



Defense Health Agency

PROCEDURES MANUAL

NUMBER 6025.13, Volume 5
August 29, 2019

Medical Affairs

SUBJECT: Clinical Quality Management in the Military Health System
Volume 5: Accreditation and Compliance

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedures Manual (DHA-PM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (q), establishes the Defense Health Agency's (DHA's) procedures to assign responsibilities and establish procedures for managing Clinical Quality Management (CQM) in the Military Health System (MHS). This DHA-PM replaces, in full, the contents of the DoD Manual 6025.13 (Reference (e)), which is targeted for cancellation. This DHA-PM, replaces, in Volume 2, the full contents, unless otherwise stated, of the following memorandums, which are targeted for cancellation: Assistant Secretary of Defense for Health Affairs Memorandum, "Policy on Reporting Joint Commission on Accreditation of Healthcare Organizations-Reviewable Sentinel Events in the Military Health System," July 13, 2004 (Reference (h)); Assistant Secretary of Defense for Health Affairs Memorandum, "Amplifying Guidance Relating to the Reporting of Sentinel Events and Personally Identifiable Information Breaches to the Office of the Assistant Secretary of Defense (Health Affairs)," February 13, 2012 (Reference (i)) [as related to the reporting of sentinel events only]; and Assistant Secretary of Defense for Health Affairs Memorandum, "Medical Quality Assurance and Clinical Quality Management in the Military Health System Sentinel Event and Root Cause Analysis Process Improvements," March 12, 2015 (Reference (j)).

2. APPLICABILITY. This DHA-PM applies to:

a. OSD, Military Departments, Office of the Chairman of the Joint Staff and the Joint Staff, Combatant Commands, Office of the Inspector General of the DoD, Defense Agencies, DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-PM as the "DoD Components");

b. The entire MHS, including each DoD Military Medical Treatment Facility (MTF) and all other healthcare provided by the MHS;

c. Uniformed services personnel of the active and reserve components (including National Guard personnel in a Federal duty status), civilian, contract, volunteer, and other medical or dental healthcare providers who are assigned to and deliver healthcare; and

(1) Credentialed healthcare providers who are members of the Army National Guard or the Air National Guard, while working in a non-federal status (Reference (k) are subject to the procedures, policies, and authorities, as prescribed by their respective Army Regulation Reference (l)) and Air Force Instruction (Reference (m)), or as defined in the policies, rules, procedures, and laws of the State, territory, or District of Columbia in which they are credentialed and/or privileged;

(2) Trainees who have been granted clinical privileges outside the training program when patient safety concerns arise;

d. Managed care support contractors (MCSCs), designated providers, and overseas contractors, consistent with their respective contracts awarded by the DoD.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to authority delegated in Reference (b) and based on authorities in Reference (a) through (q), that:

a. Establishes CQM procedures in the MHS to provide an organized structure for an integrated framework of programs to objectively define, measure, assure, and improve the quality of care received by MHS beneficiaries.

b. Strengthens MHS CQM accountability, transparency, and standardization in the MHS.

c. Affirms the MHS's unwavering commitment to quality healthcare for our beneficiaries, joint healthcare teams, and Combatant Commands across the globe, through CQM.

4. CANCELLED DOCUMENTS. This DHA-PM replaces, in Volume 2, the full contents of DHA-Procedural Instruction (DHA-PI) 6200.01, "Comprehensive Infection Prevention and Control (IPC) Program," April 24, 2017 (Reference (n)), which is being cancelled.

5. RESPONSIBILITIES. See Enclosure 2 of Volume 1.

6. PROCEDURES. Procedures specific to each program within the MHS CQM are addressed in Volumes 2-7 of this DHA-PM.

7. INFORMATION REQUIREMENTS. CQM uses several data capture, analysis, reporting, and decision support tools for patient safety, clinical quality assurance, and improvement to


include the electronic medical record, databases such as the Joint Centralized Credentials Quality Assurance System (JCCQAS), and the Joint Patient Safety Reporting (JPSR), data visualization and report tools on CarePoint (a SharePoint platform), and more.

8. **RELEASABILITY. Cleared for public release.** This DHA-PM is available on the Internet from the Health.mil site at: <http://www.health.mil/dhapublications>.

9. **EFFECTIVE DATE.** This DHA-PM:

a. Is effective on October 01, 2019.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date, in accordance with Reference (c).


FOR R. C. BONO
VADM, MC, USN
Director

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Glossary

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 24, 2018
- (d) DoD Instruction 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS),” February 17, 2011, as amended
- (e) DoD Manual 6025.13, “Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS),” October 29, 2013
- (f) National Defense Authorization Act for Fiscal Year 2017, Sections 702
- (g) National Defense Authorization Act for Fiscal Year 2019, Sections 711 and 712
- (h) Assistant Secretary of Defense for Health Affairs Memorandum, "Policy on Reporting Joint Commission on Accreditation of Healthcare Organizations-Reviewable Sentinel Events in the Military Health System," July 13, 2004
- (i) Assistant Secretary of Defense for Health Affairs Memorandum, "Amplifying Guidance Relating to the Reporting of Sentinel Events and Personally Identifiable Information Breaches to the Office of the Assistant Secretary of Defense (Health Affairs)," February 13, 2012
- (j) Assistant Secretary of Defense for Health Affairs Memorandum, "Medical Quality Assurance and Clinical Quality Management in the Military Health System Sentinel Event and Root Cause Analysis Process Improvements," March 12, 2015
- (k) United States Code, Title 32, Sections 502 – 505
- (l) Army Regulation 40–68, “Clinical Quality Management,” February 26, 2004, as amended
- (m) Air Force Instruction 44–119, “Medical Quality Operations,” August 16, 2011
- (n) DHA-Procedural Instruction 6200.01, "Comprehensive Infection Prevention and Control (IPC) Program," April 24, 2017, hereby cancelled
- (o) United States Code, Title 10, Section 1102
- (p) Public Law 104-191, “Health Insurance Portability and Accountability Act of 1996,” August 21, 1996, as amended
- (q) Code of Federal Regulations, Title 32, Part 199.16

ENCLOSURE 2

ACCREDITATION AND COMPLIANCE

1. GENERAL OVERVIEW. Accreditation and compliance focuses on a comprehensive, systematic process of review across the MHS, which allows MTFs to demonstrate their ability to meet DoD policy mandates, regulatory requirements, and healthcare standards. Achieving and maintaining accreditation by a recognized external accrediting organization (AO) provides benchmarks for measuring standards compliance and builds stakeholder confidence in the quality of healthcare delivered. Compliance reviews provide insight on an MTF's ability to comply with policy requirements and leadership direction. These activities involve a rigorous review of policies, processes, and procedures that allow organizations to identify any areas with gaps in compliance, and supports the MHS high reliability organization (HRO) journey.

a. Purpose. Provide guidelines for the healthcare accreditation and compliance activities of the MHS. Prescribe procedures for accreditation and compliance management and reporting.

b. Functions. This enclosure outlines procedures related to the following accreditation and compliance activities: accreditation and certification, self-assessment, assist visits, compliance visits, and knowledge sharing.

