
35

Army Regulation 40-68

Medical Services

Clinical Quality Management

Headquarters
Department of the Army
Washington, DC
26 February 2004

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-68

Clinical Quality Management

This revision--

- o Addresses requirements that resulted from the reorganization of the Army Medical Department (General Order No. 20, dated 2 October 1994). Additionally, this revision establishes Department of the Army policy and requirements governing the National Practitioner Data Bank as directed by Department of Defense Directive 6025.15 and the requirements necessary to comply with Public Law 99-660, Title IV, "The Health Care Quality Improvement Act of 1986," November 1986, Sections 11101 through 11152, Title 42, United States Code.
- o Implements Department of Defense Directive 6025.13, Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS); Department of Defense Directive 6040.37, Confidentiality of Medical Quality Assurance (QA) Records; Department of Defense Directive 6000.14, Patient Bill of Rights and Responsibilities in the Military Health System; Department of Defense Instruction 6025.17, Military Health System Patient Safety Program; Assistant Secretary of Defense for Health Affairs, Health Affairs Policy 99-007, DOD Policy on Physician Licensure; Assistant Secretary of Defense for Health Affairs, Health Affairs Policy 98-015, Policy for Provider Directories; Assistant Secretary of Defense for Health Affairs, Health Affairs Policy 94-004, DoD Inter-facility Credentials Transfer and Privileging; Assistant Secretary of Defense for Health Affairs, Health Affairs Memorandum, Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB), 11 December 1995; and Assistant Secretary of Defense for Health Affairs, Health Affairs Policy 00-009, DoD Participation in the Health Integrity and Protection Data Bank.
- o Implements new forms as noted in appendix A.
- o Establishes the role/function of the patient safety manager at the military treatment facility level.
- o Defines the role of Army Medical Department course directors in teaching the appropriate content of this regulation (chap 1).
- o Clarifies the role of the regional medical commanders in the quality management process (chap 2).
- o Clarifies the process for preparing the Annual Quality Management/Quality Improvement Program Summary Report (chap 2).
- o Clarifies requirements for military treatment facility Quality Management/Quality Improvement Program structure and processes (chap 2).

- o Expands the requirement for Joint Commission on the Accreditation of Healthcare Organizations accreditation to all fixed hospitals, troop medical and free standing clinics, and hospital-sponsored alcohol and drug abuse programs (chap 3).
- o Defines equivalencies for Joint Commission on the Accreditation of Healthcare Organizations standards when applied to Army Medical Department military treatment facilities (chap 3).
- o Eliminates the requirement for military treatment facilities to provide a copy of their Joint Commission on the Accreditation of Healthcare Organizations Survey Report to the U.S. Army Medical Command, Quality Management Division (chap 3).
- o Implements the requirement for each military treatment facility to publicly display its latest Joint Commission on the Accreditation of Healthcare Organizations Survey Summary (chap 3).
- o Defines the medical staff executive functions as required by Joint Commission on the Accreditation of Healthcare Organizations (chap 3).
- o Establishes the performance of medical staff executive and oversight functions in lieu of committees to support organization quality (chap 3).
- o Implements the requirement for each military treatment facility to compare its performance with external sources (chap 3).
- o Implements the requirement for a military treatment facility forum that directly involves beneficiaries in the processes of health care delivery (chap 3).
- o Clarifies responsibilities of military treatment facility commanders to review and utilize the results of available performance data (chap 3).
- o Deletes the requirements to utilize the Automated Quality of Care Evaluation Support System (chap 3).
- o Implements patient rights in accordance with Joint Commission on the Accreditation of Healthcare Organizations and Department of Defense guidance and the Health Insurance Portability and Accountability Act of 1996 (chap 3).
- o Provides guidance related to designated health care personnel obtaining and maintaining the proper authorizing document (that is, license, certification, registration) to practice within the specified discipline (chap 4).
- o Implements the Department of Defense policy on physician licensure, dated 29 January 1999, that eliminates the use of special licenses as a means of meeting licensure requirements to practice within the military health system (chap 4).

- o Clarifies that registered nurses and licensed vocational/practical nurses will maintain a license appropriate for the position held within the U.S. Army Medical Department (chap 4).
- o Explains the requirement for the 91Ws (Active Army/Army National Guard of the United States, and the U.S. Army Reserve) to achieve and maintain National Registry of Emergency Medical Technicians certification and for the 91WM6 to hold a valid, current license in practical/vocational nursing from a recognized State or territory (chap 4).
- o Explains exceptions (waivers) to the requirements for unrestricted license (chap 4).
- o Implements requirement for orientation of privileged providers to local medical staff rules, regulations, and policies (chap 5).
- o Establishes requirement for competency assessment of all health care personnel and competency assessment files for nonprivileged health care personnel (chap 5 and app C).
- o Implements the requirement for all health care personnel to be certified in basic life support (chap 5).
- o Establishes the requirement for anesthesia care providers to be certified, as a minimum, in advanced cardiac life support (chap 5).
- o Addresses sustainment medical training of special forces medical sergeant (18D) in Army military treatment facilities (chap 5).
- o Explains the term, "delegation" in the context of health care delivery and describes associated responsibilities (chap 5).
- o Elaborates the various types of supervision of health care personnel, especially those in trainee status, troop medical clinic screeners, and personnel not yet licensed (chap 5).
- o Establishes minimum requirements for nonprivileged health care personnel peer review (chap 6).
- o Provides descriptive information regarding the privileged health care disciplines to include education, certification, privileging requirements, and scope of practice (chap 7).
- o Incorporates essential elements from Army Regulation 40-48 (chap 7).
- o Establishes national certification and advanced practice State licensure as requirements for advanced practice registered nurses (chap 7).
- o Establishes the National Commission on Certification of Physician Assistants certification and State licensure as requirements for physician assistants (chap 7).
- o Provides guidance for the forwarding of credentials for new military accessions (Active Army/Army National Guard of the United States/U.S. Army Reserve) to the first unit of assignment (chap 8).

- o Establishes the requirement for credentials verification of all licensed, privileged, or certified personnel (chap 8).
- o Defines primary source verification and presents the acceptable methods for conducting this verification of credentials (chap 8).
- o Clarifies that primary source verification is required only one time for each established (nonrenewable) credential (chap 8).
- o Clarifies that advanced cardiac life support, advanced trauma life support, and/or pediatric advanced life support are not substitutes for the basic life support certification requirement by privileged providers (chap 8).
- o Implements guidance for use of peer recommendations in the clinical privileging and medical staff appointment processes (chap 8).
- ~~o~~ Identifies selected documents in the provider credentials and activity files that are afforded Section 1102, Title 10, United States Code protection (chap 8, app E, and app F).
- o Defines use of the inter-facility credentials transfer brief for providers assigned in a temporary duty status (chap 8, chap 9, and app H).
- o Clarifies required attachments to the inter-facility credentials transfer brief for Active Army/Army National Guard of the United States/U.S. Army Reserve (chap 8).
- o Rescinds retiree mobilization volunteers, formerly paragraph 4-14 (chap 9).
- o Clarifies privileging requirements for deputy and regional medical examiners functioning within the Armed Forces Medical Examination System (chap 9).
- o Clarifies privileging requirements for personnel assigned in support of the Organ and Tissue Procurement Program and the Armed Forces Medical Regulating System (chap 9).
- o Establishes the requirement for practitioners involved in the provision of telemedicine services to be privileged (chap 9).
- ~~o~~ Implements use of the Centralized Credentialing Quality Assurance System (chap 9).
- o Implements the clinical privileging and medical staff appointment terminology and procedures issued by the Deputy Director of Defense in Department of Defense Directive 6025.13 (chap 9).
- o Implements the use of new and significantly revised privileging forms (chap 9).
- o Clarifies the use of enhanced supervision for privileged providers (chap 9).
- o Elaborates administrative requirements associated with graduate professional education (all disciplines), especially clinical performance evaluation of trainees pursuant to initial privileging (chap 9).

- o Establishes that any privileged provider is eligible to apply for medical/dental staff appointment (chap 9).
- o Explains the responsibilities and function of the Army National Guard of the United States and the U.S. Army Reserve credentials committee/function (chap 9).
- o Clarifies the privileging process for the Army National Guard of the United States and the U.S. Army Reserve (chap 9).
- o Clarifies summary suspension and procedures associated with this temporary privileging action (chap 10).
- o Clarifies that suspension, restriction, reduction, revocation, or denial of privileges action can be imposed only after the provider has been afforded due process (chap 10).
- o Revises the adverse privileging action hearing and appeals processes for health care providers (chap 10).
- o Changes the name of the former Impaired Health Care Provider ad hoc committee to the Impaired Health Care Personnel ad hoc committee (chap 11).
- o Expands the health care personnel eligible for enrollment in the Impaired Health Care Personnel Program (chap-11).
- o Identifies the differences in management of Active Army and Army National Guard of the United States/U.S. Army Reserve impaired personnel (chap 11).
- o Establishes the requirement for a military treatment facility Patient Safety Program (chap 12).
- o Implements processes for identifying, evaluating, tracking, and reporting adverse events as part of the Patient Safety Program (chap 12).
- o Substitutes the term, "sentinel event" for the term, "serious medical incident" and includes conducting a root cause analysis as part of the evaluation process (chap 12).
- o Implements the requirement for military treatment facility commanders to report sentinel events to the Joint Commission on the Accreditation of Healthcare Organizations and to the U.S. Army Medical Command, Quality Management Division (chap 12).
- o Implements the requirements of the Safe Medical Device Act of 1990 as part of the Patient Safety Program (chap 12).
- o Defines circumstances wherein patients may elect to terminate care before it is complete (that is, against medical advice, elopement, leave without being seen) and establishes the procedures to be followed to ensure patient safety and the safety of others (chap 12).
- o Clarifies the requirement for standard of care determination for each significantly involved provider/professional in a medical malpractice case (chap 13).

- o Implements use of an electronic equivalent for Department of Defense Form 2526, Case Abstract for Malpractice Claims (chap 13).
- o Deletes requirement for all medical malpractice claims to be reviewed by the Clinical Case Review Branch and clarifies the options for review of claims (chap 13).
- o Revises the medical malpractice claims review process (chap 13).
- o Clarifies the medical malpractice claims reporting process (chap 13).
- o Outlines the responsibility of the U.S. Army Medical Command special review panel associated with medical malpractice case reporting to the National Practitioner Data Bank (chap 13).
- o Clarifies U.S. Army Medical Command processes associated with adverse privileging action reporting to the National Practitioner Data Bank (chap 14).
- o Clarifies USAMEDCOM processes associated with adverse privileging/practice and other administrative actions reported to State regulatory agencies (chap 14).
- o Clarifies pre-selection procedures and responsibilities of the civilian personnel agency, the applicant for Federal service employment, and the military treatment facility hiring officer (app G).
- o Explains the contents of and provides sample text for use in preparing the inter-facility credentials transfer (app H).
- o Provides a management control checklist for evaluation of clinical quality management administration (app J).
- o Rescinds the Military Treatment Facility Department of Nursing Quality Assurance Program (formerly app C).
- o Deletes the guidance for the Nutrition Care Division/Directorate (formerly app D).
- o Deletes the guidance for Occupational Therapy and Physical Therapy Activities (formerly app E).

Effective 26 March 2004

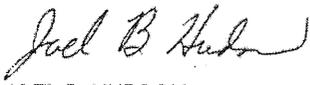
Medical Services

Clinical Quality Management

By order of the Secretary of the Army:

PETER J. SCHOOMAKER
General, United States Army
Chief of Staff

Official:


JOEL B. HUDSON
Administrative Assistant to the
Secretary of the Army

History. This publication is a major revision.

Summary. This consolidated regulation prescribes policies, procedures, and responsibilities for the administration of the Clinical Quality Management Program. It includes Department of Defense and statutory policies addressing medical services quality management requirements. In addition, it implements Department of Defense Directives 6025.13, 6040.37, and 6000.14 and other Department of Defense guidance as addressed in the summary of change.

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

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

Proponent and exception authority.

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

and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

Army management control process.

This regulation contains management control provisions and identifies key management controls that must be evaluated.

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

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

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

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*This regulation supersedes Army Regulation 40-68, dated 20 December 1989, and Army Regulation 40-48, dated 7 November 2000. It rescinds DA Forms 5440-17-R, 5440-27-R, and 5441-27-R, dated June 1991; and DA Forms 5440-26-1-R, 5440-26-2-R, 5441-17-R, 5441-26-1-R, 5441-26-2-R, and 5753-R, dated July 1989. (DA Forms 5440-26-3-R and 5441-26-3-R were rescinded in June 1995.)

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Chapter 1 Introduction

1-1. Purpose

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

1-2. References

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

1-3. Explanation of abbreviations and terms

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

1-4. Responsibilities

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

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

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

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

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

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

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

- (1) Exercise broad oversight responsibility for implementation of the AMEDD CQMP as delegated by TSG.
- (2) Represent TSG as a member of various committees and working groups sponsored by the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), Department of Defense (DOD), and other health care quality agencies.
- (3) Provide corporate-level clinical quality management (CQM) guidance within the AMEDD to include policy on credentialing, performance-based privileging, outcomes management (OM), medical staff appointment, and accreditation processes.
- (4) Provide corporate guidance, administrative and/or clinical advice, consultation, and education to define and/or clarify standards of care, practice, and policy.
- (5) Administer the corporate AMEDD Patient Safety (PS) and Risk Management (RM) Programs that include but are not be limited to: risk assessment, risk avoidance, safety practices, incident monitoring/management, adverse privileging/practice actions, sentinel events (SEs), and malpractice claims.
- (6) Provide policy guidance, consultation, monitoring, and review of SEs that occur within the AMEDD.
- (7) Monitor trends in processes and outcomes of care and report the results to both internal and external sources, as appropriate.
- (8) Collect aggregate AMEDD CQM data, as required by TSG, OASD/HA, or other agencies.
- (9) Serve as the corporate repository for select CQMP data.
- (10) Implement the administrative procedures related to reporting adverse privileging/practice actions to appropriate national, professional, and State licensure, certification, and registration agencies according to DOD guidance.
- (11) Implement the administrative procedures related to reporting providers to the NPDB according to established DOD guidance.
- (12) Maintain the AMEDD corporate contract with the Joint Commission on the Accreditation of Healthcare

Organizations (JCAHO), or other accrediting agency as approved by the OASD(HA), and provide guidance on the accreditation processes.

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

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

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

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

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

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

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

g. MTF commanders. MTF commanders will—

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) Award appropriate practice privileges to USAR/ARNG providers upon the review of inter-facility credentials transfer briefs (ICTBs) and required privileging documentation from civilian health care organizations. Current competency in the duty area of concentration (AOC) and/or specialty skill must be ensured before granting or renewing privileges for USAR/ARNG providers who do not currently hold comparable privileges within their Reserve unit.

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

h. Medical and dental USAR/ARNG commanders and State Surgeons. Medical and dental USAR/ARNG commanders and State Surgeons are responsible for the administration of the policies contained in this regulation. They are required to establish PI Programs within their respective commands and will—

(1) Designate a CQMP manager.

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

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

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

(5) Award privileges to assigned health care providers involved in delivering health care to eligible beneficiaries during unit-controlled inactive duty training (IDT) and annual training (AT) activities. Examples of these activities include physical examinations, immunizations, dental examinations, soldier readiness processing, field exercises, and medical support missions. Clinical privileging for medical treatment provided during IDT is limited to acute and emergent care.

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

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

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

(a) Types and ages of patients served.

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

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

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

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

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

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

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

j. Other MTF personnel.

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

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

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

(c) Responsible for and has oversight of the credentialing and privileging process.

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

(e) Chairperson of the executive committee of the medical staff (ECMS). (This responsibility may be delegated by the MTF commander to another appropriately qualified executive.) A dental officer with comparable credentials is chairperson of the executive committee of the dental staff (ECDS).

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

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

(h) Intervene on behalf of the commander to immediately hold in abeyance or suspend privileges when a provider's conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)

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

(j) Responsible for ensuring organizational PI activities are in place and actively participates in these processes.

(k) Ensure that an ongoing, proactive program for identifying risks to PS and for reducing medical/health care errors is implemented according to DODI 6025.17 and USAMEDCOM guidance.

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

(m) Ensure an effective peer review program (see glossary) is in place for the organization's health care professionals.

(2) *Chief, department, service, or clinic and TOE command surgeons.* In his/her area of responsibility, or technical oversight, the chief/command surgeon is/will—

(a) Responsible for all clinically related activities.

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

(c) Responsible for ongoing functional CQM activities and their integration, as appropriate, into the organizational PI Program.

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

- (e) Recommend to the medical staff the clinical privileging criteria that are relevant to the care provided in the department/service/unit.
 - (f) Recommend privileges for each provider in the department/service/unit, as authorized.
 - (g) Make recommendation to the relevant hospital authority for needed patient care services not provided by the department/service/unit or the MTF.
 - (h) Integrate the services of the department/service/unit with the primary functions of the MTF.
 - (i) Coordinate and integrate inter/intradepartmental services.
 - (j) Participate in the development and implementation of policies and procedures that guide and support the provision of services. Ensure that such policies and procedures are integrated into the overall plan for patient care.
 - (k) Determine the qualifications and competencies of department/service/unit health care personnel.
 - (l) Establish objective, quantifiable methods to continually assess and improve the quality of care and service provided. Utilize ORYX™ data, or like data, as applicable.
 - (m) Maintain quality control programs, as appropriate, and ensure that PS issues are given high priority and addressed when department/service/unit-level processes, functions, or services are designed or redesigned.
 - (n) Provide and support orientation, in-service training, and continuing education of all personnel in the department/service/unit.
 - (o) Make recommendations for space and other resources required by the department/service/unit.
 - (p) Recommend a sufficient number of qualified and competent persons to provide care.
 - (q) Participate in outside source selection for needed services.
- (3) *Privileged staff.* The privileged provider will—
- (a) Acknowledge, in writing, at the time clinical privileges and medical staff appointment (if applicable) are awarded, the intent to abide by applicable bylaws.
 - (b) When appointed a member of the credentials committee/function, make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers.
 - (c) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the privileges requested and/or according to the AOCs and additional skill identifiers (ASIs) awarded, accomplish required training, and ensure the currency of all documents and other information contained in his/her provider files.
 - (d) Participate in PI, quality control, and peer review processes.
- (4) *All other organizational assigned personnel.* Personnel, other than privileged providers, will—
- (a) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the scope of practice of the assigned position, accomplish required training, and ensure the currency of all documents and other information contained in his/her competency assessment file (CAF).
 - (b) Participate in PI, quality control, and peer review processes, as applicable.
 - (c) Ensure knowledge of and responsibility for implementing all applicable organizational policies and procedures relevant to his/her job description and/or scope of practice.
- (5) *CQM coordinator.* The CQM coordinator, or similarly titled individual (for example, PI coordinator), is tasked with overall responsibility for the organization's CQMP. The individual in this role may be expected to exercise broad oversight and to collaborate with various key staff to ensure the integration of the quality functions performed by the organization. This requires the incumbent to be an active member of the executive leadership team. He/she will—
- (a) Ensure that organization-wide PI is a dynamic process based on ongoing identification of opportunities for change.
 - (b) Provide leadership and consultative services to departments and sections within the organization with regard to credentialing and privileging issues, accreditation requirements, CQM and QA regulatory compliance issues, PI, and RM/PS.
 - (c) Participate in the development of policies for the organization, giving special consideration to the integration of and collaboration between internal administrative and clinical policies.
 - (d) Participate in the identification of opportunities for PI, recommendation of solutions for facility issues and concerns, and implementation of plans and followup activities related to organizational PI.
 - (e) Serve as subject-matter expert in conjunction with patient administration and the servicing Staff Judge Advocate/legal advisor in areas such as accreditation standards for health care documentation and the medical-legal aspects of health care practice.
 - (f) Direct the collection, analyses, and dissemination of PI data within the organization ensuring that basic statistical analyses and comparative processes are included.
 - (g) Facilitate organizational efforts to provide prevention, wellness, and specific medical condition-based management programs as well as other health management programs, as required, based on timely MTF data and identified beneficiary need.
 - (h) Ensure that facility-specific CQM and PI Program changes are identified and implemented as data analyses dictate.

(i) Keep organizational leadership informed of public policies, DOD and DA regulations and guidance, and legislative and health care trends that affect various CQM and other related health care initiatives.

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

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

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

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

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

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

Note. At the discretion of the MTF commander, responsibility for nonprivileged providers may be assigned to another individual(s).

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

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

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

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

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

(i) Conduct NPDB and other relevant inquiries and PSV to authenticate credentials of staff members for initial award/biennial renewal of clinical privileges and for initial appointment/biennial re-appointment to the medical staff.

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

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

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

(l) Ensure the CCQAS database is current and that updated CCQAS database files are transmitted to DOD and USAMEDCOM agencies, as required.

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

(n) Maintain all PCFs according to this regulation.

(o) Prepare and forward PCFs and/or ICTBs for privileged providers to the gaining MTF within the specified time requirements. (See chap 8.)

(p) In collaboration with the USAR/ARNG unit credentials manager, maintain the PCFs and CCQAS input for privileged providers in those USAR/ARNG TDA caretaker hospitals for which the MTF is responsible.

(q) Ensure that ICTBs and mandatory attachments (see paras 8-10c (AA) and 8-11b (USAR/ARNG)) are integrated into the credentials committee/function review process for timely privileging of providers.

(r) Facilitate the review of all AA/USAR/ARNG and other Federal Service PCFs or ICTBs in compliance with this regulation.

(s) Forward all requests for adverse credentialing and privileging information on individuals previously assigned or employed as privileged Federal Service providers to the USAMEDCOM QMD for action.

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

(7) *Chief, RM and/or PS*.

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

The person performing these duties will—

(a) Integrate and coordinate all RM/PS administrative and management activities within the medical/dental facility.

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

(c) Ensure that organizational RM/PS Programs are supported at all levels.

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

(e) Collaborate with executive leadership and the MTF safety and occupational health manager (comparable title) (DODI 6055.1) to ensure a comprehensive safety program for all patients, employees, visitors, volunteers, and others.

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

(g) Initiate actions and processes that will secure, preserve, and protect evidence related to an SE.

(h) Oversee the investigation of all SEs to ensure coordination of all data collection activities, completion of a thorough and credible root cause analysis (RCA), and reporting through appropriate channels. (See para 12-5 for more detailed information regarding SEs.)

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

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

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

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

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

k. *AMEDD Center and School course directors.* AMEDD Center and School course directors for all academic programs under the auspices of the AMEDD Center and School will ensure that their program of instruction contains content relevant to current AMEDD CQM policy and processes, health care facility accreditation standards, and professional practice standards. Curriculum instruction will highlight each AMEDD member's responsibility to participate in organizational CQM activities.

Chapter 2

The Clinical Quality Management Program

2-1. Purpose

The purpose of the AMEDD's medical and dental CQMP is to continuously and objectively assess key aspects of individual and institutional performance with the intent to improve the health care and services provided to eligible DOD beneficiaries and others.

2-2. The MTF Clinical Quality Management Program

a. MTF commanders will establish and resource a CQMP that coincides with any RMC/regional dental command (RDC) and/or lead agent programs, as appropriate, and meets the unique needs of the organization. When developing the facility-level CQMP, consideration must be given to requirements of the TRICARE contract in place; Centers for Medicare & Medicaid Services (CMS) (formerly Health Care Financing Administration (HCFA)), Social Security Health Insurance Program for the Aged (Medicare), JCAHO guidance and standards, and any requirements imposed by other accrediting/regulatory agencies; and any CQMP guidance provided under the auspices of the RMC/RDC. A comprehensive program requires the thoughtful integration of those criteria that, when reviewed and evaluated, offer evidence of the quality, cost, availability, and appropriateness of care and services being provided to DOD beneficiaries of all ages. Critical to the success of the CQMP is the active involvement and participation of all staff members.

b. Each facility with separate command authority will provide a single written plan that includes all departments/services/functions and will define how each of its established CQM processes will be implemented. When devising such a plan, various CQM models are available including the Find-Plan-Do-Study-Act/Plan-Do-Check-Act (that is, FOCUS) framework refined and popularized by Deming. (See glossary and app A.)

