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Off-Duty Employment Program

By HMCM (SW/FMF) Kevin Smith, USN
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Off-duty remunerative professional civilian employment, including self-employment of active duty Medical Department officers referred to as the Off-Duty Employment Program is directed by Department of Defense policy and Bureau of Medicine and Surgery directives and is subject to the following general policy guidelines:

No Medical Department Officer on active duty shall engage in any off-duty employment without first obtaining the permission of the Commanding Officers. Permission for an Officer to engage in off-duty employment shall be based on a determination by the Commanding Officer that the permission requested is consistent with these guidelines and that the proposed employment will not interfere with the officer's military duties. If approved, employment will normally not exceed 16 hours per week. Permission to engage in off-duty employment may be withdrawn at any time.

A Medical Department Officer in off-duty employment shall not assume any primary responsibility for the care of any critically ill person on a continuing basis as this will inevitably result in compromise of responsibilities to the patient, or the primacy of military obligations. Medical Department Officer trainees are prohibited from off-duty employment.

Off-duty employment shall not be conducted on military premises, involve expense to the Federal government, nor involve use of military equipment, personnel or supplies. Military personnel may not be employed by Medical Department Officers involved in off-duty employment.

Off-duty employment shall not interfere, nor be in competition, with local civilian practitioners in the health professions and must be carried out in compliance with all applicable licensing requirements. To ensure this, a statement shall be provided from the appropriate local professional association indicating that there is a need for the individual's service in the community. Local licensing requirements are the responsibility of officers wishing to engage in private practice.

MEDIGEN Website

<https://navymedicine.med.navy.mil/>

(After logging in, click on the "BUMED" tab at the top of the page and then select the "Medical Inspector General" link.)

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Naval Inspector General Website

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

Joint Commission Website

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

Those engaging in private practice are subject to all requirements of the Federal narcotic law, including registration and payment of tax.

There may be no self-referral from the military setting to their off-duty employment on the part of the military Medical Department officers. No Medical Department officer on active duty in off-duty employment may solicit or accept a fee directly or indirectly for the care of a member, retired member, or dependent of such members of the uniformed services as are entitled to medical or dental care by those services.

Medical Department Officers requesting permission to engage in off-duty employment shall submit their request to the Commanding Officer on NAVMED 1610/1, Off-duty Remunerative Professional Civilian Employment Request, and shall sign the Statement of Affirmation in the commanding officer's presence or designee.

The Commanding Officer has primary responsibility for control of off-duty employment by Medical Department Officers. Guidelines listed above serve as basis for carrying out this responsibility. Recent Medical Inspector inspections reveal a lack of consistent documentation of proper enrollment, annual verification and summary records for monitoring compliance of the off-duty employment program. Commands are encouraged to review the MEDIG program Self-Assessment Tool available on the MEDIG homepage to assess compliance of their local program.

ORAL CANCER RISK ASSESSMENT

By CAPT Bart Knox, DC, USN
MEDIG Staff Inspector

One element of the "Dental Population Health/Disease Management" program inspected by the MEDIG is BUMEDINST 6600.16A Oral Disease and Risk Management Protocols in the Navy Medical Healthcare System. The instruction directs that levels of risk for developing dental caries, periodontal diseases, and oral cancer are determined for each patient during their annual or periodic dental examination and recorded in their dental treatment record.

A common finding during MEDIG inspections is a relatively high percentages of patients at high risk for oral cancer. The majority of these high risk oral cancer classifications have been due to incorrect oral cancer risk assessments during the annual dental exam. Early diagnosis and treatment are vital to improved survival rates, so it is critical that accurate classification and prompt follow up occur for patients identified as high risk. Determination of oral cancer risk classification will prompt treatment protocols specific to the risk category as outlined in enclosure (6) of the cited instruction. Patients are classified as high oral cancer risk due to the presence of a potentially cancerous oral lesion.

