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

US Army Medical Command
15 January 2013
Executive Summary

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

The PCMH Implementation Manual establishes the standards and methods for initial implementation of the Army PCMH model. The Operations Manual will describe the quality, responsive, and comprehensive care we provide as a more patient centered system for health.

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

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

Serving to Heal…Honored to Serve!

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US Army Medical Command

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CHAPTER ONE
INTRODUCTION

1-1. Purpose

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

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

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

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

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

1-2. Vision

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

1-3. Mission

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

ARMY PCMH IMPLEMENTATION

The Implementation Roadmap (fig 2) defines the phases and critical tasks required to implement and operate the Army PCMH. Tasks can run sequentially and concurrently within each phase. Tasks such as readiness assessment, gap analysis, and training are ongoing activities that are dynamic in nature and require constant review and adjustment over time. Implementation ends at the completion of phase II. A practice will receive Medical Home status when it meets three criteria: 1) practice readiness assessment score of 7.5 or greater, 2) National Committee for Quality Assurance (NCQA) recognition level 2 or higher, and 3) satisfactory staff assessment visit (SAV) utilizing the Transformation Assessment Tool. The MTF and RMC will be expected to report implementation progress and performance on a regular basis as specific in OPORD 11-20 and associated FRAGO's.

**Figure 2. Implementation Roadmap**

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<th>PHASE III: PERFORM</th>
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<td>Practice Manager Support</td>
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**Legend**

- Red Readiness Assessment Task (Green = 1.0 completion)
- Yellow Red Readiness Assessment Task (Amber = .5 completion)
- Text in bold italics represents a task that is required for phase completion

- Red PCMH Performance Metric
- Yellow MTF Reporting Criteria
- Green RMC Reporting Criteria

**2-1. Phase 1: Prepare**

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

**Task 1. Create a Guiding Coalition**

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

Key characteristics of an effective Guiding Coalition include--

- **Multidisciplinary.** The Guiding Coalition will include primary care representation, along with other sections, or departments that represent the Accountable Care Organization (ACO). Membership includes, at a minimum--
  - Primary Care
  - Specialty Care
  - Managed Care
  - Resource Management
  - Facilities
  - Referral Management
  - Clinical Services
  - Human Resources
  - Public Affairs
  - Information Management

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

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

- **Enduring.** The work of the Guiding Coalition continues throughout the implementation process.

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

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

**Task 2. Communicate the Vision**

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

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

Tools and messaging to support the commander’s communications campaign are located at the PCMH Web site: [https://www.us.army.mil/suite/page/661214](https://www.us.army.mil/suite/page/661214).

**Task 3. Conduct Baseline Readiness Assessment Using the PCMH Readiness Assessment Criteria**

The Readiness Assessment Criteria define the baseline from which a gap analysis is developed. These standard criteria are reportable to MEDCOM and are scored as follows and detailed in table 2:

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

The sum of all factors defines the overall level of readiness. A total of 7.5 points is the minimum level to operate as a PCMH. Table 1 lists the red, amber, green criteria by focus item. Each focus item is aligned with the implementation phase during which the MTFs should become fully capable for that respective focus item.

**Task 4. Perform Gap Analysis**

The Readiness Assessment defines the baseline for the gap analysis. The Military Health System (MHS) provides funds to the Army to hire primary care manager (PCM) support staff for registered nurse (RN), licensed practical nurse (LPN)/medic, nurse’s aide (NA), medical assistant (MA), medical support assistant (MSA), and the integrated behavioral health consultant. For detailed explanation of the composition of the 3.1 support staff, see MEDCOM PCMH FAQ: “What comprises the 3.1 staff ratio specified in the PCMH
OPORD* at PCMH Web site: https://www.us.army.mil/suite/page/661214. Funding for clinical pharmacists and dietitians is from core funds or through unfinanced requirement (UFR) submission.

