



Defense Health Agency

PROCEDURES MANUAL

NUMBER 6025.13, Volume 4
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Medical Affairs

SUBJECT: Clinical Quality Management in the Military Health System
Volume 4: Credentialing and Privileging

References: See Enclosure 1

1. PURPOSE. This Defense Health Agency-Procedures Manual (DHA-PM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (s), establishes the Defense Health Agency's (DHA's) procedures to assign responsibilities and establish procedures for managing Clinical Quality Management (CQM) in the Military Health System (MHS). This DHA-PM replaces, in full, the contents of the DoD Manual 6025.13 (Reference (e)), which is targeted for cancellation. This DHA-PM, replaces, in Volume 2, the full contents, unless otherwise stated, of the following memorandums, which are targeted for cancellation: Assistant Secretary of Defense for Health Affairs Memorandum, "Policy on Reporting Joint Commission on Accreditation of Healthcare Organizations-Reviewable Sentinel Events in the Military Health System," July 13, 2004 (Reference (h)); Assistant Secretary of Defense for Health Affairs Memorandum, "Amplifying Guidance Relating to the Reporting of Sentinel Events and Personally Identifiable Information Breaches to the Office of the Assistant Secretary of Defense (Health Affairs)," February 13, 2012 (Reference (i)) [as related to the reporting of sentinel events only]; and Assistant Secretary of Defense for Health Affairs Memorandum, "Medical Quality Assurance and Clinical Quality Management in the Military Health System Sentinel Event and Root Cause Analysis Process Improvements," March 12, 2015 (Reference (j)).

2. APPLICABILITY. This DHA-PM applies to:

a. OSD, Military Departments, Office of the Chairman of the Joint Staff and the Joint Staff, Combatant Commands, Office of the Inspector General of the DoD, Defense Agencies, DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-PM as the "DoD Components");

b. The entire MHS, including each DoD Military Medical Treatment Facility (MTF) and all other healthcare provided by the MHS;

c. Uniformed services personnel of the active and reserve components (including National Guard personnel in a Federal duty status), civilian, contract, volunteer, and other medical or dental healthcare providers who are assigned to and deliver healthcare; and

(1) Credentialed healthcare providers who are members of the Army National Guard or the Air National Guard, while working in a non-federal status (Reference (k) are subject to the procedures, policies, and authorities, as prescribed by their respective Army Regulation Reference (l)) and Air Force Instruction (Reference (m)), or as defined in the policies, rules, procedures, and laws of the State, territory, or District of Columbia in which they are credentialed and/or privileged;

(2) Trainees who have been granted clinical privileges outside the training program when patient safety concerns arise;

d. Managed care support contractors (MCSCs), designated providers, and overseas contractors, consistent with their respective contracts awarded by the DoD.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to authority delegated in Reference (b) and based on authorities in Reference (a) through (s), that:

a. Establishes CQM procedures in the MHS to provide an organized structure for an integrated framework of programs to objectively define, measure, assure, and improve the quality of care received by MHS beneficiaries.

b. Strengthens MHS CQM accountability, transparency, and standardization in the MHS.

c. Affirms the MHS's unwavering commitment to quality healthcare for our beneficiaries, joint healthcare teams, and Combatant Commands across the globe, through CQM.

4. CANCELLED DOCUMENTS. This DHA-PM replaces, in Volume 2, the full contents of DHA-Procedural Instruction (DHA-PI) 6200.01, "Comprehensive Infection Prevention and Control (IPC) Program," April 24, 2017 (Reference (n)), which is being cancelled.

5. RESPONSIBILITIES. See Enclosure 2 of Volume 1.

6. PROCEDURES. Procedures specific to each program within the MHS CQM are addressed in Volumes 2-7 of this DHA-PM.

7. INFORMATION REQUIREMENTS. CQM uses several data capture, analysis, reporting, and decision support tools for patient safety, clinical quality assurance, and improvement to


include the electronic medical record, databases such as the Joint Centralized Credentials Quality Assurance System (JCCQAS), and the Joint Patient Safety Reporting (JPSR), data visualization and report tools on CarePoint (a SharePoint platform), and more.

8. **RELEASABILITY. Cleared for public release.** This DHA-PM is available on the Internet from the DHA SharePoint site at: <http://www.health.mil/dhapublications>.

9. **EFFECTIVE DATE.** This DHA-PM:

a. Is effective on October 01, 2019.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date, in accordance with Reference (c).


FOR R. C. BONO
VADM, MC, USN
Director

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
- (b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
- (d) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the MHS," February 17, 2011, as amended
- (e) DoD Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013
- (f) National Defense Authorization Act for Fiscal Year 2017, Sections 702
- (g) National Defense Authorization Act for Fiscal Year 2019, Sections 711 and 712
- (h) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy on Reporting Joint Commission on Accreditation of Healthcare Organizations-Reviewable Sentinel Events in the Military Health System," July 13, 2004
- (i) Assistant Secretary of Defense for Health Affairs Memorandum, "Amplifying Guidance Relating to the Reporting of Sentinel Events and Personally Identifiable Information Breaches to the Office of the Assistant Secretary of Defense (Health Affairs)," February 13, 2012
- (j) Assistant Secretary of Defense for Health Affairs Memorandum, "Medical Quality Assurance and Clinical Quality Management in the Military Health System Sentinel Event and Root Cause Analysis Process Improvements," March 12, 2015
- (k) United States Code, Title 32, Sections 502 – 505
- (l) Army Regulation 40–68, "Clinical Quality Management," February 26, 2004, as amended
- (m) Air Force Instruction 44–119, "Medical Quality Operations," August 16, 2011
- (n) DHA-Procedural Instruction 6200.01, "Comprehensive Infection Prevention and Control (IPC) Program," April 24, 2017, hereby cancelled
- (o) United States Code, Title 10
- (p) U.S. Department of Health and Human Services, Health Resources and Services Administration. NPDB Guidebook. Rockville, Maryland: U.S. Department of Health and Human Services, 2018
- (q) Health Affairs Policy 05-002, "Health Insurance Portability and Accountability Act National Provider Identifier Enumeration Policy for Military Health System Individual (Type 1) Health Care Providers," January 26, 2005
- (r) DoD Instruction 1402.05 "Background Checks on Individuals in DoD Child Care Services Programs," September 11, 2015, incorporating change effective July 14, 2016
- (s) United States Code, Title 34, Section 20351

ENCLOSURE 2

CREDENTIALING AND PRIVILEGING

1. GENERAL OVERVIEW. The credentialing and privileging process serves as the foundation for quality and safe care by ensuring qualified and competent staff deliver care in a manner that is consistent with their education and training, and the scope of services approved by their organization. This enclosure details the required documentation providers must have and maintain, the process for validating these credentials, and the methods for assessing competency to provide patient care.

a. Purpose. To direct the credentialing and privileging process for MHS healthcare providers.

b. Functions. The following sections related to the Credentialing and Privileging (CP) Program include requirements for licensure, credentials, and provider competency assessment. It describes the Privileging Authority and privileging process. It also addresses the responsibility of clinical leaders to manage the scope of a provider's independent practice; and the requirements for oversight of non-privileged providers.

2. KEY OPERATIONAL DEFINITIONS. Knowledge of these terms is essential to understanding the scope, core responsibilities, and procedures of the CP Program. A full list of definitions for this manual is included in the Glossary.

a. adverse practice action. Restriction, reduction, or revocation of the clinical practice of a non-privileged provider as a result of a due process professional review action, based upon evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

b. adverse privileging action. Denial, restriction, reduction, or revocation of clinical privileges as a result of a due process professional review action, based upon evidence of misconduct, impairment, incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

c. approved postgraduate training. Postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or other similar entities regulating healthcare provider training programs.

d. clinical adverse action. Action invoked against a healthcare provider, privileged or not, with the result that the authority to practice clinically is adversely affected. Adversely affected privilege(s)/practice are the result of a due process professional review action based on evidence of misconduct, impairment, incompetence, or any conduct adversely affects, or could adversely affect, the health or welfare of a patient, and that leads to the inability of a provider to exercise

their privilege(s)/practice with their own independent judgment. This is the collective term used in this manual that encompasses both an adverse practice action and an adverse privileging action.

e. clinical privileges. Permission granted by the Privileging Authority to provide medical and other patient care services. Clinical privileges define the scope and limits of practice for privileged providers and are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

f. clinical privileging. The granting of permission and responsibility of a healthcare provider to provide specified or delineated healthcare within the scope of the provider's license, certification, or registration.

g. competency assessment. Assessment of a healthcare provider's knowledge, skills, and ability to deliver high quality, safe patient care. The Military Health System (MHS) assesses providers using standards from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS), recognizing six areas of "General Competencies" including: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. These may serve as the basis for healthcare provider care evaluation and privileging decisions.

h. continuing education. Education beyond initial academic or professional preparation approved by an appropriate certifying professional organization that is relevant to the type of care or service delivered in an organization.

i. credentialing. The process of obtaining, verifying, and assessing the qualifications of both privileged and non-privileged providers to provide safe patient care services. This assessment serves as the basis for decisions regarding delineation of clinical privileges, as well as appointments and reappointments to the medical staff. The required information should include qualification data such as relevant education, training, and experience; current licensure; and specialty certification (if applicable) as well as performance data, such as current competency, and the ability to perform the selected privileges. This data is collected, verified, and assessed initially and on an ongoing basis.

j. credentials. The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare provider.

k. credentials file. A file containing pertinent information regarding an individual privileged provider to include credentialing and privileging documents, permanent performance data, medical practice reviews, continuing health education documentation, and information related to permanent adverse privileging actions.

l. credentials review. The credentials inspection and verification process conducted for healthcare providers before selection for military service, employment, and procurement. The

credentials review process is also conducted for healthcare providers before medical staff appointment and granting of clinical privileges and is repeated at the time of reappointment and renewal of privileges.

m. current competence. The state of having adequate ability and up-to-date knowledge to perform the functions of a healthcare provider in a particular discipline, as measured by meeting these criteria.

(1) The provider has actively pursued the practice of their discipline within the past two years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested and that the individual has satisfactorily practiced the discipline as determined by the results of ongoing professional practice evaluation (OPPE).

(2) The provider possesses documented evidence of appropriate continued medical education to maintain the currency of skills and knowledge.

n. denial of clinical privilege(s). Refusal to grant requested privileges to a healthcare provider at the time of initial application or renewal. Denials that result from a professional review action following appropriate due process proceedings, and relating to evidence of the provider's misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient are reported to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies. Denials that occur solely because a provider does not meet a healthcare institution's established threshold criteria for that particular privilege, should not be reported to the NPDB - these are considered decisions based on eligibility and are not deemed to be a result of a professional review action.

o. focused professional practice evaluation (FPPE). A process whereby the organization evaluates the privilege/practice of the healthcare provider who does not have documented evidence of competently performing the requested privilege, or of demonstrated practice competency, at the organization. This process may also be used when a question arises regarding a healthcare provider's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the healthcare provider's professional performance.

p. healthcare provider. Any member of the uniformed services, civilian employee of the DoD, or contract employee authorized by the DoD to perform healthcare services.

q. Joint Centralized Credentialing Quality Assurance System (JCCQAS). A secure, worldwide healthcare provider credentialing, privileging, adverse actions, and risk management web-based application mandated by the Military Health System (MHS) used in the provider credentialing and privileging process. Portions of the information contained in JCCQAS are confidential, privileged and protected from disclosure in accordance with Section 1102 of Reference (o). JCCQAS is the official file for healthcare providers credentialed and privileged within the MHS.

r. licensed independent practitioner (LIP). Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, and within the scope of the individual's license and consistent with individually granted clinical privileges.

s. monitoring and evaluation. A well-defined, time-limited, well documented plan of focused professional practice evaluation (FPPE) to confirm a healthcare provider possesses the knowledge, skills, and ability to render safe and effective healthcare. It must include a documented plan with delineation of clear expectations and measures of success. It requires a preceptor who provides full written evaluation of the monitoring period, with regular interval feedback, to both the provider and the Credentials Committee/Function. Privileges/practice remain intact during the period of monitoring and evaluation.

t. non-privileged provider. An individual who possesses a license, certification, or registration by a state, commonwealth, territory, or possession of the United States, and is only permitted to engage in the delivery of healthcare as defined in their granted scope of practice. Examples include registered nurse (RN), licensed vocational nurse (LVN), registered dental hygienist (RDH), and medical technician.

u. ongoing professional practice evaluation (OPPE). A documented summary of ongoing data collected for the purpose of assessing a healthcare provider's clinical competence and professional behavior. The information gathered during this process allows for identification of practice trends that may adversely affect, or could adversely affect, the health or welfare of a patient. It is the responsibility of the organization to determine the criteria used in the ongoing professional practice evaluation.

v. other authorizing document. A mechanism, such as registration and certification, by which a State, the District of Columbia, a Commonwealth, territory, or possession of the United States, grants authority to provide healthcare in a specified discipline. 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 an individual is professionally qualified to provide healthcare in a specified discipline. Special considerations apply in the case where healthcare is provided in a foreign country by any person who is not a national of the United States.

w. peer review. Any assessment of the quality of medical care carried out by a healthcare provider, including any such assessment of professional performance, any patient safety program Comprehensive Systematic Analysis (CSA) or report, or any other such assessment carried out by a healthcare provider under the provisions of this manual.

x. preceptor. A clinical peer who has been appointed in writing to evaluate a healthcare provider's clinical practice. The preceptor is designated for consultation, clinical feedback, and general oversight of the clinical activities of the provider. A preceptor may review medical records, and conduct direct observation of a provider's practice, however they are not required to be present for or approve the provider's procedures or clinical decisions since the provider's clinical privilege(s)/practice is not restricted in any manner. [Contrast with the definition for "proctor".]

y. primary source verification (PSV). Validation that a document is true and valid through contact with the issuing institution or its authorized agent.

z. privileged provider. An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare within defined scope of practice.

aa. Privileging Authority. The Privileging Authority is a designated official who grants permission to individuals to provide specific care, treatment, or services within well-defined limits. The Privileging Authority also initiates and makes determinations on clinical adverse actions.

ab. proctor. A clinical peer who has been appointed in writing to supervise all or some of a healthcare provider's clinical practice. The proctor is required in order for the provider to proceed in exercising designated clinical privilege(s)/practice. The proctor provides direct oversight of designated clinical activities and must co-sign all such documentation conducted by the provider. Certain procedures may require proctor approval prior to performing. All designated procedures will require some period of direct observation by the proctor. Proctors are required for providers with supervised privileges, and for those who have had a clinical adverse action taken against them with subsequent restriction in privilege(s)/practice. [Contrast with the definition for "preceptor".]

ac. Report Authority. The official with responsibility to report to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies following appropriate due process proceedings. The Report Authority is:

(1) The Director of the DHA with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the DHA.

(2) The Surgeon General of the Army, Navy, or Air Force, respectively, with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the Army, Navy, or Air Force, respectively.

(3) In cases in which the healthcare provider is privileged by more than one of the Report Authorities listed in subparagraphs (1) and (2), the one whose responsibility applies to the Privileging Authority most responsible for the matters under review. In cases of uncertainty, the DHA Director will designate the Report Authority. The designated Report Authority will ensure there is a comprehensive review of the entire matter.

ad. telemedicine. Telemedicine, also known as telehealth or virtual health, is the use of telecommunications and information technologies to provide health assessment, treatment, diagnosis, intervention, consultation, clinical supervision, education, and information across distances.

(1) distant site. The distant site is where the healthcare provider providing the medical service is located at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may function as a distant site for purposes of this manual.

(2) originating site. The originating site is the location of a patient at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may be considered an originating site for purposes of this manual.

ae. virtual medical center (VMC). A VMC is an organization which serves as a coordination body overseeing the delivery of healthcare via telemedicine. The DoD VMC must operate in affiliation with an accredited MTF or be independently accredited. If the DoD VMC does not have its own Privileging Authority, it should use the Privileging Authority of an accredited MTF with which it is affiliated. The DoD VMC, acting as a distant site, must have a process in place to accept quality and safety feedback on the care provided, and take action as appropriate.

3. GOVERNANCE STRUCTURE

a. The DHA CP Program is managed by the CQM Branch in the Clinical Support Division (CSD) under the Deputy Assistant Director for Medical Affairs (DAD MA) within the DHA. The DHA CP Program Lead manages program operations in collaboration with the DoD Joint Credentials Working Group and ad hoc groups for JCCQAS.

b. The DoD Joint Credentials Working Group is co-chaired by the Deputy Assistant Secretary of Defense for Health Affairs ASD(HA) Health Services Policy and Oversight designee, and the DAD MA representative. Representatives should include members from the DHA CP Program, the Military Departments, DHA and DoD Offices of General Counsel, and subject matter experts as needed. The purpose of this working group is to develop, promote, and provide oversight, direction, and guidance to improve the quality of the CP Program and manage the JCCQAS to serve and support the overall needs of the CP Program.

