ARMY PCMH Implementation Manual
Leaders Guide to Army Patient Centered Medical Home Transformation

U.S. Army Medical Command
30 January 2014
Executive Summary

The Patient Centered Medical Home (PCMH) is the foundation of health and readiness for all our beneficiaries and will be the key element for transformation from a healthcare system to a System For Health. Timely implementation is essential for our strategic success.

Implementation is divided into two phases. During the preparation phase a leadership team (guiding coalition) is assembled, leaders share the vision with their organization, and a standard readiness assessment is completed in which personnel, process, equipment, and training requirements are identified. During the recognition phase, practices receive approval to enter the NCQA recognition process and the PCMH practice’s multi-disciplinary team is assembled and trained to work together utilizing proven processes and key enablers such as MAPS 2.0, secure messaging, service recovery matrix, etc. Successful completion of the recognition phase is marked by an officially validated PCMH practice which has achieved a minimum state of readiness, attained level II or higher NCQA recognition, and completed the region-led staff assessment visit. Once validated, the practice will continue to improve and refine the processes; incorporate advanced practices; gain efficiency; and achieve better health and readiness outcomes. Our patients will be active partners and our staff more empowered and integrated. Care will be seamlessly coordinated and systems will be aligned resulting in a consistent, quality experience, and—ultimately—better health for those we serve.

Army Medicine, indeed health care in the United States, is at a cross roads. PCMH will set our true north and establish the irreversible momentum we need to continually improve readiness, resilience, and ensure we are the health system of choice for all our beneficiaries. Our Nation depends on our ability to improve the health of those that have worn and continue to wear the cloth of our Nation and the Families that support them. PCMH will serve as the foundation for ensuring the ultimate patient care experience and serve as the bridge to our patients’ health decisions in the Lifespace.

The PCMH Implementation Manual establishes the standards and methods for initial implementation of the Army PCMH model. The Operations Manual describes the quality, responsive, and comprehensive care we provide as a more patient-centered System For Health.

Serving to Heal…Honored to Serve!

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CHAPTER ONE
INTRODUCTION

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 a Patient Centered Medical Home (PCMH). The Army has developed a standard PCMH implementation model called the Army PCMH. This model applies to all primary care platforms including Soldier Centered Medical Homes (SCMHs) and Community Based Medical Homes (CBMHs).

This Implementation Manual defines the standard methods and processes for implementation of the Army PCMH model. Key tasks and performance metrics are highlighted in figure 1. It is written for leaders at all levels of the organization: practice, department, military treatment facility (MTF), and regional medical command (RMC). It assumes leader engagement and commitment to transformation.

At end state, Army PCMHs will—
• Deliver a high quality and consistent patient experience that inspires our beneficiaries to choose Army Medicine.
• Minimize unwarranted variance and improve operating efficiency and effectiveness.
• Build capacity in the direct care system.
• Serve as a platform for achieving our strategic imperatives: create capacity, enhance diplomacy, and improve stamina.
• Extend our influence in the Lifespace in order to invigorate the Performance Triad: activity, nutrition, and sleep.

Army PCMH also serves as an integrating function in Army Medicine. Army PCMH is the common platform through which related initiatives are synchronized and integrated.

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.
CHAPTER TWO
ARMY PCMH IMPLEMENTATION

The Implementation Roadmap (fig 2) defines the phases and critical tasks required to implement and operate the Army PCMH. Tasks can run sequentially and concurrently within each phase. Tasks such as readiness assessment, gap analysis, and training are ongoing activities that are dynamic in nature and require constant review and adjustment over time. Implementation ends at the completion of phase II. A practice will receive Medical Home status when it meets three criteria: 1) practice readiness assessment score of 7.5 or greater for a PCMH and 13.0 or greater for an SCMH, 2) National Committee for Quality Assurance (NCQA) recognition level 2 or higher, and 3) successful completion of a staff assessment visit (SAV) by the RMC Transformation Team utilizing the Organizational Inspection Program (OIP) checklist as outlined in Phase II, Task 5 of this manual. The MTF and RMC will report implementation progress and performance on a regular basis as specified in OPORD 11-20 and associated FRAGOs.

