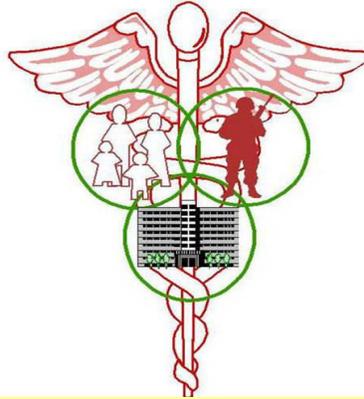


**Enhancing the Excellence of  
Military Healthcare**



**Tools for Success in Implementation and Use of CHCSII:  
Business Process Reengineering (BPR)  
And  
Tricare Next Generation Considerations  
For  
CHCS II**

Prepared by:  
**AMEDD CHCSII**  
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**14 November 2005**

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## Preface

The fielding of the Composite Health Care System (CHCS) II and the switch to the Next Generation of TRICARE Contracts has resulted in transformational changes in the clinical, business, and administrative processes within the AMEDD. This document evolved from initial business process reengineering (BPR) work that was performed by contractors at medical treatment facilities pre and post implementation of CHCSII. As the fielding of CHCSII continued and converged with the TNEX contract implementation, it became clear that the two were intertwined. Based upon a focus on improved outcomes for patient and business, this document was created based upon the experiences learned to date.

This document is not meant to be or replace any official policy. Users are referred to the respective web-sites for the most current MEPR, UCAPER, and UBO/UBU policy. As with any BPR document it is meant to focus concerns and stimulate a look at how daily activities are performed. The AMEDD has undergone considerable transition in clinical practices to decrease variation, increase efficiency and improve outcomes. While this process continues, similar reviews of business and accounting processes also must occur. The focus of BPR is simply to define what work or action is no longer needed, or what processes (rules or procedures) need to be discarded as their relevance to desired outcomes have changed. The move to the ASAM III staffing module and relative value units (RVU) replacing simple workload counting is an example of this.

It is the hope of the AMEDD CHCSII Project Office that this paper will provide assistance at all levels of an MTF to help with successful transformation. The use of CHCSII will only be a part of that success. Much of this document is based upon user experience, field feedback and questions. From continued field experience and command guidance, the program office will review and update this document on an annual basis with publication at the beginning of each fiscal year. Quarterly updates will be added as necessary to cover changing rules and regulation. Additionally interim updates will be distributed via the AMEDD CHCSII Newsletter and AKO website.

Striving always to “Enhance the Excellence of Military Healthcare – AMEDD CHCSII.”

Very Respectfully,

RON MOODY MD

LTC, MC

Program Manager, AMEDD CHCSII

Implementation and Clinical Integration

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## Section 1 - Overview

**BACKGROUND** The Composite Health Care System II (CHCS II) is the enterprise-wide solution for an electronic health records system for the Department of Defense (DoD) Military Health System (MHS). As a result of a Presidential Executive Order and Congressional Mandate, the Assistant Secretary of Defense (Health Affairs) approved the Mission Need Statement for CHCS II in November 1996. The Mission Need Statement outlined the need to implement a worldwide, single, integrated clinical information system. The Clinical Information Technology Program Office (CITPO) was charged with acquiring and implementing this Military Computer-Based Patient Record (CPR).

The Army Medical Department (AMEDD) Composite Health Care System II (CHCS II) Implementation and Clinical Integration Office is the organizational element responsible for integrating and managing the implementation of CHCS II at all Army Medical Treatment Facilities (MTFs). In 2003, after limited deployment and testing at two sites (Ft Eustis & Ft Bliss), CHCS II was approved for worldwide deployment starting in January 2004. An aggressive schedule was approved and planning commenced to deploy and integrate CHCS II to 33 different AMEDD sites over the span of three fiscal years (04-06). To date, successful deployment has occurred at 26 sites.

**SCOPE** CHCS II is part of the Army transformation as it applies to health care. Transformation involves change at all levels of an organization. The content of most change is targeted at developing new strategies, analyzing current processes and workflow and reengineering for continuous improvement. The scope of this paper is limited to BPR activities with the deployment of Block I CHCS II capabilities in the ambulatory settings.

**PURPOSE** The purpose of this document is to serve as a resource document for defining business process reengineering (BPR), providing general considerations for CHCS II implementation and integration, sharing successful BPR activities from the field related to Ambulatory Care Clinics, Soldier Readiness Processing (SRP) Centers, as well as Specialty Clinics (SC) and for highlighting some valuable lessons learned and tools for successful deployment and change to clinical and business practices.

## What Is Business Process Reengineering (BPR)?

Business processes are the methods by which business is conducted on a daily basis. They include manual and automated activities to complete a task or function. BPR is the analysis and redesign of these workflow activities.

The idea with BPR is to start with a clean slate and design new patient-focused work processes that are not encumbered by the current ones and are designed to work in the CHCSII care environment. This is not incremental change, but well-conceived changes to achieve results. With approval to deploy CHCSII world-wide came the need for immediate changes that affect existing processes related to the delivery of health care. Clinical process engineering was viewed as a necessary requirement.

The design and deployment of CHCS II is an enterprise-wide BPR effort to overcome the burdens of existing and burdensome processes. In addition, administrative processes also needed to change to ensure alignment with the mission and goals of the OTSG, MEDCOM and the MTFs.

Performance measurement is a key component of BPR to measure and validate outcomes. Other components of BPR include business process optimization, process improvement, process automation, workflow management, and change/transition management.

## Goals of Reengineering Efforts

The implementation of electronic clinical information systems is the result of business and consumer pressures to help reduce medical errors and improve overall patient safety. Added benefits include enhancing efficiency and potential cutting costs. CHCS II was designed for providers by providers with the goal of optimizing information workflow for MHS providers.

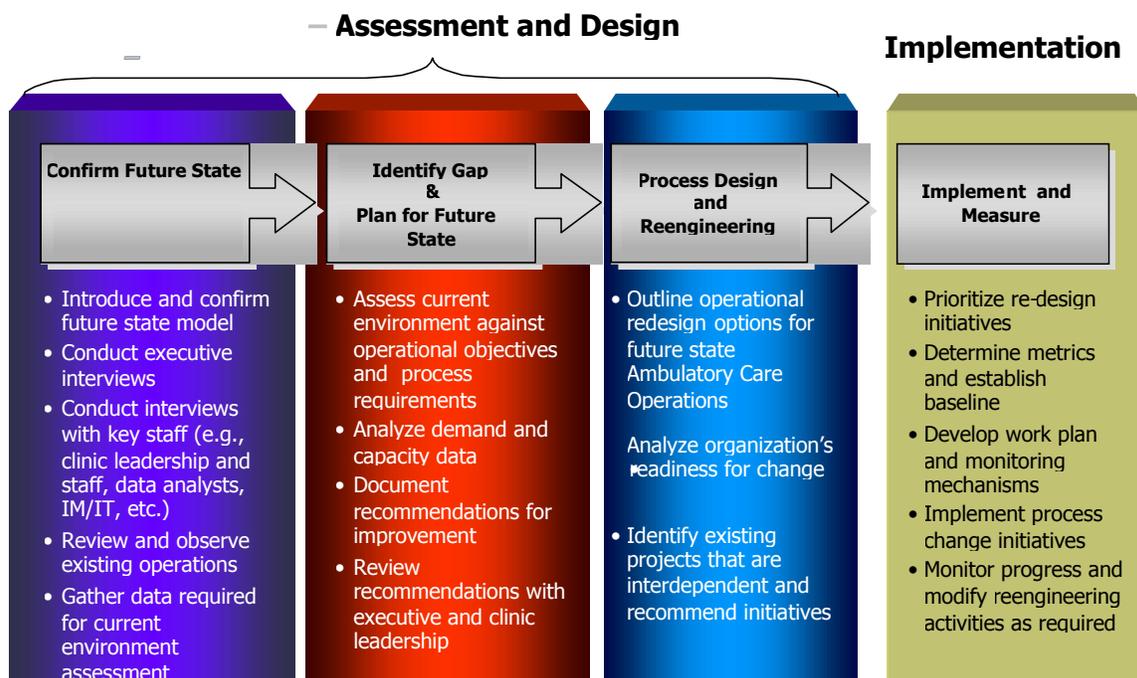
The goals of reengineering efforts with CHCS II are to:

- ◆ Improved patient care and health
- ◆ Increase the efficiency of clinic processes
- ◆ Improve productivity of staff
- ◆ Enhance collaborative care between PCMs and Specialists
- ◆ Increase access to care and utilization management
- ◆ Improve patient, stakeholder and healthcare staff satisfaction

## Section 2 - General Considerations

Planning for the activation of CHCS II at a MTF should be incorporated into the overall facility's Strategic Plan with activities initiated well in advance of CHCSII deployment. However, BPR activity and processes can be beneficial to an MTF at any stage of EMR use. It should be viewed as a continuous activity. Executive sponsorship is paramount to the success of such a significant BPR effort. Executive sponsorship gives credibility and visibility to these efforts and demonstrates the importance of achieving success and meeting strategic goals set by the MTF Leadership.

In BPR, it is important to have a clear understanding of what the future state will be after CHCS II is implemented. Process redesign methodology for successful implementation is built on understanding the future state, identifying gaps with the current environment, prioritizing re-design initiatives and then acting on them.



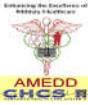
The AMEDD CHCS II Implementation and Clinical Integration Office Staff start engaging with the MTF Project Officer and Implementation Team a minimum of three months prior to their activation date.



AMEDD CHCS II PLANNING & IMPLEMENTATION

The following activities have been identified as key milestones leading up to activation. These are recommendations for successful planning and process improvement. Process ownership is instrumental to successful completion of each activity.

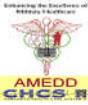
Timeline	Activity	Accountability [Action Officer]
T-1 year	<ul style="list-style-type: none"> <li>◆ Access to Care Planning, including detailed revised financing cost projections to identify risk mitigation strategies such as Locum Support, Reservists Annual Training, Borrowed Military Manpower to include GME resources.</li> <li>◆ Analyze current patient flow particularly in the ER</li> <li>◆ Evaluate the need to adjust or extend clinic hours</li> </ul>	<ul style="list-style-type: none"> <li>▪ Command Staff</li> <li>▪ DCCS</li> <li>▪ Budget Officer</li> <li>▪ MEPRS</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Estimate the potential for unfunded requirements for: desktop copiers, printers and stands for Front Desk staff; screening equipment for exam rooms</li> </ul>	<ul style="list-style-type: none"> <li>▪ Budget Officer</li> </ul>
T-200 days	<ul style="list-style-type: none"> <li>◆ Evaluate current design of exam rooms.</li> <li>◆ Encourage early submission of work orders to move furniture, PCs or exam tables to improve patient/provider positioning</li> </ul>	<ul style="list-style-type: none"> <li>▪ DCCS</li> <li>▪ Clinic OIC</li> <li>▪ Clinic NCOIC</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Validate internal processes for capturing and reporting: 1) workload, 2) Provider time, 3) E&amp;M frequency distribution by provider and clinic specialty and RVU</li> <li>◆ Establish pre-CHCSII baselines</li> </ul>	<ul style="list-style-type: none"> <li>▪ DCCS</li> <li>▪ Clinic OIC</li> <li>▪ Clinic NCOIC</li> <li>▪ Chief, Managed Care</li> <li>▪ Chief, RM</li> <li>▪ MEPRS</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Determine and document Staff Roles and desired Clinical Practice Changes (Consider the potential magnitude of concurrent changes to both current processes and learning curve of new technology)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clinic OIC</li> <li>▪ Clinic NCOIC</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Conduct a detailed assessment of CHCS Files and Tables (Include duplicate patients, provider and clinic profiles, hospital locations, User security key profiles including any necessary process owner changes for File and Table maintenance.</li> </ul>	<ul style="list-style-type: none"> <li>▪ IMD</li> <li>▪ MEPRS</li> </ul>



## AMEDD CHCS II PLANNING & IMPLEMENTATION

<b>T-180 days</b>	<ul style="list-style-type: none"> <li>◆ Identify an Action Officer to coordinate activation sequence and training plan. Recommend it be from Clinical Operations.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commander</li> <li>▪ DCCS</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Develop and coordinate an activation sequence straw man based on MTF operations</li> </ul>	<ul style="list-style-type: none"> <li>▪ DCCS</li> <li>▪ IMD</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Create the vision for your MTF staff and begin marketing efforts</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commander</li> <li>▪ DCCS</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Establish a CHCS II Steering Committee and a forum for staff to express concerns and share experiences with members of their clinical area.</li> </ul>	<ul style="list-style-type: none"> <li>▪ DCCS</li> </ul>

Timeline	Activity	Accountability [Action Officer]
<b>T-120 days</b>	<ul style="list-style-type: none"> <li>◆ Address surgery case scheduling, OB projected deliveries, and staff transitions for affects on activation sequence</li> </ul>	<ul style="list-style-type: none"> <li>▪ DCCS</li> <li>▪ Dept Chiefs</li> </ul>
	<ul style="list-style-type: none"> <li>◆ Provide for MTF focused briefings posted on Intranet such as CHCS II Test Drive, FAQs and Lunch and Learn sessions (30 minutes to cover intro section of CHCS II Video and Q&amp;A)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Project Officer</li> <li>▪ IMD</li> </ul>
<b>T-90 Days</b>	<ul style="list-style-type: none"> <li>◆ AMEDD POC engages with pre-deployment activities</li> <li>◆ Pre-Implementation Meetings (PIM) begin with CITPO</li> <li>◆ End User Devices ordered</li> <li>◆ Identify MTF Deployment Team and assign roles and responsibilities</li> <li>◆ Final Activation Sequence completed</li> <li>◆ Clinical Integration Document initiated</li> <li>◆ Command Briefings begin to endorse support</li> </ul>	<ul style="list-style-type: none"> <li>▪ Project Officer</li> <li>▪ Deployment Team</li> <li>▪ IMD</li> <li>▪ Command Suite</li> <li>▪ DCCS</li> <li>▪ MEPRS</li> </ul>
<b>T- 60 days</b>	<ul style="list-style-type: none"> <li>◆ Training Plans are finalized</li> <li>◆ User schedules are blocked for training</li> <li>◆ 60 Day PIM call</li> <li>◆ EUDs delivered and PCs imaged. Deployment begins to the clinical areas</li> </ul>	<ul style="list-style-type: none"> <li>▪ Project Officer</li> <li>▪ Deployment Team</li> <li>▪ IMD</li> <li>▪ Training coordinator</li> </ul>



## AMEDD CHCS II PLANNING & IMPLEMENTATION

T-30 days	<ul style="list-style-type: none"> <li>◆ Marketing campaign activated</li> <li>◆ 30 Day PIM Call</li> <li>◆ Clinical Integration Document finalized with wide dissemination throughout the MTF</li> <li>◆ Training schedules are posted on MTF Intranet</li> <li>◆ Sustainment Training Plans formulated</li> <li>◆ Command briefings continue to endorse support</li> </ul>	<ul style="list-style-type: none"> <li>▪ PA Office</li> <li>▪ Project Officer</li> <li>▪ Commander, DCCS</li> <li>▪ Clinical Champions</li> <li>▪ Training coordinator</li> </ul>
T-14 days	<ul style="list-style-type: none"> <li>◆ Account Creation and validation begins</li> <li>◆ Command briefings continue to endorse support</li> </ul>	<ul style="list-style-type: none"> <li>▪ IMD</li> <li>▪ Commander, DCCS</li> </ul>
T-7 days	<ul style="list-style-type: none"> <li>◆ Commander Intent Letter published and disseminated</li> </ul>	<ul style="list-style-type: none"> <li>▪ Commander</li> </ul>
T-Date	<ul style="list-style-type: none"> <li>◆ Training Begins</li> </ul>	<ul style="list-style-type: none"> <li>▪ All Staff</li> </ul>

### Section 3 - Process Flow

Process flow is simply the steps in a business process that transform a set of inputs into a set of outputs (goods or services). Key components of an ambulatory care operation are: access to care, clinic management, population health and resource management. Patients cannot receive care unless they can access care. Accessing care and establishing an appointment for a beneficiary can only be accomplished when all “pre-appointment” activities are accomplished

#### 3.1 Pre-Appointment Activities

For effective utilization of CHCS II, several pre-appointment or “behind-the-scenes” activities must be assessed and managed for successful utilization. These are:

- A. File and Table Build – *Note: If you are responsible for any level of clinic management or supervision, it is imperative to be aware of file and table issues. This will impact your business practices and data quality. Go to Appendix F for information.*
- B. Provider Schedule Templates
- C. Management of Provider Schedules
- D. Appointment Type Standardization
- E. Schedule Change Request Procedures

The following section describes the future state for each of these activities, some business process reengineering that can help achieve this state and some high-level lessons learned from implementation trial and error.

### A. Process: File & Table Build

#### Future State:

- ◆ An accurate and complete File & Table Build (See Appendix A for Further Guidance)
- ◆ All visits are captured and counted accurately
- ◆ Patient flow is regulated correctly
- ◆ Workload data and billing collection is accurate
- ◆ Performance metrics are met
- ◆ Equal panels across all PCMs addressing number of patients, beneficiary categories and acuity.

### Process: File & Table Build (Con't)

#### BPR Activities to Achieve Future State:

- ◆ Clinic operations must be defined. Does the clinic operate as one or are there sub-teams within one clinic?
- ◆ Chart out the process once operational goals are determined (follow each type of patient from check-in to check-out. Identify key events in the process)
- ◆ Establish desired scheduling and booking practice
- ◆ Identify sequence for flow for appointing (i.e. PCM → Another provider on their Team → Another provider in their Group, exceptions, etc)
- ◆ Scrub all Provider Files for accuracy (assigned location, Medical Specialty, data is consistent with CHCS User File. Coordinate with IMD, Credentials, Clinical Ops, Clinic PAS Supervisors for validation)
- ◆ Cross-validate CHCS User Names to the CHCS Provider Name and to the Credentials System (CCQAS)
- ◆ Every provider updates their user-preferences to prevent orders from being defaulted to a former location

- ◆
- ◆ All new clinics are added to the borrower file so that medical records are pulled appropriately

**Lessons Learned:**

- ✚ Add nurses to each clinic profile to ensure capability is available for receiving telephone consults
- ✚ Insure that providers are only mapped to clinics that they regularly work.
- ✚ Insure a process is present so that users in Graduate Medical Education (GME) are mapped monthly to the areas they will work.

