EXECUTIVE SUMMARY

The Patient Centered Medical Home (PCMH) is designed around one core principle: putting patients first. The PCMH is Army Medicine’s gateway to influence the Lifespace where beneficiaries make decisions on the key determinants of health and wellness—activity, nutrition, and sleep (that is, the Performance Triad). PCMH is defined by the ability to provide comprehensive primary care, promote wellness through empowered patients, and seamlessly coordinate care within the “medical neighborhood” to achieve optimal health for our beneficiaries.

PCMH is an interdisciplinary approach to deliver evidence-based, comprehensive primary care—coordinating care delivered outside of the primary care setting and proactively engaging patients as partners in health. PCMH is the center of gravity of the U.S. Army Medical Command’s transformation from a healthcare system to a System For Health. PCMH embodies the Operating Company business methodology—one that provides consistency, clarity, and accountability of services as well as value.

This PCMH Operations Manual is the keystone document that describes the standard methods and processes for operating an Army PCMH. The Operations Manual defines the essential tasks and standards in the patient journey allowing leaders to readily assess and adjust operations as needed to ensure compliance with PCMH standards of practice. This manual also defines metrics at the PCMH, military treatment facility, regional, and Army Medical Command levels. Most importantly, this manual defines how the PCMH enables the Office of The Surgeon General/Medical Command to increase its reach to maintain health, restore health, and improve health through a deliberate focus on activity, nutrition, and sleep. Effective implementation of the concepts provided in this Manual is essential for successful operation of an Army PCMH.

There are many components of the PCMH which are referenced in this Operations Manual. Annexes and leader guides to this Manual have been developed to address these components in more detail. A listing of annexes and leader guides is provided at appendix A.

PCMH is a top priority for the Army Medical Command. PCMH implementation is already underway and moving with significant momentum. Our success—and ultimately our legacy—will be measured by how well we apply the standards of PCMH across Army Medicine.

Serving to Heal…Honored to Serve

Donna A. Brock                           Patricia D. Horoho
Command Sergeant Major,                 Lieutenant General, United States Army
U.S. Army Medical Command                The Surgeon General and
                                          Commanding General,

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>2</td>
</tr>
<tr>
<td>CAMPAIGN PLAN 2020</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER ONE – INTRODUCTION TO THE PATIENT CENTERED MEDICAL HOME</td>
<td>6</td>
</tr>
<tr>
<td>1-1. Purpose</td>
<td>6</td>
</tr>
<tr>
<td>1-2. Vision</td>
<td>7</td>
</tr>
<tr>
<td>1-3. Mission</td>
<td>7</td>
</tr>
<tr>
<td>1-4. Operations Manual</td>
<td>7</td>
</tr>
<tr>
<td>CHAPTER TWO – THE PATIENT JOURNEY</td>
<td>8</td>
</tr>
<tr>
<td>2-1. The Patient Journey: Patient Joins Army Medicine</td>
<td>9</td>
</tr>
<tr>
<td>2-2. The Patient Journey: Patient Meets the Care Team</td>
<td>10</td>
</tr>
<tr>
<td>2-3. The Patient Journey: Patient Seeks or Needs Care</td>
<td>11</td>
</tr>
<tr>
<td>2-4. The Patient Journey: Patient Receives Care</td>
<td>12</td>
</tr>
<tr>
<td>2-5. The Patient Journey: Patient and System For Health Connect In the Lifespace</td>
<td>15</td>
</tr>
<tr>
<td>2-6. The Patient Journey: Patient Transitions</td>
<td>16</td>
</tr>
<tr>
<td>CHAPTER THREE – PCMH ROLES AND RESPONSIBILITIES</td>
<td>18</td>
</tr>
<tr>
<td>3-1. Patient</td>
<td>19</td>
</tr>
<tr>
<td>3-2. Primary Care Manager</td>
<td>19</td>
</tr>
<tr>
<td>3-3. Team Registered Nurse</td>
<td>19</td>
</tr>
</tbody>
</table>
3-4. Core Team (LPN/LVN/68C and 68W) .................................................. 20
3-5. Medical Support Assistant - Front Desk Clerk ........................................ 20
3-6. Nurse Case Manager .............................................................................. 21
3-7. PCMH Extended Team ........................................................................... 21
3-8. PCMH Practice Management Team .......................................................... 24
3-9. MTF Command Team ............................................................................ 25
3-10. Regional Medical Command Team ........................................................ 26
3-11. OTSG/MEDCOM .................................................................................. 27

CHAPTER FOUR – PCMH STANDARDS AND COMPLIANCE .................. 28

4-1. Medical Expense and Performance Reporting System .......................... 28
4-2. Defined Performance Standards ............................................................... 28
4-3. The Practice Status Report ..................................................................... 30
4-4. Performance Measure Dictionary ............................................................. 32

APPENDIX A – References ........................................................................ 34

APPENDIX B – Extended Team Members DMHRSi Documentation for Support to the Medical Home Practice(s) .......................................................... 35

FEEDBACK AND IMPROVEMENTS .......................................................... 38
Campaign Plan 2020 Objective 1-3.1. Patient Centered Medical Home (PCMH)

The Army PCMH model is a critical element of the Army Medicine 2020 Campaign Plan (fig 1). The PCMH model encompasses all primary care delivery sites in the direct care system, including our military treatment facility (MTF)-based PCMHs, Community Based Medical Homes (CBMHs), and Soldier Centered Medical Homes (SCMHs). The CBMH puts patient centered care in the communities where our beneficiaries live. The SCMH places this care into the units with our Soldiers and their leaders, integrating organic unit medical personnel with MTF staff. Each medical home fully embodies PCMH common operating principles and standards and our core performance metrics built on the patient experience of care; Soldier readiness; and quality, safety, and operating efficiency. The objective is to build a premier Army medical System For Health through comprehensive transformation into a patient-centered, team-based Accountable Care Organization (ACO) that improves readiness of the Force and health of our beneficiaries.
CHAPTER ONE
INTRODUCTION TO THE PATIENT CENTERED MEDICAL HOME

1-1. Purpose

Transformation from a healthcare system to a System For Health begins with transformation of our system of primary care. This renewal of primary care improves our ability to prevent disease and enhance wellness, manage chronic disease, and deliver comprehensive care through empowered teams. We transition from fragmented, uncoordinated care to comprehensive, collaborative care. We enable patient growth from passive recipient to active partner in the journey to health.

We call this transformed model of primary care the Patient Centered Medical Home. PCMH epitomizes The Surgeon General’s Operating Company Model, with clear, consistent, and accountable standards and policies that equip our regional medical commands (RMCs) and our MTFs to deliver franchise-like service that ultimately creates consistency and value for our patients across Army Medicine and around the globe. The same standards apply to all primary care enrollment sites, including SCMHs and CBMHs.

At end state, Army PCMHs will—

- Deliver a consistent, high quality care experience that distinguishes Army Medicine as the first choice for our beneficiaries.
- Minimize unwarranted variance and improve operating efficiency and effectiveness.
- Build capacity in the direct care system.
- Serve as the means to achieve our strategic imperatives: create capacity, enhance diplomacy, and improve stamina.
- Extend our influence in the Lifespace’s Performance Triad so that patients are empowered to make healthy choices related to activity, nutrition, and sleep.

A practice becomes an official Army PCMH when it meets three criteria—

- Practice readiness assessment of 7.5 or greater for a PCMH and 13.0 or greater for an SCMH.
- National Committee for Quality Assurance (NCQA) recognition level 2 or higher.
- Successful completion of a staff assessment visit (SAV) by the RMC Transformation Team utilizing the Organizational Inspection Program (OIP) checklist.

The Army PCMH is a key enabler in the global transformation of our System For Health, by integrating and synchronizing Army-wide initiatives to fulfill the Army Medicine 2020 vision of strengthening the health of our Nation by improving the health of our Army. The System For Health is defined in our Army Medicine 2020 strategy as—
**System For Health** is a partnership among Soldiers, Families, leaders, health teams, and communities to promote **Readiness, Resilience, and Responsibility**.

- **MAINTAINS** health through fitness and illness/injury prevention.
- **RESTORES** health through patient-centered care.
- **IMPROVES** health through informed choices in the Lifespace.

1-2. Vision

Inspire life-long positive changes in our beneficiary’s health through Army Medicine’s transformation from a healthcare system to a patient-centered System For Health.

1-3. Mission

Build the premier patient-centered, team-based, comprehensive System For Health that improves readiness and promotes health.