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

2-3. Collaborative responsibility

A coordinated intra- and inter-facility approach to improving patient care and health outcomes requires an intensive, integrated, and collaborative systems approach by all disciplines. Individuals that are essential to affect AMEDD CQM processes and practices must make every effort to communicate and cooperate within the major subordinate command region and with the TRICARE lead agent as CQM initiatives are being developed, resourced, and implemented.

2-4. CQMP reporting

a. *USAMEDCOM level.* The USAMEDCOM QMD will submit the AMEDD Annual CQMP Summary Report required by DODD 6025.13, or other report as directed, to OASD(HA) no later than 90 days after the end of each calendar year. This report, submitted in narrative format, is designed to demonstrate achievement of desired clinical outcomes, optimization of resource economies, enhancement of service, and other achievements that contribute to

medical readiness and quality health care delivery. The data for this report are derived from the annual, comprehensive CQMP review and summary performed by each MTF and reported to the USAMEDCOM in the MTF Annual CQMP Summary Report. (See para *b* below.) The MTF annual CQMP report will address the quality of health care rendered, beneficiary access to care, the cost associated with providing care and services, and recommendations for business process improvement. Specific topics addressed include, but are not limited to, the status of—

- (1) Medical readiness.
- (2) Licensure, registration, and certification of health care personnel.
 - (a) Total number of health care personnel, number in training, number fully trained.
 - (b) Number requiring licensure, certification, registration, and percentage of totals who are appropriately licensed, certified, registered.
 - (c) Board certification data for physicians.
 - (d) Specialty certification data for other privileged providers, as applicable.
- (3) JCAHO and other accrediting/regulatory agency survey results, as appropriate, including corrective action for Type 1 findings.
 - (4) Implementation and program effectiveness of required clinical practice guidelines (CPGs).
 - (5) Status of significant findings addressed in the MTF-specific TRICARE Operations Performance Statement report card or other DOD replacement.
 - (6) The Healthcare Consortium and its activities (DODD 6000.14).
 - (7) The currency/completeness of the organization's Directory of Health Care Providers. (See DODD 6000.14 and Health Affairs Policy 98-015.)
 - (8) Any newly implemented regulatory standards and special studies.
 - (9) NPDB and Defense Practitioner Data Bank and State or other regulatory agency reporting.
 - (10) Other data as requested by OASD(HA), DOD, or other Federal/regulatory agencies.

b. MTF level. The MTF commander will provide one copy of the MTF Annual CQMP Summary Report directly to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with a duplicate copy to the next higher headquarters, no later than 15 February of each year unless otherwise specified. In addition, one copy of the MTF-specific JCAHO report card that is posted by the MTF for beneficiary viewing will be submitted with the Annual CQMP Summary Report. The report is prepared in narrative format and includes data based on the calendar year, January through December.

2-5. Confidentiality of quality assurance documents and records

The National Defense Authorization Act for Fiscal Year 1987 (Public Law (PL) No. 99-661); Section 1102, Title 10, United States Code (10 USC 1102); and DODD 6040.37 mandate that records created by or for the DOD in a medical or dental Quality Assurance (QA) Program are confidential and privileged. PL 99-661 and subsequent guidance predicated on this law (10 USC 1102 and DODD 6040.37) preclude disclosure of, or testimony about, any records or findings, recommendations, evaluations, opinions, or actions taken as part of a QA program except in limited situations. Under the provisions of 10 USC 1102, this information is exempt from release in accordance with Exemption 3 of the Freedom of Information Act (FOIA). Additional detailed information regarding the confidentiality of QA documents and records is contained in appendix B.

Chapter 3

Organizational Performance Improvement

3-1. General

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

3-2. Processes and functions requiring measurement

Effective PI necessitates (and the JCAHO and other accrediting/regulatory agencies and organizations require) the measurement, evaluation, and comparison over time of a variety of patient-focused functions, organizational functions, and other activities. Standards addressing these activities are found in various JCAHO comprehensive accreditation manuals including those for hospitals, ambulatory care, behavioral health, home care, long-term care, laboratory services, and others. The facility's review mechanisms designed to systematically measure and continuously evaluate these activities must be collaborative and multidisciplinary.

Chapter 6 The Peer Review Process

6-1. General

Peer review of day-to-day performance, is integral to the PI and competency assessment processes for all licensed, certified, and/or registered health care personnel both privileged and nonprivileged. This routine review typically focuses on medical records' contents and direct observation of performance. However, in the context of a possible adverse privileging/practice action, the process takes on a greater degree of formality and involves fact finding, study, and analysis of a single incident that resulted in significant harm to a patient or a series of events involving a professional's performance, conduct, or condition. It is conducted in a collegial climate and is focused on obtaining all relevant information about the situation. Prior to any adverse action related to privileges/scope of practice, peer review is required for individuals who are licensed, certified, and/or registered. Likewise, in the event that an action against an individual's license (other authorizing document) may be contemplated, a formal peer review will be conducted. This chapter presents the basic framework for a formal peer review. Additional specifics associated with peer review and adverse privileging/practice actions are contained in chapter 10. Peer review in relation to an SOC determination for a medical malpractice claim is discussed in chapter 13.

6-2. The peer review function

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

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

b. Each MTF will establish peer review processes that are nonadversarial. Ideally, the peer review should be conducted as soon as possible (within 30 calendar days) after identification of the incident, circumstance, or behavior for which a peer review is warranted. The results of the peer review shall be made known to the individual in question as soon as possible following the conclusion of the peer review activities. See chapter 10 for specific time frames related to notification. The department/service chief is responsible for initiating and coordinating the peer review activities for nonprivileged personnel. For a privileged provider, the peer review is typically coordinated by the credentials or the RM committee. Peer review subjects are entitled to due process which includes, but is not limited to, the right to a hearing and the right to appeal the decision of the MTF commander to the next higher level of command. (See para 10-6f for additional detail.)

6-3. Composition of peer review board

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

6-4. The intent of peer review

Structured feedback from an individual's peers (that is, a performance assessment (chaps 5 and 9)) may be used at any time an unbiased, external review of a staff member's day-to-day performance is appropriate. This is considered an informal peer review. However, peer review as presented in this chapter is in the context of an adverse privileging/practice action and is a formal process. A formal peer review is required whenever an SOC determination must be made, or when the staff member's performance is such that an adverse practice action (for example, limitation of duty or removal from the clinical setting) is considered. The purpose of this review is to examine information obtained from the structured, unbiased investigation/inquiry and any other relevant materials. Following the review, recommendations

are presented to the commander regarding the clinical performance, competence, and liability (medical malpractice case) of the individual. The peer review mechanism is intended to—

- a. Protect the rights of the individual (afford due process).
- b. Identify systemic issues and refer to appropriate CQM channels for resolution.
- c. Separate professional actions and considerations from administrative or legal considerations.
- d. Provide timely reporting to the USAMEDCOM QMD, utilizing Department of Defense Form (DD) 2499 (Health Care Provider Action Report) (see chap 10) or DD Form 2526 (Case Abstract for Malpractice Claims) (see chap 13), when the need is identified to report a health care privileged provider or nonprivileged professional to a regulatory body.

6-5. Conducting the peer review

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

b. All procedures related to peer review (notification, withdrawal of permission for off-duty employment, hearing rights, the appeal process) are the same for both privileged and nonprivileged personnel. See chapter 10 for additional guidance associated with peer review.

6-6. Recommendations and followup reporting

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

b. The peer review function may recommend reporting the staff member to a licensing/regulatory agency. Local policy will establish who is responsible for preparation of the DD Form 2499. The MTF commander will forward this document to Commander, USAMEDCOM, MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, Texas 78234-6010, with copy furnished to the RMC or other higher headquarters, as appropriate. The recommendations of the peer review panel, and all other information related to the case, will accompany the DD 2499 when reporting of a privileged provider or nonprivileged professional to a licensing or other regulatory body is required. TSG is the sole reporting authority (para 14-3).

Chapter 7 Privileged Health Care Providers

7-1. General

a. This chapter includes general information and specific professional requirements related to each category of privileged provider (military or civilian) listed below. The information presented is intended to be a broad overview, rather than all-inclusive, and will change over time as health care requirements evolve. The privileged providers addressed include, but are not limited to—

- (1) APRN.
 - (a) Certified nurse midwife (CNM).
 - (b) CRNA.
 - (c) Clinical nurse specialist (CNS).
 - (d) NP to include family, adult, pediatric, women's health care, acute care, geriatric, emergency, and so forth.
- (2) Audiologist.
- (3) Behavioral health practitioner.
- (4) Chiropractor.
- (5) Clinical pharmacist.
- (6) Clinical psychologist.
- (7) Clinical social worker.
- (8) Dentist.
- (9) Dietitian.
- (10) OT.
- (11) Optometrist.
- (12) Physician.
- (13) PA and specialty physician assistant.

providers, as appropriate, be prepared to diagnose and appropriately manage the injuries or diseases that will result from the use of these unconventional agents.

7-3. Clinical performance review

a. Ongoing professional competency assessment and periodic formal evaluation of performance, to include both quantitative and qualitative data, are required for all privileged providers. This is accomplished at least biennially as part of the privilege reappraisal/privilege renewal processes and is documented on DA Forms 5374 and 5441. (See app A for a complete listing of DA Forms 5441 series.) An example of professional competency assessment is the periodic peer review, in the context of PI, of a representative sample of medical records. Competency assessment also includes analyses by one's peers and supervisor of specific outcomes-related data, RM data, and patient letters of appreciation or complaints, as well as direct observation of performance and verbal/written assessment of clinical knowledge/skills. Other performance review criteria, as recommended by the JCAHO or other accrediting agencies, as approved by the Office of the Secretary of Defense (Health Affairs) (OSD(HA)), may also apply. Performance-based peer review will be according to local policy.

Note. Performance review in this context applies to providers with current clinical privileges, and other professionals, who are actively engaged in the provision of patient care and services.

b. Additional requirements for enhanced supervision of the licensed novice or entry-level provider (or the experienced provider who has returned to clinical practice after a lapse (see glossary) in patient care duties) must be individually determined. This supervision will be provided by a designated individual of the same discipline or by a medical officer with more recent clinical experience.

7-4. Advanced practice registered nurse

a. Description.

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

(a) CNMs.

(b) CRNAs.

(c) CNSs.

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

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

b. Professional credentials.

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

(2) *Licensure.* APRNs will maintain a current, active, valid, unrestricted RN license in at least one U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction (para 4-4). In addition, the APRN must possess a license (or other authorizing document) for advanced practice issued by either the State Board of Nursing granting the RN license or another State. The requirement for advanced practice licensure is effective 1 July 2009.

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

c. Scope of practice.

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

(2) As designated by his/her delineated privileges or scope of practice, demonstrated competence, and experience, the APRN (independently and collaboratively with other health care professionals) performs a wide variety of tasks or duties based on organizational requirements and according to local policy. The APRN may, among other tasks, perform medical examinations and document findings; screen health records (HRECs) for individuals participating in overseas deployments or other military duties; assist in weekly inspections of confinement facilities; examine and treat prisoners in confinement; recommend temporary limited-duty profiles on DA Form 3349 (Physical Profile) for AD soldiers to

include those on flight status (AR 40-501); place patients under his/her care on quarters status (AR 40-66); and perform other duties, as authorized by the commander.

(3) The APRN may authenticate temporary limited-duty profiles for pregnancy and other conditions according to the guidance outlined in AR 40-501.

d. Certified nurse midwife.

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

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

(3) *Scope of practice.* The CNM—

(a) Provides routine prenatal care, labor and delivery management, immediate newborn care, and postpartum care. (See para (c) below.) In addition, they provide well-woman gynecological services including yearly physical exams, breast exams, pap smears, family planning services, preventive health screening, and health education. With the appropriate training and experience, the CNM may also be privileged to perform such procedures as colposcopy, ultrasound, and birth control implant insertions/removals and to provide primary care services to adult female beneficiaries.

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

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

(4) *Internship.* New graduate CNMs, and those returning to clinical practice after a lapse, may be in an intern status with enhanced supervision (see para 9-4e) for a period of up to 1 year as described in the Army Nurse Corps Certified Nurse Midwife Internship Program. This Program is flexible and must be modified to meet the needs and competencies of the individual CNM. The supervision associated with the period of internship is not considered an adverse status. A supervisor—usually an experienced CNM when available—will be designated to oversee and tailor the clinical practice experience, evaluate progress, and make recommendations for transitioning the individual to full practice and privileges.

e. Certified registered nurse anesthetist.

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

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

(3) *Scope of practice.* CRNAs will be responsible and privileged for the entire anesthetic process regardless of the patient's American Society of Anesthesiologists (ASA) physical status classification. The CRNA will—

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

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

(c) Obtain informed consent for anesthetic services.

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

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

(f) Select, obtain, and administer anesthetics, adjunct drugs, accessory drugs, and fluids necessary to manage the patient in the perianesthetic period, to maintain the patient's physiologic homeostasis, and to correct responses to the anesthesia or surgery consistent with the spectrum of anesthesia privileges.

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

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

(i) Order and initiate perioperative pain relief therapy.

(4) *Collaboration and anesthesia-related decisions.*

(a) CRNAs are expected to routinely provide independent anesthesia care for ASA physical status classification 1 and 2 patients. They are responsible and accountable for determining when a physician (an anesthesiologist if available) will be consulted for the delivery of anesthetic care to ASA patient classification status 1 and 2 patients. Consultation will be requested, as necessary, regardless of the patient's ASA classification. Collaboration, and subsequent implementation of the specific recommendations provided by the physician, does not relieve the CRNA of his/her overall responsibility to ensure the utmost safety of the patient. At all times the CRNA remains accountable for his/her decisions and all professional actions associated with the anesthesia care rendered. The consulted physician is accountable for his/her anesthesia-related decisions.

(b) For patients in ASA physical status classification 3, 4, 5, or 6, CRNAs will collaborate with a physician (anesthesiologist if available) or oral surgeon before induction of anesthesia. This collaboration may be face-to-face or by telephone. The CRNA will document the results of this interaction in the medical record. There is no requirement for a duplicate medical record entry by the physician or oral surgeon regarding the collaboration associated with the CRNA-administered anesthesia care. There is no requirement for the collaborating physician or oral surgeon to be privileged in the administration or management of anesthetics.

(c) In an MTF without an assigned or available anesthesiologist, and the surgical team desires to provide care for an ASA patient classification 3 or greater patient, there must be documented collaboration between the CRNA and the surgeon prior to the start of the case.

(d) MTF commanders may conduct clinical review of the anesthesia care provided by CRNAs utilizing an RMC-assigned team comprised of a senior anesthesiologist and a senior CRNA. The team will validate the clinical performance and competence of the CRNAs under review.

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

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

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

f. Clinical nurse specialist.

(1) *Description.* CNSs are RNs who have obtained advanced, specialized education and certification to practice independently and collaboratively as APRNs for the purpose of providing specialty care (for example, oncology, psychiatric, cardiovascular, pulmonary). CNSs participate in the care of both inpatients and outpatients and have primary responsibility for providing clinical expertise; consultation; case management; disease management; patient/family education; and research application in primary, secondary, or tertiary health care settings.

(2) *Additional professional credentials.*

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

(b) *Other.* CNSs desiring prescriptive authority must meet the criteria specified by the ANA as well as the privileging requirements as described in chapter 9 of this regulation. A CNS requesting prescriptive authority, or authorization to function beyond the routine CNS scope of practice, may be privileged to provide expanded services to designated beneficiaries (for example, patients requiring comprehensive pain management).

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

g. Nurse practitioner.

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

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

(3) *Scope of practice.*

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

(b) The NP practices according to his/her specialty, the ANA Standards of Clinical Nursing Practice for Nurse Practitioners, and his/her individual DA Form 5440 as determined by the organizational mission and scope of care and services. MTF-specific guidelines and the individual's privileges define conditions for which referral or collaborative care is appropriate.

(c) The NP delivers outpatient care in a variety of settings and may be authorized admission and discharge privileges based on the managed care business practices of the organization to which he/she is assigned. In these cases, a physician must be on call or available by telephone to provide medical consultation, collaborative management, or referral.

(4) *Internship.* New graduate NPs, and those returning to clinical practice after a lapse, may be in an intern status with enhanced supervision (see para 9-4e) for a period of up to 1 year as described in the Army Nurse Corps Nurse Practitioner Internship Program. This program is flexible and must be modified to meet the needs and competencies of the individual NP. The supervision associated with the period of internship is not considered an adverse status. A supervisor—usually an experienced NP when available—will be designated to oversee and tailor the clinical practice experience, evaluate progress, and make recommendations for transitioning the individual to full practice and privileges.

7-5. Audiologist

a. Description.

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

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

b. Professional credentials.

(1) *Education.* Audiologists must have a master's or doctoral degree in audiology from an accredited institution acceptable to DA.

(2) *Certification.* All audiologists are required to achieve and maintain national certification from either the American Board of Audiology (that is, Board Certification in Audiology) or the American Speech Language Hearing Association (that is, Certificate of Clinical Competence in Audiology). During the audiologist's mentored professional practice experience required for board certification, or the clinical fellowship prior to obtaining the Certificate of Clinical Competence in Audiology, he/she will be supervised by a qualified audiologist as defined by the American Board of Audiology or American Speech Language Hearing Association rules before being granted independent clinical privileges. The requirement for mentored professional practice experience is waived for persons earning a clinical doctorate of audiology (that is, Au.D.) degree.

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

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

7-6. Behavioral health practitioner

a. Description. Behavioral health practitioners are trained in behavioral science, counseling theories, and practical applications of behavior change principles. They may manage numerous behavioral and emotional problems, in both general and particular specialty practice levels, providing a variety of behavioral health services, including screening, treatment, and consultation. The behavioral health practitioner may develop additional expertise in psychometrics, industrial psychology, substance abuse rehabilitation, geriatric care, school or health psychology, neuropsychology,

pediatric or adolescent psychology, aeromedical psychology, and combat stress reactions.

Note: The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State licensure requirements as a doctoral-level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this regulation, using the title of behavioral health practitioner or psychological associate. (See para 7-19.)

b. Professional credentials. Behavioral health practitioners must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for category I-III level of privileges include—

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

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

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

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

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

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

- (1) Conduct screening evaluations, utilizing information from clinical interviews, nonpsychometric tests, and collateral sources, as appropriate.
- (2) Determine a provisional diagnosis according to the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- (3) Provide individual and group behavioral health treatment within the scope of practice/privileges granted.
- (4) Manage the behavioral health care of patients and refer those having needs beyond their scope of practice.
- (5) Serve as collaborator in human behavioral issues with, and consultant to, community agencies, health care providers, and organizational leaders.

d. Supervision.

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

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

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

7-7. Chiropractor

a. Description. Chiropractors provide treatment and care of spine-related neuromusculoskeletal conditions to eligible beneficiaries. The chiropractor utilizes chiropractic manipulation—also called chiropractic adjustment—to restore joint and related soft tissue function. This treatment may be used with other supporting forms of treatment (physical modalities) depending on the patient's specific needs. The chiropractic approach to health care is holistic, stressing the

patient's overall well-being. The natural, drugless, nonsurgical methods of chiropractic treatment rely on the body's inherent recuperative abilities to promote healing.

b. Professional credentials.

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

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

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

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

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

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

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

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

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

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

(6) Providing patient instruction and recommendations pertaining to hygiene, nutrition, exercise, sanitary measures, lifestyle changes, stress reduction, and modifications of ergonomic factors.

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

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

7-8. Clinical pharmacist

a. Description. Clinical pharmacists are licensed pharmacists with complex clinical skills and capabilities acquired through advanced education and practical experience. Clinical pharmacists practice collaboratively in the area of pharmacoconomics and with patients requiring therapy (for example, anticoagulant, asthma, hypertension, diabetes, hyperlipidemia, immunization, and oncology nuclear). Clinical pharmacists practice in primary care, medicine, pediatrics, geriatrics, infectious disease, nutrition, and pharmacotherapy settings. They provide medication refills. In many cases, the clinical pharmacist works directly for a physician or group of physicians in a particular specialty or primary care clinic. The pharmacist functions under clinical treatment protocols or CPGs developed in coordination with the medical staff, recommended by the P&T committee, and approved by the ECMS, or DOD/USAMEDCOM-developed and approved CPGs. Clinical pharmacists provide pharmacokinetic consultation, enteral and parenteral nutrition consultation, and perform drug therapy management activities on inpatient units and in outpatient clinics. In all cases, communication between pharmacists and physicians is essential for quality patient care. The pharmacist will promote the use of the DOD Basic Core Formulary and the Uniform Formulary Concept, as well as all DOD pharmacy policies, procedures, and DOD/USAMEDCOM CPGs.

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

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

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

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

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

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

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

Note. The didactic content of current bachelor of science programs is nearly identical to entry-level PharmD programs. The difference is that PharmD programs have 1 additional year of clinical experience.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d. *Supervision.*

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

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

7-9. Clinical psychologist

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

Note. The provisions of this section are applicable to GS 180-series counseling psychologists prepared at the doctoral degree level.

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

(1) *Category I.* The practitioner has completed predoctoral internship but has not yet completed degree requirements for a Doctor of Philosophy (Ph.D.) or Psy.D. in clinical or counseling psychology. The graduate program and internship must meet requirements of DA Pam 611-21. The practitioner assists in performance of psychological and other services and works under the supervision of a licensed psychologist.

(2) *Category II.* The practitioner has a Ph.D. or Psy.D. in clinical or counseling psychology but is not yet licensed. The graduate program and internship must meet requirements of DA Pam 611-21. The practitioner provides a full

range of psychological services as qualified to deliver by virtue of training. He/she participates in team delivery of services, research, and teaching and receives qualified supervision (per licensing criteria) from a licensed psychologist.

(3) *Category III*: The practitioner has Ph.D. or Psy.D. in clinical or counseling psychology and is licensed. Graduate programs and internships must meet requirements of DA Pam 611-21. The practitioner is recognized as possessing a high level of skill in psychological assessment, intervention, and administration of services. He/she delivers psychological services to individuals and treatment teams and may be appointed as supervising psychologist for category I and II practitioners.

(4) *Category IV*: The practitioner has a Ph.D. or Psy.D. in clinical or counseling psychology and is licensed and board certified by the American Board of Professional Psychology. Graduate programs and internships must meet requirements of DA Pam 611-21. The practitioner is recognized as possessing the highest level of skill in psychological assessment, intervention, and administration. He/she may be appointed as a supervising psychologist for category I and II practitioners.

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

(1) In general, clinical psychologists—

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

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

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

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

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

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

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

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

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

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

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

(c) The appropriate DA Form 5440 will clearly specify the wards/units to which the clinical psychologist may admit and discharge patients.

d. Supervision.

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

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

(3) Licensed clinical psychologists who are privileged in the independent practice of psychology do not require supervision except when engaging in new areas of practice. Psychologists who have not engaged in clinical practice for a period of 12 months or more will require assignment to a 12-month period of general supervision. Psychologists will adhere to guidelines of the APA which require psychologists to receive appropriate training and supervision before engaging in new practice areas.

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

7-10. Clinical social worker

a. Description. The primary mission of Army social work is to provide comprehensive professional services through

a broad range of individual, family, command level and community interventions, programs, and services to sustain, restore, or enhance the social well-being and functioning of individuals, families, units, and the Army community. Social workers are members of the health care team; most frequently working in social work service; outpatient mental health clinics, Family Advocacy Programs (AR 608-18), substance abuse treatment services, division mental health services, combat stress control detachments, and correctional facilities.

b. Professional credentials.