**B. Process: Provider Clinic Appointment Templates**

**Future State:**

- ◆ Templates are consistent for each user group
- ◆ Access standards are met
- ◆ Provider availability supports demand and PCM continuity
- ◆ Provider manipulation does not occur
- ◆ Templates accommodate mission requirements
- ◆ Supply meets demand
- ◆ Equal panels across all PCMs

**BPR Activities to Achieve Future State:**

- ◆ Assess demand and utilization patterns
- ◆ Use only approved appointment types
- ◆ Use group appointments when applicable
- ◆ Pre-approve appointment modifiers for use
- ◆ Establish size and number of provider panels. Review regularly
- ◆ Establish protocol for approving template changes
- ◆ Appoint dedicated area access staff for template management

**Lessons Learned:**

- ✚ Standardize template design for maximizing Access to Care and to ensure even allocation of workload and elimination of disparity among health care teams
- ✚ Consider schedules that can expand and contract as demand warrants
- ✚ Create procedures that consolidate the business rules for operation with the clinic



- ✚ Create standardized naming conventions to streamline the scheduling process. Instead of having different templates for every provider with a total of more than 100 templates for the clinic, develop a few standard (FP1, FP2, etc) template designs based on hours of operation. Actual patient appointment demand data can be used to determine the mix of appointments for each template
- ✚ Create schedules that offer enough access and have the possibility to expand to meet special needs (2-3 “hidden” appointments).
- ✚ Analyze the National Enrollment Database (NED) Patient File data to determine the best mix of patients to providers and how that mix coincides with the AMEDD Automated Staffing Assessment Model III (ASAM III)
- ✚ Do not allow clinics to schedule patients en masse.
- ✚ Provider templates should take into account the historic “No Show”, “Cancellation” and “unbooked” rates for the clinic. Together these constitute the “Unused Appointment Rate” for the clinic and must be considered so that the provider is not underutilized.

## B. Process: Provider Clinic Appointment Templates (con’t)

### Lessons Learned (con’t):

- ✚ Individual provider should be profiled to insure no show rates and cancellation rates are equal across clinic.

## C. Process: Management of Provider Schedules

### Future State:

- ◆ Schedules are consistent within each clinic
- ◆ Appointments support patient demand
- ◆ Appointment availability is maximized
- ◆ Access to care standards are met
- ◆ Change procedures established and enforced
- ◆ Population demographics are accommodated
- ◆ Patients are seen, as necessary, on the same day that they call for an appointment
- ◆ Practices complete *today's work today*
- ◆ No show and unfilled appointments are rare.

**BPR Activities to Achieve Future State:**

- ◆ Use only standard appointment types
- ◆ Build and publish schedules IAW organization standards
- ◆ Assign dedicated schedule coordinators
- ◆ Establish consistent level of approval authority for blocking or changing schedules
- ◆ Publish MTF standards for schedule releases and hold people accountable to meet standards
- ◆ Wave scheduling; Schedule Design

**Lessons Learned:**

- ✚ Learn to use the CHCS Managed Care Program (MCP) Module as it was designed
  - ✚ Routine blocking and freezing schedules should not be permitted
  - ✚ Consistent templates and schedules must be employed to ensure Access to Care
  - ✚ Contingency plans for unexpected emergencies are necessary
  - ✚ Utilize available tools to analyze clinic impact from schedules created
- ✚ If a high no-show rate exists, change the appointment type, increase the total available appointments, or limit advanced booking (greater than 30 days)

**D. Process: Standardized Appointment Types**

**Future State:**

- ◆ Only standardized appointment types in use
- ◆ All appointments capture workload and are counted using CHCS MCP
- ◆ Appointment types match population demand
- ◆ Limited detail codes used

**BPR Activities to Achieve Future State:**

- ◆ Appointment Detail Code Schedule Utilization reports provided routinely
- ◆ Monthly statistical reports provided routinely

**Lessons Learned:**

- ✚ Detail codes are the single largest contributor to unbooked appointments and poor access to care. Their use should be limited and all unbooked appointments should turn into same day appointments on the day of the appointment.
- ✚ Limiting the number of people who develop and manage provider schedules provides tighter control over use of non-authorized appointment types

**E. Process: SOPs for Schedule Change Requests**

**Future State:**

- ◆ Standard Operating Procedures published and updated regularly
- ◆ Parameters for acceptable changes are defined
- ◆ Appointment cancellations are limited to no more than X% (defined by the MTF) due to schedule changes

**BPR Activities to Achieve Future State:**

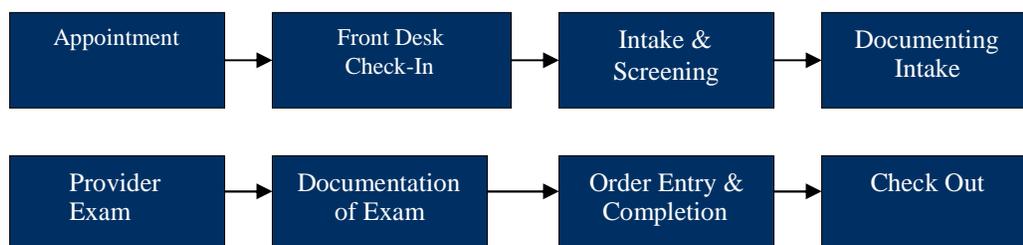
- ◆ Providers collaborate and agree upon standards for MTF-wide use
- ◆ Policies enforced through Command Sponsorship

**Lessons Learned:**

- ✚ Proactive planning 4-6 weeks prior to schedules posted is vital for eliminating multiple schedule changes
  - ✚ Authorizations for change requests need to be closely monitored and controlled
- All non-emergent schedule changes had to be made prior to being opened for booking patients

**3.2 Process Flow for Primary Care Clinics**

Patient encounters in the Primary Care setting involve a series of processes. Each process is a step in the flow of patient care and is depicted here.



The following section describes the steps involved in the patient encounter process. Each section describes the future state for each of these activities, some business process reengineering that can help achieve this state and some high-level lessons learned from implementation.

### 3.2.1 Front Desk/Check In

#### Process: Front Desk Check-In

##### Future State:

- ◆ Check-in is accomplished in less than 1 minute per patient; Self check-in
- ◆ Decreased patient waiting time
- ◆ Walk-ins and urgent visits are accommodated
- ◆ Encounter initiated at the point of check-in
- ◆ Full coverage of clinic operating hours
- ◆ HIPAA requirements are met and enforced
- ◆ Insure third party insurance is updated regularly
- ◆ DEERS data is updated by patient

##### BPR Activities to Achieve Future State:

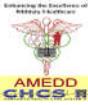
- ◆ Complete check-in at the time the patient presents to the clinic
- ◆ Establish SOP to allow clerks to check in all walk-in patients to initiate the encounter
- ◆ Sorting the patient list alphabetically enables front desk staff to support multiple clinics if they use the same front desk support (Occupational Therapy, Orthopedics, Podiatry, and PT) and expedites patient flow.
- ◆ High volume clinics can create a paper check-list to flag items that need to be completed when a patient checks in (Include: Third Party Insurance, Master Problem List Updates) until these tasks are available for completion electronically
- ◆ Staggered arrival times and work hours for clerks to support peak hours and end-of-day reconciliation process
- ◆ Phone or computer access for patients to be able to update DEERS data

#### Process: Front Desk Check-In (con't)

##### Lessons Learned:

- ✚ Staff cannot wait and periodically catch up throughout the day, as before, when using CHCSII for completing Check-In. After 20 minutes past the time of the appointment, CHCS II will not allow you to check in the patient. This has created better standards for the front desk, as they now stay on time and have more accurate records





- ✚ Stop prior practices of printing a SF600 in advance and placing it in the paper chart
- ✚ Front Desk Staff in high volume clinics developed a Check-List to flag items to be completed when the patient presents to streamline efforts and reduce Front Desk delays
- ✚ Printed SF600s at the time of check-in are used merely as a tracking tool for clinic staff until the provider completes the electronic encounter in CHCS II.
- ✚ Insure availability of Third Party Insurance forms and a process for patients to complete at check-in desk since check-in is NOT the rate limiting step in care. A process should also exist to collect and take these forms to third party collection office at the end of the workday.

### 3.2.2 Intake and Screening (including documentation)

#### Process: Intake and Screening (including documentation)

##### Future State:

- ◆ Exam rooms are utilized for both intake and screening whenever practical
- ◆ Exam rooms are strategically located to allow for efficient use by patients. This may be away from provider offices.
  - ◆ Patient information is requested and captured only once
  - ◆ Portions of S/O are completed during the screening process by the screeners
  - ◆ Nurse and technician roles are restructured to maximize for utilization and availability

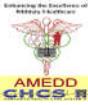
#### Process: Intake and Screening (con't)

##### BPR Activities to Achieve Future State:

- ◆ Establish team model of care delivery
- ◆ Role of the nurse and technicians are enhanced to meet future state
- ◆ Job descriptions are rewritten to redefine roles and responsibilities
- ◆ Clinic and CHCS II System Administrator validate role assignments and access authorization for all support staff to maximize utilization.

*Note: CHCS security role takes precedent over the role assigned in CHCSII. Example: If a Medic is given a provider role in CHCSII he will not be able to order medication in CHCS because he is NOT a provider in CHCS security role.*

- ◆ Adequate equipment for efficient screening; automate equipment
- ◆ Standardize all exam rooms for more efficient use of space



- ◆ Exam rooms are located away from provider offices and in close proximity to patient check-in. Exam rooms are not limited to a provider but consider using assignment preference for consistent location.
- ◆ Established screening protocols for select groups of patients
- ◆ Empower staff to make decisions and provide opportunistic care per SOP
- ◆ Questionnaire completion in CHCSII by patient prior to provider visit.

**Lessons Learned:**

- ✚ Creating Health Care Teams of providers and support staff who share common goals/commitments can prevent bottlenecks by maximizing utilization of personnel
- ✚ Appointment List promotes patient flow as all levels of the Health Care Team are aware of the status of the patient
- ✚ By equipping each room or every other room with automatic vital machine monitors, the staff is able to do vital signs and begin documenting part of the S/O portion of the note per clinic protocol. The end result is more exam rooms being available. Room turnover time is minimized, bottlenecks are eliminated, and the S/O participation by the nursing staff makes the provider more efficient. The individual savings allowed 1 more patient per day to be seen by each provider.

**3.2.3 Provider Encounter and Documentation**

**Process: Provider Encounter and Documentation**

**Future State**

- ◆ Improved delivery of care
- ◆ All clinical data readily available at the point of care
- ◆ Near complete EMR available anytime (24 X 7)
- ◆ Increased reliability and accuracy of coding
- ◆ Documentation is completed at the time of the encounter or by COB
- ◆ 100% of visits are documented in CHCS II (Note: TSG metric is 85% or more by 6 months after implementation)
- ◆ All Encounters signed by the end of each workday

**BPR Activities to Achieve Future State**

- ◆ Standard templates identified for each specialty area for initial use.
- ◆ AIM Forms which all appear like pieces of electronic paper for documenting care should be adopted for use by all users. The AIM forms are specialty area specific.
- ◆

- ◆ Clinical Champions identified for each specialty area for trouble-shooting and marketing support
- ◆ Run pre-CHCS II reports to establish baseline on access, productivity and continuity
- ◆ Establish standardized reports required for compliance monitoring.
- ◆ Realign personnel to enable the health care team to see any patient who presents without staffing shuffles or bottlenecks
- ◆ Focus on providing care not counting visits

**Lessons Learned:**

- ✚ Initially, select one agreed-upon AIM Form for clinic-wide use. Choosing certain templates and loading into favorite folders will help providers gain quick access to complete documentation for all encounters while learning to use CHCSII
- ✚ Establish protocols for care delivery and maintenance of preventative services.
- ✚ Team documentation to support complete documentation at the time of the visit to improve efficiency, quality of the note
- ✚ Insure appropriate level of nursing skill is scheduled to be in clinic to meet demands such as immunization, injections, etc.

**3.2.4 Order Entry**

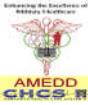
**Process: Order Entry**

**Future State:**

- ◆ All orders entered into CHCS II are captured and coded accurately
- ◆ No delays or resubmits as a result of user error
- ◆ Non-provider staff are authorized to enter orders based on pre-approved order sets
- ◆ Orders entered before the patient leaves the office/exam room
- ◆ Preventative services delivered by protocol before seeing the provider

**BPR Activities to Achieve Future State:**

- ◆ Create and use order sets in CHCSII for common diagnosis, conditions, situations for each clinical area
- ◆ Utilization of non-provider staff for entering pre-approved order sets
- ◆ Optimized utilization of clinical nurses for completing order entry for designated order sets



**Lessons Learned:**

- ✚ Maximize the nurse as a resource to complete all of the non-provider order entries for pre-visit ancillary services, to complete some of the Subjective and Objective (S and O) portion of encounter notes, to complete and document patient education, and to carry out all orders during the actual clinic visit.

**3.2.5 Treatments/Procedures**

**Process: Treatments/procedures**

**Future State:**

- ◆ All office visits and/or a procedure is completed and documented in CHCS II
- ◆ Equipment and supplies are available at all times to prevent patient delays in care
- ◆ Documentation of all procedures and treatments are completed at the time of care
- ◆ Non-physician team members deliver care appropriate to their scope of practice, freeing physician providers to focus attention on diagnosing and developing treatment options

**BPR Activities to Achieve Future State:**

- ◆ Standardized stocking of exam and procedure rooms
- ◆ Roles and responsibilities for stocking and ordering are identified
- ◆ Access to documentation modules are validated and approved for each new support staff team member upon arrival and assigned to a clinical area
- ◆ Nurse schedules aligned with patient appointments requiring nursing care

**Lessons Learned:**

- ✚ Ensuring availability of a licensed nurse when patient appointments require treatments and procedures that need to be completed by this level of support staff will result in increased efficiency for the Health Care Team.
- ✚ Consider re-evaluating the ratio of Medical Techs/CNAs to LVNs and RNs. By aligning the providers with at least LVNs supported by CNAs, teams are able to see and treat patients effectively without delays in care.

### 3.2.6 Check Out

Process: Check Out
<p><b>Future State:</b></p> <ul style="list-style-type: none"> <li>◆ All patients receive adequate education and follow up instructions for each visit</li> <li>◆ All referrals for specialty care are entered into CHCSII prior to the patient leaving the office visit</li> <li>◆ All end of day reconciliations are completed at close of business each workday</li> </ul>
<p><b>BPR Activities to Achieve Future State:</b></p> <ul style="list-style-type: none"> <li>◆ Provider schedules are released at least 6 weeks in advance to allow appropriate follow-up visits to be scheduled prior to the patient leaving the clinic</li> <li>◆ Self Care instructions are provided by the Clinical Nurse as much as possible</li> <li>◆ All patients Left Without Being Seen (LWBS) are identified and follow-up calls completed on each</li> </ul>
<p><b>Lessons Learned:</b></p> <ul style="list-style-type: none"> <li>✚ End of Day (EOD) comparisons need to be completed between CHCS I and II. CHCSII does not allow changes to patient status after 2359 HRS on the day of care.</li> <li>✚ Any EOD discrepancy should be corrected and reported to supervisor</li> <li>✚ Common patient handouts can be saved on local LAN or printed out to nursing station from Tricare-on-Line (TOL), MDCONSULT, or other web service</li> <li>✚ Intranet access is available while using CHCSII. Users need to define internet site favorites, patient educations handout sites, and default printers to take advantage of this.</li> </ul>

### 3.3 Process Flow for Specialty Clinics

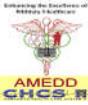
This section will describe process flow specific to Specialty Clinics. Activities of a patient encounter are similar to that of a PCC visit. The steps of the process are the same to include all pre-appointment activities. For all Specialty Clinics, the process starts with a patient appointment once a consult or referral is submitted and authorized by the gaining MTF.

### 3.3.1 Front Desk Check In

Process: Front Desk Check In
<p><b>Future State:</b></p> <ul style="list-style-type: none"> <li>◆ Front desk staff support check-in process for all clinical areas of a Specialty Service</li> <li>◆ Encounter initiated at the point of check-in</li> <li>◆ Full coverage of clinic operating hours</li> <li>◆ All consult appointments are booked against an open consult appointment</li> </ul>
<p><b>BPR Activities to Achieve Future State:</b></p> <ul style="list-style-type: none"> <li>◆ Enable all Front Desk personnel be added to the clinic profiles within the areas they support</li> <li>◆ Initiate 100% check-in at the time the patient presents prior to CHCS II deployment</li> <li>◆ Allow access by Front Desk Staff to initiate the patient encounter in CHCS II by checking or walking the patient into the EMR</li> <li>◆ Staggered arrival times to eliminate bottlenecks and improve support staff utilization when required</li> </ul>
<p><b>Lessons Learned:</b></p> <ul style="list-style-type: none"> <li>✚ In such locations like the Orthopedic clinic, clerical scheduling access is required for all associated clinics such as PT, OT, Podiatry, and APV Ortho Clinic</li> <li>✚ Patients can be “walked in” when they necessitate being seen without an appointment by using an ACUT appointment or Walk-in appointment. Use “Find only patients enrolled to this facility” to aid in searching for the patient</li> <li>✚ Printed SF600s at the time of check-in remain a valuable aid for tracking where the patient is throughout their clinic encounter and for taking notes for use in completing the electronic encounter in CHCS II once the visit is complete</li> </ul>

### 3.3.2 Screening and Documentation

Process: Screening & Documentation
<p><b>Future State:</b></p> <ul style="list-style-type: none"> <li>◆ Exam rooms are close to check-in and are utilized for intake and screening</li> <li>◆ Patient information requested and captured only once</li> <li>◆ S/O information provided and populated from consult entry without duplicating information and data gathering</li> </ul>



- ◆ Nurse and technician roles are redefined with adequate module access for documenting

**BPR Activities to Achieve Future State:**

- ◆ Role of the nurse and technician enhanced to meet future state
- ◆ Clinic OIC and CHCS II System Administrator validate role assignments and access authorization for all support staff to maximize utilization
- ◆ Pre-establish provider-specific screening criteria for use by support staff
- ◆ State of the art screening equipment

**Lessons Learned:**

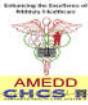
- ✚ Technicians play a vital role in patient care in Specialty Clinics. Their primary role is to screen the patients, complete the S/O and perform procedures as ordered by the treating provider.
- ✚ Paper forms specific to Specialty Clinics for documenting patient care can be eliminated once CHCS II is utilized
- ✚ Utilizing Specialty Clinic AIM Forms help to support ease of technician documentation for screening procedures and establishing guidelines for healthcare team documentation
- ✚ Use of electronic vital machine monitors can save up to one patient per day in time allocated for screening. Room turnover time can be maximized, bottlenecks eliminated, and more time allotted for more thorough documentation of the S/O for each clinic visit
- ✚ Appointment List promotes patient flow as all levels of the Health Care Team are aware of the status of the patient

**3.3.3 Provider Encounter and Documentation**

**Process: Provider Encounter and Documentation**

**Future State:**

- ◆ Problems captured the first time without repeat data gathering; CHCSII's Copy forward function used at follow-up
- ◆ Procedure and diagnosis coding accuracy and specificity increased



- ◆ Documentation is completed at the time of the encounter or by COB
- ◆ 100% of all encounters completed in CHCSII (Note: TSG metric is 85% or more visits are documented in CHCS II 6 months after implementation
- ◆ RVUs meet or exceed MHS standards

**BPR Activities to Achieve Future State:**

- ◆ Train specialty providers on CHCS II using scenarios specific to that specialty
- ◆ Standard templates and AIM forms pre-identified for initial use based on specialty area
- ◆ AIM Forms adopted for use by all users per specialty area
- ◆ Clinical Champions identified for each specialty area for trouble-shooting and marketing support
- ◆ Run pre-CHCS II reports to establish baseline (Encounters, workload, RVUs)
- ◆ Establish standardized reports required for compliance monitoring. Pre-establish POCs for receiving reports at a pre-designated interval

**Lessons Learned:**

- ✚ Pre-select specialty AIM Form for clinic-wide use. Loading form and selected templates into favorite folders will help providers gain quick access to complete documentation and utilize the EMR
- ✚ Completing the documentation at the time of the visit improves efficiency, quality of the note, and supports a fully loaded electronic medical record for all future patient visits
- ✚ Build clinic specific order sets prior to activation
- ✚ Build clinic specific diagnosis and procedure list (numbering no more than the 15 most common) prior to activation

3.3.4 Order Entry

**Process: Order Entry**

**Future State:**

- ◆ All orders are captured electronically
- ◆ No delays or resubmits as a result of user error
- ◆ Utilization of non-provider staff for pre-approved order sets
- ◆ All orders are entered prior to patient leaving the office/exam room

**BPR Activities to Achieve Future State:**

- ◆ Optimal use of clinical nurse and technicians for pre-designated order sets
- ◆ Pre-establish order sets for high utilizers and common conditions

**Lessons Learned:**

- ✚ Maximize the nurse as a resource for completing all of the non-provider order entries for pre-visit ancillary services, to complete some of the Subjective and Objective (S and O) portion of encounter notes, for completing patient education, for administering and documenting all orders carried out during the actual clinic visit.
- ✚ Clinics review old order sets and agree on new order sets for CHCSII use.

