BY ORDER OF THE COMMANDER

Central Command Regulation 40-1
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HEADQUARTERS UNITED STATES CENTRAL COMMAND
OFFICE OF THE CHIEF OF STAFF
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Medical Services
HEALTHCARE OPERATIONS

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SUMMARY OF REVISIONS

This revision updates changes to processes and links to revised Department of Defense Instructions and Defense Health Agency Program Instructions, the Command Trauma System, Potentially Concussive Event Reporting requirements, patient documentation, and provides clarity on Headquarters United States Central Command's Quality Assurance and Quality Management programs for medical, dental, and veterinary healthcare and services provided within the United States Central Command's area of responsibility.

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SECTION 1: GENERAL

1.1. PURPOSE

This regulation establishes policy for healthcare operations and the Combatant Command (CCMD) Trauma System (CTS) within United States Central Command's (USCENTCOM) area of responsibility (AOR). To ensure safe quality care is provided in all U.S. Military Treatment Facilities (MTF), this regulation outlines the Quality Assurance (QA), Quality Management (QM), and Performance Improvement (PI) programs pursuant to references listed in this regulation. The QA/QM program includes defining AOR medical capabilities, credential review and privileging, peer review, Risk Management (RM) systems, and Patient Safety. The DoD Patient Safety Program (PSP) promotes patient safety to eliminate preventable harm by engaging, educating, and equipping healthcare personnel to incorporate evidence-based clinical practice guidelines across a continuum of care. Performance Improvement (PI) promotes the improvement of practice and systems through researching best practices, implementing clinical practice guidelines (CPG), and analyzing outcomes.

1.2. APPLICABILITY

This regulation applies to:

a. All USCENTCOM Service Component Commands (SCC), Combined Joint Task Forces (CJTF), and all other U.S. military forces operating pursuant to Title 10 within the AOR assigned or allocated to Commander, USCENTCOM by approved Global Force Management processes (e.g., Command Plan).

b. DoD civilian medical employees and DoD medical contractor or sub-contractor personnel deploying with U.S. forces (hereafter referred to as "DoD personnel") consistent with DoD and Service specific guidance.

c. Any non-DoD personnel who, under a bilateral/multilateral agreement, have been assigned and/or allocated to work in a U.S. commanded MTF (ashore or afloat).

d. DoD personnel assigned and/or allocated to work within a Department of State led healthcare facility.

1.3. REFERENCES

See Appendix I.

1.4. POLICY

HQ USCENTCOM supports DoD directives, instructions, and policies.

SECTION 2: RESPONSIBILITIES

2.1. HEADQUARTERS U.S. CENTRAL COMMAND CHIEF OF STAFF

Monitors healthcare operations and the effectiveness of HQ USCENTCOM's QA/QM programs within the AOR.

2.2. HEADQUARTERS U.S. CENTRAL COMMAND OPERATIONS DIRECTORATE

Coordinate reporting requirements for Concussion and Mild Traumatic Brain Injury (mTBI) with USCENTCOM Surgeon General (CCSG) pursuant to Reference (j).

2.3. HEADQUARTERS U.S. CENTRAL COMMAND, COMMAND SURGEON

a. Establishes the HQ USCENTCOM QA/QM program consistent with DoD directives, instructions, and policies.

b. Appoints the Chief, Clinical Operations (CLINOPS) who leads the development, implementation, and monitoring of clinical standards, systems, policies and procedures that are focused on patient care management (direct and indirect), clinical documentation, QA/QM, PI, evidence-based initiatives to enhance capabilities, and En Route Care (ERC) during patient movement evacuations. Works with Component CLINOPS, JTF CLINOPS, Trauma Medical Directors, and Trauma Program Managers to oversee compliance with joint QA/QM, and PI programs, and reporting requirements.

c. Appoints Trauma Medical Directors (TMD) who serve as trauma subject matter experts (SME) and advisors to component commanders and surgeon cells. Reviews clinical practices and preparedness of medical assets involved combat casualty care.

d. Appoints Trauma Program Managers (TPM) who serve as trauma system managers to ensure compliance with regulations, data management and QA/QM program participation of medical assets involved in combat casualty care.

e. Directs an infection prevention and control program for the AOR to identify, control, and prevent healthcare-associated infections during the provision of care in all medical, dental, and veterinary facilities.

f. Establishes and maintains an online CLINOPS portal for access to QA/QM and patient safety documents, clinical operating policy documents, and tools on the Non-classified Internet Protocol Router Network (NIPRNet) at: https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLINOPS.aspx.

g. Mandates the use of DoD Joint Patient Safety Reporting (JPSR) system for inclusion into MTFs within the AOR. Refer to: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Joint-Patient-Safety-Reporting.

h. Establishes RM programs to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support the operational environment's culture of safety.

i. Directs theater compliance with the DoD Trauma Registry (DoDTR) system. Endorses Tactical Combat Casualty Care (TCCC) guidelines for pre-hospital care, Reference (t), and the JTS Clinical Practice Guidelines (CPG) on NIPRNet at: https://jts.health.mil/index.cfm./PI_CPGs/cpgs; and mandates their implementation in MTFs within theater as evidence-based best practices established by the JTS.

j. Establishes theater entry medical training guidance for deploying healthcare units.

k. Supports the use of Virtual Health, Virtual Veterinary Services, and virtual staff assisted visits (SAV) in the AOR. Assists with coordination with Military Health System (MHS) Operational Virtual Health and the USCENTCOM AOR on a range of virtual medicine capabilities (e.g., consultation, behavioral health, and radiology) across the continuum of care and across the Services.

l. Provides recommendations to the Defense Health Agency regarding QA/QM program improvements for the operational environment.

m. Designates a Pharmacy and Therapeutics (P&T) committee to serve as the theater working group supporting the development, publication, and monitoring of medication use, pharmacy support policies, and directives, and a formulary for use by all medical activities within USCENTCOM's AOR.

(1) Appoints a senior clinician as the chairperson of the P&T committee for the development and oversight of all medication use in theater, from procurement and distribution through administration and monitoring.

(2) Approves the program for monitoring, inspection, and reporting of controlled substances pursuant to Federal regulations, DoD instructions, and Service specific policies by all operational healthcare units (medical, dental, and veterinary), both ashore and afloat.

n. Endorses compliance with HQ USCENTCOM General Order 1D (GO-1D) for prohibited activities related to photography and videotaping of human casualties, see Reference (s).

o. Establishes and maintains a medical waiver program consistent with DoD directives, instructions, and policies for force health protection.

p. Approves medical response plan for Sexual Assault Medical Forensic Exams (SAMFE) within the AOR pursuant to Department of Justice, and DoD instructions, policies, and guidelines.

q. Establishes HQ USCENTCOM Clinical Operating Protocols (CCOP), as required to supplement the JTS CPGs and TCCC guidelines, or to fill a void when guidance is absent.

r. Maintains authority to enforce or waive the requirements of this HQ USCENTCOM Regulation (CCR) for medical, dental, and veterinary services.

s. Establishes and maintains the USCENTCOM Joint Blood Program consistent with DoD directives, instructions, and policies.

t. Through the Chief, Clinical Operations, provide oversight on compliance with QA/QM and Patient Safety (PS) programs and reporting requirements. Monitor the use of JPSR system and PS trends.

u. Serve as office of primary responsibility to receive, review, and monitor USCENTCOM Service Component's reporting of Potentially Concussive Events (PCE).

2.4. HEADQUARTERS U.S. CENTRAL COMMAND SERVICE COMPONENT AND COMBINED JOINT TASK FORCES COMMANDERS

a. Implement appropriate screening procedures for concussion and mTBI, Reference (j), and submit a monthly tracking report on all PCE and all personnel (U.S. military and DoD civilians) exposed to actual or potentially concussive events, pursuant to Reference (j) on a monthly basis to joint trauma analysis and prevention of injury in combat via the designated reporting system. The report will include: the date of the PCE, the type of PCE triggering evaluation, the significant action number, a personal identifier, the Service Member's name, the unit name, unit identification code, and home duty station, the CCMD in which the event occurred, the Service Member's distance from the blast (when applicable), and the disposition following the medical evaluation. A component representative will review all submitted events. Potentially Concussive Events involve personnel who experience one of the following:

(1) Involvement in a vehicle blast event, collision, or rollover.

(2) Presence within 50 meters of a blast.

(3) Direct blow to the head or a witnessed loss of consciousness.

(4) Exposure to more than one blast event.

b. Implement TCCC guidelines, Reference (t), for all personnel.

c. Enforce USCENTCOM specific unit training guidance requirements.

d. Enforce the use of the DoD approved electronic health record systems.

2.5. HEADQUARTERS U.S. CENTRAL COMMAND STAFF JUDGE ADVOCATE

Provides legal counsel to CCSG office regarding the authorized release of documents and the exemption from release of medical QA records from HQ USCENTCOM pursuant to Reference (a), provided HQ USCENTCOM is the holder and the proper release authority of said records.

2.6. HEADQUARTERS U.S. CENTRAL COMMAND SERVICE COMPONENT AND COMBINED JOINT TASK FORCES COMMAND SURGEONS

a. Support and enforce clinical practice adherence with the TCCC guidelines, Reference (t), for all personnel.

b. Support and enforce clinical practice pursuant to practices described within JTS CPGs, Reference (x), as best practice for treatment facilities within the AOR.

c. Appoint, as needed, SMEs to serve as USCENTCOM Consultants within the AOR.

d. Collaborates with USCENTCOM Chief Nurse/Chief, CLINOPS to oversee compliance with QA/QM programs and reporting requirements. Implement the use of JPSR system and monitors for PS trends providing updates during USCENTCOM CLINOPS monthly QA/QM cross talks.

e. Leads an Infection Prevention and Control (IP&C) program for their AOR as outlined in USCENTCOM IP&C Clinical Operating Policy (CCOP 02).

f. Ensure one person at each MTF is appointed as Infection Control Officer (ICO) and ICOs assigned to Role 3 should attend the Infection Control in a Deployed Environment (6A-F22) Army Training Requirements and Resources System course. ICOs assigned to Role 2 should attend the course if class space allows.

g. Support the use of Virtual Health, Virtual Veterinary Services, and Virtual SAVs in the AOR. Assist with coordination with MHS Operational Virtual Health and the USCENTCOM AOR on a range of virtual medicine capabilities (e.g., consultation, behavioral health, radiology) across the continuum of care and across the Services.

h. Establish a credential review and privileging compliance program, where appropriate, with assigned medical, dental, and veterinary units pursuant to DoD instructions, Service specific-policies/procedures, and this CCR.

i. Establish where appropriate, Service specific/command compliance programs (e.g., command inspections/SAVs) of assigned medical, dental, and veterinary units under operational control by qualified personnel to verify compliance.

j. Follow/enforce Service review process for Standard of Care (SOC) determination related to medical, dental, and veterinary services under their operational control.

k. Establish peer review requirements for performance and competency assessment of all licensed, certified, and/or registered health care personnel both privileged and non-privileged. Medical, dental, and veterinary services will establish peer review processes that meet their Service specific regulations, instructions, and/or policies.

l. In conjunction with the Services, select an expert medical reviewer to perform potentially preventable death reviews, SOC determinations, and reporting through operational chain of commands for system opportunities for improvement.

m. Implement the DoD JPSR system into their operational healthcare units within the AOR at: https://www.health.mil/Military-Health- Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Joint-Patient-Safety- Reporting (NIPRNet).