This Operations Manual defines the standard methods and processes for operating an Army PCMH. The intent is not to be all-inclusive but rather to provide a comprehensive overview. Multiple hyperlinks and citations for landmark articles, Web sites, source documents, operation orders (OPORDs), or policies are included for the reader’s additional reference. The target audience is MTF leaders from commander to department level—both clinical and administrative—as well as RMC leaders who oversee, train, and evaluate their MTFs’ PCMH teams. Engaged and committed leaders are essential to successful transformation and operation.

*Note:* We refer frequently to the “Accountable Care Organization” in this manual. The ACO represents the MTF leadership, all clinical and non-clinical support activities such as human resources, information management, resource management, and managed care, in addition to primary, subspecialty, and surgical care lines. An ACO is unified in its responsibility for health care and support to the same group of beneficiaries to achieve quality and stewardship goals as an accountable, reliable, and effective System-For-Health organization.
CHAPTER TWO
THE PATIENT JOURNEY

The Surgeon General has directed us to make our patient’s journey seamless and familiar at every entry point into our System For Health and with each move and transition across the Army family life cycle. The global, long-term strategy for the patient journey is to enable ready and resilient Soldiers, Families, and communities in order to prevent, shape, and win our Nation’s conflicts through standardized, consistent, accurate, and accessible information and healthcare processes available to all beneficiaries across all MTFs (see fig 2).

**Figure 2. The Patient Journey**

The PCMH vision creates—

- Accountable healthcare team and empowered beneficiaries.
- Excellent and consistent patient experience and partnership for healthy and resilient Soldiers and Families.
• Loyalty to Army Medicine to provide all healthcare needs resulting in reduced cost of care and an enhanced patient experience.
• Safety and efficacy through standardized customer service that will reduce communication gaps between the care team and patient. This will ensure timely care; minimize missed opportunities for care; and improve continuous, comprehensive care for our beneficiaries.
• Efficiency by reducing customer service gaps.

ESSENTIAL TASKS: All staff members will—

• Wear MTF-standardized name badges, affixed at shoulder height.
• Greet patients using rank or courtesy title and name.
• Clearly identify themselves by name, position, and care role at each encounter and provide a warm and personable greeting to every patient.
• At the end of each encounter, ask all patients if they have any unmet needs or questions.
• Ensure telephone consults, voice mail messages, and secure messages are addressed and resolved with 24 business hours.
• Ensure patients are never asked to call back.
• Ensure that the B.A.S.I.C. communication tool is the basis for all encounters with patients. (See PCMH Consolidated Glossary: Break Barriers, Anticipate and Accommodate, Seek Solutions, Initiate and Interact, Communicate).
• Ensure use of the service recovery matrix for problem solving.
• Conduct a “warm handoff” when transferring responsibility for the patient from one staff member to the next within the practice, to include telephone calls and face-to-face visits.

2-1. The Patient Journey: Patient Joins Army Medicine

Patient information is readily available to the community in printed, internet, and social media formats (e.g., available at TRICARE Service Center, in-processing sites, clinic).

The information provided by the ACO and PCMH must be accurate and comprehensive, making it easy for patients to access and navigate our System For Health, building a collaborative relationship between the patient and healthcare team and empowering patients to take more responsibility for their health. Information includes the following:

• The Army PCMH advantage as compared to traditional primary care (offer multiple options to access services, provide team-based care, focus on care coordination, and partnership with wellness centers, etc.).
• The practice (enrollment and empanelment, range of services, how and why to access care including after-hours care, how to use the Army Medicine Secure
Messaging Service (AMSMS), etc.); an understanding of different interface options including virtual, telephonic, and remote options for care. 

Note: This Manual uses “secure messaging” and “AMSMS” interchangeably.

- Responsibilities of the patient as a partner in care (ask questions, participate in decision-making, communicate about other care, etc.).
- How to prepare for an encounter (make a list of questions, involve a trusted third party, define what will make the encounter a success).
- Quality and satisfaction metrics for the practice.
- Links to wellness, health coaching, and other resources.
- How to get a referral, the referral process, name of care coordinator, and contact information.

The PCMH provides newly empanelled patients with information to connect them with their PCMH team and to help them identify health goals. Information provided to newly empanelled patients introduces them to the care team and stresses importance and advantages of primary care manager (PCM) continuity.

The PCMH and its supporting MTF command team and ACO use the registered Army PCMH service mark (fig 3) in written and electronic communications to enhance brand awareness and pride.

![Figure 3. Army PCMH Service Mark](Image)

2-2. The Patient Journey: Patient Meets the Care Team

- **Whole care team.** The whole care team must get to know and “own” its panel of patients.
- **Primary care manager.** Collaborates with patients to identify health goals and to build a comprehensive care plan.
- **Team registered nurse (RN).** Integrates, coordinates, and synchronizes the team to serve its patients.
- **Licensed practical nurse (LPN)/licensed vocational nurse (LVN)/(68C) and medic (68W).** Facilitates the success of the visit by reinforcing team awareness of patient goals for the visit. Often provides most familiar and comfortable portal for patients to share needs and goals.
- **Medical support assistant (MSA).** Serves as the front-line ambassador for Army Medicine, setting the tone for the entire visit with a warm smile and personal...
attention. Verifies demographics, TRICARE Online (TOL) and secure messaging enrollment, and third-party insurance options.

PCMH teams have unique skills or capabilities that may be matched with patients to ensure empanelment to the correct care team. Patients will be provided an opportunity to meet the care team to build trust, to identify special goals and requirements, to strengthen communication, and to optimize healthcare utilization.

The PCM and core team (see para 3-4) know when new patients join the panel so that they can assess healthcare needs and engage patients proactively. MTF leaders and ACO teams supporting the PCMH will identify newly assigned enrollees so that PCMH teams can proactively welcome them.

Once a new patient is identified, the practice orients the patient to the PCMH care team, evaluates immediate care needs, and schedules the patient for initial intake, if required. (See New Enrollee Guidance Annex).

2-3. The Patient Journey: Patient Seeks or Needs Care

**Patient Seeks or Needs Care**

- **Whole care team.** The whole care team must get to know and “own” its panel of patients. The whole care team must be ready and available when our patients need our services.
- **PCM.** Maximizes availability and responsiveness of enrolled panel.
- **Team RN.** Aligns patient with right resources and response: face-to-face, telephone, or secure messaging with provider, nurse, or other team member.
- **Nurse case manager (NCM).** Follows written policies and procedures to identify and address the needs of high-risk patients, especially chronic pain, high utilizer, polypharmacy (CHUP) and diabetic patients.
- **LPN/LVN/68C and 68W.** Proactively reviews patient schedule 72 hours prior to prep the visit for success.
- **MSA.** Sets a positive and welcoming tone to deliver an excellent and consistent patient experience.
  - Provides frontline “service recovery.”
  - Monitors reception and resolves problems proactively.

**ESSENTIAL TASKS:** Staff will ensure that—

- Patients know they can get same-day appointments.
- The practice has a system for meeting demand for same-day appointments including the ability to monitor access and activate "surge" management plans as needed to meet same-day demand.
- Patients know they can access care by telephone.
Patients know they can access care through secure messaging and TOL.

The practice provides telephone, secure messaging, and TOL access to patients to address clinical questions and concerns in lieu of face-to-face visits. PCMs and other clinical staff provide advice in accordance with approved standard operating procedures (SOPs) and written protocols.

Patients can easily make appointments or communicate other non-clinical queries through telephone, TOL, and secure messaging.

The practice supports electronic portals for appointing and other administrative tasks as an alternative to telephone.

Patients can access the practice for care after business hours.

The practice provides advice and access after hours through the nurse advice line (NAL). The practice will review all NAL messages by the next business day.

The practice coordinates with NAL for continuity of care and seamless transition.

The MTF/ACO uses population health data to define the health profile of the enrolled population through use of CarePoint Health Application Suite (CHAS) and other sources to tailor healthcare delivery and improve health outcomes.

The practice has written policies and procedures to identify and address the preventive health needs of each empanelled patient.

Immunizations are screened proactively and are updated according to written protocols.

The practice focuses population health and Health Effectiveness Data and Information Set® (HEDIS®) principles, tasks, and deliverables in dedicated fashion to achieve reliable high quality care.

The practice follows written policies and procedures to identify and address chronic disease management.

2-4. The Patient Journey: Patient Receives Care

**Patient Receives Care**

*Whole care team.* The PCMH team will win patient trust and confidence through coordinated compassionate care where every team member works at the top of his/her license, competency, and scope of practice.

