



Joint Task Force  
National Capital Region Medical  
**INSTRUCTION**

NUMBER 6025.05

JUL 02 2012

J-3B

SUBJECT: Patient Centered Medical Home (PCMH)

References: See Enclosure 1

1. PURPOSE. This Instruction, in accordance with (IAW) the authority in References (a) through (e), establishes policy for a model of patient and family-centered healthcare that is team-based, comprehensive, and designed to fully meet the complete primary care health and wellness needs of our beneficiaries. It focuses on preventive care, early intervention, and management of health problems in order to reduce high volume, episodic, and uncoordinated care. A PCMH practice provides for all of a patient's healthcare needs, including the coordination and integration of all specialty healthcare and other professional services.
2. APPLICABILITY. This Instruction applies to the Joint Task Force National Capital Region Medical (JTF CapMed) Headquarters, Fort Belvoir Community Hospital (FBCH), and Walter Reed National Military Medical Center (WRNMMC). Any deviations or exceptions to this guidance are subject to the prior approval of Commander, JTF CapMed (CJTF) or designee.
3. POLICY. It is the JTF CapMed policy that FBCH and WRNMMC implement the new PCMH model of delivering patient and family-centered healthcare to meet the health and wellness needs of the patients. See Enclosure 4 for metrics on required Strategic Metrics Requirements and reporting to the JTF CapMed.
4. RESPONSIBILITIES. See Enclosure 2
5. PROCEDURES. See Enclosures 3 and 4
6. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Internet from the JTF CapMed Web Site at: [www.capmed.mil](http://www.capmed.mil).

JUL 02 2012

7. EFFECTIVE DATE. This Instruction is effective immediately.



STEPHEN L. JONES  
Major General, U.S. Army  
Acting Commander

Enclosures

1. References
2. Responsibilities
3. PCMH Principles for PCMH Provider Champions
4. Strategic Metrics Requirements

Glossary

Figures

1. Staffing Ratios for Personnel Assignment
2. Required Additional Personnel Support
3. Military Expense and Performance Reporting System (MEPRS) Personnel Detail

JUL 02 2012

ENCLOSURE 1REFERENCES

- (a) Deputy Secretary of Defense Memorandum, "Establishing Authority for Joint Task Force National Capital Region Medical (JTF CapMed) and JTF CapMed Transition Team (Unclassified)," September 12, 2007
- (b) Deputy Secretary of Defense Action Memo, "Civilian and Military Personnel Management Structures for the Joint Task Force National Capital Region Medical," January 15, 2009
- (c) Comprehensive Master Plan for the National Capital Region Medical, April 23, 2010
- (d) Supplement to the Comprehensive Master Plan for the National Capital Region Medical, August 31, 2010
- (e) TMA/DoD(HA), Military Health System Patient Centered Medical Home Guide, June 2011
- (f) BUMEDINST 6300.19, "Primary Care Services in Navy Medicine," May 26, 2010
- (g) Air Force Instruction 44-171, "Patient Centered Medical Home and Family Health Operations," January 18, 2011
- (h) Operation Order (OPORD) 11-20, "Army Patient Centered Medical Home," January 2011<sup>1</sup>
- (i) Section 199 of Title 32, Code of Federal Regulation (CFR), "Civilian Health and Medical Program of the Uniformed Services."
- (j) Policy Memorandum, OASD(HA), "Implementation of the Patient-Centered Medical Home Model of Primary Care in MTFs," September 18, 2009
- (k) Assistant Secretary of Defense (HA) Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011
- (l) TRICARE Medical Management Guide, 2009
- (m) Assistant Secretary of Defense (Health Affairs) Policy Memorandum 09-015, "Implementation of the 'Patient Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009
- (n) JTF CAPMED-D 1140.01, "Appointing and Scheduling Operations within the Joint Operations Area (JOA)," June 28, 2011
- (o) JTF CAPMED-I 6025.04, "Medical Quality Assurance (MQA) and Clinical Quality Management," October 5, 2011
- (p) DoD-I 8510.01, "DoD Information Assurance Certification and Accreditation Process (DIACAP)," November 28, 2007
- (q) JTF CAPMED-I 8500.02, "DoD Information Assurance Certification and Accreditation Process (DIACAP) Interim Authorization to Test (IATT)," December 08, 2011

---

<sup>1</sup> See Web Site [http://www.aap.org/sections/uniformedservices/USPS/N\\_Medical\\_Home\\_in\\_the\\_Military.pdf](http://www.aap.org/sections/uniformedservices/USPS/N_Medical_Home_in_the_Military.pdf)

JUL 02 2012

ENCLOSURE 2RESPONSIBILITIES

1. CJTF. The CJTF shall ensure implementation of PCMH within FBCH and WRNMMC IAW References (e) through (q).

2. DIRECTOR, JTF CAPMED CLINICAL AND HEALTHCARE BUSINESS OPERATIONS (J-3B). The Director, J-3B, will assist in the oversight of the implementation of PCMH within FBCH and WRNMMC as directed by the CJTF. The Director will be changing or modifying the strategic metric requirements as necessary using issuances provided directly to the Medical Treatment Facilities (MTFs).