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

(a) In order to engage in independent practice, clinical social workers must have completed an MSW, have a minimum of 2 years' post-MSW clinical social work experience, and possess the appropriate State license/certification. (If the State offers a license for independent clinical practice, this will be the level of license required. Otherwise, the license must be at the level appropriate for an MSW social worker with 2 years' experience.) These individuals may be awarded regular clinical privileges.

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

(b) Entry-level clinical social workers may be granted regular privileges with enhanced supervision as described in paragraph 9-4e. A written plan of supervision will be documented. This applies to the licensed entry-level clinical social workers possessing an MSW and less than 2 years' post-MSW experience and to clinical social workers with greater than 2 years' post-MSW experience that hold a license which does not authorize independent practice in their State of licensure.

(c) Social workers who are practicing clinical social work but have only an entry-level license from a State that offers a higher level of license, as described above, will be awarded regular privileges with enhanced supervision until they obtain the necessary level of license. Individuals will be given until 1 October 2004 to meet this independent practice licensure requirement. (This allows 2 years to meet State clinical experience/supervision requirements plus an additional year to obtain the appropriate license. Individuals who have already completed the experience and supervision requirements will be given up to 1 year to complete the examination and licensure/certification process.)

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

c. Scope of practice. Clinical social worker privileges may include but are not limited to—

- (1) Interviewing and evaluating patients.
- (2) Diagnosing mental disorders and formulating appropriate treatment plans.
- (3) Recommending administrative and medical dispositions.
- (4) Providing individual, couple, family, and group psychotherapy.

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

7-11. Dentist

a. Description. Dentists ensure the optimal oral health of the soldier through preservation, restoration, and replacement dental services and they provide dental health care to eligible DOD beneficiaries (AR 40-400). Dentists examine, diagnose, and treat or prescribe courses of treatment for beneficiaries suffering from defects, diseases, injuries, or disorders of the teeth, jaws, oral cavity, and supporting maxillofacial structures. In addition, dentists support casualty identification through dental forensic identification operations. Dental services are classified as general dentistry or specialty dentistry to include comprehensive dentistry, pediatric dentistry, periodontics, endodontics, prosthodontics, orthodontics, oral and maxillofacial surgery, oral pathology, and public health dentistry.

b. Professional credentials.

(1) *Education.*

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

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

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

c. Scope of practice. The general dentist is required and privileged to perform procedures appropriate to AOC 63A.

The specialty dentist is privileged to perform the same procedures as the general dentist in addition to those appropriate to his/her specialty. AOC. Dentists in residency training programs will perform specialty procedures as assigned and supervised by their program mentors.

7-12. Dietitian

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

Note. Dietitians who provide MNT must be privileged to perform this therapy.

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

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

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

(a) Dietetic internship.

(b) Approval of Preprofessional Practice Program.

(c) A coordinated undergraduate program in dietetics.

(3) *Licensure.* Dietitians will maintain a current, active, valid, and unrestricted dietetics license or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(4) *Scope of practice.* Dietitians may be granted clinical privileges to provide MNT that include nutrition assessment/evaluation, counseling, ordering laboratory tests and other assessment procedures, as well as implementing MNTs such as enteral/parenteral feedings for inpatients and outpatients and writing prescriptions for nutrition-related pharmaceuticals as described in paragraph 7-2c.

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

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

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

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

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

7-13. Occupational therapist

a. Description. OTs contribute to operational readiness and quality of life by providing cost-effective occupational therapy care to the fighting force and eligible beneficiaries. Occupational therapy is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health; prevent injury or disability; and which develop, improve, sustain or restore the highest possible level of independence of any individual who has an injury, illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, physical

disability, or other disorder or condition. It includes assessment by means of skilled observation or evaluation through the administration and interpretation of standardized or nonstandardized tests and measurements. OTs evaluate, treat, and consult with individuals whose abilities to cope with the tasks of everyday living are threatened or impaired by physical illness or injury, psychosocial disability, or developmental deficits. The OT uses goal-directed activities—appropriate to each person's age and social role—to restore, develop, or maintain the ability for independent, productive, and satisfying lives.

b. Professional credentials.

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

(2) *Certification.* Certification from the National Board for Certification in Occupational Therapy is required.

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

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

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

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

c. Scope of practice.

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

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

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

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

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

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

(f) Perform combat neuropsychiatric triage.

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

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

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

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

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

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

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

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

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

4. Refer patients to appropriate specialty clinics.

5. Authenticate temporary limited-duty profiles according to the guidance outlined in AR 40-501.

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

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

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

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

1. Conduct infant and pediatric developmental evaluations and treatment.

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

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

7-14. Optometrist

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

b. Professional credentials.

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

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

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

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

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

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

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

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

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

7-15. Physician

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

b. Professional credentials.

(1) *Education.* Physicians must have completed an accredited medical degree program acceptable to DA.

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

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

c. Scope of practice. Physician privileges may include, but are not limited to—

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

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

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

d. Supervision. Physicians are licensed independent practitioners and have no requirement for direct supervision. They will act independently in areas of medical and surgical care when they have demonstrated competency within their delineated privileges. Physicians in post-graduate clinical training (interns, residents, and fellows) are required to function under the supervision of experienced physicians participating in the GME system. A physician returning to practice after a lapse in providing patient care may be required to function for a specified period under the supervision of another more experienced physician (that is, enhanced supervision, as described in para 9-4e) if recommended by the credentials committee and approved by the MTF commander.

7-16. Physician assistant and specialty physician assistant

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

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

b. Professional credentials.

(1) *Education.* Military PAs must meet the criteria for commissioning as a 65D according to AR 135-101. PAs must have a baccalaureate or master's degree. They must be graduates from a PA training program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (or previously recognized accrediting body) and acceptable to the DA.

(2) *Certification.* All PAs (AA/USAR/ARNG and civilian) are required to possess current certification by the NCCPA before regular clinical privileges are granted/renewed.

(a) *Initial certification.* PAs who received their training from the Interservice Physician Assistant Training Program must take the NCCPA Physician Assistant National Certifying Examination (PANCE) immediately following Phase II of training. The Army PA is allowed two attempts to pass the PANCE. Those PAs who are unsuccessful in passing the examination on the first attempt must take the examination at the next available time it is offered. If unsuccessful in passing this certification examination on the second attempt, the individual will be processed for involuntary branch transfer according to AR 614-100.

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

(c) *Recertification.* The PA National Recertification Examination/Pathway II is required every 6 years. PAs who are unsuccessful in passing this examination after two attempts will have their privileges revoked and are prohibited from practicing in their AOC/ASI. The PA with an existing AD service obligation for training will be processed for involuntary branch transfer according to AR 614-100. Individuals with no AD service obligation may be eliminated from service according to AR 600-8-24. See MEDCOM guidance for additional NCCPA certification requirements.

(3) *Licensure.* In addition to NCCPA certification, a license as a PA from a U.S. State, the District of Columbia, Commonwealth, territory, or jurisdiction is the mandatory standard for all PAs (military and civilian) employed by the Federal Government. This requirement is effective 1 July 2009.

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

(1) *Outpatient duties.* PA outpatient duties include, but are not limited to—

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

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

(c) *Minor surgery and wound management.* PAs may perform minor surgery and wound management that require completion of an Optional Form (OF) 522 (Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures). (See AR 40-66 for instructions on the use of this form.)

(d) *Patients returning with the same complaint.* PAs must consult with a physician when a patient presents with the same unresolved complaint twice in a single episode of care. Physician consultation will be documented on either a standard form (SF) 600 (Health Record-Chronological Record of Medical Care) or an SF 513 (Medical Record-Consultation Sheet). (See AR 40-66 for instructions on the use of these forms.)—This does not apply to patients who are returning for routine follow up as directed or for treatment of chronic illnesses previously documented in their medical record.

(e) *Referral and evacuation.* Situations requiring higher levels of medical diagnosis and treatment will be referred or evacuated. In the absence of a physician, the PA will be the primary source of advice to determine the medical necessity, priority, and requirements for patient evacuation.

(f) *Authentication of medical record entries.* PAs will sign all entries made in the patient's inpatient treatment record (ITR) or outpatient treatment record (OTR). Documentation in the ITR of the patient's medical history, physical examination, and narrative summary, as well as entries on DA Form 4256 (Doctor's Orders) (see AR 40-66) require physician countersignature. Countersignature will be within 24 hours. Entries made by a PA in the HREC or the OTR do not require a physician's countersignature.

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

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

(b) Write orders for inpatient care using DA Form 4256.

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

(d) Prepare and dictate narrative summaries.

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

(f) Specific pre-operative counseling is the responsibility of the attending surgeon. PAs may not perform a pre-surgical anesthesia evaluation that requires completion of a DA Form 7389 (Medical Record-Anesthesia). (See AR 40-66.)

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

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

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

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

(4) *Medical examinations.* PAs may—

(a) Conduct medical examinations, following the guidance in AR 40-501, and as deemed appropriate by the supervising physician.

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

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

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

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

(8) *Expanded roles.* PAs with advanced education, training, experience, and the appropriate privileges may be used in specialty practice settings such as aviation medicine, cardiovascular perfusion, emergency medicine, occupational health, and orthopedics. Additions and deletions of PA specialties will be approved by the Commander, USAMED-COM, ATTN: MCHO-CL-C, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. A specialty-trained PA may perform the initial patient work-up or consultation. The consultation prepared by the PA will be reviewed and countersigned by a physician according to established CQM procedures and/or locally developed scopes of practice. Guidance for each PA specialty is as follows—

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

Aeromedical PAs—

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

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

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

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

5. Sign the DA Form 4186 (Medical Recommendation for Flying Duty) (see AR 40-501) recommending an air crew member's return to flight duty only after consultation with an FS. The name of the consulted FS will be annotated on the DA Form 4186 according to AR 600-106 and on SF 600 filed in the patient's HREC.

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

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

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

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

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

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

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

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

(c) *Emergency medicine.* A PA who successfully completes a TSG-approved graduate PA emergency medicine training program may be designated as an emergency medicine PA (EMPA), (ASI M2). EMPAs—

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

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

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

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

(d) *Occupational health.* A PA who receives a graduate level degree in occupational health/public health may be designated as an occupational health PA (OHPA). The OHPA assists the occupational medicine physician (60C) or preventive medicine physician (60D) in occupational and preventive medicine duties for the medical center (MED-CEN), medical department activity (MEDDAC), or TOE unit areas of responsibility. OHPAs—

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

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

3. Conduct illness and injury monitoring and investigations.

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

5. Provide occupational and environmental health education to soldiers and DOD civilian employees.

(e) *Orthopedics.* A PA who successfully completes a TSG-approved graduate PA orthopedic training program may be designated an orthopedic PA (ASI M1). Orthopedic PAs—

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

2. Perform minor orthopedic-related surgical procedures.

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

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

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

6. Perform all diagnostic and therapeutic orthopedic procedures for which he/she has been properly trained and privileged.

Note. Outpatient procedures by an orthopedic PA should not include any manipulation, minor surgery, or wound management requiring other than local or peripheral nerve block anesthesia.

d. Privileges.

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

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

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

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

(1) *Qualifications and duties.* The physician supervisor will—

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

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

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

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

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

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

(g) Participate in the rating of the PA for whom supervision is provided. In all cases, the physician supervisor will be included as either the PA's rater or senior rater according to AR 623-105.

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

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

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

f. CME and training. CME is critical for sustainment of clinical skills necessary for the PA to perform his/her duties.

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

(2) Readiness training is of paramount importance to prepare U.S. Army PAs for their wartime mission. Required training for AMUSARNG PAs includes—

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

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

(c) *Tropical/global medicine.* The increasing likelihood of deployments and missions in the tropical and subtropical regions of the world requires familiarity with diseases and conditions that are endemic to those areas and which pose a threat to the health and well-being of soldiers.

Note. Although the availability of this training may be limited, commanders are encouraged to require their PAs to attend.

7-17. Physical therapist

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

b. Professional credentials.

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

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

c. Scope of practice.

(1) *Category I.* Category I clinical privileges are awarded to PTs who initiate treatment based on a physician's order, and whose activities are limited to the scope of standard practice as defined by their license or certification. PTs in category I practice will—

(a) Use guidelines published by the American Physical Therapy Association.

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

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

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

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

(a) Provide NMSE without physician referral for acute musculoskeletal and neuromuscular conditions (DASG-HS-PA, subject: Suggested Guidelines for Physical Therapists Acquiring Privileges to Perform Neuromusculoskeletal Evaluations (NMSE), dated 8 August 2000). The PT so privileged may—

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

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

3. Refer patients to specialty clinics.

4. Authenticate temporary limited-duty profiles according to the guidance outlined in AR 40-501.

5. Write prescriptions for selected medications as described in paragraph 7-2c.

(b) Perform and interpret electrophysiologic tests to include nerve conduction studies, needle electromyography, and somatosensory-evoked potentials. These privileges should only be granted if the PT has met the American Board of Physical Therapy Specialties guidelines for the practice of clinical electrophysiologic physical therapy published in *Clinical Electrophysiologic Physical Therapy: Description of Advanced Clinical Practice* (1995).

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

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

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

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

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

7-18. Podiatrist

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

b. *Professional credentials.*

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

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

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

(a) American Board of Podiatric Surgery.

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

c. *Scope of practice.* A DPM may be privileged as any other member of the medical staff in the surgical service. The national standard for DPMs with the appropriate post-graduate education, as stated in *b* above, is the management of all disorders of the anatomic region of the foot and ankle and related structures affecting the foot and ankle. Podiatrists for whom residency training included medical history taking and physical examination may be privileged to perform the complete H&P for ASA patient classification status 1 and 2 patients in both the inpatient and outpatient settings. The DPM will perform and record the H&P on the appropriate medical form(s), for example, SF 504 (Clinical Record - History Part I), SF 505 (Clinical Record - History Part II, III), and SF 506 (Medical Record - Physical

Examination) for the inpatient, or SF 600 (outpatient). Patients classified as ASA patient classification status 3 and greater will require an H&P, either all or part of which is performed by a qualified physician. The podiatric portion of the H&P may be performed, recorded, and signed by the DPM; the remaining medical portion of the H&P is the responsibility of the consulting physician. Findings, conclusions, and assessment of risk will be confirmed or endorsed by a qualified physician prior to initiation of any major high-risk diagnostic or therapeutic intervention. The DPM may be privileged to admit patients only if he/she is educationally prepared to perform the H&P. Otherwise, a privileged physician must admit the patient, perform the H&P, and assume responsibility for the patient's inpatient medical care during hospitalization.

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

7-19. Psychological associate

a. Description. Psychological associates are trained in general psychology, psychometric theory, psychological testing, behavioral science, counseling theories, and practical applications of psychological principles. The psychological associate may develop additional expertise in industrial psychology, school or health psychology, neuropsychology, and pediatric or adolescent psychology.

Note. The provisions of this section are applicable to GS 180-series counseling psychologists that do not meet State requirements as a doctoral level psychologist. These individuals shall be privileged to engage in clinical practice only as defined in this regulation, using the title psychological associate or behavioral health practitioner. (See para 7-6.)

b. Professional credentials. Psychology associates must demonstrate appropriate education, skills, training, and experience to be considered for clinical privileges. The minimum educational and licensure requirements for category I-III level of privileges include—

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

(2) *Category II.* The individual has completed a master's degree program in psychology, at a fully accredited college/university, including a minimum of 6 semester hours of supervised practicum. The individual possesses licensure as a psychological associate, or the LPC/LPC-equivalent licensure (or other master's level psychology license) available in some states. The individual has a minimum of 2 years' full-time experience in the specialty in which services are performed under the supervision of a higher level privileged provider with a license in psychology.

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

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

c. Scope of practice. Individuals will practice within the guidelines of their respective State licensing boards as a licensed psychological associate (if offered by their State), or LPC (or equivalent), or "licensed mental health provider." Psychological associates adhere to the State licensing board's Code of Ethics and Conduct for psychologists or LPCs. Specific clinical privileges are granted based upon training, experience, and competency. In general, psychological associates will—

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

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

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

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

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

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

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

d. Supervision.

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

(2) Licensed psychology associates (or LPCs) with 2 or more years' experience (after attaining licensure) will

receive general supervision by a licensed psychologist according to the individual's level of competence, as assessed by his/her supervisor.

(3) Licensed psychology associates (or LPCs) with more than 2 years' experience and with a post-master's specialty degree—such as the Ed.S.—require supervision in their specialty only with difficult, high-risk cases, or for cases in which one or more of the patient's problems fall outside the scope of the associate's training.

7-20. Speech pathologist

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

b. Professional credentials.

(1) *Education.* Speech pathologists are required to have a master's or doctoral degree in speech pathology from an accredited institution acceptable to DA.

(2) *Licensure.* Speech pathologists will maintain a current, active, valid, and unrestricted license, registration, or certification from a U.S. State, District of Columbia, Commonwealth, territory, or jurisdiction.

(3) *Certification.* A Certificate of Clinical Competence from the American Speech-Language-Hearing Association is required.

c. Scope of practice. Speech pathologists follow the guidelines published by the American Speech-Language-Hearing Association. They are privileged to provide comprehensive diagnostic and therapeutic procedures of the speech and voice mechanism. Those with advanced training and current competence may be privileged to perform advanced procedures such as electrophysiological measures of speech functions, acoustic analyses of voice production, fiberoptic endoscopic evaluation of swallowing, modified barium swallow study, dysphagia therapy, stuttering treatments, and voice therapy.

d. Supervision. The speech pathologist will be supervised/provided oversight of his/her clinical practice by a more senior or experienced speech pathologist, as determined by the MTF commander. In the absence of a senior speech pathologist, a physician or other qualified privileged provider, as designated by the DCCS, may provide supervision/oversight.

Chapter 8 Credentials Review

8-1. General

Credentials are those documents presented by the health care professional, regardless of the nature of his/her practice or duty position, that constitute evidence of current licensure, certification, registration, or other authorizing document, as appropriate. In addition, professional credentials substantiate relevant education, training, and experience; current competence and judgment; and the ability to carry out the duties and responsibilities of the assigned position or, for the privileged provider, to perform the privileges requested.

8-2. Credentials authentication for military accessions

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

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

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

- (a) Personnel Data Sheet.
- (b) Professional license and PSV (copy).
- (c) Curriculum vitae (CV) or resume (copy).
- (d) Diploma (copy).
- (e) Qualifying degree official transcripts (copy).
- (f) Continuing medical or health education (copy).

(g) Malpractice insurance coverage and PSV (copy).

(h) Additional documents: board certification(s); NPDB query results; ECFMG/Fifth Pathway certificate (if applicable); and internship, residency, fellowship certification or verification, as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) *National Guard providers*. Forward documents to Strength Maintenance Division, ATTN: NGB-ASM-S (AMEDD), Suite 3400, 1411 Jefferson Davis Highway, Arlington, VA 22202-3231. Strength Maintenance Division

will forward documents to the appropriate State Surgeon/Deputy State Surgeon who will forward the documents to the designated credentials manager.

8-3. MTF authentication of professional credentials

a. Review and PSV of the authenticity of credentials for all professional health care personnel is mandatory. In no instance will an individual be assigned or privileged to perform professional duties unless appropriately qualified by education, training, and experience.

b. Verification of credentials, as stipulated in this chapter, will be accomplished for all categories of privileged and nonprivileged Federal employees: AA/USAR/ARNG military, civil service, consultant status, FNLH, contract, or volunteer health care practitioners (includes new medical school graduates and trainees completing GME in civilian deferred status). For all privileged providers, inquiry will also be made to the NPDB (para 8-7I) prior to the initial granting of clinical privileges and at each biennial renewal.

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

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

(b) *Licensure/certification/registration or other authorizing documentation.* For new military accessions, PSV of an existing license(s) prior to entry into Federal service will be accomplished by USAREC. Local policy will direct who at the MTF is responsible for PSV of license for recently assigned nonprivileged military accessions and for pre-employment licensure verification for civilians (GS, personal services contract, and volunteer). The contracting agency will verify licensure with the primary source for non-personal services contract personnel prior to the employee being assigned to the MTF for duty. For military and civilian employees, periodic license renewal, as determined by the issuing State/national agency, will likewise be authenticated with the primary source by the responsible MTF authority. The contracting agency is responsible for PSV of licensure/certification/registration renewal for non-personal services contracted employees. This requirement applies to all nonprivileged personnel who possess a license, certification, or registration as a professional credential. (See paras 8-6e and f for more information on PSV.)

(c) *State or national specialty skills certification.* This includes those offered by the ANA or other professional organization, mammography skills certification for radiology technicians, and so forth

(d) *Authentication of other discipline-specific skill or technical training to include DOD-sponsored training.* This excludes in-service education and other locally established training requirements.

(2) *Privileged staff.* Privileged provider credentials are verified, updated, and maintained during the individual's tenure with the U.S. Army by the MTF credentials manager, or other responsible authority, as designated by the commander. Professional information about the privileged provider is contained in both the PCF and the PAF.

(a) The PCF is the primary repository of permanent information related to provider credentials and performance. The contents must remain intact and the security of the information ensured at all times. Any request by the subject provider for amendment of information contained in the PCF (for example, correction of erroneous or inaccurate information, or the removal of improperly filed documents) must be considered under the provisions of the Privacy Act and AR 340-21. The PCF will be released only to the MTF commander, the credentials committee, department/service chiefs, recognized reviewing authorities, or officially appointed inspectors. The provider may authorize, in writing, release of his/her PCF to others, but the PCF should be retained in the credentials office with authorized access in that secure location. See appendix E for additional information regarding the PCF.

(b) The PAF is considered a working file that contains a variety of clinical data that are used to profile the provider's practice, to periodically reevaluate performance, and to reappraise privileges. Selected contents of this file (that is, documents that pertain to the provider's competence, clinical performance, or conduct) are transferred to the PCF, according to local procedures, for permanent inclusion in the PCF. Other contents should be maintained for a minimum of 2 years to allow tracking and trending of provider clinical performance data and other information considered significant to the organization from a business or clinical perspective. (See additional PAF information in para 8-9 and app F.)

(c) Both the PCF and the PAF contain sensitive, confidential information. Selected documents contained in these files qualify for protection under 10 USC 1102. (See app E for specific information regarding 1102 protection.) To protect these files and to maintain the integrity of the contents, the PCF and the PAF must be stored in a secure location (for example, in a file cabinet, desk drawer, and so forth that can be locked). Access to either file is limited to authorized individuals only. The PAF should be retained in the credentials office with authorized access only in that secure location. If either the PCF or the PAF is required outside this area, personal delivery by the credentials coordinator (or designated individual) is recommended. The integrity of these files and security of the contents must be maintained at all times.

(d) A provider may, on request and in the presence of the credentials manager or other command representative, be allowed to review the contents of his/her PAF and PCF.

8-4. Privileged provider credentialing

a. The credentialing process includes a series of activities designed to collect relevant data that serve as the basis for decisions regarding appointment and reappointment to the medical/dental staff, as well as delineation of individual clinical privileges. This information may also be the basis for subsequent action to expand or limit a provider's privileges.

b. Recommendations for the award of clinical privileges and medical staff appointment (if applicable) will be made by the department/service chief, acted upon by the credentials committee/function, and forwarded through the ECMS (AA facilities and USAR/ARNG units wherever feasible) to the commander for approval or disapproval. Recommendations from peers, who have firsthand knowledge of the applicant's competence, skill, and ability in the professional discipline are essential to the medical/dental staff appointment/reappointment process, as well as to the granting, renewing, or revising of clinical privileges. Peer recommendations may include written feedback from—

- (1) The PI committee/function, the majority of whose members are the provider's peers.
- (2) A department or clinical service chief who is a peer.
- (3) The ECMS, the majority of whose members are the provider's peers.
- (4) A reference letter or documented telephone conversation about the provider from a peer who is a member of the MTF's medical staff or who is from outside the organization. Peer recommendations will be maintained in the PCF and are filed with the recommendations by the provider's department or service chief.

