



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 6010.30
BUMED-M3B2
27 Mar 2015

BUMED INSTRUCTION 6010.30

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: CREDENTIALING AND PRIVILEGING PROGRAM

Ref: (a) DoD Manual 6025.13 of 29 Oct 2013
(b) The Joint Commission Hospital Accreditation Standards Manual
(c) BUMEDINST 6320.67A
(d) SECNAVINST 1920.6C
(e) DON Civilian Human Resources Manual, Subchapter 752
(f) SECNAVINST 5720.42F
(g) SECNAVINST 5211.5E
(h) BUMEDINST 6010.17B
(i) CDC MMWR 40(RR08); 1-9; 12 July 1991
(j) OASD(HA) memo, DoD MOU with Department of Veterans Affairs for the sharing of practitioner credentials of 23 May 2011
(k) SHEA Guideline for Management of Healthcare Workers Who Are Infected with Hepatitis B Virus, Hepatitis C Virus, and/or Human Immunodeficiency Virus, *Infection Control and Hospital Epidemiology*, 31(3), 203-232
(l) BUMEDINST 6320.100

Encl: (1) Designation of Privileging Authorities
(2) Roles and Responsibilities
(3) Scope of Care Provided by Health Care Practitioners
(4) Credentialing Requirements for Licensed Independent Practitioners
(5) Credentials Requirements for Clinical Support Staff – Registered Nurses (RN), Licensed Professional Nurses (LPN), Licensed Vocational Nurses (LVN), and Registered Dental Hygienists (RDH)
(6) Electronic Credentials Records
(7) Permissible Licensure Waivers
(8) Summary of Changes
(9) Acronyms
(10) Organizational Chart of Privileging Authorities

1. Purpose. To update and reissue policy and procedures for the Credentialing and Privileging Program for the Department of the Navy (DON), per references (a) and (b), and as part of the DON Clinical Quality Management Program (CQMP). Adverse privileging actions, monitoring, and reporting of practitioner or clinical support staff misconduct and due process (fair hearings and appeals) are addressed in references (a) and (c). References (d) through (l) provide additional

guidance. Enclosures (1) through (8) provide credentialing and privileging guidance. Enclosure (9) is a listing of acronyms. Enclosure (10) is the organizational chart of privileging authorities. This is a complete revision and should be read in its entirety.

2. Cancellation. BUMEDINST 6320.66E, BUMEDNOTE 6320 of 20 May 2009, and BUMED memo 6000 of 27 Jan 2009 (NAVMED Policy memo 09-002).

3. Applicability. This instruction applies to all military (active duty and reserve) and civilian health care practitioners and clinical support staff, including those assigned, employed, contracted, or under resource sharing agreements and clinical support agreements with DON activities or who are enrolled in a Navy-sponsored training programs.

4. Quality. Quality health care is a priority for Navy Medicine and includes ensuring:

a. The people who deliver health care in our system are properly qualified, trained, competent and able to provide high quality health care services.

b. Robust provider competency management processes are in place in support of continuous quality improvement initiatives.

5. Background. Reference (a) provides that:

a. The Secretary of the Navy

(1) Has policy oversight of the DON CQMP.

(2) Recommends changes in the Military Health System (MHS) CQMP to the Secretary of Defense through the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

(3) Ensures the Chief, Bureau of Medicine and Surgery (BUMED) complies fully with reference (a). Chief, BUMED, as the corporate privileging authority, has the authority to establish Navy requirements for licensure, credentials review, and clinical privileging of all DON practitioners assigned to Navy medical commands including, facilities, fleet units, Marine Corps, and other operational forces. This includes the authority to designate specific program support responsibilities to the Chief of Naval Operations (CNO) and the Commandant of the Marine Corps (CMC).

(4) Establishes, through the CNO and the CMC, the key elements of a CQMP for those operational air, ground, and fleet clinics not accredited by a nationally recognized body such as The Joint Commission (TJC).

b. Health care provider credentialing and privileging activities are a key element of the DON CQMP.

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6. TJC Requirements. This instruction complies with the governing body and medical staff standards of reference (b).

7. Credentials Review and Privileging Program. All DON organizations providing health care shall establish a credentialing and privileging program per this instruction.

8. Confidentiality

a. All personnel shall comply with reference (a).

b. Credentials records (CR) may contain documents that are not medical quality assurance records such as criminal investigative reports, indictments, court-martial records, or non-judicial punishment records. When considering written requests from regulatory or licensing agencies for copies of records that contain such documents, the procedures in reference (f) must be followed to determine which documents are releasable.

c. In all disclosures, care must be taken to protect the privacy interests of other providers and patients following the procedures in reference (g). All documentation contained in the Navy CRs are confidential and protected by 10 U.S.C. §1102 and its implementing regulations.

d. Requests by regulatory or licensing agencies for information regarding permanent adverse privileging actions or reportable misconduct must be referred to the Chief, BUMED via the Staff Judge Advocate.

9. Department of Defense (DoD) directives, instructions, publications, and manuals can be found electronically at: <http://www.dtic.mil/whs/directives/corres/dir.html>.

10. Records. Records created as a result of this instruction, regardless of media and format, shall be managed per SECNAV Manual 5210.1 of January 2012.

11. Reports. The reports required in enclosure (2), paragraphs 4d, 4m(4), 14a, and 14b; enclosure (3), paragraphs 12, 12d(4), 13d, and 29c; enclosure (6), paragraphs 5b, 5d(1), and 5d(2); and enclosure (7), paragraph 3 are exempt from reports control per SECNAV Manual 5314.1 of December 2005, Part IV, paragraph 7p.



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DESIGNATION OF PRIVILEGING AUTHORITIES

1. Designated Privileging Authorities. As required by TJC standards and directed by reference (a), Chief, BUMED serves as the governing authority and is designated as the corporate privileging authority for all DON medical department practitioners. The following are designated representatives of Chief, BUMED and are authorized to grant professional staff appointments with clinical privileges:

a. Navy Medicine (NAVMED) Region Commanders (RC) Navy Medicine East (NME); Navy Medicine West (NMW); and the BUMED Deputy Chief of Medical Operations (BUMED-M3) are designated privileging authorities for all health care practitioners within their area of responsibility (AOR). The RCs and Deputy Chief, BUMED-M3 may further delegate privileging authority for practitioners assigned to a specific command to the facility or activity commanding officer (CO) or his or her designee as appropriate.

b. Medical RCs serve as the privileging authorities for those COs in their region.

c. The designated privileging authority for practitioners assigned to, or deployed with, fleet or line units, is the Command Surgeon, Commander U.S. Fleet Forces Command (USFFC). Command Surgeon, USFFC may further delegate privileging authority to the type commander Fleet Surgeon or Force Medical Officer. Medical Department officers who serve as the privileging authority and who seek privileges in their operational assignment will request privileges from the next higher level in their AOR. The Command Surgeon, USFFC is the designated privileging authority for all Navy Environmental and Preventive Medicine Units (NEPMUs) and for Commander, Naval Air Systems Command (COMNAVAIR), Naval Sea Systems Command (NAVSEA), Naval Undersea Warfare Center (NUWC), and Naval Experimental Diving Unit (NEDU).

d. The designated privileging authority for all practitioners assigned to Marine Corps operational forces, including Functional Area Code (U) (FAC (U)) health care providers, is The Medical Officer of the Marine Corps (TMO), who may further delegate to the Marine Forces (MARFOR), Force Surgeons at the component MARFOR, and Marine Expeditionary Force (MEF). Medical Department officers who serve as the privileging authority and who seek privileges in their operational assignment, will request privileges from the next higher level in their AOR.

e. The designated privileging authority for practitioners assigned to non-clinical (administrative) billets, who wish to request privileges in order to maintain clinical competency, is the CO of the health care facility where such health care services are performed. Providers assigned to non-clinical billets are encouraged to maintain clinical competency whenever possible.

f. The designated privileging authority for Navy Reserve practitioners is the Deputy Chief, BUMED-M3. The Deputy Chief, BUMED-M3 may further delegate privileging authority for Reserve Component practitioners to the Assistant Deputy Chief, BUMED-M3 as appropriate.

g. The designated privileging authority for practitioners assigned to the Navy Medicine Operational Training Center (NMOTC), the Naval Undersea Medicine Institute (NUMI), the Naval Aerospace Medical Institute (NAMI), the Naval Expeditionary Medical Training Institute (NEMTI), the Surface Warfare Medical Institute (SWMI), the Naval Special Operations Medical Institute (NSOMI), and the Naval Trauma Training Center (NTTC) is the CO of NMOTC. The CO of NMOTC will request privileges via the Deputy Chief, BUMED-M3.

h. The designated privileging authority for dentists assigned to the Naval Postgraduate Dental School, is the Dean, Navy Medicine Professional Development Center (NMPDC). The CO of NMPDC will request privileges via the Deputy Chief, BUMED-M3.

i. The CO of Naval Hospital Jacksonville is the designated privileging authority for practitioners assigned to Atlantic Undersea Test and Evaluation Center (AUTEK), Bahamas.

j. The designated privileging authority for practitioners assigned to U.S. Naval Academy is the CO, Naval Health Clinic Annapolis.

k. The designated privileging authority for practitioners assigned to Naval Air Systems Command Operational Support Field is the CO, Naval Health Clinic Patuxent River.

l. For all providers privileged via their designated privileging authority and being deployed on individual augmentee (IA) orders, the medical services professional (MSP) will forward an Interfacility Credentials Transfer Brief (ICTB) via the Centralized Credentials and Quality Assurance System (CCQAS) database to the "DEPLOYED" unit identification code (UIC). Notate in section 11 of the ICTB the location the provider will be serving for the IA orders.

m. Requests for any other delegation of privileging authority will be considered on a case-by-case basis. All such requests must be forwarded to the Deputy Chief, BUMED-M3, via the Centralized Credentials and Privileging Directorate (CCPD), BUMED. For any billets not otherwise covered in the above designation of privileging authorities, consult BUMED-M3 to determine the appropriate delegation of privileging authority.

2. COs, RCs, and designated privileging authorities may not grant medical staff appointments or clinical privileges to themselves, but may grant medical staff appointments to their executive officers. The privileging authority must always be the next higher level in the chain of command than the position of the individual requesting privileges. For example, a CO cannot grant privileges to his or her incoming relief (successor).

3. Refer to enclosure (2) for the organizational chart of privileging authorities.

4. Refer to the CCQAS military treatment facility contacts listing for current Navy Medicine privileging authority UICs, and identification of all privileging commands. Note: When transferring an electronic CCQAS CR to commands indicating "yes" as an identified privileging

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UIC, an electronic application (E-App) for privileges will be automatically initiated. When transferring an electronic CCQAS CR to commands indicating as “no” for privileging UIC, transfer of these CRs will not initiate an E-App.

ROLES AND RESPONSIBILITIES

1. General. The corporate responsibility of the Chief, BUMED is to establish direction for the DON multi-institutional system in maintaining an effective Credentialing and Privileging Program per TJC Standards and other applicable guiding directives. The NAVMED RCs, TMO, and the Commander, USFFC serves as extensions of Chief, BUMED, functioning as privileging authorities for health care treatment facilities and operational medical units under their cognizance.

2. Policy. The DON recognizes the importance of quality of health care services and depends on the coordinated performance between the medical staff leaders and the command's performance improvement activities to ensure health care quality. The potential consequences of unqualified or impaired health care providers or provider misconduct are so significant that complete verification of credentials and complete control of the clinical privileging process is imperative. Licensure, certification, or registration is a qualification for employment as a privileged uniformed health care provider in the military health care system and is required throughout the period of employment regardless of assignment, billet type, or duties and responsibilities, (i.e., clinical, research, or executive medicine). DoD policy, reference (a), states all licensed, independent health care practitioners shall be subject to credentials review and shall be granted a medical staff appointment with clinical privileges by a designated privileging authority before providing care independently. To be eligible for a medical staff appointment with clinical privileges, providers must possess a current, valid, unrestricted license, and/or certification as required by the clinical specialty.

3. The Deputy Chief, BUMED-M3
 - a. Has responsibility for administration and technical oversight of the Credentialing and Privileging Program.

 - b. Assigns medical commands CRs maintenance responsibility for health care providers assigned to activities without medical staff services capability or outside the DON.

 - c. Ensures privileging authorities, when granting clinical privileges, confirm that the practitioner requesting clinical privileges possesses the required qualifying credentials and is currently competent to exercise the privileges granted.

 - d. Ensures privileging authorities implement the Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes as appropriate when granting clinical privileges.

4. Privileging Authorities
 - a. Issue local credentialing and privileging directives as appropriate. Branch facilities are not expected to have a separate Credentialing and Privileging Program, but are to participate in the parent command's program.

- b. All privileging authorities must also provide a mechanism for medical or dental staff involvement in the credentialing and privileging process. This function shall be performed by practitioners appointed by the privileging authorities designated from among the privileged licensed independent practitioners under their cognizance.
- c. Establish mechanisms to ensure individual practitioners function within the scope of clinical privileges granted.
- d. Privileging authorities must ensure the clinical performance and professionalism of all assigned health care providers is measured, periodically assessed, and documented at intervals not to exceed 8 months per OPPE requirements outlined in this policy. Performance Appraisal Reports (PAR) must be produced at intervals not to exceed 2 years.
- e. Privileging authorities must ensure the command maintains a CR on all health care practitioners (whether holding a staff appointment with privileges, practicing under a plan of supervision, or enrolled in full-time in-service training). Additionally, privileging authorities must ensure the command maintains a CR on health care practitioners who are assigned to other activities in which there are no designated privileging authorities, as designated by the Chief, BUMED.
- f. Privileging authorities must ensure the command follows FPPE/OPPE policies and directives per this policy to ensure current clinical competency of its practitioners.
- g. Privileging authorities shall grant clinical privileges to licensed independent practitioner using standardized, specialty-specific privileges contained in the CCQAS Master Privilege Listing.
- h. Privileging authorities shall assign non-trainee practitioners who fail to qualify for clinical privileges to practice under a plan of supervision (POS) until the required credentials are attained, verified, and privileges are granted.
- i. Health care practitioners whose clinical incompetence, professional misconduct, or impairment may adversely affect their ability to provide safe, quality patient care must be immediately removed from direct patient care activities under the provisions of references (a) and (c).
- j. Impaired practitioners, those with medical or mental health conditions, alcohol abuse, drug abuse, or dependence, must have their clinical practice reviewed by the Medical Executive Committee (MEC), or medical staff leadership, per references (a) and (c).
- k. Privileging authorities must investigate, without delay, allegations of clinical incompetence (deficits in medical knowledge, expertise, or judgment); professional misconduct (unprofessional, unethical, or criminal conduct), or impairment (medical conditions, mental health conditions, or alcohol abuse, drug abuse, or dependence), including reportable misconduct, per references (a) and (c).

l. Authority to take adverse privileging action resides at the level at which the member's privileges were approved and may not be further delegated. References (a) and (c) provide additional guidance regarding adverse privileging actions.

m. Privileging authorities may encounter circumstances that, in their judgment, require deviation from this instruction. In those rare cases the following guidance is offered:

(1) Have a sound, supportable reason for the deviation.

(2) Document rationale for the deviation.

(3) Ensure the quality of care delivered to the patient is not compromised.

(4) Notify BUMED-M3, Medical Operations, of the deviation and any other policy impact that may constrain the overall mission.

5. BUMED Director, Medical Legal Affairs

a. Provides oversight and guidance on medico-legal aspects of the Credentialing and Privileging Program with an emphasis on adverse practice actions per references (a) and (c).

b. Develops and maintains instructions implementing DON program for monitoring and reporting Navy Medicine adverse practice actions, to include incidents of reportable misconduct.