Figure 2. Implementation Roadmap
2-1. Phase 1: Prepare

Preparation involves all pre-implementation tasks and activities required to ready the PCMH practice(s) to receive NCQA recognition and operate as an Army PCMH. The preparation phase occurs prior to initiating the NCQA recognition process and should take no longer than 180 days. The conversion to a standardized Medical Expense and Performance Reporting System (MEPRS) code begins in this phase and is critical to performance measurement and accountability of financial and human resources in the PCMH.

Task 1. Create a guiding coalition

The guiding coalition is the multidisciplinary team constituted and empowered to implement the Army PCMH model across all primary sites under the authority of the MTF commander.

Key characteristics of an effective guiding coalition include—

- **Multidisciplinary.** The guiding coalition will include primary care representation, along with other sections, or departments that represent the Accountable Care Organization (ACO) (see Note, below). Membership includes, at a minimum—
  
  o Primary care
  o Specialty care
  o Managed care
  o Resource management
  o Facilities
  o Referral management
  o Clinical services
  o Human resources
  o Public affairs
  o Information management
  o Unit practice council ((Patient Caring Touch Systems (PCTS))
  o The patient and family

- **Empowered.** The MTF commander ensures that the guiding coalition is seen and respected by others in the MTF so that the group’s decisions are effective.

- **Connected.** The guiding coalition is the designated point of contact for communications to and from the RMC.

- **Enduring.** The work of the guiding coalition continues throughout the implementation process.

- **Accountable.** Members are accountable for the health of the patient and
performance of the practice. Accountability is formalized through written performance objectives that support the organization’s goals.

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.

Task 2. Communicate the vision

Communication is an enduring leadership responsibility and must be accomplished throughout the implementation and sustainment of the PCMH. MTF commanders and leaders will use every opportunity to relay the vision and purpose of Army PCMH transformation: emails, meetings, presentations. Effective communication supporting transformation of this magnitude must be—

- Simple and clear: Avoid jargon.
- Vivid: A verbal picture is worth a thousand words—use metaphor, analogy, and example.
- Repeatable: Ideas should be infectious to be spread by anyone to anyone.
- Invitational: Two-way communication is always more powerful than one-way communication.

Task 3. Conduct baseline readiness assessment using the PCMH readiness assessment criteria

The readiness assessment criteria define the baseline from which a gap analysis is developed. These standard criteria are reportable to MEDCOM and are scored as follows and detailed in tables 1 and 2:

- 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 SCMH homes will be held to the 13 point minimum. Tables 1 and 2 list the red, amber, and green criteria by focus item. Note: SCMHs must complete both table 1 and table 2. Each focus item is aligned with the implementation phase during which the MTFs should become fully capable for that respective focus item.
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<th>PCMH Readiness Assessment</th>
<th>Phase</th>
<th>Scoring Criteria</th>
<th>Score</th>
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<tr>
<td>1. Optimize Empanelment</td>
<td>1</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>
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<tr>
<td>2. PCM Exam Rooms/FTE (2 min)</td>
<td>1</td>
<td>PCM exam rooms. (G &gt; 2.0; A=1.8 - 2.0; R&lt;1.8 exam room per provider FTE)</td>
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<tr>
<td>3. PCM Support Staff per PCM FTE (3.1 personnel)</td>
<td>2</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>
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<tr>
<td>4. RN Case Manager Support</td>
<td>2</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>
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<tr>
<td>5. Practice Manager Support</td>
<td>2</td>
<td>Practice manager. Specified staffing ratio is 1 practice manager per 10K enrollees. (G=1 per 8-12K enrollees; A=1 per 12-17K enrollees; R= 0 or 1 per &gt;17K enrollees)</td>
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<tr>
<td>6. Behavioral Health Integration</td>
<td>2</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>
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<td>7. 4th Level MEPRS</td>
<td>2</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>
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<td>8. PCMH core training (17 modules plus TeamSTEPPS™ and PCTS orientation)</td>
<td>2</td>
<td>Training must be completed within 90 days of joining PCMH staff and documented in Digital Training Management System (DTMS) annually; (G&gt; 90% of on hand staff current; A= 70-90% current; R&lt;70% current)</td>
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<td>9. Secure Messaging, TSWF, MAPS 2.0 Workflow Optimization, Training, &amp; Infrastructure</td>
<td>2</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>
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<td>10. Pharmacist Integration</td>
<td>3</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>
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**PCMH Total Score**

