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CLINICAL PERFORMANCE IMPROVEMENT

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This instruction implements AFD 44-1, *Medical Operations*; DoDD 6025.13, *Clinical Quality Management Program in the Military Health Services System*; DoDD 6025.14, *Department of Defense Participation in the National Practitioner Data Bank (NPDB)*; DoDI 6025.15, *Implementation of Department of Defense Participation in the National Practitioner Data Bank*; DoDD 6040.37, *Confidentiality of Medical Quality Assurance (QA) Records*. It explains performance improvement (PI) accreditation requirements, credentials and privileging, scope of practice, and risk management (RM) programs for optimal healthcare delivery. This instruction applies to all Air Force Medical Service (AFMS) personnel to include units of the Air Reserve Components (ARC) with the exception that the ARC are exempt from the requirement for Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation and the annual PI/RM Summary. ARC Aeromedical Evacuation Squadrons (AES) participating in actual patient care will comply with applicable ARC guidance. The reporting requirement in paragraph 2.8.7. 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. Privacy Act system notice F044 AF SG K, Medical Professional Staffing Records, applies. Maintain and dispose of records created as a result of prescribed processes IAW AFMAN 37-139, *Records Disposition Schedule*.

SUMMARY OF REVISIONS

This revision incorporates IC 2001-1 and implements DoDI 6025.16, *Portability of State Licensure for Health Care Professionals*, dated 30 August 200. This revision also adds **Attachment 29, Sample Letter – Department of Defense Health Care Professionals Practicing in Civilian Health Care Facilities**. A “|” indicates revised material since the last edition. The entire text of the IC is at the last attachment.

Chapter 1—GENERAL ROLES AND RESPONSIBILITIES	14
1.1. Air Force Surgeon General (HQ USAF/SG).	14
1.2. Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/SG).	14
1.3. HQ AFRS and HQ AFPC/DPAM:	14
1.4. Command Surgeon (HQ MAJCOM/SG, ARC HQ MAJCOM/SG):	14
1.5. Medical Group Commander (MDG/CC) = Medical Wing Commander (MDW/CC) for 59 MDW or Medical Squadron Commander (MDS/CC) for ARC:	15
1.6. Chief of the Medical Staff (SGH):	15
1.7. The Medical Staff:	16
1.8. Chief, Performance Improvement = Quality Services Manager (QSM):	16
1.9. Credentials Manager:	16
1.10. Chief, Risk Management:	18
1.11. Collaborative Responsibility.	18
Chapter 2—PERFORMANCE IMPROVEMENT	19
Section 2A Accreditation	19
2.1. Medical Treatment Facility Requiring Accreditation.	19
2.2. Network Accreditation.	19
2.3. Policy Conflict with JCAHO and Other Accrediting Agencies.	19
2.4. Governing Body and Other Equivalencies for Use in JCAHO Surveys.	19
Section 2B Improving Organizational Performance	20
2.5. Functions Requiring Measurement.	20
2.6. Medical Staff Functions/Committees.	24
2.7. Sentinel Events.	24
Section 2C Competency Assessment	24
2.8. Competency assessment applies to all staff.	24
2.9. Performance Evaluation.	25
2.10. Education and Training Activities.	25
2.11. Orientation.	25
2.12. Competency factors that are critical to every person's successful job performance fall into three skill categories--cognitive, psychomotor, and interpersonal skills.	25
2.13. Non-privileged Healthcare Personnel.	26
2.14. Competency Assessment Folders (CAFs).	26

2.15. Use of CAF During Deployment, ARC Annual Tour, and PCS.	26
2.16. Privileged Healthcare Personnel:	26
Section 2D Tools and Information Sources	27
2.17. Performance Measurement Tools (PMT):	27
2.18. Air Force Medical Applications Model (AFMAM):	27
2.19. Centralized Credentials Quality Assurance System (CCQAS):	27
2.20. AFMOA/SGOC Web Site:	27
2.21. Population Health Web Site:	28
2.22. Additional Web Sites:	28
Chapter 3—LICENSURE, CERTIFICATION, AND/OR REGISTRATION OF HEALTHCARE PERSONNEL	29
Section 3A Personnel Required to be Licensed, Certified, and/or Registered	29
3.1. Scope of Licensure Requirement.	29
3.2. Professional Groups Requiring License, Certification, or Registration:	30
3.3. Obtaining and Maintaining Licenses.	31
Section 3B Management of Licensure Issues	31
3.4. Guidance on Licensure Requirements:	31
3.5. Exceptions to Licensure Requirements:	33
3.6. Failure to Obtain or Maintain a License, Certification, or Registration.	34
3.7. Clinically Restricted Licenses.	35
3.8. Annual DoD Quality Management Report (QMR), RCS: HAFMOA-SG(A)8901: .	35
3.9. Portability of State Licensure.	35
Chapter 4—THE CREDENTIALING PROCESS (APPLIES BOTH TO HOSPITALS AND TO CLINICS)	38
Section 4A Provider Credentials	38
4.1. Credentials Used in the Privileging Process:	38
Section 4B Verification of Credentials	43
4.2. Primary Source Verification (PSV).	44
4.3. Authentication that a document is a true and valid copy of the original does not constitute primary source verification.	44
4.4. Actions Following Initial Verification.	44

4.5.	Inability to obtain necessary verification	45
4.6.	Foreign language (excluding Latin) documents must be translated into English.	45
4.7.	Verification of Board Certification:	45
Section 4C	AFRS, AFPC/DPAM, and AFMS Postgraduate Training Program Director Responsibilities Re: Credentials Documentation	45
4.8.	Provider Accessions through the Air Force Recruiting Service (AFRS).	45
4.9.	Providers Attending Air Force Postgraduate Education Programs:	45
4.10.	Deferred Providers Attending Residency, Fellowship, or Other Long Term Graduate or Other Medical Education Programs in Residence at Civilian Medical Facilities.	46
Section 4D	Handling and Contents of the Provider Credentials File (PCF):	46
4.11.	Handling of the PCF.	47
4.12.	Content of the PCF.	47
4.13.	Maintenance of ARC PCFs and CCQAS Database.	48
Section 4E	Disposition of PCFs and Provider Activity Files (PAFs)	49
4.14.	Disposition of Inactive PCFs and PAFs:	49
4.15.	Disposition of the PCF when Providers Transfer.	49
4.16.	Disposition of the PCF when Providers Leave Service Employment.	49
4.17.	Closing Medical Units:	50
Section 4F	Miscellaneous	50
4.18.	Minimum documents for Granting Supervised Privileges.	50
4.19.	Facilitation of Concurrent Award of Privileges and Medical Staff Appointment.	50
Chapter 5	—THE PRIVILEGING PROCESS	51
Section 5A	Considerations in Awarding Privileges	51
5.1.	Background.	51
5.2.	General:	51
5.3.	Relationship Among Privileges, Medical Staff Appointment, and Authorization to Admit Patients.	52
5.4.	Providers Affected by the Privileging Process.	52
Section 5B	Responsibilities of Privileged Providers	53
5.5.	Providers Who Seek Privileges:	53
Section 5C	Procedures for Applying for Initial Privileges and Medical Staff Appointment	54

5.6.	AF Form 1540.	54
5.7.	Completion of Privilege List.	54
5.8.	Credentials Function Membership.	57
5.9.	Credentials Function Procedures:	57
5.10.	ARC Privileging Authority.	58
5.11.	ARC Privileging Issues:	58
5.12.	Provider Notification of Privileging.	59
5.13.	Management of Contract Provider Privileges.	59
5.14.	Privileging in a Field Environment During Peacetime Training or in Support of an Expeditionary/Contingency Mission.	59
5.15.	Care in Emergency or Wartime Situations.	60
5.16.	Procedures for Granting Privileges to Short-Term Affiliates of the MTF.	60
5.17.	Civilian Consultants.	61
Section 5D	Types of Privileges	61
5.18.	Procedures and Requirements for Specific Types of Privileges:	61
Section 5E	Medical Staff Appointment	62
5.19.	General.	62
5.20.	Types of Medical Staff Appointment.	63
5.21.	Provider Notification of Medical Staff Appointment.	64
Section 5F	Reprivileging and Reappointment Requirements	64
5.22.	General Information.	64
5.23.	Performance-Based Privileging.	64
5.24.	Provider Activity File (PAF).	64
5.25.	Biennial Review Process:	65
Section 5G	Miscellaneous Privileging Issues	66
5.26.	Management of Impaired Providers.	66
5.27.	Awarding Clinical Privileges to Medical Group Commander:	66
5.28.	Providers Attending Residency, Fellowship, or Other Long-Term Graduate Education Programs in Residence at Civilian or Other Federal Programs, Excluding the Air Force.	66
5.29.	Providers Attending Residency, Fellowship, or Other Long-Term Graduate Education Programs within the Air Force.	66

5.30. Providers Assigned to a Geographically Separated Unit must have a PCF and be awarded clinical privileges and medical staff appointment by the host unit which is the privileging authority.	67
5.31. Conscious Sedation for Dentists.	67
5.32. Telemedicine/Teleradiology.	67

Chapter 6—PROFESSIONAL SCOPE OF PRACTICE FOR ALLIED HEALTH PROFESSIONALS

68

Section 6A Allied Health Providers (All BSC and NC Privileged Providers)	68
6.1. Allied Health Provider List:	68
6.2. Audiologists:	68
6.3. Certified Nurse Midwives:	69
6.4. Certified Registered Nurse Anesthetists:	70
6.5. Clinical Dietitians:	71
6.6. Clinical Pharmacists:	73
6.7. Clinical Psychologists:	75
6.8. Clinical Social Workers:	77
6.9. Family Nurse Practitioners (Includes Adult and Primary Care Nurse Practitioners):	80
6.10. Pediatric Nurse Practitioners:	81
6.11. Women’s Health Nurse Practitioners:	83
6.12. Occupational Therapists:	84
6.13. Optometrists:	85
6.14. Physician Assistants:	85
6.15. Specialty Physician Assistants:	87
6.16. Physical Therapists:	87
6.17. Podiatrists:	89
6.18. Speech Pathologists:	90
Section 6B Medical/Dental Students	90
6.19. Medical/Dental Student Documentation in Medical Record:	90
Section 6C Enlisted and Civilian Equivalent Allied Health Professionals	91
6.20. Career Field Education and Training Plan (CFETP).	91
6.21. Alternative to CFETP.	91
6.22. Medical Technicians Utilized in Ambulance Services:	91

6.23. Certified Alcohol and Drug Abuse Counselors = Substance Abuse Counselors:	91
6.24. Registered Dental Hygienists:	93
6.25. Independent Duty Medical Technician (IDMT):	94
Chapter 7—ADVERSE ACTIONS	95
Section 7A General Information	95
7.1. General.	95
7.2. Consult with Legal Counsel.	95
7.3. Early Notifications:	95
7.4. Objectives.	95
7.5. Roles and Responsibilities:	96
7.6. Appropriate Use of Adverse Actions.	97
7.7. Identity of Persons Providing Information.	97
7.8. Allegations Involving Separated Providers or Healthcare Professionals.	97
7.9. Actions Involving the Medical Group Commander.	98
7.10. Use of Timelines.	98
Section 7B Invoking an Abeyance, Invoking a Suspension and Conducting Inquiry Procedures	98
7.11. General.	98
7.12. Invoking an Abeyance.	98
7.13. Invoking a Suspension.	99
7.14. Inquiry Procedures.	99
7.15. Notification to HQ MAJCOM/SG.	99
Section 7C Credentials Function Review Activities for Adverse Actions	99
7.16. General.	99
7.17. Notification of the Provider.	100
7.18. Withdrawal of Permission to Engage in Off-Duty Employment.	100
7.19. Credentials Review Process.	100
7.20. Composition of the Credentials Function.	100
7.21. Ensuring Impartiality of Review Personnel.	100
7.22. Credentials Function Recommendations.	101
7.23. Recommendations Forwarded to the MDG/CC.	101
Section 7D Adverse Action Hearing Procedures	102

7.24. Provider Hearing Rights and Responsibilities.	102
7.25. Provider Notification of Hearing.	102
7.26. Hearing Committee Composition.	102
7.27. Ensuring Impartiality of Review Personnel.	103
7.28. Hearing Proceedings.	103
7.29. Presentation of New Information at Hearing.	103
7.30. Hearing Committee Activities.	103
7.31. Hearing Committee Recommendations.	104
7.32. Forward Recommendations.	104
7.33. Provider Statement of Exceptions and Corrections.	105
7.34. Commander's Decision and Provider Notification.	105
7.35. Forward Documentation to HQ MAJCOM/SG.	105
Section 7E Appeal Procedures	106
7.36. General.	106
7.37. Appeals Review Process.	106
7.38. AFMOA/SGOC Notifications.	106
Section 7F Additional Administrative/Documentation Requirements Related to Adverse Actions	106
7.39. Providers Ending Affiliation with the Air Force Medical Service or Permanently Changing Station (PCS) within the Air Force while Under Review.	106
7.40. Records Location Regarding Abeyances and Suspensions.	107
7.41. Records Location Regarding Monitoring and Evaluation (M&E).	107
7.42. Management of Personnel Following Adverse Actions.	107
Section 7G Removing Non-Privileged Healthcare Professionals from Patient Care Duties	107
7.43. General.	107
7.44. Inquiry Procedures.	107
7.45. Notification to HQ MAJCOM/SG.	108
7.46. Peer Review Procedures for Non-Privileged Healthcare Professionals:	108
7.47. Forward Recommendations to the MDG/CC.	109
7.48. Hearing Procedures.	109
7.49. Forward Recommendations.	110
7.50. Statement of Exceptions and Corrections.	110
7.51. Commander's Decision and Provider Notification.	110

7.52. Appeal Procedures.	111
7.53. Individuals Ending Affiliation with the Air Force Medical Service or Permanently Changing Station (PCS) within the Air Force while Under Review.	111
7.54. Non-Privileged Healthcare Professional Documentation Requirements.	111
7.55. Management of Non-Privileged Healthcare Professionals Following Adverse Actions.	111
7.56. Removing Nurses from the Nurse Transition Program.	111
7.57. Removing Technicians from Clinical Practice.	111
Section 7H Management of Impaired Providers/Non-Privileged Healthcare Professionals	111
7.58. General.	112
7.59. Alcohol or Drug Impairment:	112
7.60. Physical/Mental Impairments:	113
7.61. Management of Individuals with Communicable Diseases that Could Affect Patient Safety:	114
Section 7I Other Management Issues Related to Adverse Actions	115
7.62. Simultaneous Adverse Action and UCMJ Action.	115
7.63. Administrative Denial of Privileges.	115
7.64. Retraining.	115
7.65. Removing Residents from Patient Care Responsibilities.	115
Section 7J Procedures for Managing Adverse Actions within Air National Guard (ANG) Units	116
7.66. Inquiry Procedures.	116
7.67. Imposing an Adverse Action.	116
Table 7.1. Two-Tiered Appeal Level for ANG Adverse Actions.	117
Section 7K Reporting and Releasing Adverse Information to National and Regulatory Agencies	117
7.68. Responding to Written Requests for Information.	117
7.69. Disposition of Reports and Actions when MTFs Close.	117
7.70. AFMOA/SGOC Responsibilities in Reportable Actions.	117
7.71. NPDB Reporting of Adverse Actions.	117
7.72. State Regulatory Agency Reporting of Adverse Actions.	118
7.73. Reporting Administrative Actions to State Regulatory Agencies.	118

Chapter 8—RISK MANAGEMENT	120
Section 8A Risk Management Program Requirements	120
8.1. Identification and Correction of Hazardous Conditions.	120
8.2. Patient Relations and Organizational Ethics.	120
Section 8B Medical Malpractice Claims.	120
8.3. General.	120
8.4. Responsibilities:	120
8.5. Managing Potentially Compensable Events (Potential Claims).	122
8.6. MTF Actions After Claim is Filed.	123
8.7. Base Claims Officer Actions to Complete the Case File:	124
8.8. Selection of Expert Medical Reviewers:	124
8.9. MLC Actions to Complete the Case File:	125
8.10. Provider Notification of SOC Met Determination.	125
8.11. Provider Notification of SOC Not Met Determination:	126
8.12. Provider Response to SOC Not Met Determination.	126
8.13. AFMOA/SGOC Processing of Provider Responses:	126
8.14. Management of SOC Indeterminate.	127
8.15. External Agency Review of Medical Malpractice Claims.	127
8.16. Management of DD Form 2526, Case Abstract for Malpractice Claims:	127
8.17. NPDB Reporting.	128
8.18. Reports to State Boards of Licensure.	128
8.19. Reporting Healthcare Trainees and Clinical Supervisors to the NPDB.	128
8.20. Provider Rights Related to Medical Malpractice Claims:	129
8.21. MTF Actions when Providers Separate while a Malpractice Case is Under Review:	129
8.22. Provider Responsibility for Notifying Future Employers of Malpractice Claims.	129
8.23. Providers With Multiple SOC Not Met Determinations.	129
8.24. Non-personal Services Contract Providers.	129
8.25. Air Force Medical Residents Working in Civilian/Department of Veteran Affairs (VA) Institutions.	130
Section 8C Medical Incident Investigation (MII)	130
8.26. Reporting Exemptions and Purpose.	130
8.27. Areas of Responsibility:	130

AFI44-119 4 JUNE 2001	11
8.28. Major Incidents Suggesting an MII.	132
8.29. Medical Incident Investigators.	132
8.30. Selection of Medical Incident Investigators.	133
8.31. Medical Incident Investigation Process.	133
8.32. Possible Criminal Behavior.	135
Section 8D Sentinel Events	135
8.33. General.	135
8.34. Definition.	135
8.35. Responsibilities of Sentinel Event Reporting:	136
Section 8E Dissemination of Risk Management Lessons Learned to the Field	137
8.36. General.	137
8.37. Responsibilities in NOTAM Dissemination:	137
Section 8F Forms Prescribed in this Instruction	138
8.38. Forms Prescribed	138
Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION	141
Attachment 2—INFORMATION CONTAINED IN AF FORM 1540A, APPLICATION FOR CLINICAL PRIVILEGES UPDATE (This Attachment Will Not Be Used in Lieu of Official Form)	156
Attachment 3—FORMAT FOR TRANSFER BRIEF MEMORANDUM	159
Attachment 4—JCAHO’S GUIDANCE ON USE OF INTERNET TO PRIMARY SOURCE VERIFY (PSV) CREDENTIALS	163
Attachment 5—CREDENTIALS TABLES	166
Attachment 6—SAMPLE RESERVE PRIVILEGE LIST OVERPRINT	169
Attachment 7—CONTENTS OF PROVIDER ACTIVITY FILE (PAF)	170
Attachment 8—SAMPLE AF FORM 22 CLINICAL PRIVILEGES EVALUATION SUMMARY	172
Attachment 9—SAMPLE IMPLEMENTATION TOOLS FOR PRIVILEGING CLINICAL PHARMACISTS	173

Attachment 10—FORMAT FOR NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES	174
Attachment 11—FORMAT FOR NOTIFICATION SUSPENSION OF CLINICAL PRIVILEGES	176
Attachment 12—FORMAT FOR NOTIFICATION OF REMOVAL FROM PATIENT CARE (Non-Privileged Healthcare Professionals)	178
Attachment 13—FORMAT FOR NOTIFICATION OF PROPOSED ADVERSE ACTION	180
Attachment 14—FORMAT FOR NOTIFICATION OF ADVERSE ACTION HEARING	182
Attachment 15—SAMPLE HEARING SCRIPT	184
Attachment 16—HEARING COMMITTEE FINDINGS AND RECOMMENDATIONS IN THE CASE OF (INSERT NAME OF INDIVIDUAL UNDER REVIEW)	191
Attachment 17—FORMAT FOR NOTIFICATION OF HEARING RECOMMENDATIONS	193
Attachment 18—FORMAT FOR NOTIFICATION OF FINAL DECISION BY MEDICAL GROUP COMMANDER	195
Attachment 19—FORMAT FOR NOTIFICATION TO INDIVIDUAL OF IMPLICATIONS OF SEPARATING OR CHANGING STATION WHILE UNDER REVIEW	197
Attachment 20—ARRANGEMENT OF RECORD OF ADVERSE ACTION PROCEEDINGS	199
Attachment 21—REPORTABLE ACTIONS OF MISCONDUCT FOR DOD HEALTHCARE PRACTITIONERS	200
Attachment 22—FORMAT FOR DD FORM 2526	202
Attachment 23—FORMAT FOR NOTIFICATION OF STANDARD OF CARE NOT MET	204
Attachment 24—FORMAT FOR NOTIFICATION OF STANDARD OF CARE MET	206
Attachment 25—CONTENTS OF MEDICAL INCIDENT INVESTIGATION (MII) REPORT	208
Attachment 26—COMPARING THE MII AND SE PROCESSES	210
Attachment 27—FORMAT FOR NOTIFICATION TO AFMOA OF REPORTABLE ACTION	211
Attachment 28—FORMAT FOR NOTIFICATION TO AFMOA/SGOC OF MII OR SE	212

**Attachment 29—SAMPLE LETTER – COORDINATION WITH STATE LICENSING BOARDS
–DEPARTMENT OF DEFENSE HEALTH CARE PROFESSIONALS
PRACTICING IN CIVILIAN HEALTH CARE FACILITIES 213**

**Attachment 30—IC 2001-1 TO AFI 44-119, CLINICAL PERFORMANCE
IMPROVEMENT 214**

Chapter 1

GENERAL ROLES AND RESPONSIBILITIES

1.1. Air Force Surgeon General (HQ USAF/SG). tablishes policy and delegates broad oversight responsibility for the PI/RM (Performance Improvement/Risk Management) programs in the Air Force Medical Service (AFMS) to Air Force Medical Operations Agency, Clinical Quality Management Division (AFMOA/SGOC).

1.1.1. AFMOA/SGOC:

1.1.1.1. Provides corporate-level guidance for clinical performance improvement within the AFMS to include policy on credentialing, performance-based privileging, and medical staff appointment.

1.1.1.2. Provides clinical consultation, defining and/or clarifying standards of care and practice in each consultant's areas of expertise.

1.1.1.3. Administers the risk management programs for the AFMS to include adverse actions and malpractice claims.

1.1.1.4. Provides policy guidance, consultation, monitoring and review of Medical Incident Investigations (MII) conducted within the AFMS.

1.1.1.5. Monitors trends in processes and outcomes of care; reporting results upward and downward.

1.2. Medical Inspection Directorate, Air Force Inspection Agency (HQ AFIA/SG). Evaluates the programs described in this instruction in Air Force medical treatment facilities and units of the ARC.

1.3. HQ AFRS and HQ AFPC/DPAM:

1.3.1. Headquarters, Air Force Recruiting Service (HQ AFRS). HQ AFRS ensures adherence to criteria for selection, commissioning, and accession of healthcare professionals Responsible for primary source verification of licensure (or other authorizing documents) and other credentials documents required for the selection process. Applications on selected healthcare professionals, containing source documents, are forwarded to AFPC/DPAM.

1.3.2. Medical Service Officer Management Division of Directorate of Assignments (HQ AFPC/DPAM). HQ AFPC/DPAM has functional oversight and management of educational programs for medical service officers. Is responsible for primary source verification of selected documents as well as collecting and forwarding initial credentials documents for deferred medical officers entering active duty to their gaining medical treatment facility (MTF) (see paragraph 4.10.).

1.4. Command Surgeon (HQ MAJCOM/SG, ARC HQ MAJCOM/SG):

1.4.1. Responsible for oversight of clinical quality management, performance improvement, and risk management activities within the command.

1.4.2. Reference AFI 38-202, *Air Force Management Headquarters and Headquarters Support Activities*, for information regarding policy making, evaluating, resourcing, and tactical and strategic planning.

1.5. Medical Group Commander (MDG/CC) = Medical Wing Commander (MDW/CC) for 59 MDW or Medical Squadron Commander (MDS/CC) for ARC:

- 1.5.1. Ensures organizational compliance to all requirements as stipulated in this instruction.
- 1.5.2. Is approval authority for award of privileges and medical staff appointment, alterations in privileges, adverse privileging actions, and written notification of same to all assigned providers. For exceptions, refer to paragraphs [1.6.6.](#), [1.6.9.](#), [5.10.](#), and [5.27.](#)
- 1.5.3. Considers input from the medical staff and appoints/selects the chief of the medical staff (SGH) and other members of the executive staff as described in the Objective Medical Group Implementation Guide (First Revision), December 1996. Executive Staff members' tenure is generally for the duration of the individual's MTF assignment. The MDG/CC also has the authority to relieve these individuals from their duties for cause. Prior to doing so, the MDG/CC should consult with the Military Personnel Flight and the base Judge Advocate General as well as advise the Wing Commander. In addition, there should be a plan to otherwise utilize this individual since the Air Force Personnel Center usually cannot reassign in an expedient manner.
- 1.5.4. The ARC privileging authority (and active duty MDG/CC for colocated reserve units) must ensure competency in the duty Air Force specialty code (AFSC) before granting or renewing privileges to providers who do not currently hold comparable privileges in a civilian healthcare organization, but would need privileges to practice their medical specialty. (Refer to [Chapter 5](#) for further information on competency assessment).

1.6. Chief of the Medical Staff (SGH):

- 1.6.1. A privileged physician holding an active appointment to the medical staff and appointed by the chief executive officer (the MDG/CC).
- 1.6.2. The principal executive staff advisor to the MDG/CC concerning matters of provider regulations, quality and scope of medical care, utilization of professional resources, and medical policy and planning.
- 1.6.3. Responsible for and has oversight of the credentialing and privileging process.
- 1.6.4. Acts as liaison between assigned members of the medical staff and the MDG/CC, and, as such, advocates on behalf of the medical staff and executive management.
- 1.6.5. Chairperson of the Executive Committee of the Medical Staff (ECOMS) and of the Credentials Function. The chair of these activities must be a physician. Therefore, in the absence of the SGH, another physician will be delegated these responsibilities upon approval of the MDG/CC.
- 1.6.6. Authorized to intervene on behalf of the MDG/CC 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 IAW the provisions outlined in this instruction.
- 1.6.7. Orients all medical staff applicants concerning Air Force (AF) bylaws governing patient care, medical staff responsibilities, professional ethics, continuing education requirements, privileging, adverse action, and due process proceedings.
- 1.6.8. May singularly review and recommend temporary privileges.

1.6.9. May grant temporary privileges when the MDG/CC is not available to do so. (This is an exception to the MDG/CC being the privileging authority).

1.6.10. Responsible for ensuring the quality of professional services provided by privileged providers. (Senior corps representative is responsible for non-privileged healthcare professionals).

1.7. The Medical Staff:

1.7.1. Providers of health care, privileged to practice in the MTF, and appointed to the medical staff by the MDG/CC (MDS/CC for ARC).

1.7.2. Participate in performance improvement and risk management activities.

1.7.3. Acknowledge their intent, in writing, at the time of initial privileging to abide by AF bylaws.

1.7.4. When appointed members of the credentials function, make recommendations on renewals, reevaluations, denials, or modifications of privileges of assigned providers.

1.7.5. Each privileged provider is responsible for maintaining currency of required training and documents contained in the credentials file.

1.8. Chief, Performance Improvement = Quality Services Manager (QSM):

1.8.1. Ensures organization-wide performance improvement program is continuously evolving. This requires being an active member of the executive team.

1.8.2. Provides leadership and consultative services to departments and agencies/sections within the organization in achieving facility regulatory, accreditation, organizational compliance, performance improvement, and risk management activities.

1.8.3. Participates in the development of policies for the organization, giving special consideration to the integration and collaboration of internal administrative and clinical policies.

1.8.4. Directs the performance improvement training and education for MTF staff and organizational leaders.

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

1.8.6. Coordinates and collaborates with risk management activities throughout the MTF such as local dissemination and management of HQ USAF/SG NOTAM and others as described in **Chapter 7** and **Chapter 8**.

1.8.7. Advisor to the MDG/CC, which includes participating in problem assessment, solution recommendations, implementation and follow-up activities regarding facility quality improvement.

1.8.8. Serves as resource to the MTF in areas such as accreditation standards for healthcare documentation and medicolegal aspects of health care.

1.8.9. On a routine basis, as determined by the executive staff, reports the results of continuous monitoring activities to the MDG/CC and executive staff for use in making performance-based decisions about the organization. Ensures that the Plan for the Provision of Patient Care is reviewed and updated at least annually.

1.9. Credentials Manager:

- 1.9.1. Technical advisor to the MDG/CC, credentials function chairperson, squadron commanders, and privileged 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 AFIs, Department of Defense (DoD) directives, and JCAHO standards, etc. **NOTE:** The ARC are not required to convene a credentials function.
- 1.9.2. Educates the commander, credentials function members, chief of the medical staff, squadron commanders, and medical staff on new policies and changes to current directives.
- 1.9.3. Maintains standards of compliance with regulatory guidelines, directives, and mandates.
- 1.9.4. Provides staff support to the MTF credentials function, if it functions separately from the ECOMS.
- 1.9.5. Serves as point of contact (POC) for initial applications for medical staff appointment and for biennial re-appointments for the medical staff.
- 1.9.6. Initiates the privileging and medical staff appointment process.
- 1.9.7. Provides guidance and support to providers during the initial and renewal privileging process.
- 1.9.8. Obtains clinical peer/supervisor reviews of healthcare providers who are in a supervisory status and those providers who hold initial medical staff appointment.
- 1.9.9. Maintains resource information for credentialing and privileging including, but not limited to, clinical service privilege lists, other AF forms, and AF instructions (AFI) 44-102, *Community Health Management*; 41-117, *Medical Service Officer Education*; AFI 44-117 ANG SUP1, *Medical Service Officer Education, Air National Guard*; and this instruction.
- 1.9.10. Manages and updates documents of evidence relevant to provider education, experience, licensure/certification, and training in the Provider's Credentials File (PCF) to ensure accuracy and currency of information.
- 1.9.11. Conducts NPDB and other inquiries, plus primary source verification to authenticate credentials of medical staff members for initial privileges and appointment to the medical staff and biennial renewal of same.
- 1.9.12. Establishes and maintains the Centralized Credentials and Quality Assurance System (CCQAS). Works with colleagues to ensure CCQAS database is current. The credentials manager maintains/updates this database IAW the CCQAS Users Manual and the Air Force/ARC Supplemental Manual. **NOTE:** The individual responsible for maintaining the PCF is also responsible to input and update CCQAS. This includes colocated Reserve units and assigned IMAs.
- 1.9.13. Researches and responds to inquiries relative to status of medical staff membership.
- 1.9.14. Maintains PCFs IAW **Chapter 4** of this instruction.
- 1.9.15. Prepares and transfers credentials/briefs to gaining MTF/unit within specified time requirements.
- 1.9.16. Works cooperatively with ARC in the following activities:
 - 1.9.16.1. Responsible for credentialing, privileging, and medical staff appointment process and maintenance of PCFs for colocated reserve units and assigned IMAs.

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

1.9.17. Serves as POC for all previously assigned providers who are now in civilian practice to confirm credentials and privileges held at that MTF. Reference paragraph 7.68.

1.9.18. Supports External Resource Sharing (ERS) agreements by assisting civilian hospitals in their review and verification of credentials.

1.10. Chief, Risk Management:

1.10.1. Directs all RM administrative and management activities within the medical facility.

1.10.2. Develops JCAHO-compliant programs for risk management, safety standards, patient rights, organizational ethics, etc., in collaboration with executive management.

1.10.3. Promotes institutional risk management programs, such as sentinel event reporting and root cause analysis, aimed at identifying and correcting deficient patterns and environment of care.

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

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

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

1.10.7. Works closely with the chief, performance improvement, to trend organizational risks and resolve them.

1.10.8. Should be aware of every potential litigation case and every DD Form 2526, **Case Abstract for Malpractice Claims**, received.

1.10.9. Works closely with the patient relations coordinator to identify any patient concern related to potential litigation or patient safety.

1.10.10. Advises the ECOMS, to include participating in problem assessment, solution recommendations, implementation, and follow-up activities regarding the quality of patient care.

1.10.11. Provides frequent consultant information and reports to executive management, committees, functions, individuals, and all levels of staff on general and specific medical risk management issues and events.

1.10.12. Initiates and ensures timely notification/briefing of commander and/or facility executive committee on individual events or when trend analysis indicates potential for major liability or catastrophe.

1.11. Collaborative Responsibility. A coordinated facility-wide approach to improving patient care and health outcomes requires an intensive, integrated, and collaborative systems approach by all disciplines. Although all disciplines listed above may not be centrally located, every effort must be made to communicate and collaborate together in planning and carrying out performance improvement and risk management programs/activities.

Chapter 2

PERFORMANCE IMPROVEMENT

Section 2A—Accreditation

2.1. Medical Treatment Facility Requiring Accreditation. All active duty fixed hospitals and free-standing ambulatory clinics shall maintain accreditation by JCAHO and/or other nationally accepted agencies such as the College of American Pathologists (CAP) and medical oversight bodies as directed by DoD, such as Clinical Lab Improvement Program. MTFs should seek accreditation under the JCAHO standards that apply to the services and delivery systems that describe their care. These standards are found in the JCAHO Comprehensive Accreditation Manual for Hospitals (CAMH), Comprehensive Accreditation Manual for Ambulatory Care (CAMAC), Standards for Behavioral Health Care, Standards for Home Care, and other JCAHO documents.

2.1.1. Operational ambulatory clinics (those treating active duty personnel only) may request a waiver from the JCAHO accreditation requirement through the major command (MAJCOM) to AFMOA/SGOC. The waiver request must stipulate the mechanism the clinic will use to ensure appropriate external oversight of its healthcare delivery system.

2.2. Network Accreditation. DoDI 5200.40, DoD *Information Technology Security Certification and Accreditation Process (DITSCAP)*, requires network accreditation for all DoD systems. DoDD 6025.13 requires regional managed care programs, as authorized by the Assistant Secretary of Defense for Health Affairs (ASD(HA)), to achieve network accreditation by either JCAHO or the National Council on Quality Assurance (NCQA). Air Force MTFs shall participate and support TRICARE Lead Agencies in achieving network accreditation.

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

2.4. Governing Body and Other Equivalencies for Use in JCAHO Surveys. The JCAHO recognizes the following equivalencies when applying standards to AF MTF (Medical Treatment Facility):

2.4.1. The Office of the Surgeon General, HQ USAF, is the governing body for all AF MTFs.

2.4.2. Federal law, DoD, and AF directives and instructions, SG policies, MAJCOM directives and policies, and local operating policies serve as the bylaws. MTFs may require separate operating instructions for issues not covered by AF policy directives (AFPD), AFIs, or other regulatory guidance. If available, these documents are also part of the formal bylaws.

2.4.3. The MTF's mission statement describes its purpose and community responsibilities.

2.4.4. The MDG/CC acts as the chief executive officer and represents the governing body locally.

2.4.5. The medical facility administrator serves as the chief operating officer.

2.4.6. The chief of the medical staff acts as the president of the medical staff.

2.4.7. The chief nurse is the nurse executive.

2.4.8. The MTF executive committee formally links the functions of the governing body representative, the chief operating officer, and the medical staff.

2.4.9. The ECOMS monitors JCAHO-required medical staff functions and clinical improvement activities.

Section 2B—Improving Organizational Performance

2.5. Functions Requiring Measurement. The review activities designed to measure these elements should be collaborative and multidisciplinary, include the dimensions of performance, and be continuously evaluated.

2.5.1. Patient-Focused Functions:

2.5.1.1. Patient Rights and Organization Ethics. The goal is to help improve patient outcomes by respecting each patient's rights and by conducting business relationships with patients and the public in an ethical manner.

2.5.1.2. Assessment of Patients. The goal is to determine what kind of care is required to meet a patient's initial needs as well as his or her needs as they change in response to care. To provide patients with the right care at the time it is needed, qualified individuals in an organization assess patient care needs throughout the patient's contact with the organization.

2.5.1.3. Care of Patients. The goal is to provide individualized care in settings responding to specific patient needs, e.g., providing supportive care, including resuscitation services; treatment of a disease or condition, including pain management; rehabilitating physical or psychosocial impairment; and promoting health. Patients deserve care that respects their choices, supports their participation in the care provided, and recognizes their right to experience achievement of their personal health goals.

2.5.1.4. Patient and Family Education. The goal is to improve patient health outcomes by promoting healthy behavior and by involving the patient in care and care decisions. Education promotes healthy behaviors, supports recovery and a speedy return to function, and enables patients to be involved in decisions about their own care. Patients must be taught that pain management is part of treatment. The organization supports patients' involvement in their care and makes sure its education process supports ongoing interaction between patients and staff.

2.5.1.5. Continuum of Care. The goal is to define, shape, and sequence the process of outpatient care, pre-admission, admission, hospitalization, and discharge, to maximize coordination of care within this continuum of care. Coordination of care includes referral to appropriate community resources. It is important for a hospital to view the patient care it provides as part of an integrated system of settings, services, healthcare practitioners, and care levels that make up a continuum of care. **NOTE:** Network quality activities are available through the Lead Agents.

2.5.2. Organization Functions:

2.5.2.1. Leadership. The goal is for organization leaders to use a framework to establish health-care services that respond to community and patient needs. Effective leadership depends on the performance of the following processes and related activities: planning and designing services; directing services; integrating and coordinating services; and improving services. The organization's ongoing performance measurement, assessment, and improvement processes monitor care,

compare outcomes to expected outcomes, and use this data to set new goals for improving overall hospital performance. Based on review of data, leaders develop and implement activities to upgrade their effectiveness. Leaders also continue to assess the community's needs and to revise the organization's mission and plans accordingly.

2.5.2.2. Management of the Environment of Care. The goal is to provide a safe, functional, supportive, and effective environment for patients, staff members, and other individuals in the facility. "Environment of care" includes building(s), equipment, and people. Effective management of the environment of care includes using processes and activities to reduce and control environmental hazards and risks, to prevent accidents and injuries, and to maintain safe conditions for patients, visitors and staff. Staff is educated about the role of the environment in safely, sensitively, and effectively supporting patient care delivery. Leaders have the responsibility to identify and to communicate environmental needs to the organization and to allocate appropriate space, equipment, and resources to safely and effectively support the organization's services.

2.5.2.3. Management of Human Resources. The goal of the management of human resources function is to identify and provide the right number and mix of competent staff to meet the needs of patients served by the organization and to fulfill its mission. The leaders are responsible for planning the qualifications, competencies, and staffing necessary to fulfill the organization's mission. Ongoing, periodic competence assessment evaluates staff members' continuing abilities to perform their duties.

2.5.2.4. Management of Information. The goal is to obtain, manage, and use information to improve patient outcomes, individual productivity, and organizational performance in patient care, governance, management, and support processes. This goal includes: ensuring timely and easy access to complete information throughout the organization; improving data accuracy; balancing requirements of security and ease of access; using aggregate and comparative data to pursue opportunities for improvement; redesigning information-related processes to improve efficiency; and increasing collaboration and information sharing to enhance patient care.

2.5.2.4.1. Medical Records Review. The goal is to ensure the quality of documentation through the presence, accuracy, and timely completion of records (medicolegal appropriateness), and to ensure medical records are prepared and kept according to AF directives and JCAHO standards. The review is performed on a representative sample of records and must represent the full scope and practice of each discipline. Emphasis will be on high-volume, high-risk, and problem-prone diagnoses with all deviations reviewed by the medical staff. The focused review will include timely completion of history and physical, presence of legally sufficient preoperative notes, timely dictation of operative reports, presence of postanesthesia notes at required intervals, timely dictation, signing of narrative summaries, and timely completion and signing of required medical records. The review must focus on the clear, complete, and accurate reflection of the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient, and patient's condition at discharge.

2.5.2.5. Surveillance, Prevention, and Control of Infection. The goal is to identify and reduce the risks of exposure to, acquiring, and transmitting of infections among patients, employees, physicians, and other licensed independent practitioners, contract service workers, volunteers, students, and visitors.

2.5.2.5.1. Infection Control Function. This is a multidisciplinary, collaborative function designed to coordinate all activities related to the surveillance, prevention, and control of nosocomial infections. The goal is to identify and reduce risks of endemic (common cause) and epidemic (special cause) nosocomial infections in patients and healthcare workers. It includes activities at the direct patient care and patient care support levels.

2.5.2.6. Improving Organizational Performance. The goal is to ensure that the organization designs processes well and systematically monitors, analyzes, and improves its performance to improve patient outcomes. Value in health care is the appropriate balance among good outcomes, excellent care and services, and costs. To add value to the care and services provided, organizations need to understand the relationship among perception of care, outcomes, and costs and how processes carried out by the organization staff affect these three issues.

2.5.2.6.1. Key Processes in All the Patient Care and Organization Functions Include: High-Risk, High-Volume, And Problem-Prone Areas. When high-volume cases are sampled, an appropriate sample size must be determined and used. Surveyors may inquire about the sample's rationale and adequacy, if it is less than 5% of the average number of cases occurring periodically (not less than quarterly) or 30 cases in that period of time (whichever is larger). The surveyor will use the following guidelines to determine when further inquiry is needed:

2.5.2.6.1.1. If the average number of cases per quarter is more than 600, at least 5% of cases are reviewed.

2.5.2.6.1.2. If the average number of cases per quarter is fewer than 600, at least 30 cases are reviewed.

2.5.2.6.1.3. Less than 30 cases will require 100% review.

2.5.2.7. Operative, Other Invasive and Noninvasive Procedures That Place Patients at Risk. To ensure the maintenance of high quality care for all patients rendered care through surgical procedures. Review is required for all procedures, for both tissue and non-tissue cases. Cases yielding tissues are screened to compare pathologic diagnosis with clinical diagnosis, adequacy of the specimen and any unexpected findings. Non-tissue cases and invasive diagnostic procedures should be checked for appropriate indications. All cases in which a discrepancy exists between preoperative and postoperative (including pathological) diagnoses are evaluated against predetermined criteria. Key processes will include selecting appropriate procedures, preparing the patient for the procedure, performing the procedure, monitoring the patient, and providing postprocedure care.

2.5.2.8. Medication Use. The goal is to ensure the maintenance of high quality pharmaceutical care for all patients rendered care through drug therapy. Develop and approve policies and procedures relating to prescribing, ordering, preparing, dispensing, administering and monitoring the medication's effect on patients. Monitor and evaluate the prescribing of drugs in the facility to ensure appropriate, safe, and effective practices for drugs used prophylactically, therapeutically, or empirically.

2.5.2.9. Use of Blood and Blood Components. The goal is to ensure that medical staff members performing blood usage functions are held to a high standard of performance. Reviews will correspond to approved policies and procedures related to the ordering, distribution, handling, dispensing, administration, and monitoring of blood products. Reviews of ordering practices and adequacy of transfusion services validate that the needs of the patient are met. There will be an

assessment of appropriateness of care in all cases in which the patient received a blood product and/or had a confirmed reaction.

2.5.2.10. Utilization Management Related to Population Health. Utilization management (UM) is a strategy for managing limited healthcare resources. UM's systematic review for over and under utilization of services linked with quality management and risk management provides the AFMS with an overarching philosophy of "Best Value" health care. Best Value balances access to services, quality, and cost. The AFMS has transitioned from an episodic disease-based healthcare model to a proactive and comprehensive population-based healthcare model. This new model incorporates key elements of UM/QM within the entire population health improvement process to include: population enrollment, epidemiological assessment, health promotion and prevention, demand management, condition/disease management, case management, referral management, discharge planning, and utilization review. The goal of UM/QM is to ensure that patients receive the right care in the right place by the right provider at the right time.

2.5.2.11. Medical Staff Credentials Function. This includes a series of activities designed to collect relevant data that will serve as the basis for decisions regarding appointments and re-appointments to the medical staff, as well as delineation of clinical privileges for individual members of the medical staff.

2.5.3. Other Areas of Measurement Include:

2.5.3.1. Needs and expectations of patients.

2.5.3.2. Views of staff regarding improvement opportunities.

2.5.3.3. Behavior Management. This includes basic learning techniques, biofeedback, aversion therapy, diet, weight modification, and smoking cessation.

2.5.3.4. An organized, comprehensive collection of shared data elements and values, such as:

2.5.3.4.1. Results of Autopsies. The goal is to ensure that the medical staff, with other appropriate staff, develops and uses criteria that identify deaths for which an autopsy should be performed. The criteria should include annotations of all attempts to secure autopsies in deaths that meet the criteria, documenting permission, system-wide notification for the medical staff, and a process for sharing information.

2.5.3.4.2. Risk Management Activities. This is a comprehensive system or process through which risks to a medical facility, and all who are served by and associated with it, are identified, classified, evaluated, and controlled to predict, limit and reduce future potentials for risk or losses. This review is designed to capture, summarize, and evaluate medical unit risk management issues.

2.5.3.4.3. Quality Control Activities. These include clinical laboratory, diagnostic radiology, radiation oncology, nutritional medicine, nuclear medicine, medical equipment, pharmaceutical equipment for preparing medications, and others.

2.5.3.5. Dimensions of Performance. These are definable, measurable, and improvable attributes of organization performance.

2.5.3.5.1. Doing the right things: efficacy, appropriateness

2.5.3.5.2. Doing the right things well: availability, timeliness, effectiveness, continuity, safety, efficiency, respect, and caring.

2.5.3.5.3. Do the patients' receive what they need?

2.5.3.5.4. Do they need what they receive?

2.6. Medical Staff Functions/Committees. JCAHO policy is to encourage the use of functions rather than committees. Many committees, which formerly required a charter and formal minutes, have been changed to "functions." The functions only require "summary reports" (not minutes) be given to the Executive Committee of the Medical Staff. This gives healthcare facilities greater latitude in how they manage these important medical staff functions by reducing administrative time in meetings, voluminous minutes, and encouraging creative cost-saving methods to achieve the desired purpose.

2.6.1. Functional Review (Summary) Reports, RCS: HAFMOA-SG(A)0003. These summary reports should contain a purpose statement and the content should be IAW the defined purpose in paragraph 2.5. The functional review reports should be simple, factual, and not include voluminous attachments. They should include meaningful information (not just data) for reviewers to be able to make informed decisions. They should include quantifiable data that is mostly longitudinal and can give a good comparison over time. For example, describing the monthly or quarterly waiting times for medication or error rates are meaningless unless you use comparative data from 6-12 months prior and explain the difference in improvement or opportunities that need to be addressed. The summary reports should also address both process and outcome.

2.6.2. Required Committees:

2.6.2.1. Executive Committee of the Medical Staff.

2.6.2.2. Safety Committee.

2.6.3. Required Functions:

2.6.3.1. Medication Use Function.

2.6.3.2. Medical Records Function.

2.6.3.3. Credentials Function.

2.6.3.4. Infection Control.

2.6.3.5. Blood and Blood Components Function, as applicable within MTF-defined scope of care.

2.6.3.6. Operative and Other Invasive Procedures Function, as applicable within MTF-defined scope of care.

2.6.3.7. Cancer Conference, as applicable within MTF-defined scope of care.

2.7. Sentinel Events. Refer to **Chapter 8, Section 2D**, beginning with paragraph **8.33**.

Section 2C—Competency Assessment

2.8. Competency assessment applies to all staff. The right skill mix, effective deployment, and appropriate competency levels of staff are critical factors in providing quality patient care and customer service. Competence is the possession of knowledge, skills, and abilities to fulfill job responsibilities. Compe-

tency 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 (employee's) role in that setting. Thus, the leaders of an organization must define the qualifications and competencies of staff required to fulfill the organization's mission. The leaders are responsible for assessing, maintaining, and improving staff competency through an ongoing series of activities. The organization:

- 2.8.1. Provides general orientation organization-wide and job-specific knowledge for all new staff, including contracted individuals and volunteers.
- 2.8.2. Assesses and documents current staff competency levels.
- 2.8.3. Identifies the competencies, including age-specific competencies, staff need in order to perform the assigned job. **NOTE:** Specific guidance on competency assessment criteria for enlisted members is found in each career field's Career Field Education and Training Plan (CFETP).
- 2.8.4. Informs staff of expectations and objective criteria to perform, improve, or enhance job performance. This includes reviewing job descriptions and performance standards.
- 2.8.5. Implements programs that enable staff to meet the competencies and performance standards established by the organization.
- 2.8.6. Evaluates program effectiveness individuals' achievement of competence.
- 2.8.7. Completes and presents annual competency report to the executive staff for evaluation.