6. CCPD, Medical Operations (BUMED-M3)

a. CCPD, BUMED will provide direct oversight of the Navy's Credentialing and Privileging Program. This provision of direct oversight applies to all military (active duty and reserve) and civilian health care practitioners and clinical support staff (as defined in this instruction), who are assigned, employed, contracted, in a Navy-sponsored training program, or under partnership agreement with any DON designated privileging authority.

b. Develops and maintains instructions implementing the DON Credentialing and Privileging Program.

c. Provides policy support and technical assistance regarding credentialing and privileging matters.

d. Maintains liaison with external agencies, including DoD, other Services, and civilian organizations regarding credentialing and privileging processes.

e. Acts as the centralized credentialing and privileging entity for Navy Reserve Component health care practitioners.

f. Coordinates and monitors implementation of the Credentialing and Privileging Program and associated processes for licensed or certified active duty, Reserve Component, civilian health care practitioners and clinical support staff, including those assigned, employed, contracted, or under resource sharing agreements and clinical support agreements with DON activities or who are enrolled in Navy-sponsored training programs.

g. Provides technical support and training for the CCQAS database of DON health care providers.

h. Completes National Practitioner Data Bank (NPDB) queries on appropriate practitioners upon medical staff appointment and/or the granting of clinical privileges, at the 2-year reappointment, or more frequently if indicated.

i. Maintains CRs for practitioners transferring to non-clinical billets or administrative duties when their CO is not a privileging authority and the health care provider will not be requesting privileges locally.

j. Archives and maintains CRs of licensed independent practitioners who have been released from active duty, reserves, retired from the Navy, or terminated employment with DON, for a period of 10 years. As such, CCPD, BUMED serves as the Navy's primary source verification entity for all CRs archived at CCPD, BUMED.

k. Provides coordination and training for Navy MSPs to include assistance and guidance associated with the use of current and future program procedures and technology.

l. Serves as the centralized credentials verification office for all direct accession, direct commission officer, and inter-service transfer candidates seeking commission in the Navy (active and reserve). Performs such pre-accession credentialing services for Commander, Navy Recruiting Command.

m. Coordinates all proposed updates to the Navy Medicine privilege listing with specialty leaders.

7. MEC

a. An MEC, formerly known as Executive Committee of the Medical Staff (ECOMS), is required for medical and dental commands. The MEC Chair will be elected by the medical staff and appointed by the privileging authority.

b. If the medical staff includes non-physician or non-dentist practitioners, representation on the committee from among these practitioners is recommended, especially when matters concerning their peer non-physician and/or non-dentist practitioners are under consideration.

c. The MEC Chair must be a senior member of the medical staff.

d. For small commands, including the operational forces, the professional staff as a whole may serve as and fulfill the functions of the MEC. This instruction recognizes there are alternative methods of organizing management of operational medical departments to meet mission requirements.

e. All members of the medical staff are eligible for appointment or election to the MEC. A medical staff member actively practicing cannot be considered ineligible based solely on the professional specialty or discipline. MEC membership includes representation from branch clinics and clinical directorates, as applicable and feasible.

f. MEC Functions:

(1) Develops local rules and regulations, and policies and procedures per TJC accreditation standards, as an extension to the Navy medical staff bylaws.

(2) Provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged at their command.

(3) Provides oversight for their command's credentialing and privileging processes.

(4) Reviews applications and makes recommendations directly to the privileging authority for medical staff membership with clinical privileges.

(5) Considers input from all sources, including peer review, concerning the appropriateness of clinical privileges requested by health care practitioners.

(6) Recommends to the privileging authority specialty and facility-specific criteria for staff appointments with clinical privileges.

(7) Provides recommendations and justifications to their command's privileging authority regarding credentialing and privileging actions.

(8) Reviews quality assurance investigations into allegations of health care practitioner clinical incompetence, professional misconduct, or impairment and makes recommendations to the privileging authority on clinical adverse actions as required by reference (a). This function can be further delegated to the Credentials Review Committee (CRC).

(9) Documents MEC actions pursuant to 10 U.S.C. §1102 by preparing and maintaining meeting minutes that include, but are not limited to:

(a) Convening of meetings.

(b) Meeting attendance.

(c) Recommendations and justification regarding credentialing and privileging actions.

(d) Rationale to support recommendations regarding deviations from this instruction.

(10) Oversees the completion of the PARs.

(11) Responsible for evaluating the FPPE/OPPE of all providers and determining actions for performance improvement to ensure patient safety.

(12) Seeks amplification and/or clarification, and makes recommendations to the privileging authority regarding practitioner professional performance when there is reason to believe the practitioner is not performing within his or her delineated clinical privileges, not abiding by policies, procedures, and bylaws per reference (h), or not practicing within acceptable standards of care.

(13) Ensures professional staff monitoring is performed per references (a) through (c).

(14) As applicable, assists in developing, reviewing, and recommending actions on local policies and procedures for providing health care services.

8. CRC

a. In facilities where workload dictates, the privileging authority may delegate credentialing and privileging functions to the CRC, to serve as a subcommittee of the MEC. Such delegations may include, but are not limited to FPPE and OPPE activities. The MEC retains responsibility for oversight and endorsement of the activities of the CRC.

b. The CRC membership shall be as follows:

(1) The CRC Chair is selected from among the membership of the MEC and appointed by the Privileging Authority.

(2) CRC members are nominated by the MEC and appointed by the Privileging Authority.

(3) Only privileged licensed independent practitioners assigned full time to the command shall be appointed to the CRC.

9. MSP

a. Are assigned to manage the command's Credentialing and Privileging Program on a full-time or part-time basis depending on the workload of the facility.

- b. Advise the privileging authority and command leadership on credentialing and privileging matters. As the subject matter experts on credentials and privileging issues, render administrative assistance to the MEC and CRC, as applicable.
- c. Maintain CRs, CRC minutes, and other administrative functions as it relates to the command's Credentialing and Privileging Program.
- d. Verify credentials information, process privileging and staff appointment applications, monitor and track licensure, certification, and registration status for all licensed independent practitioners, clinical support staff nurses (RNs, LVNs, LPNs), and RDHs.
- e. Verify providers' identification as they report to the command by viewing a current picture hospital identification (ID) card, or a valid picture ID issued by a State or federal agency such as a driver's license or passport.
- f. Maintain the following documentation in the practitioner's CR, relating to clinical performance: POS, PARs, and any other quality management clinical performance data pursuant to 10 U.S.C. §1102.
- g. Assist in the preparation and annual review of facility-specific departmental criteria with appropriate department heads, to ensure criteria are appropriate to support the granting of clinical privileges.
- h. Coordinate with CCPD, BUMED to arrange for MSP training as needed. Consult with CCPD, BUMED as needed to ensure the command's Credentials and Privileging Program is compliant with TJC standards.
- i. Manage the command's clinical adverse action process, in consultation with the command's legal office, and other related activities.

10. Department Heads

- a. Brief all practitioners applying for a medical staff appointment with clinical privileges within their department on the local Credentialing and Privileging Program.
- b. Continuously monitor the professional clinical performance, conduct, and health status of department staff members to ensure they provide health care services consistent with clinical privileges and responsibilities. Monitor quality management and medical staff activities for practitioners assigned to their department and complete PARs for those practitioners. Maintain OPPE data for all licensed independent practitioners within the department. Ensure FPPEs are implemented and completed appropriately for new providers upon checking into the command and in circumstances outlined in this policy. Ensure the OPPEs are conducted regularly and aggregated data is documented at intervals not to exceed 8 months for all providers.

c. Ensure non-privileged practitioners, clinical support staff, and other personnel providing health care services in the department receive appropriate clinical supervision.

d. Maintain approved staff appointments with delineated clinical privileges on practitioners assigned to their departments in either electronic or paper form. Ensure providers' privileging information is readily available to all internal personnel for informational purposes. For non-trainee, non-privileged practitioners practicing under supervision (i.e., clinical psychologists and social workers who have not fulfilled clinical hours required for degree), the POS shall be maintained in the department, as well as in the provider's permanent CR.

e. Recommend departmental, specialty, and facility-specific criteria for staff appointment and reappointment with clinical privileges.

f. Make recommendations for staff appointment with delineated clinical privileges based on the applicant's professional qualifications, health status (ability to perform), current competence, verified licensure, education and training, and NPDB query.

g. Use practitioner-specific results of quality management and risk management monitoring activities when making recommendations for staff appointments with clinical privileges.

11. Clinical Directors

a. Continuously monitor the professional clinical performance, conduct, and health status of clinical department heads to ensure they provide health care services consistent with clinical privileges and responsibilities. Monitor quality management and medical staff activities for clinical department heads assigned to the directorate, and complete a PAR for those practitioners. Maintain OPPE data for all licensed independent practitioners within the department. Coordinate with the MSP to ensure FPPEs are implemented and completed appropriately.

b. Monitor the credentialing and privileging process within their directorates.

12. Licensed Independent Practitioners

a. Initiate an application for membership to the medical staff and request the broadest scope of clinical privileges commensurate with their professional qualifications, level of current competence, and the facility's ability to support the privileges requested. Providers may request privileges from other Master Privilege Lists (MPLs) if appropriate (i.e., a general dentist who holds additional qualifications to perform a few endodontics procedures). Those who fail to maintain qualifications, including but not limited to an unrestricted license, or those who do not request such privileges are subject to processing for separation for cause under reference (d) for military personnel or administrative/disciplinary action including termination of employment under reference (e) for civilian personnel.

b. Comply with applicable professional staff policies, procedures, bylaws per reference (h).

c. Ensure the accuracy and currency of all credentials and privileging information reflected in their CR (i.e., licensure status, board certification, and privilege status at other facilities at all times).

d. The practitioner is responsible for providing accurate and current information and evidence of professional qualifications. The practitioner has an ongoing responsibility to immediately disclose (within 7 calendar days) to the privileging authority via the MSP any change in his or her professional qualification, to include investigations or actions by any State licensing board or certification agency. Failure to timely disclose such information may be considered professional misconduct and a basis to initiate an adverse practice action.

e. The practitioner has an ongoing responsibility to immediately disclose (within 7 calendar days) to the privileging authority via the MSP any change in his or her health status that may prevent and/or impact the practitioner's ability to provide safe healthcare. Written medical clearance may be required from the treating physician in order to remain engaged in clinical patient care.

f. Perform health care services within the scope of either the privileges granted by the privileging authority or the written POS for those practitioners required to practice under supervision.

g. Participate in professional continuing medical education (CME) programs.

h. Actively support and participate in facility quality management activities and meetings as required.

i. Provide the appropriate documentation to clarify or remove any credentials discrepancies or missing information of any type. All credentialing discrepancies or missing information requires satisfactory resolution. In the absence of required credentialing information or clarifying documentation, the privileging application is considered incomplete, and therefore cannot be processed.

13. Clinical Support Staff - RN, LPN, LVN, and RDH

a. Ensure the accuracy and currency of all credentials and clinical practice information reflected in their CR, (i.e., licensure status, certifications, and employment status at other facilities at all times).

b. Clinical support staff is responsible for providing accurate and current information and evidence of professional qualifications. Clinical support staff has an ongoing responsibility to immediately disclose (within 7 calendar days) to the privileging authority via the MSP any change in his or her professional qualification, to include investigations or actions by any State licensing board or certification agency. Failure to timely disclose such information may be considered professional misconduct and a basis to initiate an adverse practice action.

c. Clinical support staff have an ongoing responsibility to immediately disclose (within 7 calendar days) to the privileging authority via the MSP any change in his or her health status may prevent and/or impact their ability to provide safe healthcare. Written medical clearance may be required from the treatment physician in order to remain engaged in clinical patient care.

d. Perform health care services within the scope of either their assigned clinical responsibilities, approved by nursing leadership or other appropriate clinical leadership.

e. Participate in professional continuing education (CE) programs.

f. Actively support and participate in facility quality management activities and meetings as required.

g. Provide the appropriate documentation to clarify or remove any credentials discrepancies or missing information of any type. All credentialing discrepancies or missing information requires satisfactory resolution. In the absence of required credentialing information or clarifying documentation, the credentialing process is considered incomplete, and therefore the clinical support staff member should not be permitted to practice in patient care activities.

h. Clinical support staff who fail to maintain required qualifications are subject to processing for separation for cause under reference (d) for military personnel or administrative/disciplinary action including termination of employment under reference (e) for civilian personnel.

14. Specialty Leaders

a. Ensure accuracy and updates as needed (not less than once annually) to the applicable specialty privileges on the DoD Tri-Service Master Privilege Listing. Coordinate with the Army, Air Force, or other non-Navy specialty leader counterparts to ensure consistency and accuracy within the Master Privilege Listing.

b. Coordinate with appropriate Corps Chief, via CCPD, BUMED, and other stakeholders as necessary to ensure privilege lists updates are accurate and submitted for appropriate review.

15. Provider Trainees

a. Interns shall not be granted clinical privileges. Health care practitioners enrolled in residency or fellowship programs will not be granted clinical privileges in their training specialty, but may apply for, and be granted, clinical privileges in a health care specialty in which they are fully qualified. Granting staff appointments with clinical privileges to residents and fellows should be the exception rather than the rule, must have minimal impact upon the training program, and be approved in writing by the program director.

b. Navy training commands shall initiate a PAR or end of training (EOT) evaluation no less than 30 days prior to the provider's graduation date. Enclosure (3), Scope of Care Provided by Health Care Providers, paragraph 12 applies.

c. Commands receiving Navy graduates (i.e., interns, residents) shall grant the Navy medical staff appointment with clinical privileges per this instruction.

**SCOPE OF CARE
PROVIDED BY HEALTH CARE PROVIDERS**

1. General. All health care provided by health care providers must be specifically authorized and periodically appraised. Privileging authorities must not permit providers to diagnose, initiate, alter, or terminate regimens of health care, independently or under supervision, except as provided for in this instruction.

a. The authority for providers to independently diagnose, initiate, alter, or terminate regimens of health care is conveyed only through the issuance of medical staff appointments to the medical or dental staff. A medical staff appointment requires the provider to adhere to the medical staff policies, procedures, and bylaws of the medical command, per reference (h), and the code of professional ethics of their profession. Medical staff appointments must be accompanied by clinical privileges defining the scope and limits of practice authorized. The procedures and requirements of this enclosure are intended to comply with the intent of the standards for medical staff appointments of TJC, per reference (b).

b. The privileged providers at a command comprise the medical staff. Medical staff appointments will be referred to as such, as applicable to the health care treatment medical command, (i.e., a dentist appointed to the professional staff of a medical command is granted a medical staff appointment).

c. The medical staff appointment type reflects the relationship of the provider to the medical or dental staff. A medical staff appointment may not be granted in the absence of the granting of clinical privileges.

d. Medical staff appointments with clinical privileges may only be granted or renewed by the privileging authorities designated in this instruction. Privileging authorities will grant medical staff appointments with clinical privileges to practitioners only after consideration of the provider's verified license status, current competence, professional education and training, past professional performance, health status (i.e., ability to perform), and consideration of reports of the NPDB queries. Periods of clinical inactivity greater than 2 years constitute a lack of current competence, and therefore a provider with such clinical inactivity cannot be granted clinical privileges. The ability or capacity of a command to support the clinical privileges requested and the health care demands placed on the medical command must also be considered when granting or renewing medical staff appointments.

e. Provider eligibility for a medical staff appointment with clinical privileges is based on the practitioner meeting predetermined department, specialty, and command-specific criteria developed by the department head, endorsed by the MEC, and approved by the privileging authority.

f. Medical staff appointments terminate upon the provider's detachment from the command due to permanent change of station (PCS), termination of employment or contractual agreement, medical command closure, retirement, or release from active duty. Providers released from active duty transitioning to a civilian/contractor provider position at the same command, may continue their privileges if their clinical patient care role will remain unchanged. In this instance, the MSP must update the provider's CCQAS CR to reflect their accurate employment status.

g. Detailed procedures for adverse termination of medical staff appointments, suspension, denial, reduction, or revocation of clinical privileges due to substandard care or misconduct are described in references (a) and (c).

h. Care must be taken to ensure medical staff appointments are not allowed to lapse. For all lapses in clinical privileges, a memorandum for the record regarding the lapse must be included in the provider's CR. The memorandum must include lapse dates and the reason for the lapse (i.e., administrative error, leave in transit, etc.).

i. Once a medical staff appointment with clinical privileges is granted by a privileging authority, a practitioner is eligible to request to provide health care services at all other DON/DoD medical commands using the ICTB.

2. Clinical Privileges

a. Clinical privileges define the limits of patient care services a provider may render. Privileges may be granted with or without an accompanying appointment to the medical staff. Except as noted below, clinical privileges are delineated using the MPL. Providers apply for privileges using the privileges applicable to their specialty, (i.e., neurosurgeons use the neurosurgery privileges, and general dentists use the general dentistry privileges). Providers who are fully trained in more than one specialty are eligible to apply for any privileges for which they qualify.

b. The following privilege categories apply to all independent providers:

(1) Initial Privileges. Grants permission to independently provide medical care for a period not to exceed 12 months. The 12-month time period is calculated to the day. For example, standard privileges granted on August 15, 2014 will expire on August 14, 2015.

