FY 2009-2011 BUMED Business Planning Supplemental Guidance

1. Purpose
2. Mission
3. Goals and Objectives
4. General Guidance
5. Critical Initiatives
    a. Readiness/Expeditionary Planning
    b. Documented Value of Care
    c. Improved Access to Care
    d. Advance Evidence-Based Healthcare
    e. Manage Referrals
    f. Manage Pharmacy Expenses
    g. Optimize Provider Productivity
    h. Improve Labor Cost Reporting and Management
6. Critical Enablers
    a. Facility Management/Utilization
    b. Defense Medical Logistics
7. Action Plans
8. Reporting Requirements

Enclosure(2)

FY 2009-2011 BUMED Business Planning Supplemental Guidance

1. Purpose:

Business planning is an ongoing dynamic activity that encompasses all goals, strategies and activities needed to ensure an organization's survival and growth. The outcome of the business planning cycle is a consolidated Military Health System (MHS) business plan that serves as a primary input to the Prospective Payment System (PPS). The Tri-Service Business Plans serve a vital function in providing a common framework across the MHS for improving and measuring performance in the Direct Health Care system. The three core missions of the MHS are interdependent and include, 1) Operational Medicine, to include Humanitarian Assistance; 2) Maintaining a fit and healthy deployable force; 3) Peace-time healthcare. The supplemental guidance provides additional details that if followed will lead to the development of successful, executable business plan for the FY 09-11 Cycle. While Navy Medicine's primary mission is readiness and medical support to deploying forces, the effective and efficient delivery of the health benefit to our enrolled beneficiaries is also essential.

2. Mission:

- Charge Regional Commanders with oversight of Military Treatment Facility (MTF) business plans to ensure accuracy in forecasting expected workload.

- Identify MTF enrolled populations and accurately evaluate true capacity/demand gaps; analyze process changes that must occur to increase productivity while maintaining quality and consistency of the health-care provided; and limit the growth of private sector care where appropriate.

- Improve the effectiveness, cost, quality, and access of the Direct Health Care system through the development of Action Plans and integration of the Critical Initiatives (CI).

3. Goals and Objectives:

a. There are three goals for this planning cycle. First, improve the business planning process at all levels of the Enterprise in order to produce business plans that establish clearly quantifiable goals and objectives for inpatient and outpatient workload production for the MTF. Second, ensure the linkages between business planning, budget, and manpower/personnel are in place and aligned with Navy Medicine (NAVMED) strategic goals. Third, establish Action Plans that are measurable, build upon previous plans, and demonstrably improve performance across product lines and MTF operations.

b. The MHS Business Planning guidance outlines specific tasks to the Services and TRICARE Regional Offices (TROs). The specific tasks that must be addressed in the Regional and MTF Plans include:

1. Quantify FY 06 and FY 07 CI results by facility within the Executive Summary of the current business plan.
2. Conduct a qualitative review of initiatives that are not quantifiable and address the results within the Executive Summary.
3. Project the number of outpatient pharmacy prescriptions for our enrollees.
4. Continue improvements in Individual Medical Readiness, medical records documentation and coding, and patient satisfaction.
5. Identify the location and type of work performed by MTF staff outside their facility to include civilian and VA hospitals.
6. Achieve increased productivity through accuracy in business planning.
7. Train MTF staff on analyses related to market demographics.
8. Improve and enhance communication across the Regional Medical Commands, TROs and Multi-Service Market Offices (MSMO) on the development of the business plans.
9. Charge TROs with integrating MTF and MSMO plans into the TRO Regional Business Plan, and monitoring of enrollee purchased care performance against the business plans.
10. Charge TROs with reducing the rate of growth of Private Sector Care costs, managing demand, maximizing referrals to the Direct Health Care system accurately and accurately determining the purchased care workload of non-MTF enrollees.

c. BUMED provides a comprehensive checklist of elements that are required for completion of the CI Action Plans in the FY 09-11 Business Plan. The elements in this checklist ensure the Action Plans are complete and measurable with a clearly stated impact to MTF productivity. Failure to address and include the required components identified in the checklist will result in the plan being rejected by the Regions and BUMED.

4. General Guidance:

Business planning is a mandated ongoing activity that does not culminate with a brief to BUMED. It requires the monitoring of adjustments and an ongoing analysis whenever the basic components and/or assumptions driving health-care delivery change; whether it's shifts in population (demand), capacity to meet that demand, or new information technologies that could result in improvements to the delivery of care. Commands must evaluate their prior year performance (FY 07) and determine whether their performance goals have already been achieved with respect to the current business plan (FY 08-10) which was based on FY 06 performance. Adjustments to production targets during year of execution may be required based on current fiscal guidance, budget allocation and adjustments for executing future missions outlined during the prior (FY 07-09) business plan cycle that were not known in FY 06. Trends and Action Plans from both cycles should form the basis in formulating the FY 09-11 Business Plan.

