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MEMORANDUM FOR DISTRIBUTION C
MAJCOMs/FOAs/DRUs

FROM: HAF/SG
1780 Air Force Pentagon
Washington, DC 20330

SUBJECT: Air Force Guidance Memorandum to Air Force Instruction (AFI) 44-119, *Medical Quality Operations*

By Order of the Secretary of the Air Force, the 2023 Guidance Memorandum (GM) to Department of the Air Force Instruction (DAFI) 44-119, Medical Quality Operations, 16 August 2011, is extended for another year. It applies to the entire Department of the Air Force (DAF), the United States Air Force (USAF), the United States Space Force (USSF), the Air Force Reserve (AFR), and the Air National Guard (ANG). Compliance with this Memorandum is mandatory. To the extent its directions are inconsistent with other Air Force publications, the information herein prevails, in accordance with Department of the Air Force Instruction (DAFI) 90-160, *Publications and Forms Management* and Department of the Air Force Manual (DAFMAN) 90-161, *Publishing Processes and Procedures*. To the extent this publication is inconsistent with Defense Health Agency-Procedures Manual (DHA-PM) 6025.13, *Clinical Quality Management in the Military Health System*, Volumes 1-7, the DHA-PM supersedes policy in this GM.

This Air Force Guidance Memorandum updates Tools, Information Sources and other references. It changes offices symbols from the Air Force Medical Operations Agency (AFMOA) to the Air Force Medical Agency (AFMED) and AFLOA/JACC to AF/JACC. It deletes the term Health Integrity and Protection Data Bank (HIPDB) and the Defense Practitioner Data Bank (DPDB).

This Memorandum becomes void after one year has elapsed from the date of this Memorandum, or upon publication of an interim change or rewrite of DAFI 44-119, whichever is earlier.

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Attachment:
Guidance Changes to AFI 44-119

Guidance Changes

The following changes to DAFI 44-119, dated 16 August 2011, are effective immediately.

* All references to Air Force Medical Operational Agency (AFMOA) changed to Air Force Medical Agency (AFMED) throughout.

* All references to AFLOA/JACC changed to AF/JACC throughout.

* Delete all reference to Health Integrity and Protection Data Bank (HIPDB) and Defense Practitioner Data Bank (DPDB) throughout.

1.22.2. (Change) Gathers and ensures Prime Source Verification (PSV) of required documents (see Table A5.2). Scans, names in accordance with the standard naming convention and uploads documents to the provider's electronic Provider Credentials File (PCF).

1.23.2. (Change) May be required to gather and ensure PSV of required documents (see Table A5.1. and A5.4.). May be required to scan, name in accordance with the standard naming convention and upload documents to the Registered Nurses (RNs, Licensed Vocational Nurses (LVNs), Licensed Practical Nurse (LPNs), electronic PCF.

3.16. (Delete)

3.17. (Change) **Military Health System Clinical Quality Management (MHS-CQM).** (<https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Clinical-Quality-Management>) MHS-CQM helps MTFs meet the DoD's performance measures and accreditation requirements through the collection, verification, management, and reporting of The Joint Commission ORYX® and MHS Balanced Scorecard data. Lists and charts used to support these efforts are available to users with secure access.

3.18. (Change) **Population Health Website.** <https://kx.health.mil/kj/kx7/PopHealthMgmt/Pages/home.aspx>. This website provides support to DoD health professionals, at all levels, to optimize the health of their communities through an effective and efficient healthcare delivery system. The Population Health Support Division (PHSD) staff members possess a wealth of knowledge and experience in Aerospace Medicine, Behavioral Health, Bio-Statistics, Coding, Epidemiology, Dental Health, Disease Management, Healthcare Optimization, Health Information Management, Health Promotion, Health Records Management, Immunizations, Nursing, Nutrition, Preventive Medicine, Public Health, and Research and are standing by to assist.

3.20. (Change) **AFMED/SGHQ Website.** <https://kx.health.mil/AFMOA/ClinicalQuality/SitePages/Home.aspx>. This website for the AFMED/SGHQ, a Field Operating Agency (FOA) whose commander reports to the AF/SG. It is used as a primary communications tool to announce and centralize information pertaining to the field units of the AFMS. Its various sections range from the urgent to the historical and from specific AFIs to general items of information over the entire spectrum of Clinical Quality Management for the AF to include Credentials and Privileging, Risk Management, Clinical Consultants, Policy, Clinical Practice Guidelines, Continuing Education and more.

3.22. (Change) **Unit Effectiveness Inspection (UEI).** UEIs are conducted under the authority of the USAF/IG by the Air Force Inspection Agency (AFIA). UEI teams assess the ability of AF medical units to fulfill their peacetime and wartime missions. AFIA does not create health services policy. These policies are developed by the Offices of the Assistant Secretary of Defense for Health Affairs, Defense Health Agency (DHA), AF/SG, MAJCOMs and various civilian medical oversight agencies. The AFIA inspects compliance with existing policies and community standards of clinical practice. The elements are annually loaded into Management Internal Control Toolset (MICT) to assist units in their self-inspection program. See AFI 90-201, *The Air Force Inspection System*, for more information.

3.23. (Delete)

3.25. (Change) **Continuous Process Improvement.**

<https://usaf.dps.mil/teams/cpiportal/SitePages/home1.aspx> is a collection of tools and references that enables all Airmen to develop processes that are effective while preserving resources.

3.26.1. (Change) **Air Force Medical Service (AFMS).** <https://kx.health.mil/Pages/default.aspx>

3.26.2. (Change) **Air National Guard (ANG).**

<https://carepoint.health.mil/sites/ANGSG/Pages/default.aspx>

3.26.33. (Change) **Air Force Reserve Command (AFRC).**

<https://kx.health.mil/kj/kx1/AFRCCommandSurgeon/Pages/home.aspx>

4.2.5.5. (Change) **Non-Personal Services Contract Nurses.** In 1999, the National Council of State Boards of Nursing (NCSBN) developed the Nurse Licensure Compact (NLC). The NLC legislation allows for US states and territories to enter into a mutual recognition compact for nurses licensed across jurisdictional borders (refer to <https://www.ncsbn.org/index.htm>). A nurse who resides in a compact state, territory receives his/her license in that home state and can practice on that privilege in other NLC jurisdictions. The nurse is bound to practice under that state's nursing practice act where care is actually delivered.

5.2.7. (Change) Air Force Centralized Credentials Verification Office (AFCCVO) contact information is available on the AFCCVO public access website and on the Kx under the C&P toolkit. The AFCCVO public access www site at: <https://www.airforcemedicine.af.mil/AFCCVO/> contains additional information, references, and request forms.

5.4.5.9.1. (Change) For those MTFs who offer mammography services, radiologists will abide by Mammography Quality Standards Act (MQSA) requirements and submit appropriate documentation (refer to *Department of Health and Human Services, Food and Drug Administration, 21 CFR, Part 900, Quality Mammography Standards*, Final Rule; published in the Federal Register, Vol. 62, No. 208, Tuesday, October 28, 1997, effective 28 Apr 99). Written documentation that the provider meets MQSA requirements will be filed in Section VI of the PCF prior to the provider completing an E-application. Once the provider completes an e-application this documentation will be scanned, named in accordance with standard naming conventions, and uploaded to the provider's electronic PCF (see Kx C&P toolkit). The Federal Register regulation, as well as guidance documents, can be obtained from the following website: <https://www.fda.gov/radiation-emitting-products/mammography-quality-standards-act-and-program>. **(T-0).**

5.4.6.3. (Change) Department of Health and Human Services (DHHS) and TRICARE Sanction Provider Listings. DHHS maintains sanction authority on behalf of government agencies (32 C.F.R.) and maintains the listing of providers who have been sanctioned (reference sanction listing at <https://exclusions.oig.hhs.gov/>). The Defense Health Agency (DHA) may initiate its own sanction action

against a provider and maintains a list of sanctioned providers located on the following website: <https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity>. It is important to review both the DHHS and DHA listings to identify sanctioned providers who have entered into contracts or are applying for employment (accessions, civil service, etc.) with the AFMS. Paying funds to a sanctioned provider is against federal law and carries serious penalties and fines.

5.4.6.4. (Delete)

5.4.7.7. (Delete)

5.10.1. (Change) For the American Board of Medical Specialties (ABMS), the following are identified and approved as the designated official display agents for Board Certification: CertiFACTs Online, Elsevier BoardCertifiedDocs and supporting physician data file, and the American Medical Association (AMA) Physician Profile and AMA Master File. Therefore, the ABMS Board Certification information provided by these entities are considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as The Joint Commission (TJC). (Reference <https://www.abms.org/board-certification/>).

5.10.1.3. (Change) According to American Osteopathic Association (AOA), the Official Osteopathic Physician Profile Report is recognized as providing primary source information on AOA board certifications and replaces the Physician Certification Verification Letter and AOA Directory Information as official sources for osteopathic physician credentials. (Reference: <http://osteopathic.org>)

7.1. (Change) **Note 1:** For each professional group, some general background and educational requirements are listed. (Educational requirements reflect current accession criteria. Some personnel already working in the AFMS may not be required to meet the stated criteria; e.g. NPs who were awarded the 46Y3A (46N3A) or 46Y3B (46N3B) AFSC prior to 1997 as graduates of a certificate, non-graduate level education program, remain qualified for the AFSC as long as the national certification remains current). Refer to DAFMAN 36-2032, *Military Recruiting and Accessions*, for a complete listing of accession criteria and the Air Force Officer Classification Directory for AFSC qualifications. Scope of practice and supervision requirements are defined. (See specific privileges lists for further details regarding scope of practice.) Normally, enlisted medical and dental personnel operate within the guidelines established by the Career Field Education and Training Plan (CFETP) which defines the enlisted scope of practice.

7.5.2.3. (Delete)

8.5.1. (Change) Non-Privileged Providers. All officer, civilian, contract and volunteer non-privileged healthcare staff will maintain a Competency Assessment Folder (CAF) or an electronic equivalent (eCAF). If the electronic equivalent is not accessible to locations where a training folder is required, the CAF will be used, maintained in accordance with location specific requirements. See A2.1. in Attachment 2, Officer, Civilian, Contract and Volunteer Personnel (Privileged and Non-Privileged) – CAF guidelines. All enlisted medical personnel (X4XXXXX) will utilize the Air Force Training Record (AFTR) in lieu of a hard copy competency assessment folder to document competency. Documentation guidance for enlisted training is found in DAFI 36-2670, *Total Force Development* and the individual's respective CFETP. Competency assessment documentation for enlisted personnel will be maintained in AFTR.

8.5.2. (Change) In addition to requirements found in DAFI 36-2670, *Total Force Development*, all medical enlisted personnel (AFSC X4XXXXX), regardless of assignment or duty location, will also comply with the following:

(Change)

8.5.3.2. AF Form 803, *Report of Task Evaluations* (Refer to AFI 36-2670)

8.5.3.3. AETC Form 156, *Student Training Report* (Refer to AFI 36-2670)

8.5.3.4. CDC Enrollment Cards (Refer to AFI 36-2670)

8.5.3.5. AF Form 34, *Field Score Sheet* (Refer to AFI 36-2670)

8.5.3.6. Course AFI 36-2670 (Refer to AFI 36-2670)

9.18. (Change) **Command Directed Evaluations.** For military members a Command-directed evaluation (CDE) may be necessary to evaluate a mental condition that could be affecting the provider's ability to practice safely. If the provider's mental health status is in question then it shall be evaluated via a CDE, as appropriate. The commander directed mental health evaluation will be conducted IAW AFI 44-172, *Mental Health*. It may be necessary to have the evaluation completed at a different MTF to remove any appearance of bias.

9.33. (Change) **Obtaining Court Reporting Services.** The MTF is responsible for obtaining court reporting services for the hearing. Court reporters may be used from the SJA office, if available, to document the hearing process and results. Obtaining court reporting services through other means is at the cost of the MTF and not the legal office. Regardless of the source of the court reporter, the MTF must ensure that the transcript (paper or electronic) is available within 30 calendar days. If a non-DoD court reporter is retained, a business associate agreement is required IAW DODM 6025.18, *Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs*. **(T-0)**.

9.82. (Delete)

**BY ORDER OF THE
SECRETARY OF THE AIR FORCE**

AIR FORCE INSTRUCTION 44-119

16 AUGUST 2011

Medical

MEDICAL QUALITY OPERATIONS



COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements AFRPD 44-1, *Medical Operations*, DoDD 6025.13-R, *Clinical Quality Management Program (CQMP) in the Military Health Services System (MHS)*, which incorporated DoDD 6025.14, *Department of Defense Participation in the National Practitioner Data Bank (NPDB)*, DoDI 6040.37, *Confidentiality of Medical Quality Assurance (QA) Records*, DoDI 6025.15 *Implementation of Department of Defense Participation in the National Practitioner Data Bank*; DoDI 6025.16, *Portability of State Licensure for Health Care Professionals*; DoDI 6025.17, *Department of Defense (DoD) Patient Safety Program (PSP)*.

It outlines military treatment facility (MTF) roles and responsibilities in the area of clinical performance improvement (PI), explains patient safety and risk management (RM) programs, PI/accreditation/self-inspection requirements, credentials and privileging processes, and scope of practice in order to provide optimal healthcare delivery. This instruction applies to all Air Force Medical Service (AFMS) personnel and where specifically identified within this instruction for units of the Air Reserve Components (ARC) and Aeromedical Evacuation (AES). The reporting requirement in paragraphs 2.7 and 2.12 is exempt from licensing in accordance with (IAW) paragraph 2.11.12 of AFI 33-324, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*. This instruction directs collecting and maintaining information protected by the *Privacy Act of 1974* authorized by *Title 10, United States Code (U.S.C.)*, Section 8013, Secretary of the Air Force. System of Records Notice F044 AF SG K, Medical Professional Staffing Records, applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at <https://www.my.af.mil/gcss->

[af61a/afrims/afrims/](#). Implementing publications do not need to be forwarded to higher headquarters for review and coordination before publishing. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF IMT 847, *Recommendation for Change of Publication*; route AF IMT 847s from the field through the appropriate functional's chain of command.

SUMMARY OF CHANGES

This document is substantially revised and must be completely reviewed.

This revision incorporates the revised roles and responsibilities of the Clinical Quality Division within AFMOA, the interaction with the MAJCOM/SG offices, and the medical facilities. It reflects the overarching focus and emerging new standards on patient safety and stresses the importance of seamless integration with performance improvement, quality, and risk management. The intent is to work toward establishing a culture in which errors are proactively identified, incidents reported freely, and patient safety is rooted in the daily operations of the healthcare organization. It also reflects the ongoing changes in credentialing, privileging, scope of practice, adverse privileging actions, malpractice processing, and overall clinical performance improvement and risk management activities. It incorporates numerous interim policy memos regarding the same. It breaks subject matter into specific chapters, defines roles and responsibilities to include committees and medical staff functions and reintroduces the role of the Director of Base Medical Services (**Chapter 1**), and in a dedicated chapter, introduces new national standards, guidance, and culture related to Patient Safety (**Chapter 2**). This instruction provides integral guidance and tools for improving organizational performance (**Chapter 3**). It clarifies licensure requirements for all healthcare providers, to include the difference in requirements depending on contract types. It also explains the waiver of administrative requirements for physician licensure, the physician assistant waiver of licensure and the waiver process for the timeline to obtain licensure processes (**Chapter 4**), introduces the E-application for privileges and medical staff appointment, identifies credentials that are obtained off-line and describes provider documents that must be collected and primary source verified, to include responsibility and management of the documents that become part of the electronic provider credentials file (**Chapter 5**). It better defines responsibilities and processes for the privileging process, introduces the requirements for completion of the E-application and adopts standard business processes (**Chapter 6**). It describes in full the allied health professionals' educational background, scope of practice, and supervision requirements and supports the independent collaborative role of the advanced practice nurse (**Chapter 7**). It establishes and clarifies the AFMS' peer review processes and expectations to include using focused professional practice evaluations and ongoing professional practice evaluations for privileged providers and outlines the ongoing peer review process for non-privileged staff. The competency assessment folder guidelines are standardized and outlined for all officer, civilian, contractor and volunteer staff (**Chapter 8**), and the DoD standardized business process is adopted for adverse actions which standardized the adverse action processes for privileged and non-privileging providers and added an additional step with a peer review panel to validate clinical implications before the commander proceeds with the proposed adverse action, provides greater discussion of the definition and management of impaired professionals and clarification of administrative and clinical adverse actions, outlines AFMS code of conduct and approach to address intimidating

and disruptive behavior of healthcare professionals (**Chapter 9**). Provides guidance on the appropriate management of and the release of quality assurance material and disclosure. Realigns all risk management processes in one chapter, defines requirements for management of potentially compensable events, active duty disability and active duty death cases where medical care provided may have contributed to the outcome, and medical malpractice claims. Defines the roles and responsibilities in the re-engineered malpractice process (**Chapter 10**).

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Chapter 1

GENERAL ROLES AND RESPONSIBILITIES

Section 1A—General Roles and Responsibility

1.1. Assistant Secretary of the Air Force (SAF/MR). The Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR) serves as an agent of the Secretary and provides guidance, direction, and oversight for all matters pertaining to the formulation, review, and execution of plans, policies, programs, and budgets addressing Medical Quality Management.

1.2. Air Force Surgeon General (HQ USAF/SG). Establishes policy and delegates broad oversight responsibility for the Quality/Process Improvement, Patient Safety, Risk Management, Professional Staff Management (Credentialing/Privileging) and Adverse Actions programs in the Air Force Medical Service (AFMS) to Air Force Medical Operations Agency, Clinical Quality Management Division (AFMOA/SGHQ).

1.3. Commander, AFMOA. In consultation with AFMOA/SGHQ ensures patient safety, accreditation, professional staff management, risk management, and clinical performance improvement policies and processes are implemented within the MTFs.

1.4. AFMOA/SGHQ:

1.4.1. Provides corporate-level guidance for professional staff management, patient safety, accreditation, risk management, and clinical performance improvement to ensure compliance with DoD requirements.

1.4.2. Provides consultative support to the MTFs and MAJCOM/SGs.

1.4.3. Collaborates with AFMOA/SGHM to provide clinical consultation, defining and/or clarifying standards of care and practice in each consultant's area of expertise.

1.4.4. Administers the risk management programs to include adverse actions, potentially compensable events and malpractice claims.

1.4.5. Provides policy guidance, consultation, monitoring and review of Root Cause Analyses (RCA) and Medical Incident Investigations (MII).

1.4.6. Monitors trends in processes and outcomes of care to include sentinel events (SE); disseminates information both up and down the chain.

1.4.7. Serves as the AFMS liaison with civilian accreditation organizations.

1.4.8. Provides policy guidance, consultation, program management, monitoring and review of the Medical Facility Assessment and Compliance Tracking System (MedFACTS) and Centralized Credentials and Quality Assurance System (CCQAS), and the Patient Safety Reporting System.

1.5. Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/SG). Evaluates the programs described in this instruction in Air Force military treatment facilities (MTFs) and units of the Air Reserve Component (ARC).

1.6. Headquarters, Air Force Recruiting Service (HQ AFRS). (N/A for ARC) Ensures adherence to criteria for selection, commissioning, and accession of healthcare professionals.

1.7. Medical Service Officer Management Division of Directorate of Assignments (HQ AFPC/ DPAM). Has functional oversight and management of educational programs for Medical Corps officers. Coordinates with Air Force Centralized Credentials Verification Office (AFCCVO) for Primary Source Verification (PSV) of selected documents for deferred medical officers entering active duty (see paragraph 5.13.).

1.8. Air Force Centralized Credentials Verification Office (AFCCVO). Designated AFMS agent responsible for PSV of AFMS healthcare providers' credentials. Refer to Chapter 5, Section 5A for details.

1.9. Command Surgeon (HQ MAJCOM/SG, ARC HQ MAJCOM/SG). Consults with AFMOA/CC and AFMOA/SGHQ on patient safety, accreditation, professional staff management, risk management, and clinical performance improvement policies and processes implemented within the MTFs, Reserve Medical Units (RMUs) and MDGs.

1.10. Director of Base Medical Services (DBMS). Manages all Air Force medical resources (except elements of the aeromedical evacuation system, command surgeon's offices, and similar activities not engaged in patient care) located on or satellite to, an Air Force base or installation.

1.10.1. All personnel assigned or attached, required to carry out the mission of the base medical services, without regard to their organizational assignment, are under his or her professional supervision.

1.10.2. In a single wing or group base organization, the DBMS is directly responsible to the wing or group commander.

1.10.3. In a multi-wing organization the DBMS is directly responsible to the commander of an air division (when authorized) or to the host wing commander.

1.10.4. In the air base wing or group organization, the DBMS is directly responsible to the base commander. Normally, he or she is the commander of the MTF.

1.10.5. In the temporary absence of the DBMS, this duty is normally performed by the individual designated as commander.

1.10.6. The DBMS:

1.10.6.1. Supervises and directs the use of base medical resources.

1.10.6.2. In conjunction with the TRICARE contractor arranges cost-effective, high quality medical services from local civilian sources when needed care is not available through the military facility or other federal resources.

1.10.6.3. Ensures medical support is adequate to meet requirements placed on tactical units when personnel of such units are under operational control of the DBMS. Identifies shortfalls to higher headquarters.

1.10.6.4. Ensures the medical portion of base plans (including war plans, defense plans, and disaster and survival plans) by local military medical activities is adequate; also, for working closely with other staff activities and local civilian agencies.

1.10.6.5. Ensures that the training of medical personnel is carried out to maintain proficiency.

1.10.6.6. Recommends to the wing or installation commander the scope of medical services including but not limited to clinic and hospital services, based on manpower, resources, staff credentialing, and community needs in order to ensure patient safety and community health.

1.10.6.7. Acts for the wing or installation commander on matters pertaining to the base medical mission.

1.10.6.8. Advises the wing or installation commander on medical care and services required according to host-tenant agreements for satellite and tenant Air Force units, and for negotiating agreements with unit commanders on the degree of active participation in medical functions of medical elements of the tenant units. Also, the DBMS advises the commander of medical support requirements for Army and Navy activities.

1.10.6.9. Advises the wing or installation commander on the health of personnel and on health protection requirements and measures.

1.10.6.10. Assists/coordinates, commensurate with available resources, the training, support and use of all medical activities located or satellite on the base, including units and individual medical service members of the Air Force Reserve and Air National Guard.

1.10.6.11. Establishes liaison with the local health system agency to become familiar with the civilian community health planning process and the base MTF role within the health service area.

1.11. Military Treatment Facility Commander (MTF/CC) or Medical Wing Commander (MDW/ CC) and for the ARC: Reserve Medical Unit Commander (RMU/CC) or Medical Group Commander (MDG/CC):

1.11.1. In consultation with AFMOA/SGHQ ensures patient safety, accreditation, professional staff management, risk management, and clinical performance improvement policies and processes are implemented IAW this instruction.

1.11.2. Is the approval authority (or may designate approval authority during a temporary absence only) for award of privileges and medical staff appointment, alterations in privileges, and adverse privileging actions for all assigned providers to include collocated reserve medical units.

1.11.3. The ARC privileging authority (or AD MTF/CC for collocated reserve units) must ensure that ARC providers possess current clinical competency in their primary Air Force Specialty Code (AFSC) before granting or renewing privileges when they do not hold comparable privileges in a civilian healthcare organization.

1.11.4. Conducts facility strategic planning and establishes the organizational mission and vision.

1.11.5. Oversees the off-duty employment program IAW Air Force Instruction (AFI) 44-102, *Medical Care Management*.

1.11.6. Ensures MTF Anti-Fraud Program is implemented IAW DoDI 5505.12, *Anti-Fraud Program at Military Treatment Facilities (MTFs)*.

1.11.6.1. Establishes internal management control program to foster oversight of contracted healthcare providers and local civilian entities utilized to purchase supplies and services.

1.11.6.2. Establishes anti-fraud training protocol for assigned personnel.

1.11.6.3. Ensures contracted privileged and non-privileged healthcare providers are appropriately licensed (see paragraph 4.1.1.) and HHS-IG and TRICARE sanction lists are reviewed before provider works within the MTF (see paragraph 5.4.6.3).

1.11.7. Ensures program is established for shadowing medical personnel within the MTF as outlined in paragraph 5.22.

1.12. Chief of the Medical Staff (SGH) or the ARC Designated Senior Physician:

1.12.1. Must be a privileged physician holding an active appointment to the medical staff and be appointed by the chief executive officer (MTF/CC).

1.12.2. Is the principal executive staff advisor to the MTF/CC concerning matters of provider regulations, quality and scope of medical care, utilization of professional resources, and medical policy and planning.

1.12.3. Has oversight of the professional staff management program and professional practice review, patient safety program, healthcare risk management program and performance improvement activities.

1.12.4. Collaborates with functional program managers and champions initiatives to reduce risks and improve patient safety and quality of care.

1.12.5. Acts as the liaison between the members of the medical staff and the executive leadership.

1.12.6. Chairs the Executive Committee of the Medical Staff (ECOMS), the Credentials Function and the Medical Staff Function. (See SGH Handbook for more specific guidance.) In the absence of the SGH, these responsibilities will be delegated to another privileged physician upon approval of the MTF/CC.

1.12.7. Is authorized to intervene on behalf of the MTF/CC to immediately hold in abeyance or summarily 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 IAW the provisions outlined in this instruction.

1.12.8. Is responsible for orienting all medical staff applicants concerning Air Force (AF) bylaws governing patient care, medical staff responsibilities, professional ethics, continuing education requirements, privileging, adverse actions, and due process proceedings (see paragraph 3.3.2.).

1.12.9. May singularly review and award temporary privileges during periods of medical necessity (i.e., pressing patient care need).

1.12.10. Is responsible for ensuring the quality of care provided by all privileged providers and collaborates with other executive leadership to ensure quality of care for the spectrum of care provided in the facility.

1.12.11. Advises the squadron and MTF/CC when off-duty employment issues arise involving privileged providers that may negatively affect patient care and/or ability to accomplish mission requirements.

1.13. Chief Nurse (SGN) --refer to AFI 46, Series -Nursing.

1.14. Chief, Aerospace Medicine (SGP) --refer to AFI 48, Series -Aerospace Medicine.

1.15. Chief, Dental Services (SGD) --refer to AFI 47, Series -Dental.

1.16. MTF Administrator (SGA) --refer to AFI 41, Series -Health Services.

1.17. The Medical Staff:

1.17.1. Are healthcare providers privileged to practice in the MTF/RMU/MDG and appointed to the medical staff by the MTF/CC or for the ARC: MTF/CC, RMU/CC or MDG/CC.

1.17.2. Will participate in quality, patient safety, professional staff management, and risk management activities.

1.17.3. Will acknowledge their intent, in writing or by E-signature of the application, at the time of initial privileging to abide by AF bylaws. (Examples include, but are not limited to this instruction, Medical Group Instructions and other applicable documents and policies provided by AFMS.)

1.17.4. Individual members of the Medical Staff are responsible for maintaining the currency of required training, licenses and documents contained in their provider credentials file (PCF). They must provide evidence of initial and renewed currency to the MTF Credentials Manager for inclusion in their electronic PCF.

1.18. Quality/Performance Improvement (PI) Manager (N/A to ARC):

1.18.1. Designated in writing by the MTF/CC, reports to the SGH. Is responsible for the organization-wide improvement program and is an active member of and advisor to the MTF executive team. Functions to improve overall organizational performance by problem assessment, solution recommendations, implementation and follow-up activities, which could include but not be limited to, Air Force Smart Ops for the 21st Century (AFSO21) (lean and Six Sigma principles), Failure Mode and Effects Analysis (FMEAs) and RCAs.

1.18.2. Facilitates and advises the executive leadership in the development and implementation of organization-wide strategic planning, organizational goals and objectives. Develops and coordinates written policies and procedures applicable to all aspects of the Quality/PI program.

1.18.3. Directs the PI training and education for MTF staff and organizational leaders. When improvement teams are formed, provides just-in-time training on PI tools.

1.18.4. Assists the organization in identifying and developing performance indicators and related measures.

1.18.5. Guides the organization in effectively collecting and using internal and external (comparative) data to be used for identifying, developing, implementing and sustaining performance improvements.

1.18.6. Collaborates with the credentials manager and medical staff to identify and collect performance-based provider data for ongoing performance improvement initiatives and as part of the re-privileging process.

1.18.7. Collaborates with patient safety manager, risk manager, and credentials manager to integrate results of data analysis, outcomes of risk management reviews/analysis, and patient safety assessments into the performance improvement process for safe, quality healthcare.

1.18.8. Uses or coordinates the use of process analysis tools to display and analyze data, e.g., fish-bone, Pareto chart, run chart, control chart, scatter gram, etc.

1.18.9. Coordinates the dissemination of performance improvement information within the organization, ensuring basic analysis and comparative processes are included.

1.18.10. Reports the results of continuous monitoring activities to the MTF/CC and executive staff on a routine basis, as determined by the executive staff, for use in making performance-based decisions about the organization.

1.18.11. Advises the MTF executive leadership on the organization's compliance with applicable Federal, State, and DoD healthcare laws/regulations; ethics; state statutes; and AF instructions. Directs processes to ensure ongoing compliance with accreditation agency standards and regulatory requirements such as performance quality measurements, MedFACTS, and other self-inspection and assessment tools. Coordinates with the self-inspection program manager designated by the MTF/CC.

1.19. Healthcare Risk Manager (RM) (N/A to ARC):

1.19.1. Designated in writing by the MTF/CC reports to the SGH.

1.19.2. Directs all healthcare RM administrative and management activities within the medical facility. Member of committee that performs and reviews healthcare risk management functions.

1.19.3. Develops, implements and reports healthcare risk management activities and other related topics as required locally, to the executive leadership.

1.19.4. Collaborates with the SGH, the patient safety manager and the quality manager on organizational risk management activities such as SE reporting, RCAs, MIIs, Potentially Compensable Events (PCEs), quality of care and standard of care reviews aimed at identifying, analyzing, correcting, and trending deficient patterns and facilities and environment issues.

1.19.5. Ensures comprehensive management control of real and potential risks for all employees, patients, visitors, and volunteers.

1.19.6. Implements and evaluates plans to decrease facility and government liability and financial loss associated with accidents and untoward events.

1.19.7. Directs actions to preserve, protect, and secure evidence and equipment involved in untoward medical incidents.

1.19.8. Informs local legal representative or medical law consultant of potential litigation case and PCEs and takes action to mitigate loss.

1.19.9. Provides frequent consultative information and reports to the executive leadership, committees, functions, workgroups, and staff on general and specific healthcare risk management issues and events.

1.19.10. Initiates and ensures timely notification/briefing to the commander and/or the Executive Committee on events or when trend analysis indicates a potential for major liability, catastrophic event, or media exposure.

1.19.11. Facilitates MTF adverse clinical action and Healthcare Integrity and Protection Data Bank (HIPDB) requirements (see Chapter 9, Section H).

1.19.12. Disseminates and manages HQ USAF/SG Notice to Airmen (NOTAM), lessons learned, advisories, alerts and other formal communications. (See paragraph 10.9.2.).

1.20. Patient Safety Manager:

1.20.1. Designated in writing by the MTF/CC or for ARC: RMU/CC or MDG/CC, reports to the SGH.

1.20.2. Responsible for event reporting requirements related to patient safety to include collecting, routing and tracking. Analyzes events and takes appropriate action.

1.20.3. Coordinates the implementation of national patient safety goals.

1.20.4. Coordinates the current DoD Patient Safety Program healthcare team training and sustainment.

1.20.5. Coordinates and collaborates with the SGH, other appropriate senior leadership, risk manager, quality manager and other facility functions as necessary.

1.20.6. Facilitates the completion of RCAs and FMEAs; reports significant events or findings to the AFMOA/SGHQ Patient Safety Branch as required.

1.20.7. Serves as the MTF patient safety advisor/resource and confers with MTF personnel at all levels to direct patient safety initiatives.

1.20.8. Conducts an annual appraisal of the adequacy of organization-wide patient safety activities/policies/procedures to ensure program effectiveness and compliance. Uses the template provided in the current Patient Safety Handbook. Provides appraisal to the MTF Executive Committee and then forwards to AFMOA/SGHQ Patient Safety Branch.

1.20.9. Responsible for patient safety education and training to include new employee orientation and annual recurrent training.

1.20.10. Collects, routes and tracks facility events related to patient safety.

1.20.11. Submits monthly MTF event report to DoD Patient Safety Center. The report is briefed to MTF leadership. Specific reporting instructions are contained in the Patient Safety Handbook.

1.20.12. Establishes mechanism to inform executive leaders of patient safety activities at least quarterly, including lessons learned and risk reductions/elimination actions taken as a result of event analysis.

1.21. Credentials Manager (CM):

1.21.1. Designated in writing by the MTF/CC, MDG/CC, or RMU/CC reports to the SGH.

1.21.2. Serves as the technical advisor to the MTF/CC (for ARC: RMU/CC or MDG/CC), credentials function chairperson, squadron commanders, and assigned providers on issues relative to the credentialing and privileging process. Advises these individuals regarding the appropriate procedures to function within the guidelines and mandates of AF Instructions (AFI), DoD directives, civilian accreditation standards, and other mandated regulatory guidance.

1.21.3. Educates the commander, chief of the medical staff, credentials function members, squadron commanders, and medical staff on new policies and changes to current directives.

1.21.4. Monitors and maintains standards of compliance with regulatory guidelines, directives, and mandates associated with the credentialing and privileging process.

1.21.5. Maintains resource information for credentialing and privileging including, but not limited to, clinical privileges lists, other AF forms, AFI 44-102, AFI 41-117, *Medical Service Officer Education*; and this instruction.

1.21.6. Provides administrative support to the MTF (for ARC: RMU or MDG) credentials function as needed.

1.21.7. Serves as point of contact (POC) for fee-exempt DEA registration and National Provider Identifier (NPI) Type 1 registration.

1.21.8. Serves as the MTF (for ARC: RMU or MDG) Centralized Credentials and Quality Assurance System (CCQAS) Database Administrator, authorizing new user status and training individuals as required.

1.21.9. Establishes and maintains CCQAS electronic records. Ensures the CCQAS Credentialing Module database is current, maintaining and updating this database IAW the CCQAS Users Manual and AF guidance. The MTF CM is responsible for maintaining the CCQAS records for collocated Reserve units and assigned Individual Mobilization Augmentees (IMAs) **Note:** May be tasked by MTF (for ARC: RMU or MDG) leadership to create and/or maintain CCQAS electronic records for assigned non-privileged RNs, LPNs, and LVNs.

1.21.10. Initiates the credentialing, privileging and medical staff appointment process. Reviews the provider's electronic Provider's Credentials File (PCF), ensures minimum documents for routing first E-application are scanned, named IAW the standard naming convention and uploaded to the provider's credentials record. Performs data quality review of the electronic PCF and grants provider access to complete the E-application at the next privileging opportunity.

1.21.11. Provides guidance to providers during the initial and renewal privileging process.

1.21.12. Tracks completion of focused and on-going professional practice evaluations for medical staff appointment/privileging processes.

1.21.13. Routinely collaborates with the PI manager, healthcare risk manager, and medical staff to assist in collecting on-going performance-based provider data as part of the re-privileging process.

1.21.14. Manages and updates documents of evidence relevant to provider education, experience, licensure/certification, and training in the electronic PCF and ensures accuracy and currency of the information.

1.21.15. Conducts and/or coordinates with the AFCCVO to perform National Practitioner Data Bank (NPDB), HIPDB and other applicable queries, and Primary Source Verifications (PSV) to authenticate the credentials of medical staff members applying for initial privileges and appointment to the medical staff and annual and biennial renewal of same.

1.21.16. Retains the 6-part PCF previously established prior to implementation of the electronic PCF for historical purposes and forwards the file to the gaining facility for permanent change of station as required.

1.21.17. Electronically initiates Interfacility Credentials Transfer Briefs (ICTBs) to gaining MTF (for ARC: RMU or MDG) within specified time requirements. Prepares off-line ICTB for humanitarian and deployed missions and for AF staff privileged in DVA facilities using the Departments' Data Sharing memorandum of understanding. See Kx C&P toolkit for additional information.

1.21.18. Works cooperatively with ARC in the following activities:

1.21.18.1. Responsible for credentialing, privileging, and medical staff appointment process and maintenance of electronic PCFs for collocated reserve units and assigned IMAs.

1.21.18.2. Provides support to ARC personnel participating in annual tours within the MTF including, but not limited to, the entire credentialing, privileging, and medical staff appointment process.

1.21.19. Serves as POC for release of information on a provider's clinical practice that has or previously had an affiliation with the MTF.

1.22. MTF Graduate Medical Education (GME) Training Office. (N/A to ARC)

1.22.1. Maintains CCQAS electronic records for providers in training program. Ensures the CCQAS Credentialing Module database is current, maintaining and updating this database IAW the CCQAS Users Manual and AF guidance.

1.22.2. Gathers and ensures PSV of required documents (see Table A5.2). Scans, names IAW the standard naming convention (see Kx Credentialing & Privileging (C&P) Toolkit) and uploads documents to the provider's electronic PCF.

1.22.3. Serves as POC for fee-exempt DEA registration and NPI Type 1 registration for providers in the training program.

1.22.4. Performs data quality review of the electronic PCF and grants provider access to complete 1st E-application upon the completion of training program. Initiates PCS transfer of CCQAS records and providers PCF (see paragraph 5.12.).

1.23. MTF Education and Training Office.

1.23.1. May be tasked by MTF leadership to create and/or maintain CCQAS electronic records for assigned non-privileged RNs/LVNs/LPNs. Ensures the CCQAS Credentialing

Module database for these individuals is current, maintaining and updating this database IAW the CCQAS Users Manual and AF guidance.

1.23.2. May be required to gather and ensure PSV of required documents (see Table A5.1. and A5.4.). May be required to scan, name IAW the standard naming convention (see Kx C&P Toolkit) and upload documents to the RNs/LVNs/LPNs electronic PCF.

Section 1B—Committees and Functions

1.24. AFMS Policy on the Use of Functions. AFMS policy encourages the use of functions rather than committees to fulfill the requirements for accreditation. Many committees (which require a charter and formal minutes) have been changed to functions. Functions only require a summary report (not minutes) be given to the oversight leadership authority. This gives healthcare facilities greater latitude in how they manage these important activities by reducing administrative time in meetings, eliminating voluminous minutes, and encouraging creative cost-saving methods to achieve the desired purpose.

1.25. Functional Review (Summary) Reports. Summary reports should contain a purpose statement, be simple, factual, and not include voluminous attachments. They should include only meaningful information (not just data) for reviewers to use to make informed decisions about facility operations. They should include quantifiable data that is mostly longitudinal and can give a good comparison over time. For example, describing the monthly or quarterly medication events is meaningless unless you use comparative data (historical, benchmarks or industry standards) and explain the reasons for improvement or the opportunities that need to be addressed. The summary reports should also address both process and outcome. The reports should be routed to the oversight authority designated by the MTF. (See Kx Toolkit for templates.)

1.26. Required Committees:

1.26.1. MTF (for ARC: RMU or MDG) Executive Committee

1.26.2. Executive Committee of the Medical Staff (ECOMS) (N/A to ARC)

1.27. Recommended Functions: Functions will be applicable within the MTF to include Limited Scope Medical Treatment Facilities (LSMTFs) (for ARC: RMU or MDG)-defined scope of care, and may be ad hoc or included as an agenda item in an oversight committee as outlined in paragraph 1.26. The intent is to ensure information is looked at with executive oversight and review.

1.27.1. Facilities and Environment Function

1.27.2. Pharmacy and Therapeutics/Medication Management

1.27.3. Medical Records Function

1.27.4. Credentials Function

1.27.5. Infection Control Function

1.27.6. Tissue, Blood and Blood Components Function

1.27.7. Operative and Other Invasive Procedures Function

1.27.8. Cancer Function

- 1.27.9. Medical Staff Function (Professional Staff)
- 1.27.10. Population Health Workgroup/Function
- 1.27.11. Ethics Function
- 1.27.12. Resuscitative Care and/or Special Care Function
- 1.27.13. Education and Training Function
- 1.27.14. Performance Improvement/Quality/Healthcare Risk Management Function
- 1.27.15. Patient Safety Function
- 1.27.16. Information Management/Data Quality Function
- 1.27.17. Nurse Executive Function

Chapter 2

PATIENT SAFETY

2.1. Framework for Safer and More Effective Healthcare.

2.1.1. A culture of patient safety is demonstrated by an organizational commitment to provide safe, high quality patient care via a focus on collaborative teamwork, communication and effective processes. This commitment must be shared by leadership and staff members at all levels. Organizations with a culture of patient safety acknowledge that medical errors can and will occur and strive to identify and reduce risk before it results in harm.

2.1.2. Patient safety proactively and retroactively identifies potential and actual risks to safety, identifies underlying causes and makes the necessary improvements to reduce risks. It establishes processes in response to sentinel events and adverse incidents by identifying risks through a Root Cause Analysis (RCA) and implementing process improvements. Patient safety, in collaboration with other activities including performance improvement and risk management, promotes a culture of safety in which errors are identified and reported freely without retribution. The goal is to reduce variability and vulnerability for error in processes. Safety is rooted in the daily operations of the healthcare organization where proactive risk identification, assessment and control are the foundation for safe and effective healthcare.

2.1.3. This systems-based approach to advance a culture of safety, reduce vulnerability, and promote competent patient-centered care is driven by the leadership at each medical organization through the endorsement and active support of commanders, medical and nursing leadership. These concepts are anchored in the organization's mission, vision, prioritization plan, guidance and policies. Leadership will:

2.1.3.1. Model the behaviors and beliefs as well as speak the language of patient safety.

2.1.3.2. Advocate for an environment of non-blame and reduction of the fear of retribution through recognizing and encouraging good catch, near miss, and event reporting, conducting leadership rounds, and encouraging proactive approaches to problem solving with the end goal of process improvement.

2.1.3.3. Promote compliance with National Patient Safety Goals (NPSGs) and initiatives working closely with the Patient Safety Manager (PSM) and goal champions.

2.1.3.4. Focus on prospective and retrospective analysis of events, new and revised processes and systems to identify areas of high risk, high volume and high costs.

2.1.3.5. Reinforce responses to alerts and NOTAMs through thorough assessment of impact to the facility.

2.1.3.6. Ensure that the PSM is involved in key activities and provide advisement and consultation to staff.

2.1.4. Every member of the AFMS strives to create a non-punitive, learning culture by focusing on improved communication and cooperation, teamwork, systems and processes rather than blame, and prevention rather than punishment.

2.1.5. Adverse events are avoidable when preventive measures are shared and practiced.

2.1.6. Patient Safety is essential to all AFMS operations, including Aeromedical Evacuation and deployed locations.

Figure 2.1. The Components of a Patient Safety Program (N/A to ARC).



DoD Healthcare Team Coordination Program (HCTCP). TeamSTEPPS

2.2. Regulatory Compliance.

2.2.1. All MTFs regardless of accrediting organization will adhere to The Joint Commission (TJC) NPSGs including when the goals convert into TJC standards. These goals are designed to enhance the safety and quality of care provided, highlight problematic areas in healthcare and describe evidence and expert based consensus on solutions to these problems. The NPSGs shall be documented in MedFACTS for outpatient MTFs. The Joint Commission's approved self-assessment tool, Periodic Performance Review (PPR) will be used by inpatient MTFs to document compliance with the NPSGs.

2.2.2. All MTFs will utilize each patient's full name and date of birth as the two standard identifiers associated with NPSGs. Use these two patient identifiers at a minimum when providing care, treatment or services. The intent of this goal is to reliably identify the individual as the person for whom the service or treatment is intended and to match the service or treatment to that individual. These same two identifiers must be directly associated with medications, blood products, specimen containers and treatments or procedures. Standardization of this goal across the AFMS is intrinsic to the delivery of safe, high quality healthcare and system-wide solutions.

2.2.3. All MTFs will adhere to the NPSG for Universal Protocol (UP). UP applies to all surgical and non-surgical invasive procedures as determined by the MTF. MTFs will ensure UP compliance by developing facility specific processes that utilize the UP Surgical Checklist and incorporate elements of the Non-Operating Room Procedure Verification

Checklists into established processes. The checklist templates are located in the Patient Safety Handbook posted on the Kx.

2.2.4. Each inpatient facility should develop and activate a Rapid Response Team (RRT). This is a patient safety initiative designed to speed the identification of and care to patients with signs of clinical deterioration or factors suggesting impending deterioration. The facility should create an operating instruction with procedures for the team to function within. (See Kx Patient Safety website for suggested template). The team is considered a 24-hour asset that will respond to calls rapidly.

2.2.4.1. Inpatient facilities will utilize the Modified Early Warning Score (MEWS) as a component of the RRT activation. The MTF will assign individual responsibilities to ensure MEWS compliance, and complete the MEWS on all adult inpatients at least every shift.

2.3. Organizational Sharing and Collaboration.

2.3.1. The PSM will collaborate with other facility functions including Infection Control, Facilities and Environment, Medical Equipment Repair and Medical Logistics to ensure the full scope of patient safety issues are identified and acted upon.

2.3.2. When a PCE is identified, the RM will share the event information with the PSM who will research the event for process related issues. If after research the event meets the criteria for a RCA as outlined in paragraph 2.6, the PSM will then take the appropriate actions to initiate a RCA as outlined in the Patient Safety Handbook. If a RCA is not indicated, the findings and any corrective actions will be shared with the appropriate MTF leadership and forwarded to AFMOA.

2.3.3. MTFs are encouraged to participate in AF/DoD approved innovations, submit data and participate in learning forums to share lessons learned. MTFs are encouraged to collaborate with other MTFs and civilian organizations to share best practices and discuss patient safety issues for problem solving purposes. MTFs can use benchmarks from other agencies to enhance the MTF program and reduce or avoid risk. Specific MTF data cannot be shared with civilian organizations without coordination through AFMS leadership.

2.3.4. MTFs will participate in the Patient Safety Culture Survey, sponsored by the DoD Patient Safety Program, at periodic intervals. The survey is designed to evaluate the development of a culture of safety within DoD MTFs. The results of the survey will drive decision making at the local, AF, and DoD levels. The PSM is responsible for advertising the survey and encouraging participation, sharing results with leadership and patient safety champions within the organization, and developing, implementing and evaluating action plans based on the results.

2.4. Innovations and Lessons Learned.

2.4.1. Lessons learned are developed at AF and DoD levels using information from MTFs, government and civilian agencies. This information can be communicated through NOTAMs, alerts, focused reviews and periodic summaries. PSMs will ensure appropriate dissemination of information, discussion at the local MTF and action planning as required.

2.4.2. PSMs, in conjunction with the MTF executive leadership, provide a safe and open environment where anyone can share concerns and lessons learned without fear of retribution

and encourage error reporting to promote a culture of safety. Transparency is a key ingredient in promoting a non-blame environment and sharing lessons learned.

2.4.3. MTFs have the opportunity to submit patient safety innovations for consideration of AF and/or DoD patient safety awards. AFMS award specifications are IAW AFI 36-2856, *Medical Service Award*. The Office of the Chief Medical Officer (OCMO) at TRICARE Management Activity (TMA) sponsors the DoD Patient Safety Awards in conjunction with the annual Military Health System (MHS) Conference. The application is located on the DoD Patient Safety website.

2.5. Proactive Risk Identification. (N/A to ARC) A proactive risk assessment (PRA) is a systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change. Selected teams of cross-functional healthcare professionals may use a FMEA as their PRA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting after failures have occurred. PRA is useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process. Every 18 months each MTF will complete and submit to AFMOA/SGHQ at least one healthcare PRA. Refer to the Patient Safety handbook for specific requirements. Leadership direction will be sought for topic selection. The method used is IAW DoD Patient Safety Program guidance. The MTF PSM will facilitate the PRA process and provide current DoD PRA tools.

2.5.1. MTFs may submit a clinically focused AFSO21 process improvement activity as their PRA. AFSO21 tools are derived from Lean and Six Sigma methodologies to build in efficiencies through the elimination of waste. At no time should patient safety be compromised to improve efficiency. After completing an AFSO21, organizations will review it to ensure safeguards were not omitted and that streamlining a process will not lead to unintended and potentially harmful consequences. **Note:** Within the AFSO21 Continuous Process Improvement-Management Tool (CPI-MT), products containing medical quality assurance protected data will be stored in the secure folder with controlled membership to the “Users Group-SG”.

2.5.2. The MTF PSM or designee must track outcome measures and report to executive leadership no less than quarterly to ensure the success of the PRA.

2.6. RCA. (N/A to ARC)

2.6.1. An RCA is a retrospective process for identifying the basic or contributing causal factors associated with adverse events and near misses. The goal of the RCA is to identify systems factors that led to the event and solutions that can prevent or reduce the likelihood of similar events in the future. The product of the RCA is the action plan, consisting of specific, measurable steps designed to eliminate or minimize the root causes of the event and improve safety of the process. The focus is on human factors, processes and systems rather than individual blame.

2.6.2. RCAs will be completed on all sentinel events (as defined by TJC), adverse incidents (as defined by the Accreditation Association for Ambulatory Healthcare (AAAHHC) and those events meeting DoD requirements. In addition, RCAs are required on events with increased severity of harm and likelihood of reoccurrence. RCAs may also be appropriate for events of

lesser severity (near misses, good catches, close calls) or when there is a potential for a future catastrophic event. In these situations, the decision to complete an RCA will be at the discretion of the MTF Commander with guidance from the AFMOA/SGHQ.

2.6.3. Under the direction of the SGH, the MTF designee will notify their respective MAJCOM and AFMOA/SGHQ of all sentinel events, adverse incidents and other events as required by DoD. MTFs must complete and forward the Event Notification Form within 48 hours (see template in the Patient Safety Handbook). MTFs will comply with AF and DoD guidelines regarding notification and RCA submission to TJC and DoD.

2.6.4. The RCA team will be comprised of clinical leaders and subject matter experts (SMEs) to review the processes and systems surrounding the event. The team membership will vary according to the type of event analyzed with the team's goal to complete a thorough and credible interdisciplinary action plan.

2.6.5. The RCA and action plan will be completed within 45 calendar days from the date the organization first became aware of the event. Organizations shall use the format and methodology specified by the DoD Patient Safety Program. Any deviation from this requirement must be coordinated with AFMOA/SGHQ. RCAs will not contain identifying information on patients or individual healthcare personnel. RCAs are maintained as confidential quality assurance records protected by 10 U.S.C. §1102.

2.6.6. The team shall formally brief the MTF commander and senior leadership upon completion and obtain written approval of the RCA and action plan. This briefing provides the commander and other leadership the opportunity to interact with the RCA team for clarification and necessary changes.

2.6.7. The action plan shall be implemented and outcome measures tracked and reported to the Executive Committee to ensure plan effectiveness. In addition, a follow-up report in response to the intervention(s) listed in the action plan will be forwarded to AFMOA/SGHQ by the four month due date.

2.6.8. MTFs will forward a copy of all RCAs to AFMOA/SGHQ for review and feedback by the due date. Inpatient MTFs will submit RCAs to TJC as required.

2.6.9. Leaders recognize that conscientious healthcare workers who are involved in sentinel events or adverse incidents are themselves victims and require support. To that end, support systems at the MTF should provide those staff involved in the event with additional help and resources as needed.

2.6.10. If, during the course of an RCA, the competence of an individual involved in the medical event is in question, the team will also determine if the healthcare system provided every opportunity for the individual to succeed. It is crucial to identify process or system obstacles that may have affected a patient outcome. If professional competency is questioned or the event is identified as a PCE, the team leader will refer the matter to the respective corps chief(s). This is a separate process from an RCA and not under the purview of the Patient Safety program (see Chapter 8, paragraph 8.8.3 and Chapter 10).

2.6.11. The RCA team leader and the PSM will refer intentional unsafe acts to leadership to be addressed administratively. However, the RCA team should continue to review the event to determine if processes or systems contributed to the outcome.

2.7. Reporting and Data Collection.

2.7.1. Event, Near Miss, and Good Catch Reporting. Event, near miss and good catch reporting contributes to organizational performance improvement and is everyone's professional responsibility. Reporting will be non-punitive and reprisal or administrative action should not be taken against the reporter. The organization will maintain a mechanism for staff, patients and patients' families to report events, near misses and any other conditions, practices and/or situations which they believe are unsafe. The AFMS shall comply with DoD mandated safety reporting systems for both medication and non-medication events.

2.7.2. Reporting is designed to capture and analyze events to determine systems problems and minimize harm from medical errors.

2.7.3. Completing an event report does not signify blame. It is the responsibility of the person discovering the event/near miss/good catch to initiate the report process. The reporting process requires the person most knowledgeable of the event to record information related to what, when, where, how, and any known contributing factors leading to the event. Further analysis and review will be required and routed by the PSM to the appropriate leadership. Only event facts shall be addressed, personal opinion shall not be included.

2.7.4. Medication/near miss events will be captured and reported electronically using the approved DoD/AF monthly summary reporting system. Events from the pharmacy and patient care areas are equally reportable.

2.7.5. Do's and Don'ts to Event Reporting:

2.7.5.1. Do notify the PSM or designee by next duty day after becoming aware of the event. The PSM will notify chain of command within two (2) duty days of event awareness. (Sentinel Event/Adverse Incident notification shall occur immediately.)

2.7.5.2. Do report at a minimum the patient demographic information (age, sex, military branch and status), facility related information (admission date, admitting diagnosis, unit, etc.) and factual description of the event and extent of injury.

2.7.5.3. Do route event review form (paper or electronic) to PSM who will then route to other departments as appropriate.

2.7.5.4. Do maintain the confidentiality of the event review form and stamp with the Quality Assurance protection statement which protects this information from public disclosure under the provisions of 10 U.S.C. §1102.

2.7.5.5. Don't indicate in the patient's medical record that an event review form was completed and do not allow the event review form to become part of the medical record. Do record a factual account of the patient's condition in the medical record.

2.7.5.6. Don't assign blame or admit liability on the event review form or in the medical record.

2.7.5.7. Don't delay routing event review form for extra review and/or signatures.

2.7.5.8. Don't make copies of the event review form.

2.8. Event Analysis. After gathering data and information regarding processes and events, it is essential for the organization to assess and analyze the risk(s) and determine where best to focus activities/changes for improvement. The organization will use a harm and severity scale as outlined in the Patient Safety Handbook to determine the level of assessment required. Less serious events may be subject to a review such as the 8-step process or RCA while events resulting in significant harm will require an RCA.

2.9. Categorizing Reported Events. Upon receipt of event reports, the PSM classifies the event using one of the following categories and helps determine the level of assessment required. The following terms are defined in the Patient Safety handbook.

2.9.1. Near Miss/Good Catch.

2.9.2. Actual Event.

2.9.3. Sentinel Event (SE)/Adverse Incident.

2.9.4. Intentional Unsafe Act.

2.10. Tracking and Trending. PSMs will collect, collate, analyze and display data from event reviews, near misses, good catches, RCAs, FMEAs and other sources. PSMs will disseminate information to appropriate MTF committees/functions, quality managers and other individuals for patient safety improvement purposes and awareness.

2.11. Research and Development. PSMs need to be well versed in performing a literature search for current research and development models in areas relating to patient safety initiatives or requests from clinical staff. Initiatives include but are not limited to RCAs, FMEAs, implementation of new patient safety goals and facility process improvements.

2.12. Reporting and Documentation.

2.12.1. Summary Reports. The PSMs at the MTFs will complete a monthly report using the authorized web-based DoD patient safety reporting system. The report will contain a summary of events, near misses, good catches and safety initiatives that occurred in the previous month. The report is then forwarded through AFMOA/SGHQ Patient Safety to the DoD Patient Safety Center. The summary reports shall be used to discern lessons learned and improvement opportunities to support the organizations.

2.12.2. Quarterly Reports to the Executive Staff. The PSM will provide quarterly updates to the Executive Staff on organizational patient safety activities, policies and procedures to ensure program effectiveness. Content should include NPSG compliance, progress on initiatives, and analysis of events and near misses, including efforts to promote reporting.

2.12.3. Annual (CY) Evaluation/Report. The PSM shall complete an annual evaluation of the organization's patient safety program and provide the evaluation to their MTF Executive Leadership. At a minimum, the report shall include education and training on PS, analysis of data collected, lessons learned and opportunities to improve, identified results from patient safety activities, initiatives taken to eliminate or reduce risk to patients and results of these improvements. The report shall also include an appraisal of the adequacy of the MTF's patient safety activities, policies and procedures to ensure program effectiveness. A copy shall be sent to AFMOA/SGHQ Patient Safety. The due date for these reports is defined in the Patient Safety Handbook.

2.12.4. Risk Control. Many existing activities within the delivery of healthcare serve to either reduce or eliminate risk. These include, but are not limited to, policy/procedure review and revision, staff education/training/orientation, patient/family education, biomedical equipment maintenance, etc. All personnel shall be educated about the DoD and the AF Patient Safety Program, to include MTF-related risk assessment activities.

2.13. Education and Training.

2.13.1. PSM Training. The PSM will attend an approved DoD Basic Patient Safety Manager course upon hire. Sustainment patient safety training courses are also available on line through various sources. Additional training is provided at the AFMS' Quality Systems Program Assessment Review (QSPAR).

2.13.2. Executive leadership is highly encouraged to attend the DoD Basic Patient Safety Manager course. Patient safety elements are embedded in other Air Force leadership courses.

2.13.3. The organization shall educate all personnel on patient safety concepts and implementation. The PSM shall coordinate with the Group Education and Training Officer to establish a mechanism to orient and educate all staff on proactive risk identification, assessment and control principles and practices. Training shall include, but is not limited to, elements of a patient safety culture, its relevance to their position, their personal role in ensuring patient safety as a high priority, identification and reporting of patient safety events and near misses/good catch, medical team training, and basic concepts of patient safety. The PSM is a resource to identify and encourage specific staff members to pursue additional patient safety training. Training is available through the DoD Patient Safety Center and the DoD HCTCP.

2.13.4. Patient safety elements must be included in routine Leadership rounds.

2.13.5. Patient safety must be included in the MTF newcomers' orientation training.

2.13.6. Patient safety must be included in the MTF annual recurrent training.

2.13.7. Patient Safety Awareness Week provides an opportunity to highlight accomplishments and increase awareness in patient safety in a creative manner. Activities should be planned to focus on both patients and staff.

2.14. Team Training. (N/A to ARC) Working toward a culture of safety through improved communication and teamwork, organizations shall deploy the DoD HCTCP TeamSTEPPS IAW DoD 6025.13-R. TeamSTEPPS is an evidence-based comprehensive initiative designed to improve quality and safety in healthcare and is rooted in over three decades of research in high-stress, high-risk industries. TeamSTEPPS implementation shall be based on the specific mission, needs and desires of the organization. Training shall be provided to multidisciplinary teams to facilitate team collaboration and communication throughout the MTF. High risk areas and those identified through MII or RCA will have priority for implementation. As part of the implementation plan, each facility will identify a means to orient new staff to the tools, strategies and behaviors of TeamSTEPPS adopted by the facility as well as sustainment actions. The AF TeamSTEPPS program manager will coordinate with the facility POC to provide ongoing consultation, coaching and follow-up evaluations of the initiative. The MTF PSM or POC will coordinate with the AF Patient Safety Office at AFMOA/SGHQ and the AF TeamSTEPPS program manager regarding information for initial implementation. TeamSTEPPS specific

information may be found on the DoD Patient Safety website (see Patient Safety Handbook), the Patient Safety Learning Center (PSLC) or the AHRQ website.

2.15. Patient Safety Education.

2.15.1. Patients and families can help participate in their own safety. Communication with patients and families about all aspects of their care, treatment, or services is an important characteristic of a culture of safety. When patients know what to expect they are more aware of possible errors and choices. Patients can be an important source of information about potential adverse events and hazardous conditions. Every opportunity should be afforded to maximize patient education and engage the patient in their health care. Suggestions to facilitate this include “Right Start” and including patient safety as an agenda item of the Health Care Consumer Advisory Council.

2.15.2. Patients and families are educated on methods to report patient safety concerns and are encouraged to do so.

2.16. Evidence Based Design (EBD). (N/A to ARC) EBD is a process used in the planning, designing, and construction of buildings. It is uniquely suited to healthcare because of the unusually high stakes and major issues of safety and improved clinical outcomes. A natural parallel and analog to Evidence Based Medicine is currently being used in the healthcare industry to help convince decision makers to invest the time and money to build better buildings. The PSM along with infection control, environmental safety, and facility managers are integral members of the facility’s planning and design team. A team consisting of the PSM, infection control, facility safety and executive leadership are encouraged to perform periodic facility rounds to identify safety concerns.

Chapter 3

ACCREDITATION, SELF-INSPECTION, AND IMPROVING ORGANIZATIONAL PERFORMANCE

Section 3A—Accreditation (N/A to ARC)

3.1. Medical Treatment Facilities Requiring Accreditation. AFMS MTFs, to include LSMTFs, are expected to provide safe, quality healthcare to all assigned beneficiaries. All active duty fixed hospitals and free-standing ambulatory clinics will maintain civilian accreditation by nationally recognized agencies.

3.1.1. TJC is the civilian accrediting agency for AF inpatient facilities.

3.1.2. AAAHC is the civilian accrediting agency for AF outpatient facilities.

3.1.3. By close of business on the same day as the exit conference from an Air Force inspection or civilian accreditation survey, the MTF/CC will ensure a copy of all preliminary reports is faxed or sent via e-mail to AFMOA/SGHQ.

3.2. Policy Conflict with Accrediting Agencies. The AF fully supports accreditation by civilian agencies. When the military mission requirements result in a conflict with agency standards, the AF policy prevails. AFMOA/SGHQ or another appropriate authority will pursue resolution of any conflicts with the accrediting agency.

3.2.1. MTF will immediately notify AFMOA/SGHQ via phone if any type of no-notice survey or inspection occurs.

3.3. Governing Body and Other Equivalencies for Use in Accreditation Surveys. The following equivalencies apply to AFMS:

3.3.1. HQ USAF/SG is the governing body for all AF MTFs.

3.3.2. Applicable federal law, DoD, AF directives/instructions, SG policies, MAJCOM directives/policies, and local operating policies serve as the bylaws. MTFs may develop separate operating instructions for matters not covered by AF policy directive (AFPD), Air Force Instruction (AFI), or other regulatory guidance.

3.3.3. The MTF's strategic plan describes its purpose, goals, vision, and community responsibilities.

3.3.4. The MTF/CC acts as the chief executive officer and represents the governing body locally.

3.3.5. The MTF/CC designee serves as the chief operating officer (i.e., Deputy MTF/CC or another executive committee member).

3.3.6. The chief of the medical staff (SGH) is the president of the medical staff.

3.3.7. The chief nurse (SGN) is the nurse executive.

3.3.8. The MTF administrator (SGA) is the administrator.

3.3.9. The MTF Executive Committee formally links the functions of the governing body representatives, the chief operating officer, and the medical staff. MTF Executive Committee minimum membership is referenced in the AFMS Flight Path.

3.3.10. Executive Committee of the Medical Staff (ECOMS) or equivalent monitors medical staff functions and clinical improvement activities.

Section 3B—Self-inspection

3.4. General. Self-inspection at the MTF, to include LSMTFs, is a tool for leadership to evaluate programs and processes that impact the delivery of safe, quality healthcare in their area of responsibility. Most standards for self-inspection are updated at least annually by their accrediting source and require vigilant attention to ensure we meet our beneficiary and AFMS expectations for the highest quality of healthcare. The MTF leadership will ensure a continuous self-inspection process is in place for monitoring accuracy and completion of compliance standards as outlined by AFMOA, the MAJCOMs, and other national accreditation bodies as required. RMUs will comply with AFRC Self Inspection guidance and AFI 90-201, *Inspector General Activities*.

3.5. Follow Up for Non-Compliance. MTFs will follow up on non-compliance with civilian accreditation standards and Health Services Inspection (HSI) criteria.

3.5.1. MTFs accredited with TJC will follow the process directed by TJC.

3.5.2. MTFs accredited with AAAHC will follow the process directed by AFMOA/CC. See Kx Clinical Quality toolkit for more information.

3.5.3. MTFs will follow the process directed by AFIA for non-compliance with HSI criteria.

3.6. MTF or for ARC: RMU/MDG Coordination with Wing Compliance Inspections. MTFs or for ARC: RMUs/MDGs will coordinate with their associated Wing and MAJCOM leadership in regards to required compliance inspections concerning readiness, nuclear surety, environmental and occupational assessments.

3.7. Self-Inspection Program Manager Appointment. MTF/CC will appoint in writing a MTF self-inspection program manager(s) to coordinate within the MTF all of the functions in the assessment and reassessment of all standards applicable to the MTF.

3.8. New Self-Inspection Requirements. Commanders will ensure new section chiefs (officers and enlisted) accomplish self-inspections of their areas of oversight within 60 calendar days of assuming duty utilizing the mandated automated self-inspection tool (Refer to paragraph 3.11). Each MTF defines the applicable section(s) with flight level as the minimum requirement.

3.9. Ongoing Self-Assessment Reports. At a minimum, MTF staff annually assesses each compliance item and provides a status report to the MTF Executive Committee. All inpatient facilities will submit the automated Periodic Performance Review (PPR) to TJC annually as a requirement of TJC accreditation.

3.10. Compliance Oversight. The MTF Executive Committee is responsible for the evaluation of the organization's overall compliance and progress of action plans for non-compliant standards and elements. This oversight will be documented in committee minutes.

3.11. Automated Self-inspection Tools. All AFMS MTFs, to include LSMTFs, will use MedFACTS (Medical Facility Assessment and Compliance Tracking System) to score all applicable elements of the current AD Health Services Inspection (HSI) guide. Ambulatory MTFs will use MedFACTS to score the applicable national patient safety goals and current AAAHC standards. MTFs are allowed to utilize MedFACTS to track other standards, such as Unit Compliance Inspections, though each MTF will need to enter the standards into their individual folder. MTFs determine staff access, though MedFACTS visibility includes AFIA inspectors, HQ functional experts and MAJCOM staff. **Note:** ANG will use the Self-Inspection Database (SID) in accordance with AFI 90-201.

3.11.1. When an element or standard is in compliance, a brief statement to indicate evidence of compliance will be entered in MedFACTS. The statement may reference the location where further evidence of compliance may be viewed, such as shared drives, meeting minutes, or binders. Documents with further evidence of compliance may be uploaded into MedFACTS.

3.11.2. When an element or standard is not in compliance, an action plan(s) will be documented in MedFACTS. Documents containing further explanation of the action plan(s) can be uploaded in MedFACTS. Reference can be made to where other information about the action plan(s) may be viewed such as shared drives, meeting minutes, or binders.

3.11.3. When an element or standard is not in compliance, the executive leadership will receive an initial action plan update at least 60 days after the date the standard was determined non compliant. Executive leadership will continue to receive periodic reports (as determined by MTF leadership) on the status of action plans until the element or standard is in compliance.

3.11.4. MedFACTS will contain the current and previous three years of self-inspection documentation. All other self-inspection documentation will be maintained in accordance with AFMAN 33-363 and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located in the AF Records Information Management System (AFRIMS) at <https://www.my.af.mil/afrims/afrims/afrims/rims/cfm>.

3.11.5. Every person granted permission to use MedFACTS will maintain a unique user name and secure password, such as first initial with last name versus position or title. Further guidance can be obtained from the MedFACTS help desk.

3.11.6. MedFACTS self-paced training is available via the MedFACTS website. Requests for additional training need to be submitted through the MedFACTS help desk.

3.11.7. Help desk functions, system upgrades and releases, the inputting/updating of HSI elements, NPSGs, AAAHC standards will be handled by the technical development team located at Gunter AFB. The MedFACTS website contains relevant contact information.

Section 3C—Improving Organizational Performance

3.12. Improving Organizational Performance. The facility maintains an active, integrated, organized, peer-based program of quality management and improvement that links peer review, quality improvement activities, and risk management in an organized systematic way. Performance improvement is a continuous activity and involves measuring the function of important processes and services, and when indicated, identifies changes that enhance

performance. These changes are incorporated into new or existing processes, products or services, and are monitored to ensure improvements are sustained.

3.12.1. AFSO21 is a dedicated effort to maximize value and minimize waste in our operations. The mission of AFSO21 is to strengthen the ability of every Airman to improve mission performance in line with the Air Force strategic goals and objectives through continuous process improvement, enhance management effectiveness, and shape mindsets and behaviors. AFSO21 is a culture change that focuses on processes, not tasks. It evaluates the usefulness of a series of linked processes from start to finish, looking at the end-to-end system, not just a series of stand-alone processes. AFSO21 does not just look at how we can do each task better, but asks the tougher and more important questions: Why are we doing it this way and is each of the tasks relevant, productive and value added? In other words, is it necessary at all? AFSO21 is about eliminating tasks and processes that do not add value. It is about results and is to be used by commanders and personnel at all levels.

3.12.2. More information about AFSO21 is located on the AF Portal as listed in the reference appendix.

3.13. Performance Improvement. Performance improvement focuses on clinical, administrative, and cost-of-care issues, as well, as patient outcomes (results of care). The leaders establish a planned, systematic and organization-wide approach, set priorities and ensure disciplines representing the scope of care and services across the organization work collaboratively to plan and implement improvement activities. The fundamental components of PI include staff education, measuring performance through data collection, assessing current performance, utilizing the data collected to improve organizational processes, services, and overall performance and re-education.

3.13.1. PI includes evaluating the following attributes: efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety, efficiency, respect, and caring.

3.13.2. The AFMS has developed a process to identify key indicators/metrics for evaluation. These metrics, located on the Executive Global Look (EGL) website, enable the MTFs to compare practices to other similar organizations within the AF and nationally with civilian facilities through the National Committee for Quality Assurance (NCQA) benchmarks. This website provides benchmarks for performance measurement improvement efforts. The EGL performance metrics is an integral tool in the USAF/SG's efforts to promote continuous PI throughout the AFMS. The strategy is to measure success in the operation of the Air Force MTFs and drive performance standards, baselines, and best practices.

3.13.3. The MTF leadership will utilize AFMS benchmarks as a baseline for facility PI. The goal of facility PI is to ensure the organization designs processes well and systematically monitors, analyzes, and improves its performance to improve patient outcomes. The MTF Executive Committee analyzes results of key performance activities and metrics to guide tactical and strategic planning. Key performance activities are not limited to direct clinical care (e.g., logistics, patient administration, medical record availability and other support activities). Unless dictated by a higher AF authority, the organization shall select a model for process improvement such as the Eight Step OODA (Observe, Orient, Decide, Act) Loop AFSO21 problem solving cycle, Six Sigma, FOCUS-PDCA (F-Find a function to improve, O-Organize the team that knows and cares, C-Clarify and understand the process, U-Understand the sources of variation in the process, S-Select a strategy to improve the process

and outcome; P-Plan, D-Do, C-Check, A-Act), Design-Measure-Assess-Improve, or 7-Step Process. AFSO21 includes these and other corporate developed principles and tools for PI. In addition, AFSO21 can be used as a resource and reference for any PI initiative. **Note:** Within the AFSO21 Continuous Process Improvement-Management Tool (CPI-MT), products containing medical quality assurance protected data will be stored in the secure folder with controlled membership to the “Users Group-SG”.

3.13.3.1. LSMTFs will review/evaluate specific measurable data for the organization based on the population and community served and report such data to their professional staff to review for trends and to monitor the health of their population, etc. Data that is not applicable would be specified and not required. If the LSMTFs require support from another agency a memorandum of agreement will define each entities roles and responsibilities. Any supporting agency will provide ongoing consultancy and guidance, as needed.

3.13.4. PI activities, based on facility scope of practice and capability, are focused on high-risk, problem prone, high volume/top ten diagnoses and high cost areas but are not limited to those areas. Examples of potentially high-risk patient processes include blood/blood product use, surgical case review, medication administration, and emergency services. High volume/top ten diagnoses can be determined from multiple sources, i.e., coding data, Biometric Data Quality Assurance Service (BDQAS). Problem prone sources may be determined by event reporting; NOTAMs, FMEA, current literature and lessons learned from medical malpractice issues. Examples of high cost areas include medication utilization, radiology/laboratory studies, follow-up care, referral management, and surgical procedures.

3.13.5. When determining an appropriate sample size for measuring facility processes rather than an individual practice review, the sample size should be large enough to be statistically significant if possible. The following sample sizes are recommended:

3.13.5.1. Sample size of 30 cases for a population size of up to 100 (if the population size is less than 30 cases, sample 100% of available cases).

3.13.5.2. Sample size of 50 cases for a population size of 101 to 500 cases.

3.13.5.3. Sample size of 70 cases for a population size of greater than 500 cases.

3.13.6. Data is aggregated and analyzed over time. Statistical tools are used to analyze and display data such as run charts, control charts, bar graphs, etc.

3.13.7. Internal and external comparative analysis is an effective method to identify improvement opportunities. Leadership is key to PI and has responsibility for the accuracy of data collected for review and comparison with internal and external organizations, i.e., ORYX®, TJC Quality Check, and HEDIS measurements.

3.13.8. Analysis occurs for those topics chosen by leaders as PI priorities and analysis is performed when an undesirable variation occurs which changes priorities. Collected and analyzed data and lessons learned may be used to make decisions or changes that improve performance and patient safety. Results of data analysis may include: no action, more data collection, or development of an action plan.

3.13.9. Ongoing, proactive Patient Safety and Risk Management programs are essential in reducing unanticipated adverse events and safety risks to patients and are a critical part of PI.

3.13.10. Performance improvement studies submitted for quality awards must be routed through AFMOA/SGHQ before release to external organizations.

Section 3D—Tools and Information Sources

3.14. Assessment of MTF Clinical Quality. MTF clinical quality can be assessed by benchmarking nationally recognized measures. AFMS performance measurement tools (PMTs) are a major step toward improved information for better resource allocation, quality, and demand/disease management decisions at all levels. Performance is currently assessed in three major areas of healthcare: technical outcomes (readiness and managed care), customer service, and financial performance. The PMTs use standardized metrics and, where possible, automated data collection. These “foundation-building” metrics include promoting data integrity to ensure enrollment data is correct as well as identifying functional and technical deficiencies early and addressing them quickly. The goal is to make data collection, analysis, and use as easy as possible to support AFMS continuous PI. The “desired” end state is an accountable, transparent health plan with data-driven performance improvement.

3.15. The Knowledge Exchange. (<https://kx.afms.mil>) The Knowledge Exchange (Kx) is the AFMS intranet site. The Kx is designed to store, share, and exchange information among all members of the AFMS. At the heart of the Kx is an industrial strength document repository, complete with a robust security model and capacity to store terabytes of documents. The Kx contains over 350 distinct sites. They are arranged in hierarchical manner and organized by formal organization and AFMS function. These sites are referred to as “Knowledge Junctions” because each site is designed to bring together documents, people, and other sources of knowledge useful to a particular group within the AFMS.

3.16. EGL. (<https://kx.afms.mil/decisionsupport>) This website displays the performance measurement improvement efforts within AFMS. The EGL performance metrics is an integral tool in the USAF/SG’s efforts to promote continuous PI throughout the AFMS. The strategy is to measure success in the operation of the AF MTFs and drive performance standards, establishes baselines, and best practices.

3.17. Military Health System Clinical Quality Management (MHS-CQM). (<https://www.mhs-cqm.info>) MHS-CQM helps MTFs meet the DoD’s performance measures and accreditation requirements through the collection, verification, management, and reporting of The Joint Commission ORYX® and MHS Balanced Scorecard data. Lists and charts used to support these efforts are available to users with secure access.

