



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-7300

IN REPLY REFER TO

BUMEDINST 6300.19
BUMED-M3/5CCPH
26 May 2010

BUMED INSTRUCTION 6300.19

From: Chief, Bureau of Medicine and Surgery

Subj: PRIMARY CARE SERVICES IN NAVY MEDICINE

Ref: (a) ASD (HA) Policy Memorandum Implementation of the "Patient-Centered Medical Home" Model of Primary Care in MTFs of 18 Sep 2009
(b) ASD (HA) Policy Memorandum 99-033 of 3 Dec 1999
(c) ASD (HA) Policy Memorandum 06-007 of 21 Feb 2006
(d) ASD (HA) Policy Memorandum 07-009 of 5 Jul 2007
(e) NAVMED Policy Memo 06-011 of 17 Aug 2006
(f) NAVMED Policy Memo 09-004 of 12 Mar 2009
(g) Military Health System's Guide to Access Success of 15 December 2008
(h) Navy Medicine Goals and Objectives FY10-FY15
(i) CNO Ltr 6320, Ser /04UM3H1204046 of Feb 8, 2005
(j) SECNAV M-5214.1 of 1 Dec 2005

Encl: (1) Acronyms
(2) Navy Medicine Primary Care Team: Definitions and Standards
(3) Navy Medicine Primary Care Staff Roles and Responsibilities
(4) Navy Medicine Primary Care Appointing Standards
(5) Navy Medicine Primary Care Facility Standards
(6) Navy Medicine Primary Care Clinic Management Business Rules
(7) Navy Medicine Primary Care Information Management/Information Technology Guidance
(8) Navy Medicine Primary Care Standardized Metrics
(9) BUMED-Approved Provider Administrative Discounts

1. Purpose. To implement a new model of patient and family-centered health care delivery for primary care that is team-based, comprehensive, and designed to fully meet the complete primary care health and wellness needs of our patients.

2. Scope. This instruction applies to all Medical Treatment Facilities (MTFs) and their subordinate hospitals and clinics.

3. Background. The mission of Navy Medicine is to provide Force Health Protection and support the medical needs of the Navy and Marine Corps Team across the entire spectrum of operations. Navy Medicine is entrusted with the care of our Sailors, Marines, their families, and where possible, our retirees and their families. The key tenets of Force Health Protection are keeping our Sailors, Marines, and their families healthy and well while also providing superior care when they get sick. The foundation on which Force Health Protection is built is primary care services. By providing outstanding care and support in primary care, we operationalize Force Health Protection. By aligning and standardizing primary care services to best practices,

we ensure consistency of care, access, and service across Navy Medicine. Heightened operational tempo, community staffing shortfalls, personnel turnover, and other issues challenge our ability to provide continuity, timely access, and other key components of effective primary care services. We mitigate these challenges to the best of our ability by optimizing the efficiency and effectiveness of our primary care clinics. References (a) through (i) provide amplifying information; reference (g) is available at: <http://www.tricare.mil/tma/tai/cguide.aspx> and reference (h) is available at: <http://www.med.navy.mil/Pages/Default.aspx>. Enclosure (1) provides a listing of acronyms used in this instruction.

4. Concept of Operations. Navy Medicine primary care services will transition from an individual patient/individual provider model to a standardized primary care team model which will provide better access, continuity, wellness, and disease management for our patients. By standardizing primary care services and enhancing access and continuity, we improve the partnership between the patient, his or her primary care provider and their primary care team, and, where appropriate, the patient's family. That partnership focuses on sustaining and enhancing wellness in our patients as well as optimal efficient delivery of comprehensive health care services, based on the needs of our patients. This effort aligns with civilian models of enhanced primary care known as Patient-Centered Medical Home (PCMH). By creating a single PCMH for all aspects of wellness and care for our patients, we enhance our ability to meet their needs. In Navy Medicine, PCMH will be known as "Medical Home Port." This instruction sets minimum standards and operating procedures for all Navy Medicine "Medical Home Port" clinics in all of our facilities.

5. Implementation. To facilitate implementation, enclosures (2) through (9) delineate implementation guidance, minimum standards, and measures of performance for implementing and sustaining Medical Home Port clinics. This instruction focuses on implementation in Family Medicine clinics. Additional guidance for Medical Home Port implementation in Pediatrics and Internal Medicine will be published as change transmittals. Commanders, commanding officers, and officers in charge are not prohibited from implementing Medical Home Port clinics in these other areas if they desire. Full compliance with the provisions of this instruction is expected for all commanders, commanding officers, and officers in charge of facilities implementing and sustaining Medical Home Port clinics. Oversight will be provided by the three Navy Medicine clinical Region Commanders, reporting implementation progress and subsequent performance to the Bureau of Medicine and Surgery (BUMED) M3/5 on a monthly basis.

6. Timeline. Implementation across Navy Medicine will be phased. By 30 June 2010, Medical Home Port will be implemented in at least one primary care clinic in each of our major medical centers and Family Medicine teaching hospitals. Commanders, commanding officers, and officers in charge of facilities will consider all options to identify the best clinic for Medical Home Port implementation. Initial implementation is recommended at a Family Medicine clinic, due to some challenges that General Internal Medicine and General Pediatrics may have, as specialists. This will allow for a collection of lessons learned and best practices

which can be used in subsequent primary care clinic transitions to Medical Home Port at all Navy Medicine Medical Treatment Facilities (MTFs). By 30 June 2011, all primary care clinics (Family Practice, General Internal Medicine, and General Pediatrics) in Navy Medicine will have transitioned to the Medical Home Port model.

7. Responsibilities

a. Deputy Chief, BUMED, Total Force (M1)

(1) Appoint a project officer for Medical Home Port manpower implementation for manpower assessments and expertise.

(2) Develop a project schedule, resource requirements, and constraint mitigation plans to fully resource Home across Navy Medicine.

b. Deputy Chief, BUMED, Medical Operations (M3/5):

(1) Coordinate Medical Home Port activities throughout Navy Medicine for Chief, BUMED.

(2) Identify an overarching Project Manager for Medical Home Port implementation in Navy Medicine.

(3) Provide personnel with project management and change management expertise to support field activities in transitioning to Medical Home Port.

(4) Provide subject expertise and ongoing education to MTF project officers to assist them with implementation.

(5) Coordinate resource requirement submissions to other BUMED codes and track action status.

(6) Develop key metrics and a dashboard to track implementation and provide the Navy Medicine Corporate Executive Board monthly progress updates.

(7) Provide liaison with the National Committee on Quality Assurance (NCQA) to develop a corporate contract for NCQA to provide onsite visitation and assessment of Medical Home Port clinic compliance with NCQA Medical Home standards.

(8) Issue NCQA standards and the additional standards in this instruction to Navy Medicine Region Commanders for dissemination to commanding officers and officers in charge to assist them in implementation and to provide clarity on NCQA and Primary Care Advisory Board focus areas in the recognition process.

(9) Provide liaison, with BUMED M8, to TRICARE Management Activity (TMA) Patient-Centered Medical Home, performance planning, and other related workgroups. Serves as the Navy Medicine voice into any TMA plans for alteration of the Prospective Payment System/Performance Based Budgeting (PPS/PBB) process to better account for primary care goals and objectives.

c. Deputy Chief, BUMED, Logistics (M4) shall:

(1) Appoint a project officer for Medical Home Port implementation for facilities and equipment assessments and expertise.

(2) Provide consultation, as required, in support of facility improvement projects in support of Medical Home Port.

d. Deputy Chief, BUMED, Information Management/ Information Technology (M6) shall:

(1) Appoint a project officer for Medical Home Port Information Technology (IT) implementation.