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

a. accreditation. Process of review that allows healthcare organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized accrediting organization (AO).

b. auditing. A process used by health professionals to assess, evaluate, and improve care in a systematic way; used by clinical governance to safeguard high quality of clinical care for patients.

c. certification. A process by which a nationally recognized organization confirms that an individual healthcare organization has met certain predetermined standards or procedures required for certification.

d. compliance. The ongoing process of meeting the legal, ethical, and professional standards applicable to a particular healthcare organization or provider.

e. data monitoring. The systematic and ongoing collection, compilation, and organization of data pertaining to indicators for the quality and appropriateness of important aspects of care in order that problems or opportunities to improve care can be identified.

f. direct care system. Healthcare facilities and medical support organizations managed by the DoD through the Defense Health Agency (DHA) or Service Surgeons General in accordance with applicable federal laws and regulations.

g. focused review. A review that concentrates on a perceived problem area that involves a specific standard, procedure, policy or any other limited scope healthcare delivery matter.

h. medical quality assurance program (MQAP). Any peer review activity carried out before, on, or after November 14, 1986 by or for the DoD to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks as defined in Reference (o).

i. purchased care system. A component of the uniform program of medical and dental care for members and certain former members of the Services, and for their dependents where services are provided to beneficiaries by TRICARE-authorized civilian network and non-network healthcare providers and facilities.

3. GOVERNANCE STRUCTURE. The DHA Accreditation and Compliance (AC) Program is managed by the CQM Branch, in the Clinical Support Division, under the Deputy Assistant Director-Medical Affairs (DAD MA). The AC Program develops, promotes, and supports the DHA mission and the MHS Quadruple Aim through facilitation and support of compliance with nationally recognized healthcare standards utilizing HRO guiding principles.

4. SCOPE AND CORE RESPONSIBILITIES

a. Scope

- (1) Provide guidelines for the accreditation of MTFs.
- (2) Prescribe procedures for management and reporting of accreditation and compliance activities.
- (3) Provide guidance on knowledge development and management of accreditation requirement and standards.

b. Core Responsibilities

(1) DHA Headquarters

- (a) Monitor accreditation and certification of all MTFs.

(b) Analyze accreditation data for system-level patterns and trends to identify opportunities for improvement.

(c) Manage accreditation aggregation tool to provide access to survey findings and survey report.

(d) Establish, manage, and maintain a centralized and single-source accreditation contract for all MTFs.

(e) Develop recommendations for accreditation waiver requests.

(f) Manage assist and compliance visits to support assigned MTFs with policy implementation.

(2) DHA Market/Intermediate Headquarters

(a) Monitor accreditation and certification status for assigned MTFs.

(b) Analyze accreditation results to identify patterns and trends for assigned MTFs to enhance standards compliance.

(c) Support assist and compliance visits to assigned MTFs with policy implementation.

(d) Comply with the corporate contract with the AO, and provide guidance on the accreditation processes.

(e) Support compliance with AO standards, queries, and communications for assigned MTFs.

(f) Review and develop recommendations for accreditation waiver requests.

(3) MTF

(a) Maintain continuous compliance with AO standards and other regulatory or accreditation requirements, as appropriate.

(b) Investigate and prepare responses to AO queries for DHA Market/Intermediate Headquarters review prior to submission.

(c) Communicate all accreditation and compliance activities with the DHA Market/Intermediate Headquarters.

(d) Establish and maintain a self-assessment program to monitor compliance standards and regulatory compliance.

- (e) Implement and maintain compliance with DoD and DHA directives.

5. PROCEDURES

a. Accreditation and Certification

(1) Requirements

(a) MTF and purchased care healthcare facilities will maintain accreditation based on the type of facility, services delivered, and programs offered (e.g., ambulatory healthcare, behavioral healthcare, home care, and hospital healthcare).

(b) The accreditation of MTFs is to demonstrate a commitment to quality care and compliance with nationally recognized standards. It is not required nor intended to demonstrate compliance with Centers for Medicare and Medicaid Services (CMS) regulations.

(c) Accreditation requirements, standards, and survey process information are contained in the AO's policies and manuals. This information will not be duplicated in this DHA-PM.

(d) The external AO and the ensuing accreditation activities will be incorporated into the CQM functional capability and comply with the MQAP requirements in accordance with Reference (o) and Reference (p). The management of survey and related accreditation information will meet the requirements in accordance with Reference (o) and Reference (p), and the external AO will not publicly release official accreditation survey reports or other materials that contribute to accreditation decision.

(e) On occasion, federal laws and DoD policy may exceed the standards of the AO, and in such cases, the federal law or DoD prevails. MTF procedures and policies cannot use less stringent language than DoD or DHA guidance. When military mission requirements result in a conflict with AO standards, implementing instructions will be issued by DHA leadership in coordination with Service SG. The DHA AC Program will pursue resolution of any recognized inconsistency in guidance with the AO. MTFs will immediately notify respective DHA Markets/Intermediate Headquarters CQM personnel if any inconsistencies are identified.

(f) The timing of MTF accreditation surveys will be communicated, by the DHA AC Program, with the operational medical readiness entities (e.g., Health Services Inspection Team or Medical Inspector General).

(g) MTFs will maintain required certifications to meet applicable state regulations, national standards, and federal laws. MTFs may obtain programmatic or clinical specialty certifications based on the analysis of the value of the program to ensure safe, quality care.

(2) Direct Care Facilities

(a) In direct care, MHS MTFs must maintain facility (e.g., hospital, ambulatory, behavioral) accreditation by an external nationally recognized AO.

(b) The same healthcare facility AO will be utilized across the direct care system, unless a waiver is approved by Assistant Secretary of Defense for Health Affairs (ASD(HA)). The use of a consistent AO will reduce variation in the accreditation standards and survey process, supporting high reliability efforts.

(c) A CMS-approved AO will be used to the maximum extent possible.

(d) MTF accreditation must be obtained through an on-site survey process at least every 3 years.

(e) Patient Centered Medical Homes (PCMHs) must obtain and maintain certification by an external AO. The same AO will be utilized across the direct care system, unless a waiver is approved by ASD(HA). The PCMH certification helps primary care clinics provide patient-centered, comprehensive, accessible, and coordinated care delivered by primary care healthcare providers working with an interdisciplinary care team.

(f) Situations in which formal agreements are established to provide care by military personnel in civilian or other healthcare facilities, the facilities must be accredited by a CMS-approved AO, or an accreditation source approved by the ASD(HA).

(g) Operational healthcare units (deployable units that while at home station are treating only active duty personnel and Reserve Component members on duty status and that are not a component of an accredited MTF) are under separate rules with respect to accreditation.

1. On a military installation in or outside the United States, unless under the operational control of Combatant Commands, if the unit provides health care services in a fixed facility, the facility is subject to accreditation. Although not under the control of an MTF on the installation, the facility may for accreditation purposes be affiliated with the MTF, such as by memorandum of agreement, so as to be covered by the MTF's accreditation. For purposes of command and control, this may affiliate with the Commander responsibilities of the dual-hatted MTF Director/Commander. Alternatively, the separate facility may obtain accreditation in its own right.

2. As an alternative to satisfying the accreditation requirement in Paragraph 5.a.(2)(g)1. of this enclosure, the facility involved may obtain from the ASD(HA), upon a request from the Military Department concerned, an exemption from accreditation based on documentation that it operates under comparable CQM compliance mechanisms established and implemented by the Military Department. At a minimum, the functions of patient safety, healthcare risk management, credentialing and privileging, clinical measurement, and clinical quality improvement programs must be included in the CQM compliance mechanisms, and

assessments done by the Military Departments no less than every 3 years shall be sent to the DHA Headquarters AC Program.

3. Outside the United States in other locations, operational healthcare units will, to the extent practicable, operate under comparable CQM compliance mechanisms of the Military Department or Combatant Commander.