4. SCOPE AND CORE RESPONSIBILITIES

a. Privileging Authority

(1) The DHA Director/Military Department designee are the Report Authority and the Privileging Authority for their respective organizations. Privileging Authority is delegable to MTF Directors/Military Department designee, or to DHA Market Directors/Intermediate Headquarters Directors/Military Department designee for centralized CP Programs.

(2) Privileging Authorities issue local credentials review and privileging directives as appropriate.

(3) Privileging Authorities must also provide a mechanism for privileged and non-privileged provider involvement in the credentialing and privileging process.

(4) Privileging Authorities establish mechanisms to comply with the processes in this manual to ensure individual healthcare providers function within the scope of their clinical credentials, granted privileges, knowledge, skills, and abilities, and to ensure these credentials records are current.

(5) Privileging Authorities must ensure the clinical performance and professionalism of all assigned healthcare providers are measured with assessment and documentation at intervals not to exceed 6 months per the OPPE requirements outlined in this manual. Clinical Assessment Reviews/Performance Appraisal Reports must be produced at intervals not to exceed 2 years, or upon permanent change of station (PCS).

(6) Privileging Authorities must ensure MTFs have an effective peer review process and follow focused professional practice evaluation (FPPE)/OPPE policies and directives per this manual to ensure current clinical competency of its healthcare providers.

(7) Privileging Authorities shall grant clinical privileges to privileged providers using standardized, specialty-specific privileges contained in the JCCQAS Master Privilege List (MPL).

(8) Privileging Authorities direct a healthcare provider to be removed from direct patient care, in accordance with the due process procedures outlined in this manual, when a provider's suspected misconduct, impairment, incompetence, or any conduct may adversely affect, or could adversely affect, the health or welfare of a patient, or staff member.

(9) Impaired healthcare providers must have their clinical privileges/practice reviewed by the Credentials Committee/Function and the Privileging Authority. (See Enclosure 4 in Volume 3 of this manual.)

b. Legal Counsel. Servicing healthcare legal counsel, judge advocates, and civilian attorneys working for DHA or the Military Departments and performing duties supporting the MHS will, for purposes of this enclosure, provide legal counsel as needed for credentialing and privileging issues, to include policy development.

c. MTF Chief of the Medical Staff or Military Department Chief of the Medical Staff designee (descriptive term, role may also be known as Chief Medical Officer, Medical Executive Committee Chair, or other titles for similar responsibilities)

(1) Must be a privileged physician holding an active appointment to the medical staff and be appointed by the Privileging Authority.

(2) Is the principal executive staff advisor to the Privileging Authority concerning matters of healthcare provider management directives, quality, and scope of medical care.

(3) Has oversight of professional staff management and professional practice review.

(4) Acts as a liaison between the members of the medical staff and the executive leadership.

(5) When absent, the Credentials Committee/Function and healthcare provider management responsibilities will be delegated, in writing, to another privileged physician upon approval of the Privileging Authority.

(6) Is authorized to intervene on behalf of the Privileging Authority to immediately summarily suspend the privileges/practice of a provider when there are concerns that a provider's practice adversely affects, or could adversely affect, the health or welfare of a patient, or staff member, and maintain the summary suspension until the matter is investigated and resolved in accordance with the provisions outlined in Volume 3 of this DHA-PM.

(7) Ensures all medical staff applicants are oriented concerning bylaws governing patient care, medical staff responsibilities, professional ethics, off duty employment, continuing education requirements, privileging, and clinical adverse actions and due process proceedings.

(8) May singularly review and award temporary privileges in the absence of the Privileging Authority during periods of medical necessity (life threatening situations).

(9) Is accountable for ensuring the CQM procedures in this manual are followed and monitored for compliance. Collaborates with other executive leadership on the spectrum and quality of care delivered, particularly with those senior leaders accountable to CQM procedures and processes within the various clinical disciplines (e.g., Senior Nurse Executive or equivalent, Senior Enlisted Advisor or equivalent, and others).

(10) Advises senior leadership and the Privileging Authority when off-duty employment issues arise involving privileged providers that may negatively affect patient care and/or ability to accomplish mission requirements.

d. Clinical Directors/Department Heads (descriptive term, role may also be known as Medical Director, Clinical Service Chief, or other title for similar responsibilities)

(1) Brief all healthcare providers applying for a medical staff appointment with clinical privileges within their department on the local CP Program and on department or clinic specific processes and requirements.

(2) Continuously monitor the professional clinical performance, conduct, and health status of department staff members to ensure they provide healthcare services consistent with their clinical privileges and responsibilities. Monitor CQM and medical staff activities for providers assigned to their department and ensure OPPE for all providers under their supervisory leadership is conducted in accordance with this manual. Coordinate with the Medical Staff Professional (MSP)/Medical Staff Manager (MSM) to ensure FPPE monitoring and evaluation plans are implemented and completed appropriately for new providers and other circumstances in accordance with this manual. Review OPPE data no less than every 6 months for

opportunities to learn and improve the safety and quality of care, and for unfavorable performance trends.

(3) Ensure non-privileged providers, clinical support staff, and other personnel providing healthcare services in the department receive appropriate clinical supervision.

(4) Maintain approved medical staff appointments with delineated clinical privileges on privileged providers assigned to their departments. Ensure providers' privileging information is readily available to organizational healthcare personnel as appropriate.

(5) At intervals not to exceed 12 months, assess the facility-specific MPL, facility resources, and limitations. Recommend departmental, specialty, and facility-specific credentials and privileging criteria for staff appointment and reappointment.

(6) Make recommendations for medical staff appointment with clinical privileges based on the applicant's professional qualifications, health status (ability to perform), and current competence.

(7) Use provider-specific results of CQM peer review activities when making recommendations for medical staff appointments with clinical privileges.

(8) Monitor the CP Program for all healthcare providers within their departments. Coordinate with relevant senior clinical leadership as appropriate (e.g., Senior Nurse Executive, Senior Enlisted Advisor).

e. Medical Staff Professional/Medical Staff Manager (formerly known as Credentials Manager)

(1) Reports to the Chief of the Medical Staff.

(2) Serves as the technical advisor to the Privileging Authority, Credentials Committee/Function Chairperson, and assigned providers on issues related to the CP Program to include at least: appropriate procedures in accordance with this manual and other directives; accrediting organization (AO) standards; and applicable federal, state, and other mandated regulatory guidance.

(3) Coordinates and implements written policies and procedures applicable to all aspects of the CP Program and all other CQM Programs, as appropriate.

(4) Ensures providers' identification are verified by viewing, and obtaining a copy of, a current valid picture identification issued by a federal or state agency, such as a driver's license, military identification card, or passport.

(5) Provides technical management, verification, and assessments regarding credentials information; processes privileging and medical staff appointment applications; and monitors and tracks licensure, certification, and registration status for all privileged providers, as outlined in this manual, and for all non-privileged providers as directed by the Chief of the Medical Staff.

Must also ensure evidence exists in the credentials file that establishes the authority by which a non-governmental employee may be granted privileges by the Privileging Authority (e.g., volunteer agreement, information from the Contracting Officer, other).

(6) Collaborates with Clinical Directors/Department Heads to identify, collect, track, trend, and analyze OPPE and FPPE. Facilitates departmental compliance with ongoing monitoring of the medical staff for Credentials Committee/Function review and for recommendations to the Privileging Authority for re-privileging.

(7) Supports the Impaired Healthcare Provider Program as per Volume 3 of this manual.

(8) Provides support to Reserve Medical Unit Credentials Committee/Function as needed and as applicable.

(9) Serves as point of contact for fee-exempt Drug Enforcement Administration (DEA) registration and National Provider Identifier (NPI) Type 1 registration.

(10) Serves as the Privileging Authority's JCCQAS database administrator authorizing user access, education, and training on new CP procedures, processes, and policies.

(11) Establishes and maintains current information in the JCCQAS electronic database including co-located units and other assigned military personnel, as needed (i.e., Individual Mobilization Augmentees [IMAs]). Maintain all required credentialing and privileging documentation in the provider's credentials record relating to clinical performance.

(12) Initiates the credentialing, privileging, and medical staff appointment process. Performs a comprehensive data quality and risk assessment review of the electronic Provider Credentials File and ensures documents are scanned, named in accordance with the standard naming convention, and uploaded to the provider's credentials record.

(13) Performs relevant National Practitioner Data Bank (NPDB) queries, other applicable queries, and Primary Source Verifications (PSV). Performs risk assessment and authenticates the credentials of privileged medical staff members applying for initial clinical privileges and appointment to the medical staff or other changes in privileges as appropriate. Per the Chief of the Medical Staff, assures compliance with validation of non-privileged providers' credentials, as well as relevant NPDB queries, other applicable queries, and PSV upon in-processing to the organization and with other changes in practice as appropriate.

(14) Maintains a system for internal staff to properly identify healthcare providers practicing at the organization, and to confirm clinical privileges or clinical scope of practice.

(15) Provides ongoing JCCQAS reports on expiring credentials (at a minimum of quarterly), to the Chief of the Medical Staff and Credentials Committee/Function.

(16) Serves as point of contact for release of information regarding clinical privileges/practice for healthcare providers who have, or previously had, an affiliation with the organization.

(17) Establishes and supports the creation of the provider profile within the electronic health record (EHR) system in collaboration with the health information technology office to provide access to the EHR upon appropriate credentialing and privileging of healthcare providers.

(18) Ensures protection of and access to Medical Quality Assurance Program material is in accordance with Section 1102 of Reference (o).

(19) Initiates annual system reviews to identify, analyze, and determine facility and resource capabilities that may impact safe and reliable healthcare. At intervals not to exceed 12 months, a review of facility-specific departmental criteria with appropriate department heads, Credentials Committee/Function is required to ensure criteria are appropriate to support the granting of clinical privileges. The local MPL must reflect facility capabilities.

f. Graduate Medical Education (GME) Training Office

(1) Maintain JCCQAS electronic records for providers in GME training programs. Ensure the JCCQAS credentials record is current at all times. Maintain and update this database in accordance with the JCCQAS User Manual and this DHA-PM.

(2) Gather and ensure PSV of required documents, name documents in accordance with the standard naming convention, and upload documents to the provider's electronic credential record.

(3) Serve as point of contact for fee-exempt DEA registration and NPI Type 1 registration for providers in the training program.

(4) Perform data quality review of the electronic credentials record and grant provider access to complete first e-application upon completion of a training program. Initiate PCS transfer of JCCQAS records and provider's credentials record.

5. PROCEDURES

a. Licensure, Certifications, and/or Registration of Healthcare Personnel

(1) Section 1094 of Reference (o) requires that a person practicing in the MHS may not provide healthcare independently unless the person has a current license to provide such care. A healthcare provider who is a licensed independent practitioner may not provide healthcare in accordance with this enclosure unless the provider's current license is an active unrestricted license that is not subject to limitation on the scope of practice ordinarily granted to other healthcare providers for a similar specialty by the jurisdiction that granted the license.

(2) A license is a condition of employment and applies in all healthcare settings, including deployment, and assignments in foreign countries. Licensure, certification, or registration is a qualification for employment as a healthcare provider in the MHS. Healthcare providers must have one current, valid, active, and unrestricted license. Additional licenses held by a provider must be in good standing whether they are inactive, expired, or limit the provider's practice to a military setting. Providers in the MHS may not have one active license and another currently suspended or probationary license. For example, if a provider is licensed in both Texas and Tennessee, and the provider's Texas license is active, but the provider's Tennessee license is on probation, restricted, or is temporarily suspended, the provider would not meet requirements for clinical practice in the MHS.

(a) An unrestricted license:

1. Does not waive or reduce continuing education (CE) requirements (section 1094a); training; testing; investigation; or sanction authority.

2. Has no restrictions pertaining to clinical competency.

3. Does not restrict practice to a military or federal facility.

4. Does not waive the standard license fee solely on the basis of the member being in the military if such a waiver would have the appearance, as determined by the DAD MA, of a license not fully comparable in all respects to a full fee license.

5. Does not waive or extend license renewal date solely on the basis of the member being in the military.

6. Allows the healthcare provider unabridged permission to practice in any civilian community in the jurisdiction of licensure without having to take any additional action on the license.

(b) Healthcare providers who fail to maintain compliance with licensing, certification, or registration requirements outlined in this manual will be removed immediately from patient care. Such providers may be subject to personnel actions (e.g., as a condition for employment, failure to keep licensure by being late on fee payment may prompt disciplinary personnel actions), clinical adverse actions (e.g., any adverse action taken by the state authority may prompt a QAI), or both, which may lead to NPDB and other applicable certifying/regulatory agency reporting. (See Enclosure 3 of Volume 3 of this manual.) Consult with servicing healthcare legal counsel. Also, see Reference (p).

(c) Appropriated funds cannot be used to pay fees for obtaining and maintaining a license, except in the following instances: If DHA/Service mission requires a military provider to participate in an external resource sharing agreement, or training agreement, with a civilian institution that does not recognize the licensure portability statute, the provider may be reimbursed up to \$500 of the state licensure fee under Section 1096(d) and Section 2015(b) of

Reference (o). Appropriated funds may also be able to reimburse a volunteer for obtaining a license in the state where volunteering if the individual already possesses a current, valid, active, unrestricted license in any other jurisdiction, similar to other federal employees.

(3) Section 1094 of Reference (o) mandates that, notwithstanding any law regarding the licensure of healthcare providers, a designated licensed individual practitioner may practice their profession in any location in any jurisdiction of the United States, regardless of where the provider or patient is located, so long as the practice is within the scope of authorized federal duties. For this purpose:

(a) A covered healthcare provider is one who is a member of the Military Services, civilian DoD employee, personal services contractor in accordance with Section 1094 of Reference (o), or other healthcare professional credentialed and privileged at a federal healthcare institution or location specially designated by the Secretary for this purpose. The DoD VMC is considered a federal healthcare institution in accordance with Section 1094 of Reference (o).

(b) A jurisdiction of the United States is a state. For the purposes of this document, the District of Columbia, a Commonwealth, a territory, or a possession of the United States will be referred to as a state henceforth.

(c) Portability of state licensure does not apply to:

1. Non-personal services contractor healthcare providers, unless specifically stated in the applicable contract and specifically approved by the ASD(HA).

2. Non-DoD personnel, unless specifically approved by the ASD(HA) or detailed to DoD.

(d) DoD Components must follow the procedures established in this section prior to assigning licensed individual practitioners to other federal agency or non-federal healthcare institutions.

(4) The ASD(HA), as delegated by the Secretary of Defense, may waive licensure requirements outlined in this manual in special circumstances. A waiver may be considered in circumstances where a state's unrestricted licensure requirements place an undue burden on the uniformed Service member or federal employee by mandating participation in programs incongruous with federal policy. Examples include requirement to live in the state of issuance, mandatory contribution to a medical injury compensation fund, or the requirement to maintain private malpractice insurance. Waivers will not be granted on the basis of a healthcare provider's assignment in a non-clinical position.

(a) At the time of license renewal, the licensure waiver must be re-submitted. If the criteria are not met, the waiver will lapse.

(b) Requests for waiver of licensure requirement are made to ASD(HA). The waiver must be documented in JCCQAS with the date of the waiver reflecting the expiration of the applicable time period of licensure.

(5) For a U.S. citizen to be hired outside the U.S. jurisdiction, the respective Privileging Authority will obtain a waiver from the host country to hire the individual under a non-personal services contract. This waiver must have a statement that the individual will provide services only on the U.S. Federal enclave. Additionally, the individual must have a current, unrestricted license from any U.S. state, or the individual may obtain a current, unrestricted license or other authorizing document from the host nation via endorsement or reciprocity.

(6) Foreign military providers may be assigned to U.S. installations to provide medical care for their personnel only. They practice under the authority of local host agreements and are not subject to DoD CP Program requirements. The providers are not under the medical supervision or oversight of the DoD Privileging Authority. All care provided by the foreign military providers is subject to the oversight and regulations of the provider's country of licensure. Local host support agreements govern DoD support to these providers.

b. Credentialing Requirements for Privileged and Non-Privileged Providers:

(1) This section presents a comprehensive list of provider credentials. Specific credentials requirements by provider type are included in the Appendix to Enclosure 2: Specialty Specific Licensure, Training, and Other Credentials Requirements. The requirement for PSV is specified in Table: Credentials Required for Privileged and Non-Privileged Providers. PSV is required on initial privileging or on a recurrent basis, as designated.