(2) Develop a project schedule, resource requirements, and constraint mitigation plans to implement IT tools across Navy Medicine in support of Medical Home Port.

(3) Work closely with Navy Medicine Region Information Systems Officers (RISO) on implementation of IT solutions at MTFs, to include championing resolution of security and other technical constraints requiring action.

(4) Finalize requirements documentation and develop a lifecycle management plan with resource requirements to sustain and expand the supporting IT portfolio for Medical Home Port.

e. Deputy Chief, BUMED, Resource Management (M8) shall:

(1) Act as resource sponsor for all resource requirements necessary to fully implement Medical Home Port.

(2) Provide Chief, BUMED and Deputy Chief, BUMED with periodic updates on resource requirements and commitments for Medical Home Port.

(3) Execute an enterprise contract for NCQA site visits and recognition.

f. Navy Medicine Region Commanders shall:

(1) Monitor and track implementation and performance at facilities in their region implementing Medical Home Port.

(2) Identify subject experts in facility management, resource management, manpower or personnel information technology, patient administration, template management, and other skills, as required, from their staff to assist their facilities with implementation.

(3) Assess resource requirement submissions from facilities for cross-leveling or other local solutions before forwarding to BUMED M1.

g. Commander, Navy Medicine Support Command shall:

(1) Complete a full assessment, to include external review, of the current Clinic Management Course. This assessment will be completed by 30 June 2010 and will include:

(a) Complete curriculum review and revision, if needed, to meet the needs of Navy Medicine attaining Medical Home Port as our single model of primary care service delivery.

(b) Review of faculty credentials and experience, with recommendation on future faculty and whether the faculty should be military, civilian, or a combination, to provide best teaching and consultation.

(c) Review of course frequency, funding, and sustainment to train all clinic managers in Navy Medicine.

(2) Establish a regular recurring curriculum review to ensure the course continues to address the most pressing needs and training requirements to attain and sustain Medical Home Port.

(3) Provide resource requirements and other requirements necessary to implement and sustain a successful clinic management training program.

(4) Provide contracting support and assistance as needed for contract requirements in support of Medical Home Port.

h. MTF commanders, commanding officers, and officers in charge shall:

(1) Be responsible and accountable for on-time implementation of Medical Home Port at their facilities.

(2) Ensure top-down leadership involvement, visibility, and support for Medical Home Port initiatives, championing necessary change management essential for project success. Subject expertise in change management is available from BUMED, if needed.

(3) Ensure compliance with all standards and guidance in this instruction for their Medical Home Port clinics and provide appropriate resources for same. If resource requirements exceed resource allocation, forward to their Navy Medicine Region Commander a request, with justification, for resource augmentation.

(4) When satisfied their Medical Home Port clinics meet all standards and guidance in this instruction, as well as the applicable NCQA Medical Home standards, contact their Navy Medicine Region Commander to request a site visit from NCQA to recognize compliance.

(5) Appoint a project officer, the MTF Clinical Champion, who will be responsible for all aspects of Medical Home Port implementation. This Clinical Champion will lead a diverse, multidisciplinary team in the implementation, monitoring, and assessment of Medical Home Port. A senior member of the MTF Leadership team, with clinical background, is strongly recommended.

(6) Develop and utilize a project plan for Medical Home Port implementation. Subject expertise in project management is available from BUMED M3/5 to support this, if needed.

(7) Ensure participation in all Medical Home Port coordinating events and activities in Navy Medicine.

(8) Ensure access to adequate training for clinic managers and others, as necessary, for the performance of their duties in Medical Home Port.

(9) Ensure officers or civilians, with requisite rank or experience, are appointed as Clinic Managers for Medical Home Port clinics.

(10) Sustain recommended provider and support staffing levels in Medical Home Port clinics, as outlined in this instruction (see enclosure (2)).

(11) Collect and forward data, as appropriate, to their Navy Medicine Region Commanders for purposes of tracking implementation progress and subsequent performance.

(12) Keep local commanders and beneficiaries informed of progress and benefits. BUMED has a Strategic Communication Package, developed at the Naval Postgraduate School, which can be utilized if needed; this package is available upon request.

i. Chairman, Primary Care Advisory Board shall:

(1) Provide subject expertise and consultation to commanders, commanding officers, officers in charge and others, as requested, on primary care services.

(2) Stay abreast of current trends and best practices in primary care delivery models.

(3) Identify board members to augment NCQA site surveyors to assist in site evaluation for recognition by NCQA and compliance with the standards in this instruction.

8. The point of contact are CAPT Susan Chittum at (202) 762-3014, DSN 762-3014, or e-mail at: Susan.Chittum@med.navy.mil.

9. Report. The reporting requirements contained in this instruction are exempt from report control per reference (j), part IV, paragraph 7k.



T. R. CULLISON
Acting

Distribution is electronic only via the navy medicine Web site at:
<http://www.med.navy.mil/directives/Pages/default.aspx>

ACRONYMS

ACGME	Accreditation Council for Graduate Medical Education
ACUT	Acute Appointment Type
AHLTA	Armed Forces Health Longitudinal Technology Application
ASD (HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CNA	Certified Nursing Assistant
CPT	Current Procedural Terminology
DEERS	Defense Enrollment Eligibility Reporting System
DMHRSi	Defense Medical Human Resources System – internet
ECOMS	Executive Committee of the Medical Staff
ED	Emergency Department
EHR	Electronic Health Record
EST	Established Appointment Type
FM	Family Medicine
FTE	Full-time equivalents
GME	Graduate Medical Education
GS	General Schedule
HEDIS	Healthcare Effectiveness Data and Information Set
HM	Hospital Corpsman
IM	Internal Medicine
IND	Indeterminate
IT	Information Technology
LPN	Licensed Practical Nurse
MA	Medical Assistant
MCSC	Managed Care Support Contractors
MENBA	Mission Essential Non Benefit Activities
MHS	Military Health System
MRRS	Medical Readiness Reporting System
MTF	Medical Treatment Facility
NCQA	National Committee on Quality Assurance
NM MPT&E	Navy Medicine Manpower, Personnel, Training, and Education
OPAC	Open Access Appointment Type
OTC	Over the Counter
PCAB	Primary Care Advisory Board
PCM	Primary Care Manager
PCMBN	Primary Care Manager By Name
PCMH	Patient-Centered Medical Home
PCS	Permanent Change of Station
PODS	Combined Offices
PPS	Prospective Payment System
PPS/PBB	Prospective Payment System/Performance Based Budgeting
PROC	Procedure Appointment Type

RISO	Region Information Systems Officers
RN	Registered Nurse
RRC	Residency Review Committee
RVU	Relative Value Unit
SEL	Senior Enlisted Leader
SPEC	Specialty Appointment Type
TAD	Temporary Additional Duty
TEL-CON	Telephone Conference
TMA	TRICARE Management Activity
TRICARE	Department of Defense (DoD) Military Health System
UBU	Unified Biostatistical Utility
WELL	Wellness Appointment Type

NAVY MEDICINE PRIMARY CARE TEAM: DEFINITIONS AND STANDARDS

1. Definition of Primary Care. Navy Medicine Primary Care is an integrated, comprehensive, continuous way of meeting the health care needs of our patients by the Navy Medicine team. This care includes, but is not limited to, readiness, prevention wellness, behavioral health, and disease management. All aspects of care are coordinated by a privileged health care provider who is also a member of a health care provider team of three to five providers. That team is responsible for the care of their patients. Quality, safety, and readiness are hallmarks of Navy Medicine Primary Care. Measures of success in the primary care environment include quality of care, continuity, enhanced access, and satisfaction of patients and staff. This definition of all medical treatment facility (MTF) outpatient primary care clinics shall include clinics in General Internal Medicine (IM), General Pediatrics, and Family Medicine (FM).