(3) Ancillary Services. All MTFs must obtain and maintain nationally recognized certification and accreditations for ancillary services to include but are not limited to:

(a) Laboratory Services Accreditation. MTF-based clinical laboratories are accredited by the College of American Pathologists (CAP). Operational healthcare unit laboratories are inspected by CAP or approved agencies, as per DoD guidance. Additional guidance for laboratory accreditation requirements can be found in the DHA-Procedural Instruction on “Establishment & Oversight of Clinical Medical Laboratories in the Military Health System.” Accreditation inspections are typically on a 2-year cycle and are generally unannounced. The DHA Center for Laboratory Medicine Services provides regulatory administration for all DoD laboratories.

(b) Blood Bank. Each MTF blood donor center and/or transfusion service activity will be licensed and/or registered by the Food and Drug Administration (FDA). MTF blood banking activities will also maintain AABB and CAP accreditation. The DHA Armed Services Blood Program Division provides regulatory guidance used by DoD and MTF blood bank facilities involved in the manufacture, storage, distribution, and transfusion of blood products.

(c) Radiology. All MTFs must obtain and maintain nationally required accreditation and certification for radiology services, based on federal regulations (Nuclear Regulatory Commission and, FDA), DoD guidance, and national standards.

(4) Purchased Care

(a) Purchased care network hospitals and other healthcare facilities used by the MCSC or designated provider in the United States, must be accredited by a CMS approved AO, or through an accreditation source approved by the ASD(HA) in accordance with Title 32, Part 199.16, of Reference (q), TRICARE manuals, and the contracts.

(b) Host nation hospitals and other places of institutional care will meet accreditation standards of the specific host nation or U.S. commonwealth or territory. The TRICARE overseas contractor evaluates the quality, safety, and compliance with licensure/certification and malpractice insurance requirements of purchased care sector institutions every 3 years at a minimum, per TRICARE manuals and contracts.

(5) Accreditation Waivers. ASD(HA) will consider accreditation waivers on a case-by-case basis.

(a) Accreditation waivers are only to be approved in extreme circumstances. For example, a waiver may be granted when travel to the MTF poses an undue risk to the traveler.

(b) Waiver requests must include an overview of the facility (or facilities) to include location, healthcare services provided, type of beneficiaries served, the justification for the waiver, proposed implementation schedule, and quality management plan, to include monitoring of CQM programs and a reporting process.

(c) DHA Markets/Intermediate Headquarters will submit waiver requests to ASD(HA) through higher headquarters.

(d) DHA/Service higher headquarters will review all waiver requests for completeness and development of a recommendation to approve or deny request.

(e) Upon approving the waiver request, DHA/Service higher headquarters will endorse the recommendation and submit, along with the waiver request, to the ASD(HA) for decision. ASD(HA) will inform DAD-MA of any approved Service requests. The DHA AC Program will maintain a list of approved accreditation waivers and provide an annual report to ASD(HA) on the approved waivers and status of quality management activities.

(f) For any MTFs that are approved for waiver of accreditation and are exempt from the accreditation requirement, DAD MA must do the following:

1. Ensure processes are developed and implemented to ensure utilization of the same evidence-based standards for quality and PS as required for accredited MTFs.

2. At a minimum, waived MTFs will undergo higher headquarters-led comprehensive, on-site assessments of CQM every 3 years, to be submitted the DAD-MA within 30 business days of completion of the assessment visit.

(6) Accreditation Monitoring

(a) The management and administration of accreditation status and the survey process to include on-site visit, action plan development, and submission will be coordinated through DHA Markets/Intermediate Headquarters and monitored by the DHA AC Program.

(b) The DHA AC Program will monitor the timing of accreditation surveys through communication with the AO and DHA Markets/Intermediate Headquarters.

(c) Results of accreditation surveys will be aggregated for all MTFs to support the identification of system level patterns and trends for improvement. An electronic file of the accreditation findings obtained from the external AO will be uploaded at least quarterly to the accreditation aggregation tool. Accreditation findings will be reviewed for patterns and trends by subject matter experts to identify potential process improvement opportunities.

(7) Standards and Accreditation Knowledge Development

(a) Opportunities to expand knowledge on accreditation requirements and standards will be based on roles and responsibilities.

1. MTF staff: Knowledge of the requirements for accreditation and the standards related to assigned responsibilities.

2. Leadership: In-depth knowledge of accreditation requirement and leadership responsibilities.

3. Quality Leads and Accreditation Fellows: In-depth knowledge and ability to teach and mentor others in the accreditation requirements, standards, and survey process.

(b) DHA/Service Headquarters will notify DHA Markets/Intermediate Headquarters and MTFs of available educational opportunities, such as semi-annual webinar of AO standards and trends, leading practices, and lessons learned from MTF accreditation surveys.

(c) Additional opportunities for knowledge and development may be available through the AO.

(8) Governing Body and Other Equivalencies for Use in Accreditation Surveys. The following equivalencies apply to MTFs:

(a) The DHA Director serves as the governing body for MTFs.

(b) Applicable federal law, DoD policy/directives, DHA Procedural Instructions and DHA-PMs, and local operating policies serve as the bylaws.

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

(d) The MTF Director/Commander acts as the Chief Executive Officer and represents the local governing body.

(e) The MTF Director/designee (e.g., Deputy Director, Senior Administrator, or another executive committee member), serves as the Chief Operating Officer.

(f) The MTF Chief Medical Officer or equivalent serves as the President of the Medical Staff.

(g) The MTF Chief Nurse serves as the Nurse Executive.

(h) The MTF executive committee formally links the functions of the governing body representative, the Chief Operating Officer, the medical and other professional staff, with other important aspects of the organization's operation.

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

(9) Accreditation Survey Report Submission

(a) The MTF Director will submit a copy of the preliminary report as soon as available and the final report to the respective DHA Market/Intermediate Headquarters and higher headquarters within 10 business days of receipt.

(b) This requirement applies to all external healthcare accreditation surveys.

(c) The DHA AC Program staff will submit accreditation reports to ASD(HA).

(d) Evidence of standard compliance reports required by the AO will be submitted to DHA Market/Intermediate Headquarters for review prior to submission.

(10) MTF After-Action Reports

(a) Within 30 business days of completion of any survey (triennial, unannounced, surveys for cause, or focused), the MTF Director/Commander will ensure submission of an after-action report to higher headquarters through the DHA Market/Intermediate Headquarters.

(b) The report will detail the survey preparation process (planned surveys), continuous compliance activities, lessons learned as a result of the survey process, and AO identified leading practices. The DHA AC Program and DHA Market/Intermediate Headquarters CQM staff will disseminate lessons learned.

b. Self-Assessment

(1) All MTFs are required to continuously assess and maintain compliance with accreditation standards, policy mandates, and regulatory requirements.

(2) An annual self-assessment of all the accreditation standards shall be conducted and documented by the MTF staff.

(a) Information from the self-assessment shall be recorded in the designated electronic tool provided by the AO.

(b) The completed self-assessment record will be shared with the DHA Market/Intermediate Headquarters for tracking of completion and monitoring for patterns or trends.

(3) Patterns and trends will be analyzed for identification of performance improvement opportunities.

(4) Non-compliant standards, high-risk areas, and known vulnerabilities shall have ongoing monitoring.

(a) At a minimum, MTF self-assessment activities on non-compliant areas shall be performed once a month.

(b) Completed documentation shall be made available via the designated electronic tool provided by the AO.