(a) A qualifying educational degree, as required by specialty. For foreign medical graduates, an approved certificate by the Educational Commission for Foreign Medical Graduates (ECFMG) is required for graduates of foreign medical schools, other than approved schools in Canada. 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).

(b) Post-graduate training certificates (i.e., internship, residency, fellowship). All new certifications require a one-time PSV.

(c) All current professional licenses, certifications or registrations, including those the healthcare provider previously held that are now inactive, expired, or suspended, must undergo initial PSV. The healthcare provider must submit an explanation for all inactive, expired, and/or suspended licenses. In addition, for initial and renewal PSV, a list of all healthcare licenses ever held must be provided with an explanation for: any challenges to licensure or registration, any voluntary or involuntary relinquishment of licenses, or any licenses that have been subject to disciplinary action.

(d) Accounting of experiences and all gaps in active practice dating back 10 years or to the qualifying degree is required. For initial privileges, a written list of prior work history is

required. Providers previously privileged in the MHS who have not had a break in service for more than 180 days, do not require a written work history. The work history tab in JCCQAS provides documentation to fulfill the credentialing requirement of previous work history review. MSPs/MSMs will work with providers to ensure this information is accurate and up to date. Validation for work history may be obtained via contact with a prior work location by administrative staff and does not require healthcare provider or clinical leader endorsement.

(e) Current American Red Cross or American Heart Association Basic Life Support (BLS) Certification. Although Advanced Life Support (American Red Cross), Advanced Cardiovascular Life Support (American Heart Association), Advanced Trauma Life Support, Pediatric Advanced Life Support, Advanced Life Support in Obstetrics, or the Neonatal Resuscitation Program may need additional performance requirements, they are not a substitute for the BLS requirement. Privileging Authorities will ensure life support training (Basic Life Support [BLS], Advanced Life Support [ALS], Pediatric Advanced Life Support [PALS]) is available to personnel to meet deployment requirements. Waiver requests for healthcare providers who cannot perform hands-on cardiopulmonary resuscitation due to temporary or permanent physical disabilities can be sought through the Privileging Authority. Waivers for other situations, e.g., for care rendered by telemedicine providers to an originating site via privileges by proxy, may also be considered by the Privileging Authority.

(f) A DEA Administration Certificate is any Federal DEA registration(s) and/or the DoD fee-exempt DEA original certificate. Fee-exempt DEAs are issued by the DEA to physicians, dentists, podiatrists, optometrists, and prescribing psychologists. Physician assistants and advanced practice nurses who hold a State license as a mid-level practitioner are also eligible for a fee-exempt DEA. Non-personal services contract providers and volunteers are not eligible for a fee-exempt DEA (initial and renewal PSV). Any fee-exempt DEA registration or certificate cannot be used for personal use, which includes approved off-duty employment and other non-duty related activities.

(g) A National Provider Identifier (NPI) type 1 is required for healthcare providers who furnish billable healthcare services, or those who are authorized to initiate or receive referrals. The NPI Type 1 is a 10-digit provider-unique number assigned by the Centers for Medicare & Medicaid Services (CMS), at no cost, to healthcare providers, both privileged and non-privileged, who meet established eligibility criteria as stated in Reference (q). NPI is used to identify providers on claims, prescriptions, referrals, and other healthcare related documents. Providers will apply for an NPI, which is a permanent identifier that does not need to be renewed. The provider is required to update any changes to demographic information (such as address changes), as needed. The initial application and updates can be made via the National Plan and Provider Enumeration System website at <https://nppes.cms.hhs.gov>. The MSP/MSM will ensure that privileged providers obtain an NPI and the identifier is entered into JCCQAS (initial and renewal PSV); during renewal will validate that demographic data (name/address) is correct prior to routing credentials file for approval.

(h) A query of the National Practitioner Data Bank (NPDB) is required before privileges may be granted (i.e., at the time of initial medical staff appointment, initial granting of

clinical privileges, renewal of privileges, or when expanding privileges or requesting to add new privileges). For privileging by proxy, the NPDB query is optional. For non-privileged providers, the NPDB should also be queried in the credentialing process.

(i) Other malpractice information:

1. In the absence of an NPDB report, documentation of any new or old medical malpractice claims, settlements, or judicial or administrative adjudication with a brief description of the facts of each case listed. This documentation must be obtained directly from the provider's lawyer, the court, or the insurance company.

2. Dates of malpractice coverage and identification of insurance carrier dating back 10 years.

(j) Evidence of a criminal history background check (CHBC) or other fraudulent or illegal activity is required (initial and periodic reinvestigation) in accordance with References (r) and (s). For non-personal service contract personnel, the contracting agency is responsible for initiating the Federal Bureau of Investigation inquiry and completing the State criminal history inquiry portion of the CHBC. For personal service contract and volunteer personnel, the Privileging Authority is responsible for ensuring initiation and completion of the CHBCs. The Privileging Authority must ensure the CHBC has been completed and the results reflect no issues (is not a derogatory report) prior to allowing the provider to independently provide patient care to patients under 18 years of age. The CHBCs must be revalidated as required by References (r) and (s) If there has been a break in government service of 24 months or greater, a complete CHBC must be re-accomplished, even if the individual has had a security clearance and/or recent CHBC. References (r) and (s) outline how a privileged or non-privileged provider may be able to engage in patient care activities pending the completion of the CHBC. A document from the local servicing security office stating the CHBC was initiated and completed is required in accordance with References (r) and (s).

(k) For any provider (privileged and non-privileged) new to the DoD, the List of Excluded Individuals and Entities (LEIE) on the Health and Human Services website (http://oig.hhs.gov/exclusions/exclusions_list.asp) must be queried to determine if the provider has been excluded from participation in Federal Health Programs. If the provider's name appears on this list, the provider is disqualified from working for the DoD, in any capacity, for the period of time the provider is excluded and is ineligible for retention in their current position. The individual is not eligible for accession or hire into a federal service position (military or civilian). At each license, certification, or registration renewal by the privileged and non-privileged provider, a query to determine if the provider has been excluded from participation in Federal Health Programs must be conducted. Eligibility for employment is reestablished only upon the healthcare provider being removed from the LEIE. The appropriate military human resources personnel will be contacted for guidance. Supervisors of civilian employees with this adverse information on record should initiate immediate coordination with the human resources department or Contracting Officer, as applicable.

(l) Evidence of approved continuing medical and health education will be accumulated by the provider and made available to the MSP/MSM for initial privileges and staff appointment. Providers must maintain continuing education credits in accordance with state licensure and any DHA issuance.

(m) For providers accessed from the civilian sector, reference forms from at least two clinical references must be completed. These forms are completed by the healthcare provider's clinical supervisor and the Chief of the Medical Staff/Chief Medical Officer/Department. These clinical references are used to document current clinical competency and are completed by individuals who have knowledge of the applicant's clinical performance.

1. If newly accessed providers are not a member of any hospital's medical staff but are members of a group practice, equivalent individuals in the group who are familiar with the applicants' practice will complete these forms.

2. If newly accessed providers are not associated with a group practice, applicants must have peer providers familiar with their practice complete the reference forms. Letters of professional references are acceptable in lieu of military reference forms if the civilian evaluator adequately addresses all requested elements on the military reference form. At a minimum, this evaluation must address relevant training, experience, current competence, and any effects of health status on privileges being requested.

3. For providers completing a military training program, one reference form must be completed by the Training Program Director and forwarded to the gaining MTF, along with approved Graduate Medical Education (GME) specific forms from the training program, or the course-specific evaluation form.

4. For providers completing civilian training programs, the Program Director and a Senior Level Staff Provider must each complete a reference form.

5. For civilian providers and military-direct accessions requesting initial privileges, peer references must be current within 12 months of submission.

(n) Proof of professional competence

1. Civilian providers or military direct accessions applying for initial privileges can provide a copy of current or recent clinical privileges from an institution, clinical activity report with evaluation from a previous place of employment, a letter from a clinical supervisor, or case logs as documentation of clinical competence.

2. GME graduates must provide a final summative evaluation from their Program Director.

3. Providers undergoing privilege renewal or requesting privileges at a new duty station must provide a current clinical performance assessment from the clinical supervisor. The

privileges evaluated must be the same as those requested on the discipline-specific JCCQAS MPL. The clinical performance assessment will be used to document professional clinical and interpersonal skills and uploaded into JCCQAS.

4. Providers undergoing periodic privilege renewal will have performance evaluated as ongoing performance review (OPPE).

(o) Any history of adverse actions, criminal convictions, or other adjudicated actions or decisions by a hospital, state(s) boards of licensure, or other applicable certifying/regulatory agencies (as appropriate) must be reviewed by the Credentials Committee/Function and prior to any clinical practice or approval of clinical privileges. This includes voluntary or involuntary termination of professional and medical staff membership, or voluntary or involuntary suspension, reduction, restriction, or revocation of clinical privileges at a hospital or other healthcare delivery setting, and any resolved or open allegations or suspected allegations of misconduct, impairment, incompetence, or any conduct that adversely affected, or could have adversely affected, the health or welfare of a patient.

(p) Query of the Department of Health and Human Services (DHHS) and TRICARE sanctions lists is required.

(q) Healthcare provider statements (all of the following are completed with the use of the JCCQAS application form)

1. A statement by the healthcare provider of their ability to perform professional activities.

2. A statement of the applicant's health status. Healthcare providers are required to disclose their health status during privileging or at any time that there is a change affecting the ability to practice safe care. Healthcare provider must disclose all medication use.

3. Attestation by the applicant of any history of alcohol abuse or other substance use or abuse. A detailed explanation by the healthcare provider is required for any positive acknowledgement. The explanation must include details of past and current management, enrollment in impaired provider programs, and any effect on privileges currently or in the past. Providers are required to self-report any change in status during the privileging period within seven days.

4. A signed statement consenting to the inspection of records and documents pertinent to consideration of their request for accession, employment, or privileges.

5. A signed statement attesting to the accuracy of all information provided.

6. A signed statement disclosing if the healthcare provider has ever been the subject of an NPDB report, or has ever had any limitation placed on the free exercise of their privileges. Such limitation includes, but it not limited to an adverse denial of privileges, a

suspension, restriction, reduction, or a revocation of privileges. Additionally, the healthcare provider must also disclose in a signed statement if they have ever been denied a state license or had their state license under probation, suspension, or has ever been revoked.

7. Signed statement of agreement to follow the medical staff bylaws.

(r) Documented verification of identity with a federal government issued ID card.

(s) Privileging Authorities will accept current training completed at an MTF to meet requirements for specific privileges (e.g., sedation, robotic surgery, fluoroscopy, etc.). MSPs/MSMs will ensure supporting documentation of training is annotated and uploaded in the post-graduate training section of JCCQAS.

(t) The DoD Opioid Prescriber Safety Training Program is required for all providers who prescribed controlled substances and/or treat chronic pain. Training consists of two modules. Two continuing education units are awarded upon completion of training. Refresher training must be completed every 3 years thereafter.

(u) The Provider Enrollment, Chain and Ownership System (PECOS) is a Medicare program to be reimbursed for the covered services furnished to Medicare beneficiaries; however, with the implementation of Section 6405 of the Affordable Care Act, the CMS requires all physicians and non-physician practitioners to register in the Medicare program for the sole purpose of ordering or referring items or services for Medicare beneficiaries. Providers required to enroll in PECOS for the sole purpose of ordering and referring, include but are not limited to the following:

1. Physicians and non-physician practitioners (this includes licensed independent practitioners, dentists, oral surgeons, advanced practice nurses, and physician assistants) employed by the DoD/TRICARE.

2. Licensed and non-licensed interns, residents, and fellows in approved postgraduate programs.

(2) PSV is the process of verifying the validity of a provider's credentials. A reasonable effort with the primary issuing authority (two attempts) must be made to verify required documents identified in Table 1: Credentials Required for Privileged and Non-Privileged Providers.

(a) Documents and items may be primary source verified by one of the following accepted methods:

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 documented in JCCQAS, which will include the names of the organization and the individual contacted, date/time, phone number, signature, and title of the person responsible for verification.

3. American Medical Association (AMA) master file verification of U.S. medical school graduation and U.S. residency program completion. The AMA (<http://www.ama-assn.org/ama/pub/about-ama/physician-data-resources/physician-masterfile.page?>) or the AOA master files (<http://www.doprofiles.org>) may be used. Profile entries in either the AMA or AOA master files are only valid if they have been annotated as “verified.” Board Certifications will be subject to PSV with the issuing board. It is not necessary to delay the award of regular privileges pending verification of board certification if all other credentials are in order.

4. Via the internet. Such verification is acceptable if the information is obtained directly from the professional organization’s website. Identification of the individual making the website contact, and the date will be annotated on the web page printout and entered in the credentials record. Any discrepancy between information provided by the applicant and that on the website shall be pursued by personal contact with the professional organization.

(b) PSV of documents must occur on initial appointment, or assignment within the MHS before any new privileging action (e.g., renewal, modification, primary change of station).

1. Documents with no expiration date (e.g., diploma, residency certificate), must only undergo PSV one time on initial appointment within the MHS.

2. Documents that expire (e.g., license, certification), must undergo PSV when renewed and with each privileging action.

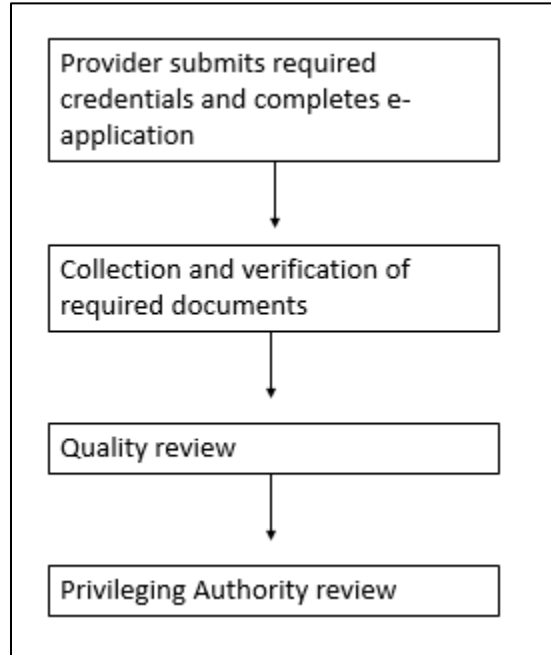
Table. Credentials Required for Privileged and Non-Privileged Providers (as applicable)

Credential	Required for Privileged Providers	PSV Required for Initial Privileges	PSV Required for Privilege Renewal	PSV Required for Privilege Modification	PSV Required for ICTB	PSV Not Required
Qualifying Degree, Diploma, ECFMG, etc.	X	X				
Postgraduate Training Certificate	X	X				
License/Certification/Registration	X	X	X	X	X	
Board Certification	X	X	X	X	X	
National Certification (NCCPA, ADA, etc.)	X	X	X	X	X	
Chronological Practice (CV, etc.)	X	X				
Proof of Professional Competence	X	X	X	X	X	
Malpractice Claims History	X	X	X			
Clinical Adverse Action and/or Disciplinary Action (if applicable)	X	X				
Current NPDB Report	X	X	X	X	X	
DEA Registration Number	X	X	X	X	X	
Clinical Reference Letters (minimum of two)	X	X	X			
Current BLS Certification	X					X
Evidence of Approved Continuing Medical/ Health Education	X					X
Verification of CHBC	X					
LEIE Query	X	X	X	X	X	
NPI (when applicable)	X					X
DHHS and TRICARE Sanctions	X	X	X	X	X	
Provider Statement of Ability to Perform Professional Activities	X					
Provider Statement of Health Status	X					
Provider Attestation of any Alcohol/Substance Use or Abuse History	X					
Provider Statement Consenting to Inspection of Records, etc.	X					
Provider Statement of Information Accuracy	X					
Proof of Identity	X					
Special Training Requirements (mammography, nuclear medicine)	X	X				

c. Privileging

(1) Privileging process overview

Figure. Privileging Process Overview



(a) Providers must complete an application for privileges and supply credentialing documentation. (See Paragraph 5.b.(1) for more information.)

(b) Credentials management office or other designated administrative office will complete credentials collection and verification requirements. (See Paragraph 5.b.(1) for more information.)

(c) Each provider undergoing consideration for clinical privileges will undergo a quality assessment of the provider's file. Quality review occurs at the level of the administrative office and clinical leaders processing the credentials application. Clinical quality review may occur through a Credentials Committee/Function or by a designated clinical leader.

(d) The Privileging Authority is the final approval for the awarding of clinical privileges.