2. Standardization of Primary Care Service Delivery. “Medical Home Port,” as Navy Medicine’s new model of primary care services, aligns with civilian models of primary care known as Patient-Centered Medical Home (PCMH), Medical Home, or other similar names. Alignment with these best practices and standardization of service delivery enhances access, care quality, outcomes, and overall patient satisfaction, while enabling better resource requirement projection in planning for the future. Deviation from standards and practices set forth in this instruction are not authorized.

3. National Committee for Quality Assurance (NCQA) Recognition. NCQA has established nationally recognized standards for PCMH, and these standards are relevant for Navy Medicine's Medical Home Port. Navy Medicine is adopting those standards through a tiered approach and augmenting them with additional requirements set forth in this instruction. The expectation is that all Medical Home Port locations will attain recognition for Level I within four months of establishing a Medical Home Port clinic, as well as, full compliance with the additional standards in this instruction. Once achieving NCQA Level I recognition through a self-assessment, Medical Home Port clinics have an additional six months to achieve NCQA Level II recognition. Therefore, Level II recognition should be achieved within ten months of establishing a Medical Home Port clinic. The Bureau of Medicine and Surgery (BUMED) has committed to provide additional guidance on the NCQA Level I and Level II recognition process. Local project officers should develop their project plans to ensure that, at completion, full compliance with both NCQA Level II and this instruction are attained. Commands will report their progress monthly to their Navy Medicine Region Commander who, in turn, will report progress to BUMED monthly in the Corporate Executive Board. Local commands should also undertake periodic self-assessments to track progress and compliance with NCQA standards and this instruction. When the commander, commanding officer, or officer in charge determines that the clinic is in full compliance, they will request a recognition visit from their Navy Medicine Region Commander. The Navy Medicine Region Commander, in turn, will approve such requests and forward them to:

Bureau of Medicine and Surgery
Attn: M3/5CCPH
2300 E Street, NW
Washington, DC 20372-5300

Alternatively, requests can be sent electronically to medicalhomeport@med.navy.mil. BUMED, in turn, will arrange a site visit to the requesting MTF by a representative from NCQA, as well as, a member representing Navy Medicine. Together, they will assess compliance with NCQA Level II standards and with the standards in this instruction. Upon successful completion of that assessment, that clinic will be distinguished as an NCQA-recognized Navy Medicine Medical Home Port and will transition from the traditional Prospective Payment System/Performance Based Budgeting (PPS/PBB) incentive model to the new primary care PPS/PBB incentive model, emphasizing improvements in access, outcome, and satisfaction.

4. Clinical Provider Availability

a. Providers should be in clinic to the maximum extent possible for patient care. Provider absence from clinic impacts their patient's ability to be seen for their health care needs while also decreasing our ability to comply with TRICARE Management Activity (TMA) access standards. It also compels our patients to identify other ways to meet their health care needs. Navy Medicine also recognizes that military providers have collateral duties, teaching responsibilities, inpatient duties, and other bona fide commitments which take them out of the clinic. In general, this is not true for contract or General Schedule (GS) physicians who should be in the clinic full time. GS physicians may have collateral duties or teaching responsibilities which take them from clinical care. In those circumstances, absence from clinical care will be in strict accordance with the administrative discounts outlined in enclosure (9).

b. Collateral duties. BUMED has approved administrative discounts for such duties, outlined in enclosure (9). Variance from these discounts is not authorized. Once discounts are applied, the remaining provider time shall be for clinic availability. Clinic availability, expressed as fractions of full time equivalents (FTE) shall be used to determine enrollment for that provider. A clinician who is available for a full 36 bookable hours each week shall be defined as a full time equivalent of 1.0. Any FTE deductions from this will be in strict accordance with BUMED-approved administrative discounts as delineated in enclosure (9). Deductions in excess of these deductions or other deductions are not authorized. All aspects of the duty day, as well as provisions for leave, liberty, or other workplace absence, as defined in applicable Navy or Federal regulations will be strictly observed.

c. Faculty responsibilities. The initial focus of this instruction shall be for Family Medicine training programs. Subsequent guidance to address similar issues for IM and Pediatrics faculties will be published at a later time in instruction change transmittals. For military physicians who are designated in writing by the commander, commanding officer, or officer in charge as faculty members for Family Medicine training programs, absence from clinical care responsibilities for teaching and other faculty-related activities is authorized. Faculty members are required to

comply with the requirements of the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC) mandate of 1400 hours per faculty full time equivalent per year spent in resident teaching, oversight, or other faculty-related activities, exclusive of other patient care responsibilities. Those 1400 hours are per full time equivalent, not per person, and includes time spent precepting and teaching in the clinic, the labor deck, the ward, after-hours teaching, and administrative time spent in lecture preparation or other faculty-related activities. Commanders, commanding officers, and officers in charge are strictly charged and accountable to ensure appropriate accounting and tracking of faculty hours is maintained and a balance attained of both meeting RRC requirements and optimizing provider clinical availability for patient care.

d. Leave and Temporary Additional Duty (TAD). Department Heads and Program Directors are expected to manage leave and TAD for their providers to minimize excessive gaps or decrements in provider availability.

e. Other reasons for clinic absence. Provider absence directly affects patient access and should be minimized. With the exception of illness, unforeseen emergencies, deployment, or command-sanctioned and approved duties, other reasons for provider absence from the clinic are not authorized and must be approved by the commander, commanding officer, or officer in charge. Navy Regulations (for active duty) and Federal regulations (for General Schedule (GS) staff) concerning allowable absences from duty shall be strictly followed. Contract personnel will follow the procedures outlined in their individual contracts. Long-standing policies regarding after-duty time off, administrative time off in excess of approved discounts may require command-level review and revision to comply with this instruction.

5. Clinical Support Staff Availability

a. To maintain maximum efficiency and effectiveness, support staff must also be available and in the clinic to support provider activity. As with provider availability, support staff availability directly correlates to patient access and our ability to meet their needs. The BUMED-approved administrative discounts in enclosure (9) shall also apply to clinical support staff, not just providers. Absence from the clinic in excess of these discounts is not authorized. The commander, commanding officer, and officer in charge are responsible to ensure maximal availability and utilization of clinical support staff in Medical Home Port clinics is maintained. Utilization of clinically trained staff in administrative duties outside of clinical care should be minimized in order to maximally support access to care in our facilities and to ensure maintenance of competency in skills that are mission essential when our forces deploy forward. With the exception of inpatient responsibilities, activities directly related to maintaining deployment readiness, advancement/career progression, the presumption should be that Medical Home Port clinic duties supersede all other activities. Likewise, clinic leadership should balance leave and TAD to ensure full continuity of services and provider support. All applicable Navy and Federal regulations concerning allowable absence from duty shall be strictly followed. Contract personnel will follow the procedures outlined in their individual contracts.

b. Staffing levels. Based on best industry practice and subject expert consultation, Navy Medicine has determined optimal support staffing levels for Medical Home Port clinics, refer to paragraphs 7 and 8 of this enclosure. Commanders, commanding officers, and officers in charge shall ensure these staffing standards are implemented and sustained in all Medical Home Port clinics. Staffing gaps, decrements, or deviations from these standards is not authorized to ensure adequate staffing; commands may need to augment existing clinic staff. In this case, commands will look internally and conduct staffing reallocation to support Medical Home Port clinics. Commanders, commanding officers, and officers in charge will utilize staff from lesser priority functions within the command and ensure those staff are adequately trained and prepared to support clinic operations. New hiring actions to support Medical Home Port are not authorized unless specifically approved by the Navy Medicine Region Commander. The Navy Medicine Region Commander will only approve those with detailed personnel utilization analysis that clearly shows internal redistribution is insufficient to support Medical Home Port staffing requirements.