**3.3.5 Treatment/Procedures**

**Process: Treatments/Procedures Completed and Documented**

**Future State:**

- ◆ All treatments and procedures are completed and documented prior to patient leaving the clinic
- ◆ No delays in care due to unavailability of staff, supplies or non-functional equipment

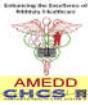
**BPR Activities to Achieve Future State:**

- ◆ Standardized stocking of treatment and procedure rooms
- ◆ Roles and responsibilities for stocking and ordering are identified
- ◆ Access to documentation modules are validated and approved for each new support staff team member upon arrival and assigned to a clinical area
- ◆ Nurse schedules aligned with patient appointments requiring nursing care

**Process: Treatments/Procedures Completed and Documented (con't)**

**Lessons Learned**

- ✚ Ensuring availability of nursing staff with adequate credentials and/or specialty training to meet the mission of the clinic and be able to carry out patient orders will maximize provider efficiency



✚ Assessing current manpower and positions and determining the level of support required for Specialty Clinic Operations is essential for ensuring a fully functional staff and posturing for the future regarding changes in manpower allocations to meet the Clinic’s Operational Mission

### 3.3.6 Check Out

Process: Check out
<p><b>Future State:</b></p> <ul style="list-style-type: none"><li>◆ All patients receive adequate education and follow up instructions for each visit</li><li>◆ Follow up appointment is made prior to the patient leaving the clinic</li><li>◆ All end of day reconciliations are completed at close of business each workday</li></ul>
<p><b>BPR Activities to Achieve Future State (for specialty clinics):</b></p> <ul style="list-style-type: none"><li>◆ Provider schedules are released at least 6 weeks in advance to allow appropriate follow-up visits to be booked prior to patient leaving the clinic.</li><li>◆ All patients Left Without Being Seen (LWBS) are identified and follow-up calls completed on each</li></ul>
<p><b>Lessons Learned:</b></p> <ul style="list-style-type: none"><li>✚ EOD comparisons need to be completed between CHCS I and II. CHCSII does not allow changes to patient status after 2359 HRS on the day of care.</li></ul>

## Section 4 - Soldier Readiness Processing Centers (SRP)

This section addresses the specialized requirements of a SRP Center regarding the use of CHCS II.

The Soldier Readiness Processing (SRP) Center provides an installation review and assistance to units who have scheduled training or operational deployments. The center validates soldier readiness in accordance with [AR and HFL 600-8-101](#) using a checklist or [Deployment and Reconstitution Tracking Software \(DARTS\)](#) application and one time processing through required SRP stations (personnel, medical, dental, finance, legal, ACS review and SRP Final Validation Station).



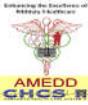
Medical reviews consist of completing DD Form 2795 Pre-Deployment Health Assessment or DD Form 2796, Post-Deployment Health Assessment; MMRB documentation or determination of waiver approval by MMRBCA for permanent 3 or 4 physical profile. DD Forms are electronically submitted to AMSA.

#### 4.1 Pre-Deployment Processing

Process: Pre-Deployment Health Assessments
<p><b>Future State:</b></p> <ul style="list-style-type: none"><li>◆ ALL patient medical information is available at SRP site with automatic retrieval and display of SRP specific information</li><li>◆ CHCS II captures and stores all deployment and medical readiness-related medical information in a separate module for ease of access and reporting</li><li>◆ Electronic DD Form 2795 is completed using CHCSII with data transfer to MEDPROS completed in real time</li><li>◆ All labs, immunizations and other pertinent medical history are simultaneously previewed at the SRP visit</li><li>◆ Deployment processing completed with one visit</li><li>◆ Consult/referrals are submitted and appointments scheduled during SRP visit using the same clinical system (CHCSII). This will also allow the ordering provider (and all future healthcare providers) to have access to the information on the completed consult.</li></ul>
<p><b>BPR Activities to Achieve Future State:</b></p> <ul style="list-style-type: none"><li>◆ Develop SRP order set</li><li>◆ Incorporate regular screening for readiness status into all clinic visits</li><li>◆ DD Forms 2795 is scanned into CHCS II (interim work around until the forms are available in CHCS II)</li><li>◆ Soldiers deploying are identified and appropriate sections on the DD Forms are completed prior to processing date</li></ul>
<p><b>Lessons Learned:</b> Work in Progress (Anticipate deployment with IMR Module-Build 838)</p>

#### 4.2 Post-Deployment Processing

Process: Post-Deployment Health Assessments



**Future State:**

- ◆ CHCS II captures and stores all post-deployment medical information in a separate module for ease of access and reporting
- ◆ Electronic DD Form 2796 is completed with data transfer to MEDPROS (and subsequently AMSA) completed in near real time
- ◆ Pre-deployment medical history is available and complete
- ◆ Medical history during deployment is available and complete
- ◆ Post-deployment processing completed with one visit
- ◆ Consult/referrals are submitted and appointments scheduled during SRP visit
- ◆ All required documentation is completed and stored in CHCS II

**BPR Activities to Achieve Future State:**

- ◆ DD Form 2796 is scanned into the CHCS II (interim work around until the forms are available in CHCS II)
- ◆ Use CHCSII immunization module to document all immunizations. This will become a direct feed to MEDPROS with completion of the bidirectional interface (Build 838)

**Lessons Learned:** Work in Progress (Anticipate deployment with IMR Module-Build 838)

This section provides further detail and useful examples regarding specific problem-prone processes identified from lessons learned while deploying and incorporating the utility of an enterprise-wide electronic medical record into patient care.

### 5.1 Utilization and Demand

Once a clinic’s population is identified, how the population will use the clinic must be determined. Unfortunately many previous business practices have focused strictly on the number of patients seen and workload counted. This may have artificially elevated calculated utilization rates in both primary care and specialty clinics.

In order to determine utilization, the best starting point is to capture the patient appointment history over the last year in a given clinic. By grouping the appointments by patients, the average number of visits per patient in comparison with the overall population can be determined. The only appointments that should be used for the purpose of this calculation are those that directly involve provider to patient contacts. Visits with nursing staff or for an intervention such as immunizations should not be used.

Considerations for total demand need to include:

- Patients who made an appointment
- Patients who walked in the door

- 
- Patients who tried to get an appointment and could not (access issues)
- Non-emergent patients who went to the ER
- Patients who refused an appointment offered to them.
- Adjustments in patient visits for seasonal variations (school physicals, flu season)

Because all of these factors must be considered when determining overall demand for a clinic, it is important to collect and analyze the appropriate data.

For example, suppose a clinic's primary care utilization rate was 4.5 visits per year for each beneficiary. In order to meet demand for a population of 20,000 beneficiaries, the clinic would have to plan for 90,000 visits per year. By dividing that number of visits by the number of Full Time Equivalent (FTE) primary care providers, the average number of appointments per provider necessary to meet demand can be determined.

In general, the average primary care clinic is open 20 visits days per month. As with resource budgeting it is best to look at provider availability over the year and not appointments available per day. The utilization rate may ebb and flow, but the annualized rate allows better planning. This is important because statistics show that the average family physician will see 25 patients per full day in clinic, but sees only 92 patients per full week in clinic. Since that same family physician on average sees only 4550 annual visits, it is easy to see how understaffing of clinics can occur if only daily productivity measures are used in calculations.

## 5.2 Primary Care Manager (PCM) Continuity and Empanelment

Increased continuity is one of the most effective ways to decrease utilization by patients and decrease total healthcare cost. Provider availability, scheduling, and population demographics often do not support PCM continuity. Without a plan, continuity rarely occurs. Patients who are unable to see their assigned PCMs have to continually repeat their medical history to new providers. These patients often feel the need to return to the new providers instead of their PCMs in order to obtain continuity. Although PCM Continuity in the military health care is always a challenge, PCM continuity supported by a team structure is very feasible and actually conducive to demand management. By creating a team of providers, goals can be set to meet the US Army Medical Command (MEDCOM) standard of PCM Continuity of 70% and PCM Team Continuity of 90%. While the PCM Continuity standard may be difficult to achieve, improved continuity is easily achievable with proper planning and expectations.

Patient panels must be managed to improve access and continuity. Often the lack of management has led to patient panels being disproportionate in number and in type of beneficiaries assigned. This leads to failure of continuity by design.

The following **recommendations** should be considered:

1. All Panels should be reviewed for the need of a one time realignment of patients. The patient population may not like this initially but in the long run better care will occur if the panels continue to be managed.

2. Written SOPs must be published and monitored to ensure panel management. At a minimum this SOP must include:

- a. An absolute cap on the number of patients that can be assigned to each PCM
- b. A rule that no PCM is empanelled over 70% until all PCMs are empanelled to 70%, then 80%, then 90%, etc.
- c. A listing of the maximum percent of a panel that can be retirees, active duty, etc. This is essential since the utilization rates of these groups are very different. For active duty it even varies by permanent party and trainees.

Appendix A provides a sample Standard Operating Procedure (SOP) on Empanelment of Enrolled Beneficiaries to Primary Care Managers.

### 5.3 Scheduling/Appointing

Once a clinic's utilization and demand have been analyzed, the clinic can then determine the number of visits per year the clinic will require to meet the demand of their population or to take care of the assigned patients. Certain adjustments can be made to create a state where access is met to include:

- Increasing the number of visits per provider
- Increasing the number of providers
- Decreasing the number of assigned patients, or plan for a portion of the population to be deferred to the network

Access can also be met by decreasing utilization rates. This can be done by providing more than one service per visit, evaluating to see if patient follow-up intervals are at appropriate lengths, and increasing continuity in primary care settings.

Clinics should use standard appointment types with all Sick call to be ACUT\$, Follow ups will be EST\$ and Immunizations and Shots will be WELL\$ appointment types. This gives the clinics an easy to read snapshot of how many patients are being seen for their respective problem or coming back for follow-up care and trend utilization. All appointments that are not booked the day prior should be converted to a same day appointment for primary care. In Specialty clinics, a trend of unfilled appointments should lead to a change in appointment types so that unfilled appointments are rare. Medicine and Surgical Specialists should be constantly reviewing their access and schedule use to determine if they can support more dependent, network, and retiree care.

Clinics should avoid the old pattern of using or creating MEPRS codes to separate out groups of patient care or to capture specific workload. This old pattern of using multiple MEPRS codes has been used extensively in the past and was based upon the old ASAM modules I and II, which gave different workload credit for different MEPRS codes. Workload is now captured via RVUs and the ASAM module is population, not workload-based. Present AMEDD regulations also call for the elimination of multiple fourth level MEPRS codes within the same clinic physical space (four walls).



An excerpt of the AMPO guidance states clearly, “The use of 4th level MEPRS/FCCs for the purpose of identifying subspecialty providers or separate functions within a clinic or work center is not necessary and does not comply with MEPRS Policy.” (Ref: <http://ampo.amedd.army.mil>)

A specific example of this would be in the Orthopedic Clinic where Cast Clinics will be deactivated. The regulation beginning in FY06 states that Cast Clinic MEPRS/FCC of BEB\* will be deactivated on the Account Subset Definition table. The Cast Clinic expenses and workload reporting will be reported in the Orthopedic Care MEPRS/FCC of BEA\*. In compliance with the Uniformed Biostatistical Utility (UBU) coding guidelines, the paraprofessional technicians and nursing staff cannot report visits in BEA\*. Only credentialed and privileged providers with skill type of 1 and 2 will be authorized to report visits in BEA\*. The paraprofessional technicians and nursing staff are authorized to report non-count visits in BEA\*. Former Cast Clinic functions such as the application and removal of casts, splints, and traction in connection with Orthopedic Care should not be reported as separate visits in CHCS, ADM, WWR, etc. Similarly the multiple orthopedic subspecialty types would not be listed if they work out of the same clinic. Different scheduling techniques can also be used to maximize use of provider time, allow more efficient collaborative use of the healthcare team and minimize patient waiting times. These include the following:

### **A. Modified Wave Scheduling**

The modified wave scheduling methodology takes advantage of the principle behind the wave approach, but is much more customer-friendly. This enables provider schedules to expand based on patient needs and demand. This ability to expand and contract schedules is useful in the primary care environment and is a stepping-stone to achieving open access.

The basic premise behind wave scheduling is front or back loading the appointment hour to enable two patients to be seen at the same time. Nursing staff becomes critical, as they complete the in-room screening of one patient while the provider is in the other exam room. However, the ability to offer wave scheduling is largely dependent upon the number of exam rooms and staffing.

This process is designed to organize all practice activities to make optimal use of the provider’s time. Specific activities associated with this process include:

- Appointments that require varying amounts of check-in preparation time and that require differing lengths of provider time are scheduled to run simultaneously. This allows the practice to accommodate long and short appointments without disrupting provider schedules or making patients wait.
- Simple cases are batched together at the beginning of each hour to reduce schedule gaps and increasing patient throughput without increasing waiting time.
- Same day appointments are batched together before lunch to use shorter appointment time slots, 10 minutes rather than 15 minutes, thus increasing the number of patients seen in a day. (these, then, cannot be abused)

- Buffer time (no scheduled appointments) is built into each hour so that catch up can take place if needed. If not needed, staff buffer time can be used to support other providers, or complete administrative responsibilities.

## **B. Scheduling Design**

This maximizes provider productivity without creating additional front desk staffing requirements. Offering enough appointments that support patient demand enables front desk staff to be more efficient. In addition, those staff responsible for booking appointments may spend less time on the phone because of a more efficient process.

The appointment detail codes can and should be reduced or eliminated from the clinic's schedules and templates. This allows the clinic to offer the correct mix of appointments based on utilization trends without daily rework. Outside of the equipment or credentialing requirements for an appointment such as age ranges for a PA, detail codes are the single largest contributor to unbooked appointments and poor access to care.

Block scheduling where all patients are instructed to arrive at the same time also increases staff burden at the beginning of a clinic and increases patient wait time.

For example (This is an historic example that needs changes): If the orthopedic cast clinic has everyone arrive at 0800, this delays the care of the scheduled patients and those arriving for the cast clinic. An artificial bottleneck (and staff stress) point is created at the check-in desk. No patient can be seen until this activity is done. The providers stand idle and fall behind waiting for patients to be processed. Recommend: All cast clinic MEPRS codes should be eliminated per MEPRS guidance and be part of the orthopedic clinic. Spacing patients out will improve the efficiency of the entire healthcare team and likely improve patient satisfaction with care.

Scheduling design, when used to its fullest extent, can increase provider and staff efficiency.

For example, an MTF decided to standardize template design and maximize access to care for their patient population. In addition, leadership wanted to create schedules that could expand and contract as demand warranted. Goals were established to create a hierarchy in which changes could be made to templates and schedules and to create a procedure that consolidated the business rules for operation within the clinic. A standardized naming convention was created to streamline the scheduling process. Instead of having different templates for every provider with a total of more than 100 templates for the clinic, a standard FP1, FP2, etc. template design was created based on hours of operation. Actual patient appointment demand data was used to determine the mix of appointments for each template.

It was found that the creation of standard templates and schedules to ensure workload was evenly allocated among the teams and the providers within the teams eliminated disparity among health care teams. Templates for all providers were created equally that offered 23 standard appointments, expandable to 26 with 3 hidden slots that could be added based on demand.

### **C. Re-look at Military Sick Call**

Military sick call is often viewed as a necessary evil to provide high volume of healthcare. The efficiency and effectiveness of this model are not reported in the medical literature. Many organizations are moving to eliminate or greatly reduce the traditional model of sick call medicine.

This has been done by limiting military sick call for only those active duty members who were unable to report for duty, and therefore allow all other active duty members to obtain appointments for routine and wellness care like any other beneficiary. This helps to improve continuity, decrease total visits, and provide the ability to ensure active duty service members are being cared for in accordance with Access to Care standards.

#### **Case Study - Soldier Centered Care**

**By**

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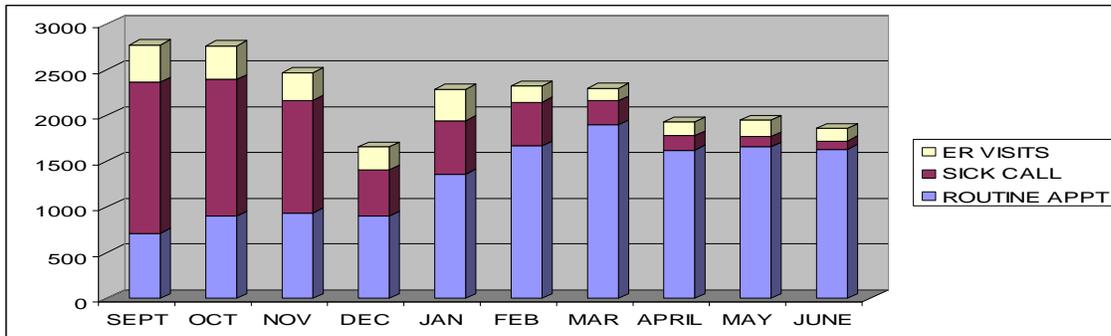
Prior to December 2004, Reynolds Army Community Hospital (RACH) based its health care for active duty soldiers on the traditional Army “Sick Call” model. This traditional model had numerous disadvantages: it limited Soldiers’ access to routine health care; it encouraged Soldiers to seek medical care for secondary gain; it overwhelmed the medical systems assets; it limited commanders’ ability to predict daily manpower shortages; it minimized medics’ opportunities to interact with patients and to train in their MOS; it reduced continuity of care; and it discouraged senior NCOs and officers from seeking medical care.

