UNITED STATES MARINE CORPS
I MARINE EXPEDITIONARY FORCE
U. S. MARINE CORPS FORCES, PACIFIC
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IN REPLY REFER TO:
I MEFO 6300.19
SURG
FEB 10 2017

I MARINE EXPEDITIONARY FORCE ORDER 6300.19

From: Commanding General, I Marine Expeditionary Force
To: Distribution List

Subj: PRIMARY CARE SERVICES AND THE MARINE CENTERED MEDICAL HOME

Ref: (a) NAVMED P-117, Chapter 13, "Garrison Care for Operational Forces"
(b) DOD/HA Policy 09-015, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs"
(c) DC, I&L and Chief, BUMED MOU dtd 10 Nov 2014
(d) I MEFO 6320.4A

Encl: (1) I Marine Expeditionary Force Marine-Centered Medical Home Standard Operating Procedures Manual Template

1. Situation

a. The Marine Corps, in collaboration with Navy Medicine, has committed itself to improving its support and care for the operational forces. Patterning after the Patient Centered Medical Home (PCMH) model of primary care, implemented by Chief, Bureau of Medicine and Surgery (BUMED) in 2009, the Marine Corps soon developed a specific adaptation of the PCMH model titled Marine Centered Medical Home (MCMH). The model is designed to maximize efficiency in clinic operations, improve access to medical care, and elevate the standard of care in the garrison setting.

b. Per reference (a), garrison care for operational forces is a shared responsibility between the Navy Surgeon General/Chief Bureau of Medicine and Surgery (BUMED) and the supported force Commanders. Thus, BUMED has established the MCMH model to capitalize on the combination of providers and assets from both "blue" Naval Hospital Staffs and "green" operational medical forces to ensure the future Marine Corps will have seamless, unobstructed access to world-class healthcare. In view of that vision, references (b) and (c) delineate specific relationships and roles of BUMED and the USMC regarding the operation of the MCMH primary care model, and reference (d) ensures clinical care operations for the I Marine Expeditionary Force (I MEF) meet regulatory requirements.

2. Mission. To formally establish the MCMH primary care model within I MEF, and to maximize the health and readiness of every Marine and Sailor in the force, both in garrison and forward deployed, in support of the I MEF warfighting mission via standardized operating procedures.

3. Execution

a. Commander's Intent and Concept of Operations

(1) Commander's Intent. Healthcare delivered to I MEF service members in the garrison environment will meet or exceed the community

standards of care. The MCMH health care delivery model is the method by which that goal will be achieved.

(2) Concept of Operations

(a) The use of appropriate healthcare facilities is critical to providing high quality care. While aid stations are established to provide temporary medical support during field, emergency, or special operations, they do not suffice for providing 21st century care in the garrison environment. Therefore, garrison medical care will be rendered in appropriate clinical spaces provided, furnished, supplied, and maintained by the local MTF. Any patient care operations conducted in a non-clinical space can only be approved by the I MEF Surgeon.

(b) In order to maximize patient care efficiency, the MCMH facilities will have minimal administrative office spaces. Individual unit commands are required to provide and maintain operational health services spaces for their medical staff's non-clinical and administrative duties (medical readiness, planning, logistics support, training, and professional counseling). These duties are not supported by the MCMH model, yet comprise a significant component of the medical department's mission. Dependent upon the unit T/O&E, Commanders should plan to provide office spaces for provider confidentiality, executive level planning, field gear and supplies storage, and a space with multiple computer access nodes for Corpsmen training and administration activities.

(c) If a unit does not have available medical administrative space and cannot procure adequate space, the unit will notify the I MEF G-4/Health Services Support Element who will coordinate with MEF G-4 Engineers and Marine Corps Base (MCB)/Marine Corps Installations Command-West (MCI-W) facilities to determine requirements and identify sufficient space to support the unit's medical administrative operations.

(d) MCMH clinical spaces will maintain compliance with The Joint Commission, Navy Medicine Inspector General (IG), and Marine Corps' Commanding General Inspection Program (CGIP) standards, and will be inspected or surveyed, when appropriate, by these organizations. The non-clinical, administrative spaces shall not be used by unit medical personnel to provide patient care, and thus are not held to these clinical space standards.

(e) All I MEF service members shall be enrolled to a Primary Care Manager (PCM) in the appropriate MCMH clinic. All service members' health records shall be maintained at the MCMH Clinic, and all service members will be eventually enrolled in the "Relay Health" secure patient messaging system to enable 24/7 access to their PCM and/or Primary Care Clinic Team.

(f) All I MEF medical providers will maintain a primary staff appointment with clinical privileges from I MEF, endorsed by the primary Privileging Authority, the I MEF Surgeon. All providers will also be required to request, through the I MEF Credentials Office, secondary staff privileges endorsed by the Naval Hospital Commander (i.e. who owns the MCMH clinic in which that provider will work daily) via an Inter-Facility Credentials Transfer Brief (ICTB). Consequently, all credentialed staff will be subject to the I MEF Medical Staff By-Laws, I MEF Medical Staff Policies and Procedures, and the policies and procedures of the Naval Hospital medical staff. However, per reference (c), all I MEF medical staff members will

remain under the direct command authority of the Marine Corps unit to which they are assigned.

(g) Each MCMH clinic will have a Senior Medical Officer (SMO) appointed by the I MEF Surgeon. The SMO is responsible to both the I MEF and Naval Hospital Privileging Authorities for conducting health services, departmental-level health care, and quality assurance activities. The SMO will exercise tactical control over all personnel assigned to support their MCMH clinic as it relates to day-to-day clinical operations in garrison. Whenever possible, the SMO will be a board-certified physician.

b. Responsibilities.

(1) Major Subordinate Command (MSC)/Major Subordinate Element (MSE). Implement and support the MCMH model of patient care as described and directed in reference (c) and this order.

(a) MSC/MSE Surgeons. Provide directorate-level supervision of the medical staff and healthcare quality assurance for all clinical operations within the MCMH facilities in their MSC/MSE in accordance with reference (d) and all other applicable policies.

(b) Unit Commanders. Ensure medical staff has adequate non-clinical space available to conduct administrative functions (See 3.a.2.b above).

(c) Clinic SMOs. Provide supervision for all clinical personnel assigned and ensure clinic standard operating procedures are locally reviewed annually to remain consistent with I MEF and Naval Hospital policy and procedures.

(d) Medical Staff/Providers. Obtain and maintain clinical privileges from the I MEF Surgeon and secondary privileges from the Naval Hospital Commander, via the I MEF Credentialing Office, and comply with all applicable policies and procedures.

(2) I MEF Surgeon

(a) Coordinate with all supporting Navy Hospital COs to ensure that I MEF garrison care meets all clinical quality standards.

(b) Appoint MCMH SMOs.

(c) Establish local policy to support garrison care.

c. Coordinating Instructions

(1) Reference (d) establishes procedures and responsibilities for health care quality management within I MEF and includes the I MEF Medical Staff Policies and Procedures.

(2) Enclosure (1) provides general policy and guidance that must be implemented at every MCMH clinic within I MEF.

(3) Disputes regarding the interpretation of reference (c), this directive, and/or enclosure (1) that cannot be resolved at the unit/MCMH clinic level will be referred via the medical chain-of-command to the I MEF Medical Executive Committee (MEC) and/or I MEF Surgeon. The I MEF MEC will work with the Navy Hospital MEC to resolve issues.

4. Administration and Logistics

a. There are no specific logistic requirements necessary to implement MCMH across the Force. Per reference (c), all MCMH clinic facilities are now owned and operated by the supporting Navy Hospital Commander. Those hospitals that support the I MEF MCMH Program include: Naval Hospital Camp Pendleton and Twenty-Nine Palms, as well as Navy Medical Center San Diego. While Marine Corps Installations Facilities Managers may provide inputs in plans, design, and location for all clinics, BUMED (supporting Navy Hospital Commanders) owns and manages all facilities, including the equipment and infrastructure supporting those facilities.

b. As a reminder, any operational (field) medical logistic requirements (i.e. Authorized Medical Allowance List (AMAL) equipment and consumables) shall be procured from 1st Supply Battalion, 1st Medical Logistics Company via the respective unit S-4. Similarly, Corpsmen Assault Packs (CAP) and Combat Life Saver (CLS) bags and associated SL-3 supplies must be procured through the respective unit S-4 Office. MCMH clinic supplies are not authorized as "SL-3 resupply stocks" for unit CAP/CLS bags.

5. Command and Signal

a. Command. This Order is applicable to all I MEF units.

b. Signal. This Order is effective the date signed.

LEWIS A. CRAPAROTTA

Distribution: I/II

I MEF MARINE-CENTERED MEDICAL HOME
STANDARD OPERATING PROCEDURES MANUAL
for
AREA MEDICAL CLINIC

Submitted by:

LCDR/CDR XXXX, MC, USN
Area Clinic SMO

Approved:

CAPT S. Hussey, MC, USN
I MEF Surgeon

Effective Date: Day Month 201X

Annual Review Date:

Signature:

Enclosure (1)

I MEF MARINE CENTERED MEDICAL HOME (MCMH)
STANDARD OPERATING PROCEDURES MANUAL
QUARTERLY REVIEW SIGNATURE PAGE

(This manual is to be kept at the front desk spaces. Signature implies that the staff member is aware of the location of this manual)

SIGNATURE	DATE	SIGNATURE	DATE

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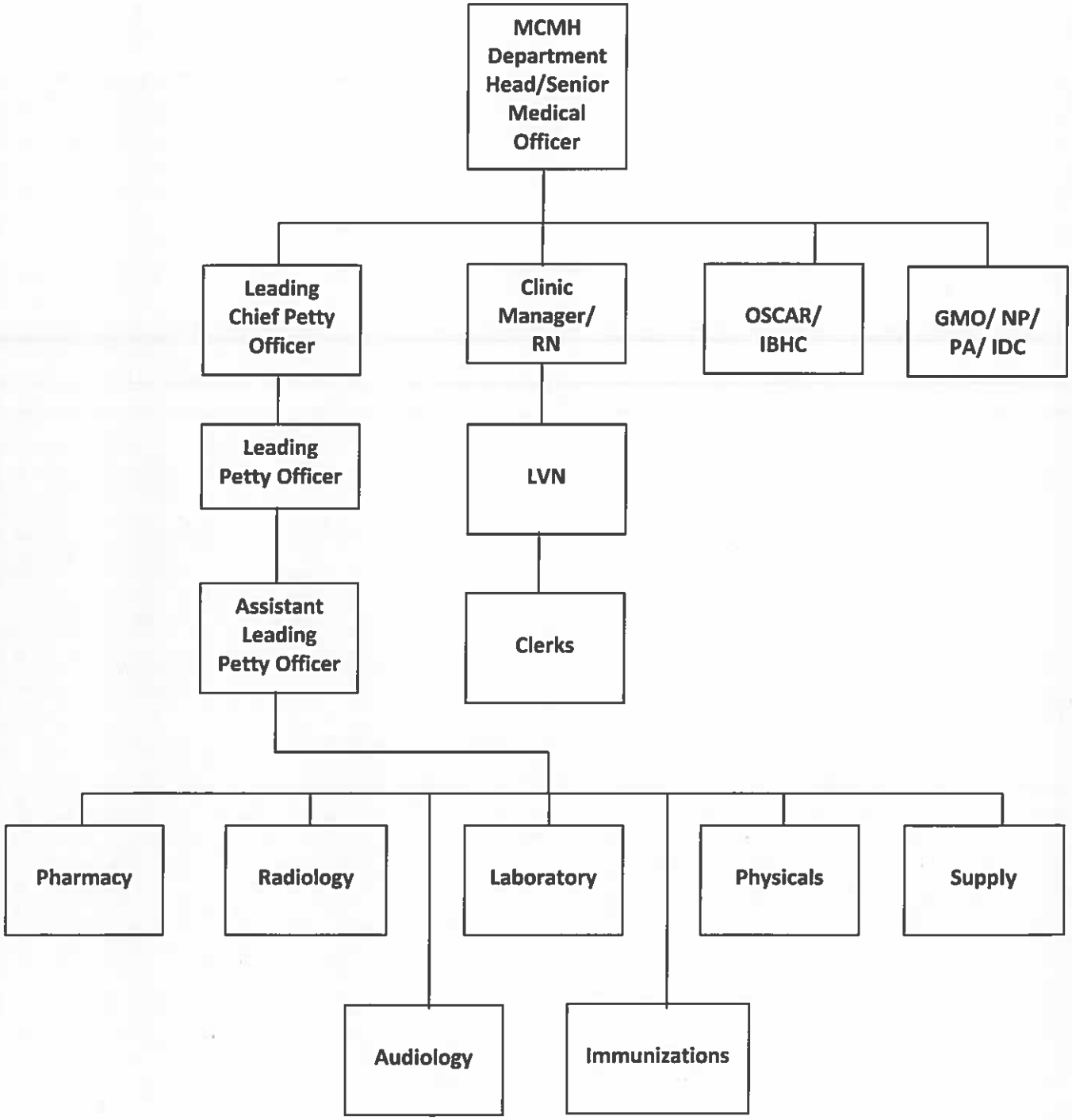
OVERVIEW

MISSION AND VISION

Mission: To maximize the health and readiness of every Marine and Sailor in the force, both in garrison and forward deployed, in support of the I MEF warfighting mission.

Vision: To serve as a model military health service organization and develop innovative methods to provide health services that meet the changing needs of the MEF.

CLINIC ORGANIZATIONAL CHART



MILITARY AND CONTRACT STAFFING

Staffing Plan: Staffing may vary throughout the year based on operational tempo and reassignments to support unit deployments. All active duty members assigned to the clinic are deployable. The general staffing plan for Marine Centered Medical Home clinics are as follows:

I MEF Area Medical Clinic:

X Family Medicine Physician - Active Duty
X General Medical Officer - Military
X Physician Assistant - Military
1 Leading Chief Petty Officer - Military
1 Registered Nurse - Civilian
2 Licensed Vocational Nurses - Civilian
1 Audiology Technician - Civilian
1 Front Desk Clerk - Civilian
1 Integrated Behavioral Health Consultant - Civilian
X Hospital Corpsmen/Medical Technicians - Military
X Preventive Medicine Technician - Military

Ancillary Services (if applicable):

X Laboratory Technician - Military
X Pharmacy Technician - Military
X Radiology Technician - Military
X Immunization Technician - Military

Contract Staff

General: All civilian hiring will be conducted by the local MTF Human Resources Office. The general duties and responsibilities of the civilian contract and GS staff will be outlined in their contracts and Position Descriptions respectively and kept on file at the local MTF Human Resources Department.

