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Internet Resources

MEDINSGEN Website

<https://nmp.med.navy.mil/>
(After logging in, click on the "TOOLS" tab at the top of the page and then select the "Navy Medical Inspector General" link.)

MEDINSGEN Self-Assessment Tool

(To access follow directions above and click on Self-Assessment Tool icon)

Naval Inspector General Website

<http://www.iq.navy.mil/index.htm>

MEDINSGEN Message

The Medical Inspector General team wishes all of Navy Medicine a very successful and fulfilling New Year. As we look forward to 2010, it is also a time to reflect on the past year. During FY 2009 inspections, the most common requirements for improvement included Self-Assessments for Industrial Hygiene as well as the Safety Program; Population Health; Command Evaluation Program and HMSB/TCCC training requirements. The most common Joint Commission findings were in the areas of Environment of Care and Life Safety. The other top three included National Patient Safety Goals, Provision of Care and Control of Infection. Our first newsletter of 2010 highlights many key programs and functions within our military treatment facilities and over the upcoming year we will be focusing on those programs that are the most challenging and problem-prone. I encourage you to share this newsletter with your staff as it contains a wealth of information. Combine our newsletters with the MEDINSGEN Self-Assessment worksheet and you have a valuable set of tool for continuous mission preparedness. As always, if you have any recommendations for how the MEDINSGEN team can improve our own processes, please email me or any members of the team. We have included our email addresses and phone numbers below.

Have a wonderful 2010!

CAPT P. K. Roark
Medical Inspector General

The Role of Leadership in Patient Safety

By CAPT Bruce Boynton, MC, USN
DEPMEDINSGEN

Mission accomplishment requires committed leadership, an observation that is as true for patient safety as any other area of Medical Treatment Facility operations. Recently, The Joint Commission highlighted the role of leadership in promoting patient safety in a Sentinel Event Alert.

All healthcare organizations erect processes and defenses to protect patients from human error. However, such defenses always have weaknesses, not unlike the holes in a slice of Swiss cheese, and these weaknesses make patients vulnerable to the effects of human error. When our defensive systems and processes fail patients are endangered. Therefore, something more is needed: leaders must create a culture of safety. A culture of safety is one in which leaders are aware of the complex interactions in clinical operations and how changes in one area effect operations in another. Leaders in an organization with a culture of safety are proactive, ask tough questions and break down the barriers between departments to ensure patients are cared for safely. Leaders must also commit the resources needed to protect patient safety. Finally, and perhaps most importantly, a culture of safety focuses on the patient, not the regulation. Safety must make sense.

Inadequate leadership was a contributing factor in half of the sentinel events reported to The Joint Commission in 2008. The Joint Commission standards require the chief executive, governing body and medical and clinical staff to create a culture of safety by:

- 1) Creating an atmosphere of trust that encourages staff to report adverse events

Joint Commission Website

<http://www.jointcommission.org/>

- 2) Allocating resources necessary to support a safety program
- 3) Discussing and reporting safety issues and indicators
- 4) Developing plans to improve safety performance

The entire report includes suggested actions for senior leadership, and can be read at the site below: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_43.htm.

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CAPT Linda Grant, NC, USN
BUMED

TJC has revised a number of NPSGs. Revisions include clarifying and streamlining certain elements of performance, moving some requirements to standards, and deleting others. These improvements were initiated to ensure the goals are relevant and focused to every applicable setting.

TJC has made an effort to highlight subjects that are 'of the highest priority to patient safety and quality care'. One of the well known goals, Universal Protocol, has been revised. Several requirements have been eliminated and some have been modified. However, there continue to be requirements that must be met.

Medication reconciliation remains, but will not be scored at this time because it is still being evaluated and refined. They expect a revised version will be available for field review sometime in the spring. Surveyors will still evaluate your processes for medication reconciliation, but findings will not factor into final accreditation decisions. MTFs should still be working on this important process for their patients.

Remember, although there are no new requirements for 2010, MTFs will be expected to be fully compliant on 1 January 2010 with the requirements for NPSG.07.03.01 through 07.05.01. These are the goals related to health care-associated infections that were to be phased in during 2009.

Diversity

By CAPT Bruce Boynton, MC, USN
DEPMEDINSGEN

When Admiral Mullen was the Chief of Naval Operations his Diversity Policy began with the statement, "Diversity is a strategic imperative for the United States Navy." Despite this top level emphasis, Medical IG surveys of BSO 18 Diversity Programs find that many commands do not understand the intent of the policy or the program requirements.

The intent of the Diversity Program is to promote and engender a workplace culture that attracts the best and brightest, embraces cultural differences as a source of strength, mentors and retains its members, and communicates these values. Diversity does not consist of merely ensuring equitable treatment under law or participating in cultural heritage celebrations.

The Navy Medicine Diversity Program requirements are outlined in BUMEDINST 5300.12. Echelon 4 Commanding Officers must:

- 1) Appoint a Diversity Action officer to coordinate local activities.