(2) Variations on the process, as described, are permitted as approved by the DHA Director (or designee). Complete provider applications and files free from quality or safety issues will be considered for privileging decisions, at a minimum, by the Clinical Supervisor, Chief of the Medical Staff, or designated clinical leader, and the Privileging Authority. Provider application and/or files that raise quality, safety, or other concerns will be reviewed by the Credentials Committee/Function for consideration and recommendation to the Privileging Authority. The Credentials Committee/Function is required to convene at least quarterly to

provide oversight of the credentialing and privileging process and to validate approved applications. In addition, the Credentials Committee/Function will convene to address any concerns with applications.

(3) Types of privileges

(a) Regular privileges: not to exceed 24 months in duration, allow the provider to independently provide medical care consistent with the provider's professional education and training and the scope of services approved by their organization. These privileges are awarded based upon the individual's education, professional license, professional certifications, experience, current competency, ability, health, and judgment. Providers with regular privileges may still require focused professional practice evaluation (FPPE) monitoring and evaluation plans for itemized privileges still requiring documented evidence of competently performing the requested privilege. A period of FPPE monitoring and evaluation is implemented for all initially requested privileges and initial medical staff appointments. (See Paragraph 5.e. for further guidance.)

(b) Supervised privileges: allow providers who have met all minimal educational requirements but lack the initial licensure, certification, or registration, or necessary experience for independent practice in accordance with this manual. Providers who fail to maintain licensure will not be placed under supervised privileges. Supervised privileges are also appropriate for providers who have not clinically practiced for a period of 2 years or more, for those providers in an orientation period required to assess competency, or at the Privileging Authority's discretion pending completion of the CHBC. Designated proctors and Clinical Supervisors will recommend to the Credentials Committee/Function an upgrade to regular privileges when appropriate. Upgrades must meet supervisory plan quality metrics and competency requirements. Supervised privileges may be granted for up to 24 months.

1. Supervised privileges are awarded in the same manner as regular privileges. A proctor with regular privileges in the same or similar discipline must be identified in writing at the time supervised privileges are awarded. The proctor, in coordination with the Clinical Supervisor, must establish a written supervision plan and schedule for periodic progress reports, which will be acknowledged by all involved personnel. This document will be scanned, appropriately named in accordance with standard naming conventions, and uploaded to the provider's electronic credentials record. Written periodic progress reports must be provided to the MSM/MSP to be presented at the Credentials Committee/Function.

2. The Clinical Supervisor, in coordination with the designated proctor, determines the degree of supervision, based on the background, experience, and demonstrated skill of the supervised provider. Supervision plans must include 100 percent co-signature of all notes and direct observation of all procedures by the respective proctor.

3. Supervision for a solo practice specialist requires a provider with the same or similar training and experience. If the Clinical Supervisor is not qualified to review a specific privilege, a plan for supervision must be coordinated with DHA Market/Intermediate Headquarters. An appropriate consultant (or other qualified specialist) may be considered for

periodic visits to proctor cases and procedures. Alternatively (or in addition), the supervised provider may be sent on temporary duty (TDY) to a healthcare facility that provides the specialty service.

(c) Temporary privileges: are awarded in an emergency (e.g., life saving measure or to prevent serious harm) when full credentials review cannot be performed. They are time limited to 30 days and will not be used to extend the renewal period. Credential requirements for temporary privileges include the following:

1. A copy of the provider's license (with PSV).
2. Verification by the facility where the provider holds regular privileges indicating that the individual is a competent and fully qualified medical staff member in good standing and that the proposed privileges are within the individual's current scope of practice and privileges.
3. Credentials Committee/Function Chairperson or designated clinical leader may recommend granting of temporary privileges to the Privileging Authority. The Privileging Authority will sign a document containing the following statement: *(Provider's name) is granted temporary privileges commensurate with privileges awarded by the (name of the provider's Privileging Authority and organization, or civilian employer) while doing duty at (name of visiting organization) from (date) to (date). Privileges are awarded to the extent supportable by this organization's capabilities. (Name of provider) is appointed as an initial-affiliate medical staff member during this time period.* This document will be scanned and uploaded to the provider's electronic credentials record.

(d) Disaster privileges: may be granted if an emergency management plan has been activated and the situation demands clinical support beyond the organization's resources. These Privileges are time limited to 30–calendar day intervals. The Privileging Authority has the option to grant Disaster Privileges on a case-by-case basis upon presentation of a government–issued photo identification and at least one of the following:

1. A current picture hospital ID card; a current license to practice and a valid picture ID issued by a federal, state, or regulatory agency; an ID indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); an ID indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity; or presentation by current hospital or medical staff member(s) with personal knowledge regarding the provider's identity.
2. The MSP/MSM begins the verification process of the individuals who have received disaster privileges as soon as the immediate situation is under control or within 72 hours. If unable to begin PSV within 72 hours, documentation should be made as to why it couldn't be started, and that the providers have shown the proper documentation for disaster privileges. This verification process is identical to the process established for granting temporary privileges. (See Paragraph 5.c.(3)(c) for more information.)

(4) Medical Staff Appointment

(a) Appointment status reflects the relationship of the provider to the medical staff. At the time a provider is granted privileges or has privileges renewed, the provider may also be granted a medical staff appointment, which runs concurrently with the privileges. Privileges must be granted before a medical staff appointment is made. A provider may not admit patients without a medical staff appointment. Medical staff appointment may be revoked without revoking privileges and privileges may be granted without granting a medical staff appointment.

(b) The type of appointment will vary depending on the privileges to be exercised, the availability of the medical staff member, and the reason the provider is assigned to the organization. Medical staff appointments as defined by DoD are as follows:

1. Initial Medical Staff Appointment: granted after the Credentials Committee/Function review and analysis of all relevant information regarding each requesting privileged provider's current licensure status, training, experience, current competence, and ability to perform the requested privileges, and last for a period of 1 year.

a. A period of FPPE monitoring and evaluation is implemented for all initial medical staff appointments. FPPE may be transitioned to OPPE during the initial medical staff appointment upon recommendation by the Clinical Supervisor and concurrence by the Credentials Committee/Function.

b. Upon recommendation of the provider's supervisor and clinical supervisor, the Credentials Committee/Function, after full review of credentials and requested privileges, may approve an active or affiliate medical staff appointment.

c. Failure to advance from an initial to active or affiliate appointment shall cause the expiration, but not termination, of the medical staff membership.

2. Active Medical Staff Appointment: assigns responsibility to the provider for all functions and duties within the medical staff. Full credentials review is required for an active staff appointment. This appointment is granted to individuals exercising regular privileges who have completed an initial medical staff appointment in the DoD. They are full-time staff members expected to participate fully in medical staff duties.

3. Affiliate Medical Staff Appointment: is for medical staff members whose medical staff responsibilities and duties are reduced or eliminated because of limited duty or employment in direct patient care in the organization. Full credentials review is required for an affiliate staff appointment. Affiliate staff appointments may be given to individuals who have completed an initial medical staff appointment at the organization, who are consultants, or to individuals who work in the organization on a part-time basis.

4. Temporary Medical Staff Appointment: is granted in emergency situations, when necessary to fulfill pressing patient care needs (i.e., life threatening situation) and when

time constraints will not allow a full credentials review. Temporary medical staff appointment is required when providers practicing under temporary privileges will be admitting patients. This appointment runs concurrently with and for the same duration as the temporary privileges.

(5) Special Considerations

(a) Low Volume Providers. Providers must maintain clinical activity to be awarded clinical privileges. Low volume providers may require FPPE monitoring and evaluation plans or supervised privileges as per this DHA-PM.

(b) Privileging Authority. An MTF Director/Commander or other clinical leaders designated as a Privileging Authority must request privileges, as applicable, through the next higher level of Privileging Authority.

(c) Shadowing. Shadowing is a time-honored recruitment tool for medical professions. In recognition of that, and with the increased emphasis on patient privacy and requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, compliance with the following guidance is required before allowing civilians to shadow medical professionals.

1. Privileging Authorities are ultimately responsible for their shadow programs. Shadowing is intended for short durations at the discretion of the Privileging Authority. This responsibility may be delegated to the appropriate Functional Manager (i.e., Chief of the Medical Staff, Chief Nurse, or other specialty Functional Managers).

2. The Privileging Authority or designated representative is/are responsible for the following:

a. Determine the appropriateness of allowing individuals to shadow medical professionals based on age, school affiliations, staff availability, and the needs within their area of responsibility in coordination with the proposed clinical supervisor of the individual. The shadowing program is not designed to circumvent the establishment of a Training Affiliation Agreement (TAA). If the individual will be getting credit toward required curricula, then a TAA may be required. The volunteer program may also offer an alternative for interested parties who do not meet the recruitment intent of the shadow program or the need for a TAA.

b. Establish a central in-processing point for all shadowing personnel.

c. Ensure that a preceptor is identified by name for every shadowing person.

d. Ensure HIPAA training is completed prior to shadow experience.

e. Ensure Hospital Employee Health Program requirements are met as applicable prior to the shadow experience.

f. Coordinate with the Medical Legal Office as appropriate.

3. The designated preceptor will ensure that shadowing personnel:

- a. Do not engage in any type of patient care.
- b. Sign a non-disclosure statement (if under 18 years of age, must have parental guardian signature).
- c. Meet Hospital Employee Health Program requirements, as applicable.

(6) Healthcare Activities Outside the MTF: there is a difference between those instances where the individual is acting in a personal capacity (such as through personal volunteer activities or outside off-duty employment (ODE)) rather than acting in an official capacity supported by the MHS (such as when DOD requires the individual to provide care).

(a) Personal non-duty related activities (paid or unpaid) that are authorized in accordance with the DHA or Service-specific guidance.

1. Benefits of federal service, such as fee-exempt DEA, portability of state licensure, and medical malpractice coverage issued for official military purposes, does not apply for use in personal employment.

2. DoD healthcare providers are strongly encouraged to request pre-approval for off-duty employment. It should not interfere with providing healthcare for the MHS or mission accomplishment.

3. Permission will be withdrawn until completion of due process procedures in clinical adverse actions, as outlined in Volume 3. Additionally, when patient care issues arise in the off-duty employment setting for which the MHS is notified, appropriate action will be taken to address those concerns.

(b) Off-base duty assignments require that healthcare providers cannot be under investigation for an unresolved allegation that, if substantiated, would result in an adverse licensing or privileging action (clinical adverse action). Providers must meet the following eligibility criteria:

1. Have a current, valid, and unrestricted license or other authorizing document such as a certificate or registration, consistent with the requirements of this enclosure that encompasses the professional activities involved in the off-base duty assignment.

2. Have current clinical competence to perform the professional duties assigned.

3. Have current clinical privileges in accordance with this manual, which encompass the professional duties assigned. Alternatively, if such duties are outside the scope of clinical privileges granted by the applicable Privileging Authority, the individual privileged provider must have clinical competence sufficient to be granted such privileges by the civilian hospital or other entity responsible for privileges at the patient site.

4. Be current with applicable continuing medical education requirements.

5. In all cases in which the off-base duty will be performed in a non-DoD healthcare facility, the healthcare provider must follow the rules and bylaws of such facility, to the extent they are applicable to the provider.

(c) Coordination with State Licensing Boards

1. Prior to a healthcare provider performing off-base duties pursuant to Section 1094 of Reference (o), the Privileging Authority must notify the applicable licensing board of the host state of the duty assignment involved. Such notification will include:

a. Healthcare provider's name, state(s) of licensure, and the approving Privileging Authority's name;

b. Location and expected duration of the off-base duty assignment;

c. Scope of duties;

d. MHS liaison official for the licensing board to contact with any questions or issues concerning the off-base duty assignment;

e. A statement that the healthcare provider meets all the qualification standards in the healthcare assignment;

f. Cite Section 1094 of Reference (o) and this DHA-PM as its underlying authority.

2. Coordination with state licensing boards is not required in cases in which the off-base duties involve the authorized provision of healthcare services through telemedicine, regardless of provider or patient location.

3. The requirements of this enclosure regarding off-base duties of non-privileged providers may be waived by the DHA Director/Service SG (or designee) on a case-by-case basis, if that official determines that such a requirement is not necessary to promote cooperation and goodwill with the state licensing board concerned and that such a waiver is consistent with this section and guidance of the ASD(HA).

(d) Investigations and Reports. In the event of any alleged or suspected allegation misconduct, impairment, incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient while on off-base duty assignment:

1. MHS personnel must cooperate with authorized officials investigating such conduct on behalf of the host state licensing board, any other licensing board that has granted a

license to the healthcare provider involved, and the non-DoD facility at which the DoD healthcare provider was performing the off-base duty assignment. Cooperation may include providing testimony and assisting in gathering evidence.

2. Upon the referral of an allegation of such conduct to the MHS by a state licensing board or an official of the non-DoD healthcare facility involved, or upon receipt of an allegation from the person or entity making the allegation, or upon otherwise learning of the allegation, the MHS authorizing Privileging Authority must make sure that the allegation is reviewed and, if it raises a substantive issue, is investigated.

(7) New Recruits and Accessions: accession of new providers will occur in accordance with Service policy.

(8) Portability: processes listed for portability allow for providers to exercise privileges authorized at one facility to gain efficient authorization to practice in other settings. Exceptions to the processes outlined in this publication or representing new innovations in privileging processes may be submitted to the DHA Director (or designee) for approval.

(a) Privileging by Proxy. Privileging by proxy allows an institution to accept the privileging decision from another Privileging Authority to authorize care. This process will be used in accordance with this DHA-PM. Verification of time-limited credentials is not a requirement for privileging by proxy.

(b) Inter-Facility Credentials Transfer Brief (ICTB)

1. When healthcare providers (including active duty, Reserve Components, civilians, and personal services contractors, and excluding non-personal services contractors) are assigned temporarily for clinical practice (e.g., MTF to MTF, or MTF to deployed assignment), the base organization must convey all relevant credentials and privileging information to the temporary duty organization. The ICTB is the approved mechanism for conveying information between organizations in these cases, though all time-limited credentials still need PSV. A provider with active privileges at a base organization will apply for clinical privileges at the temporary duty organization. The temporary duty organization retains full responsibility and authority for making privileging decisions, but may request assistance from the base organization with respect to privileging decisions.

2. The ICTB is joined with the formal application for privileges. The ICTB serves as the credentials file when making privileging decisions on temporarily assigned healthcare providers.

3. After customary departmental review and recommendation, and consideration of the gaining organization's capability, Privileging Authorities may grant privileges based on the approved privilege list from the base organization by approving it with or without recommendations. The temporary duty organization's Credentialing Committee/Function must ensure that all relevant information is considered, taking care to investigate additional information regarding the ICTB. Privileges applied for but not granted due to facility-based

limitations are not adverse privileging actions. For routine temporary duty, annual training, or manning assistance, the ICTB application should be initiated at least 60 days in advance and completed by the provider and submitted to the temporary duty organization, whenever possible. The application is routed for review and approval at the temporary duty organization. Ensure Reserve Component entities include current civilian clinical privileges lists in the Provider Credentials File. If not privileged in a civilian facility, include items such as case logs, job descriptions, and other relevant information. This additional documentation will be scanned, appropriately named and uploaded to the provider's Provider Credentials File.

a. When a provider is required to deliver recurring services at a temporary duty organization (e.g., temporary duty, manning assist, or reserve drills), the ICTB is valid for the tenure of the provider's medical staff appointment at the base organization.

b. A clinical performance assessment covering the multiple clinical duty periods, must be completed by the temporary duty organization at the end of the last clinical period, and must be submitted to the base organization as part of the re-privileging process. The completed clinical performance assessment must be uploaded into provider's credentials record.

4. The ICTB will become invalid on the expiration of the professional privileges on which it is based. If a provider's privileges are due to expire during the temporary duty, steps shall be taken by the base organization to complete renewal of the ICTB prior to its expiration. The base organization will maintain and update all credentials expiring during the course of the ICTB (i.e., a new ICTB is not required). The gaining organization must have access to the renewed credentials (via JCCQAS) or be given a copy of it to be maintained in the healthcare provider's file. The base organization must keep an accurate record of all temporary duty organizations to which an ICTB has been sent to ensure updates on provider status are forwarded as required. The organization must provide a new ICTB whenever the status of the individual provider's privileges changes (e.g., change from provisional to defined privileges, renewal of privileges, adverse privileging actions). If any Privileging Authority places a provider in summary suspension, begins a QAI, takes an adverse privileging action against a provider, or is made aware of a report to the NPDB for criminal convictions related to healthcare or other adjudicated actions or decisions related to healthcare, they must communicate this to all other Privileging Authorities under whom a provider is privileged/practices (federal and civilian).

