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A SYSTEMS ANALYSIS TO DETERMINE THE OPTIMAL ORGANIZATIONAL DESIGN FOR THE COORDINATED CARE DIVISION AT MONCRIEF ARMY COMMUNITY HOSPITAL, FORT JACKSON, SOUTH CAROLINA

A Graduate Management Project
Submitted to the Faculty of
Baylor University
In Partial Fulfillment of the
Requirements for the Degree
of
Master of Health Administration
by
Major Dennis E. Coker, MS
17 July 1992

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Abstract

The United States Army Health Services Command (HSC) has initiated its own program of coordinated care called the Gateway To Care Program. Moncrief Army Community Hospital at Fort Jackson, South Carolina, due to begin the Gateway program in fiscal year 1993, is interested in creating an internal organizational structure responsible to coordinate the delivery of cost-effective, quality health care to its Department of Defense beneficiaries from military, federal and civilian health care sources in its catchment area. Since this initiative represents a dramatic departure from past practices and procedures, the success of the program rests to a large extent on the design of the internal structure created to accomplish the designated tasks. A systems analysis was conducted to determine the optimal organizational design responsible for the coordination of the Gateway To Care program. The study included a review of the present system and an identification of alternative designs with a cost and benefit analysis. The findings and recommendations were presented to the Executive Committee requesting their implementing decision.

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Introduction

Conditions Which Prompted the Study

In an attempt to contain costs and optimize the allocation of scarce resources while providing quality care and attempting to control utilization, the emerging trend in the health care industry is managed care. The managed care movement has grown out of concerns from the government, third party payers and the general public that health care costs are spiraling higher and higher and are basically out of control. With nearly twelve percent of the Gross National Product, approximately 666 billion dollars, attributed to health care and estimates that it will continue to increase, the payers of health care are demanding a more cost-conscious approach to the delivery of health care (South Carolina Hospital Association, 1991).

The Department of Defense has implemented several alternative delivery systems similar to the civilian community's managed care programs, resulting in innovative approaches and changes to the methods and practices associated with providing health care to their authorized beneficiary population. The three largest programs are the CHAMPUS Reform Initiative (better known as CRI), the Catchment Area Management (CAM) demonstration projects and the Southeastern Region Preferred Provider Organization (PPO) (Gawaltney, 1990). Each have led to new methods of providing health care services. Each was organized and executed under Congressional approval to test the feasibility of alternative delivery systems employing managed care principles which have been evolving in the civilian sector for the last five to eight years (Boyer, Fant, Lillie and Pool, 1991).

The United States Army Health Services Command (HSC) has initiated its own version of the Department of Defense Coordinated Care Program called the Gateway To Care Program, or simply Gateway. The objectives of the Gateway initiative are threefold: insure access to medical care for all eligible beneficiaries; maintain the quality of health care from all provider sources that is equal to or greater than that of care provided by military medical treatment facilities; and contain health care costs (US Army Health Services Command, 1991). Eleven facilities are scheduled to begin Gateway programs in fiscal year 1992, with the remainder of Army Medical Department Activities (MEDDACs) due to join the program the following year.

Moncrief Army Community Hospital in Fort Jackson, South Carolina is due to begin the Gateway program in fiscal year 1993.

Moncrief Army Community Hospital is interested in creating an internal organizational structure to coordinate the delivery of cost-effective care to its authorized beneficiaries from a variety of military, federal and civilian sources. While guidance has been provided by the corporate headquarters (HSC) on the tasks for which this new organizational element is responsible, the hospital commander is free to design a structure for the individual facility to accomplish the mission.

Statement of the Management Problem

To determine the optimal design for the organizational entity responsible to coordinate the delivery of quality health care services to its beneficiary population.

Review of the Literature

Managed Care.

Boland (1991) states that managed care is difficult to define because it means different things to different people. The American Hospital Association (1988) defines managed care as "an organized program to control access to health services, designed to ensure the medical necessity of the proposed services and the delivery of services at the most cost-effective level of care" (p. 1). Simply stated, managed care is the use of different financial incentives and management controls to direct patients to efficient providers for appropriate medical care in cost-effective treatment settings (Boland, 1991). Schiffer (1992) proposes a similar definition, but he also asserts that one cannot manage care without coordinating care, and suggests that a more appropriate term should be "coordinated care."

Managed care plans were first developed in the 1920's and involved prepaid group practices. In response to the ever-increasing cost of health care, managed care took a substantial step forward with the passage of the Health Maintenance Organization Act in 1973. Managed care was perceived as an alternative delivery system which could fix the built-in incentives for excess associated with the fee-for-service system.

The managed care movement in the United States has been expanding over the last several years, with an increasing involvement on the part of hospitals. In 1982, managed care held less than one percent of the group health business market, but the percentage has grown to over 25 percent by 1990 and is expected to continue to increase (Health Insurance Association of America, 1991). Schaengold (1992) estimates that as many as 70 percent of employees with health care coverage are enrolled in a managed care plan, with expectations that the percentage could reach 90 percent by the middle of the 1990s. He calls the shift to managed care " a megatrend affecting every aspect of medical care purchasing or delivery" (p. 5).

A recent survey conducted by the American Hospital Association found that 82 percent of the 300 hospitals surveyed are involved in managed care to some extent (Cerne, 1991). A survey of hospital chief executive officers' predicted a slow, steady growth in managed care nationally and that managed care will account for 17 percent of total net patient revenues in 1991, up from 13.1 percent in 1990 (American Hospital Association, 1991a, 1991b).

In a recent Department of Commerce report, health expenditures for 1992 are expected to rise to 817 billion dollars -- a 10.7 percent increase over 1991

(South Carolina Hospital Association, 1992). The increase is reportedly due to the expansion of expensive technology, the costs associated with providing health care services to an aging population and the costs associated with professional liability. Polzer (1990) has predicted that, with the current annual increases, we could spend about fifteen percent of the Gross National Product (about 1.5 trillion dollars) on national health expenditures in the year 2000.

In view of these escalating costs and the need to optimize the utilization of scarce resources while providing quality care and attempting to control utilization, the health care industry is moving toward managed care. Kraymon (1991) stated that "many health economists consider managed care the nation's most realistic chance for containing medical expenses and insuring high-quality care" (p. 1).

A recent study regarding the Health Maintenance Organization (HMO) market penetration and hospital cost inflation in California asserts that hospitals operating in markets with high concentration of HMOs experienced significantly lower increase in costs per admission than hospitals in areas with low concentration (Robinson, 1991). Robinson's hypothesis states that the cost containment effects of HMO's can indirectly affect hospitals' behavior by stimulating more price-competitive behavior on the part of other health insurance plans.

"Many observers of managed care are predicting that it will become one of the dominant -- if not the dominant -- form of health care delivery and financing in the years to come" (Health Insurance Asssociation of America, 1991, p.22).

The Department of Defense (DoD) defines managed care as:

> a system that integrates both the delivery and financing of appropriate health care services through the following mechanisms: a select network of providers, organized in a network, who agree to provide comprehensive health care services to members; explicit standards for provider selection; formal utilization review and quality assurance programs; and significant financial incentives for consumers to choose network providers" (Office of the Surgeon General, U.S. Army [OTSG], 1991, p. 21).

In fiscal year 1991, Department of Defense expenditures for health care totalled 15.1 billion dollars, or 5.6 percent of the 273 billion dollar DoD budget (OTSG, 1991). A Government Accounting Office report estimates that the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) costs have increased from 1.4 billion dollars in 1985 to 3.6 billion dollars in fiscal year 1991 (Thompson, 1991). Department of Defense officials estimate that if health care expenditures are not curtailed through cost containment practices, the Pentagon may be spending half as much on health care as it will spend on new weapon systems (Pasztor, 1991). Pasztor (1991) reports that a management study conducted by the Pentagon rejected the thought of maintaining the status quo in military health care as being short-sighted.

In order to combat the ever-increasing costs associated with providing health care services to its authorized beneficiaries, the Department of Defense sees managed care as a solution. As a result of the integration of both the financing and the delivery of health care, managed care eliminates the incentives to overtreat, overspend and overhospitalize; puts a premium on prevention and primary care which is often neglected in traditional health care systems; and provides a closer link between primary and secondary care and a smaller incentive to refer patients to a specialist (OTSG, 1991).

Department of Defense Alternative Delivery Systems.

In order to validate their beliefs, the Department of Defense has tested several alternative delivery systems. The three largest systems are the CHAMPUS Reform Initiative (CRI); the Southeastern Region Preferred Provider Organization (PPO); and the Catchment Area Management (CAM) demonstration projects (Gawaltney, 1990).

The CHAMPUS Reform Initiative, or CRI, was implemented by Department of Defense medical treatment facilities in California and Hawaii in February 1988. It tested the ability of a single private contractor (Foundation Health Corporation) to coordinate the delivery of care for beneficiaries and attempt to reduce the costs associated with CHAMPUS program (Stern, 1991).

Implemented in July, 1990 in the military treatment facilities in the states of Florida, Georgia, Alabama, Mississippi and Tennessee, The

Southeastern Region Preferred Provider Organization (SER-PPO) was designed to test the feasibility of a regionally directed program operated by a fiscal intermediary (Boyer, et al., 1991). Operated by the Wisconsin Physicians Services (WPS), the project is designed to serve as a support contract for the individual facility commander by providing a network of civilian providers to augment the capabilities of each facility. In that regard, the military treatment facility is viewed as the "most preferred provider" and coordinates, not competes, with the civilian network (Boyer, et al., 1991).

The Catchment Area Management (CAM) demonstration was designed to test the capabilities of the military health care system to control CHAMPUS costs at the local level (Boyer, et al., 1991). Badgett stated that the focus of the CAM demonstration was to give greater latitude to the individual military treatment facility commander by making him "responsible for the provision of health care to all beneficiaries within the [catchment] area, regardless of whether the care is rendered in the military or civilian sector" (cited in Armstrong, Christal, Howard & Howe, 1990, p. 2). This includes the authority to obligate CHAMPUS funds in addition to the direct care funds. This new authority allowed the local commander to set up networks consisting of military and civilian providers. There were five sites spread across the country -- two Army, two Air Force and one Navy -- and each service was able to design and implement their own projects. The first CAM site became operational in June 1989.

While the services were allowed to develop their own sites, there were some common design features to all the CAM sites. These included the use of health care finders, voluntary enrollment, enhanced claims management, utilization management and quality assurance programs and modifications to the standard benefit package to entice beneficiaries to enroll in the program (Boyer, et al., 1991). A concern expressed by the Congressional Budget Office is that improved access to military health care will result in increased costs to the Department of Defense, due to the shift of patients from standard CHAMPUS to the military health care system (Slackman, 1991). As with the CRI demonstration, an evaluation has not been completed to determine the success of the respective sites.

Coordinated Care Program.

The Department of Defense has defined its Coordinated Care Program as one "to improve the quality, access and cost effectiveness of health care services and move the Department of Defense into a managed care environment where local medical commanders will have incentives to make health care decisions most effectively" (OTSG, 1991, p. 4). According to Doctor Enrique Mendez, Jr., (1992a), the Assistant Secretary of Defense (Health Affairs) and the senior official responsible in the Department of Defense, the strategy of the coordinated care concept is to achieve the optimal balance between the triad of access, quality and cost and "the centerpiece for the coordinated care program is the local health care delivery system" (p. 34). Tomich (1992) reported that this program is expected to transform the military health care system into a more localized, flexible system better suited to meet its beneficiaries' needs as a result of a balance between military and civilian providers. This balance is the result of local military treatment facility commanders having the authority to enter into contracts and agreements with providers in the civilian sector (Group Health Association of America, 1992).

The Department of Defense believes that health care costs can be lowered as a result of the Coordinated Care Program because unnecessary utilization of resources will drop; maximizing use of the existing direct care facilities' capabilities will cost less than using the private sector; decisions will be made based on cost-effectiveness; and careful negotiations and analysis will result in lower prices for certain services and procedures (OTSG, 1991). In a Government Accounting Office report, Thompson (1991) stated that rather than select one of the current demonstration projects for sole use in the Coordinated Care Program, the Department of Defense has decided to combine key features from each of the projects. The Coordinated Care Program uses the Catchment Area Management model of giving local hospital commanders increased responsibility and authority in their area of responsibility, but also incorporates the use of contractor services seen in the CRI project. The report concludes that the Department of Defense has made significant advances in transitioning to a managed care system, but still has some concerns over the expansion of the Coordinated Care Program. Their concerns focus on the need for more realistic expectations of the success of the implementation and the need for adopting uniform benefits and cost sharing throughout the entire system. Mendez (1992a) asserts that a comprehensive and system-wide education effort is a necessity for the program to succeed, both for the providers and the supported population.

The principles guiding the Coordinated Care Program focus on decentralized execution and local accountability with centralized monitoring. In addition, the Program aims to optimize the use of the military health service system and maintain flexibility. The principles are listed in Appendix A.

The key features of the Coordinated Care Program are "beneficiary enrollment; changes in beneficiary cost share; creation of local networks of military and civilian providers; specialized treatment facilities; merger of direct care and CHAMPUS funds; and local accountability with centralized monitoring" (OTSG, 1991, p.36).

The Coordinated Care Program has been widely criticized for its emphasis on penalties for those beneficiaries who choose not to enroll (Nelson, 1992a, 1992b, 1992c). Opponents feel that the program must offer discounts, benefits and other positive incentives to encourage participation, rather than discourage non-participation through penalties and restrictions. Congressman Murtha, chairman of the influential House Appropriation Committee's Defense Subcommittee, wants the concept of discounted medical care from government-approved networks preserved in any overhaul of the military health care system (Nelson, 1992b).

This concern has led Mr. Atwood (1992), Deputy Secretary of Defense, to issue a memorandum directing that the Coordinated Care Program eliminate the military treatment facility lock-out provisions and higher copayment and deductibles for those beneficiaries who choose not to enroll in the program. In addition, he directed the incorporation of a benefit package similar to the CHAMPUS Reform Initiative, with three options (HMO, point-of-service PPO and standard CHAMPUS).

Army Management Initiatives.

In fiscal year 1991, the Army spent 1.874 billion dollars in direct health care funds (63 percent), and 1.109 billion dollars in CHAMPUS funds (37 percent) in fiscal year 1991. The Army concluded that since health care costs will continue their upward spiral at a rate greater than the inflation rate, they must actively manage health care costs in order not to "bust" their budget.

The Army has participated in fourteen management initiatives aimed at minimizing health care expenditures, listed in Appendix A. The more significant management initiatives have included the Gateway To Care Program; the Third Party Collection Program; the Military/Civilian Health Services Partnership Program; and the establishment of PRIMUS Clinics.

A list of the Army's participation in demonstration projects of alternative health care delivery systems is found in Appendix A.

A memorandum from the Army Office of the Surgeon General directed the development of the Gateway To Care Program as the Army's Coordinated Care Program. This program is based on the results and lessons learned of the Department of Defense demonstration projects with additional guidance coming from the Army's management initiatives (OTSG, 1991).

Gateway To Care Program.

The purpose of the Gateway To Care program is to develop the Army's Coordinated Care Program using the lessons and experiences from the Army's management initiatives and demonstrations (OTSG, 1991). The Gateway To Care program focuses on targeting current users of the direct care system and CHAMPUS for voluntary enrollment in a specific plan. They will be restricted to specific primary entry points when seeking care within the health service area.

When beneficiaries enroll in a specific plan, they will be assigned to a primary care provider or clinic in the military treatment facility. Referral for necessary treatment beyond the facility's capabilities are provided by contracts or agreements with medical care networks, arranged and negotiated by the military treatment facility.

A major goal of the Gateway To Care program is to develop a health care plan that encourages beneficiary use consistent with the intent and directives of Congress (Health Services Command [HSC], 1991). Additional objectives of the Gateway To Care program are listed in Appendix A.

The key to the Gateway program will be developing medical care networks or systems designed to meet the specific needs/requirements of the individual military treatment facility. Emphasis will be placed on the recapture of CHAMPUS workload through careful analysis of beneficiary needs, present CHAMPUS usage and the restructure of military treatment facility resources and capabilities. This will include arrangements with other federal medical activities, partnerships and agreements to provide alternative care settings to the standard CHAMPUS setting at a reduced cost.

The key components of the Gateway To Care program are listed in Figure 1.

Figure 1

Gateway To Care Program Key Components

-- beneficiary membership/enrollment

-- the use of designated providers for participants (called "primary care managers")

-- the use of health care finders to provide referral/appointment management

-- the formation of a coordinated care management office

Figure 1 (continued)

Gateway To Care Program Key Components

-- the use of utilization management/control

-- the use of health information management and analyses

-- delegated authority for flexible use of CHAMPUS funds

-- the use of health services contracting

Source: OTSG, 1991.

In its corporate guidance, Health Services Command has provided a basic design of the new organizational structure for inclusion in the manpower authorization document, the Table of Distribution and Allowances, but has allowed individual hospitals to modify the structure to fit their specific needs and requirements (HSC, 1990). This recognizes the fact that there is no one best way for all institutions to organize. Table 1 details the information contained in the Table of Distribution and Allowances for the initial personnel requirements and authorizations.

Darr and Rakich (1989) take the organizational design decision a step further and emphasize that the

Table 1

Table of Distribution and Allowances

Position Title	Grade	Required	Authorized
Health Systems Manager	GS11	1	1
Utilization Management Coordinator	GS09	1	1
Management Analyst	GS09	2	1
Case Manager	GS07	1	1
Auditor	GS07	1	0
Civilian Resource Coordinator	GS07	1	1
Secretary	GS05	1	0
Budget Assistant (Typing)	GS05	1	1
Health Benefits Advisor	GS05	2	1

Source: Moncrief ACH Table of Distribution and Allowances, 1992

organization's design must be flexible enough to respond to the changing environment.

In its Organization and Functions Manual, Regulation 10-1, published in September, 1991, Health Services Command identified eighteen tasks for which the new Coordinated Care Division would be responsible. These tasks, listed in figure 2, include responsibility for the CHAMPUS program, the supplemental care program, contract negotiations, educational and informational programs, issuance of nonavailability statements and the utilization management program.

Figure 2

Tasks for the Coordinated Care Division

(1) Manage the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), including nonavailability statements.

(2) Provide information services on medical care available in other health care facilities and on health benefits available through the Veterans Administration (VA) and other Governmental agencies.

(3) Review requests for civilian supplemental care for compliance with regulatory requirements prior to command approval.

(4) Develop and maintain data and information regarding the clinical capabilities within the MTF and the civilian community.

Figure 2 (continued)

Tasks for the Coordinated Care Division

(5) Identify clinical areas within the MTF which would benefit from the implementation of a Military Civilian Health Services partnership agreement, VA/DOD sharing agreements, Direct Health Care Provider Program (DHCPP), or other initiatives which maximize the use of the MTF resources.

(6) Develop statements of work for contract purposes and agreements which support DHCPP and Partnership Program.

(7) Monitor supplemental care expenditures and identify cost effective civilian alternatives for supplemental care program use.

(8) Negotiate agreements and contracts to support the Direct Health Care Provider Program (DHCPP), the Civilian-Military Partnership Program, the Supplemental Care Program, and Veterans Administration/Department of Defense Sharing Agreement Program.

(9) Coordinate with the CHAMPUS Fiscal Intermediary, OCHAMPUS and the Coordinated Care Division, DCSCS, HSC

Figure 2 (continued)

Tasks for the Coordinated Care Division

for CHAMPUS policy guidance, reimbursement policies and practices, special program status and benefits changes.

(10) Disseminate information to beneficiaries and providers regarding the CHAMPUS and medical treatment facility (MTF) capabilities and policies.

(11) Operate the Health Care Finder program which provides information and referral services to beneficiaries and providers concerning the availability and location of medical services within the MTF catchment area.

(12) Provide information to beneficiaries and providers concerning health benefits programs available. These include but are not limited to CHAMPUS, MEDICARE, MEDICAID, Veterans medical benefits, civilian community health resources, and services provided by charity and state agencies within the catchment area.

(13) Conduct continuous monitoring of the health care resources within the catchment area, including the

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Figure 2 (continued)

Tasks for the Coordinated Care Division

military community, in order to provide current information regarding the availability and affordability of services to beneficiaries and the MTF.

(14) Issue nonavailability statements (NAS) and maintain the automated NAS issuance system in Defense Eligibility Enrollment Reporting System (DEERS) for MTF.

(15) Provide information to the commander concerning the numbers and reasons for issuance of NAS within the MTF. Provide information to beneficiaries and providers regarding the requirements for NAS.

(16) Identify opportunities and develop detailed plans for the use of CHAMPUS Funds for Other Than CHAMPUS Claims Program.

(17) Develop and maintain a utilization management system to monitor the progress of services provided under Partnership Agreements and other CHAMPUS initiatives such as Alternate Use of CHAMPUS Funds Projects.

Figure 2 (continued)

Tasks for the Coordinated Care Division

(18) Implement and monitor approved projects under alternate use projects.

Source: HSC Regulation 10-1, September, 1991.

Purpose of the Study

The purpose of this study is to design the optimal organizational structure responsible to accomplish the eighteen tasks set forth by Health Services Command in the Gateway To Care program at Moncrief Army Community Hospital.

Methods and Procedures

A systems analysis has been conducted to determine the optimal organizational design for an internal structure responsible to coordinate the delivery of affordable, quality health care to its Department of Defense beneficiaries at Moncrief Army Community Hospital. A systems analysis considers a problem in context and allows for a complete analysis of the situation in a systematic, well-organized method.

The systems analysis began with an executive summary to determine the system objectives. The eighteen tasks detailed in paragraph 3-21 of Health Services Command's Regulation 10-1 were used for the system's objectives (HSC, 1991). These are the tasks the new Coordinated Care Division is responsible for under the Gateway program.

With that initial point of reference, an examination was done of the present processes and practices in place at the Moncrief Army Community Hospital. Through the use of data flow diagrams, the processes were analyzed along with the entities and data stores used to accomplish the mission. Data flow diagrams serve to depict the relationship of data to the processes.

The use of data flow diagrams to assist in the design process and analysis has many advantages. Data flow diagrams allow an unrestricted analysis since they do not impose implementation details. They identify the processes which use the same information; involve a stepwise refinement to add as much detail as deemed appropriate; help create functional specifications; and allow the information obtained in a systems analysis to help create a system design (Madison, 1990).

This study incorporates demographic information, workload data and a critical analysis of the system's strengths and weaknesses. Once the system in place was analyzed, the guidance provided by the Department of Defense and Health Services Command's Coordinated Care Division to implement the Gateway To Care Program was examined.

Using the same data flow diagram analysis, the potential problems and areas that require modification to the present system have been identified and an examination of alternative designs that would assist the organization's transition from the present system to the new program have been offered. This analysis included the factors associated with determining the optimal location of this new division within the hierarchical structure of the hospital and its internal composition.

An economic and organizational cost and benefit analysis of the alternative designs was conducted. This analysis used guidelines associated with building a managed care program which have been identified in current literature (Boland, 1991; Shouldice, 1991; and Kongstvedt, 1989). These guidelines included cost projections and savings; marketing program;

development and selection of providers; coordination issues (internal and external); projected enrollments; quality assurance; utilization management; management information systems; and military staff considerations.

In order to assist this study, contact with the Gateway sites at Fort Campbell and Fort Gordon as well Health Services Command, was accomplished seeking information regarding their experiences and lessons learned. Fort Campbell was chosen as the primary model because it is similar in size and composition to Moncrief and Fort Gordon because of its geographical proximity. In addition, both sites implemented their Gateway programs during fiscal year 1991.

However, there are certain factors which affect the applicability and generalization of information from these sites to the Moncrief Gateway program. There are facility-specific considerations which have played a large role in the establishment and development of their Gateway programs. These considerations include the demographics of the supported beneficiary populations; the internal assets available and in place; and participation in Department of Defense demonstration projects.

Eisenhower Army Medical Center, located at Fort Gordon, is a regional medical center with several graduate medical education programs. Their role as a teaching institution and tertiary care referral center affect the organization of their Gateway program. In addition, they are part of the Southeast Region Managed Care Program, so they enjoy having a fiscal intermediary-established Preferred Provider Organization to contact, negotiate and maintain a network of providers.

Based on the cost and benefit analysis and the results of the study of the alternative organizational designs, the best alternative has been selected and recommended to the Executive Committee for adoption.

Throughout the analysis, information was collected from the two respective Gateway programs using implementation plans and Gateway report data. In addition, direct communication was used with the key leaders of the Gateway sites at Fort Campbell and Fort Gordon, to clarify the information received from the plans and reports. To verify its reliability, it was compared with the reports provided to the Coordinated Care Division at Health Services Command.

The validity of the information received through this communication with these Gateway sites have been affected to some degree by the perceptions and biases of individuals working at those sites. In order to control for that bias, the information received was verified with at least two other sources before the information was considered to be valid.

The validity and reliability of information on workload, expenses and demographics extracted from published reports is considered valid and reliable since it was screened by the appropriate authorities prior to its publication, unless there is evidence that there have been gross miscalculations or misrepresentation of the actual figures.

In order to comply with ethical considerations associated with this study, a statement was included to describe the study's purpose and design. Since the information contained in the implementation plans and Gateway report data does not deal with personal issues and is generally accepted as within official public domain, ethical considerations regarding that source of information have been taken into account.

Results

Background Information

The demographic figures for the beneficiary population obtained from a variety of sources range from 45,904 to 92,160 (Defense Medical Information Service [DMIS] & Fort Jackson, 1992). Table 2 details the variations in the population totals by beneficiary category, using the DMIS and Fort Jackson figures.

Table 2

Beneficiary Population -- Comparisons

Beneficiary Category	DMIS	Fort Jackson
Active Duty	10,977	13,378
Family Members/Active Duty	10,674	11,817
Retirees	9,426	20,974
Family Members/Retirees	12,489	45,991
Survivors	2,338	***
Total	45,904	92,160

*** Note: figures are included in the Family Members/Retirees category.

Sources: DMIS and Fort Jackson Circular 11-1, 1992.

Currently, approximately 66,000 outpatient health records are maintained at Moncrief Army Community

Hospital (personal conversation with M. Alonzo, 28 April 1992). In addition, a report on the catchment area population from the Defense Eligibility Enrollment Registration System (DEERS) estimates the eligible beneficiary population at 54,875 (Defense Manpower Data Center, 1992).

For the most part, the demographic figures are comparable for the active duty and their family members, but not the retiree, retiree family members and survivor categories. The DMIS figures portray a symmetrical relationship among the beneficiary categories with 53 percent in the retiree, retiree family member and survivor categories, but the Fort Jackson figures portray 73 percent of the population are in the retiree, retire family member and survivor categories. This discrepancy among the databases might prove significant in view of the priorities for care established by law, which have been incorporated in the Gateway program.

Using the DMIS figures for a more detailed analysis of the population reveals that 52 percent of the population are male, which is important when one considers the gender differences in health care requirements. While 42 percent of the population is in the age category 18 to 44 years, 27 percent is in the age category 45 to 64 years. A significant statistic for the Gateway program planning is that eleven percent of the population is 65 years or older, representing a population that is Medicare-eligible and not able to use the CHAMPUS program. This is even more remarkable when one considers that the DMIS figures represent the more conservative estimate of the older population.

While DMIS (1992) figures portray a slight decrease in the beneficiary population from fiscal year 1992 to fiscal year 1993, the active duty and active duty/family member categories are expected to increase significantly in fiscal year 1995. This is due to the addition of a new Soldier Support Warfighting Center, scheduled to move to Fort Jackson from Fort Benjamin Harrison, Indiana as a result of Base Realignment and Closure Act 91 (BRAC 91) decisions (Dawson, 1992). Detailed figures are contained in Table 3.

In addition to an increase in the number of active duty personnel, the type of soldier involved in the training base will make a shift from one now composed exclusively of basic and advanced individual trainees,

Table 3

Beneficiary Population Projections

Beneficiary Category	FY 1992	FY 1993	FY 1995
Active Duty (AD)	10,977	10,289	15,815
Family Members/AD	10,674	10,023	13,537
Retirees	9,426	9,510	9,672
Family Members/ Retirees	12,489	12,593	12,808
Survivors	2,338	2,360	2,398
Total	45,904	44,775	54,230

Source: DMIS, 1992 and Dawson, 1992.

who are typically younger (17 to 19 years old and a very transient population normally less than fifteen to twenty weeks on post), to one which is an older and less transient population. The Soldier Support Warfighting Center will house the officer schools for the Army's Finance and Adjutant General Corps and the Noncommissioned Officer Academy. Typically, the course duration associated with those schools are longer than initial entry training programs.

Workload Statistics

A summary of the workload statistics for the last three fiscal years is contained in Table 4.

Table 4

Workload Summary Statistics

	FY 89	FY 90	FY 91
Dispositions	9,046	8,611	8,250
Occupied Bed Days	37,974	38,306	39,681
Outpatient Visits	377,058	360,028	376,622
Total Visits	384,609	366,674	390,971
Dental Procedures	427,338	469,297	636,601
Ancillary Procedures	5,804,159	7,603,360	7,690,862

Note: Ancillary procedures include Pharmacy, Pathology and Radiology.

Source: DMIS, 1992

The trend away from inpatient care toward outpatient care is clearly evident from these figures, although the occupied bed days have increased. The drop in figures in fiscal year 1990 can be attributed to the Desert Shield/Desert Storm phenomenon. Some Moncrief Army Community Hospital staff members were sent over to Southwest Asia without immediate replacements and the hospital cut back on some of its services in preparation to handle expected casualties.

A closer inspection of the inpatient workload figures reveals that the concentration of workload was in the areas of Pulmonary/Upper Respiratory Disease, General Surgery, Internal Medicine, Psychiatry and Oncology. The most dominant workload was seen in the specialty of Pulmonary/Upper Respiratory Disease with over a third of the dispositions and twenty-three percent of the occupied bed days. During this period, Moncrief discontinued its Obstetrics and Nursery services because it was felt that the workload was not high enough to maintain the standard of practice.

The concentration of workload in the outpatient areas were in the areas associated with primary care. The primary care clinics accounted for thirty percent of all outpatient workload, followed at some distance by the emergency medical care areas. The workload attributed to emergency medical care is an indicator of an access problem, since the hospital is not a center for trauma care. The services with substantial trainee support missions (Optometry and Podiatry clinics) also had substantial clinic visit totals as did the Internal Medicine, Pediatric and Gynecology Clinics, respectively. Detailed workload statistics are contained in Appendix B.

CHAMPUS Statistics

In fiscal year 1990, the four most expensive CHAMPUS services were Psychiatry, Cardiology, Obstetrics and General Surgery, accounting for 65 percent of the almost seven million dollars spent to provide care to Moncrief's beneficiaries under the CHAMPUS program. Fiscal year 1990 has been designated the base year for Gateway program planning purposes (HSC, 1992). The top five CHAMPUS costs for fiscal years 1990 are contained in Table 5.

Table 5

Top Five CHAMPUS Costs -- Fiscal Year 1990

		Outpatient		Inpatient	
Specialty	Total Cost	Costs	Users	Costs	Users
Psychiatry	$1,429,001	$113,466	422	$1,315,535	166
Cardiology	1,172,691	237,136	1,281	935,555	268
Obstetrics	1,118,170	54,786	162	1,063,384	732
General Surgery	739,187	338,940	1,136	400,247	299
Orthopedics	480,914	356,941	878	123,973	88
1990 Totals	$6,799,310		10,238		2,778
		$1,842,456		$4,956,854	

Source: OCHAMPUS Health Care Summary Report

In fiscal year 1991, these same four services accounted for 59 percent of the almost 7.4 million dollars spent on CHAMPUS for Moncrief beneficiaries. The top five CHAMPUS costs for fiscal year 1991 are contained in Table 6.

Table 6

Top Five CHAMPUS Costs -- Fiscal Year 1991

		Outpatient		Inpatient	
Specialty	Total Cost	Costs	Users	Costs	Users
Psychiatry	$1,184,044	$176,366	530	$1,007,678	144
Obstetrics	1,167,439	76,837	199	1,090,602	742
Cardiology	1,094,374	317,521	1,208	776,853	267
General Surgery	860,826	441,219	1,325	419,607	362
Orthopedics	676,804	439,241	1,158	237,563	137
1991 Totals	$7,313,300		9,246		2,897
		$2,329,502		$4,983,798	

Source: OCHAMPUS Health Care Summary Report

Detailed CHAMPUS utilization and cost figures, by specialty, for fiscal years 1989, 1990 and 1991 are shown in Appendix B.

Systems Analysis Results (Before Gateway)

Before any changes to the current system are proposed, it is important to understand how the current system accomplishes the mission. For that reason, the current system, policies and practices employed by Moncrief Army Community Hospital were analyzed using data flow diagrams. The study focused on the eighteen tasks designated for the Coordinated Care Division. The data flow diagrams are contained in Appendix C. After careful analysis, it became apparent that the eighteen tasks are somewhat redundant and limited in their scope.

Task One -- Manage CHAMPUS.

The subtasks associated with managing the CHAMPUS program include verifying eligibility, provide advice/assistance, assist/investigate problems, obtain appointments, prepare statistical reports and process nonavailability statements. Since another task deals specifically with processing nonavailability statements, discussion of that subtask will be deferred to later in the study.

In order to verify eligibility, the patient must interact with the Health Benefit Advisor (HBA), who queries the Defense Eligibility Enrollment Reporting

System (DEERS) database to determine the patient's status and eligibility for care. Once eligibility has been verified, the HBA will interact with the patient, internal and external providers, clinics and other civilian facilities to provide advice and/or assistance. Using the CHAMPUS policy manual, information from the Office of CHAMPUS (OCHAMPUS) and the fiscal intermediary and the internal Moncrief policy, the HBA will resolve questions and provide feedback to the source of the query or move to one of the other subtasks. If the query involves an issue which requires further assistance or investigation, the HBA will conduct a more thorough search of the sources of information or refer to a higher authority for resolution. Once resolved, the HBA will provide feedback to the source of the query. When appropriate, the HBA will assist in obtaining an appointment for additional health care and provide feedback to the requestor. Once the exchange of information is complete and on a recurring basis, the HBA is required to produce a variety of statistical reports for management's review. If necessary, they may be directed to produce a special report or provide a more detailed report. These reports will be stored in the internal office files for future reference and use.

Task Two -- Provide information services.

The subtasks associated with providing information services on medical care available in other facilities include receive calls/referrals, process the requests, maintain the information, verify the information and provide information.

In order to accomplish this task, the HBA, Civilian Resource Coordinator (CRC) and the Civilian Claims Clerk (CCC) will interface with a variety of organizations. In addition to the internal organizational entities (patient, provider and clinic), they will interface with other military, federal and civilian facilities and occasionally deal with the policy making bodies -- Health Services Command, Office of the Army Surgeon General and the Office of the Assistant Secretary of Defense (Health Affairs). The HBA, CRC and CCC will use the Veterans Administration/Department of Defense Sharing Agreement, partnership and preferred provider network (PPN) agreements and files on the capabilities of other military, federal and civilian facilities. As information gets updated or revised, the staff will make whatever changes are needed in the appropriate files, thus maintaining the information. The information received or maintained may need to be verified to ensure its validity, particularly if there are inconsistencies with information already maintained in the files or in the case of a significant change from previous status. The task is complete with the provision of this information to a requestor or when it is published in an effort to educate the many organizations associated with the delivery of health care.

Task Three -- Review requests for supplemental care.

The subtasks involved in reviewing supplemental care requests include receiving the request, processing the request, obtaining a decision, communicating the results and maintaining the files.

The provider, clinic and/or patient contacts the Civilian Claims Clerk (CCC) or the Health Benefits Advisor (HBA) with a request. The request is processed by reviewing the files on partnership and preferred provider network (PPN) agreements, civilian facilities' files employing the Supplemental Care standing operating procedures (SOP). The

Civilian Resource Coordinator (CRC) gets involved in maintaining the information files. Using this information, the CCC or HBA obtains a recommendation from the service/department chief and a decision from the Deputy Commander for Clinical Services. Part of this processing includes input from the Resource Management Division on the availability of supplemental care funds. In some instances, the Commander may be involved in the approval process. The CCC or HBA communicate the decision back to the requestor (provider, clinic or patient) and update the files to reflect the results of the decision.

Task Four -- Develop and maintain information on clinical capabilities.

Developing and maintaining information regarding the clinical capabilities of the military treatment facility (MTF) and the civilian community requires that the organization receive information, contact facilities and maintain files.

Providers, federal and civilian facilities, service/department chiefs and the South Carolina Hospital Association interface with the Civilian Resource Coordinator (CRC), the Health Benefit Advisor (HBA) and the Civilian Claims Clerk (CCC) to receive information regarding the clinical capabilities of facilities in the catchment area. This information is incorporated into the files established for each military, federal or civilian facility. In addition, the CRC, HBA and CCC will contact the respective facilities on a periodic and recurring basis to validate and update the information maintained in the files.

Task Five -- Identify clinical areas for agreements or initiatives.

The subtasks of identifying clinical areas within the MTF which might benefit from an agreement or initiative include the responsibility to identify the needs, investigate the proposal, provide information regarding the programs, analyze the proposal and make a recommendation.

Needs are identified to the Civilian Resource Coordinator (CRC), Health Benefit Advisor (HBA) or Civilian Claims Clerk (CCC), Resource Management Division staff or the Utilization Management Supervisor by a provider, clinic or service/department chief or as a result of performing their duties (i.e., management reports, utilization management reviews, etc.). The next step involves the investigation of the proposal by the Management Analyst or the Resource Management Division staff. This investigation is closely linked with obtaining information regarding the possible agreements or programs that Moncrief Army Community Hospital has established. In view of this information, the proposal is analyzed and a recommendation is forwarded to the command group and the entities involved in the initial needs identification.

Task Six -- Develop statements of work.

The subtasks associated with the development of statements of work for contracts or agreements include the requirement to identify the need, gather information, analyze alternatives and prepare statements of work.

The provider and clinic can identify the need for contacts or agreements to support the partnership or the Direct Health Care Provider (DHCPP) programs. In addition, the Utilization Management Supervisor, Civilian Resource Coordinator (CRC), Management Analyst or the budget analysts in the Resource Management Division (RMD). The Management Analyst, the RMD staff or the CRC gather information to designate alternatives using the Partnership files, DHCPP files, Preferred Provider Network (PPN) files, MTF capabilities' files and any statements of work already in existence. The possible alternatives are analyzed, the best alternative selected and the statement of work prepared to support the selected alternative. The statement of work is then provided to the appropriate office for review and comment, including the Staff Judge Advocate, Fort Jackson; the Central Contracting Office, HSC; and/or the Directorate of Contracting, Fort Jackson.

Task Seven -- Monitor supplemental care expenditures.

This task includes the responsibility to monitor supplemental care fund expenditures, provide management reports, maintain files, identify civilian alternatives for supplemental care program use and make recommendations concerning selection of the best alternative.

The budget analysts in the Resource Management Division, the Civilian Claims Clerk (CCC) and the Civilian Resource Coordinator (CRC) all play a role in monitoring the supplemental care program expenditures. The main source of information is the supplemental care budget. Using this information, they prepare management reports to advise the command group on the status of the program. This information is then entered into the files maintained in supplemental care, civilian facilities, partnerships and preferred provider networks. This information is reviewed on a continuous basis to identify alternatives which might remedy the need at a more beneficial method than what is currently employed. The Management Analyst and the CRC identify the alternatives and make recommendations to the command group.

Task Eight -- Negotiate agreements and contracts.

In order to negotiate agreements and contracts to support the various programs which are part of the Gateway To Care Program, there are several subtasks which must be accomplished. This includes the responsibility to identify the need, obtain background information, contact civilian facilities, evaluate the possibilities, make proposals, prepare document, review the document and sign the document.

Needs can be identified by a host of various entities, but the main sources are the provider, the clinic and the Chief, Coordinated Care Division. In order to obtain the background information, a number of people are involved. They include the Assistant Chief, Coordinated Care Division, the Civilian Resource Coordinator (CRC), the Management Analyst and the Resource Management Division (RMD) staff. The information gathered is maintained in a variety of files, including the CHAMPUS information, MTF capabilities, civilian facilities, supplemental care, VA/DoD Sharing, DHCPP, partnership and PPN files. In addition, on a periodic basis, the CRC will contact the civilian facilities in the area to gather information on their capabilities. Using all available information, a negotiation team will be established to review the requirements and needs, and formulate and offer a proposal. This proposal will be submitted for comments and review to the Central Contracting Office, HSC and the Directorate of Contracting, Fort Jackson. Once the review is completed, any changes to the proposal (additions, deletions or modifications) will be accomplished and a document prepared. The document will be submitted to the Staff Judge Advocate, Fort Jackson for their review and approval on the legal aspects of the contract. Upon receiving clearance, the document will be forwarded to the command group for signature. The various files will be updated with any changes associated with a new agreement or contract.

Task Nine -- Coordinate for CHAMPUS policy guidance.

There are three subtasks associated with coordinating with external agencies for information regarding the CHAMPUS program. These subtasks are to coordinate with the sources of information, receive information and maintain files.

The Health Benefit Advisor (HBA) is responsible to coordinate with the CHAMPUS fiscal intermediary, the Office of CHAMPUS and the Coordinated Care Division, HSC for information. The HBA is also assisted by the Civilian Resource Coordinator (CRC). The information can be received in a number of methods: telephonic communication, written policy updates, newsletters, etc. The information is then maintained in the CHAMPUS Policy Manual, CHAMPUS information files, special programs' files and CHAMPUS benefit files.

Task Ten -- Disseminate information to beneficiaries and providers.

The subtasks associated with the requirement to disseminate information regarding CHAMPUS and MTF capabilities and policies include the responsibility to receive calls/referrals, process these calls/referrals, verify the information, investigate them and provide information.

The patient, provider or clinic will be the main sources for calls/referrals regarding CHAMPUS and MTF capabilities and policies. The HBA, the Public Affairs Officer and the Patient Assistance Officer will be assisted by the Civilian Resource Coordinator (CRC) and the Civilian Claims Clerk (CCC) in order to perform these subtasks. On occasion, a question or referral will need to be investigated or the information verified before a suitable reply can be provided. Throughout this process, the staff will refer to the information files established for the CHAMPUS Policy Manual, CHAMPUS information, MTF capabilities, special programs, CHAMPUS benefits and MTF policies. Information will be disseminated through four means: a return telephone call; flyers; using internal communications (i.e., Weekly Bulletin, staff meetings or memoranda); or using external means (i.e., produce articles to forward to the Fort Jackson Public Affairs Office for inclusion in the Post Newspaper or Post Newcomer briefings).

Task Eleven -- Operate the Health Care Finder program.

The subtasks associated with this task involve the responsibility to receive a request for an appointment/referral, query the Appointment system, schedule an appointment/referral, maintain the appointment system, notify the requestor of the appointment/referral, follow up on the appointment/referral and prepare management reports. Key staff involved in this task are the Appointment Clerk and the Patient Appointment System (PAS) Supervisor.

The request for an appointment/referral may come from a patient, provider, clinic or PPN and received by the Appointment Clerk. The Appointment Clerk queries the system to identify possible solutions, using the policies, referral and appointment system files established. The clerk will schedule the appointment/referral based on the templates on providers and PPNs in the system and the policies and procedures. The clerk then notifies the requestor of the appointment time and location and any other pertinent information or that they are unable to satisfy the request at this time. After the scheduled appointment has occurred, the appointment clerk will follow up to insure the appointment/referral was kept and an episode of care provided. This information is important to profile appointment no-shows for inclusion in management reports. The PAS Supervisor is responsible to prepare management reports for the command group on all aspects of the appointment system.

Task Twelve -- Provide information to beneficiaries and providers.

The subtasks associated with providing information concerning available health benefits programs include the responsibility to receive calls/referrals, process the calls/referrals, maintain information files, investigate special cases and provide information.

Calls/referrals are expected to come from the patient, provider, clinic or PPN and will be received by the Health Benefits Advisor (HBA), Civilian Claims Clerk (CCC), Civilian Resource Coordinator (CRC) or the Patient Assistance Office. They will process the requests by querying a variety of information files including MTF capabilities, CHAMPUS, MEDICARE, MEDICAID, civilian facilities, the Veterans Administration medical system, charity agencies and state governmental agencies. In some instances, a request may need to be investigated because of special considerations or circumstances. The staff will then provide the requestor with the information pertaining to their call/referral. Finally, the staff will be responsible to maintain their information files through continuous updates, periodic verifications and experience.

Task Thirteen -- Conduct continuous monitoring of catchment area health care resources.

The subtasks associated with the requirements to monitor the catchment area health care resources include the responsibility to collect information, validate information and maintain the information. The key staff involved in this process is the Civilian Resource Coordinator (CRC) and the Management Analyst.

Information is collected from several sources: established preferred provider networks (PPNs), civilian facilities, other federal facilities (Veterans Administration, Air Force and Eisenhower Army Medical Center), the CHAMPUS fiscal intermediary, the state Department of Health and Environmental Control (DHEC) and the South Carolina Hospital Association. Information which appears to be questionable or fictitious will be validated and verified before it is entered into the information files. The information is maintained in a variety of information files, including VA/DoD Sharing Agreement, Partnership agreements, PPNs, civilian facilities, MTF capabilities, Shaw Air Force Base Hospital and CHAMPUS information.

Task Fourteen -- Process nonavailability statements (NAS).

The subtasks associated with issuing nonavailability statements (NAS) and maintaining the automated NAS system for the MTF include the responsibility to receive requests, verify requests, identify presence of other insurance, process NAS request, obtain approval/disapproval, issue NAS, notify the requestor and operate the appeals process.

Requests for NAS will come from the patient, a civilian provider, a MACH provider or a civilian facility. These requests will be received by the Health Benefits Advisor (HBA), and normally accompanied with a statement from the civilian provider or a Defense Department Form 2161, Request for NAS. The HBA will determine if there is another major health insurance policy available by checking with the requestor. If there is, the NAS request is passed to the other health insurance policy. If no other health insurance is available, then the request is processed using a Form Letter 12 (Request for NAS). The HBA will obtain approval/disapproval with input from the respective service/department chief, the Deputy Commander for Clinical Services and, if necessary, the Commander. In addition, information will be extracted from NAS files and an information file containing the list of "approved" needs (already agreed upon by the organization). If approved, the NAS is issued using the automated Defense Eligibility Enrollment Reporting System (DEERS) and the requestor is notified. If disapproved, the requestor is notified and informed that they have the option of providing additional information in an attempt to obtain approval. In addition, the HBA will operate the appeal process, available to all eligible beneficiaries who are dissatisfied with the results of the NAS processing system. Results and outcomes of the processing system are entered and maintained in the NAS information file, for use in future NAS decisions and producing management reports.

Task Fifteen -- Provide information regarding NAS.

The subtasks associated with providing information to the facility commander regarding NAS issuance and to providers and beneficiaries regarding requirements for NAS include the responsibility to collect information regarding NAS, maintain the information, prepare the NAS report, disseminate the report, receive requests for information and provide a response to the requestor.

The Health Benefits Advisor (HBA) will collect data regarding the NAS system from the patient, provider (MACH or civilian), clinic, service/department chief and the Office of CHAMPUS. This information is entered and maintained in several information files, including MTF capabilities, the CHAMPUS policy manual, CHAMPUS information and the NAS Report. This information is used to prepare the NAS Report, which is provided to the command group and details recent NAS activities and the current status of the number of NAS issued and the reason for their issuance. In addition, the HBA will receive requests for information regarding specific cases, refer to the available information files and provide a response to the requestor regarding NAS requirements.

Task Sixteen -- Identify opportunities and develop plans.

In order to identify opportunities and develop detailed plans for the use of CHAMPUS funds for Other Than CHAMPUS Claims Program, there are eight subtasks which must be accomplished. They include the responsibility to gather data, identify high cost/high volume cases, develop alternatives, analyze alternatives, prepare a proposal, submit the proposal to HSC for approval, make necessary revisions (if necessary) and execute the proposal.

The Chief, Coordinated Care Division, Civilian Resource Coordinator (CRC), Management Analyst and the Resource Management Division (RMD) staff will participate in the gathering data for analysis. To do this, they will examine information files containing the CHAMPUS Health Care Summary Report, NAS Reports, referrals for civilian care and supplemental care referrals. The CRC, Management Analyst, Utilization Management Supervisor and RMD staff will work to identify the high cost/high volume cases and develop possible alternatives to accomplish the service. As part of the development of alternatives, input will be received from the Utilization Management Committee, which monitors the effectiveness of our management decisions, policies and systems. Alternatives will be analyzed and a proposal prepared for the commander's approval. The proposal will be submitted to HSC for their approval. If necessary, modifications and revisions will be made to the proposal. Once the proposal is approved by HSC, it will be passed to the appropriate members of the MACH staff for execution.

Task Seventeen -- Develop and maintain an utilization management system.

The development and maintenance of an utilization management system to monitor services provided under partnership agreements and other CHAMPUS alternatives requires six subtasks. They include the responsibility to expand the present Utilization Management Plan, obtain statements, verify the CHAMPUS percentage claimed, validate and document results, report results and take corrective action, as necessary.

The expansion of the present Utilization Management Plan to incorporate the peculiarities associated with the partnership agreements and other CHAMPUS initiatives will be accomplished by the hospital's Utilization Management Committee, Quality

Improvement Office staff, the Utilization Management Supervisor and the command group.