8-5. MTF credentials committee/function

Central to the responsibility of assuring quality care and improving the performance of services rendered by privileged providers are the requirements for credentials review, delineation of individual clinical privileges for professional staff members, appointment/reappointment to the medical staff and adverse privileging action hearing/appeals processes, as appropriate. These functions may be executed by the ECMS/ECDS (see glossary) or other group properly constituted to perform this series of activities, for example, the credentials committee. If the credentials committee is charged with these responsibilities, the ECMS must review and concur with all recommendations for actions associated with provider privileging and medical staff appointment/reappointment prior to their consideration by the commander.

a. Purpose.

The credentials committee/function reviews the credentials and the performance of each provider requesting clinical privileges and appointment to the medical/dental staff. Subsequent to this review, recommendations for provider privileging/appointment actions, to include those for USAR/ARNG providers for whom the committee has privileging responsibility, are made through the ECMS/ECDS to the commander. The committee's recommendations relevant to a provider's request for privileges are based upon his/her credentials, performance data, departmental peer recommendations, and the needs and capabilities of the institution.

(2) The credentials committee/function will also consider and recommend to the commander whether providers in a less-than-fully privileged status should be allowed to function under clearly defined supervision, involuntarily separated, or released from AD or civilian employment.

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

b. *Membership and duties.* The MTF commander will designate the DCCS (or other senior medical staff member) as chairperson and will name the permanent members and a designated alternate for each member of the committee. Alternates will exercise all the duties and responsibilities of the permanent voting member whom they represent.

(1) The chairperson will ensure that all assigned members receive appropriate orientation to assume the duties and responsibilities of this committee.

(2) Membership will reflect the diversity of privileged providers practicing within the facility, in outlying patient care settings under the command and control of the MTF, and in garrison-level TOE units, where present. The majority (51 percent or greater) will be fully appointed members of the medical/dental staff.

(3) No action on a provider will be taken without the presence of a majority (51 percent or greater) of the voting membership.

(4) The chairperson may request the presence of a legal advisor (nonvoting).

(5) The senior nurse executive (that is, the Chief Nurse/DCN) is a voting member.

(6) At least one voting member of the same discipline, if available, will be present when clinical privileges for a nonphysician provider are considered.

(7) Members in the same discipline as the provider being evaluated should be present when the committee acts on the credentials of such providers.

Note. This is not mandatory for actions on temporary or supervised privileges.

(8) When the credentials of any member of the group are being considered, that member will be excused from that portion of the meeting. This will be reflected in the minutes/reports.

(9) The review of credentials and privileges for the MTF commander and deputy commander will be performed according to paragraph 9-2c.

c. Meetings and reports. The credentials committee will meet, or the function initiated, as often as necessary to ensure the timely appraisal of credentials and to prevent the expiration of privileges. The chairperson will ensure there are written records of all actions recommended/taken by this group.

(1) Reports and recommendations of the committee are provided through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the commander.

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

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

(4) The chairperson may schedule an on-call meeting, as directed by the commander, or as needed to—

(a) Evaluate provider requests for modification (augmentation or reduction) of individual clinical privileges.

(b) Evaluate the credentials of providers newly assigned (initial DOD assignment, following PCS/transfer, or TDY).

(c) Reevaluate providers who are in initial or restricted categories of professional activities.

(d) Consider or make recommendations to the commander that a provider's privileges be suspended, restricted, revoked, reduced, or denied.

(5) Voting is by a show of hands, or by written or electronic ballot, with either a "yes" or "no" vote; no abstentions are allowed.

Note: Voting related to routine reprivileging actions may be accomplished by electronic means rather than paper ballot. Local policy will prescribe the application of, and any restrictions associated with, this method of credentials committee information dissemination and balloting.

In the case of an adverse privileging action against a provider, or a controversial issue involving a particular provider, the voting may be by secret ballot. If a member believes he/she should be disqualified from voting for (or against) a given individual, a request with justification is submitted to the chairperson. If the request is granted, the minutes will reflect, by name, the member who has recused him/herself from the vote.

(6) The minutes will reflect the total "yes" and "no" votes cast for each action. Voting by nonpermanent members of the committee is restricted to actions or privileges for members of their respective discipline. Disqualified members will not vote.

d. USAR/ARNG credentials management and credentials committee/function. A USAR/ARNG credentials manager will be appointed on orders. He/she will maintain a complete credentials file, and CCQAS data file, for all USAR/ARNG privileged providers within the TPU or State.

(1) USAR/ARNG medical units and State Surgeons will establish, as appropriate, a credentials committee (or ensure the function is performed by one of the mechanisms described below) to perform the various credentialing and privileging activities as outlined in this regulation. The commander or State Surgeon will not serve as chairman of the credentials committee. He/she will serve as the approval authority for all privileging actions and will sign in block 8a, DA Form 5440A, for both initial privileges/staff appointment and for renewal of privileges/staff appointment.

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

(a) The State Surgeon's credentials committee serves as the centralized credentialing authority for all ARNG health care providers in the State.

(b) USAR/ARNG medical units with a minimum of three privileged providers may form a credentials committee. Units (USAR/ARNG) may combine their privileged assets or utilize members of the NAAD or IRR in the area, to meet this requirement.

(c) Units without sufficient providers to form a credentials committee may forward the PCF for review and action to—

1. The closest medical unit that has a credentials committee.

2. A USAR unit at the next higher headquarters, as designated by the command surgeon.

3. Multiple units/States may coordinate to convene a regional credentials committee. An MOU between the participating units and/or States serves as the charter for this committee.

(3) The credentials committee will—

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

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

~~(c) Consider, and make recommendations to the commander/State Surgeon, as appropriate, that an USAR/ARNG provider's privileges be denied, suspended, resigned, reduced, or revoked.~~

8-6. Provider credentials verification

Prior to being privileged and awarded appointment to the medical/dental staff, PSV of those provider's credentials that require such verification will be accomplished. Other credentials, as noted below, will be verified as true and authentic.

a. Credentials for which renewal is not appropriate (diploma, certificate of internship, and so forth) need only be primary source verified once if the individual maintains continual employment within the DOD. Credentials that require periodic renewal will be verified upon renewal. The privileged health care provider's license is the only exception, as described in paragraph 8-7b(2).

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

c. For civil service, consultant status, FNLH, personal services contract, or volunteer health care privileged providers, credentials verification by the MTF is required. Verification of the applicant's education, training, experience; licensure; certification and/or registration; current competence; and ability to perform the requested privileges or scope of practice is required. The MTF credentials manager (or other, as designated by the commander) will ensure that PSV of all credentials has been accomplished prior to position appointment/placement of the nonmilitary employee/volunteer. See appendix F for Civilian Personnel Operations Center (CPOC)/CPAC duties/responsibilities associated with prospective employee credentials.

d. For the non-personal services contract privileged provider, the contractor is responsible for the current competence of individuals hired in support of established contract requirements and for PSV of the provider credentials noted in paragraph c above.

e. The primary source for verification of a credential is the original source of the specific document. The primary source attests to the accuracy of a qualification. A reasonable effort must be made to verify, with the primary issuing authority, all documents that require PSV. These documents become part of the PCF. Unsuccessful attempts made to obtain verification of a credential from the primary source will be documented.

f. Documents may be primary source verified by one of the following methods (listed in order of preference):

(1) *Written confirmation directly from the issuing authority.*

(2) *Verbal telephone confirmation from the issuing authority.* A detailed record of the telephone interaction will be made in the PCF to include the name of the individual contacted, the date/time, and the signature of the person responsible for verification.

(3) *American Medical Association masterfile verification of U.S. medical school graduation and U.S. residency program completion.* The American Osteopathic Association provides a similar service for osteopathic physicians.

(4) *World Wide Web PSV.* Such verification is acceptable if the information is obtained directly from the professional organization's Web site. The identification of the individual making the Web site contact and the date will be annotated on the Web page printout and this will be entered in the PCF. Any discrepancy between information provided by the applicant and that on the Web site should be pursued by personal contact with the professional organization.

(5) *Touch-tone telephone PSV.* Electronic access by telephone of a database is acceptable only if the other methods listed above are not available. The individual responsible for telephone verification will annotate in the PCF the date, time, his/her signature, and why this was the only verification method available.

g. When certificates (for example, BLS, ACLS, specialty board) are renewed, the credentials manager (or other individual as designated by the commander) must view the original renewal certificate and annotate on a photocopy of the document, "I certify this is a true and valid copy of the original." The photocopy will be signed, dated, and entered in the PCF. If verification documentation from the primary source is available for inclusion in the PCF, or other appropriate file (nonprivileged professional), the requirement to photocopy the official document(s) does not apply.

8-7. Provider credentials file

The credentials information that originates during the pre-employment/accesion application period serves as the basis of a comprehensive record (the PCF) that originates at the first unit of assignment/employment and is maintained and routinely updated throughout the provider's entire period of employment with the Federal Government. The contents of this record are permanent; however, data determined to be either erroneous or inaccurate will be removed in accordance with AR 340-21 and local policy. See appendix E for additional information regarding the PCF. The credentials contained in the PCF include the following:

Note. Those listed in paragraphs a through d below will be primary source verified.

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

(1) If the ECFMG certificate is dated prior to 1986, medical school graduation must be verified. (Prior to this date, the ECFMG did not verify graduation from medical school before issue of the certificate.)

(2) The MTF will notify the RMC/RDC who will telephonically contact the Commander, USAMEDCOM, ATTN:

MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, or the Commander, U.S. Army Dental Command, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004 for guidance and assistance when

(a) The medical/dental diploma was issued by a school in a foreign country that has no diplomatic relations with the U.S. and direct communication to primary source verify the diploma or other credentials is not possible.

(b) There are other concerns regarding the diploma or the foreign medical/dental school.

(c) PSV of credentials by a source outside the U. S. in a reasonable period of time is not forthcoming.

b. *State licenses, registrations, certifications, other authorizing documents, and current renewal certificates.*

(1) A list of all licenses ever held will be provided (on DA Form 4691 (Initial Application for Clinical Privileges and Staff Appointment)) along with an explanation of any that are not current or that have ever been subjected to disciplinary action. The provider's signature on this form indicates that the list and any related explanation are complete and accurate.

(2) Licensure of providers will be verified with the primary source, by one of the methods described in paragraph 8-6f, at the time of—

(a) Staff appointment and initial granting of clinical privileges,

(b) Reappointment or renewal/revision of clinical privileges, and

(c) Renewal of an expired license.

c. *Postgraduate training certificates (for example, residency, fellowship, nurse midwifery, nurse anesthesia school).*

d. *Specialty board and fellowship certificates.* Specialty board certificates, and certificate renewals, will be verified by direct (or electronic) contact with the issuing board. The publication, "Official American Board of Medical Specialties (ABMS) Directory of Board Certified Medical Specialists," at Web site www.abms.org, may serve as a reference, but it is not a recognized substitute for PSV with the specialty board. For individuals who are recent graduates of residency or postdoctoral programs, a letter from the program director with board certification confirmed by the individual's listing in the ABMS directory will suffice. The ABMS directory includes only those specialty boards that are members of this organization.

Note. It is not necessary to delay the award of regular privileges pending verification of board certification if all other credentials are in order.

e. *A curriculum vitae to account for all periods of time subsequent to obtaining the initial qualifying degree.*

f. *Proof of current (within 1 year or most recent clinical practice if in an administrative role) competence.* This may include letters of reference/peer recommendations from a program or department director, or peer, describing the scope of practice and/or clinical privileges in the department/service/setting in which the applicant is currently practicing. (See para j below for additional detail.) A copy of the most recent list of privileges with evaluation of the provider's performance related to assigned privileges from the current or previous place of employment/assignment may be included, if available. The extent and description of recent clinical privileges will be verified.

g. *Malpractice insurance history as requested on DA Form 5754 (Malpractice History and Clinical Privileges Questionnaire) with narrative comments, as appropriate.*

(1) Explanation of any malpractice claims, settlements, or judicial or administrative adjudication with a brief description of the facts of each claim settled on the behalf of the provider.

(2) Dates of malpractice coverage and history of suits and claims verified for the 10 years prior to initial application.

(3) Verification with the insurance carrier of all self-reported suits and claims.

h. *Detailed explanation of adverse clinical privileging and/or disciplinary action by institutions, State licensure boards, or other governing or regulatory agencies and those by any civilian medical or dental facility where the privileged provider is employed or practicing.* This will include voluntary or involuntary termination of professional and/or medical staff membership or voluntary or involuntary suspension, restriction, reduction, or revocation of clinical privileges at a hospital or other health care delivery setting and any resolved or open charges of misconduct, unethical practice, or substandard care. The "yes" and "no" questions on DA Form 5754 with appropriate explanation capture this provider-specific information.

Note. A lapse between periods of clinical privileges, that is less than 180 days, due to PCS, hospitalization, mobilization, and so forth, is not considered an adverse circumstance or voluntary termination and does not require explanation as described here.

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

j. *Letters of reference/peer recommendations.* The letters submitted with the application for Federal service are referred to in this document as letters of reference. These same letters of reference may be used for initial application for privileges/staff appointment; thereafter, for renewal of privileges/staff appointment written input in the form of peer recommendations is required. The individuals providing the letters of reference or peer recommendations should be personally familiar with the subject provider's clinical, professional, and ethical performance. Ideally, this written input

will address aspects of performance such as clinical judgment and technical skills as well as the types, appropriateness, and outcomes of the provider's surgical/procedural intervention and/or medical management.

(1) *Letters of reference.* A minimum of two current letters of reference from appropriate sources in (a) through (c) below are required for verification of experience and current competence. To best represent the applicant being considered for initial privileges and staff appointment, these letters of reference should be dated within 12 months of submission.

(a) A letter from either the chief of the hospital medical staff, the clinic administrator, the professional supervisor, or the department head, where the appointee has current clinical privileges or is professionally associated.

(b) A letter from the director or a faculty member of the appointee's training program, if the appointee was in a training program within the last year.

(c) A letter from a provider (in the appointee's discipline, if possible) who is in a position to evaluate the appointee's professional standing, character, and ability (for example, a peer or a president or secretary of the local professional society). A letter of reference from both a peer and a professional association or society are mandatory if the appointee is self-employed.

(d) The non-board certified physician who alleges to be a specialist requires two letters of reference attesting to his/her clinical competence by physicians certified in the specialty in which the non-board certified physician is practicing. For the physician who has not completed his/her initial period of qualification for board certification, two letters attesting to the applicant's clinical competence are required from board certified specialists who have current knowledge of his/her clinical practice.

(2) *Peer recommendations.* For providers (AA, USAR/ARNG, civilian, volunteer, and contracted personnel) with current privileges, peer recommendations will be submitted every 2 years as part of the clinical privileges/staff appointment renewal process.

k. *A copy of the provider's Federal narcotics license with current and prior Drug Enforcement Agency (DEA) or Controlled Drug Substance (CDS) numbers, as appropriate.*

l. *Current NPDB report on each provider.* Conducting an NPDB query within 12 months of the previous query is permissible. However, under no circumstances will a provider's query interval exceed 24 months. Query of the NPDB will occur--

(1) By the appropriate recruiting agency at the time of application for employment or appointment (military accessions). This report may be used at the initial duty station if dated within 1 year.

(2) By the MTF at the time a provider initially applies for clinical privileges (initial duty station or place of employment unless para 1c above applies) and every 24 months thereafter as part of the clinical privileges appraisal (renewal) process.

(3) If initial privileging by the provider's first MTF occurs more than 1 year after the NPDB query for entry on AD. In this case, querying the NPDB will be required as part of the initial privileging process.

(4) By the facility providing training or serving as the site of assignment, if necessary, for USAR/ARNG providers. If a valid NPDB query is present in the provider's PCF, re-query is not necessary.

(5) Providers (RC/civilian) may provide verified copies of their NPDB query response from their PCFs maintained in the civilian sector. These must be mailed by the civilian organization's credentials manager directly to the MTF credentials manager. Copies hand carried by the provider are not acceptable.

m. *Evidence of current BLS certification.* ACLS or AMLS, PALS, or advanced pediatric life support (APLS), and/or the Neonatal Resuscitation Program may be additional performance requirements, but these are not a substitute for the BLS requirement. (See para 5-1e for more specific guidance regarding emergency life support training requirements.)

n. *Evidence of approved continuing medical/health education.* Such evidence will be accumulated by the provider for intervals of not less than 2 years and made available to the credentials manager for initial privileges/appointment and for biennial renewal. The annual requirement for CME credits according to AR 351-5 or as determined by the provider's State of licensure, whichever is more stringent.

o. *Criminal history background checks (CHBCs) for all contract and volunteer providers who care for patients under the age of 18.* Other providers (AA, USAR/ARNG, and civil service) do not require a CHBC as this security check is routinely performed as part of the new accession/employment process. Contracting agencies are responsible for performing the CHBC on employees for whom this investigation is required.

(1) For non-personal service contract personnel, the contractor is responsible for completion of CHBCs and must forward results to the gaining MTF. As addressed in local policy, the MTF must ensure the CHBC has been completed prior to allowing the contracted provider to care for patients under the age of 18. For personal services contract personnel, the MTF is responsible for CHBC completion.

(2) Pending completion of the CHBC, the provider's practice will be supervised. The commander will determine the level of supervision that is required. The plan for supervision, with designated supervisor noted, will be in writing.

(3) See DODI 1402.5 or Assistant Secretary of Defense (Force Management (ASD(FM)) policy, subject: Criminal History Background Checks on Health Care Personnel, dated 20 April 92, for additional information.

p. *Special requirements for radiologists providing mammography service.* The Mammography Quality Standards Act imposes specific requirements on radiologists who are involved in providing mammography service. These providers

will abide by Mammography Quality Standards Act requirements and submit the appropriate documentation for inclusion in the PCF. (Refer to Department of Health and Human Services, Food and Drug Administration, 21 CFR, Part 900, Quality Mammography Standards, Final Rule, published in the Federal Register, Vol. 62, No. 208, Tuesday, 28 October 1997, effective 28 April 1999.) The Mammography Quality Standards Act can be found on the internet at <http://www.fda.gov/cdrh/mammography/firmamcom2.html>.

q. Special requirements for physicians providing nuclear medicine services. The radiopharmaceuticals used in nuclear medicine may only be prescribed by providers who are "authorized users" under the facility's nuclear regulatory commission license. For regular privileges in diagnostic nuclear medicine, the provider must submit documentation that he/she is an authorized user at the facility. For privileges in therapeutic nuclear medicine, there must be specific approval as an "authorized user" in this capacity as well. Approval by the commander may be for all or selected therapies.

8-8. Previous experience and reference checks

Every effort should be made to authenticate all provider credentials, stated experience, references, and other information contained in the PCF in a timely manner. Granting of clinical privileges and medical/dental staff appointment, as appropriate, will be withheld until sufficient verified data to document training, experience, and current clinical competence are available.

a. In general, reference checks should not be limited to only those references noted by the provider on the application form. Providers will be notified that other individuals may be contacted, as necessary.

b. Annotated records of each contact made with all personal and professional references will be maintained, to include names of all parties to the call, the date, and a summary of the conversation. Contacts will be advised that the providers may request and be provided this information.

8-9. Provider activity file

The PAF is the repository for supporting information and data to validate privileging of the provider by the MTF. See appendix G for suggested content of the PAF. Various PAF criteria definitions are contained in the glossary.

a. A PAF will be established and maintained for each privileged provider. It is a working file with selected contents considered confidential quality assurance (QA) documents protected by 10 USC 1102. The PAF will be filed with, but is not part of, the PCF.

b. Metric performance data, both qualitative and quantitative, and aggregate data from a representative peer group sample, are examples of the data contained in the PAF. The information and data contained are summarized and available for review and evaluation by designated staff (peer level performance assessment) and by the department or service chief for biennial provider reprivileging/reappointment to the medical/dental staff.

c. Any data included in the PAF that is not required for transfer to the PCF and is greater than 2 years old may be removed and destroyed according to local policy. (The provider will be given the opportunity to keep any productivity and computer-generated data prior to its destruction.) Data determined to be either erroneous or inaccurate will be removed from the PAF and in accordance with AR 340-21 and local policy.

d. The contents of the PAF may be used by supervisors for administrative purposes (for example, counseling, evaluation reports, preparation of GPHE documentation, and letters of reference or peer recommendations).

8-10. The inter-facility credentials transfer brief

a. The ICTB is a computer-generated summary of information contained in the PCF. It is a standardized format (see app H) for transmittal of privileged provider credentials information across the MHS (Health Affairs Policy 94-004 and Health Affairs memorandum, subject: Expanded Use of Inter-Facility Credentials Transfer Brief (ICTB), 11 December 1995). The ICTB may be used for all categories of privileged providers to include uniformed military (AA/USAR/ARNG); civilian (GS, contractors (personal services only), resource sharing); VA; and nonmilitary uniformed providers (for example, Public Health Service). This document may be maintained in a temporary PCF created by the gaining facility.

b. When a DOD provider is temporarily assigned to another MTF for clinical practice, the sending MTF must convey all relevant credentials and privileging information to the gaining MTF. The receiving commander uses this information as the basis for assessing current clinical competence and making appropriate privileging and staff appointment decisions in a timely manner.

(1) Non-personal services contract personnel (that is, individuals working for the Government, yet employed by a non-Federal agency) are not authorized temporary assignment to another MTF. Assignment for duty is only as stipulated in their contract. Use of an ICTB is not authorized.

(2) Providers (AA/USAR/ARNG) mobilized/activated in support of covert operations (that is, a command structure with privilege granting authority may not be known or available) do not require an ICTB. While the provider is TDY in this capacity, his/her PCF may be placed in an inactive status at the sending facility. The PCF will be closed out and archived. Credentials committee minutes will reflect those providers whose PCF is in an inactive status. Upon return

from deployment, the PCF will be reactivated and updated, as necessary, prior to the provider resuming assigned patient care duties.

c. Required attachments to the ICTB for AA providers include

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

d. The ICTB and required attachments accompany the formal application for privileges by the privileged provider. Information that appears in the ICTB need not be duplicated on any DA or local privileging forms that contain essentially like information. An annotation will be made on these forms, as appropriate, to "See ICTB."

e. Additional information regarding the ICTB is contained in paragraph 9-6c and in appendix H.

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

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

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

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

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

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

e. Upon completion of the required training by USAR/ARNG providers, the AA MTF will forward a DA Form 5374, the NPDB or Health Integrity and Protection Data Bank (HIPDB) query (if either was generated), and any other specific privileged provider activity data to the appropriate unit commander, the administrative headquarters, or the credentials manager responsible for custody of the PCF. This information will be forwarded by mail; it will not be hand-carried by the USAR/ARNG provider.

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

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

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

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

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

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

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

g. PCFs for mobilized soldiers will remain under the control of the USAR/ARNG unit PCF manager during the period of mobilization. If the unit PCF manager is not available, the responsibility for maintenance of these files will be delegated to the next available credentials manager in the chain of command. Transfer of the PCF to the soldier's unit of assignment within the theater of operations is not authorized. PCFs for nondeployable USAR/ARNG providers who are retained at home station will be secured and maintained as designated by the unit commander.

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

OFFICE SYMBOL

Date

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

SUBJECT: Request for Credential Documents

1. Request credential documents according to AR 40-68 for the following individual:

a. Name: (provide first and last name and middle initial)

b. Social security number (SSN): (provide full SSN)

c. Corps: AOC:

d. Date assigned to your organization:

2. Request documents be forwarded to: (provide complete mailing address to include room number and name of person receiving credentials).