Table 1. PCMH Readiness Assessment Tool

<table>
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<th>PCMH Readiness Assessment</th>
<th>Phase</th>
<th>Scoring Criteria</th>
<th>Score</th>
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<tr>
<td>1. PCM Home Teams</td>
<td>Phase 1</td>
<td>PCM Home Teams: (G=2-5 PCMs or all BDE PCMs/Home; A=5 PCMs or BDE providers are split into two PCM home teams, R=No Teams)</td>
<td></td>
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<tr>
<td>2. Optimize Empanelment</td>
<td>Phase 2</td>
<td>PCMs empanelled according to annex I, OPORD 11-20 (G= +/- 5% max capacity, A= +/- 10% max capacity, R= more or less than 10% capacity; available clinical FTE must be validated by Commander or delegated surrogate)</td>
<td></td>
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<tr>
<td>3. PCM Exam Rooms (2 min)</td>
<td>Phase 2</td>
<td>PCM Exam Rooms. (G=2.0-3.0; A=1.8-&lt;2.0; R=&lt;1.8 FTE per Provider FTE)</td>
<td></td>
</tr>
<tr>
<td>4. PCMH Team STEPPS Training</td>
<td>Phase 2</td>
<td>Team STEPPS training complete (G=All 90-100%; A=&gt;75% 75-89%; R=&lt;50% &lt;75% Staff)</td>
<td></td>
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<tr>
<td>5. AHLTA/MAPS Training &amp; Infrastructure</td>
<td>Phase 2</td>
<td>AHLTA/MAPS2.0/Workflow (G=Phase III complete; A= Phase II complete, Ill partially complete; R=Phase II not complete; (phases defined in OPORD11-47 and in Strategic Management System)</td>
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<td>6. RN Case Manager Support (incl Med Mng Cent and Respect-mil)</td>
<td>Phase 2</td>
<td>Nurse Case Manager (NCM). (G=1 per 6200 enrollees; A= 1 per 4500 or 8000 enrollees; R=1 per &lt;4500 or &gt;8000 enrollees)</td>
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<tr>
<td>7. PCM Support Staff (3.1 personnel)</td>
<td>Phase 2</td>
<td>PCM Core Support Team. (G=2.8-3.1 support staff; A=2.6-2.7 staff; R=&lt;2.6 staff per Provider FTE)</td>
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<td>8. Practice Manager Support</td>
<td>Phase 2</td>
<td>Practice Manager (PM). (G=1 per 8-12K pts; A=1 per 12-17K pts; R= 0 or 1 per &gt;17K pts)</td>
<td></td>
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<tr>
<td>9. Behavioral Health Integration</td>
<td>Phase 3</td>
<td>Behavioral Health Integration: IBHC Provider on board (G= 1 FTE per 1500-7500 enrollees and in synch with embedded BH Teams (eBH), A= 1 IBHC or in synch with eBH team per BDE, R= neither 1 IBHC or in synch with eBH</td>
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<tr>
<td>10. Pharmacist Integration</td>
<td>Phase 3</td>
<td>Pharmacist Integration- providing medication therapy management; dispensing medications alone does not count: (G= 1 clinical pharmacist per 5K-8500 pts, A= 1 clinical pharmacist per PCMH practice, or part-time dispensing meds and clinical consultation, R= integrated clinical pharmacist not assigned</td>
<td></td>
</tr>
<tr>
<td>PCMH Total Score</td>
<td></td>
<td>Greater than or equal 7.5 = min score to operate effectively</td>
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Task 4. Perform Gap Analysis (continued)

Funding for core support staff is provided in the fiscal year that the practice seeks NCQA recognition. The practice conducts a staffing gap analysis using the MEDCOM approved PCMH Support Staff Gap Assessment Template. The gap analysis is submitted through the RMC to the Office of The Surgeon General (OTSG) for approval. MEDCOM distributes funds based on the RMC validated and MEDCOM approved gap analysis. Hiring actions will occur in the year of funding.

The MEDCOM PCMH Support Staff Gap Assessment Template is available at the PCMH portal and through each RMC PCMH task force.

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

Gap analysis results determine funding and hiring requirements. Once the gap analysis is validated by the RMC, it is the official record of requirement. Subsequent re-analysis is not authorized unless a fundamental resourcing requirement has changed such as a significant population shift which changes support staff requirements.

Task 5. Apply for 4th Level MEPRS Requirements as Specified by Army MEPRS Program Office

All Army PCMH teams and practices will use Department of Defense (DOD) and Army MEPRS Program Office (AMPO) guidance and business rules for 4th-level B*Z* MEPRS code using approved and standardized file and table builds in multiple systems that will align and support the B*Z* Army Medical Home MEPRS obtained from the AMPO.

Requests for B*Z* Army Medical Home MEPRS codes should be submitted to the MTF MEPRS analyst who will forward to the AMPO office for approval. The AMPO office is the only approval authority for MEPRS codes. No later than 30 days prior to receiving a NCQA license, the practice completes the AMPO Army Medical Home Attachment. Earlier submission is encouraged. Practices seeking NCQA recognition in FY13 must submit Attachment 3 NLT 1 April 13. AMPO and MEDCOM PCMH task force will review and approve submissions within 14 days of receipt.

