

CLINICAL OPERATIONS

AT THE DECKPLATE



VOLUME 3, ISSUE 4

FALL 2010

TALES FROM AFGHANISTAN

CDR Rees Lee, MC, Deployed from NMC Portsmouth

In light of the upcoming holiday season, let us take time to remember our fellow service members stationed overseas and celebrating the holidays away from friends and family. One of our deployed service members, CDR Rees Lee, MC, is the Co-Chair of the Asthma Action Team (AAT) and has been documenting his experiences and insights in a monthly newsletter he distributes to friends and colleagues. Below is an excerpt from CDR Lee's October newsletter about the purpose of Pediatricians in a Combat Hospital in Afghanistan:

Initial Impressions



Kandahar Airfield, or KAF, is a city unto its own. It is basically a tent city of over 20,000 inhabitants built up around the Kandahar Airport. A melting pot of 20 primarily NATO nations make up the populace. Canadians, French, British, Dutch, Danes, Romanians, Slovaks, Australians, Bulgarians, just to mention the ones I can remember off the top of my head. Each one of these seem to come in army, air force and the occasional naval variety. Oh yeah: Americans of all types from Army, Air Force, Marines, Special Forces, Seabees, civilian contractors. I have even seen some Coast Guard here.

NATO Role 3 Multinational Medical Unit

The NATO Role 3 Multinational Medical Unit (MMU) provides the highest level of medical and surgical care in Afghanistan. A quick primer on NATO terminology: Role 1 is basically a battle aid station; Role 2 has advanced emergency resuscitation and some emergency surgery capability; Role 3 is a fully capable field hospital with medical, surgical and diagnostic services. The NATO handbook categorizes hospital ships like the MERCY and COMFORT as Role 3 facilities. While it would be certainly less dusty on the COMFORT, the NATO Role 3 is just as capable.

What is a Pediatrician Doing in a Combat Trauma Hospital?

Good question. It might seem nonsensical. But in fact, myself and the other pediatric trained doc, Jon Woods (pediatric intensivist extraordinaire) actually use our peds training on a daily basis. Children account for about 15% of our workload in the ICU and Ward. More than you might think. I have been assigned to the Ward for my clinical duties. Great group. Keeps me busy on call nights. Averaging 14-18 patients with a relatively high turnover. That is, 5 or so admissions and discharges each a day. Everything you learned in residency comes in handy. In fact, this would be a great experience for our residents though I am not sure what the Residency Review Committee would say about the rocket attacks

and the almost daily extra hours to assist with incoming wounded. Everyone loves the children. They come with their families who remain at their bedside and help with their care. By the time they are ready to leave, the docs, nurses and families know each other quite well. On the occasion of his child going home, one father confided to an interpreter that: "I would kill to protect those docs." Hopefully he will not need to do that. But it is illustrative of the intensity of good will caring for a child can generate. Perhaps he will tell his fellow villagers and they will feel the same way.

You never know if we make a difference beyond saving this child's life. But I think we do. By demonstrating our good will and willingness to help protect their children, perhaps next time an American patrol is in his village, this father may direct our guys away from the IED or point out the Taliban stronghold. One never knows how many soldiers lives are saved as a result of this good will. We like to think that it is quite a few. So in the end, do pediatricians make a difference at the front line in protecting our soldiers -- I pray that we do.



NATO Role 3 Ward

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2011 MHS Conference: “The Quadruple Aim: Working Together, Achieving Success”

The 2011 Military Health System Conference titled “The Quadruple Aim: Working Together, Achieving Success,” will be held January 24-27, 2011, at the Gaylord National Hotel and Convention Center in National Harbor, Maryland (<http://www.health.mil/2011mhsconference.aspx>).

This year’s conference will focus on sharing knowledge and improving provider performance in health-care delivery, research, education and training. Breakout sessions will center around furthering Quadruple Aim goals and associated strategic imperatives. This year’s breakout sessions are listed below:

- ❖ Long Term Strategies
- ❖ Developing the Healthcare Team
- ❖ Meaningful Use of Health Information
- ❖ Enabling Breakthrough Results through Research and Rapid Innovation
- ❖ Readiness
- ❖ Building Resilience and Improving Psychological Health
- ❖ Engaging Patients in Healthy Behaviors
- ❖ The Patient Centered Medical Home
- ❖ Experience of Care: Improving Quality and Safety
- ❖ Effective Patient Handoffs
- ❖ Improving Effectiveness, Managing Per Capita Costs
- ❖ TRICARE Contracts: Now and In The Future

“DID YA KNOW?”

NCQA’s Physician Practice Connections®-Patient Centered Medical Home™ (PPC-PCMH) program assesses whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.



FREE Webinar trainings available! To learn more about NCQA recognition for their PPC-PCMH Program, visit the website at <http://www.ncqa.org/tabid/631/Default.aspx>

IMPORTANT EVENTS

- **PERINATAL ADVISORY BOARD**
FEBRUARY 7-11 @ SAN DIEGO, CA
- **PRIMARY CARE ADVISORY BOARD**
JAN 31-FEB 2 @ NH CAMP PENDLETON AND NMCS D
- **MUSCULOSKELETAL CONTINUUM OF CARE ADVISORY BOARD**
FEBRUARY 10-11 @ BETHESDA, MD
- **EVIDENCE-BASED HEALTHCARE ADVISORY BOARD**
MARCH 8-9 @ PORTSMOUTH, VA
- **ORAL HEALTH ADVISORY BOARD**
DECEMBER 16TH @ BETHESDA, MD
- **BEHAVIORAL HEALTH ADVISORY BOARD**
MARCH 1-2 @ SAN DIEGO, CA
- **TRAUMA CARE ADVISORY BOARD**
TBD
- **DIABETES ACTION TEAM**
FEBRUARY @ TBD
- **ASTHMA ACTION TEAM**
MARCH 2011 WITH ARMED FORCES PUBLIC HEALTH CONFERENCE
- **TOBACCO CESSATION ACTION TEAM**
FEBRUARY 23-25 @ BETHESDA, MD

“DID YA KNOW?”

