



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO
BUMEDINST 6010.21
BUMED-36
29 Oct 96

BUMED INSTRUCTION 6010.21

From: Chief, Bureau of Medicine and Surgery

Subj: Risk Management Program

- Ref:
- (a) DoD Directive 6025.13 of 20 Jul 95 (NOTAL)
 - (b) BUMEDINST 6010.17A
 - (c) BUMEDINST 6010.13
 - (d) Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation Manual for Hospitals, current edition
 - (e) JCAHO Accreditation Manual for Ambulatory Care, current edition
 - (f) JCAHO Accreditation Manual for Home Care, current edition
 - (g) JAG Manual
 - (h) OPNAVINST 3100.6F (NOTAL)
 - (i) OPNAVINST 5102.1C
 - (j) Title 10, United States Code, section 1102 (NOTAL)
 - (k) Title 5, United States Code, section 552 (NOTAL)
 - (l) SECNAVINST 5214.2B

- Encl:
- (1) Glossary of Useful Terms
 - (2) Guidelines for Health Care Investigations
 - (3) Case Abstract for Medical Malpractice Claim, DD 2526
 - (4) Reporting Requirements
 - (5) Risk Management References
 - (6) Risk Management Resources
 - (7) Confidentiality Requirements

1. Purpose. To establish policy and assign responsibility for organizational risk management (RM) activities. To define minimal requirements for both proactive and reactive responses for RM Programs in naval medical and dental treatment facilities (MTFs and DTFs) per references (a) through (k).

2. Background. The Chief of Naval Operations and the Commandant of the Marine Corps are committed to continuously improving the quality of medical and dental care provided to Department of the Navy beneficiaries. Since the perceived malpractice crisis began in the 1970's, naval MTFs and DTFs have embraced the principles and practices of RM, however, each facility created its own policies and procedures. Some RM policy was incorporated into the Quality Assurance Program established in 1984. This still left the MTFs and DTFs without a Navy-wide standard. With the advent of managed care and the increased use of ambulatory surgery and home health care, the Navy's RM Program shall be standardized as much as possible and shall keep abreast of the changing legal atmosphere so quality of care is maintained and

the potential for significant loss of tangible and intangible assets kept to a minimum. Strong RM Programs prove cost-effective, reduce malpractice claims, decrease patient complaints, and provide an atmosphere conducive to safe, effective patient care. This instruction outlines basic component activities and functions key to a successful RM Program, and encourages innovative local efforts to document the effectiveness of a facility-wide RM Program. Additional information is provided in enclosures (1) through (6).

3. Policy. All active duty, Reserve, and civilian medical and dental personnel shall participate in ongoing measurement activities designed to identify, analyze, evaluate, and control risk.

a. MTFs and DTFs shall implement a systematic, organization-wide, and collaborative RM Program. The RM Program shall incorporate applicable elements shown in references (a) through (i) and in this instruction.

b. Individuals designated as RM Program managers shall be afforded educational opportunities commensurate with their responsibilities; at a minimum 12 classroom hours of RM continuing education per year. Full RM certification is strongly encouraged through the American Society for Health Care Risk Management or local colleges and universities. Education may be inservice military or outservice civilian-sponsored. RM education for key program managers shall be sufficient in scope and frequency to enable effective program oversight. Since risk detection and risk control is everyone's responsibility, all health care providers are encouraged to seek RM education.

c. Use information derived through analysis of RM data and other quality management activities for measurement, assessment, and improvement of key processes and systems to reduce risk.

d. Information derived through the RM process shall be used to tailor facility inservice education programs.

e. Any comprehensive RM system supports an improved delivery of preventive services in the clinical setting. Commonly referred to as wellness programs, these services are designed to inform individuals about healthy lifestyles and direct them to services and facilities that encourage these behaviors. RM shall support these activities as well as be aware of the potential risks involved.

f. Maintain command RM Program-related documentation in a secure location for 3 years before disposal. Maintain RM documents related to any investigations generated per reference (g) in a secure location at the local command for 2 years or as long as needed.

4. RM Program Components

a. An effective RM Program covers all aspects of facility operation. To implement the program requires the cooperation of the entire staff; including medical, dental, nursing, administrative staff, and all department heads. The goal of a proactive RM Program is to identify problems before an injury or loss occurs and take action to prevent or minimize its effects. To accomplish this goal means establishing early warning systems, targeting clinical areas or practices that present the greatest exposure to liability, and implementing preventive action plans to minimize the risk associated with these activities.

b. RM is a valuable resource to preserve the assets of the institution, reduce preventable injuries (reduce special cause variation), and minimize or mitigate the severity of claims, while contributing to the organization's mission of providing quality care to patients.

c. Although to actually implement an RM Program is dependent on the unique characteristics of the individual MTF and DTF, there are essential components required for an effective program. These components include:

(1) Senior administration and executive committee of the medical staff (ECOMS) and executive committee of the dental staff (ECODS) commitment and support, evidenced through appropriation of sufficient resources to manage RM activities. Effective RM Programs have proven to save three to four times their actual cost and in some cases significantly more.

(2) Designating a risk manager (and RM staff as appropriate) to coordinate all aspects of the program and to communicate loss prevention activities to key administrative personnel. As a vital component of the program, the risk manager shall:

(a) Be a part of the administrative management team and have direct access or report directly to the commanding officer (CO) or commander or the executive officer (XO) or deputy commander.

(b) Have access to all facility and professional staff data.

(c) Be knowledgeable about facility operations, including clinical practice, legal issues, accreditation standards, Federal rules and regulations, and possess good oral communication and writing skills.

(3) Support of the professional staff and their participation in reporting unexpected adverse outcomes or any event that may result in a claim.

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(4) Integration with quality management and sharing of information and findings from measurement and assessment activities on the quality of patient care and services.

(5) Establishing a formal system of quality control to identify and reduce special cause variation (sentinel events, adverse events, unexpected outcomes, or potential risks), using valid measurement tools such as fault tree analysis (FTA) and failure mode effect analysis (FMEA). Using information input from utilization management, safety, infection control, attorney requests for medical records, patient complaints, and internal customer complaints in the analysis.

(6) Prioritizing the concern for potential loss factors.

(7) Investigating all serious unanticipated or unexpected outcomes resulting in patient, staff, or visitor injury, directed at identifying and eliminating the causes of the system failure.

(8) Analyzing prospective and retrospective risk exposures for trends or patterns.

(9) Educating every member of the organization to practice and promote awareness of RM and liability control.

(10) Reviewing new contracts, ventures, programs, services, and technology to address any RM implications associated with these activities.

(11) Scheduling meetings with established professional staff and facility committees for the receipt and review of RM information or direct membership in these committees.

