



*Naval Hospital Bremerton
As-Is Business Process Models*

for the

*Naval Medical Information Management
Center (NMIMC)*

and

Provider Graphical User Interface
(PGUI)/Composite Health Care System II
(CHCSII) Implementation and Activation
Support at Navy Sites

Deliverable #4A

04 April 2005
Version 1.0

Prepared By:

*Integic Corporation
Healthcare Practice Area
3800 Concorde Parkway, Suite 200
Chantilly, Virginia 20151*

Table of Contents

Introduction.....	1
Bremerton Family Practice Clinic	5
Scheduling Process via TRAC.....	5
Scheduling Process via Clinic.....	8
Immunization Process for Appointments	11
Bremerton Family Practice Summary Tables	13
Visit Types.....	13
Documentation Tools (Forms, Questionnaires).....	15
Top ICD 9 Codes and Associated Clinical Guidelines.....	17
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	18
Naval Health Everett Family Practice Clinic.....	20
Scheduling Process via TRAC.....	20
Scheduling Process via Clinic.....	23
Immunization Process for Appointments	26
Naval Health Everett Family Practice Clinic Summary Tables.....	28
Visit Types.....	28
Documentation Tools (Forms, Questionnaires).....	30
Top ICD 9 Codes and Associated Clinical Guidelines.....	31
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	32
Bremerton General Surgery Clinic	34
Initial Visit Process.....	34
RN Surgery Scheduling Process.....	36
RN Oncology Process.....	38
RN Wound Care Process	40
Bremerton General Surgery Summary Tables.....	42
Visit Types.....	42
Documentation Tools (Forms, Questionnaires).....	43
Top ICD 9 Codes and Associated Clinical Guidelines.....	45
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	46
Bremerton Internal Medicine Clinic	48
Scheduling Process via TRAC.....	48
Scheduling Process via Clinic.....	51
Pulmonary Scheduling Process via TRAC	54

Neurology Scheduling Process via TRAC.....	57
Neurology Scheduling Process via Clinic	60
Cardiology Scheduling Process via TRAC.....	63
Cardiology Scheduling Process via Heart Station	66
Allergy Process for Appointments.....	69
Bremerton Internal Medicine Summary Tables.....	71
Visit Types.....	71
Documentation Tools (Forms, Questionnaires).....	73
Top ICD 9 Codes and Associated Clinical Guidelines.....	74
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	75
Bremerton Mental Health Clinic.....	77
Adult Psychiatry/Psychology Process	77
Social Work Process	82
Social Work Groups Process	86
Child and Adolescent Mental Health Providers Process	88
Outpatient Crisis Intervention Program (OCIP) Process.....	91
Bremerton Mental Health Clinic Summary Tables	96
Visit Types.....	96
Documentation Tools (Forms, Questionnaires).....	97
Top ICD 9 Codes and Associated Clinical Guidelines.....	104
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	105
Bremerton Obstetrics Clinic	107
New OB Screening Process	107
New OB Patient Process.....	109
Routine OB Patient Process.....	111
High Risk OB Patient Process	113
Postpartum OB Patient Process	115
C-Section Counseling Process.....	117
Walk-In OB Patient Process	119
Sick Call OB Patient Process.....	121
Telcons Process.....	123
Bremerton Obstetrics Summary Tables	125
Visit Types.....	125

Documentation Tools (Forms, Questionnaires).....	126
Top ICD 9 Codes and Associated Clinical Guidelines.....	128
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	129
Bremerton Orthopedic Clinic.....	131
Scheduling Process via TRAC.....	131
Scheduling Process via Clinic.....	134
Scheduling Process for Pre-Op and Post-Op Visits via Clinic.....	137
Bremerton Orthopedic Clinic Summary Tables.....	139
Visit Types.....	139
Documentation Tools (Forms, Questionnaires).....	140
Top ICD 9 Codes and Associated Clinical Guidelines.....	142
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	143
Bremerton Pediatric Clinic.....	145
Generic Workflow Process.....	145
Telephone Consult Process.....	147
Developmental Clinic Process.....	149
Bremerton Pediatrics Summary Tables.....	151
Visit Types.....	151
Documentation Tools (Forms, Questionnaires).....	152
Top ICD 9 Codes and Associated Clinical Guidelines.....	156
Comparison of Command and Clinic Goals, Initiatives and Metrics.....	157

Introduction

The Navy Medical Information Management Center (NMIMC) and the Bureau of Medicine and Surgery (BUMED) solicited Integic to provide the services needed to assist NMIMC in providing BUMED the required technical and functional user support for the Provider Graphical User Interface (PGUI) AND composite Health Care System II (CHCS II).

The project itself comprises multiple tasks designed to support the overall goals to increase staff efficiency, improve data quality and the quality of care, and to increase patient satisfaction.

These tasks include:

1. Business Process Reengineering;
2. Supplemental Training and Training Materials;
3. Provider GUI Support;
4. CHCS File and Table Corrections; and
5. CHCS/CHCS II Capabilities and Gap.

The purpose of this document is to focus and report on the first project objective, Business Process Reengineering (BPR). Integic completed documentation review and a site visit to determine the As-Is Business Process Models for NH Bremerton, the first of two BPR sites.

Background and BPR Purpose

The first objective requires the documentation of the current business processes within MTFs wherein either Provider GUI or CHCSII is to be installed and recommend changes to existing MTF business processes resulting from their implementation.

A Business Process Reengineering (BPR) methodology was utilized to analyze workflows and processes within eight ambulatory clinics at NH Bremerton. The overall purpose of this methodology was to critically analyze and redesign existing business processes to achieve breakthrough improvements in performance measures.

Integic selected a five phased BPR approach (Davenport, 1995) for analyzing the Navy sites that included the following:

- Phase I: Evaluate the business vision and process objectives;
- Phase II: Understand and measure existing Clinic processes;
- Phase III: Identify the Clinic processes to be reengineered;
- Phase IV: Leverage IT capabilities; and
- Phase V: Design and build a prototype of the new Clinic processes.

The activities of Phase I and II of the BPR are outlined in the next section, and the results of these two phases are summarized in the remaining sections of this document.

BPR Process

Phase I – Evaluate the business vision and process objectives

The Integic BPR Team evaluated Bremerton's business vision and process objectives by reviewing and analyzing site and clinic documents prior to the on-site visit. The documents that Integic analyzed included:

- Bremerton's 2005 Strategic Planning Command Document, Goals, and Metrics;
- Bremerton's Organizational Structure;
- The Clinics' Structure and their Business Plans (Clinic's included: Orthopedics, General Surgery, Obstetrics, Internal Medicine, Family Medicine, Pediatrics, Mental Health, Everett Family Practice);
- The Clinics' Staffing Ratios and Patient Population Mix;
- Utilization Statistics (such as, the top ICD-9, E&M Codes);
- Performance Improvement Initiatives;
- Dashboard Metrics; and
- Clinical Guidelines, Pathways, Protocols, Decision Support Criteria.

The results of this analysis were used to understand the client and then to develop the interview guides that Integic's BPR team used during the site visit.

Phase II – Understand and measure existing Clinic processes

The Integic BPR Team conducted Bremerton's site visit January 31 to February 4, 2005. The team consisted of three staff members. In order to understand and measure Bremerton's existing processes within the eight clinics selected, Integic developed interview guides specific to Clinic Commanders, the Executive Management Team/Board of Directors, Primary Care Providers, Specialty Care Providers, Nurse Managers, Corpsman, Medical Assistants, Appointment and Scheduling Staff, Medical Records Staff, Coding Staff and IT Support Services Staff.

The first day of the site visit consisted of a focus group interview to understand NH Bremerton as an organization. The BPR Team interviewed 17 stakeholders in the following areas:

- Resources and Logistics
- Ancillary Services
- Patient Support
- Primary Care
- Specialty Services
- Patient Administration
- Quality Management
- Outpatient Coding

- Management Information
- Staff Education
- Population Health
- Healthcare Operations
- Referral Management

The second, third, fourth, and fifth days of the site visit consisted of interviewing the clinic staff. The focus of these interviews included understanding the individual clinic's 2005 business plans; verifying staffing, patient, and utilization statistics; reviewing and documenting patient visit workflow; examining clinic staff's accountabilities; obtaining critical forms used by the clinics to document patients' visits; and evaluating the strengths/weaknesses of clinics. A summary of the 8 clinics selected, and the numbers and types of staff members interviewed by the Integic BPR Team follows:

	FP - Bremer- ton	FP - Everett	General Surgery	Internal Medicine	Mental Health	Obstetrics	Ortho- pedics	Pediatrics
Provider	10	3	1	7	5	5	6	7
Nurse	5	2	1	3	2	3	1	3
Corpsman	2	4	1		9	2	6	5
Technician				2				
Medical Assistant	3			2		2		
Clerk	3		1	1		2	1	
Social Worker					2			
Business Manager	1	1						
Division Officer	1							
Branch Manager		1						
OIC		1						
Admini- strator					1	1	1	2
TOTAL	25	12	4	15	19	15	15	17

Results of Phase I and Phase II

The data collected from Phase I and II – the documentation review, the group interview, and the clinic interviews – were analyzed and interpreted by the Integic BPR Team. The results were verified by each clinic point of contact with revisions and clarifications incorporated into this document. The content that follows is the As-Is Business Process Models for the eight clinics visited during the Bremerton Site Visit. Each clinic examined has its own section that contains the clinic's workflow processes described in a narrative fashion followed by the actual workflow illustration. Finally, each Clinic has three summary tables which describe:

- the Clinic's Visits and Appointment Types,
- the Clinic's present Documentation Tools/Forms, and
- the 2005 Strategic Command Goals and the 2005 Clinic Goals.

Limitations

The following section describes the study limitations identified by the Integic BPR Team. Bremerton was a previously deployed CHCSII site so the staff interviewed had already been introduced to CHCSII and had utilized the electronic medical record in their practice. The site halted utilization of CHCSII because of technical issues; therefore, some participants in the BPR site visit were not that eager to participate (perhaps skewing results).

Integic and Bremerton used a convenience sampling strategy (a purposive, non-probability sampling strategy) and a non-exhaustive clinic representation which limits generalization of results beyond this sample. Additionally, some of the interviews were truncated due to scheduling pressures and conflicts which may have interfered with responses.

Lastly, the 2005 Clinic Business Plans were unavailable to review so the Integic BPR Team could not draw conclusions on the alignment of the Command business goals to the individual Clinics' goals.

Next Steps

This document identifies the results of Phase I and Phase II of the BPR Objective (i.e., the Bremerton As-Is Models). The subsequent Phases III, IV, and V of the BPR Objective include:

Phase III – Identify Clinic Processes to Be Reengineered

Integic's BPR Team will develop To-Be Models which may contain process activities, information management requirements, new or improved business rules, resource and training requirements, data quality improvement metrics, and best practices in outpatient record management. These To-Be Models will be illustrated using process flow charts and/or activity diagrams with swim lanes.

Phase IV – Leverage IT Capabilities

Integic's BPR team will consider the future vision of CHCSII usage and incorporate site recommended best practices into the new Bremerton Clinic processes (i.e., the Bremerton To-Be Models). After developing the To-Be Models, Integic providers, nurses and support staff will simulate the To-Be Models in a Mock Clinic equipped with CHCSII workstations.

Phase V – Design and Build Prototype of New Process

Integic's BPR Team will conduct a Pros and Cons Analysis that includes the results of the simulations of the proposed design, and will then design and build Prototype To-Be Models. These models will then be reviewed and evaluated at NMIMC/BUMED Stakeholder Workshop. Integic will incorporate the Workshop findings into the final deliverable To-Be Models.

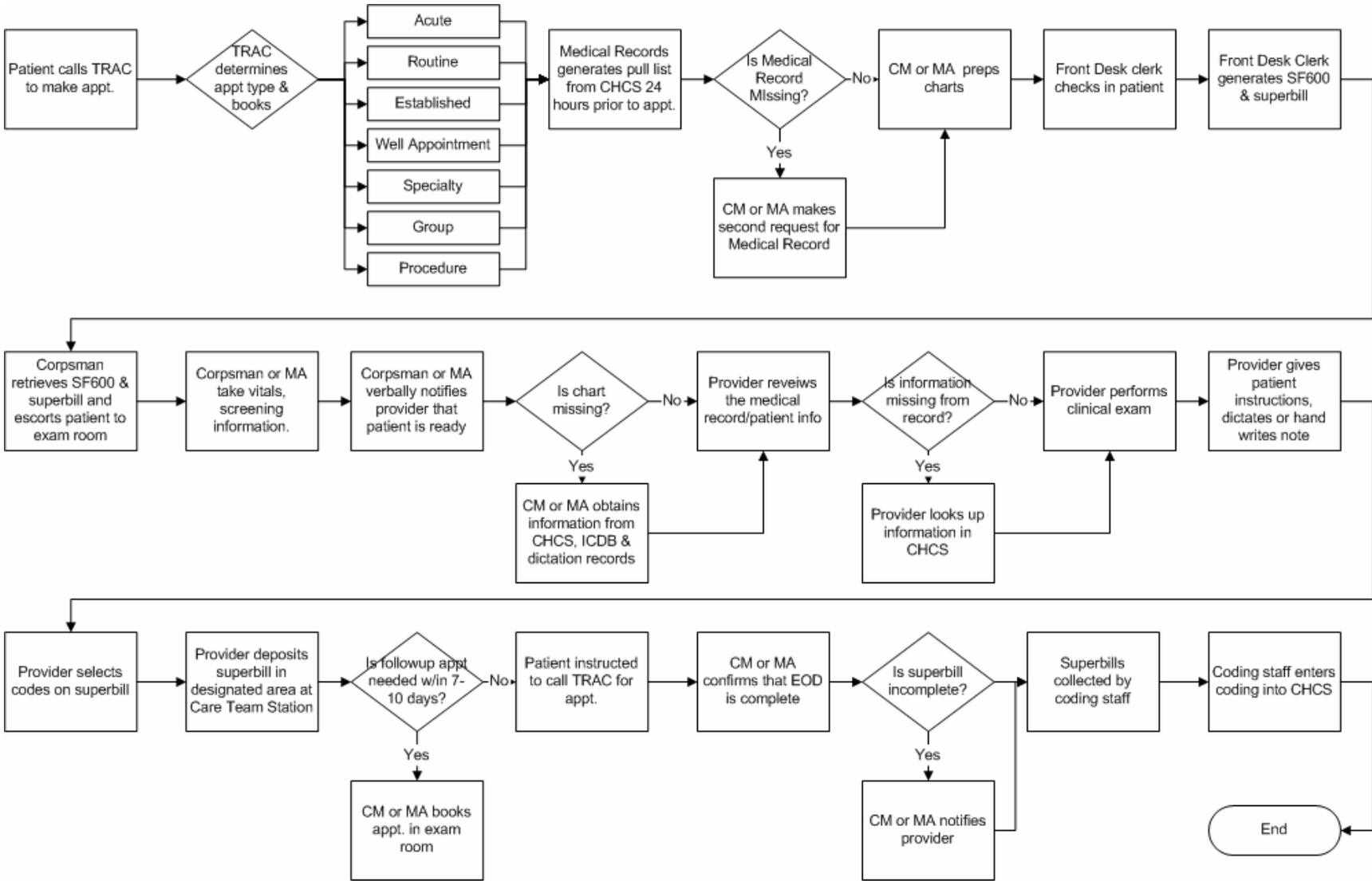
Bremerton Family Practice Clinic

Scheduling Process via TRAC

1. Scheduling: Patient calls Tricare Regional Appointment Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Acute Appointment: if the patient requires non-emergent urgent care with symptoms less than 3 days (can book this appointment the same day or next day);
 - b. Routine Appointment: if the patient requires an appointment for a problem not considered urgent (can book this appointment within 7days, and if an appointment is unavailable, can book this appointment outside the 7days, but do not exceed the 14th day);
 - c. Established Appointment: if the patient requires follow-up care;
 - d. Well Appointment: if the patient requires preventive health maintenance care, such as, physicals, well exams;
 - e. Specialty Appointment: if the patient requires a mental health counseling appointment in Family Practice with our social worker;
 - f. Group Appointment: if the patient requires group counseling session (i.e., currently used for vasectomy counseling and for pain management counseling);
 - g. Procedure Appointment: if the patient requires a medical procedure, such as, a new and/or a follow-up colposcopy.
3. Medical Records generates the record pull list from CHCS 24 hours prior to patients' actual visit. Medical Records then pulls the patients' charts that are available on file, and delivers them to Family Practice the afternoon before the patients are scheduled to visit.
4. The corpsmen/medical assistants (CM/MA) check in and prep the patients' charts when they receive them from medical records. The CM/MA updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the CM/MA put in a request to medical records to retrieve those records prior to the patient visit.
5. Patient checks-in for their appointment with front desk clerk.
6. Front desk clerk enters the patient in the system and generates the SF 600 and superbill.
7. The CM/MA retrieves the SF 600 and superbill from the printer; calls the patient and escorts the patient to the screening area (i.e., a hallway area) where height, weight, and temperature are measured.
8. The CM/MA takes the patient's pulse, respiration, blood pressure, chief complaint, allergies, current medication(s) taken, and/or history.
9. The CM/MA verbally notifies the provider that the patient is waiting in the room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the

information/results are not in the chart, the provider looks up the information in CHCS or ICDB.

11. If the provider receives no chart, the CM/MA looks up and prints any pertinent information on the patient from previous dictation, and from CHCS or ICDB, and delivers this information to the provider.
12. The provider sees the patient and performs the appropriate clinical exam, assessment and disposition.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and then dictates the patient visit, and marks/writes the most appropriate ICD, CPT, and E&M codes on the super bill. Please note: Some providers dictate and complete the superbills after each visit, while others complete them in clusters at the end of the day.
14. The provider deposits the superbills in a designated area at the Care Team Station.
15. If a follow-up appointment is needed within 7-10 days, the CM/MA books the appointment.
16. If a follow-up appointment is needed beyond 7-10 days, the patient is instructed to call the TRAC and schedule his/her own appointment.
17. Each CM/MA reviews his/her provider's appointment schedule for the day, ascertains the End-of-Day processing is complete (i.e., all appointments are closed), and checks for superbill completion for all visits that were completed.
18. If the superbill submission is incomplete, the CM/MA notifies the provider and asks for compliance.
19. All superbills are collected by the coding staff each day. Coding staff complete data entry and clarification of all coded visits. Please note: Questions regarding coding/visits are resolved by the coder, by referring to the provider, or by obtaining the chart and the dictation from the visit.

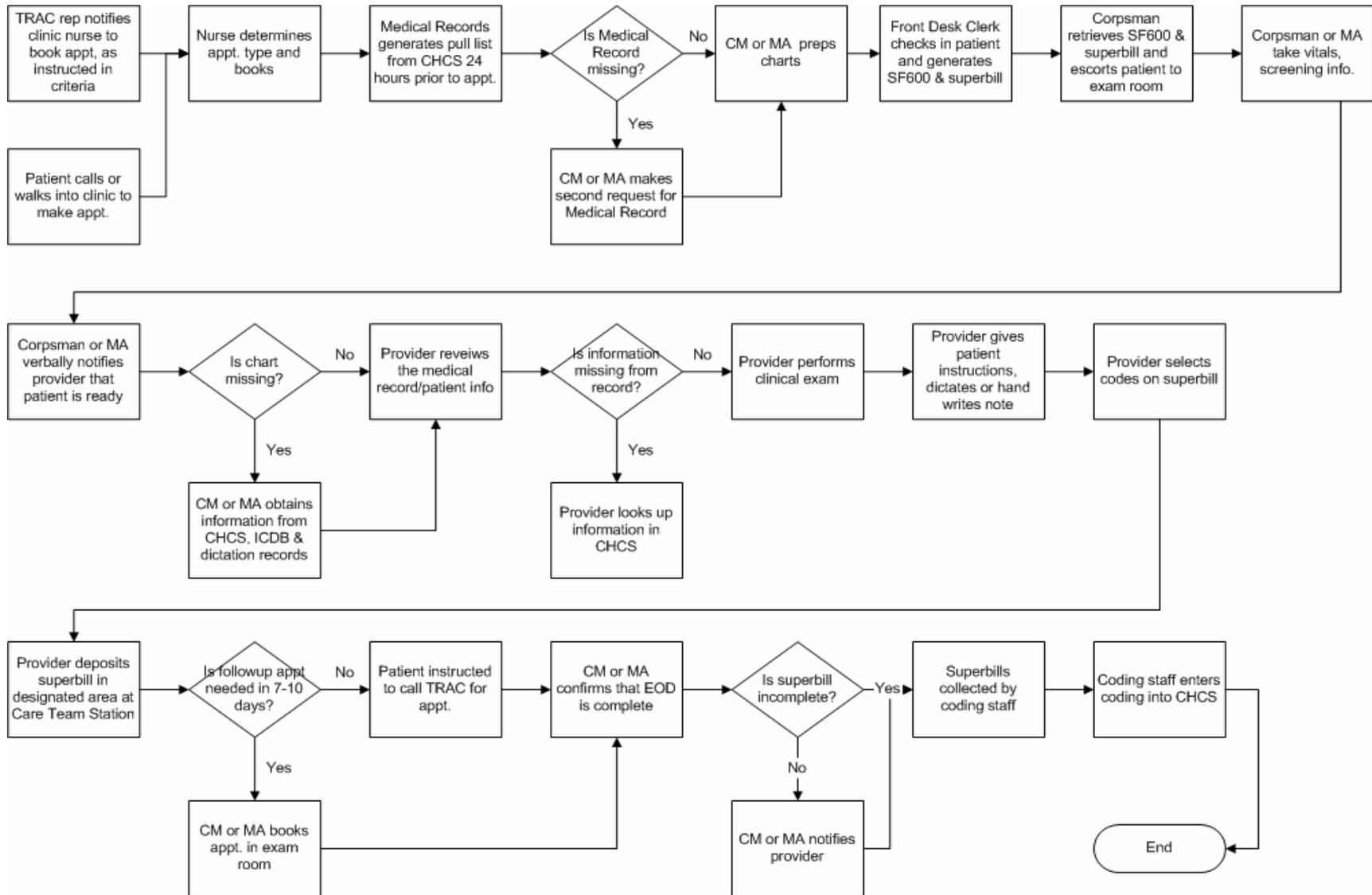


Scheduling Process via TRAC Flowchart

Scheduling Process via Clinic

1. Scheduling within the Family Practice Clinic with the nurse occurs when:
 - a. After calling TRAC, the patient is unable to obtain an appointment, and wishes to pursue by calling the clinic.
 - b. The TRAC scheduler has been instructed via the Appointment Criteria to refer the patient to Family Practice Clinic for the following instances: Pregnancy tests, Medication renewal requests, Chicken pox and lice, Female complaints of UTI/Bladder Infections, Morning After Pill requests, Mole removal requests (after being seen by the provider), and Initial Prenatal/OB appointment with the prenatal nurse.
 - c. The TRAC scheduler has been instructed via the Appointment Criteria to refer the patient to the Family Practice Clinic Template Manager for the following Procedure Appointments: Endometrial biopsies, IUD insertions, Vasectomy Procedures, Ultrasounds, Minor Surgery Consults, and for scheduling ADD/ADHD.
 - d. The TRAC scheduler informs the patient he/she can walk in to have blood pressure check, would check, or suture removal.
 - e. Patients call the Family Practice Clinic if he/she has been so instructed by the provider or if a clinic staff calls the patient for the purpose of booking an appointment (such as, laboratory result discussion as requested by the provider).
2. The nurse schedules an appointment for a patient after triaging and determining that the patient requires an appointment with a provider.
3. Medical Records generates the record pull list from CHCS 24 hours prior to patients' actual visit. Medical Records then pulls the patients' charts that are available on file, and delivers them to Family Practice the afternoon before the patients are scheduled to visit.
4. The corpsmen/medical assistants (CM/MA) check in and prep the patients' charts when they receive them from medical records. The CM/MA updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the CM/MA put in a request to medical records to retrieve those records prior to the patient visit.
5. Patient checks-in for their appointment with front desk clerk.
6. Front desk clerk enters the patient in the system and generates the SF 600 and superbill.
7. The CM/MA retrieves the SF 600 and superbill from the printer; calls the patient and escorts the patient to the screening area (i.e., a hallway area) where height, weight, and temperature are measured.
8. The CM/MA takes the patient's pulse, respiration, blood pressure, chief complaint, allergies, current medication(s) taken, and/or history.
9. The CM/MA verbally notifies the provider that the patient is waiting in the room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS or ICDB.

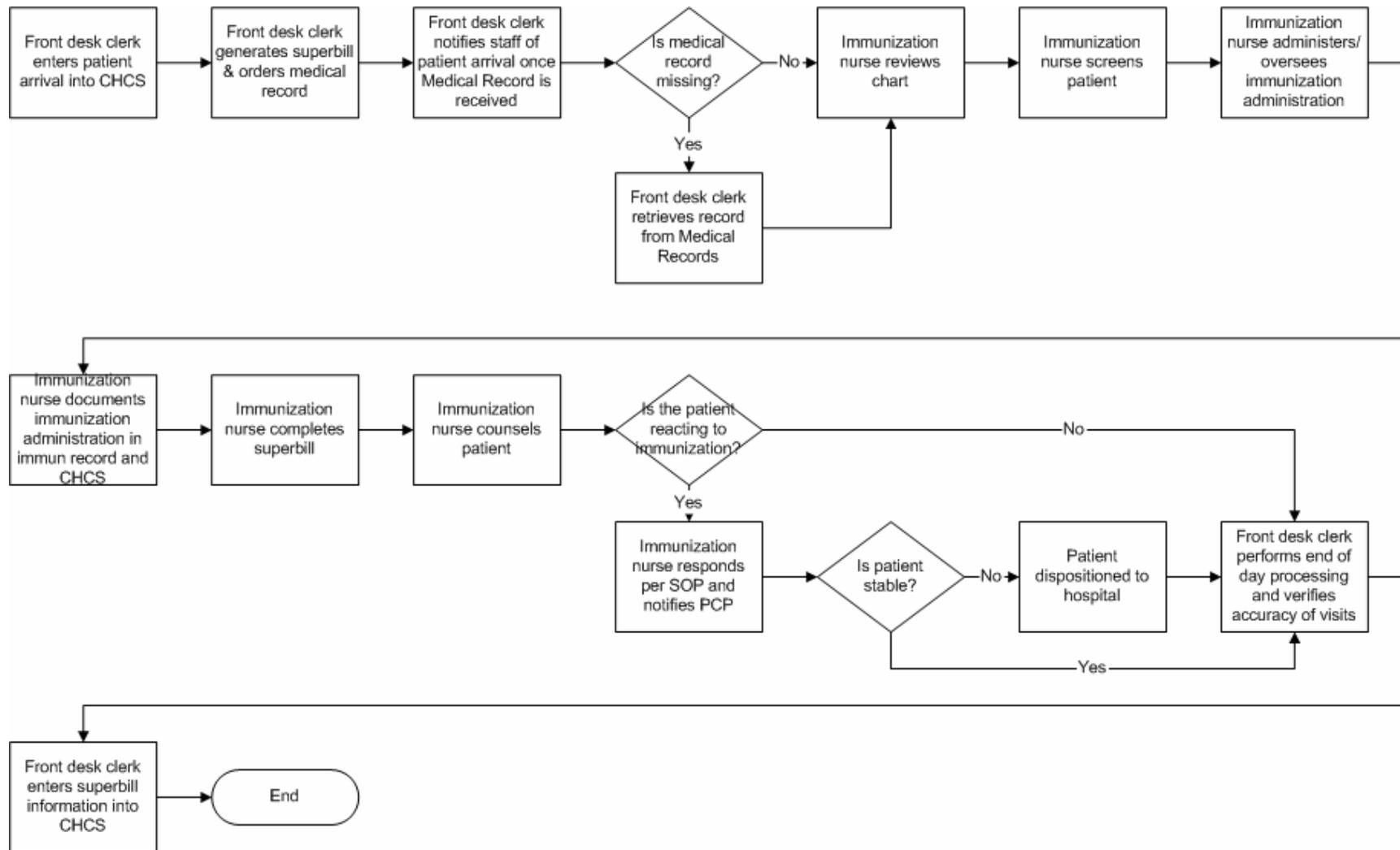
11. If the provider receives no chart, the CM/MA looks up and prints any pertinent information on the patient from previous dictation, and from CHCS or ICDB, and delivers this information to the provider.
12. The provider sees the patient and performs the appropriate clinical exam, assessment and disposition.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and then dictates the patient visit, and marks/writes the most appropriate ICD, CPT, and E&M codes on the super bill. Please note: Some providers dictate and complete the superbills after each visit, while others complete them in clusters at the end of the day.
14. The provider deposits the superbills in a designated area at the Care Team Station.
15. If a follow-up appointment is needed within 7-10 days, the CM/MA books the appointment.
16. If a follow-up appointment is needed beyond 7-10 days, the patient is instructed to call the TRAC and schedule his/her own appointment.
17. Each CM/MA reviews his/her provider's appointment schedule for the day, ascertains the End-of-Day processing is complete (i.e., all appointments are closed), and checks for superbill completion for all visits that were completed.
18. If the superbill submission is incomplete, the CM/MA notifies the provider and asks for compliance.
19. All superbills are collected by the coding staff each day. Coding staff complete data entry and clarification of all coded visits. Please note: Questions regarding coding/visits are resolved by the coder, by referring to the provider, or by obtaining the chart and the dictation from the visit.



Scheduling Process via Clinic Flowchart

Immunization Process for Appointments

1. The Front desk clerk enters patient arrival (as walk-in) into CHCS, writes identifying information onto the bottom of the Immunization superbill and orders the patients' medical records. Please note: Patients walk-in for immunization administration either immediately following a doctor's appointment or at their convenience (i.e., flu shots, overseas immunizations, PPDs, positive PPD reactions, etc). If the immunization is sought right after an appointment with a provider, patients often hand carry their medical records with them to Immunization Clinic.
2. The Front desk clerk ensures that staff is notified of patient arrival once the medical record is received (i.e., The Medical Records Department staff will hand carry patient's record for Immunization walk-ins almost immediately).
3. The Immunization nurse/staff reviews the patient's chart, screens the patient for known allergies, and identifies needed immunizations.
4. Immunizations are only given during the hours that the Family Practice Clinic is open, and is staffed by providers so that provider coverage is available for the administration of any injection.
5. The Immunization nurse/staff administers and/or oversees the administration of all immunizations according to standing orders, BUMEDINST, NAVMEDCOM instructions, and Naval Hospital Bremerton policies and procedures.
6. The Immunization nurse/staff documents the immunization administration (i.e., immunization type, dosage, time, route, etc.) in the outpatient health records, in the patient's personal immunization records, in CHCS, and then completes the superbill.
7. The Immunization nurse/staff counsel patients regarding immunizations, reactions that might occur, and the treatment of these symptoms.
8. The Immunization nurse responds appropriately to patients having untoward reactions including anaphylactic reactions per clinic standard operating procedures (notifies the primary care physician immediately and documents the reaction/outcome).
9. The Front desk clerk completes End-of-Day processing each day, and verifies the accuracy of visits that occurred. The front desk clerk enters coding information from superbills for all visits and makes necessary corrections to the End-of-Day processing report.



Immunization Process for Appointments Flowchart

Bremerton Family Practice Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Acute Appointment	ACUT	20 minutes	TRAC Representative	If the patient requires non-emergent, urgent care with symptoms less than 3 days, the appointment can be booked the same day or the next day.
Routine Appointment	ROUT	20 minutes	TRAC Representative	If the patient requires an appointment for a problem not considered urgent, the appointment can be booked within 7days; and if an appointment is unavailable, the appointment can be booked outside the 7days, but do not exceed the 14 th day.
Established Appointment	EST	20 minutes	TRAC Representative	If the patient requires follow-up care.
Well Appointment	WELL	20 minutes	TRAC Representative	If the patient requires preventive health maintenance care, such as, physicals, well exams.
Specialty Appointment	SPEC	60 minutes	TRAC Representative	If the patient requires a mental health counseling appointment by social work.
Group Appointment	GRP	20 minutes	TRAC Representative	If the patient requires group counseling session/appointment (i.e., currently for vasectomy counseling and for pain management counseling).
Procedure Appointment	PROC	30-60 minutes	TRAC Representative	If the patient requires a medical procedure, such as, a new and/or a follow-up colposcopy, vasectomy, minor procedures, ultrasounds.

