CHAPTER 3

HEALTHCARE ADMINISTRATION PROGRAMS

INTRODUCTION

One of the most important aspects of healthcare administration is the appropriate documentation and disposition of healthcare information. Although much information is now recorded in the electronic medical record (EMR); Armed Forces Health Longitudinal Technology Application (AHLTA), there remains considerable vulnerability to ensure the contents of patient information are held in accordance with laws such as the Health Information Portability and Accountability Act (HIPAA), Privacy Act, and Freedom of Information Act (FOIA). Specifically, information is only provided to persons in a need to know status.

It is imperative that all pertinent information be provided in a beneficiary’s record whether it is electronic or paper. This data follows a beneficiary until the sponsor retires or separates from military service. The medical record is the vehicle that ensures the continuum of care throughout the beneficiary’s life.

Hospital Corpsmen (HMs) are often the very first individual a beneficiary encounters upon entering a military treatment facility (MTF), outpatient or inpatient. In order to adequately assist the beneficiary, HMs must be knowledgeable and skilled in the administrative affairs concerning outpatients and inpatients.

This chapter will provide information on the function of healthcare programs with which the HM may be involved or responsible. It will discuss the legal implications in medical care, including the various aspects of consent, incident reports, and release or non-release of medical information. Further, guidance concerning the relationship and interaction with law enforcement personnel and the legal community will be outlined.

Regardless of the job title, HMs will have administrative responsibilities which may be primary or equal to their clinical responsibilities.

The role of the HM includes:

- Greeting the patient entering the clinic or inpatient floor
- Assisting patients in completing medical treatment forms
- Performing the initial assessment of the beneficiary, specifically vital signs
- Providing initial clinical documentation
- Preparing follow-up appointments for patients
- Assisting with the referral process
- Preparing and maintaining files and medical treatment records, including reports derived from them
- Developing and maintaining a proactive and responsive supply process

PATIENT ELIGIBILITY FOR HOSPITALIZATION AND NON-FEDERAL CARE

LEARNING OBJECTIVE:

*Explain the policies and procedures for DEERS and TRICARE.*

Not all persons working for the federal government are eligible for treatment in a medical treatment facility. The following resources provide guidance regarding eligibility verification by presentation of a valid identification (ID) card and utilization of the Defense Enrollment Eligibility Reporting System (DEERS).
DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

DEERS is a computer-based enrollment and eligibility verification system. It was developed to improve distribution and control of military healthcare services including the projection and allocation of costs for healthcare programs and to minimize fraudulent healthcare claims. Navy Medicine’s eligibility for care instruction, NAVMEDCOMINST 6320.3 series, provides guidance as to who and under what circumstances members can receive medical and dental care at Navy Medical Department facilities; the extent and conditions under which such care may be provided; and the collection process to pay for that care.

Family member enrollment is accomplished for all seven uniformed services (i.e., Army, Air Force, Marine Corps, Navy, Coast Guard, Public Health Service, and National Oceanic & Atmospheric Administration) by completing the Uniformed Services Identification and Privilege Card application, DD 1172. When a new ID card is obtained for the family member, the service member’s DEERS data is updated online. If problems exist within a patient’s database, active duty personnel and their family members must be referred to the sponsor’s personnel support detachment (PSD). Refer all other beneficiaries (e.g., retired personnel and their family members) to the nearest PSD.

Both DEERS and the ID card are utilized to establish eligibility for care. Initially, the HM will examine the beneficiary’s ID card. The beneficiary’s status (e.g., active or reservist; service component, etc.) is depicted on the ID card; also note the date of expiration. Next using the online computer terminal, the HM will perform an electronic DEERS check via CHCS; the DEERS verification process is outlined in OPNAVINST 1750.2 series, Defense Enrollment Eligibility Reporting System.

Eligibility

Patients who present for non-emergency treatment without a valid ID card but are in the DEERS database will not be provided medical care without first signing a statement that they are eligible and giving the reason why a valid ID card is not in their possession. If a valid ID card is not provided within 30 calendar days, the patient will be billed as a Civilian Humanitarian Non-indigent IAW the Resources Management Handbook, NAVMED P-5020. Such billing may be delayed if the commanding officer of the medical facility is convinced proof is delayed for reasons beyond the control of the patient or sponsor. In all cases where a patient presents without an ID card and does not appear in the DEERS database, non-emergency care will be denied.

REASONS FOR INELIGIBILITY—
When a DEERS check is performed and the patient is found ineligible for any of the following reasons, routine non-emergent healthcare will be denied (except as noted later in this section).

- Sponsor not enrolled in DEERS
- Family member not enrolled in DEERS
- Ineligible due to passed terminal (end) eligibility date, i.e. child who ages out at 18 years of age
- Sponsor has separated from active duty
- Spouse is divorced from sponsor and is not entitled to benefits as a former spouse
- Family member child is married
- Secretary of the Navy Designee

UNDER NO CIRCUMSTANCES WILL THE CLERK PERFORMING THE ELIGIBILITY CHECK DENY THE REQUESTED CARE. Only command-designated supervisory personnel can perform this function.
DEERS ELIGIBILITY OVERRIDES.—
The nine "DEERS eligibility overrides" are listed below. Unless otherwise stated, all overrides must be supported by a valid ID card.