On 1 December 2004, the Red Leg Clinic (RLC) implemented a more efficient and effective strategy for providing medical care to III CA soldiers. This system called “Soldier Centered Care” (SCC) is based on previously successful Open Access to Care Models. Key aspects of SCC include: a medic driven education and triage system, a significant increase in the number of available routine and open access appointments, a self-care walk-in clinic for select medical conditions, rehabilitation oriented profiles, unit leadership access to a Medical Officer of the Day (MOD) for acute soldier health concerns and close scrutiny of the system for soldier misuse and secondary gain.

SCC encourages soldiers to seek care in open access appointments by booking their appointments the day they would like to be seen. Soldiers with acute health concerns prior to PT and throughout the work day interact with medics who apply a comprehensive triage protocol to determine if the soldier’s illness is “Red” (needs care now), “Yellow” (needs care after completing a modified PT) or “Green” (can book an appointment for routine health care concern). Access for all soldiers regardless of rank is uniform and timely. Senior NCOs and Officers who historically did not use the sick call system now have a system they can access. Junior officers and enlisted soldiers now book appointments, thus no longer waste time waiting to be seen in the “cattle call system” that was “Sick Call”. Soldiers found to be misusing health care (No-show, inappropriately using the ER, etc) are brought to the attention of their command.

The success of SCC over the last six months (see bar diagram) has been a decrease in the number soldiers missing PT for an acute medical problem each month from 1600 to 90 soldiers; a decrease in the number of soldiers seeking care in the ER by 50%; a decrease in the total number of III CA soldiers seeking health care each month from 2,700 (45% of patient population) to 1,600 (26% of

patient population); a decrease in number of health care providers needed to provide care to a patient population of 6,000 from 10 providers to 6; and a significant increase in soldier, commander and health care provider satisfaction with their health care delivery system.



## 5.4 Provider Deployments/Absences

When primary care and specialty providers are deployed or have a prolonged absence such as a TDY, a plan must be in place to provide access and some degree of continuity to their patients. This includes access to clinic appointments, telephone contact, surgical follow-up and results review. The duration of the absence will often dictate the actions to be taken but even short periods of absence requires some planning.

### 5.4.1 Primary Care

The week prior to an absence of two weeks or greater:

- The provider should have an increased amount of time in clinic (if possible)
- The provider's schedule should include more ACUT and ROU and less wellness appointments so any of their patients can be seen by them and not go on a waiting list.

The week the provider returns they should:

- Be in clinic more (if possible)
- Have more ROU and Follow-Up appointments so their PCM care can catch up.

This also gives their patients a reason to wait for the continuity visit and not just come in to see another provider.

A written policy should be in place that describes:

- How TCONs will be handled and distributed if a prolonged deployment. The distribution may be by teams but could also be by the last digit of the patient's SSN. For example, all patients of Dr. Jones with a last digit of 0-3 will have their TCONs go to Dr. Smith. This effectively "temporarily reassigns" the patient to Dr. Smith. Stated differently, it temporarily expands Dr. Smith's panel but provides the patient with a chance for continuity.

- How patients will be booked. This may involve a team concept or be by last digit of patient SSN so that they are seen by the same provider and their TCONs also go to that provider.
- How test results will be handled.

#### 5.4.2 Medicine Specialties

The week prior to an absence of two weeks or greater:

- The provider should have an increased amount of time in clinic (if possible)
- The provider's schedule should include more ACUT and ROUT and less new appointments so any of their patients can be seen by them.

The week the provider returns they should:

- Be in clinic more (if possible)
- Have more ROUT and Follow-Up appointments so their patients can be scheduling appointments with them and not other providers. This also gives their patients a reason to wait for the provider and have an efficient office follow-up.

A written policy should be in place that describes:

- How TCONs will be handled and distributed if a prolonged deployment. The distribution may be by teams but could also be by the last digit of the patients SSN. If patients have a PCM, consider having the patient route back to the PCM before talking to another specialist. This may help to open access in the specialty clinic.
- How patients will be booked. This may involve procedure or disease specific follow-up. Again consider having the patient see their PCM for follow-up prior to getting a "new" referral.
- How test results will be handled.

#### 5.4.3 Surgical Specialties

The week prior to an absence of two weeks or greater:

- The provider should have an increased amount of time in clinic (if possible) to complete follow-ups. New patient evaluation should be seen by providers who will be continually engaged in their care.
- The provider's schedule should include more Follow-Up appointments with all patients being pulled off any wait list who are approaching a future follow-up.

The week the provider returns they should:

- Be in clinic more (if possible) to see old follow-ups and establish new patients for surgery.
- During provider absence, the clinic should review clinic schedules to see if less providers will allow the remaining providers to be more efficient (extra exam rooms and relative increase in support staff). The efficiency could allow more patients to be scheduled per day. Similarly, the surgical schedule should be evaluated for changes.

A written policy should be in place that describes:

- How TCONs will be handled and distributed if a prolonged deployment. The distribution may be by teams but could also be by the last digit of the patients SSN. If patients have a

PCM, consider having the patient route back to the PCM if medically appropriate before seeing another specialist. This may help to open access in the specialty clinic.

- How patients will be booked. This may involve procedure or disease specific follow-up. Again consider having the patient see their PCM for follow-up prior to getting a “new” referral.
- How test results will be handled.

### **5.5 Access to Care (ATC) Standards & Provider Productivity**

An overall lack of consistency in provider appointment templates and schedules contributes significantly to Access to Care issues. Access to Care standards is often not being met. This is caused from the lack of appointments as a result of appointments being: frozen, limited for use by appointment detail codes, or of the wrong mix of appointments types. In addition, provider templates do not take changes in demand or patient utilization into consideration. Many provider schedules are often inconsistent, ranging from 8 to 27 appointments per day per provider with equal amounts of time in clinic.

Also, Central Appointments or Clinic Clerks spend a lot of time manipulating templates, schedules and appointments. Providers often contact the clerks to block appointments, freeze slots, or make other changes to their templates and schedules. There is too often no process in place to prevent providers from canceling their schedules once appointments had already been booked. As a result, the facility cancellation rate can be high and negatively impact patient care.

Some well managed clinics demand that unless specifically approved by the clinic’s Officer in Charge (OIC) or Nurse Manager, no changes could be made to published schedules. Providers were asked to plan their time in advance, making any schedule changes in advance of schedules being opened for appointing (6 weeks out).

Appointment schedules should be built with the minimum expected appointment that the provider will be able to provide. Specific rules for using two appointment slots to create one well woman or new consult appointment can be accommodated such that all appointments are utilized. The most expensive appointment is one that is not used. Rules should also be established providing the ability to expand a schedule (overbook) for very specific reasons. This may be times of peak demand for continuity or for specific military needs (medical board consults). Establishing a vision that clearly states that the healthcare team is here for the patient can be a major factor in meeting access standards.

Annualized productivity measures are also important for establishing metrics for government services and contract provider productivity expectations and bonuses. Productivity is often variable among contract and government service employees who perform the same function. Contract employees should whenever possible have a productivity clause in their contracts. The contracts should also include ties to patient satisfaction such as the OTSG satisfaction survey to insure that



the provider just does not “churn and burn.” GS employees can also be incentivized for productivity using either the physician comparability allowance or incentive annual pay.

Comparability pay is usually fixed by a number of contract years where annual incentive pay must, by regulation, be reviewed for annual re-justification. Annual incentive pay can vary between 0 and 25% of a provider’s base pay.

Annual expectations are best to track against performance and are how budgets are based. The annual method helps to insure that the provider, clinic, and MTF are moving toward the defined and realistic target established in its business plan. Clear and defined objectives for productivity, patient satisfaction, and outcomes (when possible) should be set as part of the annual review process. It is best to use annual productivity measures and track progress toward achievement in evaluations. A sample list of performance factors for evaluating provider productivity is provided in Appendix B.

### **5.6 How Much Nursing Support is Required?**

There is no ideal nursing ratio or best practice benchmark. The goal of any patient care area is to meet its mission in the most efficient manner. The mission of the clinic also defines the type of nursing support needed. In a clinic with a large number of pediatric patients, well baby immunizations and injections are a part of the normal operations. As a result of this pediatric utilization trend, it is important to ensure that the nursing staff who are assigned there to support those injections and IV therapy are qualified and can operate within that scope of practice. The non-availability of a credentialed nurse in the immediate area when one is required to administer an injection results in lost time and efficiency. The mission of the clinic should be reviewed to see if less nursing support with more qualified nursing staff (LPN verse certified nurse assistant) would result in efficiency. By aligning providers and nursing support into a team based upon the local clinics mission, teams are able to become more efficient. In addition, many times the physical plant of the clinic and how the clinic historically operates does not lend itself to the most efficient use of support staff.

Nursing support ratios have often been misunderstood and misquoted. Comparing current numbers to industry standards is helpful while adjustments must be considered due to the uniqueness of each practice setting. Support staff can include different people depending on the source of the standard. Like comparisons must be used. For instance a recent publication by MGMA reports a ratio of support staff to provider FTE at 4.67:1, although this number includes billing clerks, housekeeping staff and others typically not used in the MHS formulas. If you were to eliminate the non-clinical staff, a more accurate ratio of 2.6:1 FTEs which includes the following: Medical Clerk: 1.0; RN: 0.44; LPN: 0.40; MA: 0.76 can be used as a benchmark for similar patient care areas.

For example, the Army’s Automated Staffing Assessment Model (ASAM) is one of many tools used to assist in establishing ratio standards. It was developed by the Manpower Division, HQ MEDCOM, to determine minimum essential staffing requirements for its medical treatment facilities (MTF). It is a population-based model and it assists commanders in business planning to



meet local market requirements. ASAM depicts Army medical requirements necessary to support peacetime healthcare delivery and medical operational readiness.

Support Staff to Specialty Care Provider Ratios are shown below.

Support Staff to Specialty Care Provider Ratios  
(Provider=MD, NP, or PA)

Specialty	RN	LPN	NA	Medical Clerk	Total Ratio
Multi-Specialty Group	0.4	0.6	0.9	0.4	2.3
Medicine Single Specialty	0.6	0.5	0.9	0.4	2.4
Surgery Single Specialty	0.4	0.6	0.9	0.4	2.3
Cardiology	0.4	0.4	0.6	0.6	2.0
OB/GYN	0.5	0.9	0.9	0.7	3.0
Psychiatry	0	0	1.0	0.2	1.2

Efficiency of patient care is eventually based upon throughput of patient visits. The flow of patients must also be considered in evaluating the support staff. Block schedules often create a heavy work load at the check-in desk and in performing vital signs. Changing block schedules can reduce the apparent inefficiency at these areas by eliminating the chaos created by the schedules. It is important to understand that the true measure of an efficient patient flow process is the time it take the patient to complete the journey from check-in to the conclusion of the time spent with the provider. Keeping this in mind will help to appropriately design the clinic schedule and clinic staffing to provide the best and most efficient care.

Collecting and verifying data integrity is critical for all functions of the medical clerk. Effective utilization of support staff is also critical to optimize patient flow and care. Consider realigning support staff into teams and re-evaluate the roles and responsibilities of each. The check-in area, it could be argued, is the most valuable component of the provider’s office. It is often the patient’s first personal encounter with his or her physician.

Starting early to complete documentation at the time of the visit improves efficiency, quality of the note, and eventually will be supported technically once the electronic medical record in CHCS II is completely deployed.

Appendix C provides a list of roles and responsibilities within the scope of practice for Medical Technicians/Medical Assistants.

Similarly for the nurses’ role, incorporating the following into their responsibilities will enhance provider time and utilization of these staff members:

- Establish nurses as part of a clinical team to support individual or a group of providers.
- Establish CHCS II access for nurses at a level that will ensure maximum use of skills and completion of all T-CONS, Consults, etc. when needed and as appropriate
- Default T-CONS to the RN for review and triage when staffing permits



- Ensure RN/LPN availability when patient appointments require this level of support to be present.
- Utilize nurses for patient teaching and discharge instruction review. Build templates for patient teaching based on top DRGs seen and treated in the clinic.

### 5.7 Use of Screening Areas vs Exam Rooms

The continued use of vitals sign/screening rooms may impede the availability of support staff. These screening area rooms often create a bottleneck for the flow of patient care and result in extra support staff assigned who work hard in waves but do not facilitate efficient clinic flow. The vital signs rooms are often located away from where provider support is given. The necessity to move patients through a vital sign/screening room also prevents the support staff from assisting the provider with collecting and documenting useful healthcare information.

**Recommendation:** Screen patients in exam rooms instead of in screening areas. Standardize and automate equipment and supply lists for all exam rooms. This reduces time required for restocking and room maintenance. For example, by equipping each exam room with automatic vital machine monitors, time saved equates to one patient per day in substituting the manual blood pressure and vital sign techniques. Exam rooms should not be limited to one provider's use.

Assignment preference can be considered for consistent location when desired. When all exam rooms become available for use by any provider, throughput of patients can increase and providers can see patients on time. For example, in a PCC with 4 providers per hallway and 8 exam rooms operating at all times, room turnaround time was maximized, bottlenecks were eliminated, and the S/O portion completed by the nursing and support staff improved efficiency. Some preliminary findings from MTF surveys determined there were too many rooms dedicated to stand-alone offices for providers and other staff, without enough patient care dedicated space. Re-assess current space for consolidation of non-patient functions and office space.

#### Other Recommendations:

- Only pull patient records IF needed. Most active duty personnel are young and healthy. By eliminating the record pull for every soldier, the records room had staff to dedicate to quickly pull records that were needed. As greater use of CHCSII occurs, this need should decrease.
- Stopping records from being pulled for every patient allows the record room to perform more important functions: scanning in external consults to clinical notes sections, printing of records for departing soldiers, filing loose elements so the chart and other task to keep the electronic paper record up to date.....*Do Today's work Today.*
- Clinic staff and healthcare team documentation into the "patient's" record is essential to efficiency. Utilization of common AIM forms or templates allow screening staff who are often EMTs to begin documentation that can be taken over and completed by the provider staff. Documentation can be "taken over" by using the EDIT note option in the S/O module or after review the provider can start a new note with reference to "above reviewed".
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- Consider having CHCSII as the only program loaded on exam room computers with generic administrative PC sign-on which does not time out. From the secure CHCSII sign-on the user can use the internet. This will allow multiple users to sign onto the computer and prevent one user from having to log off a user that has locked the computer. This process usually creates the need to reboot the entire system. The IA officer should also review and justify changing the automatic log off on exam room PCs to 15 minutes. With only CHCSII loaded security risks are mitigated. Consider access to Microsoft Office as a local desktop application on exam room PCs.
- Consider current offices with sinks be turned into Exam/Screening Rooms. Those who currently have an office should have their need reviewed with consideration to consolidate true offices (no sinks) or cubicles in one larger room. This would alleviate potential bottlenecks at the screening station and have patients screened and in the rooms waiting for the providers. Long-term plans for more efficient office space may need to be considered. Issues of office efficiency should be considered during any renovation or reconstruction. The traditional “my office and my exam room” mentality may not provide the most effective patient flow or use of staff and space.
- Consider staggered provider schedules to optimize space utilization and provide two exam rooms per provider

## Section 6 - Re-engineering Steps for Immediate Clinical/Business Improvement

**6.1 Reduce the Number of MEPRS Codes within a single Clinic (Note: As of FY06 this is an AMEDD requirement. The new rules specifically address decreasing the number of fourth level MEPRS codes for one clinic (“four walls”). No outpatient clinic (“four walls”) should have more than one MEPRS code unless an unusual event is present.**

Medical Expense and Performance Reporting System (MEPRS) codes are used to accumulate center expenses and attribute workload to specific areas. In the past, they were also used in part to assign relative work value to visits. For example, a visit to the Pediatric Well Baby clinic was weighted more than a visit to the general pediatric clinic. This led to the creation of multiple MEPRS “clinics” within a single true clinic. The use of multiple clinics causes the work of scheduling, appointing, and general clinic management to increase. Since workload is now counted by RVUs and the types of visit can be queried based upon diagnosis codes, the inefficiencies of multiple MEPRS codes for a clinic may no longer be needed.

As an example, a single Family Practice clinic in the past would have MEPRS codes for FP Well Baby, FP Well Woman, FP Adolescent, etc. For each doctor working in that clinic, a clinic template and schedule had to be maintained and entered. It took the scheduling clerk as long to enter Dr. Jones into his FP Well Baby clinics as it did for his FP Well Woman clinics. The clerks work was often increased 5 or 6 times over what it would be if there was a single FP clinic. The patient was also inconvenienced as they could only get a Well Woman or Well Child visit with their



PCM when it was on the schedule, not when it was convenient for the patient. This hampered continuity. When booking appointments the clerk's work was increased by the need to search into multiple clinics. Finally, unfilled Well Baby and Well Woman appointments were often not converted into "ACUT" appointments to be filled as same day visits. This process is equivalent to having appointment frozen or cancelled. It creates the most costly appointment, one that is not filled. This same situation happened in specialty areas where NEW Consult appointments are not filled while patient waitlist and follow-up appointments cannot be made. New Consult appointments should be converted to follow-up appointments at least 4 days in advance to allow patients time to be contacted. Also specialty specific appointment like a breast mass clinic will not be filled and the appointment are kept only for this type of exam while others could be seen. This created the most expensive appointment-the one that was not used, while there was the appearance of access problems.

Other examples:

Orthopedic clinics should have a single MEPRS code and the previous cast clinic MEPRS code should be eliminated. If multiple subspecialties of surgeons work in the same clinic, the appointment types, detail codes, and a written policy on clinic appointments will help insure appropriate booking while minimizing staff work.

Guidance that standardized 4<sup>th</sup> level MEPRS/FCCs for Pediatrics is rescinded. Do not use a 4<sup>th</sup> level MEPRS/FCC to represent subspecialty work performed in a multi-specialty/ function clinic.

Immunization clinics: Areas that exist within another clinic that were historically called an "immunization clinic" should be included within the primary care clinic MEPRS that the area exist in if the staff that work in the clinic support the area and the providers in the primary care clinic are responsible for the care given in the clinic or the standing orders used by the clinic.

