APPENDIX 3. ACCESS TO CARE

Appendix 3.1
Code of Federal Regulations 32 CFR 199.17 (p)(5)

Access standards. Preferred provider networks will have attributes of size, composition, mix of providers, and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in non-emergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

Appendix 3.2
Access Improvement Working Group Charter

Table 3.2-1 The Military Health Systems (MHS) Access Improvement Working Group (AIWG)

Military Health Systems (MHS) Access Improvement Working Group (AIWG)	
Sponsor(s): Tri-Service Patient-Centered Care Advisory Board **Scope:** The mission of the MHS Access Improvement Working Group, a working group of the Tri-Service Patient-Centered Care Advisory Board, is to develop and sustain comprehensive and standardized Department of Defense ATC guidance to improve and sustain the following ATC processes: appointment/scheduling/templating operations, ATC performance measures, appointing information systems management, empanelment, and related training opportunities. Where relevant, the Advisory Board should make recommendations to the Tri-Service PCMH Advisory and Tri-Service Specialty Care Advisory Boards for implementation approval.	**Chairperson(s): USAF, then rotating among services annually** **Stakeholders/Names:** Army Representative- Navy Representative- Air Force Representative- Coast Guard Representative- DHA Representatives- Referral Management Representatives- Medical Management Representatives- Service Medical Home Representatives- Specialty Representatives from Orthopedics, OR Specialties, OB/GYN, Mental Health and Ambulatory Specialties-
Business Case/Opportunity Statement: With the adoption of the Quadruple Aim and Patient Centered Medical Home (PCMH) as MH strategic goals, there is a significant need to update, execute and sustain a standardized set of guidance on access management in order to meet 32 CFR 199.17 access standards and the tenets of PCMH, the Quadruple Aim and the access imperatives of the uniformed services. The MHS guide to Access Success, last updated in 2008, will be replaced with this policy guidance to support current MHS strategy. Additionally, in order to support fully integrated delivery system, the MHS is implementing the Medical Neighborhood with oversight by the Tri-Service Patient-Centered Care Advisory Board. The MHS AIWG will report directly to the Tri-Service Patient-Centered Care Advisory Board to facilitate coordination.	**Goal Statement:** The goal for this working group is to meeting at least monthly to discuss and develop processes to implement and sustain standard access improvement business practice across the MHS. One of the first projects will be to write a MHS Access to Care Operations Manual. This document will be used to provide updated guidance currently contained in the MHS Guide for Access Success. Due to the closely related nature of ATC business practices to a number of related process improvement efforts, the AIWG will coordinate closely with the Tri-Service PCMH Advisory Board, Tri-Service Specialty Care Advisory Board, the Medical Management Advisory Board and the Referral Management Working Group. Representation from these groups will be both ADHOC and permanent on the AIWG.
Deliverables: 1. MHS Access to Care Operations Manual reflecting standardized ATC business rules across the Services. a. MHS Core Access to Care Guidance to include development of standardized clinic management and appointing practices. b. Drafting of MHS Access to Care Operations Manual appendices providing in depth how-to guidance in various areas of access management to include warriors in transition access management, information systems operations, use of technology, online appointing, use of secure messaging, access performance measurement, patient communications/customer services, operations checklist and more. 2. Development of marketing and education plan for users and stakeholders. 3. Integration of ATC guidance into functional requirements of MHS information systems. 4. Monthly meetings to continue to discuss and develop ATC guidance for the MHS.	

Tasks/Milestones:	Target Date	Date Achieved
Charter drafted and approved	February 2014	
MHS AIWG chair selected	February 2014	
Develop/distribute CHCS problem resolution worksheet	March 2014	
Standardize provider specialty code sorting process to delineate extenders (PharmD, BHOP, etc) working in PCMH clinics	March 2014	
Develop "Simplified Appointing" Model, creating a two or three appointment type Primary Care appointing system	April 2014	
MHS Access Ops Manual Core guidance completed/approved	August 2014	
All appendices drafted and approved	June 2015	

Tasks/Milestones:	Target Date	Date Achieved
Development and approval of a marketing and educational plan to include identification of faculty and course	December 2015	
Continuing development of policies and guidance	Ongoing	
Is there a Regulatory Requirement for this IWC/Workgroup/Committee:	**NO**	
Approved by the Chair of the Medical Operations Group:		

Source: 2014 MHS Review Group

Appendix 3.3
Summary of Access to Care Policies and Orders

DoD Policies

10 U.S. Code, Chapter 55, *Medical and Dental Care.* The U.S. Code is a consolidation and codification by subject matter of the general and permanent laws of the United States; it is currently divided into 51 titles. Title 10 contains laws relating to the Armed Forces. The provisions of law that affect military health care are codified in chapter 55 of title 10. Section 1072 defines the term "TRICARE Program" as the managed health program established by the DoD, principally by Section 1097. Section 1073 tasks the Secretary of Defense with responsibility for administering the medical and dental benefits provided in chapter 55 of title 10, including broad authority to implement and administer the TRICARE program.

Code of Federal Regulations (32 CFR), Part 199.17 *TRICARE Program.* Pursuant to the above statutory authority, the Secretary of Defense has promulgated rules and regulations at 32 CFR 199.17 governing the TRICARE Program for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the Military Health System. Section 199.17(p)(5) addresses access standards, including specific wait and travel time standards, for TRICARE Prime enrollees.

The Military Health System's (MHS) *Guide to Access Success*, 15 December 2008. The guide establishes roles, responsibilities, definitions, and guidance for implementing, sustaining, and managing MTF ATC in the MHS that meets or exceeds the access standards stated in 32 Code of Federal Regulations (CFR) 199.17. This very detailed and comprehensive guide provides MTFs with direction on appointing and schedule management, appointing in the electronic scheduling system known as the Composite Health Care System (CHCS), the Open Access model, patient eligibility and enrollment, TRICARE On Line, referrals, and specialty and mental health access. The guide provides step-by-step CHCS operations related to access to care and data quality. Templates for an access improvement plan, access manager job description, measures, and optimization strategies are included in the appendices.

Health Affairs Policy 11-005, *TRICARE Policy for Access to Care*, 23 February 2011. HA Policy 11-005 rescinded and replaced eight previous policies. It provides guidance for access standards for health care benefits under the TRICARE Program consistent with 32 CFR, Part 199.17(p)(5). The wait and travel times, priority of access to MTF care by beneficiary status, TRICARE Prime Service Area, and beneficiary waiver of travel standards are all described in detail. The standards apply to all MTFs (to the extent practicable in overseas locations).

Health Affairs Policy 09-15, *Policy Memorandum Implementation of the Patient Centered Medical Home [PCMH], Model of Priority Care in MTFs.* The policy is an established model of primary care associated with better outcomes, reduced mortality, fewer hospitalizations for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and reduced medical spending.

Health Affairs Policy 01-015, *Policy Memorandum to Refine Policy for Access to Care in Medical Treatment Facilities and Establish the TRICARE Plus Program,* 22 June 2001. HA Policy 01-015 establishes the TRICARE Plus program, an MTF primary care enrollment program available to beneficiaries not enrolled in TRICARE Prime and limited to available MTF capacity.

Army Policies

The Army Medical Department policies provide specific guidance on how to improve ATC in areas such as schedule and template management, enrollment, and referral management. In the last five years, the Army Medical Department (AMEDD) implemented an Access to Care Campaign to facilitate the transition to the PCMH model with evidence of improved access, continuity of care, and higher levels of staff and patient satisfaction. The Army monitors and reviews access-related metrics in multiple venues from the tactical level of the MTF to Health Affairs requirements. Access metrics are incorporated into the Army Medicine Campaign Plan, Annual Performance Planning Guidance, and Organizational Inspection Program. All commands have access to the TRICARE Operations Center (TOC) as the premier health care information web portal for the MHS, providing decision makers at all levels of the organization with meaningful, easy-to-use, web-based operational reports. The Army continually works with regional medical commands and MTF managed care and clinical operations to improve access principles and processes that impact Title 10 health care entitlements and the TRICARE Prime health plan.

The Office of the Surgeon General (OTSG)/ Medical Command (MEDCOM) Policy 12-006, *MEDCOM MTF Enrollment, Access and Appointment Standards for all Uniformed Service Members, with Special Emphasis on Enhanced Access to Care for Specified Populations,*[1] 13 January 2012. This policy implements many of the requirements outlined in HA Policy 11-005 and the *MHS Guide to Access Success*.

OTSG/MEDCOM Policy 11-089, *Improving MTF Practices for Provider Template and Schedule Management*, 25 October 2011 is designed to increase command and control, efficiency, and effectiveness by minimizing redundancies while also increasing access, including additional requirements for TOL and AudioCare.

OTSG/MEDCOM Policy 12-085, 18 January 2011, 21 December 2012 enhances access to care and primary care continuity through standardized appointing services.

OTSG/MEDCOM Policy 13-061, *MEDCOM MTF Referral Management Office - Overarching Core Business*. 1 November 2013. This policy formalizes MEDCOM-wide objectives, business design plans, and MHS tools for Referral Management Operations.

[1] "Specified Populations" include Wounded Warriors, Special Operating Forces, and Deploying and Re-Deploying Forces.

OTSG/MEDCOM Policy 13-065, *AMEDD Enrollment Policy*, 17 December 2013 formalizes MEDCOM-wide objectives, business designs, and tools for consistent, maximum enrollment of TRICARE Prime/Plus beneficiaries within MEDCOM.

OTSG/MEDCOM Policy 14-007, *No-Show Policy*, 7 February 2014 formalizes MEDCOM-wide objectives, business designs, and tools for MTF no-show management to improve patient access to care by limiting the number of missed appointments. Limiting no-shows improves access compliance, provider schedule management, and beneficiary expectations.

Operations Order 09-36, *Access to Care Campaign,* 30 March 2009, and subsequent fragmentary orders were launched to refocus MTF commanders on their mission-essential task of providing timely access to care. Eleven key focus areas included patient appointing and access, TOL, schedule and template management, referral management, patient satisfaction measures that provide more specific access compliance targets, and reporting requirements beyond previously issued policy guidance.

Operations Order 11-05, *Community Based Primary Care Clinics* [CBPCCs], **4 November 2010** initiated the opening of CBPCCs in off-post leased facilities closer to where our Army families live in order to improve access to quality health care. Operations Order 11-05 was subsequently renamed, ***Community-Based Medical Home***.

Operations Order 11-20, *Army Patient Centered Medical Home,* 25 January 2011, and subsequent fragmentary orders standardize health care delivery by transitioning 100 percent of direct-care enrollees to the PCMH model not later than FY 2015 in order to improve access to care, outcomes, wellness, prevention, and satisfaction while ensuring a uniform patient care experience for all beneficiaries.

Operations Order 12-50, *Soldier-Centered Medical Home* [SCMH] **4 February 2013,** and subsequent fragmentary orders implement the SCMH model at installations across the Army beginning not later than 01 March 2013 and to be completed not later than 1 October 2014 in order to improve medical readiness and ensure consistently superior health care.

***Army PCMH Operations Manual Leaders Guide to Army Patient Centered Medical Home Transformation,* 19 January 2013** describes the methods and processes for operating an Army PCMH, defines the essential tasks and standards, and details metrics at the PCMH, MTF, regional, and Army Medical Command levels. This operations manual fully supports execution of previously issued policy and operations orders and fragmentary orders.

Navy Policies

Navy's access policies are heavily focused on the PCMH model of care and the patient experience. The policies require MTF leadership to build and sustain a culture of patient-centric care within the MTF that is continuously improved upon. To ensure compliance with the access standards, Navy policy requires the frequent monitoring of access to care through measures/metrics. These are reviewed by MTF and regional and higher-level headquarters'

leadership to identify problems or deficiencies that can then be addressed quickly with operational and process changes. Navy access policy references both the *MHS Guide to Access Success* and PCMH policy as the primary drivers of access management at the Navy MTF. Both external and internal inspection agencies validate the MTFs' ability to meet access standards and adherence to policies, with onsite inspections and face-to-face patient interviews and MTF metrics briefs.

BUMEDINST 6300, *Primary Care Services in Navy Medicine*, 5 April 2010 is the primary policy for Navy medicine with regard to access to care. This policy was created to implement a new delivery model of patient- and family-centered care from an individual patient and individual provider to a team-based model for primary care services. This new design would be comprehensive to fully meet primary care health and wellness needs of patients. The primary goal is the health and wellness of Sailors, Marines, and their families, as well as acute care needs when they become ill. By providing comprehensive support in primary care, they operationalize force health protection. By utilizing the team approach, they mitigate challenges such as operational tempo, staffing shortfalls, and personnel turnover. They also increase access to care, standardize primary care services, and improve the partnership between the patient, provider(s), and the primary care team. Ultimately, this will align with civilian models of PCMH. In Navy Medicine, this is referred to as "Medical Home Port." This instruction outlines the transition from current practices to implementation of the new model, defines terms and standards of the primary care team, clarifies roles and responsibilities, applies appointment standards, outlines facility standards, sets forth business rules in which to operate, documents information management/information technology guidance, standardizes metrics for performance, and approves BUMED provider administrative discounts.

NAVMED Policy 09-004, *Access to Care Management Policy for Navy Medicine Military Treatment Facilities*, (12 March 2009) is the secondary policy that identifies how Navy Medicine executes the access standards. The policy provides a framework for MTFs to implement and sustain a systematic Access plan to ensure that the access standards as specified in 32 CRF 199.17 are carried out. The policy refers the user back to the *MHS Guide to Access Success* of 2008 as a reference in standardizing roles, responsibilities, definitions, and guidance for implementing, sustaining, and managing access to care across Navy medicine. Primary care guidance within this policy is now superseded by later instruction related to the PCMH and the establishment of the Medical Home Port Program within Navy Medicine, BUMEDINST 6300.19.

Air Force Policies

Relevant Air Force policies focus on the timely access to appropriate care and patient safety. The goal is to build and sustain a culture of continuous process improvement within the MTF, with frequently monitoring to identify issues and resolve them quickly. Policy implementation requires a robust training for both new and existing staff. In addition, as with the other Services, external and internal inspection agencies conduct onsite inspections and patient interviews to validate the MTFs' ability to meet access standards.

Air Force Instruction (AFI) 44-176, *Access to Care Continuum*, 12 September 2011, is the leading Air Force ATC policy, and the culmination of several previously published access policy memoranda from 28 March 2001, ***Improving Appointing and Access Business Practices***, through 22 Feb 11, ***AFMS Access to Care Functions Guidance***. AFI Policy 44-176 defines the roles and responsibilities of headquarters, MTF commanders, and MTF staff in ensuring that 32 CFR, Section 199.17 ATC standards and the DHA ATC policy 11-005, ***TRICARE Policy for Access to Care*** are met. The AFI also incorporates the guidance from the Military Health System's ***Guide to Access Success,*** (December 2008). AFI directives and recommended guidance documents the following topics: appointing and schedule execution and management; enrollment empanelment levels; telephony metrics; maximizing use of TOL and AudioCare Appointment Reminder applications; specialty care and mental health access; nurse-run clinics; open/enhanced access strategies; appointing agent and group practice manager training; referral management; reserve component access to care; non-enrolled patient access to care; and actions when demand exceeds available appointments. The AFI requires MTFs to have processes in place to perform ongoing reviews of booked and unused appointments and effectiveness of the MTF's ATC program. Specific access, referral management, and telephony metrics are measured and reported to MTF leadership and higher headquarters. The AFI references and is consistent with AFI 44-171, PCMH, Family Health Operations, and other relevant Air Force policies. The Air Force Inspection Agency's inspection criteria include elements to ensure compliance with AFI 44-176.

Air Force Instruction (AFI) 44-171, *Patient Centered Medical Home and Family Health Operations*, 18 January 2011 defines and implements standards for Air Force Family Health Clinic business practices and supports to meet the PCMH goals of optimal patient-centered care for enrolled patients using evidence-based clinical practice grounded in established population health principles, patient and staff satisfaction, and continuous process improvement. AFI Policy 44-171 is consistent and aligns with DHA policy 09-015, ***Policy Memorandum Implementation of the Patient-Centered Medical Home Model of Primary Care in MTFs***. The AFI consolidates published policy memoranda on optimizing primary care and PCMH from 2004 to 2010. AFI Policy 44-171 defines specific roles and responsibilities of policy execution/accountability from AF/SG, intermediary commands, through the individual PCMH team members. The AFI outlines directives and recommended guidance on clinical, business, and deployment operations and identifies the following measures to be reported monthly: continuity of care with PCM; technician availability; available appointments/week; HEDIS measures; RVU productivity; patient satisfaction; use of purchased care emergency room/urgent primary care clinics; and the case mix index. The AFI recommends that the measures be reviewed with the clinic staff on a monthly basis and states that the AF Inspection Agency will inspect MTF compliance with policy criteria.

AFMS Referral Management Guide (1 May 2014). To increase patient satisfaction, meet specialty care access standards, and assist providers with obtaining specialty care referral results, the Air Force Medical Service (AFMS) published the first *AFMS Referral Management Guide* in 2003, establishing a Referral Management Center (RMC) at each MTF and standardized referral operations across the enterprise. To continuously improve the referral process, the business rules are reviewed and updated approximately every two years by multi-disciplinary stakeholders. The

guide is an inclusive reference for 32 C.F.R. § 199.17, MHS, and AFMS policies, TRICARE contractor roles and responsibilities in the referral process, and civilian accreditation requirements for care coordination and referral management. The guide includes standardized business rules, outlining the referral process from the time the referral is written to the time the referring provider is notified of the referral results scanned into the electronic health record. The RMC is charged with educating the patient about the referral process, booking the patient's MTF specialty care appointment before leaving the MTF, providing the referring provider/PCM with the initial and follow-up referral results, thus alleviating the provider and clinical team from the administrative burden of referral tracking, and facilitating recapture of MTF direct care capabilities in support of readiness, currency, and decreasing purchased care costs. The referral management business rules were added to the 2014 revision of AFI 44-176, *The Access to Care Continuum*, currently in formal coordination.

Defense Health Agency, National Capital Region Medical Directorate (NCR MD) Policies

The Joint Task Force for the National Capital Region (JTF CAPMED) was a transitional organization put in place to oversee the consolidation of the medical assets of the area. Policy for the operation of the NCR MD facilities was established as JTF CAPMED Policy. In 2013, JTF CAPMED was disestablished and replaced by the NCR MD as a directorate of the DHA. JTF CAPMED policies remain in effect until NCR MD generates newer policies. JTF CAPMED INST 6015.01 links directly to the 32 C.F.R. § 199.17 and establishes the referral management process, delineates responsibility for template management, and a number of other operational aspects of access to care. In addition, it utilizes the 2008 *MHS Guide to Access Success* as a core reference for best practices regarding access to care. NCR MD is currently revising this instruction under TASKORD 140612 01 NCR MD.

JTF CAPMED 6015.1, Appointing, Template, Demand and Referral Management, 03 January 2013. This policy establishes the Integrated Referral Management Appointing Center (IRMAC) as the authority to optimize appointing and Referral Management services for TRICARE beneficiaries in the NCR MD. It provides consolidated guidance to meet access standards, as well as instructions to maximize access through defined referral management processes, and the efficient use of patient appointing and template management at MTFs within the NCR MD. The instruction also delineates responsibilities for execution of the integrated referral and appointment management procedures at the JTF CAPMED Commander, IRMAC Director and Template Coordinator, Joint MTF Commander, and Center Directors levels respectively.

NCR MD Standard Operating Procedure For Appointing, Template, Demand, and Referral Management (Draft) establishes standard operating procedures within the Enhanced Multi Service Market, NCR.

Purchased Care Policies

This section outlines the policies for the purchased care component within the 50 United States and District of Columbia (US) and outside the United States (Overseas) (also called the TRICARE Overseas Program (TOP)).

TRICARE Policy Manual. The policy manual is written and maintained by the DHA. The manual provides a description of program benefits, adjudication guidance, policy interpretations, and decisions implementing the TRICARE Program.

TRICARE Operations Manual (TOM) Chapter 5, Section 1.Paragraphs 1.0 – 2.0. The TOM is written and maintained by the DHA. Chapter 5 directs the contractor to establish provider networks based on specific requirements and standards included in the chapter. Paragraph 2.2 notes that the access standards specified in reference 32 C.F.R. § 199.17 shall apply in each network area and that the contractor is responsible for developing and implementing a system for continuously monitoring and evaluating network adequacy.

TOM Chapter 6. This chapter of the TOM provides the contractor with specific instructions concerning enrollment of eligible beneficiaries in the TRICARE Prime program. Paragraph 9.0 details the access standards and provides guidance as to how travel times are to be calculated. Contractual access requirements for the Provider Network include the following:

- The Contractor shall ensure that the standards for access, in terms of beneficiary travel time, appointment wait time, and office wait time for various categories of services are met for beneficiaries residing in TRICARE Prime Service Areas (PSAs). These standards shall be met in a manner that achieves beneficiary satisfaction with access to network providers and services as set forth in the contract. The Contractor shall define metrics, and collect data about them, that give insight to the degree to which the access standards are being met.

- TOM 6010.56M, February 1, 2008, Chapter 5, Section 1, Paragraph 2.2: Each PSA is considered to be a separate service area to which access standards apply. The contractor shall develop and implement a system for continuously monitoring and evaluating network adequacy.

  The contractor shall establish provider networks for the delivery of Prime and Extra services to ensure that all access standards are met at the start of health care delivery and continuously maintained in all PSAs in the Region.

  The contractor shall adjust provider networks and services as necessary to compensate for changes in MTF capabilities and capacities, when and where they occur over the life of the contract, including those resulting from short-notice unanticipated facility expansion, MTF provider deployment, downsizing and/or closures. Changes in MTF capabilities and capacities may occur frequently over the life of the contract without prior notice. The Contractor shall ensure that all eligible beneficiaries who live in PSAs have the opportunity to enroll, add additional family members, or remain enrolled in the Prime program regardless

of such changes. The Contractor shall ensure that MTF enrollees residing outside PSAs have the opportunity to add additional family members or remain enrolled in the Prime program regardless of such changes.

Each TRICARE Regional Contractors is required to have a credentialed provider network. The West is accredited by the National Credentialing Quality Association; the North and South networks are accredited by URAC (formerly known as the Utilization Review Accreditation Commission). To receive this status, the TRICARE Regional Contractors must demonstrate access to the full range of providers and services, provider credentialing, and quality oversight as prescribed by these organizations. If certain government requirements are more stringent, the contractor is required to abide by the more stringent requirements.

The TRICARE Regional Contractors provide each TRO with region-specific Network Adequacy Reports monthly, comparing total unique providers contracted to the projected number of contracts required. When the report shows areas where there may be a shortage of contracted physicians, the TRICARE Regional Contractors examines network performance in the area to identify the precise effect of the shortage and work to identify and recruit additional providers as necessary.

The TRICARE Regional Contractors also submit monthly Network Inadequacy Reports, defined in the contract as any occurrence of a TRICARE Prime beneficiary being referred to a network provider outside of the time and/or distance standards (except when the beneficiary waives the access standard), or any beneficiary being referred to a non-network provider. The TRICARE Regional Contractors report "significant" network inadequacies to the Contracting Officer and/or designee within 48 hours of identification of the significant network inadequacy.

The TROs work with the TRICARE Regional Contractors to monitor and improve access to care through their Performance Management Review (PMR) meetings. They routinely monitor the 96 percent referrals to network, drive time, referrals to non-network providers, and satisfaction data for access to care. In the PMR, the TROs and TRICARE Regional Contractors routinely review appointment wait times, referral volume, and referral utilization, and take action as needed.

TRICARE policy requires beneficiaries to obtain a referral for urgent care clinic visits when their primary care manager (PCM) is unavailable.

Appendix 3.4
Summary of External Reviews Related to Access to Care

External Reviews

A 10-year retrospective review of DoD Inspector General (IG) and Government Accountability Office (GAO) reports identified 34 reports with potential relevance to access to care. Seven GAO reports issued between 2007 and 2014 were determined to be relevant, and all but one focused on access to purchased care primary care. None of the reports addressed the access standards required by 32CFR 199.17, and only one included recommendations for executive action.

The reports focused primarily on access to civilian providers for non-enrolled TRICARE Standard and Extra beneficiaries, a population for whom access standards are not defined by federal law. Each report is described below, with slightly more detail on the only one (GAO 14-384) that included recommendations.

GAO-07-941R TRICARE: Changes to Access Policies and Payment Rates for Services Provided by Civilian Obstetricians.

FINDINGS: Our finding that more than three-fourths of Prime Service Areas (PSAs) met their physician supply targets for all reported periods is an indicator that access was not likely a problem for most TRICARE beneficiaries seeking obstetric care. However, we could not be conclusive about access from the contractors' data alone because of other factors that can influence access. (No recommendations.)

GAO-13-205 DoD HEALTH CARE: Domestic Health Care for Female Service Members.

FINDINGS: This report describes 1) the extent that DoD's policies for assessing individual medical readiness including unique health care issues of female service members; 2) the availability of health care services to meet the unique needs of female service members at domestic Army installations; and 3) the extent to which DoD's research organizations have identified a need for research on the specific health care needs of female service members who have served in combat. (No recommendations.)

GAO-14-384 DEFENSE HEALTH CARE: More-Specific Guidance Needed for Assessing Non-enrolled TRICARE Beneficiaries' Access to Care.

FINDING: GAO found that the TROs' efforts to implement the action memo's recommendations have resulted in limited and inconsistent methods for identifying and addressing areas with potential access problems, which in some instances have included the use of judgment in place of clear criteria for making these determinations.

RECOMMENDATION: Secretary of Defense requires the Director of DHA to enhance existing guidance for the TROs to include more specificity on assessing non-enrolled beneficiaries'

access to care. Specifically, the guidance should contain criteria for analyzing and interpreting the non-enrolled beneficiary and civilian provider surveys' results and the beneficiary population sizing model to facilitate a more rigorous and consistent approach across regions for identifying locations with potential access problems and determining whether actions should be taken.

GAO-13-364 TRICARE Multilayer Surveys Indicate Problems with Access to Care for Non-enrolled Beneficiaries.

FINDINGS: Overall, during 2008-2011, an estimated one in three non-enrolled beneficiaries experienced problems finding any type of civilian provider—primary, specialty, or mental health care provider—who would accept TRICARE. Non-enrolled beneficiaries' satisfaction did not differ across types of areas, but was generally lower than that of Medicare fee-for-service beneficiaries. Civilian providers' acceptance of new TRICARE patients has decreased over time; mental health providers report lower awareness and acceptance than other provider types. Collective results of TMA's beneficiary and civilian provider surveys indicate specific geographic areas where non-enrolled beneficiaries have experienced access problems.

GAO-11-500 DEFENSE HEALTH Access to Civilian Providers under TRICARE Standard and Extra.

FINDINGS: Reimbursement rates have been cited as the primary impediment that hinders beneficiaries' access to civilian health care and mental health care providers under TRICARE Standard and Extra. Another main impediment to TRICARE beneficiaries' access to civilian providers is a shortage of certain provider specialties, both at the national and local levels. However, TMA is limited in its ability to address provider shortages because this impediment affects the entire health care delivery system and is not specific to the TRICARE program. Access to mental health care is a concern for all TRICARE beneficiaries, and it has been affected by provider shortages and other issues, including providers' lack of knowledge about combat-related issues, providers' concerns about reimbursement rates, and providers' lack of awareness about TRICARE. TMA and its contractors have used various feedback mechanisms, such as surveys, to gauge beneficiaries' access to care under TRICARE Standard and Extra. More recently, TMA officials have taken steps to develop a model to help identify geographic areas where beneficiaries that use TRICARE Standard and Extra may experience access problems. However, because this initiative is still evolving, it is too early to determine its effectiveness.

GAO-10-402 DEFENSE HEALTH CARE 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans.

FINDINGS: DoD's implementation of beneficiary and provider surveys for 2008 followed the Office of Management and Budget survey standards and generally addressed the survey requirements outlined in the NDAA. In general beneficiaries rated their satisfaction similarly to users of other health plans. Survey results from 2008 indicate that a higher percentage of non-enrolled beneficiaries in PSAs experienced problems accessing care from primary care physicians or nurses than those in non-PSAs. Non-enrolled beneficiaries in PSAs and non-PSAs surveyed in 2008 rated satisfaction with their health care similarly to each other and to

beneficiaries of commercial health care plans. These provider survey results are not representative of all providers in surveyed areas but provide limited information that indicates differences among providers' awareness and acceptance of TRICARE.

GAO-07-48 Access to Care for Beneficiaries who have not enrolled in TRICARE's Managed Care Option.

FINDING: TMA's surveys to network and non-network civilian providers on their willingness to accept non-enrolled TRICARE patients and beneficiary satisfaction with access to care met the NDAA directive. GAO stated that DoD did not designate a senior official to have oversight responsibility as required in the NDAA. TMA disagreed with meeting the directive to designate a senior official to oversee non-enrolled TRICARE beneficiaries' access to care.

Appendix 3.5
Access to Care Education Courses

Access improvement seminars provide training to managers on the most up-to-date information on access policy, access data analysis, PCMH operations, secure messaging, performance measurements, demand management, population/empanelment management, appointing and schedule management, appointing information systems and telephony management, customer service management, referral management, and general process improvement techniques. The courses include:

CHCS Managed Care Program Course: Appointment Booking Fundamentals (2 hours). This course trains all CHCS users who book appointments on the booking process for primary care clinics and referrals in specialty clinics. Emphasis is given to the proper use of access to care standards linked to appropriate appointment types.

CHCS Patient Appointing Services (PAS): Schedule Creation and Maintenance (2 hours). This VC course trains lead clerks and super-users to create provider schedules for later use in patient appointment booking. Students learn on how to create, open, replicate, and print provider schedules. The course also focuses on steps used to maintain/modify provider schedules. Students learn how to change providers in a schedule, freeze and release schedules, add appointments to the wait list, cancel appointments by facility, and modify, add, and delete appointments in a schedule.

CHCS PAS: Template Creation (2 hours). This VC course trains designated PAS users to create, replicate, print, and delete daily and weekly provider templates for later use in developing clinic schedules.

CHCS PAS/Monthly Capitation Payment: Front Desk Functions (2 hours). This course instructs front desk clerks to complete specified clinic functions through both AHLTA and legacy CHCS. Students learn to process unscheduled visits (walk-in, sick-call, and telephone consultations), and how to check-in individual and multiple patients, cancel and display patient appointments, and perform end-of-day (EOD) processing.

CHCS PAS/MCP: Advanced Front Desk Functions (1.5 hours). This VC course ensures that PAS/MCP clerks, clerk supervisors, and super users are able to effectively join/split appointment slots, log non-MTF appointments, cancel/reschedule appointments, enter an appointment refusal, and locate, and print PAS/MCP reports.

CHCS PAS/MCP: Consult Tracking Process (1.5 hours). This course follows the flow of consult tracking when using both AHLTA and CHCS, and includes ordering, reviewing and booking a consult, patient check-in, resulting and closing a consult. Students learn how to view consults in progress in both AHLTA and CHCS, and review T-cons as entered from AHLTA. This course is intended for multiple types of users consults: providers who enter consult orders in AHLTA, referral management department staff who use CHCS) to review and book consult

orders, medical personnel who check in consult order appointments in AHLTA, and specialty providers who enter the patient encounter results in AHLTA.

CHCS PAS/MCP: Notify Patients Menu (1 hour). This course addresses three clinic lists that are associated with changes/issues regarding a patient's clinic appointment: cancellation list, no-show list, and the wait list. Site personnel who notify patients of changes/issues related to their clinic appointments learn to notify patients by telephone or mailer when an appointment is cancelled (by facility, division, or clinic), rescheduled, or when an appointment was not kept. Notification of the patient prior to booking an appointment from the clinic's wait list is also covered.

Army Basic Healthcare Administration Course (Phase 1&2) (60 hours). This course prepares clinic management professionals on the basic concepts, principles, and applications of health administration in MTFs. Training includes information on PCMH, data quality management control, CHCS, Armed Forces Health Longitudinal Technology Application (AHLTA), Medical Expense and Performance Reporting System, Defense Medical Human Resources System internet, Performance-Based Adjustment Mode, Army Provider-Level Satisfaction Survey, leadership, teamwork, change management, customer service, health care continuing education, and strategic and performance (business) planning. Implemented in March 2011, 4 instructors trained 1,359 individuals (U.S. Army Medical Department (AMEDD) active Army officers, non-commissioned officers, and Department of the Army civilians) between FY 2011 and FY 2013. Trainees' job roles included: Health System Administrator, Health System Specialist, Medical Records Administrator, Medical Records Technician, Medical Support Assistant, Miscellaneous Administration and Program (Medical), and Miscellaneous Clerk and Assistant (Medical).

Navy Clinic Management Course (32 hours). This 4-day course targets primary and specialty clinic teams to advance their expertise in the skills, knowledge, and tools necessary to successfully integrate the MHS and the Navy's Bureau of Medicine and Surgery' strategic goals into their daily practices as an accountable care organization in a variety of health care settings. Teams of 3-4 members are nominated to represent clinic teams for each class. Parent commands identify the clinics of focus for improvement efforts and identify members of that clinic team to attend the course. Updated in 2010, 3 traveling staff trained 823 individuals (O, E, GS, and contract) between FY 2011 and FY 2013.

Air Force Medical Service (AFMS) Appointing Information Systems Hands-on Training Course (23.4 hours). The course provides students with the detailed know-how on various appointing functions, operations, and management utilizing the Composite Health Care Systems (CHCS). Comprehensive training is provided combining MHS/AFMS policy and correct CHCS templates, schedules, and file and table building. Taught over a 4-day period, the course provides hands-on training, lectures, and practical exercises arming students with knowledge to make improvements in MTF appointing operations and to improve access at their MTF. Instruction on data analysis and report review teaches the most efficient approaches to finding, extracting, printing, and analyzing provider schedules/patient appointment data within CHCS, AFMS, and MHS data. Implemented in 2006, the course's three instructors trained 141

individuals (officer (O), enlisted (E), general schedule (GS), and contract) between FY 2011 and FY 2013.

AFMS Access Improvement Seminar (18.4 hours). This course provides access managers with instruction on the most up-to-date information in the areas of access policy, access data analysis, PCMH operations, secure messaging, access performance measurements, demand management, population/empanelment management, appointing and schedule management, appointing information systems and telephony management, customer service management, referral management, and general process improvement techniques. Implemented in 2003, the course's 12 instructors trained 795 individuals (O, E, GS, and contract) between FY 2011 and FY 2013. Trainees had the following job roles: group practice managers (GPM), assistant GPMs, selected enlisted, chief of the medical staff, medical operations and support squadron commanders, clinic nurses, PCMH physicians/providers, template managers, appointment center supervisors, family health/primary care element leaders & non-commissioned officers in charge, and any other clinic staff involved in appointing management.

AFMS Group Practice Management Course (40 hours). This course provides training for those personnel being assigned to group practice manager (GPM) positions. Emphasis is placed on the skills required to prepare the health services administrator to effectively manage and support the assigned clinics to ensure that beneficiaries receive access to medical care within standards. The curriculum consists of practice management concepts, including and responsibilities, population health overview, data management, templating/scheduling skills in MHS appointing information systems, and training for electronic hands-on web-based tools. Implemented in 2011, 1 instructor trained 161 individuals (O, E, and GS) between FY 2011 and FY 2013. Trainees' job roles included: officers and GS-equivalents currently assigned or pending assignment to a GPM position, enlisted members filling the role of GPM, assistant, office manager, or similar role requiring knowledge of GPM practices.

Appendix 3.6
Access to Care Standards

A review of the access to care literature revealed no national benchmarks or scientific evidence to support appointment scheduling standards for three general appointment types: urgent (acute) care, routine care, and specialty care referrals, although some private providers have established standards based on patient perception of reasonable access.[2] Table 3.6-1 compares MHS with 16 health care providers in terms of acute, routine, and specialty care standards.

Table 3.6-1 Comparison of MHS Access Standards with those of Other Health Care Providers

PLAN	Urgent/ Acute Care (Within X Hours)	Routine Care (Within X Days)	Specialty Care Referrals (Within X Days)
MHS (Military Health System)	24	7 calendar	28 calendar
Aetna Plans	24	7 (assume calendar)	(open access)
Anthem Blue Cross (CA)	24	10 business (12 calendar)	15 business (21 calendar)
Blue Cross-Blue Shield (MI)	48	4 calendar	n/a
Blue Cross-Blue Shield (NC)	24	3 calendar	14 calendar
Boston HealthNet Plan (MA)	48	10 (assume calendar)	30 (assume calendar)
Care1st Health Plan (CA)	48	10 business (12 calendar)	15 calendar
Community Health Plan (WA)	24	7 calendar	n/a
Coventry Health Care (WV)	48	3 calendar	n/a
Dept. of Managed Care (CA)	48	10 business (14 calendar)	15 business (21 calendar)
Emblem Health (NY)	24	28 (assume calendar)	28 calendar
Humana ChoiceCare PPO	24	7-14 calendar	21 business (26 calendar)
Independence Blue Cross (PA)	24	14 (assume calendar)	28 calendar
Managed Health Services (WI)	24	7 calendar	60 calendar
MVP Health Care (NY)	24	3 calendar	28 – 42 calendar
Preferred IPA (CA)	24	7 calendar	14 calendar
UnitedHealthcare	24	14 (assume calendar)	n/a

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Source: Multiple Sources

[2] Health plan members' experiences: percentage of adult health plan members who reported how often it was easy to get needed care. 2013 September. National Quality Measures Clearinghouse: 009073 National Committee for Quality Assurance - Health Care Accreditation Organization. Available at: http://www.qualitymeasures.ahrq.gov/browse/by-topic-detail.aspx?id=40307&ct=3&term=access.

Appendix 3.7 MTF-Level Access Data

Table 3.7-1 All Measure Results, by Facility

Facility Information						Time to Appointment							TOL	Satisfaction				
						% Meeting Standard		Days to Appointment		Days to Third Next Appointment				Getting needed care			HCSDB	
										PriCare								
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]	% TOL enabled	Svc	TROSS	ATC (TROSS)	Get Care Quickly	Get Needed Care
0001	FOX ARMY HEALTH CENTER	Army	Clinic	1	11,561	98%	93%	0.36	11.35	1.0	4.6	18.6	82%	82%	76%	65%	75.9	87.6
0003	LYSTER AHC	Army	Clinic	1	17,469	98%	93%	0.24	12.90	0.7	5.0	10.4	88%	90%	76%	64%	80.1	83.8
0004	42ND MEDICAL GROUP	Air Force	Clinic	1	15,832	97%	97%	0.47	9.86	3.1	6.1	9.1	66%	94%	58%	54%	74.7	74.7
0005	BASSETT ACH	Army	Hospital	5	24,439	96%	95%	0.39	11.48	2.0	5.4	11.5	62%	84%	68%	56%	n/a	n/a
0006	673rd MEDICAL GROUP	Air Force	Hospital	2	36,887	92%	92%	0.62	13.43	1.3	6.8	13.4	66%	97%	74%	58%	75.1	75.2
0008	R W BLISS ARMY HEALTH CENTER	Army	Clinic	1	12,503	94%	97%	0.91	9.26	2.9	7.6	9.8	83%	83%	81%	61%	75.6	74.2

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0009	56th MEDICAL GROUP	Air Force	Clinic	1	26,650	98%	96%	0.25	12.38	0.9	5.0	14.1	76%	98%	82%	66%	73.9	84.4
0010	355th MEDICAL GROUP	Air Force	Clinic	1	21,244	87%	95%	0.79	12.12	2.9	9.1	10.8	76%	96%	81%	58%	84.1	80.6
0013	19th MEDICAL GROUP-LITTLE ROCK	Air Force	Clinic	1	14,168	97%	96%	0.39	10.64	1.2	5.8	15.7	82%	96%	62%	51%	67.1	76.6
0014	60th MEDICAL GROUP	Air Force	Medical Center	3	38,832	89%	94%	1.08	12.76	5.6	9.6	14.5	64%	95%	67%	54%	64.5	76.9
0015	9th MEDICAL GROUP	Air Force	Clinic	1	9,918	95%	99%	0.42	7.90	1.9	5.0	10.5	65%	94%	64%	45%	n/a	n/a
0018	30th MEDICAL GROUP	Air Force	Clinic	1	7,796	95%	97%	0.49	9.37	1.4	5.3	14.6	68%	96%	75%	62%	75	78.6
0019	412th MEDICAL GROUP	Air Force	Clinic	1	7,193	97%	98%	0.34	8.47	1.3	4.2	11.4	77%	95%	79%	64%	63.7	78.9

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0024	NH CAMP PENDLETON	Navy	Hospital	12	57,873	94%	96%	0.72	12.36	0.8	4.4	10.8	56%	93%	65%	58%	74.8	79.6
0028	NH LEMOORE	Navy	Hospital	2	13,782	93%	97%	0.66	12.50	0.9	2.9	10.9	51%	96%	68%	64%	83.1	n/a
0029	NMC SAN DIEGO	Navy	Medical Center	12	95,047	93%	91%	0.79	13.16	1.2	6.4	15.5	28%	94%	71%	55%	76	84.3
0030	NH TWENTYNINE PALMS	Navy	Hospital	3	13,864	98%	96%	0.32	12.04	1.0	3.1	8.7	31%	96%	72%	65%	n/a	84.9
0032	EVANS ACH	Army	Hospital	14	70,934	97%	96%	0.28	11.72	1.5	3.7	12.8	55%	80%	70%	62%	78.4	80.8
0033	10TH MEDICAL GROUP	Air Force	Clinic	1	28,556	96%	96%	0.47	13.34	1.3	4.1	11.1	65%	99%	78%	65%	70.1	85.9
0036	436th MEDICAL GROUP	Air Force	Clinic	1	11,597	97%	95%	0.42	13.38	1.5	7.1	12.8	81%	95%	66%	56%	n/a	n/a
0038	NH PENSACOLA	Navy	Hospital	11	52,304	96%	96%	0.49	9.36	0.7	3.2	9.0	69%	96%	80%	70%	78.3	86.3

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0039	NH JACKSONVILLE	Navy	Hospital	6	59,539	94%	96%	0.81	10.09	0.9	3.9	11.9	68%	93%	69%	60%	80.2	76.9
0042	96th MEDICAL GROUP	Air Force	Hospital	2	36,861	93%	92%	0.67	14.14	1.7	9.1	14.6	75%	95%	69%	58%	59.1	70.3
0043	325th MEDICAL GROUP	Air Force	Clinic	1	13,200	99%	87%	0.30	16.90	1.0	9.7	11.4	74%	93%	78%	66%	72.9	78.4
0045	6th MEDICAL GROUP	Air Force	Clinic	2	38,007	95%	93%	0.55	13.63	2.7	5.3	12.8	66%	98%	75%	66%	72.2	79.9
0046	45th MEDICAL GROUP	Air Force	Clinic	1	14,592	95%	96%	0.44	9.67	1.4	11.9	10.5	82%	96%	78%	72%	79.3	74.1
0047	EISENHOWER AMC	Army	Medical Center	6	44,883	98%	95%	0.32	10.41	0.8	3.3	10.9	73%	83%	72%	62%	82.6	75.9
0048	MARTIN ACH	Army	Hospital	11	53,856	92%	95%	0.79	9.79	1.4	7.5	7.4	72%	81%	66%	54%	n/a	n/a
0049	WINN ACH	Army	Hospital	5	60,846	95%	93%	0.68	12.78	1.5	8.0	12.7	64%	78%	61%	59%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0050	23rd MEDICAL GROUP	Air Force	Clinic	1	10,398	96%	95%	0.28	9.56	1.1	6.5	9.2	91%	98%	72%	56%	n/a	n/a
0051	78th MEDICAL GROUP	Air Force	Clinic	1	15,318	97%	96%	0.31	8.47	2.0	4.6	6.6	53%	95%	76%	71%	75.7	88.2
0052	TRIPLER AMC	Army	Medical Center	4	67,200	92%	94%	0.90	12.28	2.0	4.8	11.8	55%	83%	68%	61%	85.3	82.9
0053	366th MEDICAL GROUP	Air Force	Hospital	1	10,134	97%	97%	0.32	12.19	2.2	6.5	15.3	84%	93%	73%	62%	79.5	88.8
0055	375th MEDICAL GROUP	Air Force	Clinic	2	24,141	97%	96%	0.45	12.92	1.5	5.0	15.6	71%	97%	75%	59%	81.8	80.6
0057	IRWIN ACH	Army	Hospital	8	41,779	82%	96%	2.31	11.06	2.6	5.3	10.5	81%	82%	68%	65%	88.9	77.7
0058	MUNSON ARMY HEALTH CENTER	Army	Clinic	3	16,963	99%	96%	0.21	11.96	0.7	3.0	12.8	82%	91%	81%	72%	81.6	79.9
0059	22nd MEDICAL GROUP	Air Force	Clinic	1	11,622	96%	93%	0.48	10.20	2.1	5.2	11.5	89%	96%	81%	65%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0060	BLANCHFIELD ACH	Army	Hospital	11	72,709	97%	93%	0.31	12.60	1.9	5.3	10.7	43%	82%	68%	59%	57.9	78.4
0061	IRELAND ACH	Army	Hospital	6	31,436	96%	92%	0.37	14.66	0.9	7.4	13.4	72%	81%	71%	62%	76.3	67.3
0062	2nd MEDICAL GROUP	Air Force	Clinic	1	16,899	96%	96%	0.46	11.58	1.6	4.5	14.7	85%	94%	73%	60%	71.9	77.9
0064	BAYNE-JONES ACH	Army	Hospital	6	23,225	98%	97%	0.32	11.49	1.3	5.4	12.3	72%	86%	70%	63%	80.2	73.3
0066	779th MEDICAL GROUP	Air Force	Clinic	3	28,672	93%	87%	0.70	15.25	2.3	6.6	19.9	68%	92%	74%	61%	71.4	72
0067	WALTER REED NATIONAL MILITARY MEDICAL CNTR	NCR	Medical Center	4	40,211	73%	87%	2.53	14.53	3.1	9.7	16.0	44%	88%	69%	61%	67	64.7
0068	NHC PATUXENT RIVER	Navy	Clinic	4	14,898	92%	92%	0.59	11.48	1.0	9.5	11.2	0%	96%	70%	59%	71.3	72.4

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0069	KIMBROUGH AMBULATORY CARE CENTER	Army	Clinic	10	59,676	89%	90%	0.63	13.06	1.9	5.5	15.1	77%	86%	69%	60%	75.7	71.1
0073	81st MEDICAL GROUP	Air Force	Medical Center	1	25,880	95%	93%	0.61	14.58	5.5	7.1	14.8	56%	97%	75%	59%	72.2	79.7
0074	14th MEDICAL GROUP	Air Force	Clinic	1	3,944	91%	99%	1.09	9.38	0.7	6.4	11.1	66%	96%	77%	64%	77.7	87.3
0075	L. WOOD ACH	Army	Hospital	3	23,148	82%	96%	2.20	10.73	1.6	4.4	9.9	66%	85%	69%	60%	74.5	74.6
0076	509th MEDICAL GROUP	Air Force	Clinic	1	12,107	98%	95%	0.22	11.41	1.1	10.8	16.7	76%	92%	74%	58%	66.9	76.6
0077	341st MEDICAL GROUP	Air Force	Clinic	1	9,829	97%	96%	0.54	10.91	2.7	9.6	9.6	84%	97%	66%	63%	67.6	73
0078	55th MEDICAL GROUP	Air Force	Clinic	1	27,115	97%	95%	0.39	11.75	1.7	5.3	11.3	91%	97%	70%	58%	77.1	75.3

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0079	MIKE O'CALLAGHAN FEDERAL HOSPITAL	Air Force	Medical Center	2	48,894	88%	91%	1.20	14.42	4.5	12.5	15.9	52%	98%	67%	55%	69.7	73.6
0083	377th MEDICAL GROUP	Air Force	Clinic	1	12,342	97%	94%	0.30	12.24	1.2	3.5	7.5	72%	93%	83%	63%	72.1	76.8
0084	49th MEDICAL GROUP	Air Force	Clinic	1	10,168	97%	97%	0.27	10.74	1.6	7.2	4.1	72%	97%	64%	50%	n/a	n/a
0085	27th SPECIAL OPERATIONS MEDICAL GROUP	Air Force	Clinic	1	11,104	94%	91%	0.38	15.24	2.0	9.5	27.2	76%	97%	66%	53%	n/a	n/a
0086	KELLER ACH	Army	Hospital	7	13,033	93%	94%	0.72	12.30	2.0	5.5	12.3	64%	89%	76%	75%	n/a	n/a
0089	WOMACK AMC	Army	Medical Center	13	124,077	94%	93%	0.81	11.68	1.1	4.7	15.4	78%	76%	63%	59%	67.9	72.8
0090	4th MEDICAL GROUP	Air Force	Clinic	1	10,521	97%	94%	0.14	10.02	2.1	4.6	6.3	66%	95%	72%	60%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0091	NH CAMP LEJEUNE	Navy	Hospital	8	36,615	91%	93%	0.64	10.67	1.3	7.3	14.4	43%	92%	72%	67%	73	62.5
0092	NHC CHERRY POINT	Navy	Clinic	1	21,669	99%	96%	0.24	9.81	0.8	2.8	8.6	64%	93%	73%	64%	70.9	74
0093	319th MEDICAL GROUP	Air Force	Clinic	1	5,053	93%	96%	0.44	9.12	2.6	6.5	19.3	16%	97%	80%	75%	n/a	n/a
0094	5th MEDICAL GROUP	Air Force	Clinic	1	12,813	92%	96%	0.60	12.23	1.6	6.6	17.0	94%	98%	81%	69%	68.3	89.2
0095	88th MEDICAL GROUP	Air Force	Medical Center	1	37,403	95%	90%	0.55	14.52	3.3	9.7	16.9	86%	97%	76%	65%	76.3	73
0096	72nd MEDICAL GROUP	Air Force	Clinic	1	18,523	85%	96%	1.05	10.86	3.2	11.5	13.4	39%	96%	73%	39%	63.9	75.3
0097	97th MEDICAL GROUP	Air Force	Clinic	1	4,598	88%	89%	0.62	12.00	1.2	4.8	11.2	80%	99%	87%	74%	n/a	n/a
0098	REYNOLDS ACH	Army	Hospital	4	30,414	93%	95%	0.61	11.31	2.3	5.9	11.7	87%	84%	68%	58%	75.5	86.3

