DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
WASHINGTON D C 20372-5120

IN REPLY REFER TO
BUMEDINST 6010.13
BUMED-3C4
19 Aug 91

BUMED INSTRUCTION 6010.13

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: QUALITY ASSURANCE (QA) PROGRAM

Ref: (a) DoD Directive 6025.13 of 17 Nov 88 (NOTAL)
(b) BUMEDINST 6000.2D (NOTAL)
(c) Accreditation Manual for Hospitals, current edition
(d) Ambulatory Healthcare Standards Manual, current edition
(e) BUMEDINST 6320.66
(f) NEHC-TECH 89-1 for Nosocomial Infection Control Manual for Inpatient Facilities
(g) NEHC-TECH 89-2 for Nosocomial Infection Control Manual for Ambulatory Care Facilities
(h) BUMEDINST 6600.10
(i) Title 10, United States Code, Section 1102 (NOTAL)
(j) SECNAVINST 5720.42E
(k) SECNAVINST 5211.5C

Encl: (1) Definitions and Acronyms
(2) Clinical Performance Profile Reporting Format
(3) Potentially Compensable Events (PCEs) for Medical and Dental Treatment Facilities
(4) Case Abstract for Malpractice Claims Instruction Sheet, DD 2526
(5) Shore MTF and DTF Management Information Report Format, MED 6010-24
(6) Operational MTF and DTF Management Information Report Format, MED 6010-25

1. Purpose. To establish policy, publish procedures, and assign responsibility for quality assurance (QA) and risk management (RM) activities in Navy fixed (shore-based with permanent structures) and nonfixed (moveable shore or fleet-based) medical and dental treatment facilities (MTF and DTF) per reference (a).

2. Cancellation. NAVMEDCOMINST 6010.6 and NAVMED 6010/20.

3. Background. The Chief of Naval Operations (CNO) and the Commandant of the Marine Corps (CMC) are committed to providing the highest quality medical and dental care to Department of the Navy (DON) beneficiaries. The QA program was originally issued

in 1984 to standardize QA activities within Naval Medical Command MTFs. Naval Medical Department policy, procedures, and responsibilities for naval DTFs ashore and afloat were issued in 1987 and incorporated into this instruction in 1989. This instruction:

a. Updates and recognizes the experience and creativity of Navy health care personnel who continue to contribute to the evolving QA program of the naval Medical Department.

b. Outlines a compilation of basic component activities and functions key to QA program success.

c. Encourages innovative local efforts to document the delivery of continually improving quality medical and dental care through an optimally efficient and effective QA program.

d. Provides a list of definitions and acronyms used within the instruction in enclosure (1).

4. Applicability. Applies to all health care personnel providing services in naval MTFs and DTFs, fixed and nonfixed.

5. Policy. All active duty (ACDU), Reserve, and civilian medical and dental personnel must participate in ongoing monitoring and evaluation processes designed to assess the quality and appropriateness of the services they provide.

a. All fixed and nonfixed MTFs and DTFs must implement a QA program. The program will incorporate, at a minimum, applicable elements outlined in this instruction.

b. Consistent with references (b) through (d), fixed MTFs and DTFs meeting applicable criteria must gain and maintain accreditation by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission, JCAHO).

c. Individuals responsible for QA program management must be afforded educational opportunities commensurate with their responsibilities. Education may be inservice military or outservice civilian sponsored. QA education for key program managers must be sufficient in scope and frequency to enable effective program oversight.

d. Information derived through the QA process and other continuous quality improvement (CQI) activities must be used to support performance appraisal for privileged practitioners, clinical support staff, and other health care personnel.

e. Information derived through the QA process must be used in tailoring facility inservice education programs.

f. Routine QA program-related documentation must be maintained in a secure location for a period of 5 years before disposal. QA inquiries and medical records related to a potentially compensable event (PCE) and Judge Advocate General (JAGMAN) investigations must be maintained in a secure location at the local command for a minimum of 2 years or as long as needed thereafter.

6. QA Program Objectives. Specific objectives of all medical and dental QA programs are to:

a. Systematically monitor services provided to identify opportunities to improve patient care.

b. Identify, assess, and decrease risk to patients and staff thereby reducing exposure to liability.

c. Justify resources needed to maintain and preferably exceed acceptable standards of patient care service.

d. Communicate important QA information to effect sound clinical and management decision-making at all levels of the organization.

e. Integrate, track, and trend QA information to identify significant patterns or processes which may need indepth review, addressed by CQI techniques or other intervention.

f. Support credentials review and privileging activities following reference (e).

g. Identify educational and training needs.

h. In fixed MTFs that meet criteria for accreditation, per reference (b), gain and sustain compliance with Joint Commission accreditation standards.

7. QA Program Requirements

a. The program is guided by a plan. At a minimum, the plan includes:

(1) Program objectives.

(2) Organization and responsibilities.

(3) Scope of the QA program to include the methodology for obtaining customers' input on quality.

(4) Required QA functions including what is to be done, by whom, and how frequently.

(5) Information flow and review needs.

(6) Annual review of program effectiveness with revision as necessary.

(7) Methodology by which data generated by the QA program is used to continuously improve the command and patient care.

b. The program is structured to permit innovative approaches, creativity, and variations in local processes.

c. The program generates validated facility and provider specific information concerning patient care services (both positive and negative) from criteria-based peer review activities and functions.

d. The program ensures the participation of all personnel in monitoring and evaluation of the quality and appropriateness of patient care services they provide. Monitoring and evaluation activities include:

(1) An ongoing, planned, and systematic approach to information collection.