- We suggest that the Diversity Officer be someone other than the Command Equal Opportunity Officer (CMEO) and that the appointment be in writing.
- 2) Incorporate Diversity into the annual training plan, command newsletter, etc. Examples include cultural heritage celebrations and staff orientation programs.
 - 3) Partner with local schools for Diversity pipeline and outreach efforts. Examples include Science Internships for local college students, Big Brother and Big Sister programs, Junior Achievement, tutoring at local schools and sponsoring and judging local science projects.
 - 4) Encourage staff to participate in "peer to peer" recruiting programs. Examples of this include staff participation in community and professional organizations, enlisted career days and mentoring programs. Retaining existing talent is as important as recruiting new talent.

It is important for a Command to document its Diversity activities. We often find that commands are involved in many wonderful, but undocumented, recruiting, mentoring and outreach projects that they had not thought of as part of their Diversity efforts.

Command Managed Equal Opportunity (CMEO) Program

By HMCM (SW/FMF) Kevin Smith, USN
MEDINSGEN Staff

Commanding Officers and Officers-in-Charge shall create, shape, and maintain a positive Equal Opportunity (EO) environment through policy communication, training, education, enforcement, and assessment. The CMEO program is intended to be one of many Commanding Officer tools for the prevention of unprofessional behavior and ensuring EO goals are obtained. All BSO-18 commands are required to have a robust and all encompassing CMEO program, which includes, a trained Command Training Team (CTT), Command Assessment Team (CAT), and facilitate Navy Pride and Professionalism (NPP) training.

Overall the CMEO programs surveyed within the last six months are largely in compliance with current directives, however below are a few areas that commands should pay specific attention to when evaluating the CMEO program:

- Commanding Officers shall ensure Defense Equal Opportunity Management Institute Climate Survey (DEOCS) is completed within 90 days of assuming command and then annually thereafter.
- Develop a Plan of Action and Milestone and implement actions as necessary to address findings of DEOCS.
- Submit an executive summary of DEOCS to the Bureau of Medicine and Surgery (BUMED) Equal Opportunity Advisor (EOA) via ISIC within 60 days.
- Ensure commands have a properly composed CAT membership and ensure CAT members have completed required training.
- Ensure NPP facilitators have completed required CTT training prior to presenting NPP. NPP shall be provided within 30 days of members reporting per OPNAVINST 1740.3C, Command Sponsor and Indoctrination Programs.

Commands are highly encouraged to periodically evaluate the EO program using the CMEO checklist provided in OPNAVINST 5354.1F, Navy Equal Opportunity Program. Most importantly, commands shall maintain a dynamic EO program which promotes an environment in which all personnel can perform to the maximum of their ability without institutional or individual biases.

Organizational Performance Improvement Network-OPIN

By CAPT KIM LEBEL, NC, USN
MEDINSGEN Staff

A well used email group located on the global address list as OPIN-2009 is a network that exists today as a powerful resource for obtaining needed instructions, forms and various documents that assist organizations with Joint Commission accreditation, Navy policy and patient safety regulation compliance. Admiral Cowan once said to a group of us old hats at a PI conference, "Steal with rat like cunning" and from that statement the network was born as a means to share ideas, instructions, policies, and get clarification on processes that were not yet clear or evolving. It is much easier we learned to borrow and tweak an existing document than write one from scratch.

The OPIN was created approximately ten years ago by Performance Improvement (PI) Coordinators to communicate and help each other comply with multiple requirements in the absence of BUMED guidance. The OPI group asked Admiral Martin in the late 1990s why was there no Quality Manager at BUMED. She informed them that there once was a billet but it had been gapped for several years. Shortly thereafter Captain David McCarthy filled that billet at BUMED. By the time he arrived all corporate knowledge of the positions function was lost. He began working to reestablish the BUMED quality connection along side Ms Carmen Birk the corporate Risk Manager. There have been a couple of unsuccessful attempts to update the Quality Assurance BUMED instruction (6010.13) over the past years however Captain Linda Grant who succeeded Captain McCarthy reports that the existing Quality Assurance instruction dated 1991 has been completely reconstructed to reflect today's practices, renamed and is making its way through the approval process. There is no estimated date of release at this time.

The historical development of Organizational PI began in 1984 when PI was Quality Assurance (QA). QA had short-term goals and retrospective reviews that often resulted in disciplinary actions for problems that were inappropriately blamed on poor performance. By the early 1990's the approach changed to a systematic and scientific focus on the process performance rather than that of the staff which elevated QA to Quality Improvement (QI). By the late 1990's QI evolved into PI as systems theory became the basis to organizational improvement as a means to understand complex process problems. By the 2000's Navy Medicine's business model had changed. Operational efficiency and effectiveness had become key components to business operations for BSO-18 Military Treatment Facilities. The drive to reduce cost, improve customer satisfaction and improve care quality moved us into a new era of defect assessment which today has become Lean Six Sigma.

