic Association

#### **ADT**

active duty for training

#### **ADTMC**

algorithm-directed troop medical care

#### **AFIP**

Armed Forces Institute of Pathology

#### **AGD**

Advanced General Dentistry (12 month)

#### **AMA**

against medical advice

#### **AMEDD**

Army Medical Department

#### **AN**

Army Nurse Corps

#### **ANA**

American Nurses Association

#### **AOC**

area of concentration (formerly SSI)

#### **APA**

American Psychological Association

#### **APLS**

advanced pediatric life support

#### **APRN**

advanced practice registered nurse

#### **AR**

Army regulation

**ARCCA**

Army Reserve Clinical Credentials Activity

**ARIMS**

Army Records Information Management System

**ARNG**

Army National Guard

**ASA**

American Society of Anesthesiologists

**ASAP**

Army Substance Abuse Program

**ASD(HA)**

Assistant Secretary of Defense for Health Affairs

**ASI**

additional skill identifier

**AT**

annual training

**ATLS**

advanced trauma life support

**BLS**

basic life support

**CAF**

competency assessment file

**CCQAS**

Centralized Credentials Quality Assurance System

**CCRB**

consultation case review branch

**CDS**

controlled drug substance

**CD-ROM**

compact disk-read only memory

**CE**

continuing education

**CEMR**

civilian employee medical record

**CFR**

Code of Federal Regulation

**CHBC**

criminal history background checks

**CHN**

community health nurse

**CID**

Criminal Investigation Division

**CJA**

claims judge advocate (MEDDAC), center judge advocate (MEDCEN), command judge advocate (OCONUS)

**CME**

continuing medical education

**CMS**

Centers for Medicare & Medicaid Services (previously HCFA)

**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

**DC**

Dental Corps

**DCA**

deputy commander for administration

**DCCS**

deputy commander for clinical services

**DCN**

deputy commander for nursing

**DD**

Department of Defense form

**DEA**

Drug Enforcement Agency

**DENTAC**

dental activity

**DHS**

director of health services

**DOD**

Department of Defense

**DODD**

Department of Defense Directive

**DODI**

Department of Defense Instruction

**DPDB**

Defense Practitioner Data Bank

**DPM**

Doctor of Podiatric Medicine

**DTF**

dental treatment facility

**ECDS**

executive committee of the dental staff

**ECFMG**

Educational Commission for Foreign Medical Graduates

**ECMS**

executive committee of the medial staff

**EMPA**

emergency medicine physician assistant

**EPSQ**

Electronic Personnel Security Questionnaire

**ESA**

expiration of service agreement

**ETS**

expiration of term of service

**FAP**

Financial Assistance Program

**FDA**

Food and Drug Administration

**FNLH**

foreign national local hire

**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

**HCFA**

Health Care Financing Administration (now referred to as Centers for Medicare & Medicaid Services)

**HIPDB**

Healthcare Integrity and Protection Data Bank

**H&P**

history and physical

**HQDA**

Headquarters, Department of the Army

**HRC**

U.S. Army Human Resources Command

**HREC**

health record

**HSD**

Health Services Directorate

**ICD**

international classification of diseases

**ICTB**

inter-facility credentials transfer brief

**IDT**

inactive duty training

**IG**

inspector general

**IHCP**

impaired health care personnel

**IHCPC**

impaired health care personnel committee

**IHCPP**

Impaired Health Care Personnel Program

**IMA**

individual mobilization augmentee

**IPAP**

Interservice Physician Assistant Training Program

**IRR**

Individual Ready Reserve

**ITR**

inpatient treatment record

**LPC**

licensed professional counselor

**LPN/LVN**

licensed practical nurse/licensed vocational nurse

**MC**

Medical Corps

**M&E**

monitoring and evaluation

**MEB**

medical evaluation board

**MEDCEN**

Medical center

**MEDDAC**

medical department activity (Army)