(1) Ensure TMD and TPM are trained pursuant to the CTS program. TPMs should receive refresher and continuing education on PS activities as required.

(2) Ensure subordinate medical units integrate PS and PI activities identified in this CCR into all PI projects. Ensures program activities receive interdisciplinary support from the MTF staff and other support as necessary for an effective PS/PI program.

n. Ensure subordinate medical units have systems and/or hardware pursuant to Reference (o), policy for electronic documentation, when available, for medical, dental, and veterinary care.

o. Establish policy and guidance for all subordinate medical units to comply with clinical documentation and upload all records (including loose medical documentation) into Theater Medical Data Store (TMDS).

p. Assist with the development of CCOPs, as required to supplement the JTS CPGs and TCCC guidelines, or to fill a void when guidance is absent.

q. Develop RM programs to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support the operational environment's culture of safety.

r. When directed, perform a clinical review and evaluation of patient care outcomes from reported out-of-standard Medical Evacuation (MEDEVAC) missions that result in a decline in patient condition.

s. Identify respective members to the P&T committee, ensuring a broad mix of members that include clinical and medical logistics specialties from across the AOR.

t. Monitor compliance on the procurement, management, inspection, and reporting for all classes of controlled substances by their operational healthcare units pursuant to Federal regulations, DoD instructions, and Service specific policies.

u. Ensure compliance with GO-1D and monitor compliance regarding prohibited activities within USCENTCOM's AOR specifically clinical photography and videotaping within operational healthcare units.

v. Require at a minimum, Role 3 healthcare facilities and enduring fixed Role 2 (ashore and afloat) have appropriate capability to provide experienced and trained Sexual Assault Medical Forensic Exam providers and coordinate access to experienced and trained Sexual Assault Response Coordinator (SARC) and Sexual Assault Prevention and Response Victim Advocate services. Victims of sexual assault, regardless of reporting status, are medically evacuated for an exam as soon as possible within operational needs. See References (b), (e), and (f).

(1) Ensure personnel assigned to perform SAMFE requirements have completed mandatory pre-deployment training pursuant to USCENTCOM guidance, see Reference (r).

(2) Ensure treatment locations and mobile teams utilize the appropriate sexual assault examination kit for evidence collection, see Reference (s).

(3) Implement when necessary quality assurance and case reviews of sexual assault care provided by treatment facilities and mobile response teams.

(4) Establish coordination between SAMFEs and the SARC for continued support of sexual assault victim. SARCs are responsible for a "hand-off" between theater and the victim's home base.

w. Monitor immunization program compliance and to DoD directives, instructions, and Service specific guidelines and review annually pursuant to Reference (g). The Continuous Quality Immunization Improvement Process (CQIIP) is not an inspection. The CQIIP is a tool developed pursuant to DoD policy and recommendations from the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices. The CQIIP/Virtual CQIIP Customer Tool asks questions about each of the eight standards to help identify areas of improvement and provide an understanding of the current processes of an immunization program. This is a valuable resource to assist immunizations sites with providing the best practices available for immunizations delivery. The CQIIP tool can be found at: https://health.mil/Military-Health-Topics/Health-Readiness/Immunization-Healthcare/Continuous-Quality-Immunization-Improvement-Process.

x. Ensure appropriate personnel are trained on the inventory, storage, cold chain management, administration, and reporting processes for immunizations and vaccines. Refer to Reference (l) for training opportunities. Access to information and training for Vaccine Storage and Handling can be found at: https://health.mil/Military-Health-Topics/Health-Readiness/Immunization-Healthcare/Vaccine-Storage-and-Handling.

y. Direct all MTFs identified as Role 1, Role 2, and Role 3 to implement DoD instructions, and Service specific guidelines regarding the evaluation, treatment, documentation, and reporting for patients diagnosed with PCE, concussion, and/or mTBI.

z. Optimize use of virtual medicine programs (e.g., consultation, behavioral health, radiology, and virtual SAV) within the AOR.

aa. Manage at the component level a medical waiver process pursuant to DoD, HQ USCENTCOM and Service specific directives, instructions, and policies.

bb. Mandate the inclusion of CCOPs, JTS CPGs, and TCCC guidelines as best practice guidelines within their operational healthcare units to ensure standardized patient care services.

cc. Monitor trauma documentation compliance in both pre-hospital and in the MTFs pursuant to this CCR, TCCC guidelines, and JTS CPGs. Oversee transmission of medical records to the JTS for abstraction into the DoDTR either by direct transmission (Health Insurance Portability

and Accountability Act [HIPAA] secure) or by upload into TMDS in combination with a trauma log to allow identification of records uploaded.

SECTION 3: UNITED STATES CENTRAL COMMAND TRAUMA SYSTEM

3.1. OVERVIEW

a. The USCENTCOM CTS is established pursuant to Reference (i). The purpose of the CTS is to oversee a coordinated trauma system that can be rapidly scaled to accommodate combat operations, post-conflict operations, or other contingency operation requirements identified by the Combatant Commander (CCDR). The CTS is organized based on Reference (m) doctrine with Roles of Care designated through the medical support plan of any given operation. Adjustments to roles of care are done through the chain of command to USCENTCOM. It operates with the developmental guidance, operational support, and clinical oversight of the JTS in the JTS's capacity as Defense Center of Excellence for trauma care and trauma systems. The CTS will always maintain a framework of core functions throughout all phases of operations to facilitate the ability for rapid expansion and adaptation based on the CCDR's requirements.

b. The CTS is a scalable regional trauma system that meets the mission requirements identified by the CCMD in coordination with JTS, Defense Health Agency (DHA) to support stated DoD policy per Reference (i).

c. Key Aspects of the USCENTCOM CTS:

(1) The USCENTCOM CTS Command and Operation TMD and TPM, are appointed by the USCENTCOM Command Surgeon pursuant to USCENTCOM Clinical Operations.

(2) Command Trauma Medical Director (CTMD) – Serves as primary liaison between DHA/JTS, Command Surgeon, Components, and Theater TMD. Provides oversight over trauma care delivery in the USCENTCOM AOR in coordination with JTS and theater trauma medical directors. Shapes USCENTCOM policy and regulations for providing trauma care.

(3) Command Trauma Program Manager (CTPM) – Ensures reporting compliance with DoDTR. Ensure reporting compliance with the DoDTR and communication of data collections for best trauma practices between CTS and the JTS. To manage quality management, performance improvement, patient safety processes, and programs and ensure TMD and TPMs carry out similar operations. Shapes USCENTCOM policy and regulations for providing trauma care.

(4) Each operation in the AOR is expected to have an Operation TMD and TPM. Functions of both the TMD and TPM can be held by one person when component medical assets in the AOR are minimal.

(5) Operation Trauma Medical Director – Trauma subject matter expert for component and/or task force commanders. Provides on-site oversight over component and/or JTF medical assets. Reports to CTMD.

(6) Operation Trauma Program Manager – Manages quality programs and oversees data reporting for their operational area. Reports to CTPM.

(7) TMD Responsibilities:

(a) Consultant and subject matter expert on the provision of trauma care for component and joint task force commanders. Leads the multidisciplinary activities for the trauma program within their assigned operational area.

(b) Oversees detailed case review of index cases in order to identify opportunities for improvement.

(c) Leads trauma performance improvement and facilitates communication between all roles of care and trauma providers; works in conjunction with multidisciplinary team.

(d) Advocates for practice consistent with JTS CPGs, TCCC, and other authoritative sources of standards of care (i.e., Emergency War Surgery, Advanced Trauma Life Support [ATLS], Trauma Nursing Core Course [TNCC], etc.)

(e) Actively participates and promotes attendance to the JTS Combat Casualty Care and JTS PI Conferences.

(8) TPM:

(a) Ensures clinical trauma records are completed in a timely fashion and works with the Patient Administration Director element to ensure the records are sent to the JTS.

(b) Collaborates with TMD to provide detailed case reviews to communicate lessons learned and encourage best practices.

(c) Serves as the Patient Safety Lead for their assigned AOR and is an extension of the USCENTCOM Chief, CLINOPS for patient safety. Works in collaboration with the TMD. Actively engages with the TMD and the multidisciplinary team to improve trauma patient outcomes.

(d) Facilitates documentation of trauma care, leads PI and patient safety programs for the assigned operation. The TPM collaborates with the JTS PI team members.

d. Trauma Naming Convention

(1) All trauma patients entering into Role 2 and 3 facilities will be provided a trauma name/trauma designation per the Patient Administration (PAD) USCENTCOM naming convention.

(2) The trauma name once established will be used at all facilities to link records for future quality improvement and process improvement.

(3) North Atlantic Treaty Organization and U.S. personnel will use their real name, upon discovery, as the primary registration. Any pseudo names/trauma designations will be linked with the real name.

(4) Non-U.S. personnel will be identified by their trauma name throughout their time at USCENTCOM facilities.

e. Trauma System Patient Care and Movement

(1) Trauma casualties pursuant to the operation's medical rules of eligibility (MEDROE) will be brought to the closest appropriate role of care for initial triage and management.

(a) All roles of care will provide treatment appropriate to their skill level and consistent with published JTS CPGs and TCCC guidelines.

(b) For all trauma patients, Role 1 personnel must complete Reference (u), Role 1 must complete DA Form 4700, *Medical Record – Supplemental Medical Data*, OP5, Tactical Evacuation (TACEVAC) After Action Report (AAR) and Patient Care Record (PCR) is used to document care provided during movement to or between Roles of Care, and Role 2 personnel must complete Reference (v) or Mass Casualty (MASCAL) Austere Trauma Team Resuscitation Records and copies of these documents should be forwarded with the patient to the next role of care.

(c) Role 2 and greater facilities will register patients with a trauma designation in accordance with USCENTCOM trauma naming convention.

1. Trauma designation will be done with coordination with the local PAD.

2. The trauma designation will be carried throughout the continuum of care to facilitate review of medical records.

3. Records from earlier care will be collected and labeled with the appropriate trauma designation, then scanned/uploaded into TMDS.

4. After stabilization, patients will be dispositioned according to the applicable MEDROE and either held for definitive care, transferred to local facilities, or MEDEVAC to higher role of care.

(d) Fixed-wing aircraft patient movement between Role 2 and higher echelons of care, as well as movement out of theater is coordinated with TRANSCOM Patient Movement Requirements Center-East (TPMRC-E). Patient Movement Requests (PMR) will be submitted in U.S. Transportation Command (USTRANSCOM) Regulating and Command and Control Evacuation System (TRAC2ES) (www.trac2es.transport.mil) and any Urgent (within 12 hours to preserve life/limb/eyesight) or Priority (within 24 hours to preserve life/limb/eyesight) move requires a call to TPMRC-E. The phone number is Defense Switched Network (DSN) 314 480-8040 or commercial 011-49-6371-47.

(e) Fixed-wing aircraft patient movement between Role 2 and higher echelons of care, as well as movement out of theater is coordinated with TPMRC-East. PMRs will be submitted in TRAC2ES (www.trac2es.transport.mil) and any Urgent (within 12 hours to preserve life/limb/eyesight) or Priority (within 24 hours to preserve life/limb/eyesight) move requires a call to TPMRC-E. The phone number is DSN 314 480-8040 or commercial 011-49-6371-47.

f. Trauma System Data Management

(1) Weekly casualty logs containing the date, names and social security/pseudo-social security numbers of trauma patients are to be submitted to JTS for abstracting into the DoDTR to facilitate PI. The logs can be sent via e-mail or DoD Safe to: dha.jbsa.j-3.list.jts-trauma-log@mail.mil.

