



Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6000.04

June 17, 2021

DAD-MA

SUBJECT: Military Health System (MHS) Clinical Communities

References: See Enclosure 1.

1. **PURPOSE.** This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of Reference (c) through (l), establishes the Defense Health Agency's (DHA) procedures and requirements for operating the MHS Clinical Communities.

2. **BACKGROUND.** In 2014, the Secretary of Defense directed that the MHS transform into a High Reliability Organization (HRO), as outlined in Reference (e). HROs focus the entire workforce to proactively mitigate errors related to safety by identifying problems and high-risk situations that may lead to harm.

a. MHS Clinical Communities lead the clinical Continuous Process Improvement (CPI) HRO domain of change, enabling front line clinicians to optimize clinical performance improvement outcomes in health and readiness by collaborating with internal and external stakeholders while eliminating harm throughout the MHS. MHS Clinical Communities create, track, and share high reliability conditions (processes, standards, metrics, and cost) at the point of care by identifying and resolving unwarranted variation and fostering a culture of safety and innovation. MHS Clinical Communities drive integration toward MHS coordination, boost clinician engagement, develop patient/person-centered care pathways, focus on clinical CPI, and coordinate with Clinical Support Services (CSS) and Enabling Expertise (EE).

b. MHS Clinical Communities are an MHS-wide network of multidisciplinary groups of healthcare personnel working toward common goals in a particular care area. MHS Clinical Communities are focused on interrelated care processes with high value, that house and align clinical specialties focused on the patient perspective across the care spectrum. They are not Integrated Practice Units (IPUs), specialty groups, product lines, or arranged by diagnoses. The MHS Clinical Communities operationalize the four MHS HRO domains of change of Leadership Engagement, Culture of Safety, CPI, and Patient Centeredness. Clinical Community Advisory Council (CCAC) Co-conveners and MHS Clinical Community Chairs engage key Governance

bodies, including Clinical Quality Management (CQM), Clinical Management Teams (CMTs), Markets, Small Market and Stand-Alone Military Medical Treatment Facility Organization (SSO), Defense Health Agency Regions (DHARs), and the CCAC, all of which consist of subject matter experts (SMEs) and leaders from across the DHA. MHS Clinical Community Chairs and representatives foster a culture of quality and safety through data-driven decision-making, standardization of processes, and the adoption of high reliability and industry leading practices. The data-driven clinical CPI activities addressed in this DHA-PI include monitoring and reporting relevant metrics, ensuring data visibility and transparency, and utilizing metrics to constantly assess and evaluate clinical performance.

3. APPLICABILITY. This DHA-PI applies to the DHA, DHA components (activities under the authority, direction, and control of DHA), Military Departments, Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, and Combatant Commands.

4. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (a) through (c), that the Director, DHA will be responsible for ensuring each MHS Clinical Community has program management administrative support.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosure 3.

7. PROPONENT AND WAIVERS. The proponent of this publication is the Deputy Assistant Director (DAD), Medical Affairs (MA). When Activities are unable to comply with this publication, the activity may request a waiver that must include a justification, to include an analysis of the risk associated with not granting the waiver. The activity director or senior leader will submit the waiver request through their supervisory chain to the DAD-MA to determine if the waiver may be granted by the Director, DHA or their designee.

8. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the internet from the Health.mil site at: <https://health.mil/Reference-Center/Policies> and is also available to authorized users from the DHA SharePoint site at: <https://info.health.mil/cos/admin/pubs/SitePages/Home.aspx>.

9. EFFECTIVE DATE. This DHA-PI:

- a. Is effective upon signature.

June 17, 2021

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date, in accordance with Reference (c).

/S/
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LTG, MC, USA
Director

Enclosures

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ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 21, 2018
- (d) DHA-Administrative Instruction 109, “Decision-Making Architecture (DMA),” October 15, 2019
- (e) Secretary of Defense Memorandum, “MHS Action Plan for Access, Quality Care, and Patient Safety,” October 1, 2014¹
- (f) DHA-Procedural Manual 6025.13, “Clinical Quality Management in the Military Health System, Volume 1-7: Clinical Quality Improvement,” August 29, 2019
- (g) Title 42, Code of Federal Regulations, Part 493
- (h) DHA-Procedural Instruction 5400.01, “Public Affairs and Strategic Communications,” July 15, 2019
- (i) DHA CCAC Charter, September 20, 2017²
- (j) DoD Instruction 6440.03, “DOD Laboratory Network (DLN),” June 10, 2011
- (k) DoD Instruction 6040.47, “Joint Trauma System (JTS),” September 28, 2016, as amended
- (l) DoD Instruction 6000.19, “Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers,” February 7, 2020

¹This reference can be found at:

https://archive.defense.gov/home/features/2014/0614_healthreview/docs/SD_Action_Memo.pdf.

² This reference can be found at:

https://info.health.mil/sites/hro/CCAC_Docs/CCAC%20Charter%2031%20Jan%20-%20Final.pdf.

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs, and in accordance with References (a) through (l), will:

a. Require Market, SSO, DHAR, and Military Medical Treatment Facility (MTF) Clinical Leads which includes, but is not limited, to Market Directors and Market Chief Medical Officers (CMO), to assign responsibilities to monitor implementation of this DHA-PI to direct consistent application across the DHA, Markets, SSO, DHARs, and MTFs.

b. Provide oversight support, staff, and issue guidance to facilitate MHS Clinical Community decision-making and activities.

c. Provide guidance to the Secretaries of the Military Departments on issues related to high reliability, including CPI and Clinical Community priorities.

d. Coordinate with the Military Departments to appoint core MHS Clinical Community members, as requested by the Director, DHA.

e. Coordinate with the Military Departments to identify and provide EE SMEs to the CCAC and MHS Clinical Communities, as requested by the Director, DHA or designee, including (but not limited to) analytics, informatics, and Information Technology (IT) EE (Enclosures 4 and 5).

2. ASSISTANT DIRECTOR (AD), HEALTH CARE ADMINISTRATION (HCA), DHA. The AD-HCA, must:

a. Advise the Director, DHA and make recommendations to ensure MHS Clinical Communities and the CCAC have sufficient resources and staff support to promote and maintain the effectiveness of MHS Clinical Communities (Reference (d)).

b. Facilitate MHS Clinical Community deliverables through the development and achievement of highly reliable conditions (processes, standards, metrics, and cost) at the point of care, throughout the DHA.

c. Require Clinical Community CPI initiatives to be patient/person-centered, in addition to implementing highly reliable and innovative processes, to resolve unwarranted variation in clinical care delivery, foster a culture of increased safety, improve outcomes, and decrease waste.

3. AD, COMBAT SUPPORT (CS), DHA. The AD-CS must:

- a. Advise the Director, DHA on initiatives that directly align MHS Clinical Community efforts with the Combatant Support requirements in support of the Combatant Commanders.
- b. Assign personnel to participate in MHS Clinical Communities Working Groups, as required to synchronize initiatives and execute requirements outlined in Reference (k) and (l).
- c. Oversee coordination between the Joint Knowledge Skills and Abilities Program Management Office and the MHS Clinical Communities to identify the readiness values that support an HRO.

4. AD, MANAGEMENT/COMPONENT ACQUISITION EXECUTIVE (M/CAE), DHA. The AD-M/CAE must:

- a. Coordinate with AD-HCA and AD-CS to provide support to the MHS Clinical Communities.
- b. Provide CAE oversight and execution to support MHS Clinical Communities.
- c. Direct strategic guidance and prioritization to support the DHA mission.