*PCM.* Provides quality care to clarify patient health goals and empowers patient action. Documents care on Tri-Service Workflow (TSWF) form using Medical Applications and Process Solutions (MAPS) 2.0 tools.

*Team RN.* Facilitates the morning huddle to synchronize care coordination (triaging patients).
  - Facilitates patient education.
  - Ensures coordinated handoff and transitions of care.

*LPN/LVN/68C and 68W.* Performs the initial intake on TSWF.
  - Delivers care within validated scope of competency and scope of practice in partnership with provider.
  - Provides patient education.
• Nurse case manager. Focuses on disease management and care integration of patients with complex needs to decrease morbidity, utilization, and hospitalization.
  o Manages CHUP list.
  o Manages diabetic registry.
  o Documents in AHLTA.

As part of the patient-centered care process, PCMH emphasizes the importance of new patient intake, the daily team huddle to review and prioritize clinic workload, and the importance of balancing traditional workflow using telephone consults, NAL, and non-face-to-face workflow using secure messaging. These three areas are further discussed below.

NEW PATIENT INTAKE

Below are the essential tasks related to the clinical business processes that occur after a patient has been newly registered, enrolled, and assigned or transferred to a PCMH (See New Enrollee Guidance Annex).

ESSENTIAL TASKS: The PCMH team—

• Identifies new patients for each PCM using the Composite Health Care System (CHCS) Future Enrollment Reports (FERs).
• Makes initial contact with new patients, orients the patient to the PCMH care team and evaluates immediate care needs.
• Performs a comprehensive review of records.
• Coordinates and/or schedules the patient’s pre-visit services and schedules appointment for the initial visit with the PCM, if indicated. Note: The patient may also perform/assist with this task.

TEAM HUDDLE

• PCMH team uses team huddles to review daily activities, team work, and resource management related to patient care and clinic operations.

• Huddles may take place in two parts: The first part involves the entire practice to discuss staffing optimization and clinical preparation; the second part involves the core team to discuss visit preparation, transitions of care, and schedule optimization.
  o The huddle is focused and brief (no more than 10 minutes).
  o All staff members participate in the daily huddle.
  o Defense Medical Human Resources Systems internet™ (Team STEPPS™) communication tools will be used for the huddle process.

THE FIVE HUDDLE STANDARDS
• **Core team staffing assessment.** Core team staffing levels are evaluated to identify staffing gaps and attempt to close them through staffing realignments.

• **Access management/re-alignment.** Clinic schedules are reviewed 72 hours in advance in order to maximize PCM continuity and to evaluate if the patient’s care needs can be met through a non-traditional (non-face-to-face) option.

• **Visit preparation.** Clinic schedules are reviewed 72 hours in advance to determine if there are patients who should be contacted for pre-visit testing or to obtain necessary documents.

• **Transitions of care.** The PCMH identifies patients who have had transitions of care since last huddle.

• **Clinic preparation.** Scheduled appointments for that day are reviewed to ensure efficient room assignment, supply availability, procedure equipment setup, supervision, etc.

### NON-FACE-TO-FACE PATIENT CARE

Non face-to-face patient care includes NAL consults to the team and AMSMS. Effective use of these options is critical to building practice capacity—make each face-to-face encounter count. These non face-to-face patient care options also extend the PCMH team’s reach into the Lifespace, enabling patients and Families to avoid unnecessary trips to the clinic with associated travel, time, and parking issues.

### TELEPHONE CONSULTATIONS

The PCMH staffing model increases the range of individuals available to respond to telephone consultations.

**TELEPHONE CONSULTATIONS ESSENTIAL TASK:**

• Employ PCMH team member-specific standing protocols for management of prescription renewals, diagnostic checks or orders, referral management, HEDIS® service interventions, and other consultation services.

### ARMY MEDICINE SECURE MESSAGING SERVICE

AMSMS provides one of the most powerful practice tools to link with patients where they live and work. AMSMS’s capabilities to identify and meet health needs, to shape and enhance value of face-to-face visits, and to share important information and education must be exploited by effective medical homes.

**SECURE MESSAGING ESSENTIAL TASKS:**

• **Inboxes.** Establish two common inboxes—administrative and clinical—that are regularly monitored by appropriate team members during duty hours for appropriate routing.
• **Administrative message inbox.** The administrative inbox is managed by the ACO or PCMH support staff who take necessary action and respond to patient requests within 24 hours (A level performance), 48 hours (B level performance), or 72 hours (C level performance). The clinical message inbox is managed by the nursing staff in a similar fashion and responds to patient requests within 24 hours (A level performance), 48 hours (B level performance), or 72 hours (C level performance).

• **Clinical inbox.** The nursing staff creates a telephone consult to document the interaction in the electronic health record (EHR). Only the messages requiring a response from the provider are forwarded to the patient’s provider. The PCMH team will use AMSMS to create patient and team reminders for action using “schedule a message” function to be delivered to the appropriate person at the appropriate time to remind them of the action to be performed.

• **Result notification.** Non-critical results may be notified to the patient via AMSMS.

• **Chronic disease management.** Use AMSMS to maintain contact with patients and to share the care plan to optimize self-management and health status at home; provide educational materials, schedule messages, follow-up reminders, and health coaching.

• **Broadcast messaging.** All patients in the practice, or specific cohorts of patients in the practice, will be provided AMSMS notifications appropriate for mass communication (e.g., availability of influenza vaccination opportunities).

2-5. The Patient Journey: Patient and System For Health Connect in the Lifespace

The Lifespace is where our patients make decisions on activity, nutrition, and sleep (the Performance Triad) that affect their lives and health. Most patients spend only about 100 minutes per year in face-to-face contact time with our clinics. PCMHs must target the Lifespace where our patients live and work to focus on the Performance Triad and to motivate and empower our patients to make healthy life choices. Improving the health of the population requires a comprehensive and interdisciplinary approach. The PCMH may lack the resources to independently address complex behavioral change for sustained weight loss, smoking cessation, or stress management. Partnerships with Army wellness centers (AWCs), when available, provide essential tools and capabilities in effective Lifespace decisions. (Refer to the AWC Annex.) The PCMH team performs the following critical functions to support the patient in making choices in their Lifespace:

• **PCM.** Collaborates with patient to define goals and decisions to improve health and includes Lifespace and wellness plans in comprehensive care plan.

• **Team RN.** Optimizes comprehensive care plan with patient.

• **LPN/LVN/68C and 68W.** Includes (within scope of practice and competency) questions about Lifespace during intake and ensures patient understanding of care plan and transition at end of appointment.
ESSENTIAL TASKS: The PCMH team will—

- Select and employ best media options to target the patient and reinforce the education received during the face-to-face encounter.
- At time of care plan development, pre-program a series of messages (to be sent at a future date via secure messaging) using templates where appropriate to remind, coach, and encourage.
- Conduct ongoing collaboration and coordination with AWCs to impact Soldier readiness and beneficiary wellness by leveraging assessment, patient education, health coaching, and behavioral modification capabilities.
- Maintain seamless continuity of information exchange with wellness centers.
- Convene interdisciplinary meetings with the PCM, team RN, clinical pharmacist (CP), NCM, and internal behavioral health consultant (IBHC) for patients who need complex intervention coordination.
- Use TSWF/MAPS 2.0 forms for assessment, care, and coaching documentation.

2-6. The Patient Journey: Patient Transitions

Patient Transitions:

- **PCM.** Prepare appropriate summary for each transition.
- **PCM and core team.** Ensure patient understands comprehensive care plan.
- **MSA.** Seek coordinating documentation.
- **NCM.** Manage and integrate all transitions for continuous care for complex patients.

Regardless of point of care, PCMH patients receive timely, coordinated, effective handoffs—a “warm healthcare handshake”–from one provider team to another provider team to ensure a seamless transition. PCMH teams must “plug in” with inpatient and emergency facilities used by their patients to receive coordinating information. Patients have instructions and information in hand to share with other healthcare members during transitions of care. The Surgeon General wants these “handshakes” to connect patients and Families as they move between installations confident that the Army PCMHs will be their home in the System For Health.

Within the MTF, the ACO demonstrates team commitment to facilitate a coordinated approach to ensure smooth and integrated movement of PCMH patients within the MTF and to proactively and effectively coordinate the exchange and flow of clinically important data such as lab, radiology, or prescriptions and to ensure follow-up and coordination.

The PCMH and ACO proactively manage care transitions.

