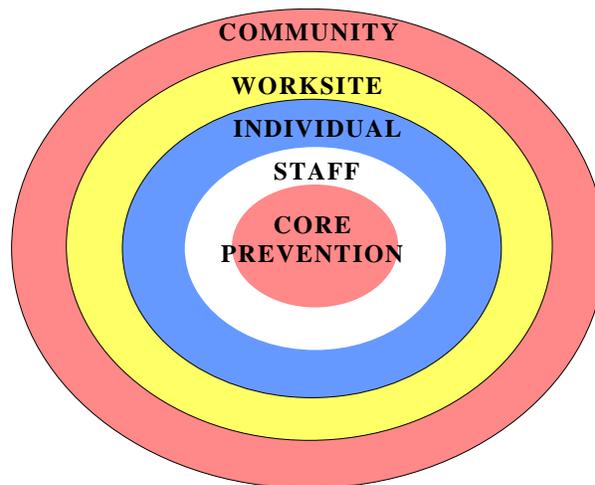


APPENDIX A
**Plan for Implementation of Put Prevention Into
Practice (PPIP) and Training Staff and Educating
Beneficiaries in Health and Fitness**

**Plan for
Implementation of Put Prevention Into Practice (PPIP)
and
Training Staff and Educating Beneficiaries
in Health and Fitness**

1. **Concept.** The Prevention Umbrella Concept serves as the philosophy to ensure that this plan establishes a link between the new preventive atmosphere (clinical preventive services, health promotion, and wellness) and the more traditional prevention (occupational health, infection control, communicable disease surveillance, vector control, food and water sanitation, etc.).

At the core of this plan is the prevention component which encompasses health promotion and wellness, Clinical Preventive Services, and self care. In order to accomplish the implementation of preventive health care as a coordinated effort throughout MHS and DOD, there must be a collaborative effort that starts with a consistent education program for our staff and beneficiaries and spreads concentrically throughout the worksite and community. Only through the creation of a common culture of prevention can we target our diminishing resources towards maintaining and promoting the individual health of our beneficiaries and the places they work and live.



2. **Test Sites.**

Each of the Services selected model sites where the plan will be implemented on a test basis. When the test data has been gathered and analyzed, and, if proven successful, the plan will be implemented DOD wide. Proposed model sites are:

- a. U.S. Army: Fort Bliss, Texas

b. U.S. Navy: Camp LeJeune, NC (Marine Corps Base); Jacksonville, FL; and Bremerton, WA

c. U.S. Air Force: Brooks Air Force Base, San Antonio, TX.

3. Timelines:

a. Broad Brush Plan due to DOD Health Affairs - 30 Jun 97

b. DOD Health Affairs' Approval of Broad Brush Plan - 31 Jul 97

c. Detailed Plan Completed - Sep 97

d. Obtain dedicated dollars for development of education program and model site training sessions (approximately \$60,000) - Oct 97

e. Baseline Evaluation initiated by Forensic Medical Advisory Service (FMAS) - Nov 97

f. Training Developed for Model Site Implementation - Jan 98

g. Structure in Place at Model Test Sites - Jan 98

h. Model Site Training Session - Jan 98

i. Implementation at Model Test Site - Apr 98

j. Core and Basic Training Accomplished - Apr 99

k. Evaluation - Preliminary Limited Evaluation by FMAS - Oct 98; Final Evaluation by FMAS - Apr 99

4. The components of the plan are defined as follows:

a. Phase One. Level one, the Core is Prevention, which encompasses:

(1) **Health Promotion and Wellness** (HP&W), as defined in DOD 1010.10 to include:

(a) Tobacco and other cessation programs

(b) Nutrition

(c) Injury Prevention

- (d) Hypertension Screening
- (e) Stress Management
- (f) Suicide Prevention
- (g) HIV/STD Education (submitted for inclusion in Draft DOD 1010.10)

- (h) Substance Abuse
- (i) Physical Fitness
- (j) Spiritual Fitness
- (k) Oral Health
- (l) Evaluation

(2) **Clinical Preventive Services (CPS)**, as defined in the PPIP Campaign, to include:

(a) Screening as defined by the U.S. Preventive Services Task Force Guide to Clinical Preventive Services and the TRICARE Prime Benefits Package

- (b) Immunizations
- (c) Chemoprophylaxis
- (d) Counseling
- (e) Evaluation
- (f) Supporting core materials and common resources

(3) **Self Care**, to include:

- (a) Standardized, age specific reference books
- (b) Training on how to use the reference books
- (c) 24-hour Nurse Advice Line provided by contractor
- (d) Evaluation Component

(4) **TRICARE Managed Care Contracts incorporate standardized DOD MHS Preventive Initiatives.**

(5) Recommended structure of the Prevention Core components includes:

(a) Prevention Oversight Committee (POC)(members include broad representation from the Military Treatment Facilities, PPIP and HP&W Coordinators, Champions) will provide guidance to the PPIP Coordinators.

- PPIP Coordinator (Full time position reporting directly to the Commander)

- Champion/Consultant (A health care provider with membership on the Oversight Committee and an advocate of PPIP)

- Committee Chairman selected from POC membership by the Commander

(b) HP&W Committee (Community/Prevention/Health Promotion focused, with representation from installation/base) will provide guidance to the HP&W Coordinator.

- HP&W Coordinator (Full-time position reporting directly to the Commander)

(6) Evaluation of the Prevention Core components includes the following elements:

(a) Structure (Manpower, tools, checklists and supporting materials)

- Types of Evaluation Tools

- Checklist (e.g., the Air Force's Health Services Inspection Checklist)

- Supporting Materials include the following:

* Self-Care Book (used by the individual at home)
* Clinicians Handbook of Preventive Services (used by providers and nurses)

* Green, M. (Ed). 1994. Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents. Arlington, VA. National Center for Education in Maternal and Child Health.(For pediatrics and adolescents)

* Guidelines for Adolescent Preventive Services (GAPS)

* Health Promotion and Disease Prevention in

Clinical Practice (Textbook for Providers)

* U.S. Preventive Services Task Force Guide to Clinical Preventive Services

* Common Flow Sheets

(b) Processes

- Assessment (HEAR is DOD designated instrument for health risk assessment)

- Intervention (Clinical PM report cards, on-going dialogue and providing initial counseling)

- Evaluation - Self Assessment/Self Inspection

- Internal/External Customer Focus

- Documentation

(c) Metrics/Outcomes

- Utilization of outcomes for marketing

- Report Cards

b. Level two, Education and Training of Staff:

(1) Executive Staff (includes MTF and Installation staff)

(2) Clinical Staff includes:

(a) Providers (Military Primary Care Managers and Nonprimary Care Managers)

(b) Ancillary Staff (Noncredentialed health care workers)

(c) Administrative Staff

(d) Civilian Health Care Provider Partnerships

(3) Prevention is incorporated into the curricula at the following levels of education/training:

(a) Core (centrally)- military medical indoctrination courses (Professional Military Education requirements)

- (b) Orientation (centrally and locally)
 - (c) Continuing (locally, regionally, and correspondence)
 - (d) Train-the-Trainer Programs (e.g. Health Promotion Director Training Course)
 - (e) Risk Communication
- (4) Documentation of training is maintained at all levels and will be service unique.
- (5) Available community-based resources are fully utilized.

c. Level three, Individual Education at the Treatment Facility:

- (1) Includes PPIP, HP&W and Self Care (**See Appendix A**)
- (2) Provided through multi-media systems to include, but not limited to, walk-ins, telephone consultations, videotapes, posters, television, and Internet
- (3) Tailored to the individual based on assessments
- (4) Keeps the individual advised of available installation and community based resources
- (5) Fostered through a culture change from the old clinical to the new prevention atmosphere
- (6) Documented in the individuals' records and on flowsheets

d. Phase Two commences at Level four, Worksite Education, which is individually and organizationally based:

- (1) Includes the Worksite Wellness Outreach Program (**See Appendix B**)
- (2) Provided through multi-media systems
- (3) Tailored based on assessments
- (4) Utilizes Train-the-Trainer programs
- (5) Includes documentation (the most effective means of

documentation and notification remains to be determined)

(6) Utilizes Mobile Units (for remote employees)

e. Phase Three incorporates Level five, Community Education and includes:

(1) Population

(a) All military beneficiaries

(b) Family members

(c) Retirees

(d) Others in the local community (as defined by each installation)

(2) Marketing a consistent message across the services

(a) Responsibility:

-Prevention Oversight and Health Promotion and Wellness Committees

-Public Affairs Office

-TRICARE and Lead Agent Marketing offices

(b) Focus:

- Maintains a general awareness of prevention

- Markets Self Care tools

- Keeps those listed above advised of available resources and available training

- Ensures the self care books are readily available

- Coordinated with the Prevention Oversight and HP&W Committees

(3) Partnership with Community Assets

(4) Community Assessment and Program Development based on Model Standards, Planned Approach To Community Health (PATCH), Assessment Protocol for Excellence in Public Health (APEXPH), and

Community Chronic Disease Prevention Program (CCDPP) (**See Appendix C**)

5. Recommendations.

a. Develop Staffing Structure for Primary Care sufficient to provide acute care, chronic care, and clinical preventive services.

b. Develop Staffing Structure for health promotion and wellness to provide individual, workplace, and community based health promotion and health education.

c. Approve AF Form 1480A as DD Form XX *Adult Preventive and Chronic Care Flowsheet*.

d. Establish Tri-Service Summary of Care Flowsheet forms for children and well-baby care.

e. Select standardized self-care book to be in use by all TRICARE regions by Jan 2000 and establish annual review process.

f. Establish National 1-800 phone number for all regions to be in place by Jan 2000.

g. Establish PPIP Working Group to prepare detailed implementation and evaluation plan for Core Prevention components. (Completed)

APPENDIX A

MHS Prevention Break-Through: Implementing and Assessing A Model Clinical Preventive Services Program

I. BACKGROUND

A. "Put Prevention Into Practice" (PPIP) is a national prevention implementation initiative developed by the US Public Health Service's Office of Disease Prevention and Health Promotion (ODPHP). The purpose of the program is to enhance the delivery of preventive care in primary care practice and to achieve the health promotion and disease prevention objectives of the nation established in Healthy People 2000. Numerous federal agencies, state, and county health departments, professional medical associations, health care organizations, health insurance companies, "Fortune 500" corporations, and consumer groups are all participating in this effort. The Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) and the Surgeons General of the Air Force, Army, and Navy have endorsed this program and expect its timely implementation within the Military Health Services System (MHS).

B. In October 1994, a Tri-Service "Put Prevention Into Practice Implementation Conference" was held. The goals of the meeting were to demonstrate the need for PPIP in MHS; seek the program's support at the highest levels of DOD and Services' medical leadership; review the scientific basis for PPIP's development and effectiveness; identify barriers to delivering clinical preventive services within the MHS; develop strategies to overcome identified barriers; develop buy-in for the program among the various medical commanders, providers, nurses, health promotion officers, public health officers, medical administrators, and others who attended the meeting; and to begin developing implementation plans for TRICARE regions and medical treatment facilities (MTFs).

C. Dr. Stephen C. Joseph, OASD/HA, stated during the October 1994 conference, "Military medicine does a good job of preparing our forces as a population, and increasingly as individuals, for staying healthy and avoiding accidental injuries; but we must continue to strive for more. We need to bring prevention and health promotion into every patient encounter whether the purpose is a visit or hospitalization. We need to identify those who are heavy drinkers, those who still smoke, and those who have less than healthy behaviors. So undoubtedly, PPIP will increase the readiness of the force; and in the long-term will prove to be an effective and beneficial use of our health care resources."

D. To meet the MHS goal, the Services have been directed to develop a program that would showcase a "prevention breakthrough." To develop this breakthrough requires reassessing barriers (e.g., staffing, resources, training), developing a viable implementation plan to overcome the barriers, and developing indicators to monitor effective implementation.

II. TEST SITES: Proposed model sites are:

- A. U.S. Army: Fort Bliss, TX
- B. U.S. Navy: Jacksonville, FL, Bremerton, WA and Camp LeJeune, NC (U.S. Marine Corps Base)
- C. U.S. Air Force: Brooks AFB, TX
- D. U.S. Coast Guard: Washington, DC and Hawaii

III. TIMELINE

- A. Detailed Plan Completed - September 1997
- B. Initiate Baseline Evaluation by Forensic Medical Advisory Service (FMAS) - November 1997.
- C. Model Site Training Session - 12 - 16 January 1998
- D. Structure in Place at Model Test sites - January 1998
- E. Phased Implementation of PPIP Education and Training at Model Test Sites - February - March 1998 (**See Annex 1**)
- F. Implementation at Model Test Site - April 1998
- G. Preliminary Evaluation by FMAS - October 1998 (**Annex 1**)
- H. Final Evaluation by FMAS - April 1999

IV. PROJECT GOAL

The overall concept of this project is to implement a PPIP campaign, which creates a specific prevention based health system that enhances the delivery of Clinical Preventive Services (CPS). These guidelines will be Tri-Service to promote implementation and maintenance of high quality, synchronized CPS delivery systems. A major goal is to implement administrative and information systems which reduce barriers of CPS at the MTF.

The objectives in **Annex 2** must be met and will be periodically reviewed for evidence of a systemic change that a prevention system is being implemented.

V. ELEMENTS/CRITERIA

A. Administrative Objectives (**Annex 2**)

1. Administration/Oversight

a. Prevention Oversight Committee

(1) Is composed of:

(a) Management

(b) Providers

(c) Nurses

(d) Quality Assurance

(e) Administration

(f) Health Promotion

(g) Public Health

(h) Enlisted Personnel

(i) Dental

(j) PPIP Coordinator

(2) The chairman will be selected by the MTF Commander.

(3) Provides oversight for PPIP with a clearly defined charter.

(4) Is involved in continual assessment, implementation, and evaluation of PPIP initiatives.

b. PPIP Coordinator. There is a full time PPIP Coordinator/Program Manager who coordinates all local PPIP activities.

c. Provider Prevention Champion. A provider prevention champion is available with at least 25 percent of his/her duty time dedicated to the PPIP program.

d. "Policy for Put Prevention into Practice (PPIP)" Memorandum. Memorandum from the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) is available.

e. Processes/MTF Plan. The plan documents how PPIP is instituted.

f. PPIP Flowsheet (**Annex 3**). A DD Form XX is used consistently and contains accurate data (either manual or electronic). **Annex 4** contains DD Form XXB, *Adult Preventive and Chronic Care Flowsheet Continuation Sheet*. **Annex 5** contains the DD Form XX, *Adult Preventive and Chronic Care Flowsheet*, Instructional Tool.

g. PPIP counseling is being documented on SF 600 using the SOAP"P" format. The additional "P" is for prevention counseling documentation.

h. Performance feedback to providers and staff is accomplished.

(1) Medical managers review individual performance measures with providers.

(2) Measures include compliance with form completion, adherence to prevention recommendations, percent of individuals who accept offered interventions, success rate of various intervention programs, etc.

2. Education/Training (**Annex 6**).

a. Focused skills training (both initial and recurring) is developed and conducted for primary care managers, nurses, technicians, clerical staff, medical records personnel, volunteers, and other providers working with prevention clients, for example:

(1) PPIP and prevention concepts are incorporated into the basic curricula in facilities that have provider, nurse, technician, and ancillary health training programs.

(2) Principles and practices of prevention intervention are included in all educational forums in the medical facility, e.g., grand rounds, journal clubs, local CME/CEU meetings, etc.

b. PPIP education for TRICARE Prime patients is accomplished via informational handouts and video presentations in waiting areas, articles in base and local newspapers, presentations at various installation and community meetings, radio and TV spots, and through referrals to health educators.

3. Resources/Systems.

a. Staffing structure for primary care is sufficient to provide acute care, chronic care, and clinical preventive services.

b. PPIP Coordinator has a dedicated computer with Internet access.

c. PPIP publications are available in clinical areas.

(1) Clinician's Handbook for Preventive Services

(2) Adult Preventive Services Timeline

(3) Child Preventive Services Timeline

(4) PPIP Waiting Room Poster

(5) Optional PPIP materials may also be used at the discretion of each Service.

d. TRICARE Prime patients have the Prevention Flowsheet (DD Form XX) in their medical record; it contains accurate data and is consistently updated.

e. An adequate reminder system/follow-up is in place to provide ongoing motivation to the clients (specific implementation determined by service).

f. A Service specific health risk assessment system is in place to ensure indicated testing and/or counseling is accomplished. Migration to Health Enrollment and Assessment Review (HEAR) is health risk assessment system designated by OASD/HA for use throughout all TRICARE Regions.

4. Marketing.

a. Executive staff indicates an understanding of preventive services and facilitates implementation.

b. Medical staff indicates an understanding of preventive services and practices prevention.

c. TRICARE Prime patients indicate an understanding of preventive services and partner with PCM in prevention.