The OPIN therefore is an invaluable medium to obtain information for personnel who are in need of most anything compliance based. Anyone can access the mail group from the global address list in Outlook. Select OPIN-2009 and release your question to most experienced and knowledgeable systems thinkers the Navy has to offer. Many of the people registered to OPIN-2009 are seasoned Performance Improvement Professionals who are belted in Lean Six Sigma, or Certified Professionals in Health Care Quality or both. The Joint Commission Fellows are there as well. New PI staffers should contact the mail group owner, Virginia Nava at Navy Medicine West to request inclusion. We reserve the right to maintain it as an exclusive PI group with limited member access.

Mental Health Routine Access to Care

By CDR Scott Pyne, MC, USN
MEDINSGEN Staff

It is difficult to miss commentary on the challenges of mental health care for our military in this time of war. The Washington Post, USA Today, Los Angeles Times, National Public Radio, and many other news outlets frequently address the mental health of our returning service members from Afghanistan and Iraq. This is especially critical in response to tragic events like Fort Hood, Texas and Camp Liberty, Iraq.

In June 2007 in response to the Department of Defense (DoD) Task Force on Mental Health, Health Affairs provided guidance for access to mental health care with HA POLICY 07-022. This stated that, "All initial appointments to evaluate a Service or family member's new or reemerged behavioral health need are considered primary care and will be evaluated by a provider, who is professionally capable and specifically privileged to perform mental health assessments." Beneficiaries may request behavioral health assessments within Emergency, Urgent or Routine time frames. Accordingly Navy Medicine issued NAVMED POLICY 08-001 supporting the Health Affairs Policy and further directing that, "... Military Treatment Facilities (MTFs) will now use the routine (ROUT) appointment type in both primary care and mental health clinics to provide the same level of access to mental health services as for other medical conditions." The MHS Guide to Access Success provides details on incorporating routine and other appointment types into clinical templates.

MTF access processes are reviewed during Medical Inspector General (MEDIG) visits and in preparation, MHS Insight and TRICARE Operations Center tools and data are analyzed for access standard compliance. Recent observations have been made in regards to Mental Health Access to Care. Some MTFs have not modified their mental health templates to reflect routine appointment types and several who have are not able to meet the 90% access standard of 7 days for routine appointments. Interestingly these MTFs often easily meet or exceed their specialty (SPEC) access standard of 28 days. Some of these inconsistencies may be the result of booking processes within the MTF. These issues were indirectly addressed recently during the November 24, 2009 Corporate Executive Board review of Patient Satisfaction data for access to mental health care.

I encourage MTFs to review their Mental Health Clinic templates ensuring the inclusion of routine (ROUT) appointments and to review their appointing processes into specific appointment types. The TRICARE Operations Center's Template Analysis Tools Access to Care Summary Report and Archive may be used to monitor compliance. <http://mytoc.tma.osd.mil/#>

List of Inspected MEDINSGEN Programs

Deployment Readiness

- Health Services Augmentation Program (HSAP)
- Hospital Corpsman Skills Basic (HMSB)/Tactical Combat Casualty Care (TCCC) Programs
- Independent Duty Corpsman (IDC) Program
- Periodic Health Assessment (PHA) for Individual Medical Readiness (IMR)

Effective Force Health Protection

- Antiterrorism, Force Protection and Physical Security
- Deployment Health Assessments
- Emergency Management Plan
- Limited Duty Program
- Operational Forces Medical Liaison Services (OFMLS)

People

- Awards and Recognition Program
- Bachelor Quarters' Management
- Civilian Drug Free Workplace Program
- Civilian Personnel Management
- Command Managed Equal Opportunity (CMEQ) and Command Assessment Program
- Command Sponsor and Indoctrination Program

- Diversity Program
- Drug and Alcohol Program Advisor (DAPA) Program
- Echelon V/VI Oversight (if applicable)
- Education and Training Program
- Good Order and Discipline Program
- Navy Family Ombudsman Program
- Navy Performance Evaluation System (Fitness Reports and Enlisted Evaluations)
- Navy Retention and Career Development Program
- Navy Voting Assistance Program
- Off-Duty Employment Program
- Physical Readiness Program
- Staff Supervision of Physician Trainees (if applicable)
- Urinalysis Program

Quality of Care

- Access to Care
 - AHLTA
 - Health Information Management
 - Medical Records Management
 - Custody and Control
 - Record Retirement
 - Protected Health Information
 - Medical Records Coding
 - Medical Records Review
 - Medical Records Forms Management
 - Information Management/Information Technology
 - Navy Records Management Program
- Population Health
- Referral Management

Patient and Family Centered Care

- Case Management Program
- Customer Relations Program
- Educational and Developmental Intervention Services (EDIS) (if applicable)
- Pastoral Care Program (if applicable)
- Sexual Assault Prevention and Response Program
- Staff and Beneficiary Surveys
- Performance Based Budget
- Fraud, Waste and Mismanagement Program
- Standard Organization Compliance
- Research and Development

Human Research Development

- Human Research Protection Program
- Biosurety
- Research Ethics

Financial Resources Management

Materials Management

Safety and Occupational Health