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Acute Appointment Routine Appointment Established Appointment Well Appointment Specialty Appointment Group Appointment	ACUT\$ ROUT\$ EST\$ WELL\$ SPEC\$ GRP\$	20 minutes	Clinic Staff	After calling TRAC, the patient is unable to obtain an appointment, and wishes to pursue by calling the clinic. The TRAC scheduler informs the patient he/she can walk in to have blood pressure check, would check, or suture removal. Patients call the Family Practice Clinic if he/she has been so instructed by the provider or if a clinic staff calls the patient for the purpose of booking an appointment (such as, laboratory result discussion as requested by the provider).
Acute Appointment Routine Appointment Established Appointment Well Appointment Specialty Appointment Group Appointment	ACUT\$ ROUT\$ EST\$ WELL\$ SPEC\$ GRP\$	20 minutes	Clinic Staff	The TRAC scheduler has been instructed via the Appointment Criteria to refer the patient to Family Practice Clinic for the following instances: Pregnancy tests, Medication renewal requests, Chicken pox and lice, Female complaints of UTI/Bladder Infections, Morning After Pill requests, Mole removal requests (after being seen by the provider), and Initial Prenatal/OB appointment with the prenatal nurse.
Procedure Appointment	PROC\$	Length of Visit varies based on the procedure.	Clinic Template Manager	The TRAC scheduler has been instructed via the Appointment Criteria to refer the patient to the Family Practice Clinic Template Manager for the following Procedure Appointments: Endometrial biopsies, IUD insertions, Vasectomy Procedures, Ultrasounds, Minor Surgery Consults, and for scheduling ADD/ADHD.
Immunization Appointment		10-15 minutes	Immunization Nurse	The patient generally walks-in for an immunization either immediately following a doctor's appointment or walks-in/phones with an immunization request.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
N/A – i.e., Walk-in Form	N/A	Patient	Walk-In	3x5 form
Naval Hospital Bremerton Family Medicine Department i.e., Pre-Visit Form	N/A	Patient/Provider	All Appointments/Visits	Form illustrates patient's main reason for visit and the patient's instructions.
Walk-In Request Form for Family Medicine	N/A	Patient	Walk-In	8x10 form
2 Month Well Child Visit	NHBREM 6400/18	Provider/Parent	Well Appointment	
4 Month Well Child Visit	NHBREM 6400/25	Provider/Parent	Well Appointment	
6 Month Well Child Visit	NHBREM 6400/31	Provider/Parent	Well Appointment	
9 Month Well Child Visit	NHBREM 6400/20	Provider/Parent	Well Appointment	
12 Month Well Child Visit	NHBREM 6400/22	Provider/Parent	Well Appointment	
18 Month Well Child Visit	NHBREM 6400/29	Provider/Parent	Well Appointment	
24 Month Well Child Visit	NHBREM 6400/19	Provider/Parent	Well Appointment	
3 Year Well Child Visit	NHBREM 6400/24	Provider/Parent	Well Appointment	
4-5 Year Well Child Visit	NHBREM 6400/26	Provider/Parent	Well Appointment	
6-9 Year Well Child Visit	NHBREM 6400/21	Provider/Parent	Well Appointment	
10-12 Year Well Child Visit	NHBREM 6400/23	Provider/Parent	Well Appointment	
13-18 Year Well Child Visit	NHBREM 6400/28	Provider/Parent	Well Appointment	
Pediatric Outpatient Visit	NHBREM 6400/30	Provider	Outpatient Visit	
Women's Health Care	NHBREM OP #126	Provider	Well Appointment	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Pap Smear/Mammogram Form	NHBREM OP #139	Provider	Pap Appointment	
Upper Respiratory Infection Exam	NHBREM OP#1	Patient/Provider	Acute Appointment	
Well Male Form	N/A	Provider	Well Appointment	Requested development of form
Diabetic Form	N/A			Electronic form sent
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
General Medical Examination (V70)	
Normal Pregnancy (V22)	
Other and Unspecified Procedures and Aftercare (V58) – Long-Term (Current) Use of Anticoagulants (V58.61) Attention to Surgical Dressings and Sutures (V58.3)	Anticoagulant Clinic/Coumadin Clinic
Health Supervision Of Infant of Child (V20)	
Essential Hypertension (401)	HTN Guideline
Special Investigations and Examinations (V72) – Gynecological Examination (V72.3) Routine Gynecological Examination (V72.31)	
Diabetes Mellitus (250)	Diabetes Guideline
Other and Unspecified Disorders of Joint (719)	
Other and Unspecified Disorders of Back (724)	
Acute Upper Respiratory Infection of Multiple of Unspecified (465)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.					
Manage network purchased care.					
Develop a coding education and training program					
Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.			Lipids, Dysplasia, Referrals		
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
People: Develop an efficient integrated human capital strategy to optimize mission accomplishments					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

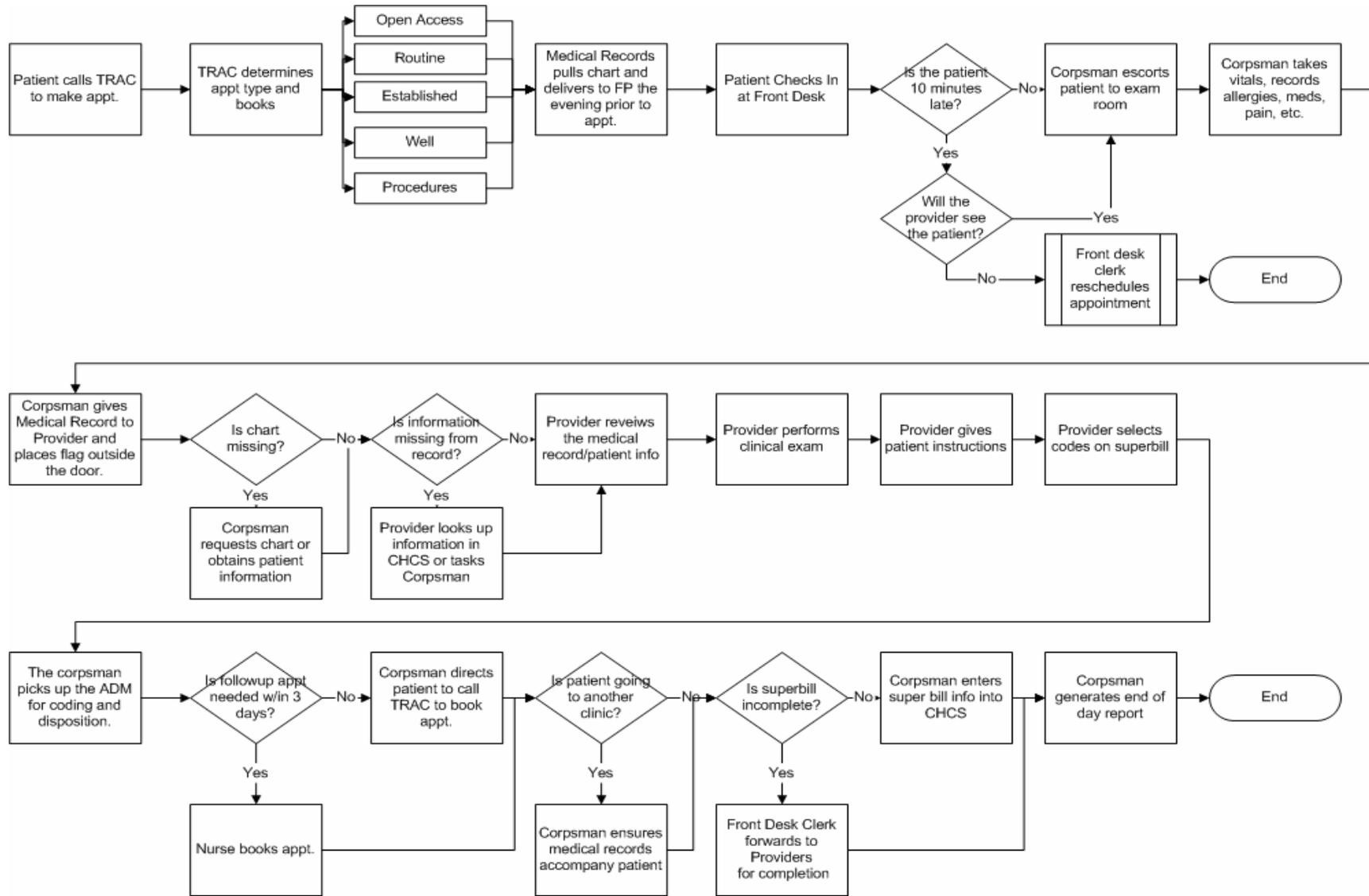
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.			Develop and deploy staff satisfaction survey.		
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Naval Health Everett Family Practice Clinic

Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Open Access Appointment: Designed for Acute concerns only (such as, acute infectious disease, headache, musculoskeletal injuries, pain, persistent fever, wound drainage, anxiety/alcoholism, and depression);
 - b. Routine Appointment: Designed for patients with less acute issues or a second or greater visit for a specific problem with the same provider who evaluated the patient on their last visit; if same provider not available use different provider;
 - c. Established Appointment: Designed for patients who require follow-up care (i.e., ADD/ADHD, or defined by provider for a specific follow-up timeframe);
 - d. Well Appointment: Designed for patients requiring preventive health maintenance care (such as, annual physicals, well child exams, well women exams, school/sports physicals);
 - e. Procedures Preparation/Mental Health Concerns/Counseling Appointment.
3. The patient is instructed to report to their appointment 15 minutes prior to the actual appointment time (Everett Policy).
4. Medical Records goes into CHCS and looks at the Pull List for appointments made by TRAC and charges out Medical Records to Family Practice for the following day. Medical Records then pulls the patients' charts, and delivers them to Family Practice the evening before the patients are scheduled to visit.
5. The Front Desk clerk receives the patients' chart from medical records the day before. If the patient is scheduled for a same day appointment, the clinic staff picks up the medical record.
6. Patient enters clinic and checks-in with front desk clerk. The front desk clerk confirms the patient's identity, appointment, and ensures the patient's health record is prepared correctly. If the patient appears 15 minutes prior to their appointment time, they will be seen. If the patient appears after the 10 minute late policy, the provider has the right to ask the patient to reschedule. This Policy allows for a 25 minute window for the patient to be seen.
7. The front desk clerk alerts the corpsman assigned to a particular provider that the patient has checked in and is waiting to be seen.
8. The corpsman escorts the patient to the screening and/or the examination room.
9. The corpsman takes and records the patient's vital signs (temperature, blood pressure, pulse, and respiration) in the medical record. The corpsman will note the patient's chief complaint in the S.O.A.P. note portion of the medical record. Additionally, the corpsman will record all current medications the patient is taking, list any known allergies, and complete the questions for pain, cholesterol, pap, etc. If patients are under the age 12, a height and weight must also be recorded. And for infants (0-24mos.), length, weight, and head circumference are required to be recorded.

10. The corpsman gives the medical record to the provider and places a flag outside the door that signifies to the provider that the patient is waiting in the room.
11. The provider reviews the medical record prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS or tasks the corpsman to contact the outside facility to have the information faxed to the nurses' office for inclusion in the medical record.
12. If no chart is available the corpsman will notify medical records again asking for retrieval, and if available, the corpsman will go to medical records to get it. If no chart is found, the corpsman will help the provider locate any pertinent information on the patient that they require.
13. The provider sees the patient and performs the appropriate clinical exam.
14. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
15. The corpsman picks up the ADM from the provider(s) for coding and disposition.
16. If a follow-up appointment is needed within three days, the clinic nurse books the appointment.
17. If a follow-up appointment is needed outside of three days, the patient is directed to call TRAC to book the appointment.
18. The corpsman also ensures that medical records are sent to another department of the clinic that the patient needs to be seen at so that proper documentation can occur (i.e. immunizations, patient education, case management).
19. The corpsman enters the super bill information into the computer and generates the end of day report.
20. If the super bill is incomplete, the front desk clerk forwards them to the provider for completion.



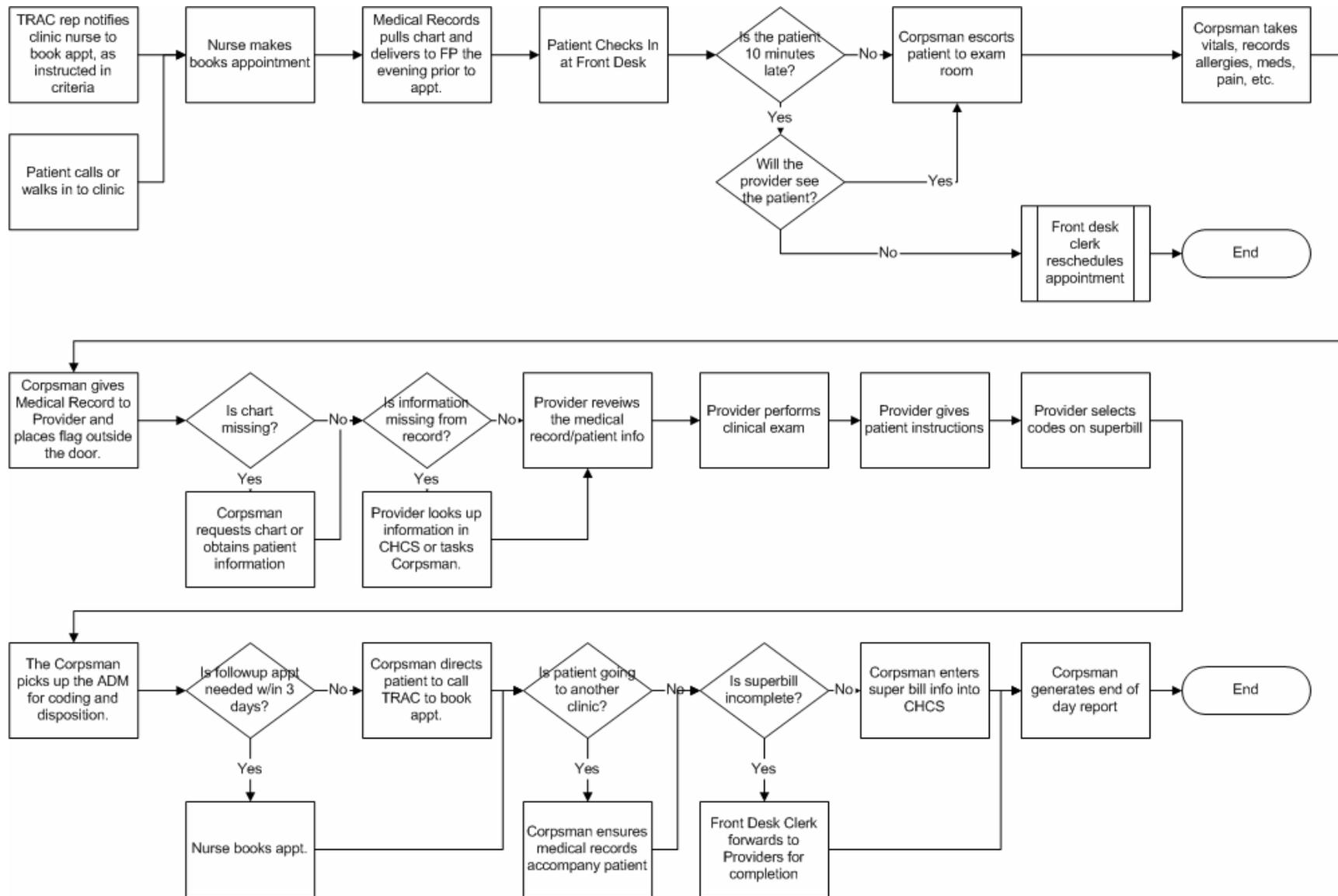
Scheduling Process via TRAC Flowchart

Scheduling Process via Clinic

1. Scheduling within the Family Practice Clinic with the nurse occurs when:
 - a. The TRAC representative calls the Family Practice Clinic (i.e., nurse) because the representative is unsure how to triage the patient and is unsure as to the appointment type to schedule for this patient.
 - b. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Family Practice Clinic (i.e., nurse), for the following conditions: Chicken pox, Lice, Ringworm, Scabies, Abnormal pap, IUD placement, Colposcopy, Sore throat, Measles, UTI, Medication refills, Initial evaluation for back manipulation, Initial evaluation for AD/AHD).
 - c. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Nurse Educator, for the following information or counseling: Breast Exams, Diabetic Counseling, High Cholesterol, Weight Loss, Endoscopy, Colonoscopy, Birth Control Methods, Healthy Heart Program, IUD Counseling, General health questions.
 - d. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Family Practice Clinic (i.e., nurse), for the following Procedure Evaluations: Toenail removal, Skin tag removal, Mole removal, Incise/Drain, Cyst.
 - e. The patient calls the nurse directly at the Family Practice Clinic to make an appointment (usually for similar instances described in b).
 - f. The patient walks-in the Family Practice Clinic and requests an acute appointment (i.e. the patient sees the nurse in person to schedule appointment).
2. The nurse schedules the appropriate appointment type.
3. The patient is instructed to report to their appointment 15 minutes prior to the actual appointment time (Everett Policy).
4. Medical Records receives requests from Family Practice to retrieve the patients' medical records prior to the patients' actual visit. Medical Records then pulls the patients' chart, and a representative (i.e., clerk) from Family Practice retrieves the medical record from the Records Department prior to the patients' scheduled visit.
5. Patient enters clinic and checks-in with front desk clerk. The front desk clerk confirms the patient's identity, appointment, and ensures the patient's health record is prepared correctly. If the patient appears 15 minutes prior to their appointment time, they will be seen. If the patient appears after the 10 minute late policy, the provider has the right to ask the patient to reschedule or honor the late appointment time.
6. The front desk clerk alerts the corpsman assigned to a particular provider that the patient has checked in and is waiting to be seen.
7. The corpsman escorts the patient to the screening and/or the examination room.
8. The corpsman takes and records the patient's vital signs (temperature, blood pressure, pulse, and respiration) in the medical record. The corpsman will note the patient's chief complaint in the S.O.A.P. note portion of the medical record. Additionally, the corpsman will record all

current medications the patient is taking, list any known allergies, and complete the questions for pain, cholesterol, pap, etc. If patients are under the age 12, a height and weight must also be recorded. And for infants (0-24mos.), length, weight, and head circumference are required to be recorded.

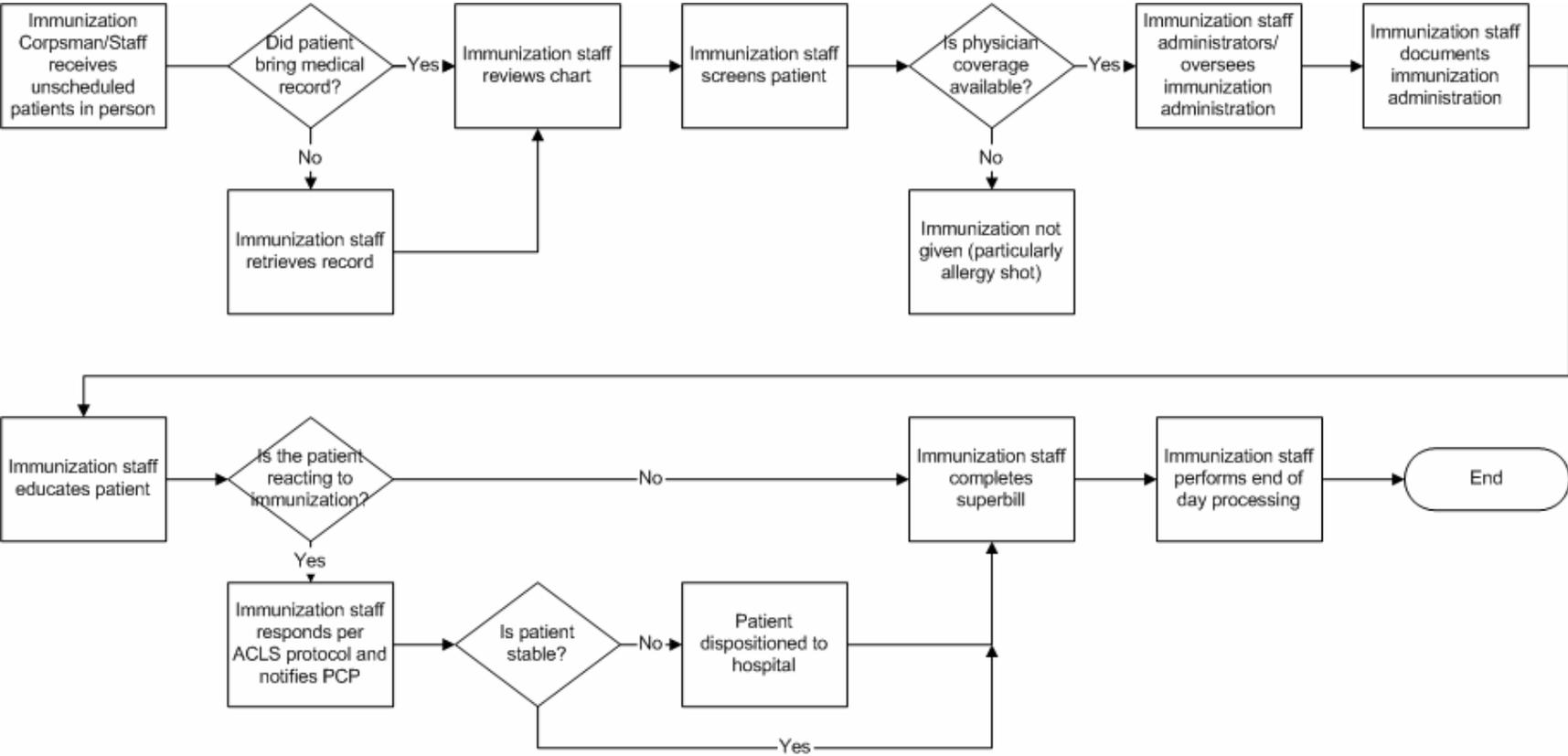
9. The corpsman gives the medical record to the provider and places a flag outside the door that signifies to the provider that the patient is waiting in the room.
10. The provider reviews the medical record prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS or tasks the corpsman to contact the outside facility to have the information faxed to the nurses' office for inclusion in the medical record.
11. If no chart is available the corpsman will notify medical records again asking for retrieval, and if available, the corpsman will go to medical records to get it. If no chart is found, the corpsman will help the provider locate any pertinent information on the patient that they require.
12. The provider sees the patient and performs the appropriate clinical exam.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
14. The corpsman picks up the ADM from the provider(s) for coding and disposition.
15. If a follow-up appointment is needed within three days, the clinic nurse books the appointment.
16. If a follow-up appointment is needed outside of three days, the patient is directed to call TRAC to book the appointment.
17. The corpsman also ensures that medical records accompany any patient sent to another part of the clinic so that proper documentation can occur (i.e. immunizations, patient education, case management).
18. The corpsman enters the super bill information into the computer and generates the end of day report.
19. If the super bill is incomplete, the front desk clerk forwards them to the provider for completion.



Scheduling Process via Clinic Flowchart

Immunization Process for Appointments

1. The Immunization corpsman/staff receives unscheduled patients in person. The patient generally walks-in to the Immunization Clinic either immediately following a doctor's appointment and hand carries his or her own medical record, or walks-in/phones with an immunization request where the medical record will need to be retrieved (i.e., Flu shots, Overseas immunizations, PPDs, Positive PPD reactions, etc).
2. The Immunization corpsman/staff ensures that staff is available for encounter processing/generation. If the patient is not hand carrying his or her own medical record, the Immunization staff orders the medical record from the medical record's department for the patient being seen in the Immunization clinic. Generally, the Immunization staff will go to medical records to retrieve the chart (the record's department delivers medical records only at scheduled intervals).
3. The Immunization staff reviews the patient's chart, screens the patient for known allergies, previous immunizations, and needed immunizations.
4. The Immunization staff assures that physician coverage is available prior to the administration of injections (particularly allergy shots).
5. The Immunization staff then administers and/or oversees the administration of all immunizations according to physician orders, BUMEDINST, NAVMEDCOM instructions, and Naval Hospital Bremerton policies and procedures.
6. The Immunization staff documents the immunization administration (i.e., immunization type, dosage, time, route, etc.) in the outpatient health records and in the patient's immunization records.
7. The Immunization staff educates patients regarding immunizations, reactions that might occur, and the treatment of these symptoms.
8. The Immunization staff responds appropriately to patients having untoward reactions including anaphylactic reactions per ACLS protocol (notifies the primary care provider immediately and documents the reaction/outcome).
9. The Immunization staff completes a super bill prior to the patient leaving the Family Practice clinic.
10. The Immunization staff assists with computer data input, statistical information gathering, report generation, and codes for visits. Then, he or she completes superbills for all visits and performs end of day processing for patient appointments.



Immunization Process for Appointments

Naval Health Everett Family Practice Clinic Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Open Access Appointment	OPAC\$	20 minutes	TRAC Representative	If the patient requires an appointment for an acute problem, concerns such as, acute infectious disease, headache, musculoskeletal injuries, pain, persistent fever, wound drainage, anxiety/alcoholism, and depression.
	OPAC	20 minutes	Clinic Staff	
Routine Appointment	ROUT	20 minutes	TRAC Representative	If the patient requires care that is defined as second or greater visit for a specific problem with the same provider who evaluated the patient on their last visit, or if the same provider is not available use, different provider.
Established Appointment	EST	20 minutes	TRAC Representative	If the patient requires follow-up care (i.e., ADD/ADHD).
Well Appointment	WELL	30 minutes	TRAC Representative	If the patient requires preventive health maintenance care, such as, annual physicals, well child exams, well women exams, school/sports physicals.
	WELL\$	30 minutes	Clinic Nurse	
Procedures Appointment	PROC	60 minutes	Clinic Nurse	If the patient requires a medical procedure, length of visit varies based on procedure.
Open Access Appointment	OPAC\$	20 minutes	Clinic Nurse	The TRAC representative calls the Family Practice Clinic (i.e., nurse) because the representative is unsure how to triage the patient and is unsure as to which appointment type to schedule for this patient. The nurse triages the call and books the most appropriate appointment type based on the same business rules stated above.
Well Appointment	WELL\$	30 minutes	Clinic Nurse	
Acute Appointment Well Appointment	ACUT\$	20 minutes	Clinic Nurse	The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Family Practice
	WELL\$	30 minutes	Clinic Nurse	

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Specialty Appointment	SPEC\$	20 minutes	Clinic Nurse	Clinic (i.e., nurse), for the following conditions: Chicken pox, Lice, Ringworm, Scabies, Abnormal pap, IUD placement, Colposcopy, Sore throat, Measles, UTI, Medication refill, Initial evaluation for back, AD/AHD, The nurse triages the call and books the most appropriate appointment type based on the same business rules stated on page 9.
Counseling Appointment Education Appointment			Nurse Educator	The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Nurse Educator for counseling, i.e., diabetic counseling, etc.
Procedure Appointment	PROC\$	Varies based on the procedure.	Clinic Nurse	If the patient requires a medical procedure, such as, toenail removal, skin tag removal, mole removal, incise, drain, cyst.
Immunization Appointment	Walk-In		Immunization Staff	The patient walks-in for an immunization either immediately following a doctor's appointment or walks-in/phones with an immunization request.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Sore Throat Protocol/ Questionnaire*	600-108	Provider	Acute Appointment	
Vomiting and Diarrhea Protocol/Questionnaire*	600-108	Provider	Acute Appointment	
Upper Respiratory Symptoms' Protocol/ Questionnaire*	600	Provider	Acute Appointment	
Vaginal Discharge Protocol/Questionnaire*	600-108	Provider	Acute Appointment	
Elevated BP Protocol/ Questionnaire*	600-108	Provider	Acute Appointment	
Ear Pain Protocol/ Questionnaire*	600-108	Provider	Acute Appointment	
Acute Pain Protocol/ Questionnaire*	600-108	Provider	Acute Appointment	
Standard Well Baby Form		Provider (PAs do not see infants less than a month old)	Well Appointment	
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

* Signifies - Protocols that do not always require an appointment booking/visit to be utilized.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
General Medical Examination (V70)	
Health Supervision of Infant or Child (V20)	
Acute Upper Respiratory Infection of Multiple or Unspecified Site (465)	
Allergic Rhinitis (477)	
Other and Unspecified Disorders of Joint (719) – Pain in Joint Involving Lower Leg (719.46), Pain in Joint Involving Shoulder Region (719.41), Pain in Joint Involving Hand (719.44)	
Other and Unspecified Disorders of Back (724) – Backache, Unspecified (724.5), Lumbago (724.2), Other Symptoms Referable to Back (724.8), Sciatica (724.3)	
Suppurative and Unspecified Otitis Media (382)	
Depressive Disorder, Not Elsewhere Classified (311)	
Other Diseases Due to Viruses and Chlamydiae (078)	
Essential Hypertension (401)	HTN Guideline

Comparison of Command and Clinic Goals, Initiatives and Metrics

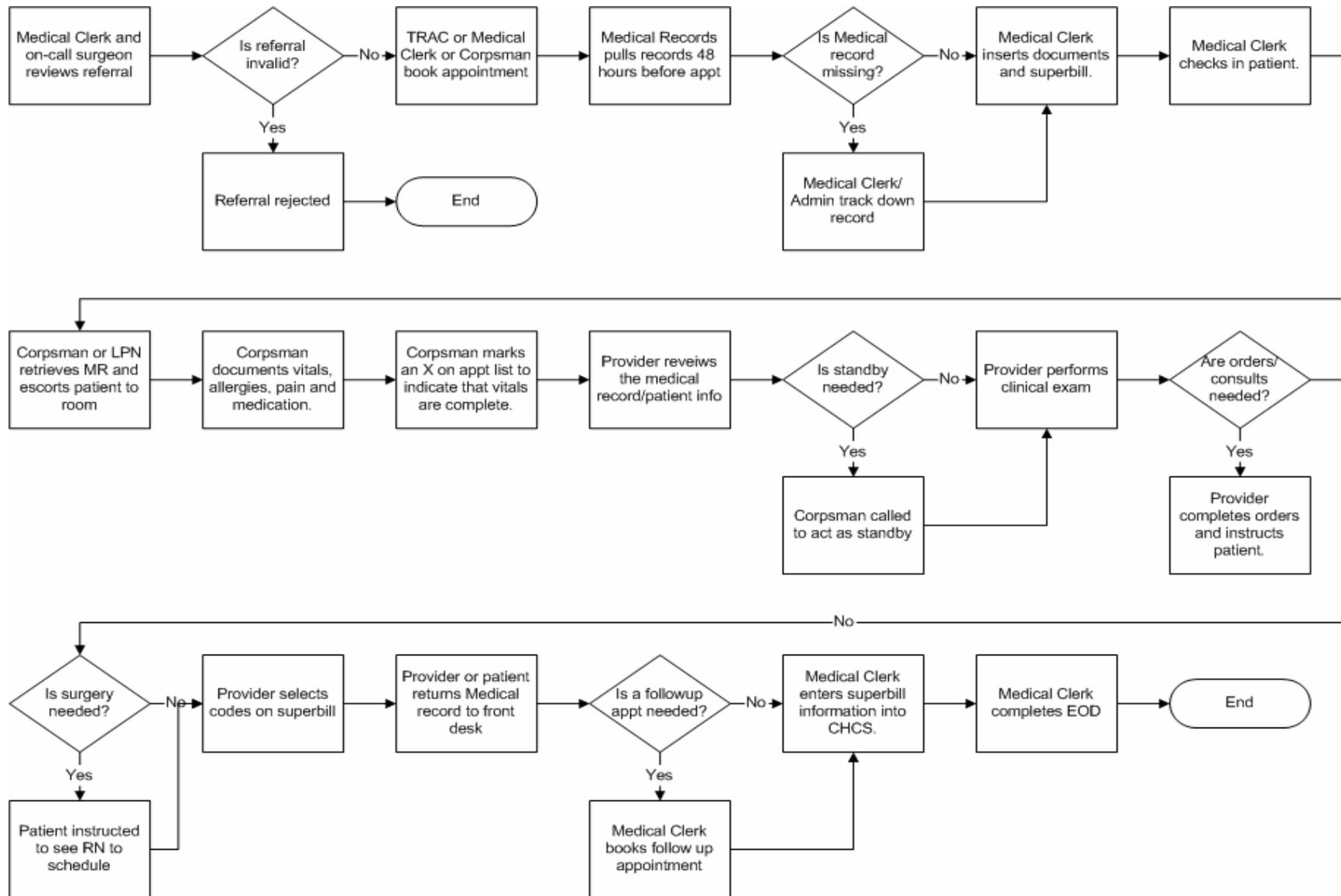
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.					
Manage network purchased care.					
Develop a coding education and training program					
Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
People: Develop an efficient integrated human capital strategy to optimize mission accomplishments					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Bremerton General Surgery Clinic

Initial Visit Process

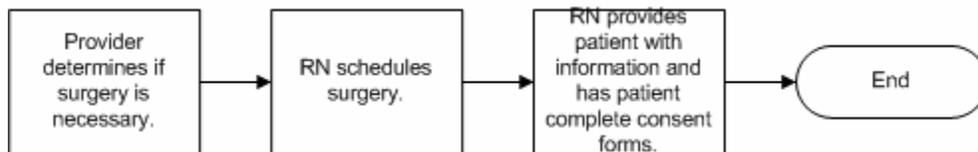
1. Medical Clerk and on-call surgeon review referrals.
2. TRAC or Medical Clerk or Corpsman book appointment.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to General Surgery the night before the patients are scheduled to visit.
4. As needed: Medical Clerk tracks medical records down.
5. Medical Clerk places SF600 in chart, prints labs, referral and workers compensation (if applicable).
6. Patient enters clinic and checks-in with Medical Clerk.
7. Medical Clerk checks ID and verifies address, telephone and insurance.
8. Corpsman takes patient back to exam room and documents vitals, allergies, pain and medication. Once completed corpsman writes an "X" by the patients name on the appointment list. Corpsman places medical record in Providers office if the patient is in the exam room or on the chart rack if patient is in waiting room.
9. As needed: Corpsman may act as a standby (i.e., to assist provider with medical procedures, etc.).
10. The provider reviews chart.
11. The provider sees the patient and performs the appropriate clinical exam.
12. As needed: The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.).
13. As needed: Provider determines if surgery is needed (or can be done at this clinic).
14. As needed: If surgery is necessary patient is sent to the RN (see RN surgery scheduling workflow for details).
15. The provider selects the most appropriate ICD, CPT, and E&M codes on the super bill.
16. The provider or the patient returns the Medical Record and superbill to the front desk to check out.
17. As needed: Corpsman or Medical Clerk book a follow-up appointment.
18. Medical Clerk enters the super bill information into the computer and generates the end of day report.