5. Critical Initiatives:

The eight critical initiatives and two supporting enablers are the drivers of MTF productivity and are essential to achieving optimal efficiency, cost containment and improving the quality of health-care while maximizing revenue generation to ensure fully funded Direct Health

Care System. By focusing on performance improvement within these areas, Regional and MTF plans are linked to the NAVMED and MHS Strategic Plans. Commands will continue to focus on the eight Critical Initiative areas described below. In doing so, each business plan will follow the parameters as detailed in the following descriptions and prescribed in the MHS Business Planning Tool:

a. **Readiness/Expeditionary Planning.** With Readiness being the command's core mission, MTFs will concentrate on three focus areas: Maintaining a ready medical force, maintaining a medically ready force, and planning for sustained operations when medical forces deploy in support of operational requirements. Force health protection requires medical personnel to deploy with operational forces. Therefore, plans must also be in place to mitigate the effects deployment of medical assets may have on MTF productivity. Developing these plans and processes requires a multidisciplinary team. In the area of "medical ready force", it is vitally important that MTFs continually monitor and strive to improve the use of MRRS/SAMS as required and expected for all active duty enrollees. The medical deployable force requirement refers to the MTFs' responsibility to have visibility of deploying forces and provide sufficient support to maintain 90 percent fully medically ready rates, and provide 100 percent Pre Deployment Health Assessments, Post Deployment Health Assessment, and Post Deployment Health Reassessment. Quantifying the impact of deploying medical forces on the continuity of care provided to Navy beneficiaries is a critical element of business planning. Each MTF must develop plans that allow for efficient utilization of resources and take into consideration internal/external cross-leveling and make/buy analyses. MTFs should collaborate with Operational Health Support Units (OHSUs) in monitoring and supporting reserve IMR.

Navy's point of contact is:

CAPT Hourigan (619) 767-6586 jane.hourigan@med.navy.mill.

b. **Documented Value of Care.** MTFs will focus on documentation of care provided to beneficiaries, and incorporate a Coding Compliance Plan to ensure internal procedures support coding accuracy. Coding plans should include procedures to support provider education on documentation of medical necessity to support coding, coding of all medical records (inpatient and outpatient), and quality assurance of coded encounters. Each MTF will analyze current coding practices (refer to coding guidance for effective use of BUMED's contract if applicable) against expected 100 percent accuracy and incorporate measures to identify training requirements, coding requirements, monitor/validate coder productivity, identify/mitigate impediments to coding productivity, and develop a back-up plan to address coding system down times.

Navy's point of contact is:

Ms. Susan Pierce (202) 762-3162 susan.pierce@med.navy.mil

c. **Improve Access to Care (ATC).** The Navy FY 2009 Tri-Service Business Plan Access to Care (ATC) Campaign includes the following eight initiatives:

- Effective Use of Customer Service Contract
- Telephone Service
- Provider Support Staff Utilization and Ratio
- Patient Appointing and Referral Management
- TRICARE On-Line (TOL) Appointment Booking
- 45-days Continuous Availability
- Forecasting Demand
- Provider Panel Sizes

The FY 2009 Business Plan requires that parent MTFs choose two ATC initiatives, to include all child DMIS facilities.

A new ATC initiative added to the Business Plan is Forecasting Demand, which allows MTF Commanding Officers to plan for the needs of the population and accommodate those needs accordingly. Elements to consider when evaluating demand are patient population, historical utilization rates, and expected trends for demand on the organization's services. For example, through careful analysis of enrolled population seasonal utilization trends over a period of several years of available services at the MTF as well as of individuals deferred to the network due to non-availability, an MTF Commander can build enough supply through disciplined staffing and scheduling to meet the true demand of the beneficiaries.

The second ATC initiative added to the Business Plan, provider panel sizes for Primary Care Managers (PCMs), provides MTFs the opportunity to improve ATC by managing the number of beneficiaries assigned to each provider. Patient acuity, population served, and PCM utilization all have a clear impact on staffing ratios and directly affect provider panel sizes. Differences in patient acuity should be acknowledged in assigning beneficiaries to panels, recognizing that, generally, physicians care for patients with higher clinical acuity than non-physician providers. Additionally, scope of practice of PCMs will impact panel sizes. For example, Family Practice physicians who are performing obstetrical services will spend some of their time with prenatal care and deliveries, so panel sizes are adjusted to accommodate practice patterns while meeting the primary care needs of the panel. Finally, care should be taken to avoid applying uniform panel size standards without regard to the size of the facility providing service to the members. Larger facilities may achieve economies of scale while smaller MTFs may in fact require smaller panel sizes to maintain required services for the patient population served.

Commanding Officers should balance panel size and acuity with provider roles in the MTF to maximize access for enrollees' demand for services. Panels balanced by acuity allow an equitable spread of workload across the MTF, and have demonstrated to increase continuity and preventive services which can aid in decreasing avoidable demand on the system while

maintaining quality and satisfaction.

The benefit of well-designed panels is that with the support of staff, a PCM can better know the patients and their needs, and thus establish relationships that promote self care and preventive measures. Additionally, opportunities for patient education are enhanced, better utilization of services and increased trust, as well as improved staff satisfaction.

As providers become familiar with the patients in their panels, less time is required for review of history etc, during clinic visits. This enhances productivity, and increases ATC while improving continuity of care.