3. POC is (provide POC name) at telephone (DSN and commercial), or e-mail (provide e-mail address).

SIGNATURE BLOCK

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

Chapter 9

The Privileging Process and Medical Staff Appointment

9-1. General

Privileging is the process whereby a specific scope and content of patient care services (delineated clinical privileges) are authorized for a health care provider by the privileging authority (MTF/USAR/ARNG unit commander/State Surgeon). Such authority is based on an evaluation of the individual's credentials, performance, and the specific needs of the organization.

a. The privileging process is directed solely and specifically to the provision of quality patient care and is not a disciplinary or personnel management mechanism. Privileging actions may, however, accompany actions of an administrative or judicial nature or may engender such actions.

b. A number of privileging actions, both routine and adverse, are available to the commander at the recommendation of the credentials committee. The routine privileging actions that are addressed in this chapter include privilege approval (with or without restrictions), privilege reappraisal, and privilege renewal. Adverse privileging actions include privilege restriction, reduction, suspension, revocation, and denial. These, and the non-adverse privileging action of placing a provider's privileges in abeyance and summary suspension, are discussed in chapter 10.

c. Privileges are facility-specific. As such, the facility's characteristics, supportive resources, and staff are considered in the privileging decisions.

d. Each department or service chief will develop criteria relevant to the award of clinical privileges for the department or service and will identify what privileges are appropriate for the scope of work in the given setting. DA Form 5440-series provides basic privileging criteria and other information that are applicable to the practice discipline. The form provides space for comments and privileges to be added, as needed, based on the MTF's scope of services, the provider's experience, and the DOD beneficiary health care requirements.

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

e. Providers will be granted clinical privileges appropriate to the settings in which they practice. This includes various departmental services, clinics, and the emergency center/service/department, both within the MTF and in MTF controlled outlying locations.

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

(1) In this regulation, "good standing" requires that the employee is--

(a) Not in a remedial training program.

(b) Able to practice independently.

(c) Functioning with privileges that have not been reduced, restricted, suspended, revoked, or denied.

(2) For civilian employees whose privileges are not in good standing, the MTF commander may elect to--

(a) Terminate the employee.

(b) Change the employee to a position at a lower grade (may be voluntary or involuntary).

(c) Reassign the employee to a position for which privileges are not required (may be voluntary or involuntary).

Note. Any financial incentives associated with the previously held position shall be terminated.

g. Reappraisal of defined clinical privileges will take place at least every 24 months (prior to the renewal of privileges) and when a provider is reassigned to a new duty station. (See paras 9-4d(2) and 9-4e.) For USAR/ARNG providers, see para 9-8d(1). Renewal of clinical privileges is based on the provider's professional qualifications and demonstrated competence to perform the privileges requested. Providers who are assigned to nonclinical duty positions (for example, commander, USAREC or Office of TSG staff officer, or AMEDD Center and School instructor) who desire medical staff membership or clinical privileges are subject to the same procedures as all other applicants for membership or privileges. These individuals will only be privileged if they are expressly engaged in patient care activities appropriate to the discipline in which they are requesting privileges. The medical staff bylaws will address how the current competence of providers in administrative positions will be assessed for reappointment and clinical reprivileging. Examples of criteria that may be considered include, but are not limited to, department/service chief interview; documented continuing education/training; the acceptable interval between performance of procedures that are identified as complex, high risk, or problem prone; available patient outcomes assessment data; and clinical practice hours per month/year.

9-2. Practitioners who may be privileged

a. Health care practitioners who function independently to initiate, alter, or terminate a regimen of medical care must be privileged. In this regulation, practitioners who are granted privileges are referred to as providers. Providers

include audiologists, behavioral health practitioners, chiropractors, clinical pharmacists, clinical psychologists, clinical social workers, dentists, dietitians, nurse anesthetists, nurse midwives, NPs, OTs, optometrists, PTs, physicians, PAs, podiatrists, psychological associates, speech therapists, and substance abuse rehabilitation counselors. Also included are CNSs, CHNs, and OHNs who, in selected circumstances and at the discretion of the commander, may be granted clinical privileges (see chap 7) and SBBs.

b. Members of the health care staff who function under a standard job description in the performance of their duties—utilizing practice guidelines or standing policies and/or procedures—do not require clinical privileges. Department/service chiefs are responsible for the ongoing assessment of the competence of personnel to safely perform assigned duties. For those who are not privileged, an internal certification process may be used to designate selected personnel who have achieved the competence needed to perform specific complex, high-risk, or problem-prone clinical functions.

c. Special privileging considerations are as follows.

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

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

(b) The DCCS is excused from the credentials committee meeting (if he/she is being reviewed), and the remaining senior member of the credentials committee will act as chairperson.

(c) The credentials committee recommendations regarding clinical privileges and medical/dental staff appointment for the DCCS (or like DC position) will be submitted through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the local MTF commander for approval/disapproval.

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

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

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

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

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

(2) *Emergency or disaster situations.* Scope of practice limitations as defined by the clinical privileges granted by the MTF may be ignored only in bona fide emergency circumstances (see glossary) or disaster situations. In such cases, providers are expected to intervene and to do everything possible to save the patient's life or to prevent injury, or to effectively respond to a significant increase in demand for medical treatment. This includes requesting consultation with available medical resources and coordinating care and services as appropriate.

(3) *The Armed Forces Medical Examiner System.* This system, as addressed in DODD 5154.24, authorizes medico-legal death investigations for all DOD MTFs. The range of support includes onsite autopsies by deputy or regional medical examiners, telephonic consultations, and written reports. Deputy and regional medical examiners generally hold privileges granted by the AFIP. Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their Armed Forces Medical Examiner credentials to the commanding officer. An application for medical staff appointment with clinical privileges is not required for this service.

(4) *The Organ and Tissue Procurement Program and the Armed Services Medical Regulating System.* Organ donation and transplant conducted by organ and tissue procurement teams, and the related treatment provided within MTFs by personnel assigned to the Armed Forces Medical Regulating System, is addressed in DODD 6465.3. These personnel are authorized to perform their duties in Federal facilities without formal credentials review and privileging. However, the individuals assigned to support these programs will present sufficient documentation (for example, official orders, assignment letter, or identification card) to the MTF commander to establish their authorization to perform these services.

(5) *Musculoskeletal manipulations.* Musculoskeletal manipulations involve palpation and other manual techniques used to evaluate and correct somatic dysfunction that impairs or alters function of the somatic systems. These include the skeletal, arthrodiagonal, myofascial, vascular, lymphatic, and neural systems. This does not refer to the spinal or peripheral joint manipulations commonly used by PTs that are included in their accepted standard scope of practice as defined by the American Physical Therapy Association. The following policy guidance applies to the performance of musculoskeletal manipulation procedures.

(a) Privileged providers—other than doctors of osteopathy, PTs, and chiropractors for whom manipulation is

considered part of their routine scope of practice with evidence of appropriate education, training, and experience acceptable to the credentials committee may be granted specific privileges to perform musculoskeletal manual manipulations. For PTs who perform NMSEs; see paragraph 7-17c(2)(a).

(b) Only specifically privileged physicians (Doctor of Medicine or Osteopathy) may perform manipulation procedures using general anesthesia or intravenous medications. An appropriately privileged anesthesiologist or nurse anesthetist will administer the required anesthesia or sedation for these procedures.

(6) *Privileging for new medical procedures and technology.* The privileging process remains the same. Particular attention will be focused on provider training, experience, and competence and MTF capabilities in granting privileges for use of recently developed or approved technologies and equipment.

(a) *New procedure.* Prior to the introduction of a substantially new and innovative procedure into an MTF, the commander will ensure that privileging criteria are developed at the departmental level and endorsed by the credentials committee. The criteria will include the specific preparatory training that providers must complete prior to being granted the privilege to perform the new procedure. The privileging process for providers will be accomplished prior to the procedure being performed on eligible beneficiaries.

(b) *New technology.* MTF commanders will ensure that new technology (for example, excimer lasers) does not surpass the staff's abilities. MTF commanders will establish safety protocols for an instrument's use and provide for proper privileging procedures prior to the application or use of the new technology. The plan for implementation of new technology must include training of nonprivileged support staff. Adverse patient outcomes involving equipment malfunction will be reported according to MTF policy and will include notification of the DS manager/risk manager. (See para 12-10.)

(7) *Miscellaneous privileging issues.*

(a) *Telemedicine.* Telemedicine involves electronic communication or other communication technologies to provide or support clinical care at a distance.

1. The medical/dental staff will determine which clinical services are appropriately delivered via telemedicine link.

2. If an individual prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient via telemedicine link, the provider will be credentialed and privileged by the organization receiving the service(s). The organization may use the credentials information provided on the ICTB and appropriate attachments (see para 8-10b (AA) or 8-11b (USAR/ARNG)) as the basis for provider privileging, as long as the decision to delineate privileges is made at the facility receiving the telemedicine service. Appropriate use of the telemedicine equipment by the provider must be considered in clinical privileging decisions.

Impairment or impairment potential. A physical or psychological condition that adversely affects (or has the potential to adversely affect) or limits an individual's ability to safely execute his/her responsibilities in providing health care can be considered an impairment. This includes alcohol or other drug dependency/abuse or mental health disorders. Typically, acute or chronic medical conditions will require a limited-duty profile or medical evaluation board (MEB) to decide fitness for duty of the military member. Comparable processes exist for the civilian employee with duty restrictions related to health problems. Such circumstances are managed as medical problems (short or long term) and are not considered impairments. The credentials committee/function will review the performance of privileged providers who are impaired to determine to what extent their impairment hampers their ability to safely practice the privileges they have been granted. The provider's condition or impairment may require modification of his/her clinical privileges, as appropriate. For further information, see chapters 10 and 11.

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

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

(e) *Dentists administering conscious sedation.* As with all procedures, the award of specific privileges to a dentist to perform conscious sedation is based upon appropriate education, training, and experience. Because this skill is not part of basic dental education, specific training in this procedure must be obtained and documented before dentists can be authorized to administer conscious sedation.

(f) *Complementary and alternative medicine.* Application and/or use of these techniques and therapies (acupuncture, homeopathy, massage therapy, and so forth) are gaining acceptance within the MHS. With the approval of the commander, these may be integrated into the broad array of health care and services offered to DOD beneficiaries by qualified providers. Privileges may be granted following the guidance relative to new procedures detailed in paragraph (6)(a) above.

9-3. Categories of clinical privileges

Clinical privileges define the scope and limits of independent patient care services that a provider may render within

the granting health care organization. Privileges may be granted with or without an accompanying appointment to the medical/dental staff. The three categories of clinical privileges that may be awarded are:

a. Regular privileges.

(1) Regular privileges grant the provider permission to independently provide medical, dental, and other patient care services in the facility within defined limits. Regular privileges are granted to providers only after full verification and review of credentials. Regular privileges will not exceed a 24-month period without renewal.

(2) In granting regular privileges, the commander will define the limits of those privileges to include whether or not enhanced supervision is required. The nature and extent of enhanced supervision will be delineated in writing. The commander will also specify limits on regular privileges based upon the MTF mission requirements and the ability to support the requested privileges.

(3) A provider granted regular privileges may be considered for any type of medical staff appointment as discussed in paragraph 9-5d.

b. Temporary privileges.

(1) Temporary privileges authorize a provider to independently provide medical, dental, and other patient care services on a time-limited basis to meet pressing patient care needs when time constraints will not allow full credentials review. The use of temporary privileges should be rare. This category of privileges is appropriate in bona fide patient emergency situations or a declared disaster and is not intended for the administrative convenience of the department/service. Temporary privileges will not exceed a period of 30 days and are not subject to renewal. Any subsequent request for consecutive privileges should be assessed to determine if regular privileges are more appropriate.

(2) Because the MTF has not conducted a thorough credentials review prior to granting temporary privileges, there is an added degree of risk relevant to the competency of the provider. In order to minimize the risk associated with granting temporary privileges, the following actions, as a minimum, will occur.

(a) A copy of the provider's license will be obtained and verified with the issuing agency.

(b) Telephonic contact will be made with the facility where the provider has regular privileges to verify that the individual is clinically competent, fully qualified, and that the requested privileges are within the individual's current scope of practice and privileges. The chief of the medical staff, department chair, or other appropriate authority may provide this information. Or, if available, the ICTB may be used for the purpose of granting temporary privileges.

(3) A complete, thorough credentials review will occur during the period of the temporary privileges.

(4) Temporary privileges may be granted with or without a temporary appointment to the medical staff.

(5) The use of temporary privileges is authorized for all categories of providers.

c. Supervised privileges.

(1) Supervised privileges are granted to providers who do not meet the requirements for independent practice because they lack the necessary license, certification, or other authorizing document. These providers are not eligible for a medical staff appointment and are unable to practice independently. Providers working under supervised privileges can practice only under a written plan of supervision with a licensed person of the same or a similar discipline. See paragraph 5-3 for additional information regarding supervision of practice.

(2) This category of privileges will not be granted to licensed providers, or providers holding other authorizing documents, even though the defined limits of their privileges include supervision.

(3) Supervised privileges should not be confused with enhanced supervision of practice offered to those privileged providers who, for a defined period of time, require oversight of their clinical practice. (See para 9-4e for additional information regarding enhanced supervision.)

(4) Supervised privileges will be granted for periods not to exceed 24 months. Providers who are required to have a license will obtain that license within the time frame specified in chapter 4. These providers may request regular privileges and a medical/dental staff appointment once a license is obtained.

9-4. The clinical privileging process

a. Forms required for award of privileges. Performance data and other information (appropriate DA forms) to be considered in the privileging process are maintained in the PAF. These documents are transferred to the PCF, as appropriate, upon biennial renewal of the provider's clinical privileges (para 9-4c(6)), PCS, or separation from service/employment. The original will be placed in the PCF with a copy furnished to the provider.

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

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

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

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

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

(4) *DA Form 5440*. The appropriate discipline-specific DA Form 5440 (as delineated in app A) will be used to document the request by the provider for clinical privileges and the recommendation for approval by the department/service chief and the credentials committee. Any variance between the privileges requested by the provider and the privileges recommended for approval by the supervisor should be discussed prior to submission of the DA Form 5440. Any unresolved discrepancies must be explained in Section II, Comments, for consideration by the credentials committee. These forms may contain categorical (patient risk and provider training requirements) and itemized disease and procedure-based privileging information by discipline. The disease-related and procedural content of this form will be individualized to address the current competency of the provider requesting privileges as well as the needs and capabilities of the MTF. The requirements for residency training and board certification as stated on the DA Form 5440 cannot be changed at the local level. The entire DA Form 5440-series is available in the AMEDD Electronic Forms Support System and at http://www.apd.army.mil/USAFM_forms/PUBformrange_f.asp for printing and/or local reproduction on 8 1/2 by 11-inch paper.

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

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

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

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

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

b. Initial application for privileges.

(1) Upon arrival at the first duty station or place of DOD employment, the provider must submit a request for initial clinical privileges. The request will include the following:

(a) DA Form 4691.

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

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

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

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

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

(2) The request will be reviewed by the department or service chief who will properly code each category, if applicable, and privilege in the appropriate column of the DA Form 5440. The recommendation by the department or service chief for the award or the limitation of privileges requested will include specific rationale or justification of

same in the "Comments" area (Section II). The request will then be forwarded to the MTF credentials committee/function for review.

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

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

(a) DA Form 5440A will be used to record the executive level medical staff recommendations and the commander's decision concerning the clinical privileges and medical/dental staff appointment of providers. Credentials committee/function minutes/reports will reflect deliberations made by this committee regarding both privileging and appointment status for each provider.

(b) The type of medical/dental staff appointment, if applicable, will be recorded in Block 6b, DA Form 5440A.

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

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

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

(f) When privileges are modified from those requested, the reason will be stated in block 7. (Examples of such reasons include lack of technological resources, lack of support staff, privileges unauthorized by the AMEDD, lack of provider credentials, lack of demonstrated competency, or lack of professional performance.)

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

c. Periodic reappraisal and renewal of privileges.

(1) Provider performance will be continuously monitored through facility-specific ongoing performance assessment activities to ensure that quality patient care is rendered. Providers are responsible for submitting CME, continuing dental education, or documentation of other discipline-specific professional education, licensure renewals, BLS certification renewals, and other certification renewals or credential updates to the PCF manager in a timely manner.

(2) Clinical privileges are in effect for a period not to exceed 24 months from the date granted. It is the responsibility of each provider to request the renewal of his/her clinical privileges and medical/dental staff appointment (if applicable) every 2 years. The request for renewal will be submitted far enough in advance to permit an evaluation of current clinical privileges and performance. Failure to request renewal in a timely fashion may result in the expiration of the provider's privileges.

(3) For clinical privileges renewal, DA 4691-1 will be submitted. Appropriate attachments include a new DA Form 5440 and 5754 completed and signed by the provider and DA Forms 5441 and 5374 prepared by the individual's department/service chief.

(4) DA Form 5441 documents the assessment of the provider's performance of currently assigned privileges and his/her professional performance according to established standards. Reappraisal and renewal of clinical privileges are based on provider performance, facility capabilities, and the needs of the beneficiaries. (See app A for a complete listing of the DA Forms 5440 and 5441 series.)

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

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

(c) DA Form 5374 will be used to evaluate professional clinical and interpersonal skills. It will be completed by the department/service/clinic chief and will include both qualitative and quantitative performance data. The assessment will address the individual's clinical and technical skills based on locally determined performance criteria, as well as a comparative analysis of the provider's performance in relation to aggregate data from a representative peer group sample. The comparative analysis that is performed should contain both intra- and inter-facility data.

(5) A review of provider credentials will be conducted. Privilege reappraisal and subsequent renewal will be based

on education, training, experience, clinical performance evaluations, provider activity profile data, professional conduct, PE activities, and the provider's capability to perform the requested privileges (formerly called health status).

(6) If the provider's performance is deemed to be substandard, or not current, enhanced supervision may be required for a period of time as specified by the commander (para *e* below), or remedial training may be warranted (para *f* below).

(7) At the time of privilege reappraisal/renewal, other than current data may be removed from the PAF and destroyed (or given to the provider). This will take place only after it has been determined, based on credentials committee criteria, that this information is reflected accurately and completely in the current performance appraisal and other privilege delineation information contained in the PCF.

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

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

(1) Upon notification of the provider's impending PCS/transfer to another MTF, the losing unit will complete new DA Forms 5441 and 5374. The biennial appraisal will be considered current if it was completed within 6 months of departure. The credentials manager of the losing MTF will forward these forms together with the PCF and the provider's CCQAS file, by certified return receipt requested mail to the receiving unit. The files will be forwarded far enough in advance to ensure arrival at the receiving facility at least 15 days prior to the provider's reporting date. Any documents that have not been included in the PCF, prior to its release, will be forwarded at the earliest possible opportunity. If the gaining facility has not received these documents upon the provider's arrival, immediate action should be taken to locate these sensitive files.

(2) The gaining MTF will use this documentation as the basis for initiating clinical privileging and medical/dental staff appointment actions. The PCF will include the most recent clinical performance appraisals (DA Forms 5440 and 5374), even if the provider transfers to a leadership or administrative position involving no clinical practice or to student status (para 9-5).

(3) With the release of CCQAS version 2.6, the data contained in this restricted-access data base—in conjunction with DA Forms 5374 and 5441—will facilitate the privileging of newly assigned providers. Preliminary review of credentials for privileging and medical staff appointment can begin in advance of the provider's actual arrival or the facility's receipt of either PCF.

(4) Electronic telephonic communication between facility credentials managers regarding providers in transit is likewise encouraged. The information documented as a result of these interactions may serve in place of the actual forms in the privileging process. Any credentialing/privileging action taken by the credentials committee based on other than actual documents in the PCF will be annotated in meeting minutes/reports. Verification of receipt of the document(s) in question, and that it is in order, will be noted in subsequent meeting minutes/reports.

(5) Upon arrival at the new duty station or place of employment, the provider will submit a request for renewal of clinical privileges and, if applicable, medical/dental staff appointment. The request will include the documents noted above. Transfer between AMEDD facilities is considered continuous DOD service under the same GB (TSG) and, provided the stipulations of paragraph *a*(1) above are met, renewal of provider privileges and professional staff reappointment are appropriate.

(6) The provider (AA/USAR/ARNG) will apply for privileges immediately but in no case later than 5 duty days (10 duty days for OCONUS providers) following arrival. The USAR/ARNG privileged provider will meet with the unit credentials manager as soon as possible to submit his/her credentials for review and to apply for unit-level privileges, if appropriate. All providers must be privileged prior to being involved in or assigned to patient care activities.

e. Enhanced supervision for providers.

(1) Enhanced supervision is not an adverse privileging action against a provider. It does not alter the individual's medical/dental staff appointment status nor does it reduce the provider's category of privileges as awarded by the institution.

(2) Enhanced supervision for up to 6 months (with extension granted on an individual basis) may be required when, in the best interest of quality patient care, the privileged provider's performance warrants closer attention or scrutiny. Some examples include—

(a) Following a PCS move or during a TDY to ensure full clinical competence.

(b) When privileges for a new procedure or technology are considered.

(c) For providers returning to clinical practice following an extended absence from patient care responsibilities.

(d) For the novice provider who is developing his/her clinical practice skills.

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

(4) Routine, ongoing performance assessment is the basis for all PI activities and is essential for providers with all types of medical/dental staff appointments and all categories of privileges. The credentials committee/function will recommend, for the commander's approval, the specific enhanced supervision requirements based upon the provider's needs.

(a) The requirement for enhanced supervision will be indicated in block 6e of DA Form 5440A. The provider's performance will be reviewed by the credentials committee upon completion of the specified time period for the supervision. If it is determined that the supervision is no longer required, a new annotation will be made in block 5. The appropriate credential committee/function minutes/report will reflect this decision. The provider's privileging period will not change.

(b) The requirement for supervision to determine or monitor the clinical competence of newly assigned providers, those who practice infrequently, or those requesting new privileges is not considered adverse and does not require reporting.

(c) If the period required for enhanced supervision is greater than 12 months, remedial training for the privileged provider should be considered.

(d) In contrast to the above, requirements for supervision resulting from an adverse privileging action (for example, restriction of privileges) will be reported as adverse according to the procedures outlined in paragraph 10-6f(5).

f. Formal remedial training program.

(1) When a provider with clinical privileges fails to maintain required proficiency levels to practice in his/her specialty, at the discretion of the commander, a remedial training plan designed to enhance proficiency levels may be implemented. The decision to implement a formal remedial training program must be based on the individual circumstances of the provider and any additional unit-related considerations.

(2) The formal remedial training program, as addressed here, is appropriate for AD service-obligated providers who have had their privileges either suspended or restricted by the facility commander. (See para 10-6f(5).) Providers who have had their privileges reduced or revoked are not eligible for remedial training.

(3) The unique nature of each situation necessitates an individualized approach to determining the length of the formal training, the location, and other specifics.

(4) In the interest of the privileged provider, this training is best accomplished after PCS to a new assignment or during a period of TDY.

(5) Requests for remedial training will be initiated by the provider's current MTF commander and forwarded through the next higher headquarters to Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Requests concerning dentists will be forwarded to the Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004. Specific criteria defining the expected trainee outcomes will be included as part of the request.

(6) The goals, duration, and location of remedial training will be addressed in recommendations to TSG by the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or the Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004 in consultation with the appropriate specialty consultant to TSG.

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

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

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

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

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

(9) In contrast to formal remedial training, informal training may be utilized for any category/discipline of provider/professional at any time. This is coordinated at the local level by the individual's chain of command. The USAR/ARNG provider who wishes to re-establish clinical competency may request, through his/her chain of command, an AT opportunity for skills enhancement purposes.

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

(1) If a provider requests modification of his/her clinical privileges for the upcoming period, a new DA Form 5440 will be prepared with the specific privileges to be modified appropriately coded. The requested modification may be for augmentation or reduction of privileges. If the request is for an augmentation of privileges, documentation of

appropriate education, training, and experience to support the additional privileges is required. Providers who request privileges substantially less than those of members of their specialty AOC or skill identifier (SI) will require careful evaluation and subsequent action by the credentials committee.

