Defense Health Agency

PROCEDURES MANUAL

NUMBER 6025.13, Volume 7
August 29, 2019

Medical Affairs

SUBJECT: Clinical Quality Management in the Military Health System, Volume 7: Clinical Quality Improvement

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 (u), 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 (u), 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 Health.mil 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

Enclosures
1. References
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Glossary

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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 Military Health System," 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) DoD Instruction 6200.05, "Force Health Protection Quality Assurance (FHPQA) Program," June 16, 2016, as amended
(p) DHA-Procedural Instruction 6200.05, "Force Health Protection Quality Assurance (FHPQA) Program," May 2, 2018
(q) Quality Improvement, U.S. Department of Health and Human Services Health Resources and Services Administration, April 2011[1]
(r) Centers for Medicare & Medicaid Services (CMS) Quality Initiatives, CMS' Center for Clinical Standards & Quality, April 19, 2018[2]

[1] This reference can be found at: https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/qualityimprovement.pdf
[2] This reference can be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/index.html

(s) U.S. Department of Veterans Affairs (VA) Quality of Care, VA Health Care, March 29, 2016[3]
(t) QI Essentials Toolkit: Failure Modes and Effects Analysis (FMEA) Tool, Institute for Healthcare Improvement, 2017[4]
(u) United States Code, Title 10 Section 1102

[3] This reference can be found at: https://www.va.gov/QUALITYOFCARE/index.asp
[4] This reference can be found at: http://www.ihi.org/resources/Pages/Tools/FailureModesandEffectsAnalysisTool.aspx

ENCLOSURE 2

CLINICAL QUALITY IMPROVEMENT

1. GENERAL OVERVIEW. The MHS Clinical Quality Improvement (CQI) Program focuses on improving the quality of care and services delivered regardless of the environment (direct care, purchased care, and operational environments). A key component of CQI is a dedicated clinical quality performance measurement system to evaluate quality-of-care outcomes, compare outcomes with national or evidence-based standards, and prioritize and act on opportunities for improvement. For DoD readiness mission healthcare issues, the Force Health Protection Quality Assurance Program provides another aspect of clinical quality performance measurement and is conducted in accordance with References (o) and (p). CQI is operationalized through the MHS High Reliability Operating Model (HROM). The MHS HROM enables frontline staff to drive MHS-wide performance improvements for an integrated system of readiness and health; empower MHS-level Clinical Communities to create conditions for high reliability at the point of care (processes, standards, and metrics); and hold the MHS accountable to MHS standards and optimal clinical outcomes. The Clinical Communities are a formalized mechanism to defer to expertise for: improving patient outcomes, eliminating preventable harm and waste, improving performance and innovation, maximizing value, developing MHS process standards, reducing unnecessary variability, and embedding learning and safety culture across all care sites.

a. Purpose. Provide guidelines for the CQI activities of the MTFs. Prescribe the procedures for CQI management and reporting.

b. Functions. This enclosure outlines procedures related to CQI tools, methodologies, leading practice submission, external entity data sharing, external entity collaboration, Clinical Communities, data repository management, and collection and dissemination of leading practices.

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

a. 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 (Reference (q)).

b. 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.

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

d. 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.

e. 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.

f. 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.

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

h. 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.

3. GOVERNANCE STRUCTURE. The DHA CQI Program is managed out of the CQM Branch, in the Clinical Support Division, under the DHA, Deputy Assistant Director for Medical Affairs (DAD MA). CQI Program activities align with the MHS Quadruple Aim and strategic guidance from DHA leadership.

4. SCOPE AND CORE RESPONSIBILITIES

a. Scope

(1) Provide guidelines for CQI initiatives across the MHS.

(2) Prescribe procedures for the management and reporting of CQI activities.

b. Core Responsibilities

(1) DHA Headquarters/Military Department Designee

(a) Monitor CQI activities of respective units/MTFs.

(b) Ensure CQI projects are captured in the DHA-approved project repository.

(c) Support MHS Clinical Communities in identification of leading practices.

(d) Establish processes to share CQI leading practices across the MHS.

(e) Ensure support for CQM education and training activities appropriate for targeted MHS personnel audiences, and support advancing the development of CQM professionals.

