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OPNAVINST 6320.7B
MCO 6320.4A
N093/CMC-MED
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OPNAV INSTRUCTION 6320.7B
MARINE CORPS ORDER 6320.4A

From: Chief of Naval Operations
Commandant of the Marine Corps

Subj: HEALTH CARE QUALITY ASSURANCE POLICIES FOR OPERATING FORCES

Ref: (a) BUMEDINST 6010.30
(b) DoD Instruction 6025.13 of 17 February 2011
(c) ASN (M&RA) memo of 6 Jan 06 (NOTAL)
(d) BUMEDINST 6010.13
(e) OPNAVINST 6400.1D
(f) DHA-PM 6025.13 Vol 3 of 29 August 2019
(g) BUMEDINST 6550.10B

Encl: (1) Definitions
(2) Operational Forces Medical Occurrence Screening List
(3) Operational Forces Dental Occurrence Screening List

1. Purpose. To update policy, reissue policy, prescribe procedures and assign responsibilities regarding the quality assurance (QA) of health care provided to the operating forces. This instruction is a complete revision and should be reviewed in its entirety. The changes in subparagraphs 1a through 1d have been implemented.

a. Deleted previous enclosures and paragraphs detailing professional qualifications and privileging procedures as they are covered in reference (a).

b. Revised subparagraph 8f to clarify ongoing monitoring of event outcomes.

c. Added four new provider types to enclosure (1).

d. Added nine new screening requirements to enclosure (2) and three new screening requirements to enclosure (3).

2. Cancellation. OPNAVINST 6320.7A and MCO 6320.4.

3. Scope and Applicability. The provisions of this instruction apply to all privileged and non-privileged healthcare providers assigned to the operating forces of the Navy and Marine Corps as identified in enclosure (1).

4. Background.

a. The Secretary of the Navy (SECNAV) has policy oversight of the clinical quality management program within Department of the Navy (DON) per reference (b) and has assigned the Chief, Bureau of Medicine and Surgery (BUMED) as the DON corporate privileging authority per reference (c). As the corporate privileging authority, Chief, BUMED has authority to establish Navy requirements for licensure, credentials review and clinical privileging of all the DON providers assigned to fleet units and U. S. Marine Corps operational units. Chief, BUMED has the authority to designate specific program support responsibilities to the Chief of Naval Operations (CNO) and the Commandant of the Marine Corps (CMC).

b. Quality health care is a priority for DON and includes ensuring the people who deliver the health care are properly qualified, trained, competent and able to provide high quality healthcare services. The CNO and CMC will direct the establishment of key elements of clinical quality management program for those operational air, ground and fleet clinics not accredited by a nationally recognized body.

c. Robust provider competency management processes are in place in support of continuous quality improvement initiatives.

5. Policy. Per reference (b), all healthcare providers assigned to operational forces must:

a. Participate in ongoing monitoring and evaluation to identify and resolve problems which directly or indirectly impact patient care. The findings of the clinical quality management program will be used in the periodic credentials review or evaluation of all healthcare providers. Methodologies that may be utilized in implementing this program are found in references (d) through (f).

b. Ensure licensed independent healthcare providers are subject to credentials review and privileging per reference (a).

c. Ensure non-privileged healthcare providers (as defined in enclosure (1), paragraph 3) are subject to credentials review to determine if they are qualified to provide health care per references (a) and (e).

d. Establish the procedures for the handling of allegations of clinical incompetence, impairment and professional misconduct involving privileged and non-privileged providers, reference (f).

e. Establish credentials committees for operating forces units which will normally be established by the privileging authority and will consist of privileged providers.

f. Establish Joint committees of collocated operating forces and medical military facilities as authorized by the appropriate privileging authority.

6. Responsibilities.

a. Chief, BUMED will:

(1) Establish a program policy and oversee its implementation and coordination by designating the command surgeons, Commander U.S. Fleet Forces Command (COMUSFLTFORCOM), Commander Naval Special Warfare Command (COMNAVSPECWAR) and The Medical Officer of the Marine Corps (TMO) as privileging authorities per reference (a).

(2) Assist in developing the list of qualifications and standards for non-privileged healthcare providers per references (a) and (e).

(3) Provide guidance and advice as requested.

b. COMUSFLTFORCOM, COMNAVSPECWAR and TMO will:

(1) Assume overall QA program oversight and coordination.

(2) Incorporate the policy of this instruction into local QA and credentials review and privileging programs, with sufficient scope to ensure current clinical competence and provision of health care by all healthcare providers.

(3) Establish agreements with Naval Medical Forces Atlantic and Naval Medical Forces Pacific via letter or memorandum of understanding to obtain necessary support and assistance, if required.

