

# Military Health System Patient Centered Medical Home Guide

June 2011



## **Introduction**

The Military Health System (MHS) Patient Centered Medical Home (PCMH) Guide was developed by Service Subject Matter Experts in collaboration with the TRICARE Management Activity (TMA), the Tri-Service PCMH Working Group, and the Tri-Service PCMH Advisory Board. The guide is intended to provide information and recommendations; it is not a substitute for Service-specific guidance. Throughout the guide, concepts are discussed and where applicable, Service-specific guidance is referenced or provided.

This guide will be updated as additional information becomes available or guidance is amended. If you have any questions or suggestions on how to improve the guide, please send an email to the TMA PCMH Branch at [TMAPCMH@tma.osd.mil](mailto:TMAPCMH@tma.osd.mil).

John P. Kugler, MD, MPH  
COL (RET), MC, USA  
Deputy Chief Medical Officer  
Office of the Chief Medical Officer  
TMA/DOD(HA)

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# Chapter 1

## General Concepts

### WHAT IS A PATIENT CENTERED MEDICAL HOME (PCMH)?

The PCMH is a team-based model, led by a physician, which provides continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes. The model is based on the concept that the best healthcare has a strong primary care (PC) foundation with quality and resource efficiency incentives. The PCMH is a departure from previous, traditional healthcare models because it focuses on the “whole person” concept, preventive care and early intervention and management of health problems rather than on high-volume, episodic, over-specialized and inefficient care. A PCMH practice is responsible for all of a patient’s healthcare needs and for coordinating/integrating specialty healthcare and other professional services.

### Background

The PCMH concept was introduced in 1967 by the American Academy of Pediatrics (AAP) in response to rising costs, fewer resources, greater demand, decreasing patient satisfaction and lower quality healthcare outcomes compared to other industrialized nations.

### PCMH Endorsements

PCMH was adopted by Family Medicine in 2002 as part of the “Future of Family Medicine” project.<sup>1</sup> Since then, the PCMH concept has been endorsed by American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), American Osteopathic Association (AOA) and 18 other physician organizations including the Academy of Neurology and the American College of Cardiology. Finally, the PCMH concept has been fully endorsed by several large third party payers, employers and health plans. The leading proponent of the concept is the Patient-Centered Primary Care Collaborative (PCPCC).<sup>2</sup>

### Seven Core PCMH Principles

The AAP, AAFP, ACP, and AOA developed the following joint principles to describe the PCMH practice concept:<sup>3</sup>

***Personal Physician:*** Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician-directed Medical Practice:*** The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

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<sup>1</sup> American Academy of Family Physicians, <http://www.aafp.org/online/en/home/membership/initiatives/futurefamilymed.html>

<sup>2</sup> Patient-Centered Primary Care Collaborative, <http://www.pcpcc.net>

<sup>3</sup> American College of Physicians, [http://www.acponline.org/running\\_practice/pcmh/demonstrations/jointprinc\\_05\\_17.pdf](http://www.acponline.org/running_practice/pcmh/demonstrations/jointprinc_05_17.pdf)

**Whole Person Orientation:** The personal physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

**Care is Coordinated and/or Integrated:** Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care in a culturally and linguistically appropriate manner when and where they need it.

**Quality and Safety:** Quality and safety are hallmarks of the medical home: Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

- Evidence-based medicine and clinical decision-support tools guide decision-making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

**Enhanced Access:** Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Payment Reform:** Payment appropriately recognizes the added value provided to patients who have a PCMH. The payment structure should:

- Reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support provision of enhanced communication access such as secure email and telephone consultation.
- Recognize the value of physician work associated with remote monitoring of clinical data using technology.

- Allow for separate fee-for-service payments for face-to-face visits. Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.
- Recognize case mix differences in the patient population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow for additional payments for achieving measurable and continuous quality improvements.

## PCMH PRACTICE CONCEPTS

An effective PCMH practice will:<sup>4</sup>

- Take personal responsibility and accountability for the ongoing care of patients.
- Be accessible to their patients on short notice for expanded hours and open scheduling.
- Be able to conduct consultations through email and telephone.
- Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records.
- Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required.
- Advise patients on preventive care based on environmental and genetic risk factors they face.
- Help patients make healthy lifestyle decisions.
- Coordinate care, when needed, making sure procedures are relevant, necessary and performed efficiently.

## Payment and Incentives

The PCPCC supports a three-part payment model to realign payment incentives in support of PCMH. This three-part model combines traditional fee-for-service for office visits with:<sup>5</sup>

- A **monthly** care coordination payment for the physician and non-physician work that falls outside of a face-to-face visit and for the system infrastructure (e.g. health information technologies) needed to achieve better outcomes.
- A visit-based fee-for-service component that recognizes visit-based services that are currently paid under the present fee-for-service payment system and maintains an incentive for the physician to see the patient in an office-visit when appropriate.
- A performance-based **component** that recognizes achievement of quality and efficiency goals.

## THE BENEFITS OF THE PCMH MODEL

The PCMH model is based on a strong PC platform including continuous access to a personal provider, a team that is responsible for all of the patient's health care needs, a practice built on the principles of patient-centeredness, and fully leveraged use of health information and communication systems. A regular source of efficient, effective and comprehensive PC results

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<sup>4</sup> Patient Centered Primary Care Collaborative, <http://www.pcpcc.net/patient-centered-medical-home>

<sup>5</sup> American College of Physicians, [http://www.acponline.org/running\\_practice/pcmh/cost\\_benefit/index.html](http://www.acponline.org/running_practice/pcmh/cost_benefit/index.html)



in better health outcomes and quality, lower costs, greater patient access to needed services and increased patient satisfaction. Evidence demonstrates that “care delivered by PC providers in a Patient Centered Medical Home is consistently associated with ***better outcomes, reduced mortality, fewer preventable hospital admissions*** for patients with chronic diseases, ***lower utilization, improved patient compliance*** with recommended care, ***and lower Medicare Spending***.”<sup>6</sup>

### **SPECIALTY CARE AND THE PCMH MODEL**

The PCMH provider is not a “gatekeeper” and the model is not designed or incentivized to prevent appropriate referrals to a specialist; instead, the PCMH provider is expected to make referrals based on his or her clinical judgment and current evidence-based practice. To facilitate referrals, the PCMH model is designed to improve communication and coordination of care between the personal provider, care team, and specialist. Communication and coordination will increase both providers’ knowledge of the patient, increase the likelihood of the patient’s compliance and ultimately lead to a higher quality referral.<sup>7</sup>

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<sup>6</sup> Uniformed Service Academy of Family Physicians,  
[http://usafp.org/PCMH-Files/PCPCC-Files/Evidence\\_of\\_Quality\\_-\\_2008-10-30.pdf](http://usafp.org/PCMH-Files/PCPCC-Files/Evidence_of_Quality_-_2008-10-30.pdf)

<sup>7</sup> American College of Physicians,  
[http://www.acponline.org/running\\_practice/pcmh/understanding/specialty\\_physicians.htm](http://www.acponline.org/running_practice/pcmh/understanding/specialty_physicians.htm)

## Chapter 2

# Patient Centered Medical Home (PCMH) and the Military Health System (MHS)

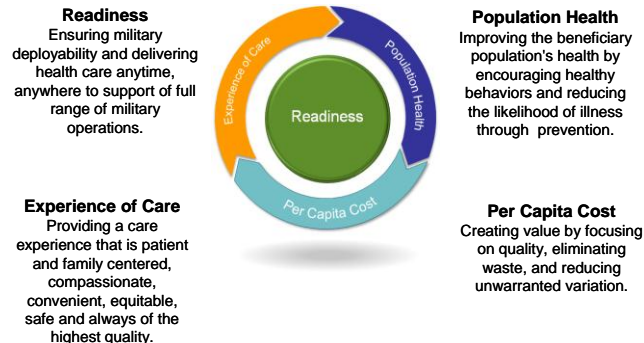
### MHS BACKGROUND

TRICARE came into being in 1996. Prior to TRICARE implementation, Military Health System (MHS) PC practices provided episodic sick call and routine medical care. Patients were seen at their servicing direct care system (DCS) military treatment facility (MTF) or used the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Patients were not enrolled to a specific PC manager or team; patient enrollment panels existed at only a few select clinics on a test basis. In an attempt to better manage patients' PC and to increase both access and satisfaction, the PC Manager by Name (PCMBN) policy was implemented in 1999 across the MHS, with varying degrees of success.

By the summer of 2008, the MHS senior leadership became aware of a crisis in patient perception. Not only were there continued access to care concerns in the DCS, but there were persistent patient satisfaction gaps between the direct and purchased care sectors, resulting in the DCS losing beneficiary enrollment market share to the purchased care sector. In response, the MHS senior leadership directed the TRICARE Management Activity and Service Subject Matter Experts (SMEs) to develop plans to enhance primary health care for all beneficiaries. The concepts of PCMH were adopted by all Services as the framework for a new PC model in the MHS.

### Quadruple Aim

The MHS uses the Quadruple Aim model to illustrate the following four goals: Readiness, Population Health, Experience of Care and Per Capita Cost. The PCMH model is consistent with and supports all four goals in the MHS' Quadruple Aim.



### POLICIES

Several MHS policies address PC and PCMH operations. In addition, there are Service-specific policies that address PC; Service-specific policies are consistent with MHS policies.

## MHS Policies

The main MHS policies addressing PC and PCMH operations are discussed below:

- **PCMH MHS Policy Memorandum:** The MHS' PCMH policy is identified in the Policy Memorandum Implementation of the 'Patient Centered Medical Home' Model of Primary Care in MTFs, dated September 18 2009.<sup>8</sup> The PCMH Policy Memorandum establishes PCMH as the MHS' PC model and discusses basic team organization principles, PCMBN requirements and specialty applicability and identifies outcome performance measures.
- **ASD(HA) Policy 11-005 TRICARE Policy for Access to Care**, dated February 23, 2011: Policy 11-005 provides clarification of guidance for access to care standards and related activities for health benefits under the TRICARE program. Specific requirements discuss access to care for emergency, urgent (acute), routine, wellness/health promotion and referral appointments. It also establishes standards for office wait times, referrals and authorizations as well as identifies beneficiary category priorities for access.<sup>9</sup>

### *Service-Specific Policies:*

- **Army:** Operation Order (OPORD) 11-20, Army Patient Centered Medical Home, dated January 2011.
- **Navy:** Navy Medical Home Port (MHP) is the Navy model for implementing PCMH in Navy MTFs. Bureau of Medicine and Surgery (BUMED) Instruction 6300.19 dated May 26, 2010.
- ◆ **Air Force:** Family Health Operations is the Air Force model for implementing PCMH in Air Force Family Health Clinics. Air Force Instruction 44-171, Patient Centered Medical Home and Family Health Operations, dated 18 January 2011.

## ACCESS STANDARDS:

**ASD(HA) Policy 11-005 TRICARE Policy for Access to Care** identifies the following access standards for Prime enrollees.

- **Emergency Care:** Beneficiaries seeking emergency care should proceed to the nearest emergency room or call 911. Emergency services are covered in circumstances where acute symptoms are of sufficient severity that a "prudent layperson" could reasonably expect the absence of medical attention would result in serious health risks or death.
- **Urgent (Acute) Care:** Beneficiaries must have an appointment to visit a provider within 24 hours and within 30 minutes travel time of the beneficiary's residence.
- **Routine Care:** Beneficiaries must have an appointment to visit a provider within seven calendar days and within 30 minutes travel time of the beneficiary's residence.
- **Well-Patient Visits:** Beneficiaries must have an appointment with a provider within four weeks (28 calendar days) and within 30 minutes travel time of the beneficiary's residence.
- **Referrals for Specialty Care Services:** Beneficiaries must have an appointment with a provider within four weeks (28 calendar days) or sooner, if required, and within one hour's travel time from the beneficiary's residence. A basic principle of the TRICARE

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<sup>8</sup> National Naval Medical Center PCMH, [http://www.bethesda.med.navy.mil/patient/health\\_care/medical\\_services/internal\\_medicine/PCMH%20Policy%20Memo%20-%20signed.pdf](http://www.bethesda.med.navy.mil/patient/health_care/medical_services/internal_medicine/PCMH%20Policy%20Memo%20-%20signed.pdf)

<sup>9</sup> MHS Policies, [http://www.health.mil/Libraries/HA\\_Policies\\_and\\_Guidelines/11-005.pdf](http://www.health.mil/Libraries/HA_Policies_and_Guidelines/11-005.pdf)

program and the MHS business design is that MTFs have first priority for providing referred specialty care or inpatient care for all enrollees. If the MTF does not have the capability to provide needed care or cannot provide the care within the required access standards, then the care will be referred to the TRICARE provider network. MTFs will request referral of their TRICARE Prime enrollees to a non-network civilian provider only when it is in the best interest of the Government and the beneficiary, either clinically or financially.

**Other References:** Other access to care (ATC) references include the CFR 32 199.17, *Access to Care*<sup>10</sup> and the *MHS guide to Access Success*, dated January 22, 2008.<sup>11</sup>

***Service-Specific Information:***

- **Army:** OPOD 9-36 HQ, USA MEDCOM, 30 March 2009. Access to Care Campaign
- **Navy:** NAVMED Policy 09-004, "Access to Care Management Policy for Navy Medicine Military Treatment Facilities of March 12, 2009
- ◆ **Air Force:** Air Force Medical System (AFMS) Access To Care Functions Guidance as of August 2010

**MILITARY UNIQUE ISSUES IN ADOPTING PCMH**

Although the PCMH model's first core principle is for a *personal physician*, the MHS is PCM-based and involves both PC physicians and non-physician providers/extenders. All MHS PCM providers are able to effectively operate as PCMH team leaders. The principle of a *physician-directed medical practice* is easily translatable to the MHS; the concept of a team of professionals, under the leadership of a team leader, is a highly valued key component of the MHS culture. The MHS already focuses on a *whole person orientation*; active duty, retired service members and their families expect that all aspects of care are to be comprehensively addressed. All MHS beneficiaries are entitled to comprehensive, accessible PC that is **coordinated/integrated**. While processes are in place to deliver that care, the challenge is in the execution; further work needs to be done in this area. The principle of *quality and safety* is fully implemented in the MHS. The MHS has embraced the evidence-based model of care, including an evidence-based medical benefit, extensive DoD/VA Clinical Practice Guidelines (CPG) program and a sophisticated and evolving Patient Safety Program. The MHS recognizes the principle of *enhanced access* through formal policy. Access standards for PC are clearly stated and defined for acute, routine, specialty and wellness visits. Finally, from the MHS *payment* perspective, the financial model remains rigid and constrained by external budgetary realities. Significant effort will be required to align PCMH performance with MHS financial incentives.

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<sup>10</sup> Code of Federal Regulations, Title 32: National Defense,  
[http://edocket.access.gpo.gov/cfr\\_2005/julqtr/pdf/32cfr199.17.pdf](http://edocket.access.gpo.gov/cfr_2005/julqtr/pdf/32cfr199.17.pdf)

<sup>11</sup> TMA Website, <http://www.tricare.mil/tma/tai/downloads/03-28-2008/MHSGuidetoAccessSuccess.pdf>

## **Chapter 3**

### **General Implementation Guidance**

#### **FOUR BASIC PCMH PRINCIPLES**

PCMH efforts are driven by four basic principles, which are measurable and can be assigned to accountable individuals:

**Continuity:** Provider with enrollee at all visits, or their PCMH partner's enrollees, and provider with support staff at all clinic sessions. This is looked at both from the provider's relationship with their patients and the patient's view with his provider and/or his team.

**Provider templates:** Templates will deliver a standard number of appointments every week the provider is available.

**Control:** Providers have control (through the Chief of Medical Staff) of their templates, and correspondingly their support staff schedules in coordination with the unit leadership within clinic hours.