B. Clinical Objectives (**Annex 7**). Note: There will be two sets of measurements. The measurements reported centrally will be gathered and reported as part of the official report to MHS. The measurements reported centrally will be collected, analyzed

and reported by FMAS. The measurements reported locally will be collected by FMAS and used internally by the MTF and Services as additional information for quality assurance initiatives.

1. Alcohol.
 - a. Queried regarding alcohol use during 5-year period (**central** set)
 - b. Screened for potential heavy use (**central** set)
 - c. Follow-up - Counseling (**central** set)
 - d. Accident/Injury - Visits (**local** set)
 - e. If accident/injury - Queried regarding alcohol use (**local** set)
 - f. If accident/injury - Visits with heavy use indicated (**local** set)
 - g. Follow-up - Program Referral (**local** set)
2. Cholesterol.
 - a. Any screening during 5-year period (**central** set)
 - b. Follow-up - Repeat Test (**central** set)
 - c. Follow-up - Lipoprotein (**central** set)
 - d. Follow-up - Counseling (**central** set)
 - e. Follow-up - Medication (**local** set)
3. Immunizations.
 - a. 2 year olds
 - (1) Diphtheria, Tetanus, and Pertussis Immunizations (4 DPT); Oral or Inactivated Polio Vaccine (3 Polio); and Measles, Mumps, and Rubella Vaccine Series (1 MMR) (**central** set)
 - (2) Hepatitis B (3), Haemophilus Influenzae Type b (3), and Varicella (1) Vaccines (**central** set)

- b. Active duty
 - (1) Influenza (**central** set)
 - (2) Hepatitis A (**central** set)
- 4. Mammograms.
 - a. Breast cancer screening (**central** set)
 - b. Follow-up - Days to notification of abnormal result (**central** set)
 - c. Follow-up - Days from notification to follow-up (**local** set)
 - d. Follow-up - Days from mammogram to follow-up (**local** set)
- 5. Pap Smear.
 - a. Cervical cancer screening (**central** set)
 - b. Follow-up - Days to notification of abnormal result (**central** set)
 - c. Follow-up - Days from notification to follow-up (**local** set)
 - d. Follow-up - Days from Pap Smear to follow-up (**local** set)
- 6. Reproductive Counseling.
 - a. Ever queried/advised regarding STDs during 5-year period (**central** set)
 - b. Follow-up - Counseling (**central** set)
 - c. Follow-up - Hepatitis B Vaccine (**central** set)
- 7. Tobacco.
 - a. Screening for use (**central** set)
 - b. Advising smoker to quit (**central** set)

B. Monitoring and Evaluation.

1. FMAS Corporation will be contracted to provide the clinical objective evaluation.

2. As part of the agreement with FMAS, the model sites will be responsible for ensuring the required medical records are available for the review process. Each model site is to make every effort to locate and have available the medical records at the MTF prior to FMAS's arrival.

3. The implementation objectives will be evaluated with the use of site surveys, database analysis, and record review.

4. As part of the evaluation process, the 1996 *Clinical Preventive Services Quality Management Review* will be used as a standard for developing the initial baseline. The 1996 report represents the first comprehensive effort to evaluate key ambulatory care quality parameters across different age groups, beneficiary categories and clinical interventions in the MHS.

Annexes:

1. Phased Implementation of PPIP
2. Table - Administrative Objectives
3. DD Form XX, *Adult Preventive and Chronic Care Flowsheet Form*
4. DD Form XX, *Adult Preventive and Chronic Care Flowsheet - Continuation Sheet*
5. DD Form XXB, *Adult Preventive and Chronic Care Flowsheet General Instructions*
6. Table - Staff Education Requirements
7. Table - Clinical Objectives

ANNEX 1

PHASED IMPLEMENTATION FOR PPIP

PPIP implementation will be completed in several phases. The initial phase will begin with the establishment of a systems approach to preventive health care. Changes in administrative procedures, staffing levels, training, and information systems that reduce the barriers to the delivery of Clinical Preventive Services are necessary to accomplish systemic change. Most of the outcomes at the end of this phase will be derived from the new processes needed to build this prevention based system.

FMAS Corporation will be contracted to establish baselines for the delivery of Clinical Preventive Services. As the new systems approach is used in Primary Care Clinics, clinical outcomes can be prospectively tracked and compared to these baselines. An assessment of progress in these clinical outcomes will be conducted six months after the start-up at each site. These clinical outcomes evaluated at this midpoint assessment will be an abbreviated set of all those outcomes to be measured one year after start-up. Process outcomes will be measured as a component in internal quality review by each test site.

Process Outcomes (measured 6 months after start-up)

1. Prevention Committee established.
2. PPIP Coordinator appointed.
3. PPIP Provider Champion appointed.
4. PPIP local plan completed.
5. DD Form XX flowsheet used in at least 75% of TRICARE Prime medical records.
6. PPIP Counseling documented on SF600 in at least 75% of TRICARE Prime medical records.
7. SOAP-P medical record format used in at least 75% of TRICARE Prime medical records.
8. Performance feedback to providers completed monthly.
9. PPIP Training completed for 75% of primary care staff.
10. PPIP educational materials provided to 75% of TRICARE Prime patients seen at medical facility.

11. PPIP Coordinator has dedicated computer with Internet access.
12. PPIP Clinician's Handbook provided to 75% of primary care staff.
13. Reminder system established.
14. Risk assessment and counseling available for TRICARE Prime enrollees. Summary population report available for all enrollees with completed risk assessments.

Clinical Outcome Objectives (measured 6 months after start-up) Note: At 12 months after start-up the criteria will increase to at least 20% above baseline or at least 90% as outlined in Annex 7.

1. Screening for alcohol use baseline established.
2. Screening for alcohol use increased from baseline to at least 10% above baseline for or at least 60%.
3. Screening for potential heavy alcohol use baseline established.
4. Screening for potential heavy alcohol use increased from baseline to at least 10% above baseline or at least 60%.
5. Cholesterol screening baseline established.
6. Cholesterol screening increased from baseline to at least 10% above baseline or at least 60%.
7. Immunizations baseline established for children at age two.
8. Immunizations for children at age two increased from baseline by at least 10% or at least 75%.
9. Influenza immunization baseline established for active duty personnel.
10. Influenza immunizations increased from baseline by at least 10% or at least 75%.
11. Mammogram screening baseline rate established for women 50-69 years.
12. Mammogram screen rates increased above baseline by at least 10% or at least 60%.

13. Pap smear baseline established for women 21 to 64.
14. Pap smear rates increased above baseline by at least 10% or at least 60%.
15. Reproductive counseling baseline rates established for adults ages 17 years and over.
16. Reproductive counseling rates increased above baseline by at least 10% or at least 60%.
17. Sexually Transmitted Disease (STD): baseline screening for Hepatitis B established for adults ages 17 years and older.
18. Rates for Hepatitis B increased above baseline by at least 10% or at least 60%.
19. Tobacco use screening baseline established.
20. Tobacco use screening increased above baseline by at least 10% or at least 60%.

Annex 2
DOD PPIP Model Project
Administrative Objectives*
Table

General Objective Area	Element	Indicator	Tool for Obtaining Data
Administration/Oversight	Prevention Oversight Committee	1. Is composed of management, providers, nursing, quality assurance, administration, health promotion, public health, enlisted personnel, dental, and PPIP. 2. Provides oversight for PPIP with a clearly defined charter. 3. Is involved in continual assessment, implementation, and evaluation of PPIP initiatives.	Survey
Administration/Oversight	PPIP Coordinator	There is a full time PPIP Coordinator/Program Manager who coordinates all local PPIP activities.	Survey
Administration/Oversight	Provider Prevention Champion	A provider prevention champion is available with at least 25 percent of his/her duty time dedicated to the PPIP program.	Survey
Administration/Oversight	"Policy for Put Prevention into Practice (PPIP)" Memorandum.	Memorandum from the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) is available.	Survey
Administration/Oversight	Processes/MTF Plan	A Process/MTF Plan is available documenting how PPIP is instituted	Survey
Administration/Oversight	PPIP Flowsheet	A DD Form XX Flowsheet is used consistently and contains accurate data (either manual or electronic).	Medical Records and PHCS
Administration/Oversight	SF 600	PPIP counseling is being documented on SF 600 using the SOAP"P" format. The additional "P" is for prevention counseling documentation. (either manual or electronic).	Medical Records
Administration/Oversight	Performance Feedback	Performance feedback to providers and staff is accomplished 1. Medical managers review individual performance measures with providers 2. Measures include compliance with form completion, adherence to prevention recommendations, percent of individuals who accept offered interventions, success rate of various intervention programs, etc.	Survey and medical records chart audit