**MHS**

military health system

**MILPO**

military personnel office

**MNT**

medical nutrition therapy

**MOA**

memorandum of agreement

**MOS**

military occupational specialty

**MOU**

memorandum of understanding

**MQA**

medical quality assurance

**MRD**

mandatory release date

**MRMC**

(U.S. Army) Medical Research and Materiel Command

**MS**

Medical Service Corps

**MSW**

master of social work

**MTF**

military treatment facility

**NAAD**

National AMEDD Augmentation Detachment

**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

**NMSE**

neuromusculoskeletal evaluation

**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

**OCONUS**

outside continental United States

**OD**

doctor of optometry

**OER**

officer evaluation report

**OHN**

occupational health nurse

**OHPA**

occupational health physician assistant

**OJT**

on-the-job training

**OM**

outcomes management

**OPM**

Office of Personnel Management

**OT**

occupational therapist

**OTJAG**

Office of The Judge Advocate General

**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

**PAO**

public affairs office

**PCE**

potentially compensable event

**PCF**

provider credentials file

**PCS**

permanent change of station

**PDCA/PDSA**

plan, do, check/study, act

**PGY**

postgraduate year

**Ph.D.**

doctor of philosophy

**PharmD**

doctor of pharmacy

**PI**

performance improvement

**PL**

public law

**POC**

point of contact

**PS**

patient safety

**PSP**

Patient Safety Program

**PSV**

primary source verification

**PT**

physical therapist

**P&T**

pharmacy and therapeutics

**QA**

quality assurance

**QMD**

Quality Management Division

**RCA**

root cause analysis

**RDC**

regional dental command

**RM**

risk management

**RMC**

regional medical command

**RN**

registered nurse

**ROTC**

Reserve Officer Training Corps

**RTF**

residential treatment facility

**SAC**

safety assessment code

**SBB**

specialist in blood banking

**SE**

sentinel event

**SERE**

survival, evasion, resistance, and escape

**SF**

standard form

**SI**

skill identifier (formerly ASI)

**SJA**

staff judge advocate

**SMDA**

Safe Medical Device Act

**SRP**

special review panel

**SSN**

social security number

**SOC**

standard of care

**SP**

Army Medical Specialist Corps

**TCF**

training credentials file

**TDA**

table of distribution and allowances

**TDY**

temporary duty

**TJC**

The Joint Commission

**TOE**

table(s) of organization and equipment

**TPU**

troop program unit

**TSG**

The Surgeon General

**UAP**

unlicensed assistive personnel

**UCMJ**

Uniform Code of Military Justice

**UM**

utilization management

**UR**

utilization review

**U.S.**

United States

**USADENCOM**

U.S. Army Dental Command

**USAMEDCOM**

U.S. Army Medical Command

**USAR**

U.S. Army Reserve

**USARCS**

U.S. Army Claims Service

**USAREC**

U.S. Army Recruiting Command

**USC**

United States Code

**USMLE**

United States Medical Licensing Examination

**VA**

Department of Veteran's Affairs

**VC**

Veterinary Corps

**WWW**

World Wide Web

**Section II****Terms****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.

**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.

**Advance directive**

A document or documentation that allows an individual to provide direction about future medical care or to designate another person(s) to make medical decisions if the individual loses his/her capacity for decision-making. Advance directives may include living wills, durable powers of attorney, do-not-resuscitate orders, right to die, or similar documentation expressing the individual's preferences as specified in the Patient Self-Determination Act.

**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.

*Note.* 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.

**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 close calls (near misses) for trends and patterns. This information is utilized by the organization for process improvement interventions.

**Alcohol abuse**

The nondependent use of alcohol to an extent that it has an adverse effect on the user's health or behavior, Family, community, or DOD.

**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 the Army Substance Abuse Program (ASAP).

**American Board of Medical Specialties**

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.

**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/dental staff**

A designation by the GB that stipulates the provider's relationship to the medical/dental 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.

**Appropriateness criteria**

Criteria that represent the clinical circumstances that support a decision to perform a diagnostic, therapeutic, or surgical procedure.

**Army Substance Abuse Program**

The Army's official program for prevention, identification, treatment, and management of personnel with alcohol and drug-related problems.

**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*).

*Note.* The "PS" before each number refers to "physical status."

- a. PS1 - A normal, healthy patient.
- b. PS2 - A patient with mild systemic disease.
- c. PS3 - A patient with severe systemic disease.

- d.* PS4 - A patient with severe systemic disease that is a constant threat to life.
- e.* PS5 - A moribund patient who is not expected to survive without the operation.
- f.* PS6 - A declared brain-dead patient whose organs are being removed for donor purposes.
- g.* 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:

- a.* The systematic collection and review of beneficiary-specific data, as it applies to PI activities.
- b.* 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/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.* 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.
- b.* 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 military health system.

**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.

**Caretaker hospital**

A USAR hospital that provides total replacement (that is, backfill) of deployed AD PROFIS assets of an active TOE hospital that is embedded in a TDA MTF.

**Centralized Credentials Quality Assurance System**

The DOD database maintained by each MTF that assists the credentials manager with control of credentials, managing the credentialing/privileging processes, reports, letter generation, preparing provider PCS paperwork and the ICTB.

Information is available to managers at all levels for generating DOD and other reports, personnel management, and for planning purposes.

**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/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/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.

**Civilian network health care providers**

Independent contractors of the Government (or other independent entities having business arrangements with the Government). Each civilian network provider must have adequate professional liability insurance and must agree to indemnify the U.S. Government for any liability that may be assessed against the U.S. Government that is attributable to any action or omission of the provider.

