Army Regulation 40–68

Medical Services

Clinical Quality Management

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

Headquarters
Department of the Army
Washington, DC
26 February 2004

UNCLASSIFIED

SUMMARY of CHANGE

AR 40–68
Clinical Quality Management

This rapid action revision, dated 22 May 2009--

- Establishes specific responsibilities for credentialing functions by Army Reserve Clinical Credentialing Affairs, Human Resources Command-St.Louis, and Active Army units (para 1-4*h*).

- Replaces all content in chapter 2 with new guidance regarding the Executive Committee of the Medical Staff; medical staff bylaws; military treatment facility committees and functions; and departmental/service organization, structure, and leadership (chap 2).

- Eliminates the requirement to submit the annual military treatment facility Quality Management Program Summary Report to the U.S. Army Medical Command (previously covered in chap 2).

- Identifies the American Nurses Association Standards of Nursing Practice or other national professional organizations' standards as the source of practice expectations (para 3-3*b*(7)).

- Relocates information regarding confidentiality of quality assurance documents from paragraph 2-5 to chapter 3 (para 3-7).

- Requires veterinarians to maintain a current, active, valid, and unrestricted license to practice independently within their defined scope of practice (para 4-4*a*(1)).

- Specifies the educational preparation by an accredited institution for military and civilian registered nurses and licensed practical nurses and requires the National Council Licensure Examination- Registered Nurses/ Practical Nurses for the military Army Nurse Corps and 68WM6/M3 (para 4-6*c*).

- Restates the requirement for an unrestricted license (all Corps) and explains the process for limited waiver/exception (paras 4-6*g* and 4-7).

- Clarifies the licensure requirement for personal services versus non-personal services contract healthcare personnel (para 4-8*a*).

- Specifies the use of DA Forms 7653 and 7654 for competency verification of Army Nurses Corps personnel with skill identifier 8A (Critical Care) and M5 (Emergency Nursing) (para 5-1*a*(1)(b)).

- Requires currency of emergency life support training at all times (para 5-1*e*).

- Deletes the requirement for the advanced practice registered nurse, other than the non-personal services advanced practice registered nurse, to possess and maintain advanced practice licensure (para 7-4*b*(2)).

- Restates the collaborative interaction required between the certified registered nurse anesthetist and anesthesiologist or operating surgeon (para 7-4*e*(4)(a)-(c)).

- Authorizes selected prescription writing by occupational therapists (para 7-13*c*(2)(a)(6)).

- Updates professional credentials requirements for physician assistants (para 7-16*b*).

- Clarifies Category I and II privileges for physical therapists (para 7-17*c*).

- Provides 10 USC 1102 protection to all documents in the provider credential file and the provider activity file (paras 8-3*b*(2)(c) and 8-9*a*).

- Stipulates that the chairperson of the credentials committee will be a physician and that he/she will vote only in event of a tie (paras 8-5*b* and 8-5*c*(5).

- Indicates that the responsibility for credentials verification for contracted personnel will be specified in the contract (para 8-6*d*).

- Allows use of the American Board of Medical Specialties Web site to verify board certification (para 8-7*d*).

- Exempts providers outside the continental United States from the requirement of a current Drug Enforcement Agency certificate (para 8-7*k*).

- Directs that qualified healthcare providers obtain a National Provider Identifier (para 8-7*r*).

- Provides detailed information related to telemedicine procedures (para 9-2*c*(7)(a)).

- Directs the military treatment facility credentials office to maintain the provider credential file for any assigned provider not currently involved in clinical practice (para 9-6*b*).

- Provides new instruction for U.S. Army Reserve/Army National Guard deployment privileging (para 9-8*c*(4)(d)).

- Clarifies that peer review for an adverse privileging/practice action be performed by a panel (para 10-6*e*(2)(c)).

- Requires that a physician chair the adverse actions hearing board (para 10-8*a*) and that he/she will vote only in the event of a tie (para 10-8*g*).

- Eliminates the requirement for verbatim transcript of the adverse actions hearing board (para 10-8*e*(3)).

- States that the voluntary modification of privileges/practice as a result of a medical or behavioral condition is not an adverse privileging/practice action (para 11-4*c*).

- Revises the risk management content entirety and omits reference to the now disbanded Consultation Case Review Branch (paras 13-1 through 13-5).

- Specifies that any death/disability of a military member as a result of medical care will be treated as a potentially compensable event (para 13-5*b*).

- Revises the layout and contents of the competency assessment file (app C).