2010 Navy Case Manager of the Year Award

On October 14, 2010, Ms. Marjorie Ingelsby, the Lead Case Manager at Naval Hospital Jacksonville, received the 2010 First Annual Navy Case Manager of the Year Award. Ms. Ingelsby’s contributions to the MHS Case Management program are well-known throughout her community and are highly recognized by her colleagues. Some of these accomplishments include

- ✓ Creation of a TRICARE Management Activity deployment health learning module
- ✓ Expert presentation at the Case Management Society of America’s 2010 Annual Meeting
- ✓ Establishment of formalized Case Management services for patients with autism, to name a few

Ms. Ingelsby is supported by a dedicated Case Management staff that also deserves recognition for their part in this distinguished award.

NAVY AND MARINE CORPS PUBLIC HEALTH CENTER

DON CANCER REGISTRY PROGRAM

Tara Blando, MPH & Liz Butts, MHP, CPC, RHIA, NMCPHC

The publication of the American Joint Committee on Cancer (AJCC) titled *AJCC Staging Manual, 7th Edition*, released in 2010 has significantly increased the scope of cancer data collected by DON cancer registrars with documentation in the Automated Central Tumor Registry (ACTUR) database. The ACTUR system was established in 1986 and was designed to provide the uniformed services medical treatment facilities with the capability to compile, track, and report cancer data on Department of Defense (DoD) beneficiaries.

The Navy Tumor Registry Program provides direction to and monitoring of, cancer data collected by DON cancer registries. It is the primary vehicle for distribution of information on cancer incidence, treatment, and outcomes for cancer surveillance. Because human papillomavirus (HPV) plays a role in the pathogenesis of some cancers, registrars can now collect HPV data for an expanded list of head and neck cancers. This includes specificity codes for high risk HPV types, 16 and 18. It is knowledge about HPV related cancers that contributed to the development of vaccines to protect against the most virulent forms. The NMCPHC cancer information pages (www.nmcphe.med.navy.mil/Data_Statistics/Cancer_and_Tumor_Registry/) contain a detailed list of sites for which HPV data is collected.

DATABASE FACTS

- ✓ ACTUR database contains over 339,000 cancer records of raw data from all DoD facilities, including data from 1997 and earlier.
 - Central registry consolidates data from multiple DoD facilities into single clean records for each incidence of cancer.
 - Available clean dataset spans 1998-2009.
 - Work on 2010 data consolidation and de-duplication has commenced.
- ✓ Inquiries concerning access to either database can be made by contacting the Navy Cancer and Tumor Registry Consultant, contact information listed below.
- ✓ Besides extensive site specific factors such as HPV, HER2/neu (breast) or CEA outcomes (colon) both databases contain demographic, diagnostic, treatment and follow-up data used for cancer survival studies.
- ✓ Both registries include treatment data on beneficiaries that have been referred to civilian facilities for all or part of their treatment.

Information: NMCPHC at <http://www.nmcphe.med.navy.mil/>

Contact: Navy Cancer and Tumor Registry at tumreg@nehc.mar.med.navy.mil or (757) 953-1824.

BREAST CANCER SCREENING RECOMMENDATIONS

CAPT Paul Rockswold, MC, NMCPHC

As of November 2009, the U.S. Preventative Services Task Force (USPSTF) recommends biennial breast cancer screenings for all women aged 50-74. The decision to begin biennial screening before the age of 50 should be left to the individual, and should take into account the context of the patient.

Due to the recommendations of the USPSTF, the Surgeon General recommends: "routine biennial screening mammography for women aged 50-74. However, routine biennial screening mammography from aged 40-49 may be indicated based on health care provider discussions with the patient and based on risk factors."

What Does This Mean?

- The **Population Health Navigator** includes measure for Percentage of women continuously enrolled to the MTF ages **52-69 years** who had breast cancer screening in the previous 24 months
- The **BUMED Business Planning Supplemental Guidance** includes a critical initiative for Advanced Evidence-Based Healthcare (EBHC), determined essential to achieving optimal efficiency, cost containment and improving the quality of healthcare. The EBHC critical initiative mandates monitoring the new evidence-based recommendation for breast cancer screening
- The **Manual of the Medical Department** Chapter 15, Article 15-112 has been updated to include the new guidance.
- Providers should follow the new guidelines of the USPSTF and the Surgeon General when administering mammographies to their patient populations.

For more information on current breast cancer screening recommendations, please see the NMCPHC link www.nmcphe.med.navy.mil/Data_Statistics/Cancer_and_Tumor_Registry/

You can visit the USPSTF Website for the summary of their recommendations for breast cancer screening at http://www.uspreventiveservicestaskforce.org/uspstf/usp_sbrca.htm

PRIMARY CARE

CAREPOINT IS COMING.....



WHAT IS CAREPOINT?

The first MHS-wide Web-based platform for reporting metrics, PHI, and collecting PHI on survey tools

WHY DO WE NEED CAREPOINT?