ESSENTIAL TASKS: The PCMH team ensures that—
The practice uses CHAS Looking Glass to track diagnostic tests that have been ordered but not performed. The status is reported back to the ordering care team so that they can coach and remind patients to complete required evaluation.

The practice tracks prescriptions that are not picked up and the status is reported back to the ordering care team.

The practice follows up with the patient on missed appointments (direct and network care) and inactivated or unbooked referrals.

The practice routinely asks patients about care they receive outside the PCMH.

The practice has an effective established process for receiving notifications and reports of care (including admission notifications and discharge summaries) from referral sites and other care locations, particularly for urgent, emergency, and inpatient care outside the PCMH.

Every patient receives a summary of care, reconciled medication list, and care plan at end of visit, before leaving PCMH facility.

The practice schedules follow-up appointments before the patient leaves the clinic.

In cases of network referrals, there is a reliable process for assuring authorization and an easy process for booking the appointment.

Every patient referred to another point of care receives appropriate supporting information to share with the receiving consultant or care site.
CHAPTER THREE
PCMH ROLES AND RESPONSIBILITIES

PCMH is the heart of Army Medicine’s transformation to an Operating Company Model. We expect to see the same processes, the same patient-centered culture, and the same PCMH team roles and responsibilities at all Army Medicine medical homes. Patients and staff must be able to move between PCMHs and feel immediately at home. A high functioning team should improve with shared experience; therefore, commanders align resources and implement PCMH processes at the earliest opportunity to ensure appropriate staffing of each practice. This includes, but is not limited to, reassigning or realigning providers and support staff into the PCMH practices. This process is continuous and evolves over time as the practice transforms.

PCMH team members operate at the “top of their license, practice, or scope of competency” in expanded roles to enable the full scope of effective team-based care. MEDCOM has standardized position descriptions (PDs) for the PCMH positions that are located on FASCLASS (https://acpol2.army.mil/fasclass/inbox/default.asp). The list of standardized PDs can be found on the Army PCMH Resource Center (https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/default.aspx). The mandated use of the PCMH standardized PDs ensures that PCMH personnel have the necessary skills and scope of responsibility for a highly effective practice. MTFs must partner with the local Civilian Personnel Advisory Center to equip their PCMH practices with the right people to do the right work. MTFs must coordinate with the local bargaining unit to ensure compliance with labor and hiring practices. During transformation, it is imperative to develop a local hiring and manning plan in advance of the fiscal year.

Most Army PCMHs face the challenge of continual replacement of staff due to Army life cycle transitions. Core Content training, TeamSTEPPS™ training, MAPS 2.0/TSWF training, and Integrated Clinical Database/CarePoint (“PCMH Huddle Tool”) are critical training elements for the PCMH. Sustainment and refresher training are ongoing activities to maintain the competence and effectiveness of the practice. The PCMH must have a plan to effectively “on board” new employees with critical training elements.

The medical neighborhood consists of the network of other clinicians and services providing health care to patients. The medical neighborhood is expected to deliver coordinated care, effective communications, and shared decision-making. It is intended to improve the patient experience, improve patient outcomes, improve patient safety, and reduce healthcare costs. The medical neighborhood includes inpatient care; post-acute rehabilitation; emergency care; specialty and subspecialty care; ancillary services (physical therapy, occupational therapy, podiatry, and speech therapy); diagnostic services (laboratory and radiology); and patient education and health promotion programs (wellness/preventive medicine).
PCMH imposes new roles and responsibilities on departments and sections that interact with primary care. These roles and responsibilities begin with the patient.

3-1. Patient

Our patients are our center. They evaluate our care and customer service standards and exercise a choice to stay with Army Medicine—or look elsewhere. They are consumers whose healthcare consumption decisions drive cost and efficiency. They are stakeholders with a vested interest in the health and future of Army Medicine. They are engaged, active participants in decisions and activities that determine their health. A PCMH’s greatest privilege is to set the conditions for patients to choose health for themselves and their Families.

3-2. Primary Care Manager

The PCM is a key member of the PCMH team. There are three to five (3-5) PCMs assigned per PCMH. The PCM—

- Will partner with the patient to achieve an optimal therapeutic relationship that aligns the patient with the negotiated treatment plan.
- Is trained, properly equipped, and integrated into a high functioning team in order to maximize effectiveness of the PCM-patient relationship.
- Works in concert with other team members, allowing them to effectively contribute their capabilities to coordinated care.
- Is empanelled by the ACO per guidelines in MEDCOM OPORD 11-20, fragmentary order (FRAGO) 8, Annex I, Change1.
- Collaborates with team members to optimize the team’s performance metrics (e.g., access to care, leakage to the network, HEDIS® compliance, and the Army Provider Level Satisfaction Survey (APLSS)).
- Documents the comprehensive care plan in the EHR using TSWF tools.
- Uses clinical information management/information technology enablers (e.g., MAPS 2.0, secure messaging, voice recognition, and macro tools) to efficiently optimize the available time for patient interaction.
- Leads/attends daily huddles.
- Coordinates and collaborates with team members, specialists, community resources, and Family members to develop and maintain a goal-oriented, comprehensive, and comprehensible integrated plan of care with which the patient will comply.

3-3. Team Registered Nurse

The team RN is a professional nurse who provides independent, comprehensive, and evidence-based ambulatory nursing care to patients within the medical home. Annex C of MEDCOM OPORD 11-20 delineates the staffing structure. Annex D of MEDCOM OPORD 11-20, FRAGO 3 provides the RN ratio requirements and is counted in the 3.1
combined direct/shared support staff. Team RN applies in-depth knowledge of professional nursing theories, principles, and procedures, as well as critical thinking skills to formulate a nursing assessment, develop and implement a plan of care, and document patient care treatments/interventions. The team RN—

- Conducts daily team huddles and directs the PCM and core team to ensure efficient patient flow and prompt attention to the patient’s individual condition.
- Routinely screens walk-in patients and patients calling by telephone or through secure email messaging to assess severity of their condition, provide advice, and determine the need for PCM intervention.
- Assesses preventive health and chronic disease management needs of the empanelled patients using available computer tools and DOD/VA clinical guidelines.
- Assists patient and Family with identification of health interventions and goal development to optimize level of health.
- Educates patients, Family members/significant others, and/or caregivers in the principles of health prevention and promotion, to encourage and enhance a state of wellness.

3-4. Core Team (LPN/LVN/68C and 68W)

The core team is comprised of 3.1 combined direct/shared support staff consisting of, LVN/LPN (68C) and medic (68W). Annex C of MEDCOM OPORD 11-20 delineates the staffing structure. Annex D of MEDCOM OPORD 11-20, FRAGO 3 provides the support staff ratio requirements specified by defined position. The collaborative efforts of each staff member promote the delivery of comprehensive, high quality health care in a fully coordinated and synchronized manner. Each position functions within a defined scope of practice or competency.

- The core team assists the PCM and team RN with elements of direct patient care, documentation in the EHR utilizing the TSWF alternate input method form, medication reconciliation, patient education, and specified follow-up. A delineation of clinical tasks is located in the PD.
- Staff members complete training for Military Health System Population Health Portal, MAPS 2.0, and AMSMS.

3-5. Medical Support Assistant – Front Desk Clerk. The MSA—

- Is a customer service advocate, acting as the communication link between the PCM, PCM team, and the patient/Family.
- Employs customer service skills defined in B.A.S.I.C. communications and service recovery standards.
- Executes the patient processing procedures (reception and transition); books appointments as required; receives and routes all telephonic and/or virtual communication; facilitates completion of all required pre-visit documentation (other
health insurance/third-party reimbursement, questionnaires, etc.) via hardcopy, computer formatted, or kiosk media. (Refer to the Reception and Transition Annex.)

- Assists with TOL and AMSMS registration and other support activities such as consult tracking, follow-up facilitation, and specialty appointing within scope of the defined PD.
- Tracks, coordinates, and facilitates specific services. The clerk ensures that referral and specialty care ordered by the PCM team is appointed, kept, and resulted back to the PCM team.
- Assists with the transfer of information to and from specialty providers and network healthcare organizations.