The utilization management system used to monitor the agreements will require teamwork by the Utilization Management Supervisor and the Civilian Resource Coordinator (CRC) working with the CHAMPUS fiscal intermediary. The statements will be obtained from the CHAMPUS fiscal intermediary and reviewed to determine if the appropriate CHAMPUS percentage was claimed. This task will rely on information contained in the partnership and PPN agreement files and the CHAMPUS Prevailing Rates file. The results of the review of the statements will be validated and documented and entered into the appropriate information files. If necessary, the utilization management staff will contact the provider's office to clarify questions regarding a statement's contents. If necessary, corrective action will be taken based upon the commander's decision. Information will be entered into the appropriate information file and sent to the CHAMPUS fiscal intermediary and HSC, as deemed appropriate.

Task Eighteen -- Implement and monitor Alternate Use projects.

There are nine subtasks associated with the implementation and monitoring projects under alternate use projects. These subtasks include the responsibility to identify need, study alternatives, prepare a proposal, submit a proposal to HSC, execute the approved proposal, monitor the approved proposal and report information using management reports.

The need for alternate use projects can come from a variety of sources: a provider, service/department chief, Management Analyst, Utilization Management Supervisor, Civilian Resource Coordinator (CRC) and the Resource Management Division (RMD) staff. Alternatives will be developed by the Management Analyst and CRC using information from partnership and PPN files, MTF capabilities' files, CHAMPUS files and Alternate Use files. A proposal will be prepared and submitted to HSC for approval. If necessary, the proposal will be modified or revised and submitted again. Following HSC approval of the proposal, it will be given to the appropriate service/department chief for execution. The proposal will be monitored by the Management Analyst and RMD staff in accordance with direction and guidance from HSC. The Management Analyst will provide information to the command group and HSC via whatever management reports are required. The information obtained throughout this process will entered and maintained in the appropriate information file for future analysis and review.

Discussion

Critical Analysis of Strengths and Weaknesses

The review of the tasks for which the Coordinated Care Division will be responsible, highlights a series of weaknesses in the current system. The initial organizational structure proposed by Health Services Command for the Coordinated Care Branch is inadequate to handle the requirements of the new Gateway program. There is potential for duplication of effort in administrative responsibilities throughout the organization. In the constrained resource environment which currently exists and is projected to get worse (i.e., no additional start-up funds available, civilian hiring freeze, etc.), there is little margin for error and no room for sloppy management.

In addition, the organization has marginal experience dealing with the civilian community in terms of contract/agreement negotiations, minimal experience with managed care, and no marketing experience.

There are serious problems with information systems which hinder the ability of the organization to provide real-time information for decision making. These systems have been designed to collect and report data based on an aggregate methodology without the capability to provide the detail necessary to deal with a specific issue and lack sufficient ad hoc report formulation capability. In some cases, the information system does not exist other than on a prospective fielding list.

The transition from a traditional centrally-directed, top-driven system to a locally-directed system will be a key factor in the successful implementation of the Gateway program. The incentives and guidance are not available to assist the organization in the design of its program. How will success be measured? In addition, there are Defense Department contracts for utilization management activities on a regional or national level. Are they going to be able to provide the military treatment facility with the information necessary to manage the program?

There are strengths inherent in the present system which might not seem readily apparent at first glance or in view of the numerous weaknesses. The Army is currently experiencing very turbulent times due to the speed and extent of changes as a result of the Army downsizing (both on an institutional and individual basis); the effects of the Base Realignment and Closure Act decisions; and the anticipation of more changes from future Congressional and senior leadership decisions. The fluidity of the environment mandates a tremendous reliance on flexibility.

The challenges associated with the requirement to operate under a more business-like methodology; the transition from a traditional system which emphasized specialty care to a managed care system with priorities on primary care and prevention; and the transition to a locally-directed management program with no rules and little guidance leave little doubt that a new mindset and a nontraditional approach are needed. This gives the organization a change mandate and fosters a climate conducive to new ideas and a different way of thinking. The absence of guidance provides the opportunity to think and move "outside the box." The commander has been given the ability and, more importantly, the authority to make changes within the organization. Moncrief Army Community Hospital is very fortunate to have the opportunities which result from a solid, fertile civilian medical community. The potential for building a civilian-military network so vital to the success of the Gateway program appears to be quite favorable.

Coordinated Care Program Guidance

Guidance on the Coordinated Care Program issued by Doctor Mendez (1992b), the Assistant Secretary of Defense (Health Affairs), provided additional requirements for the implementation of the program. While this guidance does not have the effect of a regulation or instruction, it is clear that this published guidance will form the basis for the guidance and directions expected in the future and will certainly have an effect on the structure and composition of the Coordinated Care Division. Since the guidance was not written to the operational level but rather to the Surgeons General of the services, some of it does not have direct applicability.

Enrollment.

Contractors must fully participate in the quality assurance and utilization management programs of the MTF. Appropriate mechanisms must be developed to assist in monitoring the quality assurance/utilization management programs. This includes the development of new performance and outcome measures which allow for the timely flow of information. The new criteria must be measurable and allow for comparison of performance data with respect to cost, quality and access.

An extensive beneficiary and provider education program must be developed, implemented and maintained to provide information about the Coordinated Care Program. Emphasis should be placed on the transition between the existing programs and the implementation of the Coordinated Care Program. The education effort for the beneficiaries must assure that they understand the system (including the benefits and consequences of enrolling), inform them of the options available in seeking healthcare and reinforce the importance of prevention and healthy lifestyle practices. Also, beneficiaries must be briefed on the procedures to obtain pre-authorization to see non-network providers prior to receiving care for all inpatient and selected outpatient procedures, except for emergencies, or face the possibility that the cost of that care will not be reimbursed by the government. Provider education should include use of the system's components, expectations regarding the quality improvement and utilization management programs and the procedures to follow should a problem or grievance arise.

The MTF Commander must develop an enrollment policy which addresses the rules for the use of the program, a target date for enrollment to begin and the procedures to follow in order to enroll. Enrollment will normally be by family, but there are allowable exceptions. The policy must include the details associated with enrollment status changes and the MTF's interface with the DEERS system database. When possible, beneficiaries should be allowed to select the primary care provider based on the MTF's capabilities. Since the MTF is responsible for the care of enrolled beneficiaries while they are traveling or during a permanent change of station, a plan must be included to notify this MTF of any medical needs required while in transit. The MTF must set up a mechanism to track enrollment status changes and provide a management report on a regular, recurring basis. For those who choose to disenroll, a policy must be established regarding the waiting period incurred before the beneficiary will be offered the opportunity to enroll again.

Provider network development.

The MTF must establish an "adequate" mix and number of providers to satisfy anticipated demand within their catchment area. All facilities must be handicap accessible. The MTF must set up a system to identify those network providers willing to participate as a Medicare provider, and pass that information to the Health Care Finders.

The MTF must establish certification requirements for participating providers, including a credentials check at least once every two years. In addition, the MTF is responsible for continuous monitoring of each and every participating provider network, including verification of the availability of providers; provider adherence to established Coordinated Care Program (CCP) requirements; and investigation of specific complaints and/or concerns of providers and beneficiaries. The CCP requires that all providers must actively participate in the MTF's quality assurance and utilization management programs. In addition, only primary care managers can refer a beneficiary to specialty or tertiary care for one episode of care; each additional episode of care must be referred by the primary care manager.

The MTF must establish systems for a patient feedback mechanism and addressing/resolving problems. This includes the establishment of a tracking mechanism to ensure the "adequate" standards are met and identify the waiting time for an appointment (urgent -- no more than one day; routine -- no more than four weeks) and the waiting time in a provider's office (no more than 45 minutes).

The MTF must develop, implement and maintain a provider relations program to maintain effective communications between network and non-network providers to resolve issues. In addition, a provider education program must be established to inform providers of the requirements under the CCP, especially the requirements associated with the MTF's quality assurance and utilization management programs, and insure that they have access to the information they need to perform their duties.

The MTF must coordinate with the CHAMPUS fiscal intermediary to ensure appropriate, timely claims processing and quick resolution of any outstanding issues or problems.

Communication strategies.

The MTF must develop a detailed communication strategy, which follows the educational process specifically tailored to meet the needs of the various groups involved with the CCP. Media plans, consisting of press releases, interviews, and feature articles, need to complement the education effort and are a key component of the communication strategy.

The communication strategy should be phased in accordance with the implementation phasing of the program's development. For example, key personnel within the organization should receive briefings and information materials early in the program development and implementation. Beneficiaries should receive briefings approximately two to six months prior to program implementation.

Specialized Treatment Facilities.

The MTF should set up a system to integrate and incorporate the designation of specialized treatment facilities (STF) into the CCP at their facility. STFs are designed to eliminate the duplication of effort and proliferation of high technology, high cost procedures to a few sites.

This system includes the requirement by the medical staff to ensure that the care is medically necessary, obtain preauthorization for the specific procedure and establish a time limit for the care to be provided. The Health Care Finder (HCF) will identify and contact the STF, prior to the patient's departure from the MTF if possible, to determine that the STF can accept the patient in the time frame set by the medical staff. If the STF cannot provide the care within the time frame, the HCF will set up non-network care authorizations. The HCF will also identify the need for and reimbursement possibilities for the transportation to the STF; temporary lodging; and meals. If possible, the patient should not be required to physically travel to a military STF to obtain a nonavailability statement or non-network care authorization.

The MTF has the ability to grant exceptions to its STF policy on a case-by-case basis if it determines that the use of a designated STF would impose a severe hardship on the patient and his family.

The MTF has the ability to propose a local facility to the Department of Defense for designation as an STF. The request must be routed through command channels and contain justification in accordance with guidance regarding STF designation.

The MTF must communicate the details and system requirements associated with using an STF to its beneficiary population as part of its beneficiary education program.

Provider and beneficiary education.

The MTF must develop, implement and document ongoing educational programs for key staff, providers and beneficiaries. Besides providing an orientation to the CCP, MTF must insure that these three groups understand what health benefits are provided, how to gain access to the system and how to use the system. In addition, the design must incorporate the ability to monitor and evaluate the efficiency and effectiveness of the educational programs. The MTF must conduct an evaluation concurrently with the training provided with a follow-up three months later.

Subsequent educational efforts should focus more on improving the health status of the beneficiaries and be consistent with other health promotion and disease prevention programs.

The educational program for the administrative and clinical staff must include the roles and responsibilities of the commander, primary care provider and administrative staff; how to assess the needs of the beneficiary population within the catchment area and the manpower requirements necessary to provide for those needs; how to access the provider networks; how to address changes to the system; and an evaluation of the clinical and financial outcomes within the system.

The educational program for the beneficiary must include an overview of the CCP; when their beneficiary category is expected to get the opportunity to enroll; the benefit options available in the program; how to use the program; a point of contact for questions, problems and/or comments; and a survey mechanism which stimulates suggestions and provides an avenue for complaints and problem resolution.

In addition, the MTF must produce and distribute a member handbook which provides details concerning eligibility and enrollment information; the covered services and health benefits; limitations and exclusions; cost sharing requirements; coordination of benefits; grievance and complaint procedures; key telephone numbers for the program (i.e., Health Care Finders, Health Benefit Advisors, etc.); and any other conditions or details the MTF determines are pertinent to the beneficiary population. A periodic newsletter should be published at least semiannually to address changes and/or updates to the CCP and literature regarding health promotion and wellness topics. Copies of all curricula and health education materials should be forwarded through command channels.

Systems Analysis Results (After Gateway)

With the background of the Defense Department guidance, it is time to review the eighteen tasks again and attempt to identify potential problems and areas that will require modifications to the present system as a result of the Gateway program's implementation. The data flow diagrams are contained in Appendix D. It is important to remember that the transition from the present system to the Gateway program will occur over a period of time. Part of the detailed planning currently underway at Moncrief Army Community Hospital includes a tentative time phasing schedule for the program implementation process, estimated to take approximately three years.

Task One -- Manage CHAMPUS.

While there will be a fundamental change to the relationship between the direct health care system and the CHAMPUS program after the implementation of the Gateway program, the system practices will not change substantially. The beneficiary enrollment database will be a new information source to assist in the eligibility verification procedure and the Health Care Finder will play a role in assisting in the efforts to obtain an appointment for eligible beneficiaries.

Task Two -- Provide information services.

The implementation of the Gateway program will result in additional assets involved in accomplishing this task and the expansion of the civilian component of the local network. The Member Relations and Provider Relations sections will become heavily involved with providing information services regarding medical care available. Additional tasks will include the publication of Member and Provider Handbooks and periodic updates (weekly or monthly basis) to the staff and beneficiaries regarding recent changes to the program. The partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Three -- Review requests for supplemental care.

It is anticipated that the mechanics of accomplishing this task will not change much with Gateway's implementation. The Civilian Resource Coordinator will play a more substantial role as the civilian component of the network expands and broadens its capabilities. The partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Four -- Develop and maintain information on clinical capabilities.

The role of the Civilian Resource Coordinator will expand as the information base expands to incorporate the additional capabilities of the civilian-military network. The Gateway network information file will provide an additional source of information to assist in the accomplishment of this task.

Task Five -- Identify clinical areas for agreements or initiatives.

The importance of this task to the Gateway program implementation should not be understated. The essential linkpin of the new program is the creation of the civilian-military network of providers.

Management reports will play a pivotal role in the accomplishment of this task. The Chief, Coordinated Care Division and the Management Analyst will have an expanded role in this task as they will provide supervision and technical assistance to insure that the clinical areas are continuously monitored to identify opportunities for analysis of expansion of the civilian-military network. The DHCPP program, partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Six -- Develop statements of work.

This task will be very important to the successful implementation of the Gateway program. The statements of work developed in this task will create the details and criteria necessary to make the agreements or contracts fulfill their purpose. These contracts or agreements will form the basis for the civilian-military network. As with the previous task, this task will require good management information in order to structure the details and criteria. The DHCPP program, partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Seven -- Monitor supplemental care expenditures.

Except for a larger role for the Civilian Resource Coordinator and the Civilian Claims Clerk, the mechanisms in place to handle this task will not change substantially. The expanded role is due to incorporating supplemental care requirements into the Gateway network. The partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Eight -- Negotiate agreements and contracts.

The successful accomplishment of this task is vital to the success of the Gateway program because it is responsible for the creation, development and expansion of the civilian-military network. The negotiating team responsible to negotiate with civilian facilities and providers should include the Chiefs of the Coordinated Care and Resource Management Divisions, the appropriate clinical specialist (acting as a consultant), the Management Analyst and the Civilian Resource Coordinator. The quality of the management information available to the negotiating team will greatly determine the degree of success achieved. Without an opportunity to gain experience in negotiating in previous duties, the team members will need to develop their skills as negotiators in order to be effective. In addition, the DHCPP program, partnership and PPN agreement information files will be incorporated into a more comprehensive Gateway network information file.

Task Nine -- Coordinate for CHAMPUS policy guidance.

The fundamental change to the relationship between the direct health care system and the CHAMPUS program after the Gateway program implementation will affect the scope of this task to some degree, but not significantly affect the methodology presently used. The role of the Health Benefits Advisor will expand in order to provide the link between the two components, and there will be more input from the Chief, Coordinated Care Division and the Civilian Claims Clerk. This will be an important task because of the effect a potential change in a standard CHAMPUS benefit might have on the enrolled or, perhaps more importantly, the nonenrolled Gateway population.

Task Ten -- Disseminate information to beneficiaries and providers.

This task will rely heavily on the marketing plan developed and executed for the Gateway program, since the success of any managed care program is member and provider satisfaction with the system. This satisfaction will be determined to a tremendous degree by the expectations of both groups as to what the system can/cannot do and how the system works. Expectations are built based on the knowledge of the system and the perceptions developed by the beneficiary population and/or provider regarding the responsiveness of the system.

For that reason, there will be additional assets required to handle the increased information requirements. The addition of the Member Relations and Provider Relations sections will play a large role, but the roles of the other staff sections involved in this task will also probably expand as well. In addition to the information sources already in use, member and provider handbooks and an information update published monthly will be used.

Task Eleven -- Operate the Health Care Finder program.

This task promises to experience a significant amount of change with the implementation of the Gateway program. This is due to a significant expansion in the scope of their duties to incorporate obtaining appointments for the beneficiary population in the civilian component of the Gateway network in addition to the direct care system. Also, the changes associated with the establishment of the approval mechanism linking primary care managers to referral and consultant specialists will expand the volume of workload, since every patient care episode requiring specialty or tertiary care must be authorized by a primary care manager.

The present information system will have to expand dramatically in order to handle the increased volume of work associated with the anticipated increase in access into the system. Management reports will have to expand accordingly to identify and track appointment/referral waiting times across the entire network in order to verify surpassing the standards established by the Defense Department staff. Besides the input of the Civilian Resource Coordinator to assist the supervisor of the Health Care Finder section, a beneficiary population database and Gateway network file will be added to provide another source of information.

Task Twelve -- Provide information to beneficiaries and providers.

This task will expand with the addition of the Member Relations and Provider Relations sections to facilitate the providing information to beneficiaries and providers regarding the health benefits programs available. Also, the role of the Civilian Resource Coordinator will expand as the capabilities of the civilian-military network expands. The Gateway network file will be added to the sources of information available for use by the staff.

Task Thirteen -- Conduct continuous monitoring of catchment area health care resources.

The methodologies and procedures currently in use may change significantly with the implementation of the Gateway program. The role of the Civilian Resource Coordinator will expand as the local network expands. Also, input from the Member Relations section and the Health Benefits Advisor is expected to increase in order to be able to provide current information on the availability and affordability of services. As part of this expansion, the information management system will need to expand its capabilities to provide support to the staff working the issues.

The partnership and PPN agreement files will be incorporated into a more comprehensive Gateway network information file.

Task Fourteen -- Process nonavailability statements (NAS).

The methodologies associated with the accomplishment of this task is not expected to change significantly following Gateway implementation. However, it is anticipated that the role of the Health Benefit Advisor will expand, particularly as the rules associated with NAS issuance may change based on the effects and requirements of the new program. In addition, there will be input from the Health Care Finder section to assist in obtaining an appointment outside the direct health care facility or in dealing with the issues associated with a specialty treatment facility (STF). The information system should be expanded to allow for a more expeditious processing of requests for NAS. This would improve the service to beneficiaries and providers as well as provide valuable management information for decision making.

Task Fifteen -- Provide information regarding NAS.

As with the previous task, it is anticipated that the role of the Health Benefits Advisor will increase with the Gateway program's implementation. In addition, the requirement to provide information regarding the requirements for the NAS to beneficiaries and/or providers will result in the participation of the Member Relations and Provider Relations sections input and the addition of the Gateway network information file.

Task Sixteen -- Identify opportunities and develop plans.

This task may undergo substantial change after the implementation of the Gateway program. It will require a collaborative effort among the entire hospital staff and an expanded role for the Management Analyst as the action officer. The development and expansion of the local network will result from the work accomplished in regards to this task.

Task Seventeen -- Develop and maintain an utilization management system.

This task will change substantially with the implementation of the Gateway program. The change will not necessarily affect the methodology as significantly as it will affect the scope of the system. The focal point to make a managed care system work is the utilization controls in place to monitor the system. Simply increasing access without the proper utilization management controls in place to ensure appropriate management of the system will bankrupt the program in a very short time and may cause irreparable damage to the viability of the program. However, it is vital that the controls put into place be an extension of the present utilization management plan which governs the existing system.

Expansion of the present utilization plan will result in expanded roles for the Utilization Management Supervisor, Civilian Resource Coordinator and Provider Relations section. In addition, the Management Analyst and the Auditor will become involved with reviewing partnership agreements and other CHAMPUS initiatives.

The role of the information management system is vital to the system's ability to continuously monitor and track the providers in the Gateway network. Without good, real-time management information, the entire utilization management system is endangered and with it, the entire Gateway program.

Task Eighteen -- Implement and monitor Alternate Use projects.

This task is not going to be substantially effected by the implementation of the Gateway program. There will be an expanded role for the Management Analyst as the primary action officer to accomplish the details associated with this task. The partnership and PPN information files will be incorporated into a more comprehensive Gateway network file. The need for good, real-time management information will be a key determinant in the organization's ability to successfully accomplish this task.

Examination of Alternative Designs

Managed Care Guidelines.

It is important to establish criteria to evaluate proposed organizational designs to accomplish the mission requirements associated with the Gateway program. There are nine areas in the Gateway To Care program which will be used as guidelines in the organizational design of the Coordinated Care Division. The nine areas are cost projections and savings; marketing program; projected enrollments; coordination issues; development and selection of providers; utilization management; management information systems; quality assurance; and military staff considerations.

The major problem with most managed care plans is the tendency to underestimate cost projections and overestimate savings (Shouldice, 1991). This invariably leads to undercapitalization of the plan and excessive overhead costs, which in turn place the entire plan in a position of financial hardship (Kongstvedt, 1989). Boland (1991) states that managed care programs typically have a credibility problem because the promises of cost savings do not live up to the program's actual performance.

An interesting twist to the projection of costs and savings peculiar to the Gateway program is that the military treatment facility does not have the capability to establish its own rates -- the rates are determined by the Department of Defense irrespective of the specific facility's needs or capabilities. As a result, it will be very important to track the medical expenses and utilization and create management reports which provide solid information from which managerial decisions affecting the program can be made.

The focus of marketing activities is to meet the needs of the customer population while remaining within the boundaries of the organization's capabilities and resources (Shouldice, 1991). The role of marketing is absolutely critical to the Gateway program -- effective marketing leads to enrollment; enrollment leads to the establishment of a strong program; and a strong program will be able to expand its services and capabilities (Mercer, 1989).

Enrollment projections are critical to the development of a managed care plan because they affect the staffing requirements and financial projections (Shouldice, 1991). Unfortunately, there is usually a great margin of error built in to the projections. This could result in too many people enrolling too soon overwhelming the capabilities of the system, or the opposite situation could develop and not enough people enroll, resulting in the system starving for members. Boland (1991) recommends that a managed care program limit the number of providers in the initial stages of the program's development, so that a volume of patients can be guaranteed to the participating providers and a strong relationship established. Mercer (1989) recommends estimating enrollment projections conservatively at the beginning, then checking the progress on a monthly basis. This would build flexibility and controls into the enrollment process to moderate the system's expansion.

Coordination issues between the various components of the Gateway program, both internal and external to the military treatment facility, will require innovative approaches. The health care environment has gotten so complex and integrated that a change in one element of a managed care program could result in several unintended and unexpected consequences. For this reason, Shouldice (1991) recommends the establishment of strong control processes within an "organizational structure with clearly identifiable focal points of responsibility for all managerial, administrative and service functions" (p. 14).

In a managed care program, success or failure depends on the provider's ability to provide cost-effective, quality care and limit unnecessary utilization of services (Shouldice, 1991; Kongstvedt, 1989). Berry and Pavia (1991) predict that the "managed healthcare organization of the future will focus and revolve around the provider. That is where the care is delivered, costs incurred and the key decisions are made" (p. 231). As a result, the development of a network and selection of providers are absolutely critical functions. Kongstvedt (1989) reinforces the point that it is essential that the credentials process does not permit any unqualified, unmotivated providers to participate in the network.

An interesting twist in the Defense Department's Coordinated Care Program implementation (includes the Gateway program) is the requirement for the military treatment facility to accept "all qualified providers" (Mendez, 1992b). This puts additional pressure on the military treatment facility to determine its capabilities and needs and then determine the selection criteria accordingly.

Utilization management is defined as "deliberate action to induce a more economical mix of treatment inputs without sacrificing health outcomes" (p. 372, Milstein, Bergthold, and Selbovitz, 1991). The utilization management program will play a significant role in the success or failure of the Gateway program. For example, Shouldice (1991) reports that since hospital services account for roughly fifty percent of all health expenditures, inpatient services represent the greatest potential for cost savings in a managed care program. He advocates establishing three levels of review for the utilization management program: inpatient care (first priority), ambulatory care (third priority) and catastrophic care (second priority).

In addition, there are several areas which require daily attention if the program is to be successful in reducing unnecessary care and optimizing the resources available. These areas include, but are not limited to discharge planning; the use of alternative care facilities (i.e., specialized nursing facilities, step-down units, home health care, etc.); the authorization system for the link between primary care and specialists; and the requirement for an information management system which can capture and process utilization data daily (Kongstvedt, 1989).

Shouldice (1991) states that a management information system must be able to perform two critical functions: provide an integrated database to provide and monitor patient services; and produce management reports. The Gateway program is reliant on the ability of an information system to provide meaningful information at the right time to the right people in the right format. Harrington (1991) states that the complexity of the managed care program mandates the ability of information systems to provide new and better data -- more than ever produced or expected in the past. The system's design should focus on identifying the information needed to make quality decisions, avoiding redundancy and including authorization capabilities (Kongstvedt, 1989). Software and hardware decisions should be based on the requirements of the system, rather than fitting the system to the hardware and software procured.

One of the biggest concerns most people have with a managed care plan is the belief that quality will suffer in favor of efforts to cut costs. In fact, the restriction of choice inherent in a managed care program, such as the Gateway program, creates an obligation to ensure the quality of services provided (Kongstvedt, 1989; Shouldice, 1991). Kongstvedt (1989) advises that credentials is the critical function of the quality assurance program; that providers must have input in the development of the criteria established for use in the program; and that patient complaints are considered as a valuable source of information regarding the provider's performance.

Shouldice (1991) reports that, under a managed care program, most providers operate under some kind of financial incentives -- they assume varying levels of risk in exchange for potential rewards and benefits. Military staff considerations in the Gateway program need to include the fact that military providers, potentially working under identical conditions as their civilian counterparts, are not affected in the same manner. The Gateway program needs to provide incentives and rewards which are available and appropriate for the military provider.

Alternative designs.

There are three proposals to consider in the organizational design of the Coordinated Care Division. The first alternative (Option A) would be to retain the current organizational structure of the Coordinated Care Branch and expand the resources into that structure. The second alternative (Option B) would include a restructuring of the administrative support staff in the hospital to shift and/or consolidate resources without any increase or additional resources. The structure would be based on the requirements of the Gateway program . The third alternative (Option C) would be a combination of the first two alternatives, with a restructure of the administrative support staff combined with an increase in resources to the new organizational structure.

Table 7 details the comparisons of the three options with the nine areas used as guidelines. If the option would have a positive effect on the area, then it will reflect a "+;" a negative effect will reflect a "-;" and no effect will reflect "n" (for none).

Table 7

Comparison of Alternatives

	Option A	Option B	Option C
Cost projections and savings	-	+	n
Marketing program	-	+	+
Projected enrollments	n	n	n
Coordination issues	-	+	+
Development/selection of providers	-	n	+
Utilization management	n	+	+
MIS	n	+	+
Quality assurance	n	n	+
Military staff considerations	n	+	+

In terms of cost projection and savings, Option A and C have a greater possibility of generating excessive overhead costs. While that possibility is somewhat mitigated in Option C due to the ability to shift resources as part of the reorganization and consolidation, Option B has the best potential to positively affect the organization through a consolidation of similar functions and shifting of assets.

Options B and C were considered superior to Option A in view of the marketing program because of their restructuring aspect; the traditional organizational structure would be potentially more difficult to respond to the requirements of a new program.

In the area of projected enrollments, all three options were rated the same due to the possibility for the margin of error causing staffing projections and financial projections to be off target.

In dealing with coordination issues, Options B and C were considered superior because of the ability to change the structure to fit the needs of the program. Option A poses a problem because of its orientation toward the traditional approach and its lack of flexibility.

In terms of the development and selection of providers, Option A was viewed as the least favorable because of its traditional structure and lack of flexibility. Option C was rated superior to Option B because, while both would allow for better support of providers, Option C would have more resources with which to work.

The requirements of the utilization management program under the Gateway program will require a significant expansion in volume and scope than the present system possesses. Options B and C were considered superior because of the possibility for optimization of resources with the restructuring.

In view of the requirements for the management information system to provide 'new and better' data in order to facilitate the implementation of the Gateway program, Options B and C were rated superior. With the ability to restructure the components of the system, the potential for an improved allocation of resources warrants the higher rating.

In terms of the quality assurance program, Option C was rated to superior to the other two options. While Option C may require potentially more resources to accomplish the guidance established, there is the potential for additional resources in addition to the ability to shift resources.

When reviewing the military staff considerations against the three options, Option B and C were rated superior. Option A has the onerous task of proposing new incentives and rewards within the constraints of the structure of the current system. Options B and C are more flexible in their design and should be potentially easier to adjust to a new situation.

The estimated costs associated with each option are projected in Table 8. It is important not to underestimate the potential resulting from reorganizing and consolidating resources.

Table 8

Estimated Costs of Options ($000s)

	Option A	Option B	Option C
Personnel	$114	0	$246
Contracts	15	15	15
Equipment	150	150	160
Other	5	5	5
Totals	$284	$170	$426

Source: FY 1993 Moncrief ACH Gateway Business Plan

Option A has the potential to maintain a potential duplication of effort in administrative responsibilities -- a situation that cannot be tolerated in a resource constrained environment. Options B and C build on the strengths of the system and work to eliminate the inadequacy of the original structure of the Coordinated Care Branch. While Option C costs more than Option B, its potential to better handle the complex and demanding tasks associated with the Gateway program make it the best alternative.

Optimal location.

In attempting to determine the optimal location for the Coordinated Care Division inside the organizational hierarchy, it is helpful to review what other military treatment facilities have done. Approximately half of the facilities have placed their Coordinated Care Divisions under the Deputy Commander for Clinical Services while the rest have aligned their program under the Deputy Commander for Administration. Since the program will focus around the clinical aspects of the system, this study recommends the alignment of the Coordinated Care Division under the Deputy Commander for Clinical

Services. This recommendation concurs with the ideas presented in a Coordinated Care Concept Paper developed by the staff at Health Services Command (Gawaltney, 1990). The Deputy Commander for Administration will continue to play an absolutely vital role in providing senior administrative leadership and direction.

In terms of the composition of the Coordinated Care Division, it is important to look at what other facilities have done. It appears that the predominant factor in the decision of how to organize this new division rested on the internal capabilities and personalities physically present in the military treatment facility at the time the decision was rendered. Segal (1990) described his Managed Care Branch as the organizational entity which would "organize and connect the parts of the existing health-care delivery system and ... manage the system effectively" (p. 623). His branch includes health care contracting and CHAMPUS experts, a nurse case manager, a fiscal intermediary liaison, a civilian resource coordinator and a budget/evaluation analyst.

Armstrong, et al. (1990) found that the implementation of the CAM demonstration required several staffing changes to support organizational restructuring and both Army CAM sites established divisions to oversee the implementation. Fort Carson established the Patient Services Division from elements of the Patient Administration and Clinical Support Divisions. Fort Sill established their CAM Project Office under the Chief, Patient Administration Division. The respective divisions assumed control of the coordinated care operations and became responsible for training, marketing, information management, patient relations and case management functions (Armstrong, et al., 1990).

The Coordinated Care Division at Fort Campbell grew out of the Patient Administration Division and remains under the control of the Deputy Commander for Administration (Jordan, 1991). The plan for their division is an expansion of the structure of the Coordinated Care Branch.

Eisenhower Army Medical Center took a slightly different approach as they felt the new the program should be run by a full-time clinician with rank equivalent to other department and division chiefs (Hastings, 1991). The structure of the Department of Primary and Coordinated Care is divided into the

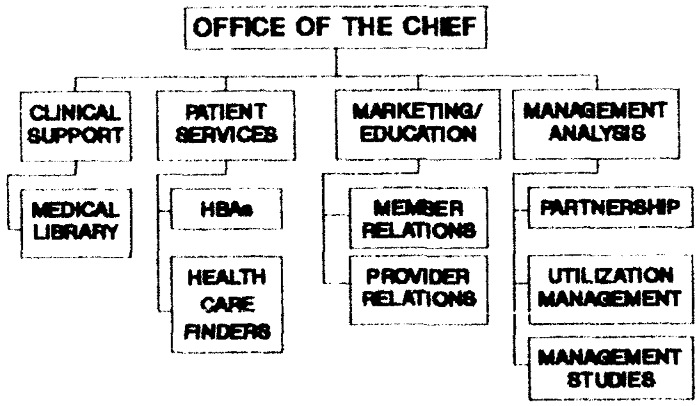
Clinical Branch and the Health Systems Branch (personal conversation with J. Fuzy, 15 May 1992).

Coordinated Care Division.

The proposed organizational structure of the Coordinated Care Division at Moncrief Army Community Hospital is presented in Figure 3. A detailed description of the positions is contained in Appendix E. The critical factor in determining the division's

Figure 3

Coordinated Care Division


OFFICE OF THE CHIEF
CLINICAL SUPPORT
PATIENT SERVICES
MARKETING/ EDUCATION
MANAGEMENT ANALYSIS
MEDICAL LIBRARY
HBAs
HEALTH CARE FINDERS
MEMBER RELATIONS
PROVIDER RELATIONS
PARTNERSHIP
UTILIZATION MANAGEMENT
MANAGEMENT STUDIES

design is the functional requirements of the Gateway program, contained in the eighteen tasks analyzed in this study and the guidance received from the Office of the Assistant Secretary of Defense (Health Affairs).

The assets of the Coordinated Care Branch of the Patient Administration Division were placed on this template and it was readily apparent that those assets were insufficient for the volume and diversity of tasks required by the Gateway program. Based on the strengths and weaknesses identified in the analysis of present organizational system, it was determined that the best approach to reduce the possible duplication of effort in administrative support functions was to consolidate the assets of the Coordinated Care Branch with those of the Clinical Support Division. The Clinical Support Division is the organizational entity tasked with providing administrative support to the Deputy Commander for Clinical Services and the subordinate clinical departments (HSC, 1991).

The proposed structure of the division calls for four branches: Clinical Support, Patient Services, Marketing and Education and Management Analysis.

In addition, the Office of the Chief has been increased with the addition of the Health Systems Manager from the Coordinated Care Branch as the division's Assistant Chief. This civilian positio not only provides additional, much-needed supervis and technical expertise but also allows for conti within the senior leadership level of the division

The Clinical Support Branch, formed from the assets of the Ambulatory Care Support Branch, Clin Support Division, will continue to be responsible administrative support tasks to the Deputy Commander for Clinical Services and the clinical departments. In addition, the Medical Library sec will be incorporated into this branch.

The Patient Services Branch will be composed o the Health Benefits Advisors, who are the experts advising beneficiaries on the CHAMPUS program, and Health Care Finders section. A modification of th former Patient Appointment System clerks, the Heal Care Finders will have an expanded role as the lia between the patient and the Gateway program in obtaining referrals and appointments.

Originally, this Health Care Finders section w going to be responsible for the management and maintenance of the appointment system, the preparation of management reports and technical consultant and trainer for the Health Care Finder personnel assigned to the various clinics throughout the hospital. However, their role may be expanded into the centralized office for appointment/referral scheduling if the Coordinated Care Program implements a Preferred Provider Organization option (Atwood, 1992).

Staffing for these sections should increase as the civilian-military network expands. Initially, the role of the Health Care Finder will be filled by the Appointment Clerk positions already in the various clinics. However, these assets will need to be reviewed for possible consolidation and reorganization. Funding for additional Health Care Finder positions has been requested in the fiscal year 1993 Gateway Business Plan as part of the expansion plans for the Primary Care initiative.

The Marketing and Education Branch plays an absolutely vital role to the success and maintenance of the Gateway program. This branch, composed of the Member Relations and Provider Relations sections, will have the responsibility for the education program outlined in the Defense Department guidance for the beneficiary and provider populations. Initially staffed from the assets of the Patient Representative Office, the Member Relations section will be responsible for program enrollment, complaint resolution and general assistance to the beneficiary population.

The Marketing and Education Branch will grow as the beneficiary and provider population supported increase, but initially they will be assisted by other resources within the organization. For example, the task of the initial beneficiary enrollment to the Gateway program will probably require the creation of a task force. It is possible that a consultant or marketing firm may be contracted to assist with the establishment of the marketing program. Funds have been requested in the fiscal year 1993 business plan for marketing and educational materials (member handbooks, provider handbooks, flyers, brochures, etc.).

The Management Analysis Branch consists of three sections: Partnership, Utilization Management and Management Studies. The Partnership section includes the Civilian Resource Coordinator, who will have a significant expansion in the volume and scope of activities under the Gateway program implementation. It is very possible that Moncrief may contract with a consultant or managed care firm to assist with the development of the preferred provider networks and negotiation of the agreements. While this would lessen the volume of activities for the Partnership section, it would still be a vital component of the program. Funding to pay for the consultant or firm would probably come from either a proposal to the Gateway business plan or an Alternate Use project.

The Utilization Management section will have the responsibility to oversee the expansion of the institution's utilization management plan to the providers and facilities which sign agreements and participate in the civilian-military network. Funding for the initial positions in this section have been requested in the fiscal year 1993 business plan including a supervisor and a nurse and clerk to monitor Psychiatry expenditures. It is important to remember that while this section will operate independently in unchartered territory (i.e., outside the organization's four walls), it must work closely with the Quality Improvement Section in accomplishing the execution, monitoring and reporting requirements of the organization's Quality Improvement Plan. There is a possibility that the proliferation of utilization management firms in the civilian sector may lead to a contract for one of those organizations to perform the utilization management duties for this organization. In this event, there is still a need for the liaison personnel and funding would probably come from the business plan or an Alternate Use project.

The Management Studies section will consist of management analysts who will have the responsibility of reviewing the data generated by the Gateway program and identify opportunities for agreements, evaluate alternatives and make recommendations to the senior leadership of the division and the organization's command group. Presently, these duties are fulfilled by resources on loan from the Resource Management Division. Plans call for these positions to be funded as the requirement for their services overwhelms the capability of the Resource Management Division assets to provide assistance.

A contributing factor to this consolidation decision is the nursing reorganization pilot study recently approved by HSC (Page, 1992). Under this pilot study, the ambulatory nursing assets have been repositioned directly under the control of the respective clinical department chiefs (i.e., Surgery, Medicine, Primary Care and Psychiatry). This pilot study has moved the organization toward a product line orientation, which will accommodate the Gateway program. In addition to the nursing assets, the administrative, clerical and receptionist support staff formerly in the Clinical Support Division have been transferred to the outpatient clinics. As a result, the mission requirements of the Clinical Support Division have changed as well.

Conclusions and Recommendations

This study concludes that the implementation of the Gateway To Care program at Moncrief Army Community Hospital will necessitate the establishment of the Coordinated Care Division. This organizational entity will be charged with the responsibility to coordinate the delivery of quality health care services to the eligible beneficiary population.

After careful review of the demands and requirements of the Gateway To Care program, the strengths and weaknesses associated with the current organizational structure and the expected changes required to make the transition to this new program, this study proposes a consolidation of the Clinical Support Division and the Coordinated Care Branch to form the Coordinated Care Division.

The consolidation of these assets is a logical progression in view of the Gateway program requirements and the nursing reorganization pilot study and while it may result in modest increased costs, it should provide an improved organizational structure better suited for the administrative support requirements associated with the Gateway To Care Program. This consolidation will help to transform Moncrief Army Community Hospital from its current structure to a more streamlined approach better suited to meet the requirements of the future.

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Appendix A

General Information

Table A-1

Coordinated Care Program Principles

-- Serve beneficiaries to provide a combat-ready force

-- Based on decentralized execution

-- Have local accountability with centralized direction and monitoring

-- Achieve greater equity

-- Be flexible and easy to administer

-- Optimize use of the military health services system (MHSS)

Source: Tomich, 1992

Table A-2

Army Management Initiatives

Gateway To Care Program

Military/Civilian Health Services Partnership Program

Third Party Collection Program

PRIMUS Clinics

Table A-2 (continued)

Army Management Initiatives

Uniformed Services Treatment Facilities

Alternate Use of CHAMPUS Funds

VA/DoD Sharing Agreements

CHAMPUS Precertification

Outpatient Nonavailability Statements

Medicare Reimbursement to Military Treatment Facilities

MEDICARE Economic Index

Diagnosis Related Groups

Personnel Services Contracting for Health Care Providers

The Health Care Finder/ Participating Provider Program

Source: OTSG, 1991.

Table A-3

Army Demonstration Projects

CHAMPUS Reform Initiative (CRI)

Catchment Area Management (CAM)

Fort Bragg Mental Health Services Demonstration

Table A-3 (continued)

Army Demonstration Projects

Fort Drum (Military/Civilian) Health Care Demonstration

The European After Duty Hours Outpatient Care Demonstration

Southeast Region Preferred Provider Organization (SE PPO)

The Expanded Home Health Care/Case Management Demonstration

Composite Health Care System (CHCS)

Source: OTSG, 1991

Table A-4

Gateway To Care Program Objectives

-- enhance the Army health care delivery system

-- improve access to quality medical care in the most appropriate cost effective location

-- maximize use of the DoD medical treatment facilities

Table A-4 (continued)

Gateway To Care Program Objectives

-- negotiate cost effective high quality civilian medical networks to supplement the direct care system

-- control the rate of health care cost growth in the Army

-- improve beneficiary satisfaction with the Army health care system

Source: OTSG, 1991

Appendix B

Demographic, Workload and CHAMPUS Statistics

Table B-1

Beneficiary Population -- Age/Sex Demographics

Age Group	Male	Female	Totals
0 - 17	4,731	4,527	9,258
18 - 44	10,577	8,560	19,137
45 - 64	6,007	6,246	12,253
> 65	2,596	2,660	5,256
Totals	23,911	21,993	45,904

Source: DMIS, 1992

Table B-2

Dispositions

Code	Clinical Specialty	FY 89	FY 90	FY 91
AAA	Internal Medicine	713	705	758
AAB	Cardiology	27	29	7
AAD	Dermatology	60	39	26
AAF	Gastroenterology	48	222	268
AAH	Intensive Care (Medical)	272	297	263
AAK	Oncology	364	373	246

Table B-2 (continued)

Dispositions

Code	Clinical Specialty	FY 89	FY 90	FY 91
AAL	Pulmonary/Upper Respiratory Disease	3,596	2,767	2,748
ABA	General Surgery	813	821	759
ABC	Intensive Care (Surgical)	13	16	17
ABE	Ophthalmology	128	138	146
ABF	Oral Surgery	54	329	441
ABG	Otorhinolaryngology	247	199	239
ABK	Urology	155	233	167
ACA	Gynecology	135	382	380
ACB	Obstetrics	430	33	---
ADA	Pediatrics	199	275	235
ADB	Nursery	352	12	---
AEA	Orthopedics	504	712	577
AEB	Podiatry	293	325	362
AFA	Psychiatrics	643	482	608
	Totals	9,046	8,611	8,250

Source: DMIS, 1992

Table B-3

Occupied Bed Days

Code	Clinical Specialty	FY 89	FY 90	FY 91
AAA	Internal Medicine	4,351	3,955	4,821
AAB	Cardiology	93	169	41
AAD	Dermatology	235	121	64
AAF	Gastroenterology	89	320	469
AAH	Intensive Care (Medical)	1,580	1,450	1,430
AAK	Oncology	3,850	4,228	3,028
AAL	Pulmonary/Upper Respiratory Disease	8,973	7,972	9,103
ABA	General Surgery	4,252	3,719	4,046
ABC	Intensive Care (Surgical)	253	180	265
ABE	Ophthalmology	354	327	432
ABF	Oral Surgery	201	849	1,023
ABG	Otorhinolaryngology	549	593	379
ABK	Urology	799	1,180	968
ACA	Gynecology	421	1,456	1,463
ACB	Obstetrics	1,667	66	---
ADA	Pediatrics	721	946	799
ADB	Nursery	1,198	35	---
AEA	Orthopedics	3,068	4,403	4,339

Table B-3 (continued)

Occupied Bed Days

Code	Clinical Specialty	FY 89	FY 90	FY 91
AEB	Podiatry	1,314	1,169	2,241
AFA	Psychiatrics	4,006	4,848	4,763
	Totals	37,974	38,306	39,681

Source: DMIS, 1992

Table B-4

Outpatient Visits

Code	Clinical Specialty	FY 89	FY 90	FY 91
BAA	Internal Medicine Clinic	22,940	23,428	18,920
BAB	Allergy Clinic	6,985	7,607	6,307
BAG	Gastroenterology Clinic	134	626	1,199
BAL	Nutrition Clinic	1,865	1,512	1,203
BAM	Oncology Clinic	2,749	2,808	2,904
BAP	Dermatology Clinic	9,907	9,641	9,889
BBA	General Surgery Clinic	6,297	7,125	6,815
BBD	Ophthalmology Clinic	5,034	5,004	4,717
BBF	Otorhinolaryngology Clinic	3,079	2,242	2,333

Table B-4

Outpatient Visits (continued)

Code	Clinical Specialty	FY 89	FY 90	FY 91
BBI	Urology Clinic	3,698	4,364	4,148
BCB	Gynecology Clinic	15,620	17,906	17,883
BCC	Obstetrics Clinic	5,001	157	---
BDA	Pediatric Clinic	19,766	20,857	19,375
BDC	Well Baby Clinic	1,324	1,507	1,352
BEA	Orthopedic Clinic	9,442	10,141	8,878
BEB	Cast Clinic	4,554	5,669	4,794
BED	Neuromusculoskeletal Screening Clinic	11,534	8,916	9,817
BEE	Orthopedic Appliance Clinic	795	692	1,373
BEF	Podiatry Clinic	22,135	20,691	21,014
BFA	Psychiatry Clinic	1,191	1,996	1,069
BFB	Psychology Clinic	1,176	2,066	1,304
BFC	Child Guidance Clinic	1,657	2,108	625
BFD	Mental Health Clinic	3,470	4,944	7,620
BFE	Social Work Clinic	1,178	1,567	1,835
BFF	Substance Abuse Rehabilitation Clinic	3,635	3,230	2,718

Table B-4 (continued)

Outpatient Visits

Code	Clinical Specialty	FY 89	FY 90	FY 91
BHA	Primary Care Clinics	112,175	105,602	116,383
BHB	Medical Examination Clinic	4,777	3,984	3,503
BHC	Optometry Clinic	33,087	30,975	41,119
BHD	Audiology Clinic	14,026	8,983	11,978
BHF	Community Health Clinic	7,261	7,316	2,981
BHG	Occupational Health Clinic	3,335	2,864	3,621
BIA	Emergency Medical Care	35,320	33,437	38,415
BJA	Flight Medicine Care	813	689	530
	Totals	375,960	360,654	376,622

Source: DMIS, 1992

Table B-5

Total Visits

Code	Clinical Specialty	FY 89	FY 90	FY 91
BAA	Internal Medicine Clinic	23,074	23,490	25,037
BAB	Allergy Clinic	7,031	7,629	6,313
BAG	Gastroenterology Clinic	134	760	1,568
BAL	Nutrition Clinic	2,901	2,893	2,464

Table B-5 (continued)

Total Visits

Code	Clinical Specialty	FY 89	FY 90	FY 91
BAM	Oncology Clinic	3,344	2,831	2,904
BAP	Dermatology Clinic	10,009	9,767	9,981
BBA	General Surgery Clinic	6,413	7,142	6,860
BBD	Ophthalmology Clinic	5,198	5,163	4,841
BBF	Otorhinolaryngology Clinic	3,186	2,316	2,334
BBI	Urology Clinic	3,785	4,375	4,157
BCB	Gynecology Clinic	15,660	17,982	17,972
BCC	Obstetrics Clinic	5,001	157	---
BDA	Pediatric Clinic	19,805	20,857	19,375
BDC	Well Baby Clinic	1,324	1,507	1,352
BEA	Orthopedic Clinic	10,501	11,293	10,102
BEB	Cast Clinic	4,612	5,962	4,905
BED	Neuromusculoskeletal Screening Clinic	11,534	8,916	9,817
BEE	Orthopedic Appliance Clinic	806	692	1,553
BEF	Podiatry Clinic	22,726	10,734	21,057

Table B-5 (continued)

Total Visits

Code	Clinical Specialty	FY 89	FY 90	FY 9
BFA	Psychiatry Clinic	1,314	2,059	1,17
BFB	Psychology Clinic	1,176	2,066	1,63
BFC	Child Guidance Clinic	1,657	2,110	62
BFD	Mental Health Clinic	3,470	4,944	7,62
BFE	Social Work Clinic	4,346	4,603	6,08
BFF	Substance Abuse Rehabilitation Clinic	3,635	3,230	2,71
BHA	Primary Care Clinics	112,175	105,602	116,38
BHB	Medical Examination Clinic	4,777	3,984	3,50
BHC	Optometry Clinic	33,087	30,975	41,11
BHD	Audiology Clinic	14,026	8,986	11,97
BHF	Community Health Clinic	7,330	7,419	2,98
BHG	Occupational Health Clinic	3,341	2,864	3,62
BIA	Emergency Medical Care	35,320	33,437	38,41
BJA	Flight Medicine Care	813	689	53
	Totals	383,511	367,434	390,97

Source: DMIS, 1992

Table B-6

Top Ten CHAMPUS Costs -- Fiscal Year 1990

		Outpatient		Inpatient	
Specialty	Total Cost	Costs	Users	Costs	Users
Psychiatry	$1,429,001	$113,466	422	$1,315,535	166
Cardiology	1,172,691	237,136	1,281	935,555	268
Obstetrics	1,118,170	54,786	162	1,063,384	732
Gen Surgery	739,187	338,940	1,136	400,247	299
Orthopedics	480,914	356,941	878	123,973	88
Gynecology	431,298	220,914	1,300	210,384	207
Pulmonary/Resp	309,631	157,615	885	152,016	195
Gastro.	264,118	118,088	732	146,030	162
Urology	224,212	147,556	843	76,656	129
Other	630,088	97,014	734	533,074	532
Totals	$6,799,310	$1,842,456	10,238	$4,956,854	2,778