5. Reporting elements for the ICTB must be acquired electronically from JCCQAS.

a. Non-personal services contract personnel (personnel rendering the services who are not subject, either by the contract's terms or by the manner of its administration, to the supervision and control usually prevailing in relationships between the Government and its employees) are not authorized temporary assignment to another MHS organization. Assignment for duty is only as stipulated in their contract. Use of an ICTB is not authorized.

b. In addition to the ICTB or VETPRO (the Veterans Administration (VA) electronic credentials database) Coordinator Summary, providers must complete an application for privileges at the temporary duty organization. If a provider meets the credentialing and

privileging requirements as set forth in this DHA-PM, privileges may be granted. The credentialing information on the ICTB/VETPRO Coordinator Summary provided by the base organization will serve as the credentials verifications for all credentials that do not expire. All time-limited credentials (e.g., licensure), must be verified by the MSP at the temporary duty organization. When practicing under an ICTB/VETPRO Coordinator Summary, the provider functions as a member of the medical staff and participates fully in the temporary duty organization's CQM programs.

6. Providers going on temporary duty to locations without JCCQAS access will hand carry a hard-copy ICTB.

(c) Sharing Functionality. The sharing functionality in JCCQAS allows a provider's base organization to share that provider's JCCQAS credentials record with other organizations. This process may be used in at least the following situations:

1. Enhanced Multi-Service Markets (eMSM).
2. Specialty providers routinely supporting temporary duty organizations.
3. Dual assigned providers who are in the National Guard or Reserve, and are also civilian employees in a DoD or VA facility.
4. VA healthcare providers providing healthcare services at DoD facilities:
 - a. A VA healthcare provider with shared assignments identified in JCCQAS allows for a facility to share the provider's record and to generate a concurrent application for one or more facilities. The provider completes a single e-application for use by all these facilities.
 - b. VA healthcare providers must meet the credentialing and privileging requirements as set forth in this DHA-PM, prior to privileges being granted with the exception of privileging by proxy for telemedicine.

(d) Telemedicine (See definition in Paragraph 2.ad.)

1. Telemedicine does not require modification of delineated privileges and should not be annotated as a delineated item for privileged providers. Training, or other required pre-requisites to the practice of telemedicine will be tracked separately from the privileging list. Providers privileged at a distant site may engage in telemedicine services to patients at an originating site within the care catchment area of the distant site with no additional privileging actions.
2. In general, telemedicine services may be rendered by a provider privileged at a distant site to a patient at an originating site, once the originating site's Privileging Authority approves the distant site provider's requested telemedicine privileges by proxy. Information regarding the telemedicine services provided will be incorporated into the provider's

OPPE/FPPE by the distant site. The originating site will communicate any issues or concerns regarding the quality of the provider's care or professionalism to the distant site as necessary. Healthcare Risk Management cases regarding care delivered by telemedicine, to include adverse privileging actions, are the distant site Privileging Authority's responsibility. The following paragraphs describe: telemedicine services by or to the VA, not supported by the DoD Virtual Medical Center (VMC); telemedicine services provided by non-DoD or VA providers, not supported by the DoD VMC; and telemedicine services supported by the DoD VMC.

3. For telemedicine services provided by or to the VA, not supported by the DoD VMC: an ICTB or VETPRO summary from the DoD or VA provider's distant site will be used by the originating site to validate credentials and requested privileges. The Privileging Authority at the originating site may grant telemedicine privileges by proxy based on the originating site's Credentials Committee/Function recommendation after review of the information provided.

4. For telemedicine services provided by non-DoD or VA providers, not supported by the DoD VMC: the use of an originating or distant site that is not a DoD or VA organization, but is a civilian healthcare organization, TRICARE contracted provider's office, or other location approved by ASD(HA) for this purpose is permissible unless restricted by the DHA Director. Prior to engaging in telemedicine services, and at a minimum, the following will be addressed in a written agreement between the originating site and the distant site:

a. Both the originating and distant sites must be accredited by the accrediting organization (AO) designated by the ASD(HA). In particular, standards for telemedicine and privileging by proxy must be met.

b. If the distant site is not a DoD or VA organization, or otherwise does not have access to the ICTB, its medical staff CP Program must meet the accreditation standards by the AO designated by the ASD(HA).

c. The provider must be privileged at the distant site to provide telemedicine services, and the distant site must provide a current list of the provider's privileges to the originating site.

d. The distant site must maintain evidence of an internal review of the provider's performance of these privileges, and must provide to the originating site information for use to assess the provider's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to DoD Reportable Events (see Volume 2 of this manual), that result from the telemedicine services provided, and complaints about the provider from patients, other healthcare providers, or staff, at the originating site.

e. Patients and providers are provided with a secure and private setting.

f. Arrangements have been made for appropriate clinical support, including access by local emergency services, should the need arise.

5. For telemedicine services supported by the DoD VMC:

a. The DoD VMC may serve as an originating site, or both an originating and distant site in the delivery of care via telemedicine. The DoD VMC, as outlined in this manual, must either be affiliated with an accredited MTF or be independently accredited. Like an MTF, the DoD VMC may have its own Privileging Authority, or its Privileging Authority would be the Privileging Authority of the accredited MTF/DHA Market with which it is affiliated. The DoD VMC must have a process in place to accept and take action on quality and safety feedback on the care provided. Care delivered must meet the quality and safety standards of the ASD(HA) approved accrediting organization.

b. DoD VMC as an originating site. Telemedicine services may occur by a privileged provider from a distant site to the DoD VMC as originating site, once the DoD VMC's Privileging Authority approves the provider's privileges by proxy. Telemedicine services provided will be incorporated into the provider's OPPE/FPPE by the distant site. The originating site will communicate any issues or concerns regarding the quality of the provider's care or the provider's professionalism to the distant site as necessary. Healthcare Risk Management cases regarding care at the originating site, to include adverse privileging actions, are the distant site Privileging Authority's responsibility.

c. DoD VMC as both an originating and distant site. The DoD VMC may act as an originating site, and as a distant site when its Privileging Authority performs credentials verification and privileging in accordance with the credentialing and privileging process outlined in this DHA-PM. In this case, the DoD VMC has responsibility as the distant site to conduct OPPE/FPPE and perform quality oversight for the provider. Healthcare Risk Management cases regarding care at the originating site, to include adverse privileging actions, are the DoD VMC Privileging Authority's responsibility. The DoD VMC, if not independently accredited, could use the resources of an affiliated MTF to assist with regulatory compliance of clinical quality management programs.

d. Provider Credential Records. Maintenance of provider credential records will be performed in accordance with this manual. The official credentials record is JCCQAS and is the record that is subject to compliance inspections. The six-part hard-copy credential record will become a historical file only. For newly assigned providers without a historic credential record, a temporary credentials file will be established by the MSP/MSM to store documentation that has been collected at that site. This documentation must be appropriately named and uploaded to the provider's electronic credential record upon receipt, as the electronic JCCQAS record is the provider's official credentials file. The temporary file is not subject to compliance inspections but serves as a repository of historical documents if needed in the future. Any hard-copy records or temporary records are considered part of the system of record and need to be handled accordingly.

e. Peer Review Process of Clinical Performance: FPPE and OPPE.

(1) Assessing healthcare provider competency to deliver high-quality, safe patient care is an integral part of credentialing and privileging processes. Deriving standards based on

collaboration between the ACGME and the ABMS, six areas of “General Competencies” are recognized: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. These elements constitute areas used for the determination of provider competency. The following are designated methods of documenting privileged provider competency, and non-privileged provider competency where applicable.

(2) The Medical Staff is responsible for the Professional Practice Evaluation Process. The Credentials Committee/Function is responsible for monitoring compliance with this manual. The Credentials Committee/Function receives regular status reports from each medical director related to the progress of all providers on FPPE monitoring and evaluation plans and any problems identified during OPPE. The Chief of the Medical Staff will notify in writing and discuss with privileged providers the results of the FPPE. Non-privileged providers are notified and provided feedback by respective clinical leadership for their FPPE. FPPE results and reviews/forms are placed in a secure Provider Activity File (PAF) in a CQM office, or similar secure location, or in a secure location for non-privileged providers without a PAF per respective senior clinical leadership (e.g., Senior Nurse Executive for nurses). Feedback from the OPPE will be reviewed with the healthcare providers with documentation maintained in the securely stored PAF/performance documentation. The securely stored PAF/performance documentation is part of the official system of records.

(3) There are many sources of performance data and no set number of charts to review. The number should be adequate to compare providers, as determined by the Chief of the Medical Staff in collaboration with respective department chairs, or by appropriate clinical leadership for non-privileged providers. For low volume/high-risk activities, a 100 percent chart review would be appropriate. The provider and departments must receive data and feedback. This information may be obtained through periodic medical record review, direct observation, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient. Much of this data can be collected by clinical and administrative support staff.

(4) Provider performance information is privileged and protected from disclosure in accordance with Section 1102 of Reference (o), and stored securely as per Paragraph 5.e.(2) of this enclosure. Elements for review may include: pharmacy profiles, medical record completion, blood and drug utilization evaluations, known procedure complications, Incident/Adverse Event information, morbidity and mortality summaries, infection rates, National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS[®]) and The Joint Commission ORYX measures, patient satisfaction/complaints, patient advocacy information and additional elements as defined by the clinical department or medical staff. Elements for non-privileged providers are as determined by respective appropriate clinical leadership.

(5) FPPE

(a) FPPE is a time-limited performance review of a provider’s clinical practice whereby a provider’s care is evaluated closely by another provider(s). Institution of an FPPE monitoring and evaluation plan is not considered an adverse action, does not alter the medical staff appointment status, and does not reduce or restrict a provider’s privileges. FPPE

monitoring and evaluation plans can be used regularly as an opportunity for learning and improvement, and is required to validate clinical competency for all providers reporting to a clinical assignment for the first time. Privileging Authorities have the responsibility for facilitating skill refresher training and FPPE monitoring and evaluation plans for individuals returning from deployments or assignments with low volume patient encounters. Finally, a period of FPPE with a monitoring and evaluation plan may be indicated for concerns of substandard care, or incompetence, when there is not sufficient information to warrant immediate removal from practice through summary suspension and initiation of a QAI. Such concerns ideally come to light through OPPE or an FPPE monitoring and evaluation plan, rather than from a patient safety event.

(b) The Credentials Committee/Function approves placing providers into FPPE to ensure the quality of the monitoring and evaluation plan and is relevant to the reason for instituting the plan, monitor the provider's progress, identify leading practices with this process – and to ensure that immediate removal from practice with summary suspension and initiation of a QAI is not warranted (as per Volume 3 of this manual).

(c) The FPPE monitoring and evaluation plan must be submitted in writing to the Credentials Committee/Function for endorsement, and will include at least the reason why the FPPE monitoring and evaluation period was instituted, the provider(s) responsible for precepting the individual, the quality of care metrics and criteria to be used, and the volume of care or the duration of time (or both) for the monitoring period. Both chart review and direct observation of care covering all areas of concern, are to be included in the plan. The identified preceptor(s) will be identified in the plan, and will be afforded time in their schedule to conduct the requirements of the FPPE with monitoring and evaluation. There must be written feedback, as well as formal discussions with the provider under review on a scheduled basis. Immediate verbal and written feedback is to be provided when concerns or issues are identified and includes evidence-based recommendations and best practices to allow provider remediation.

(d) At a minimum, a monthly status update in writing will be provided to the Credentials Committee/Function for review. The FPPE with monitoring and evaluation may be ended prior to the established completion time (or case volume). With each status update, and/or the final review, the Credentials Committee/Function must decide:

1. If the provider has met or exceeded the plan's performance criteria, and whether to transition the provider to OPPE.
2. If the provider is failing to meet the plan's performance criteria, and whether to recommend to the Privileging Authority to place the provider in summary suspension and initiate a QAI. (See Volume 3 of this manual for further guidance.)
3. If during this period of FPPE monitoring and evaluation, issues were identified that require extension of the monitoring period, e.g., significant deviations from standards of care, insufficient activity during the monitoring period.

(e) For organizations that have a single provider practicing a specialty,

coordination with the DHA Market/Intermediate Headquarters for an appropriate FPPE monitoring and evaluation plan must include 100 percent chart review of invasive procedures performed during the initial medical staff appointment FPPE. In addition, a provider of similar skillset, if not same specialty, could evaluate quality processes associated with these procedures (e.g., hand hygiene, teamwork, proper communication with OR staff and anesthesia, proper consents for procedure, use of time outs, and so on). An appropriate consultant (or other qualified specialist) may also be considered for periodic visits to precept cases and procedures. Alternatively (or in addition), the provider may be sent on temporary duty (TDY) to a healthcare facility that provides the specialty service (e.g., skill refresher training after a low volume assignment).

(6) Ongoing Professional Practice Evaluation (OPPE): OPPE is the continuous evaluation of a provider's professional performance, rather than an episodic evaluation. The OPPE process forms the basis of evaluation of a provider's clinical competence and professional behavior and allows for early identification and resolution of performance problems or concerns. Clinical leaders are responsible for conducting competency assessment of privileged providers at intervals not to exceed 6 months. It also serves as a mechanism to monitor the implementation of clinical guidelines or performance improvement initiatives that involve patient care delivery. Data must be collected via direct observation or medical record review.

f. Humanitarian Missions. The military Senior Medical Department Representative (SMDR) assigned to a foreign humanitarian mission is responsible for monitoring the quality and safety of the healthcare rendered by all providers participating in the DoD mission. The SMDR is required to review the credentials of all providers assigned to the DoD mission and to authorize those qualified providers to practice their specialties. The SMDR is the final authority on which healthcare providers participate in the DoD foreign humanitarian mission.

(1) All DoD providers (active duty, Reserve Component, DoD civilian employee), as well as employees of DoD contractors carrying out contract work, will report as assigned with a current medical readiness certification. A complete ICTB letter from the provider's primary Privileging Authority will be generated and must be reviewed by the SMDR. The SMDR is required to review the credentials of all providers assigned to the DoD mission and to authorize those qualified providers to practice in their clinical specialties.

(2) A host nation may require documentation or copies of medical school diplomas and State licenses as a condition for medical personnel practicing in that country. If required by a host nation, such documentation may be provided to the host nation. The host country should be requested to return the documents after review, and/or agree to protect the documents from further release.

(3) If a copy of the ICTB letter is also provided to a host country, sensitive personal identifying information (e.g., Social Security number, date of birth, home address, and DEA number) will be redacted prior to release.

(4) The Medical Director of a non-governmental organization (NGO) is responsible for providing appropriate information documentation and verifying education, training, licensing,

and current clinical competence to the SMDR for all its participating members when requesting authorization for the NGO to be a participant in the DoD humanitarian mission.

(5) An NGO may be a cooperating party with a DoD humanitarian mission. An NGO may not become part of the DoD mission if the NGO is not providing healthcare services in or on a DoD facility or platform (such as a field hospital or hospital ship), but rather is providing services independently while receiving logistical support from the DoD. In such cases, the SMDR is not responsible for verifying education, training, licensing, and current clinical competence of the NGO's members, or monitoring their professional services. However, the SMDR will obtain assurance from the Medical Director of the NGO that the Medical Director accepts that responsibility. The SMDR will also ensure host nation officials have no misunderstanding regarding the relationship between the DoD and the NGO with respect to the humanitarian mission.

(6) All foreign providers (i.e., providers not licensed in any jurisdiction of the United States), will meet the credentialing and licensing standards of their respective country. A foreign provider's request for authorization to participate as part of a DoD humanitarian mission should include, to the extent practicable, supporting documentation of medical training, country certification or licensure, education, practice specialty, and current clinical competencies. A period of observed practice will be performed to assess skill level prior to assignment of clinical duties.

(7) Ensuring that all medical care provided as part of DoD foreign humanitarian missions meets applicable quality and safety standards is the responsibility of the assigned SMDRs. NGOs involved as a cooperating party, but not becoming a participant in the DoD humanitarian mission, are to accept comparable responsibilities. The role of the NGO, as either a participant in the DoD humanitarian mission or a cooperating party with a DoD humanitarian mission, should be clearly expressed in the memorandum of understanding between DoD and the NGO for that mission, and should include:

(a) Credentialing/privileging requirements and authorization (within the United States or territory); and

(b) Credentialing/privileging requirements and authorization (within foreign nations).

APPENDIX

SPECIALTY SPECIFIC LICENSURE, TRAINING, AND OTHER CREDENTIALS
REQUIREMENTS

This appendix outlines the minimum education and credentials requirements required by specialty. The DHA or Services may impose additional requirements; for civilian employees, follow U.S. Office of Personnel Management (OPM) position guidelines. Specialties not listed in this appendix follow Service-specific guidance unless superseded by DHA guidance.