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0100	NAVAL HLTH CLINIC NEW ENGLAND	Navy	Clinic	4	26,545	96%	96%	0.38	8.21	0.7	4.9	6.5	45%	95%	73%	61%	84.1	78.1
0101	20th MEDICAL GROUP	Air Force	Clinic	1	13,682	94%	97%	0.50	9.80	2.1	6.2	13.1	69%	91%	76%	63%	71.1	71
0103	NAVAL HEALTH CLINIC CHARLESTON	Navy	Clinic	1	15,669	97%	95%	0.37	9.95	0.9	1.7	13.7	52%	94%	78%	66%	75.1	84.7
0104	NH BEAUFORT	Navy	Hospital	3	10,960	97%	98%	0.44	6.95	1.1	2.8	7.3	42%	96%	85%	72%	69.2	89.2
0105	MONCRIEF ACH	Army	Hospital	4	25,058	92%	96%	0.80	11.19	1.7	4.7	14.5	79%	84%	71%	69%	75	87.2
0106	28th MEDICAL GROUP	Air Force	Clinic	1	10,985	99%	98%	0.18	10.22	0.8	2.5	9.8	76%	95%	83%	76%	n/a	n/a
0108	WILLIAM BEAUMONT AMC	Army	Medical Center	8	73,245	94%	94%	0.65	12.47	4.1	3.4	12.0	74%	82%	67%	65%	61.1	59.8

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0109	BROOKE AMC-SAN ANTONIO MMC JBSA FSH	Army	Medical Center	6	56,862	96%	92%	0.45	14.08	2.0	7.5	10.8	83%	85%	69%	60%	76.7	88.5
0110	DARNALL AMC	Army	Medical Center	14	100,277	55%	94%	5.83	12.27	4.1	8.7	13.7	87%	77%	61%	60%	55.7	64
0112	7th MEDICAL GROUP	Air Force	Clinic	1	10,419	96%	98%	0.29	7.41	3.2	5.5	9.4	58%	95%	64%	50%	75.1	79.6
0113	82nd MEDICAL GROUP	Air Force	Clinic	1	9,675	92%	96%	1.04	10.06	2.5	4.5	7.6	54%	99%	66%	50%	75.4	75.9
0114	47th MEDICAL GROUP	Air Force	Clinic	1	3,643	96%	91%	0.37	10.35	1.0	3.7	16.1	51%	98%	79%	62%	n/a	75.8
0117	59th MEDICAL WING	Air Force	Medical Center	3	55,339	96%	93%	0.39	13.60	1.6	5.3	14.6	80%	98%	69%	60%	68.6	80.1
0118	NHC CORPUS CHRISTI	Navy	Clinic	3	12,956	86%	94%	0.67	9.57	1.0	4.8	10.5	27%	92%	77%	60%	66.8	67

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0119	75th MEDICAL GROUP	Air Force	Clinic	1	17,292	98%	97%	0.38	8.50	1.6	5.3	10.1	81%	97%	74%	66%	74.2	69.8
0120	633rd MEDICAL GROUP	Air Force	Hospital	1	37,735	86%	90%	1.37	15.44	5.5	9.2	17.3	82%	96%	60%	51%	59.7	87
0121	MCDONALD ARMY HEALTH CENTER	Army	Clinic	4	26,151	95%	92%	0.49	14.26	1.1	3.3	16.8	76%	86%	73%	61%	63.1	67
0122	KENNER AHC	Army	Clinic	4	21,058	94%	95%	0.60	12.53	1.0	7.2	8.5	72%	80%	66%	61%	71.2	78.5
0123	FORT BELVOIR COMMUNITY HOSPITAL	NCR	Hospital	3	78,983	87%	89%	1.40	14.92	2.0	8.5	17.5	59%	80%	64%	58%	58.6	58.2
0124	NMC PORTSMOUTH	Navy	Medical Center	10	104,151	93%	91%	1.32	14.46	1.0	9.2	15.9	42%	92%	68%	64%	70.9	66.7
0125	MADIGAN AMC	Army	Medical Center	15	118,070	94%	92%	0.70	13.72	2.1	6.0	16.1	63%	81%	68%	53%	71.4	56.6

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0126	NH BREMERTON	Navy	Hospital	4	34,272	96%	95%	0.77	12.43	0.7	4.1	11.8	67%	94%	72%	61%	82.4	78.9
0127	NH OAK HARBOR	Navy	Hospital	1	14,481	97%	93%	0.32	11.80	0.4	3.6	10.8	63%	96%	78%	72%	77.7	72.7
0128	92nd MEDICAL GROUP	Air Force	Clinic	1	10,912	99%	98%	0.44	9.12	1.4	4.5	6.9	57%	97%	78%	73%	85.6	74
0129	90th MEDICAL GROUP	Air Force	Clinic	1	8,755	95%	96%	0.35	13.59	1.4	8.3	15.6	60%	93%	75%	68%	73.1	n/a
0131	WEED ACH	Army	Hospital	6	10,413	98%	95%	0.46	13.72	1.2	2.5	11.0	86%	77%	65%	58%	66.8	72
0203	354th MEDICAL GROUP	Air Force	Clinic	1	5,575	96%	98%	0.29	11.64	2.3	5.6	8.7	68%	94%	76%	63%	n/a	n/a
0248	61st MEDICAL GROUP	Air Force	Clinic	2	7,695	99%	97%	0.21	11.97	0.8	4.1	17.2	88%	97%	65%	44%	71.8	64.6
0252	21st MEDICAL GROUP	Air Force	Clinic	2	26,632	97%	98%	0.41	10.76	1.6	8.4	13.7	53%	97%	72%	65%	70.1	70

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0280	NHC HAWAII	Navy	Clinic	5	29,857	63%	98%	8.16	9.00	0.8	3.3	12.4	38%	94%	75%	67%	79	81.4
0287	15th MEDICAL GROUP	Air Force	Clinic	1	14,394	95%	94%	0.52	13.53	1.3	7.5	10.6	68%	93%	76%	57%	n/a	n/a
0306	NHC ANNAPOLIS	Navy	Clinic	6	12,593	95%	98%	0.44	6.49	1.0	3.8	5.8	35%	95%	79%	76%	74.5	86.9
0310	66th MEDICAL GROUP	Air Force	Clinic	1	5,808	96%	87%	0.26	9.32	2.1	5.1	8.3	88%	96%	69%	61%	74.7	78
0326	87th MEDICAL GROUP	Air Force	Clinic	1	17,453	96%	95%	0.44	11.87	1.4	9.3	14.4	84%	95%	64%	44%	n/a	n/a
0330	GUTHRIE AHC	Army	Clinic	7	32,569	98%	93%	0.31	14.39	1.6	4.8	10.4	79%	81%	67%	61%	n/a	n/a
0338	71st MEDICAL GROUP	Air Force	Clinic	1	4,042	91%	94%	0.44	12.40	3.8	2.9	13.6	78%	96%	81%	67%	n/a	n/a
0356	628th MEDICAL GROUP	Air Force	Clinic	1	12,242	97%	96%	0.42	10.29	2.0	4.4	7.8	77%	97%	76%	51%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0364	17th MEDICAL GROUP	Air Force	Clinic	1	8,959	98%	92%	0.37	13.51	1.9	6.5	10.2	84%	98%	80%	56%	82.1	82.4
0366	359th MEDICAL GROUP	Air Force	Clinic	1	24,365	95%	97%	0.62	11.64	1.6	6.0	7.4	90%	93%	81%	63%	69.9	72.4
0385	NHC QUANTICO	Navy	Clinic	5	19,973	83%	90%	1.00	10.13	0.9	3.3	11.0	0%	95%	65%	49%	65.6	59.7
0395	62nd MEDICAL SQUADRON	Air Force	Clinic	1	3,925	98%	97%	0.29	10.28	1.2	4.1	12.6	21%	87%	54%	40%	n/a	n/a
0413	579TH MEDICAL GROUP	Air Force	Clinic	1	8,646	90%	94%	0.61	8.57	2.2	6.5	10.0	79%	96%	63%	49%	n/a	n/a
0607	LANDSTUHL REGIONAL MEDCEN	Army	Medical Center	12	50,495	95%	93%	0.46	12.11	1.2	7.6	11.4	84%	80%	70%	73%	73	69.1
0609	BAVARIA MEDDAC	Army	Clinic	8	29,164	97%	96%	0.25	7.68	1.3	4.6	9.8	87%	88%	77%	73%	61.9	67.3

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0610	BG CRAWFORD F. SAMS USAHC-CAMP ZAMA	Army	Clinic	1	2,064	99%	96%	0.21	11.14	0.7	4.4	10.4	97%	92%	83%	78%	n/a	n/a
0612	BRIAN ALLGOOD ACH	Army	Hospital	8	32,920	96%	95%	0.38	13.50	1.4	6.0	14.4	69%	77%	77%	57%	n/a	n/a
0615	NH GUANTANAMO BAY	Navy	Hospital	1	2,800	64%	97%	4.27	8.56	0.6	7.9	6.9	0%	93%	72%	85%	n/a	n/a
0617	NH NAPLES	Navy	Hospital	2	5,221	93%	96%	0.96	9.91	0.6	3.5	10.8	67%	95%	78%	72%	n/a	n/a
0618	NH ROTA	Navy	Hospital	1	2,606	92%	98%	1.08	8.81	0.7	0.7	6.2	70%	95%	88%	79%	n/a	n/a
0620	NH GUAM	Navy	Hospital	2	13,547	96%	96%	0.47	12.64	0.9	5.3	10.2	58%	95%	78%	73%	79.7	74.9
0621	NH OKINAWA	Navy	Hospital	9	32,075	95%	95%	0.43	11.55	0.8	4.4	10.3	53%	92%	71%	56%	80.5	71.6
0622	NH YOKOSUKA	Navy	Hospital	9	30,696	98%	97%	0.31	11.07	0.8	2.8	9.6	58%	95%	76%	69%	79.9	71.7
0624	NH SIGONELLA	Navy	Hospital	3	8,760	97%	98%	0.29	8.60	0.8	2.0	7.9	40%	95%	84%	71%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0629	65th MEDICAL GROUP	Air Force	Clinic	1	1,217	95%	97%	0.37	7.33	0.9	4.3	6.8	91%	99%	74%	80%	n/a	n/a
0633	48th MEDICAL GROUP	Air Force	Hospital	1	18,141	91%	94%	0.69	14.47	2.1	6.6	17.7	81%	95%	73%	66%	71.5	76.6
0635	39th MEDICAL GROUP	Air Force	Clinic	1	2,279	87%	94%	1.01	9.82	1.4	6.5	7.9	52%	97%	84%	72%	n/a	n/a
0637	8th MEDICAL GROUP	Air Force	Clinic	1	2,327	98%	97%	0.32	8.96	3.6	4.5	7.5	26%	No Data	70%	63%	n/a	n/a
0638	51st MEDICAL GROUP	Air Force	Hospital	1	7,639	97%	96%	0.47	11.06	1.7	7.2	14.2	88%	92%	67%	56%	71.6	n/a
0639	35th MEDICAL GROUP	Air Force	Hospital	1	7,171	60%	93%	6.82	12.46	2.5	5.2	10.5	65%	93%	69%	65%	n/a	n/a
0640	374th MEDICAL GROUP	Air Force	Hospital	1	7,017	90%	94%	0.60	13.24	3.0	9.1	13.1	82%	94%	76%	67%	83.3	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0653	422 ABS MEDICAL FLIGHT	Air Force	Limited Scope MTF	1	1,017	97%	98%	0.43	10.79	3.0	6.0	21.2	96%	93%	80%	73%	n/a	n/a
0799	470 MEDICAL FLIGHT	Air Force	Limited Scope MTF	1	2,291	97%	94%	0.31	12.39	1.0	4.3	ND	87%	97%	89%	66%	n/a	n/a
0802	36th MEDICAL GROUP	Air Force	Clinic	1	5,975	94%	96%	0.52	12.38	2.3	7.7	13.6	87%	93%	77%	53%	n/a	n/a
0804	18th MEDICAL GROUP	Air Force	Clinic	1	16,081	98%	97%	0.20	13.42	2.2	6.8	14.7	69%	94%	64%	63%	58.4	70.7
0805	52nd MEDICAL GROUP	Air Force	Clinic	1	7,584	97%	82%	0.37	18.01	1.0	4.4	14.4	76%	93%	81%	63%	77.3	86
0806	86th MEDICAL GROUP	Air Force	Clinic	1	19,878	96%	95%	0.46	12.86	1.9	6.2	17.0	66%	95%	78%	61%	78.6	77.1
0808	31st MEDICAL GROUP	Air Force	Hospital	1	7,262	97%	95%	0.42	11.90	1.0	5.5	16.7	76%	95%	78%	72%	n/a	n/a

Facility Information						Time to Appointment							TOL	Satisfaction				
DMIS ID	Facility Name	Service	Facility Type	MTFs	Enrolled	% Meeting Standard		Days to Appointment		Days to Third Next Appointment			% TOL enabled	Getting needed care		ATC (TROSS)	HCSDB	
										PriCare				Svc	TROSS		Get Care Quickly	Get Needed Care
						A[1]	S[2]	A[1]	S[2]	A[1]	R[3]	S[2]						
0814	423 MDS-RAF ALCONBURY	Air Force	Limited Scope MTF	1	2,294	96%	89%	0.37	11.62	1.2	2.7	37.1	84%	98%	78%	52%	n/a	n/a
7139	1st SPECIAL OPERATIONS MEDICAL GROUP	Air Force	Clinic	1	15,825	96%	89%	0.30	12.92	3.1	5.8	13.5	41%	96%	73%	56%	59.7	74
7200	460th MED GRP-BUCKLEY AFB	Air Force	Clinic	1	8,570	97%	83%	0.37	17.16	1.0	5.7	14.1	84%	95%	79%	66%	n/a	n/a
7234	MENWITH HILL MEDICAL CENTER	Air Force	Limited Scope MTF	1	658	97%	91%	0.26	10.23	0.7	3.7	19.7	99%	97%	82%	85%	n/a	n/a
MHS Average for FY14					3,380,654	92%	93%	0.97	12.4	1.86	6.2	12.9	70%	82%	71%	60%	75%	73%

1 Acute
2 Specialty
3 Routine

2014 MHS Review Group
Source: TRICARE Operations Center (TOC); TRICARE Outpatient Satisfaction Survey (TROSS); Air Force Services Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS); Patient Satisfaction Survey (PSS), Healthcare Survey of DoD Beneficiaries (HCSDB); June 2014

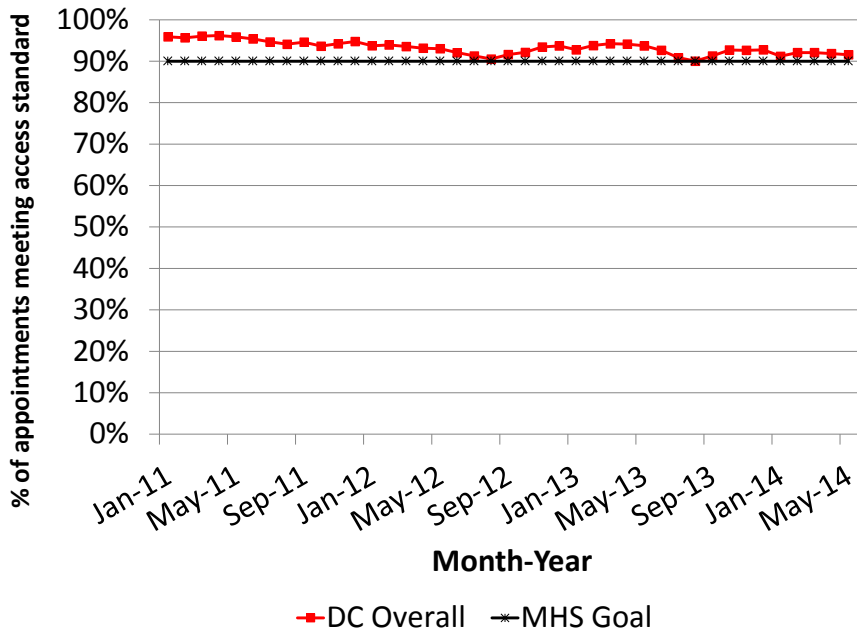
Appendix 3.8
Percent of Appointments Met Analysis – Direct Component

Percent of Acute Appointments Meeting the TRICARE Access Standard

The total number of routine appointments booked in primary and specialty care is measured against the MHS access standard of 24 hours. The MHS goal is for 90 percent of acute appointments booked to be within the acute access standard. This measure evaluates appointments coded in CHCS as acute and open access.

Overall: In FY 2014 to date, 92 percent of acute appointments booked in CHCS are meeting the MHS access standard of 24 hours, which is better than the MHS goal of 90 percent (see Figure 3.8-1).

Figure 3.8-1 Acute Appointments Meeting Access Standard - Direct Care Component Overall: MHS Goal >90%

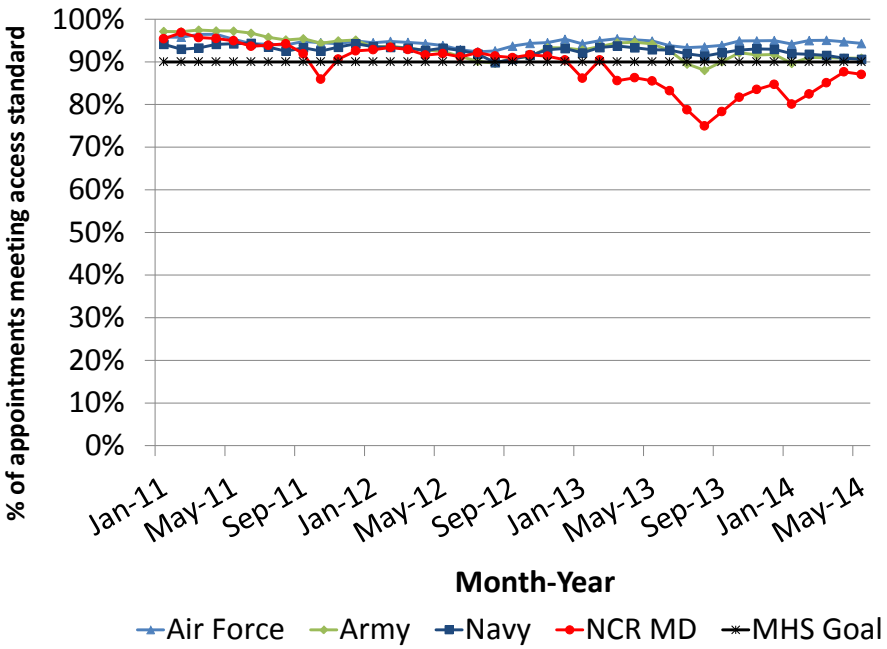


2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Civilian Comparison: The average percent of acute appointments meeting the MHS access standard is 92 percent, which is higher than Health System 3, which reports 86 percent of all appointments are within 28 days.

Service-Level: All Services except NCR MD are meeting the MHS goal of 90 percent or more acute appointments meeting the MHS access standard for acute care. The Air Force, Navy, and Army are all performing better than the MHS goal of 90 percent, at 95 percent, 92 percent and 91 percent, respectively. NCR MD is performing below the MHS goal at 84 percent.

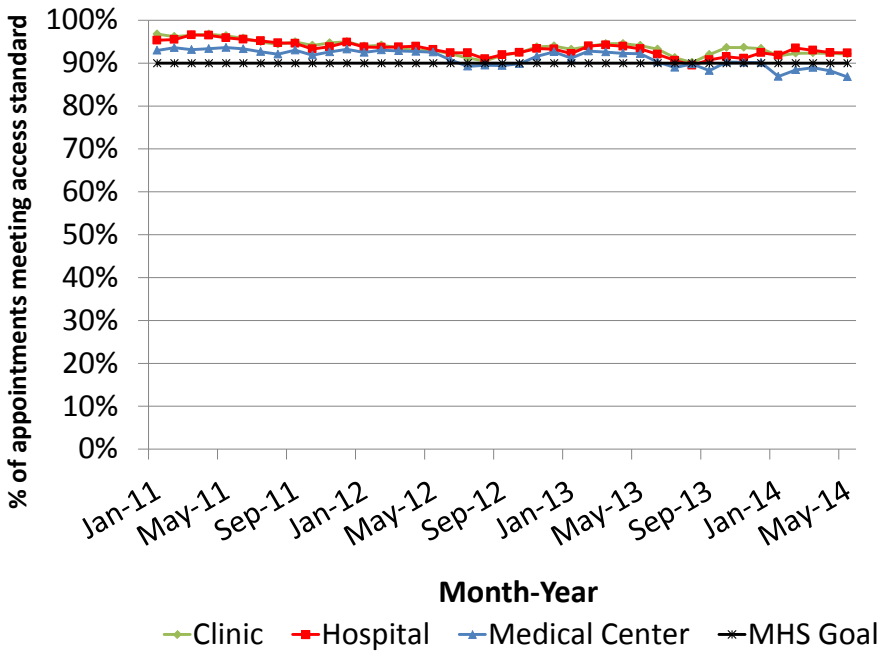
Figure 3.8-2 Acute Appointments Meeting Access Standard, by Service – MHS Goal: >90%



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: Clinics and hospitals did better than the MHS goal of 90 percent, averaging 93 percent and 92 percent, respectively. The medical center FY 2014 average of 89 percent did not meet the MHS goal of 90 percent of acute appointments meeting the MHS access standard.

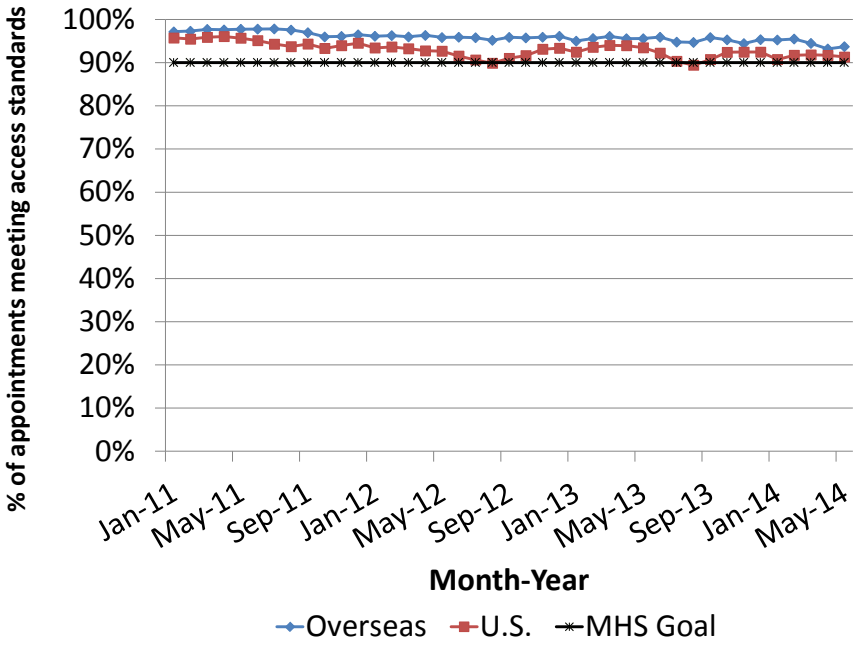
Figure 3.8-3 Acute Appointments Meeting Access Standard, by Facility Type – MHS Goal: >90%



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: Facilities located overseas had better performance compared to facilities located in the United States. The percent of acute appointments meeting the MHS access standard was 94 percent overseas, compared to 92 percent in the United States, with both groups meeting the MHS goal.

Figure 3.8-4 Acute Appointments Meeting Access Standard, by Location – MHS Goal: >90%



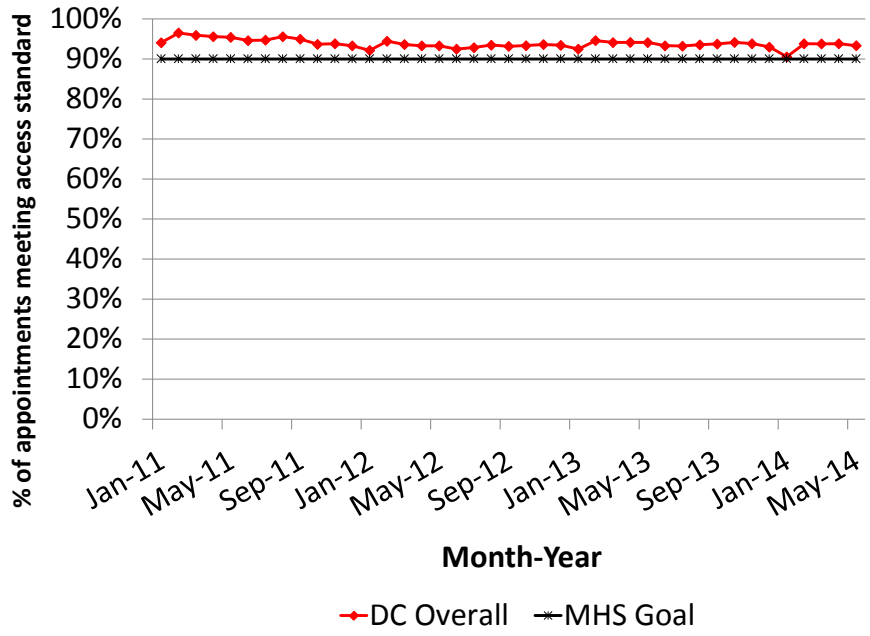
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Percent of Specialty Appointments Meeting the Tricare Access Standard

The total number of specialty appointments booked is measured against the MHS access standard of 28 days. The MHS goal is for 90 percent of specialty appointments booked to be within the MHS specialty access standard. This measure evaluates specialty appointments.

MHS Overall: In FY 2014 to date, 93 percent of specialty appointments booked in CHCS are meeting the MHS standard of 28 days, which meets the MHS goal of 90 percent or more.

Figure 3.8-5 Specialty Appointments Meeting Access Standard – Overall: MHS Goal >90%

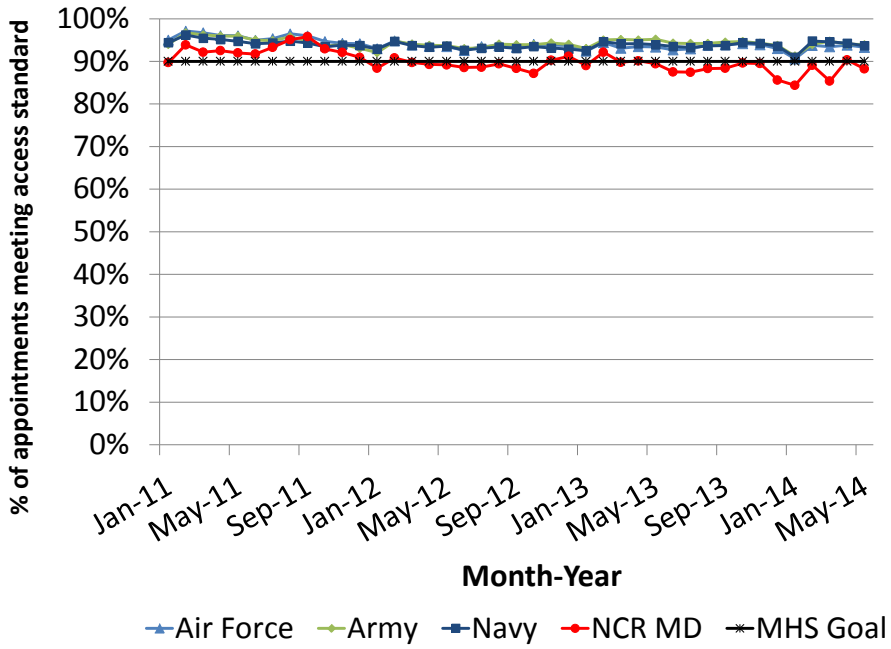


2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Civilian Comparison: The average percent of specialty appointments meeting the MHS access standard is 93 percent, which is higher than Health System 3, which reports 86 percent of all appointments are within 28 days.

Service-Level: All Services except NCR MD are meeting the MHS goal of 90 percent or more specialty appointments meeting the MHS access standard. The Air Force, Navy, and Army are all performing better than the MHS goal of 90 percent, at 93 percent, 94 percent and 94 percent, respectively. NCR MD is performing below the MHS goal at 88 percent.

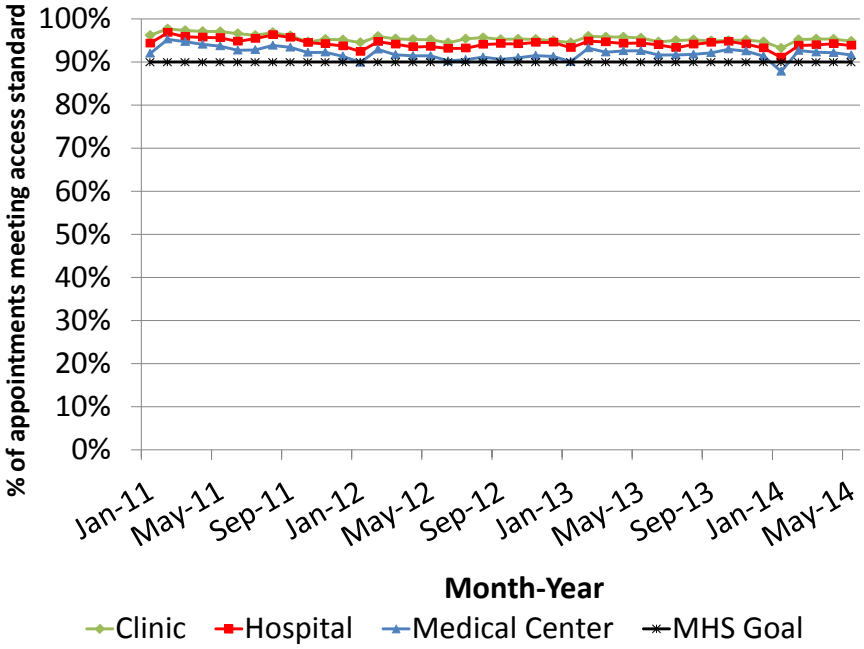
Figure 3.8-6 Specialty Appointments Meeting Access Standard, by Service – MHS Goal: >90%



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: Clinics, hospitals and medical centers outperformed the MHS goal of 90 percent, averaging 95 percent, 94 percent and 92 percent, respectively. All MTF type groups meet the MHS access standard.

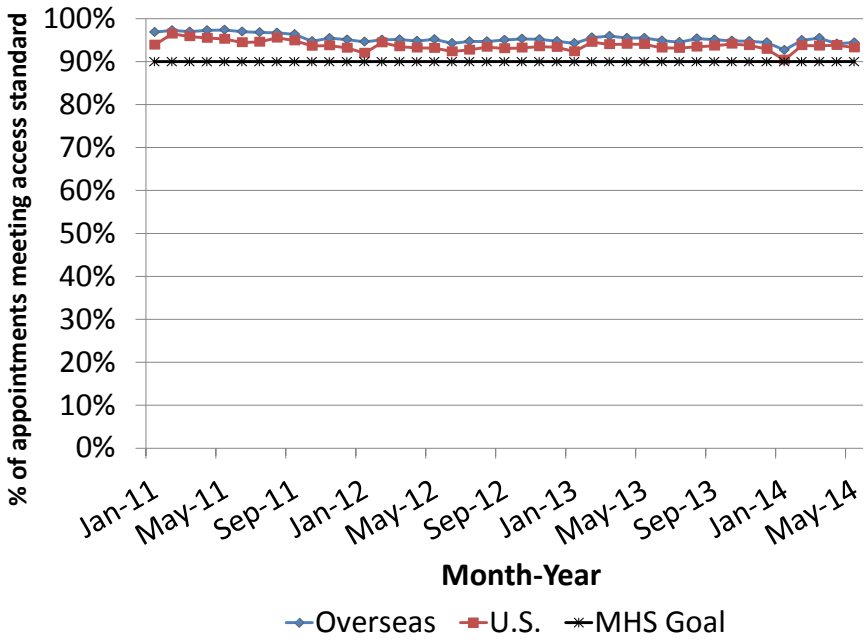
Figure 3.8-7 Specialty Appointments Meeting Access Standard, by Facility Type – Goal: >90%



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: Facilities located overseas had better performance compared to facilities located in the United States. The percent of specialty appointments meeting the MHS access standard was 94 percent overseas, compared to 93 percent in the United States, with both groups meeting the MHS goal.

Figure 3.8-8 Specialty Appointments Meeting Access Standard, by Location – Goal: >90%



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

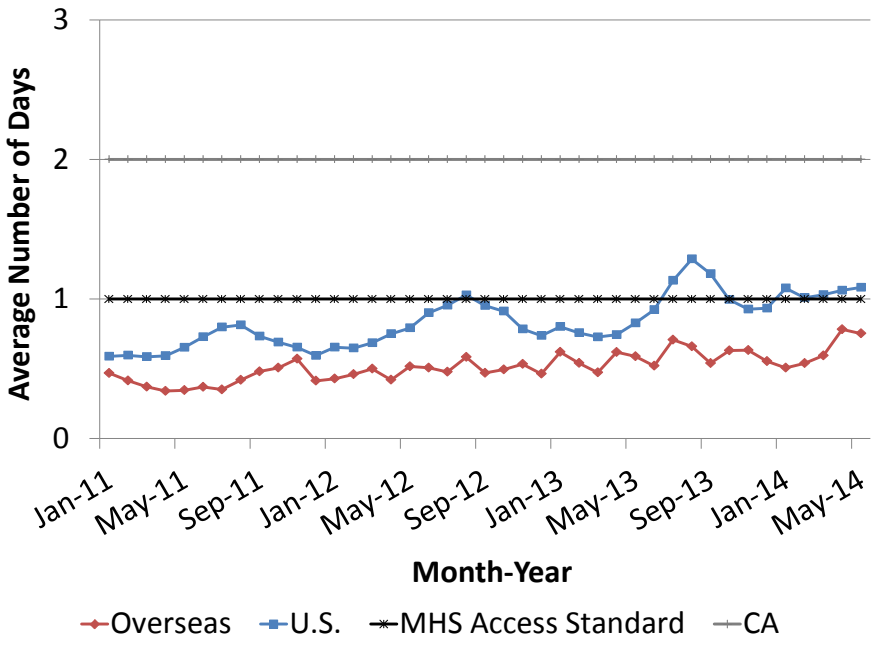
Appendix 3.9
Overseas and United States Access Measures – Direct Care Component

Acute Appointments

Number of Days to Acute Appointment

Facilities located overseas had better performance compared to facilities located in the United States. The average days to acute appointments overseas is 0.61 days in FY 2014 compared to 1.03 days for facilities located in the United States. Both groups performed better than the CA acute access standard.

Figure 3.9-1 Average Number of Days to an Acute Appointment, by Location – Direct Care Component: MHS Access Standard ≤ 1 day

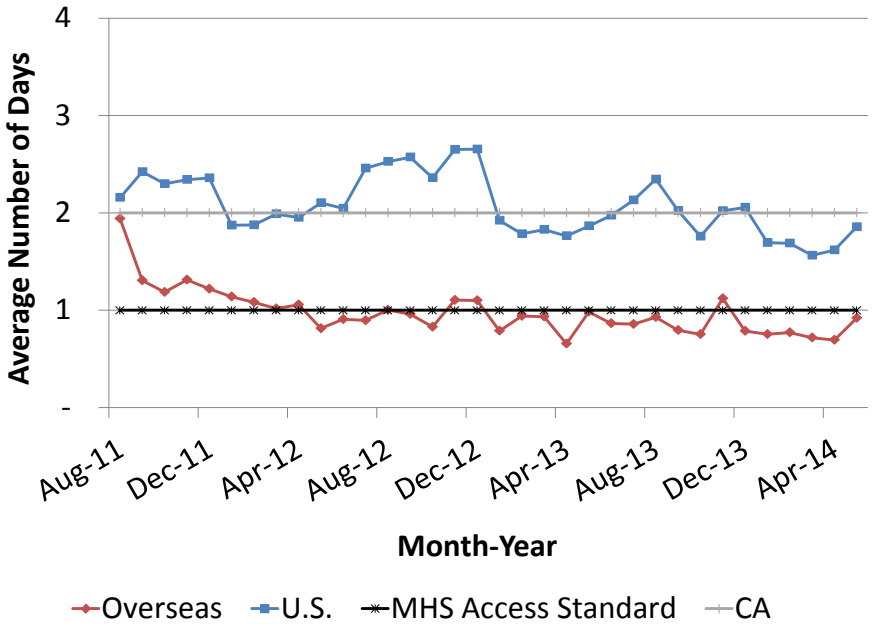


2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Third next available acute appointment

Facilities located overseas had better performance compared to facilities located in the United States. The average days to acute appointments overseas is 0.80 days in FY 2014 compared to 1.9 days for facilities located in the United States. Both groups performed better than the CA acute access standard.

Figure 3.9-2 Average Number of Days to Third Next Acute Appointment, by Location – Direct Care Component: MHS Access Standard ≤ 1 day



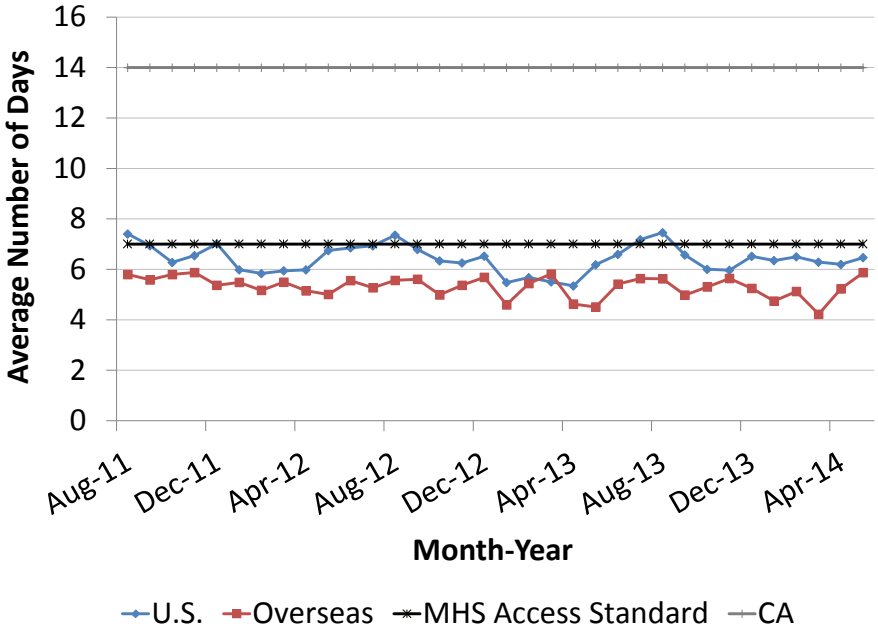
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Routine Appointments

Number of days to third next routine appointment in primary care

Facilities located overseas had better performance compared to facilities located in the United States. The average days to routine appointments overseas is 5.2 days in FY 2014 compared to 6.3 days for facilities located in the United States. Both groups performed better than the MHS standard of 7 days and the CA standard of 10 business days (14 calendar days).

Figure 3.9-3 Average Number of Days Third Next Routine Appointment, by Location – Direct Care Component: MHS Access Standard ≤ 1 day



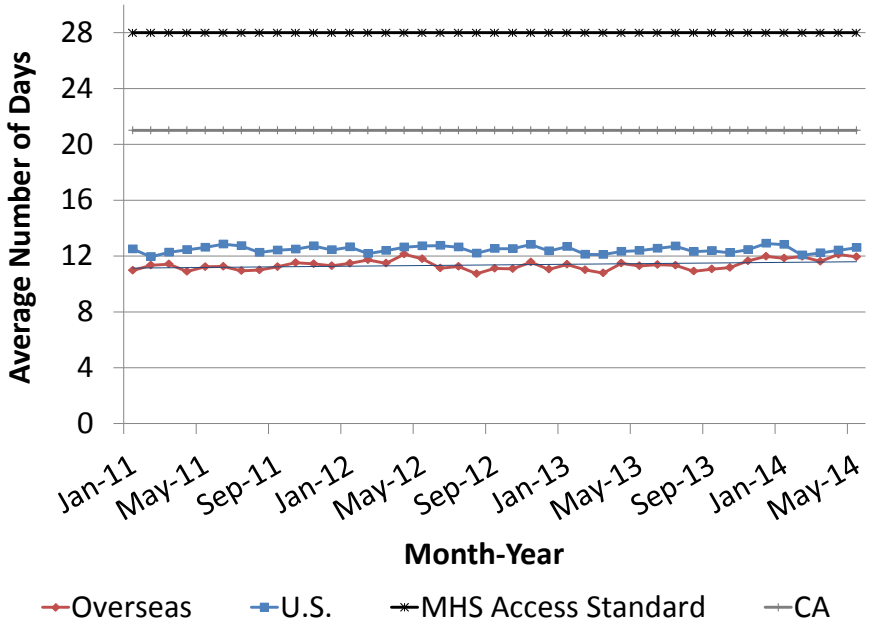
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Specialty

Number of Days to Specialty Appointment

Facilities located overseas had slightly better performance compared to facilities located in the United States. The FY 2014 average number of days to specialty appointments overseas is 11.5 days compared to 12.5 days in facilities located in the United States. Both groups performed better than the MHS standard of 28 days and the CA standard of 15 business days (21 calendar days).

Figure 3.9-4 Average Number of Days to Specialty Appointment, by Location – MHS Access Standard

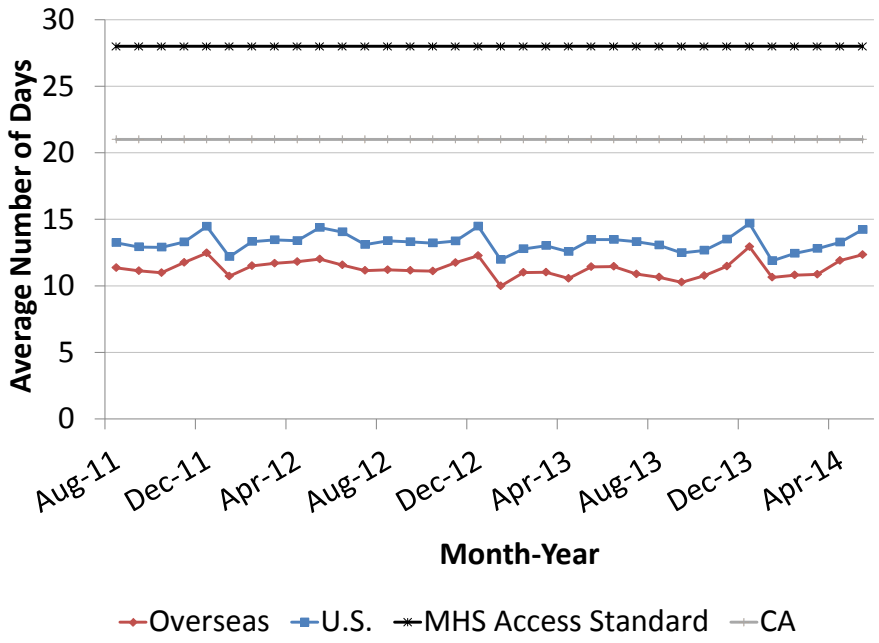


2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Number of Days to Third Next Specialty Appointment

Facilities located overseas had slightly better performance compared to facilities located in the United States. The FY 2014 average number of days to specialty appointments overseas is 11.8 days compared to 13.2 days in facilities located in the United States. Both groups performed better than the MHS access standard of 28 days and the CA specialty access standard of 15 business days (21 calendar days).

Figure 3.9-5 Average Number of Days to Third Next Specialty Appointment, by Location – MHS Access Standard



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Appendix 3.10
Outlier Analysis

Average Number of Days to an Acute Appointment

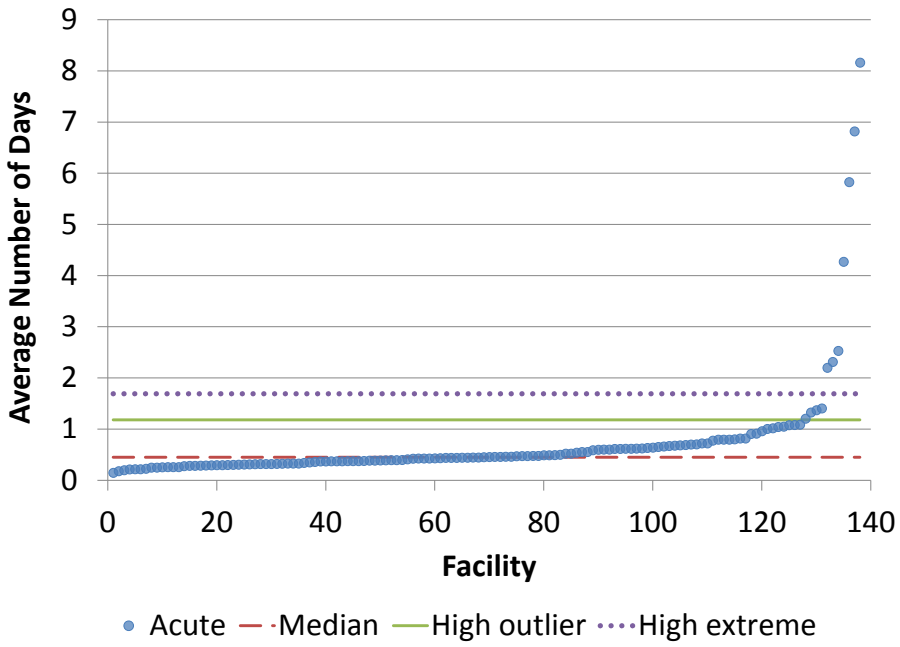
The FY 2014 mean was 0.97 days and the median was .45 days; 87 percent of MTFs have a lower average number of days to acute appointments than the mean. There are four high outliers and seven extreme outliers (see Table 3.10-1 and Figure 3.10-1).

Table 3.10-1 Average Number of Days to an Acute Appointment Summary, FY 2014 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR* 1.5	IQR* 3	Low outlier	Low extreme	High outlier	High extreme
0.14	8.16	0.45	0.33	0.67	0.34	0.51	1.02	(0.18)	(0.69)	1.18	1.69

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-1 Average Number of Days to an Acute Appointment – by Facility, FY 2014 to Date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Average Number of Days to Third Next Acute Appointment in Primary Care

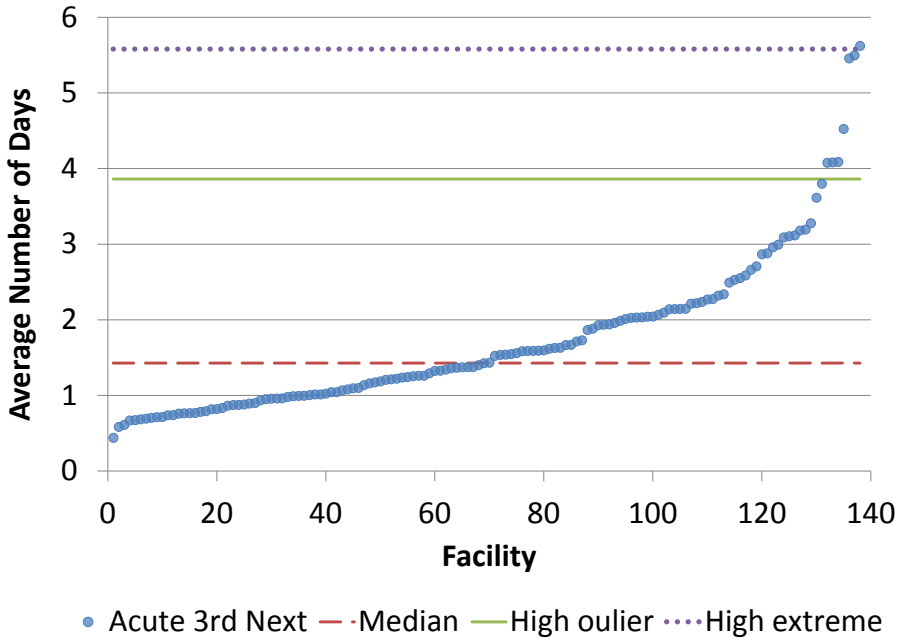
The FY 2014 mean was 1.86 days and the median was 1.4 days; 64 percent of MTFs have a lower average number of days to third next appointment than the mean. There are six high outliers and one extreme outlier (see Table 3.10-2 and Figure 3.10-2).

Table 3.10-2 Average Number of Days to Third Next Acute Appointment – Summary FY 2014 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR* 1.5	IQR* 3	Low outlier	Low extreme	High outlier	High extreme
0.4	5.6	1.4	0.99	2.14	1.14	1.72	3.44	(0.73)	(2.45)	3.86	5.58

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-2 Average Number of Days to Third Next Acute Appointment – by Facility, FY 2014 to Date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Average Number of Days to Third Next Routine Appointment in Primary Care

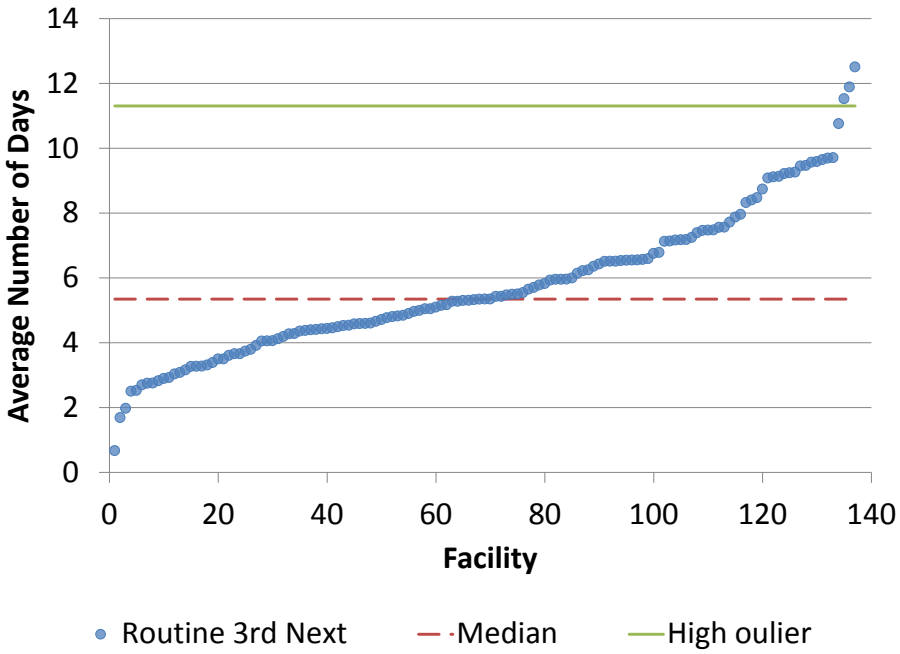
The FY 2014 mean was 6.2 days and the median was 5.3 days; 64 percent of MTFs have a lower average number of days to third next appointment than the mean. There are three high outliers and no extreme outliers (see Table 3.10-3 and Figure 3.10-3).