(2) Comprehensive monitoring activities that encompass all aspects of patient care services provided by the clinical and support services, trainee groups not permitted to practice independently, and administrative staff.

(3) Use of predetermined written criteria that reflect current knowledge and clinical experience to evaluate services provided.

(4) Evaluation of information collected to identify opportunities to improve patient care services, clinical performance, and support service processes.

(5) Integration of information derived from monitoring and evaluating activities with appropriate departments and services to aid facility-wide tracking and trending of information.

(6) Documentation of findings, conclusions, recommendations, actions taken, and followup of actions taken to ensure problem resolution.

(7) Communication of appropriate information through established channels.

(8) Use of practitioner-specific results of QA monitoring activities, in part, to support staff appointments and the

granting of clinical privileges. Enclosure (2), the Clinical Performance Profile (previously titled the Provider Activity Profile), provides a format for compiling and summarizing individual-specific information per reference (e). The Clinical Performance Profile is an internal document.

(9) Use of QA monitoring activities to support performance appraisal of those not holding clinical privileges.

e. MTF or DTF Facility-wide Functions

(1) All MTF or DTF activities under the cognizance of a privileging authority defined by reference (e) are for QA purposes, an MTF or DTF facility-wide function or program.

(2) Monitoring of Health Care. MTFs and DTFs must have programs for continuous monitoring of the quality and appropriateness of health care. These programs must review data on demographics of patient populations, customer needs and expectations, productivity of the health care facility, access to care, morbidity, mortality, processes of care, outcomes of care, occurrence screening, resources (personnel, facilities, and equipment), and management effectiveness. MTFs and DTFs, with guidance from higher authority, must develop clinical monitoring programs.

(3) RM. All treatment facilities must fully integrate into their QA program RM procedures requiring review of cases and events that represent liability or injury risk to patients and staff, and must recommend methods of decreasing liability risk. The RM program, at a minimum, must include procedures describing review of the following subjects:

(a) All malpractice claims.

(b) JAGMAN investigations.

(c) All PCEs, including at a minimum, those events listed in enclosure (3).

(d) Management variance reports for nonpatient related events.

(e) Results of occurrence screening or other appropriate clinical monitoring processes.

(f) Patient complaints or requests through inspector general (IG), congressional, and patient assistance and contact offices.

(g) Collecting, tracking, and trending of patient contact and patient satisfaction information including procedures for using such information in TQL efforts.

(4) Safety review, including evaluation of actual or potential accidents and injuries.

(5) Infection control surveillance per references (f) and (g), or the Dental Infection Control Program per reference (h).

(6) Utilization Review (UR). MTFs and DTFs will have UR programs to monitor resource use and to recommend ways to balance assigned mission statements with existing health care resources. At a minimum, UR monitoring will include the following subjects:

(a) For inpatient fixed MTFs, planned review of care received by hospitalized patients with excessive lengths of stay for diagnoses, diagnosis related groups (DRG), or procedures as specified by MTF or higher authority.

(b) For inpatient fixed MTFs, policies on discharge planning.

(c) Under, over, or misuse of medical or dental resources.

(d) Review and assessment of resource usage statistics on accessibility of care, personnel and staffing, and volume of care actually delivered to patients.

(e) Equipment maintenance and procurement policies.

(7) Integration of information generated through automated quality of care evaluation systems, if available.

f. Medical staff functions, as applicable under the direction of the executive committee of the medical staff (ECOMS):

(1) Clinical department or service monitoring and evaluation of the quality and appropriateness of important aspects of care. Clinical indicators required by the Joint Commission as well as those developed by the clinical departments must be used. Department or service minutes must document monthly review of the results. Facility-wide occurrence screening, department or service-specific clinical occurrences, and Civilian External Peer Review (CEPR) data are also examples of indicators.

(2) Outcomes of applicable facility-wide monitors (i.e., infection control, UR, and safety review).

(3) Surgical case review.

(4) Blood usage review.

(5) Drug usage evaluation.

(6) Pharmacy and therapeutics review.

(7) Medical record review.

(8) Credentials review and privileging.

(9) Practice volume data.

g. Dental staff functions, as applicable under the direction of the executive committee of the dental staff (ECODS):

(1) Clinical department or service review of monitoring and evaluation of the quality and appropriateness of important aspects of care. Clinical indicators required by the Joint Commission as well as those developed by the clinical departments must be used. Department or service minutes must document monthly review of the results. Facility-wide occurrence screening, department or service-specific clinical occurrences, and CEPR data are also examples of indicators.

(2) Outcomes of applicable facility-wide monitors (i.e., infection control, UR, and safety review).

(3) Dental record review.

(3) Drug usage evaluation.

(4) Credentials review and privileging.

(5) Practice volume data.

h. Nursing staff and administrative staff functions, as applicable, under the direction of the command QA committee.

(1) Monitoring and evaluation of the quality and appropriateness of care by the use of clinical indicators including those provided by the Joint Commission as well as indicators developed locally to monitor important aspects of care in compliance with Joint Commission requirements. In addition, facility-wide occurrence screening and department or service-specific clinical occurrences can be used as indicators.