In August 2008, the AF Integrated Healthcare Toolset identified the MHSPHP for migration and modernization. There was no Web-based platform available to securely host personal health information (PHI) management activities jointly across Army, Navy, AF, Coast Guard, TROS, TMA, and Designated Providers. There was no platform available to leadership, commands, MTFs, and contract partner. In addition, there was no platform available that allows significant modifications and enhancements without a DIACAP or major Release Management

WHAT WILL CAREPOINT DO?

- MHS Population Health Portal Homepage
- You can tailor it!
 - Portlets can be collapsed or closed making page customizable
 - Customizable and exportable charts will be available.
- More information available!
 - Counts will be displayed for Demographics, BenCat, Disease/Condition Prevalence and Action Lists
 - Action List counts will be linked to Action List in Patient Management module
 - Disease/Condition Prevalence and Action Lists counts will reflect nightly data refreshes and locally-entered data
- Data updated more often!
 - Action lists values for tests will be refreshed nightly (once)
 - Enrollment will be refreshed monthly
 - User entered inclusions/exclusions will impact counts nightly
 - Completed and Due counts will adjust daily

Welcome to CarePoint!

CarePoint provides access to various DoD healthcare modules. Each application you wish to use will have a different registration process, but once you are initially granted access to CarePoint and the individual applications within, you will be able to seamlessly navigate from one application to another with a single login. You will no longer be required to remember different user names and passwords.

A screenshot of the CarePoint login interface. It features a blue background with a green header bar. The header bar contains three input fields: 'USERNAME', 'PASSWORD', and 'LOG IN' with a right-pointing arrow. Below the header bar, there are two buttons: 'REQUEST ACCESS' with a right-pointing arrow, and 'FORGOT USERNAME/PASSWORD' with a right-pointing arrow.

NCQA RECOGNIZING MEDICAL HOME PORT PRACTICES IN MHS

Regina Julian, *TRICARE Management Activity*



The MHS has contracted with the National Committee on Quality Assurance (NCQA) to conduct recognition surveys of our Patient Centered Medical Home (PCMH) Practices, in coordination with the individual Services. The MHS recognizes the PCMH concept as the strategic initiative expected to have the greatest impact on the Quadruple Aim. As a result, all PCMH practices are encouraged to participate in the recognition process, in coordination with their individual Services.

- MTFs will complete an NCQA Baseline Self-Assessment
 - All 411 MHS PCMH practices will participate in a baseline self-assessment of their practices in the Dec 2010/Jan 2011 timeframe.
 - Accomplished using an on-line NCQA tool, which asks "yes" and "no" questions regarding individual PCMH practice operating procedures relative to NCQA PCMH standards and guidelines
 - Navy MHP practices are not required to upload any documentation or data in the baseline assessment.
 - BUMED will identify those practices which will participate in the full recognition process FYs 2011-2013.

◆ Interested personnel are encouraged to attend sessions at the Primary Care Transformation and Patient Centered Medical Home Track at the MHS Conference 24-27 Jan 2011. ◆

If you have questions, please contact the BUMED Medical Home Program Management Office, CDR Mary Greenberg, NC, at Mary.Greenberg@med.navy.mil.

PRIMARY CARE

A DECKPLATE STORY - NBHC GROTON: BECOMING A MEDICAL HOME

Lynn Peters APRN, MS, CCM, NHCNE Groton

On May 26, 2010 BUMED Instruction 6300.19 was signed instituting a new policy for the provision of Primary Care Services within Navy Medicine. This instruction states that all of Primary Care within the scope of BUMED will be delivered using the Patient-Centered Medical Home model's team-based care approach and it will be called Medical Home Port. The primary goal of the Medical Home Port model of care is to provide care through a holistic approach and to empower a partnership between the patient and Primary Care to help the patient achieve their optimum health. The Naval Branch Health Clinic (NBHC) Groton, one of four clinics that make up Naval Health Clinic New England (NHCNE), is the pilot site for the implementation of the Medical Home Port model of care within the Command. NBHC Groton is an outpatient care clinic. The Home Port Planning team is comprised of staff from the Primary Care, Patient Administration, Ancillary Services, Healthcare Operations, Fiscal, Information Technology, Referral Management, and Facilities Departments, and Ombudsman. The team has approached this major change in healthcare delivery with efforts aimed at marketing to staff and beneficiaries in to order to increase buy-in.

Scheduling and templates are being adjusted to maximize access to care and appointment availability. We are building time into provider schedules for walk-in patients throughout the day and each provider will begin their day with 50% of appointments open for scheduling of same day care in order to decrease unnecessary ER utilization. Same day appointment scheduling will be the responsibility of the Medical Home Port team, allowing for pre-assessment of patient needs ensuring the proper level of care for each patient.

Staff offices and exam rooms have been relocated to better facilitate team communication and patient care flow. The clinic is being designed to have four Medical Home Port Piers; 2 Family Practice and 1 Pediatric along with one Operational Pier to care for operational forces and students. The Piers will be composed of military and civilian providers, Registered Nurses (RN), Licensed Practical Nurses (LPN), Medical Assistants (MA), Corpsmen and Clerical Staff with an Independent Duty Corpsman component of the operational Pier. NBHC Groton unique in that we serve a large non-enrollee population. The Operational Pier will serve the non-enrolled

operational submarine community, operational units from other services requiring care in the New England region, as well as the Naval Submarine School student population.

The clinic has plans to embed a Clinical Pharmacist and Behavioral Health Provider in FY 11 within the Medical Home Port to assist in increasing patient access to care and to ensure collaboration between services to avoid delays in meeting patient needs. Wellness nurses and a Nutritionist have also been moved into the clinic to assist with timely patient education and intervention. Case Managers will work in collaboration with teams to ensure complex, unstable patient needs are met.

Nurses will play a large role in maintaining team communication and in coordinating and providing care for those patients enrolled to the teams. Nurses and support staff will operate at the highest level of their licensure with nursing pathways being developed to standardize the highest level of care across the Piers. All RNs, LPNs, MAs and Corpsmen are undergoing regular training to assess patients and initiate provider visits to assist in the efficiency of healthcare delivery to patients requesting same day evaluation in the clinic and to avoid unnecessary ER utilization.

Daily team huddles will be used to discuss and plan for opportunities to maximize the benefits of each patient. Teams will prepare for appointments by pre-arranging needed labs, diagnostic testing, refills, referrals, and addressing patient needs to maximize patient experience and have staff work at their highest level.

Team members are being cross-trained to be able to function in appointment scheduling, patient check-in, patient assessments and documentation in order to maintain patient access and flow, even in times of staffing outage and deployments.

The NBHC Groton is making great strides to optimize the health care experience for all of our beneficiaries and to provide evidence-based patient-centered care to those we serve.

BRAVO ZULU!

NEW TOBACCO FREE COMPOUNDS!

- ❖ September 16th - NH Beaufort and Branch Health Clinics Parris Island and MCAS Beaufort
- ❖ November 18th - NH Pensacola and all 12 Branch Health Clinics!
- ❖ January 1st - NHC Quantico and BUMED headquarters
- ❖ For a list of NavMed facilities and information/resources on how your MTF can go tobacco-free, visit:
http://www.nmcpbc.med.navy.mil/Healthy_Living/Tobacco_Cessation/tobacco_MTFToBaccoFreeCampus.aspx



CARE COORDINATION

INTRANSITION – Bridging an Important Gap for Service Members Receiving Mental Health Care

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) provides *inTransition*, a program to assist servicemembers currently receiving behavioral health treatment and going through a transition. With one-third of the military relocating every year, DCoE understands that change – *transition* – is a part of military culture. Transitions, such as a permanent change of station or even temporary duty, are likely to cause disruption in the life of the servicemember and his or her family. Furthermore, transitions in status, whether to active duty or standing down to re-enter civilian life, are certain to produce high levels of stress. Any of these life transitions can interfere with the continuity of mental health care that a servicemember is currently receiving. That is why the *inTransition* program is mission-critical in bridging the gap between the time a servicemember transitions from a current or referring provider until he or she is connected with a gaining provider.

Keeping Servicemembers Engaged in Their Treatment

The purpose of the program is to provide personalized coaching, support and motivation to reduce the likelihood of the servicemember disengaging from treatment. Each servicemember is assigned a transition support coach who provides guidance and resources on healthy living and encourages the servicemember to remain in treatment during his or her transition.

Important points about the *inTransition* program:

- *inTransition* is a voluntary coaching and assistance program that supports servicemembers' efforts to achieve and maintain wellness while they are transitioning between health care systems or providers, or undergoing a change in status or location change.
- There is no cost to the servicemember or the provider to use the *inTransition* program.
- *inTransition*'s highly qualified coaching staff consists of master's-level, licensed behavioral health clinicians trained in servicemember issues.
- Providers are to refer all appropriate servicemembers to the *inTransition* program.
- *inTransition* is not a substitute for mental health care and treatment. *inTransition* coaches provide the coaching and motivation necessary to keep servicemembers engaged in their treatment plan.

***inTransition* Website Offers Providers More Information**

- ✓ News, FAQs and information about upcoming *inTransition* Web trainings can be found at www.health.mil/inTransition.
- ✓ Downloadable communication materials including brochures, posters and flyers can also be found at www.health.mil/inTransition.
- ✓ If you would like to order hard copy printed communication materials, at no cost to you, go to <http://intransition.contentcloset.com/> to place your order.
- ✓ Contact for more information:
 - 1-800-424-7877 inside the United States;
 - 1-800-424-4685 (DSN) outside the United States toll-free;
 - 1-314-387-4700 outside the United States collect.

So please take advantage of this resource on behalf of the servicemembers in your care.

NAVY & MARINE CORPS RESTORATION EFFORTS **CDR Jennifer Reed, MSC, BUMED M3/5 COCP**

The Human Performance Resource Center (HPRC) is the Department of Defense (DoD) focal point for information in the area of Human Performance Optimization (HPO). It is housed at the Uniformed Services University and reports to the Deputy Assistant Secretary of Defense, Force Health Protection and Readiness. Our simple definition of HPO includes those medical areas that will optimize the warrior both physically and mentally to carry out the mission in any environment. It also includes those medical areas that will make the warrior more resistant to physical and mental trauma and illness and, if injured or ill, able to bounce back faster. The major goals for HPRC are: 1) to provide evidence-based information on HPO to the warrior, healthcare providers, leadership, and researchers; 2) to answer questions from the field on HPO issues; 3) to facilitate communication, collaboration, and coordination of HPO research between and among warriors, healthcare providers, line leadership, and researchers; and 4) to provide DoD and uniformed service leadership with HPO information for the development of instructions and policies.

The website www.humanperformancecenter.org has been the principal tool to transmit information on HPO. The website continually undergoes revisions and updates to appeal to the communities it serves. It contains information on physical fitness, operating in severe environments, nutrition, dietary supplements (including access to the Natural Medicine Comprehensive Database), mind tactics (mental fitness), and family/social issues. The information is presented at a level of understanding for non-professionals, but with elements that enable those interested to mine data from the available research at a more technical level. HPRC has also held conferences that answer specific needs to gather subject-matter experts together to formulate evidence-based answers to questions that are still controversial or new. HPRC has twice so far gathered subject-matter experts on nutrition and high-intensity training and is producing guidelines in those areas. A work group was also put together to define "total force fitness" so the Chairman of the Joint Chiefs of Staff could formulate an instruction.

HPRC exists to serve as a major conduit of HPO information to warriors, healthcare providers, line leadership, and researchers. It can also help facilitate coordination, collaboration, and communication among and within the different communities served in order to formulate answers to HPO issues.

HPRC is there to help whenever we can. Consider how HPRC—the only DoD website and resource center devoted solely to HPO—can help disseminate your information or facilitate the success of your projects.

DISEASE MANAGEMENT

HOW IS PHARMACY ENGAGED IN TOBACCO CESSATION?

LCDR Eric Parsons, MSC, NHC Great Lakes

In the ever demanding world of healthcare provision within the Military Healthcare System (MHS), providers are increasingly finding themselves with insufficient time to address all of their patient's healthcare concerns in one visit. This can result in patient dissatisfaction due to

- 1) Inconvenience of having to schedule and wait for an additional appointment at a future date in order to have their healthcare concerns addressed and
- 2) Appointment unavailability resulting from increased demand on the MHS for additional appointments.

Leveraging a pharmacist's skills in the ambulatory care setting can facilitate increased access to care while assisting in alleviating some of the demand placed on providers. Pharmacists continue to remain one of, if not the most readily patient-accessible members of the healthcare team. A patient can walk into most any Military Health Care System (MHS) or retail pharmacy during normal hours of operation, and if they are willing to wait a couple of minutes, speak to a pharmacist about their medication concerns –no appointment necessary.

It is this capacity to provide the patient the opportunity to rapidly access the health care system, when it is convenient for them to do so, and their expertise in the rapidly changing world of pharmacotherapy which makes the pharmacist an ideal provisioner of select ambulatory healthcare, of which one area is tobacco cessation therapy.

INNOVATION: Pharmacists at CAPT James A. Lovell FHCC

The newly formed CAPT James A. Lovell Federal Health Care Center, a partnership between former Naval Health Clinic Great Lakes and the North Chicago Veterans Administration, utilizes pharmacists in such a manner. Pharmacists complete specific tobacco cessation training, becoming credentialed within the command, forming a Provider/Pharmacist collaborative tobacco cessation program.

Under this program patients are able to present to the outpatient pharmacy requesting tobacco cessation therapy, at which point the pharmacist takes the patients history, explains the tobacco cessation program, initiates cessation counseling, and facilitates the selection of an appropriate cessation therapy (prescription, non-prescription, or non-medicinal) based on patient discussion and medication profile review. Proper use, side effects, and length of therapy are also reviewed, alternative tobacco cessation resources are provided, and follow-up occurs at two week intervals with the patient returning to the outpatient pharmacy at their convenience should they wish to continue.

By leveraging pharmacist availability and pharmacotherapy expertise in this manner we succeed in meeting our healthcare mission of facilitating force readiness. Additionally, our patients benefit from increased access to care in the form of readily accessible cessation counseling and therapy on their own terms; providers gain precious clinic time which is freed up by reducing workload in this area; and pharmacists continue to demonstrate that the benefits of their clinical expertise expand beyond the dispensing counter.

AAT Webcast Training

The BUMED Asthma Action Team (AAT) disease management training lecture series announces the next in its series of webcasts to be presented on **December 14, 2010: "Strategies for Improving Asthma Outcomes in the Primary Care Setting"** presented by Dr. Dr. Henry Wojtczak. We are pleased to announce you can now earn CME/CE credits by participating in the Asthma Webcasts!

Future Webcast Training Schedule:

- ❖ **February 8, 2011: Topic: ED Community- Update On Emergency Care of Asthmatics**

Sessions will be offered 4 times throughout the day to allow maximal participation (0900 ET, 1200 ET, 1500 ET & 1800 ET) & archived for future access. The Webcast will be available at <https://connect.dco.dod.mil/asthmawebcast> Mark your calendars now for these exciting training opportunities!

DAT Webcast Training

The BUMED Diabetes Action Team (DAT) disease management training lecture series announces the next in its series to be presented on **January 11, 2011: "2011 ADA Diabetes Guidelines Update"** presented by Ms. Rose Duncan.

Future Webcast Training Schedule:

- ❖ **March 1, 2011: Hot Topics in the Management of Diabetes**
Presented by: Vigersky - Diretor, Diabetes Institute Walter Reed Health Care System
- ❖ **May 2, 2011: Diet and Diabetes Management**
Presented By: Ms. Eva Brzezinski, NMC San Diego

Sessions will be offered 4 times throughout the day to allow maximal participation (0900 ET, 1200 ET, 1500 ET & 1800 ET) & archived for future access. The Webcast will be at <https://connect.dco.dod.mil/datwebcast>. Mark your calendars now for these exciting training opportunities!

DISEASE MANAGEMENT

PBB AND TOBACCO CESSATION METRICS

Jessica Newton, *Navy and Marine Corps Public Health Center*

The application of these metrics aim to standardize the Navy Medicine tobacco use documentation and diagnosis process, ensuring patient smoking status will consistently be up-to-date in medical records. Equipped with this information, clinicians will then be able to easily identify current tobacco users, determine patient motivation to quit, and proceed with the appropriate method of counseling or intervention. Three metrics to guide standardization of care are being implemented for the Navy Bureau of Medicine (BUMED) Performance Based Budget (PBB). The underlying assumption is that providing budgetary incentives for improved performance will increase compliance with the clinical practice guidelines for tobacco screening, ensuring standardization of addressing tobacco users in the DON. Navy MTF performance will be tracked over time to measure performance and process improvement in tobacco screening compared to the established DoD performance benchmarks.