(a) Logs should include trauma cases occurring between Monday through Sunday and sent the following Monday.

(b) Include all initial trauma (battle and non-battle) visits including all nationalities and patient categories including those transferred, killed in action, dead on arrival, and died of wounds.

(2) A copy of medical records should be sent with patients through all movements.

(3) TMDS will serve as the final destination of documentation for physical records produced within the USCENTCOM AOR. Records will be abstracted into the DoDTR.

(4) At the last role of care prior to exit from USCENTCOM AOR, medical records should be loaded into the TMDS.

(5) TPMs will discuss record keeping issues with roles of care within their operational area as needed to ensure compliance and to ably advise TMDs and their component commands on issues.

(6) Medical common operating picture provides an accurate understanding of medical resources arrayed in the AOR.

(a) TMDs and TPMs are expected to be able to interface and review data to support roles of care.

(b) Phone numbers and e-mails of key points of contact must be updated regularly.

g. CTS Modification at Start of Military Operations

(1) Supplementation of USCENTCOM HQ and forward operating units may be required. Depending on the phase and nature of the operation, medical support will be requested from JTS/DHA to supplement data collection through Request for Forces process.

(2) Personnel requirements will be continuously assessed and reduced dependent on operational needs.

h. CTS Readiness Requirements

(1) Personnel should have training consistent with USCENTCOM Theater Entry Guidance.

(2) Theater medical assets are expected to have a plan for casualty management and walking blood bank (WBB) processes.

(a) Each medical unit (Role 1 through 3) in the AOR is expected to document and simulate their respective casualty management and WBB plans when arriving at any new location or with any significant transition of medical personnel.

(b) TMDs will ensure Role 2 and 3 medical units have plans, simulated, and be available to advise on plan creation.

(3) CTS training will be hosted and funded by DHA as part of pre-deployment activities.

i. Blood resuscitation and banking

(1) Resuscitation with blood products should be use should be consistent with JTS CPGs.

(2) Food and Drug Administration (FDA) approved products should be the primary source of blood products.

(3) Fresh Whole Blood (FWB) and WBB training will be sustained at all roles of care for implementation when FDA-approved products are not available.

(4) Blood transfusion documentation is transferred to PAD to be incorporated into the patient medical record.

(5) Blood product distribution is coordinate through the Joint Blood Program Officer DSN 318-436-8589, or voice over secure internet protocol 308-532-0034.

(6) All Transfusions should be documented in TMDS within 48 hours of transfusion.

j. Quality Improvement

(1) Improvement of clinical care for military trauma patients is a central goal of the CTS and is a primary purpose of the DoDTR.

(2) TMDs will discuss trauma all issues relevant to casualty care within the AOR at least monthly at USCENTCOM QA/QM meetings or more frequently as necessary to ably advise their respective commands.

(3) TMDs in coordination with the JTS DoDTR will have access to USCENTCOM DoDTR data to assess trends and outcome at theater roles of care.

(a) Quality improvement, process improvement, and clinical research will be done pursuant to Reference (p).

(b) TMDs will facilitate investigation by personnel within their operational area.

(4) All personnel involved in trauma care delivery are encouraged to participate in JTS trauma related meetings.

3.2. PATIENT CARE MANAGEMENT

The immediate goal is to prevent loss of life, limb, eyesight, and brain function; to treat for return to duty or to optimize outcomes (preserve functionality). Varying degrees of patient care services are conducted by medical assets within treatment facilities (ashore and afloat) at Role 1, Role 2, and Role 3 as well with medical assets performing ERC during patient evacuation/movement. A successful CLINOPS program integrates evidence-based guidelines established by the JTS and other authoritative sources to ensure the right interventions are performed by the right person, at the right time, in the right sequence, using the right equipment for the right reason. CLINOPS endorses the use of evidence-based standards that reduces clinical variance and enhances quality of patient care across the spectrum of healthcare.

3.3. HEADQUARTERS U.S. CENTRAL COMMAND CLINICAL OPERATING PROTOCOLS AND JOINT TRAUMA SYSTEM CLINICAL PRACTICE GUIDELINES

a. CCOPs are developed within the CLINOPS branch to provide theater specific guidance to medical assets on patient care systems, processes, and practices not necessarily covered by the JTS CPGs, and TCCC Guidelines, or found to be absent from current guidelines.

(1) CCOPs are processed through a clinical working group established by the Chief of Clinical Operations that includes JTS and SMEs to ensure there is an integration of medical scientific knowledge balanced with operational roles and limitations.

(2) CCOPs are considered dynamic documents and will be reviewed annually. They will be updated at a minimum of every 24 months to adapt to evolving operational requirements and for the timely integration of evidence-based clinical care.

(3) CCOPs are located on the CCSG NIPRNet SharePoint: https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLINOPS.aspx.

b. HQ USCENTCOM endorses and directs the use of JTS CPGs. These CPGs are evidence-based and created by a body of experts.

3.4. PATIENT MOVEMENT/EVACUATION

a. Perform effective and efficient movement/evacuation of both trauma and non-trauma patients from Point of Injury/Illness (POI)/Role 1 through Role 4 MTF while maintaining an appropriate level of ERC. ERC is defined as the continuation of care, during movement between health service support capabilities in the continuum of care, without clinically compromising the patient's condition.

b. Two mission types are performed in theater:

(1) Pre-hospital evacuation. Rapid evacuation from POI/initial care to an appropriate role of care by either non-medical platforms (referred to as Casualty Evacuation [CASEVAC]) or by medical platforms (referred to as MEDEVAC). Personnel will refer to the TCCC guidelines, Reference (t), for casualty management.

(2) Inter-facility transfer. Coordinated movement of patients (by air or ground) between treatment facilities. For clinical guidelines addressing patient preparation, ERC and post transport evaluation, personnel will refer to CCOPs and CPGs for movement between roles of care. USCENTCOM Patient Movement SharePoint site can be accessed at: https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-PTMVT.aspx. All inter-theater patient movement will follow USTRANSCOM policy.

3.5. VIRTUAL HEALTH SYSTEMS

a. MTF Commanders should work to optimize the use of virtual medicine programs in their footprint to serve as a force multiplier, particularly for high-value and low density specialties, and those that are resource intensive. These can include telehealth patient encounters, virtual provider consultation, and virtual SAVs.

b. Pursuant to Reference (k), all healthcare providers providing or participating in Virtual Health visits will complete the DHA Virtual Health Provider Training.

c. Several virtual platforms exist to support deployed providers and medical staff.

(1) Global Teleconsultation Platform (GTP) – This is a secure, web-based worldwide consultation program for providers. GTP allows remote providers to submit clinical questions, photos, pathology reports, and radiology images to over 90 specialists. This platform is for non-urgent consult requests and questions are typically answered within 24 hours. Providers visit https://help.nmcp.med.navy.mil to request a GTP account.

(2) Advanced Virtual Support for OpeRational Forces (ADVISOR) – This platform provides 24/7 on demand urgent/emergent consultation services to operational forces for contingency support. This is a synchronous platform that provides access to multiple specialty services and can be used for contingency support when skills are not available within the medical chain of command. To use ADVISOR, call Commercial 1-833-ADVSRLN (238-7756) or DSN (312) 429-9089. For more information visit ADVISOR (health.mil).

(3) Virtual Inspection and LINKUP in Theater (VITAL-T) – This platform is a worldwide program established to address geographic remotes of medical facilities and enable robust quality and safety, infection control, provider training, and similar programs. By leveraging Virtual Health technology to promptly link clinical sites virtually in real time with remote experts, this resource facilitates improved risk identification and mitigation in the remote healthcare environment.

(a) Medical treatment facilities within the USCENTCOM AOR will support this program as a means to improve patient care, and patient and staff safety. The form and requirements of the VITAL-T event is determined by the inspector and can vary from being a static meeting to instruction for staff with inspector viewing the facility in real time.

(b) Technology requirements for facilities are a mobile webcam connected to NIPRNet or internet. It is recommended to have an external webcam connected to a NIPRNet laptop/NIPRNet, with additional use of a rolling cart (e.g., workstation on wheels) to facilitate movement within the facility as needed.

d. Support Virtual Veterinary Service for advice and consultation for care of animals, primarily Military Working Dogs.

SECTION 4: QUALITY ASSURANCE

4.1. GENERAL

This section outlines essential components to a QA program for evaluating quality of care delivered to patients (medical/dental/veterinary) by healthcare teams in theater. QA programs stress the importance of assessment and evaluation of the care provided, identification of problems in the delivery of care, activities to overcome those difficulties, and the systematic monitoring to ensure effectiveness of corrective actions. HQ USCENTCOM's QA program includes defining theater medical capabilities, credential review, privileging for both U.S. and non-U.S. medical personnel, peer review, PI, and a RM system.

4.2. CONFIDENTIALITY OF QUALITY ASSURANCE DOCUMENTS

a. Reference (a) mandates that records created by or for the DoD in a medical QA program are confidential and privileged. Such records are not disclosed to any person or entity, except as provided by Subsection (c) of 1102.

b. Medical QA records may not be disclosed, used in testimony, or released to any person or entity without the written consent and/or authorization from the Staff Judge Advocate servicing the appropriate release authority or MTF Commander.

c. Pursuant to Reference (a), QA information is exempt from release pursuant to Exemption 3 of the Freedom of Information Act (FOIA).

d. Medical and dental QA documents are labeled: "This is a medical or dental QA document protected from release pursuant to 10 U.S.C. § 1102. DO NOT RELEASE without proper authority."

e. Documents that are not produced for the sole purpose of medical or dental QA are not labeled citing this statute.

4.3. SCOPE OF MEDICAL CAPABILITIES

a. Theater medical assets are organized based on Reference (m).

b. Medical assets can be presumed to have an increasing capability to deal with medical conditions and provide resuscitative capabilities as roles of care progress from 1 to 3 within any given operational area.

c. First Responder Capability

(1) Role 1 treatment provided by non-medical TCCC, medical personnel, treatment squads, or canine TCCC for working animals, emphasizes measures necessary (e.g., controlling hemorrhage, maintaining an airway, preventing shock, protecting wounds, immobilizing fractures and other measures as necessary) for the casualty to return to duty or to be stabilized for evacuation to an MTF.

(2) Scope of Care: Routine healthcare will follow TCCC guidelines, see Reference (t).

(3) Blood product availability: None. Limited availability may be possible based on a risk profile determination for units conducting combat operations far forward. If available, low titer group O whole blood may be given when clinically indicated. Contact the Joint Blood Program Office. See Reference (n).

d. Role 2 Forward Resuscitative/Surgical Care Capability, which includes ashore and afloat medical capabilities, provides advanced resuscitation and damage control surgery to further stabilize casualties who would not survive evacuation to the next role of care.

(1) Role 2 Light Maneuver is a light, highly mobile medical unit designed to support maneuver formations.

(2) Role 2 Enhanced provides basic secondary health care built around primary surgery, intensive care unit, and inpatient beds. A Role 2 Enhanced facility is able to stabilize post-surgical cases for evacuation to a Role 4 facility without the requirement to route to a higher Role 3 facility.