**Only if the clinic space is dedicated to that subspecialty and has its own administrative and support staff, use of a 4<sup>th</sup> level MEPRS/FCC is appropriate.**

**Recommendations:**

- Limit MEPRS codes to the smallest number possible. Consolidate MEPRS codes by true clinics ("four walls"). The Family Practice clinics should be the FP clinic and if a pediatrician or internist is working in the clinic they should be in the same clinic code. However, multiple specialty clinics which are part of a Department should not be combined in a single clinic. Subspecialty clinics in the same clinic space should ONLY have separate MEPRS codes if they utilize completely separate support staff and space. Also multiple separate primary care clinics should not be combined into one MEPRS code for the convenience of appointment scheduling or other business reasons.
- Clinic templates should contain a mix of appointments for each day (ACUT, Routine, Follow-up). This will permit greater continuity and smooth workflow.
- As few restrictions as possible on appointments should be made in the appointment comment field so that patients can have a greater chance of seeing their PCM.



- All appointments should convert to a same day appointment if not filled by the end of the prior workday.
- Clear business rules must be written that detail who can change, alter or cancel clinic schedules.
- Although discussed in the context of primary care, the numbers of MEPRS should be reduced for specialty areas for similar reasons. MEPRS codes would be kept for specialty type and APV.
- MEPRS guidance should be reviewed regularly so that MEPRS codes that change or are eliminated such as the Cast Clinic MEPRS can be changed and proper workload accounting can occur.

Further detailed information can be found in the *Army Reference MEPRS Guidelines* at <http://ampo.amedd.army.mil/> (See FY06 Guidance)

## 6.2 Organized UCAPERS

Uniform Chart of Accounts Personnel Utilization System (UCAPERS) - There is considerable variability in knowledge about UCAPERS reporting and equal variability in how hours are reported. This may stem from different beliefs about how these hours are used. Like MEPRS, the use of these hours has changed over time.

The following examples are provided:

1. Hours reported are used to calculate FTE of staff. It is NOT used to see how many hours of overtime staff is working.
2. Previous calculation methods (pre-FY06) equated 40 hours per week to a single FTE with both the persons clinical hours and administrative hours being combined as time available for patient care. Therefore, a staff member who reports 60 hours of work is equated to 1.5 available staff.

FY06 guidance clarifies who can report administrative time and what is to be reported as administrative time. **Effective in FY06, only credentialed providers with a skill type of 1 (Physician), or a skill type of 2 (Direct Care Provider) who are assigned to Inpatient (A) and Outpatient (B) MEPRS/FCC accounts are authorized to report Medical administrative time.** Clarification on what is and IS NOT to be counted as administrative time is also given. Most notably the new rules clearly state that time completing outpatient care documentation after clinic hour is NOT to be counted as administrative time and that **time allotted for general "clinic administrative time" that is not for specific meeting or GME/GDE activity is NOT to be reported as administrative time.** The hours spent after clinic documenting in a business management since is an issue of personal/individual efficiency but does create an extra FTE. General administrative time is assumed to be provided to facilitate normal patient care and is therefore captured as patient care time. For specific questions and further clarification refer to the AMPO guidance (Ref: <http://ampo.amedd.army.mil>)



Considering the above, how hours are reported have a significant impact on the report of FTE availability. Providers may consider reported their clinical care hours to include only those hours that they were in clinic when the clinic was open so that individual variations in charting efficiencies do not create the potential appearance of more staff. Total clinical hours for any week should never be less than 40 **minus** the hours spent in the following GME, time away from duty (leave, tdy, etc) and true administrative time. The official UCAPER current (2000) policy states – “Available Time. Hours spent in support of the healthcare mission”. These hours do not include lunch, breaks, or physical training outside of normal duty hours. With this in mind and an understanding of how the documented clinical hours of availability impact the FTE count in a work center, specific guidance should be considered to insure standard, consistent and accurate reporting of hours. Items such as the start of the duty day and the lunch/break policy should be clarified to staff. Understanding this and based upon consistent and accurate reporting of hours, commands may want to investigate the clinical behavior and work hour reporting practices of individuals whose report more than 1 FTE of clinical available man-hours (168) per month. Individual reporting may exceed 40 hours per week with the cumulative hours of true administrative, GME, inpatient, TDY, and training time is added to total clinical available hours. With the new FY06 guidance, a person reporting hours over 40 per week will only role up on reports as being more than 1 FTE if their total available clinical hours exceed 40 hours week or 168 hours month.

3. Hours need to be reported against all work centers in which the individual staff works. This is particularly true of providers because if RVUs are reported against that MEPRS code, then hours must also be reported. If this does not occur an error will be reported. *Example: Doctor Jones earns RVUs working in the Internal Medicine Clinic but only reports hours on his UCAPERS sheet for clinical time in the Cardiology Clinic. This may create an error and possible erroneous workload numbers.*
4. The most common errors of reporting are also the ones that have the greatest negative impact on the facility. These errors include reporting hours present when the staff member is on leave, TDY, or no longer present. It is important to have a method to validate that staff who are absent are not being reported as present.
5. Although there are multiple MEPRS codes, the key categories in which work hours accumulate include: outpatient clinics, inpatient areas, GME, military readiness (training or providing medical support for readiness) and time not at work (deployment, leave, and holiday). The way time has often been previous reported and counted “administrative time” in most cases resulted in that time being counted as time available in clinic. In consistent reporting and understanding of administrative time has created much variation in practices.

Pre FY06 Example: A provider who reports 30 hours in clinic, 30 hours administrative time, and 10 GME hours in a week is again counted as 1.5 FTE available in clinic. The RVUs generated by that provider is divided by 1.5 to obtain the RVU per FTE. This is also true if 20 hours are reported in clinic and 40 hours in an inpatient area or in the operating room. The provider is counted as a total of 1.5 FTE for the facility.



FY06 Guidance Example: The same provider reports 40 hours in clinic (adding his charting time and general clinic admin time, 20 hours in true meeting, and 10 GME hours in a week. The true administrative time and GME hours are not counted as time available in clinic. The provider is counted as 1 FTE in clinic and his RVU are divided by 1.0.

6. New for FY06 is another key category for time and workload reporting. This area is called External Workload that may apply. If a MTF has staff rendering care to DoD beneficiaries at a local civilian hospital or Veteran Administration (VA) facility, the MTF must now request a DMIS code for that facility for users to report time and workload.

Example: External Workload - In the past, expenses associated with work performed outside of the MTF were captured in an FC\*\* MEPRS Functional Cost Code account but workload was not captured. Beginning in FY06, the following methodology will be used for capturing external workload and expenses for work performed external to the MTF. For example, if a provider who is assigned to Eisenhower Army Medical Center delivers obstetric care in the local civilian facility for DoD beneficiaries, the provider's time and workload will be captured in DMIS ID 5433 representing the Medical College of Georgia (the local civilian facility) and MEPRS/FCC of BCB\*, thus capturing the professional services (RVUs) for the delivery. This methodology will provide the required data to support efficiency studies. Each MTF that has provider providing such external care should request a DMIS ID for the VA or civilian facility with which the MTF has an external agreement through their AMPO Analyst who will coordinate with PASBA. Civilian institutions will receive a DMIS ID in the 5000 series and VA facilities will receive a DMIS ID in the 2000 series.

### 6.3 Specific GME UCAPER Guidance and Issues

#### 6.3.1. Administrative Time Reporting

Interns, Residents and Fellows in Medical (GME) and Dental (GDE) **will not report any time under any MEPRS administrative overhead account (E%)**. Time spent in attendance in meetings and activities will be coded in the GME/GDE MEPR codes of FAN% OR FAQ%. Administrative codes specifically not authorized for Interns/Residents are as listed below. These codes should be used for reporting credentialed staff medical time. Time spent completing medical charts and time allotted as "clinic administrative time" should NOT be reported as administrative time but as clinical time. Clinical time defined as time structured to manage personnel, or clinic/facility activities.

EBCJ - Committees/Meetings

EBC1 - Medical Boards

EBC2 - JCAHO Activities

EBC3 - Clinic Management (i.e., Personnel Actions/ Supervision, Peer Chart Review),

EBC4 - Other Administrative Time (i.e., Patient Care Research)

EBC5 - All Dental Administrative Duties.

Providers assigned as **Command Staff, Department Chiefs**, etc should be assigned to a **EB\*\* MEPRS/FCC accounts** to perform administrative duties so all administrative related time should remain in their assigned EB\*\* MEPRS/FCC account. These individual should report any clinic



clinical contact hours under the MEPRS code of the clinic where the care is delivered. **Refer to DOD 6010-13M, Chapter 2, C2.5.2.**

### 6.3.2 Intern/Resident “Teaching Time”

Interns, Residents, Fellows are not authorized to report time in the teaching/preceptor MEPRS codes of EBE%, EBI%, or EBFN. Time spent assisting others in GME/GDE or in teaching medical students must be coded to the appropriate student MEPRS code of FAM%, FAN%, FAO%, FAP%, FAN% or FAQ%.

### 6.3.3 Physical Training

Only Mandatory Physical Training (PT) Tests performed during official duty hours can be reported as PT in GFA%. The Mandatory PT Test occurs twice a year. Since those in GME/GDE are not provided time to perform any other PT during the official duty day, only time spent performing these mandatory PT Tests during the normal duty day is authorized for reporting in GFA%.

### 6.3.4 External Rotations

Rotation to a civilian or military accredited GME/GDE institution is charged to the appropriate FCC account, or to the appropriate external work center MEPRS code.

### 6.3.5 General GME UCAPERS/MEPRS Rules

Adherence to the following rules will insure proper accounting for workload hours so that GME hours of trainees are not inappropriately added to any clinic FTE account. Again, it is emphasized that the UCAPERS reporting of hours should NOT be used as a means of tracking resident work hours for the ACGME. The hours for resident like staff accumulate to be counted mathematically as an FTE worth of available time in clinic. This is approximately 40-hours per week or 168-hours per month. Like staff residents reporting more than a maximum of 40 hours per week in clinical activity could appear as more than one (1) FTE equivalent. Processes should be in place to insure that resident clinical work hours are reported in the MEPRS codes of the various clinics where they may have provided the clinical care. Also resident time should be capture and resident should NEVER report hours as administrative time or GME time. The resident should first account for all hours in the individual clinics MEPRS spent in scheduled ambulatory clinical care and hours in direct inpatient care. Second they should report time away from duty, i.e. leave, TDY, or external rotations at no more than 8 hours per day.

#### 6.3.5.1 FAM – Graduate Medical Education (GME) Intern and Resident Expenses – Physicians Program

For the trainee who has completed the first year of training, labor distribution during the second and later years of GME (in which the curricula requires mainly performance of clinical tasks) shall be 30 percent chargeable to this code and 70 percent chargeable to the work center(s) the trainee



supports. For manpower purposes, all students including 1<sup>st</sup> year students and 2nd and later year students are assigned to this account.

#### 6.3.5.2 EBEA – Graduate Medical Education (GME) Support Expenses

The methodology to capture and report GME/GDE Support Staff labor hours (FTEs) is to account any GME support hours under EBE code. These functions when conducted at the MTF may include, but are not limited to, attending rounds, precepting residents in clinic (when the patients being attended are not patients of the preceptor), educational committee meetings, preparation and presentation of educational lectures, and counseling of residents. This code should also be used to report the work hours of those military and civilian personnel staff who conduct and direct GME programs. The code for dental GDE support is EBDI.

6.3.5.3 EBFM – This code should be used by staff physicians when reporting hours spent teaching/mentoring trainees in GME/GDE or students in a **clinic setting** when they are **not** performing hands-on patient care, and are supervising the Interns/Residents perform patient care. Note: The Interns/Residents should report their direct patient care time in the appropriate clinical MEPRS code.

#### **Recommendations:**

- Ensure that a simple process is in place so that actual hours are reported and individual who are not at work or no longer assigned to an area are not being counted incorrectly.
- Consider using the clinic work schedule to report hours in clinic with a fixed plan for reporting 40 hours per FTE. This plan should report all clinical hours first with the maximum of 8-hours per day, 40 hours per week as a person can only be 1 FTE.
- Implement a process to comply with external workload accounting.
- Monitor compliance with reporting and use simple spreadsheets to capture work hours against the main UCAPERS code.

Appendix D provides a sample Departmental Policy titled, “Completion and Compliance Rate of UCAPERS: Process for Appropriate Accounting for Work Hours.” Appendix E provides a sample worksheet.

Further detailed information can be accessed at <http://ampo.amedd.army.mil/ucapers/index.html>

#### **6.4 Capturing Workload from Inpatient Rounds (Industry Based Workload Alignment -Business Accounting - IBWA)**

This is an area of workload (RVU) that is under captured. Inpatient round consultations are captured as workload for your clinic. This is consistent with the professional fee charged in civilian facilities. The basic criterion for capturing this workload is a completed and signed note by an



attending provider. If a resident is involved in providing care there are other documentation considerations. (See Local Coding Experts).

It is just as important to close out every IBWA clinic visit as it to close out every office visit for coding purposes. CHCSII can be used to document and complete an IBWA round. The encounter print out would need to be incorporated into the inpatient record. As this may create an issue with inpatient record management, a simple first step is to establish a process of providing an inpatient billing sheet to a coder or clerical staff to input the code for the round in the ADM module of CHCSII. This can be done using a simple check off sheet as illustrated in Appendix E. These can be printed similar to prescription pads with the providers leaving them at a central collection point on each ward. Random coder audits and education can improve the accuracy of coding until a centralized inpatient module of CHCSII is fielded.

### 6.5 Capturing Clinic and ER Consults as CONSULT Visits

Consult visits are also an area of workload that is misreported. As noted in the section above, it is important for the clerical staff to book a clinic appointment against an open consult. It is also important to insure that the *Type of Service* is changed on the disposition screen of CHCSII to *Outpatient Consult*. This will automatically change the E&M code. A consultant may code the

initial visit with a patient that occurs at the request of another provider. If the consultant provider initiates a follow-up visit, the follow-up visit is coded using the appropriate office or other outpatient code for established patients (99211-99215). The patient may be re-consulted to the same consultant or another consultant for the same or a new problem. At this time the initial visit is again captured as a consultative visit.

Many facilities do not capture ER consult visit in a manner to maximize their workload capture. As with an IBWA round, the ER consultant visit is billed against your outpatient clinic. It is the professional fee that you would charge in civilian practice while the ER charges an institutional fee. Using a similar process to the IBWA rounds, this workload can be easily captured until this can be done electronically. The overprint in Appendix E has an area to utilize for ER consults. The ER consultant would have a “walk in” visit booked for the patient in their clinic and code it as a consultant visit that occurred in the ER.

### 6.6 Transition to TNEX system based upon RVUs from prior Visit Count based Workload Accounting System

Many present business processes were implemented not to improve care or provide efficiency but to count workload. Historically, patients were even “admitted” in order to receive increased workload for outpatient clinics. This included the “efficiency” of doing admission paperwork. Although these days have passed, many practices are still in place that do not support efficiency, data quality, third party billing, or meeting AMEDD Metrics. These systems former business processes are sometimes difficult to change as individuals sense that their “personal value” is being reduced as workload is no longer counted under their name. Healthcare always has and will always be a team



effort. RVUs are earned by the healthcare team but reported (and billed) in most instances by the provider.

Examples:

1) Patient is seen for a well child visit by the physician and sent for immunizations. This is a single office visit and the workload for immunization is also linked to the diagnosis and counted under the provider name. In the past, this often was two workload counts with the immunization clinic counting a visit when the immunization “clinic” was in the clinic area (four walls) as the initial visit. The workload credit was reported under the nursing staff giving the immunization. The RVU value and business billing rules are better served by this being a single visit when the encounter occurs in the same clinic. It is also more efficient for the clinic and patient with no redundant check in. If a patient must go to a separate clinic (different four walls, different support staff, and provider staff) then the patient would be signed into that Immunization Clinic as a separate visit.

2) Patient is seen in the cast clinic for a follow-up. The patient should be appointed by the provider responsible for the patient care. The cast technician can document in the record and the provider will evaluate the visit and documentation and sign the encounter. The cast clinic technician does not bill for RVU or accrue workload in their name. They contribute as part of the team. A single visit occurs on each occasion of care.

3) Multiple other examples occur as 99211 visits. These are visits performed by the clinic staff based upon established clinic rules. They do NOT require the patient to be directly seen by the provider. The rules for such visits vary by specialty/clinical area. Each area should review if any encounter that is being counted as a nursing visit or any encounter that is generating RVUs under the name of an individual other than a provider qualifies as a 99211 visit. In CHCSII such visits will be checked in under the responsible provider’s name (who already has medic-legal liability for the visit. The staff can complete the note, which then must be reviewed and signed by the provider.

### 6.7 Clinic-Specific Coding Education

The under coding of office visits is high in both civilian and military practices. This stems from both a knowledge gap and a fear of fraudulent billing. As CHCSII is deployed, there is an opportunity to begin focusing on clinic and individual coding activities. This will improve the workload captured for the military and prepare the provider for future civilian practice. The accuracy of coding is a joint responsibility of the provider and coder. Ultimately providers are accountable for the coding done by their practice. By providing clinic and provider specific feedback, maximum benefit can occur without wasted time by provider in coding classes that cover issues that are irrelevant to their practice.

The following is a list of common items usually missed in coding:

1. E&M under-coding can occur with CHCSII. This is most commonly due to inappropriate use of free text or using a template that was not designed to accommodate a higher code. The AMEDD- Reviewed AIM forms and templates in the Enterprise Folder of CHCSII have been reviewed to assist with appropriate coding. These are all labeled with owner as “Department of Defense” and have AMEDD in the name.



2. Failure to use a V code for physicals and to select a **Prev Med Eval/MGT** Services Type for the visit in the Disposition Module.

Example: A well child visit coded as an outpatient visit will typically have an E&M code of 99213 with an RVU value of 0.67. That same visit as a Prev Med Eval/MGT visit with a V70 diagnosis code (physical exam) will have an E&M code of 99395 with an RVU value of almost 2.0. Triple the workload value for the same work.

3. Failure to select the proper **EXAM TYPE** for subspecialty areas in the Disposition Module.

Example: The coding rules change for ENT specific exam verse a general medical exam. A provider can use either or that is appropriate (and gives more value).

4. Failure to document common CPTs that were done (Pulse ox, EKG, immunization, etc)

5. Failure to use modifier codes with visits (such as a -25 modifier when a patient comes in for two distinct problems)

6. Failure to document office procedure correctly.

The coding guidance for each of these is beyond the scope of this paper. A local plan should be established to evaluate and improve these areas as needed. Coding reviews should focus on specific areas of coding that can be tracked and improved. If a clinic has an appropriate distribution of E&M codes, the review should focus on areas that would yield better ROI.

### **6.8 Reduced Waste – Eliminated No-Shows and Unfilled Appointments**

This step is what most of the BPR paper has addressed. By reviewing the current business practices, the number of frozen appointments, unbooked appointments, and no-shows should be reduced. A goal for all these UNFILLED appointments should be established and monitored. They are the most expensive appointment that the MTF has. The Template Analysis Tool (TAT) on the TMA website provides an excellent way to graphically access and drill down on these issues. This information is available on all MHS clinics for all to see and compare.