**Clinical competence**

The knowledge, skills, and abilities of a health care provider/professional that contribute to effective intervention in illness or injury. The health care individual's demonstrated capability to perform in keeping with defined expectations.

**Clinical consultant**

A professional practitioner (who has interest and special knowledge, training, and expertise in a professional field of endeavor) appointed by TSG or in select instances by the MTF commander, to serve as the subject matter expert in support of the AMEDD/MTF mission.

**Clinical nurse specialist**

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/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.

**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/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**

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 "near miss" incidents. An example of a close call is a surgical procedure almost performed on the wrong patient but caught before the surgery was initiated.

**Committee of the whole**

In smaller, less complex hospitals, the entire medical staff comprises a committee that performs the activities and functions of the ECMS.

**Community health nurse**

An RN who has successfully completed the U.S. Army non-degree producing course, Principles of Military Preventive Medicine (6A-F5), or who holds a master's degree in public health nursing. The individual 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:

- a. 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.
- b. 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,
- c. 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—

- a. Restriction of access to data and information to individuals who have a need, a reason, and permission for such access.
- b. An individual's right, within the law, to personal and informational privacy, including his or her health care records.

**Consultation case review branch**

AMEDD activity that provides a legal and/or clinical opinion concerning the standard of patient care in a malpractice claim case.

**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 (nonprivileged 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/dental staff appointment and award of clinical privileges. Thereafter, the review is due at the time of biennial staff reappointment and renewal of privileges.

**Credentials, verified**

Professional documents for which confirmation of authenticity has been obtained from the primary (issuing) source by the military service or representative of the military service. Confirmation, independent of the practitioner, is a key criterion. Once verified, confirmation of authenticity with the primary source need not be repeated during subsequent credentials review (except for provider license) for the length of the individual's continuous employment by the Federal Government.

**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).

**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 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 5th amendment right to notice of a hearing and 14th 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 ACGME.

**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.

**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.

**Executive committee of the medical/dental 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/or privileged dentists on the dental staff.

**Facility**

A designated unit, organization, institution, or physical structure either military (AA/USAR/ARNG) or civilian. As used in this AR, 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:

- a. 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;
- b. Received undergraduate education abroad at a medical school listed in the World Health Organization World Directory of Medical Schools;
- c. Completed all formal requirements of the foreign medical school except internship and/or social service, and passed Step 1 of the USMLE. (Those who have completed all the requirements of the foreign medical school are NOT eligible.)

*Note.* After successful completion of a year of clinical training, that is, post-graduate year one (PGY-1), sponsored by a U.S. medical school accredited by the Liaison Committee on Medical Education, and having passed USMLE Step 2, the candidate receives a Fifth Pathway certificate and is eligible to enter residency training (PGY-2 and beyond) as an international medical graduate.

**FOCUS PDCA/PDSA**

A process improvement methodology to—Find a process to improve; Organize an effort; Clarify current knowledge of the process; Understand the sources of variation; and Select the process improvement. In addition, those involved must—Plan the improvement and data collection; Do the improvement, data collection, and analysis; Check or Study the results; Act to hold the gains and continue improving the process.

**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 AMEDD, this is TSG.

**Graduate professional health education**

Structured, discipline-specific professional health care related training that is accredited by a national body (for example, the ACGME, National League for Nursing, and so forth), approved by DA, 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 (AA/USAR/ARNG) 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 (AA/USAR/ARNG) and civilian (GS and those working under contractual or similar arrangement) personnel granted privileges to diagnose, initiate, alter, or terminate health care treatment regimens within the scope of his/her license, certification, or registration.

**Health care services**

The services intended to directly or indirectly contribute to the health and well-being of patients.

**Impaired health care personnel**

A privileged provider or nonprivileged 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, that entail a high degree of risk for beneficiaries, or that tend to produce problems for patients. Such activities are deemed important for the purpose of M&E.

**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 (ICD)**

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.

**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.

- a. Current.* Active, not revoked, suspended, or lapsed in registration.
- b. Active.* Characterized by present activity, participation, practice, or use.
- c. 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.
- d. Unrestricted.* Not subject to limitations on the scope of practice ordinarily granted all other applicants for similar specialty in the granting jurisdiction.

**Licensed practical nurse/licensed vocational nurse**

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.

**Limitation of privileges**

See Restriction.

**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 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) within the MTF who hold regular privileges and who are characterized by primary responsibility to the GB for the quality of patient care within the MTF.

**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:

- a. Initial.* Granted to a provider when he/she is first assigned/employed in a DOD MTF, or if the provider has a lapse of greater than 180 days since holding a medical/dental staff appointment in a DOD MTF.
- b. Active.* Granted to a provider exercising regular privileges and meeting all qualifications for medical/dental staff membership after successful completion of the initial appointment period.
- c. 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/dental staff nor expected to fully participate in activities of the medical/dental staff.