Table 3.10-3 Average Number of Days to Third Next Routine Appointment – Summary FY 2014 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR* 1.5	IQR *3	Low outlier	Low extreme	High outlier	High extreme
0.70	12.5	5.30	4.36	7.14	2.78	4.17	8.33	0.19	(3.98)	11.30	15.47

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-3 Average Days to Third Next Routine Appointment – by Facility, FY2014 to Date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Average Number of Days to Specialty Appointment

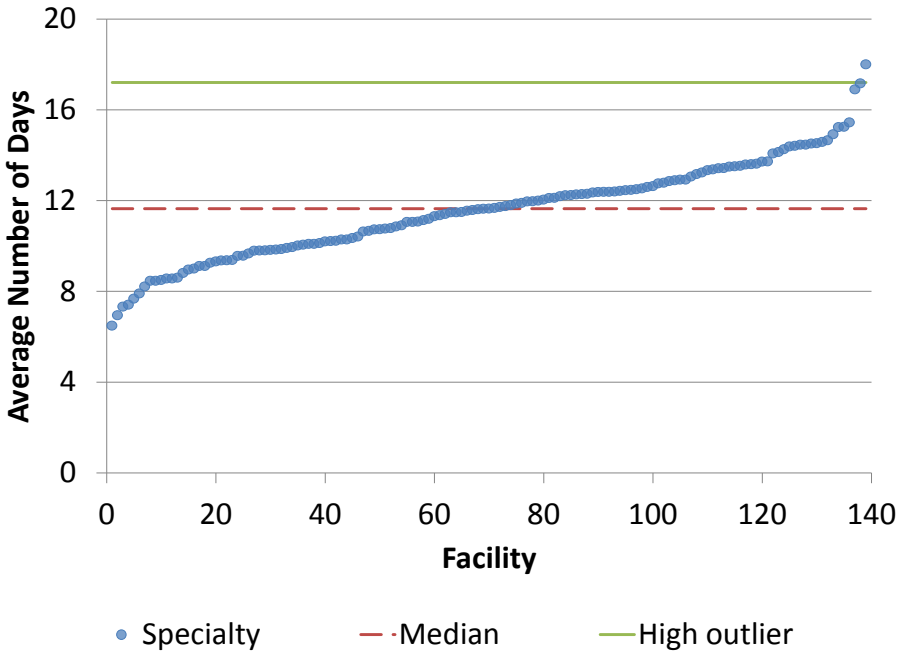
The FY 2014 mean was 12.4 days and the median was 11.6 days; 67 percent of MTFs have a lower average number of days to third next appointment than the mean. There is one high outlier, which is still within the MHS access standard and no extreme outliers (see Table 3.10-4 and Figure 3.10-4).

Table 3.10-4 Average Number of Days to Specialty Appointment – Summary FY 2014 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR *1.5	IQR *3	Low outlier	Low extreme	High outlier	High extreme
6.49	18.01	11.64	10.04	12.91	2.87	4.30	8.60	5.74	1.44	17.21	21.51

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-4 Average Number of Days to Specialty Appointment – by Facility, FY 2014 to Date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Average Days to Third Next Specialty Care Appointment

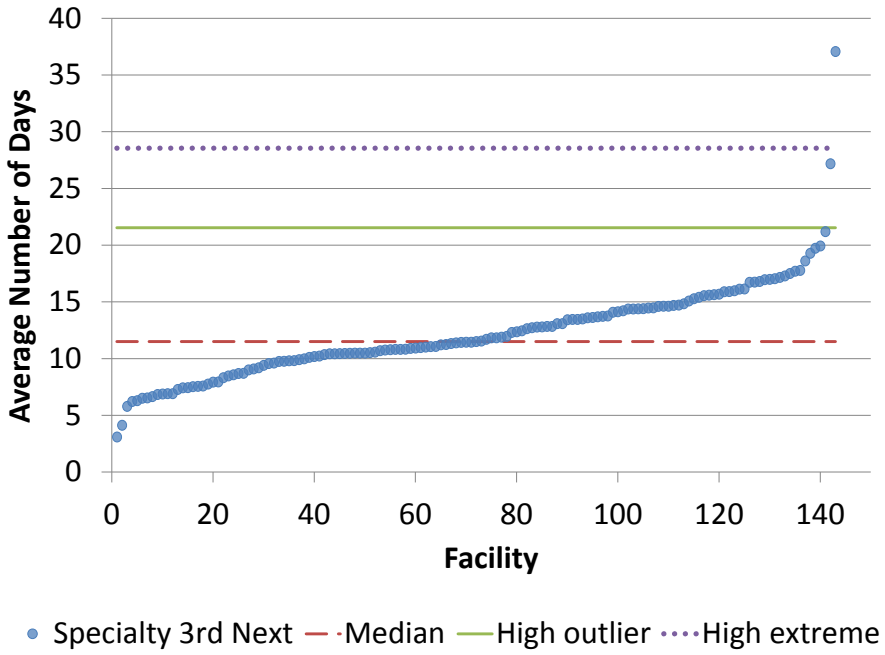
The FY 2014 mean was 6.2 days and the median was 5.3 days; 64 percent of MTFs have a lower average number of days to third next appointment than the mean. There is one high outlier, although it is still within the MHS access standard for specialty care and one extreme outlier (see Table 3.10-5 and Figures 3.10-5).

Table 3.10-5 Average Number of Days to Third Next Specialty Appointment – Summary FY 2014 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR* 1.5	IQR* 3	Low outlier	Low extreme	High outlier	High extreme
3.1	37.1	11.5	9.9	14.5	4.7	7.0	14.0	2.8	(4.2)	21.5	28.5

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-5 Average Days to Third Next Specialty Appointment – by Facility, FY 2014 to date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Percent Appointments Web-Enabled for TRICARE OnLine (TOL) Booking

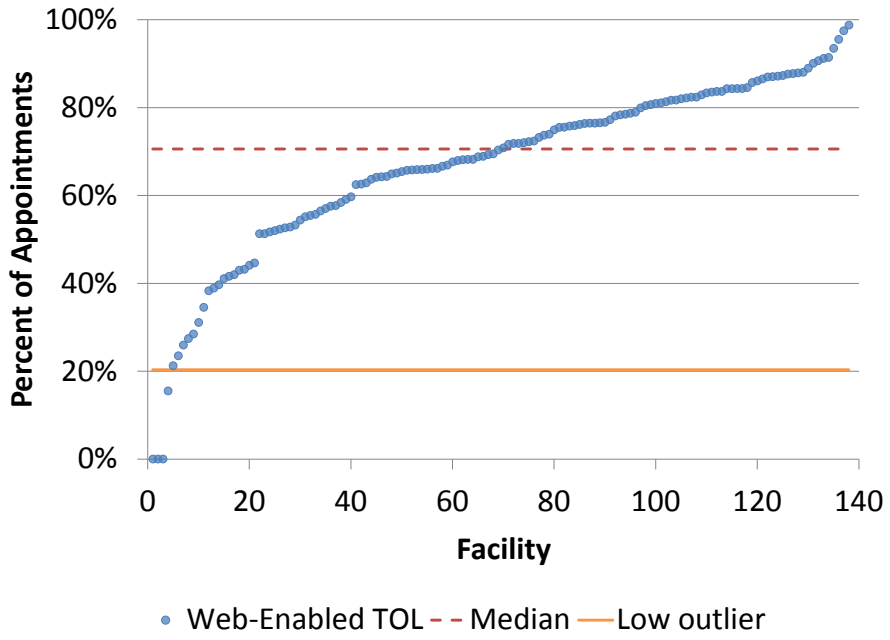
The FY 2014 mean was 70 percent and the median was 71 percent days. There are four low outliers and no extreme outliers (see Table 3.10-6 and Figure 3.10-6).

Table 3.10-6 Percent of Web-Enabled Appointment for TOL Booking – Summary FY14 to Date

Min	Max	Median	25 perc	75 perc	IQR	IQR *1.5	IQR *3	Low outlier	Low extreme	High outlier	High extreme
0.0	1.0	71%	0.57	0.82	0.25	0.37	0.74	0.20	(0.16)	1.19	1.55

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.10-6 Percent of Web-Enabled Appointments for TOL Booking – by Parent Facility, FY 2014 to date



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Patient Satisfaction With Getting Care When Needed (Service Surveys)

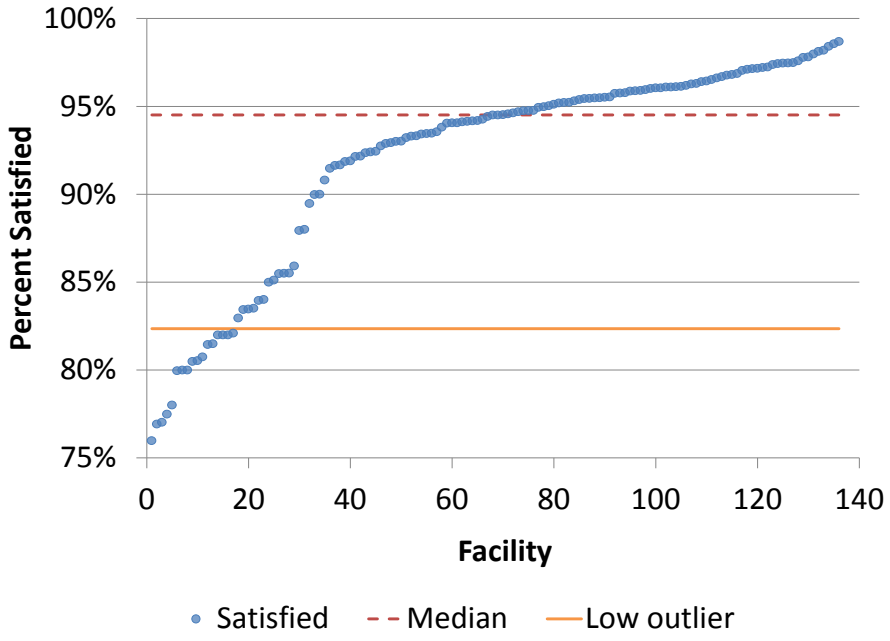
The FY 2014 mean was 82 percent and the median was 95 percent; 86 percent of MTFs have higher satisfaction than the mean. There are 17 low and no extreme outliers (see Table 3.10- 7 and Figure 3.10-7).

Table 3.10-7 Percent Satisfied with Access to Care – By Parent Facility, November 2013 – May 2014

Min	Max	Median	25 perc	75 perc	IQR	IQR *1.5	IQR *3	Low outlier	Low extreme	High outlier	High extreme
76%	99%	95%	91%	96%	6%	8%	16%	82%	74%	104%	113%

2014 MHS Review Group
Source: Air Force Services Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS); Patient Satisfaction Survey (PSS), June 2014

Figure 3.10-7 Percent Satisfied with Access to Care – By Parent Facility, November 2013 – May 2014



2014 MHS Review Group
Source: Air Force Services Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS); Patient Satisfaction Survey (PSS), June 2014

Patient Satisfaction with Access to Care (TROSS)

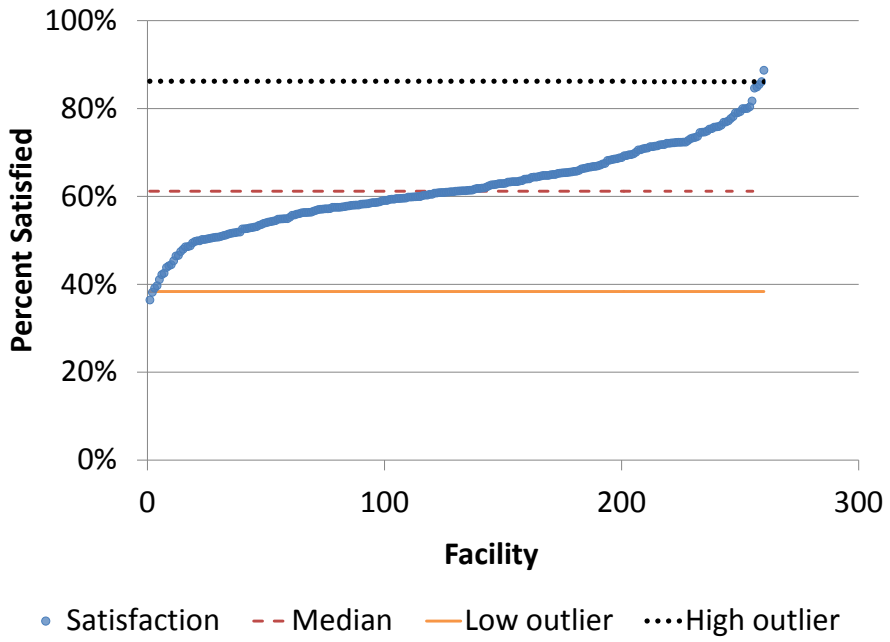
The FY 2014 mean was 60 percent and the median was 61 percent; 60 percent of MTFs have higher satisfaction than the mean. There is one high outlier and two low outliers; there are no extreme outliers (see Table 3.10-8 and Figure 3.10-8).

Table 3.10-8 TROSS – Percent Satisfied with Access to Care – Summary, FY 2013

Min	Max	Median	25 perc	75 perc	IQR	IQR*1.5	IQR*3	Low outlier	Low extreme	High outlier	High extreme
36%	89%	61%	56%	68%	12%	18%	36%	38%	20%	86%	104%

2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Figure 3.10-8 TROSS – Percent Satisfied with Access to Care – by Facility, FY2013

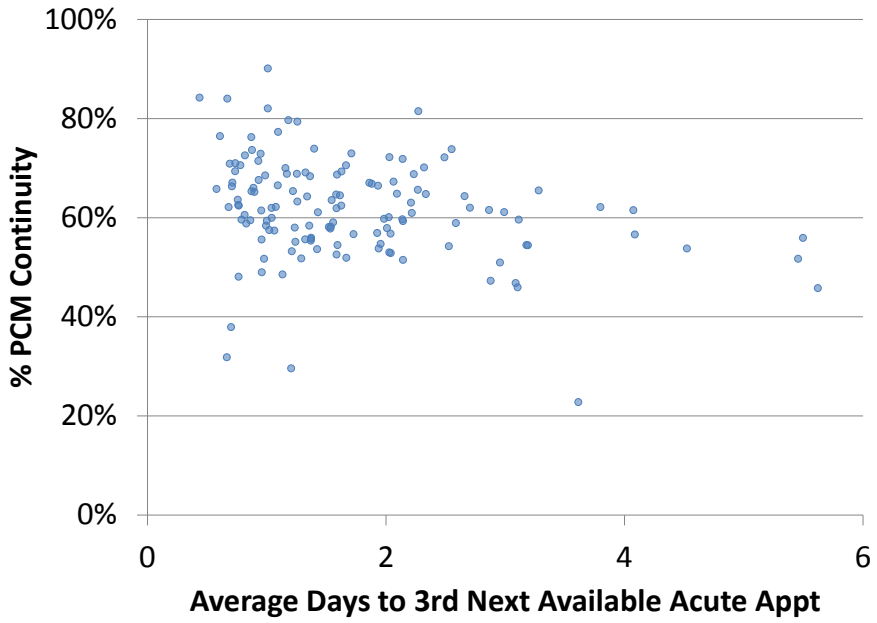


2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Appendix 3.11
Correlation Analyses

The higher the Primary Care Manager (PCM) Continuity the lower the average number of days to third next acute appointments. Correlation: -0.296138 Test Stat: -3.60240 P-value: 0.00044207 (see Figure 3.11-1).

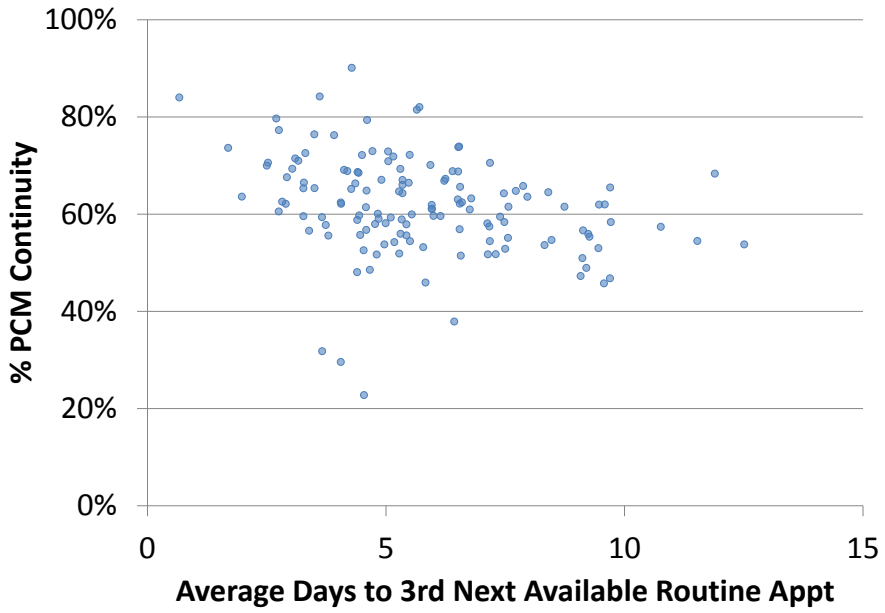
Figure 3.11-1 Correlation between PCM Continuity and Average Number of Days to Third Next Available Acute Appointment



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

The higher the PCM Continuity the lower the average number of days to third next routine appointments. Correlation: -0.307779 Test Stat: -3.75851 P-value: 0.0002535 (see Figure 3.11-2).

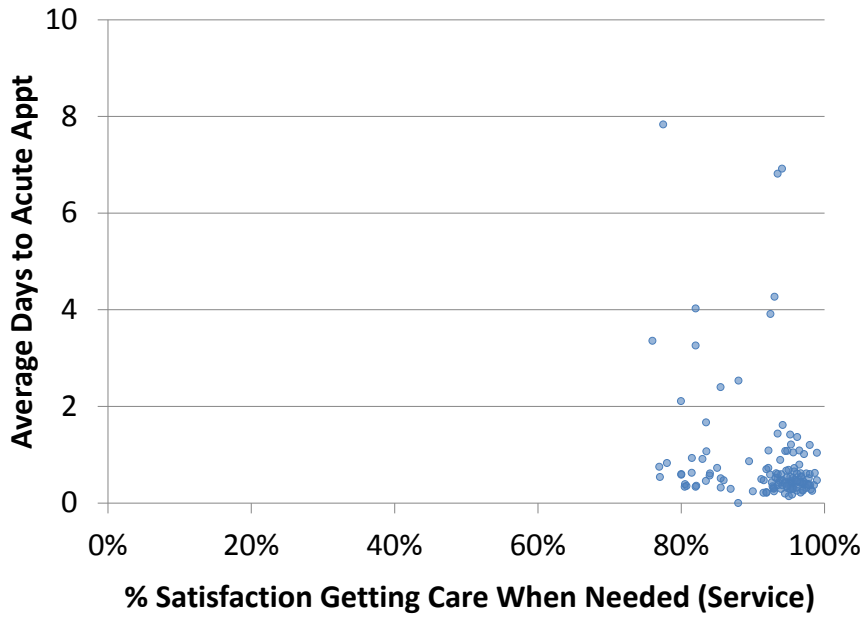
Figure 3.11-2 Correlation between PCM Continuity and Average Number of Days to Third Next Routine Appointment



2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

The lower the average number of days to an acute appointment, the higher the patient satisfaction with getting care when needed. Correlation: -0.262694 Test Stat: -3.150303 P-value: 0.0020119 (see Figure 3.11-3).

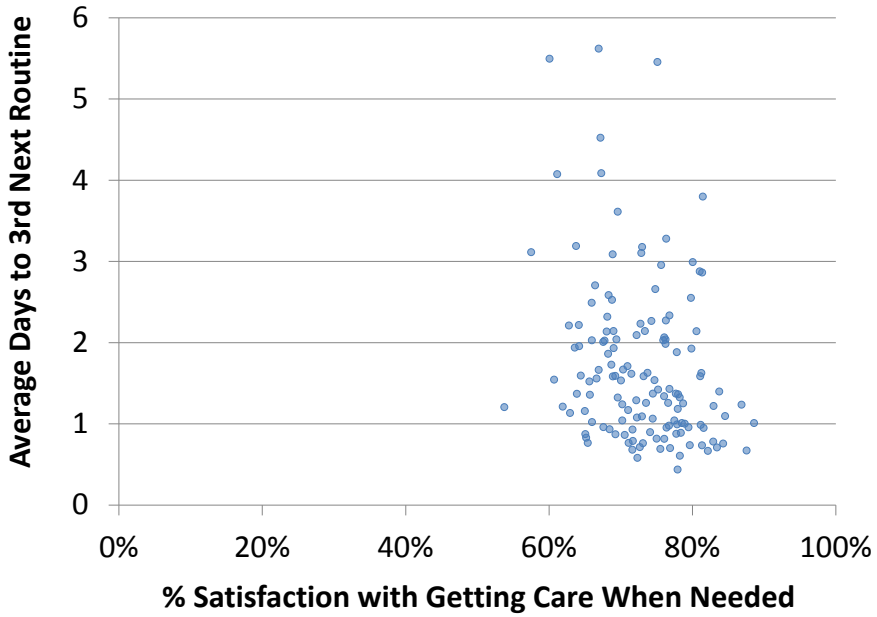
Figure 3.11-3 Correlation between Average Number of Days to Acute Appointment and Satisfaction with Getting Care When Needed (Service Surveys)



2014 MHS Review Group
Source: TRICARE Operations Center (TOC); Air Force Services Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS); Patient Satisfaction Survey (PSS), June 2014

The lower the average number of days to third next acute appointments, the higher the patient satisfaction with getting care when needed. Correlation: -0.272474 Test Stat: -3.290956 P-value: 0.0012766 (see Figure 3.11-4).

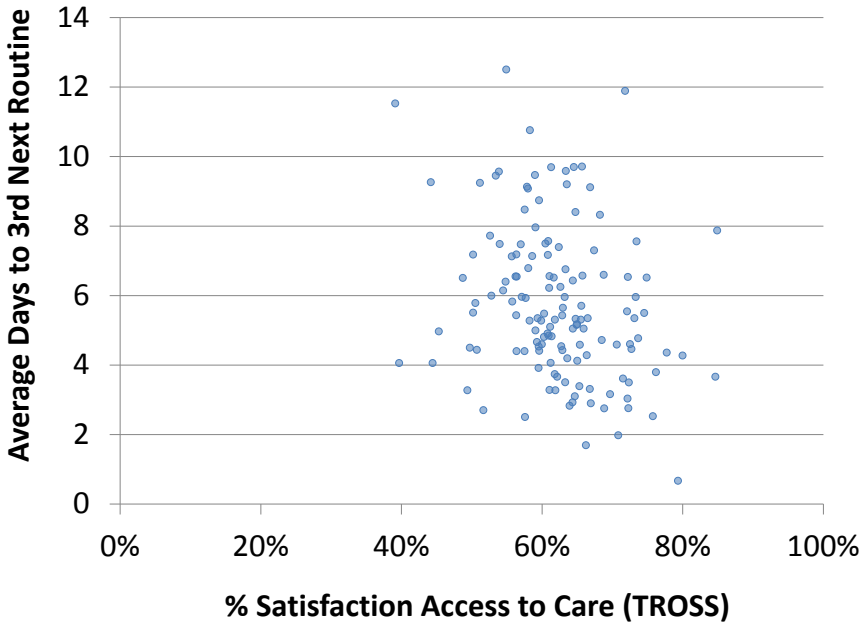
Figure 3.11-4 Correlation between Average Number of Days to Third Next Available Appointment and Satisfaction with Getting Care When Needed



2014 MHS Review Group
Source: TRICARE Operations Center (TOC) and TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

The lower the average number of days to third next routine appointments, the higher the patient satisfaction with getting care when needed. Correlation: -0.278075 Test Stat: -3.363605 P-value: 0.0010015 (see Figure 3.11-5).

Figure 3.11-5 Correlation between Average of Days to Third Next Available Routine Appointment and Satisfaction with Access to Care



2014 MHS Review Group
Source: TRICARE Operations Center (TOC) and TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Appendix 3.12
TROSS and HCSDB Questions and Benchmarks

Table 3.12-1 TROSS and HCSDB Questions and Benchmarks – Access When Needed

TROSS Question	Question in Composite (if applicable)	Rating Scale for Satisfied
C1: Access to Care Composite	Q8: Received appt as soon as needed for urgent care	Almost Always, Always
	Q10: Received appt as soon as needed for routine care	Almost Always, Always
	Q13: Answer to medical question same day (calls during office hours)	Almost Always, Always
	Q15: Answer to medical question as soon as needed (calls after office hours)	Almost Always, Always
	Q16: Answer to time spent in the waiting room and exam room. See provider within 15 minutes	Almost Always, Always
Q3a: See Provider When Needed	Q3a: Answer to saw provider when needed	Agree, Strongly Agree

2014 MHS Review Group
Source: Department of Defense Tricare Outpatient Satisfaction Survey, July 2014

HCSDB: HCSDB is sent randomly to all MHS-eligible users and non-users, independent of whether they had a recent encounter. Respondents include those enrolled to TRICARE Prime (MTF and network enrollees) and non-enrolled beneficiaries who may receive care in MTFs or through the purchased care component. For this report, only the HCSDB results for Prime enrollees are presented (Note: Prime beneficiaries enrolled to the network are presented in the purchased care section). Beneficiary responses to two composite questions that address the beneficiary's ability to get care quickly and get needed care are evaluated, which are displayed in Table 3.12-2.

Table 3.12-2 TROSS and HCSDB Questions and Benchmarks – Getting Care Quickly and Getting Care When Needed

Composite #	Question	Rating Scale for Satisfied
Get Care Quickly Composite	Q7: In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?	Usually, Always
	Q10: In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?	Usually, Always
Getting Needed Care - Composite	Question 37: In the last 12 months, how often did you get an appointment to see a specialist as soon as you needed?	Usually, Always
	Question 45: In the last 12 months, how often was it easy to get the care, tests, or treatment you needed?	Usually, Always

2014 MHS Review Group
Source: Health Care Survey of DoD Beneficiaries, July 2014

TROSS and HCSDB metrics are compared to benchmarks established by AHRQ through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). CAHPS publicly reports the results of patient satisfaction questions by percentile. Based on these percentiles, benchmarks are identified and used to compare the MHS to the national level of patient satisfaction with ATC. The percentiles for FY 2013 are displayed in Table 3.7 in this report (Note that the percentiles change annually). The MHS compares to the CAHPS 75th percentile for its TROSS questions and the 50th percentile for its HCSDB questions. There is no benchmark for the TROSS question asking whether the patient gets care when needed.

Table 3.12-3 CAHPS Percentiles (Benchmark Highlighted), TROSS and HCSDB

Percentile grouping	TROSS FY 2013 Access to Care Composite	HCSDB FY 2013 Get Care Quickly Composite	HCSDB FY 2013 Get Care When Needed Composite
	%	%	%
90% or greater	69	89	89
75%-90%	60	88	87
50%-74%	47	86	85
25%-49%	34	84	82
<25%	<34	<83.5	<81.9

2014 MHS Review Group
Source: Consumer Assessment of Healthcare Providers and Consumers (CAHPS), June 2014

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APPENDIX 4. QUALITY OF CARE

Appendix 4.1
Summaries of Statute, Regulation, Instructions, and Other Guidance

DoD Policies

10 United States Code (USC), Sections 1079 and 1102: The U.S. Code is the codification by subject matter of the general and permanent laws; it is divided into 51 titles. Section 1079(o) provides the Secretary with authority to establish a Peer Review Organization (PRO) program using the Medicare PRO program as a model, and excludes from TRICARE coverage care not considered medically or psychologically necessary per the PRO. Section 1102 addresses the confidentiality, as well as authorized disclosures, of medical quality assurance (MQA) records created by or for DoD as part of a MQA program.

Code of Federal Regulations (32 CFR), Part 199: Part 199 of the Code of Federal Regulations contains the regulations published in the Federal Register relating to the CHAMPUS/TRICARE program. Section 199.15 establishes rules and procedures for the CHAMPUS Quality and Utilization Review Peer Review Organization program. In specific, it establishes rules and procedures to review the quality, completeness and adequacy of purchased care provided, as well as its necessity, appropriateness and reasonableness. In accordance with 32 CFR 199.4(a)(10), all benefits under the CHAMPUS program are subject to review under the CHAMPUS Quality and Utilization Review PRO program. All quality assurance and utilization review requirements for the basic CHAMPUS program, as set forth in 199.4 and 199.15, are applicable to Prime, Standard, and Extra under the TRICARE program in accordance with 199.17(j).

DoDM 6010.51, The TRICARE Operations Manual: The manual is written and maintained by the Defense Health Agency. The manual provides instructions and requirements for claims processing and health delivery under TRICARE. It is an integral part of the managed care support contracts. Specifically, Chapter 7, Section 4 defines the requirements for purchased care contractors to operate a CQMP, which results in demonstrable quality improvement in the health care provided beneficiaries, and in the processes and services delivered by the contractor. Chapter 17, Section 3 describes that for active duty members, a referral from an MTF or an authorization from a service point of contact shall be deemed to constitute direction to bypass provider certification.

DoDM 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) Manual: This manual reissues DoD 6025.13-R)) as a DoD manual in accordance with the authority in DoD Directive (DoDD) 5124.02 and DoD Instruction (DoDI) 6025.13 and the guidance in DoDI 5025.01. It implements policy, assigns responsibilities, and provides procedures for managing DoD MQA and clinical quality management.

DoDI 6025.13, Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS) Instructions: The corresponding DoD Instructions primarily

reissues DoD Directive (DoDD) 6025.13 as a DoD Instruction (DoDI) in accordance with the authority in DoDD 5124.02 and establishes DoD policy on issues related to MQA programs and clinical quality management activities.

DoDD 5010.42, DoD-Wide Continuous Process Improvement (CPI)/Lean Six Sigma (LSS) Program: In Accordance with the authority in Section 113 of title 10, United States Code, this Directive establishes policy and assigns responsibilities to institutionalize CPI/LSS as one of the primary approaches to assessing and improving the efficiency and effectiveness of DoD processes in support of the Department's national defense mission.

DoDI 5010.43, Implementation and Management of the DoD-Wide Continuous Process Improvement/Lean Six Sigma (CPI/LSS) Program: This corresponding instruction document establishes policy, assigns responsibilities, and provides guidance for the DoD-wide implementation of the CPI/LSS.

DoDM 6440.02, Clinical Laboratory Improvement Program (CLIP) Procedures: In accordance with the authority in DoD Directive 5136.01 and the policy in DoD Instruction (DoDI) 6440.02, this manual implements policy, assigns responsibilities, and provides for standards and procedures for managing the CLIP. This manual states the minimal conditions that all laboratories must meet to be certified to perform testing on human specimens under the CLIP.

Health Affairs Policy 98-010, 1998: HA Policy 98-010, Policy for Improving Access and Quality in the Military Health System, was a memorandum issued January 08, 1998 due to media criticisms of military medicine and renewed congressional interest in the quality of care provided to beneficiaries. The memorandum identified 13 issues and requested a summary of how the office resolved each issue or planned for resolution by January 20, 1998.

Health Affairs Policy 10-008, Policy Memorandum for Military Health System Health Care Quality Assurance Data Transparency: HA Policy 10-008, dated October 20, 2010, required the MHS to make relevant quality assurance information readily available and transparent to beneficiaries, enrollees, and providers in an understandable manner.

Health Affairs Policy 09-019, Policy Memorandum for Military Health System Data Quality Management Control Program, Revised Reporting Documents: HA Policy 09-019, dated September 21, 2009, revised the Data Quality Management Control Review List and the Data Quality Statement of DoDI 6040.40 (MHS Data Quality Management Control Procedures), dated November 26, 2002. These important documents are the basis for the Military Treatment Facility (MTF) Report Format submitted monthly from MTFs. The changes recommended in the memorandum were incorporated into the DoDI through a reissuance process and were authorized in the DoDI.

Health Affairs Policy 02-016, Military Health System Definition of Quality in Health Care: HA Policy 02-016, dated May 09, 2002, responded to the Healthcare Quality Initiatives Review Panel's recommendation to promulgate a definition of "quality" concerning health care and

related services within the MHS to orient current and future measurement initiatives. The definition of quality health care was adopted by the TRICARE Clinical Quality Forum (TCQF).

Executive Order 13410, Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs: To ensure that Federal health care programs promote quality and efficient delivery of health care through the use of health IT, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers.

Health Affairs Memorandum, Policy for Comprehensive Pain Management: The memorandum, dated March 2011, resulted from a requirement within NDAA FY 2010 Section 711, that the MHS develop a comprehensive pain management policy and that all Services provide education/training to their health care providers on acute chronic pain education, use evidence-based recommendations for pain care, and make educational/training materials available to beneficiaries.

Health Affairs Memorandum, Partnership for Patients: In an effort to move towards achieving its quality goals, the MHS has also partnered with public and private organizations. For example, in 2011, Assistant Secretary of Defense for Health Affairs (ASD [HA]) pledged that the MHS would support the Partnership for Patients Initiative. The goal of this initiative, led by the Centers for Medicare & Medicaid Services (CMS), was to bring together hospital leaders, employers, caregivers, and patient advocates, along with State and Federal government leaders, to improve the safety, reliability and cost of hospital care review.

Army Policies

Army Regulation (AR) 40-68, Clinical Quality Management: This regulation establishes policies, procedures, and responsibilities for the administration of AMEDD Clinical Quality Management Program. It emphasizes the need to continually and objectively assess key aspects of individual and institutional performance to improve health care.

Army Medicine 2020 Campaign Plan: The Plan establishes the framework through which the AMEDD will achieve end sate of a responsive and reliable health service in support of all those entrusted to its care.

Medical Command (MEDCOM) Cir 40-15, Pain Assessment Documentation: This circular provides policy and implementing instructions for U.S. Army Medical Command (MEDCOM) Form 734-R (Medical Record–Pain Assessment). This form is to be completed by patients and will facilitate inpatient, health record (HREC), enhanced ambulatory record (EAR), and outpatient treatment record (OTR) documentation by cueing practitioners to document key aspects in their assessment and treatment of acute and chronic pain patients on the standard form (SF) 600 (Health Record-Chronological Record of Medical Care) (HREC, outpatient, EAR) or SF 509 (Medical Record–Progress Notes) (inpatient).

Medical Command (MEDCOM) Cir 40-13, Depression Outpatient Forms: This circular provides policy and implementing instructions for use of the depression outpatient forms prescribed by this circular: U.S. Army Medical Command (MEDCOM) Form 717-R, Depression Outpatient Documentation and MEDCOM Form 723-R, Behavioral Health Referral/Response Documentation. These forms will facilitate OTR documentation by cueing MTF practitioners to document key aspects in their assessment and treatment of depressed patients.

Medical Command (MEDCOM) Cir 40-12, Tobacco Cessation Out-Patient Forms: This circular provides policy and implementing instructions for use of the tobacco cessation outpatient form prescribed by this circular: U.S. Army Medical Command (MEDCOM) Form 709-R (Tobacco Cessation Documentation). This form will facilitate OTR documentation by cueing practitioners to document key aspects in their assessment and treatment of patients who use tobacco products.

Medical Command (MEDCOM) Cir 40-6, Low Back Pain Documentation: This circular provides policy and implementing instructions for use of the low back pain forms prescribed by this circular: U.S. Army Medical Command (MEDCOM) low back pain documentation form. This form will facilitate OTR documentation by cueing practitioners to document assessment and treatment of patients with low back pain.

The Office of the Surgeon General (OTSG)/ Medical Command (MEDCOM) Policy 14-046, Transition of Care Process for Preventing Readmissions: This policy defines the minimum standards for transitions of care related to the hospital in-patient and ED admission and discharge process for a Patient Centered Medical Home (PCMH).

Navy Policies

BUMEDINST 6010.13, Quality Assurance (QA) Program: This overarching instructional document for Navy Medicine establishes policy, publishes procedures, and assigns responsibility for Quality Assurance and Risk Management activities in Navy fixed (shore-based with permanent structures) and non-fixed (moveable shore or fleet-based) medical and dental treatment facilities in accordance with DoD Directive 6025.13.

BUMEDINST 6000.2E, Accreditation of Fixed Medical Treatment Facilities: This instructional document establishes policy, publishes procedures, and assigns responsibility for the accreditation of Navy Medicine's medical treatment facilities.

NavMed West Instructions 6010.1C, Policy and Procedures for Reporting Regional Quality Assurance and Accreditation to Navy Medicine West: This instructional document establishes policy, assigns responsibility and publishes regional guidelines for communicating selected Quality Assurance (QA) activities to Navy Medicine West (NMW), and outlines reporting guidelines for selected QA activities to NMW.

NavMed East Instructions 6010.1A, Policy and Procedures for Reporting Regional Quality Assurance and Accreditation Initiatives to Navy Medicine East: This instructional document

establishes policy, assigns responsibility and publishes regional guidelines for communicating selected QA activities to the Navy Medicine East (NME) region, and outlines reporting guidelines for selected QA activities to NME.

BUMED INSTRUCTION 5220.5, Navy Medicine Continuous Process Improvement/ Lean Six Sigma (CPI/LSS): This instructional document recognizes Continuous Process Improvement CPPI/LSS as an essential approach for improving organizational performance and achieving strategic and operational priorities at all levels of the enterprise. This instruction establishes policy and provides guidance to institutionalize and fully implement CPI/LSS throughout Navy Medicine in alignment with the DoD and Department of the Navy.

Air Force Policies

Air Force Instruction (AFI) 44-171, Patient-Centered Medical Home and Family Health Operations: This instruction defines and implements standards for Air Force Family Health Clinic business practices and supports to execute the PCMH concept and meet the following goals: optimal patient-centered care for enrolled patients using evidence-based clinical practice grounded in established population health principles, patient and staff satisfaction, and continuous process improvement of PCMH execution. It is consistent and aligns with DHA policy 09-015, Policy Memorandum Implementation of the Patient-Centered Medical Home Model of Primary Care in MTFs. The AFI is the culmination of published policy memoranda on optimizing primary care and executing the principles of PCMH from 2004 to 2010. The AFI defines specific roles and responsibilities of policy execution/accountability from AF/SG, intermediary commands, through the individual PCMH team members. It states that once the MTF is trained on PCMH by the Air Force Medical Operations Agency PCMH implementation team, the AFI becomes effective. The AFI outlines directive and recommended guidance on clinical, business, and deployment operations and identifies measures. The following measures are collected and provided by headquarters to the Medical Group commander on a monthly basis: continuity of care with PCM, technician availability, 90 available appointments/week; HEDIS® measures, RVU productivity, patient satisfaction per Service Delivery Assessment questionnaires, use of Purchased Care emergency room/urgent primary care clinics, and case mix index. The AFI recommends that the measures be reviewed with the clinic staff on a monthly basis. The AFI states the AF Inspection Agency will inspect MTF compliance of policy criteria.

Air Force Policy Directive 44-1, Medical Operations: This policy establishes the policies that the Air Force Medical Service (AFMS) will use to ensure that the highest standards of practice are applied to all aspects of health care rendered to eligible beneficiaries.

Air Force Instruction 44-108, Infection Prevention and Control Program: This instruction describes procedures for preventing and controlling health care-associated infections (HAIs) in patients, visitors, volunteers and staff within any health care setting such as MTFs, LSMTFs, AESs, Air Reserve Component Medical Units, and Dental Clinics.

Air Force Instruction 44-102, Medical Care Management: This overarching instructional document implements Air Force Policy Directive AFPD 44-1, Medical Operations, and provides

guidance for the organization and delivery of medical care. It implements various publications of DOD recognized professional organizations, The Joint Commission, the Accreditation Association for Ambulatory Health Care (AAAHC), and appropriate health and safety agencies. This instruction applies to all personnel assigned to or working in Air Force MTFs, Air Reserve Component (ARC) medical units and Aeromedical Evacuation units, including Reserve and Guard personnel during their active duty and Unit Training Assembly periods, civilian, volunteer personnel and trainees.

Air Force Instruction 44-119, Medical Quality Operations: This instructional policy implements AFPD 44-1, Medical Operations, DoDD 6025.13-R, Clinical Quality Management Program (CQMP) in the MHS, and outlines MTF roles and responsibilities in the area of clinical performance improvement (PI), explains patient safety and risk management (RM) programs, PI/accreditation/self-inspection requirements, credentials and privileging processes, and scope of practice in order to provide optimal health care delivery. This instruction applies to all Air Force Medical Service (AFMS) personnel and where specifically identified within this instruction for units of the Air Reserve Components (ARC) and Aeromedical Evacuation (AES).

Air Force Medical Service (AFMS) Strategic Plan, Objective E6: Reduce Variation to Create Reliability: The AFMS Strategic Plan has placed efforts to reduce variation and create reliability across the entire AFMS (and in every product line). The AFMS Strategic Objective E6: Reduce Variation to Create Reliability has facilitated the creation of work groups around various product lines in order to create standards that were implemented across the AFMS. Standards were created in the areas of Obstetrics, Intensive Care Units, Wrong Site Surgeries, Tissue Tracking, Patient Flow, and Readmissions. For each area, toolkits were developed to facilitate implementation.

Air Force Instruction 90-201, Special Management - The Air Force Inspection System: The instruction, dated August 02, 2013, provides a complete list of authorized inspections for Air Force facilities and includes a policy reference for each inspection.

Air Force Medical Service, Implementation of AFMS Support Staff Protocol (SSP): This document establishes the policies and provides guidance to SSPs (support staff protocols), as well as establishes strategies for implementation and sustainment of the SSPs. SSPs provide standardization, a key component of Patient Centered Medical Home (PCMH) success, and remain a primary objective of MTFs nursing services standards.

Air Force Medical Operations Agency, Standardized Use of Medical Readiness Decision Support System to Document TeamSTEPPS®: This memorandum standardizes documentation of TeamSTEPPS® training in the Education and Training module of MRDSS (Medical Readiness Decision Support System). TeamSTEPPS® is an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among the health care team. As per AFI 44-119, Chapter 2, the organization shall educate all personnel on patient safety concepts and implementation, which includes team training.

Surgeon General (SG) Doc 11-002, Partnership for Patients: This memorandum establishes Air Force support for and commitment to the Partnership for Patients Program.

Surgeon General (SG) Doc 10-0014, Requirement to Attend the Lean for Healthcare Course: This memorandum establishes the requirement that all Military Treatment Facility commanders must attend the Lean for Healthcare Course as a means to provide Air Force Medical Service leaders with the knowledge and tools to lead change in their organizations. Application of continuous process improvement tools in daily clinical operations requires leaders who foster and sustain a culture that constantly reduces waste and enhances quality. Lean for health care training is an excellent way to prepare leaders to translate these principles into action.

National Capital Region (NCR) Policies

6025.01 JTF Clinical Quality Manual: This Manual implements the policy guidance, procedures, and responsibilities for the administration of a Clinical Quality Management (CQM) Program (CQMP) by the Joint Task Force National Capital Region Medical (JTF CapMed) within the National Capital Region (NCR) under the guidance of DoD Instruction 6025.13, and Army Regulation 40-68. It also describes the relationships between JTF CapMed and the Military Services for quality management and administration functions for issues related to personnel assigned to inpatient Medical Treatment Facilities [(MTFs), i.e., FBCH and WRNMMC] in the NCR and the Joint Pathology Center (JPC).

Appendix 4.2
Internal and External Reports

Key Findings

The first key finding indicates the need for an enhanced MHS structure and process for disseminating and implementing study findings. Traditionally, study recommendations are presented at the Clinical Quality Forum (CQF) or the Scientific Advisory Panel (SAP), but often subsequent communication to the Services varies. In the new MHS governance structure, (see Section 2 of this report), the CQF will report its findings to the Medical Operations Group (MOG). In its role as a liaison to senior leadership, the MOG can facilitate better communication of findings and development of action plans, and ensure follow up on action plans reported to senior leadership.

A second finding was the lack of a formal mechanism to monitor internal and external study recommendations throughout the multiple layers of the organization to assess resulting change to policy or procedures. The new governance structure has greater potential for collaboration; however, a clear response system is needed to monitor positive and negative outcomes, as well as to identify ongoing research and implementation gaps.

The third finding from the internal and external study review highlights the difficulties in achieving accurate and efficient bidirectional transmission of data between outpatient and inpatient records. This concern was raised in several reports, including prenatal care, case management, and asthma studies. Collecting and analyzing appropriate metrics and information will continue to be a challenge until a new electronic health record (EHR) system linking inpatient and outpatient records is acquired.

Finally, in a number of studies reviewed, study methodology was not adequate for the study objectives and often data needed for analysis was not accessible to the authors to answer the study questions.

The 10-year retrospective review of studies and reports identified 51 studies and reports, of which 23 were potentially relevant to quality of care in the MHS. Each of the relevant studies and reports is described below.

Study Summaries

Lumetra External Review: In 2007, Congress mandated an external review of the MHS's Medical Quality Improvement Program (MQIP). The assessment was conducted from October 2007 through July 2008 to address how well DoD managed medical quality in its health care system. Lumetra made multiple recommendations, many of which were implemented following publication of the report.

Evaluation of Tobacco Use Cessation Programs (2008): The purpose of this comprehensive evaluation was to assess the overall impact and efficacy of tobacco cessation initiatives, and to

evaluate the status of tobacco control and tobacco use cessation policies and programs at the Service level and at military installations. The report recommended an update to DoD policy; improvement in tracking of tobacco use prevalence, incidence, and medication costs of treating tobacco addiction; cost-benefit analysis; and a standard set of program process and outcome measures.

Evaluation of Hypertension among Beneficiaries with Diabetes Mellitus – Study Arm #1: Blood Pressure Control in the TRICARE Direct Care System (2008): The purpose of the study was three-fold: 1) examine blood pressure (BP) control observed in the TRICARE direct care component during calendar year 2007; 2) examine MHS service utilization and clinical characteristics associated with BP control; and 3) examine MHS hypertension medication regimens associated with BP control. The study recommended that a stepped-care approach of pharmacotherapy and therapeutic lifestyle change should be used to achieve BP targets, modifying the treatment plan when the targets are not achieved. It also suggested that standardized measuring regimens, BP management, and goal setting may further optimize BP control performance in the direct care system.

Evaluation of Influenza Immunization Rates among Enrolled Beneficiaries with Diagnosed Asthma, Heart Failure, and/or Acute Myocardial Infarction In the Military Health System (2008): The purpose of the study was to determine influenza immunization status and health care utilization during FY 2008 for those MTF beneficiaries with three high-risk chronic conditions (asthma, congestive heart failure [CHF], history of acute MI). The study recommended improvement in vaccination programs for high-risk patients diagnosed with asthma, CHF, or AMI to target beneficiaries with no evidence of receipt of the flu vaccine by end of November. Additionally, it recommended a future study to track availability of flu vaccine within cardiac and specialty clinics for enrolled MHS beneficiaries in high-risk categories.

Case Management Services for TRICARE Beneficiaries with Serious Mental Health Conditions - Part 1 (2010) and Part 2 (2011): The objective of the report was to describe and evaluate Case Management (CM) services among TRICARE behavioral health patients with potentially serious mental illness during FY 2010. The report made three major recommendations: 1) Develop a standard template in AHLTA to document mental health information that is essential to all providers who may provide care for beneficiaries with mental health conditions, 2) Undertake a randomized controlled trial if a definitive answer as to the effectiveness of CM in the MHS is needed; 3) Consider revising the DoD Medical Management Guide to more clearly and specifically incorporate either the AHRQ framework or the CMSA standards of practice as measurable performance objectives.

Prenatal Care Among Women with Uncomplicated Deliveries (2011): The purpose of the study was to examine compliance with the Clinical Practice Guideline (CPG) on prenatal care utilization, prenatal routine testing and pregnancy outcomes among women with uncomplicated deliveries from FY 2006 to FY 2010. The study recommended improving the coding and documentation of routine prenatal care, improving documentation of maternal Group B

Streptococcal prophylaxis in the newborn record, and developing a predictive model for prenatal appointments.

Cervical Cancer Screening Within DoD (2011): The purpose of the study was to describe DoD MHS beneficiaries and their screening for cervical cancer, including: 1) proportion of women from 18-20 years of age that are receiving PAPs and the proportion that had an abnormal test result; 2) intervals between PAPs for women between 21 and 64 years; 3) number of DoD beneficiaries that had cervical intra-epithelial neoplasia grade 2+ (CIN 2+) on a PAP and the proportion that had a 3-year negative history for CIN 2+ on a PAP; 4) among DoD beneficiaries with CIN 2+, the frequency interval of PAPs; and 5) among women with CIN 2+, the proportion of women that had appropriate follow up and the time interval for reevaluation. The report recommended emphasizing to clinicians and patients the importance of timely and appropriate follow up when PAPs are abnormal and developing a system to track results, and subsequent follow ups using the administrative database (the system could appropriately flag patient records for timely repeat PAPs or diagnostic procedures when the initial PAP results indicate necessity). Additionally, it recommended aligning PAP screening recommendations for all active duty women with the latest U.S. Preventive Services Task Force and American Congress of Obstetrics and Gynecology recommendations and to further educate providers on latest changes to cervical cancer screening recommendations within each Service.

Low Back Pain Evaluation and Treatment in the Military Health System: The purpose of the study was to collect and describe the baseline measures of key metrics and quality indicators associated with evidence-based care for the treatment and management of low back pain (LBP) in the MHS. The report recommended the implementation and use of LBP monitoring metrics and quality indicators with ongoing evaluation and monitoring at the local level of the MTF where the care is actually delivered. It also recommended the development and implementation of technological tools to facilitate adherence with guideline-concordant practice, such as an updated AHLTA template. Another recommendation was to continue the development, implementation, and use of education targeting recommended use of imaging studies in the evaluation of LBP (e.g., LBP CPG toolkit) and the design and development of proactive patient education, both inside and outside of primary care clinics.

Childhood and Adolescent Overweight / Obesity Evaluation, Recognition, and Counseling in Direct Care System Outpatient Care (2012): The purpose of the study was to investigate quality of care metrics for pediatric overweight and obese patients seeking outpatient care in MTFs and gain a more reliable understanding of BMI percentile assessments, overweight/obesity diagnosis, and counseling performed in direct care component outpatient care among patients identified as overweight or obese in Central Data Repository (CDR) data. The report made several recommendations, including: 1) Develop a MHS-wide, standardized CPG to address pediatric overweight/obesity, 2) Increase investment in nutrition specialty care across direct care outpatient clinics and/or revise TRICARE coverage policy to open access outside of the direct care component 3) Consider moving the current MHS childhood obesity quality measure on overweight/obesity diagnoses away from development to finalization, and 4) Continue developing a CDR-based methodology to adequately estimate quality of counseling as part of MHS's childhood obesity quality measures initiative.

Prenatal Care among Women with Uncomplicated Deliveries (2012): The purpose of the study was to examine prenatal care outpatient visit patterns, both routine and non-routine, among women who subsequently had an uncomplicated delivery. The report recommended improved coding and documentation of routine prenatal care, identification of reasons for the deficit of early prenatal care visits, and development of a predictive model for prenatal appointments.

Chronic Opioid Therapy Report (2012): The purpose of the report was to describe MHS chronic opioid therapy patients, and to estimate and characterize the prevalence of possible and potential opioid misuse. The report recommended validating the TROUP scoring system before applying data to MHS population, and for the MHS to operationalize a valid misuse predictive system in a real time automated risk detection program. It also recommended improving the CPGs to assist clinicians in making better decisions regarding opioid prescriptions. Additional training for clinicians to integrate a future MHS automated predictive system into an opioid pain management therapy was also a recommendation.