3. FBCH AND WRNMMC COMMANDERS. The FBCH and WRNMMC Commanders shall:

a. Be responsible and accountable for the implementation of PCMH at their facilities. MTF Commanders should apprise the CJTF of their ability to fully implement and sustain PCMH at their MTFs.

b. Identify points of contact at the MTF who will be PCMH Champions/subject matter experts for training and coordination on the PCMH concept for the hospital staff; as well as job-specific training for members of the PCMH.

c. Follow the recommended staffing ratios for JTF CapMed depicted in the figures below to ensure optimum implementation of PCMH. Service-specific ratios are in IAW References (e) through (h).

Figure 1. Staffing Ratios for Personnel Assignment

Skill Type	Team Member	FTE <sup>1</sup>
Skill Type 1 and 2	Provider FTE per team	3-5
Skill Type 3	Registered Nurse per provider FTE	0.667
Skill Type 4	Ancillary Staff per provider FTE	1.8
Skill Type 5	Clerical Staff per provider FTE	0.75
	Total Support per provider FTE	3.217

<sup>1</sup> Full-time Equivalent (FTE)

JUL 02 2012

Figure 2. Required Additional Personnel Support

Additional Team Support *	
Behavioral Health Provider	1 for clinics with 7,500 or more enrollees
Nurse Case Manager	1 per 6,200 enrollees
Group Practice Manager	1 per 10,000 enrollees
Pharmacist	1 per 10,000 enrollees
Clinic Nurse OIC	
Clinic NCOIC	
Dietician	1 per 7,500 enrollees

\* Acuity-based staffing for these disciplines is currently under review

Figure 3. MEPRS Personnel Detail

Skill Type Category	Skill Type Nomenclature	Skill Type Suffix/Personnel Within Category
Skill Type 1	Clinician	1D = Dentist 1F = Fellow-Medical 1N = Intern-Medical 1P = Physician 1R = Resident-Medical 1S = Intern-Dental 1T = Fellow-Dental 1U = Resident-Dental 1V = Veterinarians
Skill Type 2	Direct Care Professional	2A = Nurse Anesthetist 2C = Community Health Nurse (Cred) 2H = Occ Health Nurse (Cred) 2M = Nurse Midwife 2N = Nurse Practitioner 2P = Physician Asst 2S = Clinical Nurse Spec 2W = Student-Non GME/GDE 2Z = All Others in ST 2
Skill Type 3	Registered Nurse	3C = Community Health Nurse (Non-Cred) 3E = Nurse Case Manager 3H = Occ Health Nurse (Non-Cred) 3R = Registered Nurse 3W = Student-Non GME/GDE 3Z = All Others in ST 3
Skill Type 4	Direct Care Para Professional	4A = Nursing Assistant 4L = LPN/LVN 4W = Student-Non GME/GDE 4Z = All Others in ST 4
Skill Type 5	Admin/Clerical	5A = Administrators 5C = Clerical 5L = Logistics 5W = Student-Non GME/GDE 5Z = All Others in ST 5

JUL 02 2012

d. Based upon empanelment targets of provider availability and their continuity of practice, JTF CapMed recommends that providers realize 1,100 -1,300 adult patients for every full-time equivalent provider on the Medical Home Team, and 1,000-1,100 for pediatric patients. Acuity-based empanelment is currently under review.

e. Minimize collateral duties which can take military providers out of the clinic because provider availability is critical to PCMH success. The following responsibilities should be considered. Ensure that FTE deductions align with those listed in the JTF CapMed Annual Performance Planning Guidance.

f. Institute Medical Home support staffing IAW Reference (e).

(1) Ensure these staffing ratios of support staff are preserved and consistently available.

(2) Redistribute staff from other areas as needed.

g. Provide suitable facilities.

h. Establish appointing protocols to maximize continuity with patients appointed to their PCMH provider to the maximum extent possible.

4. MEDICAL HOME STAFF. Medical Home staff shall:

a. Use References (e) through (h) as guidance for the staffing roles of the Registered Nurse, ancillary nursing support, clerical staff, etc., of the roles inherent within the PCMH model.

b. Ensure each member of the PCMH Team has specific, delineated responsibilities for which they are accountable in ensuring an optimal Medical Home Team IAW Reference (e).

c. Ensure that all staff receives orientation to PCMH training to effectively implement PCMH. Initial and sustainment training includes but is not limited to TEAM STEPPS and Tri-Service Work Flow (TSWF).