SCOPE OF CARE, SERVICES AND HOURS OF OPERATIONS

Scope of Care and Services: The health care delivery model, Marine Centered Medical Home (MCMH), is based on the BUMED Medical Home Port model, and shall be operated and maintained IAW the Joint Commission for Accreditation of Healthcare Organizations (JCAHO) standards of care. This model focuses on the continuity and environment of care, and is intended to facilitate the provision of primary care in a safe and familiar clinical environment. MCMH clinics have been established, specifically, to provide comprehensive garrison medical care to Marines and Sailors within I MEF, as well as operational medical support to unit training exercises. Although each MCMH clinic may not have all primary care capabilities, MCMH clinics generally provide the following services to Active Duty Marines and Sailors:

- Primary Care
- Acute/Urgent Care
- Ancillary Services (Laboratory, Pharmacy and Radiology)
- Military Physicals
- Periodic Health Assessments (PHAs)
- Immunizations/Preventive Medicine
- Mental Health/Integrated Behavioral Health (IBH)
- Deployment Health

Note: Although the Medical Clinic will triage and treat acute injuries and illnesses to the best of their ability, it is not equipped or staffed to provide Emergency Medical Services or after hours/weekend care. All emergencies will be referred to the nearest Military Treatment Facility's (MTF's) Emergency Department and/or the region's Fire Department / Emergency Services (EMS) by calling 911.

Hours of Operations: Monday - Friday: 0800-1630 (hours may differ slightly within each MCMH clinic). Holiday hours will be set by the Clinic Department Head/Senior Medical Officer in conjunction with the USMC line Commanders.

SERVICES

AUDIOLOGY

Ref: (a) DOD Instruction 6055.12
(b) MARADMIN 010/12

Purpose: To provide audiology services and assessment to enrolled active duty beneficiaries per references (a) and (b).

Procedures

1. Audiometry Testing

a. All patients will report to the audiology booth with his/her medical record and a completed Hearing Conservation Annual Training form per reference (b).

b. Upon completion of testing, the technician will provide the patient with a copy of their test, provide patient education, create an AHLTA encounter, and record the encounter in MRRS.

c. Any patient who fails an audiogram will report back to the medical clinic audiology department the following business day for a second test.

d. Patients who fail an audiogram for the second time will make an appointment with the local MTF Hearing Conservation Department within two (2) to four (4) weeks for further testing.

2. Documentation

a. DD2215 Reference Audiogram

b. DD2216 Hearing Conservation Data

c. A minimum requirement of training as an Audiology OJT (on-the-job training) is required to input all audiograms into AHLTA (see Paragraph 4 on training).

3. Audiology Stand Downs

a. Units are responsible for providing their own audiology technicians and keeping the medical clinic's chain of command informed of the schedule.

b. Reservations for the Mobile Hearing Conservation and Audiometric Testing (MOHCAT) vehicle will be handled by the medical clinic staff or the individual requesting unit.

c. Reservations will be requested through the local MTF Hearing Conservation Department.

d. The medical clinic or requesting unit representative is responsible for picking up the MOHCAT laptop from the MTF Hearing Conservation Department, maintaining the laptop, and returning it.

4. Training

a. All On-The-Job (OJT) training will be conducted by the local MTF Hearing Conservation section.

b. The medical clinic or individual units will coordinate with the local MTF Hearing Conservation for required training and certifications.

c. OJT certification expires five (5) years from date of issue.

d. OJT certification documentation is required to be maintained in the member's training record.

INTEGRATED BEHAVIORAL HEALTH (IBH)

Ref: (a) BHIP-MHP Practice Manual
(b) Navy Practice Standards Manual for Behavioral Health Integration in the MHP

Purpose: To deliver focused, consultation-based, services to patients and PCMs using a Primary Care Behavioral Health Model of service delivery. The IBHC offers assistance when behaviors, stress, worry, or emotional concerns are interfering with the patient's daily life. The IBHC works in cooperation with the clinic primary care providers and provides brief, solution-focused interventions as defined in references (a) and (b).

Procedures

1. The IBHC receives referrals from primary care providers for patients who require assistance primarily for, but not limited to, the following conditions:

a. Headaches, sleep problems, chronic pain, smoking cessation, mild depression, anxiety, anger, stress, bereavement and family/relationship difficulties.

2. Patients are booked into 30 minute appointments. If patients require more than four (4) appointments for any single condition they should be referred to a higher level of care.

3. Following initial and follow-on appointments, the IBHC will contact the primary care provider to provide feedback on the appointment and the agreed upon treatment plan. The IHBC can also assist with referring patients to a higher level of care when applicable.

4. Patients are able to self-refer should they feel that they can benefit for the support and treatment the IBHC is able to provide. To self-refer, patients can call the Patient Appointment Line and ask to speak to the LVN Care Coordinator who may refer them to the IHBC.

5. Literature on the use of Marine Corps Community Services (MCSS) or the Marine Family Life Counselor (MFLC) will be available in the clinic for patients.

OPERATIONAL STRESS CONTROL & READINESS (OSCAR)

Ref: (a) DOD Instruction 6490.04
(b) DOD Instruction 6490.08
(c) DOD Instruction 6490.01

Purpose: To assist commanders in preventing, identifying, and managing combat and operational stress in their units IAW references (a) through (c).

Procedures

1. Patients who check in at the I MEF area medical clinic duty desk with concerns or symptoms related to operational stress will be screened and if necessary directed to the nearest OSCAR provider for specialized mental health care.

2. Referrals

a. Referrals to the OSCAR department will be coordinated between requesting medical provider and the OSCAR Psychiatric Technician.

b. Referrals will be triaged by the OSCAR Psychiatric Technician and if deemed appropriate, an appointment will be made.

3. After-Hours Medical Care

a. Determine if the patient needs emergent care. If not, annotate patient contact information and forward to the OSCAR office for follow-up contact.

b. If it is determined that the patient needs emergent care (suicidal, homicidal, or psychotic behavior), they will be sent directly to Emergency Room at the local MTF. All efforts will be made to contact the MTF Emergency Department to alert them to the arrival of the patient and provide a clinical history.

(1) Patients are required to be escorted to the Naval Hospital. The escort will stay with patient until relieved by a competent medical authority. Patient will be admitted to the Mental Health Department or released by the Mental Health Department without a suicide watch.

(2) For patients who are discharged from the ED after a mental health evaluation, they will follow up at the Lake O'Neil clinic or with the appropriate embedded provider (OSCAR, Division Psychiatry, IBHC, etc.) the next business day. Immediately after the follow up MH evaluation, the patient will report directly to their respective unit medical provider.

4. Command directed evaluations must adhere to the following guidance:

a. Command must contact the OSCAR/Mental Health provider to provide necessary information and schedule an appointment for the patient to be evaluated.

b. Commanding Officer must inform the member that a Mental Health appointment has been scheduled for that member, and be given the specific date/time to the member. Also, it is highly recommended the Commander reassure the member that no stigma or repercussions will occur as a result of seeing mental health.

c. Further guidance regarding command directed mental health evaluations can be located in reference (a).

LABORATORY

Ref: (a) Naval Hospital Camp Pendleton Laboratory User's Manual

Purpose: To provide laboratory capability to active duty beneficiaries as deemed necessary by a medical provider. For further details, see the local MTF laboratory SOP in ref (a).

Procedures

1. Accessioning Guidelines and Laboratory Procedures:

a. Once laboratory test has been ordered by a medical provider, patients will report to the Laboratory Department for completion of ordered tests. Patient's identification will be confirmed prior to start of laboratory test by verifying their name and date of birth with their ID card.

b. Upon positive confirmation of patient's identification, patient will be logged into CHCS and labels will be printed for all specimen tests.

c. For tests requiring patient fasting, confirm that patient has only consumed water or black coffee within the last 12 hours.

d. All laboratory tests will be conducted utilizing proper personal protective equipment. Verify patient's allergies prior to conducting all testing.

e. Once laboratory tests have been conducted, laboratory technician will utilize universal precautions for equipment disposal.

f. All specimens will be labeled immediately after conducting tests.

2. All specimens, to include DNA and urine, will be handled in accordance with procedures outlined in the supporting MTF's Laboratory SOP, reference (a).

3. Close-Out Procedures:

a. Transmittal list will be generated every work day.

b. Each laboratory and specimen type will be on a separate transmittal list.

c. All items requiring transport will be put into a labeled biohazard bag along with the associated list.

d. Copies of transmittal lists will be maintained by the laboratory department for 6 months.

e. Once all laboratory specimens are sorted and properly labeled, they will be stored in a container approved for the shipment of biohazard items. Specimens requiring refrigeration will be kept in the laboratory department's refrigerator until shipment.

f. Specimens needing transport to the local MTF laboratory for analysis will be transported by either a hospital approved courier service or by a duty vehicle driven by a member of the medical staff properly trained on specimen transport.

4. Department Maintenance

a. Temperature checks will be completed at the beginning of the day (0730) and end of the day (1630) on the laboratory workspace refrigerators and freezers. Note: Lab specimens should not to be kept overnight in the clinic if possible.

b. Weekly function checks will be completed on the eye wash station by thorough completion of the following tasks:

c. All laboratory supplies will be ordered through the local MTF Supply Department.

PHARMACY

Ref: (a) Manual of the Medical Department, Chapter 21

Appendix: (1) DD Form 1289 Prescription
(2) SALAD poster
(3) HAM poster
(4) Over-the-Counter Medication Form

Purpose: To provide pharmacy support to the active duty beneficiaries utilizing established national pharmacy practice standards as guidelines for pharmacy operations per reference (a). For further details, review the local MTF Pharmacy SOP.

Procedures:

1. Tasks:

(1) Dispense and refill medication ordered by providers through AHLTA or CHCS using appropriate procedures.

(2) Return medications with an expiration date within 3 months to the local MTF Pharmacy Department.

(3) Maintain pharmacy stock; reorder medications as needed. Verify expiration dates.

2. Dispensing Medication and Refill Procedures:

a. All medication will be ordered by a medical provider electronically utilizing the AHLTA or CHCS system. Note: In the event that AHLTA or CHCS is experiencing technical difficulties, all medications will be ordered by a medical provider utilizing DD Form 1289 (Appendix 1) for submission to the clinic pharmacy or local MTF pharmacy.

b. Beneficiaries will show the Pharmacy Technician/OJT their ID card prior to their medications being dispensed.

c. Pharmacy Tech/OJT will scan all meds through Script Pro System Automated Tele-Pharmacy, if available.

d. Pharmacy Tech/OJT will place patient name and RX stickers in appropriate locations on the log sheet and a Licensed Independent Provider (LIP) will sign the log sheet.

3. Medication Administration:

a. The following will be verified by a pharmacist or LIP prior to all medications being dispensed or administered within the I MEF area medical clinic:

(1) Right Person

(2) Right Medication

(3) Right Dose

(4) Right Time

(5) Right Route

4. Formulary and Inventory:

a. A copy of the High Alert/ Sound Alike - Look Alike Drugs (HAM/SALAD) poster will be posted in the pharmacy, if applicable to clinic's formulary. A "high alert" sticker must be placed on the Epinephrine stock (Appendices 2 and 3).

b. A copy of the supporting MTF Pharmacy formulary will be available in the clinic and will be accessible to all providers.

c. Inventories will be completed on a monthly basis. Pharmacy Tech/OJT will ensure a minimum stock level for all medications is on hand. If not, necessary medication will be ordered through the supporting MTF pharmacy.

5. Over-the-Counter (OTC) Medication Program:

a. Rules:

(1) Patients may not receive medications simply by asking for them. Patients must be assessed by a medical team member prior to dispensing OTC medications.

(2) Patients are allowed a maximum of three OTC medications per month.

b. OTC form (Appendix 4) must be filled out completely prior to any medications being dispensed.

c. OTC Medication Request forms must be signed by both the patient and a sick call qualified Corpsman.

d. All OTC recipients will have an encounter documented in AHLTA with proper coding and the OTC form will be scanned and attached to the encounter.

6. Required Training for OJT Pharmacy Techs:

a. A minimum of thirty (30) days on-the-job-training (OJT) from a pharmacy tech and/or pharmacist is required through either the I MEF area medical clinic or local MTF with completion of an initial competency assessment and PQS.

b. PQS will be reviewed and signed by a Pharmacist at either the area medical clinic or local MTF prior to completion.

c. OJT certification documentation is required to be maintained in the member's training record.

RADIOLOGY

Ref: (a) NAVMED P-5055, Radiation Health Protection Manual

Purpose: To provide radiology services to active duty beneficiaries.

Procedures

1. Duties of Radiology Technician/Radiology OJT:

a. Performs a variety of routine radiographic examinations on active duty members only. Responsible for explaining the procedure, positioning the patient, selecting and setting technical factors, setting up and adjusting accessory equipment and taking the necessary exposures.

b. Ensures that x-ray requests contain complete patient information and verifies appropriateness of the examination. Confirm the identity of the patient by verifying the name and date of birth match their ID card.

c. Documents and reports equipment malfunction to the local MTF Radiology and Biomedical Engineering Departments.

d. Cleans x-ray equipment between each patient in accordance with radiologic standards and maintains the cleanliness of the department at all times per reference (a).

e. Cleans all x-ray cassettes monthly; documents the cleaning in the Cassette Cleaning Log.

f. Submits requisitions for supplies through the I MEF area medical clinic Supply Petty Officer.

2. Radiation Safety: All examinations must be performed in accordance with the local MTF Radiology Department Diagnostic Views Protocol, per reference (a).

3. Radiation Monitoring: Technicians and OJTs are generally not issued Thermo Luminescent Devices (TLD) since overexposure risk is minimal. The radiation exposure levels for OJTs are monitored with a clinic wall mounted TLD.