1. ADVANCED PRACTICE NURSES (APNs)

a. Graduation from a master's or doctoral degree program in nursing approved by an organization authorized by the Department of Education to accredit schools of nursing, with a focus in the specialty of specific privileges being requested.

b. Must obtain and maintain certification by the relevant certification body for the given APN specialty.

c. Given the unusual circumstances that some state licensing boards require APNs to have a supervising or collaborating physician to be licensed in the same state in order to be eligible for advanced level nursing licenses, some state restrictions may be impractical and not in the best interest of delivery of healthcare in the DHA. Waivers for the advanced practice nursing license may be granted for those APNs who are ineligible for the advanced level licensure due incongruence with this DHA-PM, and for whom there is clear documentation establishing the military's need for the individual to practice beyond the scope of their license or certification. To be eligible for a license waiver the nurse is required to:

(1) Have an active, unrestricted license to practice as a registered nurse.

(2) Have successfully completed an accredited educational program for advanced practice as a certified nurse practitioner, certified nurse midwife, CRNA, or certified clinical nurse specialist. Those completing their respective programs after December 31, 2001, must be educationally prepared at the master's level or above.

(3) Have passed their specialty-specific national certifying examination.

(4) Have accumulated continuing education credit in accordance with the national certifying organization's requirement for certification or recertification.

(5) Maintains active certification in accordance with the national certifying organization's stipulations.

d. Completion of a formal post-graduate certificate program in the relevant specialty (postmaster's certificate programs). APNs require the following certification as follows:

- (1) Adult Nurse Practitioners. National certification in specialty (i.e., certification through the ANCC).
- (2) Acute Care Nurse Practitioners. National certification in specialty (i.e., certification through the ANCC).
- (3) Certified Registered Nurse Anesthetists. National certification in specialty (Certification by the Council on Certification of Nurse Anesthetists).
- (4) Certified Nurse Midwives (CNM). National certification in specialty (Certification by the American College of Nurse Midwives Certification Council. Prior to 1990, certification was via the American College of Nurse Midwives).
- (5) Family Nurse Practitioners. National certification in specialty (i.e., certification by the ANCC or the American Academy of Nurse Practitioners (AANP)).
- (6) Pediatric Nurse Practitioners (PNP). National certification in specialty (i.e., certification through the Pediatric Nursing Certification Board (PNCB) or the ANCC).
- (7) Women's Health Nurse Practitioners (WHNP). National certification in specialty (e.g., certification through the National Certification Corporation (NCC) for obstetric, gynecologic, and primary care to women).
- (8) Psychiatric/Mental Health Nurse Practitioners (P/MHNP). National certification in specialty (e.g., certification by the ANCC).

2. AUDIOLOGISTS

- a. Master's degree in audiology or Doctor of Audiology (Au.D) degree.
- b. National certification (Certificate of Clinical Competence from the American Speech-Language-Hearing Association) or American Board of Audiology (ABA) certification.
- c. Licensure from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

3. CERTIFIED DRUG COUNSELORS: SUBSTANCE COUNSELORS. In accordance with DHA or Service-specific policy.

4. CHIROPRACTORS

- a. Graduate of a chiropractic college accredited by the Counsel on Chiropractic Education (CCE) and possess a current, valid, and unrestricted license to practice as a Doctor of Chiropractic from a U.S. state, territory, or district.
- b. Licensure as a Doctor of Chiropractic.
- c. A minimum of 2 years full-time active chiropractic experience in which they have consistently administered both diagnostic and treatment services.

5. CLINICAL NURSE SPECIALISTS (CNSs)

- a. Completion of graduate-level study leading to a master's or doctoral degree as a CNS.
- b. National certification in the specialty for which the nurse is assigned as a CNS (e.g., Pediatrics).
- c. Licensure from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

6. CLINICAL PSYCHOLOGISTS

- a. A doctoral degree in clinical or counseling psychology (Ph.D. or Psy.D.) from an American Psychological Association (APA)-accredited university or professional school.
- b. An APA-accredited pre-doctoral internship in professional psychology (this 1-year internship is part of an APA-accredited doctoral program). Waiver of an APA-accredited program must be staffed through the DHA. Clinical psychologists commissioned or employed prior to publication of this DHA-PM must have completed a 1-year clinical internship. (Completion of a non-APA-accredited program is acceptable for those psychologists already commissioned or employed prior to publication of this DHA-PM).
- c. Current state license in clinical psychology from a U.S. state, territory, or district (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).
- d. For direct accessions and Health Professions Scholarship Program graduates refer to DHA or Service-specific guidance.
- e. Additional requirements for psychology privileges are as follows:
 - (1) To Prescribe and Dispense Psychotropic Medications. In accordance with Service-specific guidance until superseded by DHA guidance.
 - (2) Neuropsychological Assessment. Requires a 2-year post-doctoral fellowship in neuropsychology or the equivalent in specialized training and supervised practice.

(3) Pediatric Psychology Privileges. Requires a 1-year post–doctoral fellowship in pediatric psychology or the equivalent in specialized training and supervised practice.

(4) Clinical Health Psychology. May require a 2-year post–doctoral fellowship in health psychology or the equivalent in specialized training and supervised practice or as otherwise instructed by Service policy.

(5) Forensic Psychology. Completion of a full-time (at least 1 year) post–doctoral training program in forensic psychology or the equivalent in specialized training and supervised practice. This program must meet curriculum requirements consistent with the APA’s definition of forensic psychology as a specialty.

(6) Survival, Evasion, Resistance and Escape (SERE) Psychology. Requires the completion of all DoD requirements for SERE Psychology certification. This includes graduation from a Level C SERE course and the SERE orientation course, as well as continuation training or participation in reintegration operations at least biannually.

7. CLINICAL SOCIAL WORKERS

a. Master of Social Work (MSW) degree from an accredited school of social work.

b. Experience in clinical social work, either through a master’s-level practicum or 2 years post-MSW experience.

c. License/certification from a U.S. jurisdiction. Effective October 1, 1998, State licensure/certification at any MSW level became the qualifying document, while national certification became optional. Social workers on active duty, unless specifically exempted as an entry-level clinical social worker, must be licensed/certified by a United States jurisdiction at a level that allows practice of clinical social work without supervision. Exception to policy includes those individuals who have yet to complete the 2 years of post-MSW supervised experience (not applicable to the Reserve Component) required by State licensure that allows independent practice without supervision. Social workers accessed without an independent clinical practice level license (not applicable to the reserve component) must obtain such license within 3 years of accession.

8. DENTISTS

a. Graduation from a dental school approved by the Commission on Accreditation of Dental and Auxiliary Educational Programs of the American Dental Association (ADA) or the Commission on Dental Accreditation of Canada of the Canadian Dental Association.

b. Completion of a training program approved by the Commission on Accreditation of Dental and Auxiliary Educational Programs of the ADA or the Commission on Dental Accreditation of Canada of the Canadian Dental Association, for specialties other than general dentistry.

c. Licensure from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

d. For direct accessions and Health Professions Scholarship Program (HPSP) graduates, refer to DHA or Service-specific guidance.

9. FLIGHT MEDICINE AND UNDERSEA MEDICINE

a. Privileges in flight medicine may be awarded after completion of the U.S. Navy, U.S. Army, or U.S. Air Force Flight Medicine training program. For any previously trained flight surgeon who has not practiced flight medicine in a Service-specific setting in greater than 2 years, follow DHA or Service-specific guidance.

b. Privileges in undersea medicine may be awarded after completion of the Naval Undersea Medical Institute. Undersea medical officers (UMOs) who have been out of practice for greater than 5 years will undergo Officer Refresher Training at the Naval Undersea Medical Institute.

10. LICENSED REGISTERED NURSES (RNs)

a. Active duty registered nurses must have graduated from a bachelor's degree program in nursing (BSN) accredited by a national nursing accrediting agency recognized by the U.S. Department of Education. Registered nurses who have associate degrees in nursing (ADN) or are graduates of diploma programs and do not have a BSN are not eligible unless they also have a post-baccalaureate (master's or doctorate) degree in nursing.

b. Civilian registered nurse positions follow OPM guidance. Contract registered nurses must have graduated from an accredited professional nursing educational program.

c. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

d. Foreign Trained RNs. Certification by the Commission on Graduates of Foreign Nursing Schools (CGFNS).

11. LICENSED VOCATIONAL NURSES (LVNs)/LICENSED PROFESSIONAL NURSES (LPNs)

- a. Graduation from a State Board of Nursing approved LPN/LVN training program or completion of equivalent military training that permits sitting for the State licensure examination.
- b. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

12. MARRIAGE AND FAMILY THERAPISTS. Master's or doctoral degree in marriage and family therapy from a program Accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or a qualifying graduate degree in an allied mental health field from a regionally accredited education institution in conjunction with a program of marriage and family therapy study that is equivalent to the COAMFTE standards as defined by the American Association of Marriage and Family Therapy (AAMFT); State license from a U.S. state, territory, or district; and clinical membership credentials issued by the AAMFT.

13. OCCUPATIONAL THERAPISTS

- a. Master's degree from a program accredited by the Accreditation Council of Occupational Therapy.
- b. Certification by the National Board for Certification in Occupational Therapy, Inc.
- c. Completion of 6 months of clinical internship (usually accomplished prior to graduation and must be done in order to be eligible to take the certification exam).
- d. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).
- e. Completion of professional coursework in the specialty area such as Educational and Developmental Intervention Services (EDIS).

14. OPTOMETRISTS

- a. Doctor of Optometry degree from an accredited organization.
- b. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).
- c. Board certification is encouraged but is not required. DHA-recognized board certification for optometrists: Fellowship in the American Academy of Optometry (FAAO), American Board of Optometry (ABO), and The American Board of Certification in Medical Optometry (ABCMO).

15. PHARMACISTS.

a. Bachelor's or doctorate degree in pharmacy from an accredited training instituted by the Accreditation Council for Pharmacy Education (ACPE) Pharmacy College, or a Foreign Pharmacy Graduate Examination Committee (FPGEC) certificate, and active licensure from a U.S. state, territory, or district.

b. The scope of services offered at the facility is the main determinant if clinical pharmacist privileges are required.

c. Additional requirements for pharmacy privileges are as follows:

(1) Master of Science degree. Doctor of Pharmacy degree (Pharm.D.) preferred.

(2) Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmacy Specialties or completion of a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy.

(3) License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

16. PHYSICAL THERAPISTS

a. Entry-level physical therapists must be graduates of a physical therapy program accredited by the American Physical Therapy Association (APTA) Commission on Accreditation in Physical Therapy Education.

b. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

c. Completion of professional coursework in the specialty area such as Educational and Developmental Intervention Services (EDIS).

d. Trigger point dry needling requirements are in accordance with Service-specific requirements until superseded by DHA guidance.

17. PHYSICIANS

a. Graduation from a medical school in the United States, Canada, or approved by the Liaison Committee on Medical Education of the American Medical Association (AMA), graduation from a college of osteopathy approved by the American Osteopathic Association (AOA), or graduation from a medical school with evidence of Educational Commission for

Foreign Medical Graduates (ECFMG) certification. For physicians employed within the DoD, DHA, and U.S. Department of Veterans Affairs (VA) health systems before January 1, 2017, successful completion of the Fifth Pathway is acceptable in place of ECFMG certification.

b. Completion of an accredited residency approved by the Accreditation Council for Graduate Medical Education (ACGME) or the AOA in the same specialty for which privileges are requested, for all specialties other than general medical officer, flight surgeon, and undersea medicine. Physicians who have completed a physician internship program (postgraduate year-1) may be privileged as general medical officers, in accordance with Service-specific policy.

c. Licensure from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

d. Those active duty personnel accessed from professional training or who complete other training and 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 or within 1 year of completion of postgraduate year one (post-graduate year-1) for Doctors of Medicine (MD) and Doctors of Osteopathy (DO). For physicians to be eligible for licensure, they must successfully complete Step III of the U.S. Medical Licensing Exam (USMLE) (Comprehensive Osteopathic Medical Licensing Examination (COMLEX) for DOs) and complete one year of postgraduate (PG) training. In order to meet the DHA requirement, physicians who choose to be licensed in a State that requires more than 1 year of post-graduate training must also obtain a license from another State that requires only 1 year of post-graduate training. Failure to obtain a license within the timeframes outlined in this DHA-PM may result in administrative discharge actions in accordance with Service-specific guidance.

e. The DoD only recognizes certifications issued by boards that are members of the American Board of Medical Specialties (ABMS) or the AOA Bureau of Osteopathic Specialists (initial and renewal PSV).

18. PHYSICIAN ASSISTANTS (PAs)

a. Graduation from a Physician Assistant Education Program accredited by the Accreditation Review Commission for Physician Assistant Education, Inc. or its predecessors, and acceptable to the Service-specific guidelines.

b. PAs must obtain initial certification by the National Commission on Certification of Physician Assistants (NCCPA) within 12 months of graduation. Civilian accessions must be certified prior to employment.

c. PAs are required to maintain NCCPA certification. Certification is maintained by meeting NCCPA continuing medical education and re-examination requirements as outlined in the NCCPA recertification process.

d. Licensure waivers for PAs. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) waives the license requirement for PAs who meet required criteria:

(1) Have successfully completed an educational program for PAs accredited by the Accreditation Review Commission on Education for the PA or, prior to 2001, by either the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs.

(2) Have passed the PA National Certifying Examination administered by the National Commission on Certification of PAs. Achieve and maintain recertification with the National Commission on Certification of PAs.

(3) Successful completion of a training program for PAs recognized by Accreditation Review Commission on Education for the Physician Assistant and current certification by the NCCPA.

(4) Non-personal service contract personnel are ineligible for licensure waivers and must abide by the State requirements of the MTF location.

(5) National Guard PAs in Active Guard Reserve/Title 10 status may be eligible for licensure waivers if credentialed and privileged through an MTF. Traditional/Title 32 drilling PAs are ineligible for licensure waivers and must hold a State license.

e. Additional requirements for care provided by PAs:

(1) A physician collaborator must be appointed and endorse the application for clinical privileges. An alternate physician must be appointed in writing to act in the absence of the primary collaborator.

(2) PAs will have access to a physician for the purpose of advice and collaboration. This access may also be telephonically or via e-mail. PA subspecialty privileges must occur under the clinical supervision of a physician specialist in the same specialty (i.e., an orthopedic PA must be supervised by an orthopedic surgeon).

(3) Consultation with the collaborating physician must be sought and documented when complex cases or complications are encountered. Consultation may include, but is not limited to, discussion of the case before or in the course of treatment, or timely review and discussion following disposition of the case.

f. Specialty PAs:

(1) In addition to the education requirements listed in this DHA-PM for PAs, specialty PAs must complete residency or fellowship training of 12 months or more in a medical specialty program acceptable to the DHA.

(2) Specialty PAs are trained at approved sites within the DoD, or at accredited civilian institutions.

(3) For civilian PAs, contractual language or position description sets the scope of practice (i.e., Orthopedic PA, Urology PA, etc.).

(4) Flight medicine/Aerospace Operational Medicine PA requires completion of the U.S. Navy, U.S. Army, or U.S. Air Force Flight Surgery training program and requirements in accordance to Service instruction. For any previously trained flight medicine PA who has not practiced flight medicine in a Navy Aviation Medicine setting in greater than 2 years follow DHA or Service-specific guidance.

19. PODIATRISTS

a. Graduate of a college of podiatric medicine Accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association (APMA).

b. Completion of 24 months of podiatric surgical residency training preferred. Completion of 12 months podiatric surgical residency training, plus a 12-month podiatric orthopedic/primary podiatric medical residency, will be considered on a case by case basis.

c. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

20. RADIOLOGISTS. Radiologists providing mammography must meet the requirements of the Mammography Quality Standards Act (MQSA) and submit appropriate documentation with their credentials (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, October 28, 1997*, effective April 28, 1999).

Documentation will be scanned, named in accordance with standard naming conventions, and maintained in JCCQAS. The Federal Register regulation, as well as guidance documents, is available online at <https://www.fda.gov/radiation-emittingproducts/mammographyqualitystandardsactandprogram/default.htm>.

21. REGISTERED DENTAL HYGIENISTS (RDHs)

a. Completion of a dental hygiene certificate program accredited by the Commission on Dental Accreditation of the ADA. Most dental hygiene programs are located at community colleges and grant an associate degree after 2 years of training. However, there are also numerous bachelor's and master's degree programs at colleges and universities that require an additional 2 to 4 years of education.

b. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).

c. Successfully pass the National Board Dental Hygiene Examination (NBDHE). In rare circumstances at MTFs in foreign countries, foreign trained RDHs who have not completed the NBDHE can be credentialed on a case-by-case basis based on demonstrated evidence of current competency.

22. REGISTERED DIETICIANS

a. Completion of at least a bachelor's degree from an accredited college or university and completion of a didactic program in dietetics approved by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA).

b. Successful completion of one of the following CADE-approved supervised practice programs:

(1) Dietetic internship with generalist or military emphasis.