3-6. Nurse Case Manager

The NCM is a professional RN who comprehensively manages the complex healthcare needs for defined PCMHs. Per MEDCOM OPORD 11-20, one NCM is assigned per six full-time equivalent (FTE) PCMs or 6200 enrollees. The NCM interfaces with the PCMH team members to synchronize healthcare management for identified patients along the healthcare continuum. MEDCOM OPORD 13-25 provides further clarification on NCM responsibilities and training requirements. The NCM—

- Must attend the AMEDDC&S Resident Nurse Case Management Course and complete designated Military Health System (MHS) online care management courses.
- Assumes key responsibilities including management of CHUP patients and the diabetic registry.
- Identifies team patients with chronic, catastrophic, complex, high utilization, high-risk or high-cost healthcare diagnoses to decrease the fragmentation of healthcare delivery.
- Synchronizes recommendations with the PCM, core team, team RN, and others such as, the pharmacist, dietitian, and medical management (MM) personnel at daily team huddles and throughout the workday to promote comprehensive healthcare management and optimize healthcare delivery systems.
- Reviews the comprehensive care plans with the PCM and inter-disciplinary team members in a collaborative fashion to ensure effective care coordination within specified timeframes.
- Coordinates with MM to ensure information related to hospitalizations and emergency room (ER) visits for assigned team patients is identified for appropriate follow-up.
- Documents and codes all services in AHLTA using DOD-established provider specialty codes, Health Insurance Portability and Accountability Act taxonomy codes, Medical Expense and Performance Reporting System (MEPRS) codes, diagnosis codes, and Healthcare Common Procedure Coding System codes.

3-7. PCMH Extended Team
The PCMH extended team includes behavioral health providers, CPs, dietitians, and rehabilitation and reintegration providers. Their templates and availability are designed to ensure maximum engagement with the PCM, core team, and NCMs.

All members of the extended team—

- Collaborate with PCMH team members to provide interdisciplinary comprehensive care and to educate beneficiaries, clinical staff, and other leaders.
- Attend the daily team huddle.
- Assist the PCMH to improve clinical outcomes for acute conditions through early assessment, intervention, and follow-up monitoring in the PCM home or practice.
- Focus on resolving problems within the PCMH.
- Document all patient encounters in the EHR.
- Assess patient needs through individual appointments or group appointments organized around common conditions or as part of an interdisciplinary assessment and intervention for individual patients.
- Participate in extended team appointments that may take the form of—
  - Pre-appointment planning or post-appointment patient education and health coaching;
  - Formal consultation, such as when the pharmacist initiates or PCM requests medication management services based on routine screening criteria; or
  - Follow-up referral for long-term disease management.
- Document support to the PCMH in the Defense Medical Human Resources Systems internet (DMHRSi) and schedule appointments in accordance with appendix B of this Manual.

**Behavioral health.** The IBHC and behavioral health care facilitator (BHCF) work as members of the PCMH team. Staffing is based on ratios established by guidance from the Office of the Chief Medical Officer, TRICARE Management Activity as follows:

- 1 IBHC per 3,000 enrolled adult population.
- 2 IBHCs per 15,000 enrolled adult population.
- 3 IBHCs per 30,000 enrolled adult population.
- 1 BHCF >7,500 enrolled adult population (at least 1 BHCF per installation).

*Note:* At installations where enrollment is less than 7,500 adults, the IBHC will be responsible to perform both IBHC and BHCF roles.

The goals of PCMH-based behavioral health (BH) treatment are to improve clinical outcomes for acute BH and BH-related co-morbid conditions through utilization of BH screening, assessment, intervention, follow-up monitoring, and/or appropriate triage and referrals to specialty BH care. (Refer to the Behavioral Health Annex.)

- BH staff will coordinate behavioral health care with the PCMH team for acute care and collaborative management and mitigation.
BH staff will refer chronic behavioral healthcare management to the specialty BH clinic.

Clinical pharmacist. The CP provides professional consultation regarding the MM of the patient in collaboration with the PCM and PCMH core team members. OPORD 11-20 requires one pharmacist FTE for every 6500 enrollees. The CP—

- Assesses patient’s medication-related needs and identifies medication-related problems, particularly with polypharmacy patients.
- Develops care plans with individualized therapy goals, especially with chronic disease management in close collaboration with the PCMH NCM.
- Educates patients about medication regimens to enhance compliance and to collaborate with patients for clinical success and early identification of adverse effects. (Refer to the Clinical Pharmacy Annex.)

Dietitian. The dietitian provides professional consultation related to nutrition care in collaboration with the PCM and PCMH core team members. Per MEDCOM OPORD 11-20, the staffing requirements are one dietitian for practices with more than 7500 enrollees (~0.05 dietician FTEs for each brigade in SCMHs). Dietitians provide consultation, education, and counsel in the areas of diet, food, nutrition, and human performance. Nutrition interventions address health promotion and illness prevention strategies targeted at populations, groups, or individuals, as well as specialized treatment regimens and rehabilitation support for nutrition-related illnesses. Dietitians develop individualized eating plans based on a comprehensive nutritional assessment. To extend their impact, they train PCMH staff and other healthcare professionals. They promote behavioral changes related to food choices, eating habits, and meal preparation methods to enable active participation by patients in selecting their own options for health care, wellness, and prevention. (Refer to the Nutrition Care Services Annex.)

Rehabilitation and reintegration providers. Rehabilitation and reintegration providers promote early diagnosis and precise treatment for musculoskeletal and concussive injuries, resulting in decreased medication use and earlier return to desired lifestyle. By providing treatment, instruction, and education, rehabilitation providers support the activity component of the Performance Triad and foster active participation in the Lifespace. Specific staffing ratios for rehabilitation and reintegration providers are to be determined. However, rehabilitation and reintegration providers support the PCMH in one of three ways—

- Fully integrated with the PCMH team.
- Designated MTF asset with a specific number of hours dedicated to the PCMH practice.
- Serve as a consultant on an as-needed basis.
PCMH rehabilitation and reintegration providers assist in shaping the appropriate plan of care within the scope of their capabilities—

- Musculoskeletal.
- Pain management.
- Traumatic brain injury and concussion care.
  - Liaison with National Intrepid Center of Excellence (NICoE) and NICoE Satellites, if available.
  - Neurocognitive testing.

3-8. PCMH Practice Management Team

*Medical director/clinic officer in charge (OIC).* The medical director/clinic OIC is a physician, nurse practitioner (NP), or physician assistant (PA) who is the senior clinical expert and primary clinical decision maker in the PCMH, PCMH practice, or department. There is one medical director/clinic OIC assigned per PCMH. The medical director/clinic OIC—

- Attends the daily team huddle.
- Conducts focused and ongoing professional practice evaluation (peer review), provides oversight for all requests for privileges, and is the primary point of contact for any risk management concerns occurring in patients empanelled within the home or practice.
- Collaborates with the clinical nurse officer-in-charge (CNOIC) and practice manager or non-commissioned officer in charge (NCOIC) on any clinical decisions regarding clinical SOPs, access management decisions, or changes to patient centered/team based workflow.
- Provides expert medical care to empanelled patients.

*Clinical nurse officer in charge.* The CNOIC is a professional RN, designated to directly supervise the nursing and ancillary support staff assigned to the PCMH team. Per MEDCOM OPORD 11-20, Annex C, one CNOIC is assigned per each PCMH practice. This position is responsible for the oversight of the assigned nursing staff’s scope of practice/scope of competency and provision of nursing services within the PCMH practice. *Note:* The CNOIC position aligned at the “department” level is not calculated as part of the 3.1 PCMH support staff model. The CNOIC—

- Attends the daily team huddle.
- Supervises all assigned nursing and ancillary support staff (military and civilian) to include the NCM and population health nurse, but does not supervise assigned NPs.
- Collaborates with the NCOIC and/or practice manager focusing on the daily clinical and administrative operations of the practice by monitoring defined clinical performance metrics, DMHRSi accuracy, staffing requirements, and daily operational functions of the practice to ensure compliance with The Joint Commission (TJC) and NCQA standards.
• Should attend the Clinical Nurse OIC/NCOIC Leader Development Course. Completion of the Department of the Army Supervisor Development Course is mandated for all supervisors of civilian personnel.

Practice manager. The practice manager can be a military officer, non-commissioned officer, or civilian (not a contractor) who provides administrative management and oversight of the PCMH. As defined in the practice management body of knowledge, the practice manager will have knowledge, skills, and abilities in practice leadership, business operations, human resources, information management, patient care/safety systems, and quality/risk management. There will be one practice manager per 10,000 enrollees. PCMH practices with less than 10,000 enrollees will designate practice management responsibility to an internal or external individual/office to ensure an efficient delivery of health care. Individual(s) performing the role of practice manager will complete the Basic Health Care Administrators Course and, when available, the Group Practice Managers Course.