Detailed instructions on the establishment of the new MEPRS can be found in the most recent version of the AMPO guidance published each fiscal year and posted to the PCMH Web site: [https://www.us.army.mil/suite/page/661214](https://www.us.army.mil/suite/page/661214) and OPORD 11-20 FRAGO 6.

Task 6. Close the Gaps

Closing the gaps occurs throughout the implementation process spanning all phases.
Table 1, the PCMH Readiness Assessment Tool specifies which gaps need to be closed to proceed to the next phase of implementation.

**Personnel Gaps**
The validated support staff gap analysis is the authorization document to hire. RMCs will allocate funds and final hiring authorizations based on the gap analysis. Regions track hiring actions in relation to the gap analysis. Once MTFs determine, RMC supports, and MEDCOM/OTSG approves the manpower mix required to support the transition to the PCMH delivery of primary care, MTFs must follow the guidance in the 7 May 2012 MCHR-C memo subject: Placement of Current Employees to Support Patient Centered Medical Home (PCMH) to staff their PCMH clinics. Additionally, management must ensure that personnel are aligned and placed against an authorized position in their PCHM TDA in accordance with annex C (PCHM Structure) to OPORD 11-20. As this process may take considerable time, this does not preclude the MTF from detailing the existing staff and begin working under the new PCMH roles and responsibilities. Every effort should be made to effect no-cost lateral reassignments, from and to the same grade, to minimize the cost for the PCMH.

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

**Training Gaps**
Core Content Training, TeamSTEPPS Training, MAPS 2.0/TriService Workflow (TSWF) Training, and Integrated Clinical Database (ICDB)/CarePoint (“PCMH Huddle Tool”) are critical training elements for the PCMH. Training on these can begin in the Prepare Phase with practice ready and trained by the end of the Recognize Phase. Sustainment and refresher training are ongoing activities to maintain the competence and effectiveness of the practice. The PCMH must have a plan to effectively “on board” new employees with critical training elements.

**Facilities/Equipment Gaps**
RMCs will conduct facilities assessments to meet the two exam room per provider readiness criteria and optimize facility utilization to support PCMH implementation. Funding for facility modification projects will come out of core sustainment, recapitalization, and maintenance (SRM) funds. Any projects that exceed SRM funding budgets or thresholds will be submitted through normal request channels specifically identified in support of PCMH. RMCs will conduct similar assessments for medical and IT equipment to support PCMH. Funding will be processed through normal Capital
Equipment Expense Program (CEEP) channels specifically identified in support of PCMH.

2-2 Phase II: Recognize

Army Medicine’s goal is for all direct care enrollees to be seen in an Army PCMH recognized by NCQA as Level 2 or above no later than 1 October 2014. The RMC will conduct a readiness assessment for all practices using the readiness assessment criteria as one method to determine when a practice is ready to seek recognition. A score of 7.5 is considered the minimum to operate effectively as a PCMH, but is not a limiting factor for seeking recognition. The practice will begin familiarization with the NCQA standards during the preparation phase and should be ready to begin the process immediately. Phase 2 begins when the practice receives a license from NCQA. NCQA recognition will take no longer than 180 days.

The Surgeon General/MEDCOM Commander and the Deputy Commanding General for Operations are closely tracking the accelerated transformation of primary care into PCMH practices. Implementation actions that will be tracked strategically by MEDCOM are—

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

Task 1. NCQA Application

Once practices are confirmed for participation in the NCQA recognition process, MEDCOM obtains a license specific for each practice. NCQA will contact the practice directly via email to provide access to the NCQA website. Phase II begins officially on the day the practice receives the license from NCQA and will have 180 days to complete the survey and receive recognition results. The practice provider, nurse, and administrative teams will work together to complete the survey for recognition. MEDCOM will coordinate the NCQA process through the RMC.


Task 2. Training

- Core Content Training

The Army PCMH Core Content training has been developed by MEDCOM and will be provided by the RMC Transformation Teams. Training modules are aggregated into two multi-day blocks of training: Step 1 and Step 2. Steps 1 and 2 can be completed in
separate training sessions or in one combined session. Training is not restricted to primary care staff. All involved sections of the ACO attend training. Initial and sustainment training resources include the Army PCMH Interactive Multi-Media Instruction Suite produced through the AMEDD C&S and available on-line or by DVD.