**Greater than or equal 7.5 = min score to operate effectively**

*Table 1. PCMH Readiness Assessment Tool*
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<th>CMH Readiness Assessment</th>
<th>Phase</th>
<th>Scoring Criteria</th>
<th>Score</th>
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<tr>
<td>11. Installation Specific Health Service Plan (ISHSP) IAW DA EXORD 015-10</td>
<td>1</td>
<td>G= ISHSP signed by senior commander and RMC CG; A= ISHSP in staffing, but unsigned; R= no ISHSP in staffing</td>
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<td>12. Lab on site</td>
<td>1</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>
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<tr>
<td>13. Pharmacy on site</td>
<td>1</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>
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<td>14. Radiology on site</td>
<td>1</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>
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<tr>
<td>15. PT area on site</td>
<td>1</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>
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<td>16. Physical therapist integration</td>
<td>3</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>
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<td>17. Dietitian integration</td>
<td>3</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>
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**SCMH Total Score**  
Greater than or equal 13.0 = min score to operate effectively

*Table 2. SCMH Readiness Assessment Tool*
**Task 4. Perform gap analysis**

The readiness assessment criteria define the baseline for the gap analysis. The Military Health System (MHS) provides funds to the Army to hire primary care manager (PCM) support staff such as registered nurse (RN), licensed practical nurse (LPN)/licensed vocational nurse (LVN), medical support assistant (MSA), and the integrated behavioral health consultant. For detailed explanation of the composition of the 3.1 support staff, see MEDCOM PCMH FAQ: “What comprises the 3.1 staff ratio specified in the PCMH OPORD” at PCMH Web site: https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/default.aspx

Funding for clinical pharmacists and dietitians is from core funds or through unfinanced requirement (UFR) submissions.

In FY14, PCMH will be funded utilizing the Integrated Resource Incentive System. This is a change from the previous methodology which used the gap analyses completed between RMCs and the PCMH service line to meet NCQA standards.

Activities will conduct staffing gap analysis using the MEDCOM-approved PCMH Support Staff Gap Assessment Template. This template is available at the PCMH portal and through each RMC PCMH task force. The gap analysis is submitted through the RMC to the Office of The Surgeon General (OTSG) for approval.

Funds distribution will be based on personnel required to meet the enrollment projections set forth in the activity’s FY14 Performance Plan. The identified gap should synchronize with additional personnel required to meet those enrollment projections.

The required PCMs and core support staff are auto calculated based on the staffing ratio in OPORD 11-20, annex D. The MTF enters “on-hand” staffing, including existing open vice hiring actions. Clinical nurse officers in charge (CNOICs)/non-commissioned officers in charge (NCOICs) and staff assigned in a table of distribution and allowances (TDA) position not working in the PCMH count as “on-hand.”

Gap analysis results determine funding and hiring requirements. Once the gap analysis is validated by the RMC, it is the official record of requirement. Subsequent re-analysis is not authorized unless a fundamental resourcing requirement has changed such as a significant population shift or a decrease in military personnel staffing levels both of which impact support staff requirements or ratios.

**Task 5. Apply for 4th level MEPRS requirements as specified by the Army MEPRS Program Office**

All Army PCMH homes and practices will use Department of Defense (DOD) and Army MEPRS Program Office (AMPO) guidance and business rules for 4th-level B*Z* MEPRS code using 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 the AMPO.
Requests for B-Z* Army Medical Home MEPRS codes should be submitted to the MTF MEPRS analyst who will forward through the RMC to the AMPO for approval. The AMPO is the only approval authority for MEPRS codes. No later than 30 days prior to receiving an NCQA license, the practice completes the AMPO Army Medical Home attachment (earlier submission is encouraged). The AMPO and MEDCOM PCMH task force will review and approve submissions within 14 days of receipt.

Detailed instructions on the establishment of the new MEPRS codes can be found in OPORD 11-20 FRAGO 5 and 7 as well as the most recent version of the AMPO guidance published each fiscal year and posted to the PCMH Resource Center: https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/ResourceManagementDivision(RMD).aspx.

Task 6. Close the gaps

Closing the gaps occurs throughout the implementation process spanning all phases. The readiness criteria in Table 1, above, helps to identify which gaps need to be closed to proceed to the next phase of implementation.