(2) Regular Privileges. Grants permission to independently provide medical care for a period not to exceed 24 months. The 24-month time period is calculated to the day. For example, standard privileges granted on August 15, 2014 will expire on August 14, 2016.

(3) Temporary Privileges. May be granted:

(a) To satisfy an important patient care, treatment or service need, and

(b) When an applicant for new privileges has a complete application which raises no concerns is waiting for credentials review by the MEC or CRC (whichever is applicable), and approval by the privileging authority. In this case, verification of the following is required.

Note: Application for “new” privileges includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges requesting one or more additional privileges; and an individual who is in the reappointment or reprivileging process and is requesting one or more additional privileges. Temporary privileges can be granted by the privileging authority, based on the recommendation of the MEC Chair, and may not exceed 120 days. In order to qualify for temporary privileges, an applicant must meet all of the following requirements:

1. Current licensure.
2. Relevant education and training.
3. Current competence.
4. Ability to perform privileges requested (health status).
5. Must meet all other criteria required by local medical staff policies and procedures.
6. NPDB report.
7. No current or previously successful challenge to licensure or registration.
8. No subsection to involuntarily termination of medical staff membership at another organization.
9. No subsection to involuntary limitation, reduction, denial, or loss of clinical privileges.

c. Each of the specialty-specific privileges in the MPL contains two categories of privileges, core and non-core.

(1) Core privileges constitute the expected baseline scope of care for a fully trained and currently competent practitioner of a specific health care specialty. Core privileges should be applied for and granted as a single entity. However, not every privilege within each of the Navy’s core privileges for each medical specialty can be supported at every Navy command. Each command should identify and indicate command-specific facility limitations for both core and non-core privileges. Privileging authorities must inform practitioners of any command-specific limitations that preclude providing health care services within the core privileges. These limitations will be determined by the department, endorsed by the MEC, approved by the

privileging authority, and reviewed annually by the command. Core privileges cannot be modified locally; however, each facility must identify all facility supported and limited privileges within the core privileges (i.e., medical treatment facility (MTF), Branch Health Clinic, etc.). Changes to the core privileges listed on the MPL can be made only by the applicable specialty leader. Core privileges will be identified on the CCQAS MPL with a red letter "C" in front of the privilege.

(2) Non-core privileges are itemized, command-specific privileges that are relevant to the specific health care specialty. Additionally non-core privileges fall outside the general core scope of care due to:

- (a) The level of risk and/or specialty training necessary;
- (b) The requirement for unique medical command support staff or equipment; or
- (c) The level of technical sophistication required to support the privilege.

Note: Non-core privileges may be requested and granted on an item-by-item basis. Criteria for granting non-core privileges must be developed by the department, endorsed by the MEC, approved by the privileging authority, and reviewed annually. Non-core privileges may be modified locally to reflect the scope of care the medical command can support and expects to provide.

(3) In instances where the expected scope of care is very limited or significantly less than the full core privileges, the medical command may grant itemized privileges to be exercised exclusively at its medical command.

(4) Practitioners, to the degree permitted by their license, training, the law, or DON rules and regulations, are authorized and expected to render such care as is necessary to save the life or protect the welfare of individuals in an emergency situation. Accordingly, emergency privileges are automatically awarded to practitioners by virtue of their staff appointment, negating the need for individual or specific delineation of emergency privileges. The provision of this paragraph does not negate the requirement for practitioners assigned to provide emergency care services to hold appropriate clinical privileges or be appropriately supervised if practicing under supervision.

3. Application for Initial Medical Staff Appointment with Clinical Privileges

a. The applicant is provided copies of, or access to, and agrees in writing to abide by local credentialing and privileging directives, professional staff policies, procedures, and bylaws per reference (h), and if applicable, a code of ethics. The code of ethics may be included as a component of the staff policies and procedures. The applicant shall as part of the privilege application process, submit a signed statement pledging to ensure or provide for continuous care of his or her patients.

b. All credentialing should be completed for all practitioners entering the DON system prior to employment or contracting.

c. References (a) through (c) require the health status of applicants for staff appointments be considered at the time of appointment. The department head must assess the physical and mental health status of the applicant during the application process as part of the endorsement for staff appointment. If needed, a physician, (i.e., department head, or appropriate licensed independent practitioner), will confirm the applicant's statement of the ability to perform privileges requested. Health status consideration by the department head and other parties may be accomplished through a variety of means, including, but not limited to, review of:

(1) A statement from the applicant's physician or a report of a physical examination indicating the applicant is free of mental or physical impairments.

(2) The applicant's statements regarding health status on the application for privileges and the Personal and Professional Information Sheet (PPIS) or CCQAS E-App, including updates.

(3) The PARs from previous commands.

(4) Responses to requests for credentials and privileging information from other institutions or agencies.

d. The MSP and the department head compare the information provided through the application process with the applicant's CR or the ICTB, confirming the presence and verification of all required documentation. The medical staff will not act on an application that is incomplete. Incomplete applications shall not qualify for an appointment recommendation, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process.

4. Granting of Initial Medical Staff Appointments

a. An initial appointment is granted to a provider when first assigned or employed in a DoD MTF, or when the provider has had a lapse in clinical privileges of greater than 180 calendar days since having a medical or dental staff appointment in a DoD MTF. The initial appointment will not exceed 12 months. An initial appointment leads to an active or affiliate medical staff appointment and may 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 that appointment.

b. The Privileging authority grants initial staff appointments with clinical privileges:

(1) Upon receipt of the practitioner's application for an initial staff appointment, with review of the applicant's credentials (professional education and training, license status and history, consideration of health status, NPDB query, and current clinical competence) is completed.

(2) After applicable department head, director (if applicable), CRC (if applicable), and MEC review of the application and CR to determine current clinical competence demonstrated within the past 2 years, supported by practitioner-specific data and information generated by organizational quality management activities, and endorsement of the practitioner's application for staff appointment with delineated clinical privileges.

(3) For a period not to exceed 12 months.

(4) In writing or via the CCQAS E-app. The appointment is effective when the privileging authority dates and endorses the application.

c. After the practitioner was granted an appointment, upon receipt of orders indicating imminent deployment, the MSP shall prepare an ICTB generated in CCQAS, and forward it to the contingency assignment.

5. Affiliate Staff Appointment with Clinical Privileges. Affiliate appointments may be granted to an individual provider exercising regular privileges who has completed an initial-affiliate appointment period. Providers with affiliate appointments are not assigned organizational responsibilities of the medical/dental staff nor are they expected to be a full participant in activities of the medical/dental staff. Affiliate appointment is appropriate for consultants and individuals who are not assigned to the MTF, but who work part-time providing patient care. Affiliate appointment will not exceed 24 months.

6. Application for Active Medical Staff Appointment with Clinical Privileges

a. The applicant is provided copies of, or access to, and agrees in writing or via the CCQAS Electronic Privilege Application Attestation, to abide by local credentialing and privileging directives, professional staff policies, procedures, and bylaws per reference (h), and if applicable, a code of ethics. The code of ethics may be included as a component of the staff policies and procedures. The applicant shall submit a signed statement pledging to ensure or provide for continuous care of his or her patients.

b. For practitioners reporting from DON treatment facilities, the applicant's detaching PAR serves as a letter of reference from and evidence of demonstrated competence at the detaching medical command.

c. All credentialing should be completed for all practitioners entering the DON system prior to employment or contracting.

d. References (a) through (c) require the health status of applicants for staff appointments be considered at the time of appointment. The department head must assess the physical and mental health status of the applicant during the application process as part of the endorsement for staff appointment. If needed, a physician, (i.e., department head, or appropriate licensed independent

practitioner), will confirm the applicant's statement of the ability to perform privileges requested. Health status consideration by the department head and other parties may be accomplished through a variety of means, including, but not limited to, review of:

- (1) A statement from the applicant's physician or a report of a physical examination indicating the applicant is free of mental or physical impairments.
- (2) The applicant's statements regarding health status on the application for privileges and the PPIS or CCQAS E-App, including updates.
- (3) The PARs from previous commands.
- (4) Responses to requests for credentials and privileging information from other institutions or agencies.

e. The MSP and the department head compare the information provided through the application process with the applicant's CR or the ICTB, confirming the presence and verification of all required documentation. The medical staff will not act on an application that is incomplete. Incomplete applications shall not qualify for an appointment recommendation, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process.

7. Granting of Active Medical Staff Appointments

a. Active staff appointments are granted under one of two circumstances:

- (1) After a period of practice under a POS during which all of the pre-established criteria for an active staff appointment have been met.
- (2) Upon reporting to a new assignment after possessing an active staff appointment within the previous 2 years at another DON medical command, requiring the endorsement of the department head and the privileging authority. The local privileging authority may require additional endorsements.

b. The privileging authority grants active staff appointments with clinical privileges:

(1) Upon receipt of the practitioner's application for an active staff appointment, and after review of the applicant's credentials (professional education and training, license status and history, consideration of health status, NPDB query, and current clinical competence) is completed.

(2) After applicable department head, director (if applicable), CRC (if applicable), and MEC review of the application and CR to determine current clinical competence demonstrated

within the past 2-year appointment cycle, supported by practitioner-specific data and information generated by organizational quality management activities, and endorsement of the practitioner's application for staff appointment with delineated clinical privileges.

(3) For a period not to exceed 2 years.

(4) In writing or via the CCQAS E-app. The appointment is effective when the Privileging Authority dates and endorses the application.

c. After the practitioner was granted an appointment, upon receipt of orders indicating imminent deployment, the MSP shall prepare an ICTB generated in CCQAS, and forward it to the contingency assignment.

8. Professional Practice Evaluation

a. The Professional Practice Evaluation includes six areas of general competencies as established by the joint initiative of the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties. Professional practice evaluations will be conducted to assess a provider's performance in the following six areas:

(1) Patient Care. Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

(2) Medical/Clinical Knowledge. Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

(3) Practice-Based Learning and Improvement. Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.

(4) Interpersonal and Communication Skills. Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

(5) Professionalism. Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

(6) Systems-Based Practice. Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

b. Any professional practice issues that have been identified during the professional practice evaluation by the department, along with recommendations for performance improvement will be referred to the MEC.

9. FPPE

a. A process that requires monitoring and evaluation of a licensed independent practitioner's professional performance and competence to identify practitioner issues that may impact quality of care and patient safety.

b. An FPPE will be conducted in the following circumstances:

(1) For all licensed independent practitioners assigned at a DON medical command for the first time.

(2) When a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care.

(3) When a practitioner has credentials, training or experience to suggest competence, but does not have documented evidence of competently performing the requested privilege.

(4) When a practitioner requests a new privilege or scope of practice, and has credentials, training or experience to suggest competence, but MEC determines additional information or a period of evaluation is needed to confirm competency.

(5) When a new procedure or modality is to be performed and if the MEC determines an FPPE is required to evaluate competence of the provider and monitor safety.

(6) When a practitioner's competency is questioned in relation to an adverse event, sentinel event, other negative outcomes, or a close call. In this circumstance, the MEC and privileging authority need to be consulted to determine if an FPPE is required, or if adverse privileging should be pursued.

c. Criteria. The type of data to be collected is determined by the department and approved by the Chair of the MEC. One or any combination of the following data/processes may be reviewed, as applicable to the provider's practice:

(1) Operative and other clinical procedures and outcomes.

(2) Blood usage.

(3) Pharmaceutical usage.

(4) Morbidity and Mortality data.

(5) Quality of care measures.

(6) Appropriateness of patient-care and documentation as determined by Clinical Pertinence Peer Review (chart review).

(7) Performance Measures data.

(8) Medical record documentation/timeliness.

(9) Clinical practice patterns.

(10) Length of stay patterns.

(11) Utilization review data.

(12) Requests for tests and procedures.

(13) Use of consultants.

(14) Other monitoring criteria as determined by the department head and or director as applicable to the practice or privilege(s).

d. Methods. The information may be acquired through one or any combination of the following methods:

(1) Periodic medical record peer review.

(2) Direct observation.

(3) Monitoring of diagnostic and treatment techniques.

(4) Monitoring clinical practice patterns.

(5) Simulation.

(6) Proctoring.

(7) Peer review: internal or external.

(8) Discussion with other individuals involved in the care of each patient (such as consulting physicians, assistants at surgery, nursing, and administrative personnel).

(9) Other methods as determined by the department head and/or director as applicable to the practice or privilege(s).

e. Duration. A period not to exceed 6 months for all new practitioners. For all other situations, the duration will be determined by the department head and/or director based on the circumstance and the privilege(s) involved. Department heads review the data at the end of the monitoring period to assess practitioner's ability to provide safe, high quality patient care. The monitoring period can be extended by the director and/or MEC based on the practitioner's current clinical competence, data analysis, practice pattern, ability to perform the privilege, and/or recommendation from the department head.

f. Monitoring by external source. Monitoring can be performed by an external source if the department head/director or MEC determines that adequate monitoring cannot be accomplished by internal sources based on the specific privilege(s), practitioner, or the circumstance leading to the monitoring.

g. Action. Information obtained from the FPPE is reviewed by the department head. System issues should result in actions for improvement in systems or processes. Any performance concerns or deviations from standards of care should be addressed by the department head with the individual provider for corrective action. Serious concerns should be brought to the attention of the director and MEC Chair for further review and appropriate corrective action. The MEC may recommend to the privileging authority to limit, revise, or revoke an existing privilege based on the information from the FPPE.

10. OPPE. A process of ongoing evaluation of a practitioner's professional performance to identify practitioner issues that may impact quality of care and patient safety.

a. Circumstances. OPPE is a continuous evaluation process for all practitioners.

b. Criteria. The type of data to be collected is determined by the individual's department and approved by the MEC Chair. One or any combination of the following data/processes may be reviewed, as applicable to the provider's practice:

- (1) Operative and other clinical procedures and outcomes.
- (2) Blood usage.
- (3) Pharmaceutical usage.
- (4) Morbidity and Mortality data.
- (5) Quality of care measures.
- (6) Appropriateness of patient-care and documentation as determined by Clinical Pertinence Peer Review (chart review).
- (7) Performance Measures data.

(8) Medical record documentation/timeliness.

(9) Clinical practice patterns.

(10) Length of stay patterns.

(11) Utilization review data.

(12) Requests for tests and procedures.

(13) Use of consultants.

(14) Other monitoring criteria as determined by the department head and or director as applicable to the practice or privilege(s).

c. Methods. The information may be acquired through one or any combination of the following methods:

(1) Periodic medical record peer review.

(2) Direct observation.

(3) Monitoring of diagnostic and treatment techniques.

(4) Monitoring clinical practice patterns.

(5) Simulation.

(6) Proctoring.

(7) Peer review: internal or external.

(8) Discussion with other individuals involved in the care of each patient (such as consulting physicians, assistants at surgery, nursing, and administrative personnel).

(9) Other methods as determined by the department head and/or director as applicable to the practice or privilege(s).

d. Duration. OPPE is a continuous evaluation process for all practitioners. The data should be aggregated and reviewed by department head at a minimum of once every 8 months.

e. Monitoring by external source. Monitoring can be performed by an external source if the department head/director and/or MEC determine that adequate monitoring cannot be accomplished by internal sources based on the specific privilege(s) or practice.

f. Action. Information obtained from the OPPE is reviewed by the department head. System issues should result in actions for improvement in systems or processes. Any performance concerns or deviations from standards of care should be addressed by the department head/director with the individual practitioner for corrective action. Serious concerns should be brought to the attention of the MEC Chair for further review and appropriate corrective action. OPPE is factored into the decision to maintain existing privilege(s), or to limit or revise, or revoke an existing privilege prior to or at the time of renewal.

11. FPPE/OPPE for Temporary Assignment

a. For all temporary assignments, less than 90 days, an abbreviated FPPE/OPPE is required. Although 100 percent monitoring is not required, an adequate sample, as determined by the local medical staff, is required to ensure competency can be validated.

b. For any selected reserves practitioner requiring an ICTB for the purposes of exclusively performing physical health assessments (PHA), an FPPE/OPPE is not required. Performing PHAs is not part of any of the Navy's core privileges and therefore does not meet the intent of the FPPE/OPPE.