**Satisfaction:** Patient, provider, and support staff satisfaction are carefully monitored.

#### **LEADERSHIP IMPLICATIONS AND TIPS**

The concept of "medical home" must be fully understood by the MTF executive leadership. MTF processes should be developed and tailored to at least two distinct populations implied by the PCMH concept:

- Patients who have elected to make the MTF their medical home for all PC, regardless of the locale where referral care is available.
- Those enrollees who choose not to make the MTF their medical home and obtain their PC elsewhere.

"Medical home" patients will be proactively managed through the PCMH Team, and become the only population with which the MTF can establish true continuity as well as the most appropriate population upon which to measure MTF performance. Enrollees who do not appear to make the MTF their medical home present a significant challenge to the MTF Executive leadership concerning continued enrollment, and proactive vs. reactive management of their care. This must be negotiated with the patient if he or she is identified as not making the MTF his/her true medical home.

#### **PCMH Commitment and Prioritization**

Leadership must be committed to the PCMH concept at all levels, making it the priority for all business and process planning. Issues such as deployment, TDYs and other taskings must be proactively planned for in the design of the MTF PCMH program and team makeup. In addition, strategic realignment of existing resources, to include funding, staffing and space, may be required. MTF processes such as meetings and training must be scheduled around PCMH. Local incidental taskings by the host unit can create a significant issue for MTF commanders; therefore, MTF commanders must aggressively market the PCMH concept and its benefits to appropriate leadership in order to gain understanding and support.

### **PCMH and Performance Measures**

Leadership must fully comprehend patient outcome measures vs. corporate performance measures. Patient outcome measures apply to the clinical outcomes of each patient in the population of medical home patients as defined by the CPGs. Corporate population-based performance measures include Healthcare Effectiveness Data Information System (HEDIS) and some applications of Pay for Performance, which do not reflect individual outcomes. Meeting standards in HEDIS, for instance, in no way reflects true individual outcomes. In fact, up to 30 percent of patients included in a satisfactory HEDIS cohort receive no care in the MTF. PCMH demands that each patient who is enrolled to the MTF will be ensured their outcomes are managed to the maximum extent possible.

### **PCMH and Demand Management**

Leadership must prepare for the possibility of increased need for acute care outside the team if demand exceeds the reasonable capability of the PCMH team; this should be expected to improve as the team matures and processes improve. While all enrollee care is important to the team, when all care cannot be delivered in a safe and quality fashion, the team would rather sacrifice less consequential acute, episodic care than sacrifice continuity of care of complex enrolled patients, wellness exams and procedures. The preservation of more complex care ensures not only that continuity is maintained for the care for which it is most vital but also contributes to the maintenance of currency of skills for all staff members.

### **PCMH and Cultural Change**

Leadership at both the MTF and Headquarter (HQ) levels, must be cognizant that PCMH is a complete culture change and it takes time, and ongoing direct support of the MTFs and clinical personnel who accomplish the job everyday, to incorporate this change. The standardized implementation process requires corporate patience to incorporate the change process. MTF change and implementation will take a minimum of 18-24 months, and will become a continuing process improvement effort. Changes in measurements will lag behind standup at any MTF by the same amount of time.

### **PCMH and Process Improvement**

PCMH implementation is a process improvement initiative. By its nature, the process is initially directive; however, MTFs should look at each of their internal processes that impact PCMH, and establish intensive formal process improvement action on these processes using the specific Service recommended methodology as they gain experience. The ongoing success of PCMH across the MHS depends upon this continuing effort, and the sharing of results.

### **CHANGING THE CULTURE**

The most important culture change with PCMH is the “ownership” of one’s patients at all levels. Continuity will not be achieved without this commitment by all involved. The principle of “today’s work today” is the most important single concept the team must learn and accomplish. Unlike the failed efforts of Open Access where the goal was an appointment today (with anyone), in PCMH the principle becomes meeting the needs of every one of the team’s patients who accesses the system that day. Clearly in an MTF with a mature population health program, the need isn’t necessarily met within the team.

### ***Accountability:***

Ownership generates accountability: the provider-led team is accountable for meeting the patients' needs. This accountability extends from access to outcomes. Initially, the most difficult goal to achieve will be the "today's work today" component of access. The MTF must balance access and continuity with greater emphasis on the latter.

### ***Scope of Practice:***

Maximization of scope of practice for all members of the team becomes a priority. This goes beyond the use of clinical support staff protocols and training. The personal and corporate expectation that each team member proactively reaches out and takes care of the patient to the maximum of their scope at each encounter becomes a mindset, which is crucial to the success of PCMH.

### ***Patient Culture:***

Patient's expectations and behaviors need to be modified and managed as they are empowered to become active participants in maintaining their own health status. Our patient population has been conditioned to judge the quality of their care heavily weighted on access to the near exclusion of outcomes. Our patients must become zealots of continuity with their team vs. immediate access. The caveat to this is that the MTF and the team must deliver this promised continuity or patients will continue to value only convenience. The strategy to meet this expectation will involve concepts such as the team becoming familiar with their patients, template management to provide access for "their" patients, and accurate first-call protocols that emphasize continuity for key patient populations.

## **STAKEHOLDER COMMUNICATION AND TRAINING**

### **Key Stake-holders**

Clinical (MTF Internal) stakeholders include not only the PCMH Team, but all ancillary care units, administrative personnel, and MTF leadership. MTF communication efforts should have three key components:

- Communication, education and training to MTF staff, specifically focusing on training that is tailored to team members' roles and functions
- Communication and education outreach to line leadership and key external stakeholder groups (e.g. retirees, spouses, enlisted councils, etc.)
- Communication and education outreach to patients designed to change patient culture, educate patients on PCMH operations and how it will affect them and patient empowerment/activation

### **Communicating With and Getting Buy-In From MTF Staff**

Preparing the MTF for PCMH must begin with thorough educating and gaining support of executive leadership and clinical stakeholders, coupled with initial strategic planning. The importance of MTF staff education and buy-in should not be underestimated. MTF personnel are key messengers to other members of the community. Therefore, MTF communication should be early and as comprehensive and transparent as possible, with emphasis placed on training and the roles each staff member will play in PCMH operations.

### **Educating Line Leadership on PCMH**

Education and outreach efforts must include a key group we serve: the active duty military units we support. MTFs should establish a strategy to brief at senior leader “standup”, senior enlisted/first sergeant groups, and other established unit leadership meetings. Many units will already have established peer relationships with line counterparts to resolve unit-MTF issues. Using these relationships for one-on-one marketing is extremely effective.

**Suggested Methods:** Key MTF staff members should participate in line meetings and provide information on what PCMH is, what the benefits are, the implementation process and what leadership and their personnel can expect. Specific methods include face-to-face meetings with most senior staff, briefings to more general staff and background/point papers.

### **Educating and Reaching Out To Patients**

The key message in any education and outreach effort to patients is that the MTF and PCMH are striving to meet their needs. A key strategy in meeting patient needs while ensuring quality care and improved patient outcomes is provider continuity. Patients should be made aware that it is in their best interest to choose continuity with their assigned provider over simply choosing the most convenient appointment. While we understand that access is a key patient satisfier, we need to stress to our patients that access must be coupled with continuity; effective patient outreach and education can make a difference in helping patients find a balance. This may result in more walk-in appointments than usual in initial stages, but the AF experience has shown that once trust in appropriate access to one’s own provider builds, this quickly tails off. Marketing PCMH as an access-disruptive event (“pardon our mess while we build a better clinic”) is counterproductive, and unnecessary. The stand-up of PCMH models in MHS MTFs largely has been transparent to MHS beneficiaries.

**Methods:** MTFs with mature PCMH programs generally have used commonplace methods for educating enrollees. These include information on the installation commander’s channel, installation newspapers, briefings to groups (senior enlisted, military spouse, etc.), videos of trusted MTF staff explaining PCMH operations set up in patient waiting and pharmacy areas and promotional flyers. One of the most effective methods has been the on-going PCMH team’s demonstration of commitment to continuity and to increasingly accessible, quality health care. In addition, MTFs should ensure they provide PCMH marketing and information at installation newcomers’ briefings.

## **STRATEGIES FOR IMPROVING PATIENT SATISFACTION**

In addition to communicating and marketing to patients, the most effective method is to deliver on the promise of high quality accessible healthcare. Communication and availability of a helpful voice at the other end of the line is crucial. Those patients who have problems working the health care/appointment system must have someone knowledgeable to whom to speak. The development of an effective telephone tree (that provides early transfer vs. being a demand management tool), and training of all those who answer initial calls to the MTF (appointment personnel are key) are the most important elements in this effort. PCMH practices must emphasize that patients’ needs must be handled on the first telephone call rather than having them call again at a later date. Mechanisms should be in place to allow patient access to other members of the healthcare team, (e. g., pharmacists and nurses) via telephone, secure messaging, etc. For example, if patients report problems with their medications, or appear to be having



difficulty complying with their medication regimen, they may be referred for Medication Therapy Management (MTM) services to the MTF pharmacy.

**POPULATION HEALTH (PH) AND MEDICAL MANAGEMENT:**

Continuity of care through all processes from enrollment through referral management activities is crucial to the implementation of effective PH and PCMH. Standardized processes must be defined and communicated to all team members. In addition, each member of the PCMH team has skills that must be leveraged to their full potential. PCMH operations require each team member to work at the top of their specific specialty capabilities. Finally, certain cohorts of patients must be managed by specialty healthcare providers, outside the traditional provider visit. These concepts are covered in the 2009 MHS Medical Management (MM) Guide.<sup>12</sup> Care coordination between the MM team and the PCMH team is a key component of provider ownership of enrollees. MTFs must adopt Clinical Practice Guidelines (CPGs) that have been validated by a Nationally recognized, evidenced based source, (e.g. DoD/VA, American Diabetes Association (ADA), etc).“ The failure of effective population health efforts can almost always be traced to a disconnect at this first crucial step in population health management.

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<sup>12</sup> TMA Website, [http://www.tricare.mil/ocmo/download/MMG\\_v3\\_2009.pdf](http://www.tricare.mil/ocmo/download/MMG_v3_2009.pdf)

## **Chapter 4**

### **Improving Access to Care and Quality**

#### **IMPROVING ACCESS TO CARE**

The recurring theme that transcends all access strategies in the PCMH environment is continuity of care. Providing continuity for the team's patients who need it most has created minor acute access issues at some MTFs. The patients who most need continuity in general are those with chronic conditions who need careful monitoring or care (preventive and interventional). Because the appointment clerks cannot triage a patient, the PCMH team should develop a way to identify high utilizers and chronically ill patients so every effort can be made to provide them with same day or routine appointments with their assigned provider. Effectiveness of this strategy requires the team to be fully familiar with their patients, as well as a mechanism to identify and route them appropriately at first call.

#### **General Access Management:**

Administrative practice management and teams will develop templates that allow for maximum access, focusing on the goal to "see today's patients today." The team, working with data on their enrolled population available through MHS IM/IT tools, will ensure that the type of appointments available match actual demand of the population. PCMH teams should monitor appointment supply and demand trends to adjust appointment available and types, as necessary in order to best meet patient needs and maximize resources. Detail codes may be used when needed; however, excessive use of detail codes may result in restriction of access. Freezing, blocking or other similar restrictions is discouraged.

#### **Schedules**

PCMH team clinics will establish a minimum staffing threshold to meet access requirements. Schedules should be made in advance of the appointment templates and serve as the basis for developing templates to ensure adequate staffing for the provider. Leaves, TDYs, down days and other time off must be approved and coordinated with leadership to minimize impact on access. The GPM will assist team leadership in projecting team member absences to ensure adequate access. Time off should be projected as far out as feasible. MTF leadership will establish local policy. Template changes will be approved by leadership.

#### **Appointing:**

The appointing telephone system tree should reflect the design of PCMH operating concepts to ensure patients can expediently reach PCM booking clerks for their assigned PCM. Files and tables will be created to ensure the patient is first booked to their PCM. If the PCM is not available, the patient should be booked to the other provider on their team. Local policies will dictate additional guidance if neither of the FHT providers is available. Telephone "trees" and appointing clerk protocols should give clear guidance to those making appointments at the first call as to where to book the patient. This would ideally include the authority to refer minor acute care to network or Urgent Care Clinic resources when access conditions require. Care must be taken to not involve the clerks in medical triage.

## **IMPROVING QUALITY**

### **Evidence-based Healthcare**

In the PCMH environment, the use of evidence- based practice and use of Clinical Practice Guidelines (CPGs) are core processes in the delivery of healthcare. When providers and staff implement and adhere to evidence-based practice as the foundation for a comprehensive population health program, the results will be improved care and outcomes, less variation in care provided and decreased costs. The provision of evidence-based care in other settings is covered in other DOD and Service specific guidance.

Evidence-based practice is the integration of clinical expertise, patient participation, and evidence into the decision making process for patient care. Clinical expertise refers to the clinician's experience, education and clinical skills. Patients bring personal concerns, expectations, and differing levels of ability to participate in their own care. The evidence is found in clinically relevant research conducted using valid and reliable methods. The best clinical evidence, from well-designed, well-conducted studies, is appropriate for the decision at hand and considers the benefits as well as the potential harms of the treatment considered.

Evidence-based practice assists the healthcare provider to apply research, clinical guidelines, and other relevant information to clinical decision making. It enables healthcare providers of all disciplines to address questions with an informed approach. This process provides practitioners the tools to improve their clinical effectiveness and positively affect the delivery of healthcare. In the PCMH environment, the implementation of evidence-based practice is the responsibility of all health care team members, at all levels. One mechanism for implementing evidence-based care is the adoption of CPGs.

### **Clinical Practice Guidelines**

CPGs are systematically developed, evidence-based, nationally recognized statements to assist both the practitioner and patient in making appropriate decisions for specific clinical circumstances. CPGs provide recommendations for the performance or exclusion of specific procedures or services based on evidence derived from rigorous review and synthesis of published medical literature. CPGs help standardize processes and may be used as a framework for evaluating interventions by specifying treatment goals and outcomes measures. Quality of care can be measured through evaluation of process and outcome measures based on CPG recommendations. For example, the percentage of patients with diabetes with a completed A1C in the last 12 months serves as a process measure for the PCMH while the number of patients with diabetes with an LDL below 100 serves the PCMH as an outcome measure of patient care. It is intuitive that MTFs using CPGs have meaningful clinical measures available to evaluate care provided. As a benchmark, the DOD utilizes the HEDIS to compare performance to private sector healthcare organizations.

When successfully implemented, CPGs offer MTFs of all sizes the opportunity to improve patient outcomes by decreasing variation in practice, promoting delivery of appropriate care, preventing errors, improving clinical results and decreasing costs by reducing inappropriate utilization of healthcare services.

### **Clinical Decision Support Tools**

Measurement of outcomes is essential to a successful MM program.<sup>13</sup> Utilization Management (UM) outcome measures are commonly divided into daily, monthly, and quarterly summaries, and may further be broken out into outpatient, inpatient, and ancillary services. The TMA Population Health, Medical Management, and Patient Centered Medical Home Division (PHMM & PCMHD) maintains a centralized, external contract to license and distribute specific criteria and guidelines to MTFs and TRICARE Regional Offices (TROs). The selected products are not the only products available in the industry, but are believed to be the best choices for the MHS. These products apply to both the ambulatory care arena and inpatient care. Both criteria sets are evidence-based guidelines that provide clinical decision making criteria to identify appropriate utilization and resources necessary for an individual patient's severity of illness, co-morbidities, and complications in the review process. Use of either set of guidelines is intended to guide the reviewer toward the safest and most efficient level of care. Additionally, the outpatient tools provide guidelines and authorization support for procedures, diagnostic tests, imaging, rehabilitation services, durable medical equipment, injectibles and more.<sup>16</sup> Authorization guidelines are primarily used by utilization managers to assist providers in determining appropriate levels of care and whether or not the patient meets criteria for that specific care level.