- **Personnel gaps**
  The validated support staff gap analysis is the authorization document to hire. Upon confirmation of fund availability, activities will initiate hiring actions as soon as possible to meet FY14 performance plan objectives. Regions track hiring actions in relation to the gap analysis. Once MTFs determine, RMC supports, and MEDCOM/OTSG approves the manpower mix required to support the transition to the PCMH delivery of primary care, MTFs must follow staffing guidance for their PCMH clinics in accordance with guidance provided by the MEDCOM Chief of Staff in a memorandum to the RMC commanders dated 7 May 2012 (available on the PCMH Resource Center: https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/ResourceManagementDivision(RMD).aspx). Additionally, management must ensure that personnel are aligned and placed against an authorized position in their PCMH TDA in accordance with OPORD 11-20, annex C (PCMH Structure). This process may take considerable time; therefore, the MTF may detail the existing staff and begin working under the new PCMH roles and responsibilities. Every effort should be made to effect no-cost lateral reassignments, from and to the same grade, to minimize the cost for the PCMH.

  PCMH team members work at the “top of their license, scope of practice, or scope of competency.” MEDCOM has classified and published standard job descriptions for most positions in the PCMH. Some classifications are at a higher grade than legacy positions. Use of new position descriptions is required to ensure that the care team can operate at higher levels and perform the new work required in the PCMH model. The MTF can submit UFRs to fund upgrading existing staff to a higher grade. MTFs must engage with the local Civilian Personnel Advisory Center and Union to ensure
compliance with labor and hiring practices as needed. Hiring and manning plans must be completed in advance of the resourcing year. The comprehensive list of standardized position descriptions is available through RMC and MEDCOM Human Resources and posted on the PCMH Resource Center: https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Documents/Forms/AllItems.aspx.

- **Training gaps**
  Core Content training, Team Strategies and Tools to Enhance Performance and Patient Safety™ (TeamSTEPPS™) training, Medical Applications and Process Solutions (MAPS 2.0)/TriService Workflow (TSWF) training, and Integrated Clinical Database (ICDB)/CarePoint (“PCMH Huddle Tool”) are critical training elements for the PCMH. Training can begin in the Prepare Phase with practice ready and trained by the end of the Recognize Phase. 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.

- **Facilities/equipment/information technology gaps**
  RMCs will conduct facility assessments to meet the two-exam-room-per-provider-readiness criteria and optimize facility utilization to support PCMH implementation. If external funding is required for facility modification projects, activities should submit a UFR through their region to the MEDCOM PCMH Taskforce. Upon approval, the MEDCOM PCMH Taskforce will submit the UFR to MEDCOM G8/9 for prioritization and resourcing.

  RMCs will conduct similar assessments for medical and information technology equipment to support PCMH. Funding will be processed through normal Capital Equipment Expense Program channels specifically identified in support of PCMH. CBMHs follow a MEDCOM standardized facility and equipment model. The facility model, with three exam rooms per PCM, supports larger panels if staffing levels and the other factors referenced in OPORD 11-20, Annex I are present.

2-2. Phase II: Recognize

Army Medicine’s goal is for all direct care enrollees to be seen in an Army PCMH recognized by NCQA as Level 2 or above no later than 1 October 2014. The RMC will conduct an SAV using the OIP checklist criteria for all practices. A key component of the SAV is the readiness assessment to determine when a practice is ready to seek recognition. Scores of 7.5 for a PCMH and 13.0 for an SCMH are considered the minimum to operate effectively, but are not a limiting factor for seeking recognition. The practice will begin familiarization with the NCQA standards during the preparation phase and should be ready to begin the process immediately. Phase 2 begins when the practice receives an NCQA license. NCQA recognition will take no longer than 180 days.
The Surgeon General/MEDCOM Commander and the Deputy Commanding General for Operations are closely tracking the accelerated transformation of primary care into PCMH practices. Implementation actions that will be tracked strategically by MEDCOM are—

- Two exam rooms per provider.
- MAPS 2.0 training.
- 4th Level MEPRS code activated.
- Completed RMC SAV; using OIP checklist (successful performance on metrics is NOT required for transformation).
- NCQA level 2 or 3 recognition.