NCOIC. The NCOIC provides administrative and supervisory support to allow clinical care teams to focus on providing medical services to patients in the PCMH. The NCOIC position aligned at the “department” level is not calculated as part of the 3.1 support staff model. The NCOIC—

• Attends the daily team huddle.
• Tracks access and provider availability, tracks appointment templates.
• Maintains the clinic budget, manages equipment and supplies.
• Oversees clerical staff and monitors telephone calls and consults.
• Tracks DMHRSi submissions for PCMH team.
• Makes recommendations to improve clinic efficiency and effectiveness in meeting patient needs using resources to promote quality and cost-effective patient centered care.
• Teams with CNOIC to ensure compliance with TJC and NCQA standards.
• Ensures safety and emergency preparedness.
• Provides technical advice, support, and assistance to all staff.
• Provides front-line service recovery.

3-9. MTF Command Team

The MTF command team is directly responsible as an ACO whose focus is to align and coordinate various resources and specialties in order to provide quality driven and comprehensive health care for a patient population.

ACO and PCMH success require patient-centered integrated and coordinated care to be the number one command and organization priority. Engaged organizational leadership motivates high performance and success by recognizing the patient as the portal to ensure an excellent and consistent patient experience throughout the ACO. Command teams must track and guide PCMH performance from the department to the
practice and eventually to the PCMH 4th Level MEPRS to optimize value as a highly reliable and accountable System For Health.

MTF command team responsibilities—

- Conduct a bimonthly interim process review (IPR) to evaluate PCMH measures of performance and effectiveness.
- Manage enrollment and empanelment in collaboration with TRICARE regional offices to increase MTF PCMH enrollment by at least 5% over the next 3 years compared to FY12 average enrollment. If increased enrollment is not possible, PCMH providers and team size will be optimally aligned with empanelled population.
- Monitor NCQA recognition progress congruent with FY14 implementation deadline.
- Ensure effective education and training for team members on the core components of PCMH.
- Specify customer service, service recovery, and coordination of care in the performance standards for all assigned PCMH staff.
- Develop incentives for the PCMH team based on exceptional performance and quality targets.

3-10. Regional Medical Command Team

The RMC team implements the policy and guidance from the MEDCOM PCMH Task Force (TF) across all regional primary care practices to achieve The Surgeon General’s goal of an excellent and consistent patient experience. The RMC team will drive effective PCMH implementation and recognition for its practices and will support their optimal performance and successful sustainment. The RMC team will provide relevant and tailored PCMH training for all practices. The composition of the team will include appropriately trained personnel to leverage credibility and expertise for effective implementation and sustained operations as detailed in FRAGO 1 of OPORD 11-20—

- RMC core team members—
  - PCM (physician, NP, PA).
  - RN.
  - Administrative officer.
  - Senior non-commissioned officer.
  - Medical informatics expert/clinical systems trainer.
- RMC augmentation team members—
  - BH provider.
  - CP.
  - Dietitian.
  - Population health expert.
- RMC team responsibilities—
  - Conduct SAV using the OIP guide for verification of MTF site assessment and gap analysis.
  - Coordinate education and training of MTF PCMH teams.
- Apply the PCMH standards.
- Provide oversight for the region’s PCMH implementation progress.
- Monitor PCMH and promote performance through participation in regional and MEDCOM data reviews and reports.
- Conduct the OIP of the MTFs within the region.
Effective, engaged leaders are essential to PCMH success. OTSG/MEDCOM identifies and communicates the end state according to The Surgeon General’s Army Medicine 2020 Campaign Plan and directs standards and policy for the RMC and MTF commanders. Compliance is tracked through continual metric surveillance and networked communication with PCMH leaders. The Deputy Commanding General for Operations is responsible to ensure effective implementation and operation of PCMHs that deliver an excellent and consistent patient experience.

The nucleus of the team is the MEDCOM PCMH Transformation Team within the Healthcare Delivery Directorate of the G-3/5/7, assisted by the One Staff.

OTSG/MEDCOM responsibilities—

- Develop and review PCMH governing policies and procedures.
- Monitor PCMH transformation and implementation process.
- Develop educational requirements and material for PCMH teams.
- Educate and train RMC PCMH teams.
- Track practice performance.
- Link Army PCMH leaders in regular updates to ensure rapid synchronization of guidance and requirements for successful Operating Company Model performance.
- Provide OIP requirements for both RMC and MTF PCMH teams.
- Develop “Handshake Medicine” policies and procedures to guarantee an excellent and consistent patient experience and effective transitions for both patients and staff from one location to another across Army Medicine.
CHAPTER FOUR
PCMH STANDARDS AND COMPLIANCE

This chapter defines standards and compliance for PCMH organizations across the patient journey to ensure that the delivery of health services is accountable, reliable, and effective and ensures an excellent and consistent patient experience. PCMH is key to our Army Medicine 2020 objective of accountable, reliable, and effective health services. We operate in a cost culture environment supported by a resource framework, nested within an Operating Company Model, directly linked to performance supported by relevant and reliable metrics. The Surgeon General is committed to value outcomes over activity as we generate capacity to impact the lives of more beneficiaries by improving health and satisfaction while controlling cost and reducing unwarranted variation and waste.

4-1. Medical Expense and Performance Reporting System

All Army PCMH teams and practices will use DOD and Army MEPRS Program Office (AMPO) guidance and business rules for 4th-level B*Z* MEPRS code by employing approved and standardized file and table builds in multiple systems that will align and support the B*Z* Army Medical Home MEPRS code obtained from AMPO. This requirement enables the tracking of performance and effectiveness data at the team and practice level which is essential to show improved outcomes through the PCMH.

No later than 120 days after AMPO approves 4th-level B*Z* MEPRS codes, MTFs will transition to new MEPRS codes and deactivate legacy codes. OTSG/MEDCOM and AMPO will review financial systems and Composite Health Care System (CHCS) files and tables to validate correct implementation and data quality.

4-2. Defined Performance Standards

The PCMH model is based on the premise that a strong primary care foundation for each beneficiary is required to maximize healthcare quality, optimize patient empowerment, and lower overall costs. Successful PCMH practices achieve their full potential to improve the healthcare experience by providing: continuity and coordination of care, proactive population-based health management, preventive and wellness services, and support for patient self-management. Several performance measures are monitored at various levels of the MHS (see fig 4). MTFs remain accountable for the performance of tactical level measures for all tasks of OPORD 09-36 and both FRAGO 1 & 2 to OPORD 09-36, unless otherwise superseded by OPORD 11-20.

Strategic-level metrics (table 3 and fig 4) will be monitored monthly by MEDCOM PCMH TF and analysts on behalf of the Deputy Commanding General for Operations. RMCs and MTFs will drive successful and effective PCMH value through continuous monitoring of PCMH performance. January 2013 strategic metrics, grouped by alignment with Military Health System Quadruple Aim, are—
• QUAD AIM. Stewardship
  o Enrollment from primary care empanelment tool.
  o ER utilization.
  o Network leakage of primary care (where enrollees go for care).
• QUAD AIM. Patient experience
  o PCM by name continuity (percentage).
  o Patient satisfaction (% satisfaction from APLSS question 20).
  o Staff satisfaction (Health Affairs staff satisfaction survey).
• QUAD AIM. Quality
  o HEDIS® composite score.
• QUAD AIM. Readiness
  o Medical readiness category (MRC) category 4 (periodic health assessment).

Figure 4 captures key PCMH/SCMH performance metrics.
4-3. The Practice Status Report

The PCMH and SCMH readiness assessment matrix transforms to the practice status report during implementation Phase III. The readiness assessment criteria are reportable to MEDCOM on a monthly basis and are scored as follows and are delineated in tables 1 (PCMH) and 2 (SCMH):

- Red = 0
- Amber = 0.5
- Green = 1.0

The sum of all factors defines the overall level of readiness. A total of 7.5 points is the minimum level to operate as a PCMH; a total of 13 points is the minimum level to operate as a SCMH. Of note, PCMH practices containing SCMHs will be held to the 13 point minimum. Table 1 (PCMH) and table 2 (SCMH) list the red, amber, green criteria by focus item. Note: SCMHs must complete table 1 and table 2.