6. Patient Empanelment

a. Empanelment targets will be based on provider availability for their continuity practice. While this is no prescribed floor for patient empanelment, BUMED strongly recommends that providers should realize 1,100 patients is the minimum, but not to exceed 1,300 patients, for every full time equivalent provider on the Medical Home Port team. Deviations from this target enrollment range may be required as a result of variations in health acuity or demand of the enrolled population but must be approved by the commander, commanding officer, or officer in charge. Most current panel sizes are below this target range. Incremental growth is authorized but commanders, commanding officers, and officers in charge are strictly charged to ensure panel size growth attains the target enrollment range within a reasonable time period, normally 6 months or less. Medical Home Port clinics will be rewarded based on a per enrolled patient formula that assesses outcome, access, satisfaction, and other measures. Therefore, panel sizes in excess of this ceiling are not authorized unless approved by the Navy Medicine Region Commander and justified with supporting capacity data. Clinics may not over enroll to increase financial reward unless supporting capacity data shows that increased enrollment can be done without impact to access or other outcome measures.

b. Closed panel. Once NCQA recognition is attained, then that Medical Home Port clinic will serve a closed panel. They will only be responsible for meeting the needs of their enrolled patients. Medical Home Port clinics will not be responsible for the patients of other providers outside their clinic or non-enrolled patients. The only exceptions to this shall be newborns of enrolled patients who are less than 60 days old and are awaiting TRICARE enrollment, as well as, foreign nationals or dignitaries. Patients with exceptional Graduate Medical Education (GME) value should be empanelled. The Chief of Naval Operations guidance specifies that MTFs cannot enroll students who are assigned to that command for less than 179 days per reference (i), paragraph 2a(1). For commands serving schools, one way to align to this guidance is by establishing dedicated clinics to provide care for all students. It is the responsibility of the

commander, commanding officer, or officer in charge to ensure Medical Home Port clinics are not tasked to provide care for patients outside their panels. If capacity exists for additional care, then it is the responsibility of the commander, commanding officer, or officer in charge to adjust panel sizes to fully utilize providers, subject to the limitations above.

7. Provider Team Staffing. The Medical Home Port team is responsible for the care of their empanelled patients 24 hours per day, 7 days per week, and 365 days per year. Composition and staffing of that team will be critical to meet this requirement. Each Medical Home Port team will consist of three to five privileged providers. On rare exception, one or two additional providers may be added to the team to cover for accepted administrative discounts of other team providers and ensure a consistently available three to five FTE's for the team. Providers who practice infrequently (house staff, physicians assigned to staff billets, or operational forces who practice at the hospital periodically) shall not be counted as part of the provider team.

a. When a Medical Home Port provider team consists of three providers, at least one must be a physician. In addition, this Medical Home Port provider team will have no more than a total of 0.75 FTE administrative discounts deductions for the entire provider team and empanelment will appropriately reflect those deductions.

b. When a Medical Home Port provider team consists of four to five providers, at least two must be physicians. A four provider team for a Medical Home Port clinic will have no more than a total of 1.0 FTE administrative discounts for the entire provider team. A five provider team will have no more than a total of 1.25 total administrative discounts

c. Commands should strive to ensure that at least 50 percent of each provider team is civilian. This civilian presence is critical to continuity and necessary to mitigate provider absence from deployment, permanent change of station (PCS) cycle gaps, and other military-unique requirements.

d. As primary care personnel deploy to support the operational requirements of the Navy and Marine Corps team, the Medical Home Port team faces challenges in maintaining access and continuity. Commanders, commanding officers, and officers in charge and Navy Medicine Region Commanders have tools at their disposal to mitigate these events, to include cross-leveling, local hires, locum tenens, and other tools. Most deployments occur with sufficient notice to allow utilization of these tools. Predictability of deployments will allow for sufficient planning to avoid gaps. Commanders, commanding officers, and officers in charge shall take all appropriate actions to ensure gaps do not occur as a result of deployments or other provider absences. In the rare instance where gaps are unavoidable and after approval of the Navy Medicine Region Commander, commanding officers, and officers in charge may allow for adjustments in empanelment to ensure access, quality, and other measures are sustained for the patients of Medical Home Port team. Lack of planning for a predictable deployment or gap is not an authorized reason to adjust empanelment.

8. Medical Home Port Support Staffing. Each Medical Home Port team shall consist of the following support per provider Full Time Equivalent:

Position	Per Provider Full Time Equivalent
▪ Team Clinic Nurse	0.5
▪ Ancillary Nursing Personnel (e.g., Licensed Practical Nurse (LPN), Hospital Corpsman (HM), Certified Nursing Assistant (CNA), Medical Assistant (MA), etc.)	2.5 ¹
▪ Clerical Staff/Medical Clerk	0.75
▪ Behavioral Health Provider	1 per 7,500 enrollees ²
▪ Nurse or Health Educator (patient self-management)	1 per 7,500 enrollees ²
Management	Recommendation
▪ Clinic Management	1 per Department ³
Integrated Care Services (as applicable) to augment Medical Home Port Team	Recommendation
▪ Case Management	1 per 7,200 ⁴
▪ Pharmacy (if offered)	<ul style="list-style-type: none"> ▪ <u>Anticoagulation Services</u>: 1 per 200 patients enrolled in anticoagulation management ▪ <u>Antilipidemic Services</u>: 1 per 4000 enrollees diagnosed with dyslipidemia ▪ <u>Prescription Renewal Clinical</u>: 0.5 per 10,000 enrollees ▪ <u>OTC Clinic</u>: 0.15 per 10,000 enrollees ▪ <u>Medication Reconciliation</u>: 0.4 per 100 records reviewed weekly (10% of 1,000 visits)
▪ Nutrition	As determined by local assessment ²

¹ MTFs must assess the amount of time HMs are available to participate in the Medical Home Port team to provide the necessary development, while also considering other training and initiatives they must complete to ensure they are ready to deploy.

² Needs should be determined locally based on population demographics, demand for services, and cost effectiveness of implementation.

³ Smaller MTFs may benefit from a single clinic manager for all of primary care while larger MTFs (Naval Medical Centers and Family Practice Teaching MTFs) and clinics will likely require 1 per primary care department.

⁴ MTFs may adjust the numbers of case managers, depending on population health acuity and need.

Commanders, commanding officers, and officers in charge shall ensure these staffing ratios are preserved and consistently available. This may require staff redistribution from other areas, as determined by the commander, commanding officer, or officer in charge.