Navy's points of contact are:

CDR Whippen (202) 762-3146 thomas.whippen@med.navy.mil

LCDR Lynch (202) 762-3020 james.lynch3@med.navy.mil

d. **Advance Evidence-Based Healthcare (EBHC).** Health-care practice based on the best evidence now comprises the standard of care within the MHS. All MTFs and Dental Treatment Facilities (DTFs) are expected to design and evaluate clinical processes that delineate how the command leadership plans to improve adherence to the use of evidence-based health care and clinical advances within their facilities. MTFs are also expected to promote healthy communities via the implementation and evaluation of enterprise-wide population health and medical management initiatives. MTFs are not expected to create an action plan for strategic performance measures which are pending development (e.g., obesity, tobacco cessation).

1. The use of evidence-based healthcare (EBHC) and medical management (MM) will improve "clinical production effectiveness" by reducing variation and increasing consistency in care strategies for patients and families with identified diseases and conditions. Resource utilization and individual health outcomes have been shown to improve through the use of medical management initiatives. MTF leadership is expected to demonstrate a focus on provider and staff education regarding new medical management business processes.

2. Evidence that each MTF is coordinating care processes to improve the quality of care delivered should be documented and routinely analyzed. Resources should be in place to achieve the goal of improving the population health status for a set of potentially high-cost chronic and preventable diseases.

3. MTFs are encouraged to adapt (to your location) and adhere to DoD/VA Clinical Practice Guidelines (CPGs) as a methodology to improve the use of EBHC since they have been shown to improve the quality and reduce the costs of healthcare services for selected populations. A reasonable number of clinically relevant CPG metrics can be monitored to demonstrate improved clinical and business outcomes. MTF leadership is expected to demonstrate that processes for data collection, analysis and adherence to selected CPGs and other metrics (namely, Health Plan Employer Data and Information Set (HEDIS) benchmarks) are well defined and regularly reviewed with members of multidisciplinary care teams.

4. EBHC Critical Initiative success is based in part on the MTF's ability to meet or exceed the CY 2006 90th percentile of the seven Health Plan Employer Data and Information Set (HEDIS® and ORYX) measures for asthma, diabetes (three individual measures), breast cancer screening, cervical cancer screening, and colorectal cancer screening for MTF enrollees. A main data resource for collecting this information will be the Military Health System Population Health Portal (MHSPHP) also known in the Navy as the Population Health Navigator (PHN) found at https://pophealth.afms.mil/tsphp/login/login.cfm. HEDIS® benchmarks are based on the standards from the National Committee for Quality Assurance (NCQA). The Population Health Navigator Dashboard electronically displays these performance measures and can be found at https://dataquality.med.navy.mil/pophealth.

(a) Asthma:

- Percentage of continuously enrolled beneficiaries, ages 5–56, with persistent asthma who are prescribed long-term controller medications are considered acceptable as a primary therapy for the long-term control of asthma. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **94.1 percent.**

(b) Diabetes:

- Percentage of continuously enrolled beneficiaries, ages 18-75, with diabetes, who had an A1c test in the past 12 months. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **92.7 percent.**
- Percentage of continuously enrolled beneficiaries, ages 18-75, with diabetes, who had an A1c value less than or equal to 9.0 percent (no A1c test during the past year will be assumed to be above 9.0 percent). Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **79.6 percent.**
- Percentage of continuously enrolled beneficiaries, ages 18-75, with diabetes, who had an (LDL) test in the last 12 months) with a value less than 100mg/dl. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **52.6 percent.**

(c) Cancer Screening:

- Breast: Percentage of women continuously enrolled to the MTF, ages 52-69 years, who had breast cancer screening in the previous 24 months. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **80.2 percent.**
- Cervical: Percentage of women continuously enrolled to the MTF, ages 21-64, who have had a cervical cancer screening within the last 36 months. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **87.9 percent.**
- Colorectal: Percentage of MTF enrollees, ages 51-80, who had appropriate colorectal cancer screening. Screening intervals vary according to the method of screening. Appropriate screening must meet one of four criteria: fecal occult test within the last 12 months; flexible sigmoidoscopy within the last 60 months; double contrast barium enema within the last 60 months; colonoscopy within the

last 120 months. Goal: Meet or exceed the previous year's HEDIS® 90th percentile. The 2006 HEDIS® 90th percentile is **63.5 percent.**

5. Active duty dental readiness and dental health. Each MTF will:

(a) Address the percent of active duty members who are dentally ready (dental class 1 or 2). The goal is for 95 percent of service members to be dentally ready.

(b) Address the percent of active duty members who are dentally healthy (dental class 1) and have a plan for incrementally increasing the percent that are dentally healthy to 65 percent by the end of FY 09.

(c) Use DENCAS as the data source for measuring dental readiness and dental health.

(d) Address system(s) that are in place for unit commanders and dental activities to monitor the dental readiness and dental health of assigned units and appoint personnel requiring examination and/or treatment within established ATC standards.

6. Details regarding resources and requirements to support disease & condition management programs are available in Navy Policy 06-011 of August 2006. To plan for successful improvement in the use of EBHC, MTFs must accomplish the following tasks:

(a) Review disease management recommendations for asthma, diabetes mellitus, and screening for breast, cervical and colorectal cancer. The PHN Action Lists can be used to monitor clinical performance to improve clinical outcomes and prioritize MM interventions for improved population health.