12. Performance Appraisal Report/Clinical Appraisal Report (PAR/CAR)

a. A PAR is required to evaluate clinical performance for licensed independent practitioners and is intended to permanently document clinical performance. A PAR can also be utilized to compile and report OPPE data. The PAR must specifically address the current clinical performance of all core and non-core privileges granted for each set of core privileges granted to a practitioner. For example, if a physician has core privileges in both family medicine and flight surgery, each specialty core section must be separately evaluated and documented on the PAR. Separate PAR documents may be utilized to capture performance data in multiple specialties.

b. A CAR is required to evaluate clinical performance for non-licensed independent practitioners, to include clinical support staff nurses (RN, LVN, and LPN) and RDH. The CAR must specifically address, the current clinical performance in the nursing subspecialty for which the clinical support staff RN is assigned duties, or the clinical performance in the scope of care assigned to an RDH.

c. PAR/CAR templates will be maintained by CCPD, BUMED. All commands must use BUMED approved PAR templates supplied by CCPD, BUMED. Although cosmetic modifications to the format may be made (i.e., conversion of the document into a PDF writeable or electronic format, etc.), the contents of the PAR/CAR templates may not be altered unless approved by CCPD, BUMED.

d. PAR/CARs are required under the following circumstances:

(1) Upon completion of temporary duty or alternative worksite exceeding 4 continuous days.

(2) At the time of reappointment to the medical staff or appropriate entity for non-licensed independent practitioners during time of recredentialing.

(3) Upon transfer, separation, retirement, or termination.

(4) When significant new information about a detaching practitioner's performance or conduct becomes available after the practitioner detaches. In this case, a special PAR/CAR must be forwarded to the practitioner's gaining privileging authority. The special PAR/CAR is the appropriate vehicle to forward results of Judge Advocate General Manual (JAGMAN) investigations, civilian external peer review, or investigations into allegations of misconduct or substandard care to the gaining privileging authority. Information included on the detaching PAR need not be reiterated on the special PAR. A potentially adverse PAR must be acted upon and finalized by the sending command, even if the provider has already detached.

(5) At intervals not to exceed 24 months for non-licensed independent practitioner clinical support staff, and as required to document FPPE/OPPE performance for all licensed independent practitioners.

e. The practitioner must be given an opportunity to review and sign the PAR/CAR, and either a signature or evidence that valid attempts were made to obtain a signature is required. If the practitioner has already detached from the command, forward a copy of the PAR/CAR to the practitioner at their next duty station or forwarding address for separating/retiring or detaching Reserve or civilian/contracted practitioners. When forwarding a copy of the PAR/CAR to the practitioner, such evidence that valid attempts to reach the practitioner, and they were given an opportunity to review and sign his or her PAR, could include:

(1) Obtaining his or her signature or;

(2) Annotate on the bottom of the original PAR/CAR the date a copy of the PAR/CAR was forwarded to the practitioner or;

(3) A documented statement that the practitioner received the PAR but refused to sign (if applicable) or;

(4) A copy of the FedEx or Certified Mail receipt or delivery confirmation (in cases where the practitioner has left the facility).

f. In instances when the practitioner disputes information reported on their PAR/CAR, the practitioner's written statement(s) must be reviewed by the MEC. A memorandum for the record, or other official documentation, provided by the MEC Chair, is required to ensure consideration of the practitioner's comments, and/or resolution of the issues documented on the CAR/PAR.

g. Any adverse marks on the PAR/CAR require a detailed written summary to include an explanation of the actions or deficiencies that support the adverse mark; a statement about the corrective steps taken to address the actions or deficiencies; and an evaluation of the progress

made by the provider at the time the PAR/CAR is being prepared. Performance evaluation is an ongoing process; therefore, any deficiencies should be timely addressed with the practitioner to allow an opportunity for improvement and not reserved until preparing the PAR/CAR. Any adverse PAR/CAR must be supported by separate documentation (i.e., written counseling, memoranda, e-mails, FPPEs, training courses, etc.) that is maintained within the department or directorate. Additional guidance may be sought from the command's Health Law Advisor or Staff Judge Advocate.

13. Renewal of Medical Staff Appointments with Clinical Privileges

a. Practitioners with active staff appointments must apply for reappointment to the medical staff and renewal of clinical privileges. Requests for renewal of medical appointments should include any proposed modifications to the practitioner's current clinical privileges.

b. Reappointment is based on evaluation of the practitioner's credentials using predetermined department and specialty-specific criteria.

c. Evaluation of practitioner-specific data and information generated by organizational quality management activities are of prime importance, and it is imperative in the assessment of current competence to justify reappointment to the medical or dental staff and renewal of clinical privileges. In cases where the practitioner is providing health care at civilian treatment facilities during the appointment period undergoing appraisal, it is both appropriate and recommended to solicit and consider clinical performance information from the other facilities in determining current clinical competence.

d. The practitioner's department head, or the operational equivalent, must submit a PAR, based on OPPE data, in support of reappointment to the staff and endorse the practitioner's application.

e. Both the practitioner's application and the PAR, with the department head's endorsement, are reviewed and subsequently endorsed by the directorate, CRC (if applicable), and MEC before approval by the privileging authority. The reappointment shall be granted:

(1) For a period not to exceed 2 years.

(2) In writing, either electronically (i.e., via CCQAS) or via hardcopy notification. The appointment is effective when the privileging authority dates and endorses the application.

14. Revision/Modification to Clinical Privileges

a. Requests to revise previously approved clinical privileges are sent to the privileging authority via the department head, directorate, CRC (if applicable), and MEC. Revision examples include:

- (1) Add or delete privileges to an existing set of core;
- (2) Add or delete itemized privileges to an existing itemized list; and
- (3) Add or delete a core in its entirety.

b. Supporting documentation is required for all revisions to clinical privileges. Enhanced or additional skills qualifying a practitioner for revisions of clinical privileges may be acquired through practice under a POS or through additional education or training.

c. The expiration date of the practitioner's current medical staff appointment shall not be altered when revising clinical privileges.

15. Withdrawal of Clinical Privileges

a. Requests for voluntary withdrawal of clinical privileges, if the practitioner is the subject of a quality assurance investigation or is the subject of allegations of substandard care or misconduct, will not be accepted.

b. Requests to voluntarily withdraw clinical privileges to correct administrative errors may be accepted, and if so, will become effective upon approval by the privileging authority.

16. Healthcare Providers Assigned to In-service Training Programs

a. Providers in full-time in-service training programs providing health care services must be supervised by a licensed independent practitioner with clinical privileges. Written descriptions of the role, responsibilities, and scope of practice for providers in in-service training programs must be defined by the program director at the medical command using criteria endorsed by the executive committee for graduate medical education and approved by the privileging authority. Medical command policies must clearly define who may write patient care orders, the circumstances under which they may do so, and what entries, if any, must be countersigned by a clinical supervisor.

b. The provision of health care by non-privileged practitioners must be authorized and defined by a command-approved POS, specific to the practitioner, which contains the following elements:

- (1) Scope of care permitted.
- (2) Level of supervision required. The level of supervision required is determined by the privileging authority, unless that authority is specifically delegated to another member of the medical staff leadership.
- (3) Identification of supervisor(s).

(4) Evaluation criteria.

(5) Frequency of evaluations.

17. PCS or Transfer

a. Practitioners reporting for permanent duty, who previously held an active staff appointment with core clinical privileges, are eligible for an active staff appointment with clinical privileges at their new gaining command if the most current PAR verifies demonstrated current clinical competence from within the last 2 years, for the privileges requested.

b. For non-core privileges, the practitioner must meet the privileging criteria relevant to the requested non-core privileges at the gaining command. Denial of non-core privileges at the gaining command for any of the following reasons is not an adverse privileging action:

(1) Failure to meet the privileging criteria for non-core privileges at the gaining command.

(2) The inability of the gaining medical command to support the non-core privileges due to medical command restrictions, lack of support staff, health care demands placed on the medical command that dictate the practitioner's assigned clinical duties, or equipment.

18. Health Care Services Provided at Other DON Treatment Facilities

a. The current privileging authority's MSP will forward an ICTB, via CCQAS, at the request of the gaining command.

b. The provider must request authority to exercise clinical privileges at the gaining command. Denial of a request to practice on an ICTB is not to be considered adverse in nature since the denial can be affected for a multitude of reasons (i.e., the medical command does not need the particular skills of the practitioner, the medical command cannot support the practitioner's request, the funds may not be available to support the request, etc.). No additional application for privileges is necessary at the gaining medical command for a Navy practitioner practicing at a Navy medical command when exercising only core privileges. When practicing under an ICTB, the practitioner functions as a member of the medical staff, and participates fully in the gaining command's quality management program.

c. A request to exercise core privileges granted by a Navy facility at another Navy facility can only be used when temporarily transferring credentials and core privileges of a provider who holds core privileges at another Navy command. This concept is commonly referred to as "privileging by proxy;" however, such a transfer of credentials and core privileges cannot be applied to granting of itemized or non-core privileges, except for telemedicine privileging purposes. Refer to paragraph 23 of this instruction for telemedicine privileging guidelines.

d. Any non-core privileges must be requested separately via the gaining command's privileging authority, using either a CCQAS E-app or hardcopy paper application for privileges, except for telemedicine privileging purposes.

e. A PAR will be completed for periods exceeding 4 days, and/or following a plan of supervision. The PAR must be completed and uploaded into provider's CCQAS CR.

f. When the practitioner provides recurring services at another medical command, (i.e., temporary duty or reserve drills), the ICTB is valid for the tenure of the practitioner's medical staff appointment at the parent medical command. A PAR covering the multiple clinical duty periods, must be completed at the end of the last clinical period, and must be submitted to the parent command as part of the re-privileging process.

19. Health Care Services Provided by DoD and the Department of Veterans Affairs (VA) Healthcare Practitioners

a. For or all other DoD healthcare practitioners providing health care services at a Navy medical command, the MSP will request an ICTB or a CCQAS "assignment" record, via CCQAS, from the parent command.

b. Per reference (j), for VA healthcare providers providing health care services at a Navy medical command, the MSP will request a VETPRO coordinator summary from the parent command.

c. When the ICTB or VETPRO coordinator summary is received, the provider must complete an application for privileges at the gaining command. If a provider meets the Navy's credentialing and privileging requirements as set forth in this policy, privileges will be granted. The credentialing information on the ICTB/VETPRO Coordinator Summary provided by the parent command will serve as the credentials verifications for all static credentials. All time-limited credentials (i.e., licensure), must be verified by the Navy MSP at the gaining command. When practicing under an ICTB/VETPRO Coordinator Summary, the practitioner functions as a member of the medical staff and participates fully in the gaining command's quality management program.

d. Since other DoD Services and the VA utilize an itemized privileging method, those practitioners practicing in a DON medical command will need to request itemized privileges.

20. Reserve Component Practitioners

a. When a Reserve Component practitioner is assigned duty involving the provision of health care services at a medical command, the gaining command must request an ICTB from CCPD, BUMED.

b. When a Reserve Component practitioner is recalled to temporary active duty (1-3 years) CCPD, BUMED remains the privileging authority, and the gaining activity will request an ICTB from CCPD, BUMED for the duration of the recall. When a Reserve Component practitioner is recalled permanently to Active Duty, the CR and CCQAS record is transferred to the gaining command.

c. When a Reserve Component practitioner is hired as a civilian or contractor at a DoD medical command, CCPD, BUMED remains the Credentials Verification Authority. The civilian activity will create a civilian "assignment" for the purpose of independently privileging the provider in their civilian capacity.

21. Health Care Services Provided by Non-DON Trainees

a. Non-DON trainees performing health care services under supervision as part of a cooperative agreement with a training institution are not eligible for a staff appointment with clinical privileges. A credentials file for such practitioners is not required.

b. Documentation of the following must be maintained in the command's Medical Staff Services Office (MSSO):

(1) Written authorization from the privileging authority for the practitioner to provide a specified scope of health care services while under the supervision of a specified practitioner who holds a professional staff appointment with clinical privileges in the same or similar specialty as the trainee.

(2) The designated supervisor(s) is responsible for oversight, coordination, and any required follow-up care related to the health care services provided by the trainee.

(3) A copy of the evaluation completed at the conclusion of the training period.

22. POS

a. A POS can only be utilized for licensed independent practitioners who have not been granted clinical privileges. A POS cannot be utilized for a practitioner who qualifies for, and/or holds clinical privileges.

b. If the licensed independent practitioner does not meet all credentialing requirements (i.e., does not hold valid, unrestricted licensure; does not have documented evidence of education and training to perform the requested privilege(s); etc.), the licensed independent practitioner must be placed under a written POS in order to participate in patient care activities and must be supervised by a licensed independent practitioner who holds privileges. A POS implemented because a licensed independent practitioner does not fully meet the credentialing requirements, but is otherwise considered safe for patient care activities, is not adverse.

c. A written POS can be utilized to supervise and precept training for non-core privileges newly requested by a licensed independent practitioner, or to refresh clinical skills for any portion of core privileges the licensed independent practitioner may not have performed within the last 2 years. A POS of this nature is not adverse.

d. A POS must be utilized following adverse privileging, if remedial training is required to retrain the practitioner to perform clinical skills.

e. When there is no supervising provider available at the applicable command, privileges should not be granted until arrangements for a period of direct supervision under the POS can be arranged.

f. A POS should be utilized for non-licensed independent practitioners who do not meet all credentialing requirements (i.e., does not hold valid, unrestricted licensure; does not have sufficient documented evidence of current clinical competency; etc.). In this case, the non-licensed independent practitioner should be placed under a written POS in order to participate in patient care activities, and must be supervised by a non-licensed independent practitioner who holds all required credentials to practice nursing in the appropriate non-licensed independent practitioner specialty (i.e., critical care nursing, emergency medicine trauma nursing, etc.). A POS implemented because a non-licensed independent practitioner does not fully meet the credentialing requirements, but is otherwise considered safe for patient care activities, is not considered adverse.

23. Telemedicine Credentialing and Privileging

a. The following definitions are provided in this enclosure for clarity:

(1) The Originating Site is the location of a patient at the time the service is provided via telemedicine, and

(2) The Distant site is where the practitioner providing the medical service is located at the time the service is provided via telemedicine.

b. For Navy practitioners providing telemedicine services (Distant Site) for another Navy medical command (Originating Site), the following is required:

(1) The provider must request authority to exercise current privileges at the Originating Site.

(2) The Originating Site must obtain an ICTB and copy of the provider's current privileges (include core and non-core privileges).

(3) The Originating Site must perform credentials review and determine if the provider's current privileges meet the patient care need.

(4) The Privileging Authority at the originating site must grant approval for the practitioner to practice current privileges held via telemedicine at the originating site based on the credentialing and privileging information on the ICTB.

c. For DoD and VA practitioners providing telemedicine services for a Navy medical command (originating site), an ICTB or VETPRO Summary will be used to validate the credentials and privileges from the DoD/VA practitioner's medical facility (distant site). For DoD and VA practitioners providing telemedicine for a Navy command, the Privileging Authority at the originating site may grant privileges based on its medical staff recommendations and the credentialing and privileging information provided by the distant site via the ICTB/VETPRO Summary.

d. For telemedicine health care services provided by non-DoD/VA practitioners, the credentialing and privileging of the distant site can be accepted by the originating site if the distant site is accredited by TJC. In this case, the Privileging Authority of the originating site may grant privileges based on its medical staff recommendations and the credentialing and privileging decisions provided by the distant site hospital. All licensed independent practitioners who are responsible for the patient's care, treatment, and services via telemedicine are credentialed and privileged to do so at the originating site through the following mechanisms. The following requirements apply:

(1) The distant site fully credentials and privileges the practitioner according to TJC standards.

(2) The practitioner must be privileged at the distant site to provide telemedicine services, and the distant site must provide a current list of the practitioner's privileges to the originating-site.

(3) The distant site must maintain evidence of an internal review of the practitioner's performance of these privileges and must provide to the originating site information for use to assess the practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by TJC that result from the telemedicine services provided; and complaints about the licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site.

(4) There is a written agreement between the originating site where the patient receiving telemedicine services is located and the distant site.

(5) The originating site must query the NPDB for all practitioners applying for telemedicine privileges.

24. Support of the Armed Forces Medical Examiner (AFME) System. The AFME System provides support for medico legal death investigations to all DoD medical commands. The range of support includes onsite performance of autopsies by deputy or regional medical examiners,

telephonic consultations, and written reports. Deputy and regional medical examiners generally hold privileges granted by Walter Reed National Military Medical Center, Bethesda. Deputy and regional medical examiners are authorized to perform autopsies upon presentation of their AFME credentials to the Privileging Authority. An application for staff appointment with clinical privileges is not required for this service.