### **6.9 Align Outcomes, Actions, and Incentives**

Successful transformation will be dependent on the degree to which a clear vision is created, communicated, and understood by all. It is essential that the desired end state be incorporated into the all activities within the MTF. The vision and rationale for change must be established and reinforced regularly. The progress toward and reaching established goals must be celebrated as often as hurdles are acknowledge. Regular communication of this process and awards at the department, service and clinic level are essential. As important as this strategic alignment is success depends on aligning the individual actions with the MTF and corporate goals.



### 6.9.1 Performance Measures and Goal Alignment

The military performance evaluation (NCOER, and OER) along with the government service (GS) evaluation (TAPES) must be aligned with desired outcomes. An example of how this is given in Appendix B with reference to GS provider bonuses. These measures should be made part of their performance appraisal with objective measures. Likewise, the rest of the healthcare team should have objective measures such as clinic level patient satisfaction and productivity as part of the performance objective of clerks, medics, nurses, etc. This serves to align the healthcare team toward and reinforce the importance of the outcome. Contracts for providers and ancillary support should also include these as part of the performance based contract. The contract for a physician should not say “Will have a schedule of 21 per day” but instead that the provider will “see 21 patients per day”. This way no-shows and unfilled appointment slots are not rewarded.

### 6.9.2 Performance Measures and Incentives

Most MTFs set aside a percent of civilian pay for incentive awards. These funds are often only given out at the end of the evaluation period and may not appropriate different performance or assist in changing behaviors. Awards such as “On the Spot” cash award should be considered for regular use. These awards in the amount of \$25 or \$50 should be given at the discretion of the clinic, service, and department leadership (with a annual cap). The purpose of these awards is to acknowledge individual events of excellence performance even if the individual is not usually an excellent performer. By using “on the spot” awards immediate recognition can be made while the employee will receive the funds in a later paycheck. The importance of command letters to younger enlisted should not be overlooked along with letters of praise for contract personnel who can use those to assist with future advancement.

Government Service Provider productivity can be incentives as previous noted by two main methods. Annual incentive awards can equal up to 25% of their base salary. These annual awards are NOT part of their salary but are earned (or lost) and by regulation require an annual review. For those GA providers who qualify, there is also Physician Comparability Allowances that can be provided based upon contracts of varying years. These can be used to align performance and to retain quality professionals. The cost of unfilled positions and the cost of working to remove less than optimal provider should be considered when deciding on the amount of a PCA to offer for multi-year contracts. Finally, the military can be rewarded at all levels by granting passes that were earned for excellence, educational opportunity, and military recognition as appropriate.

## 6.10 Other New or Often Missed Business Rules

### 6.10.1 Case Management – FAZ2 replaces ELA2

Guidance published in May 2004 established MEPR code ELA2 for reporting of Case Managers, Medical Processing Assistants, RN Case Managers, and others who are involved in **GWOT-related Soldier care** (Medical Board, Medical Hold, or Medical Holdover). Beginning in FY06, the time and expenses involved in the Case Management of these patients should be changed to and reported



using the MEPRS/FCC FAZ2. These Medical Hold and Medical Holdover patients are under the general care of a Primary Care Manager. However, the patient may have occasion to see the Case Manager without a visit with the provider and the Case Manager will document notes in the outpatient medical record, although the details of how the encounter should be coded are still being resolved. It is the encounter with the case manager, apart from the clinic visit, that will be accounted for in the FAZ2 MEPRS/FCC.

### 6.10.2 Inpatient Clinical Nutrition Management – BAL replaces EIC

Effective with October 2006 reporting, the Inpatient Clinical Nutrition Management MEPRS/FCC of EIC is **deactivated**. All basic and comprehensive nutrition care for inpatients and those activities currently outlined in DOD 6010.13-M for EIC will be captured as inpatients visits in the MEPRS/FCC BAL (Nutrition Clinic). The reporting of both inpatient and outpatient visits in BAL will eliminate the inconsistencies in reporting Nutrition Care.

### 6.10.3 Capturing DD clinic work - EKG, EEG, and EMG

FY05 policy was if the work center that performs the EKG, EEG, or EMG test is in a separately organized area with its own physically separate location then the technicians should capture their time and workload for performing a test in the EKG, EEG, or EMG work center (DD\*\* MEPRS/FCC). Conversely FY05 policy stated, if tests are performed in an ambulatory clinic by clinic staff, the staff's time and workload were to be captured in the ambulatory clinic (B\*\*\*).

Beginning in FY06, when the test is performed in an ambulatory clinic by the technician, the technicians should continue to report their time and test counts in the DD \*\* (EKG, EEG, or EMG) work center but also report their CPT workload in the ambulatory clinic. The provider who requested the test and is present in the ambulatory clinic during the test will capture the CPT workload in ADM/CHCS II. This will result in the creation of a SADR with CPTs that generate RVUs for the appropriate ambulatory clinic.

### 6.10.4 Reading EKG

Previous EKG policy issued in May 2004 indicated that when a physician is required to read/interpret all EKGs for an MTF, the physician's time should be reported in the DDA\* work center. That guidance conflicted with UBU coding guidelines and is **rescinded**. The physician who reads/interprets the test should capture their workload and time in their ambulatory work center (B\*\*\* MEPR). Per the coding guidelines, if the read/interpretation of the test is independent of the patient's visit, it should be billed using the 99499 E/M code and use of the appropriate CPT code for billing/accounting.

Together these provide a substantial arsenal to help align individual, clinic, and service actions with the outcomes desired from BUSINESS (CLINICAL) PROCESS REENGINEERING.

### 6.10.5 Physical Therapy Inpatient Visits



Recent audits indicate that some MTFs may not be capturing physical therapy visits for inpatients. This is lost workload (DoD 6010.13-M visit definition). Per the UBU guidelines, **all** inpatient therapy encounters should be captured using ADM. The system will prompt, “Are you from the attending service?” The response should be “No.” This will generate a SADR. The DoD MEPRS Manual states that an inpatient visit **shall** be counted **each time** contact is made by a clinic or specialty service member (other than the healthcare provider from the admitting/treating clinic or specialty service) with patients on hospital units or wards, when such services are scheduled through the respective clinic or specialty service.

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**Appendix A: Sample SOP on Empanelment**

**Policy on  
Empanelment of Enrolled Beneficiaries to Primary Care Managers**

1. Purpose: The purpose of this document is to provide instruction for the establishment of primary care empanelment to MTF Alpha enrolled patients and to establish the method for review of beneficiary and provider empanelment changes. The goal is to establish a single standard of care by which empanelment is made and to assure the maximum possibility of continuity of care.
2. Background: The assignment of every MTF beneficiary to a primary care manager is a DOD mandate. This policy establishes the mechanism to assure that the right patients are empanelled to the right provider based upon the established roles of each MTF Alpha primary care clinic and the providers assigned to those clinics. This program is known as Primary Care Manager by Name (PCMBN).

It is well established that regular visits by a patient with their primary care managers (continuity) leads to decreased healthcare cost, improve patient satisfaction with healthcare, improved healthcare outcomes, improved provider satisfaction, and decreased healthcare utilization. It has also been established that continuity visits can be conducted in a shorter period of time with the same or increased delivery of preventive healthcare services. The importance of these factors will increase as CHCSII is implemented.

For continuity to occur the patient must be assigned to a PCM and be able to have regular access to that PCM when healthcare is require.

3. Responsibilities
  - a. The Chief, Primary Care is the action officer responsible for PCMBN. He will
    - i. Establish PC provider panel sizes
    - ii. Create the rules for assignment of patients to clinics and individual providers (Appendix A)
    - iii. Maintain a policy for reviewing requests for exceptions to establish empanelment policy (Appendix B)
    - iv. Annually review empanelment issues with C, DOM as related to the IMC
    - v. Refer request for second level review on empanelment concerns issues to the DCCS.
    - vi. Establish and report upon continuity to the Ambulatory Care Committee.
    - vii. Work together to improve empanelment issues monthly with the Chief, Department of Managed Care (C, DMC)
    - viii. Assure patients are notified of initial empanelment and changes of empanelment made by personnel assigned to the D, PC.
  - b. The Chief, Department of Medicine will
    - i. Determine the panel sized for IMC providers and residents



- ii. Review empanelment concerns annually and as needed with the C, PC
    - iii. Be responsible for the continuity and access of patients assigned to the IMC.
  - c. The Chief, Department of Managed Care will
    - i. Be the liaison with TRICARE Contractor to assure timely enrollment and empanelment under TNEX.
    - ii. Be responsible for assuring empanelment occurs by established policies.
    - iii. Monitor contractor compliance with enrollment and empanelment process once the contractor assumes empanelment responsibilities.
    - iv. Provide monthly a current list of PCMs with their current empanelment to the C, PC
    - v. Assure patients are notified of initial empanelment and changes of empanelment made by the personnel assigned to his department.
  - d. The Deputy Commander for Clinical Services (DCCS) will be the reviewer and arbitrator of empanelment issues.
- 4. Metrics
  - a. Continuity Goals
    - i. Book 80% of all calls within 7 days (except wellness)
    - ii. D, PC - 

<u>PCM</u>	<u>Group</u>
70% OB visits	90% OB
70% EST/WELL	80% EST/WELL
70% Routine	80% Rout
40% Acute	60% Acute
  - b. Less than 500 patients enrolled who are not empanelled.
  - c. Clinic Continuity Goals – Global Continuity
    - i. FPC (residency) – 60% PCM, 90% clinic
    - ii. IMC - 60% PCM, 90% clinic
    - iii. TMCX - 70% PCM, 95% clinic
    - iv. Contract – 80% PCM, 95% clinic
- 5. POC is undersigned.

(SAMPLE)

Policy on Empanelment of Enrolled Beneficiaries to Primary Care Managers

Guideline for Empanelment of Patients to Eisenhower Army Medical Center (EAMC) Primary Care Providers

1. General
  - a. Only Patients who are enrolled to MTF Alpha under TRICARE Prime or TRICARE Plus will be empanelled to a PCM at MTF Alpha.
  - b. All patients living within the EAMC catchment area who wish to be enrolled in TRICARE Prime will be empanelled to a PCM at MTF Alpha
  - c. Patients living outside of MTF Alpha catchment area as defined by zip codes will not be enrolled or empanelled at MTF Alpha.
  - d. Dependent parents will not be enrolled or empanelled to MTF Alpha.
  - e. A maximum of 5100 TRICARE Plus enrollees will be empanelled to MTF Alpha (See #5).
  - f. To the extent possible family members should be enrolled to the same clinic and to the same PCM.
  - g. If there is not an empanelment slot available for a TRICARE Prime eligible beneficiary who is living within the catchment area the C, Primary Care will be notified to make corrections. The patients will NOT be automatically enrolled to network PCM.
  - h. Patients may request exceptions to policy in writing through Health Benefit Section to the C, Primary Care. The request for exception should contain specific reasons supported the request. A written response to exceptions to policy will be completed within 7 days of receipt of the request.
  - i. Empanelled patients may request a change of provider in writing. For non-active duty patients this change will be granted up to twice annually provided the clinic/individual has open PCM slots specific to the patient's request. Active duty service members may change providers within clinics but the C, Primary Care, must approve any request for a change of clinic assignment.
  - j. Panel Sizes will be published by the C, Primary Care quarterly and may be modified sooner. Panel sizes are established based upon individual provider duties and productivity expectation (access). The Department of Managed Care will maintain the provider file and table for empanelment.
  - k. Panels will include a designation of total patients as well as total number by age, beneficiary category, gender, and other restrictions as applicable. See chart at Appendix C.
  - l. All available empanelment slots by category will be filled to 80% before any single provider or clinic exceeds 80%. Once all clinics are at 80%, all empanelment slots by category will be filled to 90% before any provider/clinic exceeds 90%.
  - m. No provider will be empanelled beyond 100% without permission of the C, Primary Care except for cases of obstetric and newborn care as noted below (See #6).

- n. Managed care or the TRICARE Contractor will keep current the list of empanelment and publish this monthly for review by the C, Primary Care.
2. Active Duty Empanelment is by Military Unit
  - a. Hospital clinics – MEDDAC, DENTAC and Veterinarian Activity.
  - b. TMCX – All other permanent party units.
  - c. Individual active duty service members may be assigned to a clinic other than the one designated for their unit after approval by the C, Primary Care or his designee.
3. Active Duty Dependents enrolled in PRIME and enrolled to a MTF Alpha DMIS code may be empanelled as follows
  - a. Hospital Clinics – These clinics will empanel dependents consistent with the established CHCS file and table.
  - b. TMCX – Only dependent of active duty members of the assigned units can be empanelled to this clinic.
4. Retired Beneficiaries and their dependents who are enrolled in TRICARE Prime and live within the catchment area
  - a. Hospital Clinics – All these clinics will accept empanelment of these beneficiaries as space (file and table empanelment capacity) permits.
  - b. TMCX – No retiree or retired dependents will be empanelled in this clinic.
5. TRICARE Plus beneficiaries in general will be greater than 65 years old and are primary seen at MTF Alpha for reasons of graduate medical education and training. New enrollees to TRICARE Plus occur by the aging in of TRICARE Prime beneficiaries as they reach 65 years old. MTF Alpha will contact the retiree to verify their desire to be enrolled in TRICARE Plus before the retirees 65<sup>th</sup> birthday. The C, Department of Managed Care
  - a. FPC
    - i. Will have capacity to enroll ##### TRICARE Plus beneficiaries.
    - ii. 20% of resident panel reserved for TPLUS
    - iii. Minimum of 15% of staff physicians panels reserved for TPLUS
  - b. IMC
    - i. Will have capacity to enroll ##### TRICARE Plus Beneficiaries.
    - ii. 50% of resident panel reserved for TPLUS
    - iii. Minimum of 50% of staff physicians panels reserved for TPLUS
  - c. TMCX will not have TRICARE Plus Beneficiaries empanelled to them. Patients aging into TRICARE Plus and those patients granted an exception to enter the TPLUS program from these clinics will be assigned to another clinic.
  - d. TRICARE Plus beneficiaries will only be empanelled to residents and board certified physicians.
  - e. Once the maximum of XXXXXX TRICARE Enrollees to the MTF has been reached





**Appendix B: Factors Effecting Civilian (GS) Retention Pay**

This is provided as an example of defined objective measures used to evaluate, compare, and provide incentives for GS employees. By establishing objective performance goals that are aligned with department and command vision and mission, both management and the providers can be clear on expectations. What gets measured gets done and (with incentives) improved.

Item	Goal	Possible	Earned
<b>Productivity - 10%</b>			
a. RVU per year (4 > 4500, 2 > 3500)*		4	
b. Visits (goal specific to clinic)		4	
c. TCON (if clinic does not do TCONS then % goes to Visits)		2	
d. Comp Time (-1% per 20 hrs)	0		
<b>Satisfaction (OTSG Survey) - 8%</b>		3	
a. Listened (provider% - clinic %)			
> 9 = 4%, 5-9 = 3%, -3 or less = -2%			
b. Respect (provider% - clinic %)			
> 9 = 4%, 5-9 = 3%, -3 or less = -2%			
<b>Administrative - 5%</b>			
a. MPL Completion - chart audit		2%	
b. Records Completion within 24 hrs		1%	
c. Satisfactory Chart Review %		2%	
<b>CME - 3%</b>	> 75 hours/yr	3%	
	50-75 hours	2%	
	25-49 hrs	1%	
<b>Shift work (variable up to 5%)</b>			
<b>Projects or Activity bettering healthcare</b>		2%	
<b>Negative Factors (Counseling and performance issues)</b>			
<b>MAXIMUM (cannot exceed 25%)</b>			

Regularly validate metrics with comparison of MTF and Regional Command peer comparisons. These Metric may need to be adjusted after the first year of CHCSII use.

## Appendix C: Roles for Support Staff

### Roles and Responsibilities for Medical Technician/Medical Assistants:

- Takes vitals, weigh patient and **initiate CHCSII SOAP note documentation by using the AIM forms to start documentation on the S/O portion of the patient encounter**
- Screens for preventative services (EKG, PAP Smears, colonoscopy, mammograms, immunizations out-of-date)
- Records medication use
- List allergies
- Documents tobacco and alcohol use
- Circles abnormal vital signs and weight
- Complete chronic pain documentation, as appropriate
- Drapes appropriate body area for provider examination
- Monitors exam room flag as occupied and monitors availability
- Notifies patient if provider is delayed
- Collects and prepares specimens; transports to lab
- Assists in procedures
- Removes sutures
- Turns over patient care room
- Collects records from patient care room; checks for completeness, returns to front desk clerk after each visit
- Supports provider as needed during patient visit
- Cleans and maintains patient care room
- Stocks patient care rooms
- Enters labs, X-rays, prescriptions, etc. into CHCS under provider direction and co-signature
- Retrieves labs from CHCS and documents on flow sheet for CPG's
- Transports patients
- Maintains equipment
- Serves as standby for patient care
- Performs specialized activities with physician training and supervision
- Administers immunizations
- Assists with patient education (handouts)
- Medical record management
- Maintains core competencies as specified by Command SOP



## Appendix D: UCAPERS Policy Statement (SAMPLE)

### Policy Statement

#### Completion and Compliance Rate of UCAPERS: Process for Appropriate Accounting for Work Hours

1. **PURPOSE:** The purpose of this policy is to provide administrative guidance for UCAPERS accuracy and completion within the Department XXXX. The overall goal is to improve data quality.
2. **REFERENCE:** RM instructions, TMA Guidelines, AMPO Guideline FY06, and DODI 6010.
3. **SCOPE:** This policy applies to all providers and clinics within the XXXX.
4. **GENERAL GUIDANCE:**
  - a. All services/sections/clinics will utilize the applicable XXXX UCAPERS reporting sheet. Sheets exist for clerical and nursing personnel, residents, and staff health care providers.
  - b. Every employee should be made aware of the importance of accurate UCAPERS reporting.
  - c. The following supervisors will complete or insure completion of the XXXX UCAPERS work sheet for their staff:
    - i. CAS Clerks – CAS supervisor
    - ii. Clinic clerks and nursing staff – NCOIC
    - iii. Physicians and PA/NP – Clinic OIC
    - iv. Residents – Resident training assistant
    - v. Department Command Group – Individual
  - d. UCAPERS work sheets will be completed and submitted weekly for nursing and clerical staff and monthly for provider staff.
  - e. True administrative time will only be reported for providers (MD/DO/PA/NP)
  - f. Hours are to be reported against the clinic where the work occurred.
  - g. Reported ours in clinical care cannot exceed the number of hours the clinic is open.
  - h. Total clinic and inpatient direct care hours that were spent in support of the healthcare mission should be reported. Supervisor should be aware of individual who regularly report over 40 hours of clinical time per week or 168 hours per month. This number may indicate reporting issues or individual efficiency issues that need to be addressed. Note: Time completing clinic notes is clinic time NOT administrative time and time given for general administrative time that is not fixed



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to a MTF meeting, GME or supervisory activity is reported as CLINICS time. Hours of availability normally starts with the time that patient care starts.