Source: OCHAMPUS Health Care Summary Report

Table B-7

Top Ten CHAMPUS Costs -- Fiscal Year 1991

		Outpatient		Inpatient	
Specialty	Total Cost	Costs	Users	Costs	Users
Psychiatry	$1,184,044	$176,366	530	$1,007,678	144
Obstetrics	1,167,439	76,837	199	1,090,602	742
Cardiology	1,094,374	317,521	1,208	776,853	267
Gen Surgery	860,826	441,219	1,325	419,607	362
Orthopedics	676,804	439,241	1,158	237,563	137
Gynecology	477,999	255,009	1,353	222,990	198
Pulmonary/Resp	391,938	208,353	926	183,585	219
ENT	353,188	227,548	1,243	125,640	175
Neurology	261,666	88,381	411	173,285	80
Other	845,022	99,027	893	745,995	573
Totals	$7,313,300			$4,983,798	2,897
		$2,329,502	9,246		

Source: OCHAMPUS Health Care Summary Report

Table B-8

CHAMPUS Utilization

Specialty	FY 1989 Users	FY 1990 Users	FY 1991 Users
Medicine			
Adverse Reactions	164	156	183
Allergy	235	250	367
Cardiology	1,225	1,368	1,295
Dermatology	398	503	669
Endocrinology	297	346	199
Other	611	1,222	1,414
Surgery			
Obstetrics	744	747	761
Gynecology	693	1,329	1,371
Ophthalmology	280	352	350
ENT	486	728	1,232
General Surgery	997	1,277	1,502
Neurosurgery	94	113	138
Orthopedics	865	902	1,191
Thoracic Surgery	57	35	48
Urology	629	890	981
Grand Total	10,968	13,975	8,852

Source: OCHAMPUS Health Care Summary Report

Table B-9

CHAMPUS Costs

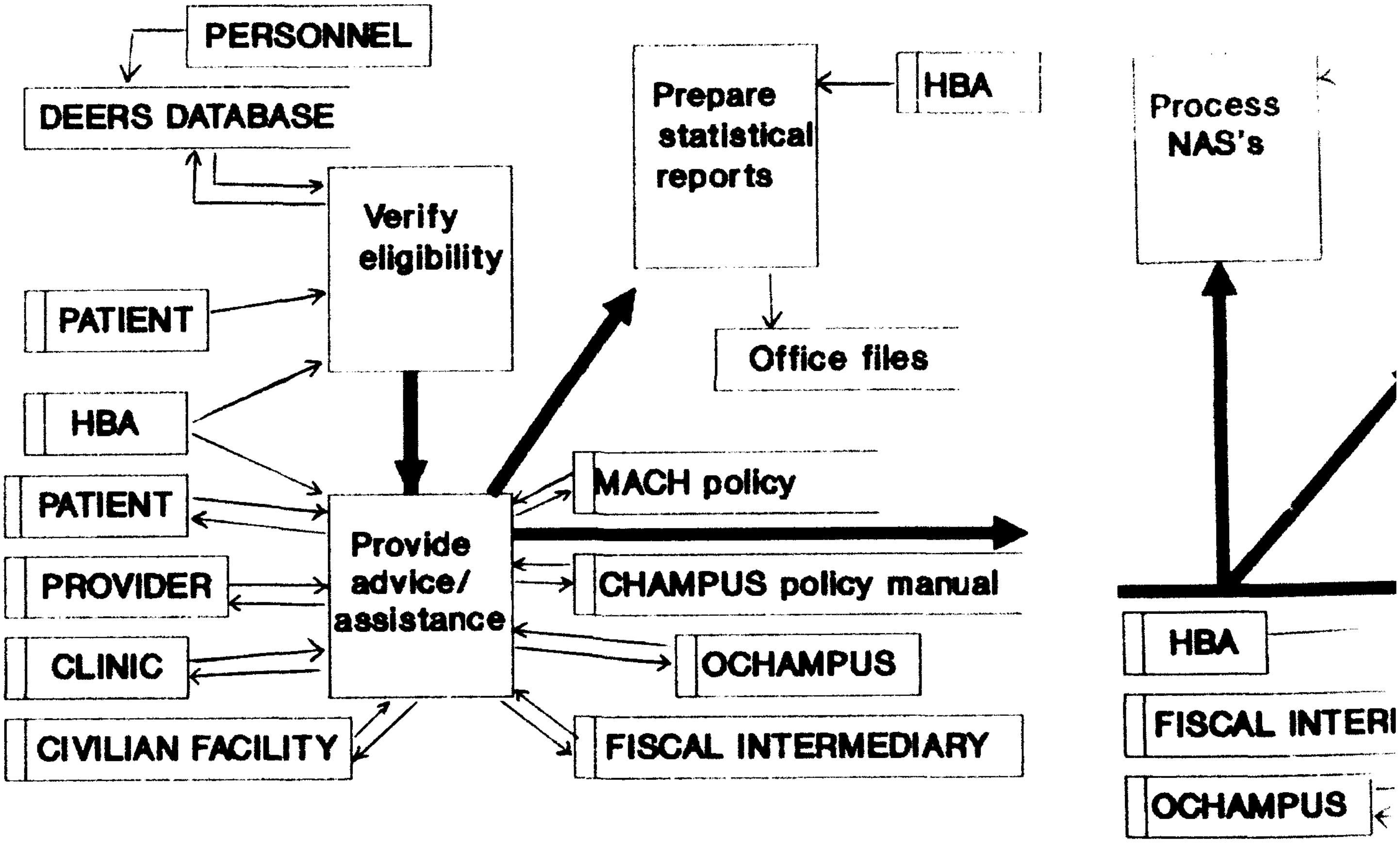
Specialty	FY 1989 Cost	FY 1990 Cost	FY 1991 Cost
Medicine			
Adverse Reactions	$34,402	$38,409	$46,191
Allergy	48,992	68,507	78,451
Cardiology	848,783	1,172,691	1,094,374
Dermatology	49,490	66,776	92,484
Endocrinology	66,207	63,310	189,404
Other	111,852	630,088	845,022
Surgery			
Obstetrics	932,602	1,118,170	1,167,439
Gynecology	427,811	431,298	477,999
Ophthalmology	93,378	181,876	160,975
ENT	121,552	187,790	353,189
General Surgery	419,830	739,187	860,826
Neurosurgery	163,067	125,705	157,574
Orthopedics	499,926	480,913	676,804
Thoracic Surgery	90,032	61,619	40,116
Urology	191,760	224,212	254,694
Grand Total	$6,507,282	$8,121,455	$8,931,843

Source: OCHAMPUS Health Care Summary Report

Appendix C

Systems Analysis Results (Before Gateway)

Task One -- Manage CHAMPUS.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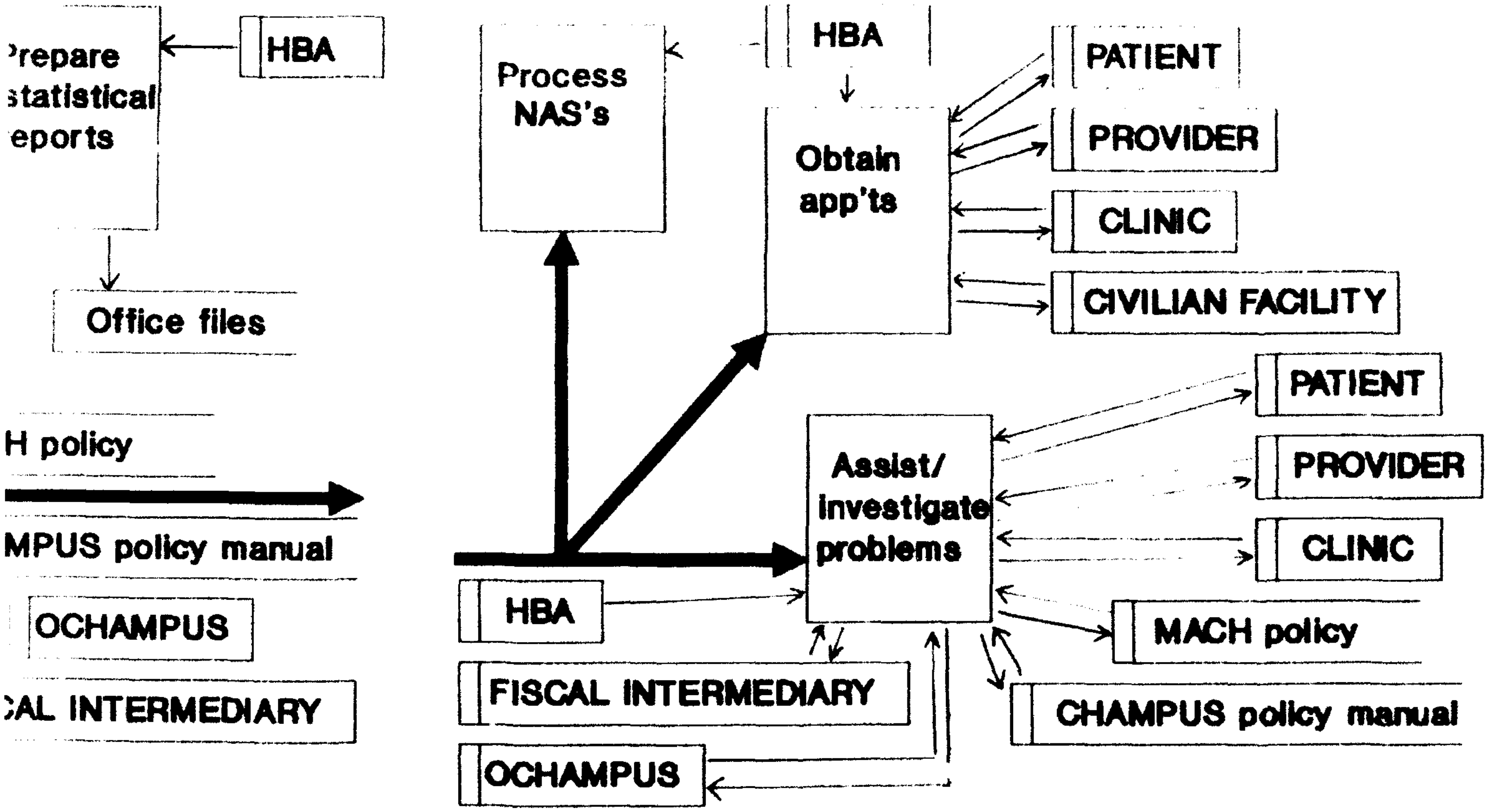
(Before Gateway)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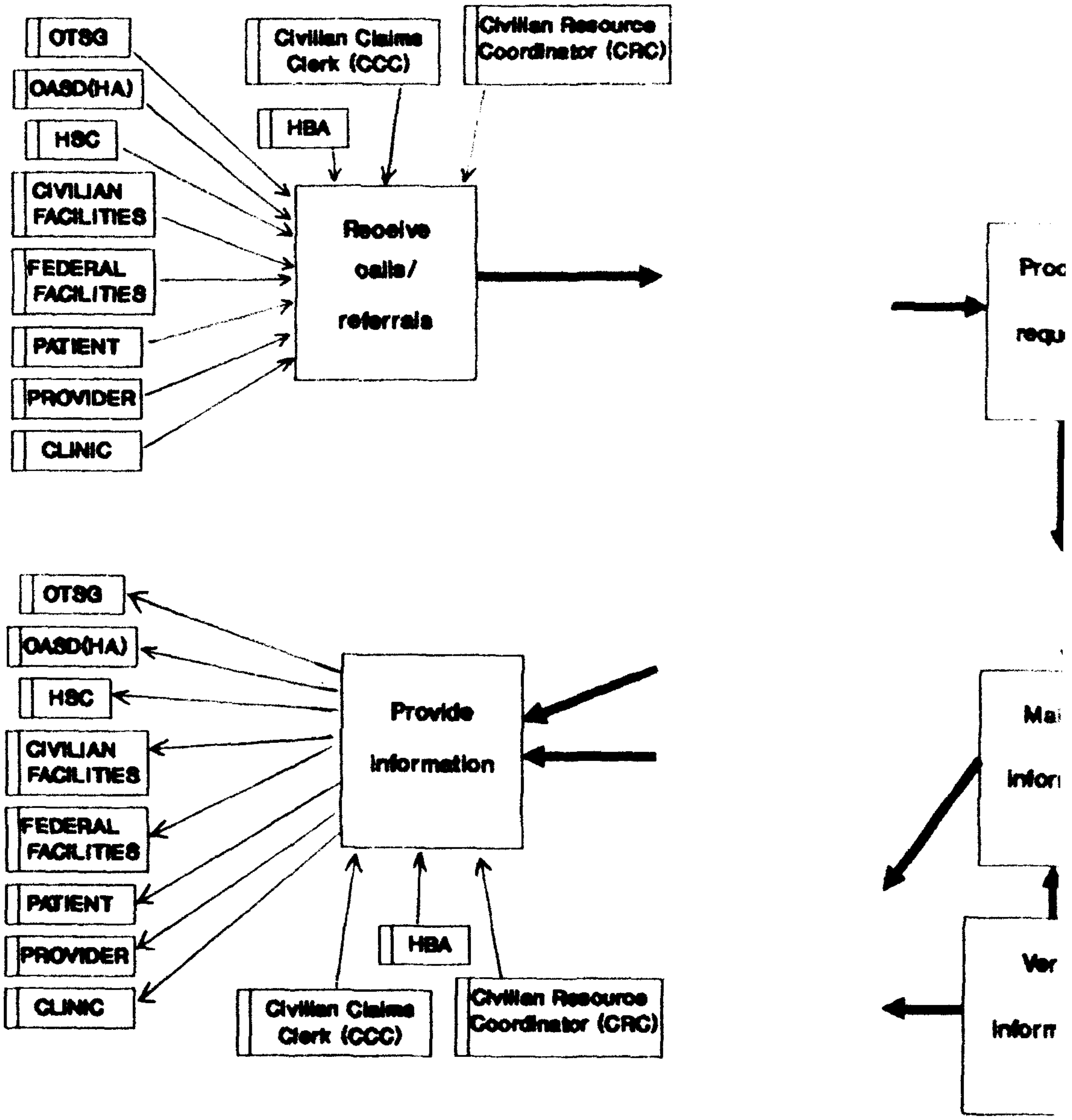
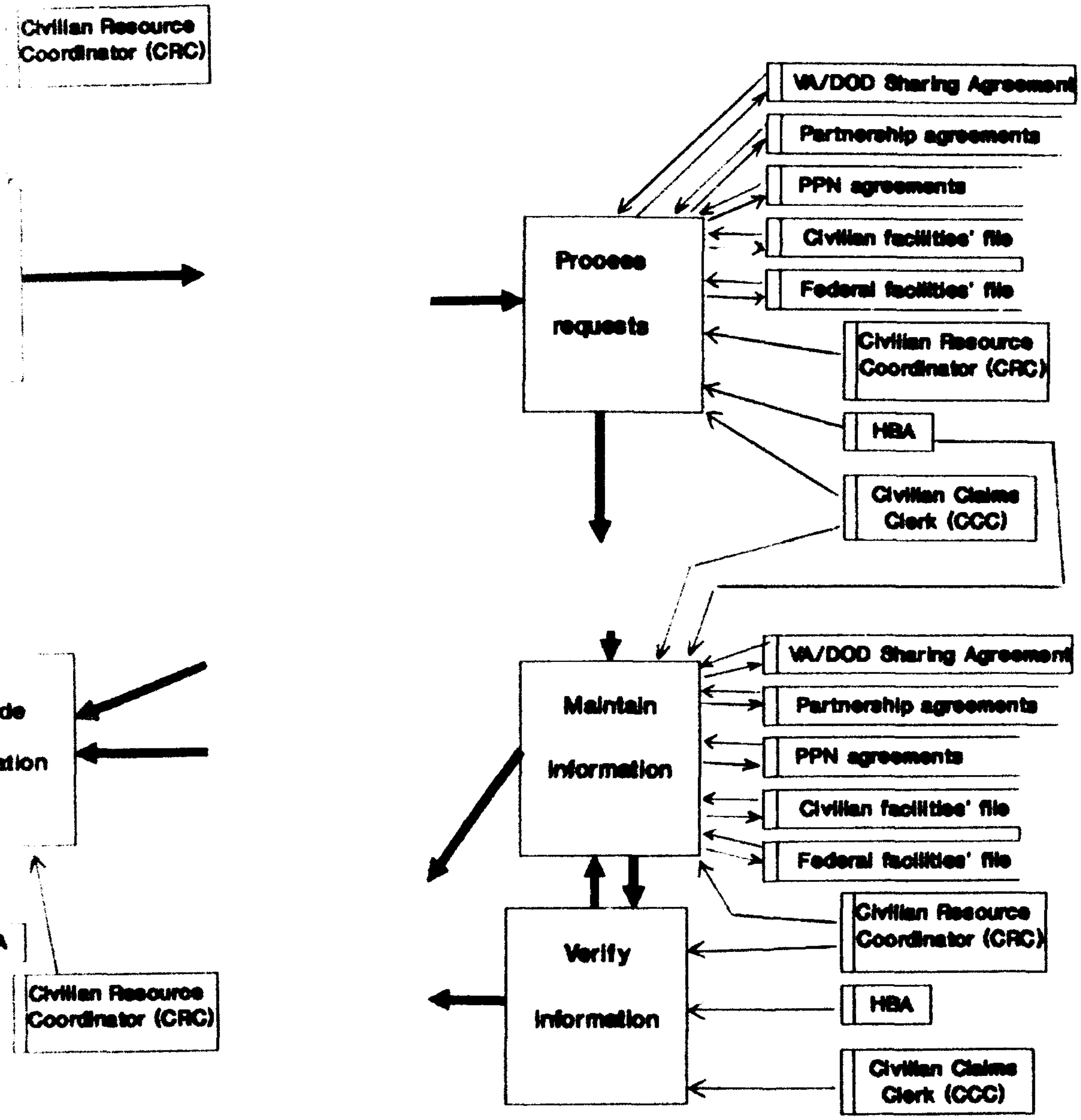
HBA
FISCAL INTERMEDIARY
OCHAMPUS

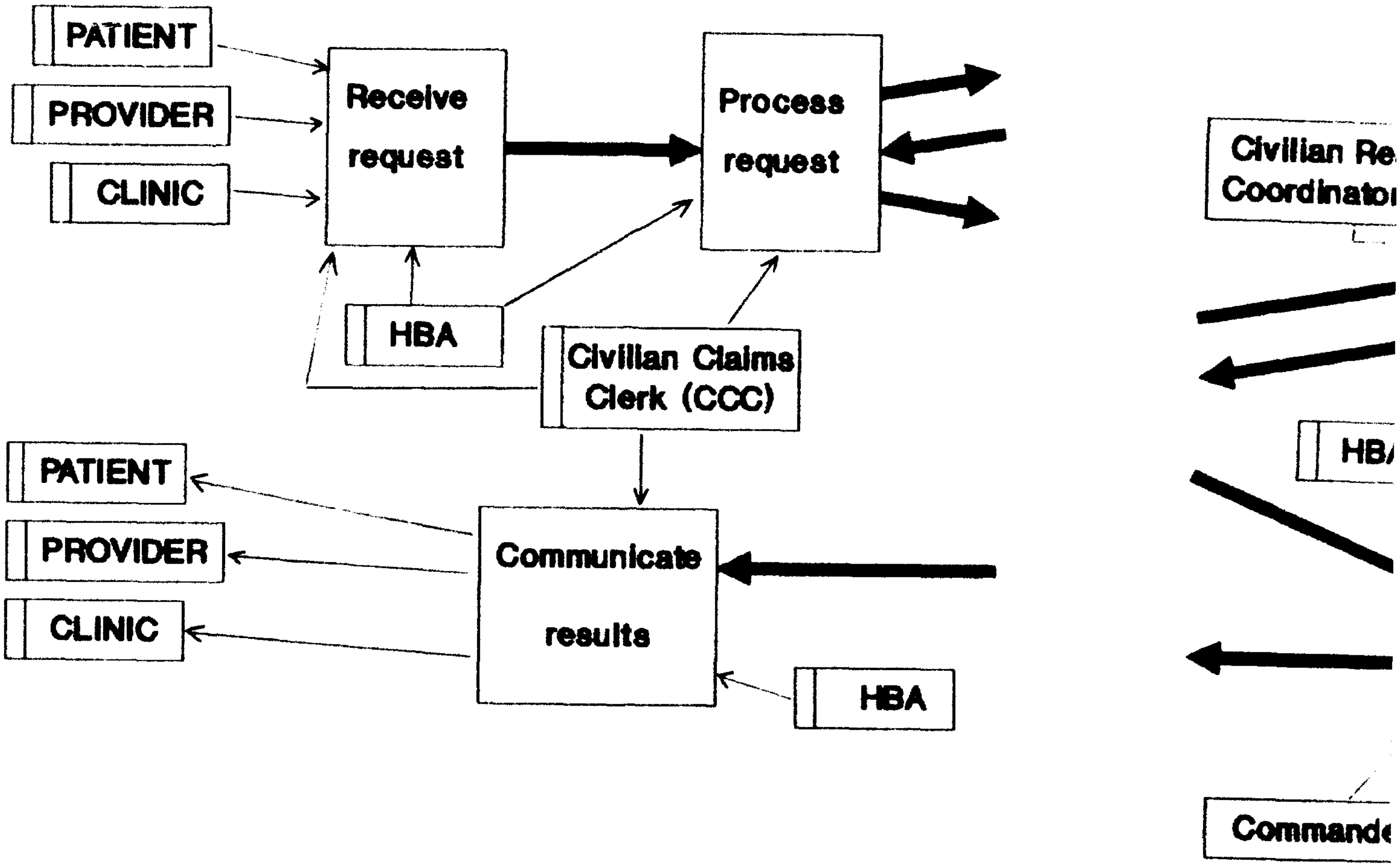
Task Two -- Provide information services.


OTSG
OASD(HA)
HSC
CIVILIAN FACILITIES
FEDERAL FACILITIES
PATIENT
PROVIDER
CLINIC
Civilian Claims Clerk (CCC)
HBA
Civilian Resource Coordinator (CRC)
Receive calls/ referrals
Proc
requ
OTSG
OASD(HA)
HSC
CIVILIAN FACILITIES
FEDERAL FACILITIES
PATIENT
PROVIDER
CLINIC
Provide information
HBA
Civilian Claims Clerk (CCC)
Civilian Resource Coordinator (CRC)
Ma
Infor
Ver
inform

tion services.

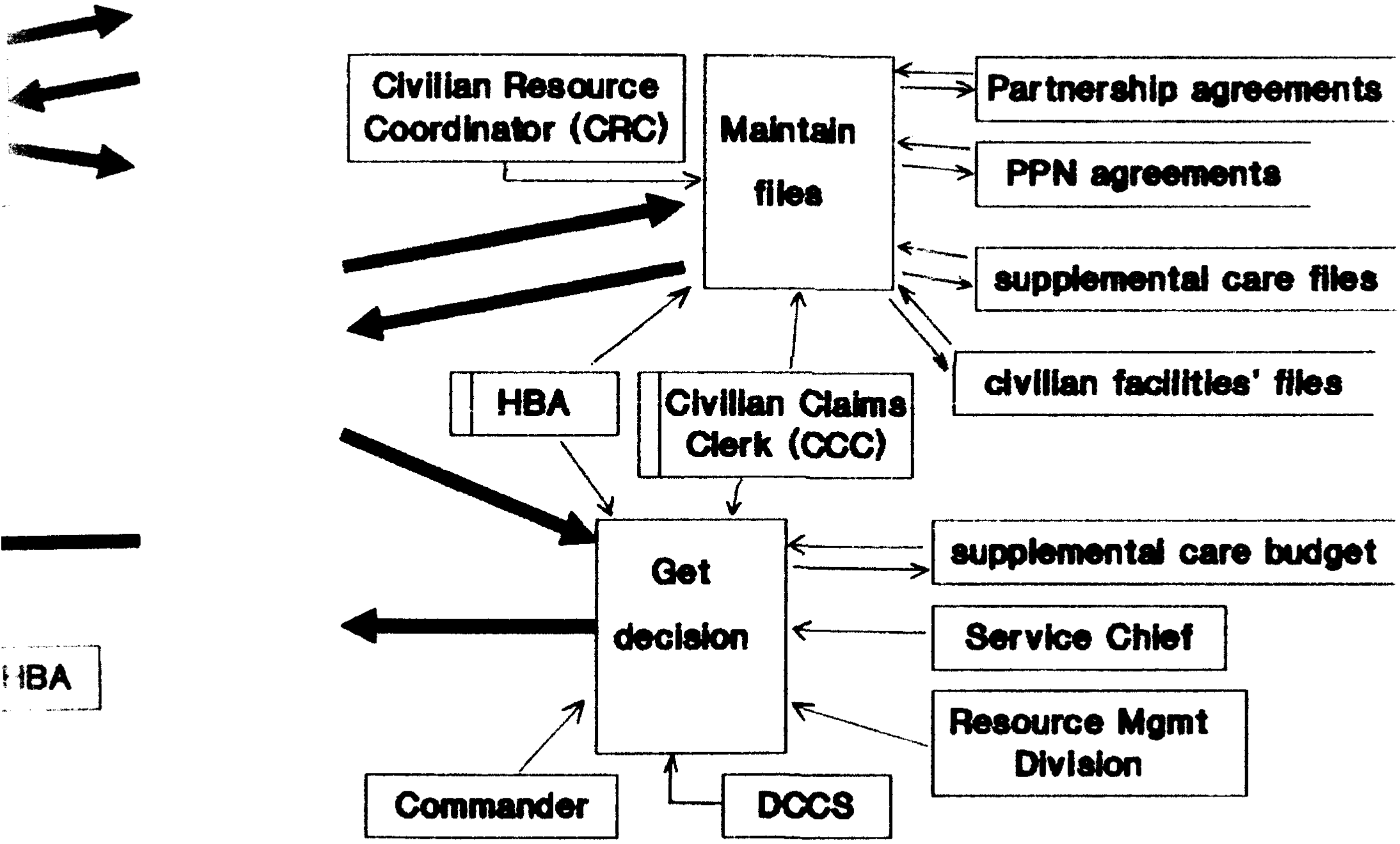

Civilian Resource Coordinator (CRC)
de
tion
Civilian Resource Coordinator (CRC)
Process requests
VA/DOD Sharing Agreement
Partnership agreements
PPN agreements
Civilian facilities' file
Federal facilities' file
Civilian Resource Coordinator (CRC)
HBA
Civilian Claims Clerk (CCC)
Maintain information
VA/DOD Sharing Agreement
Partnership agreements
PPN agreements
Civilian facilities' file
Federal facilities' file
Civilian Resource Coordinator (CRC)
HBA
Civilian Claims Clerk (CCC)
Verify information

Task Three -- Review requests for supplemental care.

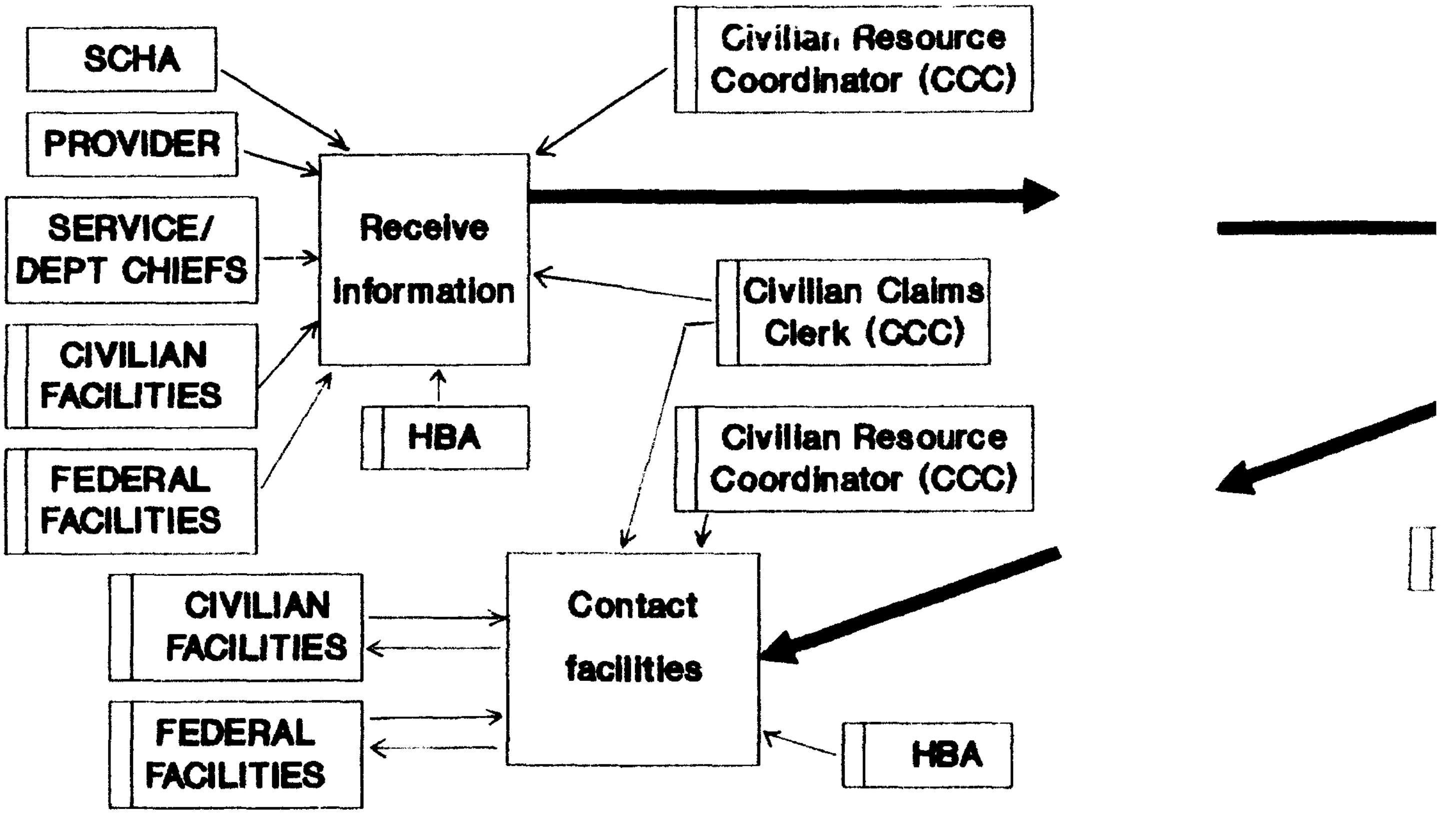

PATIENT
PROVIDER
CLINIC
Receive request
Process request
HBA
Civilian Claims Clerk (CCC)
Civilian Re
Coordinato
PATIENT
PROVIDER
CLINIC
Communicate results
HBA
HB
Commande

Division
140

ental

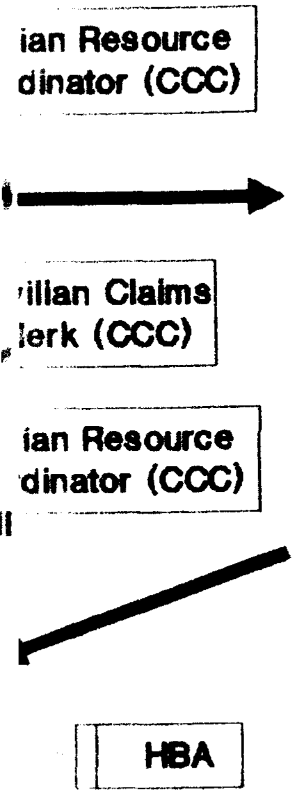

Civilian Resource Coordinator (CRC)
Maintain files
Partnership agreements
PPN agreements
supplemental care files
civilian facilities' files
HBA
Civilian Claims Clerk (CCC)
Get decision
supplemental care budget
Service Chief
Resource Mgmt Division
Commander
DCCS
HBA

Task Four -- Develop and maintain information on clinical capabilities.

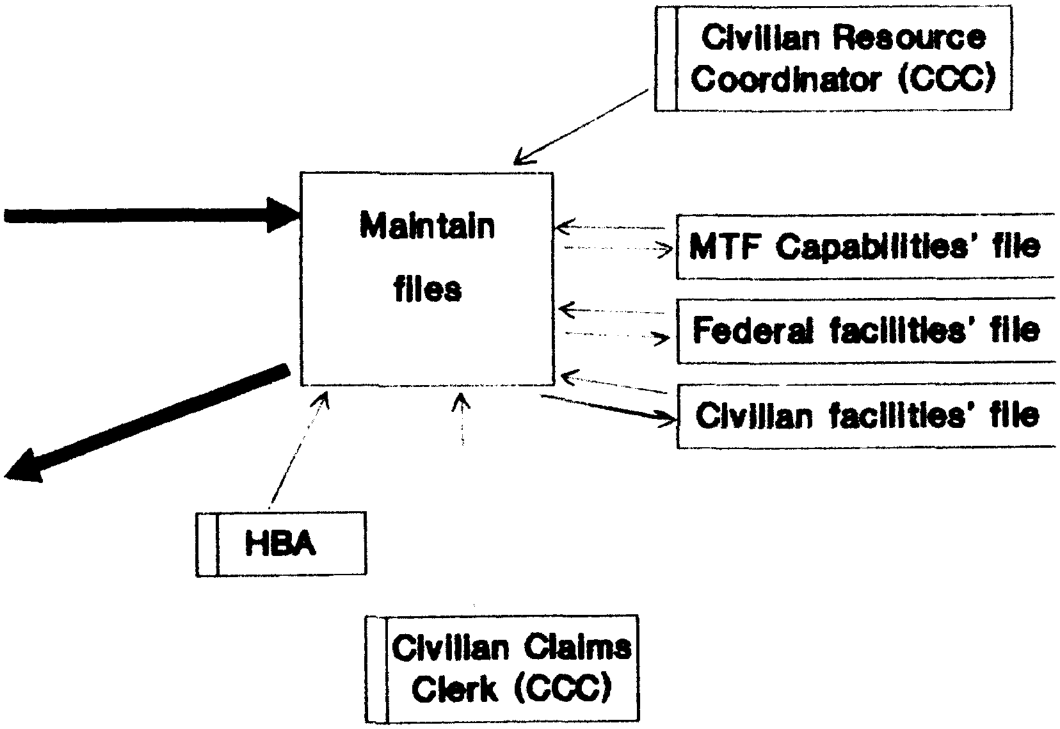

SCHA
PROVIDER
SERVICE/ DEPT CHIEFS
CIVILIAN FACILITIES
FEDERAL FACILITIES
Receive Information
HBA
Civilian Resource Coordinator (CCC)
Civilian Claims Clerk (CCC)
Civilian Resource Coordinator (CCC)
CIVILIAN FACILITIES
FEDERAL FACILITIES
Contact facilities
HBA

ed Care Division
141

information on

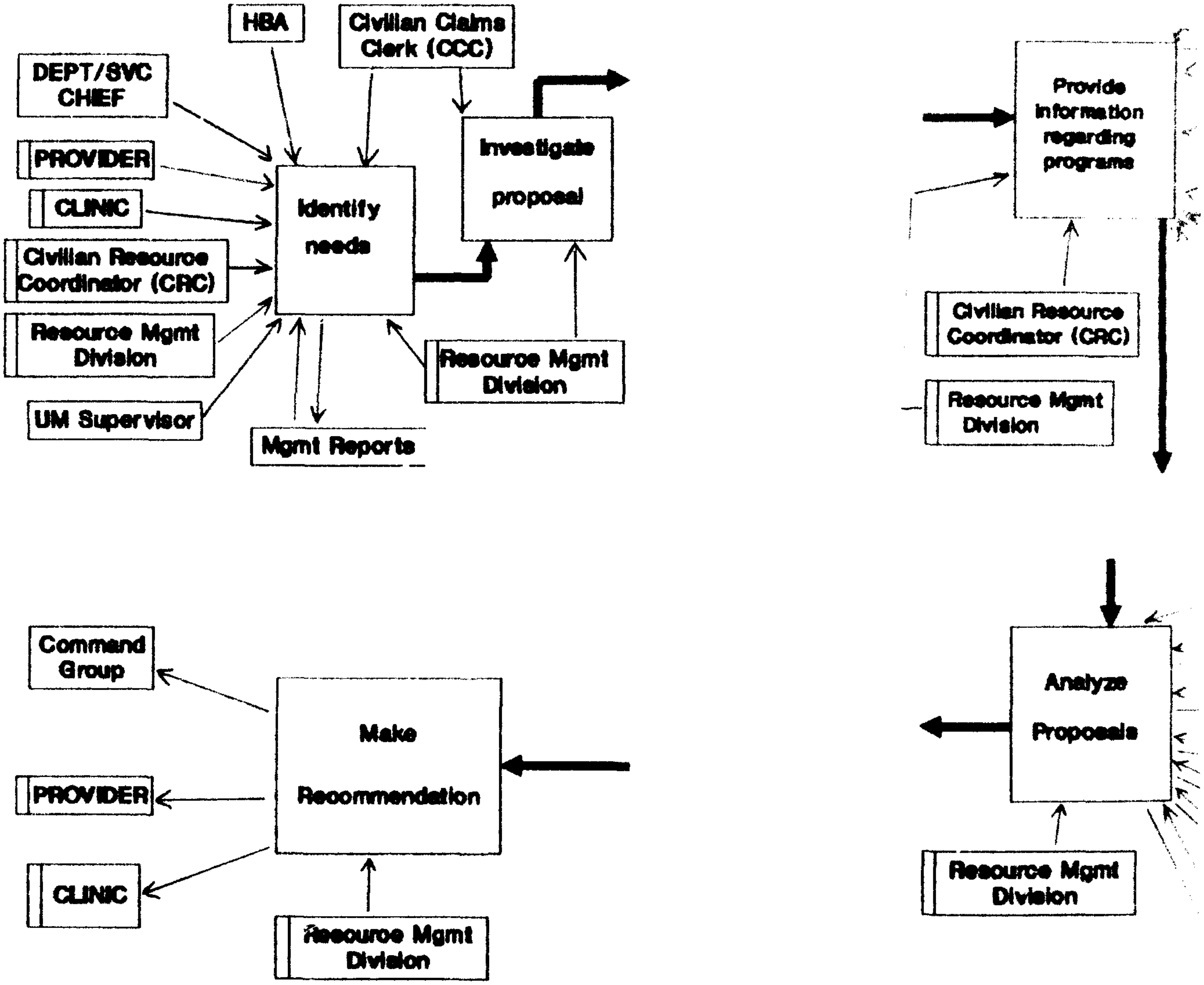


ian Resource
dinator (CCC)
ilian Claims
lerk (CCC)
ian Resource
dinator (CCC)
HBA

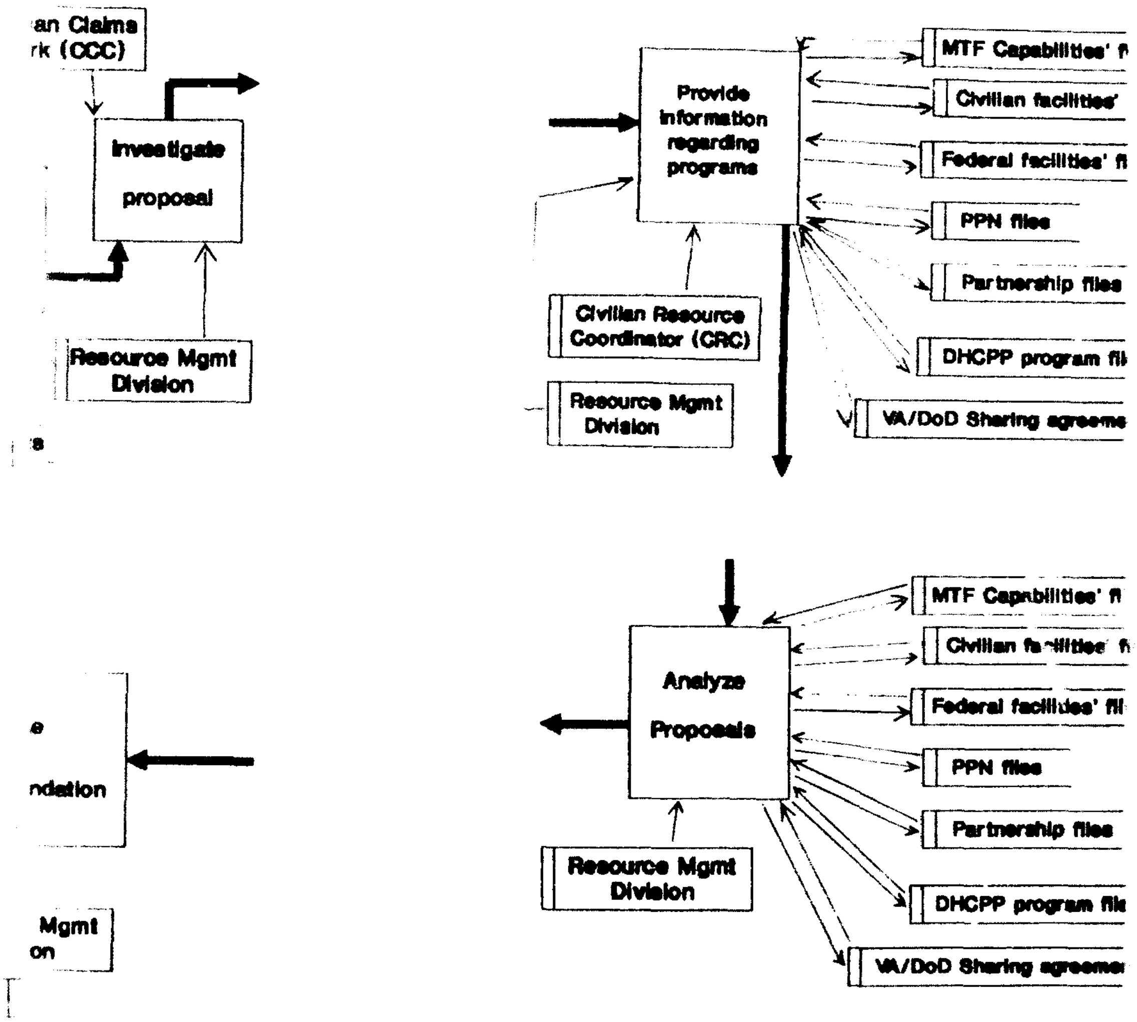


Civilian Resource Coordinator (CCC)
Maintain files
MTF Capabilities' file
Federal facilities' file
Civilian facilities' file
HBA
Civilian Claims Clerk (CCC)

Task Five -- Identify clinical areas for agreements and initiatives.


HBA
Civilian Claims Clerk (CCC)
DEPT/SVC CHIEF
PROVIDER
CLINIC
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
UM Supervisor
Identify needs
Mgmt Reports
Investigate proposal
Resource Mgmt Division
Provide information regarding programs
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
Analyze Proposals
Resource Mgmt Division
Command Group
PROVIDER
CLINIC
Make Recommendation
Resource Mgmt Division

linical areas for


an Claims
rk (CCC)
Investigate proposal
Resource Mgmt Division
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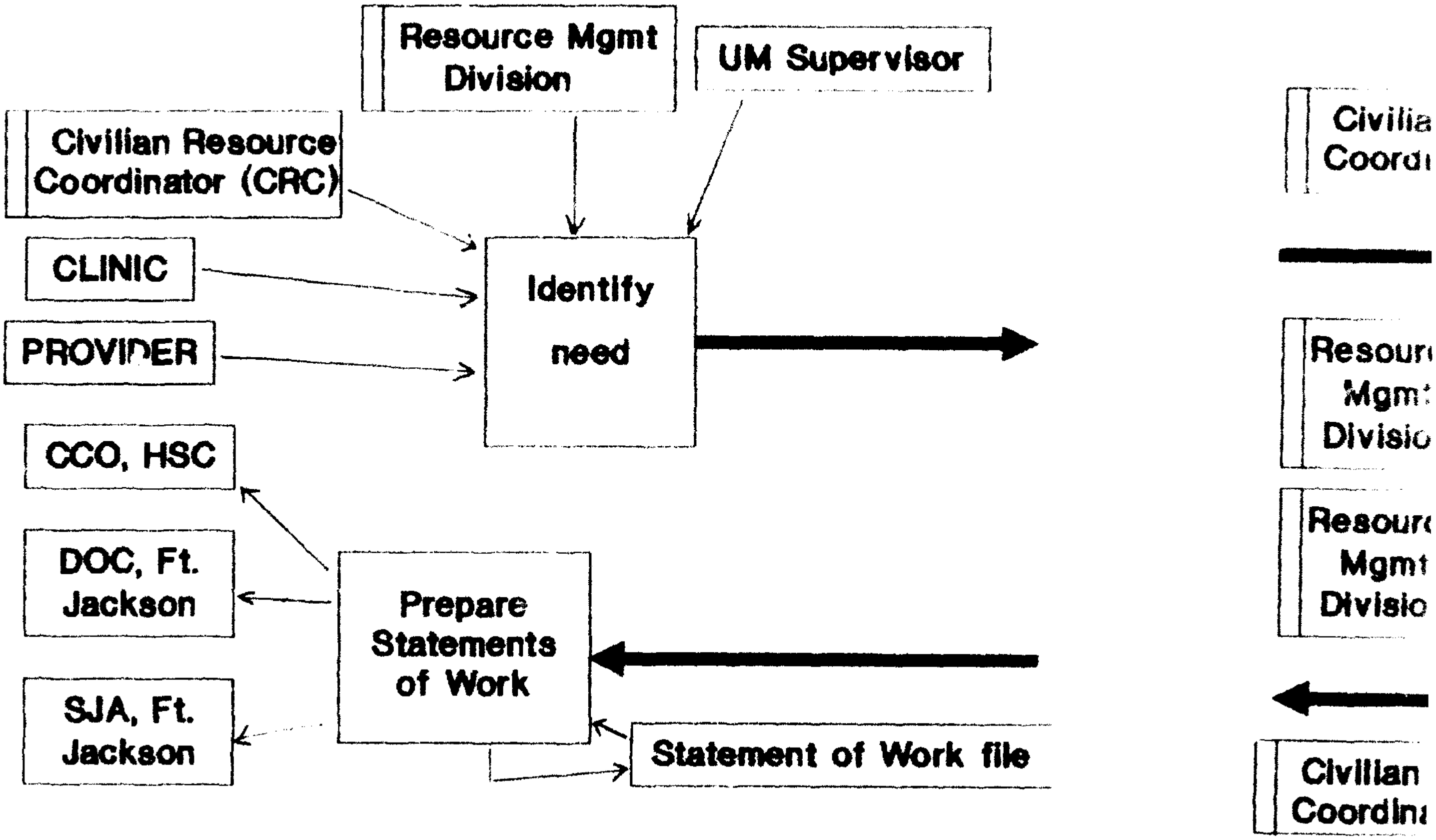
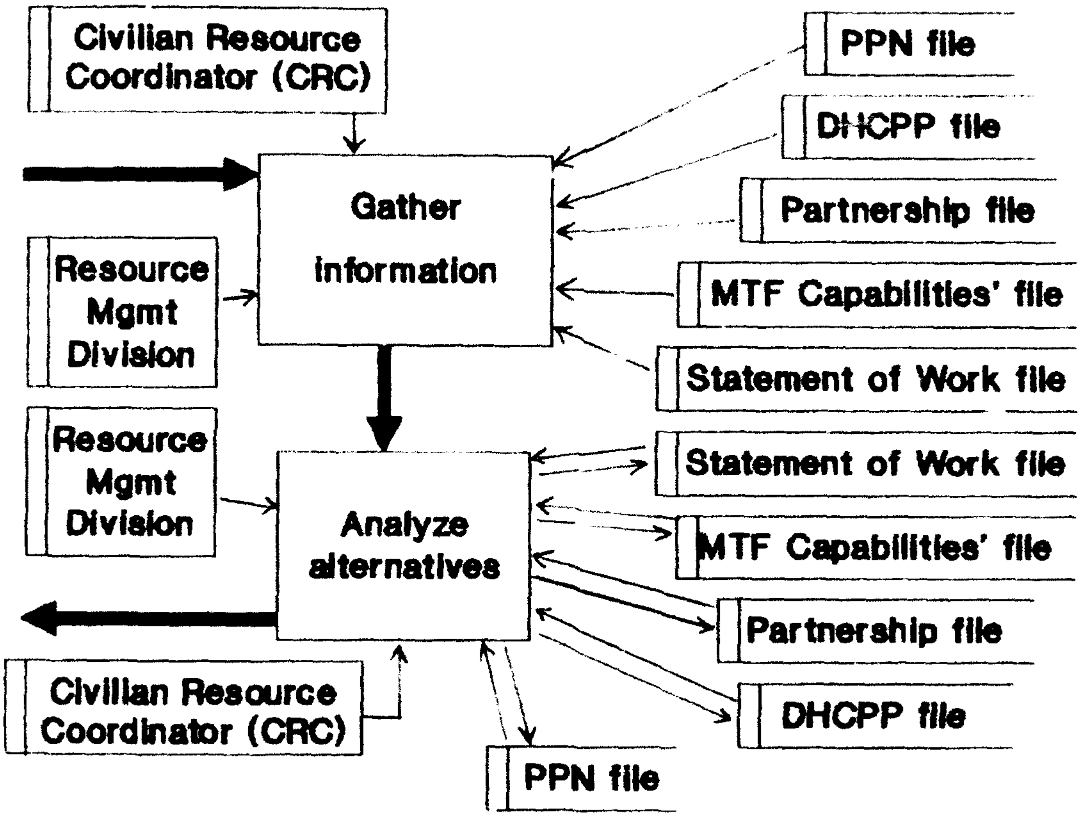
e
ndation
Mgmt
on
Provide information regarding programs
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
MTF Capabilities' f
Civilian facilities'
Federal facilities' fi
PPN files
Partnership files
DHCPP program fi
VA/DoD Sharing agreeme
Analyze Proposals
Resource Mgmt Division
MTF Capabilities' fi
Civilian facilities' fi
Federal facilities' fil
PPN files
Partnership files
DHCPP program fil
VA/DoD Sharing agreeme

Task Six -- Develop statements of work.