JUL 02 2012

ENCLOSURE 3PCMH PRINCIPLES FOR PCMH PROVIDER CHAMPIONS

1. PATIENT CONTINUITY. An essential feature of PCMH for its empanelled patients is patient continuity. The PCMH Team Leader/PCMH Provider Champion is a provider who leads a team of individuals at the practice level. The team collectively takes responsibility for the ongoing care of patients. The provider supplies all the patient's healthcare needs or takes responsibility for appropriately arranging care with other qualified professionals. Healthcare is coordinated and/or integrated across all levels of care; such as, subspecialty care, hospitals, home health agencies, and nursing homes.

a. The PCMH Provider Champion ensures patient empanelment targets are based upon provider availability for continuity of practice. The process of cross-booking patients to other PCMH Teams should be minimized and done only when there are extended temporary duties, deployments, or prolonged absences.

b. The PCMH Provider Champion develops action plans that anticipate short- and long-term provider and clinic support staff shortages (i.e., TDY, leave, illness and deployments).

c. The PCMH Provider Champion identifies opportunities to maximize patient continuity and through scheduling of floaters, non-empanelled medical officers/providers, and individual mobilization augmentees, as available.

2. PROVIDER TEMPLATES. Templates should deliver a standard number of appointments for every week the provider is available. Appointing protocols will be established by the MTF Hospital Commander to maximize continuity with patients appointed to their PCMH provider to the maximum extent possible.

a. The PCMH Provider Champion ensures the PCMH coordinates with the Integrated Referral Management and Appointing Center IAW Reference (n) as required to assure beneficiary access appointing services meet appointing standards.

b. Telephone "trees" and appointing clerk protocols should give clear guidance to those making appointments at the first call (one-call resolution concept) as to where to book the patient. This would ideally include the authority to refer minor acute care to network or Urgent Care Clinic resources when access conditions require.

c. A lack of available appointments consistently impedes the ability for patients to achieve first-call resolution when trying to make an appointment. For this reason, the clinics will maintain six week rolling schedules for their providers. Clinic manager or surrogate that creates templates will review appointment availability at least twice a week to adjust templates based on demand. PCMH clinics will have an established mechanism to contact provider or provider team during non-duty hours.

JUL 02 2012

3. CONTROL. Service chiefs, in coordination with unit leadership, will ensure that provider and support staff availability meet clinical demand IAW Reference (o).
  
4. SATISFACTION. Patient, provider, and support staff satisfaction are carefully monitored by Health Affairs/TRICARE Management Activity (HA/TMA) surveys on a quarterly basis and will be provided to the PCMH teams.
  
5. APPOINTMENT TYPES. The following appointment types will be used for template development (the terms in parentheses refer to the definitions seen in Armed Forces Health Longitudinal Technology Application):
  - a. Open Access: Open Access (OPAC) appointment types are for patients to be seen within 24 hours.
  
  - b. Established: Established (EST) appointments types are for patients that can be scheduled beyond 24hrs or that the provider specifies for follow up. EST appointments will not exceed more than 20% of a provider's template schedule per month.
  
  - c. Procedure: Procedure (PROC) appointment types for outpatient procedures.
  
  - d. Provider Book Only: Provider Book Only (PBO) detail code will not exceed more than 10% of a provider's templated schedule per month.
  
6. SECURE MESSAGING. Secure Messaging is a safe, efficient, cost-effective asynchronous method for patients and their care teams to communicate on a variety of topics such as test results, preventive care and follow up reminders, as well as, beneficial patient education. It will also assist in the triage and provision of care for minor problems.
  - a. Care teams will implement and utilize Secure Messaging to improve and increase communication with enrolled patients.
  
  - b. The goal for care team response time to secure messages is 48 hours and should not exceed 72 hours. Provider schedules will have dedicated time allocated daily to respond to secure messages.
  
  - c. Care teams will document the patient message and care team response in AHLTA as a T-CON titled "virtual visit encounter." The documentation needs to meet the code requirements, such as not relating to a reportable service which happened within the prior 7 days.
  
  - d. Documentation must demonstrate evaluation and management in order to be coded as 98969 and 99444.

JUL 02 2012

e. Providers and care teams should increase enrollment of their empanelled patients to the secure messaging service by at least 15% per year with a goal of 100% enrollment. Additionally, care teams will actively promote the use of this capability among patients and staff.

f. Secure Messaging monthly utilization reports will be provided to clinical service chiefs and reported quarterly at the JTF CapMed Review and Analysis (R&A).