FY11 METRICS:

Tobacco Use Screening: The tobacco screening PBB metric was released in FY09. The goal of this metric is to increase screening and recording of tobacco use status at all patient encounters in each Navy Military Treatment Facility (MTF). This is the first of three tobacco cessation metrics developed to standardize the process for addressing tobacco users. The metric measures the percentage of adult encounters in which the vitals module was opened that tobacco-use status was recorded over a 6 month period.

Tobacco User Diagnosis: The tobacco screening PBB metric was released in FY10. The goal of this metric is to increase diagnosis of tobacco users with a tobacco related ICD-9 code at least once a year in each Navy Military Treatment Facility (MTF). This is the second of three tobacco cessation metrics developed to standardize the process for addressing tobacco users. The metric measures the percentage of unique adults who had the “YES” box checked for the tobacco-use status at their most recent visit and had a documented tobacco related ICD9 diagnosis code at any point within the 12 month reporting period.

DATA SOURCE:

Data is queried from Clinical Data Mart (CDM). CDM is the clinical reporting tool for AHLTA which equips Military Health System (MHS) analysts and clinicians with patient-centric data to help them identify and assess trends to optimize clinical performance. CDM is able to mine non-coded fields as well (free text fields).

ANNUAL GRADING:

MTFs are not required to collect their own data. Raw data is sent monthly by NMCPHC to BUMED M8 and temporal trends are assessed for each Navy Parent Treatment MTF. BUMED only incentivizes performance at mid-year review. The metrics were associated with \$4.4M in FY09 and \$_.M in FY10. Monetary rewards allocated to these metrics will be \$_. in FY11.

TOOLS FOR IMPROVEMENT:

- 1) **NMCPHC Clinical Epidemiology Website:** Metric overview, metric methods, frequently asked questions, and a copy of Navy-wide raw data sent to BUMED are available on the NMCPHC Clinical Epidemiology Website. Full details of what is available can be found at: http://www-nehc.med.navy.mil/Data_Statistics/Clinical_Epidemiology/clinicalepidemiology.aspx
- 2) **CDM Pre-canned Detail Reports:** NMCPHC is offering a Pre-canned Action List Report for MTFs to run in CDM that will support local efforts to manage the processes tracked by this metric. These reports are more detailed than what is necessary to execute PBB. The drill down reports are designed to be run locally for just the parent and it's child sites, and will be made available to local users to run at their digression. Within these reports, end users are able to view Parent MTF, Child MTF, MEPRS, Provider, and Patient stratification of tobacco metric performance. The report is available as of November 2010. If you would like to apply for a CDM account, contact the MHS Help Desk at 1-800-600-9332 (CONUS) or 1-866-637-8725 (OCONUS). To request that a copy of this report be sent to your CDM inbox, please email health-analysis@nehc.mar.med.navy.mil.
- 3) **Population Health Navigator (PHN) Dashboard:** Both the Screening and Diagnosis metrics have been posted on the PHN Dashboard, so this will serve as an alternate method of monitoring performance and temporal trends. This dashboard is available through the NMCPHC website: http://www-nehc.med.navy.mil/Data_Statistics/Clinical_Epidemiology/pophealthnav.aspx
- 4) **BUMED PBB Reports:** Overall facility level performance (without award values while in a shadow state) is intended to be distributed with future BUMED PBB reports in FY2011, as well as within MHS Insight. To receive this report, use the contact information to request to be added to the “PBB Tobacco Cessation” global outlook group.



DISEASE MANAGEMENT

Understanding ICD-9-CM Coding for Diabetes Mellitus

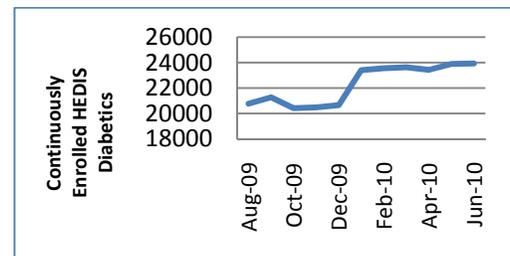
CAPT Alan B. Douglass, MC, NMC San Diego; CAPT Gregory J. Kunz, MC, NMC San Diego,
& LCDR Vinh Q. Mai, MC, NMMC Bethesda

One of the ways in which the quality of health care delivery is measured in the Military Health System (MHS) is through the Healthcare Effectiveness Data and Information Set (HEDIS®). The HEDIS metrics are a set of criteria used to benchmark Military Treatment Facilities (MTFs) and Managed Care Support Contractors (MCSC) using a common methodology. HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Certain measures are selected and reported through the MHS Population Health Portal (MHSPHP) to support an evidence-based approach to population health and quality assessment, providing a means of tracking improvements in disease management. Some of the criteria used to choose which measures will be tracked include conditions considered to be high risk and high cost that involve a high volume of patients. Diabetes mellitus certainly meets these criteria. Currently the MHSPHP reports three HEDIS metrics related to diabetes mellitus. These are the percentage of patients enrolled to Tricare Prime/Plus with type 1 or type 2 diabetes, age 18-75, (1) with at least one A1C test during the past year, (2) with A1C values >9.0% or no A1C test during the past year, and (3) who had an LDL cholesterol <100 mg/dl. It is noteworthy to emphasize that clinical information for eligible patients, who are seen outside the catchment areas (i.e. civilian settings) is not captured.