(3) Scope of Care: Will follow JTS CPGs, see Reference (x).

(4) Blood product availability: Low titer group O whole blood. The WBB will be utilized for immediate resupply until a scheduled shipment can be executed. Depending on mission requirements and equipment set, packed red blood cells, liquid plasma/fresh frozen plasma, and cryoprecipitate may be available upon request. See Reference (n).

e. Theater Hospitalization Capability

(1) Role 3 patients are treated in a medical or veterinary facility (for working animals), staffed and equipped to provide care to all categories of patients, to include resuscitation, initial wound surgery, and post-operative recovery. Patients who are unable to survive movement over long distances receive surgical care (with intensive care services) as close to the supported unit as the tactical situation allows.

(2) Scope of Care: Will follow JTS CPGs, Reference (x).

(3) Blood product availability: The full complement of blood products are available at the Role 3 level of care: Packed red blood cells, low titer group O whole blood, fresh frozen plasma/liquid plasma, cryoprecipitate, and platelets. See Reference (n).

f. ERC Capability provides continuation of care during movement/evacuation with medical personnel and equipment without clinically compromising the patient's condition.

(1) Blood product availability: Low titer group O whole blood and packed red blood cells, depending on mission requirements and equipment sets. Please see Paragraph 3.5d for CCOP-01: Urgent Resuscitation Using Blood Products during Tactical Evacuation from POI. Contact the Joint Blood Program Office.

g. Blood product availability and utilization, see Reference (aa).

(1) The current recommendation from the JTS CPG states that whole blood is the preferred product for pre-hospital resuscitation. In a facility capable of providing surgical care (Role 2 or higher), whole blood or component therapy can be used for damage control resuscitation, depending on whole blood availability. When whole blood availability is limited, sites should reserve whole blood for casualties with clinically significant shock or coagulopathy.

(2) Due to the limited availability of low titer group O whole blood, the Joint Blood Program Office must assess units with surgical capability to establish a risk profile based on type of unit, mission, and transfusion history in order to estimate the quantity of whole blood each unit will have on hand. Other factors affect the assessment such as amount of whole blood coming into theater, geographical location of each unit, and shipping timeframes.

(3) Sites with surgical capability should implement the WBB program. Guidelines for the WBB can be found in the Whole Blood Transfusion 15 May 2018 ID21 CPG guidance found at: https://jts.health.mil/index.cfm/PI_CPGs/cpgs. Sites should establish teams to operate the WBB program using personnel that aren't directly involved in patient care. The WBB program should be trained and tested frequently. Please note that a donor can only donate every 56 days. Sites should conduct prescreening events and maintain a donor roster with point of contact and blood type information. The prescreened donors will provide blood samples that will be sent to Lackland Air Force Base (AFB) for infectious disease testing every 90 days.

(4) Whole blood collected on site using the WBB program presents a higher risk of disease transmission since donors aren't tested for infectious diseases by a FDA licensed testing facility, therefore the products are not licensed/approved by the FDA. Use this product when approved FDA products are not available. Risk mitigation steps include:

(a) Transfuse only group-specific whole blood.

(b) Antibody-A and Antibody-B antibody titers can be measured in group O whole blood and only units containing a low titer of antibody are designated as low titer and can be used as universal whole blood.

(5) All sites must have a TMDS account and manage their blood product inventory daily in order to receive timely resupply shipments. TMDS can be found at: https://tmds.tmip.osd.mil/portal/. Contact the Joint Blood Program Office to create an account and reporting requirements, Reference (aa).

4.4. CREDENTIAL REVIEW AND PRIVILEGING

a. Credentials are those documents presented by the health care professional, regardless of the nature of his/her practice or duty position, that constitute evidence of current licensure, certification, registration, or other authorizing document, as appropriate. Professional credentials substantiate:

(1) Relevant education.

(2) Training and experience.

(3) Current competence and judgment.

b. Credentials document the ability to carry out the duties and responsibilities of the assigned position and to perform privileges requested.

c. Privileges granted to providers/practitioners are facility specific and based on resources as well as the procedures and types of services provided within a MTF.

d. U.S. military healthcare personnel will have their credentials reviewed, validated, and privileges granted pursuant to Service standards. All credentials must be validated to remain good (not expire) through deployment, see References (h) and (k). For non-U.S. providers and practitioners, Commanders will coordinate with Component Surgeon and CCSG/Clinical Operations to obtain credentialing and privileging through the Services, DHA, and Health Affairs.

e. Peer review programs will include non-U.S. military healthcare personnel assigned and/or allocated to work within a medical, dental, or veterinary facility, accounting for differences in scope of practice.

4.5. PATIENT DOCUMENTATION

a. USCENTCOM will enforce compliance with this objective and ensure that all care provided is included in the patient's longitudinal health record and support. Medical personnel will record all patient care from Role1 to Role 3 in the patient Armed Forces Longitudinal Technology Application-Theater (AHLTA-T)/Health Assessment Lite Operations (HALO)/ Theater Medical Information Program-Joint Composite Health Care System Cache (TC2), at the MTF on all patients cared for within the deployed healthcare system U.S. military, civilian, contract, coalition, and host national patients.

b. While deployed in support of contingency operations, the deployed EHR, will be the primary means for documenting care in the operational or contingency setting. When the EHR is unavailable medical care will be recorded on the paper version on approved forms until and EHR solution is developed.

c. Although the primary means to document medical care is through the EHR, paper-based Service Treatment Record (STR) are also important for the conservation and improvement of patient health and continuity of care. When the EHR is unavailable, a paper version of all approved forms includes but are not limited to:

(1) POI. Reference (u) is used at the POI on all casualties. Ensure document is completed and sent with the patient. If unable to send with patient, documents are sent to JTS at: usarmy.jbsa.medcom-aisr.lists.jts-prehospital@mail.mil.

(2) Role 1 through Role 3, Reference (v) is used for documenting patients' battle and non-battle injuries, medical treatment, and resuscitation care provided at DoD MTFs with surgical capability or an emergency department (ED). For trauma resuscitations in situations where

personnel are limited and an individual cannot be dedicated entirely to documentation, the MASCAL/Austere Trauma Team Resuscitation Record, 14 January 2019, is an abridged version of Reference (v) and may be substituted for Reference (v). Instructions can be found on the JTS website: https://jts.amedd.army.mil. All patients with significant injuries requiring hospital admission for trauma (to include transfer to a host nation hospital) and all trauma deaths with surgical team contact require a resuscitation record. Personnel will accurately complete form and upload (scan) to TMDS on NIPRNet at: https://tmds.tmip.osd.mil/portal.

(3) If unable to scan documents at the location where care was provided, such as Role 1 and Role 2 with limited information technology (IT) system resources and capabilities, coordinate and forward all paper-based documents to the respective Role 3. Role 3 will scan documents into the patient's EMR (electronic medical record) and TMDS documentation.

(4) All medical facilities and surgical teams will submit the identifying information of patients (Trauma Log) with a completed Reference (v) to the JTS. The trauma log is submitted weekly; listing all trauma patients with their identifying information (may utilize pseudo names as needed). The medical providers will complete Reference (v) for each trauma patient using the same name or pseudo name as the trauma log.

d. Management of Non-Electronic Patient Care Records

(1) Healthcare providers and professionals are responsible for documenting, treating, or caring for the patient(s) in the operational or contingency setting according to DoD instructions, JTS CPGs, HQ USCENTCOM CCOPs, and Service-specific policies. All entries must be legible, dated, timed, and signed by the individual making the entry.

(2) Patient care records, to include paper-based, late entry, and Carded-For- Record-Only from Role 1, Role 2, and Role 3 MTFs must be:

(a) Scanned and uploaded to TMDS.

(b) The medical professional will document care, and PAD or a representative will record, upload and transfer to a Role 3 to track and register the patient in the EHR HER (HALO/AHLTA-T/TC2) to be recorded in TMDS; or, the respective Role 3 will be accountable for all Role 2/Role 2E under the AOR to record, track and ship all Inpatient Treatment Record (ITR), Ambulatory Patient Visits (APV), and Carded for Record Only CRO records for processing to the following address:

Deployed Medical Records Processing Center (DMRPC
2273 Reynolds Rd, Bldg. 4025
JBSA, Fort Sam Houston, TX 78234-5053

e. PAD staff or representative maintaining custody of the patients will manage all detainee health records (inpatient and outpatient) according to DoD directives, instructions, and Service-specific policies.

4.6. CLINICAL IMAGERY

a. Except as authorized for official use and purposes discussed in subparagraphs, Reference (s) prohibits the taking, making, possession, reproduction, or transfer, (to include uploading) of photographs, videos, depictions, and audio-visual recordings of the following: human casualties (including detainees), defined as deceased, wounded, or injured human beings to include separated body parts, organs, and biological material, resulting from either combat or noncombat activities. Prohibition does not apply to the possession of photographic or video images acquired solely from open media sources (e.g., possessing print or online images from recognized magazines and newspapers).

b. Official use and purposes for taking photographs or videos include, but not limited to:

(1) Evidence collection within an MTF (e.g., sexual assault victims).

(2) Wounded personnel while in an MTF and during periods of recovery, only with the patient's expressed consent.

(3) Images intended solely for professional consultation, with medical providers, at other treatment facilities in the course of patient care.

4.7. MEDICAL RECORDS REVIEW

a. MTFs (Role 1 to Role 3) and pre-hospital personnel will perform medical records management on a representative sample of records that exemplify the full scope and practice of each discipline with an emphasis on high-volume, high-risk, and problem-prone diagnoses.

b. Role 1/Role 2 with limited IT system resources will coordinate and forward all paper-based medical documents created at their facility to the respective Role 3. Role 3 will scan the patient's EMR into the TMDS as attachments. The deployed EMR (AHLTA-T/HALO, TC2), if available, will be the primary means for documenting care in the operational or contingency setting. Paper-based documentation is the alternate documentation method and uploads documentation into a patient's EMR–either AHLTA-T or TMDS.

c. Documentation in the primary EMR, ITR, or APV will be clear and complete, and will accurately record the diagnosis, results of diagnostic tests, therapy rendered, condition and progress of the patient, and their condition at time of discharge/transfer.

(1) Reference (u), used for pre-hospital care. Pre-hospital records will be clear, complete and will accurately record POI by documenting in a Mechanism, Injury, Symptoms, and Treatment report. It can be accessed on NIPRNet at: https://deployedmedicine.com/market/171/content/858.

(2) DA Form 4700 is used to document care provided during movement to or between MTFs. This form can be accessed from the JTS website on NIPRNet at: https://www.jts.amedd.army.mil/assets/docs/forms/DA4700_OP5_JTS_TACEVAC-AAR&PCR.pdf.

d. All patient encounters will be closed within 48-72 hours of a patient's visit.

(1) All medical encounters shall be closed immediately when a patient is referred or dispositioned to another MTF. The electronic record will be transmitted into TMDS for the next provider to access for continuity of care.

(2) Complete pre-hospital documents upon transfer of the patient to an MTF, and within 24 hours of mission completion.

(3) Operational healthcare units will establish supervisory oversight and management of their open medical encounters, and pre-hospital documents.

