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In recent years this country's civilian health care industry has been confronted with numerous significant challenges. Increased competition, major modifications to payment plans the pressures of cost containment--these and other demanding conditions have already resulted in dramatic changes in the organization and delivery of health care. A recently developed program entitled the Military-Civilian Health Services Partnership Program offers tremendous promise in meeting these challenges of cost containment and increased efficiency.

The problem which this study addressed was the absence of a standardized methodology to assess needs and prioritize the selection of Military-Civilian Health Services Partnership Program agreements at Bayne-Jones Army Community Hospital, Fort Polk, Louisiana. As one step toward enhancing the hospital commander's abilities to manage resources under these increasingly challenging conditions, this research sought to develop a model to assist in the establishment of Military-Civilian Health Services Partnership Program agreements

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involving the use of civilian physicians within military medical treatment facilities. The model is designed to aid the commander and his supporting staff in the objective identification of outpatient clinical specialities which need to be recruited. Further, the model then lends itself to the ranking of the competing specialties to establish priorities for selection and implementation of Military-Civilian Health Services Partnership Program agreements.

In defining the decision support model, the CHAMPUS Program and other notable predecessors of the Military-Civilian Health Services Partnership Program are explored. Subsequently, the model is detailed and demonstrated through an evaluation of the existing Partnership Program agreements at Bayne-Jones Army Community Hospital. Finally, recommendations are offered regarding the formal adoption and utilization of the decision support model at that facility.

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT POLK, LOUISIANA 71459-6000

REPLY TO
ATTENTION OF:

HSXV-CSD

27 September 1989

MEMORANDUM THRU COL Douglas A. Barton, Deputy Commander for Administration/Preceptor, Bayne-Jones Army Community Hospital, Fort Polk, LA 71459-6000

FOR Residency Committee, U.S. Army-Baylor University Graduate Program in Health Care Administration (HSHA-IHC), Academy of Health Sciences, U.S. Army, Fort Sam Houston, TX 78234-6100

SUBJECT: Graduate Management Project

1. The Graduate Management Project is returned with modifications and clarification accomplished, per previous guidance of assigned readers. Also enclosed are the Report Documentation Page (DD Form 1473), and the Administrative Residency Statement.

2. POC is the undersigned at AV 863-3512/3795.

Encl

DAVID D. CROWELL
CPT, MS
C, Amb Care Spt Branch, CSD

ADMINISTRATIVE RESIDENCY STATEMENT

Date 28 Aug 89

This is to certify that Captain David D. Crowell has successfully completed the administrative residency in health administration on 21 July 1989 at Bayne-Jones Army Community Hospital, Fort Polk, Louisiana, and that he has submitted supporting material necessary to meet residency requirements published by the US Army-Baylor University Graduate Program in Health Care Administration.

GRADE: (PASS) FAIL (Circle one)

DOUGLAS A. BARTON
COL, MS
Deputy Commander for
Administration/Preceptor

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GRADE: (PASS) FAIL (Circle one)

DOUGLAS A. BARTON
COL, MS
Deputy Commander for
Administration/Preceptor

A STUDY TO DEVELOP

A DECISION SUPPORT MODEL FOR THE ASSESSMENT OF NEEDS AND PRIORITIZATION OF RECRUITMENT/SELECTION ACTIVITIES UNDER THE MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM AT BAYNE-JONES ARMY COMMUNITY HOSPITAL

A Graduate Management Project

Submitted to the Faculty of Baylor University

in Partial Fulfillment of the Requirements for the Degree

of

Master of Health Care Administration

by

Captain David D. Crowell

July 1989

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I would like to acknowledge the extensive support and cooperation which I have received during this academic pursuit. A special thank you is long overdue to my wife, Dong Hee, and my children for their patience and understanding. More recently, I have been fortunate to have encountered an exceptional mentor in the person of Colonel Douglas A. Barton. He has been instrumental in the success of this residency and my continued progress within the field of health care administration. To all of these and the many others who have assisted me along the way, I send my thanks and appreciation.

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I. Introduction

Conditions Which Prompted the Study

In recent years this country's civilian health care industry has been confronted with numerous significant challenges. Increased competition, major modifications to payment plans, the pressures of cost containment--these and other demanding conditions have already resulted in dramatic changes in the organization and delivery of health care. "The escalation of costs for health care has become sufficiently painful in the United States to lead to multiple changes: business groups on health, preferred provider organizations (PPOs), and chilling talk of rationing health care...." (Holmberg 37). The implementation of the prospective payment system (PPS) and its attendant diagnosis related groups (DRGs) serves as a major indicator of a general realization that costs associated with health care have escalated to precarious levels.

A similar awareness has developed within the Department of Defense (DoD) health care system. Although initially limited to the Veterans Administration and civilian health care institutions, DRGs have now been applied within the military system, effective 1 October 1988 (Glick 256). While the full impact of DRGs on funding of those medical facilities will not be felt immediately due to a phased in schedule of application, this is one more clear signal of the necessity for major shifts in the way in which health services are planned and delivered within the DoD environment.

Further evidence of this increasing emphasis upon cost containment and the need for enhanced efficiency and productivity within the military medical system is also demonstrated in the projected changes in the management of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). "Beginning in fiscal year 1988, the budget responsibility for CHAMPUS was placed directly on the managers of the military medical departments" (Mayer 1). Individual hospital commanders may soon expect to be provided with a certain allocation of CHAMPUS dollars, and they will then be responsible for tailoring the expenditure of those funds based on in-house limitations and cost effectiveness considerations. Ultimately, this same management philosophy might be extended to include the entire range of medical services and provider systems located within each catchment area (CHAMPUS Fact Sheet). Catchment area management, if adopted, will present hospital commanders with significant challenges regarding the establishment and mix of delivery systems for the provision of effective and efficient health care.

A recently developed program offers tremendous promise in meeting these challenges of cost containment and increased efficiency. Entitled the Military-Civilian Health Services Partnership Program, its primary purpose is "to integrate specific health care resources with the [military medical treatment facility] which will result in a financial savings to CHAMPUS." Potential secondary benefits include "increased beneficiary satisfaction, training opportunities for [military medical treatment facility] staff, conservation of supplemental funds, and elimination of patient backlog" (Schultz 1).

The application of agreements under the Partnership Program enhances the availability and accessibility of health care services by allowing civilian physicians to treat CHAMPUS beneficiaries within the military treatment facility (internal agreements). Additionally, military physicians are able to provide care to those same categories of patients who are admitted to civilian hospitals (external agreements).

In regards to the latter case, while remaining responsible for CHAMPUS copayments and deductibles for their hospital care, the patients are able to avoid additional payments for physician charges. Both aspects of the program benefit the individual beneficiaries through the elimination of the normal CHAMPUS deductible and copayment requirements, while increasing service capacity within the medical treatment facility and thereby reducing CHAMPUS costs. Unlike its predecessor, the Joint Health Benefits Delivery Program, the Partnership Program also authorizes the treatment of other beneficiary categories through means of Supplemental Care funding, which further expands the positive impacts mentioned above.

As one step toward enhancing the hospital commander's abilities to manage resources under increasingly challenging conditions, this research sought to develop a model to assist in the establishment of Military-Civilian Health Services Partnership Program agreements involving the use of civilian physicians within military medical treatment facilities. It was felt that such a model would aid the commander and his supporting staff in the objective identification of outpatient clinical specialities which need to be recruited. Further, the model would then lend itself to the ranking of the competing

specialities to establish priorities for selection and implementation of Military-Civilian Health Services Partnership Program agreements.

Although this research was specifically directed toward the administration of the Military-Civilian Health Services Partnership Program at Bayne-Jones Army Community Hospital, the attractiveness of a generalizable and exportable decision support model was recognized. When possible, techniques and methodologies utilized within the course of data collection, analysis, and utilization were pursued within that context. Subsequently, the results of this research offer useful application in the analysis of services and potential delivery sources at any DoD medical treatment facility.

Problem Statement

The problem which this study addressed was the absence of a standardized methodology to assess needs and prioritize the selection of Military-Civilian Health Services Partnership Program agreements at Bayne-Jones Army Community Hospital, Fort Polk, Louisiana.

Objectives

The following objectives were achieved to accomplish this management project:

1. Conduct a literature review regarding the following subject areas:

   a. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

   b. The Joint Health Benefits Delivery Program.

   c. The CHAMPUS Reform Initiative (CRI).

   d. The Military-Civilian Health Services Partnership Program.

2. Review current policy, procedures, and regulations for the initiation of agreements under the Military-Civilian Health Services Partnership Program at Bayne-Jones Army Community Hospital.

3. Analyze patient volumes and waiting times for appointments within each outpatient medical speciality.

4. Collect and analyze data pertaining to the CHAMPUS costs associated with the provision of outpatient services to beneficiaries within the Bayne-Jones Army Community Hospital catchment area.

5. Collect and analyze data pertaining to the direct costs associated with the provision of outpatient services within Bayne-Jones Army Community Hospital.

6. Collect and analyze data pertaining to the expenditure of Supplemental Care funds for outpatient services at Bayne-Jones Army Community Hospital.

7. Analyze the allocation and distribution of military physicians to Bayne-Jones Army Community Hospital.

8. Identify other special considerations related to the provision of specific forms of outpatient services.

9. Demonstrate use of the decision support model through the evaluation of previous selections of Military-Civilian Health Service Partnership Program agreements at Bayne-Jones Army Community Hospital.

10. Specify recommendations regarding the adoption of the decision support model at Bayne-Jones Army Community Hospital.

Criteria

The following criteria were applied during the course of the project:

1. Current levels of outpatient services were not decremented.

2. Initiation of agreements under the Military-Civilian Health Services Partnership Program continued to be justified as follows:

a) Services to be provided met a need for health care services that were not currently being met by internal Bayne-Jones Army Community Hospital resources.

b) Provision of services under the Military-Civilian Health Services Partnership Program were required to be more economical than that currently available under the standard CHAMPUS benefits program.

c) Provision of services under the Military-Civilian Health Services Partnership Program were not to be inconsistent with the mission of Bayne-Jones Army Community Hospital.

d) Established standards of quality health care were maintained during the use of agreements under the Military-Civilian Services Partnership Program.

Assumption

In the context of this study, the following assumption applied:

Data obtained from official sources were considered accurate, adequate, and representative of the demand for and use of outpatient clinical services.

Limitation

The scope of this study was limited to the examination of the internal portion of the Military-Civilian Health Services Partnership Program. External agreements, as well as inpatient care under internal agreements, were not considered.

Research Methodology

The research effort conformed to the following methodology:

1. Relevant documentation were collected and reviewed in order to trace the evolution of the Military-Civilian Health Services Partnership Program from CHAMPUS, the Joint Health Benefits Delivery Program, and the CHAMPUS Reform Initiative.

2. Relevant data pertaining to outpatient services provided at Bayne-Jones Army Community Hospital during Fiscal Year 1988 were collected and analyzed to accomplish the identification of:

   a) Relevant patient populations

   b) Patient volumes

   c) Waiting times for appointments.

3. Data regarding the direct costs associated with the provision of outpatient services within Bayne-Jones Army Community Hospital during Fiscal Year 1988 were collected and analyzed.

4. Data regarding the expenditure of Supplemental Care funds for outpatient services during Fiscal Year 1988 were collected and analyzed.

5. CHAMPUS expenditures for outpatient services within the catchment area during Fiscal Year 1988 were determined.

6. Previous trends in military physician allocation and distribution to Bayne-Jones Army Community Hospital were reviewed.

7. Other factors requiring consideration and inclusion within the decision support system; i.e., staffing constraints, work space limitations, supplies and equipment, etc., were identified.

8. Data components were analyzed and applied within the context of the decision support model to assess Military-Civilian Health Services Partnership Program agreements previously selected and implemented at Bayne-Jones Army Community Hospital.

Review of the Literature

> Hospitals are sacred places where modern miracles occur and where the state of the art and science of medicine is advanced.
>
> Hospitals are also crass economic entities where millions of dollars are exchanged for services rendered. There is yet a great deal to be learned about the interface of these two natures of hospital operations. Many of the important questions of quality assurance and cost containment hinge on our ability to understand the delicate balance of clinical and financial influence on the medical care process. (Studnicki qtd. in Glick 258).

In recent years, this country's civilian health care industry has been confronted with many dramatic changes. Previous beliefs that this nation could support the health care needs of all its citizens, regardless of the cost, have been confronted with the harsh realities of limited resources and ever-increasing demand. Organizations composing that industry have been challenged to develop new ideas regarding the means and methods by which health care is produced and delivered. The generation and implementation of such ideas has often been accompanied by a struggle of containing costs while maintaining desired levels of accessibility and quality of care. Confrontations continue between those parties who view the provision of care as an humanitarian act of social consciousness versus those who would pursue

its delivery purely as an economic entity, a service subject to the usual laws of good business (Thurow 611).

These same concerns of containing costs and ensuring optimal utilization of limited resources, fueled by spiraling costs and a critical federal budget deficit, have placed military treatment facilities within DoD in a position quite similar to their civilian counterparts. Budgeting constraints are felt throughout the system, while at the same time the number of eligible beneficiaries continues to grow (Brown 58). Increasingly, leaders and managers at all levels are pressed to develop new, more effective ways of doing business--the business of health care delivery.

Many of the attempts made within DoD to answer demands for access to care by a growing population of eligible beneficiaries have been related to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). A recently developed program offers significant promise in meeting the dual challenges of cost containment and increased efficiency. Entitled the Military-Civilian Health Services Partnership Program, it allows for an integration of medical resources available within the catchment area to reduce CHAMPUS expenditures. In addition to a reduction of costs, this program offers great potential for increasing the availability of and access to services. Obviously, such improvements may be expected to result in greater satisfaction of patients eligible to use the military health care system. A review of the CHAMPUS program and other notable

program predecessors is provided in order to better prepare the reader for an examination of the Military-Civilian Health Services Partnership Program.

CHAMPUS

Although there is often a misperception, the right to receive medical care through the military medical system is limited by Title 10 of the U.S. Code to active duty service members only. Other nonactive beneficiaries--retirees and dependents of both active duty and retirees--may receive care only as space is available. When it is not possible for members of these latter beneficiary categories to receive required medical care within DoD treatment facilities, they are able to utilize the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). As stated by Lieutenant General Frank Ledford, the current Surgeon General of the U.S. Army, "We do not have the capabilities to take care of everyone in the direct-care system. But dependents and retirees by law have a right to care under CHAMPUS" (qtd. in Roth 6). A general description of the CHAMPUS program follows.

CHAMPUS may be viewed as a supplemental health plan for its eligible beneficiaries in that it provides for a sharing of the financial exposure which accompanies the accessing of medical care utilizing civilian medical resources. While CHAMPUS does not provide coverage for all diagnostic and treatment services, it does address a wide range of health care services which are termed "medically necessary." In addition to doctor bills, CHAMPUS will pay for hospital bills, medical supplies, and certain types of other residential treatment for the provision of such care (CHAMPUS Handbook 21).

Specific categories of CHAMPUS eligible beneficiaries include:

--Husbands, wives, and unmarried children of active duty service members.

--Retirees, their husbands or wives, and unmarried children.

--Unremarried husbands and wives and unmarried children of active duty or retired servicemembers who have died.

--Husbands, wives and unmarried children of reservists who are ordered to active duty for more than 30 days or reservists who die [while] on active duty.

--Former spouses of active or retired military who were married to a servicemember or former member who had performed at least 20 years of creditable service for retirement purposes at the time the divorce or annulment occurred [with certain restrictions].

--Certain family members of active duty service members who were court-martialed and separated for spouse or child abuse. (CHAMPUS Handbook 15-16).

Depending upon their specific category of eligibility, beneficiaries may expect that up to 80 per cent of their medical bills will be covered by CHAMPUS. However, certain requirements must be met before this coverage is assured. First, as was previously mentioned, the services received must be included on CHAMPUS' list of medically necessary care. Second, in the case of inpatient care, a statement of nonavailability must be obtained from the military treatment facility within the catchment area, attesting to the fact that such care is not available within that same facility. A nonavailability statement is

currently not required when obtaining outpatient medical care. Finally, the individual provider or health care facility must have formally agreed to participate in CHAMPUS by accepting previously established "allowable charges" (CHAMPUS Handbook 10).

Although the use of CHAMPUS has preserved the nonactive member's ability to access necessary medical care in a time of resource shortages within DoD, that access has not been without its own price. The leadership of the military health care establishment, including Lieutenant General Ledford, acknowledges that it is much less expensive to provide care within military treatment facilities, rather than through civilian providers and facilities. Estimations have been presented which indicate that it takes approximately $1.41 in CHAMPUS dollars to produce that amount of care which could be provided for only $1.00 within military treatment facilities (Roth 6). Meanwhile, funding requirements for the CHAMPUS program have continued to escalate. "In recent years funding for CHAMPUS has tripled, from about $485 million in 1979 to more than $2 billion in 1987" (CBO 1). With these recognitions, a significant incentive is presented to modify the delivery of health care to eligible beneficiaries to allow for a more cost-effective system of delivery, while continuing to address beneficiaries' requirements for availability and access to care. One major modification which resulted took the form of the Joint Health Benefits Delivery Program, and is viewed as a major precursor to the Partnership Program. The Joint Health Benefits Delivery Program is reviewed next in furthering an understanding of the environmental and systemic forces which subsequently led to the

development of the Military-Civilian Health Services Partnership Program.

Joint Health Benefits Delivery Program

DoD instructions for the implementation of the Joint Health Benefits Delivery Program were published on 10 January 1983. Those instructions announced the intention of DoD to establish a program to "integrate specific resources of [the military and CHAMPUS] by allowing CHAMPUS beneficiaries to receive inpatient medical care and outpatient services from civilian health care providers using the resources of military [medical treatment facilities] under the provisions of CHAMPUS" (DoD Instruction 6010.12 2). That program entailed the establishment of agreements to permit civilian health care providers to provide covered medical care to CHAMPUS eligible beneficiaries. A sample of the agreement documents entered into by the physician, CHAMPUS, and the military facility is provided at Appendix A. The care was to be provided within the military treatment facility, and would make maximum use of that facility's resources; i.e., speciality consultants, ancillary services, supplies, and equipment. Major objectives associated with the program included maximizing the use of the military direct medical care system while containing CHAMPUS costs, particularly in regard to the provision of inpatient care (Becker 1).

Key aspects of the program included the negotiation of provider fees with each civilian physician. Based on those negotiations, CHAMPUS reimbursement for provider fees might be somewhat less than the standard CHAMPUS allowable charges under the traditional program. Even more significant, with inpatient care provided within the

military treatment facility, civilian hospital charges would be totally avoided.

In addition to gaining enhanced access to services within the military treatment facility, at least one beneficiary category received a direct financial benefit through use of the Joint Health Benefits Delivery Program. Dependents of active duty members receiving their inpatient care and treatment under this program were not required to make any of the copayments normally required by CHAMPUS. This group's financial obligation was limited to the daily subsistence charge for the period of hospitalization (at that time $6.55 per day). Other CHAMPUS eligible beneficiary categories continued to share the costs of inpatient care and were responsible for 25 percent of the civilian physician's fee, in addition to the daily subsistence charge. Outpatient care was subject to the normal CHAMPUS deductibles and copayments (Becker 2).

The Joint Health Benefits Delivery Program should be recognized as one of the earlier attempts to exercise a new brand of creativity and innovation in modifying the use of CHAMPUS in conjunction with military medical resources. Its implementation appears to have resulted in a strengthened awareness of the problems associated with the military health care system, as well as for the potential modifications to increase efficiency and improve accessibility. Efforts of this nature have continued and have led to major initiatives such as the CHAMPUS Reform Initiative (CRI). The CRI is

discussed next in order to identify its impact upon the subsequent development of the Military-Civilian Health Care Services Partnership Program.

CHAMPUS Reform Initiative (CRI)

An executive summary prepared by the Office of the Assistant Secretary of Defense for Health Affairs in June 1986, identified the incentive behind the development of the CRI. This project entailed an attempt to address ongoing problems with the CHAMPUS program. Specific concerns which were acknowledged included:

Poor coordination. Although CHAMPUS accounts for a substantial proportion of total care, there is inadequate coordination between the military and civilian components of the Military Health Services System.

Inadequate access. With substantial beneficiary cost-sharing requirements, CHAMPUS does not offer an affordable alternative to the long delays in obtaining appointments in military facilities, particularly for outpatient primary care.

Excessive costs. With its outdated payment methods, CHAMPUS costs have been rising faster than health care costs generally, making civilian care too expensive for many military families and wasting DoD health care dollars.

Little quality monitoring. With its present fragmented structure, CHAMPUS has been limited in its ability to monitor the quality of care provided to beneficiaries in the civilian sector.

Complex procedures. When using CHAMPUS, beneficiaries and providers are frustrated by complex procedures and long

delays in receiving payment of claims. (OASD-HA Executive Summary 10).

Those same systemic concerns subsequently formed the objectives to be achieved through the CRI. Key components of the initiative involved "DoD plans to award three regional fixed-price, or 'at-risk' contracts, covering the entire United States, under which the contractors [would] assume financial responsibility for virtually all health care services provided under CHAMPUS" (OASD-HA Fact Sheet 11). The government would use its significant buying power in order to secure major discounts from those health care groups competing for the award of a contract of this magnitude. Having achieved a greater cost effectiveness by this means, other stipulations included within the request for proposal and ultimately the contract would address the other problem areas identified above.

Portions of the CRI have produced relatively successful results, most readily observable within the demonstration projects established in California and Hawaii. However, the objective to establish regional fixed-price contracts throughout the United States has not been achieved. The major problem: an inability to attract contractors to assume the significant risks inherent within the fixed-price contracts. This, in conjunction with a patient population notorious for their rates of utilizing medical services, has resulted in an almost complete absence of bids, with no additional contracts yet being awarded. Subsequently, the CRI remains limited to the demonstration projects in California and Hawaii (Burlage 10).

With such severe problems attendant to this initiative, other alternatives to addressing the significant concerns which CRI had identified have been necessitated. One alternative which has displayed impressive potential is the Military-Civilian Health Services Partnership Program, upon which the remainder of this paper is focused.

Military-Civilian Health Services Partnership Program

DoD Instruction Number 6010.12, issued on 22 October 1987, activated the Military-Civilian Health Services Partnership Program. Those instructions are provided at Appendix B. In its essence, the program is a revision of the previous Joint Health Benefits Delivery Program, with objectives very similar to the latter program. Its primary aim is to achieve the imperative improvement to the cost effectiveness of the CHAMPUS program which was so well-recognized by the programs previously described. Details of the Military-Civilian Health Services Partnership Program (and the means by which it is to accomplish this goal) follow.

As an expansion and replacement of the Joint Health Benefits Delivery Program, the Military-Civilian Health Services Partnership Program shares a mutual foundation with its predecessor: it authorizes commanders of military medical treatment facilities to establish agreements with civilian practitioners to provide services to CHAMPUS eligible beneficiaries. But the Partnership Program incorporates several modifications to address the earlier shortcomings identified within the Joint Health Benefits Delivery Program. The primary modifications are listed as follows:

> --Eliminates the requirement for the beneficiary to pay the CHAMPUS deductible and copayment if the care is provided in a military [medical treatment facility] (Internal Partnership Agreement).

--Provides authority for military providers to treat CHAMPUS eligible partners in civilian medical facilities (External Partnership Agreement) thus saving both the government and the patient their apportioned cost of civilian provider fees.

--Provides a simplified 30-day approval process for negotiated partnership agreements.

--Allows for the payment of the costs of certain support personnel, equipment, and supplies furnished by the civilian provider when these resources are not otherwise available in the military [medical treatment facility], provided the costs are included in the provider's allowable charges and the services are a CHAMPUS benefit.

--Permits the [military medical treatment facility] commander...to use currently available supplemental care funds to provide for the treatment of noneligible CHAMPUS beneficiaries (i.e., active duty personnel, MEDICARE eligible dependents or retirees, dependent parents, etc.) at negotiated rates. (Munley 1).

The establishment of agreements under the Partnership Program offers significant potential for the reduction of costs while enhancing the accessibility and availability of health care services to the entire beneficiary population. These improvements are achieved by permitting civilian physicians to treat CHAMPUS beneficiaries within the military treatment facility, with reimbursement occurring at negotiated and discounted rates. Also, rather than restricting the

agreements to only physicians, it also allows agreements to include support personnel, equipment, and supplies when advantageous to the government. Another agreement option entails the use of military physicians to provide care to those same categories of patients who are admitted to civilian hospitals. Although still responsible for CHAMPUS copayments and deductibles for their civilian hospital care, the patients are then able to avoid additional payments for physician charges. Both aspects of the program benefit individual beneficiaries through the elimination of the normal CHAMPUS deductible and copayment, while increasing service capacity within the military medical treatment facility and reducing CHAMPUS costs (Munley 1-3). Unlike its predecessor, the Joint Health Benefits Delivery Program, the Partnership Program also includes an authorization for the treatment of other beneficiary categories through the means of Supplemental Care funding, which further expands the positive impacts mentioned above (Munley 1).

The actual establishment of the written agreement under the Partnership Program is designed to be uncomplicated and expeditious. A sample of the memorandum of understanding which embodies the agreement is provided at Appendix C. The decision to pursue such an agreement is dependent upon its ability to meet the following stated criteria:

> (1) Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing [military medical treatment facility] resources.

(2) Use of the Partnership Program is more economical to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS program.

(3) Use of the Partnership Program is consistent with the mission of the [military medical treatment facility].