- Make additional rapid action revision changes (chaps 6, 7, 8, 9, 10, 11, 13,14, and apps E, F, G, H, I, J).

Headquarters
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26 February 2004

*Army Regulation 40–68

Effective 26 March 2004

Medical Services

Clinical Quality Management

By Order of the Secretary of the Army:

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

Official:

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

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

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

Applicability. This regulation applies to the Active Army, the Army National Guard of the United States, including periods when operating in an Army National Guard capacity, and U.S. Army Reserve. This document applies in both the table of distribution and allowances and table of organization and equipment environments. It applies to all personnel (Active Army, Army National Guard of the United States, the U.S. Army Reserve, civilian employees, contract personnel, and foreign national local hires) who work within medical department activities, medical centers, dental activities, and organizations for which the Army Medical Department is the responsible official. This publication is applicable during mobilization.

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

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

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

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

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

Contents (Listed by paragraph and page number)

*This regulation supersedes AR 40–68, dated 26 February 2004. This regulation supersedes Army Regulation 40–68, dated 20 December 1989, and Army Regulation 40–48, dated 7 November 2000. It rescinds DA Forms 5440–17–R, 5440–27–R, and 5441–27–R, dated June 1991; and DA Forms 5440–26–1–R, 5440–26–2–R 5441–17–R, 5441–26–1–R, 5441–26–2–R, and 5753–R, dated July 1989. (DA Forms 5440–26–3–R and 5441–26–3–R were rescinded in June 1995.) This edition publishes a rapid action revision.

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Figure List

Glossary

Chapter 1
Introduction

1–1. Purpose
This regulation establishes policies, procedures, and responsibilities for the administration of the Army Medical Department (AMEDD) Clinical Quality Management Program (CQMP).

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities
a. The Surgeon General. The Surgeon General (TSG), as the senior medical officer in the Department of Army (DA), is/will—

(1) Responsible for the quality of health care delivered to all categories of beneficiaries.

(2) Establish CQMP policy to implement Department of Defense (DOD) 6025.13–R, other applicable DODD/ Department of Defense Instructions (DODIs), and current accrediting/regulatory guidance.

(3) Responsible for the quality of care provided in all military treatment facilities (MTFs) within the AMEDD. Serves as the governing body (GB) for health care facilities worldwide.

(4) The sole authority for reporting adverse privileging/practice actions and malpractice claims against providers to State and other regulatory agencies and to the National Practitioner Data Bank (NPDB).

(5) Delegate GB authority to MTF commanders, thus, making them responsible and accountable for the quality of health care provided in their treatment facilities.

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

(1) Ensure adherence to requirements for selection, commissioning, and accession of health care professionals.

(2) Responsible for primary source verification (PSV) of licensure, or other authorizing documents for the AMEDD new accession, as well as collecting and forwarding these documents to the appropriate unit of assignment.

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

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

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

(1) Exercise broad oversight responsibility for implementation of the AMEDD CQMP as delegated by TSG.

(2) Represent TSG as a member of various committees and working groups sponsored by the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA), Department of Defense (DOD), and other health care quality agencies.

(3) Provide corporate-level clinical quality management (CQM) guidance within the AMEDD to include policy on credentialing, performance-based privileging, outcomes management (OM), medical staff appointment, and accreditation processes.

(4) Provide corporate guidance, administrative and/or clinical advice, consultation, and education to define and/or clarify standards of care, practice, and policy.

(5) Administer the corporate AMEDD Patient Safety (PS) and Risk Management (RM) Programs that include but are not be limited to: risk assessment, risk avoidance, safety practices, incident monitoring/management, adverse privileging/practice actions, sentinel events (SEs), and malpractice claims.

(6) Provide policy guidance, consultation, monitoring, and review of SEs that occur within the AMEDD.

(7) Monitor trends in processes and outcomes of care and report the results to both internal and external sources, as appropriate.

(8) Collect aggregate AMEDD CQM data, as required by TSG, OASD/HA, or other agencies.

(9) Serve as the corporate repository for select CQMP data.

(10) Implement the administrative procedures related to reporting adverse privileging/practice actions to appropriate national, professional, and State licensure, certification, and registration agencies according to DOD guidance.

(11) Implement the administrative procedures related to reporting providers to the NPDB according to established DOD guidance.

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

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

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

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

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

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

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

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

g. MTF commanders. MTF commanders will—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Designate a CQMP manager.

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

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

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

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

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

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

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

(a) Types and ages of patients served.

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

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

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

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

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

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

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

j. Other MTF personnel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) A licensed professional registered nurse.