***Inpatient evidence-based clinical decision support criteria*** are also included in MHS care determinations and provide measurable, objective, clinical indicators reflecting the need for hospitalization and for diagnostic and therapeutic services in both the medical-surgical and behavioral health arenas.<sup>14</sup> These criteria are based on the severity of the patient's illness and the intensity of the services required, rather than on diagnosis. Use of inpatient decision support assists medical staff to identify key clinical and business needs, while ensuring the appropriate level of care is identified. Additionally, key level of care transitions are highlighted to ensure safe and effective care is maintained along the continuum of care.

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<sup>13</sup> TRICARE Management Activity (2009). Medical Management Guide, Version 3.0. Retrieved from <http://www.tricare.mil/OCMO/>

## **Chapter 5**

### **Manpower, Staffing and Practice Management**

Each Service has specific processes for the funding of MTFs, based on the MHS and Service SGs' current guidance on business planning. These processes involve both a look at historical utilization as well as projected needs based on the anticipated mission of the host installation and patient demand. Changes in MTF services (including deployment impacts), changes in beneficiary totals, anticipated market share penetration, and available in-house specialty care are all variables that are analyzed in relation to the MTF's PCMH effort. The 2-year MHS future budgeting process, Program Objective Memorandum (POM) cycle can present significant challenges to the MTF in the face of host installation mission changes.

#### **ROLES AND RESPONSIBILITIES**

General roles and responsibilities are similar across all Services.

##### **PC Provider**

Each enrolled patient will be assigned to a specific provider who will be responsible for the patient's care coordination and oversight. The provider will address medical issues in a compassionate, comprehensive, and integrative manner utilizing a team approach. The provider will ensure that wellness and medical reconciliation needs are addressed by the health care team and will monitor care coordination, as necessary. The provider will utilize evidence-based CPGs and engage patients actively in their health care, ensuring that self-management instructions are given at all appropriate opportunities.

##### **Team Nurse (Registered Nurse (RN))**

The Team Nurse (RN) is an instrumental resource in providing continuity of care within the PC clinic environment. The RN serves as the care manager for assigned patients to coordinate care and other necessary services to meet the needs of the patient, as determined by the patient's PC provider. The RN also provides necessary leadership and fulfills an educator role in the clinic. These leadership responsibilities include, but are not limited to, supervision of the ancillary nursing and support staff in their daily activities and professional development; and ensure team members maximize their training and competencies. The RN will also collaborate with the Case Management (CM) and Disease Management (DM) staff on chronic health care services.

##### **Ancillary Nursing Support**

The ancillary nursing staff, to include Licensed Practical Nurses, enlisted or equivalent personnel, Certified Nursing Assistants, Medical Assistants, etc, provides invaluable support to the PCMH Team. They will assist in provider support activities related to patient care, patient education, documentation of chronic medical conditions, documentation of preventive services, medication reconciliation, and coordination of patient check-out and follow-up. They will receive direct guidance and supervision by both the nurse and provider.

### **Independent Pharmacy Services**

Pharmacy staff, to include pharmacists trained to provide medication therapy management (MTM) services for PCMH patients with complex drug regimens or who otherwise need assistance with managing their drug regimen. These services are independent of dispensing activities and those services provided by privileged pharmacists who render care in pharmacy-run clinics. The MTM pharmacist will work directly with the patient and other PCMH team members to optimize the patients' pharmacotherapy care.

### **Clerical Staff**

The clerical staff includes medical clerks and others who provide administrative support of clinic activities, front desk operations, telephone management, and records management. They are vital members of the team. They facilitate patient check-in, verification of Defense Enrollment Eligibility Reporting System (DEERS) eligibility and collection of other health insurance information. In addition, they assist patients in navigating the health care system to include: supporting clinic team management of population health, coordinating and/or scheduling acute and chronic care, arranging follow-up, coordinating specialty referrals, and telephone/asynchronous secure patient messaging.

### **Behavioral Health Provider**

The behavioral health provider helps meet the mental health needs of the enrolled population as part of improving their overall health. The intent is to provide ready access for both patient care and provider consultation in meeting the holistic needs of patients. Goals include improved early recognition, treatment, and management of psychosocial/behavioral problems and conditions. Services will be integrated into the PCMH clinic to provide necessary consultative services and training to other members of the health care team. Patients may need to be referred to specialty mental health care, as appropriate.

### **Nurse Educator, Health Educator, or Disease Manager**

The nurse educator, health educator, or Disease Manager will assist the PC team to encourage healthy lifestyles and wellness by educating patients about behaviors that can prevent or mitigate diseases, injuries, and other health problems. They provide a ready source of patient support and education immediately available to the team and patients. Services they provide include (based on their level of experience and certification): education regarding chronic conditions and patient self-management, training patients and caregivers on medical devices, assisting patients to set/attain behavior-change goals, nutrition education and counseling in support of command nutritionists or dietitians, education on medication management based on physician-directed protocols, and access to health care and community resources.

### **Clinic Manager**

Each clinic generally will be assigned a clinic manager. Duties will include but are not limited to tracking access, tracking provider availability, managing appointment templates/availability, overseeing clerical staff, managing telephone calls and consults, tracking performance, Defense Medical Human Resources System – internet (DHMRSi) submissions, and making recommendations to improve clinic efficiency and effectiveness in meeting patient needs. The clinic manager will also review patient satisfaction submissions to identify and recommend improvement opportunities. The clinic manager will ensure

completion of necessary forms for third party collections and will track same for the clinic. Finally, the clinic manager will assist in tracking clinic performance under the Prospective Payment System (PPS).

**Other Team Members:**

Please see Chapter 7 for discussion of case and utilization managers as well as other specialty integration information.

**MINIMUM STAFFING REQUIREMENTS**

Each Service has minimum staffing requirements discussed in more detail in official Service PCMH guidance.

**OFFICE ORGANIZATION/CLINIC DESIGN**

The key consideration in physical plant supporting PCMH is the proximity of essential personnel. This demands consideration that the FHTs, Practice managers, DM, CM staff, and in the AF, Health care Integrator (HCI) be within the same area of the clinical space or if not logistically possible as close to one another as feasible. It is also necessary to provide office space conducive to patient confidentiality and adequate exam/treatment room space for clinical personnel, to include the Disease Managers and Case Managers.

**Space:** A minimum of two exam rooms per provider and office space to accommodate two providers, a nurse and five unlicensed assistant personnel (UAP) (i.e. Medical Technicians (Air Force), Corpsmen (Navy), Medics (Army) per team. Exact location of all team members will be determined locally, as influenced by space constraints, but MTFs will ensure that team members are in close proximity to facilitate team operations and communication. The goal is to design clinical space to allow the most efficient workflow. The following guidelines also improve efficiency and improve the ability of team members to collaborate:

- Defined Team/Practice “real estate”
- Check-in: Teams/Practices may have individual or centralized clinic check-in areas depending on resources and other constraints
- Team “Pods” facilitate discussion; ensure you have huddle and collaboration space
- Do not spread out exam room footprint; make it as concentrated as possible
- Have all exam rooms set up identically to facilitate ease of use
- Have space (temporary or fixed) and IM/IT capabilities for all team members to be able to accomplish their required documentation
- Set up an area for patients to make follow-on appointments before departing the team space

**APPOINTMENT TYPES AND USES**

PCMH teams will use the following appointment types:

- **Acute:** Acute or ACUT appointment types are for patients to be seen within 24 hours.
- **Routine:** Routine appointments are for patients to be seen within 7 days.
- **Established:** Established or EST appointments are for patients that the provider specifies for follow up.

- **Wellness:** Wellness or WELL appointment types will only be used for patient wellness visits and provision of preventive services. WELL appointments are to be seen within 28 days.
- **Telecon:** Telephone assessment, education and counseling may be effectively used by the health care team. All interactions should be documented in AHLTA and coded appropriately. Nurse telephone encounters regarding symptom based calls should include documentation of the decision support tool and protocol used and be reviewed by a provider within 24 hours. Nurses utilizing telehealth encounters should abide by appropriate national standards and service-specific requirements.
- **Group Appointments:** Group appointments can be used as appropriate to meet the needs of the facility. Group appointments can be effective in DM efforts, as the group setting allows the staff to provide education in an efficient manner, while providing a support network for the client.
- **Open Access (OPAC):** [Pending update; check with your Service for policies on open access appointing in the interim.]



## **Chapter 6**

### **Leveraging Health IT and MHS Data Tools**

IM/IT tools are needed for achieving NCQA recognition as a PCMH, for providing the breadth of services needed for quality care as embodied in the PCMH concept and for measuring and demonstrating outcomes for PC Teams, clinics and MTFs. All IM/IT tools are subject to review and accreditation/certification by the MHS and/or Service-specific Information Assurance authorities.

#### **MHS MANAGEMENT ANALYSIS AND REPORTING TOOL (M2)**

M2 is a powerful tool used to obtain summary and detailed views of population, clinical, and financial data from all MHS regions. M2 includes MTFs and commercial network claims data integrated with eligibility and enrollment data. This integrated data enhances support to healthcare managers across the MHS. M2 allows users to perform trend analyses, conduct patient and provider profiling studies, and conduct business case analyses to maximize health plan efficiency. Available data sets include information on eligibility, TRICARE enrollment, healthcare services and System production data. A full list is provided in Appendix X.

#### **CLINICAL DATA MART (CDM)**

The CDM is the clinical reporting tool for AHLTA. It allows users to measure, analyze, and manage performance of direct patient care, wellness, prevention, and DM of the MHS patient population. The CDM can be used to create ad hoc queries to help measure quality, safety, and efficiency. CDM accounts are created by the local MTF system administrator. Types of account (based on demonstrated need) include MTF Access (non- Protected Health Information [PHI] and PHI levels), Enterprise Access (non-PHI and PHI levels), and Provider Access (PHI level). Account access can be requested through an Account Authorization Request Form (AARF). To obtain the form, you must register at the EIDS Web Portal at <https://eids.ha.osd.mil>. Instructions are available at:

[http://www.health.mil/Libraries/Documents\\_Word\\_PDF\\_PPT\\_etc/MHS\\_Insight\\_Access\\_Instructions.doc](http://www.health.mil/Libraries/Documents_Word_PDF_PPT_etc/MHS_Insight_Access_Instructions.doc). For questions or assistance with completion of these requirements, please contact the MHS Help Desk at 1-800-600-9322 (CONUS) or 1-866-637-8725 (OCONUS).

#### **AHLTA AND MEDICAL MANAGEMENT (MM)**

AHLTA has no effective MM tools, documentation, or tracking capabilities to manage populations of patients such as diabetics. These tools are kept by most MTFs as Excel® spreadsheets and manually updated monthly, with documentation of care separately entered in AHLTA.

#### **MHS POPULATION HEALTH PORTAL (MHSPHP/CarePoint)**

The Military Health System Population Health Portal (MHSPHP)/Carepoint module transforms Department of Defense (DoD) and Network health care administrative data into actionable information. The application utilizes health care action lists to identify MTF TRICARE Prime and Plus enrollees in need of potential clinical preventive services, disease management or case management. The HEDIS® methodologies or DoD/VA Clinical Practice Guidelines outline the specific data sources and methodology used within MHSPHP. The data available through this

application provides both patient level and general population statistics concentrating on demographics, disease management and preventive services information. This evolution of the MHSPHP provides an intuitive “front end” for the user that is tab based. The newest features of this iteration include: 1) ability to enter lab results and screenings for patients with other health insurance and/or who are seen in purchased care, 2) nightly processes to capture lab and screening tests with updates to both action lists and patient counts, and 3) option to exclude patients off patient lists (e.g. chronic refusers, patient deceased, miscoded diagnosis, etc. Various spreadsheets can be generated for MM personnel for specific population management. The updated MHSPHP in CarePoint is being Beta tested in September 2010; TMA expects CarePoint to be fielded to all MTFs by the end FY11. Account requests and Service Representative Information can be found at <https://carepoint.afms.mil>, select the ‘Request Access link.

### **TRICARE ON-LINE**

TRICARE On-Line (TOL) has the potential to become the medical home patient’s primary portal to access healthcare. The potential to streamline communication with the MTF is nearly limitless. A robust TOL would handle a huge amount of routine healthcare business from appointing to referrals to results reporting and minimize the very inefficient current methods of communication via telephone and standard mail. Standard reports include PCM continuity and other important measures broke down by Service, MTF and clinic.

### **SECURE MESSAGING**

Secure messaging is an essential part of a PHR and PCMH operation. Integrating this function into TOL as part of a web-based tool addresses HIPAA and network security issues, and once the patient provides password and access permission, communication between the MTF and providers becomes simple, and avoids the hassles common to telephone use. The advantage of documentation of contacts is an added benefit, and “cut and paste” allows transfer to an AHLTA note. The possibilities of this technology are near limitless, and are proven by those medical activities that have used Commercial-Off-The Shelf (COTS) technology. Utilization of this function is planned and will be standardized. In July 2010, the Clinical Proponency Steering Committee (CPSC) directed that the MHS would be using a single secure messaging system with a goal for consolidation to begin in July 2011.<sup>15</sup>

### **Goals and Uses of Secure Messaging**

Secure messaging should allow for asynchronous communication/coordination between patients and providers, providers and consultants, and between PC team members. Enterprise remote access to both secure messaging and the Electronic Health Record (EHR) is the desired state. The ability to designate surrogates is an important feature in this capability. The ability to allow any PC team member to receive and respond to messages is also important. This would allow patients to be managed by the whole team, including non-privileged providers. Ideally, this secure patient-provider messaging capability should be integrated into the EHR as a service. Until this is integrated, any patient communication should be manually entered into the EHR using a copy and paste or equivalent methodology. The PC team, consultants, and the patients

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<sup>15</sup> MHS IM/IT Strategic Plan for 2010-2015 – Action Plan Document, 2 Nov 10

need to be able to attach files to the secure message. All currently available solutions for secure messaging allow for attachment of files. Due to security restrictions, those files must be limited to non-executable files (no Zip files; no database files). The purpose of asynchronous secure messaging is to provide the following capabilities, which are available or supported by all current iterations of secure messaging:

- Demand management
- Results distribution (e.g., laboratory and X-Ray results)
- Preventive healthcare communication
- Broadcast messaging/announcements (e.g., influenza vaccine availability)
- Minor illness/injury management
- Prescription renewals

### **MEDICAL CONTINUUM OF CARE REQUIREMENTS**

The MTF will ensure a process to identify at-risk beneficiaries requiring further evaluation during in-processing. At-risk conditions include unstable chronic medical/mental health conditions, new-onset diseases/labs/pathology findings requiring follow up, active referrals, or medical conditions requiring continued MM oversight or provider action. The MTF will ensure that a process exists to capture information from all enrolled beneficiaries.

The MTF will ensure that a process exists to identify at-risk individuals known to be leaving the facility (primarily active duty and family members identified through focusing on patients requiring continued CM, follow-up specialty care or action for critical lab/radiology findings. The MTF is responsible to ensure measures are in place to track timeliness and accuracy of these processes. The MTF will ensure that appropriate resources and contact information are available to facilitate a smooth and complete when the enrollee and his/her family depart to a new duty station. The following resources will be provided at minimum:

- Access to Emergency Care during transit
- MTF appointment line at gaining facility
- Information regarding Prenatal/Prenatal Care services
- TRICARE Operation and Patient Administration contact information
- Exceptional Family Member Program MTF point of contact
- Family Readiness Center
- Military Once Source (on-line website)
- Guidance on how to obtain refills in the event of loss or stolen medications during travel

## **Chapter 7**

### **Specialty Integration**

Every component of MM is integral to the PCMH concept, as each activity supports a team approach to patient care. With robust MM programs, the MHS will be able to manage complex patient care and improve patient outcomes by decreasing variation in clinical management. MM, as defined in the MHS Medical Management Guide, combines the PCMH team clinical and business operations to the MTF business plan, while at the same time optimizing MTF specialty care. In addition, referrals to specialty care must be integrated into PCMH operations.