Initial Visit Process Flowchart

RN Surgery Scheduling Process

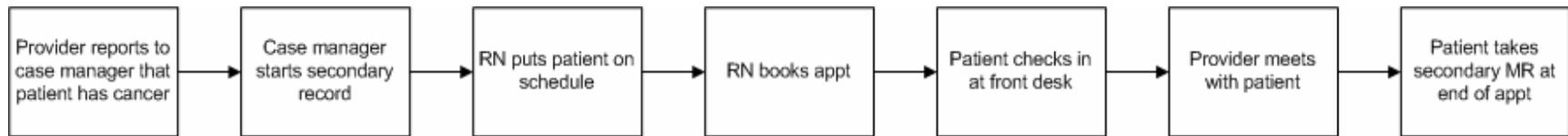
1. Provider determines that surgery is necessary.
2. RN schedules surgery
 - a. ORMA
 - b. CHCS pre-op
 - c. CHCS post-op
 - d. Surgery
 - e. Log Book
3. RN provides patient with information and has patient complete consent forms.



RN Surgery Scheduling Process Flowchart

RN Oncology Process

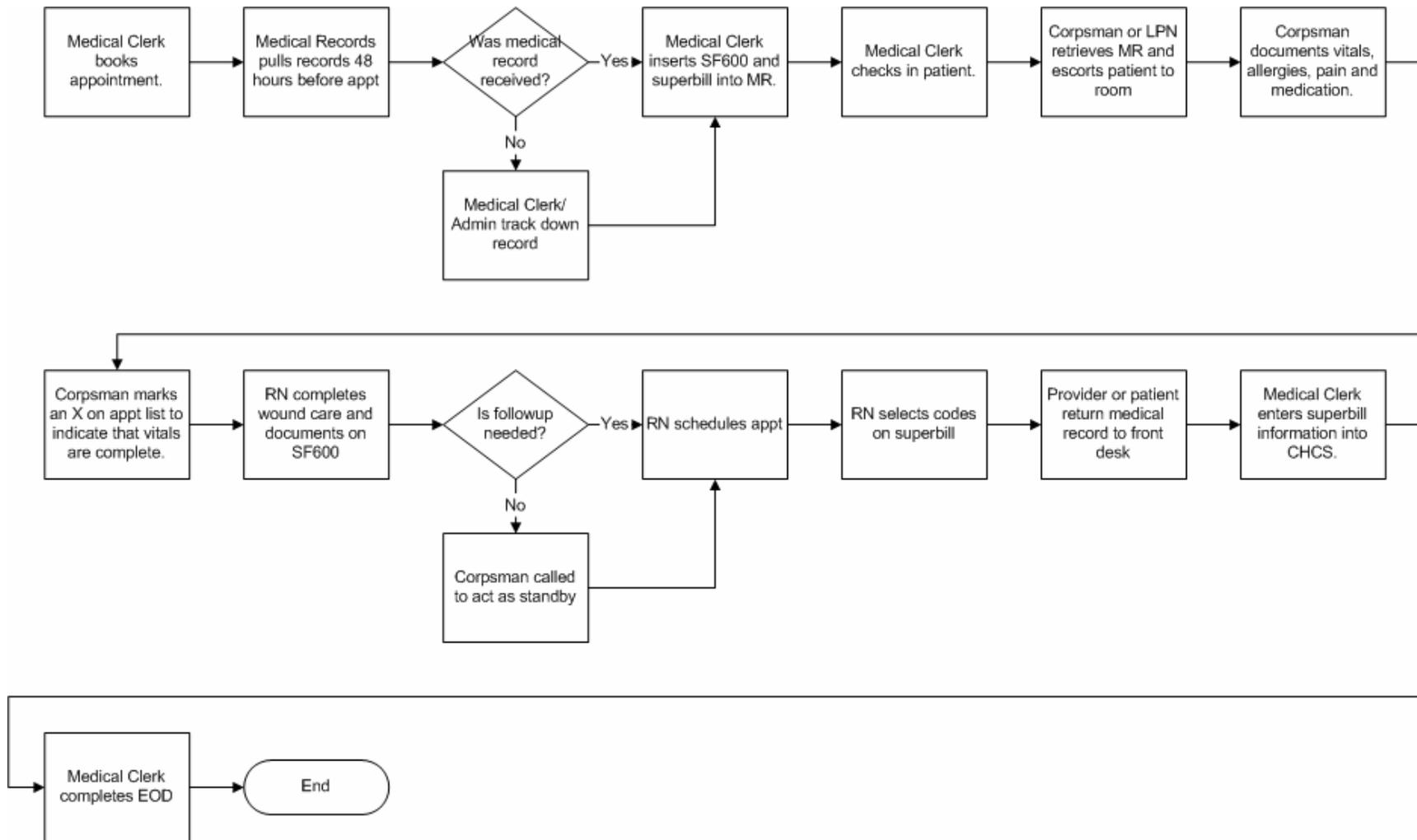
1. Provider reports to Case Manager (RN) that patient has cancer.
2. Case Manager starts secondary medical record that contains the following:
 - a. Tumor Board Forms
 - b. SF600 overlay
 - c. Staging Sheet from the American Joint Committee of Cancer
 - d. A copy of protocol for that cancer
 - e. Patient education sheets
3. Using standard protocol and patient information provided by the surgeon, the Case Manager (RN) books the most appropriate appointment type:
 - 3 month follow-up visit with corresponding laboratory and x-ray orders.
 - 6 month follow-up visit with corresponding laboratory and x-ray orders.
4. Patient checks in at front desk.
5. Provider sees patient.
6. Patient takes secondary medical record with them (Bremerton does not have Oncology).



RN Oncology Process Flowchart

RN Wound Care Process

1. Medical Clerk books appointment with RN.
2. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to General Surgery the night before the patients are scheduled to visit.
3. As needed: Medical Clerk tracks medical records down.
4. Medical Clerk places SF600 in chart.
5. Patient enters clinic and checks-in with Medical Clerk.
6. Medical Clerk checks ID and verifies address, telephone and insurance.
7. Corpsman takes patient back to exam room and documents vitals, allergies, pain and medication. Once completed corpsman writes an "X" by the patients name on the appointment list. Corpsman places medical record in Providers office if the patient is in the exam room or on the chart rack if patient is in waiting room.
8. RN checks wound for infection, completes wound care, and documents care in medical record.
9. RN schedules follow-up (generally every week until healed).
10. The RN completes superbill.
11. Provider or patient returns the Medical Record and superbill to the front desk to check out.
12. Medical Clerk enters the super bill information into the computer and generates the end of day report.



RN Wound Care Process Flowchart

Bremerton General Surgery Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Specialty Appointment (i.e., Initial Visit)	SPEC/SPEC\$	30 minutes	Medical Clerk, TRAC Representative	On call provider reviews consult to determine if appropriate for clinic. TRAC books 1/3 of these appointments. TRAC cannot see \$ appointments. These allow scheduling flexibility.
Established Appointment (i.e., Pre-Op, Post-Op, Wound care, Walk-in)	EST/EST\$	15 minutes	Medical Clerk, TRAC Representative	Follow-up appointment. TRAC books 1/3 of these appointments. TRAC cannot see \$ appointments. These allow scheduling flexibility.
Minor Procedures	PROC\$	45 minutes	Medical Clerk	Used for minor procedures such as mole, lypoma, etc.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Superbill	BBAA ELV 091202	Provider	All	
SF600	SF600	Provider, CM	Follow-up	
SF513	SF513	RN	Initial	
Doctors Orders	SF508	Provider		
SF600 Overlay	SF600	RN	Cancer follow-up – RN visit	
Tumor Board Summary Sheet for CA	N/A	RN	Cancer follow-up – RN visit	
General Surgery Pre-Op Rounds	N/A	Provider	Pre-Op	
Authority for Admission	NHBREM 6300/2 (REV 5/01)	Provider	Pre-Op	
Abbreviated medical record	SF539	Provider		
Progress Notes	SF509	Provider		
Same Day Surgery	NHBREM 34 (5-92)	Provider		
Informed Consent Form	NHBREM 6420 (12-02)	Provider, Patient		
Outpatient Minor Surgery Note	SF600	Provider		
Surgical Site Verification Checklist	NHBREM 6350 (1-03)	Provider		
Third Party Collection Program	NHBREM 12800/5 (REV 8-00)	Medical Clerk		

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Doctor Input on Discharge Progress Note and Active Duty Disposition Form	NHBREM 6320/22 (REV 2-2000)	Provider	Sick Call	
Patient Management Advice	NHBREM 6320/27 (REV 7-94)	Provider		
Post Op Teaching General Surgery	N/A	RN	Post Op	
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Follow-Up Examination (V67)	
Pilonidal Cyst (685)	
Other Disorders of Breast (611)	
Inguinal Hernia (550)	
Other Hernia of Abdominal Cavity NOS (553)	
Hemorrhoids (455)	
Lipoma (214)	
Diseases of Esophagus (530)	
Special Investigations and Examinations (V72)	
Cholelithiasis (574)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.					
Manage network purchased care.					
Develop a coding education and training program					
Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
People: Develop an efficient integrated human capital strategy to optimize mission accomplishments					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

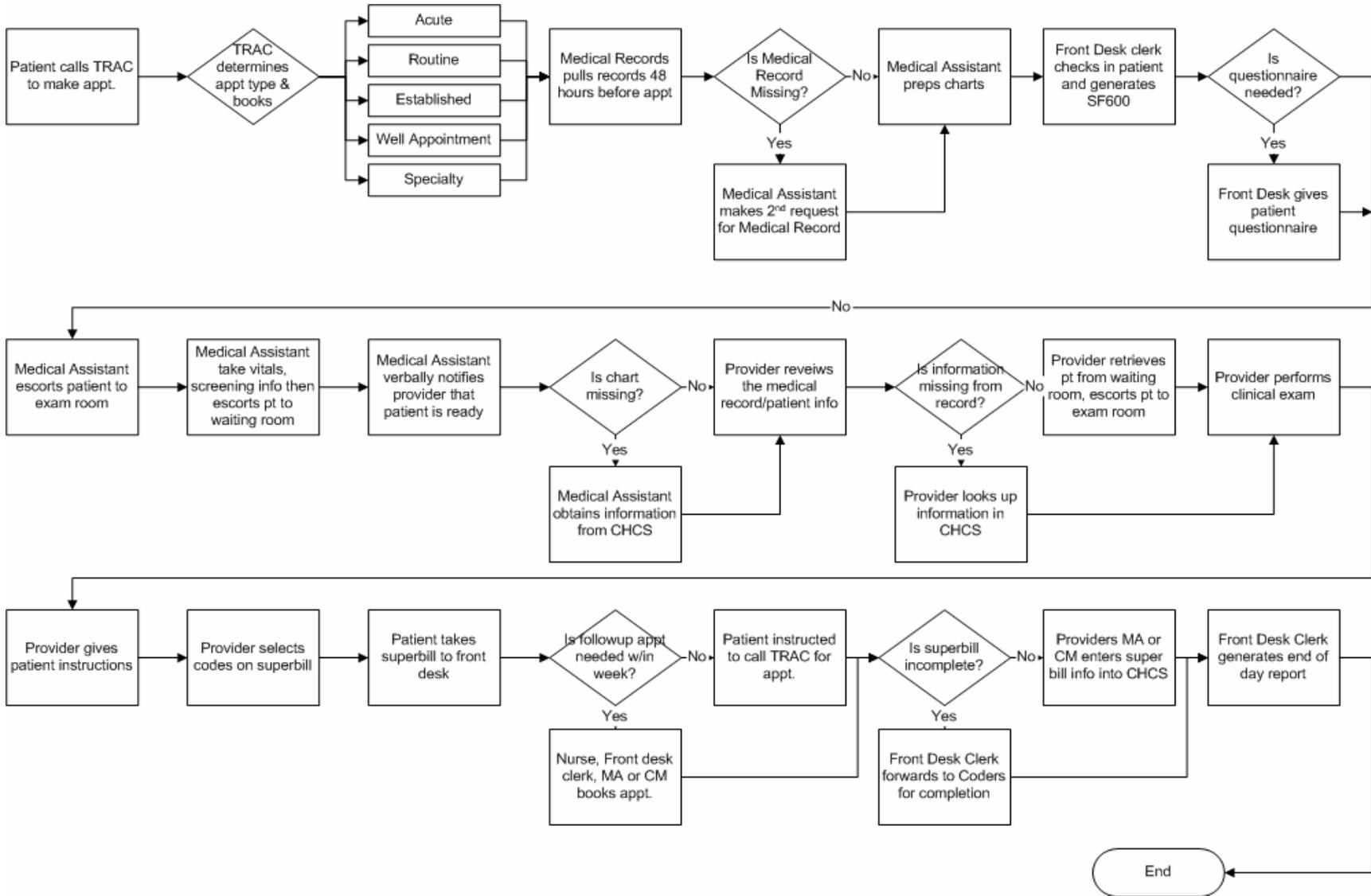
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Bremerton Internal Medicine Clinic

Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Acute Appointment: if the patient requires non-emergent urgent care; such as, flu, cough, pain, strains, etc. (book this within 24 hours);
 - b. Routine Appointment: if the patient requires an appointment for a new health care problem, not considered urgent;
 - c. Established Appointment: if the patient requires a follow-up for consults already seen in Internal Medicine once or for enrolled patients;
 - d. Well Appointment: if the patient requires preventive health maintenance type of care, such as, physicals, new patient appointment; and
 - e. Specialty Appointment: used exclusively for consults to IMC for the first two visits.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine the night before the patients are scheduled to visit (Please note: Internal Medicine stated that this does not routinely occur; they often see patients without their medical records).
4. The medical assistant check-in and prep the patients' charts when they receive them from medical records. The medical assistant updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the medical assistant puts in a second request to medical records to retrieve those records prior to the patient visit.
5. Patient enters clinic and checks-in with front desk clerk. The front desk clerk gives the patient any required questionnaires (i.e., ROS assessment questionnaire) to complete while waiting.
6. Front desk clerk enters the patient in the system and generates the SF 600.
7. The medical assistant retrieves the SF 600 from the printer; calls the patient and escorts the patient to the screening and/or the examination room.
8. The medical assistant takes the patient's height, weight, vital signs (temperature, blood pressure, pulse, and respiration), chief complaint, history, and/or other pertinent patient information and then escorts the patient back to the waiting room.
9. The medical assistant verbally notifies the provider that the patient is waiting in the waiting room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) and the ROS questionnaire (completed by the patient) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.

11. If the provider receives no chart, the medical assistant looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
12. The provider retrieves the patient from the waiting room and escorts the patient to the exam room.
13. The provider performs the appropriate clinical exam.
14. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
15. The patient brings the super bill to the front desk to check out.
16. If a follow-up appointment is needed within the week, the clinic nurse, front desk clerk, Medical Assistant or Corpsman (i.e., HM) creates the appointment.
17. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment, or book the appointment with the front desk prior to leaving the clinic.
18. The provider's Medical Assistant/Corpsman (i.e., HM) enters the super bill information into the computer and generates the end of day report.
19. If the super bill is incomplete, the front desk clerk forwards them to the coders for completion.

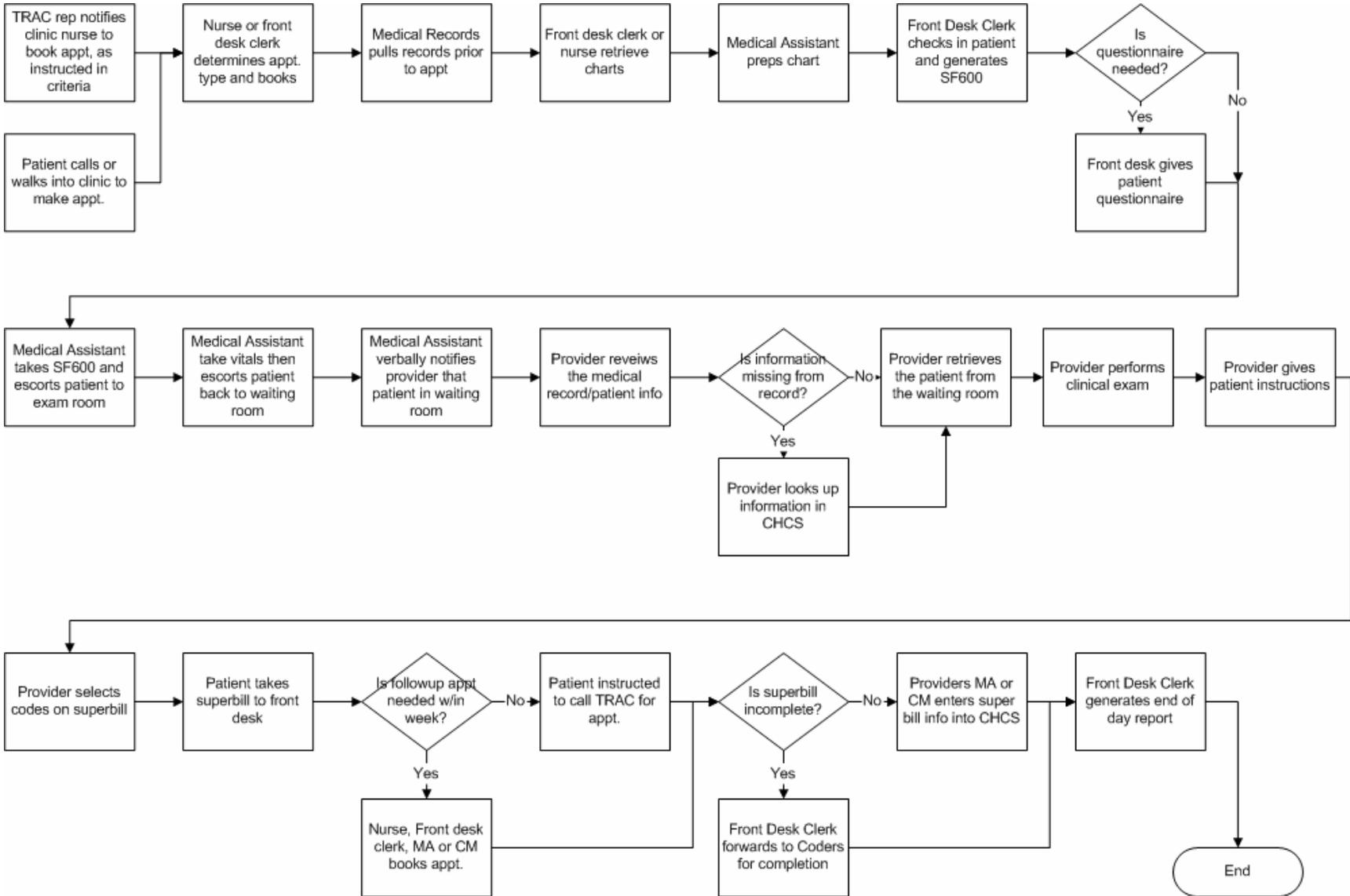


Scheduling Process via TRAC Flowchart

Scheduling Process via Clinic

1. Scheduling within the Internal Medicine Clinic with the nurse occurs when:
 - a. The TRAC representative calls the Internal Medicine Clinic (i.e., nurse) because the representative is unsure how to triage the patient and is unsure as to the appointment type to schedule for this patient.
 - b. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Internal Medicine Clinic (i.e., nurse), for the following instances: when appointments are not available, when the patient has questions for the nurses/providers, when a patient requests a medication reorder, lab results, and/or BP checks, or is advised to go to the ED.
 - c. The patient calls the clinic directly at the Internal Medicine Clinic to make an appointment.
 - d. The patient walks-in the Internal Medicine Clinic and requests an appointment.
2. The nurse or front desk clerk schedules the appointment.
3. Medical Records receives requests from Internal Medicine to retrieve the patients' medical records prior to the patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine. Generally, the front desk clerk and/or the nurse will go to medical records to retrieve the chart (the record's department delivers medical records only at scheduled intervals).
4. The medical assistant check-in and prep the patients' charts when they receive them from medical records. The medical assistant updates the charts with test results, consults, etc., when appropriate.
5. Patient enters clinic and checks-in with front desk clerk. The front desk clerk gives the patient any required questionnaires (i.e., ROS assessment questionnaire) to complete while waiting.
6. Front desk clerk enters the patient in the system and generates the SF 600.
7. The medical assistant retrieves the SF 600 from the printer; calls the patient and escorts the patient to the screening and/or the examination room.
8. The medical assistant takes the patient's height, weight, vital signs (temperature, blood pressure, pulse, and respiration), chief complaint and/or history, and then escorts the patient back to the waiting room.
9. The medical assistant verbally notifies the provider that the patient is waiting in the waiting room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) and the ROS questionnaire (completed by the patient) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
11. If the provider receives no chart, the medical assistant looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.

12. The provider retrieves the patient from the waiting room and escorts the patient to the exam room.
13. The provider performs the appropriate clinical exam.
14. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
15. The patient brings the super bill to the front desk to check out.
16. If a follow-up appointment is needed within the week, the clinic nurse, front desk clerk, Medical Assistant or Corpsman (i.e., HM) creates the appointment.
17. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment, or book the appointment with the front desk prior to leaving the clinic.
18. The provider's Medical Assistant/Corpsman (i.e., HM) enters the super bill information into the computer and generates the end of day report.
19. If the super bill is incomplete, the front desk clerk forwards them to the coders for completion.

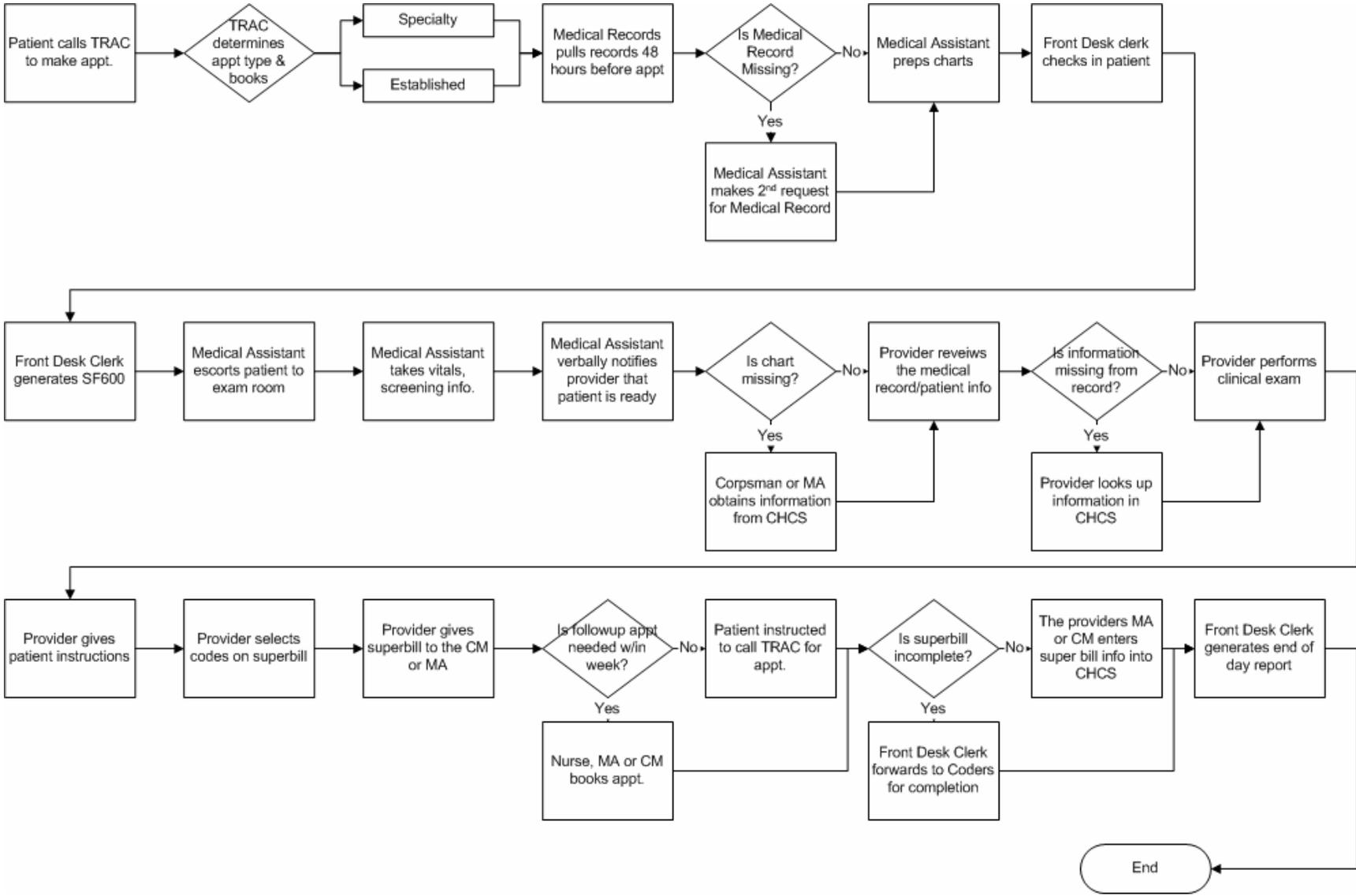


Scheduling Process via Clinic Flowchart

Pulmonary Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Specialty Appointment: if the patient requires a specialty care appointment (must have a consult).
 - b. Established Appointment: if the patient requires follow up care.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine the night before the patients are scheduled to visit (Please note: Internal Medicine stated that this does not routinely occur; they often see patients without their medical records).
4. The medical assistant checks-in and preps the patients' charts when they receive them from medical records. The medical assistant updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the medical assistant puts in a second request to medical records to retrieve those records prior to the patient visit.
5. Patient enters clinic and checks-in with front desk clerk/medical assistant.
6. Front desk clerk enters the patient in the system and generates the SF 600.
7. The medical assistant retrieves the SF 600 from the printer; calls the patient and escorts the patient to the screening and/or the examination room.
8. The medical assistant takes the patient's height, weight, vital signs (temperature, blood pressure, pulse, and respiration), chief complaint, history, and other pertinent information.
9. The medical assistant verbally notifies the provider that the patient is waiting in the room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
11. If the provider receives no chart, the medical assistant looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
12. The provider sees the patient and performs the appropriate clinical exam.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
14. The provider gives the super bill to the Medical Assistant or Corpsman (i.e., HM).
15. If a follow-up appointment is needed within the week, the clinic nurse, Medical Assistant, or Corpsman (i.e., HM) creates the appointment.
16. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
17. The provider's Medical Assistant or Corpsman (i.e., HM) enters the super bill information into the computer and generates the end of day report.

18. If the super bill is incomplete, the front desk clerk forwards them to the coders for completion.

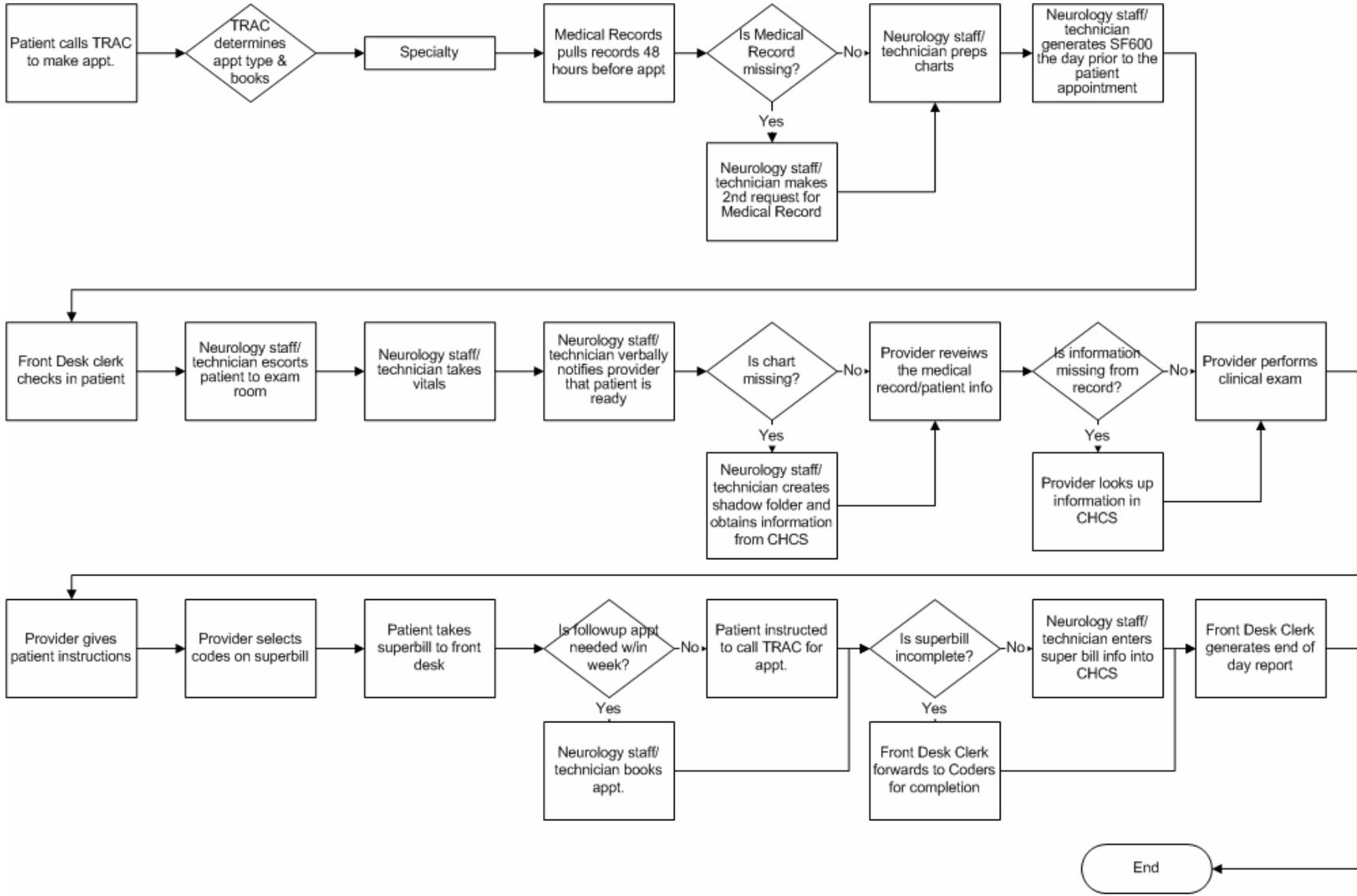


Pulmonary Scheduling Process via TRAC Flowchart

Neurology Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Specialty Appointment: if the patient requires a specialty care appointment (must have a consult).
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine during working hours prior to the patients scheduled visit.
4. The neurology staff/technician checks-in and preps the patients' charts when they receive them from medical records. The neurology staff/technician updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the neurology staff/technician puts in a second request to medical records to retrieve those records prior to the patient visit.
5. The neurology staff/technician generates the SF 600 the day prior to the patient appointment.
6. Patient enters clinic and checks-in with front desk clerk/medical assistant.
7. The neurology staff/technician places the SF 600 in a shadow folder when the medical record is not available with the patient (i.e., not hand carried). Please note: Shadow folders include vital signs and other reports necessary for the provider.
8. The neurology staff/technician escorts the patient to the screening and/or the examination room.
9. The neurology staff/technician takes the patient's height, weight, and vital signs (temperature, blood pressure, pulse, and respiration).
10. The neurology staff/technician notifies the provider that the patient is waiting in the room.
11. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
12. If the provider receives no chart, the neurology staff looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
13. The provider sees the patient and performs the appropriate clinical exam.
14. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
15. The patient brings the super bill to the front desk to check out.
16. If a follow-up appointment is needed within the week, the neurology staff/technician creates the appointment.
17. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.

18. The neurology staff/technician enters the super bill information into the computer and generates the end of day report.
19. If the super bill is incomplete, the front desk clerk forwards them to the coders for completion.