(4) Establish protocols for strike group and other operational commanders to effectively monitor and control medical care throughout the battle or exercise theater.

7. Personal Qualification Standard Review Process. The privileging authority or designee must conduct a thorough evaluation of the current competency of all non-privileged healthcare providers assigned to the operating forces annually. This evaluation will be a written report and will address personal qualification standards, a QA monitoring of care provided and will be forwarded and maintained by the command surgeon of the unit to which the provider is assigned. A copy of this report will be placed in the non-privileged healthcare provider's file.

8. QA Program.

a. The program must be of sufficient scope to identify, resolve and prevent problems which impact the safe delivery of patient care. The findings and results of the QA program must be utilized in the periodic credentials review or evaluation of all healthcare providers assigned to the operating forces.

b. Documents and records created by the QA program are QA documents under section 1102 of Title10, United States Code (U.S.C.) QA documents and records may not be disclosed to any person or entity, except as provided in section 1102(c) of Title 10, U.S.C. Per section 1102(c), 10 U.S.C. and Department of Defense (DoD) Manual 5400.07, these records are exempt from the disclosure requirements of section 552 of Title 5, U.S.C. Questions concerning authorized release should be directed to appropriate BUMED legal counsel.

c. A written evaluation of the QA program must be compiled annually by each privileging authority and submitted appropriately to COMUSFLTFORCOM or TMO. Additionally, an assessment of compliance with reference (e) regarding the maintenance of independent duty corpsman (IDC) certifications must be attached as an enclosure to the submitted evaluation. For the purposes of this instruction, the COMNAVSPECWAR force medical officer must submit their report to COMUSFLTFORCOM. COMNAVSPECWAR force medical officer's report to COMUSFLTFORCOM must include actions taken to resolve and prevent future occurrences of identified problems which adversely impact patient care.

d. COMUSFLTFORCOM, COMNAVSPECWAR and TMO forward a consolidated report of their respective privileging authorities' written evaluations to the Director, High Reliability (BUMED-N95).

e. Each privileging authority will annually review and ensure compliance with this instruction and references (a) through (g), the annual submission of QA data, maintenance of credentials and certification records of privileged and non-privileged providers and procedures for storage and record keeping of medical and clinical utilization. This will be accomplished by the inspection of logs, records and minutes of event's screens reviewed and actions (written and electronic) for the purpose of assessing the care given. Problems which are identified must be documented and tracked by the privileging authority until they are resolved.

f. Ongoing monitoring of event outcome (formerly occurrence) screens will occur as a result of periodic review by group and squadron medical officers as mandated by the privileging authority. Periodic review of records (after each primary care visit, sick bay admission or randomly) will be done to identify any adverse outcomes as provided in enclosures (2) and (3) and approved by the designated privileging authority. This check may be performed by a screener or a provider. The identified events will be reviewed during consultative visits or inspections for accuracy and compliance. The results of this process will be included in the mandated regular reports sent to COMUSFLTFORCOM or TMO. The electronic patient safety reporting system will be the final repository for these events.

g. At all times, commanding officers and their respective surgeons have the ultimate accountability for the health and welfare of their personnel. When on extended deployment, the monitoring of the quality of health care rendered by independent, non-privileged healthcare providers must be continued in an effective manner per reference (e). Emphasis must be placed upon evaluation of independent non-privileged healthcare providers' patterns of health care, consultation and referral (medical evacuation).

9. Privacy Act.

a. Any misuse or unauthorized disclosure of personally identifiable information (PII) may result in both civil and criminal penalties. The DON recognizes that the privacy of an individual is a personal and fundamental right that must be respected and protected. The DON's need to collect, use, maintain or disseminate PII about individuals for purposes of discharging its statutory responsibilities must be balanced against the individuals' right to be protected against unwarranted invasion of privacy. All collection, use, maintenance or dissemination of PII must be per the Privacy Act of 1974, as amended (5 U.S.C. 552a) and implemented per SECNAVINST 5211.5F.

b. The DoD Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs (DoD Manual 6025.18) issued pursuant to the Health Insurance Portability and Accountability Act of 1996, applies to most records containing individually identifiable health information. DoD Manual 6025.18 may place additional procedural requirements on the uses and disclosures of such information beyond those found in the Privacy Act of 1974.

10. Records Management.

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the DON Assistant for Administration, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the OPNAV Records Management Program (DNS-16).

11. Review and Effective Date. Per OPNAVINST 5215.17A, Director, Healthcare Operation (BUMED-M3) will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency and consistency with Federal, DoD, SECNAV and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST

5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

12. Information Control Management. Symbol OPNAV 6320-1 is assigned to the reporting requirements in paragraphs 7, subparagraphs 8c and 8d and approved for reports information management control by SECNAV M-5214.1, 31 December 2005.