(2) DHA Markets/Intermediate Headquarters

(a) Monitor MTF CQI Programs and support analysis to identify patterns, trends, and opportunities for improvement locally and system-wide.

(b) Forward leading practices and/or identified opportunities for system-wide CQI to MHS Clinical Communities or DHA CQI Program as appropriate. (Clinical Communities focus on prioritized patient-centered conditions. Outside of those prioritized conditions and care pathway development, DHA CQI Program can help coordinate strategically aligned leading clinical practices and/or identified CQI opportunities for system-wide improvement.)

(c) Upload MTF CQI project products to the DHA-approved project repository (https://carepoint.health.mil/sites/SPIDR/SitePages/Home.aspx).

(3) Clinical Communities

(a) Provide clinical leadership and guidance on respective Clinical Community activities.

(b) Evaluate key clinical processes and care pathways (when developed) for patient-centered CQI priorities, leading practices, and evidence-based care standardization.

(c) Provide input for clinical quality strategy development, and organizational performance improvement (e.g., through the Quadruple Aim Performance Plan), as per high reliability organization (HRO) guiding principles.

(d) Support knowledge sharing and care pathway implementation, garnering feedback from identified stakeholders (especially patients), for iterative scale and spread of CQI initiatives across the MHS.

(e) Other responsibilities as identified/endorsed by the DAD MA

(4) MTF/Military Department Clinical Activities

(a) Ensure MTF/Military Department healthcare staff are educated and trained, as directed by higher headquarters, on their role in support of CQI and application of HRO guiding principles.

(b) Identify CQI projects, in annual performance plans, and ensure alignment to DHA strategic guidance and forward to appropriate DHA Market/Intermediate Headquarters.

(c) Employ improvement science methodologies in CQI Program activities.

(d) Support MHS Clinical Community care pathway development and implementation as directed by higher headquarters. Support other CQI initiatives as appropriate.

(e) Provide feedback on clinical issues/concerns, and identify leading practices for potential MHS-wide spread through DHA Markets/Intermediate Headquarters and/or Clinical Communities.

5. PROCEDURES

a. CQI. Evidence-based clinical practices, national healthcare standards, advancements in PS, and patient-reported outcomes all provide input for CQI initiatives. The MHS is committed to continuous improvement of the care it delivers.

b. Guidelines for CQI

(1) A critical component of CQI is a dedicated system to confirm quality-of-care outcomes; compare outcomes with national or evidence-based standards; prioritize opportunities for improvement; and scientifically design, implement, and sustain improvements.

(2) The CQI Program activities focus on demonstrable improvement in the quality of healthcare provided, and the health status of populations served.

(a) The CQI program establishes a planned, systematic approach to enable frontline staff to drive system-wide performance improvement in readiness and health. Coordination with federal partners provides opportunities for the MHS to participate in national efforts to improve care while leveraging their expertise for data-driven CQI in the MHS (Reference (r) and (s)).

(b) The use of the scientific method to build robust performance capabilities across the DHA enhances the development of sustained change.

(c) Clinical Community involvement in CQI is essential.

1. The Clinical Community construct is designed to define, prioritize, and implement initiatives to enable frontline staff to drive MHS-wide performance improvement for an integrated system of readiness and health.

2. CQI will be guided by organizational and Clinical Community priorities.

3. Performance on clinical measurements compared to benchmarking and evidence-based practice standards will be used to identify priorities for improvement.

(d) CQI factors for project success:

1. Determine the goal and aims in the initial project development phase. Record goals and refer to them regularly to maintain the focus of the group and to meet project milestones.

2. Involve frontline staff in the improvement project. The frontline staff have in-depth knowledge on how a process does or needs to work to reach the desired outcomes. The frontline staff will be intimately involved in implementing the new or redesigned process.

3. Determine if a single, consistent process exists or if multiple processes are used to complete the work included in the performance improvement project. Study existing processes to gain the thorough knowledge of current performance.

4. Plan for data collection. Data will be needed throughout the improvement project to determine if the change made was just a change or an improvement. Data collected on project performance both pre- and post-improvement helps determine the success of the project.