(4) Any ITR or APV, or mental health records generated at all theaters and contingency operation locations will be collected and transferred to the Deployment Medical Records Processing Center, Fort Sam Houston, Texas, for scanning. These paper elements will be integrated with the member's DoD Health Record and STR located at their permanent duty station and Reserve and Guard units until the record is accessible in electronic medium.

e. Operational healthcare units will comply with DoD Instructions and Service specific guidance for handling loose medical documents within theater. Refer to Reference (c).

4.8. RISK MANAGEMENT

a. Commanders establish RM programs consistent with their Service's processes. MTF's will follow their Services reporting processes. RM focuses on the potential risk of death or disability to patients arising from possible substandard medical or dental care. The following tools and products capture RM activities:

(1) The event resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

(2) Suicide of any individual receiving care, treatment or services in a staffed around-the-clock care setting, or within 72 hours of discharge.

(3) Unintended retention of a foreign object in an individual after surgery or other procedure.

(4) Surgery on the wrong individual or wrong body part.

(5) Abduction of any individual receiving care, treatment, or services.

(6) Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient.

(7) Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the MTF.

(8) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

(9) Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.

(10) Unanticipated death of a full-term infant.

(11) Discharge of an infant to the wrong family.

(12) Any intrapartum (related to the birth process) maternal death. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

b. Quality Control review with SOC determination is performed to assess how care met or did not meet current standards. The final report is submitted to CCSG.

c. "Intentional Unsafe Act" refers to an adverse event or near miss that resulted from gross negligence or possible criminal activity. Investigation and consideration of corrective actions on intentional unsafe acts are within the purview of the DoD such as removal from care, legal consultation, administrative action, adverse action, license board or National Practice Disciplinary Board notification. Any recommendations for adverse privileging action or referral to licensing board must go through the provider's privileging authority.

4.9. PERFORMANCE IMPROVEMENT PROGRAM

a. PI program is the systematic process aimed at achieving HQ USCENTCOM's healthcare mission by improving effectiveness, empowering personnel, and streamlining the decision-making process.

b. Fundamental components of PI include staff education, measuring performance through data collection, assessing current performance and utilizing the data collected to improve HQ USCENTCOM processes, services, and overall performance.

c. PI projects support examining an internal process, program, or system with the intent to develop and implement an action plan specifically designed to eliminate an identified problem or improve inefficiency, see Appendix B for sample PI tool.

d. Dimensions of performance are definable, measurable, and improvable attributes of the operational healthcare unit's performance.

e. All PI projects in the AOR must be submitted to USCENTCOM Clinical Operations to ensure Institutional Review Board (IRB) review and approval. They are required to have a signed "Non-Research Determination" memorandum prior to initiation of the project. Please see Appendix C for instructions.

f. PI project results are utilized in certain educational or academic forums, such as lessons learned, practice guidelines, or AARs.

g. Submit all publications referencing USCENTCOM AOR and/or those done under the auspices of a USCENTCOM PI project to the USCENTCOM Chief, Clinical Operations per Reference (p) for review and approval to release.

SECTION 5: PATIENT SAFETY

5.1. COMMUNICATION AND TEAMWORK

a. Communication and teamwork failures continue to be the leading cause of adverse events within the healthcare system according to the DoD PS office.

b. CCSG recognizes that communication and teamwork are vital elements in the delivery of quality healthcare. Units deploying to HQ USCENTCOM's AOR will train on the DHA Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS). TeamSTEPPS is an evidence-based framework developed by the DoD Patient Safety Program for improving Patient Safety (PS) through better communication and teamwork skills much like Crew Resource Management for aviation.

c. TeamSTEPPS training tools can be accessed on NIPRNet at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/TeamSTEPPS.

d. The goal of TeamSTEPPS is to develop highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients.

e. DoD also embraces High Reliability Organization principles which they have adopted to Ready Reliable Care (RRC) principles and domains of safe care. RRC is focused on improving communications and has developed the Ready Reliable Care Safety Communication Bundle, a set of six standardized communication practices as outlined in DHA Procedural Instruction 6025.45, *Ready Reliable Care Safety Communication Bundle*. For more information use the following link: https://carepoint.health.mil/sites/RRCSCB/SitePages/RRCSCB%20Home.aspx.

5.2. PATIENT SAFETY PROGRAM

a. This chapter outlines functions of the DoD mandated Joint Patient Safety program which emphasizes reporting events that directly involve a patient (e.g., patient fall, unanticipated patient death, medication error, or a medical device failure that caused or might have caused an injury to a patient). With safety rooted in the daily operations of HQ USCENTCOM's healthcare operations, DoD promotes the system JPSR which is a standardized approach for home base as well as operational/expeditionary medical units to report patient safety events during deployed operations, analyze the data, develop and execute action plans.

b. All Reportable Events (RE) or adverse serious harm outcomes will be reported to the CCSG within 24 hours.

c. JPSR products are QA documents. JPSR event documents will be protected from disclosure pursuant to Reference (d) and must not be released without the written consent and/or authorization from MTF Staff Judge Advocate. There are penalties for disclosing the Patient Safety Reporting (PSR) or its contents to unauthorized persons.

d. Theater JPSR Core Principles.

(1) Leadership engagement to promote transparency and blame-free reporting in the AOR.

(2) Identify actual and potential problems (Unsafe Conditions) within healthcare systems and services established within theater, both ashore and afloat.

(3) Analyze incidents with a focus on systems and processes, not individuals.

(4) Implement effective AOR-wide actions to improve and standardize PS and healthcare quality across the continuum of care (e.g., Patient Safety Recognition Program, Patient Safety Manager Theater Cross Talk).

(5) Where appropriate, units across the continuum of care are able to incorporate the national patient safety goals into their PSPs, see Appendix F.

e. JPSR Capabilities for Theater.

(1) Provide standardized reporting for deployed medical, dental, and veterinary units across the theater to the same reporting system used at home station.

(2) Promote information sharing by automating the non-standardized paper-based systems previously used.

(3) Capture not only surgical mistakes, medication errors, and non-medication events occurring with our patients, but also Near-miss, No-Harm, and Unsafe Conditions.

(4) Maintain confidentiality through anonymous reporting.

f. Personnel in the AOR will use the DoD JPSR system, where available, to report a Patient Safety Event (PSE). Access the DoD site NIPRNet at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Joint-Patient-Safety-Reporting and follow instructions for submission of a PSE. These submissions may be made anonymously or include the user's contact information.

g. If unable to access JPSR system, unit personnel will follow their Service specific guidelines for submission of PSE's during deployment and provide copies to the appropriate Service component and/or CJTF Command Surgeon's office. Any healthcare team member may submit a PSR.

h. Personnel identified/assigned as a PSM or PS Reviewer/Handler must complete an Account Authorization Request Form (AARF) for theater access to HQ USCENTCOM's hierarchy. PSMs will complete Section 1 only and forward the AARF to their Chief, CLINOPs. The PSM will participate in the HQ USCENTCOM monthly CLINOPS QA/QM cross talks and come prepared to share PI projects and PS trends. All PSMs and leaders will attend the Air Force Medical Service and DHA-sponsored virtual patient safety course for the deployed MTF or service equivalent.

(1) AARF is obtained from the PSR Application Registration Page on NIPRNet at: https://patientsafety.csd.disa.mil/. Complete Section 1 only and forward AARF to Component or CJTF CLINOPS for processing.

(2) PSMs and Reviewer/Handlers must complete the following on-line training requirements for submission of the AARF:

(a) HIPAA and Privacy Act Training (NIPRNet): https://jkodirect.jten.mil/Atlas2/faces/page/login/Login.seam.

(b) Cyber Awareness Training (NIPRNet) https://cs.signal.army.mil/login.asp or https://public.cyber.mil/training/cyber-awareness-challenge/.

(3) Once the AARF is approved, PSMs and Reviewer/Handlers must register for a User Account. Registration is completed on the PSR NIPRNet site: https://patientsafety.csd.disa.mil/.

i. PSE is defined as an event, incident, or condition that could have resulted or did result in harm to the patient. A PSE can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error.

(1) Health Safety Reviews (HSR) and specifically a Comprehensive Systematic Analysis (CSA) is a class of problem solving methods/tools aimed at identifying the contributing (systems and human) factors of a patient harm event or RE; see Patient Safety Learning Center resources such as the HSR Handbook at https://info.health.mil/hco/clinicsup/patientsafety/PSLCHome/SitePages/Home.aspx.

(2) Event and/or medical incident investigation to determine how the system contributed to the adverse outcome. Tools for conducting a CSA can be found at https://info.health.mil/hco/clinicsup/patientsafety/PSLCHome/SitePages/Resources.aspx.

j. A RE is any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) resulting in death, permanent harm, or severe temporary harm, as per the Agency for Healthcare and Research Quality (AHRQ) Harm Scale; or meeting the Joint Commission's sentinel event (SE) or the National Quality Forum's serious reportable event (SRE) definitions. Reviewable Reportable Events (DoD RE) that are pertinent to Roles 1, 2, or 3 in the operational environment are located in a table or matrix in the Enclosure of DHA-PM 6025.13, Volume 2.

k. RE CSA investigations are conducted by the responsible service component where the event occurred with input from their Service medical safety office.

5.3. PATIENT MOVEMENT SAFETY REPORTING

a. Maximizing safety during the movement or evacuation of patients in USCENTCOM's AOR is a primary concern for CCSG. An effective PSP encompasses a system-wide approach for identifying events during patient movement/evacuation, taking corrective actions, monitoring, evaluating, and benchmarking resulting in processes that are effective, efficient, and safe.

b. Units involved in patient movement/evacuation will include HQ USCENTCOM's Patient Movement/Evacuation Safety Goals (see Appendix D) where appropriate, in their safety program. These goals focus on safety trends considered to be of high risk, problem prone or of high volume within patient movement.

c. Patients are within the Aeromedical Evacuation (AE) system from the time a Patient Movement Request is submitted into the TRAC2ES for validation until the patient is accepted by receiving personnel at the Aerial Port of Debarkation.

d. PSRs occurring in the AE system (fixed-wing movement) are submitted using the JPSR.

SECTION 6: ADMINISTRATIVE INSTRUCTIONS

6.1. PROPONENT

The proponent of this regulation is the HQ USCENTCOM SG. Units are invited to submit comments and suggested improvements directly to HQ USCENTCOM ATTN: CCSG, 7115 South Boundary Boulevard, MacDill AFB FL 33621-5101.

6.2. ACCESSIBILITY

Publications and Forms are available on the USCENTCOM SIPRNet Releasable (REL) Publications Information Portal at the following link: https://ccj6.rel.centcom.smil.mil/R_DIV/RD/RDP/SitePages/Home.aspx.

6.3. RELEASABILITY

There are no releasability restrictions on this instruction within the U.S. Federal Government. Contact the USCENTCOM FOIA Office if requested for public release pursuant to the FOIA.

6.4. EXPIRATION

This regulation will expire in five years pursuant to USCENTCOM CCR 25-30, *Preparation of Administrative Publications*, unless revised or rescinded.

OFFICIAL:

DAVID S. DOYLE
Major General, U.S. Army
Chief of Staff

APPENDIX A: CREDENTIAL REVIEW AND PRIVILEGING

1. U.S. and military healthcare personnel must have their credentials reviewed and privileges granted prior to deployment to work within U.S. commanded military healthcare facilities. Credential review is required to ensure healthcare personnel have the education, training, experience, physical and mental health, and skills to fulfill the requirements of the position, and to support clinical requirements. Privileges granted to providers/practitioners are facility specific and based on resources as well as the procedures and types of services provided within the treatment facility.