2.9. Performance Evaluation. Each staff member's performance is evaluated by the organization, usually by the person who directly supervises the individual's day-to-day work. These evaluations are analyzed for patterns or trends related to specific performance issues. Based upon these evaluations, additional training or education may be needed, as well as more formal corrective action, as indicated.

2.10. Education and Training Activities. In-service education, continuing education, and training activities are provided to assist all staff in acquiring, maintaining, and improving competence.

2.11. Orientation. All staff, throughout their tenure with the organization, should receive information and training on new equipment, new procedures, new or revised policies, or new performance expectations. **NOTE:** Specific education, training, and orientation criteria for enlisted members is found in the CFETP and is maintained by the individual's supervisor.

2.12. Competency factors that are critical to every person's successful job performance fall into three skill categories--cognitive, psychomotor, and interpersonal skills.

- 2.12.1. Cognitive or critical thinking skills include recognizing that the patient is having difficulty breathing and doing further assessment to determine probable cause.
- 2.12.2. Psychomotor or knowledge-based physical task skills include performing cardiopulmonary resuscitation (CPR), inserting an intravenous line for medication administration, or word processing or typing reports for the laboratory director. Knowledge-based skills include "knowing" how to do the assessment, knowing the right thing to do in a specific situation, or knowing where to get the correct information if you don't "know how" to do something.
- 2.12.3. Interpersonal skills include meeting, greeting, and interviewing patients in the admitting office, handling lost visitors, and working effectively within an assigned team or work group.

2.13. Non-privileged Healthcare Personnel. A competency assessment folder (CAF) should be kept by the individual's (officer and enlisted) supervisor and made available to the individual. Specific guidance on the CAF is provided in AFI 36-2201, *Developing, Managing, and Conducting Training*, as well as the CFETPs. As a minimum, these folders should include the following: (Examples of each are in parenthesis):

2.13.1. Job Description including qualifications and performance standards. (Description of job and additional duties).

2.13.2. Core competency assessment (initial and ongoing), orientation to the organization and specific department or service in which the employee works. (List of core competencies, responsibilities, organization/department orientation checklists, curriculum vitae, regulatory references, AF Form 55, **Employee Safety and Health Record**).

2.13.3. Documentation of certifications, registrations, and professional licensure. (Board certifications, professional affiliations, formal education diplomas, professional military education [PME] diplomas, technical school diplomas, internship/fellowship/education with industry [EWI] participation documentation).

2.13.3.1. The AFRS primary source verifies licensure for all new accessions who are required to have a license, certification, or registration (reference paragraphs **3.1.** and **3.2.** for listing of personal and professional groups). The MTF is responsible to monitor and, if necessary, verify licensure for all healthcare personnel. Credential managers are responsible for privileged providers, as described in **Chapter 4**; responsibility for non-privileged personnel is at the MDG/CC's discretion. Based on MTF size, structure and human resource factors, suggest senior corps representatives, squadron commanders, or staff development be delegated this responsibility.

2.13.3.2. Do not keep original or exact duplication of professional license in folder; rather, annotate date, method, POC contacted, and name of individual doing the license verification.

2.13.4. Ongoing education and training. (Continuing medical education [CME], symposia, in-service programs, medical readiness training [warskills competencies documentation]).

2.13.5. Professional achievement and miscellaneous. (Published books/articles, committee memberships, awards, decorations, community service, etc.).

2.14. Competency Assessment Folders (CAFs). CAFs are not counseling folders and should not contain confidential performance evaluation/appraisal documentation.

2.15. Use of CAF During Deployment, ARC Annual Tour, and PCS. The CAF should accompany staff during deployment, a tour of duty (TDY) (i.e., manning assistance), ARC annual tour, and PCS. **NOTE:** For privileged providers, the PCF equals the CAF. During deployment, TDY, and ARC annual tour, it is not appropriate or necessary to send the entire PCF; rather, forward the Interfacility Credentials Transfer Brief and a copy of the privilege list, as described in paragraph **4.1.20**. At PCS, the PCF is mailed directly from the losing MTF to the gaining MTF, as described in paragraph **4.15**.

2.16. Privileged Healthcare Personnel:

2.16.1. Documentation of a privileged provider's credentials is located in the PCF, which is maintained by the credentials manager. (Refer to **Chapter 4**).

2.16.2. Competency assessment for initial appointment/privileges and biennial renewal is accomplished through the credentialing process which is based on performance measures.

2.16.2.1. Initial competency assessment is based on documented training; letters of recommendation and/or supervised practice; and other measures such as data documented on AF Form 22, **Clinical Privileges Evaluation Summary**; AF Form 475, **Education/Training Record**; AF Form 494, **Academic/Clinical Evaluation Report**; and AF Form 1562, **Credentials Evaluation of Health Care Practitioners**.

2.16.2.2. The biennial renewal process integrates output from performance-based determinants collected on an ongoing basis. Reference **Chapter 5** for further information.

Section 2D—Tools and Information Sources

2.17. Performance Measurement Tools (PMT): AFMS 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, automate data collection. These “foundation-building” metrics include promoting data integrity to ensure enrollment data is correct (thus ensuring correct funding of our MTFs as DoD moves to capitation financing) as well as identifying functional and technical deficiencies early and addressing them quickly. The goal is to make data collection, analysis, and utilization as easy as possible to support AFMS continuous quality improvement. The “desired” end state is an accountable health plan with data-driven quality improvement “built in,” not “added on.”

2.18. Air Force Medical Applications Model (AFMAM): AFMAM is now a web-based program designed to automate and streamline various Air Force Medical Service functional processes. The AFMAM program can be used as a self-paced, tutorial training program. It provides indoctrination instruction for entry level, supervisory, and management level positions. The model also includes a reference library containing more than 200 documents on DoD and AF regulations, instructions, and policy guidance. In addition, JCAHO’s Comprehensive Accreditation Manual for Hospitals is now available in this reference library. Among the many features of AFMAM, it can perform a global search (model-wide search), bookmark favorite areas, and launch the standard Microsoft applications to access more than 200 forms and template-styled documents. AFMAM is also a communications tool for the long-range planning and execution of future medical programs. Reference: <http://afmam.satx.disa.mil/>.

2.19. Centralized Credentials Quality Assurance System (CCQAS): CCQAS is a DoD database maintained in each MTF credentials office and centralized at AFMOA/SGOC. The CCQAS software assists the credentials managers with control of credentials, managing the credentialing/privileging process, reports, letter generation, PCS and interfacility transfer briefs. Managers at all levels also use the information in CCQAS for generating DoD and congressional reports, personnel management, and planning purposes. CCQAS will eventually include risk management and privileging modules so that essentially the entire quality assurance process is automated.

2.20. AFMOA/SGOC Web Site: This World Wide Web site is the internet site for the Clinical Quality Management Division of the Air Force Medical Operations Agency, a Field Operating Agency (FOA) whose commander reports to the Air Force Surgeon General. It is used as a primary communications tool

to announce and centralize information pertaining to the field units of the USAF Medical Service. Its various sections range from the urgent to the historical and from specific AF instructions to general items of information over the entire spectrum of Clinical Quality Management for the Air Force to include Credentials & Privileging, Risk Management, Clinical Consultants, AF Policy, Clinical Practice Guidelines, Continuing Education and more. Reference: <http://sg-www.satx.disa.mil/moasgoc/index.htm>.

2.21. Population Health Web Site: Information, guidelines, tool kits, etc. regarding the DoD/VA Clinical Practice Guidelines are available at: <http://www.phso.brooks.af.mil>.

2.22. Additional Web Sites: The Air Force, Air National Guard, and Air Force Reserve Command Surgeons General each has a dedicated web site as follows:

- 2.22.1. HQ USAF/SG - <http://sg-www.satx.disa.mil>
- 2.22.2. ANG/SG – <http://airguard.ang.af.mil/sg>
- 2.22.3. AFRC/SG – <http://w3.afrc.af.mil/hq/sg/default.htm>
- 2.22.4. JCAHO's site can be accessed at: www.jcaho.org

Chapter 3

LICENSURE, CERTIFICATION, AND/OR REGISTRATION OF HEALTHCARE PERSONNEL

Section 3A—Personnel Required to be Licensed, Certified, and/or Registered

3.1. Scope of Licensure Requirement. Military, civil service, personal services contract personnel, and American Red Cross volunteers who require a license, certification, or registration to perform their duties must maintain a license or other authorizing document such as certification or registration from any US jurisdiction. (**NOTE:** Dietitians, physician assistants, and substance abuse counselors are exempt from the requirement for an authorizing document from a US jurisdiction. For these professional groups, national registration/certification meets the requirement). Managed care support contract (MCSC) resource-sharing providers, other non-personal services contract personnel, and non-Red Cross volunteers providing care in the MTF must be licensed in the jurisdiction in which the MTF is located.

3.1.1. Assignment to a position not involving direct patient care within or outside an MTF does not eliminate the requirement for license or authorizing document.

3.1.2. American Red Cross volunteers are indemnified for malpractice, meaning they are covered by the Federal Tort Claims Act when practicing within their scope of care. Non-Red Cross volunteers must provide their own malpractice coverage.

3.1.3. Contract Providers. The licensure requirement for contract personnel is determined by the type of contract--personal services vs. non-personal services.

3.1.3.1. Personal services contract employees must maintain an active license or authorizing document from any U.S. jurisdiction while non-personal services contract employees must maintain an active license or authorizing document from the state in which they are practicing.

3.1.3.2. The best way to differentiate between these types of contracts is to consider the relationship between the MTF and the individual. Personal services contract employees are managed as if they are civil service or active duty. The government is more directly involved in the hiring process and, importantly, indemnifies the individual for malpractice--(i.e., they are covered by the Federal Tort Claims Act). On the other hand, non-personal service contract personnel are hired by an outside contractor who manages the individual and handles problems with performance, etc. Specifically, this individual is not covered by the Federal Tort Claims Act; rather, the contractor is responsible to ensure that the individual has malpractice coverage and, in fact, often indemnifies its employee.

3.1.3.3. The terms of current contracts must be honored even if the licensure requirement differs from that stated above. However, future contracts will include the above distinctions.

3.1.3.4. MCSC “network providers” practice in the local community as a primary care manager (PCM) or specialist. Because they do not practice in the MTF, they are neither credentialed nor privileged by the MTF. They must be licensed according to the regulatory requirements of the state in which they are practicing.

3.1.3.5. Overseas. The host country must grant a waiver to permit an American citizen to be hired under a non-personal services contract. This waiver must include the fact that the individual is to provide services only on the US federal enclave and is required to be licensed in any US jurisdic-

tion 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.

3.1.4. Non-Personal Service Contract Physician Assistants (PAs). Depending on the specific state, this provider may have supervision requirements imposed by the state board of licensure that exceed Air Force requirements. For those PAs who require additional supervision, there are two 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 original or copies of records for this external review; 2) The MTF petitions the state board of licensure to honor licensure portability (refer to Title 10 U.S.C., Section 1094) so that the MTF physician supervisor may provide all of the necessary supervision. In this case, the MTF would be obligated to meet the state's supervision requirements even if it exceeds the AFMS' requirements as described in paragraph 6.14.4. Ideally, should the MTF need to utilize contracted physician assistants, it is suggested they be hired via personal services contracts.

3.2. Professional Groups Requiring License, Certification, or Registration:

3.2.1. The following healthcare practitioners must possess and maintain an active, current, valid, and unrestricted license from a US jurisdiction before practicing independently within the defined scope of practice for their specialty: audiologists, chiropractors, clinical social workers, clinical psychologists, dentists, dental hygienists, occupational therapists, optometrists, pharmacists, physical therapists, physicians, podiatrists, practical nurses, registered nurses, and speech pathologists. The intent is to submit to an agency that has the authority to issue and revoke permission to practice.

3.2.1.1. See paragraph 3.4.6. for discussion of an unrestricted license.

3.2.1.2. Physician assistants are exempt from this requirement due to the fact that most states have very specific supervision requirements that are impractical if not impossible to meet in our diverse and mobile population. Refer to paragraph 3.2.2. for the authorizing document required of physician assistants.

3.2.1.3. Newly accessed clinical social workers must, at a minimum, have a Master of Social Work (MSW) level of state licensure and be working on an "independent clinical practice" level of license. "Independent clinical practice level" is defined as a license that authorizes an individual to work as a clinical social worker without supervision. Clinical social workers already on active duty or otherwise employed by the Air Force as clinical social workers on the effective date of this Instruction, will be required to have an "independent clinical practice level" license as of 1 Oct 02. Refer to paragraph 6.8.2. for additional information.

3.2.1.4. Pursuant to Act 202, Session Laws of Hawaii 1996, licensing of social workers will be automatically repealed on 31 Dec 00. While it's possible this legislation will be overturned during the next legislative session, there is no guarantee this will take place. Therefore, social workers who are licensed only in Hawaii must obtain licensure in another state by 31 Dec 00. Depending on legislative outcome, failure to obtain licensure in another state may result in these individuals not meeting Air Force licensure requirements and subsequent administrative action for failure to comply with policy.

3.2.1.5. Refer to **Chapter 6** for further information about requirements for specific allied health professionals.

3.2.2. The following healthcare practitioners must possess and maintain an active, current, valid, and unrestricted registration or certification by a national professional agency: clinical dietitians, physician assistants, and substance abuse counselors. **NOTE:** For clinical dietitians and substance abuse counselors, this national agency or member state issues a registration/certification and may also revoke same. Physician assistants are not required to be licensed by a US jurisdiction but may obtain same.

3.2.3. The following registered nurse (RN) healthcare practitioners must possess and maintain a current, valid, and unrestricted RN license from a US jurisdiction (as described in paragraph 3.2.1.) as well as national specialty certification: nurse practitioners, nurse midwives, and nurse anesthetists.

3.3. Obtaining and Maintaining Licenses. Obtaining and maintaining a license or other authorizing document is the professional and personal responsibility of each healthcare professional. There will be certain circumstances where Department of Justice representation will be sought to defend a license. Personnel cannot use appropriated funds to pay fees for obtaining and maintaining a license. Permissive temporary duty is authorized for military personnel taking license examinations. Civilian employees can be excused from duty to take license examinations.

3.3.1. One exception to this is the case in which military providers are required to be licensed in the state of practice in order to participate in a resource sharing agreement with a civilian institution. Federal statute, Title 10 U.S.C., Section 1096, allows the Secretary of Defense to reimburse the military member up to \$500.00 toward obtaining said license. This is expected to be used only for civilian facilities that will not recognize the licensure portability statute described in 10 U.S.C. 1094.

3.3.2. Reference 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.

Section 3B—Management of Licensure Issues

3.4. Guidance on Licensure Requirements:

3.4.1. Those personnel accessed from professional training or who complete other training and require a license, registration, and/or certification 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 (PG1) for doctors of medicine (MD) and doctors of osteopathy (DO), or within 2½ years after award of doctoral degree for clinical psychologists. Failure to meet this requirement will be handled as described in paragraph 3.6.

3.4.1.1. For physicians to be eligible for licensure, they must successfully complete Step III of the United States Medical Licensing Exam (USMLE) and complete 1 year of postgraduate (PG) training. In order to meet the Air Force requirement, physicians who choose to be licensed in a state that requires more than 1 year of PG training must first obtain a license from a state that requires only 1 year of PG training.

3.4.2. According to DoDI 6025.13, *Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS)*, healthcare providers who do not yet meet licensure, certification, and/or registration requirements may practice only under a written plan of supervision and are awarded supervised privileges. 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 5.18.2. and Attachment 1 for definition of “supervised privileges” for further information).

3.4.3. Licensure Requirements for Clinical Psychologists. Clinical psychologists who have not been awarded their doctoral degree 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 Air Force. 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. Thus, 2 ½ years is allowed to accommodate state licensing requirements, initial testing and, if necessary, the opportunity to take the exam a second time. (Reference paragraphs 6.7.4. through 6.7.9. for information regarding supervision and privileging requirements).

3.4.4. Licensure Requirements for Dentists, New Dental Accessions, Health Professions Scholarship Program (HPSP) 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:

3.4.4.1. Direct accession new graduates must, at a minimum, 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 reporting to Commissioned Officer Training (COT). A license must be obtained within 365 days of arrival at the first permanent duty location.

3.4.4.2. Graduates who must serve an active duty service commitment for a health professions scholarship and new graduates entering an AF Advanced Education in General Dentistry Program (AEGD-1) must, at a minimum, 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 reporting to COT. A license must be obtained within 365 days of arrival at the first permanent duty station.

3.4.4.3. Failure to obtain a license within 365 days of arrival at the first permanent duty station may result in administrative discharge actions IAW AFI 36-3207, *Separating Commissioned Officers*. (Reference paragraph 3.6. for further information).

3.4.5. All civilian healthcare personnel considering employment or other affiliation with the AFMS, who have been trained through civilian schools or programs and who have had an opportunity to test for licensure or other authorization, must obtain and maintain a current, valid, and unrestricted license, certification, or registration as required before direct accession or other affiliation with the AFMS. (See AFI 36-2005, *Appointment in Commissioned Grades and Designation and Assignment in Professional Categories--Reserve of the Air Force and United States Air Force*, for licensure requirements that may be waived for accessions).

3.4.6. Meaning of Unrestricted License:

3.4.6.1. For non-physician professionals who are members of the Biomedical Services Corps, Dental Corps (DC), and Nurse Corps, 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.

3.4.6.2. For physicians who are members of the Medical Corps (MC), effective 1 Oct 99, an unrestricted license is one in which the individual has met all clinical, professional, and administrative requirements.

3.4.6.2.1. The physician must have a license that permits him or her to practice in the state of licensure immediately, seeing non-DoD beneficiaries, without first taking any action on that license.

3.4.6.2.2. In other words, if one must first pay a renewal fee, demonstrate malpractice insurance/risk pool payment, be subject to disciplinary action if found not complying with requirement to pay malpractice/risk pool fees, or is only permitted to practice in the federal jurisdiction, effective 1 Oct 99, this is no longer an acceptable license.

3.4.6.2.3. A physician employed by the military 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.

3.4.6.2.4. This requirement applies to physicians in residency programs, once they become eligible for licensure as described in paragraphs [3.4.1.](#) and [3.4.1.1.](#)

3.4.6.2.5. This requirement and the effective date were established by United States law. Specifically, 10 U.S.C. 1094, *Licensure requirement for health-care professionals*, was amended by Section 734 of the Strom Thurmond National Defense Authorization Act for FY 99.

3.5. Exceptions to Licensure Requirements:

3.5.1. Physician Licensure Policy Effective 1 Oct 99. Legislation does permit waiver of the requirement for individuals in "unusual circumstances." The ASD(HA) allows waiver of administrative licensure requirements that are unusual, substantial, and inharmonious with federal policy. Examples include payment of malpractice/risk pool fees and a requirement to reside or to be practicing in the state of licensure. **NOTE:** If the only administrative requirement is payment of renewal fees, this will not be waived.

3.5.1.1. Waiver of permissible administrative requirements is not automatic. The Service must first submit a particular state to the ASD(HA) for consideration. Once determined to be permissible, each physician must submit an application for waiver (obtained from the credentials manager). Once the waiver is granted, it is only good for that renewal period. Therefore, the physician must submit a new application for each licensure renewal period. Upon PCS, waivers do not need to be renewed.

3.5.1.2. If a physician has, and intends to maintain, two or more licenses with state-exempted administrative requirements, and the new licensure requirement can be met by paying renewal fees (vs. applying for waiver as just described), he or she is not eligible for waiver of administrative licensure requirement.

3.5.1.3. The HQ USAF/SG has delegated waiver authority to MAJCOM/SG who, in turn, may delegate this authority to the MDG/CC. Those with waiver authority are reminded there is no independent judgement or decision-making in this activity. In order to approve a waiver request, the ASD(HA) must first have identified the specific requirement is eligible for waiver.

3.5.1.3.1. Should a state have an unusual and substantial administrative requirement that is yet to be identified, submit this along with supporting documentation using the waiver application via MAJCOM/SG to AFMOA/SGOC for the HQ USAF/SG's review. If the HQ USAF/SG determines there is merit, request will be submitted to the ASD(HA) for consideration. The ASD(HA)'s decision will then be forwarded to MAJCOM/SG.

3.5.1.3.2. Approved waivers are to be placed in Section VI of the PCF next to the copy of the provider's license.

3.5.1.3.3. At the end of each fiscal year, each MAJCOM must submit a report on the licensure status of healthcare personnel within their commands. The number of physicians who have been granted a waiver, along with the type of waiver, is part of this report that becomes part of the DoD Quality Management Report (QMR). Refer to paragraph 3.8. for further information about the QMR.

3.5.1.3.4. Because of the complexity of this situation, to include the changing environment of state licensure policies, this entire process remains dynamic. Therefore, be alert to policy memoranda regarding this subject. Further guidance will be sent via conventional and electronic mail as well as posted to the AFMOA/SGOC's homepage.

3.5.2. 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 3.1. and 3.2. through 3.2.1. and are required to have documented proof of English language competency and current clinical skills. Newly employed healthcare personnel shall practice with supervision for 1 year. Monitoring and evaluation of practice 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:

3.5.2.1. 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

3.5.2.2. Demonstration of all of the following:

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

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

3.5.2.2.3. 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.

3.5.3. 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 3.5.2., 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.

3.6. Failure to Obtain or Maintain a License, Certification, or Registration. An individual who does not have an active, current, valid, unrestricted license or other authorizing document will not practice

independently. 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:

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

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

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

3.6.3.1. The MTF forwards the package containing the MDG/CC's recommendation, along with supporting documentation, for separation/discharge or waiver of licensure policy to the MAJ-COM/SG who, in turn, makes a recommendation for separation/discharge or waiver. The MAJ-COM/SG forwards the package to AFMOA/SGOC who presents the case to the HQ USAF/SG. If the HQ USAF/SG's recommendation is for separation/discharge, the package is forwarded to AFPC/DPAM for disposition.

3.6.4. The ARC providers who lose their license, certification, or registration due to misconduct or incompetence may be separated under AFI 36-3209, *Separation and Retirement Procedures for Air National Guard and Air Force Reserve Members*.

3.6.5. Civilian 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 local-hire personnel.

3.7. Clinically Restricted Licenses. All individuals who are licensed or maintain certification or registration must immediately notify their supervisor and 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 considered or actual clinical or professional restrictions imposed on the individual and take appropriate action.

3.8. Annual DoD Quality Management Report (QMR), RCS: HAFMOA-SG(A)8901:

3.8.1. At the end of each fiscal year (FY), each Service submits data regarding the total number of healthcare personnel, both active duty and civilian; number in training; number fully trained; licensure status; board certification data for physicians; and results of JCAHO surveys to the ASD(HA). Most of this data is maintained in centralized databases such as CCQAS. However, CCQAS only contains privileged providers and, therefore, some of this data must still be forwarded from the MTF to the MAJCOM to AFMOA/SGOC, or from the graduate training program to the HQ AFPC/DPAME to AFMOA/SGOC.

3.8.2. At the end of each FY, be prepared to receive this data call. Since this is an evolving DoD report, the specific information requested may change over time.

3.9. Portability of State Licensure. DoDI 6025.16 establishes procedures under Title 10 U.S.C. 1094(d) to permit licensed physicians and other healthcare professionals of the Military Health System (MHS) who are members of the Armed Forces to perform authorized duties for the Department of Defense in any

authorized location. AFMS officials responsible will, prior to assigning licensed providers to off-base duties, follow the procedures established in this AFI to promote cooperation and good will 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.

3.9.1. Qualifications. To be eligible for assignment of off-base duties, the healthcare professional will have the following qualifications:

3.9.1.1. The healthcare professional will have a current, valid, and unrestricted license or other authorizing document such as certificate or registration (Reference paragraph 3.2.1., which encompasses the professional activities involved in the off-base duty assignment.

3.9.1.2. A healthcare professional will 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.

3.9.1.3. The healthcare professional will have current clinical competence to perform the professional duties assigned.

3.9.1.4. In the case of physicians and other privileged providers, the healthcare professional will have current clinical privileges granted and maintained in accordance with **Chapter 5**. 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.

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

3.9.1.5.1. 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.

3.9.1.5.2. The physician will have maintained current competence, in that if 10 years or more have passed since completion of the licensing examination, the physician must have ABMS/AOA specialty board certification.

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

3.9.1.6. 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 by-laws of such facility, to the extent they are applicable to the professional.

3.9.2. Coordination with State Licensing Boards. Prior to a healthcare professional performing off-base duties under the authority of Title 10 U.S.C. 1094(d), the AFMS official responsible (MDG/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 (MDG/CC); and the MHS liaison official (MDG/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 Title 10 U.S. C. 1094(d) and

DoDI 6025.16 as underlying authority and will include a statement that the healthcare professional meets all qualification standards of paragraph 3.9.1. See Attachment 29 for sample notification letter.

3.9.3. Investigations and Reports. 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, reference DoDI 6025.16, paragraphs 6.3.1. through 6.3.3.

3.9.4. Supplemental Agreements. AFMS officials responsible are authorized to enter into memoranda of agreement or other appropriate arrangements consistent with DoDI 6025.16 and other applicable law and DoD issuances to facilitate accomplishment of the purposes of that DoDI.

Chapter 4

THE CREDENTIALING PROCESS (APPLIES BOTH TO HOSPITALS AND TO CLINICS)

Section 4A—Provider Credentials

4.1. Credentials Used in the Privileging Process:

4.1.1. [VERIFIED] Copies of qualifying degrees, diplomas, ECFMG, or Fifth Pathway certification, as appropriate.

4.1.1.1. Must verify medical school graduation if the ECFMG certificate was issued prior to 1986, because medical school graduation was not verified prior to issuing the certificate.

4.1.1.2. The ECFMG certificate does not specify the name of the medical school.

4.1.2. [VERIFIED] Copies of postgraduate training certificates (i.e., internship, residency, fellowship, nurse midwife, nurse practitioner, or nurse anesthesia school).

4.1.2.1. Training provided in a DoD MTF does not require primary source verification if the training can be verified in the provider's personnel record. The personnel record, an officer SURF from the Air Force Personnel Center (AFPC) web page, or a rip from PC III can be used as a secondary source verification, if annotated appropriately as described in paragraph 4.2.2.

4.1.2.2. Credentials Managers may primary source verify (PSV) this information, if preferred. Contact HQ AFPC/DPAME, DSN 665-2638, for POC at specific graduate medical education (GME) program who can verify this training, if the files have not yet been archived.

4.1.3. [VERIFIED] Copies of all Current Professional Licenses, Registration, or Certification Documents. (Refer to paragraph 4.4. for requirements regarding renewal of these documents).

4.1.3.1. Upon PCS or every 4 years, whichever occurs first, the gaining MTF must re-primary source verify licensure of physicians only.

4.1.4. [VERIFIED] Copies of Specialty Board Certificates, if Applicable. (See paragraph 4.7.)

4.1.5. National Practitioner Data Bank (NPDB) Query Results:

4.1.5.1. Recruiting Services will query the NPDB for all privileged providers during the accession process and credentials managers will query the NPDB before the individual is granted privileges initially, and as part of the biennial review process. **NOTE:** MTF credentials managers are not required to retrospectively query non-physician and non-dental providers who are already privileged. However, as all providers come up for biennial renewal, NPDB queries must be accomplished.

4.1.5.2. It is acceptable to query less than 24 months from the previous query. However, once privileged, under no circumstances will the provider's NPDB query interval exceed 24 months.

4.1.6. Federation of State Medical Boards (FSMB) Query Results. Effective the date of this Instruction, the FSMB query is required for physicians and physician assistants (PAs). The FSMB database may contain disciplinary information that is not reportable to the NPDB. For example, criminal activity unrelated to clinical practice, actions that take place during the provider's residency/training program, or adverse privileging actions for physician assistants may only be available through the

FSMB query. Documentation of the most recent query is filed in Section II of the PCF. Historical queries are filed in Section V.

4.1.6.1. The FSMB query is optional, not required, for providers accessed from AF training.

4.1.6.2. Recruiting Services will initiate the FSMB query on all physician and physician assistant recruits.

4.1.6.3. MTF credentials managers will initiate the FSMB query for civilian and contract providers hired directly by the MTF and for military physicians and PAs who were in a deferred status for training.

4.1.6.4. For civilian and contract physicians and PAs, and active duty physicians and PAs recruited and placed in deferred status to attend civilian training programs, MTF credentials managers will also query the FSMB for the first two biennial reviews. Any cases pending resolution at the time of employment with the AFMS are likely to be resolved and reported within 4 years. (Reference paragraph 4.10. for discussion of deferred status providers). **NOTE:** For those physicians and PAs who were in deferred status to attend civilian training programs, MTF credentials managers must query the FSMB prior to a provider being granted initial privileges.

4.1.6.5. The query will be through AFMSA/SGSLC, 8901 - 18th Street, Brooks AFB TX 78235-5217, DSN 240-3944. All FSMB queries must be in writing. The request may be mailed or faxed to (202) 536-2984 or DSN 240-2984.

4.1.6.5.1. All inquiries must include the provider's full name, Social Security Administration number (SSN), date of birth (DOB), medical school, graduation year, and ECFMG certificate number, if applicable. Include an MTF point of contact with the request.

4.1.6.6. FSMB queries are not required if provider is a direct transfer from another DoD MTF, either as an active duty or civilian provider, and their PCF has a record of all required FSMB queries.

4.1.6.7. For those physicians and PAs who are required to have an FSMB query but due to confusion regarding who was responsible for same, may not have one, the FSMB query will be accomplished as part of the next biennial renewal of privileges. For civilian and contract providers who have been employed by the AFMS for less than 4 years, accomplish the FSMB query at next biennial renewal and again at the subsequent biennial renewal.

4.1.7. The AF Form 1540, Application for Clinical Privileges, and AF Form 1540A, Application for Clinical Privileges Update, must be completed before initiating practice, except in emergency situations (refer to paragraph 5.18.2.). The provider must complete sections 1-9. A new AF Form 1540 and AF Form 1540A must be completed when reassigned to a new unit. (See **Attachment 2** for information contained in AF Form 1540A)

4.1.7.1. The AFRS will use AF Form 24, **Application for Appointment as Reserve of the Air Force or USAF without Component**, for active duty applicants in lieu of AF Form 1540. These forms will reflect all information relevant to the provider from his or her current practice. The provider will need to complete AF Form 1540 and AF Form 1540A when he or she applies for privileges at the MTF.

4.1.8. Provider's Health Status Documentation:

4.1.8.1. An individual'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 biennial renewal. The provider must state his or her health status, which is then validated as described in paragraph 4.1.8.3., by someone familiar with the individual's health status, as it relates to their ability to perform the requested privileges.

4.1.8.2. The credentials manager will ensure that each applicant has addressed his or her ability to provide health care. This is done by ensuring the provider completes the health status statement (Section VIII, Block I) of AF Form 1540, as well as AF Form 1540A, in which the provider addresses his or her physical, mental, and emotional fitness to perform the requested privileges. Although a separate health statement is not required, facility-specific forms regarding health status may also be used.

4.1.8.3. For initial privileges and medical staff appointment, validation could be accomplished by the director of the provider's training program; chief of service, or SGH at the institution where the individual is currently privileged; a peer; or designated privileged provider at the MTF. For biennial renewal, confirmation may be accomplished by at least a countersignature on AF Form 1540A by an individual who is familiar with the provider and has the authority to do so, such as the chief of service, SGH, or designated privileged provider at the MTF.

4.1.9. (For Recruiting Services and New Civilian Physicians only) Medical Mal practice Documentation. The applicant will advise the Air Force of his or her entire malpractice history. If the applicant answers "yes" to Section VIII, Block J, on the AF Form 1540, he or she must provide the following information:

4.1.9.1. Copies of the complaint and answer, including amendments (and)

4.1.9.2. A medicolegal opinion stating the standard of care (SOC) determination, nature of claim, and status of claim. This document must be obtained directly from the provider's lawyer, the court, or the insurance company.

4.1.9.3. A single claim, in any prior 5-year period, beyond the most recent five years, need not be investigated to the detail noted, unless it resulted in the restriction of a license or privileges.

4.1.10. Adverse Action Documentation. If there is any evidence of an adverse clinical privilege action at any MTF, obtain information on that action.

4.1.11. Prior Privilege Lists. The AFRS for military accessions, and MTF for civilian accessions, will obtain copies of privileges awarded by the MTF where the provider's most recent practice took place, or copies of applicable Air Force standardized clinical privilege lists (AF Forms 244, 2815 through 2830, and 3928, 3929, and 3930). The credentials privilege list reflects what the applicant's peers feel the provider is qualified to perform.

4.1.11.1. For newly accessed providers from civilian practice, if the provider had privileges for less than 1 year at the prior MTF, then privileges need to be obtained from another MTF where he or she practiced prior to the past year.

4.1.12. AF Form 1562, Credentials Evaluation of Health Care Practitioners:

4.1.12.1. For contract, civil service, active duty, and ARC providers accessed from the civilian sector, three AF Forms 1562 must be completed. The provider's clinical supervisor, credentials

function chairperson, and one peer must each prepare AF Form 1562. When feasible, the AF Forms 1562 should be obtained from the references listed on AF Form 1540.

4.1.12.1.1. If the newly accessed provider is not on any hospital staff, but is a member of a group practice, equivalent individuals in the group who are familiar with the provider's practice should complete these forms.

4.1.12.1.2. Providers accessing from independent practice must have equivalent providers who are familiar with their practice complete the AF Form 1562.

4.1.12.1.3. For ARC accessions, three AF Forms 1562 must be obtained as described above. However, the peer completing AF Form 1562 may not be assigned to the same ARC medical unit.

4.1.12.1.4. The credentials function chairperson may delegate completion of AF Form 1562 to a senior privileged provider who interacts with the applicant in the clinical arena.

4.1.12.2. For providers completing an AFMS training program, one AF Form 1562 will be completed by the training program director and forwarded to the gaining MTF, along with the last AF Form 494, from the training program. Residents in Aerospace Medicine (RAM) may use AF Form 475; dentists may submit a letter in lieu of AF Form 494.

4.1.12.2.1. Item 11 of AF Form 1562 is based on the standardized privilege list for the specialty in which the provider has been trained.

4.1.12.3. For active duty providers PCSing from a DOD MTF, three AF Forms 1562 will be completed by the losing MTF. The provider's clinical supervisor, credentials function chairperson, and one peer must each prepare an AF Form 1562. Item 11 of the AF Form 1562 is based on the list of privileges approved for the transferring provider at the losing MTF.

4.1.12.3.1. For dentists, other than oral maxillofacial surgeons, the dental surgeon (SGD) and two other dental peers will complete AF Forms 1562. If there are not two dental peers assigned, the SGD, SGH, and one dental peer will complete these forms. (If there is no dental peer assigned, then only the SGD and the SGH will complete the AF Forms 1562. For oral maxillofacial surgeons, the SGD, the chief of surgery, and one other dental peer will complete AF Form 1562).

4.1.13. AF Form 22 is used to summarize data collected for performance based privileging for biennial reappointment.

4.1.14. Continuing Health Education (CHE) Documentation. IAW AFI 41-117, *Medical Service Officer Education*, (for active duty) or AFI 41-117 ANG SUP1, *Medical Service Officer Education, Air National Guard*, (for the ANG), providers must produce evidence of accumulated CHE on the occasion of their initial appointment and at least one month prior to biennial reappointment. For specific CEU or CHE requirements, refer to AFI 41-117. Reference paragraph [4.12.4.](#) for CHE documentation requirements.

4.1.15. Emergency Resuscitation Training Documentation. Resuscitation training requirements for personnel involved in direct patient care are outlined in AFI 44-102, *Community Health Management*.

4.1.16. AF Form 494 (AF Form 475, or letter for residents in aerospace medicine [RAMs] and dentists, respectively) is completed by the training program director for providers coming from a military training program. Reference paragraph **4.9.** for further information.

4.1.17. Criminal History Background Checks (CHBC). CHBCs are required for all contract providers who care for patients under the age of 18. Active duty, 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.

4.1.17.1. For non-personal service contract personnel, the contractor is responsible for completion of CHBCs and must forward results to the gaining MTF. The MTF must ensure the CHBC has been completed. (For personal service contract personnel, the MTF is responsible for completion of CHBCs.) For further information, reference DoDI 1402.5, *Criminal History Background Checks on Individuals in Child Care Services*, or contact the Air Force Medical Support Agency (AFMSA/SGSLC), at DSN 240-8044 for subject matter expertise in contracting.

4.1.17.2. 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.

4.1.17.3. CHBCs must be repeated every 5 years.

4.1.17.4. CHBCs are to go back as far as possible, to age 18. Prior to age 18, the documents are not accessible.

4.1.17.5. If there has been a break in government service, a complete CHBC must be reaccomplished, even if the individual has had a recent CHBC. It does not cost more to review data from age 18 versus a shorter time interval.

4.1.17.6. DoDI 1402.5 requires “criminal history background checks for all existing and newly hired individuals involved in the provision of child care services as Federal employees, contractors, or in Federal facilities to children under the age of 18.” While it permits DoD to provisionally hire individuals before completion of the CHBC, it requires caregivers to be “within sight and under the supervision of an individual whose background checks have been completed, with no derogatory reports.”

4.1.17.6.1. The ASD(HA) clarified this mandate for DoD health care personnel in a Policy Memorandum dated 20 Apr 92. “Pending completion of background checks, the Surgeons General shall require close clinical supervision and full compliance with existing DoD Directives, Instructions, and other guidance...on quality assurance, risk management, licensure, employee orientation, and credentials verification. These policies rely on process and judgment, and meet the intent of the ‘direct sight supervision’ provision, affording local commanders a flexible and reasonable alternative.”

4.1.17.6.2. Therefore, the MDG/CC will determine what constitutes “close clinical supervision” for individuals whose CHBCs are pending--either supervised privileges ensuring protection of patients under the age of 18 or line-of-sight supervision (i.e., chaperoned by an individual whose background check has been successfully completed) at all times when caring for these patients.

4.1.18. Mammography Quality Standards Act (MQSA) Documentation:

4.1.18.1. 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). This documentation is to be filed in Section VI of the PCF. The Federal Register regulation, as well as guidance documents, can be obtained by faxing a request to (301) 986-8015 or at the following web site: <http://www.fda.gov/cdrh/dmgrp.html>.

4.1.19. Civilian Provider Interview Documentation. The SGH is responsible for interviewing and orienting new civilian and contract hires to the facility rules and regulations. For civilian providers hired directly by the MTF, a privileged provider of the professional staff may also interview the applicant and may be delegated by the SGH to conduct the orientation. Contract groups may be delegated this authority for contract personnel. The statement of the interview, with the provider's acknowledgment, will be included in section I of the credentials file.

4.1.19.1. Interviews by the SGH are highly recommended for all new providers. **NOTE:** For ARC, interviews will be conducted by the MDS/CC.

4.1.19.2. Evidence of interviews and orientation must be maintained in Section I of the PCF.

4.1.20. Interfacility Credentials Transfer Brief (ICTB) = Reserve Component Processing (RCP) for ARC. The ICTB/RCP facilitates transfer of credentials and the privileging process for MTFs or Dental Treatment Facilities receiving active duty, guard, reserve, civil service, contract, resource sharing, Department of Veterans Affairs (VA), and non-military uniformed healthcare providers on a temporary practice assignment.

4.1.20.1. The sending MTF conveys pertinent credentials and privileging information to the gaining MTF using the ICTB/RCP. This has become automated via CCQAS. (Refer to **Attachment 3** for required format and CCQAS User's Guide for additional information).

4.1.20.1.1. The sending MDG/CC or ARC privileging authority must sign the ICTB/RCP. This hard-copy document is to be sent by registered, certified, or other accountable mailing source to the gaining MTF, along with a copy of the provider's current clinical privilege list.

4.1.20.1.2. Simultaneously, the electronic ICTB/RCP will be annotated to reflect the date and name of the individual who signed the ICTB/RCP and forwarded electronically for immediate use by the gaining MTF. A copy of the provider's current clinical privilege list will be faxed to the gaining MTF.

4.1.20.2. The receiving commander uses the ICTB/RCP and current clinical privilege list as a basis for awarding privileges, upon arrival at the gaining MTF.

4.1.20.3. Retain a copy of the ICTB/RCP. Upon completion of the TDY, file ICTB/RCP in Section V of the PCF. **NOTE:** For ongoing, recurrent TDY, unless the privileges or status change, it is not necessary to generate a new ICTB/RCP for each TDY. In this case, maintain a log of each TDY, noting, "no change in privilege status," and file in Section V of the PCF. Likewise, minor changes such as license renewal or basic life support (BLS) recertification may be annotated using pen-and-ink changes.

Section 4B—Verification of Credentials

4.2. Primary Source Verification (PSV). A reasonable effort must be made to verify, with the primary issuing authority, all documents noted in paragraph 4.1. with the word “[VERIFIED].” Documents can be verified by one of the following methods, which are listed in descending order of preference. The greatest preference is written verification, then verbal via telephone, then the American Medical Association (AMA) Masterfile, then the world wide web, and, finally, the least preferred method is touchtone telephone verification. The “chain of transmission” of the document or information is what distinguishes primary source verification from secondary verification. The document or information must come from the issuing authority to be considered primary source verification. **NOTE:** A reasonable attempt is defined as making a second attempt to solicit the necessary information. If still unsuccessful, annotate your efforts, file documentation in section VI of the PCF, and identify the problem to the MAJCOM quality manager.

4.2.1. Written Confirmation from the Issuing Authority. This confirmation should be included in section VI of the PCF. 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 not primary source verification.

4.2.2. Verbal Telephone Confirmation from the Issuing Authority. This confirmation must be annotated in section VI of the PCF, either on the copy of the document being verified or on a separate listing of documents verified. The verification annotation will indicate the date, agency contacted for the verification, agency phone number, name of the individual at the agency who verified the information, and the signature and signature block of the person who did the verification.

4.2.3. AMA Masterfile physician profiles can be used as primary source verification of US medical school graduation and US residency program completion. The AMA current fee per profile is \$15.00. Contact 1-800-665-2882 or <http://www.ama-assn.org> for further information and guidance in obtaining an access code. The American Osteopathic Association (AOA) Masterfile is the primary source verification for osteopathic physicians and can be reached at 1-800-621-1773, extension 8145.

4.2.4. World Wide Web, or Internet, primary source verification is acceptable, if the criteria, as published in the JCAHO 6 Aug 98 Memorandum, are met. (Refer to **Attachment 4**).

4.2.5. Touchtone Telephone primary source verification (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. In addition to following the procedures outlined in paragraph 4.2.2., one must annotate that this was the only available method of primary source verification.

4.3. Authentication that a document is a true and valid copy of the original does not constitute primary source verification. (Refer to paragraph 4.2. for discussion of primary source verification).

4.4. Actions Following Initial Verification. Credentials do not need to be re-verified as long as the individual is continually with the DoD and the item in question does not expire and require reissue. **NOTE:** Physician licensure is an exception as described in paragraph 4.1.3.1. Keep in mind, license renewal is not the same as license reissue.

4.4.1. Based on JCAHO standards, placing a copy of the renewal certificate in the PCF is acceptable, but the credentials manager must view the original renewal certificate and validate the photocopy as a

true and valid copy. The statement “ I certify this is a true and valid copy of the original” should be entered on the photocopy, signed, and dated by the credentials manager or designated authority.

4.5. Inability to obtain necessary verification should 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.

4.6. Foreign language (excluding Latin) documents must be translated into English.

4.7. Verification of Board Certification:

4.7.1. Specialty board certificates will be verified by directly contacting the issuing board or indirectly by referencing the annual publication, “Official ABMS Directory of Board Certified Medical Specialists” (formally known as the “Compendium of Certified Medical Specialties”). This document is also available in CD-ROM, published three times a year, but is much more expensive and may only be cost-effective for a large facility. Documentation of PSV may be accomplished by obtaining a copy of the “Directory” page with the provider’s listing and placing it in the PCF with the word “Directory,” date, and signature of the credentials manager.

4.7.2. JCAHO accepts verification through the American Board of Medical Specialties (ABMS) as primary source verification, since the ABMS maintains the information for the respective boards.

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

4.7.4. It is not necessary to delay awarding regular privileges pending verification of Board Certification.

Section 4C—AFRS, AFPC/DPAM, and AFMS Postgraduate Training Program Director Responsibilities Re: Credentials Documentation

4.8. Provider Accessions through the Air Force Recruiting Service (AFRS). Recruiting personnel must primary source verify licensure and other credentials documents required for the selection process and compile the following credentials documents: license or other authorizing document, qualifying degree/diploma/ECFMG certification, postgraduate training certificate, board certification, NPDB query, and the FSMB query. In addition, the AFRS will compile the following forms and information as described in paragraphs 4.1.7. through 4.1.12. AF Form 24 (in lieu of AF Form 1540), malpractice and adverse privileging history, copies of previous privilege lists, AF Form 1562, and provider health status. These documents are forwarded to HQ AFPC/DPAM/SG. HQ AFPC/DPAM sends all original credentials documents, including verification of same by registered, certified, or other accountable mailing source, to the provider’s initial MTF assignment, or appropriate ARC authority, at least 15 days before the provider’s reporting date. See Credentials [Table A5.1.](#) in [Attachment 5.](#)

4.9. Providers Attending Air Force Postgraduate Education Programs:

4.9.1. The director of medical education at the MTF that provides the training for an individual will create and maintain a medical training record and a PAF at the initiation of training.

4.9.1.1. The medical training record will contain verified copies of all applicable documents

4.9.1.2. The PAF will include qualitative performance data and academic performance evaluations, which are to be completed at least every 6 months.

4.9.2. When training is completed, the director of medical education at the MTF prepares a final evaluation to reflect all material in the PAF. This includes the following:

4.9.2.1. AF Form 1562.

4.9.2.2. AF Form 494, or equivalent as described in paragraph [4.1.12.2](#).

4.9.2.3. Annotated privilege list indicating the student's ability to perform treatments and procedures by annotating the appropriate code in the designated column of the applicable Air Force privilege list.

4.9.3. The final evaluation is filed in the medical training record.

4.9.3.1. The medical training record becomes the basis for the PCF to include verified copies of all applicable documents.

4.9.4. The director of medical education at the losing MTF will send the PCF to the gaining MTF by certified or express mail to arrive no later than 15 days after date of graduation.

4.9.5. Reference Credentials [Table A5.2](#). in [Attachment 5](#) for summary of training program responsibilities in collection and verification of credentials.

4.10. Deferred Providers Attending Residency, Fellowship, or Other Long Term Graduate or Other Medical Education Programs in Residence at Civilian Medical Facilities. Recruiting Services has no further contact with providers who are recruited and then placed in deferred status to attend civilian training. Deferred providers attending non-sponsored civilian residency programs are in obligated reserve status. Personnel issues are managed by the Air Reserve Personnel Center (ARPC). 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](#).