**Task 1. NCQA application**

Once practices are confirmed for participation in the NCQA recognition process, MEDCOM obtains a license specific for each practice. The MEDCOM POC will acquire, manage, and distribute NCQA licenses to the practice subject matter expert (SME). The practice will identify a primary and an alternate POC to serve as the practice SMEs. MEDCOM forwards the application packet (passwords and “how to” instructions) to each practice’s SME. Simultaneously, the practice’s commander receives a letter from the Deputy Commanding General of Operations outlining the requirements and road ahead for each practice. Phase II begins officially on the day the practice receives the NCQA license and the practice will have 180 days to complete the survey and receive recognition results. The practice provider, nurse, and administrative teams will work together to complete the survey for recognition. MEDCOM will coordinate the NCQA process through the RMC.

To facilitate your success, NCQA resources are listed on the Army PCMH Resource Center website: [https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/TransformationProducts.aspx](https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/TransformationProducts.aspx)

**Task 2. Training**

- **Core Content Training**
  The Army PCMH Core Content training has been developed by MEDCOM and will be provided by RMC Transformation Teams. Training modules are aggregated into two multi-day blocks of training: Step 1 and Step 2. Steps 1 and 2 can be completed in separate training sessions or in one combined session. Training is not restricted to primary care staff. All involved sections of the ACO attend training. Initial and sustainment training resources include the Army PCMH Interactive Multi-Media Instruction Suite produced through the AMEDD C&S and available online at the Army PCMH Resource Center or by DVD. DVD copies can be obtained by contacting the PCMH Task Force. Army PCMH Resource Center website: [https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/TrainingProducts.aspx](https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/TrainingProducts.aspx)
TeamSTEPPS™ training
TeamSTEPPS™ training is essential to enhanced care team performance and patient safety, and is, therefore, required training for all members of the Army PCMH. TeamSTEPPS™ training requirements are defined in MEDCOM OPORD 11-38 at the Office of Quality Management Web site: https://www.qmo.amedd.army.mil/ptsafety/TeamSTEPPS.htm

MAPS 2.0/TSWF training
In accordance with OPORD 11-47 (MEDCOM AHLTA PROVIDER SATISFACTION - MAPS) and subsequent FRAGOs, and following guidance provided in the MAPS 2.0 Executive Playbook with related training and implementation resources, MTF leaders ensure readiness, deployment, and sustainment of the standardized MAPS 2.0 program in every PCMH. TriService Workflow Alternate Input Method (TSWF AIM) templates for AHLTA with partnered MAPS tools are the required documentation tools used in the PCMH. MAPS 2.0 using TSWF is an essential component of patient-centered workflow. Leaders must ensure all clinical team members in the PCMH are properly trained in the standard workflow processes and tools included in the MAPS 2.0 program and that all necessary infrastructure, hardware, and software are available and functioning at peak performance. Adherence to the MAPS 2.0 standard program is monitored and enforced locally.

ICDB/CarePoint and PCMH huddle tool
Leaders will ensure that all staff in the PCMH responsible for huddle preparation have a Carepoint account and receive adequate training on the use of the Huddle Tool. Requests for Carepoint access are initiated through the MHS Population Health Portal: https://mhsphp.afms.mil/.

Army Medicine Secure Messaging Service
Army Medicine Secure Messaging Service (AMSMS) is a suite of capabilities intended to reduce reliance on telephonic patient communications and to replace some face-to-face visits related to chronic disease management. AMSMS is a secure system allowing communication between the patient and one or more members of their care team, as well as between members of the care team and outside consultants involved in the patient’s care.

AMSMS is intended to be the primary means of communicating between patients and team members. Dedicated staff must be identified and trained using the MEDCOM AMSMS standard train-the-trainer curriculum to maintain the system and provide sustainment training. This is an MTF and RMC responsibility with support from the MEDCOM Project Management Office and Capability Managers Office. Refer to AMSMS OPORD 12-57, any subsequent FRAGOS, and the supporting guide and related support materials all located at the PCMH Web site: https://mitc.amedd.army.mil/sites/CIO/Resources/ACSE/Pages/AMSMS_SecureMessaging.aspx.