3.18. Population Health Website. (<https://kx.afms.mil/pophealthmgmt>) This website provides support to DoD health professionals, at all levels, to optimize the health of their communities through an effective and efficient healthcare delivery system. The Population Health Support Division (PHSD) staff members possess a wealth of knowledge and experience in Aerospace Medicine, Behavioral Health, Bio-Statistics, Coding, Epidemiology, Dental Health, Disease Management, Healthcare Optimization, Health Information Management, Health Promotion, Health Records Management, Immunizations, Nursing, Nutrition, Preventive Medicine, Public Health, and Research and are standing by to assist.

3.19. Clinical Practice Guidelines. (<http://www.healthquality.va.gov/>) The guidelines on this site are those endorsed by Veteran’s Health Association’s National Clinical Practice Guidelines

Council. Clinical practice guideline development initially evolved in response to studies demonstrating significant variations in risk-adjusted practice patterns and costs. Researchers hypothesized that establishing criteria for the appropriate use of procedures and services might decrease inappropriate utilization and improve patient outcomes. While definitive evidence is not yet available, these clinical practice guidelines appear to be having an appreciable impact on medical care. Guidelines, act as generic tools to improve the processes of care for patient cohorts, serve to reduce errors, and provide consistent quality of care and utilization of resources throughout the system. Guidelines also are cornerstones for accountability and facilitate learning and the conduct of research.

3.20. AFMOA/SGHQ Website. (<https://kx.afms.mil/clinicalquality>) This website for the AFMOA/SGHQ, a Field Operating Agency (FOA) whose commander reports to the AF/SG. It is used as a primary communications tool to announce and centralize information pertaining to the field units of the AFMS. Its various sections range from the urgent to the historical and from specific AFIs to general items of information over the entire spectrum of Clinical Quality Management for the AF to include Credentials and Privileging, Risk Management, Clinical Consultants, Policy, Clinical Practice Guidelines, Continuing Education and more.

3.21. Centralized Credentials Quality Assurance System (CCQAS). (<https://ccqas.csd.disa.mil>) CCQAS is a worldwide, web-based Tri-Service DoD database that contains credentialing, privileging, adverse actions, and risk management information designed to assist MTFs in managing their assigned healthcare providers. CCQAS assists the MTF in managing the credentialing/privileging/risk management processes and generates reports and letters.

3.22. Health Services Inspection (HSI). (<https://afkm.wpafb.af.mil/ASPs/CoP/OpenCoP.asp?Filter=OO-SG-AF-80>) HSIs are conducted under the authority of the USAF/IG by the Air Force Inspection Agency (AFIA). HSI teams assess the ability of AF medical units to fulfill their peacetime and wartime missions. *AFIA does not create health services policy.* These policies are developed by the Offices of the Assistant Secretary of Defense for Health Affairs, USAF/SG, MAJCOMs and various civilian medical oversight agencies. The AFIA inspects compliance with existing policies and community standards of clinical practice. The most current HSI Guide is available at the AFIA website. The Elements are annually loaded into MedFACTS to assist units in their self-inspection program.

3.23. Accreditation Association for Ambulatory Healthcare (AAAH). (<http://www.aaahc.org>) Also known as AAAHC or the Accreditation Association, AAAHC is a private, non-profit organization that assists ambulatory healthcare organizations in improving the quality of care provided to patients. It accomplishes this by setting standards, measuring performance and providing consultation and education where needed.

3.24. The Joint Commission (TJC). (<http://www.jointcommission.org>) An independent, not-for-profit organization, TJC maintains state-of-the-art standards that focus on improving the quality and safety of care provided by healthcare organizations. TJC's comprehensive accreditation process evaluates an organization's compliance with these standards and other accreditation requirements. Their website has multiple tools and frequently asked questions to assist organizations in compliance.

3.25. AFISO21 (Air Force Smart Ops for the 21st Century). (<https://www.my.af.mil/gcss-af/USAF/ep/globalTab.do?command=org&pageId=681742&channelPageId=-1898914>)

Collection of tools and references that enables all Airmen to develop processes that are effective while preserving resources.

3.26. Surgeon Generals Websites. The Surgeon Generals are responsible for providing medical guidance and policy to Air Force agencies. The websites provide current policy, guidance, and references and resources for all medical staff. AF, ANG, and AFRC SGs each have dedicated website as follows:

- 3.26.1. Air Force Medical Service (AFMS). (<https://kx.afms.mil/kxweb/home.do>).
- 3.26.2. Air National Guard (ANG) (<https://www.my.af.mil/gcss-f/USAF/ep/globalTab.do?command=org&pageId=681742&channelPageId=-152682>).
- 3.26.3. Air Force Reserve Command (AFRC) (<https://kx.afms.mil/afrcsg>).

Chapter 4

LICENSURE, CERTIFICATION, AND/OR REGISTRATION OF HEALTHCARE PERSONNEL

Section 4A—Personnel Required to be Licensed, Certified, and/or Registered

4.1. Professional Groups Requiring License, Certification, and/or Registration:

4.1.1. The following healthcare practitioners must possess and maintain an active (characterized by present activity, participation, practice, or use); current (not revoked, suspended, or lapsed); valid (the issuing authority accepts and considers professional performance and conduct in determining continued licensure); and unrestricted (not subject to state imposed stipulations or restriction pertaining to the scope, location, or type of practice ordinarily granted to all other applicants for similar licensure in the granting jurisdiction) license from a US jurisdiction before practicing independently within the defined scope of practice for their specialty: audiologists, chiropractors, clinical psychologists, clinical social workers, dentists, dental hygienists, occupational therapists, optometrists, pharmacists, physical therapists, physicians, physician assistants (non-personal service contract only), podiatrists, practical/vocational nurses, registered nurses (RN), advanced practice nurses (RN and APN license, see paragraph 4.1.1.6 for more detail), and speech pathologists. See paragraph 4.4.5. for further discussion of an unrestricted license.

4.1.1.1. State licensing boards and other national agencies issue and may revoke authorizing documents to practice (licensure, registration, certification). When an action is taken against a provider's ability to practice, the AF informs the appropriate state licensing boards and other national agencies IAW DoD 6025.13-R and Federal law (as outlined in paragraphs 9.71., 9.73., and 9.74.2.).

4.1.1.2. Physician Assistants (PAs) must possess and maintain an active, current, valid, and unrestricted nationally recognized certification. In addition, non-personal service contract PAs are required to be licensed in the state of practice.

4.1.1.2.1. PAs (other than non-personal services contract PAs) are exempt from the licensure requirement due to the fact that most states have specific supervision requirements that are impractical, if not impossible, to meet given the diverse and mobile population in DoD medical operations. In response, Assistant Secretary of Defense for Health Affairs has exercised the authority to waive the license requirement, as long as the PA has successfully met the criteria outlined in paragraph 7.16., when privileges are initially granted or renewed. Therefore, PAs who have been granted privileges within the MHS by an authorized privileging authority will be automatically granted a waiver. This waiver is automated and the information is pre-populated in CCQAS under the licensure tab. The waiver date matches the date privileges were granted and expires with privileges or the expiration date of the national certification, whichever comes first. The waiver is automatically reissued based on renewal of privileges and/or national certification. Monitoring for compliance will be accomplished by the Standard Unlicensed Provider Report in CCQAS; therefore, the unlicensed tab within CCQAS should be completed.

4.1.1.3. Newly accessed military clinical social workers must, at a minimum, have a Master of Social Work (MSW) level of state license and be working toward obtaining a license that allows practice of clinical social work without supervision. Non-military and Reserve clinical social workers must have the level of state licensure that is unrestricted and allows independent clinical practice without supervision. (Refer to paragraph 7.10. for additional information).

4.1.1.4. Certified alcohol and drug abuse counselors (CADAC) must possess and maintain an active, current, valid, and unrestricted nationally recognized certification (refer to paragraph 7.22.).

4.1.1.5. Clinical dietitians must possess and maintain an active, current, valid, and unrestricted nationally recognized registration (refer to paragraph 7.7.).

4.1.1.6. The following advanced practice registered nurses must possess and maintain a current, valid, and unrestricted RN license from a US jurisdiction (as described in paragraphs 4.1.1. and 4.4.5.2.) as well as an AF approved national specialty certification: nurse anesthetists, nurse-midwives, and nurse practitioners. Advanced practice registered nurses in the AFMS must be licensed to the advanced practice level IAW the US jurisdiction requirements of their currently held RN license. Some US jurisdictions provide a separate license for the advanced practice specialty; others provide only one license which indicates an advanced level of practice.

4.1.1.7. Refer to Chapter 7 for further information about licensure, registration, and/or certification requirements for healthcare professionals.

4.2. Authorizing Document to Practice.

4.2.1. Scope of Licensure Requirement. Military, civil service, personal services contract personnel, and volunteers (reference DoDI 1100.21, *Voluntary Services in the Department of Defense*) who require a license to perform their duties must maintain a license from any US jurisdiction. Non-personal services contract personnel providing care within the MTF must be licensed in the jurisdiction in which the MTF is located.

4.2.2. Other Authorizing Documents to Practice. For those whose authorizing document to practice is a national certification (physician assistant, substance abuse counselor) or registration (dietitian); they are exempt from maintaining a license from a particular jurisdiction (i.e., US state/territory).

4.2.3. Deployed personnel must possess and maintain an active, current, valid, and unrestricted license or other required authorizing document to practice (i.e., national certification) and be privileged to practice independently.

4.2.4. Assignment to a position not involving direct patient care within or outside an MTF does not eliminate the requirement to maintain an active, current, valid, unrestricted license and/or authorizing document to practice.

4.2.5. Contract Providers. The type of contract determines the licensure requirement for contract personnel, whether it is personal services or non-personal services. The best way to differentiate between these types of contracts is to consider the relationship between the MTF and the individual.

4.2.5.1. Personal services contract employees are managed and supervised as if they are civil service or active duty. For purposes of liability they are considered government employees. Personal services contract employees must maintain a current, active, unrestricted license from any US jurisdiction or an authorizing document to practice as outlined in paragraph 4.1.1.

4.2.5.2. Non-personal services contract personnel are independent contractors and are required to carry professional liability insurance. The Federal Tort Claims Act does NOT cover this individual. The contractor is responsible to ensure that the individual has malpractice liability coverage and often indemnifies its employee. Non-personal services contract employees must maintain a current, unrestricted, active license from the state in which they are practicing and, if required, a certification or registration when caring for patients within the MTF.

4.2.5.3. Non-Personal Services Contract Providers Involved in Telehealth. Non-personal services contract providers engaged in telehealth need to comply with the licensure requirements for telehealth in the state in which the patient is located.

4.2.5.4. Non-Personal Services Contract Physician Assistants (PAs). Depending on the specific state, this provider may have supervision requirements imposed by the state board of licensure that exceeds AF requirements. For those PAs who require additional supervision, there are three possible methods to meet this need, listed in the order of preference: 1) The contractor is responsible to provide the additional supervision. In this case, the MTF would cooperate by providing copies of records for this external review ensuring HIPAA requirements are met; 2) The MTF petitions the state board of licensure to honor licensure portability (refer to 10 U.S.C., §1094) to allow the MTF physician supervisor to provide all of the necessary supervision; 3) A physician assigned to the MTF meets the state licensure requirements to provide the supervision. When a MTF provider is providing supervision they are obligated to meet the state's supervision requirements even if it exceeds the AFMS' requirements as described in paragraph 7.16. Ideally, should the MTF need to utilize contracted PAs, it is recommended they be hired via personal services contracts.

4.2.5.5. Non-Personal Services Contract Nurses. In 1999, the National Council of State Boards of Nursing (NCSBN) developed the Nurse Licensure Compact (NLC). The NLC legislation allows for US states and territories to enter into a mutual recognition compact for nurses licensed across jurisdictional borders (refer to <http://www.ncsbn.org/nlc/index.ast>). A nurse who resides in a compact state/territory receives his/her license in that home state and can practice on that privilege in other NLC jurisdictions. The nurse is bound to practice under that state's nursing practice act where care is actually delivered.

4.2.5.5.1. If a contract nurse is licensed in a state not included in the NLC and is practicing in a MTF he/she must be licensed according to the regulatory requirements of the state in which they are practicing.

4.2.5.6. Contract providers who practice exclusively outside the MTF are not credentialed or privileged by the MTF, for example, optometrists contracted by AAFES. All contract providers who perform their duties in the MTF must be credentialed and privileged by the MTF according to AF requirements and, if non-personal services

contractors, must be licensed according to the regulatory requirements of the State in which they are practicing. EXCEPTION: Providers contracted for interpretative services, reference paragraph 6.39.

4.2.6. American Citizens Hired Overseas. In order for an MTF located outside the US jurisdiction to hire an American citizen under a non-personal services contract, the MTF must obtain a waiver from the host country. This waiver must include a statement that the individual is to provide services only on the US Federal enclave and is required to be licensed in any US jurisdiction rather than the host nation. Another option is for the individual to obtain a license, or other authorizing document, from the host nation via endorsement or reciprocity.

4.3. Obtaining and Maintaining Licenses. Obtaining and maintaining a license or other authorizing documents to practice is the professional and personal responsibility of each healthcare professional, regardless of whether they are functioning in a clinical, non-clinical or administrative role.

4.3.1. Permissive temporary duty is authorized for military personnel taking license examinations. Civilian employees will be in official duty status when obtaining and renewing professional credentials, to include professional accreditation, state/municipally-imposed professional licenses, professional certifications and examinations to obtain such credentials IAW AFI 36-815, *Absence and Leave*.

4.3.2. All civilian healthcare personnel considering employment or other affiliation with the AFMS, must obtain and maintain an active, current, valid, and unrestricted license, certification, or registration as a condition of employment. Personnel cannot use appropriated funds to pay fees for obtaining and maintaining a license except in the following instances:

4.3.2.1. When the MTF requires military providers to participate in an external resource sharing agreement with a civilian institution that does not recognize the licensure portability statute (described in paragraph 4.8.), the military provider must be licensed in the state of practice. In this instance, Federal Statute, *Title 10 United States Code Section 1096*, allows the Secretary of Defense to reimburse the military member up to \$500.00 (of the amount of the license fee paid by the member) from local MTF funds toward obtaining said license.

4.3.2.2. Active duty dental hygienists may submit a voucher for reimbursement of costs associated with obtaining and maintaining state licensure. MTFs can use DHP O&M appropriated funds to provide reimbursement.

4.3.3. Refer to AFI 41-104, *Professional Board and National Certification Examinations*, for guidance on circumstances in which a military member may be reimbursed for fees and expenses associated with taking professional board and national certification exams.

4.3.4. The status of individual professional licensure, certification, and/or registration for all healthcare practitioners will be monitored at the MTF or for ARC: RMU/MDG level on a regular basis (see paragraphs 5.3.3. through 5.3.5.) for those healthcare professionals required to be entered in CCQAS. Those healthcare professionals who have not yet obtained the required authorizing document to practice must have a written explanation documented in the provider's CCQAS record on the unlicensed tab within the

licensure/registration/certification section. Monitoring of the licensure, registration, and/or certification status may be accomplished utilizing the standard CCQAS reports.

4.3.4.1. The status of authorizing documents to practice for healthcare professionals who are required to maintain a license, registration, or certification but are not currently mandated to be entered in CCQAS (see paragraph 5.3.2.) will be monitored in accordance with MTF or for ARC: RMU/MDG local policy. CCQAS could be used to track the license, registration or certification of these individuals.

4.3.5. AFMOA/SGHQ oversees the quality of data in CCQAS and works directly with the MTF or ARC POC to identify unlicensed providers and provide guidance on resolution.

Section 4B—Management of Licensure Issues

4.4. Guidance on Licensure Requirements:

4.4.1. Those active duty personnel accessed from professional training or who complete other training and require a license, certification, and/or registration to practice, must obtain such authorizing documents within 1 year of the date when all required didactic and clinical requirements are met or within 1 year of completion of postgraduate year one (PGY-1) for doctors of medicine (MD) and doctors of osteopathy (DO). Failure to meet this requirement will be handled as described in paragraph 4.6.

4.4.1.1. For physicians to be eligible for licensure, they must successfully complete Step III of the United States Medical Licensing Exam (USMLE) (Comprehensive Osteopathic Medical Licensing Examination (COMLEX) for DOs) and complete 1 year of postgraduate (PG) training. In order to meet the AF requirement, physicians who choose to be licensed in a state that requires more than 1 year of PG training must also obtain a license from another state that requires only 1 year of PG training.

4.4.2. According to DoD 6025.13-R, healthcare providers who do not yet meet licensure, certification, and/or registration requirements may practice only under a written plan of supervision. Within the AFMS, those healthcare practitioners who do not meet the licensure, certification and/or registration requirements may be granted supervised privileges and are required to have a written plan of supervision. The supervision provided must be from a licensed, fully qualified, independently practicing, and, if appropriate, privileged provider of the same or similar specialty. (See paragraph 6.28.2. for further information and Attachment 1 for definition of supervised privileges.)

4.4.3. Licensure Requirements for Clinical Psychologists. Clinical psychologists who have not been awarded their doctoral degree (N/A to the ARC) are required to make continual progress toward completion of their doctoral dissertation and state licensure requirements throughout the period of their initial contract with the AF. Those who have been awarded their doctoral degree are required to make continual progress toward state licensure requirements throughout the period of their initial contract with the AF (N/A to the ARC). Due to differences in dissertation requirements, no specific guideline can be defined for all clinical psychologists. In most cases, the time required is 20 months. The majority of states require 1 year of postdoctoral supervision before a clinical psychologist is eligible for testing and licensure. Clinical psychologists are allowed 3 years from the date the doctoral degree is awarded or the date the clinical internship is completed (whichever is earlier) to obtain a state

license to accommodate the variation of state licensing requirements. (Reference paragraphs 7.9.4. and 7.9.5. for information regarding supervision and privileging requirements.)

4.4.4. Licensure Requirements for Dentists, New Dental Accessions, Health Professions Scholarship Program (HPSP) Dental Graduates, and Advanced Education in General Dentistry (AEGD) Residents. Dentists must hold a current, active, unrestricted license to practice dentistry in a state or jurisdiction of the US except as noted below:

4.4.4.1. Direct accession dentists must show proof of having passed both Part 1 and Part 2 of the National Board and a state or regional licensing clinical board exam. In addition, they must show proof of having applied for a license to practice dentistry prior to entering AD. An unrestricted active license must be obtained within 1 year of arrival at the first permanent duty location.

4.4.4.2. Health Professions Scholarship Program (HPSP) graduates who must serve an AD service commitment, and other new dental graduates entering an AF PGY-1 program must show proof of having passed both Part 1 and Part 2 of the National Board and of having taken a state or regional licensing clinical board exam prior to entering AD. A license must be obtained within 1 year of arrival at the first permanent duty station for members not completing a PGY-1 program. PGY-1 program graduates who are applying for licensure based on the completion of PGY-1 program have an additional 6 months to obtain licensure.

4.4.4.3. Failure to obtain a license within the time frames outlined above may result in administrative discharge actions IAW AFI 36-3207, *Separating Commissioned Officers*. (Reference paragraph 4.6. for further information).

4.4.5. Meaning of Unrestricted License:

4.4.5.1. For non-physician professionals who are members of the Biomedical Sciences Corps (BSC) and Dental Corps (DC), an unrestricted license (meaning authorizing document) is one in which the individual has met all clinical and professional requirements, has no clinical limitations or restrictions, and is able to practice full scope of care in the jurisdiction once all administrative requirements are met. Therefore, for non-physicians, state waiver of renewal fees, malpractice insurance, payment into risk pool, etc., may be accepted as long as the license is clinically and professionally equivalent to the individual's civilian counterpart's license.

4.4.5.2. For Nurse Corps (NC) and Medical Corps (MC) healthcare professionals an unrestricted license is one in which the individual has met all clinical, professional, and administrative requirements, and has no clinical limitations or restrictions. The healthcare professional must be able to practice in the jurisdiction of the issuing agency immediately seeing non-DoD beneficiaries without first taking any additional action (i.e., pay a renewal fee) on the license.

4.4.5.3. A non-personal services contract physician working within the MTF must have a medical license that meets all clinical, professional, and administrative requirements of the issuing state and be no different than his or her civilian counterpart's license (reference paragraph 4.5.2. for exceptions).

4.4.5.4. This requirement applies to physicians in residency programs, once they become eligible for licensure as described in paragraphs 4.4.1. and 4.4.1.1.

4.5. Waiver of Administrative Licensure Requirements for Physicians (Not Applicable for Non-Personal Services Contract Physicians):

4.5.1. DoD 6025.13-R outlines the provisions for implementation of 10 U.S.C. §1094 which allows a waiver of the unrestricted scope requirement only in “unusual circumstances.” The ASD (HA) permits waiver of administrative licensure requirements that are unusual, substantial, and inharmonious with Federal policy. Examples include payment of malpractice/risk pool fees or requirement to reside or to be practicing in the state of licensure.

4.5.1.1. If the only administrative requirement is payment of renewal fees, this will not be waived.

4.5.1.2. Waiver of permissible administrative requirements is not automatic. Once determined to be eligible for waiver, each physician must submit an application for waiver (see Attachment 3). Once the waiver is granted, it is only good for that licensure renewal period. The physician must submit a new application for each licensure renewal period. Waivers are not renewed upon PCS unless it coincides with that licensure renewal period.

4.5.1.2.1. Approved waivers are scanned as the second page of the provider’s license document, named IAW the document naming conventions located in the Kx C&P toolkit, uploaded to the provider’s electronic PCF (CCQAS record) and annotated in CCQAS. Waivers approved prior to the completion of the provider’s 1st E-application were filed in Section VI of the PCF with the copy of the provider’s license.

4.5.1.3. If a physician has, and intends to maintain, two or more licenses with state-exempted administrative requirements, and the licensure requirement can be met by paying renewal fees (versus applying for waiver as just described), he or she is not eligible for waiver of administrative licensure requirement. In addition, the waiver is not required if the provider has a current, valid and unrestricted license from another US jurisdiction.

4.5.1.4. The HQ USAF/SG has delegated waiver authority to the MTF/CC. For physicians attending AFIT programs the delegated waiver authority will be HQ AETC/SG. For physicians in deferred/re-deferred training programs the delegated waiver authority will be AFPC/DPAM. Waivers will be granted for only those states approved by ASD/(HA). (See Attachment 3 and the Kx C&P toolkit for list of approved states.)

4.5.1.5. If a state has an unusual and substantial administrative licensure requirement, not previously identified by DoD, a waiver request package may be generated by the MTF. This package contains the waiver request memorandum (see Attachment 3 and the Kx C&P toolkit for waiver request memorandum template) and detailed information along with supporting documentation from the state licensing board. The complete package is forwarded to AFMOA/SGHQ to coordinate the HQ USAF/SG review. If HQ USAF/SG determines there is merit, the request will be submitted to the ASD(HA) for consideration. The ASD(HA)’s decision will then be disseminated to the MTF/CC.

4.5.2. Overseas Local Hire Healthcare Providers Caring for DoD Beneficiaries. Healthcare personnel from jurisdictions other than the US require written practice authorization (permission to practice) to fulfill the requirements in paragraphs 4.1. through 4.2.1. and are required to have documented proof of English language competency and current clinical skills. Newly employed healthcare personnel shall practice with supervised privileges/practice for 1 year. Focused and ongoing professional practice evaluation will provide evidence of current competence to serve as the basis for continuation of practice. During this time, continued practice authorization must be obtained based on the following:

4.5.2.1. Certification by the Educational Commission for Foreign Medical Graduates (ECFMG) (for physicians), certification by the Commission on Graduates of Foreign Nursing Schools (CGFNS) (for nurses), or

4.5.2.2. Demonstration of all of the following:

4.5.2.2.1. Comprehension and proficiency in oral and written use of the English language provided by an external agency.

4.5.2.2.2. Clinical competency documented and assessed by objective performance measures.

4.5.2.2.3. Possession of either a current, valid, unrestricted license, certification, registration, or other authorizing document to practice in the country of employment (host nation) or a license, certification, or registration accepted by the US as a basis for employment and practice in that country.

4.5.3. Foreign National Physicians and Dentists Whose Practice Is Limited to Foreign National Employees of the US at Overseas Locations. These providers are exempt from the requirements of paragraph 4.5.2. but must possess a license or equivalent that would enable them to care independently for patients in the country of residence (host nation). **Note:** This applies only to MTFs located overseas.

4.6. Failure to Obtain or Maintain a License, Certification, or Registration.

4.6.1. A healthcare professional who does not obtain an active, current, valid, unrestricted license or other authorizing document will not practice independently (see paragraph 4.4. for guidance on requirements).

4.6.2. Healthcare professionals who fail to maintain a license, registration or certification will be removed from independent practice and privileged providers will be placed in abeyance. If time *exceeds 30 days* of abeyance, the provider will be placed in summary suspension IAW paragraph 9.20. until the license, registration or certification is renewed. Issuing agency grace periods are not honored by the AFMS when renewing a license, certification, or registration.

4.6.3. One or more of the following actions will be taken when a healthcare professional fails to obtain or maintain a required license, certification, or registration within the specified time frame:

4.6.3.1. Subject to the needs of the AFMS, the individual may be cross-trained into another career field or revert to previous AFSC, if applicable.

4.6.3.2. MTF/CCs should take action to withdraw the provider's additional special pay and incentive special pay (if applicable). Related references: Medical Officer Specialty Pay Plan, published yearly, and AFI 41-109, *Special Pay for Health Professionals*.

4.6.3.3. Regular and Reserve officers on extended AD may be involuntarily separated under AFI 36-3206, *Administrative Discharge Procedures for Commissioned Officers*, or AFI 36-3207, *Separating Commissioned Officers*, or both.

4.6.3.4. The MTF/CC may request a waiver of the timeline to obtain licensure, certification, and/ or registration.

4.6.3.4.1. The MTF forwards the package containing the MTF/CC's recommendation along with supporting justification for either a waiver of the timeline to obtain licensure, certification, and/or registration (see paragraph 4.4.) or request for separation/discharge to AFMOA/SGHQ.

4.6.3.4.2. AFMOA/SGHQ will ensure appropriate documentation and coordination of the waiver package and present the case to AFMOA/CC. AFMOA/CC may approve waivers up to 12 months. Waivers disapproved by AFMOA/CC or exceeding 12 months will be submitted to HQ USAF/DSG for disposition with informational copy to MAJCOM/SG. If the HQ USAF/DSG recommends separation/discharge, the package will be forwarded to AFPC/DPAM for disposition.

4.6.4. ARC providers who fail to maintain their required license, certification, or registration may be separated under AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*.

4.6.4.1. For Reserve Personnel Only: National Registry of Emergency Medical Technician (NREMT) certification for the award and retention of AFSCs 4N0XX is required. Personnel who have not maintained their certification will be entered into training status code "T" for a 90 day period. These individuals will not be a deployable asset (SORTS reporting will reflect this action) nor will they be allowed to perform duties which require patient care. Individuals in Training Specialty Code "T" are ineligible for reassignment, reenlistment or promotion. Their commander will evaluate members after the 90-day period and those individuals who have not obtained the required certification will initiate action to withdrawal their AFSC IAW AFI 36-2101, *Classifying Military Personnel (Officers and Enlisted)*. If the members do not voluntarily retrain, the commander may initiate involuntary retraining or re-assign to the Inactive Ready Reserve.

4.6.5. Civil service personnel may be terminated under AFI 36-704, *Discipline and Adverse Actions*. All MTFs will consult with their supporting civilian personnel office for potential actions with civil service or local-hire personnel.

4.6.6. Contract personnel who failed to maintain required authorizing document to practice may be terminated under their contract. All MTFs will consult with their local contracting officer for consideration of termination of contract.

4.7. Clinically Restricted Licenses. All individuals who are licensed or maintain certification or registration must immediately notify their clinical supervisor and MTF senior corps representative when an agency is considering or has imposed a clinical or professional restriction

on their license, certification, or registration. For privileged providers, the credentials function will evaluate the proposed or actual clinical or professional restrictions imposed on the individual's license/certification/registration and take appropriate action.

4.8. Portability of State Licensure. DoD 6025.13-R establishes procedures under Title 10 U.S.C. §1094(d) to permit licensed military physicians and other military healthcare professionals to perform DoD official duties in authorized locations. AFMS officials responsible will, prior to assigning licensed providers to off-base duties, follow the procedures established in this AFI to promote cooperation and goodwill with State licensing boards. Off-base duties include, but are not limited to, training or skill maintenance duties in non-DoD healthcare facilities; professional activities performed under the authority of the military-civilian health services partnership program; and telemedicine services involving a patient outside an MTF and any military installation. Off-base duties do not include participation in approved post-graduate training of physicians.

4.8.1. Qualifications. To be eligible for assignment of off-base duties, the healthcare professional will:

4.8.1.1. Have and maintain a current, valid, and unrestricted license or other authorizing document (i.e., certificate or registration, reference paragraph 4.2.) that encompasses the professional activities involved in the off-base duty assignment.

4.8.1.2. Not be assigned to off-base duties if there is an unresolved allegation, which, if substantiated, would result in an adverse licensing or privileging action.

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

4.8.1.4. In the case of physicians and other privileged providers, current clinical privileges will be granted and maintained IAW Chapter 6. Alternatively, if such duties are outside the scope of clinical privileges granted by the applicable privileging authority, the provider will have clinical competence sufficient for such privileges.

4.8.1.5. In the case of physicians, the following additional qualification requirements apply:

4.8.1.5.1. The physician will have completed at least three years of approved post-graduate training (including completion of PGY-3) or have achieved American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) specialty board certification.

4.8.1.5.2. The physician will have maintained current competence, in that if ten years or more have passed since completion of the licensing examination, the physician must have ABMS/ AOA specialty board certification.

4.8.1.5.3. The physician will be current with applicable continuing medical education requirements as delineated in AFI 41-117, *Medical Service Officer Education*.

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

4.8.2. Coordination with State Licensing Boards Prior to Performing Assigned Duty locations. Prior to a healthcare professional performing off-base duties under the authority of

10 U.S.C. 1094(d), the AFMS official responsible (MTF/CC) will notify the applicable licensing board of the host State of the duty assignment involved. Such notification will include the name of the healthcare professional; the healthcare professional's State(s) of licensure; the location and expected duration of the off-base duty assignment; the scope of duties; the healthcare professional's commanding officer (MTF/CC); and the MHS liaison official (MTF/CC or designee, such as the SGH) for the licensing board to contact with any questions or issues concerning the off-base duty assignment. The notification will also reference 10 U.S.C. §1094(d) and DoD 6025.13-R as underlying authority and will include a statement that the healthcare professional meets all qualification standards of paragraph 4.8.1. (See Kx website C&P toolkit for notification letter template).

4.8.3. Investigations and Reports. Refer to DoD 6025.13-R in the event of any allegation of misconduct on the part of the military healthcare professional arising from the healthcare professional's performance of the off-base duty assignment. All individuals who are licensed or maintain certification or registration at the MTF must immediately notify their clinical supervisor and MTF senior corps representative when a Federal/state agency or facility, to which they are assigned off-base, is conducting an inquiry or investigation regarding their performance or conduct.

Chapter 5

THE CREDENTIALING PROCESS (APPLIES TO HOSPITALS, CLINICS, AND ARC MEDICAL UNITS)

Section 5A—Centralized Credentialing

5.1. AF/SG’s Vision of Centralized Credentialing. To accomplish the AF/SG’s vision of centralized credentialing and meet the AF/SG’s goal of putting healthcare practitioners to work as soon as possible, the AFMS has implemented a multi-factorial solution through the establishment and implementation of the Air Force Centralized Credentials Verification Office (AFCCVO) coupled with the use of the Centralized Credentials Quality Assurance System (CCQAS).

5.2. Air Force Centralized Credentials Verification Office (AFCCVO). The AFCCVO is the designated AFMS agent to be used for primary source verification (PSV) of healthcare provider credentials and queries. The AFCCVO’s principle function is support of the credentialing and privileging processes at AF MTFs and ARC medical units.

5.2.1. AFMOA/SGHQ will identify credentialing and privileging requirements, develop implementation guidance and resolve credential verification issues as they arise.

5.2.2. The AFCCVO will complete PSV on provider credentials and conduct appropriate queries for accessions and providers graduating from civilian training programs (AFIT, FAP, Health Professional Scholarship Program (HPSP), deferred, re-deferred, AFRC Health Professions Stipend Program). In addition, the AFCCVO will be the central repository for the PCFs/CCQAS files for providers attending AFIT and other civilian training programs and providers not assigned to an MTF that are in non-clinical, administrative, and special duty assignment positions and do not hold privileges at an MTF or medical unit.

5.2.3. The AFCCVO enters the provider’s information into CCQAS, maintains the provider credentials documentation and CCQAS file until the provider receives orders to an MTF. If the provider is not assigned to an MTF but is in a non-clinical, administrative or special duty assignment, the AFCCVO maintains the file until the provider requests privileges at an associated MTF. Upon notification of assignment the AFCCVO will perform PSV of authorizing documents to practice and conduct data bank queries and forward the historical PCF, if applicable to the gaining MTF or ARC CM. Any credentials the AFCCVO collects or generates to include verifications and query results will be scanned, appropriately named, and uploaded to the provider’s electronic PCF. Hard copy documents will be maintained in a temporary file for 2 years after the CCQAS record is PCSd to the MTF or unit of assignment. **Note:** The AFCCVO performs PSVs/queries on behalf of the MTF, therefore, the MTF CM does not re-accomplish this work. However, the MTF CM (for ANG unit: ANG CM) is responsible for appropriately identifying and investigating all “red flags” in the documentation provided from the AFCCVO and in the provider’s application for privileges/medical staff appointment.

5.2.4. The AFCCVO performs PSV and applicable queries upon request by the MTF or for ARC: RMU/MDG (new contract and civil service employees, providers PCSing to/from MTFs/RMUs/MDGs, or providers undergoing annual or biennial review).

5.2.5. During the accession process for AD and ARC providers, the AFCCVO will perform the National Practitioner Data Bank (NPDB)/Healthcare Integrity and Protection Data Bank (HIPDB) queries. The NPDB/HIPDB will re-queried upon notification of accession with the MTF assignment before the individual is initially granted privileges. The CM will request the AFCCVO query the NPDB/HIPDB as part of the annual or biennial review process (reference paragraph 5.4.6.1.). The query results will be scanned, appropriately named and uploaded to the provider's CCQAS record. The CCQAS record will be updated and if required, transferred (PCSD) to the MTF of assignment. The AFCCVO's electronic query results will be maintained at the AFCCVO for a period of two years.

5.2.6. The AFCCVO will process all Federation of State Medical Boards (FSMB) queries, if required. The CM will request the query be performed via CCQAS. On the NPDB/HIPDB/FSMB tab, in the "FSMB Information" section, click the "Request Query" block (reference paragraph 5.4.6.2. to determine when it would be appropriate to request a FSMB query). Upon completion, the AFCCVO will update the results in CCQAS, scan and upload the query documentation to the provider's electronic PCF.

5.2.7. AFCCVO contact information is available on the AFCCVO public access website and on the Kx under the C&P toolkit. The AFCCVO public access WWW site at: <http://airforcemedicine.afms.mil/afccvo> contains additional information, references, and request forms.

5.3. Centralized Credentials Quality Assurance System (CCQAS). CCQAS is a DoD-mandated MHS web-based, secure, worldwide provider credentialing, privileging, adverse action and risk management application used in the provider credentialing and privileging process.

5.3.1. The CCQAS database contains QA records created by or for the DoD, as part of the medical QA program. These records are confidential, privileged, and protected from disclosure IAW 10 U.S.C. §1102.

5.3.1.1. The CCQAS electronic PCF will be initiated and updated IAW the CCQAS User's Manual which can be found in the CCQAS "Help" menu and as outlined in the tools available on the Kx C&P toolkit.

5.3.2. In accordance with DoD policy the following list of healthcare providers, practitioners, and ancillary personnel must be included in CCQAS. Unless otherwise specified, the requirement applies to AD (including trainees in service programs, service-sponsored training, or long-term civilian schooling; anyone counting against end strength), reserve components, Federal civilians, civilian contractors, those providers working under contractual agreements within the MTF, and volunteers.

5.3.2.1. Physicians

5.3.2.2. Dentists

5.3.2.3. Advanced Practice Nurses

5.3.2.4. Physical Therapists

5.3.2.5. Podiatrists

5.3.2.6. Optometrists

5.3.2.7. Clinical Dieticians

5.3.2.8. Clinical Social Workers

5.3.2.9. Pharmacists

5.3.2.10. Clinical Psychologists

5.3.2.11. Occupational Therapists

5.3.2.12. Audiologists

5.3.2.13. Speech Pathologists

5.3.2.14. Physician Assistants

5.3.2.15. Chiropractors

5.3.2.16. Dental Hygienists

5.3.2.17. Mental Health Counselors (to include CADACs)

5.3.2.18. Professional Counselors

5.3.2.19. Marriage and Family Therapists

5.3.2.20. Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses (within timeline required by revised DoD Manual or 2 years from the date of this publication, whichever is earlier).

5.3.3. The CCQAS database is web-based and accessible by MAJCOMs, AFMOA, HQ USAF/SG, and DoD for policy decisions. It is paramount that the information entered is current, complete, and accurate, and any comments entered in any “Remarks” section must be factual, objective, and professional. CCQAS contains the provider’s electronic PCF and the provider may access his/her PCF.

5.3.4. The credentials managers, AFCCVO staff, education and training and graduate education program office representatives are expected to ensure the data quality of information entered in CCQAS. When appropriate, the data contained within CCQAS and the PCF/training record will be reviewed and reconcile. The provider electronic PCF will be updated appropriately whenever there is an updated credential (i.e., training, licensure, risk management documents).

5.3.5. The MTF/RMU/MDG CM will run periodic reports from CCQAS to assist the MTF leadership with effective management of the credentialing and privileging process and to ensure high data quality.

Section 5B—Provider Credentials

5.4. Documents Used in the Credentialing Process. Credentialing is the process of obtaining, verifying, and assessing the qualifications of healthcare practitioners to provide safe patient care services. This assessment serves as the basis for decisions regarding delineation of clinical privileges as well as appointments and reappointments to the medical staff. The required information should include qualification data such as relevant training and experience, current licensure, specialty certification (if applicable) as well as performance data such as current competence and the ability to perform privileges requested. This data is collected, verified and assessed initially and on an ongoing basis and requires the following documents:

5.4.1. AF Form 1540, *Application for Clinical Privileges/Medical Staff Appointment*. A provider who does not have an approved E-application on file will be required to initially complete an AF Form 1540. The provider must have an approved application (either a paper application or the E-application) and be awarded privileges prior to initiating practice in the AFMS. Providers requesting privileges and medical staff appointment previously awarded privileges within the AFMS who are not able to complete an E-application will complete an AF Form 1540A, *Application for Clinical Privileges/Medical Staff Appointment Update*, see paragraph 5.4.2.

5.4.1.1. The AF Form 1540 must be filled in completely, with no unexplained time gaps in work history from the date of completion of professional education/training.

5.4.1.2. On the AF Form 1540 applicants must list all licenses and/or other authorizing documents and narcotics registration(s) ever held, both active and inactive. In addition, applicants must provide an explanation of all licenses and narcotics registrations that are not current, involuntarily relinquished, or subjected to disciplinary action, voluntary or involuntary limitation, suspension, or revocation.

5.4.1.3. Applicants must provide explanation of any voluntary or involuntary termination or refusal of medical staff appointment.

5.4.1.4. Applicants must provide explanation of any voluntary or involuntary suspension, restriction, or reduction on clinical privileges, including requests for privileges that have been denied or granted with stated limitations or restrictions.

5.4.1.4.1. Section VIII, Question B asks, “Have you ever had a voluntary or involuntary limitation, reduction, revocation, suspension, denial, or loss of clinical privileges?” This applies to both temporary and permanent actions. **Note:** Suspension is a temporary removal or restriction of all or a portion of privileges, one whose privileges have been suspended must answer “yes” to this question. (For further information, refer to Chapter 9, Adverse Actions).

5.4.1.5. Medical Malpractice Documentation. If the answer to Section VIII, Question E is “yes,” applicants must provide written disclosure to the AFMS of their entire medical malpractice history and supply the following documentation:

5.4.1.5.1. A copy of the complaint and answer, including amendments.

5.4.1.5.2. A medical legal opinion stating the standard of care (SOC) determination, nature of claim, status of claim, and amount (if paid). This document must be obtained directly from the provider’s lawyer, the court, or the insurance company, to include a statement that a SOC determination does not exist if that is the case.

5.4.1.6. Adverse Action Documentation. If there is any evidence of an adverse action (adverse privileging/practice, DHHS/TRICARE sanction action or a HIPDB report) at any healthcare facility, the applicant must supply information on that action.

5.4.1.7. Additional information for newly accessed ARC personnel:

5.4.1.7.1. When applicant completes Section IV, Present and Military and Civilian Assignments, on the AF Form 1540, he/she must include previous and current AD, civilian and ARC assignments.

5.4.1.7.2. For Section VII, References, list individuals most familiar with the provider's professional skills and capabilities. References may be from an individual's previous MTF or a civilian facility in which he or she most recently held privileges or was employed.

5.4.1.7.3. For ARC privileging issues see paragraph 6.18.

5.4.2. AF Form 1540A, *Application for Clinical Privileges/Medical Staff Appointment Update* (if applicable). Providers requesting privileges and medical staff appointment previously awarded privileges within the AFMS who are not able to complete an E-application will complete this form at the time of reappointment or renewal of clinical privileges at the current MTF/RMU/MDG, or at the time of change in privileges at the current MTF/RMU/MDG. The applicant must review the most recent completed application, whether an E-application (filed in the provider's historical 6-part PCF) or the AF Form 1540 and complete a new AF Form 1540A as required. This form will only be used when the provider is unable to complete an E-application.

5.4.2.1. The AF Form 1540A will be placed with the previously completed AF Form 1540 and any subsequent AF Forms 1540A completed since the initial application. These documents become part of the permanent documentation in Section I of the PCF. This documentation will be scanned, named IAW the standard naming conventions, and uploaded to the provider's electronic PCF (see Kx C&P toolkit).

5.4.3. Provider's Health Status Documentation:

5.4.3.1. An applicant completing an application (off-line or E-application) must attest to their health status by answering questions and providing additional remarks for any affirmative response.

5.4.3.2. An applicant's physical, mental, and emotional fitness to perform requested privileges must be evaluated. This is accomplished during the provider's initial application for privileges and upon each annual or biennial renewal. The provider completes the applicable application: AF Form 1540, Section IX, Health Status, AF Form 1540A, Section VI, or the Health Status questions in the E-application and provides information addressing affirmative responses. The provider may be required to provide additional information, e.g., a statement of diagnosis, prognosis, and implications for clinical performance from the primary physician treating the provider or an additional medical evaluation may be directed as needed.

5.4.3.2.1. The clinical supervisor confirms the provider's physical and mental ability and qualifications to perform the requested privileges. For initial privileges and medical staff appointment, additional documentation may be required to be able to confirm the provider's health status and ability to perform the requested privileges. Reviewers' recommendations for privileges/medical staff appointment in the E-application process are based on the provider's health status information contained within the E-application. If adequate information is not available to make a recommendation for privileges/medical staff appointment the reviewer will return the application without action to enable the concern to be adequately addressed.

5.4.3.2.2. Refer to AFI 44-102, *Medical Care Management*, for information on providers with specific infectious diseases.

5.4.4. AF Forms 1562, *Credentials Evaluation of Health Care Practitioners*:

5.4.4.1. For providers accessed from the civilian sector, two AF Forms 1562 must be completed. Preferably these forms are completed by the provider's clinical supervisor and the chief of the medical staff. These peer references are used to document current clinical competency and are completed by individuals who have knowledge of the applicant's clinical performance.

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

5.4.4.1.2. If newly accessed providers are not associated with a group practice, applicants must have peer providers familiar with their practice complete the AF Forms 1562.

5.4.4.1.3. Letters of professional reference are acceptable in lieu of an AF Form 1562 if the civilian evaluator adequately addresses all requested elements on the AF Form 1562. At a minimum, this evaluation must address relevant training and experience, current competence, and any effects of health status on privileges being requested.

5.4.4.2. For providers completing an AFMS training program, one AF Form 1562 must be completed by the training program director and forwarded to the gaining MTF, along with any AF Forms 494 from the training program. Program directors for the Residency in Aerospace Medicine (RAM) training, Pharmacy Residency and Clinical Psychology Residency may submit an AF Form 475 in lieu of the AF Form 494. For dental residents, an AF Form 475 or a letter may be submitted in lieu of AF Form 494.

5.4.4.3. For providers completing civilian training programs, the program director and a senior level staff provider must each complete an AF Form 1562.

5.4.4.4. Providers PCSing or transferring from a DoD MTF/RMU/MDG, require two AF Forms 1562 and the AF Form 22, *Clinical Privileges Evaluation Summary*. The AF Form 22 will be completed by the clinical supervisor.

5.4.5. Since the PSV of the credentials document is the critical component in credentialing, copies of the following credentials no longer need to be submitted with applications for privileges as long as the data regarding the credential is supplied in the AF Form 1540:

5.4.5.1. Qualifying degree, Educational Commission for Foreign Medical Graduates (ECFMG) certificate or Fifth Pathway certificate for individuals who obtained premedical education in the US and received undergraduate medical education abroad. (See Attachment 1 for detailed definitions of ECFMG and Fifth Pathway). This information must be PSVd as indicated in paragraph 5.5.

5.4.5.1.1. **Note:** The foreign medical school degree must be PSVd with the issuing institution if an ECFMG certificate was issued prior to 1986 because medical school graduation was not verified by the ECFMG prior to that time.

5.4.5.2. Postgraduate training certificates (i.e., internship, residency, fellowship, Aerospace Medicine Primary (AMP) course, or nurse anesthesia, nurse midwifery, nurse practitioner programs). This information must be PSVd as indicated in paragraph 5.5. with the following exception: Postgraduate training completed at a DoD MTF may be

verified by review of the applicant's military personnel record or an officer SURF from the Air Force Personnel Center web site, any of which must be annotated appropriately as described in paragraph 5.5.

5.4.5.3. All current professional licenses, registrations, and certifications, as well as ones the provider previously held that are now inactive, expired, and/or suspended. These documents must be PSVd.

5.4.5.3.1. The AFCCVO, on behalf of the MTF/RMU/MDG, must PSV (as indicated in paragraph 5.5.) the license/certification/registration at the time of appointment, initial granting of clinical privileges, at reappointment or renewal or any revision of clinical privileges, and at the time of license/certification/registration expiration.

5.4.5.4. Specialty board certificates upon certification and recertification, if applicable. This information must be PSVd as indicated in paragraph 5.5. See paragraph 5.7.1. for additional information on verification of specialty board recertification.

5.4.5.5. State Controlled Substance Registration (CRS), if applicable. This information must be PSVd as indicated in paragraph 5.5.

5.4.5.6. Emergency Resuscitation Training Documentation. Resuscitation training requirements for personnel involved in direct patient care are outlined in AFI 44-102.

5.4.5.7. Continuing Health Education (CHE) Documentation. Continuing education is an adjunct to maintaining clinical skills and current competence. Therefore, all providers must participate and produce evidence of accumulated CHE at initial appointment and at least 60 days prior to reappointment. For specific continuing education requirements, refer to AFI 41-117. **Note:** CHE that results in awarding specific privileges or that constitutes "Additional Qualifying Training" must be PSVd (e.g., Aerospace Medicine Primary course; conscious sedation training). Documentation of the PSV of the CHE upon which privileges are awarded will be scanned, named IAW standard naming conventions and uploaded to the provider's electronic PCF. An entry is also required within CCQAS under the post graduate training tab.

5.4.5.8. Prior Clinical Privileges Lists.

5.4.5.8.1. The AFRS (for military accessions) and the MTF (for civilian accessions) will obtain copies of privileges awarded by the healthcare facility where the provider's most recent practice took place. For providers coming directly from a training program, applicable AF clinical privileges forms completed by the training program clinical supervisor meet this requirement. These forms reflect what the training program clinical supervisor deemed the applicant is qualified to perform. (See Attachment 1 for list of available clinical privileging forms).

5.4.5.8.2. For newly accessed providers from civilian practice, if the provider had privileges for less than one year at the prior healthcare facility, then privileges need to be obtained from another healthcare facility where the provider practiced prior to that year, if applicable. If the provider does not hold privileges at a healthcare facility, he/she must provide an applicable AF clinical privileges form completed by a peer familiar with the applicant's clinical practice. An applicant who is in private practice

and is not privileged at a civilian facility is required to submit a memorandum stating this fact.

5.4.5.8.3. Privileges for ARC personnel are based, in part, upon the applicant's civilian practice. A copy of the privileges lists from all current places of civilian practice must be provided. If the provider is in private practice and has no privileges or medical staff appointment with any civilian institution, a memorandum from the provider stating this fact must be provided.

5.4.5.9. Mammography Quality Standards Act (MQSA) Documentation:

5.4.5.9.1. For those MTFs who offer mammography services, radiologists will abide by MQSA requirements and submit appropriate documentation (refer to Department of Health and Human Services, Food and Drug Administration, 21 CFR, Part 900, Quality Mammography Standards, Final Rule; published in the *Federal Register*, Vol. 62, No. 208, Tuesday, October 28, 1997, effective 28 Apr 99). Written documentation that the provider meets MQSA requirements will be filed in Section VI of the PCF prior to the provider completing an E-application. Once the provider completes an E-application this documentation will be scanned, named IAW standard naming conventions, and uploaded to the provider's electronic PCF (see Kx C&P toolkit). The Federal Register regulation, as well as guidance documents, can be obtained from the following website: <http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActand> Program.

5.4.5.10. National Provider Identifier (NPI) Registration. The NPI is a unique health identifier for healthcare providers. This will be required for all privileged providers, residents, IDMTs and clinical nurses providing billable services (reference paragraph 6.40. for application process/ additional information).

5.4.5.11. Any Federal Drug Enforcement Administration (DEA) registration(s) and/or the DoD fee-exempt DEA original certificate (reference paragraph 6.41.). Fee-exempt DEAs are issued to physicians, dentists, podiatrists, optometrist, and prescribing psychologists. Physician assistants and advanced practice nurses who hold a state license as a mid-level practitioner are also eligible for a fee-exempt DEA. See Kx C&P toolkit for the latest DEA guidance for issuance of fee-exempt DEAs.

5.4.6. Data Bank Queries:

5.4.6.1. NPDB/HIPDB Queries. NPDB/HIPDB queries will be made by the AFCCVO on behalf of the MTF/RMU/MDG (reference paragraph 5.2.5.) at the time of initial medical staff appointment, initial granting of clinical privileges, renewal of privileges or when expanding privileges or requesting to add new privileges. There may be other circumstances in which it would be appropriate to query the NPDB/HIPDB.

5.4.6.2. FSMB Queries. Effective 1 May 04, FSMB queries are only required one time for physicians or physician assistants with a practice history prior to 1 Jan 95. This change is due to the redundancy of information contained in the NPDB and extremely low positive FSMB query results obtained. If there is a question concerning a provider's clinical practice history, an FSMB query may be requested through the AFCCVO (reference paragraph 5.2.6.).

5.4.6.3. Department of Health and Human Services (DHHS) and TRICARE Sanction Provider Listings. DHHS maintains sanction authority on behalf of government agencies (32 C.F.R.) and maintains the listing of providers who have been sanctioned (reference sanction listing at [http:// exclusions.oig.hhs.gov/](http://exclusions.oig.hhs.gov/)). TRICARE may initiate its own sanction action against a provider and maintains a list of sanctioned providers located on the following website: [www.tricare.osd.mil/ fraud](http://www.tricare.osd.mil/fraud). It is important to review both the DHHS and TRICARE listings to identify sanctioned providers who have entered into contracts or are applying for employment (accessions, civil service, etc.) with the AFMS. Paying funds to a sanctioned provider is against federal law and carries serious penalties and fines.

5.4.6.3.1. When a company is hired to provide healthcare providers, whether under a non-personal or personal service contract, the company is required to perform the appropriate sanction checks prior to presenting an otherwise qualified candidate. The company will provide the website printout of the query results annotated IAW para 5.5.4.7. The MTF/RMU/MDG CM will scan the query results, name IAW standard naming conventions, and upload the documents to the provider's electronic PCF (see Kx C&P toolkit).

5.4.6.3.2. AFCCVO will query the listings for accessions, providers graduating from out-of-service training programs, and other providers at the MTF/RMU/MDG request. The query results will be scanned, named IAW standard naming conventions, and uploaded to the provider's electronic PCF (see Kx C&P toolkit).

5.4.6.3.3. The MTF/RMU/MDG is responsible to review these exclusion lists to ensure there is not a sanction against any provider seeking employment through federal government service. The website printout of the query results will be annotated IAW para 5.5.4.7, scanned, named IAW standard naming conventions and uploaded to the provider's electronic PCF (see Kx C&P toolkit).

5.4.6.4. Defense Practitioner Data Bank (DPDB) Queries. AFMOA/SGHQ, Risk Management Operations, will upload the document indicating a positive DPDB report to the provider's credentials record under Document tab File type "DPDB Report" as outlined in the document naming convention (see KX C&P toolkit). The AFCCVO (if E-application was routed to the CVO for PSV) or the MTF/RMU/MDG CM will review the provider's documents within CCQAS to identify whether a positive DPDB query is entered. The AFCCVO (if application routed to the CVO for PSV) or the MTF/RMU/MDG CM will enter a comment under the Comments tab in the provider's E-application to indicate: "No DPDB report on file in the document section" or "DPDB report on file, see document section for additional information." The query will be performed at the time of privileging (if the provider has previously been privileged within a DoD MTF/RMU/MDG) and renewal of privileges (IAW DoD 6025.13-R), any positive results will be considered, as part of the provider's application during the privileging process. Types of reports generated by the DPDB queries include Ferres Barred, malpractice reports, and disability awards when associated with medical negligence.

5.4.7. Criminal History Background Checks (CHBC). CHBCs are required for all contract and volunteer providers caring for children under the age of 18 on a "frequent and regular" basis. The AFMS defines frequent and regular as patient workload of greater than 20% under

the age of 18 based on empanelled population or historical clinical information. Those contract or volunteer providers working in emergency services will be required to have CHBCs regardless of patient workload percentages. AD, ARC, and civil service providers do not require a CHBC, since background checks are completed on these providers prior to accession. CHBCs are based on fingerprints obtained by a government law enforcement officer, as well as inquiries conducted through the Federal Bureau of Investigation and State Criminal History Repositories.

5.4.7.1. For non-personal service contract personnel, the contractor is responsible for initiating the Federal Bureau of Investigation inquiry and completing the state criminal history inquiry portion of the CHBC. For personal service contract and volunteer personnel, the MTF security manager is responsible for initiating and completing the CHBCs. The MTF CM coordinates with the security manager to track the status and completion of the CHBC. For further information, reference DoDI 1402.5, *Criminal History Background Checks on Individuals in Child Care Services*.

5.4.7.2. The original or certified copy of the final results of the CHBC is required and must be kept in the PCF for the life of the contract.

5.4.7.3. CHBCs must be revalidated every 5 years. The revalidation consists of the installation records check and the Defense Central Investigative Index name check and covers the time period since the completion of the last background check.

5.4.7.4. CHBCs are to go back as far as possible, to age 18.

5.4.7.5. If there has been a break in government service, a complete CHBC must be reaccomplished, even if the individual has had a security clearance and/or recent CHBC.

5.4.7.6. Per DoD guidance, pending the completion of the CHBC, the AF/SG requires the privileged provider to have close clinical supervision. The MTF/CC will determine what constitutes "close clinical supervision."

5.4.7.7. The MTF/CC (for ARC: RMU/CC or MDG/CC) may request a CHBC on any personnel in their command at his/her discretion.

5.4.8. Utilizing the ICTB in Lieu of AF Form 1540. The ICTB facilitates transfer of credentials used by the receiving facility/deployed locations when privileged providers are assigned for temporary duty. The sending MTF/RMU/MDG conveys pertinent credentials and privileging information to the gaining MTF/RMU/MDG.

5.4.8.1. CCQAS Transfer (ICTB) E-application. The CCQAS Transfer (ICTB) E-application will be utilized for those providers being sent via ICTB to another DoD MTF/RMU/MDG. (Refer to CCQAS User's Guide for additional information).

5.4.8.1.1. For routine TDY, annual training, or manning assistance, the ICTB must be initiated in CCQAS and the provider must submit their Transfer (ICTB) E-application requesting privileges at the gaining MTF/RMU/MDG at least 60 days in advance, whenever possible. ARC entities will scan, appropriately name and upload to the provider's electronic PCF the current military and civilian clinical privileges lists (see KX C&P toolkit).

5.4.8.1.2. For ongoing, recurrent TDYs, unless the privileges at the sending MTF/RMU/MDG expire or are modified, it is not necessary to generate a new

ICTB/AF Form 22/AF Form 1562 for each TDY. The period of the ICTB expiration should be concurrent with the privileges/medical staff appointment expiration at the sending MTF/RMU/MDG.

5.4.8.1.3. Upon Conclusion of the CCQAS Transfer (ICTB) E-application. The TDY location will obtain a performance evaluation (i.e., AF Form 22 or 1562) and scan, appropriately name and upload to the provider's electronic PCF. This includes ANG providers who are returning from Annual Training or other TDY missions at AD MTF locations, e.g. ANG CRTCs, etc.

5.4.8.2. Hard Copy ICTB. Providers going on a temporary clinical assignment at a non-privileging UIC (i.e., deployed using "DEPLOYED" UIC or humanitarian mission using "HUMANITY" UIC) or to a Veterans Administration (VA) facility will require the generation of a hard copy ICTB. To initiate the hard copy ICTB within CCQAS, use the generate ICTB button to create the ICTB letter. **Note:** A CCQAS Transfer (ICTB) E-application is not generated or required. The hard copy ICTB package includes the ICTB letter, a copy of the provider's current clinical privileges list(s), and a blank performance evaluation form (i.e., AF Form 22 or 1562).

5.4.8.2.1. The sending MTF/CC, ARC privileging authority, or designee must sign the ICTB.

5.4.8.2.2. For routine TDY, annual training, or manning assistance, the Transfer (ICTB) E-application should be completed by the provider and submitted to the gaining MTF at least 60 days in advance, whenever possible. ARC entities will include current military and civilian clinical privileges lists and via the ICTB e-Application the new privileges list prepared by the involved provider to reflect requested privileges at the gaining facility. The supporting documentation should be scanned, appropriately named and uploaded to the provider's electronic PCF. If the provider has an approved E-application on file, the approved privileges may be downloaded from the privileges tab within the CRED record.

5.4.8.2.3. Any hard-copy ICTB initiated after the provider has completed an E-application will be scanned, appropriately named and uploaded to the electronic provider's credentials file. If the provider has not completed an E-application, maintain a copy of the hard copy ICTB in Section V of the PCF. When possible, obtain a performance assessment for the TDY period (i.e., AF Form 22 or 1562). Maintain the AF Form 22 or AF Form 1562 completed by the TDY location in Section II of the PCF for the biennial period. The performance assessment should be scanned, appropriately named and uploaded to the provider's electronic PCF.

Section 5C—Verification of Credentials

5.5. Primary Source Verification (PSV). Primary source is defined as the original source of a specific credential that can verify the accuracy of a qualification reported by a practitioner or licensed individual. PSV is required for clinical staff required by the organization or state to have a license, registration, or certification. Examples include medical school (for qualifying degree), graduate medical education program (for residency training), and state medical board (for license). A reasonable effort must be made to verify, with the primary issuing authority, all

documents identified in Section 5B as requiring PSV. Documents can be verified by one of the following methods: written verification, verbal via telephone, by obtaining an American Medical Association (AMA) Master file, American Osteopathic Association (AOA) Master file, World Wide Web, and, least preferred, touchtone telephone verification. The “chain of transmission” of the document or information is what distinguishes PSV from secondary source verification. The document or information must come directly from the issuing authority to be considered a PSV. Documents delivered and/or provided directly from the practitioner still require PSV. Copies of diplomas, certificates, licenses, etc. are NOT considered PSV, even if one personally makes the copy from the original document. **Note:** A reasonable attempt to PSV the document is defined as making a second attempt to solicit the necessary information. If still unsuccessful, annotate the effort, file documentation in Section VI of the PCF, and identify the problem to the MTF SGH or ARC privileging authority.

5.5.1. Written Confirmation from the Issuing Authority. For current credentials this confirmation is scanned, named IAW standard naming conventions, and uploaded to the provider’s electronic PCF (See Kx C&P toolkit). In the case of qualifying degrees, certified copies of the final college transcripts are acceptable if the type of degree and the date it was conferred are included on the transcript and the document came directly from the issuing authority. Reviewing a certified or raised seal copy of the final college transcript submitted by the provider is unacceptable and not considered PSV.

5.5.2. Verbal Telephone Confirmation from the Issuing Authority. This confirmation must be annotated on the copy of the document being verified or on a separate memorandum, and scanned, named IAW standard naming conventions, and uploaded to the provider’s electronic PCF (see Kx C&P toolkit). The documentation of the verification will be filed in Section VI of the pre-existing hard copy PCF or if there is not a hard-copy PCF, a provider specific folder to hold transitory/temporary credentialing documents. The verification annotation will indicate the date of the conversation, agency contacted for the verification, agency phone number, name and title of the individual at the agency who verified the information, the specific information provided, and the signature and signature block of the person who performed the verification. The signature block of the person requesting verification will include full name, title, and organizational address and phone number.

5.5.3. The following are considered designated equivalent primary verifications sources:

5.5.3.1. The American Medical Association (AMA) Physician Master file may be used for PSV of US medical school graduation and US residency program completion. For further information and guidance in obtaining an access code, call 1-800-665-2882 or access information on-line at <http://www.ama-assn.org>. There is a fee per profile for each of these services. To maximize savings to the AFMS, the AFCCVO will conduct this verification when required.

5.5.3.2. The AOA Master file may be used as PSV for US medical school and US residency program completions for osteopathic physicians. The commercial telephone number for the AOA is 1-800-621-1773, extension 8145. There is a fee per profile for each of these services. To maximize savings to the AFMS the AFCCVO will conduct this verification when required.

5.5.3.3. The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of physician’s graduation from a foreign medical school. (Refer to paragraph

5.4.5.1. and ECFMG in Attachment 1, Terms for a detailed definition.) To maximize savings to the AFMS the AFCCVO will conduct this verification when required.

5.5.4. Internet or WWW Verifications. The use of a professional organization's WWW site is permitted for PSV of credentials by a healthcare organization (HCO) or its contracted Credentials Verification Organization (CVO) if:

5.5.4.1. The information is obtained directly from the professional organization's WWW site. Use of the WWW site of another recognized professional organization is permitted if it is used as the platform to reach the intended site. The HCO and, when applicable its CVO, must confirm the WWW site used is the professional organization's official WWW site.

5.5.4.2. The HCO and, when applicable its CVO, will assure itself that the source WWW site, when not located at, and under the direct control of, the professional organization, receives its information directly from the professional organization's database through encrypted transmission. When the source WWW site is located at, and is under the control of, the professional organization, the HCO and, when applicable its CVO, should assure itself that if the WWW site does not receive its information from the database by encrypted transmission, it is protected from alteration by unauthorized individuals.

5.5.4.3. The information on the WWW site contains all of the information required for the PSV process of the specific credential, to include, sufficient information to properly identify the applicant. For example, name alone might not be sufficient to distinguish the applicant.

5.5.4.4. The HCO and, when applicable its CVO, must know the currency of information on the WWW site. Information on the WWW site that is supplemental to the information undergoing PSV, such as a state licensing board's WWW site including information on the individual's specialty, is not to be used as PSV data, although it may be useful in evaluating the overall package of information gathered by the HCO on the practitioner.

5.5.4.5. Any discrepancy between information provided by the applicant and that on the WWW site must be followed up with the professional organization by correspondence or telephone.

5.5.4.6. The fact that adverse information is not presented on the WWW site does not deter the HCO from contacting the professional organization by telephone or written correspondence if the other information gathered by the HCO warrants it or if there is a discrepancy between what the applicant provided and the information on the WWW site.

5.5.4.7. The signature block of the person completing verification, along with the date, will be placed on the WWW site printout or other record of information and will include the individual's full name, title, and organizational address and phone number. If the HCO uses a CVO that gathers information directly from a professional organization's WWW site, they must ensure that the CVO identifies the employee who made the WWW site contact and gathered the information along with the date of that action. If that information is in turn transmitted electronically to the HCO, the HCO must also identify the medical staff specialist who gathered the information from the CVO, along with the date.

5.5.5. Touchtone Telephone PSV. Touchtone telephone PSV (in which the caller does not speak with an actual person; instead, electronically accesses a database) is acceptable only if the other methods listed above are not possible and must be annotated as such. Follow the procedures outlined in paragraph 5.5.2. for specific guidance and procedures.

5.6. Credential Document Authentication. Annotating authentication true and valid copy of a credentialing document is not an acceptable method of PSV.

5.7. Actions Following Initial Verification. As long as the provider is continually employed by the DoD, the following apply:

5.7.1. Licenses, registrations, certifications must be re-verified as described in paragraph 5.4.5.3.1. Specialty board certifications with expiration dates must be re-verified (PSV) at time of reissue. Specialty boards that have implemented new certification standards which specify that ongoing certification with the board is contingent upon meeting the requirements of Maintenance of Certification (MOC) will require annual re-verification as outlined by the respective board (see Kx C&P toolkit for additional information). Once a diplomate's current, time-limited board certification expires, these individuals will enroll in MOC and successfully complete requirements to maintain certification.

5.7.2. Credentials which do not expire or require reissue, such as qualifying degree, do not need to be re-verified as long as the practitioner is continually employed by the DoD.

5.8. Inability to Obtain Necessary Credentials PSV. Inability to obtain necessary credential verification will be considered when recommending the award of privileges and may result in a modification of privileges or failure to award privileges. **Note:** If unable to obtain verification due to destruction of original documents by fire or natural disaster, annotate the reason the PSV could not be completed and attempt to at least secondary source verify the information.

5.9. Foreign language (excluding Latin) documents must be translated into English. ECFMG documents that are from 1985 or earlier must be translated into English and the qualifying foreign medical degree must be PSVd with the issuing institution. The only exception is if the qualifying foreign medical degree is from 1986 or later because the ECFMG PSVs these documents.

5.10. Verification of Board Certification. Specialty board certificates will be PSVd. This can be done directly with the certifying board or by using one of the approved sources:

5.10.1. For the American Board of Medical Specialties (ABMS), the following are identified and approved as the designated "official" display agents for Board Certification: CertiFACTs Online, Elsevier BoardCertifiedDocs and supporting physician data file, and the AMA Physician Profile and AMA Master File. Therefore, the ABMS Board Certification information provided by these entities are considered a designated equivalent source in regard to credentialing standards set forth by accrediting bodies such as the TJC. (Reference www.abms.org/bcdata.asp).

5.10.1.1. MTFs will use the AFCCVO services to fully utilize the AFMS subscription for verification of board certification.

5.10.1.2. According to ABMS, the official ABMS Directory of Board Certified Medical Specialists, 37th edition and subsequent print editions will no longer be used for PSV for

credentialing purposes. The ABMS Medical Specialists PLUS CD-ROM was phased out in June 2005 for PSV purposes.

5.10.1.3. According to AOA, the Official Osteopathic Physician Profile Report is recognized as providing primary source information on AOA board certifications and replaces the Physician Certification Verification Letter and AOA Directory Information as official sources for osteopathic physician credentials. (Reference: <https://secure.aoa-net.org/webprof>)

5.10.1.4. Verifications through ABMS or AOA apply only to those specialty boards that are members of the ABMS or AOA. Certification by non-ABMS or AOA boards must be verified directly with the respective board. Reference AFI 41-104, *Professional Board and National Certification Examinations*, for listing of approved certifying agencies.

5.10.2. It is not necessary to delay the award of privileges pending verification of board certification, because board certification is not an AFMS requirement for privileging.

Section 5D—AFRS, AFPC/DPAM, and AFMS Postgraduate Training Program Director Responsibilities for Credentials Documentation

5.11. Provider Accessions through the Air Force Recruiting Service (AFRS). Recruiting personnel will utilize the services of the AFCCVO for PSV of required credentials and to perform required queries used in the selection process. The AFRS will assemble the required credentials documents/forms and information as described in paragraphs 5.4. through 5.4.5.11. The AFRS will then forward all documents to the AFCCVO for processing (see 5.2.7. for contact information). The AFCCVO enters the provider into CCQAS, performs the PSV of the required credentials, conducts required queries, and sends a summary report to AFRS. Any red flags found in the verification and query process must be brought to the attention of AFRS for future investigation and appropriate clearance. Upon notification of accession and receipt of orders, the AFCCVO re-PSVs the license, repeats the applicable queries, updates the verifications in CCQAS and then forwards the CCQAS record electronically to the gaining unit [PCS to gaining MTF/RMU/MDG Unit Identification Code (UIC)] no earlier than 60 days and at least 15 days prior to the provider's report not-later-than date, when date of notification of accession and assignment allows. See para 5.2.3. for disposition of credentials/forms at the AFCCVO. See Credentials Table A5.1. in Attachment 5. See 5.21. for non-privileged medical professional NPDB/HIPDB queries.

5.11.1. The ARC accession credential requirements are the same as outlined in paragraph 5.4. This includes Reserve providers participating in the Health Professions Stipend Program (see paragraph 5.2.2.). *EXCEPTION:* The ANG unit will forward the results of the AFCCVO's credentials verifications/queries and the accession package to state's "The Adjutant General" (TAG) office. Copies of credentials documents will be maintained by the unit CM and will not be forwarded with the initial package.

5.12. Providers Attending Air Force Postgraduate Education Programs.

5.12.1. The director of medical education at the MTF that provides training for an individual will create and maintain a resident medical training record (as outlined in AFI 41-117) and a CCQAS record at the initiation and throughout the duration of training.

5.12.1.1. PSVd copies of all applicable credentialing documents will be scanned, appropriately named and uploaded into the provider's electronic PCF.

5.12.2. When training is completed, the director of medical education at the MTF prepares a final evaluation as outlined in AFI 41-117. The following completed documentation will be scanned, appropriately named and uploaded to the provider's electronic PCF:

5.12.2.1. AF Form 1562, *Credentials Evaluation of Health Care Practitioners*.

5.12.2.2. AF Form 494, *Academic/Clinical Evaluation Report*. AF Form 494 is completed for physicians by the training program director. Program directors for the Residency in Aerospace Medicine (RAM) training may submit an AF Form 475, *Education/Training Report*, in lieu of an AF Form 494. For dental residents and allied health programs, an AF Form 475 or a letter may be submitted in lieu of AF Form 494. **Note:** AF Form 475s will be completed for graduating students IAW AFI 36-2406, *Officer and Enlisted Evaluation Systems*.

5.12.2.3. Annotated clinical privileges forms. The training program director will indicate the student's ability to perform treatments and procedures by annotating the appropriate code in the "Verified" column of the applicable hard copy AF clinical privileges list and sign the clinical supervisor block.

5.12.2.4. An original signed verification (i.e., memorandum, letter, or other document to serve as PSV) of successful training program completion. This includes verification for those persons completing first post-graduate year (PGY-1) training.

5.12.3. Following training program completion the credentials, verifications and other documents cited above remain at the training institution as part of the medical education file. The applicable scanned documents are uploaded to the electronic provider's credentials file and are utilized in the credentialing and privileging process when the provider transfers to a new duty assignment.

5.12.4. The training program director or his/her designee at the losing training site will scan, appropriately name and upload the required credentials (which includes documentation of PSVs and credentials documents) to the provider's electronic PCF and transfer the CCQAS record to the gaining facility. If there is a pre-existing hard copy PCF (if trainee maintained a PCF at a DoD MTF prior to attending training program) it will be transferred to the CM at the gaining MTF by certified or express mail to arrive no later than 15 days before the provider's report not-later-than date.

5.12.5. Reference Credentials Table A5.2. in Attachment 5 for summary of training program responsibilities in collection and verification of credentials.

5.12.6. The training program office will maintain copies of applicable credentialing documents IAW AFI 41-117.

5.13. Deferred Providers Attending Residency, Fellowship, or Other Long-Term Graduate or Other Medical Education Programs in Residence at Civilian Medical Facilities. Recruiting Service has no further contact with providers who are recruited and then placed in deferred status to attend civilian training. Guidance concerning graduate education, licensure, and PSV of graduation from basic educational program is provided by HQ AFPC/DPAM. See Credentials Table A5.3. in Attachment 5.

5.13.1. Providers in residency programs will be licensed as described in paragraphs 4.4.1. through 4.4.1.1.

5.13.2. AFCCVO will provide an AF Form 1540, two AF Forms 1562, and the appropriate clinical privileges form(s) to providers for completion. At completion of training, the AFCCVO will PSV credentials IAW paragraph 5.5. and verify proper completion of all forms. The AFCCVO will then scan, appropriately name and upload copies of licenses, certificate(s) of residency completion, AF Form 1540, two AF Forms 1562, clinical privileges form(s), and other credentials documents, to the provider's electronic PCF no later than 15 days prior to report not-later-than date. See Credentials Table A5.3. in Attachment 5.

Section 5E—Provider Credentials File (PCF)

5.14. Electronic PCF. Effective upon the publication of this AFI, the official PCF for a provider who has been privileged within the AFMS will be the CCQAS record and will be referred to as an electronic PCF. The 6-part hard-copy PCF will become a historical file only and the electronic PCF will be subject to compliance inspections. For newly assigned providers without a historic PCF, a temporary credentials file will be established at the local MTF/RMU/MDG to store documentation that has been collected at that site. This documentation must be scanned, appropriately named and uploaded to the provider's electronic PCF upon receipt, as the electronic CCQAS record is the provider's official credentials file. The temporary file is not subject to compliance inspections but serves as a repository of historical documents if needed in the future. A printed copy of the provider's current approved E-application will be maintained in the temporary file in case of inaccessibility of the CCQAS web site. If the provider is unable to complete an E-application, the approved off-line application for privileges and medical staff appointment must be scanned, appropriately named and uploaded to the electronic PCF.

5.15. Handling of the PCF. The Privacy Act of 1974 (as implemented by AFI 33-332, *Air Force Privacy Act Program*); 10 U.S.C. §1102; and DoD 6025.13-R govern access and release of information in PCFs, the temporary file and any provider information from the CCQAS database.

5.15.1. The cover of all historical PCFs and any temporary credentials file must contain the following two statements: 1) "Privacy Act of 1974 governs access to this file," and 2) "This is a Quality Assurance document protected from release by Federal Law, 10 U.S.C. §1102."

5.15.2. Historical Hard Copy PCFs and the temporary credentials file will be maintained in a secure manner. Providers may review their files, but they may not remove them from the control of the CM. Refer to the Kx C&P Toolkit for historical information on the contents of the PCF. The provider's electronic PCF has replaced the hard copy 6-part PCF. Any previously established 6-part PCF folders are now maintained and transferred for historical purposes only.

5.16. Maintenance of ARC Electronic PCFs. In addition to paragraph 5.14., the following apply to the ARC:

5.16.1. Each ARC medical unit commander will appoint, in writing, an officer and/or senior non-commissioned officer as the credentials manager/liaison. They should also appoint an assistant credentials manager/liaison.

5.16.2. The electronic PCF is established and maintained by the MTF CM if collocated and at the ARC medical unit of assignment if non-collocated. For IMA reservists the electronic PCF is maintained at the unit of attachment. For ARC collocated providers, the electronic PCF is maintained by the AD host MTF; however, the ARC CM/liaison will have management oversight within CCQAS of the ARC providers for military related duties. The privileging authority lies with the location of the electronic PCF. If the provider is working as a civilian provider in an AD facility, the AD facility CM will contact the ARC unit and determine who will maintain the primary CRED record within CCQAS. An ICTB record will be created for the other facility/unit. In this situation the ICTB record provides a mechanism within CCQAS to share and track credentials and is used due to the current limitations of CCQAS.