(2) If the modification reduces the provider's privileges, written justification will be submitted with the DA Form 5440. The credentials committee will determine if—

(a) The request is warranted and what accommodations are appropriate considering the individual's special needs associated with a medical condition or other documented situation related to performance deficit(s).

(b) The privileged provider will undergo a period of structured training. If the training is approved (does not include the formal remedial training described above), the temporary modification of privileges, if 30 days or less, will not result in an adverse privileging action.

(c) A recommendation should be made to change the provider's AOC or SI and terminate any special pay.

(d) Separation in a less-than-fully-privileged status should be recommended.

(3) A privileged provider cannot voluntarily request a modification of privileges in order to avoid an adverse privileging action. A voluntary surrender or restriction of privileges while under investigation for possible professional incompetence or unprofessional conduct, or as part of an agreement with the organization for not conducting an investigation or professional review action, will be reported to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010. Such actions may require subsequent reporting to the NPDB according to paragraph 10-12a(1).

h. GPHE participants.

(1) Supervision.

(a) Physician and dental providers with regular privileges in the same AOC or SI and an active appointment on the medical/dental staff will supervise MC/DC graduate level clinical residency and fellowship program participants. Nonphysician privileged providers in graduate clinical training programs will be supervised by a provider with the same or similar AOC/SI and regular privileges or by a physician.

(b) The degree of supervision (direct or indirect) afforded the provider in student status will be appropriate to the individual's level of progress, the risk of the procedure, and the seriousness of the patient's illness. (See para 5-3/2(a) for additional information regarding supervision of GPHE trainees.) Consultant consultation will be obtained for any patient for whom a substantial risk is implied or the diagnosis is obscure. This consultation will be documented on SF 509 (Medical Record-Progress Notes), on SF 513, or on SF 600. (See AR 40-66 for instructions on the use of these forms.) Situations that require mandatory direct supervision will be identified by the program director—in writing—and documented in writing and be provided to all those involved.

(2) *Privileges/staff appointment for eligible trainees.* Fellows and other privileged providers involved in a second residency may apply for regular privileges in their primary specialty (for example, fellows in plastic surgery who are eligible for regular privileges in otolaryngology may apply for otolaryngology privileges; eligible pediatricians in endocrinology fellowships may apply for pediatric privileges). These providers may be granted either an active or affiliate appointment according to their expected participation in medical staff activities or an initial appointment if they have not held a medical staff appointment in a DOD facility during the past 180 days.

(3) *Training credentials files (TCFs).* A TCF and a PAF will be developed and maintained during GPHE for interns, residents, and other trainees (all disciplines), in military training programs, for whom a PCF has not yet been established. The TCF will be initiated during the first year of training and will contain verified copies of diplomas, licenses, clearing house reports, training certificates, practice experience documents, curriculum vitae, and other documents, as appropriate. TCFs and PAFs will be maintained by the GME director or as indicated by the commander. Performance assessments will be conducted at least every 6 months; on an annual basis the department chief will provide a written recommendation to approve/disapprove matriculation to the next year's training level. All such assessments will be filed in the PAF. Other documentation such as letters of appreciation, patient complaints, and other reports that may lend themselves to trending or profiling the trainee's performance will also be filed in his/her PAF.

(4) *Clinical performance evaluation.* Prior to completion of the clinical training program, trainees will submit the appropriate discipline-specific DA Form 5440 through their service and department chiefs to the GPHE committee (military setting) or to their faculty advisor/preceptor (civilian setting). The trainee, based on a self-appraisal, is attesting to his/her current level of competence related to privileges appropriate to his/her specialty.

(a) One month prior to completion of the training, the trainee's clinical supervisor will complete, and the GPHE committee (or committee with comparable professional oversight authority) will authenticate, DA Forms 5441 and 5374. These documents address the trainee's professional skills, abilities, and competence and reflect recommendations for clinical privileges at the provider's subsequent duty assignment based on his/her performance during training. DA Forms 5440, 5441, and 5374 will become a permanent part of the TCF. The information contained in the TCF becomes the basis for the PCF.

(b) The GPHE committee will decide which, if any, of the interval performance assessments and other data accumulated during the training period will remain in the TCF. In instances where an MTF GPHE committee does not exist, a comparable line of academic authority must be locally established based on the availability of professional resources. The MTF commander will delegate responsibility for the duties performed by the GPHE office/committee,

for academic/clinical oversight, and for documentation of the trainee's clinical competence, as appropriate. The TCF will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. In the absence of GPHE committee, as a minimum DA Forms 5440, 5441, and 5374 will be forwarded by the supervisor through the credentials committee/function to the trainee's next unit of assignment.

(c) DA Forms 5440, 5441, and 5374 are available at Web site <http://www.apd.army.mil/>. Each corps will ensure that instructions for proper completion, authentication, and transmittal to the first unit of assignment are provided to military and GS civilian trainees enrolled in civilian GPHE/long-term health education and training clinical programs. The trainee will ensure that the completed documents are mailed by the authorized supervisor (program director/faculty member/preceptor) to the trainee's first unit of assignment (ATTN: MTF Credentials Office). These documents will not be relinquished to the trainee. The performance data contained on the DA Forms 5441 and 5374 serve as the basis for award of initial clinical privileges and professional staff appointment. Clinical performance evaluation is in addition to, and does not substitute for, the academic evaluation report that is required in accordance with AR 623-1.

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

(6) *Reporting.* The administrative management and reporting of providers who fail to complete or are removed from a training program for substandard performance or unprofessional conduct will be made according to paragraphs 9-7, 10-13, and 10-15.

i. *Formal on-the-job training (OJT).* OJT programs involve formal, structured training designed to provide knowledge and technical expertise to providers who are expected to receive privileges in a given AOC or SI or for augmentation of clinical privileges associated with new technology or a new procedure(s). The commander will require a written program of instruction, specific learning objectives, and clearly identified training outcomes for the OJT program.

(1) Providers with defined privileges in the same AOC or SI will supervise OJT trainees. The degree of supervision will be appropriate to each trainee's level of progress, the risk of the procedure, and the seriousness of the patient's illness. The trainee will obtain concurrent consultation for any patient for whom a substantial risk is implied or the diagnosis is obscure. Situations requiring mandatory direct supervision will be identified in writing by the OJT program director/coordinator, and documentation of this requirement will be provided to all those involved.

(2) Individuals progressing unsatisfactorily in a formal OJT program will be managed according to established training program procedures.

(3) One month prior to completion of training, the preceptor will complete DA Forms 5441 and 5374 which will reflect those clinical privileges warranted at the individual's MTF of assignment based on performance during training. These forms will be forwarded through the GPHE committee, if one exists, otherwise through the credentials committee, to the gaining facility. They will be forwarded by certified return receipt requested mail, to the credentials coordinator at the gaining facility to arrive 15 days prior to PCS. The gaining facility will use this information as the basis for granting clinical privileges. These forms become a permanent part of the individual's PCF.

9-5. Medical/dental staff appointment

a. Appointment to the medical/dental staff is a process distinct from that of granting clinical privileges. While similar data are considered for these concurrent procedures, they are separate recommendations to the commander by the credentials committee and must be reflected as such in the credentials committee minutes. DA Form 4691 or DA Form 4691-1, signed by the privileged provider and submitted to the credentials committee, is utilized to request clinical privileges and medical/dental staff appointment, if desired.

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

(1) An appointment to the medical/dental staff can be granted only to licensed, certified, or registered providers and it must be accompanied by the granting of clinical privileges.

(2) A medical staff appointment is required for privileged providers to admit patients to inpatient services.

(3) Medical staff membership is not required of individually privileged nonphysician providers who do not admit patients, but they may request membership, if desired.

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

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

d. The type of appointment will vary depending upon the clinical privileges granted, the availability of the provider

to the facility, and the defined role of the provider in the delivery of health care by the MTF. There are five categories of medical staff appointment:

(1) *Initial appointment.*

(a) An initial medical/dental staff appointment is granted to a provider when he/she is first assigned or employed in a DOD MTF. Or, if the provider (AA/USAR/ARNG) has not held a medical staff appointment in a DOD MTF during the previous 180 days, an initial appointment is the only appointment that will be granted. This is in the best interest of quality patient care and is not intended to reflect negatively on the individually privileged provider. The initial appointment will not exceed a 12-month period.

(b) During the initial appointment period, the privileged staff member's performance will be under review by the responsible department/service/clinic chief(s) to determine clinical competence and to evaluate the provider's knowledge and conduct with respect to the medical/dental staff bylaws, policies, procedures, regulations, and code of professional conduct. The commander will determine specific supervisory requirements for the provider when an initial appointment is granted.

(c) A provider may subsequently be granted either an active or an affiliate medical staff membership depending upon his/her type of employment or relationship with the medical/dental staff. Advancement from initial to active or affiliate appointment status is discretionary and is not a right of the appointee. Advancement will depend upon the appointee's qualifications, performance, and the needs of the facility. When an appointee is not advanced because of changing needs of the facility, the medical/dental staff appointment will expire; this is not considered an adverse occurrence.

(2) *Active appointment.*

(a) An active appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical/dental staff, according to the needs of the Government, after successfully completing the initial appointment period. A provider who has completed an initial appointment period at another MTF, and has not had a lapse of greater than 180 days, may be granted an active appointment upon arrival at the new duty station. Active appointments will not exceed a 24-month period without renewal.

(b) Medical/dental staff members with active appointments will participate fully in appropriate activities of the medical/dental staff. Active members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical staff and are responsible for being knowledgeable of the same.

(3) *Affiliate appointment.*

(a) An affiliate appointment is granted to a provider exercising regular privileges and meeting all qualifications for membership on the medical/dental staff, according to the needs of the Government, after successfully completing the initial appointment period. A provider with an affiliate appointment, due to conditions of employment, is neither assigned organizational responsibilities of the medical/dental staff nor expected to be a full participant in activities of the medical/dental staff. Affiliate appointments will not exceed a 24-month period without renewal.

(b) The category of affiliate member was created to relieve certain medical/dental staff members of the requirement to serve on medical/dental staff committees, including the ECMS/ECDS. An affiliate membership is not based on professional discipline or specialty but rather on duty requirements and commitments. Affiliate members may, therefore, be precluded from membership on the ECMS/ECDS and may be relieved of the requirement to participate in other medical/dental staff committees and activities. Affiliate members, however, will be encouraged to participate in department/service/clinic and medical/dental staff meetings and PI activities. Affiliate members will agree to abide by all bylaws, rules, regulations, policies, and procedures of the medical/dental staff and are responsible for being knowledgeable of the same. The MTF will keep affiliate members informed of changes to the bylaws, rules, regulations, policies, and procedures of the medical/dental staff.

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

(4) *Temporary appointment.* A temporary appointment is granted in emergency or disaster situations when time constraints will not allow full credentials review but when there are pressing patient care needs and a temporarily privileged provider will be admitting patients. The use of temporary appointments should be rare. The temporary appointment will be time limited and will not exceed 30 days. A complete, thorough credentials review will occur during the period of the temporary appointment.

(5) *No appointment.* Providers without a license or other authorizing document, or who have not been granted clinical privileges, will not be appointed to the medical/dental staff. These providers do not share medical/dental staff responsibility to the GB for medical/dental staff surveillance, review, and quality improvement activities within the MTF; they are not authorized admitting privileges.

e. When a provider is privileged and appointed to the medical/dental staff, if applicable, the commander will advise the provider—in writing—of his/her defined privileges and the medical staff appointment that has been granted. DA

Form 5440A will be utilized for this purpose, with or without a cover memorandum (fig. 9-1). The provider will acknowledge receipt of the privileges and professional staff appointment, if applicable, by signed memorandum.

9-6. Provider privileging for TDY and other actions involving the PCF

a. Provider TDY.

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

(2) The ICTB, which serves in place of documents contained in the PCF, is joined with the formal application for privileges (DA 4691 or DA Form 4691-1) and supplants sections of these forms containing essentially like information. Every effort must be made to avoid unnecessary duplication of information in the privileging of temporarily assigned providers. (See app H for guidance on the preparation of the ICTB.)

(3) When privileges are requested other than those granted at the sending facility, additional documentation will be provided supporting these new privileges (for example, training documentation or privileging and evaluation documentation from another hospital). The gaining facility will review this documentation, in addition to the ICTB, to evaluate the provider's competencies and to determine what privileges will be granted.

(4) After customary departmental/service/clinic and credentials committee review and recommendation, and consideration of the facility's capability, the gaining MTF commander may grant privileges, with or without modifications, based on the approved privilege list from the sending MTF/unit. The gaining facility will use DA Form 5440A for notifying providers of their clinical appointments and for documenting the same. Privileges applied for but not granted, due to facility-based limitations, are not adverse privileging actions.

(5) The ICTB becomes invalid upon expiration of the clinical privileges and professional staff appointment (sending facility) on which it is based. If the provider is assigned temporarily for several brief periods to the same location, the ICTB remains valid over the duration of the combined periods, provided the clinical privileges and medical/dental staff appointment (if applicable) at the sending MTF remain active. If other credentials have expired in the interim, telephonic or message confirmation of the renewal of the credential(s) with the facility holding the PCF will suffice. A new ICTB is not required. A record of the telephone call or the message confirmation will be maintained in the PCF at the gaining facility. The sending facility will keep an accurate record of each MTF to which an ICTB is sent to ensure updates on provider status are forwarded as required. The sending MTF will provide a new ICTB whenever the provider's privileges change (for example, renewal of privileges, adverse privileging actions, and so forth).

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

b. *Administrative assignment.* If the privileged provider is assigned to a position involving no clinical practice (for example, USAMEDCOM, MRMCM, AMEDD Center and School) or attends a civilian or military school (other than GPHE or other graduate level training for which clinical privileges are required), the PCF and CCQAS provider file will be forwarded to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, for other than DC providers. Dental officer files will be sent to Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004. These files will be held until requested. If the provider applies for privileges at a local MTF while in an academic or administrative position, the facility credentials manager will request the PCF for clinical privileging and medical staff appointment, if appropriate.

c. *Academic assignment.* For those attending military graduate medical/dental education, or other graduate level professional health education, the PCF and CCQAS provider file will be forwarded to the military facility conducting the internship, residency, or fellowship training. For those attending civilian graduate medical or dental education, the losing facility will send a copy of the PCF, by certified return receipt requested mail, to the civilian institution and the original, along with the provider's CCQAS file, to the appropriate command as identified in paragraph a above.

9-7. Separation of privileged providers

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

b. *Civilian.* A civilian provider's failure to attain or to maintain the required proficiency may be the basis for separation from Federal service. Commanders will consider separation under one of the following three options, each of which requires close coordination and consultation with the servicing CPOC/CPAC, as appropriate:

(1) *Separation during probation.* If the GS provider is serving as a new DOD employee under a probationary appointment (initial competitive appointment, typically a 365-day period), he/she may be separated under the provisions of Section 315.804, Title 5, CFR. Such an action should be completed before the end of the last duty day prior to the provider's 365th day following appointment. For providers who are in a probationary status, this is the preferred

course of action. Close scrutiny of employees during their first year of employment is encouraged to identify potential clinical practice problems.

(2) *Separation based on performance.* This option is based on poor performance of one or more critical elements in a provider's performance plan and need not include a loss of privileges. This action is taken under the provisions of Title 5, Part 752, CFR. Organizational leadership must be aware of significant employee rights to include rights to notice, opportunity to improve, and opportunity to seek external review.

(3) *Separation based on loss of qualifications.* This alternative is based on the fact that the provider is no longer qualified to perform the duties of the position to which he/she was appointed or when misconduct or malfeasance is the issue. This option may also be exercised if provider misconduct or malfeasance is the issue. (The misconduct must be related to the individual's ability to perform the duties of the position, that is, the "nexus" requirement.) In this instance, there are significant employee rights to notice, hearing, representation, and appeal beyond the agency.

9-8. USAR/ARNG privileging procedures

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

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

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

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

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

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

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

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

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

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

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

(a) IRR and IMA members. Commander, HRC, ATTN: AHRC-SG, 1 Reserve Way, St. Louis, MO 63132-5200.

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

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

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

e. Remote site training, medical site support, and tactical exercise support.

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

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

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

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

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

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

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

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

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

d. Evaluation of USAR/ARNG providers/activities.

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

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

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

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

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

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

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

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

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

OFFICE SYMBOL (640-10e)

(Date)

MEMORANDUM FOR (Applicant's Name, Department/Service)

SUBJECT: Clinical Privileges and Medical Staff Appointment Status

1. Your application for clinical privileges and medical staff appointment at (MTF name) was reviewed by the credentials committee at the (date) meeting. Based on review and recommendations of that committee and the executive committee of the medical/dental staff, and approval by the commander, (MTF name), clinical privileges are granted as specified at enclosure (DA Form 5440-XX, Delineation of Clinical Privileges).
2. You are granted (specify category) privileges for the period (date) through (date) as specified on DA Form 5440-XX.
3. You are granted a/an (specify status) appointment to the medical staff for the period (date) through (date), as indicated on DA Form 5440A.
4. Two copies of this memorandum and attachments are provided. Please acknowledge receipt on the attached memorandum and return the original to the Credentials Office. The second copy of the memorandum, a copy of your delineated privileges (DA Form 5440-XX), a copy of the approval of clinical privileges/medical staff appointment (DA Form 5440A), and a copy of the plan of supervision, if applicable, are provided for your files.

Encls

1. DA Form 5440-XX
2. DA Form 5440A
3. Plan of supervision (if applicable)

Signature Block
Credentials Manager

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

S: (Suspense date)

PROVIDER'S OFFICE SYMBOL (640-10e)

date

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

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

I hereby acknowledge receipt of a copy of DA Form 5440A granting me clinical privileges (to include/but not to include admitting privileges) and (appointment to the medical staff). A listing of my approved clinical privileges (DA Form 5440-XX) (and plan of supervision) as addressed in the memorandum from the commander has also been provided. I understand that I am granted 10 duty days from receipt of this memorandum to appeal the commander's decision, should I disagree.

(Signature of Provider)

(Typed Name)

(Grade, Corps)

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

Chapter 10 Adverse Clinical Privileging/Practice Actions

10-1. General

This chapter describes the management of adverse privileging/practice actions for privileged providers and other professionals. The process has four steps: investigation, professional peer review, hearing, and appeal. The term, "provider" is used for individuals granted clinical privileges. In select instances, information contained in this chapter may also apply to the nonprivileged professional. In those instances, the term, "professional" will be used. (See chap 6 for adverse practice action and peer review information regarding nonprivileged personnel.)

10-2. Command responsibility

a. Action taken on the part of the commander against a provider's privileges (professional's scope of practice) may be warranted based on performance suspected or deemed not to be in the best interest of quality patient care. These actions include holding in abeyance, denying, suspending, restricting, reducing, or revoking clinical privileges/practice. The action taken may be immediate (summary) in the event of a critical incident or as a result of the credential committee's deliberation (routine) on information made available through CQM reporting channels.

b. The commander's prerogative to hold in abeyance, to deny, or to summarily suspend clinical privileges/practice is exercised when there is reasonable cause to doubt the individual's competence to practice or for any other cause affecting the safety of patients or others. Reasonable cause includes—

- (1) A single incident of gross negligence.
- (2) A pattern of inappropriate prescribing.
- (3) A pattern of substandard care.

- (4) An act of incompetence or negligence causing death or serious bodily injury.
- (5) Abuse of legal or illegal drugs or diagnosis of alcohol dependence. (See chap 11.)
- (6) Documented alcohol or other drug impairment and the individual refuses/fails rehabilitation or a psychiatric disorder that is not responsive to treatment.

(7) Significant unprofessional conduct.

c. The specific intent of all those involved in any adverse action against a provider's privileges (adverse practice action for the professional) should be—

- (1) To protect the safety and well-being of all patients for whom health care is provided.
- (2) To safeguard the quality and efficiency of care delivered within the AMEDD.
- (3) To protect the rights of the individual(s) in question (afford due process).
- (4) To ensure timely resolution of the issues related to provider/professional performance.
- (5) To separate the professional actions and considerations from any associated administrative or legal considerations.
- (6) To allow timely reporting of individuals to professional regulatory agencies, if required.

d. When an MTF closes, careful attention will be given to the disposition of adverse privileging/practice action information. Records will not be destroyed. The credentials manager at the closing facility will forward all files, reports, and adverse privileging/practice actions information (archived and active) to the RMC/RDC. The RMC/RDC assumes responsibility for the resolution of any pending adverse action cases (privileging/practice or administrative) and the maintenance of all records, files, and reports.

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

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

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

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

Note. For any adverse privileging/practice action that involves the USAMEDCOM/USADENCOM, the USAMEDCOM, Office of the Staff Judge Advocate will review the case file for legal sufficiency prior to final action by TSG.

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

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

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

a. Adverse privileging/practice actions addressed in this chapter and any related administrative or legal actions must be handled separately. MTF and RMC/RDC commanders must ensure that, when appropriate, adverse privileging/practice action is taken and that the associated procedures are managed in a timely manner.

b. An adverse privileging/practice action is considered appropriate when there is evidence of incompetence, unprofessional conduct, or impairment and the provider/professional refuses to voluntarily modify or relinquish his/her privileges/scope of practice. For example, evidence may include deficits in medical knowledge, expertise, or judgment (competence); unprofessional, unethical, or criminal conduct (serious misdemeanor or felony) (conduct); or mental health disorders or alcohol/drug impairment (condition) that reduce or prevent the individual from safely executing his/her responsibilities in providing health care.

c. If an acute or chronic medical problem, mental health condition, or alcohol/drug impairment interferes with the provider's/professional's performance of clinical duties, the individual will submit a request to appropriately modify his/her privileges or scope of practice. This is considered an administrative action not an adverse privileging/practice action. The request with supporting evidence/information and the appropriate DA Form 5440 reflecting the modified privileges will be submitted according to local privileging procedures. The DA Forms 5441 and 5374 will be processed

in the same manner as any other request for change of clinical privileges. See chapter 11 for further information regarding privileging actions and impairments.

d. Actions that do not meet these stated criteria may warrant authorized administrative or legal attention and action, as appropriate.

e. If warranted, adverse privileging/practice action must be taken regardless of the individual's affiliation with the organization (for example, contracted employee, volunteer) or duty status within the MTF.

f. Severing the employment relationship (to include PCS, separation, or retirement) in lieu of taking the adverse privileging/practice action that is indicated is not appropriate.

g. In situations involving illegal activity (for example, narcotics pilfering, physical/sexual abuse of a patient, and so forth) the CJA will be notified and an adverse privileging/practice action initiated as soon as possible following initiation of the Criminal Investigation Division (CID) investigation. Concurrent action by the CID and the MTF will facilitate timely notification to outside agencies of those individuals for whom such notice is warranted. No reporting to regulatory agencies by the USAMEDCOM will occur until final resolution of the CID investigation and all relevant information concerning the incident is available to TSG.

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

a. *Individuals providing implicating information.* The AMEDD will make all reasonable efforts to protect the identity of persons who offer information that may result in an adverse privileging/practice action against another provider or professional. For example, the name of the individual providing information will be protected unless the due process rights of the provider/professional who is the subject of the action require disclosure or if disclosure is deemed appropriate pursuant to a request under the FOIA. No disciplinary action, punishment, or any form of retaliatory action will be taken against a person who submits information concerning a provider/professional unless it is later determined that the information was false and the person providing the information acted maliciously.

b. *Allegations involving providers/professionals separated from service.* Any allegations of substandard performance or misconduct reported to have occurred prior to an individual's separation from Federal service must be investigated, even though the individual in question is no longer on AD or employed by the Federal Government. The responsibility for investigating these situations, which may result in a provider/professional adverse privileging/practice action, will remain with the MTF in which the alleged substandard performance or misconduct occurred, with assistance as necessary from the RMC/RDC. The MTF will notify the provider/professional of the allegations under review and will afford the individual the opportunity to supply information on his/her behalf. If the MTF is no longer operational, the RMC/RDC will assume these responsibilities.