(2) Practice volume data.

(3) Outcomes of applicable facility-wide monitors (i.e., infection control, UR, and safety review).

8. QA Program Committees

a. Inpatient fixed MTFs must have the following standing committees:

(1) ECOMS. Responsible for all medical staff functions.

(2) QA Committee. Multidisciplinary and provides a forum for discussion and oversight of all nonmedical staff QA functions. An executive management team may perform the command QA committee function if it meets at least monthly.

(3) Safety Committee.

(4) Infection Control Committee.

b. Fixed ambulatory care medical facilities must have the following committees:

(1) ECOMS. There is one ECOMS per individual privileging authority as designated by reference (e).

(2) QA Committee. This multidisciplinary committee is required when there is more than a single professional discipline providing patient care within the facility or type command (TYCOM) under the cognizance of a single privileging authority as defined by reference (e). Some small ambulatory care facilities staffed with physicians and technical support personnel only, may properly address all QA issues through the ECOMS rather than a separate QA committee.

c. In nonfixed medical facilities the privileging authority is required to have an ECOMS.

d. In fixed and nonfixed dental facilities the privileging authority is required to appoint an ECODS.

e. QA program activities may require additional committees to aid program implementation and integration of comprehensive, efficient activities. These activities may be consolidated into multifunction committees with individual functions assigned to specific individuals. If consolidated, the minutes generated must specifically address each review function.

9. Responsibilities

a. Chief, Bureau of Medicine and Surgery (BUMED)

(1) Interprets Department of Defense (DoD), Secretary of the Navy (SECNAV), and CNO policies and provides guidance for Navy-wide QA program implementation.

(2) Monitors implementation and coordination of medical and dental QA programs in fixed (shore-based with permanent structures) and nonfixed (moveable shore or fleet-based) MTFs and DTFs by the Medical IG oversight and healthcare support office (HLTHCARE SUPPO) assistance visits as requested or required.

(3) Provides consultation, educational support, and QA-related information to Navy treatment facilities.

(4) Submits an annual QA program summary report required by reference (a).

(5) Reviews PCEs and malpractice RM data reported centrally by MTFs and DTFs. Uses data abstracted from every malpractice claim for central reporting to the Assistant Secretary of Defense (Health Affairs) (ASD/HA) and to the National Practitioner Data Bank created by P.L. 99-660. MED-3C4 uses enclosure (4) to report to ASD/HA every closed malpractice claim. Provider-specific data elements are not required for those cases closed through administrative denial of payment or where the health care incident occurred before January 1, 1985. Report adjudicated cases after trial and updates or corrections submitted if the results are changed on appeal per enclosure (4).

(6) Serves as liaison with the Deputy Assistant Judge Advocate General (Claims and Tort Litigation) and ensures the completion and accuracy of DD 2526 per enclosure (4).

(7) Maintains a risk management database (RMDB).

b. Fleet Commanders in Chief (FLTCINCs). Ensure that subordinate commanders comply with this instruction.

c. Type Commanders (TYCOM)

(1) Implement and coordinate a TYCOM-wide QA program. TYCOMS may elect to have a fleet-wide medical and dental QA program under the cognizance of the fleet medical and dental officer.

(2) Ensure at a minimum, QA assist visits to each subordinate medical and dental command as required to maintain optimal QA program function.

d. Officers in Charge of Naval Healthcare Support Offices

(1) Provide technical support and assistance for QA-related issues on request to fixed and nonfixed naval medical and dental activities.

(2) Provide technical analysis and recommend corrective action, per reference (b), to fixed MTF commanding officers in regard to implementation status reports to meet the Joint Commission accreditation survey type I recommendations.

e. Commanding Officers, Officers in Charge, and Senior Medical and Dental Department Representatives of Treatment Facilities

(1) Implement an effective, flexible, integrated, and comprehensive QA program, guided by a written plan.

(2) Per reference (b), MTFs meeting the criteria for participation in the Joint Commission survey process must maintain accreditation. Standards for accreditation are outlined in references (c) and (d). All MTFs not meeting the criteria for participation in the Joint Commission survey process, must strive to comply with applicable standards to the extent practical within available resources.

(3) All PCEs per enclosure (3) and all other cases involving serious injury or prolonged disability regardless of whether the patient is in ACDU or civilian status must be included in MTF or DTF databases for analysis and be reported to MED-3C4 using the enclosure (4) format.

f. Naval School of Health Sciences, Bethesda, MD

(1) Conduct two educational workshops each year in the principles, components, and management of QA programs for naval Medical Department personnel.

(2) Periodically evaluate and modify as necessary QA educational programs to meet user and management needs.

10. Reporting Requirements

a. Fixed Medical and Dental Treatment Facilities

(1) MTFs and DTFs (claimancy 18 only) must forward an annual assessment of the preceding fiscal year's QA program to MED-3C4 with a copy to the cognizant responsible line commander and HLTHCARE SUPPO to reach BUMED by 15 January of each year using the enclosure (5) format.

(2) Submit special interest items on request.

b. TYCOMs

(1) TYCOMs with privileging authority as defined by reference (e), must forward an annual assessment of the preceding fiscal year's TYCOM QA program to MED-3C4 with a copy to the cognizant FLTCINC and HLTHCARE SUPPO to reach BUMED by 15 January of each year using the enclosure (6) format.