Education/Training	Train all assigned medical personnel, participating in the PPIP Program, in the concept of PPIP, office materials used, documentation required, tools used in discussing prevention with patients, and outcome measurements	Focused skills training (both initial and recurring) are developed and targeted to primary care managers, nurses, technicians, clerical staff, medical records personnel, volunteers, and any other providers working with prevention clients, for example: 1. PPIP and prevention concepts is incorporated into the basic curricula in facilities that have provider, nursing, technician, and ancillary health training programs 2. Principles and practice of prevention interventions are included in all educational forums in the medical facility, e.g., grand rounds, journal clubs, local CME/CEU meetings, etc.	Survey
Education/Training	Provided prevention educational opportunities to TRICARE Prime patients and other beneficiaries.	PPIP education for TRICARE Prime patients is accomplished via: Informational handouts and video presentations in waiting areas, articles in base and local newspapers, presentations at various installation and community meetings, radio and TV spots, and through referrals to health educators. Standardized material will be provided by the MHS Working Group.	Survey
Resources/Systems	Staffing	Staffing structure for primary care sufficient to provide acute care, chronic care, and clinical preventive services.	Survey
Resources/Systems	Computer and Internet Support	PPIP Coordinator has a dedicated computer with Internet access	Survey
Resources/Systems	PPIP Publications	PPIP publications are available in clinical areas. 1. At least 90 percent of the primary care providers have a current copy of the "Clinician's Handbook of Preventive Services." 2. At least 90 percent of the exam rooms and waiting areas have the Timeline and PPIP Posters.	Survey
Resources/Systems	PPIP Forms	At least 90 percent of the TRICARE Prime patients seen by a PCM within the last year have the Prevention Flowsheet in their medical record, which are used consistently and contain accurate data.	Survey
Resources/Systems	Reminder System	Adequate reminder system/follow-up is in place to provide ongoing motivation to the clients (specific implementation determined by service).	Survey
Resources/Systems	Service specific Health Risk Assessment System (HEAR is DOD designated system)	A Service specific health risk assessment system is in place to ensure indicated testing and/or counseling is accomplished.	Survey
Marketing	Increase awareness of executive staff concerning preventive services	Executive staff indicates an understanding of preventive services	Survey
Marketing	Increase awareness of medical staff concerning preventive services	Medical staff indicates an understanding of preventive services	Survey
Marketing	Increase awareness of patients concerning preventive services	TRICARE Prime patients indicate an understanding of preventive services	Survey

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

VI FAMILY HISTORY *(See Key)*

KEY: M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather

Cancer <i>(Specify)</i>	
Cardiovascular Disease <i>(Specify)</i>	
Diabetes <i>(Specify)</i>	
Mental Illness / Chemical Dependency <i>(Specify)</i>	

VII SCREENING EXAMS *(See Key)*

KEY: * = Actual Result, ** = TRICARE Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused, NA = Not Indicated ? = Next Due

TEST	FREQUENCY	YEAR						
		AGE						
1 Clinical Disease Prev Eval / PHA (HEAR)	ANNUAL		0	0	0	0	0	0
*2 Weight	ANNUAL for Active Duty		0	0	0	0	0	0
*3 Height	ANNUAL for Active Duty		0	0	0	0	0	0
*4 Blood Pressure	Once q 2 yrs for BP< 130/85, Annually if greater		0	0	0	0	0	0
*5 Cholesterol**	q 5 yrs for age > 18 q year if prev abn		0	0	0	0	0	0
6 Hearing	Clinician's Discretion		0	0	0	0	0	0
7 Skin Exam <i>(Cancer)</i>	Annual if at Risk		0	0	0	0	0	0
8 Oral / Dental**	Annual		0	0	0	0	0	0
9 Eye / Vision**	Routine acuity with periodic assessment Diabetics annually Glaucoma Check: Blacks q 3-5 yrs age 20-39 ALL q 2-4 years age 40-64		0	0	0	0	0	0
10 Breast Exam	Annual: > 40 yrs		0	0	0	0	0	0
11 Mammogram**	Baseline @ 40, q 2 yrs 40-50 annually > 50		0	0	0	0	0	0
12 PAP <i>** (Digital Rectal Exam)</i>	Baseline: Age 18 or onset of sexual activity After 3 nl annual exams, perform q 1-3 years		0	0	0	0	0	0
13 Fecal Occult Blood	Annual: > 50 yrs		0	0	0	0	0	0
14 Sigmoid	Every 3-5 yrs: > 50 yrs		0	0	0	0	0	0
15 Colonoscopy**	High Risk q 5 years: > 40 yrs		0	0	0	0	0	0
16 Testicular**	High Risk annual 13-39 yrs		0	0	0	0	0	0
17 Prostate** <i>** (Digital Rectal Exam)</i>	With P. E. > 40 yrs <i>(presently recommended annually)</i>		0	0	0	0	0	0
18 Rubella Screen <i>(Females)</i>	Once between ages 12-18 yrs <i>(unless previously vaccinated)</i>		0	0	0	0	0	0
19 Occupational Screening Exams	Appropriate to Exposures		0	0	0	0	0	0
20			0	0	0	0	0	0
21			0	0	0	0	0	0
22			0	0	0	0	0	0

DD FORM XX

NOT AN OFFICIAL FORM

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

VIII OCCUPATIONAL HISTORY / RISK

PRP Y N

Flying Status Y N

(Enter numeric class in sub block)

IX IMMUNIZATIONS

	Date (DDMMYYYY)		Date (DDMMYYYY)		Date (DDMMYYYY)		Date (DDMMYYYY)
Hep A #1		MMR #1		Td (q 10 yrs) (Last)			
Hep A #2		MMR #2		Td (Due)			
Hep B #1		Pneumococcus		Yellow Fever (Last)			
Hep B #2		Polio OPV = O IPV = I		Yellow Fever (Due)			
Hep B #3							

Typhoid <small>(Enter numeric class in sub block)</small>	Oral =0 Typhim Vi = 1 Typhoid USP =2	Last Date:	Date:	Date:	Date:	Date:	Date:
Anthrax	Initial Date:	2 Week Date:	4 Week Date:	6 Month Date:	12 Month Date:	18 Month Date:	
PPD <small>(Enter mm and Date)</small>	mm:	mm:	mm:	mm:	mm:	mm:	mm:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Influenza	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Varicella	Date:	Date:	J E V	Date:	Date:	Date:	Date:
Meningo	Date:	Date:		Other:	Date:	Date:	Date:
Adeno	Date:	Date:		Other:	Date:	Date:	Date:

X READINESS

DNA	Date:	Blood Type	Date:	Result:	G6PD	Date:	Result:	Sickle Cell	Date:	Result:
Permanent Profile Change	Date:	P:	U:	L:		H:	E:	S:		
Glasses / Gas Mask Rx:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Dental Exam <small>(Enter numeric class in sub block)</small>	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
HIV Testing	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Fitness <small>(in sub block enter P=Pass F=Fail W=Waiver)</small>	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:

XI PRE / POST DEPLOYMENT HISTORY

LOCATION:						
Predeployment	Date:	Date:	Date:	Date:	Date:	Date:
Postdeployment	Date:	Date:	Date:	Date:	Date:	Date:
LOCATION:						
Predeployment	Date:	Date:	Date:	Date:	Date:	Date:
Postdeployment	Date:	Date:	Date:	Date:	Date:	Date:
CHART AUDIT	0	0	0	0	0	0

PRIVACY ACT STATEMENT

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU

AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) is required to identify and retrieve health records.

ROUTINE USES

The primary use of this information is to provide, plan, and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: aid in preventive health and communicable disease control programs and report medical condition required by law to federal, state, and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state or local government upon request in the pursuit of their official duties.

WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL IF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Annex 5

DD FORM XX, ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET GENERAL INSTRUCTIONS

This instructional tool clarifies documentation for DD Form XX, *Adult Preventive and Chronic Care Flowsheet*, for use with all active duty and TRICARE Prime enrollees. It explains the organization of the form and outlines methods of incorporating this form into the medical system. DD Form XX replaces the current service specific patient problem list (DA Form 5571, *Master Problem List*; SF 539, *Problem Summary List*; and AF Form 1480, *Summary of Care*) and adult PPIP flowsheet. DD Form XX consolidates the information from these two forms, giving providers in the field more information to streamline care, and assures all standards of care are met. The form, after approval by DoD, will be utilized by all Services and provide continuity of care in the TRICARE system and during deployment. DD Form XX is intended as an interim measure until the Preventive Health Care System (PHCS) is deployed to all sites and the form becomes automated. The life expectancy of this form is six (6) years.