4.10.1. Providers in residency programs will be licensed as described in paragraph [3.4](#).

4.10.2. HQ AFPC/DPAM will give each provider an AF Form 1540, an AF Form 1562, and the appropriate privilege list(s) to be completed by the education director for immediate action. (Reference paragraph [4.9.2.3](#). for further instructions.)

4.10.3. Copies of license(s), certificate of residency completion, and other credentials documents, as well as completed AF Forms 1540 and 1562, including privilege lists, are forwarded to the gaining MTF no later than 15 days after date of graduation.

4.10.3.1. Before completing training, HQ AFPC/DPAM will primary source verify the individual's medical school graduation.

4.10.3.2. The gaining MTF is responsible to verify all other credentials that are not verified by HQ AFPC/DPAM.

Section 4D—Handling and Contents of the Provider Credentials File (PCF):

4.11. Handling of the PCF. The Privacy Act of 1974 (as implemented by AFI 33-332, *Air Force Privacy Act Program*); Title 10 U.S.C., Section 1102; and DoDD 6040.37, *Confidentiality of Medical Quality Assurance (QA) Records*; govern access and release of information in PCFs and the local CCQAS database.

4.11.1. The cover of all PCFs 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, Title 10 U.S.C., Section 1102.”

4.11.2. PCFs will be maintained in a secure manner. Providers may review their files, but they may not remove them from the control of the local custodian.

4.11.3. CCQAS credentials files will be maintained and updated IAW the CCQAS User’s Manual and the Air Force/ARC Supplemental Manual.

4.12. Content of the PCF. The file for each provider must be divided into six separate sections using a six-part folder. **NOTE:** For providers received under an ICTB, the documents must be contained in a folder; however, it does not need to be maintained in six separate sections. The PCF is not an appropriate repository of safety briefings and other human resource documents.

4.12.1. Section I--Privileging Documents. Section I includes the current application for privileges (AF Form 1540 and AF Form 1540A) and privilege list(s). Memoranda for designated supervisor (for one on supervised privileges) and physician preceptor, if required, are placed in this section. Locally required chronic disease lists are also filed in this section as applicable.

4.12.1.1. This section will also contain letters of notification to, and acknowledgment by, the provider of awarded privileges and medical staff appointment.

4.12.1.2. The incoming interview and provider’s statement of orientation to the facility bylaws are also placed in this section.

4.12.2. Section II--Performance Data. This section includes permanent documents that reflect relevant and factual performance data of the provider.

4.12.2.1. It may include, but is not limited to, current AF Form 22, AF Form 1562, or AF Form 494, the most recent NPDB/FSMB query, and the CHBC documentation.

4.12.2.2. For civilian and ARC providers, this section includes the current civilian privilege list(s) and the most recent statement of renewal of privileges from the civilian institution(s) where the provider has privileges. **NOTE:** In the case of an ARC provider who is in private practice and is not privileged at a civilian facility, place a memo stating this fact in this section.

4.12.3. Section III--Medical Practice Review. This section includes:

4.12.3.1. DD Form 2499, **Health Care Provider Action Report**, (if applicable). (Does not apply to ARC providers’ civilian practices).

4.12.3.2. Documents of permanent credentials function actions. Records of hearings may be kept separate if too bulky, but must be cross-referenced. The hearing record is a permanent part of the PCF if revocation, restriction, reduction, or denial of privileges resulted from the action. It must be transferred with the PCF when the provider is reassigned.

4.12.3.2.1. Reference paragraphs 7.40. and 7.41. for further information about filing documents related to abeyance, suspension, and monitoring and evaluations.

4.12.3.3. Completed DD Form 2526. (Does not apply to ARC providers' civilian practices).

4.12.4. Section IV--Continuing Health Education. AF Form 1541, **Credentials Continuing Health Education Training Record**, (which may reference computer file) records all training. This form is initiated at the provider's first assignment and is used until it is full. When full, start a new form and attach it to the prior form. Keep these forms in the PCF until it is destroyed.

4.12.4.1. If using a local electronic database, annotate in this section where the local electronic database file information can be located. At the time of PCS, print a copy of the database file and insert in section IV.

4.12.4.2. Copies of training certificates need not be kept in the PCF.

4.12.4.3. AF Form 1541/local electronic database also verifies BLS, advanced cardiac life support (ACLS), and advanced trauma life support (ATLS) training. Annotate verification of date of training and date of expiration.

4.12.4.4. For nurse practitioners, anesthetists, and midwives, AF Form 2665, **Air Force Nurse Corps Education Summary**, (continuing education activities) may be used in place of AF Form 1541 or local electronic database. If the AF Form 1541 is used for these providers, the total number of CHEs obtained over each consecutive 3-year time span must be annotated on the form.

4.12.5. Section V--Historical Data. This section includes previous FSMB queries, AF Forms 1540, AF Form 22, privilege lists, copies of ICTBs sent to MTF when provider served in TDY status, and AF Forms 1562 that are no longer current, as well as those from previous units of assignment. For ARC personnel, include clinical privileging documentation from previous annual tours, extended active duty assignments, and civilian medical facilities. **NOTE:** Since the most recent NPDB query contains a complete historical record, it is not necessary to maintain copies of previous NPDB reports. However, maintain an ongoing log or flow sheet of previous queries to include date and name of individual who conducted the query. This documents that the required queries actually took place.

4.12.6. Section VI—Credentials. This section includes copies of diplomas; certificates of internship, fellowship, and residency training; specialty board certification; state licenses, to include validation/verification of renewals (as required) via flow sheet or on copies of license renewals; waivers of licensure requirements; acknowledgement of DoD licensure requirements for physicians, if applicable; Drug Enforcement Agency certificate, if applicable; ECFMG certificate; and additional documents for justification of any privileges requested (i.e., dental). Documentation of the verification of these documents, if required, is also included in this section.

4.13. Maintenance of ARC PCFs and CCQAS Database. In addition to paragraph 4.12., the following apply to the ARC:

4.13.1. The PCF is established and maintained at the medical unit of assignment. For AFRC collocated/associate providers, the PCF and CCQAS database are maintained by the active duty host MTF. The privileging authority lies with the location of the PCF.

4.13.2. A geographically separated unit (GSU) provider's PCF and CCQAS database are maintained by the host medical unit or attached MTF.

4.13.3. Each ARC medical unit commander will appoint, in writing, the most qualified officer or senior non-commissioned officer as the credentials manager. The credentials manager will maintain and secure the PCFs and have access to CCQAS. **NOTE:** Recommend the MDS/CC appoint an assistant credentials manager.

4.13.4. Credentials manager for colocated/associate AFRC medical units will act as liaison between the active duty MTF and the medical unit for proper record maintenance.

4.13.5. The active duty MTF unit of attachment for Individual Mobilization Augmentees (IMAs) and Reinforcement Designees (RDs), who work for points but no pay, will create and maintain a PCF and CCQAS database on each provider.

Section 4E—Disposition of PCFs and Provider Activity Files (PAFs)

4.14. Disposition of Inactive PCFs and PAFs:

4.14.1. Medical units will maintain PCFs IAW AFMAN 37-139, *Records Disposition Schedule*. An inactive PCF may apply to providers in special assignments, re-entry into a residency, some headquarters staff positions, providers not in patient care assignments, or civilian contractors not currently seeing patients. The MTF where the provider last practiced will maintain the PCF.

4.14.2. All active duty facilities maintain a PAF which contains information on a provider which is used by the supervisor when filling out an evaluation of the provider for the 2-year review, etc. These files may include items such as patient complaints, in addition to items that have never been validated or verified. These files are kept for 1 year after the provider PCSs, separates, retires, or terminates employment and are then destroyed. While not required for ARC personnel, they may be used and are to be handled as just described.

4.15. Disposition of the PCF when Providers Transfer. The losing medical unit sends the PCF 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. This also applies to providers approved for interservice transfer. **EXCEPTION:** For providers assigned to HQ USAF, HQ MAJCOMS, or other staff positions whose primary duties do not involve direct patient care, the losing MTF keeps the PCF until the MTF where the individual applies for privileges requests it. **NOTE:** Be sure to include the completed AF Forms 1562 and AF Form 22 with the PCF, as described in paragraphs **4.15.1** and **4.15.2**. Once the PCF is forwarded, should there be any change in the provider's status, the losing MTF is responsible to report same to the gaining MTF.

4.15.1. When a provider transfers, the credentials function chairperson, clinical supervisor, and one peer at the losing MTF complete separate AF Forms 1562, as described in paragraphs **4.1.12.3** and **4.1.12.3.1** for non-dental and dental providers, respectively. The losing MTF must include all three forms in the PCF when it sends the PCF to the gaining MTF.

4.15.2. Completion of AF Form 22. The clinical supervisor at the losing MTF completes an AF Form 22 when the Air Force reassigns a provider to another MTF.

4.16. Disposition of the PCF when Providers Leave Service Employment. When a provider separates, retires, or terminates employment, contractual, or volunteer services, the MTF keeps his or her PCF according to AFI 37-138. If the provider transfers to the ARC, keep the file until the ARC request it. If a

separating or retiring military provider accepts immediate civilian employment at the same MTF, the privileges remain valid for the duration of original privilege period. However, if there is any interim employment, consider obtaining letter of recommendation from interim employer as well as NPDB query.

4.16.1. Completion of AF Form 22: The clinical supervisor will complete a final AF Form 22 to be placed in the provider's PCF.

4.17. Closing Medical Units:

4.17.1. Inactive PCFs will be sent to the medical unit's HQ MAJCOM/SG. Provider Activity Files (PAFs) and other items not ordinarily contained within the PCF should not be forwarded along with the PCF. However, the contents of the PAF will be summarized on an AF Form 22 which becomes part of the PCF.

4.17.2. Medical Units will attempt to notify providers of the location of their PCFs.

4.17.3. PCFs of active Individual Mobilization Augmentee (IMA) and Reinforcement Designee (RD) providers who have not been reassigned will be sent to HQ ARPC/SG.

4.17.4. HQ MAJCOM/SG will maintain PCFs IAW AFI 37-138 and will be responsible for replying to requests from prospective employers for provider practice summaries.

Section 4F—Miscellaneous

4.18. Minimum documents for Granting Supervised Privileges. For unlicensed providers to be considered for supervised privileges, after fulfilling all requirements specified in paragraphs **4.1.1.** through **4.1.19.**, the minimum documents required for review are:

4.18.1. [VERIFIED] Copy of license, registration, or certification (if applicable).

4.18.2. [VERIFIED] Copy of qualifying degrees and diploma.

4.18.3. [VERIFIED] Copies of postgraduate training certificates.

4.19. Facilitation of Concurrent Award of Privileges and Medical Staff Appointment. A provider who is awarded an initial medical staff appointment may later be granted a regular or affiliate appointment valid through the remaining period in which the privileges are held. Conversely, one who is awarded initial medical staff appointment (valid for only 12 months) may also be awarded privileges for 12 months rather than the maximum 24 months. This way, at the end of 12 months, the provider's practice is reviewed and may be granted active or affiliate medical staff appointment which, along with privileges, are valid for up to 24 months.

Chapter 5

THE PRIVILEGING PROCESS

Section 5A—Considerations in Awarding Privileges

5.1. 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 amount and quality of supervised clinical practice should be considered when awarding privileges.

5.1.1. Newly accessed providers who have not had a period of supervised clinical practice, and providers whose duties have not included clinical practice for an extended period, should be considered for supervised privileges.

5.1.2. The delineation of privileges should also consider the capabilities of the MTF support staff, equipment, and other resources that may restrict a provider's services.

5.1.3. Privileges are both individual and MTF/ARC medical unit specific.

5.1.4. Providers assigned to a GSU must have a PCF and be awarded clinical privileges by the appropriate privileging authority. (Refer to paragraph 4.13.2. for further information).

5.1.5. See *Section D* for discussion of types of privileges.

5.2. General:

5.2.1. Privileges must be appropriate to the training and background of the provider. All providers being considered for a specific privilege must be judged against appropriate standards of training and qualifications.

5.2.2. Privileges for ARC personnel are based, in part, upon the provider's civilian practice. Therefore, the expectation is that ARC personnel are actively practicing in the civilian community. For example, because dentists are usually only in private practice and not privileged by a healthcare organization, they must maintain an established number of hours of civilian practice (reference AFI 47-101, *Managing Air Force Dental Services*). Without civilian practice, it may be very difficult to generate enough workload to be fully ready to meet mission requirements as well as to generate sufficient data upon which to do performance-based privileging.

5.2.2.1. In support of medical readiness, the military duties of ARC personnel should primarily 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 majority of military activities should be as a flight surgeon.

5.2.3. Except for those functioning in strictly administrative or non-patient care research positions as part of their official DoD duties, providers referenced in paragraph 5.4. must be eligible for the award of clinical privileges as a condition of employment or continued service with the Air Force.

5.2.4. Credentialing and privileging is not a discipline 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/resource management activi-

ties. However, the MDG/CC or the MDS/CC must review acts of provider misconduct to determine if the misconduct has an impact on the provider's scope of practice.

5.3. Relationship Among Privileges, Medical Staff Appointment, and Authorization to Admit Patients. Before a provider can admit patients, the MDG/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 Air Force facility if not given a medical staff appointment. Requirements that specifically authorize providers to admit are privileges appropriate to inpatient care and medical staff appointment. For additional information, refer to paragraph **5.20.** and **Chapter 6.**

5.4. Providers Affected by the Privileging Process. This guidance applies to the following providers when they provide care or services in Air Force MTFs or ARC medical units.

5.4.1. Military (active duty and ARC).

5.4.2. Civilian (civil service, overseas local-hire, contract, volunteer, network providers, Veterans Administration, health resources sharing agreements).

5.4.3. Each provider with independent authority to begin, alter, or end a plan of treatment for a patient shall be privileged.

5.4.4. The HQ USAF/SG defines the scope of practice for each category of provider to be awarded clinical privileges. (For additional information, refer to **Chapter 6, Professional Scope of Practice for Allied Health Professionals.**). Only providers in the following professions may be awarded privileges: audiologists, chiropractors (only at HQ-designated demonstration sites, see paragraph **5.4.8.**), clinical dietitians, clinical pharmacists, clinical psychologists, clinical social workers, dentists, certified nurse anesthetists, certified nurse midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, physicians, podiatrists, and speech pathologists.

5.4.5. Privileges are not awarded to interns, residents, fellows, or advanced practice nurses in preceptor programs for clinical duties performed in their training roles.

5.4.5.1. Those who have completed a residency or equivalent program or meet requirements to function as a General Medical Officer (GMO), and, therefore, are fully qualified in one specialty, may be privileged and appointed to the medical staff to perform patient care in that fully qualified clinical specialty. Affiliate medical staff appointment is the most appropriate way to accomplish this since their primary focus is on their educational program. (Reference paragraph **5.20.3.**)

5.4.5.2. 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.

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

5.4.7. Privileges are not awarded to clinical dietitians in health and wellness centers (HAWC), social workers in family support centers (FSC), or social workers in family advocacy outreach manager positions providing outreach and prevention services in family advocacy programs (FAP), unless

those providers are also involved in the provision of patient care that requires privileges. (Refer to paragraph 6.5. for more information).

5.4.8. For those MTFs designated by the HQ USAF/SG to participate in the DoD Demonstration Project, chiropractors have been hired under contract and privileged to perform chiropractic services. Once the demonstration project is complete, these services will cease unless authorized by DoD to continue.

Section 5B—Responsibilities of Privileged Providers

5.5. Providers Who Seek Privileges:

5.5.1. Complete and/or review, for currency and accuracy, all application forms used for privileges before they are reviewed by the credentials function.

5.5.2. Comply with MTF regulations and the CHE standards for their specialty. (Reference paragraph 4.1.14. and 4.12.4. for further information).

5.5.3. Maintain appropriate documentation of CHE and promptly provides pertinent CHE updates, via copies of specific CHE coursework, to the credentials manager for data input and filing. At a minimum, providers will produce these documents upon initial application for privileges and at biennial renewal.

5.5.4. Review performance data as provided in their PAF, composite health care system (CHCS), or other databases.

5.5.5. Provide current documented information for their credentials file and promptly provide updates to the credentials manager as changes occur.

5.5.6. Complete orientation regarding AF rules, regulations, and policies governing patient care and medical staff responsibilities by the chief of the medical staff or designee. Providers will also be oriented to continuity of care responsibilities, ethics policies, and continuing education requirements and opportunities. The applicant will acknowledge intent to abide by these standards, in writing, on AF Form 1540 and AF Form 1540A.

5.5.7. Specific guidance for completing AF Form 1540 and AF Form 1540A:

5.5.7.1. Applicants must list all licenses or other authorizing documents and narcotics registration they currently hold, both active and inactive. In addition, applicants must provide an explanation of any licenses and narcotics registrations that are not current, have been voluntarily relinquished, or have been subjected to disciplinary action, voluntary or involuntary limitation, suspension, or revocation.

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

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

5.5.7.3.1. The AF Form 1540, Section VIII, D. asks, "Have your privileges at any institution ever been limited, restricted, or revoked?" This applies to both temporary and permanent actions. Because suspension is a temporary removal or restriction of all or a portion of privi-

leges, one whose privileges have been suspended must answer yes to this question. For further information, refer to paragraphs [7.13.2](#).

5.5.8. This entire process is validated and updated at biennial renewal of privileges and medical staff appointment. Prior to renewal, the provider must verify the information on AF Form 1540 is still accurate, complete Block XIV, A., and complete a new AF Form 1540A.

Section 5C—Procedures for Applying for Initial Privileges and Medical Staff Appointment

5.6. AF Form 1540. Providers apply for privileges and appointment by submitting an AF Form 1540 and AF Form 1540A, along with the other basic credentials. Forms must be filled in completely, with no time gaps, from the date of professional training.

5.6.1. The clinical supervisor must review the AF Form 1540 with the provider, make recommendations, complete the form, and return it to the credentials function chairperson.

5.6.2. Review of the AF 1540 for Senior Staff Members. When senior medical officers, such as the flight chief or chief of the medical staff, apply for privileges and medical staff appointment, a qualified privileged provider in a like specialty acts as the clinical supervisor. This clinical supervisor reviews the credentials file and the request for privileges and makes recommendations on privileges to the credentials function.

5.6.3. For ARC Personnel:

5.6.3.1. The provider will complete AF Form 1540, Section IV, to include the following: previous active duty, civilian, guard and/or reserve assignments (but not including ARC annual training), as well as current civilian position, guard and reserve assignments. For references, list individuals who are 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.

5.6.3.2. Privileges for guard and reserve personnel are based, in part, upon the providers' civilian practice.

5.6.3.3. A copy of the provider's privileges (if applicable) from all current places of civilian practice must be placed in the PCF. If the provider, such as a dentist, is in private practice and has no privileges or medical staff appointment with any civilian institution, a memorandum stating this fact will be completed and placed in Section II of the PCF. This must be reaccomplished at biennial renewal.

5.6.3.4. Three AF Forms 1562 from the provider's civilian area of practice, also must be completed by the civilian clinical supervisor and by two civilian peers. If there is no civilian clinical supervisor, then replace with an additional AF Form 1562 from a civilian peer.

5.7. Completion of Privilege List. The applicant fills out the appropriate privilege list for his or her specialty. (ANG to use National Guard Bureau [NGB] forms; AFRC to use appropriate overprints.) (Reference [Attachment 6](#) for sample content of a Reserve privilege list.)

5.7.1. Instructions for completing privilege list:

5.7.1.1. Part I--List of Privileges. The practitioner enters the appropriate code number in the block marked "Requested" for each privilege. This is to reflect the level that represents his or her

current capability and should not consider any known facility limitations. With the exception of part-time civilian providers, each block must have a code number (see paragraph 5.7.1.8. for explanation of codes). The practitioner signs and dates the form and sends it to his or her clinical supervisor.

5.7.1.1.1. NOTE: Upon renewal of privileges, items previously crossed out due to lack of facility support should be replaced with code “3.”

5.7.1.1.2. NOTE: For those privilege lists that include more than one type of professional (i.e., family practice includes physicians as well as physician assistants and some nurse practitioners, inapplicable sections may be crossed through.

5.7.1.1.3. NOTE: 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.

5.7.1.2. Part II--Clinical Supervisor's Recommendation. The supervisor reviews the requested privileges, enters appropriate code for each privilege as described in paragraph 5.7.1.3., and checks the appropriate block, signs and dates the form, and sends it to the chief of service or the next privileged provider in the clinical chain of command.

5.7.1.3. The clinical supervisor enters the appropriate code number in the block marked “Approved” for each privilege. Each block must have a code number. **NOTE:** Upon renewal of privileges, applicants should replace items previously crossed out due to lack of facility support with the appropriate code number.

5.7.1.3.1. NOTE : For dentists, the clinical supervisor enters the appropriate code number in the block marked “Verified” (rather than “Approved”) for each privilege as described above.

5.7.1.4. The flight chief/chief of service (who is next in the clinical chain of command) reviews the requested privileges and checks the appropriate block, signs and dates the AF Form 1540 and sends package to the credentials function chairperson.

5.7.1.5. The credentials function chairperson checks the appropriate block, signs, and dates the AF Form 1540 and sends package to the MDG/CC.

5.7.1.6. The MDG/CC, acting on the recommendations of the credentials function, awards, renews, and revises individual provider privileges.

5.7.1.7. Revisions and Corrections. To change a code number, the originator of the revision forwards a written request, with supporting documentation, to his or her clinical supervisor for recommendation who endorses and forwards it to the credentials function chairperson. The function sends its recommendation to the MDG/CC, in turn. The MDG/CC notifies the provider, in writing, of the decision. If approved, the credentials function chairperson makes the change in pen, initials, and dates each. Any corrections must be initialed in ink. Attach the MDG/CC's written decision to the provider's current privilege list.

5.7.1.8. Modification. Any discrepancy between the requested privileges versus those that are granted must be addressed on AF Form 1540. The most common example is when the MTF grants requested privileges, except as modified by a code “3,” based on facility limitations. Less commonly, the provider may request code “1” but the MDG/CC grants code “2” for some specific privileges. For initial applications, the MDG/CC 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 paragraphs 7.6. and 7.22.5. for further information.)

5.7.1.9. Codes are defined as:

5.7.1.9.1. Code 1: Fully competent, within the defined scope of practice. Clinical oversight may be required as defined in AFI 44-102, *Community Health Management*. Clinical oversight of some allied health providers is required as described in **Chapter 6**.

5.7.1.9.2. Code 2: Supervision is required. Providers are unlicensed/uncertified, lack current relevant clinical experience, or if used when CHBCs are pending (see paragraph 4.1.17.6.2.). (Refer to Glossary for definition of supervision).

5.7.1.9.3. Code 3: Privileges are not approved due to lack of facility support (reserved for credentials function use only).

5.7.1.9.4. Code 4: Privileges are not requested/approved due to lack of expertise or proficiency, or due to physical disability or limitation.

5.7.1.9.5. Code 5: Privileges may be performed with consultation (ANG only).

5.7.1.9.6. NOTE: Granting a specific privilege as code “1” or code “2” is not the same as overall granting regular or supervised privileges. Refer to **Section 5D** for a full description of types of privileges the MDG/CC may grant.

5.7.2. Providers who feel they are no longer competent to perform a specific procedure should enter code “2” or code “4” on the appropriate section of the privilege 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 code “2” privileges. (Refer to Glossary for definition of supervision).

5.7.2.1. For those who are unlicensed/uncertified or if used when CHBCs are pending (see paragraph 4.1.17.6.2.), all approved privileges must be code “2.” In this situation, the provider also will be granted supervised privileges since he or she is not eligible for regular privileges. (Refer to paragraph 5.18.3. for further information).

5.7.2.2. It is possible to have a mixture of various codes and still be granted regular 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.

5.7.2.3. The plan of supervision as described in paragraph 5.18.3.1. does not necessarily apply to those providers granted regular privileges but with some specific privileges (code “2”). It is possible that the provider does not plan to or need to progress to a code “1.” The degree and type of supervision for those items marked code “2” is at the supervisor’s discretion. Privileges may be changed to 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.

5.7.3. Maintenance of Master Privilege Lists. Each MTF will keep master copies of the standardized (straw man) privilege lists to reflect, through appropriate coding in the approved column, those privileges that the MTF cannot support due to professional policies or lack of adequate equipment or personnel. These master copies should help ensure that all personnel understand the limitations of the

MTF and hasten the process for awarding privileges. The master copies will be reviewed by the credentials function and updated annually. **NOTE:** This does not apply to ANG.

5.8. Credentials Function Membership. Each MTF with five or more privileged providers must have a credentials function. ARC medical units are not required to establish a credentials function (reference paragraph 5.10. below).

5.8.1. If the MTF has fewer than five privileged providers, provider PCFs will be sent to the next larger MTF in the same geographical area (generally the same MTF they use for consultation). The consulting MTF credentials function reviews the PCF and makes privileging recommendations to the referring MDG/CC.

5.8.2. All privileged providers within the MTF are eligible to serve as members of the credentials function. The MDG/CC may use members of the affiliate medical staff to meet this requirement.

5.8.3. Credentials function composition should reflect the diversity of providers practicing within the facility, but, as a minimum, there should be representatives from each corps with privileged staff members.

5.8.4. When the function is considering awarding clinical privileges to an allied health provider, the MDG/CC will temporarily appoint at least one voting member from the same discipline to the function (if one is locally available). **NOTE:** This policy is not required for actions on temporary or supervised privileges.

5.8.5. The chief nurse executive should be a non-voting member and serve as an advisor to the credentials function.

5.9. Credentials Function Procedures:

5.9.1. 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 MDG/CC who then awards or denies clinical privileges.

5.9.2. Credentials function proceedings are documented in the summary report that is provided to the executive committee of the medical staff.

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

5.9.4. The credentials function should formally meet at least quarterly to maintain appropriate oversight of the entire process. It is not necessary to formally meet as a group for every privilege and medical staff appointment application, provided the appropriate individuals review the PCF, make their recommendations, and are in agreement. However, if there are concerns about an individual's request for privileges and, most definitely, for potential adverse actions, the group must have the opportunity to engage in a live discussion. Refer to paragraph 2.6. for further information about functions versus committees.

5.9.5. The credentials function must not make a privileging recommendation on a provider when less than a majority of the credentials function members eligible to vote is present or able to be involved in the process. The exception to this is the use of fast track award of privileges and medical staff appointment.

5.9.6. Fast Track Award of Privileges and Medical Staff Appointment. The credentials function (consisting of, at a minimum, a peer, department chair, and the chief of the medical staff) thoroughly evaluates the PCF, PAF, and the provider's application for privileges (AF Form 1540) and votes "yes" on the record by signing the AF Form 1540 which is then forwarded to the MDG/CC. As previously stated, if the vote is "no," the group needs to formally discuss the application. Either way, the credentials function proceeding is documented in the summary report that is provided to ECOMS. These fast track proceedings will be validated at the next quarterly meeting of the credentials function. In the event that the credentials function recommends modifying the award of privileges, this should be recorded as an administrative action rather than as an adverse action.

5.10. ARC Privileging Authority. The ANG and non-colocated reserve medical units are not required to maintain a credentials function as part of the privileging process. This applies only for health care provided by ARC personnel in their ARC medical units for unit training assemblies (UTA) and, therefore, these privileges are only for the ARC medical units. Reserve colocated units and health care provided by ARC personnel during annual training and special assignments that take place within an active duty MTF must follow the privileging process as described in this chapter.

5.10.1. ANG Privileging Authority:

5.10.1.1. The ANG MDS/CCs will review the PCF and award privileges to the provider. If the MDS/CC is not a physician, the senior physician in the unit will review the PCF and make privileging recommendations to the MDS/CC who is the privileging authority. In this case, the privileging authority for the senior physician is extended to the State Air Surgeon (SAS).

5.10.1.2. Each state air surgeon will review the PCF and award privileges to all privileged MDS/CCs within their state. In the absence of an SAS, this authority is extended to the ANG/SG.

5.10.1.3. The ANG/SG will review the PCF and award privileges to SASs and is the final privileging authority for the ANG. Forward the PCFs to ANG/SGSE, 3500 Fetchet Avenue, Andrews AFB, MD 20762-5157.

5.10.2. Reserve Privileging Authority:

5.10.2.1. The MDS/CC will review the PCF and award privileges to the provider. If the MDS/CC is not a physician, the senior physician in the unit will review the PCF 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 Surgeon General (RSG/SG).

5.10.2.2. The RSG/SG will review the PCF and award privileges to the MDS/CCs within his or her region.

5.10.2.3. The AFRC/SG will review the PCF and award privileges to the RSG/SG and is the final privileging authority for the reserves.

5.11. ARC Privileging Issues:

5.11.1. Providers who are assigned to, or who provide services in, medical units must have a PCF and be awarded clinical privileges before practicing medicine.

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

5.11.1.2. 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, etc.

5.11.2. Privileges awarded to ARC medical providers for UTAs will not apply when doing annual training or special assignments at an active duty MTF.

5.11.3. When AFRC providers are assigned to a colocated/associate medical unit, the host active duty MDG/CC awards UTA privileges for Reserve medical unit activities. These include physical examinations, wing medical support functions (immunizations and initiation of consultation requests), and any activities that take place within the active duty MTF.

5.11.4. If Category J reservists (who work without pay or points) do not participate often enough for the commander to grant privileges, then their files should be maintained at the attached medical treatment facility on inactive status. These files can be updated once the provider presents a copy of his or her current license, copies of AF Form 1562 from an annual tour, and a new civilian privilege list.

5.12. Provider Notification of Privileging. When a provider is privileged, the MDG/CC or ARC privileging authority will advise the provider, in writing, of the privileges granted. The provider has 14 calendar days to acknowledge receipt and accept or comment on the decision of the MDG/CC or ARC privileging authority.

5.13. 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 a PCF and be awarded clinical privileges before providing medical services.

5.13.1. Contract healthcare providers will participate in performance improvement activities in accordance with the MTF PI/RM processes.

5.13.2. A formally assigned Quality Assurance Evaluator (QAE), knowledgeable about the standard of care for contractor-provided services, will perform healthcare contract surveillance. The OPR for medical contract issues is HQ AFMSA/SGSLC, Brooks AFB TX 78235-5217 (DSN 240-8044).

5.13.3. According to MTF PI/RM policy, the quality assurance evaluator will report issues or incidents involving contract healthcare providers to the MTF medical logistics office who, in turn, reports to the base contracting officer or to appropriate TRICARE channels for resource-sharing providers. The chief of the medical staff will be notified promptly of any quality of care issues identified by the QAE.

5.14. 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:

5.14.1. If providers will practice in a fixed MTF, the MTF personnel will review credentials and award appropriate privileges. To expedite privileging actions, deploying medical units should provide an ICTB at least 15 days in advance of the arrival date. In addition, some host countries require actual copies of various credentials such as licenses and/or BLS or ACLS certification.

5.14.2. If providers will not practice in a fixed MTF, the deployed medical commander is, in general, responsible for the scope of practice of the deployed unit. The senior physician at the deployed location will assist non-physician commanders in determining the appropriate scope of practice.

5.14.2.1. 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 commander. The deployed unit should not exceed the scope of practice specified by the commander of the fixed MTF.

5.14.2.2. 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.

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

5.14.2.4. Squadron medical elements (SMEs), and/or providers deploying to a remote location or field environment, should deploy with a copy of their ICTB and current privilege list(s).

5.14.2.5. 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.

5.14.3. The MAJCOM/SG responsible for the deployed location should be contacted for further guidance/clarification. Waiver authority for policy related to deployed units is the responsibility of AFMOA/CC or the HQ USAF/SG.

5.15. 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.

5.16. Procedures for Granting Privileges to Short-Term Affiliates of the MTF. This guidance applies to military consultants, ARC personnel, and other short-term affiliates. A short-term affiliate applies for regular privileges only if he or she will provide direct patient care.

5.16.1. The MDG/CC may grant regular privileges in advance to active duty, reserve, or guard short-term affiliates when it will hasten the availability of their services. The provider's home unit may send advance copies of the provider's current ICTB and standardized privilege lists (or civilian privilege lists in the case of ARC personnel) to the MTF in which the provider will perform duty. The MDG/CC may grant privileges and staff appointment after the privileges are delineated on a standardized privilege list. No further action is necessary at the time a consultant or ARC personnel goes to work at the MTF for the duration of the current home-base privileges.

5.16.2. If the MDG/CC does not grant award of privileges in advance, the active duty, reserve, or guard unit will fax and/or electronically mail a copy of the provider's current ICTB and standardized privilege list to the MTF. The MDG/CC or his or her designee will review these forms and indicate the clinical privileges that the MTF can support.

5.16.3. The MTF will grant privileges for ARC personnel based on their duty AFSC and the provider's civilian privileges. A standard privilege list (straw man) will be used to annotate the privileges granted. This privilege list is good for a maximum of **14** calendar days.

5.16.4. The credentials function chairperson will sign and date the privileging list and the MDG/CC will grant the privileges at his or her discretion.

5.16.4.1. The MDG/CC will sign a document containing the following statements and attach it to the provider's AF Form 1540 or ICTB for this purpose: "(Provider name) is granted regular privileges commensurate with those awarded by the (name of 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 an (affiliate, initial) medical staff member during this time period."

5.16.4.2. Once privileges have been formally awarded, copies of privilege lists should be given to the provider and sent to appropriate clinical areas.

5.16.5. For military personnel, the clinical supervisor is required to complete an AF Form 1562 and send it to the parent unit.

5.17. Civilian Consultants. Follow procedures described in paragraphs **5.16.** through 5.16.4.3. for civilian consultants. Civilian consultants must also present a current curriculum vitae, a copy of their current civilian privilege 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 credentials officer, and dated within 1 year. The letter must list the provider's credentials, to include NPDB query and health status, and must verify his or her professional degree(s), postgraduate training, if applicable, board certification, and current professional license(s).

Section 5D—Types of Privileges

5.18. Procedures and Requirements for Specific Types of Privileges:

5.18.1. 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.

5.18.1.1. They are based upon the individual's education, professional license, professional certifications, experience, competence, ability, health, and judgment.

5.18.1.2. The MDG/CC reviews the recommendation of the credentials function, and approves, denies, or modifies regular privileges. (For ARC privileging authority, refer to paragraph **5.10.**)

5.18.1.3. NOTE: Marking some privileges with a 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 (refer to paragraph **5.18.3.**) and is qualified to practice some privileges independently.

5.18.2. Temporary Privileges. 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 5 days. Credentials requirements include the following:

5.18.2.1. A copy of the provider's license must be obtained and primary source verified.

5.18.2.2. Verification (documented in the credentials file) by the facility where the provider has regular privileges 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.

5.18.2.3. The credentials function chairperson then recommends granting of temporary privileges to the MDG/CC. If the MDG/CC is not available, the credentials function chairperson may grant the privileges.

5.18.3. Supervised privileges. Supervised privileges may be granted to providers who lack the necessary licensure or certification for independent practice if all minimal educational requirements are met. The credentials function may also recommend supervised privileges for recent accessions without an adequate period of supervised clinical practice, providers who have not clinically practiced for a period of 2 years or more or those providers in an orientation period required to assess competency. Supervised privileges may be granted for up to 2 years. They may be renewed by the MDG/CC or ARC privileging authority for extenuating circumstances.

5.18.3.1. 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 and schedule for periodic progress reports must be placed in Section I of the PCF.

5.18.3.2. 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."

5.18.3.3. All privileges must be marked in approved column with a code "2" indicating all are performed under supervision.

5.18.3.4. Supervision for a "lone specialist" may be handled several ways. The provider who has the most similar training and experience may supervise the specialist. If the supervisor is not qualified to review a specific procedure, the records should be sent for review to the regional consultant in that discipline. The regional consultant (or other qualified specialist) also may be invited to make periodic visits to the MTF to review cases or assist with procedures. The supervised provider may also be sent TDY to a facility that provides the specialty service or manning assistance in that specialty can be requested.

Section 5E—Medical Staff Appointment

5.19. 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. Privileges may be granted with or without a medical staff appointment.

5.20. 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:

5.20.1. Initial Medical Staff Appointment. This medical staff status 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.

5.20.1.1. During this period, the medical staff member's performance will be under close 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, lack of necessary licensure, etc., as described in paragraph 5.18.3.

5.20.1.2. 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 provider's responsibilities associated with the target appointment.

5.20.1.3. Failure to advance from an initial to active or affiliate appointment shall cause the expiration of (but not termination of) medical staff membership. **NOTE:** An initial medical staff appointment may be renewed to accommodate licensing boards' requirements for extended clinical hours before becoming eligible for licensure. For example, this will be necessary for newly graduated clinical psychologists).

5.20.1.4. Initial appointments require full credentials review.

5.20.1.5. Before the initial medical staff appointment ends, 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 MDG/CC. Professional activities include conduct (behavioral patterns) which may or may not directly affect the provider's ability to perform clinical duties.

5.20.2. 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.

5.20.3. 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, who are consultants, or to individuals who work in the MTF on a part-time basis.

5.20.4. Temporary Medical Staff Appointment. Temporary appointments are granted primarily in emergency situations when necessary to fulfill pressing patient care needs and 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.

5.21. Provider Notification of Medical Staff Appointment. When a provider is appointed to the medical staff, the MDG/CC will advise the provider, in writing, of the appointment granted. The provider has 14 calendar days to acknowledge receipt and to accept or to appeal the decision of the MDG/CC.

Section 5F—Reprivileging and Reappointment Requirements

5.22. General Information. The credentials function will continuously evaluate the quality of each provider's practice.

5.22.1. The credentials function will formally review, and the MDG/CC or the ARC privileging authority must reconsider, each provider's privileges and medical staff appointment at least every 24 months following the initial awarding of regular privileges.

5.22.2. The service chief, department chairperson, credentials function, and the MDG/CC or ARC privileging authority must review each provider's file and recommend renewal of privileges and medical staff appointment.

5.22.3. If any reviewer does not recommend renewal, the reviewer must provide an explanation to the credentials function chairperson or to the MDG/CC (or the ARC privileging authority).

5.22.3.1. The recommendations are then considered by the credentials function that makes recommendations to the MDG/CC.

5.23. Performance-Based Privileging. Biennial re-privileging is based upon provider performance data. To ensure that the necessary data is collected and used in the re-privileging process, the medical unit will develop a plan for data collection. The plan for all medical units will be to:

5.23.1. Identify performance data needs by provider type.

5.23.2. Determine form of individual data elements (i.e., nominal, ratio, etc.) and the sample size.

5.23.3. Identify data sources for particular data elements.

5.23.4. Identify the frequency of data collection.

5.23.5. Identify responsibilities for data collection.

5.23.6. Integrate with population health activities within the MTF and explicitly identify the relationship to utilization management.

5.23.7. Include a data collection plan. Refer to [Attachment 8](#) for sample AF Form 22.

5.24. Provider Activity File (PAF). The PAF contains only temporary QA documents as 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 PCF and is afforded the same security measures as the PCF. It is kept in a secure location separate from the PCF. Recommend the SGH maintain the PAF. 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. The ARC are no longer required to maintain a PAF on all providers but must summarize

performance data using AF Form 22 as described in paragraph 5.22.3. However, a PAF should be used for temporary QA documents.

5.24.1. Disposition of information within the PAF. The PAF will not accompany the PCF when the Air Force reassigns the provider to another MTF. However, all data in the PAF that leads to the restriction, limitation, denial, revocation, or voluntary surrender of privileges must be immediately transferred to section III of the PCF. If privileges are suspended or modified due to issues involving clinical performance, all supporting documents from the PAF will be transferred to Section III of the PCF. The MTF will destroy the PAF one year after the provider leaves the MTF. A closing MTF will destroy any remaining PAFs prior to final closure, unless otherwise instructed by AFI 37-138 and as described in paragraph 4.17.1.

5.25. Biennial Review Process:

5.25.1. The credentials function chairperson and ARC credentials managers will announce the date of the review at least 30 days in advance. Privileges must be evaluated prior to reaching 24 months. At the end the 24th month, privileges become expired. Providers will review their PCF and PAF (annotate same by placing their initials in Item #9 of AF Form 1540A) and update the AF Form 1540 and AF Form 1541.

5.25.2. The provider's clinical supervisor will use the PAF to complete an AF Form 22 summarizing all pertinent information on the performance and conduct of the provider during the period of evaluation. The form may be tailored to the provider's particular practice patterns through use of the "Remarks" section on the form. (See Attachment 8 for sample forms). The AF Form 22 becomes a permanent part of the PCF. The completed AF Form 22 is forwarded with the PCF to the credentials function for use in the reprivileging process.

5.25.3. ARC use the AF Form 22 as follows:

5.25.3.1. Active duty MTFs will use the AF Form 22 to summarize performance of ARC providers on extended tours.

5.25.3.2. The ARC medical units will use AF Form 22 to summarize activities that take place within their unit.

5.25.4. Consultant Assistance. Credentials functions that lack the expertise to adequately evaluate a provider's privileges will ask HQ MAJCOM/SG for the assistance of a consultant. The MTF is permitted to consult directly with an appropriate DoD/VA facility which has the specific specialty required to provide an adequate evaluation. A minimum of 30 patient charts must be reviewed.

5.25.5. As outlined in paragraph 5.9., the credentials function reviews the PCF, the PAF, and the AF Form 22, and makes recommendations to the MDG/CC who makes the final decision. If the decision constitutes an adverse clinical privilege action because of provider conduct or performance, follow the notice and hearing procedures outlined in Chapter 7.

5.25.6. ARC personnel. Privileges for ARC personnel are based on the provider's duty AFSC and their civilian practice. A copy of the privileges from all current places of civilian practice must be placed in the PCF along with the accompanying biennial reappointments. Three new AF Forms 1562 must also be completed and are to come from his or her military as well as civilian areas of practice. An AF Form 1562 is to be completed by the annual tour clinical supervisor, by the civilian clinical supervisor, and by a civilian peer. If there is no annual tour and/or civilian clinical supervisor, then

replace it with an additional AF Form 1562 from civilian peer(s). Refer to paragraph [5.6.3.3](#) for those in private practice and not privileged.

5.25.7. CHE. Each individual's participation in CHE must be documented and considered in decisions about reappointment to the medical staff or renewal or revision of individual clinical privileges.

5.25.7.1. The educational activities must support, at least in part, the privileges granted.

5.25.7.2. A statement listing the number of verifiable continuing education hours completed that relate to the specific clinical privileges meets the intent of these standards. Reference paragraph [4.12.4](#) for discussion of CHE documentation and paragraph [5.5.2](#) and [5.5.3](#) for providers' responsibilities.

Section 5G—Miscellaneous Privileging Issues

5.26. 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 health care 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 [Section 7H](#) of [Chapter 7](#).

5.27. Awarding Clinical Privileges to Medical Group Commander:

5.27.1. The local credentials function will review these credentials and send their recommendations, the PCF, and the PAF of the MDG/CC to HQ MAJCOM/SG for approval. When an MDG/CC also serves as MAJCOM/SG, the credentials function sends this information for review and decision to AFMOA/CC through AFMOA/SGOC, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050.

5.27.2. Reprivileging the MDG/CC. The reprivileging process is the same for the MDG/CC as for any other provider except that the PCF, PAF, and AF Form 22 are forwarded to the MAJCOM/SG for final review and award of privileges.

5.28. Providers Attending Residency, Fellowship, or Other Long-Term Graduate Education Programs in Residence at Civilian or Other Federal Programs, Excluding the Air Force. These individuals are under administrative control of AFIT/CIM, 2950 P Street, Wright-Patterson AFB OH 45433-7765. MDG/CCs of providers selected for these programs must send the PCF, no later than 30 days prior to provider's departure, by registered, certified, or any other accountable mailing source to AFIT/CIM for holding during the duration of the training program. AFIT/CIM is responsible for forwarding a copy of the PCF to the gaining clinical facility, if a copy is required. After the individual graduates, AFIT/CIM ensures that all professional evaluations are obtained and placed in the PCF. AFIT/CIM must send the PCF by an accountable mailing source to the gaining MTF to arrive at least 15 days after the date of graduation.

5.29. Providers Attending Residency, Fellowship, or Other Long-Term Graduate Education Programs within the Air Force. The provider's losing MTF sends the PCF by registered mail to the director of education of the training MTF for filing until the provider completes the program. Upon graduation, the director of education must send the PCF, by an accountable mailing source, to the gaining MTF to arrive at least 15 days before the provider's reporting date.

5.30. Providers Assigned to a Geographically Separated Unit must have a PCF and be awarded clinical privileges and medical staff appointment by the host unit which is the privileging authority.

5.31. Conscious Sedation for Dentists. Conscious sedation is discussed in AFI 44-102, *Community Health Management*. 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 6.18. of AFI 47-101, *Managing Air Force Dental Services*, addresses specific training guidelines that must be met for dentists to be permitted to do conscious sedation.

5.32. Telemedicine/Teleradiology. 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. For example, a cardiologist who, at the request of a physician assistant, interprets an EKG is acting as a consultant. Likewise, a radiologist who interprets an x-ray, or a dermatologist who diagnoses a skin lesion and suggests or recommends a treatment plan, is functioning as a consultant and need not be privileged at your MTF.

Chapter 6

PROFESSIONAL SCOPE OF PRACTICE FOR ALLIED HEALTH PROFESSIONALS

Section 6A—Allied Health Providers (All BSC and NC Privileged Providers)

6.1. Allied Health Provider List:

- 6.1.1. Audiologists
- 6.1.2. Certified Nurse Midwives
- 6.1.3. Certified Registered Nurse Anesthetists
- 6.1.4. Clinical Dietitians
- 6.1.5. Clinical Pharmacists
- 6.1.6. Clinical Psychologists
- 6.1.7. Clinical Social Workers
- 6.1.8. Family Nurse Practitioners (Includes Adult and Primary Care Nurse Practitioners)
- 6.1.9. Pediatric Nurse Practitioners
- 6.1.10. Women's Health Nurse Practitioners
- 6.1.11. Occupational Therapists
- 6.1.12. Optometrists
- 6.1.13. Physician Assistants
- 6.1.14. Specialty Physician Assistants
- 6.1.15. Physical Therapists
- 6.1.16. Podiatrists
- 6.1.17. Speech Pathologists

NOTE: 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 46N3A or 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 AFMAN 36-2105, Officer Classification, for AFSC qualifications. Scope of practice and supervision requirements are defined. (See specific privilege lists for further details regarding scope of practice.)

6.2. Audiologists:

6.2.1. Background. Audiologists ensure operational readiness and quality-of-life to the fighting force and eligible beneficiaries by providing cost-effective hearing health care through state-of-the-art audiological services, including prevention, medical surveillance, education, and research.

6.2.1.1. Support the flying mission of DoD personnel by implementing the Air Force Hearing Conservation Program and preventing noise-induced hearing loss to enhance auditory performance in operational environments. Audiologists diagnose and treat hearing deficits of aircrew members and beneficiaries by prescribing amplification and other hearing devices, and, when necessary, refer for medical intervention.

6.2.2. Education and Certification Requirements:

6.2.2.1. Graduation from an accredited master's degree program acceptable to the HQ USAF/SG.

6.2.2.2. Licensure from a US jurisdiction.

6.2.2.3. National certification (Certificate of Clinical Competence [CCC] from the American Speech-Language-Hearing Association).

6.2.3. Scope of Practice. Audiologists follow the guidelines published by the American Speech-Language-Hearing Association, American Academy of Audiology, and the National Hearing Conservation Association.

6.2.3.1. Audiologists are privileged to provide diagnostic and therapeutic procedures of the hearing mechanism. 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.