25. Support for the Organ and Tissue Procurement Program and the Armed Services Medical Regulating System. Organ donations and transplants conducted by organ and tissue procurement teams, and treatment provided within Navy medical commands by personnel assigned to the Armed Forces Medical Regulating System to patients under their care, are authorized to be performed without formal credentials review and privileging under this instruction. However, personnel assigned in support of these programs must present sufficient documentation (i.e., official orders, assignment letter or identification card) to the Privileging Authority of the medical command to establish their authorization to perform the services.

26. Foreign National Local Hire (FNLH) Licensed Independent Practitioners will meet the same credentialing and privileging requirements of other practitioners within the same specialty, with the exception of U.S. licensure.

27. FNLH non-Licensed Independent Practitioners may be credentialed to work in overseas commands on a case by case basis contingent upon operational requirements and validated clinical competency for the scope of practice assigned.

28. Providers with Infectious Diseases. Per reference (k), health care providers who have a potentially infectious disease or who are undergoing treatment or evaluation for a temporary medical condition that may impact their ability to provide safe patient care will be temporarily reassigned to non-direct patient care activities. This administrative reassignment is not an adverse action. Reference (k) is available at:
<https://www.cpsa.on.ca/uploadedFiles/members/membership/shear-guideline.pdf>.

a. The limitation of privileges of a provider infected with hepatitis B virus (HBV), hepatitis C virus (HCV), and/or the human immunodeficiency virus (HIV), solely based upon a risk of disease transmission to a patient, is considered administrative and is not an adverse privileging action. Example: An HIV-infected obstetrician who is outwardly healthy, but who is restricted from performing exposure-prone invasive surgical procedures due to a risk of provider-to-patient HIV transmission.

b. The limitation or revocation of privileges of a provider infected with HBV, HCV, or HIV as a result of medical impairment caused by severe illness is considered an adverse privileging action. Example: An HIV-infected provider who has become physically debilitated to the point he or she can no longer practice.

c. HBV, HCV, and/or HIV positive results are not to be documented in the credentials record (CR). Health care providers are required to disclose HBV, HCV, and/or HIV to the Privileging Authority only. Teaching blood borne pathogens precautions are required for renewal of clinical privileges for the health care provider with positive HBV, HCV, and/or HIV.

d. Before allowing a provider infected with HBV, HCV, HIV, or similar communicable life-threatening infectious disease, to perform an exposure-prone invasive procedure, a Privileging Authority must evaluate each individual case using current Society for Healthcare Epidemiology of America (SHEA) Guideline for Management of Healthcare Workers Who Are Infected with HBV, HCV, and/or HIV. This document specifically states, "Providers infected with HBV, HCV, and/or HIV who are adhering to the SHEA guidelines above should not be required to disclose their infection status to any patient (unless the provider has been the source for an exposure for a patient.) Any provider who is aware that he or she is the source of a significant patient exposure to his or her blood or hazardous body fluid should undergo testing for infection with blood borne pathogens, even if not known to be infected with HBV, HCV, and/or HIV."

29. Humanitarian Assignments

a. Navy Medicine follows reference (a) for credentialing and privileging of healthcare providers for foreign humanitarian missions.

b. The military Senior Medical Department Representative (SMDR) assigned to a foreign humanitarian mission is responsible for monitoring the quality and safety of the medical care rendered by all providers participating in the DoD mission. The SMDR is the final authority on which health care providers participate in the DoD foreign humanitarian mission. The SMDR is required to review the credentials of all providers assigned to the DoD mission and to authorize those qualified providers to practice their specialties. An ICTB, VETPRO Summary or statement signed by the medical director of a non-governmental organization (NGO) providing appropriate information/documentation verifying education, training, licensing, and current clinical competence will be used for this purpose.

c. In medical humanitarian missions, a host nation may require documentation and/or copies of qualifying degrees and licenses, or other credentials as a condition for medical personnel practicing in that country. If required by the host nation, such documentation should be provided. The host nation should be requested to return the documents after review and/or agree to protect the documents from release. If a copy of the DoD Credentials Transfer Brief is also provided to the host nation, sensitive personal identifying information (i.e., social security number, date of birth, home address, etc.) must be redacted prior to release.

d. All foreign providers participating in humanitarian missions (i.e., providers not licensed in any jurisdiction of the United States) shall meet the credentialing and licensing standards of their respective country. A foreign provider's request for authorization to participate as part of a DoD humanitarian mission should include, to the extent practicable, supporting documentation of:

medical training, country certification/licensure, education, practice specialty, and current clinical competencies. A period of observed practice should be performed to assess skill level prior to assignment of clinical duties.

30. Portability of Licensure

a. General provision. Title 10, U.S.C., §1094(d) mandates that, notwithstanding any law regarding the licensure of healthcare providers, a designated licensed individual provider may practice his or her profession at any location in any jurisdiction of the United States, regardless of where the provider or patient are located, so long as the practice is within the scope of authorized federal duties.

b. Reference (a) specifies the qualifications required for assignment to off-base duties.

c. Coordination with State Licensing Boards

(1) Prior to a healthcare provider performing off-base duties, the facility must notify the applicable licensing board of the host State of the duty assignment involved. Such notification will include:

(a) Healthcare provider's name, State(s) of licensure, and CO.

(b) Location and expected duration of the off-base duty assignment.

(c) Scope of duties.

(d) Facility liaison official for the licensing board to contact with any question or issues concerning the off-base assignment.

(e) A statement that the healthcare provider meets all the qualification standards required for assignment to off-base duties.

(2) The requirement to notify the State licensing board regarding off-base duties of non-physicians may be waived on a case by case basis if the facility official determines that such a requirement is not necessary to promote cooperation and goodwill with the State licensing board concerned, and such a waiver is consistent with reference (a) and guidance of the ASD(HA).

CREDENTIALING REQUIREMENTS FOR LICENSED INDEPENDENT PRACTITIONERS

1. To be eligible for a medical staff appointment with clinical privileges, licensed independent practitioner must meet the following requirements. Note: For the purposes of this policy, the term “licensed independent practitioner” refers to all physicians, dentists, allied health practitioners, and advanced practice nurses.

a. Possession of an active, valid, unrestricted license from a U.S. State, territory, or district. Licensure must be primary source verified (PSV) upon granting of initial appointment/privileges, reappointment/renewal of privileges, revision of privileges, and expiration. A current, valid, unrestricted license or certification is one which is not expired or been suspended or revoked, one in which the issuing authority accepts and considers quality assurance (quality management) information, and is not subject to restriction pertaining to that scope, location, and type of practice ordinarily granted all other applicants for similar licensure or certification in the granting jurisdiction. If the practitioner does not possess a license or certification exemption, or is not otherwise specifically authorized to practice independently without a license or certification, the practitioner must be placed under a POS to participate in patient care activities.

b. Documented evidence of current clinical competence. In order have “current” clinical competence evaluated; the practitioner must have performed the requested clinical privilege(s) within the past 2 years. Periods of clinical inactivity for the privilege(s) requested, (greater than 2 years) is considered a lack of current competence.

c. Ability to perform. Absence of health issues which would prohibit safe and effective patient care to be rendered.

d. Completion of Education. Completion of appropriate and relevant education and training for the medical specialty privileges being requested.

2. Physicians

a. Graduation from a medical school in the United States, Canada, or Puerto Rico approved by the Liaison Committee on Medical Education of the American Medical Association (AMA), or graduation from a college of osteopathy approved by the American Osteopathic Association (AOA). Graduates of medical schools other than those listed above must have achieved Educational Commission for Foreign Medical Graduates (ECFMG) certification.

b. Completion of an accredited residency approved by the ACGME or the AOA, for all specialties other than general medical officer, flight surgeon, and undersea medicine.

c. Although not identified specifically in the core privileges, all physicians who have clinical privileges with current staff appointments are authorized to perform clinical histories and physical examinations consistent with their privileges.

d. Criteria for non-core privileges of primary care sports medicine

(1) Completion of an accredited primary care residency and privileged in the specialty of family medicine, pediatrics, internal medicine or emergency medicine.

(2) Completion of a sports medicine fellowship accredited by the Residency Review Committee (RRC) of the ACGME or AOA.

e. Criteria for Osteopathic Manipulative Medicine (OMM). Definitions:

(1) Osteopathic Medicine (OM). A complete system of medical care with a philosophy that combines the needs of the patient with current practice of medicine, surgery, and obstetrics, and emphasizes the interrelationships between structure and function, and an appreciation of the body's ability to heal itself.

(2) Osteopathic Physician. Doctor of Osteopathy (DO). A person with full, unlimited medical practice rights who has achieved the nationally recognized academic and professional standards within their country to practice diagnosis and treatment based upon the principles of osteopathic philosophy. Individual countries establish the national academic and professional standards for osteopathic physicians practicing within their countries.

(3) OMM. The application of osteopathic philosophy, structural diagnosis, and use of osteopathic manipulative treatment in the diagnosis and management of the patient.

(4) Osteopathic Manipulative Treatment or Therapy (OMT). The therapeutic application of manually guided forces by an Osteopathic Physician to improve physiologic function and/or support homeostasis that have been altered by somatic dysfunction. OMT employs a variety of techniques.

(a) Osteopathic physicians are qualified to independently prescribe and use OMM after successfully graduating medical school, internship, and obtaining licensure in a State, territory, or district.

(b) Indications for the use of OMM are those, which informed DO physicians believe would benefit the patient. OMM is indicated in the following, but is not limited to: somatic dysfunction, neck pain, low back pain, chronic pain syndromes, ligamentous strain, postural imbalance, muscular spasm, osseous reduction, and other conditions where the patient would be expected to benefit from short or long-term use of OMM.

(c) Consultation requirements for the use of OMM should include evidence of a previously considered differential diagnosis and appropriate supportive workup.

(d) OMM will be included in the peer review process to assess appropriate clinical judgment, clinical decision-making, and proficiency in the use of OMM procedures.

(e) While not identified specifically in each core privilege list, DO physicians who have demonstrated current clinical competency for the privilege, and by virtue of their DO degree and unique training, are authorized to perform OMM, and need not request it as a core or non-core privilege.

(f) Allopathic physicians must practice under a POS, under the supervision of a DO who holds OMT privileges, to be eligible for OMT privileges.

f. Neurotology requires completion of a residency in Otolaryngology, and either:

(1) A neurotology fellowship accredited by the ACGME or,

(2) Board certification in Neurotology by the American Board of Medical Specialties.

g. Flight Surgery

(1) Completion of the Flight Surgery training program at NAMI.

(2) For any previously trained Navy Flight Surgeon who has not completed the flight surgery training within the last 12 months, or practiced Flight Surgery in greater than 2 years, completion of the 2-week Flight Surgery refresher training at NAMI is mandatory for privileges to be granted.

h. General Medical Officer (GMO)

(1) Graduation from physician internship (Postgraduate Year-1) within the last 6 months or any Navy physician who currently holds privileges in the following specialties: Family medicine, internal medicine, emergency medicine, flight surgery, undersea medicine, aviation medicine, and aerospace medicine.

(2) For any other physician specialists requesting GMO core privileges, current clinical competency for GMO core privileges must be demonstrated and documented within the last 2 years.

3. Dentists

a. Graduation from a dental school approved by the Commission on Accreditation of Dental and Auxiliary Educational Programs of the American Dental Association (ADA) or the Commission on Dental Accreditation of Canada of the Canadian Dental Association.

b. Completion of a training program approved by the Commission on Accreditation of Dental and Auxiliary Educational Programs of the ADA or the Commission on Dental Accreditation of Canada of the Canadian Dental Association, for specialties other than general dentistry.

4. Advanced Practice Registered Nurses (APRN)

a. Graduation from a masters or doctoral degree program in nursing approved by an organization authorized by the Department of Education to accredit schools of nursing, with a focus in the specialty of specific privileges being requested.

b. Must obtain and maintain certification by the relevant certification body for the given APRN specialty. National certification must be obtained within 12 months of graduation from an approved certifying body (i.e., American Nurses Credentialing Center). In rare circumstances, a waiver of this 12-month requirement will be considered on a case-by-case basis. Such approvals will be granted by the Privileging Authority with prior review and endorsement from the relevant nursing Navy Specialty Leader (i.e., Family Nurse Practitioner (FNP), Certified Registered Nurse Anesthetist (CNRA), etc.) and Assistant Director, Nurse Corps Policy and Practice.

c. Possession of a current, valid and unrestricted license as a registered nurse and/or advanced practice nurse as required by the State issuing the license.

d. Completion of a formal post-graduate certificate program in the relevant specialty. These programs are most commonly referred to as postmaster's certificate programs.

e. APRNs are licensed independent practitioner s in the Navy. The APRN specialties recognized by Navy Medicine are as follows:

- (1) CRNA.
- (2) Certified Nurse Midwife (CNM).
- (3) FNP.
- (4) Pediatric Nurse Practitioner, (PNP).
- (5) Women's Health Nurse Practitioner (WHNP).
- (6) Psychiatric/Mental Health Nurse Practitioner.

Note: Other APRN specialties (Adult Nurse Practitioner, Emergency Nurse Practitioner, etc.) may be granted itemized privileged based on the same criteria as the recognized APRN specialties by the local Privileging Authority on a case-by-case basis per with the needs of the command.

f. APRNs who are granted privileges may prescribe all medicines (including Schedule II through V), durable medical goods and other equipment and supplies required within their scope of practice.

5. Allied Health Practitioners

a. Audiology. Master's degree in audiology or Doctor of Audiology (Au.D) degree, State license to practice and board certification through either a Certificate of Clinical competence (Audiology) from the American Speech-Language-Hearing Association (ASHA), or certification through the American Board of Audiology. Individuals enrolled in a clinical residency program are subject to the licensure requirements of the State in which they are completing their residency and operate under the supervision of a credentialed audiologist per the above guidelines.

b. Chiropractic. Graduate of a chiropractic college accredited by the Counsel on Chiropractic Education (CCE) and possess a current, valid, and unrestricted license to practice as a Doctor of Chiropractic from a U.S. State, territory, or district.

c. Clinical Psychology. A doctoral degree in clinical or counseling psychology (PhD or PsyD) from an American Psychological Association (APA) accredited university or professional school, a 1-year APA-accredited clinical internship, and current State license in clinical psychology from a U.S. State, territory, or district. Waivers for the APA accredited internship requirement may be considered for individuals who have completed an APA-accredited post-doctoral residency or fellowship or have attained board certification by the American Board of Professional Psychology (ABPP). (Note: Clinical psychologists commissioned/employed prior to the publication of this policy may be exempt from requirements to have completed an APA accredited clinical internship. Clinical psychologists commissioned/employed prior to publication of this policy must have completed a 1-year clinical internship; however, completion of a non-accredited program is acceptable for those psychologists already commissioned or employed in the Navy prior to publication of this policy revision.). Additional requirements for non-core clinical psychology privileges are as follows:

(1) To prescribe and dispense psychotropic medications. Requires completion of the APA recommended training in psycho-pharmacology. This includes successful passage of the Psychopharmacology Examination for Psychologists from the APA's College of Professional Psychology and completion of 100 supervised cases by a licensed prescriber. This privilege allows the psychologist to prescribe and dispense psychotropic and adjunctive medications.

(2) The admission of patients

(a) If approved by the local privileging authority, clinical psychologists may admit patients to the hospital if a physician member of the active medical staff conducts or directly supervises the admitting medical history and conducts the physical examination. All patients admitted for care by clinical psychologists shall receive the same basic medical appraisal as patients admitted to other departments or services.

(b) A physician assumes responsibility for the care of the patient's medical problems which are outside the psychologist's scope of practice, both at the time of admission and during hospitalization.

(c) Where a dispute exists regarding proposed treatment between a physician and a clinical psychologist involving medical or surgical factors outside the scope of the psychologist's privileges, the physician's orders supersede the clinical psychologist's orders. These occurrences will immediately be referred to the chair of the department or the medical director for consultation.

(d) Patients cannot be discharged without a physician's signature.

(3) Neuropsychological assessment. Requires a 2-year postdoctoral fellowship in neuropsychology or the equivalent in specialized training and supervised practice.

(4) Pediatric psychology privileges. Requires a 1-year postdoctoral fellowship in pediatric psychology or the equivalent in specialized training and supervised practice.