(2) Forward special interest items on request.

c. Commanding Officers, Officers in Charge, and Senior Medical and Dental Department Representatives of Treatment Facilities

(1) Submit case abstract for malpractice claims, enclosure (4), to MED-3C4 for each PCE review that is required by enclosure (3).

(2) Submit case abstract for malpractice claims, enclosure (4), to MED-3C5 for each JAGMAN investigation initiated.

(3) Submit special interest items on request.

11. Confidentiality. Documents and records created per this instruction are medical QA materials within the meaning of reference (i) and are therefore exempt from the requirements of the Freedom of Information Act, reference (j). Do not disclose such records to any person or entity except as permitted below. Testimony from any person who reviews, creates, or participates in any proceeding that reviews or creates such records may not be required or permitted, with respect to such record, proceeding, or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as follows:

a. To a Federal executive agency or private organization if the record or testimony is needed for licensing, accreditation functions, or monitoring of DoD health care facilities as required by law.

b. To an administrative or judicial proceeding commenced by a present or former DoD health care practitioner concerning the termination, suspension, limitation, or revocation of clinical privileges of such health care practitioner.

c. To a governmental board, agency, or to a professional health care society or organization which needs the record or testimony to perform licensing, privileging, or monitoring of professional standards concerning any health care practitioner who is or was a member or employee of the DoD.

d. To an institution that provides health care services and requires the record or testimony to assess the professional qualifications of a health care provider who is or was a member or employee of the DoD and has applied for or been granted authority or employment to provide health care services for such institution.

e. To an officer, employee, or contractor of the DoD who has a need for such record or testimony to perform official duties.

f. To a criminal or civil law enforcement agency or instrumentality charged with the protection of public health or safety, if a qualified representative of the agency makes a written request for the record or testimony for a purpose authorized by law or in an administrative or judicial proceeding commenced by such an agency, but only with respect to the subject of such proceeding.

g. To an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency referred to in paragraph 5f, but only with respect to the subject of such proceedings.

h. To an individual who makes an appropriate Privacy Act request under reference (k).

12. Reports

a. Risk management case review and malpractice information reports are assigned report control symbol DD-HA(AR)1782(6010) and are provided as enclosure (4).

b. The Management Information Reports required by paragraph 10, are assigned report control symbols MED 6010-24 and MED 6010-25. These reports are approved for 3 years from the date of this instruction. Enclosure (5) is the Shore MTF and DTF Management Information Report Format. Enclosure (6) is the Operational MTF and DTF Management Information Report Format.

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Stocked:
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DEFINITIONS AND ACRONYMS

1. Health Care Providers. Personnel involved in the delivery of health care as set forth below:

a. Health Care Practitioners. Military (ACDU and Reserve) and DON civilian providers (Federal civil service, foreign national hire, volunteers, contract, or partnership) required by reference (e) to be granted clinical privileges to independently diagnose, initiate, alter, or terminate health care treatment regimens. This includes physicians, dentists, nurse practitioners, nurse midwives, nurse anesthetists, clinical psychologists, optometrists, clinical dieticians, podiatrists, clinical social workers, clinical pharmacists, physical therapists, occupational therapists, audiologists, speech pathologists, and physician assistants. Individuals enrolled in training programs leading to qualification for clinical privileges are also considered health care practitioners, for purposes of this instruction.

b. Clinical Support Staff. Personnel who are required to be licensed but are not included in the definition of health care practitioners. This category includes pharmacists, dental hygienists, and nonprivileged nurses.

c. Nonlicensed Support Staff. Nonlicensed personnel who provide support services to the medical, dental, and clinical staffs in addition to administrative, logistical, maintenance, and other personnel not involved in direct patient care.

2. Outcome Monitors. Specified outcomes of health care processes that are identified and subjected to trend analysis and used in appropriate CQI efforts. Examples include neonatal death rate, mortality following coronary artery bypass surgery, readmission rate following discharge, nosocomial infection rate, post-transfusion hepatitis rate, and wound evisceration or dehiscence rate.

a. Validation. A determination concerning a monitor outcome confirmed through the peer review process.

b. Delinquency. Used as a portion of the inpatient medical record review function, it is reserved for MTFs with inpatient capabilities. A medical record is considered delinquent if all required record components are not completed within 30 days of patient discharge. Examples of items needing completion are operation reports and discharge summaries.

c. Deficiency. The state in which there is a variance from preestablished minimally acceptable standards of care. A variance is reportable following confirmation through the peer

review process. The variance can be quantified in terms of time, frequency of action, quality of record completion, or quality of services provided, but should be pertinent to clinical practice.

d. Nosocomial Infection. An inpatient acquired infection not present or incubating at the time of admission. An infection is considered nosocomial if it first becomes apparent 72 hours (or more) after admission.

e. Postoperative Wound Infection. A wound infection that develops after surgery.

3. Peer Review. The process by which practitioners of the same or like discipline evaluate the outcomes of QA program-related monitoring activities. Commonly used to reach a conclusion when an expected structure, process, or outcome of patient care standard is not met. Peer review offers a practitioner the forum for problem solving and action as indicated.