• **TeamSTEPPS Training**
  TeamSTEPPS training is essential to enhanced care team performance and patient safety. TeamSTEPPS training requirements are defined in MEDCOM OPORD 11-38 at the Army PCMH Web site: [https://www.us.army.mil/suite/page/661214](https://www.us.army.mil/suite/page/661214).

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

• **ICDB/CarePoint (“PCMH Huddle Tool”)**
  Leaders will ensure that all staff in the PCMH responsible for huddle preparation have a Carepoint account and receive adequate training on the use of the Huddle Tool. Requests for Carepoint access are initiated through the MEDCOM Evidence Based Practice office at (210) 221-6527.

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

AMSMS is intended to be the primary means of communicating with patients and team members. Dedicated staff must be identified and trained using the MEDCOM AMSMS standard train-the-trainer curriculum to maintain the system and provide sustainment training. This is an MTF and RMC responsibility with support from the MEDCOM Project Management Office and Capability Managers Office. Refer to AMSMS OPORD 12-57 any subsequent FRAGOS and the supporting guide and related support materials all located at the PCMH Web site: [https://www.us.army.mil/suite/page/661214](https://www.us.army.mil/suite/page/661214).
Task 3. Optimize Empanelment

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


Task 4. Activate/Implement 4th Level MEPRS Utilization

Practices will transition to new MEPRS code and deactivate legacy codes before the end of Phase II. It is imperative that practices aggressively act to accomplish this task to provide effective performance measurement and accountability of financial and human resources in the PCMH. The AMPO and MEDCOM PCMH program office will review financial systems and Composite Health Care System (CHCS) files and table to validate correct implementation and data quality after the new codes are operational. Practices in phase II are required to report weekly status reports through the RMC to MEDCOM AMPO until the new codes are operational.

Task 5. Transformation Assessment Visit

Staff assistance visits will be conducted by the RMC using the Transformation Assessment Tool as the standard to assess successful implementation of core principles and standards within the PCMH practice and ACO. Successful achievement of performance benchmarks detailed in the tool is not required for Army PCMH recognition. The PCMH Transformation Assessment Tool tracks the healthcare delivery process starting with Patient Welcome and progressing through Empanelment, The Care Team, Accessing Care, Service Standards and Workflow, Integrated Care, Patient Activation, Care Coordination, and Process Improvement.

Task 6. Submit an NCQA Survey

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

NCQA Standards are aligned with the six primary care core components—

1. Enhance access and continuity.
2. Identify and manage patient populations.
3. Plan and manage care.
4. Provide self-care and community support.
5. Track and coordinate care.

Task 7. Become a Validated Army Patient Centered Medical Home

A practice becomes an official Army PCMH when it meets three criteria:
- Practice readiness assessment of 7.5 or greater.
- NCQA recognition level 2 or higher.
- Successful validation by the RMC Transformation Team during an SAV utilizing the Transformation Assessment Tool.

2.3 Phase III: Perform

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

Successful PCMH practices achieve their full potential to improve the healthcare experience by providing continuity and coordination of care, proactive population-based health management, preventive and wellness services and support for patient self-management. MTFs remain accountable for the performance of tactical level measures for all tasks of OPORD 09-36 (Access to Care Campaign) and both FRAGO 1 & 2 to OPORD 09-36, unless otherwise superseded by OPORD 11-20.

Current (JAN 2013) strategic metrics are--

- Enrollment from Enrollment Capacity Model.
- Emergency room utilization.
- Network leakage of primary care (where enrollees go for care).
- PCM by name continuity (volume and percentage).
- Patient satisfaction (APLSS question 20).
- Staff satisfaction (MEDCOM Speaks!).
- HEDIS® Composite Score.
- Medical Readiness Category (MRC) Category 4.
3-1. Accountable Care Organization

Army Medicine is transforming to a Patient-Centered System For Health, dedicated to providing a consistent patient experience. PCMH teams promote the delivery of comprehensive, high quality health care in a fully coordinated and synchronized manner. The PCMH team roles and responsibilities are outlined in figure 3 and table 2, below, and include the PCM core team, PCMH practice, and ACO.

The ACO consists of the MTF leadership and all clinical and non-clinical support activities responsible for health care and support to the same group of beneficiaries. The ACO includes, but is not limited to: human resources, information management, resource management, managed care, in addition to primary care, subspecialty, and surgical care lines. Leaders of these staff activities, as well as their subordinates, must understand the PCMH mission and appreciate the priority of effort required to support the patient-provider partnership.