<table>
<thead>
<tr>
<th>PCMH Readiness Assessment</th>
<th>Scoring Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Optimize Empanelment</td>
<td>PCMs empanelled according to OPORD 11-20, FRAGO 8, Annex I, Change 1 (G= +/- 5% max capacity; A= +/- 10% max capacity; R= more or less than 10% capacity); available clinical FTE must be validated by MTF commander or designated surrogate</td>
<td></td>
</tr>
<tr>
<td>2. PCM Exam Rooms/FTE (2 min)</td>
<td>PCM exam rooms. (G &gt; 2.0; A=1.8 - 2.0; R&lt;1.8 exam room per provider FTE)</td>
<td></td>
</tr>
<tr>
<td>3. PCM Support Staff per PCM FTE (3.1 personnel)</td>
<td>PCM core support team = number of support staff per PCM FTE; (G &gt; 2.8; A=2.6 - 2.8; R&lt;2.6 support staff)</td>
<td></td>
</tr>
<tr>
<td>4. RN Case Manager Support</td>
<td>Nurse case manager. (G= +/- 5% staff ratio (1 per 6200 enrollees); A= +/- 10% staff ratio; R= more or less than 10% staff ratio); includes NCM from Medical Management Center; does not include BH-case manager</td>
<td></td>
</tr>
<tr>
<td>5. Practice Manager Support</td>
<td>Practice manager. (G=1 per 8-12K enrollees; A=1 per 12-17K enrollees; R= 0 or 1 per &gt;17K enrollees)</td>
<td></td>
</tr>
<tr>
<td>6. Behavioral Health Integration</td>
<td>Behavioral health integration: IBHC provider on board (G=1 FTE per 1500-7500 enrollees and in synch with embedded BH teams (eBHs); A=1 IBHC or in synch with eBH team per brigade (BDE); R = neither 1 IBHC nor in synch with eBH)</td>
<td></td>
</tr>
<tr>
<td>PCMH Readiness Assessment</td>
<td>Scoring Criteria</td>
<td>Score</td>
</tr>
<tr>
<td>---------------------------</td>
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<tr>
<td>7. 4th Level MEPRS</td>
<td>4th Level MEPRS. (G=MEPRS Code active and validated by MEDCOM; A=MEPRS request (Attachment 3 IAW OPORD 11-20, FRAGO 7, Annex M) approved by MEDCOM, but not active or validated by MEDCOM; R= MEPRS request not approved by MEDCOM)</td>
<td></td>
</tr>
<tr>
<td>8. PCMH core training (17 modules plus TeamSTEPPS™ and PCTS orientation)</td>
<td>Training must be completed within 90 days of joining PCMH staff and documented in Digital Training Management System (DTMS) annually; (G= 90% of on hand staff current; A= 70-90% current; R&lt;70% current)</td>
<td></td>
</tr>
<tr>
<td>9. Secure Messaging, TSWF, MAPS2.0 Workflow Optimization, Training, &amp; Infrastructure</td>
<td>AMSMS and MAPS 2.0 trained (IAW AMSMS OPORD 12-57 and MAPS 2.0 OPORD11-47) and documented in DTMS (G &gt;90% staff designated to use AMSMS and MAPS 2.0 Phase III complete; A=70-90% and MAPS 2.0 Phase II complete; R&lt;70% and/or MAPS 2.0 Phase II not complete)</td>
<td></td>
</tr>
<tr>
<td>10. Pharmacist Integration</td>
<td>Integrated clinical pharmacist must be directly involved in medication management, aligned with the empanelled patients and their care team, and integrated within team-based workflow. Specified staffing ratio is 1 pharmacist per 6500 enrollees. (G = 1 pharmacist to 5800-7200 enrolled; A = 1 per &lt;5800 or &gt;7200 or 1 per 5800-7200 but supporting remotely; R = no pharmacist aligned with PCMH/SCMH, or pharmacist only dispensing medication)</td>
<td></td>
</tr>
</tbody>
</table>

PCMH Total Score
Greater than or equal 7.5 = min score to operate effectively

Table 1. PCMH Readiness Assessment Matrix

<table>
<thead>
<tr>
<th>SCMH Readiness Assessment</th>
<th>Scoring Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Installation Specific Health Service Plan (ISHSP) IAW DA EXORD 015-10</td>
<td>G= ISHSP signed by senior commander and RMC CG; A= ISHSP in staffing, but unsigned; R= no ISHSP in staffing</td>
<td></td>
</tr>
<tr>
<td>12. Lab on site</td>
<td>G= Full lab on site or specimens obtained on site with submission for processing in &lt;24 hours; A= Lab or draw capability within walking distance of the SCMH; R= Lab or draw capabilities not within walking capabilities of the SCMH</td>
<td></td>
</tr>
<tr>
<td>SCMH Readiness Assessment</td>
<td>Scoring Criteria</td>
<td>Score</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------</td>
<td>-------</td>
</tr>
<tr>
<td>13. Pharmacy on site</td>
<td>G= Full pharmacy on site at SCMH; A= Partial pharmacy on site or within walking distance of the SCMH; R=Satellite pharmacy not within walking distance of the SCMH</td>
<td></td>
</tr>
<tr>
<td>14. Radiology on site</td>
<td>G= Radiology suite on site with full plain film capabilities and ASAP radiologist interpretation; A= Radiology capability within walking distance of the SCMH and ASAP radiologist interpretation; R= Radiology capabilities not within walking capabilities of the SCMH or radiologist interpretation not available within 4 hours of x ray completion</td>
<td></td>
</tr>
<tr>
<td>15. PT area on site</td>
<td>G= Functional PT area on site; A= Functional PT area at satellite location within walking distance of SCMH; R= PT area at MTF only</td>
<td></td>
</tr>
<tr>
<td>16. Physical therapist integration</td>
<td>Integrated physical therapist must be on site; aligned with assigned Soldiers, their unit providers, and the rest of the care team; and integrated within the team-based workflow. Specified staffing ratio is 2 per BDE or BDE equivalent (4000 Soldiers). (G= 2.0 FTE per BDE or BDE equivalent; A= &lt; 2.0 FTE or 2.0 FTE aligned with BDE but supporting remotely within walking distance of SCMH; R= No physical therapist on site or within walking distance)</td>
<td></td>
</tr>
<tr>
<td>17. Dietitian integration</td>
<td>Integrated dietitian must be aligned with empanelled patients and their care team and integrated within team-based workflow. Specified staffing ratio is 1 dietitian per 7500 enrollees. (G = 1 per 6700-8300; A = 1 per &lt;6700 or &gt;8300 OR 1 per 6700-8300, but supporting remotely; R = no dietitian aligned with SCMH)</td>
<td></td>
</tr>
<tr>
<td>SCMH Total Score</td>
<td>Greater than or equal 13.0 = min score to operate effectively</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. SCMH Readiness Assessment Matrix

4-4. Performance Measure Dictionary

The Army PCMH Key Performance Measure Dictionary (see table 3) lists key performance measures for PCMH and SCMH that are evaluated at various levels of the organization on a monthly or quarterly basis. The dictionary includes the name of the measure, operational definition, data source, and reporting frequencies and thresholds for red, amber, and green. Furthermore, detailed practice-specific guidance to manage the day-to-day business will be codified in a group practice manual that identifies specific tasks to ensure success.
<table>
<thead>
<tr>
<th>MEASURE</th>
<th>OPERATIONAL DEFINITION</th>
<th>AMBER THRESHOLD</th>
<th>GREEN THRESHOLD</th>
<th>MTF TO RMC</th>
<th>RMC TO MEDCOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled to Capacity</td>
<td>Percentage representing the gap from the calculated empanelment cap using the PCMH Empanelment Tool</td>
<td>5-10% above/below capacity</td>
<td>&lt; 5% above or below PCM Capacity</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>ER Utilization</td>
<td># of visits to the ER per 100 enrollees per year</td>
<td>40-50</td>
<td>&lt;40</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Primary Care Leakage</td>
<td>Primary care RVUs completed in network compared with total primary care RVUs for enrollees</td>
<td>3-5%</td>
<td>&lt;3%</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>PCM Continuity</td>
<td>Primary care visits (ACUT, OPAC, WELL, EST, ROUT, and PCM) where the patient saw their assigned PCM (Includes when PCM was seeing patients and when PCM was not seeing patients)</td>
<td>55%-64%</td>
<td>&gt;64%</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>% of patients satisfied with overall clinic visit (Q20 from Army Provider Level Satisfaction Surveys)</td>
<td>90-95%</td>
<td>&gt;95%</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Staff Satisfaction</td>
<td>Staff satisfaction according to the Health Affairs Primary Care Satisfaction</td>
<td>63-67%</td>
<td>&gt;67%</td>
<td>Q</td>
<td>Q</td>
</tr>
<tr>
<td>HEDIS Composite</td>
<td>Composite of eight NCQA health service performance metrics: screening for cervical cancer, breast cancer, colon cancer, chlamydia; diabetes x3, asthma control</td>
<td>60-87.5% Composite score – 24/40 = 60% (points per metric based on percentile)</td>
<td>&gt;87.5% Composite score – 35/40 = 87.5% (points per metric based on percentile)</td>
<td>M</td>
<td>M</td>
</tr>
<tr>
<td>Medical Readiness (MRC4)</td>
<td>Percent of Soldiers that have not had a PHA within the past 12 mos.</td>
<td>5-8%</td>
<td>&lt;5%</td>
<td>M</td>
<td>M</td>
</tr>
</tbody>
</table>
Table 3. Army PCMH Key Performance Measure Dictionary