4. Potentially Compensable Event (PCE) (Adverse Event). An event or outcome during the process of medical or dental care in which the patient suffers a lack of improvement, injury, or illness of severity greater than ordinarily experienced by patients with similar procedures or illnesses. Injury or disability must be classified as follows:

a. None or Minor. Examples include appendectomy surgery for perforated appendix but with no delay in recovery, missed diagnosis of fracture recognized at a later date and healing with no residual deformity, or delayed recovery from anesthesia not impeding overall recovery.

b. Temporary. Examples include falls with laceration or fracture, appendectomy with a single postoperative episode of sepsis, delayed union of a fracture, incisional hernia, and fracture of a tooth during anesthesia.

c. Long-Term Permanent. Examples include fall with resultant neurological injury, healed forearm fracture with loss of motion in wrist or elbow, postoperative inadvertent retention of a foreign body, loss of a thumb or finger, anesthetic-related cardiac or respiratory arrest, and loss of life other than in terminal illness.

5. Quality Assurance (QA). The formal and systematic exercise of monitoring and reviewing medical care delivery and outcome; designing activities to improve health care and overcome identified deficiencies in providers, facilities, or support systems; and carrying out followup steps or procedures to ensure

that actions have been effective, that no new problems have been introduced, and that individual improvements in quality as a result of process improvement is maintained.

6. Quality Health Care. Health care in any given situation which:

a. Is thought by knowledgeable, responsible clinicians to be in consonance with practice of the applicable professional community.

b. Is associated with a high probability for good clinical results.

c. Meets or exceeds policies, guidance, and general requirements of authorized accrediting organizations.

d. Is perceived by customers to be caring, competent, and effective, and of high quality.

7. Continuous Quality Improvement (CQI). A structured approach which continuously analyzes clinical and administrative processes within pre-established boundaries using various analytic tables. The goal is to improve efficiency and effectiveness of such processes by addressing and eliminating special cause variations, eliminating nonvalue added steps, identifying and solving process problems, and making other carefully planned and tested changes to reduce overall process variation.

ACRONYMS

ACDU	Active Duty
ADP	Automated Data Processing
AQCESS	Automated Quality of Care Evaluation Support System
ASD/HA	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CEPRP	Civilian External Peer Review Program
CINC	Commander in Chief
CMC	Commandant of the Marine Corps
CNO	Chief of Naval Operations
CONUS	Continental United States
CQI	Continuous Quality Improvement
DoD	Department of Defense
DON	Department of the Navy
DRG	Diagnosis Related Groups
DTF	Dental Treatment Facility
ECODS	Executive Committee of the Dental Staff
ECOMS	Executive Committee of the Medical Staff
FMF	Fleet Marine Force
HLTHCARE SUPPO	Naval Healthcare Support Office
ICD9-CM	International Classification of Diseases, Ninth Edition-Clinical Modification
ICF	Individual Credentials Files
IPF	Individual Professional File
LOS	Length of Stay
IG	Inspector General
JAGMAN	Judge Advocate General Manual
MTF	Medical Treatment Facility
OCONUS	Outside the Continental United States
PC-Based	Personal Computer-Based
QA	Quality Assurance
RM	Risk Management
RMDB	Risk Management Database
SECNAV	Secretary of the Navy
SSN	Social Security Number
TAD	Temporary Additional Duty
TYCOM	Fleet Type Commander
UR	Utilization Review
USC	United States Code

CLINICAL PERFORMANCE PROFILE REPORTING FORMAT

Practitioner Name:_____ SSN# _____

	6 Month Period Period #				
1. Volume Data	1	2	3	4	TOTAL
a. # Admissions/outpatient encounters	____	____	____	____	____
b. # Days deployed and temporary additional duty (TAD) not available	____	____	____	____	____
c. # Major procedures (locally define and specify; should be specialty specific)	____	____	____	____	____
d. % of time in direct patient care	____	____	____	____	____
2. Occurrence Screens					
a. Validated facility-specific					
(1) # Category I	____	____	____	____	____
(2) # Category II	____	____	____	____	____
(3) # Category III	____	____	____	____	____
(4) # Category IV	____	____	____	____	____
b. Validated department-specific					
(1) # Category I	____	____	____	____	____
(2) # Category II	____	____	____	____	____
(3) # Category III	____	____	____	____	____
(4) # Category IV	____	____	____	____	____

3. Medical Staff Monitors

   a. Surgical case review

      (1) # Validated deficiencies ____ ____ ____ ____ ____

      (2) # Cases reviewed ____ ____ ____ ____ ____

   b. Blood usage review

      (1) # Validated deficiencies ____ ____ ____ ____ ____

      (2) # Transfusions ____ ____ ____ ____ ____

   c. Drug usage review

      (1) # Validated deficiencies ____ ____ ____ ____ ____

      (2) # Reviewed ____ ____ ____ ____ ____

   d. Medical record review

      (1) # Validated delinquencies ____ ____ ____ ____ ____

      (2) # Validated deficiencies ____ ____ ____ ____ ____

      (3) # Reviewed for deficiencies ____ ____ ____ ____ ____

4. Dental Staff Monitors

   a. Dental record review

      (1) # Validated delinquencies ____ ____ ____ ____ ____

      (2) # Validated deficiencies ____ ____ ____ ____ ____

      (3) # Reviewed for deficiencies ____ ____ ____ ____ ____

b. Drug usage review

(1) # Validated deficiencies ____ ____ ____ ____ ____

(2) # Reviewed ____ ____ ____ ____ ____

5. Facility-wide Monitors

a. Utilization review

(1) # Validated denied admissions ____ ____ ____ ____ ____

(2) # Validated DRG or length of stay (LOS) deficiencies ____ ____ ____ ____ ____

b. Infection control

(1) # Validated nosocomial infections ____ ____ ____ ____ ____

(2) # Validated surgical wound infections ____ ____ ____ ____ ____

c. Civilian External Peer Review Program (CEPRP)