(b) Evaluate the current performance of population health initiatives and determine the extent that MM principles guide current care practices for each selected condition. Use data resources (e.g., PHN) to identify improvements to be made in population health delivered at the facility. Estimate relevant purchased care costs (e.g., expenditures for enrolled asthma patients seeking care for asthma at civilian emergency departments) for comparison to MTF resource utilization.

(c) Determine the level of leadership support, data sources, resource support requirements, clinical champions, clinical business process reengineering needs, case management needs, etc., needed to improve use of EBHC.

(d) Designate specific staff to periodically monitor MM processes and regularly compare performance metrics with CPG and HEDIS® performance goals. Multidisciplinary care teams are to routinely assess and evaluate effectiveness of work performed.

(e) Commanding Officers should critically assess the cost-effectiveness of purchased versus direct care to determine ideal resource utilization.

(f) Adjust financial resources, staffing, processes, etc., as needed to accomplish adherence to EBHC practices. Once goals have been reached, set higher performance goals based on a timely review and evaluation of the analysis.

(g) Maintain a system to monitor and improve dental readiness and dental health of service members within units. Aim to maximize clinical efficiencies in the delivery of dental care to include multi-chair dentistry, one-stop shopping, expanded functionality, MSMO referrals and other efficiency improvements.

Navy's points of contact are:

Disease Management — CDR Von Thun (202) 762-3198 annette.vonthun@med.navy.mil.

Dental Measures — LCDR Matis (202) 762-3008 steven.matis@med.navy.mil.

Population Health Navigator — LCDR Richards (202) 762-0564 vanessa.richards@med.navy.mil.

e. **Manage Referrals.** Referral management is a process for managing and tracking patient referrals both internal and external to the MTF. The referral process is a key element to successful managed care of our beneficiaries. The FY 08 Business Plan for referral management focuses on initiatives which have additional impact on the six focus areas: customer service, telephone services, provider support staff utilization and ratio, patient appointing and referral management and TRICARE On-Line (TOL) appointment booking. The FY 09 Business Plan requires the parent MTF to choose one referral management initiative which includes all child DMIS facilities. The self assessment will guide the choice of initiatives by determining multi-service market and individual MTF performance based on the well established referral management performance outcomes as defined in the TRICARE Operations Manual (TOM) and Commander's Guide to Access Success.

Navy's point of contact is:

CAPT Kiser (202) 762-3550 william.kiser@med.navy.mil

f. **Manage Pharmacy Expenses.** The objective of this Critical Initiative is to ensure Sailors, Marines and eligible DoD beneficiaries receive appropriate, safe and cost effective drug therapy at our MTFs. Today, a growing number of new and expensive prescription drugs are used as first line treatments for an increasing number of diseases. This causes the total cost of the prescription drug benefit to grow substantially. Prescription drug costs have stabilized over the last two years due to enhanced formulary management, improved utilization of generic drugs, no block-buster new drugs on the market, and more appropriate utilization of brand drugs. Continued vigilance is critical to ensure appropriate use while managing pharmaceutical expenditures in the future.

1. The MTF Commanding Officer is not responsible for drug spending in the private sector or outside of the MTF (retail pharmacy network and TRICARE Mail Order Pharmacy [TMOP]). However, measures undertaken to control MTF expenditures, such as formulary changes, may inadvertently increase the retail network pharmacy expenditures.

2. Each MTF Commanding Officer is responsible for appropriately managing costs and accountability for staying within their targeted fiscal year pharmaceutical expenditure plan by monitoring and seeking to implement clinically appropriate cost avoidance measures and improvements to MTF pharmacy operational efficiencies. This can best be achieved through

proactive Pharmacy and Medical Staff leadership within the MTF Pharmacy and Therapeutics (P & T) Committee.

3. Patients have the option to choose one of the three points of service (MTF, retail network, and TMOP). MTFs should attempt to keep expenditures to a minimum by striving to fill all MTF enrollee prescriptions written by their respective MTF providers. This would reduce retail pharmacy network expenditures by MTF enrollees for prescriptions. MTFs should also strive to maximize authorized collections for pharmaceuticals through the facility's third party collection program (TPCP).

4. The pharmacy should serve as the primary source of supply within the MTF for all pharmaceuticals (with some rare exceptions). All MTF pharmacy chiefs are expected to locally review and continually monitor their inventory management processes. This includes the establishment of appropriate but fiscally responsible medication stock levels internal to the pharmacy as well as in all other facility drug storage and utilization areas. Further, the establishment of procedures to prevent drug diversion, effective management of the pharmaceutical return goods' program and the on-hand inventory are expected to be part of the MTF routine management priorities.

5. The MTF Pharmacy Head must be actively engaged with the medical staff, resource managers and other appropriate MTF stakeholders in the pharmaceutical cost management process. They should take the lead working in cooperation with key members of the MTF business planning team to include the comptroller, business or managed care office, and the Pharmacy and Therapeutics Committee.

6. Pharmacy Chiefs will require access to all applicable data systems (for example, MEPRS, M2, PDTS, CHCS) in order to best serve the command by advising the MTF leadership on FY 07 cost control goals and subsequent utilization and cost trends.

