

## CREDENTIALLED PROVIDERS

**SECTION 1. GENERAL:** Credentialed providers are employees who are required by regulation to maintain privileges in order to provide patient care. Those health care providers who are Physicians and Dentists in the bargaining unit have General Schedule position descriptions, are “exempt” for FLSA purposes (and therefore do not earn overtime or compensatory time), and all Title 5, U.S.C. regulations apply to them. Other bargaining unit health care providers are employed under Title 38, not Title 5.

**SECTION 2. PHYSICIAN AND DENTIST PAY PLAN:** For pay purposes, Physicians and Dentists fall under the Physicians and Dentists Pay Plan (PDPP), which blends the authorities of Title 5 and Title 38 to provide the Department of Defense (DoD) with a viable compensation system designed to enhance its recruitment and retention of highly qualified medical professionals. Pay for physicians who are bargaining unit employees is governed by Title 38, Department of Defense Instruction DoDI 1400.25, and the requirements imposed by the Health Professions Civilian Compensation Standing Committee (HPCCSC).

**A. Annual Pay:** The sum of base pay and market pay equals the employee’s annual pay.

**B. Base Pay:** The base pay component of the PDPP is based on provisions in Title 5, United States Code (U.S.C.) Base pay excludes locality-based comparability pay or a special salary supplement and is set at the appropriate GS grade and step IAW DoDI 1400.25, Volume 543.

**C. Market Pay:** Physicians and Dentists are also eligible for market pay, which is a supplement to their basic pay. The market pay component is based on provisions of Title 38, U.S.C. The Department of Defense Market Pay is based on the pay table and tier structure established by the Secretary of the Department of Veterans Affairs (VA) and published in Volume 74, Number 151, Federal Register [Reference (h), or in any published VA update superseding Reference (h)] to the extent appropriate.

1. Physicians and Dentists are assigned to a table based on their specialty and a tier based on the scope of their responsibilities. Providers who work at multiple facilities will be considered for the highest tier for which they provide services in the National Capital Region, e.g., a provider at DTHC who teaches at WRNMMC should be considered for a higher market pay.
2. Should the applicable requirements for PDPP be changed by HPCCSC, the Agency will provide the Union with notice and an opportunity to bargain prior to implementation in accordance with applicable law and the Mid-Term Bargaining Article of this CBA.
3. If the VA increases the minimum pay for a tier, then a bargaining unit Physician or Dentist whose total annual salary is set at the minimum of the tier will receive a market pay increase to reflect that change.

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4. A Physician or Dentist will also receive a permanent market pay increase to at least the minimum of a pay range if he or she is reassigned or promoted, on a permanent or temporary basis, to a table/tier with a higher minimum pay amount than his or her current salary.
5. A non-voluntary Management Directed Reassignment shall not result in a loss of Market Pay.

**D. Recruitment, Relocation, and Retention:** Physicians and Dentists under the PDPP may be eligible for recruitment, relocation, retention incentives. Basic Title 5 rules apply to these incentives, the percentages for which are based on annual pay (not base pay). In some cases, annual pay plus one or more of these incentives may cause compensation to exceed the tier maximum. Only annual pay counts for retirement and all other benefits.

**E. Performance Awards:** Physicians and Dentists are eligible for performance awards under the provisions of this CBA.

**F. Biennial Review:** The Parties recognize that primary discretion over PDPP rests with the HPCCSC. The PDPP biennial review shall be conducted in accordance with applicable law, DODI 1400.25 and guidelines issued by the HPCCSC.

1. The Agency agrees to administer PDPP to recruit and retain high quality employees in order to be competitive in the local market, and to establish a set schedule for the biennial review by specialty which shall be provided to the Union every January. Upon request the Agency will meet with the Union to discuss the requirements for the biennial review and the application of the HPCCSC guidelines, and including any change in the percentile used to set market pay for the average salary range for a given specialty in the NCR geographic region.
2. The Agency agrees to provide the Union with the data and other information prepared for the analysis of the biennial review which relates to bargaining unit employees. Any data concerning bargaining unit Physicians and Dentists obtained by the Agency for general distribution or posted on websites will also be made available to the Union.
3. Employees shall be notified in writing at least fifteen (15) days prior to their biennial or other review. Upon request, employees have the right to meet with the appropriate official and to submit their resume and pertinent information for due consideration by that official in completing the Pay Setting Worksheet (PSW) that will be submitted to the Activity Compensation Panel (ACP).

**G. Agency Input to the HPCCSC:** Communication between the Agency and the HPCCSC will be handled in the following manner:

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1. If the Committee solicits comments from the Agency, the Agency will meet with the Union to receive input prior to responding.
2. If the Agency chooses to request a clarification or modification of PDPP requirements from the Committee, the Parties will meet, upon request, prior to such submissions.
3. If the Union wishes to submit clarification or proposed modifications to the Committee, the Parties will meet. Upon Agency concurrence, these suggestions will be forwarded to the Committee.