4. Required Training for OJT Radiology Techs

a. A minimum of thirty (30) days on-the-job-training (OJT) from a radiology technician at the local MTF Radiology Department.

b. Complete a two (2) day radiation safety class conducted by the local MTF Radiation Health Officer.

c. Complete an initial competency assessment and an annual assessment thereafter.

d. OJT certification documentation is required to be maintained in the member's training record.

PREVENTIVE MEDICINE

Ref: (a) I MEF Immunization Requirements and Guidelines
(b) NAVMED P-5010, Manual of the Preventive Medicine
(c) BUMEDINST 6230.15B, Immunizations and Chemoprophylaxis
(d) Advisory Committee on Immunization Practices (ACIP)

Appendix: (5) Vaccine Order Form

Purpose: To maximize combat readiness by providing preventive medicine advice, conducting technical surveillance, and providing environmental health recommendations.

Procedures

1. General: The Clinic Preventive Medicine Department will employ a Preventive Medicine Technician (PMT) and/or a Preventive Medicine Representative (PMR).

2. Ordering Immunizations:

a. Immunizations will be ordered utilizing the local MTF's Vaccine Order Form. The medical clinic's PMT/PMR will fill out the vaccine order form (Appendix 5), and submit the order form to their MSC Surgeon's Preventive Medicine Department. The MSC Surgeon's office will verify, endorse, and forward the request to the I MEF Surgeon's Office for second endorsement. The I MEF Surgeon's Office will forward the completed request to the local MTF's Preventive Medicine Unit (PMU), per reference (a).

b. Immunization requests submission timelines must be in accordance with the local MTF's Preventive Medicine Department policy.

c. The local MTF Preventive Medicine Department will notify the requesting clinic to coordinate pick up. Units may call the local MTF's Preventive Medicine Department to validate receipt of request.

3. Picking-Up and Dropping-Off Immunizations:

a. Immunizations can only be picked up or returned by a representative that has completed the Preventive Medicine Immunization Course.

b. Immunizations pick up days and times will be set by policy of the local MTF.

4. Vaccine Storage and Handling:

a. Vaccines need to be stored in a dedicated vaccine storage unit with temperatures checked and logged twice a day to verify that temperatures are within established parameters. In the event that this cannot happen (i.e. extended training exercise, weekends, holidays or during power outages) immunizations need to be returned to the local MTF Preventive Medicine Department unless an automated monitoring system is in place. For further detail see reference (a) I MEF Immunization Requirements and Guidelines.

b. To minimize waste and ensure vaccine effectiveness, inventory vaccines weekly and check expiration dates. Document inventory and rotate vaccine stock to ensure vaccines with the shortest remaining shelf life are used first. Keep identical lot numbers together.

c. Vaccines noted to be in excess of need should be returned to the local MTF 60-90 days prior to expiration for redistribution.

d. Vaccine will be returned to the MTF prior to deployment to avoid the risk of expiring or being stored incorrectly.

e. Dispose of expired or deteriorated vaccines in the proper pharmaceutical waste container per reference (a).

5. Administering Immunizations:

a. Prior to the administration of immunizations, every patient needs to complete a "Screening Checklist for Contraindications to Vaccines for Adults." http://www.immunize.org/catg.d/p4065.pdf.

b. All patients receiving immunizations will be offered proper literature and education prior to the administration of any immunizations.

c. All immunizations will be given in the dosages and at intervals prescribed by current instruction and/or manufacturer recommendations and in accordance with refs (a) through (d).

d. Immunizations must not be drawn-up from vial to syringe until the Corpsmen/Medical Technician is ready to administer the immunization.

e. Confirm the identity of the patient, prior to administering immunization, by verifying the name and date of birth with their ID card.

f. Live virus vaccines can either be administered simultaneously or separated by greater than 28 days from other live viruses and inactivated vaccines. If multiple vaccines are administered at a single visit, administer each preparation at a different anatomic site.

g. Immunization series will never be compressed or deviated from the recommended immunization cycle.

h. Immunizations in women of childbearing age:

(1) Women who are receiving MMR, or any combination of measles, mumps, or rubella, must sign a statement that they are not pregnant and do not intend to become pregnant within three (3) months of receiving vaccination per ref (a)through (d). This document must be placed in their medical record.

(2) Most routine immunizations will be waived during pregnancy. Live, attenuated viruses and live bacterial vaccines generally are contraindicated during pregnancy. For further information regarding immunization during pregnancy refer to references (a) through (d).

i. After administering immunizations, discard sharps in an automatic closing sharp container which must be closed when not in use and must contain a demographic label, containing the clinic address.

6. Documentation:

a. Record all immunizations into the patient's medical record.

b. Document all immunizations in the Medical Readiness Reporting System (MRRS) within 24 hours of administration.

c. Immunization rosters and MRRS entries must indicate name, rank, date of immunization, last four of their SSN/EDIPI, type of immunization given, lot number and manufacturer.

7. Immunization Reactions:

a. Administration of immunizations may result in reactions. These reactions can range from a local reaction to anaphylaxis. If the medical provider determines that a patient has experienced an adverse reaction, the PMT/PMR will prepare a Vaccine Adverse Event Reporting System (VAERS) report.

b. Per Joint Regulation, BUMED 6230.15b, reference (c), persons who receive immunizations should be observed for 15 to 20 minutes after being immunized.

c. Clinics or activities administering immunizations must develop and maintain a written plan for emergency response, to include management of anaphylaxis and fainting.

d. Whenever vaccines are administered, at least one person present must be trained in basic cardiopulmonary resuscitation, oropharyngeal airway management, and recognition and initial treatment of anaphylaxis with epinephrine.

e. The following equipment must be immediately accessible on scene: stethoscope, blood pressure cuff (sphygmomanometer), minimum of three adult doses of epinephrine (1:1000), oral airway, bag valve mask or equipment to administer oxygen by positive pressure, and the equipment and ability to activate an emergency medical system. Other equipment and/or medications (i.e. injectable antihistamines, corticosteroids, vasopressors, glucagon, albuterol, and IV fluids with administration sets), depending on the clinical setting and local policy, may be included beyond the minimum requirements listed above.

8. Training: Preventive Medicine Representatives (PMR), Preventive Medicine Technicians (PMT) and any other medical staff who administer immunizations require eight hours of annual immunization training. For further details regarding training, see reference (a). Available options to satisfy the training requirement include local MTF training and online courses. Check with the I MEF Preventive Medicine Officer for a listing of available courses.

OPERATIONS

APPOINTMENT LINE / CALL CENTER

Purpose: To provide active duty beneficiaries an alternate method of scheduling appointments.

Procedures

1. From 0730-1630 on work days, the patient appointment line will be active and manned by a representative from the clinic.

2. After 1630 the phone line will play a prerecorded message directing patients to Nurses Advice Line. This number can be dialed directly at 1-800-TRICARE (874-2273).

3. Scheduling Same-Day Appointments:

a. Every patient should be offered a same-day appointment regardless of reason, if available.

a. If no appointments are available with the patient's primary provider, the patient should be triaged and:

(1) If able to wait, book the patient for an appointment on the next day.

(2) If unable to wait, request the patient walk-in and then schedule the patient with a different provider.

4. Schedule Future Appointments:

a. Reasons: general health check-ups, follow-up appointments, physicals, etc.

b. Review Physicals SOP for proper guidance on scheduling physicals and medical certifications.

5. Telephone Consultations:

a. Consultations that should be sent to providers:

(1) Medication renewals
(2) Lab or radiology results
(3) General questions

b. Consultations that should be sent to nurses: Referral follow-ups.

CLINIC FLOW

Purpose: To establish and outline the flow of patients within the clinic.

Procedures

1. Making Appointments. Patients can make an appointment utilizing the following services:

a. Calling the Patient Appointment Line during working hours. The line will be manned by a representative from the clinic during normal business hours.

b. Reporting to their unit's medical administrative space and scheduling an appointment with the duty Corpsman/Medical Technician.

2. Appointment Check-In

a. Patients must arrive 15 minutes prior to appointment.

b. Upon check-in, the front desk clerk will check the patient in utilizing AHLTA and patient will complete the TSWF Encounter Worksheet.

c. Providers are responsible for ensuring their patients are seen in a timely manner.

d. Appointments are cancelled if patient is 15 minutes late; "No shows" will be documented and reported to the patient's command.

3. Examination Rooms

a. Patients will be escorted into the patient exam room by a clinic Corpsman/Medical technician.

b. Same-sex stand-by Corpsmen/Medical Technician/Nurses will be made available by the clinic if requested.

4. Ancillary Support: Clinic Corpsmen/Medical Technicians are responsible for escorting their patients to the appropriate ancillary support section, if available. Consults, lab orders, and prescriptions will be entered into AHLTA prior to escorting patients, unless it is an emergency.

EMERGENCY MEDICAL TREATMENT

Ref: (a) Naval Hospital Camp Pendleton Emergency Department SOP

Purpose: To provide world class, life sustaining medical care to injured active duty beneficiaries until stabilized or evacuated to a higher echelon of medical care, per reference (a).

Procedures

1. All emergency medical care, when feasible, will be completed utilizing the clinic Trauma Bay/Treatment Room.

2. All medical care will be completed under the direction of a licensed medical provider.

3. Periodic training will be established by the medical clinic Training Petty Officer and attended by all hands. Training will focus on emergency medicine within a clinic setting and conducted through scenario based training and power point instructions.

4. All urgent and emergent transfers to the local MTF require a provider-to-provider consult.

5. The clinic shall develop an individualized Emergency Medical Care Plan that addresses the staffing and management of emergent medical situations that may occur in the clinic during regular business hours.

FRONT DESK CHECK-IN

Ref: (a) NAVMED P-117, Manual of the Medical Department

Appendix: (6) TSWF Encounter Worksheet

Purpose: To provide an efficient, streamlined patient check-in and clinical encounter tracking process.

Procedures

1. Command Check-Ins:

a. Marines and Sailors, regardless of rank, may check into the clinic at any time during regular business hours.

b. The active duty member's medical record will be updated and verified in MRRS. They will then immediately proceed to the Immunizations Department for required immunizations and Preventive Health Assessment (PHA), as necessary per ref (a).

2. Appointment Check-In:

a. Patients will arrive 15 mins prior to appointment time

b. Upon check-in, the clerk will confirm the identity of the patient by verifying their name and date of birth matches their ID card. The clerk will check-in the patient utilizing AHLTA. If the patient does not have a scheduled appointment then they will be scheduled. If there are no available appointments, the Clinical Manager will triage and book an appointment as necessary. If the patient needs to be seen immediately, an unscheduled visit will be booked into CHCS. Emergent patients will be treated utilizing the clinic's Emergency Medical Care Plan (see section on Emergency Medical Treatment).

c. Designated staff (clerk/nurse) will conduct medication reconciliation on all patients during check-in.

d. Once the patient has an appointment and has been checked-in, he/she will receive/complete the TSWF Encounter Worksheet.

e. Periodically and randomly patients will be asked to complete the patient satisfaction survey (Appendix 6) to assist the medical clinic in evaluating their performance. The patient

satisfaction survey is reviewed by the Process Improvement Coordinator, Senior Enlisted Leader, and clinic Department Head/Senior Medical Officer.

LIGHT DUTY

Ref: (a) NAVMED P-117 Manual of the Medical Department

Appendix: (7) Light Duty Chit

Purpose: To establish procedures for issuing light duty chits to active duty beneficiaries due to injury or illness per ref (a).

Procedures

1. Light Duty:

a. Is an established period of time when the patient reports to their workspace but is excused from the performance of certain physical aspects of military duty.

b. Patients can only be put on light duty status by a medical provider (which includes IDC).

c. A period of light duty restriction may last a maximum of 30 days. A follow up appointment to reassess the patient is required at the termination of the light duty period.

d. Any patient on light duty for 60 days or more (2 consecutive 30 day light duty periods) will be brought to the attention of the unit's medical officer, if not already done.

e. Light duty may not exceed 90 days (3 consecutive periods of 30 days) for the same medical condition, inclusive of any convalescent leave periods.

f. At the end of the light duty period, or at any time during the period of light duty, the patient may either be immediately returned to a medically unrestricted full duty status or if the patient has reached the 90 day maximum, they will be referred to the local MTF for placement on a Limited Duty Board (LIMDU) or an initial Medical Evaluation Board (MEB).

2. Light Duty Chit:

a. Medical providers recommending a patient for a light duty status will utilize the Light Duty Chit (Appendix 7).

b. The medical provider will clearly annotate the restrictions and limitations imposed upon the member's duty, as well as the time period required in a light duty status.

c. The patient will be provided with 2 copies of the light duty chit: one (1) for the patient and one (1) for the patient's chain of command.

d. The light duty chit will be scanned into the patient's Electronic Health Record (EHR).

e. The attending medical provider will ensure the member is included into the unit's daily Sick and Injured Report.

LIMITED DUTY/PHYSICAL EVALUATION BOARDS

Ref: (a) SECNAVINST 1850.4E

Purpose: To establish a framework to manage beneficiaries involved in the TLD/PEB process outlined in reference (a).

Procedure:

1. A medical clinic representative will serve as the Temporary Limited Duty (TLD) and Physical Evaluation Board (PEB) medical liaison to the local MTF and to the unit's LIMDU Coordinator in order to provide care coordination for patients enrolled in these programs.

2. The TLD/PEB Liaison will be appointed in writing by the medical clinic Department Head.

3. Duties:

a. Conduct monthly reviews of previous and pending appointments.

(1) Note no-shows or frequent appointment cancellations.

(2) Review encounters with specialists and MTF case managers for plans of care.

(3) Gain proficiency in the online Limited Duty tracking system (LIMDU Smart).

b. Attend scheduled meetings as deemed appropriate by the Senior Medical Officer/Department Head, including unit Force Preservation Boards, with unit command leaders as requested. Provide status updates and discuss pending issues.

c. Provide assistance to unit representatives with TLD/PEB forms:

(1) Non-Medical Assessment (NMA)
(2) NAVMEDINST 6100/5
(3) NAVMEDINST 6100/6
(4) Wounded Warrior Battalion referral

4. Each unit will have an appointed TLD/PEB liaison with which the medical clinic liaison will coordinate and address issues.