7. Access to these data systems will assist the MTF pharmacy in identifying and monitoring pharmaceutical cost management strategies. This data should be monitored and evaluated for both MTF enrolled and non-enrolled populations. Active management of the pharmacy benefit requires a focus on per member per month (PMPM) drug costs. Understanding the dynamics underlying both the current drug cost increases and future cost trends are key to implementing drug utilization strategies.

8. It is expected that every MTF pharmacy operation will have as part of the facility's overall business plan an outpatient (ambulatory) pharmacy patient safety and customer service improvement component. These components focus on both the quality of care delivered and the reduction and prevention of medication errors.

9. The four focus areas of the FY 09 – 11 Pharmacy Critical Initiative business planning process are:

(a) Pharmacy Data Integrity - Since pharmacy operations are high volume, high cost and highly visible, it is imperative that MTF pharmacy data be as accurate as possible.

Pharmacy data generated from CHCS is the cornerstone of PDTS and M2, used to drive enterprise-wide decisions that impact the entire MHS. A partnership between MTF providers and pharmacy personnel is needed to maintain pharmacy data integrity. Several tips to assist MTF pharmacies in improving data integrity are located within the business tool. As the MHS transitions to PPS, pharmacy data integrity will become increasingly important.

(b) Pharmaceutical Prime Vendor Contract Compliance – Active management of pharmaceutical inventory will increase operational efficiencies and decrease expenses. As a part of the business plan, MTF pharmacies are expected to monitor the utilization of DoD mandatory pharmaceutical contracts. In the past, Navy and DoD have lost significant savings potential which could have been achieved through the ongoing utilization of these contracts. Additionally, contract prices charged to the MTF pharmacy must be monitored at the MTF level with appropriate corrective actions taken through the pharmaceutical prime vendor to request and receive credit adjustments if incorrectly charged.

(c) Medication Therapy Management - In addition to data integrity and inventory management, a third component of the Pharmacy Critical Initiative is Medication Therapy Management. Navy pharmacy has extensive experience in providing these services to our beneficiary population. Pharmacist-run clinics have shown to improve patient outcomes and reduce costs, yet most MTF pharmacist resources are used in the drug distribution process. Strategic improvements that allow the MTFs to capitalize on the pharmacist's skill sets should be made to continue improving outcomes and reduce costs within these clinics.

(d) Prospective Payment System - Lastly, PPS is the future of MHS funding for pharmacy services provided to MTF enrolled beneficiaries. Beginning in January 2007, MTF pharmacies will be required to project MTF outpatient prescription workload by beneficiary category. This first year will allow the MTF pharmacy to gain experience, identify limitations, validate data, and allow processes to be adjusted as needed without adversely impacting pharmacy operations.

10. Tasks for MTF pharmacies include:

(a) Thoroughly read and understand the entire pharmacy business module before attempting to complete. Understand when an action plan is required to be developed and implemented.

(b) Gather data and information for your business plan for your parent and outlying clinic medical facilities that have a pharmacy. The data and information gathered should be analyzed separately and in aggregate. Most information can be found by accessing hyperlinks found throughout the business plan. You may be required to seek out some information from local MTF sources. Explore opportunities for improvement or cost savings.

(c) Identify pharmacist-run clinics and document clinical pharmacy workload in MEPRS as directed by Service guidance.

(d) Review historical prescription volume and adjust projections based upon future

operational requirements.

Navy's point of contact is:

CAPT Price (202) 762-3004 david.price@med.navy.mil.

g. **Optimize Provider Productivity.** In FY 09, Health Affairs (HA) will continue to budget each Military Service for health-care rendered as measured by total Service production of Relative Weighted Products (RWP), and Relative Value Units (RVU). A decrease in production will result in a decrease in funding allocation to the Service by HA. Potential gains or losses in Navy Medicine funding allocation will be passed down to the individual MTF based on their performance via BUMED's Performance Based Budget (PBB) process.

Provider productivity is critical to the MTF and Navy Medicine's bottom line. To maximize productivity, MTFs must focus on the administrative and clinical processes and support given to providers in order to optimize the value and the delivery of health care. The focus should not be only on the volume of patients seen but on appropriate appointing, template management, case mix, documentation, accurate coding of professional and institutional services and billing. Doing so can result in significant increases in production and revenue with minimal increase in effort.

1. EFFICIENCY GOALS. The Provider Productivity Critical Initiative assesses the efficient use of providers to deliver quality healthcare and improve access to care for our beneficiaries. Productivity benchmarks have been established for different clinical specialties that are based on the civilian Medical Group Management Association (MGMA) standards for Academic and Private Practice. These benchmarks reflect total professional work performed regardless of place of service because the civilian sector workload accounting is by institutional and professional work not inpatient and outpatient. As a result when applying benchmarks to provider productivity it is necessary to include total work performed regardless of MEPRS code. This is best done by use of the Provider Specialty Codes (PSC) which provides visibility of all work performed regardless of location. This requires that providers are assigned the correct PSC and not assigned to generic codes in which the workload does not count. It is equally important to capture all inpatient professional rounds (A MEPR code Standard Ambulatory Data Record (SADR's)) as well as consults to truly assess provider productivity. This is particularly true for surgical specialties where many of the procedures performed result in admissions. The benchmark RVU's represent the RVU goal each specialty should strive to produce once the MTF has optimized processes and support to mirror the civilian sector from which the standards are derived. If excess demand exists and specialty benchmarks are not being met each MTF should carefully study their enrollment, facilities, and support staff to determine if the excess demand can be met within the Direct Health Care System.