Validated standard of care variations ____ ____ ____ ____ ____

d. Patient Contact Point Program

(1) # Validated patient compliments ____ ____ ____ ____ ____

(2) # Validated patient complaints ____ ____ ____ ____ ____

e. Liability Claims/JAGMAN Investigations/ PCE Reviews

In which practitioner was principal focus ____ ____ ____ ____ ____

6. Professional Development

a. # of continuing education credit hours awarded	____	____	____	____	____
b. # of papers published & professional presentations	____	____	____	____	____
c. Other recognitions of positive professional achievement	____	____	____	____	____
Department Head Initials*	____	____	____	____	____
Practitioner Initials*	____	____	____	____	____

* Attach Comments as Required

This document is produced as a portion of the Bureau of Medicine and Surgery's Quality Assurance Program. Information herein is confidential and privileged under the provisions of 10 USC 1102 (1986).

POTENTIALLY COMPENSABLE EVENTS (PCEs) FOR MEDICAL AND DENTAL TREATMENT FACILITIES

1. Unexpected death (including suicides).

2. Any complication of treatment which results in:

   a. A corrective operative procedure.

   b. Brain damage.

   c. Motor weakness.

   d. Sensory nerve injury.

   e. Total or partial loss of limb.*

   f. Loss of use of limb.*

   g. Sensory organ loss or impairment.

   h. Reproductive organ loss or impairment.*

3. Inadvertent blood transfusion with HIV or hepatitis virus contaminated blood.*

4. Procedure performed on wrong patient or body part (includes extraction of wrong tooth).

* - Does not apply to Dental Treatment Facilities

CASE ABSTRACT FOR MALPRACTICE CLAIMS INSTRUCTION SHEET
DD 2526

1. Cognizant treatment facilities will submit the attached form to BUMED concurrently with the completion of a JAGMAN investigation for each health care incident for which a claim (or claims) is made or anticipated.

a. Cognizant treatment facilities must complete sections 1, 2a-d, 3a and b, 6a-c, 7a-h, 8a-c, 11a-h, 12a-c, 13a-c, 14a, 16a-e, and 18a-c of DD 2526 and forward to MED-3C4 within 30 days of the event for all PCEs. The submitting MTF will complete those same sections and attach them to all JAGMAN health care investigations and forwarded to MED-3C5.

(1) List the diagnoses, procedures, and International Classification of Diseases, Ninth Edition - Clinical Modification (ICD9-CM) codes from the health care record in sections 12 and 13. In the event of ambulatory care where ICD9-CM codes are not available, list the most applicable diagnoses and procedures found in the health care record.

(2) List the allegations in the case of a claim that are provided by the claimant or the claimant's attorney in section 16a.

(3) Indicate the professional review findings on the standard of care in section 16. If standards were not met, so indicate in items 16b(2). If section 16b(2) is marked, then complete section 16c(1)-(4), as applicable. If a practitioner or provider is identified in the peer review process as a causative agent to the event, then identify the practitioner or provider in section 7a-c. If no practitioner or provider is identified as the causative agent, then identify the primary practitioner (attending staff) responsible for the care of the patient. The ECOMS or ECODS, as appropriate, is the body responsible and accountable for practitioner peer review.

b. If a new or additional claim is submitted for an event previously reported, so indicate in section 2 of DD 2526 and resubmit to MED-3C5. This requirement for resubmission of DD 2526 applies to all change of information based on appeal, additional peer review or administrative action.

c. Commanding officers of reporting facilities ensure that the ECOMS or ECODS provide the required professional review required by section 16.

2. The Deputy Assistant Judge Advocate General (Claims and Tort Litigation) will provide information required by sections 10 and 15 to MED-3C4.

3. MED-3C4 will maintain all information contained in DD 2526 in a computerized RMDB and periodically perform risk management and quality of care analysis. BUMED will provide lessons learned from this analysis to applicable treatment facilities.

SHORE MTF AND DTF
MANAGEMENT INFORMATION REPORT FORMAT
MED 6010-24

Facility: _____ UIC:_____ FY 19___

1. Structure

a. Type of Facility

____ Fixed inpatient teaching MTF
____ Fixed inpatient nonteaching MTF in the continental United States (CONUS)
____ Fixed inpatient nonteaching MTF outside the continental United States (OCONUS)
____ Fixed outpatient MTF
____ Fixed DTF
____ Other (explain)_____

b. Standing QA-Related Committees

____ QA
____ Risk Management
____ Safety
____ Infection Control
____ Executive Committee of the Medical or Dental Staff
____ Credentials Committee
____ Surgical Case Review
____ Blood Usage Review
____ Drug Usage Evaluation
____ Pharmacy and Therapeutics Function
____ Medical Records Review Function
____ Utilization Review
____ Special Care Units
____ Additional Committees (explain)

_____

_____

c. Facility QA Program Organization. Are QA-related functions organized under a local plan?