Figure 3. PCMH Collaboration Model

PCMH COLLABORATION MODEL
3-2. PCMH Staff Model

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

3-3. Medical Neighborhood

The Medical Neighborhood consists of the network of other clinicians and services providing health care to patients. The Medical Neighborhood is expected to deliver coordinated care, effective communications, and shared decision-making. It is intended to improve the patient experience, improve patient outcomes, improve patient safety, and reduce healthcare costs. The Medical Neighborhood includes inpatient care, post-acute rehabilitation, emergency care, specialty and subspecialty care, ancillary services (physical therapy, occupational therapy, podiatry, and speech therapy), diagnostic services (laboratory and radiology), and patient education and health promotion programs (wellness/preventive medicine).

Table 2. Roles and Responsibilities (PCMH, Medical Neighborhood, ACO)

<table>
<thead>
<tr>
<th>PCMH LEVEL</th>
<th>ROLES</th>
<th>KEY RESPONSIBILITIES</th>
<th>RATIO</th>
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<tbody>
<tr>
<td>PCMH CORE TEAM</td>
<td>• Medical Director/Clinic OIC</td>
<td>The senior clinical expert and primary clinical decision maker for the PCMH Home.</td>
<td>1 FTE per PCMH Home</td>
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<td></td>
<td>• Primary Care Manager (PCM) MD/DO/NP/PA</td>
<td>Provides coordinated, comprehensive primary care to empanelled Patients.</td>
<td>Per enrollment guidelines in MEDCOM OPORD 11-20, Annex I</td>
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<td></td>
<td>• Team Registered Nurse (RN)</td>
<td>Leads the continuity of care delivery and care plan implementation, establishes priorities for patient care, evaluates patient progress and provides patient education.</td>
<td>Part of 3.1 core team staff. Refer MEDCOM OPORD, Annex D.</td>
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<td></td>
<td>• Licensed Practical Nurse / Licensed Vocational Nurse (LPN/LVN)</td>
<td>Provides direct nursing care within scope of practice, assists with the implementation of the care plan.</td>
<td>Part of 3.1 core team staff. Refer MEDCOM OPORD, Annex D.</td>
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<tr>
<td></td>
<td>• Medic</td>
<td>Provides direct nursing care within scope of competencies, assists with the implementation of the care plan.</td>
<td>Part of 3.1 core team staff. Refer MEDCOM OPORD, Annex D.</td>
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<td></td>
<td>• Certified Nurse Assistant (CNA); Medical Technicians; Medical Assistants</td>
<td>Provides direct nursing care within scope of competencies, enhances PCM functioning by supporting daily clinical procedures.</td>
<td>Part of 3.1 core team staff. Refer MEDCOM OPORD, Annex D.</td>
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<tr>
<td></td>
<td>• Medical Clerk / Administrative Assistant (MA)</td>
<td>Provides direct administrative patient support services, acts as the front line customer service advocate, and serves as the communication link between the</td>
<td>1 FTE per 3 FTE PCM Refer to annex OPORD 11-20, AnnexD-1</td>
</tr>
<tr>
<td>PCMH LEVEL</td>
<td>ROLES</td>
<td>KEY RESPONSIBILITIES</td>
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<tr>
<td>PCMH PRACTICE</td>
<td></td>
<td>patient and the PCM care team.</td>
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<td></td>
<td>• Practice Manager</td>
<td>Provides management oversight of clinic operations.</td>
<td>1 FTE per &gt;10,000 enrollees</td>
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<td></td>
<td>• Clinical Nurse OIC (CNOIC)</td>
<td>Oversees the scope of practice and provision of nursing services provided.</td>
<td>Part of 3.1 core team staff. 1 FTE per Practice</td>
</tr>
<tr>
<td></td>
<td>• Clinical NCOIC</td>
<td>Oversees and consults on the scope of practice and provision of care provided by the technicians and enlisted staffs.</td>
<td>Part of 3.1 core team staff, if not at department level. 1 FTE per Practice</td>
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<td></td>
<td>• Nurse Case Manager (NCM)</td>
<td>Synchronizes healthcare management for patients with chronic, catastrophic, or complex medical conditions, or identified as high utilization or high risk.</td>
<td>Part of 3.1 core team staff. 1 FTE per &gt;6500</td>
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<td></td>
<td>• Population Health Nurse (PHN)</td>
<td>Coordinates and implements health promotion practices and measures.</td>
<td>Part of 3.1 core team staff. 1 FTE per 10 FTE PCMs</td>
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<td></td>
<td>• Behavioral Health (BH) Provider</td>
<td>Provides coordinated, short-term Behavioral Health care, assists PCMs in recognizing and treating BH disorders and psychosocial problems.</td>
<td>1 FTE PER ≥ 7500 enrollees</td>
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<td></td>
<td>• Pharmacist</td>