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

d. *Use of time lines.* Time lines will be specified in calendar days for actions required of the command and in duty days (that is, actual working days for the individual involved) when related to corresponding actions required of the provider/professional. If the final day for any specified time line falls on a weekend or Federal (or training) holiday, the time line will be extended to the MTF's next business/duty day. The time lines are established to allow the individual in question adequate time to prepare for and sufficiently participate in the proceedings and to facilitate timely resolution of the adverse privileging/practice action. While it is important that the time limits reflected in this regulation are met, no rights will accrue to the benefit of an affected provider/professional, in an otherwise proper action, based solely on the organization's failure to meet such time limits.

e. *Withdrawal of permission to engage in off-duty employment.*

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

(2) Notification in response to abeyance of privileges/practice is at the commander's discretion.

(3) The commander must revoke permission for off-duty health-care-related employment if an individual has been indicted or titled for any of the acts of unprofessional conduct listed in appendix I.

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

(5) Any new application for off-duty employment submitted during an adverse privileging/practice action review will not be approved until the privileges/practice duties of the individual have been restored.

f. Information to State and other regulatory agencies. Every effort must be made at the local level, and by appropriate USAMEDCOM QMD staff, to assist in the investigation of the incident(s) by State boards or other regulatory agencies. Information made available to licensing/regulatory bodies will be provided only by the USAMEDCOM QMD. The MTF documentation submitted to the USAMEDCOM (for example, DD Form 2499, other supporting data) should be as complete and accurate as possible to facilitate appropriate action against the individual's license by the State licensing or other regulatory agencies. Should the State/regulatory agency require additional facts to fairly evaluate the provider/professional in question, the USAMEDCOM will assist by contacting the facility-level POC who has credible knowledge of the situation being reported.

10-6. Invoking an adverse privileging/practice action

When a provider's conduct, condition, or performance requires action to protect the health or safety of patients, his/her clinical privileges/practice will be placed in abeyance or suspended while a thorough and impartial investigation is conducted. The fact-finding period allows time to gather and carefully evaluate additional information regarding the situation prior to initiation of an adverse privileging/practice action, if deemed appropriate.

a. Abeyance.

(1) An abeyance is not an adverse privileging/practice action. However, the individual is formally placed "on notice" that scrutiny of his/her practice has begun which may result in an adverse privileging action or other administrative action. The commander, DCCS, or department chief may take this action against a provider/professional.

(2) An abeyance action is taken by the appropriate authority when an evaluation of performance appears warranted, but information is insufficient to suspend privileges/practice or the potential hazard to patients or patient care is not well defined. In any case, prudence dictates that the individual not be permitted to render patient care. During the period of abeyance the provider is assigned to nonclinical duties until the investigation is complete. DD Form 2499 will be initiated and forwarded (for informational purposes only) to the USAMEDCOM QMD, with copy furnished to the RMC or other higher headquarters, as appropriate.

(3) An abeyance is valid for 15 calendar days and may be extended by the commander, if required, provided the total period of abeyance does not exceed 30 calendar days. On the 31st day, if the abeyance is not closed, the action automatically becomes a summary suspension of clinical privileges/practice. This is a temporary action. Once the case is closed, all documentation associated with an unfounded abeyance action will be destroyed.

(4) An abeyance that is not resolved when the individual terminates his/her relationship with the MTF (that is, resigns his/her position or is released from AD) automatically becomes a suspension of privileges. This is considered a final action and the suspension of the provider's privileges/practice will be reported as outlined in chapter 14.

b. Suspension. There are two types of suspension associated with clinical privileges: summary suspension (a temporary action) and suspension (a final privileging action).

(1) Summary suspension of clinical privileges/practice is a temporary removal of privileges (full or partial) that is used to limit a provider's/professional's practice while the investigation and due process procedures are conducted or while performance reevaluation, targeted training, or rehabilitation is completed.

(a) As noted in paragraph *a(3)* above, a summary suspension is automatically imposed following 30 calendar days of abeyance, if the fact-finding procedures and related actions have not been completed. Every effort must be made to conclude the investigation in a timely manner in order to reinstate the individual's privileges/practice, if warranted, or to proceed with other appropriate interventions or an adverse privileging/practice action.

(b) In cases where the individual's misconduct, professional incompetence, or negligence is obvious and this poses a clear and evident threat to the safety of patients or the well-being of others, instead of an abeyance, a summary suspension of clinical privileges/practice should be the initial course of action.

(2) The commander will invoke the summary suspension of clinical privileges/practice. This immediately details the individual in question to nonclinical duties. Specific instructions to the provider/professional related to his/her duty will be included in the commander's written notification of suspension. A summary suspension of privileges/practice will last only as long as needed for other definitive adverse privileging/practice action (that is, restriction, reduction, suspension, denial, or revocation) to be taken. While these actions, if longer than 30 days in duration, are reportable to the NPDB (see para 14-3b), summary suspension of clinical privileges within the DOD is not reported to the NPDB. DD Form 2499 will be initiated (informational purposes) and forwarded to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with copy furnished to the RMC or other higher headquarters, as appropriate. At the conclusion of the period of summary suspension, if the case is unsubstantiated or unfounded, all documentation associated with this action will be destroyed. No information concerning this incident will be entered into the PCF.

(3) A suspension of privileges (final determination) is an adverse privileging action and, therefore, must be identified as such. Suspensions must be disclosed when applying for future privileges, licensure/certification/registration, or malpractice insurance. The suspension must be disclosed even if subsequent action results in reinstatement. Explanation of the reasons for the suspension and its final outcome may be offered by the provider/professional at the time of disclosure.

c. Notification procedures.

(1) Privileged provider or professional.

(a) The individual will be notified in writing within 14 calendar days that his/her clinical privileges/practice have been placed in abeyance/summary suspension. The memorandum (see fig 10-1)—delivered in person or by certified return receipt requested mail—will state the basis for the abeyance/summary suspension, the duration of the action, that a QA investigation will be conducted, and that the results of the process will be reviewed by the credentials committee.

(b) If only a portion of the provider's clinical privileges or professional's scope of practice are being placed in abeyance/summary suspension, the notification letter must state this.

(c) In addition, the notification must state that an abeyance not resolved within 30 calendar days (or when the individual terminates his/her relationship with the MTF) will become a summary suspension.

(d) The notification letter should also explain the implications of leaving military service or Federal employment while a privilege/practice action is underway. (See para a(4) above.) The provider will acknowledge receipt of this notification by signed memorandum. (See fig 10-2.) If the provider refuses to sign the memorandum, a responsible official may indicate "refused to sign" where the signature would normally appear.

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

(a) The MTF commander will notify the USAMEDCOM and the next higher headquarters when a provider's privileges/professional scope of practice have been either placed in abeyance or summarily suspended. Notification utilizing DD Form 2499 will be made within 3 working days.

(b) Other available information regarding any egregious situation of a sensitive or a potentially notorious nature, any incident of gross negligence, and any act of incompetence or negligence causing death or serious bodily injury (an SE), or allegations thereof, will be transmitted electronically to the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010, with copy furnished to the RMC or other higher headquarters, as appropriate.

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

d. The CQM QA investigation.

(1) In cases of abeyance or summary suspension of clinical privileges/practice, there will be an immediate and rigorous investigation to collect the relevant facts and information. Every effort must be made to ensure a thorough, fair, honest, and unbiased review of the matter(s) under investigation.

(a) The MTF commander (designee) will appoint an officer (a disinterested third party), pursuant to the authority of this regulation, to conduct the investigation and to report the results to the credentials committee or for nonprivileged individuals to the department/service chief.

(b) The investigating officer may testify at any hearing conducted following the investigation and may be required to provide clarifying information or respond to questions from the credentials committee, as appropriate. However, if the individual is a member of the credentials committee, he/she is disqualified from any formal committee vote on this matter.

(c) To ensure a comprehensive, independent review of the event, the MTF commander may request that a provider/professional with the appropriate specialty background and credentials be made available from the next higher headquarters, or from another Service, to conduct the investigation.

(d) To maximize the objectivity of the process, a recognized, unaffiliated civilian specialist may be requested, if practical, to actively participate in the investigation.

(2) The investigation may include voluntary consultation with the individual in question, review of any relevant documents, or discussions with other individuals having knowledge of the situation.

(a) When the investigation is complete, the report submitted by the investigating officer will present the factual findings with appropriate justification or details and may include the investigating officer's conclusions or recommendations.

(b) In select circumstances, the commander need not wait until the conclusion of the investigation to return the provider to clinical duties. If the early phases of the investigation clearly indicate the absence of substandard performance or other problems, the credentials committee should meet, review the preliminary details of the investigation, and advise the commander of such without delay. In situations where provider misconduct or malfeasance may be apparent or suspected, the commander will be notified immediately. Other action (for example, Article 32 or AR 15-6 investigation) on the part of the commander may be appropriate. The servicing Judge Advocate shall be consulted.

Note. For nonprivileged professionals, information regarding the CQM QA investigation is returned to the department/service chief. The credentials committee is involved in direct management of privileged providers only. See chapter 6 for information regarding nonprivileged professional peer review mechanisms.

e. Credentials committee action.

(1) At the conclusion of the investigation, the credentials committee will review and carefully consider the investigative officer's report. The report, along with other information collected, is the basis of the peer review that may be warranted and subsequent recommendations to the commander for adverse privileging action against the provider.

(2) After reviewing the CQM QA investigation report and/or other pertinent information, the credentials committee chairperson may recommend to the commander that—

(a) No further action be taken (that is, the evidence available did not warrant a privileging action) and the provider's clinical privileges in abeyance be fully reinstated.

(b) The provider's clinical privileges currently held in abeyance be summarily suspended pending a formal peer review.

(c) A peer review panel be convened to evaluate the available information and to determine if the SOC was met. This function may be conducted under the auspices of the credentials committee or the RM committee as is customary for the organization and according to local policy. The appropriate authority, according to local policy, will ensure that the provider receives written notification of the forthcoming peer review (fig 10-3) and is advised of his/her rights to due process.

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

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

(1) *The intent.* When a provider's privileges have been summarily suspended (or otherwise adversely affected), a peer review (internal or external) will be conducted to evaluate the provider's performance, conduct, or condition to determine the extent of the problem(s) and to make recommendations through the credentials committee to the commander.

(a) To avoid the possibility of bias, those individuals who are involved in the peer review (for SOC determination or evaluation of the provider's conduct, condition, or competence) should not participate as voting members for subsequent credentials or RM committee actions involving the named provider.

(b) The professional review by a committee of the provider's peers must focus on how the action under review impacts the provider's ability to practice clinically.

(c) The provider in question does not have the right to be present during the proceedings; however, he/she shall have the opportunity to provide a written statement regarding the events under review, to appear before the committee and make a verbal statement, to clarify issues in the case as needed, to ask questions, and to respond to questions from the committee.

(d) The provider is encouraged to consult with legal counsel at any step in an adverse privileging action; however, the peer review is not a legal proceeding.

(2) *Provider notification of a scheduled peer review.* The individual in question will acknowledge receipt of notification of forthcoming peer review, using a format similar to the memorandum acknowledging notification of abeyance/summary action. (See fig 10-2.) The written notification to the provider, within 14 calendar days of the decision to conduct the peer review, will contain—

(a) The date, time, and location of the peer review.

(b) A statement of the alleged facts, events, conduct, or omissions subject to review. To maintain the confidentiality of any patients who may be associated with the evaluation of the individual's conduct or performance, the patient's hospital admission number or initials will be used.

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

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

(e) Reference to the MTF peer review policy for additional guidance.

(3) *Peer review panel composition.* The provider peer review panel must be comprised of an odd number of members, except as noted in paragraph (4) below.

(a) One person will be designated as the chairperson/facilitator.

(b) The members will be of similar background, grade, years' experience in the same professional capacity/specialty, and so forth as the provider in question. Panel members may be brought in from other MTFs to meet this requirement (that is, to conduct an internal peer review) or the case file and all supporting documentation may be forwarded to another MTF (military or civilian) for an external peer review to be performed. Local policy will stipulate the circumstances under which an external peer review is required. The peer review panel may also be convened by audio/video-conference if there are insufficient qualified providers in a given location to perform this function.

(c) Except in cases of an unfounded or unsubstantiated abeyance action or summary suspension of a provider's privileges, the credentials manager will maintain an administrative file containing the peer review documentation associated with an adverse privileging action for possible future reference. The Army Records Information Management System (ARIMS) retention schedule at <https://www.arims.army.mil/specifies> the period of time this record may be kept at the MTF. Documents retained in this file may include: list of references used; list of documents reviewed; list of personnel interviewed; inventory of documents reviewed and returned; a confidentiality statement to be signed by each of the panel participants; or the commander's letter of appointment to the peer review for each member. All documentation associated with an unfounded abeyance action or summary suspension will be destroyed.

(4) *Impartiality of the peer review participants.* This review process is a function of the provider's peers. Personnel

participating in this process must be able to impartially review the case and render an objective decision at the conclusion of deliberation. The following individuals should not be voting participants in the peer review of the provider in question:

(a) The individual's direct supervisor.

(b) Providers for whom the individual is the supervisor, to include immediate or senior rater for OERs or endorsing official for civilian performance appraisals.

(c) The individual who suspended the provider's privileges or who recommended administrative or legal action against the provider in this case or previous cases.

(d) Any person who investigated the case.

(e) Any person whose testimony plays a significant part in the case.

(f) Any member who is participating, or has participated, in other administrative proceedings (courts-martial board or administrative review board) involving the provider in question.

(g) Any member who is reviewing, or has reviewed, the provider's actions under consideration by the credentials committee.

(h) The credentials/RM committee chairperson.

(5) *Recommendations regarding clinical privileges.* The conclusions reached should be readily supported by rationale that specifically addresses the issues for which the peer review was conducted. Minority opinions and views of the peer review panel will be considered and appropriately entered into the record of the panel's activities. If additional information is required, the case may be referred back for further action to the individual(s) who conducted the inquiry. The peer review panel considers the information from the CQM QA investigation and any other relevant facts and makes recommendations to the credentials committee regarding the provider's clinical privileges. One of the following recommendations may be made:

(a) *Reinstatement.* The return of privileges to the original privilege state. Reinstatement may include provisions for provider M&E with stipulations as to the nature and duration of the M&E. This is not an adverse privileging action; it is not reportable to regulatory agencies, and no hearing or appeal is offered. If M&E exceeds 30 days, this is deemed a conditional reinstatement of privileges and will be reported by the USAMEDCOM QMD to the appropriate State/regulatory agencies.

(b) *Suspension.* The temporary removal of all or a portion of a provider's privileges resulting from incompetence, negligence, or unprofessional conduct. (See para b(3) above.)

(c) *Restriction.* A temporary or permanent limit placed on all or a portion of the provider's clinical privileges. The provider may be required to obtain concurrence before providing all or some specified health care procedures within the scope of his/her license, certification, or registration. The restriction may require some type of supervision.

(d) *Reduction.* The permanent removal of a portion of the provider's clinical privileges. The reduction of privileges may be based on misconduct, physical impairment, or other factors limiting a provider's capability.

(e) *Revocation.* The permanent removal of all clinical privileges and termination of the provider's patient care duties. In most cases, this action will be followed by administrative procedures to terminate the individual's DOD services. This action can only be taken after the provider has been afforded hearing rights. (See para 10-7.) Prior to the hearing, the MTF may decide/notify/refer to this only as an intent to revoke clinical privileges/practice.

(f) *Denial.* Refusal of a request for privileges due to substandard performance, professional misconduct, or impairment. This may occur at the time of initial application for privileges or when renewal of privileges is requested.

(6) *Credentials committee recommendations to the commander.* Within 7 calendar days of completing the peer review process, the panel's recommendation(s), along with the case evidence, will be forwarded to the credentials committee. Following any additional review of the facts of the case, the credentials committee will include its recommendation(s), which may or may not coincide with those of the peer review panel, and the entire case file with recommendations is forwarded to the commander.

(7) *Action by the commander.*

(a) The commander has 14 calendar days from receipt of the recommendation(s) to review and to decide what privileging action to take based on the facts provided. The commander is not bound by the recommendations of the credentials committee or the peer review panel.

(b) The commander will provide written notification to the provider of the privileging action to be taken and the justification for this action addressing all specified allegations (fig 10-4). If the provider is a contractor, a copy of the notification is forwarded to the responsible contracting office, and a letter documenting these actions is provided to the contractor at the address of record.

(c) If the proposed action is to deny, suspend, restrict, reduce, or revoke the provider's privileges, the commander must advise the provider in writing of his/her hearing and appeal rights. The commander must address in the notice to the provider the specific allegations that constitute grounds for the hearing and will include relevant dates and copies of patient records that are pertinent to the hearing.

(d) For providers whose privileges have been restricted to the extent that they are no longer performing the full range of normal duties in their specialty practice, follow-on administrative action may be required.

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

2. If the provider is to be retained on AD, appropriate personnel or administrative action will be taken to change his/her AOC or SI and discontinue specialty pay. The MTF commander will make his/her recommendation through the RMC, through the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 to HRC (ATTN: TAPC-OPH appropriate career branch), 200 Stovall Street, Alexandria, VA 22322-0417. The DTF commander will make his/her recommendations through the RDC, through Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004 through the Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 to HRC (ATTN: TAPC-OPH appropriate career branch), 200 Stovall Street, Alexandria, VA 22322-0417. See paragraph 10-16e for guidance regarding USAR/ARNG personnel.

g. Other credentials committee actions.

(1) In the case of suspected drug or alcohol involvement, a member of the impaired health care personnel committee (IHPCPC) will be appointed to the ad hoc group that will conduct the peer review. (See chap 11.)

(2) The credentials committee will ensure that peer review findings are considered when provider-specific credentialing and privileging decisions are rendered and, as appropriate, in the organization's PI processes. Summary peer review conclusions will be tracked over time and any PI actions based on these conclusions will be monitored for effectiveness.

(3) The credentials committee is responsible for executive oversight and analysis of aggregate data related to all adverse privileging/scope of practice actions within the organization. Privileged provider data are contained in credentials committee minutes. For the nonprivileged health care professional, a copy of the CQM QA investigation, peer review activity, and the subsequent recommendations for action provided to the commander, will be forwarded by the appropriate department chief to the credentials committee.

10-7. Provider hearing rights

a. Written notice of hearing rights. Notification of the commander's decision for action against a provider's privileges will be delivered to the provider, either in person or by certified return receipt requested mail (fig 10-4). The notification will be made as soon as is practical but in no case later than 14 calendar days after the recommendations are made by the credentials committee to the commander. The same written notification requirement and time line exist when the CQM QA investigation suggests reasonable cause. When the commander's proposed action is to deny, suspend, restrict, reduce, or revoke the provider's privileges, the following requirements apply.

(1) The written notice to the provider will specify the deficiencies substantiated by the peer review process, the proposed adverse privileging action to be taken by the commander, and the right of the provider to request and to be present at a formal hearing.

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

b. Provider participation. If the provider wishes to request a hearing, he/she will have 10 duty days, from date of receipt of the notification of recommended adverse privileging action, to respond in writing to the credentials committee chairperson.

(1) Prior to the hearing, the provider will have access to all information that will be presented for consideration at the hearing.

(2) The provider may voluntarily waive his/her right to a hearing. This decision is final and not subject to appeal.

(3) If the provider waives his/her right to a hearing, recommendations from the credentials committee (and peer review panel if this review was conducted) will be forwarded to the MTF commander for review and decision. A copy of the commander's decision regarding the adverse privileging action and the provider's notice of said action will be filed in the PCF.

(4) Waiver of hearing and appeal rights will result in a report to the NPDB according to paragraph 14-3b.

(5) Failure on the part of the provider to request a hearing, or failure to appear at the scheduled hearing (absent good cause), constitutes waiver of hearing and appeal rights. At the request of the provider, the commander will determine the existence of good cause.

(6) If the provider is unable to appear in person at the hearing due to unusual or urgent circumstances, alternate means of obtaining his/her personal participation will be offered (for example, written deposition, telephone conference call).

10-8. Hearing board procedures

a. The senior member of the hearing board will be designated as the chairperson. Members of the hearing board shall be individuals who were not involved in the peer review of the provider in question.

(1) The hearing is administrative in nature. Therefore, the rules of evidence prescribed for trials by courts-martial or

for proceedings in a court of law are not applicable. For further guidance, see AR 15-6, paragraph 3-6. If criminal misconduct is suspected, the president of the board will seek the advice of the servicing judge advocate before proceeding.

(2) The committee will be fully informed of the facts to allow an intelligent, reasonable, good faith judgment. The committee may question witnesses and examine documents, as necessary, to collect pertinent information.

(3) For procedural guidance on how to conduct the hearing, AR 15-6 may be consulted, but its provisions are not mandatory.

b. The chairperson of the hearing board will advise the provider in writing (fig 10-6), delivered in person, with provider receipt acknowledged by signed memorandum (fig 10-7), or by certified return receipt requested mail, of the following:

(1) The adverse privileging action under consideration that is the grounds for the hearing; any specific dates, facts; and all pertinent documents applicable to the case.

(2) The time and location of the hearing. The hearing should convene within 10 duty days (not less than 5 days but not more than 10 days) from the provider's receipt of the hearing notification unless extended for good cause by the hearing board chairperson. For USAR/ARNG providers, the hearing will be convened within 30 calendar days of provider notification.

(3) The names of the witnesses who will be called to testify at the hearing.

(4) His/her right to be present, to submit evidence, to question witnesses called, and to call witnesses on his/her behalf. The provider should be advised that he/she is responsible for arranging the presence of his/her witnesses and that failure of such witnesses to appear will not constitute a procedural error or basis for delay of the proceedings.

(5) The right to consult legal counsel. Providers whose personnel status entitles them to receive legal assistance may contact their servicing office of the SJA for legal advice if desired. Legal representation in this matter is not an entitlement but may be provided subject to resource limitations as determined by the supervisory judge advocate in the office of the SJA or Trial Defense Service. Providers may obtain advice or representation from civilian counsel at no expense to the Government. To determine if a provider is eligible to receive legal assistance, consult AR 27-3.

c. The provider is encouraged to consult with legal counsel or any other representative. Civilian counsel obtained by the provider will be at no expense to the Government. Such representatives may attend and advise the provider during the hearing and, subject to the discretion of the hearing committee chairperson, they may be permitted to explain the soldier's position in this matter (if the individual agrees). They will not be permitted to ask questions, respond to questions on behalf of the provider, call or question witnesses, or seek to or enter material into the record.

d. During a hearing involving a civilian provider, the exclusive representative of the appropriate bargaining unit (union or contract agency) has the right to be present, if requested by the provider, under the following conditions:

(1) When a civilian provider as a member of the bargaining unit is the subject of the proceedings or a requested witness.

(2) When the civilian provider reasonably believes that the investigation could lead to disciplinary action. Unless specifically required by the collective bargaining agreement, there is no requirement to advise the employee that the representative could be present under these circumstances.

(a) If the civilian provider requests the presence of the exclusive representative, a reasonable amount of time will be allowed for this to be accomplished. The servicing CPOC/CPAC, as appropriate, and labor union counselor will be consulted before denying such a request.

(b) The role of the exclusive representative is not wholly passive, although he/she will not be permitted to make the proceedings adversarial.

(c) Subject to the discretion of the hearing board chairperson, the exclusive representative may be permitted to explain the employee's position in this matter (if the employee agrees) or to persuade the employee to cooperate in the proceedings.

e. The hearing board will review all the material presented, including that submitted by the provider. The chairperson will arrange for the orderly presentation of information and will rule on any objections made by the provider.

(1) If criminal misconduct, including dereliction of duty, is known or suspected, the chairperson of the hearing board will advise the provider of his/her rights, using DA Form 3881 (Rights Warning Procedure/Waiver Certificate). (See AR 190-30 for instructions on the use of this form.)