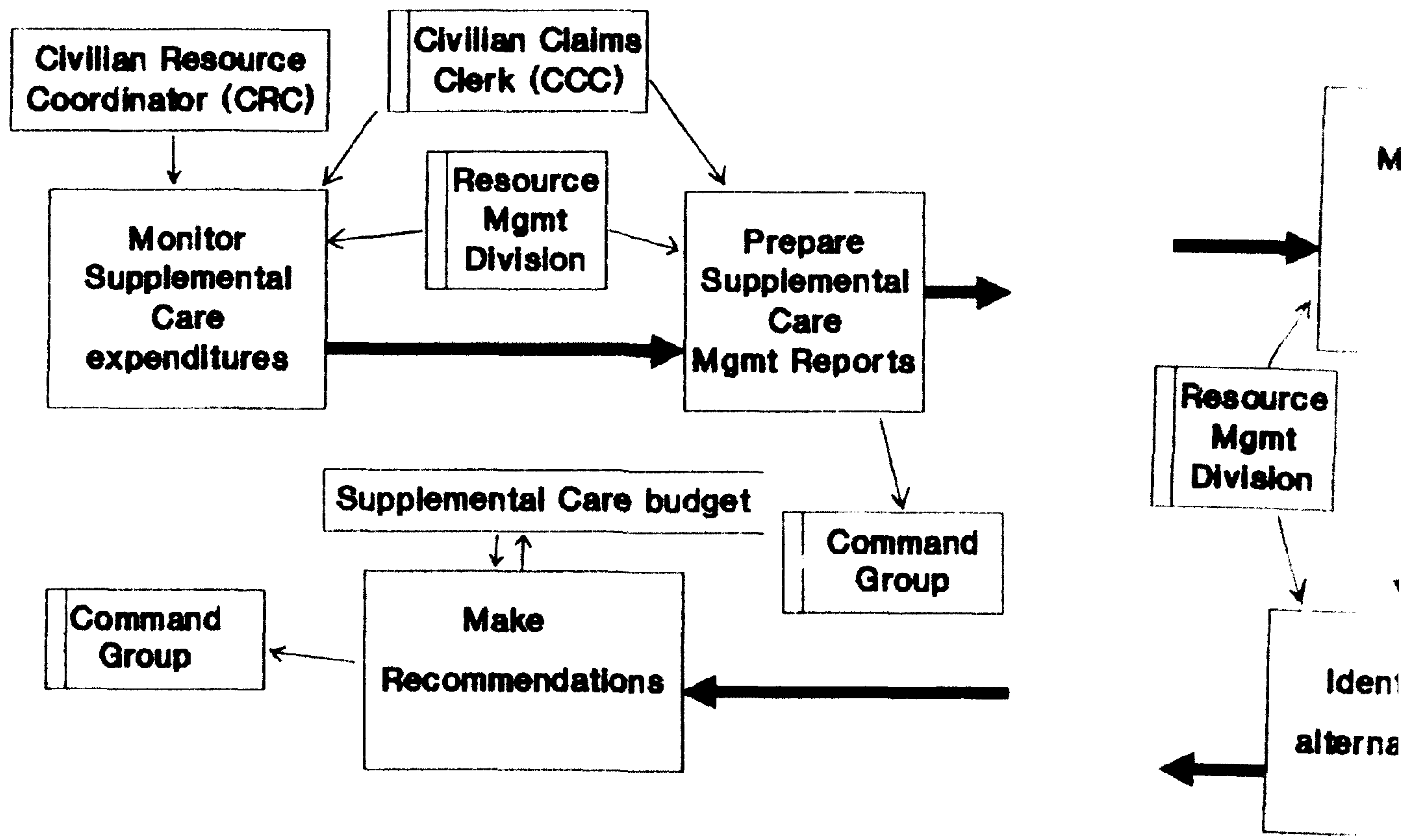

Resource Mgmt Division
UM Supervisor
Civilian Resource Coordinator (CRC)
CLINIC
PROVIDER
Identify need
CCO, HSC
DOC, Ft. Jackson
SJA, Ft. Jackson
Prepare Statements of Work
Statement of Work file
Civilia
Coordi
Resour
Mgm
Divisio
Resour
Mgmt
Divisio
Civilian
Coordin

on
43


Civilian Resource Coordinator (CRC)
Gather information
Resource Mgmt Division
PPN file
DHCPP file
Partnership file
MTF Capabilities' file
Statement of Work file
Resource Mgmt Division
Analyze alternatives
Statement of Work file
MTF Capabilities' file
Partnership file
DHCPP file
Civilian Resource Coordinator (CRC)
PPN file

le

Task Seven -- Monitor supplemental care expenditures.


Civilian Resource Coordinator (CRC)
Civilian Claims Clerk (CCC)
Resource Mgmt Division
Monitor Supplemental Care expenditures
Prepare Supplemental Care Mgmt Reports
Supplemental Care budget
Command Group
Make Recommendations
Command Group
Resource Mgmt Division
M
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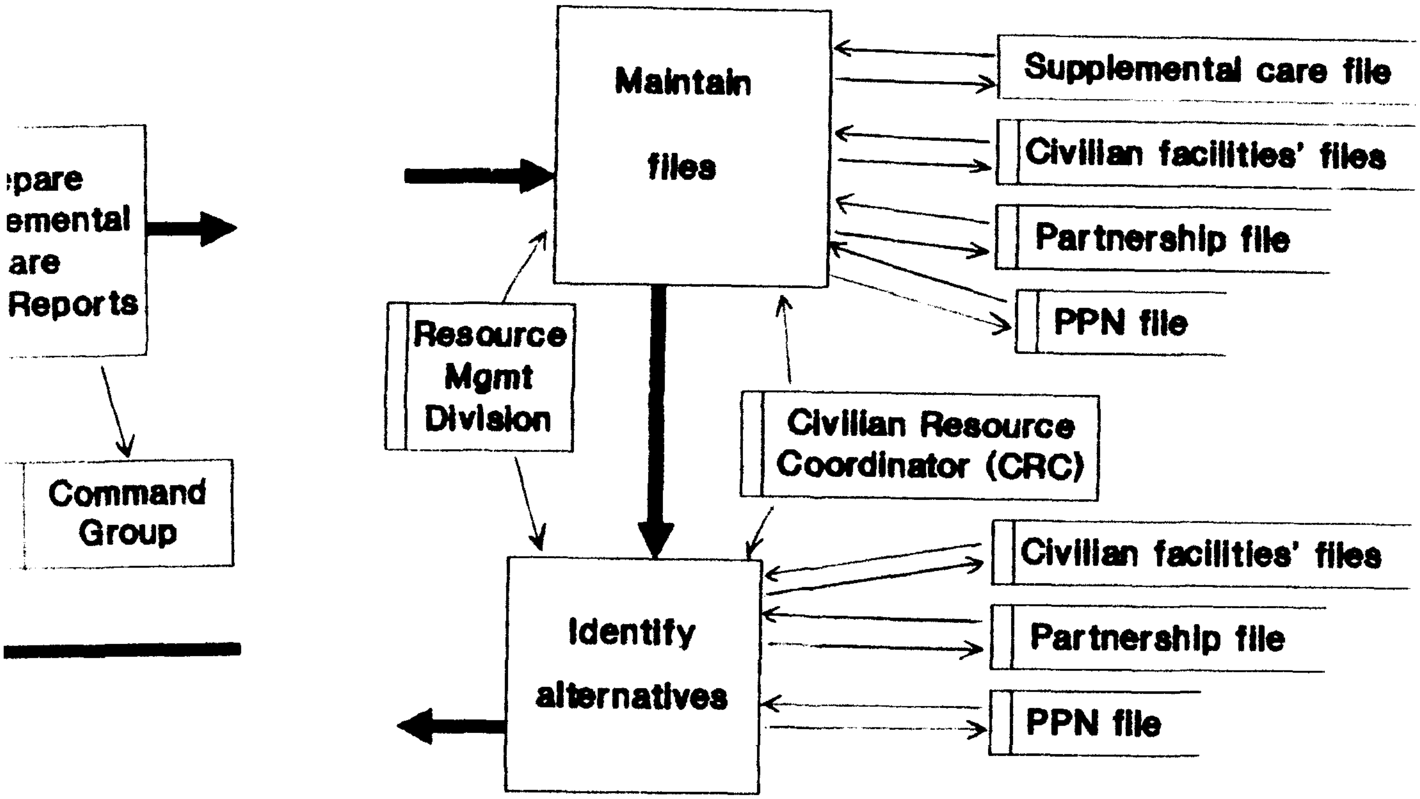
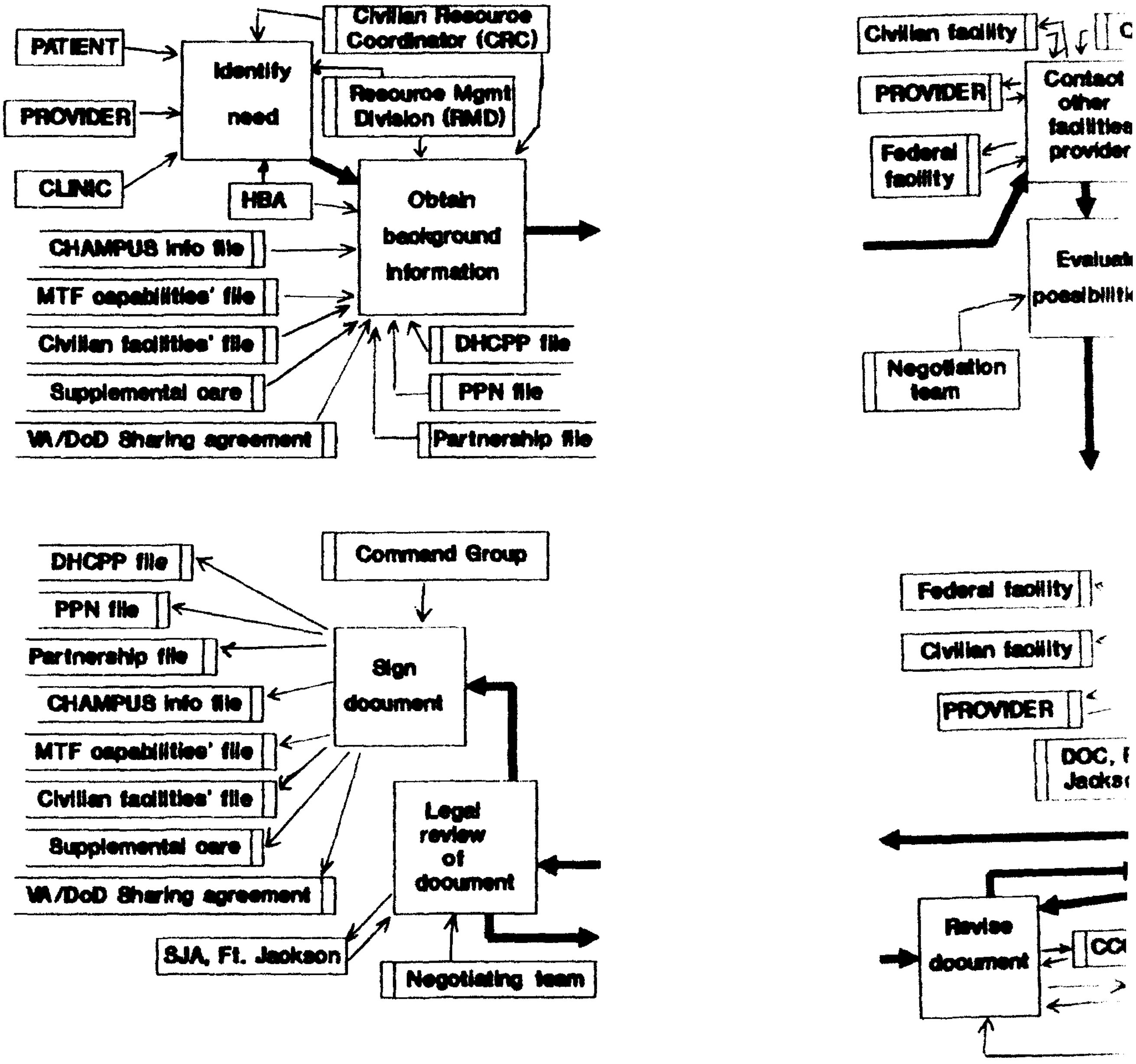
alterna

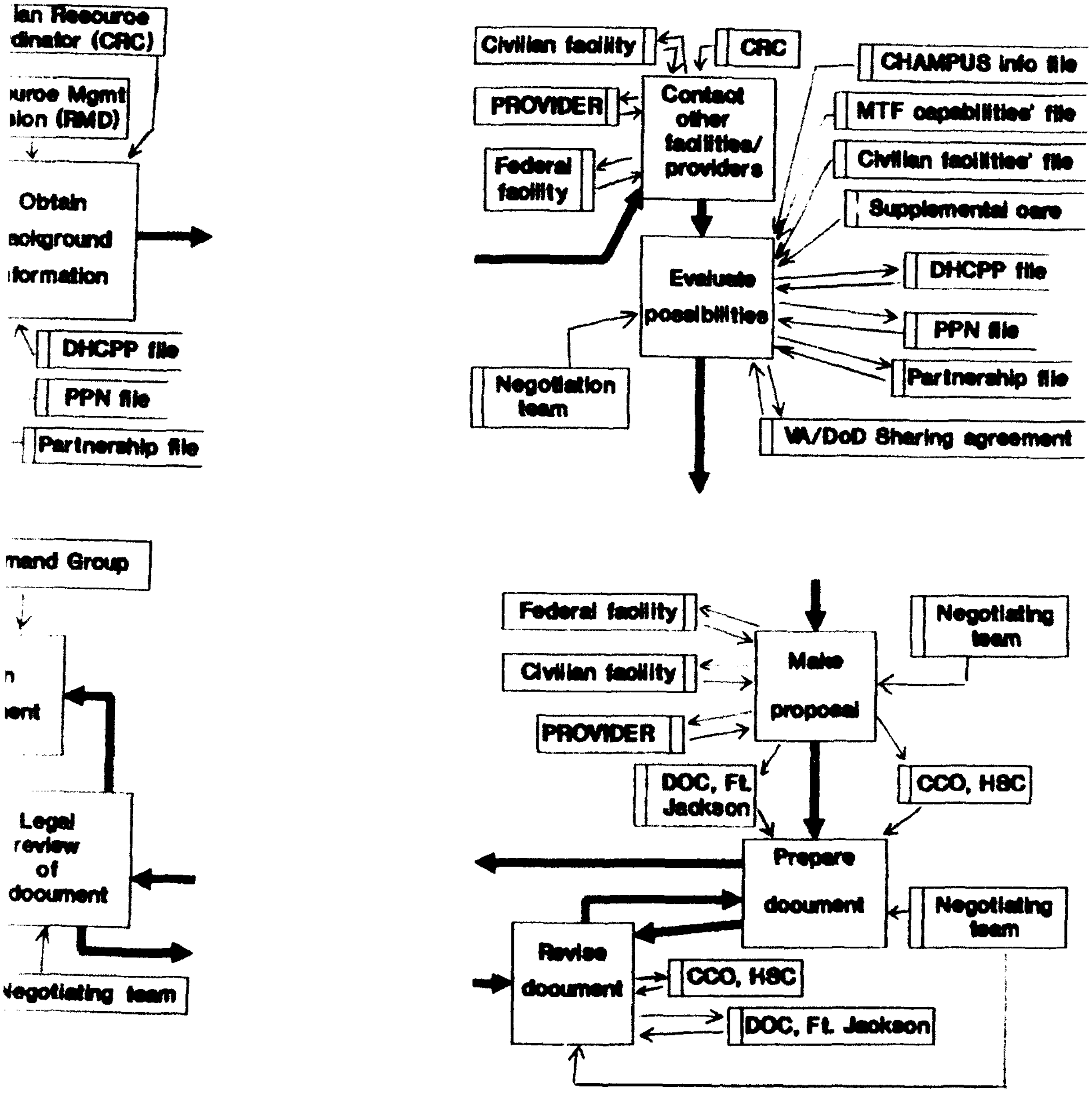
are


Maintain files
Supplemental care file
Civilian facilities' files
Partnership file
PPN file
pare
emental
are
Reports
Command Group
Resource Mgmt Division
Civilian Resource Coordinator (CRC)
Identify alternatives
Civilian facilities' files
Partnership file
PPN file

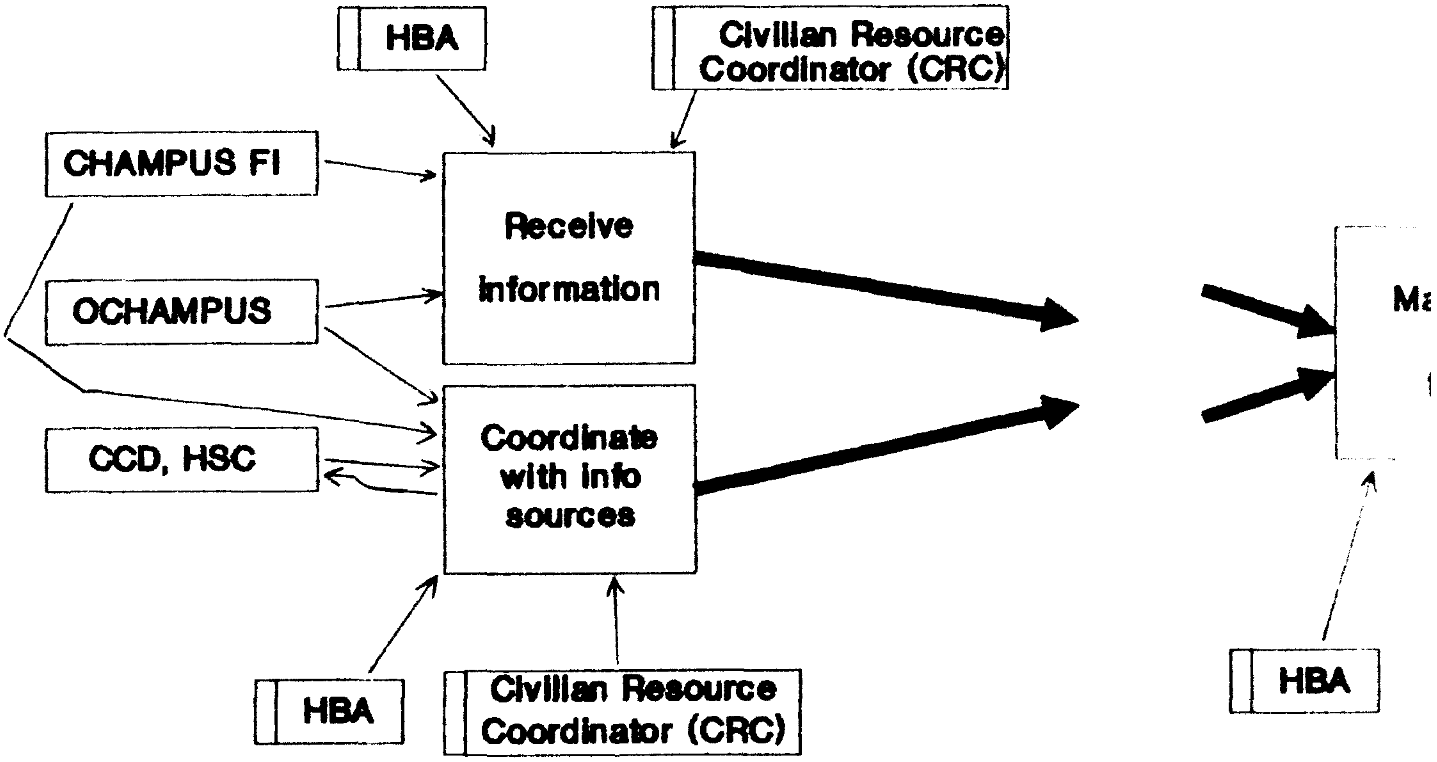
Task Eight -- Negotiate agreements and contracts.


PATIENT
PROVIDER
CLINIC
Identify need
Civilian Resource Coordinator (CRC)
Resource Mgmt Division (RMD)
HBA
Obtain background information
CHAMPUS info file
MTF capabilities' file
Civilian facilities' file
Supplemental care
VA/DoD Sharing agreement
DHCPP file
PPN file
Partnership file
Civilian facility
PROVIDER
Federal facility
Contact other facilities provider
Evaluat
possibiliti
Negotiation team
Command Group
DHCPP file
PPN file
Partnership file
CHAMPUS info file
MTF capabilities' file
Civilian facilities' file
Supplemental care
VA/DoD Sharing agreement
Sign document
Legal review of document
SJA, Ft. Jackson
Negotiating team
Federal facility
Civilian facility
PROVIDER
DOC,
Jacks
Revise document
CC

greements and contracts.

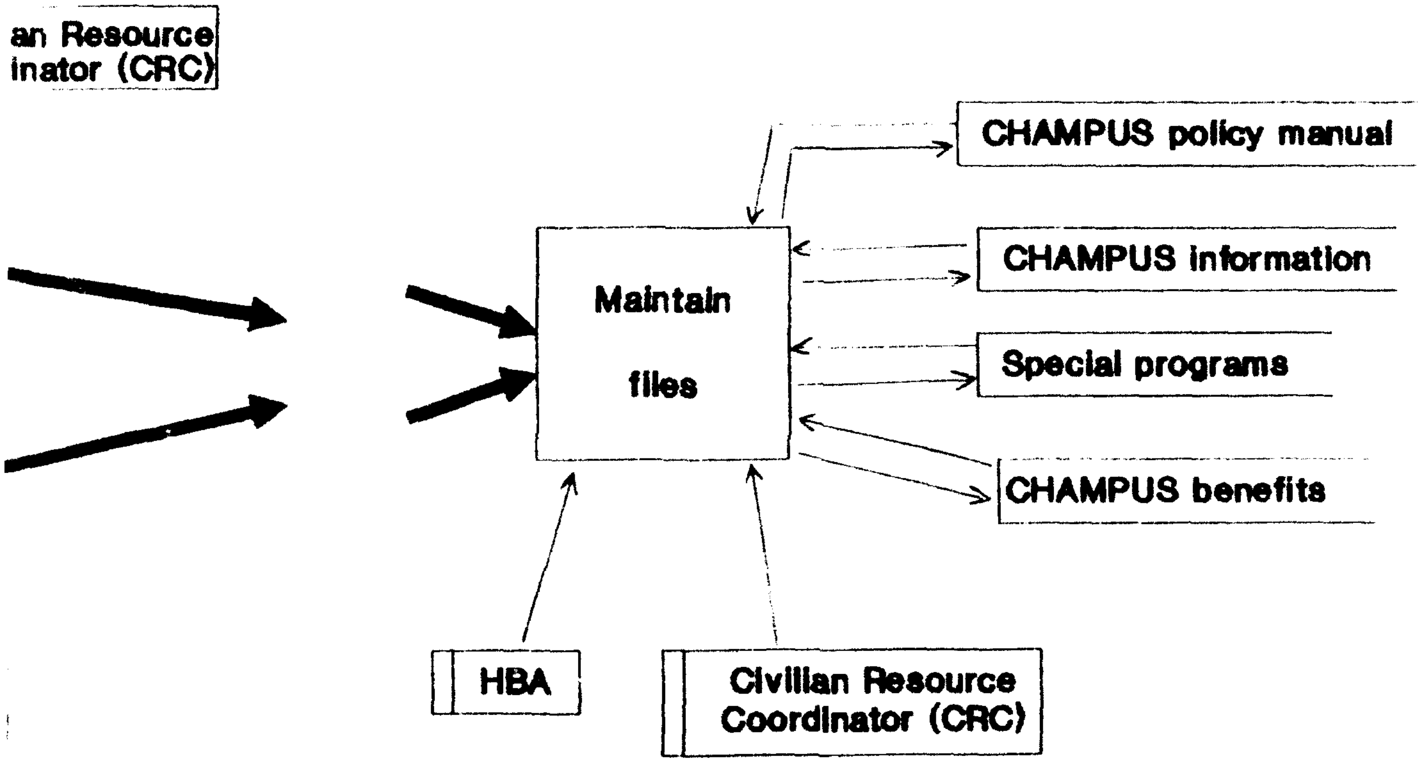

lan Resource
dinator (CRC)
ource Mgmt
sion (RMD)
Obtain
ackground
formation
DHCPP file
PPN file
Partnership file
Civilian facility
CRC
PROVIDER
Contact other facilities/ providers
Federal facility
CHAMPUS info file
MTF capabilities' file
Civilian facilities' file
Supplemental care
Evaluate possibilities
DHCPP file
PPN file
Partnership file
Negotiation team
VA/DoD Sharing agreement
mand Group
n
ent
Legal review of document
Negotiating team
Federal facility
Civilian facility
PROVIDER
Make proposal
Negotiating team
DOC, Ft. Jackson
CCO, HSC
Prepare document
Negotiating team
Revise document
CCO, HSC
DOC, Ft. Jackson

Task Nine -- Coordinate for CHAMPUS policy guidance.

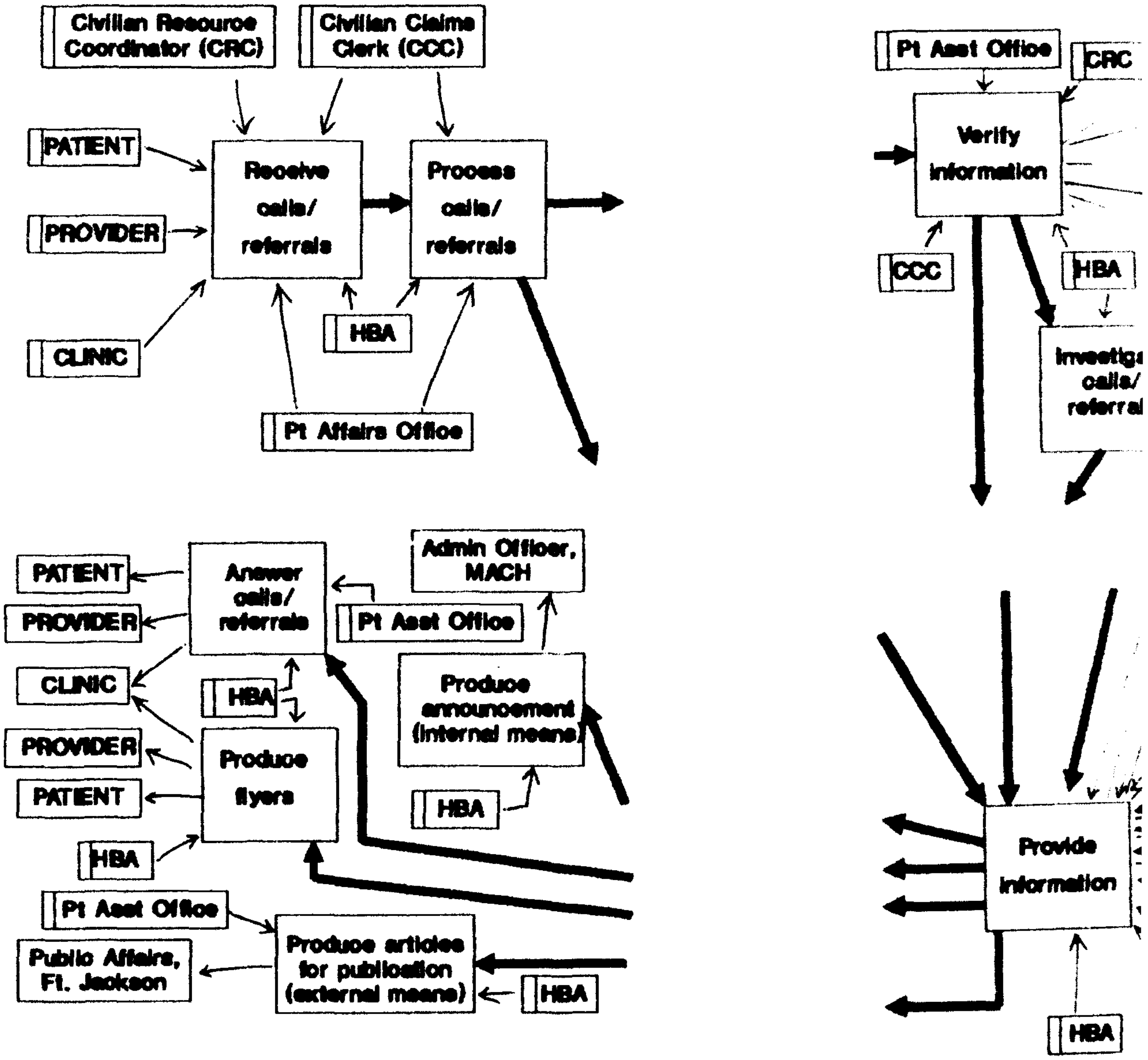

HBA
Civilian Resource Coordinator (CRC)
CHAMPUS FI
OCHAMPUS
CCD, HSC
Receive information
Coordinate with info sources
HBA
Civilian Resource Coordinator (CRC)
HBA
Ma

ted Care Division
146

US policy

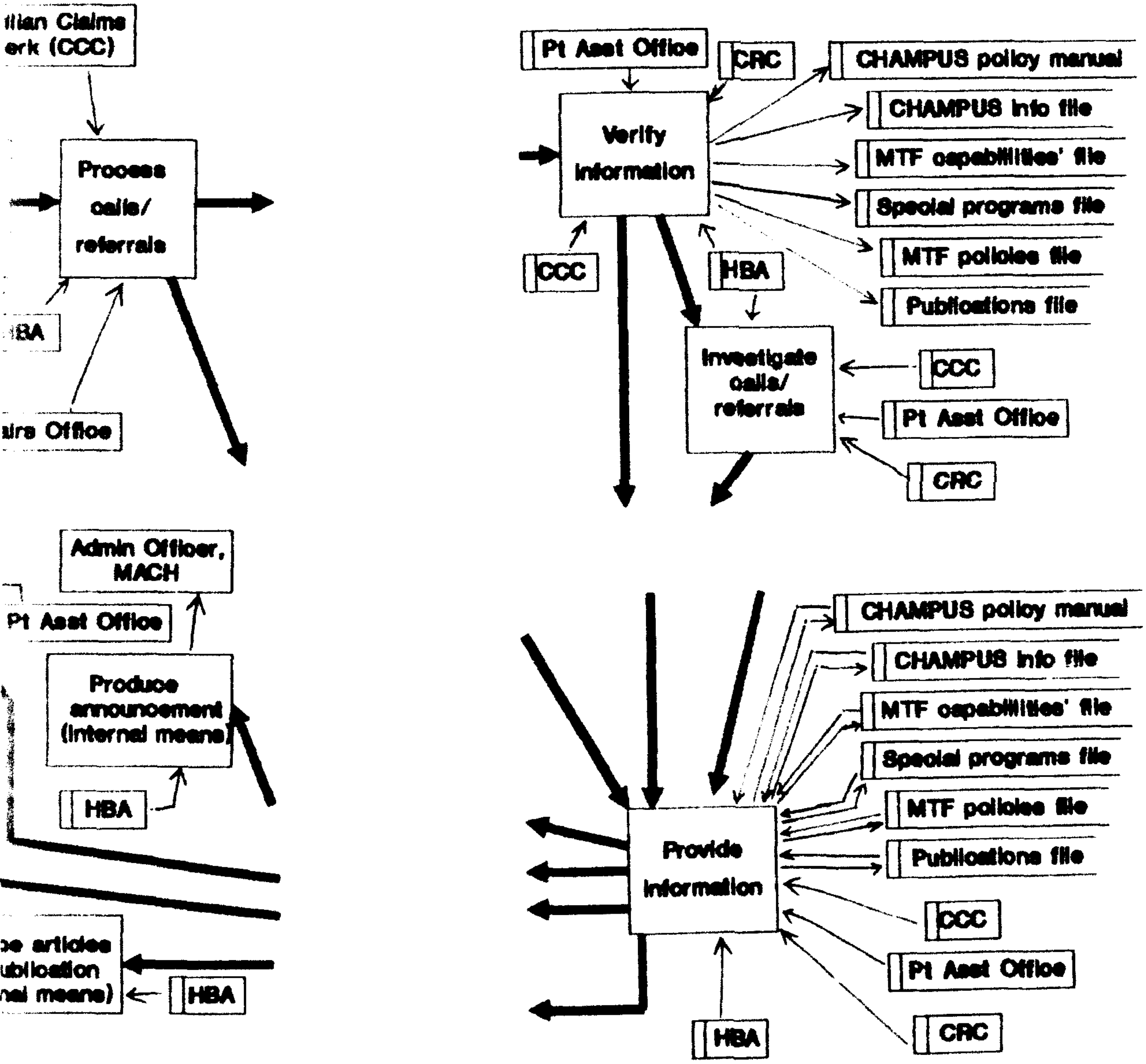

an Resource
inator (CRC)
CHAMPUS policy manual
CHAMPUS information
Maintain
files
Special programs
CHAMPUS benefits
HBA
Civilian Resource
Coordinator (CRC)

Task Ten -- Disseminate information to beneficiaries and providers.

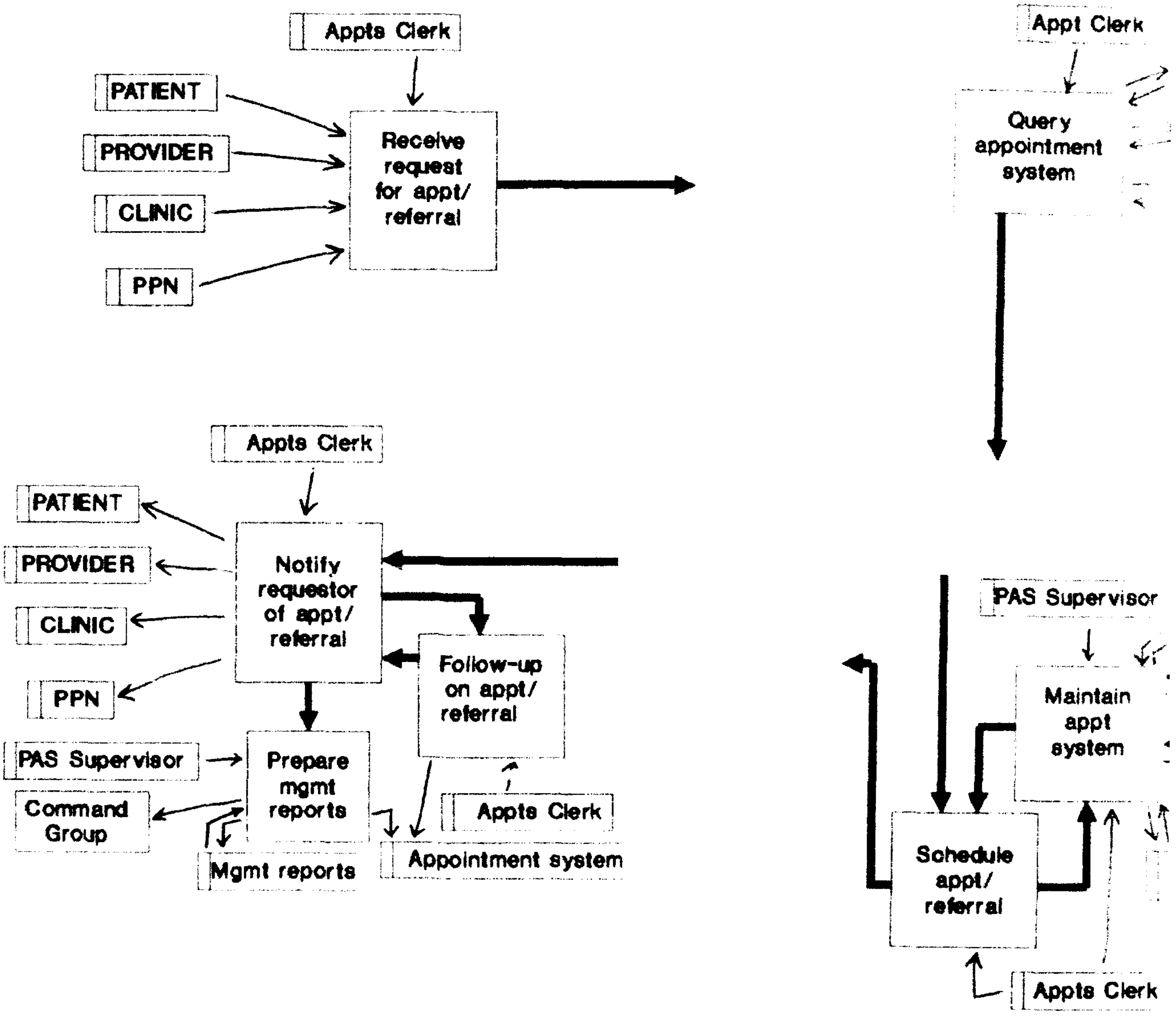

Civilian Resource Coordinator (CRC)
Civilian Claims Clerk (CCC)
PATIENT
PROVIDER
CLINIC
Receive calls/ referrals
Process calls/ referrals
HBA
Pt Affairs Office
Pt Asst Office
CRC
Verify information
CCC
HBA
Investig
calls/
referral
PATIENT
PROVIDER
CLINIC
PROVIDER
PATIENT
Answer calls/ referrals
Admin Officer, MACH
Pt Asst Office
HBA
Produce flyers
Produce announcement (internal means)
HBA
HBA
Pt Asst Office
Public Affairs, Ft. Jackson
Produce articles for publication (external means)
HBA
Provide information
HBA

te information to

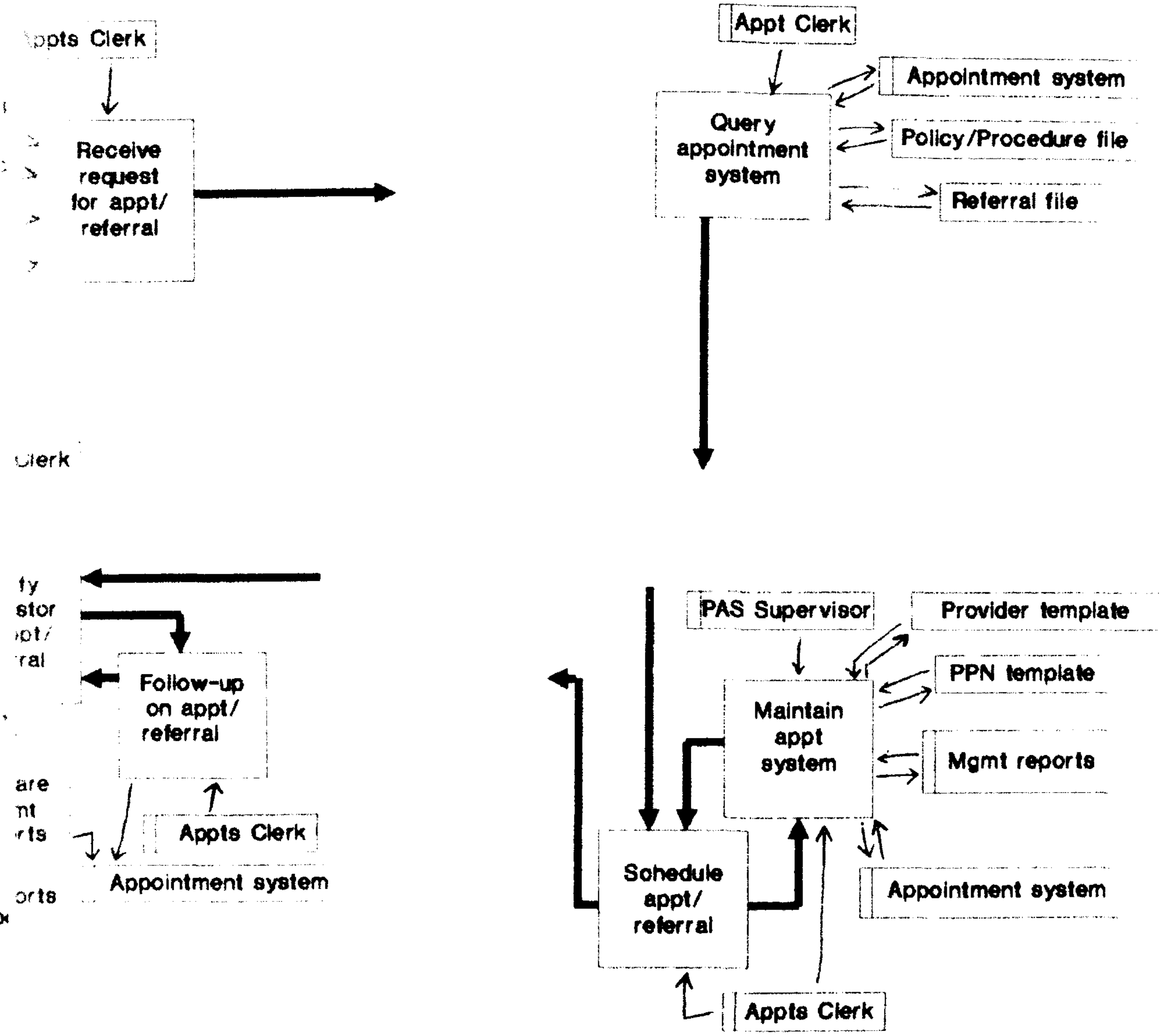
rs.


ilian Claims
erk (CCC)
Process calls/ referrals
BA
irs Office
Pt Asst Office
CRC
CHAMPUS policy manual
CHAMPUS info file
MTF capabilities' file
Special programs file
MTF policies file
Publications file
Verify information
CCC
HBA
Investigate calls/ referrals
CCC
Pt Asst Office
CRC
Admin Officer, MACH
Pt Asst Office
Produce announcement (internal means)
HBA
oe articles
ublication
nal means)
HBA
CHAMPUS policy manual
CHAMPUS info file
MTF capabilities' file
Special programs file
MTF policies file
Publications file
Provide information
CCC
Pt Asst Office
CRC
HBA

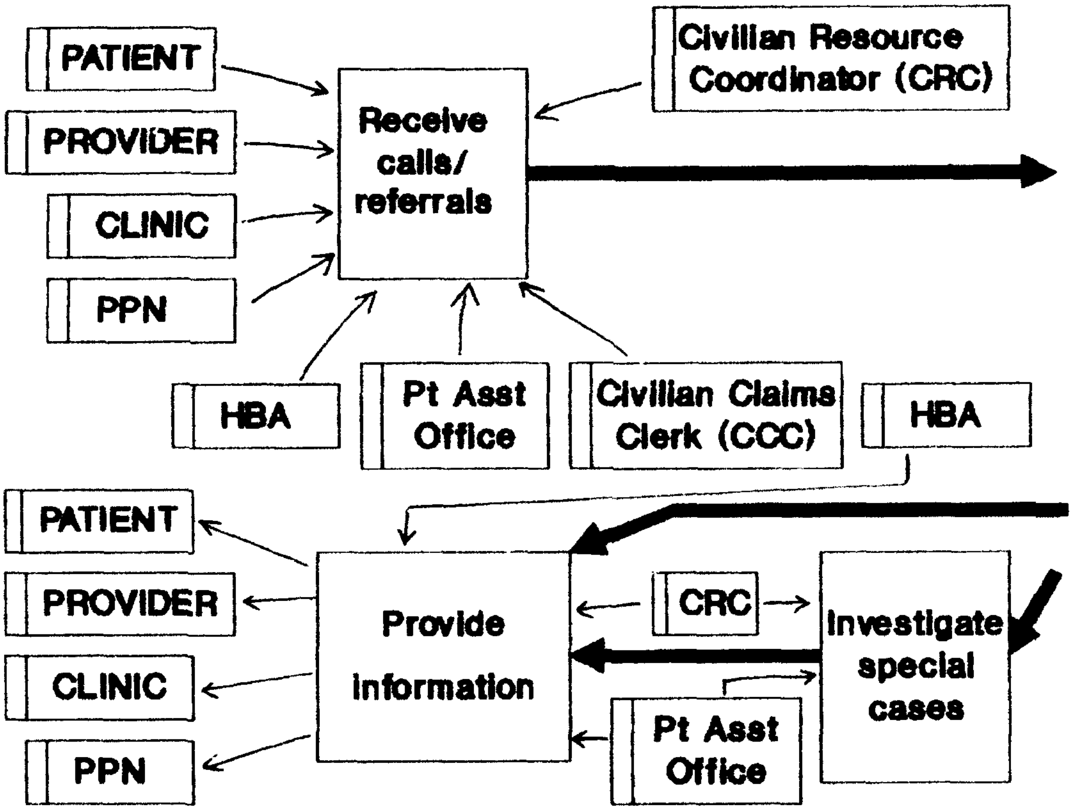
Task Eleven -- Operate the Health Care Finder program.


Appts Clerk
PATIENT
PROVIDER
CLINIC
PPN
Receive request for appt/ referral
Appt Clerk
Query appointment system
Appts Clerk
PATIENT
PROVIDER
CLINIC
PPN
Notify requestor of appt/ referral
Follow-up on appt/ referral
PAS Supervisor
Prepare mgmt reports
Command Group
Mgmt reports
Appts Clerk
Appointment system
PAS Supervisor
Maintain appt system
Schedule appt/ referral
Appts Clerk

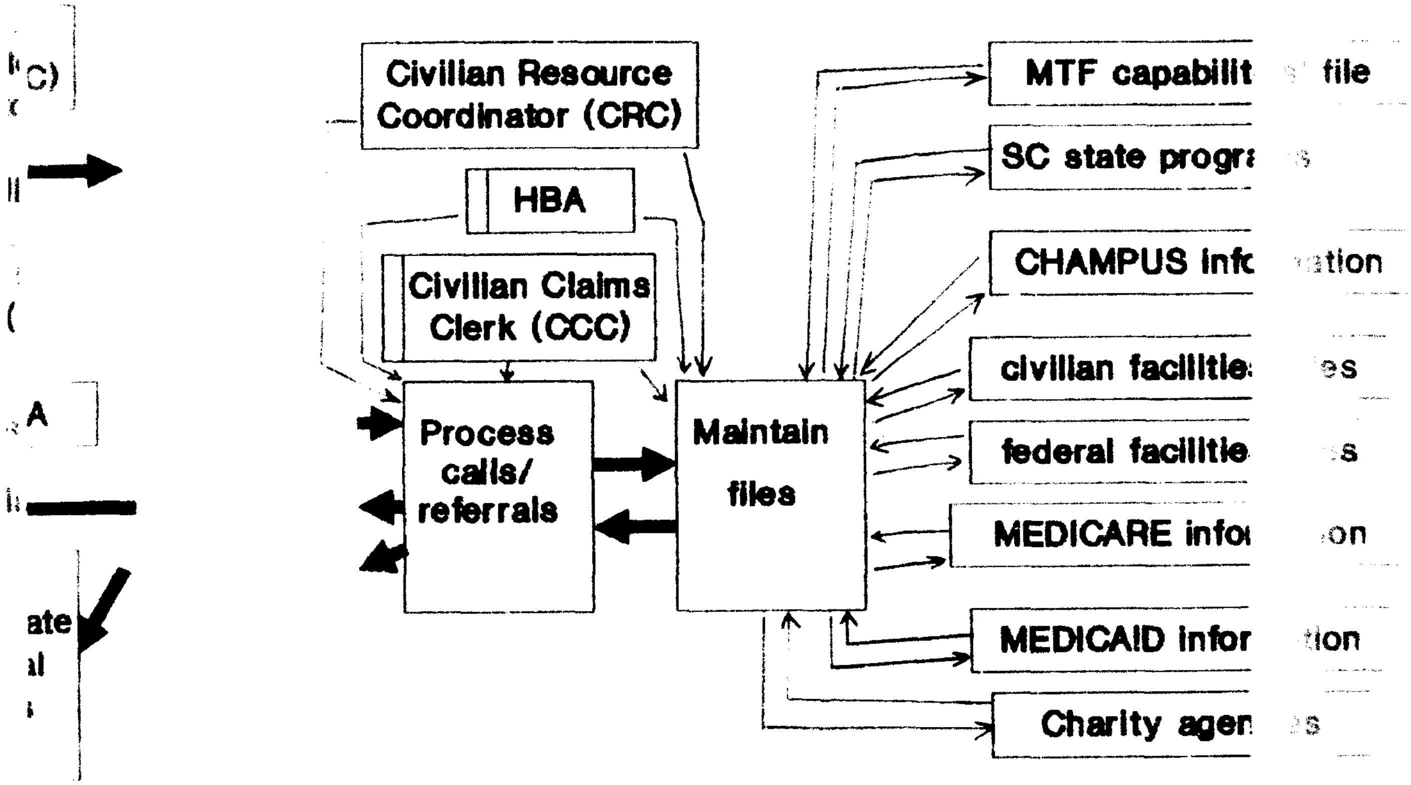
te the Health Care Finder


ppts Clerk
Receive request for appt/ referral
Appt Clerk
Query appointment system
Appointment system
Policy/Procedure file
Referral file
lerk
fy
stor
pt/
ral
Follow-up on appt/ referral
are
nt
rts
orts
Appts Clerk
Appointment system
PAS Supervisor
Provider template
PPN template
Maintain appt system
Mgmt reports
Appointment system
Schedule appt/ referral
Appts Clerk

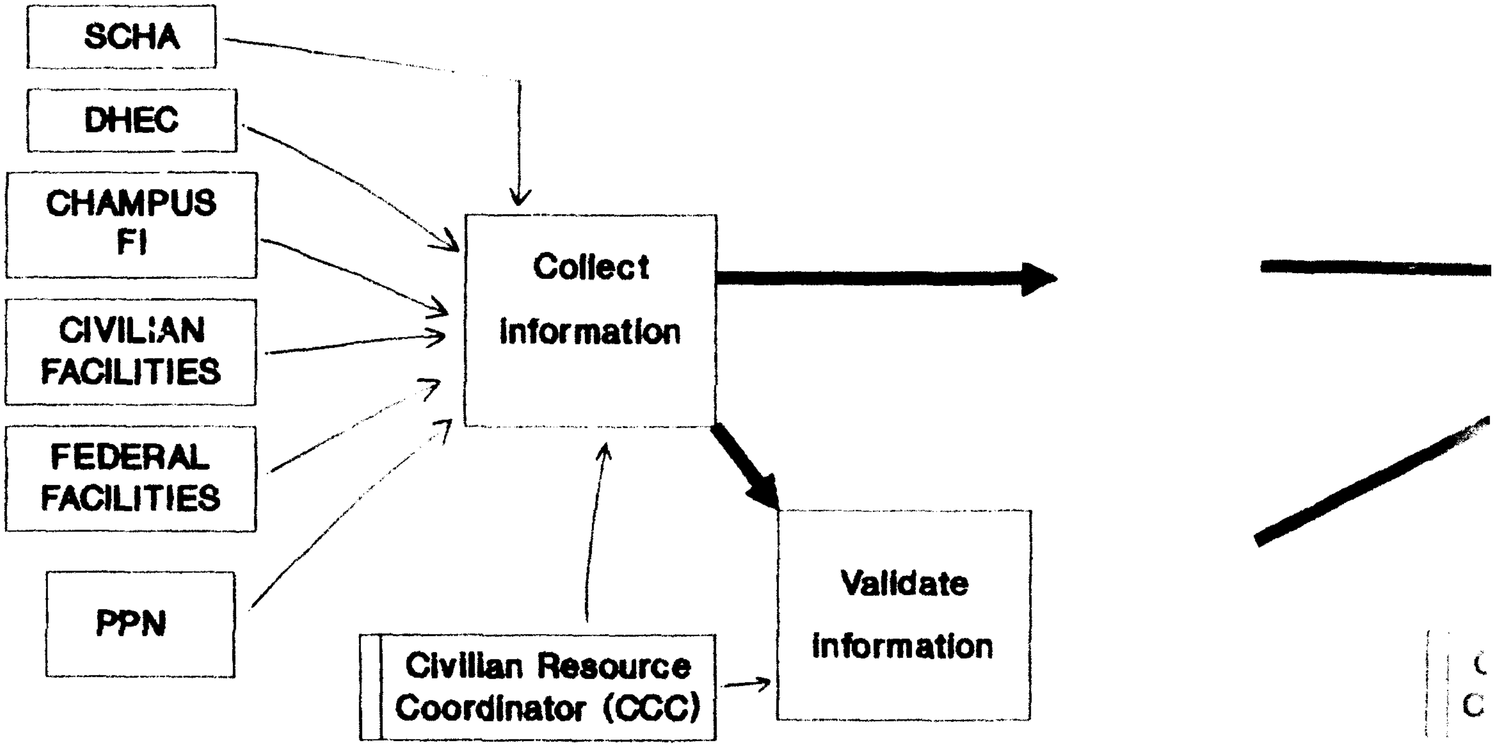
Task Twelve -- Provide information to beneficiaries and providers.