5.16.2.1. ANG medical units collocated with AD MTFs should establish credentialing and privileging responsibilities with the MTF Credentials Function via a MOU or HTSA. Otherwise, the ANG medical unit will maintain the unit providers' credentials files and grant appropriate privileges.

5.16.3. Non-collocated ARC medical units will maintain their assigned providers' electronic PCF.

5.16.4. The host MTF of a geographically separated medical reserve unit will maintain the AFRC providers' electronic PCFs.

5.16.5. For ARC SMEs and Rapid Engineers Deployable Heavy Operational Repair Squadrons Engineer (RED HORSE) units, the electronic PCF is maintained by the host medical unit.

5.16.6. The credentials liaison for the collocated ARC medical units will act as liaison between the AD MTF and the ARC medical unit to ensure appropriate PCF documentation is provided (reference paragraphs 5.4. through 5.4.5.11.).

5.16.6.1. The ARC medical unit CC, SGH (or equivalent), unit credentials liaison and provider are responsible for forwarding all required credentials necessary to prepare the electronic PCF for the privileging process to the active duty MTF CM.

5.16.6.2. All supporting credentialing documentation for renewals must be submitted to the MTF/RMU/MDG CM at least 90 days prior to the privileging expiration date. This includes: AF Forms 22s and/or 1562s, civilian privileges lists or memorandum for record if the provider does not have civilian privileges and any CHEs documentation that has not been previously provided to the CM.

5.16.7. The AD MTF unit of attachment for Individual Mobilization Augmentees (IMAs) and Participating Individual Ready Reserve (PIRR) providers will create and maintain the assigned provider's electronic PCF.

Section 5F—Disposition of PCFs/CCQAS Records and Provider Activity Files (PAFs)

5.17. Disposition of Active PCFs/CCQAS Records When Providers Transfer.

5.17.1. The losing medical unit will complete a data quality review of the electronic PCF ensuring the minimum documents for an E-application are scanned, named IAW standard naming conventions, and uploaded (see Kx C&P toolkit). The historical hard copy PCF will

be sent by registered, certified or any other accountable mailing source to the gaining medical unit to arrive not later than 30 days before the provider's reporting date, when possible. This also applies to providers approved for inter-service transfers. The losing medical unit CM will assist the provider in completing the transfer E-application if required. The temporary credentials file will be retained at the losing MTF/RMU/MDG for a period of two years as it contains copies of documentation that has been scanned, appropriately named and uploaded to the provider's electronic PCF.

5.17.2. When a provider is reassigned, the SGH or ARC physician designee or clinical supervisor, and one peer at the losing MTF each complete a separate AF Form 1562 and the clinical supervisor completes an AF Form 22 as described in paragraph 5.4.4.4. The losing MTF CMs will scan, name IAW standard naming conventions and upload to the provider's electronic PCF. The hard copy forms (AF Forms 1562s and 22s) will be included in the historical PCF.

5.17.3. Providers not assigned to an MTF that are working in administrative positions (i.e., HQ USAF, HQ MAJCOMs, or other staff positions) that do not request privileges at a nearby MTF and those providers attending either AFIT-sponsored or non-sponsored (deferred/re-deferred) civilian training programs will have their historical PCFs and electronic PCF maintained by the AFCCVO. The historical PCF file is sent by an accountable mailing source and the provider's electronic PCF is transferred to the AFCCVO no later than 30 days after the provider's departure. For providers in re-deferred status include a copy of the separation orders in the provider documentation sent to the AFCCVO. Once received the AFCCVO becomes responsible for maintaining the PCFs for the duration of provider's assignment or if provider applies for privileges, the PCFs are forwarded to the requesting MTF/RMU/MDG.

5.17.4. For providers in administrative positions and those entering re-deferred civilian training programs the provider's electronic PCF is transferred to the AFCCVO Unit Identification Code (UIC). For providers attending AFIT-sponsored civilian training programs the provider's electronic PCF is transferred to the AFIT "WE0JF66J" UIC. **Note:** The AFCCVO manages both the CCQAS AFCCVO and AFIT UICs. The losing MTF CM notifies the provider of record location.

5.17.5. Historical and electronic PCFs for providers in military post graduate training programs associated with an MTF will be sent to the MTF-specific training program office and the appropriate GME UIC (refer to paragraph 5.12. for specific guidance and responsibilities). See the Kx C&P toolkit for additional information.

5.17.6. The provider is responsible to provide licensure, registration, certification, CHE, and BLS/ACLS/ATLS recertification updates to the appropriate office managing their electronic PCF.

5.18. Disposition of Inactive PCFs, CCQAS Records, and PAFs.

5.18.1. Medical units will maintain inactive PCFs of retired or separated providers IAW the Air Force Records Disposition Schedule (RDS), Table 44-7, Rules 3 and 4, in the Air Force Records Information Management System (AFRIMS). The AF RDS is available on-line at <https://www.my.af.mil/afirms/afirms/afirms/rims.cfm>.

5.18.2. Disposition of the PCF when providers leave employment. When a provider separates, retires, or terminates employment, contractual, or volunteer services, the MTF/RMU maintains his or her PCF as described above. The CCQAS record is deactivated and the clinical supervisor completes a final AF Form 22 to be placed in the provider's electronic PCF.

5.18.2.1. If a provider is offered and accepts employment at the same MTF within 30 days, any appropriate privileges awarded during the original privileging period prior to the change in status will automatically continue for the duration of that original privileging period without need for renewal. It may be appropriate to change the provider's medical staff appointment if the provider is no longer working full time at the MTF. This continuation of awarded privileges also applies to contract providers already privileged by the MTF when the contract ends and the provider is re-hired under a new contract and returns to work in the MTF without more than a 30 day gap. However, for all types of providers, if there is any interim clinical employment outside the MTF, CMs must obtain a letter of recommendation from the interim employer. Should the letter of recommendation contain cautionary information about the provider, that information may be used as a basis for further and broader inquiry, and possibly a reason for denial of continuation of previously held privileges. Also, if a contract provider's status changes from personal services to non-personal services, licensure and medical malpractice insurance requirement must be met. Review the Kx C&P toolkit for guidance on deactivation, update and linking of CCQAS records.

5.18.2.2. If the provider transfers to the ARC, the CCQAS record will be deactivated as above. The historical PCF is maintained at the MTF until requested by the ARC and then forwarded via the most cost effective accountable mail source. The gaining ARC unit will reenter the provider into CCQAS, link with the previous CRED record and update the record with the provider's new role before the new E-application is initiated.

5.18.2.3. All ANG medical units will forward the inactive historical PCFs to NGB/SG with a memorandum stating the reason why the historical PCF is being forwarded and deactivate the electronic PCF (i.e., separation, retirement, death, etc.). The NGB/SG will maintain historical PCFs as described in paragraph 5.18.1. Historical PCFs will be forwarded by the most cost effective accountable mail source to: NGB/SG, Attention: Credential Manager, 3500 Fetchet Avenue, Andrews AFB MD 20762-5157.

5.18.3. All AD facilities will maintain a PAF (see Attachment 7) containing cumulative data information on a provider. This data will be used by the supervisor when filling out an evaluation of the provider for the 2 year review, etc. Files are kept for 2 year after the provider PCSs, separates, retires, or terminates employment and are then destroyed.

5.18.3.1. Facilities will maintain PAFs for IMA/ Participating Individual Ready Reserve (PIRR) providers attached to their MTF.

5.19. Closing Medical Units.

5.19.1. Inactive historical PCFs will be sent by the most cost effective accountable mail source to AFMOA/SGHQ. AFRC unit PCFs will be forwarded to AFRC/SG. ANG units will forward PCFs as outlined in paragraph 5.18.2.3. PAFs and other items not ordinarily contained within the PCF are not forwarded along with the PCF. However, the contents of

the PAF will be summarized on an AF Form 22 which becomes part of the electronic PCF and is filed in the historical PCF forwarded to AFMOA/SGHQ; AFRC/SG; or NGB/SG as applicable. The provider's electronic PCF will be deactivated.

5.19.1.1. AFMOA/SGHQ will maintain PCFs as described in paragraph 5.19.1. and will be responsible for replying to requests from prospective employers for provider practice summaries.

5.19.2. Medical units will attempt to notify providers of the location of their historical PCFs.

5.19.3. PCFs of active IMA and PIRR providers who have not been reassigned will be sent to HQ ARPC/SG.

Section 5G—Non-Privileged Medical Professionals

5.20. PSV for Non-privileged Medical Professionals.

5.20.1. Non-privileged medical professionals required by the organization, by law, or regulation to practice their profession must obtain and maintain an active, current, valid, unrestricted license, registration or certification. The organization verifies by primary source at the time of hire and upon expiration/renewal of the credentials.

5.20.1.1. AFRS will accomplish PSV for all medical accessions requiring licensure, registration or certification IAW paragraph 5.5.

5.20.1.2. Each MTF shall determine the office responsible for PSV of licensure, registration or certification of non-privileged medical professionals. This applies when hiring civil service, personal service contractor, non-personal service contractor, and volunteer employees and upon expiration and/or renewal of the licensure, registration, or certification. **Note:** For professionals hired through a non-personal service contract, the contractor is responsible to perform the PSVs and forward the documentation to the identified MTF office. This information must be primary source verified as indicated in paragraph 5.5.

5.20.1.3. Non-privileged medical professionals must provide information on all licenses, registrations, or certifications active, inactive, or lapsed. An explanation for any licenses, registrations, certification that are not current, have been involuntarily relinquished, or have been subjected to disciplinary action, voluntary or involuntary suspension, reduction, restriction, or revocation must also be provided.

5.20.1.4. For accessions and other employee applicants, any information concerning unfavorable actions against any licenses, registrations, certifications will be forwarded through the appropriate clinical chain of command to AFMOA/SGHQ, for coordination with the Chief Consultant, Nursing Services, for consideration and employment recommendation.

5.21. NPDB/HIPDB queries for RNs/LVNs/LPNs.

5.21.1. AFRS will accomplish a one-time NPDB/HIPDB query for all nurse (RNs/LVN/LPNs) accessions except for Nurse Transition Program accessions who have no prior nurse experience. For new contract, GS, and volunteer nursing applicants, each

MTF/CC will determine the office responsible for querying the NPDB/HIPDB for nursing services.

5.21.1.1. All positive reports will be forwarded through the appropriate clinical chain of command to AFMOA/SGHQ, to the attention of the Chief Consultant, Nursing Services, for consideration and employment recommendation.

5.21.1.2. HQ AFRC/RS will accomplish a onetime NPDB/HIPDB query for all nurse (RN/LVN/ LPN) accessions. All positive reports (i.e., those with derogatory information) will be forwarded to HQ AFRC/SGO and the Reserve Nurse Career Field Manager for consideration and employment recommendation.

Section 5H—Screening Other Personnel Within the MTF

5.22. Shadowing of Medical Personnel in a Military Treatment Facility. Shadowing is a time-honored recruitment tool, not only for medical professions, but for the Air Force in general. In recognition of that, and with the increased emphasis on patient privacy and requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, all MTFs will comply with the following guidance before allowing civilians to shadow AF medical professionals.

5.22.1. The MDG/CC is ultimately responsible for the shadow program in their MTF. Shadowing is intended for short durations at the MDG/CC's discretion. The MDG/CC may delegate this responsibility to the appropriate MTF Functional Manager(s).

5.22.2. The MDG/CC or designated representative is/are responsible for the following:

5.22.2.1. Determine the appropriateness of allowing individuals to shadow medical professionals based on age, school affiliations, staff availability and the needs of the AFMS within their area of responsibility in coordination with the appropriate squadron commander. **Note:** The shadowing program is not designed to circumvent the establishment of a Training Affiliation Agreement (TAA). If the individual will be getting credit toward required curricula then a TAA may be required (see AFI 41-108, *Training Affiliation Agreement Program*). The MTF volunteer program (AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health System (MHS)*, 10 USC 1588 and DODI 1100.21) may also offer an alternative for interested parties who do not meet the recruitment intent of the shadow program or the need for a TAA.

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

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

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

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

5.22.2.6. Coordinate with Medical Legal Office as appropriate.

5.22.3. The designated preceptor will ensure that shadowing personnel:

5.22.3.1. Do not engage in any type of patient care.

5.22.3.2. Sign a non-disclosure statement (see Kx C&P toolkit).

5.22.3.3. Meet Hospital Employee Health Program requirements, as applicable.

5.22.3.4. The designated preceptor will obtain verbal patient consent for observation and document consent for observation in the medical record.

Chapter 6

THE PRIVILEGING PROCESS

Section 6A—Considerations in Awarding Privileges

6.1. Background. Privileges define the limits of patient care services the provider may render. They are based upon education, training, experience, health status, demonstrated current clinical competence, professional behavior, and certifying examinations. The degree of supervised clinical practice will be considered when awarding privileges.

6.1.1. Newly accessed military providers who do not have adequate documentation of current clinical competence (i.e., sole practice providers with minimal clinical performance data), and providers whose duties have not included clinical practice for an extended period, should be recommended for supervised privileges. **Note:** As a condition of employment, contract and government civilian providers must meet all applicable credentialing requirements outlined in this AFI and be fully qualified to perform within the scope of their practice.

6.1.2. The capabilities of the support staff, equipment, and other resources that may restrict a provider's services will be considered when verifying the delineation of privileges at the MTF.

6.1.3. See Section 6D for discussion of types of privileges.

6.2. General Information.

6.2.1. Privileges must be appropriate to the training, background, and demonstrated current clinical competence of the provider. All providers being considered for a specific privilege must be evaluated against appropriate training and qualification standards. All AFRC providers must be engaged in direct patient care that meets or exceeds the minimum requirements for privileging in their specialty or be officially and temporarily exempted by their licensing authority (e.g., for academic or administrative purposes).

6.2.2. Privileges are both individual and MTF/ARC medical unit specific. Military members requesting privileges should hold an AFSC (duty, primary, secondary, etc.) associated with that specialty. ARC providers will train to their duty AFSC. ARC providers assigned to unit's during unit training assembly (UTA) will request UTA privileges in addition to duty AFSC privileges; however, only UTA privileges are supported during the UTA.

6.2.3. Providers referenced in paragraph 6.6.1. must be eligible for the award of clinical privileges as a condition of employment or continued service with the AF, except for those functioning in strictly administrative or non-patient care research positions as their official DoD duties.

6.2.4. Providers who interpret medical data on individual patients must be privileged and privileging should require documentation of some regular or periodic clinical practice, adequate enough to maintain currency.

6.2.5. Privileging is not a disciplinary mechanism and will not be used as punishment for activities unrelated to clinical practice. It is a program for continually monitoring and

assessing the performance of providers using the results of process improvement, peer review, and risk management activities. However, the MTF/CC (for ARC: RMU/CC or MDG/CC) must review acts of provider misconduct to determine if the misconduct has an impact on patient/staff safety and the provider's scope of practice.

6.3. Relationship Among Privileges, Medical Staff Appointment, and Authorization to Admit Patients. Before a provider can admit patients, the MTF/CC must award the provider appropriate privileges and appoint him or her a member of the medical staff. Under no circumstances will a provider, not yet given a medical staff appointment, admit patients to an AF facility. Requirements that specifically authorize providers to admit are privileges appropriate to inpatient care and medical staff appointment. For additional information, reference Section 6D and Section 6E.

6.4. Electronic Privileging Process. The privileging module within CCQAS is used to privilege providers within DoD. In unique scenarios the provider may need to complete a hard copy (paper) application for privileges and medical staff appointment; however, this should be the exception (e.g., contractors or individuals who are not issued a Common Access Card [CAC], or dual status providers who, due to current limitations of CCQAS, are unable to complete separate E-applications). The hard copy application for providers new to the AFMS may be utilized to collect data to determine employment eligibility, create the CCQAS credentialing record, and privilege the provider if unable to complete an E-application. Once providers obtain their CAC an E-application should be completed. See the Kx C&P toolkit for additional information on the current rules of engagement for completing the E-application to document the privileging decision made off-line. The expectation is that the modules within CCQAS are fully utilized to provide oversight of the credentialing and privileging processes within the MTF. The MTF/RMU/MDG CM grants providers access to CCQAS to complete the E-application and reviews and routes the application. See Section 6B and the Kx C&P toolkit for mandated requirements for the electronic PCF and the electronic privileging process.

6.5. Master Clinical Privileges List. Each AD MTF will maintain master copies ("Strawman") within the CCQAS privileging module and the AF standardized clinical privilege lists. For each delineated item the verified column reflects (radio button "Not Supported" or code "3") those privileges that the MTF cannot support due to professional policies or lack of adequate equipment or personnel. The master strawman for ARC UICs at non-collocated AFRC bases will reflect "Not Supported" for Duty AFSC privileges (see paragraph 6.2.2.). The master privileges lists are specific to the MTF and are utilized in verifying and awarding privileges. Any changes to the master strawman within CCQAS will be reviewed and approved by the credentials function. Additions and changes to supported capabilities should be approved by the credentials function before the E-application is routed to the Level 1 reviewer. The master lists (within CCQAS and off-line) will be reviewed by the credentials function and updated at least annually. This review will be documented on the printed privileges list and noted in the credentials function report. **Note:** It is necessary to maintain the AF standardized clinical privileges lists in addition to the master privileges lists within CCQAS to accommodate unique scenarios where a provider does not have a CAC and is unable to complete an online application.

6.6. Providers Affected by the Privileging Process. Each provider with independent authority to begin, alter, or end a plan of treatment for a patient shall be privileged. Providers must be privileged before they begin providing patient care services in the AF MTFs and/or ARC medical units. Only military (AD/ ARC) and civilian (civil service, overseas local hire, contract,

volunteer, Department of Veterans Affairs) providers in the following professions may be awarded privileges:

6.6.1. Audiologists, chiropractors (only at DoD-designated sites), clinical dietitians, clinical pharmacists, clinical psychologists, clinical social workers, dentists, certified registered nurse anesthetists, certified nurse midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, physicians, podiatrists, and speech pathologists. **Note:** Clinical nurses assigned to clinical nurse positions that hold nurse practitioner credentials cannot be privileged within the AFMS. The restriction is not applicable to the ARC.

6.6.2. The HQ USAF/SG defines the scope of practice for each category of provider to be awarded clinical privileges. Chapter 7 outlines the professional scopes of practice for allied health professionals. In addition, the AF Officer Classification Directory outlines requirements for professional qualifications for the various specialties.

6.6.3. The ASD(HA) establishes which professional groups may be awarded privileges. To seek approval to add another group, submit written request to AFMOA/SGHQ who will review, appropriately staff, and forward to the ASD(HA), if deemed appropriate.

6.6.4. Privileges are not awarded to interns, residents, or advanced practice nurse students in training programs.

6.6.5. Fellows and physicians attending a second residency (have completed a previous residency) and fully qualified in a specialty may be privileged and appointed to the medical staff to perform patient care to maintain competency as long as it does not interfere with current training.

6.6.6. Dentists who are licensed in a US jurisdiction but undergoing postgraduate training may be granted core privileges. Dentists enrolled in postgraduate training remain subject to supervised practice within the requirements of the residency program.

6.6.7. Privileges are not awarded to social workers in Airman Family Readiness Centers, social workers hired as sexual assault prevention and response coordinators, or social workers in family advocacy outreach manager positions providing outreach and prevention services in family advocacy programs (FAPs).

Section 6B—The Electronic Privileging Process

6.7. CCQAS Credentialing Record. Before the provider is granted access to complete a first E-application, the CM will conduct a data quality review of the CCQAS credentialing record. The record will be compared with the historical PCF and updated as required. The designated minimum documents will be scanned, appropriately named, and uploaded to the provider's electronic PCF (CCQAS record) before routing the E-application (See Appendix A and B in the Kx C&P toolkit). Once the document is uploaded to the electronic PCF, the CM will open the document to ensure it is appropriately scanned with good image quality, is uploaded to the correct provider record and is named correctly to include the file type and short file description. Once the provider completes an E-application, all documents generated outside of the CCQAS E-application that would have previously been maintained in the 6-part PCF will be scanned, appropriately named and uploaded to the provider's electronic PCF. The previously established 6-part folder will become a historical repository, appropriately safeguarded and transferred when

providers are reassigned to another MTF but will no longer be the official record for compliance with credentialing and privileging requirements. The electronic PCF (CCQAS record) will be the official PCF. See paragraph 5.14 for requirements to establish and maintain a working file for providers that have not previously had an established 6-part PCF. Paper documents will be filed in the historic 6-part PCF or the working file but will not be subject to inspection. The snapshot of the provider's approved E-application will be printed (two-sided) and filed in Section 1 of the historic 6-part PCF or the working file (if provider did not previously have a 6-part PCF) to serve as a backup if unable to access CCQAS (this serves as a contingency plan if the network is unavailable).

6.8. Completion of E-application. The CM will grant provider access/initiate application to CCQAS to complete the E-application. Quick guides are available to assist the provider in completing the E-application (see Kx C&P toolkit). The provider will E-sign the application and attest to the validity of the data entered; therefore, it is prudent that the provider review each section within the application and update as required. The CM will review the submitted application for completeness and identify potential issues or items requiring additional information from the provider. The CM review includes if the provider is requesting privileges and the type of privileges requested. The CM will return the E-application to the provider if additional information is needed. Once the application has been appropriately primary source verified and queries performed (see paragraphs 5.2.3. and 5.2.4.), the CM will set up the electronic routing of the application for review, recommendation and approval. At a minimum, the application will be routed to the clinical supervisor (Level 1 Reviewer) for the privileges requested, the Chief of the Medical Staff (Level 5 Committee Chair), and the privileging authority. If the provider is requesting privileges in more than one specialty the application will be routed to multiple Level 1 reviewers to obtain a recommendation for award of requested privileges. See paragraph 6.33 for routing the MTF/CC's applications and paragraph 6.18 for non-collocated ARC units CC's/senior physician's applications.

Section 6C—The Credentials Function

6.9. Overview of the Process. Routine review and recommendations for award of privileges and medical staff appointment for applications that do not have any issues can be done electronically without convening the credentials function. The application will be routed as a minimum to the clinical supervisor, chief of the medical staff and then the privileging authority. These individuals are acting on behalf of the medical staff. Any applications with issues (potential issues) must be addressed off line and the credentials function must be convened. In addition, at any time during the electronic routing of an application if issues arise, the application will be taken off line, the issues addressed, and then the application can be completed on line. The credentials function will be required to meet at least quarterly to provide oversight of the credentialing and privileging process and validate any applications approved since the function last met. In addition, the credentials function will be convened to address any applications with issues. An ad hoc credentials function will be convened IAW chapter 9 to address potential adverse privileging/practice actions. ECOMS (for non-collocated AFRC: RMU/SGH) provides oversight of the credentials function.

6.10. Credentials Function Membership. Each MTF with five or more privileged providers must have a credentials function. If the MTF has fewer than five privileged providers, provider E-applications will be routed to another facility as directed by AFMOA/SGHQ. The consulting

MTF credentials function reviews the E-application and makes privileging recommendations to the referring MTF/CC. ARC medical units are not required to establish a credentials function.

6.10.1. Credentials function composition should reflect the diversity of providers practicing within the facility, but, at a minimum, there should be representatives from each corps with privileged staff members. All privileged providers within the MTF are eligible to serve as members of the credentials function. The MTF/CC may have members of the affiliate medical staff serve to meet this requirement.

6.10.2. When the credentials function is validating the award of clinical privileges to an allied health provider, the SGH will select at least one member from the same discipline to serve as a voting member (if one is locally available). This voting member can be included in the routing of the E-application; however, would not be assigned as the Level 1 reviewer, which is reserved for the clinical supervisor. There may be a need to confer with someone of the same discipline from AFMOA or the referral MTF to ensure privileging recommendations are appropriate. **Note:** This policy is not required for awarding temporary or supervised privileges.

6.10.3. The chief nurse serves as an advisor to the credentials function as a non-voting member.

6.11. Credentials Function Procedures.

6.11.1. The medical staff, through the credentials function, reviews provider requests for privileges and medical staff appointment, provider credentials and performance data, and recommends privileges and staff appointment to the MTF/CC. The MTF/CC is the privileging authority who then awards or denies clinical privileges. (Reference paragraph 9.27.3.6. denial of clinical privileges.) The credentials function will formally meet at least quarterly to maintain appropriate oversight of the entire process (see Kx C&P toolkit for an example of a standard agenda). The credentials function must also be convened to review any E-application or paper application for privileges and medical staff appointment that warrants further review and discussion before a recommendation can be made to the privileging authority.

6.11.2. The process of individually reviewing and making a recommendation on the privileges application without convening a credentials function is known as “fast tracking” and should only be used for “clean” applications. If there are concerns about an individual’s request for privileges and, most definitely, for potential adverse actions, the credentials function must have the opportunity to engage in a live discussion.

6.11.2.1. The E-application: Routine applications will be routed electronically within CCQAS so the appropriate individuals can review the application and make their recommendations to the privileging authority. The application will be routed at a minimum to the clinical supervisor (Level 1 Reviewer), chief of the medical staff (Level 5 Committee Chair) and then the privileging authority. These individuals are acting on behalf of the medical staff. The E-application, once completed by the provider, reviewed by the credentials manager, and required credentials PSVd, is routed via the CCQAS privileging module to the appropriate individuals who thoroughly review and evaluate the E-application and make a recommendation to the privileging authority.

6.11.2.2. Off-line application: If the provider had not completed the E-application, the clinical supervisor and chief of the medical staff would need to review the PCF, PAF, and the provider's application for privileges (AF Form 1540/1540A). They vote "yes" on the record by signing the AF Form 1540/1540A which is then forwarded to the MTF/CC. If the vote is "no," the credentials function must formally meet to discuss the application.

6.11.2.3. Validation of Decisions Made on Applications. The credentials function will review and validate all applications (to include all fast tracked applications) acted upon by the privileging authority since the last scheduled credentials function. The majority of the credentials function members eligible to vote should be present or able to be involved in the process. In the event that the credentials function recommends modifying the fast track privileges that were awarded, this is recorded as an administrative action rather than an adverse privileging action.

6.11.2.4. When evaluating a member of the credentials function, the chairperson must excuse the individual from that portion of the meeting or activity. Annotate his or her absence in the credentials function summary report.

6.11.2.5. Whenever it is necessary for the credentials function to meet to review an application before a privileging recommendation can be made (e.g., presence of potential issues), the majority of the credentials function members eligible to vote should be present or able to be involved in the process.

6.11.3. Credentials function proceedings are documented in the summary report that is provided to the ECOMS.

Section 6D—The Privileging Process within the MTF or ARC medical units

6.12. Providers Seeking Privileges.

6.12.1. Complete and/or review the E-application, for currency and accuracy, answer the practice history and health status questions and E-sign the application. Chapter 5 outlines the credentials that are used in the credentialing and privileging process to include the application forms if the provider was not able to complete an E-application. See quick guide for completion of application in Kx C&P toolkit.

6.12.2. Within the E-application the provider selects and completes the appropriate clinical privileges list(s) for his or her specialty(ies). General Medical Officers (GMOs) complete the Family Practice privileges list (if required to complete an off-line application use the AF Form 2816, Clinical Privileges-Family Practice and Primary Care Physicians). GMOs trained in aerospace medicine complete the Preventive Medicine Sub-specialists (Aerospace Medicine, Occupational Medicine, and Preventive Medicine) privileges list (if required to complete an off-line application: AF Form 4305, Clinical Privileges-Preventive Medicine Sub-specialists Aerospace Medicine, Occupational Medicine, and Preventive Medicine). ARC providers will complete the Unit Training Assembly privileges list for their corps (if required to complete an off-line application use the AF Form 4318, Clinical Privileges-Air Reserve Component (ARC)-UTA) and their primary AFSC clinical privileges list. (**Note:** The primary AFSC clinical privileges list will contain all code "Not Supported" or "3s" as these functions are not supported on UTA weekends and cannot be verified by the ARC medical units). The ARC provider's completion of the duty AFSC privileges provides

information on what the provider feels they are competent to perform and facilitates award of privileges during periods of active duty.

6.12.2.1. Instructions for completing privileges list: Requested privileges are based on education, training, current competency and ability to perform and will not consider any known facility limitations. Privileges requested must be substantiated by supporting documentation. The provider must indicate a designation for each delineated privilege. **Note:** Contract providers only request privileges within the specialty for the contracted service they provide within the MTF. Reserve providers must hold appropriate AFSCs for privileges requested.

6.12.2.1.1. E-application: The applicant selects the appropriate designation: “Fully Competent”; “With Supervision”; or “Not Requested” for each privilege. The provider reviews and completes the clinical privileges contained within the E-application.

6.12.2.1.2. Off-line application: The applicant enters the appropriate code number in the block marked “Requested” for each privilege. Code “1” for “Fully Competent”; code “2” for “With Supervision” and code “4” for “Not Requested”. Each block must have a code number. The applicant signs and dates the form and returns it to the CM.

6.12.2.2. For those providers who are required to complete the off-line privileges lists that include more than one type of profession (i.e., psychiatry includes clinical psychologists and clinical social workers), inapplicable sections may be crossed through. Because many part-time civilian providers are utilized for very specific skills rather than their full scope of care, they may request only those privileges they intend to use at the MTF.

6.12.2.3. Providers who feel they are no longer competent to perform a specific procedure should request “With Supervision” (code “2”) or “Not Requested” (code “4”) on the appropriate section of the privileges list. This is not considered an adverse statement or action. Once they gain needed training and/or experience and again feel competent to provide that care, they may apply for and be granted unsupervised privileges in that area. The provider’s clinical supervisor is responsible for determining the degree of supervision required for “With Supervision” (code “2”) privileges (refer to Glossary for definition of supervision).

6.12.3. Comply with MTF/RMU/MDG by-laws, rules and regulations.

6.12.4. Maintain appropriate documentation of CHE and promptly provide pertinent CHE updates, via copies of specific CHE coursework, to the credentials manager for data input. Once updated in CCQAS, the supporting documentation may be returned to the provider unless specifically related to the privileges awarded (i.e., conscious sedation). At a minimum, providers will produce these documents upon initial application for privileges and at biennial renewal. Providers may enter this information when they complete their E-application. Refer to paragraph 5.4.5.7. for further information.

6.12.4.1. If the requested privileges are based on the attainment of continuing education, the CM will enter the training on the post graduate training tab within CCQAS. The CM will scan, name IAW standard naming conventions (see Kx C&P toolkit) and upload the training certificate to the provider’s electronic PCF.

6.12.5. Review performance data as provided in their PAFs, Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA) (described in glossary) and/or other applicable databases.

6.12.6. Provide updates on credentials maintained in the electronic PCF to the CM or ARC credentials liaison for non-located medical units as changes occur.

6.12.7. Complete orientation.

6.12.8. Acknowledge award of privileges.

6.12.8.1. E-application: Acknowledge award of privileges via the E-application once privileges and/or medical staff appointment is granted. Providers may download or print a copy of their approved E-application to include approved clinical privileges list.

6.12.8.2. Off-line application: Complete off-line acknowledgement letter for award of privileges/medical staff appointment once the privileging authority grants privileges and/or medical staff appointment. The providers will be given a copy of their approved clinical privileges list.

6.13. Clinical Supervisors.

6.13.1. Meet with the applicant (if possible) to discuss clinical capabilities, expectations, and unique MTF requirements before the provider completes their clinical privileges list(s). This discussion may occur telephonically or via email as the provider may have the opportunity to complete the E-application prior to arrival at the MTF if he/she is currently assigned to another DoD facility.

6.13.2. Review the application package.

6.13.2.1. Clinical Supervisors who lack the expertise to adequately evaluate a provider's privileges will ask AFMOA/SGHQ for assistance. AFMOA/SGHQ will coordinate with specialty consultants to identify reviewers. The MTF/RMU/MDG is permitted to consult directly with an appropriate DoD/VA facility which has the specific specialty required to provide an adequate evaluation. Both of these options should be coordinated with the MTF/RMU/MDG SGH. Refer to chapter on peer review for consultation.

6.13.2.2. For senior staff providers, such as the flight commander or chief of the medical staff, applying for privileges and/or medical staff appointment, a qualified privileged provider in a like specialty acts as the clinical supervisor. This individual serves as the clinical supervisor as they possess the clinical expertise to provide appropriate clinical oversight of the provider's practice regardless of the provider's position or military rank.

6.13.3. Verify requested privileges after review of the provider's completed application.

6.13.3.1. E-application: Ensure appropriate delineation of verified requested privileges. Note that the provider's requested privileges automatically default into the Level 1 column. (See paragraph 6.13.3.3. for further discussion.) The privileges not supported at the MTF are displayed within the E-application. Once the requested privileges are reviewed, select the appropriate recommendation and E-sign the application.

6.13.3.2. Off-line application: Complete the clinical supervisor's recommendation on submitted privilege lists. Review the requested privileges (in conjunction with the facility's master privilege lists to ensure "Not Supported" (code "3") is entered as

required, enter either "Fully Competent" (code "1"), "With Supervision" (code "2"), or "Not Requested" (code "4") as appropriate (reference 6.12.2.1.2.) in the block marked "Verified" for each line item, select the appropriate recommendation block, and sign the application.

6.13.3.3. Any differences between the provider's requested privileges and those that are verified by the clinical supervisor shall be reviewed with the provider. One example is when the provider requests "Fully Competent" (code "1") but the clinical supervisor verifies "With Supervision" (code "2") for some specific privileges. Every attempt should be made by the clinical supervisor to educate the provider on the MTF bylaws, rules and regulations in an effort to appropriately complete the application for privileges. The clinical supervisor will return the E-application without action to allow the provider to address the differences. Any remaining differences must be addressed with a comment for the delineated item within the E-application or for the off-line application, on the applicable AF Form 1540/1540A as a modification of the requested privileges.

6.13.3.4. Verifying specific privileges as "Fully Competent" (code "1") or "With Supervision" (code "2") is not the same as overall regular or supervised privileges. Refer to Section 6E for a full description of the type of privileges that may be granted.

6.13.3.5. For providers who do not yet have their authorizing document to practice (i.e., license, certification, registration), privileges requested "Fully Competent" or "With Supervision" (code "1" or "2") must be verified by the clinical supervisor as "With Supervision" (code "2"). The clinical supervisor will be required to enter a comment for each delineated item. The comment could be copied and then pasted into each required field. In this situation, the provider will be granted supervised privileges with a plan of supervision until regular privileges are awarded.

6.13.3.6. It is possible to have a mixture of various codes and still be granted regular privileges. Regular privileges may be granted if the provider does not meet the criteria for supervised privileges and is qualified to practice some privileges independently (Refer to Attachment 1 for definition of supervised privileges).

6.13.3.7. The plan of supervision as described in paragraph 6.28.2.1. is not required for those providers granted regular privileges but with some specific "With Supervision" (code "2") privileges. It is possible that the provider does not plan to or need to progress to "Fully Competent" (code "1"). The degree and type of supervision for those items annotated "With Supervision" (code "2") is at the clinical supervisor's discretion. Privileges may be upgraded to "Fully Competent" (code "1") following credentials function review of documented evidence of additional training/education through a formal program or via locally planned and executed upgrade training. An E-application (Modification E-application or E-application if the provider does not have an approved E-application to date) for modification of privileges would be completed.

6.13.4. The clinical supervisor will check the appropriate block on the AF Form 1540/1540A (whichever is applicable), signs and dates the form if an off-line application was completed (see paragraph 6.4.).

6.13.5. After the clinical supervisor reviews the completed application it is routed per the established MTF routing schema. It may be routed to the chief of service or the next

privileged provider in the clinical chain of command. At a minimum, it must be routed to the chief of the medical staff before routing to the privileging authority for action.

6.14. Chiefs of Service/Department Chairperson.

6.14.1. E-application. Will review the provider's E-application, select appropriate recommendation, and E-sign the application. "Return the application without action" to address any discrepancies off-line. Once the issue is appropriately addressed, continue the E-application process.

6.14.2. Off-line application: The chief of service or the next privileged provider in the clinical chain of command reviews the application package, checks the appropriate block on the AF Form 1540/1540A, signs and dates the form.

6.14.2.1. Any discrepancies between the provider's requested privileges and those that are recommended for approval must be addressed on the applicable AF Form 1540/1540A.

6.14.2.2. Returns the application package to the CM for routing to the Credentials Function chairperson.

6.15. Credentials Function Chairperson (SGH or the ARC Designated Physician).

6.15.1. Ensure all incoming providers complete orientation to include information on applicable DoD, AF, and local instructions, policies, and procedures governing patient care and medical staff responsibilities. Providers will also be oriented to continuity of care responsibilities, ethics policies, and continuing education requirements and opportunities.

6.15.1.1. For civilian providers hired directly by the MTF, the SGH is responsible for interviewing and orienting new civilian hires. The SGH may delegate this function to another active member of the medical staff. Contract groups may also be delegated this authority for contract personnel.

6.15.1.2. The documentation that orientation was completed should be filed in the provider's PAF as this documentation is not needed to make a credentialing and privileging recommendation; therefore, it would not be filed in the provider's electronic PCF. Prior to the establishment of the electronic PCF, this documentation was filed in Section I of the PCF. It is not necessary to place this documentation in the PAF for provider who had previously completed the orientation at the current MTF.

6.15.2. Will review the provider's application.

6.15.2.1. E-application: Select appropriate recommendation and E-sign the application. "Return the application without action" to address any discrepancies off-line. Once the issue is appropriately addressed, continue the E-application process.

6.15.2.2. Off-line application: Review the application package, check the appropriate block on the AF Form 1540/1540A, sign, and date the form. Any discrepancies between the provider's requested privileges and those that are recommended for approval must be addressed on the applicable AF Form 1540/1540A. Ensure the package is forwarded to the MTF/CC for approval.

6.16. The MTF/CC or ARC Privileging Authority.

6.16.1. Consider the recommendations of the credentials function chairperson (or ARC designated physician) and take action to award individual provider privileges.

6.16.1.1. E-application: “Return the application without action” to address any discrepancies off-line is an option available to the privileging authority. Once the issue is appropriately addressed, continue the E-application process. Any discrepancies between the provider’s requested privileges and those that are recommended for approval must be addressed by entering a comment for the delineated privilege item within the E-application. If this would result in a potential adverse privileging action, do not approve the E-application until the issue is taken off-line and the provider is afforded due process. **Note:** For initial applications, the privileging authority may limit privileges when there is no evidence of actual or suspected substandard performance (e.g., the provider has not practiced for an extended period of time). This does not constitute a denial of privileges and, therefore, is not an adverse privileging action (reference Chapter 9 for further information).

6.16.1.2. Off-line application: Any discrepancies between the provider’s requested privileges and those that are recommended for approval must be addressed by entering a comment in the Remarks section of the AF Form 1540/1540A. Sign and date the form. **Note:** For initial applications, the privileging authority may limit privileges when there is no evidence of actual or suspected substandard performance (e.g., the provider has not practiced for an extended period of time). This does not constitute a denial of privileges and, therefore, is not an adverse privileging action (reference Chapter 9 for further information).

6.16.2. Provider acknowledgement of privileges awarded.

6.16.2.1. E-application: Once the privileging authority has E-signed the application, the CM will electronically route the application to the provider for acknowledgement of the privileges granted. The provider then has 14 calendar days to acknowledge receipt and accept or appeal the decision of the privileging authority. For the ARC, the provider has 60 calendar days to acknowledge receipt and accept or appeal the decision of the MTF/CC (for non-collocated ARC: RMU/CC or MDG/CC). This serves as the official notification of privileges/medical staff appointment. The provider should review privileges granted and may download and/or print a copy of their complete application or the approved privileges from the E-application.

6.16.2.2. Off-line application: Will advise the provider, in writing, of the privileges granted. The provider then has 14 calendar days to acknowledge receipt and accept or appeal the decision of the privileging authority. For the ARC, the provider has 60 calendar days to acknowledge receipt and accept or appeal the decision of the MTF/CC (for non-collocated ARC: RMU/CC or MDG/CC). The provider should be given a copy of their off-line approved privileges.

6.17. Modification of Privileges Revisions and Corrections to Privilege Lists. To change a designation or code number on the currently approved privilege list or to add privileges not previously requested, the applicant will consult with the CM as this will be handled via completion of an E-application. If the provider has an approved E-application on file, they will request a Modification E-application (see Quick Guide on Kx C&P toolkit) and appropriately annotate the clinical privileges within the E-application to reflect the modification. Providers

who do not have an approved E-application on file will complete an E-application to reflect the modification to their current off-line privileges. The supporting documentation for the modification of the privileges is forwarded to the CM to be scanned, named IAW the standard naming conventions (see Kx C&P toolkit) and uploaded to the provider's electronic PCF. The E-application is then appropriately PSVd (must re-PSV authorizing document to practice [license/certification/registration] and conduct NPDB/HIPDB queries, routed IAW MTF established routing for E-applications and then approved by the privileging authority.

6.18. ARC Privileging Process. The privileging authority for reserve collocated medical units and ARC personnel providing healthcare during the AF training cycle and special assignments that take place within an AD MTF is the host AD MTF/CC. The privileging authority for non-collocated medical units is as follows:

6.18.1. ANG Privileging Authority (MDG/CC) for non-collocated medical units.

6.18.1.1. The MDG/CC will review the E-application and recommendations by designated senior physician and award privileges to assigned providers. If the MDG/CC is not a physician; the senior physician in the unit will review the E-application and make privileging recommendations to the MDG/CC, who grants privileges to the requesting providers. In this case, the privileging authority for the senior physician is extended to the State Air Surgeon (SAS).

6.18.1.2. Each SAS will review the MDG/CCs E-application (within their state) and award them privileges. In the absence of an SAS, this authority is extended to the NGB/SG.

6.18.1.3. The NGB/SG will review the E-application and award privileges to SASs and is the final privileging authority for the ANG.

6.18.2. AFRC Privileging Authority (RMU/CC) for non-collocated medical units.

6.18.2.1. The RMU/CC will review the E-application and recommendations by the SGP or SGH and award privileges to assigned providers. If the RMU/CC is not a physician, the senior physician in the unit will review the E-application and make privileging recommendations to the MDS/CC. In this case, the privileging authority for the senior physician is extended to the Regional Support Group (RSG)/SG.

6.18.2.2. The RSG/SG will review the E-application and award privileges to the RMU/CCs within his or her region. If the RSG/SG is not a physician, the senior physician in the RSG/SG will review the E-application and make privileging recommendations to the RSG/SG. If no RSG physician is available, the reviewer will be AFRC/SG.

6.18.2.3. The AFRC/SG will review the E-application and award privileges to the RSG/SG, or senior physician, if applicable, and is the final privileging authority for the AFRC.

6.19. ARC Privileging Issues.

6.19.1. ARC providers will complete the E-application selecting UTA privileges and the duty AFSC privileges within the E-application. The AF Form 4318, Clinical Privileges-Air Reserve Components (UTA), and duty AFSC privileges list as applicable are available as a data collection tool for new accession and as a backup to the E-application. Off-line

applications should not be completed for providers already privileged within the AFMS; instead providers should complete E-applications.

6.19.2. Awarding of the UTA and duty AFSC privileges are based, in part, upon the provider's civilian work experience and duty specific training.

6.19.2.1. In support of medical readiness, the military duties of ARC personnel should focus on their duty AFSC. For example, even though an individual is a general surgeon in civilian practice, if his or her military duty AFSC is a flight surgeon, the military activities should be as a flight surgeon.

6.19.3. Providers who are assigned to and who provide patient care services in medical units must have a CCQAS record with appropriate verified credentials and be awarded clinical privileges before beginning practice.

6.19.4. Providers will not be privileged or provide any patient care services without attending UTAs and maintaining training requirements.

6.19.5. Providers will not be privileged or provide any medical services while attending training unless specifically assigned to a support tasking such as support for an operational readiness inspection (ORI), etc.

6.19.6. Although the ARC medical provider must request duty AFSC privileges when completing an application for privileges, the duty AFSC privileges are not supported during UTA. Likewise, UTA privileges awarded to ARC medical providers for UTAs will not apply when assigned clinical duties in an AEF training cycle, annual tour or on special assignments at an AD MTF. The providers should be awarded appropriate AFSC-specific privileges supported at the assigned location during this period.

6.19.7. When an ARC medical unit is collocated with an active duty MTF, the host AD MTF/CC awards privileges for ARC providers. These include UTA privileges and activities that take place within the AD MTF directly associated with the ARC readiness requirements and unit training. A Transfer (ICTB) E-application would be required for the ARC provider to perform duty AFSC privileges within the MTF during annual training or on a special assignment.

6.19.8. If Participating Individual Ready Reserve (PIRR) providers do not participate often enough for the privileging authority to grant privileges, their files shall be maintained at the attached MTF in an inactive status. The file can be reactivated when the provider returns and completes an application for clinical privileges which initiates the credentialing and privileging process.

6.20. Management of ANG Providers Practicing at Combat Readiness Training Center (CRTC). This section outlines the specific management of ANG providers providing clinical care at designated CRTC locations. NGB/SG and AFMOA/CC will designate the AD MTF responsible to privilege ANG physicians providing clinical medicine at the designated CRTC locations. Prior to rendering care at the CRTC location, the prospective ANG flight surgeon/physician must be granted privileges for clinical care by the designated AD MTF. All non-primary care trained flight surgeons (for example, radiologists, pathologists, etc.) desiring to practice clinical medicine at the CRTC without sufficient current clinical competency in primary care must be granted supervised privileges and a physician trained in a primary clinical practice

field will be identified who can provide clinical supervision and a review of patient care delivery. The NGB/SG will be responsible for identifying the supervising physician.

6.20.1. All ANG physicians seeking clinical privileges at the CRTC location must complete a Transfer (ICTB) E-application via CCQAS. Documentation supporting current clinical competency (to include recent primary care practice experiences when available) must be scanned, appropriately named and uploaded into the provider's electronic PCF. This documentation would include current civilian privilege lists or a MFR stating the provider does not hold privileges in the civilian sector.

6.20.2. The scope of practice at the CRTC locations will be defined and approved by the NGB/SGP and coordinated with the designated AD MTFs.

6.20.3. A peer review process for the care delivered by each physician at the CRTC will be in effect. The NGB/SG will define criteria to be utilized in the review of the clinical work performed at the CRTC location. The NGB/SGP will appoint a clinical peer to review the clinical care delivery documentation. If two or more physicians are assigned to the CRTC location and are fully competent in the scope of practice provided, then the peer review can be accomplished at the CRTC. Documentation of the completed peer review will be provided to the NGB/SGP and the designated AD MTF.

6.20.4. For a solo practicing CRTC physician or if the assigned physicians are not fully competent in the scope of practice provided at the CRTC location, records for peer review must be copied and forwarded to the NGB/SGP for review.

6.20.5. The number of records for peer review for each assigned provider is outlined below.

6.20.5.1. 30 or less patients seen during tour: 100% chart review.

6.20.5.2. 31-100 patients seen during tour: 30 charts reviewed.

6.20.5.3. 101-500 patients seen during tour: 50 charts reviewed.

6.20.6. NGB/SGP will ensure chart review is accomplished in a timely manner and forwarded to the designated AD MTF for review/oversight.

6.20.7. In the event the peer review results indicate a clinical adverse action should be taken, the NGB/SG will identify and appoint the investigating officer after consultation with the designated AD MTF/CC. The investigating officer will forward the results of the investigation to the AD MTF/CC for review and action.

6.20.8. The NGB/SGP will maintain a template for the support agreements between the various CRTC locations and the designated AD MTFs.

6.21. Management of Contract Provider Privileges. Contract healthcare provider privileges will be managed IAW established DoD and AFMS credentialing, privileging, and medical staff appointment processes, outlined in this instruction and in DoD directives. Providers who are assigned to, or who provide care in the MTF must have an electronic PCF and be awarded clinical privileges before providing medical services. See paragraph 5.18.2.1. for management of contract providers already privileged by the MTF when the contract ends and the provider is re-hired under a new contract.

6.21.1. Contracts impacting credentialed and/or privileged personnel will be coordinated with the Chief of the Medical Staff and the CM.

6.21.2. Contract healthcare providers should participate in medical staff activities.

6.21.3. Formally assigned and trained Quality Assurance Personnel (QAP), knowledgeable about the Performance Work Statement (PWS) for contractor-provided services, will perform healthcare contract surveillance. **Note:** IAW AFI 41-209, *Medical Logistics Support*, Chapter 4, work statements must be coordinated through the base contracting offices. HQ AFMOA/SGMLC is available at Fort Detrick, MD 21702-5006 (DSN 343-8077) to provide advice on preparing PWS, quality surveillance plans, and other documents required to procureable medical service contracts.

6.21.4. According to MTF PI/RM policy, QAP will report issues or incidents involving non-personal services contract healthcare providers IAW local policy, to the appropriate MTF medical logistics office who, in turn, reports to the base contracting officer or to the appropriate TRICARE channels. The QAP will promptly notify the SGH of any quality of care issues identified.

6.22. Privileging in a Field Environment during Peacetime Training or in Support of an Expeditionary/Contingency Mission. When a medical unit deploys for peacetime training or expeditionary/contingency missions, the scope of practice for its assigned providers is defined as follows:

6.22.1. If providers will practice in a fixed MTF, the MTF will review credentials and award appropriate privileges. A Transfer (ICTB) E-application will be initiated by the sending MTF. To expedite privileging actions, deploying medical units should provide an ICTB at least 15 days in advance of the arrival date.

6.22.2. If providers will not practice in a fixed MTF, the deployed medical commander is responsible for the scope of practice of the deployed unit. The sending MTF/RMU/MDG CM will initiate an ICTB letter within CCQAS; however, the Transfer (ICTB) E-application will not be generated. Providers will deploy with a copy of their ICTB letter and current clinical privileges list(s), and civilian privileges lists (or MFR stating they do not hold privileges in the civilian sector), as applicable. The senior physician at the deployed location will assist non-physician commanders in determining the appropriate scope of practice.

6.22.2.1. The scope of practice of deployed units providing care in an area, which is normally the responsibility of a fixed MTF, must coordinate the level of care provided in the field environment with the fixed MTF/CC.

6.22.2.2. In field locations where a fixed MTF does not have responsibility for care, providers should not exceed the privileges defined by their home MTF/ARC medical unit and the capabilities of the deployed unit itself.

6.22.2.3. Deployed personnel will be familiar with the medical, dental, and ancillary capabilities of the referral MTF and host country healthcare facilities.

6.22.2.4. Privileging actions are not appropriate in the field environment. Privileges are not granted and adverse privileging actions are not initiated outside of fixed MTFs. If necessary, the commander may limit or stop the practice of a provider in the field by issuing a verbal or written order to the provider. Should this occur, the commander is responsible to report this action to the provider's home unit. (See paragraph 9.11. and Chapter 9 for additional information).

6.22.3. The C-NAF SG responsible for the deployed location is contacted for further guidance/clarification. Waivers for deployed locations will be submitted through the C-NAF SG to AFMOA/SGHQ. AFMOA/CC is the waiver authority for policy related to deployed units.

6.23. Care in Emergency or Wartime Situations. In emergency or wartime situations where referral or alternative care is not available, privileged providers must, to the extent allowed by their licenses, clinical ability, and absent competent refusal to consent, do everything necessary to save the life of an individual or to avoid serious health impairment.

6.24. Granting Privileges to Short-Term Affiliates using the ICTB. This guidance applies to manning assistance, consultants, ARC personnel, and other short-term affiliates. A short-term affiliate applies for clinical privileges only if he or she will perform temporary duties by providing direct patient care at a gaining AD MTF. (See Section 6E for the medical staff appointment process). The sending MTF or ARC medical unit conveys pertinent credentials and privileging information to the gaining MTF using the ICTB which is automated in CCQAS. (Refer to Attachment 6 for required ICTB format to be used when CCQAS is unavailable. See the User's Guide for additional information on CCQAS).

6.24.1. On-line Transfer (ICTB) Application: Providers requiring an ICTB who do not yet have an approved E-application on file must first complete and have an approved E-application on file. The CM then initiates the Transfer (ICTB) E-application NLT 60 days prior to the TDY. In addition to the Transfer (ICTB) E-application, ARC personnel will have the copy of current military and civilian privileges lists (if not privileged in the civilian facility, include MFR indicating such). This additional documentation will be scanned, appropriately named and uploaded to the provider's electronic PCF. The provider must complete the Transfer (ICTB) E-application NLT 30 days prior to the TDY start date which will be routed for review and approval at the gaining MTF. Before the provider can practice at the ICTB location the provider must have an approved Transfer (ICTB) E-application at the receiving MTF.

6.24.2. Off-line ICTB: Will only be generated when the provider is going to a deployed, humanitarian or field location. The sending MTF or RMU/CM initiates the ICTB letter within CCQAS. The sending MTF/CC (or designee) or ARC privileging authority must sign the ICTB letter. The hard-copy ICTB package (signed ICTB letter, copies of the provider's current approved clinical privileges list, and for ARC personnel civilian privileges lists [if not privileged in the civilian facility, include MFR]) is sent at least 60 days in advance by registered, certified, or other accountable mailing source to the gaining MTF. In addition, some host countries require actual copies of various credentials such as licenses and/or BLS or ACLS certification.

6.24.3. At the gaining MTF:

6.24.3.1. The Transfer (ICTB) E-application will be reviewed, primary source verified, and routed at the gaining MTF as with any other E-application.

6.24.3.2. At the completion of the provider's assignment, the clinical supervisor completes an AF Form 1562 or AF Form 22, which is then returned to the parent unit.

6.25. Generating ICTB for Telemedicine. The CM will initiate the Transfer (ICTB) E-application for providers engaged in telemedicine. Refer to paragraph 6.38. to determine if, when

initiated, the E-application should be suppressed. If the provider is providing consultative or interpretative services the E-application is suppressed; however, the receiving facility will review the sending MTF's approved application that is available within CCQAS to ensure the provider has the appropriate credentials to perform the requested services. If the provider is beginning, altering or terminating care, the provider will need to complete the E-application for the receiving facility and the application would be routed and approved at the receiving MTF regardless of the provider's physical location.

6.26. Generating ICTBs for DoD Providers Working in Veterans Affairs Facilities. The Department of Veterans Affairs (VA) and the DoD have established a Memorandum of Understanding (MOU) to facilitate the credentialing of healthcare providers between the VA and the DoD. This MOU establishes the guidelines for sharing the credentialing data collected and verified by one Department with the other which will expedite the appointment process of those providers who are shared across Departments. The off-line ICTB will be generated from CCQAS for DoD providers seeking privileges within VA facilities. The off-line ICTB, hard copy of approved privileges, and copies of the PSVs of non-time limited credentials will be provided to the VA for DoD providers working in VA facilities under the credentials sharing MOU. VA facilities will provide a VetPro Coordinator's Summary in lieu of the off-line ICTB for VA providers seeking privileges in AFMS facilities. More detailed guidance and the current MOU can be found in the Kx C&P toolkit.

6.27. Civilian Consultants. Follow procedures outlined below for civilian consultants who are short-term affiliates. The documents listed below collectively serve as the ICTB:

6.27.1. A current curriculum vitae, a copy of their current civilian privileges list, an original letter from their current institution verifying that their credentials are being actively monitored, and proof of medical malpractice coverage/limits of liability. The letter must be on the official letterhead of the organization, signed by the chief of medical staff, and dated within one year. The letter must list the provider's credentials, to include NPDB/HIPDB query results and health status, and must verify his or her professional degree(s), postgraduate training, board certification, and current professional license(s). **Note:** Civilian consultants must comply with the host state licensure laws.

6.27.2. The AFCCVO, on behalf of the MTF, PSVs the provider's license/authorizing document to practice, obtains a NPDB/HIPDB query and, if applicable, FSMB query and DHHS/TRICARE sanctioned provider listing review (reference paragraph 5.4.6.3.).

6.27.3. The MTF/CC will sign a document containing the following statement and attach it to the provider's "ICTB" as outlined in paragraph 6.27.1.: "(Provider's name) is granted regular privileges commensurate with those awarded by the (name of the provider's MTF or civilian employer) credentials function while doing duty at (name of visiting MTF) from (date) to (date). Privileges are awarded to the extent supportable by the facility's capabilities. (Name of provider) is appointed as an initial-affiliate medical staff member during this time period."

Section 6E—Types of Privileges

6.28. Procedures and Requirements for Specific Types of Privileges.

6.28.1. Regular Privileges. Regular privileges are granted to providers only after full verification and review of credentials. Regular privileges allow the provider to independently provide medical care within defined limits. These privileges are based upon the individual's education, professional license, professional certifications, experience, competence, ability, health, and judgment.

6.28.1.1. Selecting "With Supervision" (code "2") does not place a provider in the same category as a provider granted supervised privileges. Regular privileges may be granted if the provider is not in a category that requires a period of supervised privileges and is qualified to practice some privileges independently.

6.28.1.2. Clinical pharmacists, physician assistants and physical therapists (with prescriptive authority) are required to have a clinical preceptor appointed in writing and may be granted regular privileges according to their scope of practice. **Note:** Physical therapists without privileges for writing prescriptions will not require a physician preceptor but a clinical supervisor as with any other privileged provider. (Reference Chapter 7 for additional information).

6.28.1.3. APNs no longer require a physician preceptor be identified in writing but must have a physician supervisor available for consultation and collaboration. (Reference Chapter 7 for additional information).

6.28.2. Supervised Privileges. Supervised privileges will be granted to providers who lack the necessary licensure or certification for independent practice if all minimal educational requirements are met. Providers who fail to maintain licensure will not be placed under supervised privileges (reference paragraph 4.4.2.). The credentials function should also recommend supervised privileges for recent accessions without adequate documentation of current clinical competence, for providers who have not clinically practiced for a period of 2 years or more, for those providers in an orientation period required to assess competency, or at the commander's discretion, pending completion of the CHBC. The clinical supervisor will recommend upgrades to regular privileges when appropriate. Supervised privileges may be granted for up to two years and may be renewed by the privileging authority in extenuating circumstances.

6.28.2.1. Supervised privileges are awarded in the same manner as regular privileges except that a clinical supervisor with regular privileges in the same scope of practice must be named, in writing, at the time privileges are awarded. A written supervision plan (see Kx C&P for suggested template) and schedule for periodic progress reports must be prepared by the clinical supervisor and acknowledged by all involved personnel. This document will be scanned, appropriately named IAW standard naming conventions (See Kx C&P toolkit), and uploaded to the provider's electronic PCF. Written periodic progress reports must be provided to the CM to be presented at the Credentials Function.

6.28.2.2. The clinical supervisor determines the required degree of supervision, based on the background, experience, and demonstrated skill of the supervised provider. Degrees of supervision are described in the glossary under "Supervision."

6.28.2.3. The clinical supervisor will select "With Supervision" (code "2") for all delineated privileges and enter a comment indicating all are performed under supervision.

6.28.2.4. Supervision for a “sole practice specialist” may be provided in several different ways (refer to Chapter 8, Competency Assessment and Peer Review). The provider who has the most similar training and experience may clinically supervise the specialist. If the clinical supervisor is not qualified to review a specific procedure, the records will be sent for review to the regional consultant or other qualified reviewer in that discipline. The regional consultant (or other qualified specialist) may be invited to make periodic visits to the MTF to review cases or assist with procedures. The supervised provider may be sent TDY to a facility that provides the specialty service, or manning assistance in that specialty may be requested.

6.28.3. Temporary Privileges (This is not applicable to the ARC). Temporary privileges are awarded on an emergency basis to meet a pressing patient care need when full credentials review cannot be performed. They are time limited to 30 days and will NOT be used to extend the renewal period.

6.28.3.1. Credentials requirements include the following:

6.28.3.1.1. A copy of the provider’s license must be obtained and primary source verified.

6.28.3.1.2. Verification (documented in the electronic PCF) by the facility where the provider holds regular privileges indicating that the individual is a competent, fully qualified medical staff member in good standing and that the proposed privileges are within the individual’s current scope of practice and privileges.

6.28.3.2. The credentials function chairperson then recommends granting of temporary privileges to the privileging authority. If he/she is not available, the credentials function chairperson may grant the privileges. The privileging authority will sign a document containing the following statement: “(Provider’s name) is granted temporary privileges commensurate with privileges awarded by the (name of the provider’s MTF or civilian employer) credentials function while doing duty at (name of visiting MTF) from (date) to (date). Privileges are awarded to the extent supportable by the facility’s capabilities. (Name of provider) is appointed as an initial-affiliate medical staff member during this time period.” This document will be scanned and uploaded to the provider’s electronic PCF.

6.28.4. Disaster Privileges. Disaster privileges may be granted when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs. This is not accomplished on-line in CCQAS. (For additional information for scope of practice see paragraph 6.23.). The privileging authority or the SGH or designee(s) has the option to grant disaster privileges, but is not required to do so. The decision to grant disaster privileges is on a case-by-case basis at his/her discretion, upon presentation of any of the following:

6.28.4.1. A current picture hospital ID card; or a current license to practice and a valid picture ID issued by a state, Federal, or regulatory agency; or Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); or Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state,

or municipal entity; or Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

6.28.4.2. The MTF begins the verification process of the individuals who have received disaster privileges as soon as the immediate situation is under control. This verification process is identical to the process established for granting temporary privileges (refer to paragraph 6.28.3.1.2.).

Section 6F—Medical Staff Appointment (This not applicable to the ANG)

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

6.30. Types of Medical Staff Appointment. The type of appointment will vary depending on the privileges to be exercised, the availability of the medical staff member to the facility, and the reason he or she is practicing at the MTF. Medical staff appointments as defined by DoD are as follows:

6.30.1. Initial Medical Staff Appointment. Initial medical staff appointment is granted to a provider during his or her first 12 months of privileged practice within the AFMS, or after a period of greater than 180 days without an active or affiliate medical staff appointment in a DoD MTF. Initial appointments require full credentials function review.

6.30.1.1. During this period, the medical staff member's performance will be under close review by his/her clinical supervisor for clinical competence as well as for compliance with the facility's policies, procedures, bylaws, and code of professional conduct. During this period, the member may also have supervised privileges based on lack of experience, lack of necessary licensure, etc., as described in paragraph 6.28.2.

6.30.1.2. An initial medical staff appointment leads to an active or affiliate medical staff appointment and should be designated as such when granted (i.e., initial-active, or initial-affiliate). When designated in this way, the appointment indicates the provider's responsibilities associated with the target appointment.

6.30.1.3. Before the initial medical staff appointment ends, the provider will complete an E-application. The CM will grant providers, who had initially completed an off-line application, access/initiate application so the provider can complete an E-application. CCQAS will automatically generate a renewal application for those providers who had initially completed an E-application. The provider will need to update the "type of appointment requested" on the position tab to "active" or "affiliate", as applicable. The clinical supervisor and the credentials function must review the provider's performance, both clinically and professionally as a member of the medical staff, to determine if an active or affiliate staff appointment should be awarded and make recommendations to the MTF/CC. **Note:** Professional activities include conduct (behavioral patterns) which may or may not directly affect the provider's ability to perform clinical duties.

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

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

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

6.30.4. Temporary Medical Staff Appointment. Temporary medical staff appointment is granted in emergency situations when necessary to fulfill pressing patient care needs and, when time constraints will not allow a full credentials review. Temporary medical staff appointment is required when providers practicing under temporary privileges will be admitting patients. This appointment runs concurrently with and for the same duration as the temporary privileges.

Section 6G—Reprivileging and Reappointment Requirements

6.31. General Information. The Credentials Function will continuously evaluate the quality of each provider's practice (Reference Chapter 8, Competency Assessment and Peer Review for additional information). Biennial re-privileging is based upon provider performance data. The AF Form 22 is used to summarize performance data used in the reprivileging decision. The form will be scanned, appropriately named and uploaded to the electronic PCF before the renewal application is routed to the clinical supervisor.

6.31.1. The Credentials Function will formally review, and the privileging authority must reconsider, each provider's privileges and medical staff appointment at least every 24 months. **Note:** Providers awarded an initial medical staff appointment must have their privileges and medical staff appointment reviewed and renewed after the initial 12 months.

6.31.2. If a provider's privileges lapse prior to renewal, the provider will be removed from patient care until the complete reprivileging process is accomplished. There is not a mechanism to extend privileges past the expiration date. Unprivileged providers will not continue to provide patient care services (Reference paragraph 6.6.). A memorandum should be included in the PCF explaining the reason for the privilege lapse. (See Kx C&P toolkit). **Note:** If the provider has been practicing with lapsed privileges, 100% of the provider's records from that period must be reviewed by another privileged provider and countersigned. This is a serious risk management issue for the provider, the clinical supervisor responsible for review of the records, the MTF, and the AFMS. Management reports contained within CCQAS should be used to preclude having providers practice with lapsed privileges.

6.31.3. At a minimum, the clinical supervisor, SGH, and the MTF/CC or ARC privileging authority must review each provider's E-application and recommend renewal of privileges and medical staff appointment.

6.31.4. If any reviewer does not recommend renewal, the E-application will be returned without action and the issue addressed off-line. The reviewer must provide an explanation to the credentials function chairperson or to the privileging authority. Once the issue has been resolved, the E-application process can continue to appropriately document the privileging decision.

6.32. Reprivileging and Reappointment Process.

6.32.1. The CM will, through the parameters set within the CCQAS privileging module for providers with an approved E-application on file or by separate correspondence, notify the providers of the need to complete their E-application for renewal of clinical privileges, at least 90 days in advance of the biennial review. Privileges must be evaluated prior to reaching 24 months. At the end of 24 months, privileges expire. **Note:** Providers initially awarded an Initial Medical Staff Appointment will expire after 12 months.

6.32.1.1. Provider completes the E-application for privileges (reference paragraph 6.4).

6.32.1.2. ARC providers must also provide current privileges from all civilian practice (reference paragraph 5.4.5.8.3.).

6.32.1.3. The AF Form 22 is required when privileges are renewed. The data for the AF Form 22 should include peer review results (reference Chapter 8, Competency Assessment and Peer Review), outcome metrics, and other ongoing evidence-based competency assessments. The form may be tailored or overprinted to the provider's particular practice patterns through use of the "Remarks" section on the form. (Refer to AFMOA/SGHQ website at <https://kx.afms.mil/clinicalquality> for sample AF Form 22s). The AF Form 22 is scanned, named IAW standard naming conventions and uploaded to the provider's electronic PCF (see Kx C&P toolkit.). This off-line clinical performance assessment will be used to summarize and capture data from focused professional practice evaluations and on-going professional practice evaluations (see chapter 8 for additional information). **Note:** Future enhancements within the CCQAS privileging module may facilitate the completion of an on-line Performance Assessment Report (PAR). In the interim, the CM will cancel the on-line PAR and the AF Form 22 will be used instead. AFMOA/SGHQ will provide updated guidance when the on-line PAR replaces the use of the AF Form 22.

6.32.1.3.1. The provider's clinical supervisor will use the PAF (refer to paragraph 6.33. below for additional information), if applicable, to complete an AF Form 22 to summarize all pertinent information on the performance and conduct of the provider during the period of evaluation.

6.32.1.3.2. AF Form 22s should be completed by an assigned clinical supervisor for deployments, annual tours (for ARC personnel), manning assistance and routine TDYs. For ARC personnel: If no AF Form 22 was accomplished then provide an AF Form 1562 along with a copy of current civilian privilege list.

6.32.1.4. Provider submits new CHE information to CM for updating prior to the initiation of the E-application or the provider may enter the information when completing the E-application (reference paragraph 5.4.5.7.).

6.32.1.5. The renewal application is then completed like any other E-application. See section 6B for additional guidance.

6.33. Provider Activity File (PAF).

6.33.1. The PAF contains only temporary QA documents, contents are described in [Attachment 7](#). It includes documents such as data collected for performance-based privileging during the specified period of time. The Privacy Act of 1974 and 10 U.S.C. §1102, governs access to PAFs. The PAF cover must contain the following statement: “THE PRIVACY ACT OF 1974 GOVERNS ACCESS TO THIS FILE” and “QUALITY ASSURANCE DOCUMENT EXEMPT FROM DISCOVERY IAW TITLE 10 U.S.C., SECTION 1102. DO NOT RELEASE.” The PAF is an extension of the electronic and historic PCF. It is maintained in a separate off-line folder and kept in a secure location. This file is not appropriate for safety briefings and other human resource documents. Providers can review their files, but they cannot remove them from the control of the local custodian. With the exception of IMAs, the ARC is not required to maintain a PAF on providers but must summarize performance data using AF Form 22 (refer to paragraph 6.32.1.3.).

6.33.2. Disposition of information within the PAF. The PAF will not accompany the electronic PCF or the historical paper PCF when the AF reassigns the provider to another MTF. The PAF contents are summarized on the AF Form 22 which is scanned, named IAW standard naming conventions and uploaded to the provider’s electronic PCF (See Kx C&P toolkit). However, all data in the PAF that leads to the restriction, reduction, revocation, denial, or voluntary surrender of privileges becomes part of the adverse action case file and is maintained in Section III of the historic PCF or if appropriate, the working file. The appropriate documents are scanned, appropriately named and uploaded to the provider’s electronic PCF. Contact AFMOA/SGHQ for additional information when dealing with appropriate disposition of adverse action documentation. For additional details on the disposition of the PAF, refer to paragraphs 5.18. and 5.19. Contact AFMOA/SGHQ for requests to transfer PAFs to a gaining MTF.

Section 6H—Miscellaneous Privileging Issues

6.34. Management of Impaired Providers. Any medical condition that does (or potentially could) adversely affect an individual’s ability to safely execute his or her responsibilities in providing healthcare can be considered an impairment. This includes alcohol or drug impairment, medical conditions, or mental health disorder. The credentials function will review individuals who are impaired and determine if their health status hampers their practice. For further information refer to Chapter 9, Section 9E.

6.35. Awarding/Renewing Clinical Privileges to MTF/CC. The CM will contact AFMOA/SGHQ CCQAS database administrator to establish the appropriate routing of the E-application. The local credentials function will review the E-application and make recommendations. The MTF SGH will be assigned as the Level 5 Committee Chairperson reviewer. The Inpatient or the Outpatient SGH Consultant at AMFOA will be assigned as the

Level 6 Committee Chairperson reviewer. The AFMOA/CC will be assigned as the Privileging Authority.

6.36. Providers Assigned to Geographically Separated Units (GSUs). Providers assigned to GSUs must have an electronic PCF and be awarded clinical privileges and medical staff appointment by the host unit which is the privileging authority. **Note:** GSUs are physically separated from the host unit but are supported by and are under the command and control of the host unit commander. ARC non-collocated units are not considered GSUs and the individual unit commander has operational command and control of its activities.

6.37. Conscious Sedation for Dentists. Conscious sedation is discussed in AFI 44-102. As with all procedures, award of specific privileges to perform conscious sedation is based upon appropriate education, training, and experience. Because this skill is not part of basic dental education, paragraph 6.22. of AFI 47-101, *Managing AF Dental Services*, addresses specific training guidelines that must be met for dentists to be permitted to do conscious sedation. This training is annotated under the Post Graduate Training tab within the provider's electronic PCF and the supporting documentation is scanned, named IAW the standard naming conventions, and uploaded to the provider's electronic PCF.

6.38. Telemedicine and Consultative Services.

6.38.1. A provider who engages in consultation services from a remote site does not have to be credentialed and privileged at the referring MTF. However, if this provider directs patient care, (i.e., orders a treatment or course of action), then he or she must be privileged by the MTF where the care is provided.

6.38.2. Providers Engaged in Telemedicine Services. The CM at the sending MTF will initiate a Transfer (ICTB) E-application within CCQAS. If the provider is only providing consultative services at the site where the patient is located the E-application within CCQAS is suppressed when the ICTB is initiated. This serves as notice to the receiving MTF that the provider is providing consultative services to their facility and provides an opportunity for the credentials function to review the snapshot of the provider's approved application from the sending MTF. This serves as the mechanism by which the receiving facility approves services provided. If the provider is directing treatment, the Transfer (ICTB) E-application would be completed by the provider and routed for approval at the receiving MTF. This ICTB E-application is then processed as outlined in paragraph 6.24.

6.39. Interpretive Services Not Covered by Telemedicine Standards.

6.39.1. Interpretative services are services in which a licensed independent practitioner (LIP) provides official readings of images, tracings, or specimens (this may be accomplished through a telemedicine link). Examples of practitioners who often perform these services are radiologists and pathologists. Usually, these services are obtained under contract.

6.39.2. For contracted patient care, treatment, and interpretive services, the originating site will use both the credentialing information and privileging decisions from the TJC or DoD AAAHC accredited distant site if the staff at the originating site knows that the LIP providing services holds the appropriate privileges at that distant site.

6.39.2.1. If the interpretive services are provided by providers at another DoD MTF (distant site) an ICTB will be initiated and the CM will suppress the initiation of the

Transfer (ICTB) E-application. The originating MTF (via the CCQAS ICTB record) will then have access to review the providers approved privileges and ensure that all services provided by the contracted individuals are within the scope of his or her privileges.

6.39.2.2. All contracts for interpretive services should specify in the contract that the contracting entity will ensure that all services provided by the contracted individuals will be within the scope of his or her privileges.

6.39.2.3. If the contracted individuals are not privileged within a DoD MTF (but the facility is accredited by TJC or AAAHC), the originating site must obtain a copy of their current privileging lists to ensure they are appropriately privileged to perform the requested interpretative services.

6.39.3. Providers providing these types of services that are not privileged within a DoD MTF or another TJC or DoD AAAHC-accredited organization must be fully credentialed and privileged by the MTF.

Section 6I—Applying for Other Documents Monitored by the Medical Staff Office

6.40. Applying for National Provider Identifier (NPI). Beginning 23 May 05, Public Law 104-191, NPI final rule (45 Code of Federal Regulations, Part 162) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For DoD purposes, all healthcare providers who furnish billable healthcare services or those who may initiate and/or receive referrals must obtain an NPI Type 1. This includes but is not limited to privileged providers, residents, and IDMTs. NPIs will be assigned at no fee by the Centers for Medicare and Medicaid Services (CMS).

6.40.1. Providers will apply for and receive only one NPI, which will be a permanent identifier and does not need to be renewed. The provider, however, must update any changes to his/her demographic information as needed, such as address changes. The initial application and updates can be made via the National Plan and Provider Enumeration System (NPPES) web site at <https://nppes.cms.hhs.gov>.

6.40.2. At the time of application for privileges, the CMs will query the provider to see if they have obtained an NPI and, if not; provide guidance on the NPI application process. Once the NPI is obtained, the CM will file a copy in the electronic PCF and forward a copy to the MTF NPI POC for Defense Medical Human Resource System Internet (DMHRSi). If DMHRSi is not yet deployed at the MTF, the MTF CM will forward a copy of the NPI to the AFCCVO for input into DMHRSi.

6.40.2.1. IDMTs will apply for an NPI and forward a hardcopy of their NPI to the IDMT Program Coordinator and the MTF POC for entering NPIs into DMHRSi.

6.40.2.2. For ANG providers, the CM submits a copy of the NPI to ANG/SG, Attention: Credential Manager, 3500 Fetchet Avenue, Andrews AFB MD 20762-5157.

6.40.3. DMHRSi is the database of record for the NPI. Once the NPI number is entered into DMHRSi, it is pushed to CCQAS and other applications within the MHS. The NPI cannot be released from the 10 U.S.C. §1102 protected CCQAS database or the PCF. Any questions on the appropriate release should be forwarded to AFMOA/SGHQ.