These patients require follow-up in 7-10 days, a biopsy if no change is seen at the follow up visit, and oral cancer risk education per enclosure (9) of the instruction.

Moderate oral cancer risk patients have no questionable lesions and one or more of the following risk factors: Tobacco use, moderate to heavy alcohol use (>2 drinks per day), and age 55 or older. These patients require oral cancer risk education per enclosure (9) of the instruction and one year recall.

Due to the large number of patients that have been incorrectly classified as high risk for oral cancer, one of the first steps is to correct the classification of oral cancer risk patients and ensure subsequent risk level classifications are accurate, including in records received at check-in. Dental clinics are highly encouraged to conduct a comprehensive review of all dental records of patients classified as high risk for oral cancer to evaluate compliance with assessment guidelines in the instruction. Risk level classifications must be corrected in the dental record after appropriate reviews, which may include patient recall. Dental Common Access System (DENCAS) entries must also be updated. As required, the clinic should provide training and calibration to ensure providers conduct accurate oral cancer, caries, and periodontal risk assessments and follow protocols in accordance with the BUMED instruction. Finally, the clinic must ensure a recall system is in place for all high risk oral disease patients. Please refer to the MEDIG website, Self-Assessment Tool “Dental Population Health/Disease Management” program assistance to ensure that your command is in compliance.

Pitfalls for The Hospitalman Skills Basic (HMSB) and Tactical Combat Casualty Care (TCCC) Program

By CAPT Scott Pyne MC, USN
MEDIG Staff Inspector

BUMEDINST 1510.23C was released 24 JUN 2009 with a purpose to establish guidelines to enhance operational readiness of Hospital Corpsmen (HM). This Navy program is one of many inspected by the Medical Inspector General and has seen an increase in findings during recent command surveys.

To summarize the instruction, Commanding Officers are responsible for five elements within the program: 1) Implement a formal HMSB Program and exercise responsibility for the training, 2) Ensure all HMs (E-1 through E-7) complete competency training in all five skills of HMSB, 3) Ensure standardized training program, adequately trained instructors and appropriate documentation of HMSB validation, 4) Ensure all HMs complete the EMWBT, and 5) Ensure deploying HMs are schedule to attend the TCCC course.

Completion of HMSB is required within 90 days of reporting to the first BSO-18 command and revalidated within 90 days of deployment. TCCC shall be completed within 180 days of deployment notification to an Individual Augmentation (IA) or Health Service Augment Program (HSAP) assignment.

Overall commands have very robust HMSB training programs that are well organized and conducted according to guidelines. The predominant finding is a failure to ensure that all HMs, E-1 through E-7, have completed HMSB training within the established 90 days of reporting to their command.

Three common deficiencies have been noted in this assurance of training. HMs who have served at several operational and BSO-18 commands may not have evidence of completion of HMSB training. The gaining BSO-18 command should ensure completion of HMSB training for all E-1 through E-7 within 90 days of reporting. If the training cannot be verified it is the command's responsibility to ensure its completion.

Personnel assigned to branch clinics have often failed to complete HMSB training. Commands must ensure all of their personnel, regardless of their assigned location of work, complete this requirement. Finally and most commonly, commands often do not have a mechanism to ensure that eligible personnel complete HMSB training within the 90 day requirement. Managers of this program may maintain separate training compliance spreadsheets; routinely pull DMHRSi data; or develop another mechanism to track completion rates, but they must be able to demonstrate completion of training within established timelines.

Overall commands are doing a fine job with HMSB training, but need to focus on ensuring all eligible HMs have training documentation and develop a means to document they have met the 90 day timeline.

Navy Records Management Program - Development and Maintenance of File Plans

By LCDR James Perry, MSC, USN
MEDIG Staff Inspector / Investigator

Navy records management is an important part of ensuring that the business of a command is maintained according to Instruction and policy and the decisions made by the commands senior leadership. The creation of such records and their utilization for their intended purpose is not the end of their story, how and where they are maintained as well as their disposition is equally as important.