Yes ____ No ____

If no, explain how QA functions are organized:

_____

_____

_____

d. Number of Man Hours Devoted to QA Program Implementation Each Week by All Categories of Facility Personnel

(1) Officer _____

(2) Enlisted _____

(3) Civilian _____

e. Number of Additional Man Hours Required to Optimally Implement Facility QA Program Requirements by All Categories of Personnel

(1) Officer _____

(2) Enlisted _____

(3) Civilian _____

f. Number of QA-related Courses or Conferences Attended by Key Command Personnel within the Past Fiscal Year

	Course sponsor			
	BUMED	HLTHCARE SUPPO	NSHS	OTHER
(1) Chair, ECOMS/ECODS				
(2) Chair, Credentials				
(3) PAC				
(4) XO				
(5) QAPA/QADA				
(6) QA Coordinator				
(7) RM Coordinator				
(8) Directorates				
(9) Clinical Dept. Head				
(10) Nursing Dept. Head				
(11) Admin Dept. Head				
(12) Other				
TOTAL				

g. QA-Related Minute Preparation, Routing, and Endorsement. Are QA-related minutes generally prepared, routed, and endorsed before the next scheduled meeting?

Yes ____ No ____

Average number of days for cycle completion: _____

h. Automated Data Processing (ADP) Support. Is ADP support used to support QA-related functions?

Yes ____ No ____

If yes, indicate system:

(1) Personal computer (PC) based Yes ____ No ____

If yes, indicate software:

(a) Word processing Yes ____ No ____

(b) Database management Yes ____ No ____

(c) Spreadsheet Yes ____ No ____

(2) Automated quality of care evaluation support system (AQCESS) Yes ____ No ____

If yes, indicate modules in use:

(a) Patient Admitting System Yes ____ No ____

(b) QA Yes ____ No ____

(c) Credentials Yes ____ No ____

(d) Emergency Room Yes ____ No ____

(3) CHCS Yes ____ No ____

2. Credentials Review and Privileging

a. Number of active individual credentials files (ICFs) maintained as of 30 September by type:

(1) ACDU _____

(2) Civil Service _____

(3) Partnership _____

(4) Contract _____

(5) Inactive Reserve _____

(6) Other _____

(7) Total _____

b. Number of practitioners holding clinical privileges at reporting facility: _____

c. Number of provisional professional staff appointments granted in the last fiscal year: _____

d. Number of initial active professional staff appointments granted in the last fiscal year: _____

e. Number of active professional staff reappointments granted in the last fiscal year: _____

f. Number of active individual professional files (IPFs) maintained as of 30 September by type:

(1) ACDU _____

(2) Civil Service _____

(3) Partnership _____

(4) Contract _____

(5) Inactive Reserve _____

(6) Total _____

3. Risk Management

a. Number of potentially compensable events (PCE) reviews initiated in the last fiscal year: _____

b. Number of patient care-related JAGMAN investigations initiated in last fiscal year: _____

c. Facility RM monitoring includes:

(1) Risk-sensitive occurrence screens Yes ____ No ____

(2) Management variance reports Yes ____ No ____

(3) Patient satisfaction surveys Yes ____ No ____

(4) Number of patient contact point program compliments and complaints initiated in the last fiscal year by category:

Category	Compliments	Complaints
(a) Quality of care	____	____
(b) Access to care	____	____
(c) Requests for health records	____	____

Category	Compliments	Complaints
(d) Patient dispositions	____	____
(e) Death	____	____
(f) Medical bills	____	____
(g) CHAMPUS	____	____
(h) Prescriptions	____	____
(i) Benefits	____	____
(j) Other	____	____
(k) Total of (a) through (j)	____	____

(5) List improvements effected by the patient contact program in the last fiscal year: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(6) Number of congressional inquiries in the last fiscal year by category:

(a) Quality of care ____

(b) Access to care ____

(c) Requests for health records ____

(d) Patient dispositions ____

(e) Death ____

(f) Medical bills ____

(g) CHAMPUS ____

(h) Prescriptions ____

(i) Benefits ____

(j) Other ____

(k) Total ____

d. Risk management monitoring has identified significant trends in the provision of health care services:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous calendar year:

Trend	Action Taken *

4. Facility-wide QA Functions

a. Utilization review (including over, under, or misuse of support services) is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

b. Infection control surveillance is a component of the facility QA program:

Yes ____ No ____

If yes:

(1) Indicate type of surveillance: 100% ___ Sample ___

(2) Postoperative wound infections:

(a) Total number of wound infections: ____

(b) Total number of invasive procedures: ____

(3) List trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

c. Patient and staff safety monitoring is a component of the facility QA program:

Yes____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

d. Occurrence Screens. Number of occurrence screens initiated in last fiscal year by:

(1) Location

(a) Ambulatory care (MTF and DTF) ____

(b) Emergency care (MTF only) ____

(c) Inpatient care (MTF only) ____

(d) Total ____

(2) Practitioner Related

(a) # Category I ____

(b) # Category II ____

(c) # Category III ____

(d) # Category IV ____

(e) Total ____

(3) Clinical Support Staff Related

(a) # Category I ____

(b) # Category II ____

(c) # Category III ____

(d) # Category IV ____

(e) Total ____

(4) Occurrence screen monitoring has identified significant trends in the provision of patient care services:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend Action Taken *