1. DD 1172—The patient presents an original or copy of the DD 1172 used for DEERS enrollment. There are other specific items required for verification, and current service directives must be checked.

2. All Other Family Members Recently Becoming Eligible for Benefits—New mothers, babies, recent adoption, and dependent parents.

3. New Identification Card—Patients presenting with a new valid ID card, issued within the previous 120 days, will not be denied care.

4. Ineligible Due to ID Card Expiration—When the database shows a patient as ineligible because of ID card expiration, care may be rendered as long as the patient has a new ID card issued within the previous 120 days. After 120 days, follow the procedure in item 1, above.

5. Sponsors Entering Active Duty Status for a Period of Greater than 30 Days—A copy of orders ordering a reservist or guardsman to an active duty period of greater than 30 days may be accepted for the first 120 days of the active duty period. After that, follow the procedure in item 1 above.

6. Newborns—Newborns will not be denied care for a period of 60 days. On the 61st day the newborn will shift to TRICARE STANDARD if not enrolled in Prime. Enrollment into Prime CANNOT occur unless the newborn is put on the sponsor’s Page 2 and enrolled in DEERS. Newborns of Dependent Daughters must be approved for Secretary of the Navy Designee or they are not eligible for care.

7. Emergency Care—This is a medical decision and shall be determined by criteria established within the command.

8. Sponsor’s Duty Station is Outside the 50 United States or has an APO/FPO Address—Family members whose sponsors are assigned outside the 50 United States or to a duty station with an APO/FPO address will not be denied care as long as the sponsor is enrolled and eligible in DEERS.

9. Survivors—When an eligibility check indicates that a deceased sponsor is not enrolled in DEERS or the survivor is listed as the sponsor; the survivor will be treated on the first visit and referred to the appropriate personnel support detachment (PSD) for correction of the DEERS database. For second and subsequent visits, the survivor will be required to follow the procedure in item 1, above. While deceased, the sponsor remains the sponsor in order to facilitate eligibility for family members.

DEERS ELIGIBILITY EXCEPTIONS.—
The following beneficiaries are categorized as “DEERS Eligibility Exceptions.” Although authorized care, they may not be authorized to be enrolled in the DEERS system. These beneficiaries will NOT be denied care based upon a DEERS check.

- Secretary of the Navy Designees—Secretary of the Navy Designees will be treated as indicated on their letter of designation.

- Foreign Military Personnel—These personnel and their family members, assigned through Personnel Exchange Programs or other means, are or may be eligible. Eligible members may also include
  - North Atlantic Treaty Organization (NATO) military personnel and their family members stationed in or passing through the United States
  - Crew and passengers of visiting military aircraft; and
  - Crews of ships of NATO nations that come into port
Other foreign military personnel may be eligible through Public Law or DoD agreements. As such, they will be treated IAW current service directives.

Patients in other organizations, such as Red Cross workers, Secret Service agents, Federal Aviation Administration personnel, and some non-retiree veterans are also in this category of possible beneficiaries due to agreements. Ensure current eligibility requirements are met for these personnel prior to treatment.

TRICARE

TRICARE is an enhancement of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE is a medical benefits program established to manage the care services in military MTFs. Additionally, it manages the cost-sharing charges for medically necessary civilian services and supplies required in the diagnosis and treatment of illness or injury. TRICARE is utilized if the required services are not available from the direct care system of the Department of Defense treatment facilities or designated MTFs/DTFs.

Information pertaining to eligibility, extent of care, providers, cost, and claims is contained in the booklet *Sailing with TRICARE, for Sailors and Their Families*. A copy of this publication, along with the TRICARE Provider Directory and other helpful TRICARE information is available at a local TRICARE Service Center. Guidance is also available via the DoD TRICARE homepage, http://www.tricare.osd.mil. Information regarding the TRICARE Dental Program can be found in the TRICARE Dental Program Benefit Booklet or the DoD TRICARE Dental Program homepage, www.tricareddentalprogram.com.

DENTAL CARE ELIGIBILITY

There are several types of dental care including routine, emergency, and elective. The person’s eligibility will determine the type of treatment that can be provided. Active duty members and reservists recalled to active duty for a period of more than 30 days are eligible for all services. Family members are eligible to enroll in the TRICARE Dental Plan as long as the service member (active duty or reservist) has at least 12 months remaining on active duty.

Patient Registration

Patient Registration is an important part of the eligibility process either establishing it or confirming it. Patient registration is usually performed in outpatient medical records or in admissions and dispositions.

Priority of Care

Naval Dental Treatment Facilities (DTFs) and clinics will provide care to all eligible beneficiaries subject to the capabilities of the professional staff and availability of space and facilities.

In those instances when care cannot be rendered to all eligible beneficiaries, care will be prioritized based on the criteria outlined in the following list without regard to the sponsoring uniformed service.

Priority Categories

Cat. 1A.—Members of the uniformed services on active duty

Cat. 1B.—Members of a Reserve Component of the Armed Forces and National Guard personnel

Cat. 2.—Family member of active duty members of the uniformed services; family members of persons who died while in such a status

Cat. 3.—Members of the Senior Reserve Officers’ Training Corps

Cat. 4.—Retired members of the uniformed services and their family members (including family members of deceased retired members)

Cat. 5.—Civilian employees of the Federal Government

Cat. 6.—All others
The rendering of emergency dental treatment to any person when such treatment is necessary affects the above priority categorization, i.e. pediatric patient with an emergency will supersede an active duty person awaiting a routine procedure.

ROUTINE DENTAL CARE.—Treatment includes all the medical, surgical, and restorative treatments of oral disease, injuries, and deficiencies that come within the field of dentistry. These services are reserved for active duty members and reservists recalled to active duty beyond 30 days. Family members and retirees are treated via the current TRICARE Dental Plan or other dental insurance plan. Routine services are preventive and corrective which include:

- Dental examinations and oral health instruction (OHI)
- Restoration of lost tooth structure
- Treatment of periodontal conditions
- Surgical procedures
- Replacement of missing teeth essential to personal appearance, the performance of military duty, or the proper mastication of food

EMERGENCY DENTAL CARE.—Treatment is necessary to relieve pain, control bleeding, and manage acute septic conditions or injuries to the oral-facial structures. Emergency dental care is authorized worldwide for personnel of all categories.

ELECTIVE DENTAL CARE.—May be authorized upon evaluation by the dental officer IAW Navy policy. Examples of elective dental care are malocclusion, orthodontics, replacing amalgam fillings with gold crowns, etc.

NAVY MEDICINE’S QUALITY ASSURANCE PROGRAM

LEARNING OBJECTIVE:

Explain the philosophy of Navy Medicine’s Quality Assurance Program.

The Quality Assurance Program uses various sources of data to evaluate the degree of excellence and to make improvements as needed for quality care. Quality assurance activities reflect what patients and providers expect of each other. Quality assurance activities are highly valued by The Joint Commission (TJC) and Medical Inspector General (MED IG).

Many of the principles, standards, and organizational requirements of The Joint Commission (TJC) have been adopted and are contained in OPNAVINST 6320.7 series, Health Care Quality Assurance Policies for Operating Forces. BUMEDINST 6010.13 series, Quality Assurance Program, lists the required elements for process improvement (quality assurance) programs of naval hospitals, medical clinics, and dental clinics.

The delivery of quality health care has always been a driving force in the operational and managed care of MTF’s and DTF’s. The Navy’s Health Care Relations Program (BUMED Instruction 6300.10 series), provides general guidance to the establishment of this program. The program has three parts, which are Internal, External and Patient Relations.
PATIENT RELATIONS AND COMMAND PATIENT CONTACT POINT PROGRAMS

LEARNING OBJECTIVE:

Explain the philosophy of the Patient Relations Program and the Patient Contact Point Program.

Navy healthcare professionals have long understood the need for good communication between the patient and the medical department staff. The atmosphere in which care is given has a tremendous impact on the patient’s perception of the quality. The quality of medical and dental care rendered may be superb; however, the care can be perceived by the patient to be substandard due to poor interpersonal skills of those assigned to patient contact points (where the patient and healthcare professional meet). Many complaints voiced by patients would not occur if personnel consistently presented a courteous and knowledgeable attitude that reflected a genuine concern for the patient.

PATIENT RELATIONS PROGRAM

The primary goal of the Patient Relations Program is to help resolve patient complaints and problems through patient intervention and negotiations in accordance with BUMEDINST 6300.10 series. As an adjunct to this goal, the program strives to enhance the channels of communication between the hospital and the patient population.

PATIENT CONTACT POINT PROGRAM

The Patient Contact Point Program, a subset of the Patient Relations Program, ensures an effective means of resolving such issues before the patient departs the facility. All Navy treatment facilities have this program which allows patients to provide any complaints or compliments relating to the treatment received.

PATIENT CONTACT REPRESENTATIVE

Patient contact representatives are appointed in writing by the commanding officer and have their picture posted at the front desk or in the reception area visible to all patients. Patient compliments and complaints are routed through the patient contact representative to the chain of command for action and incorporation into the command’s annual assessment for the Quality Assurance (QA) Program. Follow BUMEDINST 6010.13 series and your clinic’s instruction for follow-up actions and reporting instructions.

PATIENTS’ BILL OF RIGHTS AND RESPONSIBILITIES

Patients’ Bill of Rights and Responsibilities are posted next to the Patient Contact Representative’s picture. Figure 3-1 illustrates the Patients’ Bill of Rights and Responsibilities.

PATIENT SURVEYS

Patient survey forms should be located at the front desk area. These forms originate at each clinic and ask questions regarding the patient’s visit. Completed forms are returned to the clinic staff for compilation and submission with the command’s annual assessment of the QA Program.
# A Patient's Bill of Rights and Responsibilities

<table>
<thead>
<tr>
<th>Rights</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>1. Medical Care and Dental Care. The right to quality care, and treatment consistent with available resources and generally accepted standards. The patient has the right also to refuse treatment to the extent permitted by law and Government regulations, and to be informed of the consequences of his or her refusal. When concerned about the care received, the patient has a right to request review of the adequacy of care.</td>
<td>1. Providing Information. The responsibility to provide, to the best of his or her knowledge, accurate and complete information about complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health. A patient has the responsibility to let his or her primary health care provider know whether he or she understands the treatment and what is expected of him or her.</td>
</tr>
<tr>
<td>2. Pain Management. The right to receive information about pain and pain relief measures, a concerned staff committed to pain prevention and management and health professionals who respond quickly to reports of pain.</td>
<td>2. Pain Management. The responsibility to ask your doctor or nurse what to expect regarding pain and pain management, to discuss pain relief options, and to actively participate in your pain control.</td>
</tr>
<tr>
<td>3. Respectful Treatment. The right to considerate and respectful care, with recognition of his or her personal dignity.</td>
<td>3. Respect and Consideration. The responsibility for being considerate of the rights of other patients and MTF or DTF health care personnel and for assisting in the control of noise, smoking, and the number of visitors. The patient is responsible for being respectful of the property of other persons and of the facility.</td>
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<tr>
<td>4. Privacy and Confidentiality. The right, within law and military regulations, to privacy and confidentiality concerning medical care.</td>
<td>4. Compliance with Medical Care. The responsibility for complying with the medical and nursing treatment plan, including follow-up care, recommended by health care providers. This includes keeping appointments on time and notifying the MTF or DTF when appointments cannot be kept.</td>
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<tr>
<td>5. Identity. The right to know at all times the identity, professional status, and professional credentials of health care personnel, as well as the name of the health care provider primarily responsible for his or her care.</td>
<td>5. Medical Records. The responsibility for ensuring that medical records are promptly returned to the medical facility for appropriate filing and maintenance when records are transported by the patient for the purpose of medical appointment or consultation, etc. All medical records documenting care provided by any MTF or DTF are the property of the U.S. Government.</td>
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<tr>
<td>6. Explanation of Care. The right to an explanation concerning his or her diagnosis, treatment procedures, and prognosis of illness in terms the patient can be expected to understand. When it is not medically advisable to give such information to the patient, the information absence, another appropriate person.</td>
<td>6. MTF and DTF Rules and Regulations. The responsibility for following the MTF or DTF rules and regulations affecting patient care conduct. Regulations regarding smoking should be followed by all patients.</td>
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<tr>
<td>7. Informed Consent. The right to be advised in non-clinical terms of information needed to make knowledgeable decisions on consent or refusal treatment. Such information should include significant complications, risks, benefits, and alternative treatments available.</td>
<td>7. Reporting of Patient Complaints. The responsibility for helping the MTF or DTF commander provide the best possible care to all beneficiaries. Patient’s recommendations, questions, or complaints should be reported to the patient contact representative.</td>
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<td>8. Research Projects. The right to be advised if the facility proposes to engage in or perform research associated with his or her care or treatment. The patient has the right to refuse to participate in any research projects.</td>
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<tr>
<td>9. Safe Environment. The right to care and treatment in a safe environment.</td>
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<tr>
<td>10. Medical Treatment Facility (MTF) or Dental Treatment Facility (DTF) Rules and Regulations. The right to be informed of the facility rules and regulations that relate to patient or visitor conduct. The patient should be informed about smoking rules and should expect compliance with those rules from other individual. Patients are entitled to information about the MTF or DTF mechanism for the initiation, review, and resolution of patient complaints.</td>
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</tr>
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Figure 3-1.—Patient's Bill of Rights and Responsibilities

3-7
MEDICAL TREATMENT RECORDS

An essential part of the administrative duties of a HM is preparing and maintaining the medical record with associated forms; guidance is found in the Manual of the Medical Department (MANMED) Chapter 16. Use of the term “medical records” includes records maintained by both medical and dental treatment facilities and to records in both paper and automated (electronic) formats.

The purpose of the medical record (paper and electronic) is to provide an individual chronological record of medical treatment afforded members of naval service. The record has significant current and long-term medical-legal value to the individual concerned, their survivors, and the U. S. Government. Medical, dental and occupational health examinations, evaluations and histories as well as evaluation of illness and subsequent treatments, are documented in this record.

FAMILY ADVOCACY PROGRAM

LEARNING OBJECTIVE:

Explain the policies and procedures pertaining to the Family Advocacy Program.

The purpose of the Family Advocacy Program is to identify and monitor spouse or child abuse/neglect (whether physical or psychological) and sexual abuse in military families. The program is guided by SECNAVINST 1752.3 series, Family Advocacy Program and BUMEDINST 6320.70 series. A Family Advocacy Representative (FAR), usually a staff member of the local treatment facility, manages the program. A base-wide committee, comprised of medical, line, chaplain, and Family Service Center personnel, reviews abuse cases and determines whether each case is established, suspected, or unfounded. Established cases are reported to the central registry at BUMED. Service statistics are compiled and the future assignment of established abusers is monitored and controlled via this registry.

If abuse is suspected by the HM there is a moral and legal obligation to report the actual or suspected abuse to the chain of command and or legal authorities as appropriate.

DRUG AND ALCOHOL ABUSE PREVENTION AND CONTROL PROGRAM

LEARNING OBJECTIVE:

Explain policies and procedures pertaining to the Drug and Alcohol Abuse Prevention and Control Program.

The policies governing the Alcohol and Drug Abuse Prevention and Control Program encompass the Navy’s approach on eliminating alcohol and drug abuse. It provides methods of deterrence and prevention along with education and treatment of individuals found guilty of abuse or in need of substance abuse treatment.

Alcohol consumption is a personal decision of each individual; however, personnel should be aware that the minimum allowable age to consume alcohol is 21. The Navy satisfies the decision of each individual by taking an approach of “Responsible Use.”

The Navy’s Policy on drug abuse is “Zero Tolerance.” Navy drug abuse is not subordinate to any foreign, state, or local regulation, which may permit the use, possession, distribution, or prescription of controlled substances. Personnel in violation of this provision are in violation of a lawful general order and shall be subjected to disciplinary and administrative action as appropriate.

The Drug and Alcohol Program Advisor (DAPA) is the command’s primary advisor for all alcohol and drug matters. Among other duties, DAPAs conduct administrative screenings, prepare required reports, provide prevention education, and monitor aftercare. Additional responsibilities of the DAPA are outlined in OPNAVINST 5350.4 series, Drug and Alcohol Abuse Prevention and Control.
PHYSICAL READINESS PROGRAM

LEARNING OBJECTIVE:

Explain the policies and procedures pertaining to the Physical Readiness Program.

The policies governing this program are outlined in OPNAVINST 6110.1 series, Physical Readiness Program. Currently, physical readiness testing is required for all personnel on a semi-annual basis. Testing, education, and training information are provided through a network of collateral duty command fitness coordinators. In addition to program implementation, specific Medical Department responsibilities include:

- Providing technical assistance to BUPERS
- Conducting lifestyle, fitness, and obesity research
- Reviewing health status and granting waivers for individuals unable to safely participate in physical fitness testing and training
- Assisting in the development of exercise prescriptions

LEGAL IMPLICATIONS IN MEDICAL CARE

LEARNING OBJECTIVE:

Explain the policies and procedures pertaining to consent for medical treatment, incident reports, and release of medical information.

There are few aspects of healthcare that do not have legal implications. Every time a patient interacts with the staff of a medical or dental treatment facility, the potential for legal entanglement exists. Although the law has become more and more involved in the operation of hospitals, the exercise of common sense combined with knowledge of those situations that require special care will protect the hospital and its staff from most legal situations.

This section addresses some of the situations that regularly occur and have legal consequences, including the policy and instructions that apply to those situations. The law is an inexact science subject to widely varying circumstances. The information in this chapter cannot substitute for the advice of an attorney; consult with hospital or area Judge Advocate General (JAG) Corps officers or Navy civil service lawyers on medical-legal issues.

CONSENT REQUIREMENTS FOR MEDICAL TREATMENT

With limited exceptions, every person has the right not to be touched without giving permission first. Consent must be obtained before medical treatment is initiated. Failure to obtain consent may result in the healthcare provider being responsible for medical malpractice and/or assault and battery upon the patient.

Informed Consent

"Consent" in the medical setting refers to a patient's expressed or implied agreement to submit to an examination or treatment. "Informed consent" requires that the healthcare provider give the patient all the information necessary for a knowledgeable decision. In order to be considered "lawful consent" the patient must have made a knowledgeable decision with full awareness of the consequences; without it there is no lawful consent. The proposed procedure must be described in lay terms for patient understanding regarding the nature, the risk, and the alternatives of what is proposed. The higher the risk or the seriousness of the consequences requires a greater duty to disclose.

NOTE:
The duty to inform and explain rests with the provider.
THIS RESPONSIBILITY CANNOT BE DELEGATED.
For common medical procedures that are considered simple and risk-free, a provider is not required to explain consequences that are generally understood to be remote. A determination of what is simple and common should be made from the perspective of appropriate medical standards.

Emergency Situations

Consent before treatment is not necessary when treatment appears to be immediately required to prevent significant deterioration or aggravation of a patient’s condition. This applies especially in life-threatening situations when it is not possible to obtain a valid consent from the patient or a person authorized to consent for the patient. The existence and scope of the emergency should be adequately documented. When the patient is unable to give consent, the appropriate course of treatment based upon a qualified medical assessment of what a "reasonable person would expect" becomes the guiding principle for continued emergent care.

Who May Consent

The determination of who has authority to consent to medical treatment is based on an evaluation of the competency of the patient. If competent, the patient alone has the authority to consent. Competency refers to the ability to understand the nature and consequences of one’s decisions. In the absence of contrary evidence, it is assumed that the patient presenting for treatment is competent. If the patient is incompetent, either by reason of statutory incompetence (e.g., a minor) or by reason of a physical or mental impairment, the inquiry must turn to whoever has the legal capacity to consent on behalf of the patient. Parents and guardians will have the authority to consent for their minor children. In many states a husband or wife may give consent for an incompetent spouse. It is the law of the state in which the hospital is located that controls the question of "substitute consent."

There may be paperwork, called an advance directive, that indicates who can provide informed consent for the patient. The form may be a healthcare surrogate designation, healthcare power of attorney, or a general power of attorney. This form is filed in the patient’s healthcare record and documented in the electronic health record (i.e. CHCS/AHLTA) for quick retrieval in order to consult with the appropriate person on behalf of the patient.

Forms of Consent

Consent for medical treatment should be obtained through an open discussion between the provider and patient during which the patient expressly agrees to the procedure. The consent should be documented by having the patient sign appropriate forms and by the provider noting any important details of the discussion in the treatment record.

In certain limited circumstances, the consent of an individual for simple medical treatment may be implied from the circumstances. Implied consent arises by reasonable inference from the conduct of the patient or the individual authorized to consent for the patient. For example, a patient who rolls up a sleeve when told it is time to draw blood is providing implied consent by this action. Reliance on this form of consent is strongly discouraged except in the most routine, risk-free examinations and procedures.

Witness to Consent

Any competent adult may witness the patient’s consent. It is a conflict of interest to have a staff member who is participating in the patient’s procedure to act as a witness; utilize a staff member of the hospital who is not participating in the procedure. It is not advisable for a relative of the patient to act as a witness.

Duration of Consent

Consent is valid as long as there has been no material change in the circumstances between the date that consent was given and the date of the procedure. It is desirable that a new consent be obtained if there is a significant time lapse (per command policy) or if the patient has been discharged and readmitted due to postponement of the procedure.
INCIDENT REPORTS

Incident reporting falls under Title 10 U.S.C. 1102, Confidentiality of Medical Quality Assurance Records. When an event occurs that harms an individual, illustrates a potential for harm, or evidences serious dissatisfaction by patients, visitors, or staff, a risk-management incident has taken place. Examples of such episodes include the following:

- A patient is helped out of bed by family despite directions to the contrary by staff members. The patient falls and is injured
- Excessive silver nitrate is put into the eyes of a newborn impairing vision
- The mother of the child complains about the care that has been given to the child and informs a staff member that the issue will be discussed with a lawyer

When a member of the staff becomes aware of an incident, there is a responsibility to make the hospital command aware of the situation. The mechanism for doing this is the quality care system. Quality Care Review (QCR) reports are designed to promptly document all circumstances surrounding an event, to alert the commanding officer, Command Risk Manager, and other involved administrators and clinicians of a potential liability situation. It also establishes an information base to monitor and evaluate the number and types of incidents that take place in the facility.

QCRs by nature contain a great deal of information that would be of interest to persons filing claims or lawsuits against the Navy for alleged substandard medical care. The law recognizes the need for hospitals to have a reliable means of discovering and correcting problems; most states have enacted laws that make incident reports confidential. A person cannot obtain a copy of an incident report to help in the legal action against the hospital.

QCRs lose their "protected" status if they are misused or mishandled. It is important to treat these reports like all confidential documents. All copies require the permission of the risk manager and the legal officer. Do not include the report in the patient’s treatment record. The report should be limited to the facts and must not contain conclusions. Reports should be addressed and forwarded directly to the risk manager of the hospital. Guidance concerning the Risk Management Program is found in BUMEDINST 6010.21 series.

RELEASE OF MEDICAL INFORMATION

Two federal statutes, the Privacy Act and the Freedom of Information Act (FOIA) combine to establish the criteria for collecting, maintaining, and releasing medical treatment records.

Freedom of Information Act (FOIA)

FOIA governs the disclosure of documents maintained by government agencies. A written request for Department of the Navy (DoN) records that refer to FOIA must be responded to IAW the provisions of the Act. DoN will make available to any person all documents provided the requester reasonably describes the records sought and promises to pay for reasonable search and photocopy costs. Each naval activity is responsible for developing procedures for ensuring the prompt handling, retrieval, and review of requested records. The official having responsibility for the records has 20 working days to respond to the requester.

A naval record will be withheld only when it is exempt from disclosure under FOIA. One basis for exempting a record from disclosure applies to personnel, medical, and similar files. The release of these files would constitute a clearly unwarranted invasion of personal privacy. This concern over clearly unwarranted privacy intrusion is reflected in the provisions of the Privacy Act while FOIA covers Protected Health Information (PHI) outside the covered entity.

Privacy Act

The public’s concern over governmental functions led to the creation of FOIA. It became obvious that a balance had to be made between the public’s right to know and the Government’s protected rights and interests. One of these
competing interests was the protection of an individual’s personal right to privacy. In response to this need, the Privacy Act of 1974 was enacted. The Privacy Act establishes safeguards concerning the right to privacy by regulating the collection, maintenance, use, and dissemination of personal information by federal agencies.

The Privacy Act requires federal agencies to:

- Permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated by the agency
- Permit an individual to prevent records pertaining to him or her and obtained by the agency for a particular purpose from being used or made available for another purpose without the individual’s consent
- Permit an individual to gain access to information pertaining to him or her in federal agency records, have a copy made for all or any portion thereof; and correct or amend such records
- Collect, maintain, use, or disseminate any record of identifiable personal information in a manner that ensures such action is for a necessary and useful purpose, that the information is current and accurate, and that adequate safeguards are provided to prevent misuse of such information
- Permit exemptions from the requirements of the Privacy Act only in those cases where there is specific statutory authority to do so
- Be subject to civil suits for any damages that occur as a result of willful or intentional violation of any individual’s rights under the Privacy Act

In addition, any employee of an agency who intentionally violates certain provisions of the Privacy Act is subject to criminal prosecution and fines.

HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT

The Health Information Portability and Accountability Act (HIPAA) was enacted into law in 1996. The overall goal is to provide safeguards for protected health information (PHI) to ensure patient privacy is maintained. The Privacy Rule addresses appropriate disclosure of PHI while the Security Rule addresses electronic disclosures.

HIPAA Privacy Rule

The HIPAA Privacy Rule creates business processes to protect the use and disclosure of protected health information (PHI). PHI is individually identifiable health information, including demographics, in paper, electronic, or oral form. PHI is not limited to the documents contained in the official medical record. The HIPAA Privacy Rule allows the use and disclosure of PHI for treatment, payment, and health care operations without written authorization from the patient. Other uses and disclosures require permission. The compliance date for the HIPAA Privacy rule was April 14, 2003 and is guided by DODINST 6025.18 series, DOD Health Information Privacy Regulation.

Required Uses and Disclosures

By law, treatment facilities may disclose health information to the patient unless it has been determined by a competent medical authority that it would be harmful. Treatment facilities must also disclose health information to the Secretary of the Department of Health and Human Services (HHS) for investigations or determinations of compliance with laws on the protection of the patient’s health information.
TREATMENT.—Treatment facilities use and disclose protected health information to provide, coordinate, or manage the patient’s health care with a third party. For example, the facility may disclose PHI, as necessary, to other military and or TRICARE contractors who are providing care or consultation to patients. This includes pharmacists who may be provided information on other drugs the patient was previously prescribed to identify potential interactions. In emergencies, facilities will use and disclose PHI to provide urgent treatment.

PAYMENT.—PHI will be used to obtain payment for health care services. This includes certain activities the facility undertakes before it approves or pays for the health care services recommended. For example, obtaining approval for a hospital stay might require that PHI be disclosed to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS.—PHI may be disclosed to support the daily activities related to health care. These activities include, but are not limited to, quality assessment activities, investigations, oversight or staff performance reviews, training of medical students, licensing, and communications.

HIPAA Security Rule

The HIPAA Security Rule is designed to provide protection for individually identifiable health information that is maintained, transmitted, or received in electronic form—not just the information in standard transactions. All covered entities were to be in compliance with the HIPAA Security Rule no later than April 20, 2005. The safeguards in the HIPAA Security Rule are divided into three categories: Administrative Safeguards, Physical Safeguards, and Technical Safeguards. The guiding instruction for HIPAA Security is DoD 8580.02-R series, DoD Health Information Security Regulation.

Security and privacy are linked in an effort to protect the privacy of health information. The Privacy Rule sets standards for how protected health information (PHI) should be controlled by setting forth which uses and disclosures are authorized. The Security Rule defines the safeguards to protect that PHI. It is important to recognize that the Security Rule has greater limitations than the Privacy Rule, as the Security Rule only applies to PHI in electronic form.

MEDICAL CONDITIONS AND LAW ENFORCEMENT PERSONNEL

LEARNING OBJECTIVE:

Describe the policies and procedures pertaining to prisoner patients, victims of alleged sexual assault and rape, substance abuse and control, probable-cause searches, and line-of-duty and misconduct investigations.

Some medical conditions will result in the involvement of law enforcement personnel. Individuals who are injured while committing a criminal offense; victims of abuse, neglect, or assault; impaired or injured as a result of drug abuse; or injured as a result of a traffic accident will often be the subject of an official investigation. The investigators will want to question the patient or the healthcare providers treating the patient. Authorities may request the medical records of the patient as well as take the patient into custody.

Under the Posse Comitatus Act, a federal statute enacted in 1956 (18 U.S.C. § 1385), it is unlawful for the U.S. military to be used to enforce or assist in the enforcement of federal or state civil laws. There are many exemptions to this act, but the issue for healthcare providers is settled by asking the following question:

"Is the medical procedure being done on this patient for a legitimate medical reason, or is it only being performed to assist civil law enforcement?"

Provided there is a reasonable medical justification for the procedure, the results of the procedure may be shared with civil law enforcement officials under the circumstances covered below.
Cooperation with law enforcement officials, to the extent possible, is required. Provided there are no medical contraindications, patients who are suspected of having committed an offense or are presumed victims of criminal activity will be made available to speak with investigators. Access to medical treatment records is governed by the Privacy Act and FOIA.

Records of patients may be made available to U.S. Navy investigators once they have established the need to know. This determination will be made by the hospital JAG or public affairs officer (PAO). Other Department of Defense, federal, state, or local law enforcement officers may have access to treatment records if access is necessary as part of a criminal investigation and there is no unwarranted violation of the privacy rights of the individual involved. Local health and social service departments may be provided information from the record. The same guidelines for accessing treatment records apply to staff members' conversations with investigating officers.

**DELIVERY OF A PATIENT UNDER WARRANT OF ARREST**

No patient may be released from treatment before it is medically reasonable to do so. Once it is determined that the individual can be released without significant risk of harm, the following guidelines regarding release to law enforcement authorities apply.

**Non-active Duty Patients**— When a non-active duty patient is released from medical treatment, the facility no longer exercises any degree of control, and normal legal processes will occur. No official action by hospital personnel is required before local authorities take custody of the released patient. There may be occasions, however, when law enforcement officials should be notified of an imminent release of a patient.

**Active Duty Patients**— The commanding officer is authorized to deliver personnel to federal law enforcement authorities who display proper credentials and represent to the command that a federal warrant for the arrest of the individual concerned has been issued. There are circumstances in which delivery may be refused; however, guidance should be sought from a judge advocate of the Navy or Marine Corps when delivery is to be denied.

Normally, it is the responsibility of the permanent command to take custody and control of an active duty member suspected of committing an offense. If the member is an unauthorized absentee (UA) and the command to which assigned is not in the same geographic area as the treatment facility, release of the patient should be coordinated with the nearest Transient Personnel Unit (TPU) or Military Prisoner Escort Unit. Close liaison with the member's permanent command should be established.

In cases where delivery of an active duty patient is requested by local civil authorities, and the treatment facility is located within the requesting jurisdiction or aboard a ship within the territorial waters of such jurisdiction, commanding officers are authorized to deliver the patient when a proper warrant is presented. Whenever possible, a judge advocate of the Navy or Marine Corps should be consulted before delivery. If the treatment facility is located outside the jurisdiction requesting delivery, only a General Courts-Martial authority (as defined by the Uniform Code of Military Justice, Manual for Courts-Martial and Navy Regulations) is authorized to arrange for delivery of such patient. Extradition, return agreements, and other prerequisites to delivery will have to be completed.

When disciplinary proceedings involving military offenses are pending, the treatment facility should obtain legal guidance from a judge advocate before delivering a patient to federal, state, or local authorities. When the commanding officer considers that extraordinary circumstances exist which indicate that delivery should be denied, then the Judge Advocate General of the Navy must be notified of the circumstances by message or phone.
PRISONER PATIENTS

Prisoner patients fall into three categories of eligible beneficiaries:

- Enemy prisoners of war and other detained personnel
- Non-military federal prisoners
- Military prisoners

Enemy Prisoners of War and Other Detained Personnel

Enemy prisoners of war and other detained personnel are entitled to all necessary care, subject to the availability of care and facilities.

Non-military Federal Prisoners

Non-military federal prisoners are authorized only emergency care. When such care is being provided, the institution to which the prisoner is sentenced must furnish security personnel to ensure custody of the prisoner and safety of others in the facility. Upon completion of emergency care, arrangements will be made to transfer these individuals to a non-military treatment facility or for return to the institution to which sentenced.

Military Prisoners

Status of Forces policy is to protect, to the maximum extent possible, the rights of U.S. personnel who may be subject to criminal trial by foreign courts and imprisonment in foreign prisons. Active duty members are generally separated from the service until they have completed their term of imprisonment and returned to the United States. During this confinement, they will normally retain healthcare benefits.

Military prisoners (those sentenced under the Uniform Code of Military Justice) with punitive discharges that have been executed but the sentences have not expired are authorized care. Individuals on appellate leave, awaiting execution of a punitive discharge, are entitled to care. Military prisoners with punitive discharges that have been executed and require hospitalization beyond expiration of their sentences are not eligible for care; they may be hospitalized as civilian humanitarian non-military indigents until disposition is made to some other facility.

SEXUAL ASSAULT AND RAPE

Sexual assault and rape are criminal offenses, often associated with serious physical injury. The management of cases involving sexual assault and rape must be a joint medical and legal function. A sexual assault investigation kit, supplied by the Naval Criminal Investigative Service (NCIS), is used to gather and preserve evidence of a crime. This kit includes step-by-step procedures for examination of the patient and a checklist of specimens to be collected.

To safeguard and obtain evidence to be used in legal proceedings, liaison among the naval treatment facility, military and civil investigative agencies, and state and local agencies (such as Child and Spouse Protective Services) should be established. Medical personnel are not to judge, defend, or prosecute the individuals involved.

NAVYEDCOMINST 6310.3 series, Management of Alleged or Suspected Sexual Assault and Rape Cases, provides guidance for care, evaluation, and medico-legal documentation of the alleged victim.
Treat the patient with respect and courtesy and provide appropriate privacy. Careful attention to psychological factors must be given to lessen the impact of the incident. When a minor is involved, the reaction of adults may be more harmful than the actual assault itself. Tactful questioning and use of appropriate terminology are of extreme importance throughout the history taking and examination. OPNAVINST 1752.1 series, Sexual Assault Victim Intervention (SAVI) Program, and SECNAVINST 5800.11 series, Victim and Witness Program, provide guidance for the care and support of alleged victims of sexual assault.

CHILD AND SPOUSE ABUSE AND NEGLECT

The nature of child and spouse abuse and neglect requires a careful patient history and physical examination by a medical provider to identify or rule out past and present injuries. The policies and guidelines established by the Navy Family Advocacy Program must be followed. This program was provided earlier in this chapter and is outlined in SECNAVINST 1752.3 series and BUMEDINST 6320.70 series.

SUMMARY

Retaining high medical standards and quality healthcare require a robust healthcare administration support structure. DEERS management and the determination of patient eligibility are crucial components. There are numerous health-related programs established to benefit and support eligible beneficiaries. Good quality assurance creates better patient relations, thereby minimizing legal problems. Substance abuse and family advocacy programs identify problems before they become unmanageable. The physical readiness program helps build a healthier Sailor, thus eliminating needless patient visits.

This chapter provided an overview of the HM's responsibilities in the areas of administrative and legal interaction with authorities. Legal cases are lost because of failure to adhere to the proper administrative procedures. The HM must be aware of these procedures and ensure that they are followed precisely.