(b) The principal executive staff advisor to the commander on matters concerning the scope of patient care services and clinical policy (specifically related to the provision of nursing care and services and nurse staffing standards), nursing policy, and the availability and utilization of nursing resources.

(c) Act as liaison between members of the nursing staff and the commander and, as such, advocate for the provision of quality nursing care, treatment, and services.

(d) Participate in the development, implementation, and integration into the organization's overall plan for patient care, policies and procedures that guide and support the provision of quality patient care services.

(e) A voting member of the ECMS (or comparably named committee).

(f) Ensure PI activities are in place in all arenas in which nursing care, treatment, or services are rendered and actively participate in these processes.

(g) A voting member of the MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel.

(h) Reduce or appropriately limit the scope of practice of any nursing staff member whose competence, quality of care, behavior/conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)

(i) Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/healthcare errors according to DOD 6025.13–R and USAMEDCOM guidance.

(j) An active participant in the organization's RM program.

(k) Ensure the presence of an effective nursing peer review program (see glossary).

(l) Executive staff advisor to the commander for other non-nursing hospital personnel and services under his/her supervision and authority, with the associated quality management responsibilities as noted above.

(3) *Chief, department, service, or clinic and TOE command surgeons.* (References to departments and services include alternate organizational structures such as product line teams or multidisciplinary care teams in facilities with these alternative structures.) For clinical department/services/clinics with chiefs who are not physicians, also see paragraph 2–3. In his/her area of responsibility, or technical oversight, the chief/command surgeon is/will—

(a) Responsible for all clinically related activities.

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

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

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

(e) Recommend to the medical staff the clinical privileging criteria that are relevant to the care provided in the department/service/unit.

(f) Recommend privileges for each provider in the department/service/unit, as authorized.

(g) Make recommendation to the relevant hospital authority for needed patient care services not provided by the department/service/unit or the MTF.

(h) Integrate the services of the department/service/unit with the primary functions of the MTF.

(i) Coordinate and integrate inter/intradepartmental services.

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

(k) Determine the qualifications and competencies of department/service/unit health care personnel.

(l) Establish objective, quantifiable methods to continually assess and improve the quality of care and service provided. Utilize ORYX^{TM} data, or like data, as applicable.

(m) Maintain quality control programs, as appropriate, and ensure that PS issues are given high priority and addressed when department/service/unit-level processes, functions, or services are designed or redesigned.

(n) Provide and support orientation, in-service training, and continuing education of all personnel in the department/service/unit.

(o) Make recommendations for space and other resources required by the department/service/unit.

(p) Recommend a sufficient number of qualified and competent persons to provide care.

(q) Participate in outside source selection for needed services.

(4) *Privileged staff.* The privileged provider will—

(a) Acknowledge, in writing, at the time clinical privileges and medical staff appointment (if applicable) are awarded, the intent to abide by applicable bylaws.

(b) When appointed a member of the credentials committee/function, make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers.

(c) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the privileges requested and/or according to the AOCs and additional skill identifiers (ASIs) awarded, accomplish required training, and ensure the currency of all documents and other information contained in his/her provider files.

(d) Participate in PI, quality control, and peer review processes.

(5) *All other organizational assigned personnel.* Personnel, other than privileged providers, will—

(a) Ensure completion of organization and unit-based orientation, maintain current competency and ability to perform the scope of practice of the assigned position, accomplish required training, and ensure the currency of all documents and other information contained in his/her competency assessment file (CAF).

(b) Participate in PI, quality control, and peer review processes, as applicable.

(c) Ensure knowledge of and responsibility for implementing all applicable organizational policies and procedures relevant to his/her job description and/or scope of practice.

(6) *CQM coordinator*. The CQM coordinator, or similarly titled individual (for example, PI coordinator), is tasked with overall responsibility for the organization's CQMP. The individual in this role may be expected to exercise broad oversight and to collaborate with various key staff to ensure the integration of the quality functions performed by the organization. This requires the incumbent to be an active member of the executive leadership team. He/she will—

(a) Ensure that organization-wide PI is a dynamic process based on ongoing identification of opportunities for change.

(b) Provide leadership and consultative services to departments and sections within the organization with regard to credentialing and privileging issues, accreditation requirements, CQM and QA regulatory compliance issues, PI, and RM/PS.

(c) Participate in the development of policies for the organization, giving special consideration to the integration of and collaboration between internal administrative and clinical policies.

(d) Participate in the identification of opportunities for PI, recommendation of solutions for facility issues and concerns, and implementation of plans and followup activities related to organizational PI.