When evaluating provider productivity the time in clinical activities needs further clarification. The current standard is for providers to spend a minimum of 36 hours per week in direct clinical activities not including time on call or duty. This is so providers are afforded time to complete military unique obligations and training. For clinic based specialties such as primary care this represents 36 bookable clinic hours a week. However for surgical specialties the 36 hours should include OR time as well as clinic time and if two days a week are spent in the OR then obviously

36 bookable hours in clinic will not be possible. It is necessary then for MTFs to critically analyze the efficient use of OR time and staff as well as clinic time and staff to determine the overall efficiency and productivity of surgical providers and determine where their time is best utilized. For specialties such as emergency medicine where patients are not scheduled, the standard is 36 hours in the primary MEPRS code for that specialty. If an MTF has other providers such as Family Practice staffing their emergency room (ER), then the time spent in the ER should be considered in the total 36 clinical hours a week not in addition to the 36 hours.

2. FACILITIES. The minimum standard for primary care is two examination rooms for each provider to maximize efficiency and productivity. Applying a similar standard for specialty clinics will also benefit productivity. Coordination of provider schedules and templates is critical to ensure that examination rooms are not left under utilized when providers are on leave, TAD, or even in the OR for the day. Use of clinical facility space for non-patient care activities is inefficient and adversely effects patient care, productivity and access to care. Process improvement methodologies (such as Lean Six Sigma) should be used in an effort to maximize space utilization, improve service functions and customer "flow" throughout the healthcare delivery process and eliminate "bottle necks" to care.

3. SUPPORT STAFF. All MTFs should strive to provide adequate clinical and administrative support staff for providers to ensure the provider's time is not consumed with duties that can and should be performed by support staff. Along with the Provider Specialty Benchmarks a table is provided with the MGMA median number of clinical support staff per provider full time equivalent (FTE) by specialty. To achieve benchmark goals for productivity, MTFs should afford providers a similar level of support. The consistency of support staff is equally important, efficiency is gained when support staff and providers work as a team with support staff anticipating provider's needs prior to being asked. This degree of efficiency is difficult to obtain with constant rotation of support staff.

Some specialty workload is a function of technician supported care. RVUs in Physical and Occupational Therapy, Cast Room, Orthotics, Pulmonary Medicine, etc. are the result of the specialty provider and their technicians. The RVU goals in these areas should not be construed as the effort of a single specialty provider, but include technician support as well. However, care provided by technicians must have proper oversight with processes in place to appoint, document and code this workload similar to what would be done in the civilian sector in order to optimize the RVU production and revenue generation through PPS and Other Health Insurance (OHI).

4. MANAGING DEMAND. The use of MTF specific RVU/RWP production targets may propose a greater RVU/RWP capacity than the MTFs reported in previous years. If so, the MTF must review their historical demand for healthcare to determine if an opportunity exists for recapture of workload from the network. When analyzing the demand, a comparison of workload performed in the network is the starting point, followed by the determination of how much of that workload could realistically be recaptured in FY 09. Capacity should not automatically be increased if demand exists without first conducting an analysis to ensure that further capacity is indeed possible. Managing demand also requires commands to actively track and reduce, or otherwise compensate for, patient no-shows and cancellations.

5. PATIENT RECORDS. Key elements to consider for maximizing provider productivity include development and use of templates for more efficient documentation in AHLTA, use of dictation, appropriate coding of all encounters, one-on-one feedback to providers of coding audit results with continued education on documentation necessary for coding to maximize the RVUs per encounter, accurate reporting of provider time spent in clinical activities, and completing the end-of-day processing in a timely manner. Each MTF should examine these and other processes to determine areas that need improvement to increase productivity.

Navy's point of contact is:

CAPT Buckley (202) 762-3381 robert.buckley@med.navy.mil.

h. **Improve Labor Cost Reporting and Management.** Accurately assigning personnel and labor reporting is of utmost concern and importance. Labor is generating increasing costs that over time may not be sustainable for Navy Medicine. Currently, labor expenses account for approximately 70 percent of each MTF's total costs.

1. Disconnects among manpower, personnel and labor assignment systems have resulted in inconsistencies in labor reporting. These inconsistencies have made it difficult to determine a benchmark for labor expenses and gauge whether it is correct for the Enterprise to expect 70 percent of an MTF's total costs be attributed to labor. Commanding Officers must ensure compliance with defined labor reporting guidelines. Meeting the standard of 100 percent timecard entry and labor reporting is key to our ability to predict and secure adequate resources for the command. Analysis needs to be performed at each MTF to ensure personnel at your MTF are being correctly identified in manpower and personnel systems which are used to report labor data in labor reporting systems; your MTF has the right Functional Cost Codes (FCCs) to assign them; the personnel are assigned to the right places; and the labor is distributed properly and accurately reflects where the personnel are working.