6.41. DoD Fee-Exempt DEA Certification. Licensed physicians, residents, dentists, podiatrists, optometrists and clinical psychologists with prescriptive authority should obtain a DoD fee-exempt DEA certificate. Licensed physician assistants and licensed advanced practice nurses are eligible for a fee-exempt DEA. This fee-exempt DEA will only be used for official duties in the care of DoD beneficiaries and may not be used for any other category of patients. The number will be used for prescribing and administering only and will not be used for purchasing or storing of controlled substances. In addition to the DEA application, the provider will complete and sign the statement of understanding. The MTF CM will verify licensure, sign the application certifying the provider meets the requirements for a fee-exempt DEA certificate and forward the application and statement of understanding to the DEA. The original DEA certificate and a copy of the statement of understanding will be scanned, named IAW standard naming conventions, and uploaded to the provider's electronic PCF (see Kx C&P toolkit). A copy of the DEA certificate will be provided to the provider. The DEA will be reissued when the provider PCSs (with new practice location address) and will be voluntarily surrendered upon separation/termination of military service/employment. For specific information on this process refer to the Kx C&P toolkit.

Chapter 7

PROFESSIONAL SCOPE OF PRACTICE FOR ALLIED HEALTH PROFESSIONALS

Section 7A—Allied Health Providers (BSC, NC, and Civilian/Contract-Equivalent Privileged Providers)

7.1. Allied Health Provider List.

- 7.1.1. Acute Care Nurse Practitioners (paragraph 7.2.)
- 7.1.2. Audiologists (paragraph 7.3.)
- 7.1.3. Certified Nurse Midwives (paragraph 7.4.)
- 7.1.4. Certified Registered Nurse Anesthetists (paragraph 7.5.)
- 7.1.5. Chiropractors (paragraph 7.6.)
- 7.1.6. Clinical Dietitians (paragraph 7.7)
- 7.1.7. Clinical Pharmacists (paragraph 7.8.)
- 7.1.8. Clinical Psychologists (paragraph 7.9.)
- 7.1.9. Clinical Social Workers (paragraph 7.10.)
- 7.1.10. Family Nurse Practitioners (paragraph 7.11.)
- 7.1.11. Occupational Therapists (paragraph 7.12.)
- 7.1.12. Optometrists (paragraph 7.13.)
- 7.1.13. Pediatric Nurse Practitioners (paragraph 7.14.)
- 7.1.14. Physical Therapists (paragraph 7.15.)
- 7.1.15. Physician Assistants (paragraph 7.16.)
- 7.1.16. Physician Assistants Specialty (paragraph 7.17.)
- 7.1.17. Podiatrists (paragraph 7.18.)
- 7.1.18. Psychiatric/Mental Health Nurse Practitioners (paragraph 7.19.)
- 7.1.19. Speech Pathologists (paragraph 7.20.)
- 7.1.20. Women's Health Nurse Practitioners (paragraph 7.21.)

Section 7B—Non-Privileged Allied Health Professionals List (NC, Enlisted, and Civilian/Contract Equivalent)

7.1. 21. Certified Alcohol/Drug Abuse Counselors (CADACs) = Substance Abuse Counselors (paragraph 7.22.).

- 7.1.22. Independent Duty Medical Technicians (IDMTs) (paragraph 7.26.).
- 7.1.23. Licensed Registered Nurses (RNs) (paragraph 7.24.).
- 7.1.24. Licensed Practical/Vocational Nurses (LPNs/LVNs) (paragraph 7.25.).

7.1.25. Medical Technicians (paragraph 7.27.).

7.1.26. Medical Technicians Utilized in Ambulance Services (paragraph 7.28.).

7.1.27. Registered Dental Hygienists (paragraph 7.23.).

Note 1: For each professional group, some general background and educational requirements are listed. (Educational requirements reflect current accession criteria. Some personnel already working in the AFMS may not be required to meet the stated criteria; i.e., NPs who were awarded the 46Y3A (46N3A) or 46Y3B (46N3B) AFSC prior to 1997 as graduates of a certificate, non-graduate level education program, remain qualified for the AFSC as long as the national certification remains current). Refer to AFI 36-2005, *Appointment in Commissioned Grade and Designation and Assignment in Professional Categories--Reserve of the Air Force and United States Air Force*, and ANGI 36-2005, *Appointment of Officers in the Air National Guard of the United States and Reserves of the Air Force*, for a complete listing of accession criteria and the Air Force Officer Classification Directory for AFSC qualifications. Scope of practice and supervision requirements are defined. (See specific privileges lists for further details regarding scope of practice.) Normally, enlisted medical and dental personnel operate within the guidelines established by the Career Field Education and Training Plan (CFETP) which defines the enlisted scope of practice. Civilian Medical and Nursing Assistants must function within the scope of practice as defined by the state where the MTF is physically located. Newly hired contract personnel are fully qualified within their specialty and must present evidence of current competency.

Note 2: Privileged-Advanced Practice Nurses (P-APNs): Non-privileged Nurse Practitioners, Certified Nurse Midwives, and Certified Nurse Anesthetists must first be officially awarded the appropriate specialty 46YX AFSC, and be assigned to an authorized APN billet to be privileged and function in a privileged provider role. This restriction is not applicable to the ARC. P-APNs who move into non-direct patient care positions may function as providers to maintain currency. The Chief of Medical Staff and Chief of Nursing Services, IAW MTF policies and procedures, shall establish guidance on the use of these providers. For awarding of the 46YX to Non-AF sponsored APNs, see AFI 46-101, *Nursing Services and Operations (applies to Active Duty only)*.

7.2. Acute Care Nurse Practitioners.

7.2.1. Background. Acute Care Nurse Practitioners (ACNP) are registered nurses who have obtained advanced education, training and certification to practice independently, providing care to acute, critical and complex chronically ill/injured adults, in the inpatient critical or intensive care settings. The ACNP practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.2.2. Education/Licensure/Certification Requirements:

7.2.2.1. Graduation from a master's degree program with specialization as an acute care nurse practitioner accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.2.2.2. Licensure as addressed in Chapter 4.

7.2.2.3. National certification in specialty (i.e., certification through the American Nurses Credentialing Center [ANCC]).

7.2.3. Scope of Practice:

7.2.3.1. ACNPs practice independently and collaboratively in the inpatient critical or intensive care setting caring for acute, critical or complex chronically ill or injured adult patients. Actively participate in multidisciplinary care meetings and patient rounds, and serve as a liaison between nursing and physician staff.

7.2.3. 2 May participate as a member of a specific specialty or consult service to include a specialty-based clinic; however, 80% of practice must be direct patient care in the inpatient critical or intensive care setting.

7.2.3.3. Diagnose and provide ongoing management of medical, surgical and trauma patients; order and interpret diagnostic studies; monitor and provide appropriate nutrition therapy; teach, counsel and advise patients, families, and staff about current medical conditions. Initiate admission, transfer and discharge orders; and perform pre-operative and post-operative management.

7.2.3.4. Perform invasive and non-invasive procedures as defined and approved on the provider privileges list; provide on-going ventilation management; initiate and evaluate treatment regimens which may include prescribing, monitoring and altering medications appropriate for privileged scope of care.

7.2.3.5. May act independently in areas of demonstrated competency within the designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.2.3.6. May pull call and work as sole provider with physician consultation available as described in paragraph 7.2.4.1. if these specific privileges have been granted as “Fully Competent” or code “1” on the privileges list.

7.2.4. Supervision:

7.2.4.1. ACNPs granted MTF privileges must have physician (privileged for the same scope of practice) consultation available either in person, by phone, or electronic means when they are performing direct patient care activities.

7.2.4.2. As with any privileged provider, ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B.

7.3. Audiologists.

7.3.1. Background. Deliver state-of-the-art audiological services, including prevention, medical surveillance, education, and research.

7.3.1.1. Support the flying mission of DoD personnel by implementing the AF Hearing Conservation Program to prevent noise-induced hearing loss and enhance auditory performance in operational environments.

7.3.2. Education/Licensure/Certification Requirements:

7.3.2.1. Graduation from an accredited master’s or doctoral degree from an accredited program acceptable to the HQ USAF/SG.

7.3.2.2. Licensure from a US jurisdiction.

7.3.2.3. National certification (Certificate of Clinical Competence from the American Speech-Language-Hearing Association) or American Board of Audiology (ABA) certification.

7.3.3. Scope of Practice:

7.3.3.1. Practice IAW the guidelines published by the American Speech-Language-Hearing Association, American Academy of Audiology, and the National Hearing Conservation Association.

7.3.3.2. Audiologists are privileged to provide comprehensive diagnostic and therapeutic procedures of the hearing and balance mechanisms. Audiologists also manage the hearing conservation programs. Those with advanced training and current competence may be privileged to perform procedures such as intraoperative monitoring of the cranial nerves, cerumen removal, cochlear implant assessment and management, posturography, and other advanced balance mechanism evaluations.

7.3.3.3. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their clinical privileges list.

7.3.4. Supervision. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.4. Certified Nurse Midwives (CNM).

7.4.1. Background. CNMs are registered nurses who have obtained advanced education, training, and certification in midwifery. Nurse-midwifery practice is the independent management of women’s healthcare, focusing particularly on pregnancy, childbirth, postpartum period, and care of the newborn, as well as the family planning and gynecological needs of women. The CNM practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.4.2. Education/Licensure/Certification Requirements:

7.4.2.1. Graduation from a master’s degree program with specialization in midwifery accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.4.2.2. Licensure as addressed in Chapter 4.

7.4.2.3. National certification in specialty (Certification by the American College of Nurse Midwives Certification Council. Prior to 1990, certification was via the American College of Nurse Midwives).

7.4.3. Scope of Practice:

7.4.3.1. Practice IAW the Standards for the Practice of Nurse Midwifery, as defined by the American College of Nurse Midwives (ACNM). MTF-specific protocols define conditions for which referral or collaborative care (co-manage) is appropriate.

7.4.3.2. Management of newborns outside the delivery suite or birthing room requires specific privileges.

7.4.3.2. Provide routine prenatal care, labor and delivery management, immediate newborn care, and postpartum care. In addition, CNMs provide well woman gynecological services including physical exams, breast exams, Pap smears, family planning services, preventive health screening, and health education.

7.4.3.3. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.4.3.4. May perform outpatient care and have admission and discharge privileges when an obstetrician is on call and available by phone to provide for medical consultation, collaborative management, or referral.

7.4.3.5. May provide obstetrical call within their scope of practice and expertise utilizing physician consultation and/or co-management to provide comprehensive care for the high-risk patient according to MTF protocols.

7.4.4. Supervision:

7.4.4.1. CNMs granted MTF privileges must have physician (privileged to the same scope of practice) consultation available either in person or by phone when they are performing direct patient care activities.

7.4.4.2. As with any privileged provider, ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B.

7.5. Certified Registered Nurse Anesthetists (CRNA).

7.5.1. Background. CRNAs are registered nurses who have obtained advanced didactic education, clinical residency, certification, and are independently licensed to administer anesthesia. Nurse anesthesia practice includes but is not limited to pre-anesthetic evaluation/assessment and patient preparation; intraoperative anesthesia management and postoperative follow-up and evaluation. The CRNA practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.5.2. Education/Licensure/Certification Requirements:

7.5.2.1. Graduation from a master’s degree program with specialization in nurse anesthesia accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2025 entry level to practice will be at the doctoral level.

7.5.2.2. Licensure as addressed in Chapter 4.

7.5.2.3.

7.5.2.6. National certification in specialty (Certification by the Council on Certification of Nurse Anesthetists).

7.5.3. Scope of Practice:

7.5.3.1. May act independently in areas of demonstrated competency within their designated scope of practice as indicated by “Fully Competent” or code “1” on the privileges list for all American Society of Anesthesiologists (ASA) Classifications: 1, 2, 3, 4 or 5 including “E” for urgent/emergent obstetric care.

7.5.3.2. CRNAs will consult with an anesthesiologist or any other medical specialty for patients who require such medical consultation based on acuity of the health condition or complexity of the surgical procedure. Consultation will be based on the judgment of the CRNA in coordination with the attending surgeon. The CRNA remains responsible and accountable for determining when consultation with a physician specialist (e.g., anesthesiologist, cardiologist, internist) is needed during any patient encounter. These provider-to-provider consultations may be verbal, written, or electronic; will be documented in the patient’s medical record; should include the name of the specialist consulted; and include a brief outline of the anesthetic plan developed or the recommended course of action. A collaborative relationship is a key component for safe, quality healthcare.

7.5.3.3. Provide anesthesia “on-call” within their scope of practice and expertise, utilizing consultation and/or shared responsibility for patient care.

7.5.3.4. CRNAs are accountable for the preoperative assessment of all patients for whom they are the primary anesthesia provider and will ensure the patients are appropriately prepared for anesthesia. This holds for patients of all ASA classifications. It also applies for anesthesia services in which the patient may have had the pre-anesthesia assessment performed by another provider in an anesthesia preoperative clinic. Specialists, including but not limited to surgeons and/or anesthesiologists, are not required to countersign a preoperative assessment or the anesthesia record.

7.5.4. Supervision:

7.5.4.1. CRNAs granted MTF privileges must have physician consultation (privileged to the same scope of practice) available either in person or by phone when they are performing direct patient care activities.

7.5.4.2. As with any privileged provider, ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B

7.6. Chiropractors.

7.6.1. Background. The practice of chiropractic focuses on the relationship between structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. Doctors of Chiropractic ensure operational readiness and quality of life to the fighting force through state-of-the-art chiropractic diagnosis and treatment services, including prevention, health promotion, education, and research.

7.6.2. Education/Licensure/Certification Requirements:

7.6.2.1. Graduation from a chiropractic college accredited by the Council on Chiropractic Education or its successor.

7.6.2.2. Licensure as a Doctor of Chiropractic (if a non-personal service contractor, the license must be in the state in which he or she will be hired and practice).

7.6.2.3. Member in good standing with the State Board of Chiropractic Examiners in the state in which he or she practices.

7.6.2.4. A minimum of two years full-time active chiropractic experience in which he or she has consistently administered both diagnostic and treatment services.

7.6.3. Scope of Practice.

7.6.3.1. Provide chiropractic diagnosis and treatments, excluding vaginal examinations, and consistent with current chiropractic literature and guidance from the DoD Oversight Advisory Committee on Chiropractic. This generally includes the adjustment and manipulation of the articulations and adjacent soft tissues for the human body, particularly the spinal column.

7.6.3.2. Serve as consultants in chiropractic for other healthcare professionals in the military healthcare system.

7.6.3.3. Are involved in prevention and wellness activities, screening, and promotion of positive health behaviors.

7.6.3.4. Provide neuromusculoskeletal evaluation for musculoskeletal and neuromuscular conditions which may include the privileges of ordering appropriate radiographs and laboratory tests, initiating temporary duty limiting condition reports, admitting or discharging to and from quarters, and referring to other specialists appropriate to the patient's needs.

7.6.3.5. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.6.4. Supervision. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.7. Registered Dietitians.

7.7.1. Background. Registered Dietitians may be AD, contract or civil service. Registered Dietitians provide nutrition services to include but not limited to: providing medical nutrition therapy (MNT), defined as the assessment of patient nutritional status followed by therapy, ranging from diet modification and counseling to administration of specialized nutrition therapies such as enteral and/or parenteral feedings; procuring, managing, and safeguarding all nutritional medicine resources; supervising food production and service operations; educating patients, healthcare providers and staff; assessing individual, population, and environmental nutrition needs for the base population; analyzing assessment tools to assess the nutrition status and needs of the beneficiary population; determining/prioritizing appropriate installation nutrition programs and clinical protocols; and serving as nutrition consultant to the community. Registered Dietitians may work in the MTF in a clinical setting

or augment MNT clinical services at their local base. Community/Wellness dietitians may work in a Health and Wellness Center or other location. All Registered Dietitians must be credentialed/privileged healthcare providers regardless of setting.

7.7.2. Education and Registration Requirements: The minimum criteria for determining an applicant's ability to provide Nutrition Services within the scope of clinical privileges are:

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

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

7.7.2.2.1. Dietetic internship with generalist or military emphasis.

7.7.2.2.2. Coordinated program in dietetics with generalist emphasis.

7.7.2.3. Current registration by the Commission on Dietetic Registration of the ADA or proof of eligibility to take the ADA registration examination. If applicant entered the AF as a "fully qualified" dietitian, registration must be completed prior to accession. If applicant is a graduate of the Military Dietetic Internship Consortium, registration must be obtained within 4 months of graduation.

7.7.3. Scope of Practice:

7.7.3.1. MTF Dietitians:

7.7.3.1.1. May be granted clinical privileges to provide MNT for inpatients and outpatients using ADA's Nutrition Care Process.

7.7.3.1.2. May be privileged to order enteral feedings, parenteral formulas, transitional feedings, and additional laboratory tests to support nutrition therapy decisions.

7.7.3.1.3. Refer to other healthcare providers and base agencies, such as diabetes educator; women, infants, and children (WIC) program; hospice; home healthcare; and other community support programs.

7.7.3.1.4. Act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.7.3.2. Community/Wellness Dietitians:

7.7.3.2.1. May be granted limited clinical privileges to provide MNT for outpatients using ADA's Nutrition Care Process. MNT will be limited to those areas specified on their privilege list which support AF Health Promotion goals.

7.7.3.2.2. Refer to other healthcare providers and base agencies as needed, such as diabetes educator; WIC; hospice; home healthcare; and other community support programs.

7.7.3.2.3. Assess base population and environmental nutrition needs including using DoD/AF specific data sources to collect, identify gaps and analyze needs assessment data to determine and prioritize nutrition interventions.

7.7.3.2.4. Plan, collaborate, implement and evaluate community nutrition strategies, interventions and programs at locations where beneficiaries live and work (e.g., installation, units, fitness center, MTF, youth centers, dining facilities, commissary).

7.7.3.2.5. Utilize multiple, evidence-based strategies and interventions focusing primarily on those with the largest reach within a target group to impact population behavior and outcomes.

7.7.3.2.6. Act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.7.4. Supervision. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records or community nutrition interventions, direct observation of performance, and verbal/written assessment of clinical knowledge/skills or community nutrition interventions.

7.8. Clinical Pharmacists.

7.8.1. Background. Clinical pharmacists are licensed pharmacists with advanced training or acquired clinical skills through practice experience. Clinical pharmacists practice collaboratively in settings such as anticoagulant, asthma, hypertension, diabetes, hyperlipidemia, immunizations, and medication refill clinics. In many cases, the clinical pharmacist works directly for a physician or a group of physicians in a particular specialty clinic. They function under agreements or protocols developed in coordination with the medical staff via the Pharmacy & Therapeutics (P&T) Committee and approved by the ECOMS. They provide pharmacokinetic consults, enteral and parenteral nutrition consults, and drug therapy management activities on inpatient units. In all cases, the communication between pharmacists and providers is essential for quality patient care. This section is not intended to address the scope of pharmacy practice legally conveyed by possession of a valid pharmacy license.

7.8.2. Education/Licensure/Certification Requirements: Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include:

7.8.2.1. Valid pharmacy license as described in this instruction and

7.8.2.2. PharmD degree, with documentation of appropriate education, training, and/or CME in the practice of clinical pharmacy or

7.8.2.3. Master of Science (MS) degree in pharmacy from a clinically oriented program, with documentation of appropriate education, training, and/or CME in the practice of clinical pharmacy or

7.8.2.4. Bachelor of Science (BS) degree in pharmacy with documentation of appropriate education, training, and/or CME in the practice of clinical pharmacy, or

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

7.8.2.6. Completion of a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy.

7.8.2.7. To perform limited physical assessment (i.e., assessment focused on specific system under examination), one must have documentation of appropriate education, training, and/or CME. **Note:** This course work is usually included in PharmD programs but may not be for bachelor's and master's programs. Other sources may include documentation of completion of Physical Assessment Education Program and/or certification.

7.8.3. Scope of Practice. Pharmacists may be granted clinical privileges by the MTF commander to provide direct patient care under agreements or protocols coordinated with the medical staff. Communication with the patient's physician, through documentation of clinical activities in the patient medical record and other verbal/written means, is necessary to ensure continuity of care. Pharmacist privileges may include, but are not limited to:

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

7.8.3.2. Ordering and evaluating laboratory tests necessary to evaluate drug therapy effects and outcomes.

7.8.3.3. Initiating, modifying, or discontinuing medications for ongoing therapy of chronic disease states (e.g., hypertension, hyperlipidemia, anticoagulant, diabetes, asthma, smoking cessation, refill clinics, etc.), in cooperation with the attending physician.

7.8.3.4. Monitoring and managing pharmacotherapy requiring periodic adjustment due to specific or changing pharmacokinetic characteristics (e.g., aminoglycosides, phenytoin, anticoagulants).

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

7.8.3.6. Administering prescription or non-prescription drugs according to established agreements or protocols.

7.8.3.7. Assessing metabolic needs and ordering therapeutic enteral or parenteral nutrition products in the inpatient setting in consultation with the attending physician.

7.8.3.8. Evaluating medical and medication histories for drug-related problems and adjusting drug therapy accordingly.

7.8.3.9. Consulting with other healthcare providers (e.g., physicians, dietitians, nurses, physical therapists, etc.) about patient treatment needs or options.

7.8.3.10. Conducting and coordinating clinical investigations and research (consistent with other healthcare professionals) approved by a local or regional Investigational Review Board (IRB) and participating in outcome studies generated by the department of pharmacy and approved by the P&T Committee.

7.8.3.11. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.8.4. Supervision:

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

7.8.4.2. All clinical pharmacists must work via protocols approved by the ECOMS and practice with the supervision of a physician preceptor, identified in writing. Prior to the provider completing an initial E-application within CCQAS this information was placed in Section I of the PCF. Once the provider has an approved E-application, this letter will be scanned, named IAW standard naming conventions (see Kx C&P toolkit) and uploaded to the provider’s electronic PCF. The preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the clinical pharmacist’s practice. Reference sample protocols and other implementation tools posted on the AFMOA/SGHQ website at <https://kx.af.ms.mil/clinical> quality.

7.8.4.3. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.9. Clinical Psychologists.

7.9.1. Background. Clinical psychology is the discipline of professional psychology dedicated to the scientific understanding of factors operating in the etiology, maintenance, and potential change of human behavior, habits, and lifestyles. Clinical psychologists are trained in providing assessment, diagnosis and treatment of mental health disorders and mental health promotion programs for individuals and groups experiencing ongoing mental and physical problems.

7.9.2. Education and Licensure Requirements: Clinical psychologists must demonstrate appropriate skills, training, and experience to be considered for clinical privileges. Minimum educational requirements include:

7.9.2.1. A doctor of philosophy (PhD) or a doctor of psychology (PsyD) degree in clinical, counseling, or combined professional-scientific psychology from a program accredited by the American Psychological Association (APA). Waiver of this requirement (i.e., graduates of regionally accredited universities or schools of professional psychology) must be staffed through AFMOA/SGHW. **Note:** If the requirement in paragraph 7.9.2.2. is waived, the qualifying degree must be from a program accredited by the APA.

7.9.2.2. An APA-accredited predoctoral internship in professional psychology (This 1-year internship is part of an APA-accredited doctoral program. The AF accepts this internship from any APA-accredited site including designated AF sites). Waiver of an APA-accredited program must be staffed through AFMOA/SGHW. **Note:** If the

requirement in paragraph 7.9.2.1. is waived, the internship must be an APA-accredited doctoral program.

7.9.2.3. An optional postdoctoral fellowship allows for subspecialization in operations/aviation psychology, child/adolescent psychology, clinical health psychology, or neuropsychology.

7.9.2.4. Valid license to practice psychology from a US jurisdiction.

7.9.3. Scope of Practice:

7.9.3.1. Conduct clinical interviews and interpret psychological tests/assessments.

7.9.3.2. Diagnose mental disorders and formulate treatment plans.

7.9.3.3. Provide individual and group psychotherapy, hypnosis (See AFI 44-102), formal sex therapy (See AFI 44-102), and biofeedback (chief of the medical staff should review the provider's credentials with the consultant for clinical psychology if they are unfamiliar with the credentials requirements).

7.9.3.4. Recommend administrative and medical dispositions.

7.9.3.5. Perform neuropsychological screening.

7.9.3.6. Perform comprehensive neuropsychological evaluations (must have postdoctoral fellowship training as described above).

7.9.3.7. Admit, treat, and discharge patients (with physician oversight) to/from inpatient units with mental health capability.

7.9.3.8. Admit/discharge patients to/from substance abuse rehabilitation centers.

7.9.3.9. Makes recommendations to medical evaluation boards when requested.

7.9.3.10. Determine the degree of impairment for military service and for civilian social and industrial adaptability due to mental disorders.

7.9.3.11. Perform safety and risk assessments.

7.9.3.12. Serve on competency and sanity boards.

7.9.3.13. Certify stability for the sensitive duty programs such as PRP, security clearances, and special access.

7.9.3.14. Assess for mental competency when administrative or legal matters arise.

7.9.3.15. Perform commander-directed mental health evaluations (CDEs) and act as behavioral health consultants to commanders and first sergeants.

7.9.3.16. Serve on aircraft mishap investigation boards (must have completed appropriate training program such as Air Force Aircraft Mishap Investigation and Prevention Course).

7.9.3.17. Those clinical psychologists designated by the HQ USAF/SG, who participated in the DoD Psychopharmacology Demonstration Project (PDP) and were thereby granted prescriptive authority, may continue to have prescriptive authority for the remainder of their tenure with the AFMS. Prescriptive authority may also be granted to fully qualified psychologists who have completed a Master's Degree in clinical psychopharmacology,

successfully passed the Psychopharmacology Exam for Psychologist (PEP), and who have received a minimum of one year of documented supervision. Supervision must be provided by a psychiatrist or a psychologist with prescriptive authority.

7.9.3.18. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.9.4. Supervision:

7.9.4.1. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.9.4.2. Unlicensed clinical psychologists (N/A to the ARC) who have completed their doctorate:

7.9.4.2.1. May be granted supervised privileges and an initial medical staff appointment.

7.9.4.2.2. Are supervised by a fully qualified licensed provider who will establish a plan of supervision based on the unlicensed psychologist’s skills and needs. At a minimum, the supervisor will meet with the unlicensed psychologist for at least one hour every week to meet state licensure requirements.

7.9.4.2.3. Supervision can be obtained from one of the following (listed in order of preference):

7.9.4.2.3.1. A privileged mental health provider at the MTF, including a reservist, if assigned, or

7.9.4.2.3.2. A licensed provider at a nearby Veteran Administration (VA) facility or a nearby MTF, or

7.9.4.2.3.3. A licensed civilian psychologist in the local community.

7.9.4.2.4. **Note:** As described in Chapter 6, the clinical supervisor must be a provider who has regular privileges in the scope of practice for which he or she is supervising. *EXCEPTION:* A VA provider or civilian psychologist shall have full credentials review as a consultant, as described in paragraph 6.27.

7.9.5. Miscellaneous:

7.9.5.1. Psychologists who have not met all doctoral requirements (N/A to the ARC), meaning not yet completed dissertation (all but dissertation [ABD]):

7.9.5.1.1. Cannot be privileged.

7.9.5.1.2. Must obtain a recommended scope of practice from the training director for his or her AF clinical psychology internship program. The recommended scope of practice will be submitted to the MTF credentials function for approval.

7.9.5.1.3. Must practice with a basic written plan of supervision and a designated preceptor.

7.9.5.1.4. Must have written medical documentation co-signed by a mental health provider.

7.9.5.1.5. Regardless of degree status, supervision of psychological testing work must be done by a psychologist.

7.9.5.2. If at all possible, other clinical psychologists will supervise entry level psychologists. Most states require this type of supervision.

7.9.5.3. When a psychologist who is granted “supervised privileges” needs to make a recommendation regarding a patient in a special duty program assignment, the recommendation should be reviewed by a mental health provider at the local MTF. If this is not possible, the review may be accomplished by a privileged mental health provider at a different MTF. The supervised psychologist must document his or her discussion with the supervisor in the mental health record. This annotation, and any other documented recommendations about the special duty program patient, will be cosigned by a privileged physician at the local MTF.

7.10. Clinical Social Workers.

7.10.1. Background. AF social workers facilitate individual, family, and corporate health. Clinical social workers are key members of the mental health team, most frequently working in mental health clinics, family advocacy programs, and substance abuse treatment services. They also provide clinical case management services to enrolled beneficiaries.

7.10.2. Education/Licensure/Certification Requirements:

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

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

7.10.2.3. License/certification from a US jurisdiction. Effective 1 Oct 98, state licensure/certification at any MSW level became the qualifying document, while national certification became optional. Social workers on AD or employed by the AF, unless specifically exempted as an entry-level clinical social worker, must be licensed/certified by a US jurisdiction at a level that allows practice of clinical social work without supervision. Exception to policy includes those individuals who have yet to complete the two years of post-MSW supervised experience (N/A to the ARC) required by state licensure that allows independent practice without supervision (i.e., ROTC cadets in MSW programs and personnel who have completed MSWs through AF-sponsored or off-duty education). Social Workers accessed without an independent clinical practice level license (N/A to the ARC) must obtain such license within three years of accession.

7.10.2.4. Entry level clinical social workers (N/A to the ARC) are individuals who have been awarded a state license/certification available to master’s-level social workers with less than two years of post-MSW experience. These individuals must be awarded supervised privileges.

7.10.2.4.1. **Note:** Clinical social workers with more than two years of post-MSW experience will also be considered entry level if they hold a license which would not authorize them to practice without supervision in their state of licensure.

7.10.2.5. Fully qualified clinical social workers are individuals who have completed an MSW, a minimum of two years post-MSW social work experience, and possess a state license/certification that allows practice without supervision. These individuals may be awarded regular privileges.

7.10.2.5.1. Those AF social workers, who are practicing clinical social work with a license that would require supervision for the practice of clinical social work (N/A to the ARC), are to be placed on supervised privileges as an administrative (not adverse) action until they obtain the necessary level of license.

7.10.2.5.2. The issue of licensure for clinical social workers is complicated by the fact that US jurisdictions have such varied approaches to licensure for social workers. Some states do not license social workers until they have a minimum of two years of post-MSW experience. Some have multiple levels of licensure which differentiate among associates degree, bachelors degree, and MSW-level social workers. States with multiple levels of licensure frequently also differentiate between clinical and non-clinical (or generalist) social workers. In some states, clinical social workers must be designated as "licensed clinical social workers" or "licensed independent clinical social worker" in order to be allowed to practice clinical social work without supervision. Social workers are instructed that the license they require for a "fully qualified" status is a "license that allows the practice of clinical social work without supervision." The license must allow the full scope of clinical practice, including the diagnosis of mental disorders. If questions about the license remains, the chief of the medical staff should review the social worker's licensure status with the consultant for clinical social work.

7.10.3. Scope of Practice:

7.10.3.1. Conduct clinical interviews and evaluate patients.

7.10.3.2. Diagnose mental disorders and formulate diagnosis and treatment plans.

7.10.3.3. Recommend administrative and medical dispositions.

7.10.3.4. Provide individual, couple, family, and group psychotherapy; hypnosis (refer to AFI 44-102); formal sex therapy (refer to AFI 44-102); and biofeedback, when appropriately trained to do so. The chief of the medical staff should review the provider's credentials with the consultant for clinical social work if he or she is unfamiliar with the credentials requirements.

7.10.3.5. Admit, treat, and discharge patients, with physician oversight, to/from inpatient substance abuse treatment programs.

7.10.3.6. Perform risk assessments and determine degree of danger posed by the patient.

7.10.3.7. Screen records and personnel for security clearances and make administrative recommendations.

7.10.3.8. Perform CDEs; PhD required.

7.10.3.9. Serve as behavioral health consultant to commanders, first sergeants, and medical personnel.

7.10.3.10. Serve on aircraft mishap investigation boards (must have completed appropriate training program such as Air Force Aircraft Mishap Investigation and Prevention Course).

7.10.3.11. Serve on Family Advocacy command assistance teams (must have completed training required by AFMOA/SGHW).

7.10.3.12. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.10.4. Supervision:

7.10.4.1. Generally, other clinical social workers will supervise entry-level social workers, if at all possible. In order to meet licensure requirements, some states require supervision by licensed clinical social workers with a specific number of years of experience. The requirement of the specific state in which a license that allows practice of clinical social work without supervision shall be considered during the development of a social worker’s plan of supervision. Fully qualified psychologists or psychiatrists could supervise if an MSW provider is unavailable. Consider utilizing a Reserve or VA social worker to provide supervision for someone whose state requires supervision by an individual who is licensed in that state.

7.10.4.2. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.11. Family Nurse Practitioners.

7.11.1. Background. Family Nurse Practitioners (FNP) are registered nurses who have obtained advanced education, training, and certification to practice independently to provide primary healthcare for well and sick individuals from birth to advanced age, including pregnant and postpartum women. The FNP practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.11.2. Education/Licensure/Certification Requirements:

7.11.2.1. Graduation from a master’s degree program with specialization as a family nurse practitioner accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.11.2.2. Licensure as addressed in Chapter 4.

7.11.2.3. National certification in specialty (i.e., certification by the American Nurses Credentialing Center [ANCC] or the American Academy of Nurse Practitioners [AANP]).

7.11.3. Scope of Practice:

7.11.3.1. FNP's practice independently and collaboratively to provide primary healthcare for well and sick individuals from birth to advanced age to include obstetrical and post-partum patients in an outpatient family practice or primary care setting. Healthcare includes:

7.11.3.1.1. Diagnose and manage acute episodic and chronic illnesses, minor traumas, and behavioral/psychological problems. Teach, counsel and advise patients and families about current health status, illness(es), and health promotion and disease prevention activities appropriate for patient age and condition.

7.11.3.1.2. Perform therapeutic procedures as defined and approved on the provider privileges list; and initiate and evaluate treatment regimens which may include prescribing and dispensing medications appropriate for privileged scope of care.

7.11.3.1.3. May work in urgent care/acute care/fast track clinics regardless of locations.

7.11.3.1.4. May act independently in areas of demonstrated competency within the designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.11.3.1.5. May pull PCM primary call and work as sole provider with physician consultation available as described below if these specific privileges have been granted as "Fully Competent" or code "1" on the privileges list.

7.11.4. Supervision:

7.11.4.1. FNP's granted MTF privileges must have physician (privileged for the same scope of practice) consultation available, either in person, by phone, or electronic means, when they are performing ambulatory clinic direct patient care activities, to include acute care.

7.11.4.2. As with any privileged provider ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B.

7.12. Occupational Therapists.

7.12.1. Background. Occupational therapists (OTs) provide services to include prevention, health promotion, ergonomics, wound care, and upper extremity rehabilitation. Other rehabilitation patients typically evaluated and treated by OT include, but are not limited to, physically disabled patients (those with arthritis, cerebrovascular accident, hand injuries, and neurologically impaired patients), mental health/substance abuse patients, and pediatric/developmentally delayed patients.

7.12.2. Education and Certification Requirements:

7.12.2.1. Master of science/art or entry level master's degree in OT (Master of Occupational Therapy) from an accredited OT program acceptable to the HQ USAF/SG.

7.12.2.2. Certification by the National Board for Certification in Occupational Therapy, Inc.

7.12.2.3. Completion of 6 months of clinical internship (usually accomplished prior to graduation and must be done in order to be eligible to take the certification exam).

7.12.2.4. License from a US jurisdiction.

7.12.2.5. Occupational Therapy Doctoral (OTD) is the advanced degree.

7.12.3. Scope of Practice:

7.12.3.1. Provide evaluation and treatment services under the guidelines of the American Occupational Therapy Association.

7.12.3.2. Serve as consultants in occupational therapy for other healthcare professionals.

7.12.3.3. OT privileges may include, but are not limited to, assessing patient's functional status and planning therapy, based upon physician-established diagnosis.

7.12.3.4. Advanced degree in clinical specialty may include hand therapy and/or ergonomics.

7.12.3.5. Provide direct access to prevention and wellness activities, screening, and promotion of positive health behaviors.

7.12.3.6. Providing direct access (i.e., no referral needed) neuromusculoskeletal evaluation for acute musculoskeletal and neuromuscular conditions. This may include the privileges of ordering appropriate radiographs and laboratory tests, initiating temporary duty limiting condition reports, admitting or discharging to and from quarters, referring to other specialists appropriate to the patient's needs, and prescribing medications such as nonsteroidal anti-inflammatories and over-the-counter analgesics.

7.12.3.7. Evaluating and treating infants in the neonatal intensive care unit.

7.12.3.8. Neurodevelopmental evaluation and treatment.

7.12.3.9. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.12.4. Supervision:

7.12.4.1. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.12.4.1.1. OTs who have prescription privileges must have a physician preceptor identified in writing for oversight of the clinical aspect of patient care. The physician preceptor will review the OT's prescribing practices as part of the ongoing, proactive peer review process.

7.13. Optometrists.

7.13.1. Background. Doctors of optometry are primary eye care professionals who provide comprehensive management of disorders and diseases of the eye, associated structures, and visual system, as well as diagnosis of related systemic conditions. Optometrists also co-manage conditions that affect the ocular health and vision of their patients or refer them to secondary/tertiary levels of care, when indicated.

7.13.2. Education/Licensure/Certification Requirements:

7.13.2.1. Doctor of optometry degree from an accredited 4-year college of optometry approved by the HQ USAF/SG.

7.13.2.2. Licensure from a US jurisdiction.

7.13.2.3. The AFMS recognizes Fellowship in the American Academy of Optometry (FAAO) as board certification for optometrists. Board certification is encouraged but is not required.

7.13.3. Scope of Practice:

7.13.3.1. Provide comprehensive eye care services including evaluation, diagnosis and treatment of diseases and disorders of the eye, associated structures, and visual system, as well as diagnosis of related systemic diseases. Optometrists practice independently and collaboratively with other healthcare providers.

7.13.3.2. Co-manage post surgical eye cases and ocular complications of systemic disease. Refer to higher levels of care when indicated.

7.13.3.3. Serve as eye care consultants for other healthcare professionals in the military healthcare system.

7.13.3.4. Promote operational readiness, prevention and wellness, vision conservation/safety, and education and training activities.

7.13.3.5. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.13.4. Supervision. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.14. Pediatric Nurse Practitioners (PNP).

7.14.1. Background. PNPs are registered nurses who have obtained advanced practice education, training, and certification to practice independently to provide primary healthcare to pediatric patients. The PNP practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.14.2. Education/Licensure/Certification Requirements:

7.14.2.1. Graduation from a Master’s degree program with specialization as a pediatric nurse practitioner accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.14.2.2. Licensure as addressed in Chapter 4.

7.14.2.3. National certification in specialty (i.e., certification through the Pediatric Nursing Certification Board [PNCB] or the American Nurses Credentialing Center [ANCC]).

7.14.3. Scope of Practice:

7.14.3.1. PNPs practice independently and collaboratively providing healthcare for well and sick children from birth to adolescence and is an integral, active member of the pediatric healthcare team, caring for neonates, infants, children, and adolescents up to age 21.

7.14.3.1.1. Diagnose and manage acute episodic and chronic illnesses, minor traumas, and behavioral/psychological problems. Teach, counsel and advise patients and families about current health status, illness(es), and health promotion and disease prevention activities appropriate for child's age and condition.

7.14.3.1.2. Perform therapeutic procedures as defined and approved on the provider privileges list; and initiate and evaluate treatment regimens which may include prescribing and dispensing medications appropriate for privileges scope of care.

7.14.3.2. PNP scope and standards of practice guidelines are published by the National Association of Pediatric Nurse Practitioners (NAPNAP).

7.14.3.3. PNPs may act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.14.3.4. PNPs may pull pediatric PCM primary call and work as sole provider with physician consultation available as described below if these specific privileges have been granted as "Fully Competent" or code "1" on the privileges list.

7.14.4. Supervision:

7.14.4.1. PNPs granted MTF privileges must have physician (privileged for the same scope of practice) consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities.

7.14.4.2. As with any privileged provider, ongoing professional practice evaluation (OPPE) or proactive peer review process is required. See Chapter 8, Section B.

7.15. Physical Therapists.

7.15.1. Background. Physical therapists, in home station and expeditionary environments, provide services including comprehensive management of musculoskeletal and neuromuscular disorders for acute, sub-acute and chronic conditions, prevention, health promotion, ergonomics, wound care, research and education.

7.15.2. Education/Licensure/Certification Requirements:

7.15.2.1. Entry level physical therapists must be graduates of a physical therapy program acceptable to the HQ USAF/SG and accredited by the American Physical Therapy Association (APTA) Commission on Accreditation in Physical Therapy Education.

7.15.2.2. Licensure from a US jurisdiction.

7.15.2.3. All Air Force Physical Therapists are expected to qualify and earn supplemental privileges allowing them to perform initial evaluation without physician referral, assign quarters status, order medications within a limited formulary, order appropriate diagnostic imaging and laboratory studies. Therapists awarded these privileges will be designated as an “Advanced Clinical Specialist”. These privileges are necessary for therapists to perform successfully in an expeditionary environment. It is expected that entry-level therapists will achieve advanced clinical specialist status within 4 years of joining the Air Force. Advanced clinical specialists in physical therapy must meet the following requirements.

7.15.2.3.1. 1) APTA advanced clinical specialty board certification, 2) Post entry-level residency credentialed by the APTA, post entry-level fellowship credentialed by the APTA, post-entry level master’s, DPT, tDPT, DSc or PhD in physical therapy-related field, 3) Over 4,000 hours in direct physical therapy practice and 4) Completion of the USAF Advanced Physical Therapy course or the US Army Advanced Clinical Operation and Practice course.

7.15.2.3.2. Sustainment requirements for advanced clinical specialists in physical therapy: 1) Maintain APTA advanced clinical specialty board certification, 2) Complete annual CEUs or courses in a residency, fellowship or academic program specific to advanced clinical specialist credentials; or completion of the USAF Advanced Physical Therapy course or the US Army Advanced Clinical Operation and Practice course, and 3) Perform sufficient hours of direct patient care to maintain board certification and clinical competency.

7.15.3. Scope of Practice.

7.15.3.1. Practice according to the guidelines published by the APTA.

7.15.3.2. Provide physical therapy evaluation and diagnostic/treatment services for patients.

7.15.3.3. Serve as consultants in musculoskeletal and neuromuscular conditions for other healthcare professionals.

7.15.3.4. Provide direct access for musculoskeletal and neuromuscular conditions, prevention and wellness activities, screening and promotion of healthy lifestyles.

7.15.3.5. Advanced clinical specialists in physical therapy are those with post entry-level education and/or training as described in section 7.15.2.3. Advanced clinical practice in physical therapy includes, but is not limited to:

7.15.3.5.1. Providing direct access (i.e., no referral needed) evaluation and treatment for acute, subacute and chronic musculoskeletal and neuromuscular conditions. This includes the privileges of ordering appropriate diagnostic imaging and laboratory tests, initiating temporary profiles up to 90 days in length, admitting or discharging to and from quarters, referring to other specialists and prescribing nonsteroidal anti-inflammatories, non-narcotic analgesics and designated muscle relaxants (i.e., flexoril) from the MTF formulary.

7.15.3.5.2. Performing needle insertion for electrodiagnostic testing, and “Dry Needling” procedures.

7.15.3.5.3. Evaluating and treating infants in the neonatal intensive care unit.

7.15.3.5.4. Neurodevelopmental evaluation and treatment.

7.15.3.6. May act independently in areas of demonstrated currency and competency within their designated scope of practice, as indicated by code “1” on their privileges list.

7.15.4. Supervision:

7.15.4.1. As with any privileged provider, an ongoing, proactive peer review process (as outlined in **Chapter 8**) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.15.4.1.1. Physical Therapists who have been identified as an “Advanced Clinical Specialist” must have a peer Physical Therapist Advanced Clinical Specialist designated by the SGH, in writing, as part of the ongoing, proactive peer review process. The peer Physical Therapist Advanced Clinical Specialist will review the practices for direct access evaluation and treatment, diagnostic imaging and laboratory utilization and profiling/quarters. The number of cases and patients and frequency of the peer review to determine currency and competency will be at the discretion of the local SGH.

7.15.4.1.2. Physical Therapists who have been identified as an “Advanced Clinical Specialist” and is prescribing medications must have a preceptor identified by the SGH, in writing, as part of the ongoing, proactive peer review process. Prior to the provider completing an initial E-application within CCQAS the preceptor letter was placed in Section I of the PCF. Once the provider has an approved E-application, this letter will be scanned, appropriately named and uploaded to the document section within the provider’s CCQAS credentialing record. The preceptor will review the practices for prescribing medications. The number of cases and patients and frequency of the preceptor peer review to determine currency and competency of the “Advanced Clinical Specialists” will be at the discretion of the local SGH.

7.16. Physician Assistants (PA).

7.16.1. Background. PAs are health professionals whose practice is centered on patient care and disease prevention and may include clinical teaching, patient education, research, and administrative activities. PAs are certified to practice independently and collaboratively in providing primary healthcare.

7.16.2. Education and Certification Requirements:

7.16.2.1. Graduation from a physician assistant education program accredited by the Accreditation Review Commission for Physician Assistant Education, Inc. (ARC-PA) or its predecessors, and acceptable to the HQ USAF/SG.

7.16.2.2. PAs must obtain initial certification by the National Commission on Certification of Physician Assistants (NCCPA) within 12 months of graduation. **Note:** Civilian accessions must be certified prior to entering active, or ARC duty.

7.16.2.3. Refer to paragraph 4.1.1.2.1. for licensure requirements and waiver. For non-personal service contractor PAs a state license from the state they are practicing is required along with the national certification.

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

7.16.2.5. Specialty PAs must complete an additional residency or fellowship program acceptable to the HQ USAF/SG. Reference paragraph 7.17. for further information.

7.16.3. Scope of Practice:

7.16.3.1. Are credentialed through the MTF and privileged as a staff member of the particular service in which they practice.

7.16.3.2. Diagnose patient medical conditions and plan therapy appropriate for the diagnosis to include performing procedures, ordering and evaluating diagnostic studies, prescribing medications and other therapeutic modalities, and providing for follow-up, referral, or consultative care.

7.16.3.3. May cover PCM primary call and work as sole provider with physician consultation available as described below if these specific privileges have been granted as "Fully Competent" or code "1" on the Physician Assistant privileges list. Ultimately, this is a local MTF decision, based primarily on the PA's physician supervisor, the needs of the patient population served, and the capabilities of the MTF.

7.16.3.4. PAs may work in the ED managing patients, consistent with their training and experience. Refer to paragraph 7.16.5. for additional information.

7.16.3.5. PAs who are privileged to assist with inpatient care may admit patients to the admitting physician's service after first consulting with the admitting physician. All patient orders must be reviewed and cosigned by the physician within 72 hours.

7.16.3.6. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.16.4. Supervision:

7.16.4.1. A physician preceptor must be identified, in writing, for each PA. Prior to the provider completing an initial E-application within CCQAS this information was placed in Section I of the PCF. Once the provider has an approved E-application, this letter will be scanned, named IAW the standard naming conventions (see Kx C&P toolkit) and uploaded to the PA's electronic PCF.

7.16.4.2. Preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the PA's practice.

7.16.4.3. PAs must have physician consultation available either in person, by phone, or electronic means when they are performing patient care activities. If the primary preceptor is not available, any physician on staff who is privileged for a similar scope of practice may supervise/precept or be consulted by the PA.

7.16.4.4. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.16.5. Supervision of PAs in the Emergency Department (ED).

7.16.5.1. The ED physician must be present in the facility and be immediately available by two-way voice communication.

7.16.5.2. The ED physician reviews the medical record of each patient under the care of the PA prior to the patient's departure from the ED (except for Emergency Medicine Specialty Physician Assistants as described in paragraph 7.17.4.1.1.).

7.17. Physician Assistants (Specialty).

7.17.1. Background. Specialty Physician Assistants (SPAs) are physician assistants who have met all of the definitions and requirements of physician assistants described in paragraph 7.16.2. and have received subsequent additional training in a medical or surgical specialty. Areas of specialty PA practice include, but are not limited to, orthopedics, otorhinolaryngology, general surgery, cardiac perfusion, hematology/oncology/bone marrow transplant, and emergency medicine.

7.17.2. Education and Certification Requirements.

7.17.2.1. In addition to the education requirements listed in 7.16.2., specialty PAs must complete residency or fellowship training of 12 months or more in a medical specialty program acceptable to the HQ USAF/SG.

7.17.2.2. Specialty PAs are trained at approved sites within the AF, DoD, or at accredited civilian institutions. Most AF PA specialty training programs award an AFSC specialty shred out upon completion.

7.17.3. Scope of Practice:

7.17.3.1. Is consistent with the scope of practice defined in paragraph 7.16.3., but expanded to reflect the nature of the specialty practice approved/supported by the medical specialty staff. Approval follows the privileging process outlined in Chapter 6. SPAs use the privileges list designated for the specialty physician, as well as the Physician Assistant privileges list, as appropriate. This in no way infers that the PA is practicing as a specialty physician, but practicing within the respective scope of care as a specialty physician assistant.

7.17.3.2. May cover primary specialty call with specialty physician consultation available as described in paragraphs 7.16.3.3. While on call, the SPA will practice under the supervision of the physician specialist on call, since in responding to ED or other calls the SPA may be required to perform beyond the scope of practice of the on-scene physician.

7.17.4. Supervision:

7.17.4.1. Supervision requirements outlined in paragraph 7.16.4. and 7.16.5. apply. Recognizing that the specialty PA possesses unique skills, primary supervision and oversight shall be by a physician of the same specialty (if available).

7.17.4.1.1. Emergency Medicine SPAs practicing within their approved scope of practice in the ED are exempt from having the ED physician review the medical record of each patient prior to the patient's departure from the ED.

7.17.4.2. SPAs may be assigned to MTFs where there is no physician of the same specialty assigned. In such cases, a staff physician in a specialty most closely overlapping that of the SPA should be assigned as preceptor. However, to fully practice in the specialty, like-specialty physician consultation must be available by phone or other electronic means. Arrangements must be made for one or more physician specialist(s) from a military MTF to accomplish ongoing performance review and assessment as described in paragraph 7.16.4.4. Arrangements may be made either locally or through AFMOA/SGHQ. The specialty preceptor(s) will be identified in Section I of the SPA's PCF prior to the SPA completing an initial E-application within CCQAS. Once the SPA has an approved E-application, this letter will be scanned, named IAW the standard naming conventions (see Kx C&P toolkit) and uploaded to the SPA's electronic PCF. Performance review and assessment reports will be filed in the SPA's PAF.

7.18. Podiatrists.

7.18.1. Background. 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, ankle, and related structures. Podiatrists are part of the orthopedic/surgery service.

7.18.2. Education/Licensure/Certification Requirements:

7.18.2.1. Doctor of Podiatric Medicine (4-year DPM degree) from an accredited college or university of podiatric medicine acceptable to the HQ USAF/SG.

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

7.18.2.3. Licensure from a US jurisdiction.

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

7.18.2.4.1. American Board of Podiatric Surgery.

7.18.2.4.2. American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

7.18.3. Scope of Practice:

7.18.3.1. Are authorized to provide podiatric services independently (without clinical supervision or direction). The national standard for podiatric medical doctors with

appropriate postgraduate education, as stated above, is the anatomic region of the foot and ankle as well as related structures affecting the foot and ankle.

7.18.3.2. May admit patients as necessary, to include performing complete H&P examination. If the podiatrist's educational program/privileging background does not permit the podiatrist to perform his/her own H&P examination, then a physician privileged in the MTF must perform the H&P exam and take responsibility for providing related care while the patient is hospitalized.

7.18.3.3. Practice independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.18.4. Supervision. None required. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.19. Psychiatric/Mental Health Nurse Practitioners (P/MHNP).

7.19.1. Background. P/MHNP are registered nurses who have obtained advanced practice education, training, and certification to practice independently to provide comprehensive psychiatric and mental healthcare to adults. The P/MHNPs practices within a healthcare system that provides consultation, collaborative patient care management, or referral as indicated by the health status of the client.

7.19.2. Education/Licensure/Certification Requirements:

7.19.2.1. Graduation from a master's degree program with specialization as a psychiatric-mental health nurse practitioner accredited by a national nursing accreditation agency recognized by the US Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.19.2.2. Licensure is addressed in Chapter 4.

7.19.2.3. National certification in specialty (i.e., certification by the American Nurses Credentialing Center).

7.19.3. Scope of Practice:

7.19.3.1. P/MHNPs provide comprehensive psychiatric and mental healthcare to adults over 18 years of age. They conduct biopsychosocial assessment, treatment, education, health promotion and disease prevention to adult patients, families and the community.

7.19.3.1.1. Diagnose, treat and manage acute and chronic illnesses, minor traumas and mental disorders within scope of competence; prescribe therapies to include pharmacological agents within scope of care.

7.19.3.1.2. Educate and serve as consultant and liaison to other units/clinics.

7.19.3.1.3. Provide crisis oriented care and therapeutic counseling/psychotherapy to individuals, couples, families and groups.

7.19.3.2. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.19.3.3. P/MHNPs may pull after hours Mental Health call with physician consultation available as described below if these specific privileges have been granted as indicated by “Fully Competent” or code “1” on their privileges list.

7.19.4. Supervision.

7.19.4.1. P/MHNPs granted MTF privileges must have a physician (privileged for the same scope of practice) consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities.

7.19.4.2. As with any privileged provider, an ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B.

7.20. Speech Pathologists.

7.20.1. Background. Speech pathologists ensure operational readiness and quality-of-life to the fighting force and eligible beneficiaries by providing cost-effective speech communication healthcare. Speech, language, voice, and swallowing state-of-the-art services are offered, including prevention, medical surveillance, education, and research.

7.20.2. Education/Licensure/Certification Requirements:

7.20.2.1. Master’s or doctoral degree from an accredited institution acceptable to the HQ USAF/ SG.

7.20.2.2. Licensure from a US jurisdiction.

7.20.2.3. National certification (Certificate of Clinical Competence from the American Speech-Language-Hearing Association).

7.20.3. Scope of Practice:

7.20.3.1. Follow the guidelines published by the American Speech-Language-Hearing Association.

7.20.3.2. Are privileged to provide diagnostic and therapeutic procedures for speech, language, and voice. Those with advanced training and current competence may be privileged to perform advance procedures such as prosthetic management, electrophysiological measures of speech functions, acoustic analysis of voice production, fiberoptic endoscopic evaluation of swallowing, modified barium swallow study, dysphagia therapy, stuttering treatment, augmentative communication, and treatment of central auditory processing disorders.

7.20.3.3. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by “Fully Competent” or code “1” on their privileges list.

7.20.4. Supervision. As with any privileged provider, an ongoing, proactive peer review process (as outlined in Chapter 8) is required. Periodic review of performance is required at least biennially as part of the competency-based privileging process. Examples of competency assessment include periodic review of a representative sample of medical

records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.21. Women's Health Nurse Practitioners (WHNP).

7.21.1. Background. WHNPs are registered nurses who have obtained advanced education, training, and certification to practice independently providing comprehensive women's healthcare throughout the lifespan, with an emphasis on reproductive, gynecologic, and family-centered health education. The WHNP practices within a healthcare system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

7.21.2. Education/Licensure/Certification Requirements:

7.21.2.1. Graduation from a master's degree program with specialization as a women's health nurse practitioner accredited by a national nursing accrediting agency recognized by the U.S. Department of Education. By 2015 entry level to practice will be at the doctoral level.

7.21.2.2. Licensure is addressed in Chapter 4.

7.21.2.3. National certification in specialty (i.e., certification through the National Certification Corporation (NCC) for the obstetric, gynecologic, and neonatal nursing specialties).

7.21.3. Scope of Practice:

7.21.3.1. May be granted clinical privileges to provide primary ambulatory healthcare to both obstetrical and gynecological patients. Clinical privileges include:

7.21.3.1.1. Diagnose and manage acute episodic and chronic illnesses, minor traumas and behavioral/psychological problems related to women's health. Teach, counsel and advise patients, families and communities about current health status, illness(es), and health promotion and disease prevention activities appropriate for age and condition.

7.21.3.1.2. Perform well woman exams, comprehensive family planning counseling, infertility evaluations and sexually transmitted infections care.

7.21.3.1.3. Perform initial obstetrical visits and routine prenatal and post partum care for low risk pregnancies.

7.21.3.1.4. Perform therapeutic procedures as defined and approved on the provider privileges list; and initiate and evaluate treatment regimens which may include prescribing and dispensing medications appropriate for privileged scope of care.

7.21.3.1.5. May perform additional skills such as colposcopy, limited ultrasound, and contraceptive implant insertions/removals, based on appropriate education and training.

7.21.3.2. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by "Fully Competent" or code "1" on their privileges list.

7.21.3.3. May work as sole provider with physician consultation available as described below if these specific privileges have been granted as “Fully Competent” or code “1” on the privileges list.

7.21.4. Supervision:

7.21.4.1. WHNPs must have physician (privileged for the same scope of practice) consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities.

7.21.4.2. As with any privileged provider, an ongoing professional practice evaluation (OPPE) is required. See Chapter 8, Section B.

Section 7D—Non-Privileged Allied Health Professionals (NC, Enlisted, Civilian/Contract Equivalent)

7.22. Certified Alcohol and Drug Abuse Counselors = Substance Abuse Counselors:

7.22.1. Background. Mental health technicians serve in clinical roles as Certified Alcohol and Drug Abuse Counselors (CADACs) in the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program. They provide services in the following 12 core functions outlined by the International Certification and Reciprocity Consortium (ICRC): screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, education, referral, report and record keeping, and consultation.

7.22.2. Education and Certification Requirements:

7.22.2.1. Have a minimum of 270 hours didactic instruction and 6,000 hours within the 12 core functions of substance abuse counseling, 300 of which must be accomplished via direct supervision by another fully qualified CADAC or privileged mental health provider.

7.22.2.2. Have a signed agreement to practice under strict USAF ethical guidelines.
Note: Ethical guidelines are state/board specific.

7.22.2.3. Pass a recognized written examination administered by the USAF.

7.22.2.4. Obtain nationally recognized certification from the ICRC.

7.22.2.5. Recertify every three years by obtaining 60 hours continuing professional education within the behavioral sciences, as outlined by the AF Substance Abuse Counselor Certifying Handbook.

7.22.2.6. The Air Force Substance Abuse Counselor Certification program issues the certification and has the authority to revoke certification for cause.

7.22.3. Scope of Practice/Supervision:

7.22.3.1. Perform the 12 core functions independently as directed by the ADAPT program manager. Provide treatment planning, crisis intervention, and group treatment under the supervision of a privileged mental health provider. For initial assessment, development of or changing a treatment plan, and crisis intervention, privileged mental health providers are responsible for “eyes on” supervision of CADACs. This is defined as direct contact with the patient of sufficient length and interaction to validate the

assessment and recommendation note made in the chart by the CADAC before the patient departs the appointment. Supervising privileged mental health providers must document supervision in the medical record following each episode supervised.

7.22.3.2. The ADAPT program manager is responsible for the clinical practice of CADACs and is familiar with the training needs of CADACs working in other areas of the mental health career field. Therefore, the ADAPT program manager maintains training records of all CADACs working in substance abuse. To ensure ongoing training and competency assessment for CADACs, the ADAPT program manager, or designee, must observe the CADAC while providing individual or group treatment, at least two times per month for a total of at least two hours monthly. Competency assessments will focus on direct client contact within the 12 core functions of substance abuse counseling, and will be documented in the CADAC's training record. In fulfilling this requirement, the observer and counselor will abide by strict ethical standards.

7.22.3.3. Non-certified 3-level mental health technicians who are in training may conduct the 12 core functions only when supervised by a CADAC or privileged mental health provider. They will require direct supervision during the entire patient contact. At the discretion of the ADAPTPM following a period of direct observation and evaluation, non-certified 5-level and 7-level mental health technicians may conduct the 12 core functions without direct supervision. A privileged provider is responsible for eyes-on supervision before the patient departs the appointment. Eyes-on supervision is defined as direct contact with the patient of sufficient length and interaction to validate the assessment and recommendation before the patient departs the appointment. The privileged mental health provider who performed this supervision must cosign the note in the patient record.

7.23. Registered Dental Hygienists.

7.23.1. Background. Dental hygienists are licensed professionals who work as members of healthcare delivery teams. Hygienists use their knowledge and clinical skills to provide preventive, educational, and therapeutic services for patients in all military treatment settings. They identify, treat, and/or prevent oral diseases such as dental caries, periodontitis, and oral cancer. They also recognize, clinically manage, and arrange for referral of patients for medical treatment who have clinical signs and/or symptoms of systemic diseases such as diabetes mellitus, nutritional disorder, cardiovascular disease, and AIDS. Hygienists with advanced training are capable of performing expanded duties such as administering local anesthesia, placing and finishing interim/provisional restorations, and making impressions for diagnostic casts.

7.23.2. Education/Licensure/Certification Requirements:

7.23.2.1. Dental hygienists must demonstrate appropriate skills, training, and experience to be authorized to practice. Minimum educational requirements include:

7.23.2.1.1. Completion of a dental hygiene certificate program accredited by the Commission on Dental Accreditation of the American Dental Association. Most dental hygiene programs are located at community colleges and grant an associate degree after 2 years of training. However, there are also numerous bachelor and

master's degree programs at colleges and universities that require an additional 2 to 4 years of education.

7.23.2.2. License to practice dental hygiene from a US jurisdiction.

7.23.2.3. Successful challenge of the National Board Dental Hygiene Examination.

7.23.3. Scope of Practice. Current dental hygiene practice encourages patient treatment that should be approached as a continuous process of care rather than a series of delegated duties or procedures. Predetermined clinical protocols and performance standards should be established to clearly delineate clinical responsibilities. Following are dental hygiene competencies commonly used for practice in most USAF treatment settings:

7.23.3.1. Complete an evaluation of every patient and formulate a dental hygiene diagnosis and treatment plan, in collaboration with the dentist and patient.

7.23.3.2. Complete preventive treatment and education to promote the values of oral and general health and wellness to support population health strategies. Common activities include dental prophylaxis, hygiene and tissue indices, tobacco cessation counseling, professional topical fluoride treatment, oral health counseling, and application of pit and fissure sealants.

7.23.3.3. Provide specialized treatment designed to achieve and maintain oral health. Specialized treatment includes scaling and root planning of tooth surfaces, application of local chemotherapeutic agents, control of pain and anxiety, continuous evaluation of the patient's response to therapy, provision of long-term supportive dental care, and management of medical emergencies.

7.23.3.4. Provide community oral health services in a variety of settings, depending on the local mission, resources, and opportunities for community involvement. Community outreach programs are often associated with special and recurring events such as national children's dental health month, health fairs, oral cancer screening programs, tobacco cessation classes, and prenatal counseling programs.

7.23.4. Supervision:

7.23.4.1. Dental hygienists function under the indirect or general supervision of a dentist, as defined by the American Dental Association. This requires that a dentist must diagnose conditions to be treated, must personally authorize the procedures, and must evaluate the performance of the dental hygienist and give clinical feedback.

7.23.4.2. Indirect supervision requires the dentist to be in the clinic or treatment facility and to be physically available to provide consultation and oversight. General supervision does not require the dentist to remain in the clinic or treatment facility, but the dentist must be available for consultation by phone while the hygienist is performing direct patient care activities.

7.23.4.3. The degree of supervision required varies with the nature of the procedure and the medical and dental history of the patient. Appropriate levels of supervision must be chosen that will not jeopardize the systemic or oral health of the patient.

7.23.4.4. As with any healthcare professional, an ongoing, proactive peer review process and periodic review of performance is required and is accomplished at least annually as

part of the performance review process. Examples of competency assessment include periodic review of a representative sample of dental records, direct observation of performance, and verbal/written assessment of clinical knowledge/skills.

7.24. Licensed Registered Nurses.

7.24.1. Background. Registered Nurses (RNs) have completed education and training in professional nursing practice. The American Nurses Association defines nursing as the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities and populations.

7.24.2. Education/Licensure/Certification Requirements:

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

7.24.2.2. Civilian and contract registered nurses must have graduated from an associate degree (AD) or a baccalaureate degree program in nursing (BSN) accredited by a national nursing accrediting agency recognized by the US Department of Education. By 2020 entry level to practice in the AF will be at the baccalaureate level of education.

7.24.2.3. Licensure is addressed in Chapter 4.

7.24.2.4. National certification by an AF SG1 approved certifying organization is highly encouraged. Required certifications are IAW career path guidance and specialty positions. See Chapter 7 for P-APN specialty requirements

7.24.3. Scope of Practice: Registered nurses practice in a variety of inpatient and outpatient settings based on the individual's level of experience and the job description. See AFI 46-101, *Nursing Services and Operations*.

7.25. Licensed Practical/Vocational Nurses.

7.25.1. Background. Licensed Practical/Vocational Nurses (LPNs/LVNs) have completed education, training, and licensure in practical nursing. Civilian and contract LPNs/LVNs are recognized and utilized in the AF as equivalent 5 and 7 level 4N0s.

7.25.2. Education/Licensure/Certification Requirements:

7.25.2.1. Graduation from a State Board of Nursing approved LPN/LVN training program or completion of equivalent military training that permits sitting for the state licensure examination.

7.25.2.2. Licensure is addressed in Chapter 4.

7.25.3. Scope Practice:

7.25.3.1. Performs all relevant care within the LPN/LVN job description and local competencies IAW the applicable state practice act.

7.25.3.2. Conducts focused nursing assessments of the health status of individuals; participates in the planning of nursing care needs and in modifying the nursing care plan; implements appropriate care within scope of practice; implements teaching plans for patients with common and well-defined learning needs; provides direct basic nursing care; assists in the evaluation of the patient's responses and outcomes to therapeutic interventions; and utilizes a problem-solving approach as the basis for decision-making in practice.

7.26. Independent Duty Medical Technician (IDMT). See AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, for description of this role. IDMTs follow AFI 44-103, AFMAN 44-158, *The Air Force Independent Duty Medical Technician and Dental Treatment Protocols*, and the 4N0X1 CFETP. For information regarding the ANG, reference ANGI 40-103, *Medical Support to Geographically Separated Units (GSUs)*. Ongoing regular peer review is required.

7.27. Medical Technicians (4N0X1X). The 4N0X1X utilizes the nursing process for patients by promoting and maintaining health, preventing disease and disability, and caring for and rehabilitating individuals who are experiencing an altered health state, while contributing to their ultimate quality of life until death. 4N0X1X personnel perform all relevant care and specialty competencies IAW their CFETP.

7.28. Medical Technicians Utilized in Ambulance Services. All medical technicians assigned to the ambulance service either as a full time job or occasionally to assist with patient transfers or other special mission, must hold, at a minimum, current certification as a National Registry Emergency Medical Technician (EMT)-Basic. Individuals who hold a state or national level EMT-Paramedic certification meet the NREMT-Basic requirement.

7.28.1. Composition of Ambulance Crews: Ambulance crews consist of at least two NREMT-Basics.

7.28.2. Prehospital Emergency Care: Prehospital emergency medical care personnel follow physician-approved protocols and have two-way voice communication with physicians. Note: Every AFMS ambulance service must use the standardized and approved USAF EMT-B protocols with locally approved additions. These approved protocols are available on the WWW site at <https://webm.sheppard.af.mil/882TRG/383/emt/emthome.html>.

7.28.3. MTFs who have a paramedic-level ambulance service must use Air Force EMT Paramedic protocols. MTF Medical Directors will submit waiver requests through the MAJCOM/SG to AFMOA/SGN for HAF/SG1N approval.

7.29. Authorization for Nurse Extended Scope of Practice/Waiver for 4NX0 to Perform Clinical (Patient Care) Tasks Not Outlined in the CFETP (Applies to active duty and air reserve component only).

7.29.1. Under the concept of Federal Supremacy, the Air Force may, for the purpose of its mission, utilize nurses for tasks that may be beyond those authorized by the state that issued the individual's license. Similarly, aerospace medical service technicians may be asked to perform tasks beyond their normal training and scope of practice as outlined in their CFETP.

7.29.2. Utilization of nurses and aerospace medical service technicians (4NXXX) for extended scope of practice must meet three criteria:

7.29.2.1. The expanded scope of the task must be mission essential.

7.29.2.2. The member must be trained for the expanded scope by a competent trainer and that training must be documented.

7.29.2.3. The expanded role is restricted solely to military mission performance and it requires annual review and approval.

7.29.3. When the medical leadership or health care team decides that a nurse needs to perform clinical tasks outside his/her scope of care, or a 4NXXX needs to perform tasks not in the CFETP, the organization must request a Scope of Practice Waiver along with a copy of the lesson plan for waiver approval. HAF/SG1N is the final waiver authority for nurses; the AF Career Field Manager is the final waiver authority for enlisted.

7.29.3.1. Nurse Waiver Routing Process: MTF SGN/SGH; MTF/CC; MAJCOM/SG; AFMOA/SGN/SGH; HAF/SG1N.

7.29.3.2. Enlisted Waiver Routing Process: MTF/SGN/4N Functional/SGH; MTF/CC; MAJCOM/SG; AFMOA/SGN/SGH; HAF/SG1N.

7.29.4. In all cases, training and annual revalidation for additional clinical tasks for nurses will be documented and certified on a competency assessment checklist and filed in the member's Competency Assessment Folder (CAF). For aerospace medical service technicians, training and annual re-validation will be formally certified on AF IMT 797, *Job Qualification Standard Continuation/Command JQS*, and maintained in the individual's electronic Air Force Training Record (AFTR). Training references for all tasks beyond any individual's scope of practice or the CFETP will be maintained in the duty section where these tasks are performed.

7.29.5. Waiver requests will include the following:

7.29.5.1. Specific task to be added and the rationale for expanding practice, to include who and where within the MTF.

7.29.5.2. Task checklist/algorithm.

7.29.5.3. Training plan, protocol(s), and references.

7.29.5.4. Procedures for competency validation/verification/re-verification.

7.29.5.5. Plan for obtaining and maintaining competency for this expanded practice.

7.29.6. All waiver requests must be resubmitted annually for re-verification and approval.

Section 7E—Miscellaneous Issues: Medical/Dental Students.

7.30. Medical/Dental Student Documentation in Medical Records.

7.30.1. Medical/dental students must indicate their status when signing an entry by indicating the year of training. For example, sign "MS-3" for a third-year student and "MS-4" for a fourth-year student.

7.30.2. Supervising physician must countersign all patient record entries written by medical students within 24 hours.

7.30.3. Orders written by medical/dental students are not valid until a supervising physician reviews and co-signs the order.

7.30.3.1. Medical/dental students are prohibited from giving verbal orders.

7.30.4. The H&P examination must be countersigned by the attending physician or senior resident before it becomes part of the medical record.

7.30.5. Medical/dental students may not obtain informed consent.

7.30.6. For the ANG, reference ANGI 41-102, *Early Appointment Program for Physicians*, for further guidance regarding third and fourth-year medical students.

Chapter 8

COMPETENCY ASSESSMENT AND PEER REVIEW

Section 8A—Competency Assessment

8.1. Staff Competency Assessment. Competency assessment is a continuous process that includes but is not limited to MTF and work center orientation, license verification, certification maintenance, in-service training, continuing education and skills/task performance. Competency assessment is required of all clinical and non-clinical staff members. The MTF staff is defined as all military (officer and enlisted), civilian, contract, volunteer personnel and to include students working under educational support agreements. The right skill mix, job knowledge, and appropriate competency levels of staff are critical factors in providing quality patient care and customer service. Competence is the ability of a staff member to apply decision-making, psychomotor, and interpersonal skills at the level of knowledge expected for the current duty position. Competency is demonstrated by performance in a designated setting, consistent with established standards of performance that are determined by the work setting and the individual's role in that setting.

8.2. MTF Leadership Ensures Appropriate Individual Skill Mix. MTF leadership ensures individuals with the appropriate skill mix fill the correct role within the organization. The leaders are responsible for assessing, maintaining, and improving staff competency through an ongoing series of activities. The education and training staff:

8.2.1. Provides an organization wide and work center specific orientation for all new staff.

8.2.2. Assesses and documents current staff competency levels on an on-going basis. Competency documentation for all non-privileged staff will be maintained in the Competency Assessment Folder (CAF) or an electronic training record such as the Air Force Training Record (AFTR) in use by all enlisted personnel.

8.2.3. Reports the percentage of staff that completes documentation of their competency assessment to MTF leadership on a quarterly basis.

8.2.4. Identifies the competencies, which should include the needs of the patient population, types of procedures performed, conditions or diseases treated and equipment used in the facility, which each staff member requires to perform the assigned job. **Note:** Specific guidance on competency assessment criteria for enlisted members is found in the respective Career Field Education and Training Plan (CFETP).

8.2.5. Provides feedback to staff of expectations and objective criteria to perform, improve, or enhance job performance. This includes reviewing job descriptions and performance standards on an annual basis.

8.2.6. Implements programs that enable staff to meet the competencies and performance standards established by the organization.

8.2.7. Completes and presents annual status of the training report to the MTF Executive Committee for evaluation. The annual training report should include at a minimum, but is not limited to, education and training process improvements, status of life support training, orientation process and completion, Enlisted Specialty Training (EST), in-service education,

competency assessment, Emergency Medical Technician (EMT) training, Independent Duty Medical Technician (IDMT) training, other AFSC specific training and continuing education.

8.3. Staff Member Competency Assessment. Each staff member's competence is assessed by the organization, usually by the person who directly supervises the individual's day-to-day work. These assessments are analyzed for patterns or trends. Based upon these trends and analyses, additional training or education may be needed. Individual competency assessments may indicate more formal corrective action is needed. The MTF develops and implements a plan when further individual education or training is indicated.

8.4. Staff Orientation and Ongoing Competency Training. Orientation to the MTF, continuing education, in-service education, readiness skills verification, work-center specific competency-based orientation and just-in-time training are provided to assist all staff in acquiring, maintaining, and improving competence. All staff, throughout their tenure with the organization, should receive information on new or revised policies, new performance expectations, new procedures, and training on new equipment.

8.5. Competency Assessment Folder Requirements.

8.5.1. Non-Privileged Providers. All officer, civilian, contract and volunteer non-privileged healthcare staff will maintain a CAF or an electronic equivalent. If the electronic equivalent is not accessible to locations where a training folder is required, the CAF will be used/maintained IAW location specific requirements. See A2.1. in Attachment 2, **Officer, Civilian, Contract and Volunteer Personnel (Privileged and Non-Privileged)—Competency Assessment Folder** guidelines. All enlisted medical personnel (X4XXXXX) will utilize the AFTR in lieu of a hard copy competency assessment folder to document competency. Documentation guidance for enlisted training is found in AFI 36-2201, *Air Force Training Program On-The-Job Training Administration*, and the individual's respective CFETP. Competency assessment documentation for enlisted personnel will be maintained in AFTR.

8.5.1.1. Active Duty Air Force MTF education and training staff will have a grace period of 180 days from the publication date of this AFI to comply with the transition to the revised Officer, Civilian, Contract and Volunteer Personnel (Privileged and Non-Privileged) — Competency Assessment Folder. The Air Force Reserve Component and the Air National Guard will have 365 days from publication date to comply.

8.5.2. In addition to requirements found in AFI 36-2201, all medical enlisted personnel (AFSC X4XXXXX), regardless of assignment or duty location, will also comply with the following:

8.5.2.1. All CMSgts and below will have an active AFTR record. At a minimum, records for fully qualified individuals (7 levels and higher), will include work center orientation/training documentation on an AF Form 623A, *On-The-Job Training Record Continuation Sheet*, inservice and any applicable recurrent training on AF Forms 1098, *Special Task Certification and Recurring Training*, and any other continuing education documentation/certification requirements mandated by the individual's Career Field Manager (CFM).

8.5.2.2. All Senior Noncommissioned Officers (MSgt – CMSgt) who are providing patient care will maintain a current specialty training standard (STS) and appropriate AF

Form 797, *Job Qualification Standard Continuation/Command JQS*, or AF Form 1098 documentation. All clinical tasks being performed will be signed off on the individual's STS/AF Form 797 or AF Form 1098 in AFTR.