Task 3. Optimize empanelment
Optimal provider panel size is the cornerstone of providing timely access and patient care management. The combination of provider available time to see patients, panel acuity, and patient utilization determine an optimal panel size for which access to comprehensive care is assured. The practice and ACO collaborate to achieve the following objectives: 1) optimum balance between PCM core team and PCM Home available time for care (face-to-face and virtual) and the measured demand by empanelled beneficiaries; 2) panel parity including even distribution among PCM core teams and PCMHs of high utilizer/high acuity patients or patients with multiple chronic conditions; 3) active monitoring, reporting, and management of access trends such as utilization rate, satisfaction with access, available clinician time, and movement of significant patient population over extended time periods such as deployments or base realignments.

For detailed guidance regarding determination of panel sizes, see PCMH OPORD 11-20 Annex and the PCMH Operations Manual.

**Task 4. Activate/implement 4th level MEPRS utilization**

Practices will transition to new MEPRS codes and deactivate legacy codes before the end of Phase II. It is imperative that practices aggressively act to accomplish this task to provide effective performance measurement and accountability of financial and human resources in the PCMH. The AMPO and MEDCOM Primary Care Service Line will review financial systems and Composite Health Care System (CHCS) files and tables to validate correct implementation and data quality after the new codes are operational. Practices in phase II are required to report weekly status reports through the RMC to the MEDCOM AMPO until the new codes are operational in accordance with OPORD 11-20, FRAGO 7, Annex M. [https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/ResourceManagementDivision(RMD).aspx](https://mitc.amedd.army.mil/sites/Communities/APCMHRC/Pages/ResourceManagementDivision(RMD).aspx).

**Task 5. Transformation assessment visit**

SAVs will be conducted by the RMC using the PCMH OIP checklist as the standard to assess successful implementation of core principles and standards within the PCMH practice and ACO, as well as provide guidance and support as needed. Successful achievement of performance benchmarks detailed in the tool is not required for Army PCMH recognition. The PCMH OIP checklist supports the healthcare delivery process by focusing on areas beginning with patient welcome and progressing through empanelment, the care team, accessing care, service standards and workflow, integrated care, patient activation, care coordination, and process improvement.

**Task 6. Submit an NCQA survey**

The practice completes the NCQA survey online through the NCQA website. The RMC will conduct a quality control review of the survey before submission. The goal is to
submit the survey in time to receive recognition within 180 days of receiving the license. NCQA can take up to 30 days to complete a full review. Practices will use the 2011 NCQA Standards. Practices must achieve a score of 50% or higher on must-pass elements. NCQA Standards are aligned with the six primary care core components—

- Enhance access and continuity.
- Identify and manage patient populations.
- Plan and manage care.
- Provide self-care and community support.
- Track and coordinate care.
- Measure and improve performance.

**Task 7. Become a validated Army Patient Centered Medical Home**

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

- Practice readiness assessment of 7.5 or greater for PCMHs (13.0 or greater for SCMHs).
- NCQA recognition level 2 or higher.
- Successful completion of an SAV by the RMC Transformation Team utilizing the OIP checklist.

**2-3. Phase III: Perform**

In Phase III, the clinic has achieved PCMH status and will have just begun the journey to operating as a PCMH. During Phase III, the practice will continue to close the resource gaps and implement advanced capabilities of the PCMH such as advanced access and extended team member integration. The Army PCMH Operations Manual and annexes are the official references for the Army PCMH.

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. 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.

January 2013 strategic metrics are—

- Enrollment from Enrollment Capacity Model.
- Emergency room utilization.
- Network leakage of primary care (where enrollees go for care).
- PCM by name continuity (volume and percentage).
- Patient satisfaction (Army Provider Level Satisfaction Survey question 20).
- Staff satisfaction (TRICARE Management Activity survey).
- Health Effectiveness Data and Information Set® (HEDIS®) composite score.
• Medical Readiness Category–Category 4.

Beginning in FY14, compliance with published PCMH standards will be inspected under the MEDCOM OIP consistent with the applicable OIP annual plan. Under this Program, MEDCOM inspects each RMC for compliance with published RMC-level PCMH standards. The RMC inspects its MTFs for compliance with published MTF-level PCMH standards. RMCs need not inspect all MTF-level PCMH standards at all Phase 3 practices. The RMC must conduct the MTF inspection in such a way as to ensure consistent compliance with published MTF-level PCMH standards at all MTF Phase 3 practices.
CHAPTER THREE
PCMH ROLES AND RESPONSIBILITIES

3-1. Accountable Care Organization

Army Medicine is transforming to a patient-centered System For Health, dedicated to providing a consistent patient experience. The PCMH promotes the delivery of comprehensive, high quality health care in a fully coordinated and synchronized manner. The PCMH roles and responsibilities are outlined in figure 3 and table 3, below, and include the PCM core team, PCMH practice, and the ACO.