(c) The DHA AC Program and DHA Market/Intermediate Headquarters designated staff shall have the capability and access to review self-assessment documentation.

(d) Documentation will be analyzed for patterns and trends for the identification and implementation of new and/or updates to existing procedures.

(5) Action plans shall be completed for identified non-compliant standards. Completed action plans shall be submitted via the designated electronic tool provided by the AO.

(6) DHA Markets/Intermediate Headquarters are responsible for monitoring patterns and trends and the completion of submitted action plans.

c. Accreditation Assist Visits. The accreditation assist visit is a systematic review of routine operations and ongoing quality improvement efforts at the MTF, supporting continuous compliance with accreditation standards. It is an internally driven process conducted by military, government, and/or contracted staff, available to MTFs to support compliance with a multitude of laws, regulations, policies, and accreditation standards.

(1) The DHA AC Program will administer and lead, with support of the DHA Markets/Intermediate Headquarters, the coordination of accreditation assist visits to ensure needed subject matter experts, such as an Accreditation Fellow, are included on the team.

(2) An accreditation assist visit is usually conducted in the 12–18 month timeframe prior to the projected accreditation survey date.

(3) A report containing an overview of the accreditation assist visit team; activities completed during the visit, identified areas of excellence, and opportunities for improvement will be completed and provided to the MTF and DHA Market/Intermediate Headquarters within 30 business days of the visit.

(4) MTFs will develop and submit plans of action and milestones (POAM) for identified non-compliance with laws, regulations, policies, and standards to the respective DHA Market/Intermediate Headquarters within 30 business days of receiving the accreditation assist visit report.

(a) Once corrective actions (CAs) are completed, the finalized POAM and any accompanying documents shall be submitted to DHA Market/Intermediate Headquarters staff.

(b) The DHA Markets/Intermediate Headquarters are responsible for monitoring patterns and trends, and the completion of POAMs.

d. Focused Assist Visits

(1) A focused assist visit is a systems-based review of a specific program or process, conducted by a specialized team resulting in guidance to assist the MTF with standards compliance and improvement activities.

(2) Leadership from the MTF, DHA Market/Intermediate Headquarters, or DHA/Service Headquarters may request a focused assist visit.

(a) DHA/Service Headquarters, with support of the DHA Market/Intermediate Headquarters, will manage and lead coordination of focused assist visits to ensure needed subject matter experts are included on the focused assist visit review team.

(b) These visits may include but are not limited to: consultative assessment of quality care, significant accreditation compliance issues, subject matter expert visits for consultation and knowledge development, program implementation, and modification or assessment visits.

(3) A report containing an overview of the focused assist visit team findings will be submitted to the MTF and DHA Market/Intermediate Headquarters within 30 business days of the visit noting any discrepancies that will need follow-up actions.

(a) A POAM will be completed by the MTF and submitted to DHA Market/Intermediate Headquarters staff within 30 business days of the focused assist visit team report for identified opportunities for improvement.

(b) DHA Markets/Intermediate Headquarters are responsible for monitoring patterns and trends, and that POAMs are successfully implemented.

e. Compliance Visits

(1) A compliance visit is focused on the use of internal audits to monitor adherence to applicable statutes, regulations, and program requirements by a group of multidisciplinary subject matter experts. Auditing activities are retrospective, and may include the evaluation of an organization, system, process, or enterprise to ascertain the validity and reliability of information, and to provide an assessment of internal mandates.

(2) Compliance visits are directed by DHA Market/Intermediate Headquarters or DHA/Service Headquarters leadership.

(3) DHA/Service Headquarters, with support of the DHA Markets/Intermediate Headquarters, will manage and lead coordination of compliance visits to ensure needed subject matter experts are included on the compliance visit review team.

(4) The MTF will be informed of the objective of the compliance visit prior to inspection.

(5) The information provided will include the purpose, goal, or target of the review. The visit may have more than one objective depending on the direction from leadership.

(6) A report containing an overview of the compliance visit team will be submitted to the MTF, and respective DHA Market/Intermediate Headquarters within 30 business days of the visit, noting any discrepancies that will need follow-up actions.

(7) MTFs will complete and submit a POAM for identified discrepancies within 30 business days of receiving the compliance visit report.

(8) DHA Markets/Intermediate Headquarters will be responsible for monitoring patterns and trends, and ensuring that the POAM are successfully implemented.

f. Knowledge Sharing and Feedback Loop

(1) Information from accreditation and compliance activities will be gathered to develop knowledge and advance skills in meeting national standards, policies, and procedures. The DHA AC Program will gather information on accreditation and assist visits to identify opportunities for knowledge development.

(2) The DHA AC Program will compile, aggregate, and disseminate information from compliance activities for MHS-wide sharing.

(3) The DHA AC Program will ensure closure of the feedback loop is accomplished for all accreditation, assist visits, and compliance visits completed.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

Unless otherwise noted, these abbreviations and acronyms are for the purpose of this DHA-PM

AABB	AABB (formerly known as American Association of Blood Banks)
AAMFT	American Association of Marriage and Family Therapy
AAO	American Academy of Optometry
ABA	American Board of Audiology
ABCMO	American Board of Certification in Medical Optometry
ABMS	American Board of Medical Specialties
ABO	American Board of Optometry
AC	accreditation and compliance
ACS	American College of Surgeons
ACGME	Accreditation Council for Graduate Medical Education
ACLS	Advanced Cardiac Life Support
ACPE	Accreditation Council for Pharmacy Education
AD CS	Assistant Director for Combat Support
ADA	American Dental Association
ADA	American with Disabilities Act
ADN	Associate's Degree in Nursing
AHRQ	Agency for Healthcare Research and Quality
ALS	Advanced Life Support
AMA	American Medical Association
ANCC	American Nurses Credentialing Center
AO	accrediting organization
AOA	American Osteopathic Association
APA	American Psychological Association
APMA	American Podiatric Medical Association
APN	advance practice nurse
APTA	American Physical Therapy Association
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASHA	American Speech-Language-Hearing Association
Au.D.	Doctor of Audiology
BAA	business associate agreement
BLS	Basic Life Support
BSN	Bachelor of Science in Nursing
CAC	Common Access Card
CADE	Commission on Accreditation for Dietetics Education
CAI	Corrective Action Implementation
CAP	College of American Pathologists
CCE	Council on Chiropractic Education
CDR	Commission on Dietetic Registration

CE	continuing education
CFR	Code of Federal Regulations
CGFNS	Commission on Graduates of Foreign Nursing Schools
CHBC	Criminal History Background Check
CIS	Criminal Investigative Service
CLIP	Clinical Laboratory Improvement Program
CM	clinical measurement
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CNM	certified nurse midwife
CNS	certified nurse specialist
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
COMLEX	Comprehensive Osteopathic Medical Licensing Examination
COR	Contracting Officer's Representative
CP	credentialing and privileging
CPME	Council on Podiatric Medical Education
CQI	clinical quality improvement
CQIS	Clinical Quality Improvement Studies
CQM	clinical quality management
CRNA	certified registered nurse anesthetist
CSA	Comprehensive Systematic Analysis
CUSP	Comprehensive Unit-based Safety Program
CVO	Centralized Credentials Verification Office
DAD MA	Deputy Assistant Director for Medical Affairs
DEA	Drug Enforcement Agency
DES	Disability Evaluation System
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DHA-PM	Defense Health Agency-Procedures Manual
DHHS	Department of Health and Human Services
DMAT	Disaster Medical Assistance Team
D.O.	Doctor of Osteopathic Medicine
DoD RE	DoD Reportable Event
DSA	data sharing agreement
DSAA	data sharing agreement application
DLA	Defense Logistics Agency
EDIS	Educational and Developmental Intervention Services
EHR	electronic health record
ECFMG	Educational Commission for Foreign Medical Graduates
EIDS	Enterprise Intelligence and Data Solutions
eMSM	Enhanced Multi-Service Market
ER	emergency room
ERM	enterprise risk management

FAAO	Fellowship in the American Academy of Optometry
FDA	Food and Drug Administration
FHPQA	Force Health Protection Quality Assurance
FMEA	Failure Mode Effect Analysis
FNLH	Foreign National Local Hire
FNP	family nurse practitioner
FOIA	Freedom of Information Act
FPGEC	Foreign Pharmacy Graduation Examination Committee
FPPE	focused professional practice evaluation
GME	Graduate Medical Education
GS	General Schedule
GTT	Global Trigger Tool
HAI	healthcare-associated infection
HAR	Hazards, Alerts, and Recalls
HAR-NESS	Hazards, Alerts, and Recalls Notice System
HEDIS [®]	Healthcare Effectiveness Data and Information Set
HIPDB	Health Integrity Protection Data Bank
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	health information technology
HPSP	Health Professions Scholarship Program
HRM	healthcare risk management
HRO	high reliability organization
HROM	High Reliability Operating Model
ICTB	Inter-facility Credentials Transfer Brief
IDES	Integrated Disability Evaluation System
IHPP	Impaired Healthcare Provider Program
IMA	Individual Mobilization Augmentee
IO	Investigating Office
IOM	Institute of Medicine
IPC	infection prevention and control
IPCWG	Infection Prevention and Control Working Group
JCCQAS	Joint Centralized Credentials Quality Assurance System
JOES	Joint Outpatient Experience Survey
JPSR	Joint Patient Safety Reporting
LEIE	List of Excluded Individuals and Entities
LIP	licensed independent practitioner
LPN	licensed practical nurse
LVN	licensed vocational nurse
MC	Medical Corps
MCSC	Managed Care Support Contractor

M.D.	Doctor of Medicine
MEB	medical evaluation board
MEDLOG	Medical Logistics Division
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MOU	memorandum of understanding
MPL	Master Privilege List
MQA	medical quality assurance
MQAP	medical quality assurance program
MQAR	medical quality assurance record
MQSA	Mammography Quality Standards Act
MSM	medical staff manager
MSP	medical staff professional
MSW	Master of Social Work
MTF	military medical treatment facility
NBDHE	National Board Dental Hygiene Examination
NCC	National Certification Corporation
NCQA	National Committee of Quality Assurance
NCCPA	National Commission on Certification of Physician Assistants
NDAA	National Defense Authorization Act
NGO	non-governmental organization
NHSN	National Healthcare Safety Network
NOTO	Number of Times Occurred
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPIC	National Perinatal Information Center
NQF	National Quality Forum
NSQIP [®]	National Surgical Quality Improvement Program
OCONUS	outside the continental United States
ODE	off-duty employment
OHU	operational healthcare unit
OPM	Office of Personnel Management
OPPE	ongoing professional practice evaluation
OSD	Office of the Secretary of Defense
PA	physician assistant
PA-C	Physician Assistant-Certified
PAF	Provider Activity File
PALS	Pediatric Advanced Life Support
PCE	potentially compensable event
PCMH	Patient Centered Medical Home
PCS	permanent change of station
PDCA	Plan-Do-Check-Act
PDSA	Plan-Do-Study-Act

PEB	physical evaluation board
PEBLO	Physical Evaluation Board Liaison Officer
PECOS	Provider Enrollment, Chain and Ownership System
PG	Postgraduate
Pharm.D.	Doctor of Pharmacy
Ph.D.	Doctor of Philosophy
PHI	protected health information
PHM	Population Health Management
PII	personally identifiable information
PIV	Personal Identity Verification Card
P/MHNP	psychiatric/mental health nurse practitioner
POAM	Plans of Action and Milestones
POC	point of contact
PNCB	Pediatric Nursing Certification Board
PNP	pediatric nurse practitioner
PQDR	Product Quality Deficiency Report
PQI	Prevention Quality Indicator
PRA	proactive risk assessment
PS	patient safety
PSC	personal services contract
PSI	Patient Safety Indicator
PSIC	Patient Safety Improvement Collaborative
PSLC	Patient Safety Learning Center
PSM	patient safety manager
PSP	Patient Safety Program
PSPC	Patient Safety Professional Course
PSQAC	Patient Safety Quality Academic Collaborative
PSR	patient safety report
PSV	primary source verification
Psy.D.	Doctor of Psychology
QA	quality assurance
QAI	Quality Assurance Investigation
QAIO	Quality Assurance Investigating Officer
RAG	Risk Assessment Grade
RCA	root cause analysis
RDH	registered dental hygienist
RD	registered dietitian
RDN	registered dietitian nutritionist
RMWG	Risk Management Working Group
RN	registered nurse
SAFE	Sexual Assault Forensic Exam
SAMFE	Sexual Assault Medical Forensic Examiner
SANE-A [®]	Sexual Assault Nurse Examiner – Adult/Adolescent

SDD	Solution Delivery Division
SE	sentinel event
SE MOS	Sentinel Event Measures of Success
SERCA	Safety Event Root Cause Analysis
SERE	survival, evasion, resistance and escape
SG	Surgeon General
SHEA	Society for Healthcare Epidemiology of America
SIP	significantly involved provider
SMDR	senior medical department representative
SME	subject matter expert
SOC	standard of care
SRE	serious reportable event
STEEEP	safe, timely, effective, efficient, equitable, patient-centered
T-TPQ	TeamSTEPPS™ Teamwork Perceptions Questionnaire
TAA	training affiliation agreement
TDY	temporary duty
TeamSTEPPS™	Team Strategies and Tools to Enhance Performance and Patient Safety
TJC	The Joint Commission
TRISS	TRICARE Inpatient Satisfaction Survey
U.S.C.	United States Code
UCMJ	Uniform Code of Military Justice
UMO	Undersea Medical Officer
USMLE	United States Medical Licensing Exam
USN	United States Navy
USTRANSCOM	United States Transportation Command
USU	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs
VADM	Vice Admiral
VMC	virtual medical center
VTC	video teleconferencing
WHNP	women's health nurse practitioner

PART II. DEFINITIONS

Unless otherwise noted, these terms and their definitions are for the purpose of this DHA-PM.

accreditation. Process of review that allows healthcare organizations to demonstrate their ability to meet regulatory requirements and standards established by a recognized accrediting organization (AO).

adverse event. See definition for patient safety (PS) event.

adverse practice action. Restriction, reduction, or revocation of the clinical practice of a non-privileged provider as a result of a due process professional review action, based upon evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

adverse privileging action. Denial, restriction, reduction, or revocation of clinical privileges as a result of a due process professional review action, based upon evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient.

Agency for Healthcare Research and Quality (AHRQ) Harm Scale. The AHRQ Harm Scale can be found in the AHRQ Common Formats – Hospital Version 2.0, and includes the following assignment categories:

No-Harm: Event reached the patient, but no harm was evident.

Mild Harm: Bodily or psychological injury resulting in minimal symptoms or loss of function, or injury limited to additional treatment, monitoring, and/or increased length of stay.

Moderate Harm: Bodily or psychological injury adversely affecting functional ability or quality of life, but not at the level of severe harm.