2. U.S. MTF Commanders will:

a. Review and validate that U.S. providers/practitioners have met their privileging requirements pursuant to DoD instructions, Service specific policies, and grant approval to work within the MTF.

b. Validate current credentials and privileges and grant approval to work within the MTF. For non-U.S. providers and practitioners, Commanders will coordinate with Component Surgeon and CCSG/Clinical Operations to obtain credentialing and privileging through the Services, DHA, and Health Affairs.

c. Review and sign the Credential Review and Privileging Record (CCSG Form 1, fillable PDF) Part VI, or appoint/designate alternate signature authority when required. This document is a method for the local MTF leadership to grant approval to work within the MTF and validate what the provider is permitted to do in the local facility as compared with the current credentials and privileges reviewed/received prior to deployment.

d. Responsible for the overall quality and safety of health care performance by formally and systematically assessing, monitoring and reviewing health care delivery and patient care outcomes within the MTF.

e. Appoint a senior physician to provide technical advice, oversight, and direction on credential review and privileging procedures, guidelines, and mandates pursuant to DoD Directives, instructions, Service regulations, this CCR, and other regulatory agency requirements for providers/practitioners.

f. Appoint senior nurse and/or Non-Commissioned Officer (NCO) to provide technical advice, oversight, and direction on credential review procedures, guidelines, and mandates pursuant to DoD directives, instructions, Service regulations, this CCR, and other regulatory agency requirements for nursing and non-nursing personnel.

g. U.S. senior physician will: Provide technical oversight and management for the process of review, and verification of U.S. and non-U.S. providers'/practitioners' license, certification, registration, health status, and other authorizing documents required to practice within a U.S. MTF.

3. Determine privileging classification from the following:

a. Regular privileges.

b. Supervised privileges under a U.S. supervisor with regular privileges. Must have a plan of supervision developed and implemented for a period determined by the MTF Commander, and if applicable, the country senior medical representative.

c. U.S. Senior Nurse/NCO will provide technical oversight and management for the process of review, and verification of U.S. and non-U.S. nursing and non-nursing license, certification, registration, health status, and other authorizing documents required to practice/perform within their scope of care.

4. U.S. Senior Physician, Senior Nurse, and NCO will:

a. When available, will refer to the Centralized Credentials Quality Assurance System (CCQAS) website at: https://ccqas.csd.disa.mil/, for information on U.S. personnel as a basis for assessing clinical competence and current privileging status.

b. Provide U.S. and non-U.S. military healthcare personnel with a standardized orientation program to the MTF that includes for the non-U.S. personnel an emphasis on understanding U.S. clinical specialties not recognized by that country/nation.

c. Ensure U.S. and non-U.S. military healthcare personnel participate in a peer review process; taking into account, differences in the non-U.S. personnel's scope of practice/care.

d. Review Parts I through IV of the Credential Review and Privileging Record. Complete and sign Part V and submit to MTF Commander or their designee for final signature. Credential Review and Privileging Record is available at: https://intelshare.intelink.gov/SitePages/CCSG-CLINOPS.aspx.

5. Senior Military Clinical Representative.

a. U.S. and non-U.S. senior military clinical (medical and/or nursing) representatives (SMCR) from home station (U.S.) or supplying country/nation (non-U.S.) have a responsibility to ensure their healthcare personnel assigned or designated to provide clinical services, are mentally and physically capable of exercising assigned clinical duties.

b. Non-U.S. SMCR will ensure their healthcare personnel have a working knowledge of the English language, written and spoken.

c. Their personnel are immunized against Hepatitis B and medically cleared of active Tuberculosis, Hepatitis C, and Human Immunodeficiency Virus.

d. U.S. military healthcare personnel will ensure, prior to their deployment to theater, data in CCQAS is complete for review by the gaining facilities senior clinical representative. Alternatively, the Inter-Facility Credentials Brief is a mechanism for the transfer of the individual's credentials and competencies for the gaining facility, References (k) and (h).

6. Non-U.S. Military Personnel.

a. When designated to provide clinical practice at a U.S. led healthcare facility from Role 1 to Role 3, the supplying country/nation must convey all relevant credentials and privileging information to the gaining U.S. facility.

b. Complete Parts I through III on the Credential Review and Privileging Record (CCSG Form 1). Sign, date and submit to their SMCR for completion of Part IV.

(1) Healthcare worker completes Parts I-IV.

(2) Chief Medical Officer/Chief Nursing Officer/Senior NCO reviews member's CCQAS and/or ICTB and completes Part V.

(3) Facility commander completes Part VI by validating privileges concurrent with the role of care and facility support and remains current through deployment.

c. This form is presented by the health care professional which constitutes evidence of current licensure, certification, registration, or other authorizing document, as appropriate.

Figure 1. Credential Review and Privileging Form

USCENTCOM COMMAND SURGEON (CCSG)

Credential Review and Privileging Record for U.S. and Non-U.S. Military Healthcare Personnel

PART I Administrative Information (Complete a through j)

a. Name (Last, First, Initial)

b. Effective Period (YYYYMMDD) From To

c. Rank/Grade or Title

d. Gaining Treatment Facility

e. Nationality

f. Location (e.g., Afghanistan, Iraq, Jordan)

g. Profession
- Provider
- Practitioner
- Nursing
- Non-Nursing

h. Service (Army, Air Force, Navy, Marine)

i. Age Groups (Check all that apply)
- Neonates (Birth – 28 Days)
- Infants (1-24 mos)
- Children (2-12 yrs)
- Adolescents (13-17 yrs)
- Young Adults (18-23 yrs)
- Adults (24-65 yrs
- Geriatrics (> 65 yrs)

j. Privileges Requested (Specify discipline(s))
- Aerospace Medicine
- Anesthesia
- Clinical Pharmacy
- Dentistry
- Emergency Medicine
- Family Practice
- General Surgery
- Internal Medicine
- Neurology
- Nurse Anesthesia
- Nurse Practitioner
- Obstetrics/Gynecology
- Occupational Therapy
- Orthopedic Surgery
- Pediatrics
- Physical Therapy
- Physician Assistant
- Psychiatry
- Psychology
- Radiology
- Urology
- Other:
- Surgical Specialty:

PART II U.S. and Non U.S. Military Healthcare Personnel

- Inter-Facility Transfer Brief (ITCB) from Home Station
- Provide Competency Assessment File (CAF) from Home Station

PART III U.S. and Non U.S. Military Healthcare Personnel (Complete a through e)

Initial	
	a. Agree to follow staff bylaws/policies and procedures of the gaining treatment facility.
	b. Agree to participate in USCENTCOM clinical quality management/assurance programs (e.g., Peer Review, Patient Safety Reporting, Infection Control, Risk Management and Joint Trauma Registry/Pre-Hospital Registry).
	c. **U.S. personnel**: If deemed necessary by the senior clinical leadership or CDR, agree to a preceptor for an initial period of time.
	d. **Non-U.S. personnel**: If deemed necessary by the senior clinical leadership or CDR, and in coordination with the individual country senior clinical representative, agree to a preceptor for an initial period of time.

e. Candidate Signature: Date: Submit completed form to your Senior Military Clinical Rep (SMCR)

PART IV U.S. and Non U.S. Senior Military Clinical Representative (Complete a through k)

a. Have you ever had any history of adverse clinical privilege or disciplinary actions?	No	Yes
b. Are you physically and mentally capable of exercising clinical privileges/scope of practice?	No	Yes
c.Do you possesses requisite qualifications?	No	Yes

d. SMCR Signature: Date: Submit completed form to the U.S. MTF or Service Component SG

PART V U.S. Treatment Facility Senior Physician/Nurse/NCO (Complete a through i)

a. Credential Review
- Approve
- Disapprove

b. Effective Period (YYYYMMDD) From To

c. Plan of Supervision
- Required
- Not Required

d. Type of Privileges Granted (Providers/Practitioners Only)
- Regular
- Supervised
- Denied
- Rescinded

e. Admitting Privileges (Providers/Practitioners Only)
- Requested
- Not Requested
- Granted
- Not Granted

f. Effective Period of Supervision (YYYYMMDD) From To

g. Check Appropriate Box
- Based on review of the information submitted in support of the **provider's/practitioner's** licensure, education and training, and his/her demonstrated competence, privileges are approved as requested and are in effect as noted in Part V (b).
- Based on review of the information submitted in support of the **nursing/non-nursing personnel's** licensure, certification, education and training, and his/her demonstrated competence, has been approved and are in effect as noted in Part V (b).

h. Name of Supervisor (if applicable)

i. U.S. Senior Physician/Nurse/NCO Signature: Date:

PART VI U.S. Treatment Facility Commander or Designee to Complete

i. Print and Sign: Date:

USCENTCOM CCSG Form 1 February 2019

APPENDIX B: SAMPLE PERFORMANCE IMPROVEMENT TOOL

1. The cycle of PI is the formal process of:

a. Gathering meaningful data that is relevant, timely, organized, and accurate.

b. Transforming the data into information through a process of evaluation and analysis.

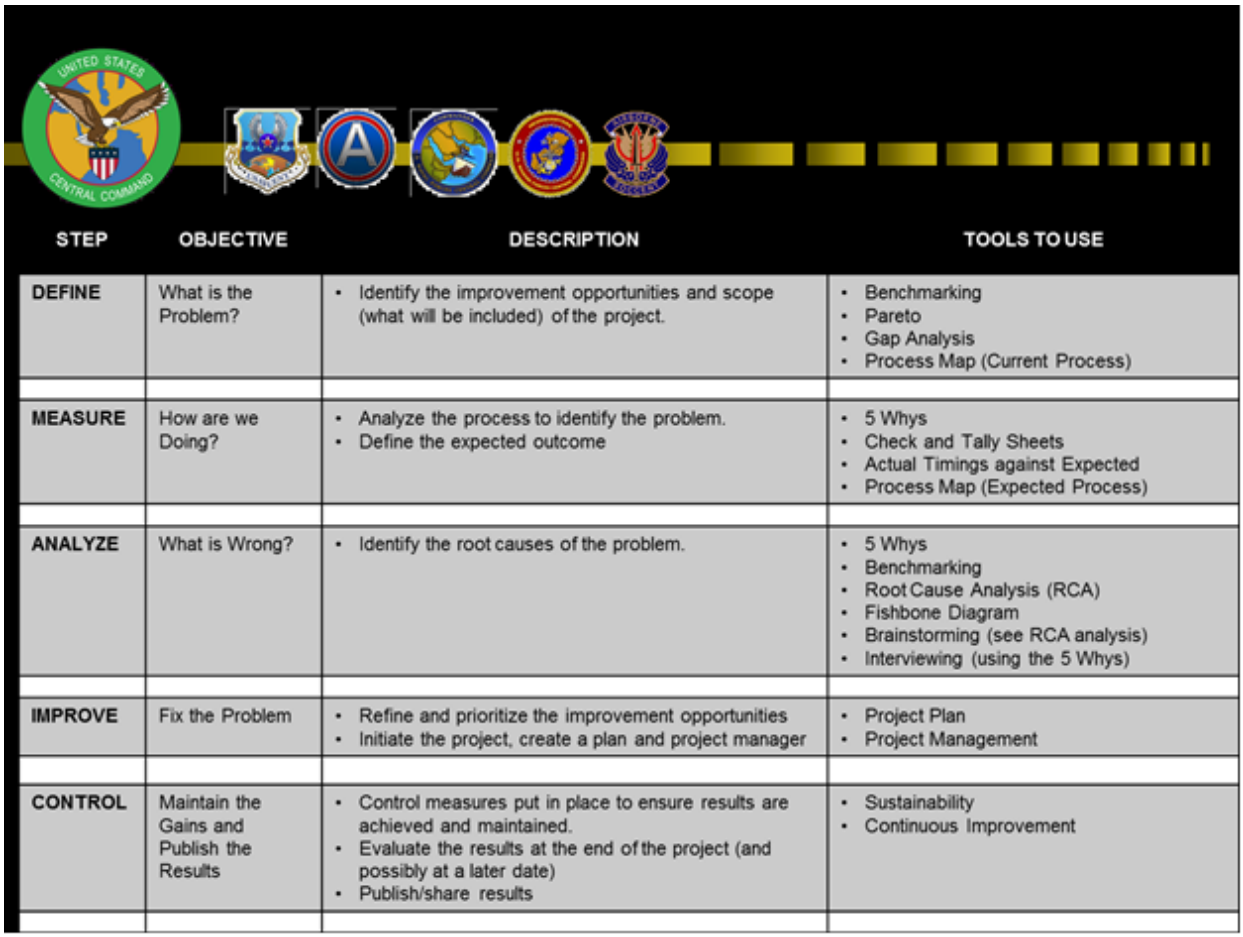
c. Extracting information to obtain knowledge of the current system's strengths and weaknesses.

d. Developing a plan of action to apply the knowledge gained to improve processes.

e. Sustaining implementation of the plan of action, and continuing evaluation of ongoing results.