Evaluation of Chlamydia Trachomatis Screening for Active Duty Women (2007): The purpose of the study was to evaluate the recruit screening and annual chlamydia screening program for active duty females. Between October 2005 and April 2007, chlamydia testing and prevalence rates among active duty women, younger than age 25 and who entered the services during FY 2005, were calculated to determine compliance with the service policies regarding annual testing. The report urged services to follow current policies for annual chlamydia screening and recommended to conduct a follow-up study on screening, type of testing, and frequency of other testing simultaneously with chlamydia (e.g., PAP, Human Papilloma Virus [HPV]).

Chronic Heart Failure Care Performance Measures in the Military Health System (2007): The purpose of the study was to examine baseline MHS chronic heart failure data for 10 measures, 7 of which were being followed and reported by the IHI in its 2006 "Protecting 5 Million Lives from Harm" campaign. These measures included left ventricular systolic (LVS) function assessment, ACE inhibitor or ARB at discharge (D/C), anticoagulant at D/C for chronic heart failure patients with A-fib, smoking cessation advice and counseling, D/C instructions, and flu and pneumococcal immunizations. The other three measures included 30-day readmission rates, use of beta-blocker medications for chronic health care patients, and 90-day visit to ED or admission rate for heart failure after ED D/C for heart failure. The report recommended that DoD examine practices to improve counseling for weight monitoring, as this procedure can have a significant impact on hospital admissions and readmissions. Additionally, increasing the rate at which appropriate beta-blockers are prescribed for heart failure can also affect hospitalizations, as well as premature mortality.

Postpartum Depression in the Military Health System: The purpose of the study was to evaluate Postpartum Depression (PPD) rates among beneficiaries with liveborn deliveries. The report indicated that risk factors and differential PPD rates suggest populations may be served with improved monitoring based on certain risk characteristics. PPD may be predictable and there may be proactive means to identify for PPD.

Clinical Practice Guidelines in Military Health System (2006): The purpose of the report was to evaluate the level of CPG implementation across the MHS direct care component, and to report Primary Care Manager (PCM) attitudes regarding knowledge and use of CPGs. The report also attempted to quantify a return on investment to the MHS. The report provided the following recommendations: 1) Critically review VA/DoD CPG efforts within MHS to increase provider awareness, 2) Determine cause(s) of low provider response rate (13 percent), 3) Use survey results in context of relative provider sample size; and 4) Use study results in future CPG studies.

Military Health System Clinical Practice Guideline Implementation Evaluation- Phase 1 Quest development: The survey was developed to measure MHS health care provider attitude, awareness, knowledge, and use of CPGs, as well as identify any barriers to CPG use. The data was used to determine if there is a relationship between quality (process and outcome) of care and the availability and the provider use of CPGs.

Discharge instructions following hospitalization for heart failure (2005): The study used the data set to examine the relationship between heart failure discharge instruction documentation during a heart failure hospitalization and readmission to the hospital within 30 days. The study additionally examined 60- and 90-day re-hospitalizations for heart failure at all MTFs, pre-existing comorbidities, utilization of services following the index hospitalization and mortality of heart failure patients, and MTF services for heart failure patients. In light of the large number of beneficiaries who did not receive heart failure medications following discharge and given that medications are an effective treatment, the report recommended examining heart failure medication prescription patterns at MTFs. Additionally, it recommended studying the differences in the process of care between MTFs with heart failure clinical (HFCs) and without HFCs to understand the lack of difference in readmission outcomes between the two groups of MTFs.

DoD Medical Treatment Facilities Patient Safety Indicator (PSI) 17, Birth Trauma: The purpose of this study was to investigate the high rate of birth trauma in FY 2003 by measuring birth trauma in administrative data and in data abstracted from hospital inpatient birth records for FY 2004. The two methods of measuring birth trauma were then compared for agreement in identifying birth trauma. The study found that the percentage agreement between the administrative data identification of birth trauma and the medical record identification of trauma was 21.65 percent and 24 MTFs had percentage agreement of 25 percent or less. The study concluded that birth trauma coding at MTFs was not of sufficient quality at that time to allow the AHRQ birth trauma PSI to be calculated using SIDR data. The birth trauma rate at MTFs for FY04 using medical records data was below the AHRQ benchmark, indicating that the quality of care for infants born at MTFs is high. Recommendations were to: 1) implement ongoing obstetric coding audits across all MTFs delivering babies, and based on those audit findings, establish an appropriate ongoing system-wide training program to elevate coding proficiency to 100 percent accuracy; and 2) monitor birth trauma coding at MTFs to ensure standardization before collecting and publishing birth trauma rates.

Obstetric Utilization and Quality of Care (KePRO, Purchased Care only): The purpose of the study was to better understand the Purchased Care obstetrical practices and resulting maternal and infant outcomes related to elective induction or cesarean section between 37 and 39 completed weeks of gestation. Two of The Joint Commission's Perinatal Care (PC) Core Measures dealing with Elective Delivery (PC01) and Cesarean Section (PC02) were evaluated in this study as well as ACOG standard requiring 39 completed weeks of gestation prior to elective delivery. The report recommended that regional differences in elective delivery and C-section rates may warrant further investigation and that a study with a larger sample size would facilitate better understanding the drivers of regional differences. Because The Joint Commission's measure guidelines stipulate inclusion of factors that are not found in the administrative claims data (e.g., weeks of gestation, parity, and delivery position), only a fraction of the selected charts qualified for each clinical inclusion measure. As such, a large sample size would provide greater strength to future study conclusions.

30-Day Readmissions (KePRO, Purchased Care only) (2013): The purpose of the study was to evaluate best-practice discharge process and to identify potential drivers of unscheduled hospital readmissions among TRICARE's Prime beneficiaries who had a primary discharge diagnosis of Heart Failure (HF), Acute Myocardial (AMI) Infarction, or Pneumonia (PN). The report recommended for a prospective randomized study to assess the impact of one or more such discharge initiatives, such as patient education and arranging for post-discharge follow-up appointments, on re-hospitalization rates.

TRICARE Low Back Pain (KePRO, Purchased Care only) (2012): This focused study was conducted to better understand the diagnosis, treatment, and outcomes associated with TRICARE enrollees suffering from low back pain who received care in the Purchased Care environment. The study identified provider adherence to evidence-based practice guidelines including screening for red flag conditions, the rate of imaging procedures commonly used in the assessment of LBP for patients with positive or negative red flag condition screenings, and the magnitude and scope of physical therapy as part of low back pain treatment. The report indicated that while the final sample of 1,475 records does provide enough information to highlight general trends in the population as a whole on the use of imaging studies in LBP, comparisons between regions would benefit from a larger, more representative sample taken from each region.

A Report to Congress: Study Incidence of Breast Cancer among Members of Armed Services (2014): DoD submitted the report in accordance with the National Defense Authorization Act for Fiscal Year 2013 (HR 4310), section 737. The findings from the report reflected the MHS's commitment to implement policies and laws that are most likely to improve the quality and effectiveness of breast care to include prevention, early detection, and awareness of risks for breast cancer among all MHS eligible beneficiaries. The foundation of this commitment was the design and delivery of a comprehensive breast care benefit that continuously assesses each component of the breast care experience and that draws on evidenced-based clinical practices, cutting-edge cancer diagnostics, treatment technologies, and evidence from high-priority clinical cancer trials. DoD's internal efforts and considerations are ongoing and have not required changes to law or policy for implementation. The report also

indicated that within the current policy, legislative framework, and future directions for research, the military health benefit continue to support a comprehensive consideration of promising technologies and treatments for breast cancer preventive care and treatments.

Views of Quality of Care in MTF and Civilian Systems Among TRICARE Prime Beneficiaries: The Survey of TRICARE Prime Beneficiaries was conducted to examine how their experiences with the MHS varied by where the care was received, MTF versus PCM assignment. Beneficiaries assigned to civilian PCM as opposed to MTF were more likely to rate higher the quality of care at both civilian and military facility. The results indicated that the survey should be repeated to include questions as to why beneficiaries rate as they do and determine potential MTF improvements to perceived quality of care. It also recommended determining if prior (pre-TRICARE) health insurance experience affected beneficiary perception of quality of care.

Volume of Complex Procedures and Conditions at Military Treatment Facilities: The study examined the average annual volume of complex surgical procedures and medical conditions with a high risk of mortality across MTFs guided by the assumption that greater volume among MTF surgeons and staff can promote and improve clinical skills necessary to safely treat patients with complex conditions. The report recommended measuring availability and productivity of surgeons in MTFs and determining if PCM are referring Inpatient Quality Indicators (IQI) procedures to MTF or civilian hospitals.

Appendix 4.3
Quality of Care Education and Training

Air Force Training

The Air Force has several methods of providing training related to quality care, each geared to the various levels of leadership, supervisors and staff. Formal training is offered in multiple locations with oversight provided by the Air Education Training Command (AETC), the USAF School of Aerospace Medicine (USAFSAM), or AFMOA. In the Air Force, there are currently 107 courses addressing quality of care, among the over 228 formal courses identified. There are 48 courses in particular that dedicated 787 total hours to the study of quality.

The Air Force provides resources and training on quality of care and key quality programs to Airmen and personnel. Although Air Force medics of all ranks receive extensive quality training during their professional development, there is no specific policy requiring or defining that training. Formal courses designed for senior leaders provide the education and skills required to lead organizations in providing quality health care. Instruction on quality totaled over 52 hours in these courses with 875 personnel attending within the last three years. Medical Group (MDG) Commanders attend the AF Medical Service Group Commanders' Course, the University of Tennessee Lean Healthcare Leader's Course, and the MDG Commander Aerospace Medicine Workshop. Additionally, the Chief of Medical Staff Symposium, the Nursing Practice Oversight Council, both Intermediate Executive Skills Courses and the Chief Aeromedical Services & Advanced Flight Surgeon Symposium are required for personnel identified for leadership positions within AF MTFs. MDG Commanders and Group Superintendents also attend an additional 4-16 hours of training at the AFMS annual Leadership Symposium.

Airmen in mid-level leadership roles receive 8-12 hours of combined quality and patient safety training, whereas staff serving as Chief of Quality or Chief of the Medical Staff, attend Quality Systems Program Assessment Review (QSPAR) Symposium receiving up to 40 hours of accredited quality education. Dental leaders receive 4 hours of annual quality and patient safety instruction at the annual Dental Leadership Course. Finally, a majority of Airmen participate in accreditation preparation and receive training in The Joint Commission or AAAHC performance standards.

Training on quality in formal courses is also incorporated within various entry-level and advanced training courses for supervisors and staff. There are 48 courses with a total of 787 hours specifically dedicated to Quality. There were 14,925 members trained in those courses from FY11-FY13.

Medical Airmen also completed training with alternate methods using Computer-Based Training (CBT) through USAFSAM and SWANK. There are 51 courses offered through these platforms that specifically provided Quality training. Additionally, there are nine CBT courses available and tracked within the Advanced Distributive Learning System (ADLS). This system is the AF corporate solution for tracking training online. There were 68,515 instances that members accessed these courses in the last two years.

At the MTFs, those responsible in monitoring HEDIS® or ORYX ® measure of care performance, receive targeted instruction, whereas National Surgical Quality Program (NSQIP®) participants attend annual conferences to learn from established sites. Likewise, all Air Force hospitals participate in the National Perinatal Information Center (NPIC) program and train personnel on interpretation of perinatal outcome data. Furthermore, in an effort to enhance care quality at MTFs, the Air Force has invested in simulation technology for Obstetrics providers, with modules covering various obstetrics topics.

Army Training

Army training efforts concerning topics related to quality of care is provided through a multi-tiered system and defined as training that focuses on evidence based practices and objective measures of performance such as; Joint Commission ORYX® Core Measures Set, National Perinatal Information Center Data, Healthcare Effectiveness Data and Information Set (HEDIS®) Measures, Patient Surveys, Primary Care Manager (PCM) Continuity, Accreditation, and Certification.

Annually, the Army Medical Command issues training requirements. Current mandatory quality of care training includes ten hours of initial (on-boarding) training, followed by approximately eight hours of training, to be conducted every three years. Furthermore, Individual Regional Medical Commands and MTFs may require additional periodic training at the discretion of Commander; often based on performance measures and command inspection findings. In an effort to ensure compliance with Army policies, the Army Digital Training Management System is used to monitor the training status of Army commanders, supervisors and staff. In the event of lack of compliance with training requirements, facility training office notifies noncompliant staff member and their supervisors. Furthermore, to ensure visibility of compliance levels, individual and unit training status levels are briefed to the commanders monthly.

The Army Medical Department Center and School (AMEDD CS) is the entity providing centralized training to commanders, supervisors, and staff. Since 2011, AMEDD CS has provided an average of 10,300 hours of advanced level "quality of care" training annually to 1,555 supervisory and command personnel. This is in addition to the MEDCOM universal mandatory training requirements.

Training efforts to enhance quality of care are supported via a robust MEDCOM LSS PI program. During the last four years, 420 personnel have completed Green Belt training and 198 Black Belt Training. There are 35 Master Black Belt trained personnel in MEDCOM to provide guidance and advice in process improvement. Improvement projects are shared via posting to the Army "PowerSteering" web site. Process improvement projects have focused on improving the Patient Centered Medical Home experience to improving the quality of care provided to Army health system beneficiaries.

Navy Training

BUMEDINST 6010.13 says, "Individuals responsible for QA program management must by afforded educational opportunities commensurate with their responsibilities. Education may be provided within the military our through civilian sponsored services. QA education for key program managers must be sufficient in scope and frequency to enable effective program oversight." Providing safe, quality care is paramount to Navy Medicine. Navy Medicine offers the following training specific to quality to its MTF personnel:

1. Annual Joint Commission/Navy training. Audience includes staff working in patient safety, quality improvement, risk management, and the medical staff.
2. In 2012, all MTF quality staff had access to the Institute for Healthcare Improvement (IHI) open school. Numerous quality courses were offered; the ability to track course completion was not available.
3. Each year the Nurse Corps selects and sends one officer to The Joint Commission for a one-year fellowship. Follow-on tours are at the regions or Medical Centers (MEDCEN). Fellows survey each MTF in their AOR in between TJC triennial survey (and as needed) to assess compliance with standards. This initiative helps to provide an assessment of quality and sharing of best practices.
4. Navy has a robust Lean Six Sigma program. Navy Medicine's Lean Six Sigma program was launched in 2006 pursuant to higher authority directives from the Deputy Secretary of Defense, Secretary of the Navy, and Secretary of Defense. Navy Medicine's Lean Six Sigma program is structured to provide both training and mentoring throughout the Navy Medicine enterprise. The Bureau of Medicine and Surgery (BUMED) Office of Strategy Management serves as the Program Executive Office responsible for setting policy, development of standard operating procedures, training support, curriculum management, staff certification, financial validation, website development, and software management for the program. In addition, BUMED directs coordination and alignment with other process improvement entities at the BUMED, Tri-Service, and Department of the Navy levels.
    a. The Lean Six Sigma governing structure includes senior military members that serve as the Regional Black Belts, providing oversight and direction of the Lean Six Sigma activities at the respective region; and Master Black Belt's that serve as process experts and technical advisors on project management, tool selection, and statistical analysis.
    b. As of 1 July 2013, the Lean Six Sigma program has achieved a 1:11.4 program Return on Investment with more than $239 million in cost avoidance and cost savings. All enterprise projects launched in FY 14 align with one of the BUMED Strategic Planning goals of Readiness, Value and Jointness.
    c. As of July 2014, 340 Lean Six Sigma projects have been completed with a validated cost avoidance/cost savings of more than $239 million. There are currently 45 active Lean Six Sigma projects in progress that target improving patient safety, quality of care, clinical efficiency, and standardization throughout the Navy Medicine enterprise.

   d. Navy Medicine has a total of eleven staff members that provide full time support to the Lean Six Sigma program; BUMED-5 total; NME-3 total; NMW-3 total. The staff serves as Regional Black Belts, Master Black Belts, Black Belts, and administrative support staff for training, software management, program communication and logistics.
   e. The Lean Six Sigma training curriculum provides participants advanced knowledge on value stream mapping of the current and future state, risk prioritization, continuous process flow, Failure Mode Effects Analysis (FMEA), data analysis, statistical process control, mistake proofing, visual cuing and process standardization. A total of 2,815 Navy Medicine staff have been trained including 1,140 Champions, 185 Black Belts and 1,490 Green Belts. Additionally, 30,969 CEUs and 3677 CMEs have been awarded. The goal of the training program has been to infuse a culture of continuous improvement throughout the Navy Medicine enterprise.
5. Other available training is addressed in the safety working group but also ties into quality. It includes TapRooT®, AHRQ TeamSTEPPS®, and Systems Engineering Initiative for Patient Safety (SEIPS) training.

Ongoing Bureau of Medicine and Surgery Patient Safety/Quality Management/Risk Management Department provides training in the following:

1. Monthly infection prevention video teleconferences (VTC)
2. Bi-monthly patient safety/risk/quality management VTCs
3. Quarterly VTCs for the Executive Committee of the Medical Staff and medical staff coordinators.
4. Training/education is provided to the Senior Nurse Executives as needed/requested.

Additional training is provided by the MTF to staff; the specifics of MTF training are not available at the headquarters level. There is no standardization of quality training requirements for the Navy.

Purchased Care Education and Training

The contractors are required to maintain qualified and experienced key personnel to meet the requirements of their contract. This is accomplished through the Clinical Quality Management Program plan, which provides the staff qualifications and responsibilities required.

Appendix 4.4
Data Review: Supporting Data and Figures

Accreditation and Certifications – Supporting Tables and Figures

Table 4.4-1 Number of Accreditations and Certifications by Type and Service

Service	TJC	AAAHC	Lab & Blood Bank[3]	Radiology & Nuclear Medicine	Subspecialties	Advanced Medical and Dental Education
Air Force	13	63	110	70	23	47
Army	30	-	42	23	6	29
Navy	27	-	62	1	9	27
NCR	2	-	7	5	3	7
Total	72	63	221	99	41	110

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HEDIS® Measures of Performance - Supporting Tables and Figures

Table 4.4-2 HEDIS® rating based on NCQA benchmark

HEDIS® rating based on NCQA benchmark	
Star Rating	**Percentile**
★★★★★	At or above the 90th Percentile
★★★★	Between the 75th and 89th Percentile
★★★	Between the 50th and 74th Percentile
★★	Between the 25th and 49th Percentile
★	Below the 25th Percentile

2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

[3] Reported number of accredited laboratories at MTFs, not the number of accredited MTFs.

Table 4.4-3 Percent of Eligible Patients Receiving Select Care Measures, External Comparison: MHS vs. HEDIS® (2010 - 2013)

HEDIS® Measures	2010	2011	2012	2013	% Change in Rate (12 to 13)	HMO Nat'l Avg. (12)	HEDIS® Benchmark Status (13)
Antidepressant Medication Management: Acute Phase	64.98	66.22	65.68	68.51	2.83	69.1	★★★
Antidepressant Medication Management: Continuation Phase	41.64	43.27	42.68	46.08	3.4	53.6	★★
Use of Appropriate Medications for People With Asthma: Overall Rate	97.29	96.42	95.78	94.71	-1.07	91.2	★★★★
Breast Cancer Screening	70.57	69.09	69.13	68.88	-0.26	70.3	★★
Cervical Cancer Screening	79.87	79.69	78.75	76.87	-1.88	75.5	★★
Chlamydia Screening	67.34	64.3	60.82	59.72	-1.11	45.1	★★★★
Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Control)	55.36	56.55	56.7	59.57	2.87	59.9	★★
Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C Screening)	77.97	76.38	78.15	77.56	-0.59	88.3	★
Colorectal Cancer Screening	67.61	68.7	68.1	69.82	1.72	63.3	★★★★
Diabetes HbA1c <=9	76.82	76.82	77.24	78.2	0.96	71.5	★★★
Comprehensive Diabetes Care: HbA1c <7 percent for a Selected Population	52.21	53.27	53.39	53.53	0.14	43.2	★★★★★
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8 percent)	69.38	69.6	69.23	70.38	1.15	61.3	★★★★
Diabetes HbA1c Screening	83.87	83.78	84.4	84.89	0.49	87.2	★
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	53.67	54.91	52.99	55.8	2.81	48.4	★★★★
Comprehensive Diabetes Care: LDL Cholesterol Screening	80.13	80.12	80.41	80.69	0.29	85.4	★
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	74.92	77.23	78.46	74.84	-3.62	76.0	★★
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	55.38	59.6	62.79	58.46	-4.33	57.9	★★
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	62.7	68.75	73.86	79.15	5.3	78.2	★★

Green – indicates positive change with statistical significance
Red – indicates negative change with statistical significance
No color – indicates lack of statistical significance
2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

Table 4.4-4 Service Level & Purchased Care HEDIS® Performance (2013)

HEDIS Measures	Air Force	Army	Navy	NCR	TRO
Antidepressant Medication Management: Acute Phase	★★★★★	★★	★★★	★★★★	★★★
Antidepressant Medication Management: Continuation Phase	★★★	★	★★	★★★	★★★
Use of Appropriate Medications for People With Asthma: Overall Rate	★★★★★	★★★★★	★★★★	★★★★★	★★★
Breast Cancer Screening	★★★	★★★★	★★★★	★★★	★
Cervical Cancer Screening	★★★	★★★★★	★★★★★	★★★★	★
Chlamydia Screening	★★★★	★★★★★	★★★★★	★★★★	
Cholesterol Management	★★	★★	★★★★	★★★	
Cholesterol Screening	★	★	★★	★	★
Colorectal Cancer Screening	★★★★	★★★★★	★★★★★	★★★	★★★
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9 percent)— Lower rates signify better performance	★★★	★★★	★★★★	★★★★	
Comprehensive Diabetes Care: HbA1c <7 percent for a Selected Population	★★★★★	★★★★★	★★★★★	★★★★★	
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8 percent)	★★★★	★★★★	★★★★★	★★★★★	
Comprehensive Diabetes Care: HbA1c Screening	★★	★★	★★★	★★	★
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	★★★★	★★★★	★★★★★	★★★★	
Comprehensive Diabetes Care: LDL Cholesterol Screening	★★	★★★	★★★★	★★	★
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	★★	★★★★	★★★	★★	★
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	★★	★★★★	★★★★	★★	★
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	★★	★★	★★	★★	★★

2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

Table 4.4-5 HEDIS® Measures: CONUS – OCONUS

HEDIS® Measures (CONUS/OCONUS)	2013 OCONUS (percent of Patients)	Change in Rate (2012 to 2013) OCONUS	2013 Star Rating OCONUS	2013 CONUS (percent of Patients)	Percent Change in Rate (2012 to 2013) CONUS	2013 Star Rating CONUS
Antidepressant Medication Management: Acute Phase	64.01	3.79	★★	68.75	2.79	★★★
Antidepressant Medication Management: Continuation Phase	40.77	4.58	★	46.37	3.35	★★
Use of Appropriate Medications for People With Asthma: Asthma Medication Rate	95.33	-1.43	★★★★★	94.68	-1.06	★★★★
Breast Cancer Screening	65.8	-3.58	★	68.95	-0.18	★★
Cervical Cancer Screening	84.6	-4.51	★★★★★	76.44	-1.76	★★
Chlamydia Screening in Women: Total Rate	66.11	1.28	★★★★★	59.12	-1.33	★★★★
Cholesterol Management for Patients with Cardiovascular Conditions: LDL Control (<100 mg/dL)	60.04	11.49	★★	59.56	2.78	★★
Cholesterol Management for Patients with Cardiovascular Conditions: LDL Cholesterol Screening	84.99	3.83	★	77.47	-0.67	★
Colorectal Cancer Screening	67.82	-4.7	★★★	69.86	1.77	★★★★
Comprehensive Diabetes Care: Poor Glycemic Control (HbA1c >9 percent)—Lower rates signify better performance	79.17	4.56	★★★★	78.16	0.89	★★★
Comprehensive Diabetes Care: HbA1c <7 percent for a Selected Population	50.14	-2.12	★★★★★	53.64	0.23	★★★★★
Comprehensive Diabetes Care: Good Glycemic Control (HbA1c <8 percent)	69.31	2.7	★★★★	70.41	1.14	★★★★
Comprehensive Diabetes Care: HbA1c Screening	89.63	5.16	★★	84.79	0.4	★
Comprehensive Diabetes Care: LDL Cholesterol Control (<100 mg/dL)	54.12	12.28	★★★★	55.86	2.69	★★★★
Comprehensive Diabetes Care: LDL Cholesterol Screening	86.82	4.91	★★★	80.58	0.18	★
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	94.63	0.41	★★★★★	74.08	-3.78	★★
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	89.27	0.12	★★★★★	57.29	-4.52	★★
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	80.9	8.42	★★★	79.02	5.07	★★

2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

Table 4.4-6 Percent of Eligible Purchased Care Patients Receiving Select Care Measures, External Comparison: MHS vs. HEDIS® (2010 – 2013)

HEDIS® Measures Purchased Care (TRO)	2010	2011	2012	2013	% Change in Rate (12 to 13)	HMO Nat'l Avg. (12)	HEDIS® Benchmark Status (13)
Antidepressant Medication Management: Acute Phase	63.61	64.77	64.75	68.78	4.03	69.1	★★★
Antidepressant Medication Management: Continuation Phase	42.79	45.68	45.12	49.64	4.52	53.6	★★★
Use of Appropriate Medications for People With Asthma: Overall Rate	97.2	94.75	94.4	92.68	-1.71	91.2	★★★
Breast Cancer Screening	66.45	64.49	63.93	63.46	-0.47	70.3	★
Cervical Cancer Screening	71.9	71.38	70.13	68.9	-1.23	75.5	★
Cholesterol Screening	73.67	73.67	74.26	71.52	-2.74	88.3	★
Colorectal Cancer Screening	61.57	62.9	63.48	64.18	0.7	63.3	★★★
Comprehensive Diabetes Care: HbA1c Screening	78.27	77.71	78.6	78.03	-0.57	87.2	★
Comprehensive Diabetes Care: LDL Cholesterol Screening	74.33	73.65	74.22	72.48	-1.73	85.4	★
Follow-Up After Hospitalization for Mental Illness: Within 30 Days Post-Discharge	63.21	61.82	61.92	57.4	-4.52	76.0	★
Follow-Up After Hospitalization for Mental Illness: Within 7 Days Post-Discharge	38.24	36.73	40.18	34.43	-5.74	57.9	★
Well-Child Visits (Ages 0–15 Months): Six or More Well-Child Visits	69.55	74.79	75.73	77.97	2.24	78.2	★★

Green – indicates positive change with statistical significance
Red – indicates negative change with statistical significance
No color – indicates lack of statistical significance
2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

Table 4.4-7 Star Ratings for OCONUS from 2010 to 2013

HEDIS® Measures (OCONUS)	2010	2011	2012	2013	Change in Rate (12 to 13)	Current Rating
Antidepressant - Acute	60.98	61.54	60.23	64.01	3.79	★★
Antidepressant – Continuous	35.01	36.67	36.2	40.77	4.58	★
Asthma Appropriate Meds	96.67	97.67	96.76	95.33	-1.43	★★★★★
Breast Cancer Screening	69.02	67.22	69.38	65.8	-3.58	★
Cervical Cancer Screening	87.62	88.63	89.11	84.6	-4.51	★★★★★
Chlamydia Screening	70.3	67.62	64.84	66.11	1.28	★★★★★
Cholesterol Management	51.65	55.53	48.55	60.04	11.49	★★
Cholesterol Screening	80.92	80.58	81.16	84.99	3.83	★
Colorectal Cancer Screening	65.76	67.91	72.52	67.82	-4.7	★★★

HEDIS® Measures (OCONUS)	2010	2011	2012	2013	Change in Rate (12 to 13)	Current Rating
Diabetes A1C <=9	74.44	74.31	74.61	79.17	4.56	★★★★
Diabetes A1C <7	46.29	48.41	52.27	50.14	-2.12	★★★★★
Diabetes A1C <8	65.21	65.62	66.61	69.31	2.7	★★★★
Diabetes A1C Screening	85.27	86.22	84.47	89.63	5.16	★★
Diabetes LDL Control	48.06	48.85	41.85	54.12	12.28	★★★★
Diabetes LDL Screening	81.94	83.82	81.91	86.82	4.91	★★★
Mental FU 30 Days	89.67	91.85	94.22	94.63	0.41	★★★★★
Mental FU 7 Days	83.37	85.05	89.15	89.27	0.12	★★★★★
Well Child >=6 Visits	59.55	63.12	72.48	80.9	8.42	★★★

Green – indicates positive change with statistical significance; Red – indicates negative change with statistical significance; No color – indicates lack of statistical significance
2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

Table 4.4-8 Star Ratings for CONUS from 2010 to 2013

HEDIS® Measures (CONUS)	2010	2011	2012	2013	Change in Rate (2012 to 2013)	Current Rating
Antidepressant - Acute	65.24	66.48	65.96	68.75	2.79	★★★
Antidepressant – Continuous	42.07	43.64	43.02	46.37	3.35	★★
Asthma Appropriate Meds	97.32	96.36	95.74	94.68	-1.06	★★★★
Breast Cancer Screening	70.6	69.13	69.13	68.95	-0.18	★★
Cervical Cancer Screening	79.42	79.17	78.2	76.44	-1.76	★★
Chlamydia Screening	67.05	63.97	60.46	59.12	-1.33	★★★★
Cholesterol Management	55.41	56.57	56.77	59.56	2.78	★★
Cholesterol Screening	77.92	76.34	78.14	77.47	-0.67	★
Colorectal Cancer Screening	67.64	68.71	68.09	69.86	1.77	★★★★
Diabetes A1C <=9	76.9	76.91	77.28	78.16	0.89	★★★
Diabetes A1C <7	52.44	53.46	53.41	53.64	0.23	★★★★★
Diabetes A1C <8	69.52	69.74	69.27	70.41	1.14	★★★★
Diabetes A1C Screening	83.84	83.73	84.4	84.79	0.4	★
Diabetes LDL Control	53.86	55.11	53.17	55.86	2.69	★★★★
Diabetes LDL Screening	80.09	80.05	80.39	80.58	0.18	★
Mental FU 30 Days	74.5	76.65	77.87	74.08	-3.78	★★
Mental FU 7 Days	54.57	58.61	61.81	57.29	-4.52	★★
Well Child >=6 Visits	62.96	69.16	73.95	79.02	5.07	★★

Green – indicates positive change with statistical significance; Red – indicates negative change with statistical significance; No color – indicates lack of statistical significance
2014 MHS Review Group
Source: MHS Population Health Portal, June 2014

HEDIS® Methodological Considerations

There are mitigating factors that can account for some of the considerable lag between HEDIS® measure performance in the Purchased Care component compared to Direct Care. The Defense Enrollment

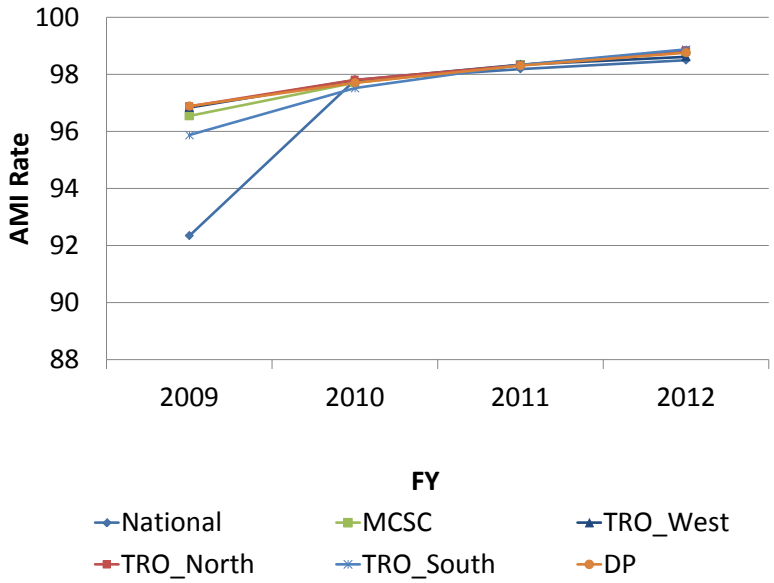
Eligibility Reporting System (DEERS) database captures information on beneficiary enrollment in TRICARE Prime and also on beneficiaries with Other Health Insurance (OHI). HEDIS® calculations are performed only on Prime enrollees and normally exclude patients with OHI. Previous MHS studies have shown that OHI documentation in DEERS, which is dependent on beneficiary self-reporting, is significantly understated resulting in an inflated denominator for various HEDIS® measures. Commercial health plans exclude beneficiaries with Primary OHI and use supplemental databases to capture clinical information about their enrolled population that would otherwise not be available. The MHS only uses financial claims data. Within the DHA, efforts are currently underway to improve the fidelity of OHI documentation and allow the regional contractors to use supplemental databases.

Quality of Care in the Purchased Care Component– Supporting Tables and Figures

Figure 4.4-1 displays the performance of TRICARE network hospitals compared to national benchmarks on Hospital Compare composite measure of performance.

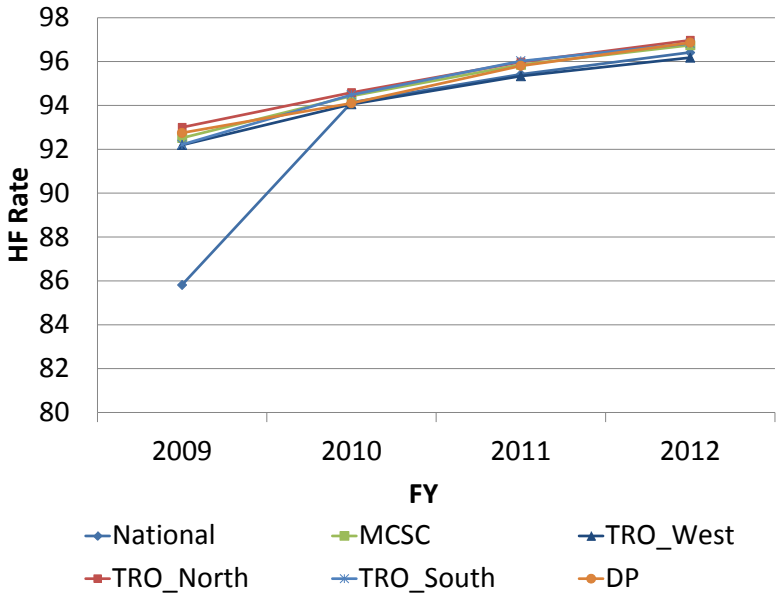
Figure 4.4-1 Hospital Compare Measures in Purchased Care Component

Figure 4.4-1a Purchased Care Acute Myocardial Infarction (AMI) Rate, FY09 – FY12



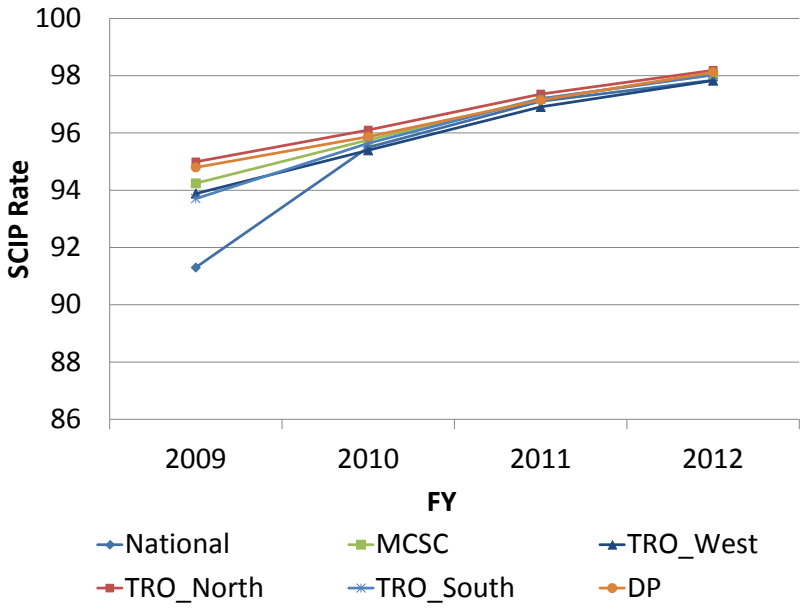
2014 MHS Review Group
Source: Centers for Medicare & and Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

Figure 4.4-1b Purchased Care Heart Failure (HF) Rate, FY09 – FY12



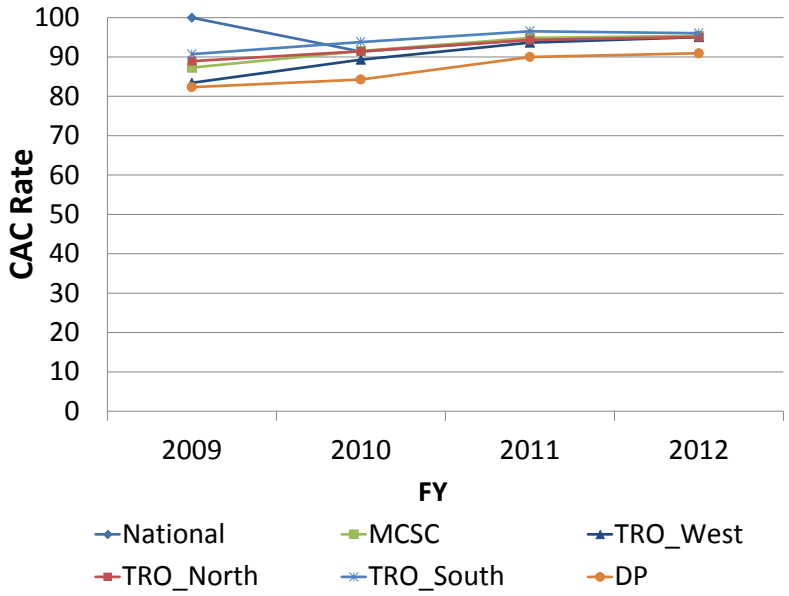
2014 MHS Review Group
Source: Centers for Medicare & Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

Figure 4.4-1c Purchased Care Surgical Care (SCIP) Rate, FY09 – FY12



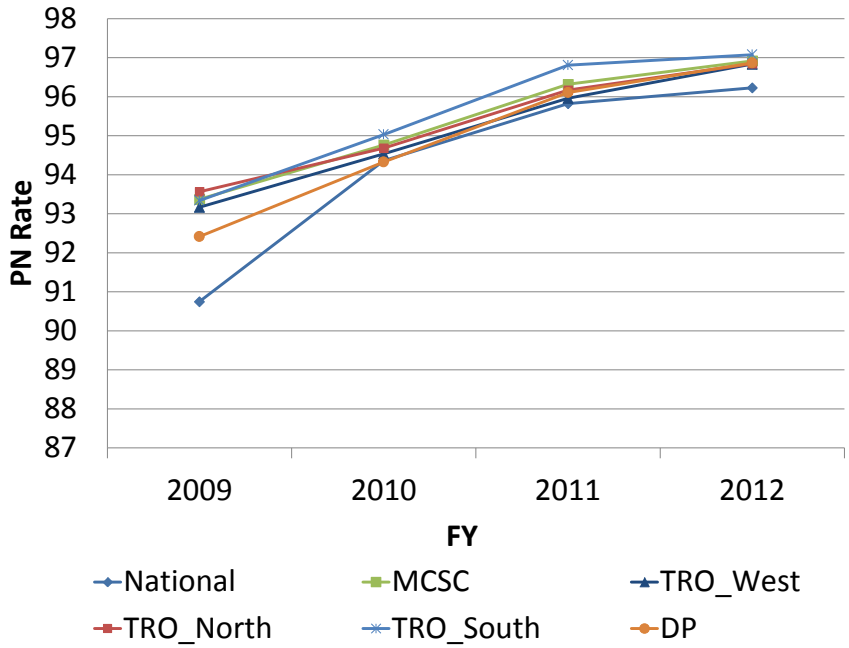
2014 MHS Review Group
Source: Centers for Medicare & Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

Figure 4.4-1d Purchased Care Children's Asthma Care (CAC) Rate, FY09 – FY12



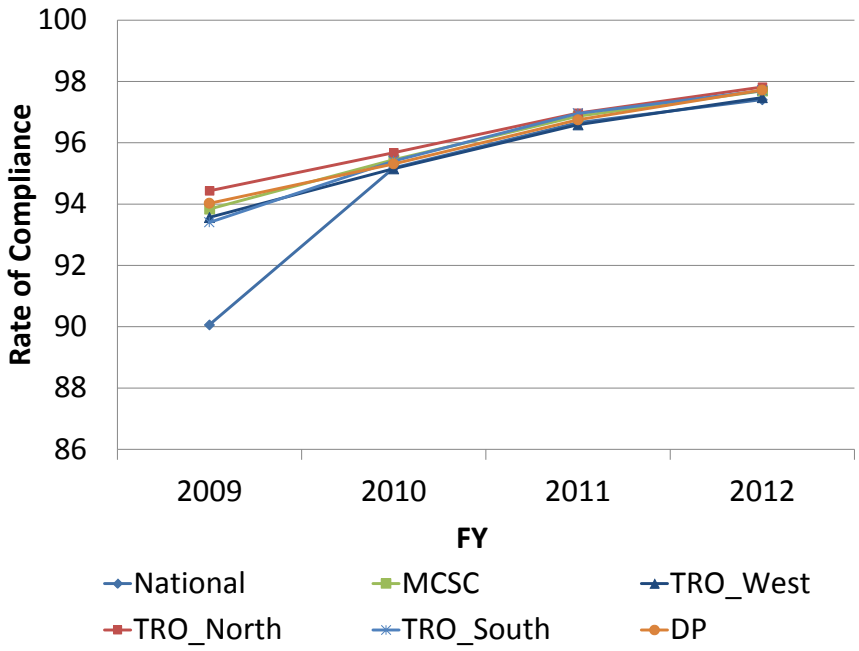
2014 MHS Review Group
Source: Centers for Medicare & Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

Figure 4.4-1e Purchased Care Pneumonia Rate, FY09 – FY12



2014 MHS Review Group
Source: Centers for Medicare & Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

Figure 4.4-1f Purchased Overall Rate, FY09 – FY12



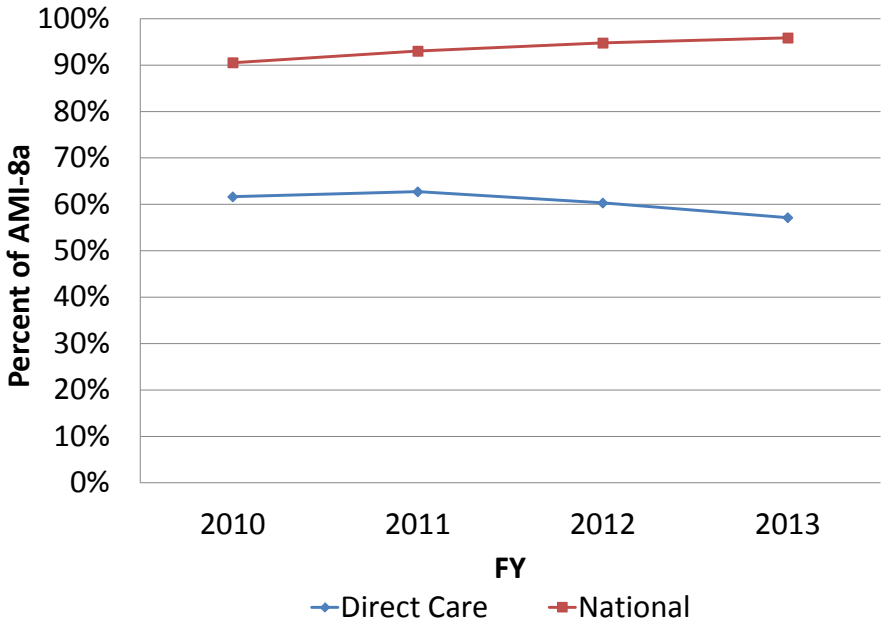
2014 MHS Review Group
Source: Centers for Medicare & Medicaid Services, Hospital Compare Data File, June 2014; MHS Mart (M2) Comprehensive Ambulatory/Professional Encounters Record (CAPER), June 2014

ORYX® – National Hospital Quality Measures – Supporting Tables and Figures

The figures below show 2010-2013 measures contributing to low composite measures for direct care when compared to national benchmarks.

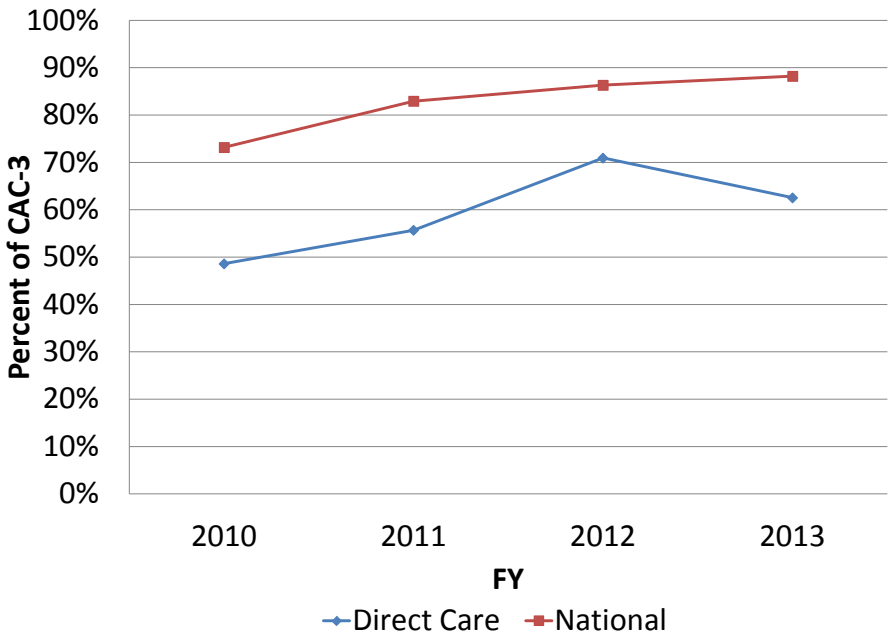
Figure 4.4-2 TJC Oryx Core Measures

Figure 4.4-2a Primary Percutaneous Coronary Intervention (AMI-8a), FY10 – FY13



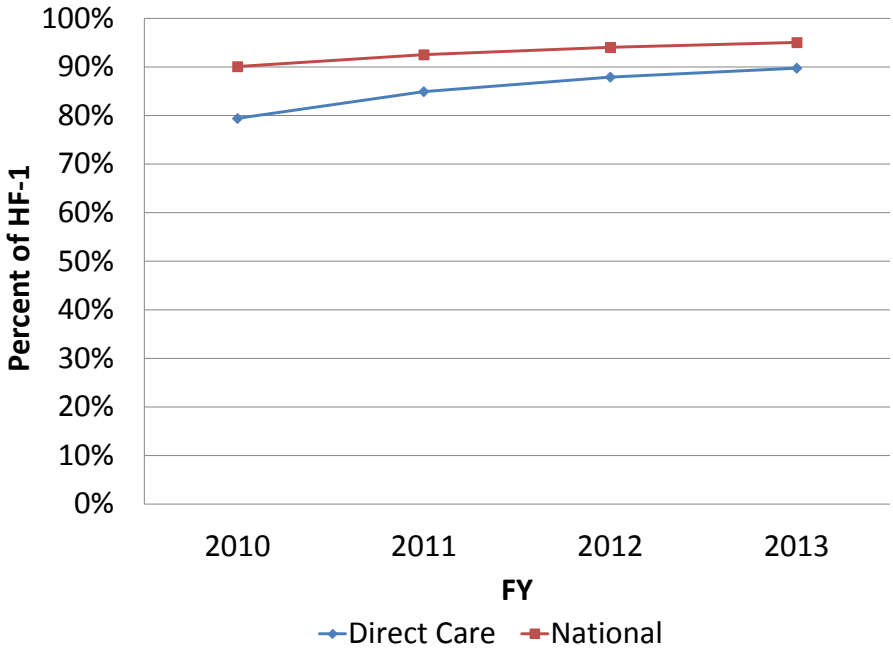
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2b Home Management Plan of Care Given to Patient/Caregiver (CAC-3), FY10 – FY13



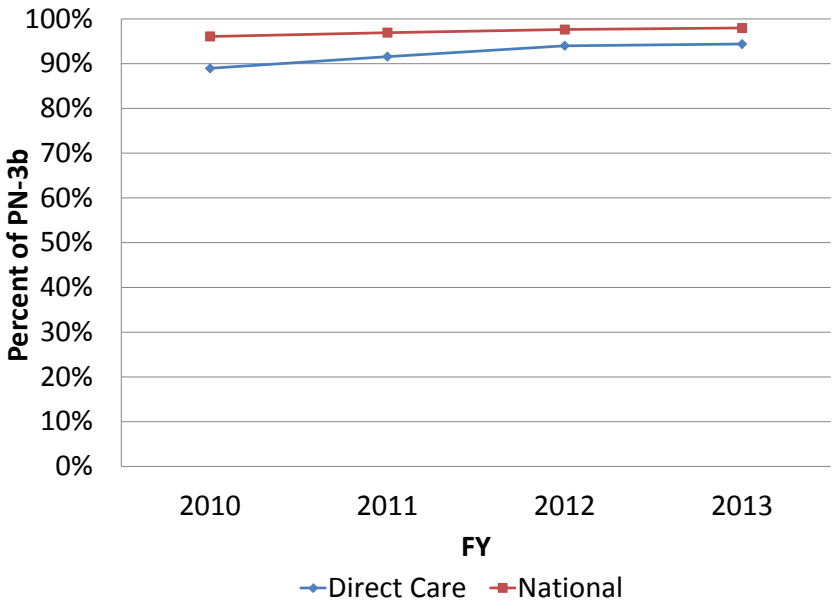
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2c Discharge Instructions (HF-1), FY10 – FY13



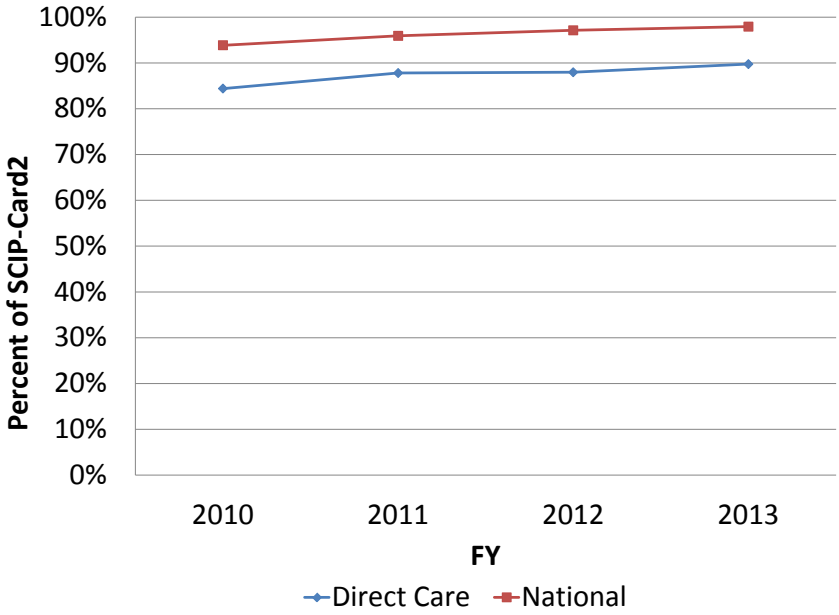
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2d Blood Cultures Performed in the ED prior to Initial Antibiotic in Hospital (PN-3b), FY10 – FY13



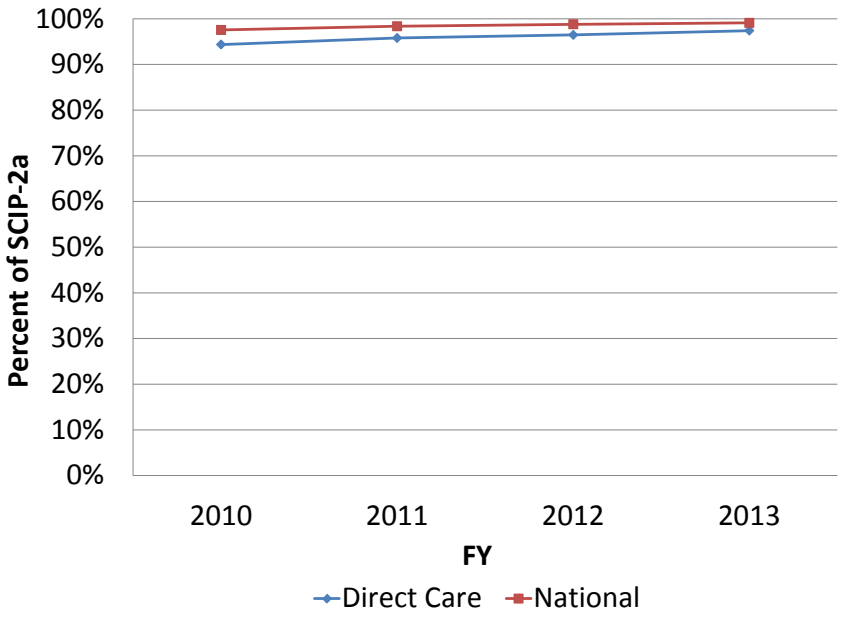
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2e Surgery Patients on Beta-Blocker Therapy prior to Arrival Who Received a Beta-Blocker During the Perioperative Period (SCIP-Card2), FY10 – FY13



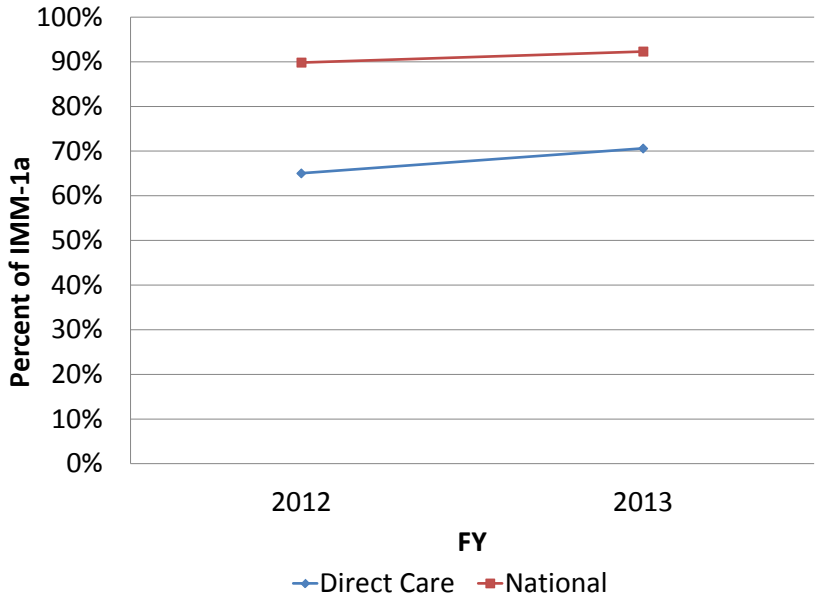
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2f Prophylactic Antibiotic Selection for Surgical Patients (SCIP-2a), FY10 – FY13



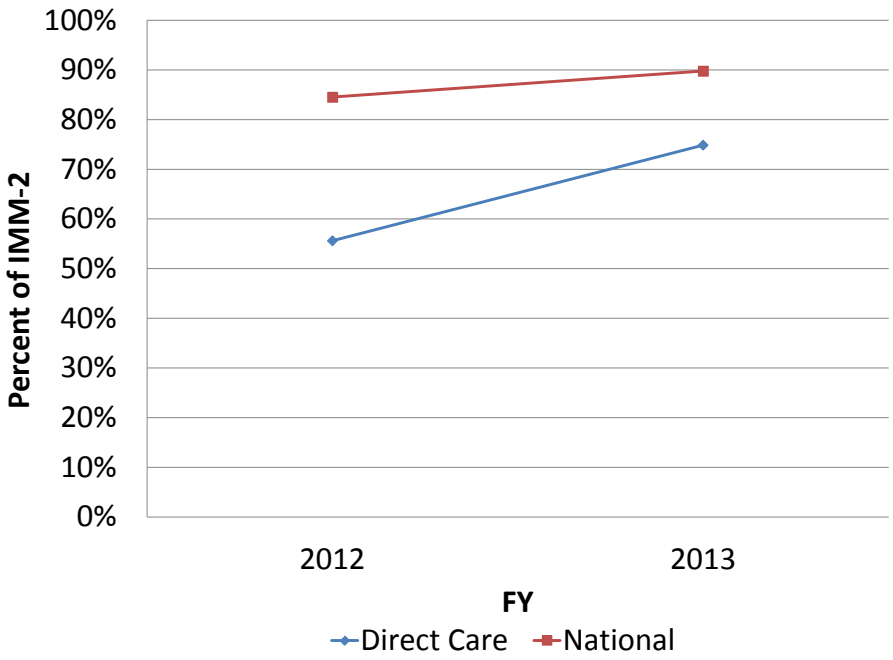
2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2g Pneumococcal Immunization (IMM-1a), FY12 – FY13



2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

Figure 4.4-2h Influenza Immunization (IMM-2)



2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, July 2014. Data are displayed by fiscal year because the original data were provided in that form.

The table below provides more information on TJC definitions for common cause and special cause variation.

Table 4.4-9a ORYX® TJC Definitions

Common cause variation is the noise within the process and is characterized by:
Phenomena constantly active with the process,
Predictable variation within given limits,
Expected variation within a historical experience base,
Lack of significance in individual high or low values.
Unexpected special cause variation is characterized by:
New, unanticipated, emergent, or previously neglected phenomena within the system,
Variation inherently unpredictable,
Unexpected variation outside the historical experience base, and
Evidence of some inherent change in the system or our knowledge of it.

2014 MHS Review Group
Source: The Joint Commission National Hospital Accrediting Agency, February 2011

Table 4.4-9b ORYX® Index Score Criteria

Index Score	Meaning
3	Perfect score: meets measure 100% of time
2	> 3 standard deviations above the national average
1	Within +/- 3 standard deviations from the national average
0	> 3 standard deviations below the national average

2014 MHS Review Group
Source: DoD Joint Commission Core Measure Database, June 2014

The control limits describe the natural variability of a process over time. A process that is in statistical control can be further analyzed to determine whether performance is at an acceptable level. The control limits are set to three standard deviations above and below the center line. The upper control limit (UCL) is calculated by adding three times the standard deviation for the quarter to the national average. The lower control limit (LCL) is calculated by subtracting three times the standard deviation for the quarter from the national average. The target performance level for MTFs is an index score of one or greater.

Table 4.4-9c Direct Care Average Index Score

Measure	FY10	FY11	FY12	FY13	Status
AMI 1	1	1	1	2	**E**
AMI 2	1	0	1	0	**N**
AMI 3	2	2	1	2	**E**
AMI 5	1	0	1	0	**N**
AMI 7a	0	1	1	1	**S**
AMI 8a	0	0	0	0	**N**
AMI 10		1	1	1	**S**
CAC 1a	2	2	1	3	**E**
CAC 2a	1	1	0	1	**S**
CAC 3	0	0	0	0	**N**
HF 1	0	0	0	0	**N**
HF 2	1	0	0	1	**S**
HF 3	1	1	1	1	**S**
HBIPS 1a	ND	ND	3	2	**E**
HBIPS 4a	ND	ND	1	2	**E**
HBIPS 5a	ND	ND	1	1	**S**
HBIPS 6a	ND	ND	0	0	**N**
HBIPS 7a	ND	ND	1	0	**N**
OP 6	1	1	0	0	**N**
OP 7	1	1	1	1	**S**
PC 1	ND	ND	2	1	**S**

Measure	FY10	FY11	FY12	FY13	Status
PC 2	ND	ND	2	2	E
PC 3	ND	ND	1	0	N
PC 5	ND	ND	2	2	E
PN 3a	1	1	1	1	S
PN 3b	0	0	0	0	N
PN 6a	1	1	0	0	N
PN 6b	1	1	1	1	S
SCIP 1a	0	0	0	1	S
SCIP 2a	2	0	0	0	N
SCIP 3a	0	0	1	0	N
SCIP 4	1	0	1	1	S
SCIP 6	0	0	1	1	S
SCIP 9	2	0	1	1	S
SCIP Card 2	0	0	0	0	N
SCIP VTE 2	1	0	0	0	N
STK 1	ND	ND	3	2	E
STK 2	ND	ND	3	3	E
STK 3	ND	ND	2	3	E
STK 4	ND	ND	2	3	E
STK 5	ND	ND	3	3	E
STK 6	ND	ND	2	3	E
STK 8	ND	ND	2	1	S
STK 10	ND	ND	1	2	E
VTE 1	ND	1	2	2	E
VTE 2	ND	1	1	1	S
VTE 3	ND	2	1	1	S
VTE 4	ND	2	2	3	E
VTE 5	ND	0	0	1	S
VTE 6	ND	2	2	1	S
IMM 1a	ND	ND	0	0	N
IMM 2	ND	ND	0	0	N
SUB 1	ND	ND	1	0	N
SUB 2	ND	ND	2	1	S
SUB 3	ND	ND	1	1	S
SUB 4	ND	ND	1	1	S
TOB 1	ND	ND	1	1	S
TOB 2	ND	ND	1	1	S

Measure	FY10	FY11	FY12	FY13	Status
TOB 3	ND	ND	1	1	S
TOB 4	ND	ND	2	1	S

Statistical comparison is done on rate measures only, ED measures are continuous

E = Exceeding
S = Showing improvement or meeting target
N = Needs Improvement

Index Score	Meaning
3	Perfect score: meets measure 100% of time
2	> 3 standard deviations above the national average
1	Within +/- 3 standard deviations from the national average
0	> 3 standard deviations below the national average

2014 MHS Review Group; ND indicates No Data.
Source: DoD Joint Commission Core Measure Database, June 2014

Table 4.4-10 provides a description of each measure set to include AMI, CAC, HBIPS, HF, OP, PC, PN, SCIP, STK, VTE, IMM, and SUB.

Table 4.4-10 TJC Oryx® Measures

Measure Set	Measure	Description
Acute Myocardial Infarction	AMI1	Aspirin at Arrival
Acute Myocardial Infarction	AMI2	Aspirin Prescribed at Discharge
Acute Myocardial Infarction	AMI3	ACEI or ARB for LVSD
Acute Myocardial Infarction	AMI5	Beta-Blocker Prescribed at Discharge
Acute Myocardial Infarction	AMI7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival
Acute Myocardial Infarction	AMI8a	Primary PCI Received Within 90 Minutes of Hospital Arrival
Acute Myocardial Infarction	AMI10	Statins Prescribed at Discharge
Children's Asthma Care	CAC1a	Relievers for Inpatient Asthma (age 2 years through 17 years) – Overall Rate
Children's Asthma Care	CAC2a	Systemic Corticosteroids for Inpatient Asthma (age 2 years through 17years) – Overall Rate
Children's Asthma Care	CAC3	Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver

Measure Set	Measure	Description
Hospital-Based Inpatient Psychiatric Services	HBIPS1a	Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed - Overall Rate
Hospital-Based Inpatient Psychiatric Services	HBIPS4a	Patients Discharged on Multiple Antipsychotic Medications - Overall Rate
Hospital-Based Inpatient Psychiatric Services	HBIPS5a	Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification - Overall Rate
Hospital-Based Inpatient Psychiatric Services	HBIPS6a	Post Discharge Continuing Care Plan Created - Overall Rate
Hospital-Based Inpatient Psychiatric Services	HBIPS7a	Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge - Overall Rate
Heart Failure	HF1	Discharge Instructions
Heart Failure	HF2	Evaluation of LVS Function
Heart Failure	HF3	ACEI or ARB for LVSD
Hospital Outpatient Department	OP6	Prophylactic Antibiotic Initiated Within One Hour Prior to Surgical Incision
Hospital Outpatient Department	OP7	Prophylactic Antibiotic Selection for Surgical Patients
Perinatal Care	PC1	Elective Delivery
Perinatal Care	PC2	Cesarean Section - Overall Rate
Perinatal Care	PC3	Antenatal Steroids
Perinatal Care	PC5	Exclusive Breast Milk Feeding
Pneumonia	PN3a	Blood Cultures Performed Within 24 Hours Prior to or 24 Hours After Hospital Arrival for Patients Who Were Transferred or Admitted to the ICU Within 24 Hours of Hospital Arrival
Pneumonia	PN3b	Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
Pneumonia	PN6a	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients – ICU Patients
Pneumonia	PN6b	Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients – Non-ICU Patients
Surgical Care Improvement Project	SCIP1a	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision - Overall Rate
Surgical Care Improvement Project	SCIP2a	Prophylactic Antibiotic Selection for Surgical Patients - Overall Rate
Surgical Care Improvement Project	SCIP3a	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time - Overall Rate

Measure Set	Measure	Description
Surgical Care Improvement Project	SCIP4	Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose
Surgical Care Improvement Project	SCIP6	Surgery Patients with Appropriate Hair Removal
Surgical Care Improvement Project	SCIP9	Urinary Catheter Removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with Day of Surgery Being Day Zero
Surgical Care Improvement Project	SCIPCard2	Surgery Patients on Beta-Blocker Therapy Prior to Admission Who Received a Beta-Blocker During the Perioperative Period
Surgical Care Improvement Project	SCIPVTE2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
Stroke	STK1	Stroke Patients with DVT Prophylaxis
Stroke	STK2	Discharged on Antithrombotic Therapy
Stroke	STK3	Anticoagulation Therapy for Atrial Fibrillation/Flutter
Stroke	STK4	Thrombolytic Therapy
Stroke	STK5	Antithrombiotic Therapy by End of Hospital Day Two
Stroke	STK6	Discharged on Statin Medication
Stroke	STK8	Stroke Education
Stroke	STK10	Assessed for Rehabilitation
Venous Thromboembolism	VTE1	VTE Prophylaxis
Venous Thromboembolism	VTE2	ICU VTE Prophylaxis
Venous Thromboembolism	VTE3	VTE Patients With Anticoagulation Overlap Therapy
Venous Thromboembolism	VTE4	VTE Patients Receiving UFH with Dosages/Platelet Count Monitoring by Protocol or Nomogram
Venous Thromboembolism	VTE5	VTE Discharge Instructions
Venous Thromboembolism	VTE6	Incidence of Potentially Preventable VTE
Immunization	IMM1a	Pneumococcal Immunization (PPV23) - Overall Rate
Immunization	IMM2	Influenza Immunization
Substance Use	SUB1	Alcohol Use Screening
Substance Use	SUB2	Alcohol Use Brief Intervention Provided or Offered
Substance Use	SUB3	Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge

Measure Set	Measure	Description
Substance Use	SUB4	Alcohol and Drug Use: Assessing Status after Discharge
Tobacco Treatment	TOB1	Tobacco Use Screening
Tobacco Treatment	TOB2	Tobacco Use Treatment Provided or Offered
Tobacco Treatment	TOB3	Tobacco Use Treatment Provided or Offered at Discharge
Tobacco Treatment	TOB4	Tobacco Use: Assessing Status after Discharge

2014 MHS Review Group
Source: DoD Joint Commission Core Measure Database, June 2014

Table 4.4-11 shows direct care performance (N=55) on 16 core measures for 4Q2012-3Q2013.

Table 4.4-11 MTF ORYX® Core Measure Status for 4Q 2012 – 3Q2013

MTF	AMI	CAC	HF	HBIPS	OP	PC	PN	SCIP	STK	VTE	IMM	SUB	TOB
31 MDG - Aviano AB	---	---	---	---	---	S	---	S	---	N	N	---	---
96 MDG - Eglin AFB	**S**	**E**	**E**	**---**	**---**	**S**	**E**	**E**	**---**	**E**	**---**	**---**	**---**
3 MDG - Elmendorf AFB	**S**	**---**	**E**	**---**	**---**	**S**	**E**	**E**	**---**	**S**	**---**	**---**	**---**
81 MDG - Keesler AFB	**S**	**E**	**E**	**---**	**E**	**S**	**E**	**E**	**---**	**---**	**---**	**---**	**---**
48 MDG - Lakenheath AB	---	E	---	---	S	S	S	E	---	N	---	---	---
1 MDG - Langley AFB	S	E	S	---	N	S	E	E	---	S	---	---	---
35 MDG - Misawa AB	---	E	---	---	---	S	N	E	---	N	S	---	S
366 MDG - Mountain Home AFB	---	---	E	---	---	S	N	E	---	N	N	---	---
99 MDG - Nellis AFB	S	E	S	N	---	S	E	E	---	E	---	---	---
51 MDG - Osan AB	---	---	---	---	---	---	S	N	---	S	N	N	S
60 MDG - Travis AFB	**S**	**E**	**S**	**S**	**---**	**S**	**E**	**S**	**---**	**E**	**---**	**---**	**---**
88 MDG - Wright-Patterson AFB	**S**	**---**	**E**	**---**	**---**	**S**	**S**	**S**	**---**	**E**	**---**	**---**	**---**
374 MDG - Yokota AB	---	E	---	---	---	S	N	S	---	N	---	---	S
Bassett ACH	**---**	**E**	**S**	**---**	**---**	**S**	**S**	**E**	**---**	**S**	**---**	**---**	**---**
Bayne-Jones ACH	**---**	**E**	**E**	**---**	**---**	**S**	**S**	**E**	**---**	**S**	**---**	**---**	**---**
Wm Beaumont AMC	S	E	E	E	---	N	S	S	---	E	---	---	---
Blanchfield ACH	**S**	**E**	**E**	**---**	**---**	**S**	**E**	**E**	**---**	**---**	**---**	**---**	**---**
Brooke AMC	S	E	E	S	N	S	S	S	E	N	---	N	N
Darnall ACH	N	E	E	S	---	S	S	S	---	---	---	---	---
D. Eisenhower AMC	**S**	**E**	**E**	**S**	**---**	**---**	**S**	**S**	**---**	**E**	**---**	**---**	**---**
Evans ACH	---	E	S	---	---	S	S	N	---	E	---	---	---
Ireland ACH	**---**	**E**	**S**	**---**	**---**	**S**	**S**	**S**	**---**	**S**	**---**	**---**	**---**
Irwin ACH	**---**	**E**	**---**	**---**	**E**	**S**	**S**	**S**	**---**	**---**	**---**	**---**	**---**
Keller ACH	---	E	---	---	---	S	S	S	---	N	N	---	---
Madigan AMC	**S**	**E**	**S**	**S**	**---**	**S**	**S**	**S**	**---**	**E**	**---**	**---**	**---**
Martin ACH	**S**	**E**	**E**	**S**	**---**	**S**	**S**	**E**	**---**	**E**	**---**	**---**	**---**
Moncrief ACH	---	---	---	S	E	---	N	E	---	S	---	---	---
Reynolds ACH	S	E	E	---	---	N	S	S	---	---	---	---	---
Tripler AMC	**S**	**E**	**E**	**S**	**---**	**S**	**S**	**S**	**---**	**E**	**---**	**---**	**---**
Winn ACH	N	E	E	E	E	S	S	S	---	---	---	---	---
Brian Allgood Medical Center	**---**	**E**	**---**	**S**	**---**	**S**	**S**	**S**	**---**	**S**	**---**	**---**	**---**
Landstuhl AMC	**S**	**E**	**E**	**E**	**---**	**S**	**E**	**E**	**---**	**---**	**---**	**---**	**---**
Weed ACH	---	E	---	---	---	N	N	E	---	N	N	---	---
Womack AMC	**S**	**E**	**S**	**S**	**---**	**S**	**E**	**S**	**---**	**E**	**---**	**---**	**---**
Gen L. Wood ACH	N	E	E	E	---	N	E	E	---	S	---	---	---
NH Beaufort	---	---	---	---	E	---	S	S	---	N	N	---	---
NH Bremerton	S	E	E	---	---	S	E	E	---	S	N	---	---
NH Camp LeJeune	**S**	**E**	**S**	**S**	**---**	**S**	**E**	**S**	**---**	**S**	**---**	**---**	**---**
NH Camp Pendleton	**---**	**E**	**E**	**---**	**S**	**S**	**E**	**E**	**---**	**---**	**---**	**---**	**---**
USNH Guam	**---**	**---**	**E**	**---**	**---**	**S**	**E**	**E**	**---**	**E**	**---**	**---**	**---**
USNH Guantanamo Bay	---	---	---	---	---	S	N	S	---	N	N	---	S
NH Jacksonville	S	E	E	---	---	N	E	S	---	---	---	---	---
NH Lemoore	---	E	---	---	---	N	N	E	---	N	---	N	S
USNH Naples	---	---	---	---	---	N	---	E	---	N	---	---	---
NH Oak Harbor	---	---	---	---	---	N	---	E	---	N	---	---	---
USNH Okinawa	N	E	E	S	---	S	E	E	---	S	---	S	---
NH Pensacola	S	---	S	---	---	S	E	E	---	E	---	---	---
NMC Portsmouth	S	E	E	S	---	N	S	S	---	---	---	---	S
USNH Rota	---	E	E	---	---	N	---	S	---	N	S	---	---
NMC San Diego	**S**	**E**	**E**	**S**	**---**	**S**	**E**	**E**	**---**	**E**	**---**	**---**	**---**
USNH Sigonella	---	---	---	---	---	S	---	S	---	N	N	---	S
NH Twentynine Palms	---	S	---	---	---	S	S	E	---	N	---	---	S
USNH Yokosuka	N	E	E	---	---	S	S	E	---	E	---	---	S
Ft Belvoir Community Hospital	**S**	**S**	**E**	**S**	**---**	**S**	**E**	**S**	**---**	**E**	**---**	**---**	**---**
Walter Reed NMMC - Bethesda	**S**	**E**	**E**	**S**	**---**	**S**	**E**	**E**	**---**	**E**	**---**	**---**	**---**

Bold MTFs have no composite measures needing improvement when statistically compared to national benchmarks

E = Excelling S = Showing improvement or meeting target N = Need improvement

2014 MHS Review Group; Source: DoD Joint Commission Core Measure Database: June 2014

Table 4.4-12 shows TJC Direct Care Top Performers for 2010-2012. These facilities maintained a composite rate of 95 percent.[4]

Table 4.4-12 Military Treatment Facility Joint Commission Top Performers (2010 – 2012)[5]

MTF	SCIP	PN	VTE	HF
2010				
Bayne-Jones Army Community Hospital	x			
Moncrief Army Community Hospital		x		
2011				
Weed Army Community Hospital			x	
Irwin Army Community Hospital	x			
Bayne-Jones Army Community Hospital	x		x	
Keller Army Community Hospital (VTE)			x	
2012				
Naval Hospital Pensacola	x		x	
96th Medical Group	x	x	x	
81st Medical Group	x			x
48th Medical Group RAF Lakenheath			x	

2014 MHS Review Group
Source: DoD Joint Commission Core Measure Database, June 2014

[4] Note: Only 49/55 DoD facilities are eligible for recognition. The 2013 list will be published November 8, 2014. Surgical Care and VTE measures are the top two measures receiving recognition.
[5] Ibid.

Table 4.4-13 below shows TJC ORYX® comparison of Direct Care to 3 external health systems.

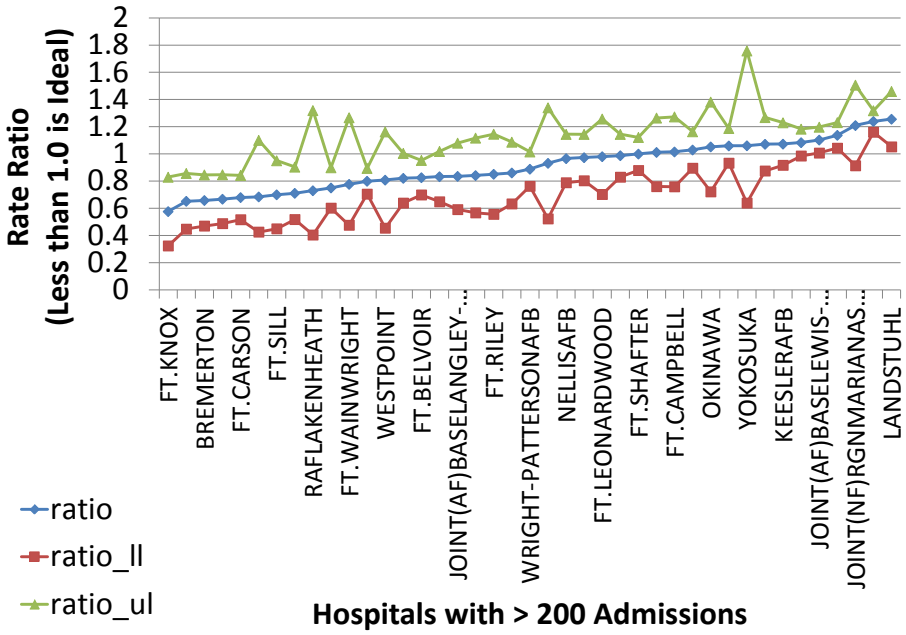
Table 4.4-13 TJC Oryx® MTF to External Health System Comparison

Measure	National	DoD	HS3	HS2-1	HS2-4	HS2-2	HS1-1	HS1-2	HS1-3	HS1-4	HS1-5	HS1-6	HS1-7	HS1-8	HS1-9	HS1-10	HS1-11	HS1-12	HS1-13	HS1-14
AMI1	99.4%	99.8%	ND	99.7%	99.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	99.3%	100.0%	100.0%	100.0%	100.0%
AMI2	99.3%	97.0%	ND	100.0%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
AMI3	98.0%	98.0%	ND	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
AMI5	99.2%	96.3%	ND	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
AMI7a	57.0%	50.0%	ND	ND	ND	ND	100.0%	100.0%	100.0%	100.0%	100.0%	ND	ND	ND	100.0%	100.0%	ND	ND	50.0%	100.0%
AMI8a	95.9%	57.1%	ND	100.0%	94.2%	100.0%	ND	ND	ND	ND	ND	100.0%	ND	ND	ND	ND	ND	ND	ND	ND
AMI10	98.5%	98.1%	ND	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HF1	95.0%	89.8%	ND	ND	ND	ND	100.0%	98.5%	98.6%	99.4%	100.0%	98.3%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	98.5%
HF2	99.5%	98.9%	ND	100.0%	99.7%	100.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
HF3	97.3%	96.2%	ND	95.9%	96.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%
PN3a	98.4%	95.2%	ND	100.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
PN3b	98.0%	94.4%	ND	ND	ND	ND	100.0%	98.4%	99.4%	100.0%	100.0%	96.8%	100.0%	98.4%	99.4%	100.0%	100.0%	98.7%	95.0%	98.5%
PN6a	92.5%	78.2%	ND	92.3%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	ND	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
PN6b	96.9%	96.3%	ND	100.0%	99.2%	99.4%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%
SCIP1a	98.8%	98.1%	ND	99.3%	98.8%	97.4%	99.2%	98.8%	98.2%	100.0%	99.7%	99.5%	100.0%	100.0%	99.7%	99.7%	99.3%	99.3%	99.6%	99.0%
SCIP2a	99.1%	97.4%	ND	99.5%	99.8%	99.0%	99.2%	99.7%	98.8%	99.6%	100.0%	98.5%	100.0%	100.0%	100.0%	99.3%	100.0%	99.7%	99.6%	99.7%
SCIP3a	98.0%	96.5%	ND	98.1%	98.3%	98.5%	100.0%	97.6%	98.4%	99.2%	100.0%	99.3%	100.0%	100.0%	99.4%	99.3%	99.6%	100.0%	99.6%	99.7%
SCIP4	96.7%	95.3%	ND	94.4%	98.7%	96.0%	ND	ND	ND	ND	ND	97.9%	ND	ND	ND	ND	ND	ND	ND	ND
SCIP6	99.9%	99.7%	ND	100.0%	100.0%	99.7%	100.0%	99.8%	100.0%	99.7%	100.0%	99.9%	99.0%	100.0%	100.0%	99.8%	99.8%	100.0%	100.0%	100.0%
SCIP9	97.6%	98.4%	ND	99.4%	93.3%	98.4%	98.8%	98.0%	98.9%	99.6%	99.4%	99.1%	100.0%	100.0%	99.4%	99.7%	100.0%	100.0%	100.0%	99.3%
SCIPCard2	97.9%	89.7%	ND	99.7%	98.1%	99.7%	100.0%	99.3%	97.7%	99.1%	99.1%	98.3%	100.0%	100.0%	100.0%	97.3%	99.3%	100.0%	97.8%	99.2%
SCIPVTE2	98.2%	96.2%	ND	98.3%	97.5%	97.8%	100.0%	99.7%	99.5%	100.0%	100.0%	99.8%	100.0%	100.0%	99.7%	99.3%	100.0%	99.8%	100.0%	99.7%
PC1	5.0%	4.6%	7.4%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
VTE1	91.6%	95.7%	82.6%	91.8%	90.3%	86.8%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
VTE2	95.0%	97.2%	92.1%	100.0%	97.3%	94.5%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND

National, DoD and Wisconsin Collaborative rates are aggregated by FY 2013. Institutions rates are aggregated by CY 2013.
Blue indicates lowest rate in the measure comparison.
Gold represents highest score
Red letters indicate limited reporting by other institutions.
HS-A, HS-B used since original values did not match de-identification key values
2014 MHS Review Group
Source: DoD Joint Commission Core Measure Database, June 2014

Thirty Day Readmissions - Supporting Figures and Tables

Figure 4.4-3 Thirty-Day Risk-Adjusted Readmission Rate Ratio (Observed/Expected)



2014 MHS Review Group
Source: DoD Joint Commission Core Measure Database, June 2014

Military Health System Perinatal Care - Supporting Figures and Tables

The MHS has 52 MTFs that provide inpatient obstetrical care. The nine perinatal and neonatal centers are Naval Medical Center San Diego, Naval Medical Center Portsmouth, U.S. Naval Hospital Okinawa, Walter Reed National Military Medical Center, Tripler Army Medical Center, Madigan Army Medical Center, Darnall Army Community Hospital, and San Antonio Military Medical Center. Landstuhl Army Regional Medical Center and Okinawa are the two OCONUS facilities.

The Defense Health Agency (DHA) oversees the National Capital Region-Medical Directorate (NCR-MD) that includes two MTFs, Walter Reed National Military Medical Center and Ft. Belvoir Community Hospital. These two facilities make up the rates and averages in the NCR. NCR has been impacted with an issue of inadequate number of coders resulting in a large number of un-coded charts. This has resulted in significant inaccuracy in data from administrative claims data pulls from the Standard Inpatient Data Record (SIDR). When this issue was discovered in 2012, the decision was made to remove the NCR-MD from the MHS averages until the coding issue was rectified. In the data presented in this report, NCR-MD data is represented in the MHS data in the following charts/graphs: Operative Vaginal Deliveries - Vacuum Extraction; Operative Vaginal Deliveries – Forceps; Postpartum Readmissions to Delivery Site; Inborn Readmissions to Birth MTF; Patient Safety Indicator (PSI) 17; PSI 18; PSI

19; Postpartum Hemorrhage; Vaginal Delivery Coded for Shoulder Dystocia; Inborn Mortality greater than or equal to 500 grams.

National Perinatal Information Center (NPIC) – Additional Information

NPIC averages are based on 86 facilities with 700,000 combined annual maternal and infant discharge data creating one of the largest repositories for hospital based perinatal clinical and financial discharge data in the country. Many of the hospitals in the NPIC database are large perinatal hospitals that provide the majority of their care in normal mother infant care settings, but care for the high risk dyads similar to the nine MHS OB specialty facilities. When the complexity of the mother or the infant exceeds the capabilities of the facility the mother infant dyad is transferred to an appropriate level of care. This ability to transfer out of the MHS decreases the percentage of complicated patients treated in the MHS as a whole when compared to NPIC larger perinatal member facilities.

Tables 4.4-14a-c Descriptive Measures

Table 4.4-14a Total Deliveries

	2010	2011	2012	2013
ARMY (21 MTFs)	24,056	24,410	26,366	25,246
NAVY (17 MTFs)	16,440	15,516	15,974	14,975
AIR FORCE (12 MTFs)	6,402	6,353	5,935	5,654
NCRMD (2 MTFs)	2,825	2,846	2,443	2,388
MHS (52 MTFs)	49,723	49,125	50,718	48,263
CONUS (37 MTFs)	44,072	43,279	45,032	42,745
OCONUS (15 MTFs)	5,651	5,846	5,686	5,518
MEDCEN (14 MTFs)	22,961	23,907	24,216	23,759
HOSPITAL (38 MTFs)	26,762	25,218	26,502	24,504
SPECIALTY (10 MTFs)	23,021	21,705	21,839	21,685

2014 MHS Review Group
Source: National Perinatal Information Center Database, July 2014

Table 4.4-14b Percent Deliveries (MHS)

	2010	2011	2012	2013
ARMY (21 MTFs)	48%	50%	52%	52%
NAVY (17 MTFs)	33%	32%	31%	31%
AIR FORCE (12 MTFs)	13%	13%	12%	12%
NCRMD (2 MTFs)	6%	6%	5%	5%
MHS				
CONUS (37 MTFs)	89%	88%	89%	89%
OCONUS (15 MTFs)	11%	12%	11%	11%
MEDCEN (14 MTFs)	46.2%	48.7%	47.7%	49.2%
HOSPITAL (38 MTFs)	53.8%	51.3%	52.3%	50.8%
Total MHS Deliveries	49,723	49,125	50,718	48,263

2014 MHS Review Group
Source: National Perinatal Information Center Database, July 2014

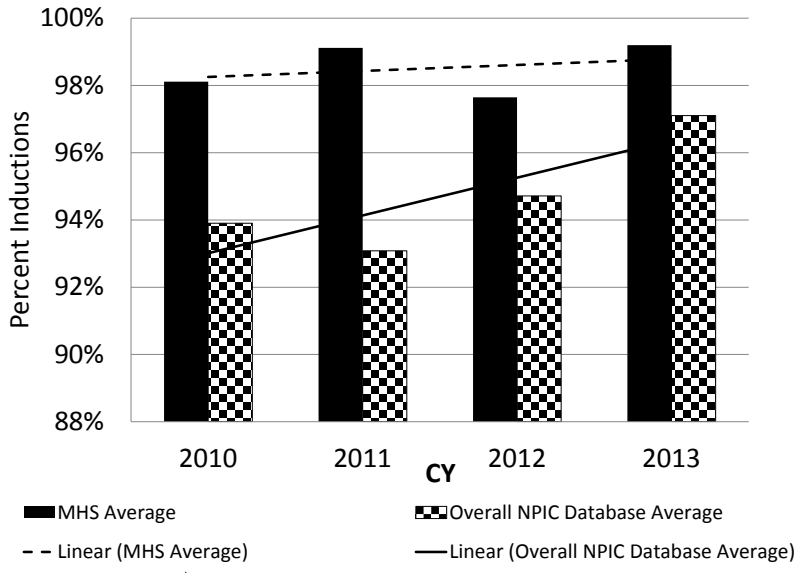
Table 4.4-14c Percent C-Section

	2010	2011	2012	2013
ARMY (21 MTFs)	25.56%	25.29%	25.06%	24.84%
NAVY (17 MTFs)	26.46%	26.97%	25.33%	26.24%
AIR FORCE (12 MTFs)	25.62%	26.49%	27.60%	27.61%
NCRMD (2 MTFs)	30.65%	28.46%	29.23%	31.45%
CONUS (37 MTFs)	26.35%	26.27%	25.67%	25.86%
OCONUS (15 MTFs)	24.67%	25.38%	25.47%	26.44%
MEDCEN (14 MTFs)	26.74%	27.15%	26.58%	27.04%
HOSPITAL (38 MTFs)	25.65%	25.23%	24.79%	24.85%
SPECIALTY (10 MTFs)	26.88%	27.34%	26.57%	27.18%
MHS (52 MTFs)	26.15%	26.16%	25.64%	25.93%
NPIC	35.20%	35.10%	34.70%	34.80%

2014 MHS Review Group
Source: National Perinatal Information Center Database, July 2014

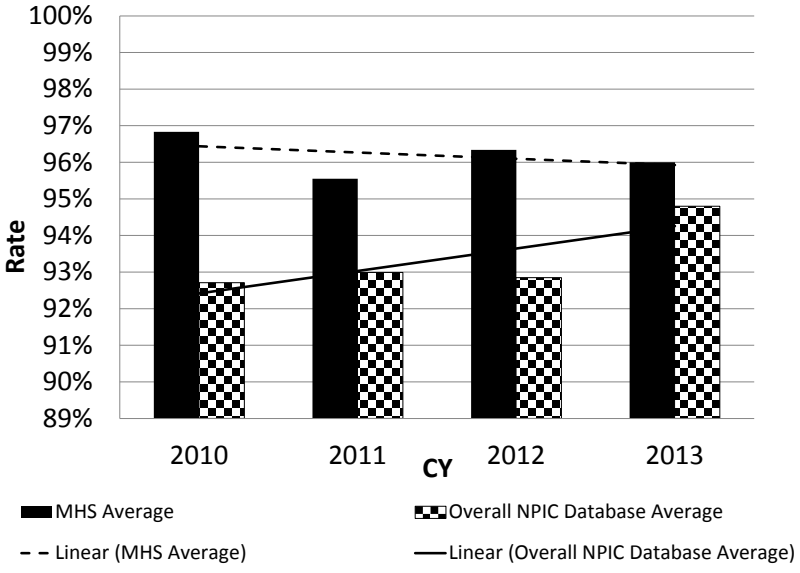
Figures for Comparative Measures

Figure 4.4-4a MHS Level-Induction of Labor at Less Than 37 Weeks Gestation with Medical Indication, CY10 – CY13



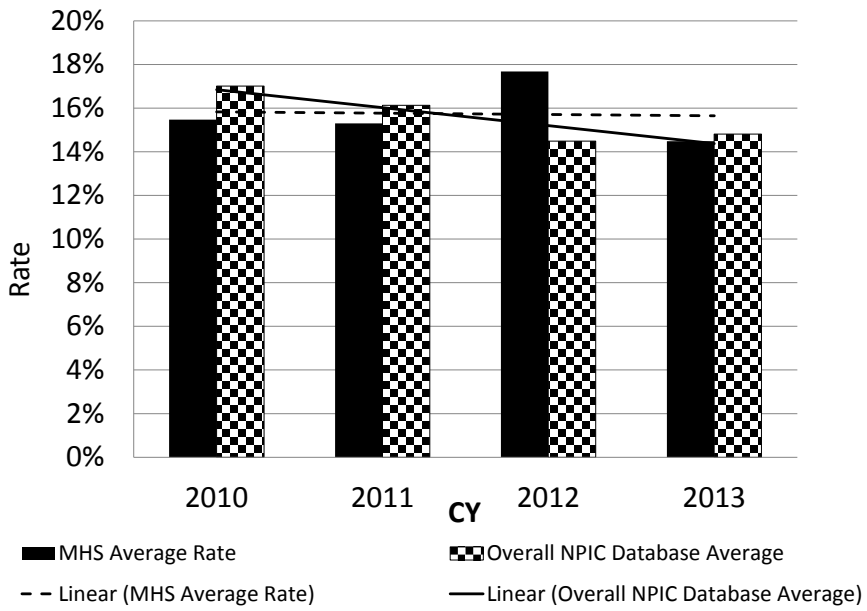
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-4b MHS Level C-Section at Less Than 37 Weeks Gestation with Medical Indication, CY10 – CY13



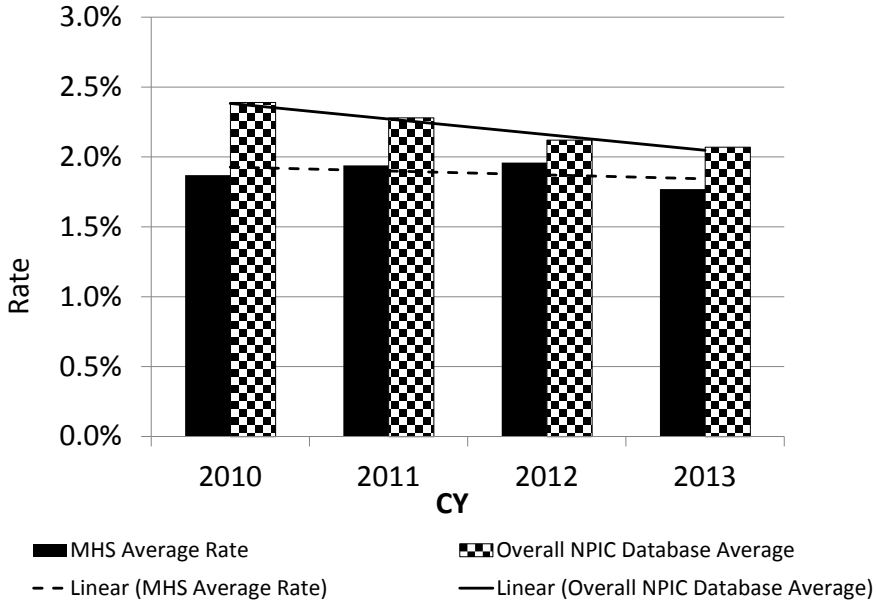
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-5 MHS Level Patient Safety Indicator (PSI) 18, CY10 – CY13



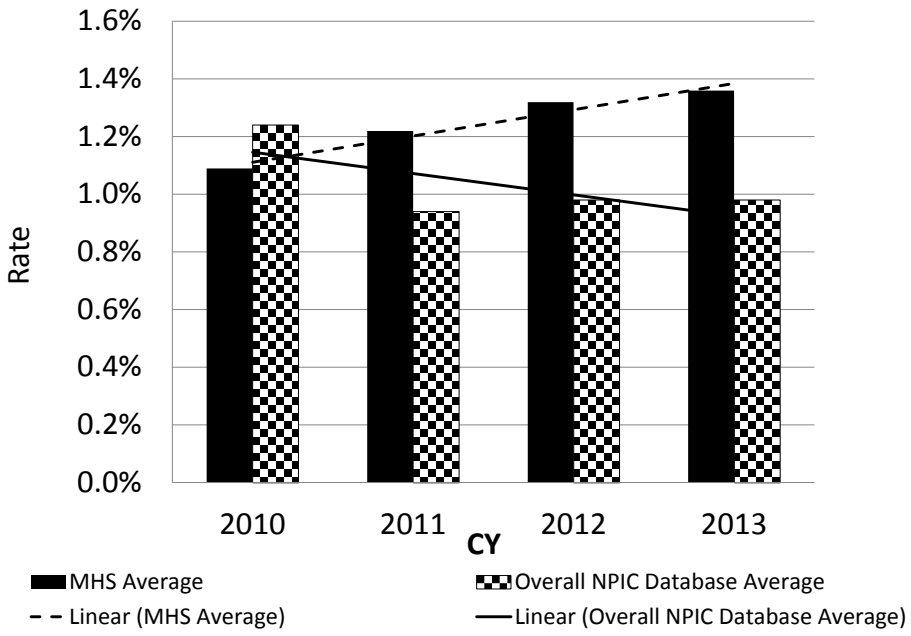
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-6 Annual Rate of PSI 19 Obstetric Trauma-Vaginal Delivery without Instruments, CY10 – CY13



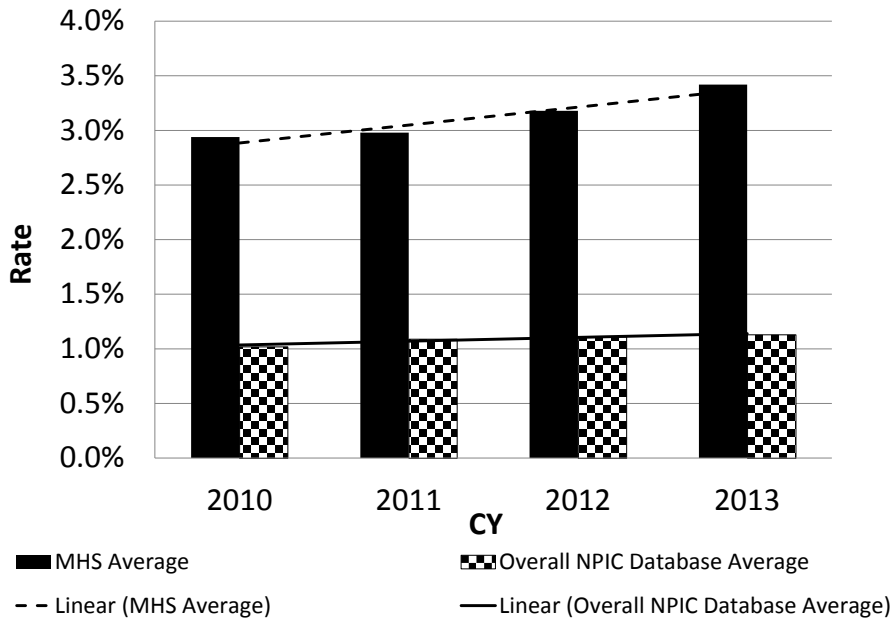
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-7 Annual Rate of Postpartum Readmissions to Delivery Site, CY10 – CY13



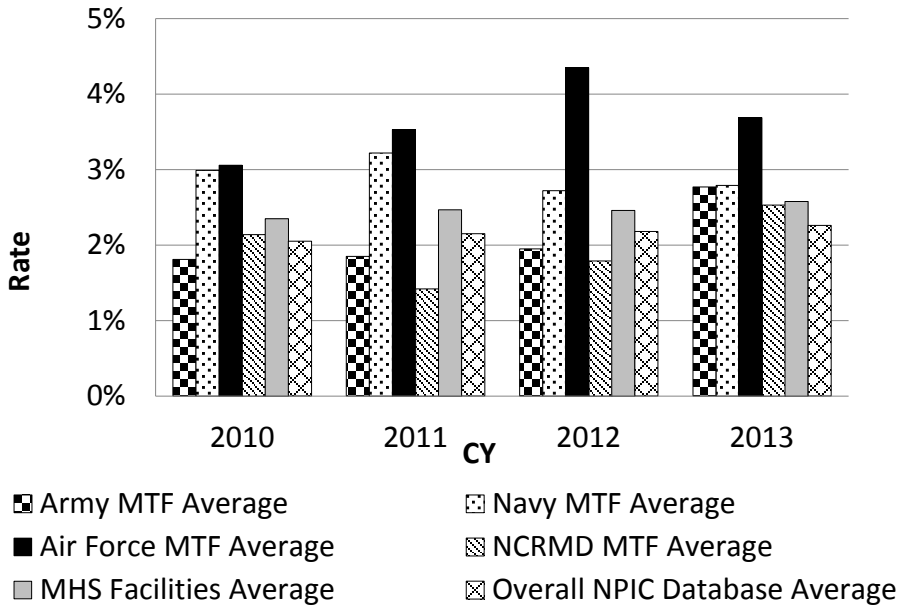
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-8 Annual Percent of Inborn Readmissions to Birth Site, CY10 – CY13



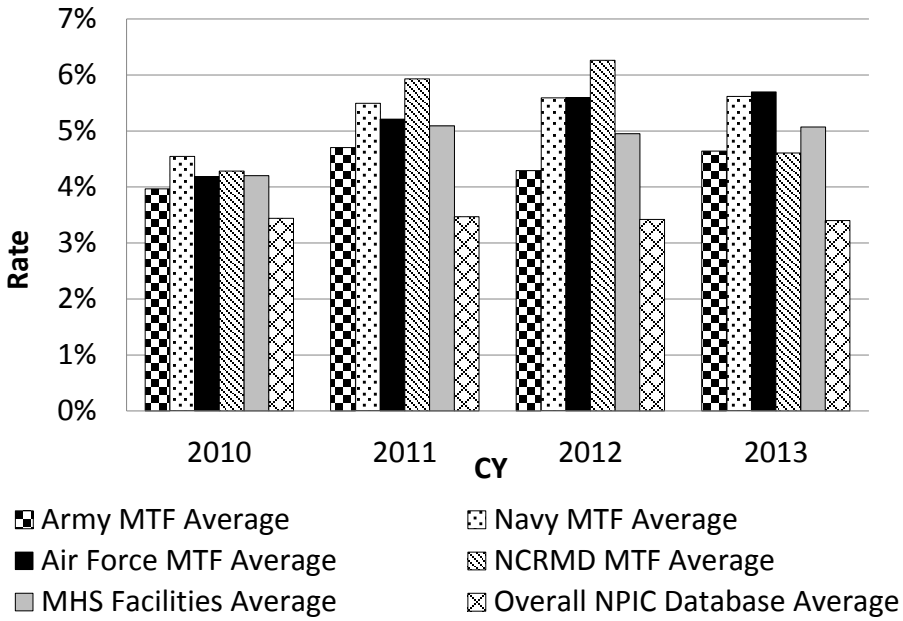
2014 MHS Review Group
Source: National Perinatal Information
Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-9 Annual Rate of Vaginal Deliveries Coded with Shoulder Dystocia by Branch of Service, CY10 – CY13



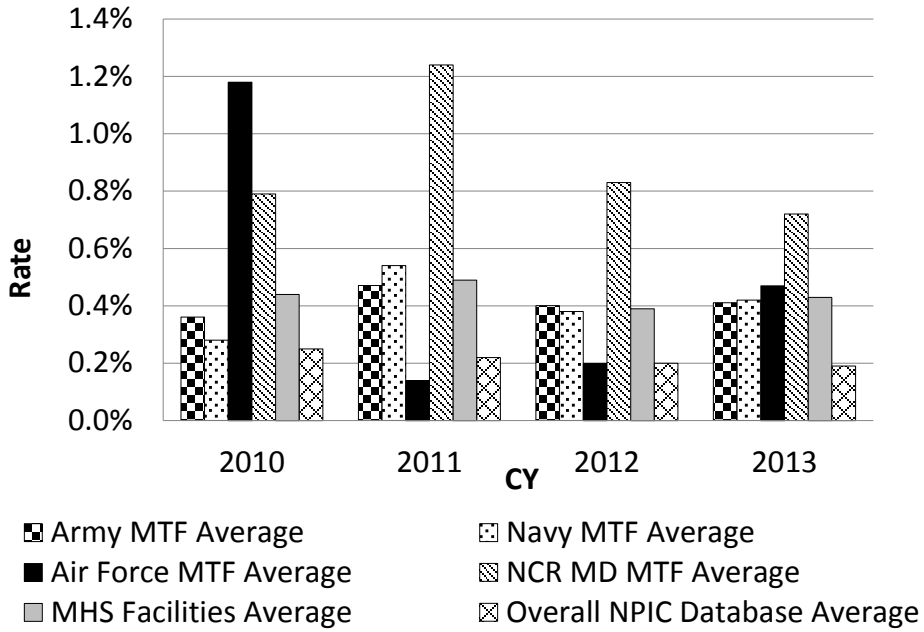
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-10 Annual Rate of Postpartum Hemorrhage by Branch of Service, CY10 – CY13