5. RM Program Requirements

a. The program is guided by a written plan. The plan includes at a minimum:

(1) Program objectives which reflect the MTF or DTF philosophy.

(2) Organization and responsibilities.

(3) A designated risk manager who reports directly to the CO or XO.

(4) A preventive action plan (quality planning).

(5) A surveillance action plan (quality assurance).

(6) A corrective action plan (quality improvement).

(7) Methods for obtaining information regarding potential claims, sentinel events, Manual of the Judge Advocate General (JAGMAN) investigations (litigation reports and command investigations), malpractice claims, peer review of serious deviations from the standard of care, patient complaints, safety violations, attorney requests for medical records, and congressional inquiries as a basis for corrective and preventive action plans.

(8) Identifying the information flow processes to maintain quality of care services and prevention of potential problems.

(9) Annual review of program effectiveness with recommendations and revisions where needed.

(10) Electronic means of data retrieval and storage that can be used to track RM trends, disseminate lessons learned, evaluate potential risk, improve patient satisfaction, and analyze paid closed claims.

(11) Written RM reports to the CO or commander at least twice per year.

b. RM Education

(1) Include RM information in orientation programs for:

(a) New employees.

(b) New residents and interns.

(c) New medical and dental staff appointees.

(2) Risk manager to conduct inservice education and continuing education programs on RM topics at least 4 hours in the classroom annually.

c. Risk managers shall have e-mail and internet capability.

6. Responsibilities

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

(1) Interprets Department of Defense (DoD), Secretary of the Navy, and Chief of Naval Operations policies and provides guidance for Navy-wide RM Program implementation.

(2) Monitors implementation and coordination of medical and dental RM Programs in fixed (shore-based with permanent

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structures) MTFs and DTFs by the Medical Inspector General oversight and naval healthcare support office (HLTHCARE SUPPO) assistance visits as requested or required.

(3) Provides RM consultation, educational support, and RM-related information to Navy MTFs and DTFs.

(4) Reviews sentinel events 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 for Health Affairs (ASD(HA)). MED-361 will use enclosure (3), and the Centralized Credentials and Quality Assurance System (CCQAS) to report paid, closed malpractice claims to ASD(HA).

(5) 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 (3).

(6) Maintains an RM database.

b. Officers in Charge (OIC) of HLTHCARE SUPPOS

(1) Provide technical support and assistance for RM related issues, by request, to naval medical and dental activities.

(2) Provide educational support to the field incorporating RM in at least one regional seminar annually.

c. COs, OICs, and Senior Medical and Dental Department Representatives of Treatment Facilities

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

(2) Include cases involving serious injury or prolonged disability, regardless of whether the patient is in active duty or civilian status, in MTF or DTF databases for analysis and report to MED-361 using enclosure (4) format.

7. Reporting Requirements. MTFs and DTFs

a. Per reference (g), MTFs and DTFs shall provide two copies of all health care incidents whether command investigations or litigation reports in which the adequacy of medical care is an issue or involve significant potential claims, permanent disability, or death to the Chief, Bureau of Medicine and Surgery (MED-36) along with a case summary using DD 2526. The DD 2526 shall be completed by the facility risk manager and go with every

investigation forwarded to MED-36. DD 2526 is an automated form and may be submitted electronically. In the future each risk manager shall enter the data directly into the CCQAS.

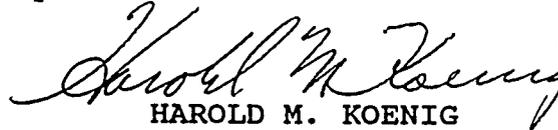
b. Submit special interest items on request.

c. Submit unit situation reports per reference (h), chapter 2, section XI for major sentinel events or events likely to cause immediate local or national media coverage.

8. Confidentiality. Quality assurance documents and records created per this instruction are medical QA materials within the meaning of reference (j) and are, therefore, exempt from the requirements of the Freedom of Information Act, reference (k). Confidentiality requirements are more detailed in enclosure (7).

9. Form. DD 2526 (OCT 92), Case Abstract for Malpractice Claims is provided as enclosure (3).

10. Report Exemption. The reporting requirements included in this instruction are exempt from reports control by reference (1), part IV, paragraph G8.


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GLOSSARY OF USEFUL TERMS

1. Adverse Events. Adverse events include unexpected deaths; patient, staff, or visitor injury resulting in disability, misdiagnosis, or serious illness in which the adequacy of medical care is reasonably in question or patient, visitor, or staff dissatisfaction is of such magnitude that it could raise the potential for a claim, congressional interest, or jeopardize the public image of the Navy.
2. Brain Death. A determination of death following accepted medical standards. The uniform determination of death has been codified in the laws of most States as follows: Only an individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is considered dead.
3. Capitation Risk. Capitation is a health care reimbursement methodology in which a payer and a provider negotiate a set amount per patient, per month for a defined set of services. The risk is the cost of individual catastrophic medical claims exceeding the total negotiated reimbursement or the aggregate of provider expenses exceeding the annual reimbursement. This type of risk is sometimes confused with pure static risk or medical malpractice risk.
4. Chain of Custody and Chain of Evidence. A rule of evidence in a legal proceeding requiring custody of a piece of evidence, such as a piece of malfunctioning equipment alleged to have caused an injury, be continuously documented from the time of the incident until its introduction into evidence. The chain of custody includes identification of each custodian and each transfer of custody.
5. Claim. In health care, a patient's demand for payment for injury, or lost or damaged property that resulted from alleged negligence of the facility, the physician or dentist, or the employees or agents of either.
6. Claims Management. This is a risk management function. The person who performs this function gets reports of professional and general liability claims against the institution, its employees, and agents, and manages them to conclusion. In the Navy, this is done by the Office of the Judge Advocate General (OJAG-35).
7. Closed Claims Survey. This is a method used to determine trends in professional liability by keeping track of significant information from claims as they are closed. Examples of significant events to be trended include the allegation brought

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by the claimant, the amount of payment required to close the claim, the amount of expense incurred in managing the claim, and who was named in the claim.