5. DAD-MA, DHA. The DAD-MA must:

- a. Act as the CMO for DHA to provide clinical and strategic vision and guidance to enable the DHA-wide execution of clinical CPI, ensuring MHS Clinical Community initiatives align with DHA strategic priorities as part of the MHS HRO transformation.
- b. Exercise shared decision-making authority in collaboration with the DAD, Health Care Operations (HCO) to support the MHS Clinical Communities' initiatives and priorities across MTF Direct Care and TRICARE Private Sector Care domains.
- c. Develop, disseminate, and advance the High Reliability Operating Model (Enclosure 6) for DHA operations.
- d. Create and disseminate clinical practice recommendations via a standardized template to DHA Markets and MTFs.
- e. Maintain and update the CCAC charter, as required, and coordinate across MHS Clinical Communities.
- f. Request and designate clinical SMEs from the Military Departments and DHA to support MHS Clinical Community priorities and projects.

g. Plan for and request alignment of sufficient resources through standardized DHA resourcing processes to advise Clinical Communities and operationalize Clinical Community strategies across the DHA.

h. Plan for and request, through the DHA's strategic Planning, Programing, Budgeting and Execution processes, alignment of sufficient resources and expertise, such as CSS and EE, to MHS Clinical Communities at the Headquarters levels. See Enclosures 4 and 7 for categories of CSS and EE.

i. Oversee collaboration of MHS Clinical Communities and CCAC with the Clinical Support Division and CQM Branch activities to identify, monitor, and track clinical CPI.

j. Require visibility and advancement of MHS Clinical Community innovations and efforts to DHA leadership and applicable external stakeholders.

k. Elevate issues regarding MHS Clinical Communities to the appropriate levels of leadership.

l. Liaise with CSS and EE to support the CCAC and MHS Clinical Communities.

m. Facilitate and monitor implementation and reporting of specific MHS Clinical Community measures to assess adoption and implementation of Care Pathways, clinical CPI outcomes, and other MHS Clinical Community initiatives, as well as generation of structured project-proposal slide decks (i.e., "A3s"—see Definitions section) to report measures related to Clinical Community initiatives.

n. Through the CCAC, develop and sustain a strategy for educating and training MHS Clinical Community Chairs, MHS Clinical Communities, Sub-Communities, Working Groups, Development Teams, and MTF Healthcare Effectiveness Teams (HETs) to equip DHA leaders, clinicians, and staff with the skills necessary to support MHS Clinical Communities.

o. Coordinate, through the CCAC, with AD-CS; DAD, Education and Training; and Uniformed Services University of the Health Sciences (USUHS) to create and update, as needed, a stratified training approach and recommended curriculum appropriate to different learner profiles, including: MHS executive leaders, MHS Clinical Community leaders, MHS Clinical Community interdisciplinary teams, Market, SSO, DHAR and MTF frontline clinicians, MTF Command leaders, and MTF new onboarding clinicians.

6. DAD-HCO, DHA. The DAD-HCO must:

a. Exercise shared decision-making authority with DAD-MA in support of MHS Clinical Community initiatives and priorities.

b. Coordinate healthcare operations, including Private Sector Care, CSS, EE, SMEs, and partnerships aligned to DAD-HCO, with AD-CS, DAD-MA, the CCAC, and MHS Clinical Communities.

c. Facilitate Markets, SSO, DHARs, and MTFs access and understanding of standardized processes and clinical CPI efforts, as outlined in DHA publications.

7. DAD, STRATEGY, PLANS, AND FUNCTIONAL INTEGRATION (SP&FI), DHA. The DAD-SP&FI must:

a. Facilitate Markets', SSO, DHARs', and MTFs' access to strategic guidance, a prioritization process, and tools to determine resources and staff necessary to support clinical CPI activities, including (but not limited to) developing, piloting, evaluating, and sustaining DHA-wide deployment of care pathways, workflows, IPU, and CPI projects.

b. Assist DAD-MA in identifying and providing CSS, EE, and SMEs to the CCAC and MHS Clinical Communities, including (but not limited to) analytics, Health Informatics, and Program and PM.

c. Facilitate Clinical Community project teams through the lifecycle of a Quality Improvement initiative.

d. Require Market and MTF planned improvements as submitted through the annual Quadruple Aim Performance Plan (QPP) planning process are provided to the Clinical Community members for performance monitoring.

e. Require Clinical Communities recommended improvement projects are captured through the annual Quadruple Aim Performance Plans with applicable performance baseline, targets, and procedures to close gaps.

f. Support QPP specific activities between Clinical Communities/CMT chairs and Market, SSO, and HROCMT leads.

g. Provide coaching and mentoring for headquarters-level Clinical Community working groups including A3 documentation, performance measure development, piloting of new or improved clinical pathway development, and Plan of Action and Milestones development.

h. Assist in development of standardized operating procedures, tools, templates, and reporting mechanisms.

i. Support standardization of processes within clinical communities.

j. Support Clinical Community leads in the development of DHA Practice Recommendations.

- k. Assist in Leading Practice evaluation and selection.
- l. Assist with prioritization of projects and metrics, and make recommendations to the QPP.
- m. Support documentation of initiatives/projects are in the DHA-approved project repository website: <https://carepoint.health.mil/sites/SPIDR/SitePages/Home.aspx>.
- n. Support Clinical Communities in closing performance gaps by recommending appropriate CPI methods and providing coaching throughout the execution of those methodologies.
- o. Work with committees, Markets, SSO, DHARs, MTFs, and appropriate DAD-SP&FI staff to track and analyze quality data.

8. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments will:

- a. Appoint core Clinical Community members, as requested by the Director, DHA.
- b. Prioritize implementation of standardized MHS approaches to CPI across all Clinical Communities.

9. THE CHAIRMAN OF THE JOINT STAFF AND COMBATANT COMMANDERS. The Chairman of the Joint Staff and Combatant Commanders will:

- a. Support implementation of Clinical Community care pathways and other Clinical Communities initiatives and leading practices in overseas MTFs, where appropriate.
- b. Review and apply Clinical Communities' clinical recommendations in the deployed setting, as appropriate, to optimize healthcare delivery across the patient care continuum.

10. CCAC CO-CONVENERS. The CCAC Co-Conveners will:

- a. Enable collaboration across MHS Clinical Communities on solutions to improve clinical, quality, and safety performance outcomes.
- b. Provide clinical insight and prioritize MHS Clinical Community projects and metrics for leadership consideration, and potential inclusion in the DHA's multi-year Strategic Plan (aligned to the Planning, Programing, Budgeting and Execution process), the annual DHA Campaign Plan, and QPP guidance.
- c. Leverage the collective expertise of all MHS Clinical Communities and position them to accelerate CPI in clinical and safety culture across the MHS.

d. Collaborate with groups, councils, committees, Markets, SSO, DHARs, MTFs, and SMEs in leading, evidence-based practices at all levels throughout the MHS to analyze clinical quality (to include safety) data to support CPI.

e. Seek and facilitate Clinical Community collaboration with the CSS and EE to promote highly reliable processes and high value, patient/person-centered outcomes.

f. Monitor, evaluate, and report on Clinical Community activities to DAD-MA.

g. Convene the CCAC meetings, as needed, but no less than monthly.

h. Support establishment and execution of high-level MHS Clinical Community goals, align efforts within the community, facilitate effective communication, and remove barriers to direct establishment of critical structures and systems.

i. Endorse and support bi-directional dissemination of information to and from DAD-MA and associated stakeholders.

j. Encourage cooperation and participation in stakeholder activities and support knowledge transfer across the MHS.

k. Elicit patient co-production of care through participation in activities such as identification of high value outcomes and corresponding processes to achieve those outcomes.

11. CMT CHAIRS. CMTs standardize the models of clinical care in use across the MHS and drive continuous improvement. DAD-MA directs and synchronizes the CMT chairs to execute the following functions:

a. Support standardized models of clinical care, including (but not limited to) MHS Clinical Communities and IPUs, as requested by DAD-MA, in collaboration with the Military Departments, Markets, SSO, DHARs, and MTFs.

b. Facilitate implementation and evaluate outcomes of IPUs to improve condition-based care.

c. Require Clinical Leader communication between CMTs to facilitate implementation of MHS Clinical Community projects and initiatives across CMTs at the DHA, Market, SSO, DHARs, and MTF levels.

d. Implement DHA evidence-based practice recommendations and care pathways, and identify, assess, and report to leadership on gaps or barriers in clinical policy, procedures, guidance, or resourcing.

e. Facilitate execution of CPI to support, facilitate, and monitor the translation of successful initiatives MHS-wide.

f. Inform development of metrics and standards based on initiatives and projects, in conjunction with groups inclusive of (but not limited to) MHS Clinical Communities, CMTs, and the CQM Branch.

g. Oversee MHS Clinical Communities' performance and outcomes.