5. Member's Responsibilities:

a. Sign page 13 acknowledging the responsibilities of being on TLD.

b. Report to all scheduled appointments.

c. Complete reevaluation 30 days prior to the expiration of TLD period.

d. Keep command and unit medical staff informed of any changes.

e. Coordinate any leave periods with the MTF specialty clinic to which assigned.

MINOR PROCEDURES

Ref: (a) NAVHOSP CAMPEN Instruction 6320.16B
(b) AANA Standards of Practice, Current Edition
(c) NAVEDTRA 14295B

Appendix: (8) Standard Form 522 (SF-522)
(9) Procedure "Final Time-Out" Template

Purpose: To outline the policies for conducting minor procedures in the garrison clinic, references (a) through (c).

Procedures

1. All minor procedures will be completed within the medical clinic Trauma Bay or dedicated procedure area.

2. Informed consent from the patient will be obtained and documented before a procedure is performed. Written consent is required (except in emergency situations) and will be recorded on an SF-522 (Appendix 8).

3. The provider performing/supervising the procedure will use the SF-522 to provide an explanation of the procedure, risks, benefits, and any alternatives to the procedure.

4. Pre-procedure verification process (a.k.a. "Time Out") must be done prior to all procedures and documented in AHLTA using the Procedure "Final Time-Out" Template (Appendix 9).

5. The consent form will include the following:

a. Date
b. Place of Treatment
c. Significant Risks
d. Benefits of Procedure
e. Alternatives to Procedure (including alternative of no treatment)

6. The provider must have been granted privileges to perform the procedure by the I MEF Privileging Authority.

7. Following the procedure, the provider will document the procedure in a post-procedure note in AHLTA.

PHYSICALS

Ref: (a) NAVMED P-117, Chap 15

Purpose: To conduct physical examinations outlined in reference (a) and coordinate physical examination appointments for medical providers.

Procedures

1. Patients will report to the clinic upon receipt of orders requiring a physical examination. The Physicals Department Petty Officer will provide the patient with appropriate paperwork necessary for the completion of the physical examination and provide direction/guidance as necessary.

2. The patient will complete all required documentation, laboratory tests, and procedures according to ref (a). The Physicals Petty Officer will file all necessary paperwork in the patient's medical record.

3. Once all prerequisites are completed, the Physicals Petty Officer will review the examination paperwork for completeness and accuracy. The Physicals Petty Officer will then schedule an appointment with the medical provider.

4. Upon completion of the physical examination by a medical provider, a copy of the physical examination forms will be scanned and attached to the patient's electronic health record encounter.

PROVIDER TEMPLATES AND SCHEDULING

Ref: (a) CHCS II Block 1 User's Manual

Purpose: To establish a procedure for scheduling patients for medical providers per reference (a) and provide increased access to care for active duty beneficiaries.

Procedures

1. Each unit provider will determine the appropriate appointment template layout for their unit's workload and training schedule, consisting of ACUTE and EST appointments.

2. Weekly, at a designated time, each unit provider will provide the designated Clinic Template Manager with their schedule requests for the next work week.

3. The Clinic Template Manager will publish the requested schedules in CHCS.

4. For requested schedule changes greater than 24 hours in advance, the unit provider will contact the Clinic Template Manager with the summary of changes.

a. The Clinic Template Manager will make the necessary adjustments in CHCS.

b. The Clinic Department Head/Senior Medical Officer will reschedule any existing booked appointments.

5. For emergency schedule changes less than 24 hours in advance, unit providers will immediately inform the Clinic Template Manager to ensure open appointments are deleted from CHCS. The Clinic Department Head/Senior Medical Officer will either reschedule or assist in the reassignment of patients who have already have appointments.

6. The RN and LVN will be provided access with provider scheduling authorization keys.

RECORDS REQUEST

Ref: (a) BUMED Instruction 6150.38A
(b) MARADMIN 308/11, COMMANDER ACCESS TO HEALTH INFORMATION

Appendix: (10) DD Form 2870: Authorization of Disclosure of Medical or Dental Information
(11) DD Form 2963: U.S. Marine Corps Service Treatment Record Certification Form

Purpose: To provide a process for active duty beneficiaries to receive copies of all medical treatment received while serving in the United States military per reference (a). Medical clinic staff will ensure both the patient's right to personal privacy and the government's legal access to necessary information regarding its beneficiaries is followed according to HIPAA guidelines.

Procedures

1. Information that may be released without the patient's consent per reference (b):

a. Name and rank of patient
b. Date of admission or disposition
c. Age
d. Sex
e. Component, base, station or organization
f. Marital status (if requested)
g. Occupation/Job Title (if requested)
h. Present medical assessment (in the following terms only: good, fair, serious or critical) (if requested)
i. Patient's state of consciousness

2. More detailed information will only be released if the patient gives their informed consent and the medical clinic receives a signed copy of the DD 2870 (Appendix 10).

3. To obtain copies of medical records:

a. Member completes DD Form 2870 and submits it to the Medical Records Department at the clinic.

b. Member's AHLTA notes will be digitally copied to a disc and available for pickup within 48 hours.

c. To obtain copies of their medical record, the member will sign out their medical record on a NAVMED 6150/7 form (Pink medical record tracker card). The pink card will be retained by the clinic until member returns with medical record.

4. Retiring medical records:

a. For Naval personnel, upon separation from active duty, the service member's health record and dental record must be retired and mailed to Naval Medical Records Activity, St Louis.

b. For Marine Corps personnel, a DD Form 2963 (Appendix 11) must be completed and attached to the Medical and Dental Record and turned in to IPAC within 45 days of separation to ensure VA benefits can be determined in a timely manner.

REFERRAL MANAGEMENT

Ref: (a) TRICARE Provider Handbook

Purpose: To establish a streamlined and efficient process for the management and tracking of patient referrals to medical specialists.

Procedures

1. Initially the patient will be evaluated by a provider at the medical clinic.

2. During the patient's appointment, if deemed appropriate, the patient will be referred to a medical specialist by their primary care manager per reference (a).

3. At the end of the patient's appointment, the patient will be educated to await a call from specialty clinic. If no call is received within 5-7 days, the patient will contact the unit medical staff for further assistance.

4. The clinic LVN Care Coordinator will conduct weekly checks on pending referrals within CHCS. It is recommended that each unit generate and update their Referral Tracker as necessary.

5. If a referral was rejected due to insufficient info, the LVN will notify the referring provider.

SUPPLY

Appendix: (12) Equipment Custody Record Card
(13) Inventory List

Purpose: To ensure that the medical clinic is adequately stocked at all times with medical equipment and supplies required for the mission's success.

Procedures

1. General Duties: The Clinic's Supply Petty Officer is responsible for the procurement, custody, and issuance of medical and administrative supplies.

2. Tasks:

a. Complete all tasks and directions as ordered to by chain of command.

b. Material Safety Data Sheets (MSDS) must be maintained in a binder for all hazardous materials. This includes products that contain hazardous chemicals in quantities of 1% or greater, or 0.1% or greater, if the chemical is a carcinogen. These products are not allowed in patient or common areas.

c. Ensure Preventive Maintenance (PM) is being performed by the MTF Biomedical Repair Department and documented per the manufacturer's instruction. Equipment should have PM stickers and any broken equipment needs a visible sign saying "do not use" and the repair information.

3. Defense Medical Logistics Standard Support (DMLSS):

a. DMLSS is a computer program that is used to place all medical supply requests through the local MTF supply department.

b. To gain access to DMLSS a request form must be filled out by the local MTF Supply Department and signed by the medical clinic Senior Enlisted Leader (SEL).

4. ServMart:

a. ServMart is used by Marine Corps Supply department to purchase administrative and operational supplies.

b. All orders will be approved by the LPO and SEL prior to submission to the local area Marines Corps Supply Officer.

c. Each unit in the medical clinic will have a Supply Petty Officer who will maintain a requisition report detailing all ServMart expenditures.

5. Equipment Custody Record (ECR):

a. ECR cards (Appendix 12) will be utilized for all medical non-consumable medical equipment issued.

b. ECR cards will be created by the medical clinic Supply Petty Officer and/or unit Supply Petty Officers and maintained until item is returned.

6. Inventory Lists:

a. The medical clinic Supply Petty Officer is responsible for maintaining inventory lists of all working stock and bulk stock items.

b. Inventory lists (see example in Appendix 13) will detail item, order number, quantity and expiration date if applicable.

c. All consumable medical equipment will be stocked and utilized using a proper rotation system.

TRANSPORTATION - GROUND

Appendix: (14) SF 513 - Patient Consultation/Transfer Form

Purpose: To outline the policy and procedures for ground transportation associated with transporting patients from the medical clinic to a higher echelon of care (i.e. local MTF).

Procedures

1. The requesting provider is responsible for ensuring execution of appropriate ground transportation.

2. Once the determination is made to utilize ambulance services, the requesting medical provider will designate a Corpsman/Medical technician/Nurse to contact 911. The call will be dispatched to the local MTF Emergency Service Dispatch Center which includes EMS, PMO, and Fire.

3. The following information will be provided to the requested ambulance service:

    a. Patient Name
    b. Patient's Full Social Security Number
    c. Patient Sex
    d. Patient Injuries/Illness
    e. Requesting Location

4. The requesting medical provider will contact the local MTF Emergency Department to speak with an accepting physician and give a report on the patient.

5. Requesting medical provider will fill out the top half of the SF-513 (Appendix 14).

6. Requesting medical provider will fill out the Patient Transfer Form, if applicable, from the local MTF Patient Administration Department.

TRANSPORTATION - AEROMEDICAL

Purpose: To outline the policy and procedures for air transportation associated with transporting patients from the medical clinic to a higher echelon of care (i.e. local MTF) or civilian facility.

Procedures

1. The determination to transport a casualty via helicopter will be determined by a licensed provider and Emergency Medical Services.

2. The requesting provider and ambulance company are responsible for ensuring execution of appropriate air transportation when required.

3. Once the determination is made to utilize air evacuation, the medical clinic staff will immediately inform the patient's chain of command and complete the requisite SF-513 (Appendix 15) on behalf of the patient.

4. The ambulance company will contact Base Range Control to clear air space and grant permission to conduct an aeromedical evacuation.

5. The medical clinic will assist as necessary in the treatment, transportation, and evacuation of the patient as directed by the ambulance company.

TREATMENT AREAS

Purpose: To ensure appropriate and spaces are available for the treatment of active duty beneficiaries, performance of procedures, and/or treatment of life-threatening injuries.

Procedures

1. Patient Exam Rooms:

a. Post the "Patient Bill of Rights" in all patient care areas.

b. Maintain minimum stock requirements at all times.

c. Replenish used medical supplies as soon as possible.

d. Resupply consumable medical equipment via request to the clinic Supply Petty Officer (see Supply section).

e. Defective or broken medical equipment shall be replaced or repaired by turning equipment into the clinic Supply Petty Officer. The Supply Petty Officer will submit the appropriate documentation to the MTF Biomedical Repair Department.

f. Patient exam rooms will be inspected at the close of business by the clinic staff and reported to the Clinic Manager.

g. Patient exams room assignments will be determined by the clinic leadership.

SUPPLEMENTAL POLICY

BIO-HAZARD DISPOSAL

Ref: (a) BUMEDINST 6280.1B

Purpose: To establish basic standards for a Clinic Bio-hazardous Waste Management Control Program. This program ensures the proper documentation, collection, storage, transportation, and disposal of biohazardous waste IAW reference (a).

Procedure:

1. Non-Regulated Medical Waste (Non-RMW)/Trash: These items are generated in the health care setting, but are non-infectious and require no special treatment before disposal. Non-RMW can be processed as general waste, using accepted methods of collection, storage, transportation and disposal. Examples include:

a. Used hygiene products (i.e., diapers, facial tissues and sanitary napkins)

b. Absorbent materials containing very small amounts of blood or other body fluids

2. Regulated Medical Waste (RMW):

a. All clinics are required to check with their local MTF Environmental Safety office to determine if a Bio-Hazard permit (for collection and/or storage) for Bio-Hazardous waste is required.

b. Regulated Waste: Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious wastes.

c. Other Infectious Materials:

(1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, and body fluid visibly contaminated with blood and all body fluids in

situations where it is difficult or impossible to differentiate between body fluids.

(2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead)

3. Pharmaceutical Wastes: Pharmaceutical wastes are disposed of in accordance with the local MTF Pharmacy procedures.

4. Collection and Segregation:

a. Separate RMW from other waste at its point of origin. RMW shall be placed in containers, bags, or sharps containers (as appropriate for waste) that are labeled with the universal biohazard symbol placard and the word "BIOHAZARD".

b. Line containers with plastic bags of sufficient thickness (typically 3 millimeters), durability, puncture resistance, and burst strength to prevent rupture or leaks. Bags shall be of sufficient quality and thickness so that a single bag will handle most situations. Bags shall be labeled or color coded red. Do not overload bags.

c. Dispose of Sharps (used and unused) waste as well as discarded vaccines/vaccine containers in rigid, puncture resistant sharps containers. Never clip, cut, bend or recap needles or overfill sharps containers. Close sharps containers before removal or replacement to prevent spillage or protrusion of contents during handling, storage, or transport.

d. All sharps containers must be marked with the clinic demographics.

4. Packaging and Handling:

a. Place sharps containers in a second container (plastic bag or rigid box) which is labeled and/or color coded before treatment and disposal.

b. Minimize human exposure to RMW during transport to treatment or storage areas.

c. Place all anatomical pathology waste into double walled corrugated boxes or equivalent rigid containers that are double-lined with plastic bags for transport and incineration in an infectious waste incinerator. Containers shall be labeled or color coded.

5. Storage:

a. RMW will be stored in a designated RMW storage area. Storage of RMW, if authorized by on site permit, shall not exceed seven (7) days. The entrance to the storage room will be labeled "RMW" and have a posted Universal Biohazard Sign.

b. RMW storage must not exceed storage times specified in current contracts for removal/disposal. RMW containers must display proper end of use date.

c. Biohazardous waste permits, if required, will be requested and funded by Base Environmental Safety in conjunction with Navy Medicine Environmental Safety (located at local MTF) and the local county.