8. Consequential Loss. This is a loss not directly caused by damage to property, but arises as a result of damage, as in the case of food spoilage from refrigeration failure resulting from fire damage to the refrigerator.
9. Contract. An agreement by two or more parties to assume obligations, not otherwise required of them, for consideration that is enforceable in a court of law. Contracts may be written, oral, or implied.
10. Credentialing and Privileging. This is a process undertaken by an MTF or DTF CO or commander, on the recommendation of the medical staff, to review the qualifications of applicants for appointment to the medical or dental staff, to those seeking reappointment, and to define their scope of practice and the procedures they may perform in the institution.
11. Damages. Monetary compensation for an injury.
12. Deep Pocket. "Deep Pocket" is a colloquial term for an organization, corporation, or sometimes an individual perceived to have sufficient assets to pay a loss and so is worth bringing into lawsuit to ensure a larger pool of money to pay damages.
13. Deposition. This is testimony taken during discovery by either party of the other party or of witnesses. The testimony is taken orally under oath outside the courtroom, and a word-for-word record is made.
14. Discovery. Techniques used by the parties to a lawsuit to gather information that is in the jurisdiction and control of the other party. Common discovery techniques include requests for the production of documents, depositions, and interrogatories.
15. Diagnosis-Related Groups (DRGs). The Health Care Financing Administration, which administers the Medicare Program, has developed 467 groups of diagnosis of illnesses upon which it bases its payments to hospitals for care of Medicare patients.
16. Fault Tree Analysis (FTA) is a diagrammatic approach to evaluate the components of a system and its interrelationships to evaluate and identify the possible causes of specified failures in the system.
17. Failure Mode Effect Analysis (FMEA) is the method used to minimize the likelihood of failure in a system. It focuses on

identifying the origins of process or product failure and taking preventive action based on this analysis. The purpose of FMEA is to:

- a. Analyze the probable causes of product or process failure.
- b. Determine and quantify the effect failure will have on the customer.
- c. Identify the part of the process responsible for the failure.
- d. Identify the variable to focus on for detection and prevention.

18. Generic Occurrence Screening. This is the screening of patient records for defined adverse clinical and sentinel events.

19. Hold Harmless. This clause is frequently inserted in contracts between buyers and sellers of products or services by which party A to the contract requires party B to assume the costs of claims when both are sued by party C, who is not a party to the contract, but claims injury as a result of the products or service.

20. Implied Consent. Consent to health care diagnosis or treatment manifested by action or by silence that raises the presumption that an authorization is given. For example, a patient who attends a mass immunization clinic gives the implied consent to inoculations being administered at the site. Also, in a life-threatening emergency, the law implies consent to such reasonable treatment as is deemed medically necessary.

21. Incident. This is generally accepted by most risk managers to mean any happening not consistent with the routine operation of the facility or routine care of a particular patient.

22. Incident Reporting. This system is used in health care institutions by employees to report any occurrence outside the routine so information can be used for loss prevention and claims management activities. A standard form is used for reporting incidents.

23. Indemnity. To agree to reimburse another for an actual loss sustained. Bonds and some insurance policies provide for indemnification of the insured in consideration for the premium charged.

24. Informed Consent. This is a patient's agreement to a particular course of treatment based upon disclosure by the physician (or other provider who has the legal duty to seek consent before providing treatment) of the relevant facts.

25. Loss Prevention. This is a risk management function. The person who performs this function identifies the risk or loss throughout the institution and implements systems to prevent or minimize the risk or loss.
26. Malpractice. The failure of one providing professional services, such as a lawyer, doctor, or accountant, to exercise that degree of skill that would be exercised by the average, prudent member of that profession, with the result that the person seeking the service has suffered an injury or loss.
27. Negligence. Failure to use that degree of care that a reasonable prudent person would use under similar circumstances. Negligence may be instituted by acts of either omission or commission, or both.
28. Negligent Hiring. This is a legal theory under which an employer may be held liable for the wrongful acts of its employee, if the employer failed to discover facts about the employee that were available to the employer and would have predicted the wrongful act.
29. Occurrence Screening. This is the screening of patient records for defined adverse clinical events, including such occurrences as adverse drug reactions, unplanned transfers to critical care units, or return to the emergency department within a specified number of days for the same illness or injury.
30. Peer Review. This is the process by which the diagnosis, care, and treatment of patients is reviewed and evaluated for purposes of employment, appointment, reappointment, privileging, or corrective action.
31. Privilege. This is the protection from being required to disclose information. The most commonly held privileges include the patient-physician privilege. The laws of each State define the privileges held in that State and who may hold them.
32. Proactive Risk Management. Identifying problems before an injury or loss occurs and taking action to prevent its effect by:
 - a. Developing and implementing early warning systems, i.e., facility-wide adverse occurrence and sentinel event reporting.
 - b. Targeting, for increased monitoring, clinical practice areas which present the greatest exposure to liability, i.e., emergency room, obstetrics/gynecology, and anesthesia departments.
 - c. Developing and implementing a preventive action plan to minimize risks associated with high-risk, high-liability activities, i.e., having pathology slides involving a suspicious diagnosis reviewed by a second pathologist.

33. Quality Assurance. Activities employed to provide confidence that a product or service will satisfy design specification. Within an organization, quality assurance provides confidence to management that the product or service will be fit for use by the customer.

34. Quality Control. This is the routine monitoring of a process to detect out-of-control conditions and remove the source.

35. Quality Improvement. A structured activity to introduce fundamental changes to achieve higher levels of performance. It represents the introduction of beneficial change. Quality improvement is changing the status-quo.

36. Quality Planning. This is an organizational process involving a series of universal steps:

- a. Identifying the customers.
- b. Determining the needs and expectations of customers.
- c. Developing product and process features which respond to customer's needs.
- d. Developing processes which are consistently able to produce those product and process features.
- e. Implementing the resulting plans.

37. Reactive RM. The identification of problems after a loss or injury has occurred and taking action to minimize its effect by:

- a. Investigating serious unanticipated adverse outcomes resulting in patient, staff, or visitor injury.
- b. Analyzing risk exposures for trends or patterns, and identifying opportunities for process, system, or performance improvement.
- c. Developing and implementing a corrective action plan, i.e., the initialing, by a provider, of laboratory charts before placement in the medical record after overlooked laboratory results caused injury to a patient.

38. Risk Acceptance. The decision not to transfer an identified risk, but instead to assume its financial consequences.

39. Risk Analysis. The process used by the person or persons assigned RM functions to determine the potential severity of the loss from an identified risk, the probability the loss happened, and alternatives for dealing with the risk.

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40. Risk Avoidance. The decision not to undertake a particular activity because the risk associated with the activity is unacceptable.

41. Risk Identification. The process used by the person or persons assigned RM functions to identify situations, policies, or practices that could result in financial loss to the institution.

42. Risk Management. Investigation and analysis of the frequency of causes of adverse incidents that injure patients, visitors, and staff and the development of measures to minimize risk, and re-engineer systems to protect the financial sovereignty of the Navy against the consequences of pure static risk and the costs of risks.

43. Risk Reduction. A loss control strategy by which a risk is identified and steps are taken to minimize its financial impact or the frequency of its occurrence.

44. Risk Transfer. The procedure of shifting risk of loss to another party who agrees to accept it. Examples of risk transfers are insurance, warranties, and "hold harmless" agreements.