<td>Provides coordinated medication management, identifies medication related problems, develops care plans with therapy goals, and serves as medication educator for both Patients and providers.</td>
<td>1 FTE per ≥ 6500 enrollees (amended in Operations Manual)</td>
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<tr>
<td></td>
<td>• Dietitian</td>
<td>Provides coordinated nutrition education and support to targeted populations, groups and individuals.</td>
<td>1 FTE ≥ 7500 enrollees</td>
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<tr>
<td>MTF ACO/Clinical Neighborhood</td>
<td>Supports all IM/IT infrastructure requirements, manages MAPS 2.0, AMSMS, and ICDB/CHAS training and implementation.</td>
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<tr>
<td>Information Management Director (IMD)</td>
<td>Manages hiring actions for validated medical home positions, assists with gap analyses for staffing, performs realignment and reassignment actions.</td>
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<tr>
<td>Chief Medical Information Officer (CMIO)</td>
<td>Tracks training in DTMS/APEQS, manages taskers, tracks and coordinates SAV/OIP. Manages “Mobilization Plan.”</td>
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<tr>
<td>Human Resources (HR)</td>
<td>Performs space requirement assessments and allocation to optimally support integrated practice activities.</td>
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<tr>
<td>Operations/Training</td>
<td>Leads strategic communications planning and activities related to marketing focused on both Patients and staff.</td>
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<tr>
<td>Logistics</td>
<td>Supports and manages all supply and equipment needs.</td>
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<tr>
<td>Facilities Management</td>
<td>Manages Patient enrollment and empanelment to support optimal patient care.</td>
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<tr>
<td>Public Affairs Office (PAO)</td>
<td>Supports the medical home by appropriately appointing Patients to the proper PCM/team.</td>
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<tr>
<td>Managed Care / CLINOPS / PAD</td>
<td>Identifies and manages Family Members with special care needs.</td>
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<tr>
<td>Central Appointments</td>
<td>Provides comprehensive, timely radiology services.</td>
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<tr>
<td>Exceptional Family Member Program (EFMP)</td>
<td>Provides comprehensive, timely laboratory services.</td>
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<tr>
<td>Radiology</td>
<td>Manages network referrals and consultations, ensures timely feedback to referring provider.</td>
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<tr>
<td>Laboratory</td>
<td>Supports credentials and privileging of all providers and care team, leads TeamSTEPPS™ training.</td>
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<tr>
<td>Emergency Department</td>
<td>Coordinates with MEDCOM for assignment and activation of MEPRS codes, assists with manpower and PCMH data analyses.</td>
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<tr>
<td>Quality Management (QM)</td>
<td>Supports all mandatory initial and sustainment training requirements for the PCMH staff.</td>
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<tr>
<td>Referrals Management</td>
<td>Manages and coordinates network referrals and consultations, ensures timely feedback to referring provider.</td>
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<tr>
<td>Resource Management (RM)</td>
<td>Supports all IM/IT infrastructure requirements, manages MAPS 2.0, AMSMS, and ICDB/CHAS training and implementation.</td>
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<tr>
<td>Graduate Medical Education (GME)</td>
<td>Manages and coordinates network referrals and consultations, ensures timely feedback to referring provider.</td>
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<tr>
<td>Staff Education &amp; Training</td>
<td>Supports credentials and privileging of all providers and care team, leads TeamSTEPPS™ training.</td>
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</table>
Appendix A

References

All references will be maintained on the PCMH Web site at
https://www.us.army.mil/suite/page/661214

GLOSSARY

Section I
Abbreviations

ACO
Accountable Care Organization

AMEDD C&S
Army Medical Department Center and School

AMH
Army Medical Home

AMPO
Army MEPRS Program Office

AMSMS
Army Medicine Secure Messaging Service

ATRRS
Army Training Requirements and Resources System

CBMH
Community Based Medical Home

CEEP
Capital Equipment Expense Program

CHAS
CarePoint Healthcare Application Suite

CHCS
Composite Health Care System

CHUP
Chronic Disease, High Utilizer, Polypharmacy

CNA
certified nurse assistant

CNOIC
chief nurse officer in charge

CPG
clinical practice guideline
DMHRSi
Defense Medical Human Resources Systems Internet