5. Implement strategies to maintain process changes that resulted in improved performance. Update policies, procedures, structures, orientation, annual training, team huddle information, and senior leadership reviews to consistently and repetitively reinforce the desired performance.

(e) Management and reporting of CQI activities:

1. All MTF CQI project plans to be submitted to the DHA-approved project repository website will be reviewed and endorsed by the MTF's Director/Commander prior to submission to higher headquarters.

2. MTF CQI Program leads will:

a. Coordinate with relevant Clinical Communities to prevent duplicative efforts in ongoing Clinical Community initiatives.

b. Review the DHA-approved project repository website (https://carepoint.health.mil/sites/SPIDR/SitePages/Home.aspx) prior to beginning new initiatives.

c. Submit completed CQI products through the DHA Market/Intermediate Headquarters to the respective Clinical Community for review and identification of leading practices and/or variance in care pathway implementation.

(f) Clinical Communities will review MTF CQI products to identify leading practices for potential dissemination.

(g) Consideration should be given to performance gap and desired improvement before selecting the method and tool most appropriate. Recommended tools include:

1. 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.

2. 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 the identified points of failure, and to identify the parts of the process most in need of change (Reference (t)).

3. Plan-Do-Check-Act/Plan-Do-Study-Act. 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.

4. Clinical Measurement Drivers. The driver diagram is a visual display of a team's theory of what "drives," or contributes to, the achievement of a project aim. This clear picture of a team's shared view is a useful tool for communicating to a range of stakeholders where a team is testing and working. A driver diagram shows the relationship between the overall aim of the project, the primary drivers (sometimes called "key drivers") that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver.

5. Targeted Solution Tools®. Voluntary performance improvement recommendations sponsored by The Joint Commission for Transforming Healthcare.

a. Users are guided through a process improvement methodology to measure baseline performance, identify root causes, and provide direction to customized solutions.

b. MTF staff enter data directly into the system and use results to support performance improvement activities.

c. Targeted Solution Tools® is approved by the ASD(HA) for use in the MHS.

c. Clinical Quality Improvement Studies (CQIS). DHA commissions CQIS to validate and improve processes and outcomes of the care delivered to beneficiaries. These studies are recommended and prioritized through CQM's infrastructure.

(1) The studies are for CQI and are not research studies.

(2) The studies will be conducted through the CQIS work group with the support of external organizations and include national comparative data, as available.

(3) Participation in CQIS in which data is submitted to or exchanged with an external entity requires approval by the DHA Director.

(4) All CQIS require completion of the appropriate business associate agreement (BAA) and data sharing agreement (DSA) and must comply with Reference (u).

(5) Management and use of study data will be consistent with the requirements in Volume 1 of this manual.

(6) DHA CQM staff will upload and manage CQIS on the DHA-approved project repository.

(7) The DHA CQIS work group provides recommendations to DHA CQM leadership based on study results for integration, where appropriate, into clinical quality strategic priorities and plans.

(8) The DHA CQI Program communicates study results and recommendations to appropriate stakeholders and seeks clinical SME input for future study topics.

(9) The DHA CQI Program, with DHA CQM leadership review/endorsement, provides a report at least annually to the DAD MA on CQIS, results, and recommendations, with projections for future study topics.

d. Storage/Housing Process Improvement Projects. CQI projects will be submitted to the DHA-approved project repository which will serve as a centralized collection of all process improvement projects occurring across the MHS. All elements to support the CQI program will be housed in this robust and agile system designed to meet both current and future demands in order to sustain and continue growth of quality improvement within the MHS.

e. Sharing Leading Practice: Knowledge Sharing and Feedback Loop

(1) The DHA CQI Program supports knowledge sharing for DHA CQM activities through management of a CQM knowledge architecture, primarily using DHA LaunchPad. CQM knowledge management will support higher DHA leadership guidance for knowledge management.

(2) CQM knowledge management will support CQI activities through at least the sharing of leading practices, providing readily available education and guidance documents for each of the six programs, and promoting advancement of improvement science skills and HRO guiding principles in appropriately targeted MHS audiences, and career development of MHS CQM professionals.

(3) DHA Markets/Intermediate Headquarters will provide feedback (most easily through email to content owners posted on the sites) on issues, concerns, and opportunities for knowledge development.

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 dietician 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.