DD Form XX is designed to track CPS as reported by the U.S. Preventive Services Task Force (USPSTF) in the *Guide to Preventive Services*, 2nd ed.; TRICARE Prime Benefit package; Advisory Committee on Immunization Practices (ACIP); and AFJI 48-110, AR 40-562, BUMEDINST 6230.15, and CG COMDTINST M6230.43, *Immunizations and Chemoprophylaxis* (covers immunization and deployment requirements). (Note : Sections are aligned for future use with the automated PHCS program to streamline data transference by non-medical personnel). Additional squares are added in specific prevention areas to draw attention to high risk areas and allow individualization of the form based on specific risk factors.

All information documented in the medical record is considered a part of the legal document and will not be discarded from the medical record at any time. With the initiation of DD Form XX, information from the current service specific patient problem list will be transcribed onto DD Form XX. Ink is required except in the "ordering exam" section, which is explained in Section VII below. After transcribing data, a line will be drawn through the information and the word "*Transcribed*" will be written along the line with the date, full name, rank, and Service specific specialty code of the transcribing individual. The previous Service specific patient problem list will remain with the medical record and be placed behind the current DD Form XX and the Service specific health risk assessment for Primary Care Managers Report. If there is a Service specific adult PPIP flowsheet it will **not** have to be immediately transcribed onto DD Form XX. The Service specific adult PPIP flowsheet can temporarily be attached to the bracket on the right-hand side of the inner section of DD Form XX until the patient receives his/her next (or first) prevention screening (including the Service specific health risk assessment) or enrollment in TRICARE Prime. After the patient receives his/her first full documentation of preventive services, the adult PPIP flowsheet will be placed behind the "*transcribed*" previous Service specific patient problem list. Be sure the Service specific adult PPIP flowsheet information is documented and transcribed following the same procedure as above. DD Form XX will be

located where the previous Service specific patient problem list is located. The approved order of forms is DD Form XX, the Service specific health risk assessment report, previous Service specific patient problem list, and Service specific adult PPIP flowsheet.

DD Form XXB, *Adult Preventive and Chronic Care Flowsheet - Continuation Sheet*, is a continuation form for documentation of information that cannot fit on DD Form XX or for local requirements. If an automated immunization tracking system is used, it may replace the immunization documentation on DD Form XX as long as a copy of the immunization report is attached to the DD Form XX.

Upon deployment of DD Form XX and DD Form XXB, previous editions (e.g., AF Form 1480A and AF Form 1480B) will be used until stock is depleted.

DOCUMENTATION: SECTIONS I THROUGH XI

Section I - Allergies. Write the medication and other types of allergies within the area noted.

Section II - Chronic Illness. List chronic illnesses.

Section III - Medications. List current medications to include dosage, frequency, and purpose (e.g., Inderal LA - Hypertension verses Migraine control).

Section IV - Hospitalizations/Surgeries. List hospitalizations and all surgeries to include dates.

Section V - Preventive Counseling. Date, Age, and Topic are intended to be filled in at the annual prevention assessment (e.g., TRICARE Prime enrollment, or Preventive Health Assessment, or when the Service specific health risk assessment is evaluated and the patient is counseled). **NOTE: HEAR is the DOD designated health risk assessment.** Counseling is listed from general to specific. Place the letter associated with the type of counseling given in the corresponding square (e.g., "F" for Fitness). When all preventive health topics are addressed, you may write "all areas addressed" in the block. Please circle the letter which corresponds to the individual's high risk profile. Extra squares are provided for documentation of "outstanding" high risk preventive counseling accomplished at times other than the annual assessment (e.g., alcohol abuse, mental health concerns, etc.). This is NOT to be used at EVERY visit - document counseling initiatives on the current SF 600 at every visit. **THE COUNSELING BLOCK IS NOT INTENDED TO TAKE THE PLACE OF QUALITY COUNSELING DOCUMENTATION ON THE SF 600, or assumed to be an official referral for further education at community-based services.**

Section VI - Family History. In the larger block, fill in the family member's designation with the corresponding disease, using the key provided. Specify the types of illness/disease. Document the age of the family member at the time of death if there is a correlation between the illness/disease process.

Section VII - Screening Exams.

Exams are listed from general to specific. Fill in the current year and age of the patient in the first block of the frequency field and continue out for six years.

- C CIRCLES. Circles under the date/age field are filled in to denote the next time the test is due.
- C DOCUMENTATION OF DATA.
 - C Pencil in the date the exam is ordered
 - C Use ink when the exam is completed and the results are written on the form
 - C Use the proper key code or write in the actual results in the blocks
 - C Update each flowsheet every time preventive care is ordered, performed, or results are returned.

Section VIII - Occupational History. Check the appropriate box and list the exposure hazards as needed.

Section IX - Immunizations.

Ink, sticker, rubber stamp, or automated documentation required. The date and type of immunization must be recorded. Titers will be documented by the date and result, using the corresponding date square.

Open data squares are present to allow for flexibility of this form, in case an injection or titer is required that is not presently listed.

IAW the National Vaccine Injury Compensation Program, appropriate vaccine information must be recorded (per Service specific regulatory guidance, AFJI 48-110/AR 40-562/BUMEDINST 6230.15/CG COMDTINST M6230.4E, and PHS 731 for all personnel). The date square may be filled in by hand, stamp, sticker, or via automation in order to comply with national regulations. If documentation of the date and lot number are recorded in the medical record, it does not have to be duplicated on the DD Form XX. To accomplish this labor intensive tasking, added resources (e.g. manpower, technical support, etc.) should be considered. MTFs may also use bar-coding to log in the lot information into their automated system.

Section X - Readiness. Date and information required will be placed in the appropriate spaces. The optometry prescription will be written directly below the "Glasses/Gas Mask" description block. Changes of the prescription may be documented within the date block as needed. A blank section may also be used for this information.

Section XI - Deployment. Documentation of the deployment location as well as the completion date of the pre and post deployment evaluations is entered here. If personnel run out of space for deployment history, the Continuation Sheet will be placed in the DD Form XX bracket, which is located inside the DD Form XX folder on the right hand side. Data fields on the continuation sheet can be changed to reflect the information required. Those participating in Classified Operations must also keep a record of deployments and pre- and post-op evaluations in their personnel folders.

DEPLOYMENT INSTRUCTIONS

Use of DD Form XX during deployment will be based on individual Services' regulations.

If DD Form XX is the only medical documentation to accompany military personnel, the following instructions are recommended. DD Form XX will be photocopied prior to deployment and the copy will be kept in the medical record. The original DD Form XX folder will accompany the individual to the field. If the deployed member receives medical care, a copy of SF 600 will be placed in the bracket inside the folder. On return to the MTF (post deployment), SF 600 will be removed from the DD Form XX folder and placed with the other SF 600's in the medical record. The photocopy of the **DD Form XX** will be removed and shredded when the original is placed back into the record.

CHART AUDIT

Reserved for official JCAHO and military inspections. May also be used for the auditing of this form for the test survey. Place audit date in the designated square.