- i. If using the clinic scheduling sheet to validate hours, AM and PM clinic will be considered 4 hours of available time.
- j. Time spent performing SRP, POR, or Demobilization activities will be accounted under readiness code XXXX for EVERYONE except the NCOIC and OIC of the readiness activity. The NCOIC and OIC of the SRP/POR/Demob will count their time against BHA2. All soldiers attending these activities will be a walk-in for an INDIVIDUAL appointment with the OIC of the activity. GROUP appointments will NOT be used.
- k. TDY, CME (full day), CEU (full day), training holidays and federal holidays and other activity will be counted as 8 hours per day (40 hours/ week).
- l. All employees will be checked against the departmental UCAPERS roster to insure that they are assigned to the appropriate clinic.
- m. **ALL providers (MD, DO, NP, PA) will have CHCS File and Table reflect that they can work in only the normal clinics that they work in.**

### 5. GME Specific GUIDANCE

- a. Interns
  - i. Will report a maximum of 40 hours of direct clinical time to include time in clinic and performing inpatient duties. The UCAPER system will automatically place 50% of each of these hours against a residency GME code. Intern will NOT list GME hours. Interns will NOT report any administrative time. Interns will only report military training time for their twice yearly physical fitness test. All time away from duty leave, TDY, holiday or external rotations should be accounted for.
  - ii. Time at outside facilities is reported against the external GME site MEPR. Note: The FY06 guidance will now require you to get that facility's DMIS ID and assigned a MEPR..
  - iii. Physical training time will only be reported during the bi-annual PT test.
- b. Residents
  - i. Will report 40 hours per week with hours assigned to the clinic or inpatient activity that the work occurs under. The UCAPER system will automatically place 30% of each of these hours against a residency GME code. Residents will NOT list GME hours (time being a teacher). They will NOT report any administrative time. Interns will only report military training time for their twice yearly physical fitness test. All time away from duty leave, TDY, holiday or external rotations should be accounted for.
  - ii. Time at outside facilities is reported against the external GME site MEPR. Note: The FY06 guidance will now require you to get that facility's DMIS ID and assigned a MEPR.

- iii. Physical training time will only be reported during the bi-annual PT test.
- c. Teaching Staff
  - i. Inpatient duty will be counted as 8 hours GME per day.
  - ii. Clinic teacher or procedure precepting is GME time.
  - iii. Administrative time will be counted toward the clinic that the provider is assigned. GME specific administrative time should be accounted for as GME.
  - iv. Staff time spent at a civilian care center or a Veteran's Administration facility should be counted as EXTERNAL Workload. *Note: FY06 guidance will require getting each of these external facilities a DMIS number and MEPR code to appropriate report these work hours and care delivered.*
- d. Military (excludes intern, residents)
  - i. FTX and other military training time is counted as GBAA (8 hours/day) and can include weekends.
  - ii. For soldiers who are deployed the military personnel or resource management (UCAPERS) section will be called to obtain the specific UCAPERS code that is assigned to each deployment location. Each deployment day is listed as 8 hours/day.
  - iii. If performing SRP or Demobilization use BHA2. Do NOT count against clinic time. This time counts as a portion of available clinical hours (40 hours per week).
  - iv. If involved in military training (TRNG) use MTNG. This includes PT, APFT, range or other activity during the duty week.
- e. Miscellaneous
  - i. The physical exam clerk will have a percent of her time against BAAE and BHAY. This percent should approximate the percent of retirement physicals (BAAE) and readiness physical (age specific, SRP, etc).
  - ii. Volunteer – Each clinic will make a positive report of volunteer hours as total hours per day for that clinic. The number of volunteer hours in this fashion CAN exceed 40 hours per week. All volunteer hours regardless of type of worker (clerical, administrative, nursing) will be reported here. Each clinic will be assigned a volunteer code and enter all hours worked during the reported time period under that code. Report using volunteer hours UCAPERS form.
  - iii. The final work schedule may be used to designate hours. This may include the clinic schedule for providers. If this is done, a half day scheduled in clinic will be assumed to be 4 hours of time worked in that clinic. This action is being done to assure data consistency/quality.
  - iv. In and Out Processing – Time spent performing in and out processing functions will be documented with the code PROC. This includes all activities associated with in and out processing.

6. Steps for Completion of UCAPERS
  - a. UCAPERS will send a roster monthly to the central UCAPER entry point for XXXX.
  - b. Supervisors will complete or insure completion of UCAPERS worksheets (sample attached) and give them to the data entry clerk by Friday of each week for nursing/clerical personnel and by the last day of the month for providers.
  - c. UCAPERS entry will be completed by Wednesday of the following week. Monthly reports (providers) will be completed by the 7<sup>th</sup> workday of the following month.
  - d. Supervisor will be made away of reported clinical available hours of greater than 40 hours per week or 168 hours per month for validation.
  - e. The UCAPERS completion status will be reported at the department PI meeting. The report will include:
    - i. Timeliness of receipt of UCAPERS worksheet
    - ii. Completion status
    - iii. Any discrepancy between UCAPERS reported staff that are assigned and UCAPERS worksheet reports.
  
7. The following metrics and evaluations are established:
  - i. 100% of all UCAPERS worksheet will be submitted on time.
  - ii. UCAPERS entry will be completed within 1 week of worksheet receipt.
  - iii. Maintain 100% KGADS completion for TCONS.
  - iv. 100% proper accounting for individuals in UCAPERS who are deployed or TDY.
  - v. 95% agreement of personnel assigned against their actual clinic of assignment.
  
8. Proponent for this policy is Chief, XXXX.



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SAMPLE UCAPERS WORKSHEET

UCAPERS		Outpatient Clinics/ER					
XXX Staff Provider Work Hours							
NAME:		ID:		MONTH:			
		APC	MEPR	Wk 1	Wk 2	Wk 3	WK 4
CLINICAL	FPC	BGAA	NNA6				
	FPRS	BGA9	TGA9				
	IMC	BAAA	NNC2				
	IMRS	BAA9	TGC2				
	PCC	BHAA	NNB1				
	CHC	BHAY	NNA3				
	TMC4	BHAH	NNA2				
	EFMP	BDAB	NNG1				
	ER	BIAA	NNE5				
	Prompt	BIAC	NNE5				
	OPTO	BBFA	NCC4				
	Appointments	BGAA	NNA6				
	Inpatient	9W	AAXC				
9E		AAXB					
11W		AFXB					
External Work	Civilian or VA			Need to get code assigned.			
READINESS	PT/APFT	GFAA					
	TRNG	MTNG					
	SRP visit	BHA2					
	SRP Screen	GAAE					
	FTX	GBAA					
	DEPLOY	GAA					
	TDY**						
ADMIN	ADMIN	EBC4					
	GME	EBEA	NNT9				
	CME	EBFA	EB12				
	TH/HT*						
	Leave*						
non CME	TDY						
In/Out Processing	PROC						
LTI (other)							
TOTAL HRS							
%PT CARE HRS							

Notes:  
 Staff time as ward attending is counted as GME.  
 Staff time in teacher room and procedure clinic is GME.  
**Time spent doing readiness activities (SRP/DeMOB/etc) counted toward readiness; NOT clinical. Code GAAE**  
**SRP/Demob OIC ONLY will use BHA2 and be credited with visit counts**  
 Range time, FTX, PT and other training to be accounted for under military readiness.  
 On call time only counted when actually in the facility.  
 All administrative time will be counted against the clinic the staff is assigned to.  
 Combined clinical and administrative hours should not exceed 48 hours week.

\* Enter hours only.  
 \*\* Each deployment has a specific code. Call UCAPERS for code.  
 LTI: Loaned internal. Use for work in clinic other than above. List Clinic name. Limit use as possible  
 Processing:  
 Supervisor will complete on a monthly basis and give to MEPRS input personnel for entry.



Appendix E: Inpatient Rounding (IBWA) and Consultation Workload Documentation Sheet

Medical Treatment Facility ALPHA  
 Specialty Service:  
 \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
 Service Date: \_\_\_\_\_

Diagnoses: 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

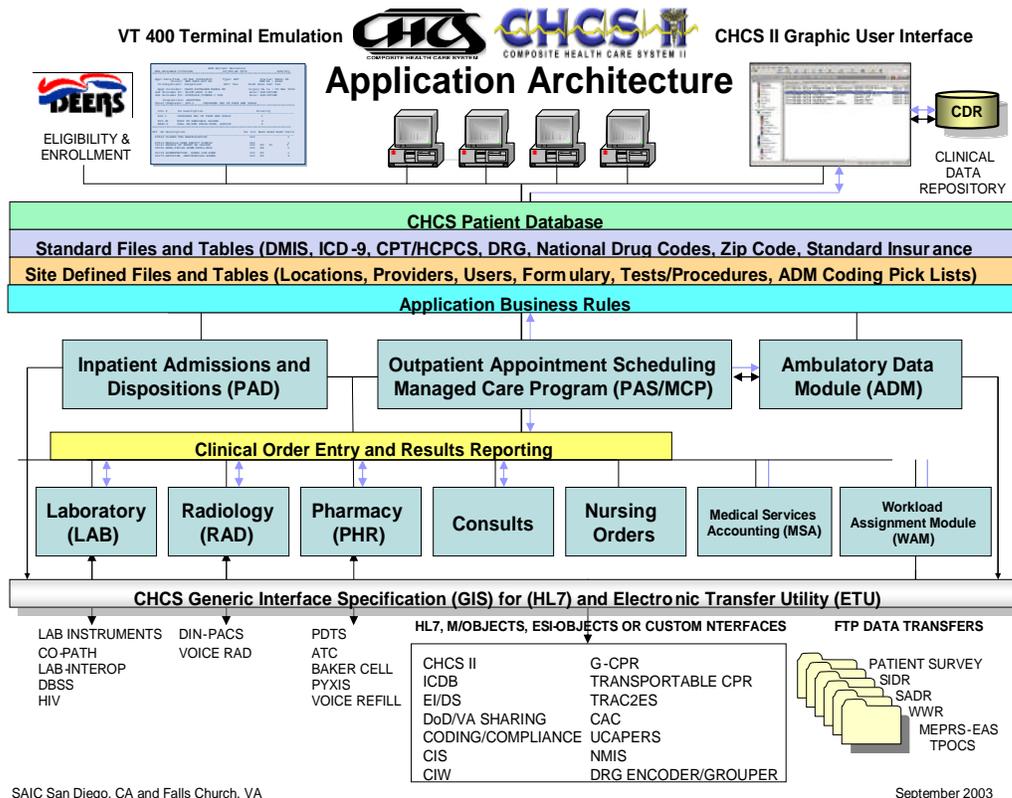
<b>Emergency Room</b>	<b>Code</b>	<b>RV U</b>	<b>Hospital – Other</b>	<b>Code</b>	<b>RV U</b>
Level I Limited	9928 1		Day 1, Stable	9922 1	
Level II Low Compl	9928 2		Day 1, Minor Compl	9922 2	
Level III Mod Compl	9928 3		Day 1, Unstable	9922 3	
Level IV High Compl	9928 4		Each subsequent day, Stable	9923 1	
Level V high Sev/Compl	9928 5		Each subsequent day, Minor Compl	9923 2	
			Each subsequent day, Unstable	9923 3	
<b>Hospital Observation</b>			Discharge Day Management	9923 8	
Hsp Obs Discharge Day	9921 7		Critical Care - 1st Hour	9929 1	
Observation Care Level 1	9921 8		Critical Care – Each Additional 30 min	9929 2	
Observation Care Level 2	9921 9		Procedure:		
Observation Care Level 3	9922 0				

### Appendix F: File and Table Build

CHCS File and Table Build is a technical exercise that defines the operational process in the CHCS system. It defines who, what, where, why, and when so the system can automate how a clinic does business. Invalid or incomplete File and Table settings in CHCS can contribute to:

- Improper workload reporting
- Inaccurate Medical Expense and Performance Reporting System (MEPRS) data
- Additional computer screens and increased level of effort to book an appointment
- Inability for a provider to work within the appropriate clinic within CHCS II
- CHCS II implementation challenges

MTF specific File and Table Build uses a combination of Standard Files and Tables and Site Defined Files and Tables available in CHCS. The picture below shows this relationship in the Application Architecture and to the Managed Care Program Module used for appointment scheduling.



### 1. Operational Assessment

The first step in determining file and table requirements is to assess the operation of how care is expected to be delivered in the clinical environment and to define the business process. As part of this activity, how you want each clinic to conduct business, rather than its current operations, must be considered. That does not mean to change practices for the sake of change, but it does present an opportunity to reassess operational practices.

Ask these questions for each clinic where patient care is delivered:

1. Does the clinic practice as one entity?
2. Are there sub-teams within the same clinic?
3. If the patient cannot get an appointment with their PCM, is there a sub-group of providers to be booked with first before the entire group is made available?
4. Are there providers who should not be an option for appointing? If so, why not?

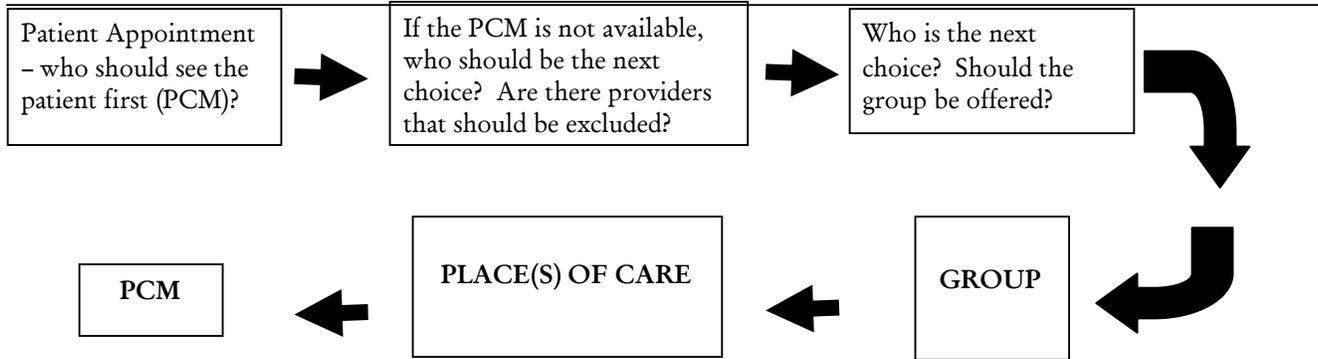
Determine how care is delivered from point of entry through and including check out. Answering all of these questions will provide the framework needed to build the appropriate file/table to support the operational needs and to evaluate whether current file/table settings currently support the business processes of a clinic.

1. Records pull – where and when should the records go? Should records be directed to a specific location? Are there multiple check-in areas?
2. Check-in for Appointment – where does this occur? Is there more than one location depending on who the PCM is? If the patient is not seen by their PCM, should the record go somewhere else?
3. Screening and Intake – Where is this done? Who does this? Does it vary based on who sees the patient? (i.e. PCM or another provider)
4. Provider Encounter – Where does this occur? Will it vary from place to place? Who documents the encounter?
5. Ancillary Support – Does this vary from clinic to clinic?
6. Referrals – Should the PCM be given notice of Referrals generated by somebody else? Who should the results be provided to?
7. Telephone Consults – Who should be able to generate and document these?
8. Check-out – Where does this occur? Can this occur at various places?

To support the operational needs of CHCS II, one must understand the proper configuration of the File and Table Build and be familiar with all of the elements of the Managed Care Program Module file structure. The Provider Group, the Place of Care and the PCM or provider relationship are critical to ensuring the business process is optimized in the technical settings.

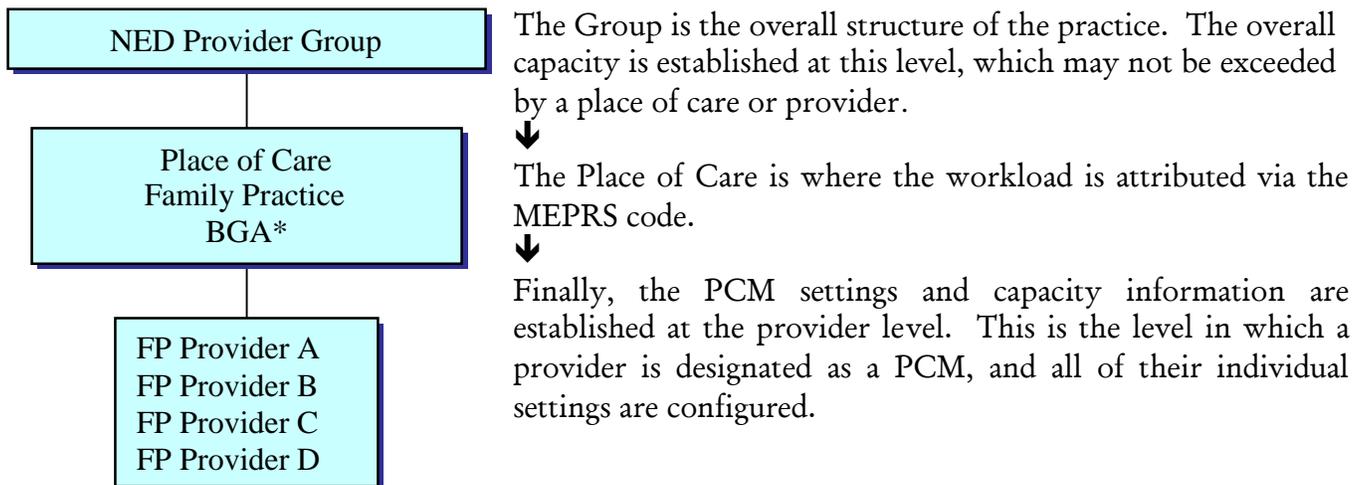


## AMEDD CHCS II PLANNING & IMPLEMENTATION



### A. NED PROVIDER GROUPS

1. The National Enrollment Database (NED) Provider Group is the “umbrella” level of the File and Table hierarchy. It represents the overall circle surrounding the technical settings of the clinic. This is the level that specifies which clinics comprise the practice, overall group capacity levels, etc. The group level of the File/Table provides the framework for all of the appointing and enrollment information for a given location.
2. If the Group settings preclude a specific beneficiary category, such as active duty or active duty family member, then none of the places of care or providers within that group can contain those patient categories. The categories within the place of care or provider may be limited, if necessary, but the settings must be “allowed” at the group level to exist at any of the lower levels.