#### **MEDICAL MANAGEMENT**

Clinical aspects of MM are generally under the direction of the Chief of Medical Staff. The Chief of Medical Staff is responsible for the clinical coordination and supervision of DM, CM and UM professional staff, along with the timely selection and approval process for MTF specific CPGs. In addition, the Chief of Medical Staff facilitates PCMH team care coordination meetings; prioritizes care using available data-bases; leads the clinical aspects of MM meetings; and chairs the Population Health Working Group (PHWG). Day-to-day MM activities are under the purview of the MTF Commander-appointed individual who provides the oversight and management necessary to ensure the appropriate care coordination of MTF MM site specific activities.

#### **Utilization Management (UM)**

UM, in collaboration with the PCMH team members, target measures and/or beneficiary processes that trigger high-cost, high-volume, or problem-prone diagnoses, procedures, services, and beneficiaries that trigger high utilization rates. The Utilization Manager is an MTF-wide asset that provides shared support to PCMH teams and is an active member during interdisciplinary care meetings to ensure effective identification of beneficiary specific utilization and resource consumption. Accordingly, the Utilization Manager makes appropriate recommendations to optimize DM and CM staff regarding high utilization or high risk enrollees. As a result, these team members can then evaluate individual beneficiary needs to identify care coordination and management requirements. The MTF and HQ leadership provide direction and consultation in selecting appropriate measures in relation to the strategic plan, and to meet the needs of the MTF. Additionally, the UM process is also essential to maintaining clinical currency within the teams and specialty clinics. This is accomplished through an active review of referral requests to identify care that can be accomplished within MTF capabilities and capacity; thus, taking action to ensure care is retained at the MTF rather than being sent to the PCS.

#### **Case Management (CM)**

CM serves as an essential link to all agencies, disciplines, private and public associations and practitioners within the delivery system. As catalysts, case managers seek to provide quality along the health care continuum, decrease fragmentation of care across many settings, enhance quality of life and contain cost. Case Managers are responsible for identifying individuals with chronic, catastrophic, complex, high utilization, high-risk or high-cost health issues who would benefit from CM services in collaboration with DMs and teams. Potential CM patients may have

acute and/or chronic illnesses, complex trauma care needs, combat stress, residuals of traumatic brain injury, community adjustment and social issues, addictions, and high utilization of healthcare services. Case Managers develop and execute individualized multi-disciplinary care plan in conjunction with the patient/family and coordinate with MTF and civilian medical resources to assure smooth transition, minimizing fragmentation of care. Case Managers are active members of inter-disciplinary patient Care Coordination meetings to ensure effective patient CM and care coordination is accomplished. Patients appropriate for CM may be identified at any step in the care continuum by any member of the healthcare/care coordination team. A close interaction is established between case managers, the interdisciplinary team members and the PC physicians to develop a plan of care for the aforementioned patients including the identification of care needs, treatment goals and interventions to achieve designated goals within specific time frames. The case manager, team, and provider review the plan to determine effectiveness and make adaptations where indicated. The case manager is to have access to timely information on hospital and ER admissions to learn about acute care episodes soon after they occur, reevaluate the plan of care and original interventions and if possible prevent future readmissions. CM staff is earned based on MTF enrollment, CM peacetime workload, and Wounded Warrior workload, so may be shared among teams.

***Initial case load determination:*** The Complex Patient Management Tool (CPMT) may be used to provide rapid assessment of patients with the most apparent need. CM nurses are empowered to proactively handle “first call” questions, symptom and problem-based issues for patients with decision support protocols, such as requests for medication refills, self care advice, referrals, clinical preventive services (CPS) and acute needs relevant to the decision support protocol. These calls can provide an opportunity for patient status validation, patient education, and for coordination with CM or UM as necessary.

***Discharge planning*** is managed by discharge planners or Case Managers. As patients appropriate for CM are often identified at inpatient discharge (DCS or PCS), discharge planning actively begins upon admission with care plan updates prior to discharge. The care plan will include ancillary services, as necessary. For DCS admissions, the first follow-up appointment will be given to the hospitalized patient prior to discharge as an MTF standard. PCMs are highly encouraged to participate in discharge planning by visiting hospitalized patients in their panels. Chief of Medical Staff at outpatient facilities will pursue avenues such as “Courtesy Privileges” at local hospitals to facilitate this process.

***CM Documentation:*** Clinical case managers are to document and code their services in AHLTA using DoD-established provider specialty codes, Health Insurance Portability and Accountability Act (HIPAA) taxonomy codes, Medical Expense Performance Reporting System (MEPRS) codes, diagnosis codes, and Healthcare Common Procedure Coding System (HCPCS) codes.

***CM Staffing:*** Case Managers are either Registered Nurses or Licensed Clinical Social Workers. Guidance received from OSD per Directive-Type Memorandum (DTM) 08-033, *Interim Guidance for Clinical CM for the Wounded, Ill, and Injured Service Member in the Military Health System*, August 26, 2009, delineates specific MHS requirements applicable to clinical case managers.

### **Disease Management (DM)**

DM is provided by professional staff members assigned under the Chief of the Medical Staff in direct support of the teams based upon team disease burden. Team providers will work directly with DM/CM staff to develop strategies for the care of their patients with more complex disease states. The Disease Managers are involved in care coordination activities (e.g. Care Coordination Team) as necessary. The DM staff's primary responsibility is to develop and execute DM for the PCMH team and positively impact their enrolled patients' disease and chronic condition outcomes in accordance with applicable CPGs, support staff protocols or clinical decision support tools. Research has shown that a clinic's willingness toward innovation can impact how effective a model is for improving care. CPGs will be used for DM of patients with chronic conditions such as asthma, hyperlipidemia, diabetes, low back pain, and hypertension among others. The DM staff's secondary responsibility is to support the PCMH team nurse by providing direct outpatient care, as directed. This care includes nursing assessment, planning, implementation and evaluation; telehealth activities; medication administration; nursing procedures; staff and patient education and training. DM staff responsibility extends to developing, implementing, and evaluating a DM program according to the DM steps as described in the Medical Management Guide, DoD TMA, current edition. Documentation of all DM patient encounters will be in accordance with DoD, Service and local policies and guidance to include any established AHLTA AIM forms, templates, MEPRS and coding guidelines. Disease Managers are empowered and expected to proactively handle "first call" questions, symptom and problem-based issues for patients with DM protocols, such as requests for medication refills, self care advice, referrals and acute needs relevant to DM protocols. These calls can provide an opportunity for patient status validation, patient education, and for coordination with CM or UM, as necessary.

The Disease Manager collaborates with the PCMH team and CM and UM on all aspects of PH and DM activities. In addition, they assist in the development of the MTF MM Plan in support of the Business Plan to ensure there is a process in place for collecting DM data, monitoring performance, identifying opportunities for improvement and initiating performance improvement programs. The Disease Manager identifies, directs and tracks appropriate patients for entry into approved CPGs for management of their specific diseases/conditions; educates individuals and groups with chronic conditions IAW CPGs; prioritizes population/patient needs; and tracks health care/DM outcomes of individual patients with chronic care conditions. In addition, the Disease Manager participates in the orientation, education and training of DM activities for clinical and non-clinical staff and coordinates and participates in interdisciplinary team meetings, designated MTF meetings, and specific MM, DM, and care coordination meetings.

### **DM and Clinical Practice Guidelines (CPGs)**

CPGs are essential tools in DM and as such are an integral part of the DM support of PCMH. CPGs are recommended based on the needs of the MTF and UM data. MTFs are highly encouraged to use DoD/VA CPGs whenever available. CPG implementation will be documented in the appropriate, Service-specific MTF Executive Committee Minutes. MTFs are expected to follow with aggressive examination of their medical home populations' needs for the implementation of MTF specific CPGs. These may include depression, hypertension,

hyperlipidemia, asthma, diabetes and low back pain. The MTF DM nurse is responsible for assisting with implementation of locally-approved CPGs in collaboration with the MTF's CPG Champion or CPG Facilitator. The Disease Manager (or individual CPG champions) in collaboration with the PCMH team will collect and analyze appropriate outcome measures relative to the CPG.

## **REFERRALS**

Referrals for specialty care are an integral part of the care coordination process within the MTF and PCMH. The MTF or PCMH will establish standardized business rules for referrals and authorizations in close collaboration with the teams. These rules should include referral reviews and appointing within the MTF/DCS when available, consult tracking and obtaining results in a timely manner from PCS providers. The ordering provider is responsible for ensuring referrals contain adequate information and details to allow appropriate handling and routing to include finite episodes of care within their referrals whenever possible. In addition, PCMs, the UM staff, and Referral Management Center (RMC) staff need to maintain awareness of specialty and ancillary services available within the MTF when accomplishing and/or reviewing referrals to the PCS, such that only services exceeding MTF capabilities and/or capacity are outsourced whenever possible. This ensures MTF optimization of services while at the same time promoting team and specialty provider currency requirements. Monitoring referrals will also serve to identify DM and CM needs. Monitoring these issues is the responsibility of the Chief of Medical Staff in collaboration with the UM nurse with regular reporting to the Professional Staff meeting.

## **DEMAND MANAGEMENT STRATEGIES**

MTFs may employ demand management strategies such as nurse/tech, Pharm-D, nutritional medicine, physical therapy, and Health and Wellness Center run clinics, as appropriate. These clinics may include cold/flu, medication refills, hypertension screening, Coumadin, diabetes, sprains/strains, urinary tract infections, nutrition counseling and other low-acuity diseases and conditions. The selection of which demand management strategies will be implemented is a local MTF determination based on beneficiary demands and care requirements. Locally-developed clinical support staff protocols will be developed under the purview of the Chief of Medical Staff and Chief Nurse Executive for licensed professional personnel, with the addition of the MTF Chief Medical Technician Functional Manager for technician staff. The Chief of Medical Staff is responsible for securing approval of all protocols before they are placed into use. Protocols will meet current standards of practice and scope of care. Personnel performing such protocols will be trained with appropriate documentation made in the training records with supervision provided in accordance with protocol requirements.

## **MEDICATION THERAPY MANAGEMENT (MTM)**

MTM is intended to provide personalized pharmacy services to optimize individual medication regimens and compliance with regimens, and improve overall therapeutic outcomes. The PCMH team should consider referring patients with complex drug regimens for medication adherence challenges for MTM consultation with a MTM- trained pharmacy staff member. The pharmacist will conduct a thorough medication review with the patient to identify the obstacles that prevent the patient from deriving the maximum benefit from their drug regimen. The pharmacist will

make recommendations to the PCMH team to address medication-related barriers to improved patient outcomes.

### **PRIVATE SECTOR CARE**

If the MTF or DCS does not have the capability or capacity, specialty care referrals will be forwarded electronically to the MCSC for specialty care approval/authorization. In addition, referrals are required for urgent/routine PC deferred to the network when MTF contingency plans are implemented to provide short-term overflow relief for PC services. The MCSC will notify the MTF, the patient, and the network provider when the referral is authorized for care. The MCSC will notify the patient via letter to make an appointment with a provider in the purchased care sector. The MCSC will not send a patient notification letter for same day and 72-hour referrals. The MCSC will provide the specialist the reason for the referral. The team is responsible for providing the additional medical information (e.g. lab reports, x-rays, medication lists etc.) to the referred specialty care provider as appropriate. The RMC/equivalent may facilitate and support this responsibility. Using best business practices, the MCSC will perform medical necessity reviews as needed, covered benefit reviews, and maintain a multi-level appeal process. The MCSC does not provide referral services for patients who are TRICARE Standard, TRICARE Plus (T-Plus), and TRICARE for Life (TFL), or who have Other Health Insurance (OHI). The RMC is responsible for assisting these beneficiary categories with their referral requirements. This can include providing a list of participating providers, answering questions, and providing an RMC point of contact (POC).

MTF Referral offices or PCMH practices are responsible for tracking and accounting to conclusion all internal and external specialty care results and MTF deferred to purchased care system (PCS) urgent/PC referrals. RMCs/equivalent will need to have mechanisms in place to track and account for their referrals such as the use of CarePoint tracking tools currently in use by the Air Force.

Under T-Nex, the MCSC is responsible for tracking network specialty care referrals for TRICARE Prime and Active Duty Service Members (ADSMs). Under T-3 and OCONUS MCSC contracts, the MCSCs are not required to track referral results. In both cases, MTFs are required to meet The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), and Service-specific inspection activities requirements to track and account for all initial specialty care and urgent/routing PC referral requests going out of/into the MTF to conclusion. Under T-3, MTF referral management offices or PCMH practices will need to establish processes to retrieve referral/consult results from the purchased care providers. Fostering a close relationship with community specialists and their staff will facilitate interagency cooperation to share pertinent patient medical information. The referring provider/PCM team is responsible for ensuring the results are reviewed/signed and forwarded to outpatient records for filing in the patient's medical records. The office or individual tracking referrals should regularly notify PCMs of non-resulted or unused referrals to allow PCMs to make appropriate clinical decisions regarding their patients; the patient's action should be documented in the medical record (e.g. patient did not show for appointment, refused, cancelled, or did not activate referral, etc.)



## Chapter 8

### Integrating Behavioral Health Providers

In 2005, the Institute of Medicine (IOM) stated that behavioral health is intertwined with health care and that the aims, rules, and strategies for health care redesign laid out in *Crossing the Quality Chasm* should be applied to behavioral health care.<sup>16</sup> In 2008 the World Health Organization (WHO) in conjunction with World Family Doctors issued *Integrating Mental Health Into Primary Care: A Global Perspective*.<sup>17</sup> The report states that "Integrating mental health services into primary care is the most viable way of closing the treatment gap and ensuring that people get the mental health care they need." As the PCMH concept has evolved, the same call to action for the integration of behavioral health as a key component of the PCMH continues. In 2010, a report commissioned by the Agency for Healthcare Research and Quality (AHRQ) *Integrating Mental Health Treatment Into the Patient Centered Medical Home* concluded "...the PCMH will not reach its full potential without adequately addressing patients' mental health needs." "...including all stakeholders in a coordinated planning and implementation process will be critical to the success of efforts to integrate mental health treatment into primary care settings."

The terms behavioral health and mental health are often used as umbrella terms that include a wide range of interventions. For clarity in this chapter, behavioral health (BH) will be used as an umbrella term to include services for 1) health behavior change (e.g., weight loss, tobacco cessation and increasing physical activity), 2) substance dependence/abuse/misuse, 3) behavioral medicine interventions (e.g., chronic pain management and insomnia) and 4) general mental health (e.g., depression and anxiety disorders).

#### Why BH Providers Are a Necessary Part of the PCMH

BH is a necessary part of PCMH because evidence shows that PC is already the defacto mechanism through which many patients receive BH care. Over 30% of individuals in the U.S. in a given year meet diagnostic criteria for a BH or substance related disorder.<sup>18</sup> These disorders account for half as many disability days as "all" physical conditions measured in a recent U.S. population co-morbidity survey.<sup>29</sup> In fact, the top five conditions driving overall health cost (work related productivity + medical + pharmacy cost) are depression, obesity, arthritis, back and neck pain and anxiety.<sup>31</sup>

Factors related to stigma, time, access and cost result in up to two-thirds of individuals who might benefit from outpatient BH care, to avoid engaging in these services.<sup>19,20</sup> Half of PCMHs

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<sup>16</sup> Improving the quality of health care for mental and substance-use conditions, Institute of Medicine, 2005

<sup>17</sup> World Health Organization (WHO)/World family doctors caring for people (Wonca). *Integrating Mental Health Into Primary Care*

<sup>18</sup> Croghan TW, Brown JD. Integrating Mental Health Treatment Into the Patient Centered Medical Home. (Prepared by Mathematica Policy Research under Contract No. HHS290200900019I TO2.) AHRQ Publication No. 10-0084-EF. Rockville, MD: Agency for Healthcare Research and Quality. June 2010.