Annex 6
Staff Education Requirements
Table

Staff Job Title	Task	Task Example	Required Education Content
Appointment Clerk	1. Counsels	1. Reminder to bring shot record 2. Reminder to bring Service specific health risk assessment printout to appointment.	Module One: 1. Overview of PPIP 2. Scripted encounters for appointment clerks 3. Customer service techniques for appointment clerks
Administrative Technician	1. Performs patient check-in/check-out 2. Provides preprinted SF600 / Service specific health risk assessment Questionnaire 3. Ensures DD Form XX template type form is in medical record 4. Counsels	1. Provide PPIP Health Habits Questionnaire 2. Communicate PPIP message of the day	Module Two: 1. Contents of Module One plus 2. Scripted encounters for administrative technicians 3. Overview of systems thinking 4. Customer service techniques for administrative technicians 5. Counseling techniques 6. Causes of morbidity and mortality 7. Stages of change
Medical Technician	1. Performs vital signs 2. Educates about Personal Health Guides 3. Reviews health habits questionnaire; 4. Counsels 5. Completes flowchart on DD Form XX template type form	1. Provide reminders for providers about specific risk factors 2. Distributes Personal Health Guides 3. PPIP message of the day.	Module Three: 1. Contents of Modules One and Two, plus 2. Scripted encounters for medical technicians 3. Customer service techniques for medical technicians 4. Algorithms for risk factors, vital signs, flowcharting 5. Counseling techniques for lifestyle risk factor reduction 6. Self-care book, personal health guides, contents of health education materials used at command 7. Preventive health and health promotion resources available in the region 8. QI process
Provider	1. Performs history and physical 2. Addresses highlighted items on Health Habits Questionnaire 3. Completes flowchart DD Form XX template type form 4. Makes preventive medicine and other appropriate referrals and consultations	1. Check boxes next to preprinted comments to indicate whether there are Preventive Health issues 2. Check boxes regarding preventive health services, clinics	Module Four: 1. Contents of Modules One, Two, and Three, plus 2. Motivational interviewing techniques 3. Decision balance techniques 4. United States Preventive Services Task Force (USPSTF) Guidelines 5. TRICARE Prime Benefit 6. Immunization training IAW ACIP guidelines 7. Clinical Preventives services

Health Educator or Nurse Educator	<ol style="list-style-type: none"> 1. Provides health education literature 2. Counsels 3. Initiates referrals per local procedures 	1. Addresses issues represented by boxes checked by provider	Module Four
Case Manager	<ol style="list-style-type: none"> 1. Provides clinical case management (e.g. diabetes) to move from tertiary prevention to secondary prevention 2. Is consultant and clinic resource for staff education 		Module Four plus: Case management skills
PPIP Coordinator	<ol style="list-style-type: none"> 1. Tracks/studies patient flow patterns in clinic(s) 2. Interfaces with UM/QM committees 3. Interfaces with case managers 4. Coordinates/ provides staff education on PPIP 5. Serves as consultant on PPIP resources 6. Performs/monitors QI 7. Complements provider champion in staff education efforts 		Module Five: <ol style="list-style-type: none"> 1. Contents of Modules One, Two, Three, and Four, plus: 2. CHCS training to get customized reports 3. PHCS training 4. Health Promotion Director Training Certification Course
PPIP Provider Champion	<ol style="list-style-type: none"> 1. Is involved with all levels of staff education 2. Advocates prevention by word and deed 3. Consults on PPIP throughout system 		Module Six: <ol style="list-style-type: none"> 1. Contents of Module Five, plus 2. Automation systems training (CHCS, PHCS) for outcomes reports 3. Population-based medical practices 4. Health outcomes
Commander, Executive Officer, MTF Executive Committee, Prevention Oversight Committee	<ol style="list-style-type: none"> 1. Reviews Service specific health risk assessment and region specific morbidity data 2. Assess and prioritize community needs 3. Directs priorities for preventive services 		Module Seven (Executive Module) <ol style="list-style-type: none"> 1. Overview of PPIP 2. Overview of systems thinking 3. USPSTF Guidelines 4. Stages of Change 5. Population-based medical practices 6. Health outcomes

Annex 7
DoD PPIP Model Project
Clinical Objectives*
Table

* Baseline data will be determined by a pre-implementation evaluation by FMAS.

Criteria	Indicator	Target Population	Tools for Obtaining Data
Alcohol: Queried Regarding Alcohol Use During 5-Year Period (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent	TRICARE Prime patients who are continuously enrolled during the reporting year	CHCS, Service specific health risk assessment, Records Review
Alcohol: Indicate Potential Heavy Use (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent. NOTE: Each service has the option of using one of three methods for screening: 5 drinks per sitting, CAGE (Cut, Annoyed, Guilty, and Eye-opener) Questionnaire, or Michigan Alcoholism Screening Test (MAST).	TRICARE Prime patients who are continuously enrolled during the reporting year, and who indicated alcohol use during the past 5-years.	CHCS, Service specific health risk assessment, Records Review
Alcohol: Follow-up: Counseling (Central Set)	Increase counseling for patients indicating potential heavy use of alcohol from baseline to at least 20 percent above baseline or at least 90 percent.	TRICARE Prime patients who are continuously enrolled during the reporting year and the preceding year, and who indicated heavy alcohol use during the past 5-year period; or patients who are treated in the MTF for an accident or injury, and who indicated heavy use of alcohol.	CHCS, Service specific health risk assessment, Records Review
Alcohol: Accident/Injury: Visits (Local Set)	Number of patient visits to the MTF for accident or injury.	Patients who are treated in the MTF for an accident or injury during the reporting year and the preceding year.	CHCS, Service specific health risk assessment, Records Review
Alcohol: If Accident/Injury: Queried regarding Alcohol Use (Local Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent	Patients who are treated in the MTF for an accident or injury during the reporting year and the preceding year.	CHCS, Service specific health risk assessment, Records Review
Alcohol: If Accident/Injury: Visits With Heavy Use Indicated (Local Set)	Number of patients visits to the MTF for accident or injury resulting in the heavy use of alcohol	Patients who are treated in the MTF for an accident or injury, and who indicated heavy use of alcohol during the reporting year and the preceding year.	CHCS, Service specific health risk assessment, Records Review

Alcohol: Follow-up: Program Referral (Local Set)	Increase patient referral to a program for assistance with cessation or decrease of alcohol intake from baseline to at least 20 percent above baseline or at least 90 percent.	TRICARE Prime patients who are continuously enrolled during the reporting year and the preceding year, and who indicated heavy alcohol use during the past 5-year period; or patients who are treated in the MTF for an accident or injury, and who indicated heavy use of alcohol	CHCS, Service specific health risk assessment, Records Review
Cholesterol: Any Screening During 5-Year Period (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent NOTE: Cholesterol criteria will following the National Cholesterol Education Program (NCEP) guidelines.	TRICARE Prime males at least 35 years and TRICARE Prime females at least 45 years who are continuously enrolled during the reporting year and the preceding year	CHCS, Service specific health risk assessment, Records Review
Cholesterol: Follow-up: Repeat Test (Central Set)	Increase follow-up from baseline to at least 20 percent above baseline or at least 90 percent NOTE: Cholesterol criteria will follow the NCEP guidelines.	TRICARE Prime males at least 35 years and TRICARE Prime females at least 45 years who are continuously enrolled during the reporting year and the preceding year, and had an abnormal cholesterol result	CHCS, Service specific health risk assessment, Records Review
Cholesterol: Follow-up: Lipoprotein (Central Set)	Increase follow-up from baseline to at least 20 percent above baseline or at least 90 percent NOTE: Cholesterol criteria will following the NCEP guidelines.	TRICARE Prime males at least 35 years and TRICARE Prime females at least 45 years who are continuously enrolled during the reporting year and the preceding year, and had an abnormal cholesterol result	CHCS, Service specific health risk assessment, Records Review
Cholesterol: Follow-up: Counseling (Central Set)	Increase follow-up from baseline to at least 20 percent above baseline or at least 90 percent NOTE: Cholesterol criteria will following the NCEP guidelines.	TRICARE Prime males at least 35 years and TRICARE Prime females at least 45 years who are continuously enrolled during the reporting year and the preceding year, and had an abnormal cholesterol result.	CHCS, Service specific health risk assessment, Records Review
Cholesterol: Follow-up: Medication (Local Set)	Percent of patients prescribed medication NOTE: Cholesterol criteria will following the NCEP guidelines.	TRICARE Prime males at least 35 years and TRICARE Prime females at least 45 years who are continuously enrolled during the reporting year and the preceding year, and had an abnormal cholesterol result.	CHCS, Service specific health risk assessment, Records Review