(e) Serve as subject-matter expert in conjunction with patient administration and the servicing Staff Judge Advocate/ legal advisor in areas such as accreditation standards for health care documentation and the medical-legal aspects of health care practice.

(f) Direct the collection, analyses, and dissemination of PI data within the organization ensuring that basic statistical analyses and comparative processes are included.

(g) Facilitate organizational efforts to provide prevention, wellness, and specific medical condition-based management programs as well as other health management programs, as required, based on timely MTF data and identified beneficiary need.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(l) Ensure the CCQAS database is current and complete.

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

(n) Maintain all PCFs according to this regulation.

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

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

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

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

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

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

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

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

The person performing these duties will—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 2
Medical Staff and Military Treatment Facility Committee Structure and Functions

2–1. General

The Joint Commission requires an organized, self-governing medical staff to provide direction and oversight of the quality of care, treatment, and services delivered by privileged providers. The organized medical staff--referred to in this publication as the ECMS, or equivalent title--is also responsible for evaluating the competency of privileged providers on an ongoing basis, delineating the scope of privileges that will be granted, ensuring a uniform standard of

care, and providing leadership in PI activities within the organization. The medical staff is accountable to the governing body (TSG) as represented by the MTF commander.

2–2. Medical staff bylaws

a. The bylaws will be developed, adopted, and amended by the medical staff and approved by the commander as representative of the governing body. The medical staff will enforce and comply with the bylaws.

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

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

(1) The qualifications, roles, and responsibilities of department chiefs. (See para 1-4 j(3).)

(2) The structure, function, size, and composition of the ECMS (or equivalent committee) and of the methods for selecting and removing its members and the organized medical staff officers.

(3) The empowerment of the ECMS to act on behalf of the medical staff.

(4) The processes for credentialing, privileging, and medical staff appointment. (See chaps 8 and 9.)

(5) The indications for automatic suspension or summary suspension of medical staff membership or clinical privileges and when these procedures are implemented. (See chap 10.)

(6) The mechanism for a fair hearing and the appeal process for an adverse privileging action. (See chap 10.)

2–3. Military treatment facility departmental structure and leadership

The bylaws will describe the qualifications, roles, and responsibilities of department chiefs.

a. Physicians or other privileged providers will be appointed as chiefs of medical departments/services by the commander. Selection will be based on qualifications including clinical and leadership experience and ability. In instances where a non-physician serves as the chief of a department/service, a physician will be selected as the medical director. The medical director will advise the chief and be responsible for practice issues outside the clinical scope of the non-physician chief. The medical director will be responsible for peer review and the credentialing and privileging of physicians and other privileged providers. The chief will represent the department/service at the ECMS and other required meetings.

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

2–4. Executive committee of the medical staff

The ECMS is authorized to carry out medical staff responsibilities and performs its work within the context of the functions of governance, leadership, and PI. The ECMS has the primary authority for activities related to self governance of the medical staff and for PI of the professional services provided by privileged healthcare providers. This committee reports to the executive committee. Note: There is currently no requirement for an executive committee of the dental staff (ECDS). Where this regulation requires information/action to route through the ECMS to the commander, it may go directly to the dental commander.

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

b. Voting membership will include the DCCS (chairperson), the DCN, and chiefs of clinical departments. Other members, qualifications for membership, and the voting status of members (who are not members of the medical staff) will be as delineated in the medical staff bylaws. Other members may include senior privileged providers from garrison-level units and chiefs of administrative divisions/services related to patient care (for example, patient administration division (PAD) and CQM).

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

d. The ECMS acts upon reports of MTF committees/functions, clinical departments, and subcommittees or workgroups designated by the ECMS. In addition, this committee provides recommendations to the commander at a minimum on the following:

(1) The medical staff structure.

(2) The process for credentials review and delineation of individual clinical privileges.

(3) Medical staff membership and termination of membership.

(4) The delineation of privileges for each eligible provider. (If the ECMS and the credentials committee are not the same body, the privileging recommendations of the credentials committee for each provider will be reviewed by the ECMS and forwarded to the commander.)

(5) The mechanism for terminating medical/dental staff membership.

(6) The mechanism for adverse actions fair hearing and appeal procedures.

(7) The participation of the medical staff in organizational PI activities.