It is important for MTFs to understand the methodology used to include TRICARE enrollees in the measure. Patients are considered continuously enrolled as long as their enrollment has not lapsed for more than 60 days during each previous 12 month period of enrollment. According to published MHSPHP Methods, two types of data are used to identify members with diabetes—pharmacy data and ICD-9-CM codes from claims/encounter data. Lab values are not used to identify diabetics. The pharmacy data criteria include ambulatory prescriptions during the past 24 month period for certain medications used to treat diabetes (does not include metformin). Because some of these medications are used for indications other than diabetes, some exclusions include a diagnosis of polycystic ovarian syndrome, steroid-induced diabetes, gestational diabetes, prediabetes, or metabolic syndrome, as long as they had no encounters that were coded for diabetes, in any setting, in the past 2 years. These diagnoses are identified through ICD-9-CM coding from claims and encounter data. The criteria to identify patients with diabetes via encounter data (within the past 24 months) include:

- Two or more face to face encounters with different dates of service in an outpatient setting
- Two or more face to face encounters in a non-acute inpatient setting
- One outpatient visit and one non-acute inpatient visit
- One acute inpatient visit

It is important to understand that the methodology changed in January 2010. Prior to that, patients with gestational diabetes and other non-diabetes mellitus hyperglycemic diagnoses were excluded from the HEDIS diabetes measures. As of January 2010, patients with these diagnoses who also had ICD-9-CM codes for diabetes recorded in an encounter data within the past 24 months were no longer excluded. Many of these patients, especially women with a history of gestational diabetes, have a very high risk for future diabetes mellitus, and this change in methodology was important to ensure that we were capturing data for those women whose diabetes did not resolve postpartum. This change led to a significant rise in the number of continuously enrolled patients identified as having diabetes mellitus in the Navy in January 2010.



While many of these patients newly-included in HEDIS diabetes measurements as of January 2010 truly do have diabetes mellitus, a significant number have been included erroneously due to errors in ICD-9-CM coding. For instance, all it takes is one ED encounter improperly coded for diabetes mellitus (250.XX) or diabetes complicating pregnancy (648.0X) instead of gestational diabetes (648.8X) for a patient with true gestational diabetes to be included in the metric for the next 24 months.

To increase awareness, the Diabetes Action Team (DAT) encourages clinical leaders and diabetes champions at all levels to widely disseminate this information to all providers through various formats of communication including but not limited to staff meetings, educational conferences for trainees (interns, residents, fellows, etc.), and ICD-9-CM training seminars for providers. The following is included as general guidance on the diagnosis of diabetes (according to current VA/DoD Clinical Practice Guidelines) and ICD-9-CM coding. A more complete guide to ICD-9-CM coding for diabetic patients and common pitfalls can be found on the DAT Sharepoint site at:

<https://esportal.med.navy.mil/SiteDirectory/PHAMO/DAT/Diabetes>

DISEASE MANAGEMENT

Coding Guidance for Diabetes

CAPT Gregory Kunz, MC, NMC San Diego,

Improper diagnosis or improper coding of diabetes may have important implications for patient care, disease management, and even future patient insurability. Improper diagnosis and coding of diabetes also hinders efforts to accurately measure and apply quality standards.

Specific criteria define the diagnosis of diabetes.

Status	Fasting Plasma Glucose (FPG) (a) (b) or, Hemoglobin A1c (c)	Casual Plasma Glucose (d)
Diabetes Mellitus	FPG ≥ 126 mg/dL (7.0 mmol/L) on two occasions OR HbA1c is $\geq 6.5\%$ and FPG ≥ 126 mg/dL (7.0 mmol/L) OR HbA1c $\geq 7\%$ on two occasions	Casual plasma glucose ≥ 200 mg/dL (11.1 mmol/L) plus symptoms of diabetes
Pre-diabetes	FPG ≥ 100 and < 126 mg/dL on two occasions OR HbA1c $> 5.7\%$ and FPG ≥ 100 and < 126 mg/dL (7.0 mmol/L)	—
Normal	FPG < 100 mg/dL HbA1c $< 5.7\%$	—

- (a) Fasting is defined as no caloric intake for at least 8 hours.
- (b) FPG is the preferred test for diagnosis, but either of the two listed is acceptable. In the absence of unequivocal hyperglycemia with acute metabolic decompensation, one of these two tests should be done on different days
- (c) Using a clinical laboratory (not a Point of Care) methodology standardized to the National Glycohemoglobin Standardization Program (NGSP)
- (d) Casual means any time of day without regard to time since the last meal; classic symptoms include polyuria, polydipsia, and unexplained weight loss.
- (e) Oral glucose tolerance testing (OGTT) is no longer recommended in routine clinical practice because it is an imprecise test with poor reproducibility. The World Health Organization suggests continued use of the OGTT for patients with blood glucose values in the "uncertain range." Also, the OGTT does seem to better predict macrovascular complications.

VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus 2010

True diabetes should be coded as: 250.XX, or 648.0

250.XX

Further specification clarifies diabetes type/control. Additional codes indicate diabetic complications, but are listed after the diabetes code:

- **357.2 Polyneuropathy in diabetes**
- **362.0 Diabetic retinopathy**
- **366.41 Diabetic cataract**
- **648.0X** (when diabetes is present prior to pregnancy; this is NOT gestational diabetes 648.8)

NOTE: 249.XX or 250.XX must be reported as a secondary code to the 648.0X

The following are NOT considered true diabetes:

- 249.XX** Secondary diabetes (diabetes mellitus that is due to drugs, chemicals, infection, etc.)
- 251.2** Hypoglycemia
- 251.8** Other specified disorders of pancreatic internal secretion
- 256.4** Polycystic ovarian syndrome
- 277.7** Dysmetabolic syndrome X
- 278.00-278.01** Obesity
- 648.8** Gestational diabetes
- 775.1** Neonatal Diabetes
- 775.0** Infant of a diabetic mother
- 790.2** Abnormal glucose
- 790.21** Impaired fasting glucose
Elevated fasting glucose
- 790.22** Impaired glucose tolerance test
- 790.29** Other abnormal glucose
Abnormal glucose NOS
Abnormal non-fasting glucose
Hyperglycemia NOS
Pre-diabetes NOS
- 791.5** Glycosuria
- 962.0** Adrenal cortical steroids

How Do I Receive the Clinical Operations Newsletter? To receive the quarterly Clinical Operations Newsletter, please email Leanne.Repko@med.navy.mil to be included on the distribution list. Thank you!