12. MARKET, SSO, AND DHARs DIRECTORS. The Market, SSO, and DHARs Directors must:

a. Identify and provide Market, SSO, and DHAR CSS, EE, and SMEs to the CCAC and MHS Clinical Communities, as directed by the Director, DHA or designee.

b. Prioritize implementation of standardized DHA approaches to clinical CPI across all MHS Clinical Communities and MTFs within their Market, SSO, or DHAR.

c. Coordinate with clinical service delivery operations to implement Clinical Community evidence-based practice recommendations and care pathways to execute highly reliable, high value, patient/person-centered experiences, and outcomes (Reference (f)).

d. Oversee alignment of MTF Clinical Lead priorities with MHS Clinical Community initiatives.

e. Coordinate with service delivery operations to make recommendations, approve requirements, and prioritize clinical CPI projects in alignment with DHA-wide initiatives.

f. Direct MTF Directors to identify, within their Market, SSO, or DHAR, an MTF facilitator and liaison for each MHS Clinical Community where correlating MHS Clinical Community initiatives are to be implemented.

g. Direct Market, SSO, or DHAR Clinical Lead to work with MTF Clinical Leads to drive and oversee patient safety, performance improvement, and quality programs at the Market, SSO, or DHAR level and require clinical excellence.

h. Provide clinical leadership for HRO initiatives and champion provider participation in HRO culture.

13. MTF DIRECTORS. The MTF Directors must:

a. Ensure MTF standard operating procedures and implementation guidance conform to all DHA guidance related to MHS Clinical Communities, as well as execute MHS Clinical Community initiatives in support of the DHA QPP.

b. Direct MHS Clinical Community initiatives to be in coordination with MTF Clinical Quality programs.

c. Be responsible for execution of Clinical Community priorities in their organization where appropriate (Reference (f)).

d. Designate a point of contact (POC) as the MTF facilitator and liaison for each MHS Clinical Community and establish HETs at MTFs where correlating MHS Clinical Community initiatives are to be implemented. This POC is responsible for working with the HET and DHA Clinical Community to implement MHS Clinical Community initiatives, where applicable.

e. Require all MTF Clinic Leads administrative staff and healthcare providers comply with the guidance and procedures in Enclosure 3.

f. Serve as the local authority for MHS Clinical Communities at the MTF to support and facilitate implementation of MHS Clinical Community initiatives at the MTF.

14. MTF CLINICAL LEAD. The MTF Clinical Lead must:

a. Collaborate with the respective DHA Market CQM personnel to drive patient safety, performance improvement, and quality programs at the MTF and ensure clinical excellence.

b. Provide clinical leadership for MHS Clinical Community initiatives and champion provider participation in MHS Clinical Communities and HRO culture.

c. Require provider participation in MHS Clinical Community initiatives, sponsor provider education regarding MHS Clinical Community activities, and disseminate patient and provider materials developed by the MHS Clinical Communities.

d. Liaise regularly with MTF Director and Market, SSO, or DHAR Clinical Leads to ensure alignment with and support of DHA clinical community initiatives.

e. Liaise with the MHS Clinical Communities and ensure linkage to MTF CQM, IPU, and HETs to facilitate awareness of MHS Clinical Community outcome data, challenges, and increase communication between MHS Clinical Community activities, members, and entities of the MTF CQM personnel, and the MTF Director.

f. Provide updates and briefings on MHS Clinical Community efforts and data-driven results to MTF leadership.

g. Require MTF standard operating procedures and implementation guidance conform to all DHA instructions.

ENCLOSURE 3

PROCEDURES

1. BACKGROUND

a. MHS Clinical Communities are a network of multidisciplinary groups of healthcare personnel across the MHS, working toward common goals in a particular care area, focused on high-value, high-impact care for interrelated care processes that house and align clinical specialties focused on the patients' perspective across the care spectrum. MHS Clinical Communities enable front line clinicians to drive System-wide clinical CPI in readiness and health, and create conditions for high reliability at the point of care (processes, standards, satisfaction, cost, and metrics). This process enables the DHA to hold itself accountable in development and implementation of standards and predictable reliability of high-value clinical and quality clinical outcomes. This minimizes undesirable variation in clinical processes by instituting standardized, evidence-based practices and processes, and selecting clinically meaningful measures to assess and monitor system effectiveness and empower data-driven decision-making.

b. MHS Clinical Communities are central to the advancement of a learning and safety culture as part of progressing the MHS toward high reliability. The primary goal of the Clinical Communities is to improve clinical outcomes across the MHS by identifying and standardizing leading evidence-based practices MHS Clinical Communities will be the leading mechanism for:

- (1) Prioritizing patient/person-centered care;
- (2) Improving patient outcomes;
- (3) Improving performance and innovation;
- (4) Eliminating preventable harm;
- (5) Embedding learning and safety culture System-wide;
- (6) Reducing variability;
- (7) Developing standard clinical processes and care pathways;
- (8) Maximizing value and decreasing waste; and
- (9) Reducing supply-sensitive demand.

c. MHS Clinical Communities are not IPUs, specialty groups, product lines, or diagnoses. Identified MHS Clinical Communities include:

- (1) Behavioral Health;
- (2) Cardiovascular;
- (3) Complex Pediatrics;
- (4) Critical Care/Trauma;
- (5) Dental;
- (6) Military Specific Care/Operational;
- (7) Neuromusculoskeletal;
- (8) Oncology;
- (9) Primary Care;
- (10) Surgical Services; and
- (11) Women and Infant.

d. Each MHS Clinical Community is supported through matrixed CSS and EE, as well as existing working groups and specialized advisory groups.

2. MHS CLINICAL COMMUNITY CORE MEMBERS AND SUPPORT. MHS Clinical Community members and support, including MHS Clinical Community Chairs and core members, will identify additional representatives, including non-core members' consultants, SMEs, or EE, as needed, to develop and implement initiatives at the point of health care delivery. Each core member representative is responsible for integrating input from his or her respective Military Department or organization, as well as to drive performance improvement. MHS Clinical Community core members will:

a. Initiate and manage clinical CPI initiatives as a primary activity and provide consultation on other DHA projects and initiatives that support the HRO mission. Selection of improvement projects and expansion of project portfolios will be done in consultation with the CCAC, DAD-MA.

b. Set clinical standards and develop clinical performance metrics, with support of EE, provide support to clinical policy, and promote CPI in alignment with DHA and MHS Strategy to support clinical CPI initiatives highlighted in the DHA annual QPP.

c. Endorse and support dissemination of information pertaining to MHS Clinical Community projects and initiatives to stakeholder groups.