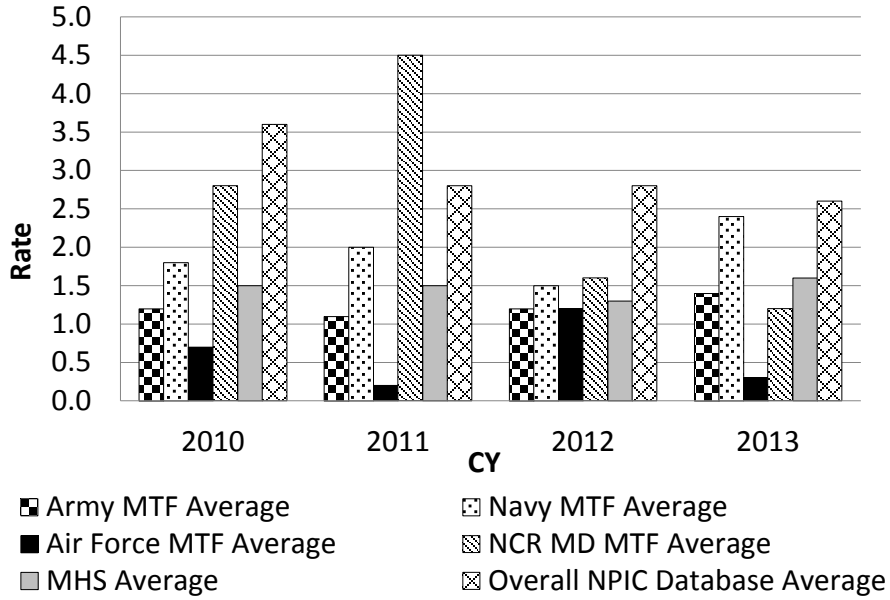
2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-11 Annual Rate of PS1 17 Injury to Neonate by Branch of Service, CY10 – CY13



2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Figure 4.4-12 Inborn Mortality Rate (per 1,000 live births) ≥ 500 Grams by Branch of Service, CY10 – CY13



2014 MHS Review Group
Source: National Perinatal Information Center/Quality Analytic Services (NPIC/QAS), July 2014

Table 4.4-15 Facility Level Data

Military Treatment Facilities by Select Maternal and Neonatal Birth Outcome Measures, CY2010-CY2013

		Measures** with ≥2 Elevated Yrs	Postpartum Hemorrhage Above/At/Below NPIC Avg				Score***	PSI 17 Birth Trauma Above/At/Below NPIC Avg				Score***	Vaginal Delivery with Coded Shoulder Dystocia Above/At/Below NPIC Avg				Score***
MTF			CY10	CY11	CY12	CY13	CY10-13	CY10	CY11	CY12	CY13	CY10-13	CY10	CY11	CY12	CY13	CY10-13
Army																	
Tripler	VH	PPH	-	△	△	△	3	-	-	-	-	0	♦	♦	♦	♦	-4
Darnall	VH	PPH,BT	△	-	△	△	3	△	△	△	△	4	-	-	♦	-	-1
Womack	VH	PPH	-	△	△	△	3	♦	-	-	♦	-2	♦	♦	♦	♦	-4
Madigan	VH	PPH,BT	△	△	△	△	4	△	△	△	-	3	♦	-	-	♦	-2
Evans	VH		-	-	-	△	1	-	-	-	-	0	♦	-	-	-	-1
Blanchfield	H	SD	△	-	-	-	1	♦	-	-	-	-1	△	△	△	△	4
Brook	H		♦	♦	-	-	-2	N/A	-	-	△	1	N/A	♦	♦	-	-2
Beaumont	H		♦	-	♦	-	-2	-	-	-	△	1	♦	♦	♦	♦	-4
Winn	M	SD	-	-	-	-	0	♦	♦	♦	-	-3	-	-	△	△	2
Irwin	M	PPH	△	△	△	-	3	-	-	△	-	1	-	-	-	-	0
Landstuhl	M		-	△	-	-	1	-	-	-	-	0	-	-	-	♦	-1
Martin	M	PPH,BT	-	△	△	△	3	△	△	-	-	2	-	-	△	-	1
Bassett	M	PPH	-	△	△	△	3	-	-	-	-	0	-	-	-	-	0
Bayne-Jones	M	PPH,SD	△	△	△	△	4	-	-	-	-	0	-	△	-	△	2
Reynolds	M	SD	♦	♦	-	-	-2	-	-	-	-	0	△	△	-	-	2
Leonard Wood	M		-	♦	♦	-	-2	-	-	-	-	0	-	-	-	-	0
Ireland	M		-	-	△	-	1	♦	♦	-	♦	-3	△	-	-	-	1
Seoul	M		-	-	-	-	0	-	-	-	-	0	♦	-	-	-	-1
Weed	L		♦	-	-	-	-1	-	-	♦	-	-1	-	-	-	-	0
Keller	L		-	-	-	-	0	♦	-	-	♦	-2	-	♦	♦	-	-2
Vincenza	L		-	-	-	-	0	♦	♦	-	♦	-3	♦	♦	-	-	-2
Air Force																	
Langley	H	PPH,BT,SD	-	△	△	△	3	△	-	-	△	2	△	△	△	△	4
Eglin	M	PPH,SD	△	△	-	△	3	N/A	♦	♦	-	-2	N/A	△	△	-	2
Elmendorf	M	PPH,SD	-	-	△	△	2	△	-	-	-	1	-	-	△	△	2
Mike O'callagan	M	PPH	♦	-	△	△	1	-	♦	♦	-	-2	-	-	-	-	0
Lakenheath	M		-	-	-	-	0	♦	♦	-	♦	-3	-	-	-	△	1
Keesler	M		-	♦	-	-	-1	N/A	-	-	♦	-1	N/A	-	-	-	0
Wright Patterson	M	PPH	-	△	△	-	2	-	-	-	-	0	-	-	-	-	0
Mountain Home	L		-	-	-	△	1	♦	-	♦	♦	-3	♦	-	♦	△	-1
Yokota AB	L		-	-	-	-	0	N/A	♦	-	-	-1	N/A	-	-	-	0
Misawa	L	PPH	△	△	-	△	3	♦	♦	♦	♦	-4	-	-	-	-	0
Aviano	L	PPH	-	△	-	△	2	-	-	-	-	0	-	-	-	-	0
David Grant	L	PPH,SD	-	△	△	△	3	-	♦	-	♦	-2	△	-	△	-	2
Navy																	
Portsmouth	VH	BT	♦	△	-	-	0	-	△	△	-	2	-	-	-	♦	-1
San Diego	VH	PPH,SD	△	△	△	△	4	-	△	-	-	1	△	△	-	-	2
Camp Lejune	H	PPH,SD	△	△	△	△	4	-	-	-	△	1	△	△	△	△	4
Camp Pendleton	M	PPH,BT	△	△	△	△	4	-	△	-	△	2	-	-	-	-	0
Okinawa	M	PPH	♦	-	△	△	1	-	-	-	-	0	-	-	-	-	0
Jacksonville	M		-	♦	-	△	0	-	-	-	♦	-1	-	△	-	-	1
Bremerton	M	PPH	△	△	-	△	3	-	-	-	-	0	-	-	△	-	1
Twenty Nine Palms	M		♦	♦	-	-	-2	-	-	-	-	0	-	△	-	-	1
Yokosuka	M	PPH	-	△	△	△	3	-	-	△	-	1	-	△	-	-	1
Pensacola	M	PPH, SD	-	△	△	△	3	-	-	-	-	0	△	△	△	-	3
Guam	M	PPH	-	△	△	△	3	♦	♦	-	-	-1	△	-	-	-	1
Lemoore	M		-	-	-	-	0	-	-	♦	♦	-2	♦	♦	-	-	-2
Oak Harbor	L		♦	♦	-	-	-2	-	-	-	-	0	-	-	-	-	0
Naples	L		-	-	-	-	0	♦	♦	♦	-	-3	-	-	-	-	0
Sigonella	L		-	△	-	-	1	♦	♦	-	-	-2	-	-	-	-	0
Rota	L		♦	♦	-	-	-2	♦	♦	♦	♦	-4	♦	♦	♦	-	-3
Guantanamo Bay	L		-	♦	♦	♦	-3	N/A	♦	♦	♦	-3	N/A	♦	♦	♦	-3
NCR-MD																	
Dewitt	M	BT	-	-	-	-	0	△	△	△	△	4	-	♦	-	-	-1
WR NMMC	M	PPH	△	△	△	△	4	-	△	-	-	1	-	-	-	♦	-1

Legend for Volume in Annual Deliveries: VH (very high) >= 2,000; H (high): 1,500 - 1,999; M (medium): 300 - 1,499; L (low): 1-299

♦ indicates MTF average was at least two standard deviations below the NPIC average (counts as -1 towards score),

\- indicates the MTF average was within two standard deviations of the NPIC average (counts as 0 towards score),

△ indicates the MTF average was at least two standard deviations above the NPIC average (counts as 1 towards score)

N/A indicates that data were not available from these MTFs in CY 2010

** PPH=Postpartum Hemorrhage, BT=Birth Trauma, SD=Shoulder Dystocia

*** Lower score is better

2014 MHS Review Group

Source: National Perinatal Information Center Database. Prepared by: Defense Health Agency, July 2014

National Surgical Quality Improvement Program (NSQIP®) - Supporting Figures and Tables

Background

The National Surgical Quality Improvement Program (NSQIP®), administered by the American College of Surgeon (ACS), is a voluntarily reported, data-driven, outcome-based program to measure the quality of surgical care. The data are adjusted for the type of surgery and how complicated the patients are to allow comparisons between facilities.

The focus of ACS NSQIP® is to assist hospitals with assessing and improving the quality of surgical care while decreasing costs. NSQIP® use abstracted actual clinical data rather than administrative data. Clinical data are more detailed, informative and capture more complications than does administrative data. NSQIP® uses a rigorous, validated sampling and measurement process, as well as validated case-mix and risk adjustment procedures that have been detailed and published elsewhere).[6]

The primary outcome measures for NSQIP® are mortality and morbidity 30 days following surgery, risk adjusted for a patient's pre-operative co-morbidities. Primary outcomes assessed are death and morbidity derived from cardiac events, pneumonia, unplanned intubation, Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE), Renal Failure, Surgical Site infection (SSI), Urinary Tract Infection (UTI), and Return to Operating Room (ROR). NSQIP® reports these measures for each sub-specialty program supported by each facility.

The process is as follows:

1. Hospitals abstract actual clinical data
2. ACS NSQIP® analyzes data
3. ACS NSQIP® reports data back to hospitals twice yearly
4. Hospitals act on their data
5. Hospitals monitor interventions with data.

NSQIP® is a national standard for surgical quality improvement with well-defined measures, data collection processes, and robust analytics that has been in use by the MHS since 2009. Currently, 507 hospitals participate in the program out of more than 5,000 community hospitals in the United States. Participation involves a significant investment of time, people, money, and a cultural commitment to performance improvement.

Inpatient Mortality Measures - Supporting Figures and Tables

Due to the availability of other process-focused quality measures, data on inpatient mortality has played a limited role in the overall MHS quality program. Inpatient mortality has traditionally not been viewed as an accurate reflection of care quality. Considerable research over the last decade has focused on the how best to use mortality measures in the assessment of inpatient care quality. What has emerged is a consensus among leading civilian organizations that the

[6] Available at: http://site.acsnsqip.org/program-specifics/data-collection-analysis-and-reporting/.

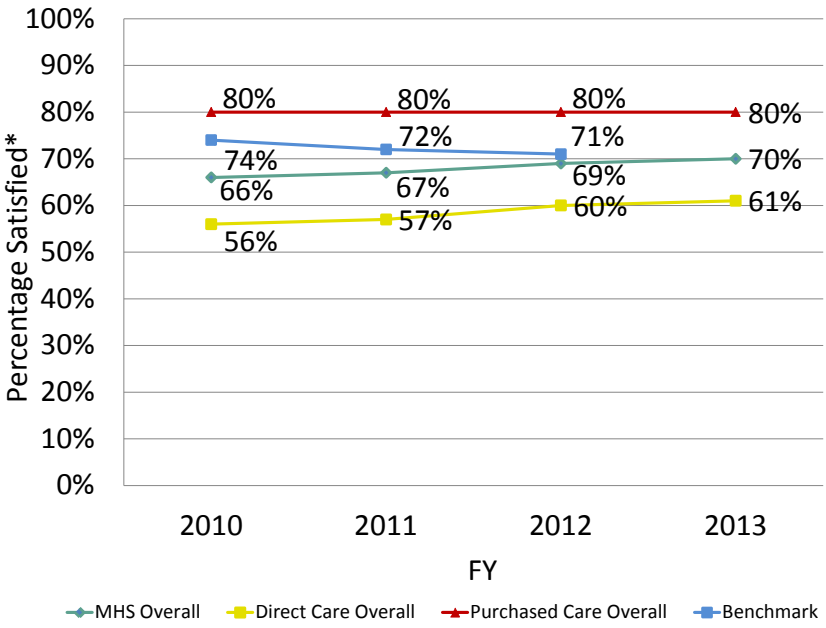
judicious use of risk adjusted mortality measures can serve a valuable role in identifying trends warranting further investigation.

Experience of Care Summary[7] - Supporting Figures and Tables

Rating of Health Care:

- MHS beneficiary overall ratings of their health care (the percentage rating 8, 9, or 10 on a 0–10 scale) increased from 66 percent in FY 2010 to 70 percent in FY 2013.
- The increased ratings between FY 2011 and FY 2012 were statistically significant when compared to the previous fiscal year.
- Among MHS beneficiaries, ratings by those using civilian outpatient care remained at 80 percent from FY 2010 to FY 2013, while ratings by those using MTF-based care increased from 56 percent in FY 2010 to 61 percent in FY 2013.
- Between FY 2010 and FY 2012, the increases were statistically significant when compared to the previous fiscal year.

Figure 4.4-13 Overall Rating of Health Care, FY10 – FY13



*"Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0-10 scale where 10 is best.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Rating of Health Plan:

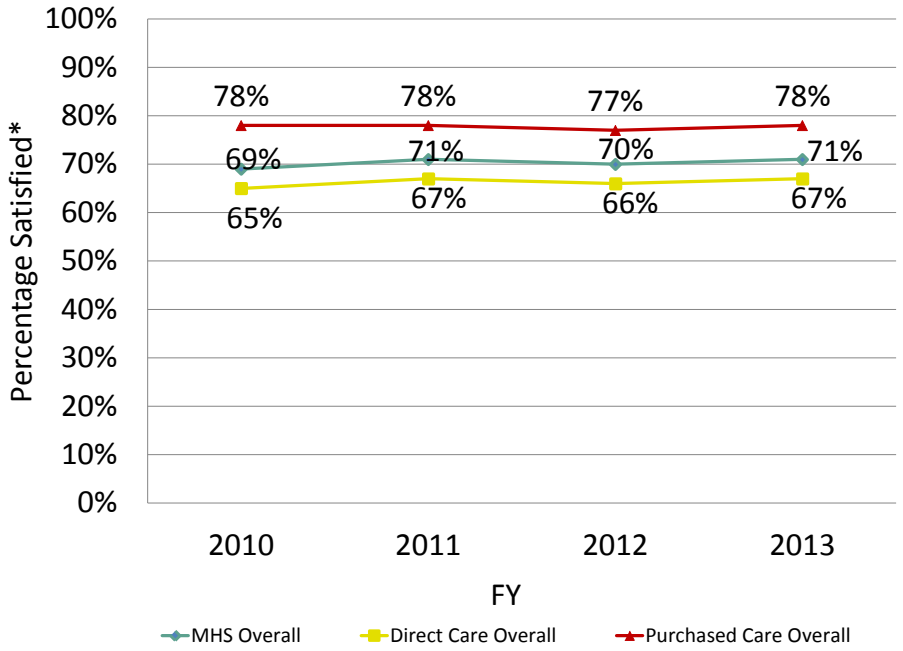
- Beneficiary overall rating of the health plan among MHS beneficiaries (the percentage rating 8, 9, or 10 on a 0–10 scale) has *slightly increased* from 69 percent in FY 2010 to

[7] Bannick, R.R, Marshall, K. MHS Quality of Care/Experience of Care and Access to Care from DHCAPE.

71 percent in FY 2013. The FY 2011 rating (71 percent) was statistically significantly *higher* compared with FY 2010.

- Health plan ratings by those receiving outpatient care at civilian facilities has also *remained stable* around 78 percent, while plan ratings for MTF-based facilities *increased* from 65 percent in FY 2010 to 67 percent in FY 2013.
- During FY 2012, there was a *statistically significant decrease* from FY 2011 for beneficiaries receiving care in civilian facilities.
- Notes: There is no civilian benchmark for Rating of Health Plan.

Figure 4.4-14 Overall Rating of Health Plan, FY10 – FY13



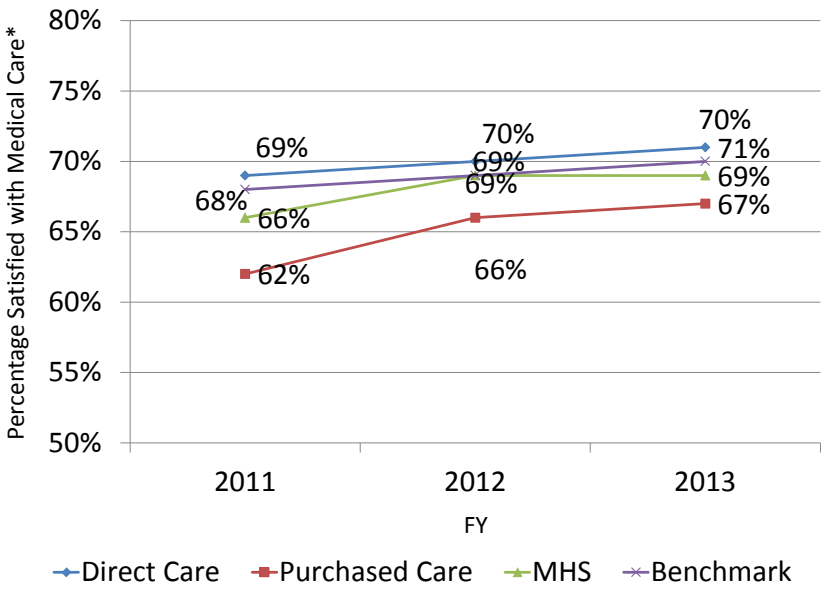
*"Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0-10 scale where 10 is best.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Overall Rating of Hospital

- Overall, beneficiaries who received care within the Purchased care component for surgical and OB care rated their hospital higher than did those in the Direct care component.
- MHS beneficiaries needing surgical care, whether discharged from MTF or civilian hospitals, rated their hospital stay higher than users that make up the civilian benchmark.
- Beneficiaries who received medical services in military facilities rated their hospital higher (71 percent for 2013) than the civilian benchmark (70 percent for 2013; CMS).

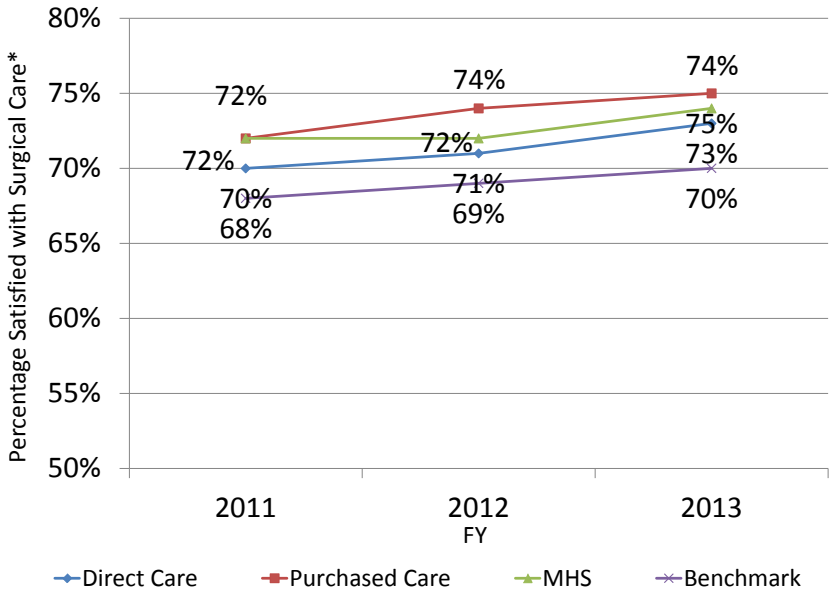
Figure 4.4-15 Overall Rating of Hospital

Figure 4.4-15a Rating of Hospital in Medical Care, FY11 – FY13



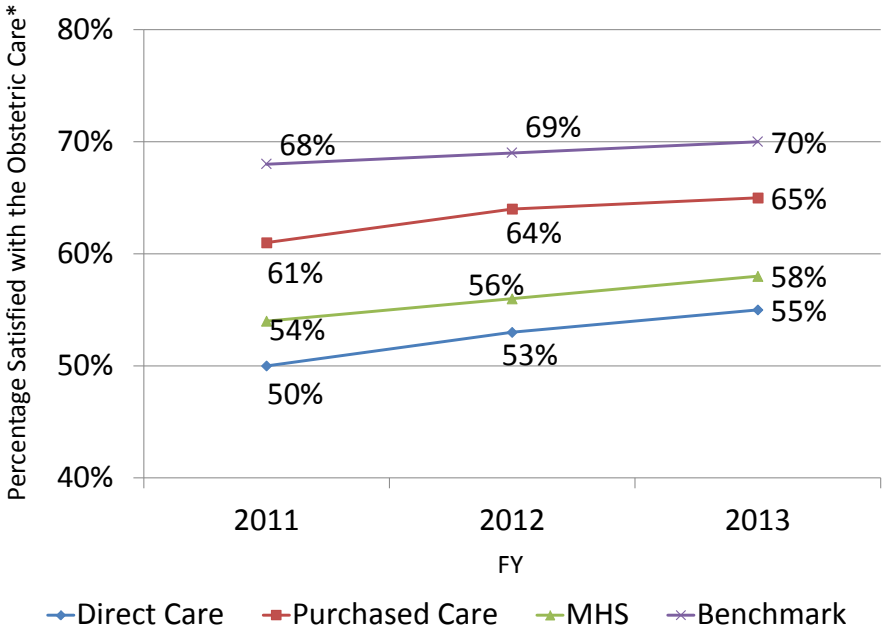
*"Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0-10 scale where 10 is best.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Figure 4.4-15b Rating of Hospital in Surgical Care, FY11 – FY13



*"Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0-10 scale where 10 is best.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Figure 4.4-15c Rating of Hospital in Obstetric Care, FY11 – FY13



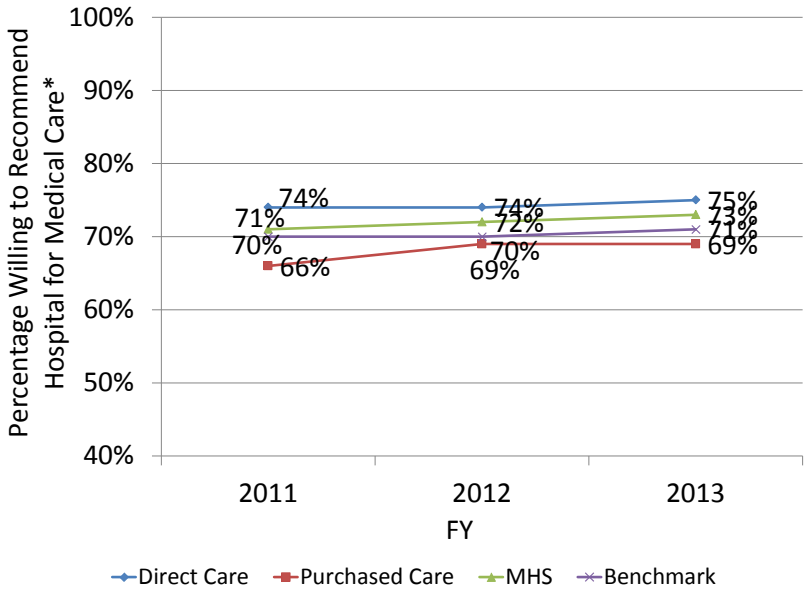
*"Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0-10 scale where 10 is best.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Willingness to Recommend Hospital

- Direct care medical and surgical product lines beneficiaries' recommendation of their hospital exceeds the civilian benchmarks, while direct care obstetrics beneficiaries' falls below the civilian benchmarks. (Figure 4.4-16).
- Purchased care beneficiaries' recommendation of their hospital consistently exceeds the civilian benchmarks for surgical and OB product lines.
- Note: Percentage reporting satisfied of willingness to recommend is a score of 'always' when asked if one would recommend a hospital to family or friends.

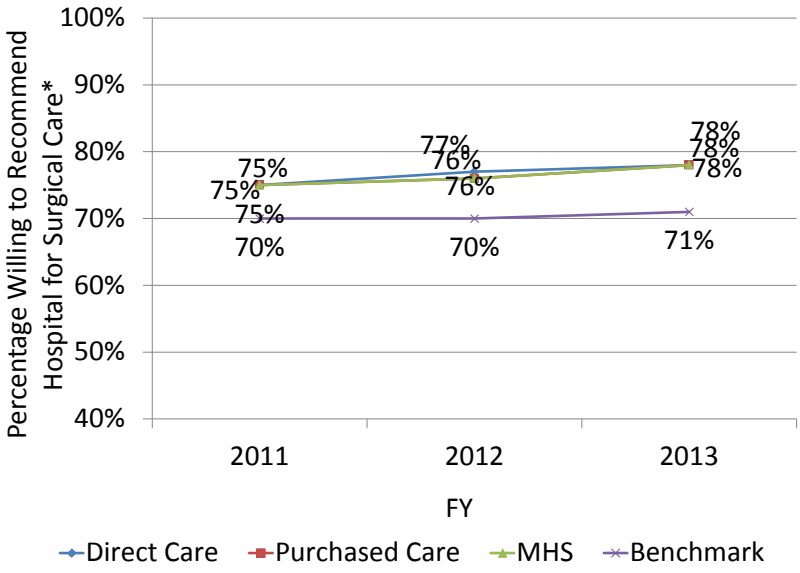
Figure 4.4-16 Willingness to Recommend Hospital

Figure 4.4-16a Willingness to Recommend Hospital for Medical Care, FY11 – FY13



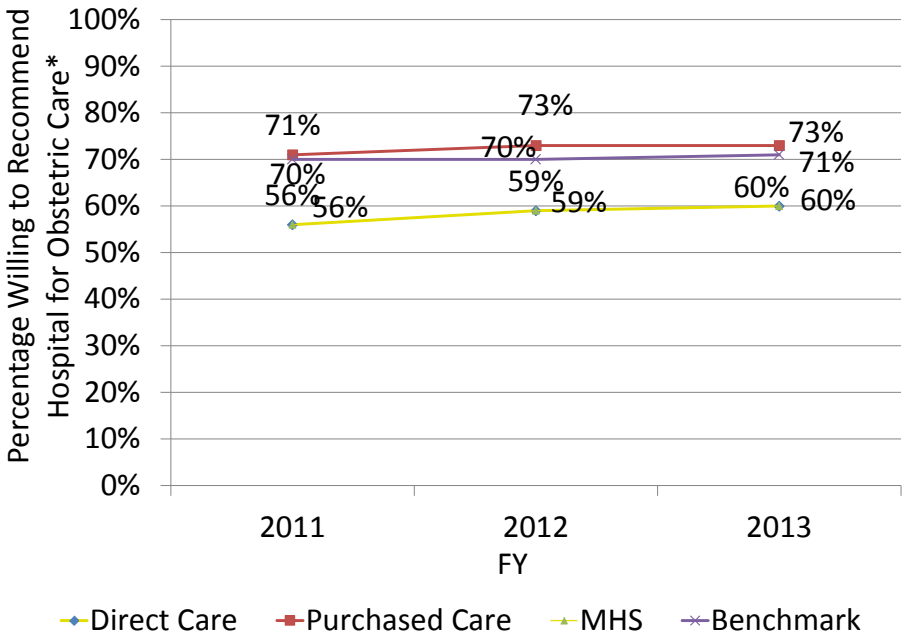
*"Percentage Reporting Satisfied" for recommendation of hospital is a score of always when asked if one would recommend a hospital to family of friends.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Figure 4.4-16b Willingness to Recommend Hospital for Surgical Care, FY11 – FY13



*"Percentage Reporting Satisfied" for recommendation of hospital is a score of always when asked if one would recommend a hospital to family of friends.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Figure 4.4-16c Willingness to Recommend Hospital for Obstetric Care, FY11 – FY13



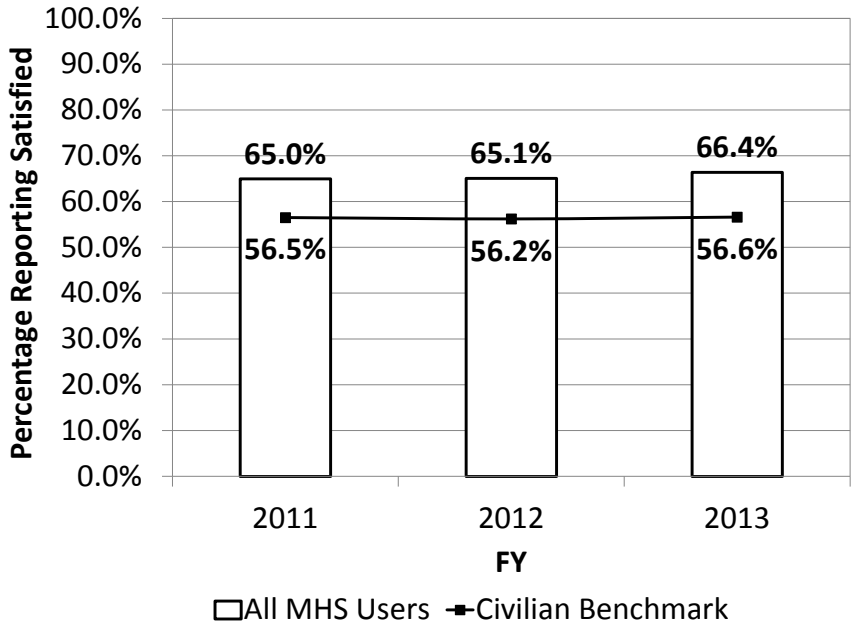
*"Percentage Reporting Satisfied" for recommendation of hospital is a score of always when asked if one would recommend a hospital to family of friends.
2014 MHS Review Group
Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013, July 2014

Quality of Care: Beneficiary Reported Experience and Satisfaction with Key Aspects of TRICARE and trends in satisfaction ratings

- MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of: 1) the health plan, in general; 2) health care; 3) personal physician; and 4) specialty care. Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals, and customer complaints.
- Satisfaction levels with health care quality and health plan increased slightly from FY 2011 to FY 2013.
- MHS satisfaction rates with health care remained below the civilian benchmarks, with the exception of health plan, which exceeded the benchmark over this period.
- Satisfaction with primary care and specialty care remained stable between FY 2011 and FY 2013.

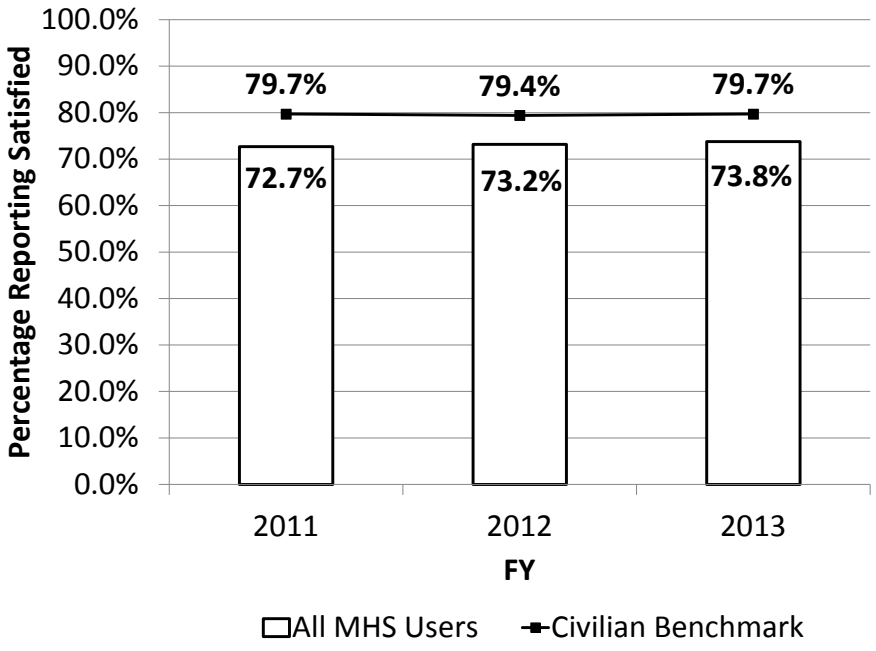
Figure 4.4-17 Reported Experience and Satisfaction with Key Aspects of TRICARE

Figure 4.4-17a Health Plan, FY11 – FY13



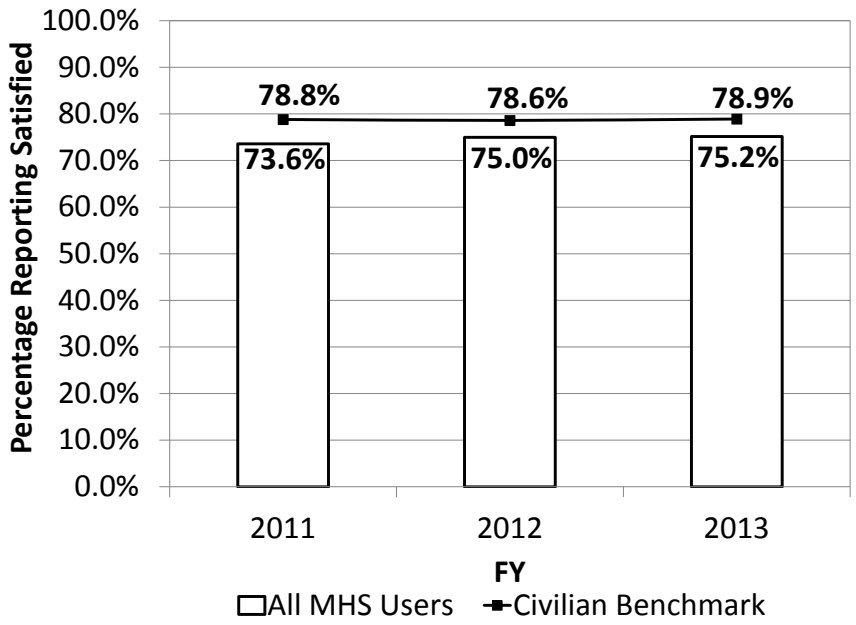
2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Figure 4.4-17b Primary Care Physician, FY11 – FY13



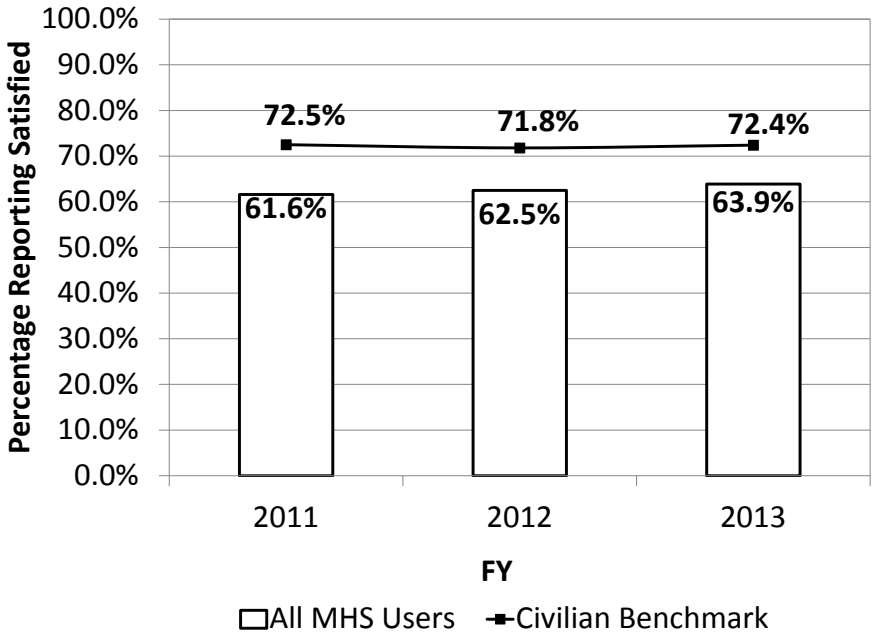
2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Figure 4.4-17c Specialty Physician, FY11 – FY13



2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Figure 4.4-17d Health Care, FY11 – FY13

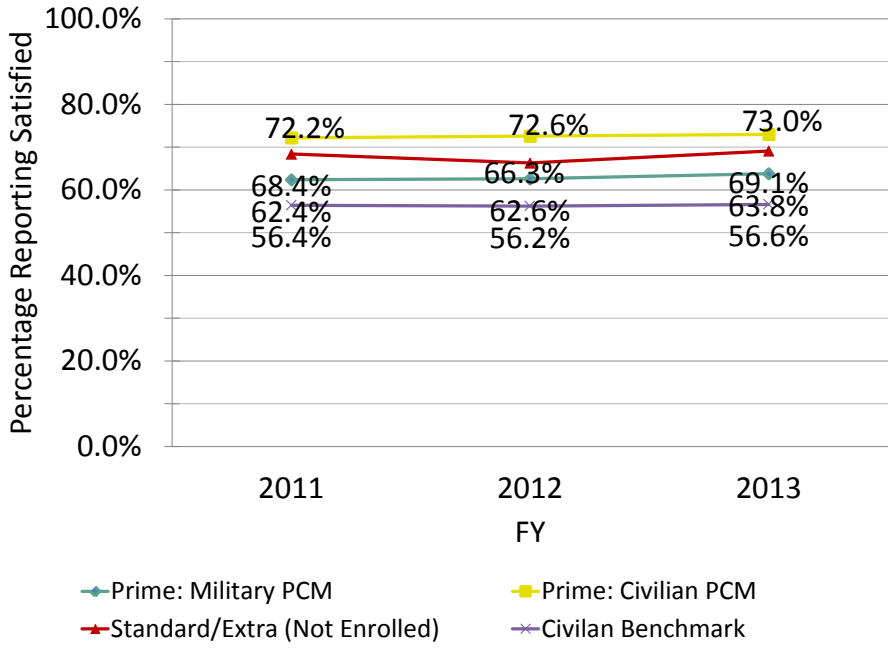


2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Quality of Care: Satisfaction with the Health Plan Based on Enrollment Status and trends in satisfaction with Health Plan based on enrollment status: (Figure 4.4-18 and Figure 4.4-19)

- DoD health care beneficiaries can participate in TRICARE in several ways: by enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.
- Satisfaction with the TRICARE health plan remained stable for Prime enrollees and non-enrollees from FY 2011 to FY 2013. The civilian benchmark also remained stable.
- During each of the past three years (FY 2011 to FY 2013), enrolled and non-enrolled MHS beneficiaries reported higher levels of satisfaction than their civilian counterparts.

Figure 4.4-18 Trends in Satisfaction with Health Plan Based on Enrollment Status, FY11 – FY13

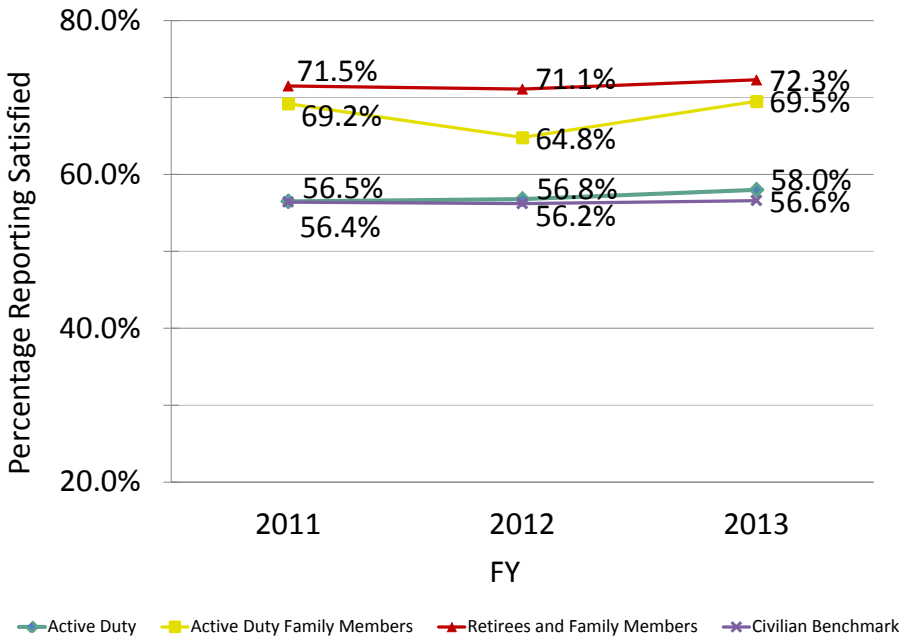


2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Quality of Care: Satisfaction with the Health Plan by Beneficiary Category and trends in satisfaction with Health Plan by beneficiary category

- Satisfaction levels of different beneficiary categories are examined to identify any diverging trends among groups.
- Satisfaction of Active Duty beneficiaries equaled the civilian benchmark in all three years (FYs 2011–2013).
- ADFM and RETFM satisfaction ratings exceeded the civilian benchmark in all three years (FYs 2011–2013).

Figure 4.4-19 Trends in Satisfaction with Health Plan Based on Beneficiary Status, FY11 – FY13

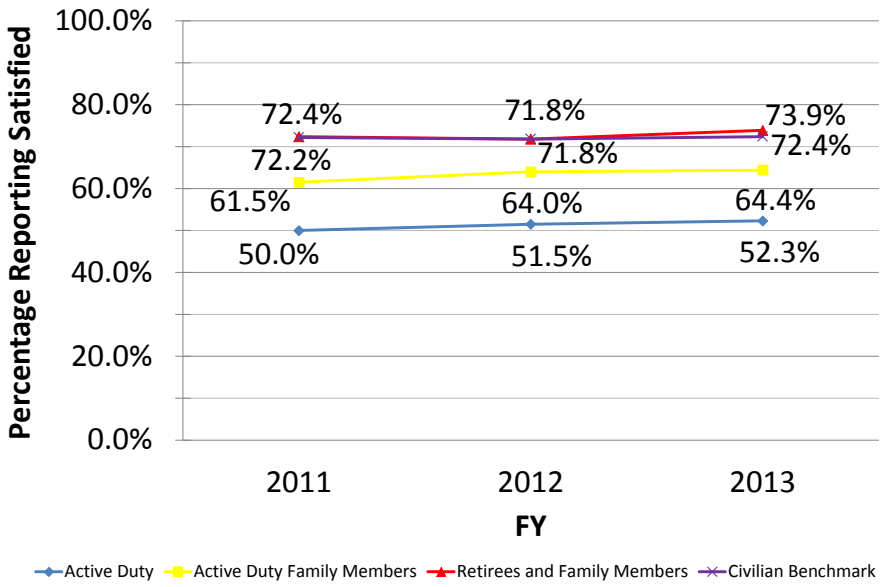


2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Quality of Care: Satisfaction with the Health Care Based by Beneficiary Category/Enrollment Status and trends in satisfaction with TRICARE Health Care by Beneficiary Category and Enrollment Status, Figures 4.4-20a and 4.4-20b, respectively.

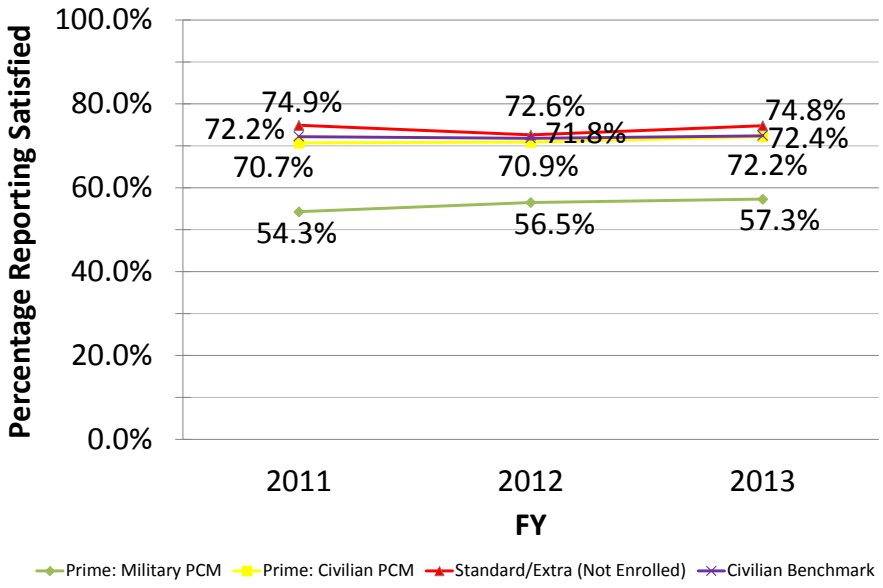
- Satisfaction remained stable during FY 2011- FY 2013 for active duty, ADFMs, and retirees and families.
- The satisfaction levels of active duty and their families continued to lag the civilian benchmark for all three years, but retirees and families equaled (no statistically significant difference) the benchmark over that time.
- The satisfaction of enrollees with military PCMs lagged the civilian benchmark in FY 2011 to FY 2013.
- Satisfaction levels of enrollees with civilian PCMs and satisfaction levels of non-enrollees equaled or exceeded the civilian benchmark.

Figure 4.4-20a Trends in Satisfaction with TRICARE Health Care Based on Beneficiary Category, FY11 – FY13



2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Figure 4.4-20b Trends in Satisfaction with TRICARE Health Care Based on Enrollment Status, FY11 – FY13

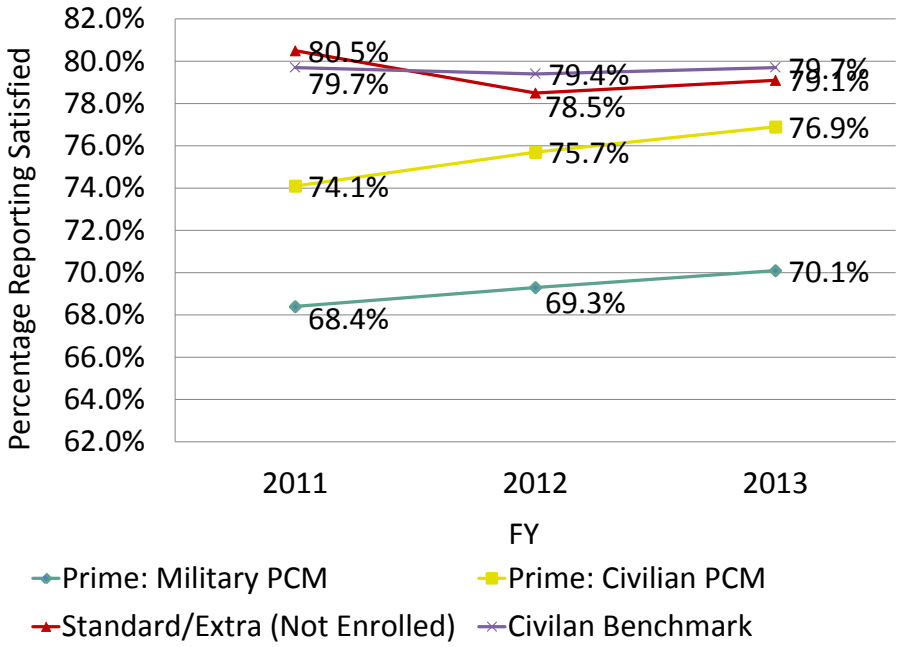


2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Quality of Care: Satisfaction with one's Personal Provider Based on Enrollment of Beneficiary Category and trends in Satisfaction with one's Personal Provider by Enrollment Status Beneficiary Category (Figure 4.4-21 and Figure 4.4-22)

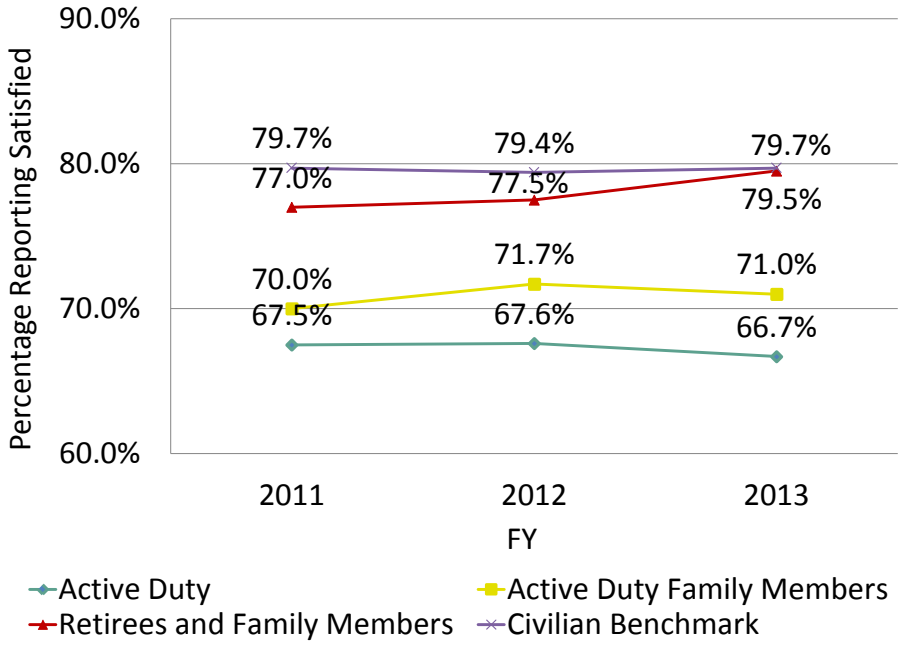
- Satisfaction levels of Prime enrollees (both military and civilian PCMs) remained below the civilian benchmarks. Satisfaction levels of non-enrollees are comparable to the civilian benchmark.
- Satisfaction levels by beneficiary category for active duty and their family members remained below the civilian benchmark, and remained steady over the three-year period for all beneficiary categories.

Figure 4.4-21 Trends in Satisfaction with One's Personal Provider Based on Enrollment Status, FY 11 – FY13



2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

Figure 4.4-22 Trends in Satisfaction with One's Personal Provider Based on Beneficiary Status, FY11 – FY13



2014 MHS Review Group
Source: TRICARE Program: Access, Cost and Quality Fiscal Year 2014 Report to Congress, July 2014

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APPENDIX 5. PATIENT SAFETY

Appendix 5.1
Patient Safety Goals

Navy

The U.S. Navy Bureau of Medicine and Surgery (BUMED) Instruction 6010.23 does not define Patient Safety. However, it states "The goal of the PSP is to prevent injuries to patients, visitors, and personnel and to minimize the negative consequences of injuries that do occur. This is accomplished through the identification, reporting, and intensive analysis of sentinel events, adverse events, and close calls. The information reported through the PSP shall be used exclusively for improving health care system and processes that impact on medical errors and patient safety...." (p. 2)

Air Force

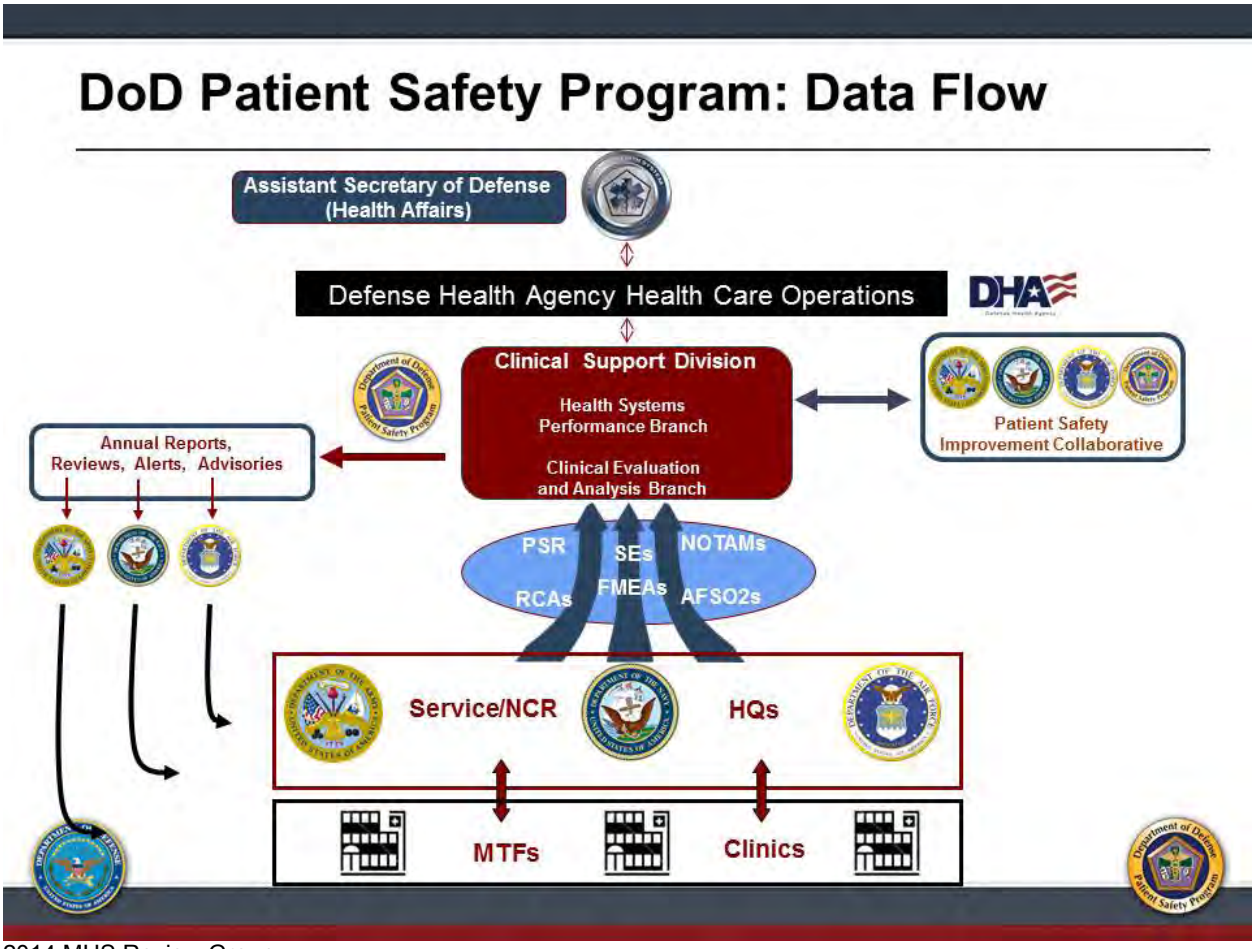
AFI44-19 states: "Patient safety proactively and retroactively identifies potential and actual risks to safety, identifies underlying causes and makes the necessary improvements to reduce risks. It establishes processes in response to sentinel events and adverse incidents by identifying risks through a Root Cause Analysis (RCA) and implementing process improvements. Patient safety, in collaboration with other activities including performance improvement and risk management, promotes a culture of safety in which errors are identified and reported freely without retribution. The goal is to reduce variability and vulnerability for error in processes. Safety is rooted in the daily operations of the health care organization where proactive risk identification, assessment and control are the foundation for safe and effective healthcare." (p. 28)

Army

Army MEDCOM Reg 40-68 states: "Patient safety activities are proactive and focus on reducing or avoiding misadventures during the delivery of medical/healthcare. Deliberate attention is required to improve medical systems and processes in order to prevent harm related to medical/healthcare interventions and to modify, reduce, or eliminate beneficiary exposure wherever possible. ...PS addresses incidents involving both potential harm (close call) to patients as well as those in which actual injury occurred (adverse event)." (p. 102).

Appendix 5.2
MHS Governance Related to Patient Safety

Figure 5.2-1 Central Defense Health Agency Structure



2014 MHS Review Group
Source: Basic Patient Safety Manager Course, Introduction Module, Updated February 2014

Patient Safety Program

The DoD Patient Safety Program (PSP) was mandated as part of the Floyd Spence National Defense Authorization Act of 2001 in an effort to ensure the safe delivery of care for to 9.6 million TRICARE beneficiaries across the MHS. PSP's mission was to promote a culture of safety to eliminate preventable patient harm by engaging, educating and equipping patient care teams to institutionalize evidence-based safe practices. The vision was to support the military mission by building organizational (Army, Navy, Air Force, and TRICARE Management Activity) commitment and capacity to implement and sustain a culture of safety to protect the health of the patients entrusted to our care. The PSP was aligned under the Office of the Chief Medical Officer, TRICARE Management Activity.

With the establishment of the DHA, the PSP was integrated with Clinical Quality and Risk Management. It was aligned, under the Health Systems Performance Branch and, in turn, the Clinical Support Division. It continues as a comprehensive program with the overarching goal of advancing a culture of patient safety and quality within the MHS. The PSP uses adverse event report-based information and lessons learned to produce products and services designed to reduce medical errors and assist with education and training in patient safety. The specific PSP goals are to:

- Engage members of the MHS, MTFs, military patients and their families in understanding patient safety and its role in maintaining military readiness.
- Create a learning environment and build competency within health care teams (inclusive of the patient and families) to understand, create, engage in, and promote a culture of safety.
- Use data to continuously improve patient safety in the MHS.
- Advance patient safety in collaboration with other national health care leaders.
- Ensure an efficient infrastructure to sustain patient safety activities and mandates through targeted goals and actions.

Before the establishment of the DHA, the PSP operated under the direction of the Patient Safety Planning and Coordinating Committee (PSPCC), a collaborative multi-Service body composed of patient safety, quality, and risk management experts. The objectives of the PSPCC were to:

- Improve the coordination of patient safety activities across the three Services, Armed Forces Institute of Pathology, Uniformed Services University, and the TRICARE Management Activity.
- Develop analysis plan for patient safety data and align it with national standards.
- Evaluate effectiveness of DoD patient safety training.
- Increase near miss reporting.
- Evaluate interventions to increase transparency after patient safety event.
- Increase transfer / implementation of patient safety in operational units.
- Increase patient awareness/involvement in patient safety initiatives.

Following the formation of the DHA, the DoD Patient Safety Improvement Collaborative (PSIC), formerly known as the Patient Safety Planning and Coordination Committee, was created to promote continuous improvement in the safety and quality of care delivered to MHS beneficiaries. This collaborative improves and fosters a culture of patient safety by developing, promoting, and supporting a comprehensive PSP aligned with MHS missions. The voting members of the PSIC consist of patient safety representatives from Army, Navy, Air Force, the National Capital Region, and the DHA. It also has advisory members (for example, Director, PSQAC, patient safety representative from the Senior Enlisted community, Section Chiefs from Clinical Quality, RM, Clinical Evaluation and Analysis Branch) and as well as ad hoc members. The specific goals of the PSIC are:

- Identify high-priority themed areas for enterprise-wide focused safety improvement intervention and tracking. Priority areas will be aligned with MHS strategic goals, will lead to a safer clinical environment, and likely to result in cost savings.
- Lead these focused improvement projects incorporating the translation of evidence into practice and health professions learning. These projects will involve tri-Service coordination to avoid duplication; they will be data-driven to demonstrate actual improvement.
- Promote knowledge transfer, transparency, and implementation of patient safety practices throughout the MHS.
- Coordinate the development, validation, and dissemination of patient safety activities across the MHS.
    - Support MHS/Service efforts to integrate patient safety into all health professions curriculum. Goal is to create clinical learning environments aimed at achieving safe high-quality patient care.
    - Disseminate patient safety information across the enterprise using multiple communication modalities.
    - Increase patient awareness and engagement in patient safety related initiatives.
    - Encourage leadership development in patient safety across the MHS.
    - Draft and review patient safety policy, instructions and/or directives.
    - Monitor the effectiveness of the DoD PSP, including training, education, data analysis, and research.
    - Foster interagency collaboration in the implementation of the PSP.

The PSIC reports directly to the MHS Clinical Quality Forum (CQF). There are differences in the Service approach to governance relative to how they are structured:

- Army and Navy MTFs fall under their Surgeon General (SG).
- Air Force MTFs fall under the line commands.
- The NCR MTFs fall under the DHA.

The DoD PSP consists of Service Patient Safety Representatives and their headquarters staff, MTF patient safety managers/staff, and the centralized Patient Safety Analysis Center (PSAC) and Patient Safety Operations. The PSP maintains a close working relationship with the Patient Safety and Quality Academic Collaborative (PSQAC) at the Uniformed Services University (USU).

Service Information

The centrally funded PSP is comprised of:

- DHA: Central Office – Three civilians and 29 contracted staff;
- NCR: Approximately four staff (two are MTF Patient Safety Managers [PSMs] – all civilian).
- Army: Approximately 44 staff (37 are MTF PSMs – AD and civilian).
- Navy: Approximately 40 staff (37 are MTF PSMs – AD, civilian, and contracted staff).

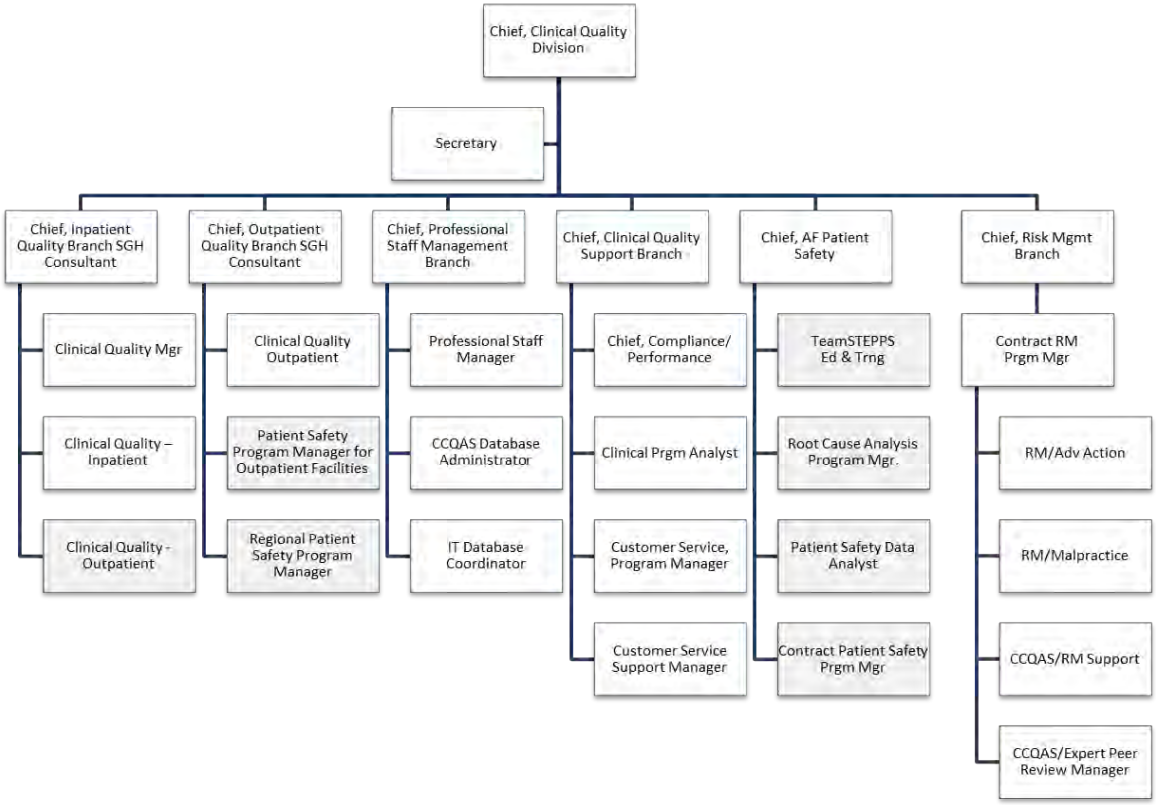
- Air Force: Approximately 91 staff (84 are MTF PSMs – all contracted staff).

Navy Governance

The Navy SG has direct authority and responsibility for the Quality oversight programs including Patient Safety and Quality. The Quality Oversight Programs (Patient Safety, Quality, Risk Management, Credentials, and Infection Prevention) are located within the BUMED Medical Operations Code (M3). BUMED's quality oversight programs have SMEs in each area to include a TJC trained fellow for Quality. Medical Operations Code reports directly to the SG. In addition, BUMED's Senior Strategy Board provides Execution and Oversight of BUMED Quality Projects and Regional Performance Reviews. Regional Commanders are responsible for oversight of the quality programs for their facilities. Regional Commands have a TJC trained fellow as a SME for Patient Safety and Quality Management. MTFs have Patient Safety and Quality Managers who, in conjunction with their physician advisors, implement these programs and provide recommendations to leadership. Various multidisciplinary committees support this effort at the MTF level.

Air Force Medical Service Governance

Figure 5.2-2 AFMOA/SGHQ Organizational Chart



2014 MHS Review Group
Source: Air Force Medical Operations Agency

The Air Force Medical Service (AFMS) strategic map demonstrates clear objectives to reduce the variability in system processes to drive reliable safe health care. A culture of patient safety is inherently about working relationships and effectively communicating in collaborative teams. This culture is patient focused and has an attitude of awareness and personal responsibility to apply safe practices with every patient encounter.

The Air Force SG establishes policy and delegates broad oversight responsibility for the AFMS Patient Safety Program to the Commander, Air Force Medical Operations Agency (AFMOA), Office of the Surgeon General, San Antonio, Texas. The AFMOA Commander ensures patient safety policies and processes are implemented in each MTF, including Aeromedical Evacuation sites and deployed locations. The Chief, Clinical Quality Management Division, AFMOA is responsible for delegating management of the program to the Chief Air Force PSP who executes the PSP program requirements via a centralized contract, which provides the manpower and expertise to operationalize the program within AFMOA and at each MTF. In turn, each MTF Commander is responsible to ensure the PSP is implemented and in compliance with DOD and AF policy.

The Clinical Quality Management Division patient safety team provides corporate-level expertise and guidance to each MTF to support compliance with DOD policy requirements. This includes:

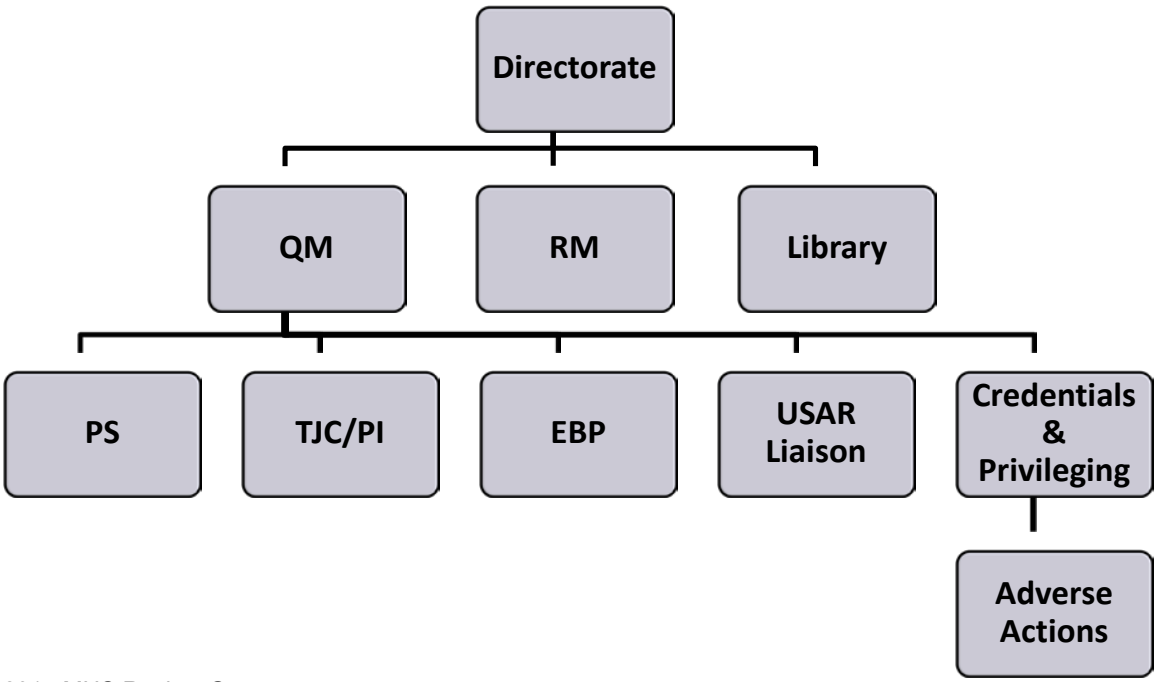
- Model the behaviors and beliefs as well as speak the language of patient safety through training / education forums, webinars, focused group teleconferences, and routine consultation with facility Patient Safety Managers (PSMs).
- Advocate for an environment of non-blame and reduction of the fear of retribution through recognizing and encouraging good catch, near miss, and event reporting, conducting leadership rounds, and encouraging proactive approaches to problem solving with the end goal of process improvement.
- Submit all MTF reviewable sentinel events through AFMS leadership to DoD Patient Safety Office.
- Root Cause Analysis (RCA) review team; guides facility RCA teams to conduct the analysis, review each RCA completed for credibility and thoroughness, track corrective action plan implementation.
- Developed and disseminated Patient Safety Handbook, which describes how to implement PSP requirements and other leading practices for patient safety.
- Promote compliance with National Patient Safety Goals and initiatives working closely with the facility PSM and goal champions.
- Focus on prospective and retrospective analysis of events, new and revised processes and systems to identify areas of high risk, high volume problem prone and high costs.
- Reinforce responses to alerts and Notice to Airmen through thorough assessment of impact to the facility.
- Monitor AFMS patient safety activities and performance improvement recommendations in regularly scheduled Performance Management Forums.

Facility PSMs serve as the local PS resource and confer with all levels of facility personnel to develop and manage the program at the MTF. PSMs collect, collate, analyze and display data from event reviews, near misses, good catches, RCAs, Proactive Risk Assessments, and other sources. PSMs disseminate information to appropriate MTF committees / functions, quality managers and other individuals for patient safety improvement purposes and awareness. Under the direction of the Chief of the Medical Staff, the MTF PSM notifies AFMOA/SGHQ of all sentinel events, and adverse incidents as required by DoD policy.

Army Governance

The Army SG has direct authority and responsibility for establishing policy and delegating broad oversight to the Deputy Surgeon General/Deputy Commanding General (Operations) (DA SG-ZB), who is directly responsible to the Army SG and has direct oversight over the Clinical Performance Assurance Directorate (CPAD). As illustrated in Figure 5.2-3, the CPAD has direct oversight over Quality Management, Risk Management, and the Library. Quality Management has direct oversight over Patient Safety, The Joint Commission/Performance Improvement, Evidence Based Practice, the USAR Liaison, Credentials & Privileging and Adverse Actions.

Figure 5.2-3 Army Governance of Patient Safety



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Source: COL. Karen T. Grace, USARMY MEDCOM HQ, July 2014

The CPAD Director is responsible for delegating management of the program to the Patient Safety Manager, CPAD who executes program requirements, which provides the manpower and expertise to operationalize the program within MEDCOM, the Regional Medical Commands (RMC), and at each MTF. SMEs within the MEDCOM PSP develop, implement, and evaluate

policies at the MEDCOM level; provide mentoring, coaching, and training in collaboration with the Regional Medical Command (RMC) Leadership and RMC Quality Management cells to the Quality and Patient Safety Managers (PSMs) within the MTFs throughout the MEDCOM. In turn, each MTF Commander is responsible to ensure the program is implemented and in compliance with DoD and Army policy.

Facility PSMs serve as the local PS resource and confer with all levels of facility personnel to develop and manage the program at the MTF. PSMs collect, collate, analyze and display data from event reviews, near misses, good catches, RCAs, Proactive Risk Assessments, and other sources. PSMs disseminate information to appropriate MTF committees / functions, quality managers and other individuals for patient safety improvement purposes and awareness. Under the direction of the Chief, Quality Management Department, the MTF PSM notifies the RMC and MEDCOM of all sentinel events, and adverse incidents as required by MEDCOM policy. MEDCOM PSP in turn, notifies Health Affairs at the SGHQ of all sentinel events.

National Capital Region Medical Directorate

NCR MD headquarters develops policy and has direct authority and responsibility for PSPs within the Joint Facilities. The Quality Management Programs (Patient Safety, Quality, Risk Management, Credentials, and Performance Improvement) are located within NCR MD's Clinical Operations Division. As directed in the NCR MD Clinical Quality Manual (CQM), each inpatient MTF Director is responsible for establishing and implementing a PSP within their respective facilities. Facility level PSMs collaborate with staff to analyze and identify trends from adverse-event reports, support educational programs in patient safety, implement safety initiatives, and help extend best practices and "lessons learned" from adverse events to other units and departments.

Appendix 5.3
Patient Safety Policies

Navy Medicine Policies

1. Patient Safety and Quality are a strategic priority for Navy Medicine. The Chief Bureau of Medicine and Surgery issued a policy memorandum on January 3, 2014, SUB: Culture of Safety in Navy Medicine. The Chief outlined the measures Navy Medicine will take to begin the transition to a high reliability organization where staff feels safe in expressing concerns or asking questions of colleagues. The metrics that have been mandated include:
    - Leadership rounds
    - PS Recognition Programs
    - TeamSTEPPS® training and implementation
    - Monitoring the impact of the above
2. Effectively promoting patient safety focuses on creating strong incentives to disclose errors made/ observed, as well as building teamwork, communication and problem solving skills. On December 18, 2002, BUMED Instruction 6010.23 "Participation in the Military Health System Patient Safety Program (MHSPSP)" was established.
   The goal of the Patient Safety Program is to:
    - Prevent injuries to patients/visitors/personnel
    - Minimize negative consequences of injuries when they do occur
3. On October 9, 2013, BUMED Instruction 3100.1 "Commander's Critical Information Requirements" was established. The following patient safety events must be reported immediately via voice reports to the Chief, BUMED:
    - Sentinel events
    - Reporting medical-related events that may adversely affect mission accomplishment
4. On January 8, 2009, the Chief, Bureau of Medicine and Surgery issued a policy memorandum SUB: Reporting Infection Prevention and Control Data to the Centers for Disease Control and Prevention (CDC). This is in support of Health Affairs Policy Memo 08-020 of December 4, 2008.
5. On January 22, 2009, the Chief, Bureau of Medicine and Surgery issued a policy memorandum SUB: Application of the Joint Commission (TJC) Universal Protocol (UP) stating that Navy Medicine will effectively address its system and processes around effective implementation of The Joint Commission's Universal Protocol.
6. On April 14, 2011, BUMED Instruction 6620.9B, "Healthcare-Associated Infection Prevention and Control Program" was implemented. This policy establishes guidance for establishing infection control program. The policy applies to all MTFs, DTFs, branch health clinics, and shipboard and Marine Corps field medical units.
7. Medicine is very complex and even well-trained, well intentional dedicated professionals can make an error. Navy Medicine implemented BUMED 6010.28, "HealthCare Resolutions Program" on May 23, 2011. The policy promotes a culture of transparency and full disclosure following unanticipated or adverse outcomes of care. Commanders from MTFs will establish a Special Assistant for Healthcare Resolutions Position or ensure that services of a Special Assistant for Healthcare Resolutions are available. All Licensed Independent Practitioners (LIP) will receive disclosure training by health care resolutions specialists and

that full transparency is practiced when there are unanticipated or adverse outcomes of care, treatment or services.

Air Force Policies

The Air Force Medical Service's (AFMS) policy (AFI 44-119) for patient safety complies with DOD policy requirements, civilian accreditation standards, and aligns with current National Patient Safety standards. The policy clearly defines patient safety program roles and responsibilities for each health care team member rendering care and for the executive leadership. Additionally, the AFMS compliments this policy with a current patient safety guidebook, which further delineates process details to ensure uniform implementation of policy requirements. The Air Force Knowledge Exchange provides AFMS personnel easy online access to tools to enhance patient safety program effectiveness.

AFMS patient safety policy focuses on personal responsibility to identify and timely report near miss and actual adverse events. The Air Force analyzes each patient safety report to ensure lessons are learned from every event for performance improvement and to share lessons learned. The Air Force policy articulates our philosophy that building a culture of safety is leadership-driven and requires every team member value and commit to the principles and practices of safe care.

Army Policies

All programs have specified roles under AR 40-68 and as directed by the MHS. These roles include collaboration and input to DoD level Quality Meetings and policy development groups. CPAD serves as the Army representative to the Clinical Quality Forum, the Clinical Measures Steering Committee, Scientific Advisory Committee, Risk Management Committee, Patient Safety Planning and Coordination Committee, Evidence Based Practice Steering Committee, Various DoD Clinical Practice Guidelines (CPG) and Clinical Advisory Group (CAG) workgroups, DoD Pharmacy and Therapeutics Committee and various tri-service pharmacy working groups. Additionally, Army MEDCOM sends a representative to the National Guard Bureau Credentialing Board and the Army Reserve Component Credentialing board as a voting member and educational consultant.

The CPAD oversees MTF implementation of policies and procedures in collaboration with the Regional Medical Commands who have direct Command authority over the facilities. The ultimate aim is an operating company model where variation is minimized and accountability is recognized at the local and corporate level. Each region has a Quality Management cell. The manning varies somewhat, however the functions include overarching Quality management, The Joint Commission (TJC) accreditation, medical staff issues including credentialing and privileging, adverse practice and privilege actions, risk management, patient safety to include sentinel event reporting and root cause analysis, and performance improvement initiatives.

The CPAD Evidence Based Practice (EBP) section is the DoD lead with the Veterans Health Administration in the development of the DoD/VA Clinical Practice Guidelines (CPG). The

Director, CPAD serves as the Co-Chair of the Evidence Based Practice Workgroup. This work group is a direct report to the Health Executive Committee. EBP is an active member of the TRI-Service Workflow group working to develop AHLTA AIM forms for the CPGs streamlining documentation and putting the CPGs to work at the point of care. This encourages the use of evidence-based medicine and improves documentation of these practices across the AMEDD. CPGs are evidence based guidelines developed based on the needs of the beneficiary population. Each CPG has a toolkit that provides a variety of educational materials and guides for the clinicians and patient.

The CPAD provides corporate level oversight through tracking quality metrics and patient safety reports, reacting to trends, educating and training, measuring success against internal and external benchmarks and looking for future improvement projects in collaboration with Service and DHA representatives. The cornerstone is the education and engagement of leadership at all levels to apply lessons learned, anticipate the next issue and to hold providers and staff accountable for evidence based practices.

Appendix 5.4
Global Trigger Tool

The MHS performed a pilot implementation of the Institute of Healthcare Improvement (IHI) Global Trigger Tool (GTT) in inpatient MTFs to evaluate it in relation to other patient safety monitoring tools currently used within the MHS. The GTT method uses random sample inpatient medical record reviews to identify iatrogenic adverse events (AEs) leading to patient harms and to measure changes in harm rates over time. The DoD currently uses AHRQ Patient Safety Indicators (PSIs), derived from administrative data, and a voluntary Patient Safety Reporting system (PSR); however, previous studies found that GTT methods identify a greater number of harms than do PSI or voluntary reporting.

Two inpatient facilities participated in the pilot, a large tertiary care medical center with a varied patient population, delivering relatively more complicated health care services (Site #1) and a community hospital primarily serving an active duty and dependent population (Site #2). Three clinically experienced medical records reviewers and a physician adjudicator underwent training in GTT methods. A random sample of 120 adult, non-psychiatric, non-rehabilitative hospitalizations, occurring during the 6-month period of October 2011 through March 2012, was obtained from each MTF. Sampling was affected by choosing 10 records from each of the 12 semimonthly periods to assure consistent temporal representation over the six months. Pre-existing data from the DoD's voluntary PSR system, as well as DoD's implementation of AHRQ PSIs, were compared to the GTT results for the two participating MTFs.

During the six-month review period, overall harm rates at Site #1 were 286.8 harms/1,000 patient days, 90.8 harms/100 hospitalizations, and 47.5 percent of hospitalizations with an identified harm. At Site #2, there were 128.8 harms/1,000 patient days, 28.3 harms/100 hospitalizations, and 22.5 percent of hospitalizations with an identified harm. The majority of harms (65.0 percent) were classified as temporary harms that required medical intervention but had no long-term effects. For Site #1, 33 voluntary PSR reports were entered into the PSR system for the same six-month period, and for Site #2 it was only one report. The majority of the 17 individual PSI calculations revealed 0.0 percent six-month prevalence rates for both sites. Combining both sites, only three of the hospitalizations where harms were observed using GTT methods also had a corresponding AHRQ PSI identified.

Based on the literature, estimated harm rates were somewhat higher than anticipated at Site #1 but consistent with expectations at Site #2. The results of this pilot altogether support the GTT as potentially filling gaps in current patient safety monitoring that PSR and AHRQ PSI cannot.

Table 5.4-1 Adverse Events Reported Across Patient Safety Measures

	Hospitalizations With a Patient Safety Measure Event; n (Number of Hospitalizations With an Event / Total Number of Hospitalizations)					
	DoD PSR[a]		AHRQ PSI[b]		GTT Harm[c]	
Site #1	33	(1.07%)	0-6	(0.0 – 13.3%)	57	(47.5%)
Site #2	1	(0.08%)	0-5	(0.0 – 15.2%)	27	(22.5%)

a DoD PSR Totals and Rates.
b AHRQ PSI Totals and Rates.
c Percent of Hospitalizations With a Harm Event.

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Source: Pilot implementation of the Institute for Healthcare Improvement Global Trigger Tool at Two Military Treatment Inpatient Facilities

Appendix 5.5
Education and Training

The following section provides details on three components of the PSP that provide the field with the skills and knowledge needed to ensure patient safety: (1) Key PSP Initiatives, (2) PS Resources and Trainings, and (3) Recognition. The section concludes with a discussion on the education and training programs taking place at the Service level.

Key PSP Initiatives

Basic Patient Safety Manager Course

Results show that DoD PSP initiatives and integration efforts are making an impact. This is evident in the positive feedback from participants in the Basic Patient Safety Manager (BPSM) Course, targeting entry-level patient safety professionals in the DoD. BPSM learners reported "high confidence" in their attainment of skills through this important training, with average evaluation scores ranging between 90 and 100 percent.

Established in 2010, the DoD BPSM Course is a workforce development system designed to provide entry-level patient safety managers (PSMs) with the competencies they need to perform effectively during their first year on the job. PSMs manage patient safety programs in installations across the MHS, functioning as change agents at the frontlines of care to eliminate preventable patient harm. Given the PSM's critical role, the DoD PSP launched a multi-year effort in 2009 to build a state-of-the-art PSM ongoing learning program integrating leading-edge findings from the patient safety and workforce development sciences. The BPSM Program consists of three components: 1) Course Pre-work - three to four hours of preparatory learning activities to familiarize participants with the field of patient safety; 2) BPSM Course - five-day integrated classroom training focused on the practical application of a systems-based approach to patient safety; and 3) Coaching - follow-up sessions between course participants and trained BPSM coaches at 3, 6 and 12 months post-course to reinforce course content, provide performance support and facilitate learning transfer to the job.

The BPSM Program's comprehensive multi-level evaluation strategy assesses program effectiveness and identifies opportunities for improvements and future learning. Additionally, the course includes a lesson on the principles and tools of event reporting in the Patient Safety Reporting (PSR) system and PSMs have access to additional online PSR courses.

TeamSTEPPS®

Developed by the DoD in collaboration with federal partners at the Agency for Healthcare Research and Quality (AHRQ), Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) includes a suite of evidence-based, ready-to-use materials and resources to integrate teamwork into any health care system. TeamSTEPPS® is designed to improve the quality, safety, and efficiency of health care to optimize patient outcomes by improving communication and other teamwork skills among health care professionals. It consists of customizable curricula necessary to successfully integrate teamwork principles into all areas of a

health care system. Several customized versions of the training curriculum have been developed by AHRQ with DoD collaboration relative to Primary Care, Long Term Care, Enhancing Patient Safety for Patients with Limited English Proficiency, Dental Care, and Simulation. Many health care organizations and MTFs use simulation as an adjunct to training initiatives. Simulation is completed in designated centers and affords the opportunity for teams to practice team skills and behaviors in a controlled environment.

AHRQ began the National Implementation of TeamSTEPPS® in 2007 with DoD support. This program provides support and guidance for all TeamSTEPPS® users through an online user support network for implementation. It also provides training through six regional training centers and has trained approximately 5,000 Master Instructors from 1,500 civilian hospitals. Approximately 35 percent of U.S. hospitals are currently engaged with TeamSTEPPS®. As a result, DoD beneficiaries who use the purchased care component to receive care at civilian hospitals also benefit from patient care team that have integrated TeamSTEPPS® into daily practice.

Through award-winning TeamSTEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety), DoD has reached nearly 132,000 stakeholders[8] including 4,400 TeamSTEPPS® trainers through its Train the Staff and Train the Trainer courses since 2010. Course evaluation data shows strong evidence that TeamSTEPPS® trainings result in increased learner confidence in abilities surrounding the five TeamSTEPPS® competency areas. Before training, 45 to 65 percent of participants reported high confidence compared to 82 to 89 percent after training. At least 84 percent of participants intended to use the tools and strategies on the job. In addition, training empowered participants to speak up for patients' safety with 82 percent reporting high confidence after training compared to 55 percent without the training.

DoD emphasis has shifted from "awareness training" to sustainment and spread of positive TeamSTEPPS® changes, requiring an increasing focus on the organizational drivers of TeamSTEPPS® success. Key organizational drivers of TeamSTEPPS® success include supportive and involved learning environment, leadership engagement at all levels, rewards and accountability systems, frontline champions, peer support, impact measurement, on-site coaching, and training and alignment with strategic goals. During coaching sessions, MTFs report a heightened focus on training with difficulty in the implementation of the tools on the units, sustainment of trainer cadres, and lack of leadership engagement.

MTFs have reported broad TeamSTEPPS® impact/outcomes, including reduced patient harm events and improved communications, clinical processes, patient activation, staff and patient satisfaction and efficiency. Integrating teamwork efforts into a coherent Quality Improvement framework is essential. TeamSTEPPS® has been effectively integrated into efforts such as Partnership for Patients (PfP), Patient Centered Medical Home (PCMH), and the various

[8] The DoD PSP tracks TeamSTEPPS® training in the ORC, while the Army and Air Force track training numbers in Service-Specific systems. Due to lack of standardization around tracking of TeamSTEPPS® training, it is not possible to know if these additional Service numbers are duplicative of those tracked in the Online Registration Center.

perinatal safety initiatives. Emphasizing teamwork improvement as a separate stand-alone initiative was never the goal.

Partnership for Patients

In April 2011, the White House and the Department of Health and Human Services unveiled a new patient safety initiative, known as the Partnership for Patients (PfP), which focuses on decreasing hospital readmissions and hospital acquired conditions (HACs) by 20 percent and 40 percent, respectively by the end of 2013.

In June 2011, the ASD(HA) pledged to support the initiative, along with 3,700 other hospitals across the nation, and agreed to work toward making DoD hospital care safer, more reliable and less costly for every patient every time. As part of this initiative, HA and Services committed to implementing standardized evidence based safety practices for 10 specific areas of preventable harm (including Readmissions) across the DoD. The goals of the PfP support the DoD Quadruple Aim and have helped the DoD achieve improved population health, experience of care, overall military readiness and lower per capita cost. PfP also supports the Assistant Secretary of Defense for Health Affairs ASD(HA) strategic initiative to implement evidence-based practices across the MHS to improve the quality and safety of care provided to our beneficiaries. Implementation of PfP was the initial step in developing a 21st century Patient Safety and Quality Program across the DoD and moving the system toward becoming a high reliability organization.

In December 2011, the Surgeons General of the component Services discussed a model for a 21st century Patient Safety and Quality Program, as well as recommendations for meeting the aims of the PfP. In order to achieve the aims of the PfP, a three phased approach was discussed:

- Planning and Design: 1 January 2012 – 30 September 2012
- Implementation: 1 October 2012 – 31 December 2012
- Monitoring and Sustainment: 1 January 2013 – Present

The DoD continues to focus on ongoing, system-wide improvement activities in an effort to further decrease incidence of harm across the board. Based on the most current CY13 data, the MHS has achieved an overall harm reduction of 18 percent between CY13 and the baseline year (CY10). The DoD has also achieved an overall 11.1 percent reduction in readmissions from the baseline year (CY10) to CY13. DoD data will be incorporated into the national results. According to The Department of Health and Human Services report dated May 7, 2014, there was a national overall 8 percent reduction for readmissions.[9] Additionally, preliminary health care data for 2011 and 2012 indicated a 9 percent decrease in HACs nationally.[10]

[9] The Department of Health and Human Services Report. May 7, 2014. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf.

[10] NASDAQ. (2014). http://m.nasdaq.com/press-release/lifepoint-achieves-significant-results-through-partnership-with-centers-for-medicare--medicaid-services-20140520-00345.

Patient Safety Portfolio of Resources

- *Annual Summaries:* The PSAC annually publishes two summaries of information submitted by the Services, an Annual Report that covers the entire Fiscal Year, and a Mid-year Report. These summaries provide an analysis of the patient safety reports (medication events, non-medication events, Root Cause Analyses, Proactive Risk Assessments, and other reports) submitted by the Services and MTF personnel during the respective reporting period. They identify trends, lessons learned, and other observations impacting the safety of patient care.
- *Focused Reviews:* In-depth, event driven analyses of specific topics based on what facilities are experiencing and reporting such as falls or unintended retained foreign objects. These analyses inform those directly engaged in providing health care of trends, notable causal factors, and useful lessons learned from events reported in MTFs and provide the latest research and innovations relative to the topic
- *Data Pulse:* The Data Pulse is published monthly and offers a Tri-Service snapshot of the PSR data, such as events by degree of harm, month and type, location type, and cumulative reporting for the DoD, as well as focus areas such as specific Partnership for Patients topics.
- *PSR SBAR:* The PSR SBAR highlights PSR-specific topics to enhance reporting and data quality, distribute knowledge, and increase learning across the DoD. Information is presented using the Situation, Background, Assessment, and Recommendation (SBAR) communication tool. The intent of the PSR SBAR product is to succinctly and quickly address issues and learning opportunities related to PSR, such as entering events, classifying events, generating reports, trending.
- *Sentinel Event Watch:* Sentinel Event Watch is a monthly publication provided to leadership with two overarching principles: near real-time distribution of Sentinel Event data and inter-service transparency of this information across the DoD. Includes a Sentinel Event Spotlight section which focuses on specific Sentinel Event category(s) and emerging trends seen at the Patient Safety Analysis Center (PSAC).
- *Alerts and Advisories:* Brief, often time-sensitive reports targeted at error-prone patient safety issues in which all targeted providers and staff should receive timely notification. The issues may involve anything used in or on patients (e.g., equipment, devices, etc.) that places them at increased risk. These notices provide background, general information, and recommendations for addressing the patient safety issue.
- *Learning Updates:* Since it was first launched in March 2011, approximately 27 issues of the Learning Update have been published and disseminated to 6,216 subscribers. Five Partnerships for Patients (PfP)-related Learning Circles have been held with an average of 49 attendees per month between October 2012 and August 2013.
- *Learning Circles:* DoD PSP hosts regular interactive webinars open to all MTFs, which focus on a variety of patient safety topics and feature subject matter experts (SMEs) who share the latest evidence, lessons learned, leading practices, and success stories from the DoD and civilian communities. Webinar materials are archived on the PSLC for users worldwide to access at a time that is convenient to their schedule and/or as "just-in-time" learning--when the topic may be particularly relevant.

- *eBulletin:* DoD PSP publishes and disseminates a monthly eBulletin to share activities, topics of interest, and PSP updates. Since September 2010 when it was first launched, 36 issues of the eBulletin have been published and disseminated to 7,253 subscribers.
- *Patient Safety Toolkits:* DoD PSP Toolkits offer just-in-time training, action steps and resource guides for specific patient safety issues targeted for health care providers, education specialists, and PSMs. Toolkit topics include: Briefs and Huddles, Debriefs, SBAR, Patient Falls Reduction, Patient Activation, and Professional Conduct.

In order to leverage national patient safety resources, the PSP also provides Military Treatment Facilities (MTFs) memberships to programs such as National Patient Safety Foundation (NPSF) Stand Up for Patient Safety and the Institute for Safe Medication Practice (ISMP). Stand Up for Patient Safety is designed to provide the tools, resources, and education necessary to launch, sustain and advance patient safety initiatives in inpatient and outpatient settings respectively. The resources help to embed patient safety principles into organizational practice, align with national patient safety goals and meet critical regulatory requirements. MTFs receive access to: professional learning series; online, self-paced, educational modules and patient safety curriculum; information updates to help staff stay current on emerging research and news; Ask Me 3 materials, a patient education/engagement program designed to promote communication between health care providers and patients; ready-to-use Patient Safety Awareness Week Toolkits; and discounted attendance at the NPSF Annual Patient Safety Congress. ISMP makes communication and education about medication errors a priority, publishing four electronic medication safety newsletters for health care professionals and consumers that collectively reach more than three million readers. ISMP's newsletters are widely recognized as some of the most timely and comprehensive medical alert systems in the world. All DoD facilities receive the following Medication Safety Alert newsletters: ISMP Medication Safety Alert! Acute Care edition; ISMP Medication Safety Alert! Community/Ambulatory Care Edition; and the ISMP Medication Safety Alert.

Publications

Significant contributions have been made to the field of Patient Safety, including 35 peer review journal articles and 7 book chapters since 2005. International and domestic leaders, including the DoD, have co-authored health care team training publications that include topics such as: TeamSTEPPS®, Teamwork, Team Training Evaluation and Simulation.

Recognition

The Quality and Patient Safety Awards, first presented in 2004, were conceived as a way to encourage and inspire organizations, raise awareness, reward successful efforts, and to communicate successes and lessons learned throughout the MHS. The award provides Senior MHS Leadership an opportunity to recognize efforts designed to improve the care delivered within the MHS. The award helps to identify those who have shown innovation and commitment to the development of systems and processes that are tightly organized around the needs of the patient. DoD seeks to promote efforts that create an environment where safe, quality care is provided and is the responsibility of all members of the team. Quality and Patient

safety initiatives submitted were focused on eliminating preventable harm, keeping patients from getting injured or sicker and helping patients heal without complications. Award submissions were evaluated through an internal board review process with evaluators familiar with expertise in education, data analysis, quality improvement, and patient safety. DoD has presented 44 awards since the inception of the award.

The DoD encourages a systems approach to creating a safer patient environment; engaging leadership; promoting collaboration across all three Services; and fostering trust, transparency, teamwork and communication. To promote a culture of safety and eliminate preventable patient harm, the PSP engages with stakeholders across the health care system – leadership, health care professionals, and beneficiaries – to provide education to ensure positive patient safety practices and safe patients.

Service Patient Safety Initiatives

In addition to the comprehensive patient safety resources made available at the DHA level, each Service also has other patient safety educational initiatives led at the headquarters level.

Navy

Navy Medicine offers the following education and training to its medical personnel:

- All new patient safety managers attend the DHA Basic Patient Safety Manager Course. This is a five day integrated classroom training focused on patient safety and root cause analysis and TapRooT® methodology. BUMED follows up with the new patient safety manager one month after the course to address questions or concerns.
- Advanced TapRooT® training is offered for patient safety/quality management staff that performs root cause analyses on a frequent basis.
- Annual The Joint Commission/Navy training for patient safety, quality improvement and risk management staff as well as the Chairperson of the Executive Committee of the Medical Staff of each MTF. This training is held at The Joint Commission (TJC) headquarters.
- AHRQ TeamSTEPPS® training (initial training and train the trainer) is implemented and attendance at the AHRQ TeamSTEPPS® conference is facilitated by BUMED.
- Membership in the American Society for Healthcare Risk Managers –the leading organization for health care risk managers is provided to each MTF Risk Manager. This organization provides current information on risk management so Navy risk managers can be cognizant of national trends and the latest approaches, innovations and resources.
- Subscription Membership in the Emergency Care Research Institute (ECRI) is provided to each MTF Risk Manager. ECRI is an independent, nonprofit organization that researches the best approaches to improving the safety, quality, and cost-effectiveness of patient care. They provide tools and references for problem solving and ongoing assessment.
- Training on the Systems Engineering Initiative for Patient Safety (SEIPS) provides a model that addresses work systems and patient safety, it provides a framework for

understanding the structures, processes and outcome in health care (hospital) related to human factors.

- Active Duty Middle managers attend the Advanced Medical Department Officer Course (AMDOC) where instruction on patient safety and risk management is taught.
- Navy Infection Preventionists are encouraged to be familiar with the products of the Association for Professionals in Infection Control and Epidemiology (APIC). They also attend epidemiology courses.
- Educational materials on patient safety are provided to facilities during National Patient Safety Week.
- Scenarios based upon content from real situations are provided to MTFs for use in simulation centers and in drills.

In addition, Navy Medicine Patient Safety/Quality Management/Risk Management Department provides formal communication sessions to discuss current progress on initiatives through:

- Monthly infection prevention video teleconferences (VTCs)
- Bi-monthly patient safety/risk/quality management VTCs
- Quarterly VTCs for the Executive Committee of the Medical Staff and medical staff services professionals.
- Annual update to BUMED leadership on the patient safety program and status of initiatives.
- Status of key patient safety program initiatives provided to BUMED Strategic Planning Group.
- Updates upon request to BUMED Advisory Boards, e.g. Women's Health-Perinatal group and key specialty leaders.
- Updates to Regional Commanding Officers on a semi-annual basis on status of the patient safety program and areas of MTF specific successes or challenges.
- Routine communications including results of data analysis, alerts, and advisories are provided on a regular basis to the MTF and Regional PS/RM/QA managers through emails and consultations.

Air Force

To support and maintain a culture of safe patient care, the Air Force has established numerous educational and training forums for health care teams and leadership. These forums focus on the importance of imbedding safe principles and practices into every patient encounter and in the systems of care overall. Germane to each educational forum are the key components to building a safe patient culture in each AFMS facility. AFMS courses are of various levels of detail dependent on the individuals' role and responsibilities. The courses vary from one hour instruction periods to five day formal courses. Patient safety topics are disseminated in non-formal means such as Annual Patient Safety reporting, AFMOA newsletters, Patient Safety Awareness Week celebrations, commanders' calls, and safety briefings. Below are examples of patient safety training within the AFMS.

Individuals (AFMS medics)

- Patient Safety Training at Newcomers Orientation
- Annual PS refresher (CBT or face to face offered)
- TeamSTEPPS® four hour initial training
- TeamSTEPPS® annual face to face re-dosing
- PSR Tool User CBT
- Commanders Calls, Just in Time training
- DoD Patient Safety Learning Center documents (SE watches, Focused Reviews, etc.) are shared with all Medics
- PS briefing at Nurse Residency Program
- AFMOA eBLAST sent to the field with PS topics
- MTFs participate in National PS week seminars
- Tailored education when required/desired
- Simulation training is conducted in multiple clinical areas for team training to enhance communication as well as improve individual currency for skills maintenance.

Patient Safety Staff

- All Patient Safety Managers (PSMs) attend five day Basic Patient Safety Managers Course
- All PSMs spend 1 day orientation at Air Force Medical Operations Agency PS/Quality Division
- IHI open school training available to all PSMs
- Duke University PS leadership course, John Hopkins PS Leadership course – attended by 37 PSMs in last three years
- AHRQ Annual TeamSTEPPS® collaborative available for some PSMs
- AF Annual five day QSPAR conference, (Quality Systems Program Assessment Review) attended by Chief of Medical Staff, Patient Safety, Quality and Risk Managers and Credentials Staff
- Aerovac and Deployed PSM courses available for JIT training
- DoD PSP offers frequent video/teleconferences for hot topics for PSMs and field
- AFMOA PS staff attend annual training for TapRooT®
- PS concepts incorporated into Medical School and GME resident education
- AF requested conference approval for attendance for The Quality and Patient Safety Educators Academy (QPSEA) – Train resident and Faculty of GME programs
- Staff Education Visits provided to MTF PS/Quality Team by AFMOA experts
- Formal Fellowship training opportunities in Patient Safety, Program offered annually
- Monthly Teleconferences offered by AFMOA SMEs with field functional managers on the Quality Team.

Leaders

- PS/Quality and Performance Management key topics addressed in MDG Commanders Course, Joint Services Intermediate Executive Skill, AF Intermediate Executive Skills, and the Annual AF Senior Leader Workshop.
- Key AF General Officers participate as mentors within the training noted here.
- DoD published Annual PS Report and DoD PS Culture Survey area shared across the AF.

Army

CPAD provides multiple training opportunities and educational resources across the AMEDD for leaders, SMEs and support staff. Alerts, information on products and best practices and opportunities for education are shared with the MTFs through their regional leads.