8.5.2.3. Independent Duty Medical Technicians (IDMTs) Assigned To Non-Medical Units.

8.5.2.3.1. AD IDMTs assigned to non-medical units will be enrolled in AFTR at the MTF where sustainment training is accomplished. Unit training managers (UTMs) will create IDMT workcenters, assign non-MDG IDMTs to the workcenter and give IDMT trainers access to the work center via the Profile II screen in AFTR. This does not negate the requirement for an IDMT competency assessment folder IAW AFI 44-103, *The Air Force IDMT Program*.

8.5.2.3.2. AFRC IDMTs assigned to non-medical units will be enrolled in AFTR and assigned to the respective unit. If the unit is not represented in AFTR the IDMT will be assigned to an IDMT workcenter in the Aerospace Medicine Flight (AMDF), Aerospace Medicine Squadron (AMDS), or Medical Squadron (MDS) on their assigned base. Non-medical UTMs will create an IDMT workcenter and will transfer IDMT training record to the medical unit UTM where clinical/sustainment training is accomplished. Medical UTMs will give IDMT trainers access via Profile Screen II in AFTR. This does not negate the requirement for an IDMT competency assessment folder IAW AFI 44-103.

8.5.3. The following items (as applicable) will be scanned (set scanner to lowest legible resolution) and attached into AFTR (under the user record tab) medical enlisted personnel (AFSC X4XXXXX), regardless of assignment or duty location:

8.5.3.1. All AF Forms 623A accomplished at the current duty station. **Note:** Previous assignment AF Forms 623A will be uploaded if AF Forms 623A documents training received at previous duty assignment and still relevant to current duty position task qualification or any historical 623A documentation related to upgrade training if the member is still in upgrade training.

8.5.3.2. AF Form 803, *Report of Task Evaluations* (Remove IAW AFI 36-2201).

8.5.3.3. AETC Form 156, *Student Training Report* (Remove IAW AFI 36-2201).

8.5.3.4. CDC Enrollment Cards (Remove IAW AFI 36-2201).

8.5.3.5. AF Form 34, *Field Score Sheet* (Remove IAW AFI 36-2201).

8.5.3.6. Course Examination Scorecard (Remove IAW AFI 36-2201).

8.5.3.7. AF Form 2096, *Classification/On-The-Job-Training Action*, (or Military Personnel Data System (MILPDS) product) with current skill level and special experience identifier (as applicable).

8.5.3.8. Current Basic Life Support Card. Remove Expired BLS card when no longer required.

8.5.3.9. Mental Health (4C0X1) will also scan and attach current certified alcohol and drug abuse counselor (CADAC) certificate.

8.5.3.10. Public Health (4EXXX) will also scan and attach:

8.5.3.10.1. Operational Entomology Course Certification.

8.5.3.10.2. Epidemiology Course Certification from the Centers for Disease Control and Prevention.

8.5.3.10.3. Hearing Conservation Certification.

8.5.3.10.4. Servsafe Training Certification (if completed).

8.5.3.11. Aerospace Medical Service (X4N0XXX) will also scan and attach current National Registry of EMTs card (SMSgts and below and CMSgts assigned to 4N0 positions on standard UTCs). (Remove expired NREMT card when no longer required.)

8.5.3.12. IDMT (4N0X1C) will also scan and attach:

8.5.3.12.1. Completed IMT 4336, *IDMT Patient Encounter Form*, or equivalent Preceptor Quality Assurance Form IAW AFI 44-103.

8.5.3.12.2. Current IDMT certification letter signed by the MTF SGH.

8.5.3.13. Laboratory Technicians (4T0X1X) will also scan and attach laboratory certifications from the American Society of Clinical Pathologists or equivalent organization.

8.5.3.14. Ophthalmic Technicians (4V0X1) will also scan and attach copies of either (or both):

8.5.3.14.1. American Optometric Association (AOA) certification (Certified Paraoptometric Technician (CPOT) or Certified Paraoptometric Assistant (CPOA)).

8.5.3.14.2. Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) certification (Certified Ophthalmic Assistant [COA]).

8.5.3.15. Dental Hygienists (4Y0X1H) will also scan and attach:

8.5.3.15.1. Hygienist diploma.

8.5.3.15.2. Hygienist license.

8.5.3.15.3. Other certification, e.g., Anesthesia and Nitrous Oxide Monitoring

8.5.3.16. Aeromedical Evacuation Units (for X prefix personnel) will also scan and attach:

8.5.3.16.1. Most recent AF Form 4023, *Aircrew Training Report*.

8.5.3.16.2. Most recent AF Form 4024, *Aircrew Training Accomplishment Report*.

8.5.3.16.3. Most recent AF Form 4025, *Aircrew Summary/Closeout Report*.

8.5.4. Scan and Attach Documentation:

8.5.4.1. When any document is scanned and attached or when a document is deleted, a note documenting the nature of the scanned/deleted document must be made on an AF Form 623A. Documents should be individually scanned, dated, and named based on document content, e.g., "CPR card_EXP date_JAN 2010."

8.5.4.2. Documentation indicating where the AF Form 55, *Employee Safety and Health Record*, is maintained. Annotate, “The AF Form 55 is maintained in the section safety binder.” The AF Form 55 will be given to the individual to hand-carry when they deploy or permanently change station (PCS).

8.5.4.3. When personnel PCS, the MTF UTM will transfer the individual’s AFTR file to the gaining unit. All base medical enlisted personnel will in and out process with the MTF UTM.

8.5.4.4. When personnel are separating, retiring, retrained to a non-medical AFSC, or PCSing to a non AF unit, UTMs will download a copy of the individual’s AFTR file (to include all attachments) onto a CD ROM and export (print) a hard copy of the individual’s record, to include all attachments. The UTM will give the CD ROM and printed record to the member. Once this is completed, the record can be archived within AFTR.

8.5.5. Privileged Providers. Electronic PCFs in CCQAS hold credentialing and privileging documents for privileged providers. The electronic PCF is maintained by the MTF CM. The 6-part PCF is retained and secured by the CM for historical purposes. For detailed information on the electronic PCF refer to *Section 5E*. Provider performance documents are maintained in the PAF (reference Attachment 7 for details). Privileged healthcare providers will also maintain a two-part CAF, which should be kept by the individual’s clinical supervisor in the work center to which the individual is assigned and be made available to the individual for periodic update and review. The privileged personnel’s CAF will include those mandatory training items not included in the individual’s electronic PCF and PAF. See A2.1. in Attachment 2, **Officer, Civilian, and Volunteer Personnel (Privileged and Non-Privileged) — Competency Assessment Folder**.

8.5.5.1. Competency assessment for initial privileges and biennial renewal is accomplished through the credentialing process and is based on performance measures established by the MTF Credentials Function (CF).

8.5.5.1.1. Initial competency assessment is based on documented training and/or clinical expertise. Evidence of training includes verifiable items in the AF Form 1540, *Application for Clinical Privileges/Medical Staff Appointment*; AF Form 22, *Clinical Privileges Evaluation Summary*; AF Form 475, *Education/Training Report*; AF Form 494, *Academic/Clinical Evaluation Report*; AF Form 1541, *Credentials Continuing Health Education Record*; and AF Form 1562, *Credentials Evaluation of Healthcare Practitioners*. These forms provide documentary evidence of competency when completed by peers, supervisors, and the chief of medical or dental staff as appropriate. Optimally letters of recommendation and/or supervised practice should be from a peer sharing a similar AFSC or specialty.

8.5.5.1.2. The biennial credentials renewal process integrates output from performance-based determinants collected on an ongoing basis. Examples of these elements of performance include analysis of variance derived from focused and ongoing professional practice reviews, comparable data analysis, and Executive Global Look (EGL) metrics. The PAF acts as a repository for information to be reviewed and evaluated but is not appropriate for containment in the electronic PCF.

Section 8B—Professional Practice Evaluation Process (Applicable to Privileged Providers Only)

8.6. General.

8.6.1. Professional practice evaluation or peer review is the evaluation of an individual's professional performance for all relevant performance dimensions using multiple sources of performance data. It should include the identification of opportunities to improve care. Professional practice evaluation is part of an ongoing performance improvement process that ensures competence and improves performance.

8.6.2. The goal of professional practice evaluation is to improve the overall provision of healthcare by assessing competency and analyzing data for evidence-based professional practice.

8.6.3. The dimensions of performance that must be measured include:

8.6.3.1. Patient Care: Provide patient care that is compassionate, appropriate, and effective for the promotion of health, the prevention of illness, the treatment of diseases and at the end of life. Measures include how quickly the provider responds to calls, timeliness of his or her consultations and whether documentation is thorough, timely and legible.

8.6.3.2. Medical Knowledge: Demonstrate current clinical knowledge and skills. The medical staff establishes expectations regarding skills, patient outcomes, and specific clinical processes. Use evidence-based guidelines, when available, as recommended by the appropriate specialty and approved through the MTF, in selecting the most effective and appropriate approaches to diagnosis and treatment.

8.6.3.3. Practice-based Learning and Improvement: Use scientific evidence and methods to investigate, evaluate, and improve patient care.

8.6.3.4. Interpersonal and Communication Skills: Demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with parents, families, and other healthcare team members.

8.6.3.5. Professionalism: Act in a professional and respectful manner at all times and adhere to a code of conduct. (See Kx Toolkit for a sample code of conduct and operating instruction template.) Respond promptly to requests for patient care needs. Completing medical records and documentation on time, committee work and attending meetings, cooperating with programs such as peer review and credentialing.

8.6.3.6. Systems-based Practice: Demonstrate both an understanding of the context and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare. Participate in the MTF's effort and policies to maintain a patient safety culture, reduce medical errors, meet National Patient Safety Goals, and improve quality.

8.7. Medical Staff Oversight. The Medical Staff is responsible for the Professional Practice Evaluation Process. The Credentials Function is responsible for monitoring compliance with this policy and procedures. The Credentials Function receives regular status reports from each medical director related to the progress of all providers on focused professional practice

evaluation (FPPE) and any problems identified during ongoing professional practice evaluation (OPPE). The SGH will notify the provider in writing of the results of the FPPE and this review/form is placed in the PAF as outlined in Chapter 5. Feedback from the OPPE will be reviewed with the provider as described in paragraph 8.9.4. and maintained in the PAF.

8.8. Focused Professional Practice Evaluation (FPPE).

8.8.1. FPPE provides a process whereby the procedure/privilege specific competence of a provider without documented evidence of competently performing the requested privileges at the MTF is evaluated. This process may also be used when a question arises regarding a currently privileged provider's ability to provide safe, high-quality patient care. FPPE is a time-limited period during which the MTF evaluates and determines the provider's professional performance.

8.8.1.1. When a provider is granted privileges for the first time, either at initial appointment or as a current member of the medical staff, the provider will undergo an initial period of focused evaluation. FPPE is required for low volume providers requesting renewal of privileges when they next exercise the low volume privilege. FPPE is also required when there is a concern regarding the provider's current competency.

8.8.1.2. Relevant information resulting from the FPPE process will be integrated into performance improvement activities, consistent with policies and procedures that are intended to preserve confidentiality and privilege of information.

8.8.1.3. A provider undergoing FPPE will be notified and informed of the findings and any follow-up steps or plans for ongoing monitoring, if indicated.

8.8.2. A FPPE plan will consider the sources of data and how it will be collected, the duration of the monitoring period and reporting the outcomes.

8.8.2.1. Sources of data and collection:

8.8.2.1.1. Each department within the privileging organization shall define the appropriate monitoring method, number of cases, and duration of proctoring period to determine what constitutes a provider's current competency.

8.8.2.1.2. This monitoring may be performed using prospective, concurrent, or retrospective approaches, as determined to be most appropriate given the provider's education, training, board certification and years of professional practice experience. Data can be obtained for all dimensions of provider competence from multiple data sources. Data may be individual care specific or rate data from multiple cases. Information sources may include: detailed medical records review, monitoring clinical patterns, simulation, proctoring, external peer review, on-site interviews or TDY of a provider to another location.

8.8.2.1.3. The data obtained will be recorded in an appropriate proctoring form.

8.8.2.2. Duration of Monitoring Period. The Credentials Function in conjunction with the individual medical directors will establish the criteria and duration of the FPPE. Duration should be based on number of records, cases, or procedures reviewed instead of a specific timeline. If during this period of FPPE, issues are identified that may result in significant deviations from standards of care, the monitoring period may be extended. Similarly, if

initial concerns are raised that require further evaluation or there is insufficient activity during that time, the monitoring period may be extended.

8.8.2.3. For those specialties where another provider may not be available to proctor initial procedures, 100% chart review of invasive procedures will be performed during the FPPE. For facilities that have single providers practicing a specialty the FPPE can be accomplished by sending records to another MTF. If the facility cannot arrange review contact the AFMOA SGH consultant for assistance.

8.8.2.4. The proctor's role is that of an evaluator, to review and observe cases, not of a supervisor or consultant. The proctor must be a member in good standing of the medical staff and have unrestricted privileges for the scope of care being proctored. Proctors will evaluate sufficient portions of the medical care rendered by the provider to be able to judge the quality of care provided in relationship to the privilege(s) requested. In addition to specialty and privilege specific issues, proctoring will address the six dimensions of performance.

8.8.2.5. The medical director or designee will determine changes to improve performance based on results of FPPEs, including proctoring, and implementation of provider-specific performance improvements plans, as appropriate for providers who complete the FPPE. The Medical Director will provide a report to the Credentials Office once a provider has successfully completed FPPE. (See Kx C&P Toolkit). The Credentials Function will be notified of the extension and consideration should be given for M&E if the concern requires further evaluation.

8.8.3. FPPE of a provider's performance may occur when issues are identified that may affect the provision of safe, high-quality medical care. The following criteria may trigger the need for this focused evaluation:

8.8.3.1. There is aggregate, valid, provider-specific data that demonstrates a significant adverse variation from internal or external benchmarks or performance.

8.8.3.2. There is a problematic pattern or trend identified as a result of the OPPE of the provider.

8.8.3.3. There is a serious complaint or quality of care concern raised against the provider.

8.8.3.4. There is evidence of behavior, health, and/or performance issues that carry an immediate threat to the health and safety of the patient, public, or other members of the healthcare team.

8.8.4. M&E, as one type of FPPE, is a specific recommendation of the Credentials Function when the function is uncertain as to the competency of at least part of a provider's practice.

8.8.4.1. M&E is a well defined, time-limited, well-documented plan for FPPE to confirm that a provider possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. The plan will include a list of specific questions, procedures, and concerns to be evaluated during the period of M&E and clear expectations and measures of success. The plan shall be coordinated through AFMOA/SGHQ.

8.8.4.2. M&E consists of a formal monitoring plan for the provider either at the assigned MTF or another facility.

8.8.4.3. The duration of M&E is variable, but often will last 2-3 months.

8.8.4.4. The supervising peer is expected to conduct constructive feedback with the provider throughout the M&E. The progress documentation shall be reviewed bimonthly by the SGH with ongoing updates to the Credentials Function. The supervising peer will provide a specific written assessment of the skills in question to the Credentials Function at the end of the period. (See Kx Toolkit for template.)

8.8.4.5. The SGH will notify the provider in writing of the results of the M&E and this review is placed in the PAF/PCF as outlined in Chapter 5. If the M&E finds concern, an adverse action may be initiated if warranted.

8.9. Ongoing Professional Practice Evaluation (OPPE).

8.9.1. OPPE is the continuous evaluation of the provider's professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence based privilege renewal system. OPPE allows the MTF to identify professional practice trends that impact on quality of care and patient safety. The information, gathered in accordance with the criteria established by the medical staff, is integrated into performance improvement activities, utilized in maintaining current privileges, revising existing privileges, or, if necessary, revoking an existing privilege prior to or at the time of renewal.

8.9.2. OPPE applies to all military and civilian providers who have been granted privileges by the MTF privileging authority. This requirement also applies to deployed providers.

8.9.3. OPPE will begin immediately after appointment to the staff and provide continuous monitoring of providers' performance. Effective OPPE is the use of systematic measurement, evaluation and follow-through. This data shall be used by the credentials function to assess clinical currency and to renew provider's privileges. This information is stored in the PAF (see Chapter 5) and is privileged and protected from disclosure under 10 U.S.C. §1102.

8.9.4. Feedback to the provider will occur at least semiannually. When practice variances (both positive and negative) are noted, feedback must occur more frequently. For example, when rules (i.e., practice standards) are broken, immediate feedback is warranted along with continued review to trend data. If review shows continued deviation from the norm, further evaluation and referral to the Credential Function is warranted. With unusual or adverse events, immediate review and action is necessary.

8.9.5. Elements for review may include: pharmacy profiles, medical record completion, blood and drug utilization evaluations, known procedure complications, Incident/Adverse Event information, morbidity and mortality summaries, infection rates, HEDIS and ORYX measures, patient satisfaction/complaints, patient advocacy information and additional elements as defined by the clinical department or medical staff.

8.9.6. There are many sources of performance data and no set number of charts to review. The number should be adequate to compare providers, as determined by the SGH or department chair. For low volume/high-risk activities, 100% chart review would be appropriate. For high volume activities, 5% chart review would be adequate. The provider

and departments must receive data and feedback. This information may be obtained through periodic medical record review, direct observation, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient. Much of this data can be collected by clinical and administrative support staff. This information is stored in the PAF (see Chapter 5) and is privileged and protected from disclosure under 10 U.S.C. §1102.

8.9.7. Summaries of OPPE review and findings will be evaluated by the Credentials Function every 6 months and presented to the ECOMS.

8.10. Standard of Care Review (SOC). SOC review is a focused quality of care evaluation of a specific case. It is initiated in response to a concern about the SOC in a specific case. As such, it results in a specific SOC determination of “met, not met or indeterminate” by the reviewer. A peer is defined as someone of the same AFSC or specialty. This peer may be within or outside of the MTF. The provider must be notified before the SOC review is initiated and must be notified of the results. The SGH will notify the provider in writing of the results of the SOC and this redacted review is placed in the PAF/PCF as outlined in Chapter 5. A result of “not met” may necessitate a FPPE and uncommonly initiate an adverse action. Morbidity and Mortality conferences could be the basis for a formal SOC review that would be reported separately.

8.11. Expert Review. Expert Review is an external quality of care review with a SOC determination of a specific case in preparation for a malpractice case against the government. The Air Force Legal Operations Agency, Tort Litigation Division (AFLOA/JACC) directs expert reviews (reference Chapter 10).

Section 8C—Non-Privileged Providers (NPP) Peer Review Process

8.12. General. Peer Review is the activity of looking objectively at the quality of care and practice of a NPP. This is accomplished by peers looking at performance-based clinical practice, records and other applicable data. There are two main types of peer review: proactive and responsive. Proactive review is ongoing and is designed to monitor and validate if NPPs are providing safe and effective healthcare and to potentially identify healthcare related problems early, including individual and system performance improvement opportunities. Responsive peer review occurs after a clinical competency problem has been suspected or identified. The concepts of peer review are applicable across all disciplines and should be applied as appropriate. The respective Senior Corps Representatives and Enlisted Functional Managers are responsible for peer review in the medical treatment facilities. Peer reviews are privileged and protected from disclosure under 10 U.S.C. §1102.

8.13. Proactive Peer Review.

8.13.1. Clinical Skills Review. A clinical skills review is routine and not adverse in nature. This review focuses on individual clinical performance and is performed by a peer. A peer is an individual with similar education, experience and background. An example is an ambulatory care nurse reviewing telephone triage encounters of another ambulatory care nurse against approved telephone triage protocols. Criteria for review should be selected by the local MTF.

8.13.2. Criteria must be clinical and defined by current standards of practice/care (i.e., approved Telephone Triage protocols/guidelines; or local Support Staff Protocols). NPP peer

review should occur quarterly. Reviews can either be random charts or more focused in nature. There is no set number of charts to review; however, the number should be adequate to assess clinical skills in a specific area (not for statistical analysis). For low volume/high-risk activities, 100% chart reviews might be appropriate. For high volume activities 5% chart review might be adequate. Results of clinical skills review should be presented to the individual reviewed, Senior Corps Representative, and the Enlisted Functional Manager, if applicable. This information should be stored in the individual's Competency Assessment Folder (CAF), or on AF IMT 803, *Report on Task Evaluations*, in the enlisted Air Force Training Record (AFTR).

8.13.3. For facilities that have single NPPs in a particular specialty (i.e., Clinical Case Manager or Allergy/Immunizations Technician) clinical skills review can be accomplished by establishing an agreement with another MTF to conduct the peer review. It may also be conducted with an agreement with another military service MTF. If the facility cannot arrange an entity to conduct their peer review, it should contact the MAJCOM/AFMOA functional for assistance.

8.14. Responsive Review. Responsive reviews are accomplished in response to any concern related to clinical performance. These reviews are done in coordination with the Senior Corps Representative, the Enlisted Functional Manager, if applicable, and the SGH. Responsive reviews consist of individual practice reviews, standards of care reviews, and expert peer reviews.

8.14.1. Individual Practice Review (IPR) is a peer review of an individual's practice through records, on-site interviews and observations. It may be independent or part of an inquiry.

8.14.2. Standard of Care Review (SOC) is a peer review of a specific incident of care and is initiated in response to a concern about individual clinical performance and a potential breach in the standard of care.

8.14.3. Expert Peer Review is an external peer review of a specific incident of care in preparation for a medical malpractice case against the government. Expert peer reviews are arranged with the Expert Peer Review Manager in AFMOA, Risk Management Operations.

Chapter 9

ADVERSE CLINICAL, ADMINISTRATIVE ACTIONS RELATED TO THE PROVISION OF HEALTHCARE AND RELATED PROFESSIONAL STAFF ISSUES

Section A—Overview of Clinical Adverse Actions

9.1. General. This section describes the management of clinical adverse actions for both privileged and non-privileged providers. A clinical adverse action is an action invoked against a healthcare provider (privileged or non-privileged), where the authority to practice healthcare for the AFMS is adversely affected. This action is taken in response to a threat to patient safety or to the integrity (bring discredit or unfavorable scrutiny) of the AFMS related to clinical incompetence, professional misconduct, or impairment. The process has five steps: inquiry period/quality assurance investigation as needed, professional review process (credentials function or other peer review function), hearing procedures, appeal procedures through the Medical Practice Review Board (MPRB), and final AF/SG review. See detailed flowchart on the adverse actions process posted on the AFMOA/SGHQ website. AFMOA/SGHQ will provide consultative support to the MTF. AFMOA/CC will ensure compliance with this policy by the MTFs. **Note:** All documents generated pursuant to the adverse action process are quality assurance documents. Therefore, the documents are protected IAW Title 10 U.S.C. §1102. These documents will be labeled, citing this statute. Do not release these documents without proper authority.

9.2. Differentiate Clinical and Administrative Adverse Actions. MTF/CC and their local SJA and MLC, in consultation with AFMOA/SGHQ, will ensure that a clinical adverse action is taken, when appropriate. Clinical adverse actions are considered appropriate when there is evidence of incompetence, unprofessional conduct, or impairment that could or has created a risk to patient(s)/staff safety or to the integrity of the AFMS. For example, evidence may indicate deficits in competence (medical knowledge, expertise, or judgment); conduct (e.g., disruptive behavior that negatively affects the working environment for staff and/or patients, unprofessional, unethical, or criminal conduct); or impairment (medical conditions, mental health conditions, or alcohol/drug abuse/dependence) that reduce or prevent the provider's ability to safely execute his or her responsibilities in providing safe healthcare. Matters that do not meet these criteria shall be handled administratively. Administrative adverse action may be taken against the provider in addition to a clinical adverse action. See Attachment 9 for examples of administrative adverse actions. Contact the SJA or MLC for advice. **Note:** When the MTF consults with legal and AFMOA/SGHQ regarding the management of an adverse action and receives conflicting guidance a telecon must be held between the MTF, legal and AFMOA/SGHQ to discuss the case to ensure the MTF/CC has information needed upon which to base a decision.

9.2.1. A clinical adverse action must be taken when appropriate, regardless of the individual's contract or other duty status within the MTF. Severing the employment relationship (to include PCS, separation, resignation, or retirement), or negotiating a contractual/employment settlement in lieu of taking an adverse action that is indicated, is not appropriate.

9.2.2. Clinical adverse actions are taken by the MTF privileging authority and follows the MTF service chain of command regardless of the provider's service affiliation. The Surgeon General responsible for the MTF taking the adverse action will make the final decision and direct reporting to the NPDB and other regulatory agencies as appropriate. See paragraph 9.38.2. for additional information regarding processing an adverse action on members from other services.

9.3. Purpose of Taking Clinical Adverse Actions:

9.3.1. To protect our patients.

9.3.2. To enhance the quality of care and protect the integrity of the AFMS.

9.3.3. To protect the rights of the provider(s) pending adverse actions.

9.3.4. To ensure timely resolution of the issues.

9.3.5. To allow timely reporting of individuals to professional regulatory agencies if required.

9.4. Consult with Legal Counsel. Prior to proceeding with any action listed in this section, for either privileged or non-privileged providers, consultation shall occur with the wing SJA and regional MLC. This will ensure compliance with due process requirements. This includes invoking an abeyance, conducting investigations/inquiries, removing a provider from patient care, and all notification letters.

9.5. Coordination with MTF Executive Leadership. Coordination of the action shall occur amongst the appropriate MTF executive leadership. For example, if an action against a privileged advanced practice nurse is contemplated, the clinical supervisor, SQ/CC, SGN, Credentials Function Chairperson (SGH), and MTF/CC will be key personnel involved in the action.

9.6. Early Notifications:

9.6.1. Notify AFMOA/SGHQ at the onset of the inquiry or adverse action process for guidance on procedures and plan of action. AFMOA/SGHQ key personnel include the SGHs, Chief, Risk Management Operations, and Chief, Professional Staff Management.

9.6.2. Federal Civil Service Employees: Consult with the employee relations specialist (Civilian Personnel Office) when an adverse action involving a civil service employee is contemplated. This consultation must be done to ensure that civilian employee guidelines are met.

9.6.3. Contract Employees: If an inquiry or adverse action invoking a contract employee is contemplated, consult with the contracting officer and Quality Assurance Personnel (QAP) as the action is initiated, IAW the provisions of the contract.

9.6.4. Host Nation Providers: If an inquiry or adverse action against a host nation contract employee is contemplated, consult with the contracting officer as the action is initiated, IAW the provisions of the contract. National Practitioner Data Bank (NPDB) reporting is not applicable; however, a report shall be placed in the Defense Practitioner Data Bank (DPDB). All due process procedures herein apply.

9.7. Roles and Responsibilities:

9.7.1. Credentials Function Chairperson:

- 9.7.1.1. Provides oversight of adverse actions. Initiates quality assurance (QA) investigation of incidents that may lead to adverse privileging action.
- 9.7.1.2. Invokes abeyance or summary suspension action on privileged providers. After consultation with the senior corps representative recommends removal of the non-privileged provider to the MTF/CC.
- 9.7.1.3. Appoints members to conduct credentials function reviews, and/or peer review panels.
- 9.7.1.4. Provides guidance on due process, substantive matters to the MTF/CC and consults with AFMOA/SGHQ, as needed.
- 9.7.1.5. Communicates abeyance, summary suspension, and/or hearing notifications to privileged provider.
- 9.7.1.6. Ensures involved privileged providers are informed of their due process rights, to include all as specified in this AFI.
- 9.7.1.7. Coordinates with Senior Corps Representative for actions involving respective corps providers.

9.7.2. Senior Corps Representative:

- 9.7.2.1. Provides oversight of adverse actions taken on non-privileged providers. With MTF/CC approval may remove the non-privileged provider from clinical duties and initiate a QA investigation of incidents that may lead to an adverse practice action.
- 9.7.2.2. Appoints at a minimum, a peer to the Credentials Function Review; the peer will provide clinical expertise as the QA investigation results are reviewed.
- 9.7.2.3. Appoints members to conduct a Peer Review Panel and to serve on a hearing panel.
- 9.7.2.4. Provides guidance on due process and substantive matters to the MTF/CC.
- 9.7.2.5. Communicates initial removal from patient care and all written notifications completed for the due process.
- 9.7.2.6. Ensures involved non-privileged providers are informed of their due process rights as specified in this chapter.

9.7.3. MTF/CC:

- 9.7.3.1. As the privileging authority for the MTF, initiates and directs due process procedures for all adverse actions.
- 9.7.3.2. Initiates or directs a designee to initiate a QA investigation when there is a need to investigate any allegations of clinical incompetence, misconduct, or impairment.
- 9.7.3.3. Proposes adverse actions on privileged and non-privileged providers.
- 9.7.3.4. Takes action on provider's privileges/non-privileged provider's clinical practice in accordance with this AFI.

9.7.3.5. For actions with an appeal submitted, the MTF/CC will review the appeal. The MTF/CC may make comments under separate cover and forward with the case file to AFMOA/SGHQ.

9.7.4. RM or designee:

9.7.4.1. Primary POC for adverse actions policy and procedures within the MTF. Supports MTF/CC, Credentials Function Chairperson and Senior Corps Representative in assuring compliance with due process requirements.

9.7.4.2. Ensures due process and notification procedures are appropriately completed in compliance with this AFI. Coordinates documentation requirements with the CM.

9.7.4.3. Forwards two copies (paper or electronic) of the entire case file to AFMOA/SGHQ after MTF/CC action is complete. AFMOA/SGHQ will review the case file and ensure completeness. AFMOA/SGHQ will then forward the case file to Risk Management Operations for final due process procedures.

9.7.4.4. Establishes/maintains adverse action system of files with all required documents. The risk manager shall coordinate and secure the system of files with the CM. All adverse clinical and administrative action files will be maintained at the MTF for a minimum of ten years after the provider separates or retires. The files are then forwarded to AFMOA/SGHQ, Risk Management Operations for archiving. The RM will ensure the CM maintains all documents pertinent to the adverse action in the PCF (including the provider electronic PCF) and appropriate risk management file for non-privileged providers. When/if a provider PCSs, the file is forwarded to the gaining MTF. Adverse action files should be filed with a case number (example: MTF name/11-001).

9.7.5. Credentials Manager: Works collaboratively with the RM to coordinate required documentation and establish adverse action files.

9.7.6. AFMOA/CC:

9.7.6.1. After consultation with AFMOA/SGHQ approves extension of summary suspension actions lasting longer than 6 months. The extension increments shall not exceed six months.

9.7.7. Medical Legal Consultants, Judge Advocates and Civilian Air Force Attorneys:

9.7.7.1. Advises the MTF/CC, Credentials Function Chairperson, Senior Corps Representative and staff regarding legal aspects of adverse actions.

9.7.7.2. Ensures legal requirements are met for the due process procedures.

9.7.7.3. Participates in hearing procedures as MTF representative and legal advisor.

9.7.8. AFMOA/SGHQ:

9.7.8.1. SGH consultants, Chief, Risk Management Operations and Chief, Professional Staff Management provide consultative support for MTFs and MAJCOM/SGs.

9.7.8.2. Coordinates resources required by the MTFs to pursue adverse actions.

9.7.8.3. Provides case summary for MAJCOM/SG.

9.7.8.4. Forwards case file to AFMOA/SGHQ, Risk Management Operations for final disposition.

9.7.9. AFMOA/SGHQ, Risk Management Operations:

9.7.9.1. Coordinates and prepares adverse action case for final AF/SG review.

9.7.9.2. Coordinates review process for appeals of adverse privilege/practice actions through the MPRB, to include expert peer review of the clinical substance of the case and legal review for due process procedures.

9.7.9.3. Reports final actions to the DPDB, NPDB, states of known licensure, and/or other regulatory agencies within 30 calendar days of the HQ USAF/SG's decision to report.

9.7.9.4. Releases information regarding adverse actions to official regulatory agencies and/or credentialing agencies, when requested.

9.7.9.5. Maintains a database of adverse actions for the AFMS. Completed adverse actions will be placed into the CCQAS adverse action module within 30 days of AF/SG final decision. Provides lessons learned from adverse actions to MTFs in closure documents and via annual education forums.

9.7.9.6. Submits reports to DoD Risk Management Committee IAW DoD 6025.13-R.

9.7.10. Chief, Clinical Quality Management Division:

9.7.10.1. Serves as the Chairperson, MPRB and oversees all adverse action cases reviewed by the MPRB.

9.7.10.2. Communicates AF/SG decision to involved provider, the MTF/CC and HQ MAJCOM/SG.

9.8. Providers Ending Affiliation with the Air Force Medical Service after Initiation of an Abeyance or an Adverse Action.

9.8.1. The MTF/CC must inform individuals who separate or end affiliation with the AFMS while under an abeyance or an adverse action review in writing of the implications of their actions and their right to request the due process procedures to be continued. **Note:** If the provider has already been notified, in writing, of the implications of leaving, then it is not necessary to repeat this notification.

9.8.2. The provider may ask that due process procedures be continued after the change in his or her employment status with the AFMS or MTF. If the provider chooses to have the due process continued, he or she must send a written request to the MTF/CC within 10 calendar days following his or her knowledge of the change in affiliation status. A report is not made to regulatory agencies until due process procedures are complete, and the final action is a reportable action.

9.8.3. If the provider chooses not to continue the adverse action due process, the MTF/CC's decision becomes the final action and is forwarded to AFMOA/SGHQ for review and reporting as indicated.

9.9. Adverse Actions for Providers No Longer Affiliated with MTF. Adverse actions may be considered for up to 12 months following cessation of a provider's affiliation with an MTF for

issues that arose during the time the provider had practiced at that MTF. The MTF will notify the provider of the allegations under review and will give the provider the opportunity to provide information on his or her behalf. All due process procedures within this instruction apply. If the MTF has closed, AFMOA/SGHQ assumes responsibility for the action.

9.10. Air Reserve Components (ARC). When a ARC provider (privileged or non-privileged) practicing in an AFMS unit or facility displays evidence of incompetence, professional misconduct, or impairment that affects the safety of patients or the integrity of the AFMS, the due process procedures in the instruction apply. The appropriate active duty Senior Corps Representative/Credential Function Chairperson will coordinate with the appropriate reserve counterpart throughout the adverse action process.

9.11. Theater of Operations. If an adverse action is being considered on a privileged or non-privileged provider in the theater of operations, the deployed MTF/CC will consider all available information found during a QA investigation and make the decision on whether to return the provider to the MTF from which the provider was deployed (permanent station) for definitive action. Due to resource constraints in the theater of operations, adverse action due process is conducted by the permanent station MTF. The deployed MTF/CC will forward all evidence and recommendations to the permanent station MTF/CC. The permanent station MTF/CC will review the information to consider an appropriate action. The provider will be automatically placed in abeyance while non-privileged providers will be removed from practice upon return to duty at the permanent station MTF, during which time an inquiry will be conducted. When a deployed ARC member is returned to the ARC unit from the theater of operations, the ARC Unit Commander/Senior Corps Representative/Credentials Function Chairperson will coordinate with the respective HQ AFRC/SGP/HQ NGB/SG to conduct a QA investigation and initiate a clinical adverse action process as prescribed in this instruction.

9.12. Actions Involving the Medical Group Commander. When information arises on a privileged MTF/CC's conduct or condition, which affects his or her ability to practice safe healthcare, the Credentials Function Chairperson will notify AFMOA/SGHQ. AFMOA/CC will initiate the adverse action following coordination with the HQ MAJCOM/SG and be responsible for the due process procedures. The HQ MAJCOM/SG will notify the commanding line officer. All non-clinical issues involving the MTF/CC will be managed by the commanding line officer.

9.13. All providers practicing within an AFMS MTF will be subject to the adverse action process prescribed within this instruction. Air Force providers privileged or granted the right to practice by other entities (e.g., other DoD services, Department of Veterans Affairs, and civilian entities [External Resource Sharing Agreements], Training Affiliation Agreements) are subject to the adverse action bylaws of that entity.

9.13.1. When an adverse privileging action is being considered on a contract employee (to include host nation contract employees) consult with the assigned Quality Assurance personnel assigned to the contract and medical logistics/base contracting office when the action is initiated IAW the provisions of the contract.

9.14. Use of Timelines. All timelines will be specified in calendar days. If the final day for any specified timeline falls on a weekend or Federal holiday, the timeline will be extended to the next business/duty day for the MTF. Timelines are designed to allow a provider adequate time to prepare for a hearing and to facilitate timely resolution of the adverse action. The MTF/CC may

grant timeline extensions on the provider's behalf for good cause. The AFMOA/CC may grant summary suspension extension after review by AFMOA/SGHQ.

Section 9B—Clinical Adverse Actions for a Privileged Provider

9.15. General. When a privileged provider's conduct, condition, or performance requires immediate action to protect the safety of patient(s)/staff or the integrity (threat to discredit or bring unfavorable scrutiny) of the AFMS, the Credentials Function Chairperson shall remove the provider from patient care duties (abeyance/summary suspension) in accordance with the provisions below while a QA investigation is conducted. The QA investigation allows gathering of factual information regarding the extent of the issues affecting the provider's ability to safely practice healthcare. If a QA investigation is not needed because the evidence (substantive matter) is obvious, the Credentials Function Chairperson will forward the information to the credentials function for review and due process procedures will continue accordingly. Prior to the issuance of any notification under this section, coordination with the appropriate legal office will be accomplished.

9.15.1. While under abeyance or summary suspension of all clinical privileges, the provider will not be reassigned to other *clinical* duties (another clinic seeing patients, etc.), a different MTF, or PCS'd to another MTF. In cases of abeyance or summary suspension of a portion of the provider's privileges, the provider may continue those privileges not affected by the abeyance or summary suspension.

9.15.2. Withdrawal of Permission to Engage in Off-Duty Employment. The MTF/CC or designee will withdraw any permission for the provider to engage in clinically-related off-duty employment from initiation of abeyance or summary suspension until all due process procedures are completed.

9.15.2.1. The MTF/CC will notify other MTFs or civilian medical treatment facilities where the provider is practicing, as identified in the provider's off-duty employment request, when the abeyance or adverse action is initiated.

9.15.2.2. The MTF/CC must withdraw permission for off-duty employment, if a provider is being investigated for any item listed in Attachment 9.

9.15.2.3. New applications for off-duty employment, during any adverse action review, will not be approved until the privileges of the individual have been restored.

9.15.3. As part of the notification process, the MTF/CC notifies the contracting officer for contract providers or the Civilian Personnel Office for a federal civilian employee.

9.15.4. Contract (including host nation contract employees). If an adverse practice action is being considered on a contract employee, consult with the assigned Quality Assurance personnel assigned to the contract and medical logistics/base contracting office when the action is initiated IAW the provisions of the contract. (See paragraph 6.21. for details on managing contract providers).

Privileged Provider—Inquiry/Quality Assurance (QA) Investigation Step, Invoking an Abeyance and/or Summary Suspension

9.16. Invoking an Abeyance. An abeyance is not an adverse privilege action; however, the provider is formally "on notice" that an investigation into his or her practice has begun that may

result in a clinical adverse action or other administrative action. If the provider's privileges are due to expire during the abeyance, the affected privileges do not lapse. Therefore, no renewal action will be taken on the affected privileges. The *affected* privileges are considered "static" during the abeyance. Unaffected privileges may be renewed if appropriate. Abeyance is used when available information may be insufficient to summarily suspend privileges or the potential risk to patient safety is not well understood, yet prudence dictates that the provider not render patient care until the quality investigation and its review is complete. It is normally imposed by the Credentials Function Chairperson, under the direction of the MTF/CC. It is valid for 30 calendar days. If the QA investigation is not complete and the MTF/CC has not made a disposition on the provider's privileges within the 30-day period of abeyance, the abeyance automatically becomes a summary suspension.

9.16.1. Provider Notification. The provider is notified, in writing, by the Credentials Function Chairperson, that his or her privileges have been placed in abeyance (including the basis and duration for the action), and that a QA investigation is being conducted (see Attachment 10). If only a portion of the provider's clinical privileges are being placed in abeyance, the notification letter must state what privileges are affected. The notification to the provider must state that the findings of the QA investigation will be reviewed by the Credentials Function. In addition, the notification must state if the abeyance is not resolved within 30 calendar days, or if the provider ends his or her relationship with the MTF and has not requested a continuation of the due process, the abeyance will become a summary suspension. **Note:** During the period of abeyance the provider shall not practice under the privileges affected, even under supervision.

9.17. QA Investigation Procedures. The QA investigation is initiated by the MTF/CC or designee, when needed to investigate any allegations of clinical incompetence, misconduct, or impairment. An investigating officer is appointed in writing (may be appointed by MTF/CC, SGH, or other appropriate MTF executive leader) and should be a peer (similar clinical privileges/specialty, education, and training) of the provider under investigation. The SGH cannot serve as the investigating officer. The MTF may consult with AFMOA/SGHQ to seek assistance with the investigating officer appointment. For example, an investigating officer may be an independent reviewer from another MTF. The purpose and scope of the QA investigation will be explicit in the written appointment. After completing the QA investigation the investigating officer will submit a written report to the Credentials Function for review. The report will organize the factual findings of the QA investigation, and include the investigating officer's conclusions and recommendations. The QA investigation report and other relevant information collected will form the basis of the credential's function review.

9.18. Command Directed Evaluations. For military members a Command-directed evaluation (CDE) may be necessary to evaluate a mental condition that could be affecting the provider's ability to practice safely. If the provider's mental health status is in question then it shall be evaluated via a CDE, as appropriate. The commander directed mental health evaluation will be conducted IAW AFI 44-109, *Mental Health, Confidentiality, and Military Law*. It may be necessary to have the evaluation completed at a different MTF to remove any appearance of bias.

9.19. Disclosure of Abeyance. An abeyance is not a reportable action, nor is it an adverse action the provider must self-report or disclose as an adverse action.

9.20. Invoking a Summary Suspension. Summary suspension is a temporary clinical adverse action used to protect patient/staff safety or the integrity of the AFMS while an investigation is ongoing. If a provider under abeyance is not reinstated within 30 calendar days, the abeyance automatically becomes a summary suspension. In cases where the provider's misconduct, clinical incompetence, or impairment is obvious and poses a significant threat to patient safety or well being, summary suspension shall be the initial action. Summary suspensions may be imposed by the MTF/CC or delegated to the Credentials Function Chairperson. If the provider's privileges are due to expire during the summary suspension, the affected privileges do not lapse. Therefore, no renewal action will be taken on the affected privileges. **Note:** During the period of summary suspension the provider shall not practice under the privileges affected, even under supervision.

9.20.1. Provider Notification. The provider will be notified, in writing, by the Credentials Function Chairperson, that the provider's clinical privileges have been summarily suspended, and that the basis for the summary suspension be reviewed by the Credentials Function (Attachment 11). If only a portion of the provider's clinical privileges are being summarily suspended, the notification letter must identify those privileges that are suspended. The summary suspension notification letter should state the implications of leaving the service or employment while a clinical adverse action is underway. A summary suspension remains in effect for up to 6 months. A request (for good cause) to extend the summary suspension beyond 6 months must be sent through AFMOA/SGHQ to the AFMOA/CC or designee for approval.

9.20.2. Disclosure of Summary Suspension. A summary suspension is a clinical adverse action and, therefore, it may be necessary for a provider to disclose this action to any agency inquiring about suspensions or adverse clinical actions. This includes applications for future privileges, licensure/certification/registration, or insurance. When disclosure is required, the summary suspension must be disclosed even if the provider's privileges were reinstated. The Credentials Function Chairperson shall advise the provider of this requirement.

9.21. Notification to HQ MAJCOM/SG. The MTF notifies HQ MAJCOM/SG and AFMOA/SGHQ when a provider's privileges are placed in summary suspension. The MTF must initiate a DD Form 2499 to document the action. This form shall be placed in the adverse action file and a copy in the electronic PCF.

9.21.1. Notification of adverse actions of a sensitive or potentially notorious nature: MTF/CC will ensure AFMOA/SGHQ and HQ MAJCOM/SG are notified. AFMOA/CC will be responsible for providing information to HQ USAF/SG leadership, as appropriate.

9.21.2. Notification for Contract (including Host Nation contract) Providers. If the provider is a member of a contract group, the Credentials Function Chairperson shall provide a copy of the notification letter, and any subsequent correspondence, to the contracting officer.

9.21.3. Notification for Federal Civilian Providers. If the provider is a Federal civilian provider, the Credentials Function Chairperson shall provide a copy of the notification letter and any subsequent correspondence, to the Civilian Personnel Office (CPO). CPO shall be kept informed throughout the adverse action process.

Credentials Function Review (CFR)

9.22. General. Professional review activities for privileged providers are performed by the Credentials Function. This review may be conducted by an ad hoc sub-committee ensuring appropriate impartial representatives with appropriate peer composition (at least one peer, which is a provider with similar awarded privileges/clinical specialty, level of training and experience, may be assigned to a different MTF). The role of the credentials function is to examine information obtained from the QA investigation, CDE if accomplished, and/or other sources (e.g., OSI report), and to make recommendations to the MTF/CC regarding the provider's ability to safely execute their clinical privileges. The focus of this professional review must be on the facts/evidence of the clinical deficits/incompetence, misconduct, or impairment that impact the provider's ability to practice safely. The provider under review does not have the right to attend the meeting; however, the provider may be asked to provide a written statement. The provider is free to consult with legal counsel at any step in an adverse action; however, the credentials function is not a legal proceeding.

9.23. Composition of the Credentials Function. The credentials function must be composed of at least three privileged providers. At least one provider shall be a peer (similar awarded privileges/clinical specialty, level of training and experience) of the individual who is the subject of the action. Providers from a different MTF may participate via video teleconferencing, audio, or in person to meet this requirement, and/or to add objectivity to the review. These providers must have the same ability to review all information/evidence as the providers physically present at the Credentials Function meeting.

9.24. Ensuring Impartiality in Credentials Function. The Credentials Function review process is a professional practice review. Personnel participating in the review must be able to impartially review the case. In an adverse action case, the personnel listed below will not participate in the credentials function review:

9.24.1. The individual's direct supervisor.

9.24.2. Subordinates of the provider under review.

9.24.3. The individual who summarily suspended or placed the provider's privileges in abeyance, or who recommended the provider's discharge from active duty.

9.24.4. Investigation officers.

9.24.5. Any person whose testimony plays a significant part in the case.

9.24.6. Any officer/provider who is participating, or has participated, in other administrative proceedings (courts-martial board or administrative review board) regarding the provider under review.

9.24.7. Any member who is reviewing, or has reviewed, the provider's actions under consideration by the Credentials Function.

9.25. Credentials Function Recommendations. The credentials function considers the QA Investigation report and recommends an action to the MTF/CC regarding the provider's clinical privileges. If additional information is required, they may refer the case back to the investigator(s) for further inquiry. The Credentials Function Review process is deliberative in nature and the documents reflecting the deliberation are protected from release (i.e., the deliberations are not disclosed to the provider, only the findings and recommendations and the allegations considered). The Credentials Function Chairperson may make other

recommendations under separate cover, to the MTF/CC. Credentials Function recommendations will be forwarded to the MTF Commander within 10 calendar days of function review completion and may include:

9.25.1. Reinstatement. The return of the provider's regular clinical privileges.

9.25.2. Reinstatement with Monitoring and Evaluation (M&E). M&E is a well-defined, time-limited, well documented plan for Focused Professional Practice Evaluation to confirm that a provider possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. It must include a documented plan (list of concerns/procedures to be evaluated during the period of M&E) with delineation of clear expectations and clear measures of success that shall be coordinated through AFMOA/SGHQ. The progress documentation shall be reviewed bimonthly by the SGH and by an ad hoc credentials function as necessary. **Note:** M&E is not a substitute for retraining. M&E is distinct from supervised practice since there is no restriction or control placed on the provider's clinical practice. It is a period to monitor the provider's practice and give feedback. It is not reportable to the NPDB. Providers shall acknowledge the conditions of the M&E in writing.

9.25.3. Convene a peer review panel.

9.26. MTF/CC Action on Credentials Function Recommendations.

9.26.1. The MTF/CC has 10 calendar days from receipt of the Credentials Function recommendations to determine what action to take; reinstate, reinstate with M&E, or convene a peer review panel. The MTF/CC is not bound by the recommendation(s) of the Credentials Function.

9.26.2. If not previously invoked, the MTF/CC may place the provider in summary suspension while the process continues. The provider is given written notice of the summary suspension. If the MTF/CC is convening a Peer Review Panel, the provider will receive written notification (see Attachment 12) of such and be provided a copy of the documentation (evidence) that will be reviewed by the Peer Review Panel.

9.26.3. The MTF/CC will provide written notification to the provider of his/her decision (reinstate, reinstate with M&E, or convene a peer review panel). The MTF/CC will provide written rationale for any action different from the Credentials Function. If the provider is a contractor, a copies of the notification letter are sent to the AF contracting office responsible for the contract and to the contract employer. For a Federal civilian provider, a copy of the letter is sent to the employee relations specialist (or other point of contact if specified) in the CPO.

9.26.4. The provider must have access to all information considered by the Credentials Function during the review process. Copies of these records are releasable to the provider and his/her legal counsel. They are released under protection of the *Privacy Act of 1974*, *Health Insurance Portability and Accountability Act (Title II) of 1996* and *Title 10 U.S.C. §1102*.

9.27. Peer Review Panel. The Peer Review Panel will be composed of at least three clinical peers of the involved provider (similar clinical specialty, education, and training). If the MTF

does not have three peers available to conduct this review, it may be accomplished using peers from other MTFs; either in person or via video or teleconferencing.

9.27.1. The provider may provide written comments to the Peer Review Panel, but does not have the right to attend this meeting. The peer review panel is not a legal proceeding.

9.27.2. The Peer Review Panel will convene within 14 calendar days after receipt of the MTF/CC's decision, the QA investigation and relevant evidence to make and forward a recommendation to the Credentials Function.

9.27.3. The recommendations may include:

9.27.3.1. Reinstatement. (See paragraph 9.25.1. for definition.)

9.27.3.2. Reinstatement with M&E. (See paragraph 9.25.2. for definition.)

9.27.3.3. Restriction. Restriction is a temporary or permanent limit placed on all or a portion of the provider's clinical privileges, so that the provider is required to obtain concurrence before providing all or some healthcare procedures within the scope of his/her certification, license, or registration. The restriction requires some form of supervision. Restriction of privileges is reportable to the NPDB.

9.27.3.4. Reduction. Reduction is the permanent removal of a portion of a provider's clinical privileges. Reduction of privileges is reportable to the NPDB.

9.27.3.5. Revocation. Revocation is the permanent removal of all of the provider's clinical privileges and the provider is removed from all patient care duties. Revocation is reportable to the NPDB.

9.27.3.6. Denial. Denial of privileges is the refusal to grant any or all of the provider-requested clinical privileges. This may occur at initial application for privileges or when renewal of privileges is requested. Denial of privileges is reportable to the NPDB.

9.28. Credentials Function. The Credentials Function will reconvene within 10 calendar days to review the Peer Review Panel's findings and recommendations, and then forward its final recommendation to the MTF/CC. The available recommendations are the same as set forth in paragraph 9.27 above.

9.28.1. The MTF/CC will give written notification (within 10 days of receipt of Credentials Function final recommendation) to the provider of the MTF/CC's proposed action and the basis (allegations) for the action. If the proposed action is to restrict, reduce, revoke, or deny the provider's privileges; then the MTF/CC must advise the provider of his/her right to a hearing and appeal rights in writing. The provider must have access to all information considered by the Credentials Function and the MTF/CC, which resulted in the basis of the proposed action.

9.29. Hearing Process. Any provider whose clinical privileges the MTF/CC intends to deny, reduce, restrict, or revoke is entitled to a hearing. The provider has 30 calendar days after receipt of the clinical adverse action notification letter to request a hearing. The commander may extend this time period if appropriate. The provider may participate in person, through a representative, and/or by other means (e.g., written deposition or teleconferencing) at their expense.

9.29.1. If no hearing request is received in 30 calendar days (or allotted time), or the individual gives written notice waiving his or her right to a hearing, then hearing rights are

waived. When the hearing is waived the appeal rights are also waived. If hearing rights are waived, then the MTF/CC acts on the provider's privileges as proposed and communicates this action, to the provider in writing. This is the MTF/CC final action. The MTF/CC will forward two copies of the case to AFMOA/SGHQ. AFMOA/SGHQ will review, ensure completeness, and prepare a case summary for the HQ MAJCOM/SG and AFMOA/CC. The case file is then sent to Chief, Risk Management Operations for coordination to the AF/SG, who directs reporting to appropriate agencies as required. Adverse actions without an appeal are not reviewed or deliberated by the MPRB.

9.29.2. If the provider requested a hearing but fails to appear for the scheduled hearing, the MTF/CC may choose to proceed with the hearing or consider the hearing waived and act on the provider's privileges as intended in the written notice of the proposed action. The appeal rights are also considered waived.

9.29.2.1. The MTF/CC will then notify the provider, and forward two copies of the case to AFMOA/SGHQ, who will prepare and send a case summary to the HQ MAJCOM/SG and AFMOA/CC. The case is then sent to Risk Management Operations who will coordinate to the AF/SG and report to appropriate agencies as directed. **Note:** For providers working in other services' MTFs the adverse action process follows the Service chain of command of the involved MTF. The provider's service SG office will be provided information throughout the process. Before the MTF's service SG makes the final decision, the case file will be forwarded to AFMOA/SGHQ. AFMOA/SGHQ will prepare a summary of the case for the HQ MAJCOM/SG (if the provider is also working in AF MTF) and AFMOA/CC. AFMOA/SGHQ will coordinate input to be provided to the MTF's service SG who will make the final decision and direct reporting to the NPDB and other regulatory agencies.

9.30. Provider Notification of Hearing. If the provider requests a hearing, the MTF/CC or chairperson of the credentials function gives the provider written notice of the hearing within 10 calendar days from the date of the provider's request. (see Attachment 14). This written notice must include:

9.30.1. The date, time, and location of the hearing, which must be no sooner than 30 calendar days from the date of the notification, but scheduled within 60 calendar days. (This gives the provider an opportunity to prepare for the hearing.)

9.30.2. The right to have a military counsel (Area Defense Counsel) appointed to assist the provider (if the provider is military). In addition the provider may hire a representative or be represented by another person of the provider's choice at their own expense.

9.30.3. The provider's right to present evidence and to call witnesses. The provider must arrange for the presence of his or her witnesses at his or her own expense.

9.30.4. The names of MTF's witnesses to be called to testify at the hearing. The right to cross-examine these witnesses. The provider shall disclose the names and contact information for all witnesses testifying on his or her behalf within 15 calendar days of the date the provider was notified of the hearing date.

9.30.5. The provider may request a delay of the hearing for good cause. Absent compelling circumstances (i.e., severe illness) delays will not be granted if the request is received by the SGH less than 5 calendar days prior to a scheduled hearing. The credentials function

chairperson evaluates the request and determines whether or not to grant a delay. The chairperson will promptly notify the provider, in writing, of his or her decision and the new date/time of the hearing, if changed.

9.30.6. Hearing is closed and confidential.

9.31. Hearing Panel Composition. When a hearing is requested, the Credentials Function Chairperson will appoint a hearing panel in writing. The provider will be notified of the hearing panel composition prior to the start of the hearing. The senior ranking member of the panel will act as chairperson unless otherwise designated in the appointment letter. To facilitate an impartial review, members who participated in the Credentials Function review or Peer Review Panel will not be appointed to the hearing panel. In smaller facilities with limited staff, hearing panel members may be requested from other MTFs. The panel will include a minimum of three privileged providers. At least one member shall be a professional peer (with similar awarded privileges, clinical specialty, and level of training and experience) as the provider under review.

9.31.1. If the MTF/CC is the provider being evaluated, or is disqualified from acting in the case, the AFMOA/CC will coordinate with the HQ MAJCOM/SG before designating a senior physician to act as the privileging authority for the case. The personnel listed below shall not serve on the hearing committee:

9.31.1.1. The individual's direct supervisor.

9.31.1.2. Subordinates of the provider under review.

9.31.1.3. The individual who placed the provider in abeyance or summarily suspended the provider's privileges or who recommended the provider's discharge from active duty.

9.31.1.4. Investigation officers or officers in the Peer Review Panel.

9.31.1.5. Any person whose testimony plays a significant part in the case.

9.31.1.6. Any officer/member who is participating, or has participated, in other administrative proceedings (courts-martial board or administrative review board) regarding the provider under review.

9.31.1.7. Any member who is reviewing, or has reviewed, the provider's actions under consideration by the credentials function.

9.31.1.8. The Credentials Function Chairperson.

9.32. Legal Advisor. The legal advisor will either be an MLC, judge advocate, or civilian attorney employed by the AF. The base SJA will appoint the legal advisor, and an attorney to present evidence on behalf of the MTF.

9.33. Obtaining Court Reporting Services. The MTF is responsible for obtaining court reporting services for the hearing. Court reporters may be used from the SJA office, if available, to document the hearing process and results. Obtaining court reporting services through other means is at the cost of the MTF and not the legal office. Regardless of the source of the court reporter, the MTF must ensure that the transcript (paper or electronic) is available within 30 calendar days. If a non-DoD court reporter is retained, a business associate agreement is required IAW DoD 6025.18-R, *Implementation of the Health Insurance Portability and Accountability Act (Title II) of 1996*.

9.34. Hearing Overview.

9.34.1. Roles and Responsibilities.

9.34.1.1. Chairperson. The chairperson of the hearing panel shall preside over the proceeding, and must consult with the appointed legal advisor to assure compliance with this section before conducting the hearing. The chairperson will rule on challenges against the legal advisor. The chairperson, with the help of the legal advisor, will arrange for the orderly presentation of evidence. The chairperson, in consultation with the legal advisor, will rule on the relevance and admissibility of substantive clinical matters.

9.34.1.2. Legal Advisor. Will ensure due process and the provider is given adequate notice and an opportunity to be heard. Once appointed, the legal advisor may rule on any procedural issues that are raised prior to or during the hearing. The legal advisor shall administer oaths to the hearing panel and witnesses, and will rule on challenges for cause, except those against the legal advisor.

9.34.2. Hearing Proceedings. These proceedings are not bound by formal rules of evidence or a strict procedural format. The chairperson and legal advisor to the hearing panel may use the hearing script on the Knowledge Exchange in the adverse action tool kit. The hearing panel may question witnesses and examine documents. The results of concurrent or previous administrative or legal proceedings shall not be presented at the hearing unless they are relevant to the provider's clinical practice and were part of the allegations being examined by the hearing panel. Any witness with knowledge relevant to the specific allegations under consideration at the hearing, including but not limited to, the investigating officer and the provider's supervisors, may testify before the hearing panel. At the close of the presentation of all of the evidence and closing statements the hearing panel will deliberate and make findings as to each allegation outlined in the notification letter and make a recommendation to the MTF/CC. The panel's deliberations are not on the record. The recommendation(s) must be one or more of the following (as defined in paragraph 9.27.3.) Reinstatement; Reinstatement with M&E; Restriction; Reduction; Revocation; or Denial. The recommendation(s) can include comments, rationale, and conclusions to explain the recommendation.

9.34.3. Presentation of New Information at Hearing. Additional information relevant to the allegations contained in the notification letter and not used in the original Credentials Function Review may be presented at the hearing. However, the provider must be informed of the additional information as soon as possible, and must be afforded reasonable time to review the information. The provider shall have access to copies of records upon which the additional information is based, so that he or she may prepare to refute it. Once the provider has reviewed the information, it must be clear on the record that the provider had adequate time to review and prepare response. Unfair surprise of new information at the hearing shall not be allowed. **Note:** New information that rises to the level of a new allegation, as determined by the legal advisor, requires adherence to the notification provisions.

9.34.4. Hearing Panel Findings and Recommendation. The hearing panel findings must be supported by a preponderance of the evidence. The term "preponderance of the evidence" simply means the greater weight of credible evidence or that the factual allegation by the Medical Group is more likely than not true. There is no requirement to prove any allegation beyond a reasonable doubt. Use best judgment, experience, and common sense in resolving

disputed and conflicting evidence. Consider the probability or improbability of each piece of evidence, and select only that evidence which is most worthy of belief. The hearing panel recommendation must be supported by the findings. The recommended action must be made by majority vote and in good faith, is required to be based upon prevailing professional standards and on the findings and conclusions from the evidence. Allegations shall be substantiated through identified incidents or situations. Reference any pertinent section of the hearing record/exhibits as needed to support the findings. A findings and recommendations worksheet shall be provided to the hearing panel prior to the deliberations (see Kx Adverse Action Toolkit). The findings and recommendations worksheet shall be signed by all hearing panel members. Any hearing committee member may accomplish a minority report. The minority report shall state who made the minority opinion (i.e., peer of the subject), be entered into the record, and be included in the hearing transcript.

9.34.5. Timeliness of Findings and Recommendations. The hearing committee will provide a report of their findings on each allegation and their recommendation for action to the MTF/CC. This report will be given to the provider within 30 days of the hearing completion.

9.34.6. Hearing Transcription. A verbatim record of the proceedings is required. In order to facilitate transcription, documentation must be made available to the recorder in an orderly fashion, with exhibit items listed and numbered as they are presented throughout the hearing. The transcript and all exhibits, once accomplished, shall include the following language at the bottom of each and every page, "This is a quality assurance document protected from release by Federal Law, Title 10 U.S.C., §1102." One original and three copies of the transcript must be prepared (may provide the hearing transcript and exhibits in electronic medium). A copy of the exhibits shall accompany each transcript. The transcript must include the hearing panel findings and recommendations to the MTF/CC. **Note:** The original transcript and one copy is forwarded to AFMOA/SGHQ. One copy is given to the provider and the last copy remains with the MTF.

9.34.7. Forward Recommendations. The hearing transcript shall be completed and all copies provided to the Credentials Function Chairperson within 30 calendar days of the hearing. If this cannot be accomplished within 30 calendar days the Credentials Function Chairperson shall notify, in writing, the provider and legal counsel of the delay.

9.34.7.1. The Credentials Function Chairperson gives a copy of all hearing panel findings and recommendations, additional recommendations, and the hearing transcript to the provider. The provider shall be informed these documents are protected IAW Title 10 U.S.C., §1102 and can only be released with proper authority.

9.35. Provider Statement of Exceptions and Corrections. After the provider has received the hearing transcript, including all exhibits, the findings and recommendations worksheet and any additional recommendations, he or she has 10 calendar days to prepare and submit a written statement of exceptions and corrections they want to present to the MTF/CC. The provider's statement should be forwarded to the MTF/CC through the Credentials Function Chairperson. If the provider requests additional time to prepare the statement of exceptions and corrections, the request must be made in writing to the Credentials Function Chairperson before the time limit has expired. Extensions may be granted (in writing) for good cause.

9.36. Commander's Decision and Provider Notification. The MTF/CC makes a decision within 10 calendar days of receiving all documentation (the hearing panel's findings/

recommendations, hearing transcript, credential function comments, and the provider's statement of exceptions and corrections). The MTF/CC may consult with legal counsel, AFMOA/SGHQ, and MAJCOM/SG during this process. The MTF/CC is not bound by the findings and recommendations of the hearing panel. The time may be extended if mission requirements dictate, but the provider must be notified immediately in writing of this extension.

9.36.1. The MTF/CC must provide written notification to the provider of the decision (reference Attachment 16). This written notification must include the action and the reasons for the action. If the MTF/CC's action is different from the hearing panel's recommendation, an explanation of the rationale for the different action must be given to the provider. If the action includes denying, reducing, restricting, or revoking privileges, the provider must also be notified of the right to submit a written appeal to the decision to AF/SG through the MTF/CC to AFMOA/SGHQ. In addition, the provider must be notified that the action may be reportable to regulatory agencies IAW DoD directives. The commander's decision is effective immediately and will require the provider to submit a modification in CCQAS of their clinical privileges to reflect the MTF/CC decision.

Provider's Appeal Following a Hearing

9.37. Provider's Appeal. The provider may make a written appeal of the MTF/CC's decision to the AF/SG. The provider must submit the appeal to the MTF/CC where the action occurred, within 10 calendar days of receiving notice of the MTF/CC's final decision. The time limit may be extended by the MTF/CC for good cause. The MTF/CC notifies AFMOA/SGHQ of any extensions granted and provides a new date when the provider's appeal can be expected. The commander will review and may consider the provider's written appeal. If the MTF Commander does not grant the appeal, it will be forwarded to the AF/SG following review by the MPRB.

9.37.1. The MTF/CC may respond and offer rebuttal evidence to any issues raised by the provider on appeal. The MTF/CC's decision remains in effect during the appeal process.
Note: The provider's right to appeal is to the Surgeon General of the MTF Service.

9.37.2. Forward Documentation to AFMOA/SGHQ. The MTF will send two copies of all documentation related to the action directly to AFMOA/SGHQ, arranged according to the template, Arrangement of Adverse Action Case File on the Knowledge Exchange in the Risk Management section. A final DD Form 2499, documented the commander's decision, will be completed and placed at Tab 3 within the case file. The MTF will wait until receipt of the provider's appeal, or validate that the provider will not appeal, before sending the case file to the AFMOA/SGHQ. The provider's appeal will be placed at Tab 2 or under separate cover, as needed. AFMOA/SGHQ will notify the respective MAJCOM/SG that an adverse action has been received and will forward the complete file to AFMOA/SGHQ, Chief, Risk Management Operations within 10 calendar days of receipt from the MTF. The MTF will use the DD Form 2499, and if necessary a separate cover letter, to forward information on the current status of the provider and to identify any associated administrative actions taken. This information will be placed at Tab 3 in the case file. The requested information will include:

9.37.2.1. Specialty Pay status.

9.37.2.2. Promotions halted.

9.37.2.3. Pending administrative discharge/separation procedures or retirement.

9.37.2.4. CDE and/or Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) pending.

9.37.2.5. Referral OPRs.

9.37.2.6. Provider resigned commission.

9.37.2.7. Related UCMJ action and/or OSI investigation results.

9.37.2.8. Removal of AFSC.

9.37.2.9. Contract Status (if applicable).

9.38. Appeals Review Process. Appellate review is based on sufficiency of due process and reasonableness of the findings and the MTF/CC's action. Provider appeals made to the AF/SG will be reviewed by an AF attorney, who will provide comments on the legal due process and administrative aspects of the case.

9.38.1. AFMOA/SGHQ will have a peer review the clinical evidence/substance of the action and the appeal.

9.38.2. If the provider is a member of a different Service, inclusion of a privileged provider from the member's Service on the MPRB should be considered. Prior to final review and action, input (review and comments) will be requested from the Surgeon General's office of the provider's Service. The Service of the provider must respond with their input within 30 days. To accomplish this, a copy of the file will be sent to the appropriate Surgeon General's office.

9.38.3. The case is then presented to the MPRB. The MPRB reviews the clinical evidence, legal due process of the case, provider's appeal, and other Service input (if submitted) and makes a final action recommendation to AF/SG.

AF/SG Review

9.39. AF/SG Review and Final Action. Chief, Risk Management Operations will prepare the case for AF/SG review and final action. The AF/SG will make the final decision in the case. The AF/SG may make an alternate decision and will provide written rationale for the alternate decision. The AF/SG will direct NPDB reporting IAW DoD directives. AFMOA/SGHQ, (Chief, Risk Management Operations) will submit the required agency reports (NPDB, FSMB, States of known licensure, and other professional/regulatory organizations IAW DoD directives).

9.40. AFMOA/SGHQ Notifications. AFMOA/SGHQ, Chief, Risk Management Operations, will prepare the final documents for the Chief, Clinical Quality Management Division (AFMOA/SGHQ) to notify the provider, his/her legal counsel if represented, MTF/CC, HQ MAJCOM/SG and AFMOA/CC. If a report is made to the NPDB, the provider will be notified by the NPDB and provided a copy of the report.

9.40.1. The provider will be given written notice of the AF/SG's final decision. When the provider is a member of a different service from the one who took the adverse action, the provider's service Surgeon General's office will be notified of the final decision.

Section 9C—Adverse Action Documentation and Record Keeping

9.41. Abeyances and Summary Suspensions Documentation.

9.41.1. Abeyance Leading to Reinstatement. Notification of abeyance and reinstatement of privileges will be kept in the PAF since it is not an adverse action. A summary to include reason for abeyance, findings and conclusions, and date of reinstatement will be annotated and maintained in the PAF.

9.41.2. Summary Suspension Leading to Reinstatement. Notification of summary suspension and reinstatement of privileges will be kept in the PCF. A summary to include reason for suspension, findings and conclusions, and date of reinstatement will be annotated on the AF Form 22 and maintained in the electronic PCF.

9.41.3. Abeyance and Summary Suspension Action Leading to Adverse Action. Action that results in restriction, reduction, revocation, or denial of privileges must be placed in the PCF along with the final documentation of the reported clinical adverse action. Clinical adverse action documentation is maintained by the last MTF where the provider was assigned for a minimum of 10 years from the date the provider ends their affiliation with the AFMS and then forwarded to AFMOA/SGHQ for archiving. Adverse action documentation is not destroyed.

9.42. Monitoring and Evaluation (M&E) Documentation.

9.42.1. M&E Leading to Reinstatement. If no adverse action is recommended, the M&E documents are filed in the PAF. The M&E plan with clear timelines, goals, and objectives must be documented. Regular written and verbal feedback must be given to the provider during the period of M&E.

9.42.2. M&E Leading to Adverse Action. If the M&E documents become evidence in an adverse action proceeding, these documents become part of the adverse action case file and are filed in the PCF. The AF Form 22 may be used to summarize the provider's performance during the M&E period.

Section 9D—Non-Privileged Providers Adverse Practice Actions

9.43. General. When a non-privileged healthcare provider's conduct, condition, or performance requires immediate action to protect the safety of patient(s)/staff or the integrity (threat to discredit or bring unfavorable scrutiny) of the AFMS, the Senior Corps Representative, in consultation with the squadron and flight commander and the individual's supervisor, shall remove the individual from all or a portion of their patient care duties. This action protects patient(s)/staff safety while a QA investigation into the non-privileged provider's practice, conduct, or possible impairment is conducted. The Senior Corps Representative will consult with the MLC and AFMOA/SGHQ when a QA investigation or adverse practice action is being considered. The Senior Corps Representative will advise the MTF/CC throughout the adverse practice action process. Non-privileged providers who are required to be licensed, certified, or registered by a U.S. jurisdiction are subject to this process. Reports of adverse actions for these providers will be to state licensing agencies and/or other agencies as appropriate to the specialty of the provider. These actions are known as adverse practice actions.

9.43.1. Notification. A healthcare provider may be removed from patient care duties while a professional QA investigation is conducted or the MTF/CC is reviewing the matter to make a decision whether or not to proceed with an adverse practice action. The non-privileged provider is given written notification (see Attachment 18) by the Senior Corps

Representative, that the provider has been removed from clinical practice and the reason for the removal (purpose of the QA investigation).

9.43.1.1. If the provider is removed from only a portion of their patient care duties, the letter must state what duties are affected. The notification to the provider must state that the findings of the QA investigation will be reviewed by the Credentials Function and may be referred to a Peer Review Function.

9.43.1.2. As part of the notification process, the MTF/CC notifies the contracting officer for contract providers or the CPO for a federal civilian employee.

9.43.1.3. Contract (including host nation contract employees). If an adverse practice action is being considered on a contract employee, consult with the assigned Quality Assurance personnel assigned to the contract and medical logistics/base contracting office when the action is initiated IAW the provisions of the contract.

9.43.2. Withdrawal of Permission to Engage in Off-Duty Employment. When a non-privileged provider is removed from patient care or an adverse action is initiated the guidance in paragraph 9.15.2. is also applicable.

QA Investigation Procedures for the Non-Privileged Provider

9.44. QA Investigation. The QA investigation is initiated by the MTF/CC or designee when needed to investigate any allegations of clinical incompetence, professional misconduct, or impairment. An investigating officer is appointed in writing (may be appointed by MTF/CC, Senior Corps Representative, or other appropriate MTF executive leader) and should be a peer (similar clinical specialty, level of education, and training) of the provider under investigation. The MTF may consult with AFMOA/SGHQ to seek assistance with the investigating officer appointment. The purpose and scope of the QA investigation will be explicit in the written appointment. After completing the QA investigation the investigating officer will submit a written report to the Credentials Function for review. If the investigating officer is reviewing clinical competency of the provider, the investigating officer shall be a peer of the subject and review relevant patient medical records, orientation/training folders, skill verification documents, professional practice reviews/evaluations, Officer Performance Reports, patient surveys, etc. If clinical practice deficits were identified while in orientation/training, the investigating officer shall determine if the provider was put on notice of the clinical practice deficiencies and offered opportunities to improve. The report will organize the factual findings of the QA investigation, and include the investigating officer's conclusions and recommendations. The QA investigation report and other relevant information collected will form the basis of the Credentials Function review.

9.45. Command Directed Evaluations. The provisions for a CDE as outlined in paragraph 9.18. is also applicable for non-privileged providers.

9.46. The Credentials Function Review (CFR). The CFR will convene and review the QA investigation findings and make an action recommendation to the MTF Commander. Legal counsel involvement is recommended. The Credentials Function composition will include at least one peer of the provider under review. See paragraph 9.23. through 9.24. for CFR composition. The Credentials Function participants must be fair and impartial. The provider under review does not have the right to attend this meeting; however, he or she may provide written comments if desired. Credentials Function recommendations will be forwarded to the

Senior Corps Representative and MTF/CC within 10 calendar days of the function's review completion and may include:

- 9.46.1. Reinstatement. Return to clinical duties.
- 9.46.2. Reinstatement with M&E. (See paragraph 9.25.2. for definition.)
- 9.46.3. Convene a peer review panel.

9.47. Notification to Non-Privileged Provider. The MTF Commander has 10 calendar days from receipt of the Credentials Function recommendations to make a determination on what action to take; reinstate, reinstate with M&E, or convene a peer review panel. The MTF/CC is not bound by the recommendation(s) of the Credentials Function or Senior Corps Representative.

9.48. Adverse Practice Action Notification to AFMOA/SGHQ and AFMOA/SGNP. Once the MTF/CC makes the decision to pursue an adverse practice action, the MTF will initiate a DD Form 2499 to document the action. This form and all documents produced for the adverse practice action are placed in the risk management case file and maintained by the MTF. The MTF key personnel (e.g., SGN, SGH, RM) will notify and maintain communication with AFMOA/SGHQ and AFMOA/SGNP of the adverse practice action progress.

Non-Privileged Provider Peer Review Panel

9.49. Peer Review Panel. The Senior Corps Representative is responsible for coordinating the Non-Privileged Provider Peer Review Panel. The Peer Review Panel will be composed of at least three clinical peers of the involved provider (similar clinical specialty, level of education and training). If the MTF does not have three peers available to conduct this review, it may be accomplished using peers from other MTFs; either in person or via video or teleconferencing. The provider will receive written notification of the date of the Peer Review Panel and be provided a copy of the documentation/evidence that will be reviewed by the Panel. The provider may submit written comments to the Peer Review Panel, but does not have the right to attend this meeting. The Peer Review Panel is not a legal proceeding. The Peer Review Panel shall convene within 14 calendar days after receipt of the MTF/CC's decision, the QA investigation report, and relevant evidence to make and forward a recommendation to the Credentials Function. The recommendations may include:

- 9.49.1. Reinstatement. Return to clinical duties.
- 9.49.2. Reinstatement with M&E. M&E is a well-defined, time-limited, well documented plan of Focused Professional Practice Evaluation monitoring to confirm the provider possesses the skill, knowledge, and ability to render safe and effective healthcare. The documented plan of M&E shall include clear expectations and measures of success that will be routinely reviewed throughout the period of M&E. M&E is distinct from supervised (restricted) practice since there is no restriction or control placed on the provider's clinical practice. It is a period to monitor the provider's practice and give feedback. This is neither an adverse action nor reportable to regulatory entities.
- 9.49.3. Restriction. Restriction is a temporary or permanent limit placed on all or a portion of the provider's clinical practice, so that the provider is required to obtain concurrence before providing all or some clinical duties within the scope of his/her certification, license, or registration. The restriction requires some form of supervision. Restriction of practice is reportable to the appropriate regulatory agencies.