Severe Harm: Bodily or psychological injury (including pain or disfigurement) that interferes substantially with functional ability or quality of life.

Death

The harm scale defined by AHRQ Common Formats – Hospital Version 2.0, further delineates harm as:

Temporary Harm. Expected to revert to approximately normal (i.e., patient’s baseline)

Permanent Harm. Not expected to revert to approximately normal (i.e., patient’s baseline)

approved postgraduate training. Postgraduate training program accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or other similar entities regulating healthcare provider training programs.

auditing. A process used by health professionals to assess, evaluate, and improve care in a systematic way; used by clinical governance to safeguard high quality of clinical care for patients.

certification. A process by which a nationally recognized organization confirms that an individual healthcare organization has met certain predetermined standards or procedures required for certification.

clinical adverse action. Action invoked against a healthcare provider, privileged or not, with the result that the authority to practice clinically is adversely affected. Adversely affected privilege(s)/practice are the result of a due process professional review action based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient, and that leads to the inability of a provider to exercise their privilege(s)/practice with their own independent judgment. This is the collective term used in this manual that encompasses both an adverse practice action and an adverse privileging action.

clinical data evaluation. Analysis of collected, compiled, and organized data pertaining to important aspects of care. Data are compared with predetermined, clinically valid criteria; variations from criteria are determined to be justified or unjustified; and problems or opportunities to improve care are identified.

clinical measurement (CM). CM uses tools to help evaluate and track the quality of healthcare services provided to beneficiaries in the Military Health System (MHS). Analyzing CM data and acting on identified trends for improvement helps ensure the MHS delivers safe, timely, effective, efficient, equitable, and patient-centered care.

clinical privileges. Permission granted by the Privileging Authority to provide medical and other patient care services. Clinical privileges define the scope and limits of practice for privileged providers and are based on the capability of the healthcare facility, licensure, relevant training and experience, current competence, health status, judgment, and peer and department head recommendations.

clinical privileging. The granting of permission and responsibility of a healthcare provider to provide specified or delineated healthcare within the scope of the provider's license, certification, or registration.

clinical quality improvement (CQI). CQI consists of systematic and continuous actions that lead to measurable improvement in healthcare services and the health status of targeted patient groups. Focuses on the application of several widely accepted process improvement methodologies to improve clinical performance and desired outcomes.

clinical quality management (CQM). The integrated processes, both clinical and administrative, that provide the framework to objectively define, measure, assure, and improve the quality and safety of care received by beneficiaries. The CQM functional capability includes the following programs: Patient Safety, Healthcare Risk Management, Credentialing and Privileging, Accreditation and Compliance, Clinical Measurement, and Clinical Quality Improvement.

competency assessment. Assessment of a healthcare provider's knowledge, skills, and ability to deliver high quality, safe patient care. The Military Health System (MHS) assesses providers

using standards from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS), recognizing six areas of “General Competencies” including: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. These may serve as the basis for healthcare provider care evaluation and privileging decisions.

compliance. The ongoing process of meeting the legal, ethical, and professional standards applicable to a particular healthcare organization or provider.

Comprehensive Systematic Analysis (CSA). CSA is a thorough, credible, and acceptable analysis following a patient safety (PS) event that seeks to identify system vulnerabilities so that they can be eliminated or mitigated in a sustainable manner to prevent reoccurrence. A root cause analysis (RCA) is one type of CSA. CSAs can also be conducted for performance improvement purposes for those events that have the potential to be catastrophic. The following guidelines support the identification of causal factors in CSAs:

Clearly show cause and effect relationships.

Use specifics and accurate descriptions of events.

Human errors must have a preceding cause.

Violations in procedure must have a proceeding cause.

Failure to act is only causal when there is a pre-existing duty to act.

continuing education. Education beyond initial academic or professional preparation approved by an appropriate certifying professional organization that is relevant to the type of care or service delivered in an organization.

Corrective Action Implementation (CAI) Plan Report. The CAI Plan Report describes the effectiveness of the corrective action after implementation. The CAI Plan Report should include identified solutions, corrective actions implemented, and measures of effectiveness and sustainment to show that a corrective action has been implemented and is reducing or eliminating the risk of reoccurrence in a lasting way.

credentialing. The process of obtaining, verifying, and assessing the qualifications of both privileged and non-privileged providers to provide safe patient care services. This assessment serves as the basis for decisions regarding delineation of clinical privileges, as well as appointments and reappointments to the medical staff. The required information should include qualification data such as relevant education, training, and experience; current licensure; and specialty certification (if applicable) as well as performance data, such as current competency, and the ability to perform the selected privileges. This data is collected, verified, and assessed initially and on an ongoing basis.

credentials. The documents that constitute evidence of appropriate education, training, licensure, experience, and expertise of a healthcare provider.

credentials file. A file containing pertinent information regarding an individual privileged provider to include credentialing and privileging documents, permanent performance data, medical practice reviews, continuing health education documentation, and information related to permanent adverse privileging actions.

credentials review. The credentials inspection and verification process conducted for healthcare providers before selection for military service, employment, and procurement. The credentials review process is also conducted for healthcare providers before medical staff appointment and granting of clinical privileges and is repeated at the time of reappointment and renewal of privileges.

current competence. The state of having adequate ability and up-to-date knowledge to perform the functions of a healthcare provider in a particular discipline, as measured by meeting these criteria:

The provider has actively pursued the practice of their discipline within the past two years by having encountered a sufficient number of clinical cases to represent a broad spectrum of the privileges requested and that the individual has satisfactorily practiced the discipline as determined by the results of ongoing professional practice evaluation (OPPE).

The provider possesses documented evidence of appropriate continued medical education to maintain the currency of skills and knowledge.

data monitoring. The systematic and ongoing collection, compilation, and organization of data pertaining to indicators for the quality and appropriateness of important aspects of care in order that problems or opportunities to improve care can be identified.

denial of clinical privilege(s). Refusal to grant requested privileges to a healthcare provider at the time of initial application or renewal. Denials that result from a professional review action following appropriate due process proceedings, and relating to evidence of the provider's misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient are reported to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies. Denials that occur solely because a provider does not meet a healthcare institution's established threshold criteria for that particular privilege, should not be reported to the NPDB - these are considered decisions based on eligibility and are not deemed to be a result of a professional review action.

denominator. The part of a fraction that is below the line and that functions as the divisor of the numerator; the population at risk in the calculation of a rate or ratio.

department/clinical unit. The department, unit, or area utilized for patient care (e.g., pharmacy, surgical area, emergency department, procedural area, nursing unit).

deviation. The action of departing from an established course or accepted standard; the amount by which a single measurement differs from a fixed value such as the mean.

direct care system. Healthcare facilities and medical support organizations managed by the DoD through the Defense Health Agency (DHA) or Service Surgeons General in accordance with applicable federal laws and regulations.