For MTFs with DMHRSi, the following FTE reports should be reviewed and used when analyzing FTEs in the Critical Initiative with emphasis on manpower changes that may be required for the MTF. The reports outlined below can be run to assess if personnel are assigned to the correct work/cost center and if those personnel are reporting their labor correctly within your MTF.

In DMHRSi, there are two fields used in the personnel assignment process, the Organization and the Group. The Organization is the department/cost center that owns the billet the person has been aligned to (assigned) and the Group is the department/cost center where the person usually works. Normally the entries in these fields should be the same unless:

- You are using the person in a different manner than what they were ordered into the command. For example: if a nurse was ordered into a billet on a ward, and when he/she arrived they were placed in the Internal Medicine Clinic, DMHRSi should reflect the ward in the Organization field and the Internal Medicine Clinic in the Group field.

Since only officers are ordered into billets, all other personnel should be correctly aligned – unless the command does not have a billet on their AMD associated with the Organization. In that situation, the command must do one of two things:

- Double-stuff the person into a billet that is already encumbered until the AMD can be updated, or
- Assign the person to the Organization the billet is associated with and enter the correct Group until the AMD can be updated.

Report #1

To evaluate the Organization, Group, and Position (billet) assignments in DMHRSi, commands should run the "All Personnel" report in the "Assignment Information" workbook in Discoverer Viewer. This report will show the current assignment for all personnel at the command. An example of this report is embedded below.

All Personnel.xls

Report #2

For a command to access where individuals are reporting their time, the "EAS Summary View Report" in the "LCA Audit Reports – Navy" workbook can be run. This report will show each task (FCC/MEPRS Code) and the number of hours and expenses (if applicable) for personnel in their commands that have approved timecards (labor is not available for use in DMHRSi until the timecard has been approved). An example of this report is embedded below

EAS SUMMARY VIEW REPORT.xls

2. Labor data is used in the calculation of provider productivity measurements (i.e., RVUs per FTE). Provider productivity measurements at a management level must be taken into account to determine Navy Medicine benchmarks for the proper number of support staff required to allow for optimum efficiency in a clinical area. Support staff data in a clinical area has been and will be used to determine clinical efficiency and/or inefficiency. This critical requirement is key when you are quantitatively being compared against your peers, the network, and are competing for resources DoD-wide. This critical requirement will allow MTFs to better plan for acquiring labor resources necessary to continue quality healthcare both in peacetime and wartime, a worthy and achievable management challenge.

3. The future of the direct care system of the MHS is envisioned to be more lean, more efficient and wherever possible, less costly. The fundamental reason for changing the structure of the work force is to maximize the use of all available personnel in peacetime and/or readiness to accomplish our medical mission. Regional Commanders and Commanding

Officers must have the correct workforce structure to facilitate human capital development (right person, right skills, and right place). A core principle of effective human resource management is to increase value and provide quality medical services to our beneficiaries. MTFs will concentrate on aligning their structure with their mission requirements and ensure that the data systems reporting the information reflect these needs.

4. Consider the following questions when completing the Labor Critical Initiative portion of the Business Plan:

a. Does the targeted issue for improvement have a stated performance measure or goal defined (i.e., Will improve by X percent)?

b. Does the plan identify requirements needed to ensure success (time, money, people, etc.)?

c. Is a method of monitoring articulated?

d. Is there an impact statement as to how success of the plan will improve the organizations/MTFs bottom line (i.e., control labor cost, result in lower costs, such as cost per RVU, etc.)?

Navy's point of contact is:

Ms. Jane Cunningham (202) 762-0551 jane.cunningham@med.navy.mil.

6. Critical Enablers:

In addition to the eight Critical Initiatives, there are two Critical Enablers added to the Business Plan that cross several CI areas:

a. **Facility Management/Utilization.** Facility management has been added to the business planning process as a critical enabler in the critical initiative analysis section. Facility space should be considered as a significant contribution in the cost of producing the workload projected in the business plans. The MTF will provide input on any past and future capital investments that are related to the capability to produce valid medical services and support services in support of the current and projected business plan objectives. The business planning tool has been modified to add this analysis directly. The business planning tool is designed to assist MTFs to develop healthcare solutions that are based on the most current information pertinent to projected inpatient and out patient workload, healthcare demographics, network capacity and other critical variables. This information can vary depending on the source and the nature of the questions being asked. It is highly recommended that the business plan workload projections and any real property solutions be compared with BRAC/Transformation initiatives before arriving at any final conclusions or recommendations.

BRAC/transformation initiatives can be accessed through the BUMED BRAC Program Office by contacting LCDR Mark Lieb, (202) 762-3525, mark.lieb@ med.navy.mil. Any differences

between the latest BRAC Navy transformation planning and the proposed MTF business plan should be clearly explained.

1. The MTF is asked to provide the number of exam rooms, the number of inpatient rooms, and number of inpatient beds. The purpose of this information is to initiate a comparative analysis of MTFs capacity related to available space and configuration. The intent is to use the analysis to arrive at space utilization measures and targets and to work toward a relationship between facility space and MTF workload output.