The baseline training and educational opportunities include:

- Monthly QM VTCs (prepared and presented by CPAD staff and including TJC education webinars).
- Data shared to date includes sentinel event data drill down by category and facility (result is sharing across the organizations; discussion of lesson learned).
- TJC findings have data for findings from 2011-2013 that shows areas to look for in preparation and is guiding policy development for the enterprise.
- Quarterly Patient Safety DCO sessions with facility and region PSMs, and bi-monthly regional patient safety manger collaborative calls.
- Bi-monthly Risk Management DCO sessions with facility and region Risk Managers.
- Scheduled and on demand DCO instruction in CCQAS and PSR.
- Patient Safety and Risk Management have milSuite sites with regular updates and discussions.
- Patient Safety Program "Root Cause" - newsletter highlighting Sentinel event lessons learned.
- DHA PSAC Focused reviews and Sentinel Event Watch, Patient Safety Annual report, Partnership for Patients (PfP) newsletters and the Data pulse highlighting patient safety metrics across the DoD.
- Blocks of instruction at AMEDD C&S courses. All of these leaders get a block of instruction on quality, patient safety and risk management and how they are to operationalize it at their MTF.
    - Pre-Command Course
    - Executive Skills Course
    - Captain's Career Course
    - Basic Officer Leader Course
    - Nurse Case Manager Course
    - Baylor Master's Program
    - Patient Administration Division Course
    - Clinical Nurse OIC Course
- Traveling team training opportunities
    - Surgical Services TeamSTEPPS® Training

  - TapRooT® Methodology and Software training
  - Team and Organizational Development Directorate (Organizational Coaching, Development, and Resilience; Self-awareness, Team Building, Change Management, Interpersonal Communication, Leader Development, and Service Excellence)
- Basic Patient Safety Manager Course in collaboration with AF, Navy and DHA.

Sharing of enterprise wide lessons learned:

- Newsletters, email notifications, phone calls, DCO, VTC, PSAC educational products are shared directly with regional and MTF leads.
- MTFs present to the AMEDD on sentinel event lessons learned, best practices in communities of practice and serve as mentors to the other facilities.
- Data from DHA and MEDCOM sources on a variety of metrics is shared as quickly as it becomes available.

National Capital Region Medical Directorate

NCR MD Patient Safety staff is required to attend the DHA sponsored Basic Patient Safety Manager Course, TapRooT®, PSR, TeamSTEPPS® trainings. Additionally, Patient Safety staff is encouraged to participate in monthly MEDCOM Quality VTCs (as per formal agreement with the Army).

Appendix 5.6
Hospital Survey on Patient Safety Culture

Table 5.6-1 Direct Care Comparison to the National Average – Safety

Hospital Survey on Patient Safety Culture 2005, 2008, and 2011: AHRQ comparison culture survey dimensions	DC Actual			AHRQ 2012 Average
	2005	2008	2011	
D1: Management Support for Patient Safety	71%	72%	72%	72%
D2: Supervisor/Manager Expectations and Actions Promoting Patient Safety	72%	73%	73%	75%
D3: Organizational Learning – Continuous Improvement	68%	69%	67%	72%
D4: Non-punitive Response to Error/Mistakes	44%	44%	42%	44%
D5: Feedback and Communication about Error	64%	64%	62%	64%
D6: Frequency of Events Reported	60%	60%	64%	63%
D7: Communication Openness	61%	61%	61%	62%
D8: Teamwork within Units	75%	75%	75%	80%
D9: Teamwork across Units	59%	59%	59%	58%
D10: Handoffs and Transitions	47%	47%	49%	45%
D11: Staffing	45%	45%	48%	56%
D12: Overall Perception of Patient Safety	66%	66%	66%	66%
Response Rate	54%	58%	43%	53%

2014 MHS Review Group
Source: Final MHS Overall Culture Survey Final Report, January 2013

Table 5.6-2 Direct Care Comparison to a National System – Safety

Hospital Survey on Patient Safety Culture 2011: AHRQ comparison culture survey dimensions	Direct Care Compared to HS3	
	DC Actual	HS3
D1: Management Support for Patient Safety	72.0%	76.7%
D2: Supervisor/Manager Expectations and Actions Promoting Patient Safety	73.0%	77.8%
D3: Organizational Learning – Continuous Improvement	67.0%	78.8%
D4: Non-punitive Response to Error/Mistakes	42.0%	45.3%
D5: Feedback and Communication about Error	62.0%	68.2%
D6: Frequency of Events Reported	64.0%	62.3%
D7: Communication Openness	61.0%	63.0%
D8: Teamwork within Units	75.0%	86.8%
D9: Teamwork across Units	59.0%	69.0%
D10: Handoffs and Transitions	49.0%	56.4%
D11: Staffing	48.0%	59.5%
D12: Overall Perception of Patient Safety	66.0%	74.5%
Response Rate	N/A	N/A

2014 MHS Review Group
Source: Final MHS Overall Culture Survey Final Report, January 2013

Appendix 5.7
PSI #90 Composite

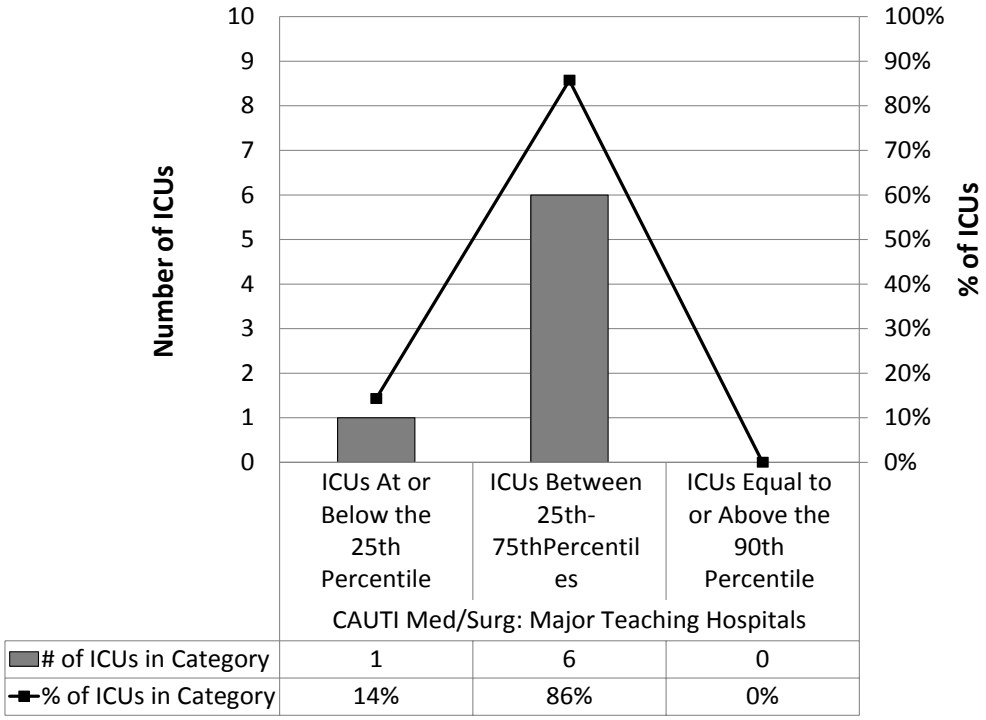
Table 5.7-1 National PSI and IQI Results for the Medicare Population – Supplementary Information (2010 – 2013)

Metric Name	Benchmark	DC Actual
PSI #90 Composite (% of MTFs Performing as well as Benchmark)	CMS .68(2010, 2011) .61(2012) and .62(2013)	2010-63% 2011-75% 2012-75% 2013-73%
	AHRQ Reference Population*	2010-81% 2011-85% 2012-93% 2013-88%

*CMS National Achievement Threshold
2014 MHS Review Group
Source: Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare & Medicaid Services (CMS), July 2014

Appendix 5.8
National Health Safety Network

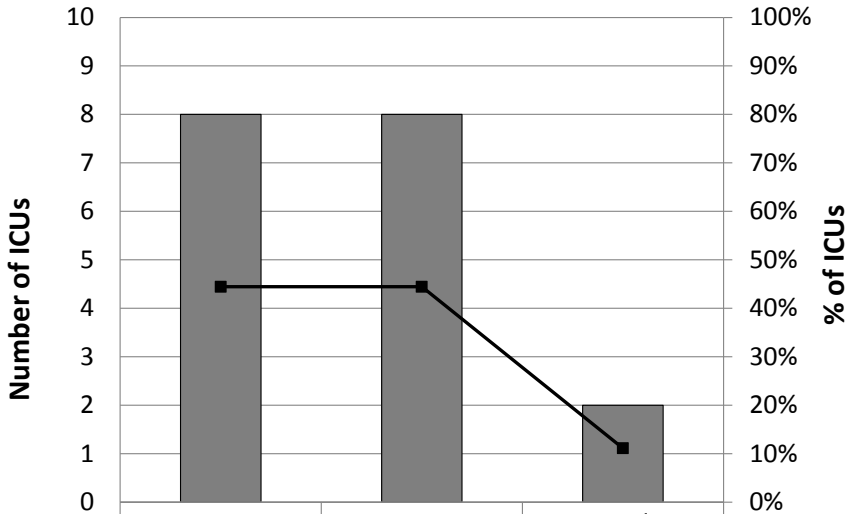
Figure 5.8-1 CAUTI Med/Surg: Major Teaching CY10 – CY13



	ICUs At or Below the 25th Percentile	ICUs Between 25th-75thPercentiles	ICUs Equal to or Above the 90th Percentile
# of ICUs in Category	1	6	0
% of ICUs in Category	14%	86%	0%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

Figure 5.8-2 CAUTI Med/Surg: Other Hospitals Less Than 15 ICU Beds CY10 – CY13

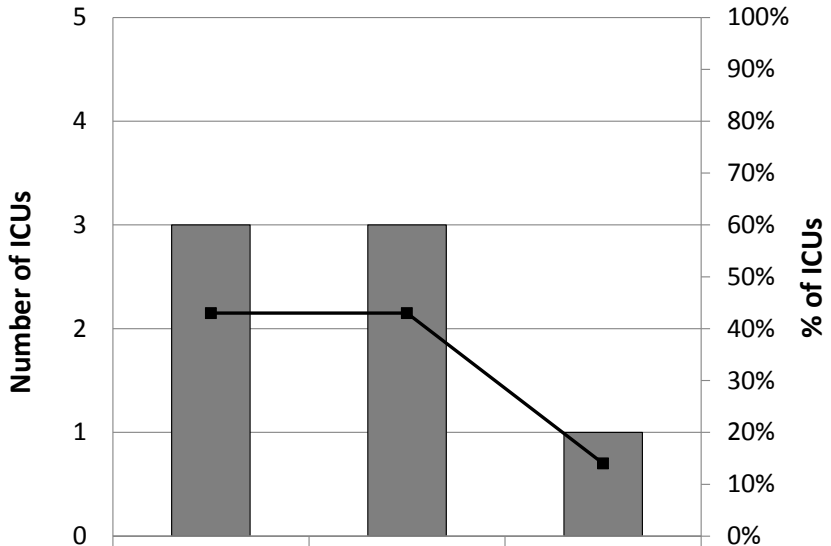


CAUTI Med/Surg: Other Hospitals with less than 15 ICU Beds

	ICUs At or Below the 25th Percentile	ICUs Between 25th-75thPercentiles	ICUs Equal to or Above the 90th Percentile
# of ICUs in Category	8	8	2
% of ICUs in Category	44%	44%	11%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

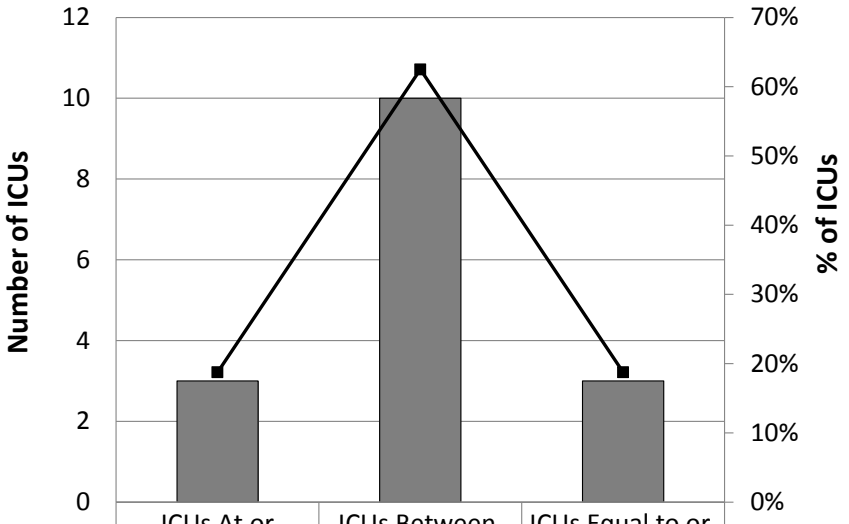
Figure 5.8-3 CLABSI Med/Surg: Major Teaching CY10 – CY13



	ICUs At or Below the 25th Percentile	ICUs Between 25th-75thPercentiles	ICUs Equal to or Above the 90th Percentile
# of ICUs in Category	3	3	1
% of ICUs in Category	43%	43%	14%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

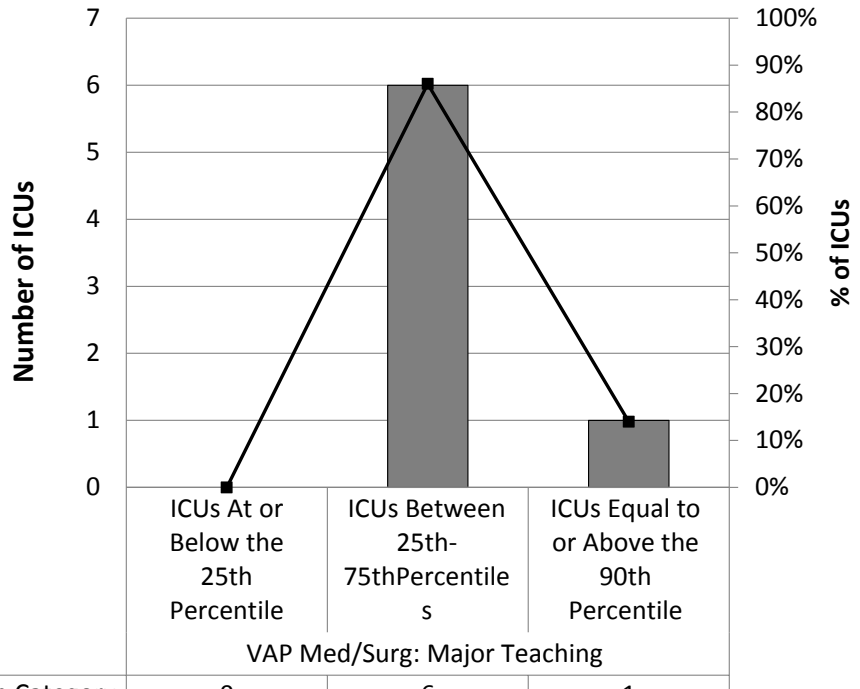
Figure 5.8-4 CLABSI Med/Surg: Other Hospitals with Less Than 15 ICU Beds CY10 – CY13



	ICUs At or Below the 25th Percentile	ICUs Between 25th-75thPercentiles	ICUs Equal to or Above the 90th Percentile
# of ICUs in Category	3	10	3
% of ICUs in Category	19%	63%	19%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

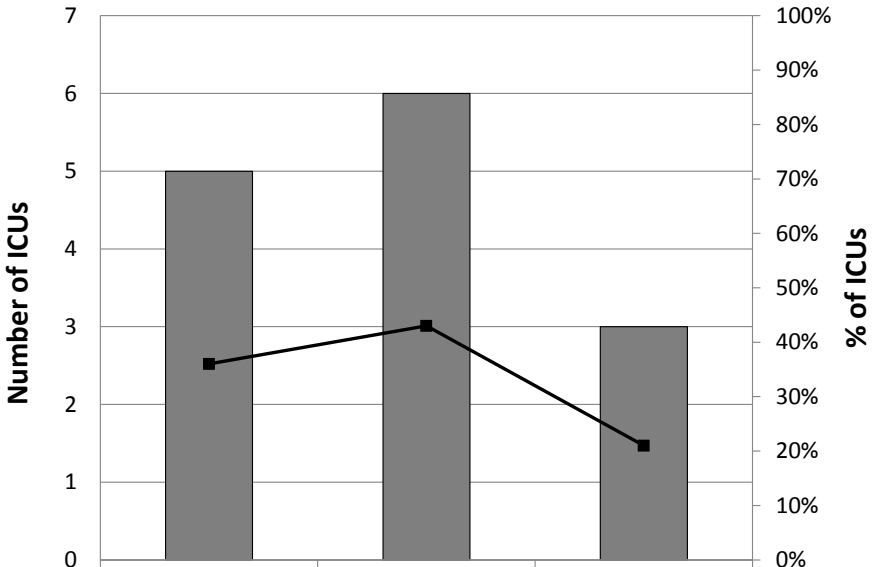
Figure 5.8-5 VAP Med/Surg: Major Teaching Hospitals CY10 – CY13



	ICUs At or Below the 25th Percentile	ICUs Between 25th-75thPercentiles	ICUs Equal to or Above the 90th Percentile
# of ICUs in Category	0	6	1
% of ICUs in Category	0%	86%	14%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

Figure 5.8-6 VAP Med/Surg: Other Hospitals with Less Than 15 ICU Beds CY10 – CY13



VAP Med/Surg: Other Hospitals with less than 15 ICU Beds			
# of ICUs in Category	5	6	3
% of ICUs in Category	36%	43%	21%

2014 MHS Review Group
Source: National Health Safety Network, July 2014

Appendix 5.9
Reviewable Sentinel Events

The definition of a reviewable sentinel event takes into account a wide array of occurrences applicable to a wide variety of health care organizations. Any or all occurrences may apply to a particular type of hospital. Thus, not all of the following occurrences may apply to your particular hospital. The subset of sentinel events that is subject to review by The Joint Commission includes any occurrence that meets any of the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition, or
- The event is one of the following (even if the outcome was not death or major permanent loss of function not related to the natural course of the patient's illness or underlying condition):
  - Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge.
  - Unanticipated death of a full-term infant.
  - Abduction of any patient receiving care, treatment, and services.
  - Discharge of an infant to the wrong family.
  - Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services.
  - Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the health care organization.
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
  - Invasive procedure, including surgery, on the wrong patient, wrong site, or wrong procedure.
  - Unintended retention of a foreign object in a patient after surgery or other invasive procedures.
  - Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter).
  - Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose.

Appendix 5.10
Site Visit Patient Safety Questions Analyzed

MTF Leadership Questions

1. What are you doing to improve patient safety?
2. Give examples of safety measures currently in place to reduce patient harm?
3. Describe how you create an environment where staff feels safe reporting errors and failures?
4. What areas did you focus on and what improvements have been made from the results of the cultural surveys?

Functional Staff & Staff Questions

1. Describe how your organization creates an environment where staff feels safe reporting errors? GIVE AN EXAMPLE
   a. How likely are you to report errors and related concerns?
2. Describe how your organization creates an environment where staff feels safe reporting near misses? GIVE AN EXAMPLE.
   a. How likely are you to report near misses?
3. Were the results of the 2011 CULTURE SURVEY communicated to you as a priority?
4. How effectively has leadership fostered a culture of safety?

Patient Questions

1. Do you feel comfortable asking questions to your care providers and MTF staff?

Town Hall Staff Questions

1. How do you report a safety issue or concern?
2. When concerned, how does the process work?
3. If you don't report, describe what steps you take to address the concern?

Town Hall Patient Questions

1. Do you feel you receive safe care here?
2. Do you feel comfortable asking questions to your care providers and MTF staff?
3. How do you report a safety issue or concern?
   a. If you don't, what steps do you take? (Subjective Response)
4. Have you been referred for care in the civilian sector? (yes/no)
   a. Did you feel like you received safe care?

Appendix 5.11
Site Visit Data

Table 5.11-1 Number of Respondent Types

Survey Site	Leadership	Subject Matter Expert (SME)*	Staff	Patient	Total
Site 1	7	5	16	10	**38**
Site 2	4	3	37	28	**72**
Site 3	4	3	16	6	**29**
Site 4	5	2	22	10	**39**
Site 5	6	3	24	11	**44**
Site 6	5	1	10	14	**30**
Site 7	5	5	13	16	**39**

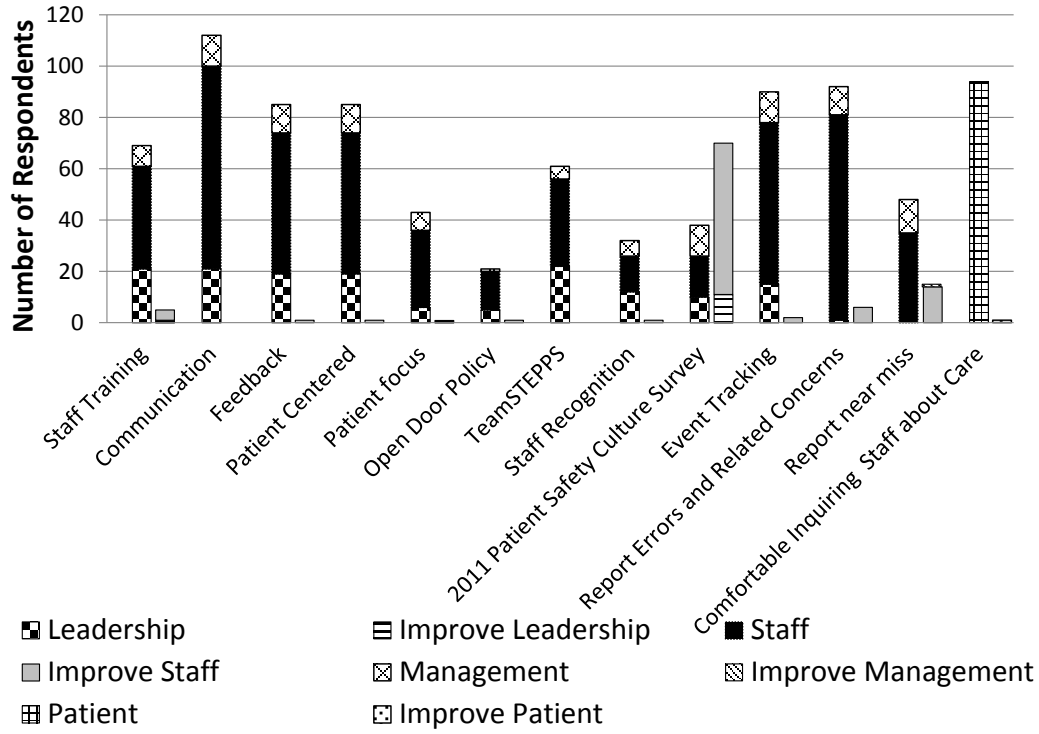
*The Focus Group SMEs at Site 1 were present during the Executive Leadership session.
2014 MHS Review Group
Source: 2014 MHS Review Site Visit Survey, July 2014

Table 5.11-2 Associated Comments from Site Visits

Theme Concept	Associated Comments from Site Visits
Staff training	Initial and annual culture of [patient] safety training, orientation and ongoing training, lots of diversity and training, culture and safety training
Communication	have good communication throughout the facility, there is two way communication, increased communication on [patient] safety, working to improve communication between disciplines
Feedback	encouraged to report incidents, non-punitive
Patient Centered Practices	Protocol for Radio tag sponges, Sharp container - moved away from duty area, Security doors, check bands on patients, hourly rounds
Patient Focus	speaking up for patient care, Patient safety is one of CMD goals, I care about my patients
Open Door Policy	Open door policy is great, CO- encourages open door policy
TeamSTEPPS®	TeamSTEPPS® training, team huddles, rewards for speaking up, mustering, sharing lessons learned, SBAR
Staff Recognition	rewards for speaking up, good catch awards, Commander Coins
2011 Patient Safety Culture Survey	I do not recall, probably happened but do not recall it, they were communicated
Event tracking	report in PSR, QA logs, leadership fixed it, patient procedure held off until more X-ray were complete
Report Errors and Related Concerns	definitely, 100%, Not supported in the past; culture is not here, Not often. No finger pointing, Advocate PSR as non punitive, staff free to report
Report Near Miss	Always, Neutral - depends on the severity, If it is something that can be improved
Comfortable Inquiring Staff about Care*	Yes, would talk with provider and RN, I've asked questions of both staff and provider

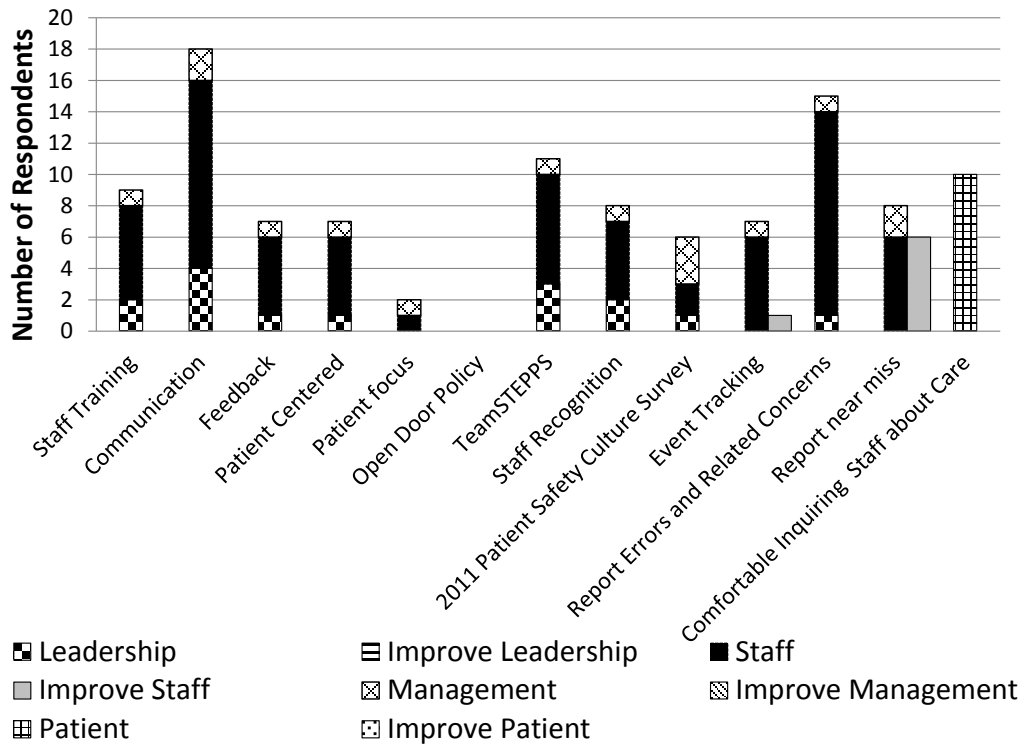
*Theme concepts from only Patient respondents
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-1 Number of Themed Concepts from Patient Safety Site Visit Rollup, CY14



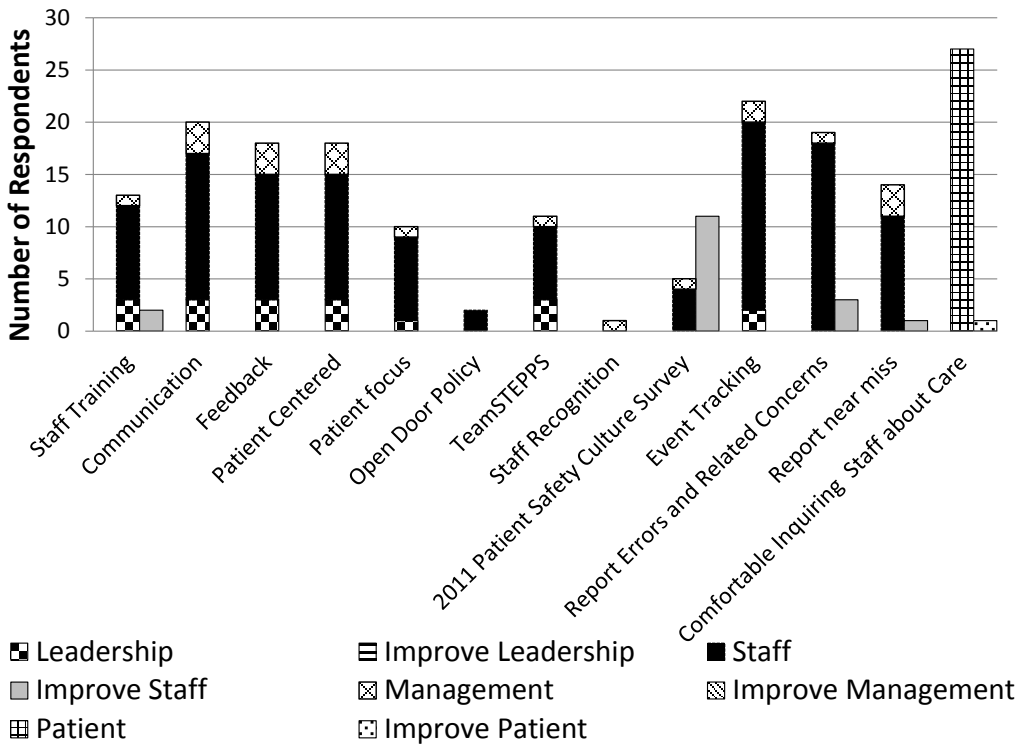
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-2 Number of Themed Concepts by Site: Site 1, CY14



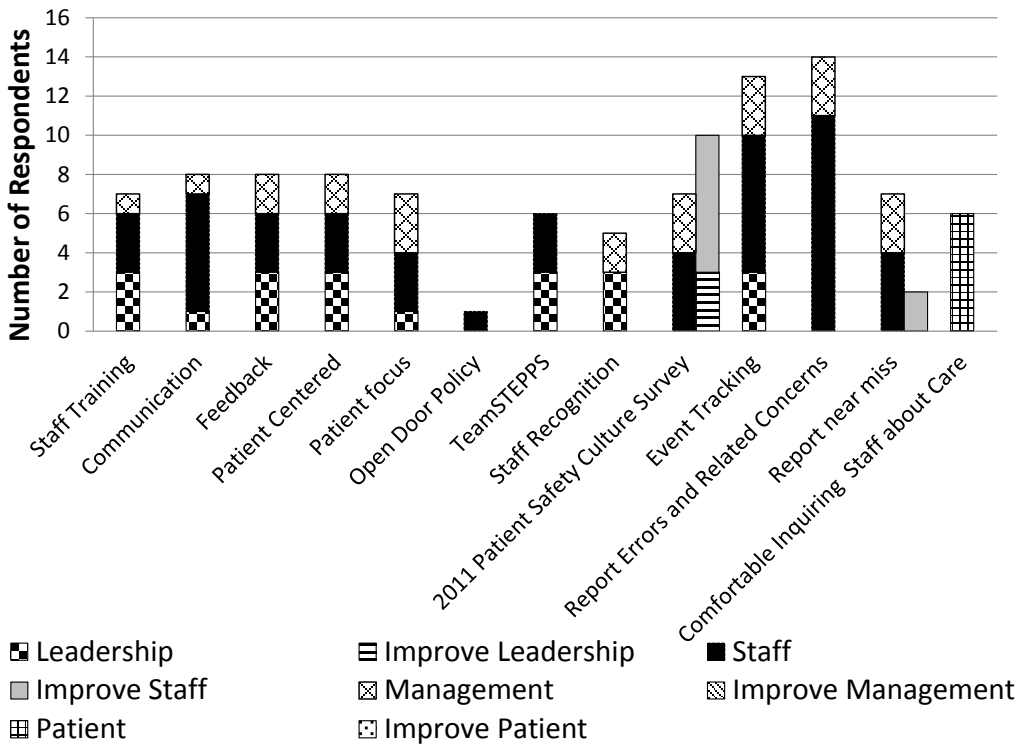
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-3 Number of Themed Concepts by Site: Site 2, CY14



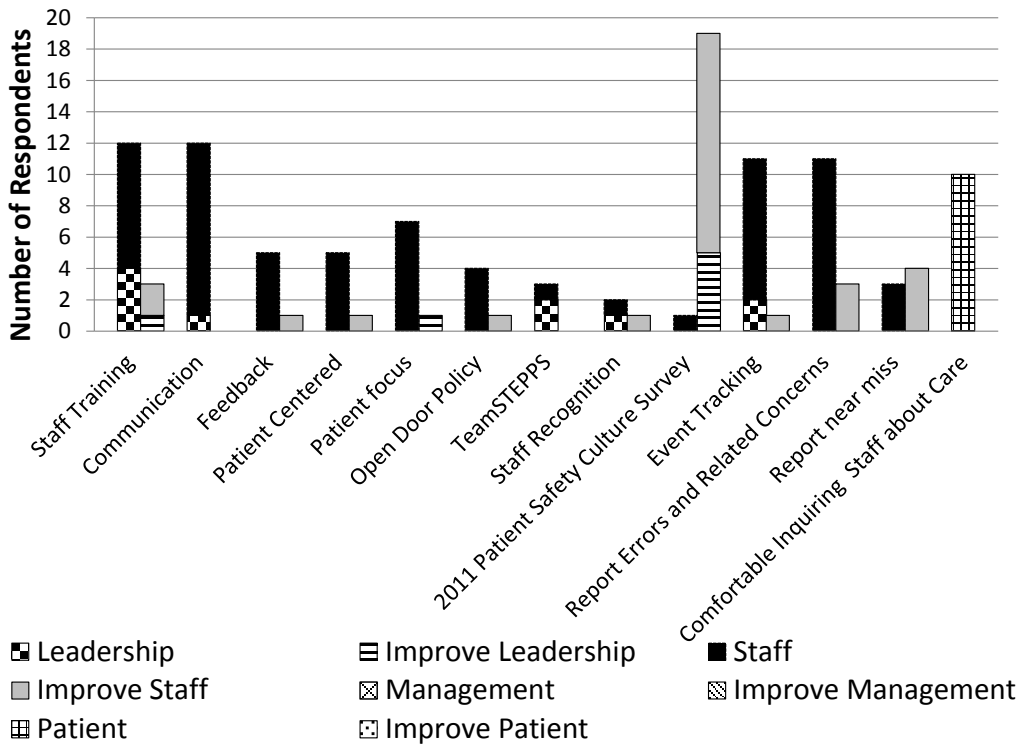
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-4 Number of Themed Concepts by Site: Site 3, CY14



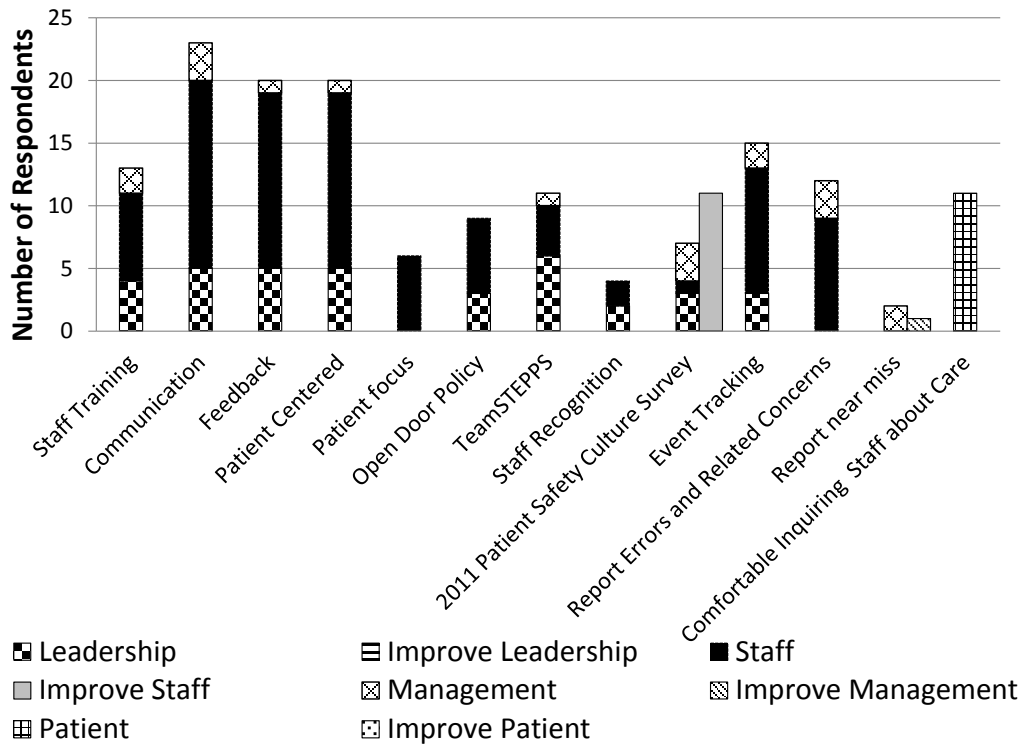
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-5 Number of Themed Concepts by Site: Site 4, CY14



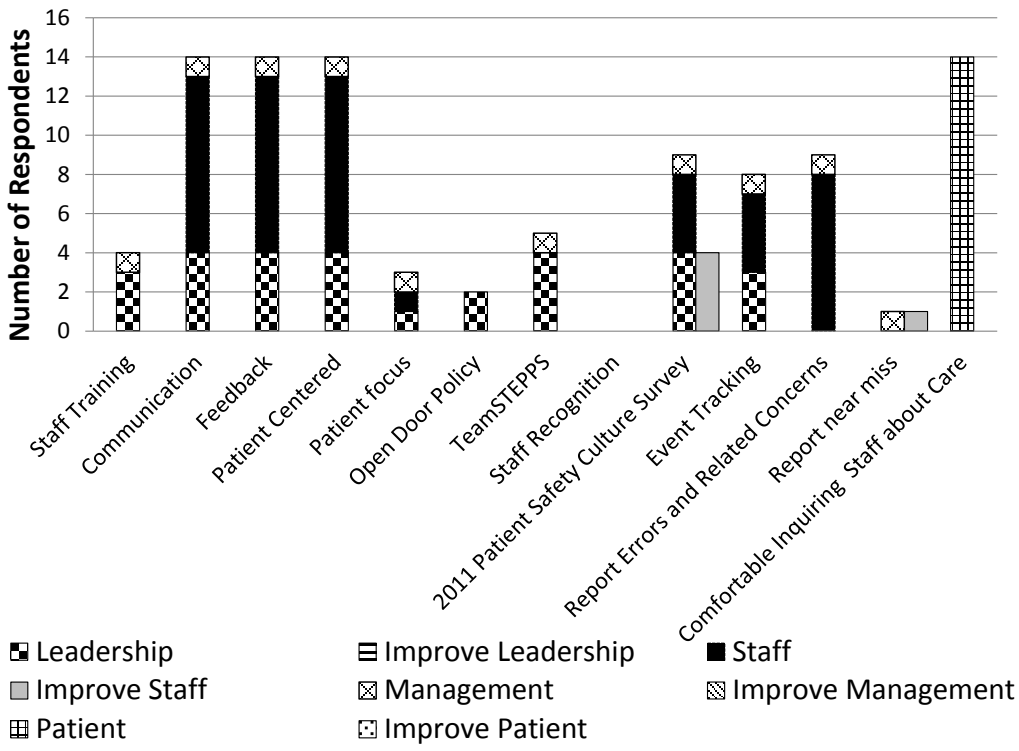
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-6 Number of Themed Concepts by Site: Site 5, CY14



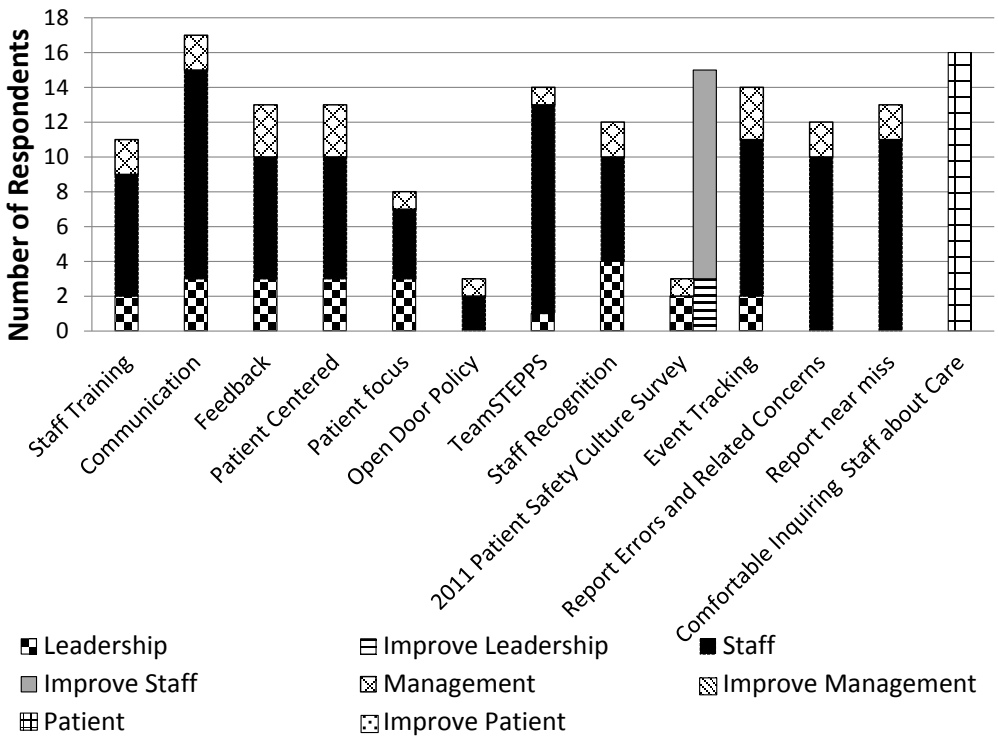
2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-7 Number of Themed Concepts by Site: Site 6, CY14



2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Figure 5.11-8 Number of Themed Concepts by Site: Site 7, CY14



2014 MHS Review Group
Source: MHS Review Site Visit Survey, July 2014

Appendix 5.12
Performance Improvement Initiatives

DHA and Service-level Performance Improvement Initiatives

Patient Safety has been a focus of the MHS direct care component for many years; service-wide performance improvement initiatives are described below:

Defense Health Agency (DHA) – Partnership for Patients

Partnership for Patients (PfP) was the first ever enterprise-wide approach to improving the safety and quality of care across the MHS for every patient every time and a key step in becoming a HRO. It is focused on making hospital care safer, more reliable, and less costly through the achievement of two goals:

- Making Care Safer: By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010.
- Improving Care Transitions: By the end of 2013, preventable complications during transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20 percent compared to 2010.

PfP implemented Evidence-Based Practices (EBPs) around ten core patient safety areas of focus that included nine hospital-acquired conditions. These areas are: Adverse Drug Events; Catheter-Associated Urinary Tract Infections; Central Line Associated Blood Stream Infections; Injuries from Falls and Immobility; Obstetrical Adverse Events; Pressure Ulcers; Surgical Site Infections; Venous Thromboembolism; Ventilator-Associated Pneumonia/Ventilator Associated Events; and Readmissions. The EBPs are outlined in a series of Implementation Guides and developed for each harm condition and readmissions.

Process and outcome measures for each harm condition and readmissions were tracked and monitored by the PfP Working Group. Analysis of the Outcome data continues to occur on a quarterly basis; the Services report MTF-level harm data on a monthly basis for more real-time opportunities for performance improvement. The Services have established systems for tracking compliance with using the relevant EBP with every patient every time, which include tracers, compliance metrics, and checklist.

The Learning Action Network (LAN) structure allowed the MHS to move toward its goal of becoming a learning organization. The LAN consisted of Learning Circles focused on performance improvement and Communities of Practice (CoPs). The CoPs are harm condition-specific champions and teams allowing all MTFs to share best practices and lessons learned surrounding PfP implementation and data tracking, and external subject matter experts to present leading practices. MTF representatives used both of these learning opportunities to help their own MTF and others fully implement standard practices and achieve PfP aims. As part of the PfP initiative, there were five Learning Circles and 171 CoP sessions with nearly 370 participants each month.

MHS has made significant impact to patient safety through the collaborative efforts with Services and DHA. Through PfP, MHS reduced overall harm by 18 percent from CY2010 (baseline) to CY2013. Comparing the current rate (CY2013Q4) to when implementation began (October 1, 2012), there has been an 18 percent reduction. MHS readmissions decreased by 11.1 percent between CY2010 (baseline) and CY2013. Since the implementation of PfP, approximately 527 total fewer harms affected patients (averaging 105 harms per quarter) and $14 million in HAC associated costs (averaging $2.8M per quarter) were avoided. Areas of opportunity for improvement include, adverse drug event (ADE) and falls, which are self-reported harms. The Services and DHA continue to collaboratively focus on PfP sustainment and ongoing patient safety and quality improvement efforts via PSIC discussions and centrally reported outcome data.

Some of the key accomplishments of PfP throughout the MHS include establishing a framework for Transformative Performance Improvement; engaging front line clinical staff and leadership; promoting data-driven decision-making; creating an effective learning organization model; and reducing overall incidence of preventable harm and readmissions since PfP implementation (CY2012 Q4).

Army – Patient CaringTouch System

The Patient CaringTouch System (PCTS) is a strategic, patient-centered comprehensive nursing framework. It was first implemented across the Army Medical Department in 2011. The PCTS is an evidence-based framework developed to reduce unwanted variance, improve care, and reduce nursing turnover.

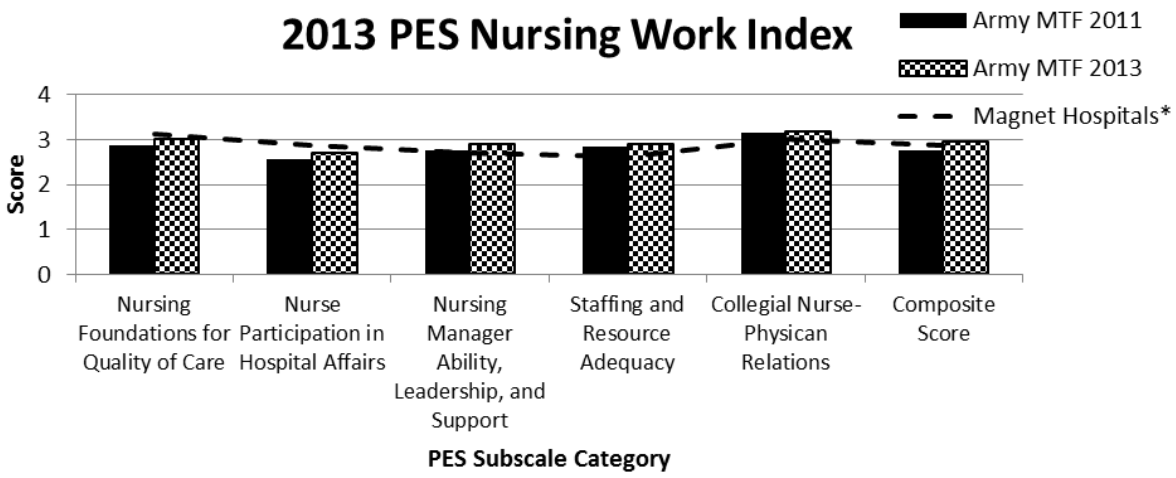
The PCTS is based on five core elements: 1) patient advocacy, 2) enhanced communication, 3) capability building, 4) evidence-based practices, and 5) healthy work environments. These elements are supported by six standards that are implemented at the clinic and unit level: 1) care teams (a care delivery model), 2) peer feedback (review and reflection on practice), 3) shared accountability (shared governance), 4) core values (guiding tenants), 5) skill building (improving knowledge), and 6) optimized performance (nurse-sensitive metrics). Four additional components reside at the regional or higher level including the Centers for Nursing Science and Clinical Inquiry, standardized documentation, leader development, and talent management.

Initial trends demonstrate improvement in several of the 10 nurse sensitive metrics such as voluntary nursing turnover, falls, falls with injury, patient satisfaction, and the practice environment. These metrics are reviewed and analyzed from the unit/clinic level to the Corps Chief. An early analysis revealed a cost avoidance of more than $9 million in nursing staff voluntary turnover and falls with injury. In 2013 Practice Environment Scale of Nursing Work Index, Army Facilities scored higher than Magnet facilities in three out of five subscales and in the overall composite scale (See Figure 5.12-1). In evaluation with the comparable health systems 2013 data, Army Hospitals had the same PES composite score (2.95) as the Magnet

designated medical centers. Hospitals with Magnet designation are recognized for nursing excellence, better patient outcomes, and reduce mortality rates[11].

Although initially an Army program, other MTFs such as Walter Reed National Military Medical Center and Ft. Belvoir adopted some of the standards of PCTS and continue towards full implementation. This program is in its fourth year and research validates the difficulty of sustaining innovations in health care. The degree to which PCTS is embedded into the organizational culture is varied. The Army, Air Force, and Navy Nurse Corps Chiefs approved a grant to formally study the degree of sustainment, patient outcomes, practice environment and make program recommendations. The results of the study are expected in early 2015.

Figure 5.12-1 PES Nursing Work Index, CY13



*McHugh, Matthew, PhD, JD, MPH, RN, "PES scores-comparisons" email to D. Patricia Patrician, 27 August 2013.
2014 MHS Review Group
Source: Patient CaringTouch System, 2013

Navy – Culture of Safety

In January 2014 after analysis of data obtained using the AHRQ patient safety culture tool, the Navy Surgeon General initiated the PS Culture Initiative. The goal of the initiative is making sure that every staff member feels empowered to speak up to protect patients, and to feel safe in expressing concerns or asking questions of colleagues regarding care provided to a patient. The Surgeon General set the following expectations of leadership:

- Participation in weekly rounds and findings/actions resulting from the rounds are shared with staff
- Establishment or enhancement of PS Recognition Programs to focus on identification of process and system issues with subsequent recognition of staff in key forums

[11] McHugh, M.D, Kelly, L.A, Smith, H.L, Wu, E.S. (2012) Lower Mortality in Magnet Hospitals, Medical Care 51(5), 382-388.

- Implementation of TeamSTEPPS® training principles and tools such as huddles, briefings, debriefs and two challenges rule
- Include TeamSTEPPS® training in the Command Orientation Program
- Five staff per week are interviewed using the communication openness and non-punitive response to error questions

Four months of data show progress in staff awareness and willingness to share concerns. The command managers and leadership find the rounds informative. Staff are asking questions and receiving feedback. This is expected to be an ongoing evolution with increasing staff involvement and empowerment.

Air Force – Surgical Site Consultant

The Air Force Medical Service (AFMS) Clinical Consultant for Surgery in collaboration with the Patient Safety Program (PSP) initiated a Lean event to reduce wrong-site/wrong person surgical events. Surgical team members participated in this Lean event as essential stakeholders in this process. The documentation of compliance is automated and sent to the Air Force Medical Operations Agency for analysis. The final data sets are being evaluated and results are pending. This initiative resulted with a team-focused process and associated checklist to assure all critical Time-Out steps are followed and documented. The intent of this new safety initiative is to reduce wrong site surgical events.