9.49.4. Reduction. Reduction is the permanent removal of a portion of a provider's clinical practice. Reduction of practice is reportable to the appropriate regulatory agencies.

9.49.5. Revocation. Revocation is the permanent removal of all of the provider's clinical practice and the provider is removed from all patient care duties. Revocation is reportable to the appropriate regulatory agencies.

9.50. Credentials Function. The Credentials Function will reconvene within 10 calendar days to review the Peer Review Panels' findings and recommendations, and then forward their final recommendation to the Senior Corps Representative and the MTF/CC. The recommendations are the same as paragraph 9.49. above. The Senior Corps Representative may make a recommendation to the MTF/CC under separate cover; however, it is the MTF/CC who will make the final decision.

9.51. The MTF/CC has 10 calendar days from receipt of the Credentials Function recommendations to make a determination on what action to take. The MTF/CC is not bound by the recommendations of the CFR, Provider Peer Panel or those of the Senior Corps Representative.

9.51.1. The MTF/CC will give written notification (within 10 calendar days of receipt of Credentials Function final recommendation) to the provider of his/her proposed action and the basis (allegations) for the proposed action. If the proposed action is to restrict, reduce, or revoke, the provider's clinical practice; then the MTF/CC must advise the provider in writing of the right to a hearing and appeal. The letter will include the specific allegations that constitute the grounds for the proposed action, include dates and pertinent medical records as appropriate. The provider must have access to all information considered by the CFR, the Peer Review Panel and the MTF/CC which resulted in the proposed action. Copies of these records are releasable to the provider and his/her legal counsel. They are released under protection of the *Privacy Act of 1974, Health Insurance Portability and Accountability Act (Title II) of 1996, and Title 10 USC §1102.*

9.51.2. If the individual is a contract employee, a copy will be sent to the AF contracting office responsible for the contract and a letter to contractor. For the federal civilian employee, a copy of the letter is sent to the employee relations specialist in the CPO.

Hearing Process for the Non-Privileged Provider

9.52. General. Any non-privileged provider who is removed from all or a portion of patient care duties may request a hearing. This includes proposed actions to reduce or revoke practice. The timelines to request a hearing and the management of the adverse practice action and case file if the non-privileged provider does not submit a request for a hearing, waives their right to a hearing or fails to appear for a scheduled hearing is the same process as for a privileged provider. See paragraphs 9.29. through 9.33. for detailed guidance that is applicable to non-privileged providers. The Senior Corps Representative acts in place of the SGH in the management of non-privileged providers.

9.53. Hearing Panel Process. The hearing process is the same as described for privileged providers in paragraph 9.34. For Non-Privileged Providers the Senior Corps Representative assumes the roles and responsibilities of the Credentials Function Chairperson in this process. The hearing panel recommendations for non-privileged providers address clinical practice instead of clinical privileges and may include:

9.53.1. Reinstatement.

9.53.2. Reinstatement with M&E.

9.53.3. Restriction.

9.53.4. Reduction.

9.53.5. Revocation

9.54. Provider Statement of Exceptions and Corrections. The provisions for non-privileged providers submitting a statement of exceptions and corrections is the same as those outlined in paragraph 9.35. for privileged providers. The senior corps representative acts in lieu of the SGH.

9.55. MTF/CC Decision and Provider Notification. The provisions for the MTF/CC decision and provider notification is the same as for privileged providers as outlined in paragraph 9.36.

9.56. Providers Appeal Following a Hearing. The provisions for the provider's appeal following a hearing are the same as for privileged providers as outlined in paragraph 9.37.

9.57. Appeal Review Process. The provisions for the appeal review process is the same as for privileged providers as outlined in paragraph 9.38.

9.58. AF/SG Review and Final Decision. The provisions for the AF/SG review and final decision is the same as for privileged providers as outlined in paragraph 9.39.

9.59. AFMOA/SGHQ Notifications. The provisions for the AFMOA/SGHQ Notification is the same as for privileged providers as outlined in paragraph 9.40.

9.60. Non-Privileged Provider Documentation Requirements. All adverse action documentation (DD Form 2499, Non-Privileged Provider Peer Review Function, and hearing documents, etc.) on non-privileged staff will be maintained and secured by the MTF risk manager/designee. The non-privileged provider's CAF or electronic equivalent will be secured/maintained by the MTF risk manager/designee during adverse action proceedings. If the non-privileged provider separates or terminates employment, the adverse action file, along with the individual's CAF or electronic equivalent, will be maintained for 10 years at the MTF (similar to the credentials folder for privileged staff), then forwarded to AFMOA/SGHQ, Risk Management Operations, for archiving. AFMOA/SGHQ, Risk Management Operations, will maintain an adverse action file in CCQAS with all mandatory data fields complete. If the provider PCSs, all adverse action documentation will be forwarded by certified mail to the gaining MTF. **Note:** These documents will not be handcarried by the provider.

9.61. Removing Nurses from the Nurse Transition Program. Registered nurses who are removed from the Nurse Transition Program (NTP) for substandard clinical performance or for unprofessional conduct may be reported to state regulatory agencies. The MTF will complete a DD Form 2499, along with supportive documentation, and forward this to AFMOA/SGHQ. AFMOA/SGHQ, Risk Management Operations will prepare the case for review by SG1 and AF/SG.

9.62. Removing Unlicensed Technicians from Clinical Practice. Unlicensed Technicians who hold certifications that are required for the performance of their duties (that are not otherwise included as a non-privileged provider) shall be afforded due process when removed from clinical practice due to issues regarding clinical competence, misconduct or impairment. Due process shall include a QA investigation (if necessary) and peer review, as outlined below,

of the clinical substance and circumstances surrounding the reason for removal. A peer review will be conducted and the technician notified of the peer review results no later than 30 calendar days from the date the technician was suspended from practice. The technician will have an opportunity to provide a written rebuttal to the peer findings. Rebuttal must be submitted no later than 15 calendar days following notification of peer review results. Once the MTF/CC takes final action, the technician may appeal the decision to AFMOA/SGHQ within 10 calendar days of the final decision. **Note:** Certified technicians may include, but not limited to: CADAC, Registered Respiratory therapists, Mammography technicians, Histopathology and Optometry.

9.62.1. Peer review will be by technicians of similar grade and experience, and hold the same certification as the one in question. At least two peers must be used in the review.

9.62.2. There is no clinical due process requirement for unlicensed technicians who do not require a certification to perform their clinical duties.

9.62.3. Decertification procedures for Independent Duty Medical Technicians are found in AFI 41-103.

Section 9E—Management of Impaired Privileged/Non-Privileged Providers

9.63. General. Any medical or mental condition that prevents or that significantly reduces an individual's ability to safely execute his or her responsibilities in providing health care may be considered an impairment. This includes alcohol or drug/substance impairment, or mental health disorder not responsive to treatment or provider refuses treatment. The Credentials Function or Senior Corps Representative will review individuals who may be impaired and determine if their health status adversely affects their clinical practice and patient safety.

9.64. Alcohol or Drug Impairment.

9.64.1. Voluntary Self-disclosure. A provider may self-disclose an alcohol or drug impairment and request treatment. The treatment may require hospitalization or travel away from the MTF. Voluntary removal from patient care duties while seeking treatment is not an adverse privilege/practice action under these circumstances, and is not reported as an adverse action to any regulatory agency. However, the removal related to the impairment may be required to be reported to regulatory agencies (e.g., State Medical Board). Any associated administrative/UCMJ action that results from alcohol or drug impairments may also be reported to regulatory agencies. Self-disclosure after notification that a QA investigation is being conducted does not meet the intent of voluntary self-disclosure as described in this paragraph. IAW DoD 6025.13-R, the AF/ SG shall report clinical adverse actions taken against providers with alcohol and/or chemical-related impairments who do not self-refer into a rehabilitation program, or those who self-refer, but do not complete the rehabilitation program or have evidence of relapse following completion of the program.

9.64.2. Determining If Adverse Action Is Needed. The MTF will consult with their MLC to review the facts of the case. The MLC will provide guidance to the MTF on adverse actions related to impairments. The base SJA advises on possible criminal violations related to impairments and will be consulted prior to questioning the provider.

9.64.3. The MTF/CC will direct a QA investigation into reports of provider impairment. Abeyance or summary suspension should be considered. The QA investigation may consider all information, which evaluates the impact of the impairment on the provider's ability to

deliver safe healthcare. This may include Command-directed mental health evaluation, blood alcohol levels, police reports, a statement from the immediate supervisor addressing any performance problems, or information from substance abuse counselors on the nature and extent of the problem and proposed treatment plan, etc. If the QA investigation determines that the impairment does not affect clinical practice and the ability to deliver safe healthcare, the Credentials Function Chairperson or Senior Corps Representative will forward the recommendation to the MTF/CC. The MTF/CC makes the final decision.

9.64.4. Any alcohol or drug event that occurs while a provider is on duty or on call must be considered for adverse privilege/practice action since it raises a significant patient safety concern. The adverse privilege/practice action process for impaired providers is as prescribed by this instruction.

9.64.5. Returning to Practice Following Substance Use Disorder Treatment and Aftercare. Clinical personnel who have undergone treatment for a substance use disorder must demonstrate a period of clinical stability without relapse before returning to clinical duties.

9.64.5.1. Aftercare Program. Following treatment, it is mandatory that providers participate in an aftercare program as part of a recovery/relapse prevention plan. The provider must be actively engaged in a post-treatment aftercare program during this post-treatment period.

9.64.5.1.1. Substance Dependence. A minimum period of six months stability following completion of treatment is mandatory for personnel recovering with a diagnosis of substance dependence before returning to clinical duties. During the six month time period, the provider will be participating in an aftercare program. It may be recommended that the provider continue to attend an aftercare program after the six month time period based on the medical needs of the provider. The required six months of stability *begins* after the completion of the treatment program.

9.64.5.1.2. Substance Abuse. A minimum period of three months stability following completion of treatment is mandatory for personnel recovering with a diagnosis of substance abuse before returning to clinical duties. During the three month time period, the provider will be participating in an aftercare program. It may be recommended that the provider continue to attend an aftercare program after the three month time period based on the medical needs of the provider. The required three months of stability *begins* after the completion of the treatment program.

9.64.5.2. Following successful completion of the recovery/relapse prevention plan (treatment and aftercare), the provider's case will be presented to the Credentials Function for reevaluation with potential partial or complete restoration of clinical privileges at that time.

9.64.5.2.1. As part of the information presented to the Credentials Function for review, input from the ADAPT program manager must be obtained as to the individual's diagnosis, prognosis, and implications for clinical performance. This includes information regarding the individual's medical stability, readiness to return to clinical duties, and risk of relapse.

9.64.5.2.2. Consultation with the MTF ADAPT Program Manager or the AFMOA ADAPT/ DDR Branch staff is strongly recommended.

9.64.5.2.3. The Credentials Function or Senior Corps Representative in consultation with the SQ/CC and individual's clinical supervisor shall also define a period of monitoring and evaluation, with regular feedback sessions documented.

9.64.6. Evidence of Relapse. Any identified relapse will be reported immediately to the Credentials Function Chairperson and/or Senior Corps Representative. The individual will be removed from patient care duties while a full reassessment is accomplished. Recommendations regarding the status and management of the provider will be made by the Credentials Function Chairperson or Senior Corps Representative and forwarded to the MTF/CC. If an adverse action is proposed, due process procedures as prescribed by this instruction will apply. Impairment relapse is reportable to the NPDB and other regulatory agencies.

9.64.7. Actions Involving Civilian Personnel. The supervisor of Federal civil service providers/ employees will contact the CPO, Employee Relations Branch, for advice prior to questioning the employee.

9.64.8. Actions Involving Contract Providers. The supervisor of contract staff will contact the QA personnel assigned to the contract and the base contracting officer to ensure that the contractor's employer is informed about the conduct or performance of a contract employee.

9.64.9. Severing the employment relationship in lieu of taking the adverse privileging/practice action that is indicated by evidence of impairment is not in compliance with this instruction.

9.65. Physical/Mental Impairments.

9.65.1. Temporary Impairments. Temporary impairments (i.e., broken arm or leg, pregnancy, scratched cornea, medication use which impacts lucid thought) will be noted on an official duty limiting condition report by the primary/treating healthcare provider. It will include an explanation regarding the prognosis and how the medical impairment/condition limits or affects the provider's clinical practice. (For example: can't operate with a broken finger, should not deliver babies with a broken arm or temporary nerve damage or loss of strength, etc.) The duty limiting condition report should also specify, to a reasonable degree of medical certainty, the length of time the duty limiting condition report is expected to be in effect. This duty limiting condition report should immediately be brought to the attention of the individual's supervisor and the Credentials Function Chairperson and/or Senior Corps Representative. A copy should be placed in the PAF for privileged providers or comparable record for non-privileged providers. While a provider is on a duty limiting condition report, restriction on the provider's practice consistent with the duty limiting condition report is not an adverse action and is not reported to regulatory agencies.

9.65.2. Permanent and Long-Term Impairments. Permanent or long-term impairments (as documented by the healthcare professionals treating the provider) shall be reviewed by the Credentials Function for privileged providers with consideration towards permanent reduction/restriction/revocation of privileges. For non-privileged providers, the Senior Corps Representative, in conjunction with the flight commander and individual's supervisor, will review long-term impairments to consider permanent practice action. These reviews will result in a written recommendation to the MTF/CC who will decide if an adverse action is

warranted. If a provider voluntarily requests a restriction/reduction/revocation of their clinical privileges/ practice, an adverse action is not required.

9.65.3. Voluntarily Restricting Practice Related to a Medical Condition. A provider may voluntarily restrict/reduce/revoke their clinical privileges/practice when a medical condition interferes with ability to perform the full scope of duties. A written request to restrict/reduce/revoke clinical privileges/ practice must be made (before an abeyance or any other adverse action process has been initiated) to the Credentials Function or to the Senior Corps Representative. This voluntary action is not an adverse privileging/practice action and is not reported as an *adverse action* to any state regulatory agency. The Credentials Function/Senior Corps Representative must approve the voluntary action and forward their recommendation for approval to the MTF/CC. Following MTF/CC concurrence, the clinical privileges/practice will be changed, as appropriate. AFMOA/SGHQ, Risk Management Operations, may be required to report the medical condition to the individual's state licensing board. The MTF will complete the template letter, located at Attachment 22 and forward this information to AFMOA/SGHQ. AFMOA/SGHQ, Risk Management Operations will then report the voluntary restriction (not an adverse action) as directed.

9.65.4. Determining if Adverse Action is Warranted. The Credentials Function or Senior Corps Representative in consultation with the SQ/CC, the individual's supervisor and the MLC may conduct a QA investigation into reports of physical/mental impairment. (This is not necessary if a provider self-discloses as stated above.) Abeyance or summary suspension should be considered. The purpose of the QA investigation is to determine the extent of the possible impairment/medical problem and whether the impairment or condition affects the provider's ability to deliver safe patient care.

9.65.4.1. The review process may consider how the impairment or condition was discovered or disclosed, a statement concerning the current clinical performance from at least one clinical or administrative supervisor, and a statement of diagnosis, prognosis, and implications for clinical performance from the primary physician treating the provider. Additional medical evaluations may be directed as needed.

9.65.4.2. If the QA investigation determines that the provider's condition does not affect clinical practice, the Credentials Function Chairperson or Senior Corps Representative will forward this recommendation to the MTF/CC.

9.65.4.3. The MTF/CC makes the final decision. If the provider is removed (not voluntarily) from all or a portion of their patient care responsibilities because the medical condition affects his or her ability to render safe patient care, then the provider is offered full due process procedures as directed in this instruction.

9.65.5. Medical Evaluation Board/Physical Evaluation Board (MEB/PEB). The MEB/PEB process is not designed to decide if a provider is capable of providing safe healthcare--it is a process to decide whether the provider is fit for military duty. Some medical conditions can produce a significant level of disability that markedly interferes with functional ability. These conditions may require a provider to voluntarily restrict/reduce/revoke one's practice or be subject to a possible restriction/reduction/revocation in privileges/practice. Action to curtail the privileges/practice of a medically impaired provider must be taken when appropriate.

9.65.6. Reassessment of Impairment Status. Impairment status and rehabilitation should be reviewed at least monthly, with input from the treating healthcare professional. The Credentials Function/Senior Corps Representative will assess each situation, on a case-by-case basis, to determine if a formal action against privileges/practice is warranted. In cases initially deemed temporary impairments, evaluations should address possible reclassification of the impairment as permanent or long-term, if initially projected recovery times are surpassed. Worsening of a condition shall be monitored and documented. Reevaluation and updating the duty limiting condition report may be indicated. Reevaluation of the provider's clinical privileges/practice is also indicated.

9.66. Management of Individuals with Communicable Diseases that Could Affect Patient Safety.

9.66.1. Determining Extent of the Exposure Risk. The Credentials Function or Senior Corps Representative (for non-privileged providers) must review the scope of practice of the provider and consult with infectious disease or preventive medicine specialists to determine the risk of transmission for the assigned AFSC of the individual. The Credentials Function or Senior Corps Representative will identify any specific exposure prone procedures (EPP) within the scope of practice for the provider (based on the provider's AFSC) and make a recommendation to the MTF/CC whether any restriction on the provider's clinical practice is warranted.

9.66.2. Voluntary Restriction of Practice. A provider may voluntarily restrict/reduce/revoke one's practice related to medical condition/communicable disease. A written request to restrict/reduce/revoke clinical privileges/practice must be made to the Credentials Function or to the Senior Corps Representative. This voluntary action is not an adverse action and is not reported as an adverse action to any state regulatory agency. The Credentials Function or Senior Corps Representative must approve the voluntary action and forward the recommendation for approval to the MTF/CC. Following MTF/CC concurrence, the clinical privileges/practice will be changed, as appropriate.

9.66.3. Restriction of Practice. If the MTF/CC determines that the individual's clinical practice must be restricted, reduced, or revoked due to concerns about the transmission of the disease while delivering healthcare, the removal of the provider from patient care duties is not an adverse privilege action. In addition, this removal is not reported as an adverse action to the NPDB or to regulatory agencies. However, the medical condition may be reported to a state licensing agency as outlined in paragraph 9.65.3.

Section 9F—Other Management Issues Related to Adverse Actions

9.67. Simultaneous Adverse Action and UCMJ Action. For some types of misconduct, criminal investigative actions may coincide with an adverse privileging/practice action. Although such actions can proceed simultaneously, a request may be made to have one action proceed over another (i.e., UCMJ action prior to adverse action). The adverse action will proceed no later than action by the courts-martial convening authority (clinical adverse action should not be deferred pending administrative appeal). Individuals serving on a panel for the UCMJ action will not be appointed to a Peer Review Panel or to the hearing process for the adverse action.

9.67.1. When Office of Special Investigations (OSI) is investigating a healthcare professional for an issue which is also the basis for an adverse privileging/practice action, the adverse privileging/practice action should be placed on hold while the OSI completes their investigation. The MTF will notify the provider in writing that the adverse privileging/practice action process is “on hold” until the OSI investigation is complete and the MTF/CC receives the findings of the OSI investigation. **Note:** Typically the provider’s privileges are placed in summary suspension, or removed from clinical practice for the non-privileged provider during the OSI investigation. The provider is given written notice of such. The OSI may be given certified copies of relevant records. The MTF must have a receipt of all records that are given to the OSI. The OSI is obligated to return all records and any other medical evidence the MTF provides. MTF personnel must not interfere with the OSI investigation.

9.67.2. If there is a conflict between the MTF and other investigating agencies regarding the continuation of an adverse action process, the base SJA will decide whether the adverse action will be postponed.

9.67.3. When the basis of an adverse action is a criminal conviction the provider is not permitted to challenge the finding of guilt.

9.68. Administrative Denial of Privileges. The Credentials Function may recommend a denial of initial privileges or denial of a renewal of clinical privileges when providers do not meet the established requirements of the accrediting entities, AFMS, or the MTF. This includes providers who have not met AF continuing education requirements, or providers who cannot provide objective data to demonstrate current clinical competence. It also includes denial based on lack of facility support for the requested privileges. These denials are not adverse privileging actions and do not require the facility to offer due process procedures.

9.69. Removing Residents from Patient Care Responsibilities. In situations where a resident is removed from a residency training program for substandard clinical practice or professional misconduct that may impact patient care, the resident may be reported to the Federation of State Medical Boards, after due process is afforded. AFI 41-117 governs the due process procedures for residents. All professional actions involving residents being permanently removed from patient care and/or removed from their residency program must be forwarded to AFMOA/SGHQ, Risk Management Operations, for immediate reporting to the FSMB. HQ AFPC/DPAM must forward the adverse action file, with all supporting documentation demonstrating due process (i.e., faculty board minutes, hearing, appeal, etc.). AFMOA/SGHQ, Risk Management Operations, is the releasing authority for information related to the FSMB report. The involved resident may appeal only the report language to AFMOA/SGHQ. The resident may appeal the action leading to the report to HQ AFPC/DPAM. The residency director may be required (by State Medical Boards and other regulatory entities) to report adverse actions taken on medical residents. In such cases, the residency director will notify AFMOA/SGHQ, Chief, Clinical Quality Management Division, before submitting such reports. AFMOA/SGHQ and SGJ will review and approve prior to any reports submitted.

Section 9G—Reporting and Releasing Adverse Information to National and Regulatory Agencies

9.70. Responding to Written Requests for Information. MTFs should reply directly to civilian medical facilities, credentialing agencies, or other official medical entities on requests for information on a provider's current practice/privilege information. All requests for information on medical malpractice claim history or adverse privilege/practice actions (clinical and administrative-HIPDB) shall be referred to AFMOA/SGHQ, Chief, Risk Management Operations. AFMOA/SGHQ is the releasing authority for such information.

9.71. Reporting Misconduct. Reports may be made, by AFMOA/SGHQ, to State Licensing/Certification Boards where a member holds license or certification to practice if the provision of the state(s) either mandate or allow proactive reporting, specified under state licensing policy, for individual or organization reporting of allegations of misconduct where there is reasonable cause (such as an arrest) that could have a serious impact on patient/staff welfare or safety. Such required reports will be forwarded to AFMOA/SGHQ for reporting.

9.72. Disposition of Reports and Actions When MTFs Close. Closing MTFs shall forward all archived and pending adverse action cases to AFMOA/SGHQ. Risk Management Operations assumes responsibility for managing these cases.

9.73. AFMOA/SGHQ Responsibilities in Reportable Actions. AFMOA/SGHQ, Risk Management Operations is responsible for reporting to regulatory agencies outside of the AF and releasing information related to medical malpractice claims history, clinical adverse actions, NPDB, and HIPDB reports.

9.74. NPDB Reporting of Adverse Actions. Only AFMOA/SGHQ makes reports to external regulatory agencies, unless directed to make such reports by AF/SG or a designee.

9.74.1. Privileged providers will be reported to the NPDB within 30 calendar days of the AF/SG final decision when:

9.74.1.1. Clinical privileges have been denied, restricted, reduced, or revoked for substandard performance, impairment, or unprofessional conduct.

9.74.1.2. A provider voluntarily surrenders clinical privileges while under investigation for issues of clinical incompetence or misconduct, or in return for not conducting such an investigation or proceedings.

9.74.1.3. Provider separates, retires, moves PCS, or terminates employment, contract, or volunteer services with their privileges summarily suspended.

9.74.2. A copy of the NPDB report will be sent to states of known licensure, the FSMB for physicians, and/or the American Association of Dental Examiners (AADE) for dentists, and other regulatory/professional organizations IAW DoD directives.

9.74.3. The following agencies will receive a notification of the final adverse action: HQ MAJCOM/SG, MTF/CC, to the subject of the action at his or her last known address and as appropriate HQ AFPC/DPAM, ANG/SG, HQ AFRC/SG, and HQ ARPC/SG.

Section 9H—Administrative Adverse Actions

9.75. Reporting to the HIPDB. This instruction serves as policy for implementing the HIPDB reporting requirement IAW the Health Insurance Portability and Accountability Act and DoD 6025.13-R. The HIPDB is a national healthcare fraud and abuse data collection program for

reporting and disclosing adverse administrative actions against personnel involved in the delivery of medical services. By direction of the Office of the Assistant Secretary of Defense/Health Affairs (ASD/HA), all personnel assigned to the AFMS, including active duty, reserve, Air National Guard, civil service, and personal service contract personnel, are subject to reporting to this data bank. The AF/SG has the authority to report those employed by the AFMS. Non-personal services contractors are not employees of the AFMS. If the non-personal services contractor commits an offense that meets the requirement for reporting to the HIPDB, the MTF/CC will submit the appropriate documentation to the contracting employer. It is the responsibility of the contractor to report the action to the HIPDB.

9.76. Roles/Responsibilities:

9.76.1. The AF/SG is responsible for reports regarding reportable administrative adverse actions taken against healthcare providers, suppliers, or practitioners providing healthcare services to active duty members or any other MHS beneficiaries in MTFs or as a part of any military unit. AF/SG has delegated broad oversight of this program to AFMOA/SGHQ, but the AF/SG makes the final decision to report to the HIPDB.

9.76.2. AFMOA/SGHQ provides oversight and consultation for HIPDB reporting. Risk Management Operations processes these actions for review and reporting and notifies, in writing the MTF/CC, MAJCOM/SG, and the individual of the final action.

9.76.3. AFMOA/SGHQ is responsible for reviewing cases for substantive matters, completion of required process, and forwarding to AFMOA/SGHQ, Risk Management Operations.

9.76.4. When the MTF/CC receives reports on administrative actions to determine whether the action should be forwarded for reporting to the HIPDB, it is imperative that the effect the action has on the provision of healthcare be clearly and completely ascertained and documented. The MTF risk manager (or Commander directed designee) shall be responsible to oversee processing of administrative actions considered for HIPDB reporting by the MTF/CC. Once the MTF process is completed, the entire package will be forwarded for reporting as indicated in this instruction.

9.76.5. SQ/CC, First Sergeants, and supervisors of medical personnel are responsible for identifying, and reporting to the MTF/CC, actions that may potentially be reported to the HIPDB (Article 15, Courts-Martial, etc.).

9.76.6. Contractor Quality Assessment Personnel will serve as the liaison between the MTF and the contractor, and will monitor the process to ensure the requirements outlined in the contract are fulfilled. Any contract Termination for Default will be reviewed and considered for reporting to the HIPDB.

9.76.7. For actions involving Federal civilians, the MTF Civilian Personnel Liaison is responsible for working with the CPO to ensure that local bargaining obligations have been met.

9.76.8. The MLC and SJA are responsible for providing legal consultation to the MTF.

9.76.9. The Credentials Function Chairperson will report those cases that meet criteria for HIPDB reporting to the MTF/CC for privileged providers. The SGH is responsible for the preliminary determination of clinical applicability (how the member's action affects the

provision of healthcare) and providing guidance to the risk manager for the process to make a reporting recommendation to the MTF/CC. The risk manager will ensure necessary documentation is contained in the HIPDB file: SGH notification letter, MTF/CC notification letter(s), DD Form 2499, final administrative action report(s), supporting documentation/evidence, and provider statement (if submitted).

9.76.10. The Senior Corps Representative will report those cases that meet criteria for HIPDB reporting to the MTF/CC for actions involving non-privileged providers. This individual is responsible for the initial preliminary determination of clinical applicability (how the member's action affects the provision of healthcare) and providing guidance to the risk manager for the process to make a reporting recommendation to the MTF/CC on and completing paperwork necessary for reporting for non-privileged providers.

9.76.11. The First Sergeant and Medical Group Superintendent will report those cases that meet criteria for HIPDB reporting involving enlisted members to the MTF/CC. The Medical Group Superintendent is responsible for the initial determination of clinical applicability (how the member's action affects or could affect the provision of healthcare) and providing guidance to the risk manager for the process to make a reporting recommendation to the MTF/CC on enlisted members.

9.77. Reportable Actions:

9.77.1. Military Personnel: Reportable actions are courts-martial convictions, once approved by the courts-martial convening authority, and non-judicial punishment imposed under Article 15 of the UCMJ, provided the convicted/punished member is a healthcare provider, supplier, or practitioner. These acts or omissions for which the member was convicted or punished must be related to the delivery of a healthcare item or service that could have affected the provision of healthcare. These include, but are not limited to, fraud, drug or alcohol-related incidents, assault, homicide, sexual misconduct, and theft. Reportable actions also include any administrative action resulting in separation, reduction in grade, involuntary military occupational specialty reclassification or other administrative action when such action is related to the delivery of a healthcare item or service. The MTF/CC will determine further reportable actions individually as they relate to the provision of healthcare.

9.77.2. Federal Civilian Personnel: Reportable actions include adverse personnel actions related to misconduct, based on acts or omissions negatively impacting the delivery of a healthcare. These include, but are not limited to, fraud, drug or alcohol-related incidents, assault, homicide, sexual misconduct, and theft. Adverse disciplinary actions include suspension of more than 14 calendar days, removal from Federal employment, and change to lower grade based on disciplinary procedures. Actions such as furlough without pay and reduction in grade or removal based on performance are not reportable, unless related to the delivery of a healthcare.

9.77.3. Contract Personnel: Reportable actions include contract termination for default taken by an MTF or medical command against a personal services or non-personal services contractor.

9.78. Procedures:

9.78.1. Upon imposition of an adverse administrative action, the SQ/CC must notify the individual in writing within 10 calendar days that the action may be reportable to the HIPDB (see sample at Attachment 23).

9.78.2. The individual involved has 10 calendar days to submit a reply stating why he/she feels the action should not be reported. If the tenth day falls on a weekend or holiday, the response is due the individual's next scheduled duty day. If no response is received within 10 calendar days, the process will continue.

9.78.3. The SQ/CC (or designee) will make a preliminary determination as to whether the act or omission did or could have a potential to adversely effect the provision of healthcare. The risk manager or designee will complete a DD Form 2499 indicating in Section 12 the effect the action does or could have on the provision of healthcare. Forward the paperwork to the MTF/CC within 10 calendar days of receipt.

9.78.4. The MTF/CC will make the final determination as to the effect on healthcare and whether the individual shall be considered for reporting to the HIPDB. He/she must notify the individual in question in writing within 10 calendar days as to the final decision (see sample letter at Attachment 23).

9.78.5. Forward two copies of the case file to AFMOA/SGHQ. Case files must contain:

9.78.5.1. SQ/CC notification letter and Commander's final letter to recommend reporting to the HIPDB and how the member's action affected or could have affected on the provision of healthcare.

9.78.5.2. For military members, AF Form 3070, *Record of Non-Judicial Punishment*, or copy of courts-martial order announcing the convening authority's initial action; for Federal civilian employees, a copy of the decision letter and Standard Form 50, *Notice of Personnel Action*, affecting the action.

9.78.5.3. DD Form 2499.

9.78.5.4. Member's written statement (if submitted). A memorandum for record, or other documentation, if the member declined to submit a statement.

9.78.5.5. Initial letter of notification to individual of potential to report to the HIPDB.

9.79. AFMOA/SGHQ Review. AFMOA/SGHQ will review the case file for completeness and forward the original to AFMOA/SGHQ, Risk Management Operations, for processing to the AF/SG, and reporting to the HIPDB.

9.80. Maintenance of HIPDB Case File at MTF. A copy of the HIPDB case file shall be maintained by the MTF for a minimum of ten years. When/if a provider PCSs, the file is forwarded to the gaining MTF. Adverse action files should be filed with a case number (example: MTF name/10-001). After ten years the file is forwarded to AFMOA/SGHQ, Risk Management Operations, for archiving. **Note:** The provider is not allowed to have possession of the file, but may be provided a copy of the file.

9.81. Courts-Martial or Federal Civilian Adverse Action Appeal. If the case involves a Courts-Martial or Federal civilian adverse action, and the individual intends to appeal, the HIPDB reporting process must continue, regardless of the status of the appellate process. A report may be made regardless of the appeal status. If the decision is overturned or modified on

appeal, and the individual had been reported to the HIPDB, an amended report will be made. An amended report will also be made in the event a non-judicial punishment action against a military member is subsequently set aside. MTF/CC should submit amended reports or requests to rescind reported actions that have been overturned according to the same procedures as outlined in this section for initial reporting.

9.82. Queries. When the NPDB is queried, a HIPDB report is given automatically. Queries are required for privileged providers when making privileging recommendations. See paragraph 5.21. which outlines a one-time query requirement for new RNs, LVNs and LPNs. An initial query could be completed on other non-privileged providers.

Section 9I—AF Clinical Code of Conduct

9.83. AF Clinical Code of Conduct. To ensure optimum patient care, the health care organization must promote a safe, cooperative, and professional environment. Staff, patients, and visitors must be treated with courtesy, respect, and dignity. It is expected that all AFMS personnel will adhere to and be accountable to this AF Clinical Code of Conduct by holding themselves and other members to these conduct standards. The AFMS has “zero tolerance” of intimidating and disruptive behaviors.

9.83.1. To support the AF Clinical Code of Conduct each MTF will:

9.83.1.1. Have an organizational process to identify and report AF Clinical Code of Conduct violations, such as intimidating and disruptive behaviors.

9.83.1.2. Utilize prevention strategies, including skills-based training and coaching.

9.83.1.3. Staff assistance procedures.

9.83.1.4. Corrective and disciplinary action plans, including documentation of all attempts to address intimidating and disruptive behaviors.

9.83.1.5. Healthcare staff education plan.

9.83.2. Appropriate Behavior to support AF Clinical Code of Conduct includes, but is not limited to:

9.83.2.1. Constructive criticism communicated in a professional, meaningful, and reasonable manner, offered in good faith with the aim of informing, educating, and improving patient care and safety. This communication should not include blame and invoke shame

9.83.2.2. Clear communication techniques

9.83.2.3. Teamwork; cooperative approaches to communicate, resolve problems, and express concerns

9.83.2.4. Expression of dissatisfaction with organizational policies/practices through appropriate forums and/or chain of command for the betterment of healthcare delivery

9.83.3. Disruptive and intimidating behavior will not be tolerated in the AFMS. Disruptive behaviors include, but are not limited to:

9.83.3.1. Verbal outburst, name calling, and physical threats or threats of retribution.

9.83.3.2. Sexual harassment.

9.83.3.3. Throwing of items in the work environment.

9.83.3.4. Refusing to perform assigned tasks.

9.83.3.5. Uncooperative attitudes during routine healthcare activities.

9.83.3.6. Reluctance or blatant refusal to answer questions or staff requests, return calls or pages.

9.83.3.7. Condescending language or voice intonation.

9.83.3.8. Berating or belittling statements.

9.83.3.9. Use of profanity or disrespectful language.

9.83.3.10. Degrading or demeaning comments regarding patients, family members, staff, or the AFMS.

9.83.4. Surveillance. Staff will report any violations of the Code of Conduct through their chain of command, risk manager, patient safety manager, or other designee.

9.83.4.1. Complaints alleging disruptive or intimidating behavior shall be made in writing, signed by the individual submitting the complaint and/or witness and submitted to supervisor, risk manager, or patient safety officer. The written report should contain the following information (see Kx AA toolkit for a template) and be maintained in a designated file such as the PAF, CAF, CFETP, etc.

9.83.4.1.1. Date, time, and location of the disruptive behavior.

9.83.4.1.2. Name of the person committing the disruptive behavior.

9.83.4.1.3. A factual description of the disruptive behavior and circumstances surrounding the situation.

9.83.4.1.4. Circumstances which precipitated the incident.

9.83.4.1.5. Name of any affected patient, family member, and/or staff members.

9.83.4.1.6. Names of witnesses, if any.

9.83.4.1.7. Consequences or outcomes from the disruptive behavior.

9.83.4.1.8. Any action taken to intervene or remedy the situation, including date, time, place and names of those intervening.

9.83.5. Interventions when disruptive behavior is identified:

9.83.5.1. Addressing disruptive behavior should be non-adversarial and focus on resolution of the discord, establishing accountability for the disruptive behavior, behavior modification strategies, and protection of safe patient care.

9.83.5.2. Apology statement.

9.83.5.3. Tiered approach to corrective action if appropriate; such as warning, LOC, LOR.

9.83.5.4. If disruptive behavior is egregious and/or affects the safety and well-being of patients and/or staff, the member committing the disruptive behavior may be removed from duties and afforded due process IAW this instruction, the adverse actions process.

9.83.5.5. Any criminal behavior shall be immediately reported to the MTF leadership and local legal authorities.

Chapter 10

HEALTHCARE RISK MANAGEMENT

Section 10A—Risk Management Program

10.1. Healthcare Risk Management. A series of ongoing, interrelated activities designed to identify, assess, manage, and monitor events and risks associated with the healthcare organization. Healthcare RMs must collaborate and coordinate these activities with patient safety, performance improvement, quality management, and other relevant functional managers throughout the organization. The goal of risk management is, after events and risks have been identified and assessed, that the organization can develop prioritized risk reduction strategies and performance improvement activities to provide safe, high-quality patient care. In addition there is information on appropriate disclosure, patient communication, and handling of QA information and documentation.

10.2. Risk Management Program. Each MTF shall have a risk management program, which focuses on identification, mitigation, and prevention of harmful patient and staff events through a process of risk reduction strategies. Risk management processes encompass activities to reduce risk to the patient(s) and family, government, healthcare personnel, and visitors.

10.2.1. Medical involvement and oversight of the risk management program must be structured, including processes to identify and analyze adverse patient events.

10.2.2. The medical staff will review variations from established standards of care/practice, implement corrective actions to reduce risk, and provide educational processes to improve care. This is accomplished either in a formal Risk Management Committee or within the ECOMS. Similarly the effectiveness of the MTF risk management program will be reviewed by the organization's committee responsible for quality assurance activities.

10.2.3. The healthcare risk management process includes 5 steps: 1) identify and analyze risk/ loss exposure, 2) consider alternative risk reduction techniques, 3) select optimal risk management technique or combination of techniques, 4) implement the selected risk management technique and 5) monitor/evaluate risk reduction technique response and process improvement outcomes.

10.3. Healthcare Risk Manager (RM).

10.3.1. The RM shall have competence in clinical risk management standards and policy, general healthcare risk management administration, competence with patient safety program and initiatives, basic knowledge of clinical disease processes, medical terminology, risk prevention and performance improvement processes. Competence must be evidenced by appropriate education or by at least one year of practical experience in clinical healthcare risk management.

10.3.2. The SGH shall support the RM with event identification and analysis (including PCEs, SEs, etc.), Medical Incident Investigations (MIIs), medical malpractice claim management, quality of care reviews with SOC determinations, adverse actions, and other risk management activities.

Section 10B—Disclosure, Patient Communication, and Handling of Quality Assurance Information and Documentation

10.4. Disclosure and Patient Communication and Immediate Actions Following an Unexpected Occurrence Causing Unanticipated Outcomes. Primary providers responsible for the patient shall disclose adverse event outcomes to patients and when appropriate, to their family members. Current research and professional literature demonstrate that appropriate disclosure of adverse outcomes may thwart rather than encourage medical malpractice action by patients. Disclosure, like an effective informed consent process, is an effective mode of patient communication.

10.4.1. Research further suggests patients' desire: 1) truthful disclosure of what happened and why (objective statement of the known facts), 2) a sincere apology and 3) commitment by the facility (system) to investigate the event to prevent recurrence. Proper disclosure does not suggest the provider(s) have committed medical negligence, but rather informs the patient/family that an unanticipated outcome has occurred, shares known facts to include the patient's current status, ongoing treatment and follow-up plan.

10.4.2. Staff may be concerned about the protection of 10 USC §1102 (quality assurance) materials. This concern should not prevent proper disclosure. Since disclosure is done as soon as possible following awareness of the adverse or unanticipated outcome the information provided in the disclosure discussion is not the result of a medical quality assurance investigation or process.

10.4.3. The intent of disclosure in this instruction is that the patient and patient's family (if appropriate) will receive cogent, factual event information without blame or fault attributed to someone. Disclosure must be understandable for the patient and family and avoid medical jargon that may confuse the patient and family. Disclosure shall be timely, acknowledge the adverse event when it is apparent and communicate when sufficient facts are available. If a language barrier exists between the provider and the patient and/or family, the MTF shall arrange for an interpreter.

10.4.4. Proper full disclosure shall address:

10.4.4.1. The immediate needs of the patient to minimize injury. The event shall be reported IAW this AFI (i.e., SE reporting if applicable, PCE, etc.).

10.4.4.2. Staff shall seek (time and circumstance permitting) advice, if needed or as appropriate, of the SGH, Chief Nurse, PSM, RM, and the base SJA or regional MLC prior to discussing the unanticipated outcome with the patient/family. The responsible provider shall have another healthcare team member attend the disclosure conference with the patient/family. The disclosure discussion should be directed by the primary responsible provider.

10.4.4.3. Disclosure communication shall be done in a location to afford privacy to the patient and family and eliminate interruptions (cell phones, pagers, etc.).

10.4.4.4. Recognize cultural, religious, and language factors of the patient and family; plan for accommodations if necessary, i.e., interpreters, sign language, etc.

10.4.4.5. Full disclosure communication includes: (1) the clinical facts known at that time, (2) empathy and education for the patient/family, (3) addressing the patient/family's

anger and concern, (4) confirmation the patient/family understand the facts, (5) timely and adequate documentation of the disclosure in the medical record, and (6) state the next steps; follow-up instructions and resources to contact.

10.5. Medical Quality Assurance Program and Materials: United States Code, Title 10, Section 1102. As defined by the statute; “medical quality assurance program” means any activity carried out before, on, or after November 14, 1986 by or for the Department of Defense (DoD) to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks.

10.5.1. “Medical quality assurance record” means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described above and are produced or compiled by the DoD (which includes the AFMS) as part of a medical quality assurance program. Examples include but are not limited to: risk management work products, patient safety work products, credentialing/privileging documents, peer review documents, and medical incident investigations.

10.5.2. Medical quality assurance records created by the AFMS as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except for the following exemptions allowed under this statute:

10.5.2.1. To a Federal executive agency or private organization, if such medical quality assurance record or testimony is needed by such agency or organization to perform licensing or accreditation functions related to DoD healthcare facilities or to perform monitoring, required by law, of DoD healthcare facilities.

10.5.2.2. To an administrative or judicial proceeding commenced by a present or former Department of Defense healthcare provider concerning the termination, suspension, or limitation of clinical privileges of such healthcare provider.

10.5.2.3. To a governmental board or agency or to a professional healthcare society or organization, if such medical quality assurance record or testimony is needed by such board, agency, society, or organization to perform licensing, credentialing, or the monitoring of professional standards with respect to any healthcare provider who is or was a member or an employee of the DoD.

10.5.2.4. To a hospital, medical center, or other institution that provides healthcare services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualifications of any healthcare provider who is or was a member or employee of the DoD and who has applied for or been granted authority or employment to provide healthcare services in or on behalf of such institution.

10.5.2.5. To an officer, employee, or contractor of the DoD who has a need for such record or testimony to perform official duties.

10.5.2.6. To a criminal or civil law enforcement agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified

representative of such agency or instrumentality makes a written request that such record or testimony be provided for a purpose authorized by law.

10.5.2.7. In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency, but only with respect to the subject of such proceeding.

10.5.3. When medical quality assurance documents are appropriately released IAW 10 U.S.C. §1102 the documents must be labeled as such and protected under cover which states the medical quality assurance protection continues to the recipient. Documents that are not produced for the purpose of medical quality assurance should not be labeled citing this statute.

10.5.3.1. Label may read as such: “This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority”.

10.5.4. Sharing medical quality assurance data. The release authority for medical quality assurance data/material (except for release to appropriate exemptions noted above) is Office of the Assistant Secretary of Defense, Health Affairs (OSD/HA). The request (see the toolkit on the Kx clinical quality website for an example) must be completed and submitted to OSD/HA Chief Medical Officer through AFMOA/SGHQ.

10.5.4.1. Aggregate statistical medical quality assurance data are expressed in the form of a number, including whole numbers, fractions or percentages. Numerical data that is derived from records within the DoD medical quality assurance program must also be in such demographic groupings that the release of the information would not lead to the identification of the patient or the provider involved in providing care. The data must be de-identified.

10.5.4.2. Office of Management and Business (OMB) required each federal agency to determine the lowest number for a grouping (“threshold rule”) which must exist before data can be released.

10.5.4.3. The “threshold rule” as defined by OMB and as it pertains to the release of information from the MHS is three (3). This means that if the grouping for the aggregated data includes several types of demographic, such as age, sex, race, active duty status, rank or service the population or number of persons meeting all of the demographics in the grouping must be greater than 3.

10.5.5. Exemption from Freedom of Information Act (FOIA). Medical quality assurance records may not be made available to any person under the FOIA. However, IAW FOIA regulation, DoD 5400-7/Air Force Supplement (current edition), medical quality assurance documents responsive to the request must be provided to the FOIA office after legal review and attached to the denial letter.

10.5.6. Penalty. Any person who willfully discloses a medical quality assurance record, knowing that such record is a medical quality assurance record, shall be fined not more than \$3,000 in the case of a first offense and not more than \$20,000 in the case of a subsequent offense.

Section 10C—Risk Management Program Implementation

10.6. Notifications. All serious adverse events are considered a potentially compensable event (PCE) and will be captured in the PCE module within CCQAS. They will be promptly investigated by the risk manager and other appropriate staff as necessary (Patient Safety Officer, Infection Control Officer, PI, etc.).

10.6.1. Any adverse event involving significant morbidity or death shall be immediately reported through the facility chain of command to AFMOA/SGHQ and HQ MAJCOM/SG. AFMOA/CC will notify HQ USAF/SG as appropriate.

10.6.2. Immediate action shall be taken to ensure the patient is protected from additional injury and to mitigate the untoward effects of the event. The patient will be informed of the effects of the adverse event and the prognosis. See Section 10B for guidance on disclosure and release of quality assurance information.

10.6.3. When an adverse event occurs, the person in charge of the clinical area where the event occurred shall ensure chain of command notification within 24 hours, including head of the service (nurse supervisor, flight commander), SGH, SGN and SQ/CC.

10.6.4. If death or life-threatening injury has occurred the commander shall also be notified.

10.6.5. This event notification is forwarded to the risk manager no later than the next duty day.

10.6.6. Adverse event notification shall contain the facts of the event and avoid conjecture about the cause of the event.

10.6.7. The risk manager will ensure the patient safety officer is informed of all events and collaborate on event analysis, risk reduction, and process improvement activities.

Section 10D—Risk/Event Identification

10.7. Identification. The RM will develop processes to identify potential and real events/risks within their organization. There are many formal and informal methods to identify the spectrum of system issues and patient and staff events/risks; some of which are requirements within the patient safety program (e.g., near miss, event identification, FMEA, RCA). Refer to chapter 2, paragraphs 2.6. through 2.8. for more information. Healthcare RMs and PSMs will implement and coordinate adverse event identification and assessment processes. The risk management and patient safety event analysis processes are distinct and generate different products. Risk management products include (but are not limited to): event reports, PCEs, MIIs, quality of care reviews with SOC determination, identification of significantly involved providers (SIPs), lessons learned, and other performance improvement/risk reduction strategies.

10.7.1. A SIP is one who actively delivered care (based on clinical record entries) in either primary or consultative roles during the episodes of care that gave rise to the allegation, regardless of SOC determination. Additional defining characteristics include providers who had the authority to start, stop or alter a course of treatment; who had the authority to recommend to start, stop, or alter a course of treatment; or who had the responsibility to implement a plan of evaluation or treatment. Authority to recommend means input was solicited and legitimate (i.e., the individual making the recommendation was acknowledged to have special expertise or other specific standing in the clinical issues). This term is not meant to include the providers who had only peripheral, yet appropriate, patient interaction,

nor those providers whose patient involvement was not reasonably related to the specific allegations of sub-standard care and injury. SIP is not dependent upon standard of care.

10.7.2. Event/Incident Reporting. The reporting process requires the person most knowledgeable of the event to record information related to what, when, where, how, and any known contributing factors leading to the event. Only event facts shall be recorded; personal opinion or conjecture shall be avoided. The AF Form 765, *Medical Treatment Facility Incident Statement*, or other tool may be used to capture event reporting. All events are also reported to the PSM. The following Do's and Don'ts apply to event/incident reporting:

10.7.2.1. *Do* notify the RM and PSM by next duty day of becoming aware of an adverse event. The risk manager will notify the chain of command of serious adverse events and events of a notorious nature immediately. (This includes all sentinel events, never events, and unanticipated deaths).

10.7.2.2. *Do* report at minimum the patient demographic information, facility related information (admission date, admitting diagnosis, unit, etc.) and factual description of the event and extent of injury.

10.7.2.3. *Do* route event identification form to patient safety manager (if not already informed).

10.7.2.4. *Do* maintain the confidentiality of the event identification form and stamp with the Quality Assurance protection statement, which protects this information from public disclosure under the provisions of 10 U.S.C. §1102.

10.7.2.5. *Don't* indicate in the patient's medical record that an event identification form was completed, do not allow the event identification form to become part of the medical record. (*Do* record a factual account of the patient's condition in the medical record.)

10.7.2.6. *Don't* assign blame or admit liability on the event identification form or in the medical record.

10.7.2.7. *Don't* delay event identification and assessment process.

10.7.2.8. *Don't* make copies of the event identification form.

10.7.3. Occurrence Screening. Another method to identify adverse events or process deviations is occurrence screening. This method uses clearly defined lists of clinical occurrences or processes with which patient medical records are screened. The screeners review the medical record against the predefined clinical or administrative criteria (event, clinical practice guideline, or process) and identify if an event occurred or there was a process deviation which could have resulted in risk to the patient.

10.7.3.1. Criteria for the screens are established by the facility and based upon high-risk, problem-prone, or low-volume clinical areas. Examples may include:

10.7.3.1.1. The operating/surgical suite may develop criteria to screen for proper informed consent process and documentation,

10.7.3.1.2. The ambulatory surgical unit may develop criteria to screen records for proper discharge instructions and follow-up and

10.7.3.1.3. The emergency room may use occurrence screening to review all patients who re-visit the emergency room within 72 hours, missing or inadequate discharge instructions or failure to give patients ordered prescriptions.

10.7.3.2. Administrative occurrence screening is also beneficial to identify process deviations that may impact the delivery of healthcare. For example, screening for inadequate or missing medication reconciliation, wait times, medical record availability or staffing patterns.

10.7.3.3. Benefits of the occurrence screening process are that the screen may identify missed events or process deviations which may have or could affect patient care.

10.7.3.4. Occurrences are shared with patient safety and performance improvement for system-wide process improvement. The data collected via the occurrence screening should be aggregated and shared with patient safety, quality management, and performance improvement.

10.7.4. Patient and Staff Surveys. Patient surveys (satisfaction and complaints) can offer valuable information and it is unique since it is from the patient's perspective. Early identification of patient dissatisfaction offers the risk manager and facility leadership the opportunity to review the incident of care and attempt to reduce the patient's dissatisfaction. It is well established that medical malpractice litigation often is a result from patient dissatisfaction and anger.

10.7.4.1. Staff surveys may be obtained by informal and formal methods. Since the healthcare team is the "sharp" end of the healthcare delivery system, it is critical to have their input regarding the risks within our system. The healthcare team is affected by the "blunt end" of the care system including the policies, procedures, regulations, and resources. The team's input and feedback must be collected, analyzed, and integrated into the risk management and performance improvement processes. This will facilitate staff involvement and result in more effective system improvement.

Section 10E—Risk Assessment

10.8. Risk Assessment. After gathering data and information regarding system processes and events it is essential to assess or analyze the risk and determine where best to focus activities/changes for improvement. Risk assessment occurs at all levels of patient care. The organization shall institute mechanisms to determine what level of assessment is required; this will be accomplished using the AHRQ Event Classification taxonomy (see Kx Clinical Quality website). This is done in collaboration with the PSM. Risk management review and analysis of identified risks and/or events is separate from the patient safety processes. The process tools from each respective program will be separate; however, the aggregated data, corrective action plans and performance improvement activities will be done collaboratively.

10.8.1. Occurrence Screening: As mentioned above, occurrence screening is a risk/event identification and assessment tool that may be used on an ongoing basis. It is well suited to identify near misses, actual events and process deviations. Data collected from occurrence screens may be used for peer review activities and are also helpful to monitor clinical practice across both professional and para-professional disciplines.

10.8.2. PCEs. A PCE is an adverse event that resulted in temporary or permanent harm to the patient and presents a possible financial loss (disability payment, malpractice claim payment or death benefit payment) to the Federal Government.

10.8.2.1. All PCEs will be identified and classified using the AHRQ Common Formats for event classification. The MTF RM will ensure the PSM is notified of the PCE. (The PSM will review the event and determine the level of analysis for the event, e.g., RCA.) Events meeting the following AHRQ categories will be identified as a PCE: Death, Severe Permanent Harm, Permanent Harm, Temporary Harm, Additional Treatment, and Emotional Distress/ Inconvenience. The AHRQ Common Formats tool is posted at <https://kx.afms.mil/>.

10.8.2.2. Utilize the following criteria to determine if patient harm has occurred in the event:

10.8.2.2.1. May have contributed to or resulted in temporary harm to the patient and required intervention,

10.8.2.2.2. May have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization,

10.8.2.2.3. May have contributed to or resulted in permanent patient harm,

10.8.2.2.4. Required intervention necessary to sustain life,

10.8.2.2.5. May have contributed to or resulted in the patient's death,

10.8.2.2.6. Was an unexpected adverse patient outcome of a member of the armed forces that suggests a potential disability separation or retirement of the member as a result of the outcome, or

10.8.2.2.7. Was an episode of care in which the patient/family communicated angst or raised serious concern about the episode of care.

10.8.2.3. All sentinel events (SEs) (as defined by TJC), adverse events (as defined by AAAHC), never events, unanticipated deaths, and medically-related active duty deaths or disability separations associated with the failure of a healthcare provider to meet the SOC will be considered a PCE and all applicable review activities will apply.

10.8.2.5. PCEs will be investigated by the Risk Management Office and includes the following activities:

10.8.2.5.1. All evidence relevant to the event will be sequestered and maintained by the risk management office, including but not limited to, medical records and telephone consults, radiology reports/exams/films/recordings, fetal monitor strips, ancillary recordings from medical monitoring devices such as anesthesia, cardiac monitors, etc. **Note:** It is critical to sequester medical equipment and recordings immediately following the event. The risk manager and SGH will ensure this process is briefed to all staff annually. (See paragraph 10.8.5. on products liability).

10.8.2.5.2. SGH will ensure appropriate disclosure (see paragraph 10.4.4.) and continuity of care is arranged for the patient.

10.8.2.5.3. Formal QOC review with SOC determination(s) (see Kx RM toolkit for a suggested template) shall be completed by an individual designated by the SGH and be initiated within 30 days of the event. The QOC review summarizes the event of care and contains several subcomponents including: event facts, chronological summary of care, identification of SIPs, determination of the SOC for each SIP, list of references/literature used to establish the SOC, identification of system issues that may have contributed to the event, and proposed recommendations for performance improvement and risk reduction activities as appropriate. The QOC review supports the MTF risk reduction and performance improvement activities and provides the necessary information should litigation result. The MTF RM will coordinate risk reduction and performance improvement activities with the PSM and other quality personnel as appropriate. PCE review procedures are completed within 180 days from event notification.

10.8.2.5.4. The RM will enter the PCE into CCQAS PCE module immediately following the event identification. The event will be entered using the following taxonomy: Base name-PCE- Yr-number. Example: Bolling-PCE-10-01. All data fields shall be completed within the CCQAS PCE module for each PCE. Additionally, the RM will create a file to maintain the paper documents produced for the PCE process since the CCQAS PCE module does not support scanning and uploading paper documents. A certified copy (paper and/or electronic) of the medical records and ancillary reports (X-rays, etc.) will be maintained as part of the PCE file. The PCE file is maintained for 10 years and the CCQAS PCE is a permanent record and is not deleted from the system.

10.8.2.5.5. SIPs should be encouraged to submit a memorandum for record following the event. This facilitates capturing the facts soon after the event. The memorandums are protected IAW Title 10 U.S.C., §1102 and maintained within the risk management PCE file.

10.8.2.5.6. All SIPs (privileged and non-privileged) will have a quality of care (QOC) review with SOC determination completed. The SOC reviews will be arranged by the risk manager and SGH and Senior Corps Representative as required. SOC reviews are completed by peers internal or external to the MTF. The event of care is measured using current standards and the review must articulate how the care met or did not meet the current standards. In some circumstances SOC may be indeterminate due to lack of information such as missing records or lost evidence.

10.8.2.5.6.1. QOC reviews will include at a minimum: summary of the event, provider(s) involvement, provider(s) status, i.e., attending, resident, etc., relevant date/times, care measured against current standards, and system issues that contributed to the event. References used in the review should be cited.

10.8.2.5.6.2. A notification letter and a copy of the SOC determination (reviewer name redacted) is given to the provider to inform them of their involvement in the PCE, their SOC determination, and the PCE process. The SGH and/or other applicable clinical leadership will present the QOC review including SOC determination with the SIP as an opportunity to provide feedback and mentoring, and to discuss the PCE process.

10.8.2.5.7. Any documents produced by the MTF for the PCE file are protected by 10 U.S.C. §1102 and shall be marked accordingly.

10.8.3. SEs are unexpected occurrences involving death or serious physical or psychological injury or risk thereof (TJC definition). The AAAHC uses the term “adverse incident” and defines it as an adverse incident, that at a minimum includes: 1) an unexpected occurrence during a healthcare encounter involving psychological injury or illness, including loss of limb or function, not related to the natural course of the patient’s illness or underlying condition, 2) any process variation for which a recurrence carries a significant chance of a serious adverse outcome, 3) events such as breaches resulting in a negative impact on a patient, even where death or loss of limb or function does not occur.

10.8.3.1. The RM will identify and analyze SEs IAW the PCE procedures; identify SIPs, obtain and secure provider memorandums (if provided), QOC reviews including SOC determinations and contributing system issues, and corrective action plan/performance improvement activities.

10.8.3.2. The QOC reviews will be given to the appropriate leadership (SGH, SGN, SGD, clinical Dept Chiefs, etc.) to be used for feedback and mentoring opportunity with SIPs.

10.8.4. Medical Incident Investigation (MII). (AFRC/SGP Review for Reserve MII.) The primary purpose of a MII is to find out how the system contributed to the adverse outcome by thoroughly investigating the facts in a non-punitive way. The ultimate goal is to learn from the event and improve healthcare by recommending system changes to reduce the risk of recurrence, thereby decreasing harm to patients.

10.8.4.1. The MII will provide a comprehensive, unbiased review of an event by a clinical team external to the MTF. The MII process is focused upon prevention, not punishment, and on improving healthcare processes to prevent recurrence of events.

10.8.4.2. The MII process may be completed in addition to an RCA. The MII and RCA may occur concurrently and there is no mandate to complete one before the other. In addition, if both an RCA and MII are performed on an event, the RCA and MII teams shall not share the findings and recommendations between the teams until both processes are complete. This ensures neither team is biased by the others investigation and conclusions. MIIs are protected from disclosure under 10 U.S.C. §1102 and the Privacy Act of 1974. The MII will not be released to external organizations without permission from the HQ USAF/SG office. Clinical lessons learned are extrapolated from the MII and RCA reports and then may be shared with MTF staff for educational and performance improvement purposes. The MII and RCA reports are not releasable to the MTF staff, the patient, or the patient’s family.

10.8.4.3. The MII will be conducted IAW with this instruction and using the MII toolkit on the Kx at <https://kx.afms.mil/clinicalquality>.

10.8.4.4. The Unit/Wing Commander may order a Command Directed Investigation (CDI) that may be accomplished in parallel with an MII. The purpose of the CDI shall be explained to MTF personnel involved (interviewed). The CDI is not conducted for medical quality assurance purposes; therefore, it is not 10 U.S.C. §1102 protected. The CC will assign an investigating officer to conduct the CDI and the report will be

submitted to the requesting CC. The CDI and MII process and products will remain separate and apart at all times.

10.8.4.5. Major Incidents Suggesting an MII. AFMOA/CC initiates an MII after coordination with the MTF/CC and HQ MAJCOM/SG. The MTF/CC, Inspector General, or the chain of command for the MTF/CC may request AFMOA/CC initiate an MII. The MII will begin within 30 calendar days of the incident. The following incidents may warrant initiation of an MII (list is not all-inclusive):

10.8.4.5.1. Inpatient suicides or active duty member suicides when the member was receiving care in Mental Health Clinic (ADAPT, Family Advocacy Program and/or mental health clinic) or other healthcare setting when under care for related illness/treatment.

10.8.4.5.2. Sentinel events as defined by TJC; adverse events as defined by AAAHC; and "Never events" as described by the National Quality Forum.

10.8.4.5.3. Those incidents where a full objective evaluation cannot be accomplished internally at the organization or base level.

10.8.4.5.4. Incidents with media attention or of a notorious nature, and incidents with high-level interests (i.e., IG complaint).

10.8.4.5.5. Any other event or series of events which either caused, or could cause, injury or death to a person who, in the opinion of the MTF/CC, AFMOA/CC or HQ MAJCOM/SG, will benefit the patient and organization from a formal investigation.

10.8.4.5.6. Those incidents where the findings of such an investigation are likely to be applicable throughout a MAJCOM or on an AFMS-wide basis.

10.8.4.6. Selection of Medical Incident Investigators. AFMOA/CC will select the MII team members and sends the MII team member appointment letters. The following criteria are used to select the medical incident investigator:

10.8.4.6.1. Is not on staff at the MTF where the incident occurred.

10.8.4.6.2. Does not have a personal interest in the investigation, or with the staff involved in the incident, therefore can act objectively.

10.8.4.6.3. Is a competent healthcare professional with appropriate and current clinical or other pertinent experience.

10.8.4.6.4. Performs no other duties during the investigation.

10.8.4.6.5. Board certified is preferred, if applicable.

10.8.4.6.6. Shall have the same or similar AFSC as those personnel involved in the medical incident.

10.8.4.7. MII Process - Roles and Responsibilities.

10.8.4.7.1. The MTF/CC:

10.8.4.7.1.1. Reports medical incidents (of a nature noted above) and consult with AFMOA/CC and HQ MAJCOM/SG to initiate an MII. This will occur within 24 hours of becoming aware of the incident.

10.8.4.7.1.2. Notifies (use event notification form on Kx Clinical Quality website) AFMOA/SGH2, MLC, and Chief, Risk Management Operations within 48 hours of the event/incident and decision to conduct an MII.

10.8.4.7.1.3. Notifies Wing/CC of MII (as appropriate).

10.8.4.7.1.4. Ensures the risk manager initiates PCE procedures and ensures all evidence involved in the incident (medical records, radiographs, medical monitoring device recordings, etc.) is sequestered.

10.8.4.7.1.5. Designates a facility POC for the MII team support (to ensure dedicated office space, equipment and administrative support for report preparation, etc.). This task may be delegated to the organization's Risk Manager.

10.8.4.7.1.6. Ensures involved staff is offered initial or acute post traumatic stress intervention.

10.8.4.7.1.7. Ensures MII team has required space and resources to conduct MII.

10.8.4.7.1.8. Develops and implements a corrective action plan based upon MII report findings and recommendations.

10.8.4.7.1.9. Sends the action plan and response briefing slides to AFMOA/SGH2 and Chief, Risk Management Operations within 15 calendar days of receiving final MII report.

10.8.4.7.1.10. When criminal behavior is suggested, consult the SJA for assistance on advisement of rights (*Uniform Code of Military Justice* (UCMJ), Article 31; or Fifth Amendment to the U.S. Constitution) and/or coordinate with the AF OSI.

10.8.4.7.2. The MTF RM:

10.8.4.7.2.1. Reports event to AFMOA/SGHQ and AFMOA/SGH2, within 48 hours of becoming aware of an incident and MTF/CC decision to conduct an MII (using the AFMOA/SGHQ notification letter template posted on the AFMOA/SGHQ WWW site at <https://kx.afms.mil/clinicalquality>). Event tracking number shall be noted on the notification letter, example AF-Base name-10-001).

10.8.4.7.2.2. Sequesters and secures all relevant medical records, radiographic studies/reports, recordable medical information devices, pertinent MTF/unit operating instructions, and all other evidence pertaining to the incident of care under investigation. The event will be entered into the CCQAS PCE module.

10.8.4.7.2.3. In consultation with the MTF/CC or SGH, notifies the supporting MLC or SJA of any incident that could result in a claim or litigation.

10.8.4.7.2.4. Maintains a copy of the MII report in a secure location at the MTF for a minimum of 10 years (report may be beneficial for JACC if medical malpractice claim is filed).

10.8.4.7.2.5. Ensures all MII documents are marked with 10 U.S.C. §1102, QA protection disclosure statement. Release of the MI beyond the MTF/CC must be

approved by HQ AF/SG office after coordination with HQ AF/SGJ.

10.8.4.7.3. The HQ MAJCOM/SG:

10.8.4.7.3.1. Consults with AFMOA/CC regarding decision to conduct an MII.

10.8.4.7.3.2. Participates in a pre-brief with the MII team, MTF and AFMOA to approve the corrective action plan.

10.8.4.7.3.3. Suggests SG NOTAM and policy changes resulting from the MII findings and recommendations.

10.8.4.7.4. AFMOA/SGH2 and Chief, Risk Management Operations:

10.8.4.7.4.1. Review the facts of the incident and provide consultative support to MTF/CC, HQ MAJCOM/SG and AFMOA/CC regarding decision to conduct an MII.

10.8.4.7.4.2. Work with AFMOA/SGHM (clinical consultants) to identify a multidisciplinary team of investigators external to the MTF to conduct the MII. The MII team of investigators should mirror the disciplines involved in the incident in order to provide the necessary clinical or other expertise. Other disciplines may be beneficial to the investigation (i.e., human performance engineer/expert) and should be considered for the MII team.

10.8.4.7.4.3. Conduct “just-in-time” training for the MII team. The MII team training toolkit is available on the Kx at <https://kx.afms.mil/clinicalquality>.

10.8.4.7.4.4. Support MII team during investigation, process questions, etc.

10.8.4.7.4.5. Assist MII team chief with brief for AFMOA/CC, HQ MAJCOM/SG, and HQ USAF/SG3.

10.8.4.7.4.6. Participate with pre-brief and assist with preparation of response slides for brief to HQ MAJCOM/SG and AFMOA/CC.

10.8.4.7.5. AFMOA/SGH2 prepares appointment letters and sends for AFMOA/CC signature.

10.8.4.7.6. Sends pre-brief and final briefing date notifications to MAJCOM/SG, AFMOA/CC, AFMOA executive assistant, AFMOA/SGHQ, AFMOA/SGH, and relevant clinical consultants.

10.8.4.7.6. Chief, Risk Management Operations:

10.8.4.7.6.1. Collects incident notification report and enters into tracking system.

10.8.4.7.6.2. Coordinates briefing dates with AFMOA/SGH2, ensuring AFMSA/SG3O and HQ USAF/SG3 notification.

10.8.4.7.6.3. Disseminates MII lessons learned to the AFMS through the HQ MAJCOM/SGs, Corps leadership and other relevant offices as appropriate (SGHs, SGNs, SGD, RM, etc.).

10.8.4.7.6.4. Coordinate requests for release or disclosure of an MII report, IAW 10 U.S.C. §1102 and the Privacy Act of 1974.

10.8.4.7.6.5. Chief, Risk Management Operations will archive MII reports for a minimum of 10 years after completion of final MII brief.

10.8.4.7.7. AFMOA/SGHQ, Quality Managers follow-up with MTF to review implementation of the action plan at six months and provide status to AFMOA/SGHQ Chief.

10.8.4.7.8. MII Team Chief:

10.8.4.7.8.1. Provides leadership for the MII team of investigators.

10.8.4.7.8.2. Facilitates a credible and thorough investigation.

10.8.4.7.8.3. Ensures necessary resources are available for MII team to conduct the investigation.

10.8.4.7.8.4. Is the MII team liaison to MTF/CC and Wing Commander (WG/CC). Briefs MTF/ CC (and if requested WG/CC) prior to initiation of and completion of MII.

10.8.4.7.8.5. Prepares a preliminary MII report and brief prior to departure from the MTF.

10.8.4.7.8.6. Briefs the MTF/CC on the investigation findings and recommendations.

10.8.4.7.8.7. If requested, briefs the WG/CC with a summary of the MII findings. This brief is tailored to avoid medical jargon that may be confusing. Emphasize the MII documents, brief, and all information produced by the MII are protected IAW 10 U.S.C. §1102 and are not releasable.

10.8.4.7.8.8. May advise the MTF/CC on the action plan based upon investigation findings.

10.8.4.7.8.9. Completes final MII report within 15 duty days after investigation is complete and provides original for MTF/CC, a copy to AFMOA/SGH2 and a copy to Chief, Risk Management Operations.

10.8.4.7.8.10. Completes draft MII brief within 15 duty days after investigation and then reviews the MII brief with the AFMOA/SGH team in preparation for briefs to AFMOA/CC, HQ MAJCOM/SG, and HQ USAF/SG3.

10.8.4.7.8.11. Coordinates briefs with AFMOA/SGH2 and AFMOA/Chief, Risk Management Operations.

10.8.4.7.8.12. Identifies implications for the AFMS and suggest policy/procedure changes, clinical lessons learned, and NOTAMs.

10.8.4.7.8.13. Possible Criminal Behavior. Notifies MTF/CC if criminal behavior is potentially identified during the investigation process. **Note:** If during an interview information is provided which gives the investigator reason to suspect the interviewee or someone else they are referring to may have committed a criminal offense, STOP the interview and contact the MTF/CC.

10.8.4.7.9. Medical Incident Investigators:

10.8.4.7.9.1. If concerned about the quality of care delivered (acts and omissions), refer their concern to the SGH, who will ensure an appropriate review of the care is conducted.

10.8.4.7.9.2. Complete a credible, thorough and unbiased investigation.

10.8.4.7.9.3. Complete a preliminary MII report before departure from the MTF.

10.8.4.7.9.4. Assist the MII Team Chief to prepare a brief to the MTF/CC with the findings and conclusions of their investigation.

10.8.4.7.9.5. Return all evidence (e.g., medical records, x-rays, equipment) to the MTF/CC (or designated individual) for safeguarding. *EXCEPTION:* In certain cases, especially those involving suspected criminal activity, the applicable law enforcement agency or SJA may maintain some, or all, of the evidence.

10.8.4.7.10. MII Process. Several factors influence the scope of the investigation, including the severity of the injury and the possibility of recurrence. The MII process is best accomplished in a systematic manner determining the sequence of events, contributing or causal factors, and recommending methods to remove or mitigate the contributing factors to prevent recurrence of the incident. The MII process includes the following steps:

10.8.4.7.10.1. Determine the sequence of events; through a review of the medical records and any witness statements; map out the flow of what happened, and when they happened based on their initial understanding of the events. Flow charts can immediately assist the team to decide what additional information is needed and later will assist the team in developing recommendations for PI. Complete initial flow chart of the event with details discovered after review of physical evidence and completion of witness interviews.

10.8.4.7.10.2. Compile physical evidence for review (medical records, laboratory studies, x-rays, EKGs, policies, procedures, emails, etc.).

10.8.4.7.10.3. Conduct witness interviews. Include those involved in the incident, those who saw or heard it, and those whose training and experience qualify them as experts. Witnesses may include: all involved staff, MTF leadership, patient, patient's family members (with their permission), significant others, or friends, co-workers, patient's military chain of command, civilian providers, etc. **Note:** Family, significant others, friends and co-workers may be appropriate witnesses in certain incidents, especially with suicide incidents.

10.8.4.7.10.3.1. It is important to note that the documents/results from the MII are not releasable to the patient and family since the investigation is a medical quality assurance document protected IAW 10 U.S.C. §1102.

10.8.4.7.10.3.2. It is not recommended to record witness interviews. If done, the witness must be informed and consent to the recording. Investigators should annotate relevant facts provided by the witnesses and summarize the interviews in the MII report.

10.8.4.7.10.3.3. Witnesses are not required to testify under oath and are not sworn in. Before performing the interview, the witnesses must be advised on

the purpose of the investigation and the limited confidentiality of their statements. The interview documents are part of the MII report and are protected quality assurance documents IAW 10 U.S.C. §1102.

10.8.4.7.10.3.4. MII team identifies any contributing factors, including human factors (see tools in MII toolkit on knowledge exchange) which may have culminated in the event.

10.8.4.7.10.3.5. Analyze each contributing factor to propose recommendations to prevent recurrence of the event. MII report must be consistent with the findings and not contradict itself.

10.8.4.7.10.3.6. Summarize facts, findings, contributing factors, recommendations, and corrective action plan in the MII report and PowerPoint brief.

10.8.4.7.10.4. Human Factors Analysis. There are many potential human factors that need to be assessed during a MII. In addition to the MII toolkit, the DoD Human Factors Guide (reference, DoDI 6055.7, *Accident Investigation, Reporting, and Record Keeping*) provides information for those who investigate, report, and analyze medical mishaps. This methodology and the tools will be utilized when conducting an MII. Human factors should be considered and addressed in the investigation.

10.8.5. Medical Devices and Products Liability.

10.8.5.1. The Food and Drug Administration Modernization Act (FDAMA) of 1997, amended by the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §321 requires manufacturers track certain devices when the Food and Drug Administration (FDA) orders them to do so. Tracking is intended to facilitate notification and recall in the event a device presents a serious risk to health that requires prompt attention. Each MTF must comply with medical device tracking and reporting IAW these regulations and establish current guidance to demonstrate compliance.

10.8.5.1.1. The FDA has issued orders to manufacturers to track implantable devices and devices used outside a facility and publishes this information in Title 21 Code of Federal Regulations (CFR) Part 821. Tracking records must be maintained for the useful life of the device, even if a patient is lost to follow up. Tracking is no longer required when documentation show that the device is returned, destroyed, explanted, or the patient dies. MTF process must support these tracking requirements (documentation must be maintained to meet regulation requirements).

10.8.5.1.1. 2. Medical Logistics will track life sustaining or life supporting supplies used within and outside the medical facility. Standard Form 380, *Reporting and Processing Medical Materiel Complaints/Quality Improvement Report*, is used for complaints involving medical supplies.

10.8.5.1.1.3. Biomedical Equipment coordinates investigation of medical devices (equipment) with the SGH, MTF RM, PSM, and Medical Logistics. Uses FDA forms and ECRI Computerized Product Reporting system (CPRS) to report medical device information.

10.8.5.1.1.4. MTF will have a forum to provide oversight of the medical device and implant tracking and reporting process, e.g., Facilities and Environment Function.

10.8.5.2. Risk Management Processes: A product liability case can arise from injuries caused by defective medical appliances, equipment, organ transplants, prosthetic devices, surgical implants, surgical equipment, hospital supplies, diagnostic equipment and hearing and visual aids. Any of these products can be the subject of a products liability lawsuit if they cause injury to a patient.

10.8.5.3. The SGH or designee will ensure the investigation and documentation of whether the involved medical devices were used in full compliance of the manufacturers' requirements. It may be necessary to utilize a clinical expert who understands the medical condition the device was intended to improve and the role of the device. In addition to statutory tracking and reporting requirements noted above, this review will be documented in the MTF quality of care review and maintained in the PCE file.