Appendix A

References

Section I
References pertinent to this Operations Manual
All references will be maintained on the Army PCMH Resource Center web site at https://mitc.amedd.army.mil/SITES/COMMUNITIES/APCMHRC/Pages/default.aspx

Section II
PCMH Annexes and Leader Guides

• Annexes
  o Army Wellness Center (AWC)
  o Behavioral Health
  o Clinical Pharmacy Services
  o Community Based Medical Home
  o Comprehensive Pain Management
  o New Patient Enrollee
  o Nutrition Care Services
  o Physical Therapy
  o Performance Triad
  o Reception and Transitions

• Leader Guides
  o Soldier Centered Medical Home
Appendix B

Extended Team Members DMHRSi Documentation for Support to the Medical Home Practice(s)

- **DMHRSi personnel assignment**
  - All employee DMHRSi organization assignments (tables of distribution and allowances (TDA) authorization) will be consistent with the employee’s TDA assignment.
  - Employees who are physically working in the Medical Home practice location for **30 days or more**, the DMHRSi People Group assignment will be the first Home listed on the TDA for that practice (Home A).
    - Behavioral Health Service Line (BHSL): All IBHCs will have authorization from a BHSL TDA Org.
  - Employees who are physically working in the Medical Home practice location for **less than 30 days** will be considered borrowed internally. The People Group will remain their primary work center (DMHRSi People Group organization).
  - Employees, who support a Medical Home practice, but are not physically performing the work at the Medical Home location, will have a DMHRSi People Group of the organization (work center) where they are physically performing the work.

- **DMHRSi tasks**
  - Each Medical Home practice will be assigned a unique cost pool MEPRS code/functional cost code (FCC) (B*X*).
  - Extended team members will report their task time to the appropriate practice cost pool MEPRS code/FCC based on where services were rendered.
    - When services are rendered in a physical location outside the Medical Home practice, the man hours will be charged to the task that represents the work center where the work was performed.
  - If an extended team member is supporting multiple practices, they will report their task time associated with that support to each of the practice cost pool MEPRS codes/FCCs as appropriate. Figure B-1 provides an example—

<table>
<thead>
<tr>
<th>Practice</th>
<th>Home</th>
<th>Home Designation</th>
<th>Cost Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRACTICE A</td>
<td>BGZA</td>
<td>A</td>
<td>BGXA</td>
</tr>
<tr>
<td>PRACTICE A</td>
<td>BGZB</td>
<td>B</td>
<td>BGXA</td>
</tr>
<tr>
<td>PRACTICE A</td>
<td>BGZC</td>
<td>C</td>
<td>BGXA</td>
</tr>
<tr>
<td>PRACTICE B</td>
<td>BGZD</td>
<td>A</td>
<td>BGXB</td>
</tr>
<tr>
<td>PRACTICE B</td>
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<td>BGXB</td>
</tr>
<tr>
<td>PRACTICE B</td>
<td>BGZF</td>
<td>C</td>
<td>BGXB</td>
</tr>
<tr>
<td>PRACTICE B</td>
<td>BGZG</td>
<td>D</td>
<td>BGXB</td>
</tr>
</tbody>
</table>

*Figure B-1. DMHRSi Cost Pool Task Cross-Walk*
• **CHCS clinic locations/MEPRS/schedules**
  o Extended team members will build 1 schedule per practice for optimal capacity.
  o The schedule/template should be built against Home A of the practice.
  o Medical Home administrative personnel will update end of day (EOD) processing after the AHLTA encounter has been completed and signed to reflect the MEPRS code/FCC associated with the empanelment of the patient from that practice.

• **Workflow and time reporting**
  o Patients are booked with extended providers using the one schedule per practice; this will ensure optimal capacity.
  o Patients arrive and are checked into AHLTA; the extended team member documents, completes/signs note within 72 hours as directed by the coding timeliness standards.
  o An administrative member of the practice will perform EOD processing and change the MEPRS code/FCC to reflect where the patient is empaneled.
  o Extended team members will report their DMHRSi task time to the appropriate cost pool MEPRS code/FCC associated with the practice they are supporting.

**Notes/recommendations**

- EOD can occur, but not recommended, prior to AHLTA note being completed/signed.
  - No write-back errors are known to be linked to this process.
- It is known, and recognized, that AHLTA and CHCS will not match.
- Use your CarePoint Reports to help aid in EOD processing.

**EXAMPLE 1**
**Extended Team Member Support to Single Practice**

During the month of December 2013, Social Worker Williams whose primary mission is in support of Medical Home Practice B, consisting of four homes (BGZD, BGZE, BGZF, BGZG), is People Group assigned to the MEPRS code/FCC BGZD as primary duty station.

- Medical Home Practice B will build one schedule for Social Worker Williams in Home A (BGZD) for the whole practice to ensure optimal patient care capacity is available.
- EOD processing will remain the responsibility of the administrative support staff from the practice and should be completed after the extended team member has signed/completed their AHLTA note (72 hour coding timeliness standard).
- The EOD process should reflect the MEPRS code/FCC associated with the Home to which the patient is empaneled.
- Social Worker Williams DMHRSi time reporting needs to reflect the cost pool MEPRS code/FCC task time in support of the Practice (BGXB) when performing clinic practice functions. (See fig B-2.)
EXAMPLE 2
Extended Team Member Support to Multiple Practices

During the month of December 2013, Psychologist Smith whose primary mission is in support of Medical Home Practice A is also providing cross-coverage support to Practice B. **Note:** Support to another practice by definition means the extended team member is physically going over to a different practice location and treating patients within the confines of the other practice. Psychologist Smith is People Group assigned to the MEPRS FCC BGZA as primary duty station.

- Medical Home Practice A, which consists of three Homes (BGZA, BGZB, BGZC), will build one schedule for Psychologist Smith in Home A (BGZA) for Practice A to ensure optimal patient care capacity is available.
- For the dates/times Psychologist Smith is also providing extended team member services support to Practice B, Psychologist Smith’s schedule in support of Practice B will be built against Home A (BGZD) of Practice B for those dates/times supporting that Practice.
- EOD processing will remain the responsibility of the administrative support staff from the practice and should be completed after the extended team member has signed/completed their AHLTA note (72 Hour Coding Timeliness).
- The EOD process should reflect the MEPRS code/FCC associated with the Home to which the patient is empanelled.
- Psychologist Smith DMHRSi time reporting needs to reflect the cost pool MEPRS code/FCC task time in support of both practices (i.e., BGXA and BGXB) when supporting those tasks/missions. (See fig B-3.)

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### Figure B-3. Example of Support to Multiple Practices

<table>
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<tr>
<th>Practice</th>
<th>Home</th>
<th>Designation</th>
<th>Provider</th>
<th>FYFM</th>
<th>ORG TDA Assignment</th>
<th>PG4 Assignment</th>
<th>CHCS Schedule / Template</th>
<th>CHCS EOD</th>
<th>CHCS Encounters</th>
<th>DMHRSi Task Time Reporting</th>
<th>DMHRSi Task Time FTE</th>
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<td>Williams, Social Worker</td>
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39
OTSG/MEDCOM G-3/5/7 Jan 2014; Version 2
FEEDBACK AND IMPROVEMENTS

The MEDCOM Primary Care Service Line welcomes feedback and improvements to this Operations Manual. Recommendations can be communicated via the link at, https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/default.aspx the Army PCMH Resource Center webpage for PCMH. All recommendations will receive consideration and response. A series of active tasks is being worked as Task Action Plans by the PCMH TF. As these action items are completed, additional standards and capabilities will be included in periodic updates to the PCMH Implementation and Operations Manuals. All updates will be sent electronically through wide distribution and will be posted on PCMH Resource Center SharePoint sites.