B. L. GILLINGHAM
Surgeon General of the Navy

G. P. OLSON
Director, Marine Corps Staff

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via:

DON Issuances website:
https://www.secnav.navy.mil/doni/default.aspx

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DEFINITIONS

1. Medical treatment facilities (MTF) and dental treatment facilities (DTF) within the operating forces are:

   a. MTFs and DTFs ashore and afloat (to include sick bays aboard ship and level two forward surgical units) which are not under budget submitting office 18.

   b. Medical and dental units of the Fleet Marine Forces.

   c. Medical and dental units in support of Navy Expeditionary Combat Command.

2. Privileged healthcare providers assigned to the operating forces are:

   a. Physicians (Medical Corps-2100).

   b. Dentists (Dental Corps-2200).

   c. Nurse Anesthetists (Nurse Corps (NC)-2900).

   d. Nurse Practitioners (NC-2900).

   e. Optometrists (Medical Service Corps (MSC)-2300).

   f. Psychologists (MSC-2300).

   g. Physical Therapists (MSC-2300).

   h. Physician Assistants (MSC-2300).

   i. Social Workers (MSC-2300).

3. Non-privileged healthcare providers are:

   a. Certified Athletic Trainers.

   b. Deep Sea Diving IDC (Hospital Corpsman (HM)-L28A).

   c. Independent Duty Submarine Corpsman (HM-L01A).

   d. Independent Duty Surface Warfare Corpsman (HM-L10A).

   e. Independent Duty Fleet Marine Force Reconnaissance (HM-L02A).

f. Registered Nurses (NC-2900).

g. Registered Dental Hygienists (HM-L35A).

4. Military Sealift Command medical care providers include all credentialed and non-credentialed staff assigned to the operating forces of Military Sealift Command. This instruction ensures the monitoring of the quality of health care provided by active duty, civil service or a civilian contractor. The providers specifically include but are not limited to those listed in subparagraphs 4a through 4c of this enclosure.

a. Medical Service Officers-9996-27).

b. Physician Assistants (GS-0603.

c. Registered Nurses (GS-0610).

5. Commanding officer, for purpose of this instruction, is synonymous with ship's master and commander(s) of MSC.

OPERATIONAL FORCES MEDICAL OCCURRENCE SCREENING LIST

1. All deaths.

2. Cardiac arrest or respiratory arrest, regardless of outcome.

3. Readmission to sick bay for the same problem.

4. Three or more primary care visits for same complaint without resolution.

5. Unplanned return to surgery.

6. Significant drug reaction.

7. Error in medication, transfusion, treatment or procedure.

8. Intravenous therapy complications.

9. Post-operative wound infection or wound-related problems.

10. Injury to patient.

11. Incomplete medical record entries.

12. Inadequate follow-up on abnormal lab or x-ray results.

13. Permanent harm not primarily related to the patient's injury, natural course of illness or underlying condition.

14. Severe temporary harm (critical, potentially life threatening harm lasting a limited amount of time but requiring transfer to a higher level of care or major surgery) not primarily related to the patients injury, natural course of illness or underlying condition.

15. Suicide within 72 hours of medical evaluation for mental health concerns.

16. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

17. Rape, sexual abuse, unconsented sexual contact, assault or homicide of any patient or medical provider in medical spaces.

18. Invasive elective procedure or elective surgery on the wrong patient, at the wrong site or that is the wrong (unintended) procedure.
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19. Unintended retention of a foreign object in a patient after an invasive procedure or surgery.

20. Any patient or medical provider injury as a result of fire, flame or unanticipated smoke, heat or flashes caused by an electro-cautery generator, laser or flammable skin preparation solution during an episode of patient care.

21. Failure to report disease incidences or outbreaks constituting a public health emergency or defined as a Tri-Service reportable event.

OPERATIONAL FORCES DENTAL OCCURRENCE SCREENING LIST

1. Death.

2. Unanticipated hospital admission.

3. Unanticipated loss of a tooth.

4. Post dental procedures and postoperative infections.

5. Treatment failures.

6. Drug reactions.

7. Medication errors.

8. Four or more dental sick call visits for same unresolved complaint.

9. Unplanned return to surgery.

10. Injury to patient.

11. Incomplete dental record entries.

12. Inadequate follow-up on abnormal lab or x-ray results.

13. Invasive elective procedure or elective surgery on the wrong patient, at the wrong site or that is the wrong (unintended) procedure.

14. Unintended retention of a foreign object in a patient after an invasive procedure or surgery.

15. Any patient or medical provider injury as a result of fire, flame or unanticipated smoke, heat or flashes caused by an electro-cautery generator, laser or flammable skin preparation solution during an episode of patient care.