*d. 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.

### **Military health system**

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 DOD.

### **Military treatment facility (MTF)**

As used in this AR, MTF infers and applies to TDA and TOE medical and dental facilities/units both AA and RC.

### **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.

### **Monitoring and evaluation**

M&E of care denotes actions taken to ensure a provider or nonprivileged professional understands and renders appropriate care. This action is not reportable to the NPDB or regulatory agencies and may include—

- a.* Elements of indirect supervision such as retrospective or concurrent review of medical records.
- b.* 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.
- c.* Observing at least two significant demonstrations of technical skill, if appropriate.

### **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.

### **National Provider Identifier**

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.

### **Near miss**

See Close call.

### **Network**

The combination of the MTF 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).

### **Nurse practitioner**

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/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.

**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 Army, participation in the various subsidized accession programs (for example, Health Professions Scholarship Program, Uniformed Services University of the Health Sciences, ROTC), 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**

Occupational and environmental health nursing is 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.

**Occupational therapist**

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.

**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.

**Other authorizing document**

Other authorizing document is—

- a. 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
- b. 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; or
- c. In the case where health care is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person 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.

**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.

- a. *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.

*b. 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 (followup) 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**

The process by which health care providers/professionals of the same discipline evaluate the care of a fellow provider/professional and make determinations about the quality of that care. In addition, a decision is made regarding whether, in a given clinical situation(s), the professional SOC was met, or not met, by the individual in question. Privileges/practice are at risk of being adversely affected.

#### **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.

#### **Physical therapist**

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.

#### **Physician**

An individual possessing a degree in medicine or osteopathy and licensed by a State, Commonwealth, territory, or jurisdiction to practice medicine.

#### **Physician assistant**

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.

#### **Plan of supervision**

A command-approved arrangement to provide supervision, specific to a practitioner, that 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.

**Potentially compensable event**

An adverse event that occurs in the delivery of health care or services with resulting injury to the patient. 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, and so forth).

**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.

**Primary source verification**

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—

*a. 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.

*b. 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.

*c. 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 commander 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 nonprivileged 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 10 USC 1102. PAF criteria include, but are not limited to—

*a.* 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.

*b.* Number of patient “deaths (failed criteria)” identifies deaths that may have been contributed to by provider failure, delay, or inappropriate diagnosis or treatment.

*c.* Number of patients with “normal tissue (failed criteria)” identifies surgical cases with normal tissue found unacceptable by surgical cases review function.

*d.* Number of medical record “deficiencies” is determined by the medical record review function.

*e.* 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.

*f.* Number of “transfusion variations” identifies instances of inappropriate blood use as determined by transfusion review or other QA/quality improvement review function.

*g.* Number of “drug use variations” identifies instances of inappropriate drug use as determined by review of the P&T committee/function or other QA/quality improvement review.

*h.* Number of “validated complaints” identifies provider-directed beneficiary complaints reviewed and found justified.

*i.* 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 10 USC 1102.

**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 assurance**

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 followup steps or procedures to ensure that actions have been effective and no new problems have been introduced.

**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 quality management.

**Quality management**

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.

**Quality management 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 nonprivileged 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.

**Registered nurse**

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.

**Reinstatement of privileges/practice**

A revision to an adverse privileging action that restores all or a portion of the provider's/nonprivileged 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.

**Residential treatment facility**

The inpatient rehabilitation element of the Army Substance Abuse Program (formerly known as the Alcohol and Drug Abuse Prevention and Control Program (ADAPCP)) which provides an intensive structured treatment program for eligible personnel in designated Army MTFs.

**Restriction of privileges/practice**

A temporary or permanent limit is placed on all or a portion of a provider's clinical privileges or the nonprivileged 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/nonprivileged 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.

**Risk management**

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.

**Root cause analysis**

A process for identifying the basic or contributing causal factor(s) associated with an adverse event or close call. The review is interdisciplinary and includes those who are closest to the process. It focuses on systems and processes, not individual performance. The analysis asks “what” and “why” until all aspects of the process are reviewed, and all contributing factors have been determined. It identifies changes that could be made in systems and processes that would improve performance and reduce the risk of adverse events or recurrence of close calls.

**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.

**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 to a patient, or the risk thereof, that is not related to the natural course of the patient’s illnesses or underlying condition. Serious injury specifically includes loss of limb or function.

**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.

**Speech pathologist**

An individual qualified by graduation from an accredited college or university with a master’s or doctoral degree in speech pathology. He/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/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.

*a.* 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 an MTF provider 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.

*b.* 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—

*a. 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.

*b. 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.

*c. 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 that 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 nonprivileged 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.

**Section III****Special Abbreviations and Terms**

This section contains no entries.

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