<p>Immunizations: 2 Year Olds: Diphtheria, Tetanus, and Pertussis Immunization; Oral or Inactivated Polio Vaccine; and Measles, Mumps, and Rubella Vaccine Series (Central Set)</p>	<p>Increase immunizations from baseline to at least 20 percent above baseline or at least 90 percent.</p>	<p>TRICARE Prime children who turned two years old during the reporting year, who are continuously enrolled for 12 months immediately preceding their second birthday.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Immunizations: 2 Year Olds: Hepatitis B Vaccine and Hemophilus Influenza B Vaccine, and Varicella (Central Set)</p>	<p>Increase immunizations from baseline to at least 20 percent above baseline or at least 90 percent.</p>	<p>TRICARE Prime children who turned two years old during the reporting year, who are continuously enrolled for 12 months immediately preceding their second birthday.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Immunizations: Active Duty: Influenza (Central Set)</p>	<p>Increase immunizations from baseline to at least 20 percent above baseline or at least 90 percent.</p>	<p>All active duty members who are continuously enrolled during the reporting year.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Immunizations: Active Duty: Hepatitis A (Central Set)</p>	<p>Increase immunizations from baseline to at least 20 percent above baseline or at least 90 percent.</p>	<p>All active duty members who are continuously enrolled during the reporting year who have at least one Hepatitis A vaccine.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Mammograms: Breast Cancer Screening (Central Set)</p>	<p>Increase screening from baseline to at least 20 percent above baseline or at least 90 percent</p>	<p>Women, ages 50 through 69 years at time of testing, who are continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Mammograms: Follow-up: Days to Notification of Abnormal (Central Set)</p>	<p>Notification period within 14 days or less, with an increase from baseline to at least 20 percent above baseline or at least 90 percent</p>	<p>Women, ages 50 through 69 years at time of testing, who are continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year, and had an abnormal mammogram.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>
<p>Mammograms: Follow-up: Days from Notification to Follow-up (Local Set)</p>	<p>Follow-up appointment within 30 days or less of notification, with an increase from baseline to at least 20 percent above baseline or at least 90 percent</p>	<p>Women, ages 50 through 69 years at time of testing, who are continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year, and had an abnormal mammogram.</p>	<p>CHCS, Service specific health risk assessment, Records Review</p>

Mammograms: Follow-up: Days from Mammogram to Follow-up (Local Set)	Follow-up appointment within 45 days or less of mammogram, with an increase from baseline to at least 20 percent above baseline or at least 90 percent	Women, ages 50 through 69 years at time of testing, who are continuously enrolled during the reporting year and the preceding year, and who had a mammogram during the reporting year or the preceding year, and had an abnormal mammogram.	CHCS, Service specific health risk assessment, Records Review
Pap Smear: Cervical Cancer Screening (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent	Women, ages 21 through 64 years who are continuously enrolled during the reporting year and who received one or more Pap tests during the reporting year or the two years prior to the reporting year.	CHCS, Service specific health risk assessment, Records Review
Pap Smear: Follow-up: Abnormal Pap Smear (Central Set)	Notification period within 14 days or less, with an increase from baseline to at least 20 percent above baseline or at least 90 percent	Women, ages 21 through 64 years who are continuously enrolled during the reporting year and who received one or more Pap tests during the reporting year or the two years prior to the reporting year, and had an abnormal Pap Smear.	CHCS, Service specific health risk assessment, Records Review
Pap Smear: Follow-up: Days from Notification to Follow-up (Local Set)	Follow-up appointment within 30 days or less of notification, with an increase from baseline to at least 20 percent above baseline or at least 90 percent	Women, ages 21 through 64 years who are continuously enrolled during the reporting year and who received one or more Pap tests during the reporting year or the two years prior to the reporting year, and had an abnormal Pap Smear.	CHCS, Service specific health risk assessment, Records Review
Pap Smear: Follow-up: Days from Pap Smear to Follow-up (Local Set)	Follow-up appointment within 45 days or less of Pap Smear, with an increase from baseline to at least 20 percent above baseline or at least 90 percent	Women, ages 21 through 64 years who are continuously enrolled during the reporting year and who received one or more Pap tests during the reporting year or the two years prior to the reporting year, and had an abnormal Pap Smear	CHCS, Service specific health risk assessment, Records Review
Reproductive Counseling: Ever Queried/Advised regarding STDs During 5-Year Period (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent	Adults, ages 17 years and older as of December 31 of the reporting year, who are continuously enrolled during the reporting year, and who are seen by a plan provider during the reporting year	CHCS, Service specific health risk assessment, Records Review

Reproductive Counseling: Follow-up: Counseling (Central Set)	Increase follow-up from baseline to at least 20 percent above baseline or at least 90 percent	Adults, ages 17 years and older as of December 31 of the reporting year, who are continuously enrolled during the reporting year, who had one or more sex partners, and who are seen by a plan provider during the reporting year.	CHCS, Service specific health risk assessment, Records Review
STD: Follow-up: Hepatitis B Vaccine (Central Set)	Increase follow-up from baseline to at least 20 percent above baseline or at least 90 percent <u>Note:</u> At least one dose of Hepatitis B vaccine	Adults, ages 17 years and older as of December 31 of the reporting year, who are continuously enrolled during the reporting year, who had one or more sex partners, and who are seen by a plan provider during the reporting year.	CHCS, Service specific health risk assessment, Records Review
Tobacco: Screening for Use (Central Set)	Increase screening from baseline to at least 20 percent above baseline or at least 90 percent	Adults, ages 17 years and older as of December 31 of the reporting year, who are continuously enrolled during the reporting year, and who are seen by a plan provider during the reporting year.	CHCS, Service specific health risk assessment, Records Review
Tobacco: Advising Smoker to Quit (Central Set)	Increase advising from baseline to at least 20 percent above baseline or at least 90 percent	Adults, ages 17 years and older as of December 31 of the reporting year, who are continuously enrolled during the reporting year, who are either current smokers or recent quitters, and who are seen by a plan provider during the reporting year.	CHCS, Service specific health risk assessment, Records Review

APPENDIX B

Steps To Developing a Worksite Health Promotion Program

I. Designing Your Program

1. Plan to reach all employees
2. Establish the health promotion committee
3. Set initial goals
4. Promote the program

II. Putting Your Program Into Action

Task 1: Screen and Refer Employees

1. Explain program and obtain consent for participation
2. Collect information using the screening form
3. Review screening results with employees
4. Refer employees to their physicians/primary care manager
5. Refer and sign up employees for health improvement programs/educational offerings
6. Enroll employees in the follow up system

Task 2: Follow Up With and Counsel Employees

1. Set priorities for follow up counseling
2. Contact employees
3. Use various methods of contact
4. Engage employees and get them started

Task 3: Follow Up With Physicians

1. Send a letter/message (whichever is appropriate or feasible)
2. Call the appropriate clinic
3. Try again
4. Repeat follow up every 6 months
5. Follow up with other providers/health care professionals

Task 4: Offer a Menu of Health Improvement Programs

1. Provide three types of programs
2. Obtain and adapt materials
3. Contact employees shortly after screening
4. Publicize/market your health improvement programs
5. Work with healthy employees as well as those who may have specific health limitations

Task 5: Organize the Worksite to Create a Healthy Environment

1. Enlist the support of key employees
2. Include key employees when planning activities
3. Organize group activities focused on health
4. Review services and policies to help change the corporate culture

III. Measuring Your Program's Results

1. Find out if your procedures work
2. Assess employee participation
3. Measure employees' progress in reducing risks
4. Figure your costs and cost-effectiveness

****Extracted From "The Wellness Outreach at Work Program: A Step-by-Step Guide", National Institute of Health & National Heart, Lung, and Blood Institute.**

Key Elements of a Worksite Health Promotion Program

Worksite Health Promotion Programs must include Healthy People 2000 goals. These goals include:

- Increasing the span of healthy life for all Americans
- Reduce health disparities among Americans
- Achieve access to preventive services for all Americans

Healthy People 2000 includes 21 measurable objectives that target expansion and enhancement of worksite health promotion programs. Many of these same objectives are incorporated into DoDD 1010.10, Health Promotion, dtd. March 11,1986, which establishes a policy to improve and maintain military readiness and the quality of life of DoD personnel and other beneficiaries.

Divided into three categories of preventive intervention (Health Promotion Objectives, Health Protection Objectives, and Preventive Services Objectives), the objectives address a full range of health promotion programming.