45. Risk Treatment. The range of choices available to handle an identified risk to the person or persons assigned RM functions.

46. Scope of Practice. In the health professions, the professional activities a health professional is authorized to perform under the laws of the State in which the health professional is licensed.

47. Sentinel Event. This is an occurrence that, when noted, requires intensive assessment. The assessment process begins when undesirable variation in performance may have occurred or is occurring. Such intensive assessments are initiated by important single events and by absolute levels, patterns, or trends that significantly and undesirably vary from those expected, based on appropriate statistical analysis. These assessments are also initiated when the organization's performance significantly and undesirably varies from recognized standards, and from other organizations, or when the organization wishes to improve already good performance.

48. Special Cause Variation. This is a source of variation in the performance or output of a process that is unpredictable and not due to causes as the system normally operates. A special cause is indicated on a control chart by a measurement that falls outside the control limits.

49. Standard of Care. In a legal proceeding, the standard against which the defendant's conduct is measured. The defendant is expected to act as an ordinary, prudent person with similar training and skill would have acted in a similar situation. If the defendant's conduct falls below this standard, the defendant may be determined to have acted negligently.

50. Utilization Review. A function performed in health care situations to ascertain the number of days the patients are hospitalized is appropriate to the severity of their illness and the resources used in their care are appropriate.

51. Vicarious Liability. Legal responsibility for the acts of someone else. For example, the hospital may be found vicariously liable for the acts of its employees.

52. Work Product Doctrine. This is a doctrine whereby material prepared by an attorney in the anticipation of litigation may be protected from discovery. The work product doctrine applies to the notes, statements of witnesses, private memoranda, and mental impressions formed by the attorney.

GUIDELINES FOR HEALTH CARE INVESTIGATIONS

1. Introduction. The Navy's RM Program deals with many different inquiries, reports, and investigations on medical incidents. The most common are investigations convened per chapter II of the JAGMAN. Other inquiries involve Navy Inspector General reports, assessments of a provider's care convened under the Navy's adverse privileging program and investigations convened under the Uniform Code of Military Justice for disciplinary purposes. The following guide references JAGMAN sections to assist the risk manager in the scope and location of commonly-encountered issues concerning health care investigations. Questions concerning whether an investigation should be convened, what type of investigation should be conducted, and other matters should be directed to the command's legal office. If questions persist, the judge advocate providing legal support to the command should contact MED-36 for resolution.

a. Preliminary Inquiry (0204). The most informal method of assessing an incident, a preliminary inquiry can be convened orally or in writing. Usually designed only to quickly assess whether an additional, more formal investigation is required, there is no prescribed format for conducting or presenting the results of a preliminary inquiry. Common medical examples include obtaining background information to assist in responding to a patient contact complaint or a congressional inquiry when the surrounding circumstances do not indicate any further investigation is warranted.

b. Health Care Investigations (0252). A report of a medical incident may be either a command or litigation-report investigation. The section sets out the types of adverse patient outcomes or allegations that require a command to convene an investigation. In general, an investigation is required when death or serious injury occurs and the adequacy of medical care provided by Government employees or in an MTF or DTF is reasonably an issue, even if a claim has not been filed or is unlikely. Examples when an investigation is required include:

- (1) Deaths (including suicides).
- (2) Unanticipated treatment complications resulting in total or partial sensory, limb, or organ loss or impairment.
- (3) HIV or hepatitis-contaminated blood transfusions.
- (4) Procedures performed on the wrong limb or body part.
- (5) Nonemergent medical procedures performed that exceed the scope of a provider's designated privileges.

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c. Command Investigation (0209). Reports to superiors in the chain of command into specific types of incidents, using a standardized format to gather, analyze, and record evidence. Note submission of DD 2526 to BUMED is required.

d. Litigation-Report Investigations (0210). Reports convened at the direction and under the control of a judge advocate when a claim or litigation has been filed or is reasonably anticipated in which the U.S. Government needs information to defend its interests. The control and format of litigation-report investigations are significantly different from command investigations. For example, witness statements and medical reviews will not be signed, and opinions and recommendations will not be provided, unless requested by the supervising judge advocate. Note submission of DD 2526 to BUMED is required.

2. Routing. JAGMAN routing of the original investigation depends on whether it is a command or litigation-report investigation. Command investigations are forwarded to the General Courts-Martial Convening Authority (GCMA) after endorsement. Following endorsement, litigation-report investigations are forwarded to the OJAG via the staff judge advocate of the GCMA. Specific guidance on JAGMAN routing is usually promulgated by Commander in Chief, U.S. Atlantic Fleet; Commander in Chief, U.S. Pacific Fleet; or Chief, Naval Education and Training as appropriate for the MTF or DTF. Forward copies of all health care investigations to Chief, Bureau of Medicine and Surgery (MED-36) and Navy Inspector General, following the command's initial endorsement.

3. Specialty Assistance. Commands and investigating officers may solicit and seek additional medical specialty help as needed from within Department of the Navy sources. Assistance in cases where a command lacks sufficient expertise to adequately investigate an incident may be arranged on a temporary additional duty basis with other Navy MTFs and DTFs in exceptional cases. MED-36 may be contacted for further assistance if the command is unable to investigate an incident due to the specialized nature of the issues or personnel whose care is under review.

CASE ABSTRACT FOR MALPRACTICE CLAIMS
INSTRUCTION SHEET FOR DD 2526

1. Cognizant treatment facilities will submit DD 2526 to BUMED concurrently with the completion of a "Litigation Report" or "Command Investigation."

a. Cognizant treatment facilities must complete sections 1, 2, leave the Report Control Symbol block blank, 3a or b, 4 (these are the dates covered by the investigation), 5 only if known, 7a, 7b, 8a through 8f (the primary physician), (additional physicians can be placed in block 19), 9, 10, 11, 12, 13a (type a short summary of the harm, if any, suffered by the patient), 15a through 15d, and 19.

(1) List the diagnoses, procedures, and International Classification of Diseases, Ninth Edition - Clinical Modification (ICD9-CM) codes from the health care record in sections 11 and 12. 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 of a claim that are provided by the claimant or the claimant's attorney in section 13a, if you know it, otherwise a short summary of the case will suffice.

(3) Indicate the professional review findings on the standard of care in section 15. If standards were not met, indicate in item 15b(2). 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 8a through 8c. 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 3 of DD 2526 and resubmit to MED-361. 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 or reporting facilities shall ensure the ECOMS or ECODS provide the required professional review required by section 15.

3. MED-361 will maintain all information contained in the DD 2526 in a computerized RM database and periodically perform RM and quality of care analyses to applicable treatment facilities.