NAVY MEDICINE PRIMARY CARE STAFF ROLES AND RESPONSIBILITIES

1. Each member of the Medical Home Port team will have specific delineated responsibilities for which they are responsible and accountable in ensuring optimal Medical Home Port efficiency and effectiveness in meeting the needs of our patients. These include, but are not limited to:

a. Primary Care Provider. Each enrolled patient will be assigned to a specific provider on the Medical Home Port provider team. That provider is responsible for the oversight and care coordination for the needs of that patient. The provider will address medical issues in a compassionate, comprehensive, and integrative manner utilizing a team approach. The provider will ensure that wellness and medical reconciliation needs are addressed by the health care team and disposition of the patient with clear follow-on instructions. The provider will perform duties based upon evidence-based clinical practice guidelines and engage patients actively in their health care. Medical providers not attached to a medical treatment facility (MTF), but who practice at the MTF to maintain clinical competency, shall not be counted as part of the Medical Home Port provider team. Examples include providers assigned to operational units or staff positions but who see patients at the MTF. They should be aligned with a single primary care team to promote continuity.

b. Medical Home Port Team Nurse (Registered Nurse (RN)). The Medical Home Port Team Nurse (RN) is an instrumental resource in providing continuity of care within the primary care clinic environment. The RN serves as the care manager for assigned patients to coordinate care and other necessary services to meet the needs of the patient, as determined by the patient's primary care provider. They also provide a necessary leadership and educator function in the clinic. These leadership responsibilities include, but are not limited to, supervision of the ancillary nursing and support staff in their daily activities and professional development; and ensure team members maximize their training and competencies. The RN will also coordinate utilization of health care services by beneficiaries, as well as management of chronic and preventive health care services.

(1) Medical Home Port Team Nurse Rotations. Personnel rotations and cross-training of personnel are important to career development and to ensure continuity during deployments. However, frequent personnel rotations can be disruptive to efficiency and lead to decreased patient satisfaction.

(2) The commander, commanding officer, or officer in charge has the responsibility to balance these factors in determining rotation plans, if any, for Medical Home Port Team Nurses. As a general rule, commanders, commanding officers, and officers in charge will make every effort to not rotate Medical Home Port Team Nurses for a minimum of one year.

c. Ancillary Nursing Support. The ancillary nursing staff, to include Licensed Practical Nurses, Hospital Corpsmen, Certified Nursing Assistants, Medical Assistants, and others, provides invaluable support to the Medical Home Port Team. They will assist in provider

support activities related to patient care, patient education, documentation of chronic medical conditions, documentation of preventive services, medication reconciliation, and coordination of patient check-out and follow-up. They will receive direct guidance and supervision by both the Medical Home Port Team Nurse and Medical Home Port Team providers.

(1) Ancillary Staff Rotations. As with the Medical Home Port Team Nurse, commanders, commanding officers, and officers in charge must balance the costs and benefits of staff rotations to allow the command to meet its readiness mission; enhance career progression for staff; and preserve Medical Home Port efficiency to optimize Medical Home Port ability to meet the needs of the patients.

(2) As a general rule, but subject to local requirements, commanders, commanding officers, and officers in charge should strive to not rotate ancillary nursing support for a minimum of one year.

d. Senior Enlisted Leader (SEL). The SEL is responsible for the care, career progression, and Sailorization of enlisted personnel in the primary care department of which the Medical Home Port clinic is a part. The SEL is responsible to provide all services, leadership, and guidance to Medical Home Port enlisted personnel as is provided to all other departmental enlisted personnel. The SEL is expected to participate in direct patient care when not actively involved in the above activities.

e. Clerical Staff. The clerical staff includes medical clerks and others who provide administrative support of clinic activities, front desk operations, telephone management, and records management. They are vital members of the Medical Home Port team. They facilitate patient check-in, verification of Defense Enrollment Eligibility Reporting System (DEERS) eligibility and collection of Other Health Insurance information. In addition, they assist patients in navigating the health care system to include: supporting clinic team management of population health, coordinating and/or scheduling acute and chronic care, arranging follow-up, coordinating specialty referrals, and telephone/asynchronous secure patient messaging. They are guided and supported by both the Department Head and the Medical Home Port Team Nurse in their activities.

f. Behavioral Health Provider. The behavioral health provider helps meet the mental health needs of the enrolled population as part of improving their overall health. The intent is to provide ready access for both patient care and provider consultation in meeting the holistic needs of patients. Goals include improved early recognition, treatment, and management of psychosocial/behavioral problems and conditions. Services will be embedded into the Medical Home Port clinic to provide necessary consultative services and training to other members of the health care team. The recommended ratio is one full time behavioral health provider per 7,500 patients enrolled. Behavioral health providers must have appropriate training and may include psychiatrists, clinical psychologists, licensed clinical social workers, and licensed professional counselors.

g. Nurse Educator or Health Educator. The nurse educator or health educator will assist the primary care team to encourage healthy lifestyles and wellness by educating patients about behaviors that can prevent or mitigate diseases, injuries, and other health problems. They provide a ready source of patient support and education immediately available to the Medical Home Port team and patients. Services they provide include (based on their level of experience and certification): education regarding chronic conditions and patient self-management, training patients and caregivers on medical devices, assisting patients to set/attain behavior-change goals, provide nutrition education and counseling in support of command nutritionists or dietitians, education on medication management based on physician-directed protocols, and providing access to health care and community resources. Commanders, commanding officers, and officers in charge will determine the need for such services among their enrolled Medical Home Port patients. In general, one Nurse Educator can serve the needs of approximately 7,500 patients.

h. Clinic Manager. Each Medical Home Port Clinic will be assigned a clinic manager who is either a military officer performing these duties as a full time job, or a civilian specifically hired for this position. In either instance, it is expected that clinic managers have sufficient and necessary training and experience in clinic management to ensure optimal clinic efficiency and success. In general, new accessions or extremely junior officers will not be Medical Home Port Clinic Managers. Likewise, commands will not hire inexperienced civilians to be trained on the job for these positions. At a minimum, personnel who have not completed the Navy Medicine Manpower, Personnel, Training, and Education (NM MPT&E) Command Clinic Management Course, or personnel who cannot demonstrate a proficient track record of clinic management in the civilian sector, will not be considered.

(1) The clinic manager provides oversight of clinic operations and management. This includes, but is not limited to tracking access, tracking provider availability, managing appointment templates/availability, overseeing clerical staff, managing telephone calls and consults, tracking performance, Defense Medical Human Resources System – internet (DMHRSi) submissions, and making recommendations to the Department Head for any required changes to improve clinic efficiency and effectiveness in meeting patient needs. The clinic manager will also review patient satisfaction submissions to identify and recommend improvement opportunities to the Department Head. The clinic manager will ensure completion of necessary forms for third party collections and will track same for the clinic. Finally, the clinic manager will assist the Department Head in tracking Medical Home Port clinic performance under the Prospective Payment System/Performance Based Budgeting (PPS/PBB) system.

(2) Augments to the Medical Home Port team shall be, as determined by individual command need, based on patient acuity and demand by the commander, commanding officer, or officer in charge. A variety of personnel may be integrated to the Medical Home Port team to enhance care and improve efficiency for health care services. These include, but are not necessarily limited to:

(a) Case Managers. Case managers may be assigned to augment Medical Home Port clinic teams when the commander, commanding officer, or officer in charge determines that the case mix and complexity of enrolled patients would benefit from comprehensive case management. Case managers may be either Registered Nurses or Licensed Social Workers. The case manager serves as an essential link to all agencies, disciplines, private and public associations and practitioners within the delivery system. The case manager provides more intensive care management and care coordination for high-risk patients with complex needs. These may include, but not necessarily be limited to, those with chronic illness, disabled patients with complex care needs, those who are a substantial risk for hospitalization, patients who are high-risk, and those who are high utilizers of health care services. In general, one case manager can meet the needs of approximately 7,200 patients. Higher acuity or need patient populations may require additional case managers, as determined by the commander, commanding officer, or officer in charge.

(b) Pharmacists may augment the Medical Home Port team, as determined by the commander, commanding officer, or officer in charge, to assist with medication education, reconciliation, or other special needs better done in a clinic setting instead of the pharmacy. Pharmacists, acting as independent providers, are uniquely positioned to improve patient safety, provide efficient and effective patient care, and improve overall clinic efficiency. Participating pharmacists must be fully privileged by the commander, commanding officer, or officer in charge. Their services may include, but not necessarily be limited to:

1. Anticoagulation clinic: medication management and patient education
2. Antilipidemic clinic: medication management and patient education
3. Prescription renewal
4. Over the counter (OTC) clinic support
5. Medication reconciliation

(c) Nutritional Supports. As with case managers and pharmacists, nutritional experts may augment the Medical Home Port team, as determined by the commander, commanding officer, or officer in charge. These may include dietitians, nutritionists, or others with subject expertise in nutrition management as it relates to health, medication interaction, and wellness. They advise on diet, food, and nutrition, including, but not limited to, health promotion and illness prevention strategies; educating patients about nutrition and administering nutrition therapy as part of the primary care team; and teaching, monitoring, advising the public, and helping to improve their quality of life through healthy eating habits.

NAVY MEDICINE PRIMARY CARE APPOINTING STANDARDS

1. Our patients lead busy, often stressful lives. We should not add to that stress by making it difficult to get an appointment with their health care provider. Likewise, we should not add to complexity for our staff by compelling them to navigate a myriad of different appointment types to find the exact specific appointment type that meets the patient's needs. Simplifying the appointing process and minimize appointment types will ensure we make it as easy as possible for our patients to see their providers when needed.

2. Appointment types. There will be four appointment types used in Medical Home Port clinics:

a. Acute Appointment Type (ACUT) or Open Access Appointment Type (OPAC). ACUT appointment types are for patients to be seen within 24 hours; OPAC appointment types are for patients to be seen the same calendar day.

b. Established Appointment Types (EST). EST appointments are for patients to be seen within a week.

c. Wellness Appointment Types (WELL) will only be used for patient wellness visits and provision of preventive services. WELL may be substituted for EST for these types of appointments and will not be used for any other appointment type. All WELL appointments will be seen within one week.

d. Procedural Services. In some cases, primary care providers routinely perform minor outpatient procedures on their patients. These might include, but are not limited to, colposcopies, treadmill testing, vasectomies, and other outpatient procedures as defined by their privileges and patient demand. These procedures are not normally appropriate for either ACUT/OPAC, EST, or WELL bookings. To maximize clinic efficiency, providers should group those procedures and perform them on a set day. They may be booked using either Procedure Type Appointments (PROC) or Specialty Type Appointment (SPEC). Not everyone will need to schedule PROC or SPEC appointments. It will depend on the individual clinic and services offered.

e. No other appointments types are authorized. Two factors will be considered when deciding which appointment type to use: (1) medical acuity, and (2) patient desires. In all instances, patients desiring a same day appointment will be seen the same day. Deferring patients to another day who desire a same day appointment is not authorized. Medical Home Port clinics will need to adjust and manage their appointment availability to accommodate patient desires. Civilian experience suggests that 50 percent of patients requesting a primary care appointment will desire a same day appointment. There is no reason to use both ACUT and OPAC appointment types for same day appointments. Commands should choose one, depending on their appointing business rules.

f. All patients not requesting a same day visit will be seen within one week, unless the patient specifically expresses a desire to be seen outside that time period. The only exception to this are medical conditions where follow-up within a week is not appropriate (ear re-checks after treatment for acute otitis media, as an example), or procedures that require preparation not appropriate for completion within one week.

3. Appointment mix. Medical Home Port clinics will need to adjust and manage their mix of appointments to meet patient demand. Clinics will modify the appointment mix between OPAC/ACUT, EST, and where necessary, WELL, as required.

4. Appointment volume. The number of appointments offered daily will be sufficient to meet the needs of the enrolled population. Patients requesting to be seen the same day, will be seen the same day. Deferrals of patients requesting same day appointments for non-emergent care to another day, the Emergency Department, or other clinics/clinical activities are not authorized. There is no recommended duration for individual appointments, since focus should be on addressing the health and well-being of the patient.

a. Commands will adjust and manage appointment availability, type, and duration to meet the health care needs of their enrolled populations. Medical Home Port clinics attaining National Committee on Quality Assurance (NCQA) Level II recognition will no longer be subject to traditional productivity-based PPS incentives, but will be judged on access, quality, outcome, and other related measures.

b. Care for non-enrolled patients. The Medical Home Port team is only responsible to provide care for their own enrolled patients. It is not authorized for the Medical Home Port team to be compelled to care for other non-enrolled patients. The only exceptions to this are newborns less than 60 days of age awaiting TRICARE enrollment, and the occasional foreign dignitary or visitor. Commands serving student populations should seek to enroll those students in either a Medical Home Port clinic or other primary care clinic. Likewise, dignitaries and patients of exceptional Graduate Medical Education (GME) value using clinical services on a regular basis should likewise be enrolled. Further, we do not reward efficiency by making our staff see another primary care team's patients. Commanders, commanding officers and officers in charge are strictly charged to ensure efficient Medical Home Port teams are not required to care for other clinic's patients. Commanders, commanding officers, and officers in charge shall also ensure Medical Home Port teams do not alter schedules or clinic hours to shorten and compress patient visits into shorter time periods in order to complete work early. Clinic hours and full scope services will be maintained; the goal is to make it easy and convenient for our patients to access care.

5. Template Management. Appointment types should be used within established booking access standards previously delineated in this instruction. Appointment types will not be changed and other appointment types are not authorized. Commanders, commanding officers, and officers in charge will monitor appointment availability, templates, and access performance to ensure patient need is met.

NAVY MEDICINE PRIMARY CARE FACILITY STANDARDS

1. Facility requirements. When spaces are configured and team members co-located to optimize patient flow and staff efficiency, communication and coordination of care is improved. Commanders, commanding officers, and officers in charge shall ensure Medical Home Port clinics have sufficient space and location to optimize efficiency. This may require moving other functions or offices, consolidating personnel into the same location/office, or other space-saving moves. Likewise, some facility modifications may be required to optimize Medical Home Port spaces after review by the facility consultant on the Subject Expert Assessment team. Commanders, commanding officers, and officers in charge will take all necessary steps to complete modifications as soon as reasonably possible. Although additional resources are not proposed, if local funds are not available, resource requests should be submitted through normal processes.

a. Clinic Layout. In general, it is recommended that key members of the primary care team be co-located in the same office space. Combined offices (PODS) for providers, nurses, support staff, as well as associated rooms for treatment or private consultation will be implemented where possible. Future military construction projects should include design features that allow for such co-location.

b. Space requirements. Each Medical Home Port clinic shall have:

- (1) Two exam rooms per provider in the clinic to promote efficiency in clinical practice.
- (2) One additional room for procedures and prolonged acute patient care and monitoring.
- (3) One private multipurpose office to be shared by team members.

c. Primary Care Departments may have multiple primary care teams. They will require, but may in most cases share, the following:

- (1) At least one conference room that may be used for shared medical appointments and patient education. Larger departments may require more than one conference room to meet clinical needs.
- (2) Behavioral Health Services. Dedicated space of sufficient size should be available to support integration of these services into primary care.
- (3) If appropriate, embedded ancillary support services shall be provided adequate space to provide patient centered consultative services within the primary care team.

NAVY MEDICINE PRIMARY CARE CLINIC MANAGEMENT BUSINESS RULES

1. Enrollment and Patient Management. Central to Medical Home Port is the concept of a treatment team and patient continuity. When a patient enrolls with one of our providers, that patient enrolls for care by all the members of the Medical Home Port team of which that provider is a member. By linking patients to teams, we enhance continuity and minimize disruptions in care for our patients. To attain these goals, the following standards shall be implemented at all Medical Home Port clinics:

a. All primary care providers participating in a Medical Home Port clinic shall be a member of the Medical Home Port clinic team of three to five providers.

b. BUMED strongly recommends that providers realize 1,100 patients is the minimum, but not to exceed 1,300 patients, for every provider full time equivalent.

c. Each patient, when enrolled to a provider, will be considered to be enrolled to that Medical Home Port team. That Medical Home Port team is responsible for the care of that patient 24 hours a day, 7 days a week, and 365 days a year. During periods of primary provider absence, care shall be given by another member of the Medical Home Port team. Patients will have access to the providers on their Medical Home Port team continuously. Access shall be either direct, where the patient can directly contact the provider or the Medical Home Port team watch after hours, or may be via a local nurse triage system. Patients will not be referred to the Emergency Department (ED) or other health care settings for questions, care, or services that could and should be performed by the Medical Home Port team.

d. At the time of enrollment, a patient shall receive a letter from the medical treatment facility (MTF) notifying them of the name of their Medical Home Port provider, the name of their Medical Home Port team, the location of that Medical Home Port team within the MTF, and a point of contact for questions or concerns.

(1) Due to contract restrictions, Navy Medicine cannot change the current process that the Managed Care Support Contractors (MCSC) uses to send out a centralized Primary Care Manager letter. Instead, the MTFs will send out their own patient letters welcoming enrolled patients to the Medical Home Port team. These letters will provide assurance to patients that, although they may still receive letters from TRICARE Management Activity (TMA), the local MTF will guarantee their Primary Care Manager (PCM) and Medical Home Port team continuity.

(2) Patients will receive only one letter unless they (1) change Medical Home Port teams, or (2) depart the area on permanent change of station (PCS) orders or retirement/release from active duty. If their primary care provider deploys or is otherwise unavailable for an extended period, the patient shall be reassigned to another provider on the same Medical Home Port team and informed by the team of that change, but will not receive another letter from the MTF.

2. Appointing Business Rules. The overarching goal of the appointing process is to make it as easy as possible for a patient to get an appointment at the date/time he or she desires. Appointing may be centralized or decentralized, depending on the individual MTF preference and needs. In some cases, the appointing system may be a hybrid. Regardless of appointing method used, appointment clerks must be trained to follow established booking rules and be accountable to the Medical Home Port team. Business practices within the primary care team are best delineated locally to serve the needs of both patients and practice. Ideally, each Medical Home Port team should have an identified clerk who is considered part of the team, irrespective of their location. That clerk will have immediate and ready access to a nurse or provider of the Medical Home Port team for consultation and assistance with appointing. Consistency and continuity in appointment clerks will lead to maximized efficiency and access. The following requirements must be met:

a. Enrolled patients calling for an appointment and requesting to be seen the same day will be seen that same day by a member of the Medical Home Port team. Medical Home Port teams will need to ensure their appointing templates can support this requirement. Cross-booking between primary care teams is not authorized, nor is referring patients to the ED, or other clinical venues for conditions that can and should be treated in their Medical Home Port clinic. All other patients will be seen within seven days unless they specifically request a later appointment or it would be medically inappropriate for them to be seen within seven days.

b. When an appointment is made, the Medical Home Port provider is the first choice for booking any appointment type. If the Medical Home Port provider is unavailable, another member of the Medical Home Port Team will see the patient.

c. Demand management is necessary to optimize access. This process empowers patients to make wiser health care decisions. A key component of demand management is effective and proactive management of patients with chronic disease. Such patients should be proactively contacted and scheduled for ongoing management of high risk chronic diseases with associated long term morbidity and mortality.

d. Clinic managers shall closely monitor ED utilization and primary care leakage as potential indicators of access problems in the Medical Home Port clinic. Where necessary, clinic managers shall adjust templates and Department Heads shall adjust provider availability, to ensure primary care health care needs of enrolled patients are being met in the Medical Home Port clinic.

e. Medical Home Port teams will have the ability of booking appointments for specialty care consults in the direct care system at the conclusion of the patient's visit. Specialty clinics are encouraged to develop guidance to assist the Medical Home Port team in submitting appropriate consults. Executive Committees of the Medical Staff should develop processes to periodically review primary care consults for appropriateness and to assist with medical staff service planning.

f. Appointments for specialty care in the network will be tracked by the Medical Home Port team, through information provided by the Managed Care Support Contractors, and results will be added to the patient's medical record by the MTF. In addition, the referring provider will be notified of those results. Alternatively, commands may use existing referral management processes. In those cases, commanders, commanding officers, and officers in charge shall ensure close coordination of referral managers with the Medical Home Port team.

3. After-Hours Medical Home Port Team Access. A patient's ability to access either their Medical Home Port provider, or if unavailable, another member of their Medical Home Port team, shall be direct and easily accomplished. Direct access involves either direct contact with the Medical Home Port provider via asynchronous messaging, telephone, pager, or some other communication device. Alternatively, contact may be through an established local nurse triage system. No other venues for patient/provider communication are authorized. Patients shall not be referred to the ED or other locations after hours for conditions that could and should be treated by their Medical Home Port Team. Commanders, commanding officers, and officers in charge are specifically tasked to monitor this and ensure patients can easily access their Medical Home Port provider or team at all times.

a. After-hours coverage may be provided by a member of the Medical Home Port team including active duty, civilian, or contract providers. Designated providers should be of same training and competency of the Medical Home Port team providers to ensure quality patient care coverage and services. The ED is not considered appropriate coverage for after-hours primary care for non-emergent conditions.

b. If a centralized nurse triage call center is utilized as part of this process, appropriate triage tools, approved by the medical staff, will be used and the designated on-call provider associated with the primary care service will be immediately and readily available for consultation.

c. All after-hours patient contact and management decisions will be communicated back to the Medical Home Port team and incorporated into the patient's medical record.

d. After-Hours Primary Care. Commanders, commanding officers, and officers in charge must ensure that the normal hours of operation for the primary care clinics meet the access needs of their enrolled population. In some cases, extended hours into the evenings, weekends, and holidays may be necessary to meet patient need in an efficient and effective manner. An indicator of the need to extend clinic hours may include leakage to ED or network for non-emergent care that could be managed within extended hours in the primary care clinic. Commands should give strong consideration to extending Medical Home Port clinic hours when an equivalent of three patients/hour is being seen for primary care concerns in other local venues (ED, etc.).

e. Emergency Department Protocols.

(1) Quality care is realized when patients and providers partner together to set and attain health care goals. Continuity of care is essential for this to succeed. It is necessary for the primary care team to partner with the ED to improve continuity of care and ensure Medical Home Port patients are seen by the Medical Home Port team whenever possible. During normal working hours and when clinically appropriate, the ED should offer patients with triaged non-urgent/emergent life threatening conditions, referral to their Medical Home Port team. ED staff will directly communicate with the Medical Home Port team to arrange a warm hand-off.

(2) Commanders, commanding officers, and officers in charge shall ensure good communication exists between the Medical Home Port team and the ED for care of enrolled Medical Home Port patients after hours. The Medical Home Port team shall ensure their patients are educated regarding appropriate ED use and the availability of the Medical Home Port team to them at all times. The ED shall refer to the Medical Home Port team the names of all enrolled Medical Home Port patients who present to the ED for non-emergent or non-urgent care. The Medical Home Port team shall ensure appropriate follow-up. The Medical Home Port clinic manager shall track ED utilization in both the direct care system and the network for enrolled Medical Home Port patients to identify frequent utilizers for possible case management as well as clinic access adequacy.