**H. Drivability:** Employees who wish to challenge the application of the PDPP requirements to their salary following any action of the ACP may file a grievance in accordance with applicable law and the Negotiated Grievance Procedure Article of this CBA. An arbitrator's jurisdiction shall be limited to matters within the Agency's discretion.

### **SECTION 3. PROVIDER AUTONOMY AND ACCOUNTABILITY:**

**A. Scope of Work:** If management chooses to assign duties to providers other than direct patient care, e.g. telephone consults, relay health messaging, and hospital related meetings, appropriate duty time will be allowed for those duties.

**B. Self-Assessment:** Providers shall assess their own learning needs and choose educational activities that meet their needs. Self-Assessments may be used by supervisors to identify areas for possible improvement (i.e. educational opportunities, mentorship, practice needs, etc.).

**C. Responsibility for Medical Practices:** Health Care Providers are responsible for rendering quality patient care in accordance with established guidelines. These guidelines may be superseded in situations where evidence-based medicine or current practice standards dictate deviation from these guidelines. To ensure quality patient care, no physician or dentist shall be required to practice in a manner which is contrary to established standards of care.

**D. Information Regarding Complaints and Compliments:** A provider will have the opportunity to review and address any compliments or complaints related to their own efforts. The provider shall be advised of any action on the complaint.

**E. Administrative Duties:** Provider failure to complete administrative actions related to patient care (i.e., the timely completion of charts) may lead to a Focused Professional Performance Evaluation (FPPE) after which a professional or credentialing action may be initiated.

**F. Disruptive Behavior:** Supervisors will use the current The Joint Commission (TJC) definition in any finding of disruptive behavior, which may lead to a plan for remediation and in egregious cases may be the cause of a professional or credentialing action.

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**G. Access to Data:** Each provider and his or her representative, if any, shall have full access to their own Provider Credentials File (PCF) and Provider Activity File (PAF). Any data included in the PAF that may be required for transfer, due to ongoing issues, to the PCF and is greater than 2 years old from the last occurrence shall be removed and destroyed according to normal procedures. The provider will be given the opportunity to keep any productivity and computer-generated data prior to its destruction. Data determined to be either erroneous or inaccurate will be removed from the PAF.



**SECTION 4. PEER REVIEW:** Peer Review will be conducted in accordance with JTF CAPMED-M 6025.01, with prior notice to the provider. If the Agency changes or updates JTF CAPMED-M 6025.01, the Union shall be provided notice and given the opportunity to bargain.

**A. Types of Peer Review:**

1. Routine Peer Review: The Agency shall continue the process of analyzing outcomes of chart reviews to identify any trend(s) and/or charting deficiencies. The review shall be based on random selection of charts and rotation of reviewers, within that specialty if possible. This review of day-to-day performance typically focuses on medical records' content and direct observation of Performance and is integral to the PI and competency assessment processes. The provider subject to routine review shall be provided with a copy of all performance assessments upon request.
2. Ongoing Professional Practice Evaluation (OPPE): This is accomplished at nine and eighteen months during the credentialing cycle for all privileged providers as part of the privilege reappraisal/privilege renewal processes may include both quantitative and qualitative data, and is documented in the Provider Activity File (PAF), which shall be made accessible to the provider.

**B. Concerns Identified During the Periodic and Routine Review:** When questions of clinical competency arise either by random or periodic review, the supervisor shall consider and address mitigating factors such as staffing, allotted time, resources, rest time, provider health, and documentation/coding issues, if raised by the provider. This shall occur prior to institution of the formal peer review process as outlined below. Non-clinical issues will be handled in accordance with the Adverse and Disciplinary Actions Article of this CBA.

**C. Range of Decisions:** In taking action regarding a patient care matter, the supervisor may consider whether the event should be accorded a low priority on a standardized Patient Safety severity assessment (such as the AHRQ Harm Scale) and may decide to take no action other than tracking, trending and subsequent aggregate review analysis of the adverse event.

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**D. Indirect and Direct Supervision:** In response to an incident, prior to any peer review process, the supervisor may take other actions, including electing to implement a direct level of supervision, which may include indirect supervision, direct supervision (including verbal direct supervision), and physically present direct supervision.

**SECTION 5. ACTIONS AGAINST PRIVILEGES:** Evidence of deficits in medical knowledge, expertise, or judgment (competence); unprofessional, unethical, or criminal conduct (serious misdemeanor or felony) (conduct); or mental health disorders or alcohol/drug impairment (condition) that reduce or prevent a provider from safely executing his or her responsibilities in providing healthcare may result in action taken against a provider's privileges (professional's scope of practice). Actions can be taken by the MTF Director based on performance, suspected or deemed not to be in the best interest of quality patient care.

**A. Abeyance or Suspension During an Investigation:** Clinical privileges/practice may be placed in abeyance or on summary suspension while a thorough and impartial investigation is conducted. This fact-finding period allows time to gather and carefully evaluate additional information regarding the situation prior to initiation of a definitive privileging/practice action.

**B. Formal Peer Review:** Peer review in the context of an adverse privileging/practice action is a sequential formal process to assess the quality of care delivered by a provider. This review could involve fact finding, study, and analysis of a single incident that resulted in significant harm to a patient, or a series of events involving a professional's performance or conduct in the context of a possible adverse privileging/practice action. The purpose of this review is to examine information obtained from the structured, unbiased investigation/inquiry and any other relevant materials.

1. **Timing:** Ideally, the peer review should be conducted as soon as possible after identification of the incident, circumstance, or behavior for which a peer review is warranted.
2. **Notification:** The Provider will be notified at the conclusion of each stage of the results and the next step. The Provider undergoing Peer Review is entitled to due process, which includes the right to submit information at any stage in the process, with the assistance of a personal or Union representative if, they so choose. The period for review (look back) shall ordinarily be no more than two years.
3. **Conduct of Review:** The initial review, either prior to or because of a suspension or abeyance, shall be conducted only by a disinterested investigator who is a peer, i.e. one from the same professional discipline/specialty as the individual undergoing review and shall be non-adversarial, conducted in a collegial climate, and be focused on obtaining all relevant information about the situation. Findings conducted by the reviewing investigator must be presented to a credentialing committee constituted IAW JTF CAPMED-M 6025.01. The Committee will make recommendations to the Director on the appropriate privileging action per this Section 5C.

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4. **Notification of Formal Peer Review:** If the credentialing committee recommends a formal action against a provider, and the Director concurs, the provider will be notified that a Formal Peer Review Panel will be convened.
5. **Peer Review Panel:** If at the completion of the Review Panel, formal action is taken against a provider's privileges, the provider will be given notice of fifteen (15) calendar days to make a written request for a Formal Hearing as outlined in JTF CAPMED-M 6025.01. In order to ensure the right to appeal, the provider must request and attend a formal hearing. Absent a hearing, the recommendation of the panel will result in the institution of the privileging action notification of the appropriate agencies.
6. **Appeal:** Following a formal hearing, the provider may appeal the decision as outlined in JTF Manual 6025.01.

**C. Restoration of Privileges and/or Remediation:** Privileges may be restored at any time during the peer review process and/or a plan for remediation instituted if indicated.

**D. Adverse Actions:** Types of actions against provider privileges include denying, suspending, restricting, reducing, and revoking clinical privileges/practice. Revocation of clinical privileges may result in termination of employment. Appropriate adverse privileging/practice actions may be recommended by the credentials committee to the MTF Director.

**SECTION 6. PROBATIONARY EMPLOYEES:** Credentialed Providers who are probationary employees may be terminated for non-disciplinary reasons only after a Summary Board Review is conducted. The employee will be given a fifteen (15) day notice, except that the notice period may be shortened if necessary to effect the separation before completion of the probationary period. The employee, on request, will be furnished a copy of the summary report of the Professional Standards Board proceedings, along with a transcript of any verbatim recording.

**SECTION 7. PHYSICIAN WELLNESS PROGRAM:** The Agency shall establish a Physician Wellness Program on a strictly voluntary basis. Management of the Physician Wellness Program will be in accordance with the Sections 4-7 of the EAP Article of this CBA. A provider may self-report and ask to participate in the Program. The decision to participate in the Physician Wellness Program shall not be used to either advantage or disadvantage a provider in regard to work assignments, performance appraisal, or in any other way. Strict confidentiality shall be maintained in all aspects of the Physician Wellness Program, including of the participating provider's peers in any monitoring or assessment of participation.

**SECTION 8. UNION REPRESENTATION:** The right to Union representation (i.e., Weingarten) will apply in peer review cases. There is a right to Union representation for Focused Professional Practice Evaluations (FPPE) but only where adverse action may be contemplated. The provider may make a written response or submission at any phase of any peer review process, and may have a personal or Union representative present, who shall be entitled to speak for the record at all phases of peer review (except for deliberations of a Panel).

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**SECTION 9. COMMITTEES AND FORUMS:**

**A. Provider LM Forum:** Using the Labor Management Forum process, the Parties agree to establish a Joint Labor Management Providers Forum at the NCR-MD level.

**B. Executive Committee of the Medical Staff (ECOMS):** Prior to the bi-annual staff meeting, bargaining unit employees will be provided notice of any vacancies on ECOMS for the two medical provider or two licensed independent provider positions elected by the medical staff. Such notice shall be provided concurrently to the Union. If no bargaining unit medical providers are elected to any ECOMS position, the Union will be entitled to appoint at least two observers to the ECOMS who shall be from among the medical staff. The observers (if any) shall be on duty time when participating in ECOMS activities.

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