While this structure works perfect for a single specialty, not all clinics are created equal. For example, some clinics may be comprised of multiple specialties, such as primary care/family practice and pediatrics. There is a requirement to differentiate their workload, but an operational need to maintain the fluidity of appointing within the team as if it were a single entity. To facilitate the operational needs, the file and table can be configured to create one team with multiple places of care. It would appear as follows:

## B. PLACES(S) OF CARE

1. The Place of Care or Clinic is the level in which the schedules and appointments actually occur. All schedules and templates are defined at this level along with clinic level capacity information
2. This is also the level at which workload is attributed via the clinic MEPRS code. The File and Table build categorizes each appointment as either a Count or No-Count and includes a patient status flag of Inpatient or Outpatient to report the number of visits.
3. The Place of Care may often be referenced as a clinic, or even a Hospital Location File. All of these names are interchangeable, as they all mean the same thing. Again, in order for the attributes to exist at a provider level, which is nested within the place of care, they must first exist at the place of care level. For example, an appointment type may not be assigned to a provider that does not first exist at the place of care level. All file and table settings operate as a hierarchy.

## C. PRIMARY CARE MANAGER (PCM)

1. A provider level must be loaded into each Place of Care in order to appoint or assign beneficiaries. The provider capacity and schedule is completed at this level.
2. A Place of Care must consider how it wants the booking flow to evolve.

Example: A clinic may want to book Active Duty (AD) beneficiaries with their PCM. If the PCM is not available, the clinic may then want to select a group of providers (other AD providers) to be defaulted to first, then only the remaining providers in the group. This creates a “group within a group” scenario.

3. Provider Profiles - MTF processes related to Provider Profile maintenance in CHCS are essential to clinic operations. Normally, the responsibility for CHCS Provider File maintenance is shared across multiple departments.
  - Providers not entered into CHCS in a timely manner impact the ability for clinics to establish Appointment Schedules.
  - The Provider Class is another key element that determines the ability for the Provider to perform Order Entry, based on Provider Signature Class.
    - The Provider Medical Specialty is critical to the reporting of work performed and the billing process as Providers that do not have a Direct Care Medical Specialty also do not have a CHAMPUS Maximum Allowable Charge (CMAC) Provider Class that is used to calculate outpatient itemized charges for outpatient services ordered or performed.
  - The assignment of the Provider Medical Specialty is a PASBA DQFAST Metric, reported on a monthly basis.



Significant focus needs to be placed on the Provider Files to ensure the data elements required for CHCS II are entered, Medical Specialty is validated, the current assigned location is updated and this information is consistent in the CHCS User File, Provider File and Credentials.

MCP follows a specific path in booking appointments. The booking process is actually the reverse of how the file/table is originally configured, meaning the booking process works backwards. Therefore, the method in which the file/table is configured directly impacts the way appointments appear to booking staff, and subsequently impacts access to care. When not build adequately, dependent processes are negatively impacted, workarounds are created, and the snowball effect occurs.

The following information is taken from the CHSC Managed Care Program Module Training Guide at the following address: <http://www.tricare.osd.mil/policy/memos/mcptrain.html>

**ISSUE: PROVIDER FILE AND TABLE BUILD OFFER PROBLEMS WITH PCM SETUP (SPECIALTY NOT INDICATED AS PCM, DUPLICATE PLACES OF CARE, CAPACITIES FOR GROUP NOT CONSISTENT WITH SUM OF MEMBER CAPACITIES, ETC.)**

**IMPACT:** Beneficiaries are improperly assigned to specialty provider rather than PCM, resulting in capacity issue. It may not be possible to assign an enrollee to the correct PCM because the provider managed care data are not set up properly.

**TRAINING ISSUE:** Run the Provider Group Report and analyze each provider's managed care data for completeness. The only item that cannot be analyzed is the list of specialties provided by a PCM. A "yes" flag must be turned on for each specialty the provider will support as a PCM. If not set to "yes" an enrollee cannot be assigned to the PCM for that specialty. The method used to analyze this report should be trained so that users can identify problems after each provider is built. Provide a check list of information to validate. Refer to CHCS MCP Report write-up for the Provider Group Report for some items on the check list.

**ISSUE: SETTING UP APPOINTMENT TYPES SO THEY WORK IN PAS AND MCP.**

**IMPACT:** PAS needs another level of appointment types at the procedure level or staff service level. The Tidewater solution is to name the clinic within the facility as an appointment type. Thus they have clinics called "Suture, MRI, Well Baby, etc." This has not worked very well for their facilities. Langley defined the clinics at the "Suture, MRI" level, then used a limited set of appointment types, e.g., follow-up, routine, new, etc. This method makes appointments easier to find.

**TRAINING ISSUE:** This is a local standardization issue. Each facility should set up an appointment type review team to standardize all their appointment types.

**ISSUE: PAS INACTIVATES A PROVIDER EFFECTIVE ON THE INACTIVATION DATE WHILE MCP INACTIVATES THE PROVIDER THE DAY AFTER THE INACTIVATION DATE**

**IMPACT:** PAS and MCP work differently when they inactivate a provider. Basically PAS inactivates the provider effective at midnight on the day the user inactivates him/her. MCP inactivates the provider effective the day after the inactivation date. In MCP the user can choose a date in the future to inactivate the provider; PAS accepts only today as the inactivation date.

PAS allows the user to inactivate a provider at the Hospital Location. The user may also inactivate a provider at the MTF level by setting the inactivation date for the specified provider in the Provider file. As a result of the inactivation date being set either in the Provider File or the Hospital Location file, CHCS will generate mail bulletins to the PAS manager's mail group notifying the user that the specified provider will have his/her schedules, templates, and profiles deleted in seven days if the inactivation date is not deleted. There is no discrepancy report.

In MCP, once a user inactivates a provider from a group or a place of care, the system checks for any attachments at either the group or provider levels. They include checking for any patients who are assigned to the provider who is acting as their PCM, or any appointments, referrals, or wait list requests linked to the provider whom the user wishes to inactivate. If any of these discrepancies exist, the user must resolve them before the provider can be inactivated. Once the discrepancies have been resolved and the inactivation date and reason for inactivation have been entered, the system will remove any cross references for the specified provider to the specified place of care. The provider will not appear on help lists effective the day after inactivation.

**TRAINING ISSUE:** In PAS, enter today's date at the Inactivation Date: field. Result: User is immediately no longer able to:

1. Book any more appointments for provider
2. Create any more schedules
3. Create any more templates

The Provider may have pending appointments. However, End Of Day processing (EOD) allows the user to change the name of the provider from the name of the provider to whom the appointment was booked to the name of the provider who actually saw the patient.

In MCP, the CHCS allows the user to inactivate a provider by entering a date in the future. The system performs a discrepancy check and notifies the user if any discrepancies exist (i.e., referrals, pending appointments, enrollees assigned to the provider as a PCM). The user must resolve the discrepancies prior to the system actually inactivating the provider.

PAS clerks and Health Care finders should not be inactivating providers. This should be done at a higher level as is the case in MCP. Health Care Finders (HCF) will only be able to access providers



via the Health Care Finder provider lists displayed in Appointment Referral Booking and Non-Enrolled Booking options. These provider lists only display active providers that meet the other search criteria (location, specialty, and patient type).

**ISSUE: USERS NEED TO DEVELOP AD HOC REPORTS (EXISTING AND PROPOSED) THAT ARE NEEDED TO FACILITATE MANAGED CARE FUNCTIONS.**

**IMPACT:** If users are not aware of the available reports and the requirements for running them, information necessary for efficient managed care operations is not disseminated. Reports are often lacking in areas such as Utilization Management, PCM performance, and other areas. The contractors must be able to print the reports at any of their remote facilities.

**TRAINING ISSUE:** Refer to CHCS MCP Report Write-up provided by DMIM (FM&I) for additional information. Establish requirements for reports and provide instructions for running them. The Report Write-up includes the names of the reports, the production frequency, the outcome expected from the use of the information, and the risks of not running them. The uses for health care management and system management are now included in the Write-Up. Sites should submit SCRs to develop new reports they need to assist with managed care operations. See Appendix G for a list of CHCS Reports.

## Appendix G: CHCS Reports

The BPR assessment includes a review of various statistics to include: clinical workload, roles and responsibilities, schedule management, and exam room functionality. The entire clinical structure must be examined to best evaluate how the clinic needs to be modified, if at all, to best support CHCS II implementation and overall patient flow.

As part of this assessment, the following reports can be used to gauge the current business process. The various CHCS report names, the CHCS menu paths to access the reports and a description of each report are shown below.

### 1. Available PCM Capacity by Provider Group

Menu Path: CA->PAS->MAN->OMCP->PRPT->1

This CHCS option generates Primary Care Manager (PCM) capacity data for one or more provider groups. The capacity data includes the number of patients currently assigned, the remaining capacity, and the breakdown of the assignment by beneficiary category. Within each group, after the group statistics are displayed, the report displays the capacities by PCM. The provider to patient ratio for PCM by Name assignment for the entire provider group can be viewed at a glance. Looking at the total number of patients assigned and multiplying that number by the utilization rate can calculate the number of appointments required to meet demand. When compared against the schedules, whether or not the current schedules will meet demand can be determined.

In order to calculate utilization, the easiest method is to capture appointment totals for a year period: count the number of visits by patient in a given period as part of the overall population. That percentage gives the clinic's utilization rate. The National utilization rate is currently set at 4.2 visits per year.

### 2. PCM Activity Report

Menu Path: CA->PAS->MAN->OMCP->PRPT->3

This CHCS option generates a report of PCM activity, for groups, individual providers, or specialty types. The report includes the PCM, place of care, PCM assignment capacity, the number of patients assigned to the PCM, the number of slots available, the number of enrollee and emergency room visits, the number of referrals made by the PCM, the number of referrals seen by the PCM, and the number of patient visits without a referral. The report date range defaults to the previous month, but can be modified. This report provides the PCM Activity trends for a given date range and is useful because it illustrates the number of assignees as well as the number of assignees who had an appointment during a given time period.

This data can be helpful in looking at the number of patients seen in a given period and to gauge whether a clinic's utilization rate is higher or lower than the national average.

### 3. PCM Assignment Mix Discrepancy Statistical Summary

Menu Path: CA->PAS->MAN->OMCP->PRPT->6

This CHCS report lists PCM Beneficiary Categories that have discrepancies. The discrepancies are identified with an asterisk or flag ("Y"). This report identifies patient loads which include beneficiaries whose age is outside the PCM's age range preferences or if the PCM Beneficiary Category Capacity is lower than the current assigned patients.

This report provides information regarding the file/table settings vs. the actual population assigned. This can provide some insight into potential file/table problems, as well as assignment issues.

### 4. Provider Patient Workload Report

Menu Path: CA->PAS->MAN->OMCP->HRPT->4

This CHCS option generates a summary report of provider workload for providers or provider groups. The report lists the patient category and status, the number of total visits per provider, and the number of different patients seen by a provider. In other words, it shows the total number of visits and allows for extrapolation of follow-up patients within a given date range. If the provider is a PCM, this is useful in evaluating whether the visits being seen trend comparatively to the panel composition for their population.

This is particularly useful when evaluating whether current schedules meet the population demand.

### 5. Refused Appointments Report

Menu Path: CA->PAS->MAN->OMCP->HRPT->5

This CHCS option generates a report of all appointments refused, for one or more patients for a given date range. The report is sorted by Refusal Status and displays the patient name, FMP/SSN, refusal reason, date/time of refusal, referral number if any, patient home phone number and specialty. The report date range defaults to the previous month, but can be modified. This report should be looked at to see exactly why appointments are being refused.

Once an appointment is refused, it is a good idea to see if the appointment was ever booked. By looking at this, a trend may be established to offer an alternative appointment at the same time or to change the time in which the appointment is offered. If the appointment was booked, how often appointment refusals are entered can be determined, and this may help in demand management and access to care planning.

### 6. Telephone Consult Report

Menu Path: CA->PAS->MAN->OMCP->HRPT->6

This CHCS option lists the telephone consults received within a given date range. This is helpful in ascertaining total demand for provider assistance and contributes to overall provider workload. Excessive telephone consults may be an indicator for access issues, but may also warrant new approaches at the MTF.

## 7. Appointment Detail Code Schedule Utilization

Menu Path: CA->PAS->MAN->OMCP->HRPT->17

This CHCS option generates one of the most difficult reports to incorporate into demand management, but is also the most critical. By looking at the types of appointments offered, the time offered, the detail codes, as well as appointment status, the clinic will be in a better position to improve access to care. As an added tool to this report, the Detail Code listing is provided as a reference. If there are a lot of detail codes in use, it is highly recommended that changes be made to the clinic schedules and templates.

Outside of the equipment or credentialing requirements for an appointment, such as age ranges for a PA, detail codes are the single largest contributor to unbooked appointments and poor access to care.

## 8. PIT Error Summary

Menu Path: CA->PAS->MAN->OMCP->DEMR->7

This CHCS option generates a summary report of PIT Errors by Error Type from the NED PIT LOG file. The report generates a summary by DMIS ID that the user selects (One, Multiple or All) and then by Error Type. This report is comprised of errors by DMIS ID as well as an overall summary. This is especially useful for CHCS platforms with multiple MTFs and multiple responsible parties. Type 16 and 17s are useful in contributing to potential duplicate patients. Type 23 errors are also noteworthy because this lends to how merges are being conducted within CHCS and may constitute the need for process change. Under the T-NEX, NED errors are critical in managing the overall patient population. The MTFs are required by contract to ensure the accuracy and management of patient files, so NED errors must be managed.

## 9. Command Facility Workload Recap Report

Menu Path: CA->PAS->SCHED->MGRM->SMGR->5

**This is the single most effective report in providing a clinic profile and identifying trends.** This CHCS option allows produces a report, on demand, that provides upper management with a three- or four-page clinic-level summary view of the following four main monthly statistical reports: Monthly Statistical Report, No-Show Statistical Report, Facility Cancellation Statistical Report, Patient Cancellation Statistical Report, and the Next Available Appointment Report. Use of this report is critical to capturing current business processes and is very helpful in identifying trends for process improvement. The following describes each of the sub-reports contained in this option:

**Monthly Statistical Report.** This report provides monthly statistics by clinics, divisions, and groups. The report lists count and non-count workloads for inpatient and outpatient visits based on the MEPRS code of the clinic. The report consists of four parts: Part 1 lists the number of inpatient/outpatient visits and appointments by clinic, and by providers within each clinic; Part 2 lists the number of inpatient/outpatient visits and appointments by patient category code;



Part 3 lists the number of inpatient/outpatient visits and appointments by MEPRS code and clinic; and

Part 4 corresponds to Parts 1, 2, and 3 and contains a totals summary for each department, division, and group. End-of-Day processing must be completed for all appointments in the specified clinic. If pending appointments and/or missing providers exist, the Delinquent End-of-Day Processing Report is printed/displayed instead of the Monthly Statistical Report. This is also a recurring report scheduled monthly via Task Manager to run at night after normal duty hours (normally between 0000 and 0500 hours).

**No-Show Statistical Report.** This report provides a profile of no-shows by provider, clinic, division, and group. End-of-Day processing must be completed for all appointments in the specified clinic. If pending appointments and/or missing providers exist, the Delinquent End-of-Day Processing Report is printed/displayed instead of the No-Show Statistical Report. This is also a recurring report scheduled monthly via Task Manager to run at night after normal duty hours (normally between 0000 and 0500 hours).

**Facility Cancellation Statistical Report.** This monthly scheduled report provides the total number of facility appointment cancellations by reason for each clinic and provider. To sort this report by department, each clinic must have the SERVICE: field defined in the Clinic Profile. The report can be ordered by clinic, division, or group. If ordered by clinic, this report shows a breakdown of facility cancellations by clinic and provider for both count and non-count (occasions of service) workload for the data range specified. If ordered by division, clinic-level statistics are summarized into a division-level report. If ordered by group, department-level statistics are summarized into a facility-level report. A high-level summary of the COUNT WORKLOAD section of this report is part of the Command Facility Workload Recap Report.

End-of-Day processing must be completed for all appointments in the specified clinic. If pending appointments and/or missing providers exist, the Delinquent End-of-Day Processing Report is printed/displayed instead of the Facility Cancellation Statistical Report. This is also a recurring report scheduled monthly via Task Manager to run at night after normal duty hours (normally between 0000 and 0500 hours).

**Patient Cancellation Statistical Report.** This monthly schedule report contains the total number of appointment cancellations by reason for each clinic and provider and the total number of appointments that were canceled by patient but rescheduled. This report is sorted by clinic or by provider and generated by clinic, division, or group. This report consists of three parts: Part 1 lists patient cancellations by clinic for both count and non-count workload; Part 2 is a division-level summary of clinic-level statistics for both count and non-count workload for the date range specified; and Part 3 is a facility-level report of clinic count and non-count workload. The system only generates Part 3 when this report is generated for a group. A high-level summary of the COUNT WORKLOAD section of the Patient Cancellation Statistical Report is part of the Command Facility Workload Recap Report.

End-of-Day processing must be completed for all appointments in the specified clinic. If pending appointments and/or missing providers exist, the Delinquent End-of-Day Processing Report is printed/displayed instead of the Patient Cancellation Report.

**Next Available Appointment Report.** This report provides a preview of the availability of appointments by appointment type and by provider within a clinic on a given date and at a time.

#### **10. Access to Care Summary Report**

Menu Path: CA->PAS->SCHED->MGRM->SMGR-> 12

This report provides information by provider, by access to care category and appointment type, how many patient appointments met and did not meet access standards. This summary report also provides the number of refusals, as well as delta between when the appointment was requested and the date of the actual appointment.

This information is helpful when modifying schedules, particularly as it relates to demand management.

### Acronyms and Definitions

AIM (Forms)	Alternate Input Method (Forms)
AMSA	Army Medical Surveillance Activity
ASAM	Automated Staffing Assessment Model
BPR	Business Process Reengineering
CCQAS	Centralized Credentials & Quality Assurance System
CITPO	Clinical Information and Technology Program Office
CMAC	CHAMPUS Maximum Allowable Charge
DEERS	Defense Enrollment Eligibility Reporting System
DMIM	Defense Medical Information Management
DMIS	Defense Medical Information System
E&M	Evaluation & Management
EMR	Electronic Medical Record
EMT	Emergency Medical Technician
FTX	Field Training Exercise
HCF	Health Care Finders
HIPAA	Health Insurance Portability and Accountability Act
IMD	Information Management Division
IBWA	Industry Based Workload Alignment
IMR	Individual Medical Readiness Module
MCP	Managed Care Program Module
MEDPROS	Medical Protection System
MEPRS	Medical Expense and Performance Reporting System
MMRB	MOS Medical Retention Board
NED	National Enrollment Database
PAS	Patient Appointment and Scheduling
PASBA	Patient Administration Systems and Biostatistical Activity



## AMEDD CHCS II PLANNING & IMPLEMENTATION

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PCM	Primary Care Manager
POC	Point of Contact
ROUT	Routine (Patient Appointment Type)
RVU	Relative Value Unit
SCR	System Change Request
SRP	Soldier Readiness Processing Center
TSG	The (Army) Surgeon General
UBU	Uniformed Biostatistical Utility
UCAPERS	Uniform Chart of Accounts for Personnel Utilization System