6.2.4. Supervision:

6.2.4.1. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of audiologist's performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.3. Certified Nurse Midwives:

6.3.1. Background. Certified nurse midwives (CNM) are registered nurses who have obtained advanced education, training, and certification in midwifery. Nurse-midwifery practice is the independent management of women's health care, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, as well as the family planning and gynecological needs of women. The CNM practices within a healthcare system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

6.3.2. Education and Certification Requirements:

6.3.2.1. Graduation from an accredited baccalaureate degree program in nursing (BSN) acceptable to the HQ USAF/SG.

6.3.2.2. Completion of an approved course in nurse midwifery acceptable to the HQ USAF/SG.

6.3.2.3. Master's degree from accredited program in specialty is required.

6.3.2.4. Licensure as an RN from at least one US jurisdiction.

6.3.2.5. 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).

6.3.3. Scope of Practice. Certified nurse midwives:

6.3.3.1. Provide routine prenatal care, labor and delivery management, immediate newborn care, and postpartum care. In addition, they provide well woman gynecological services including physical exams, breast exams, Pap smears, family planning services, preventive health screening, and health education.

6.3.3.2. Practice IAW the Standards for the Practice of Nurse Midwifery, as defined by the American College of Nurse Midwives (ACNM), and USAF Nurse Midwifery Guidelines. MTF-specific protocols define conditions for which referral or collaborative care (co-manage) is appropriate. Clinical privileges are defined on AF Form 2820, **Credentials Privilege List - Obstetrics/Gynecology**.

6.3.3.2.1. Management of newborns outside the delivery suite or birthing room requires specific privileges on AF Form 2820.

6.3.3.3. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.

6.3.3.4. 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.

6.3.3.5. 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.

6.3.4. Supervision:

6.3.4.1. CNMs granted MTF privileges must have physician consultation available either in person or by phone when they are performing direct patient care activities.

6.3.4.2. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of CNM performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.4. Certified Registered Nurse Anesthetists:

6.4.1. Background. Certified registered nurse anesthetists (CRNA) are registered nurses who have obtained advanced education, training, and certification in administration of anesthesia. Nurse anesthesia practice is the independent administration and management of patient anesthesia to include pre-operative evaluation and preparation; intraoperative management; and postoperative follow-up and evaluation. The CRNA practices within a healthcare system that provides for consultation, collaborative management, or referral as indicated by the health status of the client.

6.4.2. Education and Certification Requirements:

- 6.4.2.1. Graduation from an accredited baccalaureate degree program in nursing (BSN) acceptable to the HQ USAF/SG.
- 6.4.2.2. Completion of an approved course in nurse anesthesia acceptable to the HQ USAF/SG.
- 6.4.2.3. Master's degree from an accredited program in specialty.
- 6.4.2.4. Licensure as an RN from at least one US jurisdiction.
- 6.4.2.5. National certification in specialty (Certification by the Council on Certification of Nurse Anesthetists).

6.4.3. Scope of Practice. Certified registered nurse anesthetists:

- 6.4.3.1. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.
- 6.4.3.2. Are required to have physician or anesthesiologist countersign their preoperative assessment of the anesthesia record to ensure the patient is appropriately prepared for anesthesia. This signature recognizes the shared responsibility that the physician and the CRNA have for the evaluation of the patient's preoperative assessment
- 6.4.3.3. Consult with an anesthesiologist for children under 2 years old and patients with the American Society of Anesthesiologists (ASA) Classification III or greater. This consultation may be verbal and/or electronic and is to be documented in the patient's record. Documentation should include the name of the anesthesiologist consulted and a brief outline of the anesthetic plan developed.
- 6.4.3.4. Provide anesthesia "on-call" within their scope of practice and expertise, utilizing consultation and/or shared responsibility for patient care, to provide comprehensive anesthetic care for the high-risk patient.

6.4.4. Supervision:

- 6.4.4.1. CRNAs granted MTF privileges must have physician consultation available either in person or by phone when they are performing direct patient care activities.
- 6.4.4.2. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of CRNA performance is required and is accomplished at least biennially as part of the reprivileging 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.
- 6.4.4.3. There will be a dedicated "back-up" provider available in the event of an emergency. This back-up provider may be another anesthesia provider or a physician capable of immediately diagnosing and treating a medical emergency.

6.5. Clinical Dietitians:

6.5.1. Background. Dietitians provide nutrition services to include providing medical nutrition therapy (MNT); procuring, managing, and safeguarding all nutritional medicine flight resources supervising food production and service operations; educating patients, healthcare providers and staff; managing the nutrition component of health promotion programs; and serving as nutrition consultant

to the community. MNT is 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/parenteral feedings. **NOTE:** Dietitians who provide MNT must be privileged.

6.5.2. Education and Certification Requirements. The minimum criteria for determining an applicant's ability to provide MNT within the scope of clinical privileges are:

6.5.2.1. Completion of at least a baccalaureate degree from an accredited college or university AND completion of an American Dietetic Association (ADA) approved didactic program in dietetics.

6.5.2.2. Successful completion of one of the following ADA-accredited supervised practice programs:

6.5.2.2.1. Dietetic internship with generalist or military emphasis.

6.5.2.2.2. Preprofessional practice program (AP4).

6.5.2.2.3. Coordinated undergraduate program in dietetics with generalist emphasis.

6.5.2.3. 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 within 1 year of accession. If applicant is a graduate of the Military Dietetic Internship Consortium or of an AF dietetic internship, registration must be obtained within 1 year of graduation.

6.5.3. Scope of Practice. Dietitians may be granted clinical privileges to provide MNT which includes nutrition assessment/evaluation, counseling, ordering laboratory tests and other assessment procedures as well as implementing medical nutrition therapies such as enteral/parenteral feedings for inpatients and outpatients. (See paragraph **6.5.5.** for additional information regarding dietitians assigned to HAWCs.)

6.5.3.1. Nutrition assessment/evaluation includes evaluation of nutrient intake; activity level; appetite; intake of vitamins, minerals, nutrition supplements; weight history; taste changes; feeding problems; nausea; vomiting; diarrhea; constipation; food intolerance; food-drug interactions; unhealthy diet behaviors; socioeconomic and ethnic background; documented medical history; current diagnoses and medical treatment modalities; current drug therapy; anthropometric measures (height; weight; skin fold measurements; mid-arm and mid-arm muscle circumferences; elbow breadth; and wrist, waist hip, and neck circumferences); and clinical signs and symptoms of nutritional deficiencies.

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

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

6.5.3.4. May refer to other healthcare providers as needed to support MNT, such as diabetes educator; women, infants, and children (WIC) program; hospice; home health care; and other community support programs.

6.5.4. Supervision. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of dietitian performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.5.4.1. NOTE: If dietitian is assigned where other dietitians are not available to conduct the peer review, MAJCOM consultant dietitians can provide competency assessment to include periodic review of a representative sample of medical records, direct observation of performance, or verbal/written assessment of clinical knowledge/skills IAW AFI 44-135, *Clinical Dietetics*, the ADA Diet Manual, and the Air Force Nutrition Care Guidelines.

6.5.5. Miscellaneous. Dietitians assigned to HAWCs, providing general nutrition education according to US Surgeon General guidelines, are neither credentialed nor privileged by the MTF unless therapeutic intervention is provided. Where MNT takes place (e.g., diabetic diet consultation, calorie-restricted protocols, or lipid protocols), credentialing and privileging must be accomplished. Ideally, activities requiring privileges would take place within the MTF and not at the HAWC. However, dietitians may be dual-hatted and unable to have two physical locations. In this case, they need to differentiate between their privileged activities and HAWC activities. Reference AFI 44-102, *Community Health Management*, for further discussion about MNT.

6.6. Clinical Pharmacists:

6.6.1. 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 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 physicians 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.

6.6.2. Education and Certification Requirements. Pharmacists must demonstrate appropriate skills, training, and/or experience to be considered for clinical privileges. Minimum requirements include:

6.6.2.1. Valid pharmacy license as described in this instruction and

6.6.2.2. Postbaccalaureate PharmD degree, or

6.6.2.3. Master of science (MS) degree in pharmacy from a clinically oriented program, or

6.6.2.4. Board certification in one or more of the pharmacy specialties recognized by the Board of Pharmaceutical Specialties, or

6.6.2.5. Completion of a clinical pharmacy residency or fellowship accredited by the American Society of Health System Pharmacists or American College of Clinical Pharmacy, or

6.6.2.6. Bachelor of science (BS) degree in pharmacy with documentation of appropriate education, training, and/or CME in the practice of clinical pharmacy. **NOTE:** The didactic content of current BS programs is nearly identical to entry-level PharmD programs. The difference is that PharmD programs have 1 additional year of clinical rotation.

6.6.2.7. 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 (see privilege list, item A.6.). **NOTE:** This course work is 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.

6.6.3. 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:

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

6.6.3.2. Ordering and evaluating laboratory tests necessary to evaluate drug therapy effects and outcomes.

6.6.3.3. Initiating, modifying, or discontinuing medications for ongoing therapy of chronic disease states (e.g., hypertension, hyperlipidemia, anticoagulant, diabetes, asthma, refill clinics, etc.), in cooperation with the medical staff.

6.6.3.4. Monitoring and managing pharmacotherapy requiring periodic adjustment due to specific or changing pharmacokinetic characteristics (e.g., aminoglycosides, phenytoin, antithrombotics).

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

6.6.3.6. Administering prescription or non-prescription drugs according to established agreements or protocols.

6.6.3.7. Assessing metabolic needs and ordering therapeutic enteral or parenteral nutrition products in the inpatient setting.

6.6.3.8. Evaluating medical and medication histories for drug-related problems and adjusting drug therapy accordingly.

6.6.3.9. Consulting with other healthcare providers (e.g., physicians, dietitians, nurses, physical therapists, etc.) about patient treatment needs or options.

6.6.3.10. 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.

6.6.4. Supervision:

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

6.6.4.2. All clinical pharmacists must work via protocols approved by the ECOMS and practice with the supervision of a physician preceptor, identified in writing. This information will be placed in Section I of the PCF. The preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the clinical pharmacist's practice.

6.6.4.3. As with any privileged provider, an ongoing, professional peer review process and periodic physician review of clinical pharmacist performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.6.5. Miscellaneous:

6.6.5.1. As with any provider who has not had the opportunity to demonstrate current competency, the recommendation is to initially award supervised privileges.

6.6.5.2. Utilize the MAJCOM pharmacist point of contact or the Air Force pharmacy consultant for expert advice on credentialing evaluations, privileging decisions, peer review, etc.

6.6.5.3. Reference [Attachment 9](#) for sample protocols and other implementation tools.

6.7. Clinical Psychologists:

6.7.1. 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. Air Force clinical psychology is a multidimensional resource which serves the worldwide Air Force community by providing services at the individual, group, unit, base, and community level. Clinical psychologists are trained in providing health and mental health promotion programs for individuals and groups experiencing ongoing mental and physical problems. The premise for professional practice is grounded in the biopsychosocial model and the scientific and scholarly foundations of psychology. Clinical psychologists in the Air Force frequently develop additional expertise on human performance in the aerospace environment, in combat, and in highly stressful and disastrous situations.

6.7.2. Education and Certification Requirements. Clinical psychologists must demonstrate appropriate skills, training, and experience to be considered for clinical privileges. Minimum educational requirements include:

6.7.2.1. Valid license to practice psychology from a US jurisdiction.

6.7.2.2. A doctor of philosophy (PhD) or a doctor of psychology (PsyD) degree in clinical or counseling psychology from a regionally accredited university or graduate school. A program accredited by the American Psychological Association (APA) is preferred.

6.7.2.3. 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 to include the following three AF sites: Wilford Hall, Wright-Patterson, and Malcolm Grow).

6.7.2.4. An optional postdoctoral fellowship allows for subspecialization in aviation psychology, child/adolescent psychology, health psychology, or neuropsychology.

6.7.3. Scope of Practice. Clinical psychologists:

6.7.3.1. Conduct clinical interviews and interpret psychological tests/assessments.

6.7.3.2. Diagnose mental disorders and formulate treatment plans.

6.7.3.3. Provide individual and group psychotherapy, hypnosis (See AFI 44-102, Section 2L), formal sex therapy (See AFI 44-102, Section 2M), 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).

6.7.3.4. Recommend administrative and medical dispositions.

6.7.3.5. Perform neuropsychological screening.

6.7.3.6. Perform comprehensive neuropsychological evaluations (must have postdoctoral fellowship training as described above).

6.7.3.7. Admit, treat, and discharge patients (with physician oversight) to/from inpatient units with mental health capability.

6.7.3.8. Admit/discharge patients to/from substance abuse rehabilitation centers.

6.7.3.9. Serve as members of, and make recommendations to, medical evaluation boards.

6.7.3.10. Determine the degree of impairment for military service and for civilian social and industrial adaptability due to mental disorders.

6.7.3.11. Perform dangerousness assessments.

6.7.3.12. Serve on competency and sanity boards.

6.7.3.13. Certify stability for the sensitive duty programs such as PRP, security clearances, and special access.

6.7.3.14. Certify mental competency when administrative or legal matters arise.

6.7.3.15. Perform commander-directed mental health evaluations (CDEs) and act as behavioral health consultants to commanders and first sergeants.

6.7.3.16. Serve on aircraft mishap investigation boards (must have completed appropriate training program such as Air Force Aircraft Mishap Investigation and Prevention Course).

6.7.3.17. 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. Since this demonstrative project did not lead to an AFMS-wide change in policy, only those individuals who participated in the project and have appropriate documentation regarding this may prescribe within their scope of practice.

6.7.4. Supervision. Unlicensed clinical psychologists who have completed their doctorate:

6.7.4.1. May be granted supervised privileges.

6.7.4.2. Are supervised by a fully qualified licensed provider who will establish a plan of supervision based on the unlicensed psychologist's skills and needs. As a minimum, the supervisor will meet with the unlicensed psychologist for at least one hour every week.

6.7.4.3. Supervision can be obtained from any one of the following (listed in order of preference):

6.7.4.3.1. A privileged mental health provider at the MTF, including a reservist, if assigned,

6.7.4.3.2. A licensed provider at a nearby VA facility or a nearby MTF, or

6.7.4.3.3. A licensed civilian psychologist in the local community.

6.7.4.4. NOTE: As described in **Chapter 5**, the supervisor must be an MTF 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 **5.17**.

6.7.5. Miscellaneous.

6.7.5.1. Psychologists who have not met all doctoral requirements, meaning not yet completed dissertation (all but dissertation [ABD]):

6.7.5.1.1. Cannot be privileged.

6.7.5.1.2. Must obtain a recommended scope of practice from the training director for his or her Air Force clinical psychology internship program. The recommended scope of practice will be submitted to the MTF credentials function for approval.

6.7.5.1.3. Must practice with a basic written plan of supervision and a designated preceptor.

6.7.5.1.4. Must have written medical documentation cosigned by a mental health provider.

6.7.5.2. Regardless of degree status, supervision of psychological testing work must be done by a psychologist.

6.7.5.3. When a psychologist granted "supervised privileges" needs to make a recommendation regarding a patient in a special duty program (SDP) 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 SDP patient, will be cosigned by a privileged physician at the local MTF.

6.7.5.4. If at all possible, other clinical psychologists will supervise entry level psychologists. Most states require this type of supervision.

6.7.5.5. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of the clinical psychologist's performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.8. Clinical Social Workers:

6.8.1. Background. The mission of AF social work is to promote readiness by using a professional social systems perspective to facilitate individual, family, and corporate health in diverse and dynamic environments. Clinical social workers are key members of the mental health team, most frequently working in outpatient mental health clinics, family advocacy programs, and substance abuse treatment services.

6.8.2. Education and Certification Requirements:

6.8.2.1. An MSW degree from an accredited school of social work.

6.8.2.2. Experience in clinical social work, either through a master's-level internship or post-MSW experience.

6.8.2.3. License/certification from a US jurisdiction except for Hawaii after 31 Dec 00. (Reference paragraph **3.2.1.4**). Effective 1 Oct 98, state licensure/certification at any MSW level became the qualifying document, while national certification became optional. By 1 Oct 02, all social workers on active duty or employed by the Air Force on the effective date of this instruction, must be licensed/certified by a US jurisdiction at a level that allows independent clinical social work practice (i.e., clinical practice without supervision). A limited number of clinical social workers will continue to be accessed into the Biomedical Sciences Corps (BSC) with little to no post-MSW experience. These individuals include ROTC cadets in MSW programs and enlisted and officer personnel who have completed MSWs through Air Force- sponsored or off-duty education. These individuals would be unable to complete the 2 years of post-MSW-supervised experience required in most states for independent clinical practice licenses without having a break in service. Similarly, exceptions to accession requirements (an MSW, 2 years of post-MSW experience, and an independent clinical practice level license) will occasionally be authorized by the Director, Medical Force Management. Individuals who are accessed from ROTC or other active duty channels, as well as the Medical Force Management-authorized exceptions, will be accessed as entry level clinical social workers. These individuals will still be required to have an MSW-level license prior to assignment in a clinical social work position, but will have a maximum of 3 years from the date of accession in the BSC to obtain an independent clinical practice level license.

6.8.2.4. Entry level clinical social workers are individuals with less than 2 years of post-MSW experience who have completed an MSW degree and who have been awarded the highest level of state licensure/certification available to master's-level social workers with less than 2 years of post-SW experience. These individuals must be awarded supervised privileges.

6.8.2.4.1. NOTE: Clinical social workers with more than 2 years of post-MSW experience will also be considered entry level if they hold a license which would not authorize them independent practice in their state of licensure.

6.8.2.5. Fully qualified clinical social workers are individuals who have completed an MSW, a minimum of 2 years post-MSW clinical social work experience, and possess an appropriate state license/certification. (If the state offers a license for independent clinical practice, this will be the level of license required. Otherwise, the license must be at the level appropriate for an MSW with 2 years of experience.) These individuals may be awarded regular privileges.

6.8.2.5.1. NOTE: Those AF social workers, who are practicing clinical social work but have only an entry level license in a state that offers a higher level of license as described above, are to be placed on supervised privileges as an administrative action (not adverse) until they

obtain the necessary level of license. Individuals currently on active duty or otherwise employed by the Air Force as a clinical social worker on the effective date of this instruction will be given until 1 Oct 02 to meet this requirement. (This allows 2 years to meet state clinical experience/supervision requirements, plus 1 additional year to obtain the appropriate license. Individuals who have already completed the experience and supervision requirements will be given up to 1 year to complete the examination and licensure/certification process.)

6.8.3. Scope of Practice. Clinical social workers:

- 6.8.3.1. Conduct clinical interviews and evaluate patients.
- 6.8.3.2. Diagnose mental disorders and formulate diagnosis and treatment plans.
- 6.8.3.3. Recommend administrative and medical dispositions.
- 6.8.3.4. Provide individual, couple, family, and group psychotherapy; hypnosis (refer to AFI 44-102, Section 2L); formal sex therapy (refer to AFI 44-102, Section 2M); 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 psychology if he or she is unfamiliar with the credentials requirements.)
- 6.8.3.5. Admit, treat, and discharge patients, with physician oversight, to/from inpatient substance abuse treatment programs.
- 6.8.3.6. Perform dangerousness and risk assessments.
- 6.8.3.7. Screen records and personnel for security clearances and make administrative recommendations.
- 6.8.3.8. Perform commander-directed mental health evaluations (CDEs); PhD required.
- 6.8.3.9. Serve as behavioral health consultant to commanders and first sergeants.
- 6.8.3.10. Serve on aircraft mishap investigation boards (must have completed appropriate training program such as Air Force Aircraft Mishap Investigation and Prevention Course).
- 6.8.3.11. Serve on family advocacy command assistance teams (must have completed training required by AFMOA/SGOF).

6.8.4. Supervision:

- 6.8.4.1. Generally, other clinical social workers will supervise entry level social workers, if at all possible. In order to meet independent practice 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 an independent license will be sought should be considered during the development of a supervised social worker's plan of supervision. Psychologists or psychiatrists could supervise if an MSW provider is unavailable. In addition, 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.
- 6.8.4.2. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of clinical social worker performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.9. Family Nurse Practitioners (Includes Adult and Primary Care Nurse Practitioners):

6.9.1. Background. Family nurse practitioners (FNP) are registered nurses who have obtained advanced education, training, and certification to practice independently and collaboratively to provide primary health care for well and sick individuals from birth to advanced age. FNPs provide medical assessment, treatment, education, health promotion, and prevention to individuals, families, and the military community during peacetime, wartime, and humanitarian efforts. **NOTE:** Adult and primary care nurse practitioners share the same AFSC and have the same role as family nurse practitioners, except that their scope of practice does not include pediatrics but is focused on the adult population.

6.9.2. Education and Certification Requirements:

- 6.9.2.1. Graduation from an accredited baccalaureate degree program in nursing (BSN) acceptable to the HQ USAF/SG.
- 6.9.2.2. Completion of an approved nurse practitioner program acceptable to the HQ USAF/SG.
- 6.9.2.3. Master's degree from accredited program in specialty.
- 6.9.2.4. Licensure as an RN from at least one US jurisdiction.
- 6.9.2.5. National certification in specialty (i.e., certification by the American Nurses Credentialing Center).

6.9.3. Scope of Practice. FNPs practice independently and collaboratively with physicians in providing primary health care for well and sick individuals from birth to advanced age to include obstetrical patients in an outpatient family practice or primary care setting. FNPs do not have admission privileges. Health care includes:

- 6.9.3.1. Initial history and interval histories.
- 6.9.3.2. Physical examinations.
- 6.9.3.3. Developmental assessments and screenings.
- 6.9.3.4. Diagnostic and screening tests.
- 6.9.3.5. Psychosocial assessments.
- 6.9.3.6. Medical diagnosis.
- 6.9.3.7. Teaching and counseling regarding identified problems, health maintenance, and prevention.
- 6.9.3.8. Initiating and evaluating treatment regimens which may include prescribing and dispensing medications appropriate for privileged scope of care.
- 6.9.3.9. Performing therapeutic procedures defined and approved on privilege list.
- 6.9.3.10. Developing plans of care jointly with the patient, family, or significant other considering cultural factors, level of understanding, personal habits, and support systems.
- 6.9.3.11. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.
- 6.9.3.12. Collaborating with and/or referring to other healthcare providers, as appropriate.

6.9.3.13. May pull PCM primary call and work as sole provider in extended-hours clinics with physician consultation available as described below if these specific privileges have been granted as code "1" on the privilege list (see paragraph 5.7.1.9.1.). Until the privilege lists are updated, these items will need to be added to the form. Ultimately, this is a local MTF decision, based primarily on the FNP's physician supervisor and the needs of the patient population served by the MTF.

6.9.4. Supervision:

6.9.4.1. A physician preceptor must be identified in writing for each FNP. This memo will be placed in Section I of provider's PCF.

6.9.4.1.1. The preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the FNP's practice.

6.9.4.2. FNPs granted MTF privileges must have physician consultation available, either in person, by phone, or electronic means, when they are performing ambulatory clinic direct patient care activities, to include acute care. Ideally, the primary preceptor should routinely be available for consultation. If the primary preceptor is not available, any physician on staff who is privileged for the same scope of practice may supervise/precept or be consulted by the FNP.

6.9.4.3. Supervision of FNPs in the Emergency Services Department:

6.9.4.3.1. FNPs may augment the medical staff of the ESD when additional manpower assistance is required to meet access standards.

6.9.4.3.2. FNPs will work in this area only when deemed necessary and based on the individual's skills and competencies.

6.9.4.3.3. If the FNP is required to see patients in the ESD, the ESD physician must be present in the facility and be immediately available by two-way voice communication.

6.9.4.3.4. The ESD physician reviews the medical record of each patient under the care of the FNP prior to the patient's departure from the ESD. The exception to this is when the ESD triages the patient to ESD fast track or acute minor care areas. If the patient could have been seen initially in an acute care clinic and truly does not need ESD care, then the records review is the same as if the patient was only seen in a clinic setting.

6.9.4.4. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of FNP performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.10. Pediatric Nurse Practitioners:

6.10.1. Background. Pediatric Nurse Practitioners (PNP) are registered nurses who have obtained advanced education, training, and certification to practice independently and collaboratively to provide primary health care to pediatric clients. PNPs provide medical assessment, treatment, education, health promotion, and prevention to individuals, families, and the military community during peacetime, wartime, and humanitarian efforts.

6.10.2. Education and Certification Requirements:

- 6.10.2.1. Graduation from an accredited baccalaureate degree program in nursing (BSN) acceptable to the HQ USAF/SG.
- 6.10.2.2. Completion of an approved nurse practitioner program acceptable to the HQ USAF/SG.
- 6.10.2.3. Master's degree from accredited program in specialty. (See paragraph 6.1. "note" regarding educational requirements.)
- 6.10.2.4. Licensure as an RN from at least one US jurisdiction.
- 6.10.2.5. National certification in specialty (i.e., certification through the National Certification Board of Pediatric Nurse Practitioners and Nurses [NCBPNP/N] or the American Nurses Credentialing Center [ANCC]).

6.10.3. Scope of Practice:

- 6.10.3.1. The PNP is an integral, active member of the pediatric healthcare team, caring for neonates, infants, children, and adolescents up to age 21.
- 6.10.3.2. Pediatric nurse practitioner practice is focused on:
 - 6.10.3.2.1. Primary prevention/health promotion.
 - 6.10.3.2.2. Disease prevention.
 - 6.10.3.2.3. Diagnosis and treatment of minor acute illness.
 - 6.10.3.2.4. Coordination and care of common chronic illnesses in children.
 - 6.10.3.2.5. Appropriate referral for specialty evaluation and care.
- 6.10.3.3. PNP scope and standards of practice guidelines are published by the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP).
- 6.10.3.4. PNPs may act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.
- 6.10.3.5. PNPs may work as sole provider in extended-hours clinics with physician consultation available as described below if these specific privileges have been granted as code "1" on the privilege list (see paragraph 5.7.1.9.1.). Until the privilege list is updated, these items will need to be added to the form. Ultimately, this is a local MTF decision, based primarily on the PNP's physician supervisor and the needs of the patient population served by the MTF.

6.10.4. Supervision:

- 6.10.4.1. A physician preceptor must be identified in writing for each PNP. This memo will be placed in Section I of the PNP's PCF.
- 6.10.4.2. The preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the PNP's practice.
- 6.10.4.3. PNPs granted MTF privileges must have physician consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities. Ideally, the primary preceptor should routinely be available for consultation. If the primary preceptor is not available, any physician on staff who is privileged for the same scope of practice may supervise/precept or be consulted by the PNP.

6.10.4.4. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of PNP performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.11. Women's Health Nurse Practitioners:

6.11.1. Background. Women's Health Nurse Practitioners (WHNPs) are registered nurses who have obtained advanced education, training, and certification to practice independently and collaboratively to provide comprehensive women's health care throughout the lifespan, with an emphasis on reproductive, gynecologic, and family-centered health education. WHNPs provide medical assessment, treatment, education, health promotion, and prevention to individuals, families, and the military community during peacetime, wartime, and humanitarian efforts.

6.11.2. Education and Certification Requirements:

6.11.2.1. Graduation from an accredited baccalaureate degree program in nursing (BSN) acceptable to the HQ USAF/SG.

6.11.2.2. Completion of an approved nurse practitioner program acceptable to the HQ USAF/SG.

6.11.2.3. Master's degree from accredited program in specialty is required. (See paragraph **6.1**. "note" regarding educational requirements.)

6.11.2.4. Licensure as an RN from at least one US jurisdiction.

6.11.2.5. National certification in specialty (i.e., certification through the National Certification Corporation [NCC] for the obstetric, gynecologic, and neonatal nursing specialties).

6.11.3. Scope of Practice. WHNPs may be granted clinical privileges to provide primary ambulatory health care to both obstetrical and gynecological patients. Clinical privileges include:

6.11.3.1. Obtaining medical histories, performing physical exams, and establishing medical diagnoses.

6.11.3.2. Ordering and interpreting diagnostic studies.

6.11.3.3. Initiating appropriate treatment, to include drug therapy, within privileged scope of care.

6.11.3.4. Performing comprehensive family planning counseling; cancer screening; STD care; and procedures such as vulvar, cervical, endometrial, and shave biopsies; cryotherapy; and IUD insertion.

6.11.3.5. WHNPs may perform additional skills such as colposcopy, ultrasound, and Norplant insertions/removals, based on appropriate education and training.

6.11.3.6. WHNPs may act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.

6.11.3.7. WHNPs may work as sole provider in extended-hours clinics with physician consultation available as described below if these specific privileges have been granted as code "1" on the privilege list (see paragraph **5.7.1.9.1**). Until the privilege lists are updated, these items will need to be added to the form. Ultimately, this is a local MTF decision, based primarily on the WHNP's physician supervisor and the needs of the patient population served by the MTF.

6.11.4. Supervision:

6.11.4.1. A physician preceptor must be identified, in writing, for each WHNP. This information will be placed in Section I of the WHNP's PCF.

6.11.4.2. The preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the WHNP's practice.

6.11.4.3. WHNPs granted MTF privileges must have physician consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities. Ideally, the primary preceptor should routinely be available for consultation. If the primary preceptor is not available, any physician on staff who is privileged for the same scope of practice may supervise/precept or be consulted by the WHNP.

6.11.4.4. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of WHNP performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.12. Occupational Therapists:

6.12.1. Background. Occupational therapy (OT) is a rehabilitation profession. Patients typically evaluated and treated by OT include, but are not limited to, physically disabled patients (those with arthritis, cerebrovascular accident [CVA], hand injuries, and neurologically impaired patients), mental health/substance abuse patients, and pediatric/developmentally delayed patients.

6.12.2. Education and Certification Requirements:

6.12.2.1. Bachelor of science or entry level master's degree in OT (Master of Occupational Therapy) from an accredited OT program acceptable to the HQ USAF/SG.

6.12.2.2. Certification by the National Board for Certification in Occupational Therapy, Inc.

6.12.2.3. Completion of 6 months of clinical internship. (This is usually accomplished prior to graduation and must be done in order to be eligible to take the certification exam).

6.12.2.4. License from a US jurisdiction.

6.12.2.5. Master of science in OT is the advanced degree for one who started with bachelor of science degree (optional).

6.12.3. Scope of Practice. Occupational therapists:

6.12.3.1. Provide evaluation and treatment services for patients seen by providers in the direct care system as well as for those patients referred from civilian providers.

6.12.3.2. Communicate with referring physician through documentation of clinical activities in the patient medical record and other verbal/written means necessary to ensure continuity of care.

6.12.3.3. OT privileges may include, but are not limited to, assessing patient's functional status and planing therapy, based upon physician established diagnosis.

6.12.4. Supervision. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of OT performance is required and is accomplished at least biennially as

part of the reprivileging 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.

6.13. Optometrists:

6.13.1. Background. Doctors of optometry are independent primary healthcare providers who examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye, and associated structures, as well as diagnose related systemic conditions. As primary eye care providers, optometrists are an integral part of the healthcare team and an entry point into the healthcare system. They are skilled in the comanagement of conditions that affect the eye health and vision of their patients and are sources of referral and consultation for other healthcare professionals.

6.13.2. Education and Certification Requirements:

6.13.2.1. Doctor of optometry degree from an accredited 4-year college of optometry approved by the HQ USAF/SG.

6.13.2.2. Licensure from a US jurisdiction.

6.13.3. Scope of Practice. Optometrists:

6.13.3.1. Provide comprehensive primary eye care evaluation, diagnostic, and treatment services for all eligible patient beneficiary categories.

6.13.3.2. Comanage (with the attending ophthalmologist) post-surgical eye cases and ocular complications of systemic illness in the inpatient and outpatient settings.

6.13.3.3. Serve as consultant in optometry for other healthcare professionals in the military healthcare system.

6.13.3.4. Promote prevention and wellness, vision conservation, education and training activities, vision screening, and positive health behaviors.

6.13.4. Supervision:

6.13.4.1. Optometrists will act independently in areas of primary eye and vision care when demonstrated competency within their designated scope of practice is indicated by code "1" on their privilege lists.

6.13.4.2. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of optometrist performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.14. Physician Assistants:

6.14.1. Background. Physician assistants (PAs) are health professionals who provide primary or specialty medical care with physician supervision. Within the physician/physician assistant (PA) relationship, PAs exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services. The clinical role of physician assistants includes, but is not limited to, primary care, family practice, and specialty areas such as orthopedics, surgery, cardiac perfusion, bone

marrow transplant/oncology, emergency medicine, otorhinolaryngology, pediatrics, and internal medicine. Physician assistants deploy to provide medical support in war, humanitarian aid, and peace-keeping missions. PA practice is centered on patient care and disease prevention and may include clinical teaching, patient education, research, and administrative activities.

6.14.2. Education and Certification Requirements:

6.14.2.1. Graduation from a physician assistant training program accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and acceptable to the HQ USAF/SG. Either a bachelor's degree or a master's degree.

6.14.2.2. PAs must obtain initial board certification by the National Commission on Certification of Physician Assistants (NCCPA) within 12 months of graduation. **NOTE:** Civilian accessions should be certified prior to entering active, reserve, or guard duty.

6.14.2.3. Certification is maintained by meeting NCCPA continuing medical education and retesting requirements. Should certain operational situations preclude this, temporary waivers will be considered.

6.14.2.4. Specialty PAs must complete an additional residency or fellowship program acceptable to the HQ USAF/SG. Reference paragraph [6.15.2](#) for further information.

6.14.3. Scope of Practice. Physician Assistants:

6.14.3.1. Are credentialed through the medical treatment facility and privileged as any member of the staff of the particular service in which they practice.

6.14.3.2. Assess patient medical conditions, diagnose, plan therapy, and prescribe medications appropriate for the diagnosis to include ordering and evaluating laboratory tests, ordering and evaluating imaging studies, and providing for follow-up or referral care.

6.14.3.3. May pull PCM primary call and work as sole provider in extended-hours clinics with physician consultation available as described below if these specific privileges have been granted as code "1" on the privilege list (see paragraph [5.7.1.9.1](#)). Until the privilege lists are updated, these items will need to be added to the form. Ultimately, this is a local MTF decision, based primarily on the PA's physician supervisor and the needs of the patient population served by the MTF.

6.14.3.4. PAs may work in the ESD managing patients, consistent with their training and experience. Refer to paragraph [6.14.5](#) for additional information.

6.14.3.5. PAs who are privileged to assist with inpatient care may admit patients to the precepting physician's service after first consulting with the precepting physician. All patient orders must be reviewed and cosigned by the precepting physician within 24 hours.

6.14.3.6. May act independently in areas of demonstrated competency within their designated scope of practice, as indicated by code "1" on their privilege list.

6.14.4. Supervision:

6.14.4.1. A physician preceptor must be identified, in writing, for each PA. This information will be placed in Section I of the PA's PCF.

6.14.4.2. Preceptor must be a physician who provides consultation, clinical feedback, and general oversight of the PA's practice.

6.14.4.3. PAs granted MTF privileges must have physician consultation available either in person, by phone, or electronic means when they are performing ambulatory clinic direct patient care activities. Ideally, the primary preceptor should routinely be available for consultation. If the primary preceptor is not available, any physician on staff who is privileged for the same scope of practice may supervise/precept or be consulted by the PA.

6.14.4.4. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of PA performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.14.5. Supervision of PAs in the Emergency Services Department:

6.14.5.1. The ESD physician must be present in the facility and be immediately available by two-way voice communication.

6.14.5.2. The ESD physician reviews the medical record of each patient under the care of the PA prior to the patient's departure from the ESD. The exception to this is when the ESD triages the patient to ESD fast track or acute minor care areas. If the patient could have been seen initially in an acute care clinic and truly does not need ESD care, then the records review is the same as if the patient was only seen in a clinic setting.

6.15. Specialty Physician Assistants:

6.15.1. Background. Specialty Physician Assistants (SPAs) are physician assistants who have met all of the definitions and requirements of physician assistants described in paragraph 6.14. and have received subsequent additional training. Specialty PAs include orthopedics, otorhinolaryngology, surgery, cardiac perfusion, bone marrow transplant/oncology, and emergency medicine. Specialty physician assistants also function in internal medicine and pediatrics.

6.15.2. Education and Certification Requirements. In addition to those required of all PAs, specialty PAs must complete residency or fellowship training of 12 months or more in a medical specialty program approved by and acceptable to the HQ USAF/SG. Usually, specialty PAs have been trained at approved sites within the Air Force, DoD, or at accredited civilian institutions.

6.15.3. Scope of Practice. Is consistent with scope defined in paragraph 6.14.3. but expanded to reflect nature of specialty practice and approved/supported by the medical specialty staff, reflected in the privileging process outlined in Chapter 5. Specialty PAs use the privilege list designated for the specialty physician, as well as the family practice privilege list, as appropriate.

6.15.4. Supervision. Recognizing that the specialty PA possesses unique skills, supervision and oversight should be by a physician in that same specialty. See paragraph 6.14.4. and 6.14.5. for further requirements.

6.16. Physical Therapists:

6.16.1. Background. Physical therapists ensure operational readiness and quality of life to the fighting force and eligible beneficiaries by providing cost effective physical therapy care. This is achieved through state of the art physical therapy services, including prevention, health promotion, education and research.

6.16.2. Education and Certification Requirements:

6.16.2.1. License from a US jurisdiction

6.16.2.2. 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.

6.16.2.3. Advanced clinical specialists in physical therapy must meet the following requirements:

6.16.2.3.1. Advanced clinical specialty board certification or post-entry level residency, master's or doctorate or over 4000 hours in physical therapy practice, and

6.16.2.3.2. Completion of USAF Advanced Course; U.S. Army Neuromusculoskeletal (NMS) Evaluation Course; civilian sponsored neuromusculoskeletal course approved by BSC Associate Chief, Physical Therapy; or validation of entry-level competence in NMS evaluation.

6.16.3. Scope of Practice. Physical therapists:

6.16.3.1. Use guidelines published by the American Physical Therapy Association and the Joint Commission on Accreditation of Healthcare Organizations.

6.16.3.2. Provide physical therapy evaluation and diagnostic/treatment services for patients seen by providers in the military health care system, as well as for those referred by civilian providers.

6.16.3.3. Serve as consultants in physical therapy for other healthcare professionals in the military healthcare system.

6.16.3.4. Are involved in prevention and wellness activities, screening, and promotion of positive health behaviors.

6.16.3.5. Who are advanced clinical specialists in physical therapy with postentry-level education and/or training may be privileged to perform advanced specialty clinical practice. This may include, but is not limited to:

6.16.3.5.1. 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 profiles, 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.

6.16.3.5.2. Performing needle insertion for electrodiagnostic testing.

6.16.3.5.3. Evaluating and treating infants in the neonatal intensive care unit.

6.16.3.5.4. Neurodevelopmental evaluation and treatment.

6.16.4. Supervision. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of PT performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.17. Podiatrists:

6.17.1. 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 and related structures. Podiatrists are part of the orthopedic/surgery service.

6.17.2. Education and Certification Requirements:

6.17.2.1. Doctor of Podiatric Medicine (4-year DPM degree) from an accredited college or university of podiatric medicine acceptable to the HQ USAF/SG.

6.17.2.2. Completion of a 24-month podiatric surgical residency preferred. Completion of a 12-month podiatric surgical, plus a 12-month podiatric orthopedic/primary podiatric medical residency, accepted.

6.17.2.3. Licensure from a US jurisdiction.

6.17.2.4. 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:

6.17.2.4.1. American Board of Podiatric Surgery.

6.17.2.4.2. American Board of Podiatric Orthopedics and Primary Podiatric Medicine.

6.17.3. Scope of Practice. Doctors of podiatric medicine:

6.17.3.1. Are credentialed through their MTF and privileged as any other member of the medical staff in the surgical service. The national standard for podiatric medical doctors with appropriate postgraduate education, as stated above, is the anatomic region of the foot and ankle and related structures affecting the foot and ankle. All disorders of this area are appropriate scope of practice areas as privileged through the respective MTF.

6.17.3.2. May admit patients as necessary. If the podiatrist's educational program did not include preparation to perform history and physical (H&P) exams, 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. Inpatient Records personnel who review the record should contact the MTF credentials manager to obtain a list of podiatrists who are able to perform this H&P exam.

6.17.4. Supervision:

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

6.17.4.2. As with any privileged provider, an ongoing, professional peer review process to include periodic formal review of podiatrist performance is required and is accomplished at least biennially as part of the reprivileging 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.

6.18. Speech Pathologists:

6.18.1. Background:

6.18.1.1. Speech pathologists ensure operational readiness and quality-of-life to the fighting force and eligible beneficiaries by providing cost-effective speech communication health care through state-of-the-art services, including prevention, medical surveillance, education, and research.

6.18.1.2. Support the flying mission through implementation of communication enhancement and voice conservation in support of DoD personnel. Speech pathologists diagnose and treat speech, voice, and communication deficits of aircrew members and beneficiaries by prescribing appropriate treatment, and, when necessary, refer for medical intervention.

6.18.2. Education and Certification Requirements:

6.18.2.1. Master's degree from an accredited institution acceptable to the HQ USAF/SG.

6.18.2.2. Licensure, registration, or certification from a US jurisdiction.

6.18.2.3. National certification (Certificate of Clinical Competence [CCC] from the American Speech-Language-Hearing Association).

6.18.3. Scope of Practice. Speech pathologists:

6.18.3.1. Follow the guidelines published by the American Speech-Language-Hearing Association.

6.18.3.2. Are privileged to provide diagnostic and therapeutic procedures of the speech mechanism. Those with advanced training and current competence may be privileged to perform advance procedures such as dysphagia therapy, stuttering treatments, and voice therapy.

6.18.4. Supervision. As with any privileged provider, an ongoing, professional peer review process and periodic formal review of speech pathologist performance is required and is accomplished at least biennially as part of the reprivileging 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.

Section 6B—Medical/Dental Students

6.19. Medical/Dental Student Documentation in Medical Record:

6.19.1. Medical/dental students must indicate their status when signing an entry by indicating the year of training. For example, sign "MS-3" for a 3d-year student and "MS-4" for a 4th-year student.

6.19.2. Supervising physician must countersign all patient record entries written by medical students within 24 hours.

6.19.3. Before orders written by medical students can be executed, the supervising physician must review and sign.

6.19.4. The history and physical examination must be countersigned by the attending physician or senior resident before it becomes part of the medical record.

6.19.5. For the ANG, reference ANGI 41-102, *Early Appointment Program for Physicians*, for further guidance regarding third and 4th-year medical students.

Section 6C—Enlisted and Civilian Equivalent Allied Health Professionals

6.20. Career Field Education and Training Plan (CFETP). Normally, enlisted medical and dental personnel operate within the guidelines established by the CFETP; the CFETP defines the enlisted scope of practice.

6.21. Alternative to CFETP. For clinical (patient care) tasks not outlined in the CFETP, consult the MAJCOM/SG.

6.21.1. When the MTF executive management team determines there is need for enlisted personnel to perform tasks clearly beyond the expectations of their AFSC, the MAJCOM/SG considers and grants waivers as appropriate. Consistent with the CFETP review process, waivers will be reviewed annually.

6.21.2. In all cases, training for additional clinical tasks will be formally certified on AF Form 797, **Job Qualification Standard Continuation/Command JQS**, and maintained in the individual Enlisted Training and Competency Record. Training references for all tasks beyond the CFETP will be maintained in the duty section where these tasks are performed.

6.21.3. Waiver requests will include the following:

6.21.3.1. Rationale for expanding practice to include who and their location within the MTF.

6.21.3.2. Training protocol.

6.21.3.3. Procedures for competency validation/verification.

6.21.3.4. Guidelines for maintaining proficiency.

6.22. Medical Technicians Utilized in Ambulance Services:

6.22.1. All medical technicians assigned to the emergency services department ambulance service must hold a current certification from the National Registry of Emergency Medical Technicians (NREMT), as do all medical technicians, regardless of duty assignment. **NOTE:** For further information regarding the ANG, reference ANGI 41-104, *ANG Medical Service Function and Emergency Response Capability*.

6.22.2. Composition of Ambulance Crews: Ambulance crews consist of at least two NREMTs.

6.22.3. Prehospital Emergency Care: Prehospital emergency medical care personnel follow physician-approved protocols and keep continuous 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 worldwide web at <http://sg-www.satx.disa.mil/school/frames.html>.

6.23. Certified Alcohol and Drug Abuse Counselors = Substance Abuse Counselors:

6.23.1. Background. Mental health technicians serve in clinical roles as certified alcohol and drug abuse counselors (CADAC) or substance abuse counselors 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. Reference AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, for further information.

6.23.2. Education and Certification Requirements:

6.23.2.1. Must meet the following requirements:

6.23.2.1.1. Have a minimum of 270 hours didactic instruction and 6000 hours within the 12 core functions of substance abuse counseling, 300 of which must be accomplished via direct supervision.

6.23.2.1.2. Have a signed agreement to practice under strict USAF ethical guidelines. **NOTE:** Ethical guidelines are state/board specific.

6.23.2.1.3. Demonstrate competency in the 12 core function/46 global criterion areas in front of a board of trained evaluators. **NOTE:** Each core function has global criteria that outline the area.

6.23.2.1.4. Pass a recognized written examination administered by the USAF.

6.23.2.1.5. Obtain nationally recognized certification such as International Certification and Reciprocity Consortium (ICRC).

6.23.2.2. Recertify every 3 years by obtaining 60 hours continuing professional education within the behavioral sciences, as outlined by the AF Substance Abuse Counselor Certifying Handbook.

6.23.2.3. **NOTE:** The Air Force Substance Abuse Counselor Certification program issues the certification and has the authority to revoke certification for cause.

6.23.3. Scope of Practice/Supervision:

6.23.3.1. With the exception of initial assessment, development of or changing a treatment plan, and crisis intervention, the core functions may be performed by CADACs, independent of supervision as judged by the ADAPT program manager.

6.23.3.2. CADACs providing treatment planning, crisis intervention, and group treatment will do so under the supervision of a privileged provider. For initial assessment, development of or changing a treatment plan, and crisis intervention, privileged providers are responsible for “eyes on” supervision for 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. In treatment situations, “eyes on” supervision must be provided by some observation of direct patient contact and review of all patient charts. Supervising providers must document supervision in the medical record following each episode supervised.

6.23.3.3. 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/counseling, at least 2 hours monthly. Competency assessments shall be performed two times per month, 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.

6.23.3.4. Non-certified mental health technicians who are in training may conduct the 12 core functions only when directly supervised by a CADAC or privileged provider. Direct supervision requires “eyes-on” contact with the patient/client since the noncertified counselor is engaged in patient/client discussion. The CADAC or privileged provider who performed this supervision must cosign the note in the patient/client record.

6.24. Registered Dental Hygienists:

6.24.1. Background. Dental hygienists are licensed professionals who work as members of health-care 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 restorations, and making impressions for diagnostic casts.

6.24.2. Education and Certification Requirements. Dental hygienists must demonstrate appropriate skills, training, and experience to be authorized to practice. Minimum educational requirements include:

6.24.2.1. 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.

6.24.2.2. Successfully challenging the National Board Dental Hygiene Examination and a valid license to practice dental hygiene from a U.S. jurisdiction.

6.24.3. 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:

6.24.3.1. Complete an evaluation of every patient and formulate a dental hygiene diagnosis and treatment plan, in collaboration with the dentist and patient.

6.24.3.2. 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.

6.24.3.3. Provide specialized treatment designed to achieve and maintain oral health. Specialized treatment includes scaling and root planing 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.

6.24.3.4. 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.

6.24.4. Supervision. 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.

6.24.4.1. 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.

6.24.4.2. 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.

6.24.4.3. As with any healthcare professional, an ongoing, professional 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.