PATIENT
PROVIDER
CLINIC
PPN
Receive calls/ referrals
Civilian Resource Coordinator (CRC)
HBA
Pt Asst Office
Civilian Claims Clerk (CCC)
HBA
PATIENT
PROVIDER
CLINIC
PPN
Provide information
CRC
Investigate special cases
Pt Asst Office

Civilia
Coordi
Civili
Cle
Proc
cal
refe

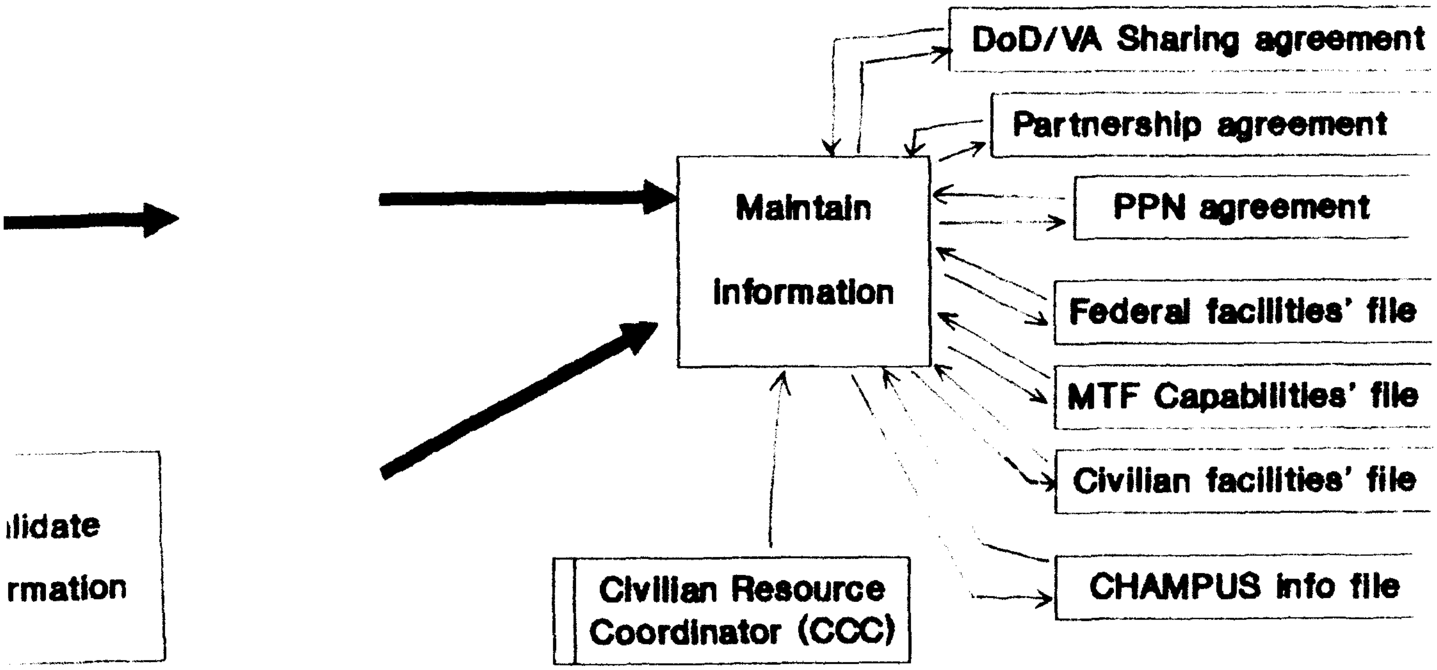

C)
A
ate
al
Civilian Resource Coordinator (CRC)
HBA
Civilian Claims Clerk (CCC)
Process calls/ referrals
Maintain files
MTF capabilit file
SC state progr
CHAMPUS infc ation
civilian facilitie es
federal facilitie s
MEDICARE infor on
MEDICAID infor tion
Charity ager s

Task Thirteen -- Conduct continuous monitoring of catchment area health resources.


SCHA
DHEC
CHAMPUS FI
CIVILIAN FACILITIES
FEDERAL FACILITIES
PPN
Collect Information
Validate Information
Civilian Resource Coordinator (CCC)

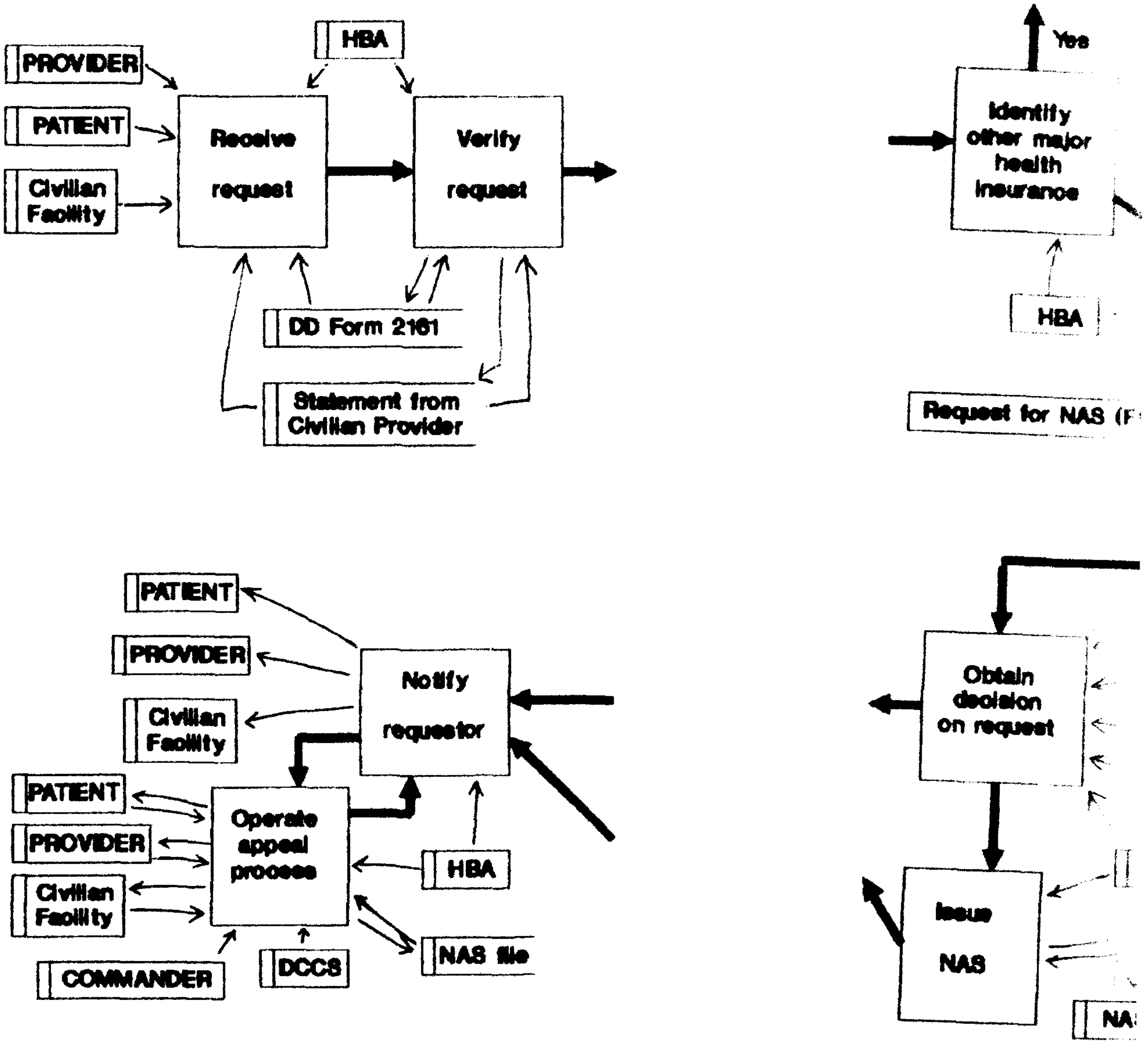
ce Division
150

itoring of

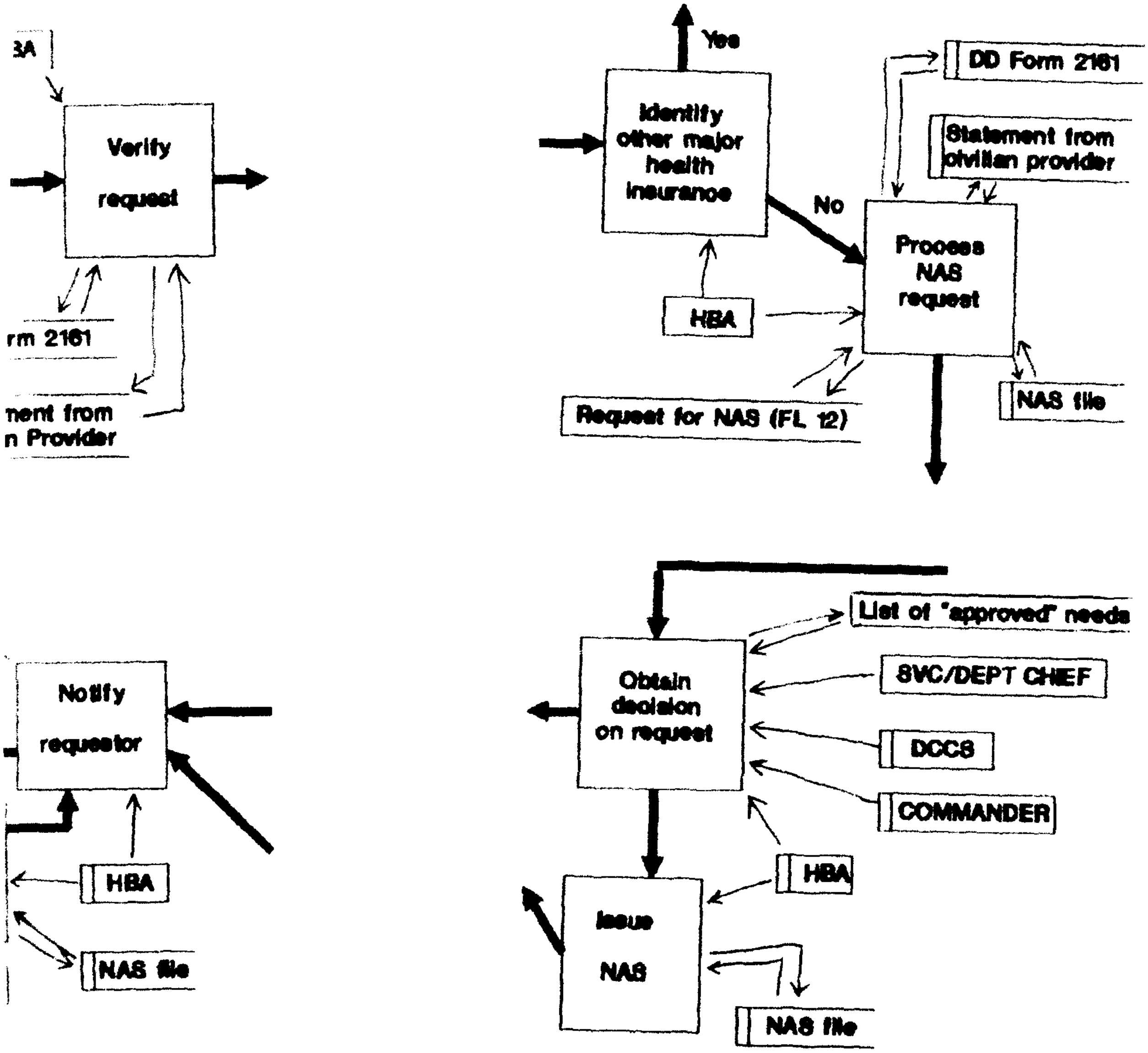


DoD/VA Sharing agreement
Partnership agreement
Maintain information
PPN agreement
Federal facilities' file
MTF Capabilities' file
Civilian facilities' file
CHAMPUS info file
Civilian Resource Coordinator (CCC)
lidate
rmation

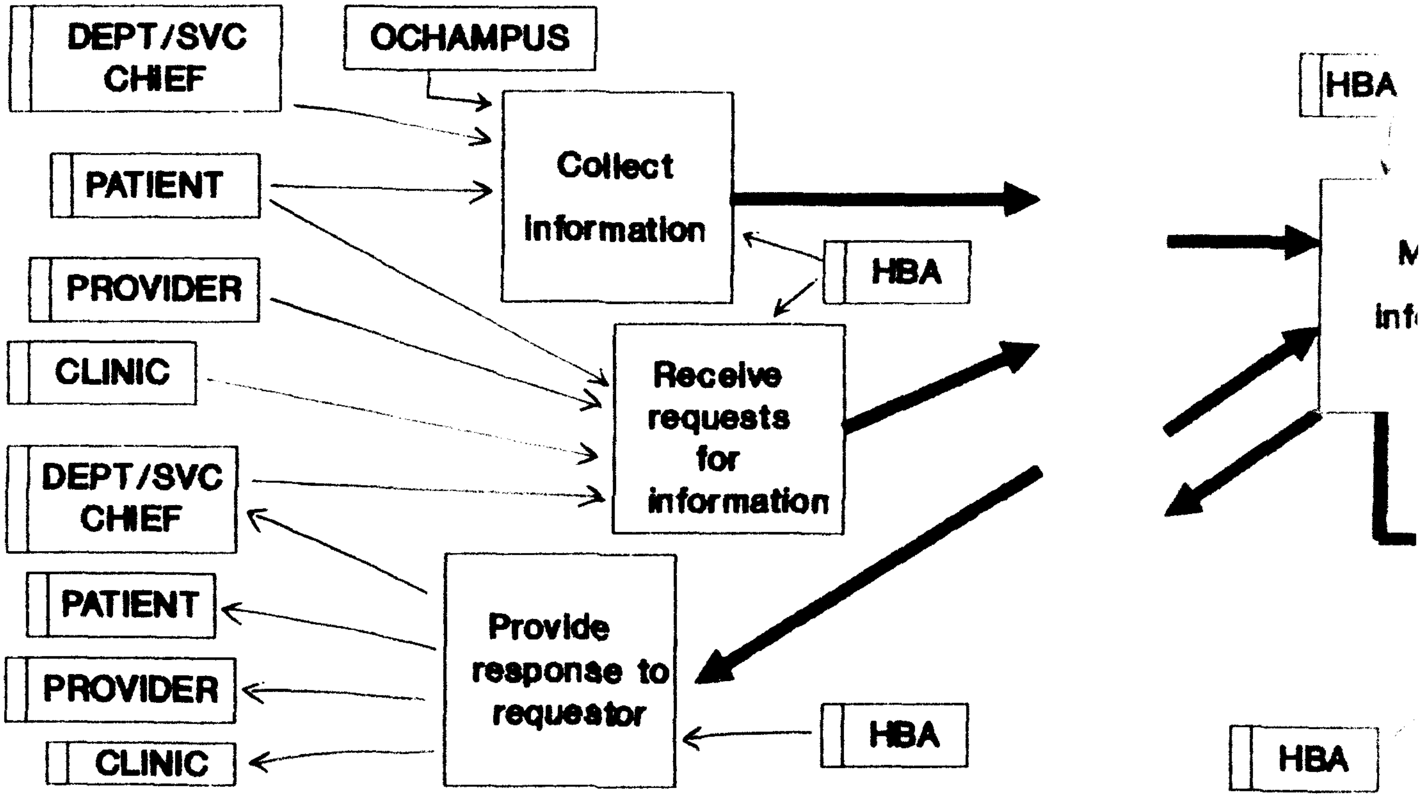
Task Fourteen -- Process nonavailability statements (NAS).


HBA
PROVIDER
PATIENT
Civilian Facility
Receive request
Verify request
DD Form 2161
Statement from Civilian Provider
Yes
Identify other major health insurance
HBA
Request for NAS (F
PATIENT
PROVIDER
Civilian Facility
Notify requestor
PATIENT
PROVIDER
Civilian Facility
Operate appeal process
HBA
NAS file
COMMANDER
DCCS
Obtain decision on request
Issue NAS
NA

s nonavailability

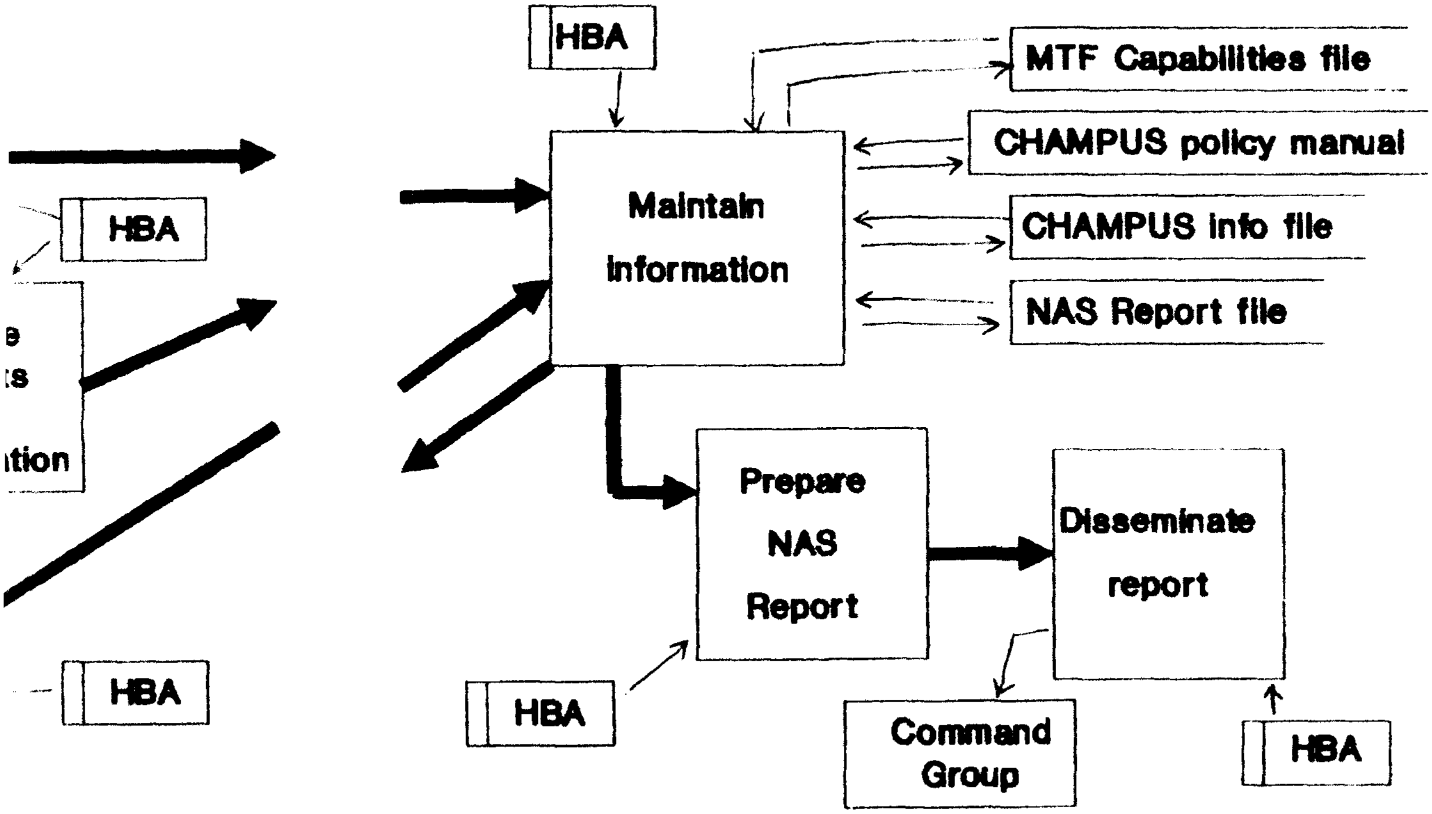

3A
Verify request
rm 2161
nent from
n Provider
Yes
Identify other major health insurance
No
DD Form 2161
Statement from civilian provider
Process NAS request
HBA
Request for NAS (FL 12)
NAS file
List of "approved" needs
SVC/DEPT CHIEF
DCCS
COMMANDER
Obtain decision on request
HBA
Issue NAS
NAS file
Notify requestor
HBA
NAS file

Task Fifteen -- Provide information regarding NAS.

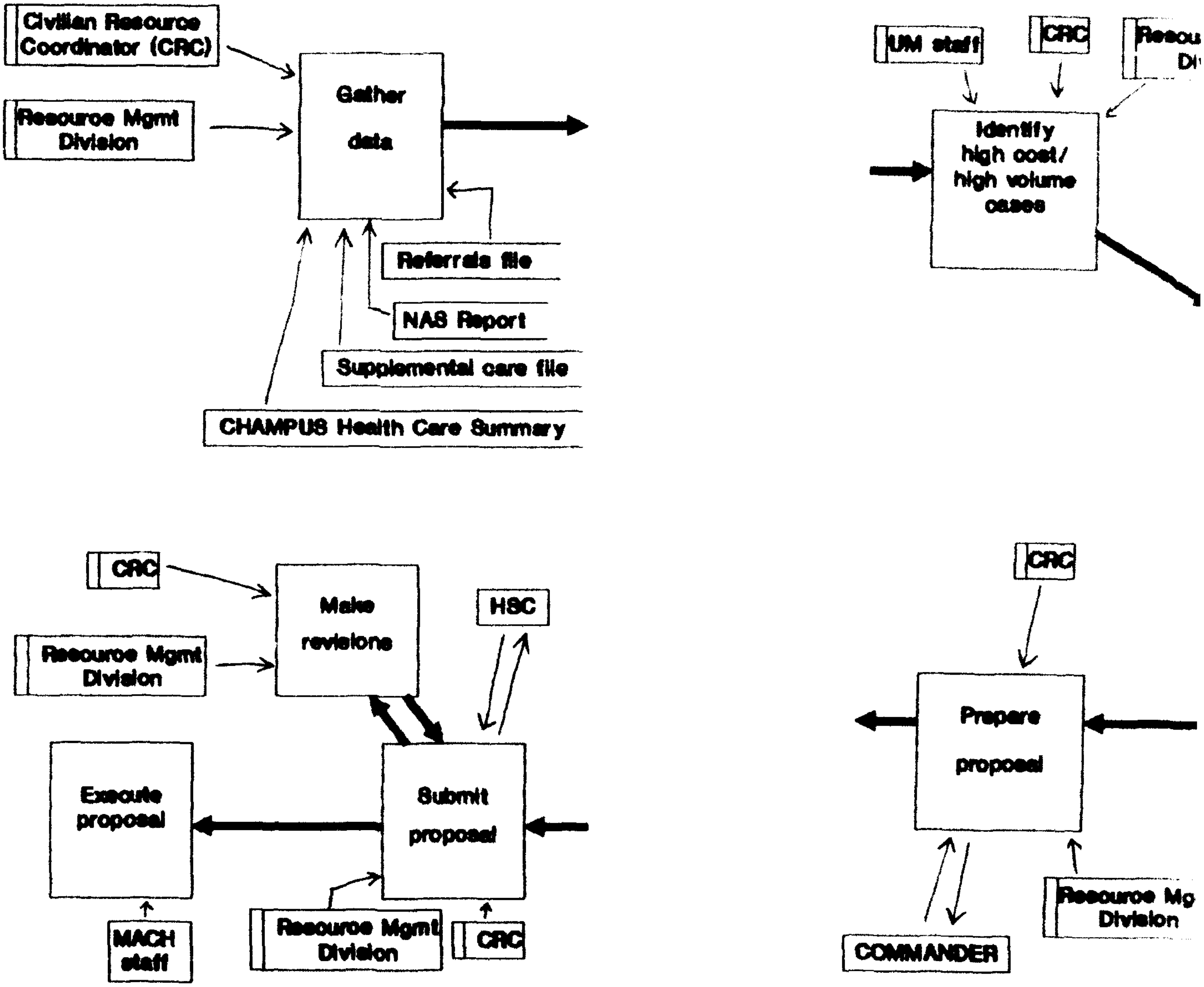

DEPT/SVC CHIEF
OCHAMPUS
HBA
PATIENT
Collect information
PROVIDER
HBA
CLINIC
Receive requests for information
DEPT/SVC CHIEF
PATIENT
Provide response to requeator
PROVIDER
HBA
CLINIC
HBA

ed Care Division
152

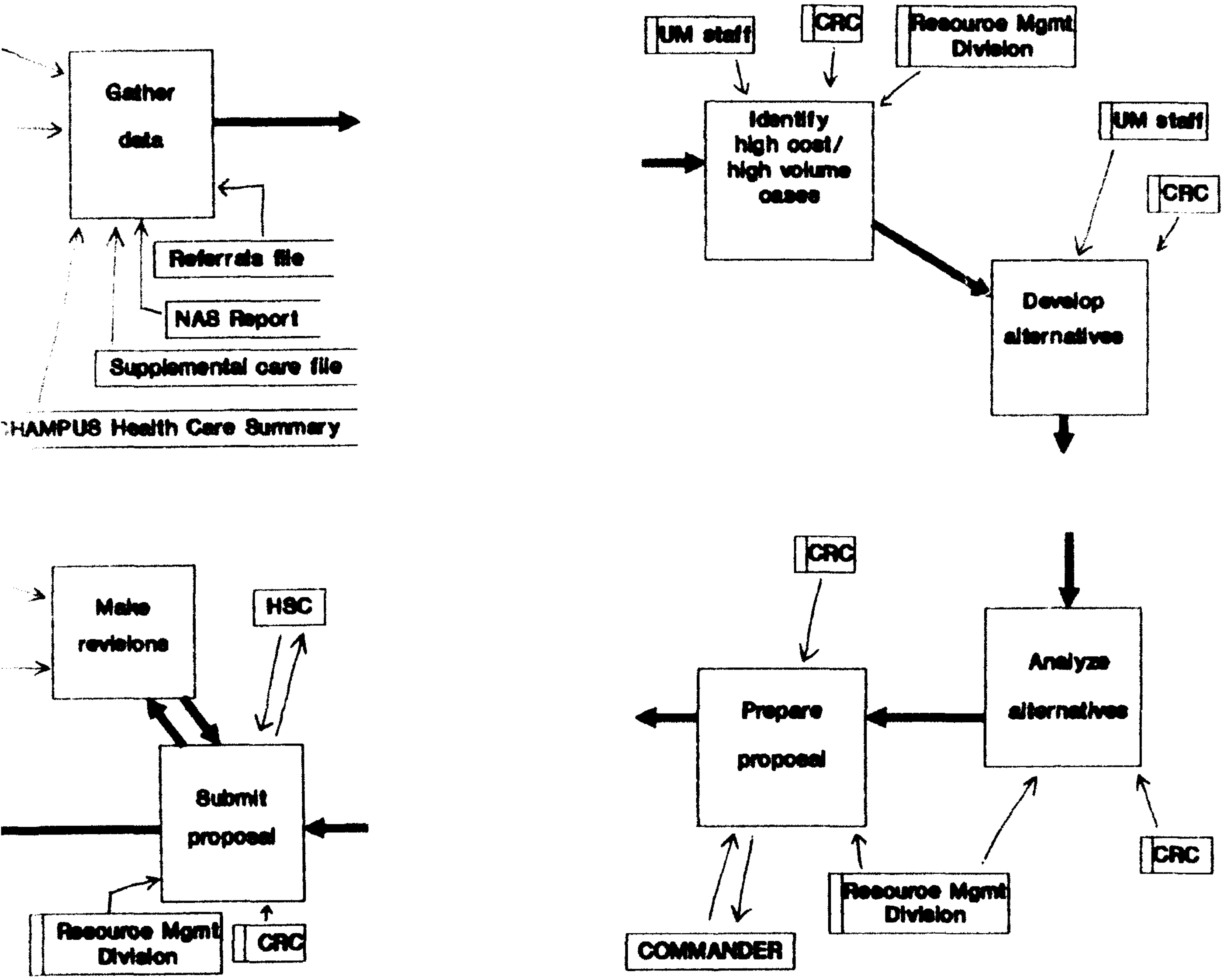
n regarding NAS.


HBA
MTF Capabilities file
CHAMPUS policy manual
CHAMPUS info file
NAS Report file
Maintain information
HBA
e
ts
ition
Prepare NAS Report
Disseminate report
HBA
HBA
Command Group
HBA

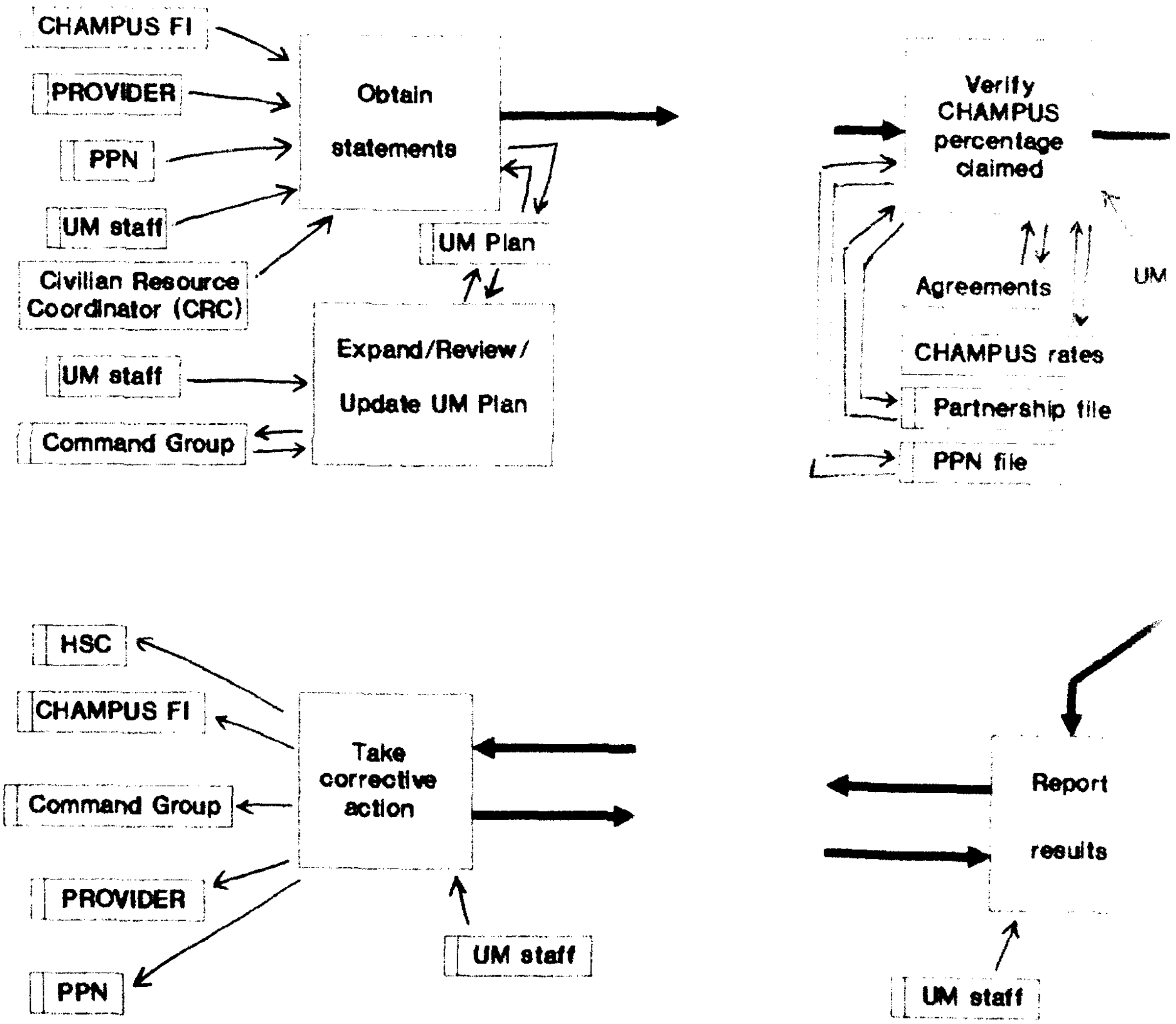
Task Sixteen -- Identify opportunities and develop plans.


Civilian Resource Coordinator (CRC)
Resource Mgmt Division
Gather data
Referrals file
NAS Report
Supplemental care file
CHAMPUS Health Care Summary
UM staff
CRC
Resou
Di
Identify high cost/ high volume cases
CRC
Make revisions
Resource Mgmt Division
HSC
Execute proposal
Submit proposal
MACH staff
Resource Mgmt Division
CRC
CRC
Prepare proposal
COMMANDER
Resource Mg
Division

Identify opportunities and develop

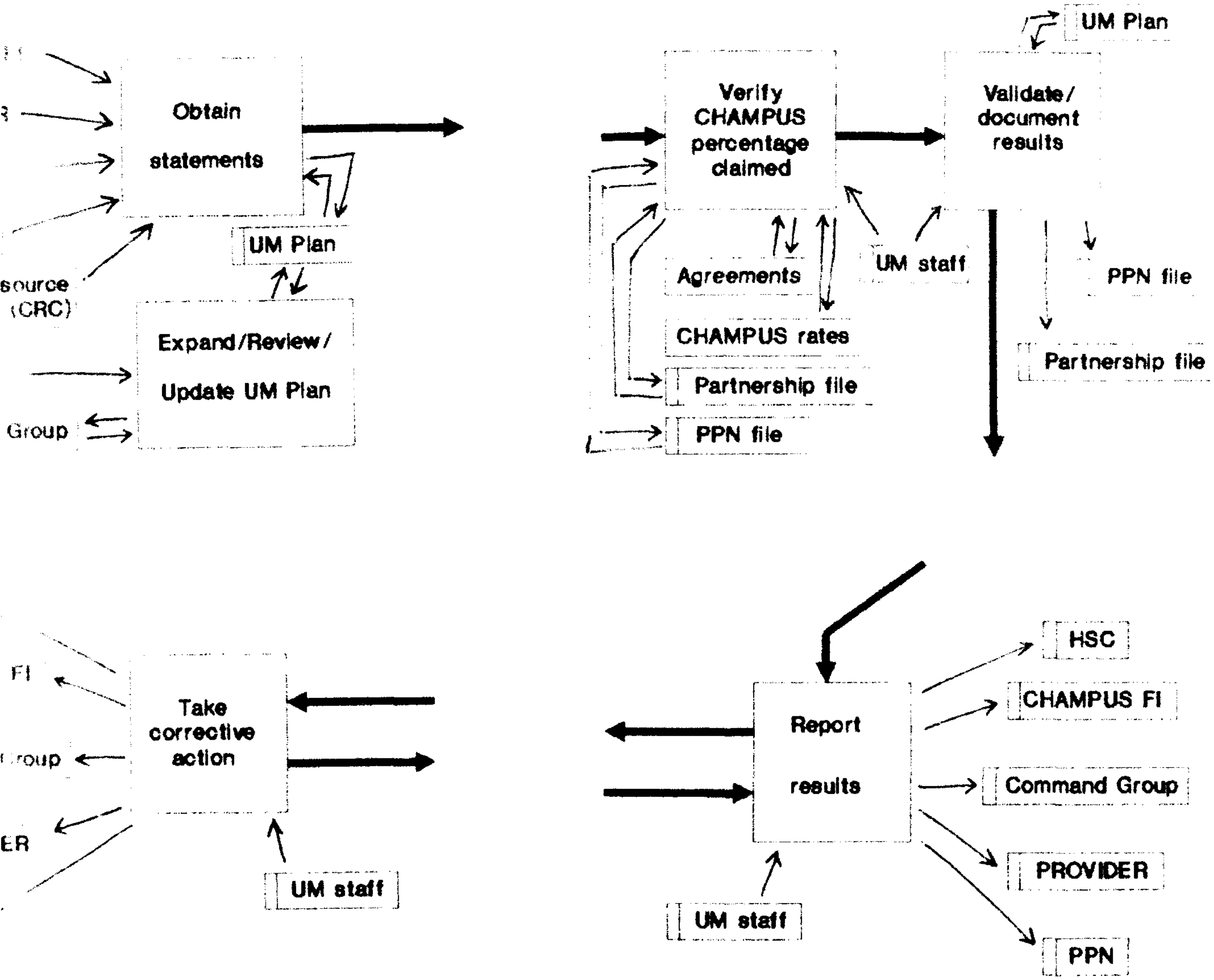

Gather data
Referrals file
NAS Report
Supplemental care file
HAMPUS Health Care Summary
UM staff
CRC
Resource Mgmt Division
Identify high cost/ high volume cases
UM staff
CRC
Develop alternatives
Make revisions
HSC
Submit proposal
Resource Mgmt Division
CRC
CRC
Prepare proposal
Analyze alternatives
COMMANDER
Resource Mgmt Division
CRC

Task Seventeen -- Develop and maintain an utilization management system.

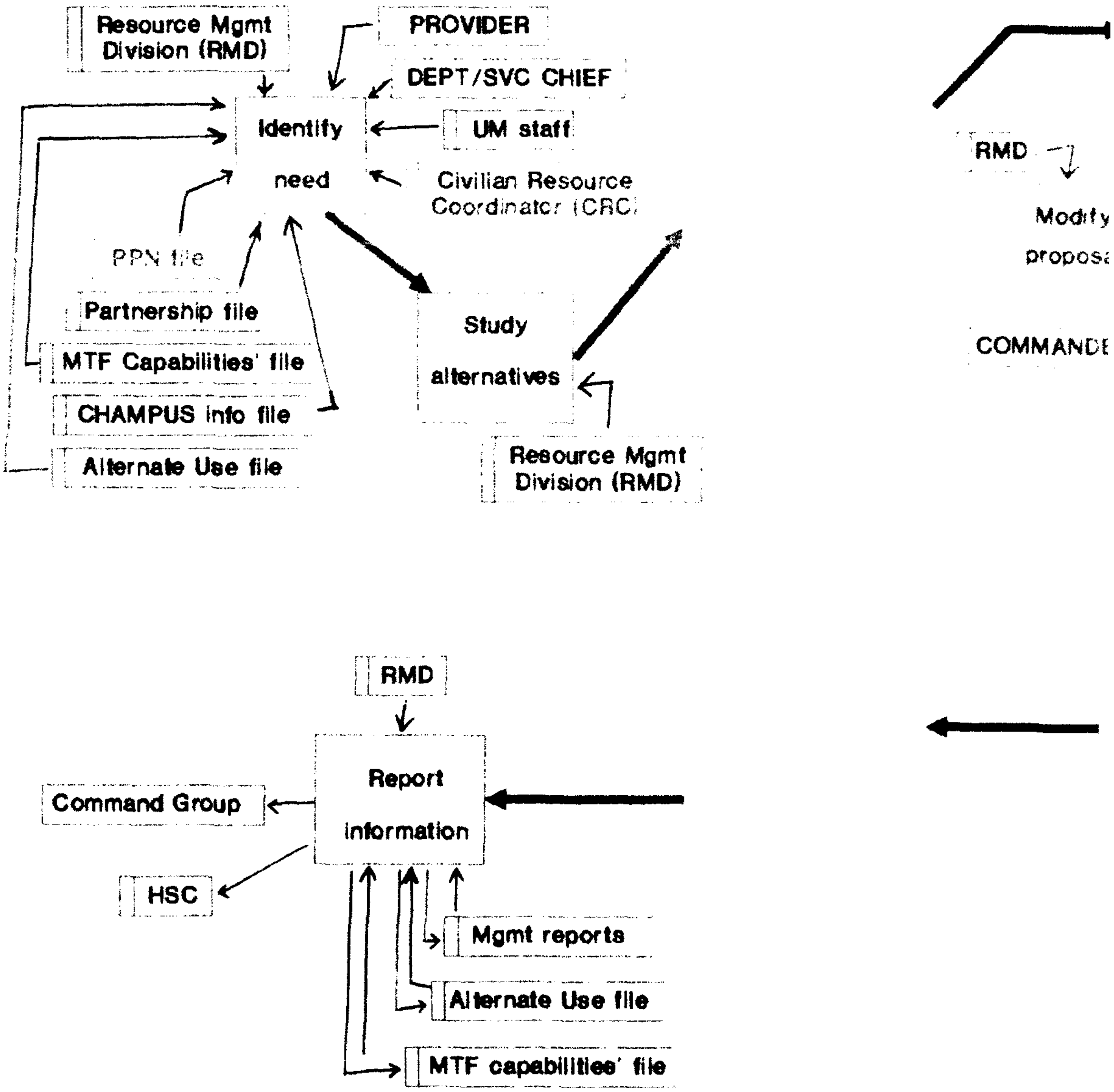

CHAMPUS FI
PROVIDER
PPN
UM staff
Civilian Resource Coordinator (CRC)
Obtain statements
UM Plan
UM staff
Command Group
Expand/Review/ Update UM Plan
Verify CHAMPUS percentage claimed
Agreements
UM
CHAMPUS rates
Partnership file
PPN file
HSC
CHAMPUS FI
Command Group
PROVIDER
PPN
Take corrective action
UM staff
Report results
UM staff

-- Develop and maintain an

ent system.

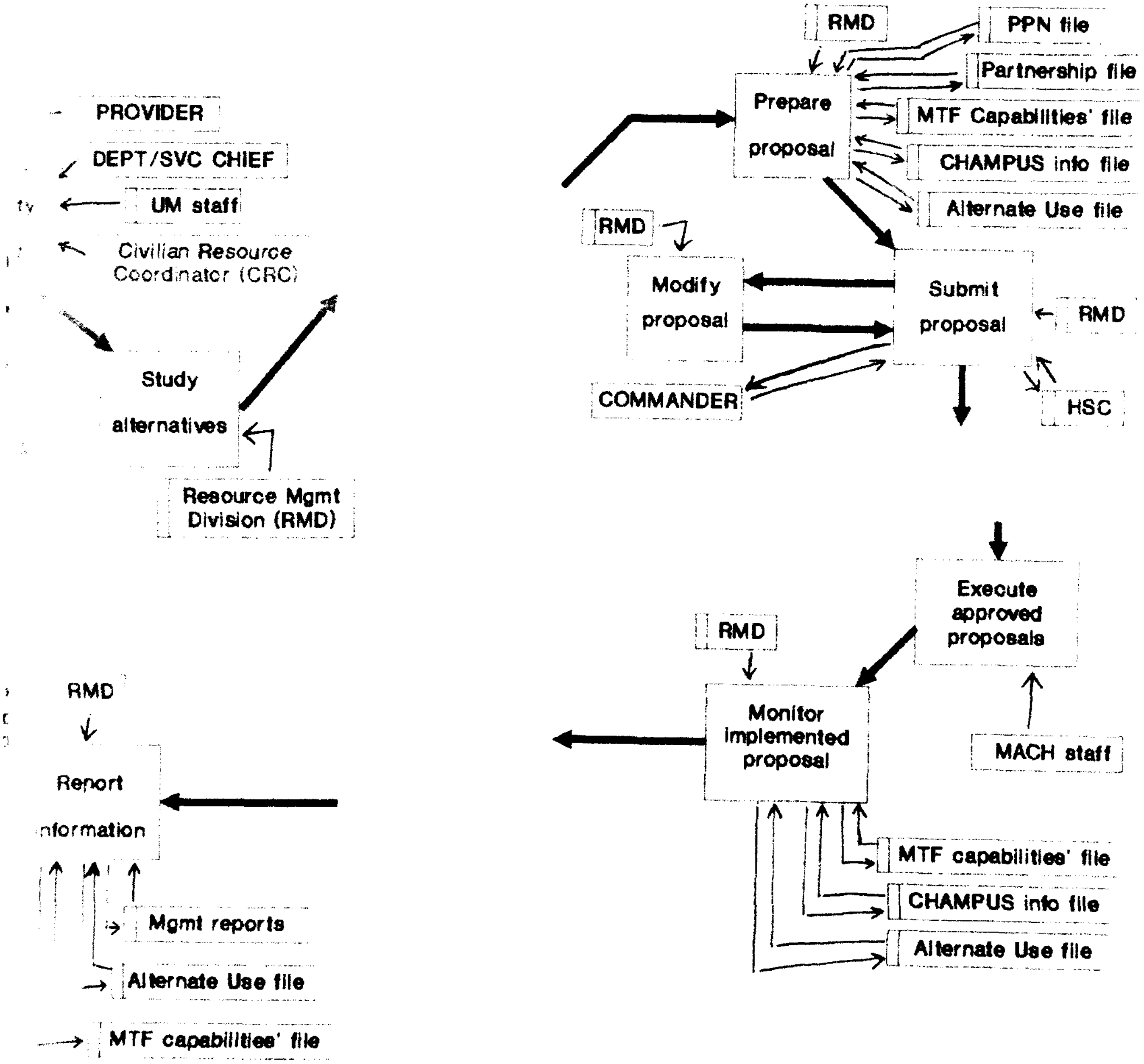

UM Plan
Obtain statements
UM Plan
source
(CRC)
Expand/Review/ Update UM Plan
Group
Verify CHAMPUS percentage claimed
Agreements
CHAMPUS rates
Partnership file
PPN file
UM staff
Validate/ document results
PPN file
Partnership file
FI
Group
ER
Take corrective action
UM staff
Report results
UM staff
HSC
CHAMPUS FI
Command Group
PROVIDER
PPN

Task Eighteen -- Implement and monitor Alternate Use projects.


