United States Air Force

Presentation

Before the House Armed Service Committee, Subcommittee on Military Personnel

Patient Safety and Quality Assurance

Witness Statement of

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Surgeon General of the Air Force

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Good afternoon Chairwoman Speier, Ranking Member Gallagher and distinguished members of the subcommittee. It is an honor and a privilege to appear before you today as the Surgeon General of the Air Force and Space Force, and to discuss Air Force Medicine Clinical Quality Management processes and functions to include Patient Safety and Healthcare Risk Management.

I would first like to thank the Committee for your longstanding support in the recent passage of the Fiscal Year 2022 budget. I would also like to reiterate the my committement to patient safety for all military health system beneficiaries. The Air Force Medical Service officially started its journey towards being a high reliability organization in 2015 when my predecessor, Lt Gen Mark A. Ediger, launched the "Trusted Care" program. Since then and even now, high-reliability remains the foundation for the care we provide which we call "Trusted Care..Anywhere. We remain partnered with the Defense Health Agency's high reliability efforts. Together with DHA, our processes ensure a culture and practice safeguarding patient safety in the operational and non-operational environments.

AFMS CQM TRANSITION TO THE DEFENSE HEALTH AGENCY

Air Force Medical Service (AFMS) Clinical Quality Management functions include oversight of Patient Safety, Healthcare Risk Management, Quality Management, Credentials and Privileging, Healthcare Compliance, as well as consultative support to Air Force Chief Medical Officers. Over the last two years, the Air Force Medical Operations legacy Clinical Quality Management office transitioned from a large organization that supported 76 military treatment facilities (MTFs), all downrange facilities, and patient transport missions, to a streamlined office supporting the operational environment.

As of 1 October 2021, the legacy Air Force Clinical Quality Management office handed over primary responsibility for Clinical Quality oversight of activities involving the delivery of clinical care in the non-operational environment to the Defense Health Agency (DHA) per the National Defense Authorization Act of 2017. Currently, our Clinical Quality Management division falls within the Air Force Medical Readiness Agency (AFMRA) and has been renamed AFMRA Operational Quality. This support now focuses on our deployed facilities, aeromedical transport capabilities and medics outside of the MTF.

I am happy to report that all Department of the Air Force operational facilities comply with *DHA-PM 6025.13 Clinical Quality Management in the Military Health System, Volumes 1-7*. Air Force MTFs began compliance on 1 October 2019 when DHA-Procedural Manuals were published. The Department of the Air Force policy, *Air Force Guidance Memorandum 44-119 Medical Quality Operations*, has been updated to align and adhere with DHA-PM 6025.13.

DEPARTMENT OF THE AIR FORCE SUPPORT OF DHA PATIENT SAFETY AND QUALITY PROGRAMS

The AFMS has worked closely with our Defense Health Agency Clinical Quality Management teammates to ensure a smooth and successful transition of MTFs and healthcare programs to the Defense Health Agency. At this time, all MTF support is provided by the Defense Health Agency. Direct support and reverse support agreements for Clinical Quality Management have been closed as of 14 March 2022. Department of the Air Force staff and talent continue to support DHA Clinical Communities through leadership positions, program support, and policy development.

THE AIR FORCE SURGEON GENERAL'S OPERATIONAL QUALITY PROGRAM

The AFMRA Operational Quality division is focused on development, implementation, and sustainment of clinical quality management procedures and guidance as it applies to the safe and quality healthcare delivery in operational environments. The primary tenants of Operational Quality are rooted in Patient Safety and Healthcare Risk Management. The Patient Safety and Healthcare Risk Management teams utilize proactive assessments to reduce risk and harm in the enterprise, as well as analysis of events to identify gaps in healthcare delivery to develop mitigation strategies to prevent future harm.

The Patient Safety team includes Patient Safety Managers for both our downrange and patient transport units, as well as members at AFMRA, Air Mobility Command, Air Force Central Command, and US Air Forces Europe and Africa. Our Healthcare Risk Management team coordinates closely with the Chief Medical Officers in the operational environment. In addition to Patient Safety and Healthcare Risk Management, AFMRA Operational Quality supports safety and quality programs through Healthcare Compliance, Credentialing and Privileging, and Quality Management.