2. The Define, Measure, Analyze, Improve, and Control PI model is an example of a tool for the PI program:

Figure 2. Performance Improvement Tool



STEP	OBJECTIVE	DESCRIPTION	TOOLS TO USE
DEFINE	What is the Problem?	• Identify the improvement opportunities and scope (what will be included) of the project.	• Benchmarking • Pareto • Gap Analysis • Process Map (Current Process)
MEASURE	How are we Doing?	• Analyze the process to identify the problem. • Define the expected outcome	• 5 Whys • Check and Tally Sheets • Actual Timings against Expected • Process Map (Expected Process)
ANALYZE	What is Wrong?	• Identify the root causes of the problem.	• 5 Whys • Benchmarking • Root Cause Analysis (RCA) • Fishbone Diagram • Brainstorming (see RCA analysis) • Interviewing (using the 5 Whys)
IMPROVE	Fix the Problem	• Refine and prioritize the improvement opportunities • Initiate the project, create a plan and project manager	• Project Plan • Project Management
CONTROL	Maintain the Gains and Publish the Results	• Control measures put in place to ensure results are achieved and maintained. • Evaluate the results at the end of the project (and possibly at a later date) • Publish/share results	• Sustainability • Continuous Improvement

APPENDIX C: NON-RESEARCH DETERMINATION MEMORANDUM

1. PI is the systematic process aimed at improving the effectiveness and efficiency of healthcare operations and is considered a non-research venue. Refer to Reference (p) for Medical research procedures. Requestors will:

a. Complete a PI project request form and obtain leadership approval. Refer to the CCSG NIPRNet SharePoint site for at: https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLINOPS.aspx.

b. Provide a description for the process, program, or system the PI project will attempt to improve or assess.

c. Purpose should not be used to fill a knowledge gap or establish/change a clinical practice guideline as this potentially crosses into a research study.

d. Specify indicators (performance or quality) that will be used to evaluate accomplishment of the purpose.

e. Determine methodology to be used to perform this project.

f. Determine data and metrics to be collected.

g. Specify the use of any pre-existing databases, such as the DoD Trauma Registry (DoDTR). To request data from the JTS go to https://jts.health.mil/index.cfm/data/data_requests.

2. Anticipate effect on the process, program, or system as a result of this project:

a. CJTF Command Surgeon or equivalent level Surgeon approval will be required for PI projects that may or will involve Host Nation or Partner Nation military medical personnel and/or facilities.

b. PI request forms will be submitted to the HQ USCENTCOM Chief, CLINOPS first to be reviewed for feasibility and endorsement. Once the CCSG approves the PI project by signing the form, the Chief, CLINOPS will then send it to the U.S. Army Medical Research and Development Command (MRDC) Institutional Review Board.

c. MRDC reviews PI request and confirms project does not constitute research as defined pursuant to Human Subjects Protection regulations.

d. MRDC provides requestor a signed memorandum with the “Determination of Non-Research” as approval for their PI project to move forward.

APPENDIX D: PATIENT MOVEMENT SAFETY GOALS FOR THEATER

CCSG supports the following ERC/AE safety goals for inclusion into HQ USCENTCOM's operational/expeditionary MTFs, AE components, and MEDEVAC PSPs. The goals are based on quality and patient safety reporting trends or problematic issues noted in previous CY 2021, as well as high risk clinical skills or processes being emphasized.

MTF ERC Goal 1: Infection prevention techniques are consistently applied to protect the health and safety of healthcare personnel and patients (CDC Infection Prevention Guidance, DoD Force Health Protection Guidance, DAFI 48-107 V1).

Objective 1.1. Conducts appropriate screening/assessment of patients pre/post AE mission (symptom identification, masking precautions, testing, etc.).

Objective 1.2. Provides effective communication with PMRC, Validating Flight Surgeon, and local MTF, indicating concerns related to Infection Control.

MTF ERC Goal 2: All patients are properly prepared for patient movement throughout the ERC System (USTRANSCOM Handbook 41-1, DAFI 48-107 V1, V3).

Objective 2.1. Ensures EHR or AF IMT 3899 series has complete and signed provider orders.

Objective 2.2. Initiates Medication Administration Record via EHR or AF IMT 3899I with medication administration annotated and signed using Zulu time.

Objective 2.3. Ensures adequate supply of ordered patient medications are provided for the flight (both inpatients and outpatients).

Objective 2.4. Ensures the patient medication orders, medications, and the Medication Administration Record (EHR or AF IMT 3899I) all match and clarifies any discrepancies or concerns before mission.

Objective 2.5. Ensures an ID band is placed on all inpatients, outpatients, and non-medical attendants.

Objective 2.6. Utilizes a Patient Preparation Checklist.

Objective 2.7. Ensures anti-hijacking is completed on all patients and attendants prior to AE mission (AFI 13-207-O).

Objective 2.8. Ensures patient meals (both regular and special diets) are ordered/arranged in advance for flight.

MTF ERC Goal 3: Improve Communication.

Objective 3.1. Utilizes standardized handoff format (i.e., Introduction, Situation, Background, Assessment, recommendation) when providing patient handoff reports to

receiving Flight Nurse for all patients in the ERC System (Handoff Forms located in TRAC2ES under "Documents," DAFI 48-107 V1).

Objective 3.2. Utilizes AE Call Criteria for patients on day of scheduled flight and ensures proper notification is made when patients meet call parameters (COPSA 21-03).

Objective 3.3. Ensures AECMs are provided with updated PMR, patient manifests, and 3899/EHR when there are clinical/mission changes.

MTF ERC Goal 4: Improve Management of DoD MTF Administrative Functions in support of Aeromedical Evacuation of patients (DAFI 48-107 V1).

Objective 4.1. Ensures appropriate patient ground transportation and manpower, based on number of patients and patient classification, are obtained for safe patient transport to and from the AE aircraft.

Objective 4.2. Ensures personnel are familiar with safe litter transfer techniques.

APPENDIX E: PATIENT SAFETY MANAGER

1. The PSM ensures a comprehensive and integrated PSP is utilized to identify and reduce preventable harm to patients in USCENTCOM's AOR. PSMs perform at a minimum, the following:

a. Utilizes the DoD JPSR system to collect, review, and evaluate PSRs from their assigned and/or appointed treatment facilities within theater.

b. Classifies PS events according to the DoD PSP guidelines.

c. Identifies PS reviewers/handlers for the different departments/sections/clinics as appropriate.

d. Ensures the reviewer/handler obtains user account and completes training pursuant to the DoD PSP.

e. Verifies the reviewer/handler understands how to use the DoD JPSR system to perform investigative reviews on PSEs.

f. Monitors reviewer/handler process to ensure timely completion of investigations.

g. Performs final review on PSEs and determines degree of harm, classification event, and approval status.

h. Informs leadership of SEs; ensures a CSA is completed within 45 days of event discovery.

i. CSAs conducted on AE related events in theater may involve multiple units and will be directed by USTRANSCOM pursuant to Air Mobility Command Surgeon and the CCSG.

j. Conducts or coordinates PS training as needed for staff members.

k. Training resources may be found on the DoD Patient Safety Learning Center at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/Patient-Safety-Learning-Center.

l. Collaborates with other facility functions such as PI, Infection Control and Prevention, RM, P&T, Medical Equipment Repair and Medical Logistics to ensure the full scope of PS issues are identified and acted upon.

m. Develops PS reports for leadership, highlighting top two to three patient safety concerns, giving emphasis to issues beyond the unit's control. Shares PS progress and PI projects with JTF and Component CLINOPS Chiefs during regularly scheduled QA/QM Crosstalks.

n. JTF/Component CLINOPS consolidates and reports PS data and PI outcomes at the monthly USCENTCOM QA/QM crosstalk to facilitate shared best practices and problem solving across the USCENTOM AOR.

o. Collaborates with the USAFCENT PS Representative on the review and analysis of Patient Movement Quality Reports for events/near miss reports affecting inpatients and outpatients from the MTFs and patients within the AE system.

p. Provides feedback to personnel submitting PS reports regarding resulting actions or outcomes, and lessons learned.

q. Informs appropriate leadership regarding the notification of PS alerts (e.g., DoD PS Alert, Clinical Operations Patient Safety Alert, and Notice to Airman, etc.) released from DoD, USTRANSCOM, and the Services.

2. PSMs assigned to AE units perform the same functions as above but utilize USTRANSCOM TRAC2ES Patient Movement Quality-Reports system to collect, review and evaluate patient safety reports for lessons learned and PI.

3. For additional information, access the Aeromedical Evacuation-Patient Movement Patient Safety Program Guide at: https://intelshare.intelink.gov/sites/ccsg/SitePages/CCSG-CLINOPS.aspx.

APPENDIX F: THEATER REPORTABLE EVENTS AND COMPREHENSIVE SYSTEMATIC ANALYSIS

1. The following RE are reported by MTF Commanders within 24 hours of event discovery through the appropriate Command Surgeon to the CCSG. Reports of events are labeled pursuant to Paragraph 4.8a. and sent to the USCENTCOM Chief, Clinical Operations. Note: A reportable RE requires MTF Commanders to perform a Healthcare Safety Review via a CSA. See also RE enclosure of Reference (n).

a. The event resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

b. Suicide of any individual receiving care, treatment, or services in a staffed around-the-clock care setting, or within 72 hours of discharge.

c. Unintended retention of a foreign object in an individual after surgery or other procedure.

d. Surgery on the wrong individual or wrong body part.

e. Abduction of any individual receiving care, treatment, or services.

f. Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient.

g. Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the MTF.

h. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

i. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care.

j. Unanticipated death of a full-term infant.

k. Discharge of an infant to the wrong family.

l. Any intrapartum (related to the birth process) maternal death. Severe maternal morbidity (not primarily related to the natural course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm.