3. MHS CLINICAL COMMUNITY INFRASTRUCTURE AND OPERATIONS

a. MHS Clinical Communities must establish a charter that defines an infrastructure and framework to organize priorities and activities. Charters will assist MHS Clinical Community teams and partners in making recommendation on priorities, defining clinical standards and metrics, and assisting with managing the scope of MHS Clinical Community consultation on projects external to the MHS Clinical Community. They prioritize the need for non-clinical time to support and complete MHS Clinical Community initiatives, clinical CPI projects, care pathways, and establish IPU, where appropriate.

b. DHA manages and administers Clinical Communities through program management support. Program Managers (PMs) actively support Clinical Communities through administrative support, coordination of CSS and EE collaboration, and facilitation of development and completion of MHS Request Submissions Portal entries for funding requests.

c. MHS Clinical Communities receive Market/SSO/DHAR-level support from CMTs, as well as from EE and CSS, to standardize clinical processes across the MHS for improved quality of care, safety, access, and patient experience.

d. Each Clinical Community nominates a chair from one of the core members.

e. MHS Clinical Communities may elect to segment project areas under two or more Sub-Communities or Working Groups to support CPI initiatives, care pathways, priorities, and projects as the portfolio of improvement projects and activities under the MHS Clinical Community.

f. MHS Clinical Communities support the stand up of HETs as a clinical quality initiative to identify and address clinical CPI, such as care pathways and IPUs.

g. The MHS Clinical Community Chair will:

(1) Work closely with the corresponding CMT(s) to facilitate scale and spread of MHS Clinical Community clinical CPI initiatives.

(2) Serve as a resource to the MHS Clinical Community for identification of clinical CPI opportunities, minimization of obstacles, and reduction of unnecessary process variation.

(3) Support full engagement of all MHS Clinical Community members, provide feedback, and clarify message intent.

(4) Serve as a liaison with other MHS Clinical Communities to oversee the work and level of effort is well supported by EE and CSS.

(5) Direct management of projects and programs to meet required outcomes by expanding and contracting the MHS Clinical Community scope as needed.

(6) Collaborate with the MHS Clinical Community to prioritize and establish Sub-Communities and Working Groups.

(7) Collaborate with the MHS Clinical Community to provide a forum for the various Sub-Communities and Working Groups falling within the MHS Clinical Community.

(8) Collaborate with the MHS Clinical Community to define and prioritize efforts related to initiatives and projects using available EE to produce data supporting quality outcomes.

(9) Serve as the MHS Clinical Community representative and core member to the CCAC.

h. MHS Clinical Community Sub-Communities will:

(1) Support ongoing priorities and objectives of the MHS Clinical Community in accordance with the MHS Clinical Community purpose statement, as outlined in the MHS Clinical Community charter.

(2) Function as long-standing groups dedicated to a specific function or population within an MHS Clinical Community.

(3) Determine membership based on the clinical scope and objectives of the group.

(4) Execute the purpose statement, provided by the MHS Clinical Community core members and issued by the MHS Clinical Community Chair, including purpose, scope, objectives, and membership composition.

(5) Engage in bi-directional learning and mentoring with MTF clinicians and HETs, which serve as the direct link to front line clinicians. Enclosure 8 provides an example of a mature MHS Clinical Community, illustrating how Sub-Communities fit under the MHS Clinical Community.

i. MHS Clinical Community Working Groups will:

(1) Function as a temporary entity stood up by an MHS Clinical Community or the CCAC on an as-needed basis, sustained for the period of time necessary to address a specific issue.

(2) Establish a statement of direction, provided by the MHS Clinical Community core members and issued by the MHS Clinical Community Chair, including purpose, scope, objectives, and membership composition.

(3) Employ CPI methods to create care pathways, define measures, set improvement aims, plan and test initiatives, and measure and report outcomes, in support of MHS Clinical Community project and initiative completion, and eventually, plan and execute MHS-wide implementation.

(4) Connect with appropriate HET and enable participation from a broader range of clinicians with domain expertise specific to that MHS Clinical Community to study an issue and develop a solution. An MHS Clinical Community and its Working Groups engage in bi-directional learning and mentoring with MTF HETs, which serve as the direct link to front line clinicians.

(5) Manage a subset of MHS Clinical Community clinical CPI project(s), as well as other activity(ies) under supervision of the MHS Clinical Community.

(6) Utilize CSS and EE resources to create or develop, recommend, and implement deliverables via CSS and EE established POCs.

j. An HET is comprised of multidisciplinary team members local to an MTF, including clinicians, CSS, and EE SMEs (when available) who are empowered to engage their MTF colleagues in clinical CPI. An HET:

(1) Serves as a short or long-term MTF-level committee that develops and coordinates grassroots clinical CPI projects or initiatives, monitors outcome data in an ongoing project or initiative, and is dedicated to improving overall safety and quality of patient care at the MTF level. This MTF-level infrastructure supports project development and innovation, while advancing HRO culture.

(2) Interfaces with its respective MTF Clinical Lead to manage population-specific improvement priorities, establish targets, monitor results, identify leading practices, require improvement plans/processes to be in place, and make necessary adjustments to drive clinical CPI plans.

(3) Represents the action arm of the MHS Clinical Communities for clinical CPI projects.

(4) Serves as a two-way linkage between the MHS Clinical Communities and MTF by supporting local MTF care pathway and project development and providing education and peer-to-peer coaching to MTF colleagues during testing and implementation.

(5) Provides mentoring and consultation, in partnership with MHS Clinical Community core leaders, to front line clinicians who are conducting local clinical CPI projects.

(6) Serves as the conduit through which local clinicians propose improvement projects and priorities for DHA-wide dissemination.

(7) Engages in bi-directional learning and collaboration with the MHS Clinical Communities and other MTF HETs.

(8) Engages and coordinates with clinicians and multidisciplinary teams through various stages of clinical CPI projects (e.g., initiation, implementation, and report), as the HET program lead.

4. CPI. MHS Clinical Communities lead the HRO domain of change CPI within the MTFs, enabling front line clinicians to optimize clinical performance to improve clinical outcomes in readiness and health, while eliminating harm throughout the MHS. Clinical CPI applies scientific process improvement methodologies to resolve unwarranted variation through incremental improvement in discrete points of care delivery. DHA CQM supports Clinical Community activities through Clinical Quality Improvement (CQI). CQI focuses on improvement of clinical performance and desired outcomes. Methodologies for designing and implementing CQI and clinical CPI are similar. Volume 7 of Reference (f) provides the basic framework for performing CPI/CQI at an MTF. MHS Clinical Communities identify leading practices, evidence-based care, and care pathways related to prioritized patient/person-centered conditions. Key clinical processes are identified and scoped to enable effective clinical CPI. External to those prioritized conditions and care pathway development, the DHA CQI Program can help coordinate strategically aligned leading clinical practices and/or identified CQI opportunities for DHA-wide improvement. Once MHS Clinical Communities have selected CPI priorities, consideration should be given to performance gaps and desired improvements before selecting a CPI method and tool. Recommended CPI tools include, but are not limited to:

a. Rapid Process Improvement or Just Do It. A fast and effective improvement approach which generally takes members of the process or value stream a week or less to complete.

b. Plan-Do-Check-Act/Plan-Do-Study-Act. A management method for the control and continuous improvement of processes and products. This four-step model includes assessing the current process, enacting the plan, evaluating and comparing data to expected outcomes, and developing corrective actions based on outcomes.

c. Clinical Measurement Drivers. The driver diagram visually displays a team's theory of what "drives," or contributes to, the achievement of a project aim. This visualization of a team's shared view is useful for communicating progress to a range of stakeholders. A driver diagram joins the overall aim of the project, the primary drivers (sometimes called "key drivers") which contribute directly to achieving the aim, the secondary drivers which are components of the primary drivers, and specific change ideas to test for each secondary driver.

5. PROJECT EVALUATION PRIORITIZATION (PEP). PEP is used to identify and prioritize projects and initiatives aligned to MHS goals. Various criteria and data are used to rank and prioritize MHS Clinical Community projects and initiatives with the guidance of MHS Clinical Community Chairs.

6. IPU. An IPU is a multidisciplinary team of MTF-level clinical and non-clinical providers organized around a medical condition or group of closely related medical conditions providing the full care cycle. They are dedicated multidisciplinary medical teams organized in a centralized facility that utilize a single administrative structure and schedule. Each patient's care is overseen by a physician lead and Care Manager with input from additional multidisciplinary care team members. The IPU, as a whole, is accountable for patient outcomes and costs. IPUs will:

- a. Organize around patients and their needs to develop workflow processes related to a specific condition (or closely related set of conditions). The patient is informed and engaged throughout the integrated care process.
- b. Interface with CMTs at MTF level to standardize care across MTFs. Implementation and evaluation of IPU is facilitated by CMTs.
- c. Coordinate with MHS Clinical Communities and HETs to support development and optimization of care delivery.
- d. Measure outcomes, costs, and processes related to clinical CPI for each patient using a common measurement platform.
- e. Consist of members who are, ideally, co-located but may work across locations, and report to the same lead provider.