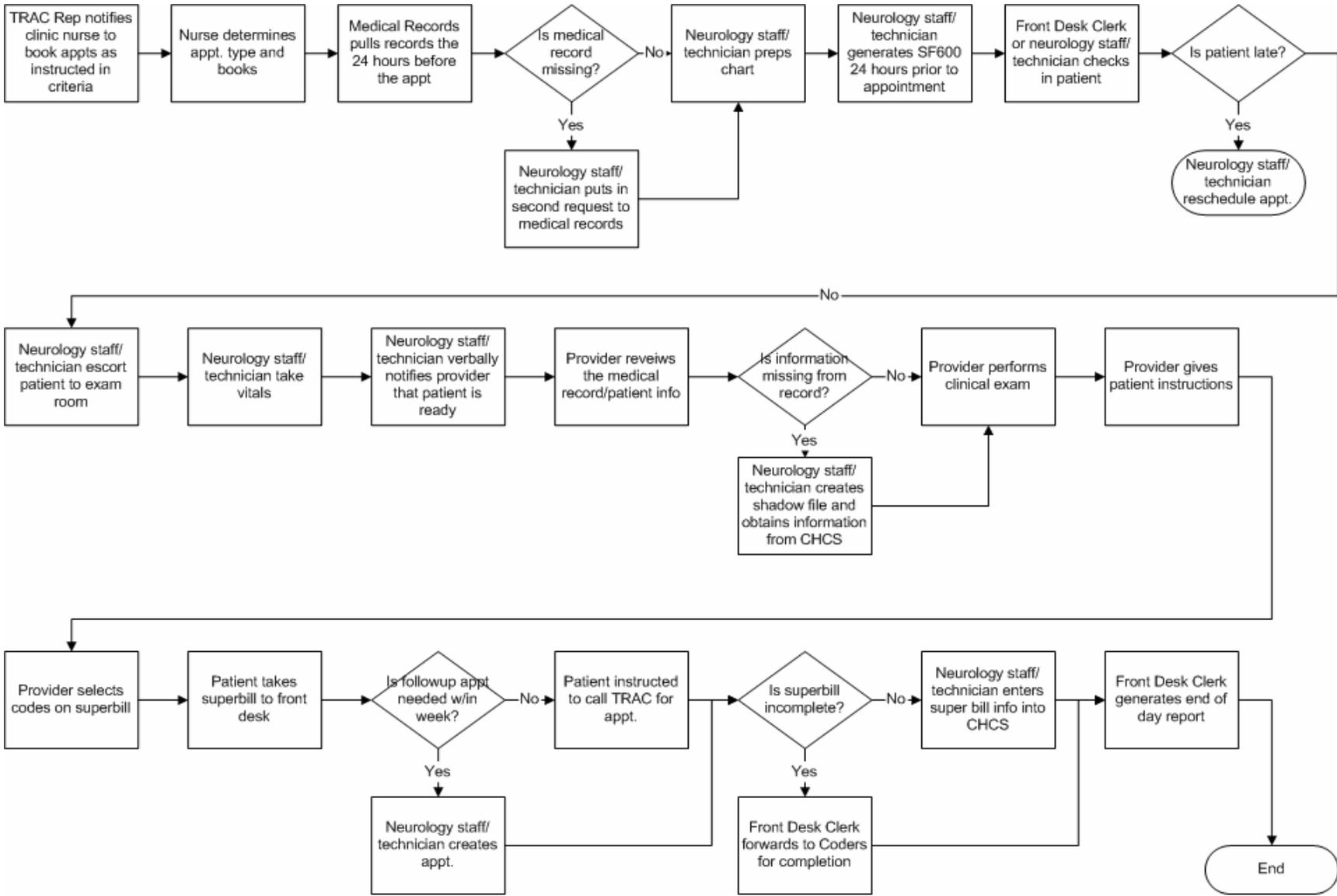


Neurology Scheduling Process via TRAC Flowchart

Neurology Scheduling Process via Clinic

1. Scheduling within the Internal Medicine – Neurology Clinic with the nurse occurs when:
 - a. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Internal Medicine Clinic (i.e., nurse), for the following instances: when appointments are not available, and to book all Routine and Established Appointments.
 - b. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Internal Medicine Clinic (i.e., nurse), for the following procedure: EEGs.
2. The nurse schedules the appointment, and instructs the patient to arrive 15 minutes prior, and if they are late, they will need to reschedule.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine 24 hours prior to patient appointment.
4. The neurology staff/technician checks-in and preps the patients' charts when they receive them from medical records. The neurology staff/technician updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the neurology staff/technician puts in a second request to medical records to retrieve those records prior to the patient visit.
5. Patient enters clinic and checks-in with front desk clerk/medical assistant.
6. Neurology staff/technician generates the SF 600 24 hours prior to appointment.
7. The neurology staff/technician places the SF 600 in a shadow folder when the medical record is not available with the patient (i.e., not hand carried). Please note: Shadow folders include vital signs and other reports necessary for the provider.
8. The neurology staff/technician escorts the patient to the screening and/or the examination room.
9. The neurology staff/technician takes the patient's height, weight, and vital signs (temperature, blood pressure, pulse, and respiration).
10. The neurology staff/technician verbally notifies the provider that the patient is waiting in the room.
11. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
12. If the provider receives no chart, the neurology staff looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
13. The provider sees the patient and performs the appropriate clinical exam.
14. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
15. The patient brings the super bill to the front desk to check out.

16. If a follow-up appointment is needed within the week, the clinic nurse creates the appointment.
17. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
18. The front desk clerk enters the super bill information into the computer and generates the end of day report.
19. If the super bill is incomplete, the front desk clerk forwards them to the coders for completion.

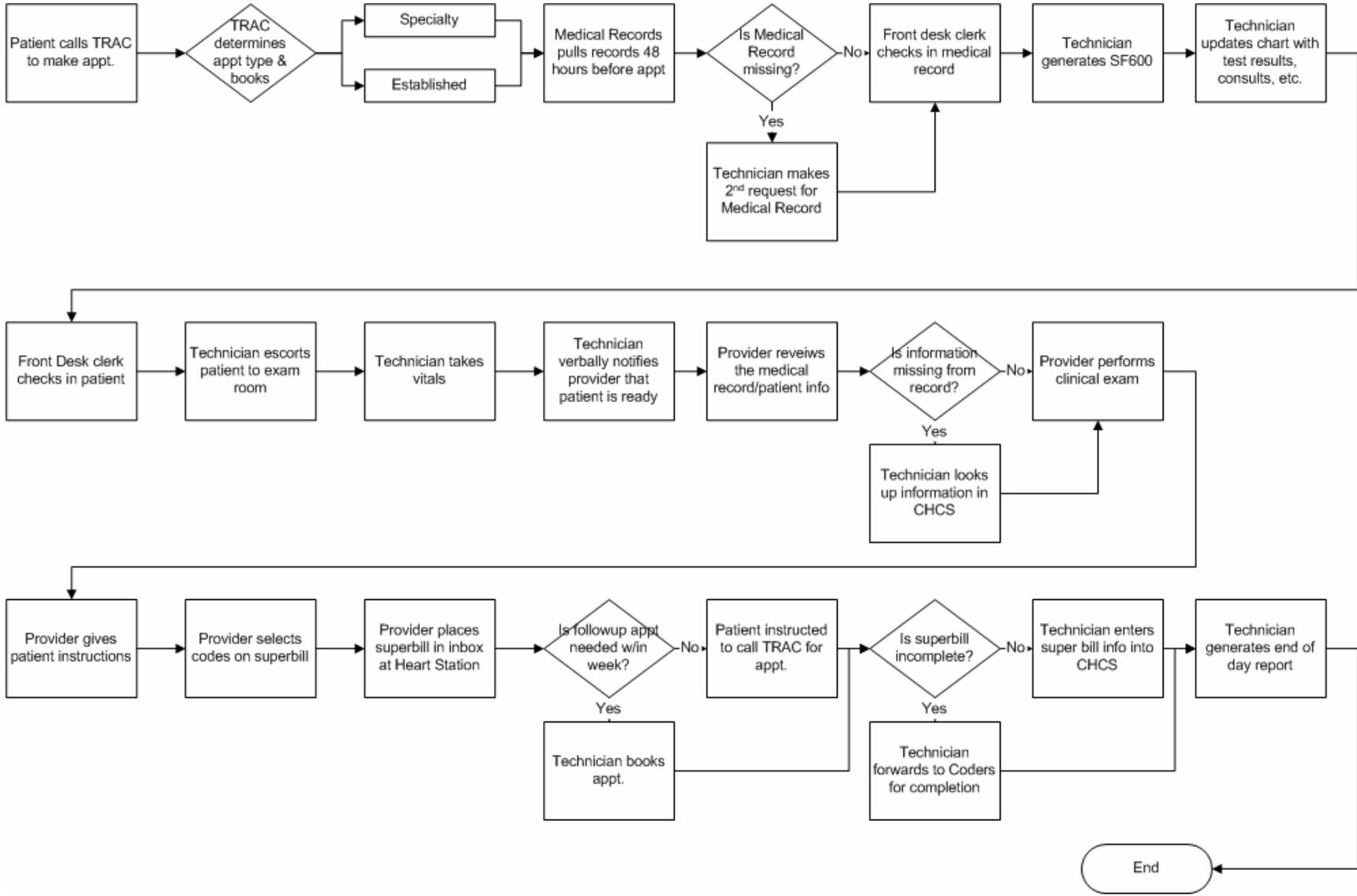


Neurology Scheduling Process via Clinic Flowchart

Cardiology Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Specialty Appointment: if the patient is new and has not been seen by Cardiology within the last 18 months, and requires a specialty care appointment.
 - b. Established Appointment: if the patient has been seen in a SPEC or EST within the last 18 months and requires a follow up appointment.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Internal Medicine the night before the patients are scheduled to visit.
4. The front desk clerk check-in the patients' charts, and the technicians prep the patients' charts when they receive them from medical records.
5. The technician generates the SF 600, updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the clinic puts in a second request to medical records to retrieve those records prior to the patient visit.
6. Patient enters clinic and checks-in with front desk clerk.
7. The technician calls the patient and escorts the patient to the screening and/or the examination room.
8. The technician takes the patient's height, weight, and vital signs (temperature, blood pressure, pulse, and respiration).
9. The technician verbally notifies the provider that the patient is waiting in the room.
10. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
11. If the provider receives no chart, the technician looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
12. The provider sees the patient and performs the appropriate clinical exam.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
14. The cardiologist places the super bill in the inbox at the Heart Station.
15. If a follow-up appointment is needed within the week, the technician creates the appointment.
16. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
17. The technicians enter the super bill information into the computer and generate the end of day report.

18. If the super bill is incomplete, the heart station technician forwards them to the coders for completion.

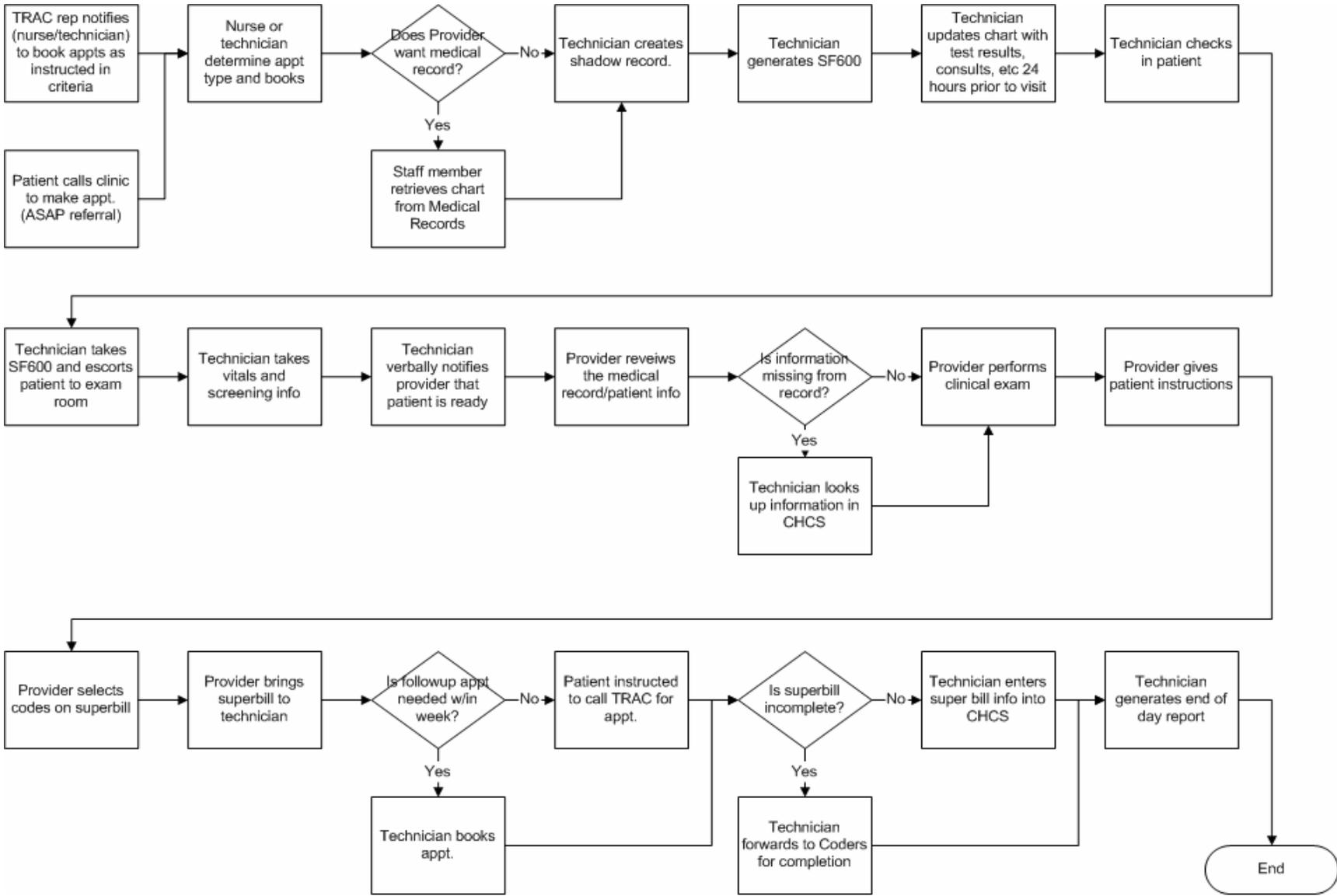


Cardiology Scheduling Process via TRAC Flowchart

Cardiology Scheduling Process via Heart Station

1. Scheduling within the Internal Medicine – Cardiology Clinic with the nurse/technician occurs when:
 - a. The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Internal Medicine - Cardiology Clinic (i.e., nurse/technician), for the following instances: when appointments are not available, if a patient calls for an appointment for an ASAP referral (their PCM/referring provider needs to contact the Cardiologist for scheduling by the Heart Station), and for procedures, such as, nuclear medicine studies, trans-esophageal echocardiograms, treadmill, and tilt-table tests.
2. The nurse/technician schedules the appointment, and instructs the patient to arrive 30 minutes prior to their scheduled appointment time for check in.
3. If the cardiologist wants the patient’s medical record, the clinic sends a staff member to Medical Records to retrieve the chart.
4. The technician checks-in and preps the patients’ charts for the cardiologist. The technician updates the charts with test results, consults, etc., when appropriate and when available. If the medical record is missing, the technician places copies of the information listed above in the clinic shadow file and sends original forms to medical records for inclusion the patient’s chart.
5. Patient enters clinic and checks-in with front desk clerk/technician.
6. The Heart Station technician enters the patient in the system and generates the SF 600.
7. The technician retrieves the SF 600 from the printer; calls the patient and escorts the patient to the screening and/or the examination room.
8. The technician takes the patient’s height, weight, and vital signs (temperature, blood pressure, pulse, and respiration).
9. The technician notifies the provider that the patient is waiting in the room.
10. The technician attempts to provide the provider with pertinent patient information 24 hours prior to the patient visit. The provider reviews the medical record (for past appointment information, past medical history, pertinent laboratory, radiology, procedure results) prior to seeing the patient. If the information/results are not in the chart, the provider looks up the information in CHCS.
11. If the provider receives no chart, the technician attempts to find the chart in the hospital, and looks up and copies any pertinent information on the patient from CHCS, and delivers this information to the provider.
12. The provider sees the patient and performs the appropriate clinical exam.
13. The provider gives the patient instructions as to the next steps (i.e., the patient may be asked to go to the laboratory/radiology department, pharmacy, health education department, etc.), and selects the most appropriate ICD, CPT, and E&M codes on the super bill.
14. The provider brings the super bill to the technician.

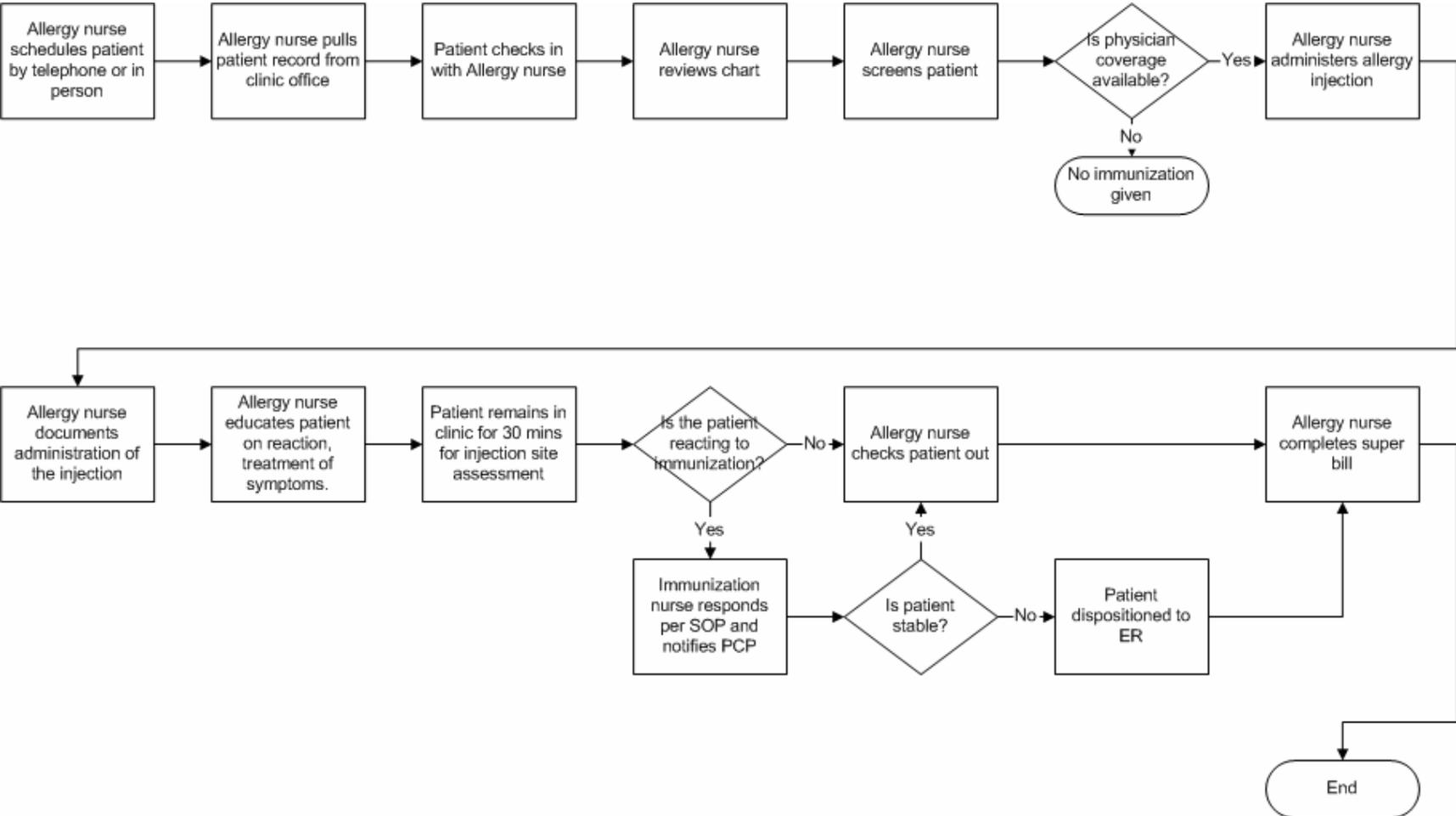
15. If a follow-up appointment is needed within the week, the clinic technician creates the appointment, or the patient is instructed to call TRAC for an appointment.
16. If a follow-up appointment is needed after the week, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
17. The heart station technician enters the super bill information into the computer and generates the end of day report.
18. If the super bill is incomplete, the heart station technician forwards them to the coders for completion.



Cardiology Scheduling Process via Heart Station Flowchart

Allergy Process for Appointments

1. The Allergy nurse schedules patients for allergy shots by telephone or in person (generally, a 10 to 15 minute appointment).
2. Allergy nurse pulls patient record kept in Clinic office before the patients' visit.
3. The patient checks in with the Allergy nurse for his/her appointment.
4. The Allergy nurse reviews the patient's chart, and calculates next patient dose per protocol.
5. The Allergy nurse assures that physician coverage is available prior to the administration of any injection.
6. The Allergy nurse then administers the allergy injection according to physician orders.
7. The Allergy nurse documents the administration of the injection (i.e., injection, medication type, dosage, time, route, etc.) in the patient's allergy records.
8. The Allergy nurse counsels patients regarding the allergy shot, reactions that might occur, and the treatment of these symptoms. The Allergy nurse reinforces this education by giving the patient an allergy injection informational pamphlet/handout to verify the patients understanding of the education information, prn.
9. The patient is instructed to remain in the Internal Medicine – Allergy Clinic for 30 minutes so that the Allergy nurse is able to access for any reactions.
10. The Allergy nurse responds appropriately to patients having untoward reactions including anaphylactic reactions per clinic standard operating procedures (notifies the primary care provider immediately and documents the reaction/outcome).
11. The Allergy nurse then checks the patient out and completes the super bill.



Allergy Process for Appointments Flowchart

Bremerton Internal Medicine Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Acute Appointment	ACUT	30 minutes	TRAC Representative	If the patient requires non-emergent, urgent care, the appointment will be booked within 24 hours.
Routine Appointment	ROUT	30 minutes	TRAC Representative	If the patient requires an appointment for a new health care problem, not considered urgent.
Established Appointment	EST	30 minutes	TRAC Representative	If the patient requires a follow-up for consults already seen in Internal Medicine once or for enrolled patients. Cardiology - If the patient has been seen in a SPEC or EST within the last 18 months and requires a follow up appointment.
Well Appointment	WELL	60 minutes	TRAC Representative	If the patient requires preventive health maintenance type of care, such as, physicals, well exams.
Specialty Appointment	SPEC	60 minutes	TRAC Representative	If the patient requires a specialty care appointment; used exclusively for consults to IMC for the first two visits (i.e., Pulmonary, Neurology, and Cardiology). Cardiology - If the patient is new and has not been seen by Cardiology within the last 18 months, book a specialty care appointment.
Acute Appointment Routine Appointment Established Appointment Well Appointment Specialty Appointment	ACUT\$ ROUT\$ EST\$ WELL\$ SPEC\$	30 minutes 30 minutes 30 minutes 60 minutes 60 minutes	Clinic Nurse	The TRAC representative calls the Internal Medicine Clinic (i.e., nurse) because the representative is unsure how to triage the patient and is unsure as to which appointment type to schedule for this patient. The nurse triages the call and books the most appropriate appointment type based on the same business rules stated on page 24.

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Acute Appointment Routine Appointment Established Appointment Well Appointment Specialty Appointment	ACUT\$ ROUT\$ EST\$ WELL\$ SPEC\$	30 minutes 30 minutes 30 minutes 60 minutes 60 minutes	Clinic Nurse	The TRAC representative has been instructed via the Appointment Criteria to refer the patient to the Internal Medicine Clinic (i.e., nurse), for the following instances: when appointments are not available, when the patient has questions for the nurses/providers, when a patient requests a medication reorder, lab results, and/or BP check. The nurse triages the call and books the most appropriate appointment type based on the same business rules stated on page 24.
Routine Appointment Established Appointment	ROUT\$ EST\$	30 minutes 30 minutes	Clinic Nurse	According to the Appointment Criteria, all routine and established appointments for neurology are required to be booked via clinic.
Procedure Appointment	PROC\$	Length of Visit varies based on the procedure.	Clinic Nurse Heart Station	If the patient requires a medical procedure, such as, EEGs. Cardiology procedures are scheduled with the Heart Station.
Allergy Appointment	EST\$	10 minutes 15 minutes	Allergy Nurse	The patient walks-in/phones for an allergy appointment. The nurse books the 10 minute appointment for patients requiring one injection. For patients requiring two or more injections, a 15 minute appointment is scheduled.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Patient Symptom List and Review of Systems		Patient	Well Appointments	Form used primarily pre-PE, but also used for new patients.
Pulmonary Functions Test Template		Provider	Pulmonary PFT Visits	Did not receive a copy of form.
Standard PE Template		Provider	Well Appointments (PE)	Requested development of standard form so all patients receive the same quality of care (a standard, comprehensive PE would be done with the same laboratory, radiology tests, etc.)
Wellness Reminders	DD2766	Patient/Provider	All Appointment Types	Did not receive a copy of form, but request was for wellness reminders/protocols to prompt providers via electronic medical record.
Allergy Dosage Worksheet		Allergy Nurse	Allergy Appointments	Did not receive a copy of form.
Telcon Tracking Worksheet		Nurse	Telephone Consults	Did not receive a copy of form.
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Certain Adverse Effects, NEC (995)	Allergy Shot Reaction Protocols
Diabetes Mellitus (250)	Diabetes Guideline
Essential Hypertension (401)	HTN Guideline
Isolation and Other Prophylactic Measures (V07)	
Hypertensive Heart Disease (402)	HTN Guideline
Other and Unspecified Disorders of Joint (719) –	
Disorders of Lipoid Metabolism (272)	Cholesterol/Hyperlipidemia Guidelines
Acquired Hypothyroidism (244)	TSH Protocols
Other and Unspecified Disorders of Back (724)	
Other Forms of Chronic Ischemic Heart Disease (414)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.					
Manage network purchased care.					
Develop a coding education and training program					
Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
People: Develop an efficient integrated human capital strategy to optimize mission accomplishments					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

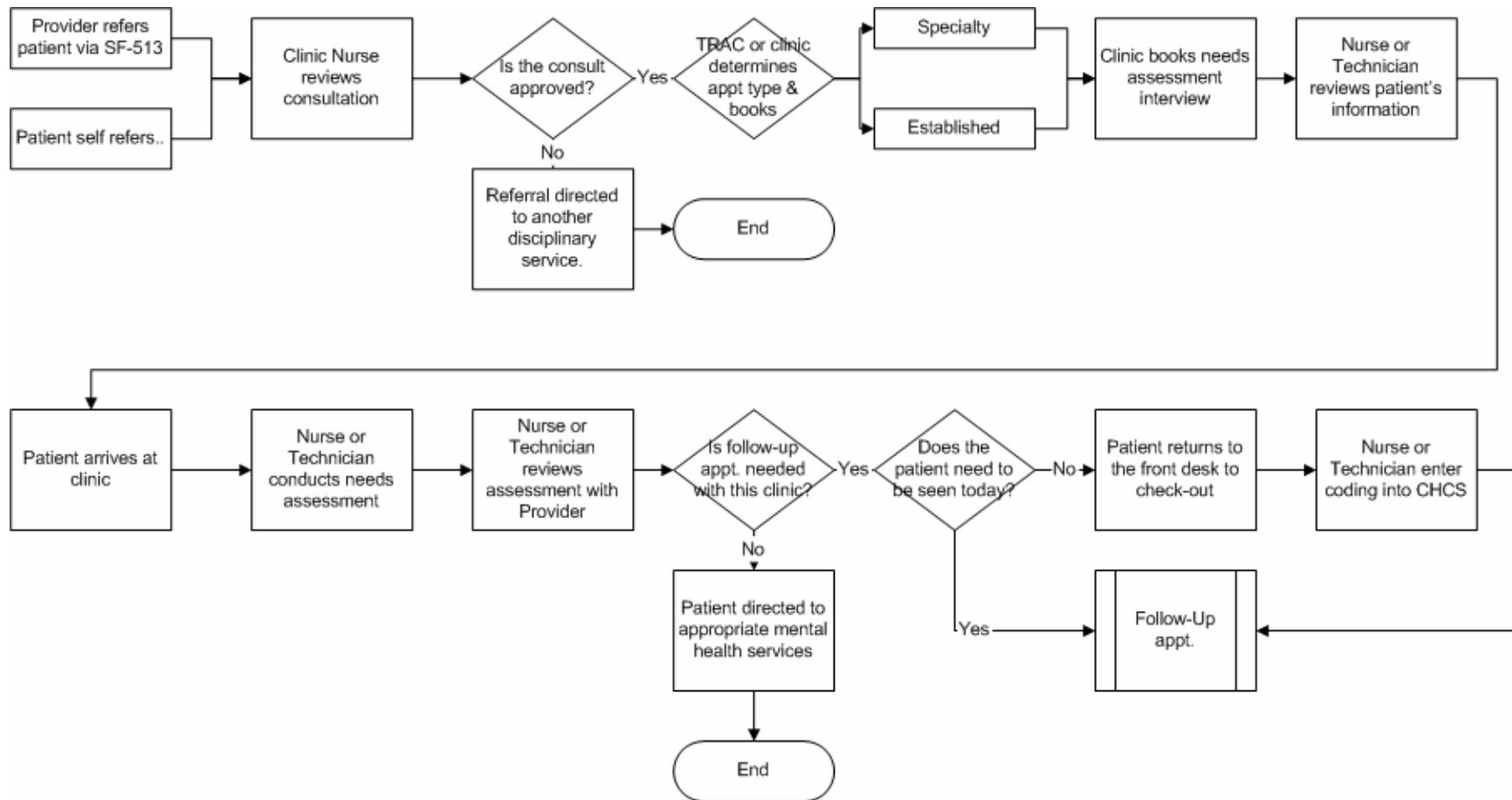
Bremerton Mental Health Clinic

Adult Psychiatry/Psychology Process

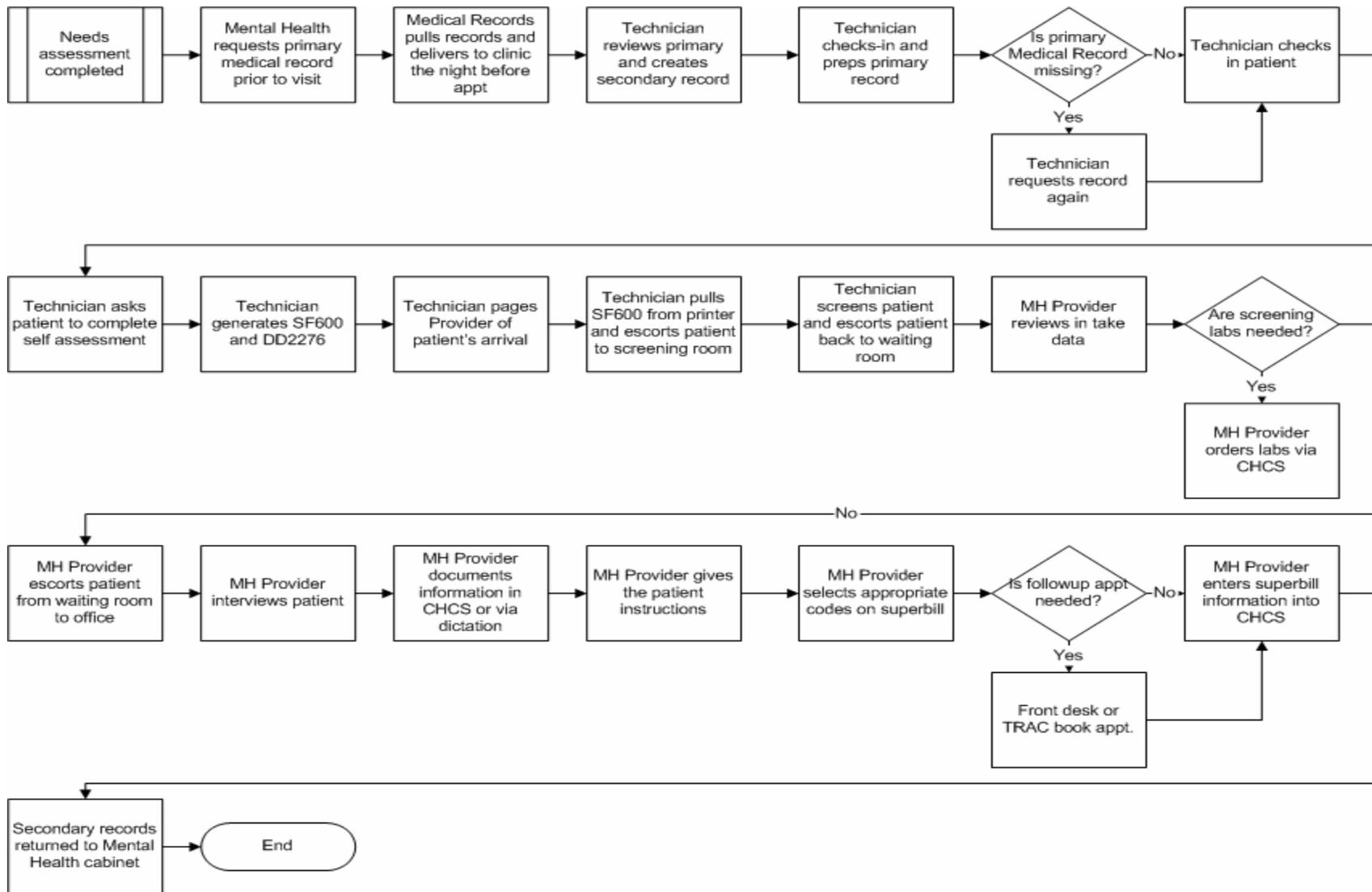
1. Referrals to the Mental Health Clinic are made via the SF-513 consult request initiated by a medical officer, psychologists, physician assistant, independent duty corpsman, primary care providers, specialty clinic providers, and Emergency Department providers. Hard copy patient information is required from the referring facility/provider. The patient can also schedule an appointment as a self-referral for Psychology only.
2. The Clinic Nurse reviews all consultations. If the consult is approved for the MTF, the patient can then call TRAC to schedule an appointment. If the consult is not approved for the MTF, the patient is referred to various multiple disciplinary services via TRI-WEST (managed care).
3. Scheduling: Patient calls Central Call Center (TRAC) or calls the clinic to make an appointment with the Mental Health Clinic. TRI-WEST will contact the patient if the referral is directed to another disciplinary service (i.e., community mental health provider, residential care, etc.).
4. TRAC Representative or the clinic schedules the patient for:
 - a. Specialty Care Appointment: If the patient is scheduling a new visit or a self-referral to Psychology.
 - b. Established Appointment: If the patient requires a follow-up visit for a previously diagnosed condition.
5. Needs Assessment interviews may be scheduled the same day or prior to a new appointment that is scheduled with an Adult Mental Health Provider. The patient will be contacted by the clinic to schedule an initial appointment that will include a Needs Assessment interview. Patients are informed of the Needs Assessment process. The needs assessment appointment is scheduled in an Appointment Book maintained at the Front Desk.
6. On the day of the interview, the Registered Nurse or Psychiatric Technician reviews the patient's medical record, available supplemental information, and the Mental Health Self-Assessment Form prior to the interview.
7. Patient meets with Nurse or Psychiatric Technician for needs assessment interview on the scheduled date.
8. The Registered Nurse or Psychiatric Technician will review the typed Needs Assessment with the Provider. If determined, the patient will meet with the Provider the same day or an appointment was/is booked for a later date and time.
9. The patient returns to the Front Desk to check-out and schedule a follow-up appointment with the Adult Mental Health Provider or is directed to appropriate mental health services as determined by the Needs Assessment interview.
10. The Registered Nurse or Psychiatric Technician enters the ICD, CPT, and E&M codes into CHCS.