10.8.5.4. In any actual or potential medical device/products liability case, the RM will ensure all evidence (e.g., any medical device, needles, pumps, supplies, drugs, vials) are immediately sequestered and preserved following the event. All equipment and/or medical appliances shall be removed from the clinical area, marked that it is out of service, and preserved for testing by biomedical engineering and the manufacturer. The relevant maintenance documents, purchase orders, and manufacturer's literature shall also be secured for review.

10.8.5.5. When surgical area medical devices and equipment are involved in a medical event (ambulatory surgery, inpatient operating room, etc.) the equipment shall be immediately removed from service and inspected by a qualified government employee (biomedical engineer) to determine whether there was a malfunction or a design flaw, and to decide whether an independent appraisal is necessary. The MTF RM will coordinate with Biomedical Equipment and Logistics. The supplier and manufacturer shall be notified and provided an opportunity to inspect (while supervised by a qualified government employee) the equipment and the actual parts involved. The SJA/legal counsel shall be notified prior to any inspection by government employees, contractor, or supplier employees. The equipment shall not be returned to service prior to inspection. Any parts replaced in the equipment involved shall be secured by the chief of the logistic division for possible evidentiary use. All original maintenance and purchase records shall be secured and photographs taken of the equipment and actual parts involved.

Section 10F—Risk Control and Risk Reduction Strategies

10.9. Risk Control and Risk Reduction. Risk identification is the foundation for safe and effective healthcare. But once the risk is identified, action is necessary to reduce or eliminate that risk. Many existing activities within the delivery of healthcare serve to either reduce or eliminate risk. These include, but are not limited to: policy/procedure review and revision, staff education/training/orientation, team training, patient/family education and biomedical equipment maintenance.

10.9.1. Elements of risk control include but are not limited to:

10.9.1.1. Competency Assessment. See chapter 8 for additional guidance on competency assessment. The MTF must ensure healthcare personnel are clinically current and competent. This is accomplished with an active, ongoing review of clinical performance.

10.9.1.2. Education and Training Activities. The organization shall have a facility and unit orientation program for all staff members, including educating staff on risk identification (e.g., near miss events, potential unsafe medical devices, adverse events), risk assessment (e.g., participation in event analysis, quality of care reviews), and risk control principles and practices.

10.9.1.2.1. Ongoing staff education/in-services should include: equipment training, mock drills (especially emergency-type procedures, high risk/low volume procedures), simulation training.

10.9.1.3. Efforts to improve healthcare team communication; formal team training and patient handover protocols, grand rounds, and patient care conferences.

10.9.1.4. Standardization; developing standard work processes, protocols, and equipment (using the same type of medical device (e.g., IV pump) within an MTF.

10.9.1.5. Checklists (surgery site verification checklist, central line care).

10.9.1.6. Simplification (simplify key work processes, use of flowcharts).

10.9.1.7. Avoid or reduce reliance on memory (procedure algorithms).

10.9.1.8. Forcing functions or constraint functions to avoid error (tubing connections, alarms).

10.9.1.9. Separating “look alike” and “sound alike” medications.

10.9.1.10. Use of evidence-based protocols or current clinical guidelines

10.9.1.11. Adequate medical record keeping; documentation must be legible, timely, accurate, and complete, including but not limited to patient complaint/concern, patient assessment, diagnosis, treatment plan, test results, follow-up strategies, and patient education.

10.9.1.12. Adequate supervision protocols and staff is educated on the protocols.

10.9.1.13. Adequate informed consent process.

10.9.1.14. Focusing care; appropriate resourcing where care is needed most; including appropriate number and type of staff (staff mix to support more junior staff, especially in high-risk clinical areas).

10.9.2. SG NOTAMs and Clinical Quality “Lessons Learned”. A NOTAM will be released to the AFMS by AFMOA/SGHQ as a means of identifying clinical concerns and sharing lessons learned from malpractice claims, adverse actions, MIIs and SEs. A NOTAM may be released for any topic of high interest and broad application within the AFMS and DoD. Upon receipt, the organization risk manager/quality manager will disseminate the NOTAM throughout the facility. The responsibilities for NOTAM generation and dissemination are discussed below. MTF personnel shall review the suggested risk reduction strategies and incorporate quality improvement changes into their current healthcare practice. SG

NOTAM(s) are a medical quality assurance document and are protected IAW 10 U.S.C. §1102, do not release without proper authority (HQ USAF/SG).

10.9.2.1. Responsibilities to develop SG NOTAMs:

10.9.2.1.1. AFMOA/SGHQ:

10.9.2.1.1.1. Reviews malpractice claims, adverse actions, MIIs, SEs, and RCAs to identify lessons learned appropriate for dissemination throughout the AFMS and DoD.

10.9.2.1.1.2. Collaborates with SG Clinical Consultants and other relevant subject matter experts to draft NOTAM.

10.9.2.1.1.3. AFMOA/SGHQ division chief coordinates review of draft NOTAM.

10.9.2.1.1.4. AFMOA/SGHQ division chief coordinates review through chain of command to AFMOA/CC.

10.9.2.1.1.5. AFMOA/CC approves release of NOTAM.

10.9.2.1.1.6. Distributes NOTAM electronically (encrypted) to the DoD Patient Safety Center, NOVA mail group, SGH, SG Clinical Consultants, PS, and RM mail groups.

10.9.2.1.1.7. Posts NOTAM at <https://kx.afms.mil/clinicalquality>.

10.9.2.1.1.8. Risk Management Operations will coordinate annual review of NOTAMS by AF/SG consultants/experts for relevance.

10.9.2.1.1.9. AFMOA/SGHQ representatives will present and discuss AF/SG NOTAMS at the MHS Clinical Quality Forum and forward to the DoD Patient Safety Center.

10.9.2.1.2. MTF RM/Designee.

10.9.2.1.2. 1 Primary point of contact within the organization for NOTAM receipt and dissemination.

10.9.2.1.2.2. Forwards NOTAM to MTF/CC, executive leadership and ensures widest MTF dissemination possible.

10.9.2.1.2.3. Reviews each NOTAM, evaluates risk reduction strategies, updates organizational policy or program, and suggests changes to reduce organization risk, if needed.

10.9.2.1.2.4. Ensures NOTAM is posted in each applicable work area for all staff members to review before rendering patient care. NOTAM review shall be part of the orientation program for new staff.

10.9.2.1.2.5. Maintains a copy of each NOTAM until it is no longer applicable/clinically current, or is superseded by new clinical practice or NOTAM.

10.9.2.1.2.6. Discusses NOTAM at the next ECOMS, Professional Staff meeting, and other forums as appropriate.

10.9.2.2. Dissemination of Clinical Quality Lessons Learned and Advisories. Clinical Quality lessons learned are informal forms of communication for sharing clinical lessons learned. These lessons learned are released from AFMOA/SGHQ for educational purposes. Clinical lessons learned are medical quality assurance documents and are protected IAW 10 U.S.C. §1102, do not release without proper authority (HQ USAF/SG).

10.9.2.2.1. AFMOA/SGHQ will collaborate with SG Clinical Consultants to draft lessons learned.

10.9.2.2.2. AFMOA/SGHQ division chief is approval authority to release clinical lessons learned to the MTFs.

10.9.2.2.3. Lessons learned will be released through functionals; SGH, SGN, PS, RM, and SG Clinical Consultants. Lessons learned will also be released through ECRI and posted on the Kx.

10.9.2.2.4. AFMOA/SGHQ representatives will present and discuss AFMS Clinical Quality Lessons Learned at the MHS Clinical Quality Forum and the DoD Risk Management Committee.

10.9.2.2.5. MTF leadership will include clinical quality lessons learned in educational opportunities to include, but not limited to: staff orientation, ProStaff, ECOMS, Patient Safety, Risk Management and Performance Improvement activities.

10.9.2.2.6. AFMOA/SGHQ will forward to DoD Patient Safety Center.

Section 10G—Management of Medical Malpractice Claims and Feres-Barred Cases; including Medically - Related Active Duty Death, and Disability Cases

10.10. DoD Requirements. Medical malpractice claims, active duty deaths related to alleged substandard healthcare, and disability cases associated with substandard healthcare will be managed in accordance with DoDM 6025.13. Claims of alleged malpractice filed under the Federal Tort Claims Act, the Military Claims Act (AFI 51-501, Tort Claims), the Foreign Claims Act or active duty death or disability payments relating to questionable or substandard healthcare provided by DoD facility or healthcare personnel will be identified, appropriate SOC determinations conducted and review/reporting by the AF/SG as required. These claims and cases are maintained and tracked in the CCQAS RM Module. All claims arising from AF MTFs will be processed by the AFMS, including identification of SIPs, final SOC determinations and reporting as directed by the AF/SG, this includes providers from different DoD services involved in AF claims.

10.10.1. Expert SOC determinations will be accomplished on each SIP.

10.10.1.1. SOC determinations include: SOC met (what the reasonable prudent provider with similar training and experience would do in similar clinical circumstances); SOC not met; or, SOC indeterminate (not enough evidence in the available records/reports/etc.) to determine the standard of care delivered.

10.10.2. DoD is required to report to the NPDB and DPDB when a medical malpractice payment is made on behalf of a healthcare provider for failure to meet an acceptable SOC. Reports shall also include those instances in which a provider's failure to meet the SOC caused or contributed to the death or disability separation of a member of the Uniformed Services.

10.10.3. Upon notification of a medical malpractice payment, AFMOA/SGHQ has 180 calendar days from payment notification date to coordinate AF/SG final SOC determination for all significantly involved provider(s) and submit the required DPDB and NPDB malpractice reports (DoDM 6025.13).

10.10.3.1. If the final AF/SG determinations are not made within 180 calendar days of payment notification, AF/SG is to report all SIPs to the DPDB and NPDB for the payment.

10.10.3.1.1. If at a later date the final SOC determination finds any of the provider(s) met the SOC, an amendment will be submitted to the DPDB and NPDB for those reports.

10.10.3.2. Upon notification of an AD death (death benefit payment) or disability payment, AFMOA/SGHQ has 180 calendar days from payment notification date to coordinate AF/SG final SOC determination for all SIP(s).

10.10.3.2.1. If the final AF/SG determinations are not made within 180 calendar days of payment notification, AF/SG is to report all significantly involved providers to the DPDB and NPDB for the payment.

10.10.3.2.1.1. If at a later date the final SOC determination finds any of the provider(s) met the SOC, an amendment will be submitted to the DPDB and NPDB for those reports.

10.11. Roles and Responsibilities for Management of Malpractice Claims, Medically-Related AD Deaths, and Disability Cases.

10.11.1. MTF/CC or Designee:

10.11.1.1. Provides oversight and guidance regarding the management of medical malpractice claims, medically-related AD death and disability cases.

10.11.1.2. For providers currently assigned to the MTF, the Commander or designee will ensure these providers are personally contacted (verbal discussion) to explain their involvement in the claim, death or disability case and their standard of care determination(s).

10.11.1.3. If involved providers have been reassigned to a different MTF, the current Commander will direct the claim/case information including the involved providers and their SOC determinations is forwarded to the new facility RM office. The new Commander will ensure the providers are personally contacted for a discussion regarding their involvement in the claim /case and their SOC determinations.

10.11.1.4. For providers who have retired, separated, or ended affiliation with the AFMS, the MTF/CC will ensure a certified or return receipt letter is sent to the last known address to provide this notification.

10.11.2. SGH or Designee:

10.11.2.1. Facilitates identification of SIPs in the allegation of the claim (noted on the SF 95, *Claim for Damage, Injury, Death*) or in medically-related active duty death or disability cases.

10.11.2.1.1. May consult with functional experts (Flight/CC, Department Chairs, SGN) to facilitate this process.

10.11.2.2. Coordinates personal and written notification to all SIP(s) with the RM (see Attachment 25).

10.11.2.3. Mentors SIPs regarding the clinical issues and reviews the medical malpractice claim, and medically-related AD death/disability case process within the AFMS and DoD.

10.11.2.4. Ensures that each MEB referred to a PEB (related to alleged substandard healthcare) has a QOC review completed.

10.11.2.5. Ensures each medically-related AD death case (related to alleged substandard healthcare) has a QOC review completed.

10.11.2.6. Reviews the MTF QOC performed on each claim and case for adequacy, lessons learned, system issues, and opportunities to improve the delivery of healthcare. In addition, reviews at ECOMS.

10.11.2.7. Reviews PCE and medical malpractice data and lessons learned at professional staff meetings.

10.11.2.8. Informs MTF/CC if a provider has more than two paid claims in which the provider failed to meet an acceptable SOC. This information shall be used within the MTF OPPE (see paragraph 8.9.) process to monitor the provider's performance.

10.11.3. MTF RM/Designee:

10.11.3.1. When notified of a malpractice claim, processes the claim as outlined in paragraph 10.13.

10.11.3.2. Enters claim, active duty death and disability cases into CCQAS and maintains all relevant RM files.

10.11.3.3. Secures, sequesters and prepares documentation required to process claims.

10.11.3.4. Ensures a QOC review with SOC determinations is completed. The QOC review is to be completed within 30 days of malpractice claim notification, medically-related AD death case, or upon a case referral from the MEB. If the QOC review with SOC determinations were previously completed for the PCE process, it is not necessary to repeat. SOC and peer review reports are confidential QA records protected by 10 U.S.C. §1102. The reports may be used and disclosed only as authorized therein.

10.11.3.5. Notifies all SIPs of their involvement in the medical malpractice claim, medically-related AD death or disability case. Written and/when feasible, verbal notifications are provided to each SIP (see Attachment 25).

10.11.3.6. Provides all SIPs a redacted copy of the relevant expert SOC determinations. **Note:** The SOC reviews will be redacted to protect the identity of the reviewer.

10.11.3.7. Facilitates submittal of SIPs written response. (See attachment 26.) If the SOC reviewer determined "SOC not met", the SIPs shall be provided an opportunity to respond in writing to this adverse expert review. If the MLB did not request an expert "peer" review on all SIPs, but expert reviews were accomplished that addressed the care

in toto; the SIPs shall be provided a redacted copy of each expert review that is relevant to them. If the claim requires review by the MPRB (payments and standard of care not met determinations); all SIPs will have an expert peer review completed for presentation to the MPRB. SIP written responses shall be forwarded to the MTF risk management office and then it is forwarded to AFMOA/SGHQ, Chief, Risk Management Operations.

10.11.3.8. The RM will transmit the providers' intent to respond, by facsimile or scanned in e-mail, to AFMOA/SGHQ within 5 calendar days after receipt of the providers' letter of intent. The original letter is maintained in the claim file. If the provider requires more time to submit a response, he/she may contact the MTF risk manager and/or AFMOA/SGHQ, Risk Management Operations to request an extension. Extensions will be granted for good cause. **Note:** If the provider elects not to respond to the claim, AFMOA/SGHQ will proceed with the clinical review process via the MPRB following final legal closure.

10.11.3.9. Prints the final DD Form 2526 from CCQAS or prepares a hard copy on each SIP and forwards final claim documentation to each SIP.

10.11.3.10. Compares all cases referred from the MEB (SOC not met or indeterminate) with the cases provided by the PEBLO (disability payments-separations/retirements) in which a disability award has been granted (see paragraph 10.11.4.) and forwards the case documents (MTF QOC review, SOC reviews for all SIPs, relevant medical records) to AFMOA/SGHQ for review by the MPRB.

10.11.3.11. Briefs MTF/CC, executive staff and ECOMS on open/pending medical malpractice claims and medically-related AD deaths/disability cases, including SOC findings, identified system issues, and clinical lessons learned (at least semi-annually).

10.11.3.12. Reviews lessons learned, system problems, and incorporates this information into patient safety, performance improvement, and risk management activities.

10.11.4. Physical Evaluation Board Liaison Officer (PEBLO): The MTF PEBLO will immediately forward to the MTF RM all PEB determinations resulting in separation or retirement of the member due to physical disability.

10.11.5. SIPs:

10.11.5.1. The SIP will provide current and/or future contact information (address, phone numbers, email) with the MTF RM and CM to ensure the MTF may communicate with the SIP regarding the status and outcome of each claim/case.

10.11.5.2. SIPs must notify the MTF/CC, in writing, of their intent to respond, within 10 calendar days of notification of SOC determination, and may do so by endorsing the SOC notification letter. Providers have 30 calendar days to submit their response. Providers may request copies of applicable medical records, monitoring strips, etc., needed to formulate a response to the SOC. These records will be supplied by the relevant MTF.

10.11.5.3. Right to Notification. The MTF/CC or designee and MTF risk manager will make reasonable attempts to ensure all SIPs are informed of the status of a claim/case in which they are significantly involved. Provider notifications should be accomplished at the following intervals:

10.11.5.3.1. Upon identification and involvement in a potentially compensable event (see Attachment 24).

10.11.5.3.2. When a malpractice claim is filed, or a medically-related active duty death or disability case is identified and the provider is identified as SIP (see Attachment 25).

10.11.5.3.3. When a SOC not met determination is sent to the MTF risk manager (see Attachment 26).

10.11.5.3.4. Notification of Final Outcome. The MTF/CC or designee will notify providers of the final outcome of malpractice claims and active duty death/disability cases. AFMOA/SGHQ will forward malpractice claim, and active duty death/disability case closure documents to the MTF risk manager. Closed claims/cases will be captured in CCQAS, and when required, AFMOA/SGHQ will forward paper documents to the MTF risk manager.

10.11.5.4. SIPs shall be provided an opportunity to respond in writing when the expert review determined "SOC not met". If the MLB did not request an expert "peer" review on all SIPs, but expert reviews were accomplished that addressed the care in toto; the SIPs shall be provided a redacted copy of each expert review that is relevant to them. If the claim requires review by the Medical Practice Review Board (payments and SOC not met determinations); all SIPs will have an expert peer review completed for presentation to the MPRB. SIP written responses shall be forwarded to the MTF RM office and then it is forwarded to AFMOA/SGHQ, Chief, Risk Management Operations.

10.11.6. Base Legal Office:

10.11.6.1. Appoints a JAG or AF civilian attorney as a nonvoting member of the appropriate MTF forum for review of risk management activities (e.g., ECOMS, MTF RM Committee).

10.11.6.2. Investigates each claim arising outside the 50 states IAW AFI 51-501, *Tort Claims*.

10.11.7. Medical Law Branch (MLB), AFLOA/JACC (CONUS claims/cases), and Base Legal Offices (outside the 50 states) Responsibilities:

10.11.7.1. Notifies the MTF RM of all newly filed medical malpractice claims and sends an electronic copy of each SF 95 to the MTF RM.

10.11.7.2. Investigates each claim and assist MTF RM with malpractice claim management.

10.11.7.3. Notifies MTF RM when additional documents/interviews, etc. are needed for legal proceedings.

10.11.7.4. Notifies the MTF RM of legal outcome of claims.

10.11.8. MLB, AFLOA/JACC:

10.11.8.1. Contacts Expert Review Manager (ERM) at AFMOA/SGHQ to coordinate necessary expert reviews for each claim. Provides ERM feedback when expert reviews

are of poor quality. ERM will forward this feedback to SGHQ Division Chief and the appropriate clinical consultant.

10.11.8.2. Provides completed expert review and appropriate documentation on closed claims and litigation to AFMOA/SGHQ, Risk Management Operations.

10.11.8.3. Reports all closed claims and litigation results to AFMOA/SGHQ monthly. Reports will include claim name, claim number, amount paid, date of payment, and type of settlement. For cases that result in litigation, when possible, provide Assistant United States Attorney documents that demonstrate SOC determinations and reasons for payment.

10.11.8.4. Responds to requests for additional information from AFMOA/SGHQ regarding settlement of a malpractice claim.

10.11.9. AFMOA/SGHQ ERM:

10.11.9.1. Coordinates all expert reviews for AFMS medical malpractice claims, as requested by MLB/JACC attorneys.

10.11.9.2. Assists AFMOA/SGHQ to obtain expert peer reviews for medically-related death and disability cases in preparation for review by the MPRB.

10.11.9.3. Maintains current list of AFMS clinical consultants and expert peer reviewers.

10.11.9.4. Coordinates and tracks requests for expert reviews from the MLB, AFLOA/JACC.

10.11.9.5. Contacts expert reviewers in coordination with the appropriate clinical consultant and establishes a suspense date for the review (45 days from receipt of all necessary documents).

10.11.9.6. Provides the MLB with the expert reviewer(s) contact information; MLB forwards the necessary claim documentation to the expert peer reviewer.

10.11.9.7. ERM monitors each claim to ensure the expert reviews are completed by the suspense date. If the expert peer reviewer cannot complete the review by the suspense date, ERM will contact a different expert reviewer and set a new suspense date in coordination with the MLB/JACC.

10.11.9.8. Notifies Chief, Risk Management Operations and appropriate clinical consultant when expert reviewers are unable to complete the reviews by suspense date since this may compromise the legal adjudication of the claim.

10.11.10. Expert Medical Reviewer(s):

10.11.10.1. Completes expert review within 45 days of receipt of all necessary documents (medical records, ancillary records, i.e., X-rays, monitor strips, etc.).

10.11.10.2. Prepares written expert review(s) based upon available evidence and SOC's applicable at the time of the incident. Cites relevant professional standards and literature to support their SOC determination.

10.11.10.3. Identifies SIPs by name, renders SOC determinations on each SIP with supporting literature/justification, and identifies system problems and opportunities to improve care (lessons learned).

10.11.10.4. Validates the SIPs identified by the MTF, identifies SIPs based upon their review (which may differ from the MTF or other peer reviews), and renders SOC determination on each SIP.

10.11.10.5. Prepares a written review according to format requested by the MLB (See template for review posted in the Kx RM toolkit). The expert peer review will be identified as a medical quality assurance document protected from release IAW 10 U.S.C. §1102.

10.11.10.6. Sends SOC written report to the MLB by suspense date. If unable to meet the suspense date, the reviewer must coordinate an extension with the MLB/ERM prior to suspense date.

10.11.11. AFMOA/SGHQ:

10.11.11.1. Chief, Risk Management Operations will provide oversight and daily guidance for malpractice claims, medically-related active duty death and disability cases.

10.11.11.2. Chief, Risk Management Operations maintains malpractice claim, medically-related active duty death/disability case data using the CCQAS RM module.

10.11.11.3. Risk Management Operations releases all AFMS malpractice data to AFIP, Department of Legal Medicine, and DoD Risk Management Committee as required.

10.11.11.4. Chief, Clinical Quality Management Division (AFMOA/SGHQ) establishes criteria for expert medical reviewer(s). At a minimum, expert peer reviewers should have a minimum of four years AD time, 4 years experience in clinical specialty, currently practicing in the clinical specialty, and preferred to have board certification/national certification.

10.11.11.5. AFMOA/SGHQ convenes the MPRB, which is chartered to review all paid medical malpractice (FTCA, MCA) claims, disability cases, and active duty death cases when the SOC's were not met (as determined by either Air Force expert peer reviews or external civilian expert peer review).

10.11.11.6. Risk Management Operations provides final claim/case information to SIPs, MTF RM (and other MTF personnel as required), and other entities appropriate to obtain malpractice claim (10 U.S.C. §1102) information (such as, State Medical/Dental/Nursing Boards, privileging entities, malpractice insurance carriers, FSMB).

10.11.11.7. Provides medical malpractice claim histories on AFMS healthcare professionals upon request (to State licensing agencies, credentialing agencies, and liability carriers as appropriate).

10.12. Disability Case Process:

10.12.1. The MTF MEB will utilize the SOC Worksheet (see Kx RM toolkit) and make an initial SOC determination for all MEB cases referred to the PEB. If the clinical expertise to make a SOC determination is not available within the MTF, the SGH may refer the case to an external reviewer (may consult with AFMOA/SGHQ to coordinate the external SOC review).

The SOC determination will be documented on the worksheet, and filed in the Risk Manager's office.

10.12.2. The SOC review will focus on conditions that may result in PEB determination to separate or retire the member due to a disability associated with or aggravated by substandard medical care.

10.12.3. If the SOC is other than "met," the case will be marked "deferred" on the Worksheet and referred to a peer for a formal QOC with SOC review. Forward the case to AFMOA/SGHQ, who will coordinate the formal SOC review.

10.12.4. If the MEB case has a SOC determination other than "met," the MTF will deem it a PCE, and all PCE procedures apply.

10.12.5. All MEBs with a SOC "not met," "indeterminate" or "deferred" will be referred to the MTF RM for immediate entry into CCQAS PCE module and will be sequentially numbered using MEB-Base name-10-01; MEB-Base name-10-02, etc. in the PCE Name field.

10.12.6. MEBs with a SOC "not met," "indeterminate" or "deferred" will also be reviewed by the ECOMS.

10.12.7. The MTF RM will enter the SOC determinations into the CCQAS PCE module and generate a DD Form 2526 (hard copy since CCQAS will not generate a DD Form 2526 from the PCE or disability module) for each SIP in the medically-related disability/death case.

10.12.8. The MTF PEBLO will provide all PEB determinations resulting in separation or retirement of the member due to physical disability to the MTF RM.

10.12.9. The MTF RM will then compare the PEBLO cases to the list of cases MEB referred for SOC not met, indeterminate, or deferred. The MTF will then forward these cases with disability payment information (or death benefit payment information) to AFMOA/SGHQ, Risk Management Operations for the formal clinical review process via the MPRB.

10.12.10. The MTF RM will scan all medical records relevant to the disability condition under review and forward the CD-ROM of the certified copy of the medical record, the MTF QOC review(s) with SOC determinations and any SOC response from the SIP(s) to AFMOA/SGHQ, Risk Management Operations. **Note:** like malpractice claims, all SIPs are offered an opportunity to respond to SOC not met/SOC indeterminate determinations.

10.12.11. AFMOA/SGHQ, Risk Management Operations will coordinate expert peer review(s) and have each case presented to the MPRB for final SOC recommendation to the AF/SG.

10.12.12. AFMOA/SGHQ, Risk Management Operations reports to DPDB and NPDB as directed by the AF/SG; when it is determined the disability/death payment was made for the provider's failure to meet the SOC, which caused or contributed to the death or disability.

10.12.13. If not completed within 180 days of disability payment notification, cases will be forwarded for reporting to the DPDB and NPDB as required. If at a later date the final SOC determination finds any of the provider(s) met the SOC, an amendment will be submitted to the DPDB and NPDB.

10.12.14. In cases where probable disability payment will be invoked at a later time (member was injured as a result of substandard care yet desires to remain on active duty) and after the SOC reviews are completed and the AF/SG has determined that the SOC was not met, the AF/SG will direct reporting to the DPDB and NPDB other compensation program and financial payments made during the first year following the adverse event which resulted in injury to the member. The payments may include, but are not limited to: medical care, supplemental care costs, rehabilitative care, associated handicap provisions (wheelchairs, prosthetic devices, home renovations, etc.), transportation costs, etc. These payments are related to the malpractice event.

10.12.15. AFMOA/SGHQ, Risk Management Operations will forward case closure documentation to the MTF RM who will ensure each SIP is provided a copy of relevant documents, including their final DD Form 2526.

10.13. Processing Medical Malpractice Claims.

10.13.1. If not completed as part of the PCE process, when the MTF RM is notified of a medical malpractice claim, the MTF RM secures all medical records, evidence, documents (i.e., operating instructions, etc.), malfunctioning medical equipment and all ancillary records (radiology films, EKGs, monitoring equipment recordings, fetal monitor strips, etc.) involved in the incident of care that gave rise to the claim. **Note:** A certified copy of the medical records is sequestered; the original medical records remain in the medical record section for appointment availability.

10.13.2. The medical records will be copied, numbered and then scanned onto CD-ROM (label CD with 10 U.S.C. §1102, HIPAA, and Privacy Act protection statements) for legal adjudication and clinical quality review processes as follows:

10.13.2.1. For outpatient records, number the pages on the bottom right hand side from the earliest entry to the latest (most current) before copying and scanning the record.

10.13.2.2. For inpatient records, number the pages on the bottom right hand side, from the latest (most current) entry to the earliest before copying and scanning the record. (This numbering is opposite from the outpatient record.)

10.13.3. MTF RM organizes a QOC review with SOC determinations on every medical malpractice claim, medically-related AD death, and referred disability case (if not completed for the PCE process) to identify lessons learned, opportunities to improve care, and examine the systems, processes, and factors leading to the claim/case outcome.

10.13.4. MTF RM or designee notifies all SIPs of their involvement in the medical malpractice claim, medically-related AD death or disability case. Written and/or verbal notifications are provided to each involved provider and include the following information:

10.13.4.1. The initial determination that a provider is significantly involved.

10.13.4.2. Preliminary QOC review with SOC determinations made by the MTF.

10.13.4.3. Redacted expert reviews done for the attorneys adjudicating the claim, when completed.

10.13.4.4. Provider's right to respond to any adverse SOC determination.

10.13.4.5. Final legal and clinical SOC determinations for each malpractice claim.

10.13.4.6. Maintains current and/or future SIP contact information to facilitate communication regarding the status of the claim/cases(s).

10.13.5. The RM ensures SIPs have access to certified copies of relevant medical records and documents for review as needed to prepare responses to SOC determination(s). A hand receipt shall be accomplished to ensure the records/documentation is returned to the risk management office.

10.13.6. The MTF RM enters malpractice claims into the CCQAS risk management claim module, medically-related active duty death cases are entered into the PCE module, and referred disability cases are entered into the disability module. Provider information is populated in CCQAS to produce a DD Form 2526 on all SIPs (including residents determined significantly involved). Note: CCQAS will not generate electronic DD Form 2526 from the PCE and disability modules.

10.13.6.1. Maintain data within CCQAS on medical malpractice claims to include, but not limited to: claimant(s) name, claim number, list all SIPs and their demographic information, SOC determinations for all SIPs, legal outcome, date of closure, system issues, and lessons learned.

10.13.7. The MTF RM releases the CCQAS malpractice claim to AFMOA/SGHQ, service level within 30 days after receipt of the redacted expert review(s) and MTF processes are complete (QOC with SOC determinations completed, SIPs notified, redacted expert reviews provided, and all mandatory CCQAS data fields are complete).

10.13.8. The MTF RM submits requested documents and evidence to the MLB at AFLOA/JACC or, for claims arising outside the 50 states, to the base legal office. These documents shall be scanned on a CD-ROM and include (but are not limited to):

10.13.8.1. MTF QOC review to include SOC determinations on significantly involved provider(s), also include any medical literature used to support the standard of care determinations.

10.13.8.2. List of significantly involved providers and their SOC reviews.

10.13.8.3. DD Form 2526 on each significantly involved provider.

10.13.8.4. Provider statement or memorandum for record (if submitted).

10.13.8.5. Witness locator list (to include a permanent address, phone number, DEROS and/or separation date, if applicable).

10.13.8.6. Applicable medical records and relevant evidence (staff schedules, on-call schedules, radiology films, consultation reports, etc), and relevant wing/medical group instructions, policies, and/or protocols.

10.13.9. AFLOA/JACC will notify AFMOA/SGHQ, Risk Management Operations of final legal outcomes/settlements when received.

10.13.10. MPRB Review Process. The MPRB reviews all SIPs by expert peer review. Following deliberations, the MPRB forwards SOC, DPDB, and NPDB reporting recommendations to the AF/SG. The AF/SG has final authority for SOC determination and reporting to the DPDB, NPDB, and other official agencies. AFMOA/SGHQ, Risk

Management Operations will make reports to the DPDB, NPDB, and state regulatory agencies at the direction of the AF/SG.

10.13.10.1. For each claim/case the MPRB will identify system issues, clinical lessons learned, and suggest policy initiatives, and clinical NOTAMS. This information will be sent to the MTF RM via closure documents.

10.13.10.2. If MPRB determines a provider is not significantly involved in a claim, the provider will be removed from the claim, all documents (DD Form 2526, etc.) are destroyed and the provider is removed from the claim file in CCQAS. The MTF RM will be informed when a provider is removed, and will delete the document from the electronic PCF or destroy the paper DD Form 2526 if one was generated. The MTF RM will then notify the provider he/she has been removed from the claim.

10.13.11. AFMOA/SGHQ, Risk Management Operations communicates final SOC determination and claim status via CCQAS Risk Management Claims Management Module to the MTF RM.

10.13.12. AFMOA/SGHQ, Risk Management Operations reports to the DPDB and NPDB as directed by the AF/SG when the AF/SG determines the disability/death payment was made on behalf of the provider who fails to meet SOC.

10.14. Management of SOC Indeterminate in Paid Malpractice Claims, and Medically-Related AD Death or Disability Cases. If the expert review of the claim/case finds SOC indeterminate for a provider, AFMOA/SGHQ, Risk Management Operations will attempt to obtain necessary documents (i.e., medical records, radiographs, etc.) to facilitate the expert peer review. However, if SOC is indeterminate due to unavailable medical records or other relevant evidence, this claim will be reviewed by the MPRB. If the MPRB concurs the SOC cannot be determined, then a SOC indeterminate will be the final SOC recommendation to the AF/SG. SOC indeterminate findings are not reported to the DPDB, NPDB, or other regulatory agencies.

10.15. External Agency (Civilian) Review of Medical Malpractice Claims.

10.15.1. AFMOA/SGHQ, Risk Management Operations will forward a copy of each paid malpractice claim and Medically-Related AD deaths/disability cases when the SOC determination is deemed to be met or a system problem is identified (no individual breaches in the SOC identified), to an external agency for review IAW DoD 6025.13-R.

10.15.2. AFMOA/SGHQ, Risk Management Operations will receive a written report from the external agency with a SOC determination on each SIP. If the SOC is determined not met by any individual provider(s), the provider(s) will be contacted by AFMOA/SGHQ, Risk Management Operations and afforded an opportunity to respond to this SOC determination, as outlined in paragraph 10.11.5.4.

10.15.3. Any medical malpractice claim, Medically-Related AD death/disability case, with SOC not met determinations; will be processed through the MPRB. The AF/SG will review the MPRB recommendations and render the final decision on SOC determination and direct reporting to the DPDB, NPDB, and other regulatory agencies as appropriate.

10.16. Management of DD Form 2526 and Case Closure Documents:

10.16.1. AFMOA/SGHQ, Risk Management Operations will annotate claim status and final SOC determination on the DD Form 2526. The completed form is available for the MTF RM

to download from the letters within the CCQAS RM module (not available from the PCE and disability sub-modules). Additionally, the final expert SOC reviews, closure documents, and lessons learned will be forwarded to the MTF RM.

10.16.2. The MTF RM or designee will inform the SIPs of the final SOC determination, the claim outcome, and provide them a copy of their final DD Form 2526. The DD Form 2526 will be sent, by certified mail, to last known address, if the provider has left employment with the Air Force. If the SIP has changed permanent stations, the current MTF RM will be responsible for sending the closure documents to the new MTF RM at the appropriate base. If the MTF is unable to locate the provider, notify AFMOA/SGHQ, Risk Management Operations for assistance with this notification process.

10.16.3. The MTF RM will ensure the DD Form 2526 is uploaded to the provider's electronic PCF. Non-privileged healthcare professional's DD Form 2526 will be maintained in a folder by the MTF RM in a secure location (this file will be regulated like the PCF is for the privileged provider).

10.16.4. For residents, a copy of the DD Form 2526 will be maintained in the training folder and a copy forwarded to the residency program director. If the resident has completed the residency program and PCS'd as a privileged provider, a copy of the DD Form 2526 will be forwarded to the gaining MTF for placement in the electronic PCF.

10.16.5. Providers found to be not significantly involved by the AF/SG shall be notified that they have been removed from the claim. MTF RM will ensure the credentials office is notified and the DD Form 2526 is removed from the provider's electronic credential file (or an appropriate folder for non-privileged providers). Providers are not obligated to report claims in which they have been found not significantly involved. Both the electronic PCF and CCQAS files will be revised to remove this claim information.

10.16.6. The MTF medical malpractice claim, medically-related AD death, and disability payment case documentation shall be maintained for a minimum of ten years after closure (medical records are returned to medical records administration circulation after the claim/case is closed). Maintaining claims/cases is necessary for future responses to claim histories for healthcare providers. After that time period, the claim/case documentation will be shredded. AFMOA/SGHQ, Risk Management Operations will archive a complete copy of the claim/case.

10.17. NPDB, DPDB, and Regulatory Agency Reporting.

10.17.1. The AF/SG has sole responsibility for reporting malpractice claims, medically-related AD death, and disability cases to the DPDB, NPDB, State Licensing Boards, and other regulatory agencies. Malpractice claim cases are also reported to the NPDB for all privileged and non-privileged SIPs found not to meet the SOC. By law, claims under the FTCA and MCA are brought against the United States and not individual providers within the AFMS. Due to these unique legal circumstances, DoD identifies SIPs and makes SOC determinations for those providers, before reports are made to the DPDB and NPDB as outlined in the formal agreement with Department of Health and Human Services. Reporting to the DPDB and NPDB applies to physicians, dentists, nurses and other healthcare providers who are required to possess a state license, registration, or certification to perform patient care duties or anyone who holds themselves out to be authorized to deliver healthcare.

10.17.2. All healthcare workers reported to the DPDB and NPDB will be notified by AFMOA/SGHQ, Risk Management Operations of the report and will receive a copy of a report from the NPDB. The MTF will also obtain and maintain a copy of the NPDB report in the appropriate file (PCF or secured risk management file for the non-privileged provider). The NPDB report is also annotated in CCQAS credentials file and risk management module (DPDB).

10.18. Reports to State Boards of Licensure. In every malpractice claim or medically-related active death/disability case, when a report is sent to the DPDB and NPDB, a duplicate report is sent to the individual's state board(s) of licensure. Only AFMOA/SGHQ may make a report to a state board of licensure, unless it specifically delegates that authority in specified circumstances.

10.19. Reporting Healthcare Trainees and Clinical Supervisors to the NPDB. A healthcare trainee is defined as any resident, intern, or other healthcare provider in a formal healthcare training status. In malpractice claims that involve residents, both the healthcare trainees and their respective clinical supervisor may be identified as SIPs. Therefore, both healthcare trainees and clinical supervisors are afforded a right to respond to the claim. The following guidance will be used in determining DPDB and NPDB reporting of these providers.

10.19.1. If the AF/SG determines that a payment was made on behalf of a healthcare trainee, and the SOC was not met, the attending provider responsible for the care delivered will be reported to the DPDB and NPDB. In such cases, the trainee will not be reported.

10.19.2. If the AF/SG makes a specific finding that the attending provider clearly met all reasonable standards of supervision and the trainee's act or omission was outside their scope of practice, and the care did not meet standards and was not reasonably foreseeable by the attending practitioner, then the trainee (not the attending practitioner) will be reported to the DPDB and NPDB.

10.20. MTF Actions When Providers Separate While a Medical Malpractice Claim, Medically-Related AD Death/Disability Case is Under Review:

10.20.1. Separating providers, privileged or non-privileged, with medical malpractice claims or medically-related AD death/ disability cases pending must provide the RM/CM with a permanent address (home of record), phone number, and all active/inactive state license numbers. This information shall be maintained in CCQAS and/or other credentials/risk management files.

10.20.2. If the base closes under BRAC, the MTF/CC or designee must ensure the entire claim file is sent to AFMOA/SGHQ, Risk Management Operations with the current address, phone number, and states of licensure of the healthcare worker.

10.21. Provider Responsibility for Notifying Future Employers of Malpractice Claims. Regardless of the outcome of a malpractice claim SOC determination, healthcare providers must disclose involvement in malpractice claims, as required by licensing or clinical privileging entities and any professional liability carrier with whom they have personal liability coverage. Although claims are filed against the government under the FTCA and MCA, and not against individual providers, a provider may be required to disclose that he or she was significantly involved in a claim(s) filed against the USAF.

10.22. Non-Personal Services Contract Providers. AF/SG has no authority to report these providers to the NPDB for malpractice claims payment since they are independent contractors and not DoD employees. The AF does not provide liability insurance coverage for non-personal contract providers and, therefore, has no jurisdiction regarding NPDB reporting for medical malpractice payments. These providers will be afforded the same rights to be notified of involvement in malpractice claims made against the Air Force, including the right to respond to AFMOA/SGHQ regarding an adverse SOC determination. AFMOA/SGHQ will notify the MTF/CC and RM of the final SOC determination made on non-personal services contract providers. The MTF/CC or designee will notify the Quality Assurance Personnel assigned to the contract and the base contracting office IAW the provisions of the contract.

10.23. Air Force Medical Residents Working in Civilian/Department of Veteran Affairs (VA) Institutions. Liability for residents working in civilian or VA institutions is governed by AFI 44-108, *Training Affiliation Agreements*. Most of these agreements direct that the other federal or civilian institution provide liability coverage for Air Force medical residents. If an Air Force medical resident is involved in a malpractice claim and the civilian or VA institution pays a claim on his or her behalf, then the medical resident is subject to the civilian or VA institution's procedures regarding NPDB reporting. The guidelines used by these agencies may differ from AF procedures related to NPDB reporting.

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Air Force Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Fifth Amendment

Freedom of Information Act

Floyd D. Spence National Defense Authorization Act for Fiscal Year 2002, Sections 742 and 754

Privacy Act of 1974 (As implemented by AFI 33-332, *Air Force Privacy Act Program*)

Title 5, United States Code, Section 5757, enacted by section 1112 of the National Defense Authorization Act for Fiscal Year 2002.

Title 10, United States Code, Section 1094, *Licensure requirement for health-care professionals*

Title 10, United States Code, Section 1096, *Military-civilian health services partnership program*

Title 10, United States Code, Section 1102, *Confidentiality of medical quality assurance records: qualified immunity for participants*

Title 10, United States Code, Section 8013, *Secretary of the Air Force*

21 Code of Federal Regulations (CFR), Part 900

Uniform Code of Military Justice (UCMJ), Article 31

DoD Patient Safety Handbook, latest edition

DoD 6025.13-R, *Clinical Quality Management Program (CQMP) in the Military Health Services System (MHS)*, 4 May 04

DoDI 1100.21, *Voluntary Services in the Department of Defense*, 11 Mar 02

DoDI 6025.16, *Portability of State Licensure for Health Care Professionals*, 31 Aug 00 (cancelled by DoD 6025.13-R)

DoDI 1402.5, *Criminal History Background Checks on Individuals in Child Care Services*, 19 Jan 93

DoDI 5200.40, *DoD Information Technology Security Certification and Accreditation Process (DITSCAP)*, 30 Dec 97

DoDI 5505.12, *Anti-Fraud Programs at Military Treatment Facilities*

AFPD 44-1, *Medical Operations*

AFPD 90-9, *Operational Risk Management*

AFI 33-332, *Privacy Act Program*

AFI 36-704, *Discipline and Adverse Actions*

AFI 36-815, *Absence and Leave*, 5 Sep 02

AFI 36-2005, Appointment in Commissioned Grades and Designation and Assignment in Professional Categories--Reserve of the Air Force and United States Air Force

AFI 36-2101, Classifying Military Personnel (Officer and Enlisted)

AFMAN 36-2105, Officer Classification

AFI 36-2201 V1-6, Air Force Training Program

AFI 36-2406, Officer and Enlisted Evaluation Systems

AFI 36-2856, Medical Service Award

AFI 36-3206, Administrative Discharge Procedures for Commissioned Officers

AFI 36-3207, Separating Commissioned Officers

AFI 36-3209, Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members

AFMAN 33-363, Management of Records

AFI 38-202, Air Force Management Headquarters and Headquarters Support Activities

AFI 41-104, Professional Board and National Certification Examinations

AFI 41-108, Training Affiliation Agreement Program

AFI 41-109, Special Pay for Health Professionals

AFI 41-115, Authorized Health Care and Health Care Benefits in the Military Health System (MHS)

AFI 41-117, Medical Service Officer Education

AFI 41-117 ANG SUP1, Medical Service Officer Education, Air National Guard

AFI 41-209, Medical Logistics Support

AFI 44-102, Medical Care Management (Title Changed from Community Health Management)

AFI 44-103, The Air Force Independent Duty Medical Technician Program

AFI 44-121, Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program

AFMAN 44-144, Nutritional Medicine

AFI 46-101, Nursing Services and Operations

AFI 47-101, Managing Air Force Dental Services

AFI 51-302, Medical Law

AFI 51-501, Tort Claims

AFI 63-124, Performance-Based Service Contracts (PBSC)

AFI 65-601 V-1, Budget Guidance and Procedures

AFI 90-201, Inspector General Activities

AFI 90-901, Operational Risk Management

AFP 90-902, *Operational Risk Management (ORM) Guidelines and Tools*

AFRIMS, *Air Force Records Information Management System (AFRIMS), AF Records Disposition System (RDS)*

ANGI 36-2005, *Appointment of Officers in the Air National Guard of the United States and Reserves of the Air Force*

ANGI 40-103, *Medical Support to Geographically Separated Units (GSUs)*, 14 Jul 98

ANGI 41-102, *Early Appointment Program for Physicians*, 30 Oct 95

Assistant Deputy Chief of Staff/Manpower and Personnel Memorandum, *Payment for Expenses to Obtain Professional Credentials*, 6 February 2006

The Joint Commission (TJC) Accreditation Manuals applicable to healthcare, current editions

TJC National Patient Safety Goals, www.jointcommission.org

Prescribed and Adopted Forms

DD Form 2499, *Health Care Provider Action Report*

DD Form 2526, *Case Abstract for Malpractice Claims*

AF Form 22, *Clinical Privileges Evaluation Summary*

AF Form 24, *Application for Appointment as Reserve of the Air Force or USAF without Component*

AF Form 55, *Employee Safety and Health Record*

AF Form 244, *Clinical Privileges - Dentist*

AF Form 475, *Education/Training Record*

AF Form 494, *Academic/Clinical Evaluation Report*

AF Form 765, *Medical Treatment Facility Incident Statement*

AF Form 797, *Job Qualification Standard Continuation/Command JQS*

AF Form 1540, *Application for Clinical Privileges/Medical Staff Appointment*

AF Form 1540A, *Application for Clinical Privileges/Medical Staff Appointment Update*

AF Form 1541, *Credentials Continuing Health Education Training Record*

AF Form 1562, *Credentials Evaluation of Health Care Practitioners*

AF Form 2665, *Air Force Nurse Corps Education Summary*

AF Form 2815, *Clinical Privileges - Internal Medicine Physician*

AF Form 2816, *Clinical Privileges - Family Practice and Primary Care Physicians*

AF Form 2816-1, *Clinical Privileges - Family and Primary Care/Adult Nurse Practitioner*

AF Form 2816-2, *Clinical Privileges - Physician Assistant*

AF Form 2817, *Clinical Privileges - Pediatrician*

AF Form 2817-1, *Clinical Privileges - Pediatric Nurse Practitioner*

AF Form 2818-1, *Clinical Privileges - General Surgeon*
AF Form 2818-2, *Clinical Privileges - Orthopaedic Surgeon*
AF Form 2818-6, *Clinical Privileges - Urologic Surgeon*
AF Form 2818-7, *Clinical Privileges - Neurologic Surgeon*
AF Form 2818-8, *Clinical Privileges - Otorhinolaryngologic Surgeon*
AF Form 2818-9, *Clinical Privileges - Ophthalmologic Surgeon*
AF Form 2818-10, *Clinical Privileges - Plastic Surgeon*
AF Form 2818-11, *Clinical Privileges - Oral and Maxillofacial Surgeon*
AF Form 2819, *Clinical Privileges - Anesthesiologist*
AF Form 2819-1, *Clinical Privileges - Certified Registered Nurse Anesthetist*
AF Form 2820, *Clinical Privileges - Obstetrician/Gynecologist*
AF Form 2820-1, *Clinical Privileges - Certified Nurse Midwife*
AF Form 2820-2, *Clinical Privileges - Women's Health Nurse Practitioner*
AF Form 2821, *Clinical Privileges - Emergency Medicine Physician*
AF Form 2822, *Clinical Privileges - Neurologist*
AF Form 2823, *Clinical Privileges - Dermatologist*
AF Form 2824, *Clinical Privileges - Mental Health Providers*
AF Form 2824-1, *Clinical Privileges - Psychiatric/Mental Health Nurse Practitioner*
AF Form 2825, *Clinical Privileges - Radiologist*
AF Form 2826, *Clinical Privileges - Pathologist*
AF Form 2827, *Clinical Privileges - Physical Therapist*
AF Form 2828, *Clinical Privileges - Occupational Therapist*
AF Form 2829, *Clinical Privileges - Podiatrist*
AF Form 2830, *Clinical Privileges - Optometrist*
AF Form 3928, *Clinical Privileges - Audiologist*
AF Form 3929, *Clinical Privileges - Speech Pathologist*
AF Form 3930, *Clinical Privileges - Dietetics Providers*
AF Form 4172, *Clinical Privileges - Clinical Pharmacist*
AF Form 4296, *Clinical Privileges - Chiropractor*
AF Form 4305, *Clinical Privileges - Preventive Medicine Subspecialties* (Aerospace Medicine, Occupational Medicine, and Preventive Medicine)
AF Form 4318, *Clinical Privileges - Air Reserve Components (UTA)*

Abbreviations and Acronyms

AAAHC—Accreditation Association for Ambulatory Health Care

AADE—American Association of Dental Examiners

AANP—American Academy of Nurse Practitioners

ABMS—American Board of Medical Specialties

ACGME—American Council of Graduate Medical Education

ACLS—Advanced Cardiac Life Support

ADA—American Dietetic Association

ADAPT—Alcohol and Drug Abuse Prevention and Treatment

AEGB—Advanced Education in General Dentistry Program

AES—Aeromedical Evacuation Squadron

AF—Air Force

AFCCVO—Air Force Centralized Credentials Verification Office

AFI—Air Force Instruction

AFIA—Air Force Inspection Agency

AFIP—Armed Forces Institute of Pathology

AFIT/CIM—Air Force Institute of Technology, Civilian Institutions

AFLSA—Air Force Legal Services Agency

AFMAM—Air Force Medical Applications Model

AFMOA—Air Force Medical Operations Agency

AFMS—Air Force Medical Service

AFPC—Air Force Personnel Center

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFRS—Air Force Recruiting Service

AFSC—Air Force Specialty Code

AHLTA—Armed Forces Health Longitudinal Tracking Application

AMA—American Medical Association

ANCC—American Nurses Credentialing Center

ANG—Air National Guard

ANG/SG—Air National Guard Air Surgeon

ANG/SGSE—Air National Guard Executive Services Branch

AOA—American Osteopathic Association
APA—American Psychological Association
APTA—American Physical Therapy Association
ARC—Air Reserve Components
ARC—PA—Accreditation Review Commission for Physician Assistant Education, Inc.
ARPC—Air Reserve Personnel Center
ASA—American Society of Anesthesiologists
ASD(HA)—Assistant Secretary of Defense for Health Affairs
ATLS—Advanced Trauma Life Support
BDQAS—Biometric Data Quality Assurance Service
BLS—Basic Life Support
BRAC—Base Realignment and Closure
BSC—Biomedical Sciences Corps
BSN—Bachelor of Science in Nursing
CAAHEP—Commission on Accreditation of Allied Health Education Programs
CADAC—Certified Alcohol and Drug Abuse Counselor = Substance Abuse Counselor
CAF—Competency Assessment Folder
CAMH—Comprehensive Accreditation Manual for Hospitals
CAP—College of American Pathologists
CC—Commander
CCQAS—Centralized Credentials Quality Assurance System
CDE—Commander-Directed (Mental Health) Evaluations
CDI—Command Directed Investigation
CDE—Continuing Dental Education
CEU—Continuing Education Unit (1 CEU = 10 continuing education hours)
CFETP—Career Field Education and Training Plan
CFR—Code of Federal Regulations
CGFNS—Commission on Graduates of Foreign Nursing Schools
CHBC—Criminal History Background Check
CHCS—Composite Health Care System
CHE—Continuing Health Education
CINC—Commander in Chief

CM—Credentials Manager

CME—Continuing Medical Education

CMS—Centers for Medicare and Medicaid Services under the Department of Health and Human Services

CN—Chief Nurse and SGN

CNE—Continuing Nursing Education

CNM—Certified Nurse Midwife

COMLEX—Comprehensive Osteopathic Medical Licensing Examination

CONUS—Continental United States

COT—Commissioned Officer Training

CPO—Civilian Personnel Office

CPR—Cardiopulmonary Resuscitation

CQMP—Clinical Quality Management Program

CRNA—Certified Registered Nurse Anesthetist

CSR—Controlled Substance Registration

CVO—Credentials Verification Organization

CY—Calendar Year

DBMS—Director of Base Medical Services

DC—Dental Corps

DEA—Drug Enforcement Administration

DHHS—Department of Health and Human Services

DMAT—Disaster Medical Assistance Team

DME—Director of Medical Education

DMHRSi—Defense Medical Human Resource System Internet

DO—Doctor of Osteopathy

DOB—Date of Birth

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

DPAM—Medical Service Officers Directorate

DPAME—Physician Education Branch

DPAMF—Force Management Branch

DPM—Doctor of Podiatric Medicine

DSN—Defense Switched Network
DTF—Dental Treatment Facility
ECFMG—Educational Commission for Foreign Medical Graduates
ECOMS—Executive Committee of the Medical Staff
EMT—Emergency Medical Technician
EPP—Exposure Prone Procedures
ERM—Contact Expert Review Manager
ERS—External Resource Sharing
ESD—Emergency Services Department
EST—Enlisted Specialty Training
FAAO—Fellowship in the American Academy of Optometry
FAP—Family Advocacy Program
FMEA—Failure Mode and Effect Analysis
FNP—Family Nurse Practitioner
FOA—Field Operating Agency
FSC—Family Support Center
FSMB—Federation of State Medical Boards
FY—Fiscal Year
GME—Graduate Medical Education
GMO—General Medical Officer
GSU—Geographically Separated Unit
HA—Health Affairs
HAWC—Health and Wellness Center
HCO—Healthcare Organization
HCTCP—Healthcare Team Coordination Program
HIPDB—Healthcare Integrity and Protection Data Bank
HIPPA—Health Insurance Portability and Accountability Act of 1996
H&P—History and Physical
HPSP—Health Professions Scholarship Program
HQ—Headquarters
HSI—Health Services Inspection
IAW—In Accordance With

ICRC—International Certification and Reciprocity Consortium

ICTB—Interfacility Credentials Transfer Brief

IDMT—Independent Duty Medical Technician

IG—Inspector General

IMA—Individual Mobilization Augmentee

IRB—Investigational Review Board

IRR—Individual Ready Reserve

JACT—Tort Claims and Litigation Division

JQS—Job Qualification Standard

KX—Knowledge Exchange

LIP—Licensed Independent Practitioners

LOC—Letter of Counseling

LOR—Letter of Reprimand

LSMTF—Limited Scope Medical Treatment Facility

MAC—Monitored Anesthesia Care

MAJCOM—Major Command

MC—Medical Corps

MCSC—Managed Care Support Contractor

MD—Doctor of Medicine

MDG/CC—Medical Group Commander

MDS/CC—Medical Squadron Commander

MDW/CC—Medical Wing Commander

M&E—Monitoring and Evaluation

MEB—Medical Evaluation Board

MEPRS—Medical Expense Performance Reporting System

MHS—Military Health Services System

MII—Medical Incident Investigation

MLC—Medical Law Consultant

MNT—Medical Nutrition Therapy

MOU—Memorandum of Understanding

MPA—Military Personnel Appropriation

MPRB—Medical Practice Review Board

MQSA—Mammography Quality Standards Act
MSA—Medical Staff Appointment
MSW—Master of Science in Social Work
MTF—Military Treatment Facility
MTF/CC—Military Treatment Facility Commander
MTM—Medical Team Management
NAF—Numbered Air Force
NALS—Neonatal Advanced Life Support
NAPNAP—National Association of Pediatric Nurse Associates and Practitioners
NC—Nurse Corps
NCBPNP/N—National Certification Board of Pediatric Nurse Practitioners and Nurses
NCCP—National Commission on Certification of Physician Assistants
NCSBN—National Council of State Boards of Nursing
NCQA—National Committee for Quality Assurance
NGB—National Guard Bureau
NLC—Nurse Licensure Compact
NLT—No Later Than
NMS—Neuromusculoskeletal
NOTAM—Notice to Airmen
NP—Nurse Practitioner
NPDB—National Practitioner Data Bank
NPI—National Provider Identifier
NPES—National Plan and Provider Enumeration System
NREMT—National Registry of Emergency Medical Technicians
NTP—Nurse Transition Program
OASD—Office of Assistant Secretary of Defense
ORI—Operational Readiness Inspection
ORM—Operational Risk Management
OSI—Office of Special Investigations
OT—Occupational Therapy
OTD—Occupational Therapy Doctoral
PA—Physician Assistant

PAF—Provider Activity File
PALS—Pediatric Advanced Life Support
PCF—Provider Credentials File
PCS—Permanent Change of Station
PDP—Psychopharmacology Demonstration Project
PEB—Physical Evaluation Board
PG—Postgraduate
PGY—Postgraduate Year
PHD—Doctor of Philosophy
PHSD—Population Health Support Division
PIM—Pre-trained Individual Manpower
PI—Performance Improvement
PIB—Performance Improvement Board
PIRR—Participating Individual Ready Reserve
PMT—Performance Measurement Tool
P/MHNP—Psychiatric/Mental Health Nurse Practitioners
PNP—Pediatric Nurse Practitioner
POC—Point of Contact
PSM—Patient Safety Manager
PSV—Primary Source Verify/Verification
PSYD—Doctor of Psychology
P&T—Pharmacy and Therapeutics
QA—Quality Assurance
QAE—Quality Assurance Evaluator (Changed to Quality Assurance Personnel)
QI—Quality Improvement
QM—Quality Manager
QMR—Quality Management Review
QSM—Quality Services Manager
RAM—Resident in Aerospace Medicine
RCA—Root Cause Analysis
RCP—Reserve Component Processing
RCS—Report Control Symbol

RD—Reinforcement Designee
RED HORSE—Rapid Engineers Deployable Heavy Operational Repair Squadron Engineer
RIP—Request for Individual Personnel
RM—Risk Management/Manager
RMC—Reserve Medical Unit
RN—Registered Nurse
RSG—Regional Support Group
SAS—State Air Surgeon
SE—Sentinel Event
SF—Standard Form
SG—Surgeon General
SGA—Administrator
SGD—Dental Surgeon
SGH—Chief of the Medical Staff
SGHQ—Clinical Quality Management Division
SGN—Chief Nurse
SGP—Chief of Aerospace Medicine
SGO—Healthcare Operations
SGSLC—Medical Logistics Division, Contracting Branch
SJA—Staff Judge Advocate
SME—Squadron Medical Element
SOC—Standard of Care
SPA—Specialty Physician Assistant
SQ/CC—Squadron Commander
SSN—Social Security Number
TAG—The Adjutant General
TJC—The Joint Commission
TMA—TRICARE Management Activity
UCMJ—Uniform Code of Military Justice
UIC—Unit Identification Code
UM—Utilization Management
USAF—United States Air Force

USMLE—United States Medical Licensing Exam

UTA—Unit Training Assembly

VA—Department of Veterans Affairs

WHNP—Women’s Health Nurse Practitioner

WG/CC—Wing Commander

WIC—Women, Infants, and Children

WWW—World Wide Web

Terms

Abeyance—The temporary removal of a privileged provider from some or all clinical duties to non-clinical duties while an internal or external peer review or inquiry is done. It cannot exceed 30 days and is not considered an adverse action.

Active Medical Staff Appointment—Active medical staff member with all accompanying responsibilities, functions, and duties within the medical staff. Full credentials review is required for an active staff appointment. This appointment is granted to individuals exercising regular privileges who have completed an initial medical staff appointment at a DoD MTF. They are full-time staff members expected to participate fully in medical staff duties. Appointment status reflects the relationship of the provider to the medical staff. At the time a provider is granted privileges or has privileges renewed, he or she may also be granted a medical staff appointment which runs concurrently with the privileges.

Adverse Events—Occurrences or conditions associated with care or services when they cause unexpected harm to a patient during such care or services. These may be because of acts of commission or omission.

Adverse Practice Action—An action against the practice of a non-privileged healthcare provider. The practice may be restricted, reduced, or revoked, based upon professional misconduct, impairment, or lack of professional competence that adversely affects the safe delivery of healthcare. An adverse practice action can only be imposed by the MTF/CC after the opportunity for a hearing has been afforded.

Adverse Privilege Action—Privileges are denied, suspended, restricted, reduced or revoked based upon professional misconduct, impairment, or lack of professional competence. An adverse action can only be imposed by the MTF/CC. The termination of professional staff appointment based upon conduct incompatible with continued professional staff membership might also result in an adverse privileging action.

Affiliate Medical Staff Appointment—This appointment is for medical staff members whose medical staff responsibilities and duties are reduced or eliminated because of limited duty or employment within the MTF. Full credentials review is required for an affiliate staff appointment. Affiliate staff appointments may be given to individuals exercising regular privileges who have completed an initial medical staff appointment at a DoD MTF, to consultants, or to individuals who work in the MTF on a part-time basis. Appointment status reflects the relationship of the provider to the medical staff. At the time a provider is granted

privileges or has privileges renewed, he or she may also be granted a medical staff appointment which runs concurrently with the privileges.

Centralized Credentials Quality Assurance System (CCQAS)—A web based for credentials, privileging, adverse action and risk management database utilized within DoD. The CCQAS software assists the credentials and risk managers with the control of credentials, managing the credentialing/privileging process, adverse actions, medical malpractice claim process, report generation, letter generation, MTF to MTF transfer of the electronic PCF, and inter-facility transfer briefs. MTF credentials and risk managers use CCQAS information for generating DoD and congressional reports, personnel management, quality assurance, and for performance improvement activities.

Certification by National Agency—Recognition by a national certifying agency or association for a particular professional group that an individual has the necessary training, background, knowledge, and skill to provide quality care within the boundaries of the profession's scope of practice. The agency or association must be recognized as sufficiently rigorous to ensure certified individuals possess the skills for independent practice within the Air Force Medical Service, and must be among those listed in AFI 41-104, *Professional Board and National Certification Examinations*.

Clinical Supervisor—That person who provides professional review of the clinical activities of a professional peer/subordinate. This may be the chief of service or senior staff member of like specialty or clinical service. For purposes of completing the AF Form 22 and recommending clinical privileges this is a peer (if possible) who is a medical staff member and is the individual best qualified, on the basis of background and training, to monitor the practice of the provider under review.

Commission on Graduates of Foreign Nursing Schools (CGFNS)—The CGFNS is an internationally recognized authority on education, registration, and licensure of nurses worldwide. The CGFNS was established to protect the public by ensuring that nurses educated in other countries, who wish to practice nursing in the United States, are eligible and qualified to meet licensure and other practice requirements. Further information may be obtained from: <http://www.cgfns.org>.

Credentialing—The process of obtaining, verifying, and assessing the qualifications of a health care provider to deliver patient care services in or for a healthcare organization.

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

Credentials Review—The credentials inspection and verification process conducted for healthcare providers before selection for military service, employment, and procurement. The credentials review process is also conducted for healthcare providers before medical staff appointment and granting of clinical privileges, and is repeated at the time of reappointment and renewal of privileges. This is based on the following four core criteria: 1) current licensure; 2) relevant education, training, or experience; 3) current competence; and 4) ability to perform requested privileges.

Credentials, Verified—Documents confirming authenticity has been obtained from the primary (issuing) source. Confirmation, independent of the provider, is a key criterion. With respect to credentials that will never change, once verified, confirmation of authenticity with the primary

course need not be repeated during subsequent credentials review. However, State licenses/certifications/registrations verifications, queries of the NPDB/HIPDB databanks and current competency shall be accomplished at every granting and renewal of privileges. **Note:** DPDB queries are only required upon renewal of privileges.

Current Competence—The state of having adequate knowledge, skills, ability, and behaviors to perform the functions of a provider in a particular discipline. Current competence is measured by meeting the following: 1) Authorized to practice a specified scope of care under a written plan of supervision at any time within the past 2 years; or, completed formal graduate professional education in a specified clinical specialty at any time within the past 2 years; or, privileged to practice a specified scope of care at any time within the past 2 years, 2) Actively pursued the practice of his or her discipline within the past 2 years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested; and, 3) Satisfactorily practiced the discipline as determined by the results of professional staff monitoring and evaluation of the quality and appropriateness of patient care.

Defense Practitioner Data Bank (DPBD)—The automated information system maintained as part of the Risk Management and Adverse Action Modules of CCQAS. It consists of data on the professional competence and conduct of licensed healthcare providers and malpractice cases involving the DoD, including all filed and paid claims. It also includes cases in which disability system or other payments are made because of personal injury or death of a member of a Uniformed Service caused by the failure of a provider to meet the professional SOC. It is electronically monitored by the Department of Legal Medicine of the Armed Forces Institute of Pathology.

Denial of Privileges—Refusal to grant requested privileges. An adverse denial of privileges (i.e., based on professional misconduct, impairment, or lack of professional competence) may only be imposed by a privileging authority after the opportunity for a hearing has been afforded. An adverse denial of privileges is reportable to the National Practitioner Data Bank (NPDB). For administrative denial of privileges refer to paragraph 9.27.3.6.

Educational Commission for Foreign Medical Graduates (ECFMG)—Required for graduates of medical schools located outside the US, Puerto Rico, and Canada. Since 1986, before awarding ECFMG certification, the ECFMG performs primary source verification of medical school graduation, requires the candidate to pass an English exam, and verifies the candidate has successfully completed Parts I and II of the United States Medical Licensing Exam (USMLE). The ECFMG will provide examination results, ECFMG certificate number, and period of validity. A copy of ECFMG or Fifth Pathway certificates (if required) for international applicants is verified through the Correspondence Department.

Failure Mode and Effects Analyses (FMEA)—A systematic, proactive method for evaluating a process to identify where and how it might fail, and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change. Selected teams of cross-functional healthcare professionals use FMEA to evaluate processes for possible failures and to prevent them by correcting the processes proactively rather than reacting after failures have occurred. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.

Feres Barred—Cases of actual or alleged medical malpractice torts for which Federal court jurisdiction is not available under the Federal Tort Claims Act based on the Supreme Court

decision in *Feres v. United States*, 340 U.S. 135 (1950), (and/or similar cases) that the military disability system and other compensation programs, rather than tort litigation, provided the exclusive remedies for military members killed or injured incident to Military Service. Although payments under such military compensation programs that are a result of medical care are not malpractice payments under NPDB rules, DoD 6025.13-R requires that they be reviewed for reporting to the Defense Practitioner Data Bank. (*Note:* Although the "*Feres doctrine*" applies to all tort cases, not just medical malpractice cases, the term "*Feres barred cases*" in DoD 6025.13-R refers only to actual or alleged torts involving medical malpractice.)

Fifth Pathway—Fifth Pathway certification is equivalent to an ECFMG certification. The Fifth Pathway program includes 1 year of supervised clinical education in a US medical school for US college graduates who completed medical school in a foreign country and is administered by the American Medical Association. For further information, access the American Medical Association website at <http://www.ama-assn.org/ama/pub/category/10255.html>.

Focused Professional Performance Evaluation (FPPE)—The time-limited evaluation of a provider's competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a provider's ability to provide safe, high-quality patient care.

Healthcare Integrity and Protection Data Bank (HIPDB)—A national healthcare fraud and abuse data collection program for reporting and disclosing adverse administrative actions against personnel involved in the delivery of medical services. By direction of the ASD/HA, all personnel assigned to the AFMS, including active duty, reserve, air national guard, civil service, and personal service contract personnel, are subject to reporting to this data bank.

Healthcare Provider/Practitioner—Any physician, dentist, nurse, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other authorization.

Healthcare Provider (NON—PRIVILEGED)—Staff members who do not have clinical privileges, but who do possess a license, certification, or registration required by this instruction, by other guidance, or by the MTF for practice. This may include pharmacists, clinical nurses (registered nurses, licensed vocational nurses), emergency medical technicians, dental hygienists, etc. It may also include practitioners who may be privileged according to this instruction, but who the MTF has decided not to privilege (i.e., clinical social workers doing discharge planning duties, dietitians working in the health and wellness center, etc.). It may also include providers in graduate military education or other training programs who are not awarded clinical privileges.

Healthcare Provider (PRIVILEGED)—Military (active or reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to begin, alter, or end a plan of treatment for a patient.

Healthcare Trainee—Any resident, intern, or other healthcare provider in a formal healthcare training status.

Host State—The State in which off-base duties are or shall be performed.

Impaired Provider—A privileged or non-privileged provider who, by reason of alcohol or drug abuse, emotional disturbance, or medical condition, has exhibited unprofessional conduct,

substandard medical practice, or professional incompetence which is, or is reasonably probable of being, detrimental to patient safety or to the proper delivery of quality patient care.

Individual Practice Review (IPR)—another term used for focused professional practice evaluation is a peer review of a provider's practice through clinical records, on-site interviews and observation, or TDY of a provider from another location (see paragraph 8.2.1.1. for M&E). A peer is defined as a professional peer with similar training, clinical experience and AFSC. IPR may be independent or part of an inquiry, and may or may not lead to an adverse action. If the IPR finds no professional deficiencies or concerns, no adverse action need occur. If the IPR finds clinical deficiencies that affect patient safety, an adverse action may be necessary.

Initial Medical Staff Appointment—Appointment status reflects the relationship of the provider to the medical staff. At the time a provider is granted privileges or has privileges renewed, he or she may also be granted a medical staff appointment. This medical staff status is granted to a provider during his or her first 12 months of practice within the Air Force Medical Service, or after a period of greater than 180 calendar days without an active or affiliate medical staff appointment in a DoD MTF. During this period, the medical staff member's performance will be under review by clinical supervisors for clinical competence as well as compliance with the facility's policies, procedures, bylaws, and code of professional conduct. During this period, the member may also have supervised privileges based on lack of experience or lack of proficiency in technical skill. An initial staff appointment leads to an active or affiliate staff appointment and should be designated as such when granted (i.e., initial-active or initial-affiliate). When designated in this way, the appointment indicates the medical staff responsibilities of the target appointment. Initial appointments require full credentials review.

Inquiry—Search for, identification, and review of information related to a provider's conduct or condition that is, or may be, detrimental to patient care or safety.

Intentional Unsafe Act—Any alleged or suspected act or omission of a provider, staff member, contractor, trainee, or volunteer pertaining to a patient involving a criminal act; a purposefully unsafe act; patient abuse; or an event caused or affected by drug or alcohol abuse. Intentional unsafe acts are matters for law enforcement, disciplinary system, or administrative investigation.

License—A grant of permission by an official agency of a US jurisdiction (a state/the District of Columbia, commonwealth, territory, or possession of the US) to provide healthcare independently within the scope of practice for the individual's discipline within that jurisdiction. A current, valid, unrestricted license is one which has not expired, been restricted, revoked, suspended, or lapsed in registration and on which the issuing authority accepts, considers, and acts on quality assurance information and continuing health education activities in determining continued licensure or certification.

Unrestricted license, certification, or registration— is one not subject to restriction pertaining to the scope, location, or type of practice ordinarily granted all other applicants for similar licensure, certification, or registration in the granting jurisdiction. Some jurisdictions issue no-fee licenses to Federal employees or military personnel. These licenses are acceptable, for non-physicians/nurses only, if the issuing authority will exercise professional regulatory control over individuals with these licenses and if the license is unrestricted. It also includes, in the case of care furnished in a foreign country by any person who is not a US national, a grant of permission by an official agency of that foreign country for that person to provide healthcare independently as a healthcare professional.

Unrestricted license (for physicians and nurses)—One in which the individual has met all clinical, professional, and administrative licensure requirements. The physician must have a license that permits him or her to practice in the state immediately, seeing non-DoD beneficiaries, without first taking any action on that license.

Unrestricted license (for non—physicians)—One in which the individual has met all clinical and professional requirements, has no clinical limitations or restrictions, and is able to practice full scope of care in the jurisdiction once all administrative licensure, certification, or registration requirements are met. Therefore, for non-physicians, state waiver of renewal fees, malpractice insurance, payment into risk pool, etc., is acceptable, as long as the license is clinically and professionally equivalent to that of the individual's civilian counterpart.

Limited Scope Medical Treatment Facility (LSMTF)—Medical element, flight, or small medical squadron assigned to a line squadron or group (e.g. Air Base Squadron, Mission Support Group or Air Base Group) with a credentialed medical provider. The LSMTF does not provide the scope of services found in a medical group.

Malpractice payment—A monetary award under the authority of the Federal Tort Claims Act, the Military Claims Act, or the Foreign Claims Act relating to the provision of healthcare services under the organizational responsibility of the Department of Defense.

Medical Staff—That body of individuals within the MTF who hold privileges and who are characterized by primary responsibility to the governing body for the quality of patient care within the MTF.

Medical Staff Appointment—Appointment status reflects the relationship of the provider to the medical staff. At the time a provider is granted privileges or has privileges renewed, he or she may also be granted a medical staff appointment which runs concurrently with the privileges. A medical staff appointment may not be made in the absence of granting privileges. A provider may not admit patients without also being appointed to the medical staff. Medical staff appointment may be revoked without revoking privileges. Privileges may be granted with or without a medical staff appointment. The type of appointment will vary, depending on the privileges to be exercised, the availability of the medical staff member to the facility, and the reason he or she is practicing at the MTF. There are four types of medical staff appointment: initial, active, affiliate, and temporary.

Monitoring and Evaluation (M&E)—M&E is a well-defined, time-limited, well documented plan (list of specific questions, procedures, and concerns to be evaluated during the period of clinical evaluation) of intensified peer review to confirm that a provider possesses the requisite knowledge, skill, and training to render safe and appropriate patient care within their scope of practice. It must include a documented plan with delineation of clear expectations and clear measures of success that shall be coordinated through MAJCOM/SG. It consists of a formal supervision of the provider either at his own or outside MTF. The duration of M&E is variable, but often will last 2-3 months. The supervising peer is expected to provide specific written assessment of the skills in question to the Credentials Function at the end of the M&E period. Furthermore, the supervising peer is expected to conduct constructive feedback with the provider throughout the M&E.

Military Health System (MHS)—The combination of military and civilian medical systems used to provide healthcare to DoD medical beneficiaries.

National Practitioner Data Bank (NPDB)—An information clearinghouse to collect and release certain information related to the professional competence and conduct of physicians, dentists, and, in some cases, other healthcare practitioners. The MHS reports medical malpractice payment reports and adverse privileging actions to the NPDB.

National Provider Identifier (NPI)—The NPI is a standard unique health identifier for healthcare providers. Effective 23 May 05 and IAW HIPAA Public Law 104-191, NPI Final rule (45 Code of Federal Regulations, Part 162) requires that all providers apply for an NPI Type 1 by 23 May 07. This will be required for all privileged providers and residents (reference paragraph 6.39. for application process and additional information). IDMTs are also required to obtain an NPI.

Near Miss—Any process variation or error or other circumstance that could have resulted in harm to a patient, but through chance or timely intervention did not reach the patient. Such events or circumstances have also been referred to as “close calls” or “good catches”.

Never Events—A list of occurrences compiled by the National Quality Forum of inexcusable outcomes in a healthcare setting. The list was compiled by the National Quality Forum. They are defined as “adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers for the purpose of public accountability.”

No Medical Staff Membership—Status of individuals who are not appointed to the medical staff and are not members of the medical staff. These individuals do not share medical staff responsibility to the governing body for medical staff surveillance, review, and performance improvement activities within the MTF, though they may be significantly involved in these activities.

Ongoing Professional Practice Evaluation (OPPE)—A documented summary of ongoing data collected for the purpose of assessing a provider’s clinical competence and professional behavior. This information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to or at the end of the two-year privilege renewal cycle.

Other Authorizing Documents—Mechanism such as registration or certification by a US jurisdiction (meaning a State/the District of Columbia, commonwealth, territory, or possession of the US) grants authority to provide healthcare in a specified discipline; or in specialties not licensed and where the requirements of the granting authority for registration or certification are highly variable, the validation by a national organization that a provider is professionally qualified to provide healthcare in a specified discipline; or in the case where healthcare is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare in a specified discipline.