6.25. Independent Duty Medical Technician (IDMT): See AFI 44-103, *The Air Force Independent Duty Medical Technician Program and Medical Support for Mobile Medical Units/Remote Sites*, for description of this role. IDMTs follow AFI 44-103 as well as the 4N0X1 CFETP. For information regarding the ANG, reference ANGI 41-103, *Medical Support to Geographically Separated Units (GSUs)*.

Chapter 7

ADVERSE ACTIONS

Section 7A—General Information

7.1. General. This chapter describes the management of adverse actions for both privileged providers and non-privileged healthcare professionals. The process has four steps: inquiry period (optional), professional review process (credentials function or peer review function), hearing procedures, and appeal procedures. The term “provider” will be used in this chapter for privileged providers. Those licensed, registered, or certified staff members who do not have clinical privileges will be referred to as non-privileged healthcare professionals. For ease in implementation of this chapter, the management of non-privileged healthcare professionals has been placed in **Section 7G**. In addition, management of impaired providers/healthcare professionals has been added to **Section 7H**. The MTF, with the HQ MAJCOM oversight, will be responsible for management of adverse actions until the appeal level is reached. The HQ MAJCOM will ensure compliance with this policy by its respective MTFs. Reporting requirements for regulatory agencies are included in **Section 7K**. **NOTE:** Refer to **Chapter 5**, paragraph **5.14**, for information related to management of providers during deployments.

7.2. Consult with Legal Counsel. Prior to proceeding with any adverse action listed in this section, for either privileged or non-privileged healthcare professionals, coordination should occur with the wing Staff Judge Advocate’s (SJA) office, as well as with the regional Medical Law Consultant (MLC). This will ensure that appropriate due process, rights, and criteria are followed from the beginning of any action that may be taken. This includes actions of abeyance, investigations/inquiries, removal from patient care, and notification letters. Coordinate promptly since both the base SJA and regional MLC may have recommendations regarding appropriate action.

7.3. Early Notifications:

7.3.1. HQ MAJCOM: Notify the HQ MAJCOM quality office early in the adverse action process for guidance on procedures and plan of action. The HQ MAJCOM is the primary point of contact on policy and procedures related to adverse actions until the appeal level is reached.

7.3.2. Civil Service Employees: Consultation with the employee relations specialist should occur prior to any adverse privilege/practice action being considered on civil service employees. This consultation must be done to ensure that civilian employee guidelines are met.

7.3.3. Contract Employees: If adverse action is being considered on a contract employee, consult with the contract officer or QAE before proceeding, IAW the provisions of the contract, as appropriate.

7.4. Objectives. The objectives of this process are as follows:

- 7.4.1. To protect the patients.
- 7.4.2. To protect the quality and efficiency of care delivered within the Air Force Medical Service.
- 7.4.3. To protect the rights of the individual(s) in question (afford due process).
- 7.4.4. To ensure timely resolution of the issues.

7.4.5. To separate the professional actions and considerations from administrative/legal considerations.

7.4.6. To allow timely reporting of individuals to professional regulatory agencies if required.

7.5. Roles and Responsibilities:

7.5.1. Credentials Function Chairperson: (Privileged Provider Actions)

7.5.1.1. Investigates incidents that may lead to adverse privilege action.

7.5.1.2. Invokes abeyance or suspension action on privileged providers.

7.5.1.3. Appoints members to conduct credentials function reviews and/or hearing procedures.

7.5.1.4. Provides additional comments/recommendations to the MDG/CC, as needed.

7.5.1.5. Communicates abeyance, suspension, and/or hearing recommendations to provider.

7.5.1.6. Ensures involved providers are informed of their due process rights as specified in this chapter.

7.5.2. Senior Corps Representative: (Non-privileged Healthcare Professional Actions)

7.5.2.1. Investigates incidents that may lead to adverse practice action.

7.5.2.2. Invokes initial removal of non-privileged healthcare professionals from patient care.

7.5.2.3. Appoints members to conduct peer review and hearing procedures.

7.5.2.4. Provides additional comments/recommendations to the MDG/CC as needed.

7.5.2.5. Communicates initial removal from patient care and hearing recommendations to non-privileged healthcare professionals.

7.5.2.6. Ensures involved healthcare professionals are informed of their due process rights as specified in this chapter.

7.5.3. Chief, Performance Improvement/Quality Service Manager:

7.5.3.1. Primary point of contact for adverse actions policy and procedures within the MTF.

7.5.3.2. Ensures due process and notification procedures are completed appropriately on non-privileged healthcare professionals.

7.5.3.3. Establishes/maintains adverse action file with all required documents.

7.5.4. Medical Group Commander:

7.5.4.1. Directs credentials function chairperson or senior corps representative to conduct inquiry procedures into provider/healthcare professional actions or misconduct.

7.5.4.2. Proposes adverse actions on privileged and non-privileged healthcare professionals.

7.5.4.3. Takes final action on provider's privileges/non-privileged healthcare professional's practice, following hearing procedures.

7.5.5. HQ MAJCOM/SG or Quality Office:

7.5.5.1. Communicates with/advises MTF during the adverse action process.

7.5.5.2. Approves extension of suspension actions lasting longer than 6 months.

7.5.5.3. Forwards case file to AFMOA/SGOC for appeal and/or reporting to regulatory agencies.

7.5.6. MLC/SJA:

7.5.6.1. Advises the MDG/CC or staff regarding legal aspects of adverse actions, as requested.

7.5.6.2. Ensures legal requirements are met for hearing procedures.

7.5.6.3. Participates in hearing procedures, as needed.

7.5.7. AFMOA/SGOC:

7.5.7.1. Conducts appeals of adverse privilege/practice actions.

7.5.7.2. Reports final actions to the NPDB, states of known licensure, and/or other regulatory agencies within 30 calendar days of the HQ USAF/SG's decision to report.

7.5.7.3. Communicates final action on appeals to involved provider, the MDG/CC and the HQ MAJCOM/SG.

7.5.7.4. Releases information regarding final actions to regulatory agencies and/or credentialing agencies, when requested.

7.5.7.5. Maintains a database of adverse actions for the Air Force Medical Service.

7.5.7.6. Submits reports to Tri-Service Risk Management Committee at least annually regarding the number of adverse actions received, number reported, any backlog/difficulties with reporting, RCS DD-HA(AR)1611 and DD-HA(AR)1762.

7.6. Appropriate Use of Adverse Actions. Adverse actions under this chapter and administrative/legal actions must be handled separately. Commanders and the HQ MAJCOMs must ensure that adverse privilege/practice action is taken, when appropriate. Adverse actions are considered appropriate when there is evidence of incompetence, unprofessional conduct, or impairment. For example, evidence may include deficits in medical knowledge, expertise, or judgement (competence); unprofessional, unethical, or criminal conduct (conduct); or medical conditions, mental health conditions, or alcohol/drug impairment that reduce or prevent the provider's ability to safely execute his or her responsibilities in providing health care. Actions that do not meet these criteria are handled administratively.

7.6.1. Privileging/practice 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, or retirement), in lieu of taking an adverse action that is indicated, is not appropriate.

7.7. Identity of Persons Providing Information. The USAF will make all reasonable efforts to protect the identity of persons who give information that could lead to an adverse privilege/practice action. For example, the names of individuals providing information that leads to an adverse action will be protected unless the due process rights of the provider who is the subject of the action require disclosure.

7.8. Allegations Involving Separated Providers or Healthcare Professionals. Allegations of substandard performance or misconduct within the past 12 months must be investigated. The responsibility for investigating these situations will remain with the MTF in which the alleged substandard performance or misconduct occurred, with assistance as necessary by the HQ MAJCOM/ SG. 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. If the MTF has closed, the HQ MAJCOM/SG assumes these responsibilities. **NOTE:** This investigation into substandard performance or misconduct is separate and distinct from the MTF quality improvement (QI) process/investigation referred to in **Chapter 8**, paragraph **8.5.**, related to potential or actual medical malpractice claims.

7.9. Actions Involving the Medical Group Commander. When information arises on a privileged MDG/CC's conduct or condition which may bear on his or her suitability for professional practice, the credentials function chairperson will notify the HQ MAJCOM/SG, who, in turn, will notify the commanding line officer. The HQ MAJCOM/SG will be responsible for any adverse privileging actions. All other issues involving the MDG/CC will be managed by the commanding line officer.

7.10. 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.

Section 7B—Invoking an Abeyance, Invoking a Suspension and Conducting Inquiry Procedures

7.11. General. When a provider's conduct, condition, or performance requires immediate action to protect the health or safety of patients, the credentials function chairperson will remove the provider from patient care duties while an inquiry is made. This allows time for gathering additional information regarding the extent of the action prior to initiating an adverse privilege action. If an inquiry is not needed, the credentials function chairperson will forward the information to the credentials function for review and action as discussed in **Section 7C** of this chapter.

7.12. Invoking an Abeyance. An abeyance is not an adverse privilege action; however, the provider is formally "on notice" that an inquiry into his or her practice has begun that may result in an adverse privilege action or other administrative action. Abeyance is used when information is insufficient to suspend privileges or the potential hazard to patients or patient care is not well understood, yet prudence dictates that the provider not render patient care until the inquiry is complete. It is normally imposed by the credentials function chairperson/SGH for the purpose of conducting an internal or external peer review or other inquiry. It may be imposed by the MTF/CC. It is valid for 30 calendar days, and may be extended for an additional 30 calendar days. If the abeyance period is not closed after 60 calendar days, the action automatically becomes a suspension of privileges. Abeyance that is not resolved when a provider ends his or her relationship with the MTF will automatically become a suspension.

7.12.1. Provider Notification. The provider is notified, in writing, that his or her privileges have been placed in abeyance (including the basis for the action and the duration of the action), and that an inquiry is being conducted (**Attachment 10**). If only a portion of the provider's clinical privileges are being placed in abeyance, the notification letter must state this. The notification must include that the results of the inquiry will be reviewed by the credentials function. In addition, the notification must state that an abeyance that is not resolved within 60 calendar days, or when a provider ends his or her relationship with the MTF, will become a suspension.

7.12.2. Disclosure of Abeyance. Abeyance is not an adverse action. Providers are not required to disclose a period of abeyance when applying for any future licensure, privileges, or insurance.

7.13. Invoking a Suspension. Suspension is a temporary adverse action and is used to control a provider's practice while an investigation is completed or while reevaluation, targeted training, or rehabilitation is completed. Suspension is automatically imposed following 60 calendar days of abeyance, if inquiry procedures have not been completed. In cases where the provider's misconduct, professional incompetence, or negligence is clear-cut and poses a threat to patient safety or well being, suspension should be used as an initial action. Suspensions can be imposed by the credentials function chairperson/SGH or the MDG/CC.

7.13.1. Provider Notification. The provider will be notified, in writing, that their clinical privileges have been suspended, the basis for the suspension, and that the action will be reviewed by the credentials function ([Attachment 11](#)). If only a portion of the provider's clinical privileges are being suspended, the notification letter must state this. The suspension notification letter should state the implications of leaving the service or employment while a privilege action is underway. A suspension should not exceed 6 months. A request to extend the suspension beyond 6 months must be sent to the HQ MAJCOM/SG or designee for approval.

7.13.2. Disclosure of Suspension. A suspension is an adverse action and, therefore, must be disclosed as such. Suspensions must be disclosed when applying for future privileges, licensure/certification/registration, or insurance. The suspension must be disclosed even if the action resulted in reinstatement. Explanation of the reasons for the suspension and final outcome can be provided.

7.14. Inquiry Procedures. When more information or background on the provider's professional and clinical performance is necessary, one or more officers may be appointed by the MDG/CC to conduct a further inquiry. For example, an independent reviewer from another MTF may be asked to conduct a record review to determine the extent of a practice problem. After completing the inquiry, the investigating officer sends a report to the credentials function chairperson. The report should organize those factual findings of the inquiry, and the basis therefore, and may include the investigating officer's conclusions or recommendations. The inquiry report along with other information collected will form the basis of the credential's function review as discussed in [Section 7C](#).

7.15. Notification to HQ MAJCOM/SG. The MTF notifies the HQ MAJCOM/SG when a provider's privileges have been suspended. In addition to the HQ MAJCOM/SG notification, the MTF must complete a DD Form 2499 to document the action. This form should be placed in the case file and kept at the MTF until the action is completed. The HQ MAJCOM/SG should notify AFMOA/SGOC about adverse actions of a sensitive or potentially notorious nature. AFMOA/SGOC will be responsible for relaying information to HQ USAF/SG, as appropriate.

Section 7C—Credentials Function Review Activities for Adverse Actions

7.16. General. Professional review activities for privileged providers are performed by the credentials function. The role of the credentials function is to examine information obtained from inquiry and/or other materials, and to make recommendations to the MDG/CC and chief of the medical staff regarding the provider's clinical privileges. Recommendations must be made in the reasonable belief that the action is warranted by the facts. The credentials function chairperson is responsible for coordinating the credentials function review activities.

7.17. Notification of the Provider. If notification of the provider has not already been accomplished, the credentials function chairperson, after consultation with the SJA or MLC, will give written notice to the provider of the decision to proceed with an abeyance or suspension action. This notification must specify the deficiencies and clearly state that the credentials function will convene on this matter (**Attachment 10** or **Attachment 11**). The individual should endorse the notification letter and a copy of the notification must be placed in the provider's credentials folder. Commander-directed medical evaluations should be considered, if appropriate.

7.17.1. Contract Providers. If the provider is a member of a contract group, give a copy of the notification letter, and any subsequent correspondence, to the contract group. Notify the contracting officer in these cases of substandard performance, impairment, or misconduct, and consult on further actions to manage these situations.

7.18. Withdrawal of Permission to Engage in Off-Duty Employment. The MDG/CC or designee must withdraw any permission for the provider to engage in clinically related off-duty employment until the privilege action under review is resolved. The MDG/CC must also notify other MTFs or civilian medical treatment facilities where the provider is practicing, as identified in the providers off-duty employment request, of any suspension or other adverse action. This notification may be done in response to abeyance of privileges at the MDG/CC's discretion. In addition, the MDG/CC must remove permission for off-duty employment, if a provider is being investigated for any item listed in **Attachment 21**. As part of the notification process, the MDG/CC notifies the contractor for contract providers. New applications for off-duty employment, during any adverse action review, should not be approved until the privileges/practice of the individual have been restored.

7.19. Credentials Review Process. When a provider has had their privileges suspended (or otherwise adversely affected), the credentials function must convene a subcommittee to determine the extent of the problems and to make recommendations to the MDG/CC and SGH or chief of the medical staff. *The focus of this professional review must be on how the action under review impacts the provider's ability to practice clinically.* The provider under review does not have the right to attend the meeting; however, he or she may be asked to provide a written statement or to attend a portion of the meeting to clarify issues in the case. The provider is free to consult with legal counsel at any step in an adverse action; however, the credentials function review is not a legal proceeding.

7.20. Composition of the Credentials Function. The credentials function must be composed of at least three members, but may include others not excluded by paragraph **7.21**. One member should be a peer (similar background, rank/grade, years experience in professional capacity, etc.) of the individual who is the subject of the action. Members may be brought in from other MTFs to meet this requirement, as needed.

7.21. Ensuring Impartiality of Review Personnel. The credentials review process is a function of professional peers. Personnel participating in the review must be able to impartially review the case. The personnel listed below should not be voting members of the credentials function review of the described provider:

7.21.1. The individual's direct supervisor.

7.21.2. Those members for whom the subject individual is the supervisor, to include the reporting official or endorsing official for performance reports.

- 7.21.3. The individual who suspended the provider's privileges or who recommended the provider's discharge from active duty.
- 7.21.4. Any person who investigated the case.
- 7.21.5. Any person whose testimony plays a significant part in the case.
- 7.21.6. Any member who is participating, or has participated, in other administrative proceedings (court-martial board or administrative review board).
- 7.21.7. Any member who is reviewing, or has reviewed, the provider's actions under consideration by the credentials function.
- 7.21.8. The credentials function chairperson.

7.22. Credentials Function Recommendations. The credentials function considers the information and any other matters resulting from an inquiry and makes recommendations to the MDG/CC and SGH/chief of the medical staff 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 following recommendations may be made:

- 7.22.1. Reinstatement.** The return of privileges or no action taken to limit or revoke the provider's privileges. Reinstatement may include provisions for monitoring and evaluation (M&E) to include nature and duration of M&E. This is not an adverse action; it is not reportable to regulatory agencies, and no hearing or appeal is offered.
- 7.22.2. Restriction.** A limit placed on all or a portion of the provider's clinical privileges so the provider is required to obtain concurrence before providing all or some specified healthcare procedures within the scope of his or her license, certification, or registration. The restriction may require some type of supervision and change in some or all privileges from code "1" to code "2."
- 7.22.3. Reduction.** The permanent removal of a portion of a provider's clinical privileges.
- 7.22.4. Revocation.** Member is permanently removed from all patient care duties.
- 7.22.5. Denial of clinical privileges.** An application for privileges or privilege renewal has been denied for substandard performance, professional misconduct, or impairment. Other reasons for denial are not considered an adverse action. (Reference paragraph [7.63.](#))

7.23. Recommendations Forwarded to the MDG/CC. The credentials function chairperson forwards the recommendation of the review, along with the case evidence, to the MDG/CC within 5 calendar days of completion of the credential's function review. The credentials function chairperson may make other recommendations to the MDG/CC with regard to the management of the provider in question. However, these should be forwarded under separate cover.

- 7.23.1. The MDG/CC has 5 calendar days from receipt of the recommendation(s) to review and determine what action to take, based on the facts provided. The MDG/CC is not bound by the recommendations of the credentials function or by those of the credentials function chairperson.
- 7.23.2. The MDG/CC then gives written notification to the provider of his or her intent to take action, identifies the proposed action, and the reasons for the action to include all specified allegations. (If the provider is a contractor, a copy is sent to the AF contract office responsible for the contract and a letter to the contractor at the address of record.)

7.23.3. If the proposed action is to deny, reduce, restrict, or revoke the provider's privileges, then the MDG/CC must advise the provider of his or her hearing and appeal rights (**Attachment 13**). The MDG/CC also must include the specific allegations that would constitute the grounds for the hearing, including dates and pertinent patient records.

Section 7D—Adverse Action Hearing Procedures

7.24. Provider Hearing Rights and Responsibilities. Any provider whose clinical privileges are denied, reduced, restricted, or revoked may request a hearing. The provider has 30 calendar days to request a hearing. This 30 calendar days affords him or her an opportunity to meet with legal counsel before proceeding. The 30 calendar days will be adhered to, IAW the timeline exceptions noted in paragraph **7.10**.

7.24.1. If no hearing request is received in 30 calendar days, or the individual gives written notice waiving his or her right to a hearing, or the individual fails to appear for a scheduled hearing, then hearing rights are waived. If hearing rights are waived, then the MDG/CC acts on the provider's privileges as proposed and communicates this action, in writing, to the provider. If the action is to deny, restrict, reduce, or revoke privileges, the provider must also be given notice of the right to appeal to AFMOA/CC through AFMOA/SGOC. This would be a final action at the facility that may be reported by AFMOA/SGOC to regulatory agencies following applicable appeal procedures.

7.25. Provider Notification of Hearing. If the provider requests a hearing, the chairperson of the credentials function gives the provider written notice of the hearing within 5 calendar days. (See **Attachment 14**). This written notice must include:

7.25.1. The date, time, and location of the hearing, which must be no sooner than 30 calendar days from the date of the notification, and scheduled within 60 calendar days. (This gives the provider an opportunity to prepare for the hearing.)

7.25.2. The right to be present, to present evidence, and to call witnesses (the provider must arrange for the presence of his or her witnesses at own expense).

7.25.3. The names of witnesses to be called to testify at the hearing.

7.25.4. The right to cross-examine these witnesses.

7.25.5. The right to have a military counsel appointed to assist the provider (if the provider is military) and/or the right to hire a civilian attorney at the provider's expense.

7.25.6. The provider may request a delay of the hearing for good reason. 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.

7.26. Hearing Committee Composition. When a hearing is requested, the credentials function chairperson will appoint a hearing committee. The provider will be notified of the hearing committee composition prior to the start of the hearing. The senior ranking member of the committee will act as chairperson unless otherwise designated by the credentials function chairperson or the MDG/CC in the appointment letter. To facilitate an impartial review, members who participated in the professional review (credentials function) should not be appointed to the hearing committee. In smaller facilities with limited staff, hear-

ing committee members may be requested from other MTFs. The committee will include a minimum of three members. At least one member should be a peer (similar experience and clinical background) as the provider under review.

7.26.1. The MDG/CC or chairperson of the credentials function may appoint persons to serve on the hearing committee, as needed. If the MDG/CC is the provider being evaluated, or is disqualified from acting in the case, the HQ MAJCOM/SG can appoint a senior physician to act as the MDG/CC for the case.

7.26.2. The legal advisor should either be an MLC from that region or a local staff judge advocate approved by the regional MLC as being sufficiently qualified. The base staff judge advocate will appoint an attorney to present evidence on behalf of the MTF.

7.26.3. The MTF is responsible for obtaining court reporting services for the hearing. Court reporters may be used from the SJA office, on a space-available basis, 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 can be available within 30 calendar days.*

7.27. Ensuring Impartiality of Review Personnel. This section on impartiality follows the same guidelines as the credentials review and cannot be overemphasized. Personnel participating in the hearing must be able to impartially review the case. Follow the guidelines under paragraph 7.2. regarding personnel who should not sit on a hearing committee.

7.27.1. The individual who suspended the provider's privileges or who recommended the provider's discharge from active duty may testify as a witness at the hearing but should not serve on the hearing committee.

7.28. Hearing Proceedings. The committee must consult with the appointed legal advisor to review compliance with this section before conducting the hearing. These proceedings are not bound by formal rules of evidence or a strict procedural format. The chairperson/legal advisor to the board may use the hearing script at [Attachment 15](#). The legal advisor shall administer oaths to hearing personnel and to witnesses, and will rule on challenges for cause, except those against the legal advisor. The chairperson will rule on challenges against the legal advisor. The committee may question witnesses and examine documents, as necessary. The hearing committee will listen to the testimony, consider all the information in the case, and make recommendations to the MDG/CC, as listed in paragraph 7.22.

7.29. Presentation of New Information at Hearing. Additional information not used in the original professional review function deliberations (credentials review or peer review) on the case 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, as well as 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 adequate time was had for preparation.

7.30. Hearing Committee Activities. The hearing committee should review all the evidence presented, including matters presented by the provider. The results of concurrent or previous administrative or legal proceedings should not be presented at the hearing unless they are **relevant** to the provider's clinical prac-

tice and were part of the allegations being examined by the hearing. The chairperson, with the help of the legal advisor, should arrange for the orderly presentation of evidence. An investigating officer may testify before the hearing committee. The legal advisor should rule on any objections made by the provider or counsel.

7.30.1. Hearing Transcription. A verbatim record of the proceedings is required. A court reporter is mandatory in these proceedings to facilitate a timely transcription. In order to facilitate transcription, documentation must be made available to the court reporter in an orderly fashion, with exhibit items listed and numbered as they are presented throughout the hearing. The transcript, once accomplished, should 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., Section 1102.” The requisite number of copies of the proceeding is forwarded as follows: the original is forwarded ultimately to AFMOA/SGOC, one copy for the HQ MAJCOM/SG, one copy for the MTF, and one copy for the provider. It is recommended that a copy of the transcript, printed in a condensed version, be obtained. A copy of the exhibits should accompany each transcript. If the respondent wishes to have more than one copy of the transcript, he or she is responsible for arranging for duplicates. The transcript should not include the actual deliberations of the hearing committee, but must include the hearing committee findings and recommendations.

7.30.2. Hearing Committee Findings. As to findings, a preponderance of the evidence standard should be applied. The term “preponderance of the evidence” simply means the greater weight of credible evidence. There is no requirement to prove any allegation beyond a reasonable doubt. Use best judgement, 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. Be convinced that each fact set forth in the findings is proven to satisfaction by a preponderance of credible evidence. After making findings, consider an appropriate recommendation. The recommended action must be made in good faith that it is required based on prevailing professional standards and on the findings. It is recommended that the findings and recommendations be accomplished at the time the hearing is concluded, that the document be signed by all hearing committee members, that minority reports be included, and the document(s) be read, preferably verbatim, into the record. The findings and recommendations of the hearing committee should also include the quality assurance identification at the bottom of each page ([Attachment 16](#)).

7.31. Hearing Committee Recommendations. After the hearing, the committee should deliberate and determine, by majority vote, recommendations they wish to make to the MDG/CC. Minority reports (opinions) are permitted. Attach the minority report to the findings and recommendations and include both the name and specialty of the minority reporter. Base the standard of proof for findings on the preponderance of the evidence. Base recommendations on the reasonable belief that the actions are warranted by the evidence. Support general statements by specifically identified incidents or situations. Reference any pertinent section of the hearing record/exhibits as needed to support the findings. Limit recommendations to the same choices listed in paragraph [7.22](#), following the credential function review activities.

7.32. Forward Recommendations. The hearing record (transcript) should be completed and made available within 30 calendar days of the hearing. The hearing record will be sent to the credentials function chairperson.

7.32.1. The credentials function meets to review the hearing committee findings and recommendations. They can submit additional comments or recommendations to the MDG/CC.

7.32.2. The credentials function chairperson gives a copy of all hearing committee findings and recommendations, additional recommendations, and the hearing transcript to the provider, as outlined in [Attachment 17](#).

7.33. Provider Statement of Exceptions and Corrections. After the provider has received the documents listed in paragraph [7.32.2](#). above, he or she has 10 calendar days to prepare and submit a written statement of exceptions and corrections or other matters that they want to present to the MDG/CC. The provider's statement should be forwarded to the MDG/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 for good cause.

7.33.1. Upon receipt of the provider's statement or expiration of the time limit, the credentials function chairperson forwards the case file to the MDG/CC for a final decision.

7.34. Commander's Decision and Provider Notification. The MDG/CC makes a final decision in the case within 10 calendar days of receiving all documentation (the hearing committee's recommendations, hearing transcript, the credentials function's additional recommendations, and any statement from the provider). The time may be extended if mission requirements dictate, but the provider must be notified immediately in writing.

7.34.1. The MDG/CC must provide written notification to the provider of final decision ([Attachment 18](#)). This written notification must include the final action and the reasons for the final action. If the MDG/CC's final action is different from the hearing committee's recommendation, an explanation of the basis for the action must be given to the provider. If the final action includes denying, reducing, restricting, or revoking privileges, the provider must also be notified of the right to appeal the final decision to AFMOA/CC through AFMOA/SGOC. In addition, the provider must be notified that the action may be reportable to regulatory agencies.

7.35. Forward Documentation to HQ MAJCOM/SG. The MTF will send all documentation related to the action directly to the HQ MAJCOM/SG, arranged in compliance with [Attachment 20](#), (Arrangement of Record of Adverse Action Proceedings) and in compliance with any additional HQ MAJCOM-specific instructions. A final DD Form 2499 will be completed and placed at Tab 3 (Commander's Final Decision). 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 HQ MAJCOM/SG. The provider's appeal will be placed at Tab 2 or under separate cover, as needed. The HQ MAJCOM/SG will notify AFMOA/SGOC that a final action has been received and will forward the complete file to AFMOA/SGOC within 10 calendar days of receipt from the MTF. The MTF may use DD Form 2499, or 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:

7.35.1. Specialty pays withheld.

7.35.2. Promotions halted.

7.35.3. Pending administrative discharge/separation procedures or retirement.

- 7.35.4. Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) pending.
- 7.35.5. Referral OPRs.
- 7.35.6. Provider resigned commission.
- 7.35.7. Related Uniform Code of Military Justice (UCMJ) action.
- 7.35.8. Removal of AFSC.
- 7.35.9. Contract Status (if applicable).

Section 7E—Appeal Procedures

7.36. General. The provider may make a written appeal of the MDG/CC's final decision to AFMOA/CC, through AFMOA/SGOC (Chief, Risk Management Operations). The provider must submit the appeal to the MTF where the action occurred, within 10 calendar days of receiving notice of the MDG/CC's decision. The time limit may be extended by the MDG/CC for good cause. The MDG/CC notifies the HQ MAJCOM/SG of any extensions granted and provides a new date when the provider's appeal can be expected. The MDG/CC's decision remains in effect during the appeal process. A provider who fails to appeal the MDG/CC's decision waives any further appeal rights. If the provider does not appeal, the HQ MAJCOM/SG will forward the case file to AFMOA/SGOC who will prepare the report to the appropriate regulatory agencies.

7.37. Appeals Review Process. Appeals made to AFMOA/CC will be reviewed by the legal advisor to the surgeon general/designee who will provide comments on the legal and administrative aspects of the case. AFMOA/SGOC will have a specialty consultant review the clinical aspects of the action. The case will meet the Air Force Medical Practice Review Board (MPRB). This board reviews the clinical and legal aspects of the case and makes a final action recommendation to AFMOA/CC. For those cases that require NPDB reporting, the case will be forwarded to the HQ USAF/SG for final action. NPDB reporting will be accomplished IAW DoD Instruction 6025.15. This instruction states that the HQ USAF/SG is the sole authority for authorizing adverse action reports to the NPDB taken at AF MTFs and, therefore, will review/approve all final actions that AFMOA/CC recommends for NPDB reporting.

7.38. AFMOA/SGOC Notifications. When a final decision has been made in the case, AFMOA/SGOC communicates the results of the appeal to the provider, to the HQ MAJCOM/SG, and to the MDG/CC. In addition, AFMOA/SGOC reports the action to appropriate regulatory agencies as outlined in Section I of this chapter.

Section 7F—Additional Administrative/Documentation Requirements Related to Adverse Actions

7.39. Providers Ending Affiliation with the Air Force Medical Service or Permanently Changing Station (PCS) within the Air Force while Under Review. The MDG/CC must inform individuals who choose to separate while under review, of the implications of their actions and their right to request the review process be continued ([Attachment 19](#)). **NOTE:** If the provider has already been notified, in writing, of the implications of leaving (through use of [Attachment 10](#), [Attachment 11](#), [Attachment 12](#), or [Attachment 13](#)), then it is not necessary to repeat this notification. Individuals who separate, retire, are discharged, end employment with the Air Force, or permanently change station within the Air Force during any phase of a privileges review action, may be reported to professional regulatory agencies. The pro-

vider may ask that the review be continued after the change in his or her status with the Air Force or MTF. If the provider chooses to have the review continued, he or she must send a written request to the office having responsibility for the case within a 5 calendar days following his or her change in status. If the MTF or AFMOA/SGOC (as appropriate) receives a request for continuation, reports to regulatory agencies will not occur until the case is closed.

7.40. Records Location Regarding Abeyances and Suspensions. Records of abeyance and suspension actions that lead to complete reinstatement of privileges will be kept in the PAF. The AF Form 22 will summarize performance, but original documents should not be put in the PCF. The MDG/CC's letter of explanation of reinstatement circumstances should be filed in the PCF and a copy given to the provider. Abeyance and suspension actions that lead to restriction, reduction, or revocation of privileges must be placed in Section III of the PCF and cannot be removed, regardless of whether the final outcome leads to a reportable adverse privilege action or complete reinstatement of privileges. The documentation of the adverse action is maintained for 8 years.

7.41. Records Location Regarding Monitoring and Evaluation (M&E). Records of M&E that lead to complete reinstatement will be kept in the PAF. The AF Form 22 can be used to summarize provider's progress with M&E. If the M&E leads to a restriction, reduction, or revocation of clinical privileges, it must be placed in Section III of the PCF, along with other documents relating to the privilege action. If the provider separates while under a period of M&E, the credentials function must meet prior to the change of status and review the progress of the M&E. If the credentials function recommends a restriction or revocation of privileges, then the provider is notified and offered a hearing and appeal. If no adverse action is recommended, then the M&E documents are filed in the PAF. If the credentials function does not meet to consider the performance of the provider, then no action is taken on the clinical privileges, and the M&E documents are filed in the PAF.

7.42. Management of Personnel Following Adverse Actions. Consider for separation or termination all providers who are permanently removed from performing the full scope of their duties, or whose conduct, medical condition, or mental state makes them unfit for patient care duties.

Section 7G—Removing Non-Privileged Healthcare Professionals from Patient Care Duties

7.43. General. When a non-privileged healthcare professional's conduct, condition, or performance requires immediate action to protect the health or safety of patients, the senior corps representative, in consultation with the squadron/flight commander and the individual's supervisor, will remove the individual from all or a portion of patient care duties. This action is similar to an abeyance, as stated in paragraph [7.12](#). The action protects patient safety while an inquiry into the extent of the action and the need for taking an adverse action is contemplated.

7.43.1. Notification. The non-privileged healthcare professional will be notified, in writing, by the senior corps representative that an inquiry is being conducted ([Attachment 12](#)). The letter will state the basis for the removal and that this may lead to a peer review.

7.44. Inquiry Procedures. When more information or background on the individual's professional and clinical performance is necessary, one or more officers may be appointed by the MDG/CC to conduct a further inquiry. For example, an independent reviewer from another MTF may be asked to conduct a records review to determine the extent of a practice problem. After completing the inquiry, the investigat-

ing officer sends a report to the senior corps representative. The report should organize the factual findings of the inquiry and the basis therefore, and may include the investigating officer's conclusions or recommendations. The inquiry report, along with other information collected, will form the basis of the peer review as discussed in paragraph 7.46.

7.45. Notification to HQ MAJCOM/SG. The MTF must complete a DD Form 2499 to document the action. This form should be placed in the case file and kept at the MTF until the action is completed. The HQ MAJCOM/SG should notify AFMOA/SGOC about adverse actions of a sensitive or potentially notorious nature. AFMOA/SGOC will be responsible for relaying information to the HQ USAF/SG, as appropriate.

7.46. Peer Review Procedures for Non-Privileged Healthcare Professionals:

7.46.1. General. Professional review activities for non-privileged healthcare professionals are accomplished by an ad hoc peer review function. Within the context of adverse actions, the ad hoc peer review function is similar to the credentials function review for privileged providers. The role of this review function is to examine information obtained from inquiry and/or other materials, and to make recommendations to the MDG/CC regarding clinical practice of the individual. Recommendations must be made in the reasonable belief that the action is warranted by the facts. The senior corps representative is responsible for coordinating the peer review function.

7.46.2. Notification of Need for Peer Review. The senior corps representative, after consultation with the SJA or MLC, will give written notice to the non-privileged healthcare professional within 10 calendar days of the decision to proceed with an adverse action. This would occur at the conclusion of an inquiry period, or following removal from patient care duties. This notification must specify the deficiencies and clearly state that a peer review will be completed (**Attachment 12**). The individual should endorse the notification letter and a copy of the notification must be placed in the individual's competency assessment folder. Commander-directed medical evaluations should be considered, if appropriate.

7.46.3. Withdrawal of Permission to Engage in Off-Duty Employment. The MDG/CC or senior corps representative must withdraw any permission for the individual to engage in clinically related off-duty employment until the adverse practice action under review is resolved.

7.46.4. Appointing a Peer Review Function. When a non-privileged healthcare professional is removed from all or a portion of patient care duties, a peer review function must be convened to determine the extent of the problems and to make recommendations for further action on the professional issues in the case. *The focus of the peer review must be on how the action under review impacts the individual's ability to practice clinically.* The non-privileged healthcare professional under review may make a written statement on his or her behalf to the peer review function. The non-privileged healthcare professional is free to consult with legal counsel at any step in an adverse action; however, the peer review function is not a legal proceeding. Therefore, the non-privileged healthcare professional is not allowed to have legal representation at the professional review session.

7.46.5. Composition of Peer Review Function. The peer review function must be composed of at least three members. One member should be a peer of the non-privileged healthcare professional who is the subject of the action. **NOTE:** For non-privileged registered nurses, all three members of the peer review function must be registered nurses.

7.46.6. Peer Review Function Recommendations. The peer review function considers the information and any other matters resulting from an inquiry and makes recommendations regarding patient care duties. If additional information is required, the professional review function may refer the case back to the investigator(s) for further inquiry. The following recommendations may be made:

7.46.6.1. Reinstatement. Return the individual to full duty or change of assignment within the MTF that does not restrict the practice of the non-privileged healthcare professional in any way. This is not an adverse action; it is not reportable to regulatory agencies and no hearing or appeal is offered.

7.46.6.2. Restriction. A limit placed on all or a portion of the non-privileged healthcare professional's practice. This restriction may require some sort of supervision. Can include change of duty assignment within the MTF with supervision. (**NOTE:** If the practice is restricted for a specified period of time [i.e. supervised practice for 3 months], no further action will be taken in the case until the period of supervision has been completed.) The results of the supervised practice must be forwarded to the senior corps representative who will forward a recommendation to the MTF/CC as delineated in paragraph 7.47. The peer review function may be reconvened at the discretion of the senior corps representative.

7.46.6.3. Reduction . Permanent removal of a portion of the non-privileged healthcare professional's patient care duties.

7.46.6.4. Revocation. Permanent removal from all direct patient care duties.

7.47. Forward Recommendations to the MDG/CC. The senior corps representative forwards the recommendation of the peer review function, along with the case evidence, to the MDG/CC within 5 calendar days of the peer review. The senior corps representative may make other recommendations to the MDG/CC with regard to the management of the non-privileged healthcare professional in question. However, these should be forwarded under separate cover.

7.47.1. The MDG/CC has 5 calendar days from receipt of the recommendation(s) to review and to determine what action to take based on the facts provided. The MDG/CC is not bound by the peer review's recommendations or those of the senior corps representative.

7.47.2. The MDG/CC then gives written notification to the non-privileged healthcare professional of his or her intent to take action and identifies the proposed action and the reasons for the action. (If the individual is a contract employee, a copy will be sent to the AF contract office responsible for the contract and a letter to contractor at the address of record.)

7.47.3. If the proposed action is to permanently reduce, restrict, or revoke the non-privileged healthcare professional's practice, then the MDG/CC's notification must advise the individual of his or her right to a hearing and appeal. (**Attachment 13**).

7.48. Hearing Procedures. The hearing process is the same as described for privileged providers in **Section 7D**. Additional guidelines included here annotate the responsibilities of the senior corps representative in this process.

7.48.1. General. Any non-privileged healthcare professional who is removed from all or a portion of patient care duties may request a hearing. This includes reduction, restriction, and/or revocation of practice. The individual has 30 calendar days to request a hearing. This 30 calendar days affords him or her an opportunity to meet with legal counsel before proceeding. The 30 calendar days will be

adhered to IAW the timeline exceptions noted in paragraph [7.10](#). The same guidance regarding failure to request a hearing is followed. Refer to [Section 7D](#), paragraph [7.24](#). In addition, the senior corps representative notifies the individual of date/time of the hearing in the same manner as described in paragraph [7.25](#)., and in [Attachment 14](#).

7.48.2. Hearing Committee Composition. When a hearing is requested, the senior corps representative will appoint a hearing committee. The non-privileged healthcare professional will be notified of the hearing committee composition prior to the start of the hearing. The senior ranking member of the committee will act as chairperson unless otherwise designated. To facilitate an impartial review, members who participated in the peer review should not be appointed to the hearing committee. In smaller facilities with limited staff, hearing committee members may be requested from other MTFs. The committee will include a minimum of three members. At least one member must be a peer as the provider under review. *NOTE:* For non-privileged registered nurses, all three members of the hearing committee must be registered nurses.

7.48.3. Hearing Committee Recommendations. Recommendations are limited to those of the peer review function as listed in paragraph [7.46.6](#).

7.49. Forward Recommendations. The hearing record (transcript) should be completed and available within 30 calendar days of the hearing. The hearing record will be sent to the senior corps representative who reviews the findings and submits additional comments, as needed, to the MDG/CC. In addition, the senior corps representative gives a copy of all hearing committee findings and recommendations, additional recommendations, and the hearing transcript to the individual, as outlined in [Attachment 17](#).

7.50. Statement of Exceptions and Corrections. The non-privileged healthcare professional has 10 calendar days after receiving the hearing committee's recommendations to prepare and submit a written statement of exceptions, corrections, or other matters that he or she wants to present to the MDG/CC. The individual's statement should be forwarded to the MDG/CC through the senior corps representative. If the non-privileged healthcare professional requests additional time to prepare the statement, this request must be made, in writing, to the senior corps representative before the time limit has expired. Extensions may be granted for good cause.

7.50.1. Upon receipt of the statement or expiration of the time limit, the senior corps representative forwards the case file to the MDG/CC for a final decision.

7.51. Commander's Decision and Provider Notification. The MDG/CC makes a final decision in the case within 10 calendar days of receiving all documentation (the hearing committee's recommendations, hearing transcript, senior corps representative's additional recommendations, and any statement from the individual). The time may be extended if mission requirements dictate, but the individual must be notified immediately, in writing.

7.51.1. The MDG/CC must provide written notification to the non-privileged healthcare professional of final decision ([Attachment 18](#)). This written notification must include the final action and the reasons for the final action. If the MDG/CC's final action is different from the hearing committee's recommendation, an explanation of the basis for the action must be given to the individual. If the final action includes reducing, restricting, or revoking practice, the individual must also be notified of the right to appeal the final decision to AFMOA/CC through AFMOA/SGOC (reference [Section 7E](#),

Appeal Procedures). In addition, the notification must include that the action may be reportable to regulatory agencies. Only AFMOA/SGOC has authority to report to external regulatory agencies.

7.52. Appeal Procedures. The appeal process for non-privileged healthcare professionals is the same as described for privileged providers in [Section 7E](#).

7.53. Individuals Ending Affiliation with the Air Force Medical Service or Permanently Changing Station (PCS) within the Air Force while Under Review. The MDG/CC must inform non-privileged healthcare professionals who choose to separate while an adverse action is under review (peer review, hearing or appeal) of the implications of their actions and their right to request the review process be continued ([Attachment 19](#)). The guidance in paragraph [7.39](#) applies to non-privileged healthcare professionals as well.

7.54. Non-Privileged Healthcare Professional Documentation Requirements. All adverse action documentation (DD Form 2499, peer review, and hearing documents, etc.) on non-privileged staff will be maintained and secured by the quality services manager/designee. The individual's competency assessment folder should be secured/maintained by the quality services manager/designee during adverse action proceedings. If the healthcare professional separates or terminates employment, the adverse action file, along with the individual's competency assessment folder, will be maintained for 8 years at the MTF (similar to the credentials folder for privileged staff). If the provider PCSs, all adverse action documentation will be mailed to the gaining MTF. These documents should never be hand-carried by the individual provider. When AFMOA/SGOC sends final disposition of the case, file this information in the case file.

7.55. Management of Non-Privileged Healthcare Professionals Following Adverse Actions. Consider for separation or termination all individuals who are permanently removed from performing the full scope of their duties, or whose conduct, medical condition, or mental state makes them unfit for patient care duties.

7.56. 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/SGOC via the HQ AETC/SGN.

7.57. Removing Technicians from Clinical Practice. Provisions in this regulation for clinical peer review may be followed for enlisted personnel, but it is not mandatory. In these cases, the peer review results will be forwarded to the MTF senior enlisted advisor, squadron commander, and senior corps representative. Any further action will be managed by the squadron commander through personnel, administrative, and/or UCMJ channels. (**NOTE:** Additional guidance for enlisted members is available in AFI 36-2102, *Classifying Military Personnel*; AFI 36-2201, *Developing, Managing and Conducting Training*; and AFI 36-2247, *Planning, Conducting, Administering, and Evaluating Training*.) Consideration should be given to notification of the licensing, registering, or certification body when appropriate. Only AFMOA/SGOC is authorized to make reports to external regulatory agencies. Submit such cases requiring reporting to AFMOA/SGOC through the HQ MAJCOM/SG.

Section 7H—Management of Impaired Providers/Non-Privileged Healthcare Professionals

7.58. General. Any medical condition that prevents or reduces an individual's ability to safely execute his or her responsibilities in providing health care can be considered an impairment. This includes alcohol or drug impairment, medical condition, or mental health disorder. The credentials function or senior corps representative will review individuals who are impaired and determine if their health status hampers their practice.

7.59. Alcohol or Drug Impairment:

7.59.1. Determining If Adverse Action Is Needed. The SJA will provide guidance to the MTF on possible criminal violations related to impairments and will be consulted prior to confronting a provider. The credentials function chairperson or senior corps representative must conduct an inquiry into reports of provider impairment. The purpose of the inquiry is to determine the extent of the problem and whether the alcohol or drug impairment affects the provider's ability to deliver safe patient care. This review process may consider any information which evaluates the impact of the impairment on the provider's ability to practice. This may include 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 inquiry determines that the impairment does not affect clinical practice, the credentials function chairperson or senior corps representative will forward this recommendation to the MDG/CC. The MDG/CC makes the final decision. Any alcohol or drug impairment 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. If the provider is removed from patient care responsibilities because the alcohol or drug impairment affects his or her ability to render safe patient care, then the provider is offered an opportunity for a hearing and an appeal, as directed in this chapter.

7.59.2. 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. 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 state regulatory agency. Any associated administrative/UCMJ action that results from drug impairments may be reported to regulatory agencies as outlined in paragraph 7.71. Self-disclosure after notification that an inquiry is being conducted does not meet the intent of voluntary self-disclosure as described in this paragraph. In addition, individuals who self-refer to an alcohol treatment program who do not complete the treatment program will be reported to regulatory agencies.

7.59.3. Returning to Practice Following Treatment. Upon anticipated return to clinical duties following treatment, the credentials function (privileged providers) or senior corps representative in consultation with the flight commander and individual's supervisor (non-privileged healthcare professionals) will evaluate the provider's need for monitoring posttreatment. The use of monitoring and evaluation may be appropriate for a specified period of time.

7.59.4. Evidence of Relapse. Any identified relapse will be reported immediately to the credentials function or senior corps representative. The individual will be removed from patient care duties while a full reassessment is accomplished. Recommendations regarding management of the provider will be made by the credentials function or senior corps representative and forwarded to the MDG/CC.

7.59.5. Actions Involving Civilian Personnel. The supervisor of civil service providers/employees will contact the Civilian Personnel Office, Employee Relations Branch, for advice prior to confrontation of the employee.

7.59.6. Actions Involving Contract Providers. The supervisor of contract staff will contact the contracting officers' representative office when there is concern about the conduct or performance of a contract employee.

7.59.7. Disclosure. The provider may be required to disclose his or her alcohol or drug impairment/treatment when applying for privileges, licensure, or insurance in the future even if an adverse privilege/practice action was not taken.

7.60. Physical/Mental Impairments:

7.60.1. Temporary Impairments. Temporary impairments (i.e., broken arm or leg, pregnancy, scratched cornea, medication use which impacts lucid thought) should be noted on a profile by an other authorized healthcare provider, with specific explanation as to how the medical impairment/condition would limit practice. (For example: can't see well enough to assess microscopic slides, 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 profile should also specify, to a reasonable degree of medical certainty, the length of time the profile is expected to be in effect. This profile should immediately be brought to the attention of the individual's supervisor and the credentials function chairperson or senior corps representative. A copy should be placed in the PAF for privileged providers.

7.60.2. Permanent and Long-Term Impairments. Permanent or long-term impairments should be reviewed by the credentials function for privileged providers with consideration towards possible permanent reduction/restriction to privileges. For non-privileged healthcare professionals, the senior corps representative, in conjunction with the flight commander and individual's supervisor, will review long-term impairments for possible permanent practice action.