11. Mental Health requests the patient's primary record prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Mental Health the night before the patients are scheduled to visit.
12. The Psychiatric Technician reviews the primary record and prepares secondary medical records to segregate sensitive patient information from the primary medical record. The secondary record may contain information supplied by the patient via questionnaires detailing current and past events in their lives as well as information from the primary record, other facilities, mental health testing, & other materials pertaining to current/past mental health conditions, etc.
13. The Psychiatric Technician checks-in and preps the patients' charts when they receive them from medical records. The technician updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the psychiatric technician puts in a second request to medical records to retrieve those records prior to the patient visit.
14. Patient enters clinic and checks-in with a Psychiatric Technician. All new patients are given the Mental Health Self-Assessment Form and the Privacy Act Statement to complete while waiting.
15. The Psychiatric Technician enters the patient in the Mental Health database and generates the SF 600 and DD2276.
16. The Psychiatric Technician pages the Adult Psychiatrist/Psychologist to announce that the patient has arrived for the visit.
17. The Psychiatric Technician retrieves the SF 600 from the printer; calls the patient and escorts the patient to the screening room.
18. The Psychiatric Technician records the patient's vital signs, including pain assessment, on the SF 600, and then escorts the patient back to the waiting room.
19. The Adult Psychiatrist/Psychologist reviews the patient's responses to the Mental Health Self-Assessment Form and reviews the patient's primary medical record (if available).
20. Only Adult Psychiatrists review the patient's appointment list, lab results, x-ray results, and medications in CHCS. For new patients, the Adult Psychiatrist may order screening labs via CHCS if the patient has not had the tests within the past year.
21. The Adult Psychiatrist/Psychologist goes to the waiting room and walks the patient to their office.
22. The Adult Psychiatrist/Psychologist interviews the patient using the proper intake evaluation forms. The Adult Psychiatrist/Psychologist documents the patient note in CHCS or dictates the note.
23. The Adult Psychiatrist/Psychologist gives the patient instructions as to the next steps/treatment plan and selects the appropriate ICD, CPT, and E&M codes for the visit.
24. The patient is taken back to the Front Desk to check-out and schedule a follow-up appointment with the Adult Psychiatrist/Psychologist. The follow-up appointment can also be scheduled via TRAC.

25. The Adult Psychiatrist/Psychologist enters the appropriate ICD, CPT, and E&M codes into CHCS.
26. The secondary medical records are acquired from the Mental Health Clinic and returned at the end of each day to the locked records cabinet located at the Mental Health Division front office. A list of the records is maintained at the Mental Health Clinic front desk.



Adult Psychiatry/Psychology Process Flowchart

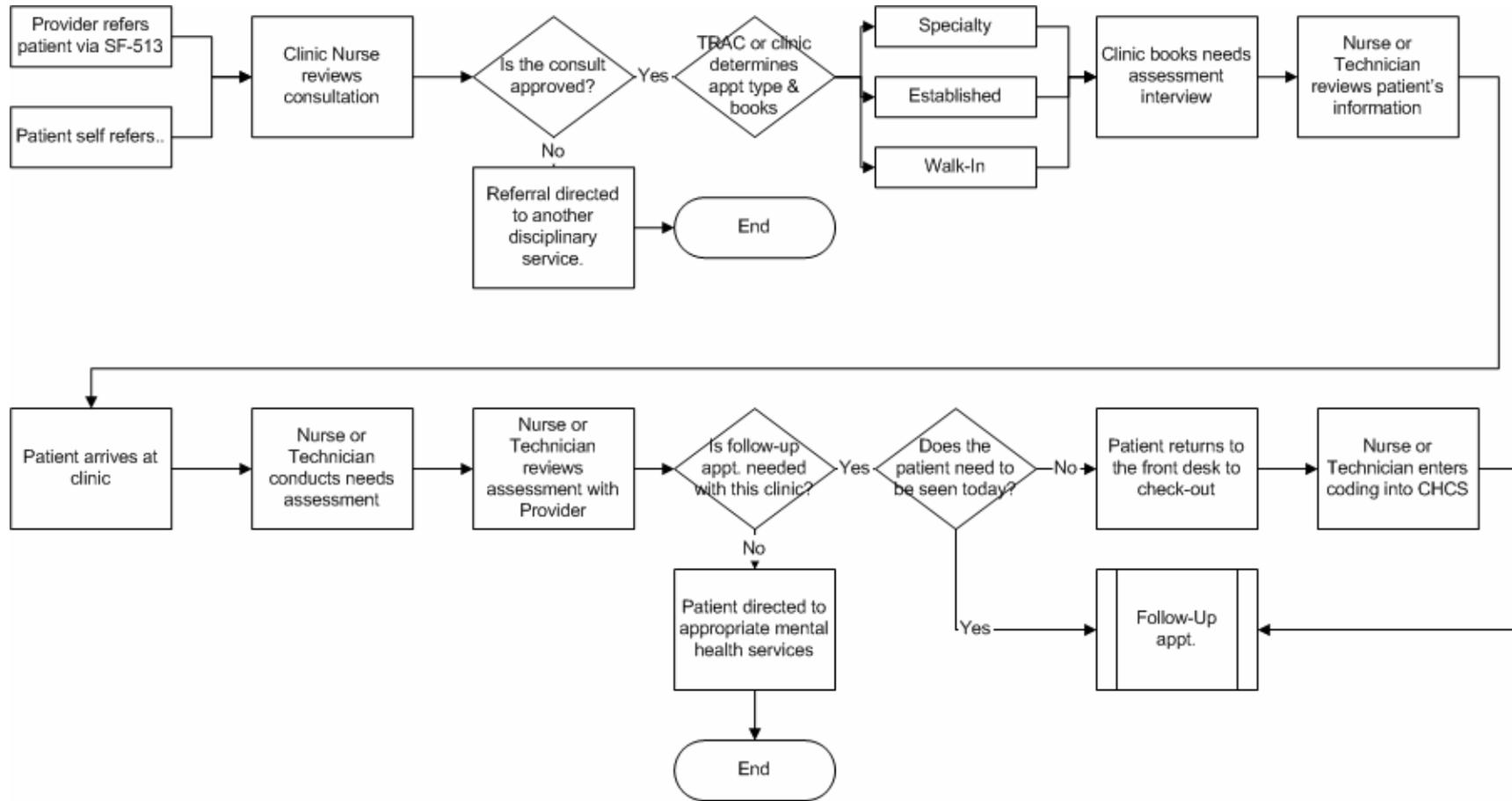


Adult Psychiatry/Psychology Process Flowchart

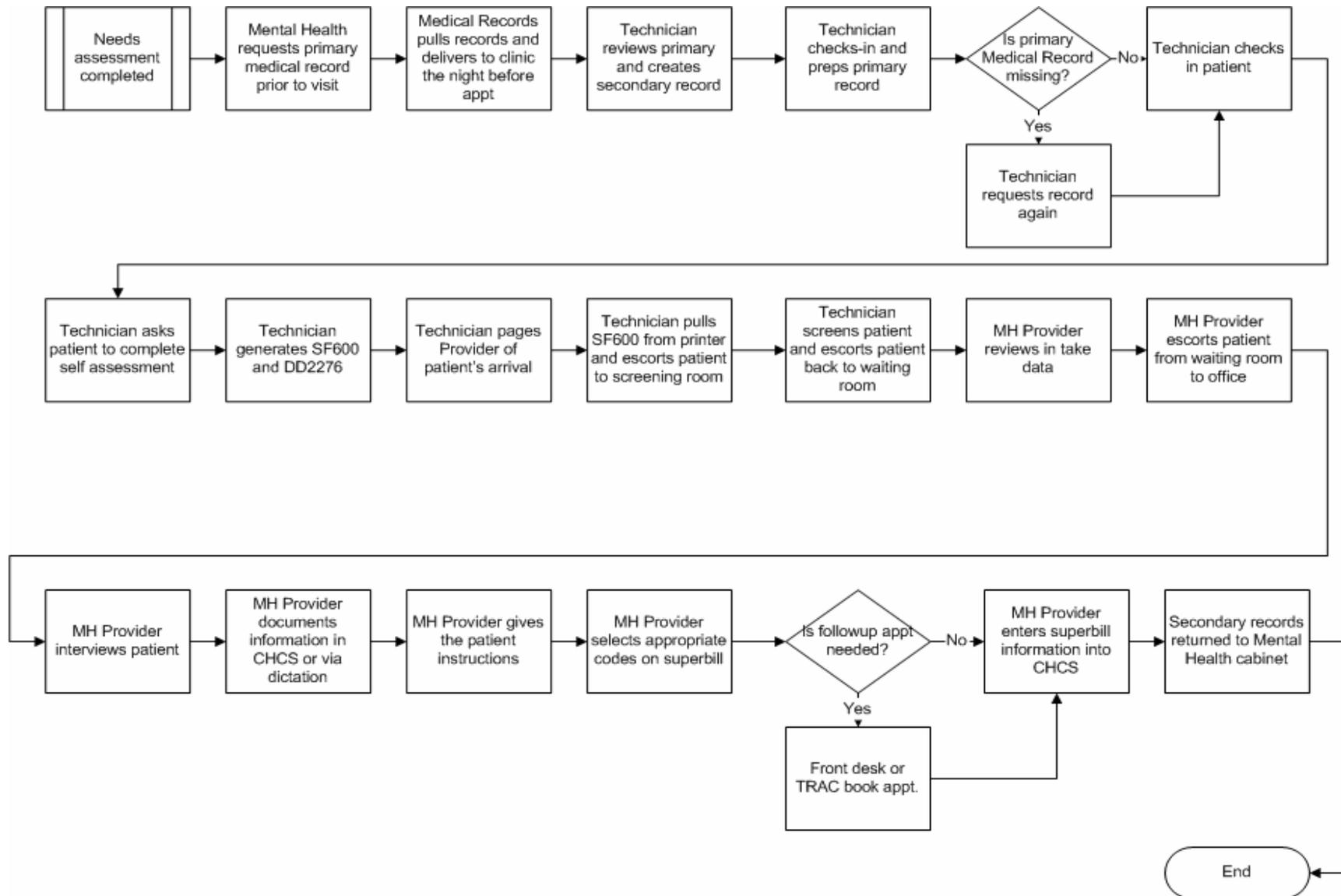
Social Work Process

1. Referrals to the Mental Health Clinic are made via the SF-513 consult request initiated by a medical officer, psychologists, physician assistant, independent duty corpsman, primary care providers, specialty clinic providers, and Emergency Department providers. Hard copy patient information is required from the referring facility/provider. The patient can also schedule an appointment as a self-referral for Psychology only.
2. The Clinic Nurse reviews all consultations. If the consult is approved for the MTF, the patient can then call TRAC to schedule an appointment. If the consult is not approved for the MTF, the patient is referred to various multiple disciplinary services via TRI-WEST (managed care).
3. Scheduling: Patient calls Central Call Center (TRAC) or the clinic to make an appointment with the Mental Health Clinic. TRI-WEST contacts the patient if the referral is directed to another disciplinary service (i.e., community mental health, residential care, etc.).
4. TRAC Representative schedules the patient for:
 - a. Specialty Care Appointment: If the patient is scheduling a new visit or a self-referral to Social Work.
 - b. Established Appointment: If the patient requires a follow-up visit for a previously diagnosed condition.
 - c. Walk-In: During the course of a scheduled appointment with a child/adolescent, the Social Work Provider may request that the Psychiatric Technician create a walk-in appointment for parent(s), sibling(s), or other family members to facilitate family counseling.
5. Needs Assessment interviews may be scheduled the same day or prior to a new appointment with the Adult Mental Health Provider. The patient will be contacted by the clinic to schedule an initial appointment that will include a Needs Assessment interview. Patients are informed of the Needs Assessment process. The needs assessment appointment is scheduled in an Appointment Book maintained at the Front Desk.
6. On the day of the needs interview, the Registered Nurse or Psychiatric Technician reviews the patient's medical record, available supplemental information, and the Mental Health Self-Assessment Form prior to the interview.
7. Patient meets with Nurse or Psychiatric Technician for needs assessment interview on the scheduled date.
8. The Registered Nurse or Psychiatric Technician will review the typed Needs Assessment with the Provider. If determined, the patient will meet with the Provider the same day or an appointment is booked for a later date and time.
9. The patient returns to the Front Desk to check-out and schedule a follow-up appointment with the Adult Mental Health Provider or is directed to appropriate mental health services as determined by the Needs Assessment interview.
10. The Registered Nurse or Psychiatric Technician enters the ICD, CPT, and E&M codes into CHCS.

11. Mental Health requests the patient's primary record prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Mental Health the night before the patients are scheduled to visit.
12. The Psychiatric Technician reviews the primary record and prepares secondary medical records to segregate sensitive patient information from the primary medical record. The secondary record may contain information supplied by the patient via questionnaires detailing current and past events in their lives as well as information from the primary record, other facilities, mental health testing, & other materials pertaining to mental health conditions, etc.
13. The Psychiatric Technician checks-in and preps the patients' charts when they receive them from medical records. The technician updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the technician puts in a second request to medical records to retrieve those records prior to the patient visit.
14. Patient enters clinic and checks-in with a Psychiatric Technician. All new patients are given the Mental Health Self-Assessment Form and the Privacy Act Statement to complete while waiting.
15. The Psychiatric Technician enters the patient in the Mental Health database and generates the SF 600 and DD2276.
16. The Psychiatric Technician pages the Social Work Provider to announce that the patient has arrived for the visit.
17. The Psychiatric Technician retrieves the SF 600 from the printer.
18. The Social Work Provider reviews the patient's responses to the Mental Health Self-Assessment Form and reviews the patient's primary medical record (if available).
19. The Social Work Provider goes to the waiting room and walks the patient to their office.
20. The Social Work Provider interviews the patient using the proper intake evaluation forms. The Social Work Provider documents the patient note in CHCS or dictates the note.
21. The Social Work Provider gives the patient instructions as to the next steps/treatment plans and selects the appropriate ICD, CPT, and E&M codes for the visit.
22. The patient is taken back to the Front Desk to check-out and schedule a follow-up appointment with the Social Work Provider. The follow-up appointment can also be scheduled via TRAC.
23. The Social Work Provider enters the appropriate ICD, CPT, and E&M codes into CHCS.
24. The secondary medical records are acquired from the Mental Health Clinic and returned at the end of each day to the locked records cabinet located at the Mental Health Division front office. A list of the records is maintained at the Mental Health Clinic front desk.



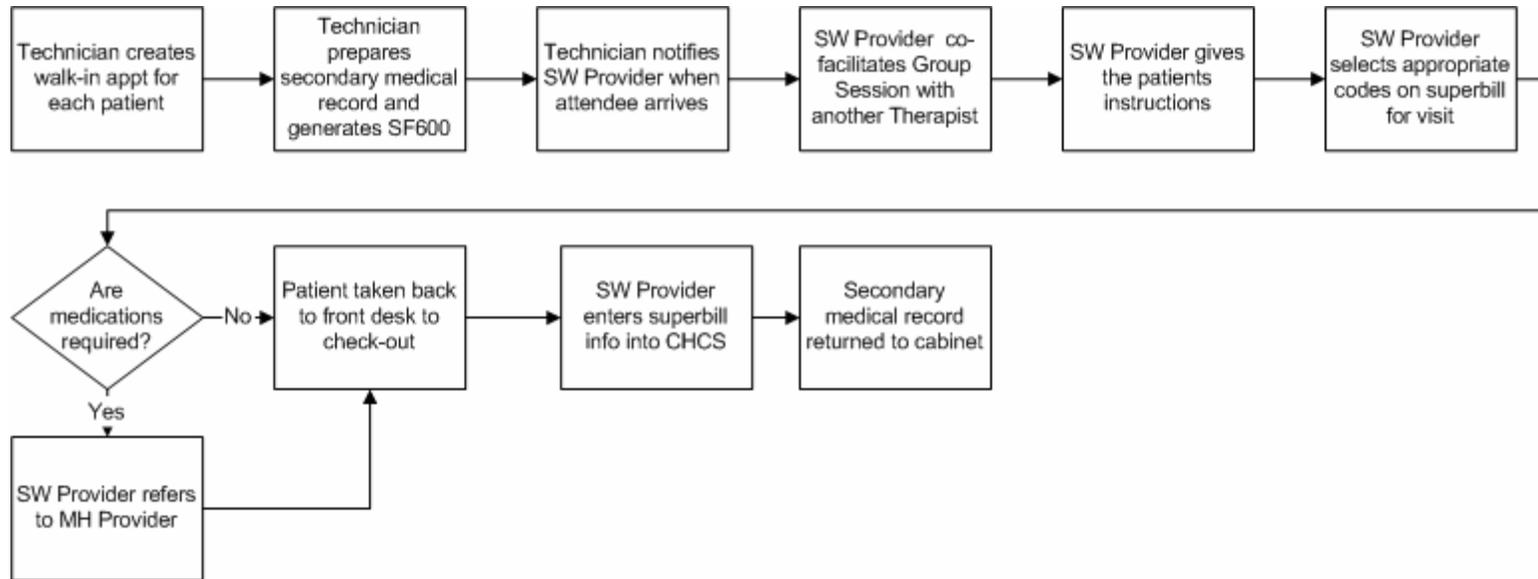
Social Work Process Flowchart



Social Work Process Flowchart

Social Work Groups Process

1. The Psychiatric Technician creates a walk-in appointment for each patient attending the Group Session with the Social Work Provider.
2. The Psychiatric Technician prepares secondary medical records for the Group patients and generates the SF 600s.
3. The Psychiatric Technician notifies the Social Work Provider as each group attendee arrives at the clinic.
4. The Social Work Provider co-facilitates the Group Session with another therapist from the Mental Health Clinic.
5. The Social Work Provider gives the patients instructions as to the next steps and selects the appropriate ICD, CPT, and E&M codes for the visit. If a patient requires medication, the Social Work Provider may refer the patient to one of the Mental Health Providers.
6. The patient is taken back to the Front Desk to check-out.
7. The Social Work Provider enters the appropriate ICD, CPT, and E&M codes into CHCS.
8. The secondary medical records are acquired from the Mental Health Clinic and returned at the end of each day to the locked records cabinet located at the Mental Health Division front office. A list of the records is maintained at the Mental Health Clinic front desk.

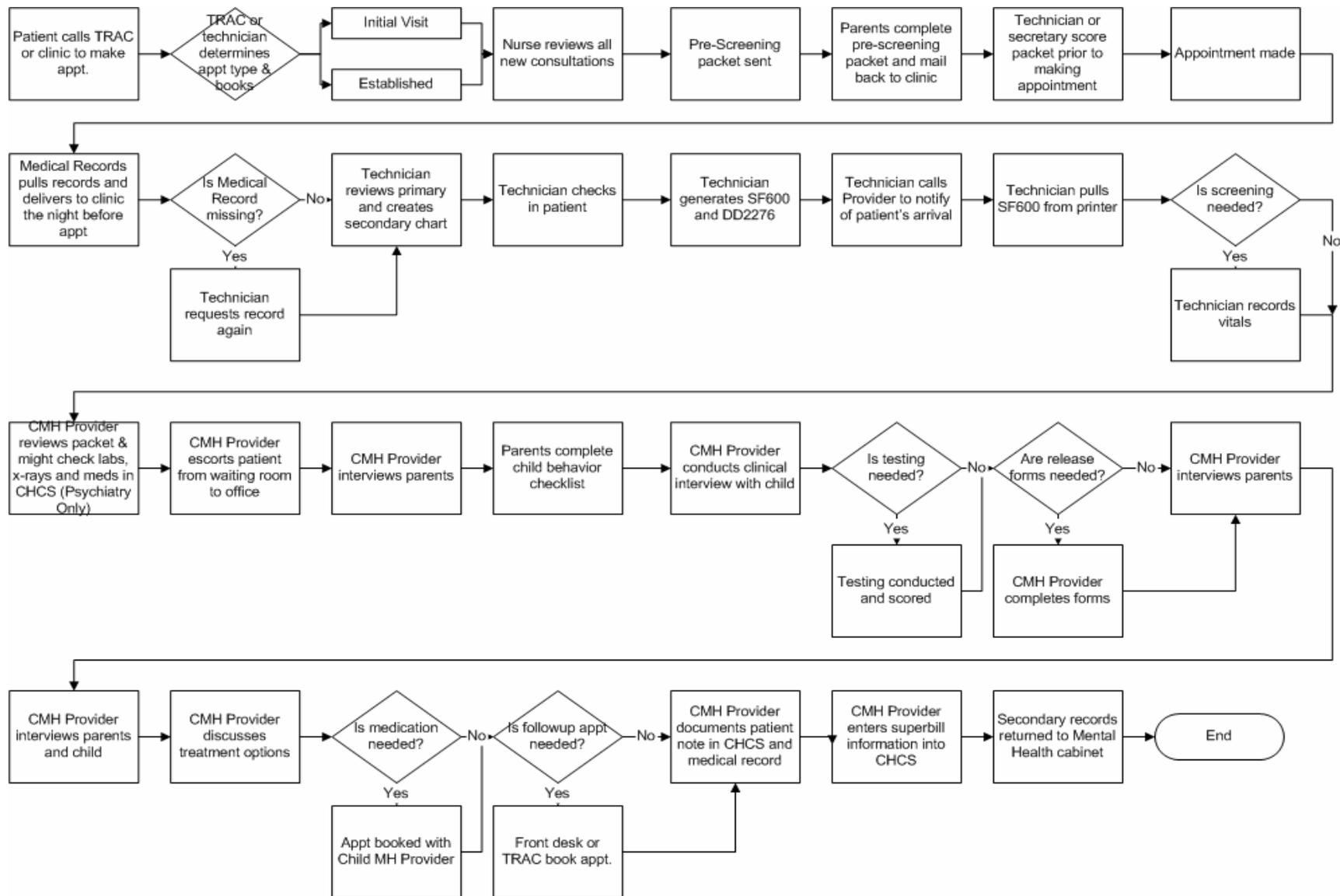


Social Work Groups Process Flowchart

Child and Adolescent Mental Health Providers Process

1. Scheduling: Patient calls Central Call Center (TRAC) or clinic to make an appointment.
2. TRAC Representative or clinic technician schedules the patient for:
 - a. Initial Visit: If the patient is referred to the clinic by the primary care provider.
 - b. Established Appointment: If the patient requires a follow-up visit for a previously diagnosed condition.
3. The routine consultation is initially reviewed by a Clinic Nurse for accuracy and appropriateness of urgency. The new appointment is scheduled through either TRAC or the Child and Adolescent Mental Health Front Desk.
4. Once the new consult has been entered into CHCS, a Pre-Screening Packet (Welcome Letter, Release of Information, Provider Specified Testing, Patient Information Form, etc.) is assembled and mailed out by the Child and Adolescent Division for review, completion, and signature by the parents, who are asked to return the packet to the clinic.
5. Once the Pre-Screening Packet is received by the Child and Adolescent Division, an appointment is scheduled for the patient. The completed packet is filed in the patient's secondary mental health record.
6. Any testing completed as part of the Pre-Screening Packet should be scored by the Psychiatric Technician or Clinic Secretary Prior to the patient's appointment.
7. Mental Health requests the patient's primary record prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Mental Health the night before the patients are scheduled to visit.
8. The Psychiatric Technician checks-in and preps the patients' charts when they receive them from medical records. The technician updates the charts with test results, consults, etc., when appropriate. If a medical record is missing, the psychiatric technician puts in a second request to medical records to retrieve those records prior to the patient visit.
9. The Psychiatric Technician reviews the primary record and prepares secondary medical records to segregate sensitive patient information from the primary medical record. The secondary record may contain information supplied by the patient via questionnaires detailing current and past events in their lives, testing, & other information that pertains to current mental health issues.
10. Patient enters clinic and checks-in with a Psychiatric Technician.
11. The Psychiatric Technician enters the patient in the system and generates the SF 600 and DD2276.
12. The Psychiatric Technician calls/pages the Child Mental Health Provider to announce that the patient has arrived for the visit.
13. The Psychiatric Technician retrieves the SF 600 from the printer.
14. When indicated, the Psychiatric Technician records the patient's vital signs on the SF 600 (vital signs are done only for Child Psychiatrist visits!).

15. The Child Mental Health Provider reviews the patient's responses to the Pre-Screening Packet and reviews the patient's primary medical record (if available).
16. The Child psychiatrist only- reviews the patient's appointment list, lab results, x-ray results, and medications in CHCS.
17. The Child Mental Health Provider goes to the waiting room and walks the patient to their office.
18. The Child Mental Health Provider interviews the patient/parent(s) to establish the problem and find determine the reason for the clinic visit.
19. The Child Mental Health Provider asks the parent(s) to complete the Child Behavior Checklist to rate their child's behavior in certain areas. The parent(s) will complete the checklist in another room.
20. While the parent(s) complete the assessments, the Child Mental Health Provider conducts a clinical interview with the child, which consists of observations, psychological assessments, and projective drawings. The child (depending on age) is also given a series of tests.
21. Depending on the reasons for the clinic visit, the child/adolescent may be taken to the Testing Room to complete computerized assessments, such as the ADHD Assessment and MMPI for Adolescents. The Psychiatric Technician will take the patient to the Testing Room and facilitate the test.
22. The Psychiatric Technicians and Clinic Secretary are trained to score certain psychological tests. Once scored, the test results are given to the Child Psychologist for review.
23. Depending on the reason for the clinic visit, the Child Mental Health Provider may send release forms to other individuals who interact with the child/adolescent on a daily basis. Release forms may be sent to school teachers, daycare providers, youth leaders, etc.
24. After completing the Child Behavior Checklist, the parents are interviewed without the child to evaluate their perceptions of the child's behavior.
25. During the parent(s)/child interview, the Child Mental Health Provider observes the interaction/dynamics between the parent(s)/child.
26. At the end of the visit, the Child Mental Health Provider discusses treatment options with the parent. If medication is an option, an appointment may be scheduled with the Child/Adolescent Psychiatrist.
27. The patient/parents are walked to the Front Desk to schedule a follow-up appointment per the Child Mental Health Provider's recommendation.
28. The Child Mental Health Provider documents the patient note in CHCS and the medical record.
29. The Child Mental Health Provider enters the appropriate ICD, CPT, and E&M codes into CHCS.
30. The secondary medical records are acquired from the Mental Health Clinic and returned at the end of each day to the locked records cabinet located at the Mental Health Division front office. A list of the records is maintained at the Mental Health Clinic front desk.



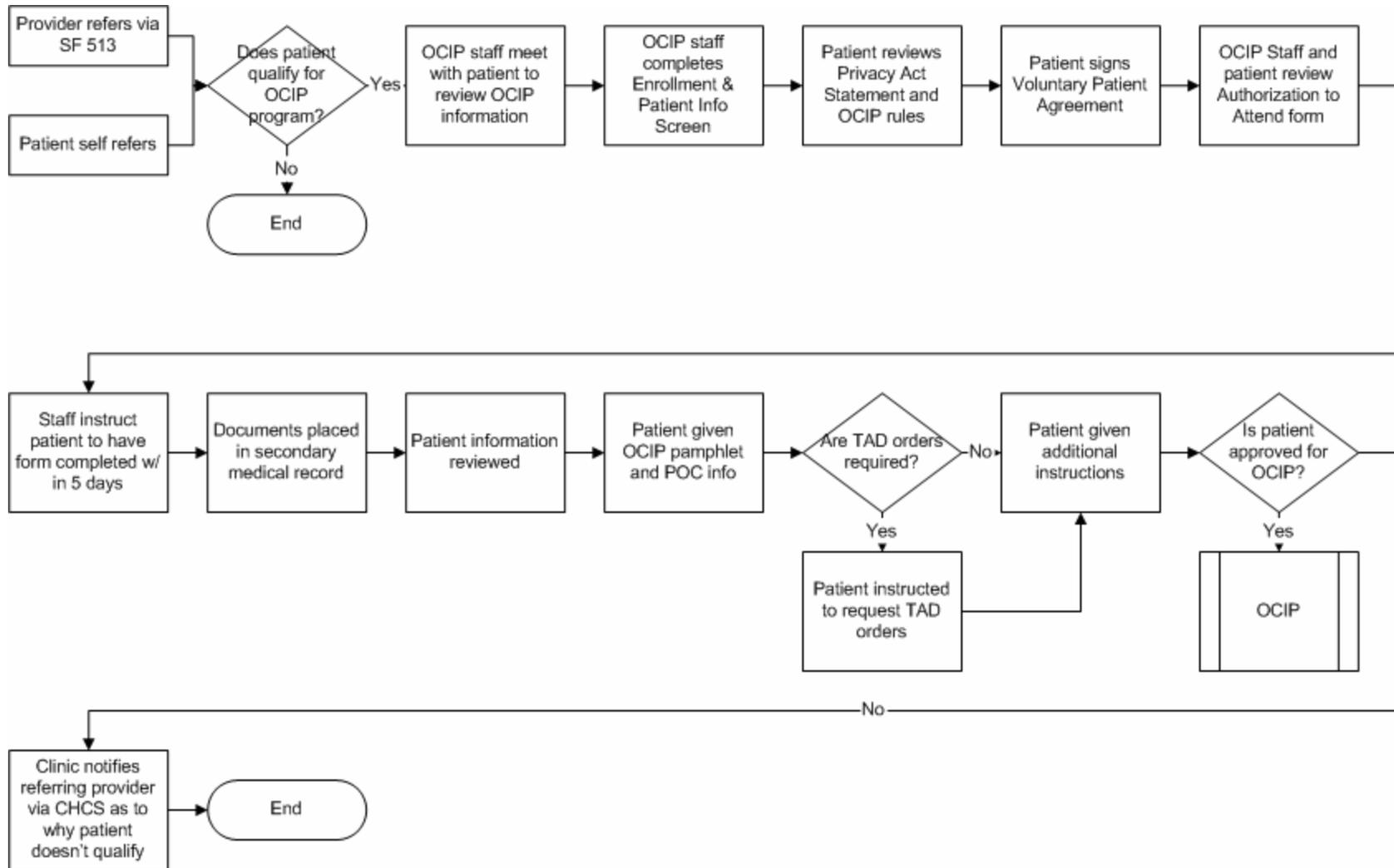
Child and Adolescent Mental Health Providers Process Flowchart

Outpatient Crisis Intervention Program (OCIP) Process

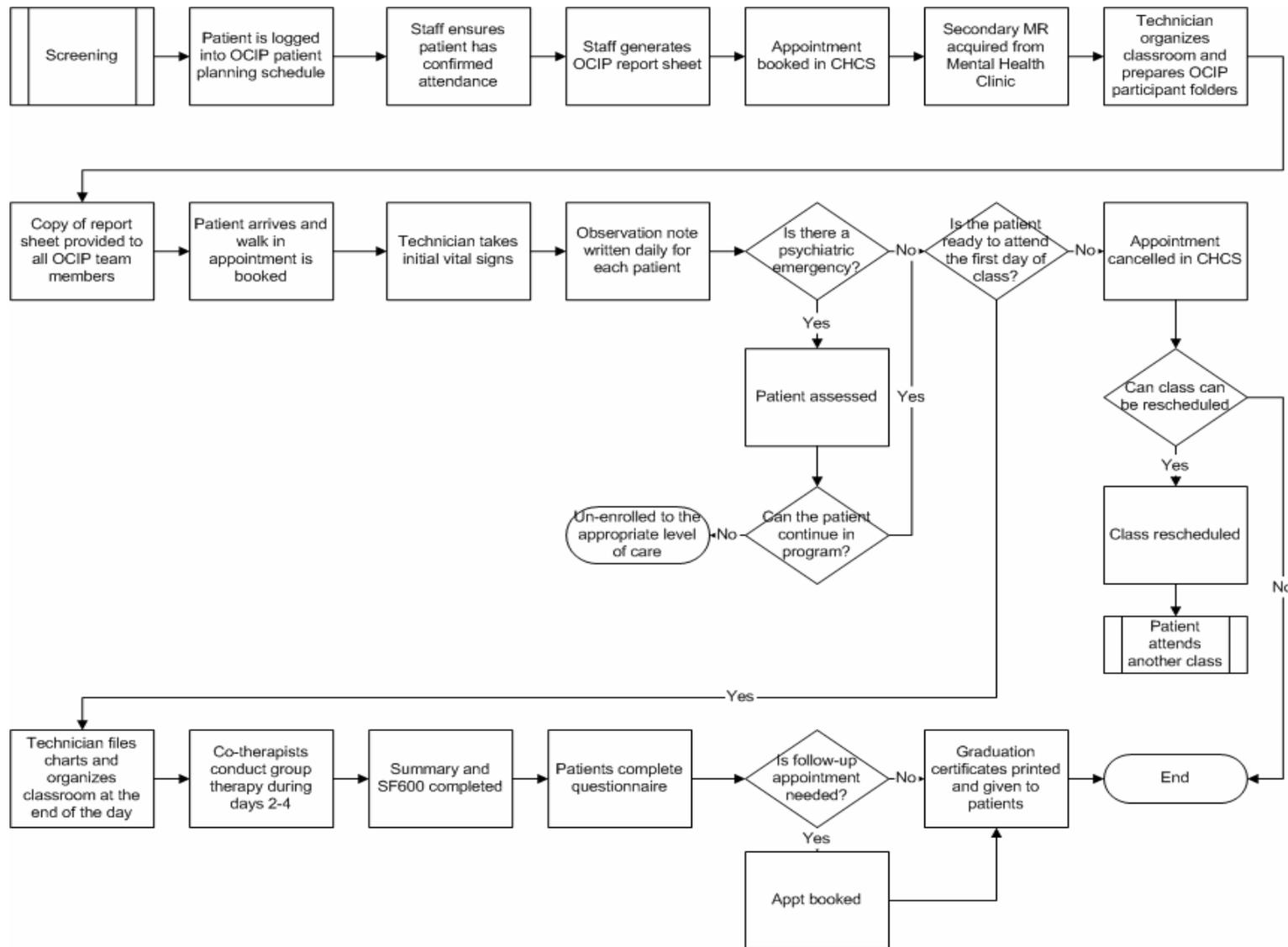
1. Scheduling: Attendance in the OCIP classes is treated as a scheduled appointment. Scheduled consults for OCIP classes are treated as SPEC appointments. (patients may self refer to OCIP)
2. The SF 513 referral form, Standard Mental Health Division intake evaluation and completed OCIP forms are required for OCIP enrollment.
3. To qualify for enrollment in the OCIP, a patient:
 - a. Must be experiencing a crisis or benefit from life skills education training.
 - b. Cannot be actively suicidal or homicidal and must contract for safety while participating in the program.
 - c. Must have approval from their command to participate. (If active duty)
 - d. Must be active duty service member, dependent, DoD employee, or retiree.
4. Upon receipt of a completed SF 513 consult request, OCIP staff will meet with the patient to review the OCIP class schedule, OCIP rules, and general information pamphlet to determine if the patient would like to participate in the program. Patient is screened for appropriateness to attend next class. If patient does not pass screening, they will not be allowed to participate in OCIP (i.e., active psychosis, delusional, etc.)
5. Per information reported by the patient, the OCIP staff will complete the OCIP Enrollment and Patient Information Screen.
6. The patient is asked to review the Privacy Act Statement and OCIP Class Rules prior to signing the Voluntary Patient Agreement.
7. The OCIP Staff and patient will review the Authorization to Attend NHB OCIP form and instruct the patient to have his/her supervisor fax the completed form to OCIP within 5 working days.
8. The Voluntary Patient Agreement and the original copy of the SF 600 titled OCIP Treatment Plan are placed into the patient's secondary mental health record. OCIP screening includes a review of the past visits/interactions and notes in the Mental Health Division secondary medical record, patient questionnaire, and completion of the SF 600 titled OCIP Treatment Plan.
9. The patient is given an OCIP pamphlet, point of contact, and telephone number for any questions that may arise.
10. If the patient is Active Duty, the patient is instructed to request TAD orders if their command will be at sea or if there is a significant distance from the hospital. TAD orders are required for berthing assignment at Schon Hall. Alternative berthing is available at Naval Station Bremerton and Bangor's BEQs. TAD orders are required for meals or those who do not receive comrats.
11. The patient is advised to bring lunch, use RIK card in the galley, or purchase lunch.
12. The patient is instructed to bring their primary medical record the first day of class.