As previously stated in paragraph 2-1, the ACO consists of the MTF leadership and all clinical and non-clinical support activities responsible for health care and support to the same group of beneficiaries. The ACO includes, but is not limited to: human resources, information management, resource management, and managed care, in addition to primary, subspecialty, and surgical care lines. Leaders of these staff activities, as well as their subordinates, must understand the PCMH mission and appreciate the priority of effort required to support the patient-provider partnership.
<table>
<thead>
<tr>
<th>ROLE</th>
<th>KEY RESPONSIBILITIES</th>
<th>RATIO</th>
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<tbody>
<tr>
<td><strong>Medical Home</strong></td>
<td></td>
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</tr>
<tr>
<td>• Medical Director/Clinic OIC</td>
<td>The senior clinical expert and primary clinical decision maker for the PCMH Home.</td>
<td>1 FTE per PCMH Home</td>
</tr>
<tr>
<td>• Primary Care Manager (PCM) MD/DO/NP/PA</td>
<td>Provides coordinated, comprehensive primary care to empanelled Patients.</td>
<td>Per enrollment guidelines in MEDCOM OPORD 11-20, Annex I</td>
</tr>
<tr>
<td>• Team Registered Nurse (RN)</td>
<td>Leads the continuity of care delivery and care plan implementation, establishes priorities for patient care, evaluates patient progress and provides patient education.</td>
<td>Part of 3.1 support staff in PCMH Home. Refer MEDCOM OPORD 11-20, Annex D.</td>
</tr>
<tr>
<td>• Licensed Practical Nurse / Licensed Vocational Nurse (LPN/LVN/68C)</td>
<td>Provides direct nursing care within scope of practice, assists with the implementation of the care plan.</td>
<td>Part of 3.1 core team. Refer MEDCOM OPORD 11-20, Annex D.</td>
</tr>
<tr>
<td>• Medic (68W)</td>
<td>Provides direct nursing care within scope of competencies, assists with the implementation of the care plan.</td>
<td>Part of 3.1 core team. Refer MEDCOM OPORD 11-20, Annex D.</td>
</tr>
<tr>
<td>• Medical Assistant (MA)</td>
<td>Provides patient care within scope of competencies, enhances PCM by performing daily administrative and clinical tasks.</td>
<td>Part of 3.1 core team. Refer MEDCOM OPORD 11-20, Annex D.</td>
</tr>
<tr>
<td>• Medical Support Assistant (MSA) – Front Desk Clerk</td>
<td>Provides direct administrative patient support services, acts as the front line customer service advocate, and serves as the communication link between the patient and the PCM care team.</td>
<td>Refer to annex OPORD 11-20, AnnexD-1.</td>
</tr>
<tr>
<td>• Practice Manager</td>
<td>Provides management oversight of clinic operations.</td>
<td>1 FTE per 10,000 enrollees</td>
</tr>
<tr>
<td>• Clinical Nurse OIC (CNOIC)</td>
<td>Oversees the scope of practice and provision of nursing services provided.</td>
<td>Part of 3.1 support staff. 1 FTE per Practice Not part of the 3.1 support staff at the Department level.</td>
</tr>
<tr>
<td>• Clinical NCOIC</td>
<td>Oversees and consults on the scope of practice and provision of care provided by the technicians and enlisted staffs.</td>
<td>Part of 3.1 support staff, if not at department level. 1 FTE per Practice Not part of the 3.1 support staff at the Department level.</td>
</tr>
<tr>
<td>• Nurse Case Manager (NCM)</td>
<td>Synchronizes healthcare management for patients with chronic, catastrophic, or complex medical conditions, or identified as high utilization or high risk.</td>
<td>Part of 3.1 support staff. 1 FTE per 6200 enrollees.</td>
</tr>
<tr>
<td>ROLE</td>
<td>KEY RESPONSIBILITIES</td>
<td>RATIO</td>
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<tr>
<td>Internal Behavioral Health Consultant (IBHC)</td>
<td>Provides coordinated, short-term Behavioral Health care, assists PCMs in recognizing and treating BH disorders and psychosocial problems.</td>
<td>1 IBHC per 3,000 enrolled adult population</td>
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<td></td>
<td></td>
<td>2 IBHCs per 15,000 enrolled adult population</td>
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<td></td>
<td></td>
<td>3 IBHCs per 30,000 enrolled adult population</td>
</tr>
<tr>
<td>Behavior Health Care Facilitator (BHCF)</td>
<td>Assists PCM and IBHC in determining patient’s response to treatment.</td>