<sup>19</sup> Hoge CW, Castro CA, Messer SC, McGurk, D, Cotting, DI, & Koffman, RL. Combat Duty In Iraq And Afghanistan, Mental Health Problems, And Barriers To Care. *NEJM*. 2004;351;13-22

<sup>20</sup> Eaton WW, Martins SS, Nestadt G, Bienvenu OS, Clarke D, & Alexandre P. The Burden Of Mental Disorders. *Epidemiologic Reviews*. 2008;30;1-14

report they can only sometimes, rarely or never get high-quality BH referrals and when a PCM does make a referral to an outpatient behavioral health clinic, 50% of patients do not make their first appointment.<sup>21</sup> Nearly 20% of deployed Service members screen positive for symptoms indicative of a BH condition.<sup>22</sup> Of these, 78% report a need for help, but less than a fourth receives BH care, partly due to stigma. The Health Care Survey of DoD Beneficiaries (2008) found almost 40% of respondents (active duty, family members and retirees) reported difficulty getting BH care, with approximately 70% of family members reporting trouble accessing urgent BH care. The challenges of accessing or getting patients to engage in outpatient BH services results in approximately half of all BH disorders being treated exclusively in primary care (PC) by a PCM without additional BH assistance.<sup>22</sup> Unfortunately, usual PC services (PC) for the treatment of BH problems have been shown to be consistently less effective than enhanced PC services that incorporate BH.<sup>36-40</sup>

### **Benefits to Treating BH Disorders**

Treating patients with BH disorders in PC provides benefits in terms of lower costs, better outcomes and improved satisfaction with healthcare. Research demonstrates that medical costs decreased 17 percent for those patients receiving BH treatment.<sup>23</sup> For example, PC treatment of depression in patients with diabetes resulted in a \$896 cost savings over 24 months and almost \$3,300 lower healthcare costs over 48 months.<sup>24,25</sup> Other quantitative and qualitative reviews of randomized controlled trials demonstrated better outcomes in depression, panic disorder, tobacco use, alcohol misuse, diabetes, irritable bowel syndrome, primary insomnia, chronic pain and somatic complaints.<sup>26,27,28,29,30</sup> Finally, studies have shown both improved patient and provider satisfaction with healthcare when BH care is integrated.<sup>31,32</sup>

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<sup>21</sup> Eaton WW, Martins SS, Nestadt G, Bienvenu OS, Clarke D, & Alexandre P. The Burden Of Mental Disorders. *Epidemiologic Reviews*. 2008;30;1-14

<sup>22</sup> Ibid

<sup>23</sup> Chiles et al., The Impact of Psychological Interventions on Medical Cost Offset: A Meta-analytic Review. *Clinical Psychology*. 1999;6:204-220

<sup>24</sup> Katon et al., Cost-effectiveness and Net benefit of Enhanced Treatment of Depression for Older Adults with Diabetes and Depression. *Diabetes Care*. 2006;29:265-270.

<sup>25</sup> Unützer et al., Long-term Cost Effects of Collaborative Care for Late-life Depression. *American Journal of Managed Care* 2008;14:95-100

<sup>26</sup> Butler et al., Integration of Mental Health/Substance Abuse and Primary Care AHRQ Publication No. 09- E003. Rockville, MD. AHRQ. 2008.

<sup>27</sup> Craven et al., Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base. *Canadian Journal of Psychiatry*. 2006;51:1S-72S.

<sup>28</sup> Gilbody et al., Costs and Consequences of Enhanced Primary Care for Depression: Systematic Review of Randomised Economic Evaluations. *British Journal of Psychiatry*, 2006;189:484-493.

<sup>29</sup> Williams et al., Systematic Review of Multifaceted Interventions to Improve Depression Care. *General Hospital Psychiatry*, 2007; 29:91-116

<sup>30</sup> Hunter et al., Integrated Behavioral Health in Primary Care: Step-by-Step Guidance for Assessment and Intervention. American Psychological Association, 2009.

<sup>31</sup> Chen et al., Satisfaction with mental health services in older primary care patients. *American Journal of Geriatric Psychiatry*. 2006; 14:371-379.

<sup>32</sup> Gallo et al., Primary Care Clinicians Evaluate Integrated and Referral Models of Behavioral Health Care for Older Adults: Results from a Multisite Effectiveness Trial (PRISM-E) *Annals of Family Medicine*. 2004; 2:305-309.

## **ALIGNMENT WITH THE QUADRUPLE AIM AND MHS STRATEGIC IMPERATIVES**

Integrating BH into PCMH supports *Individual Medical and Family Readiness*. Service members' psychological health is improved through identification and entry into treatment for service members with BH concerns. In addition, treatment in PC decreases the stigma of seeking and obtaining BH care. Integrated BH care also supports the *Experience of Care/Population Health* because evidence-based care and engaging patients in health behaviors is enhanced through improved delivery of CPGs in the PCMH. *Per Capita Costs* or Per Member Per Month (PMPM) costs are lower when BH care is integrated into a PCMH. Reduced costs are also realized through lower emergency department utilization and the recapture of family member BH services from the purchased care sector. Finally, the integration of BH care supports *Learning and Growth* by allowing PCMH team members to treat BH conditions, resulting in a more fully capable, more satisfied MHS workforce.

### **Operational and Clinical Standards for BH PROVIDERS in the PCMH**

In June 2007, the SECDEF accepted the DoD Mental Health Task Force (MHTF) recommendation (5.1.2.2) that "The military Services should integrate mental health professionals into PC settings." Integrating BH providers (e.g., social workers, psychologist) as a standard component of the PCMH is vital if the PCMH is going to fully align along the core PCMH principles and the Quadruple Aim goals of impacting readiness, population health, improved experience of care and decreased per capita cost. Unfortunately, moving BH providers to the PCMH, without changing the clinical, operational and administrative procedures for working in the PCMH will not produce the desired outcomes.

*Please check back for updates on guidance on MEPRS codes for embedded behavioral health clinicians. Guidance/policy is under development at TRICARE Management Activity, in collaboration with the Services.*

A Tri-Service Mental Health Integration Working Group (MHIWG) consisting of family medicine, social work, psychology and psychiatry reviewed the integrated care literature, drew conclusions from the review which together with clinical experience and expert opinion guided the development of recommendations setting minimum standards for integrating BH providers into the PCMH. Those recommendations will be used as the foundation for a DoDI and DoDM setting standards for BH care in the PCMH across the direct care enterprise. Pending the release of the DoDI and DoDM, the following should serve as a guide on how BH providers are integrated into the PCMH.

### **MODELS OF CARE**

The models of care that are most likely to align with PCMH core principles are the Care Management (CM) model,<sup>33</sup> the PC Behavioral Health model,<sup>34</sup> and a blended model of care.

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<sup>33</sup> Williams et al., Systematic Review of Multifaceted Interventions to Improve Depression Care. *General Hospital Psychiatry*, 2007; 29:91-116.

<sup>34</sup> Robinson, P. J, & Reiter, J. T. (2006). *Behavioral consultation and primary care: A guide to integrating services*. New York: Springer

**Care Management model:** The CM model (e.g., the Army’s RESPECT-Mil program) is a population-based model of care using specific pathways to focus on a discrete clinical problem (e.g., depression.) The PCM refers patients to a care manager, who is often a nurse, with special behavioral health training, or master’s level BH provider. The care manager follows a standard method for assessment, planning, and care facilitation and communicates with the PCM and specialty care psychiatric prescriber. PCMs and care managers share information regarding patients with a shared medical record, treatment plan, and standard of care. Typically, there is some form of systematic interface with a specialty care psychiatric prescriber (e.g., weekly case review and treatment change recommendations). Care managers may work from a separate geographical location, but they are usually *co-located* or *embedded* in the PC clinic. CM models improve the treatment of depression<sup>35,36</sup> and there are emerging data supporting the use of CM models for other clinical conditions, such as Post Traumatic Stress Disorder (PTSD), etc. Unfortunately, using the CM model alone will not meet in full the PCMH core principles and Quadruple Aim goal of comprehensive population health impact. Because the CM model focuses on a specific group (e.g., those with depression and PTSD) patients with other health problems that might benefit from behavioral health interventions (e.g., anxiety disorders, asthma, chronic pain, eating disorders, obesity, and sleep disorders) receive no additional BH in PC services. An important and efficacious model, the CM model alone does not result in *comprehensive* health impact.

**Primary Care Behavioral Health Model (PCBH):** The PCBH model (e.g., the Air Force Behavioral Health Optimization Program (BHOP) comes closer to aligning with principles of the PCMH and the Quadruple Aim goals than the CM model of care. In the PCBH model, BH providers are *embedded* within the PCMH as team members. The BH provider works with the rest of the PCMH team in a shared system to address the full spectrum of problems the patient brings to their PCMH. BH providers deliver care in the PCMH clinic where patients are seen by the PCMs. All patient populations are included with the goal of creating a team-based management approach to the full gamut of biopsychosocial needs, many of which have not been within the domain of traditional behavioral health, but managed more by clinical health psychologists or behavioral medicine specialists (e.g., smoking cessation, weight management, chronic pain, headache, sleep disturbance, health risk behavior, medical non-adherence). With this model there is one treatment plan targeting the patient’s needs and a shared medical record. The patient is likely to perceive this behavioral health care as part of his or her routine medical care. This model has an expanded population health focus. There is an emphasis on real time access to care at the exact time the need is identified and the ability to make instantaneous shared medical and behavioral health decisions, all contained with a single health care plan. This is the only model where one of the primary espoused goals is to transfer behavioral intervention skills to the PCM through repeated application of consultative interactions. Researchers have begun to show the effectiveness of the PCBH model, but the existing data is more limited compared to the randomized controlled trials showing that CM model effectiveness for treating depression.

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<sup>35</sup> Gilbody et al., Costs and Consequences of Enhanced Primary Care for Depression:

Systematic Review of Randomised Economic Evaluations. British Journal of Psychiatry, 2006;189:484-493.

<sup>36</sup> Williams et al., Systematic Review of Multifaceted Interventions to Improve Depression Care. General Hospital Psychiatry, 2007; 29:91-116.

**Blended model:** A blended model uses a combination of an *embedded* care manager using the CM model and a BH provider using the PCBH model. The care manager and a BH provider work in tandem to support the needs of the PCMH. Although the blended model has been implemented in the Veterans Administration (VA), currently there are no data demonstrating the efficacy or effectiveness of this combination.

### **RECOMMENDED STAFFING RATIOS FOR BH PROVIDERS IN PCMH**

The Tri-Service MHIWG concurred on BH provider in PC staffing ratios. Clinics with 7,500 or more empanelled patients would use a blended model of care. At least one full-time BH provider, following the PCBH model, would deliver services within the PC clinic. At least 32 hours per week would be devoted to patient contact, treatment planning, and consultation with medical providers. BH providers would also conduct educational presentations, program development, and attend staff meetings. The clinic would also employ one full-time health care professional (e.g., nurse) to fulfill the CM model piece of this blended model. The care manager would spend 32 hours per week delivering depression and PTSD care management pathway services. These services could be expanded to include clinical pathways for other problems (e.g., other anxiety disorders, obesity, diabetes, etc.) as indicated by clinic need and time availability. The BH provider would serve as a clinical supervisor for the care manager when appropriate. Note-there can be several PCMH teams in a given clinic. For instance there might be 4 teams with two PCMs each, with an enrollment of 1,200 per PCM, summing to 2,400 enrolled per team, but 9,600 enrolled in the clinic. When these PCMH teams are practicing next to each other within a given clinic “structure” the BH provider staffing ratio should be applied to the “clinic”. Using the example above there would be 1 BH provider and 1 CM providing services for the 9,600 enrollees of the 4 PCMH teams.

In smaller clinics with 1,500-7,499 empanelled patients, it was recommended that the clinic employ one full-time BH provider who will deliver services consistent with the PCBH model, or one full-time care manager providing CM model services, or one full-time BH provider delivering both PCBH and CM model services. Providing options for smaller clinics was intended to allow for clinic flexibility based on local needs and funding. If possible, having a BH provider who delivers PCBH and CM model services, will facilitate a larger population health impact than either model of service alone.

### **FACILITIES**

Operating under the assumptions of the optimal model for the PCMH, BH providers and care managers should work in the PCMH clinic. While the Tri-Service MHIWG recommends these embedded BH positions be owned by the PCMH to allow authority and accountability, ownership will be left up to the Services and local leadership to decide. The more important issue is that services be provided in the same physical location, regardless of which specialty/clinic “owns” the authorized positions. Proximity alone facilitates ease of collaboration, treatment planning, consultation and having multiple team members see the patient in the same visit or see the patient at the same time.

### **Administrative Requirements**

Patients, regardless of an appointment with a PCM, BH provider or care managers should access care through the same check-in point, wait in the same waiting room and be seen in the same

clinic. BH providers and care managers should enter brief notes, focused specifically on the presenting problem and include recommendations for the PCM. It must be emphasized that the BH provider's and care managers' notes in AHLTA are not formal mental health notes, which are maintained in the Mental Health Clinic. These AHLTA entries are accessible to PCMH team members as needed to provide efficient and appropriate care.

## **BH REFERRALS**

Depending on the severity of the patient's disorder/condition, the patient may require more intensive management of his/her BH needs. As such some patients with BH disorders who present for care in the PCMH will still need to be referred for outpatient BH care.

## **REQUIRED BH PROVIDER SKILLS FOR THE PCMH**

The BH provider will likely need the following skills if he or she is going to maximize his/her efficiency, effectiveness and long-term impact in a way that aligns with the PCMH core principles.

**Clinical Problem Knowledge Breadth:** In a PCMH, providers are prepared to provide comprehensive care and to coordinate care with other specialties when necessary. Consistent with this model, it is essential for BH providers to accept all referrals and find ways to assist anyone who comes into the clinic. This requires a BH provider be familiar with a very broad range of clinical conditions, assessments, and treatments. BH providers should know general adult mental health problems (e.g., anxiety disorders [generalized anxiety disorder, panic disorder, post traumatic stress disorder], bereavement, mood disorders, eating disorders, substance misuse/abuse dependence), and have broader familiarity with common clinical health psychology problems (e.g., chronic pain, diabetes, obesity, sexual disorders, sleep disorders, tobacco dependence). PCMH settings may also require an understanding not only of individual and adult problems, but also child and family problems. Therefore a BH provider should be familiar with a range of common child and adolescent BH problems (e.g., autism spectrum disorders, ADHD, conduct disorders, learning disorders), pediatric health (e.g., asthma, chronic illness coping, elimination disorders, habit disorders) and family problems (e.g., parenting skills, relationship difficulties).

**Ability to Adapt Assessments and Treatments:** Much of the current evidence for how to assess and treat these diagnoses has been studied in tertiary care behavioral health or clinical health psychology settings. BH providers must be able to evaluate the research base, identify the core-components of interventions, and appropriately adapt assessments and interventions for the PC setting.