Resource Mgmt Division (RMD)
PROVIDER
DEPT/SVC CHIEF
Identify need
UM staff
Civilian Resource Coordinator (CRC)
PPN file
Partnership file
MTF Capabilities' file
CHAMPUS info file
Alternate Use file
Study alternatives
Resource Mgmt Division (RMD)
RMD
Modify proposa
COMMANDE
RMD
Report information
Command Group
HSC
Mgmt reports
Alternate Use file
MTF capabilities' file

Coordinated Care Division
155

ement and monitor Alternate

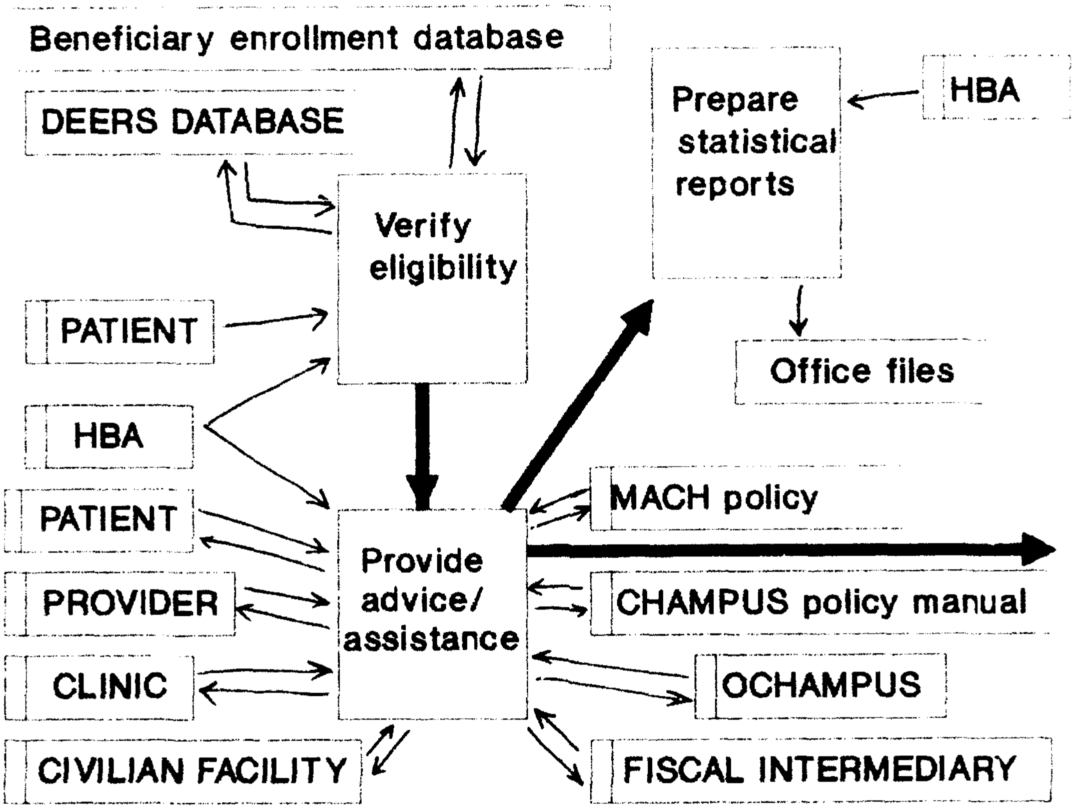


PROVIDER
DEPT/SVC CHIEF
UM staff
Civilian Resource Coordinator (CRC)
Study alternatives
Resource Mgmt Division (RMD)
RMD
PPN file
Partnership file
Prepare proposal
MTF Capabilities' file
CHAMPUS info file
Alternate Use file
RMD
Modify proposal
Submit proposal
RMD
COMMANDER
HSC
Execute approved proposals
RMD
Monitor implemented proposal
MACH staff
MTF capabilities' file
CHAMPUS info file
Alternate Use file
RMD
Report information
Mgmt reports
Alternate Use file
MTF capabilities' file

Appendix D

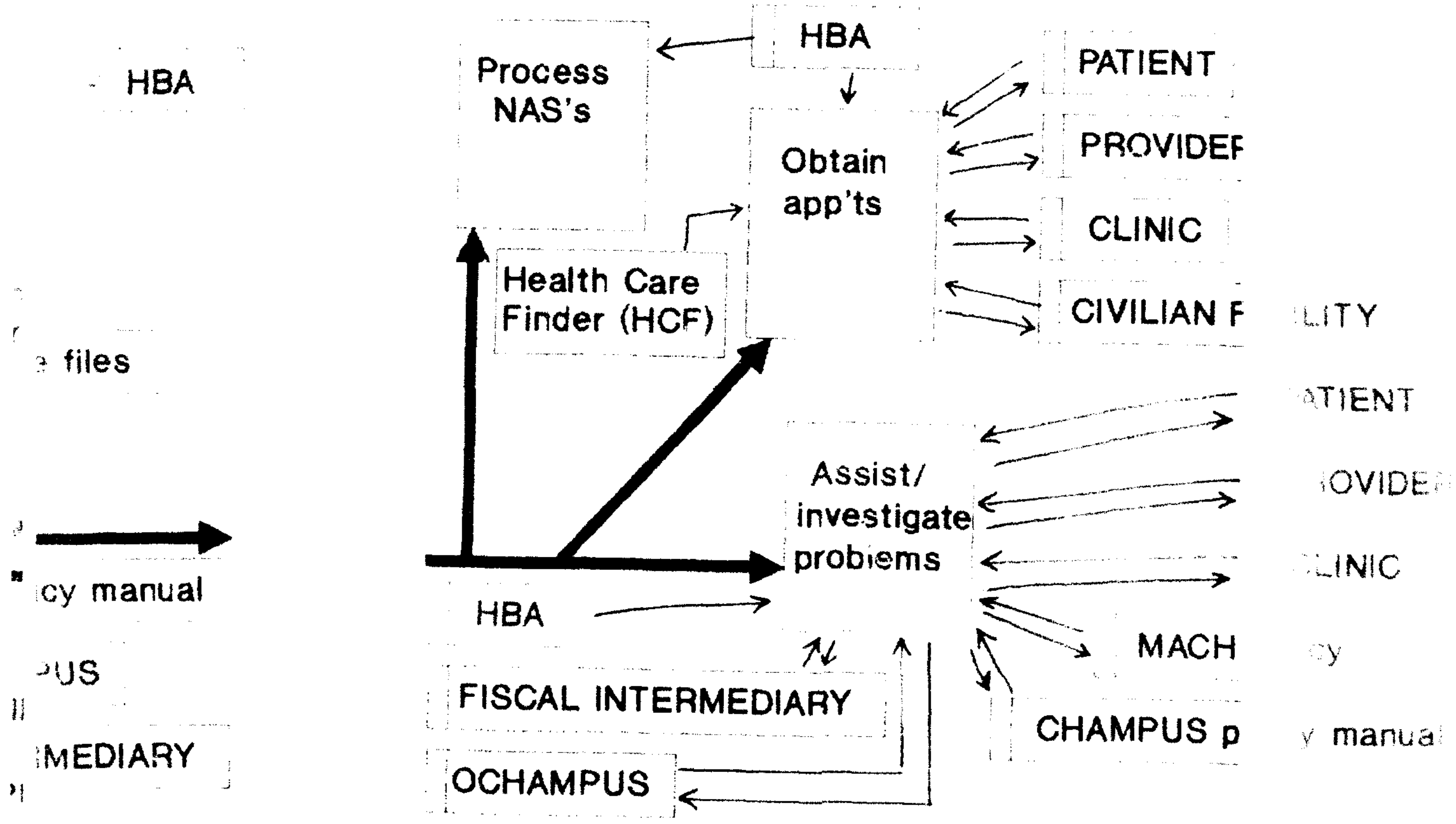
Systems Analysis Results (After Gateway)

Task One -- Manage CHAMPUS.

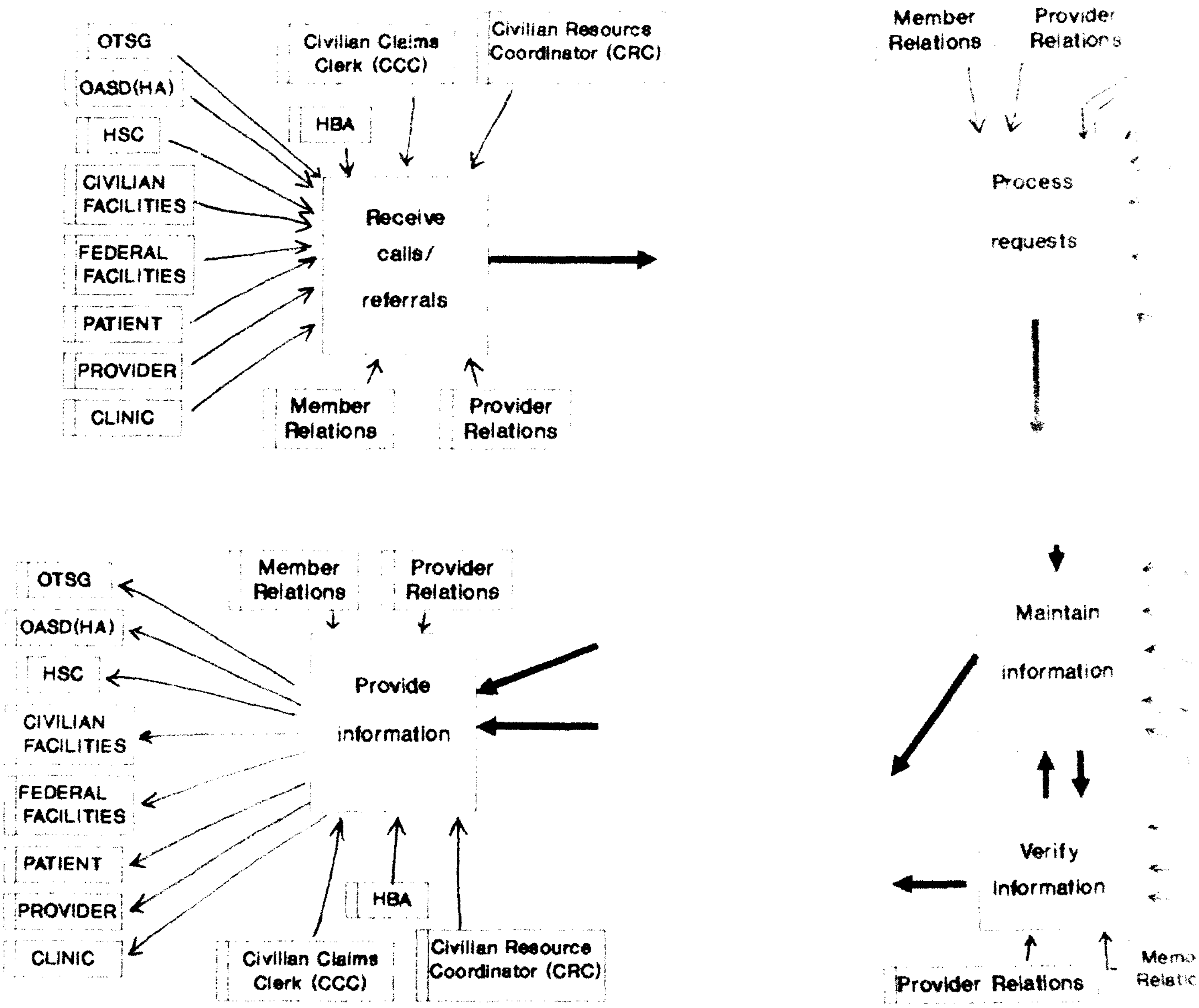

Beneficiary enrollment database
DEERS DATABASE
Verify eligibility
Prepare statistical reports
HBA
Office files
PATIENT
HBA
PATIENT
PROVIDER
CLINIC
CIVILIAN FACILITY
Provide advice/ assistance
MACH policy
CHAMPUS policy manual
OCHAMPUS
FISCAL INTERMEDIARY

Proc
NAS
He
Fin
HBA
FISCA
OCHA

eway)

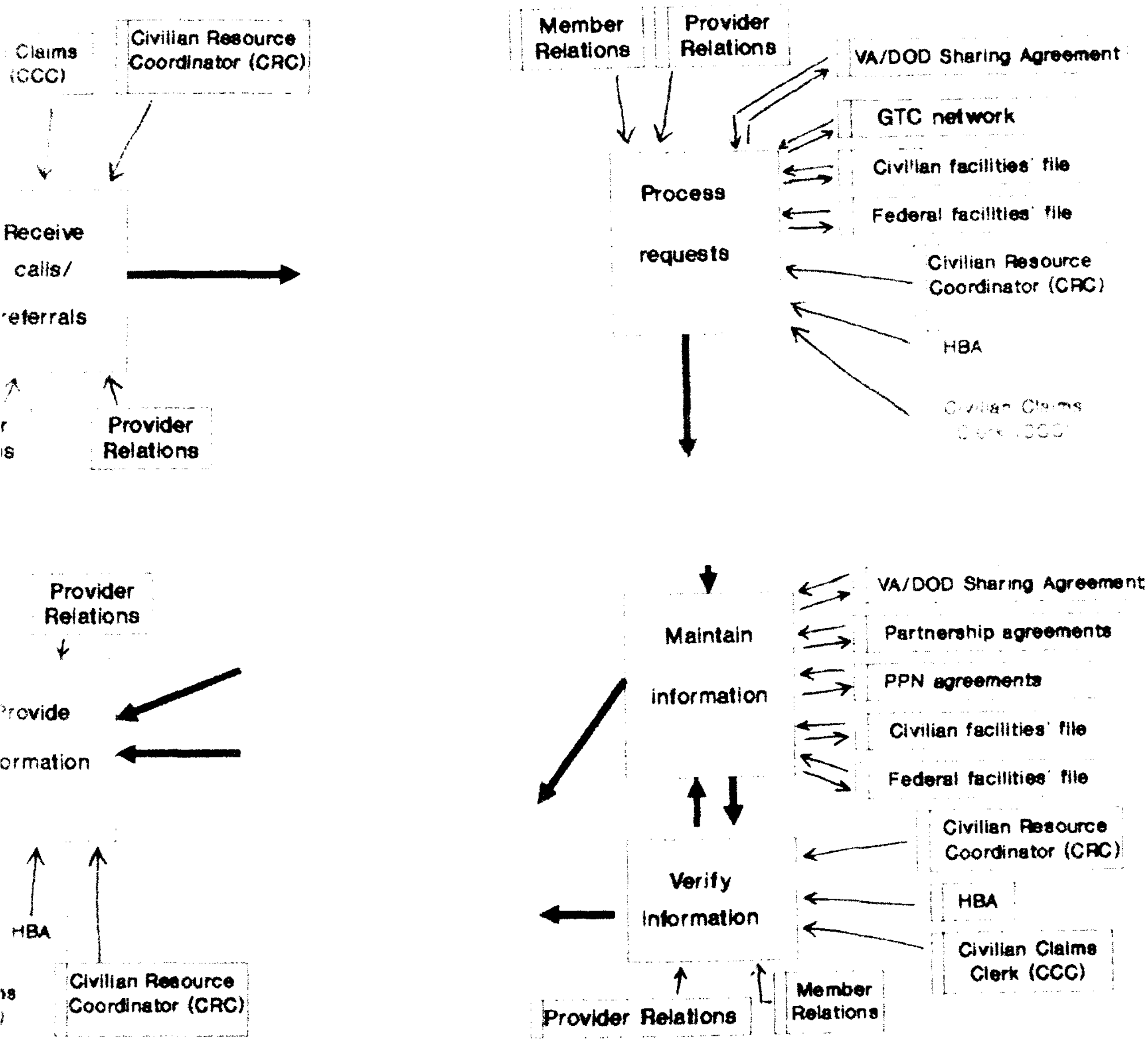

HBA
e files
cy manual
PUS
MEDIARY
HBA
Process NAS's
Obtain app'ts
Health Care Finder (HCF)
PATIENT
PROVIDEF
CLINIC
CIVILIAN F
LITY
Assist/ investigate problems
ATIENT
OVIDE
LINIC
HBA
MACH
cy
FISCAL INTERMEDIARY
CHAMPUS p
y manual
OCHAMPUS

Task Two -- Provide information services.

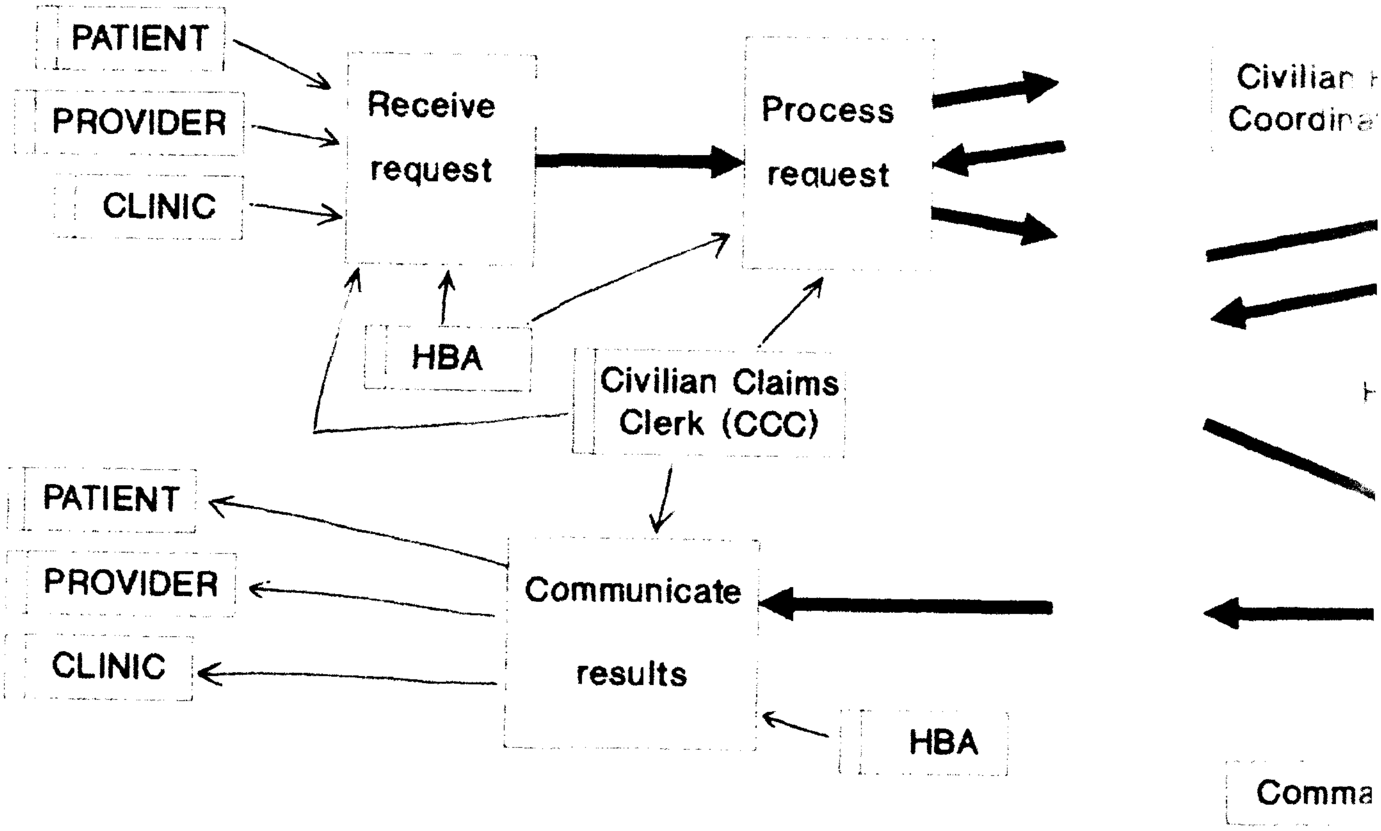

OTSG
OASD(HA)
HSC
CIVILIAN FACILITIES
FEDERAL FACILITIES
PATIENT
PROVIDER
CLINIC
Civilian Claims Clerk (CCC)
HBA
Civilian Resource Coordinator (CRC)
Receive calls/ referrals
Member Relations
Provider Relations
Member Relations
Provider Relations
Process requests
OTSG
OASD(HA)
HSC
CIVILIAN FACILITIES
FEDERAL FACILITIES
PATIENT
PROVIDER
CLINIC
Member Relations
Provider Relations
Provide information
HBA
Civilian Claims Clerk (CCC)
Civilian Resource Coordinator (CRC)
Maintain information
Verify information
Provider Relations

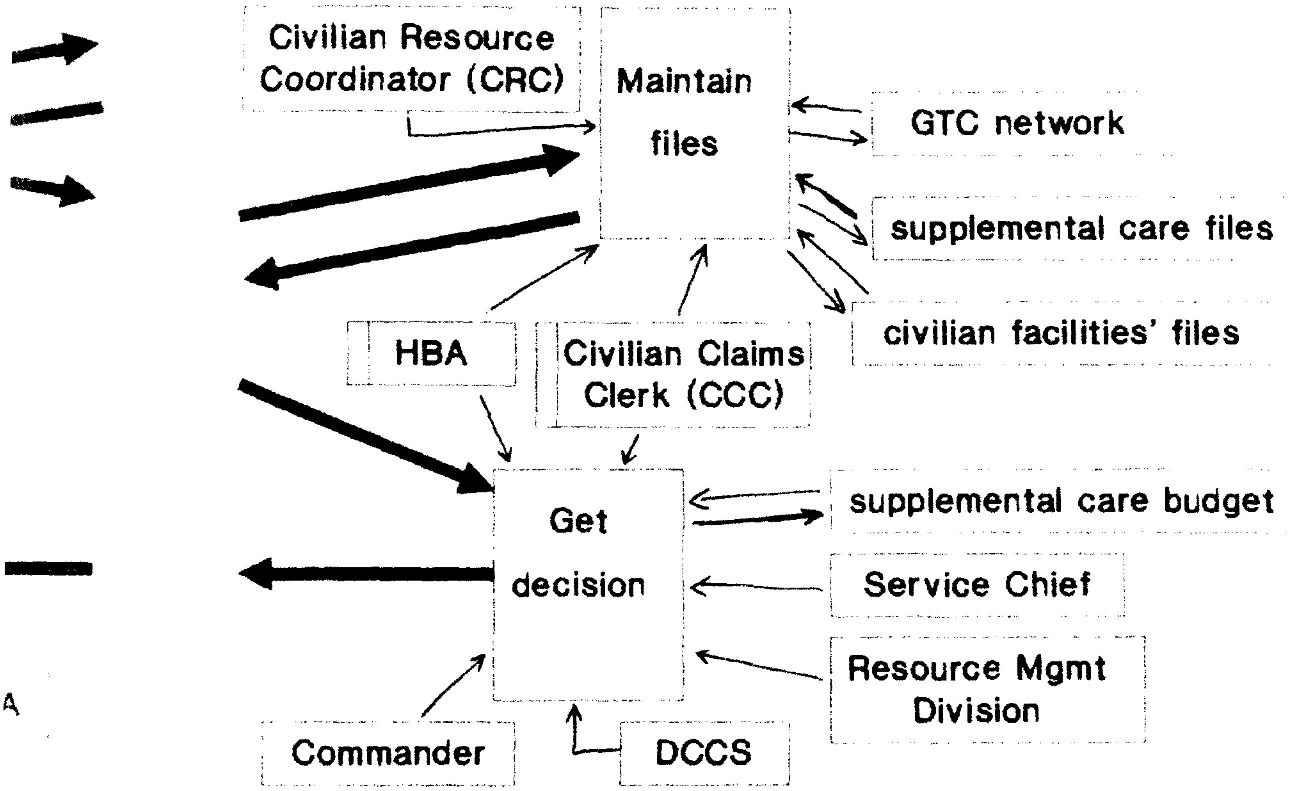
Coordinated Care Division

:mation services.

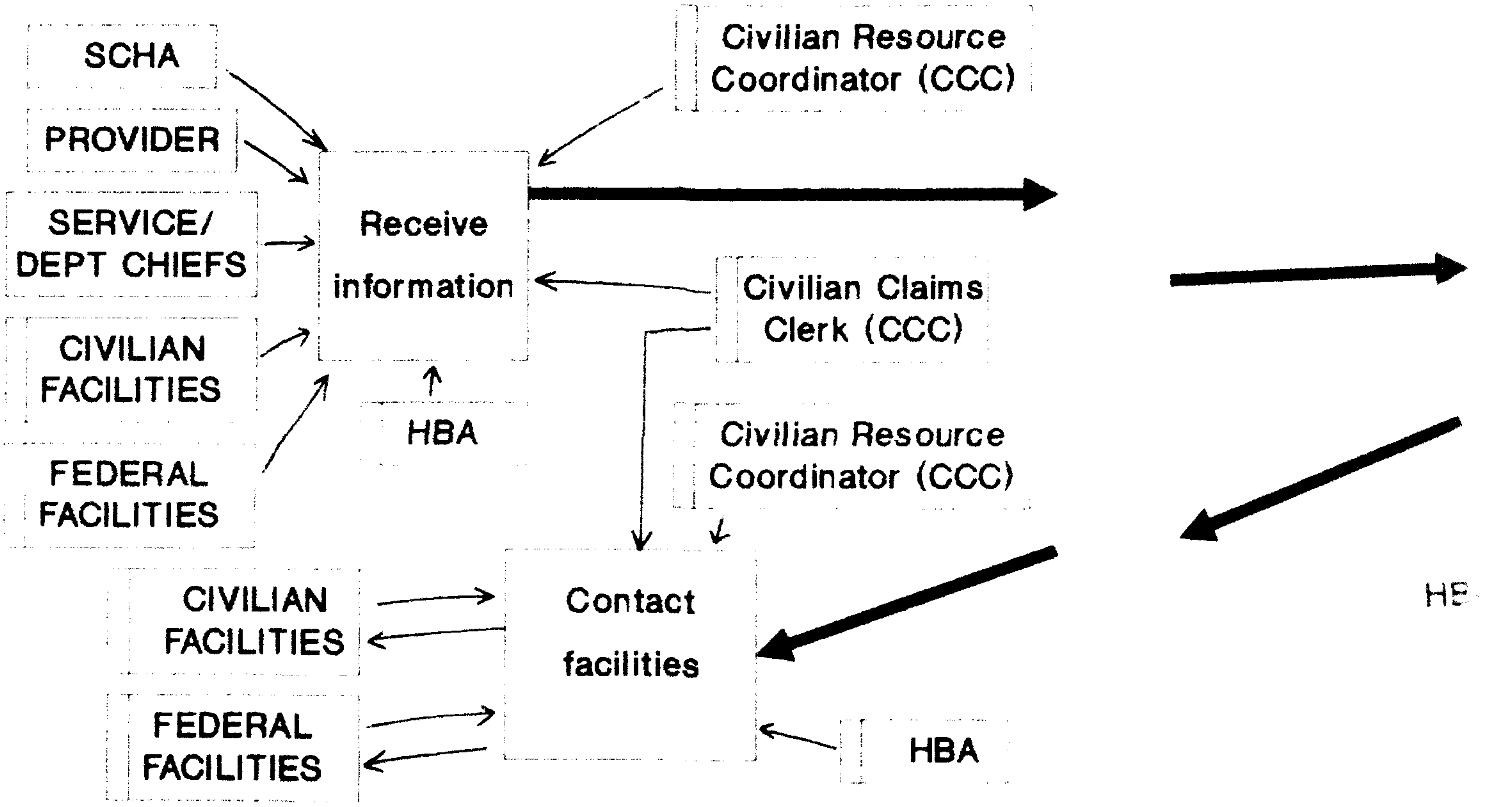

Claims
(CCC)
Civilian Resource Coordinator (CRC)
Receive calls/ referrals
r
s
Provider Relations
Member Relations
Provider Relations
VA/DOD Sharing Agreement
GTC network
Civilian facilities' file
Federal facilities' file
Civilian Resource Coordinator (CRC)
HBA
Civilian Claims Clerk (CCC)
Process requests
Provider Relations
Provide information
HBA
s
)
Civilian Resource Coordinator (CRC)
Maintain information
VA/DOD Sharing Agreement
Partnership agreements
PPN agreements
Civilian facilities' file
Federal facilities' file
Civilian Resource Coordinator (CRC)
HBA
Civilian Claims Clerk (CCC)
Verify information
Provider Relations
Member Relations

Task Three -- Review requests for supplemental care.


PATIENT
PROVIDER
CLINIC
Receive request
Process request
Civilian
Coordin
HBA
Civilian Claims Clerk (CCC)
PATIENT
PROVIDER
CLINIC
Communicate results
HBA
Comma

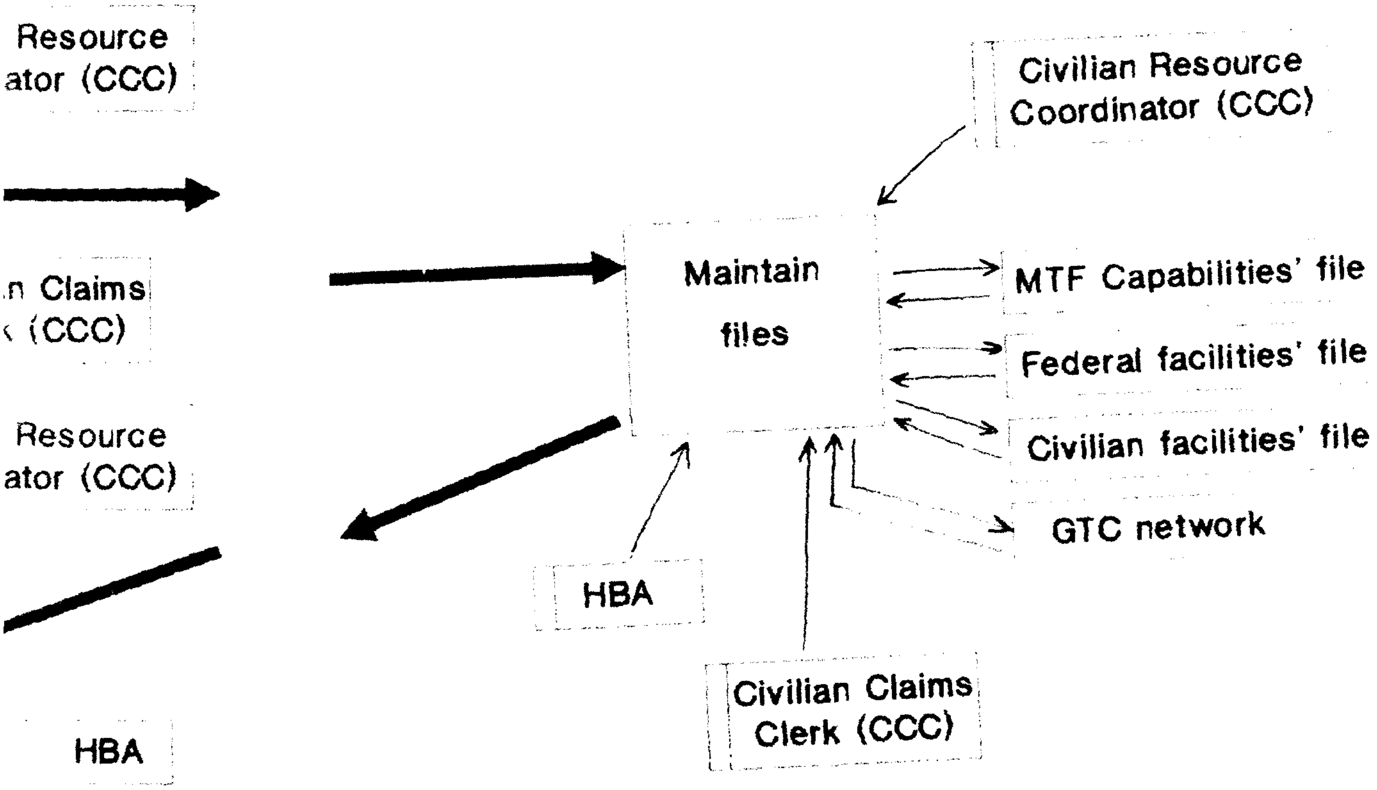

Civilian Resource Coordinator (CRC)
Maintain files
GTC network
supplemental care files
civilian facilities' files
HBA
Civilian Claims Clerk (CCC)
Get decision
supplemental care budget
Service Chief
Resource Mgmt Division
Commander
DCCS

Task Four -- Develop and maintain information on clinical capabilities.

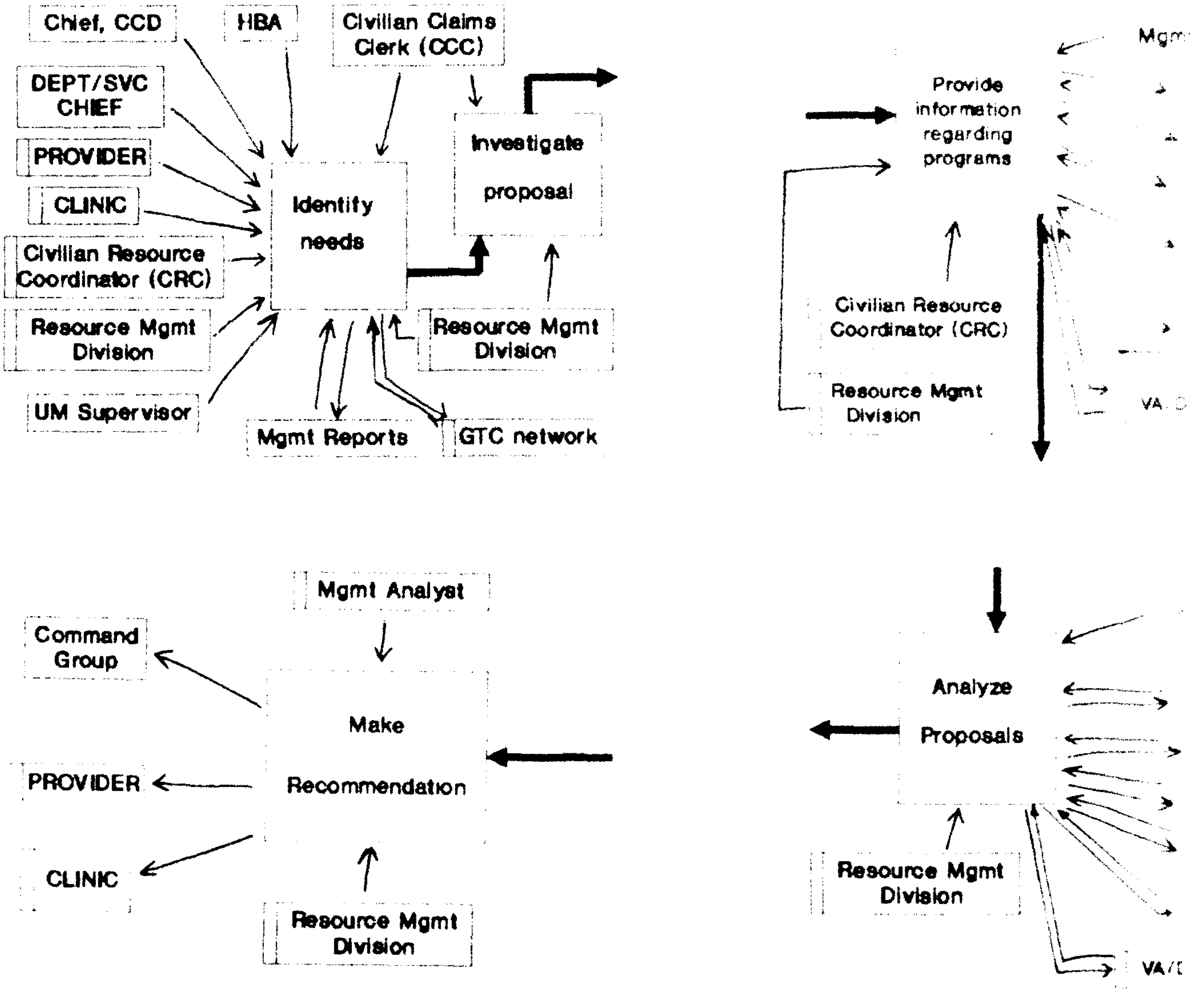

SCHA
PROVIDER
SERVICE/ DEPT CHIEFS
CIVILIAN FACILITIES
FEDERAL FACILITIES
Receive information
HBA
Civilian Resource Coordinator (CCC)
Civilian Claims Clerk (CCC)
Civilian Resource Coordinator (CCC)
CIVILIAN FACILITIES
FEDERAL FACILITIES
Contact facilities
HBA
HB

Division
159

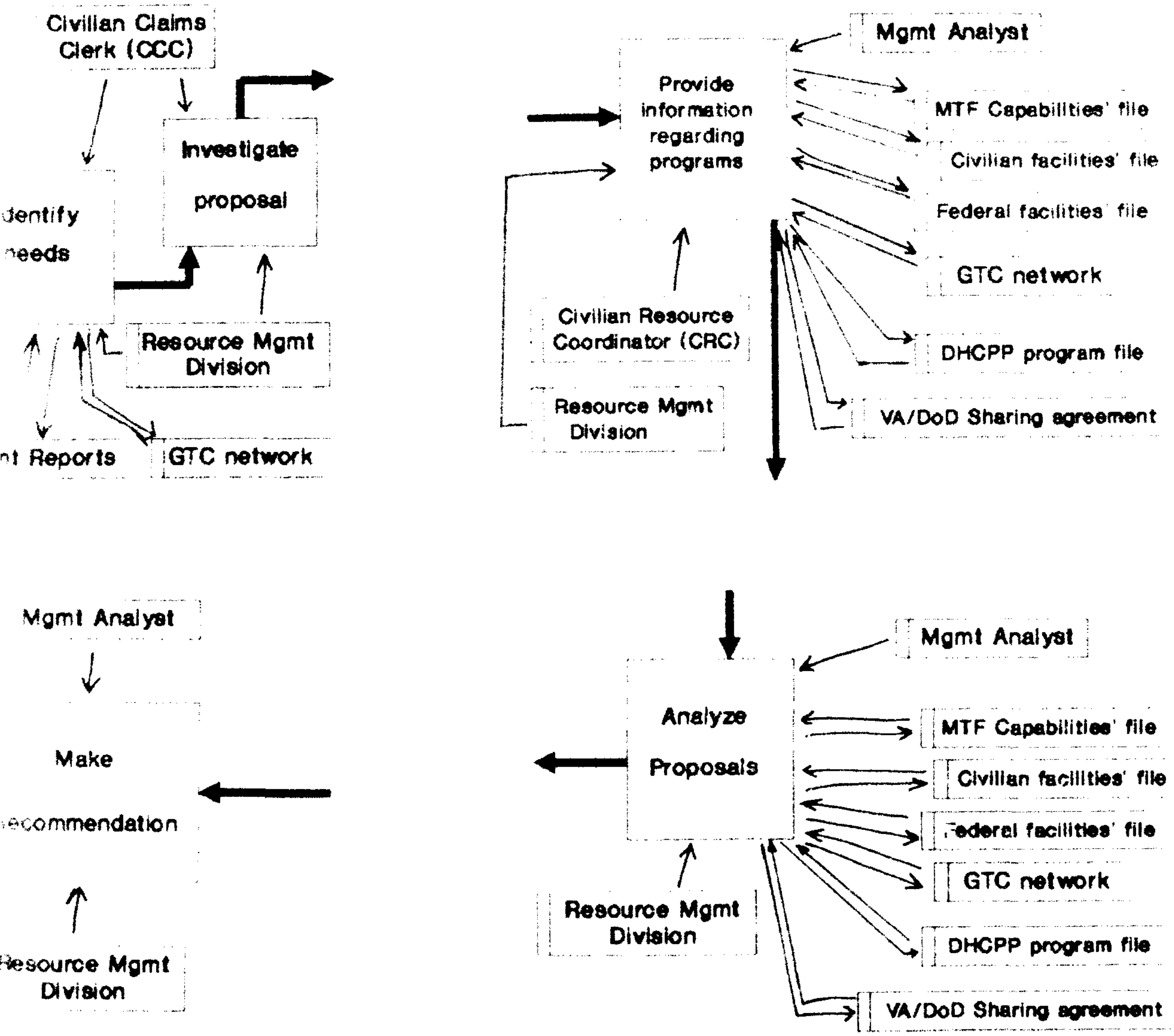
ion on


Resource
ator (CCC)
n Claims
(CCC)
Resource
ator (CCC)
HBA
Civilian Resource
Coordinator (CCC)
Maintain
files
MTF Capabilities' file
Federal facilities' file
Civilian facilities' file
GTC network
HBA
Civilian Claims
Clerk (CCC)

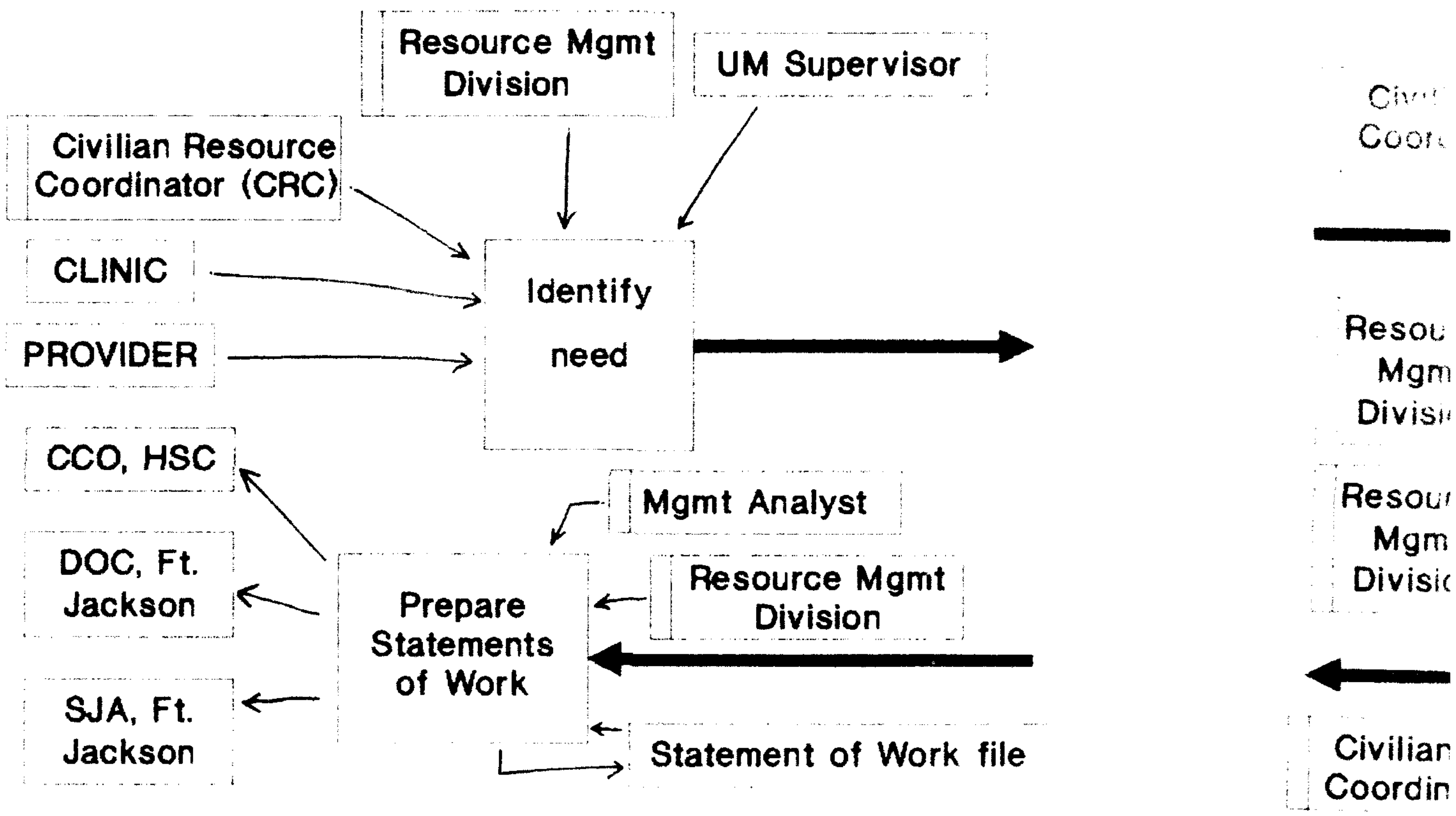
Task Five -- Identify clinical areas for agreements or initiatives.


Chief, CCD
HBA
Civilian Claims Clerk (CCC)
DEPT/SVC CHIEF
PROVIDER
CLINIC
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
UM Supervisor
Identify needs
Investigate proposal
Resource Mgmt Division
Mgmt Reports
GTC network
Mgm
Provide information regarding programs
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
VA
Mgmt Analyst
Command Group
PROVIDER
CLINIC
Make Recommendation
Resource Mgmt Division
Analyze Proposals
Resource Mgmt Division
VA

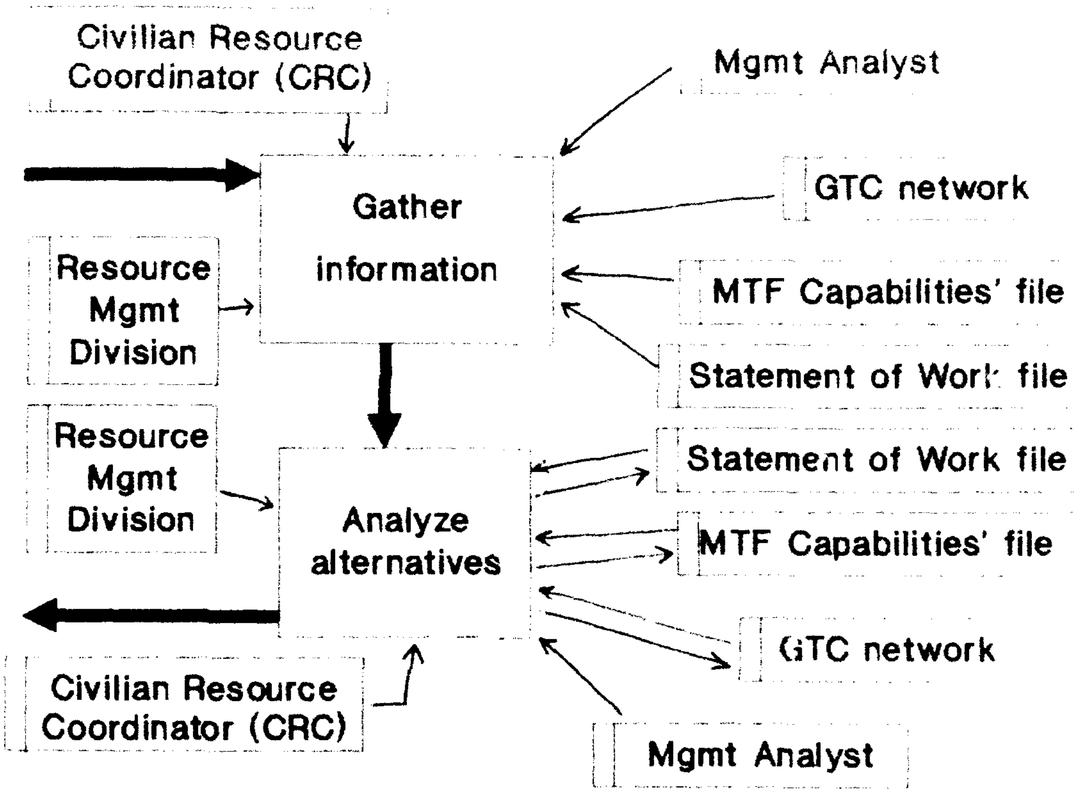
inical areas for


Civilian Claims Clerk (CCC)
Investigate proposal
dentify
needs
Resource Mgmt Division
nt Reports
GTC network
Mgmt Analyst
Provide information regarding programs
MTF Capabilities' file
Civilian facilities' file
Federal facilities' file
GTC network
Civilian Resource Coordinator (CRC)
Resource Mgmt Division
DHCPP program file
VA/DoD Sharing agreement
Mgmt Analyst
Make
ecommendation
Resource Mgmt Division
Mgmt Analyst
Analyze Proposals
MTF Capabilities' file
Civilian facilities' file
Federal facilities' file
GTC network
Resource Mgmt Division
DHCPP program file
VA/DoD Sharing agreement

Task Six -- Develop statements of work.

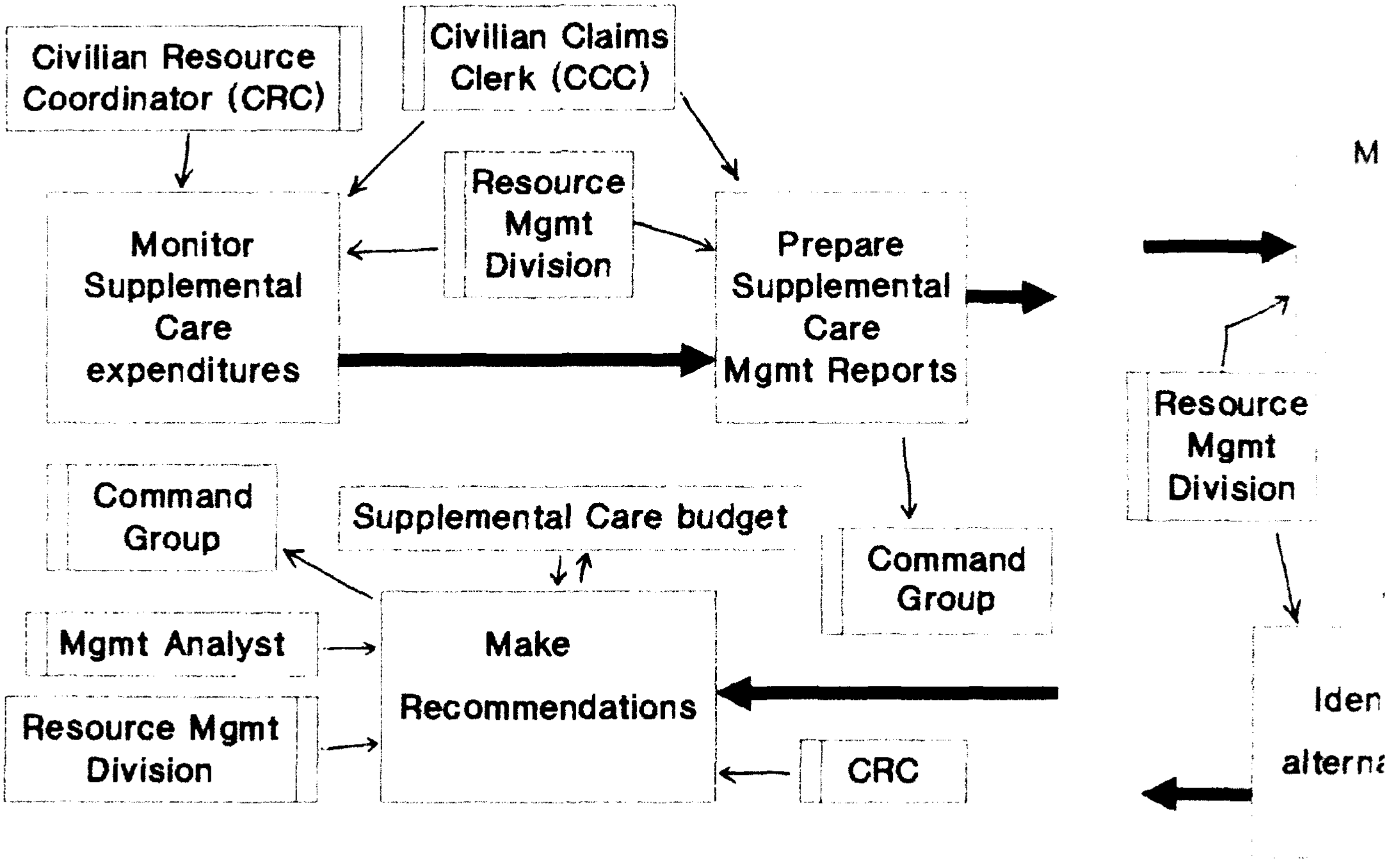

Resource Mgmt Division
UM Supervisor
Civilian Resource Coordinator (CRC)
CLINIC
PROVIDER
Identify need
CCO, HSC
DOC, Ft. Jackson
SJA, Ft. Jackson
Prepare Statements of Work
Mgmt Analyst
Resource Mgmt Division
Statement of Work file

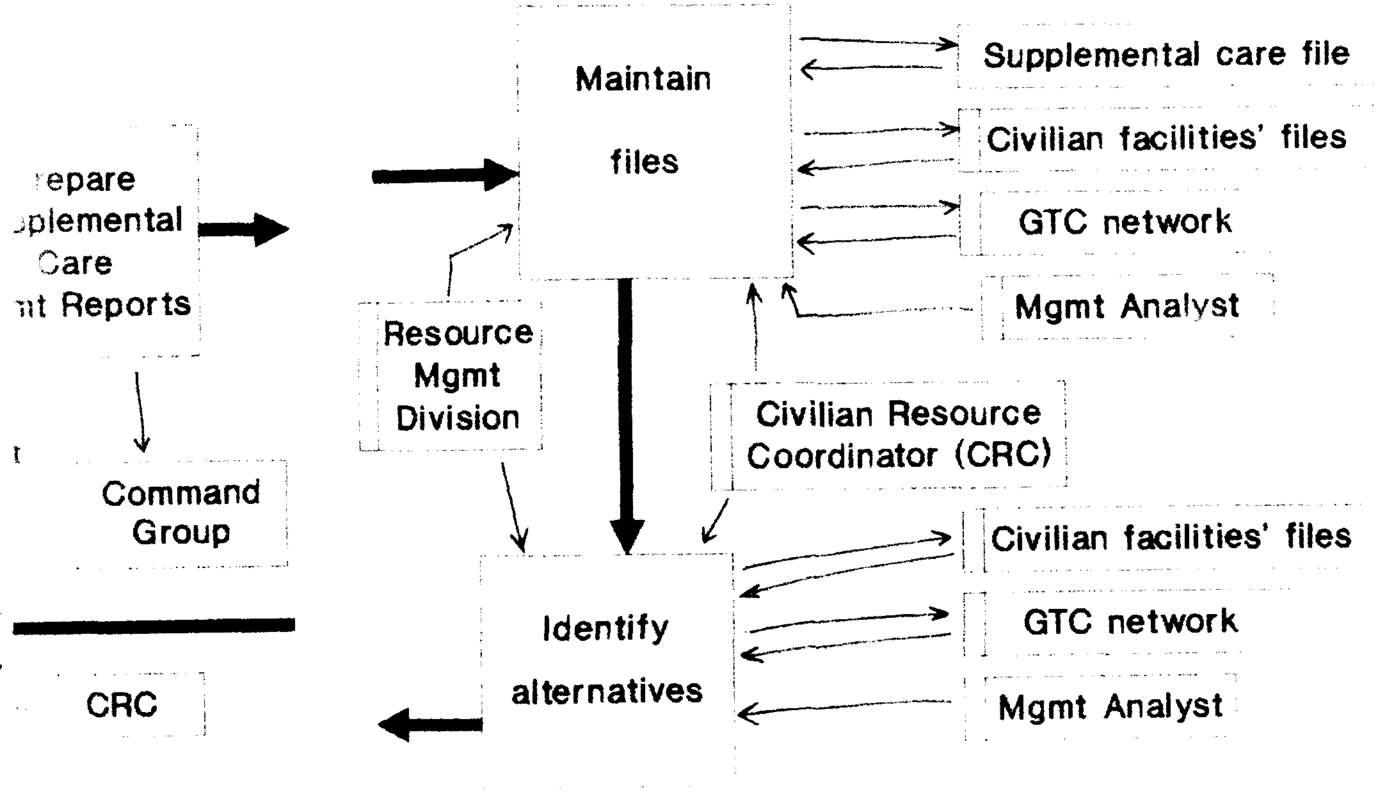
ion
61


Civilian Resource Coordinator (CRC)
Mgmt Analyst
Gather information
GTC network
Resource Mgmt Division
MTF Capabilities' file
Statement of Work file
Resource Mgmt Division
Statement of Work file
Analyze alternatives
MTF Capabilities' file
GTC network
Civilian Resource Coordinator (CRC)
Mgmt Analyst

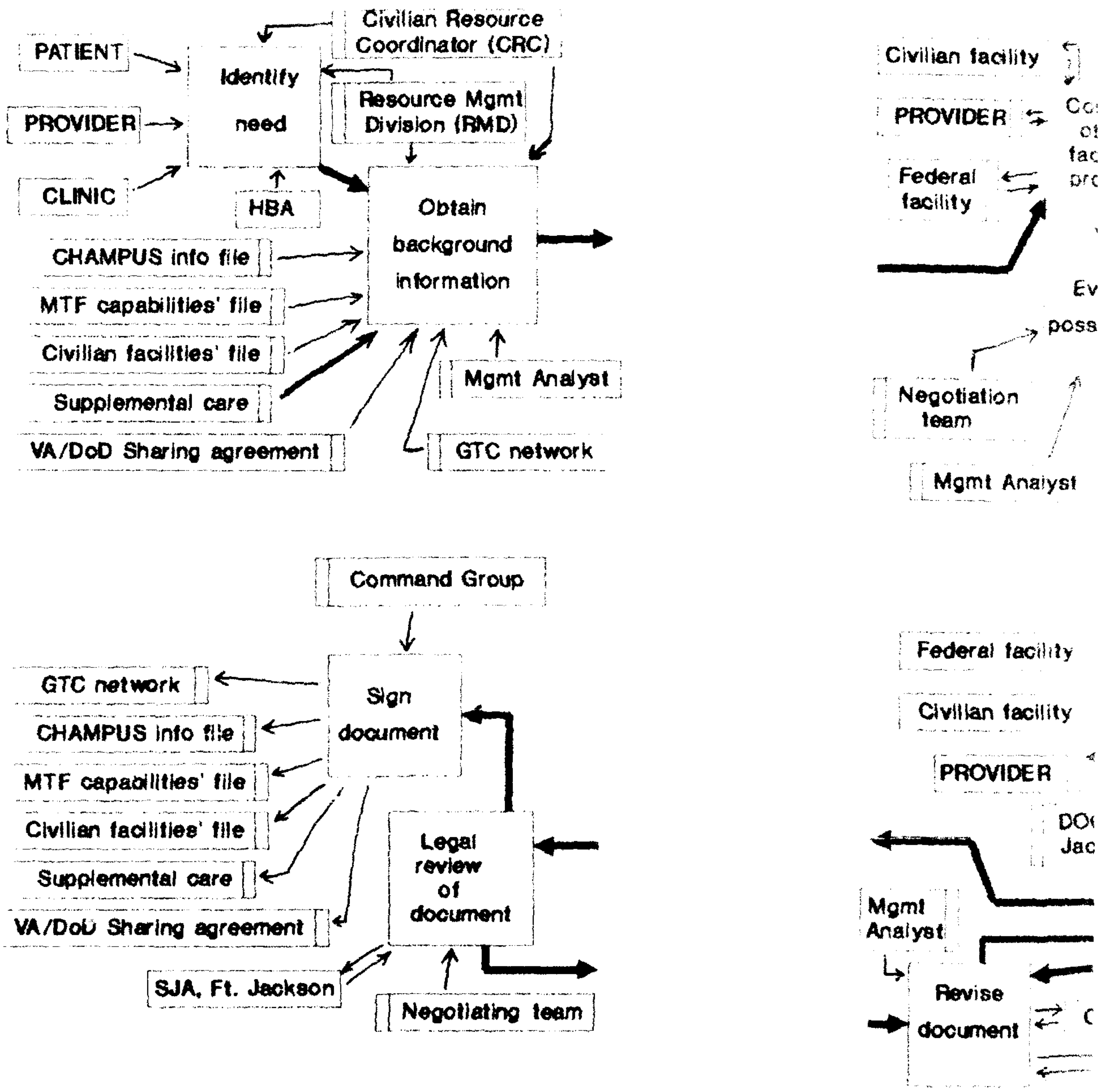
file

Task Seven -- Monitor supplemental care expenditures.

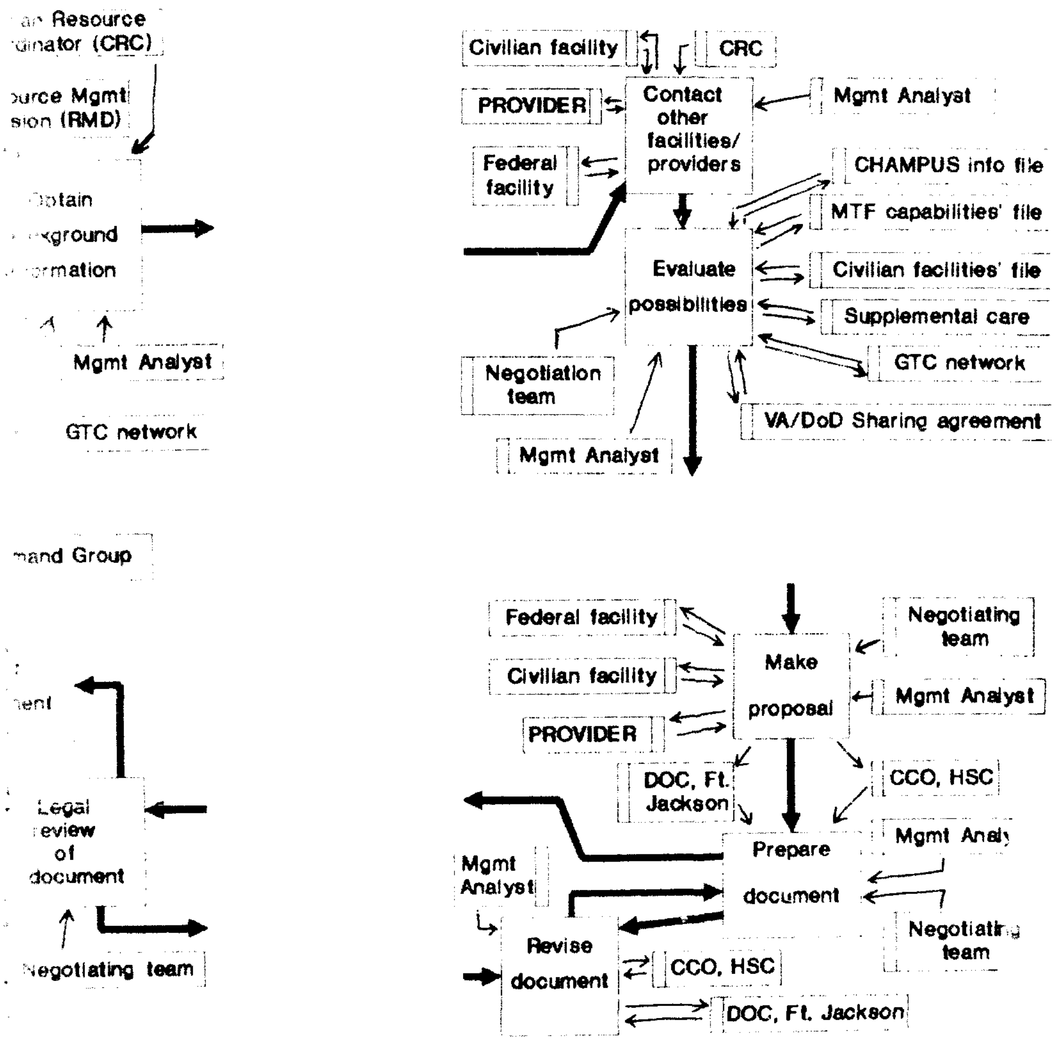

Civilian Resource Coordinator (CRC)
Civilian Claims Clerk (CCC)
Resource Mgmt Division
Monitor Supplemental Care expenditures
Prepare Supplemental Care Mgmt Reports
M
Resource Mgmt Division
Command Group
Supplemental Care budget
Command Group
Mgmt Analyst
Make Recommendations
Resource Mgmt Division
CRC
Iden
altern


epare
plemental
Care
nt Reports
Command
Group
CRC
Resource
Mgmt
Division
Maintain
files
Supplemental care file
Civilian facilities' files
GTC network
Mgmt Analyst
Civilian Resource
Coordinator (CRC)
Identify
alternatives
Civilian facilities' files
GTC network
Mgmt Analyst

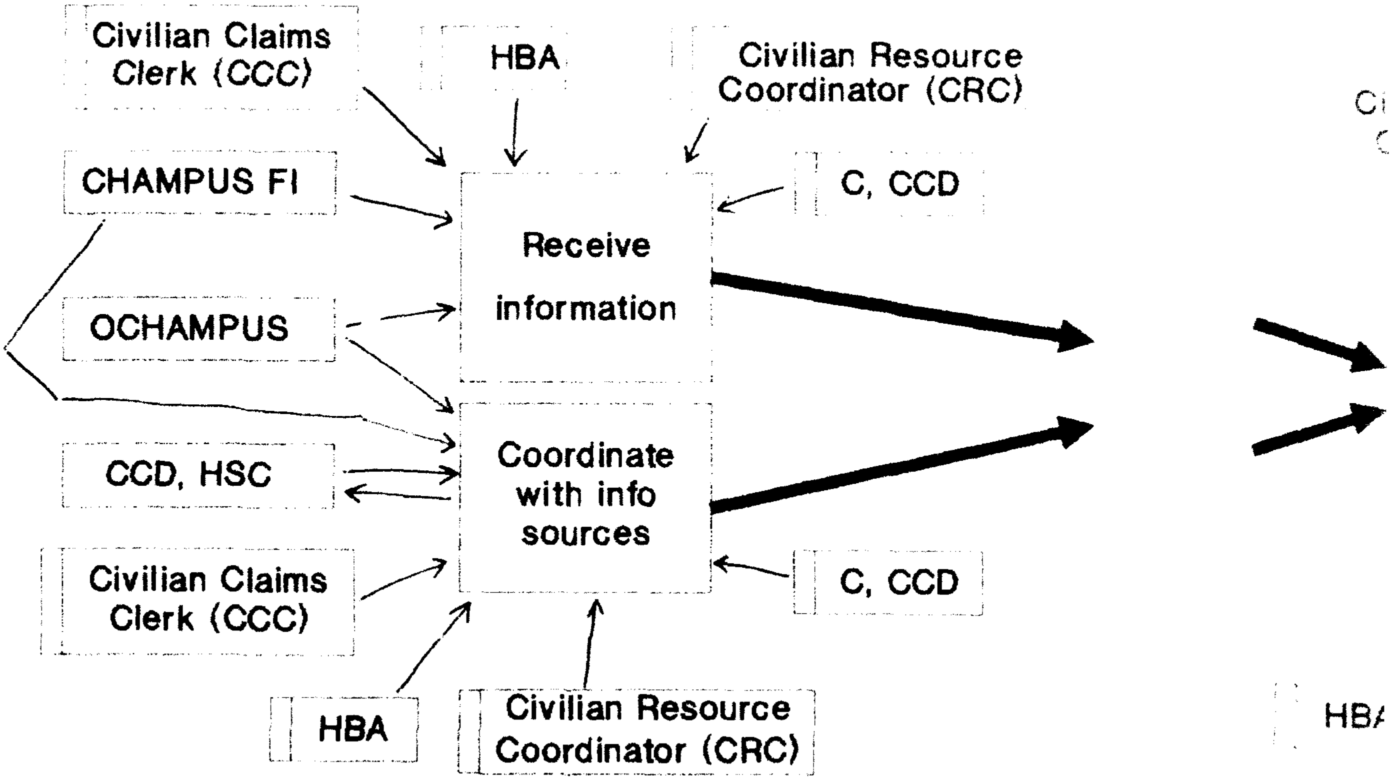
Task Eight -- Negotiate agreements and contracts.


Civilian Resource Coordinator (CRC)
PATIENT
Identify need
PROVIDER
Resource Mgmt Division (RMD)
CLINIC
HBA
Obtain background information
CHAMPUS info file
MTF capabilities' file
Civilian facilities' file
Supplemental care
Mgmt Analyst
VA/DoD Sharing agreement
GTC network
Civilian facility
PROVIDER
Co
of
fac
pro
Federal facility
Ev
poss
Negotiation team
Mgmt Analyst
Command Group
GTC network
Sign document
CHAMPUS info file
MTF capabilities' file
Civilian facilities' file
Supplemental care
Legal review of document
VA/DoD Sharing agreement
SJA, Ft. Jackson
Negotiating team
Federal facility
Civilian facility
PROVIDER
DO
Jac
Mgmt Analyst
Revise document
C

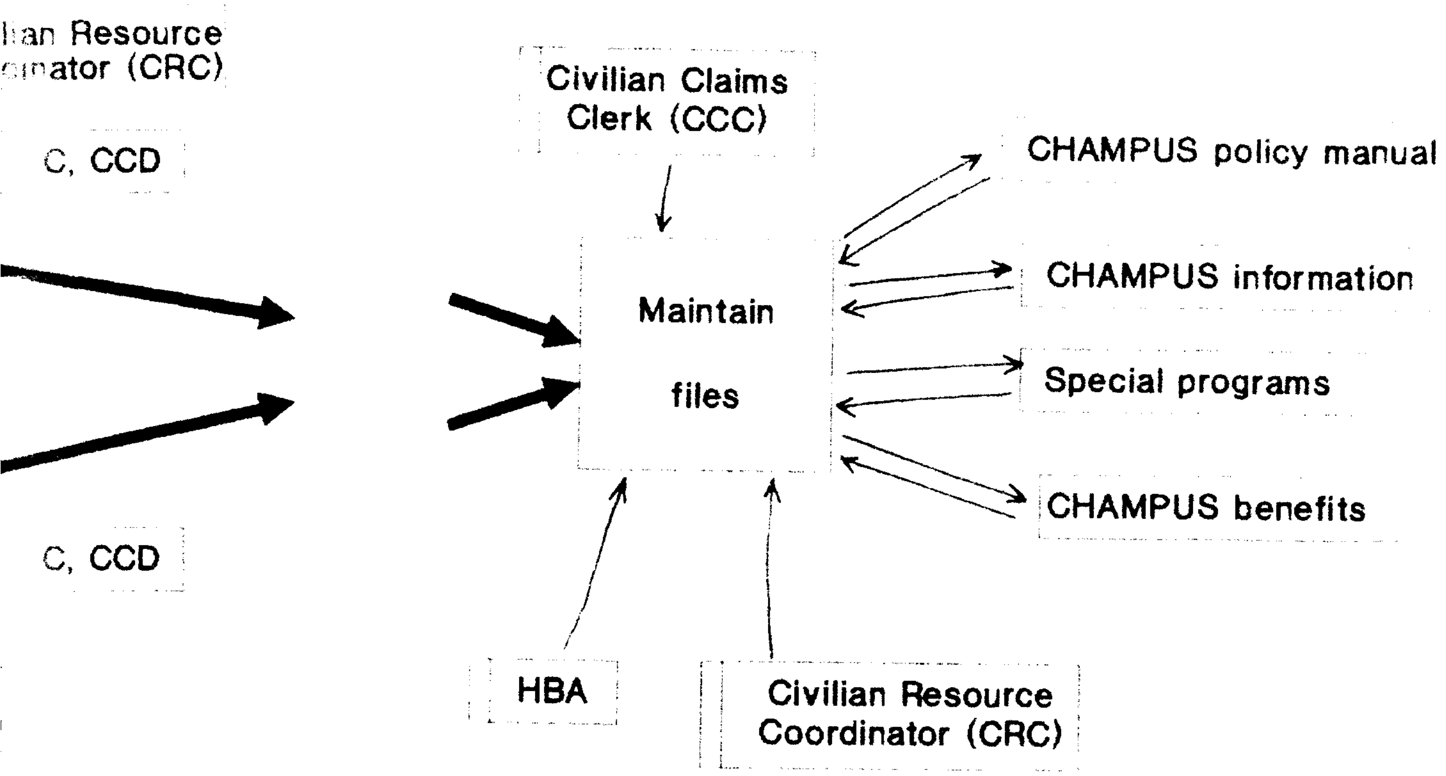
nts and contracts.


an Resource
dinator (CRC)
ource Mgmt
sion (RMD)
btain
kground
rmation
Mgmt Analyst
GTC network
Civilian facility
CRC
PROVIDER
Contact
other
facilities/
providers
Mgmt Analyst
Federal
facility
CHAMPUS info file
MTF capabilities' file
Evaluate
possibilities
Civilian facilities' file
Supplemental care
GTC network
Negotiation
team
VA/DoD Sharing agreement
Mgmt Analyst
mand Group
Federal facility
Negotiating
team
Civilian facility
Make
proposal
Mgmt Analyst
PROVIDER
ent
DOC, Ft.
Jackson
CCO, HSC
Legal
eview
of
document
Prepare
document
Mgmt Anal
Mgmt
Analyst
Negotiatin
team
Revise
document
CCO, HSC
DOC, Ft. Jackson
Negotiating team

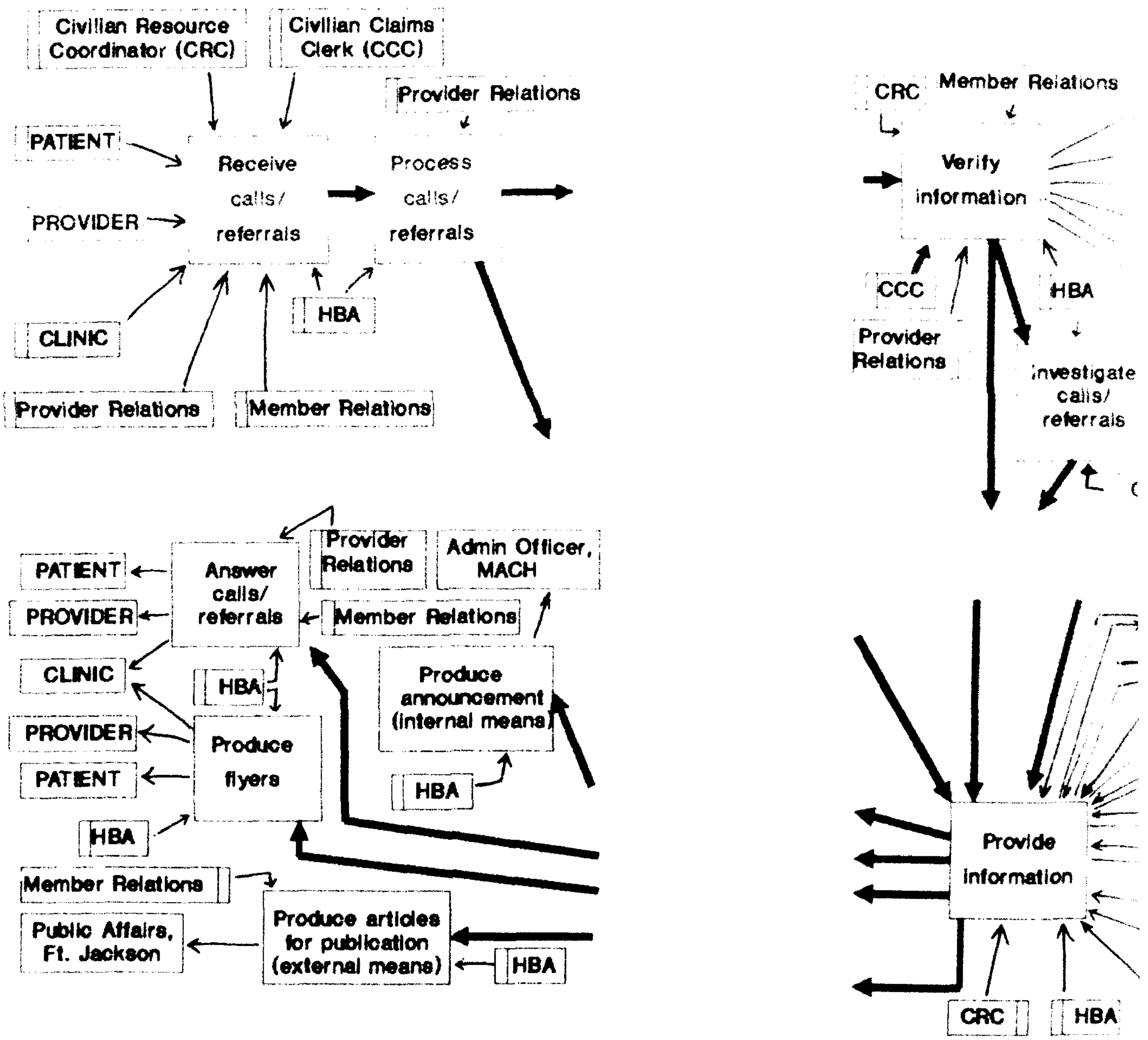
Task Nine -- Coordinate for CHAMPUS policy guidance.


Civilian Claims Clerk (CCC)
HBA
Civilian Resource Coordinator (CRC)
CHAMPUS FI
C, CCD
Receive information
OCHAMPUS
Coordinate with info sources
CCD, HSC
Civilian Claims Clerk (CCC)
C, CCD
HBA
Civilian Resource Coordinator (CRC)
Ci
HB

licy

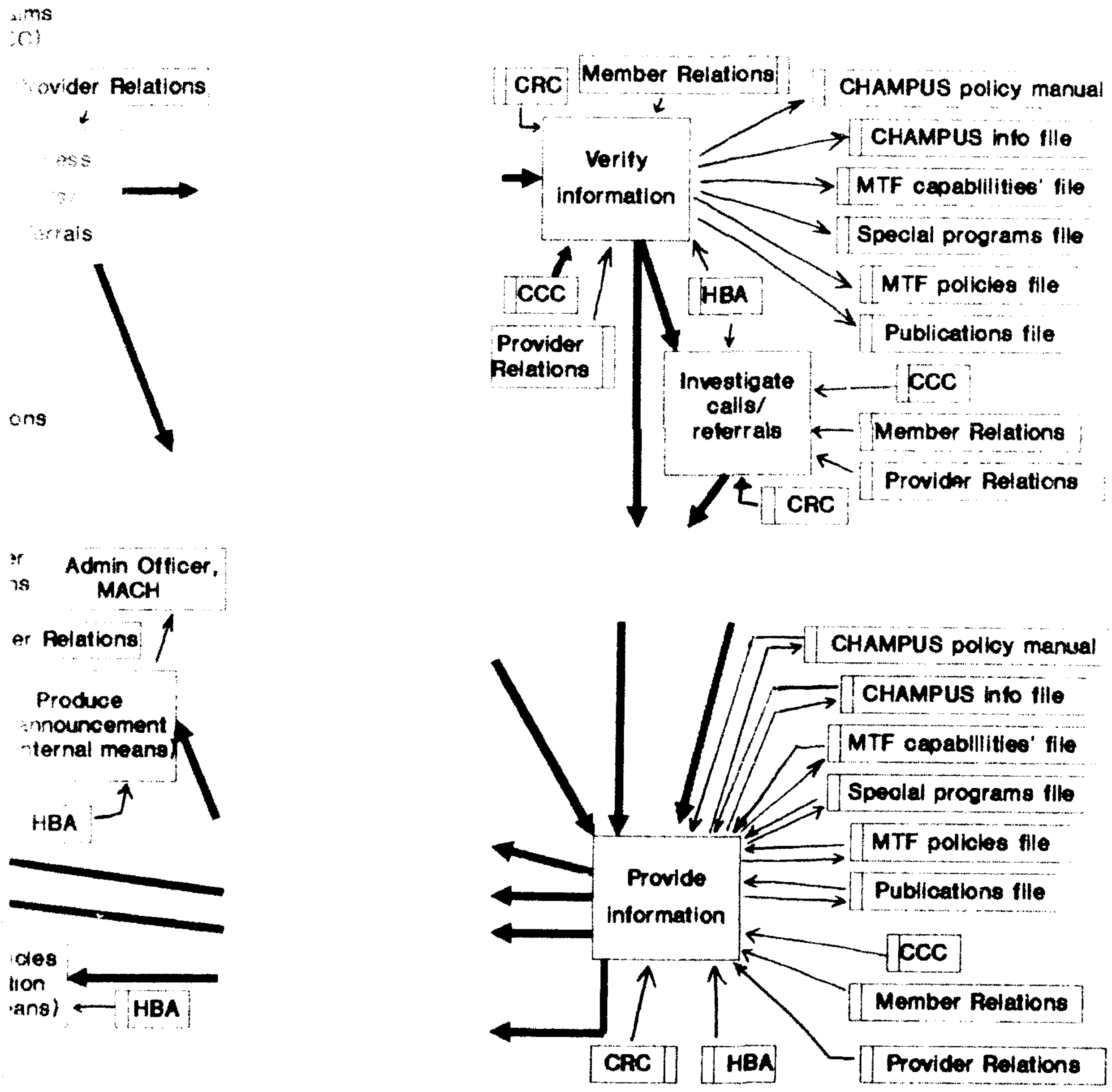

ian Resource
inator (CRC)
C, CCD
Civilian Claims Clerk (CCC)
Maintain files
CHAMPUS policy manual
CHAMPUS information
Special programs
CHAMPUS benefits
C, CCD
HBA
Civilian Resource Coordinator (CRC)

Task Ten -- Disseminate information to beneficiaries and providers.


Civilian Resource Coordinator (CRC)
Civilian Claims Clerk (CCC)
Provider Relations
PATIENT
Receive calls/ referrals
Process calls/ referrals
PROVIDER
CLINIC
HBA
Provider Relations
Member Relations
CRC
Member Relations
Verify information
CCC
Provider Relations
HBA
investigate calls/ referrals
PATIENT
PROVIDER
CLINIC
Answer calls/ referrals
Provider Relations
Admin Officer, MACH
Member Relations
HBA
Produce announcement (internal means)
PROVIDER
PATIENT
Produce flyers
HBA
HBA
Member Relations
Public Affairs, Ft. Jackson
Produce articles for publication (external means)
HBA
Provide information
CRC
HBA

nated Care Division
165

tion to



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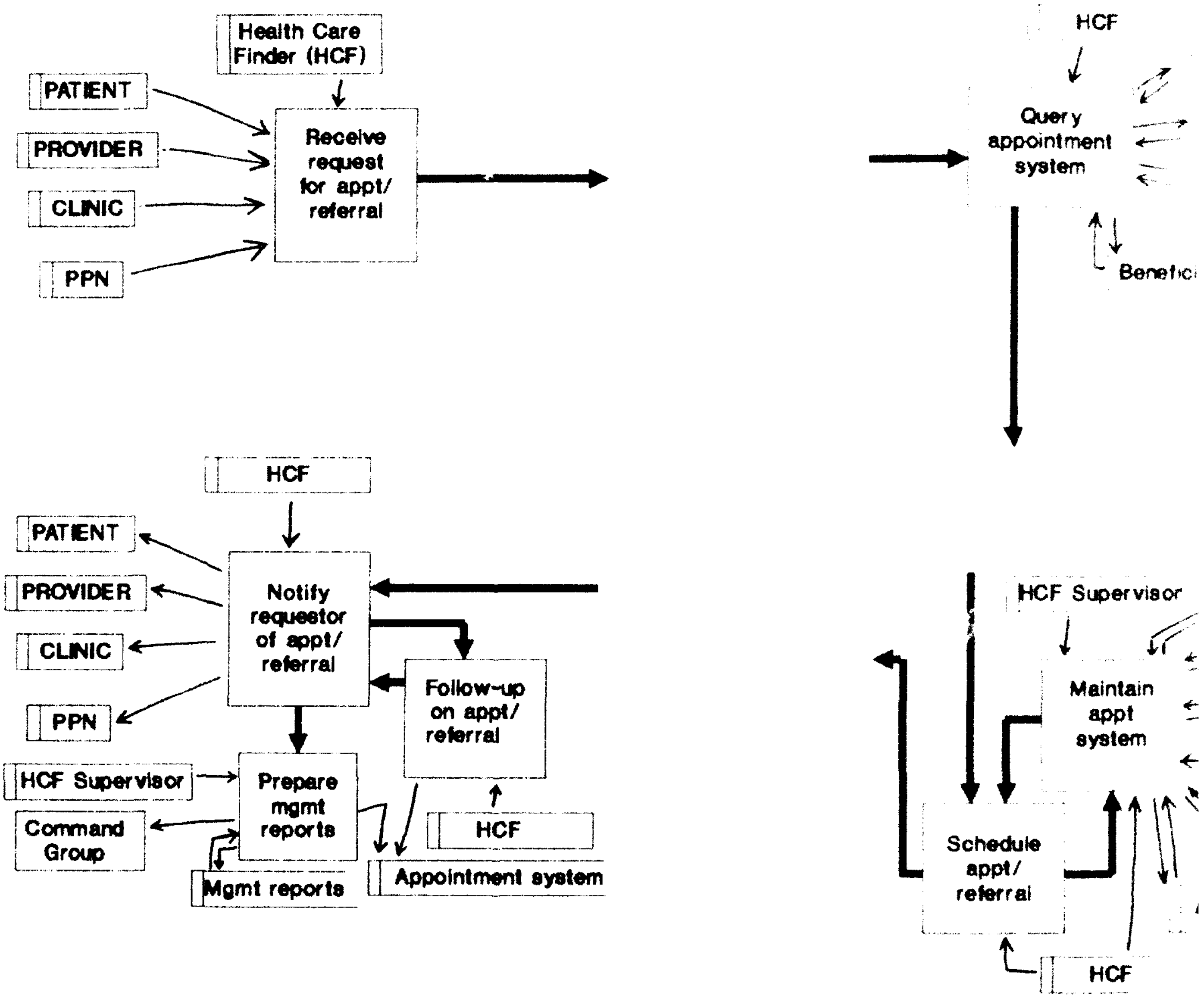
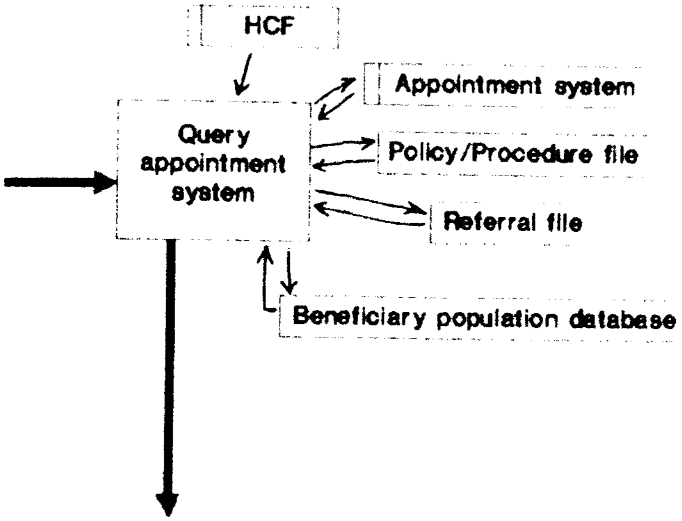
CI
ovider Relations
ess
errals
ons
CRC
Member Relations
CHAMPUS policy manual
Verify information
CHAMPUS info file
MTF capabilities' file
Special programs file
MTF policies file
Publications file
CCC
HBA
Provider Relations
Investigate calls/ referrals
CCC
Member Relations
Provider Relations
CRC
er
ns
Admin Officer, MACH
er Relations
Produce announcement
ternal means)
HBA
CHAMPUS policy manual
CHAMPUS info file
MTF capabilities' file
Special programs file
MTF policies file
Publications file
Provide information
CCC
Member Relations
Provider Relations
CRC
HBA
icies
tion
ans)
HBA

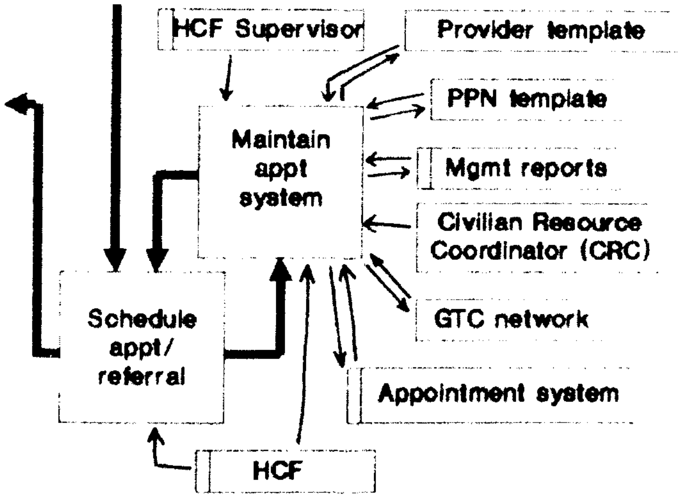
Task Eleven -- Operate the Health Care Finder program.


Health Care Finder (HCF)
PATIENT
PROVIDER
CLINIC
PPN
Receive request for appt/ referral
HCF
Query appointment system
Benefic
HCF
PATIENT
PROVIDER
CLINIC
PPN
Notify requestor of appt/ referral
Follow-up on appt/ referral
HCF Supervisor
Prepare mgmt reports
Command Group
Mgmt reports
HCF
Appointment system
HCF Supervisor
Maintain appt system
Schedule appt/ referral
HCF

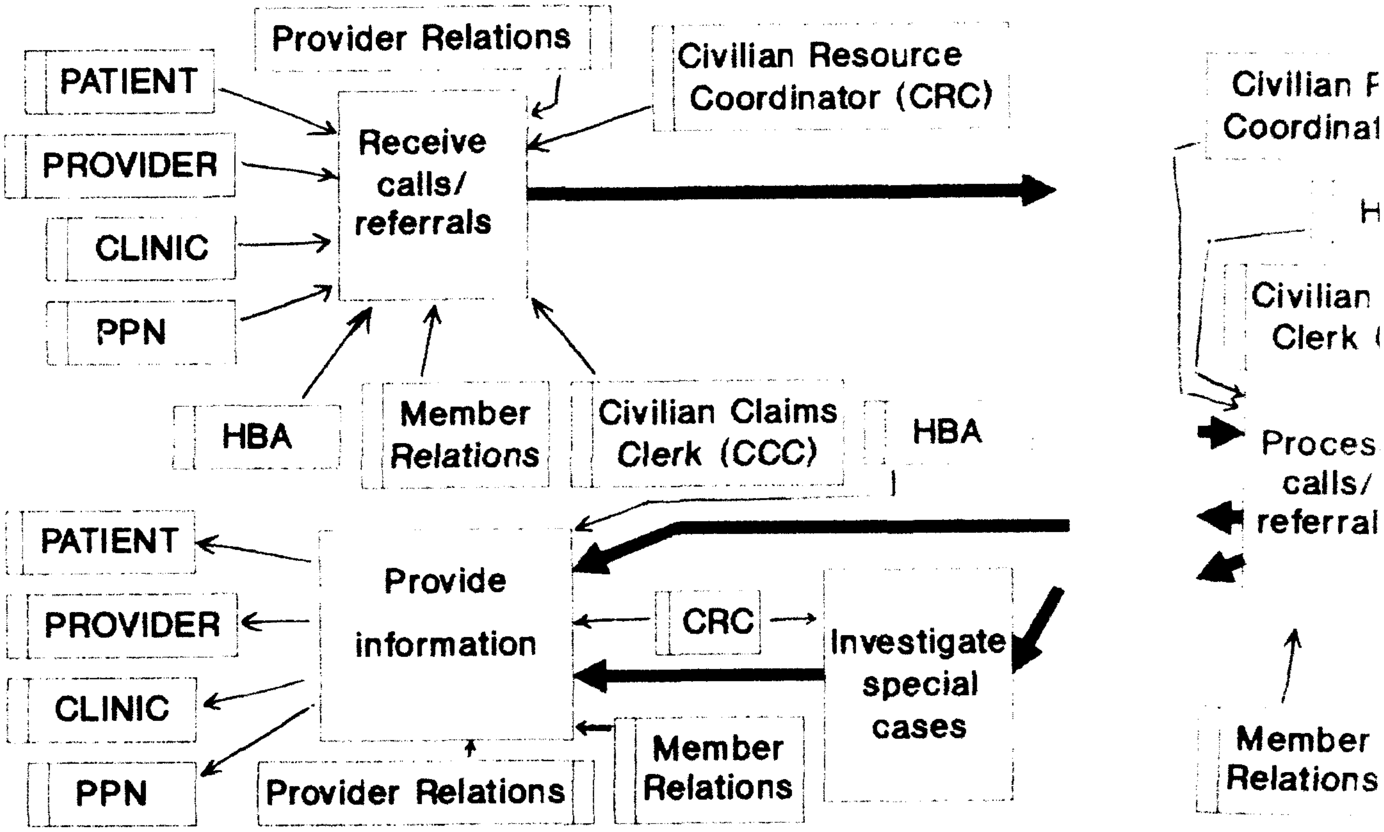
are Finder

w-up
pot/
ral
CF
ment system

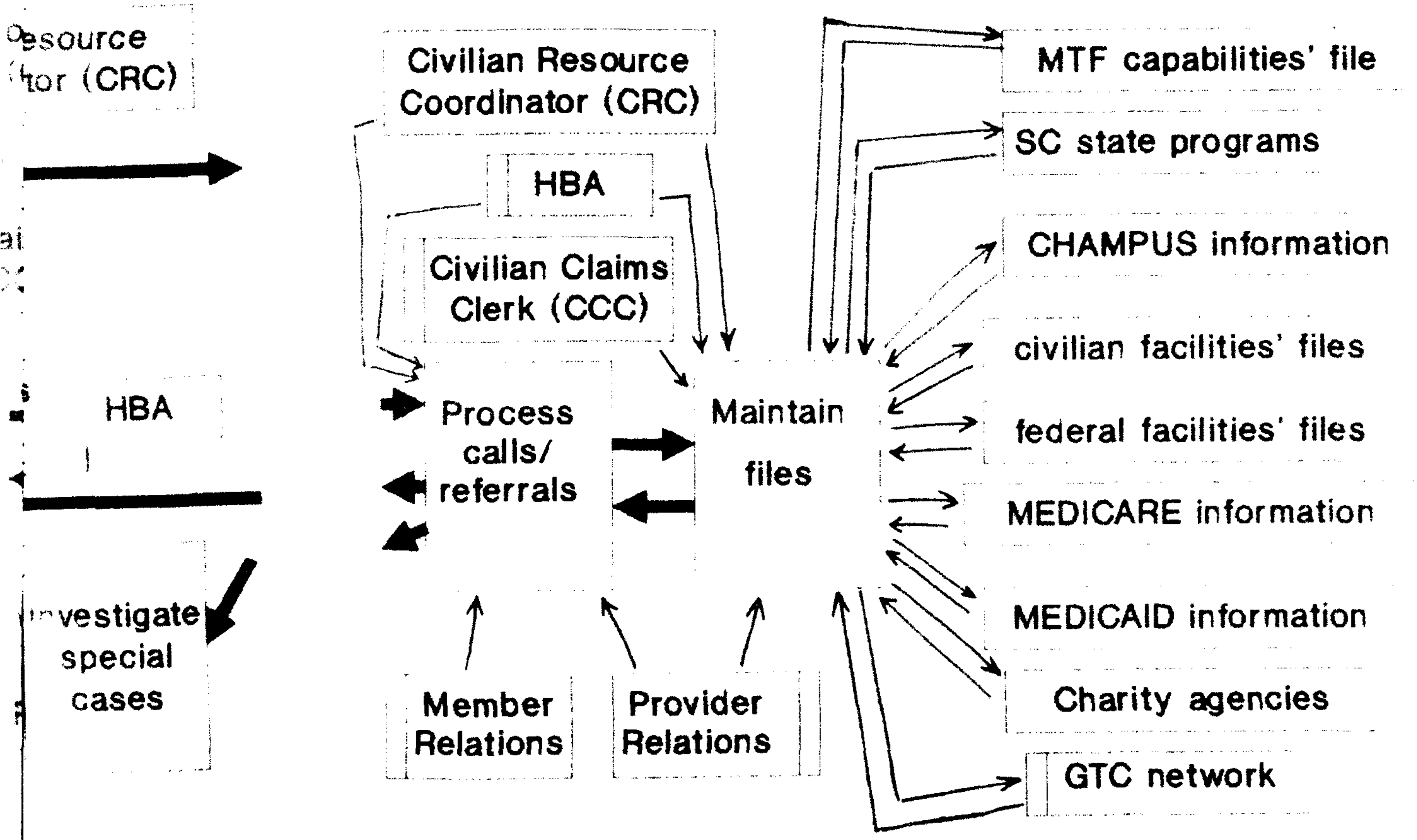

HCF
Query appointment system
Appointment system
Policy/Procedure file
Referral file
Beneficiary population database


HCF Supervisor
Provider template
PPN template
Maintain appt system
Mgmt reports
Civilian Resource Coordinator (CRC)
GTC network
Schedule appt/ referral
Appointment system
HCF

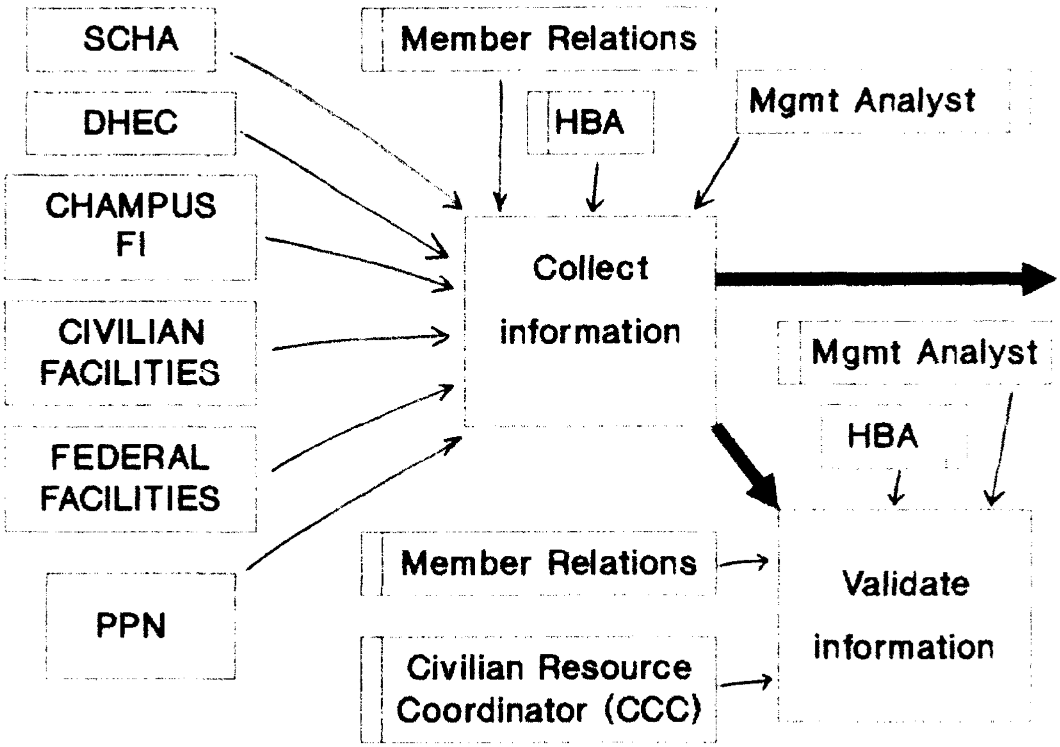
Task Twelve -- Provide information to beneficiaries and providers.


Provider Relations
PATIENT
PROVIDER
CLINIC
PPN
Receive calls/ referrals
Civilian Resource Coordinator (CRC)
HBA
Member Relations
Civilian Claims Clerk (CCC)
HBA
PATIENT
PROVIDER
CLINIC
PPN
Provide information
CRC
Investigate special cases
Provider Relations
Member Relations
Civilian F
Coordinat
H
Civilian
Clerk
Proces
calls/
referral
Member
Relations

ivision
167

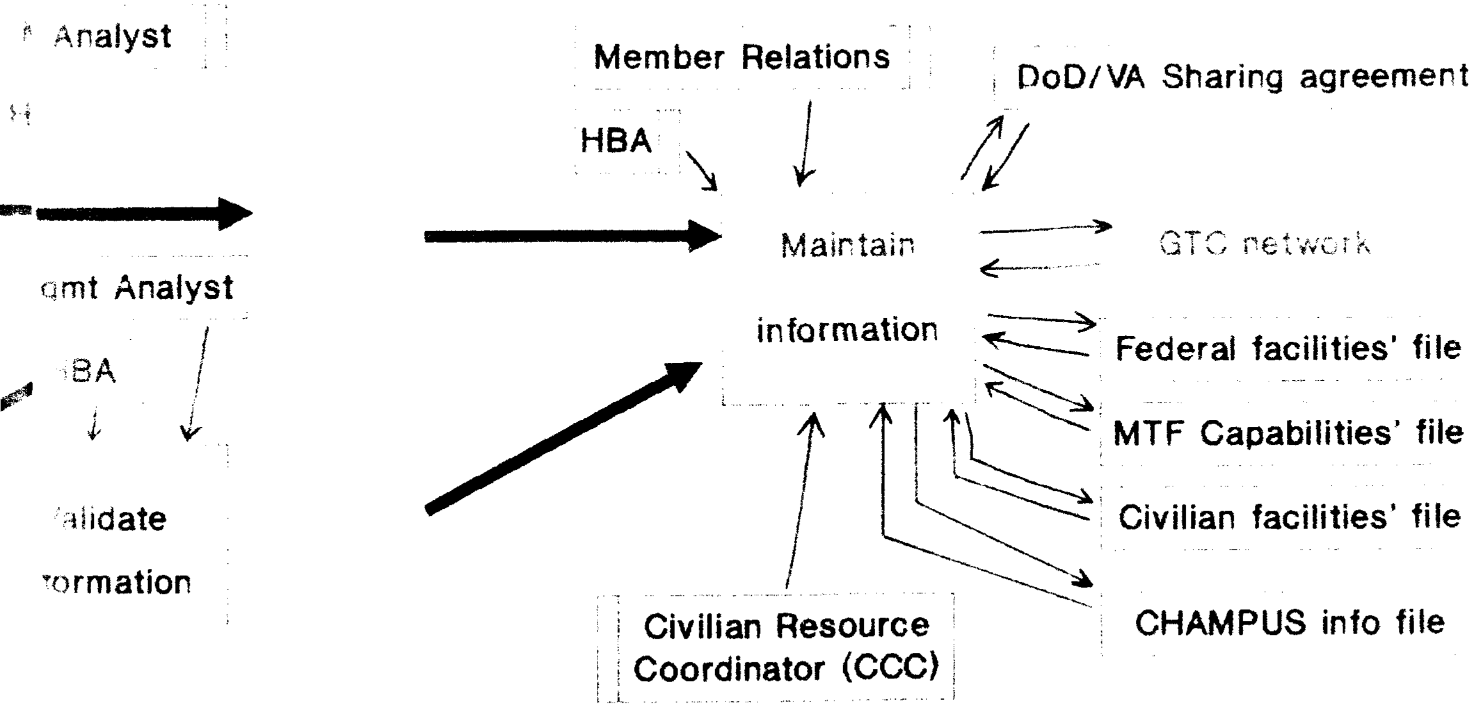

esource
tor (CRC)
HBA
vestigate
special
cases
Civilian Resource
Coordinator (CRC)
HBA
Civilian Claims
Clerk (CCC)
Process
calls/
referrals
Maintain
files
Member
Relations
Provider
Relations
MTF capabilities' file
SC state programs
CHAMPUS information
civilian facilities' files
federal facilities' files
MEDICARE information
MEDICAID information
Charity agencies
GTC network

Task Thirteen -- Conduct continuous monitoring of catchment area health resources.


SCHA
DHEC
CHAMPUS FI
CIVILIAN FACILITIES
FEDERAL FACILITIES
PPN
Member Relations
HBA
Mgmt Analyst
Collect information
Mgmt Analyst
HBA
Member Relations
Civilian Resource Coordinator (CCC)
Validate information

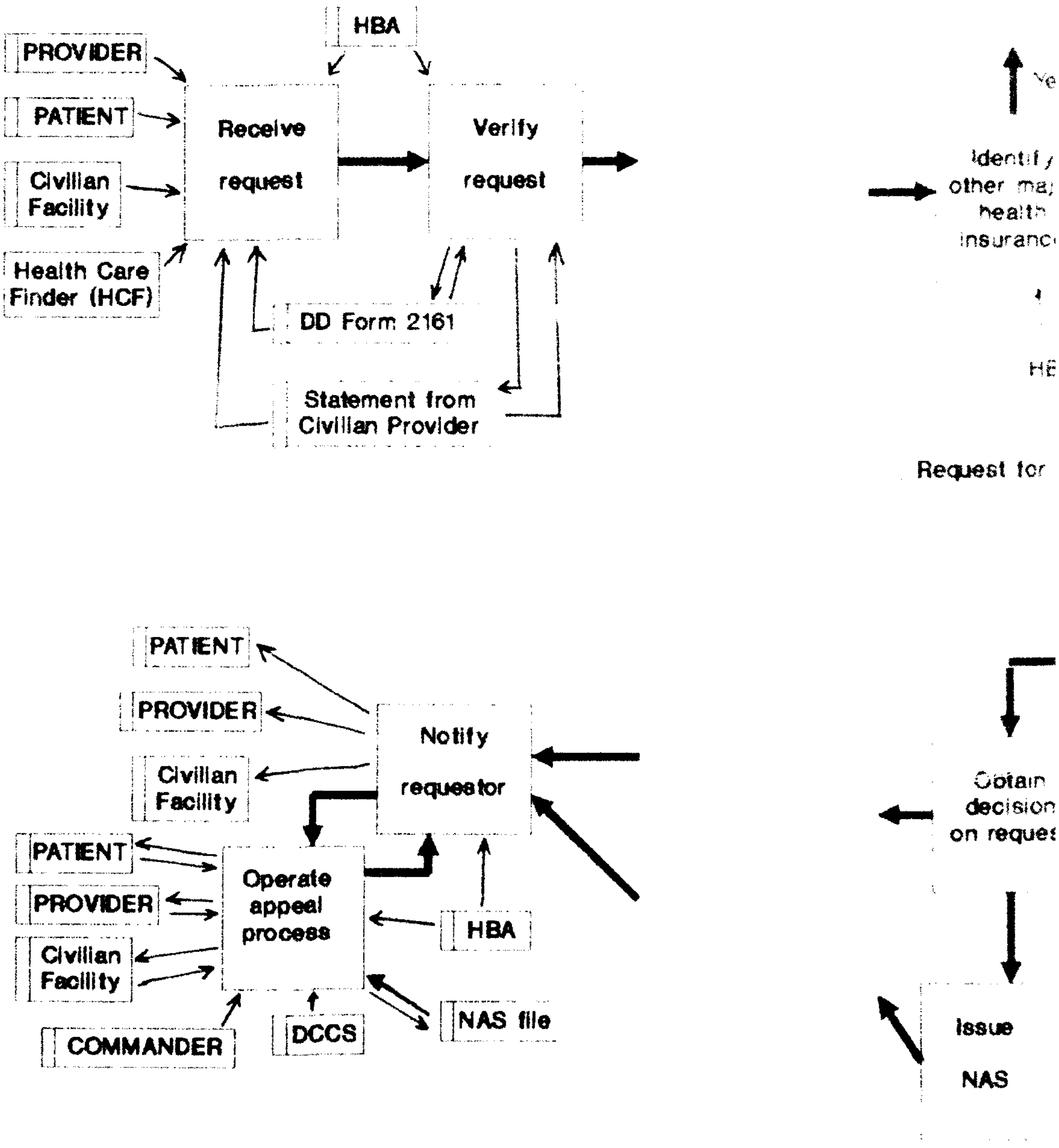
Division
168

ring of

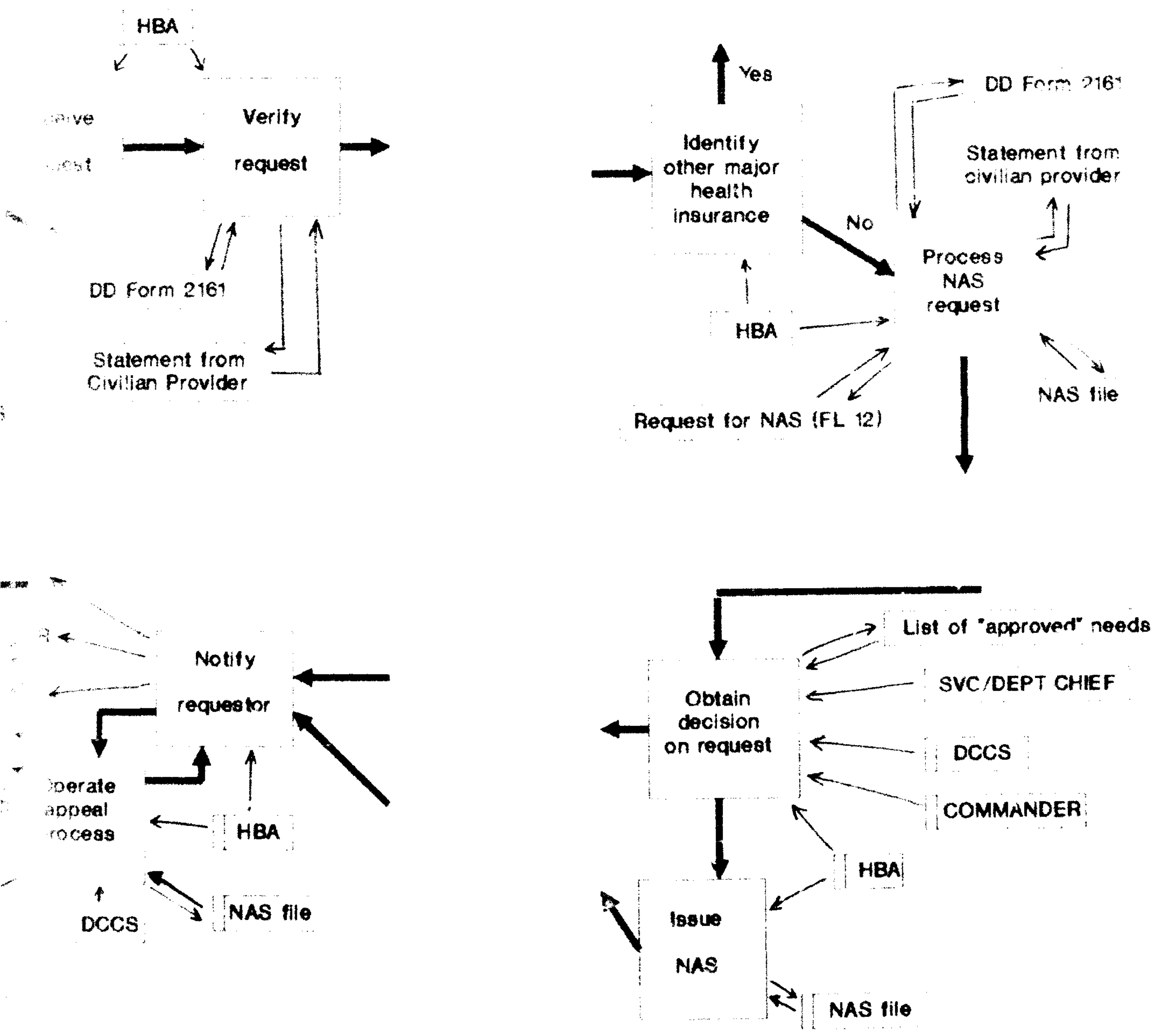


Analyst
gmt Analyst
BA
alidate
ormation
Member Relations
HBA
DoD/VA Sharing agreement
Maintain
information
GTC network
Federal facilities' file
MTF Capabilities' file
Civilian facilities' file
CHAMPUS info file
Civilian Resource
Coordinator (CCC)

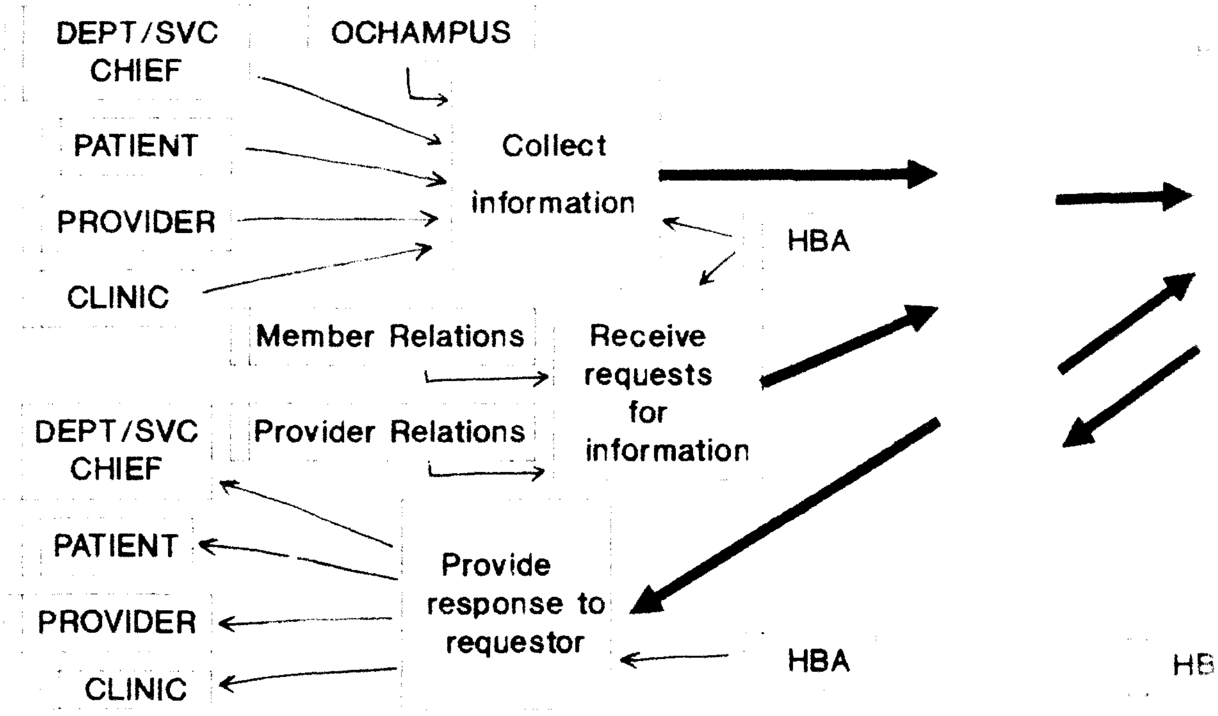
Task Fourteen -- Process nonavailability statements (NAS).


HBA
PROVIDER
PATIENT
Civilian Facility
Health Care Finder (HCF)
Receive request
Verify request
DD Form 2161
Statement from Civilian Provider
Ye
Identify other ma health insuranc
HE
Request for
PATIENT
PROVIDER
Civilian Facility
Notify requestor
PATIENT
PROVIDER
Civilian Facility
Operate appeal process
HBA
COMMANDER
DCCS
NAS file
Obtain decision on reques
Issue NAS

ess nonavailability

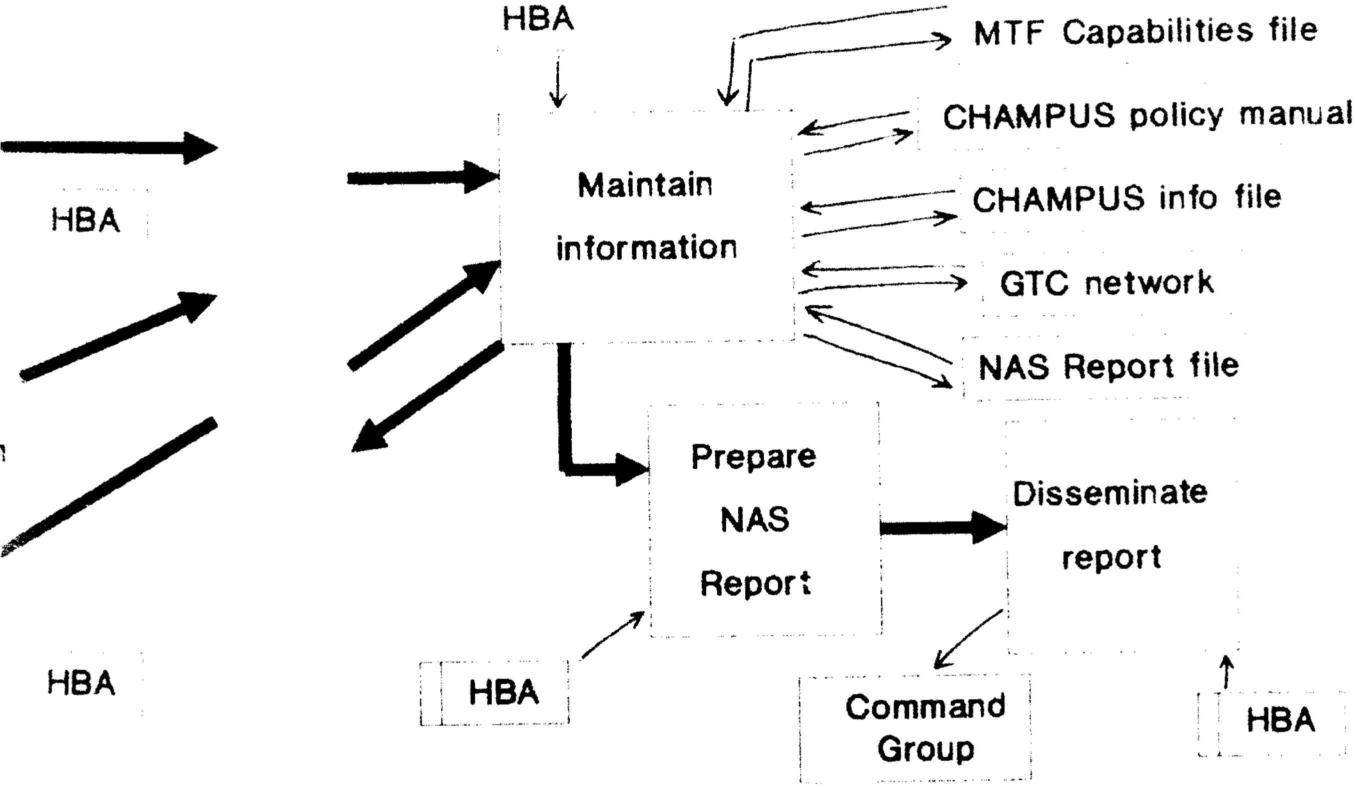

HBA
Verify request
DD Form 2161
Statement from Civilian Provider
Yes
Identify other major health insurance
No
DD Form 2161
Statement from civilian provider
Process NAS request
HBA
Request for NAS (FL 12)
NAS file
List of "approved" needs
SVC/DEPT CHIEF
Obtain decision on request
DCCS
COMMANDER
HBA
Issue NAS
NAS file
Notify requestor
perate appeal rocess
HBA
NAS file
DCCS

Task Fifteen -- Provide information regarding NAS.


DEPT/SVC CHIEF
OCHAMPUS
PATIENT
PROVIDER
CLINIC
Collect information
HBA
Member Relations
Receive requests for information
DEPT/SVC CHIEF
Provider Relations
PATIENT
Provide response to requestor
PROVIDER
CLINIC
HBA
HB

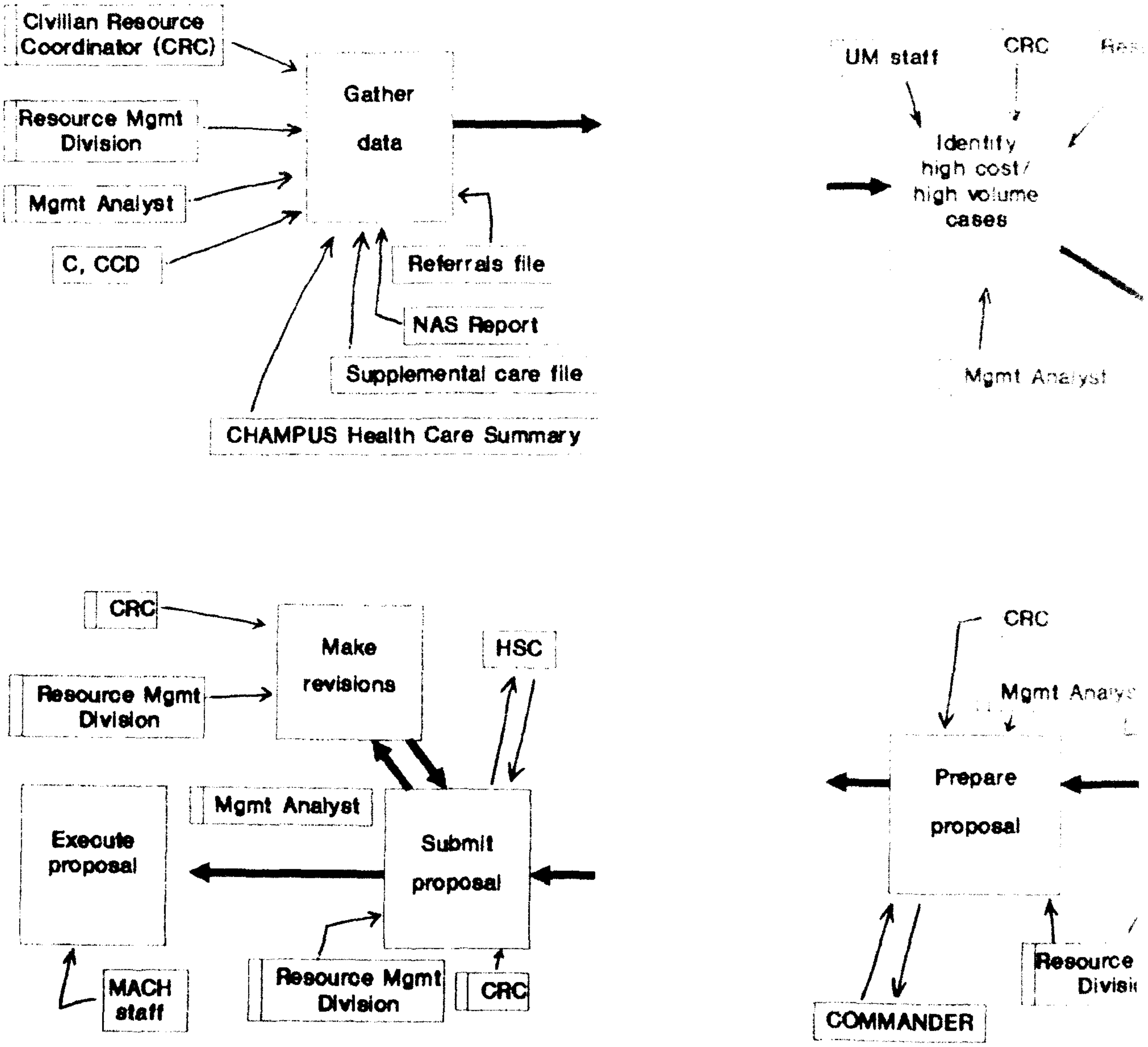
Division
170

ing NAS.

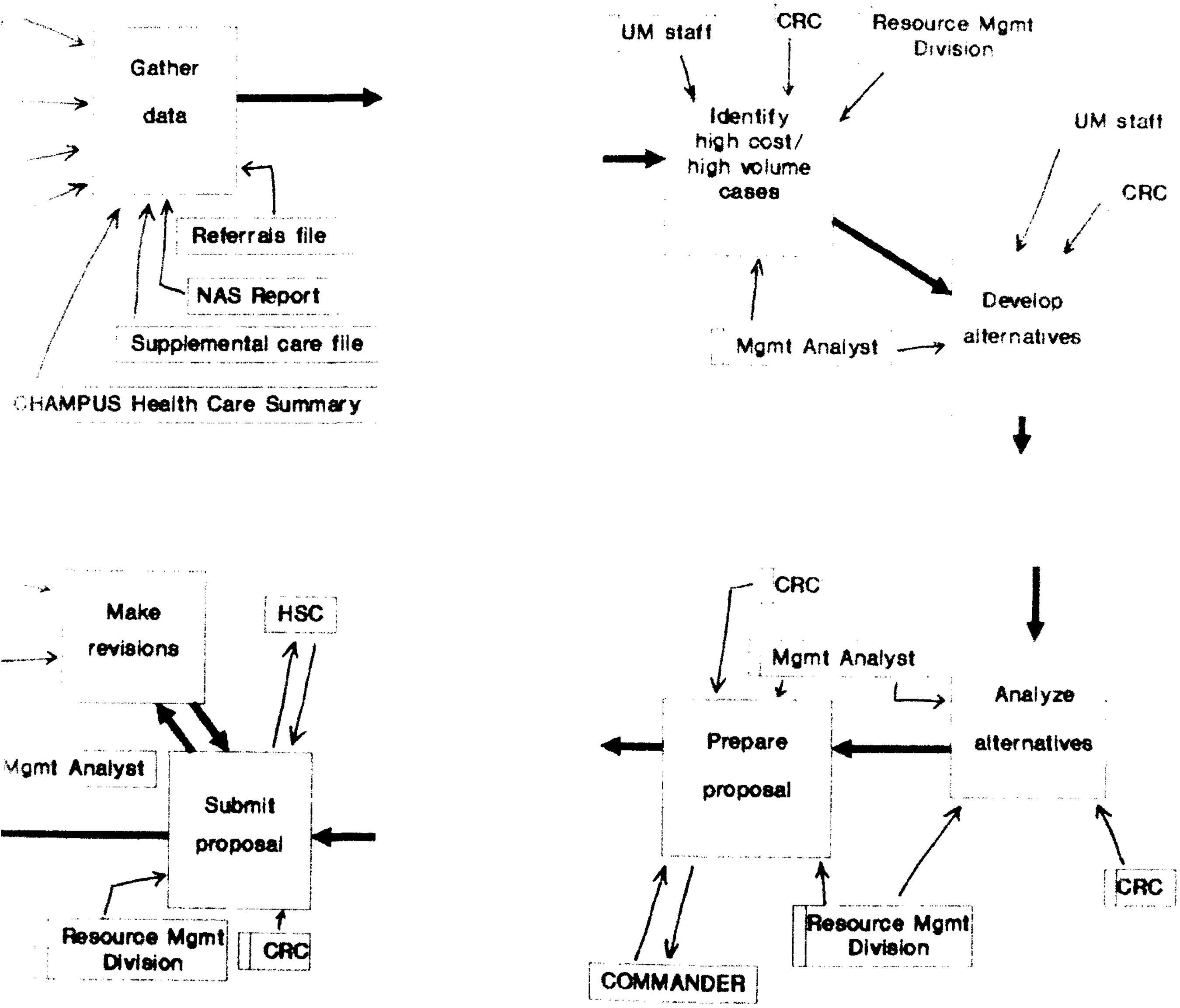


HBA
MTF Capabilities file
CHAMPUS policy manual
Maintain information
CHAMPUS info file
HBA
GTC network
NAS Report file
Prepare NAS Report
Disseminate report
HBA
HBA
Command Group
HBA

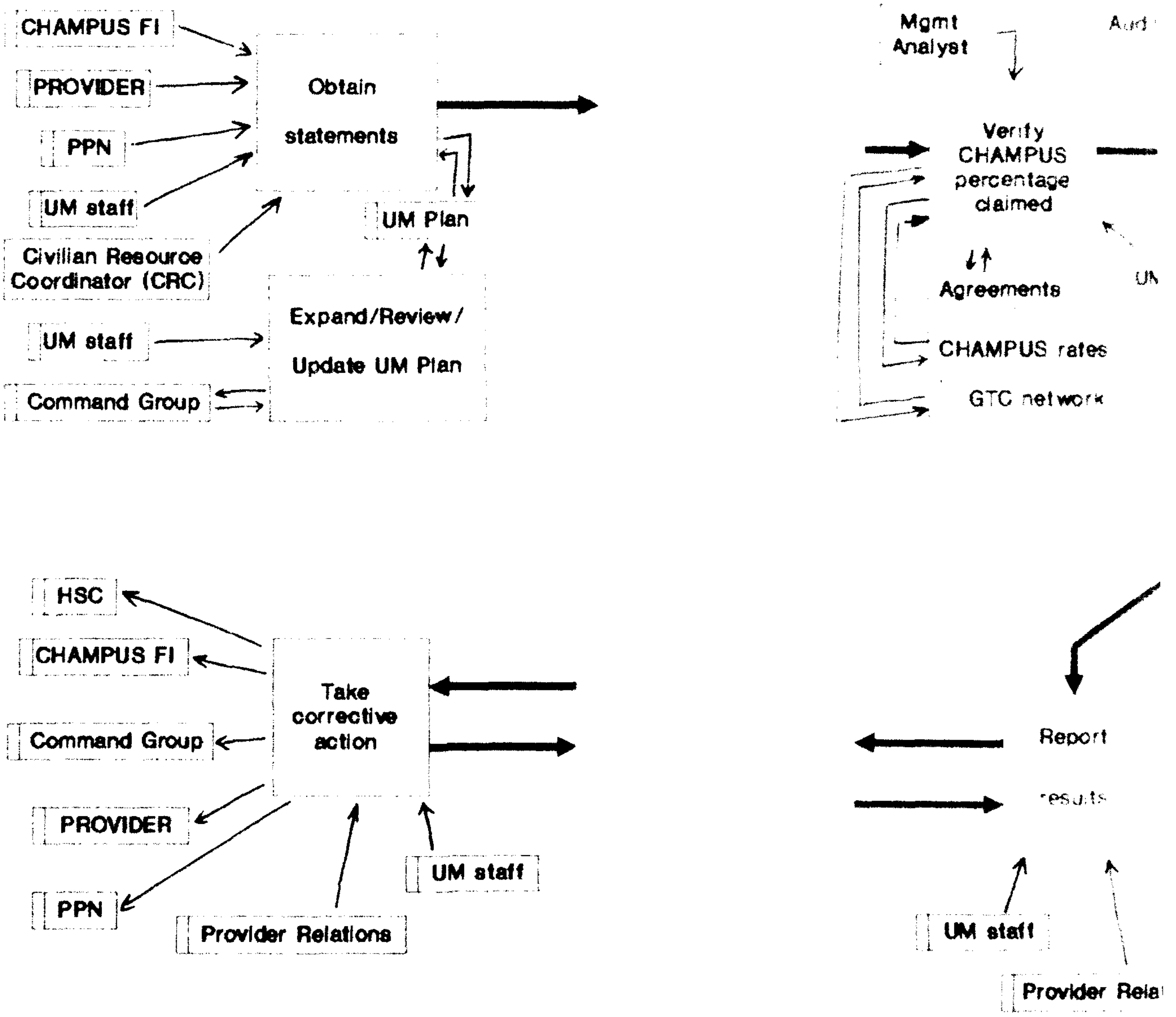
Task Sixteen -- Identify opportunities and develop plans.


Civilian Resource Coordinator (CRC)
Resource Mgmt Division
Mgmt Analyst
C, CCD
Gather data
Referrals file
NAS Report
Supplemental care file
CHAMPUS Health Care Summary
UM staff
CRC
Identify high cost/ high volume cases
Mgmt Analyst
CRC
Make revisions
Resource Mgmt Division
HSC
Mgmt Analyst
Execute proposal
Submit proposal
MACH staff
Resource Mgmt Division
CRC
CRC
Mgmt Analys
Prepare proposal
COMMANDER
Resource Divisi

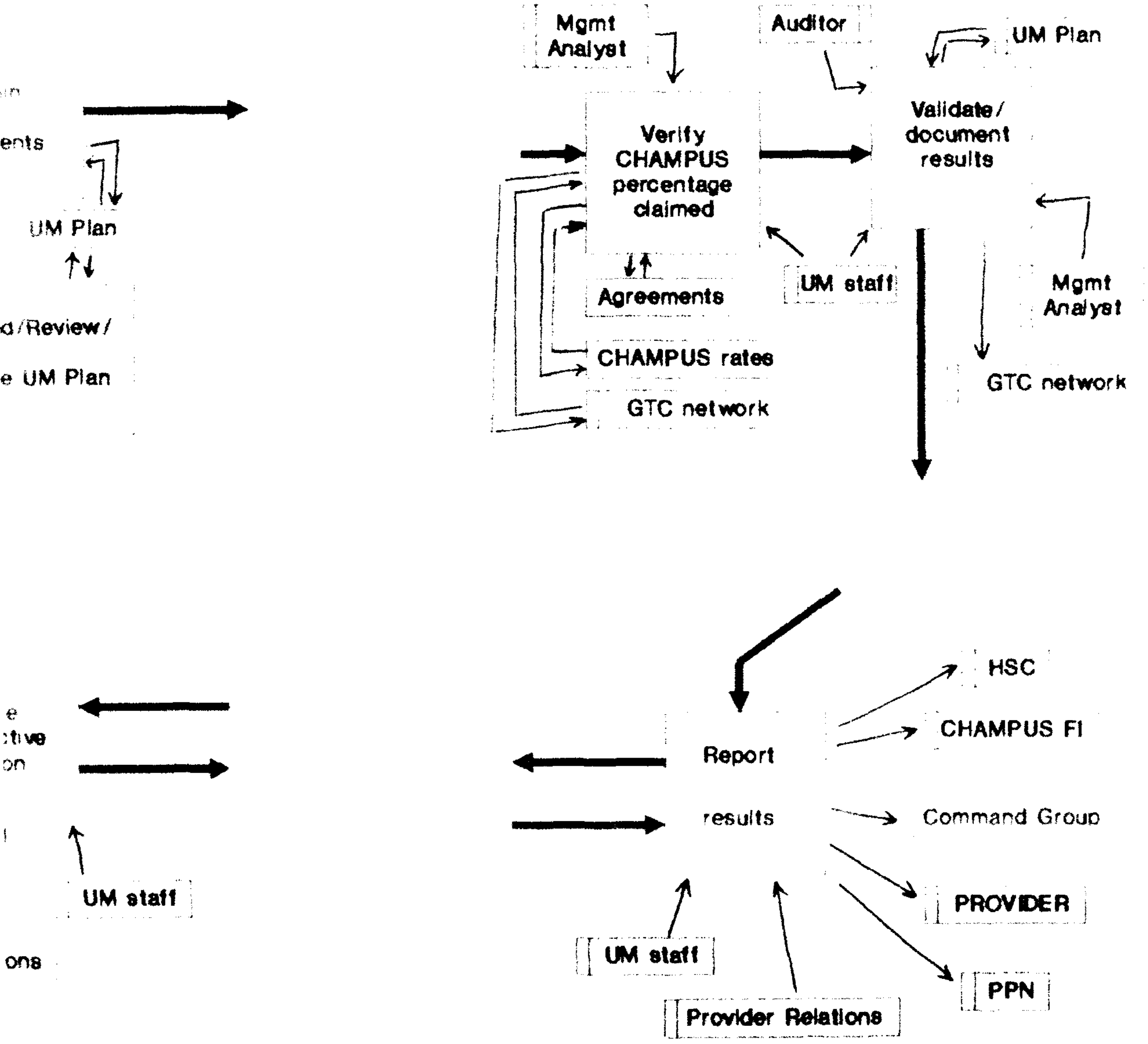
ntify opportunities and develop


Gather
data
Referrals file
NAS Report
Supplemental care file
CHAMPUS Health Care Summary
UM staff
CRC
Resource Mgmt
Division
Identify
high cost/
high volume
cases
UM staff
CRC
Mgmt Analyst
Develop
alternatives
Make
revisions
HSC
Mgmt Analyst
Submit
proposal
Resource Mgmt
Division
CRC
CRC
Mgmt Analyst
Prepare
proposal
Analyze
alternatives
COMMANDER
Resource Mgmt
Division
CRC

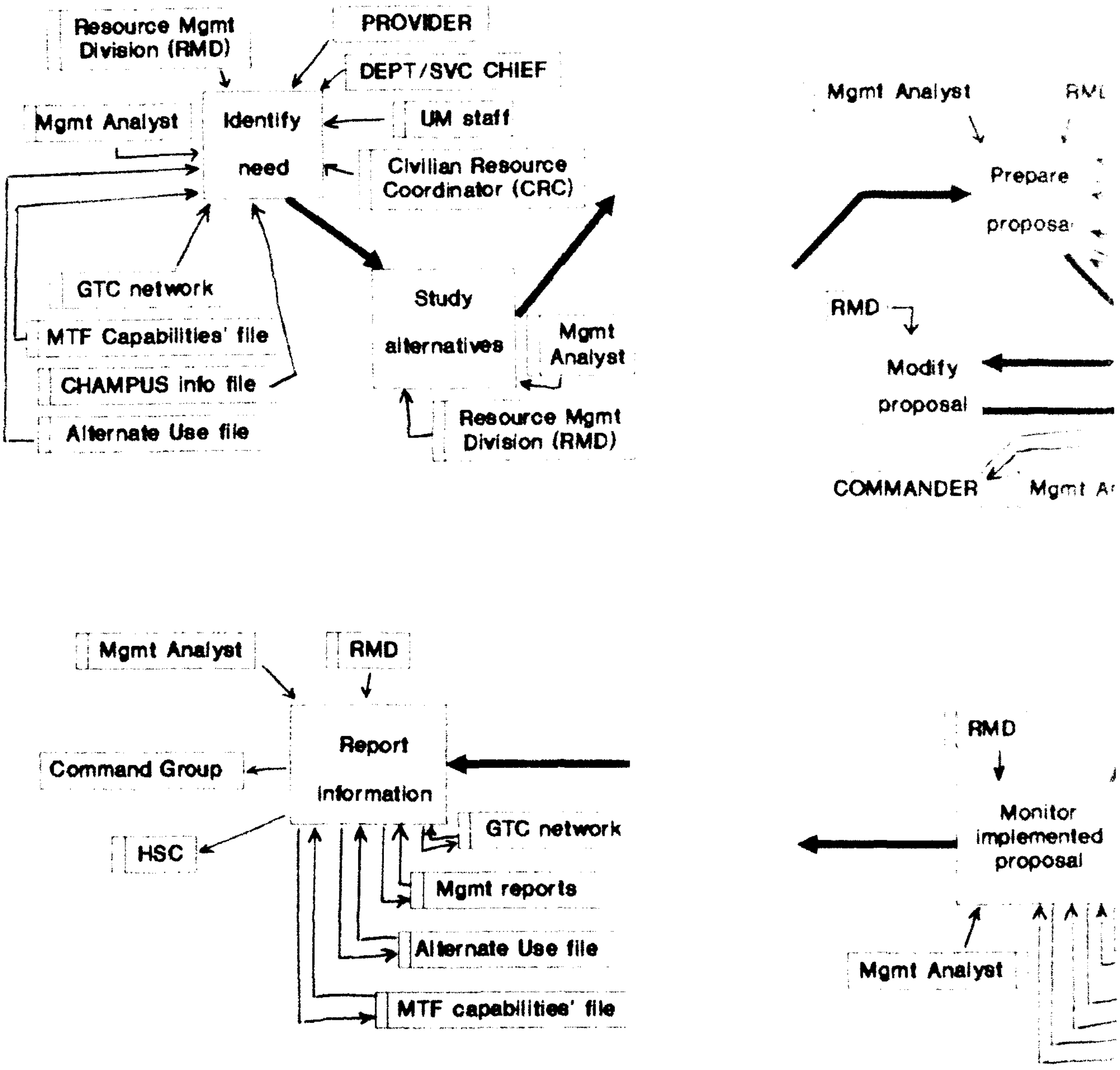
Task Seventeen -- Develop and maintain an utilization management system.


CHAMPUS FI
PROVIDER
PPN
UM staff
Civilian Resource Coordinator (CRC)
UM staff
Command Group
Obtain statements
UM Plan
Expand/Review/ Update UM Plan
Mgmt Analyst
Verify CHAMPUS percentage claimed
Agreements
CHAMPUS rates
GTC network
HSC
CHAMPUS FI
Command Group
PROVIDER
PPN
Take corrective action
Provider Relations
UM staff
Report results
UM staff
Provider Rela

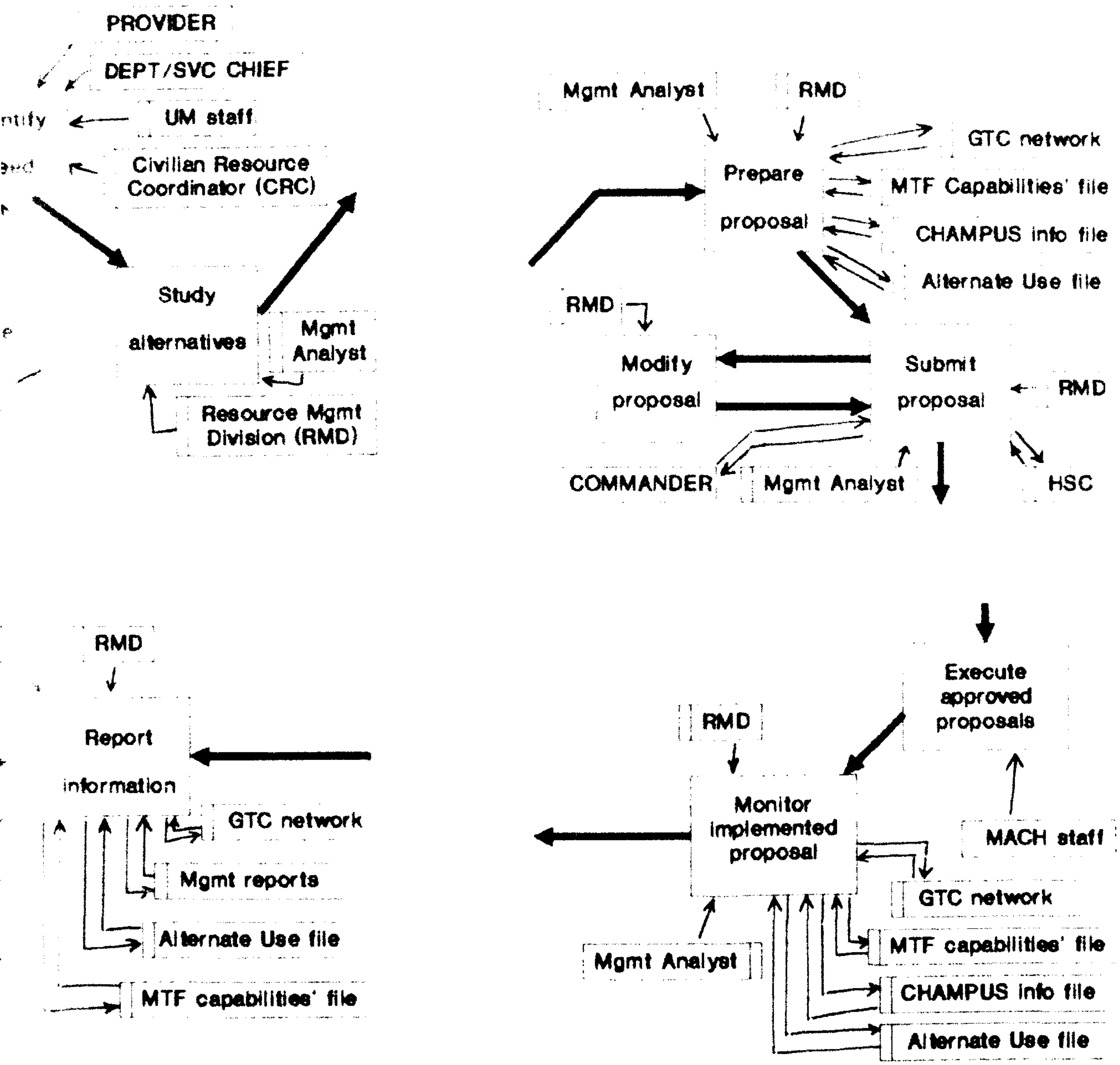
d maintain an


ents
UM Plan
d/Review/
e UM Plan
Mgmt Analyst
Auditor
UM Plan
Verify CHAMPUS percentage claimed
Validate/ document results
Agreements
UM staff
Mgmt Analyst
CHAMPUS rates
GTC network
GTC network
e
ctive
on
UM staff
ons
HSC
CHAMPUS FI
Report results
Command Group
PROVIDER
PPN
UM staff
Provider Relations

Task Eighteen -- Implement and monitor Alternate Use projects.


Resource Mgmt Division (RMD)
PROVIDER
DEPT/SVC CHIEF
Mgmt Analyst
Identify need
UM staff
Civilian Resource Coordinator (CRC)
GTC network
MTF Capabilities' file
CHAMPUS info file
Alternate Use file
Study alternatives
Mgmt Analyst
Resource Mgmt Division (RMD)
Mgmt Analyst
Prepare proposa
RMD
Modify proposal
COMMANDER
Mgmt A
Mgmt Analyst
RMD
Report information
Command Group
HSC
GTC network
Mgmt reports
Alternate Use file
MTF capabilities' file
RMD
Monitor implemented proposal
Mgmt Analyst

lement and monitor Alternate


PROVIDER
DEPT/SVC CHIEF
ntify
UM staff
Civilian Resource Coordinator (CRC)
Study alternatives
Mgmt Analyst
Resource Mgmt Division (RMD)
Mgmt Analyst
RMD
Prepare proposal
GTC network
MTF Capabilities' file
CHAMPUS info file
Alternate Use file
RMD
Modify proposal
Submit proposal
RMD
HSC
COMMANDER
Mgmt Analyst
RMD
Report information
GTC network
Mgmt reports
Alternate Use file
MTF capabilities' file
Execute approved proposals
RMD
Monitor implemented proposal
MACH staff
GTC network
MTF capabilities' file
CHAMPUS info file
Alternate Use file
Mgmt Analyst

Appendix E

Coordinated Care Division

TDA Realignment

Title	Grade	MOS	BR	Req	Auth
Office of the Chief					
Chief	04	67A00	MS	1	1
Assistant Chief	11	00671	GS	1	1
NCOIC	E7	71G40	NC	1	1
Secretary (Steno)	05	00318	GS	1	1
Paragraph Total				4	4
Clinical Support Branch					
Chief	03	67A00	MS	1	1
Professional Service NCO	E6	71G30	NC	1	1
Patient Administration Specialist	E4	71G10		1	1
Clerk Typist	03	00322	GS	1	0
Medical Clerk Typist	04	00679	GS	2	1
Paragraph Total				6	5
Medical Library					
Librarian	09	01410	GS	1	1
Library Technician	04	01411	GS	1	0
Paragraph Total				2	1

TDA Realignment

Title	Grade	MOS	BR	Req	Auth
Patient Services Branch					
Case Manager	07	00301	GS	1	1
Budget Assistant	05	00561	GS	1	1
Paragraph Total				2	2
Health Benefit Advisor					
Health Benefits Advisor	05	00962	GS	2	1
Claims Clerk	05		GS	1	0
Paragraph Total				3	1
Health Care Finder					
Supervisory Medical Clerk	05	00679	GS	1	1
Assistant Medical Clerk	04	00679	GS	1	0
Paragraph Total				2	1
Marketing/Education Branch					
Member Relations					
Patient Representative Officer	09	00671	GS	1	1
Patient Representative Assistant	05	00303	GS	1	1
Paragraph Total				2	2

TDA Realignment

Title	Grade	MOS	BR	Req	Auth
Provider Relations					
Patient Administration Specialist	E4	71G10		1	0
Paragraph Total				1	0
Management Analysis Branch					
Chief	03	67A00	MS	1	1
Professional Services NCO	E6	71G30	NC	1	1
Medical Clerk Typist	04	00679	GS	1	0
Paragraph Total				3	2
Partnership					
Civilian Resource Coordinator	07	00962	GS	1	1
Secretary	05	00318	GS	1	0
Paragraph Total				2	1
Utilization Management					
Utilization Management Coordinator	09	00301	GS	1	1
Auditor	07	00511	GS	1	0
Utilization Management Nurse		***			

*** - Note: Positions incorporated in Fiscal Year 1993 Gateway Business Plan.

TDA Realignment

Title	Grade	MOS	BR	Req	Auth
Utilization Management Clerk		***			
Paragraph Total				2	1
Management Studies					
Management Analyst	09	00343	GS	2	1
Paragraph Total				2	1

*** - Note: Positions incorporated in Fiscal Year 1993 Gateway Business Plan.

Appendix F

Ethical Statement

The purpose of the study entitled "A Systems Analysis to Determine the Optimal Organizational Design for the Coordinated Care Division at Moncrief Army Community Hospital, Fort Jackson, South Carolina" is to design the optimal organizational structure responsible to accomplish the eighteen tasks set forth by Health Services Command in the Gateway To Care program at Moncrief Army Community Hospital.

The design of the study is based on a systems analysis of the eighteen tasks as they are currently accomplished, anticipated to be accomplished under the Gateway program. The study incorporates demographic information, workload data and a critical analysis of the system's strength and weaknesses. Once the current system is analyzed, the guidance from the Department of Defense and Health Services Command's Coordinated Care Division will be examined. The study will attempt to identify potential problems and areas which require modication to the present system.

As part of the study, contact may be made with Gateway sites to seek information regarding their experiences and lessons learned. Since the

Appendix F

Ethical Statement

information contained in implementation plans and Gateway report data does not deal with personal issues and is generally accepted as within the public domain, this will take into account the ethical considerations regarding the study.

Do you have any questions regarding the study, its purpose or design?

Thank you for your assistance.