CASE ABSTRACT FOR MALPRACTICE CLAIMS		1. DATE OF REPORT (YYMMDD)	2. CLAIMANT LAST NAME	REPORT CONTROL SYMBOL
3. TYPE OF REPORT (X one)			4. DATES OF ACT(S) OR OMISSION(S) (YYMMDD)	
<input type="checkbox"/> a. INITIAL	<input type="checkbox"/> b. CORRECTION OR ADDITION		a. BEGINNING DATE	b. ENDING DATE
<input type="checkbox"/> c. REVISION TO ACTION	<input type="checkbox"/> d. VOID PREVIOUS REPORT			
5. DATE CLAIM FILED (YYMMDD)	6. DATE OF JUDGMENT OR SETTLEMENT (YYMMDD)	7. MEDICAL TREATMENT FACILITY		
		a. NAME	b. DMIS CODE	
8. PROVIDER INFORMATION				
a. NAME (Last, First, Middle Initial, Suffix)		b. SSN	c. DATE OF BIRTH (YYMMDD)	
d. NAME OF PROFESSIONAL SCHOOL ATTENDED		e. DATE GRADUATED (YYMMDD)	f. SPECIALTY CODE	
g. STATUS (X one)				
<input type="checkbox"/> (1) Army	<input type="checkbox"/> (3) Air Force	<input type="checkbox"/> (5) Civilian GS	<input type="checkbox"/> (7) Partnership External	<input type="checkbox"/> (9) Non-Personal Services Contract
<input type="checkbox"/> (2) Navy	<input type="checkbox"/> (4) PHS	<input type="checkbox"/> (6) Partnership Internal	<input type="checkbox"/> (8) Personal Services Contract	
h. SOURCE OF ACCESSION (X all that apply)				
(1) Military		(2) Civilian		
<input type="checkbox"/> (a) Volunteer	<input type="checkbox"/> (d) National Guard	<input type="checkbox"/> (a) Civil Service	<input type="checkbox"/> (d) Foreign National (Local Hire)	
<input type="checkbox"/> (b) Armed Forces Health Pro- fessional Scholarship Program	<input type="checkbox"/> (e) Reserve	<input type="checkbox"/> (b) Contracted	<input type="checkbox"/> (e) Other (Specify)	
<input type="checkbox"/> (c) Uniformed Services Univer- sity of Health Sciences	<input type="checkbox"/> (f) Other (Specify)	<input type="checkbox"/> (c) Consultant		
i. LICENSING INFORMATION				
(1) State of License	(2) License Number	(1) State of License	(2) License Number	
9. TYPE OF PROVIDER AND SPECIALTY (FIELD OF LICENSURE) (X all that apply)				
a. PHYSICIAN DEGREE	M.D. (010)	D.O. (020)		
(1) Highest Level of Specialization				
<input type="checkbox"/> (a) Board Certified	<input type="checkbox"/> (b) Residency Completed	<input type="checkbox"/> (c) In Residency (015/025)	<input type="checkbox"/> (d) No Residency	
(2) Primary Specialty				
<input type="checkbox"/> (a) In Training	<input type="checkbox"/> (h) Internal Medicine (Cont.)	<input type="checkbox"/> (i) Otorhinolaryngology	<input type="checkbox"/> (t) Surgery, General (Cont.)	
<input type="checkbox"/> (b) General Practice (GMO)	<input type="checkbox"/> (h.c) Infectious Disease	<input type="checkbox"/> (m) Orthopedics	<input type="checkbox"/> (t.d) Oncology	
<input type="checkbox"/> (c) Anesthesiology	<input type="checkbox"/> (h.d) Nephrology	<input type="checkbox"/> (n) Pathology	<input type="checkbox"/> (t.e) Pediatric	
<input type="checkbox"/> (d) Aviation Medicine	<input type="checkbox"/> (h.e) Pulmonary	<input type="checkbox"/> (o) Pediatrics	<input type="checkbox"/> (t.f) Peripheral Vascular	
<input type="checkbox"/> (e) Dermatology	<input type="checkbox"/> (h.f) Rheumatology	<input type="checkbox"/> (p) Physical Medicine	<input type="checkbox"/> (t.g) Plastic	
<input type="checkbox"/> (f) Emergency Medicine	<input type="checkbox"/> (h.g) Tropical Medicine	<input type="checkbox"/> (q) Preventive Medicine	<input type="checkbox"/> (u) Underseas Medicine	
<input type="checkbox"/> (g) Family Practice	<input type="checkbox"/> (h.h) Allergy/Immunology	<input type="checkbox"/> (r) Psychiatry	<input type="checkbox"/> (v) Urology	
<input type="checkbox"/> (h) Internal Medicine	<input type="checkbox"/> (h.i) Cardiology	<input type="checkbox"/> (s) Radiology	<input type="checkbox"/> (w) Intensivist	
<input type="checkbox"/> (h.a) Gastroenterology	<input type="checkbox"/> (h.j) Endocrinology	<input type="checkbox"/> (t) Surgery, General	<input type="checkbox"/> (x) Neonatologist	
<input type="checkbox"/> (h.b) Hematology- Oncology	<input type="checkbox"/> (i) Neurology	<input type="checkbox"/> (t.a) Cardio-Thoracic	<input type="checkbox"/> (y) Other (Specify)	
	<input type="checkbox"/> (j) Obstetrics/Gynecology	<input type="checkbox"/> (t.b) Colon-Rectal		
	<input type="checkbox"/> (k) Ophthalmology	<input type="checkbox"/> (t.c) Neurosurgery		
(3) Board Certification(s)				
b. DENTIST				
		DENTIST (030)		
(1) Highest Level of Specialization				
<input type="checkbox"/> (a) Board Certified	<input type="checkbox"/> (c) In Residency (035)	<input type="checkbox"/> (2) Primary Specialty		
<input type="checkbox"/> (b) Residency Completed	<input type="checkbox"/> (d) No Residency	<input type="checkbox"/> (a) General Dental Officer	<input type="checkbox"/> (c) Other (Specify)	
		<input type="checkbox"/> (b) Oral Surgeon		
(3) Board Certification(s)				
c. OTHER PROVIDERS				
OTHER PROVIDERS				
<input type="checkbox"/> Audiologist (400)	<input type="checkbox"/> Nurse Anesthetist (110)	<input type="checkbox"/> Optometrist (636)	<input type="checkbox"/> Registered Nurse (100)	
<input type="checkbox"/> Clinical Dietician (200)	<input type="checkbox"/> Nurse Midwife (120)	<input type="checkbox"/> Physical Therapist (430)	<input type="checkbox"/> Emergency Medical Technician	
<input type="checkbox"/> Clinical Pharmacist (050))	<input type="checkbox"/> Nurse Practitioner (130)	<input type="checkbox"/> Physician Assistant (642)	<input type="checkbox"/> Other (Specify)	
<input type="checkbox"/> Clinical Psychologist (370)	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Podiatrist (350)		
<input type="checkbox"/> Clinical Social Worker (300)	(410)	<input type="checkbox"/> Speech Pathologist (450)		