**Overarching Heuristic for Assessment and Intervention:** Behavioral health assessment and intervention in the PCMH should align with the pace and culture of the setting. The 5A's model<sup>37</sup>: Assess, Advise, Agree, Assist, and Arrange, is an evidence-based clinical heuristic that can guide BH providers in their adaptations of assessments and treatments. The 5A's format has

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<sup>37</sup> Whitlock, E. P., Orleans, C. T., Pender, N., & Allan, J. (2002). Evaluating primary care behavioral counseling interventions: An evidence-based approach. *American Journal of Preventive Medicine*, 22, 267-284.

been strongly recommended for assessment and intervention across a range of problems in PC<sup>38</sup>. The specific tasks within each of the 5A's will vary depending on the nature of the problem as well as its severity and complexity<sup>39</sup>. Nevertheless, the 5A's model can be applied to any patient in any clinic with any problem.

- **Assess phase** - An initial assessment in PC involves gathering information on physical symptoms, emotions, thoughts, behaviors, and important environmental variables like family, friends or work interactions. From a biopsychosocial perspective the goal is to determine what variables are associated with the patients' chief complaint and functioning. Then, based on patients' values and what they have control over, determine what he or she could change that would decrease symptoms associated with the chief complaint and improve functioning.
- **Advise phase** - During the advise phase, the BH provider describes to patients their options for intervention, based on the data gathered in the assessment phase. The goal is to describe the intervention and the expected outcomes as well as to advise the patient on the collaborative nature of assessment and treatment.
- **Agree phase** - To ensure a collaborative relationship towards care, BH providers need to take time to discuss what the patient wants to do based on the options discussed. The patients might also decide they do not like any of the options and suggest some of their own, or might want more time to think about their options or an opportunity to discuss options with a significant other in their lives.
- **Assist phase** - At the assist phase, the BH provider's job is to help patients learn new information, develop new skills, problem-solve and/or overcome environmental or personal barriers to implementing changes. This is where the "formal" intervention takes place.
- **Arrange phase** - In the arrange phase the BH provider should specify when, or if patients will follow-up with the BH provider, their PCM, or facilitate a referral to outpatient BH care. In the arrange phase the BH provider would also discuss what will be evaluated or what information or skill will be the focus of the return appointment. Use of the 5A's produces a personalized health-care action plan. The plan is specific, focused on health behavior change, and an integrated piece of the patient's overall healthcare plan. Ultimately the plan is then monitored and managed by the entire health care team.

**Clinical Core Competencies:** Regardless of the problems being addressed by a BH provider, there are core skills across assessments and interventions that can be used to measure the fidelity of a BH provider's practice.

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<sup>38</sup> Whitlock, E. P., Polen, M. R., Green, C. A., Orleans, C. T., & Klein, J. (2004). Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: A summary of the evidence for the U.S. preventive services task force. *Annals of Internal Medicine*, 140, 558-569.

<sup>39</sup> Whitlock, E. P., Orleans, C. T., Pender, N., & Allan, J. (2002). Evaluating primary care behavioral counseling interventions: An evidence-based approach. *American Journal of Preventive Medicine*, 22, 267-284.

- ***Applies principles of population-based care*** - PC environments are designed to facilitate the care for large numbers of people every day. A BH provider must be able to appropriately provide care for everyone along a continuum from acute need, sub-clinical problems and prevention to those who are healthy. BH providers must be able to determine which referrals are appropriate to manage in PC and which need to be referred to other locations.
- ***Defines behavioral health provider role*** - Unlike outpatient BH clinics where consent to treatment document is reviewed, BH providers need to briefly (e.g., two minutes) explain their roles in the clinic and appropriate limitations on the care and confidentiality that can be provided.
- ***Rapid problem identification*** - Outpatient BH care settings often involve comprehensive biopsychosocial assessments. The time constraints in PC, require that the BH provider skillfully determine whether the patient's perceptions of the primary problem matches what the PCP identified as the problem.
- ***Uses appropriate assessment*** - Adapting to PC requires changing the style and content of assessment questions. To more carefully guide the assessment closed-ended questions are used more frequently compared to outpatient BH clinic settings. Assessments are focused on the presenting problem and elicit how the patient's physical condition, thoughts, emotions, behaviors, habits, and environment impact the identified problem and functioning.
- ***Limits problem definition/assessment*** - In PC the goal is to understand the referral problem well enough to be able to implement the most appropriate evidence-based intervention. The scope of the assessment should focus on the factors affecting the presenting problem and not go far beyond that assessment. Screening for suicidal and homicidal risk for each patient at each appointment is not part of the culture of primary care. However, each Service should determine a standard for the frequency of these screenings when a patient sees a BH provider in primary care. Currently the Air Force policy states that every patient for every appointment with a BH provider in primary care is screened for suicidal and homicidal risk.
- ***Functional outcomes/symptom reduction recommendations*** - It should be clear to the BH provider, patient, as well as any other PCMH team member whether the recommendations and interventions have been successful. Identifying objective methods for determining whether progress is being made is an important component of BH care in the PCMH.
- ***Uses self-management skills/home-based practice*** - The majority of what the patient does to decrease symptoms and improve functioning is done outside of the PCMH appointment. The BH provider should be providing the patient with ways to make changes when the patient is away from the clinic (i.e., homework).



- ***Specific and supportable interventions*** - Recommendations made in PC must be understood by not only the BH provider and the patient, but also other PCMH team members who may be involved in maintaining behavior change plans. Interventions should involve observable and measurable behaviors (e.g., increase fun activities [read Mon, Wed, Fri from 1300-1330 in home office], increase exercise [Mon-Fri from 1700-1730, 30-minutes on stair-stepper], use relaxation skills).
- ***Clear understanding of relationship of medical and psychological systems*** - For example, the BH provider understands the biopsychosocial model of physiological disorders, can describe to the patient the relevant factors, physical, behaviors, thoughts, environment, interactions with others, impacting symptoms and functional impairments.
- ***Basic knowledge of medicines*** - Medications are a frequent course of treatment in PC. BH provider recommendations and interventions are often offered in addition to medication interventions. PCMs may look to BH providers for guidance on medications to consider for some problems (e.g., anxiety, depression). For effective communication with patients and PCMs, BH providers need to be familiar with the more commonly prescribed BH medications (e.g., analgesics, anxiolytics, anti-depressants, hypnotics, opioids) and prescribing practices that are common in their primary clinic. BH providers will not, however, make specified medication recommendations to the patient unless the BH provider is a psychiatrist.

### **Practice Management Skills:**

Perhaps the most challenging skills for a BH provider originally trained to work in an outpatient BH clinical are the practice management adaptations that are necessary for integrated BH care in the PCMH. These practice management skills require BH providers to make fundamental changes to the way they practice.

- ***Efficient use of 30-minute appointments*** - The BH provider must be able to efficiently incorporate the 5A's and demonstrate the clinical core competencies within the 30-minute timeframe usually allotted for "new" patient appointments.
- ***Staying on time*** - BH providers can quickly sabotage their schedule and the schedules of the patients waiting to see them if they are unable to manage their time in the PC clinic. Spending just 5 minutes longer with three patients can mean that subsequent patients are waiting 15 minutes or longer for their scheduled appointments.
- ***Using intermittent visit strategies*** - Unlike outpatient BH clinics that use a standard one to two week interval between appointments, in PC BH providers should use a follow-up strategy that makes the most sense for the presenting problem. Some patients may not come back at all, or may come back the next day, in a week, in one month, or in six months. Use of open access booking is also helpful in integrating BH services into PCMH. BH providers may book patients on the top of the hour and leave appointments on the half hour open and available for patients who may need a same day appointment; this also allows same day feedback to the PCM and decreases no show rates.

***Appropriate outpatient BH care use*** – Integrated BH services in the PCMH will never replace outpatient BH clinic services. BH providers need to be able to determine when a patient’s problems should not be managed in PC and instead should be referred to the outpatient BH clinic. The patients with problems that should be referred should be based on the BH provider’s scope of care, the intensity of the problem, and the patients and PCM’s preference for where care is best delivered and the Services standards for care. As a general guide, (consistent with Air Force current practice) if a patient is not responding to an intervention after 4 appointments, the BH provider in consultation with the PCM and patient should consider referral to specialty BH services outside of the PCMH. This is to insure a patient does not languish in an ineffective treatment modality. Other BH related services that should be performed outside of PCMH include medical social work (other than routine, community-resource referrals), specialized BH case-management, psychotherapy or diagnostic procedures exceeding brief assessment and intervention, long-term, group psychotherapy (although psycho-educational classes offered in the PCMH are appropriate), specialized occupational health and/or disability-management and command-directed evaluations. Legal review of the AF BHOP model stated that “care and caution need to be taken in the number of assessments provided per patient under this model” and that “the more the PC provider has control over the actual delivery of patient care (i.e., diagnosis, treatment regimen, etc.), the greater the perception that the mental health provider's role is indeed merely that of a consultant.” Although this legal review applies to the AF BHOP model, the principle is relevant to all Services, which provides the basis for its inclusion in this guide.

- ***Appropriate community resources use*** - Beyond outpatient BH clinics there are often community based services and groups that may be helpful for the patient to consider.
- ***Consultation and Communication Skills*** - One of the most valuable benefits of integrating BH services in the PCMH is the improved communication between BH providers and PCMs. Successful communication requires that BH providers adapt the ways that they communicate with medical providers to a form that facilitates the medical provider being able to efficiently listen and use the feedback. Providers should avoid profession-specific jargon or long-winded conceptualizations.
- ***Focusing on and responding to referral question*** - BH providers should always answer the referral question. If the patient’s perception of what was most important was different than the referral question, the BH provider should still be in a position to answer the question or provide a rationale for why that question was not answered.
- ***Tailoring recommendations to work pace of PC*** - The PCM should be able to easily understand the recommendations for the patient and be able to quickly facilitate the continuation of those recommendations when seeing the patient at follow-up appointments.
- ***Conducting effective feedback consultations*** - A BH provider should be able to provide feedback to a PCM quickly and use clear, concise explanations for the rationale for and the content of the interventions.

- ***Persistent follow-up*** - The BH provider should always provide feedback to the PCM. Sometimes patients present with concerns that require immediate attention (e.g., side-effects of medications, alarming medical symptoms). The BH provider should be able to distinguish which situations require urgent medical attention.

### ***Recommendations to reduce PCM workload***

- The BH provider should be able to demonstrate and communicate to the PCM how the BH visits will help to reduce the PCM's workload. For instance, the BH follow-up appointments might focus on reassessing depressive symptoms in two weeks and the BH provider offers to help the PCM by also asking about any side-effects associated with the recently started antidepressant.
- ***Documentation skills*** - In outpatient BH clinics, patient notes, particularly new patient notes, are intended to summarize complete biopsychosocial functioning of the individual. The standard of care in PC requires that notes capture the important signs and symptoms affecting patient functioning, but are not viewed as comprehensive reflections of the patients functioning.
- ***Medical notes clear and concise*** - The content of the notes should focus on the referral problem and describe the onset, frequency, and duration of signs and symptoms, while describing the functional impairment. Recommendations at the end of the note should be brief and use measurable outcomes.
- ***Documenting encounter while seeing patient*** - The patient flow and time constraints of PC requires efficient and effective time management. Documenting while engaged with the patient, helps to ensure that important information is immediately recorded and less time is spent recalling the course of the appointment. Documenting while seeing the patient must be balanced with remaining engaged with the patient, and ensuring that active listening is maintained. For example, it would be inappropriate to turn away from a patient when they are demonstrating emotional distress.
- ***Notes consistent with PCM feedback*** - What is written in the note should reflect what is verbally told to the PCM.

### **ADDITIONAL BH INTEGRATION GUIDANCE**

Additional guidance in the form of a DoDI and a DoDM that will set minimum operational, clinical, and administrative standards across Services is expected by the end of FY12.

Additional guidance is also available in the Navy's BUMED instruction 6300.19, the Air Force BHOP Clinical Practice Manual, and the Army OPOD 11-20. Additional information regarding demonstration projects and SME consultation is available by contacting LCDR Christopher L. Hunter at [Christopher.hunter@tma.osd.mil](mailto:Christopher.hunter@tma.osd.mil) or 703-681-0079.

## Chapter 9

### Pharmacy Integration

The PCMH model enables clinical pharmacists to contribute to the healthcare team through services focused on medication management. The PCPCC Medication Management Task Force supports comprehensive medication management as facilitating the efficiency and effectiveness of the PCMH team in improving patient clinical outcomes while lowering total healthcare costs.

As independent providers, pharmacists privileged through the MTF's Executive Committee and commanders are able to provide medication therapy management (MTM) services, improving patient safety and the efficiency of the clinical team. MTM services are distinct from medication dispensing and focus on a patient-centered process of care. MTM services encompass the assessment and evaluation of the patient's complete medication therapy regimen rather than focusing on an individual medication product.

MTM services are recognized through Pharmacist-only Current Procedural Terminology (CPT) codes, and the Medicare Modernization Act of 2003 established requirements for cost control and quality improvement, including MTM programs. MTM services should be documented using the Evaluation & Management (E & M) codes 99605-99607.

Although clinics and services currently provided by pharmacists focus on specialized care, such as anticoagulation clinics, the PCMH model offers the opportunity for pharmacist-provided services to grow.

#### PHARMACY SERVICES

Pharmacist-provided services include, but are not limited to services related to MTM, ambulatory care, prescription renewal, over the counter (OTC) medications, and medication reconciliation.

#### MTM Services:

There are five core elements forming a framework for the delivery of MTM services. As described by the American Pharmacists Association in the "Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, Version 2.0," the core elements include:

- **Medication Therapy Review:** a systematic process of collecting patient-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of these problems, and creating a plan to resolve them.
- **Personal Medication Record:** a comprehensive record of the patient's medications (prescription and nonprescription), herbal products, and other dietary supplements.
- **Medication-Related Action Plan:** a patient-centric document containing a list of actions for the patient to use in tracking progress for self-management.
- **Intervention And/Or Referral:** the pharmacist provides consultative services and intervenes to address medication-related problems; when necessary, the pharmacist refers the patient to a physician or other healthcare professional.

- **Documentation and Follow-up:** MTM services are documented in a consistent manner, and a follow-up MTM visit is scheduled based on the patient's medication-related needs, or the patient is transitioned from one care setting to another.

### **Ambulatory Care**

Clinics specializing in specific conditions or therapeutic management; examples include, but are not limited to: anticoagulation, hyperlipidemia, diabetes, polypharmacy, and infectious disease.

### **Prescription Renewal**

Pharmacist run renewal clinics are a mechanism for patients with chronic, stable disease states to renew prescriptions for maintenance medications for periods in between appointments with their PCM. Monitoring prescription renewal is an opportunity for referral to a PCM, MTM services, or other pharmacist-provided services.

### **Over the Counter (OTC)**

OTC programs are established to assist patients in appropriately selecting an OTC product based on the description of symptoms, with the intent to relieve the need for a scheduled appointment with a healthcare provider. This function is intended to be provided by any pharmacist, regardless of privileging, while operating within MTF-approved guidelines.

### **Medication Reconciliation**

Medication reconciliation consists of a review of a patient's complete medication regimen prior to a scheduled appointment or at any point during the care of the patient with the intent to identify safety or clinical issues, such as those related to poly-pharmacy, drug-drug interactions, or barriers to adherence. Resolution of issues can include changes to the medication profile via AHLTA, patient education, or referral to the PCMH healthcare team to include pharmacist-run MTM services.

### **STAFFING**

Each Service has specific guidelines for MTF pharmacy staffing.

## Chapter 10 Documentation and Coding

### DOCUMENTATION

For quality, effective and coordinated PCMH care, complete and accurate documentation is essential. This chapter provides guidance on types of documentation to include care plans and telecons, coding optimization, the Medical Expense and Performance Reporting System (MEPRS).