7.60.3. Voluntarily Restricting Practice Related to a Medical Condition. A provider or non-privileged healthcare professional may voluntarily restrict his or her practice when a medical condition interferes with ability to perform the full scope of duties. A written request to restrict practice must be made to the credentials function or to the senior corps representative. This voluntary restriction 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 restriction and forward their recommendation for approval to the MDG/CC. Following MDG/CC concurrence, the clinical privileges/practice will be changed, as appropriate. AFMOA/SGOC may be required to report the medical condition to the individual's state board. The MTF will complete the template letter, located at [Attachment 27](#), and forward this information to AFMOA/SGOC via the HQ MAJCOM/SG. Reference paragraph [7.72.1.3](#).

7.60.4. Determining if Adverse Action is Needed. The credentials function or senior corps representative in consultation with the squadron/flight commander and individual's supervisor may conduct an inquiry into reports of physical/mental impairment. (This is not necessary if a provider self discloses as stated above). The purpose of the inquiry is to determine the extent of the problem and whether the medical condition affects the provider's or non-privileged healthcare professional's ability to deliver safe patient care. The review process may consider how the impairment was discovered or disclosed, a statement concerning the current clinical performance from at least one immediate supervisor, a statement of diagnosis, prognosis, and implications for clinical performance from the primary physician treating the impaired provider. Additional medical evaluations may be directed as needed. If the inquiry determines that the medical condition does not affect clinical practice, the credentials function chairperson or senior corps representative will forward this recommendation to the

MDG/CC. The MDG/CC makes the final decision. If the provider or non-privileged healthcare professional is removed 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 or non-privileged healthcare professional is offered an opportunity for a hearing and an appeal, as directed in this chapter. A DD Form 2499 is completed and placed in the case file until the action is completed.

7.60.5. Medical Evaluation Board/Physical Evaluation Board (MEB/PEB). The MDG/CC is not required to take an adverse privilege action prior to a provider meeting a medical board. The MEB/PEB process is not designed to decide if a person is fit to practice--it is a tool for deciding whether they are worldwide deployable. The PEB sets a disability rating for the medical condition. 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 his or her practice or be subject to a restriction/reduction in privileges/practice. Action to curtail the privileges/practice of a medically impaired provider must be taken when appropriate.

7.60.6. Reassessment of Impairment Status. Impairment status should be reviewed periodically. The credentials function/senior corps representative should 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 impairments times are surpassed. Worsening of condition should also be monitored for additional documentation on profiles or additional restrictions to privileges/practice.

7.60.7. Disclosure. The provider may be required to disclose his or her medical condition when applying for future privileges, licensure, or insurance, even if an adverse privilege/practice action was not taken.

7.61. Management of Individuals with Communicable Diseases that Could Affect Patient Safety:

7.61.1. Determining Extent of the Exposure Risk. The credentials function or senior corps representative must review the scope of practice of the individual 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 will identify any specific exposure prone procedures (EPP) for the AFSC and make a recommendation to the MDG/CC regarding the continued practice of the provider.

7.61.2. Voluntary Restriction of Practice. The individual may voluntarily restrict his or her practice related to medical condition. A written request to restrict practice must be made to the credentials function or to the senior corps representative. This voluntary restriction 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 restriction and forward the recommendation for approval to the MDG/CC. Following MDG/CC concurrence, the clinical privileges/practice will be changed, as appropriate.

7.61.3. Restriction of Practice. If the MDG/CC determines that the individual's practice must be restricted, reduced, or revoked due to concerns about the transmission of the disease while delivering health care, the removal of the individual from patient care activities would not be an adverse privilege action. In addition, this removal would not be reported as an adverse action to the NPDB or to

regulatory agencies. The medical condition may be reported to a state licensing agency as outlined in paragraph 7.21.

7.61.4. Disclosure. The individual may be required to disclose his or her medical condition when applying for future privileges, licensure, or insurance.

7.61.5. Discharge. The individual would be subject to administrative or medical discharge proceedings, as applicable.

Section 7I—Other Management Issues Related to Adverse Actions

7.62. Simultaneous Adverse Action and UCMJ Action. For some types of unprofessional conduct, UCMJ action may coincide with an adverse action. Although both actions can proceed simultaneously, a request may be made to have one action take precedence over another (i.e., UCMJ action over adverse action). Requests to place one action on hold while the other is convening must be made, in writing, with understanding by all parties concerned. Individuals serving on a panel for UCMJ action should not be appointed to a professional review or hearing process for the adverse action.

7.63. 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 AF or the MTF. This includes providers who have not met AF continuing education requirements, or Reserve Component providers who cannot provide objective data of their clinical competence. These denials are not adverse actions and do not require the facility to offer a hearing or appeal; however, the provider must disclose these denials, with explanation, on privileging applications.

7.64. Retraining. Complete retraining of providers or non-privileged healthcare professionals is not permitted by this instruction. Both privileged providers and non-privileged healthcare professionals are expected to function within an assigned AFSC. An adverse action review may lead to suggestions of retraining the provider. The MDG/CC may elect to place the provider in suspension or restriction to accomplish a focused training program. The training should not exceed 6 months. The following definitions of training may be helpful in the management of adverse privilege/practice actions:

7.64.1. Refresher Training. Needed for individuals to “get back up to speed.” Basic fund of knowledge intact; fundamentals, skill sets, and core competencies are sound but need to be optimized. May need to reintegrate core competencies/fund of knowledge into daily repertoire. May require supervision or M&E for a brief period of time. Refresher training should not exceed 6 months in duration.

7.64.2. Skills Enhancement. Adding focused knowledge, a few skills, or core competencies to a sound foundation. Lets a provider know “what’s new.” This is done for providers who have been in an administrative role or had a limited scope of practice at another MTF. May require supervision or M&E (for specified procedures) for a brief period of time. Skills enhancement training should not exceed 6 months in duration.

7.65. 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, *Medical Service Officer Education*, 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/SGOC 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/SGOC is the releasing authority for information related to the FSMB report. The involved resident may appeal the report language only to AFMOA/SGOC. The resident must appeal the action leading to the report to HQ AFPC/DPAM.

Section 7J—Procedures for Managing Adverse Actions within Air National Guard (ANG) Units

7.66. Inquiry Procedures. Privileging authorities for ANG units are encouraged to investigate provider misconduct/incompetence/impairment or failure to disclose appropriate information/prior action to determine if adverse action is needed, as discussed in paragraph 7.12. A formal credentials function is not established with ANG units; therefore, the following guidelines apply to these units:

7.66.1. Use of Abeyance. When the extent of provider misconduct is unclear, requiring an inquiry to be completed, the provider's privileges may be placed in abeyance while the investigation is being conducted. All inquiries should be accomplished in a timely manner and adverse action taken, when appropriate. The abeyance period for ANG units that operate 2 calendar days each month will be as follows:

7.66.1.1. An initial period of 90 calendar days will be granted in which to conduct an investigation into the allegations and determine if adverse action is needed.

7.66.1.2. An additional period of 90 calendar days may be granted by the state air surgeon or ANG/SG (in cases where the state air surgeon is the privileging authority).

7.66.1.3. If the inquiry is not resolved after a total of 180 calendar days, the provider's privileges will be automatically suspended.

7.67. Imposing an Adverse Action. The privileging authority notifies the provider, in writing, of any action taken to modify privileges. This includes denial, restriction, reduction, or revocation. The reason for the action is stated, along with the specific allegations. In addition, the provider is instructed on applicable rights.

7.67.1. If a provider wishes to appeal the award, modification, or termination of privileges, he or she must do so, in writing, within 10 calendar days from the date of receipt of written notification.

7.67.2. The privileging authority will review the circumstances of the privilege action and the provider's appeal and make a recommendation to the next higher medical authority (State Air Surgeon or ANG/SG) for decision. **NOTE:** Refer to paragraph 5.10. for appropriate privileging authority for non-physician MDS/CC.

7.67.3. The State Air Surgeon will notify the appealing provider of the decision, in writing, by registered mail, with return receipt requested. The decision notice must advise the provider of the right to appeal the decision to the next higher authority.

7.67.4. The next higher appeal authorities are the ANG/SG and the HQ USAF/SG, in turn. (Reference Table 7.1. below.) The provider has 10 calendar days from the date he or she receives written notification to submit an appeal.

7.67.5. Cases requiring reporting to state regulatory agencies and the NPDB will be forwarded to AFMOA/SGOC by the ANG/SG. No reporting will occur until all applicable appeals have been conducted.

Table 7.1. Two-Tiered Appeal Level for ANG Adverse Actions.

Privileging Authority	1st Level Appeal	2nd Level Appeal
MDS/CC	State Air Surgeon	ANG/SG
State Air Surgeon	ANG/SG	HQ USAF/SG

7.67.6. Providers must disclose any adverse actions taken against their privileges in any institution to their ANG MDS/CC. Instructions on disclosure should be part of an initial interview, documented in the PCF, and signed by the provider.

7.67.7. Disposition of PCFs within ANG Units: PCFs are held on file for 5 years after provider departure, if no adverse action has taken place during the provider's tenure. If it contains adverse action information it is held 8 years.

Section 7K—Reporting and Releasing Adverse Information to National and Regulatory Agencies

7.68. Responding to Written Requests for Information. MTF should reply directly to civilian MTF on requests for information about individuals currently or previously assigned at that MTF. Such reports usually involve the application for clinical privileges at the civilian facility and require a more direct knowledge of the individual.

7.68.1. MTF will send all requests received from licensing agencies or professional organizations involving adverse actions to AFMOA/SGOC for response.

7.69. Disposition of Reports and Actions when MTFs Close. Closing MTFs should forward all archived and pending adverse action cases and credentials files to their respective HQ MAJCOM/SG. The HQ MAJCOM/SG assumes full responsibility for managing these cases.

7.70. AFMOA/SGOC Responsibilities in Reportable Actions. AFMOA/SGOC has sole responsibility for reporting to regulatory agencies outside of the Air Force and releasing information related to reported actions. When an MTF identifies a problem it feels should be reported, the MDG/CC forwards the recommendation to AFMOA/SGOC for review. The MTF must submit information to AFMOA/SGOC on a DD Form 2499 or by using the template letter at [Attachment 27](#).

7.71. NPDB Reporting of Adverse Actions. Only AFMOA/SGOC makes reports to external regulatory agencies.

7.71.1. Physicians and dentists will be reported to the NPDB within 30 calendar days of the HQ USAF/SG approval when:

7.71.1.1. Clinical privileges have been denied, restricted, reduced, or revoked for substandard performance, impairment, or unprofessional conduct.

7.71.1.2. Provider voluntarily surrenders clinical privileges while under investigation for issues of competence or conduct, or in return for not conducting such an investigation or proceedings.

7.71.1.3. Provider separates, retires, moves PCS, or terminates employment, contract, or volunteer services with their privileges suspended.

7.71.2. 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.

7.71.3. The following agencies will receive a notification of final adverse action: HQ AFPC/DPAM, ANG/SG, HQ AFRC/SG, HQ ARPC/SG, HQ MAJCOM/SG, MDG/CC, and to the applicable individual at his or her last known address.

7.72. State Regulatory Agency Reporting of Adverse Actions. Only AFMOA/SGOC makes reports to external regulatory agencies.

7.72.1. Reports will be made to state regulatory agencies on providers and non-privileged healthcare professionals when:

7.72.1.1. Privileges are denied, or a restriction, reduction, or revocation of privileges/practice has occurred. Reporting will not occur until appeal is completed.

7.72.1.2. Provider voluntarily surrenders clinical privileges while under investigation for issues of competence or conduct, or in return for not conducting such an investigation or proceedings.

7.72.1.3. Provider separates, retires, moves PCS, or terminates employment, contractual, or volunteer services with privileges suspended or while removed from patient care duties during any phase of an adverse action review.

7.72.2. The following agencies will receive a notification of final adverse action: HQ AFPC/DPAM, ANG/SG, HQ AFRC/SG, HQ ARPC/SG, HQ MAJCOM/SG, MDG/CC, and to the applicable individual at their last known address.

7.73. Reporting Administrative Actions to State Regulatory Agencies. Only AFMOA/SGOC makes reports to external regulatory agencies.

7.73.1. In addition to reporting adverse privilege/practice actions as noted above, the following administrative actions may be reported to state regulatory agencies by AFMOA/SGOC when providers:

7.73.1.1. Are separated under any administrative discharge authority.

7.73.1.2. Are separated/removed from medical care responsibilities for physical or mental disabilities that affect their ability to provide quality patient care following appropriate due process procedures.

7.73.1.3. Have a medical condition that affects their ability to render safe patient care (includes individuals who voluntarily limit their practice for medical reasons).

7.73.1.4. Are found guilty, plead guilty, or nolo contendere, separate from the service in lieu of further administrative or legal action, or separate following a voluntary written confession or admission of violation of any item listed in [Attachment 21](#). If an action is reversed on appeal, AFMOA/SGOC will notify those agencies that received an initial report.

7.73.1.5. Any other act listed in [Attachment 21](#) following applicable appeal processes.

7.73.1.6. Any other act reportable by state licensing statutes or regulations, if such act is not otherwise reported by the provisions herein.

7.73.2. AFMOA/SGOC will not report to professional regulatory agencies actions involving AFRC and ANG providers in civilian courts for acts of misconduct separate from military status.

7.73.3. AFMOA/SGOC will answer requests for information resulting from these reports. Individuals who were the subject of any material released under this instruction are entitled to a copy of that same information. Before releasing information to future employers or insurers, AFMOA/SGOC must have a signed releasing document from the provider being queried.

Chapter 8

RISK MANAGEMENT

Section 8A—Risk Management Program Requirements

8.1. Identification and Correction of Hazardous Conditions. Every MTF has the responsibility to establish a risk management program in compliance with current JCAHO standards (Management of Information, Plant, Technology and Safety Management, Improving Organizational Performance, etc.). The MTF determines circumstances or types of events requiring standardized internal reporting and develops tools to record data, in writing. The AF Form 765, **Medical Treatment Facility Incident Statement**, may be used to document and track for this purpose. The MTF risk manager works closely with the QSM to trend organizational risks and resolve them. The risk manager should be informed of every potential litigation case and every DD Form 2526 generated at the MTF.

8.2. Patient Relations and Organizational Ethics. The MTF has a responsibility to develop a patient rights and organizational ethics program in compliance with the current JCAHO standards. The patient relations coordinator should communicate any patient concerns related to potential litigation or patient safety to the MTF risk manager or QSM.

Section 8B—Medical Malpractice Claims. This section applies to all healthcare providers/ professionals (both privileged and non-privileged) who are required to possess a license, registration, or certification to provide patient care within the Air Force Medical Service.

8.3. General. The review of medical malpractice claims is an important component of the MTF performance improvement activities. The chief of the medical staff, MTF QSM, credentials manager, and risk manager must be actively involved in this process. This section outlines the reengineered malpractice process that began 1 May 96. Reengineering placed greater emphasis on the role of the MDG/CC and the expert medical review process with the goal of a quality review and faster notification for providers involved in malpractice claims.

8.3.1. The standard of care (SOC) determination is used for two entirely different arms of the medical malpractice system. The Torts Claims and Litigation Division of the Air Force Legal Services Agency (HQ AFLSA/JACT) is charged with adjudication of malpractice claims. Each claim is reviewed by medical personnel and a SOC determination rendered. This SOC determination is made to assist with liability assessment and to set compensation value. For those medical malpractice claims that result in payment, AFMOA/SGOC completes the second SOC review to determine if payment was made on behalf of an individual healthcare provider. AFMOA/SGOC, via the MPRB, reviews each malpractice claim, assigns final SOC determination, and recommends reporting to the NPDB in paid claims. *All correspondence or contact with AFMOA/SGOC in this section should be addressed to the attention of the Chief, Risk Management Operations, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050.*

8.4. Responsibilities:

8.4.1. MDG/CC, SGH, or Designee Responsibilities: (The MDG/CC is responsible for the appropriate handling of malpractice cases within the MTF.)

8.4.1.1. Identify providers who may be significantly involved.

8.4.1.2. Notify significantly involved providers of the status of medical malpractice claims in which they are involved. Written notification includes the initial determination that a provider is significantly involved, preliminary SOC determinations from expert medical reviewers, their right to respond to an adverse standard of care determination, and final outcomes of malpractice cases.

8.4.1.3. Intervene, as appropriate, to ensure the timely completion of expert medical reviews by healthcare providers assigned to his or her MTF.

8.4.2. MTF Risk Manager/Designee Responsibilities:

8.4.2.1. Secure records, films, fetal monitor strips, etc.

8.4.2.2. Organize a QI review on every medical malpractice claim to identify lessons learned, opportunities to improve care, and examine the processes and factors leading to the claim.

8.4.2.3. Submit requested documents to the base claims officer, after a claim is filed.

8.4.2.4. Share lessons learned with facility staff and the HQ MAJCOM/SG.

8.4.2.5. Notify the MDG/CC or designee of legal closure of a claim.

8.4.3. HQ MAJCOM/SG Responsibilities:

8.4.3.1. Examine the MTF QI review and expert medical reviews received from the MLC.

8.4.3.2. Submit recommendations for Air Force policy changes to AFMOA/SGOC, based on analysis of malpractice case reviews.

8.4.4. Base Claims Officer Responsibilities:

8.4.4.1. Notify the MTF risk manager and send a copy of the claim form (SF 95) to the MTF.

8.4.4.2. Investigate each claim and forward documents to the MLC.

8.4.4.3. Notify the MTF risk manager of legal outcome of claims.

8.4.5. MLC Responsibilities:

8.4.5.1. Select expert medical reviewers to render standard of care determinations.

8.4.5.2. Complete medicolegal review of the claim.

8.4.5.3. Forward appropriate documentation to the MTF, the HQ MAJCOM/SG, AFMOA/SGOC, and the base claims office.

8.4.6. Expert Medical Reviewer Responsibilities:

8.4.6.1. Analyze medical malpractice claims sent by the MLC.

8.4.6.2. Prepare written reviews based on available evidence within agreed upon time (usually within 14 calendar days of receiving the claim file).

8.4.6.3. Identify significantly involved providers, render SOC determinations, and identify system problems and opportunities to improve care.

8.4.6.4. Be willing and able to review a malpractice claim within 14 calendar days of receipt.

8.4.7. AFMOA/SGOC Responsibilities:

8.4.7.1. Establish criteria for expert medical reviewers who may be selected to perform standard of care reviews.

8.4.7.2. Convene the MPRB to review provider responses and make final SOC decisions.

8.4.7.3. Make recommendations to the USAF Surgeon General to report healthcare providers to the NPDB and state regulatory agencies.

8.4.7.4. Make reports to the NPDB and state regulatory agencies at the direction of the Surgeon General.

8.4.7.5. Communicate final SOC determination and claim status via DD Form 2526 to the MTF via the HQ MAJCOM/SG.

8.4.7.6. Recommend Air Force policy changes based on the review of medical malpractice claims.

8.4.7.7. Submit malpractice claims data to the Department of Legal Medicine at the Armed Forces Institute of Pathology (AFIP), as directed by DoDD 6025.14.

8.4.8. HQ AFLSA/JACT Responsibilities:

8.4.8.1. Report all closed claims and litigation results to AFMOA/SGOC monthly. Reports will include claim name, claim number, amount paid, date of payment, type of settlement, and reason for payment.

8.4.8.2. Respond to requests for additional information from AFMOA/SGOC regarding settlement of a malpractice claim.

8.5. Managing Potentially Compensable Events (Potential Claims). When a medical incident occurs, which may result in a medical malpractice claim being filed, the risk manager/designee should take the following actions:

8.5.1. Notify the quality service manager/designee to determine if event meets JCAHO sentinel event review and/or AF medical incident investigation (MII) criteria. Begin root cause analysis, if indicated, according to MTF policy.

8.5.2. Sequester the medical record(s) (or obtain a certified copy) to include x-rays, fetal monitor strips, and other related documents. For example, the following items may be sequestered: rhythm strips from ICU or ESD recording devices, support equipment, copies of duty schedules, current policies or operating instructions, MIIs, event reviews/incident reports, audio tapes from nurse advice line or ESD-recorded line, if applicable, etc.

8.5.3. Stamp all documents originating from the MTF with a QA disclosure statement.

8.5.4. Initiate an MTF QI review to identify opportunities to improve care, lessons learned, and examine the processes and factors that may lead to a claim.

8.5.5. Assemble list of providers involved in the care or witnesses to the event. The SGH/designee will identify the significantly involved providers. The MTF is not required to make a standard of care determination in the case but may do so if directed by the MDG/CC or SGH.

8.5.6. Notify each involved provider of the event and instruct them to write a statement concerning the facts of the incident and his or her part in the outcome. These statements will be kept on file in a secure location.

8.5.7. Collect the following information on each provider involved: name, SSN, states of known licensure and numbers, a permanent address, DEROS and/or separation date. This information should be available in CCQAS for privileged providers.

8.5.8. Keep all potential claims packages a minimum of 3 years. For potential claims involving infants or minors the package should be kept for a minimum of 5 years before destroying. **NOTE:** Original medical records that have been sequestered are never destroyed.

8.6. MTF Actions After Claim is Filed. The risk manager/designee will accomplish the following:

8.6.1. Notify the MDG/CC of the claim, locate the preclaim package described above (if it exists) and review. If the steps outlined in paragraph 8.5. above have not been completed, then they are accomplished at this time.

8.6.2. Place the claim on the ECOMS agenda and track it semiannually until receipt of legal closure. Large MTFs with a separate risk management committee may fulfill this requirement if the ECOMS reviews the risk management committee's minutes and the status of all claims are documented on these minutes at least semiannually.

8.6.3. Notify AFMOA/SGOC via the HQ MAJCOM/SG, if the claim involved a medical incident investigation or was a sentinel event reported to JCAHO.

8.6.4. Notify the involved individuals, in writing, that a claim has been filed and keep them informed of the claim status. Reasonable attempts should be made to contact all providers significantly involved in the claim but no longer stationed at the facility or employed by the Air Force.

8.6.5. Complete a DD Form 2526 on each significantly involved provider, and construct a witness list to include current or permanent addresses, DEROS and/or separation date, for each involved provider. If no provider is significantly involved, and the cause of the injury is a systems problem, the risk manager enters the facility name in Block 8a of the DD Form 2526. The MTF is responsible for generating a DD Form 2526 on additional providers identified by the expert medical reviewer(s) as being significantly involved in the claim. This request will be made by the MLC and the additional DD Form 2526 will be completed and forwarded promptly. The DD Form 2526 is available in an electronic version in AFMAM and in the Air Force Electronic Publications Library (AFEPL).

8.6.6. Send the following documents to the base claims officer (reference AFI 51-501, *Tort Claims*), within 14 calendar days of notification that a claim has been filed or by the agreed suspense date:

8.6.6.1. MTF QI review.

8.6.6.2. List of significantly involved providers.

8.6.6.3. DD Form 2526 on each significantly involved provider.

8.6.6.4. Provider statements.

8.6.6.5. Witness locator list (to include a permanent address, phone number, DEROS and/or separation date, if applicable).

8.6.6.6. Applicable medical records.

8.6.7. Assemble the medical records in the following manner:

8.6.7.1. Certified copy.

8.6.7.2. Copied only one side.

8.6.7.3. Placed in identical folders as the original.

8.6.7.4. For outpatient records, number the pages on the bottom right hand side from the earliest entry to the latest.

8.6.7.5. For inpatient records, numbered on the bottom right hand side, from the latest entry to the earliest. (The most recent inpatient record would be on the bottom.)

8.6.8. Send the MTF QI review, with identified lessons learned and opportunities to improve, to the HQ MAJCOM/SG in an electronic format (disc). A hard copy of the QI review, along with other case documents, will be sent to the HQ MAJCOM/SG by the MLC.

8.6.9. Furnish the HQ MAJCOM/SG with copies of the medical records or any other documents, when requested.

8.6.10. Place a copy of the DD Form 2526 in the significantly involved provider's credentials file, or individual professional file for non-privileged healthcare professionals, until notified by AFMOA/SGOC of final disposition. For residents, a copy of the DD 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 credentialed provider, a copy of the DD 2526 will be forwarded to the gaining MTF.

8.6.11. Should the provider PCS, a copy of the DD Form 2526 goes with the credentials folder, or individual professional file for non-privileged personnel, to the gaining MTF, until final outcome is received.

8.7. Base Claims Officer Actions to Complete the Case File:

8.7.1. Conduct legal interviews with each significantly involved provider and other witnesses to the incident.

8.7.2. Create a witness locator list with current and permanent addresses of all witnesses and providers. Although this is initially provided by the MTF, the base claims officer is responsible for updating the list with current locator information.

8.7.3. Obtain a curriculum vitae from each significantly involved provider.

8.7.4. Write a seven-point memorandum on the case.

8.7.5. Annotate the DD Form 2526, according to [Attachment 22](#), and forward the original and additional copies of the complete investigative file to the MLC. The MLC should have the claim within 75 calendar days from the date the claimant filed the claim.

8.7.6. Notify the MTF risk manager of the legal closure in the claim. This includes information related to litigation filed and litigation closures, when known.

8.8. Selection of Expert Medical Reviewers:

8.8.1. Expert reviewers should meet the following criteria: Field grade rank, 4 years on active duty, currently working in the specialty, and board certification (specialty-specific).

8.8.2. MLCs can select expert reviewers who meet the criteria listed. If an expert reviewer is desired who does not meet the above criteria, the MLC will forward the information to AFMOA/SGOC for approval.

8.9. MLC Actions to Complete the Case File:

8.9.1. Obtain a written expert medical “peer” review for each significantly involved provider identified in the claim. For example, if a general surgeon and a family practice provider were significantly involved in the claim, a surgery review and a family practice review would be completed. This also applies to non-privileged healthcare professionals who are identified as significantly involved (i.e., nurses, medical technicians, or pharmacy technicians).

8.9.2. The expert medical reviewer performs the following actions:

8.9.2.1. Validate the provider(s) identified by the MTF is/are significantly involved.

8.9.2.2. Provide a medical opinion and definitive SOC determination.

8.9.2.3. Prepare a written review according to format requested by the MLC.

8.9.2.4. Send SOC written report to the MLC by agreed suspense date (usually within 14 calendar days of case receipt).

8.9.3. If the expert identifies additional providers who are significantly involved, then the MLC will notify the MTF where the claim originated and the MTF will prepare a DD Form 2526 on each additional provider, as outlined in paragraph **8.6.4**.

8.9.4. The MLC reviews the case and writes a legal opinion, based on the expert review. This determination and a short statement of the rationale are annotated on DD Form 2526, Section 16(b)(1).

8.9.5. The MLC sends the following documents to the appropriate agencies:

8.9.5.1. MDG/CC. Each DD Form 2526 and redacted expert medical review. (The base claims officer will have an unredacted copy of the expert medical reviews if the MTF requires additional information from a review.) A cover letter will accompany the package informing the MDG/CC of their responsibility to notify the involved providers of the SOC determinations.

8.9.5.2. HQ MAJCOM/SG. Receives the same documents as the MDG/CC plus the MTF QI review and the MLC’s legal review.

8.9.5.3. AFMOA/SGOC. A complete copy of the case file with each original DD Form 2526.

8.9.5.4. Base Claims Officer. The original case file with a copy of each DD Form 2526. If the case involves x-rays or other radiological evidence of which only one copy was made, this is sent back to the base claims officer.

8.10. Provider Notification of SOC Met Determination. The MTF/RM notifies providers who were found to meet the standard of care of the status of the case. **Attachment 24** should be used for this purpose. Providers must be informed that this is a *preliminary* SOC determination and the case will be subject to additional SOC reviews. They will be notified, in writing, if an adverse standard of care review is rendered during one of these subsequent case reviews. (Reference paragraph **8.14.**, External Review of Malpractice Claims.) AFMOA/SGOC takes no action to close the case until final legal closure (denial/payment or litigation closure) has been received.

8.11. Provider Notification of SOC Not Met Determination:

8.11.1. The MDG/CC or designee notifies, in writing, all significantly involved providers who were found to breach the standard of care. Providers who breached the standard of care are potential subjects of NPDB reports, should a payment be rendered in the claim. This notification occurs upon receipt of the MLC documents described in paragraph 8.9.5. Reasonable attempts should be made to notify providers who are no longer stationed at the MTF.

8.11.2. The MTF should notify AFMOA/SGOC, in writing, within 30 calendar days of receipt of the MLC documents, if they are unable to locate providers who have left their facility. AFMOA/SGOC will attempt to locate these providers.

8.11.3. Notification should be made by registered/certified mail to those providers no longer stationed at the MTF, to document receipt.

8.12. Provider Response to SOC Not Met Determination. If SOC is not met, the MDG/CC or designee must complete the following actions:

8.12.1. Notify the individual of his or her right to respond to the adverse SOC determination. Provide the following documents to the healthcare provider to accomplish the response:

8.12.1.1. SOC not met notification letter ([Attachment 24](#)).

8.12.1.2. Expert medical review with reviewer's names and locations redacted (blacked out).

8.12.1.3. DD Form 2526 specifying the standard of care determination.

8.12.2. For those providers who no longer work at the facility, the notification will be sent, by certified mail, to the last known address. If the MTF is unable to locate a provider, notify AFMOA/SGOC in writing as described in paragraph 8.10.2.

8.12.3. Significantly involved providers must notify the MDG/CC, in writing, of intent to respond, within 10 calendar days of notification of SOC determination, and may do so by endorsing the SOC notification letter. Providers may request copies of applicable medical records, monitoring strips, etc. needed to formulate a response to the claim. These records will be supplied by the MTF.

8.12.4. The MDG/CC or designee transmits the named provider's intent to respond, by facsimile, to AFMOA/SGOC, (Attn: Chief, Risk Management), within 5 duty days after receipt of the provider's letter of intent. The original letter is filed in the PCF.

8.12.5. If the staff member elects not to respond to the claim, AFMOA/SGOC will proceed with the malpractice claim review following final legal closure. Place waiver intention letter in the PCF and promptly send one copy to AFMOA/SGOC.

8.12.6. No further action will occur in the case until the HQ AFLSA/JACT closes the claim.

8.13. AFMOA/SGOC Processing of Provider Responses:

8.13.1. The named provider prepares a written response letter that address, at a minimum, the specific SOC deviations identified by the MLC expert medical reviewer. The provider may submit any other comments or documents desired. The written response should be received by AFMOA/SGOC within 30 calendar days of signing the response intent letter. The time limit may be extended by AFMOA/SGOC for good cause.

8.13.2. AFMOA/SGOC receives the response, obtains an additional expert medical review, and schedules an MPRB meeting. Board members review the case and make a final SOC determination and NPDB report recommendation to the Surgeon General.

8.14. Management of SOC Indeterminate. If the expert review of the claim finds SOC indeterminate for an individual provider, AFMOA/SGOC will manage the case in the following manner:

8.14.1. If standard of care is indeterminate due to unavailable medical records, or lack of provider involvement in which to make a standard of care determination, then this claim will be reviewed by another peer. If the second reviewer concurs, then a SOC indeterminate will be the final SOC.

8.14.2. If the SOC indeterminate was a result of one opinion that SOC was met and one opinion that SOC was not met, AFMOA/SGOC will obtain another SOC review.

8.14.3. If any of these methods results in an SOC not met determination, then AFMOA/SGOC will contact the individual providers, provide them a copy of the expert medical review with name and location of reviewer redacted (blacked out), and afford them an opportunity to respond to the claim.

8.15. External Agency Review of Medical Malpractice Claims.

8.15.1. AFMOA/SGOC will forward a copy of each paid claim, where an SOC is deemed to be met or a system problem is identified, to an external agency for review IAW DoD (Health Affairs) policy.

8.15.2. AFMOA/SGOC will receive a written report from the external agency with a standard of care determination. If the SOC is deemed to be not met by any individual provider(s), he or she will be contacted by AFMOA/SGOC and afforded an opportunity to respond to the claim, as outlined in paragraph [8.12](#).

8.15.3. The Air Force Surgeon General maintains sole responsibility for reporting malpractice claims to the NPDB.

8.16. Management of DD Form 2526, Case Abstract for Malpractice Claims:

8.16.1. AFMOA/SGOC will annotate claim status and final the SOC determination on the DD Form 2526. The form will be forwarded to the MTF risk manager, after completion of final SOC reviews and receipt of final legal closure.

8.16.2. The base claims officer will notify the MTF/RM or designee of final settlements when received.

8.16.3. The MDG/CC or designee will inform the involved providers of final SOC determination and claim status and provide them a copy of the form. The DD Form 2526 can be sent, by certified mail, to last known address, if the provider has separated. The MTF will be responsible for sending the DD Form 2526 to the appropriate base, if the provider has changed stations.

8.16.4. File the DD Form 2526 in the provider's credentials folder. Send non-privileged healthcare professional DD Form 2526 to the QSM/RM, or designee, to maintain a folder of risk management data in a secure location.

8.16.5. AFMOA/SGOC will notify all providers who submitted a written response of the final outcome of the claim, as outlined in paragraph [8.12](#). A copy of this notification will be sent to the MTF/RM.

8.17. NPDB Reporting. The USAF Surgeon General has sole responsibility for reporting malpractice cases to the NPDB except for those cases referred to in paragraph 8.25. By law, cases for damages are brought against the United States and not individual providers under the control of the United States. Due to these unique legal circumstances, DoD has a memorandum of understanding (MOU) with the Department of Health and Human Services to identify significantly involved providers and to make standard of care determinations for those providers, before reports are made to the NPDB. Significantly involved providers are expected to work openly and honestly with the military attorneys. However, the attorneys work for the United States and are not personal attorneys for the involved provider.

8.17.1. Reports are made to the NPDB when the Surgeon General determines that a claim was paid on behalf of a healthcare provider. The following conditions require reporting:

8.17.1.1. Standard of care is not met, and payment was made on behalf of an individual provider. A payment is considered on behalf of a provider if the provider was responsible for an act or omission that was the cause (or a major contributing cause) of the harm that gave rise to the payment.

8.17.1.2. A judicial determination of negligence is made (a judge names a specific healthcare provider as negligent and documents this in the final legal documents closing a lawsuit). This is a legally binding court ruling by a judge. In these instances, the provider is reported to the NPDB, regardless of standard of care.

8.17.2. Malpractice payment reporting to the NPDB applies to physicians, dentists, nurses, and any other healthcare provider who is required to possess a license, registration, or certification to perform patient care duties. A state or jurisdiction regulates these healthcare providers to perform healthcare duties.

8.17.3. All healthcare workers reported to the NPDB will be notified by AFMOA/SGOC of the report and will receive a copy of the report. The MTF will also obtain and maintain a copy of the NPDB report.

8.18. Reports to State Boards of Licensure. In every malpractice case, when a report is sent to the NPDB, a duplicate report is sent to the individual's state board(s) of licensure. Only AFMOA/SGOC may make a report to a state board of licensure, unless it specifically delegates that authority in specified circumstances.

8.19. 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 will be identified as significantly involved providers. Therefore, both healthcare trainees and clinical supervisors are afforded a right to respond to the claim as outlined in paragraph 8.12. The following guidance will be used in determining NPDB reporting of these providers.

8.19.1. If the Surgeon General determines that a payment was made for the benefit of a healthcare trainee, the attending practitioner responsible for the delivered care shall be reported to the NPDB. In such cases, the trainee will not be reported.

8.19.2. If the Surgeon General makes a specific finding that the attending practitioner clearly met all reasonable standards of supervision and the trainee's act or omission was not reasonably foreseeable by the attending practitioner, then the trainee (not the attending practitioner) will be reported to the NPDB.

8.20. Provider Rights Related to Medical Malpractice Claims:

8.20.1. Right to Notification. The MDG/CC and MTF risk manager will make reasonable attempts to ensure providers are informed of the status of a claim. Provider notifications should be accomplished at the following intervals:

8.20.1.1. Upon identification of a potentially compensable event (reference paragraph 8.5.5.).

8.20.1.2. When a malpractice claim is filed (reference paragraph 8.6.3.).

8.20.1.3. When the SOC determination is sent to the MDG/CC by the MLC (reference paragraph 8.10.).

8.20.2. Right to Respond to a Claim. Each provider identified as being a potential subject of a NPDB report (SOC not met) will be afforded an opportunity to submit written comments on expert opinion made or rendered on his or her involvement in the case or to provide any other pertinent information. Opportunity to comment occurs before the Office of the Surgeon General's final review.

8.20.3. Right to Notification of Final Outcome. The MDG/CC or designee will notify providers of the final outcome of malpractice claims. AFMOA/SGOC will notify any provider, who submitted a written response to a claim, of the final outcome; and will provide a copy of the NPDB report, where necessary. A copy of this notification will be sent to the MTF/RM.

8.21. MTF Actions when Providers Separate while a Malpractice Case is Under Review:

8.21.1. Separating staff members with malpractice claims pending must provide the credentials manager with a permanent address (home of record), phone number, and all active/inactive state license numbers. This information should be maintained in CCQAS.

8.21.2. If the base closes under base realignment and closure (BRAC), the MDG/CC or designee must ensure the entire claim file is sent to the HQ MAJCOM/SG with the current address, phone number, and states of licensure of the healthcare worker.

8.22. Provider Responsibility for Notifying Future Employers of Malpractice Claims. Regardless of the outcome of a malpractice case or SOC determination, healthcare workers must disclose involvement in malpractice claims, as required by licensing or clinical privileging entities. Although claims are filed against the government and not against individual providers, a provider must disclose that he or she was significantly involved in a claim filed against the USAF.

8.23. Providers With Multiple SOC Not Met Determinations. The chief of the medical staff will be notified on any privileged provider who was involved in more than one malpractice claim in 3 years where SOC was breached. A review of the provider's practice may be considered appropriate. At any point, if the breaches in SOC give rise to consideration of adverse privilege action, then the procedures in [Chapter 7](#) would apply. AFMOA/SGOC may identify malpractice claim trends to the MTF to initiate a provider review.

8.24. Non-personal Services Contract Providers. AFMOA/SGOC has no authority to report these providers to the NPDB for malpractice claims payment because they are independent contractors and not DoD employees. The Air Force does not provide liability coverage (insurance) for these providers and, therefore, has no jurisdiction regarding NPDB reporting for medical malpractice. AFMOA/SGOC will

notify the MDG/CC of the final standard of care determination. The MDG/CC will notify the QAE for the contract.

8.25. 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 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.

Section 8C—Medical Incident Investigation (MII)

8.26. Reporting Exemptions and Purpose. The reporting requirements in this section are exempt from licensing IAW AFI 37-124, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections*, Paragraph 2.11.8. The purpose of an MII is to promote safety and to improve care. MIIs are protected from disclosure under 10 U.S.C. 1102.

8.27. Areas of Responsibility:

8.27.1. AFMOA/SGOC:

8.27.1.1. Analyzes incident data for systemic and other problems and reviews preventive and corrective actions posed by investigators; recommends appropriate policy for the MTF and the HQ MAJCOM involved; and, possibly, for the entire Air Force. May make recommendations to the ASD(HA).

8.27.1.2. Disseminates MII lessons learned to the field, using AFMOA/SGOC home page or the HQ USAF/SG NOTAM format.

8.27.1.3. Requests follow-up from the HQ MAJCOMs, as required, assists the HQ MAJCOMs with implementation of recommendations.

8.27.1.4. Notifies the HQ USAF/IG of incidents, when directed or as appropriate.

8.27.1.5. Authorizes release or disclosure of an MII report, as specified by the Privacy Act of 1974 and 10 U.S.C. 1102.

8.27.1.6. Disposes of reports 10 years after validation. Reports include MII executive summary, tabs I through L of the MII, any follow-up reports requested from the MTF or the HQ MAJCOM/SG. The rest of the file may be disposed of in 2 years, unless the Freedom of Information Act prevents destruction of the report. If so, destroy the file after compliance with the Freedom of Information Act is achieved (6 years).

8.27.2. Major Command Surgeon:

8.27.2.1. Determines the scope of, and indications for, the HQ MAJCOM/SG-directed MII.

8.27.2.2. Promptly reports events to AFMOA/SGOC, using format in [Attachment 28](#) within 3 duty days of becoming aware of an incident.

8.27.2.3. Initiates MII within 30 calendar days of the incident, or 30 calendar days of receiving MII request. If the event is determined to be a JCAHO reportable sentinel event, the MII team should arrive before the root cause analysis (RCA) is sent to JCAHO to assist the RCA team in review of the event.

8.27.2.4. Appoints medical incident investigators, based upon the types of personnel who cared for the patient, the issues involved in the event (may consider HQ MAJCOM or HQ USAF/SG consultants), and the overall objectivity, including consideration of potential command concerns.

8.27.2.5. Determines how to fund the investigation.

8.27.2.6. Analyzes incidents for systemic and other problems and implements preventive and corrective action in the HQ MAJCOM/SG.

8.27.2.7. Sends a copy of the report, with accompanying executive summary, to AFMOA/SGOC within 10 calendar days of completion of report, but no later than (NLT) 180 calendar days after the incident or request for MII.

8.27.2.8. Prepares a briefing (PowerPoint slide presentation) to present the findings of the MII to the HQ USAF/SG. Submits the briefing slides to AFMOA/SGOC with the MII report. **NOTE:** The briefing preparation may be delegated to the MII investigator(s).

8.27.2.9. Consults with AFMOA/SGOC regarding MII briefing procedures for the HQ USAF/SG. Coordinates and schedules briefing with the HQ USAF/SG, if required.

8.27.2.10. Disposes of the HQ MAJCOM/SG copy 2 to 6 years after the date of the report or when no longer needed, whichever comes later.

8.27.2.11. Consults with AFMOA/SGOC regarding any requests to release or disclose information from MIIs to ensure quality assurance protection is maintained. Forwards requests for release of information to AFMOA/SGOC, when requested.

8.27.3. MDG/CC and MTF Risk Manager:

8.27.3.1. Reports each medical incident or request for an MII to the HQ MAJCOM/SG, by telephone, within 24 hours of becoming aware of the incident.

8.27.3.2. After consultation with the HQ MAJCOM/SG, initiates JCAHO reporting of appropriate sentinel event, and begins appointing RCA team members.

8.27.3.3. Directs an MTF QI review, as outlined in paragraph 8.5., for any incident that may lead to a claim being filed.

8.27.3.4. Designates MTF POC for MII team support (report preparation, transportation, etc).

8.27.3.5. Makes determination as to whether the involved person or allegedly injured party was under the care of Air Force medical services. For example, this determination is needed before initiating an MII on a suicide victim.

8.27.3.6. Briefs installation commander on incident initially, and upon completion of investigation. Presents interim updates, as appropriate.

8.27.3.7. Notifies the supporting MLC or SJA of any incident that could result in a claim, litigation, or disciplinary or adverse action against medical personnel.

8.27.3.8. Maintains the evidence. Such information will not be maintained under any individual's name or personal identifier. It may be filed by type of incident and date. If the Office of Special Investigations (OSI) or the SJA become involved, they may maintain the evidence.

8.27.3.9. Dispose of MTF copy of the MII file 2 years after validation of the report or when no longer needed, whichever is later. Lessons learned may be kept for quality purposes up to 6 years or as long as needed.

8.27.3.10. Follows DoD directives and AFIs governing release of information from MIIs, consulting with the SJA as necessary. Sends written petitions to the SJA to prevent impounding of medical records by legal personnel or may designate chief, mental health, to petition against impounding.

8.27.3.11. Determines the types of providers who should investigate the incident and communicates this to the HQ MAJCOM/SG.

8.27.3.12. Ensures involved individuals are offered initial or acute post traumatic stress intervention, following catastrophic events.

8.27.3.13. Modifies, revises, or corrects disciplinary or adverse actions already taken, if findings and conclusions of MII undermine their fairness.

8.28. Major Incidents Suggesting an MII. The decision to initiate an MII rests with the MDG/CC, based upon HQ MAJCOM/SG guidance, or may be requested by higher headquarters. The following is a list of the kinds of incidents that would warrant initiation of an MII. This list is not all-inclusive:

8.28.1. Those incidents where a full objective evaluation cannot be accomplished internally at the MTF or base level.

8.28.2. An unexpected or preventable death, a significant injury, self-inflicted harm, or attempted/actual suicide while under the care of military Air Force medical services. This includes individuals released from mental health facilities or those individuals participating in an outpatient drug or alcohol substance abuse program. The initial determination of what constitutes an unexpected death, or constitutes being under the care of military medical services, rests with the MDG/CC who consults with the HQ MAJCOM/SG as needed.

8.28.3. 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 MDG/CC or HQ MAJCOM/SG, deserves a formal investigation.

8.28.4. Those incidents where the findings of such an investigation are likely to be applicable throughout a MAJCOM or on an Air Force-wide basis.

8.29. Medical Incident Investigators. A multidisciplinary team approach, depending on the issue, is the preferred method to evaluate a system of care. Whether there is a sole inquiry officer or team, each MII must clearly define the problem, focus the inquiry, and set boundaries. The investigation should begin within 30 calendar days of the incident or receipt of request for MII. The primary focus of the MII is on how the system contributed to the outcome; however, investigators are not restricted from commenting on the appropriateness of care delivered by individual providers or services. The investigator should:

8.29.1. Complete a thorough and unbiased investigation, as discussed in paragraph 8.29., and prepare a final report, as outlined in [Attachment 25](#).

8.29.2. Finalize report before departure from the base, leave one copy with the MDG/CC, and send the original plus one copy to the HQ MAJCOM/SG. Exceptions to finalizing report before departure from the base may be made by the HQ MAJCOM/SG.

8.29.3. Brief the MDG/CC before and after an investigation. Provide the MDG/CC with a copy of the written report, usually during the out-brief, after the investigation is complete.

8.29.4. Turn over the evidence (e.g., medical records, x-rays, equipment, tissue samples) to the MDG/CC 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.

8.30. Selection of Medical Incident Investigators. The medical incident investigator:

8.30.1. Is not on staff at the MTF where the incident occurred.

8.30.2. Does not have a personal interest in the investigation and can act impartially.

8.30.3. Is a competent medical person with appropriate and current experience.

8.30.4. Performs no other duties during an investigation.

8.30.5. Should be board certified, if appropriate.

8.30.6. Should have similar experience as those personnel involved in the medical incident.

8.31. Medical Incident Investigation Process. Several factors influence the scope of the investigation, including the severity of the injury and the possibility of recurrence. Minimum factors on which an investigator will obtain information and should consider in the final report are:

8.31.1. Human Factors:

8.31.1.1. Training/Licensure/Certification/Clinical Competency. Determine this for each provider/staff member involved. Was a regular peer review system in place? Were providers appropriately privileged and/or operating within their scope of practice? Were any individuals on orientation or requiring direct supervision to perform tasks? If so, were they appropriately supervised according to MTF regulations? Were medical residents appropriately supervised by teaching staff? Were staff members appropriately prepared to assume responsibilities? Review of education records may be helpful.

8.31.1.2. Knowledge by MTF Staff of Related Hospital and/or AFIs, Standards, National Guidelines. Were the instructions followed as written? Were the instructions adequately written to reflect appropriate care standards? What mechanism is used by the facility to educate staff on policies/procedures? Was this mechanism adequate/ appropriate?

8.31.1.3. Discipline. Did any of the providers have an adverse action underway, pending, or a previous adverse peer review finding? UCMJ action?

8.31.1.4. Fatigue. Review MTF policies on "crew rest," off-duty employment, schedules, and time off to determine if a fatigue factor was present. Include any lengthening of duty schedules or duty hours related to MTF deployments, medical readiness exercises, or unanticipated increases in workload or acuity.

8.31.1.5. Judgment. How were patient care decisions made? Were decisions reasonable? Based on available information? Did the provider(s) have adequate experience with the diagnosis/medical condition or was this a rare event? What mechanism was in place to refer the patient to a higher level of care? Was this mechanism adequate?

8.31.1.6. Stress. Explore individual stress level and the organizational stresses that were in place at the time of the incident to include staff turnover, increased workload, perceptions of support within management, etc.