(2) If an investigating officer was designated (para 10-6d(1)), he/she may present exhibits and testimony to the hearing board. The investigating officer will not participate in board deliberations.

(3) The hearing is considered a formal procedure and, as such, a verbatim transcript of the proceedings will be made. Coordination will occur with the servicing SJA for a DA court reporter (military or civilian) to be present, if available. If a reporter is unavailable, a secretary must record the proceedings. MTF funds may not be expended to hire a contract reporter. Because the hearing is considered a QA activity, covered by 10 USC 1102, no recording devices, other than that used by the court reporter or secretary to prepare the record, will be permitted in the hearing room.

f. Following the presentation of all evidence and relevant information, the provider being examined will be excused, and the hearing board will determine the findings and recommendations to be made through the ECMS/ECDS (AA facilities and USAR/ARNG units wherever feasible) to the commander.

Note. Each of the board's findings must be supported by a preponderance of the evidence. Each finding must be supported by a greater weight of evidence than supports a contrary conclusion, that is, evidence which, considering all evidence presented, points to a particular conclusion as being more credible and probable than any other conclusion.

Recommendations may include, but are not limited to—

- (1) Reinstatement of privileges.
 - (2) Identification of specific provider deficiencies that require improvement and the establishment of requirements such as consultation with other providers or specialists related to patient care management. (The board should not make recommendations involving the reassignment of a provider.)
 - (3) Suspension, reduction, or restriction of clinical privileges for a specified length of time. The hearing board may recommend that a provider be released from AD or Federal employment.
 - (4) Revocation of clinical privileges.
 - (5) To reconvene the hearing, after appropriate notice to the provider, to consider additional relevant evidence.
- g.* Decision of the hearing board is by majority vote. Each member of the hearing board will cast a vote either "yes" or "no." No abstentions are permitted. Voting will be by secret ballot.
- h.* The hearing board must be aware of the gravity of its responsibilities and the need to clearly document its findings and recommendations. Specifically identified incidents or situations will support general statements by the board. Copies of pertinent medical/dental records or specific case histories, to substantiate the findings of the board, will be included in the record of the proceedings. These, and any other attachments, will be tabbed as exhibits to the record.
- i.* Selected members of the credentials committee may serve as the hearing board, or the entire credentials committee may perform this function, as determined locally. Any credentials committee member who has reviewed and rendered a formal opinion/vote (that is, acted as investigating officer, peer review panel member) should recuse themselves from any subsequent proceedings. A privileged provider from the same discipline as the provider in question should be a voting member of the hearing board.
- j.* The hearing will be closed to the public; however, the provider may request that observers be permitted. The chairperson will normally grant the request but may limit the number of observers and may exclude anyone who is disruptive.
- k.* The hearing board may obtain advice concerning legal questions from the servicing SJA office. The provider should be advised of any legal questions as they arise and the answers that were provided by legal counsel.

10-9. Action on hearing recommendations

a. The record of the hearing—including findings and recommendations—will be forwarded to the MTF commander. A copy of the findings and recommendations (and, if requested, a copy of the hearing transcript) will also be delivered to the provider. (See fig 10-8.) Receipt of the hearing-related materials will be acknowledged by the provider. (See fig 10-9.) The provider has 10 duty days following receipt of the hearing board recommendations to submit a written statement of corrections, additions, or other matters related to the hearing that he/she wishes to present to the commander.

- (1) The hearing board record—to include findings and recommendations—shall be available for review by all qualified members of the credentials committee prior to the case file being forwarded to the commander.
- (2) All qualified members of the credentials committee (excluding any hearing board members or any member that acted as the investigation officer) may either concur by endorsement with the recommendations or submit separate recommendations.
- (3) If a member of the credentials committee is absent (for example, through TDY or illness) when the hearing board report is forwarded, such absence will be noted and the case forwarded to the commander without action by the absent member.

b. The servicing SJA (or DA civilian attorney) will review the record, including findings and recommendations, for legal sufficiency prior to action by the commander.

c. The commander will review the hearing record (including credentials committee/peer review panel findings and recommendations and any input from the provider in question) and make a decision regarding the provider's privileges.

- (1) The findings and recommendations contained in the hearing record are advisory only and not binding on the commander.
- (2) Written notice of the commander's decision, with the date of delivery annotated on it, will be furnished to the provider either in person or by certified return receipt requested mail. The signed receipt acknowledges the provider's receipt of the commander's decision. If the decision includes denial, suspension, restriction, reduction, or revocation of the individual's privileges, the notice should advise the provider of his/her right of appeal.
- (3) A copy of this notice will be placed in the individual's PCF. The appropriate department, service, or clinic chiefs will also be advised of the decision.

10-10. The appeals process

- a.* When the MTF commander decides to suspend, restrict, reduce, revoke, or deny clinical privileges, the provider

will be granted 10 duty days (extendable in writing by the commander for good cause) to submit a request for reconsideration to the MTF commander.

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

(2) If the provider elects to appeal the commander's decision, he/she will submit a formal request for reconsideration that identifies the errors of fact or procedure that form the basis of the request. The burden is on the provider to specify the grounds for reconsideration/appeal.

b. The MTF commander is granted 14 calendar days to consider the request. If he/she denies the request in whole or in part, the action will automatically be endorsed to TSG as an appeal. TSG is the final appellate authority for denying, suspending, restricting, reducing, or revoking clinical privileges.

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

d. The USAMEDCOM QMD will convene the appeals board for those appeals involving MEDCEN/RMC/RDC providers or commanders; the RMC/RDC is responsible for any adverse privileging action appeal from its subordinate MTFs. In either case, the appeals board will convene within 45 days of receipt of all materials related to the adverse privileging action.

e. The appeals board will consist of three privileged providers and is chaired by an officer appointed on standing orders by TSG to function in this capacity. This may be the DCCS at the RMC level (comparable RDC position), or the Director, QMD at the USAMEDCOM level or other senior officer as deemed appropriate. It is recommended that at least one member be of the same discipline and specialty as the provider whose appeal is being considered.

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

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

f. The appeals board will review all information furnished by the provider, as well as the hearing record, and all findings and recommendations, in light of the provider's alleged basis for appeal. After considering the information and evaluating the merit of the appellant's appeal, the appeals board will advise the commander (USAMEDCOM/USADENCOM or RMC/RDC) of its findings and recommendations for disposition, and whether it finds substantial evidence to support the MTF commander's adverse privileging action. For RMC-level appeals, the findings and recommendations of the board will be endorsed by the RMC commander and all documents considered by the board will be forwarded by certified return receipt requested mail to the USAMEDCOM for review and approval by the appellate authority (TSG). The findings and recommendations of the appeals board are advisory in nature and do not bind the appellate authority. To remove any potential conflict, no other parties will have input into the final decision by the appellate authority. There will be no deviation from this regulation in the review process.

g. The appellate authority will notify the provider by certified return receipt requested mail, within 45 days following adjournment of the appeals board, of the decision concerning the appeal. The RMC or MTF commander, as appropriate, will also be notified in writing. The appellate authority will provide clear guidance as to what actions the MTF is expected to take regarding the future utilization of the provider.

h. Only adverse privileging actions may be appealed under these procedures. Denial of a request for privileges for reasons unrelated to the abilities, qualifications, health, or skills of the provider is not considered an adverse privileging action.

i. Administrative action to separate the provider as a result of an adverse privileging action under paragraph 10-12 will normally be deferred pending appeal resolution. Providers who voluntarily separate prior to resolution of their appeal will be informed in writing that the process will be completed as though they were still on AD or employed in a civilian capacity. Special considerations, such as extensions of time for appeal, will not be granted.

10-11. Civilian training

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

10-12. Separation from Federal service

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

reduced, or revoked, a local command administrative review will be held to determine whether personnel action to separate the provider from Federal service should be initiated.

(1) For a provider/professional who separates from Federal service (military or civilian) in a less-than-fully-privileged status or with less-than-full scope of practice, information relative to the adverse privileging/practice action will be reported. Only TSG is authorized to report AMEDD health care personnel to the appropriate professional regulating authorities. The provider/professional will be informed of the consequences of leaving Federal service in a less-than-fully-privileged status/full scope of practice (that is, that a report will be filed with the NPDB, the Federation of State Medical Boards, State licensing board, and other regulatory agencies).

(2) For a provider/professional with a service obligation, consideration must then be given to branch transfer or reclassification action or, as an exception to policy, elimination from the Service.

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

10-13. Separation of a criminally charged provider

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

10-14. Reporting adverse privileging/practice action activities

a. The DD Form 2499 is used to report actions taken against a provider's privileges or the licensed/certified/registered professional's scope of practice.

(1) At the conclusion of the adverse privileging/practice action proceedings, documentation supporting the DD Form 2499 such as credentials committee minutes, hearing board record of proceedings, results of investigation, appeal response letter, and any other pertinent information will be forwarded, if the MTF has not already done so, with the DD Form 2499 to the USAMEDCOM/USADENCOM. A copy of these documents will also be furnished by the MTF to the next higher headquarters.

(2) The MTF commander will sign and date the DD Form 2499 in the bottom right hand corner of the "remarks section," (block 12) below any annotations contained in this section of the form.

(3) The date the DD Form 2499 is mailed to the USAMEDCOM will be annotated in the top right corner of the form.

b. The following activities will be reported through the chain of command, as indicated:

(1) *CQM QA investigations.* Provider/professional CQM QA investigations being conducted will be reported to the next higher headquarters (for informational purposes) within 7 calendar days of initiation. Appropriate documentation (that is, DD Form 2499 and other supporting materials) will follow, as stipulated below, if the evidence from the investigation supports an adverse privileging/practice action.

(2) *Clinical privileges/practice actions.* When the commander suspends, restricts, reduces, revokes, or denies (for other than facility-specific reasons) a provider's privileges or a professional's practice, or the individual voluntarily surrenders all privileges/practice while under investigation or to avoid investigation, a DD Form 2499 will be submitted within 7 calendar days following the action.

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

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

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

(d) Copies of all supporting documentation related to the adverse privileging/practice action will accompany the DD Form 2499.

(3) *Status reports.* Provider/professional status changes, using DD Form 2499, will be reported to the USAMEDCOM (MCHO-CL-Q)/USADENCOM (MCDS) with copy furnished to the next higher headquarters. Reports will be submitted every 30 days until final action has been completed and so indicated on the final DD Form 2499.

(4) *Reinstatement of clinical privileges/practice.* When the MTF commander approves total or partial restoration of

clinical privileges/practice that had previously been removed, DD Form 2499 will be submitted to USAMEDCOM (MCHO-CL-Q), with copy furnished to the next higher headquarters.

(5) *Administrative or judicial action affecting privileges/practice.* If an individual is the subject of an administrative or judicial action (for example, a court-martial), a DD Form 2499 will be submitted reflecting the modified status of the individual's privileges.

c. In the event of a suspension, restriction, reduction, revocation, or denial of clinical privileges for a military provider with permission to engage in remunerative professional employment at a civilian medical/dental health care institution, the civilian employer will be notified of adverse privileging actions, as they occur, by the MTF commander. The same requirement to report applies to nonmilitary providers working at civilian facilities. This is the only exception to TSG as the information-releasing authority.

10-15. Reportable acts of unprofessional conduct

a. Health care providers who are involved in any of the unprofessional acts/activities listed in appendix I, or similarly unprofessional actions, will be evaluated by the credentials committee (by the peer review panel and department/service chief for nonprivileged) and appropriate adverse privileging or practice recommendations will be made to the commander. Although the credentials committee is not a criminal investigative body, it can and will consider all evidence from such investigations in its deliberations. Whenever a reportable activity is identified, a DD Form 2499 will be submitted (see para 10-14b), noting any adverse privileging/practice actions that have been taken.

b. An unprofessional act is deemed to have "occurred" when the individual is indicted or titled for an offense (if applicable) or after completion of applicable investigative proceedings and command action. The commander will notify any civilian facilities in which the individual is engaged in off-duty health-care-related employment of the aforementioned. (See para 10-5e.)

c. A DD Form 2499 will be submitted on privileged providers and other nonprivileged health care personnel, whether licensed or pending licensure, who are convicted, plead guilty, plead nolo contendere, receive a discharge in lieu of courts-martial, receive a discharge in lieu of criminal investigation, or a less than honorable discharge for unprofessional conduct. Reporting will occur within 7 days of the date that formal charges were filed or the date of discharge, whichever comes first.

10-16. USAR/ARNG provider/professional adverse privileging/practice actions

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

b. If a military agency initiated the adverse privileging/practice action, that agency will forward the DD Form 2499 to Commander, USAMEDCOM, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010 or Commander, USADENCOM, ATTN: MCDS, 2050 Worth Road, Fort Sam Houston, TX 78234-6004, with copy furnished to the RMC or next higher headquarters, as appropriate. The USAMEDCOM will notify the appropriate regulatory authorities, medical commands, and the major Army commands to which the individual is assigned. Initiation of adverse privileging/practice actions will be based on individual unit assignment/attachment and type of training as follows—

(1) For all USAR/ARNG members performing duty (regardless of type) in an MTF, the commander of that facility will initiate the actions.

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

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

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

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

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

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

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

d. When the USAMEDCOM is notified by a regulatory authority, to include the Federation of State Medical Boards

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

e. A USAR/ARNG provider/professional will be considered for reclassification, branch transfer, or separation if an adverse privileging/practice action was taken which resulted in a permanent restriction or revocation of clinical privileges/scope of practice. USAR/ARNG commanders will review such assigned members and recommend disposition according to appropriate regulations, dependent upon the nature and merit of each case.

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

Note. For USAR/ARNG providers not currently holding military privileges, two peer recommendations dated within 24 months of ICTB submission are required attachments. These supplement the contents of paragraph 10 of the ICTB.

(11) *Paragraph 11.* Privileging sites/activities and contact information.

(a) Include the provider's current civilian position, place(s) of employment or facility(ies) where privileges are held, and the specialty(ies) in which the individual is privileged. A POC at each facility (including name, title, address, telephone number, facsimile number, and so forth) should be included in the event there are questions related to current civilian privileges. Civilian facilities should receive a release of information signed by the provider and should be advised that this information will be used for privileging the provider while he/she is on AD.

(b) If the provider is self-employed, provide the individual's office address, telephone number, and facsimile number.

(c) If privileges are held at several civilian facilities, provide the name and location of the place(s) where the majority of the provider's practice is conducted.

(12) *Paragraph 12.* Provider contact information. Include demographic information on how to reach the USAR/ARNG provider by mail or telephone prior to the individual reporting for TDY.

(13) *Paragraph 13.* USAR/ARNG training data. Include a listing of recent Reserve training dates, locations, and type of training performed.

(14) *Paragraph 14.* Verification of ICTB contents. Include a statement attesting to the fact that the USAR/ARNG provider's PCF was reviewed and is accurately reflected in the brief as of the date of the ICTB. A statement indicating the presence/absence of other relevant information in the PCF will also appear here. (This is a prompt by the computer at the time the ICTB is generated and is referring to "adverse information" that might be found within the PCF.) Include any additional information that is relevant to the privileging of the USAR/ARNG provider, as noted above in paragraph (11) for the ICTB.

(15) *Paragraph 15.* Other comments. Note any additional remarks pertinent to the provider's credentials and/or other privilege-related information.

(16) *Paragraph 16.* Unit credentials POC. Indicate a primary POC who has responsibility as the USAR/ARNG unit credentials manager and can address issues or concerns if a problem arises. Include both telephone and facsimile numbers, and electronic mail address, if available. If the credentials manager is not available on a full-time basis, note an alternate POC (that is, a full-time individual who is authorized access to CCQAS and can answer questions during weekday duty hours).

(17) *Paragraph 17.* Commander's signature. The privileging authority (that is, the USAR/ARNG hospital/unit commander or designee) will sign and date this document. By signing, he/she is attesting to the accuracy and the completeness of the information provided. The chief of professional services or an individual designated on an additional duty appointment may sign for the commander if so authorized. This signature serves as the Commander's recommendation that the provider be granted privileges.

c. The following documents are mandatory attachments to the ICTB for both AA and USAR/ARNG:

(1) A copy of all clinical privileges currently held, both military and civilian (that is, DA Form 5440-series and/or civilian privileging document(s)).

(2) In instances where the provider does not hold current military privileges, two professional peer recommendations dated within 24 months of submission.

(3) A completed DA Form 5440 (specific to individual's AOC).

(4) A completed DA Form 5440A, the top portion only (blocks 1-5).

(5) A completed DA Form 5754.

(6) An authorization document for release of information. This may be specific to the gaining facility, if available.

Note. For the USAR/ARNG, contact is encouraged with the specific AA facility where the individual is to report for duty. The USAR/ARNG credentials manager may submit the forms noted above to the AA facility either prior to the ICTB being generated or with the ICTB once it is prepared. If previously submitted to the gaining facility, these forms are not mandatory attachments at the time the ICTB is forwarded.

d. The ICTB should be sent to the gaining facility no later than 45 days prior to the start date of duty. This allows the AA facility sufficient time to conduct the required privileging activities (for example, to process the privileging forms, conduct the NPDB/HIPDB queries, and integrate the ICTB into the AA facility's regularly scheduled privileging process).

Appendix I

Reportable Acts of Misconduct/Unprofessional Conduct for DOD Health Care Personnel

I-1. Acts requiring reporting following command action

Acts of misconduct or unprofessional conduct, or similarly unprofessional actions, will be reported to the Federation of State Medical Boards (physicians and dentists), National Council for State Boards of Nursing (RN and LPN/LVN), and

the appropriate State agency or national professional certifying body for all health care personnel, as appropriate, following command action and completion of applicable appeal procedures in compliance with DOD guidance (DODD 6025.13). The following will be reported upon conviction by court-martial or civilian court or upon other final disposition, adjudication, or administrative action:

a. Fraud or misrepresentation involving application for enlistment, commission, employment, or affiliation with DOD service that results in removal from Service.

b. Fraud or misrepresentation involving renewal of contract for professional employment, application for or renewal of clinical privileges, or extension of a Service obligation.

c. Proof of cheating on a professional qualifying examination.

d. Entry of guilty, nolo contendere plea, or request for discharge in lieu of courts-martial while charged with a serious misdemeanor or felony.

e. Abrogating professional responsibility through any of the following or similarly unprofessional actions:

(1) Deliberately making false or misleading statements to patients regarding clinical skills and/or clinical privileges/practice.

(2) Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law.

(3) Being impaired by reason of alcohol/other drug abuse and refusing to participate in or failing to complete rehabilitation.

(4) Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons.

f. Commission of an act of sexual abuse, misconduct, or exploitation related to clinical activities or non-clinically related indications of sexual misconduct. Examples include promiscuity, bizarre sexual conduct, indecent exposure, rape, contributing to the delinquency of a minor, or child molestation. Such activities, in the commander's judgment, impair the individual's overall effectiveness and credibility within the health care system or within his/her professional or patient communities.

g. Prescribing, selling, administering, giving, or using any drug legally classified as a schedule II controlled substance, as defined by 21 USC 801-977, intended for use by the practitioner or a family member of the practitioner without an exception to policy and the expressed written permission of the MTF commander, or admitted misuse of such substances by the provider/professional.

h. Commission of any offense that is punishable in a civilian court of competent jurisdiction by a fine of more than \$1,000 or confinement for over 30 days for an offense(s) related to professional practice or which impairs the practitioner's credibility within the health care system or within his/her professional community.

i. Any violation of the UCMJ for which the individual was awarded nonjudicial punishment when the offense is related to the practitioner's ability to practice his/her profession or which impairs the practitioner's credibility within the health care system or within his/her professional community.

j. Fraud under dual compensation provisions of Federal statutes relating to directly or indirectly receiving a fee, commission, rebate, or other compensation for the treatment of patients eligible for care in a DOD MTF.

k. Failure to report to the privileging authority—

(1) Any disciplinary action taken by professional or governmental organization reportable under this regulation.

(2) Malpractice awards, judgments, or settlements occurring outside DOD facilities.

(3) Any professional sanction taken by a civilian licensing agency or health care facility.

l. Request for administrative discharge in lieu of courts-martial or administrative discharge while charged with any of the offenses noted above.

I-2. Acts reported following courts-martial or indictment

The following will be reported upon referral for trial by courts-martial or indictment in a civilian court and upon final verdict, adjudication, or administrative disposition:

a. Offenses punishable by a fine of more than \$5,000 or confinement in excess of 1 year by the civilian jurisdiction in which the alleged offense occurred.

b. Offenses punishable by confinement or imprisonment for more than 365 days under the UCMJ.

c. Entry of a guilty or nolo contendere plea, or a request for discharge in lieu of courts-martial, while charged with an offense designated in *a* or *b* above.

d. Committing an act of sexual abuse or exploitation in the practice of medicine, dentistry, nursing, or other practice of health care.

e. Inappropriately receiving compensation for treatment of patients eligible for care in DOD MTFs.

f. Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.

Appendix J Management Control Evaluation Checklist

J-1. Function

The function covered by this checklist is CQM administration.

J-2. Purpose

The purpose of this checklist is to assist local commanders and the USAMEDCOM QMD in evaluating the key management controls listed below. It is not intended to address all controls.

J-3. Instructions

Answers must be based on the actual testing of key management controls (for example, document analysis, direct observation, interviewing, data sampling, or simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key management controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2-R (Management Control Evaluation Certification Statement).

J-4. Test questions

a. *Clinical Quality Management Program.* Each MTF has established a comprehensive, integrated CQMP that is in compliance with current accrediting/regulatory guidance.

- (1) Is there a comprehensive, integrated CQMP in place in the MTF?
- (2) Is the MTF CQMP supported by a written CQM plan?
- (3) How are providers/professionals being educated about the MTF's quality issues and initiatives?
- (4) How are quality or quality-process issues that are identified by staff or beneficiaries brought to the attention of the MTF leaders?
- (5) Are CQM data collected, analyzed, and utilized by MTF leadership to improve organizational performance?
- (6) Are CQMP summary reports prepared and submitted according to applicable regulatory guidance?
- (7) Are QA documents and records maintained according to Federal law and applicable DOD guidance?

b. *Accreditation program.* Compliance with JCAHO accreditation standards is evaluated during the triennial JCAHO survey process. The standards are outlined in the current JCAHO manual as applicable to the site being surveyed. The survey results are submitted to the USAMEDCOM, QMD.

- (1) Did the MTF commander ensure compliance with JCAHO accreditation standards as evidenced by a score of 70 percent or better during its triennial accreditation survey?
- (2) Did the MTF submit its JCAHO survey preliminary report and a JCAHO survey after-action report to the USAMEDCOM, QMD?
- (3) Are the latest JCAHO survey grid score results publicly displayed in the MTF?

c. *Patient rights and responsibilities.* Each MTF has established processes that ensure patient rights and responsibilities are addressed according to JCAHO standards and DOD requirements.

- (1) Does the MTF review and incorporate the facility-specific information from DOD-sponsored beneficiary surveys into its programs and processes?
- (2) Was the MTF in compliance with current JCAHO patient rights standards during its latest JCAHO survey?
- (3) Did the MTF commander designate at least one person to be responsible for explaining to beneficiaries their rights and responsibilities?
- (4) Is a health care consumer council in place and functioning in the organization? Do the MTF leaders participate in the activities of this council? What has changed in the organization as a result of this council's actions?
- (5) Did the MTF commander include the status of patient rights implementation in the annual CQMP Summary Report?

- (6) Is an MTF report card posted or visibly displayed? What data are provided and how often is this data updated?

d. *Utilization management/outcomes management.* Each MTF establishes UM/OM processes to meet JCAHO, DOD, and USAMEDCOM requirements.

- (1) Did the MTF UM/OM plan describe the functions of the staff responsible for UM/OM within the organization as well as all processes, procedures, and criteria used to evaluate health care and services?
- (2) Did the MTF demonstrate quantifiable improvements in the processes and outcomes of care as reflected in the annual CQMP Summary Report?