13. The OCIP Screening is concluded. Patient is screened by the interviewer, to be approved/disapproved for the class. If not approved, patient is sent back to referring Provider and a CHCS message is sent to why this patient is not suitable for the program.
14. The patient is logged into the OCIP Patient Planning Schedule. The Statement of Agreement, returned Fax authorization form and enrollment screen are filled for the week the patient has been scheduled to attend the OCIP classes.
15. The patient obligations for the OCIP are as follows:
 - a. Read OCIP Class Rules.
 - b. Ask work supervisor to sign and fax to OCIP the Authorization to Attend NHB, Bremerton OCIP.
 - c. Bring Primary Medical Record on the first day of class.
 - d. Attend class in appropriate civilian attire.
 - e. Actively participate in all OCIP activities, abiding by class rules.
 - f. Maintain group participant privacy and confidentiality.
16. The OCIP staff ensures that the patient has confirmed their attendance by the Thursday before the first day of OCIP (via the supervisor signed copy of the Authorization to Attend NHB OCIP form). If the form has not been returned, the Nurse Manager or Psychiatric Technician will call the patient and/or their command by 1300.
17. The OCIP staff generates the OCIP report sheet (class roster) and a pre-group team meeting is held the Friday before the first day of OCIP to assess the makeup and needs of the group and the OCIP team.
18. The patient's appointment is scheduled in CHCS as same day booking, and, as a result, ADM sheets are generated daily during the patient's enrollment period. Generally, it is best to wait until the Monday morning start of OCIP to enter the appointments in CHCS as enrollment and attendance may change.
19. The secondary medical records are acquired from the Mental Health Clinic and returned at the end of each day to the locked records cabinet located at the Mental Health Division front office. A list of the records is maintained at the Mental Health Clinic front desk.
20. The assigned Psychiatric Technician will organize the classroom, return the secondary records, and prepare the OCIP participant folders.
21. During OCIP weeks, a copy of the OCIP report sheet is provided to all OCIP team members and Division Head. A brief summary of the patient's intake summary, including diagnosis and consult concerns are included. All CHCS entries for patients in attendance are made by the designated Psychiatric Technician.
22. When the patient arrives for the first day of the OCIP class, a same-day appointment is created in CHCS as a SPEC appointment and an ADM is manually generated for each co-therapist facilitating the OCIP course.
23. The Psychiatric Technician will take initial vital signs and document on the patient's SF 600 only on the Screening Date. If the vitals are not within normal limits, the OCIP Director or an MO in the Mental Health Division will be informed per clinic policy.

24. An observation note will be written daily for each patient in attendance.
25. The OCIP staff member will chart the patient's group participation (group note to be signed by group co-therapists) using the Group Notes SF 600 Overprint.
26. In case of a psychiatric emergency (suicidal or homicidal ideation or significant agitation): Assess the patient; notify the responsible Provider, if available. If the responsible Provider is not available, contact the Day Watch Officer and the OCIP Division Officer. After the evaluation, the treatment team will make a decision as to the patient's status. In case of disruption or unwillingness to participate, the patient will see a Program Director for appropriateness to attend class, dis-enroll, or to be scheduled for a future class.
27. If the patient does not attend the first day of class, the Psychiatric Technician will chart on the SF 600 that the patient was a "no-show". The secondary chart is updated and a follow-up phone call ensues with the patient and/or their supervisor. The OCIP Nurse is informed of the situation and the patient's chart is placed in the appropriate Provider's box. If the patient desires to reschedule, the OCIP team will meet to decide if this is feasible.
28. The Psychiatric Technician will access the CHCS II End of Day (EOD) and record if patients kept their appointment for the OCIP. If the patient did not keep the appointment, it needs to be cancelled for that day in the CHCS EOD report. The appointment will be cancelled for the rest of the week in the appropriate appointment category.
29. The assigned Psychiatric Technician will file the secondary charts in the locked records cabinet, organize the classroom, and ensure that all charting is complete for the day and that all doors are locked at the close of business.
30. Days 2-4 of the OCIP will consist of group therapy meetings facilitated by the co-therapists.
31. On the final day of the OCIP, a text summary is completed for each patient and signed by the OCIP Director. An original copy of the summary is placed in the patient's primary medical record and a copy is placed in the secondary record.
32. At the completion of the OCIP, the OCIP Final Team Note SF 600 Overprint will be completed by the treatment team for every patient.
33. Patients are asked to complete the SCL-90-R Post OCIP Questionnaire (if applicable) and OCIP Program Evaluation Form.
34. If the patient has not previously provided the OCIP staff with follow-up appointment information, this should be scheduled prior to leaving the clinic as this information is documented on the OCIP Final Team Note.
35. Graduation certificates are pre-printed and given to the patients during the graduation ceremony.
36. Patients may go through OCIP twice, if requested and justified by the responsible Provider; however, each time a full screening and intake assessment will be performed by the OCIP staff. Please note, patient must have successfully completed the program and must wait 6 months between classes.



OCIP Process Flowchart



OCIP Process Flowchart

Bremerton Mental Health Clinic Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Specialty Appointment	SPEC	60-120 minutes	Clinic staff	If the patient requires a specialty care appointment.
Established Appointment	EST	30-60 minutes	Clinic staff	If the patient requires follow-up care.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Outpatient Mental Health Clinic Procedures, Record Keeping and Confidentiality/HIPAA Policy	Clinic form	Patient	SPEC, EST	
Naval Hospital Bremerton Mental Health Department Patients' Bill of Rights and Responsibilities	Clinic form	Patient	SPEC	
Privacy Act Statement DD Form 2005 (1 Feb 76)	S/N 0102-LF-002-0051	Patient	SPEC	
Self-Assessment Tool/Form	Clinic form	Patient	SPEC	
Initial Intake Form (II. HISTORY OF PRESENT ILLNESS)	Clinic form	Clinic staff	SPEC	Forms used for both child and adult patients. (age specific)
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Routine Provider Intake Evaluation	NSN 7540-00-634-4176	Clinic staff	SPEC	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Patient Identification (Subjective/Objective Findings)	NSN 7540-00-634-4176	Mental health staff	SPEC	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Patient Interval History Questionnaire	NSN 7540-00-634-4176	Mental health staff	SPEC,EST	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Psychiatric Evaluation	NSN 7540-00-634-4176	Mental health staff	SPEC	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Psychiatric Medication Consultation Appt	NSN 7540-00-634-4176	Provider	SPEC	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Psychiatry Medication Management Follow-Up Appt	NSN 7540-00-634-4176	Provider	EST	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Psychological Evaluation	NSN 7540-00-634-4176	Provider	EST	
Intake Evaluation	N/A	Provider	SPEC	
Follow-Up Evaluation	N/A	Provider	EST	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Progress Note	NSN 7540-00-634-4176	Provider	EST	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Mental Health Consultation Report (Chief Complaint)	NSN 7540-00-634-4176	Psychiatric Technician	SPEC	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – Mental Health Consultation Report (Reason for Request)	NSN 7540-00-634-4176	Psychiatric Technician	SPEC	
Emergency Room Evaluation of Mental Health Patients	NHBREM 6000/64(6-99)	Mental Health Provider/ER Provider	SPEC, EST	
Health Record Receipt	NAVMED 6150/7 (2-74)	Psychiatric Technician	SPEC, EST	
Voluntary Observation Statement (Madigan)	N/A	Patient/Witness	SPEC, EST	
Utilization Review Tracking Sheet (Outpt Clinic Visits – Jan 2002)	N/A	Clinic Secretary & Clinic Nurse	SPEC, EST	
Authorization for Psychiatric Service Treatment	DA Form 4359, Feb 2003	Patient/Admitting Physician	SPEC, EST	
Authorization for Disclosure of Medical or Dental Information – Privacy Act Statement	DD Form 2870, Dec 2003	Patient	SPEC, EST	
Inpatient (IP) Emergency Admission Mental Health/Detox	FR340006PRAL0604 T	Provider	SPEC, EST	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Naval Hospital Bremerton Patient Transportation Request	NH BREM 615/73 (8-98)	Provider	SPEC, EST	
Physician Certificate of Transfer	N/A	DOCTORS	SPEC, EST	
Case Management/Nurse Visit Tracking Form	N/A	Nurse	SPEC, EST	
T-Con Form	N/A	STAFF	SPEC, EST	
Telephone Triage for Suicidal Caller	N/A	STAFF	SPEC, EST	
Child & Adolescent Division – Initial Visit Packet	Various	Parent/Guardian	SPEC	
Child Assessment Form	N/A	Psychiatric Technician/Provider		
NH Bremerton Child & Adolescent Mental Health Clinic SF 600 Automated Version (9/97) – Child & Adolescent Mental Health Clinic Note	NSN 7540-00-634-4176	Provider (Bachen)	EST	
NH Bremerton Child & Adolescent Mental Health Clinic SF 600 Automated Version (9/97) – Child & Adolescent Mental Health Clinic Note	NSN 7540-00-634-4176	Provider (Clem)	EST	
Conners' Parent Rating Scale – Revised (L)	Copyright 1997	Parent/Guardian	SPEC, EST	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Conners' Parent Rating Scale – Revised (S)	Copyright 1997	Parent/Guardian	SPEC, EST	
Beck Inventory	N/A	Patient (Child/Adolescent)	SPEC, EST	
CDI	Copyright 1982	Patient (Child/Adolescent)	SPEC, EST	
Child Behavior Checklist for Ages 2-3	Copyright 1988	Parent/Guardian	SPEC, EST	
Child Behavior Checklist for Ages 6-18	6-1-01 Edition – 201	Parent/Guardian	SPEC, EST	
The Piers-Harris Children's Self-Concept Scale	W-180J	Patient (Child/Adolescent)	SPEC, EST	
“What I Think and Feel” (RCMAS)	W-199D	Patient (Child/Adolescent)	SPEC, EST	
Youth Self-Report for Ages 11-18	4-95 Edition	Patient (Child/Adolescent)	SPEC, EST	
Teacher's Report Form for Ages 5-18	4-95 Edition	Teacher	SPEC, EST	
CAARS-Self Report: Long Version (CAARS-S:L)	Copyright 1998	Patient (Adult)	SPEC, EST	
NH Bremerton Child & Adolescent Mental Health Clinic SF 600 Automated Version (9/97) – Psychiatric Technician/Clinic Nurse Needs Assessment Report	NSN 7540-00-634-4176	Psychiatric Technician/Clinic Nurse	SPEC	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
NH Bremerton Child & Adolescent Mental Health Clinic SF 600 Automated Version (9/97) – Provider Intake Evaluation	NSN 7540-00-634-4176	Provider	SPEC	
OCIP Program Evaluation Form Patient/Staff Instructions	N/A	Patient/OCIP Staff	EST	
Consultation Sheet – Medical Record SF 513 (Rev 4-98)	GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)	Provider	SPEC	
OCIP Enrollment and Patient Information Screen	N/A	Patient	SPEC	
OCIP Attendance Authorization Form	N/A	Command Supervisor	SPEC,EST	
OCIP Voluntary Patient Agreement	N/A	Patient	SPEC	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – OCIP Enrollment Treatment Plan	NSN 7540-00-634-4176	OCIP Staff	SPEC	
NH Bremerton Child & Adolescent Mental Health Clinic SF 600 Automated Version (9/97) – Review of OCIP with Patient	NSN 7540-00-634-4176	OCIP Staff	SPEC	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – OCIP Follow-Up Group Notes	NSN 7540-00-634-4176	OCIP Staff	EST	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – OCIP Final Team Note	NSN 7540-00-634-4176	OCIP Staff	EST	
NH Bremerton Mental Health Clinic SF 600 Automated Version (9/97) – OCIP Treatment Summary	NSN 7540-00-634-4176	OCIP Staff	EST	
NH Bremerton OCIP Program Certificate of Completion	N/A	OCIP Director	EST	
Dictation	Based on patient's name, SSN, SSSN	STAFF	All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Other Family Circumstances (V61) – Counseling for Parent - Child Problem, Unspecified (V61.20) – Counseling for Marital and Partner Problems, Unspecified (V61.10)	
Depressive Disorder, Not Elsewhere Classified (311)	
Affective Psychoses (296)	
Neurotic Disorders (300)	
Adjustment Reaction (309)	
Hyperkinetic Syndrome of Childhood (314)	ADHD Guideline
Other Psychosocial Circumstances (V62)	
Personality Disorders (301)	
Disturbance of Emotions Specific to Childhood & Adolescence (313)	
Other Well Persons Seeking Consultation Without Complaint, Sickness (V65)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

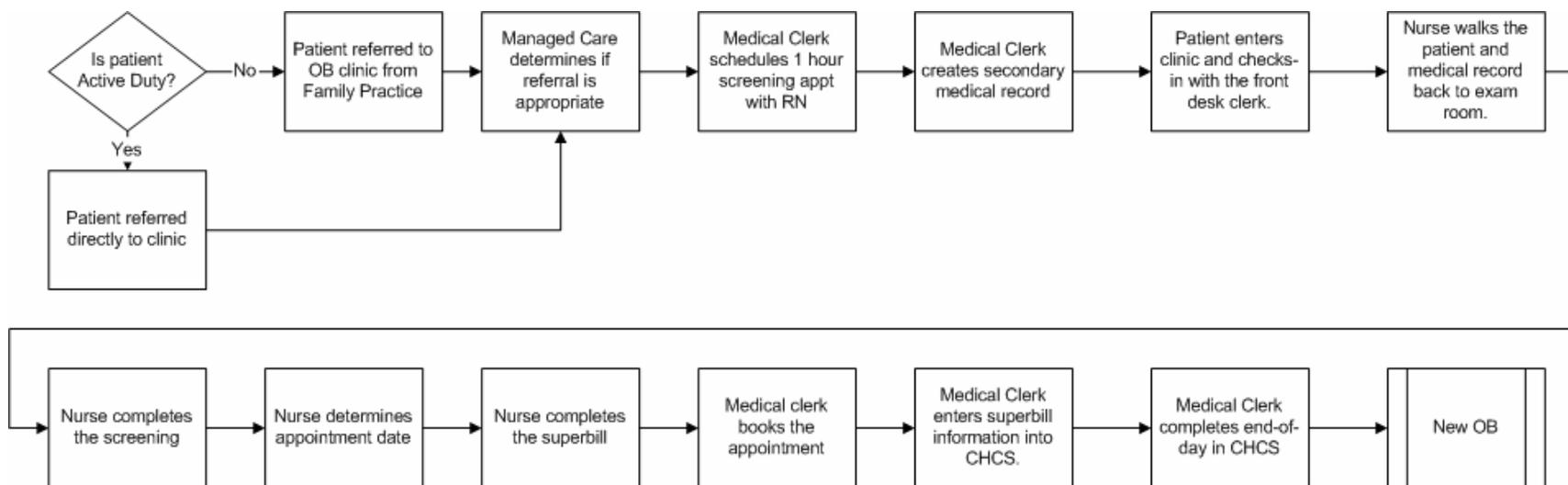
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
<p>Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.</p>					
Manage network purchased care.					
Develop a coding education and training program					
<p>Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.</p>					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
<p>People: Develop an efficient integrated human capital strategy to optimize mission accomplishments</p>					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Bremerton Obstetrics Clinic

New OB Screening Process

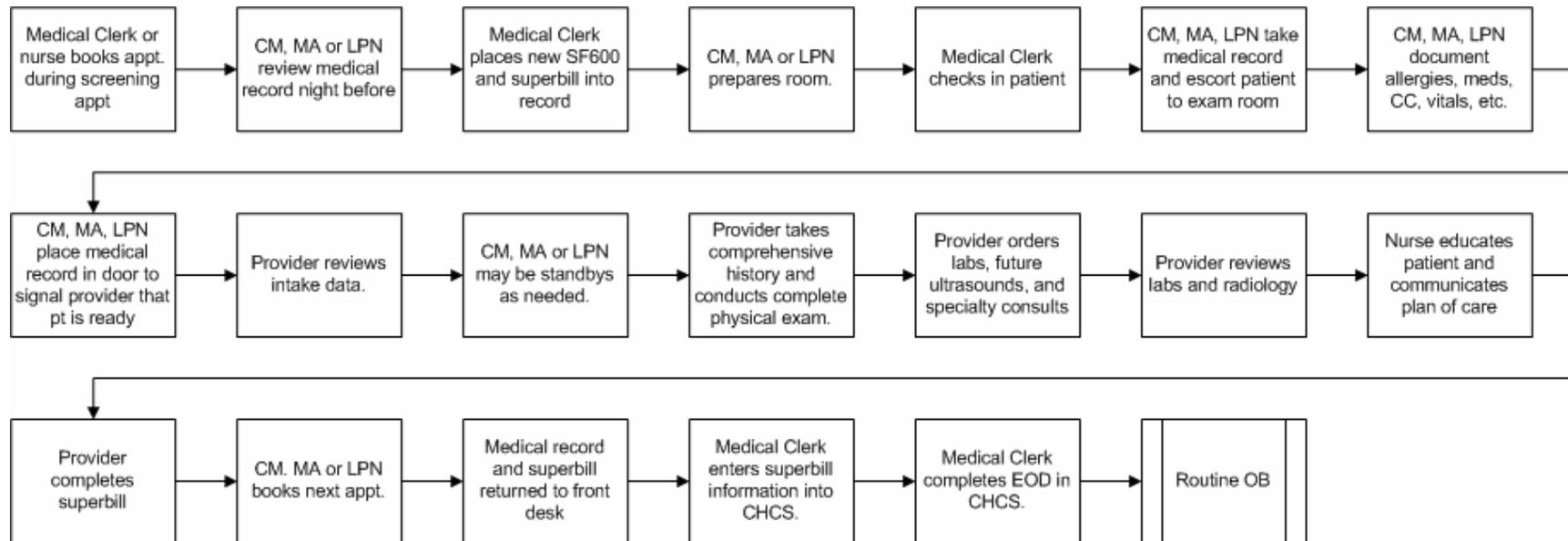
1. Patient is referred to OB clinic from Family Practice. Active duty directly referred to clinic.
2. Managed Care determines if referral is appropriate.
3. Medical Clerk schedules 1 hour screening appointment with RN.
4. Medical Clerk creates secondary medical record. Screening documents are Prenatal Medical History, Prenatal Outpatient Assessment, Prenatal Nutritional Assessment, Cystic Fibrosis Carrier Testing, Consent for HIV Antibody Testing, Privacy Act Statement, and Family Support Survey.
5. Patient enters clinic and checks-in with the front desk clerk. The front desk clerk verifies name, social security number, date of birth, address and telephone.
6. The nurse walks the patient and medical record back to exam room.
7. The nurse completes the screening which includes medical, social and personal history. The nurse provides over view of how the clinic works and how to access care/appointments.
8. The nurse determines appointment date, initiates consults, as appropriate (New Parent Support, Nutrition, etc), enters ABS, provides the statement of pregnancy to the active duty women and WIC referrals.
9. The nurse completes the superbill.
10. The medical clerk or nurse books the appointment.
11. The medical clerk enters superbill information.
12. The medical clerk completes end-of-day.



New OB Screening Process Flowchart

New OB Patient Process

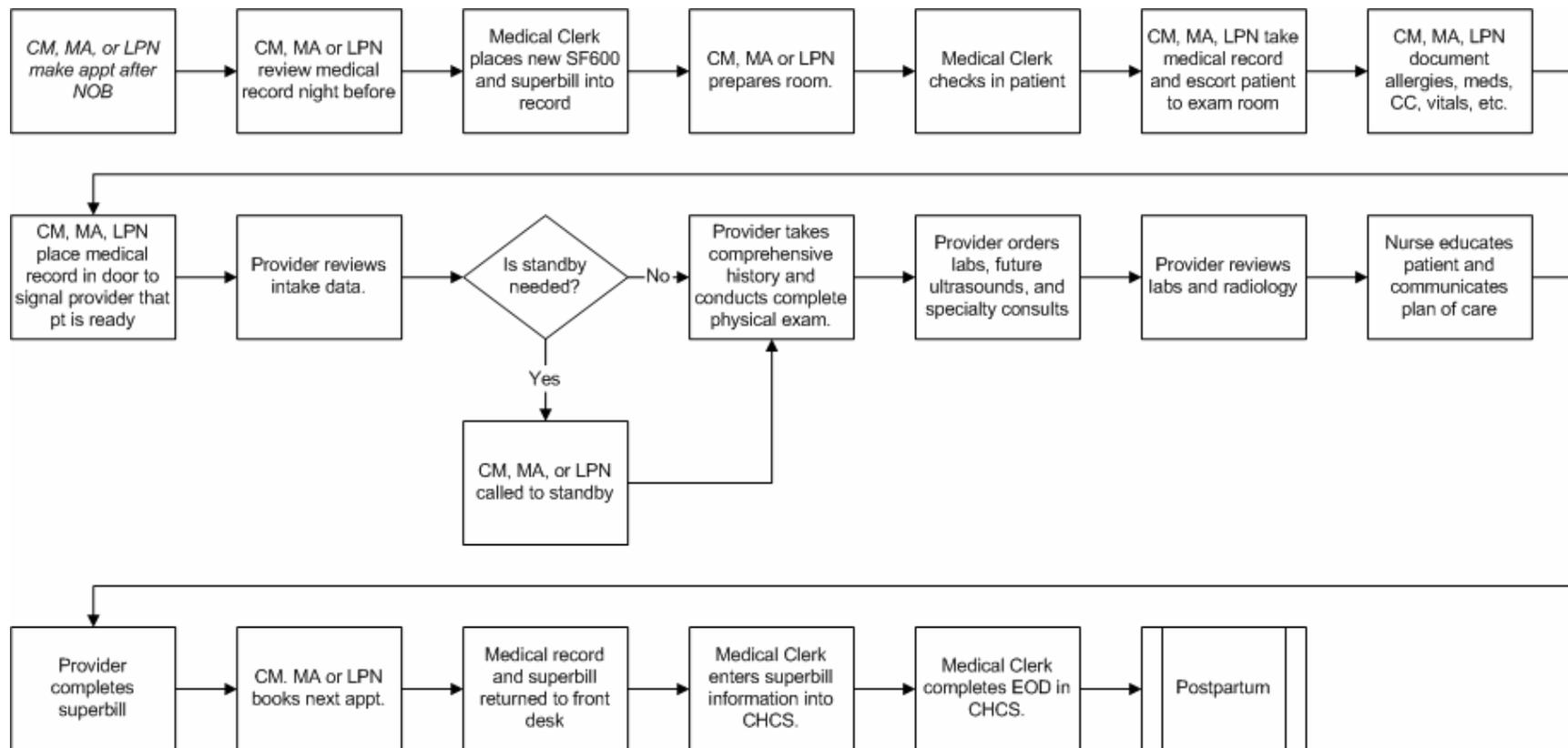
1. Medical Clerk or Nurse makes appointment after screening appointment.
2. Corpsman or Medical Assistant or LPN reviews medical record usually the night before. Pulls up and prints laboratory, consults, radiology, and medications if they are missing.
3. Secondary Medical Record pulled. Medical Clerk places new SF600 and superbill into record.
4. Corpsman or Medical Assistant or LPN prepares room.
5. Patient enters clinic and checks-in with the medical clerk. The front desk clerk verifies name, social security number, date of birth, address and telephone.
6. Corpsman or Medical Assistant or LPN greet patient and take medical record and escorts patient back to exam room.
7. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
8. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the provider that the patient is ready.
9. Provider reviews intake data.
10. As needed: Corpsman or Medical Assistant or LPN may be standbys.
11. Provider takes comprehensive history, conducts complete physical exam which includes pelvic exam, obtains cultures, pap smears, transvaginal ultrasound, and obtains pregnancy data/viability. Provides teaching/patient education (documentation).
12. Provider orders labs, future ultrasound and sends any specialty consults.
13. Provider reviews lab/radiology results. Nurse communicates with patient and educates patient of any new testing or abnormal results and coordinates the plan of care (inter departmental as well as intra departmental and external of the hospital) as needed.
14. Provider completes superbill
15. Corpsman or Medical Assistant or LPN schedule next appointment.
16. Medical record is returned to the front desk.
17. Medical Clerk enters superbill information into CHCS.
18. Medical Clerk completes end-of-day.



New OB Patient Process Flowchart

Routine OB Patient Process

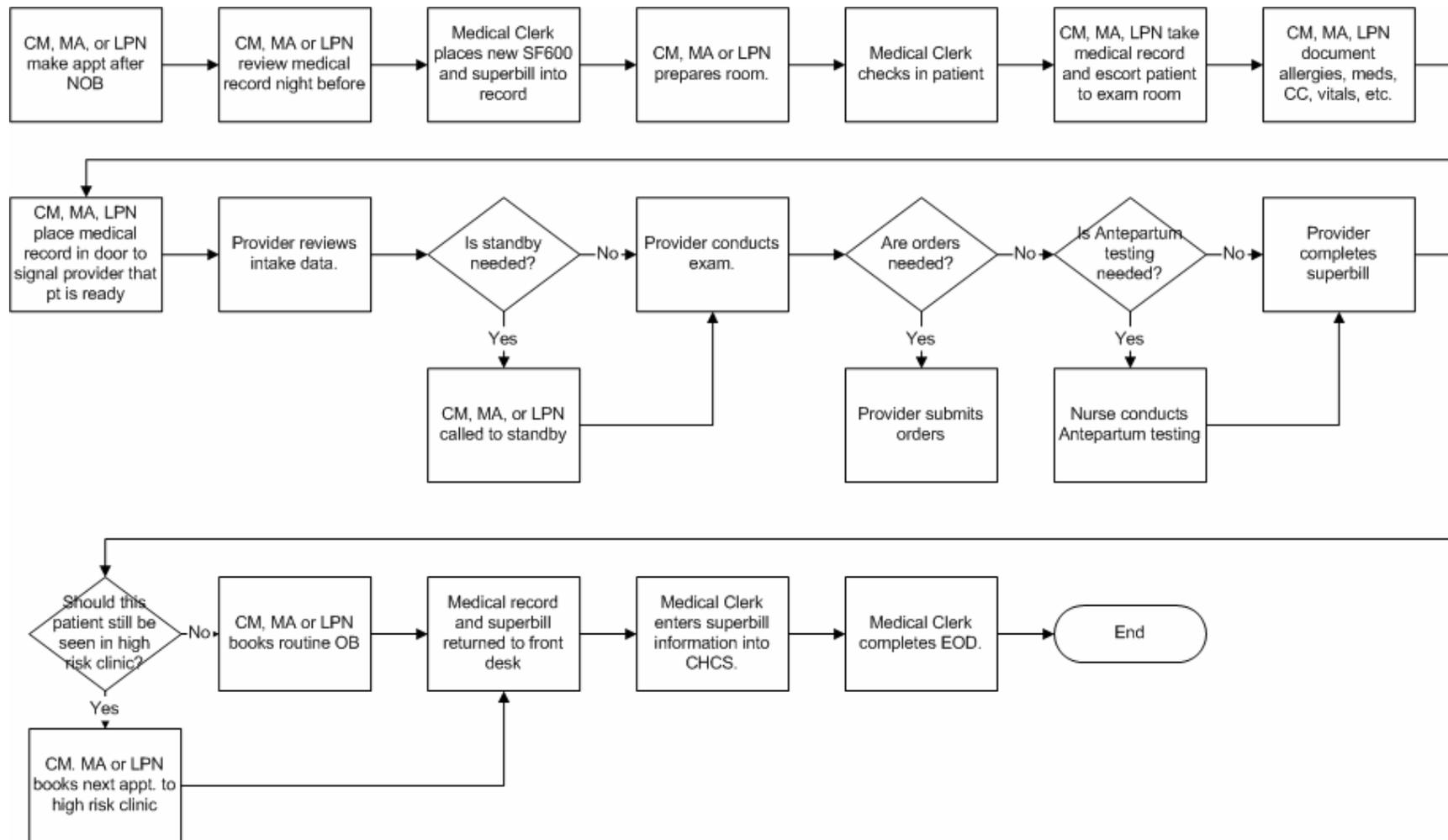
1. Corpsman, Medical Assistant or LPN makes appointment after New OB appointment.
2. Corpsman or Medical Assistant or LPN reviews medical record usually the night before. Pulls up and prints laboratory tests, consults, radiology tests, and medications if they are missing.
3. Medical Clerk places new SF600 and superbill into record.
4. Corpsman or Medical Assistant or LPN prepares room.
5. Patient enters clinic and checks-in with the front desk clerk. The front desk clerk verifies name, social security number, date of birth, address and telephone.
6. Corpsman or Medical Assistant or LPN greet patient and take medical record and patient back to exam room.
7. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
8. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the provider that the patient is ready.
9. Provider reviews intake data.
10. Corpsman or Medical Assistant or LPN may be standbys as needed.
11. Provider conducts exam.
12. As needed: Provider orders laboratory tests, consults or medications as necessary.
13. Provider reviews labs/radiology results.
14. Nurse communicates with patient and educates patient of any new testing or abnormal results and coordinates the plan of care (inter departmental as well as intra departmental and external of the hospital) as needed.
15. As needed: Nurse conducts Antepartum testing, as directed by provider.
16. Provider completes superbill.
17. Corpsman or Medical Assistant or LPN schedule next appointment.
18. Medical record is returned to the front desk.
19. Medical Clerk enters superbill information into CHCS.
20. Medical Clerk completes end-of-day.