8.31.1.7. Motivation. Consider factors such as low morale, the role of senior staff, and/or management/supervision in this assessment.

8.31.1.8. Influence of Drugs or Alcohol. Consider any impaired provider issues related to the delivery of care during the event.

8.31.2. Operational and Systemic Factors:

8.31.2.1. Communications. Include availability of clear, consistent, written guidance and communication among team members and consulting providers, etc. Explore both lateral communication (among peers, for example) and communication up the chain of command. Were the orientation, education, and training processes adequate?

8.31.2.2. Use of the MTF's Quality Improvement Program. Previous staff assistant visits for same or similar problems and most recent JCAHO/HSI inspection results to include Type I write-ups that are pertinent to the investigation.

8.31.2.3. Adequate Technical Data on Use of Biomedical Equipment. Copies of maintenance and safety reports, any notices of recall, any information indicating that the equipment frequently malfunctioned, etc.

8.31.2.4. Adequate Procedures for Accomplishing a Task. Review MTF processes and procedures, and formal vs. informal guidelines for accomplishing a task.

8.31.2.5. Adequate and Consistent MTF and HQ MAJCOM Command and Control (Supervision). Availability of telephone or electronic mail consultations when questions arise, distribution of related instructions, standards, and clinical guidelines.

8.31.2.6. Unit Staffing and Scheduling. Staffing adequacy to meet patient care demands, any evidence of short staffing, skill mix of staff assigned, etc. Review duty schedules and provider on-call schedules. What backup was available for providers who were on call? Was it a weekend or normal duty hours?

8.31.2.7. Requirement to Exceed Standard Productivity. Evidence of organizational requirement to exceed productivity, documentation that department or section is undermanned, etc.

8.31.2.8. Design Deficiency. Review layout of work area, location of supplies and equipment, familiarity of personnel with location of same, task interruptions that could be a factor. Also consider factors such as temperature and noise level.

8.31.2.9. Factors Related to the Function of the System as a Whole. Explore breakdowns in reporting, information tracking, specimen handling, case scheduling, follow-up procedures, or management failure concerning training, coordination, materiel, or supplies etc. How are patient

transferred to tertiary care? Where are the civilian hospital located? What were the weather conditions during the event?

8.31.2.10. Corporate Culture. Explore functioning within the system that may impact the performance or decisions of individuals; for example, relationship of physician staff with non-physician staff, methods of consulting for specialty services, appropriate coordination of care among physicians and non-physicians, evidence of members being afraid to ask for help, etc.

8.31.3. Witnesses. There is no requirement to tape record or to transcribe witness interviews. Investigators may summarize the interviews in an MII review.

8.31.3.1. Include those involved in the incident, those who saw or heard it, and those whose training and experience qualify them as experts. **NOTE:** Coworkers, family, and friends may be appropriate witnesses in certain incidents, especially suicides.

8.31.3.2. Are not required to testify under oath and are not sworn in.

8.31.3.3. Must be advised, before giving an interview, of the purpose of the investigation and the limited confidentiality of their statements.

8.32. Possible Criminal Behavior. If criminal behavior is potentially involved, consult the SJA for assistance on advisement of rights (Article 31, UCMJ; or Fifth Amendment) and/or coordinate with the Air Force OSI before interviewing the individual. If the interviewee does not object, advise the individual(s) of their rights and conduct interviews only if the individuals waive their rights and agree to the interviews.

8.32.1. 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 follow the procedures in paragraph **8.32**.

Section 8D—Sentinel Events

8.33. General. The ASD(HA) has directed MTFs to participate in the JACHO sentinel event (SE) program. Accredited organizations are to identify and respond appropriately to all SEs occurring in the MTF. In addition to reporting the event to JCAHO, an appropriate response includes a thorough and credible RCA, implementation of improvements to reduce risk, and monitoring the effectiveness of those improvements. The goal of the program is to reduce injuries suffered by patients in healthcare organizations. SEs do not automatically trigger the need for an MII; the MDG/CC makes that decision (Refer to MII/SE Table 8.1. in **Attachment 26**). SE information is protected from disclosure under 10 U.S.C. 1102.

8.33.1. An organization's activities in response to SEs will be routinely assessed as part of all triennial and random unannounced JCAHO surveys.

8.33.2. JCAHO will protect all information sent to them as "nondisclosable information" and will return all documents to the facility at the end of the case review.

8.34. Definition. As defined by JCAHO, a *sentinel event* is an unexpected occurrence or variation involving death, serious physical or psychological injury, or the risk thereof. Serious injury includes loss of limb or function. The phrase *or risk thereof* includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Any staff member who feels that he or she has witnessed a possible sentinel event has the responsibility to report the event to the quality services

manager/risk manager, in addition to completing the appropriate risk identification forms (e.g. incident reports).

8.34.1. Examples of Reportable Sentinel Events:

8.34.1.1. Unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition (loss of function means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or life-style change lasting beyond 2 weeks).

8.34.1.2. Suicide of an inpatient.

8.34.1.3. Infant abduction or discharge to the wrong family.

8.34.1.4. Rape (consistent with applicable law and regulation).

8.34.1.5. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

8.34.1.6. Surgery on the wrong patient or wrong body part regardless of the magnitude of the procedure.

8.35. Responsibilities of Sentinel Event Reporting:

8.35.1. MDG/CC and MTF/RM Responsibilities:

8.35.1.1. Establish an organizational culture conducive to the identification, reporting, analysis, and prevention of sentinel events.

8.35.1.2. Develop a SE reporting plan prior to SE occurrence.

8.35.1.3. Notify the HQ MAJCOM quality manager/risk manager promptly to confirm that an event meets JCAHO's SE criteria. If in doubt, call JCAHO's sentinel event hotline for guidance at (630) 792-3700.

8.35.1.4. Report a SE to JCAHO, within 5 business/duty days of its occurrence or its discovery by the organization. Implement the MTF's plan and establish a multidisciplinary RCA team within 3 business/duty days of the event, per JCAHO guidelines.

8.35.1.5. Send the final RCA and lessons learned to the HQ MAJCOM/SG for review, prior to sending the RCA to JCAHO.

8.35.1.6. Send the RCA, with action plan and evaluation methodology, to JCAHO within 45 calendar days of the initial sentinel event reporting.

8.35.1.7. Implement the system and process improvements in the action plan

8.35.1.8. Send six-month follow-up of corrective action plan to the HQ MAJCOM/SG for review, prior to sending it to JCAHO.

8.35.1.9. Ensure widest dissemination of SE alert bulletins and ensure corrective actions are in place to prevent similar SEs from occurring at the MTF.

8.35.1.10. Maintain sentinel event files in the quality/risk management office for a minimum of 5 years.

8.35.2. RCA Team Responsibilities. The team will:

8.35.2.1. Conduct a thorough internal in-depth review of the event, focusing on potential system or process problems. If an MII team is assigned to the event, the RCA team should outbrief the MII team daily.

8.35.2.2. Develop an action plan, based on the RCA findings, to make system or process improvements. The RCA may also determine that, after analysis completion, no such improvement opportunity exists.

8.35.2.3. Design a method to evaluate the effectiveness of the recommended improvements.

8.35.2.4. Submit the RCA to the MDG/CC for initial and final review.

8.35.3. HQ MAJCOM/SG Responsibilities:

8.35.3.1. Provide SE reporting guidance to the MDG/CC.

8.35.3.2. Using [Attachment 28](#), notify AFMOA/SGOC of the SE occurrence within 3 duty days of becoming aware of the event.

8.35.3.3. Review/approve the RCA prior to it being sent to JCAHO.

8.35.3.4. Forwards copies of RCA, action plan, evaluation methodology, and lessons learned to AFMOA/SGOC.

8.35.3.5. Forwards SE information to AFMOA.SGOC quarterly, as directed.

8.35.4. AFMOA/SGOC Responsibilities:

8.35.4.1. Maintains AF sentinel event database.

8.35.4.2. Send copy of completed RCA to the AFIA/SG.

8.35.4.3. Publishes lessons learned using multiple AF channels to disseminate widely.

8.35.5. AFIA Responsibility. The AFIA evaluates how MTFs are implementing and managing the sentinel event program.

Section 8E—Dissemination of Risk Management Lessons Learned to the Field

8.36. General. A NOTAM will be released to the Air Force medical community by AFMOA/SGOC as a means of identifying clinical concerns and lessons learned from malpractice claims, adverse actions, MIIs and SEs. A NOTAM may be released for any topic of high interest within the AFMS. Upon receipt, the MTF Risk Manager/Quality Services Manager will disseminate the NOTAM throughout the facility. A notebook will be maintained with a printed copy of each NOTAM that will serve as a reference for staff members and as a mandatory review item during orientation for newcomers assigned to the MTF. The responsibilities for NOTAM generation and dissemination are discussed below. MTFs are encouraged to review the suggested risk reduction strategies and incorporate quality improvement changes into their current programs/processes as needed.

8.37. Responsibilities in NOTAM Dissemination:

8.37.1. AFMOA/SGOC (Chief, Risk Management Operations):

8.37.1.1. Reviews malpractice claims, adverse actions, MIIs, and root cause analyses to identify lessons appropriate for field deployment.

8.37.1.2. Receives request from the field, the HQ MAJCOM/SG, or the HQ USAF/SG to submit a NOTAM on a subject.

8.37.1.3. Drafts NOTAM and coordinates with appropriate subject matter expert(s).

8.37.1.4. Releases NOTAM electronically to the HQ USAF/SG staff, the HQ MAJCOM/SG quality staff, the HQ Corps Chiefs, the General Officer Roundtable, and the SGH mail group.

8.37.1.5. Posts NOTAM on AFMOA/SGOC Homepage.

8.37.2. HQ MAJCOM/Quality:

8.37.2.1. Primary point of contact within command for dissemination of NOTAM to the HQ MAJCOM/SG and staff.

8.37.2.2. Upon receipt of NOTAM from AFMOA/SGOC, disseminates to the MTF/RM point of contact within each command.

8.37.2.3. Participates in the dissemination of lessons learned by submitting NOTAM subjects to AFMOA/SGOC, as needed.

8.37.2.4. Ensures each MTF within command receives and distributes NOTAM for maximum dissemination.

8.37.2.5. Forwards MTF quality improvement initiatives made in response to NOTAM to AFMOA/SGOC for inclusion on the home page.

8.37.3. MTF Risk Manager/Designee. (Primary point of contact within the MTF for NOTAM receipt and dissemination.)

8.37.3.1. Ensures widest dissemination possible.

8.37.3.2. Reviews each NOTAM, evaluates quality assurance suggestions or risk reduction strategies, reviews current MTF policy or program, suggests changes to reduce MTF risk, if needed.

8.37.3.3. Ensures NOTAM is posted in each work area for staff members and reservists to review before rendering patient care. NOTAM review will be part of the orientation of new staff.

8.37.3.4. Maintains a copy of each NOTAM for a minimum of 3 years. Forward any NOTAM generated quality improvement initiatives to the HQ MAJCOM/SG quality offices, as directed.

8.37.3.5. Discusses NOTAM at the next ECOMS.

8.37.4. Senior Corps Representative. Upon receipt of NOTAM, the senior corps representative ensures dissemination within the HQ MAJCOM and/or the MTF regarding specific clinical subject matter.

8.37.5. Commander. The commander ensures the MTF implements the NOTAM program, as directed.

Section 8F—Forms Prescribed in this Instruction

8.38. Forms Prescribed 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, Credentials Privilege List - Dental

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

AF Form 1540A, Application for Clinical Privileges 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, Credentials Privilege List - Internal Medicine

AF Form 2816, Credentials Privilege List - Family Practice, Primary Care, Aerospace Medicine

AF Form 2817, Privilege List - Pediatrics

AF Form 2818-1, Privilege List - General Surgery

AF Form 2818-2, Privilege List - Credential Privilege List - Orthopaedic Surgery

AF Form 2818-4, Privilege List - Cardiovascular Surgery

AF Form 2818-5, Privilege List - Vascular Surgery

AF Form 2818-6, Privilege List - Urologic Surgery

AF Form 2818-7, Privilege List - Neurological Surgery

AF Form 2818-8, Privilege List - Otolaryngology Surgery

AF Form 2818-9, Privilege List - Ophthalmology Surgery

AF Form 2818-10, Privilege List - Plastic Surgery

AF Form 2819, Credentials Privilege List - Anesthesiology

AF Form 2820, Credentials Privilege List - Obstetrics/Gynecology

AF Form 2821, Credentials Privilege List - Emergency Medicine

AF Form 2822, Credentials Privilege List - Neurology

AF Form 2823, Credentials Privilege List - Dermatology

AF Form 2824, Credentials Privilege List - Mental Health

AF Form 2825, Privilege List - Radiology

AF Form 2826, Credentials Privilege List - Pathology

AF Form 2827, **Privilege List - Physical Therapy**

AF Form 2828, **Credentials Privilege List - Occupational Therapy**

AF Form 2829, **Privilege List - Podiatry**

AF Form 2830, **Credentials Privilege List - Optometry**

AF Form 3928, **Privilege List - Audiology**

AF Form 3929, **Privilege List - Speech Pathology**

AF Form 3930, **Privilege List - Dietetics**

AF Form 4172, **Credentials Privilege List - Clinical Pharmacist**

NGB Form 244, **Clinical Privilege List - Dental**

NGB Form 2816, **Clinical Privilege List - Physician Assistant and Primary Care Nurse Practitioner**

NGB Form 2830, **Clinical Privilege List - Optometry**

NGB Form 2831, **Clinical Privilege List - Physician**

NGB Form 2834, **Clinical Privilege List - Mental Health**

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Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

Fifth Amendment

Freedom of Information Act

Privacy Act of 1974

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*

Title 42, United States Code, Chapter 117, *Encouraging Good Faith Professional Review Activities*, Sections 11101-11152

21 Code of Federal Regulations (CFR), Part 900

Uniform Code of Military Justice (UCMJ), Article 31

DoDD 6025.6, *Licensure of DoD Health Care Providers*, 6 Jun 88 (incorporated into DoDD 6025.13)

DoDD 6025.13, *Clinical Quality Management Program (CQMP) in the Military Health Services System (MHSS)*, 20 Jul 95

DoDD 6025.14, *Department of Defense Participation in the National Practitioner Data Bank (NPDB)* 1 Nov 90

DoDD 6040.37, *Confidentiality of Medical Quality Assurance (QA) Records*, 9 Jul 1996

DoDI 1402.5, *Criminal History Background Checks on Individuals in Child Care Services*, 19 Jan 93

DoDI 6025.13, *Clinical Quality Management Program (CQMP)*

DoDI 6025.15, *Implementation of Department of Defense Participation in the National Practitioner Data Bank*, 9 Nov 92

AFPD 44-1, *Medical Operations*

AFI 33-332, *Air Force Privacy Act Program*

AFI 36-704, *Discipline and Adverse Actions*

AFI 36-2005, *Appointment in Commissioned Grade and Designation and Assignment in Professional Categories--Reserve of the Air Force and United States Air Force*

AFI 36-2101, *Classifying Military Personnel (Officers and Airmen)*

AFMAN 36-2105, *Officer Classification*

AFI 36-2201, *Developing, Managing, and Conducting Training*

AFMAN 36-2247, *Planning, Conducting, Administering, and Evaluating Training*

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*

AFI 37-124, *The Information Collections and Reports Management Program; Controlling Internal, Public, and Interagency Air Force Information Collections.*

AFI 37-138, *Records Disposition--Procedures and Responsibilities*

AFMAN 37-139, *Records Disposition Schedule*

AFI 38-202, *Air Force Management Headquarters and Headquarters Support Activities*

AFI 41-104, *Professional Board and National Certification Examinations*

AFI 41-109, *Special Pay for Health Professionals*

AFI 41-117, *Medical Service Officer Education*

AFI 41-117 ANG SUP1, *Medical Service Officer Education, Air National Guard*

AFI 44-102, *Community Health Management*

AFI 44-103, *The Air Force Independent Duty Medical Technician Program and Medical Support for Mobile Medical Units/Remote Sites*

AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*

AFI 44-135, *Clinical Dietetics*

AFI 47-101, *Managing Air Force Dental Services*

AFI 51-302, *Medical Law*

AFI 51-501, *Tort Claims*

ANGI 36-2005, *Appointment of Officers in the Air National Guard of the United States and as Reserves of the Air Force, 15 Mar 99*

ANGI 41-102, *Early Appointment Program for Physicians, 30 Oct 95*

ANGI 41-103, *Medical Support to Geographically Separated Units (GSUs), 14 Jul 98*

ANGI 41-104, *ANG Medical Service Function and Emergency Response Capability, 31 Mar 96*

ANGR 36-05, *Administrative Separation/Discharge of Commissioned Officers and Warrant Officers of the Air National Guard of the United States (rescinded and incorporated in AFI 36-3209)*

Objective Medical Group Implementation Guide (First Revision), Dec 96

Health Affairs Policy Memorandum, *"Criminal History Background Checks on Health Care Personnel," 20 Apr 92*

Abbreviations and Acronyms

AADE—American Association of Dental Examiners

ABMS—American Board of Medical Specialties

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
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
AFMSA—Air Force Medical Support Agency
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
AMA—American Medical Association
ANG—Air National Guard
ANG/SG—Air National Guard Air Surgeon
ANG/SGSE—Air National Guard Executive Services Branch
AOA—American Osteopathic Association
ARC—Air Reserve Components
ARPC—Air Reserve Personnel Center
ASA—American Society of Anesthesiologists
ASD(HA)—Assistant Secretary of Defense for Health Affairs
ATLS—Advanced Trauma Life Support
BLS—Basic Life Support
BRAC—Base Realignment and Closure
BSC—Biomedical Services 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
CAMAC—Comprehensive Accreditation Manual for Ambulatory Care
CAMH—Comprehensive Accreditation Manual for Hospitals
CAP—College of American Pathologists
CC—Commander
CCQAS—Centralized Credentials Quality Assurance System
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
CME—Continuing Medical Education
CNM—Certified Nurse Midwife
COT—Commissioned Officer Training
CPR—Cardiopulmonary Resuscitation
CQMP—Clinical Quality Management Program
CRNA—Certified Registered Nurse Anesthetist
DC—Dental Corps
DEA—Drug Enforcement Administration
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
DSN—Defense Switched Network
DTF—Dental Treatment Facility

ECFMG—Educational Commission for Foreign Medical Graduates

ECOMS—Executive Committee of the Medical Staff

ERS—External Resource Sharing

ESD—Emergency Services Department

FAP—Family Advocacy Program

FNP—Family Nurse Practitioner

FSC—Family Support Center

FSMB—Federation of State Medical Boards

GME—Graduate Medical Education

GMO—Graduate Medical Officer

GSU—Geographically Separated Unit

HA—Health Affairs

HAWC—Health and Wellness Center

HIPDB—Healthcare Integrity and Protection Data Bank

H&P—History and Physical

HPSP—Health Professions Scholarship Program

HQ—Headquarters

IAW—In Accordance With

ICTB—Interfacility Credentials Transfer Brief

IDMT—Independent Duty Medical Technician

IG—Inspector General

IMA—Individual Mobilization Augmentee

IRB—Investigational Review Board

JACT—Tort Claims and Litigation Division

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

JQS—Job Qualification Standard

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
MHSS—Military Health Services System
MII—Medical Incident Investigation
MLC—Medical Law Consultant
MNT—Medical Nutrition Therapy
MOU—Memorandum of Understanding
MPRB—Medical Practice Review Board
MQSA—Mammography Quality Standards Act
MSA—Medical Staff Appointment
MSW—Master of Science in Social Work
MTF—Medical Treatment Facility
NALS—Neonatal Advanced Life Support
NAPNAP—National Association of Pediatric Nurse Associates and Practitioners
NC—Nurse Corps
NCSBN—National Council of State Boards of Nursing
NCQA—National Committee for Quality Assurance
NGB—National Guard Bureau
NLT—No Later Than
NMS—Neuromusculoskeletal
NOTAM—Notice to Airmen
NP—Nurse Practitioner
NPDB—National Practitioner Data Bank
NREMT—National Registry of Emergency Medical Technicians
NTP—Nurse Transition Program
OASD—Office of Assistant Secretary of Defense
OSI—Office of Special Investigations
OT—Occupational Therapy
PA—Physician Assistant
PAF—Provider Activity File
PALS—Pediatric Advanced Life Support

PCF—Provider Credentials File
PCS—Permanent Change of Station
PEB—Physical Evaluation Board
PG—Postgraduate
PHD—Doctor of Philosophy
PI—Performance Improvement
PMT—Performance Measurement Tool
PNP—Pediatric Nurse Practitioner
POC—Point of Contact
PSV—Primary Source Verify/Verification
PSYD—Doctor of Psychology
P&T—Pharmacy and Therapeutics
QA—Quality Assurance
QAE—Quality Assurance Evaluator
QI—Quality Improvement
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
RM—Risk Management/Manager
RN—Registered Nurse
RSG—Regional Support Group
SAS—State Air Surgeon
SE—Sentinel Event
SG—Surgeon General
SGD—Dental Surgeon
SGH—Chief of the Medical Staff
SGOC—Clinical Quality Management Division
SGSLC—Medical Logistics Division, Contracting Branch

SJA—Staff Judge Advocate

SME—Squadron Medical Element

SOC—Standard of Care

SSN—Social Security Number

UCMJ—Uniform Code of Military Justice

UM —Utilization Management

USAF—United States Air Force

HQ USAF/SG—Air Force Surgeon General

USMLE—United States Medical Licensing Exam

UTA—Unit Training Assembly

VA—Department of Veterans Affairs

WHNP—Women’s Health Nurse Practitioner

WIC—Women, Infants, and Children

Terms

Abeyance —The temporary removal of a privileged provider from some or all clinical duties while a peer review or inquiry is done. Abeyance is valid for 30 calendar days, but the MDG/CC may grant a single extension of 30 additional calendar days. After that, the action automatically becomes a suspension of privileges. An abeyance is not an adverse clinical privilege action and need not be disclosed as such.

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 Practice Action —An action against the practice of a non-privileged healthcare professional. The practice may be restricted, reduced, or revoked, based upon misconduct, impairment, or lack of professional competence. An adverse action can only be imposed by the MDG/CC after the opportunity for a hearing has been afforded.

Adverse Privilege Action —Privileges are denied, suspended, restricted, reduced or revoked based upon provider misconduct, impairment, or lack of professional competence. An adverse action can only be imposed by the MDG/CC.

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 database maintained in each MTF credentials office and centralized at AFMOA/SGOC. The CCQAS software assists the credentials managers with control of credentials, managing the credentialing/privileging process, reports, letter generation, PCSs, and interfacility transfer briefs. Managers at all levels also use the information in CCQAS for generating DoD and congressional reports, for personnel management, and for planning purposes. CCQAS will eventually include risk management and privileging modules so that essentially the entire quality assurance process is automated.

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 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*.

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>.

Clinical Supervisor —That person who provides professional review of the clinical activities of another. This may be the chief of service or senior staff member of like specialty or service. For purposes of completing the AF Form 22 and recommending clinical privileges on the AF Form 1540, 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 judge the practice of the provider under review.

Credentials —Documented evidence of licensure, certification, education, training, experience, or other qualification.

Credentials Review —The application and screening process whereby healthcare providers have their credentials evaluated before being selected for Air Force service, employed by the Air Force, granted clinical privileges, or assigned patient care responsibilities. 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.

Current Competence —The state of having adequate knowledge, skills, ability, and behaviors to perform the functions of a practitioner in a particular discipline. This is assessed by evaluations and recommendations from clinical supervisors and peers as well as the results of performance-improvement activities and demonstrated professional performance, clinical judgement and technical skills.

Denial of Privileges —Refusal to grant requested privileges. An adverse denial of privileges (i.e. based on misconduct or lack of professional competence, may only be imposed by a privileging authority after the opportunity for a hearing has been afforded.

Educational Commission for Foreign Medical Graduates (ECFMG) —Required for graduates of medical schools located outside the US, Puerto Rico, and Canada. Before awarding ECFMG certification, Since 1986, the ECFMG performs primary source verification of medical school graduation,

requires that the candidate passes 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 are verified through the Correspondence Department. The address of the Educational Commission for Foreign Medical Graduates is 3624 Market Street, 4th Floor, Philadelphia, PA 19104-2685; (215) 386-5900.

Fifth Pathway —Fifth Pathway certification is equivalent to an ECFMG certification. The Fifth Pathway program includes 1 year of supervised clinical education in a United States medical school for foreign medical graduates who have not previously completed a residency and is administered by the American Medical Association. For further information, contact the Department for International Foreign Medical Graduate Services at the American Medical Association; telephone (800)621-8335, extension 4677.

Healthcare Practitioner (LICENSED) —Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other authorization, as described in paragraph 3.2. of this instruction.

Healthcare Professional (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 as described in paragraph 5.5.4.

Impaired Provider/Healthcare Professional —A privileged provider or non-privileged healthcare professional 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.

Independent Privileges —Privileges that allow the holder to practice independently within the scope of care defined by the particular privileges granted. (Temporary privileges and regular privileges are examples of independent privileges, while supervised privileges are not.) Independent privileges also means that one may perform code “1” privileges without first consulting with a supervising provider. For example, even though nurse practitioners (NPs) and physician assistants (PAs) require a named physician supervisor who is responsible for providing oversight to their practice, NPs and PAs may independently perform those specific privileges granted as code “1.”

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.

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 health care 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. An 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 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 health care independently as a healthcare professional.

***Unrestricted license (for physicians)**—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.

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) —Monitoring and evaluation of care denotes actions taken to ensure a provider understands, and can render, appropriate care. M&E is not reportable to the National Practitioner Data Bank or regulatory agencies. M&E may include:

- a. Elements of indirect supervision such as retrospective or concurrent review of medical records.
- b. Verbally reviewing verbally with the provider the diagnosis, options, and decisions for care rendered by the provider on a sample of cases or on particular types of cases.
- c. Observing at least two significant tests of technical skill, if appropriate.

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 creation of the NPDB was an important step by the US government to enhance professional review efforts by making certain information concerning medical malpractice payments and adverse actions available to eligible entities and individuals.

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.

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) or national organization/agency that grants authority to provide health care independently in a specified discipline. This same US jurisdiction or national organization/agency also has the authority to revoke this permission to practice in the specified discipline. In the case where health care is provided in a foreign country by a person who is not a US national, “other authorizing document” means a grant of permission, and the authority to revoke permission, by an official agency of that foreign country for that person to provide health care independently in a specified discipline.

Peer —A provider of similar experience and clinical background.

Peer Review —The process by which healthcare providers of like or similar discipline evaluate the patient care of another provider and make determinations about the quality of that care.

Privileges —The limits of patient care services the provider may render. This permission to provide medical and other patient care services in the granting institution, within defined limits, is based on education, training, experience, health status, demonstrated current clinical competence, professional behavior, licensure, and certifying examination. Privileges may be granted with or without an accompanying medical staff appointment.

Privileging —The process whereby the MDG/CC or the MAJCOM/SG, upon recommendations from the MTF credentials function, grants privileges and responsibilities for providing 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.

Professional Review Process —The process by which healthcare providers/professionals of like or similar discipline evaluate the patient care of another provider and make recommendations to the MDG/

CC regarding clinical privileges or patient care removal. It is required for an adverse action as detailed in [Chapter 7](#). The credentials function evaluates privileged providers and an ad hoc peer review function evaluates non-privileged healthcare professionals.

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 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 Improvement Review of Malpractice Case—A process whereby administrative, patient care, lessons learned, and other information is extracted from the case review 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 healthcare professional's practice. A reduction can only be imposed by the MDG/CC after an opportunity for a hearing has been afforded.

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 a 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 healthcare professional has restoration of clinical privileges or practice. Reinstatement may include provisions for monitoring and evaluation to include 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 MDG/CC after an opportunity for a hearing has been afforded.

Revocation—An adverse action that permanently removes an individual from all patient care duties/privileges. A revocation may only be imposed by the MDG/CC after the opportunity for a hearing has been afforded.

Significantly Involved Provider—Healthcare workers who actively delivered care (based on medical record entries) in either primary or consultative roles during the episodes of care that gave rise to the allegation, regardless of standard of care 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).

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 determined by peer review.

Substandard Medical Practice or Care —Medical care rendered to a patient that fails to meet the standard of care.

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 may also be granted on the recommendation of the credentials function to newly trained providers who do not have an adequate period of supervised clinical practice in their background; to those providers whose duty has not included clinical medicine for a period of 2 years or more; or to those providers in an orientation period required to assess competency. Supervised privileges may be granted for up to 2 years. 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:

- a. **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.
- b. **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.

Suspension —An adverse action to temporarily remove or restrict all or a portion of a privileged practitioner's clinical privileges, pending investigation, reevaluation, rehabilitation, targeted training, or more permanent action. Suspensions must be disclosed by the provider when applying for future privileges, licensure/certification/registration, or insurance.

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 5.18.2. 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

**INFORMATION CONTAINED IN AF FORM 1540A,
APPLICATION FOR CLINICAL PRIVILEGES UPDATE
(THIS ATTACHMENT WILL NOT BE USED IN LIEU OF OFFICIAL FORM)**

DATE OF BIRTH _____

DATE _____

STATEMENT OF HEALTH

Have you ever had or presently have a significant medical (including mental health) problem?

YES _____ NO _____ (If Yes, please explain on separate sheet)

I have reviewed my privilege list and hereby acknowledge that I am physically and emotionally capable of performing all privileges I have requested.

YES _____ NO _____ (If No, please explain on separate sheet)

MALPRACTICE LIABILITY

Since you last completed this form, have you been a defendant or the subject of a medical malpractice liability claim, settlement, judicial or administrative adjudication, or any other resolved or open charges of inappropriate, unethical, unprofessional, or substandard care?

YES _____ NO _____ (If Yes, please explain on separate sheet)

OUTSIDE EMPLOYMENT

1. Do you have any off-duty employment? YES _____ NO _____

2. Have you voluntarily relinquished any state or district license/registration/certification or Drug Enforcement Administration (DEA) registration?

YES _____ NO _____ (If Yes, please explain on separate sheet)

3. Has your license to practice medicine in any jurisdiction ever been limited, restricted, suspended or revoked?

YES _____ NO _____ (If Yes, please explain on separate sheet)

4. Do you or have you ever had a Drug Enforcement Administration (DEA) registration?

YES _____ NO _____ (If Yes, it is current? YES _____ NO _____)
(If No, please explain on separate sheet)

5. Have you voluntarily or involuntarily terminated medical staff membership at another hospital?
(NOTE: Termination of privileges due to coming on active duty or permanent change of station (PCS) moves are to be checked No)

YES _____ NO _____ (If Yes, please explain on separate sheet)

6. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization?

YES _____ NO _____ (If Yes, please explain on separate sheet)

7. Have you voluntarily or involuntarily restricted your clinical privileges or has your request for any specific clinical privileges ever been denied or granted with stated limitations or restrictions?

YES _____ NO _____ (If Yes, please explain on separate sheet)

8. Have there been any voluntary or involuntary limitations, reductions, or loss of clinical privileges at another hospital?

YES _____ NO _____ (If Yes, please explain on separate sheet)

9. _____ I have reviewed my PCF and PAF and made corrections and updates as necessary.

(Initials)

I certify the above information is true to the best of my knowledge and I am in sound physical, emotional, and mental health. My mental and physical health can be investigated at anytime, and failure to respond to such a request would automatically allow removal of my privileges.

I have been informed that all medical staff bylaws, rules, and regulations are maintained in the _____(location). I acknowledge that as a member of the medical staff, my activities will be bound by these bylaws, rules, and regulations along with being familiar with the principles and standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). I further acknowledge my cooperation with maintaining JCAHO standards for the (numerical designation) _____ Medical Group, _____ (Base), and agree to conduct any practice according to high ethical traditions.

(SIGNATURE OF PROVIDER)

I have reviewed the provider's privilege list and confirm his/her physical and emotional ability and qualifications to perform the requested privileges.

(SIGNATURE OF CONFIRMING AUTHORITY)

Attachment 3**FORMAT FOR TRANSFER BRIEF MEMORANDUM**

A3.1. Paragraph 1. Complete name, rank (or rating, if civilian), corps, social security number, date of birth, specialty name, and AFSC.

A3.2. 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.

A3.3. Paragraph 3. List all currently held state licenses and certifications, expiration date of each, and verification status.

A3.4. Paragraph 4. List all applicable specialty board, specialty nurse, or other certifications and re-certifications, expiration date of each, and verification status.

A3.5. Paragraph 5. List all applicable life support training (BLS, ACLS, ATLS, PALS) and expiration date.

A3.6. 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).

A3.7. Paragraph 7. List date of most recent NPDB inquiry and indicate absence/presence of information in the report. In no query made, state so.

A3.8. 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).

A3.9. 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.).

A3.10. 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.

A3.11. Paragraph 11. Provide the name, title, phone number, and FAX number of the designated point of contact at the sending facility.

A3.12. General Comments:

A3.12.1. 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 medical treatment facility (MTF) or dental treatment facility (DTF) and dates of the last tour of clinical duty.

A3.12.2. 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.).

A3.12.3. 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.

A3.12.4. Credentials Functions in DoD MTF/DTFs will accept healthcare provider performance appraisals on other Service's forms as their own.

A3.12.5. MTF/DTF commanders may grant privileges based on the approved privilege 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.

SAMPLE TRANSFER BRIEF

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*
a. DEGREE: _____	_____	Y/N
ISSUING INSTITUTION: _____		
b. INTERNSHIP: _____	_____	Y/N
INSTITUTION: _____		
c. RESIDENCY: _____	_____	Y/N
INSTITUTION: _____		
d. FELLOWSHIP: _____	_____	Y/N
INSTITUTION: _____		
e. OTHER QUALIFYING TRAINING: _____	_____	Y/N
INSTITUTION: _____		

3. LICENSE/CERTIFICATION/REGISTRATION (CURRENT)	EXPIR	STATE	DATE	PSV*
a. _____	_____	_____	_____	Y/N
b. _____	_____	_____	_____	Y/N

4. SPECIALTY/BOARD CERT/RECERT	EXPIRATION DATE	PSV*
a. _____	_____	Y/N

5. LIFE SUPPORT/READINESS TRAINING	EXPIRATION DATE
a. BLS	_____
b. ACLS	_____
c. ATLS	_____
d. PALS	_____
e. NALS	_____

*Primary Source Verification

6. CURRENT STAFF APPOINTMENT WITH CLINICAL PRIVILEGES AT SENDING FACILITY

- a. TYPE OF PRIVILEGES AND EXPIRATION DATE
- b. PRIVILEGES GRANTED (PRIVILEGE LIST ATTACHED)

7. DATE OF NATIONAL PRACTITIONER DATA BANK QUERY

INFORMATION PRESENT/ABSENT IN DATA BANK

8. (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.

9. (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.]

10. 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.]

11. POC: NAME, TITLE, PHONE NUMBER, and FAX NUMBER

12. (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).

13. SIGNATURE OF PRIVILEGING AUTHORITY:

COMMANDER

DATE

Attachment 4**JCAHO'S GUIDANCE ON USE OF INTERNET TO PRIMARY SOURCE VERIFY (PSV) CREDENTIALS****Effective 08/06/98**

Clarification

- Subject:** Use of the Internet to Verify a Professional Credentials.
- Issue:** Can a Website be used to verify the professional credentials of an applicant for Medical staff appointment or Clinical Privileges?
- Clarification:** Yes. The use of a professional organization's website is permitted for Primary Source Verification (PSV) of credentials by a healthcare organization (HCO) or its contracted Credentials Verification Organization (CVO) if:
- The information is obtained directly from the professional organization's website. Use of the website of another recognized professional organization (such as the Administrators in Medicine (AIM) site of the Association of Medical Board Executive Directors) is permitted if it is used as the platform to reach the intended site. The HCO and, when applicable its CVO, must confirm that the website used is the professional organization's official website.
- The HCO and, when applicable its CVO, should assure itself that the source website, 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 website 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 website does not receive its information from the database by encrypted transmission, it is protected from alteration by unauthorized individuals.
- c. The information on the website contains all of the information required for the PSV process of the specific credential.
- d. The website should contain sufficient information to properly identify the applicant. For example, name alone might not be sufficient to distinguish the applicant.
- e. The HCO and, when applicable its CVO, should know the currency of information on the website.
- f. Information on the website that is supplemental to the information undergoing PSV, such as a state licensing board's website 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.

- g. Any discrepancy between information provided by the applicant and that on the website should be followed up with the professional organization by correspondence or telephone.
- h. The fact that adverse information is not presented on the website should not deter the HCO from contacting the professional organization by telephone or written correspondence if the other information gathered by the HCO warrants it.
- i. All of the information on source of data must be placed in the individual credentials file.
- j. The identification of the medical staff specialist who made the website contact and gathered the information, along with the date, should be entered onto the website printout or other record of the information. If the HCO uses a CVO that gathers information directly from a professional organization's website, they must ensure that the CVO identifies the employee who made the website 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.
- k. The HCO's use of a CVO that gathers information directly from a professional organization's website is subject to the guidelines for the use of CVOs found in the accreditation manual.

Survey Process: Validate through review of individual credentials files.

Scoring: No change.

References: None.

Clarification Cover Page and Worksheet

Manuals: If "yes," circle applicable manual(s) and note applicable standards; if "no," delete section.

CHAS MS 5.4.3

CAMAC HR 7.1

CAMBHC H R 4.1.1 - 4.1.1.4

CHASCN HR 3.8 - 3.15

CAMLTC HR 6.1.1

CAMLTCP HR 2.1

CAMPCLS HR 2

CHASC HR 3

AMPPO HR 3.8 - 3.15

Issue owner: E. ROSENBLATT, MD

Final.

Attachment 5

CREDENTIALS TABLES

Table A5.1. Credentials Required for Providers Who Entered the AFMS Through the AFRS and Reported to Commissioned Officer Training.

Credentials	Air Force Recruiting Service	MTF Credentials Manager
Qualifying Degree, Diploma, ECFMG, etc.*	*	* (If not documented)
PG Training* (If applicable)	*	* (If not documented)
License*	* (IAW DoD Licensure Policy)	* (If not documented)
Board Certification (If applicable)*	*	* (If not documented)
FSMB (PAs and Physicians)	X	X (If not documented)
NPDB	X	X (If not documented)
CHBC	X	
Health Status	X	X
AF Form 1540	X (AF Form 24 in lieu of 1540)	X
AF Form 1562	X	
Privilege List		X
Previous Privilege List	O	

KEY:

O = Collect document

X = Initiate document

* = Must PSV document

Table A5.2. Credentials Required for Providers Who Entered the AFMS Through the AFRS and Proceed Directly to an AFMS Training Program.

<u>Credentials</u>	<u>Air Force Training Program Office</u>	<u>MTF Credentials Manager</u>
Qualifying Degree, Diploma, ECFMG, etc.*	O	* (If not documented)
PG Training* (If applicable)	O	* (If not documented)
License*	O	* (If not documented)
Board Certification (If applicable)*	O	* (If not documented)
FSMB (PAs and Physicians)		X (If not documented)
NPDB		X
CHBC		
Health Status		X
AF Form 1540		X
AF Form 1562	O (only one 1562 is required)	
Privilege List		X
Previous Privilege List		
AF Form 494	X	

KEY:

O = Collect document & forward to MTF at least 15 days after date of graduation

X = Initiate document

* = Must PSV document

NOTES:

1. The AFRS does the FSMB and the NPDB query, collects Health Status document, and, if applicable, PSVs license, qualifying degree, PG training, and board certification.
2. The Training Record will have prime source verified copies of applicable documents to include license, qualifying degree, and if applicable, previous PG training and board certification.

Table A5.3. Credentials Required for Providers Who Entered the AFMS Through the AFRS And Placed on Deferred Status.

<u>Credentials</u>	<u>HQ AFPC/DPAME</u>	<u>MTF Credentials Manager</u>
Qualifying Degree, Diploma, ECFMG, etc.*	O	* (If not documented)
PG Training* (If applicable)	O	* (If not documented)
License*	O	* (If not documented)
Board Certification (If applicable)*	O	* (If not documented)
FSMB (PAs and Physicians)	O	X (If not documented)
NPDB	O	X
CHBC		
Health Status		X
AF Form 1540	X	
AF Form 1562	O (only one 1562 is required)	
Privilege List	O	
Previous Privilege List	Not Required	
AF Form 494	Not Required	

KEY:

O = Collect document & forward to MTF at least 15 days after date of graduation

X = Initiate document

* = Must PSV document

NOTE: The AFRS does the FSMB and the NPDB query, collects Health Status document, and, if applicable, PSVs license, qualifying degree, PG training, and board certification.

Attachment 6**SAMPLE RESERVE PRIVILEGE LIST OVERPRINT**

A6.1. Following is a sample list of clinical and aerospace privileges that can be included in a local-use overprint:

A6.1.1. Take, evaluate, and record medical histories

A6.1.2. Perform flying, non-flying, and occupational medical examinations in accordance with (IAW) AFI 48-123, including review and signing of SF 88 and SF 93.

A6.1.3. Interpret clinical laboratory studies, x-rays, EKGs, pulmonary function studies, optometric testing, and audiometric testing.

A6.1.4. **A6.1.4.**For the purpose of evaluation only, order appropriate laboratory and diagnostic studies and refer to member' private physician for treatment and follow-up.

A6.1.5. Administer and/or supervise immunizations IAW AFP 161-9 and AFI 48-110.

A6.1.6. Initiate consultation requests to appropriate specialists for the purpose of evaluating fitness for military duty.

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 are 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 ICDM-9 code 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/locked room, same as PCF). 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 option to use a central maintenance method.

Attachment 8

SAMPLE AF FORM 22 CLINICAL PRIVILEGES EVALUATION SUMMARY

A8.1. Sample AF Forms 22 are posted on SGOC's home page. They have been overprinted by local facilities and, therefore, are living examples of how to capture performance data. They are presented as samples that individual MTFs may want to adopt for their own use.

A8.2. The homepage (<http://sg-www.satx.disa.mil/moasgoc/index.htm>) listing includes:

A8.2.1. JCAHO-identified Potential Best Practice at Bolling Clinic.

A8.2.1.1. Data collection grid with criteria that corresponds to specific items in Section #12 of the form.

A8.2.1.2. Sample overprinted Form 22 for Family Practice.

A8.2.1.3. Sample overprinted Form 22 for Flight Surgeons.

A8.2.2. Sample Form 22 that captures other miscellaneous items.

A8.2.3. Items to be addressed under Section #13.

A8.2.4. Data collection grid for clinical practice reviews that corresponds to items under Section #12.

Attachment 9

SAMPLE IMPLEMENTATION TOOLS FOR PRIVILEGING CLINICAL PHARMACISTS

A9.1. The following are posted SGOC's homepage (<http://sg-www.satx.disa.mil/moasgoc/index.htm>):

A9.1.1. Pharmacist Prescription Refill Clinic Prescribing Drug Protocol

A9.1.2. Competency/Performance Standards for the Asthma Educators

A9.1.3. Pharmacist Competency/Performance Standards for Coumadin Clinic

Attachment 10

FORMAT FOR NOTIFICATION OF ABEYANCE OF CLINICAL PRIVILEGES

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER

FROM:

SUBJECT: Notice of Abeyance of Clinical Privileges

1. You are hereby notified that your clinical privileges are held in abeyance as follows: (State the scope of the action) This action is being taken in response to (State specifically those deficiencies involved). These problems have had (or could potentially have) the following adverse effects on patient care (List the untoward effects).
2. Abeyance is a temporary removal of clinical privileges for 30 calendar days. At the end of this time period, an extension of an additional 30 calendar days may be granted. After that, the action automatically becomes a suspension of privileges. An abeyance is not an adverse clinical privilege action and need not be disclosed as such on applications for clinical privileges. If your privileges have not been reinstated they will be automatically suspended.
3. The basis for this action will be investigated. Following that, the credentials function will make a recommendation on whether to reinstate, restrict, reduce, deny or revoke your clinical privileges. The MDG/CC will review their recommendations and notify you of (his or her) proposed action. At that time, if you are not satisfied with the outcome, you will have the right to request a hearing. If your privileges are not reinstated at this point, you will be afforded due process for a hearing and appeals as outlined in AFI 44-119, [Chapter 7](#).
4. 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 the National Practitioner Data Bank and/or state licensing agencies. You may request that the review of your privileges/practice continue following your (separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until final resolution of your case. If you desire a continuation, you must request it in writing prior to your (separation, retirement, discharge, termination of employment, PCS). Address your request to me.

5. (optional) During the period of (suspension or abeyance), you will be temporarily be reassigned _____ section to function as _____.

Signature

TYPED NAME and Grade

Chairperson, Credentials Function

1st Ind, Provider

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION

I acknowledge receipt of the Notice of Abeyance of Clinical Privileges, and implications of changing duty status while a review is taking place dated (date of memorandum of notification).

Signature of Provider

TYPED NAME and Grade

Attachment 11**FORMAT FOR NOTIFICATION SUSPENSION OF CLINICAL PRIVILEGES**

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER

FROM:

SUBJECT: Notice of Suspension of Clinical Privileges

1. You are hereby notified that your clinical privileges are suspended as follows: (State the scope of the action). This action is being taken in response to (State specifically those deficiencies involved). These problems have had (or could potentially have) the following adverse effects on patient care (List the untoward effects).
2. Suspension is an adverse action which temporarily (removes or restricts) the above stated clinical privileges for a period of ___ months. (If contractor, state that a copy of this memorandum will be forwarded to the group contractor). Furthermore, permission to engage in off-duty employment is withdrawn until this issue is resolved. (If contractor, state that it is “your responsibility to notify other medical facilities where you hold clinical privileges that privileges at this facility were suspended”).
3. The basis for this action will be investigated. Following that, the credentials function will make a recommendation on whether to reinstate, restrict, reduce, deny or revoke your clinical privileges. The MDG/CC will review their recommendations and notify you of (his or her) proposed action. At that time, if you are not satisfied with the outcome, you will have the right to request a hearing. If your privileges are not reinstated at this point, you will be afforded due process for a hearing and appeals as outlined in AFI 44-119, [Chapter 7](#).
4. Depending on the outcome of this action, AFMOA/SGOC may report the matter to appropriate professional regulatory agencies. I refer you to AFI 44-119, [Chapter 7](#), for information on the specific procedures involved with this action and your rights.
5. 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 the National Practitioner Data Bank and/or state licensing agencies. You may request that the review of your privileges/practice continue following your (separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until final resolution of your case. If you desire a continuation, you must request it in writing prior to your (separation, retirement, discharge, termination of employment, PCS). Address your request to me.

6. (optional) During the period of (suspension or abeyance), you will be temporarily be reassigned _____ section to function as _____.

Signature

TYPED NAME and Grade

Chairperson, Credentials Function

1st Ind, Provider

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION

I acknowledge receipt of the Notice of Suspension of Clinical Privileges, and implications of changing duty status while a review is taking place dated (date of memorandum of notification).

Signature of Provider

TYPED NAME and Grade

Attachment 12

FORMAT FOR NOTIFICATION OF REMOVAL FROM PATIENT CARE
(NON-PRIVILEGED HEALTHCARE PROFESSIONALS)

Date

MEMORANDUM FOR NAME AND GRADE OF INDIVIDUAL UNDER REVIEW

FROM: Senior Corps Representative

SUBJECT: Notice of Removal from Patient Care/Peer Review

1. You are hereby notified that you are being removed from all/portion of patient care duties as follows: (State the scope of the action). This action is being taken in response to (State specifically those deficiencies involved). These problems have had (or could potentially have) the following adverse effects on patient care (List the untoward effects).