Health Promotion Objectives:

- C Worksite Fitness Programs
- C Worksite Nutrition/Weight Management Programs

- C Worksite Smoking Policies
- C Worksite Alcohol and Drug Policies
- C Worksite Stress Management Programs
- C Worksite Health Promotion Activities
- C Health Promotion Activities for Hourly Workers

****DoD 1010 Components**

- Smoking Prevention and Cessation Programs
- Physical Fitness Programs
- Nutrition Programs
- Stress Management Programs
- Alcohol and Drug Abuse Prevention Programs
- Hypertension Prevention Programs

Health Protection Objectives:

- C Work-related Injury Deaths
- C Nonfatal Work-related Injuries
- C Cumulative Trauma Disorders/Ergonomics
- C Occupational Skin Disorders
- C Worksite Occupant Protection System Mandates
- C Occupational Noise Limitations
- C Occupational Lead Exposure
- C Occupational Lung Disease
- C Worksite Health and Safety Programs
- C Worksite Back Injury Prevention and Rehabilitation Programs

Preventive Services Objectives:

- C Worksite Blood Pressure/Cholesterol Education Programs
- C Employment of People with Disabilities
- C Occupational Exposure to HIV
- C Hepatitis B Immunizations

APPENDIX C

Community Assessment and Program Development

I. The community development paradigm views the community as both the context in which educational programs operate and the vehicle through which institutional changes in attitudes, practices and policies can be effected. The information gathered in community assessment facilitates partnerships among organizations, leaders, and various groups who play an important intervention role as channels of program dissemination. Community approaches are better integrated into the total community, since interventions are built into existing community structures. Community approaches ensure longevity of change because the social context of behavior proscribes activities and local ownership generates continuing responsibility. They are generally more comprehensive and ensure better allocation and coordination of scarce resources. The ultimate success of health promotion is the extent to which positive health changes have occurred in the targeted population. Change at the community level reinforces and supports changes made at the clinical and or individual, and worksite levels.

II. Community assessment can identify resources, problems, readiness for change and opportunities for health promotion. It can enable the community to reach consensus on goals and priorities, as well as to agree on ways and means for developing and implementing an action plan.

III. The tools necessary for community assessment and program planning and implementation are based on Healthy Communities 2000 Model Standards, Planned Approach to Community Health (PATCH), Assessment Protocol for Excellence in Public Health (APEXPH), and Community Chronic Disease Prevention Program (CCDPP).

IV. **"Model Standards: Eleven Steps Toward a Healthy Community"**

This is a guidebook and a tool for planning community public health services. It provides a link to the National objectives of Healthy People 2000 from which local objectives and targets can be developed.

Step 1 Assess and determine the role of one's health agency.
Develop a mission statement and long range vision that provides employees and the community with a clear description of health agency's role and serves as a guide for the steps that follow.

Step 2 Assess the health agency's organizational capacity.

Director of staff assesses the organization's readiness to exercise leadership. This can be accomplished by a review of the department's structure and capacity to determine skills for community support.

Step 3 Develop an agency plan to build the necessary organizational capacity.

Develop a plan that will build on the internal strengths, overcome its weaknesses, and enhance its organizational effectiveness for carrying out community wide efforts.

Step 4 Assess the community's organizational and power structures.

Work to develop partnerships with key agencies, community leaders, interest groups, and community members. Identifying key people and organizations to involve in this effort is essential to leadership success.

Step 5 Organize the community to build a stronger constituency for public health and establish a partnership for public health.

Convene community groups to assess health needs, to address health problems, and to assist in the coordination of responsibilities. Leaders should strengthen relationships and partnerships to facilitate coordinated actions that could not be realized alone.

Step 6 Assess health needs and available community resources.

A community assessment provides the information needed to identify a community's most critical health problems. Community assessment should include both formal and informal information collection. It should identify the perceptions and values of community leaders, groups, agencies, individuals, and health promotion and medical staff about health priorities for the community. The effort should also identify pertinent health statistics and survey information to identify and verify the extent of major health problems and the level of risk for subpopulations. An inventory of available community resources should be developed.

Step 7 Determine local priorities.

All Key players should be involved in the process to determine local priorities. Selection of priorities is usually the result of negotiation among community groups resulting in a selected set of health problems to be addressed.

Step 8 Select outcome and process objectives that are compatible with local priorities and the Healthy People 200 objectives. Establish your selected measurable outcome objectives then a community coalition can develop process objectives for achieving them.

Step 9 Develop community wide intervention strategies. Responsibilities are assigned so that activities can be distributed and coordinated among agencies and organizations.

Step 10 Develop and implement a plan of action. Develop and execute a plan of action that implements intervention activities and services. Establish timelines and the assignment of responsibilities for activities and services.

Step 11 Monitor and evaluate the effort on a continual basis. Achievement of local process objectives will show movement toward improved health status. New services, improved community linkages for coordinating efforts, and enhanced staff skills and morale are positive effects of using model standards.

V. **Planned Approach to Community Health (PATCH)**

A. PATCH is a process that many communities use to plan, conduct, and evaluate health promotion and disease prevention programs. The PATCH process helps a community establish a health promotion team, collect and use local data, set health priorities, and design and evaluate interventions. Adaptable to a variety of situations, the PATCH planning process can be used when a community wants to identify and address priority health problems or when the health priority to be addressed has already been selected. It can also be adapted and used by existing organizational and planning structures in the community.

B. The goal of PATCH is to increase the capacity of communities to plan, implement, and evaluate comprehensive community-based health promotion activities targeted toward priority health problems. To use the process to achieve the Healthy People or DoD 2000 objectives, by promoting health and providing prevention services at the local level.

C. Five elements are considered critical to the success of any community health promotion process. They are:

- Community members participate in the process
- Data guides the development of programs
- Participants develop a comprehensive health promotion strategy

- Evaluation emphasizes feedback and improvement
- The community capacity for health promotion is increased and ensures ownership

D. The PATCH Process:

1. Although PATCH can be adapted to various health problems and communities, the phases of the process remain the same. Thus once the mechanisms of the PATCH process are in place, only a few modifications are needed to address additional health issues. Phases can be repeated as new health priorities are identified, new target groups are selected, or new interventions are developed. The activities within phases may overlap as the process is carried out.

2. Below are the five phases that constitute PATCH:

PHASE 1: Mobilizing the Community: The community is defined, participants recruited, and a demographic profile is completed. The community group and steering committee are then organized and working groups are created. During this phase, the community is informed about PATCH so that support is gained, particularly from community leaders.

PHASE 2: Collecting and Organizing Data: Data is collected and analyzed on mortality, morbidity, community opinion, and behaviors. Both quantitative and qualitative sources are utilized. They analyze the data and determine the leading community health problems.

PHASE 3: Choosing Health Priorities: Behavioral and any additional data collected are presented to the community group or Health Promotion Committee. This group analyzes the behavioral, social, economic, political, and environmental factors that affect the behaviors that put people at risk for disease, death, disability and injury. Health priorities are identified. Community objectives related to the health priorities are set. The health priorities to be addressed initially are selected.

PHASE 4: Developing a Comprehensive Intervention Plan: The community group chooses , designs, and conducts interventions. To prevent duplication and to build on existing services, the community group identifies and assesses resources, policies, environmental measures, and programs already focused on the risk behavior and to the target group. This group devises a comprehensive health promotion strategy, sets intervention objectives, and develops an intervention plan. The Plan includes strategies, a timetable, and a work plan for completing such

tasks as recruiting and training volunteers, publicizing and conducting activities, evaluation the activities and informing the community of results.

PHASE 5: Evaluating PATCH: Evaluation is an integral part of the PATCH process. It is ongoing and serves two purposes: to monitor and assess PATCH progress during each phase of the process and to monitor and assess PATCH intervention activities. The community sets criteria for determining success and identifies data to be collected. Feedback is provided to the community to encourage future participation and to planners for use in program improvement.

VI. Assessment Protocol for Excellence in Public Health (APEXPH)

A. The APEXPH improves the system of public health in a community by enhancing its capacity to perform the core functions of assessment, policy development, and assurance. APEXPH enables the agency to assess and improve its internal organizational structure by involving the local health director and management team.

B. The process encourages and strengthens the ability of the local agency to provide leadership in the development and implementation of a community health plan.

C. Advantages to APEXPH:

- Offers self assessment to meet user needs
- Produces a practical plan of action to address the community's priority problems
- Focuses on administrative capacity, basic structure and the role of the agency in the community
- Encourages assessment of community, and higher agency relations and how to relations and how to obtain support
- Easily adapts to fit local situations and resources.

Is cyclical; by institutionalizing the process, it allows for continued adaptation as changes occur

D. APEXPH is a Three Part Process:

PART I, Organizational Capacity Assessment, calls for an internal review of a local Command. It provides for an assessment of a medical treatment facility's (MTF) basic administrative capacity and of its capacity to undertake PART II. It is conducted by Senior leadership and a team of key staff.

PART II, The Community Process, is intended to be a more public endeavor, involving key members of a community as well as department staff in assessing the health of the community and identifying the role of the MTF in relation to community strengths and health problems. It provides for the use of both objective health data and the community's perceptions of community health problems.

PART III, Completing the Cycle, integrates the plans developed during the Organizational Capacity Assessment and the Community Process into the ongoing activities of a MTF and the community it serves. It discusses policy development, assurance, monitoring and evaluation of plans developed in conducting Parts I and II.