**Needs/Enrollment Assessment:** The initial enrollment assessment is a brief needs assessment done by the MTF for the purpose of appropriate enrollment only. Initial screening may require record review; however, the minimum record review requirement is a rapid review of the patient's DD Form 2766 or other care summary for level of care required. Further review for needs assessment for the purpose of developing care plans may be delayed until assignment to a PCM is made. If the initial screening appears to indicate the patient requires more intensive MM services or complex care, the PCMH team or MM is responsible for completing a more comprehensive needs assessment of each new enrollee. In the interim, comprehensive needs assessment for new enrollees will be accomplished through records review, and/or an intake appointment. Early referral to the MM team as soon as these patients are identified as candidates for DM/UM/CM intervention is appropriate.

**Care Plans:** Care plans range from simply providing clinical preventive services to Service-specific active duty annual screenings and complex care plans requiring significant MM involving DM/UM/CM-directed care involving multidisciplinary participation. **Beneficiaries who require comprehensive services and/or who are being followed by a MM program should have a comprehensive care plan (CCP)** that generates and results from all care delivery activities. This creates an action log representing all value added patient care activities, not just face-to-face encounters. The comprehensive care plan should be individualized (contain only information relevant to that patient), proactive (generate automated requests/reminders for care activities), and integrated (organizes information logically from all data sources). Until an IM system is designed, PCMH should use standardized Tri-Service Workflow templates with copy forward feature and standardized macros to document the CCP. Care plans do not require separate documentation beyond normal AHLTA documentation. Use of AHLTA templates is encouraged for team documentation and CPGs. Care plan review and updates are required based upon acuity, and will be accomplished in AHLTA as part of the MM process.

**Patient Lists:** Accurate, up-to-date patient lists for patients enrolled to the PCMH team will be maintained using databases such as the MHSPHP/CarePoint, AHLTA, the ICDB, and CHCS defining the team's patient populations for the purpose of MM and delivery of clinical preventive services (CPS) to medical home patients.

**Telecons:** Telephone assessment, education and counseling may be effectively used by the health care team. All interactions should be documented in AHLTA and coded appropriately. Nurse telephone encounters regarding symptom based calls should include documentation of the decision support tool and protocol used and be reviewed by a provider within 24 hours.

Medication Therapy Management (MTM) Services. MTM services provided by appropriately trained pharmacists will be documented using the Evaluation & Management (E&M) codes 99605-99607. These codes were established by the Centers for Medicare and Medicaid Services (CMS) in 2008 for billing MTM services.

### **CODING OPTIMIZATION**

Accurate coding is imperative to drive optimal template and appointing management. Accurate coding will ensure proper staffing, clinical mix and supplies/equipment to match the demand of your population. Accurate coding also maximizes third party collections efforts. The MHS utilizes current coding auditors or some other means of oversight to ensure coding is accurate. Auditors should communicate positive and negative trends in data and provide training where required to maximize accuracy. Team leaders are responsible for ensuring encounter coding is accomplished in a timely manner IAW current standards. Team providers and other personnel are responsible for documenting and coding all patient encounters in accordance with DoD, Service and local policies and guidance to include any established AHLTA forms/templates, MEPRS and coding guidelines. CM staff are responsible for documenting and coding their services in the AHLTA using DoD established coding guidelines. Use of standardized AHLTA templates is highly recommended.

### **MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS)**

MEPRS is the standard cost accounting system for the Military Health System (MHS), containing Tri-Service financial, personnel, and workload data from reporting medical and dental treatment facilities worldwide. MEPRS assumes an essential role in MHS decision-making and performance evaluation by offering: Uniform performance indicators' expense data classified by work center; human resource utilization data classified by work center; and a standard methodology for cost assignment. Accuracy of MEPRS and DMHRSi is essential in order to make accurate workload, performance and resourcing decisions. For additional information, please see the TRICARE MHS MEPRS website at <http://www.meprs.info/> and also your Service-specific MEPRS reporting guidance.

## **Chapter 11**

### **Business Planning**

The MHS has developed and implemented a robust enterprise Business Planning Process. This planning process is presently centered on the Tri-Service Business Planning Tool (BPT). MTF Commanders and staff working closely with their Service-specific business planning personnel will assess and forecast their market health care requirements. The assessment process will also include measures to achieve the goals of the eight critical initiatives of the MHS Strategic Plan. The tool will roll up relatively granular data to an overall expected workload and provide a Service-level ability to predict Prospective Payment System (PPS) earnings. The MTF business plan is an overall performance based plan used to track MTF performance.

#### **THE BUSINESS PLANNING TOOL (BPT)**

The BPT is the vital first step in providing MTFs the tools necessary to efficiently manage limited MHS resources. The BPT is also the vital first-step in linking business planning with resourcing, execution, and performance monitoring. In the long-run, business planning is intended to provide a tool and process by which the MHS benefit can be managed, controlled, and maintained. The BPT will be used by MTFs to develop individual business plans. TRICARE Regional Offices (TROs) will review plans and incorporate into Regional Plans.

In the current version, the BPT projects the resources required to provide care to a specific enrolled population, as well as a coordination of care within markets. The current assessment process of the BPT includes measures to achieve the goals of the MHS including enhancing readiness and expeditionary planning, improving access to care, managing referrals, improving documented value of care, advancing evidence-based health care, optimizing provider productivity, and improving labor cost reporting and management.

#### **WORKLOAD REPORTING**

Reporting of workload will be done in a Fee for Service (FFS) environment. Workload measures are consistent with the current MHS operation of inpatient and outpatient reporting, using Relative Weighted Products (RWPs) and Bed Days for inpatient, and enhanced Relative Value Units (RVUs) for outpatient care. Data will be aggregated at the PPS Parent MTF level, and be displayed by Service, Region, and Overseas.

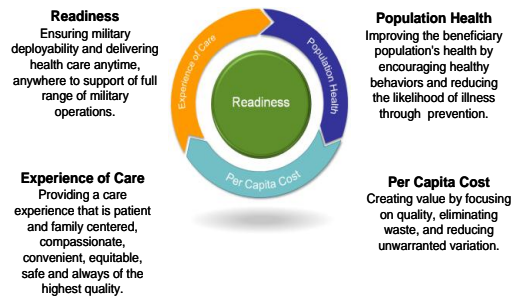


## Chapter 12

### Metrics, Benchmarking and NCQA

#### METRICS AND THE QUADRUPLE AIM

DOD's strategic vision is based on Dr. Don Berwick's "Triple Aim" [Care, Health, and Cost]<sup>40</sup>; the DOD's vision is called the "Quadruple Aim", which adds the important fourth goal of military readiness. The Quadruple Aim vision creates health care value for the military system through 1) optimized population health, 2) patient experience, safe and quality care, 3) responsible use of resources, and 4) supporting readiness in the medical military mission, as discussed in Chapter 2 of this guide. Senior Leadership recognized the PCMH model of care as the strategic enterprise initiative with the greatest potential to optimize the MHS strategic goals of the Quadruple Aim. Implementation targets have been set and a commitment to moving forward has been made with accountability links tied to outcome performance measures designed to optimize the Quadruple Aim.



#### MHS METRICS

The MHS will monitor metrics to ensure effective operation of the PCMH, MHS healthcare and impact on the Quadruple Aim. The Tri-Service PCMH Advisory Board currently is determining which metrics will be followed at the MHS level. Proposed metrics include:

- **Getting Timely Care** – access standards should be met.
- **PCM Continuity** – PCM continuity enhances healthcare, continuity of care, and enrollee/physician relationships.
- **Enrollee Satisfaction with Healthcare** – enrollee satisfaction should increase due to personal relationships with teams, timely appointments and appropriate, coordinated care.
- **ED Utilization** – PCMH should reduce unnecessary usage of ED care.
- **Per Member Per Month (PMPM)**– Per capita cost should be reduced through care management, reduction of unnecessary specialty care, and early intervention/prevention. The **Healthcare Effectiveness Data and Information Set (HEDIS)**: PCMH operations should improve a practice's HEDIS measures, which are a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks.
- **Staff satisfaction** – PCMH should enhance staff satisfaction.

<sup>40</sup> Health Affairs, "The Triple Aim: Care, Health and Cost", Berwick, Donald M. et al, 27, No. 3 (2008): 759-769.

## **PERFORMANCE PLANNING PILOTS**

The MHS also is examining the effects of a “pay for value” internal reimbursement method by implementing a pilot program at seven military installations; each of the seven sites will receive performance rewards for achieving population health, satisfaction, access, quality and utilization targets. In addition, several of the sites will have partial capitation for primary care.

## **NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) STANDARDS**

In order to support the continued transformation of primary care into PCMH practices, the MHS has contracted with the National Center for Quality Assurance (NCQA), through which MHS PCMHs will seek formal recognition. To meet the requirements for NCQA recognition, the MHS has begun systematic improvements in access to care, primary care manager continuity, secure messaging, population health tools and performance reporting. Our ability to achieve NCQA level recognition will serve as a maker for the progress of the transformation of primary care. Additional NCQA information is available at the Patient Centered Medical Home NCQA website at <http://www.ncqa.org/tabid/631/Default.aspx>

**NCQA 2008 Standards:** The 2008 NCQA PCMH Standards are effective until December 31, 2011. There are nine standards and 30 elements. Of the 30 elements, 10 are considered “must pass.” Practices must achieve a score of 50% or higher on must-pass elements. Depending on total scores, practices will be recognized as Levels 1, 2 or 3, with 3 being the highest possible rating. Standards are:

- Access And Communication
- Patient Tracking And Registry Function
- Care Management
- Self-Management Support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting And Improvement
- Advance Electronic Communications

**NCQA 2011 Standards:** The 2011 NCQA PCMH Standards are effective 28 March 2011. The number of standards decreased from nine to six and the number of “must pass” elements decreased from ten to six. Practices must achieve a score of 50% or higher on must-pass elements. In 2011, there is an increased emphasis placed on responsiveness to patients' needs and being patient/family centered. In addition, there is a stronger focus on integrating behavioral healthcare and care management, patient survey results help drive quality improvement, and patient and family involvement in quality improvement. The 2011 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

## **NCQA AND THE MHS**

The NCQA recognizes the MHS as a “multi-tier” organization. The first tier is the enterprise level, represented by the TRICARE Management Activity (TMA). The second tier is the MTFs. Finally, individual PCMH practices are the final tier. One or more teams may make up each PCMH practice. MHS PCMH practices are primary care platforms such as internal medicine, family practice, primary care, pediatrics, flight medicine and undersea medicine. The MHS’ goal is for all DCS Prime enrollees to be seen in a NCQA Level 2 PCMH at some point in the future. As a result, the number of PCMH practices recognized as PCMHs as well as the number of enrollees to PCMHs will be tracked at the TMA and Service level.

**Baseline Assessment:** All current and future PCMH practices in the MHS were sent the NCQA 2008 Standards Survey to use to assess their baseline readiness. The baseline readiness results will be used to evaluate PCMH funding return on investment at some point in the future, to identify enterprise and Service capabilities gaps, and to better assess which PCMH practices are ready to seek formal recognition from NCQA.

**Recognition Process:** Based on Service recommendations, a specific number of PCMH practices will be funded to seek formal NCQA recognition. Practices selected to seek formal recognition in FY2011 will use the NCQA 2008 Standards. Practices selected to seek formal recognition in FY2012 and beyond will use NCQA 2011 Standards.

## **Chapter 13**

### **Support and Communication**

#### **GOVERNANCE**

Each Service has identified Service offices of primary responsibility for PCMH who are responsible for providing oversight over Service PCMH implementation and policy at their Service MTFs. In addition, TMA has established the following forums:

#### **Tri-Service PCMH Advisory Board (AB)**

The Tri-Service PCMH AB is chaired by the Assistant Chief Medical Officer at TMA. Membership includes the Service PCMH representatives and other TMA functional experts in strategic management, human resources, pharmacy, and behavioral health. The AB meets monthly.

#### **Tri-Service PCMH Working Group (WG)**

The Tri-Service PCMH WG is chaired by the Director, PCMH at TMA. Membership includes Service PCMH representatives and Service SMEs. The WG is responsible for developing strategies and recommendations for the AB on issues including but not limited to guidance development, policies, IM/IT tool development, metrics, communication/marketing, and satisfaction surveys. The WG meets monthly.

#### **MHS COLLABORATIVE WEBSITE**

In order to foster the collaboration and provide information, and continue the valuable discussions that took place at the Summit, the TMA and the National Naval Medical Center (NNMC) have developed a web-based Medical Home website for the MHS and the Department of Veterans Affairs. This website, which is hosted by the Department of Health and Human Services (HHS), Agency for Healthcare Research and Quality's (AHRQ) Federal PCMH Collaborative website, is designed to provide a portal for Tri-Service and VA communication, collaboration, and document/information sharing. The DoD/ VA section of this website is password protected and restricted to current DoD and VA employees (who have an active “.mil” or “.va.gov” email account). The website will allow you to join discussion forums on a variety of PCMH implementation topics and lessons learned, upload and share unclassified documents with your colleagues, and share or learn more about upcoming PCMH-related events. The website will also highlight the most recent Service and DOD guidance available.

If you are interested in registering to gain access to this Federal DoD/VA PCMH Collaborative website, please send an email with the subject line “Add User: AHRQ PCMH Collaborative Website”, along with your name, title, email address, and organization to: [TMAPCMH@tma.osd.mil](mailto:TMAPCMH@tma.osd.mil). Once you have been registered for the website, you will receive a follow up email from the AHRQ website administrators with a link to the website, along with a username and password to access the site.

# Chapter 14

## Teamwork, Tools and Approaches

### INTRODUCTION

Effective teamwork within the PC clinic and across all elements of the healthcare system and the patient’s community will be critical to successful implementation of a PCMH practice. Foundational team skills and strategies such as communication, coordination, team leadership, and patient engagement are central to many of the PCMH core principles. The American College of Physicians recognized the significance of teamwork when it defined PCMH as: “...a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.”

### OVERVIEW & OBJECTIVES

The following section provides a high-level overview of a key set of teamwork tools and strategies that will help your facility maximize the benefits of PCMH by optimizing the team-based care you deliver to your patients across the continuum of care. These tools and strategies were designed to enhance team performance within and across clinics/units and service lines and to engage the patient and family members as active participants of the care team. For the PCMH model, these tools and strategies apply to communication, coordination, and other team activities and principles within and between three distinct yet inter-dependent teams:

- Core PC team: the PC leader, his/her team of healthcare professionals within the PC clinic or unit, and the patient and family;
- Specialty/subspecialty care team: healthcare professionals outside the PC team including – specialists/subspecialists, hospitals, home health, etc; and,
- Patient’s community team: the patient’s community care team including family members and community-based services.

For optimal implementation of a team-based PCMH practice, the PC team should apply teamwork tools and strategies within their own team as well as during communications and interactions with members from the specialty team and the patient community team. However, a phased integration of the teamwork tools and strategies is a reasonable, low-burden approach. Each facility may select the best method for achieving broad-based integration of teamwork tools and principles within their PCMH model based on their particular needs and resources. One suggested approach is to begin using the teamwork tools within your PC team and engaging each patient (and family members as appropriate) as integral members of the PC team. As clinic staff gains confidence with those practices, they may then apply relevant teamwork tools and strategies while interfacing with members of the specialty care team and the patient’s community care team.

*This section overviews simple tools to foster team-based care, promote patient safety, and maximize the positive impact of PCMH within your facility.*

*“Teamwork is essential to the Patient centered medical home; teamwork, focused around and with the patient, optimizes the medical home model.”*  
*John Kugler, MD, COL (ret. USAA), Deputy Chief Medical Officer, TRICARE Management Activity*

Decades of team performance research provide solid evidence that high performing teams possess a set of core competencies with specific knowledge, skills, and attitudes. To create and

sustain high-performing teams across the healthcare environment, the DoD Patient Safety Program in partnership with the Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) developed TeamSTEPPS® (Team Strategies & Tools to Enhance Performance & Patient Safety), an evidence-based medical team performance improvement program. The goal was to create a comprehensive set of evidence-based tools and strategies that are practical and adaptable to any healthcare organization or unit. The program includes a comprehensive suite of ready-to-use materials and training curricula to provide healthcare professionals with critical team-related knowledge, skills, and attitudes, and to offer guidance on the implementation and management of a team performance improvement effort. TeamSTEPPS provides a powerful solution for optimizing team-based care within any facility's PCMH practice.