(2) Coordinated program in dietetics with generalist emphasis.

c. Current registration by the Commission on Dietetic Registration of the ADA or proof of eligibility to take the ADA registration examination.

d. Except for a non-personal services contract provider, the authorizing document to practice for a dietitian is a national registration. They are exempt from maintaining a license from a particular jurisdiction (i.e., U.S. state, territory). Must possess the credentials of "Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN)" per the Commission on Dietetic Registration (CDR). State licensure is an option, but not a requirement.

23. REGISTERED FIRST ASSISTANT. In accordance with DHA or Service-specific policy.

24. SEXUAL ASSAULT MEDICAL FORENSIC EXAMINER (SAMFE)

a. Training for SAMFEs and healthcare providers shall be provided to maintain optimal readiness in accordance with DoDI 6310.09 and Enclosure 5 of DHA-PI 6310.09 on "Health Care Management of Patients Affected by Sexual Assault" as follows (currently in coordination):

(1) Providers eligible to become SAMFEs are Physicians, Physician Assistants, Nurse Practitioners, Nurse Midwives, Certified Registered Nurse Anesthetists, Clinical Nurse Specialists, Registered Nurses, or, in certain contingency circumstances, Independent Duty Corpsmen.

(2) In order to be identified as a DoD-approved SAMFE, providers must:

(a) Successfully complete the multi-disciplinary offered training through the inter-Service Sexual Assault Medical Forensic Examiner Course, located at Joint Base San Antonio-Fort Sam Houston, Texas, which includes hands-on clinical training and a minimum 40 didactic hours, and have demonstrated competency within 6 months or equivalent DHA training within the DoD, within the past year, or

(b) Hold a professional civilian certification with the Commission for Forensic Nursing Certification or other national certification body (e.g., SANE-A[®]) and complete the Sexual Assault Medical Forensic Examiner Course stated in Paragraph 24.a.(2)(a) of this appendix within 12 months from being appointed in a SAMFE role, or

(c) Successfully complete the 40-hour BUMED Mobile Training TeamSAMFE Course offered in FY16 (and currently discontinued); the USAMEDCOM Headquarters 40-hour didactic training and completed the clinical competency requirements; and

(d) Maintain current credentialing:

1. Tracking of credentialing will be maintained in JCCQAS or other appropriate training record for individuals not currently in JCCQAS.

2. Complete four continuing education (CE) credits in sexual assault per year.

3. Clinical competence validated by supervisor through retrospective medical record review, live proctoring, successful performance in simulation of four cases annually, or by documentation of four actual patient Sexual Assault Forensic Exams (SAFEs) per year. Practice evaluation methods include:

a. Completion of the annual SAMFE Individual Assessment form found in Enclosure 8 of DHA-PI 6310.09 on “Health Care Management of Patients Affected by Sexual Assault” (currently in coordination) to demonstrate proficiency in completing a medical-forensic examination, administered by a SAMFE.

b. SAMFE’s serving in operational billets or at isolated Commands outside continental United States (OCONUS) with exceptional limited access to live, simulated or sexual assault cases will be required to complete the DHA-approved Sexual Assault-Forensic and Clinical Management training as per DHA-PI 6310.09 on “Health Care Management of Patients Affected by Sexual Assault” (currently in coordination) and be issued a certificate of completion.

b. Completion of a peer review process as outlined in Enclosures 5 and 7 of DHA-PI 6310.09 on “Health Care Management of Patients Affected by Sexual Assault” (currently in coordination).

25. SPEECH PATHOLOGISTS

- a. Master's degree in Speech-Language Pathology, Communication Sciences and Disorders, or a directly related field from an accredited program of the Council on Academic Accreditation of the American Speech-Language-Hearing Association (ASHA).
- b. License from a United States jurisdiction (in accordance with the Licensing Requirements section in Enclosure 2 of this volume).
- c. National certification (Certificate of Clinical Competence from the American Speech-Language-Hearing Association).

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

Unless otherwise noted, these abbreviations and acronyms are for the purpose of this DHA-PM

AABB	AABB (formerly known as American Association of Blood Banks)
AAMFT	American Association of Marriage and Family Therapy
AAO	American Academy of Optometry
ABA	American Board of Audiology
ABCMO	American Board of Certification in Medical Optometry
ABMS	American Board of Medical Specialties
ABO	American Board of Optometry
AC	accreditation and compliance
ACS	American College of Surgeons
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ACPE	Accreditation Council for Pharmacy Education
AD CS	Assistant Director for Combat Support
ADA	American Dental Association
ADA	American with Disabilities Act
ADN	Associate's Degree in Nursing
AHRQ	Agency for Healthcare Research and Quality
ALS	Advanced Life Support
AMA	American Medical Association
ANCC	American Nurses Credentialing Center
AO	accrediting organization
AOA	American Osteopathic Association
APA	American Psychological Association
APMA	American Podiatric Medical Association
APN	advance practice nurse
APTA	American Physical Therapy Association
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASHA	American Speech-Language-Hearing Association
Au.D.	Doctor of Audiology
BAA	business associate agreement
BLS	Basic Life Support
BSN	Bachelor of Science in Nursing
CAC	Common Access Card
CADE	Commission on Accreditation for Dietetics Education
CAI	Corrective Action Implementation
CAP	College of American Pathologists
CCE	Council on Chiropractic Education
CDR	Commission on Dietetic Registration

CE	continuing education
CFR	Code of Federal Regulations
CGFNS	Commission on Graduates of Foreign Nursing Schools
CHBC	Criminal History Background Check
CIS	Criminal Investigative Service
CLIP	Clinical Laboratory Improvement Program
CM	clinical measurement
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CNM	certified nurse midwife
CNS	certified nurse specialist
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
COMLEX	Comprehensive Osteopathic Medical Licensing Examination
COR	Contracting Officer's Representative
CP	credentialing and privileging
CPME	Council on Podiatric Medical Education
CQI	clinical quality improvement
CQIS	Clinical Quality Improvement Studies
CQM	clinical quality management
CRNA	certified registered nurse anesthetist
CSA	Comprehensive Systematic Analysis
CUSP	Comprehensive Unit-based Safety Program
CVO	Centralized Credentials Verification Office
DAD MA	Deputy Assistant Director for Medical Affairs
DEA	Drug Enforcement Agency
DES	Disability Evaluation System
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DHA-PM	Defense Health Agency-Procedures Manual
DHHS	Department of Health and Human Services
DMAT	Disaster Medical Assistance Team
D.O.	Doctor of Osteopathic Medicine
DoD RE	DoD Reportable Event
DSA	data sharing agreement
DSAA	data sharing agreement application
DLA	Defense Logistics Agency
EDIS	Educational and Developmental Intervention Services
EHR	electronic health record
ECFMG	Educational Commission for Foreign Medical Graduates
EIDS	Enterprise Intelligence and Data Solutions
eMSM	Enhanced Multi-Service Market
ER	emergency room
ERM	enterprise risk management

FAAO	Fellowship in the American Academy of Optometry
FDA	Food and Drug Administration
FHPQA	Force Health Protection Quality Assurance
FMEA	Failure Mode Effect Analysis
FNLH	Foreign National Local Hire
FNP	family nurse practitioner
FOIA	Freedom of Information Act
FPGEC	Foreign Pharmacy Graduation Examination Committee
FPPE	focused professional practice evaluation
GME	Graduate Medical Education
GS	General Schedule
GTT	Global Trigger Tool
HAI	healthcare-associated infection
HAR	Hazards, Alerts, and Recalls
HAR-NESS	Hazards, Alerts, and Recalls Notice System
HEDIS [®]	Healthcare Effectiveness Data and Information Set
HIPDB	Health Integrity Protection Data Bank
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	health information technology
HPSP	Health Professions Scholarship Program
HRM	healthcare risk management
HRO	high reliability organization
HROM	High Reliability Operating Model
ICTB	Inter-facility Credentials Transfer Brief
IDES	Integrated Disability Evaluation System
IHPP	Impaired Healthcare Provider Program
IMA	Individual Mobilization Augmentee
IO	Investigating Office
IOM	Institute of Medicine
IPC	infection prevention and control
IPCWG	Infection Prevention and Control Working Group
JCCQAS	Joint Centralized Credentials Quality Assurance System
JOES	Joint Outpatient Experience Survey
JPSR	Joint Patient Safety Reporting
LEIE	List of Excluded Individuals and Entities
LIP	licensed independent practitioner
LPN	licensed practical nurse
LVN	licensed vocational nurse
MC	Medical Corps
MCSC	Managed Care Support Contractor

M.D.	Doctor of Medicine
MEB	medical evaluation board
MEDLOG	Medical Logistics Division
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MOU	memorandum of understanding
MPL	Master Privilege List
MQA	medical quality assurance
MQAP	medical quality assurance program
MQAR	medical quality assurance record
MQSA	Mammography Quality Standards Act
MSM	medical staff manager
MSP	medical staff professional
MSW	Master of Social Work
MTF	military medical treatment facility
NBDHE	National Board Dental Hygiene Examination
NCC	National Certification Corporation
NCQA	National Committee of Quality Assurance
NCCPA	National Commission on Certification of Physician Assistants
NDAA	National Defense Authorization Act
NGO	non-governmental organization
NHSN	National Healthcare Safety Network
NOTO	Number of Times Occurred
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPIC	National Perinatal Information Center
NQF	National Quality Forum
NSQIP [®]	National Surgical Quality Improvement Program
OCONUS	outside the continental United States
ODE	off-duty employment
OHU	operational healthcare unit
OPM	Office of Personnel Management
OPPE	ongoing professional practice evaluation
OSD	Office of the Secretary of Defense
PA	physician assistant
PA-C	Physician Assistant-Certified
PAF	Provider Activity File
PALS	Pediatric Advanced Life Support
PCE	potentially compensable event
PCMH	Patient Centered Medical Home
PCS	permanent change of station
PDCA	Plan-Do-Check-Act
PDSA	Plan-Do-Study-Act

PEB	physical evaluation board
PEBLO	Physical Evaluation Board Liaison Officer
PECOS	Provider Enrollment, Chain and Ownership System
PG	Postgraduate
Pharm.D.	Doctor of Pharmacy
Ph.D.	Doctor of Philosophy
PHI	protected health information
PHM	Population Health Management
PII	personally identifiable information
PIV	Personal Identity Verification Card
P/MHNP	psychiatric/mental health nurse practitioner
POAM	Plans of Action and Milestones
POC	point of contact
PNCB	Pediatric Nursing Certification Board
PNP	pediatric nurse practitioner
PQDR	Product Quality Deficiency Report
PQI	Prevention Quality Indicator
PRA	proactive risk assessment
PS	patient safety
PSC	personal services contract
PSI	Patient Safety Indicator
PSIC	Patient Safety Improvement Collaborative
PSLC	Patient Safety Learning Center
PSM	patient safety manager
PSP	Patient Safety Program
PSPC	Patient Safety Professional Course
PSQAC	Patient Safety Quality Academic Collaborative
PSR	patient safety report
PSV	primary source verification
Psy.D.	Doctor of Psychology
QA	quality assurance
QAI	Quality Assurance Investigation
QAIO	Quality Assurance Investigating Officer
RAG	Risk Assessment Grade
RCA	root cause analysis
RDH	registered dental hygienist
RD	registered dietitian
RDN	registered dietitian nutritionist
RMWG	Risk Management Working Group
RN	registered nurse
SAFE	Sexual Assault Forensic Exam
SAMFE	Sexual Assault Medical Forensic Examiner
SANE-A [®]	Sexual Assault Nurse Examiner – Adult/Adolescent

SDD	Solution Delivery Division
SE	sentinel event
SE MOS	Sentinel Event Measures of Success
SERCA	Safety Event Root Cause Analysis
SERE	survival, evasion, resistance and escape
SG	Surgeon General
SHEA	Society for Healthcare Epidemiology of America
SIP	significantly involved provider
SMDR	senior medical department representative
SME	subject matter expert
SOC	standard of care
SRE	serious reportable event
STEEEP	safe, timely, effective, efficient, equitable, patient-centered
T-TPQ	TeamSTEPPS™ Teamwork Perceptions Questionnaire
TAA	training affiliation agreement
TDY	temporary duty
TeamSTEPPS™	Team Strategies and Tools to Enhance Performance and Patient Safety
TJC	The Joint Commission
TRISS	TRICARE Inpatient Satisfaction Survey
U.S.C.	United States Code
UCMJ	Uniform Code of Military Justice
UMO	Undersea Medical Officer
USMLE	United States Medical Licensing Exam
USN	United States Navy
USTRANSCOM	United States Transportation Command
USU	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs
VADM	Vice Admiral
VMC	virtual medical center
VTC	video teleconferencing
WHNP	women's health nurse practitioner

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this DHA-PM.

accreditation. Process of review that allows healthcare organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized accrediting organization (AO).

adverse event. See definition for patient safety (PS) event.

adverse practice action. Restriction, reduction, or revocation of the clinical practice of a non-privileged provider as a result of a due process professional review action, based upon evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

adverse privileging action. Denial, restriction, reduction, or revocation of clinical privileges as a result of a due process professional review action, based upon evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

Agency for Healthcare Research and Quality (AHRQ) Harm Scale. The AHRQ Harm Scale can be found in the AHRQ Common Formats – Hospital Version 2.0, and includes the following assignment categories:

No-Harm: Event reached the patient, but no harm was evident.

Mild Harm: Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay.

Moderate Harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.

Severe Harm: Bodily or psychological injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.

Death

The harm scale defined by AHRQ Common Formats – Hospital Version 2.0, further delineates harm as:

Temporary Harm. Expected to revert to approximately normal (i.e., patient’s baseline)

Permanent Harm. Not expected to revert to approximately normal (i.e., patient’s baseline)

approved postgraduate training. Postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or other similar entities regulating healthcare provider training programs.

auditing. A process used by health professionals to assess, evaluate, and improve care in a systematic way; used by clinical governance to safeguard high quality of clinical care for patients.

certification. A process by which a nationally recognized organization confirms that an individual healthcare organization has met certain predetermined standards or procedures required for certification.

clinical adverse action. Action invoked against a healthcare provider, privileged or not, with the result that the authority to practice clinically is adversely affected. Adversely affected privilege(s)/practice are the result of a due process professional review action based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient, and that leads to the inability of a provider to exercise their privilege(s)/practice with their own independent judgment. This is the collective term used in this manual that encompasses both an adverse practice action and an adverse privileging action.

clinical data 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.

clinical measurement (CM). CM uses tools to help evaluate and track the quality of healthcare services provided to beneficiaries in the Military Health System (MHS). Analyzing CM data and acting on identified trends for improvement helps ensure the MHS delivers safe, timely, effective, efficient, equitable, and patient-centered care.

clinical privileges. Permission granted by the Privileging Authority to provide medical and other patient care services. Clinical privileges define the scope and limits of practice for privileged providers and are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

clinical privileging. The granting of permission and responsibility of a healthcare provider to provide specified or delineated healthcare within the scope of the provider's license, certification, or registration.

clinical quality improvement (CQI). CQI consists of systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups. Focuses on the application of several widely accepted process improvement methodologies to improve clinical performance and desired outcomes.

clinical quality management (CQM). The integrated processes, both clinical and administrative, that provide the framework to objectively define, measure, assure, and improve the quality and safety of care received by beneficiaries. The CQM functional capability includes the following programs: Patient Safety, Healthcare Risk Management, Credentialing and Privileging, Accreditation and Compliance, Clinical Measurement, and Clinical Quality Improvement.

competency assessment. Assessment of a healthcare provider's knowledge, skills, and ability to deliver high quality, safe patient care. The Military Health System (MHS) assesses providers

using standards from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS), recognizing six areas of “General Competencies” including: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. These may serve as the basis for healthcare provider care evaluation and privileging decisions.

compliance. The ongoing process of meeting the legal, ethical, and professional standards applicable to a particular healthcare organization or provider.

Comprehensive Systematic Analysis (CSA). CSA is a thorough, credible, and acceptable analysis following a patient safety (PS) event that seeks to identify system vulnerabilities so that they can be eliminated or mitigated in a sustainable manner to prevent reoccurrence. A root cause analysis (RCA) is one type of CSA. CSAs can also be conducted for performance improvement purposes for those events that have the potential to be catastrophic. The following guidelines support the identification of causal factors in CSAs:

Clearly show cause and effect relationships.

Use specifics and accurate descriptions of events.

Human errors must have a preceding cause.

Violations in procedure must have a proceeding cause.

Failure to act is only causal when there is a pre-existing duty to act.

continuing education. Education beyond initial academic or professional preparation approved by an appropriate certifying professional organization that is relevant to the type of care or service delivered in an organization.