DOD
Department of Defense

EHR
electronic health record

FTE
full-time equivalent

HEDIS®
Health Effectiveness Information Data Set

IBHC
Internal behavioral health consultant

ICDB
Integrated Clinical Database

LPN
licensed practical nurse

LVN
licensed vocational nurse

MAPS
MEDCOM AHLTA Provider Satisfaction

MEDCOM
(U.S. Army) Medical Command

MEPRS
Medical Expense Performance Reporting System

MHS
Military Health System

MM
medical management

MTF
military treatment facility
NCM  nurse case manager
NCOIC  noncommissioned officer in charge
NCQA  National Committee for Quality Assurance
OHI  other health insurance
OIC  officer in charge
OTSG  Office of The Surgeon General
PCM  primary care manager
PCMH  Patient Centered Medical Home
PCTS  Patient Caring Touch System
PHN  population health nurse
RD  registered dietitians
RMC  regional medical command
RN  registered nurse
SCMH  Soldier Centered Medical Home
SRM  sustainment, recapitalization, and maintenance
TDA
tables of distribution and allowances

TJC
The Joint Commission

TOL
TRICARE Online

TSC
TRICARE Service Center

TSWF
TriService Workflow

TSWF-AIM
TriService Workflow Alternate Input Method

UFR
unfinanced requirement

Section II
Terms

Access Call Center
A single telephonic point of entry to respond to appointment requests via phone for all primary care (MEDCOM Policy 10-063).

Accountable Care Organization
An organization responsible for healthcare and support to the same group of beneficiaries. This includes but is not limited to the MTF leadership, all clinical and non-clinical support activities such as Human Resources, Information Management, Resource Management, Managed Care, in addition to primary care, subspecialty, and surgical care lines. The organization's reimbursement and resourcing is tied to achievement of healthcare quality goals and outcomes that result in cost savings.

Army Medicine Secure Messaging Service (AMSMS)
Secure messaging is a commercial, web-based, secure platform that provides a robust set of services designed to allow patients and their healthcare team to communicate privately, at times and locations that are convenient. This secure platform works very much like an on-line secure banking web site.

B.A.S.I.C. Communication Tool
An acronym to ensure staff meets our patients' needs in a proactive manner.

Break Barriers: If there is an issue or situation preventing the delivery of our best services, it is our responsibility to break barriers to solve the problem.
Anticipate and Accommodate: Individual experience and intuition tell us when there is a need to be met. Act immediately to meet the need.

Seek Solutions: The world is full of problems. We take pride in our individual and organizational ability to find solutions.

Initiate and Interact: When someone approached us, we look at them and start the conversation by saying "hello" or "how can I help you?"

Communicate: Be clear. Always include intent in your comment or questions. Ask a question to make sure the other person understood what you intended to communicate (PCMH Training module).

Care Coordination
An approach to care management using proactive methods to optimize health outcomes and reduce risks of future complications over a short-term (two to six weeks) single episode of care. Prospective and concurrent reviews are used to identify current and future beneficiary needs (http://www.tricare.mil/mybenefit/Glossary.do?F=C).

Care Plan
A document that identifies nursing orders for a patient and serves as a guide to nursing care. It can be written for an individual patient, retrieved from a template and individualized, or preprinted for a specific disease, condition, or nursing diagnosis and individualized to the specific patient. Standardized care plans are available for a number of patient conditions. Successful care plans are patient specific and should address the total status of the patient to ensure optimal outcomes for patients during the course of their care.

CarePoint
An application Portal is the DoD healthcare application framework for business intelligence, healthcare content management, user collaboration and personalization. CarePoint is the common development platform providing quick implementation of healthcare applications with a consistent and familiar user experience.

Case Management
A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost effective outcomes (Case Management Society of America, www.cmsa.org).

Daily Huddle
“A team meeting to ensure efficient patient visits by discussing patients on the day’s schedule. A communication process may include email exchanges or messages in the medical record about the patient. NCQA reviews the practice’s communication process and an example of a meeting summary, agenda or memo to staff.” (www.ncqa.org: The ACO Structure, 2005)

Empanelment
The process by which primary care managers are identified and individual TRICARE Prime enrollees are assigned to them. Only TRICARE Prime Enrollees will be empanelled (Health Affairs Policy Memorandum 97-041).