15. PROFESSIONAL REVIEW ASSESSMENT BY MEDICAL TREATMENT FACILITY														
a. ATTRIBUTION OF CAUSE (X all that apply)						b. EVALUATION OF CARE (X one)								
<input type="checkbox"/> (1) Facility or Equipment		<input type="checkbox"/> (2) Physician		<input type="checkbox"/> (3) Personnel other than Physician		<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met						
<input type="checkbox"/> (4) Management		<input type="checkbox"/> (5) System				<input type="checkbox"/> (3) Indeterminate								
c. IDENTIFY LOCATION OF CARE (X one)														
<input type="checkbox"/> (1) Ambulatory Clinic			<input type="checkbox"/> (2) Inpatient Clinic			<input type="checkbox"/> (3) Dental Service			<input type="checkbox"/> (4) Emergency			<input type="checkbox"/> (5) Other (Specify)		
d. INJURY SEVERITY (X one)						e. INJURY DURATION (X one)								
<input type="checkbox"/> (1) None		<input type="checkbox"/> (2) Some		<input type="checkbox"/> (3) Death		<input type="checkbox"/> (1) Temporary		<input type="checkbox"/> (2) Permanent		<input type="checkbox"/> (3) Cannot Predict/Undetermined				
16. ASSESSMENT														
a. AFIP REQUIRED?		<input type="checkbox"/> YES		<input type="checkbox"/> NO (Evaluation of Care. X one)		<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met		<input type="checkbox"/> (3) Indeterminate				
b. OTHER ASSESSMENTS														
(1) UCA or Name						<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met		<input type="checkbox"/> (3) Indeterminate				
(2) UCA or Name						<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met		<input type="checkbox"/> (3) Indeterminate				
(3) UCA or Name						<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met		<input type="checkbox"/> (3) Indeterminate				
(4) UCA or Name						<input type="checkbox"/> (1) Met		<input type="checkbox"/> (2) Not Met		<input type="checkbox"/> (3) Indeterminate				
c. FINAL OTSG DETERMINATION ACT OR OMISSION CODE(S) (Refer to table on Page 4)								d. CLINICAL SERVICE CODE						
<input type="checkbox"/> (1) Primary Act or Omission Code				<input type="checkbox"/> (4) Additional Act or Omission Code				<input type="checkbox"/> (1) Primary						
<input type="checkbox"/> (2) Additional Act or Omission Code				<input type="checkbox"/> (5) Additional Act or Omission Code				<input type="checkbox"/> (2) Secondary						
<input type="checkbox"/> (3) Additional Act or Omission Code				<input type="checkbox"/> (6) Additional Act or Omission Code				<input type="checkbox"/> (3) Tertiary						
17. STANDARD OF CARE (OTSG DETERMINATION) (X one)						18. NPDB REPORTED								
<input type="checkbox"/> MET						<input type="checkbox"/> YES								
<input type="checkbox"/> NOT MET						<input type="checkbox"/> NO								
19. REMARKS														

DIAGNOSIS RELATED

- 010 Failure to diagnose (i.e., concluding that patient has no disease or condition)
- 020 Wrong diagnosis (misdiagnosis, i.e., original diagnosis is incorrect)
- 030 Improper performance of test
- 040 Unnecessary diagnostic test
- 050 Delay in diagnosis
- 060 Failure to obtain consent/lack of informed consent
- 090 Diagnosis related (NOC)*

ANESTHESIA RELATED

- 110 Failure to complete patient assessment
- 120 Failure to monitor
- 130 Failure to test equipment
- 140 Improper choice of anesthesia agent or equipment
- 150 Improper technique/induction
- 160 Improper equipment use
- 170 Improper intubation
- 180 Improper positioning
- 185 Failure to obtain consent/lack of informed consent
- 190 Anesthesia related (NOC)*

SURGERY RELATED

- 210 Failure to perform surgery
- 220 Improper positioning
- 230 Retained foreign body
- 240 Wrong body part
- 250 Improper performance of surgery
- 260 Unnecessary surgery
- 270 Delay in surgery
- 280 Improper management of surgical patient
- 285 Failure to obtain consent for surgery/lack of informed consent
- 290 Surgery related (NOC)*

MEDICATION RELATED

- 305 Failure to order appropriate medication
- 310 Wrong medication ordered
- 315 Wrong dosage ordered of correct medication
- 320 Failure to instruct on medication
- 325 Improper management of medication program
- 330 Failure to obtain consent for medication/lack of informed consent
- 340 Medication error (NOC)*
- 350 Failure to medicate
- 355 Wrong medication administered
- 360 Wrong dosage administered
- 365 Wrong patient
- 370 Wrong route
- 380 Improper technique
- 390 Medication administration related (NOC)*

INTRAVENOUS AND BLOOD PRODUCTS RELATED

- 410 Failure to monitor
- 420 Wrong solution
- 430 Improper performance
- 440 IV related (NOC)*
- 450 Failure to insure contamination free
- 460 Wrong type
- 470 Improper administration
- 480 Failure to obtain consent/lack of informed consent
- 490 Blood product related (NOC)*

OBSTETRICS RELATED

- 505 Failure to manage pregnancy
- 510 Improper choice of delivery method
- 520 Improperly performed vaginal delivery
- 525 Improperly performed C-section
- 530 Delay in delivery (induction or surgery)
- 540 Failure to obtain consent/lack of informed consent
- 550 Improperly managed labor (NOC)*
- 555 Failure to identify/treat fetal distress
- 560 Delay in treatment of fetal distress (i.e., identified but treated in untimely manner)
- 570 Retained foreign body/vaginal/uterine
- 580 Abandonment
- 590 Wrongful life/birth
- 590 Obstetrics related (NOC)*

TREATMENT RELATED

- 610 Failure to treat
- 620 Wrong treatment/procedure performed (also improper choice)
- 630 Failure to instruct patient on self care
- 640 Improper performance of a treatment/procedure
- 650 Improper management of course of treatment
- 660 Unnecessary treatment
- 665 Delay in treatment
- 670 Premature end of treatment (also abandonment)
- 675 Failure to supervise treatment/procedure
- 680 Failure to obtain consent for treatment/lack of informed consent
- 685 Failure to refer/seek consultation
- 690 Treatment related (NOC)*

MONITORING

- 710 Failure to monitor
- 720 Failure to respond to patient
- 730 Failure to report on patient condition
- 790 Monitoring related (NOC)*