*To implement PCMH effectively while managing your patients' care, we recommend at least one member from your PC team complete TeamSTEPPS training.*

This section provides information on how your facility may quickly get started with some of the most relevant TeamSTEPPS tools, strategies, and principles. While it is not intended to be a comprehensive guide to team performance improvement, this document aims to provide straightforward approaches to establishing team-based care within your PCMH practice by integrating some simple yet critical TeamSTEPPS tools, strategies, and principles.

## **GETTING STARTED**

### *Consider TeamSTEPPS Training*

It is highly recommended that at least one member of the PC team attend TeamSTEPPS training. Several years of experience with TeamSTEPPS within the MHS has shown that a TeamSTEPPS-trained staff member can greatly facilitate implementation of TeamSTEPPS tools and strategies by providing on-going coaching and feedback to the staff. However, this step is not essential if resources are limited. TeamSTEPPS tools are simple to use, and the materials were designed for immediate use without specialized training.

## **SELECT TOOLS AND STRATEGIES TO IMPLEMENT**

The following section overviews a set of easy-to-use tools and strategies that is particularly relevant to teamwork within the PC team, the specialty care team, and the patient's community team. These tools provide simple solutions to help optimize team-based care within the PCMH.

**Briefs** are short planning sessions, facilitated by the team leader, conducted prior to the start of the day or a procedure to discuss team formation; assign essential roles; establish expectations; anticipate outcomes and likely contingencies. They are an efficient method to ensure each team member knows the plan for the day, any potential risks to that plan, and expected adjustments if those contingencies should occur. Briefs are routine, occurring at predictable times, such as at the start of a clinic or before a procedure.

*Conducting daily **briefs** ensure all members of the team maintain a shared awareness of patients' plans for healthcare and wellness.*

- ✓ A brief is short; the transfer of information essential to communication often takes less than 2 minutes.
- ✓ Most teams report increased efficiency and less frustration when they conduct briefs.

- ✓ Briefs require coordination and cooperation by multiple team members to be successful.

**Huddles** are intended for problem solving and updating the plan, either updating the day's activities across multiple patients or a single patient. Huddles are used to reestablish the team's awareness of the situation, reinforcing plans in place; and assessing the need to adjust the plan. Huddles are often used by healthcare teams when a situation changes. Examples for the PC team would be an unanticipated equipment failure or the arrival in the clinic of an acutely ill patient needing additional treatment and resources and possibly transfer to definitive care.

*Call a **huddle** to problem-solve quickly, especially in the midst of a chaotic clinic.*

- ✓ Huddles provide team members with an opportunity to update each other on emerging or significant changes in the status of the environment so all team members may adapt appropriately and resources allocated as necessary.
- ✓ Unlike briefs, huddles are NOT routine; they occur as needed.
- ✓ Anyone, including the patient or family member, may request a huddle to deal with new issues, added complexities, unusual circumstances, or any need to adapt the earlier plan.

**SBAR** is a structured communication tool that can improve information exchange among healthcare team members. Although healthcare teams use it for communicating various types of patient information, SBAR was designed for communicating critical information that requires immediate attention and action concerning a patient's condition.

SBAR is a mnemonic for:

- **Situation:** What is the situation?
- **Background:** What is the clinical background?
- **Assessment:** What is the problem?
- **Recommendation:** What do I recommend/request to be done?

*When conveying patient information, **SBAR** can be used to effectively structure communication.*

- ✓ SBAR provides a framework for team members to communicate vital information in an organized, effective, and efficient manner.
- ✓ Use of SBAR as a structured communication mechanism has been shown to reduce the rate of adverse events (Haig, Sutton, & Whittington, 2005).
- ✓ Many organizations use SBAR as a tool for transferring information during patient handoffs. While SBAR allows for effectively exchanging information, it was not designed for transferring highly complex and detailed information as some handoffs may require. Several mnemonics embedded within electronic health records are used to relay patient information appropriately during patient handoffs. Within the PCMH, these handoffs may occur between PC team members or with specialty care team members. Your PC team should determine the required information to share during handoffs and provide a checklist to all team members to assure the appropriate elements are conveyed or received as part of patient care coordination/integration.

*The PC team leader can use debriefs to elicit input from the staff on team performance related to patient care, associated care processes, and operational efficiency.*

**Debriefs** are short informal information exchange team sessions that occur at the end of a procedure or specified period (such as a shift or day). They are facilitated by the team leader and designed to help the team identify opportunities to improve team performance and effectiveness; similar to a concise after-action review. Debriefs are used to:

1. Review individual and team performance
  2. Identify errors made
  3. Recognize best practices
  4. Develop a plan to improve
  5. Promote continuous learning and process improvement
- ✓ Debriefs are most effective when conducted in an environment where **honest mistakes are viewed as learning opportunities**.
  - ✓ Debriefs are most useful when they relate to specific team goals or address particular issues related to recent actions of the team. Debriefs also maintain effectiveness by **not assigning blame or failure to an individual**.
  - ✓ Mistakes in healthcare can have tragic consequences. Team events like debriefs can help reduce medical error by allowing healthcare teams to learn from their mistakes as well as their successes in an atmosphere of psychological safety.
  - ✓ Debriefs have been used for decades by high-performing teams in aviation, military units, business, and the nuclear power industry. Research has shown teams that debrief outperform teams that do not by as much as 40% (Smith-Jentsch, 2008).

**Two-Challenge Rule** is a patient advocacy strategy team members may use to assertively voice a concern to another team leader (often a superior) to ensure it has been heard. It is typically used when a team member's viewpoint does not coincide with that of a decision-maker. The Two-Challenge Rule, in conjunction with leadership that empowers all team members to "speak up" and challenge when appropriate, provides a simple tool to overcome professional hierarchies in the interest of the patient's safety and well-being. When an initial assertion is ignored:

- ✓ It is a team member's responsibility to assertively voice concern at least two times to assure it has been heard.
- ✓ The team member being challenged must acknowledge the assertion.
- ✓ If the outcome is still not acceptable, take a stronger course of action or utilize the chain of command.

**TEAMUP** is a strategy to engage patients as active members of their medical care teams for the purposes of improving the safety and quality of care delivery. It establishes a simple, structured approach to assist patients obtain the type of information they need for self-management, another component of PCMH. TEAMUP broadens the application of TeamSTEPPS tools and strategies beyond healthcare professionals by integrating the patient as a core member of the care team. Through TEAMUP, medical teams encourage their patients to become actively engaged in their own care by following the key communication and teamwork participation principles represented by the project name:

- **T**-eam together
- **E**-ducate yourself
- **A**-sk questions



- **M**-anage your medications
- **U**-nderstand changes in the game plan
- **P**-rovide your perspective

### **WHERE DO I FIND MORE INFORMATION ON THESE TEAMWORK TOOLS?**

All resources mentioned within this section can be located on the DoD Patient Safety Program website, <http://health.mil/dodpatientsafety>, by accessing the DoD Patient Safety Learning Center. Toolkits exist for most of the TeamSTEPPS tools and strategies mentioned within this document. These toolkits are intended to be short, self-contained resource modules for just-in-time learning and application. They contain everything you need to implement the associated TeamSTEPPS tool or strategy in your healthcare organization, including an educator’s (facilitation) guide; PowerPoint slides; video clips demonstrating techniques; and additional resources, such as articles, checklists, pocket guides, scenarios, case studies, and archived podcasts.

For the patient-centered specific resources, the TEAMUP brochure can be further customized for your facility and patient population. In addition, a short patient engagement module, associated PowerPoint presentation, and resource list can be used to educate your staff on effectively engaging patients for improved self-management, compliance, and clinical outcomes.

### **WHAT ARE MY NEXT STEPS?**

After reviewing this teamwork section of the PCMH model implementation guide, you may ask, “how do I start to implement these TeamSTEPPS tools and strategies?” The following incremental approach is recommended:

1. Begin with your PC team; ask them which TeamSTEPPS tools and strategies would be the most beneficial for promoting team-based care in your PCMH.
2. Access the associated toolkit, resources, and/or materials, and follow instructions for implementation.
3. Assess how the TeamSTEPPS tools and strategies are helping the various teams to perform more effectively. If you identify factors hindering use in daily practice, strategize with your team on how to overcome those barriers.
4. Work with the PC team to expand application of the selected teamwork practice to the specialty care and patient-family teams.
5. Incorporate lessons from barriers encountered and share successes when expanding TeamSTEPPS tools and strategies.
6. Share results from the teamwork practice’s impact on PCMH.
7. Reassess if/when another TeamSTEPPS tool may be incorporated to maximize the benefits of the PCMH and associated operational efficiencies. After selecting your next tool, return to step #1.

### **WHO CAN I CONTACT TO HELP?**

If you encounter challenges to accessing the teamwork resources mentioned or barriers to implementing the tools in your facility, you may contact the DoD Patient Safety Program through the website’s ‘contact us’ link <http://health.mil/dodpatientsafety/ContactUs.aspx>; you may also seek assistance from your Service Patient Safety Office; or your MTF’s Patient Safety Manager.

## Appendix A – ACRONYMS

AAAHHC	Accreditation Association for Ambulatory Health Care
AAFP	American Academy of Family Physicians
AAP	American Academy of Physicians
AARF	Account Authorization Request Form
AB	Advisory Board
ACP	American College of Physicians
ADSM	Active Duty Service Member
AF/SG	Air Force Surgeon General
AFI	Air Force Instruction
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical System
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AOA	American Osteopathic Association
BH	Behavioral Health
BHOP	Behavioral Health Optimization Program
BPT	Business Planning Tool
BUMED	Bureau of Navy Medicine and Surgery
CCP	Comprehensive Care Plan
CDM	Clinical Data Mart
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCS	Composite Health Care System
CM	Case Management or (or Care Management in Behavioral Health)
CONUS	Continental US
CPGs	Clinical Practice Guidelines
CPMT	Complex Patient Management Tool
CPS	Clinical Preventive Services
CPT	Current Procedural Terms
DCS	Direct Care System
DHMRSi	Defense Medical Human Resources System
DM	Disease Management
DM	Disease Management
DOD	Department of Defense
DODMHTF	Dept of Defense Mental Health Task Force
E & M	Evaluation and Management
ED	Emergency Department
EST	Established Appointment
FFS	Fee For Service
FHI	Family Health Initiative
FHO	Family Health Operations
FHT	Family Health Team
FM	Family Medicine
FP	Family Practice
GDLB	Good Backlog
GPM	Group Practice Manager (Air Force)
GRP	Group Appointment Type

## Appendix A – ACRONYMS (Continued)

HCI	Health Care Integrator
HEDIS	Healthcare Effectiveness Data and Information Set
HER	Electronic Health Record
IAW	In Accordance With
ICDB	Integrated Clinical Database
IM	Internal Medicine
IM/IT	Information Management/Information Technology
IT	Information Technology
LDL	Low-density lipoprotein
LPN	Licensed Practice Nurse
M2	MHS Management Analysis Reporting Tool
MA	Military Assistant (Navy)
MCSC	Managed Care Support Contractor
MDG/CC	Medical Group Commander (Air Force)
MDOS	Medical Operations Squadron (Air Force)
MEPRS	Medical Expense and Performance Reporting System
MHIWG	Mental Health Interagency Working Group
MHP	Medical Home Port (Navy)
MHP	Military Health Program
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MM	Medical Management
MTF	Military Treatment Facility
MTM	Medical Therapy Management
NAVMED	Naval Medicine
NCQA	National Center for Quality Assurance
OCONUS	Overseas from Continental US
OHI	Other Health Insurance
OPAC	Open Access Appointment Type
OPORD	Operating Order (Army)
OTC	Over the Counter
PC	Primary Care
PCAB	Primary Care Advisory Board (Navy)
PCBH	Primary Care Behavioral Health Model
PCM	Personal Care Manager
PCMBN	Primary Care Manager by Name
PCMH	Patient Centered Medical Home
PCPCC	Patient Centered Primary Care Collaborative
PCS	Permanent Change of Station
PH	Population Health
PHI	Protected Health Information
PHN	Population Health Navigator (Navy)
PHWG	Population Health Working Group
PMO	Program Management Office
PMPM	Per Member Per Month
PMPY	Per Member Per Year

## Appendix A – ACRONYMS (Continued)

POC	Point of Contact
POM	Program Objective Memorandum
PPS	Prospective Payment System
PROC	Procedural Appointment Type
PTSD	Post Traumatic Stress Disorder
RMC	Regional Medical Command
RN	Registered Nurse
RVU	Relative Value Unit
RWP	Relative Weighted Product
SDA	Service Delivery Assessment
SGH	Director of Medical Staff (Air Force)
SGN	Senior Nurse Executive (Air Force)
SME	Subject Matter Expert
SPEC	Specialty Appointment Type
TFL	TRICARE For Life
TOL	TRICARE On Line
TRO	TRICARE Regional Office
UAP	Universal Assistant Personnel
UM	Utilization Management
VA	Veteran's Administration
WELL	Wellness Appointment Type
WG	Working Group

## **Appendix B – USEFUL WEBSITES**

### **Uniformed Service Academy of Family Physicians**

<http://www.usafp.org/Patient-Centered-Medical-Home-Page.html>

### **Patient Centered Primary Care Collaborative**

<http://www.pcpcc.net/>

### **American College of Physicians PCMH Resource Site**

[http://www.acponline.org/running\\_practice/pcmh/understanding/](http://www.acponline.org/running_practice/pcmh/understanding/)

### **NCQA Recognition Website**

<http://www.ncqa.org/tabid/631/default.aspx>

### **American Academy of Pediatrics Center for Medical Home Implementation**

[http://www.medicalhomeinfo.org/how/care\\_delivery/pediatric\\_subspecialists.aspx](http://www.medicalhomeinfo.org/how/care_delivery/pediatric_subspecialists.aspx)

### **AHRQ PCMH Resource Center**

[http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_\\_home/1483](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483)

### **American College of Physicians PCMH Website**

[http://www.acponline.org/running\\_practice/pcmh/](http://www.acponline.org/running_practice/pcmh/)

### **American Academy of Family Physicians PCMH Checklist**

<http://www.usafp.org/PCMH-Files/AAFP-Files/PCMHChecklist.pdf>

## **Appendix C - M2 DATA SETS**

### **Eligibility**

- Population Summary
- DEERS Person Detail
- Eligibility Information
- Reservists
- Reservists Information

### **TRICARE Enrollment**

- TRICARE Relationship Summary
- TRICARE Relationship Detail
- Longitudinal Relationship
- Relationship Information
- TSP Information

### **Healthcare Services**

- DC Inpatient Admissions Summary
- DC Inpatient Admissions Detail
- DC Inpatients Admissions Information
- DC Professional Encounters Summary
- DC Professional Encounters
- DC Professional Encounters Information
- DC Lab Ancillary Summary
- DC Lab Ancillary Detail
- DC Lab Information
- DC Rad Ancillary Summary
- Dc Rad Ancillary Detail
- DC Rad Information
- Purchased Care Institutional Summary
- Purchased Care Institutional Detail
- Purchased Care Institutional Information
- Purchased Care Non-Institutional Summary
- Purchased Care Non-Institutional Detail
- Purchased Care Non-Institutional Information
- PDTS Summary
- PDTS
- Pharm ID or National Council for Prescription Drug Programs
- PDTS Information

### **System Production Data**

- MEPRS
- MEPRS Information
- WWR
- WWR Information