(5) Clinical Health Psychology. Requires a 2-year postdoctoral fellowship in Health Psychology or the equivalent in specialized training and supervised practice.

(6) Forensic Psychology. Completion of a full-time (at least 1 year) postdoctoral training program in forensic psychology or the equivalent in specialized training and supervised practice. This program must meet curriculum requirements consistent with the American Psychological Association's definition of forensic psychology as a specialty.

(7) Survival, Evasion, Resistance and Escape (SERE) Psychology. Requires the completion of all DoD requirements for SERE Psychology certification. This includes graduation from a Level C SERE course and the SERE orientation course, as well as continuation training or participation in reintegration operations at least biannually.

(8) Aeromedical Psychology. Requires completion of the 6-month Aeromedical Officer Course at NAMI.

d. Pharmacy. Baccalaureate or doctorate degree in pharmacy from an accredited training instituted by the Accreditation Council for Pharmacy Education (ACPE) Pharmacy College, or a Foreign Pharmacy Graduate Examination Committee (FPGEC) certificate, and active licensure from a U.S. State, territory, or district. The education qualifications to practice as a pharmacist or clinical pharmacist are the same. The scope of services offered at the facility is the main determinant if Clinical Pharmacist privileges are required. Additional requirements for non-core privileges are as follows:

(1) Prescribe medication or parenteral nutrition: In order to prescribe medications, total parenteral, peripheral parenteral, or enteral nutrition per MTF Pharmacy and Therapeutics (P&T) approved policy, generally requires one or more of the following:

(a) Doctor of Pharmacy degree (Pharm.D.) preferred.

(b) Completion of an American Society of Health-System Pharmacists (ASHP) accredited pharmacy residency program preferred or 3 years equivalent clinical or medical home experience.

(c) Completion of specialty board certified pharmacist examination pertinent to the area of practice preferred.

(d) Additional certifications or Medication Therapy Management (MTM) based educational degrees preferred.

(e) Demonstration of clinical skills acceptable to the supervising staff physician/pharmacist.

(2) Administer oral or IV medications for nausea associated with oncology (antineoplastic) or radiation therapy or to administer emergency medication for anaphylactic drug reactions or drug extravasation, generally requires one or more of the following:

(a) Doctor of Pharmacy degree (Pharm.D.) preferred.

(b) Completion of an American Society of Health-System Pharmacists (ASHP) accredited pharmacy residency program preferred or 3 years equivalent clinical.

(c) Completion of specialty board certified pharmacist examination pertinent to the area of practice preferred.

(d) Additional certifications or medication therapy management (MTM) based educational degrees preferred.

(e) Demonstration of clinical skills acceptable to the supervising staff physician/pharmacist.

(3) Clinical pharmacist duties in the specialized area of nuclear or oncology pharmacy, additional specialized training in the form of either:

(a) Completion of pharmacy practice residency program in Nuclear/Oncology Pharmacy.

(b) At least 3 years of Nuclear/Oncology Pharmacy practice experience.

(c) Demonstration of clinical skills acceptable to the supervising staff physician/pharmacist.

e. Dietetics. Baccalaureate degree with 2 years of experience or board certification, or Master's degree. Degree course work in dietetics, nutrition, exercise and sports nutrition, food

service administration, public health, or closely related program as approved by the Academy of Nutrition and Dietetics (AND). Completed a dietetic internship or pre-professional practice program, or other qualifying professional experience approved by the AND's Accreditation Council for Education in Nutrition and Dietetics (ACEND). Must possess the credential of "Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN)" per the Commission on Dietetic Registration (CDR) the credentialing agency for the AND. State licensure is an option, but not a requirement.

(1) Advanced practice in Nutrition Support. Board Certified Nutrition Support Clinician (CNSC) through the National Board for Nutrition Support Certification (NBNSC), approved through the American Society of Enteral and Parenteral Nutrition (ASPEN). Sustainment of board certification through completion of pertinent continuing education units (CEUs), demonstrated competencies and re-certification exam every 5 years.

(2) Advanced Practice as a Certified Diabetes Educator. Board Certified-Advanced Diabetes Management (BC-ADM) certification as approved/recognized through the American Association of Diabetes Educators (AADE). Sustainment of board certification through completion of CEUs of which 51 percent must be directly related to advanced diabetes management, demonstrated competencies in meeting the scope of advanced diabetes practice and re-certification exam every 5 years.

f. Marriage and Family Therapists. Master's or doctoral degree in marriage and family therapy from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or a qualifying graduate degree in an allied mental health field from a regionally accredited education institution in conjunction with a program of marriage and family therapy study that is equivalent to the COAMFTE standards as defined by the American Association of Marriage and Family Therapy (AAMFT), State license from a U.S. State, territory, or district, and clinical membership credentials issued by the AAMFT.

g. Occupational Therapy (OT). Masters' degree from a program accredited by the Accreditation Council of Occupational Therapy, national certification from the National Board on Certification for Occupational Therapy, and State licensure from a U.S. State, territory, or district as an occupational therapist. Occupational therapists previously not required to have state licensure will obtain State licensure by 29 October 2015. Case-by-case consideration will be made, via the OT Specialty Leader, for therapists with a Bachelor's degree based on their previous work experience. OTs are required to supervise OT assistants, volunteers, and students.

h. Optometry. Doctors of Optometry are independent primary health practitioners whose scope of practice comprises the comprehensive management of primary eye health care. The diagnosis, treatment, therapy, and management provided include disorders, diseases, and injuries of the eye, associated structures, and the visual system, as well as identify related systemic conditions affecting the eyes and vision. The scope of privileging includes, but is not limited to: the examination of eyes and the visual system to diagnose and treat eye diseases, injuries, and all vision, accommodative, and binocular disorders; pre and post-operative assessment to include

refractive surgery; assessment of color vision and perception; vision therapy; assessment, fitting and prescribing of eyeglasses and contact lenses; prescription and use of diagnostic and therapeutic medications and treatment for pain; superficial ocular foreign body removal and epilation; testing and analysis of computerized diagnostic tests, laboratory tests, and imaging of the eye and associated structures related to or affecting the eyes and/or visual system. Optometrists also co-manage conditions that affect the ocular health and vision of their patients or refer them to secondary/tertiary levels of care, when indicated. The following criteria must be met:

(1) Satisfactory completion of a professional educational course at a college of optometry, leading to a Doctor of Optometry degree. Some optometrists complete an additional 1-year residency in a specific area of practice.

(2) State license from a U.S. State, territory, or district. Possession of a State license allowing diagnosis and treatment of disorders of the eye and visual system, and possession of a Therapeutics Agents (TA) State license authorizing the individual to prescribe ocular therapeutic agents.

i. Physical Therapy. A minimum of a Masters' degree from a program accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE) and current State licensure as a Physical Therapist (PT) from a U.S. State, territory, or district. Case-by-case consideration will be made, via the PT Specialty Leader, for therapists with a Bachelor's degree based on their previous work experience. A transitional Doctorate of Physical Therapy (tDPT) is acceptable only if the PT also has a Master's degree from a CAPTE accredited program. PTs are required to supervise physical therapy assistants, volunteers, and students. PTs perform examination, evaluation, and testing of individuals with mechanical, physiological and developmental impairments, functional limitations and disabilities or other health and movement-related conditions. In the course of the evaluation and treatment of their patients, PTs may request appropriate imaging studies for patients, order appropriate diagnostic laboratory studies, and request consultation (refer) patients to specialty clinics. PTs may see patients without a referral, and based on a clinical assessment, determine the diagnosis, prognosis and appropriate physical therapy intervention in order to alleviate impairments, functional limitations and disabilities. These interventions may include but are not limited to: therapeutic exercise; neuromuscular re-education; manual therapy to include peripheral joint and spinal manipulation; therapeutic massage; therapeutic modalities; prescription, application and as appropriate, fabrication of casts and assistive/adaptive orthotics, prosthetics, and protective and supportive devices and equipment; strength and conditioning training; injury prevention; debridement and wound care; rehabilitative ultrasound imaging (RUSI); vestibular rehabilitation; and patient related instruction. Furthermore PT's provide consultation and education in the area of rehabilitation, wellness and injury prevention to other health professionals in the MHS, the DoD and/or VA facilities and to unit commanders; perform the physical component of human performance optimization through prevention and wellness activities, education, screening, the promotion of positive health behaviors, and engage in administration, consultation, education

and research. PTs in military settings will determine and provide temporary or permanent profiles and/or assign patients to quarters for intervals not to exceed 72 hours. Additional requirements for physical therapy non-core privileges as follows:

(1) Prescribe medications per MTF P&T policy. Requires completion of an educational course, for example, but not limited to:

(a) Formal professional course work in Pharmacology;

(b) An American Physical Therapy Association (APTA) or AMA sponsored course in Pharmacology; or

(c) The COL Kersey Advanced Orthopedic Clinical Practice Course.

(2) Aspiration and injection of joints requires a preceptorship with a medical physician until determined to be independent in practice.

(3) Casting for spasticity and/or redistribution of forces requires completion of professional coursework in the specialty area along with completion of at least one post-professional course or a preceptorship with a provider credentialed in this area.

(4) Early intervention pediatric therapy requires:

(a) Completion of professional coursework in the specialty area along with completion of at least one post-professional course or a preceptorship with a PT credentialed in this area; or

(b) Board certification in Pediatrics by the American Board of Physical Therapy Specialties.

(5) Electroneuromyographic testing requires:

(a) Completion of a post-professional training program in clinical electrophysiology and;

(b) Performance of 100 studies while under a plan of supervision by a credentialed electromyographer.

(6) Neonatal physical therapy requires:

(a) At least 6 months of work experience in the field; or

(b) Board certification in Pediatrics by the American Board of Physical Therapy Specialties.

(7) Trigger point dry needling requires:

(a) Completion of a course of instruction, for example, but not limited to:

1. Formal professional course (in dry needling or acupuncture) or;
2. Post-professional course that is endorsed by one of the following institutions: BUMED, AMA, or the APTA; and

(b) Practice under a plan of supervision from a provider credentialed in the respective clinical competency, until determined to be independent in practice.

(8) Perform and manage cardiac rehabilitation requires:

(a) American Board of Physical Therapy Specialties certification in Cardiovascular and Pulmonary; or

(b) Clinical Exercise Specialist Certification from the American College of Sports Medicine; or

(c) A minimum of 6 months of post-professional work experience in the practice area.

j. Podiatry. Graduate of a college of podiatric medicine accredited by the Council on Podiatric Medical Education (CPME) of the American Podiatric Medical Association (APMA). A 2-year Podiatric Medicine and Surgery Residency (PMSR) approved by the CPME, or documented PMSR equivalent is required and a 3-year PMSR Rearfoot Reconstruction and Ankle (RRA) program and board qualified/certified status recognized by the APMA is highly desired. State licensure from a U.S. State, territory, or district is required.

k. Social Work. Master's degree in social work (MSW) from a graduate school of social work accredited by the Council on Social Work Education (CSWE). Must have a minimum of 2 years full-time postmaster's degree supervised clinical social work experience and the highest current State licensure or State certification as a clinical social worker to practice independently from a U.S. State, territory, or district.

l. Speech Pathology. Master's degree in Speech-Language Pathology, Communication Sciences and Disorders, or a directly related field from an accredited program of the Council on Academic Accreditation of the ASHA, State licensure in speech pathology from a U.S. State, territory, or district, and Certificate of Clinical Competence (CCC-Speech-Language Pathology) from ASHA.

m. Physician Assistant (PA). Successful completion of a training program for PAs recognized by Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) and current certification by the National Commission for Certification of Physician Assistants (NCCPA), in addition to the following requirements:

(1) Collaboration Requirements. A physician collaborator must be appointed and endorse the application for clinical privileges. An alternate physician must be appointed in writing to act in the absence of the primary collaborator. Routine peer reviews will be conducted by the physician collaborator.

(a) PAs will have access to a physician for the purpose of advice and collaboration. This access may be telephonically or via e-mail. PA subspecialty privileges must occur under the clinical supervision of a physician specialist in the same specialty (i.e., an orthopedic PA must be supervised by an orthopedic surgeon).

(b) Consultation with the collaborating physician must be sought and documented when complex cases or complications are encountered. Consultation may include, but is not limited to, discussion of the case before or in the course of treatment, or timely review and discussion following disposition of the case.

(2) Physician Assistant Specialists and Non-core Privileges. Requires completion of a relevant PA fellowship. Additional clarification on the granting of non-core privileges for PAs as follows:

(a) The uniformed PA must be eligible for, and granted the PA core privileges to meet the needs of the Navy, prior to the granting of PA subspecialty non-core privileges (i.e., Orthopedics, Emergency Medicine, etc.).

(b) For civilian PAs, contractual language or position description sets the scope of practice, (i.e., Orthopedic PA, Urology PA, etc.). The civilian PA employed specifically as a PA subspecialist is not required to be granted core PA privileges; itemized privileges can be granted to define the civilian PA's scope of practice required for employment.

6. Criteria for Non-core Medical Acupuncture for Physicians and Dentists. Per reference (1), the following criteria must be satisfied for this group of practitioners to perform Medical Acupuncture:

a. Physicians (MD/DO) and dentists (DDS/DMD) who are granted Medical Acupuncture (MA) privileges may do so only within the scope of their respective clinical specialties/clinical privileges.

b. Physicians and dentists must successfully complete a medical acupuncture training program accredited by the American Board of Medical Acupuncture (ABMA), or other equivalent training (e.g., the National Certification Commission for Acupuncture and Oriental

Medicine certification), in order to receive non-core privileges. Physicians can also apply for more limited non-core privileges in the MA subtypes of auricular acupuncture (first aide or battlefield acupuncture) or myofacial trigger point injections (without injection of medication) (dry needling) by providing documentation of successful completion of training and certification courses, or inclusion of training in standard residency programs.

c. Although a State license to practice MA is not mandatory within the Navy, providers are strongly encouraged to possess a State license that permits medical acupuncture.

d. A physician or dentist may start performing MA (or its subtypes as above) earlier during their MA training program under a POS if the training program director, privileged in medical acupuncture, provides written interim performance assessments. Upon completion of the MA training program, the physician may request non-core privileges; training certification demonstrates current knowledge and procedural competency. A FPPE may be done as well. Renewal of the MA non-core privilege will be based on completion of the PAR with an endorsement from a practicing provider privileged in MA. For physicians whose MA non-core privileges have lapsed, privileges may not be granted; the physician must go under a POS. When there is no supervising provider available at the applicable MTF, privileges should not be granted until arrangements for a period of direct supervision, under the POS can be arranged.

e. Ongoing assessment of practitioner performance is required to maintain privileges. Practitioner-specific data required for the assessment includes results of peer review activities. For the purpose of OPPE, any physician privileged in MA currently practicing in the Navy may serve as a peer reviewer for another physician, and any dentist privileged in MA currently practicing in the Navy may serve as a peer reviewer for another dentist.

f. See reference (1) for more specific medical acupuncture information.

7. Criteria for Non-core Medical Acupuncture for Allied Health Practitioners (to include, but not limited to; Podiatrists, PAs, Chiropractors, NPs, PTs, and OTs, etc.). In addition to the criteria for non-core medical acupuncture for physicians and dentists listed in paragraphs 6a through 6f; per reference (1), the following criteria must be satisfied for allied health practitioners and chiropractors to perform MA as specified:

a. The non-physician privileged provider must successfully complete a MA training program accredited by the ABMA, or other equivalent training, in order to receive non-core privileges. Non-physician privileged providers can also apply for more limited non-core privileges in the MA subtypes of auricular acupuncture (first aide or battlefield acupuncture) or myofacial trigger point injections (without medication injection) (dry needling) by providing documentation of successful completion of training and certification courses, or inclusion of training in standard residency programs.

b. The chiropractor must successfully complete a chiropractor acupuncture training program that meets the requirements for the 300 hour diplomate examination by the American Board of Chiropractic Acupuncture (ABCA), or other equivalent training such as National Certification

Commission for Acupuncture and Oriental Medicine (NCCAOM) certification, in order to receive non-core privileges. Chiropractors can also apply for more limited non-core privileges in auricular acupuncture (first aide or battlefield acupuncture) or myofacial trigger point injections (without medication injection) (dry needling) by providing documentation of successful completion of training and certification.

c. A non-physician privileged provider or chiropractor may start performing acupuncture earlier during their medical or chiropractic acupuncture (or equivalent) training program under a POS if the training program director, privileged in medical or Chiropractic Acupuncture (CA) (as applicable), provides written interim performance assessments. Upon completion of the training program, the non-physician/dentist privileged provider or chiropractor may request non-core privileges; training certification demonstrates current knowledge and procedural competency. A FPPE may be done as well. Renewal of the MA non-core privilege will be based on completion of the PAR with an endorsement from a practicing medical acupuncturist (physician, dentist, or nonphysician/dentist privileged provider). Renewal of the CA non-core privilege will be based on completion of the PAR with an endorsement from a privileged medical or chiropractic acupuncture provider (as applicable). For those non-physician/dentist privileged provider or chiropractors whose MA or CA non-core privileges have lapsed, privileges may not be granted; the non-physician/dentist privileged provider or chiropractor must go under a POS. When there is no supervising provider available at the applicable MTF, privileges should not be granted until arrangements for a period of direct supervision, under a POS can be arranged.

d. Ongoing assessment of practitioner performance is a requirement in continued granting of privileges. Practitioner-specific data required for the assessment includes results of peer review activities. For the purpose of peer review for non-physician privileged providers, any privileged medical acupuncture provider currently practicing in the Navy may serve as a peer reviewer. For a chiropractor, any chiropractic acupuncture provider currently privileged and practicing in the Navy may serve as a peer reviewer.

e. See reference (l) for more specific medical acupuncture information.

8. Credentialing Criteria for Licensed Acupuncturists. Per reference (l), the following criteria must be satisfied for this group of practitioners to perform acupuncture:

a. Licensed acupuncturists are not authorized to apply for privileges, however, they can apply for approval/certification to perform licensed acupuncture as “physician extenders” under a defined scope of practice, including physician’s orders and medical note cosigning.

b. The NCCAOM, available at: <http://www.nccaom.org/>, aims to "establish, assess, and promote recognized standards of competence and safety in acupuncture and Oriental medicine..." The NCCAOM recognizes three routes for eligibility to sit for the certification examination and for application for “Diplomate of Acupuncture” status:

(1) Formal education for graduates of training programs in the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) accredited programs in the United States: <http://www.acaom.org/find-a-school/> (3-4 years of academic training);

(2) Formal education for international applicants; and

(3) Apprenticeship for United States and international applicants. NCCAOM accredited Acupuncture and Oriental Medicine (AOM) training programs for licensed acupuncture require 2,625 hours which includes 600 hours of biomedicine and clinical judgment.

c. Licensed acupuncturists may apply for approval to perform licensed acupuncture as “physician extenders” (as above) by providing written documentation of successful completion of an NCCAOM accredited licensed acupuncture course as well as NCCAOM “Diplomate of Acupuncture” status. In addition to this training documentation requirement, applicants must provide documentation of a valid licensed acupuncture State license (a State Licensure Requirement table is available on the NCCAOM Web site at <http://www.nccaom.org/regulatory-affairs/statelicensure-map>); licensed acupuncturists are only authorized to perform acupuncture techniques that fall within the scope of practice of their State license.

d. The licensed acupuncturist must successfully complete requirements of the NCCAOM and submit documentation of NCCAOM “Diplomate of Acupuncture” status. In addition to this training documentation requirement, for approval to perform licensed acupuncture as ‘privileged provider extenders, applicants must provide documentation (board letter or Web site material) of valid State licensure.

e. Approval to perform LA as “physician extenders” under a defined scope of practice shall be granted to licensed acupuncturists encompassing those disorders associated with their practice and treatable by acupuncture as per Navy Medicine policy on approved indications as detailed in reference (1).

f. Ongoing assessment of practitioner performance is a requirement in continued granting of approval/certification to perform licensed acupuncture. Practitioner-specific data required for the assessment includes results of peer review activities. For the purpose of peer review for a licensed acupuncturist, any physician acupuncturist currently privileged and practicing in the Navy may serve as a peer reviewer. Additional peer review by a licensed acupuncturist currently privileged and practicing in the Navy is desirable.

g. See reference (1) for more specific acupuncture information.

**CREDENTIALING REQUIREMENTS FOR CLINICAL SUPPORT STAFF
REGISTERED NURSES (RN), LICENSED PROFESSIONAL NURSES (LPN),
LICENSED VOCATIONAL NURSES (LVN) AND
REGISTERED DENTAL HYGIENISTS (RDH)**

1. Assignments of all clinical support staff RNs, LPNs, LVNs, and RDHs to patient care duties require the following:

- a. Possession of an active, valid, unrestricted license from a U.S. State, territory, or district. Licensure must be primary source verified (PSV) upon arrival at a new command and at license expiration and renewal.
- b. Documented education and training requirements.
- c. Documented evidence of current clinical competence. Evaluation of current clinical competence will be based on the clinical support staff member successfully functioning within the scope of practice in for their clinical assignment within the past 2 years. Periods of inactivity (if the support staff member is not functioning within the scope of practice for that clinical area assigned) for greater than 2 years will require additional orientation and monitoring to appropriately evaluate clinical competency.
- d. Affirmed health status that permits the ability to provide safe health care.

2. Additional Credentialing Requirements for Clinical Support Staff RNs:

- a. Bachelor of Science in Nursing (BSN) or approved graduate-level Nursing degree is required for all Active Duty and Reserve Component RNs. For all other RNs, graduation from an accredited RN program is required. Note: As RN educational programs evolve, some colleges and universities are not granting degrees with traditional nursing degree titles (i.e., Bachelor of Arts in Nursing, etc.). Where these programs are so titled, or not completely intuitive to the command's nursing leadership, the BUMED Deputy NC Corps Chief's office will review and evaluate course content to determine qualifications.
- b. Foreign Trained RNs. Must have completed a nursing education program and possess active, valid unrestricted Registered Nursing current State licensure from one of the U.S. States, territories, or districts.
- c. Clinical Nurse Specialists (CNS). Completion of graduate level study leading to a Masters' degree in a nursing field.

3. LVNs/LPNs. Must have completed an accredited nursing educational program and possess an active, valid, and unrestricted LVN/LPN licensure from a U.S. State, territory, or district.

4. Additional Credentialing Requirements for RDHs. Completion of National Board Dental Hygiene Examination (NBDHE) and State licensure. At all times when RDHs are performing clinical services, a supervising dentist is to be present in the facility to supervise, authorize, and evaluate the hygiene services performed based on the dentist's diagnosis and treatment orders. In rare circumstances at overseas commands, foreign trained RDHs who have not completed the NBDHE can be credentialed on a case by case basis based on demonstrated evidence of current competency.

5. All Clinical Support Staff providers must undergo credentials review prior to initial hire/accession and upon PCS transfer before authorization will be granted to participate in patient care activities. Credentials review will be ongoing thereafter at intervals not to exceed 24 months. Authorization to practice nursing or dental hygiene will be granted by a designee appointed by the Privileging Authority (i.e., Director for Nursing Services, Director for Dental Services, etc.). Any adverse actions must be taken by the Privileging Authority and will adhere to requirements set forth in reference (a).

ELECTRONIC CREDENTIALS RECORDS

1. General. Upon accession into or employment by the DON, each health care practitioner, including military trainees, will have credentials information collected, verified, and incorporated into a CCQAS electronic credentials records (CR). The CR is maintained throughout the practitioner's tenure with the DON. Compliance with this instruction results in a single, complete, verified electronic CR for each practitioner. All hardcopy documentation associated with electronic CRs, and historical hardcopy 6-part credentials files must be maintained in a secured area by the medical command the provider is assigned.

2. Collection and Verification of Credentials

a. The following items will be collected and evaluated before an individual is selected, employed, contracted, or granted a medical staff appointment by a Privileging Authority of a DON command:

(1) All relevant education/qualifying degree. ECFMG, Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS), or Fifth Pathway certificates for those graduates of foreign medical schools, other than approved schools in Canada and Puerto Rico, constitutes evidence of the qualifying degree.

(2) All relevant postgraduate training.

(3) All professional qualifying certifications (i.e., BMS, AOA, American Nurses Credentialing Center (ANCC), NCCPA, National Board for Certification in Occupational Therapy (NBCOT), etc.).

(4) All licenses and certifications held since qualifying degree including all voluntary/involuntary lapses of license(s) and expired/inactive licenses. A current, valid, unrestricted license or certification is one which is:

(a) Not expired, suspended or revoked.

(b) Is not subject to restriction pertaining to that scope, location, and type of practice ordinarily granted all other applicants for similar licensure or certification in the granting jurisdiction.

(5) Information on the practitioner's ability to perform (health status).

(6) NPDB query (Required for Licensed Independent Practitioners only). NPDB must be obtained at intervals not to exceed 2 years, and at the time of any privileging actions (i.e., renewal or revision of clinical privileges). Although not required for non-licensed independent practitioners, NPDB reports can be obtained at the discretion of the medical command.

(7) Current clinical competency documentation. Associated PARs/CARs or other clinical competency documentation will be kept in perpetuity. CRs must contain either:

(a) PAR/CAR (or equivalent evaluation of clinical performance from another DoD Service, or multi-Service market joint facility); or

(b) Two favorable recommendations from peers. Note: The definition of a peer is a practitioner from the same discipline with essentially equal qualifications. To be able to provide a reference the peer would need to be familiar with the individual's actual performance. For the nurse practitioner, physician assistant, psychologist, or social worker, ideally this should be another practitioner from the same discipline. However, in situations where there is no nurse practitioner, physician's assistant, psychologist, or social worker who could provide a peer reference, it is acceptable for a physician with essentially equal qualifications, which is familiar with the practitioner's performance, to provide the reference. For example: An internist could provide a reference for a physician assistant; an anesthesiologist could provide a reference for a nurse anesthetist; a psychiatrist could provide a reference for a psychologist; and a psychologist with similar responsibilities could provide a reference for a social worker.

(8) Department of Health and Human Services (HHS)/Office of the Inspector General (OIG) List of Excluded Individuals/Entities (LEIE). Documentation of query from the HHS/OIG to ensure the provider is not on the LEIE. Persons on the HHS/OIG LEIE are ineligible for employment in the Federal government.

(9) Professional Affiliation/Privileging History. Chronological practice experience and an accounting of all unexplained gaps in active practice or gaps in privileges back 10 years or to the date of qualifying degree. Professional affiliation/privileging history for any practitioner (military, civilian, contractor or volunteer) new to the Navy organization will be verified back to the date the practitioner conferred their qualifying degree. For practitioners who have previously been privileged in the Navy, and professional affiliation/privileging history was not previously verified, a reasonable attempt shall be made to obtain such professional affiliation/privileging history. Note: If a previous affiliation or privileges cannot be verified, a memorandum documenting the attempts to verify such affiliation and/or privileges is sufficient.

(10) Adverse Actions (if applicable). To include the following, but not limited to:

(a) Documentation of any, military or civilian, adverse privileging actions, reportable misconduct, and/or disciplinary actions by professional regulatory agencies.

(b) Documentation of all medical/nursing malpractice claims, settlements, or judicial or administrative adjudications with a brief description of the facts of each case.

(11) A current (within the last 10 years) photograph of the provider will be included and updated in the PROVIDER PHOTO section as necessary to enable positive, visual identification

of the practitioner and documented verification of providers' identification as they report to the command by viewing a current picture hospital ID card, or a valid picture ID issued by a State or federal agency such as a driver's license or passport.

(12) National Provider Identifier (NPI) is required in the PROFILE section for all licensed independent practitioners.

(13) Applicable life support training with expiration dates. At a minimum, current Basic Life Support (BLS) certification is required for all providers. BLS training and certification must adhere to guidelines developed by the American Heart Association (AHA).

(14) Drug Enforcement Agency Certification for all providers eligible to obtain a DEA certificate.

b. The items listed above, to include any pertinent or updated information, summaries of JAGMAN investigations or liability claims in which the individual was a principle party, and PARs, must be maintained in the CR. Summaries of information of an adverse nature, that occurred during DON service, which become available after the practitioner leaves DON service, must be included and maintained in the practitioner's CR.

c. At time of appointment to the medical staff and granting of privileges, renewal or revision of clinical privileges, and at the time of expiration, reappointment to the medical staff or upon the granting or renewal of privileges, the following must be PSV:

- (1) Licensure/certification.
- (2) Current competency.
- (3) Board/national certification (if applicable).
- (4) New training (if applicable).
- (5) NPDB queries must be obtained.

Note: PSV of all time-limited credentials (i.e., licensure/certification) and NPDB will be obtained within 90 days of privileging action.

d. The PSV of credentials that will never change or, "static credentials" (i.e., relevant education and training), is required only once for those credentials. Static credentials do not require re-verification by gaining Privileging Authorities unless a change in the status of the credential has occurred since the last verification or some reason exists to doubt the authenticity of the credential. PSV of credentials is required to be recorded in CCQAS.

e. If possible, the verification should come directly from the primary source. When it is not possible to obtain verification from the primary source, designated equivalent sources may be used to verify certain credentials. Acceptable sources and methods of verification include:

(1) Contact with the primary source or with an agency that has obtained verification, (i.e., AMA master file for education and training). Verification obtained by parties external to the DON that meets the DON verification standards as described is acceptable. Telephonic and/or Joint Commission approved internet/web-based verifications are acceptable.

(2) When unable to verify education and training, or qualifying degrees due to school closures or other unforeseen event, the following should be documented:

- (a) Date of verification attempts made;
- (b) Persons contacted (title and telephone number/e-mail address); and
- (c) Reason verification cannot be completed.

Note: At this point the record is considered complete and can be forwarded for credentials review.

f. In the rare occasion that a credential cannot be verified, appropriate credentialing/privileging actions can be made without the required verification. This decision will be supported by a preponderance of evidence when all other credentialing/privileging requirements have been met. The credentialing/privileging decision and justification, including all relevant documentation will be placed in the practitioner's CR and recorded in CCQAS.

g. All credentialing discrepancies require resolution through direct contact with the primary source.

h. Acceptable verification is recorded in CCQAS and clearly identifies the:

(1) Agency, name, title/position, and contact information of the person supplying confirmation of authenticity.

(2) Agency, name, and title/position and contact information of the person documenting the verification.

(3) Date of verification, facility, and MSP's signature.

i. Responsibility for collection and verification of credentials is as follows:

(1) Direct accessions, recalls to active duty, and inter-service transfers to the DON. CCPD, BUMED is responsible to create Credentials Portfolios for all Direct Accession and

Direct Commission Officers. CCPD, BUMED ensures the accession Credentials Portfolio is complete before submission to Navy Recruiting Command for professional review board consideration.

(2) Students reporting from Armed Forces Health Professions Scholarship Program (AFHPSP) and Uniformed Services University of the Health Sciences (USUHS) programs. The gaining Privileging Authority is responsible to create the CR.

(3) New civil service employees. The gaining Privileging Authority is responsible to create the CR, and must coordinate with the servicing Human Resources Office (HRO). The HRO forwards pertinent information to the appropriate Privileging Authority and the command's MSP creates the applicants CR, before hiring the individual.

(4) New contract practitioners. If the practitioner is contracted directly by the medical command, the Privileging Authority is responsible to create the CR. If the contract involves an intermediate contracting agency, that agency is responsible to create the CR and forward the information to the gaining Privileging Authority at least 30 days before the practitioner begins work under the contract. Upon receipt of the CR, the Privileging Authority is responsible for the contents of the hardcopy and electronic CR.

3. CCQAS Electronic CR. The CCQAS electronic CR encompasses all the required documentation for the purposes of credentials review and privileging.

4. Maintenance of CRs

a. Practitioners have a right to obtain, review and comment upon copies of all material in their CR, unless such documentation was requested by the source not to be disclosed to the provider.

b. The NPDB queries may not be copied per the Health Care Quality Improvement Act of 1986.

c. Before material of an adverse nature (i.e., fact or opinion which reflects negatively on personal conduct, clinical competence or performance) is placed in a CR, the practitioner shall be provided a copy and given an opportunity to provide comments. Statements by a practitioner in reply to the adverse material must also be included in the practitioner's CR when the provider makes a statement.

d. Practitioner requests for removal of material from the CR may only be accomplished per reference (g).