BIOMEDICAL EQUIPMENT / PRODUCT RELATED

- 810 Failure to inspect/monitor
- 820 Improper maintenance
- 830 Improper use
- 840 Failure to respond to warning
- 850 Failure to instruct patient on use of equipment/product
- 860 Malfunction/failure
- 890 Biomedical equipment/product related (NOC)*

MISCELLANEOUS

- 910 Inappropriate behavior of clinician (i.e., sexual misconduct allegation, assault)
- 920 Failure to protect third parties (i.e., failure to warn/protect from violent patient behavior)
- 930 Breach of confidentiality/privacy
- 940 Failure to maintain appropriate infection control
- 950 Failure to follow institutional policy or procedure
- 960 Other (Provide detailed written description)
- 990 Failure to review provider performance

REPORTING REQUIREMENTS

1. Risk managers shall be aware of specialized reporting requirements to alert higher authorities of particular types of incidents. Normally, the MTF and DTF CO, XO, Director for Administration, staff judge advocate, and RM will carefully coordinate their actions to identify known facts and circumstances once it is determined a requirement exists to make a report per Navy-wide mandate.

2. Reference (h) pertains to matters of "high Navy interest," including events that may result in significant media and political inquiries. Included in OPREP-3 NAVY BLUE reports are incidents involving death, serious injury, or illness in which the adequacy of medical care is reasonably an issue (see reference (h), section X, paragraph 1t). Reference (i) deals with mishap reports. NAVADMIN and NAVOP messages also designate when reports should be made to higher authorities for "special interest" issues.

3. MTFs and DTFs should make their immediate line commander and MED-36 aware of such incidents before making a Navy-wide report.

4. Verbal reports are encouraged when a medical command becomes aware of the possibility of a significant medical-legal incident. Such reports are not meant to be micromanagement, but rather to ensure legal and medical assistance is available at the earliest opportunity.

5. The following suggested outline is provided for guidance:

a. Nature of Incident

(1) Allegations of criminal or professional misconduct; alleged significant medical malpractice; or loss of Government property.

(2) Names and military or civilian status of any victims.

(3) Names and military or civilian status of involved MTF or DTF personnel.

b. Whether any media or congressional interest is anticipated.

c. If under investigation: JAGMAN, Naval Criminal Investigative Service, or master at arms status and estimated completion.

d. MTF or DTF point of contact.

REFERENCES

American Society for Healthcare Risk Management of the American Hospital Association. Risk Management Self Assessment Manual. American Hospital Association, 1991.

American Medical Association Patient Safety/Risk Management Subcommittee. Risk Management Principles and Commentaries for the Medical Office. Chicago: AMA, 1990.

American Society for Health Care Risk Management. Risk Management Pearls for Physicians. Chicago: American Hospital Association, 1991.

Campion, Francis X., MD, Grand Rounds on Medical Malpractice. The Risk Management Foundation of the Harvard Medical Institutions, Inc., 1990.

Gallagher, P., and Simonsen, S., Telephone Nursing Practice. Nursing Week, February 1993.

Harpster, L.M., J.D., and Veach, M.S., eds., Risk Management Handbook for Health Care Facilities. American Society for Health-care Risk Management of the AHA. American Hospital Publishing, Inc., 1990.

Illinois State Medical Inter-Insurance Exchange Managing Your Risk/In the Office/At the Hospital. Chicago, Illinois 60602.

The Journal of Legal Medicine, The American College of Legal Medicine, published quarterly by Hemisphere Publishing Corp., 1101 Vermont Ave., N.W., Suite 200, Washington, DC 20005-3521, (202) 289-2174.

Monagle, John F., et al., Medical Ethics, A Guide for Health Professionals. Maryland: Aspen Publishers Inc., 1988.

Richards, E.P, and Rathbun, K. C., Medical Risk Management. Maryland: Aspen Publishers., 1983.

Rowland, Howard S., et al., Hospital Risk Management, Forms Checklists & Guidelines. Maryland: Aspen Publishers, Inc., 1990.

Youngberg, Barbara J., Essentials of Hospital Risk Management. Maryland: Aspen Publishers, Inc., 1990.

Youngberg, B., ed., Medical-Legal Survival: A Risk Management Guide for Physicians. Oakbrook, IL: University Hospital Consortium, 1991.

Youngberg, Barbara J., Managing The Risk Of Managed Care. Maryland: Aspen Publishers, Inc., 1996.

RESOURCES

American Hospital Association
One North Franklin
Chicago, IL 60606
Telephone: (312) 422-3000

American Society for Healthcare Risk Management (ASHRM)
One North Franklin
Chicago, IL 60606
Telephone: (312) 422-3980 Telefax: (312) 422-3580

ASHRM offers 2-day risk management modules which can be used towards risk management certification. There are a total of five modules, each awards 13.25 contact hours. The annual ASHRM conference awards approximately 26 contact hours of continuing risk management education.

Legal Medicine Open File is a publication of the Armed Forces Institute of Pathology and awards one continuing medical education (CME) in risk management for reading the text and answering a brief series of questions.

MedRisk offers continuing education and risk management services for health care professionals. A variety of CME packages are available. MedRisk, 2500 City West Blvd., Suite 225, Houston, TX 77042, (713) 789-3375.

National Business Coalition on Health
1015 18th Street, N.W.
Suite 450
Washington, DC 20036
Telephone: (202) 775-9300 Telefax: (202) 775-1569

OASD (Health Affairs)
1200 Defense Pentagon
Room 3E336
Washington, DC 20301-1200
Telephone: (703) 695-3360 Telefax: (703) 693-2390

Office of Disease Prevention/Health Promotion
U.S. Department of Health and Human Services
Humphrey Building, Suite 738G
200 Independence Ave., S.W.
Washington, DC 20201
Telephone: (202) 401-0735 Telefax: (202) 205-9478

Veterans Health Administration
Department of Veterans Affairs
801 Vermont Avenue, N.W.
Washington, DC 20420
Telephone: (202) 273-5781 Telefax: (202) 273-5787

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Contact your local State RM society for local classes and certification programs. Points of contact listed below.