Routine OB Patient Process Flowchart

High Risk OB Patient Process

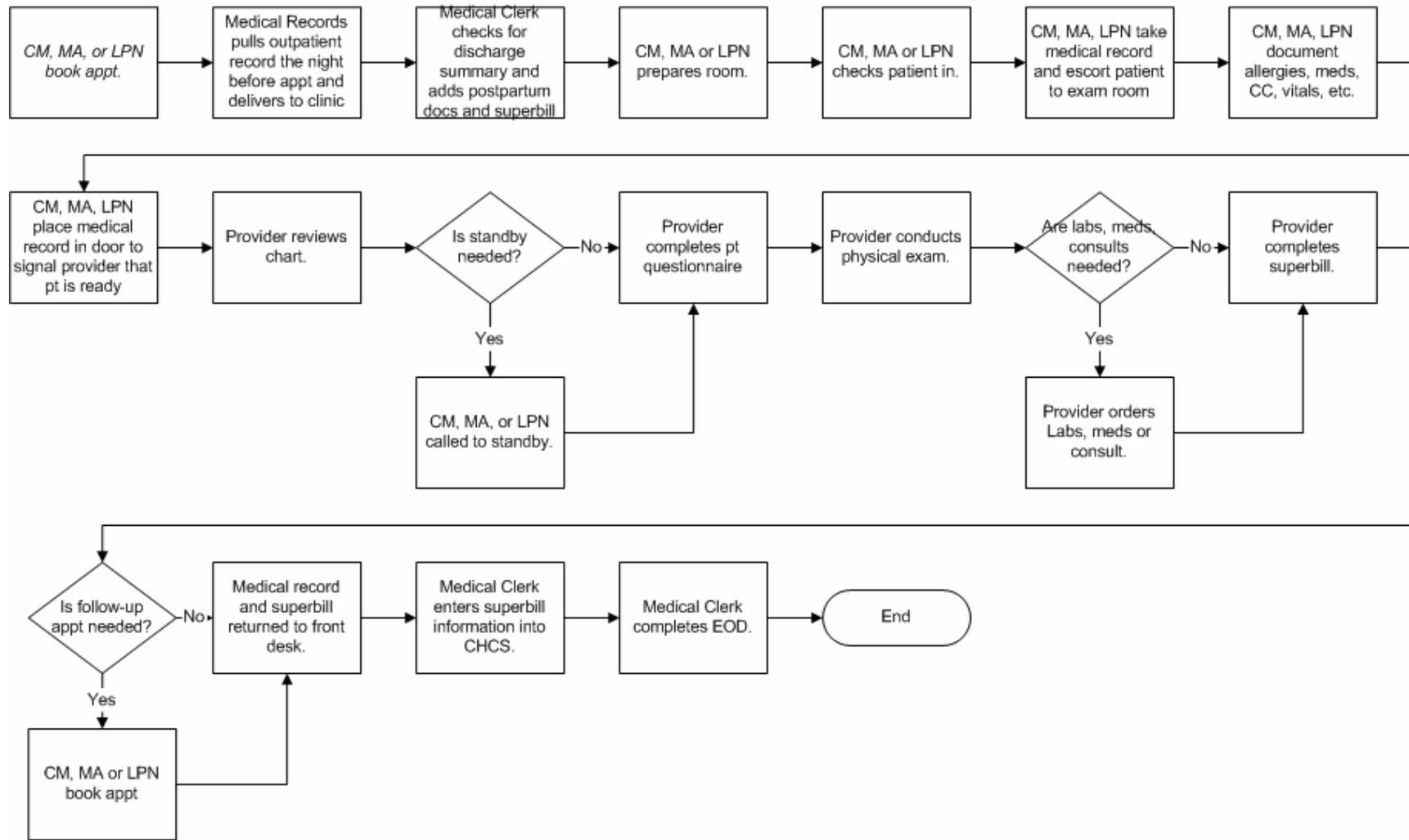
1. Corpsman, Medical Assistant or LPN makes appointment after New OB appointment.
2. Corpsman or Medical Assistant or LPN reviews medical record usually the night before. Pulls up and prints laboratory tests, consults, radiology tests, and medications if they are missing.
3. Secondary Medical Record pulled. Medical Clerk places new SF600 and superbill into record.
4. Corpsman or Medical Assistant or LPN prepares room.
5. Patient enters clinic and checks-in with the front desk clerk. The front desk clerk verifies name, ssn, DOB, address and telephone.
6. Corpsman or Medical Assistant or LPN greet patient and take medical record and patient back to exam room.
7. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
8. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the provider that the patient is ready.
9. Corpsman or Medical Assistant or LPN may be standbys as needed.
10. Provider reviews chart.
11. Provider conducts exam.
12. As needed: Provider orders laboratory tests or medications.
13. As needed: Nurse conducts Antepartum testing, per provider direction.
14. Provider completes superbill.
15. Provider determines if the patient should continue to be seen in the high risk clinic.
16. Patient is assigned to clinic Complicated OB Case Manager (RN) to coordinate consults, care and antenatal testing as applicable. Please place this in flow chart where it states "Nurse conducts Antepartum testing".
17. Corpsman or Medical Assistant or LPN schedule next appointment.
18. Medical record is returned to the front desk.
19. Medical Clerk enters superbill information into CHCS.
20. Medical Clerk completes end-of-day.



High Risk OB Patient Process Flowchart

Postpartum OB Patient Process

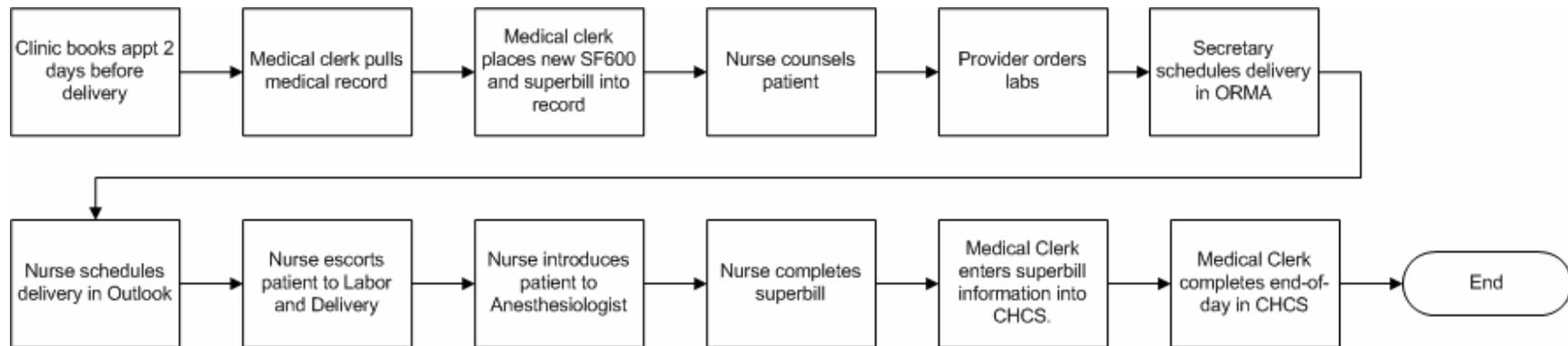
1. Corpsman or Medical Assistant or LPN book appointment.
2. Medical Records pulls outpatient record the night before the appointment.
3. Medical Clerk checks medical record for discharge summary and places SF600 overprint of postpartum questionnaire, a standard blank SF600, a pap card and a superbill in the record.
4. Corpsman, Medical Assistant or LPN prepares room.
5. Corpsman, Medical Assistant or LPN (standby) checks patient in.
6. Corpsman, Medical Assistant or LPN takes patient and medical record to the exam room.
7. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
8. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the provider that the patient is ready.
9. Provider reviews intake data.
10. Corpsman or Medical Assistant or LPN may be standbys as needed.
11. Provider completes questionnaire that includes current issues such as depression, pain, breastfeeding, birth control.
12. Provider conducts physical exam.
13. As needed: Provider orders laboratory tests, medications or consults.
14. Provider completes superbill.
15. As needed: Corpsman or Medical Assistant or LPN schedule next appointment.
16. Medical record is returned to the front desk.
17. Medical Clerk enters superbill information into CHCS.
18. Medical Clerk completes end-of-day.



Postpartum OB Patient Process Flowchart

C-Section Counseling Process

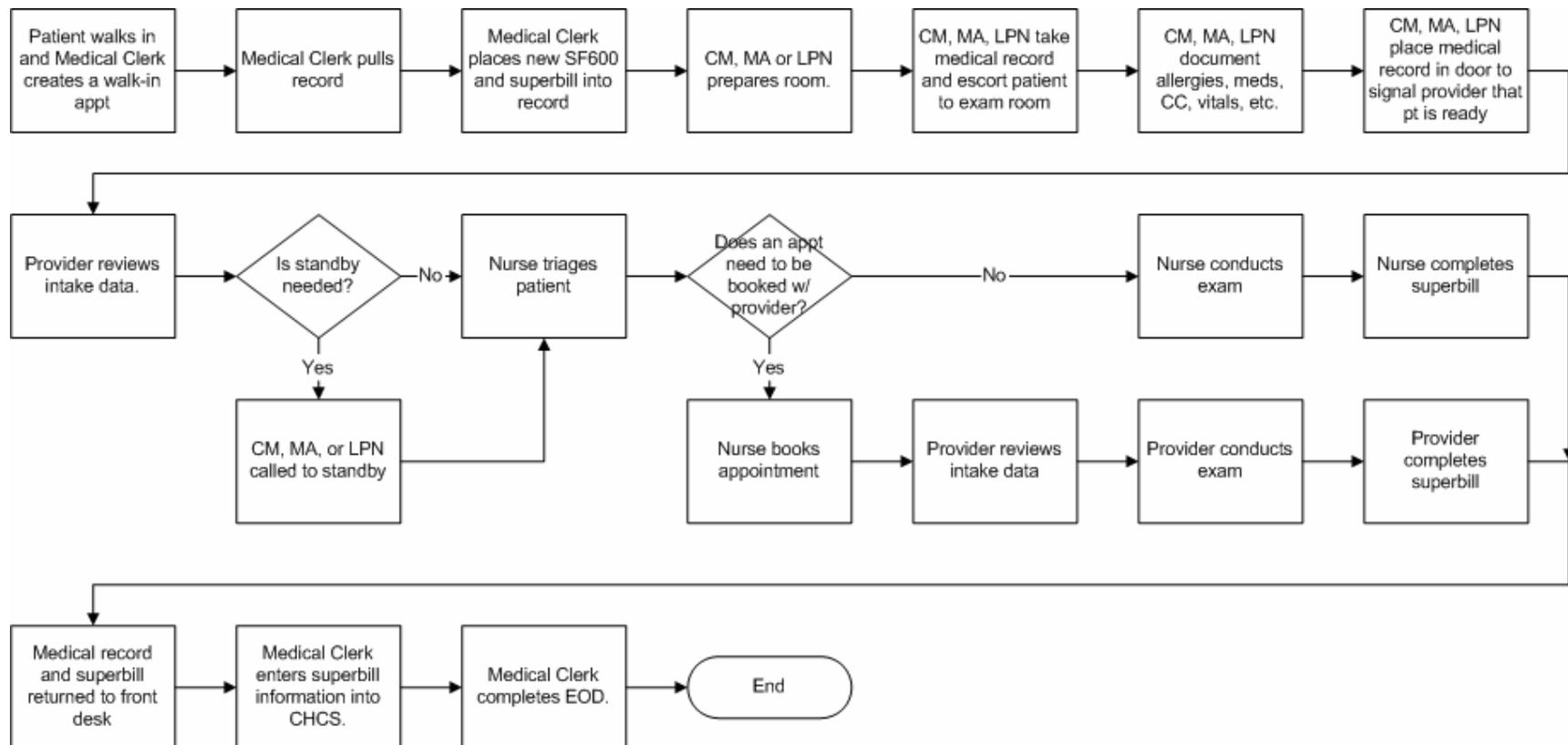
1. Appointment is booked for approximately 2 days before delivery.
2. Medical Clerk pulls medical record.
3. Medical Clerk places new SF600 and superbill into record.
4. Nurse counsels patient on what to expect and gives patient pre operative instructions.
5. Provider orders labs. Nurse enters labs in CHCS.
6. Department Secretary schedules delivery in ORMA.
7. Nurse schedules delivery in Outlook – Labor and Delivery.
8. Nurse escorts patient to Labor and Delivery to familiarize patient with Labor and Delivery.
9. Nurse coordinates Anesthesia pre operative assessment. Nurse accompanies patient to Anesthesia offices, if Anesthesia personnel available.
10. Nurse completes superbill.
11. Medical Clerk enters superbill information into CHCS.
12. Medical Clerk completes EOD.



C-Section Counseling Process Flowchart

Walk-In OB Patient Process

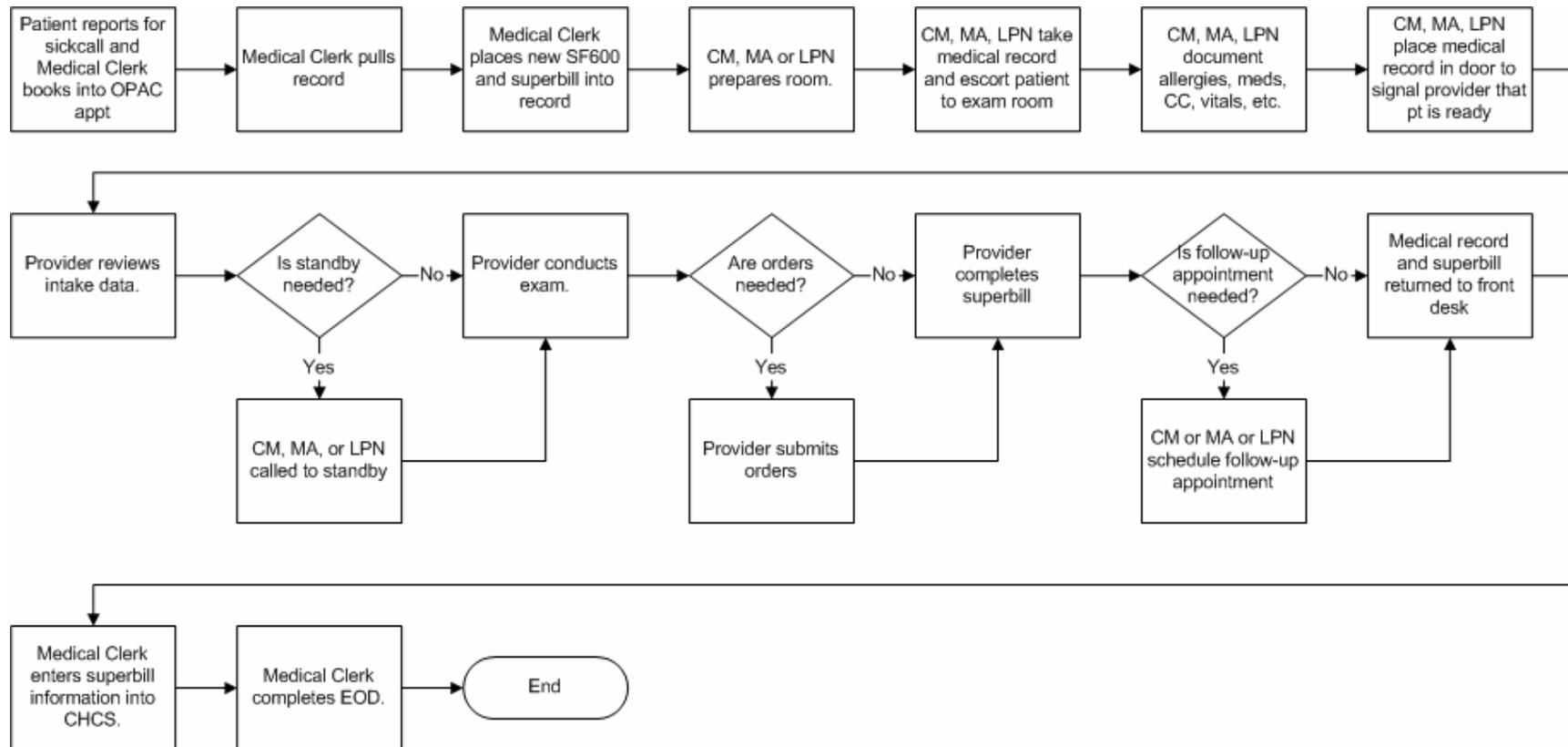
1. Patient walks-in and Medical Clerk creates a walk-in appointment for the patient.
2. Medical Clerk pulls medical record.
3. Medical Clerk places new SF600 and superbill into record.
4. Corpsman or Medical Assistant or LPN prepares room.
5. Corpsman or Medical Assistant or LPN greet patient and take medical record and patient back to exam room.
6. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
7. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the nurse that the patient is ready.
8. Corpsman or Medical Assistant or LPN may be standbys as needed.
9. Nurse triages patient.
10. As needed: Nurse books appointment to provider (i.e., When this happens a new billing and encounter form is added to the record and the original appointment is set to ADMIN status since a patient can only have 1 appointment per day per clinic).
11. If appointment with provider is not needed then nurse examines patient and completes superbill otherwise provider reviews intake data, examines patient and completes superbill.
12. Corpsman or Medical Assistant or LPN schedule next appointment if necessary.
13. Medical record is returned to the front desk.
14. Medical Clerk enters superbill information into CHCS.
15. Medical Clerk completes end-of-day.



Walk-In OB Patient Process Flowchart

Sick Call OB Patient Process

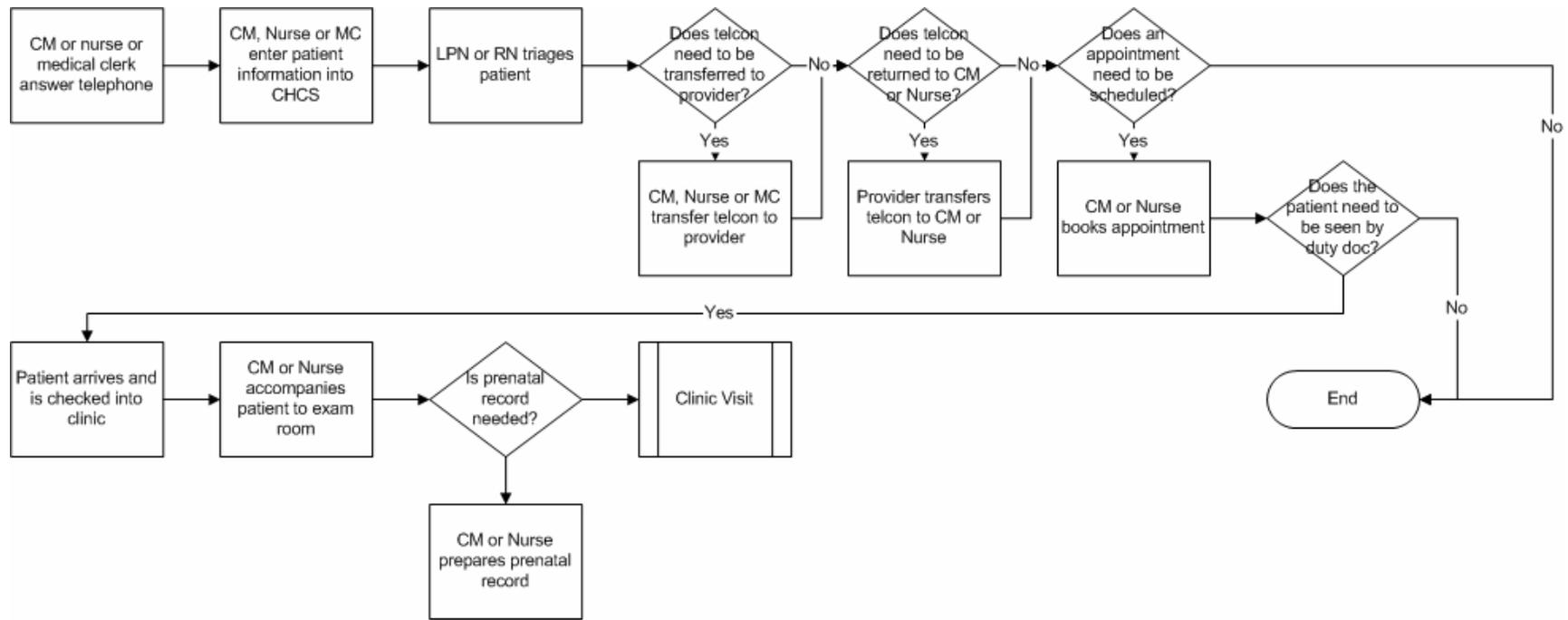
1. Patient reports to sick-call.
2. Medical Clerk schedules patient into OPAC appointment.
3. Medical Clerk pulls medical record.
4. Medical Clerk places new SF600 and superbill into record.
5. Corpsman or Medical Assistant or LPN prepares room.
6. Corpsman or Medical Assistant or LPN greet patient and take medical record and patient back to exam room.
7. Corpsman or Medical Assistant or LPN document patient's allergies, medications, chief complaint, vitals, weight, barriers to learning and pain.
8. Corpsman or Medical Assistant or LPN place medical record in the door to signal to the provider that the patient is ready.
9. Provider reviews intake data.
10. As needed: Corpsman or Medical Assistant or LPN may be standbys.
11. Provider conducts exam.
12. As needed: Provider orders laboratory tests, medications or consults.
13. Provider completes superbill.
14. As needed: Corpsman or Medical Assistant or LPN schedule next appointment.
15. Medical record is returned to the front desk.
16. Medical Clerk enters superbill information into CHCS.
17. Medical Clerk completes end-of-day.



Sick Call OB Patient Process Flowchart

Telcons Process

1. Corpsman, nurses and medical clerk answer the telephone.
2. Patient information is recorded in CHCS.
3. LPN or RN triages patient.
4. As needed: Telcon is transferred to the provider. Provider enters requests for medications, consultations or follow up tests in CHCS, as needed.
5. As needed: Telcon returned to corpsman or nurse for final discussion with patient or documentation.
6. As needed: CM or Nurse schedules appointment. Evaluates if patient needs to be seen by Duty Doc, if yes, accompanies patient to Duty Doc exam room and prepares prenatal record, if needed.



Telcons Process Flowchart

Bremerton Obstetrics Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
		60 minutes	Medical Clerk	Used for Screening OB
Specialty Appointment	SPEC\$	45 minutes	RN	Used for New OB
Routine Appointment	ROUT	20 minutes	Medical Clerk, Medical Assistant, Corpsman, LPN	Used for Routine OB patients
		20 minutes		Used for Post-Partum
		30 minutes	Medical Clerk, Medical Assistant, Corpsman, LPN	Used for High-Risk patients
		30 minutes	Medical Clerk, Medical Assistant, Corpsman, LPN	C-section counseling
				Post-Op
Walk-In	WALK-IN	15 minutes	Medical Clerk, Medical Assistant, Corpsman, LPN	Used for Walk-In patients which includes ER referrals
Open Access	OPAC	15 minutes	Secretary	Used for Sick-Call patients

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
OB GYN Superbill	N/A	Provider	All	
Prenatal Medical History	NHBREM 6410/7 (11/03)	RN	Screening	
Prenatal Outpatient Assessment	NHBREM 6410/10 (10/03)	RN	Screening	
Prenatal Nutritional Assessment	N/A	RN	Screening	
Cysstic Fibrosis Carrier Testing	NHBREM 6010/25 (10/03)	RN	Screening	
Consent for HIV Antibody Testing	NHBREM 6320/110 (6/95)	RN	Screening	
Privacy Act Statement – Health Care Records	DD Form 2005 (1 Feb 76)	RN	Screening	
Family Support Survey	N/A	RN	Screening	
New Obstetric Screening Appointment Nursing Note	NHBREM Temporary Form	RN	Screening	
Triple Marker Profile Screening Test	AFIERA FORM 05, 20000301	RN	Screening	
Antepartum Record – Genetic/Infectious Screening and Patient Education Flowsheet	NHBREM 6120/29 (Rev. 1-99)	Provider/RN	NOB/Screening	
Antepartum Record – Obstetric History	NHBREM 6200/14 (REV 10-94)	Provider/RN	NOB/Screening	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Antepartum Record	NHBREM 6320/135 (Rev. 11/00)	Provider	NOB, ROB, WI	
SF600 Overprint	SF600	Provider	NOB, ROB	Created using PB Batch process
SF600E	SF600E (Rev. 5-84)	Provider	NOB, ROB, WI	
SF600 Overprint Postpartum	SF600	Provider	Postpartum	
PAP Test Card	NHBREM 6320/69 (REV. 1-01)			
Prenatal Problem List	NHBREM6320/130 REV 11/00	Provider/Nurse	NOB, ROB, WI	
Treatment Process	NHBREM 6320/126 (REV 10-98)	Provider	NOB, ROB, WI	
Informed consent form	NHBREM 6420/1 (12-02)	Provider/Nurse	Cesarean Section Counseling Nurse Witness	
Doctors orders	SF508 NHBREM OP #58 (03/03)	Provider/Nurse	Post-Op Cesarean Section	
Nine Visit Clinical Pathway	N/A	NOB, ROB, WI		Placed in medical record during screening

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Normal Pregnancy (V22)	Nine Visit Clinical Pathway
General Medical Examination (V70)	
Postpartum Care and Examination (V24)	
Supervision of High-Risk Pregnancy (V23)	
Special Investigations and Examinations (V72)	
Health Supervision of Infant of Child (V20)	
Non-Inflammatory Disorders of Cervix (622)	
Menstrual Disorder, Other Abnormal Bleeding Female Genitalia (626)	
Other Current Conditions in Mother Complicating Pregnancy (648)	
Follow-Up Examination	

Comparison of Command and Clinic Goals, Initiatives and Metrics

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
<p>Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.</p>					
Manage network purchased care.					
Develop a coding education and training program					
<p>Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.</p>					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
<p>People: Develop an efficient integrated human capital strategy to optimize mission accomplishments</p>					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

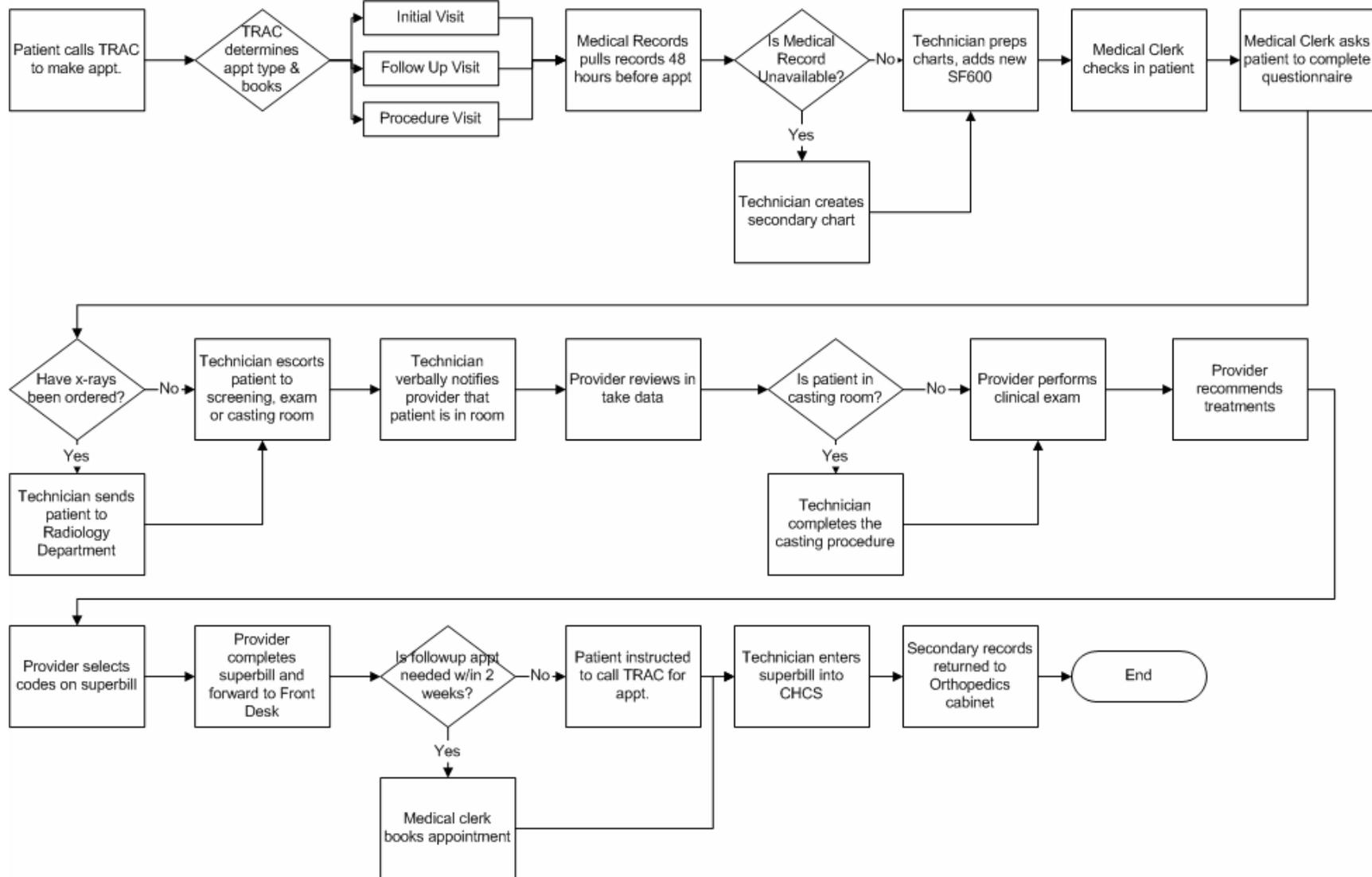
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Bremerton Orthopedic Clinic

Scheduling Process via TRAC

1. Scheduling: Patient calls Central Call Center (TRAC) to make an appointment.
2. TRAC Representative schedules the patient for:
 - a. Initial Visit (SPEC): New patients coming to the clinic for an injury or chronic pain are scheduled through TRAC per a referral from the PCM or ER. TRAC provides the date and time of the appointment as well as the name of the Provider that the patient will see. The patient receives an automated reminder of the appointment from NH Bremerton.
 - b. Follow-Up Appointment (EST): Orthopedic Clinic does not schedule follow-up appointments more than 3 weeks out. Patients are given the phone number for TRAC and the Provider's name so that the follow-up appointment is scheduled with the same Provider who completed the patient's previous visit.
 - c. Procedure (PROC): Designed for patients who are requiring a medical procedure. New consults for fractures, or follow up appointments until fracture is healed.
3. Medical Records receives the appointment schedules from TRAC 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to the Orthopedic Clinic at 1300 the day before the patients are scheduled to visit the clinic.
4. The Orthopedic Technicians check-in and prep the patients' charts when they receive them from medical records. For new patients, a secondary chart is created including the SF 600 generated by the Medical Clerk. The ADM Superbill is printed and placed in the patient's chart along with the New Patient Information questionnaire. The secondary chart is combined with the primary chart if it is available.
5. Patient enters clinic and checks-in with Medical Clerk.
6. Medical Clerk enters the patient in the system and verifies the patient's identification. Depending on the type of visit, the patient is asked to complete the appropriate questionnaire for Initial Visit or Follow-Up Visit.
7. If the Orthopedic Technician notes on the SF 600 that x-rays have been ordered for the patient, the Medical Clerk sends the patient directly to the Radiology Department when they check-in for the appointment. If no x-rays are required, the patient is directed to return to the waiting area.
8. The Orthopedic Technician calls the patient and escorts the patient to the screening, examination, or Casting Room.
9. The Orthopedic Technician verbally notifies the Orthopedic Provider that the patient is waiting in the examination or Casting Room.
10. The provider reviews the patient's responses to the Initial Visit/Follow-Up Visit questionnaires (history of present illness, past medical history, social history, review of systems) and pertinent imaging studies (i.e., x-rays if available) prior to seeing the patient.

11. The provider sees the patient and performs the appropriate clinical exam based on the patient's chief complaint. In the Casting Room, the Provider examines the patient and the Orthopedic Technician completes the casting procedure.
12. The provider recommends treatments, additional work-up, and may recommend invasive procedures, and then selects the most appropriate ICD, CPT, and E&M codes on the super bill.
13. The provider completes the super bill and forwards it to the Front Desk for input into CHCS.
14. If a follow-up appointment is needed within two weeks, the Medical Clerk creates the appointment.
15. If a follow-up appointment is needed after three weeks, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
16. The Orthopedic Technician enters the super bill information into the computer.
17. The secondary medical record is returned to the Orthopedic file cabinet.