DoD Reportable Event (DoD RE). Any patient safety (PS) event resulting in death, permanent harm, or severe temporary harm, as per the AHRQ Harm Scale; or meeting The Joint Commission's (TJC) sentinel event (SE) or the National Quality Forum's (NQF) serious reportable event (SRE) definitions. DoD REs require a Comprehensive Systematic Analysis (CSA) and follow on Corrective Action Implementation (CAI) Plan Report.

enterprise risk management (ERM). ERM provides a comprehensive framework for making risk management decisions to promote safe and reliable healthcare and to mitigate risks across the organization. Effective ERM practices are continuous in nature and support the journey to high reliability.

event reporting. The DoD Patient Safety Program (PSP) captures the full range of patient safety (PS) events listed in Volume 2 and all such events must be reported into the Joint Patient Safety Reporting (JPSR) system to be used as opportunities to prevent harm. Any PS event that reaches the patient (i.e., adverse events and no-harm events) must be reported to the appropriate Healthcare Risk Management (HRM) Program for assessment. DoD Reportable Events (DoD REs) also have reporting, notification, and analysis requirements beyond JPSR.

focused review. A review that concentrates on a perceived problem area that involves a specific standard, procedure, policy or any other limited scope healthcare delivery matter.

focused professional practice evaluation (FPPE). A process whereby the organization evaluates the privilege/practice of the healthcare provider who does not have documented evidence of competently performing the requested privilege, or of demonstrated practice competency, at the organization. This process may also be used when a question arises regarding a healthcare provider's ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the healthcare provider's professional performance.

harm. Any physical or psychological injury or damage to the health of a person, including both temporary and permanent injury.

healthcare provider. Any member of the uniformed services, civilian employee of the DoD, or contract employee authorized by the DoD to perform healthcare services.

healthcare risk management (HRM). Includes clinical and administrative activities, processes, and policies to identify, monitor, assess, mitigate, and prevent risks to the healthcare

organization, patients, and staff. By employing risk management, the healthcare organization proactively and systemically safeguards patient safety and the organization's resources, accreditations, legal/regulatory compliance, assets, and customer confidence (integrity).

intentional unsafe act. Any alleged or suspected act or omission of a healthcare provider, staff member, contractor, trainee, or volunteer pertaining to a patient that involves a criminal act, a purposefully unsafe act, patient abuse, or an event caused or affected by drug or alcohol abuse. Intentional unsafe acts are matters for law enforcement, disciplinary system, or administrative investigation.

Joint Centralized Credentials Quality Assurance System (JCCQAS). A secure, worldwide healthcare provider credentialing, privileging, adverse actions, and risk management web-based application mandated by the Military Health System (MHS) used in the provider credentialing and privileging process. Portions of the information contained in JCCQAS are confidential, privileged and protected from disclosure in accordance with Section 1102 of Title 10, United States Code. JCCQAS is the official file for healthcare providers credentialed and privileged within the MHS.

Joint Patient Safety Reporting (JPSR) system. DoD electronic system used to capture data for all types of patient safety (PS) events in Military Medical Treatment Facilities (MTF) and other applicable healthcare environments, as well as PS events tracked and trended in other programs. The MTF Patient Safety Manager (PSM) is responsible for JPSR data management, the review of facts associated with the PS event, and for ensuring an appropriate evaluation is performed as required by DHA guidance. JPSR usage is the only authorized method for the reporting of adverse events, no harm events, near misses, and unsafe conditions.

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

licensed independent practitioner (LIP). Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, and within the scope of the individual's license and consistent with individually granted clinical privileges.

measure sets. Sets of measures that focus on different aspects of healthcare delivery and are used to improve healthcare quality and help drive improvement through a consistent approach.

medical quality assurance program (MQAP). Any peer review activity carried out before, on, or after November 14, 1986 by or for the DoD to assess the quality of medical care, including activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment procedures, blood, drugs, and therapeutics), medical records, health resources management review and identification and prevention of medical or dental incidents and risks as defined in Section 1102 of Title 10, United States Code.

medical quality assurance record (MQAR). The proceedings, records, minutes, and reports that emanate from quality assurance program activities and are produced or compiled by the DoD as part of a medical quality assurance program as defined in Section 1102 of Title 10, United States Code.

Military Health System (MHS). DoD medical and dental programs, personnel, facilities, and other assets operating pursuant to Chapter 55 of DoD Directive 5136.01, by which the DoD provides:

Healthcare services and support to the Military Services during the range of military operations.

Healthcare services and support to members of the Military Services, their family members, and others entitled to DoD medical care.

monitoring and evaluation. A well-defined, time-limited, well documented plan of focused professional practice evaluation (FPPE) to confirm a healthcare provider possesses the knowledge, skills, and ability to render safe and effective healthcare. It must include a documented plan with delineation of clear expectations and measures of success. It requires a preceptor who provides full written evaluation of the monitoring period, with regular interval feedback, to both the provider and the Credentials Committee/Function. Privileges/practice remain intact during the period of monitoring and evaluation.

National Practitioner Data Bank (NPDB). The NPDB is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to healthcare practitioners, providers, and suppliers. The NPDB is managed by the Department of Health and Human Services in accordance with Section 11101 of Title 42, United States Code.

near miss event. See definition of patient safety (PS) event.

no-harm event. See definition of patient safety (PS) event.

non-privileged provider. An individual who possesses a license, certification, or registration by a state, commonwealth, territory, or possession of the United States, and is only permitted to engage in the delivery of healthcare as defined in their granted scope of practice. Examples include registered nurse (RN), licensed vocational nurse (LVN), registered dental hygienist (RDH), and medical technician.

ongoing professional practice evaluation (OPPE). A documented summary of ongoing data collected for the purpose of assessing a healthcare provider's clinical competence and professional behavior. The information gathered during this process allows for identification of practice trends that may adversely affect, or could adversely affect, the health or welfare of a patient. It is the responsibility of the organization to determine the criteria used in the ongoing professional practice evaluation.

other authorizing document. A mechanism, such as registration and certification, by which a State, the District of Columbia, a Commonwealth, territory, or possession of the United States, grants authority to provide healthcare in a specified discipline. In specialties not licensed and where the requirements of the granting authority for registration or certification are highly variable, the validation by a national organization that an individual is professionally qualified to provide healthcare in a specified discipline. Special considerations apply in the case where healthcare is provided in a foreign country by any person who is not a national of the United States.

outcomes. The result of performance (or nonperformance) of a function, process, or series of processes. States or conditions of individuals and populations attributed or attributable to antecedent healthcare. They can include adverse or beneficial results of care, short- or long-term results of care, complications, or occurrences, and are the product of the performance (or nonperformance) of one or more functions or processes.

patient safety (PS) event. A PS event is an incident or condition that could have resulted, or did result, in harm to a patient. A PS event can be but is not necessarily the result of a defective system or process design, a system or process breakdown, equipment failure or malfunction, or human error. PS events include adverse events, no-harm events, near miss events, and unsafe/hazardous conditions as defined below:

adverse event. PS event that resulted in harm to the patient. The event may occur by the omission or commission of medical care.

no-harm event. PS event that reached the patient but did not cause harm.

near miss event. PS event that did not reach the patient (also known as “close call” or “good catch”).

unsafe/hazardous condition. A condition or a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

peer. A healthcare provider with generally similar privileges, practice, clinical specialty and level of training.

peer review. Any assessment of the quality of medical care carried out by a healthcare provider, including any such assessment of professional performance, any patient safety program Comprehensive Systematic Analysis (CSA) or report, or any other such assessment carried out by a healthcare provider under provisions of this manual.

performance improvement. Continuous study and improvement of processes with the intent to achieve better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix underlying causes of persistent/systemic problems or barriers to improvement.

plan-do-check-act/plan-do-study-act (PDCA/PDSA). A management method for the control and continuous improvement of processes and products. This four-step model includes assessing the current process; enacting the plan; evaluating and comparing data to expected outcomes; and developing corrective actions based on outcomes.

potentially compensable event (PCE). Any patient safety (PS) event that both a) reaches the patient (i.e., adverse event and no-harm event) and b) has a Healthcare Risk Management assessment that determines that the event is likely to present a possible financial loss to the Federal Government. All DoD Reportable Events (DoD REs) are PCEs. All events that trigger a PCE will also be referred to the Patient Safety Manager to ensure capture in the Joint Patient Safety Reporting (JPSR) system and investigation/analysis as defined in Volume 2, Patient Safety of this manual.

preceptor. A clinical peer who has been appointed in writing to evaluate a healthcare provider's clinical practice. The preceptor is designated for consultation, clinical feedback, and general oversight of the clinical activities of the provider. A preceptor may review medical records, and conduct direct observation of a provider's practice, however they are not required to be present for or approve the provider's procedures or clinical decisions since the provider's clinical privilege(s)/practice is not restricted in any manner. [Contrast with the definition for "proctor".]

primary source verification. Validation that a document is true and valid through contact with the issuing institution or its authorized agent.

privileged provider. An individual who possesses appropriate credentials and is granted authorized clinical privileges to diagnose, initiate, alter, or terminate regimens of healthcare with defined scope of practice.