2. The MTF will also provide the answer to 5 yes/no questions intended to encourage capital investment decisions that directly support the MTF business plan. The questions are designed to allow the MTF to indicate that they have either too much space or too little space, that the space they have is not configured correctly, or that their space prohibits the MTF from moving purchased care to the direct care system. The questions are:

(1) Does the MTF have enough space in its total existing building inventory to achieve the projected workload established in this business plan? If there is a space problem identified, the MTF will provide information about how the problem is being resolved, which could include construction. The project information should include building number where space modifications are needed, the amount of space that needs to be added or modified, the cost, and the FY the work is scheduled to be completed. Also indicate if the proposed space changes are included in the latest BRAC/Navy transformation plan.

(2) Is the space within the MTF inventory configured correctly to achieve their projected level of provider productivity established in this business plan? If there is a space configuration problem, the MTF will provide information about how the problem is being resolved and what projects have been submitted as a part of the solution. The project information should include building number where space modifications are needed, the amount of space that needs to be added or modified, the cost, and the FY the work is scheduled to be completed.

(3) Is there adequate space in the MTF total building inventory to move purchased care workload into the direct care system? If there is a space problem prohibiting increases in workload capacity, the MTF will provide information about how the problem is being resolved and what projects have been submitted as a part of the solution. The project information should include building number where space modifications are needed, the amount of space that needs to be added or modified, the cost, and the FY that the work is scheduled to be completed. Are there any major spaces in the total MTF building inventory that are unoccupied?

(4) Is space requiring reconfiguration due to projected workload changes, provider productivity changes, or purchased care to direct care transfers, programmed for Medical MILCON or O&M construction in the next 5 years?

Navy's point of contact is:

LCDR Lieb (202) 762-3525 mark.lieb@med.navy.mil.

b. **Defense Medical Logistics.** Defense Medical Logistics (DML) will contribute to "managing the business" as both an enabler for MHS planning and critical initiatives development and as the driver for medical logistics support to the MHS. As an enabler and a driver, DML provides support in the form of services, supplies, and equipment to perform the MHS mission. All business planning must consider the impact an initiative has on either an increase or a decrease in medical logistics support. To ensure this impact is considered, a list of "trigger questions" will be included in the business planning tool. When developing a business planning initiative, consider if it will have an impact, either an increase or decrease, on medical logistics support related to:

- Contracted professional or support services.
- Supplies (on-hand, in storage, ordering procedures or levels, etc.).
- Equipment (new required, maintenance, excess, reutilization, disposal, etc.).
- Medical logistics or resources Automated Information Systems (AISs).
- Special programs (e.g., Homeland Defense, DoD/VA Internal and External Sharing, etc.).
- Integration or sharing with other Services or agencies.
- Emerging technologies.
- Other logistics considerations (e.g., transportation).

Navy's point of contact is:

Mr. Spencer Roberts (202) 762-0209 spencer.roberts@med.navy.mil

7. Action Plans:

A key component of the business plans are the application of quantifiable Action Plans to demonstrate how MTFs will improve performance.

a. Action plans should address those 3-4 priorities that the MTF expects to be able to reasonably improve throughout each year of the business plans, to include the establishment of performance targets. Once the targets are met, the MTF should then address another Critical Initiative from the eight or raise the expected performance target goals.

b. The Services have been asked by HA to have their MTFs select ATC and EBHCs as two of their Critical Initiatives. NAVMED has made great strides in EBHC and if the MTF is compliant with all measures, they should instead select Documented Value of Care, Labor Cost Reporting and Management, and/or Readiness/Expeditionary Planning where performance success has not yet been achieved.

c. A goal when analyzing the action plans is to identify "best practices" so that they can be promulgated throughout the enterprise. During the analysis and validation process, Regional Commands are to identify those practices with potential to improve performance for all of Navy Medicine and include them in their Executive Summary.

8. Reporting Requirements:

a. MTF Commanding Officers will approve the plans before final submission to their Regional Commanders. MTF plans will use the Executive Summary at the end of the Projections Section of the Quantitative Analysis to highlight the most significant factors impacting the MTF during this business planning cycle, provide a qualitative and quantitative review of efforts to implement the CI Action Plans, and identify best practices that have been implemented at your MTF.

b. The business of Military Health Care involves far more than what is currently valued by the PPS. To effectively manage NAVMED Healthcare requires the capture and reporting of all work performed regardless of whether it is currently valued via PPS. MTFs will provide visibility of workload not currently included in the Tri-Service Business Planning Tool, specifically MEPRS A, D and F code RVUs by attaching an excel spread sheet with current (FY 07) non MEPRS B code RVU production to their Executive Summary. In 2002 HA required the capture of all inpatient professional round encounters (IBWA's) and to date, NAVMED has an approximate 80 percent capture rate. In addition to the reporting of current A code RVU production, bedded MTFs will analyze their current status and report an expected A code RVU production based on 100 percent capture of inpatient professional rounds (IBWA).

c. Regional Commanders/MTF Commanding Officers will attach an endorsement to their Regional and MTF Plan with their concurrence and comment before final submission. All questions must be addressed in the affirmative or provide justification for any negative responses.