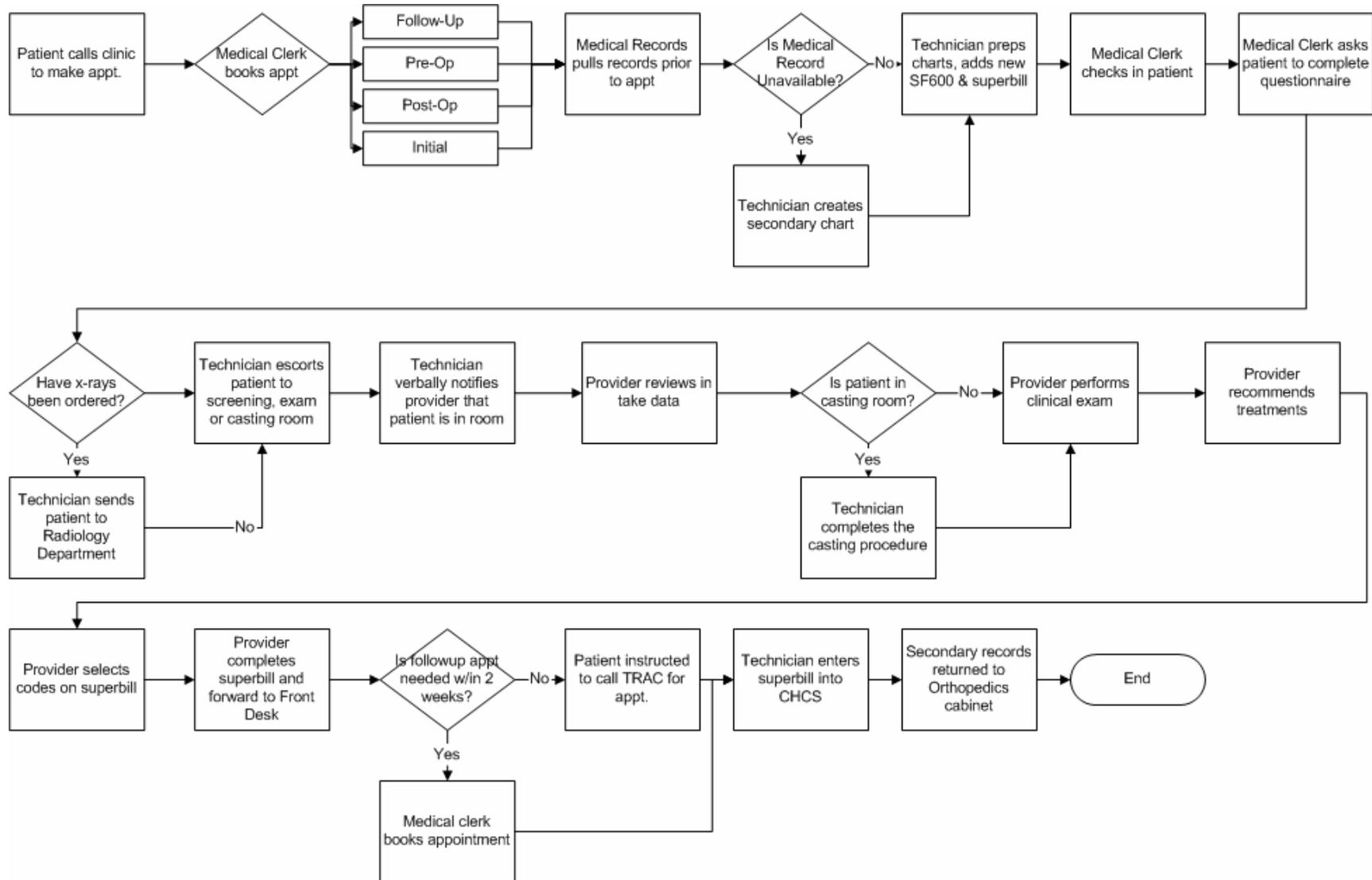


Scheduling Process via TRAC Flowchart

Scheduling Process via Clinic

1. Scheduling within the Orthopedic Clinic with the Medical Clerk occurs when:
 - a. TRAC is not able to schedule a follow-up appointment.
 - b. Patient needs to schedule a follow-up appointment for two weeks out.
 - c. Patient is referred to the Orthopedic Clinic from the ER to get casting for a fracture.
 - d. Patient needs to schedule a Pre-Op appointment.
 - e. Patient needs to schedule a Post-Op appointment.
 - f. Patient calls the Medical Clerk directly at the Orthopedic Clinic to make an appointment.
2. The Medical Clerk schedules the appointment (which is usually an established/procedure appointment).
3. Medical Records receives requests from Orthopedic Clinic to retrieve the patients' medical records prior to the patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Orthopedic Clinic at 1300 the day before the patients are scheduled to visit the clinic.
4. The Orthopedic Technicians check-in and prep the patients' charts when they receive them from medical records. For new patients, a secondary chart is created including the SF 600 generated by the Medical Clerk. The ADM Superbill is printed and placed in the patient's chart along with the New Patient Information questionnaire. The secondary chart is combined with the primary chart if it is available.
5. Patient enters clinic and checks-in with Medical Clerk.
6. Medical Clerk enters the patient in the system and verifies the patient's identification. Depending on the type of visit, the patient is asked to complete the appropriate questionnaire for Initial Visit or Follow-Up Visit.
7. If the Orthopedic Technician notes on the SF 600 that x-rays have been ordered for the patient, the Medical Clerk sends the patient directly to the Radiology Department when they check-in for the appointment. If no x-rays are required, the patient returns to the waiting area.
8. The Orthopedic Technician calls the patient and escorts the patient to the screening, examination, or Casting Room.
9. The provider reviews the patient's responses to the Initial Visit/Follow-Up Visit questionnaires (history of present illness, past medical history, social history, review of systems) and pertinent imaging studies (i.e., x-rays if available) prior to seeing the patient.
10. The provider sees the patient and performs the appropriate clinical exam based on the patient's chief complaint. In the Casting Room, the Provider examines the patient and the Orthopedic Technician completes the casting procedure.
11. The provider recommends treatments, additional work-up, and may recommend invasive procedures, and then selects the most appropriate ICD, CPT, and E&M codes on the super bill.

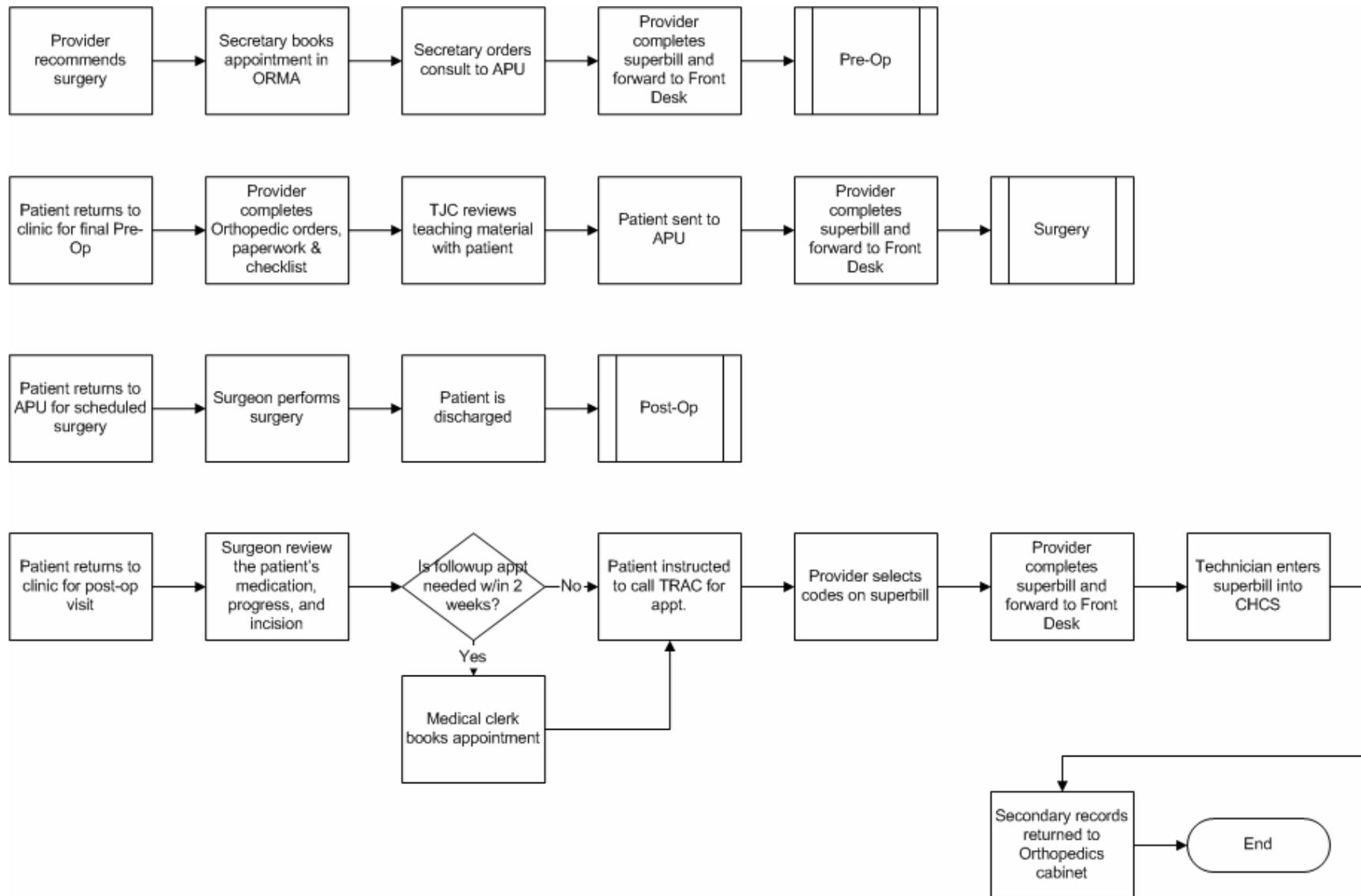
12. The provider completes the super bill and forwards it to the Front Desk for input into CHCS.
13. If a follow-up appointment is needed within two weeks, the Medical Clerk creates the appointment.
14. If a follow-up appointment is needed after three weeks, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
15. The Orthopedic Technician enters the super bill information into the computer.
16. The secondary medical record returned to Orthopedic file cabinet.



Scheduling Process via Clinic Flowchart

Scheduling Process for Pre-Op and Post-Op Visits via Clinic

1. Based on the physical exam, the Orthopedic Provider recommends surgery for the patient.
2. The patient is sent to the Orthopedic Clinic Secretary, who schedules the patient's surgery in ORMA.
3. The Orthopedic Clinic Secretary schedules the patient for an initial Pre-Op appointment and orders a consult to the Ambulatory Procedures Unit (APU). The patient is instructed to schedule appointments with other clinics such as Physical Therapy and Nutrition.
4. The provider completes the super bill and forwards it to the Front Desk for input into CHCS.
5. Patient returns to the clinic for the final Pre-Op appointment after scheduling the appointments listed in step 3.
6. The Provider completes the Orthopedic Department Orders, Paperwork, and Checklist.
7. The patient receives total joint education from the Orthopedic Clinic Total Joint Coordinators (TJC) far in advance of their appointment in the APU. The patient and the TJC Coordinator review the Pre-Op Patient Teaching Materials for the patient's scheduled surgery.
8. The patient is sent to the Ambulatory Procedure Unit (APU) with Pre-Op orders from the Provider. Tests (i.e., blood tests, chest x-ray, EKG, and urine) are taken to establish if the patient is ready for the recommended surgery.
9. The provider completes the super bill and forwards it to the Front Desk for input into CHCS.
10. The patient returns to the APU for the scheduled surgery. The Orthopedic Surgeon performs the surgery.
11. Following surgery, the patient goes to one of three places from the OR: 1) ICU, 2) Medical Surgical Suite, or 3) APU. The patient receives instruction on physical therapy and post-surgery care. From these locations, the patient is then discharged.
12. The patient returns to the Orthopedic Clinic 10-14 days after surgery for the Post-Op visit.
13. The Orthopedic Surgeon reviews the patient's medications, progress, and incision. The Provider will ask the patient to continue physical therapy as an outpatient.
14. If a follow-up appointment is needed within two weeks, the Medical Clerk creates the appointment.
15. If a follow-up appointment is needed after three weeks, the patient is instructed to call the Central Call Center (TRAC) and schedule his/her own appointment.
16. The Orthopedic Technician enters the super bill information into the computer.
17. The secondary medical record returned to Orthopedic file cabinet.



Scheduling Process for Pre-Op and Post-Op Visits via Clinic Flowchart

Bremerton Orthopedic Clinic Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Specialty Appointment	SPEC	20 minutes	TRAC Representative	Designed for patients needing a specialty care appointment. New problem with consult.
Established Appointment	EST	20 minutes	TRAC Representative	Designed for patients who require follow up care. Pt must see the same provider as before.
Procedure/Fracture	PROC	10 minutes	TRAC Representative	Designed for patients who are requiring a medical procedure. New consults for fractures, or follow up appointments until fracture is healed.

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Medical History Questionnaire for Initial Visit	N/A	Patient	SPEC	
Medical History Questionnaire for Follow-up Visit	N/A	Patient	EST	
Orthopedic Consultation Request Form	N/A	Provider	SPEC, EST	
Orthopedic Clinic Super Bill	N/A	Provider	SPEC, EST	Clinic super bill updated periodically by Dr. Thut.
Abbreviated Medical Record Standard Form 589	General Services Administration and Interagency Committee on Medical Records FIRMR (CFR) 201-45.505 October 1975	Provider	EST	Form used when Provider recommends surgery. The Orthopedic Clinic Nurse is in the process of developing a standardized form for use by all Orthopedic Providers.
Authority for Admission	N/A	Provider, Medical Clerk, Patient	EST	
Request for Elective Surgery/Hospitalization	N/A	Provider, Watch Bill Coordinator, Immediate Supervisor, Approving Official	EST	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Progress Notes Medical Record Standard Form 509 (Rev. 5-99)	Prescribed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)	Provider	EST	
Total Knee Replacement Pre-Op Patient Teaching Materials	N/A	Patient	EST	The Orthopedic Clinic Total Joint Coordinators meet with the patient to review the teaching materials.
Total Hip Replacement Pre-Op Patient Teaching Materials	N/A	Patient	EST	The Orthopedic Clinic Total Joint Coordinators meet with the patient to review the teaching materials.
Total Knee Replacement Ortho Dept Orders, Paperwork, and Checklist (Packet)	Various	Provider, Patient	EST	
Total Hip Replacement Ortho Dept Orders, Paperwork, and Checklist (Packet)	Various	Provider, Patient	EST	
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Other and Unspecified Disorders of Joint (719)	
Follow-Up Examination (V67)	
Other Disorders of Synovium, Tendon and Bursa (727)	
Peripheral Enthesopathies and Allied Syndromes (726)	
Fracture of Radius and Ulna (813)	
Osteoarthritis and Allied Disorders (715)	
Dislocation of Knee (836)	
Other Disorders of Soft Tissues (729)	
Special Investigations and Examinations (V72)	
Internal Derangement of Knee (717)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

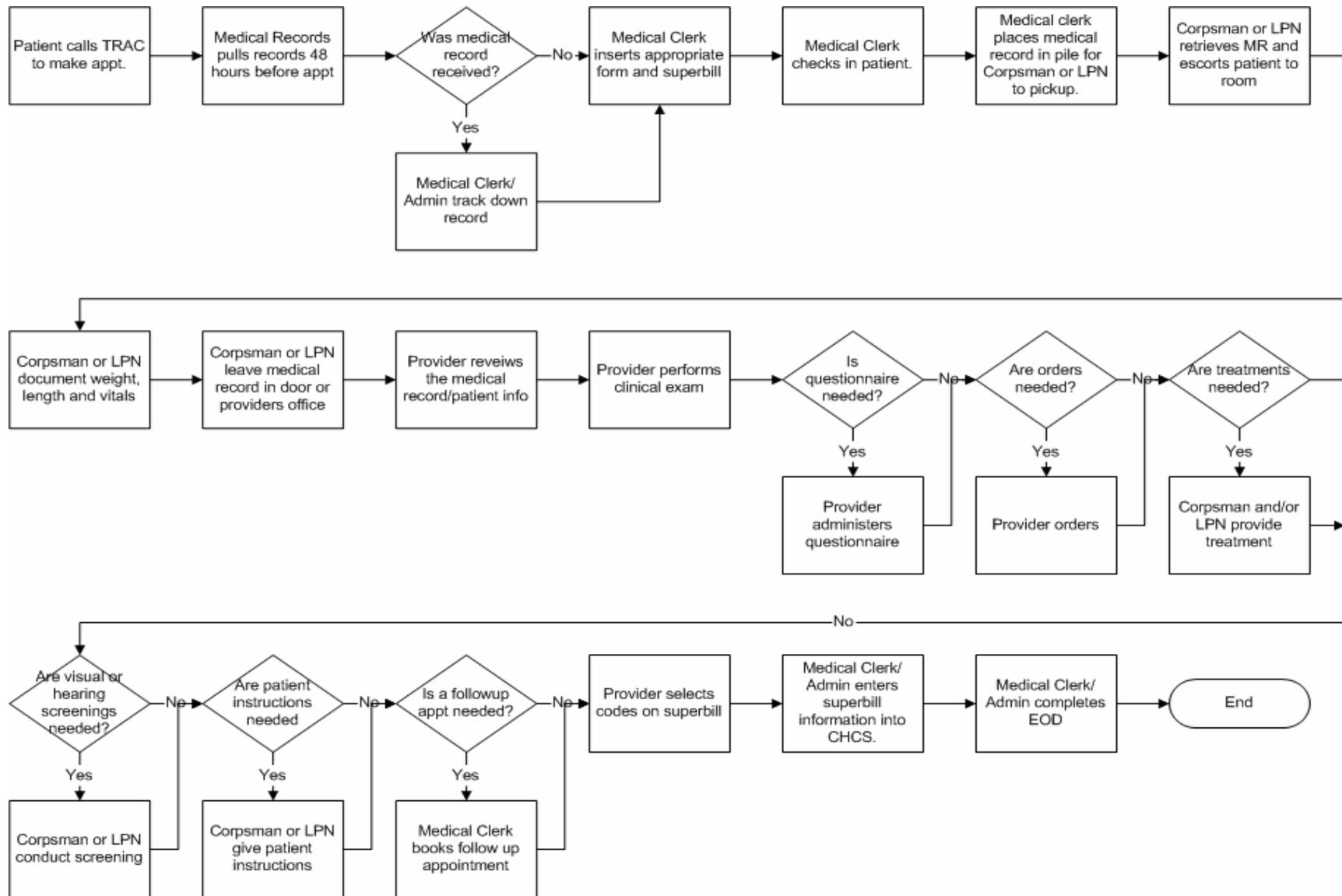
Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.					
Manage network purchased care.					
Develop a coding education and training program					
Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
People: Develop an efficient integrated human capital strategy to optimize mission accomplishments					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

Bremerton Pediatric Clinic

Generic Workflow Process

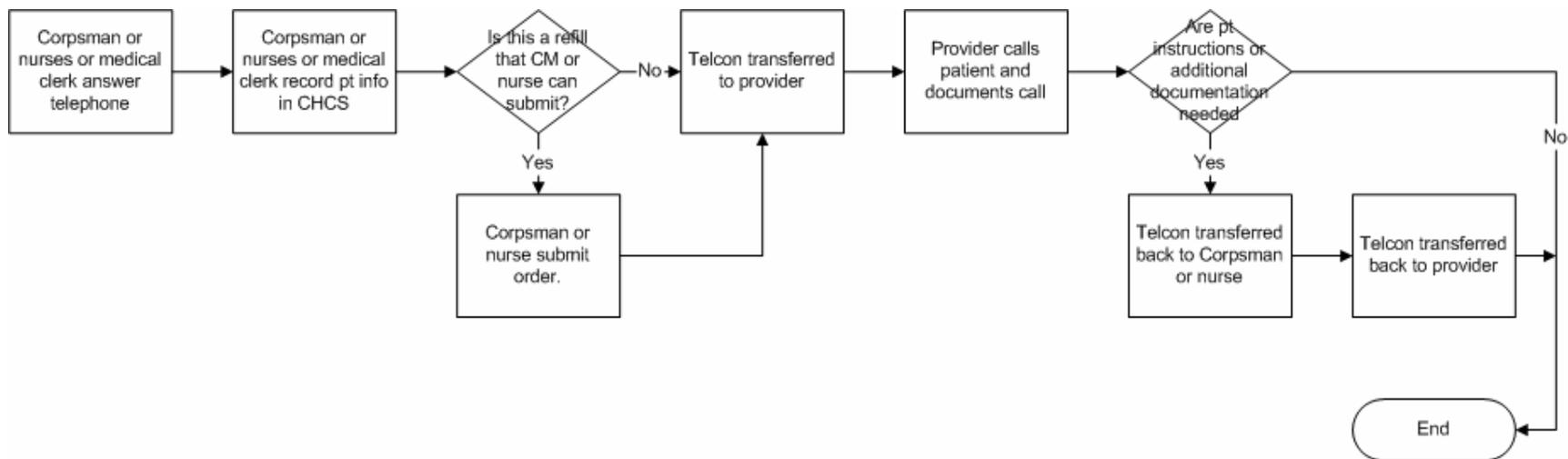
1. Patient calls Central Call Center (TRAC) to make an appointment.
2. Medical Records receives the appointment schedules from CHCS 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Pediatrics the night before the patients are scheduled to visit.
3. As needed: Medical Clerk/Administrative staff member track down Medical Record
4. Medical clerk inserts appropriate form and superbill.
5. Patient enters clinic and checks-in with the Medical clerk. Medical clerk checks ID and if no ID is available verifies name social security number and date of birth
6. Medical clerk places medical record in pile for Corpsman or nurse to pickup.
7. Corpsman or nurse retrieves medical record from pile, calls the patient and escorts the patient to the vitals or exam room.
8. Corpsman or nurse document weight, length and vitals on SF600 Overprint.
9. Corpsman or nurse leaves medical record in door or providers office.
10. Provider performs clinical exam.
11. Provider documents visit.
12. As needed: Provider administers questionnaire.
13. As needed: Provider submits orders.
14. As needed: Corpsman or nurse provides treatment such as wart treatment, ear irrigation, venipuncture, nebulizer or medication. More complicated treatments are done by the nurse.
15. As needed: Corpsman or nurse provides visual or hearing screening generally for the well visits.
16. As needed: Corpsman or nurse provides patients with instructions.
17. As needed: Medical Clerk books follow up appointment.
18. Provider completes superbill.
19. Medical Clerk enters superbill into CHCS.
20. Medical Clerk completes EOD.



Generic Workflow Process Flowchart

Telephone Consult Process

1. Corpsman, nurses and medical clerk answer the telephone (it depends on staffing).
2. Patient information is recorded in CHCS.
3. As needed: Corpsman or nurse submit prescription refill order that provider later signs.
4. All Telcons are transferred to the provider.
5. As needed: Telcon returned to corpsman or nurse for final discussion with patient or documentation. Telcon is then transferred back to the provider

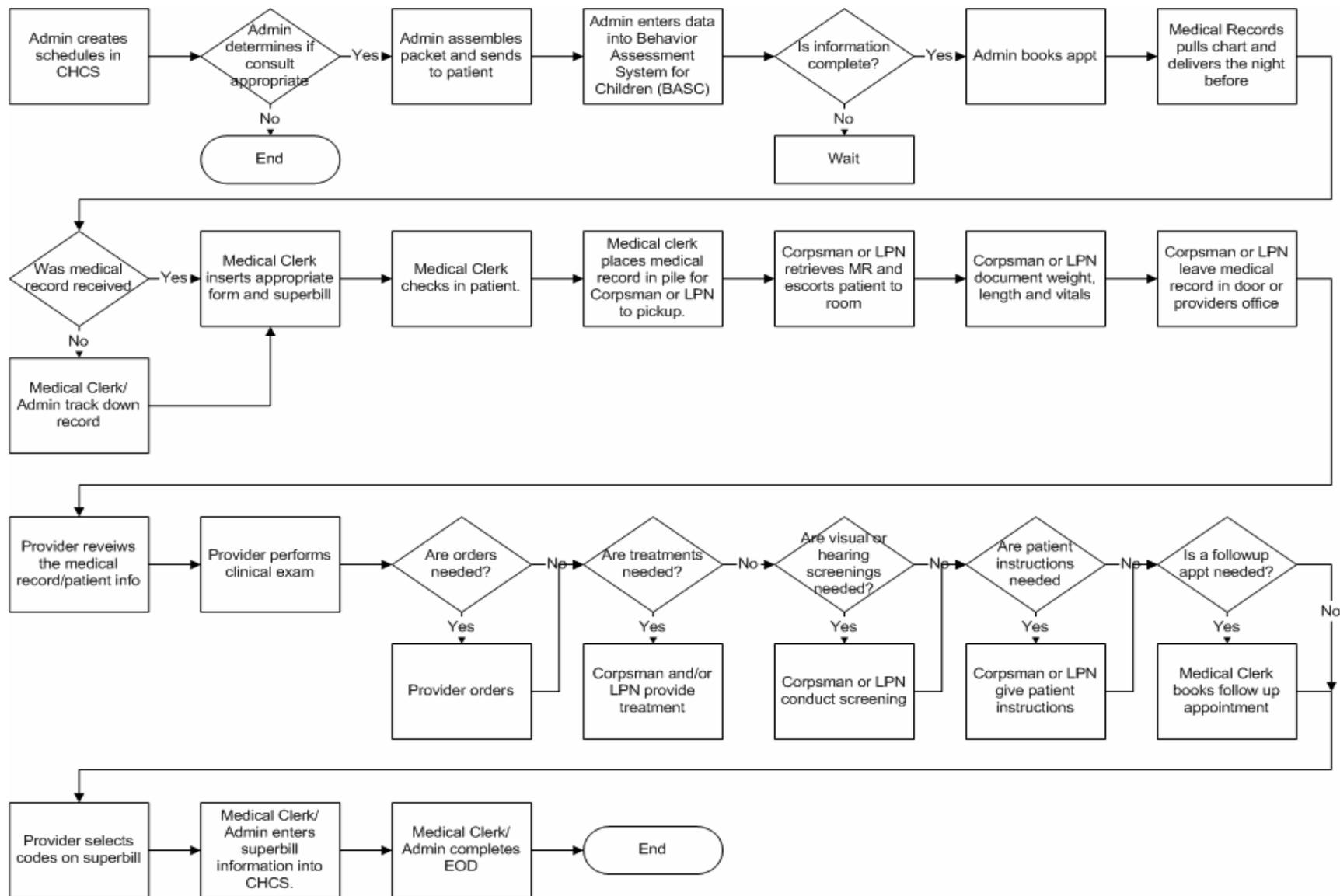


Telcons Process Flowchart

Developmental Clinic Process

Note: 1 Administrative clerk handles the developmental clinic.

1. Administrative clerk creates schedules in CHCS (no templates are used).
2. Administrative clerk reviews all consults to make sure that they are appropriate.
3. Administrative clerk assembles a packet and sends it to patient.
4. Administrative clerk enters data into Behavior Assessment System for Children (BASC enhanced).
5. Administrative clerk books appointment once information is complete.
6. Medical Records receives the appointment schedules from CHCS 48 hours prior to patients' actual visit. Medical Records then pulls the patients' charts, and delivers them to Pediatrics the night before the patients are scheduled to visit.
7. As needed: Administrative clerk tracks down Medical Record.
8. Medical clerk inserts appropriate form and superbill.
9. Patient enters clinic and checks-in with the Medical clerk. Medical clerk checks ID and if no ID is available verifies name social security number and date of birth
10. Medical clerk places medical record in pile for Corpsman or nurse to pickup.
11. Corpsman or nurse retrieves medical record from pile, calls the patient and escorts the patient to the vitals or exam room.
12. Corpsman or nurse document weight, length and vitals on SF600 Overprint.
13. Corpsman or nurse leaves medical record in door or providers office.
14. Provider documents visit.
15. As needed: Provider submits orders.
16. As needed: Corpsman or nurse provides treatment such as wart treatment, ear irrigation, venipuncture, nebulizer or medication. More complicated treatments are done by the nurse.
17. As needed: Corpsman or nurse provides visual or hearing screening generally for the well visits.
18. As needed: Corpsman or nurse provides patients with instructions.
19. As needed: Medical Clerk books follow up appointment.
20. Provider completes superbill.
21. Medical Clerk or Administrative clerk enters superbill into CHCS.
22. Medical Clerk or Administrative clerk complete EOD.



Developmental Clinic Process Flowchart

Bremerton Pediatrics Summary Tables

Visit Types

Visit Type	CHCS Appt Type	Length of Visit	Scheduler	Business Rule
Acute	ACUTE	15	Medical Clerk	Sick children
Follow-up visits	EST	15	Medical Clerk	Follow-up visits
Well exams	WELL	15	Medical Clerk	Well exams and physicals
Follow-up visits	ROUTINE	15	Medical Clerk	Follow-up visits
Specialty	SPEC	60	Medical Clerk	Madigan referral, developmental clinic, cardiology, etc

Documentation Tools (Forms, Questionnaires)

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Superbill	BDAA bh0902A	Provider	All	
Pediatric Outpatient Visit - Generic	NHBREM 6400/30 (12-03)	Provider	Generic, ADHD	
Boys: Birth to 36 months growth chart	51208 (0.05)/July 2001			
Boys: 2 to 20 years growth chart	51212 (0.05)/July 2001			
Girls: Birth to 36 months growth chart	51210 (0.05)/July 2001			
Girls: 2 to 20 years growth chart	51214 (0.05)/July 2001			
Newborn Screening – 2 nd Specimen	N/A		2 Week Well Child Visit	
2 Week Well Child Visit	NHBREM6400/27(1 2/03)		2 Week Well Child Visit	
2 Week Well Child Visit – Parent Questionnaire	NHBREM6400/27(1 2/03)		2 Week Well Child Visit	
2 Month Well Child Visit	NHBREM6400/18(1 2/03)		2 Month Well Child Visit	
2 Month Well Child Visit – Parent Questionnaire	NHBREM6400/18(1 2/03)		2 Month Well Child Visit	
4 Month Well Child Visit	NHBREM6400/25(1 2/03)		4 Month Well Child Visit	
4 Month Well Child Visit – Parent Questionnaire	NHBREM6400/25(1 2/03)		4 Month Well Child Visit	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
6 Month Well Child Visit	NHBREM6400/31(12/03)		6 Month Well Child Visit	
6 Month Well Child Visit – Parent Questionnaire	NHBREM6400/31(12/03)		6 Month Well Child Visit	
9 Month Well Child Visit	NHBREM6400/20(12/03)		9 Month Well Child Visit	
9 Month Well Child Visit – Parent Questionnaire	NHBREM6400/20(12/03)		9 Month Well Child Visit	
12 Month Well Child Visit	NHBREM6400/22(12/03)		12 Month Well Child Visit	
12 Month Well Child Visit – Parent Questionnaire	NHBREM6400/22(12/03)		12 Month Well Child Visit	
18 Month Well Child Visit	NHBREM6400/29(12/03)		18 Month Well Child Visit	
18 Month Well Child Visit - Parent Questionnaire	NHBREM6400/29(12/03)		18 Month Well Child Visit	
24 Month Well Child Visit	NHBREM6400/19(12/03)		24 Month Well Child Visit	
24 Month Well Child Visit – Parent Questionnaire	NHBREM6400/19(12/03)		24 Month Well Child Visit	
3 Year Well Child Visit	NHBREM6400/24(12/03)		3 Year Well Child Visit	
3 Year Well Child Visit – Parent Questionnaire	NHBREM6400/24(12/03)		3 Year Well Child Visit	
4-5 Year Well Child Visit	NHBREM6400/26(12/03)		4-5 Year Well Child Visit	

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
4-5 Year Well Child Visit – Parent Questionnaire	NHBREM6400/26(12/03)		4-5 Year Well Child Visit	
6-9 Year Well Child Visit	NHBREM6400/21(12/03)		6-9 Year Well Child Visit	
6-9 Year Well Child Visit – Parent Questionnaire	NHBREM6400/21(12/03)		6-9 Year Well Child Visit	
10-12 Year Well Child Visit	NHBREM6400/23(12/03)		10-12 Year Well Child Visit	
10-12 Year Well Child Visit – Parent Questionnaire	NHBREM6400/23(12/03)		10-12 Year Well Child Visit	
13-18 Year Well Child Visit	NHBREM6400/28(12/03)		13-18 Year Well Child Visit	
13-18 Year Well Child Visit – Parent Questionnaire	NHBREM6400/28(12/03)		13-18 Year Well Child Visit	
Lead Exposure Risk Assessment Questionnaire	NHBREM6260-20(3-95)		As needed	
Health History – Sports Participation	NHBREM6120/22(5-02)		Sports Physical	
Pediatric Outpatient Visit - Synagis	NHBREM 6400/30 (12-03)	Provider	Synagis Visit	Generic form Overprint
Chronological Record of Medical Care	NHBREM OP#158 (8/02)		Asthma initial and followup visit	SF600 Overprint
Chronological Record of Medical Care	NHBREM OP#159 (8/02)		Asthma initial visit	SF600 Overprint

Document Name	Document ID	Documenter	Visit Type When Utilized	Comments
Chronological Record of Medical Care – Asthma follow up questionnaire	NHBREM OP#160 (8/02)	Patient	Asthma followup visit	SF600 Overprint
Chronological Record of Medical Care – Nebulizer Treatment	SF600		Asthma visit	SF600 Overprint
Asthma Action Plan	NHBREM6710/62 (8/02)		Asthma visit	Patient handout
			Developmental Clinic	Did not receive forms
Dictation	Based on patient's name, SSN, SSSN		All	Transcriptions are stored on public folders within MS Outlook.

Top ICD 9 Codes and Associated Clinical Guidelines

Top ICD 9 Codes	Associated Clinical Guidelines
Health Supervision of Infant or Child (V20)	
Acute upper Respiratory Infection of Multiple or Unspecified (465)	
Suppurative and Unspecified Otitis Media (382)	
General Medical Examination (V70)	
Hyperkinetic Syndrome of Childhood (314)	Attention Deficit/Hyperactivity Disorder Guideline
Asthma (493)	Asthma Guideline
Acute Pharyngitis (462)	
Viral Infection in Conditions Classified Elsewhere/Site NOS (079)	
Allergic Rhinitis (477)	
Contact Dermatitis and Other Eczema (692)	

Comparison of Command and Clinic Goals, Initiatives and Metrics

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
<p>Business of Medicine: Create a Clinical Support Department which enables sound business decisions at all levels.</p>					
Manage network purchased care.					
Develop a coding education and training program					
<p>Serving Patients: Develop clinical outcome measures for provider-specific performance feedback reports.</p>					
Improve access to care.					
Develop and deploy marketing strategies to engage our staff and beneficiaries in achieving health and readiness requirements.					
Family Centered Care					
<p>People: Develop an efficient integrated human capital strategy to optimize mission accomplishments</p>					
Facilitate the integration of Medical-Dental to maximize mission attainment.					
Evaluate and address staff satisfaction.					

Command Strategic Goals - 2005	Command Performance Improvement Initiatives	Command Metrics	Clinic Business Plan (to meet command goals)	Clinic Performance Improvement Initiatives	Clinic Metrics
Evaluate and address customer satisfaction.					
Readiness: Develop a deployment contingency plan to ensure continued support of staff and Beneficiaries, utilizing lessons-learned.					