7. CONNECTED HEALTH. Connected Health is a branch of DAD-MA which spearheads the development and integration of digital health technology focused on the medical readiness of Active Duty and Reserve Component U.S. Service members beneficiaries, as well as the wellbeing of eligible beneficiaries. Products of this branch include mobile apps and websites providing 24/7 health support tools, telehealth technology providing remote care access, training for providers on use of digital health in practice, and research and analysis on current and emerging digital health technologies. Connected Health is a band of multiple efforts that leverages and integrates technology in support of MHS Clinical Community activities. At DHA Headquarters, Connected Health is aligned under DAD-MA. Connected Health efforts include (but are not limited to):

- a. DHA Connected Health's Clearinghouse team researches, compiles, and distributes information within DHA about how to support beneficiary care through advanced digital health technology. Their products include literature reviews, market research, and product briefs, which provide information and guidance to customers on leading practices for integrating and implementing digital health into practice.
- b. DHA Connected Health's Health Clinical Integration team supports mobile application development requests from the MHS Clinical Communities by assisting through the submission portal process and facilitating appropriate MHS Clinical Community endorsement and validation of new mobile application requests and requirements.
- c. DHA Connected Health's Education and Training team delivers industry leading training to military health care providers on the integration of digital health technologies and related leading practices into their clinical practice. This training is available to providers through in-person workshops, online courses, and live webinars.
- d. DHA Connected Health's Virtual Health Clinical Integration team leads development of policy, procedures, and clinical guidelines on the use and implementation of telehealth solutions

supporting the health care of DOD beneficiaries. Virtual Health is engaging with Market, SSO, and DHAR leaders and both internal and external stakeholders to establish virtual health capabilities.

8. STRATEGIC PARTNERSHIPS. Partnerships external to the DHA, spanning the enterprise, play a significant role in assisting the DoD meet their mission. The DHA has and will continue to establish strategic partnerships that the MHS Clinical Communities can leverage in support of their clinical CPI efforts. At DHA Headquarters, strategic partnerships are aligned under AD-M/CAE and requests for new partnerships must be coordinated through that office, in accordance with established procedures.

ENCLOSURE 4ENABLING EXPERTISE

1. BACKGROUND. Enabling Expertise (EE) are experts with specific high-level skills and abilities organized into specialty groups to provide certain non-clinical support to MHS Clinical Communities to develop and implement clinical Continuous Process Improvement (CPI). Located across the Military Departments and Defense Health Agency (DHA), EE are accessed through a Distribution Center. Each EE is comprised of Subject Matter Experts (SMEs) from the Military Departments and DHA that offer a suite of services to Military Health System (MHS) Clinical Communities for the advancement of projects and initiatives. EE support MHS Clinical Communities by assessing their needs, connecting leaders to SMEs, and pinpointing where and when support can be procured. EE consist of:

a. Analytics. Analytic SMEs under the DAD-SP&FI, DAD-MA, AD-CS, President USUHS, and the Military Departments will coordinate and utilize data collection and analysis methodology to identify and predict variations in care, trends, effects, decisions, and performance to improve patient outcomes. MHS Clinical Communities will utilize EE data analytics at the DHA Headquarters, Market, SSO, and DHAR, and MTF levels to support improvement project prioritization; care pathway development and testing; DHA-wide implementation; and outcomes tracking. Analytic support will aid in defining, collecting, and tracking both process and outcomes measures.

b. Change Management. Change Management SMEs under the DAD-SP&FI utilize organization change methodology, including systems analysis of the current organizational state and customized interventions, to improve organizational functions, structure, culture, climate, relationships, or behavior.

c. Clinical Informatics. Clinical Informatics SMEs collaborate with the Office of the Chief Health Informatics Officer and the Military Departments to utilize an information-based technology approach for collecting, storing, analyzing, and sharing data which optimizes the flow of information to maximize patient safety and quality of care. Clinical Informatics is responsible for (a) assistance developing requirements, (b) configuration, (c) training, (d) and optimization of health IT systems. Clinical Informatics will provide content and technology configuration support to MHS Clinical Community projects, such as care pathway integration with electronic health records.

d. CPI. CPI SMEs employ systematic methods to identify gaps and improve process and system performance with the goals of improved health and readiness outcomes, optimized and standardized processes and services, increased quality and safety, and effective and efficient use of resources. CPI support will synchronize MHS Clinical Community projects with DHA strategic goals. DHA CPI/Lean Six Sigma Program will provide CPI training programs, consultation, and certifications.

e. Education and Training. Education and Training SMEs utilize educational tools and programs to improve clinical outcomes and staff competency. MHS Clinical Community learning pathways and training plans will encompass foundational skills through advanced level curriculum in the following domains: High Reliability Principles, CPI, Patient Safety, Leadership, and Coaching. Education and Training strategies will span in-person classroom, asynchronous online webinars, site observations, and case-based learning.

f. Health IT. Health IT SMEs apply IT solutions used to store and maintain, design, and integrate information and information systems to health care projects. Health IT is responsible for (a) acquisition or procurement, (b) deployment and (c) sustainment of IT systems including the IT hardware and network. Health IT SMEs will develop technical tools for MHS Clinical Community project and program transparency, enabling the MHS Clinical Communities to facilitate adoption of care pathways and other clinical CPI projects.

g. Knowledge Management. Knowledge Management SMEs use a systematic process for collecting, creating, using, sharing, and managing organizational information and knowledge to achieve organizational goals by making the best available knowledge accessible. Knowledge Management conducts need and gap assessments in support of CPI development and identifies and selects evidenced-based knowledge solutions for clinicians. Knowledge solution materials related to MHS Clinical Community CPI projects will be developed, stored, and disseminated to promote adoption of MHS Clinical Community care pathways and CPI projects.

h. Program and Project Management. PM SMEs apply knowledge, skills, tools, and techniques to meet program requirements. PM SMEs employ a five-stage project management approach: Discovery, Scoping, Diagnostics, Implementation, and Monitoring to enable scoping and diagnostic events, implementation of large-scale pilots for solution optimization, and system-wide scale and spread of governance-approved enterprise initiatives and projects. This includes directing, coaching, mentoring, and training, as well as the provision of industry-standard project management processes, tools and templates customized for the DHA. PM will not require a Capability Cell, as each MHS Clinical Community will have its own PM responsible for providing administrative support, coordinating CSS and EE involvement, and overseeing development and completion of MHS Request Submissions Portal entries for funding requests (not inclusive).

i. Quality and Safety. Quality and Safety SMEs provide an organized structure for an integrated framework of programs to objectively define, measure, assure, and improve the quality of care received by MHS beneficiaries. They act as EE to support MHS Clinical Communities in CPI, aiming to promote safety and prevent harm, mitigate risks in the clinical aspects of health care delivery, require a qualified and competent staff and compliance with standards through measuring and assessing the quality and safety of care and services delivered. They will collaborate with MHS Clinical Communities to identify quality improvement priorities through analyzing data sources to include (but not limited to) clinical quality data.