Peer—A professional peer with similar training, clinical experience and AFSC.

Peer Review—Peer Review is the activity of looking objectively at the quality of care and practice of a provider. This is accomplished by peers looking at performance-based clinical practice, records and other applicable data.

Peer Review Panel—Panel appointed to review the clinical substantive matters of the case and offer a recommendation to the credentials function regarding the provider competency/impairment/misconduct and its effect on the delivery of healthcare.

Potentially Compensable Event—An adverse event that occurs in the delivery of healthcare and services with resulting beneficiary injury. It includes any adverse event or outcome, with or without legal fault, in which the patient experiences any unintended or unexpected negative results. (Reference paragraph 10.8.2.)

Practitioner—See Healthcare Provider (PRIVILEGED).

Privileges—Permission, defining the scope of care, to provide medical and other patient care services in the granting institution based on the individual's education, professional license, demonstrated clinical experience, clinical competence, ability, health, and judgment. Privileges may be granted with or without an accompanying medical staff appointment.

Privileging (clinical)—The process whereby the MTF/CC or the MAJCOM/SG, upon recommendations from the MTF credentials function, grants privileges and responsibilities to a healthcare provider for specified patient care services within the MTF. Clinical privileges define the scope and limits of practice for individual providers and are based on evaluation of the individual's credentials and performance.

Professional Medical Staff—Same as medical staff.

Provider Activity File (PAF)—A quality assurance file containing temporary provider-specific information and performance data used to support the reprivileging process. It also contains risk management data to include pending adverse action or potential malpractice data pending resolution. It is an extension of the PCF and contains active QA documents protected from disclosure by 10 U.S.C. §1102.

Provider Credentials File (PCF)—A folder or the electronic record within the CCQAS database containing pertinent information regarding an individual privileged provider to include credentialing and privileging documents, permanent performance data, medical practice reviews, continuing health education documentation, and information related to permanent adverse privileging actions. It is maintained in a secure manner and is protected from disclosure by 10 U.S.C. §1102.

Quality of Care Review With Standard of Care Determination—A process whereby systems review, patient care, lessons learned, and other information is extracted from the evidence involved in a PCE, and other medical events that have or could have put patients' safety at risk for use in performance improvement activities within the MTF.

Reduction of Privileges/Practice—The permanent removal of a portion of a provider's clinical privileges or a non-privileged provider's practice. A reduction can only be imposed by the MTF/CC after an opportunity for a hearing has been afforded. Reduction of privileges/practice is reportable to the NPDB.

Regular Privileges—Privileges which grant the holder permission to independently provide medical and other patient care services in the MTF, within defined limits. They are based on the individual's education, professional license and certification, experience, competence, ability, health, and judgment. Regular privileges must be renewed at least every 24 months. **NOTE:** Marking some privileges with supervision (code "2") does not place a provider in the same

category as a provider granted supervised privileges. As long as the majority of privileges are exercised independently, then granting regular privileges is the appropriate action.

Reinstatement of Privileges/Practice—A privileged provider or non-privileged provider has restoration of clinical privileges or practice. Reinstatement may include provisions for monitoring and evaluation to include the nature and duration of M&E. This is not an adverse action and is not reportable to regulatory agencies; no hearing or appeal is offered.

Restriction of Privileges/Practice—A limit placed on all or a portion of the provider's clinical privileges or non-privileged healthcare professional's practice so that the individual is required to obtain concurrence before providing all or some specified healthcare procedures within the scope of his or her license or registration. The restriction may require some type of supervision. Restriction can only be imposed by the MTF/CC after an opportunity for a hearing has been afforded. Restriction of privileges/ practice is reportable to the NPDB.

Revocation—An adverse action that permanently removes all clinical privileges or an individual from all patient care duties. A revocation may only be imposed by the MTF/CC after the opportunity for a hearing has been afforded. Revocation of privileges/practice is reportable to the NPDB.

Root Cause Analysis (RCA)—A process for identifying the basic or contributing causal factors associated with actual adverse events and near misses. An RCA includes the following characteristics: the review is interdisciplinary in nature with involvement of those closest to the process, the analysis focuses primarily on systems and processes rather than individual performance, the analysis digs deeper by asking “what” and “why” until all aspects of the process are reviewed and all contributing factors are identified, and the analysis identifies changes that may be made in systems and processes through either redesign or development of new processes or systems that may improve performance and may reduce the risk of actual adverse events or recurrence of near misses.

Sentinel Events—Unexpected occurrences involving death or serious physical or psychological injury or risk thereof.

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

Standard of Care—The accepted or correct actions of a provider, taken in order to arrive at a diagnosis or to implement treatment for a given disease, disorder, or patient problem, adjusted for the patient's presentation and other conditioning factors. The standard of care is what is

generally accepted in the healthcare discipline or specialty involved as reasonable and appropriate and is determined by peer review.

Substandard Medical Practice or Care—Medical care rendered to a patient that fails to meet the accepted standard of care.

Summary Suspension—The temporary removal of all or part of a provider's privileges, taken prior to the completion of due process procedures, based on peer assessment or command, that the action is needed to protect patients or the integrity of the command. A summary suspension may continue until due process procedures are completed. Summary suspension of privileges is not reportable to the NPDB, unless the final action is reportable.

Supervised Privileges—Privileges granted to providers who do not meet the requirements for independent practice because they lack the necessary licensure or certification. However, all minimal educational requirements must be met. They should be granted for recent accessions without adequate documentation of current clinical competence, for providers who have not clinically practiced for a period of 2 years or more, for those providers in an orientation period required to assess competency, or at the commander's discretion, pending completion of the CHBC. Supervised privileges may be granted for up to 2 years and may be renewed by the privileging authority in extenuating circumstances. The procedures for awarding supervised privileges are the same as for regular privileges except that a clinical supervisor must be named, in writing, at the time privileges are awarded, and a written supervision plan and schedule for periodic report on the provider's progress is outlined. The supervisor must be an MTF provider who has regular privileges in the scope of practice for which they are supervising. The degree of supervision required is determined by the clinical supervisor and must be appropriate to the background, experience, and demonstrated skill of the supervised provider. Degrees of supervision are described in the glossary, under "Supervision."

Supervision—The process of reviewing, observing, and accepting responsibility for the healthcare services provided by another healthcare professional. Levels of supervision are defined as:

Direct Supervision. The clinical supervisor is involved in the decision—making process. This may be further subdivided as follows: (1) **Consultative** -The supervisor is contacted by phone, e-mail, or informal consultation before implementing or changing a regimen of care. The supervisor conducts face-to-face, e-mail or telephone consultations and evaluations with the provider over patient care issues on a regular, recurring basis; (2) **Physically Present** - The supervisor is physically present through all or a portion of care.

Indirect Supervision.—The clinical supervisor performs retrospective record review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the member not exceeding the authorized scope of care.

Note: Unless an individual is in a solo practice with no interface with a hospital or other healthcare organization, all providers are supervised in some way, because of peer review, clinical evaluation, and performance—based privileging. Every provider refers patients to another provider when the case exceeds his or her scope of practice/expertise.

Temporary Medical Staff Appointment—Appointment granted primarily in emergency situations. Granting of temporary appointments should be relatively rare, and then only to fulfill pressing patient care needs. Temporary appointments are granted in situations where time

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

Temporary Privileges—Temporary privileges are awarded on an emergency basis to meet pressing patient care needs when time constraints will not allow full credentials review. They are time-limited to 5 calendar days. Credentials requirements for temporary privileges are abbreviated as described in paragraph 6.27.3. to meet the urgent need for privileging. All temporary privileges must be time-limited.

Unprofessional Conduct—Conduct either beyond or outside professional requirements for rendering patient care, which adversely affects, or could adversely affect, the health or welfare of a patient.

Verification—Confirmation of the authenticity of credentials reported by the provider using primary or secondary sources. Primary source verification is accomplished through written, telephonic, or electronic contact with the issuing agency (the primary source). The “chain of transmission” of the document or information is what distinguishes primary source verification from secondary source verification. The document or information must come from the issuing authority to be considered primary source verification. An example of secondary source verification is to review a military provider’s personnel file to validate that postgraduate training was done at a DoD facility. All verification must be documented.

Attachment 2**CONTENTS OF COMPETENCY ASSESSMENT FOLDER (CAF)****A2.1. Officer, Civilian, Contract and Volunteer Personnel (Privileged and Non-Privileged)
— Competency Assessment Folder****FRONT COVER**

Name, Rank, Last 4-SSN, AFSC, Privacy Act Statement [PERSONAL DATA PRIVACY ACT OF 1974 (5 USC 552a) 1 Aug 00 AFVA 33-276]

PART 1: SAFETY DOCUMENTATION/ JOB DESCRIPTION

Section A: AF Form 55, *Employee Safety & Health Record*, or documentation indicating where AF Form 55 is maintained.

Section B: Job Description/Performance Standards. A job/position description and the performance standards are required for all personnel. The job description must include description of responsibilities, qualifications and population served. Performance standards should mirror the officer performance report or civilian equivalent categories, (i.e., job knowledge, leadership, communication skills, etc.). Personnel will review, sign and file their job description in Part I of their CAF initially during orientation and then annually.

Section C: Orientation and Competency Documentation.

Section C1: Orientation Completion Documentation (Group/squadron/unit specific as applicable). All employees assigned to the MTF must receive orientation at the facility and unit level.

Section C2: Cross-training orientation for clinical float staff (if applicable).

Section C3: Clinical Competencies (if applicable). **Note:** Nurses and other clinical staff may also document Levels of Clinical Practice IAW local policy.

Section C4: Non-Clinical Competencies. **Note:** Either locally developed checklists or executive skills checklist may be used to document non-clinical competencies.

PART 2: TRAINING DOCUMENTATION/CONTINUING EDUCATION/LICENSURE

Section A: Mandatory Training Documentation. May use locally developed form, AF Form 1098, or an electronic version of the AF Form 1098. Initial and Annual Regulatory Training and Annual Total Force Awareness Training are also documented in MRDSS.

Section B: Continuing Education. AF Form 2665, *Summary Report of Continuing Education*, and CE Certificates (copies or original).

Section C: License Verification (RN, LPN, Non-privileged Pharmacist) **and National Certification Cards/Certificates** (TNCC, ANCC, etc.).

Section D: Other Certificates of Training (not mandatory; may be utilized as prescribed by local leadership). AF Formal Training Certificates (NSM, PME, HCI, HCO, etc.). Non-CE Certificates of Training (HIPAA, Safety, Systems, Supervisor, etc.).

A2.2. Privileged Personnel Competency Assessment Folder**FRONT COVER**

Name, Rank, Last 4-SSN, AFSC Privacy Act Statement [PERSONAL DATA PRIVACY ACT OF 1974 (5 USC 552a) 1 Aug 00 AFVA 33-276]

PART 1: SAFETY/JOB DESCRIPTION

Section A: AF Form 55, *Employee Safety & Health Record*, or document indicating where AF Form 55 is maintained.

Section B: Job Description/Performance Standards - A job/position description and the performance standards are required for privileged personnel. The job description must include description of responsibilities, qualifications and population served. Performance standards should mirror the officer performance report or civilian equivalent categories, (i.e., job knowledge, leadership, communication skills, etc.). Privileged personnel will review, sign and file their job description in Part I of their CAF initially during orientation and then annually.

Section C: Non-Clinical Competencies

Note: Either locally developed checklists or executive skills checklist may be used to document non-clinical competencies.

PART 2 ORIENTATION & TRAINING

Section A: MTF and Unit Orientation

- All employees assigned to the MTF must receive orientation at the facility and unit level.

Section B: Mandatory Training/In-service Documentation

- Mandatory Training Documentation (May use a locally developed form, AF Form 1098, or an electronic version of the AF Form 1098).

- Examples of training: Annual Refresher Training (Group-wide and unit specific), Annual Restraint training, Work Center Specific In-service training.

Note: Specifics of training can be maintained in the training plan of assigned unit.

Section C: Readiness Skills Verification (RSV) Documentation.

Section D: Other Certificates of Training (not mandatory; may be utilized as prescribed by local leadership).

- AF Formal Training Certificates (PME, PCO, etc.)

- Non-CE Certificates of Training as directed by local leadership.

- Examples: Health Insurance Portability and Accountability Act (HIPAA), Safety, Information Assurance (IA) Systems, Supervisor, etc.

Attachment 3

APPLICATION FOR WAIVER OF ADMINISTRATIVE LICENSURE
REQUIREMENTS

1. Name (Last, First, MI) Rank: SSN:
 2. Base Assigned: MAJCOM:

Instructions:

3. ___ I am applying for a waiver of the following administrative licensure requirement (**CHECK ONE**). I understand that these have already been considered by ASD/HA and are eligible to be waived. Upon renewal of this license, I must apply for another waiver. I also understand that, if I currently have another license that could meet the new licensure requirement by paying renewal fees, then I am not eligible for the following waivers:

- ___ Florida: Malpractice insurance and Neurology Injury Compensation Association (risk pool)
- ___ Kansas: Malpractice insurance and Healthcare Stabilization Fund (risk pool)
- ___ Massachusetts: Malpractice insurance
- ___ Oregon: Actual practice within the state
- ___ Pennsylvania: Malpractice insurance and Medical Professional Liability Catastrophe Loss Fund (CAT Fund) = risk pool
- ___ Colorado: Professional Liability Coverage
- ___ Virginia: Birth Related Neurological Injury Compensation Fund
- ___ Washington: Renewal fee and Continuing Education Requirement (Note: Waiver will not be granted unless provider fulfils medical education obligation)

4. ___ I am licensed in a state that has an administrative requirement that is unusual, substantial, or inharmonious with Federal Policy but is not included in the above list. I am submitting a request for waiver of the following licensure requirement (Describe in the space provided below and submit supporting documentation). I understand this request will be forward to AFMOA/SGHQ to staff for review by AFMOA/CC. If AFMOA/CC determines there is merit, request will be submitted to Assistant Secretary of Defense for Health Affairs for consideration. If approved, waiver will be granted and the guidance, beginning with "Upon renewals..." in paragraph 3 applies.

5. Signature of Applicant: _____ Date: _____

6. Waiver Authority:

Request for Waiver is Approved/Disapproved.

Date:

Signature:

Title:

Reason for Disapproval:

Note: If waiver is for paragraph 3: The MTF/CC will be the Waiver Authority. For providers attending AFIT programs, HQ AETC/SG will be the Waiver Authority. AFPC/DPAM grants waivers for providers in deferred/re-deferred training programs.

7. If waiver request is from paragraph 4, forward application to AFMOA/SGHQ.

Attachment 4

**SAMPLE LETTER – COORDINATION WITH STATE LICENSING BOARDS –
DEPARTMENT OF DEFENSE HEALTHCARE PROFESSIONALS PRACTICING IN
CIVILIAN HEALTHCARE FACILITIES**

Date

Numbered MTF /CC
Street Address
City, State Zip Code

State Board Name
Street Address
City, State Zip Code

Pursuant to Title 10, United States Code, Section 1094(d), *Licensure Requirement for Health-Care Professionals*; Department of Defense 6025.13-R, *Military Health System Clinical Quality Assurance Program Regulation*; and AF Instruction 44-119, *Medical Quality Operations*; the following information is submitted to the host State Licensing Board for the following healthcare professional. This healthcare professional is a member of the Armed Forces Military Health System, performing authorized duties for the Department of Defense in any authorized location in the host state, and meets all required qualification standards delineated in paragraph 4.8. of AFI 44-119:

Name of Healthcare Provider: _____

State of Licensure: _____

Licensure Status: _____

Location of Off-Base Assignment: _____

Expected Duration of Off-Base Assignment: _____

MTF Liaison Name: _____

MTF Liaison Number/E-mail: _____

In all cases in which the off-base duty will be performed in a non-DoD healthcare facility, the healthcare professional will follow the rules and by-laws of such facility; to the extent they are applicable to the professional.

Signature
TYPED NAME and Grade
Commander

Attachment 5

CREDENTIALS TABLES

Table A5.1. Credentials Required for Fully Qualified Active Duty Providers

Credentials	AFRS (Accessions)	AFCCVO	MTF Credentials Manager
Qualifying Degree, Diploma, ECFMG, etc	O	*F	P
Post Graduate Training	O	*F	P
License/Certification/Registration (IAW DoD Licensure Policy)	O	*F	P
Board Certification (If applicable)	O	*F	P
FSMB (PAs and Physicians, if applicable)		XF	P
NPDB/HIPDB		XF	P
DHHS and TRICARE Sanction Query		XF	P
NPI	X	F	P
CHBC - NOT REQUIRED			
Health Status	X	F	P
AF Form 1540	X	F	P
AF Form 1562 – two	X	F	P
Privileges list(s) reflecting clinical practice (civilian and/or AF lists)	O/X	F	P
AF Form 1541 (and related documents)			XP
Malpractice Documentation (if applicable)	O	F	P
Adverse Action documentation (if applicable)	O	F	P
Emergency Resuscitation Training Certification	O	F	P
DEA Registration	O	F	P

KEY:

O = Collect copy of document

X = Initiate query or document

* = Must PSV document

F = Forward to MTF NLT 15 days prior to RNLT

P = Review and process document for privileging action

Note: If the appropriate PSVs/queries have not been accomplished, upon request, the AFCCVO will accomplish as required. Request forms are available on the AFCCVO website.

Table A5.2. Credentials Required for AD Providers Who Enter the AFMS and Proceed to and Then Graduate from an AFMS Training Program

Credentials	AFRS (accessions)	AFCCVO	AF Training Program Office	MTF Credentials Manager
Qualifying Degree, Diploma, ECFMG, etc	O	*F	G+RF	+RP
Post Graduate Training	O	*F	G+RF	+RP
License/Certification/Registration (IAW DoD Licensure Policy)	O	*F	G*RF	*RP
Board Certification (If applicable)	O	*F	G+RF	+RP
FSMB (PAs and Physicians, if applicable)		XF	F	RP
NPDB/HIPDB		XF	F	RP
DHHS and TRICARE Sanction Query		XOF	F	P
NPI (initiated once provider is eligible)	X	OF	F	P
CHBC - NOT REQUIRED				
Health Status	X	OF	F	P
AF Form 1540	X	OF	F	XP
AF Form 1562 (one)			GF	P
AF Privileges list(s) reflecting clinical training obtained			GF	P
AF Form 494 (Resident in Aerospace medicine [RAM] may use AF Form 475; dentists may submit a letter in lieu of AF Form 494)			GF	P
AF Form 1541 (and related documents)				XP
Malpractice Documentation (if applicable)	X	OF	GF	P
Adverse Action documentation (if applicable)	X	OF	GF	P
Emergency Resuscitation Training Certification	X			XP
DEA Registration	X	OF	GF	P

KEY:

O = Collect copy of document prior to entering training

X = Initiate query or document

* = Must PSV document

F = Forward to gaining MTF NLT 15 days prior to RNLT

G = Initiate, update and/or collect copy of document during and/or at completion of training

P = Update, Review and process documents for privileging action

R = Upon request, the AFCCVO will conduct applicable PSVs and queries

Note: Upon notification of accession, the AFCCVO will forward all applicable documents to the MTF training program office for inclusion in the medical training record. At the completion of training the director of medical education will ensure appropriate credentials that were the contents of the medical training record along with final evaluations to the gaining MTF re scanned, appropriately named, and uploaded to the providers' electronic PCF (CCQAS record).

Table A5.3. Credentials Required for Providers Who Enter the AFMS and Proceed to Civilian Training in Sponsored and Non-Sponsored Programs.

Credentials	AFRS (Accessions)	AFCCVO	MTF Credentials Manager
Qualifying Degree, Diploma, ECFMG, etc	O	O*F	P
PG Training	O	O*F	P
License/Cert/Reg (IAW DoD Licensure Policy)	O	O*F	P
Board Certification (If applicable)	O	O*F	P
FSMB (PAs and Physicians)		XF	P
NPDB/HIPDB		XF	P
DHHS and TRICARE Sanction Query		XF	P
NPI (initiated once provider is eligible)	X	OF	P
Health Status	X	OF	P
AF Form 1540		XF	P
AF Form 1562 – two		XF	P
AF Privileges list(s) reflecting clinical training obtained		XF	P
AF Form 494 NOT REQUIRED			
AF Form 1541 (and related documents)			XP
Letter signed by program director/dean stating the start date and projected completion date.		XF	P
Malpractice Documentation (if applicable)		OF	P
Adverse Action documentation (if applicable)		OF	P
Emergency Resuscitation Training Certification		OF	P
DEA Registration		OF	P

KEY:

O = Collect copy of document

X = Initiate query or document

* = Must PSV document

F = Forward to gaining MTF NLT 15 days prior to RNLTD

P = Review and process document for privileging action

Notes:

Documents may be collected by the AFRS during the accession process or by the AFCCVO upon provider graduation depending on the level of training, (i.e., residency, fellowship).

Upon accession, the provider's electronic credentials file and CCQAS record is created and then maintained at the AFCCVO while the providers are enrolled in civilian training programs. The electronic PCF and CCQAS record are then updated with the appropriate actions, the credentials, appropriate queries and verifications scanned, appropriately named and uploaded to the electronic PCF and then transferred to the gaining MTF upon graduation.

Table A5.4. Credentials Required for Civilian Providers (Contract and Government Civilian Providers)

Credentials	Contractor for Contract Providers (Check terms of contract) Providers	Civilian Personnel Office for Govt Civilian Providers	AFCCVO	MTF CM for Contract (when not addressed in terms of Contract and Govt Civilian
Qualifying Degree, Diploma, ECFMG, etc	O*F			O*RP
Post Graduate Training	O*F			O*RP
License/Cert/Reg (IAW DoD Licensure Policy)	O*F			O*RP
Board Certification (If applicable)	O*F			O*RP
FSMB (PAs and Physicians if applicable)			X F	P
NPDB/HIPDB	XF			XRP
DHHS and TRICARE Sanction Query	XF			XRP
NPI	XF			XP
CHBC (if applicable)	XF	XF		XP
Health Status	XF			XP
AF Form 1540	XF			XP
AF Form 1562 – minimum of two (check contract)	XF			XP
Privileges list(s) reflecting clinical practice (civilian and/or AF lists)	X/OF			X/OP
AF Form 1541 (and related documents)				XP
Malpractice Documentation (if applicable)	OF			OP
Adverse Action documentation (if applicable)	OF			OP
Emergency Resuscitation Training Certification	OF			OP
DEA Registration (if applicable)	OF			OXF

KEY:

O = Collect copy of document

X = Initiate action or document

* = Must PSV document

F = Forward to MTF

P = Review and process document for privileging action

R= Upon request by MTF CM, the AFCCVO will conduct PSVs and applicable queries.

Request forms are available on the AFCCVO website.

Attachment 6**FORMAT FOR TRANSFER BRIEF MEMORANDUM**

A6.1. Paragraph 1 Complete name, rank (or rating, if civilian), corps, social security number, date of birth, specialty name, and AFSC.

A6.2. Paragraph 2 Include qualifying degree, internship, residency, and fellowship, if applicable. Include completion date of each and indicate presence/absence of primary source verification (verification status) in the PCF.

A6.3. Paragraph 3 List all currently held state licenses and certifications, expiration date of each, and verification status.

A6.4. Paragraph 4 List all applicable specialty board, specialty nurse, or other certifications and Re-certifications, expiration date of each, and verification status.

A6.5. Paragraph 5 List all applicable life support training (BLS, ACLS, ATLS, PALS) and expiration date.

A6.6. Paragraph 6 State the type of appointment (active, affiliate, etc.) currently held by the healthcare provider, and the expiration date. List privileges granted or summarize privileges and attach privilege list(s).

A6.7. Paragraph 7 List date of most recent NPDB/HIPDB inquiry and indicate absence/presence of information in the report. In no query made, state so.

A6.8. Paragraph 8 Provide a statement of the nature or purpose of the temporary assignment and request performance appraisals as appropriate. (Any of the Services' appraisal/evaluation forms will be acceptable by the sending facility).

A6.9. Paragraph 9 Provide a brief statement from an individual personally acquainted with the applicant's professional and clinical performance through observation or review to include quality assessment activities describing (a) the applicant's actual clinical performance with respect to the privileges granted at the sending facility, (b) the discharge of his or her professional obligations as a medical staff member, and (c) his or her ethical performance. This person may be a training program director for new practitioners, or a peer from prior or current commands. The statement may be taken from a current performance evaluation in the PCF; however, the person making the statement must be asked whether or not additional relevant information exists pertaining to the elements above. (Relevant information is defined as information that reflects on the current clinical competence of the provider). The paragraph must contain a statement indicating the presence/absence of other relevant information in the recommendation relating to the provider's competence for privileges as granted along with a means of direct contact with the person making the recommendation (name, title, or position held, telephone, fax, etc.).

A6.10. Paragraph 10 Provide certification that the PCF was reviewed and is accurately reflected in the brief as of (annotate the date). This paragraph must contain a statement indicating the presence/absence of other relevant information in the PCF. Of particular importance, is supplemental information accompanying primary source verification of training and licensure. Examples of other relevant information include, but are not limited to, delays in or extensions in training due to marginal performance, unprofessional conduct during training or in previous

practice settings, investigations conducted or limitations imposed by state licensing boards, adverse actions, malpractice, etc.

A6.11. Paragraph 11 Provide the name, title, phone number, and FAX number of the designated point of contact at the sending facility.

A6.12. General Comments:

A6.12.1. Paragraphs applicable to healthcare providers from Reserve or Guard components: Provide the current civilian position, place of employment or facility where privileges are held, and the clinical privileges held by the healthcare provider. If the healthcare provider is self-employed, provide the healthcare provider's office location. If privileges are held at several facilities, provide the name and location of the place or places where the majority of the practitioner's practice is conducted and a list of the clinical privileges held which are applicable to the assignment prompting the use of the Transfer Brief. Additionally, include the address and business and home telephone numbers where the practitioner may be reached prior to reporting for the assignment and the name of the military treatment facility (MTF) or dental treatment facility (DTF) and dates of the last tour of clinical duty.

A6.12.2. The Transfer Brief will be valid until expiration of the privileges upon which it is based. If the practitioner is assigned temporarily for several brief periods to the same location, the Transfer Brief remains valid over the duration of the combined periods, or until the privileges at the sending MTF/DTF expires. If other credentials have expired in the interim, telephonic or message confirmation of the renewal of the credential with the facility holding the PCF will suffice; i.e., a new Transfer Brief when the status of the provider's privileges or medical staff appointment changes (e.g., change from supervised to regular privileges, renewal of privileges, adverse clinical privileging actions, etc.).

A6.12.3. The Transfer Brief is joined with the formal application for privileges and supplants sections of applicable Military Service forms containing essentially like information. The Transfer Brief serves as PCF and is used in making the decision about whether the individual will be authorized to practice within the facility and what the individual will be authorized to do within the facility.

A6.12.4. Credentials Functions in DoD MTF/DTFs will accept healthcare provider performance appraisals on other Service's forms as their own.

A6.12.5. MTF/DTF commanders may grant privileges based on the approved privileges list from the sending MTF/DTF by approving it with or without facility specific modification. The gaining facility may use its own customary forms or formats for notifying practitioners of their clinical appointments and documenting the same. Privileges applied for but not granted due to facility based limitations are not adverse privileging actions.

INTERFACILITY CREDENTIALS TRANSFER BRIEF

Note: This format is utilized when the MTF is unable to utilize the Transfer ICTB E-application within CCQAS or unable to generate an off-line ICTB from CCQAS.

MEMORANDUM FOR (GAINING FACILITY, LOCATION) FROM: (Sending Facility/Unit, Location)

SUBJECT: Credentials and Privileging Transfer Brief

1. COMPLETE NAME, RANK, CORPS, SSN, DOB, CLINICAL SPECIALTY, and AFSC
2. EDUCATION/TRAINING COMPLETION DATE PSV*

DEGREE: _____ Y/N
 ISSUING INSTITUTION: _____

INTERNSHIP: _____ Y/N
 INSTITUTION: _____

RESIDENCY: _____ Y/N
 INSTITUTION: _____

FELLOWSHIP: _____ Y/N
 INSTITUTION: _____

OTHER QUALIFYING TRAINING: _____ Y/N I
 INSTITUTION: _____

3. LICENSE/CERTIFICATION/REGISTRATION (CURRENT) EXPIR DATE PSV*

_____ Y/N
 _____ Y/N

4. SPECIALTY/BOARD CERT/RECERT EXPIRATION DATE PSV*

a. _____ Y/N

5. LIFE SUPPORT/READINESS TRAINING EXPIRATIONS

BLS _____
 ACLS _____
 ATLS _____
 PALS _____
 NRP _____

6. DEA/CDS TYPE NUMBER EXPIRES VERIFIED*

a. _____ (*CDS only) *Primary Source
 Verification.

7. DATE OF NPDB/HIPDB/FSMB (if applicable) QUERY INFORMATION

PRESENT/ABSENT IN DATA BANK

8. CURRENT STAFF APPOINTMENT WITH CLINICAL PRIVILEGES AT SENDING
 FACILITY

TYPE OF PRIVILEGES AND EXPIRATION DATE

PRIVILEGES GRANTED (PRIVILEGES LIST ATTACHED)

9. (PROVIDER'S NAME) WILL BE PRACTICING AT YOUR FACILITY ON AN
 ONGOING BASIS. PLEASE FORWARD A PERFORMANCE APPRAISAL TO THIS
 COMMAND UPON COMPLETION OF THIS ASSIGNMENT OR BEFORE (DATE),
 WHICHEVER COMES FIRST.

10. (PROVIDER'S NAME) IS KNOWN TO BE CLINICALLY COMPETENT TO PRACTICE
 THE FULL SCOPE OF PRIVILEGES GRANTED AT (SENDING FACILITY), TO
 SATISFACTORILY DISCHARGE HIS OR HER PROFESSIONAL OBLIGATIONS, AND TO
 CONDUCT HIMSELF/HERSELF ETHICALLY, AS ATTESTED TO BY (NAME AND
 TELEPHONE NUMBER OF PERSON PERSONALLY ACQUAINTED WITH THE
 PROVIDER'S PROFESSIONAL AND CLINICAL PERFORMANCE). (NAME OF PERSON
 GIVING RECOMMENDATION) HAS/DOES NOT HAVE ADDITIONAL INFORMATION

RELATING TO (PROVIDER'S NAME) COMPETENCE TO PERFORM GRANTED PRIVILEGES. [When additional information exists, the gaining facility must be instructed to communicate with the point of contact for the purpose of exchanging the additional information.]

PROVIDER'S PCF AND THE DOCUMENTS CONTAINED THEREIN HAVE BEEN REVIEWED AND VERIFIED AS INDICATED ABOVE THE INFORMATION CONVEYED IN THIS MEMORANDUM/MESSAGE REFLECTS CREDENTIALS STATUS AS OF (DATE). [Choose from the following sentence formats, or variations thereof, to describe the presence/absence of additional relevant information in the PCF: (a) THE PCF CONTAINS NO ADDITIONAL INFORMATION RELEVANT TO THE PRIVILEGING OF THE PROVIDER IN YOUR MTF, (b) THE PCF CONTAINS ADDITIONAL RELEVANT INFORMATION REGARDING STATUS OF CURRENT LICENSE, (c) THE PCF CONTAINS ADDITIONAL RELEVANT INFORMATION THAT MAY REFLECT ON THE CURRENT COMPETENCE OF THE PROVIDER. CONTACT THIS COMMAND FOR FURTHER INFORMATION BEFORE TAKING APPOINTING AND PRIVILEGING ACTION.]

POC: NAME, TITLE, PHONE NUMBER, and FAX NUMBER

(FOR RESERVE OR GUARD) CURRENTLY HOLDS PRIVILEGES IN (SPECIALTY) AT (HOSPITAL NAME, ADDRESS). PROVIDER MAY BE REACHED AT (MAILING ADDRESS, HOME PHONE, and OFFICE PHONE).

SIGNATURE OF PRIVILEGING AUTHORITY OR DESIGNATED SGH:

COMMANDER/DESIGNEE DATE

ATTACHMENT(S):

COPY OF CURRENT PRIVILEGE LIST

(If not privileged) MEMORANDUM STATING SUCH AND COPY OF CURRENT AF FORMS

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 7**CONTENTS OF PROVIDER ACTIVITY FILE (PAF)**

A7.1. The PAF is the principal repository for supporting information and data to validate privileging of the provider at the institution. This is a QA document protected by 10 U.S.C. §1102, and is kept separate from the provider credentials file. Data and information in the PAF should include all practice pertinent materials which support the awarding of privileges. This includes metric performance data. This information and data is summarized on the AF Form 22 which is maintained in the PCF.

A7.2. Listed below is data which may be included in the PAF. There is no specific format on how the PAF is to be organized, what items are to be filed, or how data are to be presented in it. It is not limited to only that information listed below but it should include copies of any pertinent committee minutes, patient records, patient statements, and counseling statements that concern the provider. The department or service should select those items which are useful for monitoring the performance of its providers.

A7.2.1. Baseline information and metric data:

A7.2.1.1. For all providers:

A7.2.1.1.1. Facility specific provider identification number

A7.2.1.1.2. Attendance at required professional staff meetings

A7.2.1.1.3. Data on number of duty days, clinical time (i.e., percentage of time spent on clinical activities, administration, etc.)

A7.2.1.2. For outpatient providers:

A7.2.1.2.1. Average daily/monthly patient load

A7.2.1.2.2. Total annual visits

A7.2.1.2.3. Number of emergency visits

A7.2.1.3. For inpatient providers:

A7.2.1.3.1. Number of admissions

A7.2.1.3.2. Number of discharges

A7.2.1.3.3. Number of procedures by category (i.e., deliveries, surgeries, etc.)

A7.2.1.3.4. Number of special care admissions

A7.2.1.4. For emergency providers:

A7.2.1.4.1. Number of visits

A7.2.1.4.2. Number of admissions/special care admissions

A7.2.1.4.3. Number of special procedures (i.e., Thoracotomies)

A7.2.1.5. For supervised providers

A7.2.1.5.1. Periodic performance reports as required.

A7.2.2. Outcome data on mortality, morbidity, and clinical monitoring data on performance parameters which may be used to support the AF Form 22 should be maintained and expressed in rates when possible. Further items to consider are:

A7.2.2.1. Transfusion data

A7.2.2.2. Medication usage

A7.2.2.3. Department specific

A7.2.3. Utilization data. Include appropriate data on usage of high cost resources such as CT/ MRI, high cost medications, blood product utilization. As UM data becomes more available, information on lengths of stay by ICD codes and other useful information on utilization should be identified and kept.

A7.2.4. Risk management data. Synopsis of mortality and morbidity reviews, incident reports, serious events, malpractice claims, and applicable peer review materials should be included.

A7.2.5. Patient generated data. Commendations/complaints with relevant reviews attached.

A7.2.6. Other information:

A7.2.6.1. Letters of appointment to staff positions/committee duties

A7.2.6.2. Copy of curriculum vitae including any publications

A7.2.6.3. Administrative data: rate of chart delinquency, documentation deficiencies, etc.

A7.2.6.4. Participation in activities of benefit to military medicine

A7.2.6.5. Teaching activities

A7.3. The specific clinical service needs to determine which parameters are most useful to assess the provider's performance. Some performance parameters evaluated will have economic/utilization implications as well as clinical performance implications. It is not necessary to include the information in both sections of the PAF.

A7.4. The PAF must be kept secure (locked drawer/room, same as historical PCF and working credentials files). Providers may review the information in their PAF only under supervision. The PAFs are usually maintained at the clinical supervisory level. However, some facilities may opt to use a central maintenance method.

Attachment 8

**LETTER FORMAT FOR INFORMING AN INDIVIDUAL OF IMPLICATIONS OF
CHANGING EMPLOYMENT STATUS WHILE UNDER REVIEW (APPLIES TO
BOTH PRIVILEGED AND NON-PRIVILEGED PROVIDERS)**

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function or Senior Corps Representative

SUBJECT: Implications of Changing Your Employment Status During an Adverse Clinical
Action

Having received information that you are considering (**Note:** Select applicable items only: separation, retirement, discharge, ending employment with the Air Force), I am required to inform you of the implications of your change of status upon the due process of the adverse clinical action currently taking place.

According to AFI 44-119, *Medical Quality Operations*, **Chapter 9**, individuals who separate, retire, are discharged, end employment with the Air Force, or permanently change station within the Air Force while an adverse clinical action is taking place may be reported to the National Practitioner Data Bank, state licensing and/or other regulatory agencies (as applicable).

You may request the due process continue following your (**Note:** Select applicable items only: separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must request it in writing prior to your (**Note:** Select applicable items only: separation, retirement, discharge, termination of employment, PCS). Address your request to me (and AFMOA/SGHQ as appropriate for the appeal process).

Signature
Typed Name and Grade
Commander

1st Ind, Provider

Date _____

TO: CC

I acknowledge receipt of the letter notifying me of the implications of changing my employment status while the adverse clinical action is taking place.

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 9**REPORTABLE ACTIONS OF MISCONDUCT FOR DOD HEALTHCARE PRACTITIONERS**

A9.1. The following misconduct actions shall be reported, as appropriate, to the Surgeon General, the Federation of State Medical Boards, and the appropriate State agencies. (Each of the actions listed shall be cause for initiation of processing for separation for cause or for adverse personnel action under applicable Service regulations. Nothing in this Instruction limits the lawful prerogatives of commanders to discipline the members of their command, nor does anything in this Instruction limit the lawful prerogatives of civilian authorities to enforce the criminal and civil laws of their jurisdictions.)

A9.1.1. Misconduct Actions to be Reported After Due Process, Command Action, and Completion of Applicable Appeal Procedures

A9.1.1.1. Fraud or misrepresentation involving application for enlistment, commission, employment, or affiliation with DoD service that results in removal from service;

A9.1.1.2. Fraud or misrepresentation involving renewal of contract for professional employment, renewal of clinical privileges, or extension of Service obligation;

A9.1.1.3. Proof of cheating on a professional qualifying examination; and

A9.1.1.4. Abrogation of professional responsibility through any of the following actions:

A9.1.1.4.1. Deliberately making a false or misleading statement to patients as regards clinical skills or clinical privileges;

A9.1.1.4.2. Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law;

A9.1.1.4.3. Being found impaired by reason of drug abuse, alcohol abuse, or alcoholism;

A9.1.1.4.4. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons;

A9.1.1.4.5. Commission of an act of sexual abuse or exploitation related to clinical activities, or non-clinically related indications of sexual misconduct, such as promiscuity, bizarre sexual conduct, indecent exposure, rape, contributing to the delinquency of a minor, or child molestation, when, in the commander's judgment, such activities impair the practitioner's overall effectiveness and credibility within the healthcare system, or within his or her professional or patient communities;

A9.1.1.4.6. Prescribing, selling, administering, or providing controlled substances as defined by 21 U.S.C. 801-977 [reference (q)] for use by the practitioner or a family member of the practitioner without written approval of the Medical Commander, or admitted misuse of such substances by the practitioner;

A9.1.1.4.7. Failure to report to the privileging authority any disciplinary action taken by professional or governmental organizations;

A9.1.1.4.8. Failure to report to the privileging authority any malpractice awards, judgments, or settlements occurring outside of DoD facilities;

A9.1.1.4.9. Failure to report to the privileging authority any professional sanction taken by a civilian licensing agency or healthcare facility;

A9.1.1.4.10. Any violation of the Uniform Code of Military Justice [reference (e)] for which the member was awarded non judicial punishment when the offense is related to a practitioner's ability to practice his or her profession or which impairs the practitioner's credibility within the healthcare system or within his or her professional community; and,

A9.1.1.4.11. Commission of any offense that is punishable in a civilian court of competent jurisdiction by a fine of more than \$1000 or confinement for over 30 days, for offenses related to professional practice or which impair the practitioner's credibility within the healthcare system or within his or her professional community.

A9.1.2. Administrative Discharge. Discharge instead of court-martial or administrative discharge while charged with an offense designated in this enclosure after command action and completion of applicable appeal procedures.

A9.1.3. Misconduct to be Reported Upon Referral for Trial by Courts-Martial or Indictment in a Civilian Court and Upon Final Verdict Adjudication or Administrative Disposition

A9.1.3.1. 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;

A9.1.3.2. Offenses punishable by confinement or imprisonment for more than 1 year under 10 U.S.C 801-940 (reference (e));

A9.1.3.3. Entry of a guilty or nolo contendere plea, or request for discharge instead of court-martial while charged with an offense designated in subsection [A9.1.1](#) above.

A9.1.3.4. Committing an act of sexual abuse or exploitation in the practice of medicine, dentistry, nursing, or other professional practice of healthcare as may be designated by the ASD(HA);

A9.1.3.5. Inappropriately receiving compensation for treatment of patients eligible for care in DoD hospitals and,

A9.1.3.6. Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.

Attachment 10

LETTER FORMAT FOR NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES (USED FOR PRIVILEGED PROVIDER)

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function

SUBJECT: Notice of Abeyance of Clinical Privileges

You are hereby notified that your clinical privileges are placed in abeyance as follows: (state what privileges are affected, all, some (if some, state which ones). This action is being taken in response to (state the issues involved, i.e., clinical deficiencies, substandard care events, evidence of impairment, evidence of misconduct). These issues have had (or could potentially have) the following adverse effects on patient safety and healthcare delivery (list the untoward effects). (Include this sentence and state the duties assigned if provider is removed from all clinical duties: During this period of abeyance you are assigned to the following duty (state the duties assigned if the provider is removed from all clinical duties.)

Abeyance is a temporary removal of some or all clinical privileges for up to 30 calendar days. An abeyance is not an adverse clinical privilege action; therefore, it does not mandate disclosure in future official applications for state licensure or clinical privileges, nor is it reported to any regulatory agency. If, at the end of the 30-day abeyance your privileges are not reinstated, the action automatically becomes a summary suspension. A summary suspension is an adverse privileging action, therefore, it does mandate disclosure in future applications for state licensure and when applying for clinical privileges. A summary suspension is not reported to regulatory agencies unless the suspension is the final action taken by the Air Force Surgeon General (AF/SG) following due process procedures.

You are also notified that a Quality Assurance (QA) investigation will be conducted regarding the allegations specified above. If, based on the QA investigation report there is a substantial cause to proceed, a peer review panel will be conducted to review the evidence and make a recommendation to the privileging authority. Should a peer review panel be warranted you will receive written notification including when the panel will convene. The adverse action due process is found in AFI 44-119, *Medical Quality Operations*, Chapter 9.

Providers who separate, retire, are discharged, or end employment with the Air Force while an adverse action review is taking place may be reported to the National Practitioner Data Bank, Defense Practitioner Data Bank, and state licensing agencies. You may request the review of your clinical privileges continue following your (**Note:** Select applicable items: separation, retirement, discharge, termination of employment, PCS). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must request it in writing prior to your (**Note:** Select applicable items: separation, retirement, discharge, termination of employment, PCS). Address your request to me. Permission to engage in off-duty employment is hereby (**Note:** Select applicable item: denied or revoked) until further notice. During the period of abeyance, you will be temporarily assigned to the duties noted above.

Signature

Typed Name and Grade

Chairperson, Credentials Function

1st Ind, Provider

Date_____

TO: Chairperson, Credentials Function

I acknowledge receipt of the Notice of Abeyance of Clinical Privileges and the change of duty during the period of abeyance period, dated (date of the letter of notification).

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 11

**LETTER FORMAT FOR NOTIFICATION OF CLINICAL PRIVILEGES SUMMARY
SUSPENSION (USED FOR PRIVILEGED PROVIDER)**

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function

SUBJECT: Notice of Summary Suspension of Clinical Privileges

You are hereby notified that your clinical privileges are summarily suspended as follows: (state what privileges are affected, e.g., all, some, and if some, state which). This action is being taken in response to (state the issues involved, i.e., clinical deficiencies, substandard care events, evidence of impairment, evidence of misconduct). These issues have had (or could potentially have) the following adverse effects on patient safety and healthcare delivery (state the untoward effects). During this period of summary suspension you are assigned to the following duty (state the duties assigned if the provider is removed from all clinical duties).

Summary suspension is an adverse action which temporarily clinical privileges while due process procedures are conducted. Summary suspension is valid for six months, but may be extended if necessary. (If the provider is a federal civilian, state: "A copy of this letter will be forwarded to the CPO." If the provider is a contractor, state "A copy of this letter will be forwarded to the contracting office."). Permission to engage in off-duty employment is revoked until further notice. (If provider is a contractor, state "it is your responsibility to notify other medical facilities where you hold clinical privileges that your clinical privileges at this facility were suspended").

You are also notified that a Quality Assurance (QA) investigation will be conducted, (if not already completed), regarding the allegations specified above. If, based upon the QA investigation report there is a substantial cause to proceed, the Credentials Function will recommend a Peer Review Panel be conducted to review the evidence and make a recommendation to the Credentials Function. Should a Peer Review Panel be warranted you will receive written notification including when the panel will convene. The adverse privileging action due process is found in AFI 44-119, *Medical Quality Operations*, Chapter 9.

Providers who separate, retire, are discharged, or end employment with the Air Force, while an adverse privileging action is taking place may be reported to the National Practitioner Data Bank, Defense Practitioner Data Bank, and state licensing agencies. You may request the review of your clinical privileges continue following your (Select appropriate item: separation, retirement, discharge, termination of employment). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must make such request in writing prior to your (Select appropriate item: separation, retirement, discharge, termination of employment). Address your request to me.

Should you terminate your work affiliation with (MTF name) and not provide a written request to continue the due process procedures following this work termination, the summary suspension will become a suspension of clinical privileges. This will be the final action and is required to be reported to the National Practitioner Data Bank and states of licensure.

If you have any questions please contact (name of risk manager or designee) in the Clinical Quality Office (or location relevant to the MTF) at (telephone number) and (email).

Signature
Typed Name and Grade
Chairperson, Credentials Function

1st Ind, Provider

Date _____

TO: Chairperson, Credentials Function

I acknowledge receipt of the Notice of Summary Suspension of Clinical Privileges, and the change of duty during this period of suspension, dated (date of notification letter).

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 12

LETTER FORMAT FOR NOTIFICATION OF PEER REVIEW PANEL (USED FOR BOTH PRIVILEGED AND NON-PRIVILEGED PROVIDERS)

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function

SUBJECT: Notice of Peer Review Panel

This is to inform you that on (date), a Peer Review Panel will be conducted to review the following allegations: (state the allegations under review, e.g., clinical deficiencies, impairment or professional misconduct). If a Quality Assurance (QA) investigation has been completed, the QA investigation will be reviewed.

The Peer Review Panel will determine the validity of the allegations and make a recommendation to the Credentials Function, (include the following phrase if the provider is a non-privileged provider: including the Senior Corps Chief,) which in turn will make a recommendation to the Commander (privileging authority). While you do not have the right to be present for the Panel's proceedings, you may present a written statement regarding the allegations under review. In addition, the Panel may request your presence to address questions or provide clarity on issues. Please review AFI 44-119, *Medical Quality Operations*, Chapter 9, for due process details.

You have the right to seek legal counsel and be represented during this adverse privileging (use term "practice" instead of "privileging" for non-privileged provider) action. Please note, this Peer Review Panel is not a legal proceeding and you and your legal counsel are not permitted to attend this review.

Based upon the QA investigation, Peer Review Panel results, and the Credentials Function recommendation(s), the Commander will determine what action is warranted (if any). You will receive written notification from the Commander if he/she proposed any adverse action against your clinical privileges and medical staff appointment (for non-privileged provider use the phrase "clinical practice" instead of "clinical privileges and medical staff appointment").

Providers who separate, retire, are discharged, or end employment with the Air Force, while an adverse privileging (use term "practice" for non-privileged provider) action is taking place may be reported to the National Practitioner Data Bank, Defense Practitioner Data Bank, and state licensing agencies. You may request the review of your clinical privileges (use term "practice" for non-privileged provider) continue following your (Select appropriate item: separation, retirement, discharge, termination of employment). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must make such request in writing prior to your (Select appropriate item: separation, retirement, discharge, termination of employment). Address your request to me.

If you have any questions please contact (name of risk manager or designee) in the Clinical Quality Office (or location relevant to the MTF) at (telephone number) and (email).

Signature

Typed Name and Grade

Chairperson, Credentials Function

1st Ind, Provider

Date_____

TO: Chairperson, Credentials Function

I acknowledge receipt of the notice that a Peer Review Panel will convene on (date) to review the allegations noted above regarding my clinical privileges (use term “practice” for non-privileged provider).

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 13

LETTER FORMAT FOR NOTIFICATION OF PROPOSED ADVERSE ACTION

(USED FOR PRIVILEGED PROVIDER)

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: MTF Commander

SUBJECT: Notice of Proposed ((Restriction / Reduction/ Revocation /Denial) of Clinical Privileges

You are hereby notified that I propose to (deny / restrict / reduce / revoke) your clinical privileges as follows: (state the scope of the action, i.e., what privileges are affected). This action is being taken in response to (state specific allegations that were substantiated with the QA investigation, Peer Review Panel, and Credentials Function review, i.e., evidence of clinical deficiencies, impairment or condition that affects patient safety or professional misconduct). These problems had (or could have) the following adverse effects on patient care and safety (list the untoward effects).

During this time while due process procedures are ongoing your clinical privileges will (state what privileges are affected and their status during the due process, i.e., remain in summary suspension, restricted, etc).

You are advised that you have a right, upon written request, to have a hearing panel review this action. To invoke this right, you must make a written request to me within 30 calendar days from the date you receive this notification. If you fail to make a written request within this time period, or if you fail to appear for the scheduled hearing, you waive your right to the hearing and to the right to appeal to the Surgeon General. The due process procedures for this action are found in AFI44-119, *Medical Quality Operations*, Chapter 9.

Providers who separate, retire, are discharged, or end employment with the Air Force, while an adverse privileging action is taking place may be reported to the National Practitioner Data Bank, Defense Practitioner Data Bank, and state licensing agencies. You may request the review of your clinical privileges continue following your (Select appropriate item: separation, retirement, discharge, termination of employment). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must make such request in writing prior to your (Select appropriate item: separation, retirement, discharge, termination of employment). Address your request to me.

Signature

Typed Name and Grade
Commander

1st Ind, Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the Notice of the Proposed (Denial / Restriction / Reduction / Revocation) of my clinical privileges and the change of my privileges and duty during the during process procedures, dated (date of notification letter).

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 14**LETTER FORMAT FOR NOTIFICATION OF CLINICAL ADVERSE ACTION
HEARING (USED FOR PRIVILEGED AND NON-PRIVILEGED PROVIDERS)**

Date

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function / Senior Corps Representative

SUBJECT: Notification of Clinical Adverse Action Hearing

A hearing panel will conduct a hearing on allegations that may adversely affect your clinical privileges (use the term “clinical practice” for non-privileged provider). The hearing will be at (hour), on (date), at (location). You have the right to present evidence and call witnesses on your behalf, to cross-examine witnesses called by the hearing panel, and to consult and be represented by legal counsel. It is your responsibility to arrange for the presence of any witnesses you desire to participate in the hearing. If you are a military provide and so request, a military legal counsel will be made available to you. You may retain a civilian attorney at your own expense.

The panel currently expects to call these witnesses: (list of witnesses). If you fail to appear at the scheduled hearing, the MDG/CC may choose to proceed with the hearing or consider the hearing waived and act on your clinical privileges (use the term “clinical practice” for non-privileged provider) as intended in the written notice of the proposed action dated (date of notification of proposed action letter). When the hearing is waived your appeal rights are also waived.

You may request a delay of the hearing for good cause; however, absent compelling circumstances (i.e., severe illness or death of a family member) delays will not be granted if the required is received by the Chairperson, Credentials Function (for non-privileged provider add: “or Senior Corps Representative”) less than 5 calendar days prior to a scheduled hearing.

Allegations being investigated are: (state the nature of those allegations and the effect these issues are having, or could potentially have, on patient care and safety. Ensure allegations are in sufficient detail so that the provider is fully apprised of matters involved and may prepare his/her response to those allegations. Copies of medical records/documents shall be available to the provider.)

Use the following paragraph for privileged providers:

Depending on the outcome of this hearing, the AF/SG may direct AFMOA/SGHQ to report this action to the National Practitioner Data Bank, the Defense Practitioner Data Bank, states(s) of licensure, and other appropriate professional regulatory agencies. I refer you to AFI 44-119, *Clinical Quality Operations*, Chapter 9 for the specific due process procedures for this action.

Use the following paragraph for non-privileged providers:

Depending on the outcome of this hearing, the AF/SG may direct AFMOA/SGHQ to report this action to your states(s) of licensure, and other appropriate professional regulatory agencies. I refer you to AFI 44-119, *Clinical Quality Operations*, Chapter 9 for the specific due process procedures for this action.

Signature

Typed Name and Grade

Chairperson, Credentials Function or Senior Corps
Representative (for non-privileged provider)

1st Ind, Provider

Date _____

TO: Chairperson, Credentials Function or Senior Corps Representative (for non-privileged provider)

I acknowledge receipt of the Notice of Clinical Adverse Action Hearing, dated (date of letter of notification).

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 15**LETTER FORMAT FOR NOTIFICATION OF HEARING RECOMMENDATIONS
(USED FOR PRIVILEGED AND NON-PRIVILEGED PROVIDERS)**

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Chairperson, Credentials Function/Senior Corps Representative

SUBJECT: Notification of Adverse Action Hearing Recommendations in Re: Provider

The (facility) hearing panel has made the following recommendation(s) to (name and grade of MTF/CC) regarding the proposed adverse action against your clinical privileges (for non-privileged provider use the term "clinical practice") at this facility: (state the recommendation(s) including any conditions, and the duration of any restriction).

You have 10 calendar days from the date of receipt of this notification to submit a letter of exceptions and corrections to (name and grade of MTF/CC), if you so desire. (Name and grade of MTF/CC) may grant additional time for good cause. A copy of the hearing transcript is attached for your review.

Signature

Typed Name and Grade

Chairperson, Credentials Function/ Senior Corps
Representative

Attachment: Hearing Transcript

1st Ind, Provider

Date _____

TO: Chairperson, Credentials Function/Senior Corps Representative

I acknowledge receipt of the letter of Notification of Adverse Action Hearing Recommendations, dated (date of letter of notification). I understand that I have 10 calendar days to submit a statement of exceptions and corrections to the Commander.

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 16

**LETTER FORMAT OF FINAL DECISION BY MILITARY TREATMENT FACILITY
COMMANDER FOLLOWING A HEARING (USED FOR PRIVILEGED AND NON-
PRIVILEGED PROVIDERS)**

Date _____

MEMORANDUM FOR: Name and Grade of Provider

FROM: MDG/CC

SUBJECT: Final Decision in Clinical Adverse Action Proceeding Re: (insert provider's name)

Having fully reviewed the record of the subject hearing proceeding (as well as the letter of exceptions you provided), I (am approving the recommendations of the hearing panel and) direct that (the decision, including the duration of any privilege/practice (use the term "practice" if provider is a non-privileged provider) modification).

You are advised of your right to appeal, according to AFI 44-119, Medical Quality Operations. This office must receive your written appeal within 10 calendar days from the date of this letter. The time may be extended by myself or AFMOA/CC for good cause. Your appeal along with the adverse action case file will be mailed to AFMOA/SGHQ for review. A summary of the case file to include your appeal will be forwarded by AFMOA/SGHQ to HQ MAJCOM/SG for review. The Chief, Risk Management Operations, will prepare your appeal for review by the Air Force Medical Practice Review Board. Your appeal is then forwarded to the AF/SG for final decision. My decision will remain in effect during appellate proceedings.

(Optional) During the appellate period you will be temporarily reassigned to the _____ section to function as _____.

Signature

Typed Name/Grade

Commander

1st Ind, Provider

Date _____

TO: Chairperson, Credentials Function/Senior Corps Representative

I acknowledge receipt of the commander's letter of notification of Final Decision in Clinical Adverse Action Proceeding, dated (date of letter of notification).

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 17**LETTER FORMAT OF FINAL DECISION BY MILITARY TREATMENT FACILITY
COMMANDER (NO A HEARING OR APPEAL) (USED FOR PRIVILEGED
PROVIDER)**

Date _____

MEMORANDUM FOR: Name and Grade of Provider

FROM: MDG/CC

SUBJECT: Final Decision in Clinical Adverse Action Proceeding Re: (insert provider's name)

Use the appropriate paragraph:

I am in receipt of your letter dated _____ stating that you are waiving your right to a hearing and appeal regarding the proposed (denial / restriction / reduction / revocation) of your clinical privileges. This notice is to communicate my final action on your clinical privileges. I hereby (deny / restrict / reduce / revoke) your clinical privileges as follows: (specify the type of action / duration.)

I am aware you failed to appear for your scheduled clinical adverse action hearing on _____ (date). You have thereby waived your right to a hearing and appeal of the proposed adverse action. This notice is to communicate my final action on your clinical privileges. I hereby (deny / restrict / reduce / revoke) your clinical privileges as follows: (specify the type of action / duration).

I have not received a written request for a clinical adverse action hearing from you within the 30 calendar days of your receipt of my proposed action against your clinical privileges. Since you have elected not to proceed with a hearing on this matter, you have waived your right to a hearing and appeal of the proposed adverse action. This notice is to communicate my final action on your clinical privileges. I hereby (deny / restrict / reduce / revoke) your clinical privileges as follows: (specify the type of action / duration).

Use the paragraph below for all privileged providers:

This action is reportable to the National Practitioner Data Bank, the Defense Practitioner Data Bank, your state(s) of licensure, and other professional regulatory entities as appropriate. The AF/SG will review your case and direct reporting.

Signature

Typed Name/Grade

Commander

1st Ind, Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the commander's letter of notification of Final Decision in Clinical Adverse Action Proceeding, dated (date of letter of notification).

Signature of Provider

Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 18

LETTER FORMAT FOR NOTIFICATION OF REMOVAL FROM PATIENT CARE DUTIES (USED FOR NON-PRIVILEGED PROVIDER)

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: Senior Corps Representative

SUBJECT: Notice of Removal from Patient Care/Quality Assurance Investigation

You are hereby notified that you are being removed from (all/a portion of) your patient care duties as follows: (state the scope of the action, i.e., removed from all patient care duties). This action is being taken in response to (state the issues involved, i.e., evidence of clinical deficiencies, impairment, or professional misconduct). These issues have had (or could potentially have) the following adverse effects on patient care and patient safety (list the untoward effects).

You are also notified that a Quality Assurance (QA) investigation will be conducted regarding the allegations specified above. If, based on the QA investigation report there is a substantial cause to proceed, a peer review panel will be conducted to review the evidence and make a recommendation to the privileging authority. Should a peer review panel be warranted you will receive written notification including when the panel will convene. The adverse action due process is found in AFI 44-119, *Medical Quality Operations*, Chapter 9.

Depending on the outcome of this action, AFMOA/SGHQ may be directed to report the matter to appropriate professional regulatory agencies IAW DoD directives.

Note: Next paragraphs are standard (first paragraph is not necessary if not engaged in off-duty employment:

Permission to engage in off-duty employment is hereby (**Note:** Select applicable item: denied or revoked) until further notice. During this period while you are removed from clinical practice (or your clinical practice is restricted), you will be temporarily assigned to _____ section to function as a _____.

Individuals who separate, retire, are discharged, or end employment with the Air Force while an adverse action review is taking place may be reported to their state (s) licensing agencies. You may request the review of your clinical practice continue following your (**Note:** Select applicable items: separation, retirement, discharge, termination of employment, PCS). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must request it in writing prior to your (**Note:** Select applicable items: separation, retirement, discharge, termination of employment, PCS). Address your request to me.

Signature

Typed Name and Grade

Senior Corps Representative

1st Ind, Provider

Date _____

TO: Senior Corps Representative

I acknowledge receipt of the Notice of Removal from Patient Care Duties, dated (date of the letter of notification).

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 19**LETTER FORMAT FOR NOTIFICATION OF PROPOSED ADVERSE ACTION (USED FOR NON-PRIVILEGED PROVIDER)**

Date _____

MEMORANDUM FOR Name and Grade of Provider

FROM: MTF Commander

SUBJECT: Notice of Proposed ((Restriction / Reduction/ Revocation) of Clinical Practice

You are hereby notified that I propose to (restrict / reduce / revoke) your clinical practice as follows: (state the scope of the action, i.e., how clinical practice is affected). This action is being taken in response to (state specific allegations that were substantiated with the QA investigation, Peer Review Panel, and Credentials Function review, i.e., evidence of clinical deficiencies, impairment or condition that affects patient safety or professional misconduct). These problems had (or could have) the following adverse effects on patient care and safety (list the untoward effects).

During this time while due process procedures are ongoing your clinical practice will (state what practice will be allowed (if any) or if completely removed from clinical practice, state what/where their duty will be).

You are advised that you have a right, upon written request, to have a hearing panel review this action. To invoke this right, you must make a written request to me within 30 calendar days from the date you receive this notification. If you fail to make a written request within this time period, or if you fail to appear for the scheduled hearing, you waive your right to the hearing and the right to appeal the action to the Surgeon General. The due process procedures for this action are found in AFI44-119, *Medical Quality Operations*, Chapter 9.

Providers who separate, retire, are discharged, end employment with the Air Force, or permanently change station within the Air Force while an adverse action review is taking place may be reported to state licensing agencies. You may request the review of your clinical practice continue following your (Select appropriate item: separation, retirement, discharge, termination of employment). If you request continuation of the due process, a report will not be made (if indicated) until completion of the due process. If you desire a continuation, you must make such request in writing prior to your (Select appropriate item: separation, retirement, discharge, termination of employment). Address your request to me.

Signature

Typed Name and Grade

Commander

1st Ind, Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the Notice of the Proposed (Denial / Restriction / Reduction / Revocation) of my clinical practice and the change of my duty during the during process procedures, dated (date of notification letter).

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 20

**LETTER FORMAT OF FINAL DECISION BY MILITARY TREATMENT FACILITY
COMMANDER (NO A HEARING OR APPEAL) FOR NON-PRIVILEGED PROVIDER**

Date _____

MEMORANDUM FOR: Name and Grade of Provider

FROM: MDG/CC

SUBJECT: Final Decision in Clinical Adverse Action Proceeding Re: (insert provider's name)

Use the appropriate paragraph:

I am in receipt of your letter dated _____ stating that you are waiving your right to a hearing and appeal regarding the proposed (restriction / reduction / revocation) of your clinical practice. This notice is to communicate my final action on your clinical practice. I hereby (restrict / reduce / revoke) your clinical practice as follows: (specify the type of action / duration.)

I am aware you failed to appear for your scheduled clinical adverse action hearing on _____ (date). You have thereby waived your right to a hearing and appeal of the proposed adverse action. This notice is to communicate my final action on your clinical practice. I hereby (restrict / reduce / revoke) your clinical privileges as follows: (specify the type of action / duration).

I have not received a written request for a clinical adverse action hearing from you within the 30 calendar days of your receipt of my proposed action against your clinical practice. Since you have elected not to proceed with a hearing on this matter, you have waived your right to a hearing and appeal of the proposed adverse action. This notice is to communicate my final action on your clinical practice. I hereby (restrict / reduce / revoke) your clinical practice as follows: (specify the type of action / duration).

Use the paragraph below for all non-privileged providers:

This action is reportable to your state(s) of licensure, and other professional regulatory entities as appropriate. The AF/SG will review your case and direct reporting.

Signature
Typed Name/Grade
Commander

1st Ind, Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the commander's letter of notification of Final Decision in Clinical Adverse Action Proceeding, dated (date of letter of notification).

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 21**ARRANGEMENT OF ADVERSE ACTION CASE FILE**

Arrange the records of adverse action proceedings using the following index tabs. Use a tab to separate each document category, except for the cover sheet and index. The cover sheet and index contain the case file number and involved MTF. It also lists, with dates, the document categories in the record, in the order described below:

Tab 1. Reserved for record of HQ USAF/SG proceedings and decision.

Tab 2. Provider's Appeal, intent to appeal or waiver of appeal.

Tab 3. MTF/CC's final decision letter with acknowledgment by provider (date and signature). Final DD Form 2499.

Tab 4. Provider's statement of exceptions/corrections, if submitted.

Tab 5. Hearing committee findings and recommendations (minority findings and recommendations), if credentials function findings and recommendations, if any. Senior Corp Chiefs recommendations if any.

Tab 6. Hearing transcript. Tab exhibits reviewed at the hearing separately (e.g., use Tabs 6-1, 6-2 and so on). If documents were offered at the hearing, but ruled inadmissible for review, tab them together as the final subcategory of documents attached to the hearing transcript (If documents in this category are too bulky, they may be cross referenced and assembled separately.)

Tab 7. Letter of notification of hearing, with acknowledgment by the provider. Letter waiving hearing if applicable.

Tab 8. MTF/CC proposed decision following credentials review/peer review with acknowledgment by provider (date and sign).

Tab 9. Findings of Credentials Review Function and Peer Review Panel.

Include Article 15/Court Martial documentation as appropriate

Findings of inquiry, OSI investigation

Any supporting documentation reviewed by these committees should be included here.

MEB/PEB results, separation orders, etc.

Tab 10. Initial DD Form 2499, and Letters of Abeyance/Summary Suspension, if any, with acknowledgment by the provider (date and signature).

Attachment 22

LETTER FORMAT FOR NOTIFICATION TO AFMOA/SGHQ OF REPORTABLE ACTION

Date _____

MEMORANDUM FOR: AFMOA/SGHQ

(Contact AFMOA/SGHQ for current mailing address)

FROM: MTF/Office Symbol

SUBJECT: Report of Incident to State Board of Licensure

AFI 44-119 requires that we notify AFMOA/SGHQ of certain actions involving licensed providers. The following information is provided:

Individual's Name:

Date of Birth: (MM/DD/YYYY)

Social Security Number:

Home of Record: (or Current Address)

Profession: (i.e., RN, MD, Dentist, etc.)

School Attended/Year Graduated:

State and License Number(s):

Military Treatment Facility: Example: XX Medical Group, Hospital Road, XX AFB, State, ZIP

Action and Date: (Date of Action and description of the action to be submitted to the state board. For example, Dr. XX voluntarily restricted his privileges related to a medical condition that is affecting his ability to practice medicine.) (Attach supporting documents; provider letter requesting voluntary restriction, MTF/CC response letter to provider, any MEB/PEB relevant documents, etc.).

Point of Contact for further information is (give name, phone, fax, and email). Attached is supporting documentation related to this action (final DD Form 2499, Provider request letter, MTF/CC approval/ notification letter).

Signature

Typed Name /Grade

Title/Office

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 23

**LETTER FORMAT FOR NOTIFICATION TO INDIVIDUAL OF POTENTIAL HIPDB
REPORT**

Date _____

MEMORANDUM FOR: Name/Grade of Provider

FROM: SQ/CC, Senior Corps Representative, Senior Enlisted Functional

SUBJECT: Potential Report to the Healthcare Integrity Protection Data Bank (HIPDB)

This is to inform you that your actions involving (describe the situation/actions) may be reported to the Healthcare Integrity and Protection Data Bank. This is a national data bank, which tracks healthcare fraud and administrative adverse actions involving medical personnel. Upon completion of this administrative action, the (MTF/CC, name) will determine if your actions have adversely affected the provision of healthcare. If so, he/she will recommend the Air Force Surgeon General direct a report to the HIPDB on your behalf. You will be notified of the final outcome.

You have 10 calendar days from receipt of this notification to submit a written reply for my consideration. Please address your reply to me. If no reply is received, the process will continue in accordance with Air Force Instruction 44-119, **Chapter 9**.

Signature
Name/Grade
Commander

1st Ind, Provider

Date _____

MEMORANDUM FOR SQ/CC, Senior Corps Representative, Senior Enlisted Functional

I acknowledge receipt of notification that my actions may result in a report to the HIPDB. **I WILL/WILL NOT** submit a reply regarding this issue.

Signature Healthcare Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

**LETTER FORMAT FOR MTF/CC NOTIFICATION TO INDIVIDUAL OF
RECOMMENDATION FOR HIPDB REPORT**

Date _____

MEMORANDUM FOR: Name/Grade of Provider

FROM: MTF/CC

SUBJECT: Recommendation to Report to the Healthcare Integrity and Protection Data Bank
(HIPDB)

I have determined your actions have adversely affected the provision of healthcare in the following manner: (description of situation/actions/event and the affect on healthcare). I am recommending to the Air Force Surgeon General you be reported to the Healthcare Integrity and Protection Data Bank. You will be notified in writing the final outcome of this matter.

Signature

Typed Name and Grade

MTF Commander

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 24

**LETTER FORMAT FOR NOTIFICATION AS A SIGNIFICANTLY INVOLVED
PROVIDER IN A POTENTIALLY COMPENSABLE EVENT**

MEMORANDUM FOR: Name and Grade of Provider

Date _____

FROM: MTF/CC

SUBJECT: Notification as a Significantly Involved Provider in A Potentially Compensable
Event, Event #

This letter is to inform you of your involvement in a Potentially Compensable Event (PCE) (*case number*). Our facility quality of care review process found you are significantly involved in this medical event. Furthermore, this review found you (*met / did not meet*) the standard of care. You may submit a response to this review or a memorandum describing the event, which will be maintained with the PCE file.

Should a medical malpractice claim be filed, Air Force Legal Operations Agency, Medical Law Branch (AFLOA/JACC) will notify this office. You will be notified if a claim is filed and the standard of care determinations made on your behalf.

The PCE and medical malpractice claim process and regulatory requirements are detailed in Air Force Instruction 44-119, *Medical Quality Operations*, Chapter 10. Our Chief, of the Medical Staff and Risk Manager (insert POC information) are available to address your questions. Please keep the credentials office and risk management office informed of your current address so we can forward you correspondence regarding this case. Complete the attachment to this letter and return it to the risk management office. If you have any questions regarding this notification, please contact (insert POC information).

Signature

Typed name and grade

Commander

Attachment

Personal Data Sheet

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

**PERSONAL DATA SHEET FOR A SIGNIFICANTLY INVOLVED PROVIDER IN A
POTENTIALLY COMPENSABLE EVENT**

NAME: (Provider Name) _____

Last four of SSAN: _____

Date of Birth: _____

CURRENT MAILING ADDRESS:

Home address:

(Street address)_____
(City, State, Zip Code)

Business address:

_____**TELEPHONE NUMBER:**Home/Cell: _____
(Area code and number)Office: _____
(Area code and number)

For information regarding this claim, I prefer to have correspondence/data mailed to my:

- ☐ home
☐ business

E-mail address: _____

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 25

**LETTER FORMAT FOR NOTIFICATION OF SIGNIFICANTLY INVOLVED
PROVIDER WITH STANDARD OF CARE DETERMINATION**

Date _____

MEMORANDUM FOR: Name and Grade of Provider

FROM: MTF/CC

SUBJECT: Notification of Medical Malpractice Claim Involvement: Claim #

This letter is to inform you of your involvement in the malpractice claim of (claimant's name, case number). An initial quality of care review process found you are significantly involved in the allegation of this claim. This review found you (met / did not meet) the standard of care. This is a preliminary standard of care review for this claim. The Air Force Legal Operations Agency, Medical Law Branch (AFLOA/JACC) will obtain expert clinical reviews during the adjudication process. You may prepare and submit a written response to these reviews if desired. The medical malpractice claim process and regulatory requirements are detailed in Air Force Instruction 44-119, *Medical Quality Operations*, Chapter 10. Our Chief of the Medical Staff and Risk Manager (insert POC information) are available to address your questions.

Air Force Medical Operations Agency, Risk Management Operations (AFMOA/SGHQ) is responsible for final malpractice claim procedures. These procedures are not completed until the legal proceedings are closed (final legal disposition). Should a payment be rendered for this claim, further standard of care reviews will be required. If further reviews of the case determine that standard of care was breached, you will be notified and afforded an opportunity to respond. The legal adjudication and final standard of care process may take several years to complete. The time frame is dependent on legal proceedings/closure, number of healthcare providers involved, and the number of additional expert peer reviews required. Please keep the credentials office and risk management office informed of your current address so we can forward correspondence regarding this case.

Signature

Typed name and grade

Commander

1st Ind, Healthcare Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the Standard of Care (SOC) determination regarding the care I administered to (claimant's name). I understand that this is a preliminary standard of care review and the case may be subject to further SOC reviews. I understand that if at any point if a SOC not met determination is made on my behalf, I will be notified and afforded an opportunity to respond. I understand that the final processing of this claim may take years to complete, and that no action will occur until the claim has been legally closed. I will keep the credentials office and the risk management office informed of my correct address so I can receive additional correspondence related to this case.

Signature of Provider
Typed name and grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]

Attachment 26

LETTER FORMAT FOR NOTIFICATION OF STANDARD OF CARE NOT MET
DETERMINATION

Date _____

MEMORANDUM FOR: Name and Grade of Provider

FROM: MTF/CC

SUBJECT: Notification of Standard of Care Not Met Determination: Claim #

This letter is to inform you of your involvement in the malpractice claim of (claimant's name, case number). Through an expert review process it was determined that you did not meet the standard of care. A redacted copy of this review (redacted to keep the identity of the expert medical reviewer(s) confidential), is (are) attached. Following legal closure, the claim will be forwarded to the Air Force Medical Operations Agency (AFMOA/SGHQ), Risk Management Operations for final standard of care review and closure. This will include standard of care review by a peer. The Air Force Surgeon General's office must comply with provisions of the Health Care Quality Improvement Act of 1986 that pertain to reporting healthcare providers to the National Practitioner Data Bank (NPDB). Your name may be submitted to the NPDB if the claim is paid on your behalf for failure to meet the appropriate standard of care. The medical malpractice claim process and regulatory requirements are detailed in Air Force Instruction 44-119, Clinical Quality Operations, Chapter 10. Our Chief of the Medical Staff and Risk Manager (insert POC information) are available to address your questions.

You may provide a written response to this standard of care determination. It is beneficial for your response to address the reasons for which the expert reviewer stated you failed to meet the standard of care. AFMOA/SGHQ will forward your response with the claim file for expert peer review. The claim will then be presented to the Medical Practice Review Board. You have ten duty days from the date of receipt of this letter to notify me in writing of your intent to respond. Please sign Endorsement 1, the bottom portion of this letter, indicating your receipt. You may also indicate your intent to submit a written response in Endorsement 2 of this letter. This letter will be faxed to Chief, Risk Management Operations, AFMOA/SGHQ, (contact AFMOA/SGHQ for current commercial and DSN phone numbers).

If you choose to submit a written response, please provide a copy to our risk management office and then mail or fax it to AFMOA/SGHQ within 30 days of the date you received this letter.

Please address your response to Chief Risk Management Operations, AFMOA/SGHQ, (contact AFMOA/SGHQ for current mailing address).

Signature
Typed name and grade
Commander

Attachments:

1. Redacted SOC Review(s), dated _____
2. DD Form 2526

1st Ind, Provider

Date _____

TO: MTF/CC

I acknowledge receipt of the Standard of Care determination regarding the care I administered to (claimant's name). I will inform you in writing whether I will submit a written response to this

determination within 10 days. I understand that, if I submit a written response, it must be received by AFMOA/SGHQ, Chief Risk Management Operations at the address listed above NLT 30 days from the date of this endorsement.

Signature of Provider
Typed Name and Grade

2nd Ind, Provider

Date _____

TO: MTF/CC

I WILL / WILL NOT submit a written response to this Standard of Care determination in accordance with the directions given above.

Signature of Provider
Typed Name and Grade

[Insert QA statement at the bottom of each page of this letter: This is a quality assurance document protected from release pursuant to 10 U.S.C. §1102. Do not release without proper authority.]