(4) Use of the Partnership Program is consistent with high standards of quality health care established for military treatment facilities. (DoD Instruction Number 6010.12 3).

The above-stated criteria provide the basic parameters which any proposed agreement must meet to qualify for selection and implementation. However, they leave unanswered the question of the prioritization of potential agreements which must occur within each individual military medical treatment facility. Assuming that expansion of the facility through new construction is not normally a readily available option, there are limitations regarding the number of internal physician partnerships which the facility can physically support. What is required is a logical, standardized methodology to identify and prioritize agreements for selection and implementation which will provide the greatest possible benefit to the organization. As one step toward enhancing the hospital commander's abilities to manage resources under increasingly challenging conditions, this research presents a model to assist in the accomplishment of such an objective. Construction and utilization of the model is specifically targeted to internal partnership agreements, based on a current decision to restrict agreements to that type at Bayne-Jones Army

Community Hospital. Subsequently, the model suggested is presented as an aid to the commander and his supporting staff in the objective identification and prioritization of outpatient clinical specialities in which partnership agreements might be applied.

II. Discussion

The initial agreement established under the Military-Civilian Health Services Partnership Program at Bayne-Jones Army Community Hospital took effect in August 1988. Since that time several other agreements have been implemented as the organization's leaders and managers have become more knowledgeable regarding the program's features and potential for application. Partnership agreements which have been established to date include the following:

-- Family Practice (two agreements)

-- Psychiatry/Psychology/Social Work

-- Cardiology (discontinued)

-- Urology

-- Pediatrics (for use in Exceptional Family Member Program).

As knowledge regarding the program and its applications has expanded, the organizational procedures pertaining to the program have also evolved. The tendency has been one of steadily formalizing the organization and process by which proposed partnerships are identified and evaluated. The most recent version of the internal document which establishes policy guidance for the conduct of the Partnership Program at Bayne-Jones Army Community Hospital, MEDDAC Memorandum 5-1, is provided at Appendix D. That memorandum, currently pending final staffing and approval, was written by the staff of the Resource Management Division at Bayne-Jones Army Community Hospital. Although its development occurred independently of this project, it was subsequently recognized for its features which intersect the

application of the decision support model. Specific provisions of the memorandum which were considered and appropriately integrated or modified within the desired decision support model are detailed below.

Responsibilities for the various requirements associated to establishing a need for a partnership agreement are depicted within the flow chart at figure 1. This extract of the MEDDAC Memorandum 5-1 assigns the initial responsibility for identifying services which are needed but currently unmet to the department and service chiefs. In accordance with the guidance contained within MEDDAC Memorandum 5-1, "justification for these services should consider appointment backlog, number of nonavailability statements issued, etc." (2). The identified need is then communicated to the Deputy Commander for Clinical Services for his verification. If that verification occurs, the process toward an agreement continues through the remaining stages as is presented within the flow chart at figure 1. Otherwise, the process is terminated at that juncture.

It is at these initial points of the responsibility flow chart at which the proposed decision support model is targeted. Although the MEDDAC Memorandum 5-1 alludes to certain factors which might be considered in defining and validating the need for services, there is no formal description of exactly what data from which sources are to be reviewed in reaching a decision. This was the objective of the decision support model.

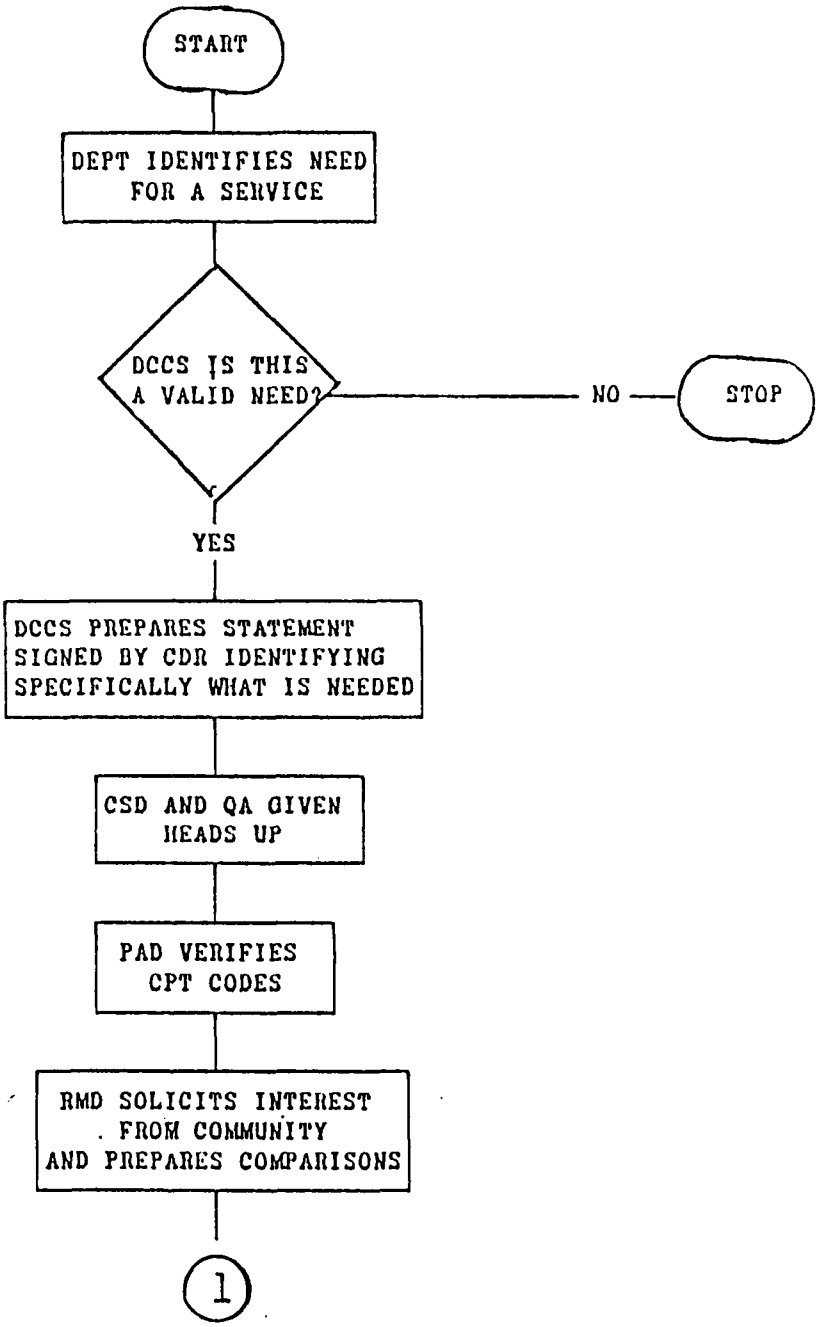

Fig. 1. Partnership Responsibility Flow Chart

MEDDAC Memorandum 5-1, "Military-Civilian Health Services Partnership Program" (draft). USAMEDDAC Fort Polk, LA. 11 July 1989.

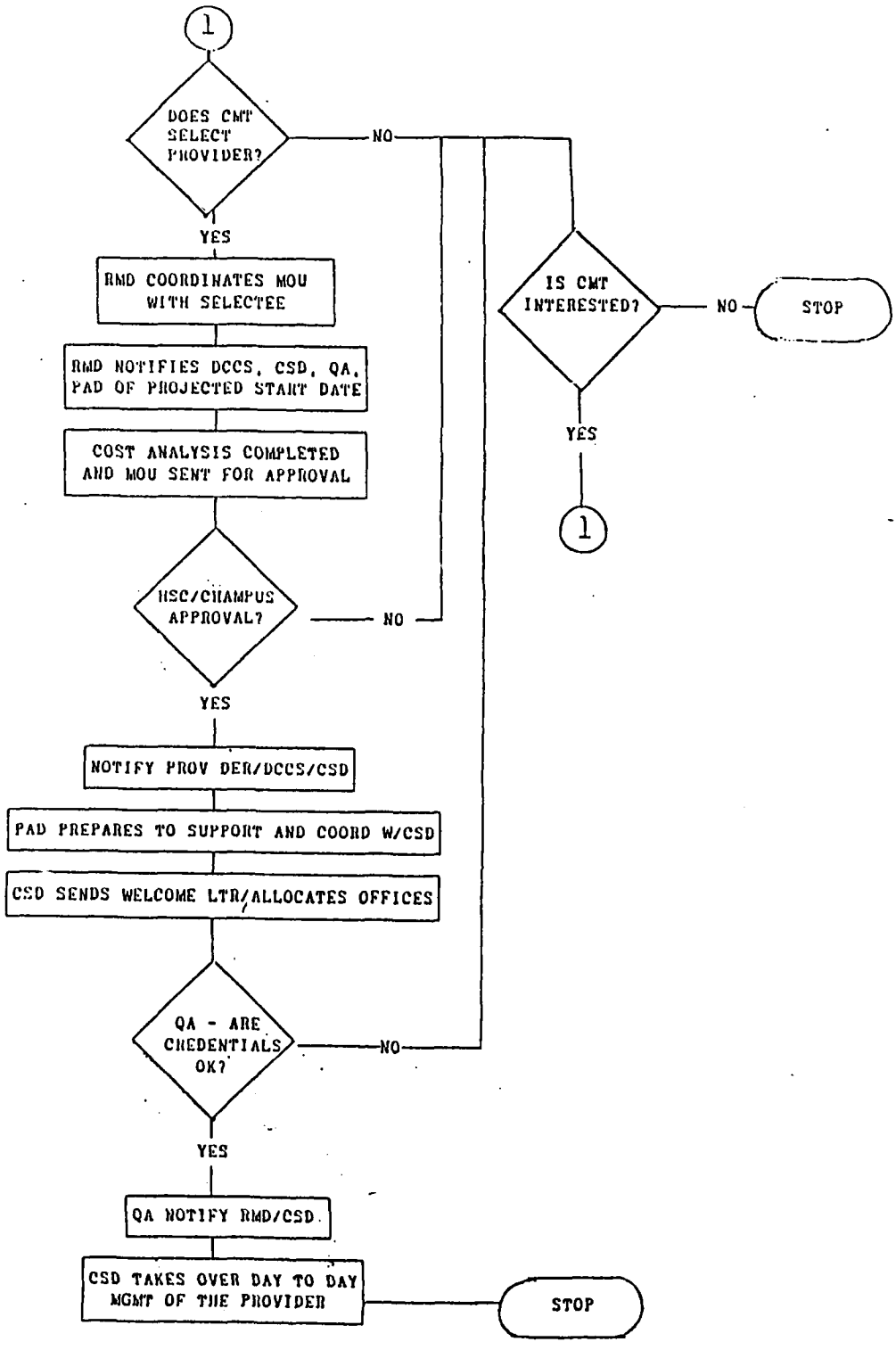

Fig. 1. Partnership Responsibility Flow Chart (Continued)

MEDDAC Memorandum 5-1, "Military-Civilian Health Services Partnership Program" (draft). USAMEDDAC Fort Polk, LA. 11 July 1989.

The Proposed Decision Support Model

The decision support model proposed for use in identifying and prioritizin[illegible]re 2. Each of it[illegible]te for the reader [illegible]

This section entails a "cook book" approach specifying how the model is applied. Subsequently, I feel that the present tense used is appropriate.

Identify Pa[illegible]

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Although the Partnership Program is specifically targeted to CHAMPUS eligible beneficiaries, there is a built-in flexibility to provide health care services to other beneficiary categories through these agreements. Subsequently, the following categories of beneficiaries must be examined, to include:

--Active duty service members

--Dependents of active duty service members

--Retirees

--Dependents of Retirees

--Federal civilian employees.

Identification of the relevant beneficiary categories, minus the federal civilian employees, is easily achieved through use of the Defense Eligibility Enrollment System (DEERS). DEERS currently has the capability to support not only a review of populations during

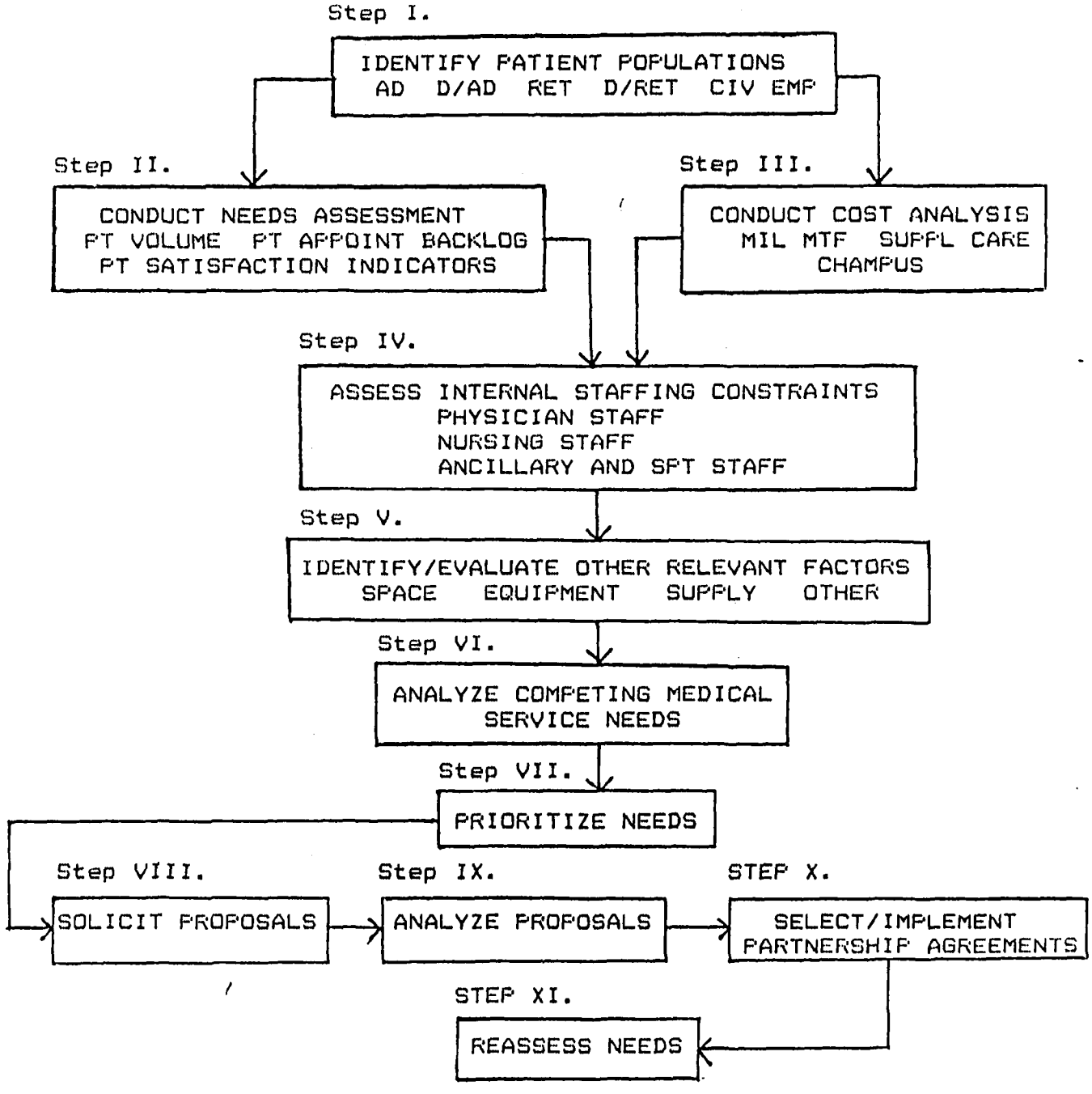

Fig. 2. Decision Support Model

Crowell, 1989.

previous fiscal years, but also a review of projected changes in future years through a system termed "RAPS" (Resource Analysis and Planning System). Appendix E presents population projections from Fiscal Year 1987 through Fiscal Year 1993, with Fiscal Year 1987 utilized as a baseline. The assessment of numbers of federal employees is also easily achieved by coordination with the local installation's Civilian Personnel Office. Having appropriately identified the relevant patient populations, the next two steps of the model may be accomplished simultaneously.

Conduct a Needs Assessment

Assessment of needs should in fact be preceded by a determination as to whether the medical service in question is considered "medically necessary" and qualifies for CHAMPUS reimbursement. Again, the potential utilization of Partnership Program agreements for other than CHAMPUS eligible beneficiaries is recognized. However, common sense and economics dictate that the bulk of the care provided through the program should be targeted toward CHAMPUS eligibles. (Note: the repetitive review of the qualification of services should be effective in reinforcing this requirement with the administrative and medical staff, thereby reducing the incidence of non-reimbursable claims.)

Assessment of need is conducted primarily on the basis of historical patient volumes and workload. These assessments are achieved through the review of two resources. The first resource, the local Patient Administration Division within the military medical treatment facility, is able to provide patient volumes for the patient

treatment episodes accomplished internally. The number of clinic visits accomplished each month is available through the MED-302 reports. That data is depicted in the spreadsheet provided at Appendix F, and reflects the number of patient visits by month and year for Fiscal Year 1988. Also included are the average monthly visits experienced by each outpatient medical speciality. Examination of the spreadsheet allows for immediate observation of the differences in patient volumes (both totals and averages) between the various clinics.

Comparative data is available with which to track the utilization of medical services accessed through the traditional CHAMPUS program. The CHAMPUS Health Care Summary by Primary Diagnosis reports (see Appendix G) may be utilized to assess the volume of services provided by this means. Additionally, this data may be combined with that of the MED-302 report in evaluating the overall demand for services within each clinic category.

Another indicator of need is available in the form of patient appointment availability. All outpatient clinics are currently required to submit a weekly report to the Clinical Support Division to identify the number of days until the next appointment is available with each physician within each clinic. This data is reflected at Appendix H and indicates the shortest waiting time available within each clinic during the reported weekly period. Subsequently, average waiting times are calculated on the basis of those reports.

An additional indicator in the assessment of needs may be deduced through the review of outpatient satisfaction surveys which are

conducted annually by the Patient Representative Office within the local military medical treatment facility. Those conducted within Bayne-Jones Army Community Hospital utilize a standardized survey instrument provided by its major subordinate command, Health Services Command. While admittedly less objective than the assessment of needs through the evaluation of patient volumes, these surveys may also provide some indication of need or perceived need within the patient population. The survey instrument and results for Fiscal Year 1989 are provided at Appendix I. Included are results by individual outpatient clinic. (Note: Survey results for Fiscal Year 1988 were not available.)

Conduct a Cost Analysis

An initial cost analysis is conducted to determine the historical expenditures for outpatient care services which are provided directly within the facility, through the use of Supplemental Care funding, and by means of the traditionaly CHAMPUS program. Data regarding the former category of costs are available through the Resource Management Division of each military medical treatment facility. Direct health care costs are captured through the Medical Expense Performance Reporting System (MEPRS) and may be utilized to calculate an average cost per clinic visit within each of the outpatient medical speciality areas. Similarly, Supplemental Care funding is tracked by the Resource Management Division and also provides for an approximate average cost per clinic visit. (Note: the qualifier "approximate" is required due to the manual methods utilized

to collect and maintain Supplemental Care costs data during Fiscal Year 1988. Enhanced automation will provide for a more detailed attribution of costs to specific outpatient clinics in the future. Data pertaining to average costs per clinic visit provided by direct care and Supplemental Care funding are presented at Appendix J.

In addition to assessing the internal costs associated with the provision of health care, it is also necessary to determine that cost of care provided through the traditional CHAMPUS program within the catchment area. The CHAMPUS Health Care Summary by Primary Diagnosis Report, previously presented at Appendix H, also identifies the average government costs for each category of care. Subsequently, this report supports a comparison of CHAMPUS costs to the direct care and Supplemental Care costs experienced within the military medical treatment facility.

Assess Internal Staffing Constraints

It should be apparent that a constant surveillance of physician staff availability must be maintained to monitor and identify local and systemic shortages within the various medical specialities. The difficulties associated with monitoring the availability and actual distribution of Medical Corps members were emphasized by Major Andrew Cornell, Clinical Medical Division, Health Services Command. His comments to this writer on 8 May 1989 revealed the absence of a long-term plan for the distribution of military physicians, with the availability of physicians often viewed as driven by the Graduate Medical Education (GME) program. The Deputy Chief of Staff for

Clinical Services at Health Services Command placed this in perspective by noting that the "drain into the teaching programs impacts on staffing our facilities short term...[while] the long term impact will be to provide trained specialists who have an obligation to the military in the future" (Butler 1). Those numbers of physicians who are available each year after GME requirements are met are reviewed and allocated during the annual Medical (MC) Distribution Conference. In the absence of other options, monitoring activities must remain primarily directed to the results of the distribution conference each year.

In addition to monitoring the availability of physicians, assessment of staffing must be extended to include a review of the requirements for nursing personnel, as well as other ancillary and support staff. Normally, these requirements must be addressed during the evaluation of specific proposals under the Partnership Program, particularly when the proposal includes the provision of such personnel in support of the physician member(s). However, early identification can and should be made regarding systemic shortages which might significantly impact upon one or more medical services. One example of this includes noting the absence of authorizations for the assignment of cardiology technicians within Bayne-Jones Army Community Hospital, and the attendant impacts upon agreements established within the cardiology medical speciality.

Identify/Evaluate other Relevant Factors

Numerous additional factors must be recognized and evaluated for their impact upon partnership agreements with outpatient medical specialities. Chief among these are those factors related to the availability of work space, equipment, and supplies. Once again, detailed examination of these factors may not be possible until conducted in respect to specific proposals and information as to the extent of support which the partnership physician intends to provide for himself/herself. However, existing shortages (or availability) of work space within outpatient clinic areas, as well as special equipment or supply requirements associated to specific medical specialities may be identifiable at this stage.

Conduct a Comparative Analysis of Competing Medical Service Needs

This portion of the model entails a review of the preceding analysis to extend across all competing medical service needs. All of those factors which were identified for each separate outpatient medical speciality are now considered in turn, to begin to identify the benefits to be gained through capturing CHAMPUS workload and increasing access to services. Outliers are identified in each of the factor areas addressed above.

Prioritize Needs

Accomplishment of this step within the model is predicated by the organizational goals and objectives established by the commander

of the military medical treatment facility. As was mentioned in the earliest portion of this discussion, there is often a struggle between two central issues -- duction.

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The model has not actually/officially been applied to do this (although this is accomplished in the following pages). This is still just a "cook book" explanation of the model & how it is to be applied.

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tl ------, a major subordinate command, Health Services Command.

Conduct a Comparative Analysis of Competing Proposals

An examination of competing proposals within a given outpatient medical specialty is pursued in a manner similar to that analysis presented above. Specific attention is warranted to the provision of staff support, as well as to items of equipment and supplies which are to be provided under the terms of the agreement. Finally, a detailed cost comparison between proposals is accomplished based on the negotiated rates for specific services to be provided.

Select/Implement Partnership Agreements

Final selection and implementation of agreements occur based on the consideration by those members specified by MEDDAC Memo 5-1. Final approval resides with the major subordinate command and CHAMPUS.

Reassess Needs

Complete reassessment of needs utilizing this same decision support model should occur on an annual basis to identify significant changes and accomplish appropriate modifications.

Assessment of Partnership Agreements at Bayne-Jones Army Community Hospital

Although insufficient information was available with which to conduct an evaluation utilizing the full decision support model, it was possible to apply several of the more demonstrable components to assess the agreements which have already been implemented at Bayne-Jones Army Community Hospital. As was previously mentioned, those agreements include:

-- Family Practice (two separate agreements)

-- Psychiatry/Psychology/Social Work

-- Cardiology (discontinued)

-- Urology

-- Pediatrics (for use in the Exceptional Family Member Program).

The review of these agreement selections proceeded primarily on the basis of the needs assessment and cost components of the proposed model. In all instances, with the exception of the patient satisfaction surveys, data utilized to evaluate the selections of provider agreements relate to Fiscal Year 1988, utilizing this as a "baseline year."

The assessment of outpatient speciality needs began with a review of the patient volumes experienced within the various clinical areas. The results of a detailed review of the MED-302 reports are presented within table 1, depicting the average number of clinic visits which were reported during this time period (Fiscal Year 1988). That volume

Table 1

Average Number Clinic Visits Per Month Outpatient Medical Specialities, Bayne-Jones Army Community Hospital, Fiscal Year 1988

Clinical Speciality/Activity	Average Number Visits/Month
Family Practice	4302
Emergency Medicine	2223
Pediatrics	859
Obstetrics	823
Internal Medicine	569
Gynecology	367
General Surgery	351
Social Work	350
Occupational Therapy	317
Dermatology	287
Physical Therapy	259
Orthopedic	235
Psychology	227
Psychiatry	202
Otorhinolaryngology	168
Opthalmology	165
Optometry	162
Audiology	130
Mental Health	128
Well Baby	124
Community Health Nurse	121
Nutrition Care	100
Adolescent Pediatrics	90
Speech Pathology	77
Podiatry	66
Neurology	30
Inhalation/Respiratory Therapy	24
Urology	8

Source: MED-302 Reports, 1 Oct 1987 thru 30 Sep 1988, Patient Administration Division, Bayne-Jones Army Community Hospital.

experienced within the Family Practice clinic was noted as almost twice as much any other outpatient activity, averaging 4,302 visits per month. At the other end of the spectrum was Urology, with an average of eight clinic visits per month.

Further indications of the extent of need for the various specialities were reflected within the average waiting time for the next available appointment. Table 2 presents this data, which resulted from weekly reports provided by each clinic to the Clinical Support Division. The waiting time ranged from 21 days (Family Practice) to five days (General Surgery).