<td>1 FTE per 7,500 adult population</td>
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<tr>
<td>Pharmacist</td>
<td>Provides coordinated medication management, identifies medication related problems, develops care plans with therapy goals, and serves as medication educator for both Patients and providers.</td>
<td>1 FTE per 6500 enrollees</td>
</tr>
<tr>
<td>Dietitian</td>
<td>Provides coordinated nutrition education and support to targeted populations, groups and individuals.</td>
<td>1 FTE 7500 enrollees</td>
</tr>
<tr>
<td>ROLE</td>
<td>KEY RESPONSIBILITIES</td>
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</table>
| • Information Management Director (IMD)  
• Chief Medical Information Officer (CMIO) | Supports all IM/IT infrastructure requirements, manages MAPS 2.0, AMSMS, and ICDB/CHAS training and implementation. |
| • Human Resources (HR) | Manages hiring actions for validated medical home positions, assists with gap analyses for staffing, performs realignment and reassignment actions. |
| • Operations/Training | Tracks training in DTMS/APEQS, manages taskers, tracks and coordinates SAV/OIP. Manages “Mobilization Plan.” |
| • Logistics | Supports and manages all supply and equipment needs. |
| • Facilities Management | Performs space requirement assessments and allocation to optimally support integrated practice activities. |
| • Public Affairs Office (PAO) | Leads strategic communications planning and activities related to marketing focused on both Patients and staff. |
| • Managed Care / CLINOPS / PAD | Manages Patient enrollment and empanelment to support optimal patient care. |
| • Central Appointments | Supports the medical home by appropriately appointing Patients to the proper PCM/team. |
| • Exceptional Family Member Program (EFMP) | Identifies and manages Family Members with special care needs. |
| • Radiology | Provides comprehensive, timely radiology services. |
| • Laboratory | Provides comprehensive, timely laboratory services. |
| • Emergency Department | Ensures timely feedback by actively communicating with PCMH team regarding patient Emergency Department visits. |
| • Quality Management (QM) | Supports credentials and privileging of all providers and care team, leads TeamSTEPPS™ training. |
| • Referrals Management | Manages and coordinates network referrals and consultations, ensures timely feedback to referring provider. |
| • Resource Management (RM) | Coordinates with MEDCOM for assignment and activation of MEPRS codes, assists with manpower and PCMH data analyses. |
| • Unit Practice Council | Focuses on health work environments, accountability and empowers clinic staff to solve problems, identify innovative ways to improve the patient care experience, and use evidence based practice to improve outcomes. |
| • Graduate Medical Education (GME)  
• Staff Education & Training | Supports all mandatory initial and sustainment training requirements for the PCMH staff. |

Table 3. Roles and Responsibilities (Medical Home, Medical Neighborhood, ACO)
3-2. PCMH Staff Model

The PCMH staffing model is defined in OPORD 11-20, Annex C. Commanders and leaders at all levels must realign and reassign personnel from within the organization (based on utilization data) prior to pursuing hiring actions.

3-3. Medical Neighborhood

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).
Appendix A
References

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
GLOSSARY

Abbreviations and terms used in this Manual are defined in the PCMH Consolidated Glossary.
FEEDBACK AND IMPROVEMENTS

The PCMH Transformation Team welcomes feedback and improvements to this Implementation Manual. Recommendations can be communicated via the link at Army PCMH Resource Center web site at https://mitc.amedd.army.mil/SITES/COMMUNITIES/APCMHRC/Pages/default.aspx

A series of active tasks is being worked as Task Action Plans (TAPs) by the PCMH TF. As these action items are completed, additional standards and capabilities will be included in updates to the PCMH Implementation and Operations Manuals as needed. All updates will be sent electronically through wide distribution and will be posted at the Army PCMH Resource Center on the Army Medicine Portal.