## 7. CLINIC ORGANIZATION AND DESIGN CATEGORIES

a. Space. A minimum of two exam rooms per provider and office space to accommodate two providers, a nurse, and five unlicensed assistant personnel (i.e., Medical Technicians (Air Force), Corpsmen (Navy), Medics (Army)) per team. Exact location of all team members will be determined locally, as influenced by space constraints, but MTFs will ensure that team members are in close proximity to facilitate team operations and communications. See Reference (e) for additional guidelines.

b. Design. Clinical space shall be designed to allow the most efficient workflow of essential personnel. This should include the Medical Home Teams, Practice Managers, Disease Management, Case Management staff, and, in the Air Force, Health Care Integrator be within the same area of the clinical space or, if not logistically possible, as close to one another as feasible. Provide office space conducive to patient confidentiality and adequate exam/treatment room space for clinical personnel, to include the Disease Managers and Case Managers.

JUL 02 2012

ENCLOSURE 4STRATEGIC METRIC REQUIREMENTS

1. The Military Health System (MHS) will monitor metrics to ensure effective operation of the PCMH and MHS healthcare and impact on the Quadruple Aim. Additional metrics may be included as deemed appropriate by Director, J-3B through issuances provided directly to the MTFs. MTFs will monitor the following metrics on a monthly basis:

a. Patient Satisfaction with Healthcare - Enrollee satisfaction should improve due to personal relationships with teams, timely appointments, and appropriate, coordinated care. Patient satisfaction will be measured via the MHS satisfaction survey.

b. Staff Satisfaction - PCMH should enhance staff satisfaction. This initiative will be measured through an MHS provider-specific survey disseminated by HA/TMA which will be measured in the Command Management System (CMS) and the JTF CapMed R&A.

c. Continuity – Patient centered medical team continuity enhances healthcare, continuity of care, and enrollee physician relationships. HA/TMA will be monitoring the access and continuity of empanelled patients to their designated provider on their PCMH Team which will be measured in the CMS and the JTF CapMed R&A.

d. Healthcare Effectiveness Data and Information Set (HEDIS) – PCMH operations should improve HEDIS measures, which are a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA) which will be measured in the CMS and the JTF CapMed R&A.

e. Readiness – Ensuring military deploy ability and delivering healthcare anytime, anywhere to support the full range of military operations, (e.g. Service member's pre-deployment health requirements). The Individual Medical Readiness (IMR) of enrolled active-duty personnel will be measured in the CMS.

f. Access to Care – Ensure 24/7 patient access to the assigned PCMH Team and/or a standardized advice/triage service as specified in the NCQA performance elements. The template manager should examine population demand on a quarterly basis, at a minimum, and adjust templates/schedules to match demand. The Third-Next Available OPAC/EST will be monitored in the CMS and the JTF CapMed R&A.

(1) Network urgent care utilization (percent of usage). What patient condition and percentage of care is deferred to the network due to the patient not being able to access care with PCM. This will be in the JTF CapMed R&A.

(2) Hospitalization rates (admissions, re-admissions within 30 days) will be measured in the CMS.

JUL 02 2012

(3) Per member per month – Per capita cost should be reduced through care management, reduction of unnecessary specialty care, and early intervention and prevention. This will be measured in the CMS and JTF CapMed R&A.

2. The following data-tracking will be maintained by the MTFs:

a. Primary Care Appointing Standards (e.g., appointment types: open access, established, procedural services)

b. Appointment mix

c. Appointment volume

d. Care for non-enrolled patients

e. Template management:

(1) Third-Next Available OPAC and Established Care Appointments (Percent of time met)

(2) Third-Next Available OPAC and Established Care Appointments (Time to next third appointment)

f. Appointing Business Rules

g. After-Hours Medical Home Team Access

h. Referral Management

i. Clinical Informatics Tools

3. Additional information requirements include:

a. Facilitating workload productivity and where the workload was generated using the fourth-level MEPRS code (e.g., BAZ\*=Internal Medicine Medical Home).

b. Capturing the value of investment in PCMH using the fourth-level MEPRS code for each clinic's workload or performance.

c. Being able to account for all costs associated with the fourth-level MEPRS code for PCMH Teams will allow MHS to determine appropriate sub-capitation rate.

4. To meet the requirements for NCQA recognition, FBCH and WRNMMC should show improvements in access to care, primary care manager continuity, secure messaging, population health tools, and performance reporting. Additional NCQA information is available at the Patient Centered Medical Home NCQA website at: <http://www.ncqa.org/tabid/631/Default.aspx>. The MHS' goal is for all Direct Care System Prime enrollees to be seen in a NCQA Level 2 PCMH at some point in future. As a result, the number of PCMH practices recognized as PCMHs as well as the number of enrollees to PCMHs will be tracked at the TMA and Service level.