Use for Removal to conduct Inquiry; not sure if it will lead to peer review:

2. The basis for this action will be investigated. The results of the investigation may lead to a peer review committee. You will be notified of the results of the inquiry and whether or not a peer review committee will be convened to review this action. See AFI 44-119, **Chapter 7** for complete information about inquiry procedures, peer review procedures and your rights.

-----OR-----

Use for notification of peer review

2. A peer review committee will convene within 10 calendar days of this notice. The purpose of the peer review is to evaluate your ability to safely render patient care. You may provide a written statement to the committee. The peer review committee will review all available documents and make a recommendation on whether to return you to full duty (reinstate practice), or restrict, reduce or revoke your clinical practice. The MDG/CC will review their recommendations and notify you of (his or her) proposed action. At that time, if you are not satisfied with the outcome, you will have the right to request a hearing. Please refer to AFI 44-119, **Chapter 7** for complete information of peer review recommendations and your rights.

Use next paragraphs in either memorandum written:

3. Depending on the outcome of this action, AFMOA/SGOC may report the matter to appropriate professional regulatory agencies. I refer you to AFI 44-119, **Chapter 7**, for information on the specific procedures involved with this action and your rights.

4. Individuals 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 that the review of your practice continue following your (separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until final resolution of your case. If you desire a continuation, you must request it in writing prior to your (separation, retirement, discharge, termination of employment, PCS). Address your request to me.

5. (optional) During the period of (removal from your clinical duties), you will be temporarily be re-assigned _____ section to function as _____.

Signature

TYPED NAME and Grade

Senior Corps Chief

1st Ind, Healthcare Professional under review

Date

MEMORANDUM FOR (SENIOR CORPS CHIEF)

I acknowledge receipt of the Notification of Removal from Patient Care memorandum dated (date of Memorandum of Notification).

Signature of member

TYPED NAME and Grade

Attachment 13

FORMAT FOR NOTIFICATION OF PROPOSED ADVERSE ACTION

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER/HEALTHCARE PROFESSIONAL

FROM: Commander

SUBJECT: Notice of Proposed (Denial) of Clinical Privileges/ (Restriction) (Reduction) (Revocation)
of Clinical Privileges/Practice

1. You are hereby notified that I propose to (deny) (restrict) (reduce) (revoke) your clinical privileges/ practice as follows: (State the scope of the action). This action is being taken in response to (State specifically those deficiencies involved). These problems have had (or could potentially have) the following adverse effects on patient care (List the untoward effects).
2. You are advised that you have the right, upon request, to have a hearing committee review this action. To have this hearing, you must make a written request to me within 30 calendar days from the date you receive this notification. If you fail to ask within that time, or if you fail to appear at a hearing so requested, you waive your rights to the hearing. If you waive your rights to a hearing, you may still exercise your right to appeal this decision to AFMOA/CC through AFMOA/SGOC.
3. Depending on the outcome of this action, AFMOA/SGOC may report the matter to appropriate professional regulatory agencies. I refer you to AFI 44-119, **Chapter 7**, for information on the specific procedures involved with this action and your rights. In addition, I refer you specifically to **Chapter 7**, paragraph **7.9**. regarding Use of Timelines.
4. According to AFI 44-119, paragraph **7.39**., individuals 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 professional regulatory agencies. You may request that the review of your adverse action continue following your (separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until final resolution of your case. If you desire a continuation, you must request it in writing prior to your (separation, retirement, discharge, termination of employment, PCS). Address your request to me (or to AFMOA/SGOC as appropriate).

Signature

TYPED NAME and Grade

Commander

1st Ind, Provider/Healthcare Professional

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION/
SENIOR CORPS REPRESENTATIVE

I acknowledge receipt of proposed (denial) (restriction) (reduction)(revocation) of clinical privileges/
practice.

Signature

TYPED NAME and Grade

Provider/Healthcare Professional

Attachment 14

FORMAT FOR NOTIFICATION OF ADVERSE ACTION HEARING

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER/HEALTHCARE PROFESSIONAL

FROM:

SUBJECT: Notification of Adverse Action Hearing

1. A hearing committee will conduct a hearing on allegations that may adversely affect your clinical privileges/practice. Depending on the final outcome, AFMOA/SGOC may report the matter to appropriate civilian regulatory agencies. I refer you to AFI 44-119, **Chapter 7** for a discussion of your rights and responsibilities in this matter.
2. Allegations being investigated are: (State the nature of those allegations and the effect these issues are having, or could potentially have, on patient care). Ensure it is in sufficient detail so that the provider is fully appraised of matters involved.
3. This 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 committee, and to consult and be represented by legal counsel. It is your responsibility to arrange for the presence of any witnesses you desire. If you are a military provider and so request, a military legal counsel will be made available to you. You may retain a civilian attorney at your own expense. The committee currently expects to call these witnesses: (list of witnesses). Failure to appear at the hearing will be construed as a waiver of those rights set out in AFI 44-119, **Chapter 7**, paragraph **7.25**. The chairperson of the hearing committee may change the time and place of the hearing upon your written request, if based on good cause.

Signature

TYPED NAME and Grade

Chairperson, Credentials Function or

Senior Corps Representative (as appropriate)

1st Ind, Provider/Healthcare Professional

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION/
SENIOR CORPS REPRESENTATIVE

I acknowledge receipt of the Memorandum of Notification of Adverse Action Hearing, dated (date of Memorandum of Notification).

Signature

TYPED NAME and Grade

Provider

Attachment 15

SAMPLE HEARING SCRIPT

Chairperson: The hearing will come to order.

Legal Advisor: This hearing is convened at (Time) on (Date) in (Room) at _____ **Medical Group**, _____ **AFB, State of** _____, pursuant to AFI 44-119, dated (list date of current version), from which a copy of **Chapter 7**, Adverse Actions, has been provided to Dr./rank _____ and his counsel. A Notification of Privileges Hearing, dated _____, was served on Dr./rank _____ on _____ (Date), and he or she acknowledged receipt of the Notification on _____ (Date). The Memorandum of Notification and the acknowledgment will be made a part of the record of this hearing at Hearing Committee Exhibit _____.

Legal Advisor: Let the record reflect that Dr./rank _____ is present with counsel. I ask at this time that Dr./rank _____'s counsel state his or her name, qualifications (including state of licensure), and address for the record.

(Military counsel will state name, grade, organization and identify self as a designated Judge Advocate of the United States Air Force. Civilian counsel will state name, business address and bar membership.)

Legal Advisor: The members of the hearing committee were detailed by Memorandum of _____, Credentials Function Chairperson/Senior Corps Representative, dated _____. The following members are present:

1. _____, Chairperson
2. _____
3. _____
4. _____
5. _____

I now ask each member of the Hearing Committee to state for the record his or her name, rank, organization and board affiliations.

(Hearing committee members will state their name, rank, organization, and board certifications).

Legal Advisor: For the record, **Capt** _____ has been detailed by _____, _____ ABW Staff Judge Advocate, as legal representative to assist in the presentation of evidence in this matter. **Capt** _____, please state your name, rank, organization, and qualifications at this time.

Legal Advisor: The assistant investigator will now state his name, rank, organization and qualifications at this time.

Legal Representative: (Answers)

Legal Advisor: For the record, I, **Capt** _____, have been detailed as **Legal Advisor** to this Hearing Committee by _____, XX ABW Staff Judge Advocate. I am a designated Judge Advocate of the United States Air Force, assigned to the ____th Air Base Wing, _____ AFB. At this time, I will enter into the record the memorandum detailing the Committee members as Exhibit ____, the memorandum detailing the Legal Representative as Exhibit ____, and the memorandum detailing me as Exhibit ____.

Legal Advisor: This hearing is convened pursuant to AFI 44-119 to take evidence, hear testimony, and to make findings and recommendations to the Medical Group Commander whether certain clinical privileges/practice of Dr./rank _____ should be revoked, modified, or reinstated. The clinical privileges/practice issues were specified in a Memorandum of Notice of Suspension of Clinical Privileges/Removal from patient care duties, dated _____. This memorandum will be entered as Hearing Committee Exhibit _____. Dr./rank _____ exercised his right to a hearing committee, by memorandum dated _____. A copy of that memorandum will be entered as Hearing Committee Exhibit _____.

Legal Advisor: Dr./rank _____, as the subject of this hearing you have the following rights:

The right to be present before all open session of this committee with or without counsel;

The right to challenge for cause any voting member of the committee;

The right to present evidence and call witnesses in your behalf, and to ask questions, either by yourself and through counsel, of any witnesses appearing before the committee. Included in your right to present evidence are the rights to testify under oath, to make an unsworn statement, and/or to remain silent. If you testify, you may be asked questions by Capt _____, (legal advisor), the Board members, or me. You may make an unsworn statement orally or in writing, personally or through your counsel, or you may use any combination of these ways. Dr./rank _____, do you understand the purpose of this hearing and your rights before it?

Member: (Answers)

Legal Advisor: We will now determine if there are challenges for cause against any member of the Hearing Committee. I will rule on all challenges for cause except a challenge against myself, the legal advisor. If a challenge for cause is made against me, the Hearing Committee Chairperson will rule on it.

Legal Advisor: I will now swear in the Hearing Committee members. Please rise and raise your right hands. "Do you swear that you will answer truthfully the questions concerning whether you should serve as a member in this credentials hearing; and that if you serve as a member of this committee, you will

faithfully and impartially make findings and recommendations according to the evidence, your conscience, and the applicable rules set forth in AFI 44-119?"

Legal Advisor: Committee Members, I will now ask you a few questions that will help determine whether you can be fair and impartial at this hearing. Please respond to my questions out loud with a YES or NO. (See AFI 44-119, [Chapter 7, 7.22.](#))

- 1) Is Dr./rank _____ the supervisor, reporting official or endorsing official on OPRs for any member of the hearing committee?
- 2) Has any member of the committee suspended the privileges (or removed from patient care) Dr./rank _____, or has any member recommended suspension of his or her privileges (or removal from patient care) prior to this hearing?
- 3) Is any member of the committee a person who investigated this case?
- 4) Is any member of the committee a principle witness in this case?
- 5) Is any committee member aware of any other reason why he or she cannot conscientiously participate in this hearing or would not render fair and impartial findings and recommendations based on the evidence and testimony presented during these proceedings?

Legal Advisor: Dr./rank _____, do you or your counsel have any questions of the committee members before stating whether you have any challenge for cause?

(If questions are for individual members, sequester the other members during the individual questioning so that they do not become "tarnished" by what they hear.)

Legal Advisor: Dr./rank _____, do you or your counsel have any challenges for cause?

Legal Advisor: Prior to taking evidence, I'd like to go over for all parties and the record the procedures that will be followed in this case. AFI 44-119, [Chapter 7](#), paragraphs [7.25.](#) through [7.33.](#) state the procedures to be followed. You will be provided with the relevant provisions of AFI 44-119. Each party has the right to present evidence and question witnesses. Members of the committee can also request relevant evidence be brought before them and will be given the opportunity to question witnesses. If there are objections to witnesses, questions, or evidence, the legal advisor, who may consult with the chairman before ruling on any objections, will sustain or overrule the objection. As stated in paragraph [7.29.](#), this hearing is not bound by formal rules of evidence. However, to keep this proceeding focused, I would advise the Chairperson to consider the relevancy of the proffered testimony or evidence and the principles of fairness in ruling on evidence. By the term "relevant evidence", I speak of testimony and evidence which will help the committee members in making findings and recommendations on the allegations contained in Hearing Committee Exhibit _____, the Notification of Privileges Hearing.

Legal Advisor: I will administer oaths or affirmations to the witnesses. In listening to evidence, I do advise the committee that you can use your experience and professional knowledge in weighing the credibility of the evidence and determining its bearing on your findings and recommendations. Paragraph 7.31. says your findings and recommendations must be based on “the reasonable belief that the actions are warranted by the evidence.” I interpret that to mean you must base your findings and recommendations on a **Preponderance of the Evidence**. In other words, to substantiate any of the allegations against Dr./rank _____, you must find it more likely than not (based on the evidence) that the allegation is true. There is no requirement to prove any allegation beyond a reasonable doubt. Dr./rank _____, do you have any objection to using Preponderance of the Evidence as the standard of proof in this hearing?

Member:

Legal Advisor: Committee Members, you must use your best judgment, experience, and common sense in resolving disputed and conflicting evidence. You must consider the probability or improbability of each piece of evidence, and select only that evidence which is most worthy of belief. You must be convinced that each fact set forth in your findings is proven to your satisfaction by **preponderance of credible evidence**. I will give you more detailed instructions on this issue immediately prior to your deliberations.

Legal Advisor: At this point, does any party or the committee member have any questions?

Legal Advisor: Are there any issues that need to be addressed before we start taking evidence?

Legal Advisor: At this time, I would ask the parties if they have been given reasonable time and notice of the evidence to be presented and the issues under consideration?

Member:

Legal Advisor: We now will provide the committee with copies of documentary evidence. **Capt (legal representative)** do you have any documentary evidence for the committee members to consider? **Legal Advisor** asks if there are any objections to the evidence. If so, the other board members may be excused while the Board President rules on admission or exclusion of documentary evidence.

Legal Advisor: Dr./rank _____, do you have any documentary evidence for the committee members to consider? (Legal Representative offers documentary evidence. **Legal Advisor** asks if there are any objections to the evidence. If so, the other board members may be excused while the Board President rules on admission or exclusion of documentary evidence.)

(After ruling on all documentary evidence, recall all board members).

Legal Advisor: Members, we will now recess, so that you can take time to familiarize yourself with these documents before hearing testimony. We will withdraw from the hearing room while you review the evidence. Once you have had a reasonable time to review the documents, let me or one of the counsel know, so we can begin to call witnesses

(Recess for review of documentary evidence)

Legal Advisor:

(Board President may allow counsel may make opening statements. This is optional. If opening statements are allowed, provider's counsel may defer making opening statement until ready to present provider's case).

Legal Advisor: Capt _____, does the government have any witnesses?

WITNESS OATH GIVEN BY LEGAL ADVISOR: *Do you swear (affirm) the evidence you provide in this hearing will be the truth, the whole truth, and nothing but the truth, (so help you God)?*

CAUTIONARY INSTRUCTION: *Do the members or either party wish this witness subject to recall? (If so, find out how to contact the witness). I ask the witness not to discuss your testimony with anyone (except counsel) outside the hearing room, while this hearing is convened, Additionally, the witness is instructed that the information and testimony from this hearing is Quality Improvement information gathered specifically for that purpose and as such is protected from release by 10 U.S.C. 1102. Unauthorized release could result in a personal fine of \$3,000. Do you understand?*

(After all evidence is presented, counsel make closing statements.)

Legal Advisor: Prior to going into deliberations, I want to instruct the members on the record as to the rules that will govern their deliberations. I direct the member and counsel to AFI 44-119, paragraph **7.32**. The hearing committee is to deliberate and determine, by majority vote, which recommendation to make to the Medical Group Commander. A minority report is permitted. As to your findings, the parties have agreed that, in this particular case, you should apply the preponderance of the evidence standard. The term "preponderance of the evidence" simply means the greater weight of credible evidence. There is no requirement to prove any allegation beyond a reasonable doubt. You must use your best judgment, experience, and common sense in resolving disputed and conflicting evidence. You must consider the probability or improbability of each piece of evidence, and select only that evidence which is most worthy of belief. You must be convinced that each fact set forth in your findings is proven to your satisfaction by preponderance of credible evidence. After you have made your findings, you should then consider an appropriate recommendation. Your recommendation should be based on the action you reasonably believe is required based on your findings.

Legal Advisor: The member's recommendations are limited to the following:

1. Reinstating Privileges/Practice:

2. Restriction of Privileges/Practice: A limit placed on all or a portion of the individual's clinical privileges/practice. The restriction may require some sort of supervision.

3. Reduction of Privileges/Practice: The permanent removal of a portion of the individual's clinical privileges/practice.
4. Revoking Privileges/Practice. A revocation is an action which permanently removes all of a practitioner's clinical privileges or removes a non-privileged healthcare professional from all patient care responsibilities.
5. Denying Privileges (in a denial case only).

Legal Advisor: Be advised that a revocation, restriction, reduction or denial action, once approved by the Air Force Surgeon General, can result in a report of the action to the National Practitioner Data Bank, to all states of known licensure, or other appropriate regulatory agencies.

Legal Advisor: (Optional) I have prepared a findings and recommendation worksheet for your use during deliberations. I have marked this worksheet as hearing committee exhibit _____. I have previously supplied this document to the parties. Does either party have an objection to the worksheet?

(If there is objection, the party making the objection should state the reason and the hearing committee chairman rules and makes changes in the worksheet as needed)

Legal Advisor: The members will deliberate in closed session. If requested by the members, I can be present during your deliberations to assist in putting your findings and recommendations in proper form. The members also are free to reopen the hearing to request additional testimony and documents.

(According to AFI 44-119, this committee has the option to notify the provider of its findings and recommendations immediately, or it can wait no longer than 30 calendar days from the close of this hearing to transmit its findings and recommendations to the chairman of the credentials function. The hearing committee should decide this issue prior to closing the hearing for deliberations and so notify the provider).

Legal Advisor: Do the parties have any additional instructions or questions prior to the members going into closed deliberations? *(If so, address any requests as appropriate, then read the following:)* Does Dr./rank _____ or his counsel wish to be advised of the post hearing procedures?

(If so, read the following):

Legal Advisor: Dr./rank _____, regardless of the hearing committee's findings and recommendations, your privileges will continue under suspension until the Medical Group Commander (MDG/CC) takes final action on the recommendation. The hearing record will be prepared and sent to the MDG/CC through the credentials function/senior corps representative. The credentials function/senior corps representative does have the option to provide separate comments and recommendations to the MDG/CC, but may not alter the findings and recommendations of this hearing committee. AFI 44-119 requires these separate comments and recommendations, along with the transcription of this hearing, will be made available to you within 30 calendar days from today. You will have 10 calendar days after receiving the hear-

ing record, recommendations, and any additional comments made, to prepare and submit a written statement of exceptions, corrections, or other matters to the MDG/CC. You may request the MDG/CC give you more time to submit these matters. The MDG/CC may extend the time to submit matters for good cause. Within 10 calendar days of receiving the recommendations, the record, and the provider's submissions, the MDG/CC will review the materials and will make a decision on the provider's privileges. The MDG/CC must provide written notice of the final decision to the provider/ non-privileged healthcare professional. This final action memorandum must include appeal rights and reporting to regulatory agencies as applicable.

(If the provider does not want rights read, or after the rights are read, state:)

Chairperson: The hearing is in recess (if the committee will announce findings/recommendations).

OR

The hearing is closed (if the committee will serve findings and recommendations on the member).

(If the committee decides to announce its findings and recommendations on the record to the provider and his counsel, the following should be read):

Chairperson: Dr./rank _____, the hearing committee makes the following findings and recommendations. *(The chairman reads the findings and recommendation and any minority findings and recommendation from the findings and recommendation worksheet).*

Chairperson: The hearing is closed.

Attachment 16

**HEARING COMMITTEE FINDINGS AND RECOMMENDATIONS
IN THE CASE OF
(INSERT NAME OF INDIVIDUAL UNDER REVIEW)**

Hearing Date:

Report Date:

1. The committee, having considered all the evidence, has arrived at the following findings and recommendations by unanimous/majority vote. We find the following allegations are substantiated or not substantiated as indicated below:

a. Allegation 1: That on (date), (location, i.e., 1st Medical Group Emergency Room),

(1) Dr. XXXXXX (list allegation as stated in official record) FINDING: Substantiated (state reason why)/Unsubstantiated (state why)

The committee further finds by unanimous/majority vote the above substantiated conduct did breach the standard of care for reasonable family/emergency room practice. This conduct did adversely affect **[had the potential to affect adversely]** the quality of patient care.

Example:

(1) Dr. XXXXXX did not respond to the notice of his patient's arrival in the Emergency Room in a timely, concerned manner. FINDING: Substantiated. Although the actual time line was difficult to establish, it is the finding of this committee based on exhibits #XX and #XX and testimony of witnesses that there was a significant delay in Dr. XXXXXX's response time.

(2) Dr. XXXXXX recorded a false time for his initial examination of the patient. FINDING: Substantiated, as per exhibit #XX and testimony of witnesses (List Witness names if necessary).

The committee further finds by unanimous/majority vote the above substantiated conduct did breach the standard of care for reasonable family/emergency room practice. This conduct did adversely affect the quality of patient care.

b. Allegation 2: That on date/location:

(1) Dr. XXXXXX (list second allegation. FINDING: Substantiated (state why)/Partially substantiated (state why)/Unsubstantiated (state why), as per exhibit #17 and testimony of Dr. XXXXXX and SSgt ZZZZZ.

The committee further finds by unanimous vote the above substantiated conduct did breach the standard of care for reasonable family/emergency room practice. This conduct did have the potential to adversely affect the quality of patient care.

c. Allegation 3: That on 17 Dec XX, at the XXX Medical Group Emergency Room,

(1) Dr. XXXXXX prescribed amoxicillin for a patient whose medical record clearly stated an allergy to penicillin. FINDING: Substantiated, as per testimony of Dr. XXXXXX and exhibits #12 and #13.

The committee further finds by unanimous vote the above substantiated conduct did breach the standard of care for reasonable family/emergency room practice. This conduct did adversely affect **[had the potential to affect adversely]** the quality of patient care.

2. The committee recommends (state action) based on the above findings.

Sample Signature blocks of committee members

For Non-Concur, indicate if minority opinion is submitted.

XXXXXXXXXXXXXXXX, Major, USAF
Family Practice Physician, Chairperson
Concur /Non-Concur

XXXXXXXXXXXXXXXX, Major, USAF
Family Practice Physician
Concur/Non-Concur

XXXXXXXXXXXXXXXX, Captain, USAF
Medical Director Emergency Services
Concur /Non-Concur

XXXXXXXXXXXXXXXX, Captain, USAF
Family Practice Physician
Concur/Non-Concur

Attachment 17

FORMAT FOR NOTIFICATION OF HEARING RECOMMENDATIONS

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER/HEALTHCARE PROFESSIONAL

FROM: Chairperson, Credentials Function/Senior Corps Representative

SUBJECT: Notification of Adverse Action Hearing Recommendations in Re: (Insert individual's name)

1. The (facility) hearing committee has made the following recommendation(s) to (name and grade of the MDG/CC) regarding your continued practice: (Set out the recommendations including any conditions, and the duration of any restriction or suspension in detail).
2. You have 10 calendar days from the date of receipt of this notification to submit a letter of exceptions to (name and grade of the MDG/CC), if you so desire. (Name and grade of the MDG/CC) may grant additional time for good cause. A copy of the hearing transcript has been made available to you.

Signature

TYPED NAME and Grade

Chairperson, Credentials Function/

Senior Corps Representative

Attachment:

Hearing Transcript

1st Ind, Provider/Healthcare Professional

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION/
SENIOR CORPS REPRESENTATIVE

I acknowledge receipt of the Memorandum of Notification of Adverse Action Hearing, dated (date of Memorandum of Notification).

Signature of Individual

TYPED NAME and Grade

Provider/Healthcare Professional

Attachment 18

**FORMAT FOR NOTIFICATION OF FINAL
DECISION BY MEDICAL GROUP COMMANDER**

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER/HEALTHCARE PROFESSIONAL

FROM: SG

SUBJECT: Final Decision in Adverse Action Proceeding Re: (Insert individual's name)

1. 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 professional review function/hearing committee and) direct that (the decision, including the duration of any privilege/practice modification should be set out in detail).

-----OR-----

If hearing waived, provider failed to show, or no hearing requested, use the following language:

1. I am in receipt of your (date) letter waiving your right to a hearing into the allegations of (state)/ I am aware that you failed to show for your scheduled hearing on (date)/ I have not received a request for a hearing from you within 30 calendar days of receipt of my proposed action against your privileges/practice. Since you have elected not to proceed with a hearing on this matter, this notice is to communicate my final action of your clinical privileges/practice. I hereby (deny, revoke, restrict, reduce your clinical privileges/practice as follows:

2. You are advised of your right to appeal, according to AFI 44-119, **Chapter 7**. Your written appeal must be received by this office within 10 calendar days of the date of this memorandum. The time can be extended by myself or HQ MAJCOM/SG for good cause. Your appeal along with the adverse action case file will be mailed to AFMOA/SGOC via HQ MAJCOM/SG. Your appeal will be managed by the Chief, Risk Management Operations, at the following address, AFMOA/SGOC, 110 Luke Avenue, Room 405, Bolling AFB, DC, 20332-7050. Depending on the outcome of any appeal proceedings, AFMOA/SGOC may report this action to regulatory agencies. My decision will remain in effect during appellate proceedings.

Signature

TYPED NAME and Grade

Commander

1st Ind, Provider/Healthcare Professional

Date

MEMORANDUM FOR CHAIRPERSON, CREDENTIALS FUNCTION/
SENIOR CORPS REPRESENTATIVE

I acknowledge receipt of the Memorandum of Notification of Commander Decision, dated (date of Memorandum of Notification).

Signature

TYPED NAME and Grade

Provider/Healthcare Professional

Attachment 19**FORMAT FOR NOTIFICATION TO INDIVIDUAL OF IMPLICATIONS OF
SEPARATING OR CHANGING STATION WHILE UNDER REVIEW**

Date

MEMORANDUM FOR NAME AND GRADE OF PROVIDER/HEALTHCARE PROFESSIONAL

FROM: SG

SUBJECT: Implications of Changing Your Employment Status
While Review of Privileges/Practice is Taking Place

1. Having received information that you are considering (separation, retirement, discharge, ending employment with the Air Force, permanently changing station within the Air Force), I am required to inform you of the implications of your action with regard to the review of your privileges/practice now taking place.
2. According to AFI 44-119, paragraph **7.39**, individuals who separate, retire, are discharged, end employment with the Air Force, or permanently change station within the Air Force while an adverse privileges review is taking place may be reported to the National Practitioner Data Bank and/or state licensing agencies.
3. You may request that the review of your privileges/practice continue following your (separation, retirement, discharge, termination of employment, PCS). If you request continuation, a report will not be made (if indicated) until final resolution of your case. If you desire a continuation, you must request it in writing prior to your (separation, retirement, discharge, termination of employment, PCS). Address your request to me (or AFMOA/SGOC as appropriate).

Signature

TYPED NAME and Grade

Commander

1st Ind, Provider/Healthcare Professional

Date

MEMORANDUM FOR CC

I acknowledge receipt of the memorandum notifying me of the implications of changing my employment status while review of my privileges/practice is taking place.

Signature

TYPED NAME and Grade

Provider/ Healthcare Professional

Attachment 20**ARRANGEMENT OF RECORD OF ADVERSE ACTION PROCEEDINGS**

A20.1. 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 name, rank, specialty, and duty assignment of the provider being reviewed. It also lists, with dates, the document categories in the record, in the order described below:

A20.1.1. **Tab 1.** Reserved for record of HQ USAF/SG proceedings and decision

A20.1.2. **Tab 2.** Provider's Appeal, intent to appeal or waiver of appeal

A20.1.3. **Tab 3.** MDG/CC's final decision memorandum with acknowledgment by provider (date and signature). A Final DD Form 2499.

A20.1.4. **Tab 4.** Provider's statement of exceptions/corrections if submitted.

A20.1.5. **Tab 5.** Hearing committee findings and recommendations; minority findings and recommendations, if any; and full credentials function findings and recommendations, if any. Senior Corps Chief's recommendations, if any.

A20.1.6. **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.)

A20.1.7. **Tab 7.** Memorandum of notification of hearing, with acknowledgment by the provider. Memorandum waiving hearing, if applicable.

A20.1.8. **Tab 8.** MDG/CC proposed decision following credentials review/peer review with acknowledgment by provider (date and sign).

A20.1.9. **Tab 9.** Findings of Professional Review Committee (credential function or peer review)

A20.1.9.1. Include Article 15/Court Martial Documentation as appropriate

A20.1.9.2. Findings of inquiry, OSI investigation

A20.1.9.3. Any supporting documentation reviewed by these committees can be included here.

A20.1.9.4. MEB/PEB results, separation orders, etc.

A20.1.10. **Tab 10.** Initial DD 2499, and Memoranda of immediate action, if any, with acknowledgment by the provider (date and signature).

Attachment 21

REPORTABLE ACTIONS OF MISCONDUCT FOR DOD HEALTHCARE PRACTITIONERS

A21.1. The following misconduct actions shall be reported, at the times prescribed, to the Surgeons General, the Federation of State Medical Boards, and the appropriate State agencies under DoD Directive 6025.13 and AFI 44-119. (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 Directive limits the lawful prerogatives of commanders to discipline the members of their command, nor does anything in this Directive limit the lawful prerogatives of civilian authorities to enforce the criminal and civil laws of their jurisdictions.)

A21.1.1. Misconduct Actions to be Reported After Command Action and Completion of Applicable Appeal Procedures

A21.1.1.1. Fraud or misrepresentation involving application for enlistment, commission, employment, or affiliation with DoD service that results in removal from service;

A21.1.1.2. Fraud or misrepresentation involving renewal of contract for professional employment, renewal of clinical privileges, or extension of Service obligation;

A21.1.1.3. Proof of cheating on a professional qualifying examination; and

A21.1.1.4. Abrogation of professional responsibility through any of the following actions:

A21.1.1.4.1. Deliberately making a false or misleading statement to patients as regards clinical skills or clinical privileges;

A21.1.1.4.2. Willfully or negligently violating the confidentiality between practitioner and patient except as required by civilian or military law;

A21.1.1.4.3. Being found impaired by reason of drug abuse, alcohol abuse, or alcoholism;

A21.1.1.4.4. Intentionally aiding or abetting the practice of medicine or dentistry by obviously incompetent or impaired persons;

A21.1.1.4.5. 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;

A21.1.1.4.6. Prescribing, selling, administering, or providing controlled substances as defined by Title 21, U.S.C., Section 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;

A21.1.1.4.7. Failure to report to the privileging authority any disciplinary action taken by professional or governmental organizations;

A21.1.1.4.8. Failure to report to the privileging authority any malpractice awards, judgments, or settlements occurring outside of DoD facilities;

A21.1.1.4.9. Failure to report to the privileging authority any professional sanction taken by a civilian licensing agency or healthcare facility;

A21.1.1.4.10. Any violation of the Uniform Code of Military Justice (reference (e)) for which the member receives 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,

A21.1.1.4.11. 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 calendar 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.

A21.1.2. 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.

A21.1.3. 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.

A21.1.3.1. Offenses punishable by a fine of more than \$5000 or confinement in excess of 1 year by the civilian jurisdiction in which the alleged offense occurred;

A21.1.3.2. Offenses punishable by confinement or imprisonment for more than 1 year under Title 10, U.S.C., Section 801-940 (reference (e));

A21.1.3.3. Entry of a guilty or nolo contendere plea, or request for discharge instead of court-martial while charged with an offense designated in subsection C.1. or 2., above;

A21.1.3.4. 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);

A21.1.3.5. Inappropriately receiving compensation for treatment of patients eligible for care in DoD hospitals; and,

A21.1.3.6. Possessing or using any drug legally classified as a controlled substance for other than acceptable therapeutic purposes.

Attachment 22**FORMAT FOR DD FORM 2526**

A22.1. The Medical Treatment Facility will initiate DD Form 2526 and complete the following items:

- 3. Type of Report
- 7a. Medical Treatment Facility
- 7b. MTF DMIS Code
- 8a. Provider's Name
- 8b. Provider's SSN
- 8c. Provider's Date of Birth
- 8d. Name of Professional School Provider Attended
- 8e. Date Graduated (YYMMDD)
- 8f. Specialty Code of Provider (AFSC)
- 8g. Status
- 8h. Source of Accession
- 8i. Licensing Information (include certification if no license)
- 9a-c. Type of Provider and Specialty
- 11a-c. Diagnoses and ICD-9-CM Codes
- 12a-c. Procedures and ICD-9-CM Codes
- 13b. Act or Omission Code
- 13c. Clinical Service Code (area where alleged negligence for each individual provider occurred) - MEPRS Code

A22.2. The Base claims officer will complete the following items:

- 2. Claimant Last Name
- 4a-b. Dates of Act(s) or Omission(s) (YYMMDD)
- 5. Date Claim Filed
- 10a. Patient Name
- 10b. Sex
- 10c. Age
- 10d. Status
- 10e. SSN of Sponsor
- 13a. Patient's allegations of negligent care. Describe the acts or omissions and injuries upon which the claim was based.

14a. Amount Claimed

14b. Adjudicative Body Case Number

A22.3. The **Medical Law Consultant** (MLC) will complete the following items:

16b.(2) MLC Review (Specifically state standard of care and rationale for each provider)

A22.4. **AFMO/SGOC** will complete the following items:

3. Type of Report

14c. Adjudicative Body Name

14d. Date of Payment (YYMMDD)

14e. Outcome

14f. Amount Paid

14g. Number of Claims for this Incident

17. Standard of Care (Office of the Surgeon General Determination)

18. NPDB Reported (Completed on AFMOA/SGOC File Copy)

19. Remarks from Office of the Surgeon General (Comments in reference to the standard of care determination)

Attachment 23**FORMAT FOR NOTIFICATION OF STANDARD OF CARE NOT MET**

Date

MEMORANDUM FOR NAME AND GRADE OF HEALTHCARE MEMBER

FROM: MTF Commander

SUBJECT: Notification of Standard of Care Not Met Determination

1. This memorandum is to inform you of your involvement in the malpractice claim of (claimant's name, case number). Through a peer review process it was determined that you did not meet the standard of care. A copy of this review (these reviews), redacted to keep the identity of the expert medical reviewer(s) confidential, is (are) attached. The case will be forwarded to the Air Force Medical Operations Agency (AFMOA) for final review and closure. 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 standard of care is not met and the claim or lawsuit is paid on your behalf.

2. You may provide a written response to the standard of care determination. Your response at a minimum should address the reasons why the professional reviewer stated you breached the standard of care. The Office of the Surgeon General will review your response along with the case file prior to a final decision. You have 10 calendar days from the date of receipt of this memorandum to notify me in writing of your intent to respond. Please sign Indorsement 1 of this memorandum, indicating your receipt. You may also indicate your intent to submit a written response in Indorsement 2 of this memorandum. The entire memorandum will be faxed to Chief Risk Management Operations, AFMOA/SGOC within 48 hours of the time you inform us of your intent to submit a response.

3. If you choose to submit a written response, you must send it directly to AFMOA within 30 calendar days of the date you received this memorandum. Please address it to the Chief of Risk Management Operations, AFMOA/SGOC, 110 Luke Avenue, Room 405, Bolling AFB, DC 20332-7050, FAX (202) 404-4043/DSN 754-4043. Provide our Risk Manager with a copy of what you send to AFMOA.

Signature

TYPED NAME and grade

Commander, MTF

Attachments:

1. Redacted Review dated dd MMM yy
2. DD Form 2526

1st Ind, Healthcare Provider

Date

MEMORANDUM FOR COMMANDER, MTF

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 calendar days. I understand that, if I submit a written response, it should focus on the reason for the SOC not met decision and it must be received by Chief Risk Management Operations at the address listed above NLT 30 calendar days from the date of this endorsement.

Signature

TYPED NAME and Grade

Healthcare Member

2d Ind, Healthcare Provider

Date

MEMORANDUM FOR COMMANDER, MTF

I WILL / WILL NOT submit a written response to this Standard of Care determination in accordance with the directions given above.

Signature

TYPED NAME and Grade

Healthcare Provider

Attachment 24**FORMAT FOR NOTIFICATION OF STANDARD OF CARE MET**

Date

MEMORANDUM FOR NAME AND GRADE OF HEALTHCARE MEMBER

FROM: MTF Commander

SUBJECT: Notification of Standard of Care Met Determination

1. This memorandum is to inform you of your involvement in the malpractice claim of (claimant's name, Case number). Through an initial peer review process it was determined that you met the standard of care. This is a preliminary standard of care review on this claim. The case will be forwarded to the Air Force Medical Operations Agency (AFMOA) for final review and closure. Please note that no action will occur until final legal closure has been completed. Should a payment be rendered in 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.

2. The final standard of care may take longer than 1 year to complete. The time frame is dependent on legal proceedings/closure, number of healthcare providers involved, and the number of additional reviews required. Please keep the credentials office/equivalent informed of a current address so you can receive correspondence regarding this case.

Signature

TYPED NAME and Grade

Commander, MTF

1st Ind, Healthcare Provider

Date

MEMORANDUM FOR COMMANDER, MTF

I acknowledge receipt of the Standard of Care 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 review. I understand that if at any point a standard of care not met determination is found, I will be notified and afforded an opportunity to respond. I understand that the final processing of this claim may take longer than 1 year, and that no action will occur until the claim has been legally closed. I will keep the credentials office/equivalent informed of my correct address so I can receive additional correspondence related to this case.

Signature

TYPED NAME and Grade Healthcare Member

Attachment 25

CONTENTS OF MEDICAL INCIDENT INVESTIGATION (MII) REPORT

A25.1. The report will be organized into three parts: Part 1 will include executive summary and briefing slides of investigative process. Part 2 will include all factual material, and Part III will include witness testimony, opinions, analyses, findings, conclusions, and recommendations. For any event where the facility initiated a Root Cause Analysis, place that documentation at Tab L. The format is as follows (adding or deleting sections according to the scope of the investigation):

A25.1.1. Part I--Executive Summary/Outbrief Slides: Prepared by HQ MAJCOM/SG or principle investigator. Included in this section is a PowerPoint presentation of the investigation.

A25.1.2. Part II--Facts:

A25.1.2.1. **Tab A.** Paraphrased factual summary of incident taken from medical records, operative reports.

A25.1.2.2. **Tab B.** List of witnesses interviewed.

A25.1.2.3. **Tab C.** Personnel data: Pertinent training, certification, and licensure of individuals directly involved in the incident. Relevant schedules for personnel coverage, staffing at the time of the incident.

A25.1.2.4. **Tab D.** Medical data, such as copies of laboratory data, x-ray reports, autopsy reports, operative reports, progress notes, nursing notes, records of emergency service visits that are relevant to the findings or recommendations in Part II.

A25.1.2.5. **Tab E.** Other factual or technical reports on the MTF and equipment: Biomedical equipment status. Availability of supplies.

A25.1.2.6. **Tab F.** Relevant policies and procedures.

A25.1.2.7. **Tab G.** Nationally recognized professional standards and state and local laws relevant to the investigation.

A25.1.3. Part III--Findings and recommendations:

A25.1.3.1. **Tab H:** Witness testimony and statements. Investigators should provide answers to the following questions:

A25.1.3.1.1. How were you involved?

A25.1.3.1.2. What did you see?

A25.1.3.1.3. What contributed to the problem?

A25.1.3.1.4. Were you comfortable with your capabilities while providing care?

A25.1.3.1.5. Is there any way to improve support in performing this job?

A25.1.3.1.6. How can we prevent this problem in the future?

A25.1.3.1.7. From your perspective, were there any warning signs and what could have been done about them?

A25.1.3.2. **Tab I:** Summary of investigation and analysis: Summary may be divided into sections identifying personnel, training, and procedural factors, facility and equipment factors, and systemic factors or causes.

A25.1.3.3. **Tab J:** Findings: Findings should be listed or discussed in the chronological order of their occurrence. Findings which reveal a cause of the incident should be specifically indicated.

A25.1.3.4. **Tab K:** Recommendations for corrective or preventive actions: Should be addressed in terms of personnel, training and procedural factors, facility and equipment factors, and systemic factors. The investigator should avoid making any specific recommendations in the report regarding administrative or disciplinary actions against an individual.

A25.1.3.5. **Tab L:** Facility Root Cause Analysis (if applicable).

Attachment 26

COMPARING THE MII AND SE PROCESSES

Table A26.1. Comparing the MII and SE Processes.

Medical Incident Investigation	Sentinel Event
<p>1. Criteria</p> <p>1.1. Incident where objective evaluation cannot be completed internally</p> <p>1.2. Unexpected or preventable death or significant injury or self inflicted harm or attempted or actual suicide while under control of AFMS</p> <p>1.3. Any other event or series of events which either caused, or could cause, injury or death to a patient that warrants formal investigation</p>	<p>1. Criteria</p> <p>1.1. A sentinel event is <u>an unexpected occurrence</u> involving death or serious physical or psychological injury, or the risk thereof.</p> <p>1.2. Serious injury specifically includes the loss of limb or function.</p> <p>1.3. The phrase, “or the risk thereof” includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.</p>
<p>2. Examples</p> <p>2.1. Unanticipated death or major permanent loss of function</p> <p>2.2. Not related to natural course of illness</p> <p>2.3. Suicide (related to medical care or treatment, not only inpatient status)</p> <p>2.4. Unexpected injury</p> <p>2.5. Any other incident that requires investigation can be the subject of an MII.</p>	<p>2. Examples</p> <p>2.1. Unanticipated death or major permanent loss of function, not related to natural course of illness</p> <p>2.2. Suicide of a inpatient</p> <p>2.3. Infant abduction or discharge to the wrong family</p> <p>2.4. Rape</p> <p>2.5. Hemolytic transfusion reaction with major blood group incompatibles</p> <p>2.6. Surgery on the wrong patient or body part</p>
<p>3. Who Conducts the Investigation</p> <p>3.1. HQ MAJCOM/SG Appointed investigators</p> <p>3.2. Objective, global review</p> <p>3.3. Identify AF wide system problems or requirements for policy change</p>	<p>3. Who Conducts the Investigation</p> <p>3.1. Multidisciplinary Team members assigned to the facility where the incident occurred</p> <p>3.2. Local, focused review of root cause</p>

Attachment 27

FORMAT FOR NOTIFICATION TO AFMOA OF REPORTABLE ACTION

Date

MEMORANDUM FOR AFMOA/SGOC

110 Luke Avenue, Room 405
Bolling AFB, DC 20332-7050

FROM:

SUBJECT: Report of Incident to State Board of Licensure

1. AFI 44-119 (reference paragraph) requires that we notify AFMOA/SGOC of certain actions involving licensed providers. The following information is provided:

- a. Individual's Name:
- b. Date of Birth: (MM/DD/YYYY)
- c. Social Security Number:
- d. Home of Record: (or Current Address)
- e. Profession: (i.e. RN, MD, Dentist, etc)
- f. School Attended/Year Graduated:
- g. State and License Number(s):
- h. Military Treatment Facility: Ex: 95th Medical Group
30 Hospital Road
Edwards AFB CA 93524-1730
- i. Action and Date: (Date of Action and description of the action to be submitted to the state board)

2. Point of Contact for further information is (give name, phone, fax, and E-mail). Attached is supporting documentation related to this action.

Signature

TYPED NAME and Grade

Title

Office

Attachment 28**FORMAT FOR NOTIFICATION TO AFMOA/SGOC OF MII OR SE**

Send this information to AFMOA/SGOC, Chief of Risk Management Operations, within 3 duty days of becoming aware of the incident.

Please indicate which type of event is being reported.

_____ Medical Incident or _____ Sentinel Event (as defined by JCAHO)

MAJCOM: _____ MTF: _____

Patient's name: _____ SSN: _____

Admission diagnosis: _____

For Events Reported to JCAHO under Sentinel Event Reporting Program:

Date of SE: _____ Date JCAHO Notified: _____

Category: _____ Unanticipated death
 _____ Major permanent loss of function
 _____ Patient suicide in 24-hour care facility
 _____ Infant abduction/Discharge to wrong family
 _____ Rape
 _____ Hemolytic transfusion reaction involving admin of blood or blood products having major blood group incompatibilities
 _____ Surgery on the wrong body part

Date Root Cause Analysis due to JCAHO: _____

MII to be done? If yes, anticipated start date: _____

Brief description of event: _____

Does this event have media interest? Please forward any newspaper articles connected with this event to AFMOA/SGOC.

Point of Contact for additional information: (full name and phone number, FAX number and E-mail)

Attachment 29

**SAMPLE LETTER – COORDINATION WITH STATE LICENSING BOARDS –DEPARTMENT
OF DEFENSE HEALTH CARE PROFESSIONALS PRACTICING IN CIVILIAN HEALTH
CARE FACILITIES**

Date

Numbered MDG/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 Instruction 6025.16, *Portability of State Licensure for Health Care Professionals*; and AF Instruction 44-119, *Clinical Performance Improvement*; the following information is submitted to the host State Licensing Board for the following health care professional. This health care 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 **3.9.1.** of AFI 44-119:

Name of Health Care 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 30

IC 2001-1 TO AFI 44-119, CLINICAL PERFORMANCE IMPROVEMENT

4 JUNE 2001

SUMMARY OF REVISIONS

This interim change (IC) 01-1 implements DoDI 6025.16, *Portability of State Licensure for Health Care Professionals*, dated 30 August 200. This IC also adds **Attachment 29, Sample Letter – Department of Defense Health Care Professionals Practicing in Civilian Health Care Facilities**.

3.9. Portability of State Licensure. DoDI 6025.16 establishes procedures under Title 10 U.S.C. 1094(d) to permit licensed physicians and other healthcare professionals of the Military Health System (MHS) who are members of the Armed Forces to perform authorized duties for the Department of Defense in any authorized location. AFMS officials responsible will, prior to assigning licensed providers to off-base duties, follow the procedures established in this AFI to promote cooperation and good will 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.

3.9.1. Qualifications. To be eligible for assignment of off-base duties, the healthcare professional will have the following qualifications:

3.9.1.1. The healthcare professional will have a current, valid, and unrestricted license or other authorizing document such as certificate or registration (Reference paragraph **3.2.1.**, which encompasses the professional activities involved in the off-base duty assignment.

3.9.1.2. A healthcare professional will 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.

3.9.1.3. The healthcare professional will have current clinical competence to perform the professional duties assigned.

3.9.1.4. In the case of physicians and other privileged providers, the healthcare professional will have current clinical privileges granted and maintained in accordance with **Chapter 5**. 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.

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

3.9.1.5.1. 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.

3.9.1.5.2. The physician will have maintained current competence, in that if 10 years or more have passed since completion of the licensing examination, the physician must have ABMS/AOA specialty board certification.

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

3.9.1.6. 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 by-laws of such facility, to the extent they are applicable to the professional.

3.9.2. Coordination with State Licensing Boards. Prior to a healthcare professional performing off-base duties under the authority of Title 10 U.S.C. 1094(d), the AFMS official responsible (MDG/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 (MDG/CC); and the MHS liaison official (MDG/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 Title 10 U.S. C. 1094(d) and DoDI 6025.16 as underlying authority and will include a statement that the healthcare professional meets all qualification standards of paragraph 3.9.1. See [Attachment 29](#) for sample notification letter.

3.9.3. Investigations and Reports. 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, reference DoDI 6025.16, paragraphs 6.3.1. through 6.3.3.

3.9.4. Supplemental Agreements. AFMS officials responsible are authorized to enter into memoranda of agreement or other appropriate arrangements consistent with DoDI 6025.16 and other applicable law and DoD issuances to facilitate accomplishment of the purposes of that DoDI.

Attachment 29

SAMPLE LETTER – COORDINATION WITH STATE LICENSING BOARDS –DEPARTMENT OF DEFENSE HEALTH CARE PROFESSIONALS PRACTICING IN CIVILIAN HEALTH CARE FACILITIES

Date

Numbered MDG/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 Instruction 6025.16, *Portability of State Licensure for Health Care Professionals*; and AF Instruction 44-119, *Clinical Performance Improvement*; the following information is submitted to the host State Licensing Board for the following health care professional. This health care 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 **3.9.1.** of AFI 44-119:

Name of Health Care 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