NAVY MEDICINE PRIMARY CARE TEAM INFORMATION
MANAGEMENT/INFORMATION TECHNOLOGY GUIDANCE

1. Background: Information Management/Information Technology (IM/IT) tools are important for achieving the National Committee on Quality Assurance (NCQA) recognition as a Medical Home Port, for providing the breadth of services need for quality care and for measuring/showing outcomes for the Medical Home Port Teams, clinics and medical treatment facilities (MTFs). All IM/IT tools are subject to review, as well as, systems certification and accreditation by the certifying agency for Navy Medicine. When such tools (such as those that follow) are certified, they can be deployed to support the Medical Home Port program.

2. Secure Messaging:

a. Navy Medicine will utilize standardized secure patient messaging. This system will allow for asynchronous communication/coordination between patients and providers, providers and consultants, and between Medical Home Port team members. The purpose of asynchronous secure messaging is to provide the following capabilities, which are available or supported by all current iterations of secure messaging: demand management; results distribution; preventive healthcare communication; broadcast messaging/announcements and; minor problem management.

b. The ability to designate "surrogates" is an important feature of secure messaging, as is the ability to allow any Medical Home Port team member to receive and respond to messages from their patients. With this capability, patients can be managed by the entire "Team" (to include non-providers).

c. An end state objective for the entire Military Health System (MHS) enterprise is for secure patient-provider messaging to be integrated into the electronic health record (EHR) as a service. Until such time however, any patient communication will be manually entered into the EHR using a copy and paste or equivalent methodology. Additionally, until the secure messaging capability is incorporated into the EHR, documentation of secure messaging encounters will occur as follows:

(1) Medical Home Port team member will open a telephone conference (TEL-CON).

(2) Medical Home Port team member will copy and paste the entire secure messaging encounter into the TEL-CON.

(3) Medical Home Port team member will code the TEL-CON using the provider or nurse telephone consult CPT codes, as appropriate, until such time that the Unified Biostatistical Utility (UBU) assigns a Relative Value Unit (RVU) value to the online messaging current procedural terminology (CPT) code. Once the secure messaging capability is integrated into the EHR, the Medical Home Port teams will use secure messaging to document and code the encounter.

3. Referral Management: Secure messaging will facilitate tracking of referrals and communication between consultants and the Medical Home Port team. This can be accomplished through the Referral Management Office or through a capability intrinsic to the secure messaging capability. During the initial phase in of the Medical Home Port program however, referral management will, by necessity, require a “copy and paste” process into the appropriate documentation area within the EHR. Currently, the most appropriate area for this is the telephone consult “Add Note” section with review and signature by the PCM. As secure messaging is integrated into the EHR, the Medical Home Port team will then use the secure message feature.

4. Clinical Informatics Tools: There are many clinical informatics tools that can better support the provision of patient care and enhance management of primary care clinics. The Medical Home Port team should utilize these tools, as necessary and as they are available. An example of such tools includes, but is not limited to: MHS Population Health Portal (Navy Population Health Navigator); MHS Insight; and TRICARE Operations Center Template Analysis Tool.

NAVY MEDICINE PRIMARY CARE STANDARDIZED METRICS

1. Standardized performance measures are critical to Navy Medicine's analysis of the impact of Medical Home Port and essential to help guide future planning. These metrics track clinical quality, satisfaction, access, and military-relevant indicators, and should correlate with the goals of the Military Health System (MHS) *Quadruple Aim* model. Metrics will be drawn from established systems of record, and universally available data to minimize additional or duplicative data collection by Medical Treatment Facilities (MTFs), while concurrently enabling valid comparisons between programs.

a. Baseline Primary Care Metrics

(1) Patient Experience of Care. TRICARE Management Activity (TMA) Access to Care Metrics:

(a) Primary Care Manager By Name (PCMBN) Continuity, Primary Care Manager (PCM)/Team Continuity (M2).

(b) Access. Composite metrics for access overall, access performance management, and patient satisfaction. (MHS Insight).

(c) Emergency Room and Urgent Care Utilization for Non-emergent Care. (M2 for direct care system, Managed Care Support Contractors (MCSC) report for network facilities.)

(d) Catchment area non-MTF urgent and primary care utilization (MCSC report).

(2) Patient Satisfaction (Navy Medicine Monitor).

(3) Population Health. Healthcare Effectiveness Data and Information Set (HEDIS) Population Health Metrics (Population Health Navigator).

(a) Asthma.

(b) Diabetes management.

(c) Breast Cancer Screening.

(d) Colon Cancer Screening.

(e) Cervical Cancer Screening.

(f) Well Baby Visit.

(4) Readiness: Indeterminate (IND) rate for enrolled active duty (MRRS).

(5) Clinic management metrics.

(a) Provider availability (Defense Medical Human Resources System – internet (DMHRSi)).

(b) Incomplete outpatient records (Armed Forces Health Longitudinal Technology Application (AHLTA)).

(c) No show rate (M2).

(d) Unbooked appointment rate (M2).

(6) Satisfaction questions under development.

(a) Able to reach Primary Care Team when I have a question regarding my health care.

(b) Perceived Quality of Life/Functional Status.

(c) Staff Satisfaction.

BUMED-APPROVED PROVIDER ADMINISTRATIVE DISCOUNTS

Provider availability is critical to Medical Home Port success. Provider time away from the clinic represents lost opportunity for our patients to see their provider and should be minimized. All time away from clinical activity shall be in strict compliance with BUMED-approved administrative discounts listed below. Any other times away from continuity practice must be approved by the commander, commanding officer, or officer in charge. The commander, commanding officer, or officer in charge will balance patient need and access when considering such requests. Such time away may include time spent in other Mission Essential Non Benefit Activities (MENBA) not outlined below, or other clinical activities that are not part of continuity practice, but are critical to mission such as procedures, Emergency Department (ED) coverage, wounded warrior care, etc. Other clinical activities outside of continuity practice will lead to deductions from continuity practice availability based on actual time away. These administrative discounts only apply to primary care, including Family Practice, General Internal Medicine, and General Pediatrics.

Non-Continuity Clinic Responsibility	Offset	Total
Director - Medical Center	0.7	0.0
Director – Other Teaching Facility	0.5	0.0
Director - Clinic/Non-Teaching	0.3	0.0
Dept Head: Small (≤75)	0.3	0.0
Dept Head: Large (>75)	0.5	0.0
ECOMS Chair	0.3	0.0
Regional EHR Champion	0.5	0.0
Facility AHLTA Champion	0.1	0.0
Facility Essentris® Champion	0.1	0.0
Specialty Leader: <100 billets	0.2	0.0
Specialty Leader: 100-299 billets	0.4	0.0
Specialty Leader: ≥300 billets	0.6	0.0
Inpatient Coverage¹		0.0
Program Director GME²		0.0
Teaching Staff GME³		0.0
Post-Call Rest⁴		0.0
Hospital Committees/BUMED Advisory Board⁵		0.0
Command approved offset		0.0
Total Clinical Availability		1.0

Legend
Offsets are by half days of clinic
¹ FTE needed to cover service divided by number of providers that share duty
² Actual RRC requirement by specialty
³ Actual RRC requirement by specialty
⁴ Actual daytime FTE lost to post call/recovery divided by the number of providers that share duty
⁵ Actual time away

Acronyms used in this table are defined in enclosure (1).