AMERICAN SOCIETY FOR HEALTHCARE RM AFFILIATED CHAPTERS

Association for Hospital Risk Management of New York, Inc.
President/Associate Director, Risk Management
Beth Israel Medical Center
First Avenue at 16th Street
New York, NY 10003
Telephone: (212) 420-4672

California Society for Healthcare Risk Management
President-elect/Loss Control Consultant
Sutter Health Risk Management
9343 Tec Center Drive
P.O. Box 160066
Sacramento, CA 95816
Telephone: (916) 364-1800 Telefax: (916) 364-1876

Capital Area Risk Manager's Association
President/Acting General Counsel
DC General Hospital
19th & Massachusetts Avenue, S.E.
Washington, DC 20003
Telephone: (202) 675-5970 Telefax: (202) 675-7871

Connecticut Society for Healthcare Risk Management
President-elect/Legal Counsel/Risk Manager
Rockville General Hospital
31 Union Street
Vernon, CT 06066
Telephone: (203) 872-5266 Telefax: (203) 872-6056

Delaware Society for Healthcare Risk Management
President/Risk Manager
Kent General Hospital
640 South State Street
Dover, DE 19901
Telephone: (302) 674-7405 Telefax: (302) 674-7419

Florida Society for Healthcare Risk Management
President/Associate Risk Manager
Holmes Regional Medical Center
1350 South Hickory Street
Melbourne, FL 32901
Telephone: (407) 727-7000 Telefax: (407) 728-5262

Georgia Society for Healthcare Risk Management
President-elect/Risk Manager
Candler Hospital
P.O. Box 9787
Savannah, GA 31412
Telephone: (912) 692-6602 Telefax: (912) 692-6811

Greater Houston Society for Healthcare Risk Management
President-elect/Legal Asst. Health Law School
McFall, Sherwood, and Sheehy
2500 Two Houston Center
909 Fannin Street
Houston, TX 77010-1003
Telephone: (713) 951-1000 Telefax: (713) 951-1199

Hawaii Association for Healthcare Risk Management
President/Director, Risk Management
St. Francis Medical Center
2230 Liliha Street
Honolulu, HI 96817
Telephone: (808) 547-6440 Telefax: (808) 541-6611

Healthcare Risk Management Society Metropolitan Chicago
President-elect/Director, Risk Management
Lutheran General Health Systems
1775 Dempster Street
Park Ridge, IL 60068
Telephone: (708) 696-8594 Telefax: (708) 823-3548

Heartland Risk Management Society
President-elect/Risk Manager
AMI St. Joseph Hospital
601 North 30th Street
Omaha, NE 68131
Telephone: (402) 449-5014 Telefax: (402) 449-4725

Illinois Society of Healthcare Risk Management
President-elect/Risk Manager/General Counsel
CGH Medical Center
100 East LeFevre Road
Sterling, IL 61081
Telephone: (815) 625-0400

Indiana Society of Healthcare Risk Management
President-elect
Supervisor, Risk Management Health Services
Phico Insurance Company
8425 Woodfield Crossing
Indianapolis, IN 46240
Telephone: (317) 469-9000

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Kentucky Society for Healthcare Risk Management
President-elect/Claims Manager
Humana, Inc.
500 West Main Street
Louisville, KY 40202
Telephone: (502) 580-3726 Telefax: (502) 580-3995

Louisiana Society for Healthcare Risk Management
President-elect/Risk Manager
Glenwood Regional Medical Center
P.O. Box 35805
West Monroe, LA 71294-5805
Telephone: (318) 329-4200 Telefax: (318) 329-4532

Maryland Society for Healthcare Risk Management
President/Risk Management Supervisor
Princeton Insurance Company
4 North Park Drive
Hunt Valley, MD 21030
Telephone: (410) 785-0900 Telefax: (410) 785-0922

Massachusetts Society for Healthcare Risk Management, Inc.
President-elect/Director, Risk Prevention
South Shore Hospital
55 Fogg Road
South Weymouth, MA 02190
Telephone: (617) 340-8803 Telefax: (617) 331-0834

Michigan Society of Healthcare Risk Management
President-elect/General Counsel
Michigan Capital Healthcare
401 West Greenlawn
Lansing, MI 48910
Telephone: (517) 377-8270 Telefax: (517) 334-2822

New Hampshire/Vermont Society for Healthcare Risk Management, Inc
President/Risk Manager
Fletcher Allen Healthcare
UHC Campus
1 South Prospect Street
Burlington, VT 05401
Telephone: (802) 656-4453 Telefax: (802) 656-8207

North Carolina Chapter of ASHRM
President-elect/Associate Director, Risk Management
Duke University Medical Center
Box 3811, DUMC
Durham, NC 27710
Telephone: (919) 684-3277 Telefax: (919) 694-8912

North Texas Society for Healthcare Risk Management
President/Professional Analysis Services, Inc.
1098 Holly Lane
Lewisville, TX 75067
Telephone: (214) 315-2579 Telefax: (214) 315-7531

Pennsylvania Association of Healthcare Risk Management
President-elect/Asst. Vice President Risk Management
Lancaster General Hospital
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604
Telephone: (717) 290-5853 Telefax: (717) 291-9657

Philadelphia Area Society for Healthcare Risk Management
President-elect/Director, Risk Management
Nazareth Hospital
2601 Holme Avenue
Philadelphia, PA 19152
Telephone: (215) 335-6310 Telefax: (215) 335-6087

Society for Healthcare Risk Management of New Jersey
President-elect/Risk Management Consultant
Health Care Insurance Co.
746 Alexander Road
Princeton, NJ 08543
Telephone: (609) 951-5824

South Carolina Society for Hospital Risk Managers and QA
Professionals
President-elect/QM Coordinator
Bon Secours-St. Francis Xavier Hospital
135 Rutledge Avenue
Charleston, SC 29401
Telephone: (803) 577-1000

Southern California Association of Healthcare Risk Managers
President-elect/Executive Director Risk Care
215 East Orangethorpe Avenue, Suite 106
Fullerton, CA 92632
Telephone: (714) 219-8242 Telefax: (714) 525-1530

Tennessee Society for Healthcare Risk Management
President-elect/Director, Risk Management Safety & Security
St. Mary's Medical Center
900 East Oak Hill Avenue
Knoxville, TN 37917
Telephone: (615) 545-7909 Telefax: (615) 545-8049

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Virginia Chapter of ASHRM
President/Director of Risk Management
Medical College of Hampton Roads
P.O. Box 1980
Norfolk, VA 23501
Telephone: (757) 446-6009 Telefax: (757) 446-6095

Washington Healthcare Risk Management Society
President/Risk Manager
Overlake Hospital Medical Center
1035 116th Avenue, N.E.
Bellevue, WA 98004
Telephone: (206) 688-5235 Telefax: (206) 688-5638

CONFIDENTIALITY REQUIREMENTS

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:

1. 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.
2. 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.
3. 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 DoD.
4. 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 DoD and has applied for or been granted authority or employment to provide health care services for such institution.
5. To an officer, employee, or contractor of DoD who has a need for such record or testimony to perform official duties.
6. 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.
7. To an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency referred to in paragraph 6 of this enclosure, but only with respect to the subject of such proceedings.