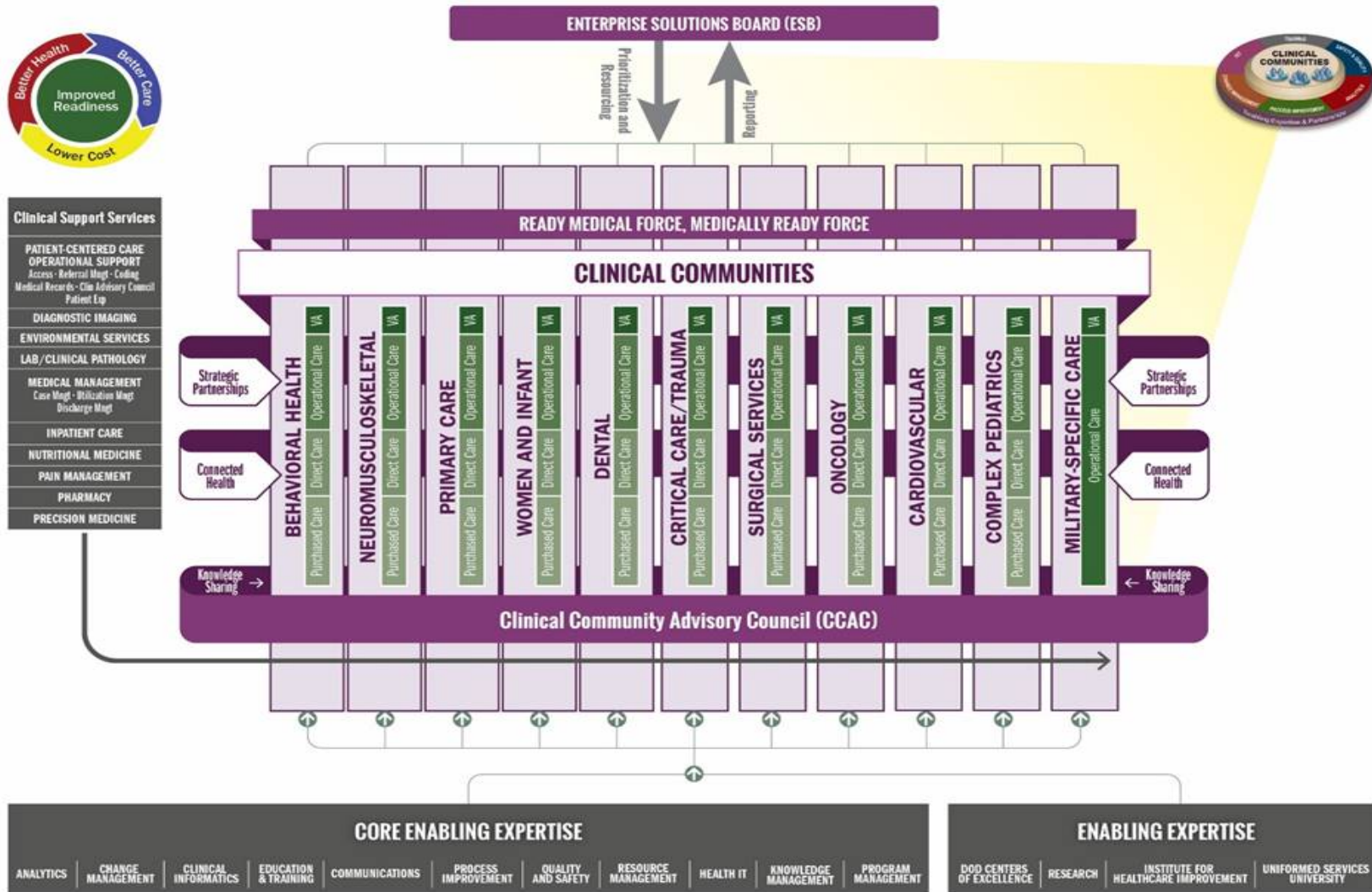
j. Research. Research SMEs, in coordination with DAD, Research and Development, create or affirm knowledge by establishing facts, reaffirming results of previous work, solving new or existing problems, supporting theories, or developing new ones. SMEs identify, set, and coordinate MHS research priorities to serve clinical interests.

k. Resource Management. Resource Management SMEs manage finances, human capital, facilities, equipment, and supplies. They efficiently and effectively manage the clinical environment and its physical and supporting resources. This is a core function of DHA, and the CSS aligned to DAD-HCO. Resource Management SMEs will provide consulting services on MHS Clinical Community performance improvement projects and initiatives to guide research design. They will also enable clinicians to find meaningful results by making DHA data sets available to MHS researchers.

l. Strategic Communications. Strategic Communications SMEs plan communication efforts, based on situational analysis and strategy, which engage audiences and/or individuals to address specific objectives. The Director of DHA Communications leads, supervises, and provides oversight of all DHA communications, as noted in Reference (h). Their messaging targets DHA leadership; Market, SSO, and DHAR leadership; and other clinicians, to facilitate knowledge of MHS Clinical Community activities in support of clinical CPI.

ENCLOSURE 5

MILITARY HEALTH SYSTEM CLINICAL COMMUNITY CONSTRUCT



8 MAY 2019

ENCLOSURE 6

HIGH RELIABILITY OPERATING MODEL

 **MHS Integrated Healthcare Delivery System
HRO Operating Model**



ENCLOSURE 7CLINICAL SUPPORT SERVICES

1. BACKGROUND. CSS extend across all clinical settings in support of care delivery across multiple clinical domains. CSS are critical to the patient care process and support clinician practice. The DHA has designated two distinct roles for these units: to serve an enterprise function in their area of subject matter expertise, and to function as SMEs to MHS Clinical Communities. Each CSS offers a suite of services to MHS Clinical Communities providing vital support to MHS Clinical Community initiatives and projects via a reciprocal working relationship. CSS are located across the Military Departments and DHA, administratively aligned to either DAD-MA or DAD-HCO, and are accessed through a Distribution Center. CSS support MHS Clinical Communities by assessing their needs, connecting leaders to SMEs, and pinpointing where and when support for MHS Clinical Communities can be procured. CSS consist of:

a. Diagnostic Imaging. Aligned under DAD-MA, Diagnostic Imaging implements and executes policy and oversight for diagnostic imaging practices, procedures, and reporting of imaging results.

b. Healthcare Optimization Division (HCO). Aligned under DAD-HCO, HCO is responsible for Primary and Specialty Care optimization, access, referrals, patient experience and virtual health execution. HCO co-chairs the Patient/person-Centered Care Operations Board with the DAD-MA representative, which is the counterpart to the CCAC. HCO implements and executes policy and oversight related to standard processes, productivity standards and metrics, performance monitoring, training and education, compliance monitoring, network care integration and centralized appointing, and referrals. In addition, they are responsible for coordinating clinical quality and safety issues with MHS Clinical Communities.

c. Inpatient Care. Aligned under DAD-HCO, Inpatient Care implements and executes policy and oversight for practices and procedures of inpatient care.

d. Laboratory Services and Clinical Pathology. Aligned under DAD-HCO, Laboratory Services and Clinical Pathology administers the DoD's Clinical Laboratory Improvement Program to meet References (g) and (j). This office manages regulatory compliance lifecycle for 1,775 laboratories from the moment they register as a new lab to renewal of certificates on a 2-year cycle after attaining inspection compliance by a nationally acceptable organization.

e. Medical Management. Aligned under DAD-MA, Medical Management is supported by the Medical Management Workgroup which oversees Medical Management activities. This CSS implements and executes policy and oversight of all Medical Management functions and activities related to Case Management, Disease Management, and Utilization Management to support standardization and readiness across the Services.

f. Nutritional Medicine. Aligned under DAD-MA, Nutritional Medicine establishes unified nutrition policies for DHA facilities using a comprehensive and collaborative approach.

g. Pain Management. Aligned under DAD-MA, Pain Management provides patients with evidence-based pain management, guided by clinical practice guidelines to treat acute pain effectively; promote non-pharmacologic pain treatment; avoid chronic pain; minimize use of opioids with appropriate prescribing, only when indicated; and provide evidence-based care for patients with chronic pain.