6. Transportation: Place RMW into rigid, leak-proof containers before transporting off-site (if responsible for transporting). Containers shall be labeled or color-coded.

7. Record Keeping:

a. All RMW disposal will be documented. Shipping paperwork/manifests will be maintained for two (2) years.

b. Disposal log book will include: date, type of waste, amount (weight, volume, or number of containers) and disposition. If disposal is conducted by local MTF or contractor, a representative from that agency shall document pick up and removal from clinic by signing clinic log.

c. Transporting company will provide written documentation of proper treatment and disposal. This documentation will be maintained for two (2) years.

8. Cleanup of Spills:

a. Clean up RMW spills immediately. Spill kits can be ordered through the local MTF and maintained by clinic staff.

b. Post staff members to prevent personnel from entering the area and potentially spreading infectious material while responders gather materials and any assistance for the cleanup.

c. Personnel must wear appropriate personal protective equipment (PPE) including gloves, coveralls, masks, and goggles to prevent exposure to RMW during cleanup.

DMHRSi

Ref: (a) DMHRSi Training Guide

Purpose: To provide a workload reporting system for contract staff, providers, and other designated medical clinic staff.

Procedures

1. The MCMH RN and LVN Staff must submit DMHRSi bi-weekly timecards by 1200 on the first workday after the reporting period per reference (a) to capture their work hours. Other Contract Staff will submit ("punch") timecards to report hours worked, leave, and sick days.

2. The designated clinic DMHRSi Nurse Supervisor will approve Contract Staff timecards by close of business on the first workday after the reporting period.

3. Workload of medical providers and medical clinic Corpsmen will be captured by the local MTF Business Management Staff via workload and patient encounters entered in CHCS or AHLTA.

FALLS PREVENTION AND POST FALL MANAGEMENT PLAN

Ref: (a) NHCP Falls Prevention and Post Fall Management Plan Number: PC.01.02.08

Purpose: To establish procedures for identifying/assessing patients at risk for falls, and to minimize fall risks in the clinic.

Procedures

1. Fall risk prevention begins at the entry point for care.

2. Department Heads/Senior Medical Officers shall:

a. Familiarize themselves with complete details of their local MTF policy, reference (a).

b. Ensure fall-related equipment and ambulatory aids (i.e crutches, walkers, wheelchairs) are available and in proper working order.

c. Ensure that all clinical staff receives education about the clinic's fall reduction program.

3. Clinical Staff (LVNs, Corpsmen, Medical Assistants, Clinical Technicians, Nursing Assistants, and Students) will perform an initial assessment based on the following easily identified fall risk factors:

a. Use of Ambulatory aides
b. Visible unnatural gait
c. Leaning on a family member or friend
d. Known patient with multiple risks, co-morbidities, polypharmacy
e. Advanced age

4. If the patient is at risk of a falls risk based on the above falls risk factors, a member or members of the primary care health care team will determine the patient's potential for falls and appropriate interventions using the outpatient falls risk assessment questionnaire in AHLTA. There are no minimum criteria for designating that a patient is at risk for falls. Regardless of cumulative factor scores, if a member of the healthcare team determines that ANY fall risk factor may lead to

a patient fall, that health care team member may designate the patient as being a fall risk.

5. If a patient is identified as a fall risk, the staff member must:

a. Assist the potential fall risk patient to a chair prior to assessment/intake.

b. Locate an assistive device for the potential fall risk patient, as needed.

c. Communicate potential fall risk to other clinic staff.

d. Depending on the severity of risk for a potential fall, a staff member may need to be identified to stay with the patient and escort them during their clinic visit.

e. Escort the patient to the exam room and seat the patient on a sturdy chair. Do NOT put the patient on the exam table.

f. Identify the patient as a fall risk by placing a fall risk/falling star sign on the exam room door

g. After the completion of the patient's appointment, a staff member must assist the patient to their final destination.

6. Providers must:

a. Consult with subject matter experts (e.g. pharmacist, physical therapist, specialists, etc) for plan of action, if this is the first time the patient is recognized to be a fall risk. Interventions may include but are not limited to: Assessment and follow-up, exercise (especially balance), gait training and assistive devices, medication review and adjustment, treatment (e.g., visual, cardiac, orthostatic), referral to physical therapy/occupational therapy, environmental assessment/modification, home assessment.

b. Document patient fall(s) incident and treatment course in patients electronic record; Report patient falls, and any treatment provided for fall-related injuries. See reference (a) for further information about reporting and documenting falls.

RESTRAINT OF PATIENTS

Ref: (a) NAVHOSP CAMPEN INSTRUCTION 5530.3H
(b) The Joint Commission Hospital Accreditation Standards
(c) Medicare and Medicaid Programs: Hospital Conditions of Participation: Patients' Rights 42 CFR 482.13, 71 (236) FR 71427, December 8, 2006

Purpose: To provide standards of practice for the safe and appropriate use of restraint devices in accordance with references (a) through (c).

Procedures

1. Per reference (c), a restraint is:

a. Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.

b. A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

c. A restraint does not include devices such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

2. Restraint has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of a patient's rights, and even death. Every effort will be made to limit restraint use, protect the patient's health and safety while preserving his/ her rights, dignity, and well-being. The safest and least restrictive restraint method will be used and all forms of restraint will be discontinued as soon as possible. Alternate measures to restraint should be attempted, or at least considered. Alternate measures can be found in reference (a).

3. Only devices manufactured for the purpose of restraint will be used, and their use will be only as the manufacturer intended. No makeshift restraint devices will be used. See reference (a) for authorized restraint devices.

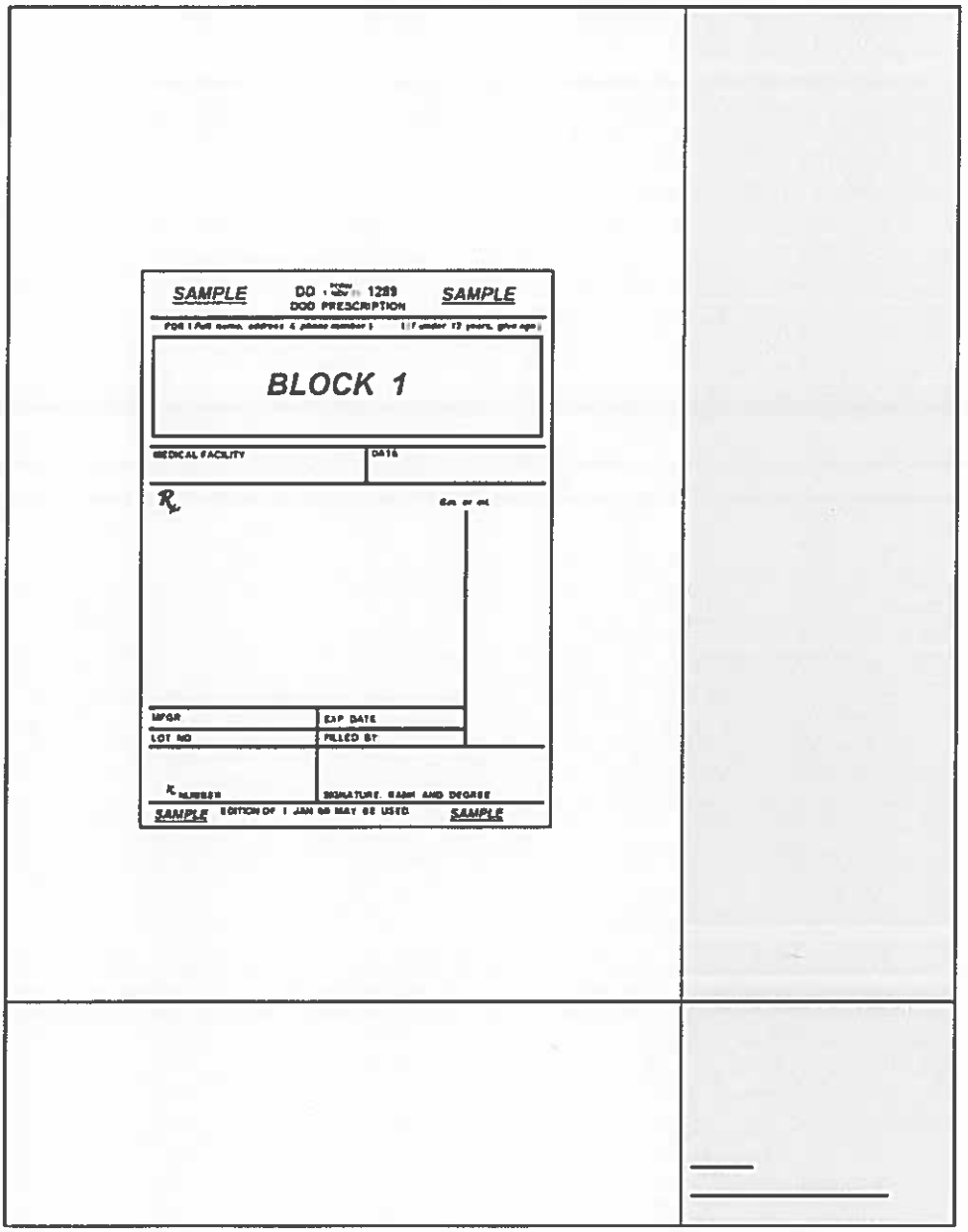
4. Restraint orders must be written by a Licensed Independent Practitioner (LIP), which includes physicians, nurse practitioners and physician assistants trained in mental health, per reference (a).

5. See reference (a) for details on the process and documentation of the usage of a patient restraint.

6. Department Heads/Senior Medical Officers will familiarize themselves with reference (a) and ensure all clinical staff complete initial, and periodic, restraint training and competency certification. Documentation will be maintained in individual training records.

APPENDICES

1. DD Form 1289 - Prescription Request Form
2. SALAD Poster Example
3. HAM Poster Example
4. Over-the-Counter Medication Request Form
5. Vaccine Order Form
6. TSWF Encounter Worksheet
7. Light Duty Chit
8. Standard Form 522 - Special Procedures Permission Form
9. Universal Protocol Checklist Example
10. DD Form 2870 - Medical/Dental Info Release Authority Form
11. DD Form 2963 - Service Treatment Record Certification Form
12. Equipment Custody Record Card
13. Equipment/Supply Inventory List
14. Standard Form 513 - Patient Consultation/Transfer Form



Appendix 1 - DD Form 1289
(Prescription Request Form)

Naval Hospital Camp Pendleton's Sound-Alike & Look-Alike Medications

Problematic Drug Names	Monitoring Locations	Responsible Department	Safety Strategies (Recommendations)
• Alprazolam (Xanax) • Lorazepam (Ativan)	Inpatient Outpatient	Nursing Pharmacy	* Program SALAD reminder in CHCS. * Utilize automation to fill prescriptions. * Repeat both brand and generic name when taking verbal order
• Lipid-based amphotericin vs. conventional forms of amphotericin • AmBisome (amphotericin B liposomal) • Abelcet (amphotericin B lipid complex) • Amphocin, Fungizone (amphotericin B desoxycholate)	Inpatient	Pharmacy Nursing	* Included in "On-Call Pharmacist Protocol" * Stock only 1 lipid-based product: AmBisome * Maximum dose program in CHCS to generate alert if dose is excessive * Reminder "Must call pharmacist" program in CHCS * Order should include dose written in mg/kg (example: AmBisome 5mg/kg/day) * Always verify "amphoterin B" orders with provider
• Cefazolin • Ceftriaxone	Inpatient	Pharmacy	*Store SALAD in different locations (not alphabetized)
• Celexa Citalopram • Celebrex Celecoxib	Inpatient Outpatient	Pharmacy Nursing	* Utilize "TALLman" characters
Diprivan Diflucan	Inpatient	Pharmacy Nursing	* Utilize "TALLman" characters *Determine purpose of medication before dispensing or administration.
• ePHEDrine • EPInephrine • Effexor Effexor XR	Inpatient Inpatient Outpatient	Pharmacy Nursing Pharmacy Nursing	*Utilize "TALLman" characters ** Awareness of SALAD drugs
• Folic Acid Folinic Acid • Leucovorin	Inpatient Outpatient	Pharmacy Nursing	*Determine purpose of medication before dispensing or administration *Store Leucovorin separately in oral chemo locker or iv room chemo shelves
• Heparin • Hespan	Inpatient	Pharmacy Nursing	* Determine the purpose of medication before dispensing or drug administration * Store SALAD in different locations
Hydrocodone Oxycodone	Inpatient Outpatient	Pharmacy Nursing	* Utilize automation to fill prescriptions.
• hydromorphone (Dilaudid) • morphine (Astramorph, Duramorph, Infumorph)	Inpatient	Pharmacy Medical Nursing	* Stock specific strengths for each product that are dissimilar * Ensure health care providers are aware products are not interchangeable * Make "Dilaudid" as the only displayed name in Pyxis
• hydroxyzine (Atarax) • hydralazine (Apresoline)	Inpatient Outpatient	Pharmacy Medical Nursing	* Determine the purpose of medication before dispensing or drug administration * Utilize "TALLman" characters in Pyxis cabinets * Include indication for use on orders
• Novolog Novolin • Humulin Humalog • Insulin combinations	Inpatient Outpatient	Pharmacy Nursing	*Utilize "TALLman" characters *Only novoLIN R will be stocked at nursing station