5. Medical Staff Monitors

a. Surgical case review of discrepancies between preoperative diagnosis and postoperative pathological diagnoses for all specimen cases and review of the clinical indications for all invasive procedures (non-specimen therapeutic and invasive diagnostic procedures) in all locations within the facility is a component of the facility QA program:

Yes ____No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend Action Taken *

b. Blood usage review of the appropriateness (indications) for all cases of transfusions of whole blood, red blood cells, platelets, fresh frozen plasma, albumin, autologous red blood

cells, and cryo-precipitate, as well as, review of all significant transfusion reactions is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

c. Drug usage evaluation of the prophylactic, therapeutic, and empiric use of at least four high risk, high volume, and problem prone antibiotic and non-antibiotic drugs annually is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

d. Medical record review of the timeliness of completion and the clinical pertinence (clarity, completeness, and accuracy of the document) is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

e. Pharmacy and therapeutics function including the definition and review of all significant adverse drug reactions is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

6. Dental Staff Monitors

a. Dental record review of the clinical pertinence (clarity, completeness, and accuracy of the document) is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

b. Drug usage evaluation of the prophylactic, therapeutic, and empiric use of at least two high risk, high volume, and problem prone antibiotic and non-antibiotic drugs annually is a component of the facility QA program:

Yes ____ No ____

If yes, list trends (positive and negative) identified by monitoring and action taken in previous fiscal year:

Trend	Action Taken *

* Actions taken codes:

1 – Positively reinforced current practices
2 – Increased patient care services
3 – Decreased patient care services
4 – Changed practices or procedures
5 – Altered staffing patterns
6 – Replaced or repaired equipment

* Actions taken code: (continued)

7 – Changed facility or unit physical structure
8 – Continued to monitor
9 – Forwarded validated information to practitioner's clinical performance profile
10 – Initiated privileging action
11 – Other (explain)

8. Summary (completion is mandatory). Describe improvements in patient care services not previously listed as a result of the facility QA program:

OPERATIONAL MTF AND DTF
MANAGEMENT INFORMATION REPORT FORMAT
MED 6010-25

Reporting Command: _____ UIC: _____ FY 19 _____

1. Structure

a. Number of subordinate facilities:

_____ Nonfixed MTF
_____ Nonfixed DTF
_____ Other (explain)_____

b. TYCOM QA Program Organization. Are QA-related functions organized under a TYCOM plan?

Yes ____ No ____

If no, explain how QA functions are organized:

_____

_____

_____

_____

2. Credentials Review and Privileging

a. Number of practitioners holding staff appointments with clinical privileges at TYCOM facilities: _____

b. Number of professional staff appointments and reappointments granted in the last fiscal year at TYCOM facilities: _____

3. Risk Management (RM)

a. Number of patient care-related Judge Advocate General Manual (JAGMAN) investigations initiated in last fiscal year: _____

b. TYCOM risk management monitoring includes:

(1) Occurrence screens Yes ___ No ___ NA ___

(2) Management variance reports Yes ___ No ___ NA ___

(3) Patient satisfaction surveys Yes ___ No ___ NA ___

(4) Patient contact point program Yes ___ No ___ NA ___

4. TYCOM Facility-wide QA Functions

a. Infection control surveillance is a component of the TYCOM QA program:

Yes ____ No ____

b. Patient and staff safety monitoring is a component of the TYCOM QA program:

Yes____ No ____

5. Medical Staff Monitors

a. Surgical case review of discrepancies between preoperative diagnosis and postoperative pathological diagnoses for all specimen cases and review of the clinical indications for all invasive procedures (non-specimen therapeutic and invasive diagnostic procedures) in all locations is a component of the TYCOM QA program:

Yes ____ No ____ NA ____

b. Blood usage review of the appropriateness (indications) for all cases of transfusions of whole blood, red blood cells, platelets, fresh frozen plasma, albumin, autologous red blood cells, and cryo-precipitate, as well as, review of all significant transfusion reactions is a component of the TYCOM QA program:

Yes ____ No ____ NA ____

c. Drug usage evaluation of the prophylactic, therapeutic, and empiric use of at least four high risk, high volume, and problem prone antibiotic and non-antibiotic drugs annually is a component of the TYCOM QA program:

Yes ____ No ____ NA ____

d. Medical record review of the timeliness of completion and the clinical pertinence (clarity, completeness, and accuracy of the document) is a component of the TYCOM QA program:

Yes ____ No ____

e. Pharmacy and therapeutics function including the definition and review of all significant adverse drug reactions is a component of the TYCOM QA program:

Yes ____ No ____ NA ____

6. Dental Staff Monitors

a. Dental record review of the clinical pertinence (clarity, completeness, and accuracy of the document) is a component of the TYCOM QA program:

Yes ____ No ____

b. Drug usage evaluation of the prophylactic, therapeutic, and empiric use of at least two high risk, high volume, and problem prone antibiotic and non-antibiotic drugs annually is a component of the TYCOM QA program:

Yes ____ No ____

8. Summary (completion is mandatory). Describe improvements in patient care services as a result of subordinate facility QA program:

b. Drug usage evaluation of the prophylactic, therapeutic, and empiric use of at least two high risk, high volume, and problem prone antibiotic and non-antibiotic drugs annually is a component of the TYCOM QA program:

Yes ____ No ____

8. Summary (completion is mandatory). Describe improvements in patient care services as a result of subordinate facility QA program: