

CHAMPVA Fact Sheet 01-16
For Outpatient Providers and Office Managers

What is CHAMPVA?

CHAMPVA (the Civilian Health and Medical Program of the Department of Veterans Affairs) is a federal health benefits program administered by the Department of Veterans Affairs. CHAMPVA is a Fee for Service (indemnity plan) program. CHAMPVA provides reimbursement for most medical expenses – inpatient, outpatient, mental health, prescription medication, skilled nursing care, and durable medical equipment (DME). There is a very limited adjunct dental benefit that requires pre-authorization.

How does CHAMPVA relate to CHAMPUS/TRICARE?

CHAMPVA bases its benefit structure on CHAMPUS/TRICARE Standard option. There are no other ties between the programs. CHAMPVA is administered by the Department of Veterans Affairs Health Administration Center in Denver, CO.

CHAMPVA does not have a preferred provider or HMO option like TRICARE, it is solely a fee-for-service plan. Bottom line – CHAMPVA is NOT CHAMPUS/TRICARE!

Is pre-authorization required for services?

The *only* pre-authorization requirements for CHAMPVA are for: organ and bone marrow transplants, hospice, dental care; DME worth more than \$300 and most mental health or substance abuse services.

Additionally, some payments are made based on specific clinical guidelines. Two common examples are breast reduction and weight reduction surgical procedures. The CHAMPVA Handbook has details.

Do I need approvals for referrals to specialists or for diagnostic tests?

No -- except for services that require pre-authorization mentioned above.

What kind of case management and utilization review is performed?

Clinical claims reviews are performed for a variety of medical services including: DME utilization; mental health/substance abuse services; physical, occupational and speech therapy; home health; hospice; skilled nursing; rehabilitation and utilization of controlled substances.

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Is there a contract or agreement that I must sign to accept/participate in CHAMPVA?

No! CHAMPVA does not have contract providers. Providers must be properly licensed in their state to receive payment from CHAMPVA and not be on the MEDICARE exclusion list.

Providers may elect to participate in CHAMPVA by submitting a claim. Beneficiaries must pay the provider your their cost share and any charges for non-covered services.

Do providers have to accept the CHAMPVA allowable rate?

Yes, under 38 CFR section 272(b) (3) and (4), providers must accept the CHAMPVA allowable rate and cannot balance bill.

How do providers get a claim paid?

Send a HCFA 1500 or UB 92 to P.O. Box 65024, Denver, CO 80206-9024. This is the ONLY address for CHAMPVA. *Don't use the address that you have for CHAMPUS/TRICARE.* If the patient has other health insurance (OHI), bill them first and send a copy of the OHI EOB with the CHAMPVA claim to the Health Administration Center. By law, CHAMPVA is always a second payor except to Medicaid or State Victims of Crime Compensation Programs and supplemental CHAMPVA policies.

What does CHAMPVA pay?

In most cases, CHAMPVA pays equivalent MEDICARE/TRICARE rates. CHAMPVA has a deductible (\$50/per person up to \$100 per family per calendar year) and a cost share of 25%. Providers should collect the 25% cost share from the patient except when the patient has other health insurance.

If the patient has other health insurance, then in most cases, CHAMPVA pays the lessor of either 75% of the allowable amount or the remainder of the charges and the beneficiary will normally have no cost share.

How fast does CHAMPVA pay?

CHAMPVA normally pays 95 percent of claims within 30 days.

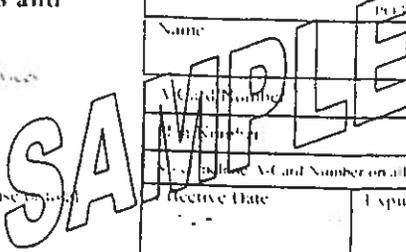
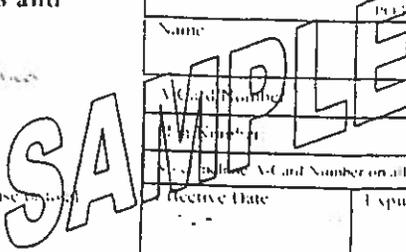
Are there special considerations for Ambulatory Surgery Centers?

Yes, these must be MEDICARE approved.

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How do I know someone is CHAMPVA eligible?

Every CHAMPVA beneficiary has a CHAMPVA Authorization Card that looks like this (not all cards have a Plan Number or Group Number):

<p>CHAMPVA Benefit Coverage Limitations – see the CHAMPVA Handbook for information on covered benefits and limitations.</p> <p>Preauthorization is required for the following services:</p> <ul style="list-style-type: none"> • Organ and bone marrow transplants • Hospice services • Most mental health substance abuse services • All dental care • All durable medical equipment with a purchase or rental price of \$300 or more <p>Preauthorization Requests</p> <p>Medical Services 1-800-733-8387 Mental Health Substance Abuse 1-800-424-1018</p>	<p align="center">  Department of Veterans Affairs Health Administration Center CHAMPVA Authorization Card <small>P.O. Box 65023 Denver, CO 80206-9023</small> </p>	
	Name	
	<p>  </p>	
	Plan Number	Group Number
	<p>  </p>	
Effective Date	Expiration Date	<p align="center">Assistance 1-800-733-8387</p>

VA Form 10-7959, Feb 2001 (RS)

How do I get more information?

- Check the CHAMPVA web site at www.va.gov/hac
- Write CHAMPVA at P.O. Box 65023, Denver, CO 80206-9023
- E-mail: hac.inq@med.va.gov
- Call 1-800-733-8387, Monday-Friday from 9:00- 5:00 PM Eastern Time.

TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

This form is for eligible beneficiaries who want to enroll in TRICARE Prime, TRICARE Prime Remote (TPR) and US Family Health Plan. This form is for new enrollments and Primary Care Manager (PCM) changes. This form may be used to request a PCM change within the same military treatment facility or civilian clinic or at a new facility or new TRICARE region. This form should be used to transfer enrollment within the 50 United States and Washington, D.C.

Review the eligible categories (1 through 4) below to determine the application sections you must complete.

If you are eligible to enroll (identified below), then complete the required sections:

Eligible Categories	Section I Sponsor Information	Section II Enrolling Family Members	Section III Other Health Insurance	Section IV Reason for PCM Change	Section V Signature	Section VI Enrollment Fee Payment
1. Active Duty Service Members, Reserve Component Members called or ordered to active duty for 30 days or more	X			Complete if changing PCM		
2. Active Duty Family Members and Survivors of Active Duty (first three years in survivor status)	X	X	X	Complete if changing PCM	X	
3. Active Duty Family Members of Reserve Component Members called or ordered to active duty for 179 days or more. Must be eligible in DEERS	X	X	X	Complete if changing PCM	X	
4. Retirees, retiree family members, survivors, and eligible former spouses under 65 years of age who reside within the 50 United States or Washington, D.C.	X	X	X	Complete if changing PCM	X	X (Must include required payment)
5. ADFMs, Retirees, retiree family members, survivors and eligible former spouses 65 years or older and entitled to Medicare Part A. (Applicable only to US Family Health Plan)	X	X	X	Complete if changing PCM	X	X (If not enrolled in Medicare Part B)

GENERAL INSTRUCTIONS:

- Print all information in ink. Make sure the information is complete and accurate.
- Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center Support Office at 1-800-538-9552 or refer to your name as printed on your military ID card.
- There are two address fields for the sponsor and each family member. The Residence address block should be completed if it is known. If you haven't established a residence at the time you are completing this form, insert "To be determined." in the Residence address block and complete the "Mailing" address block. The "Mailing" address block is only to be completed if mail is to be sent to an address other than the residence address. If the "Mailing" address block is blank, all mail will be sent to the residence address. The addresses and telephone numbers you include on this form will update DEERS.

It is very important that you update your personal information in DEERS whenever your residence address, mailing address or phone number changes. Please see # 2

above.

4. Sign and date the application (Section V).
5. Please keep a copy of the completed TRICARE Prime application/PCM change form for your records.
6. TRICARE Prime - Active duty service members are required to enroll in Prime. Active duty family members, retirees and their family members are encouraged, but not required, to enroll in Prime.
7. TRICARE Prime Remote (TPR) is a program for active duty service members and their family members when the sponsor lives and works over 50 miles or one hour drive from a Military Treatment Facility (MTF) and the family member lives with the sponsor.
8. Submit completed Application/PCM Change form to the address below. If you are requesting a PCM change within the same MTF, submit the completed Application/PCM Change form to the local MTF. For enrollment or PCM changes in the US Family Health Plan please see number 12 below.

[Contractor's Name]
[Street Address]
[City, State, ZIP+4]

Applications can be mailed to the contractor identified above or dropped off at a TRICARE Service Center (TSC). Contact the local TSC in person or call the telephone number listed below in number 8 to determine when your new or transferred enrollment will begin.

9. For information on the TRICARE Prime procedures, contact the TRICARE Office identified below or visit the TMA Website at www.tricare.osd.mil.
10. For enrollment assistance, please call [Contractor's Name] at 1-~~888-XXXX-XXXX~~ or [Contractor's Name].
11. US Family Health Plan is a TRICARE Prime enrollment option for eligible individuals and families who live in seven specific parts of the country: Seattle Washington, Cleveland, Ohio, Portland Maine, Brighton, Massachusetts, Staten Island, New York, Baltimore, Maryland, and Houston, Texas. The primary difference between other TRICARE options and the US Family Health Plan is that US Family Health Plan may be used by uniformed services retirees and their eligible family members who are age 65 or older.
12. For enrollment or PCM changes in the US Family Health Plan, submit the completed Application/PCM Change form to the US Family Health Plan address listed below.

[US Family Health Plan]
[Street Address]
[City, State, ZIP+4]

For questions regarding enrollment/PCM changes in the US Family Health Plan, contact the US Family Health Plan member services at [1-800-XXX-XXXX]

AGENCY DISCLOSURE STATEMENT

Public reporting burden for this collection of information is estimated to average fifteen (15) minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0728-00008), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR APPLICATION TO THE ADDRESS ABOVE.. SEND YOUR APPLICATION TO THE ADDRESS SHOWN ON THE APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

- (1) Authority: 5 USC 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May 15, 2000.
- (2) Purpose: To evaluate eligibility for medical care provided by civilian sources to Military Health Services System beneficiaries applying for coverage under the TRICARE Program (32 CFR 199.17).
- (3) Uses: Information from application forms and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.
- (4) Disclosure: Voluntary; however, failure to provide information will result in the denial of enrollment.

TRICARE PRIME ENROLLMENT APPLICATION AND PCM CHANGE FORM

Form Approved
OMB No. 0720-0008
Expires

(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)

<i>Check one box</i>	Prime Enrollment	Prime Remote Enrollment	USFHP Enrollment	PCM Change
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SECTION I - SPONSOR INFORMATION

1. Sponsor Social Security Number (SSN)

2. Date of Birth (YYYYMMDD)

3. Sponsor Name (Last, First, Middle Initial) (Must match DEERS)

4. Sponsor is: (X one)

Active Duty

Deceased (Go to Section II)

Retired

Former Spouse (Go to Section II)

5. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code)

6. Mailing Address (If different than residence address)

7. Sponsor Telephone Number (Include Area Code) Home: ()

Work: ()

8. City and Country of Military Assignment (OCONUS Only)

9. Member's Unit and Unit Identification Code (UTC) (if known)

10. Zip Code of Work Address

11. E-Mail Address

12. Sponsor's Enrollment Status:
(Check one box)

New Enrollment

PCM Change

Already Enrolled (go to section II)

13. Sponsor Primary Care Manager (PCM) Preference: (Honoring your preferences depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.

a. PCM Name and Address
(if known)1st Choice2nd Choice

b. PCM Specialty

No Preference

Family/General Practice

Flight Medicine

Internal Medicine

c. Preferred PCM Gender

No Preference

Male

Female

1.

a. Name (Last, First, Middle Initial) Must match DEERS

b. Date of Birth (YYYYMMDD)

c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) Same as Sponsord. Mailing Address (If different than residence address) Same as Sponsor

e. Relationship to Sponsor

Spouse

Former Spouse

Child

f. Telephone Numbers (Include Area Code) Home: ()

Work: ()

(If different from sponsors)

g. Primary Care Manager (PCM) Preference (Honoring your preferences depends upon availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.

1. PCM Name and Address

(Check box if same as sponsor)

1st Choice Same as sponsor2nd Choice Same as Sponsor

2. PCM Specialty

No Preference

Family/General Practice

Internal Medicine

Attachment 2

3. Preferred PCM Gender	Flight Medicine	-	Pediatrics	
	No Preference		Male	Female

REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME			
SPONSOR INFO	Sponsor Social Security Number (SSN)		
	Sponsor Name (Last, First, Middle Initial) Must match DEERS)		
SECTION II - CONTINUED ADDITIONAL FAMILY MEMBER INFORMATION	a. Name (Last, First, Middle Initial Must Match Deers		
	b. Date of birth (YYYYMMDD)		
	c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) <input type="checkbox"/> Same as Sponsor		
	d. Mailing Address (If different than residence address)		
	e. Relationship to sponsor (X one)	Spouse	Child
		Former Spouse	
	f. Telephone numbers Include Area Code) Home: () Work: ()		
	g. Primary care manager (PCM) preference Honoring your preferences depends upon the availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.		
	1. PCM Name and Address (if known)	1 st Choice <input type="checkbox"/> Same as Sponsor	2 nd Choice <input type="checkbox"/> Same as Sponsor
	2. PCM Specialty	No preference	Family General Practice
	Flight Medicine	Pediatrics	
3. PCM Gender	No Preference	Male	Female
SECTION II - CONTINUED ADDITIONAL FAMILY MEMBER INFORMATION	a. Name (Last, First, Middle Initial) Must Match Deers		
	b. Date of birth (YYYYMMDD)		
	c. Residence Address (Street/P.O. Box, Apt No., City, State, ZIP Code) <input type="checkbox"/> Same as Sponsor		
	d. Mailing Address (If different than residence address)		
	e. Relationship to sponsor (X one)	Spouse	Child
		Former Spouse	
	f. Telephone numbers Include Area Code) Home: () Work: ()		
	g. Primary care manager (PCM) preference Honoring your preferences depends upon the availability and local Military Treatment Facility (MTF) policy. Contact your TRICARE Service Center, preferred MTF or US Family Health Plan Member Services for availability of PCMs.) Complete all that apply.		
	1. PCM Name and Address (if known)	1 st Choice <input type="checkbox"/> Same as Sponsor	2 nd Choice <input type="checkbox"/> Same as Sponsor
	2. PCM Specialty	No preference	Family General Practice
	Flight Medicine	Pediatrics	
3. PCM Gender	No Preference	Male	Female

REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME			
SPONSOR INFO	Sponsor Social Security Number (SSN)		- -
	Sponsor Name (Last, First, Middle Initial) Must match DEERS		
OHI	SECTION III – OTHER HEALTH INSURANCE (OHI) COVERAGE		
	Are any enrolling family members or is the retiree sponsor currently covered by OHI ? (not a TRICARE Supplement)		No
	If yes, provide the name of the other health insurance and the insurance identification number.		Yes
(Name of other health insurance) and (insurance identification number)			
SECTION IV – REASON FOR PCM CHANGE			
REASON FOR PCM CHANGE	Reason for change (X one per affected family member)	Move	Other (explain)
		Move	Other (explain)
		Move	Other (explain)
		Move	Other (explain)
SIGNATURE	SECTION V—SIGNATURE of the Sponsor, spouse or other legal guardian of the beneficiary		
	I understand that it is my responsibility to comply with all required TRICARE Prime procedures. By signing the form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.		
Signature		Date Signed	

-REPEATED SPONSOR SOCIAL SECURITY NUMBER AND NAME

SPONSOR INFO	Sponsor Social Security Number (SSN)	_____
	Sponsor Name (Last, First, Middle Initial) Must match DEERS	_____

SECTION VI – PAYMENT OF TRICARE PRIME ENROLLMENT FEES NOTE: This Section is only for retirees, retiree family members, survivors and eligible former spouses. Retired beneficiaries enrolled in Medicare Part B may have their enrollment fees waived if they provide a copy of their Medicare card as proof of enrollment in Medicare Part B. Explain all split enrollments (retiree family enrollment in more than one TRICARE Region) on separate sheet of paper. Certain survivors of active duty members pay no enrollment fee during the first three years in survivor status.

1. PAYMENT FEE OPTIONS	MONTHLY	QUARTERLY	ANNUAL
2. PLAN SELECTION (X One)	Single \$19.17	Single \$57.50	Single \$230.00
	Family \$38.34	Family \$115.00	Family \$460.00
3. PAYMENT METHOD (X One)	a. Allotment for Retired Pay (Complete A below)	a. Check/Cashiers Check/ Money Order*	a. Check/Cashiers Check/ Money Order*
	b. Electronic Funds Transfer (Complete B below)	b. VISA or Master Card (Complete C below)	b. VISA or Master Card (Complete C below)

Note: Quarterly and annual bills will be sent on a quarterly and annual basis, respectively. Monthly bills will not be sent.
 * Make check payable to the Contractor's Name

MONTHLY ALLOTMENT	A	I _____ choose to have my enrollment fees automatically paid by monthly allotment from my Uniformed Services retired pay. (Signature of Sponsor) (NOTE: Only retired Uniformed Services members may establish an allotment from their retired pay)
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ELECTRONIC FUNDS TRANSFER	B	I _____ choose to have my enrollment fees automatically paid by monthly electronic funds transfer. (Signature of Account Holder)
	1. Name and Address of Financial Institution	
	2. Financial Institution's Telephone Number:	
	1. Account Information (Check one box)	Savings _____ Checking (Attach Voided Check) _____
	4. Account Number	
	5. Bank or ABA Routing Number	
6. Name on Account		

CREDIT CARD	C	I _____ choose to have my enrollment fees automatically billed to my credit card. (Signature of Card Holder) (annual and quarterly payments only).
	1. Name on Credit Card	
	2. Credit Card Number	
	3. Type of Credit Card	VISA _____ Master Card _____
		Expiration date (MMYY) _____

TRICARE DISENROLLMENT APPLICATION

This form is for eligible beneficiaries whose enrollment in TRICARE Prime, TRICARE Prime Remote, or US Family Health Plan is voluntary.

GENERAL INSTRUCTIONS:

1. Print all information in ink. Make sure the information is complete and accurate.
2. Ensure personal information matches information in the Defense Enrollment Eligibility Reporting System (DEERS). To check your DEERS information, call the Defense Manpower Data Center (DMDC) Support Office at 1-800-538-9552 or refer to your name as printed on your ID card. The mailing address and telephone numbers you include on this form will update DEERS.
3. Sign and date the application (Section III).
4. Please keep a copy of the completed application for your records.
5. For TRICARE Prime and TRICARE Prime Remote disenrollments, submit your completed disenrollment application to the TRICARE contractor in your area or the TRICARE Service Center. For US Family Health plan see number 8 below.

Contractor Name
 Street Address
 City State ZIP+4

6. For information on TRICARE, visit the TRICARE Website at www.tricare.osd.mil.
7. For information on TRICARE, please call 1-888-DoD-LIFE or 1-888-363-5433.
8. For US Family Health Plan disenrollments, submit your completed disenrollment application to the US Family Health Plan facility where you are currently enrolled.

Contractor Name
 Street Address
 City State ZIP+4

9. For information on US Family Health Plan, visit the US Family Health Plan Website at www.usfhp.org
10. For information on US Family Health Plan, please call [1-800-XXX-XXXX].

AGENCY DISCLOSURE STATEMENT

Public reporting burden for this collection of information is estimated to average five (5) minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Directorate for Information Operations and Reports (0720-0008), 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number. PLEASE DO NOT RETURN YOUR DISENROLLMENT APPLICATION TO THE ADDRESSES ABOVE. SEND YOUR DISENROLLMENT APPLICATION TO THE ADDRESS SHOWN ON THE DISENROLLMENT APPLICATION INSTRUCTION SHEET.

PRIVACY ACT STATEMENT

- (1) Authority: 5 USC 552a, 10 U.S.C. 1079 and 1086, 58 FR 45318, 65 FR 30966, May 15, 2000.
- (2) Purpose: To implement disenrollment from TRICARE Prime, TRICARE Prime Remote or the Uniformed Services Family Health Plan as requested by the enrollee.
- (3) Uses: Information from disenrollment application and related documents may be given to the Department of Health and Human Services, and/or the Department of Transportation consistent with their statutory administrative responsibilities under TRICARE; to the Department of Justice for representation of the Secretary of Defense in civil actions. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation related to the operation of the TRICARE Program.
- (4) Disclosure: Voluntary; however, failure to provide information will result in continued enrollment and responsibility for payment of an enrollment fee.

TRICARE DISENROLLMENT APPLICATION	
(Please read Agency Disclosure Notice, Privacy Act Statement, and Instructions before completing this form.)	
SECTION I - SPONSOR INFORMATION (Must be completed on all applications)	
SPONSOR INFO	1. Sponsor Social Security Number (SSN) _____
	2. Sponsor Name (Last, First, Middle Initial) _____
	3. Date of Birth (YYYYMMDD) _____
SECTION II: INDIVIDUAL(S) REQUESTING DISENROLLMENT	
INDIVIDUAL DISENROLLMENT	1. a. Name (Last, First, Middle Initial) _____
	b. Date of Birth (YYYYMMDD) _____
	c. Relationship to Sponsor <input type="checkbox"/> Self <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child <input type="checkbox"/>
	d. Reason for Disenrollment (Check one)
	<input type="checkbox"/> Moved <input type="checkbox"/> Loss of TRICARE eligibility <input type="checkbox"/> Loss of Prime eligibility due to turning 65 years of age (Prime only)
	<input type="checkbox"/> Death <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> Request for Voluntary Disenrollment
	<input type="checkbox"/> Other (Explain): _____
e. Requested Disenrollment Date (YYYYMMDD): _____	
f. Telephone Number (Include Area Code) Home: () _____ Work () _____	
INDIVIDUAL DISENROLLMENT	2. a. Name (Last, First, Middle Initial) _____
	b. Date of Birth (YYYYMMDD) _____
	c. Relationship to Sponsor <input type="checkbox"/> Self <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child <input type="checkbox"/>
	d. Reason for Disenrollment (Check one)
	<input type="checkbox"/> Moved <input type="checkbox"/> Loss of TRICARE eligibility <input type="checkbox"/> Loss of Prime eligibility due to turning 65 years of age (Prime only)
	<input type="checkbox"/> Death <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> Request for Voluntary Disenrollment
	<input type="checkbox"/> Other (Explain): _____
e. Requested Disenrollment Date (YYYYMMDD): _____	
f. Telephone Number (Include Area Code) Home: () _____ Work () _____	
INDIVIDUAL DISENROLLMENT	3. a. Name (Last, First, Middle Initial) _____
	b. Date of Birth (YYYYMMDD) _____
	c. Relationship to Sponsor <input type="checkbox"/> Self <input type="checkbox"/> Retiree <input type="checkbox"/> Spouse <input type="checkbox"/> Former Spouse <input type="checkbox"/> Child <input type="checkbox"/>
	d. Reason for Disenrollment (Check one)
	<input type="checkbox"/> Moved <input type="checkbox"/> Loss of TRICARE eligibility <input type="checkbox"/> Loss of Prime eligibility due to turning 65 years of age (Prime only)
	<input type="checkbox"/> Death <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> Request for Voluntary Disenrollment
	<input type="checkbox"/> Other (Explain): _____
e. Requested Disenrollment Date (YYYYMMDD): _____	
f. Telephone Number (Include Area Code) Home: () _____ Work () _____	
SECTION III - SIGNATURE	
By signing this form, I certify that the information on this form is true, accurate and complete. Federal funds are involved in this program and any false claims, statements, comments or concealment of a material fact may be subject to fine and imprisonment under applicable Federal law.	
_____ Signature	_____ Date Signed

ATTACHMENT 4
MHS DATA REPOSITORY POINT-IN-TIME EXTRACT

The tabulation of MHS eligibles is based on the MHS Data Repository (MDR) Point-in-Time Extract (PITE). The MDR PITE is derived from the DEERS PITE, a monthly snapshot of the new DEERS Oracle database, reflecting beneficiary status at the end of the month as observed a few days into the next month. The MDR PITE includes additional fields (such as improved zip codes of residence for active duty Navy, and improved catchment area of residence for all) and also includes "flags" to identify unduplicated persons who have current MHS eligibility. This MDR file is tabulated to produce the monthly reports of counts of eligibles referenced in the contract.

Attachment 8
List of Data Package Contents

The exhibits, attachments, and documents listed below are an integral part of the contract. The contractor shall comply with the directions provided in these documents. Documentation incorporated into this contract by reference has the same force and effect as if set forth in full text.

<u>ITEM</u>	<u>DESCRIPTION</u>	<u>DATE</u>
Document 11	<u>Military Treatment Facility, Direct Care Data</u> Utilization data for inpatient and outpatient care. Contains both summary and detail files.	
	<u>DEERS Population Data</u> MHS enrollment and eligibility data. Contains both summary and detail files.	
	<u>TRICARE/CHAMPUS Purchased Care Data</u> Cost and workload data for inpatient and outpatient care. Contains both summary and detail files.	
	<u>T-NEX Reference Files</u> Contains PRIME non-catchment area , BRAC, and TPR zip codes, catchment area directories, contract regional file, CMAC pricing, DRG weights and rates, CHAMPVA eligibles, and TRICARE Service Center information.	

Attachment 8 cont.

List of Data Package Contents

QID	Agency	Location	Category	Quantity	Unit	Value	Notes	Agency	Category	Quantity	Unit	Value	Notes
0036	436th Med Gp	On MTF	F	817	6	6	Office Furniture	0730-1630					
0037	Waifer Reed AMIC - Washington DC	In MTF	A	3,744	4	4	FAX Machine, Copier,	0730-1630					
0066	S9 Mdg, Andrews AFB	On Base	F	1,980	18	18	Office Furniture, Also, T1	0730-1630					
0067	National Naval Medical Center	National Naval Medical Building 1307	N	475	4	4	Desks/Office space	0730-1600					
0094	EMCJ, Pax	Building 1307	N	1,075	5	5	Office Furniture	0730-1630					
0060	Kimberly Ambulance on Ft Belvoir	Ft. Meade, AFB, In-House	A	817	4	4	Office Furniture	0730-1600					
0081	Ft Monmouth	In MTF	A	600	6	6	Office Furniture	0730-1630					
0123	Devlet TSC	In MTF	A	370	4	3	Office furniture, phone	0730-1630					
0056	Penagon Health Clinic	In MTF	A	300	3	3	Office Furniture	0730-1630					
0096	AMC L, Annapolis	In MTF	N	600	3	3	Office Furniture	0730-1630					
0098	Kirk	On Base	A	500	4	4	Office Furniture	0730-1630					
0099	AMC Ft Detrick	In MTF	A	289	3	3	Office Furniture	0730-1630					
0030	Hanscom AFB - 66th Med Gp	On Base	F	1,300	8	8	Office Furniture	0730-1630					
0026	305 Mdg McGuire AFB	On	F	2,500	5	5	Office Furniture	0730-1630					
0030	Gandhi AMC - Ft. Drum	In MTF	A	3,000	10	10	Office Furniture	0730-1630					
0052	Dunham, Carlisle	MTF And Other Bldg	A	1,100	9	9	3 free standing desks, 7	0730-1630					
0013	11th Medical Gp	Rolling AFB	F	220	2	2	7 cubicles (with desks)	0730-1630					
0038	Ft Hamilton	In MTF	A	300	3	3	Approx 15 chairs	0730-1630					
0004	Fairfax TSC	Fairfax AMC, VA	A	580	4	3	3 book cases / storage	0730-1630					
0001	Woodbridge TSC	In Clinic	A	400	3	3 (Gov) plus	Racks	0730-1630					
0012	Wonnack SIG	In Robinson Clinic, On	A	100	3	1	Fax machine	0800-1630					
0026	Wonnack SIG	In Joel Clinic, On Base	A	100	3	1	Photocopy machine	0800-1630					
0029	Wonnack SIG	In Clark Clinic, On Base	A	100	3	1	Reception station	0800-1630					
0029	Wonnack AMC TSC	In MTF	A	3,500	(1) T-1	16	15 desks, 35 chairs, 1 table,	0700-1700					
0091	Sevynon Johnson AFB Mc	On Base, Next To MTF	F	1,000	(1) T-1	12	None	0730-1630					
0092	NHCL/SFO	NHCL	N	900	(1) T-1, (1)	6	None	0730-1630					
0030	NH Cherry Point	MTF	N	1,745	13	15	None	0730-1630					
0031	Langley	On Base	F	1,516	10	10	None	0700-1700					
0032	McDonnell ACFT - Ft Belvoir TSC	In MTF	A	4,000	(1) T-1	9	None	0730-1630					
0033	Kenner AMC	Ft Lee	A	1,444	1	None	None	0730-1630					
0024	Portsmouth TSC	On Base, In A Trailer Next	N	3,000	(1) T-1	12	Trailer only	0730-1700					
0039	ICAP Office	MTX Compound	N	65	1	1	1 modular desk with chair	1000-1600					
0045	6 Mdg, MacDill AFB	Off Base - Currently Building 9204, #104, 105,	F	4,320	16 voice, 4	23	NONE	0800-1700					
0018	Martin ACFT	Off Base - Currently Building 9204, #104, 105,	A	2,240	14	10 contractor	NONE	0800-1630					
0010	William ACFT	Ft Stewart, GA	A	1,949	25	16	7 CHCS Terminals and 3	0800-1630					
0051	Moody	On Campur	F	2,131	16	12	None	0830-1700					
0021	58th Med Gp Fedons	On Base	F	1,900	11, plus 6 toll	11 - MICS	wating room TV,	0800-1700					
0003	511 C base/region	In The MTF	F	1,512	8	15	None - CHCS terminals	0730-1630					
0003	511 C base/region	MTX CHAS	N	3,083	17	15 Contractor	7 CHCS computers	0730-1630					
							17 CHCS	0800-1700					

Attachment 8 cont
List of Data Package Contents

0104	NH Beaufort	1st Deck Building 1	3	N	1,500	1	8 CIGS	1 Dot Matrix Printer	0730-1700
0105	Monterey Army	Fort Jackson	3	A	1,942	10	10	1 shelving unit	0700-1700
0112	Tuttle AFB	Hunter Army Airfield	3	A	120	2	1	1 telephone	0800-1630
0125	BMFC Albany	Bldg 7209	3	N	800	10 contractor	5 contractor	None	0730-1630
0136	437th Afc-Chas AFB	CAF-B-BSR ONLY	3	N	100	1	1 govt owned	CRIS Term/phone/desk	0800-1515
0136	437 Afdg - Charleston	On Base	3	F	100	17	2 contractor	CRIS Term/phone/desk	0800-1700
0105	BMFC Mayport	Bldg 1363	3	N	100	2	2 contractor	2 modular desks; 2 chairs;	0730-1600
0117	BMFC Hwy West	Bldg E-48	3	N	800	5 contractor	4 contractor	4 modular desks; 6 chairs;	0730-1600
0001	Fox AFB	Redstone Arsenal	1	A	2,454	12	11	2 Desks, 3 chairs	0730-1630
0004	42d Med Gp - Maxwell AFB	Maxwell Clinic	4	F	1,200	Provided by	provided by	CIGS terminals/printers	0730-1630
0038	Pill Pensacola	1st floor, Mann Building	4	N	1,964	Contractor	Contractor	Desk x 17, Filing Cabinets	0730-1630
0043	325th Med Gp - Tyndall AFB	Tyndall AFB	4	F	4,000	15	2 CIGS	8 computer terminals, 2	0730-1630
0023	86 Med Gp - Keesler Med Ctr	Biloxi MS	4	F	* Off-post				0700-1700
0024	Columbus AFB	In NTTF	4	F	1,100	8	6	none	0730-1630
0107	BMC NSA Mid-South	Family Sup Service Bldg	4	N	2,800	Contractor	none	CIGS printer	0730-1630
0117	NRMC Meridian	Located in Branch Medical	4	N	805	Contractor	Contractor	Contractor Provides	0730-1630
0055	375 Afdg, Scott AFB	On Base	5	F	3000	3	22	None	0800-2000, NI-
0056	Great Lakes	On Base	5	N	3600	3	22	None	0800-2000 NI-
0060	Blanchfield ACH-Ft. Campbell TN	On Post	5	A	4800	3	28	None	0800-2000 NI-
0061	IACH, Ft. Knox	In Hospital	5	A	2500	3	25	None	0800-2000 NI-
0095	Wright Patterson Oh- 44th Med Gp	On Base	5	F	1839	3	14	None	0730-1930 NI-
0013	34th Medical Group	Inside NTTF	6	F	1,868	24	18	None	0730-1630
0062	Barksdale AFB La	In The NTTF	6	F	1,250	18	12	None	0730-1630
0064	Bayne-Jones ACH-Ft. Polk	In-House	6	A	1354.48	1 toll free,	8	1 LA75 Printer	0730-1630
0096	72nd Med Gp-Linkel	On Base	6	F	3,100	18	20	1 Printer Stand	0800-1630
0097	97 Afdg - Altus AFB	On Base	6	F	880	4	5	9 terminals	0800-1615
0098	Reynolds ACH	Altus AFB, OK	6	F	1,908	20 telephone,	20	CHCS terminal & printer	0730-1630
0100	Brooke ANC-Ft. Sam Houston	Fort Sill, OK, In-House	6	A	6328	48, plus 2	29	None	0730-1630
0110	Dannell ACH-Ft. Hood	In-House	6	A	6,850	22 and 1	2	32 Desks, 72 Chairs, 3	0730-1630
0112	Dyess AFB TX	On-Post	6	A	2,729	13	11	15 Chairs, 15 Workstations	0730-1630
0113	Sheppard AFB	On Base	6	F	1,762	9 plus 2 fax	9	3 workstations; 1 credenza;	0730-1630
0111	Laughlin AFB - 47th Med Gp	Del Rio, TX	6	F	777	5	5	1 printer	0730-1630
0117	Willford Hall Medical Center	Lackland AFB	6	F	2,440	84	32	None	0730-1700
0118	NHCC	NTTF	6	N	892	11	12	None	0730-1600
0138	71st Afdg	Vance AFB	6	F	508	5	4	None	0800-1630
0163	31st In Med Squad-Brooks	On Base	6	F	90	1	1	None	0745-1645
0164	Goodfellow AFB	Main Lobby	6	F	1,089	7	11	None	0800-1630
0166	Randolph AFB - TSC Hq	Randolph AFB	6	F	581	8	4	6 Workstations; 1 credenza	0730-1630
0166	Randolph AFB - Bsr	Randolph AFB	6	F	183	3	2	None	0730-1630

Attachment 8 cont.

List of Data Package Contents

Item ID	Location	Room/Building	Category	Quantity	Value	Notes	Item Description	Item Code
0369	BMC Kingsville	BLDG 3775	N	280	4	3	None	0800-1630
0018	Vandenberg AFB	On Base, In Clinic	F	1,621	6	7	stations (desks, chairs, file	0730-1700
0019	95th Med Grp-Edwards	On Base	F	1,030	5	5	None	0730-1730
0024	NHCP	On Base, 6-South	N	1,200	3	9	Work Center	0730-1730
0026	NACC Ph	On Base, Trailer	N	940	12	5	None	0730-1730
0029	NMCSD (TSC)	On Base, Bldg. 2-1	N	1,600	16	13	None	0730-1730
0030	NH 29 Palms	On Base, 1st Floor, 1st	N	450	9	4	4 desks, 1 cabinet, 2o	0730-1730
0131	Weed ACH	On Base	A	1,220	4	4	1 LaserJet Printer, 1 Digital	0730-1700
0212	BMC China Lake	On Base, 1st Floor, NE	N	450	2	2	2 desks, 3 cabinets	0800-1700
0232	MCAS Miramar (BSO)	On Base, Bldg. 2496	N	154	4	2	2 Modular Office Units	0730-1600
0233	NAB Coronado (BSO)	On Base, Bldg. 506	N	166	2	1	None	1230-1630 AI
0234	Navsta San Diego (BSO)	On Base, Bldg. 270	N	579	2	1	None	0800-1130 AI
0248	Los Angeles AFB	ON BASE	F	1,000	7	5	None	0700-1600
0269	BMC Yuma	On Base, Trailer	N	940	5	4	None	0730-1730
0014	60th Medical Group	Inside MTF	F	445	5 phone lines,	5	None	0700-1700
0015	Beale AFB CA	In The MTF	F	370	4	4	2 desks/counter	0700-1700
0028	NH Lemoore	1st Deck, Bldg 937, West	N	423	5	5	1 printer	0700-1700
0114	60 Mdg - Travis AFB CA	On	F	475	7	7	None	0700-1700
0125	MAMC	Fort Lewis, WA	A	1,720	15	13	None	0700-1700
0126	NHB	Bldg. HP-17, 3rd Deck	N	672	0	0	7 workstations, 4-5draw file	0700-1700
0127	Naval Hospital, Oak Harbor	Rooms 314 & 315 First	N	389	6	6	None	0700-1700
0128	92d Medical Group	On Base	F	992	11	8	1 CHCS Printer	0700-1700
0395	62 Mdg, McChord	On	F	544	3	3	Chair, Desk	0730-1630
7138	Everett BMC	Bldg. 2010	N	200	0	0	2 office wk. chairs, 1	0700-1700
0052	Tripler AMC	Tripler AMC	A	1,216	11	10	None	0700-1700
0280	NMCL Pearl Harbor	BMC Makalapa	N	196	1	1	All except terminal	0730-1600
0285	MCAS Kb	BMC K Bay	N	90	1	1	All except terminal	0730-1600
0437	Schofield Brks AHC	Schofield Brks AHC	A	80	1	1	3 Desks, 3 Chairs, 2	0730-1600
0616	NHRR	NHRR	N	840	7	7	7 Computers, 1 copier, 1	0730-1600
0005	Bassett Army Medical Center	Pt Wainwright	A	468	2	3	All furniture is government	0730-1630
0006	3 Mdg	Elmendorf AFB	F	846	Unknown/Co	8	All furniture is government	0730-1630
0203	354 Mdg	Eielson AFB	F	150	1	1	All furniture is government	0730-1630
0008	R W Bliss AHC-Ft. Huachuca	In-House	A	1993	11, plus 1 toll	12	1 Desk, 4 Chairs, 1 Cart, 1	0730-1630
0009	56 Med Grp - Luke AFB AZ	On Base	F	2,863	31	31	None	0730-1630
0010	Davis Monthan AFB AZ	In The MTF	F	1,620	24	24	1 CHCS Terminal, 1	0730-1700
0032	Evans ACH-Ft. Carson	In-House	A	950	8, plus 1 toll	8	15 Chairs, 1 Table, 1 file	0730-1615
0033	10th Medical Group	USAF ACADEMY	F	656	9	3	4 WORK STATIONS	0730-1615
0053	Mountain Home AFB ID	In The MTF	F	920	13	13	None	0730-1630
0057	Irwin ACH-Ft. Riley	In-House	A	1,994	29	20	(1) DOT MATRIX	0730-1630

Attachment 9

Intermediate Commands Requiring Read Only Access to Contractor's Data Warehouse

HQ ACC/SG
162 Dodd Blvd Ste 100
Langley AFB VA 23665-1995

HQ AETC/SG
63 Main Circle Ste 3
Randolph AFB TX 78150-4544

HQ AFMC/SG
4225 Logistics Avenue Rm N209
Wright-Patterson AFB OH 45433-5761

HQ AFRC/SG
155 Richard Ray Blvd
Robins AFB GA 31098-1635

HQ AFSOC/SG
100 Bartley St, Ste 210E
Hurlburt Fld FL 32544-5273

HQ AFSPC/SG
150 Vandenberg Street Ste 1105
Peterson AFB CO 80914-4550

HQ AMC/SG
203 Losey Street Room 1600
Scott AFB IL 62225-5219

HQ ANG/SG
3500 Fetchet Avenue
Andrews AFB MD 20762-5157

HQ AFRC/SG
155 Richard Ray Blvd
Robins AFB GA 31098-1635

HQ ARPC/SG
6760 E. Irvington Place, STE 7000
Denver CO 80280-7000

HQ PACAF/SG
25 E Street Ste D-1
Hickam AFB HI 96853-5418

HQ USAFE/SG
Unit 3050, Box 130
APO AE 09094-0103

Naval Healthcare Support Office, San Diego
4170 Norman Scott Road, Bldg 3232
San Diego, CA 92316

Naval Healthcare Support Office, Jacksonville
H2005 Knight Ln
Jacksonville, FL 32212-0140

Military Medical Support Office
320 B Street
Great Lakes, IL 60088-6999

North Atlantic RMC
Walter Reed Army Medical Center, Washington D.C.

South East RMC
Ft Gordon, GA

Great Plains RMC
Ft Sam Houston, TX

Western RMC
Ft Lewis, WA

Pacific RMC
Tripler Army Medical Center, HI

European RMC
Heidelberg, Germany

IIOF

THE INTERNATIONAL QUALITY FEDERATION

Serious
Reportable Events
in Healthcare

A
CONSENSUS
REPORT

THE NATIONAL QUALITY FORUM

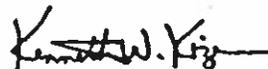
Foreword

Healthcare errors are a leading cause of morbidity and mortality in the United States. There is no national reporting of such occurrences, but a number of states require reporting of at least some types of healthcare errors and adverse events from at least some healthcare settings; however, there is no standard definition of what constitutes an error or adverse event. It is widely agreed that even where there is mandatory reporting of errors and adverse events, they are grossly underreported, due at least in part to ambiguity about what is to be reported.

As part of a comprehensive approach to improving patient safety, the Institute of Medicine (IOM) recommended that healthcare errors and adverse events be reported in a systematic manner. The federal government's Quality Interagency Coordination Task Force concurred with the IOM's recommendations for greater healthcare error and adverse event reporting, and the National Quality Forum was charged with identifying a core list of preventable, serious adverse events. This report has been prepared as part of fulfilling that charge.

Serious Reportable Events in Healthcare identifies 27 adverse events that are serious, largely preventable, and of concern to both the public and healthcare providers. The NQF encourages widespread adoption of this list of serious reportable events by states. If systematically utilized for reporting, analysis of the data will provide both caregivers and consumers with important information about the safety of healthcare and opportunities for improvement.

The report reflects the collective efforts of the NQF and its broad-based membership, the project's Steering Committee and its Ex Officio Special Advisory Panel of state officials, the Milbank Memorial Fund, the federal government, and many other interested stakeholders. We are grateful to all for their commitment to improving patient safety and healthcare quality.



Kenneth W. Kizer, MD, MPH
President and Chief Executive Officer

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THE NATIONAL QUALITY FORUM

Serious Reportable Events in Healthcare

Table of Contents

Executive Summary.....	v
Introduction.....	1
Purpose of the List	2
Criteria for Including Events on the List.....	3
Box A – Definitions of Terms Used in Criteria	3
List of Serious Reportable Events	4
Box B – Definitions of Key Terms	4
Implementation and Reporting Issues.....	5
Table 1 – List of Serious Reportable Events	6
Use of Reports Based on the List.....	10
Recommendations for Research.....	12
Process for Updating the List.....	13
Acknowledgments	13
Appendix A – Steering Committee, Liaison Members, Ex Officio Special Advisory Panel, Project Staff.....	A-1
Appendix B – Steering Committee Commentary	B-1
Appendix C – Glossary	C-1
Appendix D – Members and Board of Directors	D-1
Appendix E – Consensus Development Process: Summary	E-1
Index.....	F-1

THE NATIONAL QUALITY FORUM

Executive Summary

Lapses in patient safety are a major healthcare quality problem. Currently, few data exist that can provide reliable and consistent information on the number and type of the most serious preventable adverse events. Moreover, even when data are reported, such reporting varies widely by locale.

The objective of the National Quality Forum's (NQF) project on Serious Reportable Events in Healthcare is to establish agreement on a set of serious preventable adverse events that might form the basis for a national state-based event reporting system and that could lead to substantial improvements in patient care. The primary reason for identifying a standardized set of serious reportable events that would be reported on a mandatory basis would be to facilitate public accountability.

This report does not call for mandatory reporting. However, if a state has an existing system or establishes a reporting system, using the list of events recommended in this report would enable standardized data collection and reporting of such events within and across states. Whether and how states disclose these data to the public is a policy matter not discussed in this report.

The report identifies 27 serious adverse events that should be reported by all licensed healthcare facilities. The events are grouped into six categories: surgical, product or device, patient protection, care management, environmental, and criminal acts. Also identified in the report are standardized definitions of key terms. The NQF consensus list of serious reportable events is a starting point. Whether additional specification is needed for the events should be addressed as part of the pilot testing that the federal government intends to pursue.

THE NATIONAL QUALITY FORUM

Serious Reportable Events in Healthcare

Introduction

Lapses in patient safety are a major healthcare quality problem, and the occurrence of patient harm due to such lapses is remarkably common. A large majority of these lapses are preventable.

Recent studies suggest that most lapses in patient safety are the unintended consequences of a highly complex and imperfect healthcare delivery system in which individual minor mishaps occasionally combine to yield harmful, and sometimes disastrous, results.¹ Relatively few of these adverse events are related to professional misconduct or criminal acts.

Identifying where and when in the care process mishaps are most likely to occur and changing the processes of care to reduce the chance of harm requires reliable information about preventable adverse events. At present, few such data exist, since there is no standardized reporting system across states to provide reliable and consistent information on the number and type of the most serious preventable adverse events, including acts of misconduct.

The objective of the National Quality Forum's (NQF) project on Serious Reportable Events in Healthcare is to establish agreement on a set of serious preventable adverse events—sometimes called “never events”—that might form the basis for a national state-based event reporting system and that could lead to substantial improvements in the quality of patient care.² As described later in this document, a number of complementary activities to track adverse events and to identify and disseminate solutions for improving patient safety and

¹Kohn LT, Corrigan JM, Donaldson MD, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.

²This project was undertaken initially at the request of the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS). It was funded primarily by the Milbank Memorial Fund, with additional funds from AHRQ, CMS, and other entities as noted in the acknowledgments.

quality of care are needed. This report addresses one of these activities - the provision of standardized information on serious events for use by states in assuring accountability to the public. Appendix B presents additional background information, including more detail about the deliberations of the project's Steering Committee.

Purpose of the List

The primary reason for identifying a standardized set of serious reportable events that would be mandatorily reported is to facilitate public accountability for the occurrence of these adverse events in the delivery of healthcare. For this purpose, *public accountability* is considered to be the obligation or duty of specific individuals and/or institutions to make information about their actions or performance available to the public or a public agency (or its designee) that has responsibility for oversight and is answerable to the general public. Whether or how such data might be disclosed to the public after being reported to the responsible agency (e.g., in a de-identified manner or in aggregated regional reports naming individual healthcare providers, etc.) is a policy decision for the states, although at least some degree of public disclosure is recommended.

The public expects healthcare professionals and providers and their organizations to take all necessary and appropriate measures to ensure that care is safe, and the public looks to government and other oversight authorities to make sure that this is done. The occurrence of a serious and presumptively preventable injury, such as amputating the wrong leg or transfusing the wrong type of blood, suggests but does not prove that a flaw exists in the healthcare organization's efforts to safeguard patients. It is reasonable for the public to expect an oversight body to investigate serious adverse events, such as those identified in this report, as part of its responsibility for ensuring patient safety. Privacy protections for both individuals and organizations are also an important responsibility.

Accountability entails both an obligation of healthcare organizations to report on their performance and of state or

oversight bodies to enforce compliance with accepted standards. Both parties have a responsibility and an obligation to use the information to improve patient safety. The NQF list of serious reportable events is intended to facilitate fulfillment of this obligation. Reporting, monitoring, and acting upon the reports constitutes a basic level of oversight.

Criteria for Including Events on the List

The core set of events described in this report is not intended to capture all events that might possibly be useful to report. Rather, the items on this list are events that are:

- of concern to both the public and health-care professionals and providers;
- clearly identifiable and measurable, and thus feasible to include in a reporting system; and
- of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility.

To qualify for this core list of serious reportable events, an event must be:

Unambiguous, usually preventable, serious, and any of the following:

- a. Adverse and/or
- b. Indicative of a problem in a health-care facility's safety systems and/or
- c. Important for public credibility or public accountability.

The use of the term "usually preventable" recognizes that some of these events are not always avoidable, given the complexity of healthcare. The presence of an event on the list, therefore, is not an a priori judgment either of a systems failure or a lack of due care. Of note, the frequency with which an event occurs was considered but was not accepted as a criterion for inclusion of events on the list. Many serious events that are not frequent are cause for considerable concern when they occur.

An essential foundation for compiling this initial NQF list – and for updating the list in the future – is the definition of the terms that encompass the criteria. (See Box A.)

Box A – Definitions of Terms Used in Criteria

Event means a discrete, auditable, and clearly defined occurrence.

Adverse describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

Preventable describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.

Serious describes an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility or, when referring to other than an adverse event, an event the occurrence of which is not trivial.

Unambiguous refers to an event that is clearly defined and easily identified.

List of Serious Reportable Events

Table 1 presents 27 serious reportable events that should be reported and investigated by all healthcare facilities as they occur; it is emphasized that individual incidents should be reported, not frequencies of events. The events are organized in six categories – five that relate to the provision of care (surgical, product or device, patient protection, care management, and environmental) and one category that includes four criminal events. These latter events involve illegal acts, or acts of misconduct, and are included because they could be indicative of an environment that is unsafe for patients. Although a healthcare facility cannot eliminate all risk of these events – e.g., of assault – it can take various preventive measures to reduce that risk. (See Table 1 on pages 6 and 7.)

By intent, this list of serious reportable events is relatively short and only includes

clearly defined events. It was compiled with the understanding that a short and clearly defined list is more likely to be understood and widely utilized.

Finally, standardized terminology is essential if the NQF consensus list is to be implemented consistently by states and others. In compiling this list, three terms are used by the NQF as “terms of art.” (See Box B.) For the list to be used for comparative purposes within and across entities over time, changes to the definitions of these terms are likely to have a material effect on data collection and make comparative trend analyses impossible. Appendix C presents definitions for other terms, including terms that do not require as rigorous standardization as those found in Box B, but whose use is recommended. Besides terminology, additional detailed specifications may need to be developed during pilot tests for some of the events to ensure standardized data collection.

Box B – Definitions of Key Terms

Associated with means that it is reasonable to initially assume that the adverse event was due to the referenced course of care; further investigation and/or root cause analysis of the unplanned event may be needed to confirm or refute the presumed relationship.

Disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Healthcare facility means any licensed facility that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence, or other care of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare facilities include, but are not limited to, hospitals, nursing homes, rehabilitation centers, medical centers or offices, outpatient dialysis centers, reproductive health centers, independent clinical laboratories, hospices, and ambulatory surgical centers.

...the information on ...

Implementation and Reporting Issues

...the information on ...

Standardization

...the information on ...

...the information on ...

...the information on ...

Table 1 – List of Serious Reportable Events

EVENT	ADDITIONAL SPECIFICATIONS
1. SURGICAL EVENTS	
A. Surgery performed on the wrong body part	Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
B. Surgery performed on the wrong patient	Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
C. Wrong surgical procedure performed on a patient	Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
D. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.
E. Intraoperative or immediately post-operative death in an ASA Class I patient	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.
2. PRODUCT OR DEVICE EVENTS	
A. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.
B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.
C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility	Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.
3. PATIENT PROTECTION EVENTS	
A. Infant discharged to the wrong person	
B. Patient death or serious disability associated with patient elopement (disappearance) for more than four hours	Excludes events involving competent adults.
C. Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility	Defined as events that result from patient actions after admission to a healthcare facility. Excludes deaths resulting from self-inflicted injuries that were the reason for admission to the healthcare facility.

Table 1 – List of Serious Reportable Events (continued)

EVENT	ADDITIONAL SPECIFICATIONS
4. CARE MANAGEMENT EVENTS	
A. Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)	Excludes reasonable differences in clinical judgment on drug selection and dose.
B. Patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products	
C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare facility	Includes events that occur within 42 days post-delivery. Excludes deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy.
D. Patient death or serious disability associated with hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility	
E. Death or serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates	Hyperbilirubinemia is defined as bilirubin levels >30 mg/dl. Neonates refers to the first 28 days of life.
F. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility	Excludes progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.
G. Patient death or serious disability due to spinal manipulative therapy	
5. ENVIRONMENTAL EVENTS	
A. Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility	Excludes events involving planned treatments such as electric countershock.
B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances	
C. Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility	
D. Patient death associated with a fall while being cared for in a healthcare facility	
E. Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility	
6. CRIMINAL EVENTS	
A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider	
B. Abduction of a patient of any age	
C. Sexual assault on a patient within or on the grounds of a healthcare facility	
D. Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility	

expand the list. However, maintaining the integrity of the definitions and specifications in the NQF consensus list is essential if the list is to be used to obtain information that is comparable within and across states. That is, if a state wishes to expand an existing event, it should do so by specifying and collecting the additional information as a separate event. Ideally, new events would only be included after a broad-based review was conducted and consensus was reached, as in the process used to develop this list.

Specification

Additional specification of some events on the NQF list may be necessary to ensure its consistent implementation and standardized data collection. Without additional specification, the events may be interpreted and reported differently.* This issue should be addressed as part of the subsequent pilot testing and refinement process that should be undertaken by the federal government, in partnership with interested states, as follow-up to this report.

To further facilitate consistent reporting, it would be advantageous to link the events on the NQF consensus list with some type of national standardized system of codes. Two such commonly used classification systems are the International Classification of Diseases (ICD) and the Current Procedural Terminology (CPT). ICD codes serve as tools for classifying morbidity data for medical records indexing, medical care review, and compilation of health statistics; they are also used in many states to bill for hospital services. CPT codes are used to provide a uniform language that accurately describes medical, surgical, and diagnostic services, thereby serving as an effective means for reliable nationwide communication among physicians, patients, and third parties.

* For example, if a patient were injured from a device malfunction and needed to use crutches at the time of discharge, some states might interpret this to mean "serious disability," whereas other states might not. However, if the event were to be further specified such that serious disability includes all patients discharged on crutches, in a wheelchair, etc., then this would enable more consistent reporting. Without additional specification, the interpretation of what constitutes "serious disability" becomes a judgment call.

CPT codes are currently used in federal programs such as Medicare and Medicaid to code and describe healthcare services, primarily for billing purposes.⁴

If each event on the list could be linked to an ICD or CPT code, this would represent significant progress toward ensuring that events are consistently reported among states. It would also ease the burden of reporting for healthcare facilities. Currently, however, only about half of the events can be accurately reported using an existing ICD code and even fewer using an existing CPT code. Pilots should facilitate the use of new "test codes," derived from the ICD and/or CPT systems, that correlate with each event. Simultaneously, the process for reviewing and updating both sets of codes should be investigated.

Reporting

The events described in this list are intended to be reportable by all licensed healthcare facilities in states that adopt the NQF list as part of an adverse events reporting system. As noted, to achieve a national system that yields data comparable within and across states, reporting of the events must be implemented uniformly. Sophisticated information technology systems are not a prerequisite to implementing such reporting, although an interoperable, national healthcare information infrastructure would significantly ease the burden of reporting on facilities. A number of individual events on this list are elements of other public and private

reporting systems, such as the U.S. Food and Drug Administration's MedWatch system for adverse events related to drugs, devices, and biologics and the U.S. Pharmacopeia's MedMarx system and National Coordinating Council for Medication Error Reporting and Prevention for drug-related adverse events. Illegal acts are reportable to the criminal justice system, and some criminal events on this list are also reportable to state licensing bodies. However, there is no national consistency in such reporting. By entrusting the reporting of events on this list to a single state agency or state-designated entity, a comprehensive state-based reporting system can evolve that complements the states' public health surveillance role. An additional benefit of a comparable reporting system is that aggregate data may be large enough for statistical analyses of very low incidence events; this would facilitate the identification of ways to further reduce the occurrence of these adverse events.

Compliance with reporting serious adverse events will depend on how the state deals with concerns about discoverability, peer review protections, and legal liability. Experience with other reporting systems tells us that avoiding accusations of blame, along with providing appropriate legal and privacy protections, will encourage reporting. Additionally, a state-based reporting system should include feedback to the individual institutions and to those designing and implementing findings from root cause analyses and other quality

⁴American Medical Association. CPT process - how a code becomes a code. Available at www.ama-assn.org/ama/pub/category/3882.html.

improvement activities. Mere counting of events has no inherent value. Indeed, underlying any reporting system should be both the ability and the intent to improve the effectiveness, efficiency, and quality of healthcare services.

Reducing Burden

To reduce the reporting burden on healthcare professionals and healthcare facilities, states should institute policies that permit facilities to report an event only once to a single state entity. Other relevant state-based reporting systems (e.g., reporting to state healthcare licensing entities) should retrieve reports from the primary receiving entity, not through a duplicate report from the facility. If this is not done, states should, at minimum, enact policies that allow the same data in the same form to be filed with multiple agencies.

The federal government should similarly standardize and coordinate with states. Until a standardized reporting framework is pursued, including coordination with existing voluntary and mandatory systems, the burden on individual healthcare professionals and healthcare facilities to meet the requirements of divergent systems will be a source of frustration that wastes resources and diminishes the potential for public accountability and quality improvement.

Use of Reports Based on the List

While the intended use of the NQF's consensus list of serious reportable events is to facilitate public accountability, little will be accomplished if the response

is merely to record them or if the reports are used to punish healthcare organizations. The data should be used to actually improve patient safety.

Meaningful accountability requires that both healthcare organizations and oversight agencies use the reports to improve patient safety. There are two main methods by which this can be accomplished.

First, when an event occurs, it should be investigated to determine the underlying system problems and/or failures (e.g., via a root cause analysis). The identified problem should then be corrected to prevent recurrence of the event. Prevention strategies can include identifying points in the system of care where protocols should be changed, new or different technology implemented, training revised, and/or other processes changed. These activities are the responsibility of the healthcare organization.

Second, aggregate information about serious reportable events from multiple healthcare organizations can be used to improve safety if the lessons learned from their investigations of the underlying system problems and/or failures are disseminated to other healthcare organizations. Such outreach would allow others to take appropriate measures to prevent similar events in their own institutions. Dissemination of this important information is possible if the oversight agency or its designee collects information not only about the adverse events themselves, but also about the findings from the investigations (e.g., the root cause analyses) of the events. This report does not address reporting of the findings of the investigations or issues related to such reporting.

While public availability of report-related data is important, so too is public education about what the data does, or does not, mean. Because most of the events in the list are likely to be rare, fair comparisons across institutions based on the rate of these events may be impossible based on current risk adjustment and statistical methods. Even multiyear comparisons will most likely not permit fair comparisons. Hence, data derived from reports of events on this list should not be interpreted as meaning that an individual institution is of better or lesser quality, nor should it alone be used for selecting an institution.

Additionally, regional population-based rates are more likely to reflect valid data, particularly for tracking trends over time. States may wish to collaborate in data analysis efforts so that regional information can be disclosed to consumers and purchasers. Institution-based rates are unlikely to be useful initially, but research to examine the statistical validity of such rates could enhance the future usefulness of the information to consumers, purchasers, and providers.

Recommendations for Research

Considering items that were not included on the list led to the identification of areas for which additional research might have overcome the shortfalls that led to exclusion of the event. Moreover, while identification of a core list of serious adverse events is an important first step, it must be followed by the development of mechanisms or models to translate the list from concept to practice.

Specifically, the following research issues should be addressed:

- exploring effective mechanisms to collect data and communicate serious reportable events to the public;
- examining how data derived from using the NQF list can be disclosed in a way that meets the public's needs, yet is balanced with the need for providers to learn from mistakes.

- testing the operational value and utility of the events on the list, including research on the necessity to support such a list and the public's perceptions of the impact of the list;
- identifying ICD, CPT, or other codes that correlate with each serious reportable event on the list;
- investigating the process for reviewing and updating ICD and/or CPT codes; and
- defining comparable risk adjustment measures when individuals' risk to experience the event is dissimilar.

Finally, the pilot tests proposed by the federal government's Quality Interagency Coordination Task Force to evaluate implementation of the list should also examine the extent to which the data drive healthcare quality improvement.⁴

Process for Updating the List

This consensus list of serious reportable events should not be considered static. At the same time, implementation of the list and pilot tests should be permitted to proceed for a period of time without being complicated by the introduction of new definitions or events. Currently, it is difficult to project when the list should be updated. It is recommended that in about 18 months, the NQF should convene a committee, subject to funding, to consider how to update the list.

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⁴*Doing What Counts for Patient Safety: Federal Action to Reduce Medical Errors and Their Impact, Report of the Quality Interagency Coordination Task Force (QUIC) to the President.* Washington, DC: U.S. Government Printing Office, February 2000.

THE NATIONAL QUALITY FORUM

Appendix A

Steering Committee¹

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¹Steering Committee meetings were held on December 20, 2000; February 21, 2001; March 23, 2001 (conference call); April 17, 2001; and May 4, 2001 (conference call).

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Appendix B

Steering Committee Commentary

Introduction

This project, like all National Quality Forum (NQF) activities, has involved the active participation of representatives from across the spectrum of healthcare stakeholders. This appendix summarizes the rationale and evidence supporting the recommendations of the Steering Committee, which is the first step in the NQF Consensus Process (Appendix E).

As a first step, the Steering Committee discussed the purpose of a core list of serious reportable events and established criteria for including an event on the list. The Steering Committee then identified numerous candidate events, including on the list only those that met the criteria. The Steering Committee also discussed issues of implementation and reporting.

An Ex Officio Special Advisory Panel (Appendix A) comprising state health policymakers was convened to provide the Steering Committee with states' perspectives, in particular regarding issues relating to the adoption of the list by states.

In addition to the input provided by the Ex Officio Special Advisory Panel, the Steering Committee's deliberations were informed by:

- direct input from NQF members and nonmembers during meetings of the Steering Committee;
- information from the literature, including studies on state experiences with healthcare error reporting from the National Academy for State Health Policy¹;

¹Rosenthal J, Riley T, Booth M. *State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey*. Portland Me: National Academy of State Health Policy; April 2000.

- an informal survey of state requirements for reporting of illegal acts and acts of professional misconduct conducted by the National Association of Health Data Organizations² and supplemented with information NQF obtained directly from states; and
- substantial input solicited by the NQF from its member organizations, as well as from other organizations having expertise in the areas of specific candidate events.

Purpose of the List

As noted in the report, this project is intended to enable the development of a consistent and reliable state-based national healthcare error reporting system. Standardized reporting about these events would begin to address the dearth of information about healthcare errors and unintended adverse events. The Steering Committee is aware that U.S. Agency for Healthcare Research and Quality intends to use the list for state-based pilot test(s) and encourages the rapid deployment of such projects.

The Steering Committee noted that it is well established that the current lack of data stems from the fact that reporting a healthcare error is widely believed to invite blame and legal liability on the part of the caregiver or institution involved, without leading to any positive changes in the system of care that might prevent the

same error from occurring again.³ From the perspective of the provider, there is no perceived benefit to reporting even serious errors and significant reason to not do so. As a result, there exists neither data to support providers' efforts to improve the system of care, nor data to allow consumers, purchasers, or policymakers to assess the quality of care and motivate improvements.

The void in information about healthcare errors useful to providers and consumers does not result from a lack of attempts to collect such data. According to the National Academy of State Health Policy, 15 states require hospitals to report at least some kinds of adverse events related to healthcare, and 6 states have voluntary reporting systems.¹

Notable national reporting efforts also exist, and the Steering Committee discussed these during its deliberations. For example, the U.S. Food and Drug Administration (FDA) MedWatch program receives reports of adverse events related to the use of drugs, biologics, and devices that are voluntarily submitted by providers and the public through its MedWatch program, and the U.S. Centers for Disease Control and Prevention collects data on hospital-acquired infections, a very common unintended adverse event. In the private sector, the Joint Commission on Accreditation of Healthcare Organizations operates a "Sentinel Event" reporting program, ECRI maintains a database based on voluntary

¹Love D. Executive Director, National Association of Health Data Organizations, Salt Lake City, Utah. *Letter to the National Quality Forum*; January 24, 2001.

²Kohn LT, Corrigan JM, Donaldson MD, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 2000.

reporting of medical device-related errors and problems, and both the U.S. Pharmacopeia and Institute for Safe Medication Practices maintain a database of voluntarily reported medication errors, which are also shared with FDA. These efforts are clearly important and provide vital information to the organizations that sponsor them – e.g., FDA analyzes MedWatch data to determine whether a particular drug poses a previously unrecognized risk of side effects. Nevertheless, existing reporting systems suffer from three major problems:

- Severe underreporting. Most reporting systems are voluntary, and there are few incentives and significant disincentives at work. Often, an individual may not even know whether an error or event should be reported, or to whom. Even states with mandatory reporting systems have serious underreporting due, at least in part, to providers' belief that reporting will only bring investigation and punishment.
- Lack of comparability. No standardized nomenclature or breadth of required elements and/or events exists. Existing reporting efforts generally focus on only a few types of errors and events, and each focuses on different ones. Even where the general information sought is similar, the data are largely not comparable due to differences in definitions and data specifications.
- Lack of information sharing and feedback. States generally cannot find out what errors in their locales have been reported to national reporting systems, and consumers or purchasers cannot learn about adverse events in their communities. Even health professionals

and institutions reporting the data usually cannot learn what errors or events have occurred (let alone which are common) in their own peer group, which decreases the ability to monitor performance and make improvements.

In the context of the problems with current reporting systems, the Steering Committee considered the purpose of a state-based reporting system that would be based on a list of events endorsed by the NQF, since the purpose would affect the design of the list and the criteria by which candidate events for the list would be judged. Specifically:

- Should the primary purpose of the list be to support hospitals' internal quality improvement efforts? If so, the list might focus on common, high-frequency patient injuries and be designed around data collection that is intrinsic to the provision of care.
- Alternatively, should the primary purpose of the list be for public accountability to enable the public, or entities acting on their behalf, to monitor the incidence of errors or adverse events of particular interest or concern to the public? If so, the list might be designed to place more emphasis on serious events, such as patient deaths resulting from errors.

After considering the draft framework being discussed by the NQF's Strategic Framework Board and the links between measurement for internal improvement and measurement for accountability and selection of providers, the Steering Committee concluded that the primary purpose of the list of serious reportable

events should be public accountability but also, importantly, that the reports acquired using this list should be used to facilitate systematic quality improvement. Furthermore, the Steering Committee concluded that public accountability does not itself imply that the information gathered for this purpose can be usable for selection of providers. It does imply an obligation to use the data to motivate and support improvements through information sharing and feedback to healthcare providers.

The usefulness of the data for quality improvement also depends on adequate resources for monitoring and improvement interventions. Without prioritizing resources for this function, the value of the data will be diminished. Furthermore, the commitment to translate the data for public accountability must be approached with the consideration of building consumer trust in the healthcare system.

Criteria for Inclusion of Events on the List

Because the Steering Committee defined the primary purpose of the list as public accountability, it agreed that the seriousness of an event, particularly the level of harm actually resulting to the patient, was of primary importance. Hence, the Steering Committee spent considerable time debating an appropriate definition of "serious" and applied the criterion in such a way that events involving death or disability to the patient received especially great attention. However, the Steering Committee also felt that some events, when they occur, so

strongly indicate a high risk of potential harm that they should be reported even if the actual harm to a particular patient is not serious. Surgery performed on the wrong patient, for example, was deemed to meet this criterion, even if the surgery did not result in the death or disability of the patient.

Since reports, at a minimum in aggregated and de-identified form, likely would be available to state agencies and could be made available to the general public to demonstrate public accountability, the Steering Committee also concluded that events on the list must be unambiguous to reduce disincentives for reporting as well as the confusion about whether an event should be reported. The ability to clearly define, quantify, and audit events were all considered as separate criteria. The Steering Committee ultimately decided that all of these concepts were captured by the term "unambiguous," which was defined to encompass these concepts.

The distinction between "unintended" and "preventable" a criterion for events to include on the list was debated at length. "Unintended" was considered to be less associated with the implication that someone was to blame for an event and also was considered to have the advantage of capturing events that, upon analysis, suggest methods of prevention that would otherwise be unknown. On the other hand, there was concern that many unintended events are truly not preventable given current knowledge, and reporting such events to an external body, particularly if the data were eventually summarized for

- "Patient death from a hospital-acquired (nosocomial) infection" was excluded. The Steering Committee concluded that there was insufficient evidence on the preventability of many of these infections and further agreed that the issue of risk adjustment would complicate reporting of this event.
- "Failure to treat a patient according to accepted standards of practice" (e.g., not providing appropriate therapies to a patient with acute coronary syndrome; failing to treat sexually transmitted diseases; not monitoring blood sugar in a diabetic patient undergoing surgery; or failing to offer immunizations to a child or infant) was eliminated because acts of omission of these types did not have sufficient specification, although an event merely being an act of omission was not a criterion *per se* for exclusion.
- "Any act by a caregiver that reflects gross negligence, malfeasance, reprehensible ignorance, or criminal intent" was excluded because agreement was not reached on how to define the key terms and whether the criterion that it was unambiguous could be determined outside the legal context.
- "Any other patient death or serious injury/illness not anticipated in the normal course of events and believed to be due to the processes of care" was excluded from the list because the Steering Committee believed identifying such an event was too difficult to operationalize.

Note that the Steering Committee deliberated specifically about a written request that event 4C, "maternal death or serious disability associated with labor or delivery

in a low-risk pregnancy while being cared for in a healthcare facility" (with additional specifications; see Table 1), be deleted from the list. The Steering Committee felt that the event, as defined and in particular further specified, clearly met the criteria and was also quite important for public credibility – as recognized by the fact that most states currently require mandatory reporting of maternal deaths associated with labor and delivery.

Research

At several junctures during the Steering Committee's deliberations – e.g., as the purpose of the list was contemplated, as events were excluded, and as reporting systems were considered – the Steering Committee identified specific gaps in the current knowledge base that would benefit from research. In making these recommendations in the report, the Steering Committee emphasizes that the list is not all inclusive. Rather, the focus is on priority research areas that would advance or improve identifying and reporting serious adverse events and/or implementing the proposed list.

THE NATIONAL QUALITY FORUM

Appendix C Glossary

The following terms are defined as they apply to the NQF's list of serious reportable events.

Adverse describes a negative consequence of care that results in unintended injury or illness, which may or may not have been preventable.

ASA (American Society of Anesthesiologists) Class I patient refers to a normal, healthy patient, i.e., one who has no organic, physiologic, biochemical, or psychiatric disturbance. The pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Associated with means that it is reasonable to assume initially that the adverse event was due to the referenced course of care; the unplanned event may be subject to further investigation and/or root cause analysis in order to confirm or refute the presumed relationship.

Biologics refers to therapeutics and products, including blood and vaccines, derived from living sources (such as humans, animals, and microorganisms).

Device refers to an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including a component part or accessory, which is recognized in the official National Formulary, the U.S. Pharmacopeia, or any supplement to them; intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease; or intended to affect the structure or any function; and that does not achieve any of its primary intended purposes through chemical action and that is not dependent upon being metabolized for the achievement of any of its primary intended purposes. This includes items such as sutures, prepackaged procedure kits, laerdal defibrillators, pacemakers, contact lenses, etc.

Disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual.

Electrocution is death by electric shock.

Error is the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning).

Event means a discrete, auditable, and clearly defined occurrence.

Healthcare facility means any licensed facility that is organized, maintained, and operated for the diagnosis, prevention, treatment, rehabilitation, convalescence, or other care of human illness or injury, physical or mental, including care during and after pregnancy. Healthcare facilities include hospitals, nursing homes, rehabilitation centers, reproductive health centers, independent clinical laboratories, hospices, and ambulatory surgical centers.

Hypoglycemia is a physiologic state in which the blood sugar falls below 60 mg/dl and physiological and/or neurological dysfunction begins.

Intended use is the use of a device as described on the label and associated materials provided by the device's manufacturers.

Kernicterus refers to the medical condition in which elevated levels of bilirubin cause brain damage.

Low-risk pregnancy refers to a woman aged 18-39, with no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome.

Patient elopement refers to any situation in which an admitted patient (i.e., inpatient) leaves the healthcare facility without staff being aware that the patient has done so.

Preventable describes an event that could have been anticipated and prepared for, but that occurs because of an error or other system failure.

Public accountability is the obligation or duty of specific individuals and/or institutions to make information about their actions or performance available to the public or a public organization or agency (or its designee) that has responsibility for oversight and is answerable to the general public.

Serious describes an event that results in death or loss of a body part or disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient healthcare facility or, when referring to other than an adverse event, an event whose occurrence is grave.

Spinal manipulative therapy encompasses all types of manual techniques, including spinal mobilization (movement of a joint within its physiologic range of motion) and manipulation (movement beyond its physiologic range of motion), regardless of their precise anatomic and physiologic focus or their discipline of origin.

Toxic substance refers to chemicals that are present in sufficient concentration to pose a hazard to human health.

Unambiguous refers to an event that is clearly defined and easily identified.

THE NATIONAL QUALITY FORUM

Appendix D

Members*

Consumer Council

AARP
 AFL-CIO
 California Health Decisions
 Consumer Coalition for Quality Health Care
 March of Dimes
 National Partnership for Women and Families

Provider and Health Plan Council

Academic Oncology Resources, LLC
 Alliance of Independent Academic Medical Centers
 American Academy of Family Physicians
 American Academy of Ophthalmology
 American Academy of Physician Assistants
 American Association of Health Plans
 American Association of Nurse Anesthetists
 American College of Cardiology
 American College of Medical Quality
 American College of Obstetricians and Gynecologists
 American College of Physicians-American Society of Internal Medicine
 American College of Radiology
 American Hospital Association
 American Medical Association
 American Nurses Association
 American Optometric Association

American Osteopathic Association
 American Society for Therapeutic Radiology and Oncology
 American Society of Health-System Pharmacists
 College of American Pathologists
 Council of Medical Specialty Societies
 Empire Blue Cross and Blue Shield
 Federation of American Hospitals
 Geisinger Health Plan
 Greater New York Hospital Association
 Healthcare Leadership Council
 HealthSource/Hudson Health Plan
 Henry Ford Health System
 Hoag Hospital
 Kaiser Permanente
 National Association of Chain Drug Stores
 National Association of Children's Hospitals and Related Institutions
 National Association of Public Hospitals and Health Systems
 Premier, Inc.
 South Nassau Communities Hospital
 State University of New York, College of Optometry
 UnitedHealth Group
 University Affiliates, IPA
 US Department of Defense (Health Affairs)
 US Department of Labor
 US Veterans Health Administration
 VHA, Inc.
 Yale New Haven Health

*As of July 2001, when the NQF Consensus Development Process for this report was initiated.

Purchaser Council
 Buyers Health Care Action Group
 Central Florida Health Care Coalition
 Deloitte & Touche, LLP
 Employer Health Care Alliance Cooperative
 (The Alliance)
 Ford Motor Co.
 General Motors Corp.
 The Leapfrog Group
 Maine Health Management Coalition
 Midwest Business Group on Health
 National Association of State Medicaid Directors
 National Business Coalition on Health
 New York State Health Accountability Foundation
 Pacific Business Group on Health
 Schaller Anderson, Inc.
 US Centers for Medicare and Medicaid Services
 US Office of Personnel Management
 Washington Business Group on Health

Research and Quality Improvement Council
 AAAHC - Institute for Quality Improvement
 Alliance of Community Health Plans
 American Board for Certification in Orthotics
 and Prosthetics
 American Board of Internal Medicine
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 ACC/AHA Taskforce on Performance Measures
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 Health System
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 HealthHelp, Inc.
 Health Sector Management Program -
 Duke University
 Illinois Department of Public Health
 Institute for Clinical Evaluation
 Institute for Safe Medication Practices
 IPRO
 Jefferson Health System, Office of Health Policy
 and Clinical Outcomes
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 Organizations
 Keystone Peer Review Organization
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 MidAtlantic Renal Coalition
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 National Center for Clinical Outcomes Research
 National Committee for Quality Assurance
 National Committee for Quality Health Care
 National Patient Safety Foundation
 National Pharmaceutical Council
 Physician Consortium for Performance Improvement
 Press, Ganey Associates
 Rhode Island and Providence Plantations,
 Department of Health
 Texas Medical Foundation
 United Hospital Fund
 University of North Carolina - Program on
 Health Outcomes
 US Agency for Healthcare Research and Quality
 US Centers for Disease Control and Prevention
 US Health Resources and Services Administration
 US National Institutes of Health
 US Pharmacopeia
 Virginia Hospital Research and Education
 Foundation

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THE NATIONAL QUALITY FORUM

Appendix E

Consensus Development Process: Summary

The National Quality Forum (NQF) is a voluntary consensus standards organization. The NQF brings together diverse healthcare stakeholders to develop consensus on core measures of healthcare quality. The primary participants in the NQF consensus process are NQF member organizations. These include:

- consumer and patient groups;
- health care purchasers;
- health care providers and health plans; and
- research and quality improvement organizations.

Any organization interested in healthcare quality measurement and improvement can apply to be a member of the NQF. Membership information is available on the NQF website.

Members of the public with particular expertise in a given topic may also be invited to participate in the early identification of draft standards as technical advisors or Steering Committee members. In addition, the NQF consensus process explicitly recognizes a role for the general public to comment on draft standards and to appeal quality measurement standards adopted by the NQF. Information on NQF projects, including information on NQF meetings open to the public, is posted on the NQF website (www.qualityforum.org).

Each project the NQF undertakes is guided by a Steering Committee (or Review Committee) composed of individuals from each of the four critical stakeholder perspectives. With the assistance of NQF staff and technical advisory panels and the ongoing input of other NQF members, a Steering Committee conducts an overall assessment

of the state of the field in the particular topic area and recommends a set of draft measures, indicators, or practices for review, along with the rationale for selecting them. The recommended measure set is distributed for review and comment, first to NQF members and then to the general public.

Following the comment period, a revised product is distributed to NQF Members for voting. The vote need not be unanimous within or across all Member Councils for consensus to be achieved. If a majority of members within each Council do not vote approval, staff attempt to reconcile differences among members to maximize agreement a second round of voting is conducted. Proposed products that have undergone this process and have

been approved by at least two Member Councils after the second round of voting are forwarded to the NQF Board of Directors for consideration. All products must be approved by a vote of the NQF Board.

Affected parties may appeal standards approved by the NQF Board of Directors. Once a measure set has been approved, the federal government may utilize the information for standardization purposes in accordance with the provisions of the National Technology Transfer Advancement Act of 1995 (P.L. 104-113) and the Office of Management and Budget Circular A-119.

Standards are updated as warranted.

For this report, the NQF Consensus Process, version 1.3 was in effect. The complete process can be found at www.qualityforum.org.

THE NATIONAL QUALITY FORUM

Index

- Accountability (public)
 - definition of, 2
 - importance of, 2-3
 - use of reports for, 10-11
- Adverse, definition of, 3
- Agency for Healthcare Research and Quality, 13
- Ambulatory surgical centers, applicability of list for, 4
- Burden, reducing, 10
- California HealthCare Foundation, 13
- Care management events
 - hemolytic reactions, 7
 - hypoglycemia, 7
 - kernicterus, 7
 - maternal death in childbirth, 7
 - medication errors, 7
 - pressure ulcers, 7
 - spinal manipulative therapy, 7
- Centers for Medicare and Medicaid Services, 13
- Clinical laboratories, applicability of list for, 4
- Codes. *See* Specification
- Consensus Process (NQF), E1-2
- Consumers, use of list by, 11-12
- Criminal events
 - battery, 7
 - impersonation of caregiver, 7
 - patient abduction, 7
 - sexual assault, 7
- Criteria
 - for including events on the list, 3
 - key terms used for, 3
- Current Procedural Terminology (CPT), 8-9, 13
- Definitions
 - of additional terms, 4, C-1-2
 - of adverse, 3
 - of associated with, 4
 - of disability, 4
 - of event, 3
 - of healthcare facility, 4
 - of key terms, 4
 - of preventable, 3
 - of public accountability, 2
 - of serious, 3
 - of terms requiring standardization for implementation, 3
 - of unambiguous, 3
 - terms used in criteria, 3
 - see also* Terminology
- Dialysis centers, applicability of list for, 4
- Disability, definition of, 4
- Disclosure, 2-3
- Environmental events
 - burns, 7
 - contamination of gases or gas lines, 7
 - electric shock, 7
 - falls, 7
 - restraints or bed rails, 7
- Error, definition of, C-2
- Events
 - care management, 7
 - criminal, 7
 - definition of, 3
 - environmental, 7
 - frequency of as criterion, 3
 - patient protection, 6
 - product or device, 6
 - specification for, 6-7, 8-9
 - surgical, 6

- Federal government
 - pilot tests funded by, 13
 - role in standardization and coordination, 10
- Healthcare facility, definition of, 4
- Horace W. Goldsmith Foundation, 13
- Hospices, applicability of list for, 4
- Hospitals, applicability of list for, 4
- Implementation and reporting, issues in, 5, 8-10
- Institute of Medicine, 5
- International Classification of Diseases (ICD), 8-9, 13
- Laboratories, clinical, applicability of list for, 4
- List.
 - care management events on, 7
 - criminal events on, 7
 - criteria used for, 3
 - environmental events on, 7
 - facilities encompassed by, 4
 - implementation of, 5, 8-10
 - organization of, 4
 - patient protection events on, 6
 - process for updating, 13
 - product or device events on, 6
 - purpose of, 1, 2-3
 - reporting events from, 9-10
 - specifications for, 6-9
 - standardized terminology and implementation of, 5, 8
 - surgical events on, 6
 - use of reports based on, 10-11
- Milbank Memorial Fund, 13
- National Coordinating Council for Medication Error Reporting and Prevention, 9
- National Quality Forum
 - consensus process of, E1-2
 - list of serious reportable events endorsed by, 6-7
 - purpose of project, 1
- Nursing homes, applicability of list for, 4
- Patient protection events
 - infant discharge, 6
 - patient elopement, 6
 - patient suicide, 6
- Pilot tests, importance of, 13
- Preventable, definition of, 3
- Product or device events
 - contaminated drugs, devices or biologics, 6
 - relating to intravascular air embolism, 6
 - use other than intended, 6
- Purchasers, use of list by, 11-12
- Quality Improvement Organizations, use of list by, 11
- Quality Interagency Coordination Task Force (U.S.), 13
- Reports
 - lack of standardized system, 5, 8
 - of individual incidents not frequencies, 4
 - reducing burden of, 10
 - research to improve, 12-13
 - use of, 10-12
- Reproductive health centers, applicability of list for, 4
- Research, recommendations for, 12-13
- Robert Wood Johnson Foundation, 13
- Serious, definition of, 3
- Serious reportable events
 - list of, 6-7
 - origin of NQF project on, 1-2
- Specifications
 - event by event, 6-7
 - possible need for additional, 8-9
- Standardization
 - importance to data collection and reporting, 5, 8
 - of definitions, 4
 - of reporting, 5, 8
- State governments, role of in event reporting systems, 1, 5, 8, 9-10
- Steering Committee, report of, B1-6
- Surgical events
 - intraoperative death in a class ASA 1 patient, 6
 - performed on wrong body part, 6
 - performed on wrong patient, 6
 - retention of foreign object, 6
 - wrong procedure performed, 6
- Terminology
 - importance of standardized, 4-5, 8
 - see also* Definitions
- Unambiguous, definition of, 3
- United Hospital Fund of New York, 13
- U.S. Food and Drug Administration, MedWatch system of, 9
- U.S. Pharmacopeia, MedMarx system of, 9

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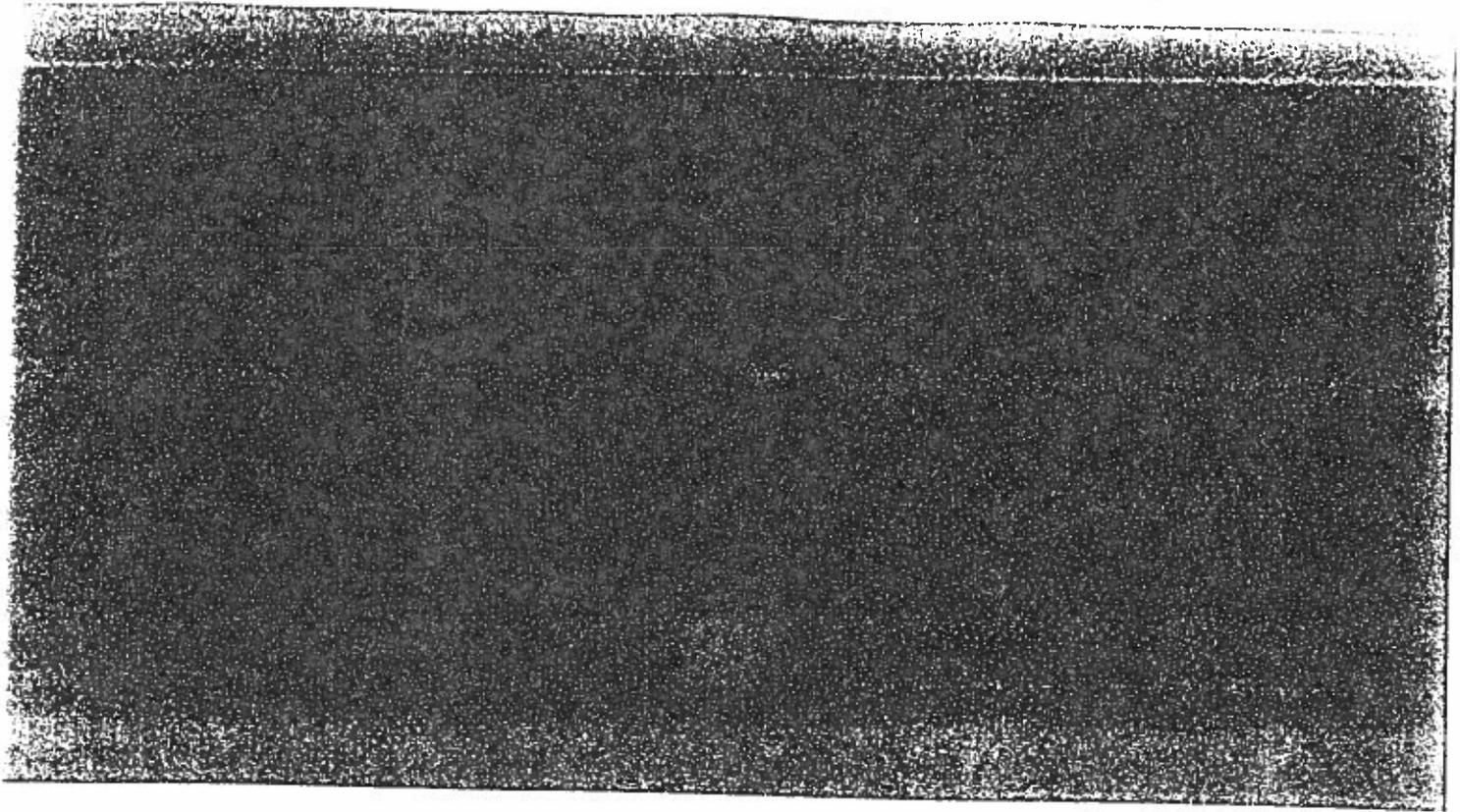
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THE NATIONAL QUALITY FORUM (NQF) is a private, nonprofit, open membership, public benefit corporation whose mission is to improve the American healthcare system so that it can be counted on to provide safe, timely, compassionate, and accountable care using the best current knowledge. Established in 1999, the NQF is a unique public-private partnership having broad participation from all parts of the healthcare industry. As a voluntary consensus standards setting organization, the NQF seeks to develop a common vision for healthcare quality improvement, create a foundation for standardized healthcare performance data collection and reporting, and identify a national strategy for healthcare quality improvement. The NQF provides an equitable mechanism for addressing the disparate priorities of healthcare's many stakeholders.



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 0006 HOSP 3rd MED GRP-ELMENDORF
 0008 CLINIC R W BLISS AHC-FT. HUACHUCA
 0009 HOSP 56th MED GRP-LUKE
 0010 CLINIC 355th MED GRP-DAVIS MONTHAN
 0013 CLINIC 314th MED GRP-LITTLE ROCK
 0014 HOSP 60th MED GRP-TRAVIS
 0015 CLINIC 9th MED GRP-BEALE
 0018 CLINIC 30th MED GRP-VANDENBERG
 0019 CLINIC 95th MED GRP-EDWARDS
 0024 HOSP NH CAMP PENDLETON
 0026 CLINIC NACC PORT HUENEME
 0028 HOSP NH LEMOORE
 0029 HOSP NMC SAN DIEGO
 0030 HOSP NH TWENTYNINE PALMS
 0032 HOSP EVANS ACH-FT. CARSON
 0033 HOSP 10th MED GROUP-USAF ACADEMY CO
 0034 CLINIC USCG CLINIC NEW LONDON
 0035 CLINIC NACC GROTON
 0036 CLINIC 436th MED GRP-DOVER
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 0039 HOSP NH JACKSONVILLE
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 0055 HOSP 375th MED GRP-SCOTT
 0056 HOSP NH GREAT LAKES
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 0058 CLINIC MUNSON AHC-FT. LEAVENWORTH

MAXWELL AFB
 FT. WAINWRIGHT
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Attachment 11

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0060	HOSP	BLANCHFIELD ACH-FT. CAMPBELL	FT. CAMPBELL
0061	HOSP	IRELAND ACH-FT. KNOX	FT. KNOX
0062	CLINIC	2nd MED GRP-BARKSDALE	BARKSDALE AFB
0064	HOSP	BAYNE-JONES ACH-FT. POLK	FT. POLK
0066	HOSP	89th MED GRP-ANDREWS	ANDREWS AFB
0067	HOSP	NNMC BETHESDA	BETHESDA
0068	CLINIC	NMCL PATUXENT RIVER	PATUXENT RIVER
0069	CLINIC	KIMBROUGH AMB CAR CEN-FT MEADE	FT. MEADE
0073	HOSP	81st MED GRP-KEESLER	KEESLER AFB
0074	CLINIC	14th MED GRP-COLUMBUS	COLUMBUS AFB
0075	HOSP	L. WOOD ACH-FT. LEONARD WOOD	FT. LEONARD WOOD
0076	CLINIC	509th MED GRP-WHITEMAN	WHITEMAN AFB
0077	CLINIC	341st MED GRP-MALMSTROM	MALMSTROM AFB
0078	HOSP	55th MED GRP-OFFUTT	OFFUTT AFB
0079	HOSP	99th MED GRP-O'CALLAGHAN HOSP	NELLIS AFB
0081	CLINIC	PATTERSON AHC-FT. MONMOUTH	FT. MONMOUTH
0083	CLINIC	377th MED GRP-KIRTLAND	KIRTLAND AFB
0084	CLINIC	49th MED GRP-HOLLOMAN	HOLLOMAN AFB
0085	CLINIC	27th MED GRP-CANNON	CANNON AFB
0086	HOSP	KELLER ACH-WEST POINT	WEST POINT
0089	HOSP	WOMACK AMC-FT. BRAGG	FT. BRAGG
0090	CLINIC	4th MED GRP-SEYMOUR JOHNSON	SEYMOUR JOHNSON AFB
0091	HOSP	NH CAMP LEJEUNE	CAMP LEJEUNE
0092	HOSP	NH CHERRY POINT	CHERRY POINT
0093	CLINIC	319th MED GRP-GRAND FORKS	GRAND FORKS AFB
0094	CLINIC	5th MED GRP-MINOT	MINOT AFB
0095	HOSP	74th MED GRP-WRIGHT-PATTERSON	WRIGHT-PATTERSON AFB
0096	CLINIC	72nd MED GRP-TINKER	TINKER AFB
0097	CLINIC	97th MED GRP-ALTUS	ALTUS AFB
0098	HOSP	REYNOLDS ACH-FT. SILL	FT. SILL
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0117	HOSP	59th MED WING-LACKLAND	LACKLAND AFB
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0119	CLINIC	75th MED GRP-HILL	HILL AFB
0120	HOSP	1st MED GRP-LANGLEY	LANGLEY AFB
0121	HOSP	MCDONALD ACH-FT. EUSTIS	FT. EUSTIS
0122	CLINIC	KENNER AHC-FT. LEE	FT. LEE
0123	HOSP	DEWITT ACH-FT. BELVOIR	FT. BELVOIR
0124	HOSP	NMC PORTSMOUTH	PORTSMOUTH
0125	HOSP	MADIGAN AMC-FT. LEWIS	FT. LEWIS
0126	HOSP	NH BREMERTON	BREMERTON
0127	HOSP	NH OAK HARBOR	OAK HARBOR
0128	CLINIC	92nd MED GRP-FAIRCHILD	FAIRCHILD AFB
0129	CLINIC	90th MED GRP-F.E. WARREN	F.E. WARREN AFB
0130	CLINIC	USCG CLINIC KODIAK	KODIAK
0131	HOSP	WEED ACH-FT. IRWIN	FT. IRWIN
0203	CLINIC	354th MED GRP-EIELSON	EIELSON AFB
0212	CLINIC	BMC NAVWPNCN CHINA LAKE	CHINA LAKE
0232	CLINIC	BMC MCAS MIRAMAR	SAN DIEGO
0233	CLINIC	BMC CORONADO	CORONADO
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0366	CLINIC	12th MED GRP-RANDOLPH	RANDOLPH AFB - TSC/Hcf
0369	CLINIC	BMC KINGSVILLE	KINGSVILLE
0370	CLINIC	BMC FORT WORTH	DALLAS
0385	CLINIC	NMCL QUANTICO	QUANTICO
0390	CLINIC	ANDREW RADER AHC-FT. MYER	FT. MYER
0395	CLINIC	62nd MED GRP-MCCHORD	MCCHORD AFB
0405	CLINIC	BMC MAYPORT	MAYPORT
0413	CLINIC	11TH MED GRP-BOLLING	BOLLING AFB
0416	CLINIC	MOBILE USCG CLINIC	MOBILE
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0423	CLINIC	NEW ORLEANS USCG CLINIC	NEW ORLEANS
0424	CLINIC	USCG CLINIC BALTIMORE	BALTIMORE
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0426	CLINIC	BOSTON USCG CLINIC	BOSTON
0427	CLINIC	TRAVERSE CITY USCG CLINIC	TRAVERSE CITY
0428	CLINIC	CAPE MAY USCG CLINIC	CAPE MAY
0430	CLINIC	ELIZABETH CITY USCG CLINIC	ELIZABETH CITY
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0437	CLINIC	SCHOFIELD BARRACKS AHC	SCHOFIELD BARRACKS
0438	CLINIC	HAMILTON AINESWORTH AHC	FT. HAMILTON
0517	CLINIC	BMC KEY WEST	KEY WEST
0656	CLINIC	BMC INGLESIDE	INGLESIDE
5196	CLINIC	USCG CLINIC ACTIVITIES NEW YORK	ACTIVITIES NEW YORK
6200	CLINIC	FAMILY HEALTH CENTER FAIRFAX	FAIRFAX
6201	CLINIC	FAMILY HEALTH CENTER WOODBRIDG	WOODBRIDGE
7043	CLINIC	USCG CLINIC HONOLULU	HONOLULU
7044	CLINIC	USCG CLINIC JUNEAU	JUNEAU
7045	CLINIC	USCG CLINIC NORTH BEND	NORTH BEND
7046	CLINIC	USCG CLINIC SAN PEDRO	SAN PEDRO
7047	CLINIC	USCG CLINIC SITKA	SITKA
7048	CLINIC	USCG CLINIC BASE MIAMI	MIAMI BEACH
7082	CLINIC	GROUP GALVESTON CG CLINIC	GALVESTON
7083	CLINIC	GROUP HUMBOLDT BAY CG CLINIC	HUMBOLDT BAY
7138	CLINIC	NMCL EVERETT	EVERETT
7143	CLINIC	AHC ROBINSON-FT. BRAGG	FT. BRAGG
7200	CLINIC	460 MDS-BUCKLEY AFB	BUCKLEY AFB
7286	CLINIC	JOEL AHC	FT. BRAGG-NC
7294	CLINIC	CLARK HEALTH CLINIC-FT BRAGG	FORT BRAGG

Attachment 12

SMALL BUSINESS, VETERAN-OWNED SMALL BUSINESS, SERVICE-DISABLED VETERAN-OWNED SMALL BUSINESS, SMALL DISADVANTAGED BUSINESS, HUBZONE SMALL BUSINESS, AND WOMEN-OWNED SMALL BUSINESS SUBCONTRACTING PLAN

The following is hereby submitted as a Subcontracting Plan for Humana Military Healthcare Services, Inc. pursuant to: Federal Acquisition Regulation, Part 19.704, Subcontracting Plan Requirements; and clauses 52.219-8, Utilization of Small Business Concerns; 52.219-9, Small Business Subcontracting Plan; and 52.219-16, Liquidated Damages – Subcontracting Plan.

1. HMHS' goals for the Subcontracting Plan are detailed below covering the period from Phase-in through Option Year 5:

- a. Total estimated amount of subcontracts/purchases to be \$ [] awarded.
- b. HMHS has established, in this Subcontracting Plan, the following goals for awards to small business, veteran-owned small business, service-disabled veteran-owned small business, small disadvantaged business, HUBZone small business, and women-owned small business:

	<u>Percentage Goals</u>	<u>Dollars</u>
Small Business (SB)*	┌	
Veteran-Owned (VOSB)		
Service-Disabled Vet-Owned (SDVOB)		
Small Disadvantaged (SDB)		
HUBZone (HUBZ)		
Women-Owned (WOSB)		

* The percentage goals and dollar goals indicated above for Small Business include the other listed categories as a subset.

Large Business []
Total (Small Business + Large Business)

Subcontracting Plan - South Region									
Product/ Service Areas	Phase In								
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB	Total SB	Total LB	Total Sub-Contracting Dollars
Outside Sources									
Repairs and Maintenance									
Supplies									
Miscellaneous Expenses									
Marketing and Fulfillment									
Printing/Specialty Items									
Total Dollars									
Percentage of Total									

Subcontracting Plan - South Region										
Product/ Service Areas	Option Year 1									
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB	Total SB	Total LB	Total Sub-Contracting Dollars	
Outside Sources										
Repairs and Maintenance										
Supplies										
Miscellaneous Expenses										
Marketing and Fulfillment										
Printing/Specialty Items										
Total Dollars										
Percentage of Total										

Subcontracting Plan - South Region										
Product/ Service Areas	Option Year 2									
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB.	Total SB	Total LB	Total Sub-Contracting Dollars	
Outside Sources										
Repairs and Maintenance										
Supplies										
Miscellaneous Expenses										
Marketing and Fulfillment										
Printing/Specialty Items										
Total Dollars										
Percentage of Total										

Subcontracting Plan - South Region										
Product/ Service Areas	VOSB	SDVOSB	SDB	Option Year 3				Total SB	Total LB	Total Sub-Contracting Dollars
				HUBZ	WOSB	OTHER SB				
Outside Sources										
Repairs and Maintenance										
Supplies										
Miscellaneous Expenses										
Marketing and Fulfillment										
Printing/Specialty Items										
Total Dollars										
Percentage of Total										

Subcontracting Plan - South Region									
Product/ Service Areas	Option Year 4								
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB	Total SB	Total LB	Total Sub-Contracting Dollars
Outside Sources									
Repairs and Maintenance									
Supplies									
Miscellaneous Expenses									
Marketing and Fulfillment									
Printing/Specialty Items									
Total Dollars									
Percentage of Total									

Subcontracting Plan - South Region									
Product/ Service Areas	Option Year 5								
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB	Total SB	Total LB	Total Sub-Contracting Dollars
Outside Sources									
Repairs and Maintenance									
Supplies									
Miscellaneous Expenses									
Marketing and Fulfillment									
Printing/Specialty Items									
Total Dollars									
Percentage of Total									

Subcontracting Plan - South Region									
Product/ Service Areas	Total								
	VOSB	SDVOSB	SDB	HUBZ	WOSB	OTHER SB	Total SB	Total LB	Total Sub-Contracting Dollars
Outside Sources									
Repairs and Maintenance									
Supplies									
Miscellaneous Expenses									
Marketing and Fulfillment									
Printing/Specialty Items									
Total Dollars									
Percentage of Total									

2. The following method was used in developing subcontract goals:

HMHS identified all of the principle products and/or service areas deemed essential to the performance of its contract. From these, all product and/or service areas that are amenable for overall subcontracting/purchasing purposes were identified.

Business firms which have the qualifications and capabilities needed by HMHS to assure the effective performance of our contract will be utilized for subcontracting/purchasing opportunities.

This plan excludes expenditures with HMHS' large business subcontractors performing Health Care Delivery, Mental Health Care, and Claims Processing. These companies are large businesses who have been required by HMHS to develop Subcontracting Plans of their own for submittal to HMHS. HMHS will monitor the subcontracting plan activities of the subcontractors to insure that their plans and actions are reasonable and that they accomplish all required reporting.

This plan also excludes expenditures which offer little or no possibility of performance by a Small Business or are expenditures with governmental or quasi-government organizations. Examples include: Water services, Gas & Electric services, Telephone services, etc.

3. Potential suppliers will be identified by one or more of the following means:

- a. Known/recognized industry source
- b. Prior satisfactory performance
- c. Contractor source lists
- d. The SBA Procurement Automated Source System (PASS)
- e. Small/Minority/Veterans/Women-Owned Business Directories
- f. Commercial purchasing catalogues

4. Indirect and overhead costs have not been included in the goals specified above.

5. The below named individual will administer the Contractor's subcontracting program:

Name: George K. Mitchell

Title: Director, Contract Compliance

Company: Humana Military Healthcare Services, Inc.

Address: 500 West Main Street

City, State, ZIP: Louisville, KY 40202

Telephone No.: (502) 580-1934

This individual's duties, as they relate to the HMHS subcontracting program, are as follows:

- a. Encourages buyers and technical personnel to solicit SB/VOSB/SDVOSB/SDB/HZSB/WOSB sources.
- b. Establishes and maintains source lists of SB/VOSB/SDVOSB/SDB/HZSB/WOSB concerns.
- c. Assists in conducting vendor surveys to determine SB/VOSB/SDVOSB/SDB/HZSB/WOSB supplier capabilities.
- d. Provides guidance to program and technical personnel regarding timely development of SB/VOSB/SDVOSB/SDB/HZSB/WOSB competitive sources.
- e. Provides guidance and assistance to SB/VOSB/SDVOSB/SDB/HZSB/WOSB concerns to ensure that they have an equitable opportunity to compete for subcontracts.
- f. Continuously searches for qualified sources to be added to the SB/VOSB/SDVOSB/SDB/HZSB/WOSB source lists.
- g. Monitors Contractor and lower-tier subcontractor compliance with the SB/VOSB/SDVOSB/SDB/HZSB/WOSB Subcontracting Plans.

- h. Submits required periodic reports and coordinates HMHS activities with respect to any studies/surveys that may be required by federal agencies or the SBA.
 - i. Attempts to increase awards to SB/VOSB/SDVOSB/SDB/ HZSB/WOSB concerns by encouraging attendance of procurement personnel at business opportunity workshops, minority business seminars, and conferences and trade fairs, and by providing motivational training and counseling to purchasing personnel.
 - j. Obtains the assistance of others, as necessary, to aid in the performance of the above duties.
6. The following efforts will be taken to assure that small businesses, veteran-owned small businesses, service-disabled small businesses, small disadvantaged businesses, HUBZone small businesses, and women-owned small businesses will have an equitable opportunity to compete for subcontracts:
- a. Outreach efforts will be made as follows:
 - 1. Contacts with small, minority, and women-owned trade associations.
 - 2. Contacts with business development organizations.
 - 3. Contacts with veterans service organizations.
 - 4. Attend small business procurement conferences and trade fairs.
 - 5. Guidance and assistance for SB/VOSB/SDVOSB/SDB/ HZSB/WOSB concerns.
 - b. The following internal efforts will be made:
 - 1. Maintenance of SB/VOSB/ SDVOSB/SDB/ HZSB/WOSB certifications and self certifications.
 - 2. Activities will be monitored to evaluate compliance with the subcontracting plan.

3. Encourage buyers and technical personnel to participate in the program.

7. HMHS agrees that the clause, "Utilization of Small Business Concerns" (FAR 52.219-8) will be included in all subcontracts that offer further subcontracting opportunities, and that HMHS will require all subcontractors (except small business concerns) who receive subcontracts in excess of \$500,000 to adopt a plan similar to this one. Such plans will be reviewed by comparing them with the provisions of FAR 52.219-9, "Small Business Subcontracting Plan," to assure that all minimum requirements of an acceptable subcontracting plan have been satisfied. The acceptability of percentage goals will be determined on a case-by-case basis depending on:
 - The supplies/services involved
 - The availability of potential small, veteran-owned, service-disabled veteran-owned, small disadvantaged, HUBZone, and women-owned small business subcontractors, and
 - Prior experience

Once approved and implemented, the plans will be monitored through the submission of periodic reports, and/or visits to the affected subcontractor's facilities to review applicable records and evaluate the subcontractor's performance.

8. HMHS will submit such periodic reports and cooperate in any studies or surveys as may be required by the contracting agency or the Small Business Administration, including the following:
 - a. SF 294 - Submit on a semi-annual basis. The report for October 1 through March 31st is due on April 30th. The report for April 1st through September 30th is due on October 31st.
 - b. SF 295 - Submit on a semi-annual basis. The report for October 1st through March 31st is due on April 30th. The report from October 1st through September 30th is due on October 31st. Both reports will be mailed to:

U.S. Small Business Administration
Office of Government Contracting – Area III
223 Peachtree Street, NE, Ste 1805
Atlanta, Georgia 30303

Defense Contracting Management Agency Dayton
Attn: DCMDE-GYDU
1725 Van Patton Drive, Area C, Bldg 30
Wright Patterson AFB, Ohio 45433-5302

Contracting Officer
TRICARE Management Activity
Contracting Administrative Branch
16401 East Centretech Parkway
Aurora, Colorado 80011-9043

9. HMHS will maintain the following types of records to document compliance with this subcontracting plan:
- a. Small and small disadvantaged businesses source lists (e.g., PRO-Net), guides, and other data identifying small business, veteran-owned small business, service-disabled small business, small disadvantaged business, HUBZone small business, and women-owned small business concern vendors.
 - b. Organizations contacted in an attempt to locate sources that are small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, or women-owned small business concerns.
 - c. On a contract-by-contract basis, records on all subcontract solicitations over \$100,000, indicating on each solicitation (1) whether small businesses were solicited, and if not, why not; (2) whether veteran-owned small businesses were solicited, and if not, why not; (3) whether service-disabled veteran-owned small businesses were solicited, and if not, why not; (4) whether HUBZone small businesses were solicited, and if not, why not; (5)

- whether small disadvantaged businesses were solicited, and if not, why not; (6) whether women-owned small business concerns were solicited and, if not, why not; and (7) if small business concerns were solicited, but did not receive the award, the reason(s) for non-award.
- d. Memberships/contacts with organizations involved in assisting small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small businesses to participate in the performance of contracts awarded by federal agencies. HMHS will participate in the meetings of the DoD North Central Regional Council for Small Business Education and Advocacy.
 - e. Memberships in professional organizations committed to implementing federal acquisition policies. HMHS associates are members of the National Contract Management Association (NCMA).
 - f. Records of any outreach efforts to contact:
 - 1. Trade associations
 - 2. Business development organizations
 - 3. Conferences and trade fairs to locate small, veteran-owned, service-disabled veteran-owned, HUBZone small, small disadvantaged, and women-owned small business sources
 - 4. Veterans service organizations
 - g. Records of internal guidance and encouragement provided to buyers through:
 - 1. Workshops, seminars, training, etc.
 - 2. Monitoring performance to evaluate compliance with the program's requirements.
 - h. On a contract-by-contract basis, records to support subcontract award data to include name and address of subcontractor(s).

10. Subcontracting Plan Implementation:

In order to effectively implement this Subcontracting Plan, HMHS will:

- a. Promulgate and issue company-wide policy statements in support of this effort.
- b. Demonstrate continuing management interest and involvement in support of this effort through such actions as regular reviews of progress and establishment of overall goals and objectives.
- c. Train and motivate all HMHS associates involved in the procurement process regarding the need to include small business, veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns in the procurement process.
- d. Counsel and discuss subcontracting opportunities with those small business concerns as are suggested by the local Defense Contract Management Agency, Director for Small Business, responsible for monitoring performance under this program and/or representatives of the SBA.

Approved: 
Bruce Mitterer
Contracting Officer