Updated May 2015

Appendix 2 - "SALAD" Poster

Naval Hospital Camp Pendleton High Risk or High Alert Medications

Medication	Action to be taken by medical, nursing, and pharmacy staff as applicable. **Please check appropriate references for additional information on these medications**
AMIODARONE IV	- For continuous infusion requires D5W, DO NOT use empty evacuated containers - Rapid load 150mg diluted to 100ml D5W over 10 minutes - Cardiac arrest 300mg bolus followed by 10ml flush - Slow infusion 1mg/min; maintenance infusion 0.5mg/min
DIGOXIN IV	- Administer over minimum 5 minutes - Monitor serum levels and chemistry panel
HEPARIN IV DRIP	- Premade concentration - Use Essentris Protocol for monitoring aPTT
HYDROXYZINE	- Intramuscular route only – Never IV push or infusion
INSULIN	- Standard IV Drip is 1 unit/ml regular insulin in 100ml NS - Ensure correct product is selected for subcutaneous use
INVESTIGATIONAL DRUGS	- Verify drug class, dose, expected benefits
IV ADRENERGIC AGONISTS (epinephrine, phenylephrine, norepinhephrine)	- Clarify dose and concentration appropriate for route and indication
IV NARCOTICS (ie, fentanyl)	Monitor sedation and respiratory status. Stock and/or volume minimized by pharmacy.
MAGNESIUM SULFATE IV	- 50% Vials kept in Pharmacy only, except special use in crash carts, ICU, ED, and L&D - Verify dose, concentration, and route (50% must be diluted for IV use, may be used IM)
MANNITOL	Use in-line filter (0.22micron) when administering. Monitor renal function, daily fluid I&O, serum electrolytes, serum and urine osmolality
METOPROLOL IV	- Continuous ECG and BP monitoring is required during administration - Acute MI: 5mg every 2 minutes X 3 doses - Push 5mg over one minute - Slow IV infusion add 5-10mg metoprolol to 50ml NS and administer over 30 minutes
NITROGLYCERIN INFUSION	- Check concentration: e.g. 250 ml glass bt. 200 mcg/ml & not> 400 mcg/ml - Check dose: mcg/min by indication (Angina,HTN,CHF,Pulm.Edema) Titrate. - Monitor hemodynamic (BP)
NITROPRUSSIDE SODIUM	- Monitor for cyanide toxicity - Max rate 10mcg/kg/min - Requires continuous BP monitoring
PCA NARCOTICS	- Pump settings must be double checked by second RN
PEDIATRIC MEDICATION (<12 YEARS)	- Associated with a high number of errors due to dosing calculations - Verify dose according to patient weight (weight in kg required) - Verify concentration of prescribed drug
POTASSIUM CHLORIDE IV	- Standard: Minimum infusion time and max concentration 10mEq/100ml over one hour - ICU with cardiac monitoring: 10mEq/50ml CENTRAL line over 30 minutes - Concentrated (2mEq/ml or greater) not stocked outside pharmacy
POTASSIUM PHOSPHATE IV	- Order in mMol of phosphate (contains 1.47mEq Potassium per mMol phosphate) - Max infusion rate dependent on potassium concentration - Concentrated (3mMol/ml or greater) not stocked outside pharmacy
PROPRANOLOL IV	- Continuous ECG and BP monitoring is required during administration - Dose 1mg to 3mg IV, each 1mg over one minute - Monitor for at least 2 minutes before repeating dose
SODIUM CHLORIDE HYPERTONIC SOLN > 0.9%,	- Pharmacy: RPh Calculation Check Required - CENTRAL LINE - Concentrated (>0.9%) not stocked outside pharmacy
SOUND-ALIKE/LOOK-ALIKE	- Refer to separate list on recommended actions to mitigate risks
THEOPHYLLINE IV	- Loading and maintenance doses based on IBW - Monitor levels
THROMBOLYTIC: ALTEPLASE	- Dose based on ABW - Concurrent use of Heparin and aspirin - Multiple dosing regimens dependent on indication
VALPROATE SODIUM IV (DEPACON)	- Monitor therapeutic plasma levels - Infuse over 60 minutes, max 20mg/min
WARFARIN (COUMADIN)	- Narrow therapeutic index, monitor INR

May 2015

Appendix 3 - "HAM" Poster Example

Camp Pendleton Naval Hospital and Branch Health Clinics
Over-the-Counter Medication Request
Print Clearly

Patient's Name:_____ Birth Date:_____
Sponsor's SSN: _____ Allergies:_____

MEDICATIONS

Patient may not specifically ask for medications. Must be assessed for symptoms
Children younger than 2 years old are not eligible for medications via this OTC Program
Patient allowed 3 OTC medications per person per month maximum
****No additional medications available through OTC Program****

Initial	Pain/Fever	Initial	Skin
	1. Acetaminophen 160mg/5ml Elixir #1 Bottle		12. Hydrocortisone 1% Cream #1 Tube
	2. Acetaminophen 325mg Tablet #1 Bottle (>6yrs)		13. Calamine Lotion #1 Bottle
	3. Ibuprofen 100mg/5ml Susp #1 Bottle		14. Clotrimazole 1% Cream #1 Tube
	4. Ibuprofen 200mg Tablet #1 Bottle (>12 yrs)		15. Bacitracin Ointment #1 Tube
			16. Zinc Oxide 20% Ointment #1 Tube
	Antacid		**Vaginal**
	5. Maalox (equivalent) Susp. #1 Bottle (>12 yrs)		17. Clotrimazole 7 Vaginal Cream #1 Box (>12yrs)
	Cough		**Anti-diarrheal**
	6. Guaifenesin/Dextromethorphan (Robitussin DM) 100-10mg/5ml Syrup #1 Bottle (>12 yrs)		18. Bismuth Sub. 262mg/15ml #1 Bottle (>12yrs)
	7. Guaifenesin 100mg/5ml Syrup #1 Bottle		19. Loperamide 2mg Capsule #1 Box (>6yrs)
	8. Mucinex ER (equivalent) 600mg Tabs #1 Box (>12yrs)		
	Antihistamine		**Miscellaneous**
	9. Loratadine 10mg Tablet #1 Box (>6yrs)		20. Saline Nose Spray #1 Bottle
	10. Diphenhydramine 12.5mg/5ml Syrup #1 Bottle		21. Cepacol (equivalent) Throat Lozenges #1 Box
	11. Diphenhydramine 25mg Capsule #1 Box (>6yrs)		

By signing, I certify that the following statements are true to the best of my knowledge:

1. I do not wish to see a physician or other health care provider for advice.
2. I understand this medication is for minor illnesses or conditions only.
3. If symptoms worsen or do not improve within 48 hours, the person for whom medications are intended should be seen by a medical provider.
4. Only an eligible beneficiary will use this medication.
5. The person using this medication is not on flight status, is not pregnant, does not have any known allergies to the medications requested, and is older than 2 years.
6. The person using these medications will read the package carefully for dosing instructions and precautions.

Patient's (Parent/Guardian's) signature & date

_____
(Print Name)

_____ _____
(Signature and date)

Triage Nurse (Registered Nurse)/Sick Call Qualified HM (IDC or completed course)

_____
(Print Name)

_____ _____
(Department)

_____ _____
(Signature and date)

*Pharmacy: enter in patient medication profile and file form with prescription records

Appendix 4 - Over-the-Counter Medication Request Form

Active Duty Adult Vaccine Order Form

Naval Hospital Camp Pendleton, Preventive Medicine Department
PO Box 555191, Camp Pendleton, CA 92055-5191
Telephone: (760) 725-1270 FAX: (760) 725-0564 Email: [redacted]

Unit / Facility Name: _____ *Use the same name with each order*

Unit / Facility Address (Building Number): _____

Telephone Number: _____ FAX: _____

Person Completing Form: _____ Title: _____ Email Address: _____

Date:

Requested Vaccine Pick Up Date: ** Note: All vaccine requests not picked up on the date requested will be cancelled after 5 working days
Vaccines are not issued on Fridays

☐ Maintenance Doses ☐ Stand Down Date of Stand Down: Date of Vaccine Return:

Endorsement
To: Preventive Medicine Department, Naval Hospital Camp Pendleton
Via: (1) MSC Surgeon's Office (1st Marine Division / 3rd Marine Air Wing / 1st Marine Logistics Group / MEF HQ Group)
Forwarded recommending: ☐ Approval / ☐ Disapproval MRRS Validation Performed?: ☐ Yes / ☐ No

_____ _____
Print Name Signature

(2) I-MEF Preventive Medicine Officer / MILVAX Agency Representative
Forwarded: ☐ Approved / ☐ Disapproved MRRS Validation Performed?: ☐ Yes / ☐ No

_____ _____
Print Name Signature

Vaccine	Vaccine Name	Current Inventory	Doses Ordered	Doses Received	Vaccine Lot #	Expiration Date	Unit/Boxes Issued
Anthrax							
Gardasil (HPV)							
HEP A (Adult)							
HEP B (Adult)							
Hep A/B							
Ixiaro (JEV)							
Meningococcal							
MMR							
Pneumococcal							
PPD							
Polio							
Rabies							
Smallpox							
Tdap							
Typhoid							
Varicella							
Yellow Fever							
FLU VACCINE							
Flumist							
PFS Injectable Flu							
MDV Injectable Flu							

Issuer Name & Signature _____ Date issued __/__/__

Receiver's Name and Signature _____ Date received __/__/__

NHCP Immunizations Program (Rev 3/2012)

Appendix 5 - Vaccine Order Form

Name _____ DOB: _____

Email Address : _____ Contact Phone Number: _____

TSWF ADULT ENCOUNTER WORKSHEET with SF600 (v20110309)

What is the reason for today's visit? _____

How long have you had this issue? _____ Please circle if this issue is getting better worse

Please rate your pain level on a scale of 0 (no pain) to 10 (severe pain): #___/10

Please complete information below: *If you have filled this form out before, please only list changes since last visit.*

Current Medications	Medical Conditions	Surgeries/Hospitalizations (Dates)	Family History (biological siblings, parents, grandparents) (Circle all that apply)
PLEASE INCLUDE DOSAGE. IF YOU HAVE A LIST WITH YOU HAVE IT READY. If you take medications, do you always remember to take them? ☐Yes ☐No	*Do you have any of the following? (circle)* *High Blood pressure* *High Cholesterol* *Diabetes* *Asthma* *Heart Disease* *Obesity* *Cancer* *Had a Heart Attack* *Other:* ie: chronic pain, migraines, sleep apnea		*HIGH BLOOD PRESSURE:* *HIGH CHOLESTEROL:* *DIABETES:* *CANCER:* *OTHER:* ie: Heart Attack, Stroke

Please check if you take: ☐Vitamins ☐ Over the counter meds ☐ Dietary Supplements ☐ Herbal meds ☐Weight loss meds

Please list any allergies you have (drug, food, latex) _____

☐Yes ☐No Do you consume any alcohol? If yes, Type? _____ frequency? _____ amount? _____

☐Yes ☐No Do you now or have you ever used tobacco products? (If YES, check the box that applies to you)
☐ I CURRENTLY USE TOBACCO PRODUCTS What type of tobacco? _____ How much per day? _____
☐ I QUIT USING TOBACCO PRODUCTS When did you quit? _____

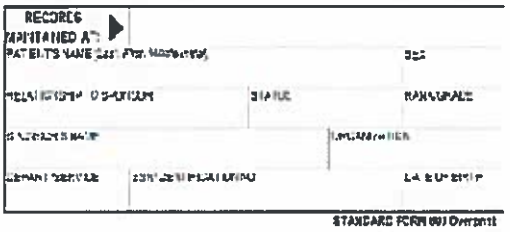
Over the last 2 weeks, how often have you been bothered by any of the following problems?

	[0]	[1]	[2]	[3]
Little interest or pleasure in doing things	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
Feeling down, depressed, or hopeless	☐ Not at all	☐ several days	☐ More than half the days	☐ Nearly every day

Would you say your general health is? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

☐Yes ☐No Is this visit deployment related? If yes, when and where was deployment _____

Date of last PHA _____



Appendix 6 - TSWF
Encounter Worksheet

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	I MEF HEADQUARTERS GROUP, GROUP AID STATION
	SNM WAS EVALUATED BY THE GAS AND THE FOLLOWING LIMITATIONS ARE RECOMMENDED
	Medical Diagnosis:
	Duty Status: SIQ 24hrs / 48hrs Light Duty
	Light Duty for _____ days, today is day 1. Schedule Follow up Appointment if needed.
	__√__ Check restricted activides , LINE THROUGH activities that are permitted.
	____ Run ____ Hikes
	____ Pull-Ups ____ Range
	__ Push-Ups ____ Lifting > 10lbs
	____ Crunches ____ Standing > 15min
	____ MCMAP ____ Obstacle Course
	____ Other:
	__√__ Check the following recommended Low Impact/Rehabilitation activites.
	__ Walking ____ Swim
	Elliptical ____ Stationary Bicycle
	_ Treadmill ____ Rice (Rest, Ice, Compress, Elevation)
	____ Other:
	The above duty modifications have been determined by your condition. You are expected to return to F.U.L.L DUTY upon expiration of this LIM.
	Member Signature: X
	Medical Provider Signature:

Patient's Identification (Use this space for Mechanical Imprint)	RECORDS MAINTAINED AT:	CG I MEF / I MHG MEDICAL	
	PATIENT'S NAME (Last, First, Middle Initial)		SEX: Male/ Female
	RELATIONSHIP TO SPONSOR: SELF	STATUS	RANK/GRADE
	SPONSOR'S NAME: SELF		ORGANIZATION: CG I MEF / I MHG
	DEPARTMENT/SERVICE: DOD/USMC	BENEFICIARY IDENTIFICATION NO.	DATE OF BIRTH

Fillable SF600 by BeMajorAdStaior.com — CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (EF)

Appendix 7 - Light Duty Chit

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1a. (Check all applicable items)		1b. DESCRIBE
☐ OPERATION OR PROCEDURE	☐ SEDATION	
☐ ANESTHESIA	☐ TRANSFUSION	

B. STATEMENT OF REQUEST

2. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be (describe operation or procedure in layman's language)

which is to be performed by or under the direction of Dr. _____

3. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

4. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

5. Exceptions to surgery or anesthesia, if any are: _____
(If "none", so state)

6. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

7. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.

b. Said pictures be used only for purposes for medical/dental study or research.

8. I understand that as indicated a Health Care Industry Representative or other authorized personnel may be present.

(Cross out any parts above which are not appropriate)

C. SIGNATURES

(Appropriate items in parts A and B must be completed before signing)

9. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above. I have also discussed potential problems related to recuperation, possible results of non-treatment, and significant alternative therapies.