Corrective Action Implementation (CAI) Plan Report. The CAI Plan Report describes the effectiveness of the corrective action after implementation. The CAI Plan Report should include identified solutions, corrective actions implemented, and measures of effectiveness and sustainment to show that a corrective action has been implemented and is reducing or eliminating the risk of reoccurrence in a lasting way.

credentialing. The process of obtaining, verifying, and assessing the qualifications of both privileged and non-privileged providers to provide safe patient care services. This assessment serves as the basis for decisions regarding delineation of clinical privileges, as well as appointments and reappointments to the medical staff. The required information should include qualification data such as relevant education, training, and experience; current licensure; and specialty certification (if applicable) as well as performance data, such as current competency, and the ability to perform the selected privileges. This data is collected, verified, and assessed initially and on an ongoing basis.

credentials. The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare provider.

credentials file. A file containing pertinent information regarding an individual privileged provider to include credentialing and privileging documents, permanent performance data, medical practice reviews, continuing health education documentation, and information related to permanent adverse privileging actions.

credentials review. The credentials inspection and verification process conducted for healthcare providers before selection for military service, employment, and procurement. The credentials review process is also conducted for healthcare providers before medical staff appointment and granting of clinical privileges and is repeated at the time of reappointment and renewal of privileges.

current competence. The state of having adequate ability and up-to-date knowledge to perform the functions of a healthcare provider in a particular discipline, as measured by meeting these criteria:

The provider has actively pursued the practice of their discipline within the past two years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested and that the individual has satisfactorily practiced the discipline as determined by the results of ongoing professional practice evaluation (OPPE).

The provider possesses documented evidence of appropriate continued medical education to maintain the currency of skills and knowledge.

data 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.

denial of clinical privilege(s). Refusal to grant requested privileges to a healthcare provider at the time of initial application or renewal. Denials that result from a professional review action following appropriate due process proceedings, and relating to evidence of the provider's misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient are reported to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies. Denials that occur solely because a provider does not meet a healthcare institution's established threshold criteria for that particular privilege, should not be reported to the NPDB - these are considered decisions based on eligibility and are not deemed to be a result of a professional review action.

denominator. The part of a fraction that is below the line and that functions as the divisor of the numerator; the population at risk in the calculation of a rate or ratio.

department/clinical unit. The department, unit, or area utilized for patient care (e.g., pharmacy, surgical area, emergency department, procedural area, nursing unit).

deviation. The action of departing from an established course or accepted standard; the amount by which a single measurement differs from a fixed value such as the mean.

direct care system. Healthcare facilities and medical support organizations managed by the DoD through the Defense Health Agency (DHA) or Service Surgeons General in accordance with applicable federal laws and regulations.

DoD Reportable Event (DoD RE). Any patient safety (PS) event resulting in death, permanent harm, or severe temporary harm, as per the AHRQ Harm Scale; or meeting The Joint Commission's (TJC) sentinel event (SE) or the National Quality Forum's (NQF) serious reportable event (SRE) definitions. DoD REs require a Comprehensive Systematic Analysis (CSA) and follow on Corrective Action Implementation (CAI) Plan Report.

enterprise risk management (ERM). ERM provides a comprehensive framework for making risk management decisions to promote safe and reliable healthcare and to mitigate risks across the organization. Effective ERM practices are continuous in nature and support the journey to high reliability.

event reporting. The DoD Patient Safety Program (PSP) captures the full range of patient safety (PS) events listed in Volume 2 and all such events must be reported into the Joint Patient Safety Reporting (JPSR) system to be used as opportunities to prevent harm. Any PS event that reaches the patient (i.e., adverse events and no-harm events) must be reported to the appropriate Healthcare Risk Management (HRM) Program for assessment. DoD Reportable Events (DoD REs) also have reporting, notification, and analysis requirements beyond JPSR.

focused review. A review that concentrates on a perceived problem area that involves a specific standard, procedure, policy or any other limited scope healthcare delivery matter.

focused professional practice evaluation (FPPE). A process whereby the organization evaluates the privilege/practice of the healthcare provider who does not have documented evidence of competently performing the requested privilege, or of demonstrated practice competency, at the organization. This process may also be used when a question arises regarding a healthcare provider's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the healthcare provider's professional performance.

harm. Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury.

healthcare provider. Any member of the uniformed services, civilian employee of the DoD, or contract employee authorized by the DoD to perform healthcare services.

healthcare risk management (HRM). Includes clinical and administrative activities, processes, and policies to identify, monitor, assess, mitigate, and prevent risks to the healthcare

organization, patients, and staff. By employing risk management, the healthcare organization proactively and systemically safeguards patient safety and the organization's resources, accreditations, legal/regulatory compliance, assets, and customer confidence (integrity).

intentional unsafe act. Any alleged or suspected act or omission of a healthcare 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 law enforcement, disciplinary system, or administrative investigation.

Joint Centralized Credentials Quality Assurance System (JCCQAS). A secure, worldwide healthcare provider credentialing, privileging, adverse actions, and risk management web-based application mandated by the Military Health System (MHS) used in the provider credentialing and privileging process. Portions of the information contained in JCCQAS are confidential, privileged and protected from disclosure in accordance with Section 1102 of Title 10, United States Code. JCCQAS is the official file for healthcare providers credentialed and privileged within the MHS.

Joint Patient Safety Reporting (JPSR) system. DoD electronic system used to capture data for all types of patient safety (PS) events in Military Medical Treatment Facilities (MTF) and other applicable healthcare environments, as well as PS events tracked and trended in other programs. The MTF Patient Safety Manager (PSM) is responsible for JPSR data management, the review of facts associated with the PS event, and for ensuring an appropriate evaluation is performed as required by DHA guidance. JPSR usage is the only authorized method for the reporting of adverse events, no harm events, near misses, and unsafe conditions.

lean. A process of continuous cycle improvement to maximize value by improving efficiencies and decreasing waste.

licensed independent practitioner (LIP). Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, and within the scope of the individual's license and consistent with individually granted clinical privileges.

measure sets. Sets of measures that focus on different aspects of healthcare delivery and are used to improve healthcare quality and help drive improvement through a consistent approach.

medical quality assurance program (MQAP). Any peer review activity carried out before, on, or after November 14, 1986 by or for the DoD to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks as defined in Section 1102 of Title 10, United States Code.

medical quality assurance record (MQAR). The proceedings, records, minutes, and reports that emanate from quality assurance program activities and are produced or compiled by the DoD as part of a medical quality assurance program as defined in Section 1102 of Title 10, United States Code.

Military Health System (MHS). DoD medical and dental programs, personnel, facilities, and other assets operating pursuant to Chapter 55 of DoD Directive 5136.01, by which the DoD provides:

Healthcare services and support to the Military Services during the range of military operations.

Healthcare services and support to members of the Military Services, their family members, and others entitled to DoD medical care.

monitoring and evaluation. A well-defined, time-limited, well documented plan of focused professional practice evaluation (FPPE) to confirm a healthcare provider possesses the knowledge, skills, and ability to render safe and effective healthcare. It must include a documented plan with delineation of clear expectations and measures of success. It requires a preceptor who provides full written evaluation of the monitoring period, with regular interval feedback, to both the provider and the Credentials Committee/Function. Privileges/practice remain intact during the period of monitoring and evaluation.

National Practitioner Data Bank (NPDB). The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to healthcare practitioners, providers, and suppliers. The NPDB is managed by the Department of Health and Human Services in accordance with Section 11101 of Title 42, United States Code.

near miss event. See definition of patient safety (PS) event.

no-harm event. See definition of patient safety (PS) event.

non-privileged provider. An individual who possesses a license, certification, or registration by a state, commonwealth, territory, or possession of the United States, and is only permitted to engage in the delivery of healthcare as defined in their granted scope of practice. Examples include registered nurse (RN), licensed vocational nurse (LVN), registered dental hygienist (RDH), and medical technician.

ongoing professional practice evaluation (OPPE). A documented summary of ongoing data collected for the purpose of assessing a healthcare provider's clinical competence and professional behavior. The information gathered during this process allows for identification of practice trends that may adversely affect, or could adversely affect, the health or welfare of a patient. It is the responsibility of the organization to determine the criteria used in the ongoing professional practice evaluation.

other authorizing document. A mechanism, such as registration and certification, by which a State, the District of Columbia, a Commonwealth, territory, or possession of the United States, grants authority to provide healthcare in a specified discipline. 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 an individual is professionally qualified to provide healthcare in a specified discipline. Special considerations apply in the case where healthcare is provided in a foreign country by any person who is not a national of the United States.

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 healthcare. 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 safety (PS) event. A PS event is an incident or condition that could have resulted, or did result, in harm to a patient. A PS event can be but is not necessarily the result of a defective system or process design, a system or process breakdown, equipment failure or malfunction, or human error. PS events include adverse events, no-harm events, near miss events, and unsafe/hazardous conditions as defined below:

adverse event. PS event that resulted in harm to the patient. The event may occur by the omission or commission of medical care.

no-harm event. PS event that reached the patient but did not cause harm.

near miss event. PS event that did not reach the patient (also known as “close call” or “good catch”).

unsafe/hazardous condition. A condition or a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

peer. A healthcare provider with generally similar privileges, practice, clinical specialty and level of training.

peer review. Any assessment of the quality of medical care carried out by a healthcare provider, including any such assessment of professional performance, any patient safety program Comprehensive Systematic Analysis (CSA) or report, or any other such assessment carried out by a healthcare provider under provisions of this manual.

performance improvement. Continuous study and improvement of processes with the intent to achieve better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.

plan-do-check-act/plan-do-study-act (PDCA/PDSA). A management method for the control and continuous improvement of processes and products. This four-step model includes assessing the current process; enacting the plan; evaluating and comparing data to expected outcomes; and developing corrective actions based on outcomes.

potentially compensable event (PCE). Any patient safety (PS) event that both a) reaches the patient (i.e., adverse event and no-harm event) and b) has a Healthcare Risk Management assessment that determines that the event is likely to present a possible financial loss to the Federal Government. All DoD Reportable Events (DoD REs) are PCEs. All events that trigger a PCE will also be referred to the Patient Safety Manager to ensure capture in the Joint Patient Safety Reporting (JPSR) system and investigation/analysis as defined in Volume 2, Patient Safety of this manual.

preceptor. A clinical peer who has been appointed in writing to evaluate a healthcare provider's clinical practice. The preceptor is designated for consultation, clinical feedback, and general oversight of the clinical activities of the provider. A preceptor may review medical records, and conduct direct observation of a provider's practice, however they are not required to be present for or approve the provider's procedures or clinical decisions since the provider's clinical privilege(s)/practice is not restricted in any manner. [Contrast with the definition for "proctor".]

primary source verification. Validation that a document is true and valid through contact with the issuing institution or its authorized agent.

privileged provider. An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare with defined scope of practice.

Privileging Authority. The Privileging Authority is a designated official who grants permission to individuals to provide specific care, treatment, or services within well-defined limits. The Privileging Authority also initiates and makes determinations on clinical adverse actions.

proactive risk assessment (PRA). Process used to identify, rate, and prioritize risks and/or hazards. Based on a risk assessment, policies, procedures and controls may be put into place to manage the risk as appropriate to the organization, with the intent of reducing risk to the lowest possible level. A form of PRA is Failure Mode Effect Analysis (FMEA): a systematic, proactive method for evaluating a process to identify where and how it might fail, to assess the relative impact of different failures, and to identify the parts of the process that are most in need of change.

process. A goal-directed, interrelated series of actions, events, mechanisms, or steps. Processes should always be designed with flexibility in mind and the ability to periodically introduce controlled, measurable changes.

proctor. A clinical peer who has been appointed in writing to supervise all or some of a healthcare provider's clinical practice. The proctor is required in order for the provider to proceed in exercising designated clinical privilege(s)/practice. The proctor provides direct

oversight of designated clinical activities and must co-sign all such documentation conducted by the provider. Certain procedures may require proctor approval prior to performing. All designated procedures will require some period of direct observation by the proctor. Proctors are required for providers with supervised privileges, and for those who have had a clinical adverse action taken against them with subsequent restriction in privilege(s)/practice. [Contrast with the definition for “preceptor”.]

purchased care system. A component of the uniform program of medical and dental care for members and certain former members of the Services, and for their dependents where services are provided to beneficiaries by TRICARE-authorized civilian network and non-network healthcare providers and facilities.

quality healthcare. The degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Care that is evidence-based and provided in a technically and culturally competent manner with good communication and shared decision making as defined in the Institute of Medicine’s (IOM) *Crossing the Quality Chasm: A New Health System for the 21st Century*.

rapid process improvement or just do it. A fast and effective approach to improve a process that usually takes a week or less completed by the members of the process or value stream.

reduction of clinical privilege(s)/practice. A portion of a healthcare provider’s clinical privilege(s)/practice that is permanently removed as a result of a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Reductions in privilege(s)/practice are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

reinstatement of clinical privilege(s)/practice. The return of regular clinical privilege(s)/practice as a result of a professional review action following appropriate due process proceedings that may or may not include a period of monitoring and evaluation. Reinstatement after a clinical adverse action that was previously reported to the National Practitioner Data Bank (NPDB) is documented in the Revision-to-Action Report to the NPDB. Reinstatement is also reported to state(s) of licensure, and other applicable certifying/regulatory agencies.

Report Authority. The official with responsibility to report to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies following appropriate due process proceedings. The Report Authority is:

- (1) The Director of the DHA with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the DHA.
- (2) The Surgeon General of the Army, Navy, or Air Force, respectively, with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the Army, Navy, or Air Force, respectively.

(3) In cases in which the healthcare provider is privileged by more than one of the Report Authorities listed in subparagraphs (1) and (2), the one whose responsibility applies to the Privileging Authority most responsible for the matters under review. In cases of uncertainty, the DHA Director will designate the Report Authority. The designated Report Authority will ensure there is a comprehensive review of the entire matter.

restriction of clinical privilege(s)/practice. A temporary or permanent limit placed on a portion of a healthcare provider's clinical privilege(s)/practice that results from a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Restricted privilege(s)/practice require supervision by a proctor. Restrictions are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

revocation of clinical privileges/practice. The permanent removal of all of a healthcare provider's clinical privileges/practice as a result of a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Revocations of privileges/practice are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

significantly involved provider (SIP). A SIP is one who actively delivered care (based on clinical record entries) in either primary or consultative roles during the episodes of care that gave rise to the allegation, regardless of standard of care (SOC) determination. Additional defining characteristics include providers that: have the authority to start, stop or alter a course of treatment; have the authority to recommend to start, stop, or alter a course of treatment; or have the responsibility to implement a plan of evaluation or treatment. Authority to recommend means that input was solicited and legitimate (i.e., the individual making the recommendation was acknowledged to have special expertise or other specific standing in the clinical issues). This term is not meant to include the providers who had only peripheral, yet appropriate, patient interaction, nor those providers whose patient involvement was not reasonably related to the specific indications or allegations of sub-standard care and injury.

Six Sigma. The focus is a data-driven approach and methodology for eliminating defects and reducing variability. The goal is to achieve measurable and quantifiable returns by developing processes to achieve stable and predictable results and identifying procedures that can be defined, measured, analyzed, improved upon, and controlled. A commitment from the entire organization, especially high-level management, is essential to achieve sustainment in quality management.

standard of care (SOC). Healthcare judgments and actions of a healthcare provider generally accepted in the discipline or specialty involved as reasonable and appropriate.

summary suspension of clinical privilege(s)/practice. The temporary removal of all or a portion of a healthcare provider's privilege(s)/practice, taken prior to the completion of due process

procedures, based on determination by the Privileging Authority for concerns regarding suspected misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. A summary suspension continues until due process proceedings are complete. All summary suspensions of privileged providers that last longer than 30 calendar days must be reported to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

telemedicine. Telemedicine, also known as telehealth or virtual health, is the use of telecommunications and information technologies to provide health assessment, treatment, diagnosis, intervention, consultation, clinical supervision, education, and information across distances.

distant site. The distant site is where the healthcare provider providing the medical service is located at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may function as a distant site for purposes of this manual.

originating site. The originating site is the location of a patient at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may be considered an originating site for purposes of this manual.

trainee. Any resident, intern, or other healthcare provider in a formal healthcare training status.

unsafe/hazardous condition. See definition for patient safety (PS) event.

variation. An undesirable deviation from expected outcomes.

virtual medical center (VMC). A VMC is an organization which serves as a coordination body overseeing the delivery of healthcare via telemedicine. The DoD VMC must operate in affiliation with an accredited MTF or be independently accredited. If the DoD VMC does not have its own Privileging Authority, it should use the Privileging Authority of an accredited MTF with which it is affiliated. The DoD VMC, acting as a distant site, must have a process in place to accept quality and safety feedback on the care provided, and take action as appropriate.