2–5. Medical staff participation in performance improvement activities

a. Required functions. The Joint Commission requires the medical staff to provide leadership in measuring, assessing, and improving processes that primarily depend on the activities of privileged providers, as well as participating in organization-wide PI activities. All committee minutes/reports regarding these activities will be routed through the ECMS to the commander. As a minimum, the following functions will be evaluated, documented, tracked, and reported—

(1) Medical assessment and treatment of patients.
(2) Use of medications.
(3) Use of blood and blood components.
(4) Operative and other procedures.
(5) Appropriateness of clinical practice patterns.
(6) Significant departures from established patterns of clinical practice.
(7) Use of information about adverse privileging decisions.
(8) Use of developed criteria for autopsies.
(9) Sentinel event data.
(10) Patient safety data.

b. Suggested functions. Other PI functions that may be significant to the organization include: medical records review, tumor board/cancer conference, pain management processes, outcomes related to cardiopulmonary resuscitation, and services provided to high-risk populations.

2–6. Other military treatment facility organizational functions and committees

The Joint Commission requires an ECMS (or committee with a similar function). In addition, TJC directs the performance of other select functions; however, a committee need not be dedicated to that purpose. These functions must be accomplished by the organization, on a recurring basis, with documentation forwarded to the ECMS. The use of minutes or summary reports to document the function is a facility-level decision. Certain other committees (such as risk management) are required by agencies other than TJC, as noted below. The following committees/functions are required by this regulation:

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

b. Patient safety committee/function. PS activities are designed to maintain and improve healthcare processes and practices, reduce the potential for harm to patients, and ensure the general safety and security of patients in all settings. Membership of this multidisciplinary committee will be according to guidance from USAMEDCOM (MCHO–CL–Q). The PS committee reports through the ECMS to the executive committee

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

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

e. Impaired healthcare personnel committee. See chapter 11.

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

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

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

Chapter 3
The Clinical Quality Management Program and Organizational Performance Improvement

3–1. The Clinical Quality Management Program

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

b. Military treatment facility/dental activity (DENTAC) commanders will establish and resource a CQMP that coincides with any RMC/regional dental command (RDC) and/or DOD programs, as appropriate, and meets the unique needs of the organization. When developing the facility-level CQMP, consideration must be given to all accreditation and regulatory requirements. A comprehensive program requires integration of these criteria that offer evidence of the quality, cost, availability, and appropriateness of care and services being provided to DOD beneficiaries of all ages. Critical to the success of the CQMP is the active involvement and participation of all staff members.

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

d. Each MTF/DENTAC will maintain a single written plan that includes all departments/services/functions and will define how each of its established CQM processes and PI activities will be implemented. When devising such a plan, various CQM models are available including the Find-Plan-Do-Study-Act/Plan-Do-Check-Act (that is, FOCUS/PDCA) framework (see glossary and app A).

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

3–2. Processes and functions requiring measurement

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

3–3. Performance improvement data sources and analyses

a. Successful PI will be based on effective use of both clinical and administrative data from a variety of sources. The MTF/DENTAC, in coordination with the RMC/RDC and USAMEDCOM, will determine which data are appropriate to consider for the purpose of organizational improvement.

b. Various activities, programs, and processes such as those in (1) through (7), below, merit consideration as sources of information that may influence the PI Program within the organization.

(1) Beneficiary and health care professional education and feedback sessions;

(2) CPG-based condition management programs;

(3) Putting Prevention into Practice, Healthy People 2010, and other illness prevention and health promotion activities;

(4) UM activities such as demand and referral management, case management, and discharge planning;

(5) Provider, clinic, and clinic team profiling related to morbidity, mortality, length of stay, access, disease and prevention program and/or outcomes-related metrics, patient satisfaction, and cost;

(6) Discipline-specific standards of care for privileged providers; and

(7) American Nurses Association (ANA) Standards of Nursing Practice or other nursing specialty organization's standards of practice (for example, the Association of periOperative Registered Nurses or the American Association of Critical Care Nursing, as appropriate) for the delivery of nursing care and recognized practice standards for other healthcare specialties.

c. An expected consequence of effective data analyses related to OM/UM activities is the identification of those clinical practices with significant positive outcomes that are successfully contributing to the organization's PI objectives. At the same time, practices that are ineffective in promoting PI objectives (that is, result in negative outcomes) may be noted. Careful analysis of the risk-adjusted outcomes data will facilitate determination of both best and least effective practices for the organization. Organizational personnel, working in small focus groups, may be tasked to address processes that result in statistically significant positive or negative outcomes. These personnel should carefully evaluate the circumstances resulting in negative patient/organizational outcomes with specific emphasis on recommendations for PI. Those circumstances with notably positive outcomes may warrant promulgation throughout the organization, the AMEDD, or the DOD.