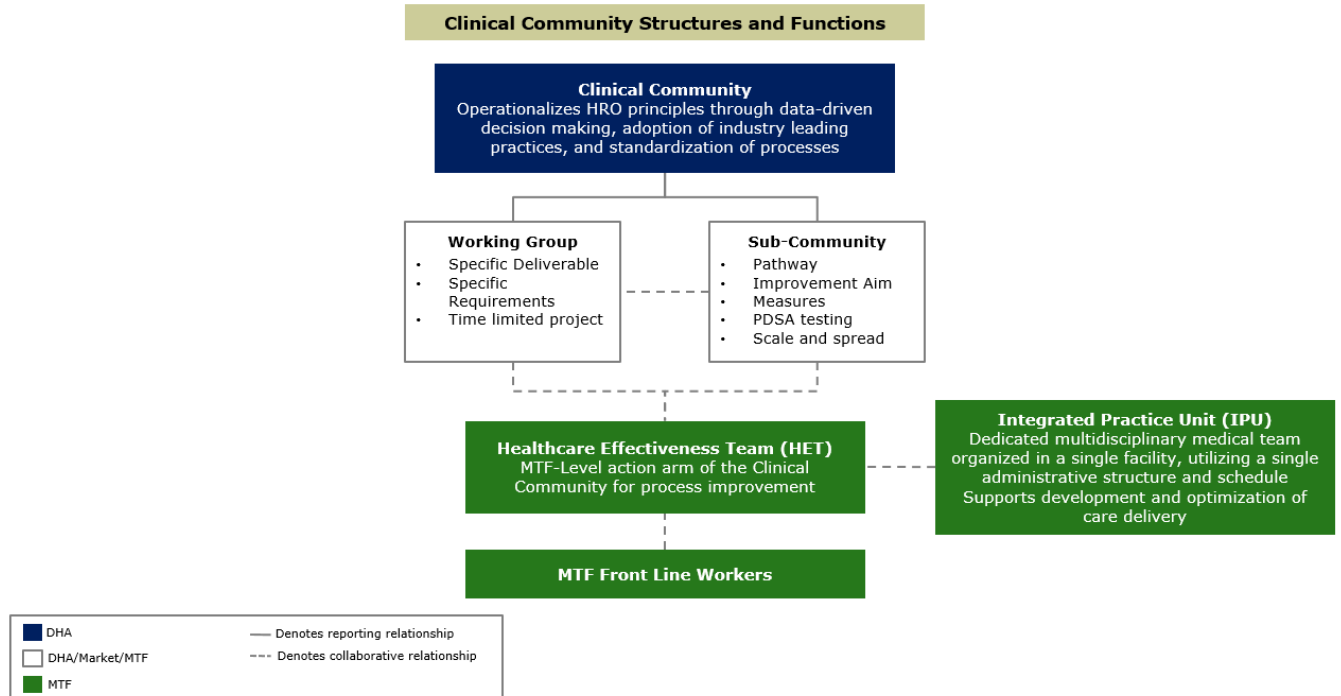
h. Pharmacy. Aligned under DAD-HCO, with support of the Pharmacy and Therapeutics Committee, Pharmacy SMEs look to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of DoD beneficiaries in an effective, efficient, and fiscally responsible manner.

i. Precision Medicine. Aligned under DAD-MA, Precision Medicine is an emerging approach for disease treatment and prevention that considers individual variability in patients' genes, environment, and lifestyle. This approach allows providers and researchers to more accurately predict which treatment and prevention strategies will be most effective for certain populations.

ENCLOSURE 8

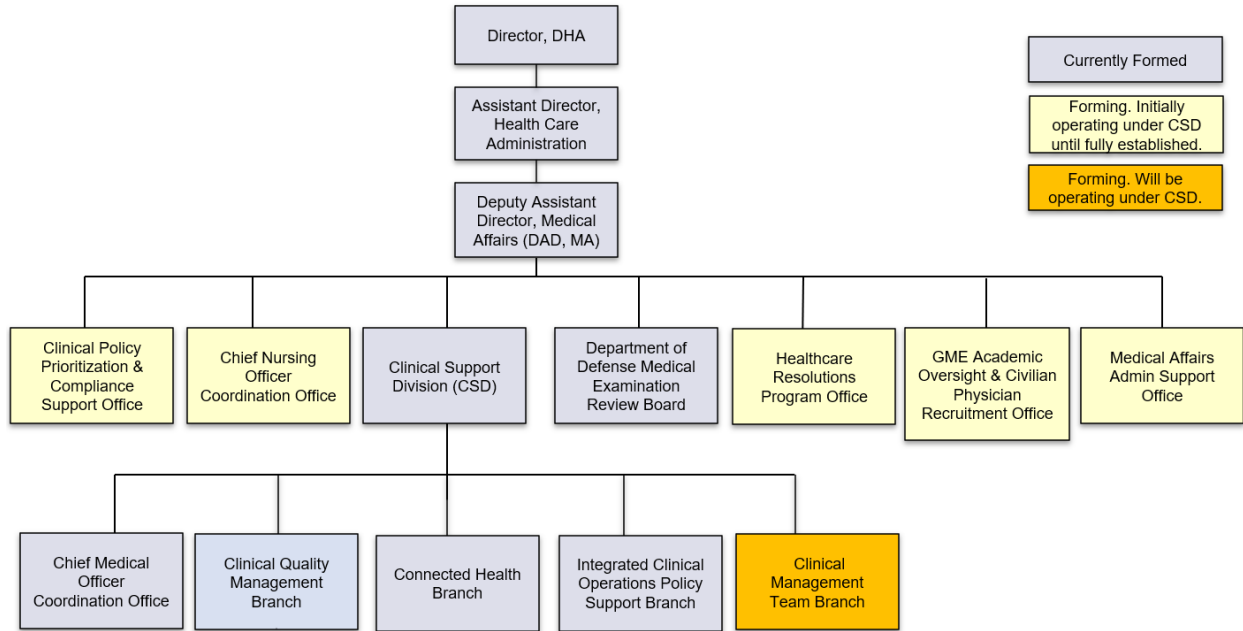
MILITARY HEALTH SYSTEM CLINICAL COMMUNITY STRUCTURE

This graphic displays MHS Clinical Community structure, scope and/or function, as well as coordination of the MHS Clinical Community components.