AIR FORCE MEDICAL SERVICE CREDENTIALING AND PRIVILEGING

Credentialing and privileging of uniformed personnel delivering healthcare in Air Force operational environments occurs through an Inter-facility Credentials Transfer Brief (ICTB) in accordance with DHA-PM 6025.13*, Clinical Quality Management in the Military Health System, Volume 4: Credentialing and Privileging*. All privileged providers delivering healthcare in the operational environment deploy with an ICTB. The Expeditionary Commander and Chief Medical Officer (SGH) review and accept the ICTB as the provider's privileges to deliver healthcare in the operational environment. Operational facilities do not have Unit Identification Codes and are non-privileging locations, meaning that the medical commander in the deployed environment is not a privileging authority. Therefore, all healthcare delivered in the deployed environment occurs via the clinical privileges granted to the provider at their home-based MTF.

AIR FORCE MEDICAL SERVICE OPERATIONAL QUALITY FOCUS

The AFMRA Operational Quality team is focused on mitigation and reduction of risk in the delivery of operational healthcare. Proactive management of safe and quality care includes review of Joint Patient Safety Reports from our downrange and patient transport environments. Trends in Patient Safety Reports allows development and improvement of healthcare delivery processes to reduce the potential for harm during patient care in deployed and patient transport environments. Despite our focus on mitigation and reduction of risk and harm, there are times when a harm event reaches a patient. Every downrange facility has a patient safety trained active duty member who assists in risk mitigation. To ensure safe and quality care during patient movement, the patient transport environment has a dedicated Joint Patient Safety Reporting system and three dedicated Patient Safety Managers to review safety events that occur during transport of patients.

When a patient safety event occurs in the Air Force operational environment, the event is entered into the Joint Patient Safety Reporting System. A patient safety event is identified as an event that could cause harm but did not reach the patient, or caused harm by reaching the patient. Upon event identification, the AFMRA Patient Safety and Healthcare Risk Management teams are contacted by the

Chief Medical Officer or Patient Safety Manager at the location where the patient safety event occurred to coordinate and initiate a review of the event. The Patient Safety event review occurs through an analysis of the processes that comprise healthcare delivery to identify the gaps that contributed to or caused the event. A harm event, which may also be referred to as an adverse event, is analyzed utilizing the Department of Defense Reportable Event tool to identify the level of harm that occurred. If an event is identified to be a serious harm event, an in depth patient safety event called a Comprehensive Systematic Analysis ensues. The Comprehensive Systematic Analysis identifies areas for improvement and develops corrective actions to prevent future harm.

While the Patient Safety investigation focuses on the processes of healthcare delivery, there are additional Healthcare Risk Management activites to review the standard of care that was delivered, including an evaluation for a Potentially Compensable Event. For events that occur in the Air Force operational environment, the Healthcare Risk Management activities are referred to the significantly involved provider's home military treatment facility for processing since the operational facility does not grant clinical privileges and does not have a commander with privileging authority. The Potentially Compensable Event is entered into the Joint Centralized Credentials Quality Assurance System (JCCQAS), significantly involved providers are identified, and a review of the healthcare that was delivered to the potentially harmed patient occurs. The review of the healthcare delivery is called a standard of care review. Once the standard of care review is complete, the MTF Healthcare Risk Management team complete the checklist and the JCCQAS entry. In cases of Active Duty death or disability, the Potentially Compensable Event continues to be processed per the DHA-PM 6025.13, Volume 3 for review and finalization to include potential reviews by AFMRA Operational Quality and the Surgeon General's office.

If the standard of care review identifies potential misconduct, significant deviation from the standard of care, or identifies other significant concerns, the Chief Medical Officer and Privileging Authority could initiate an adverse action. The adverse action would include a Quality Assurance Investigation which consists of a detailed review of the healthcare rendered by any significantly involved provider.

CONCLUSION

The AFMS has remained committed to being a Highly Reliable Organization and is committed to maintaining the quality and safety of care delivered in the operational environment. The AFMRA Operational Quality program focuses on risk mitigation, transparency, and delivery of *Trusted Care Anywhere*. This is accomplished through thorough policy and process development, and by working hand-in-hand with the Defense Health Agency. A culture of learning and safety is paramount to the success of our Operational Quality Program. I am confident our AFMS team is doing all they can to ensure our Airmen and Guardians get the safe, high quality healthcare they deserve, and I remain dedicated to safeguarding that diligence as their Surgeon General.