**Enrollment**

The process by which participation status in the TRICARE MHS Managed Care Program is established (http://www.tricare.mil).

**Handshake Medicine**

Policies and procedures to guarantee a consistent patient experience and effective transitions for both patients and staff from one location to another across Army Medicine.

**HEDIS® (Healthcare Effectiveness Data and Information Set)**

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. Altogether, HEDIS® consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS® data, and because the measures are so specifically defined, HEDIS® makes it possible to compare the performance of health plans on an "apples-to-apples" basis (www.ncqa.org).

**Integrated Clinical Database (ICDB)**

The ICDB is an effective “user-friendly” system that presents clinical data in a tailored, manageable structure. With a uniform architecture and integrated views for the provider team, it supports patient care, data analysis, and research. While leveraging legacy systems such as CHCS, it enables a transition platform for emerging technologies. (http://www.himss.org/content/files/ambulatorydocs/ICDB.pdf)

**Lifespace**

Also see White Space. The Lifespace is when we make decisions on sleep, activity, and nutrition. We estimate that most patients visit a doctor 1 to 5 times a year, and each visit is about 20 minutes each. Those 100 minutes is the most we can influence patient health. The other 525,500 minutes in our lives is when we’re at work, or at home with our families. It’s in this Lifespace where the choices we make impact our lives and our health. In this Lifespace, we want to focus on the Triad of factors that our patients can become invested and help to manage their health—Activity, Sleep and Nutrition.

**Nurse Advice Line**

TRICARE defines Nurse Advice Line as providing around-the-clock access to medical information and advice. The Nurse Advice Line provides RNs who can answer questions, provide self-care advice, and help you decide if you need to seek immediate care; an audio health library with easy-to-understand information on hundreds of topics. Help with managing chronic conditions, such as diabetes or asthma. In some locations, the nurse may be able to directly schedule appointments at your military treatment facility if needed (www.tricare.mil).

**Operating Company Model**
The OCM is foundational approach to organization that leverages centralized control, decentralized execution to an enterprise-wide organizational standard. An OCM is designed around integrated, standard processes across the organization. Performance metrics and decision-making are clearly defined for these processes, driving accountability. High focus and priority is given to process quality, repeatability, and standards to drive a better, more consistent patient experience while also containing costs. The OCM emphasizes clarity, consistency and accountability across five pillars:

- **Process structure:** How we get things done to a high quality standard
- **Organizational structure:** How we deploy our people in support of our mission
- **Governance and decision-making:** Who “makes the call” when we have competing priorities
- **Performance metrics and accountability:** How we understand and communicate our performance
- **Culture:** How we work together to support these goals and make them part of our “DNA”

**Polypharmacy**
A patient treated for multiple conditions with a variety of medications prescribed by several healthcare providers. When a patient receives four or more medications that include one or more psychotropic agents and/or central nervous system depressants, within a 30 day-period they meet the definition for polypharmacy.

**Primary Care Provider (aka Primary Care Manager, PCM)**
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.

**TRICARE Online**
Provides secure access to online features such as appointments, prescriptions, and personal health data for DoD beneficiaries receiving care through a military treatment facility.

**White Space**
Also see Lifespace. The time between doctors’ visits and that this is where the majority of decisions that affect an individual’s health are made. She spoke of the need to reach patients on an individual level and to empower them in maintaining and enhancing their own health and well-being (The Surgeon General of the United States Army; [http://www.dvidshub.net/news/83066/military-health-period-transformation-says-woodson-rooney-horoho#ixzz2Fdk3qBux](http://www.dvidshub.net/news/83066/military-health-period-transformation-says-woodson-rooney-horoho#ixzz2Fdk3qBux)).
FEEDBACK AND IMPROVEMENTS

The PCMH Transformation Team welcomes feedback and improvements to this implementation manual. Recommendations can be communicated via the link at https://www.us.army.mil/suite/page/661214, the Army Knowledge On Line webpage for PCMH. All recommendations will receive consideration and response. A series of active tasks is being worked as Task Action Plans (TAPs) by the PCMH TF. As these action items are completed, additional standards and capabilities will be included in quarterly updates to the PCMH Implementation and Operations Manual. All updates will be sent electronically through wide distribution and will be posted on PCMH AKO webpage and MEDCOM PCMH SharePoint sites.