_____
(Signature of Counseling Physician/Dentist)

10. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	(Signature of Patient)	(Date and Time)

11. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) _____

Sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness, excluding members of operating team)	(Signature of Sponsor/Legal Guardian)	(Date and Time)

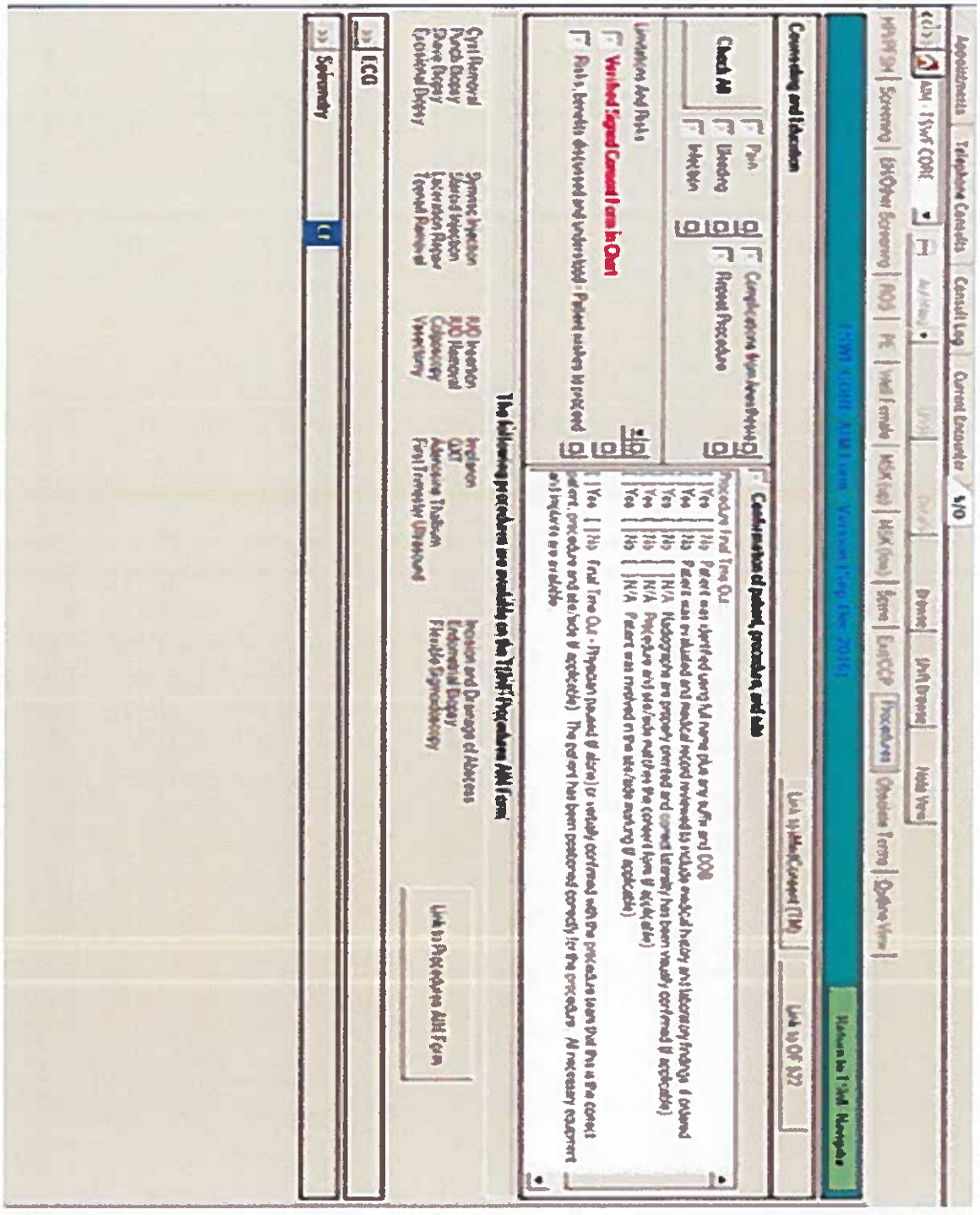
PATIENT'S IDENTIFICATION (If typed or written details, give: Name – last, first, middle; ID no. (SSN or other); hospital or medical facility)	REGISTER NO.	WARD NO.

REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Medical Record

OPTIONAL FORM 522 (REV. 7/2000)
Prescribed by GSA/ICMR FMR (41 CFR) 102-194.30(i)
DoD Exception to OF 522 approved by GSA

Appendix 8 – SF-522 – Special Procedures Permission Form



Appendix 9 - Universal Protocols
Checklist Example

AUTHORIZATION FOR DISCLOSURE OF MEDICAL OR DENTAL INFORMATION

PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), the notice informs you of the purpose of the form and how it will be used. Please read it carefully.
AUTHORITY: Public Law 104-191; E.O. 9397 (SSAN); DoD 6025.18-R.
PRINCIPAL PURPOSE(S): This form is to provide the Military Treatment Facility/Dental Treatment Facility/TRICARE Health Plan with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual for: personal use; insurance; continued medical care; school; legal; retirement/separation; or other reasons.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the protected health information.
This form will not be used for the authorization to disclose alcohol or drug abuse patient information from medical records or for authorization to disclose information from records of an alcohol or drug abuse treatment program. In addition, any use as an authorization to use or disclose psychotherapy notes may not be combined with another authorization except one to use or disclose psychotherapy notes.

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER
4. PERIOD OF TREATMENT: FROM - TO (YYYYMMDD)	5. TYPE OF TREATMENT (X one) ☐ OUTPATIENT ☐ INPATIENT ☐ BOTH	

SECTION II - DISCLOSURE

6. I AUTHORIZE _____ TO RELEASE MY PATIENT INFORMATION TO:
(Name of Facility/TRICARE Health Plan)

a. NAME OF PERSON OR ORGANIZATION TO RECEIVE MY MEDICAL INFORMATION	b. ADDRESS (Street, City, State and ZIP Code)
c. TELEPHONE (Include Area Code)	d. FAX (Include Area Code)

7. REASON FOR REQUEST/USE OF MEDICAL INFORMATION (X as applicable)
☐ PERSONAL USE ☐ CONTINUED MEDICAL CARE ☐ SCHOOL ☐ OTHER (Specify)
☐ INSURANCE ☐ RETIREMENT/SEPARATION ☐ LEGAL

8. INFORMATION TO BE RELEASED

9. AUTHORIZATION START DATE (YYYYMMDD)	10. AUTHORIZATION EXPIRATION ☐ DATE (YYYYMMDD) ☐ ACTION COMPLETED

SECTION III - RELEASE AUTHORIZATION

I understand that:
a. I have the right to revoke this authorization at any time. My revocation must be in writing and provided to the facility where my medical records are kept or to the TMA Privacy Officer if this is an authorization for information possessed by the TRICARE Health Plan rather than an MTF or DTF. I am aware that if I later revoke this authorization, the person(s) I herein name will have used and/or disclosed my protected information on the basis of this authorization.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR §164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

11. SIGNATURE OF PATIENT/PARENT/LEGAL REPRESENTATIVE	12. RELATIONSHIP TO PATIENT (If applicable)	13. DATE (YYYYMMDD)

SECTION IV - FOR STAFF USE ONLY *(To be completed only upon receipt of written revocation)*

14. X IF APPLICABLE: ☐ AUTHORIZATION REVOKED	15. REVOCATION COMPLETED BY	16. DATE (YYYYMMDD)
17. IMPRINT OF PATIENT IDENTIFICATION PLATE WHEN AVAILABLE	SPONSOR NAME: SPONSOR RANK: FMP/SPONSOR SSN: BRANCH OF SERVICE: PHONE NUMBER:	

DD FORM 2870, DEC 2003

Adobe Professional 8.0

Appendix 10 - DD Form 2870 - Medical/Dental Info Release Authority Form

SERVICE TREATMENT RECORD (STR) CERTIFICATION

(Read instructions on back before completing form.)

TO: Veterans Benefits Administration, VA Regional Office	1. DATE OF CERTIFICATION (YYYYMMDD)

2. FROM *(Sending Organization and complete mailing address)*

This information is made available to Department of Veterans Affairs (VA) for utilization in potential claims processing. Please utilize information as appropriate.

The information herein is For Official Use Only (FOUO) and must be protected under the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA). These records should be handled with confidentiality to ensure the veteran/patient's privacy. Unauthorized disclosure or misuse of this personal information may result in criminal and/or civil penalties.

3. SERVICE MEMBER IDENTIFICATION

a. NAME *(Last, First, Middle Initial)*	b. SSN *(Last 4 digits)*/DoD ID NO.

4. CERTIFICATION

_____

(Insert type of document.)

A thorough review of all known DoD or United States Coast Guard (USCG) systems, as appropriate, has been accomplished as directed by DoDI 6040.45. As such, other than the records being enclosed herein, it has been concluded that no further records exist for the service member, and the STR is complete as of the certification date of this form. In the event additional documentation is discovered, it will immediately be made available to VA for utilization in potential claims processing.

COMMENTS:

**NOTE. If separating member has served less than 180 days, enter "Entry Level Separation" in comments area below.

5. OFFICE OF PRIMARY RESPONSIBILITY

a. OFFICE NAME AND ADDRESS

b. POINT OF CONTACT NAME *(Last, First, Middle Initial)*

c. EMAIL ADDRESS	d. TELEPHONE NUMBER *(Include Area Code/DSN)*

DD FORM 2963, MAR 2014 PREVIOUS EDITION IS OBSOLETE. Adobe Designer 9.0

Appendix 11 - Service Treatment Record Certification Form

EQUIPMENT CUSTODY RECORD (4-43)

NAVMC 10359 (Rev. 1-43) (EF) Previous editions will not be used

RESPONSIBLE UNIT					AUTHORITY (T/E, Allowance List, etc.)	
DATE	VOUCHER NUMBER	INCREASED	DECREASED	BALANCE	REMARKS	SIGNATURE
		BROUGHT FORWARD				
		CARRIED FORWARD				

CONTROL NUMBER	DESCRIPTION	ALLOWANCE
STOCK NUMBER		ACCOUNT NUMBER

Adobe Designer 8.0

Appendix 12 - Equipment Custody Record Form

item_id	item_description	qty_on_hand	packed	price	cust_catalog_price
#SHEAR-BLK	1CC VANISHPOINT 25G X 5/8 SAFETY	7	EA	7.25	7.25
0000349420	2" KINESIOLOGY TACTICAL TAPE, ROCKTAPE,	12	EA	6.56	6.56
000305	23G X 3/4IN 12IN TUBING W/WING	32	BX	10.99	10.99
001100AA01	3 INCH CLOTH TAPE	1	PG	87.69	87.69
001201	3M TEGADERM IV TRANS DRSG, 3-1/2 X 4-1/2	22	EA	0.67	0.67
001203	6IN BANDAGE WRAP 6IN X 5.5 YDS 10 PK	27	EA	1.04	1.04
U2604-2	WEBCOL ALCOHOL PREP PAD BX/200	5	BT	39.38	39.38
VSI124030	WOUND CLOSURE TRAY CS/20	21	CS	280.25	280.25
X2610	WRAP 24X24 DISPOSABLE	33	EA	0.25	0.25
ZZ-0056	ZIP-IT BAGS 4X4 1000/CS	6	EA	8.73	8.73

WALL TO WALL INVENTORY COMPLETED BY (PRINT& SIGN):_rank_last, first/_____

WALL TO WALL INVENTORY COMPLETION DATE:_____

INVENTORY RESPONSIBLE OFFICER (RO) (PRINT& SIGN):_rank_last, first/_____

Appendix 13 - Supply
Inventory Sheet Example

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CONSULTATION SHEET

REQUEST

TO:	FROM: (Requesting physician or activity)	DATE OF REQUEST

REASON FOR REQUEST (Complaints and findings)

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION	☐ ROUTINE ☐ TODAY
		☐ BEDSIDE ☐ ON CALL	☐ 72 HOURS ☐ EMERGENCY

CONSULTATION REPORT

RECORDS REVIEWED ☐ YES ☐ NO PATIENT EXAMINED ☐ YES ☐ NO TELEMEDICINE ☐ YES ☐ NO

(Continue on reverse side)

SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/ SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME (Last, first, middle)	SPONSOR'S ID NUMBER (SSN or Other)	
PATIENT'S IDENTIFICATION (For typed or written entries, give: Name — last, first middle; ID no. (SSN or other); Sex; Date of Birth; Rank/Grade)		REGISTER NO.	WARD NO.

CONSULTATION SHEET
Medical Record

STANDARD FORM 513 (REV. 4-98)
Prescribed by GSA/ICMR (41 CFR) 101-11.203(b)(10)

Appendix 14 - SF-513 - Patient Consultation/Transfer Form

MEMORANDUM OF UNDERSTANDING

BETWEEN

BUREAU OF MEDICINE AND SURGERY

AND

UNITED STATES MARINE CORPS

1. Purpose. This Memorandum of Understanding (MOU) is entered into between the Bureau of Medicine and Surgery (BUMED), U.S. Navy, and the U.S. Marine Corps (USMC). The purpose of this MOU is to describe the roles and relationships of BUMED and the USMC in regard to the Marine Centered Medical Home (MCMH) healthcare model to include support services provided by BUMED activities and responsibilities for USMC organic medical personnel working within BUMED Medical Treatment Facilities (MTFs) caring for Marines and Sailors in their respective MCMH.

2. Authority. This agreement is composed per BUMEDINST 6320.66E, MCO 6320.4, BUMEDINST 7050.1B, OPNAVINST 4000.84C, DoDI 4000.19, DoDI 6490.15, NAVSO P-1000, and NAVMED P-117 Chapter 13.