Privileging Authority. The Privileging Authority is a designated official who grants permission to individuals to provide specific care, treatment, or services within well-defined limits. The Privileging Authority also initiates and makes determinations on clinical adverse actions.

proactive risk assessment (PRA). Process used to identify, rate, and prioritize risks and/or hazards. Based on a risk assessment, policies, procedures and controls may be put into place to manage the risk as appropriate to the organization, with the intent of reducing risk to the lowest possible level. A form of PRA is Failure Mode Effect Analysis (FMEA): a systematic, proactive method for evaluating a process to identify where and how it might fail, to assess the relative impact of different failures, and to identify the parts of the process that are most in need of change.

process. A goal-directed, interrelated series of actions, events, mechanisms, or steps. Processes should always be designed with flexibility in mind and the ability to periodically introduce controlled, measurable changes.

proctor. A clinical peer who has been appointed in writing to supervise all or some of a healthcare provider's clinical practice. The proctor is required in order for the provider to proceed in exercising designated clinical privilege(s)/practice. The proctor provides direct

oversight of designated clinical activities and must co-sign all such documentation conducted by the provider. Certain procedures may require proctor approval prior to performing. All designated procedures will require some period of direct observation by the proctor. Proctors are required for providers with supervised privileges, and for those who have had a clinical adverse action taken against them with subsequent restriction in privilege(s)/practice. [Contrast with the definition for “preceptor”.]

purchased care system. A component of the uniform program of medical and dental care for members and certain former members of the Services, and for their dependents where services are provided to beneficiaries by TRICARE-authorized civilian network and non-network healthcare providers and facilities.

quality healthcare. The degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Care that is evidence-based and provided in a technically and culturally competent manner with good communication and shared decision making as defined in the Institute of Medicine’s (IOM) *Crossing the Quality Chasm: A New Health System for the 21st Century*.

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

reduction of clinical privilege(s)/practice. A portion of a healthcare provider’s clinical privilege(s)/practice that is permanently removed as a result of a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Reductions in privilege(s)/practice are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

reinstatement of clinical privilege(s)/practice. The return of regular clinical privilege(s)/practice as a result of a professional review action following appropriate due process proceedings that may or may not include a period of monitoring and evaluation. Reinstatement after a clinical adverse action that was previously reported to the National Practitioner Data Bank (NPDB) is documented in the Revision-to-Action Report to the NPDB. Reinstatement is also reported to state(s) of licensure, and other applicable certifying/regulatory agencies.

Report Authority. The official with responsibility to report to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies following appropriate due process proceedings. The Report Authority is:

- (1) The Director of the DHA with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the DHA.
- (2) The Surgeon General of the Army, Navy, or Air Force, respectively, with respect to matters arising from acts or omissions of healthcare providers privileged by a Privileging Authority under the responsibility of the Army, Navy, or Air Force, respectively.

(3) In cases in which the healthcare provider is privileged by more than one of the Report Authorities listed in subparagraphs (1) and (2), the one whose responsibility applies to the Privileging Authority most responsible for the matters under review. In cases of uncertainty, the DHA Director will designate the Report Authority. The designated Report Authority will ensure there is a comprehensive review of the entire matter.

restriction of clinical privilege(s)/practice. A temporary or permanent limit placed on a portion of a healthcare provider's clinical privilege(s)/practice that results from a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Restricted privilege(s)/practice require supervision by a proctor. Restrictions are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

revocation of clinical privileges/practice. The permanent removal of all of a healthcare provider's clinical privileges/practice as a result of a professional review action following appropriate due process proceedings. It may be based on evidence of misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Revocations of privileges/practice are reportable to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

significantly involved provider (SIP). A SIP is one who actively delivered care (based on clinical record entries) in either primary or consultative roles during the episodes of care that gave rise to the allegation, regardless of standard of care (SOC) determination. Additional defining characteristics include providers that: have the authority to start, stop or alter a course of treatment; have the authority to recommend to start, stop, or alter a course of treatment; or have the responsibility to implement a plan of evaluation or treatment. Authority to recommend means that input was solicited and legitimate (i.e., the individual making the recommendation was acknowledged to have special expertise or other specific standing in the clinical issues). This term is not meant to include the providers who had only peripheral, yet appropriate, patient interaction, nor those providers whose patient involvement was not reasonably related to the specific indications or allegations of sub-standard care and injury.

Six Sigma. The focus is a data-driven approach and methodology for eliminating defects and reducing variability. The goal is to achieve measurable and quantifiable returns by developing processes to achieve stable and predictable results and identifying procedures that can be defined, measured, analyzed, improved upon, and controlled. A commitment from the entire organization, especially high-level management, is essential to achieve sustainment in quality management.

standard of care (SOC). Healthcare judgments and actions of a healthcare provider generally accepted in the discipline or specialty involved as reasonable and appropriate.

summary suspension of clinical privilege(s)/practice. The temporary removal of all or a portion of a healthcare provider's privilege(s)/practice, taken prior to the completion of due process

procedures, based on determination by the Privileging Authority for concerns regarding suspected misconduct, impairment, or incompetence, or any conduct that adversely affects, or could adversely affect, the health or welfare of a patient. A summary suspension continues until due process proceedings are complete. All summary suspensions of privileged providers that last longer than 30 calendar days must be reported to the National Practitioner Data Bank (NPDB), state(s) of licensure, and other applicable certifying/regulatory agencies.

telemedicine. Telemedicine, also known as telehealth or virtual health, is the use of telecommunications and information technologies to provide health assessment, treatment, diagnosis, intervention, consultation, clinical supervision, education, and information across distances.

distant site. The distant site is where the healthcare provider providing the medical service is located at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may function as a distant site for purposes of this manual.

originating site. The originating site is the location of a patient at the time the service is provided via telemedicine. The DoD virtual medical center (VMC) may be considered an originating site for purposes of this manual.

trainee. Any resident, intern, or other healthcare provider in a formal healthcare training status.

unsafe/hazardous condition. See definition for patient safety (PS) event.

variation. An undesirable deviation from expected outcomes.

virtual medical center (VMC). A VMC is an organization which serves as a coordination body overseeing the delivery of healthcare via telemedicine. The DoD VMC must operate in affiliation with an accredited MTF or be independently accredited. If the DoD VMC does not have its own Privileging Authority, it should use the Privileging Authority of an accredited MTF with which it is affiliated. The DoD VMC, acting as a distant site, must have a process in place to accept quality and safety feedback on the care provided, and take action as appropriate.