2. CSA is conducted with oversight from the responsible component's patient safety office. A CSA is a class of problem-solving methods aimed at identifying all the contributing systems and human factors of problems or events. The practice of a CSA is predicated on the belief that problems are best solved by attempting to correct or eliminate contributing factors as opposed to merely addressing the immediately obvious individuals involved and symptoms.

3. CSA is a critical feature of any safety management system because it enables answers to questions posed by high risk, high impact events (including near misses) – what happened, why it occurred, and what can be done to prevent it from happening again.

4. CSA will:

a. Identify weaknesses in a process or system.

b. Gain a thorough understanding of why an event occurred.

c. Determine the causal and contributing factors.

d. Lead to the development of sustainable action plans to counter weaknesses and prevent or reduce the likelihood of similar events in the future.

e. Be investigated as soon as allowable after an incident is identified; once initiated, root cause analysis will be completed within 45 business days and final report will be shared with the CCSG.

APPENDIX G: NATIONAL PATIENT SAFETY GOALS

Figure 3. Joint Commission Safety Goals

2022 Hospital National Patient Safety Goals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly	
NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
Improve staff communication	
NPSG.02.03.01	Get important test results to the right staff person on time.
Use medicines safely	
NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.
Use alarms safely	
NPSG.06.01.01	Make improvements to ensure that alarms on medical equipment are heard and responded to on time.
Prevent infection	
NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
Identify patient safety risks	
NPSG.15.01.01	Reduce the risk for suicide.
Prevent mistakes in surgery	
UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.

The Joint Commission

This is an easy-to-read document. It has been created for the public. The exact language of the goals can be found at www.jointcommission.org.

APPENDIX H: GLOSSARY

1. Abbreviations, Acronyms, and Initialisms. Pursuant to the *DoD Dictionary of Military and Associated Terms*, an abbreviation is a shortened form of a word or phrase pronounced as a word (e.g., SecDef). An acronym is a shortened form of a phrase of words, where the letters of the acronym stand for the terms of its meaning and is also read as a word (e.g., ASAP [as soon as possible]). An initialism is a shortened form of a word or phrase that is not spoken as a word; each letter is spoken separately (e.g., DoD).

AAR	After Action Report
AARF	Account Authorization Request Form
ADVISOR	Advanced Virtual Support for OpeRational Forces
AE	Aeronautical Evacuation
AFB	Air Force Base
AHLTA-T	Armed Forces Health Longitudinal Technology Application-Theater
AOR	Area of Responsibility
APV	Ambulatory Patient Visits
CASEVAC	Casualty Evacuation
CCDR	Combatant Commander
CCMD	Combatant Command
CCOP	United States Central Command Clinical Operating Protocols
CCQAS	Centralized Credentials Quality Assurance System
CCR	United States Central Command Regulation
CCSG	United States Central Command, Command Surgeon General
CDC	Centers for Disease Control and Prevention
CJTF	Combined Joint Task Forces
CLINOPS	Clinical Operations
CPG	Clinical Practice Guidelines
CQIIP	Continuous Quality Immunization Improvement Process
CSA	Comprehensive Systematic Analysis
CTMD	Command Trauma Medical Director
CTPM	Command Trauma Program Manager
CTS	Combatant Command Trauma Systems
DHA	Defense Health Agency
DMRPC	Deployed Medical Records Processing Center
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDTR	Department of Defense Trauma Registry
DSN	Defense Switched Network
ED	Emergency Department
ERC	En Route Care
FDA	Food and Drug Administration
FOIA	Freedom of Information Act
GO	General Order
GO-1C	General Order 1C
GTP	Global Teleconsultation Platform

HALO	Health Assessment Lite Operations
HIPAA	Health Insurance Portability and Accountability Act
HSR	Health Safety Reviews
ICO	Infection Control Officer
IP&C	Infection Prevention and Control
IT	Information Technology
ITR	Inpatient Treatment Record
JPSR	Joint Patient Safety Reporting
MEDEVAC	Medical Evacuation
MEDROE	Medical Rules Of Eligibility
MHS	Military Health System
MIST	Mechanism, Injury, Symptoms, and Treatment
MRDC	Medical Research and Development Command
mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NCO	Non-commissioned Officer
NIPRNet	Non-classified Internet Protocol Router Network
OIR	Operation INHERENT RESOLVE
P&T	Pharmacy and Therapeutics
PAD	Patient Administration
PCA	Patient Controlled Anesthesia
PCE	Potentially Concussive Events
PCR	Patient Care Record
PI	Performance Improvement
PM/E	Patient Movement/Evacuation
PMR	Patient Movement Requests
POI	Point of Injury/Illness
PS	Patient Safety
PSE	Patient Safety Event
PSM	Patient Safety Manager
PSP	Patient Safety Programs
PSR	Patient Safety Reporting
QA	Quality Assurance
QM	Quality Management
RCA	Root Cause Analysis
RE	Reportable Events
RM	Risk Management
RRC	Ready Reliable Care
RTD	Return to Duty
SAMFE	Sexual Assault Medical Forensic Exam/Examiner
SARC	Sexual Assault Response Coordinator
SAV	Staff Assisted Visits
SCC	Service Component Commands
SE	Sentinel Events
SMCR	Senior Military Clinical Representative
SME	Subject Matter Expert

SOC	Standard of Care
STR	Service Treatment Record
TACEVAC	Tactical Evacuation
TC2	Theater Medical Information Program-Joint Composite Health Care System Cache
TCCC	Tactical Combat Casualty Care
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety
TMD	Trauma Medical Directors
TMDS	Theater Medical Data Store
TNC	Trauma Nurse Coordinator
TPM	Trauma Program Managers
TPMRC-E	TRANSCOM Patient Movement Requirements Center - East
TRAC2ES	Transportation Regulating and Command and Control Evacuation System
U.S.C.	United States Code
USCENTCOM	United States Central Command
USTRANSCOM	United States Transportation Command
VITAL-T	Virtual Inspection and LINKUP in Theater
WBB	Walking Blood Bank

2. Terms/Definitions. Unless otherwise noted, these terms and their definition are for the purpose of this regulation.

clinical competence. The knowledge, skills, and abilities of a healthcare provider/professional who contributes to effective intervention in illness or injury. The healthcare individual's demonstrated capability to perform in keeping with defined expectations.

clinical privileges. Permission to provide medical and other patient care services in the granting institution, within defined limits, based on the individual's education, professional license, experience, ability, health, and judgment.

CQIIP. An assessment which provides valuable resources to assist immunization sites with providing our stakeholders with the best practices available for immunization delivery.

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

CTMD. Serves as primary liaison between DHA/JTS, Command Surgeon, Components, and Theater TMD. Provides oversight over trauma care delivery in the CENTCOM AOR in coordination with JTS and theater trauma medical directors.

CTPM. Ensures reporting compliance for or when needed administrator of the DoDTR. Ensures communication of data and best trauma practices between CTS and Joint Trauma System (JTS). Manage quality management, quality improvement, performance improvement, patient safety processes and programs and ensures similar processes are carried out by the TMD and TPMs.

CTS. Regional trauma system that can be scaled to contingency requirements identified by the CCMD.

denial of privileges. Refusal to grant requested privileges to a provider due to professional or clinical concerns, or due to facility-specific limitations.

direct patient care. Healthcare interventions, services, or activities that engage the provider/professional in face- to- face contact with a patient. Examples are: conducting patient assessment, performing health and physical examination, taking an x-ray, assisting patient with activities (walking/dressing/eating), and the collecting, reporting, and documenting data related to these activities.

DoDTR. Comprehensive DoD Trauma Registry.

en route combat casualty care. Trauma care delivered to a casualty during transport to or between medical facilities.

evidence-based CPG. Systematically developed statements to assist the healthcare team with the decision-making process in patient care. CPGs describe appropriate care based on the best available scientific evidence and broad consensus as well as reduced inappropriate variation in practice.

healthcare personnel. Individuals involved in the direct or indirect delivery of health services or patient care.

indirect patient care. Healthcare related activities that complement or augment direct care but typically do not involve immediate contact with the patient. Examples are: Performing a procedure on a specimen in the lab, processing or interpreting radiological films, reviewing data contained in a medical record, preparing pharmaceuticals or intravenous solutions, and the collecting, reporting, and documenting of data related to these activities.

infection prevention and control program. A program designed to promote safe patient care by limiting the spread of infection. Infection control programs include disease surveillance, hand hygiene, equipment decontamination, and sterilization.

JTS CPG. A set of prehospital and hospital trauma management clinical Practice Guidelines that are evidence-based medicine practice recommendations distilled into guidelines to remove medical practice variations and improve outcomes.

JTS. An enduring global trauma care system and supports performance global performance improvement capabilities in support of the full range of military operations. The DoDTR is a comprehensive trauma registry that is foundational for data driven performance improvement.

just culture. Is a culture of trust, learning, and accountability whereby the rules are clear between individual accountability and system failures, thus empowering staff to report adverse events, due to leadership's commitment to process and system changes.

medical quality assurance program. The term refers to any peer review activity carried out before, on, or after November 14, 1986 by the DoD to assess the quality of medical care. This includes activities conducted by individuals, military medical or dental treatment facility committees, or other review bodies responsible for quality assurance, credentials, infection control, patient care assessment (including treatment protocols, blood, drugs, and therapeutics), medical records, health resources management review and identification, prevention of medical or dental incidents, and risks.

medical quality assurance record. Refers to proceedings, records, minutes, and reports that emanate from QA program activities and are produced or compiled by the DoD as part of a Medical Quality Assurance Program (see definition above).

MTF. A facility established for the purpose of furnishing medical and/or dental care to eligible individuals (Joint Publication 4-02).

QM programs. A structured series of coordinated activities and procedures that emphasize leadership commitment to quality performance regardless of the practice site (including operational/expeditionary environments), a supportive organizational culture, and the evaluation of the effectiveness of clinical PI activities.

SAMFE. A health care provider trained or certified to conduct sexual assault examinations.

situation, background, assessment, and recommendation/request communication tool. A technique to structure critical information primarily for spoken delivery is organized to assist with patient hand-offs, patient transfers, critical conversations and telephone calls. Situation, Background, Assessment, and Recommendation/Request promotes the sharing of patient information in a clear, complete, concise and structured format, leading to improved communication between team members.

TCCC. A set of standardized DoD prehospital trauma management guidelines customized for use in the military tactical setting that maintains a sharp focus on injury survivability and death preventability resulting from combat.

TRAC2ES. TRAC2ES is an automated information system that combines transportation, logistics, and clinical decision support elements into a seamless patient movement information management system, which is capable of visualizing, assessing, and prioritizing patient movement requirements, assigning proper resources and distributing relevant data to efficiently deliver patients.

virtual health. The act of utilizing technological devices to connect patients and providers are disparate sites for the purposes of providing health care services.

virtual veterinary service. The act of utilizing technological devices to connect Veterinary clinics for the purpose of consultations on providing veterinary service to injured animals.

VITAL-T. an innovative initiative that leverages pre-existing Virtual Health capabilities to conduct “real time” synchronous virtual SAV at remote clinical sites, maximizing access of these

sites to dedicated quality and safety assets and SME, and/or to other SMEs which improve the quality and safety of processes that directly affect patient safety and readiness.

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