3. Cancelation. This agreement cancels the MCMH MOU between BUMED and USMC signed 23 January 2013.

4. Discussion.

a. The patient centered medical home (PCMH) construct has been shown to improve health outcomes, enhance patient and provider satisfaction, and control healthcare costs through improved access to quality care. These are desired outcomes for the Navy and Marine Corps team as they are linked to individual and unit medical readiness. The PCMH construct operated by Navy Medicine is known as Medical Home Port (MHP); a similar, tailored program, referred to as MCMH, will be operated for Marine Operational Forces in garrison. The hallmark of the MHP and MCMH concept is 24/7 access to a member of the healthcare team.

b. The primary mission of USMC organic medical personnel is to support expeditionary operations. The MCMH will play a critical role ensuring USMC forces are always prepared for these operations. In addition to providing required support for MCMHs, commanders will continue to ensure USMC organic medical personnel remain operationally ready for immediate support to any contingency or expeditionary operation.

c. The use of appropriate health facilities is critical to providing high quality healthcare. Therefore, Navy Medicine, consistent with its mission, will advocate to the Defense Health Agency (DHA) on behalf of the Marine Corps to provide appropriate clinical space to MCMH teams. When USMC organic medical personnel (Physicians, Physician Assistants, other allied health professionals, Independent Duty Corpsmen, and Corpsmen) are working within local MTF spaces, they are not gained as part of Navy Medicine staff, nor are they counted for manning or staffing purposes as part of the Navy Medicine assigned staff. When working in local MTF spaces, USMC organic medical personnel remain under the command authority of their USMC command or unit.

d. When USMC organic medical personnel practice in local MTF spaces, they will use the allocated clinical spaces to provide garrison primary care for active duty Marines and Sailors assigned to the USMC units aligned to the MCMH. Workload generated by the MCMH practice, when performed in local MTF spaces, will be attributable to that MTF.

e. USMC organic medical personnel will retain existing health service support administrative spaces within their respective units to carry out administrative and operational duties when not engaged in clinical duties in the MCMH.

f. The MCMH construct encourages Corpsmen to operate at the top of their clinical skill set and demonstrate competencies necessary for practice in a forward deployed environment.

5. Healthcare Model. The basic staffing model for MCMH is delineated in the following paragraphs and subsequently evaluated for its ability to achieve the desired outcomes based on a set of performance metrics mutually agreed upon by Headquarters Marine Corps (HQMC) Health Service (HS) and BUMED Medical Operations (M3). Each MCMH site may include one or more MCMH teams based on the size of their respective patient population.

a. For each MCMH team, BUMED will provide one Registered Nurse (RN), one Licensed Practical Nurse (LPN), one care coordinator, and one to three clerks (depending on whether centralized or decentralized appointing is used). These personnel will be BUMED-gained assets and may be active duty, General Schedule civilian, or contractor (see Command and Control, 5j).

b. BUMED Wounded, Ill, and Injured (M9) and MHP Program Management Office (M3B7), as part of the Behavioral Health Integration Program, will embed behavioral health providers at each

MCMH site with an enrolled population of 3,000 or more, and will provide appropriate embedded behavioral health provider support to the MCMH teams, consistent with DoDI 6490.15.

c. Active duty Marines and Sailors assigned to units cared for in the MCMH sites will be enrolled to the existing MTF Defense Medical Information System Identifier (DMIS ID) that currently exists for the respective MTF in which the MCMH will operate. If the MCMH will operate in a Navy Medicine facility that currently does not have a DMIS ID, BUMED will request creation of a new DMIS for the purposes of the MCMH site. MTF personnel will ensure USMC personnel are enrolled to the respective MCMH Primary Care Manager (PCM) and assigned to the appropriate DMIS.

d. Each MCMH team will be assigned a specific Functional Cost Code (FCC) compliant with Navy Medicine's 4th level Medical Expense and Performance Reporting System (MEPRS) policy, as well as a place of care in the Composite Health Care System (CHCS). MCMH practices will utilize the code "BGZ*" as their FCC. Specific guidance regarding necessary tasks related to implementation of 4th level MEPRS for the MCMH will be provided separately by BUMED Resource Management/Comptroller (M8).

e. The MCMH will be a patient-centered, team-based system of care that aligns with a population of Marines, approximately 4,000 to 5,000 in size (generally at the Regiment or Group level) as appropriate to mission and unit requirements and relative proximity to clinical services. USMC organic medical personnel assigned to the units enrolled in the MCMH team will provide all primary medical care to Marines and Sailors, regardless of unit, assigned to the respective MCMH. MCMH practices will also provide care to active duty USMC and Navy personnel temporarily assigned to units served by the MCMH.

f. USMC organic medical providers will maintain clinical privileges through their designated USMC privileging authority and will request dual MTF privileges, based on their credentials, through an Inter-Facility Credentials Transfer Brief (ICTB), approved by the MTF Commanding Officer in which the MCMH operates. They will report all time spent in clinical practice in the MCMH within the BUMED facility to the appropriate FCC (BGZ*) in the Defense Medical Human Resource System internet (DMHRSi) as borrowed labor. The MCMH represents a partnership between local MTFs and the organic medical personnel assigned to the Marine Corps. As such, organic Marine Corps medical personnel assigned to the MCMH are responsible for providing adequate and consistent coverage to ensure continuity of MCMH operations. Navy Medicine personnel will

stand ready to support the MCMH during times of deployment and contingency operations when no other organic Marine Corps assets are available.

g. USMC organic medical personnel will:

(1) Complete all MTF training requirements for healthcare workers, including Armed Forces Health Longitudinal Technology Application (AHLTA) and CHCS training.

(2) Comply with all applicable BUMED medical staff bylaws and local MTF medical Staff policies and procedures, which may include, but are not limited to: credentialing, competency assessments, safety, patient safety, workload accounting, peer review, education and training, information security, orientation, annual training, patient medical privacy, health screening and immunizations, customer service, equipment utilization and safety, materiel management, patient rights and responsibilities, infection control and Joint Commission readiness.

(3) Use local MTF purchased, inspected and maintained equipment when performing duties within the MCMH.

(4) Document all patient care in AHLTA, CHCS, and any other applicable systems.

(5) Use standardized appointment templates and appointing processes that promote open access to care, including 24-hour phone access to a member of the MCMH team.

(6) Be provided with, and adopt, the MTF's secure patient messaging system as an important vehicle for providing access and delivering healthcare services to Navy and Marine Corps patients enrolled at the MCMH sites. They will develop internal procedures for secure patient messaging within their group practice and for individual members of their MCMH team. MCMH teams will ensure all e-messages are handled in a timely manner by appropriate personnel.

(7) Ensure sufficient clinical support to the MCMH while balancing availability of their assigned units to meet operational demands. USMC unit leaders will maintain command and control of their organic medical personnel. To provide appropriate access to patients, schedules will be open and available at least two weeks in advance. Schedules should be inclusive of both morning and afternoon sessions, Monday through Friday, except command-approved holidays or liberty, and to meet other operational requirements at the discretion of local leadership.

(8) Continue to meet all operational and training requirements of their parent unit. To minimize disruption of clinic operations, personnel will, to the greatest extent possible, ensure their clinic schedule does not conflict with these command requirements. Abrupt clinic cancellations have a significant negative impact on clinic operations and should be minimized whenever possible by proper advanced planning.

(9) Coordinate with local Marine Corps leadership to ensure a plan for continuation of medical coverage for Marines remaining behind during deployment, also known as Remain Behind Element (RBE), when planning operations. Units anticipating provider coverage issues should notify the Senior Medical Officer (SMO) and their local Marine leadership as early as possible prior to deployment and Temporary Additional Duty (TAD) assignments.

h. BUMED subordinate commands shall provide:

(1) Personnel support as detailed in sections 5a and 5b.

(2) Furnished clinical spaces within the local MTF, as available, for MCMH practices to operate their clinical practice, as well as mutually agreed local site improvements to optimize patient care and workflow within the MCMH.

(3) Required training per local facility education and training policies. The MTF will monitor, document and ensure training assistance for required training of USMC organic medical personnel. Training will include, but is not limited to AHLTA, CHCS, Tri-Service Work Flow, appointing processes, secure messaging and enrollment practices.

(4) Medical equipment and consumable supplies necessary for garrison primary care to USMC organic providers in support of clinical duties performed in local MTF spaces.

(5) Applicable training by appropriate personnel to USMC organic medical personnel regarding safe, proper use and shutdown of local MTF equipment. Only medical staff with appropriate training will use BUMED laboratory, preventive medicine or radiology equipment.

(6) Access to, and training for, applicable MTF electronic systems and licenses, including secure messaging, following approval by the MTF Head, Management Information Department, upon completion of the following requirements and any additional items as required by BUMED policy (subject to change):

(a) Health Insurance Portability and Accountability Act (HIPPA) Privacy 101 training,

(b) Navy Enterprise Information Technology User Acknowledgement Form,

(c) Initial Department of Defense (DoD) Information Security training,

(d) Annual DoD Security Awareness training, and

(e) A favorable background check.

(7) Training tailored to the unique MCMH population on implementation and management of their medical home practices. Training will be established and provided by BUMED personnel in conjunction with HQMC (HS) staff. As MCMH matures, select USMC organic medical personnel may be asked to speak in the Navy Medicine Professional Development Center's (NMPDC) Clinic Management Course.

i. MTF Commanding Officers (CO) at MCMH sites will verify Clinical Activity File (CAF) maintenance, ensure required peer review of treatment records is performed, and ensure completion of periodic and close out Performance Appraisal Reports (PARs) on all USMC providers privileged through an ICTB.

j. Command and Control. USMC unit commanders will maintain operational and administrative command and control of their organic medical personnel, whether performing administrative or operational functions in unit spaces, or clinical functions in the MCMH.

(1) Each MCMH team will be led by a Senior Medical Officer (SMO) from one of the units participating in the MCMH, designated by the relevant USMC headquarters authority (e.g. the SMO of a regimental MCMH will be designated by the regiment commander; the SMO of a multiple command area MCMH will be designated by mutual agreement of relevant headquarters commanders or the Marine Expeditionary Force (MEF) commander). The SMO will meet regularly and collaborate with the MTF designated liaison to refine and maintain efficient operations of the MCMH, ensuring compliance with this MOU.

(2) The SMO will oversee and supervise (tactical control) the clinical responsibilities, functions, and schedules of USMC organic medical personnel while they conduct MCMH clinical activities.

(3) The MTF CO will have administrative command and control over local MTF/BUMED personnel assigned to the MCMH.

(4) The MTF CO will designate an MTF Liaison to enhance collaboration and improve communication between the MCMH and the local MTF.

(5) The SMO will oversee and supervise (tactical control) local MTF personnel in the day-to-day performance of their clinical duties in support of the MCMH. Per local policy, performance evaluations for assigned local MTF personnel supporting the MCMH practice will be completed collaboratively between the SMO and the MTF Liaison.

(6) The MTF CO will have overall responsibility and authority for clinical quality standards (quality control) in MCMHs in their facilities.

k. Metrics for MCMH sites' performance will be reviewed and compared to established MHP benchmarks quarterly between BUMED M3B7 and HQMC (HS) to promote performance improvement and learning among the MCMH practices. The MCMH teams will be assessed regarding team continuity, PCM continuity, access to care, patient satisfaction, readiness, percent of kept consult appointments, and Emergency Department/Urgent Care utilization. New mutually agreed upon metrics may be introduced, as necessary, to measure USMC operational priorities.

l. Those MCMH sites operating in BUMED MTF facilities will maintain compliance with all Joint Commission standards and USMC and BUMED Inspector General (IG) standards, and will participate in MTF Joint Commission surveys and USMC and BUMED IG surveys, as well as any other applicable inspections or surveys to which the MTF is subject.

6. Communications. The USMC MCMH designated SMO will collaborate with local MTF Liaison, designated by the MTF CO, to ensure optimal communication regarding pertinent issues, matters of mutual impact, understanding of this MOU and issues relating to higher authority policy and The Joint Commission. At a minimum, quarterly meetings are recommended.

7. Information Security. Security of BUMED computer systems is a priority. Access to data networks or personal computers is not authorized until approved security measures and training requirements are satisfied, as outlined in this MOU, DoDI 6025.18, and local facility instructions.

8. Workload Reporting. USMC providers will enter medical workload in AHLTA. Per Medical Expense and Performance Reporting System (MEPRS) Manual DoD 6010.13M, and BUMED guidance, USMC providers will enter workload resulting from their patient's visits into the applicable information systems using their respective MCMH DMIS code.

9. Health Information Privacy. All parties will comply with DoDI 6025.18, Privacy of Individually Identifiable Health Information in DoD Health Care Programs, December 19, 2002 and DoD 6025.18-R, DoD Health Information Privacy Regulation, January 23, 2003.

10. Effective Period. The effective period of this MOU is nine years from the date of final signature. It may be continued without change during that period, but must be reviewed annually as directed by the signatories.

11. Termination. This MOU may be cancelled at any time by mutual consent of the parties concerned. The MOU may also be terminated by either party upon giving 45-days written notice to the other party. In the case of mobilization or other emergency, the MOU may be terminated as to a particular MCMH immediately upon written notice by either party, and it will remain in force during mobilization or other emergency only within BUMED activity's capabilities.

12. Modification, Change, or Amendment. Any modifications, changes, or amendments to this MOU must be in writing, and are contingent upon approval and signature by all parties.

13. Resources. Execution of this MOU is contingent upon local BUMED funding availability. Therefore, approval of this MOU does not constitute approval of additional resources, nor does it establish or validate additional program requirements. Any funding or billet requirements that cannot be accommodated within the BUMED local facility budget must be separately addressed through normal budget processes or other special programs. Any requirements to alter or renovate BUMED-owned space to accommodate a MCMH must be submitted, approved, and funded in accordance with the BUMED Special Projects Program. Nothing in this MOU should be construed to require the construction of additional space to support the MCMH program in an existing facility.

14. Disputes. Any disputes relating to this support agreement will, subject to any applicable law, executive order, directive, or instruction, be resolved by consultations between the Parties or in accordance with DoDI 4000.19. However, any disputes regarding the interpretation of this support agreement that cannot be resolved at

the lowest levels within BUMED M3 and HQMC (HS), will be elevated for resolution to the Surgeon General of the Navy, Chief, Bureau of Medicine and Surgery, and the Deputy Commandant for Installations and Logistics (I&L), as the final arbiters.

15. Concurrence. All parties to this MOU concur with the intent, level of support, and the resource commitment of this agreement.

M. L. NATHAN
Vice Admiral, Medical Corps
United States Navy
Surgeon General of the Navy
Chief, Bureau of Medicine and
Surgery

10/23/2014
Date

W. M. FAULKNER
Lieutenant General
United States Marine Corps
Deputy Commandant for
Installations and Logistics

10 November, 2014
Date