Table 3 summarizes the most recent patient satisfaction surveys in respect to patients' evaluations of the waiting time they experienced in obtaining an appointment. Rankings were based on "Very Satisfied," "Acceptable," and "Dissatisfied." Survey results indicated that 75 percent of the respondents expressed dissatisfaction with the waiting time for an Opthalmology appointment. The two Family Practice clinics were each reported separately, and both were present in the top five of those areas with which patients were least satisfied.

Tables 4, 5, and 6 present data which support a cost analysis by distinguishing the average costs per clinic visit provided through direct care, Supplemental Care, and the traditional CHAMPUS program, respectively. The largest total expenditure under the traditional CHAMPUS program during Fiscal Year 1988 was for psychiatry services ($203,531). Mental health related services also appeared as having the highest average cost utilizing Supplemental Care funding.

Table 2

Average Waiting Time Until Next Available Clinic Appointment, Outpatient Medical Specialities, Bayne-Jones Army Community Hospital, Fiscal Year 1988

Clinical Speciality/Activity	Average # Days Until Next Appt
Family Practice	21
OB/GYN	21
Neurology	19
Dermatology	19
Pediatrics	17
Opthalmology	17
Optometry	14
Otolaryngology	11
Internal Medicine	11
Podiatry	10
Orthopedics	9
Audiology	8
General Surgery	5

(Note: Waiting times for other outpatient medical speciality areas not reported.)

Source: Weekly Reports of Next Available Patient Appointment, Clinical Support Division, Bayne-Jones Army Community Hospital.

Table 3

Patient Satisfaction Survey Results, Subject: Waiting Time to Obtain an Appointment, Outpatient Medical Specialities, Bayne-Jones Army Community Hospital, Fiscal Year 1989

Clinical Speciality/Activity	VSAT	ACCEPT	DSAT
Opthalmology	25 %	0 %	75 %
Family Practice (Quad #3)	29	38	33
Otolaryngology	75	0	25
GYN	60	20	20
Family Practice (Quad #4)	64	22	14
Optometry	43	43	14
Orthopedics	75	12.5	12.5
Internal Medicine	38	50	12
Pediatrics	38	50	12
Physical Therapy	44	44	12
OB	69	23	8
General Surgery	71	29	0
Psychiatry	50	50	0
Pulmonary Function	50	50	0
Community Health	0	100	0
Dermatology	100	0	0
Occupational Health	100	0	0
Occupational Therapy	100	0	0
Podiatry	100	0	0
Social Work	100	0	0
Nutrition	100	0	0

Source: 1st Quarter, FY 1989 Outpatient Questionnaire, Patient Representative Office, Clinical Support Division, Bayne-Jones Army Community Hospital.

Table 4

Average Cost Per Clinic Visit, Direct Care Cost, Outpatient Medical Specialities, Bayne-Jones Army Community Hospital, Fiscal Year 1988

Clinical Speciality/Activity	Average Cost per Visit
Internal Medicine	105.13
Orthopedics	94.41
Audiology	93.04
Emergency Medical	85.96
General Surgery	77.14
EENT	74.68
GYN	72.02
Pediatrics	69.24
Podiatry	68.16
Opthalamology	63.35
Family Practice	60.43
Mental Health	56.60
ADAPCP	52.62
OB	51.53
Dermatology	42.75
Adolescent Pediatrics	42.31
Optometry	40.50
Social Work	34.40
Well Baby	32.98
Community Health	26.31
Neurology	25.03
Nutrition	19.50

Source: Cost Analysis prepared by Resource Management Division, Bayne-Jones Army Community Hospital, Fort Polk, LA.

Table 5

Average Cost Per Clinic Visit, Supplemental Care Costs, Outpatient Medical Specialities, Bayne-Jones Army Community Hospital Fiscal Year 1988

Clinical Speciality/Activity	Average Cost per Visit
Mental Health	$ 1231.25
General Surgery	967.50
GYN	502.00
Pediatrics	378.10
Audiology	342.30
Internal Medicine	302.96
Neurology	143.19
Opthalamology	106.92
EENT	99.00
Dermatology	86.67

Source: Resource Management Division, Bayne-Jones Army Community Hospital.

Table 6

Average Costs per Clinic Visit/Number Visits/Total Costs, CHAMPUS (Government) Cost for Outpatient Medical Services, Fort Polk, LA Catchment Area, Fiscal Year 1988

Clinical Speciality/Activity	Average Cost per Visit	X	# Visits	=	Total Govt Cost
Psychiatry Group 2	$ 52.12		3373		$ 175,800.76
GYN	147.88		1124		166,217.12
Urology	292.89		488		142,930.32
ENT	81.73		1193		97,503.89
Orthopedics	71.52		972		69,517.44
General Surgery	95.15		702		66,795.30
Gastroenterology	101.88		545		55,524.60
Pulmonary/Respiratory	55.58		829		46,075.82
Cardiology	58.94		683		40,256.02
Opthalamology	103.20		279		28,792.80
Psychiatry Group 1	56.25		493		27,731.25
Dermatology	43.30		534		23,122.20
Infectious Disease	60.32		289		17,432.48
Endocrinology	82.56		209		17,338.64
Special Pediatrics	248.17		48		11,912.16
Nephrology	443.29		24		10,638.96
Rheumatology	22.46		322		7,232.12
Hematology	88.03		62		5,457.86
Neurosurgery	188.04		28		5,265.12
OB	176.92		24		4,246.08
Thoracic Surgery	215.79		19		4,100.01
Nutritional	36.40		5		182.00

Source: CHAMPUS Health Care Summary by Primary Diagnosis Report, based on Care Received from Oct 1987 thru Sep 1988.

However, mental health services provided through direct care were occasioned by relatively moderate costs ($56 per visit), with the range of those costs being $105 (Internal Medicine), and $19 (Nutrition Care) per visit.

Conclusions resulting from the review of data presented at Tables 1 - 6 are presented as follows:

-- Family Practice. Patient volumes, average waiting time until the next available appointment, and patient satisfaction survey results all supported the selection of partnership agreements within this area. Secondary benefits included flexibility in temporarily assigning military Family Practice physicians to meet unanticipated needs, as well as providing for a continuity in primary care during seasonal shortages of military physicians. Primary constraints pertained to necessary office space, with some potential to overcome this through the organization of an "after-hours" clinic.

-- Psychiatry/Psychology/Social Work. An agreement encompassing these three areas is essential in view of the tremendous costs which have been experienced under the traditional CHAMPUS program, as well as the average Supplemental Care costs associated with the service area. Additional support for this agreement was related to the relative isolation of the Fort Polk community.

-- Pediatrics (Exceptional Family Member Program). The additional support for the screening of children under the Exceptional Family Member Program (EFMP) is justified based on the sensitivity of that mission, as well as the volume of visits experienced within the Pediatrics Clinic. Pediatrics was exceeded only by Family Practice

and the Emergency Room in the average number of visits per month during Fiscal Year 1988. Additionally, the average waiting times for a Pediatrics appointment was relatively lengthy (17 days). These factors, in conjunction with a shortage of military pediatricians assigned to this facility, provide ample justification for the prioritization and selection of an agreement within this area. Utilization of the physician partner for the accomplishment of the EFMP screening activity would allow for the dedication of the military pediatricians to clinic duties, and should help to preclude further decrement of services within the Pediatrics Clinic.

-- Urology. The provision of outpatient Urology services through the traditional CHAMPUS program entailed an expenditure of $142,930 during Fiscal Year 1988. Ranked third by total government cost, this service had the highest cost per visit of all outpatient services provided through that program. The potential to recapture this CHAMPUS workload within the military treatment facility clearly marks this agreement as desirable.

A final comment is appropriate in regard to the Cardiology partnership agreement which was recently terminated at Bayne-Jones Army Community Hospital. Input from the Resource Management Division indicated that the primary reason for the termination was the lack of patient volume experienced by the partnership group. A review of table 6 supports this conclusion based on the relatively low volume of services provided by the traditional CHAMPUS program in Fiscal Year 1988. The total government cost associated with the provision of that

service under the traditional CHAMPUS program did not provide substantial support for the pursuit of a new agreement in the Cardiology area.

III. Conclusions and Recommendations

Conclusions

In a study completed by the Congressional Budget Office in 1988, that office noted that:

> High costs, wide beneficiary dissatisfaction, and inadequate readiness for war have stirred widespread interest in changing the military's system of health care. Large sums are at stake.... About 9 million people are entitled to use [this system], including not only the 2.2 million men and women on active duty but their roughly 3 million dependents along with about 4 million retired military personnel and their dependents and survivors (xi).

The stakes are indeed high. The two persistent issues of cost containment and access to care continue to challenge leaders at all levels within the military health care system. Just as with their civilian counterparts, these leaders must exert new and innovative means of accomplishing the provision of care upon which so many are dependent. In this respect, the Military-Civilian Health Services Partnership Program presents tremendous potential for achieving greater cost efficiencies in the delivery of care while optimizing the access of the system's eligible beneficiaries. However, to ensure that the greatest benefit is realized through this program, there must be an objective, systematic analysis to precede the selection and implementation of agreements.

The proposed decision support model provides the foundation for such an analysis. Its use will assure that agreements are ultimate al goals ar nts will share a iternal staffing

The s to advance ill unknowns s program isodes of medica ..., it is entirely conceivable that the generation of increased demand based on enhanced availability and accessibility could eventually drive overall costs to unacceptable levels. Here again, the decision support model supports an effective data collection effort which can later be assessed for changes, trends, and patterns occurring within specific catchment areas.

The model has not yet been included in Meddac Memo 5-1 – Although I have included that as a recommendation on p 54 this page

Recommendations

It is recommended that the proposed decision support model be accepted, incorporated within MEDDAC Memorandum 5-1, and utilized as a standardized methodology for future assessments, selections, and continuations of Military-Civilian Health Services Partnership Program agreements at Bayne-Jones Army Community Hospital.

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Jan 10, 83
6010.12 (Encl 1)

DEPARTMENT OF DEFENSE

OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE

UNIFORMED SERVICES

AURORA, COLORADO 80045

CHAMPUS HEALTH CARE PROVIDER AGREEMENT

THIS AGREEMENT, entered into as of the_____day of_____, 19__, by and between_____ of _____, hereinafter referred to as the participating health care provider, and the United States of America, hereinafter referred to as the government.

WITNESSETH:

WHEREAS, the participating health care provider entered into an agreement as of _____ (attachment 1) whereby staff privileges at _____, hereinafter referred to as the hospital, were conditionally granted by the government through the (enter Military Department) for (enter specialty) care of beneficiaries of the Civilian Health and Medical Program of the Uniformed Services, hereinafter referred to as CHAMPUS; and

WHEREAS, the government, through (enter Military Department) is interested in achieving optimum use of existing Health Benefits Program resources authorized under Title 10, United States Code, Chapter 55;

NOW, THEREFORE, in consideration of the aforementioned premises, the parties hereto agree as follows:

1. That the participating health care provider shall apply, have approved, and exercise staff privileges at the hospital for inpatient medical care and outpatient services that are directly related to the inpatient medical care (enter specialty) furnished to all patients who are CHAMPUS beneficiaries pursuant to the terms of the Memorandum of Understanding entered into with the government.

2. That the participating health care provider shall accept the CHAMPUS-determined allowable charge as payment in full for all CHAMPUS-authorized (enter specialty) services furnished to CHAMPUS beneficiaries pursuant to this Agreement.

3. That the participating health care provider shall bill the CHAMPUS beneficiary or sponsor only for the amount of the beneficiary's cost-share and any appropriate deductibles, if any, of the allowable charge for such services, and will neither bill nor collect from the CHAMPUS beneficiary or sponsor any amounts exceeding the CHAMPUS-determined allowable charge for the authorized services.

4. That the participating health care provider, or authorized representative, shall sign the CHAMPUS claim form as prepared by the hospital, confirming that the specific medical care itemized on the claim form was in fact rendered

to the beneficiary or patient on the dates indicated and that the health care provider agrees to the CHAMPUS participation agreement on the claim form as modified by this Agreement.

5. That for purposes of this Agreement only, the CHAMPUS-determined allowable charge shall be the fee schedule attached hereto as attachment 2, as negotiated by the parties and reviewed annually, but in no event shall such allowable charge exceed the prevailing charge, as determined by CHAMPUS methodology, for similar services in the same locality where the participating health care provider furnished the medical care. The participating health care provider shall furnish all service charge information requested by the government necessary for negotiation and review of the attached fee schedule.

6. Except as modified by this Agreement, care furnished by the participating health care provider under CHAMPUS shall be subject to DoD 6010.8-R, "Implementation of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 16, 1977, as amended, and policy established by OCHAMPUS.

7. That this Agreement shall continue in effect through _____, unless sooner terminated by mutual written agreement of the parties or as otherwise provided hereinafter.

8. That this Agreement may be terminated by the government upon documentation of suspension or revocation of clinical privileges, failure to abide by the provisions of the Agreement, abuse of its provisions or abuse or fraud committed against any agency of the government by the participating health care provider, and that pending any investigation of fraud or abuse, payments due and owing by the government under this Agreement may be suspended by the government.

IN WITNESS WHEREOF, each of the parties hereunto has executed this Agreement effective as of the day and year first above written.

UNITED STATES OF AMERICA

By_____
Title Director, OCHAMPUS
Aurora, Colorado 80045

PARTICIPATING HEALTH CARE PROVIDER

_____
Name

_____
Address

MEMORANDUM OF UNDERSTANDING BETWEEN

THE (enter medical treatment facility) AND (enter health care provider's name)

CITY OF _____ STATE _____

A. GENERAL

1. This agreement is entered into by and between _____, hereinafter referred to as the hospital, and _____, hereinafter referred to as the participating health care provider.

2. The purpose of this agreement is to integrate specific (enter Military Department) hospital and OCHAMPUS resources to provide (enter specialty) services for CHAMPUS beneficiaries in selected (enter Military Department) hospitals.

3. The participating health care provider is licensed to practice medicine in the State of _____ and has completed application for clinical privileges at the hospital for the purpose of practicing medicine in (enter specialty). The participating health care provider agrees to all the terms and conditions of the application for clinical privileges at the hospital as well as the terms and conditions of this Memorandum of Understanding and also the attached CHAMPUS Health Care Provider Agreement.

4. The hospital is a U.S. Government health care facility within the Department of Defense operated by the U.S. (enter Military Department). The hospital is accountable to the Surgeon General of the (enter Military Department) as the equivalent of the Board of Trustees. The commander of (enter Military Department hospital) is the local representative of the Board of Trustees and is responsible for the operation of the hospital.

B. ARTICLES OF AGREEMENT

1. The Hospital shall:

a. Review past and current performance, determine qualifications, and select potential participating health care providers.

b. Comply with Utilization Review and Quality Assurance Directives and regulations of the (enter Military Department), including but not limited to:

(1) Ensuring that participating health care providers are credentialed in accordance with DoD and Military Department regulations and the hospital bylaws.

(2) Ensuring that participating health care providers adhere to (enter Military Department) hospital bylaws and DoD and Military Department regulations to the same extent and in the same manner as (enter Military Department) health care providers.

c. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement to the extent available and authorized for that facility.

d. Provide administrative support to participating health care providers, including:

(1) Maintenance of patient records, including transcription and copying service as may be necessary to satisfy both (enter Military Department) and private practitioner recordkeeping requirements.

(2) Maintenance of participating health care provider case, workload, and credentials files in support of credentialing processes.

(3) CHAMPUS claim preparation using the fee schedule as the submitted charge, certification, and submission, including obtaining appropriate signatures and assembling necessary medical documentation from patient records, as required.

(4) Reasonable accommodations within the hospital for such periods of time as the participating health care provider may be on after-hours call.

(5) Authorizing subsistence at hospital dining facilities at the rates prescribed for civilian guests.

e. Educate (enter Military Department) hospital staff personnel, beneficiaries, participating health care providers, and other interested civilian providers about the Joint Health Benefits Delivery Program.

f. Provide appropriate reimbursement for care rendered in the hospital to patients not eligible for CHAMPUS benefits.

g. Advise beneficiaries that CHAMPUS payment for services provided in the hospital under this agreement is contingent upon compliance with DoD 6010.8-R and current CHAMPUS operating policies.

2. The Participating Health Care Provider shall:

a. Monitor overall inpatient medical care and outpatient services that are directly related to the inpatient medical care of patients referred as a part of this agreement except that portion of care rendered by or at the direction of (enter Military Department) health care providers.

b. Oversee personal liability coverage applicable to clinical privileges granted with possible indemnification of the U.S. Government as a third-party beneficiary and provide full disclosure of all information, including but not limited to past performance as required by the credentialing process.

c. Abide by hospital bylaws and DoD and Military Department regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

d. Abide by unique (enter Military Department) requirements concerning the nature of limited privileged communication between patient and health care provider as may be necessary for security and personnel reliability programs.

e. Use of all available (enter Military Department) resources, that is, specialty consultations, ancillary services, and equipment and supplies for the optimal care of patients under this agreement.

f. Adhere to the CHAMPUS Health Care Provider Agreement and claim submission requirements concerning allowable payment for services rendered (see attachment 2).

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power to execute such agreement, to any other person, company, or corporation, without the other party's previous written consent.

2. In the event of illness or incapacity rendering the participating health care provider incapable of delivering services, care for patients under this agreement shall be transferred to other participating health care providers at the discretion of the commander of (enter Military Department hospital).

3. Notwithstanding the above, it is understood that the minimum term of this agreement is 1 year with the option to renew for a 1-year period based upon mutual agreement. Termination of this agreement shall be predicated upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of the government.

4. It is understood that the participating health care provider shall abide by (enter Military Department) rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating health care providers shall abide by (enter Military Department) regulations concerning release of information to the public, including advance approval from the (enter Military Department) before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of the hospital, OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

7. The hospital's liability for actions of its employees (hospital staff and Military Department practitioners, but excluding participating health care providers) is governed by Title 10, United States Code, Section 1089.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement effective on this _____ day of _____, 19____.

UNITED STATES OF AMERICA

By _____

Title _____ _____

PARTICIPATING HEALTH CARE PROVIDER

_____
Name

_____
Address

B

Department of Defense
INSTRUCTION

October 22, 1987
NUMBER 6010.12

ASD(HA)

SUBJECT: Military-Civilian Health Services Partnership Program

References: (a) DoD Instruction 6010.12, "Joint Health Benefits Delivery Program," January 10, 1983 (hereby canceled)
(b) DoD Instruction 6010.8, "Administration of the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS)," October 24, 1984
(c) DoD Directive 6000.7, "Dissemination of Information on Medical Officers," July 29, 1982
(d) DoD 6010.8-R, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," March 1986, authorized by DoD Instruction 6010.8, October 24, 1984
(e) through (h), see enclosure 1

A. REISSUANCE AND PURPOSE

This Instruction:

1. Reissues reference (a).

2. Updates procedures to enable the Military Departments to make health care services in their medical treatment facilities (MTFs) more available to health care beneficiaries using the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and, to combine military and civilian health care resources to improve the cost-effectiveness of the DoD health care delivery system.

B. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Organization of the Joint Chiefs of Staff (OJCS), the Unified and Specified Commands, the Inspector General of the Department of Defense (IG, DoD), the Uniformed Services University of the Health Sciences (USUHS), the Defense Agencies, and DoD Field Activities (hereafter referred to collectively as "DoD Components"). The term "Military Services," as used herein, refers to the Army, Navy, Air Force and Marine Corps.

C. DEFINITIONS

The terms used in this Instruction are defined in enclosure 2.

D. POLICY

1. It is DoD policy to establish a Military-Civilian Health Services Partnership Program (hereafter called the Partnership Program) to integrate specific health care resources between facilities of the Uniformed Services and providers in the civilian health care community. It allows CHAMPUS beneficiaries to receive inpatient care and outpatient services through the CHAMPUS program from civilian personnel providing health care services in MTFs and from uniformed service professional providers in civilian facilities. This policy applies when the MTF is unable to provide sufficient health care services for CHAMPUS beneficiaries through the MTF's own resources.

2. Under this policy:

a. The DoD health care delivery system can operate more efficiently by using the CHAMPUS program to supplement the MTF rather than disengaging the patient to CHAMPUS, the more costly health care component.

b. Health care resources eligible for use under the Partnership Program include providers, support personnel, equipment, and supplies.

c. Charges that accrue to all CHAMPUS beneficiaries for care from a civilian health care provider in the MTF shall be the same as those for MTF patients under the care of a military health care provider (10 U.S.C. 1096(c)), reference (e).

E. RESPONSIBILITIES

1. The Secretaries of the Military Departments shall:

a. Encourage MTF Commanders and their staffs to implement the Partnership Program in their facilities.

b. Educate MTF Commanders and their staffs, beneficiaries, and interested civilian health care personnel about the Partnership Program with the assistance of OCHAMPUS as appropriate.

c. Monitor the savings accrued by using the Partnership Program.

d. Review and evaluate authority related to the Partnership Program operations in the Military Departments.

2. The Surgeons General of the Military Departments shall provide the authority to implement the Partnership Program based on prior approval of their Military Department Secretary.

3. The Director, Office of the Civilian Health and Medical Program of the Uniformed Services, subject to the direction of the Assistant Secretary of Defense (Health Affairs), shall:

a. Promulgate and manage benefit and financial policy issues related to the Partnership Program.

b. Develop a program evaluation process to ensure that the Partnership Program accomplishes the purpose for which it was developed.

c. Provide support for implementation of this Instruction consistent with DoD Instruction 6010.8, reference (b).

d. Provide such information as may be available, upon request, on the use and costs of health care services in a specific geographic area.

e. Develop and provide model partnership agreements to contain terms, conditions and procedures of the partnerships.

4. The Commanders of Military Medical Treatment Facilities, shall:

a. Analyze potential applications of the Partnership Program (including both internal and external partnership agreements) on a case-by-case basis and make a determination prior to entering into each partnership agreement that all of the following criteria are met in that case:

(1) Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.

(2) Use of the Partnership Program is more economical to the Government than referring the need for health care services to the civilian community under the normal operation of the CHAMPUS program.

(3) Use of the Partnership Program is consistent with the mission of the MTF.

(4) Use of the Partnership Program is consistent with high standards of quality health care established for military treatment facilities.

b. In applying the criteria listed in paragraph E.4.a., above, take into account the following points of consideration:

(1) In verifying an unmet need for health care services, consider appointment waiting times, number of Nonavailability Statements issued for a particular service, CHAMPUS use in the area, and other pertinent factors.

(2) In reviewing cost impacts, make a comparison between CHAMPUS costs for that health care service in the community without use of the Partnership Program and providing the service through the Partnership Program. This comparison should take into account the extent, if at all, that the provider in an internal agreement will be supported by his or her own personnel and other resources under his or her direct control and supervision, and in external agreements, the provider fees which would otherwise be applicable under the regular CHAMPUS program.

(3) Ensure that the agreement does not compromise the mission of the facility, and that the health care resources to be provided are consistent with the level and type of health care resources generally provided by the MTF.

(4) Review the capability of the facility's credentialing process and quality assurance program to determine whether they are sufficient to monitor the partnership agreement, and consider both the nature and the number of such agreements for the facility.

c. Ensure that all liability issues relating to the Partnership Program are properly addressed and ensure that the participating civilian health care providers have sufficient liability insurance coverage to protect OCHAMPUS beneficiaries as well as the government.

d. Provide quality assurance controls through the medical staff appointment and reappointment procedures, the specific delineation of clinical privileges, periodic in-depth health care provider review and appraisal, and the stipulation that participating civilian health care providers adhere to MTF instructions and medical staff bylaws to the same extent required of Military Department health care providers. The usual Service procedures will be used to ensure notification of the Federation of State Medical Boards, the National Data Bank, and OCHAMPUS of those practitioners who have had their clinical privileges limited, suspended, or revoked while a participant in the Partnership Program (DoD Directive 6000.7, reference (c)).

e. Ensure that health care services provided CHAMPUS beneficiaries under the terms of the Partnership Program are consistent with the CHAMPUS range of benefits outlined in current DoD Directives and OCHAMPUS operating policies (DoD Directive 6010.8 and DoD 6010.8-R, references (b) and (d)). Services other than authorized CHAMPUS benefits may be provided in the MTF upon approval of the MTF Commander, in which case the MTF will be responsible for paying the health care provider's charges.

f. Ensure that providers who are potential participators in the Partnership Program are given fair selection opportunities to participate in the program through appropriate notification of opportunities, such as notice to local medical and professional societies, and objective selection standards.

g. Require participating health care personnel to the extent practical to use MTF health care resources, that is, specialty consultants, ancillary services, equipment, and supplies, when such resources are available.

h. Assist in providing appropriate administrative support as necessary to expedite participating health care personnel reimbursements, but not in violation of the prohibition against a Government employee acting as a representative for a claimant against the Government as provided for in 18 U.S.C. 203, 205, reference (h).

i. Encourage beneficiaries to use the services available under partnership agreements rather than those available through the regular CHAMPUS program for care that, in the absence of the Partnership Program, would require issuance of a Nonavailability Statement.

j. Compute charges for beneficiaries under the internal partnership agreement (not under external partnership agreements) as charges are computed for MTF care services (10 U.S.C. 1096(c), reference (e)).

k. Ensure that the participating civilian providers:

(1) Meet the licensing and privileging requirements of the MTF with an internal agreement (DoD Directives 6025.4 and 6025.6, references (f) and (g)).

(2) Agree to comply with all rules and procedures of the MTF.

(3) Provide full professional liability insurance covering acts or omission of such health care provider, as well as those of support personnel, not covered by 10 U.S.C. 1089, and other resources supporting that provider to the same extent as is usual and customary in civilian practice in the community.

(4) Qualify as an authorized CHAMPUS provider under DoD 6010.8-R, reference (d).

F. PROCEDURES

1. Before a partnership agreement may be executed and implemented, the commander of the military medical facility involved shall submit the proposed agreement to the Director, OCHAMPUS, or designee, and the Surgeon General of the appropriate Military Department, or designee. The agreement shall be effective in accordance with its terms on the 30th calendar day, or on the day of approval if earlier than the 30th calendar day, after the Director, OCHAMPUS and the Surgeon General receive it. If the agreement is disapproved, a written statement of reasons for disapproval shall be sent to both the military facility involved and either the Surgeon General or OCHAMPUS, whichever is appropriate. Disapproval by either the Surgeon General or OCHAMPUS shall constitute disapproval.

2. A partnership agreement may contain a provision to provide for supplemental care money to be paid to health care providers for active duty care and for other non-CHAMPUS beneficiary cooperative care.

3. A partnership agreement shall not last longer than 2 years with an option to renew for a 2 year period based upon mutual agreement between the military treatment facility and the civilian provider and may be renewed on its expiration in the same manner as new partnership agreements are established.

4. Notification must be made to providers with existing agreements under the Joint Health Benefits Delivery Program (JHBDP) of the Partnership Program and the need to convert the agreement. The converted agreement will be valid upon the signature of the civilian provider and the military medical commander for the duration of the JHBDP agreement. Beginning January 1, 1988, all agreements made under the JHBDP not then converted to partnership agreements shall be deemed to be partnership agreements for the purposes of this Instruction.

G. INFORMATION REQUIREMENTS

The MTF Commander shall provide semi-annual reports to the major medical command for consolidation to the Surgeon General of the appropriate Military Department and to the Director, OCHAMPUS. The reports shall include information on the numbers of partnership agreements in place, new agreements and expired ones during that period, the medical service discipline or provider category associated with the agreement, and an explanation of charges billed under the program. These reports will be due the last working day of June and September of each year.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

William Mayer, M.D.

William Mayer, M.D.
Assistant Secretary of Defense
(Health Affairs)

Enclosures - 4
1. References
2. Definitions
3. Internal Partnership Agreement Model
4. External Partnership Agreement Model

REFERENCES, continued

(e) Title 10, United States Code, Sections 1089, 1096
(f) DoD Directive 6025.4, "Credentialing of Health Care Providers," February 11, 1985
(g) DoD Directive 6025.6, "Licensure of DoD Health Care Providers," July 18, 1985
(h) Title 18, United States Code, Sections 203, 205

DEFINITIONS

1. External Partnership Agreement. An agreement between an MTF Commander (of both hospitals and/or clinics) and a CHAMPUS authorized institutional provider whereby health care personnel employed by a military MTF provide medical services to CHAMPUS beneficiaries in a civilian facility, with authorized costs associated with the use of the facility financed through CHAMPUS in accordance with cost sharing policies outlined in DoD 6010.8-R, reference (d). See Enclosure 4.

2. Health Care Personnel. Full or part-time health care professionals and support personnel.

3. Health Care Providers. Civilian health care services personnel who participate in, and facilities which deliver, clinical patient care and services and who are authorized CHAMPUS providers.

4. Internal Partnership Agreement. An agreement executed between an MTF Commander (of both hospitals and/or clinics) and a CHAMPUS authorized civilian health care provider which will enable the use of civilian health care personnel or other resources to provide medical services to beneficiaries on the premises of the MTF. Charges for this care will be paid through CHAMPUS with beneficiary cost shares computed as for MTF services (10 U.S.C. 1096(c), reference (e)). See Enclosure 3.

5. Other Resources. Equipment, supplies, and any other items or facilities necessary for health care services, but not including health care personnel, when such other resources are used by or are needed to support a health care provider under a partnership agreement.

6. Support Personnel. Non-DoD personnel, not covered by 10 U.S.C. 1089, directly supporting a health care provider under a partnership agreement on the premises of the MTF, under the direct control and supervision of such provider, during the delivery of health care, in the same manner as would be usual and customary in a normal health care office or other applicable clinical setting in the civilian community.

C

MEMORANDUM OF UNDERSTANDING

BETWEEN THE Bayne-Jones Army Community Hospital AND _____

CITY OF Fort Polk STATE OF Louisiana

A. GENERAL

1. This agreement is entered into by and between Bayne-Jones Army Community Hospital, hereinafter referred to as the hospital, and _____, hereinafter referred to as the participating health care provider.

2. The purpose of this agreement is to integrate specific U.S. Army hospital and Office of the Civilian Health and Medical Programs of the Uniformed Services (OCHAMPUS) resources to provide _____ services for Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS) and Non-CHAMPUS beneficiaries in Bayne-Jones Army Community Hospital.

3. The participating health care provider is licensed to practice medicine in the state of Louisiana and has completed application for clinical privileges at the hospital for the purpose of practicing medicine in _____. The participating health care provider agrees to all the terms and conditions of the application for clinical privileges at the hospital as well as the terms and conditions of this Memorandum of Understanding.

4. The hospital is a U.S. Government health care facility within the Department of Defense operated by the U.S. Department of the Army. The hospital is accountable to the Surgeon General of the Department of the Army as the equivalent of the Board of Trustees. The Commander of Bayne-Jones Army Community Hospital is the local representative of the Board of Trustees and is responsible for the operation of the hospital.

5. It is expressly agreed and understood that the professional services rendered by the participating health care provider are rendered in its capacity as an independent contractor. While this Memorandum of Understanding contains provisions to allow the government to evaluate the quality of medical care provided, to credential the participating health care provider, and for certain other administrative requirements, the government retains no control or supervision over the professional aspects of the services rendered by the participating health care provider, including by example its professional medical judgments, disgnoses, or specific medical treatments. The participating health care provider shall be solely liable for any liability producing act or omission by it or its employees or agents and shall idemnify the government against all liability or loss arising from any liability producing act or omissions by it, its employees, or its agents. The participating health care provider shall maintain professional liability insurance which coverage shall apply to the participating health care providers service rendered under this Agreement at Bayne-Jones Army Community Hospital. A certificate of insurance evidencing the required coverage shall be provided prior to the commencement of services under this Agreement.

B. ARTICLES OF AGREEMENT

1. The hospital commander, or designee, shall:

a. Review past and current performances, determine qualifications or (including review of liability insurance coverage) and select potential participating health care providers.

b. Comply with Utilization Review and Quality Assurance Directives and regulations of the Department of the Army, including but not limited to:

(1) Ensuring that participating health care providers are credentialed in accordance with DOD and Military Department regulations and the hospital bylaws.

(2) Ensuring that participating health care providers adhere to the Department of the Army hospital bylaws and DOD and Military Department regulations to the same extent and in the same manner as Department of the Army health care providers.

c. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement to the extent available and authorized for that facility.

d. Provide administrative support to participating health care providers, to the extent available and authorized for that facility, including:

(1) Maintenance of patient records, including transcription and copying service as may be necessary to satisfy both the Department of the Army and private practitioner recordkeeping requirements.

(2) Maintenance of participating health care provider case, workload, and credentials files in support of credentialing processes.

(3) CHAMPUS Claim administration requirements including certification and submission, but only to the extent that it is not prohibited by 18 U.S.C. 203, 205.

(4) Resonable accomodations within the hospital for such periods of time as the participating health care provider may be on after-hours call.

(5) Authorizing subsistence at hospital dining facilities at the rates prescribed for civilian guests.

e. Educate the Department of the Army hospital staff personnel, beneficiaries, participating health care providers and other interested civilian providers about the Partnership Program.

f. Provide appropriate reimbursement for care rendered in the hospital to patients not eligible for CHAMPUS benefits.

g. Encourage beneficiaries to use the services of this agreement rather than other CHAMPUS services for care that, in the absence of the Partnership Program, would require issuance of a Nonavailability Statement.

2. The Participating Health Care Provider shall:

a. Meet the licensing and privileging requirements of the MTF (DoD Directives 6025.4 and 6025.2).

b. Monitor overall inpatient medical care and outpatient services that are directly related to the inpatient medical care of patients referred as a part of this agreement except that portion of care rendered by or at the direction of the Department of the Army health care providers.

c. Provide full professional liability insurance covering acts or omission of such health care provider, as well as those of support personnel not covered by 10 U.S.C. 1089 and other resources supporting that provider as part of this agreement to the same extent as is usual and customary in civilian practical in the community.

d. Provide personal liability coverage applicable to clinical privilieges granted with indemnification of the U. S. Government as a third-party beneficiary.

e. Provide full disclosure of all information, including but not limited to past performances as required by the credentialing process.

f. Abide by hospital bylaws and DoD and Military regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

g. Abide by unique Department of the Army requirements concerning the nature of limited privilged communication between patient and health care provider as may be necessary for security and personnel reliability programs.

h. Use all available Department of the Army resources; that is, specialty consultations, ancillary services, and equipment and supplies for the optimal care of patients under this agreement.

i. Adhere to the CHAMPUS Health Care Provider Agreement (see Annex A) and claim submission requirements concerning allowable payment for services rendered.

j. Provide clerical and/or nursing personnel necessary for the proper care and management of patients under this Memorandum of Understanding.

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power to execute such agreement, to any other person, company, or corporations, without the other party's previous written consent.

2. In the event of an illness or incapacity rendering the participating health care provider incapable of delivering services, care for patients under this agreement shall be transferred to other participating health care providers at the discretion of the Commander of Bayne-Jones Army Community Hospital.

3. The minimum term of this agreement is two years with the option to renew for a 2-year period based upon mutal agreement. Termination of this agreement shall be predicated upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of the government.

4. It is understood that the participating health care provider shall abide by the Department of the Army rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating health care providers shall abide by the Department of the Army regulations concerning release of information to the public, including advance approval from the Department of the Army before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of the hospital, OCHAMPUS and the Assistant Secretary of Defense (Health Affairs).

7. The hospital's liability for actions of its employees (hospital staff and Military Department practitioners, but excluding participating health care providers) is governed by Title 28, U.S.C., Sec 1346 and 2671, et. seq. and Title 10, U.S.C. Sec 1089.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreement effective this _____ day of _____ 1988.

PARTICIPATING HEALTH CARE PROVIDER

_____
NAME

_____

_____
ADDRESS

UNITED STATES OF AMERICA

_____
NAME

_____
TITLE

ANNEX A TO: MEMORANDUM OF UNDERSTANDING BETWEEN THE BAYNE-JONES ARMY COMMUNITY HOSPITAL AND _____, CITY OF FORT POLK STATE OF LOUISIANA

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE
UNIFORMED SERVICES
AURORA, COLORADO 80045

CHAMPUS HEALTH CARE PROVIDER AGREEMENT

THIS AGREEMENT, entered into as of the _____ day of _____, 1988, by and between _____ hereinafter referred to as the participating health care provider, and the United States of America, hereinafter referred to as the government.

WITNESSETH:

WHEREAS, the participating health care provider entered into a Memorandum of Understanding whereby staff at Bayne-Jones Army Community Hospital, hereinafter referred to as the hospital, were conditionally granted by the government through the Department of the Army for _____ care of beneficiaries of the Civilian Health and Medical Program of the Uniformed Services, hereinafter referred to as CHAMPUS; and

WHEREAS, the government, through the Department of the Army is interested in achieving optimum use of existing Health Benefits Program resources authorized under Title 10, United States Code, Chapter 55;

NOW, THEREFORE, in consideration of the aforementioned premises, the parties hereto agree as follows:

1. That the participating health care provider shall apply, have approved, and exercise staff privileges as an independent contractor at the hospital for inpatient medical care and outpatient services that are directly related to the _____ services, furnished to all patients who are CHAMPUS beneficiaries pursuant to the terms of the Memorandum of Understanding entered into with the government.

2. That the participating health care provider shall accept the CHAMPUS-determined allowable charge as payment in full for all CHAMPUS-authorized _____ services furnished to CHAMPUS beneficiaries pursuant to this Agreement.

3. That the participating health care provider shall bill the CHAMPUS office only for the approved amount of the allowable charge for such services, and will neither bill nor collect from the CHAMPUS beneficiary or sponsor any amounts exceeding the CHAMPUS-determined allowable charge for the authorized services.

4. That the participating health care provider, or authorized representative, shall sign the CHAMPUS claim form as prepared by the hospital, confirming that the specific medical care itemized on the claim form was in fact rendered to the beneficiary or patient on the dates indicated and that the health care provider agrees to the CHAMPUS participation agreement on the claim form as modified by this Agreement.

5. That for the purposes of this Agreement only, the CHAMPUS-determined allowable charge shall be the fee schedule attached hereto as attachment 2, as negotiated by the parties and reviewed annually, but in no event shall such allowable charge exceed the prevailing charges, as determined by CHAMPUS methodology, for similar services in the same locality where the participating health care provider furnished the medical care. The participating health care provider shall furnish all service charge information requested by the government necessary for negotiation and review of the attached fee schedule. The participating health care provider is responsible for his or her own self-employment social security tax and income tax. The government will not withhold such payments from fees paid as provided herein.

6. Except as modified by this Agreement, care furnished by the participating health care provider under CHAMPUS shall be subject to DOD 6010.8-R, "Implementation of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 16, 1977, as amended and policy established by OCHAMPUS.

7. That this Agreement shall continue in effect through _____, unless sooner terminated by mutual written agreement of the parties or as otherwise provided hereinafter.

8. That this Agreement may be terminated by the government upon documentation of suspension or revocation of clinical privileges, failure to abide by the provisions of the Agreement, abuse of its provisions or abuse or fraud committed against any agency of the government by the participating health care provider, and that pending any investigation of fraud or abuse, payments due and owing by the government under this Agreement may be suspended by the government.

PARTICIPATING HEALTH CARE PROVIDER	UNITED STATES OF AMERICA
_____	_____
NAME	NAME
_____	_____
_____	TITLE
ADDRESS	

ANNEX B TO: MEMORANDUM OF UNDERSTANDING BETWEEN THE BAYNE-JONES ARMY COMMUNITY HOSPITAL AND _____ CITY OF FORT POLK STATE OF LOUISIANA

I agree to accept the CHAMPUS determined allowable charges for the below listed

_____

MEMORANDUM OF UNDERSTANDING
BETWEEN THE BAYNE JONES ARMY COMMUNITY HOSPITAL
AND _____
CITY OF Fort Polk STATE OF Louisiana

A. GENERAL

1. This agreement is entered into by and between Bayne Jones Army Community Hospital, hereinafter referred to as the hospital, and _____, hereinafter referred to as the participating health care entity. The term "participating health care entity" includes the individual practitioners identified on the attached list.

2. The purpose of this agreement is to integrate specific U.S. Army hospital and Office of the Civilian Health and Medical Programs of the Uniformed Services (OCHAMPUS) program resources to provide _____ services for Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS) beneficiaries in Bayne Jones Army Community Hospital.

3. Individual practitioners identified on the attached list by the participating health care entity are licensed to practice medicine in the State of Louisiana and have completed application for clinical privileges at the hospital for the purpose of practicing medicine in Louisiana. The participating health care entity agrees to all the terms and conditions of the application for clinical privileges at the hospital as well as the terms and conditions of this Memorandum of Understanding.

4. The hospital is a U.S. Government health care facility within the Department of Defense operated by the U.S. Department of the Army. The hospital is accountable to the Surgeon General of the Department of the Army as the equivalent of the Board of Trustees. The commander of the hospital is the local representative of the Board of Trustees and is responsible for the operation of the hospital.

5. It is expressly agreed and understood that the professional services rendered by the participating health care provider are rendered in its capacity an an independent contractor. While this Memorandum of Understanding contains provisions to allow the government to evaluate the quality of medical care provided, to credential the participating health care provider, and for certain other administrative requirements, the government retains no control or supervision over the professional aspects of the services rendered by the participating health care provider, including by example its professional medical judgments, diagnoses, or specific medical treatments. The participating health care provider shall be solely liable for any liability producing act or omission by it or its employees or agents and shall idemnify the government against all liability or loss arising from any liability producing act or omissions by it, its employees, or its agents. The participating health care provider shall maintain professional liability insurance which coverage shall apply to the participating health care providers service rendered under this Agreement at Bayne Jones Army Community Hospital. A certificate of insurance evidencing the required coverage shall be provided prior to the commencement of services under this Agreement.

B. ARTICLES OF AGREEMENT

1. The hospital commander, or designee, shall:

a. Review past and current performance of, determine qualifications of (including review of liability insurance coverage), and select potential participating health care entities.

b. Comply with Utilization Review and Quality Assurance Directives and regulations of the Department of the Army, including but not limited to:

(1) Ensuring that individual practitioners of participating health care entities are credentialed in accordance with DoD and Military regulations and the hospital bylaws.

(2) Ensuring that individual practitioners of participating health care entities adhere to the Department of the Army hospital bylaws and DoD and Military regulations to the same extent and in the same manner as Department of the Army health care providers.

c. Provide facilities, ancillary support, diagnostic and therapeutic services, and equipment and supplies necessary for the proper care and management of patients under this agreement to the extent available and authorized for that facility.

d. Provide administrative support to participating health care entities and individual practitioners to the extent available and authorized for that facility, including:

(1) Maintenance of patient records, including transcription and copying services as may be necessary to satisfy both Department of the Army and private practitioner recordkeeping requirements.

(2) Maintenance of individual practitioner case, workload, and credentials files in support of credentialing processes.

(3) CHAMPUS administration requirements, including certification and submission but only to the extent that it is not prohibited by 18 U.S.C. 203, 205.

(4) Reasonable accommodations within the hospital for such periods of time as a participating health care practitioner may be on after-hours call.

(5) Authorizing subsistence at hospital dining facilities at the rates prescribed for civilian guests.

e. Educate Department of the Army hospital staff personnel, beneficiaries, participating health care entities, and other interested civilian providers about the Partnership Program.

f. Provide appropriate reimbursement for care rendered in the hospital to patients not eligible for CHAMPUS benefits.

g. Encourage beneficiaries to use the services of this agreement rather than other CHAMPUS services for care that, in the absence of the Partnership Program, would require issuance of a Nonavailability Statement.

h. Notify the appropriate Fiscal Intermediary of all additions to or deletions from the attached list of practitioners by the participating health care entity.

2. The Participating Health Care Entity shall:

a. Meet the licensing and privileging requirements of the MTF (DoD Directives 6025.4 and 6025.2).

b. Monitor overall inpatient medical care and outpatient services that are directly related to the inpatient medical care of patients referred as a part of this agreement except that portion of care rendered by or at the direction of Department of the Army health care providers.

c. Provide full professional liability insurance covering acts or omission of such health care provider, as well as those of support personnel not covered by 10 U.S. C. 1089 and other resources supporting that provider as part of this agreement to the same extent as is usual and customary in civilian practice in the community.

d. Provide personal liability coverage applicable to clinical privileges granted with indemnification of the U.S. Government as a third-party beneficiary.

e. Provide full disclosure of all information, including but not limited to past performance as required by the credentialing process.

f. Abide by hospital bylaws and DoD and Military Department regulations with regard to Utilization Review and Quality Assurance Directives, including but not limited to inservice training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing.

g. Abide by Department of the Army requirements concerning the nature of limited privileged communication between patient and health care provider as may be necessary for security and personnel reliability programs.

h. Use all available Department of the Army resources; that is, specialty consultations, ancillary services, and equipment and supplies for the optimal care of patients under this agreement.

i. Adhere to the CHAMPUS Health Care Provider Agreement (see Annex A) and claim submission requirements concerning allowable payment for services rendered.

j. Maintain the currency of the attached list of practitioners by immediately notifying the hospital of all additions and deletions and comply with the preceding articles of agreement for each addition.

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this agreement or the right, title, or interest therein, or the power

to execute such agreement, to any other person, company, or corporations, without the other party's previous written consent.

2. In the event of illness or incapacity rendering a participating health care practitioner incapable of delivering services, care for patients under this agreement shall be transferred to other participating health care practitioners at the discretion of the commander of Bayne Jones Army Community Hospital.

3. The minimum term of this agreement is 2 years with the option to renew for a 2-year period based upon mutual agreement. Termination of this agreement shall be predicated upon satisfactory written notice to the other party not less than 90 days before the proposed termination date. However, the 90-day notice may be waived by mutual consent of the parties to the agreement or unilaterally for the convenience of the government.

4. It is understood that the participating health care entity shall abide by Department of the Army rules concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974.

5. Participating health care entities shall abide by Department of the Army regulations concerning release of information to the public, including advance approval from the Department of the Army before publication of technical papers in professional and scientific journals.

6. It is understood that no care rendered pursuant to this agreement will be a part of a study, research grant, or other test without the written consent of the hospital, OCHAMPUS, and the Assistant Secretary of Defense (Health Affairs).

7. The hospital's liability for actions of its employees (hospital staff and Military Department practitioners, but excluding participating health care entities) is governed by Title 10, United States Code, Section 1089.

IN WITNESS WHEREOF, each of the parties hereunto has executed this agreements effective on this _____ day of _____ 1988.

PARTICIPATING HEALTH CARE ENTITY

_____
NAME

_____
POSITION

_____

_____
ADDRESS

UNITED STATES OF AMERICA

_____
GARLAND E. McCARTY
COL, MC
Commanding

ANNEX A TO: MEMORANDUM OF UNDERSTANDING BETWEEN THE BAYNE-JONES ARMY COMMUNITY HOSPITAL AND _____, CITY OF FORT POLK STATE OF LOUISIANA

DEPARTMENT OF DEFENSE
OFFICE OF CIVILIAN HEALTH AND MEDICAL PROGRAM
OF THE
UNIFORMED SERVICES
AURORA, COLORADO 80045

CHAMPUS HEALTH CARE PROVIDER AGREEMENT

THIS AGREEMENT, entered into as of the _____ day of _____, 1988, by and between _____ hereinafter referred to as the participating health care provider, and the United States of America, hereinafter referred to as the government.

WITNESSETH:

WHEREAS, the participating health care provider entered into a Memorandum of Understanding whereby staff at Bayne-Jones Army Community Hospital, hereinafter referred to as the hospital, were conditionally granted by the government through the Department of the Army for _____ care of beneficiaries of the Civilian Health and Medical Program of the Uniformed Services, hereinafter referred to as CHAMPUS; and

WHEREAS, the government, through the Department of the Army is interested in achieving optimum use of existing Health Benefits Program resources authorized under Title 10, United States Code, Chapter 55;

NOW, THEREFORE, in consideration of the aforementioned premises, the parties hereto agree as follows:

1. That the participating health care provider shall apply, have approved, and exercise staff privileges as an independent contractor at the hospital for inpatient medical care and outpatient services that are directly related to the _____ services, furnished to all patients who are CHAMPUS beneficiaries pursuant to the terms of the Memorandum of Understanding entered into with the government.

2. That the participating health care provider shall accept the CHAMPUS-determined allowable charge as payment in full for all CHAMPUS-authorized _____ services furnished to CHAMPUS beneficiaries pursuant to this Agreement.

3. That the participating health care provider shall bill the CHAMPUS office only the approved allowable charge for such services, and will neither bill nor collect from the CHAMPUS beneficiary or sponsor any amounts exceeding the CHAMPUS-determined allowable charge for the authorized services.

4. That the participating health care provider, or authorized representative, shall sign the CHAMPUS claim form as prepared by the hospital, confirming that the specific medical care itemized on the claim form was in fact rendered to the beneficiary or patient on the dates indicated and that the health care provider agrees to the CHAMPUS participation agreement on the claim form as modified by this Agreement.

5. That for the purposes of this Agreement only, the CHAMPUS-determined allowable charge shall be the fee schedule attached hereto as attachment 2, as negotiated by the parties and reviewed annually, but in no event shall such allowable charge exceed the prevailing charges, as determined by CHAMPUS methodology, for similar services in the same locality where the participating health care provider furnished the medical care. The participating health care provider shall furnish all service charge information requested by the government necessary for negotiation and review of the attached fee schedule. The participating health care provider is responsible for his or her own self-employment social security tax and income tax. The government will not withhold such payments from fees paid as provided herein.

6. Except as modified by this Agreement, care furnished by the participating health care provider under CHAMPUS shall be subject to DOD 6010.8-R, "Implementation of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," January 16, 1977, as amended and policy established by OCHAMPUS.

7. That this Agreement shall continue in effect through _____, unless sooner terminated by mutual written agreement of the parties or as otherwise provided hereinafter.

8. That this Agreement may be terminated by the government upon documentation of suspension or revocation of clinical privileges, failure to abide by the provisions of the Agreement, abuse of its provisions or abuse or fraud committed against any agency of the government by the participating health care provider, and that pending any investigation of fraud or abuse, payments due and owing by the government under this Agreement may be suspended by the government.

PARTICIPATING HEALTH CARE PROVIDER	UNITED STATES OF AMERICA
_____	_____
NAME	NAME
_____	_____
_____	TITLE
ADDRESS	

ANNEX B TO: MEMORANDUM OF UNDERSTANDING BETWEEN THE BAYNE-JONES ARMY COMMUNITY HOSPITAL AND _____ CITY OF FORT POLK STATE OF LOUISIANA

We agree to accept the CHAMPUS determined allowable charges for the below listed

D

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
Fort Polk, Louisiana 71459-6000

MEDDAC Memorandum
Number 5-1

11 July 1989

Management
MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

1. PURPOSE. This memorandum establishes policy guidance for the Military-Civilian Health Services Partnership Program. It includes establishing Memorandums of Understanding (MOUs) as well as operating under the provisions of these MOUs.

2. SCOPE. The Military-Civilian Health Services Partnership Program allows civilian physicians to treat CHAMPUS beneficiaries and non-eligible CHAMPUS beneficiaries in a military treatment facility (MTF). This program will primarily be used for outpatient services. Contracts with civilian physicians under OMA funded contracts and the Direct Health Care Provider Program (DHCPP) are not considered under this program.

3. REFERENCE.

a. DoD Instructions 6010.12, "Joint Health Benefits Delivery Program", dated October 22, 1987.

b. HSCL-M letter, dated 29 January 1988, subject: Implementation of Military-Civilian Health Services Partnership Program.

c. AR 40-66, "Medical Records and Quality Assurance Administration", dated 1 April 1987.

d. AR 40-121, "Uniform Services Health Benefits Program", dated 15 April 1985.

e. HSCL-M letter, dated 18 May 1988, subject: Military-Civilian Health Services Partnership Program: Appointment No-Show Policy.

f. HSCL-M Information Paper, dated 8 September 1988, subject: Malpractice Insurance for Physicians Under the Partnership.

4. GENERAL.

a. The program allows the MTF commander to use supplemental care funds to

provide for the treatment of non-eligible CHAMPUS beneficiaries at the negotiated rates.

b. The prices negotiated with civilian physicians will reduce overall government expenditures for health care services. Beneficiaries save also because they do not have to pay the CHAMPUS copayment and deductible.

c. Selection criteria for selecting a Partnership Program provider will, as a minimum, include:

(1) Board certification in specialty.

(2) Proximity to BJACH for patient care continuity.

(3) Responsiveness to needs of BJACH.

(4) Capability for coverage of providers' absences.

(5) Provision of ancillary/support personnel to BJACH.

(6) Price of services.

d. A Flowchart depicting the action sequence of responsible offices is at Annex B.

5. RESPONSIBILITIES.

a. Department and Services Chiefs will:

(1) Identify physician or other health care provider services that are not sufficiently available in the MEDDAC.

(2) Communicate these needs to the DCCS. The justification for these services should consider appointment backlog, number of nonavailability statements issued, etc.

b. The DCCS will:

(1) Initiate the process of bringing in Partnership Providers by submitting a statement certifying that the services of the provider is necessary. Commander, MEDDAC should sign this statement. See example Memo at Annex A.

(2) Verify need for health care services by considering: appointment backlog, number of Nonavailability Statements issued, CHAMPUS use in the area, Supplemental Care Program usage and other pertinent factors.

(3) Specify in writing the daily working hours and the days per week each participating provider will work and provide this information to Resource Management Division. See example Memo at Annex A.

(4) Determine that the use of the Partnership Program is consistent with high standards of quality health care established for military treatment facilities.

(5) Define the Scope of Practice for participating physicians in the Partnership Program.

(6) Ensure that participating health care providers comply with all rules, regulations, and procedures of the MTF.

(7) Assign sponsorship responsibility for the partnership program provider. The department chief of the practitioner's specialty will act as the sponsor and will provide an overview of expected clinical practice, hospital mission and orientation, formulary overview, pharmacy signature card, committee review, etc.

c. Resource Management Division will:

(1) Contact all potential health care providers within 10 working days (based on DCCS input, Annex A) to determine their rates, availability, and willingness to participate. Letters should explain minimal insurance coverage needed, credentialing requirements, and provide other information as appropriate. Additionally, the letters should state which other offices may be contacting them.

(2) Ensure that providers who are potential participants in the Partnership Program are given fair selection opportunities to participat· in the program through appropriate notification of opportunities.

(3) Analyze applications from interested civilian physicians on a case-by-case basis and make a determination prior to entering into each partnership agreement, that all the following criteria are met.

(a) Service to be provided will meet a need for health care services that are not adequately being met by, and/or cannot be met with, existing MTF resources.

(b) The Partnership agreement will be more economical to the Government that under the normal operation of the CHAMPUS program.

(c) Use of the Partnership Program is consistent with the mission of the MTF.

(4) Present information on the interested candidates to a selection committee comprised of the following officers: Deputy Commander for Administration, Deputy Commander for Clinical Services, Chief, Department of Nursing, Chief, Resource Management Division, and Chief, Clinical Support Division plus one other individual from the depart.ent/service concerned (i.e., Chief, Department of Medicine). The committee will recommend a provider IAW criteria in para 4c to the Commander.

(5) Act as recorder to the committee which recommends partnership program health care providersto the Commander.

(6) Forward the recommendation of the committee to the Commander.

(7) Contact and coordinate with the providers selected by the Commander to ensure all information needed to prepare the Memorandum of Understanding (MOU) is received.

(8) Prepare a rate schedule listing procedure, code, and allowable rate for each procedure. The maximum allowable rate is determined by CHAMPUS.

(9) Prepare the Memorandum of Understanding (MOU) between the medical treatment facility and the provider using the format listed in DOD Instruction 6010.12, dated 22 October 1987. Forward the completed MOU with completed rate schedule to the participating provider for signature. After the provider signs and returns the MOU, forward the MOU with rate schedule to the Commander, USAMEDDAC for his signature and notify the DCCS.

(10) Prepare an estimate of cost savings. The estimate must show that there is a savings to the government (in addition to the patient). The savings will be comprised of saving per procedure as well as ancillary savings.

(11) Forward the signed original MOU and estimate of cost savings to the CHAMPUS Fiscal Intermediary (FI) serving the MTF for approval. A copy of the MOU and cost estimate is also forwarded to Headquarters, Health Services Command for approval. The FI and HSC have 30 days to approve or disapprove. If no disapproval is received, then the MOU is approved.

(12) Notify, after the coordination with the Commander, DCCS, PAD, and CSD, the provider of the start date of services. Provide the participating provider with the name of the CSD point of contact who will coordinate office areas, supplies, etc.

(13) Establish a file for each Partnership MOU which contains as a minimum: DCCS statement that the services are necessary, QA statement that the provider is credentialed, approved MOU (with rate schedule), and certificate of insurance.

(14) Forward claims for payment for other than CHAMPUS beneficiaries to Finance & Accounting after C, PAD has certified the claims are proper for payment.

(15) Send one copy of the completed MOU (including rate schedule) to PAD for use in processing and verifying CHAMPUS claims submissions.

(16) Renew existing MOU's at least annually and not longer than biannually in the same manner as new partnership MOU's are established.

(17) Prepare and send quarterly reports to HSC and OCHAMPUS. The reports shall include information on the numbers of partnership MOU's in place, new MOU's and expired ones during that period, the medical service discipline or provider category associated with the MOU, and an explanation of charges billed under the program. Reports are due the last working day of the month following the end of the quarter.

(18) Provide a copy of the certificate of insurance to the QA Coordinator for inclusion in the credentials file.

(19) Ensure that all liability issues relating to the Partnership Program are properly addressed and ensure that the participating civilian health care providers carry liability insurance coverage which is usual and customary for their specialty to protect CHAMPUS beneficiaries as well as the government. Participating physicians will be considered to have met this requirement by:

(a) Participating in the Louisiana Patient Compensation Fund (L.A.R.S. 40:1299,41-40:1299.48); or

(b) Maintaining liability insurance in the amount of $1,000,000 per incident during the term of the MOU.

1 The liability insurance may be on either an occurrences basis or on a claims made basis. If the policy is on a claims made basis, an extended reporting endorsement (tail) for a period of no less than 3 years after the end of the MOU term must also be provided.

2 A certificate of insurance evidencing the required coverage shall be provided to the RMD prior to the commencement of services under this MOU.

3 The policies evidencing required insurance shall also contain an endorsement to the effect that any cancellation or any material change adversely affecting the Government's interest shall not be effective until 30 days after RMD has received written notice from the insurer or the participating physician. If during the performance period of the MOU, the participating physician changes insurance providers, the physician must provide evidence that the Government will be indemnified to the limits specified for the entire period of the MOU either under the new policy or a combination of old and new policies.

d. The Quality Assurance Coordinator will:

(1) Provide quality assurance controls through the medical staff appointment and reappointment procedures, the specific delineation of clinical privileges, periodic in-depth health care provider review and appraisal, and the stipulation that participating civilian health care providers adhere to MTF instructions and medical staff bylaws to the same extent required of Military Department health care providers. The appropriate service procedures

will be used to ensure notification of HSC and the Surgeon General's Office of those practitioners who have had their clinical privileges limited, suspended, or revoked while a participant in the Partnership Program.

(2) Submit to Resource Management Division the names of credentialed providers.

e. Patient Administration Division will:

(1) Ensure that health care services are provided IAW current DoD Directives and OCHAMPUS operating policies (DoD Directive 6010.8 and DoD 6010.8R).

(2) Review all CPT Codes for correctness prior to solicitation.

(3) Verify eligibility for CHAMPUS and Supplemental care.

(4) Ensure that services other than authorized CHAMPUS benefits (i.e., supplemental care) have been approved by the Commander.

(5) Assist in providing administrative support as necessary to expedite the processing of participating health care provider reimbursements, but not in violation of the prohibition against a Government employee acting as a representative for a claimant against the Government as provided for in 18 U.S.C. 203, 205.

(6) Encourage beneficiaries to use the services available under partnership agreements rather than those available through the regular CHAMPUS program when in the best interest of the patient and the government (e.g. public meetings).

(7) Prepare, certify, and forward to Resource Management Division, Budget Branch, all SF 1034's with invoices for payment of charges for other than CHAMPUS beneficiaries (supplemental care for active duty soldiers).

(8) Forward to Resource Management Division an explanation of charges billed under the program by CPT Code monthly.

(9) Report and verify the workload statistics for CHAMPUS and Supplemental care patients treated IAW existing procedures.

(10) Responsible for conducting Simple Random Sampling audits of claims to ensure compliance with CHAMPUS and other appropriate regulations.

f. C, Clinical Support Division will:

(1) Coordinate with the DCCS to determine which specific procedures (by Current Procedure Terminology code) are necessary upon notification (from

clinicians or DCCS) that a need for a partnership provider exists. The DCCS will provide this information to C, Clinical Support Division, C, Patient Administration Division; and C, Resource Management Division. See Annex A for example.

(2) Coordinate the approved start date (per OCHAMPUS and HSC) of the provider with the DCCS and other appropriate staff elements. This coordination will be in writing.

(3) Notify the Credentialing Committee of Partnership Providers who must be credentialed.

(4) Determine hospital location for the partnership provider and administrative support.

(5) Provide receptionist/administrative support.

(6) Coordinate with clinic NCOIC that will have responsibility for the Partnership provider to ensure that those necessary supplies are available prior to the start date of provider's services.

(7) Ensure that the clinic NCOIC appropriately hand receipts all government equipment that the Partnership practitioner will utilize, and that the clinic NCOIC performs periodic hand receipt checks to ensure accountability.

(8) Monitor the use of supplies through the use of the CPD system for internal control purposes.

(9) Ensure that appropriate signs are conspicuously placed in patient waiting areas that state the following:

MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM

The following non-DOD affiliated, private health care practitioners are providing services at Bayne-Jones Army Community Hospital for your convenience through the Military-Civilian Health Services Partnership Program:

PRACTITIONERS SERVICES

Your use of the Partnership Program is voluntary. Questions or comments about the Partnership Program should be addressed to: Commander, USAMEDDAC, ATTN: HSXV-RMD, Fort Polk, LA 71459-6000, telephone extension 3114.

(10) Provide a welcome packet and letter which will be mailed to the practitioner prior to his/her arrival. Noted in the welcome letter will be a POC for administrative matters (CSD) and professional matters (dept chief).

(11) Coordinate orientation visits with C, PAD for final patient administration guidance and with the department chief of service responsible for partnership provider services.

g. Utilization Review Committee will:

(1) Review the resource utilization and workload generated by the participating physicians on a semi-annual basis.

(2) Resolve discrepancies brought forward by C, PAD which are noted between the participating physician MOU and the negotiated percentage of the CHAMPUS allowable charge.

h. Department of Nursing will provide orientation to any nursing personnel who are participating in the partnership program (either as a provider or an assistant).

The proponent agency of this memorandum is the Resource Management Division. Users are invited to send comments to the Commander, USAMEDDAC, ATTN: HSXV-RMD, Fort Polk, Louisiana 71459-6000.

FOR THE COMMANDER:

OFFICIAL

DOUGLAS A. BARTON
COL, MS
Deputy Commander for Administration

ANNEXES
A - Memorandum (DCCS Recommendation)
B - Flowchart

DISTRIBUTION
H
RMD-20

ANNEX A

HSXV-DCCS (Date)

MEMORANDUM THRU C, Patient Administration Division

THRU C, Clinical Support Division

THRU QA Coordinator

FOR C, Resource Management Division

SUBJECT: Military-Civilian Health Services Partnership Program

1. BJACH has an unfulfilled demand for (NAME OF SPECIALTY) services. These needs are not being adequately met by existing MTF resources. This is evidenced by: _____ (list here reasons, i.e., backlog, number of nonavailability statements issued, etc.).

2. The specific procedures BJACH needs are:

CPT CODE	NAME OF PROCEDURE	ESTIMATED QUANTITY

3. Once the Memorandum of Agreement is signed by (NAME OF PROVIDER) and the Commander, BJACH, and then is approved by USAHSC and OCHAMPUS, (NAME OF PROVIDER) will provide (NAME OF SPECIALTY) services (NUMBER OF DAYS PER WEEK), from (HOURS SERVICES WILL BE PROVIDED).

4. The target start date is: _____. This will allow time for the credentialing process to be completed and for the 35 day HSC/CHAMPUS approval process.

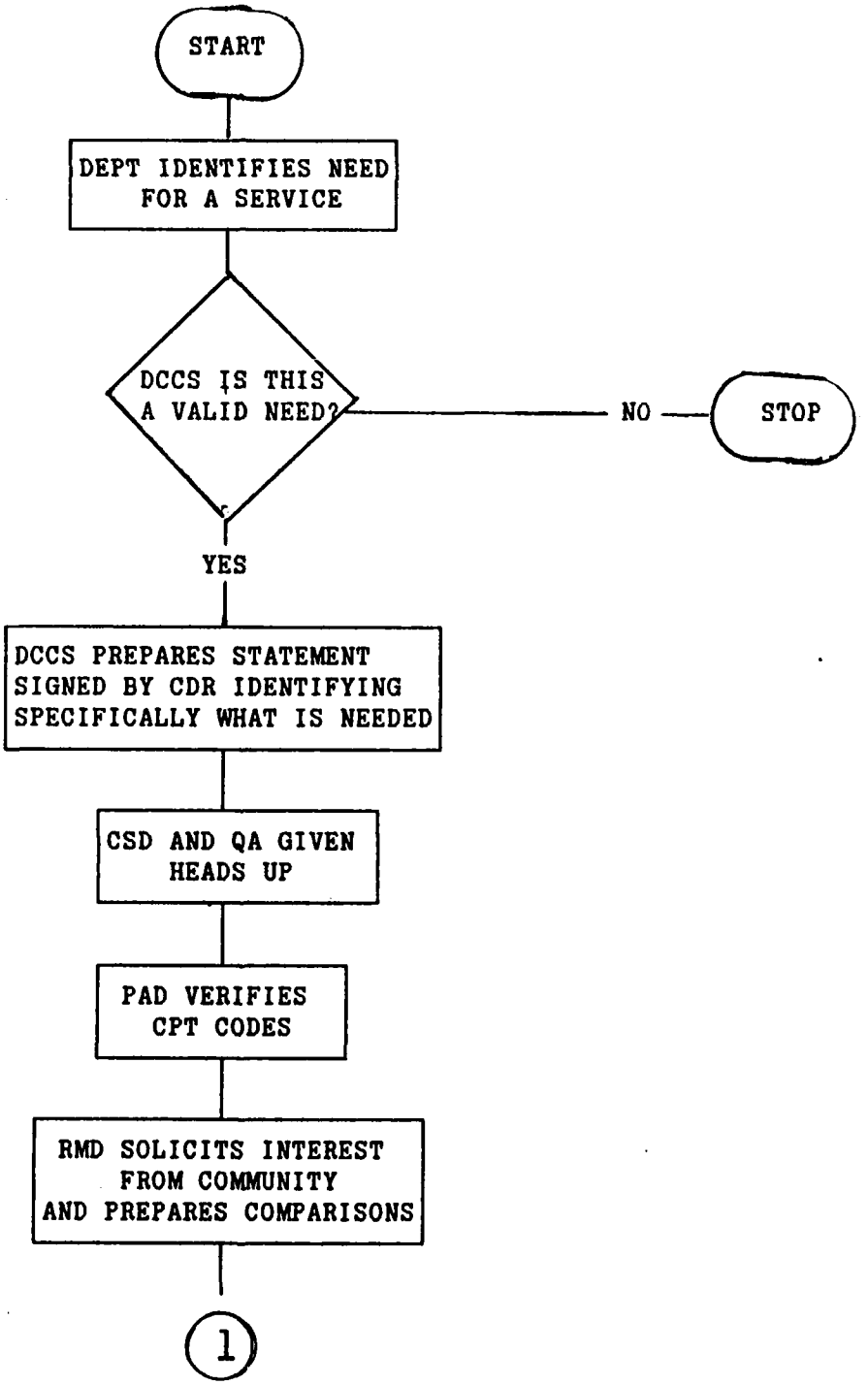
5. (NAME OF PROVIDER), (ADDRESS), (TELEPHONE NUMBER) has indicated he/she is willing to participate in the Military-Civilian Health Service Partnership Program to provide these services to BJACH.

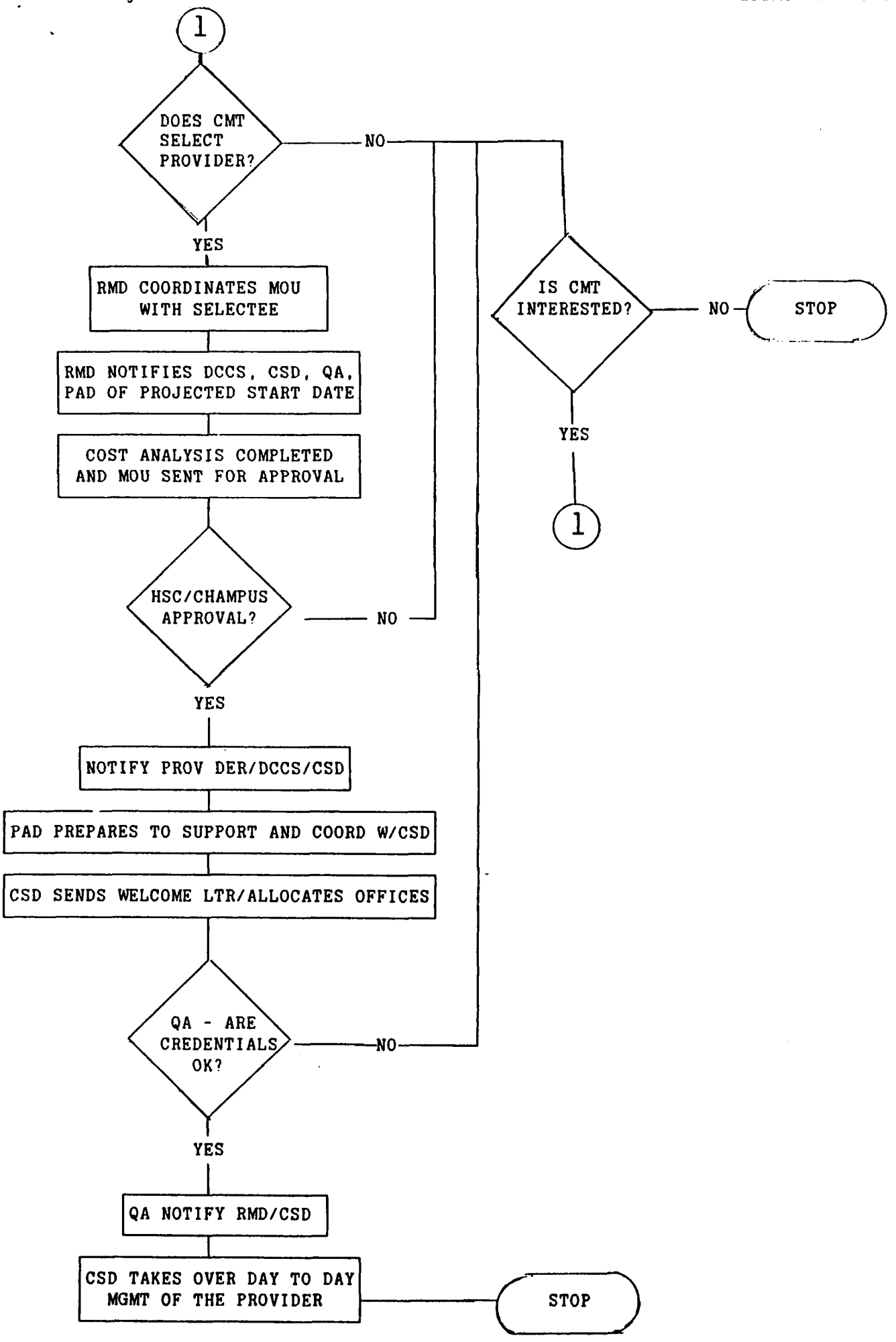
FRED A. CECERE
COL, MC
Commanding

CF:
Deputy Cdr for Admin
C, Log Div
C, Dept of Nursing

ANNEX B

PARTNERSHIP FLOW CHART RESPONSIBILITY





RAPS FY87 BASELINE POPULATIONS

MAY 31, 1989
09:51:40

BAYNE-JONES AH FT POLK

POPULATION BY SPONSOR SERVICE BRANCH

ONSOR RVICE	ACTIVE DUTY COUNT	DEPS OF ACT DTY COUNT	RETIRED COUNT	DEPS OF RETIRED COUNT	DEPS OF RETIRED ADD EST	SURVIV COUNT	TOTAL
RMY	14694	20595	1663	3000	171	439	40562
AVY	1	6	134	171	35	13	360
FLOAT	0	1	--	--	--	--	1
SMC	0	0	21	25	8	11	65
SAF	65	98	267	365	24	45	864
SCG	0	0	1	4	0	0	5
THER	0	0	0	0	0	15	15
OTAL	14760	20700	2086	3565	238	523	41872

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"REPRODUCED AT GOVERNMENT EXPENSE"

RAPS POPULATION PROJECTION REPORT
FY88 BASED UPON FY87 BASELINE
BAYNE-JONES AH FT POLK

MAY 31, 1989
09:51:40

POPULATION BY SPONSOR SERVICE BRANCH

ONSOR RVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
RMY	14617	20484	1693	3036	172	444	40436
AVY	1	6	136	172	35	13	362
FLOAT	0	1	--	--	--	--	1
SMC	0	0	21	25	8	11	65
SAF	65	98	271	369	24	45	872
SCG	0	0	1	4	0	0	5
THER	0	0	0	0	0	15	15
OTAL	14683	20589	2111	3606	239	528	41756

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RAPS POPULATION PROJECTION REPORT — MAY 31, 1989
FY89 BASED UPON FY87 BASELINE — 09:51:40
BAYNE-JONES AH FT POLK

POPULATION BY SPONSOR SERVICE BRANCH

ONSOR RVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
RMY	14672	20582	1708	3081	174	451	40648
AVY	1	6	138	177	35	13	370
FLOAT	0	1	--	--	--	--	1
SMC	0	0	21	25	8	11	65
SAF	65	98	276	378	24	46	887
SCG	0	0	1	4	0	0	5
THER	0	0	0	0	0	15	15
OTAL	14738	20667	2144	3665	241	536	41991

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"REPRODUCED AT GOVERNMENT EXPENSE"

RAPS POPULATION PROJECTION REPORT — MAY 31, 1989
FY90 BASED UPON FY87 BASELINE — 09:51:40
BAYNE-JONES AH FT POLK

POPULATION BY SPONSOR SERVICE BRANCH

ONSOR RVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
RMY	14672	20562	1727	3116	174	456	40707
AVY	1	6	141	181	38	13	380
FLOAT	0	1	--	--	--	--	1
SMC	0	0	21	25	8	11	65
SAF	65	98	280	382	24	47	896
SCG	0	0	1	4	0	0	5
THER	0	0	0	0	0	15	15
OTAL	14738	20667	2170	3708	244	542	42069

Up Home [Alt-C] - Clear Buffer Bytes Queued = 0
Region PgDn End [Alt-S] - Save to Disk [Esc] - Quit

RAPS POPULATION PROJECTION REPORT — MAY 31, 1989
FY91 BASED UPON FY87 BASELINE — 09:51:40
BAYNE-JONES AH FT POLK

POPULATION BY SPONSOR SERVICE BRANCH

SPONSOR SERVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
ARMY	14672	20562	1745	3152	176	461	40768
NAVY	1	6	143	184	38	13	385
AFLOAT	0	1	--	--	--	--	1
USMC	0	0	21	25	8	11	65
USAF	65	98	284	387	26	48	908
USCG	0	0	1	4	0	0	5
OTHER	0	0	0	0	0	15	15
TOTAL	14738	20667	2194	3752	248	548	42147

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RAPS POPULATION PROJECTION REPORT — MAY 31, 1989
FY92 BASED UPON FY87 BASELINE — 09:51:40
BAYNE-JONES AH FT POLK

POPULATION BY SPONSOR SERVICE BRANCH

SPONSOR SERVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
ARMY	14672	20562	1764	3183	179	465	40825
NAVY	1	6	146	186	38	14	391
AFLOAT	0	1	--	--	--	--	1
USMC	0	0	21	25	8	11	65
USAF	65	98	287	392	26	48	916
USCG	0	0	1	4	0	0	5
OTHER	0	0	0	0	0	15	15
TOTAL	14738	20667	2219	3790	251	553	42218

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RAPS POPULATION PROJECTION REPORT
FY93 BASED UPON FY87 BASELINE
BAYNE-JONES AH FT POLK

MAY 31, 1989
09:51:40

POPULATION BY SPONSOR SERVICE BRANCH

SPNSOR SERVICE	ACTIVE DUTY	DEP ACT DTY	RETIRED	DEP RETIRED ENROLL	DEP RETIRED PTN ENR	SURVIV	TOTAL
ARMY	14672	20562	1780	3212	183	471	40880
NAVY	1	6	147	190	38	14	396
NFLOAT	0	1	--	--	--	--	1
USMC	0	0	21	25	8	11	66
USAF	65	98	290	396	26	48	923
USCG	0	0	1	4	0	0	5
OTHER	0	0	0	0	0	15	15
TOTAL	14738	20667	2239	3827	255	559	42285

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F

Outpatient Clinic Visits - Fiscal Year 1988
by CHAMPUS Eligible Beneficiaries
Bayne-Jones Army Community Hospital
(Source: MED-302 Reports Oct 1987 - Sep 1988)

	Internal Medicine	Dermatology	Neurology	Nutrition	General Surg	Opthalmology
Oct87	679	368	20	91	347	173
Nov87	692	271	21	59	328	120
Dec87	479	221	25	61	308	126
Jan88	488	351	31	72	323	176
Feb88	716	304	51	93	380	186
Mar88	749	447	45	91	357	162
Apr88	550	348	34	75	375	129
May88	502	195	21	68	328	208
Jun88	360	48	27	74	398	109
Jul88	343	187	20	136	313	206
Aug88	639	381	27	170	389	154
Sep88	632	325	38	204	371	231
Total:	6829	3446	360	1194	4217	1980
Average:	569.08	287.17	30.00	99.50	351.42	165.00

Outpatient Clinic Visits - Fiscal Year 1988
by CHAMPUS Eligible Beneficiaries
Bayne-Jones Army Community Hospital
(Source: MED-302 Reports Oct 1987 - Sep 1988)

	Otorhinolaryngol	Urology	Gynecology	Obstetrics	Pediatrics	Adolescent Peds
Oct87	184	18	358	811	1097	132
Nov87	159	0	275	728	1001	107
Dec87	111	22	271	670	1012	74
Jan88	153	21	443	839	1236	127
Feb88	164	0	485	841	1462	139
Mar88	178	11	285	856	1116	121
Apr88	223	12	447	784	1069	87
May88	176	11	475	803	551	82
Jun88	120	0	349	974	801	34
Jul88	168	0	304	916	273	29
Aug88	186	0	365	755	338	64
Sep88	197	0	342	398	348	87
Total:	2019	95	4399	9875	10304	1083
Average:	168.25	7.92	366.58	822.92	858.67	90.25

Outpatient Clinic Visits - Fiscal Year 1988
by CHAMPUS Eligible Beneficiaries
Bayne-Jones Army Community Hospital
(Source: MED-302 Reports Oct 1987 - Sep 1988)

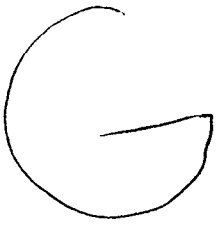
	Well Baby	Orthopedic	Podiatry	Psychiatry	Psychology	Mental Health
Oct87	84	266	31	186	358	0
Nov87	70	226	71	192	289	0
Dec87	63	225	72	146	234	0
Jan88	79	192	98	212	248	0
Feb88	63	226	62	264	305	0
Mar88	104	253	52	369	363	0
Apr88	145	236	71	549	284	0
May88	143	276	74	333	250	0
Jun88	172	221	80	0	0	584
Jul88	187	178	47	64	71	271
Aug88	193	250	63	71	164	327
Sep88	190	267	65	41	155	356
Total:	1493	2816	786	2427	2721	1538
Average:	124.42	234.67	65.50	202.25	226.75	128.17

Outpatient Clinic Visits - Fiscal Year 1988
by CHAMPUS Eligible Beneficiaries
Bayne-Jones Army Community Hospital
(Source: MED-302 Reports Oct 1987 - Sep 1988)

	Family Practice	Optometry	Audiology	Speech Path	Emerg Medical	Inhal/RespTherp
Oct87	4740	50	74	94	2159	34
Nov87	4741	53	78	74	1934	39
Dec87	4555	42	116	93	1994	12
Jan88	4676	65	130	97	2546	13
Feb88	4574	97	133	94	2452	34
Mar88	4778	243	183	141	2440	23
Apr88	3963	171	146	100	2139	22
May88	4279	257	116	121	2642	22
Jun88	3502	236	186	108	2006	41
Jul88	2792	240	134	0	2060	12
Aug88	4535	236	159	0	2133	10
Sep88	4489	248	109	0	2176	22
Total:	51624	1938	1564	922	26681	284
Average:	4302.00	161.50	130.33	76.83	2223.42	23.67

Outpatient Clinic Visits - Fiscal Year 1988
by CHAMPUS Eligible Beneficiaries
Bayne-Jones Army Community Hospital
(Source: MED-302 Reports Oct 1987 - Sep 1988)

	Occup Therapy	Physical Therapy	Social Work	CommunHlthNurse
Oct87	330	269	340	161
Nov87	222	288	300	43
Dec87	314	194	228	93
Jan88	348	279	292	133
Feb88	274	276	260	139
Mar88	336	325	339	122
Apr88	340	265	254	104
May88	331	333	288	112
Jun88	273	261	367	108
Jul88	282	211	349	153
Aug88	401	243	524	175
Sep88	358	159	662	105
Total:	3809	3103	4203	1448
Average:	317.42	258.58	350.25	120.67



REPORT SPECIFICATIONS PAGE

THIS REPORT SUMMARIZES EXPENDITURE AND UTILIZATION DATA. INPATIENT AND OUTPATIENT DATA ARE PROVIDED FOR TWENTY-SEVEN MEDICAL CATEGORIES, WITH GRAND TOTALS. THE REPORTS ARE BASED ON BENEFICIARY RESIDENCE ZIP CODE. FOR CATCHMENT AREA REPORTS, THE MILITARY HEALTH SERVICES SYSTEM CATCHMENT AREA DIRECTORY IN EFFECT DURING THE REPORT PERIOD IS USED TO DETEMINE THE CATCHMENT AREAS.

THIS REPORT EXCLUDES THE FOLLOWING TYPES OF DATA: CHAMPVA; CONTRACTOR-DENIED CLAIMS; CLAIMS WITH ZERO GOVERNMENT OR CONTRACTOR COST; PROGRAM FOR THE HANDICAPPED; ADJUNCTIVE DENTAL; AND OUTPATIENT DRUG CLAIMS. ALL FOREIGN COUNTRY CLAIMS ARE INCLUDED. BILLED CHARGES FOR DENIED LINE ITEMS ARE INCLUDED, BUT THE NUMBER OF SERVICES IS NOT.

THIS REPORT REFLECTS CARE PROVIDED UNDER CHAMPUS IN A MOVING 12-MONTH PERIOD. THE DATA COLLECTION PERIOD IS 15 MONTHS. SEE THE "USER'S GUIDE FOR THE CHAMPUS WORKLOAD REPORTS" FOR ESTIMATED COMPLETION RATES.

THE REPORT CONTAINS STANDARD CHAMPUS, CHAMPUS REFORM INITIATIVE (CRI), AND MENTAL HEALTH DEMONSTRATION (NORFOLK, VA) DATA. HOWEVER, THE CRI DATA ARE INCOMPLETE.

FOR MORE DETAILED INFORMATION ABOUT THIS REPORT, REFER TO THE USER'S GUIDE.

OCHAMPUS
INFORMATION SYSTEMS DIVISION
STATISTICS BRANCH
MARCH 1989

HR01

********** CATEGORY OF CARE - INTERNAL MEDICINE **********

	ADVERSE REACTIONS	ALLERGY	CARDIOLOGY (VASCULAR DISEASE)	DERMATOLOGY	ENDOCRINOLOGY	GASTRO-ENTEROLOGY	HEMATOLOGY
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	7	2	26	3	3	13	2
DEPNT OF ACT DUTY SPONSOR	6	2	4	2	1	11	0
RETIREE	0	0	14	0	2	0	0
DEPNT OF RET OR DEC SPONSOR	1	0	8	1	0	2	2
TOTAL HOSPITAL ADMISSIONS	8	2	33	3	2	13	2
HOSPITAL DAYS	23	12	134	35	4	34	9
AVERAGE LENGTH OF STAY (DAYS)	2.88	6.00	4.06	11.67	2.00	2.62	4.50
AVERAGE DAILY PATIENT LOAD	0.06	0.03	0.37	0.10	0.01	0.09	0.02
TOTAL GOVERNMENT COST	10,180	3,874	99,031	3,485	2,426	13,589	2,340
TOTAL PATIENT COST	1,506	2,042	32,058	4,126	1,032	2,419	1,466
TOTAL GOVT AND PATIENT COST	11,686	5,916	131,089	7,611	3,458	16,008	3,806
AVG GOVT COST PER ADMISSION	1,272.50	1,937.00	3,000.94	1,161.67	1,213.00	1,045.31	1,170.00
AVG GOVT COST PER DAY	442.61	322.83	739.04	99.57	606.50	399.68	260.00
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	13	6	57	7	5	30	6
DEPNT OF ACT DUTY SPONSOR	10	5	16	5	0	17	3
RETIREE	0	1	24	1	2	5	1
DEPNT OF RET OR DEC SPONSOR	3	0	17	1	3	8	2
NUMBER OF VISITS	21	24	250	46	17	85	16
NUMBER OF NON-VISIT SERVICES	46	1	476	5	1	56	28
TOTAL GOVERNMENT COST	7,599	995	52,283	1,925	653	6,049	842
TOTAL PATIENT COST	1,392	328	60,944	457	238	1,531	430
TOTAL GOVT AND PATIENT COST	8,991	1,323	113,227	2,382	891	7,580	1,272
III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	15	6	59	7	7	34	7
DEPNT OF ACT DUTY SPONSOR	11	5	16	5	1	20	3
RETIREE	0	1	25	1	3	5	1
DEPNT OF RET OR DEC SPONSOR	4	0	18	1	3	9	3
TOTAL GOVERNMENT COST	17,780	4,868	151,314	5,410	3,079	19,638	3,182
TOTAL PATIENT COST	2,898	2,371	93,002	4,583	1,271	3,950	1,897
TOTAL GOVT AND PATIENT COST	20,678	7,239	244,316	9,993	4,350	23,588	5,079
AVG GOVT COST PER ADMISSION	2,222.50	2,434.00	4,585.27	1,803.33	1,539.50	1,510.62	1,591.00
AVG GOVT COST PER DAY	773.04	405.67	1,129.21	154.57	769.75	577.59	353.56
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	109	107	337	361	124	382	40
DEPNT OF ACT DUTY SPONSOR	77	66	76	250	37	238	30
RETIREE	10	3	108	30	32	46	3
DEPNT OF RET OR DEC SPONSOR	22	40	155	81	56	98	7
NUMBER OF VISITS	197	308	683	534	209	545	62
NUMBER OF NON-VISIT SERVICES	185	125	460	365	285	772	77
TOTAL GOVERNMENT COST	14,136	11,380	40,257	23,122	17,255	55,522	5,458
TOTAL PATIENT COST	5,937	8,266	22,682	13,951	7,369	30,225	2,825
TOTAL GOVT AND PATIENT COST	20,073	19,646	62,939	37,073	24,624	85,747	8,283
AVG GOVT COST PER VISIT	71.76	36.95	58.94	43.30	82.56	101.88	88.03
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	0	1	0	0	3	0
DEPNT OF ACT DUTY SPONSOR	0	0	1	0	0	3	0
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	1,901	0	0	4,994	0
TOTAL PATIENT COST	0	0	25	0	0	75	0
TOTAL GOVT AND PATIENT COST	0	0	1,926	0	0	5,069	0
VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	116	110	371	366	129	398	47
DEPNT OF ACT DUTY SPONSOR	81	69	89	254	38	248	33
RETIREE	10	3	121	30	34	47	4
DEPNT OF RET OR DEC SPONSOR	25	40	163	82	58	103	10
TOTAL GOVERNMENT COST	31,916	16,248	193,472	28,533	20,334	80,155	8,641
TOTAL PATIENT COST	8,835	10,637	115,709	18,534	8,640	34,249	4,721
TOTAL GOVT AND PATIENT COST	40,751	26,885	309,181	47,067	28,974	114,404	13,362

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

********** CATEGORY OF CARE - INTERNAL MEDICINE **********

	INFECTIOUS DISEASE	NEPHROLOGY	NEUROLOGY	NUTRITIONAL	PULMONARY/ RESPIRATORY	RHEUMATOLOGY	OTHER
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	2	4	13	0	30	0	3
DEPNT OF ACT DUTY SPONSOR	1	2	8	0	10	0	3
RETIREE	0	1	3	0	13	0	0
DEPNT OF RET OR DEC SPONSOR	1	1	2	0	7	0	0
TOTAL HOSPITAL ADMISSIONS	2	5	13	0	37	0	3
HOSPITAL DAYS	13	20	84	0	204	0	12
AVERAGE LENGTH OF STAY (DAYS)	6.50	4.00	6.46	0.00	5.51	0.00	4.00
AVERAGE DAILY PATIENT LOAD	0.04	0.05	0.23	0.00	0.56	0.00	0.03
TOTAL GOVERNMENT COST	3,111	12,733	62,446	0	92,884	0	4,751
TOTAL PATIENT COST	28	3,191	5,903	0	29,988	0	96
TOTAL GOVT AND PATIENT COST	3,139	15,924	68,349	0	122,872	0	4,847
AVG GOVT COST PER ADMISSION	1,555.50	2,546.60	4,803.54	0.00	2,510.38	0.00	1,583.67
AVG GOVT COST PER DAY	239.31	636.65	743.40	0.00	455.31	0.00	395.92
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	12	9	34	1	59	3	70
DEPNT OF ACT DUTY SPONSOR	9	5	22	0	18	0	39
RETIREE	0	1	5	0	24	1	13
DEPNT OF RET OR DEC SPONSOR	3	3	7	1	17	2	18
NUMBER OF VISITS	37	31	261	2	347	38	48
NUMBER OF NON-VISIT SERVICES	158	41	251	4	389	0	306
TOTAL GOVERNMENT COST	5,937	10,175	35,241	487	36,746	587	15,430
TOTAL PATIENT COST	702	4,462	1,354	162	18,165	711	2,339
TOTAL GOVT AND PATIENT COST	6,639	14,637	36,595	649	54,911	1,298	17,769
III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	13	9	38	1	66	3	71
DEPNT OF ACT DUTY SPONSOR	10	5	24	0	22	0	40
RETIREE	0	1	6	0	27	1	13
DEPNT OF RET OR DEC SPONSOR	3	3	8	1	17	2	18
TOTAL GOVERNMENT COST	9,048	22,908	97,688	487	129,630	587	20,181
TOTAL PATIENT COST	731	7,653	7,257	162	48,153	711	2,434
TOTAL GOVT AND PATIENT COST	9,779	30,561	104,945	649	177,783	1,298	22,615
AVG GOVT COST PER ADMISSION	4,524.00	4,581.60	7,514.46	0.00	3,503.51	0.00	6,727.00
AVG GOVT COST PER DAY	696.00	1,145.40	1,162.95	0.00	635.44	0.00	1,681.75
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	206	28	195	3	485	93	313
DEPNT OF ACT DUTY SPONSOR	165	20	87	3	277	24	245
RETIREE	11	3	40	0	74	26	17
DEPNT OF RET OR DEC SPONSOR	31	5	68	0	134	43	52
NUMBER OF VISITS	289	24	320	5	829	322	342
NUMBER OF NON-VISIT SERVICES	348	64	182	6	686	213	396
TOTAL GOVERNMENT COST	17,432	10,639	24,448	182	46,073	7,232	31,259
TOTAL PATIENT COST	9,015	4,129	11,947	141	28,295	6,004	15,316
TOTAL GOVT AND PATIENT COST	26,447	14,768	36,395	323	74,368	13,236	46,575
AVG GOVT COST PER VISIT	60.32	443.29	76.40	36.40	55.58	22.46	91.40
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	0	1	0	3	0	1
DEPNT OF ACT DUTY SPONSOR	0	0	1	0	3	0	1
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	0
TOTAL GOVERNMENT COST	0	0	1,810	0	7,440	0	2,139
TOTAL PATIENT COST	0	0	25	0	75	0	25
TOTAL GOVT AND PATIENT COST	0	0	1,835	0	7,515	0	2,164
VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	215	32	219	4	521	95	374
DEPNT OF ACT DUTY SPONSOR	173	22	100	3	293	24	279
RETIREE	11	4	45	0	87	26	28
DEPNT OF RET OR DEC SPONSOR	32	6	74	1	142	45	68
TOTAL GOVERNMENT COST	26,480	33,546	123,946	668	183,143	7,819	53,580
TOTAL PATIENT COST	9,746	11,782	19,229	304	76,523	6,715	17,776
TOTAL GOVT AND PATIENT COST	36,226	45,328	143,175	972	259,666	14,534	71,356

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

********** CATEGORY OF CARE **********

	DENTAL	OBSTETRICS	GYNECOLOGY	OPHTHALMOLOGY	PSYCHIATRY GROUP 1	PSYCHIATRY GROUP 2	SPECIAL PEDIATRICS
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	0	97	7	3	63	66	16
DEPNT OF ACT DUTY SPONSOR	0	92	2	0	47	53	15
RETIREE	0	0	0	1	2	3	0
DEPNT OF RET OR DEC SPONSOR	0	5	5	2	14	10	1
TOTAL HOSPITAL ADMISSIONS	0	99	7	4	66	62	15
HOSPITAL DAYS	0	1,040	32	14	1,697	1,660	261
AVERAGE LENGTH OF STAY (DAYS)	0.00	10.51	4.57	3.50	25.71	26.77	17.40
AVERAGE DAILY PATIENT LOAD	0.00	2.85	0.09	0.04	4.65	4.55	0.72
TOTAL GOVERNMENT COST	0	744,459	13,896	4,575	739,932	772,336	400,127
TOTAL PATIENT COST	0	20,918	6,896	2,756	75,672	53,910	2,194
TOTAL GOVT AND PATIENT COST	0	765,377	20,792	7,331	815,604	826,246	402,321
AVG GOVT COST PER ADMISSION	0.00	7,519.79	1,985.14	1,143.75	11,211.09	12,457.03	26,675.13
AVG GOVT COST PER DAY	0.00	715.83	434.25	326.79	436.02	465.26	1,533.05
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	1	106	19	10	55	51	70
DEPNT OF ACT DUTY SPONSOR	1	98	5	6	37	42	65
RETIREE	0	0	0	1	2	3	0
DEPNT OF RET OR DEC SPONSOR	0	8	14	3	16	6	5
NUMBER OF VISITS	0	151	3	19	1,058	941	329
NUMBER OF NON-VISIT SERVICES	1	725	59	24	34	5	5,410
TOTAL GOVERNMENT COST	104	75,119	12,270	11,868	73,194	67,946	261,387
TOTAL PATIENT COST	416	7,582	17,881	8,461	7,014	7,292	2,365
TOTAL GOVT AND PATIENT COST	520	82,701	30,151	20,329	80,208	75,238	263,752
III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	1	152	20	11	74	72	74
DEPNT OF ACT DUTY SPONSOR	1	143	6	6	51	58	68
RETIREE	0	0	0	1	2	4	0
DEPNT OF RET OR DEC SPONSOR	0	10	14	4	21	10	6
TOTAL GOVERNMENT COST	104	819,578	26,165	16,442	813,126	840,281	661,514
TOTAL PATIENT COST	416	28,500	24,777	11,217	82,686	61,202	4,559
TOTAL GOVT AND PATIENT COST	520	848,078	50,942	27,659	895,812	901,483	666,073
AVG GOVT COST PER ADMISSION	0.00	8,278.57	3,737.86	4,110.50	12,320.09	13,552.92	44,100.93
AVG GOVT COST PER DAY	0.00	788.06	817.66	1,174.43	479.15	506.19	2,534.54
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	13	34	643	146	97	355	56
DEPNT OF ACT DUTY SPONSOR	9	32	528	89	54	302	37
RETIREE	2	0	1	20	7	7	5
DEPNT OF RET OR DEC SPONSOR	2	2	116	37	36	49	14
NUMBER OF VISITS	17	24	1,124	279	493	3,373	48
NUMBER OF NON-VISIT SERVICES	9	42	1,730	97	51	34	136
TOTAL GOVERNMENT COST	759	4,246	166,218	28,792	27,731	175,815	11,912
TOTAL PATIENT COST	1,257	1,642	52,847	24,497	10,696	60,200	4,288
TOTAL GOVT AND PATIENT COST	2,016	5,888	219,065	53,289	38,427	236,015	16,200
AVG GOVT COST PER VISIT	44.65	176.92	147.88	103.20	56.25	52.12	248.17
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	0	25	40	3	0	0	0
DEPNT OF ACT DUTY SPONSOR	0	23	40	3	0	0	0
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	2	0	0	0	0	0
TOTAL GOVERNMENT COST	0	8,907	77,011	2,776	0	0	0
TOTAL PATIENT COST	0	1,368	1,000	75	0	0	0
TOTAL GOVT AND PATIENT COST	0	10,275	78,011	2,851	0	0	0
VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	14	187	655	155	154	411	120
DEPNT OF ACT DUTY SPONSOR	10	176	535	94	92	346	96
RETIREE	2	0	1	21	9	10	5
DEPNT OF RET OR DEC SPONSOR	2	12	121	40	53	58	20
TOTAL GOVERNMENT COST	863	832,731	269,394	48,011	840,857	1,016,097	673,426
TOTAL PATIENT COST	1,673	31,510	78,624	35,788	93,382	121,402	8,847
TOTAL GOVT AND PATIENT COST	2,536	864,241	348,018	83,799	934,239	1,137,499	682,273

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

UNDUPLICATED

********** CATEGORY OF CARE - SURGERY **********

	EAR, NOSE AND THROAT	GENERAL SURGERY	NEURO-SURGERY	ORTHOPEDICS	THORACIC SURGERY	UROLOGY	GRAND TOTAL FOR ALL CATEGORIES
I INPATIENT HOSPITAL SERVICES							
USER BENEFICIARIES	11	35	7	20	2	17	426
DEPNT OF ACT DUTY SPONSOR	7	18	2	13	0	8	292
RETIREE	2	8	3	0	2	6	55
DEPNT OF RET OR DEC SPONSOR	2	9	2	7	0	3	80
TOTAL HOSPITAL ADMISSIONS	11	38	7	22	2	19	475
HOSPITAL DAYS	28	267	37	82	16	98	5,816
AVERAGE LENGTH OF STAY (DAYS)	2.55	7.03	5.29	3.73	8.00	5.16	12.24
AVERAGE DAILY PATIENT LOAD	0.08	0.73	0.10	0.22	0.04	0.27	15.93
TOTAL GOVERNMENT COST	11,906	113,030	18,553	51,443	10,979	30,534	3,222,621
TOTAL PATIENT COST	3,842	24,554	14,074	11,343	4,871	9,973	314,858
TOTAL GOVT AND PATIENT COST	15,748	137,584	32,627	62,786	15,850	40,507	3,537,479
AVG GOVT COST PER ADMISSION	1,082.36	2,974.47	2,650.43	2,338.32	5,489.50	1,607.05	6,784.47
AVG GOVT COST PER DAY	425.21	423.33	501.43	627.35	686.19	311.57	554.10
II INPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	15	50	15	30	3	29	542
DEPNT OF ACT DUTY SPONSOR	8	26	5	16	0	14	349
RETIREE	3	10	5	2	3	6	77
DEPNT OF RET OR DEC SPONSOR	4	14	5	12	0	9	117
NUMBER OF VISITS	15	181	33	81	2	109	4,145
NUMBER OF NON-VISIT SERVICES	36	432	113	110	5	93	8,809
TOTAL GOVERNMENT COST	6,426	54,582	14,722	32,143	837	21,811	807,356
TOTAL PATIENT COST	2,146	17,538	7,002	13,347	315	10,444	195,018
TOTAL GOVT AND PATIENT COST	8,572	72,120	21,724	45,490	1,152	32,255	1,002,374
III TOTAL INPATIENT SERVICES							
USER BENEFICIARIES	19	60	17	34	3	31	608
DEPNT OF ACT DUTY SPONSOR	12	31	6	19	0	15	398
RETIREE	3	12	5	2	3	6	81
DEPNT OF RET OR DEC SPONSOR	4	17	6	13	0	10	131
TOTAL GOVERNMENT COST	18,332	167,612	33,274	83,586	11,816	52,346	4,029,977
TOTAL PATIENT COST	5,988	42,092	21,076	24,690	5,186	20,417	509,876
TOTAL GOVT AND PATIENT COST	24,320	209,704	54,350	108,276	17,002	72,763	4,539,853
AVG GOVT COST PER ADMISSION	1,666.55	4,410.84	4,753.43	3,799.36	5,908.00	2,755.05	8,484.16
AVG GOVT COST PER DAY	654.71	627.76	899.30	1,019.34	738.50	534.14	692.91
IV OUTPATIENT PROFESSIONAL SERVICES							
USER BENEFICIARIES	600	421	33	389	9	394	3,715
DEPNT OF ACT DUTY SPONSOR	457	233	13	204	2	266	2,457
RETIREE	24	54	7	56	5	35	399
DEPNT OF RET OR DEC SPONSOR	120	135	13	131	2	96	880
NUMBER OF VISITS	1,193	702	28	972	19	488	13,429
NUMBER OF NON-VISIT SERVICES	606	1,045	41	799	34	993	9,781
TOTAL GOVERNMENT COST	97,506	66,794	5,265	69,513	4,100	142,929	1,105,975
TOTAL PATIENT COST	28,714	46,317	2,542	43,212	4,671	31,115	478,100
TOTAL GOVT AND PATIENT COST	126,220	113,111	7,807	112,725	8,771	174,044	1,584,075
AVG GOVT COST PER VISIT	81.73	95.15	188.04	71.52	215.79	292.89	82.36
V OUTPATIENT CARE COST SHARED AS INPATIENT							
USER BENEFICIARIES	50	7	1	8	0	64	206
DEPNT OF ACT DUTY SPONSOR	50	7	1	8	0	64	204
RETIREE	0	0	0	0	0	0	0
DEPNT OF RET OR DEC SPONSOR	0	0	0	0	0	0	2
TOTAL GOVERNMENT COST	36,830	7,533	1,880	13,016	0	112,279	278,519
TOTAL PATIENT COST	3,675	150	25	2,339	0	1,600	10,457
TOTAL GOVT AND PATIENT COST	40,505	7,683	1,905	15,355	0	113,879	288,976
VI TOTAL INPATIENT AND OUTPATIENT CARE							
USER BENEFICIARIES	613	455	42	407	10	416	4,018
DEPNT OF ACT DUTY SPONSOR	466	256	18	216	2	202	2,698
RETIREE	25	58	8	57	6	37	420
DEPNT OF RET OR DEC SPONSOR	123	142	16	136	2	100	922
TOTAL GOVERNMENT COST	152,667	241,939	40,420	166,115	15,916	307,554	5,414,471
TOTAL PATIENT COST	38,377	88,559	23,643	70,240	9,857	53,132	998,433
TOTAL GOVT AND PATIENT COST	191,044	330,498	64,063	236,355	25,773	360,686	6,412,904

NOTE: REFER TO PAGE 1 (SPECIFICATIONS PAGE) OF THIS REPORT FOR CLARIFICATION OF THE DATA WHICH APPEARS ON THIS REPORT.

Waiting Times until Next Available Appointment
Outpatient Medical Specialities
Fiscal Year 1988
Bayne-Jones Army Community Hospital
(Source: Weekly Reports to Clinical Support Division)

	Optometry		Opthalmology		Otolaryngology		Audiology	Internal Medicine New Pt		Internal Medicine Follow up	
10Oct87	**		26		20		14	21		6	
80ct87	**		11		20		11	18		7	
150ct87	**		8		18		6	13		5	
220ct87	**		8		13		7	8		7	
290ct87	**		5		27		6	6		4	
5Nov87	**		25		26	*	4	26	*	7	
12Nov87	**		19		19	*	6	19	*	19	*
3Dec87	**		11		19	*	6	19	*	19	*
10Dec87	**		21		21	*	5	21	*	47	
17Dec87	**		4		18		18	15	*	40	
6Jan88	**		6		14		5	26	*	20	
14Jan88	**		7		18		7	18	*	12	
21Jan88	**		4		13		5	11	*	11	*
28Jan88	**		1		27		7	13		7	
4Feb88	**		7		25	*	5	25	*	25	*
11Feb88	**		11		20		7	18	*	27	
18Feb88	**		11		20		6	21		11	
25Feb88	**		25		18		4	29		29	
3Mar88	13		29		13		6	22		19	
11Mar88	34		31		3		3	11		11	
17Mar88	15		39		15	*	11	7		18	
24Mar88	32		38		11		11	26		7	
31Mar88	33		39		4		4	31	*	19	
7Apr88	32		36		6		4	33		12	
14Apr88	29		35		6		5	26		6	
21Apr88	13		35		4		4	19		6	
28Apr88	33	*	33	*	4		6	7		6	
5May88	32		27	*	4		14	4		4	
12May88	29		21		4		12	5		7	
19May88	29		14		4		5	25		6	
26May88	34		36	*	1		7	18		6	
2Jun88	29		5		5		6	12		12	
9Jun88	4		8		4		4	6		6	
16Jun88	26		22		1		5	20		20	
23Jun88	25		18		13		4	5		5	
30Jun88	25		15		5		5	5		5	
7Jul88	21		11		1		4	1		1	
14Jul88	4		5		4		5	6		1	
21Jul88	5		4		4		6	21		21	
29Jul88	3		14		3		19	5		10	
4Aug88	21		27		4		18	11		6	
11Aug88	27		8		4		14	6		6	
18Aug88	22		19		11		13	6		5	
25Aug88	22		4		7		13	1		1	

1Sep88	21	12		11	11	5	5
8Sep88	20	5		4	12	13	11
15Sep88	20	5		8	11	5	5
22Sep88	20	7		6	7	6	6
29Sep88	19	33	*	4	5	5	5
Total:	692	845		534	383	700	561
Average:	14.12	17.24		10.90	7.82	14.29	11.45

Notes:

* Estimate based on no appointments available
until end of the month or following month.
** Appointments not available for other than Active Duty.

Waiting Times until Next Available Appointment
Outpatient Medical Specialities
Fiscal Year 1988
Bayne-Jones Army Community Hospital
(Source: Weekly Reports to Clinical Support Division)

	Neurology				Dermatology		Pediatrics		Surgery	
	New Pt		Follow up						New Pt	Follow up
10Oct87	12		30	*	18		21		5	18
80ct87	24	*	24	*	11		19		6	6
150ct87	26		33		14		12		11	12
220ct87	19		26		11		8		12	8
290ct87	26		26		14		14		4	4
5Nov87	26		19		26		14		4	4
12Nov87	19		26		32		13		12	6
3Dec87	12		12		19	*	19	*	4	4
10Dec87	5		5		28		28		4	4
17Dec87	5		12		34		26		12	12
6Jan88	6		6		6		9		6	5
14Jan88	19		19		21		12		12	5
21Jan88	19		19		20		11		5	4
28Jan88	19		19		26		6		5	5
4Feb88	12		12		25	*	12		12	4
11Feb88	33		33		25		18		5	6
18Feb88	19		19		1		12		5	4
25Feb88	35	*	35	*	15		11		5	8
3Mar88	29	*	29	*	15		4		4	4
11Mar88	21	*	21	*	17		21	*	5	6
17Mar88	15	*	15	*	18		18		5	5
24Mar88	9	*	9	*	18		11		4	4
31Mar88	**		**		19		5		4	4
7Apr88	**		**		14		20		4	4
14Apr88	**		**		18		15		5	5
21Apr88	**		**		15		22		5	5
28Apr88	**		**		33	*	33	*	5	5
5May88	**		**		27	*	27	*	5	5
12May88	**		**		20		4		4	4
19May88	**		**		13		13	*	5	5
26May88	**		**		6		36	*	6	6
2Jun88	**		**		1		4		4	4
9Jun88	**		**		**		54	*	4	4
16Jun88	**		**		**		46	*	4	4
23Jun88	**		**		**		39	*	7	7
30Jun88	**		**		**		32	*	5	5
7Jul88	**		**		**		27		6	6
14Jul88	**		**		**		14		7	7
21Jul88	**		**		**		7		1	1
29Jul88	**		**		13		3		3	3
4Aug88	**		**		20		11		4	4
11Aug88	**		**		21		7		1	1
18Aug88	**		**		26		11		1	1
25Aug88	**		**		25		13		1	1

1Sep88	**	**	30	*	7	5	5
8Sep88	**	**	27		11	5	5
15Sep88	**	**	33		14	4	4
22Sep88	**	**	29		14	4	4
29Sep88	**	**	25		18	1	1
Total:	410	449	803		826	257	248
Average:	8.37	9.16	16.39		16.86	5.24	5.06

Notes:

* Estimate based on no appointments available
until end of the month or following month.
** Appointments not available for other than Active Duty.

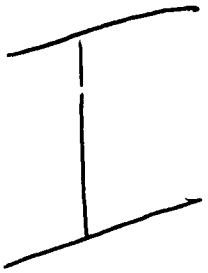
Waiting Times until Next Available Appointment
Outpatient Medical Specialities
Fiscal Year 1988
Bayne-Jones Army Community Hospital
(Source: Weekly Reports to Clinical Support Division)

	OB/Gyn				FamilyPractice		Orthothopedics		Podiatry	
	New Pt		Follow up				New Pt	Follow up	New Pt	Follow up
1Oct87	5		4		30	*	**	**	***	***
8Oct87	11		11		8		**	**	***	***
15Oct87	4		5		8		**	**	3	3
22Oct87	11		11		6		**	**	7	7
29Oct87	4		4		11		**	**	6	7
5Nov87	12		25		5		**	**	5	5
12Nov87	19		19		13		**	**	5	5
3Dec87	19	*	19	*	7		**	**	6	4
10Dec87	25		25		21	*	**	**	6	7
17Dec87	22		19		15	*	**	**	4	18
6Jan88	19		19		20		**	**	5	1
14Jan88	18		19		14		**	**	7	7
21Jan88	11		18		13		**	**	6	6
28Jan88	25		26		26		**	**	0	4
4Feb88	25		26		25		**	**	6	14
11Feb88	12		15		18	*	**	**	12	18
18Feb88	12		33		12	*	11	1	7	12
25Feb88	32		32		35	*	7	6	5	11
3Mar88	29		29		29	*	4	1	26	26
11Mar88	21		21		21	*	10	6	32	31
17Mar88	18		18		26		11	13	5	5
24Mar88	8		8		38	*	11	8	25	25
31Mar88	26		26		31	*	12	15	20	25
7Apr88	25		25		24	*	12	6	19	24
14Apr88	25		25		17	*	11	6	20	21
21Apr88	25		25		40	*	18	15	14	26
28Apr88	18		18		33	*	18	20	20	21
5May88	11		11		27	*	12	12	18	18
12May88	19		19		20	*	5	6	12	12
19May88	21		21		44	*	5	13	12	12
26May88	28		28		36	*	26	6	10	7
2Jun88	29	*	29	*	29	*	26	13	5	5
9Jun88	22	*	22	*	22	*	26	13	4	4
16Jun88	46	*	46	*	46	*	20	20	4	4
23Jun88	39	*	39	*	39	*	19	13	12	13
30Jun88	32	*	32	*	32	*	18	8	13	13
7Jul88	25	*	25	*	25	*	12	8	8	7
14Jul88	32		32		18	*	11	5	5	5
21Jul88	18		18		11	*	11	6	7	7
29Jul88	31		31		11		3	5	11	13
4Aug88	26		26		28	*	11	8	5	7
11Aug88	22		22		21	*	5	7	13	8
18Aug88	25		25		14	*	4	6	6	6
25Aug88	12		12		7	*	4	8	5	7

1Sep88	30	*	30	*	7	13	8	13	14
8Sep88	23	*	23	*	7	11	8	12	14
15Sep88	18		18		5	11	6	12	15
22Sep88	11		11		6	5	6	6	14
29Sep88	22		22		12	11	3	12	15
Total:	1023		1067		1013	394	285	476	553
Average:	20.88		21.78		20.67	8.04	5.82	9.71	11.29

Notes:

* Estimate based on no appointments available
until end of the month or following month.
** Appointments not available for other than Active Duty.



OUTPATIENT SATISFACTION SURVEY

(HSC Reg 40-5)

CLINIC _____ HSC MTF _____ APPT _____ NON-APPT _____

STATUS ☐ ACTIVE DUTY ☐ ACTIVE DUTY DEPENDENT
☐ RETIRED ☐ RETIRED DEPENDENT
☐ OTHER *(civilian employee, civilian emergency, etc.)*

INFORMATION FROM THIS SURVEY WILL HELP US TO PROVIDE YOU THE BEST POSSIBLE MEDICAL CARE. To insure the accuracy of this survey, it is most important that you answer each question which applies to TODAY'S VISIT. It should take less than 3 minutes to complete the survey. All responses will be held in strictest confidence.

SECTION I

PLACE AN "X" IN THE APPROPRIATE BOX	TODAY'S VISIT			
HOW SATISFIED WERE YOU WITH:	VERY SATISFIED	ACCEPTABLE	DISSATISFIED	DOES NOT APPLY TO TODAY'S VISIT
The clinic receptionist?				
The nursing staff?				
The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)				
The overall care you received?				
The explanation of your problem?				
The explanation about your medications?				
The explanation of your treatment/follow-up?				
The answers to your questions?				
The concern for your privacy?				
The appointment personnel?				
The medical records personnel?				
The laboratory staff?				
3. The x-ray staff?				
4. The pharmacy staff?				
5. The parking facilities?				
6. The directions within the hospital area?				
HOW SATISFIED WERE YOU WITH THE WAITING TIME:				
7. To obtain an appointment?				
8. At the medical records room?				
9. Before being seen for treatment?				
0. To have an x-ray taken?				
1. At the pharmacy?				
2. To have a laboratory test taken?				

SECTION II *(For local use overprint)*

IF YOU HAVE ANY ADDITIONAL COMMENTS OR SUGGESTIONS, PLEASE WRITE THEM ON THE REVERSE.
Please deposit your completed survey form in the box provided at the Pharmacy, X-Ray or Laboratory. Thank you for taking time to answer this survey.

COMMUNITY HEALTH NURSE

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA. 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	1	0	0	0	1	100	0	0
2.	The nursing staff?	1	0	0	0	1	100	0	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1	0	0	0	1	100	0	0
4.	The overall care you received?	1	0	0	0	1	100	0	0
5.	The explanation of your problem?	1	0	0	0	1	100	0	0
6.	The explanation about your medications?	1	0	0	0	1	100	0	0
7.	The explanation of your treatment/follow-up?	1	0	0	0	1	100	0	0
8.	The answers to your questions?	1	0	0	0	1	100	0	0
9.	The concern for your privacy?	1	0	0	0	1	100	0	0
10.	The appointment personnel?	1	0	0	0	1	100	0	0
11.	The medical records personnel?	1	0	0	0	1	100	0	0
12.	The laboratory staff?	1	0	0	0	1	100	0	0
13.	The x-ray staff?	1	0	0	0	1	100	0	0
14.	The pharmacy staff?	1	0	0	0	1	100	0	0
15.	The parking facilities?	0	1	0	0	1	0	100	0
16.	The directions within the hospital area?	1	0	0	0	1	100	0	0
	SUB-TOTAL:	15	1	0	0	16	94	6	0
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	0	1	0	0	1	0	100	0
18.	At the medical records room?	0	1	0	0	1	0	100	0
19.	Before being seen for treatment?	0	1	0	0	1	0	100	0
20.	To have an x-ray taken?	1	0	0	0	1	100	0	0
21.	At the pharmacy?	1	0	0	0	1	100	0	0
22.	To have a laboratory test taken?	1	0	0	0	1	100	0	0
	SUB-TOTAL:	3	3	0		6	50	50	0
	GRAND TOTAL:	18	4	0	0	22	82	18	0

DERMATOLOGY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
1. The clinic receptionist?	2	0	0	0	2	100	0	0
2. The nursing staff?	2	0	0	0	2	100	0	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1	1	0	0	2	50	50	0
4. The overall care you received?	1	1	0	0	2	50	50	0
5. The explanation of your problem?	1	1	0	0	2	50	50	0
6. The explanation about your medications?	0	1	0	1	1	0	100	0
7. The explanation of your treatment/follow-up?	1	1	0	0	2	50	50	0
8. The answers to your questions?	1	1	0	0	2	50	50	0
9. The concern for your privacy?	2	0	0	0	2	100	0	0
10. The appointment personnel?	0	0	0	2	0	0	0	0
11. The medical records personnel?	0	0	0	2	0	0	0	0
12. The laboratory staff?	0	1	0	1	1	0	100	0
13. The x-ray staff?	0	1	0	1	1	0	100	0
14. The pharmacy staff?	1	0	0	1	1	100	0	0
15. The parking facilities?	1	0	0	1	1	100	0	0
16. The directions within the hospital area?	2	0	0	0	2	100	0	0
SUB-TOTAL:	15	8	0	10	23	65	35	0
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	1	0	0	1	1	100	0	0
18. At the medical records room?	1	1	0	0	2	50	50	0
19. Before being seen for treatment?	1	1	0	0	2	50	50	0
20. To have an x-ray taken?	0	0	0	2	0	0	0	0
21. At the pharmacy?	0	0	1	1	1	0	0	100
22. To have a laboratory test taken?	0	0	0	2	0	0	0	0
SUB-TOTAL:	3	2	1	6	6	50	33	17
GRAND TOTAL:	18	10	1	16	29	62	34	4

GEN SURGERY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	6	1	0	0	7	86	14	0
2.	The nursing staff?	6	0	0	1	6	100	0	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	7	0	0	0	7	100	0	0
4.	The overall care you received?	7	0	0	0	7	100	0	0
5.	The explanation of your problem?	6	1	0	0	7	86	14	0
6.	The explanation about your medications?	3	1	0	3	4	75	25	0
7.	The explanation of your treatment/follow-up?	7	0	0	0	7	100	0	0
8.	The answers to your questions?	7	0	0	0	7	100	0	0
9.	The concern for your privacy?	4	3	0	0	7	57	43	0
10.	The appointment personnel?	4	2	0	1	6	67	33	0
11.	The medical records personnel?	2	3	0	2	5	40	60	0
12.	The laboratory staff?	2	1	0	4	3	67	33	0
13.	The x-ray staff?	0	2	0	5	2	0	100	0
14.	The pharmacy staff?	2	3	0	2	5	40	60	0
15.	The parking facilities?	2	5	0	0	7	29	71	0
16.	The directions within the hospital area?	3	3	0	1	6	50	50	0
	SUB-TOTAL:	68	25	0	19	93	73	27	0
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	5	2	0	0	7	71	29	0
18.	At the medical records room?	2	2	1	3	5	40	40	20
19.	Before being seen for treatment?	4	2	0	1	6	67	33	0
20.	To have an x-ray taken?	0	2	0	5	2	0	100	0
21.	At the pharmacy?	1	3	0	3	4	25	75	0
22.	To have a laboratory test taken?	0	1	1	5	2	0	50	50
	SUB-TOTAL:	12	12	2	16	26	46	46	8
	GRAND TOTAL:	80	37	2	35	119	67	31	2

GYN

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
1. The clinic receptionist?	5	1	0	0	6	83	17	0
2. The nursing staff?	5	1	0	0	6	83	17	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	5	1	0	0	6	83	17	0
4. The overall care you received?	5	1	0	0	6	83	17	0
5. The explanation of your problem?	4	1	0	1	5	80	20	0
6. The explanation about your medications?	2	2	0	2	4	50	50	0
7. The explanation of your treatment/follow-up?	4	1	0	1	5	80	20	0
8. The answers to your questions?	5	1	0	0	6	83	17	0
9. The concern for your privacy?	5	1	0	0	6	83	17	0
10. The appointment personnel?	4	2	0	0	6	67	33	0
11. The medical records personnel?	3	2	0	1	5	60	40	0
12. The laboratory staff?	2	1	0	3	5	67	33	0
13. The x-ray staff?	0	1	0	5	1	0	100	0
14. The pharmacy staff?	2	2	0	2	4	50	50	0
15. The parking facilities?	1	4	1	0	6	17	66	17
16. The directions within the hospital area?	3	2	0	1	5	60	40	0
SUB-TOTAL:	55	24	1	16	80	69	30	1
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	3	1	1	1	5	60	20	20
18. At the medical records room?	2	1	0	3	3	67	33	0
19. Before being seen for treatment?	2	2	1	1	5	40	40	20
20. To have an x-ray taken?	0	1	0	5	1	0	100	0
21. At the pharmacy?	1	3	0	2	4	25	75	0
22. To have a laboratory test taken?	0	2	0	4	2	0	100	0
SUB-TOTAL:	8	10	2	16	20	40	50	10
GRAND TOTAL:	63	34	3	32	100	63	24	3

INTERNAL MEDICINE

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-5000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	6	2	0	0	8	75	25	0
2.	The nursing staff?	6	2	0	0	8	75	25	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	8	0	0	0	8	100	0	0
4.	The overall care you received?	6	2	0	0	8	75	25	0
5.	The explanation of your problem?	6	1	1	0	8	75	12.5	12.5
6.	The explanation about your medications?	6	1	0	1	7	86	14	0
7.	The explanation of your treatment/follow-up?	7	0	0	1	7	100	0	0
8.	The answers to your questions?	7	0	0	1	7	100	0	0
9.	The concern for your privacy?	5	2	0	1	7	71	29	0
10.	The appointment personnel?	6	2	0	0	8	75	25	0
11.	The medical records personnel?	5	1	1	1	7	71	14.5	14.5
12.	The laboratory staff?	5	2	0	1	7	71	29	0
13.	The x-ray staff?	5	0	0	3	5	100	0	0
14.	The pharmacy staff?	5	2	0	1	7	71	29	0
15.	The parking facilities?	3	4	1	0	8	38	50	12
16.	The directions within the hospital area?	6	2	0	0	8	75	25	0
	SUB-TOTAL:	92	23	3	10	118	78	19	3
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	3	4	1	0	8	38	50	12
18.	At the medical records room?	6	1	1	0	8	75	12.5	12.5
19.	Before being seen for treatment?	3	5	0	0	8	38	62	0
20.	To have an x-ray taken?	3	2	0	3	5	60	40	0
21.	At the pharmacy?	4	2	1	1	7	57	29	14
22.	To have a laboratory test taken?	6	2	0	0	8	75	25	0
	SUB-TOTAL:	25	16	3	4	44	57	36	7
	GRAND TOTAL:	117	39	6	14	162	72	24	4

O.B.

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
1. The clinic receptionist?	12	1	0	0	13	92	8	0
2. The nursing staff?	13	0	0	0	13	100	0	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	12	1	0	0	13	92	8	0
4. The overall care you received?	12	1	0	0	13	92	8	0
5. The explanation of your problem?	9	3	0	1	12	75	25	0
6. The explanation about your medications?	8	2	0	3	10	80	20	0
7. The explanation of your treatment/follow-up?	9	2	0	2	11	82	18	0
8. The answers to your questions?	11	1	0	1	12	92	8	0
9. The concern for your privacy?	10	2	0	1	12	83	17	0
10. The appointment personnel?	11	2	0	0	13	83	17	0
11. The medical records personnel?	7	3	0	3	10	70	30	0
12. The laboratory staff?	5	5	0	3	10	50	50	0
13. The x-ray staff?	5	2	0	6	7	71	29	0
14. The pharmacy staff?	4	4	0	5	8	50	50	0
15. The parking facilities?	1	7	5	0	13	8	54	38
16. The directions within the hospital area?	5	6	1	1	12	42	50	8
SUB-TOTAL:	134	42	6	26	182	74	23	3
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	9	3	1	0	13	69	23	8
18. At the medical records room?	4	3	0	6	7	57	43	0
19. Before being seen for treatment?	3	9	1	0	13	23	69	8
20. To have an x-ray taken?	4	2	0	7	6	67	33	0
21. At the pharmacy?	4	3	0	6	7	57	43	0
22. To have a laboratory test taken?	3	4	0	6	7	43	57	0
SUB-TOTAL:	27	24	2	25	53	51	45	4
GRAND TOTAL:	161	66	8	51	235	69	28	3

OCCUPATIONAL THERAPY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
1. The clinic receptionist?	1	0	0	5	1	100	0	0
2. The nursing staff?	2	0	0	4	2	100	0	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	6	0	0	0	6	100	0	0
4. The overall care you received?	5	0	0	1	5	100	0	0
5. The explanation of your problem?	5	0	0	1	5	100	0	0
6. The explanation about your medications?	1	1	0	4	2	50	50	0
7. The explanation of your treatment/follow-up?	5	0	0	1	5	100	0	0
8. The answers to your questions?	4	1	0	1	5	80	20	0
9. The concern for your privacy?	3	0	0	3	3	100	0	0
10. The appointment personnel?	2	0	0	4	2	100	0	0
11. The medical records personnel?	1	0	0	5	1	100	0	0
12. The laboratory staff?	1	0	0	5	1	100	0	0
13. The x-ray staff?	1	1	0	4	2	50	50	0
14. The pharmacy staff?	1	0	0	5	1	100	0	0
15. The parking facilities?	1	1	1	3	3	33.3	33.3	33.3
16. The directions within the hospital area?	2	0	0	4	2	100	0	0
SUB-TOTAL:	41	4	1	50	46	89	9	2
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	3	0	0	3	3	100	0	0
18. At the medical records room?	1	0	0	5	1	100	0	0
19. Before being seen for treatment?	3	0	0	3	3	100	0	0
20. To have an x-ray taken?	1	0	1	4	2	50	0	50
21. At the pharmacy?	1	1	0	4	2	50	50	0
22. To have a laboratory test taken?	1	0	0	5	1	100	0	0
SUB-TOTAL:	10	1	1	24	12	84	8	8
GRAND TOTAL:	51	5	2	74	58	88	9	3

OPTHALMOLOGY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
1. The clinic receptionist?	4	0	0	0	4	100	0	0
2. The nursing staff?	3	1	0	0	4	75	25	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	3	1	0	0	4	75	25	0
4. The overall care you received?	3	1	0	0	4	75	25	0
5. The explanation of your problem?	3	1	0	0	4	75	25	0
6. The explanation about your medications?	3	1	0	0	4	75	25	0
7. The explanation of your treatment/follow-up?	3	0	1	0	4	75	0	25
8. The answers to your questions?	3	1	0	0	4	75	25	0
9. The concern for your privacy?	4	0	0	0	4	100	0	0
10. The appointment personnel?	2	1	1	0	4	50	25	25
11. The medical records personnel?	3	1	0	0	4	75	25	0
12. The laboratory staff?	3	0	0	1	3	100	0	0
13. The x-ray staff?	3	0	0	1	3	100	0	0
14. The pharmacy staff?	3	1	0	0	4	75	25	0
15. The parking facilities?	3	1	0	0	4	75	25	0
16. The directions within the hospital area?	3	1	0	0	4	75	25	0
SUB-TOTAL:	49	11	2	2	62	79	18	3
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	1	0	3	0	4	25	0	75
18. At the medical records room?	2	1	1	0	4	50	25	25
19. Before being seen for treatment?	2	2	0	0	4	50	50	0
20. To have an x-ray taken?	2	1	0	1	3	67	33	0
21. At the pharmacy?	3	1	0	0	4	75	25	0
22. To have a laboratory test taken?	3	1	0	0	4	75	25	0
SUB-TOTAL:	13	6	4	1	23	57	26	17
GRAND TOTAL:	62	17	6	3	85	73	20	7

OPTOMETRY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	7	0	0	0	7	100	0	0
2.	The nursing staff?	4	1	0	2	5	80	20	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	5	2	0	0	7	71	29	0
4.	The overall care you received?	3	2	0	2	5	60	40	0
5.	The explanation of your problem?	5	2	0	0	7	71	29	0
6.	The explanation about your medications?	2	0	1	4	3	67	0	33
7.	The explanation of your treatment/follow-up?	3	2	0	2	5	60	40	0
8.	The answers to your questions?	6	0	0	1	6	100	0	0
9.	The concern for your privacy?	6	0	0	1	6	100	0	0
10.	The appointment personnel?	6	1	0	0	7	86	14	0
11.	The medical records personnel?	7	0	0	0	7	100	0	0
12.	The laboratory staff?	6	1	0	0	7	86	14	0
13.	The x-ray staff?	2	1	0	4	3	67	33	0
14.	The pharmacy staff?	3	1	0	3	4	75	25	0
15.	The parking facilities?	4	0	3	0	7	57	0	43
16.	The directions within the hospital area?	1	3	0	3	4	25	75	0
	SUB-TOTAL:	70	16	4	22	90	78	18	4
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	3	3	1	0	7	43	43	14
18.	At the medical records room?	3	2	0	2	5	60	40	0
19.	Before being seen for treatment?	3	3	0	1	6	50	50	0
20.	To have an x-ray taken?	3	2	0	2	5	60	40	0
21.	At the pharmacy?	1	1	1	4	3	33.3	33.3	33.3
22.	To have a laboratory test taken?	1	4	0	2	5	20	80	0
	SUB-TOTAL:	14	15	2	11	31	45	48	7
	GRAND TOTAL:	84	31	6	33	121	69	26	5

OCCUPATIONAL HEALTH

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+	ACCEPT	+	DSAT	-	DNA	=	TOTAL	=	VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:													
1. The clinic receptionist?	7		1		0		0		8		88	12	0
2. The nursing staff?	8		0		0		0		8		100	0	0
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	7		0		0		1		7		100	0	0
4. The overall care you received?	7		1		0		0		8		88	12	0
5. The explanation of your problem?	5		0		0		3		5		100	0	0
6. The explanation about your medications?	6		0		0		2		6		100	0	0
7. The explanation of your treatment/follow-up?	6		0		0		2		6		100	0	0
8. The answers to your questions?	8		0		0		0		8		100	0	0
9. The concern for your privacy?	7		0		0		1		7		100	0	0
10. The appointment personnel?	6		1		0		1		7		86	14	0
11. The medical records personnel?	7		0		0		1		7		100	0	0
12. The laboratory staff?	5		0		0		3		5		100	0	0
13. The x-ray staff?	4		0		0		4		4		100	0	0
14. The pharmacy staff?	4		0		0		4		4		100	0	0
15. The parking facilities?	6		0		0		2		6		100	0	0
16. The directions within the hospital area?	5		0		0		3		5		100	0	0
SUB-TOTAL:	98		3		0		27		101		97	3	0
HOW SATISFIED WERE YOU WITH THE WAITING TIME:													
17. To obtain an appointment?	6		0		0		2		6		100	0	0
18. At the medical records room?	6		0		0		2		6		100	0	0
19. Before being seen for treatment?	6		0		0		2		6		100	0	0
20. To have an x-ray taken?	4		0		0		4		4		100	0	0
21. At the pharmacy?	4		0		0		4		4		100	0	0
22. To have a laboratory test taken?	4		0		0		4		4		100	0	0
SUB-TOTAL:	30		0		0		18		30		100	0	0
GRAND TOTAL:	128		3		0		45		131		98	2	0

ORTHO

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	10	0	0	0	10	100	0	0
2.	The nursing staff?	8	1	0	1	9	89	11	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	9	1	0	0	10	90	10	0
4.	The overall care you received?	6	3	0	1	9	67	33	0
5.	The explanation of your problem?	6	2	1	1	9	67	22	11
6.	The explanation about your medications?	5	3	1	1	9	56	33	11
7.	The explanation of your treatment/follow-up?	6	2	1	1	9	67	22	11
8.	The answers to your questions?	8	1	1	0	10	80	10	10
9.	The concern for your privacy?	9	1	0	0	10	90	10	0
10.	The appointment personnel?	7	1	0	2	8	88	12	0
11.	The medical records personnel?	7	1	0	2	8	88	12	0
12.	The laboratory staff?	6	0	0	4	6	100	0	0
13.	The x-ray staff?	4	1	1	4	6	66	17	17
14.	The pharmacy staff?	4	4	0	2	8	50	50	0
15.	The parking facilities?	3	5	2	0	10	30	50	20
16.	The directions within the hospital area?	6	3	0	1	9	67	33	0
	SUB-TOTAL:	104	29	7	20	140	74	21	5
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	6	1	1	2	8	75	12.5	12.5
18.	At the medical records room?	5	3	0	2	8	63	37	0
19.	Before being seen for treatment?	7	3	0	0	10	70	30	0
20.	To have an x-ray taken?	5	1	1	3	7	72	14	14
21.	At the pharmacy?	5	2	1	2	8	62	25	13
22.	To have a laboratory test taken?	5	2	0	3	7	71	29	0
	SUB-TOTAL:	33	12	3	12	48	69	25	6
	GRAND TOTAL:	137	41	10	32	188	73	22	5

OTOLARYNGOLOGY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	4	0	0	0	4	100	0	0
2.	The nursing staff?	3	0	0	1	3	100	0	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	4	0	0	0	4	100	0	0
4.	The overall care you received?	4	0	0	0	4	100	0	0
5.	The explanation of your problem?	4	0	0	0	4	100	0	0
6.	The explanation about your medications?	3	0	0	1	3	100	0	0
7.	The explanation of your treatment/follow-up?	3	0	0	1	3	100	0	0
8.	The answers to your questions?	4	0	0	0	4	100	0	0
9.	The concern for your privacy?	3	0	0	1	3	100	0	0
10.	The appointment personnel?	3	0	0	1	3	100	0	0
11.	The medical records personnel?	2	0	0	2	2	100	0	0
12.	The laboratory staff?	0	0	0	4	0	0	0	0
13.	The x-ray staff?	0	0	0	4	0	0	0	0
14.	The pharmacy staff?	0	0	0	4	0	0	0	0
15.	The parking facilities?	1	3	0	0	4	25	75	0
16.	The directions within the hospital area?	3	0	0	1	3	100	0	0
	SUB-TOTAL:	41	3	0	20	44	93	7	0
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	3	0	1	0	4	75	0	25
18.	At the medical records room?	1	1	0	2	2	50	50	0
19.	Before being seen for treatment?	3	1	0	0	4	75	25	0
20.	To have an x-ray taken?	0	0	0	4	0	0	0	0
21.	At the pharmacy?	0	0	0	4	0	0	0	0
22.	To have a laboratory test taken?	0	0	0	4	0	0	0	0
	SUB-TOTAL:	7	2	1	14	10	70	20	10
	GRAND TOTAL:	48	5	1	34	54	89	9	2

PEDS

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	6	2	0	0	8	75	25	0
2.	The nursing staff?	6	2	0	0	8	75	25	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	6	2	0	0	8	75	25	0
4.	The overall care you received?	5	3	0	0	8	63	37	0
5.	The explanation of your problem?	6	2	0	0	8	75	25	0
6.	The explanation about your medications?	6	1	0	1	7	86	14	0
7.	The explanation of your treatment/follow-up?	7	1	0	0	8	88	12	0
8.	The answers to your questions?	6	2	0	0	8	75	25	0
9.	The concern for your privacy?	5	2	0	1	7	71	29	0
10.	The appointment personnel?	4	2	0	2	6	67	33	0
11.	The medical records personnel?	5	2	0	1	7	71	29	0
12.	The laboratory staff?	2	3	0	3	5	40	60	0
13.	The x-ray staff?	1	1	0	6	2	50	50	0
14.	The pharmacy staff?	2	3	2	1	7	29	42	29
15.	The parking facilities?	1	5	2	0	8	12	63	25
16.	The directions within the hospital area?	4	4	0	0	8	50	50	0
	SUB-TOTAL:	72	37	4	15	113	64	33	3
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	3	4	1	0	8	38	50	12
18.	At the medical records room?	4	2	0	2	6	67	33	0
19.	Before being seen for treatment?	5	2	1	0	8	63	25	12
20.	To have an x-ray taken?	1	1	0	6	2	50	50	0
21.	At the pharmacy?	0	5	2	1	7	0	71	29
22.	To have a laboratory test taken?	1	2	1	4	4	25	50	25
	SUB-TOTAL:	14	16	5	13	35	40	46	14
	GRAND TOTAL:	86	53	9	28	148	58	36	6

P.T.

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	19	0	0	0	19	100	0	0
2.	The nursing staff?	15	3	0	1	18	83	17	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	15	2	1	1	18	83	11	6
4.	The overall care you received?	15	3	1	0	19	79	16	5
5.	The explanation of your problem?	14	4	1	0	19	74	21	5
6.	The explanation about your medications?	10	1	0	8	11	91	9	0
7.	The explanation of your treatment/follow-up?	16	2	0	1	18	89	11	0
8.	The answers to your questions?	13	4	1	1	18	72	22	6
9.	The concern for your privacy?	12	3	0	4	15	80	20	0
10.	The appointment personnel?	14	1	0	4	15	93	7	0
11.	The medical records personnel?	9	2	0	8	11	82	18	0
12.	The laboratory staff?	7	2	0	10	9	78	22	0
13.	The x-ray staff?	8	3	0	8	11	73	27	0
14.	The pharmacy staff?	8	2	1	8	11	73	18	9
15.	The parking facilities?	2	9	7	1	19	11	50	39
16.	The directions within the hospital area?	11	6	1	1	18	61	33	6
	SUB-TOTAL:	188	47	13	56	248	76	19	5
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	7	7	2	3	16	44	44	12
18.	At the medical records room?	6	5	1	7	12	50	42	8
19.	Before being seen for treatment?	8	7	1	3	16	50	44	6
20.	To have an x-ray taken?	5	5	2	7	12	42	42	16
21.	At the pharmacy?	5	5	3	6	13	38	38	24
22.	To have a laboratory test taken?	4	6	1	8	11	36	55	9
	SUB-TOTAL:	35	35	10	34	80	44	44	12
	GRAND TOTAL:	223	82	23	90	328	68	25	7

PODIATRY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	1	0	0	0	1	100	0	0
2.	The nursing staff?	1	0	0	0	1	100	0	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1	0	0	0	1	100	0	0
4.	The overall care you received?	1	0	0	0	1	100	0	0
5.	The explanation of your problem?	1	0	0	0	1	100	0	0
6.	The explanation about your medications?	1	0	0	0	1	100	0	0
7.	The explanation of your treatment/follow-up?	1	0	0	0	1	100	0	0
8.	The answers to your questions?	1	0	0	0	1	100	0	0
9.	The concern for your privacy?	1	0	0	0	1	100	0	0
10.	The appointment personnel?	1	0	0	0	1	100	0	0
11.	The medical records personnel?	1	0	0	0	1	100	0	0
12.	The laboratory staff?	1	0	0	0	1	100	0	0
13.	The x-ray staff?	1	0	0	0	1	100	0	0
14.	The pharmacy staff?	1	0	0	0	1	100	0	0
15.	The parking facilities?	0	0	1	0	1	0	0	100
16.	The directions within the hospital area?	1	0	0	0	1	100	0	0
	SUB-TOTAL:	15	0	1	0	16	94	0	6
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	1	0	0	0	1	100	0	0
18.	At the medical records room?	1	0	0	0	1	100	0	0
19.	Before being seen for treatment?	1	0	0	0	1	100	0	0
20.	To have an x-ray taken?	1	0	0	0	1	100	0	0
21.	At the pharmacy?	1	0	0	0	1	100	0	0
22.	To have a laboratory test taken?	1	0	0	0	1	100	0	0
	SUB-TOTAL:	6	0	0	0	6	100	0	0
	GRAND TOTAL:	21	0	1	0	22	95	0	5

PSYCHIATRY

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	12	1	0	0	13	92	8	0
2.	The nursing staff?	4	1	0	8	5	80	20	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	9	2	0	2	11	82	18	0
4.	The overall care you received?	10	2	0	1	12	83	17	0
5.	The explanation of your problem?	10	2	0	1	12	83	17	0
6.	The explanation about your medications?	5	1	0	7	6	83	17	0
7.	The explanation of your treatment/follow-up?	8	3	0	2	11	73	27	0
8.	The answers to your questions?	9	2	0	2	11	82	18	0
9.	The concern for your privacy?	10	1	0	2	11	91	9	0
10.	The appointment personnel?	10	1	0	2	11	91	9	0
11.	The medical records personnel?	2	3	0	8	5	40	60	0
12.	The laboratory staff?	1	3	0	9	4	25	75	0
13.	The x-ray staff?	2	2	0	9	4	50	50	0
14.	The pharmacy staff?	1	4	1	7	6	17	66	17
15.	The parking facilities?	5	5	0	3	10	50	50	0
16.	The directions within the hospital area?	1	3	0	9	4	25	75	0
	SUB-TOTAL:	99	36	1	72	136	73	26	1
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	6	6	0	1	12	50	50	0
18.	At the medical records room?	2	2	0	9	4	50	50	0
19.	Before being seen for treatment?	8	3	0	2	11	73	27	0
20.	To have an x-ray taken?	2	2	1	8	5	40	40	20
21.	At the pharmacy?	1	2	2	8	5	20	40	40
22.	To have a laboratory test taken?	1	3	1	8	5	20	60	20
	SUB-TOTAL:	20	18	4	36	42	48	43	9
	GRAND TOTAL:	119	54	5	108	178	67	30	3

PULMONARY FUNCTION

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	1	1	0	0	2	50	50	0
2.	The nursing staff?	1	1	0	0	2	50	50	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1	1	0	0	2	50	50	0
4.	The overall care you received?	1	1	0	0	2	50	50	0
5.	The explanation of your problem?	0	1	0	1	1	0	100	0
6.	The explanation about your medications?	0	1	0	1	1	0	100	0
7.	The explanation of your treatment/follow-up?	0	1	0	1	1	0	100	0
8.	The answers to your questions?	0	1	0	1	1	0	100	0
9.	The concern for your privacy?	1	1	0	0	2	50	50	0
10.	The appointment personnel?	1	1	0	0	2	50	50	0
11.	The medical records personnel?	0	1	0	1	1	0	100	0
12.	The laboratory staff?	1	1	0	0	2	50	50	0
13.	The x-ray staff?	1	1	0	0	2	50	50	0
14.	The pharmacy staff?	1	1	0	0	2	50	50	0
15.	The parking facilities?	1	1	0	0	2	50	50	0
16.	The directions within the hospital area?	1	1	0	0	2	50	50	0
	SUB-TOTAL:	11	16	0	5	27	41	59	0
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	1	1	0	0	2	50	50	0
18.	At the medical records room?	1	1	0	0	2	50	50	0
19.	Before being seen for treatment?	1	1	0	0	2	50	50	0
20.	To have an x-ray taken?	1	1	0	0	2	50	50	0
21.	At the pharmacy?	1	1	0	0	2	50	50	0
22.	To have a laboratory test taken?	1	1	0	0	2	50	50	0
	SUB-TOTAL:	6	6	0	0	12	50	50	0
	GRAND TOTAL:	17	22	0	5	39	44	56	0

SOCIAL WORK

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
. The clinic receptionist?	1	0	0	0	1	100	0	0
.. The nursing staff?	0	0	0	1	0	0	0	0
.. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1	0	0	0	1	100	0	0
. The overall care you received?	1	0	0	0	1	100	0	0
. The explanation of your problem?	1	0	0	0	1	100	0	0
. The explanation about your medications?	1	0	0	0	1	100	0	0
. The explanation of your treatment/follow-up?	1	0	0	0	1	100	0	0
. The answers to your questions?	1	0	0	0	1	100	0	0
. The concern for your privacy?	1	0	0	0	1	100	0	0
0. The appointment personnel?	0	0	0	1	0	0	0	0
1. The medical records personnel?	0	0	0	1	0	0	0	0
2. The laboratory staff?	0	0	0	1	0	0	0	0
3. The x-ray staff?	0	0	0	1	0	0	0	0
14. The pharmacy staff?	0	1	0	0	1	0	100	0
15. The parking facilities?	0	1	0	0	1	0	100	0
16. The directions within the hospital area?								
SUB-TOTAL:	9	2	0	5	11	82	18	0
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17. To obtain an appointment?	1	0	0	0	1	100	0	0
18. At the medical records room?	0	0	0	1	0	0	0	0
19. Before being seen for treatment?	1	0	0	0	1	100	0	0
20. To have an x-ray taken?	0	0	0	1	0	0	0	0
21. At the pharmacy?	0	0	0	1	0	0	0	0
2. To have a laboratory test taken?	0	0	0	1	0	0	0	0
SUB-TOTAL:	2	0	0	4	2	100	0	0
GRAND TOTAL:	11	2	0	9	13	85	15	0

F.P. #3

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:								
1.	The clinic receptionist?	21	7	0	0	28	75	25	0
2.	The nursing staff?	19	10	0	0	28	64	36	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	19	8	0	1	27	70	30	0
4.	The overall care you received?	13	13	0	2	26	50	50	0
5.	The explanation of your problem?	13	9	1	5	23	57	39	4
6.	The explanation about your medications?	10	8	1	9	19	53	42	7
7.	The explanation of your treatment/follow-up?	13	7	1	7	21	62	33	5
8.	The answers to your questions?	13	8	2	5	23	57	35	8
9.	The concern for your privacy?	14	11	0	3	25	56	44	0
10.	The appointment personnel?	9	9	3	7	21	43	43	14
11.	The medical records personnel?	9	7	2	10	18	50	39	11
12.	The laboratory staff?	5	7	0	16	12	42	58	0
13.	The x-ray staff?	5	3	0	20	8	63	37	0
14.	The pharmacy staff?	6	9	0	13	15	40	60	0
15.	The parking facilities?	6	14	8	0	28	21	50	29
16.	The directions within the hospital area?	14	12	1	1	27	52	44	4
	SUB-TOTAL:	188	142	19	99	349	54	41	5
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
17.	To obtain an appointment?	7	9	8	4	24	29	38	33
18.	At the medical records room?	5	9	1	13	15	33	60	7
19.	Before being seen for treatment?	13	13	1	1	27	48	48	4
20.	To have an x-ray taken?	3	4	1	20	8	38	50	12
21.	At the pharmacy?	2	10	2	14	14	14	72	14
22.	To have a laboratory test taken?	4	6	1	17	11	36	35	9
	SUB-TOTAL:	34	51	14	69	99	34	52	14
	GRAND TOTAL:	222	193	33	168	448	50	43	7

F.P. #4

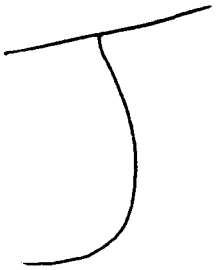
OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

		VSAT	+	ACCEPT	+	DSAT	-	DNA	=	TOTAL	=	VSAT%	ACCEPT%	DSAT%
	HOW SATISFIED WERE YOU WITH:													
1.	The clinic receptionist?	14		2		0		0		16		88	12	0
2.	The nursing staff?	12		4		0		0		16		75	25	0
3.	The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	12		4		0		0		16		75	25	0
4.	The overall care you received?	12		4		0		0		16		75	25	0
5.	The explanation of your problem?	9		6		0		1		15		60	40	0
6.	The explanation about your medications?	6		6		0		4		12		50	50	0
7.	The explanation of your treatment/follow-up?	8		7		0		1		15		53	47	0
8.	The answers to your questions?	10		5		0		1		15		67	33	0
9.	The concern for your privacy?	10		5		0		1		15		67	33	0
10.	The appointment personnel?	10		4		0		2		14		71	29	0
11.	The medical records personnel?	7		5		0		4		12		58	42	0
12.	The laboratory staff?	5		3		0		8		8		63	37	0
13.	The x-ray staff?	6		2		0		8		8		75	25	0
14.	The pharmacy staff?	7		3		0		6		10		70	30	0
15.	The parking facilities?	3		7		4		2		14		21	50	29
16.	The directions within the hospital area?	10		4		0		2		14		71	29	0
	SUB-TOTAL:	141		71		4		40		216		65	33	2
	HOW SATISFIED WERE YOU WITH THE WAITING TIME:													
17.	To obtain an appointment?	9		3		2		2		14		64	22	14
18.	At the medical records room?	4		7		0		5		11		36	64	0
19.	Before being seen for treatment?	7		5		1		3		13		54	38	8
20.	To have an x-ray taken?	3		4		0		9		7		43	57	0
21.	At the pharmacy?	2		7		1		6		10		20	70	10
22.	To have a laboratory test taken?	1		6		0		9		7		14	86	0
	SUB-TOTAL:	26		32		4		34		62		42	52	6
	GRAND TOTAL:	167		103		8		74		278		60	37	3

NUTRITION

OUTPATIENT QUESTIONNAIRE
BAYNE-JONES ARMY COMMUNITY HOSPITAL, FORT POLK, LOUISIANA, 71459-6000

	VSAT	+ ACCEPT	+ DSAT	- DNA	= TOTAL	= VSAT%	ACCEPT%	DSAT%
HOW SATISFIED WERE YOU WITH:								
. The clinic receptionist?	2	0	0	0	2	100	0	0
. The nursing staff?	1	0	0	1	1	100	0	0
. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	2	0	0	0	2	100	0	0
. The overall care you received?	2	0	0	0	2	100	0	0
. The explanation of your problem?	2	0	0	0	2	100	0	0
. The explanation about your medications?	2	0	0	0	2	100	0	0
. The explanation of your treatment/follow-up?	2	0	0	0	2	100	0	0
. The answers to your questions?	2	0	0	0	2	100	0	0
. The concern for your privacy?	2	0	0	0	2	100	0	0
0. The appointment personnel?	1	0	0	1	1	100	0	0
1. The medical records personnel?	1	0	0	1	1	100	0	0
2. The laboratory staff?	1	0	0	1	1	100	0	0
3. The x-ray staff?	1	0	0	1	1	100	0	0
4. The pharmacy staff?	1	1	0	0	2	50	50	0
5. The parking facilities?	2	0	0	0	2	100	0	0
6. The directions within the hospital area?								
SUB-TOTAL:	26	1	0	5	27	96	4	0
HOW SATISFIED WERE YOU WITH THE WAITING TIME:								
7. To obtain an appointment?	2	0	0	0	2	100	0	0
8. At the medical records room?	1	0	0	1	1	100	0	0
9. Before being seen for treatment?	1	0	0	1	1	100	0	0
0. To have an x-ray taken?	1	0	0	1	1	100	0	0
1. At the pharmacy?	1	0	0	1	1	100	0	0
2. To have a laboratory test taken?	1	0	0	1	1	100	0	0
SUB-TOTAL:	7	0	0	5	7	100	0	0
GRAND TOTAL:	33	1	0	10	34	97	3	0



FY 88 COST PER CLINIC VISIT

ACTIVITY	MEPERS COST	SUPPLEMENTAL COST
INTERNAL MEDICINE	$105.13	$302.96
NEUROLOGY	25.03	143.19
NUTRITION	19.50	
DERMATOLOGY	42.75	86.67
GENERAL SURGERY	77.14	967.50
OPHTHALMOLOGY	63.35	106.92
EENT	74.68	99.00
UROLOGY	-0-	919.35
GYN	72.02	502.00
OB	51.53	
PEDIATRICS	69.24	378.10
ADOLESCENT	42.31	
WELL BABY	32.98	
EFMP	1153.38	
ORTHOPEDICS	94.41	
CAST	35.79	
ORTHO APPLIANCE	99.79	
PODIATRY	68.16	
MENTAL HEALTH	56.60	1231.25
SOCIAL WORK	34.40	
ADAPCP	52.62	
FAMILY PRACTICE	60.43	
PRIMARY CARE	50.74	
MEDICAL EXAM	135.96	
OPTOMETRY	40.50	
AUDIOLOGY	93.04	342.30
COMMUNITY HEALTH	26.31	
OCCUPATIONAL HEALTH	38.33	
EMERGENCY MEDICAL	85.96	
FLIGHT MEDICINE	61.82	