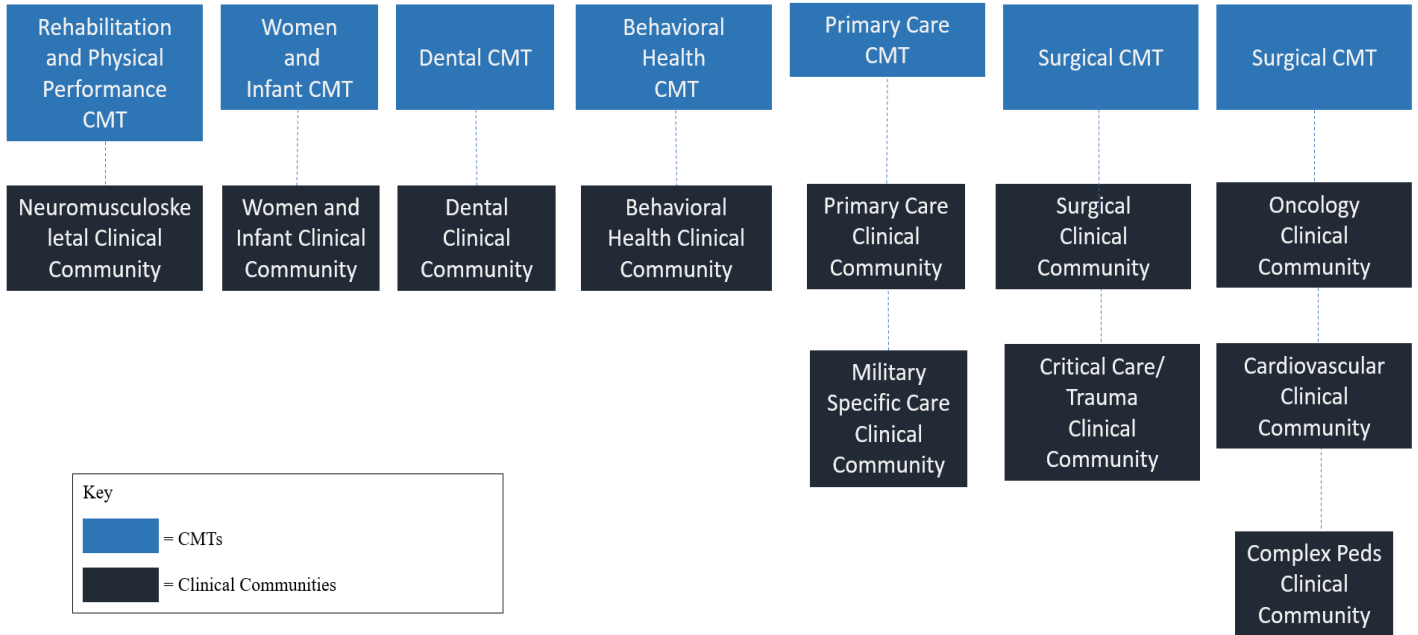
ENCLOSURE 9

DEFENSE HEALTH AGENCY HEADQUARTERS CLINICAL MANAGEMENT TEAM
ORGANIZATIONAL ALIGNMENT



ENCLOSURE 10

FUNCTIONAL ALIGNMENT OF CLINICAL COMMUNITIES TO CLINICAL
MANAGEMENT TEAMS



GLOSSARYPART I. ABBREVIATIONS AND ACRONYMS

AD-CS	Assistant Director, Combat Support
AD-HCA	Assistant Director, Health Care Administration
AD-M/CAE	Assistant Director, Management/Component Acquisition Executive
CCAC	Clinical Community Advisory Council
CMO	Chief Medical Officer
CMT	Clinical Management Team
CPI	continuous process improvement
CQI	clinical quality improvement
CSS	Clinical Support Services
DAD	Deputy Assistant Director
DHA	Defense Health Agency
DHA-PI	Defense Health Agency Procedural Instruction
DHAR	Defense Health Agency Region
EE	Enabling Expertise
HET	Healthcare Effectiveness Team
HCO	Healthcare Operations
HRO	High Reliability Organization
IPU	Integrated Practice Unit
IT	information technology
MA	Medical Affairs
MHS	Military Health System
MTF	Military Medical Treatment Facility
PEP	Project Evaluation and Prioritization
POC	point of contact
QPP	Quadruple Aim Performance Plan
SME	subject matter expert
SP&FI	Strategy, Plans, and Functional Integration
SSO	Small Market and Stand-Alone Medical Treatment Facility Organization

PART II. DEFINITIONS

*- Unless otherwise noted, these terms and their definitions are for the purpose of this DHA-PI

Activities. 1) A unit, organization, or installation performing a function or mission. 2) A function, mission, action, or collection of actions.

A3. Structured problem-solving and continuous-improvement approach used by the DHA to facilitate process improvement projects. Historically an A3 was printed on a single sheet of A3-size paper which is where the name is sourced from.

Care Pathway. A documented sequence of clinical interventions, placed in an appropriate timeframe, written and agreed to by a multidisciplinary team. They help a patient with a specific condition or diagnosis move progressively through a clinical experience to a desired outcome.

CCAC. Leverages the collective expertise of the MHS Clinical Communities and accelerates high reliability across the MHS by positioning them to deliver CPI in clinical practice. The CCAC is a forum that promotes the standardization of health care practices across the MHS, and is a mechanism of collective coordination, synergy and support, and a forum for generating collaborative solutions among all MHS Clinical Communities, CSS, and EE. The CCAC reports to the DHA CMO and also develops an oversight plan to achieve improvements in performance priorities. Performance priorities are linked to the QPP priorities, monitor performance on established QPP priorities, report progress toward systemic goals and high reliability made through MHS Clinical Community efforts, develop corrective actions for QPP performance gaps, and address leadership-directed improvement efforts. The CCAC is not a decision-making body nor an entity of Governance.

CMO. At the Market level, the lead physician/clinician responsible for, at a minimum, clinical operations functions aligned to the DHA DAD-MA, specifically: policy, procedures, and direction of clinical quality and process improvement, patient safety, infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting. CMOs may be responsible for other health care operations or health care administration responsibilities as assigned by the Market Director.

CLINICAL PRACTICE RECOMMENDATIONS. Evidence-based, standardized guidance to assist healthcare providers in making decisions regarding appropriate healthcare delivery recommendations for specific clinical conditions, with understanding that healthcare providers may need to deviate from the practice recommendation base on needs of individual patients.

CMTs. Operational, executionary arm of clinical care delivery comprised of clinical, administrative, ancillary support staff that implement and monitor standardized clinical care. CMTs are arranged by major clinical focus areas and support operational aspects of clinical care, including overseeing the implementation of standardized MHS approaches to CPI across all MHS Clinical Communities, including (but not limited to) policy implementation/execution, clinical operations, and resourcing (Enclosures 5 and 9).

CSS. Services that extend over all clinical settings in support of the delivery of care across multiple clinical domains. CSS are critical to the patient care process and support clinician practice. They are a vital part of the MHS Clinical Community construct as they provide support for MHS Clinical Community initiatives and projects via a reciprocal working relationship.

EE. Capability Cells that provide subject matter expertise to support MHS Clinical Communities in the areas of: Analytics, Change Management, Clinical Informatics, CPI, Data Science, Education and Training, Health IT, Knowledge Management, PM, Research, Resource Management, and Strategic Communications.

HETs. A multidisciplinary team of clinicians and support staff (e.g., analysts, informatics, and trainers) at MTFs who are empowered to engage their local clinicians in CPI. HETs will also educate, train, and mentor peers during pathway and guideline implementation.

IPUs. Multidisciplinary care teams that treat the condition, as well as the complications and circumstances that commonly accompany a disease. The practice unit is organized around patient needs and is responsible for the full cycle of patient care, encompassing inpatient and outpatient care, rehabilitative care, and supporting services, including (but not limited to) nutrition, case management, and behavioral health. They deliver patient care at an MTF organized around a medical condition or set of closely related conditions which can be formatted by a care pathway.

Military Medical Treatment Facility Clinical Quality Management. CQM staff at the MTF level, including program areas of patient safety, healthcare risk management, credentialing and privileging, accreditation and compliance, clinical measurement, and CQI.

MHS Clinical Communities. MHS-wide network of multidisciplinary group of health care personnel, working toward common goals in a particular care area, focused on high-value, high-impact care for interrelated care processes that house and align clinical specialties focused on the patient's perspective across the care spectrum. They are not IPUs, specialty groups, product lines, or arranged by diagnoses.

PEP. A process, utilized by the MHS Clinical Communities, to identify and prioritize projects and initiatives aligned to enterprise goals. Various criteria and data will be used to rank and prioritize MHS Clinical Community projects and initiatives with the guidance of MHS Clinical Communities.

Sub-Community. In a mature MHS Clinical Community model, a Sub-Community includes long-standing development teams and related support groups, still under the purview of the MHS Clinical Community, dedicated to a specific clinical domain area or population. The Sub-Community facilitates the inclusion of multi-disciplinary clinical teams from Services or MTFs who have a highly specialized expertise in a sub-domain of the MHS Clinical Community. For example, the Primary Care Clinical Community may elect to form three Sub-Communities: Pediatric Preventative, Adult Preventative, and Adult Chronic Complex. A Sub-Community may also include an aligned MHS Working Group. For example, Patient Centered Medical Home Working Group may be a Sub-Community under the Primary Care Clinical Community.

Working Group. A multidisciplinary group assembled by the MHS Clinical Community on an as-needed, time-limited basis for a specific deliverable, such as a data tool to support a Development Team's improvement initiative. The Working Group may utilize EE and may also engage Service and MTF teams to study an issue or develop a solution.