PERINATAL CARE

UPDATES TO AWHONN STAFFING GUIDELINES

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has updated its staffing guidelines. Major recommended changes include the following REGISTERED nurse to patient ratios:

New Guidelines	Former Guidelines
1:2-3 - New Triage guidelines	No guidelines
1:1 - Natural or unmedicated childbirth	1:2
1:1 - intrapartum pitocin infusions	Not specified
1:3 - couplets for routine postpartum care	1:3-4
1:2 - couplets for postpartum magnesium sulfate	1:3

- ✓ Lactation consultants:
 - 1.9 FTE per 1000 births (Level III center)
 - 1.6 FTE per 1000 births (Level II facility)
 - 1.2 FTE per 1000 births (Level I facility)
- ✓ Minimum staffing for low-volume birth centers = 2 RNs immediately available at all times

What Do You Need to Know?

- ✓ Updated staffing guidelines assume the presence of clerical and ancillary personnel.
- ✓ Changes reflect evolving trends in care, as prior staffing guidelines were developed in 1983 and since then, there have been significant increases in medical interventions, elective procedures, childbearing women with comorbidities, among various other issues.
- ✓ Maternal Child and NICU Specialty Leader CDR Julie Hillery anticipates that implementation of these recommendations will require as much as a 50% increase of full-time RNs for most units, which will be a significant cost and resource challenge for all facilities nationwide.
- ✓ If the recommendations are endorsed by AAP/ ACOG and published in the next edition of "Guidelines for Perinatal Care", they will shift from "recommendations" to the standard of care.
- ✓ MTF-level PABs should work collaboratively with local leadership to evaluate current nursing resources, identify and prioritize deficits, and begin working to increasing resources when possible.

S.T.A.B.L.E INSTRUCTOR COURSE DATES:

- ❖ NMCS D 21-22 March 2011;
Contact: cynthia.schultz@med.navy.mil
- ❖ NNMC 09-10 May 2011
Contact: jason.layton@med.navy.mil
- ❖ NMCP 11-12 May 2011
Contact: alexander.holston@med.navy.mil

QUALITY COMPARISONS IN A SNAPSHOT – Using Perinatal Index and latest ORYX for Performance Improvement

The new Perinatal Index is BUMED's latest performance improvement tool aimed at evaluating the Navy's Perinatal healthcare in the areas of Neonatal and Maternal Health. The Index, rolled out in October of 2010, offers MTFs a quality comparison report in an easy-to-read format. It provides a colorful snapshot of the state of quality management at Navy MTFs, by aggregating calculated scores across various processes and clinical outcomes per MTF, as well as an MTF's score on the Weighted Modified Adverse Outcome Score (WMAOS). These calculations assign an MTF a numerical value based upon its performance relative to the MHS or Navy averages.

Healthcare quality measures for the index are presented in a graphical spreadsheet format, using color coding for easy comparison. Results are categorized by both index score and facility type, with MTFs listed in green with scores above the MHS average, yellow for those at the MHS average, and red for MTFs below the MHS average.

Also available for performance improvement evaluations are the latest reports from ORYX. The final report for the April-June 2010 period has been released. It includes rates for:

- ❖ PC-01 - Elective Delivery
- ❖ PC-02 - Cesarean Section
- ❖ PC-03 - Antenatal Steroids
- ❖ PC-04 - Health Care-Associated Bloodstream Infections in Neonates
- ❖ PC-05 - Exclusive Breast Milk Feeding

RECOMMENDATION:

- ❖ MTFs compare their numbers to the Navy averages. National benchmarks available beginning in March 2011.
- ❖ Contact your MTF Quality Management Department for more information on the new Perinatal Index and ORYX reports.

PERINATAL HOT TOPICS AND RESOURCES

1. **"Purple Books" are Coming!** Shipments of the new *Pregnancy and Childbirth* are underway. Revised sections include evidence-based research recommendations for prenatal care, as per recently updated *VA/DoD Management of Pregnancy CPG*.
 - ✓ Order online: <https://www.qmo.amedd.army.mil/>
 - ✓ Full PDF copy of the book: https://www.qmo.amedd.army.mil/pregnancy/patient_binder.pdf
2. **The Parent Review** provides prenatal/pediatric evidence-based education material via automated email.
 - ✓ MTFs > 500 births enroll: www.DoDparenting.org
 - ✓ MTFs < 500 births enroll: www.militaryonesource.com.
 - ✓ POC: Debra Zalvan Debra@tprmedia.com.
3. **Text4Baby:** Delivers set text messages regarding a healthy pregnancy and delivery. <http://www.text4baby.org/>
 - ✓ Available through state agencies; not endorsed by the DoD
4. **The New Neonatal Resuscitation Program (NRP) 6th Edition** Access 2010 AHA NRP Guidelines at www.aap.org/nrp.