The two systems of maintenance of Navy Records are either centralized or decentralized. Both equally valid and are utilized throughout the Navy Medicine Enterprise, but the key to maintaining Command Records is the development of file plans.

As described in BUMEDINST 5210.10 file plans are to be developed and reviewed annual to ensure maintenance and disposition of command records are being followed. These file plans identify Standard Subject Identification Code (SSIC), record title, record format, location maintained, media type, and whether the record is of a vital nature. If a centralized system is established, the file plan is to be located in the area where command records are located.

The file plan can be held within the Command Records Program Binder or in a specific drawer of the secure record retention area where the records are held. If a decentralized system is established, individual specific file plans that are held in defined areas of the command by approved and appointed records custodians must be established.

These file plans are usually limited to a few specific record types specific to the day to day business that may be carried out by a Department Head or Director and as with a centralized file system, file plans should be held within a Command Records Program Binder, and held by each records custodian or with the records maintained by the custodian.

Whether or not the command has a centralized or decentralized file system, the Command Records Coordinator is to maintain a master file plan of all record types developed and maintained by the command. Though Commanding Officers may authorize a decentralized file system, the designated authority for the Navy Record Management Program lies with the Command Navy Records Program Manager. This being the case, it is their responsibility to ensure that file plans are established and up to date in regards to their day to day maintenance and disposition of the commands records through regular file plan review.

Mental Health Evaluations

By Ms Sonja Pyle, (Ret. NC, USN)
MEDIG Staff Investigator

One of the various types of hotline cases presented to the Medical Inspector General's office that has a high substantiation rate is alleged improper mental health evaluations (MHEs). The Department of Defense(DoD), Directive 6490.1 defines a MHE as "a clinical assessment of a service member for a mental, physical, or personality disorder, the purpose of which is to determine a Service member's clinical mental health status and/or fitness and/or suitability for service."

This does not include self-referral (or voluntary referral), diagnostic referral by a physician not in the member's chain of command, responsibility/competency inquiries, Family Advocacy Program, drug/alcohol rehab programs or evaluations required by Service regulations. DoD Instruction 6490.4, provides guidance to mental healthcare providers and Commanding Officers regarding evaluations, treatment, and recommendations for administrative management of service members referred for mental health evaluations who may suffer from serious mental disorders and who may be imminently or potentially dangerous.



Allegations of improper MHEs can be avoided by following the procedures outlined in the two DoD instructions mentioned above and the following: Non-emergent referrals can only be made by the Commanding Officer, Commanding Officers must consult with the mental healthcare provider, send a memorandum to the Commanding Officer of the medical treatment facility, Commanding Officers of military treatment facilities who wish to refer a Service member for a non-emergency MHE shall forward to the chairman of that mental health department a memorandum formally requesting the MHE; and at least two business days in advance provide the member a referral memorandum including a statement of rights.

Commanding Officers should provide appropriate periodic training for all Service members and DoD civilian employees in the initial management and referral of service members who are believed to be imminently dangerous. Supervisors should be aware that if they believe one of their staff needs a MHE and is so convinced that they “threaten” the member, they should just inform the Commanding Officer that the staff member requires a MHE. The Commanding Officer than can do a command directed referral and, if done correctly, there should not be any problems.

If a member is willing to go voluntarily, the supervisor should not be involved at all and, in most cases, probably should not even know about it. When a supervisor threatens the service member by saying something to the effect of, “If you do not go voluntarily, we will go to the Commanding Officer and inform him/her in order to do a mandated exam,” and the service member does go after this “coercion”, she/he is not there voluntarily. When this is done, allegations of improper MHE can be substantiated as this is coercion. To avoid any potential of an improper MHE, refer strictly to DoD Directive 6490.1 and DoD Instruction 6490.4 and/or your local behavioral health department.