5. CR Disposition

a. MSPs shall ensure all hardcopy documentation associated with the corresponding electronic CR is uploaded when forwarding CRs to a gaining command or the archives.

b. For providers transferring within the DoD, the CR is forwarded to the gaining command. If the PAR/CAR is not completed prior to the transfer of the CR, the CR should be sent 30 days prior to the provider's detach date to expedite the transfer of the CR. Then the PAR/CAR must be uploaded into the provider's electronic CR (DOCUMENTS section) after the electronic transfer. The CRs of providers transferring to non-clinical assignments or to clinical full-time Out-Service Training (OST) will be forwarded to the CCPD, BUMED (use UIC N00018), by the detaching command. A memorandum from the detaching command should be forwarded to the practitioner informing them of their CR location.

c. For practitioners ordered to full-time in-service graduate education, the CR will be forwarded to the gaining training facility.

d. For Active Duty, Reserve Component, civilian, contract or volunteer licensed independent practitioners who have separated or terminated DON employment:

(1) If no permanent adverse privileging action or reportable misconduct exists, the CR record will be forwarded to CCPD Archives, BUMED (use UIC N00018A) and will be retained in an archived status for 10 years. In no case will a hard copy CR record be destroyed without first entering all applicable information into the CCQAS electronic record.

(2) If permanent adverse privileging action or reportable misconduct exists, the CR, with all corresponding hardcopy documentation, will be forwarded to the BUMED Staff Judge Advocate for the Surgeon General (use UIC N00018L), for indefinite retention.

e. For Active Duty, Reserve Component, civilian, contract or volunteer non-licensed independent practitioners who have separated or terminated DON employment, the CCQAS Electronic CR is deactivated at the last command the practitioner was employed. The hardcopy historical credentials file (if one exists) will be retained at the last command the practitioner was employed in an archived status for 10 years.

PERMISSIBLE LICENSURE WAIVERS

1. Per reference (a), the DoD requires all providers to have an unrestricted license to practice. However, some States have permitted military providers to be licensed in special licensure categories that waive certain requirements (such as continuing education) and include restrictions on the scope of practice (such as limiting practice to federal facilities). Providers are not permitted a waiver of any requirements pertaining to clinical competency. Any provider license in a licensure category that restricts the provider to practice in a federal facility, or within some other confined limitations, or waives continuing education requirements, does not comply with the requirement for an "unrestricted license." Providers are required to hold an unrestricted license that is not subject to limitation on the scope of practice ordinarily granted, unless a waiver is granted based on "unusual circumstances." If a provider has two or more State licenses, one with restrictions that would be removed through the payment of the standard license fee and others in States for which waivers are authorized, the physician must obtain an unrestricted license in the first State by paying the standard license renewal fee.
2. Any provider identified as having a restricted license must be placed under a POS within 72 hours of identification. Providers who hold a license from a State approved by the DoD for a waiver, who do not have an approved waiver, must obtain a waiver within 72 hours of identification, or be placed under a POS within 72 hours of identification, until the waiver is approved.
3. CCPD, BUMED, manages the Navy licensure waivers process, and is the Chief, BUMED delegated approval authority for this process. As such, all provider licensure waiver requests shall be submitted in writing from the provider to CCPD, BUMED, via their Privileging Authority, for review and consideration. A sample Provider Licensure Waiver Request letter can be provided by the provider's Privileging Authority/Medical Staff Office or CCPD, BUMED.

SUMMARY OF CHANGES

Both The Joint Commission (TJC) Hospital Accreditation Standards and the Department of Defense (DoD) 6025.13, The Medical Quality Assurance (MQA), and Clinical Quality Management in the Military Health System (MHS), have published significant changes since BUMEDINST 6320.66E was issued in August 2006. This revision of the BUMEDINST 6320.66 is a complete revision which incorporates the aforementioned TJC and MHS policy changes to ensure Navy Medicine's compliance with current accreditation standards, and DoD directives. This revision also incorporates Change Transmittals 1 through 5 of the BUMEDINST 6320.66E, as well as other pertinent policy memos.

This is a complete revision and rewrite of the instruction. The amended and updated instruction is submitted with the following changes:

- ❑ MASTER PRIVILEGE LISTS (MPL) – See enclosure (2), page 2, paragraph 4g and enclosure (2), page 10, paragraph 14a: Change Transmittal 4 of the BUMEDINST 6320.66 removed all privilege lists from the instruction. This revision provides additional details and guidelines for utilizing, maintaining, and revising the MPLs.
- ❑ FPPE/OPPE – See enclosure (3), page 9, paragraph 9 through page 13, paragraph 11): TJC created Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) hospital accreditation standards in 2008. This revision cancels BUMED memorandum of 27 January 2009, FPPE and OPPE, and provides additional details and guidelines which adhere to industry standards for the same.
- ❑ CREDENTIALING REQUIREMENTS FOR LICENSED INDEPENDENT PRACTITIONERS – See enclosure (4): All credentialing requirements were reviewed and updated, as needed, by each applicable Clinical Provider Specialty Leader (i.e., clinical psychologist, obstetrician and gynecologist, oral and maxillofacial surgery, family nurse practitioner, occupational therapist, physical therapist, etc.).
- ❑ ACUPUNCTURE – See enclosure 4, page 12-15, paragraphs 6-8: This revision incorporates additional guidance for credentialing criteria and privileging standards for granting Medical Acupuncture privileges to independent practitioners and credentialing standards for Licensed Acupuncturists per BUMEDINST 6320.100 of 11 March 2013.
- ❑ CLINICAL SUPPORT STAFF CREDENTIALING – See enclosure (5), pages 58-59: This revision provides additional credentialing guidelines for Clinical Support Staff to include: RNs, LVNs, LPNs, and RDHs.
- ❑ CCQAS ELECTRONIC CREDENTIALS RECORD (CR) – See enclosure (6), pages 60-65: This revision establishes the CCQAS Electronic CR as the sole repository for provider credentialing data.

- ❑ PERMISSABLE WAIVERS – See enclosure (7), page 66: The revision mirrors updated licensing standards and regulations for permissible waivers per the DoD Manual 6025.13.
- ❑ PRIVILEGING AUTHORITY DESIGNATION – See enclosure 10: This revision includes a new Privileging Authority Designation chart for ease of identifying each Privileging Authority within Navy Medicine.

ACRONYMS

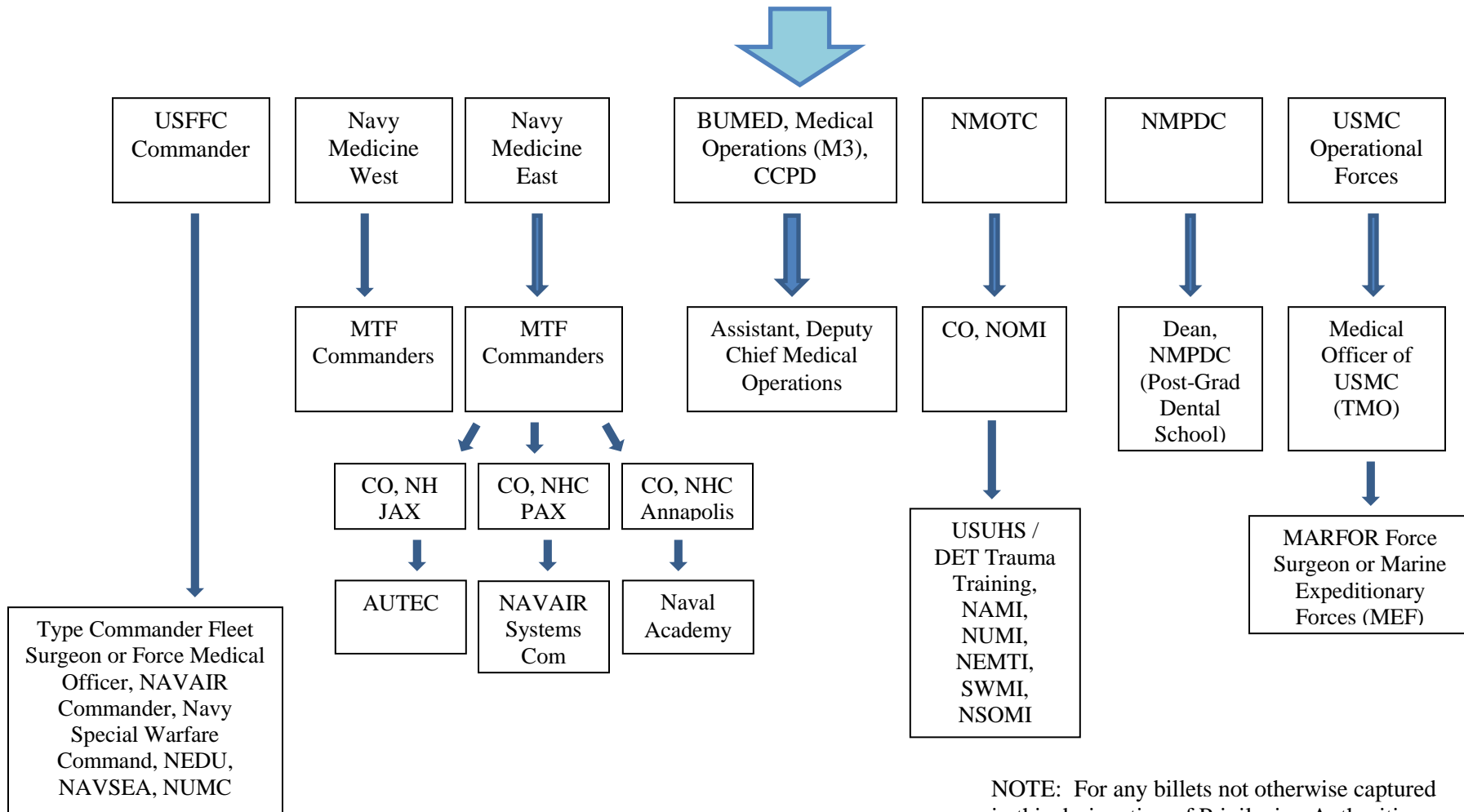
AADE	American Association of Diabetes Educators
AAMFT	American Association of Marriage and Family Therapy
ABCA	American Board of Chiropractic Acupuncture
ABMA	American Board of Medical Acupuncture
ABPP	American Board of Professional Psychology
ACAOM	Accreditation Commission for Acupuncture and Oriental Medicine
ACEND	Accreditation Council for Education in Nutrition and Dietetics
ACGME	Accreditation Council for Graduate Medical Education
ACPE	Accreditation Council for Pharmacy Education
ADA	American Dental Association
AFHPSP	Armed Forces Health Professions Scholarship Program
AFME	Armed Forces Medical Examiner
AHA	American Heart Association
AMA	American Medical Association
ANCC	American Nurses Credentialing Center
AND	Academy of Nutrition and Dietetics
AOA	American Osteopathic Association
AOM	Acupuncture and Oriental Medicine
AOR	Area of Responsibility
APA	American Psychological Association
APMA	American Podiatric Medical Association
APRN	Advanced Practice Registered Nurses
APTA	American Physical Therapy Association
ARC-PA	Accreditation Review Commission on Education for the Physician Assistant
ASD(HA)	Assistant Secretary of Defense for Health Affairs
ASHA	American Speech-Language-Hearing Association
ASHP	American Society of Health-System Pharmacists
ASPEN	American Society of Enteral and Parenteral Nutrition
AU.D	Doctor of Audiology
AUTEC	Atlantic Undersea Test and Evaluation Center
BC-ADM	Board Certified-Advanced Diabetes Management
BLS	Basic Life Support
BMS	Bachelor of Medical Science
BSN	Bachelor of Science in Nursing
BUMED	Bureau of Medicine and Surgery
CA	Chiropractic Acupuncture
CAPTE	Commission on Accreditation in Physical Therapy Education
CAR	Clinical Appraisal Report
CCC	Certificate of Clinical Competence
CCE	Counsel on Chiropractic Education
CCPD	Centralized Credentials and Privileging Directorate
CCQAS	Centralized Credentials and Quality Assurance System

CDR	Commission on Dietetic Registration
CE	Continuing Education
CEU	Continuing Education Unit
CMC	Commandant of the Marine Corps
CME	Continuing Medical Education
CNM	Certified Nurse Midwife
CNO	Chief of Naval Operations
CNS	Clinical Nurse Specialists
CNSP	Certified Nutrition Support Clinician
CO	Commanding Officer
COAMFTE	Commission on Accreditation for Marriage and Family Therapy Education
COMNAVAIR	Commander, Naval Air Systems Command
CPME	Council on Podiatric Medical Education
CQMP	Clinical Quality Management Program
CR	Credentials Records
CRC	Credentials Review Committee
CSWE	Council on Social Work Education
DO	Doctor of Osteopathy
DON	Department of the Navy
E-App	Electronic Application
ECFMG	Educational Commission for Foreign Medical Graduates
ECOMS	Executive Committee of the Medical Staff
EOC	End of Training
FAC (U)	Functional Area Code
FMGEMS	Foreign Medical Graduate Examination in the Medical Sciences
FNLH	Foreign National Local Hire
FNP	Family Nurse Practitioner
FPGEC	Foreign Pharmacy Graduate Examination Committee
FPPE	Focused Professional Practice Evaluation
GMO	General Medical Officer
HBB	Hepatitis B Virus
HCV	Hepatitis C Virus
HHS	Health and Human Services
HIV	Human Immunodeficiency Virus
HRO	Human Resources Office
IA	Individual Augmentee
ICTB	Interfacility Credentials Transfer Brief
ID	Identification
JAGMAN	Judge Advocate General Manual
LEIE	List of Excluded Individuals/Entities
LPN	Licensed Professional Nurses
LVN	Licensed Vocational Nurses
MA	Medical Acupuncture
MARFOR	Marine Forces

MEC	Medical Executive Committee
MEF	Marine Expeditionary Force
MHS	Military Health System
MPL	Master Privilege Lists
MSP	Medical Services Professional
MSSO	Medical Staff Services Office
MSW	Master's Degree in Social Work
MTF	Medical Treatment Facility
MTM	Medication Therapy Management
NAMI	Naval Aerospace Medical Institute
NAVSEA	Naval Sea Systems Command
NBCOT	National Board for Certification in Occupational Therapy
NBDHE	National Board Dental Hygiene Examination
NBNSC	National Board for Nutrition Support Certification
NCCAOM	National Certification Commission for Acupuncture and Oriental Medicine
NCCPA	National Commission for Certification of Physician Assistants
NEDU	Naval Experimental Dive Unit
NEMTI	Naval Expeditionary Medical Training Institute
NEPMUs	Navy Environmental and Preventive Medicine Units
NGO	Non-Governmental Organization
NME	Navy Medicine East
NMOTC	Navy Medicine Operational Training Center
NMPDC	Navy Medicine Professional Development Center
NMW	Navy Medicine West
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NSOMI	Naval Special Operations Medical Institute
NTTC	Naval Trauma Training Center
NUMI	Naval Undersea Medicine Institute
NUWC	Naval Undersea Warfare Command
OIG	Office of the Inspector General
OPPE	Ongoing Professional Practice Evaluation
OM	Osteopathic Medicine
OMM	Osteopathic Manipulative Medicine
OMT	Osteopathic Manipulative Treatment or Therapy
OT	Occupational Therapy
P&T	Pharmacy and Therapeutics
PA	Physician Assistant
PAR	Performance Appraisal Report
PCS	Permanent Change of Station
PHA	Physical Health Assessments
PMSR	Podiatric Medicine and Surgery Residency
PNP	Pediatric Nurse Practitioner
POS	Plan of Supervision

PPIS	Personal and Professional Information Sheet
PSV	Primary Source Verified
PT	Physical Therapist
RC	Region Commanders
RD	Registered Dietitian
RDH	Registered Dental Hygienists
RDN	Registered Dietitian Nutritionist
RN	Registered Nurses
RRA	Rearfoot Reconstruction and Ankle
RRC	Residency Review Committee
RUSI	Rehabilitative Ultrasound Imaging
SERE	Survival, Evasion, Resistance and Escape
SHEA	Society for Healthcare Epidemiology of America
SMDR	Senior Medical Department Representative
SWMI	Surface Warfare Medical Institute
TA	Therapeutics Agents
TDPT	Transitional Doctorate of Physical Therapy
TJC	The Joint Commission
TMO	The Medical Officer of the Marine Corps
UIC	Unit Identification Code
USFFC	U.S. Fleet Forces Command
USUHS	Uniformed Services University of the Health Sciences
VA	Veteran's Affairs
WHNP	Women's Health Nurse Practitioner

BUREAU OF MEDICINE AND SURGERY (BUMED)



NOTE: For any billets not otherwise captured in this designation of Privileging Authorities, consult CCPD, BUMED to determine the appropriate delegation of privileging authority.