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Medicine

IMPLEMENTING PUT PREVENTION INTO PRACTICE

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This pamphlet implements AFPD 44-1, *Medical Operations,* AFI 44-102, *Community Health Management,* and DoD Health Affairs Policy 9800027, *Policy for Put Prevention into Practice*. The pamphlet provides guidance for the organization and delivery of the Air Force *Put Prevention into Practice Program*. It implements various publications of Department of Defense (DoD), recognized professional medical organizations, and the Department of Health and Human Services *Put Prevention into Practice Program.* This pamphlet applies to all personnel assigned to or working in Air Force Medical Treatment Facilities (MTF), including Reserve and Guard personnel during their active duty periods, civilian, contract, volunteer personnel and trainees. This pamphlet is referred to in AFI 44-102, *Community Health Management* as Air Force Pamphlet 44-155, *Clinical Preventive Services.* Services described in this pamphlet apply to all TRICARE Prime Beneficiaries, active duty and non-active duty, IAW guidelines set forth in the Report of U.S. Preventive Services Task Force *Guide to Clinical Preventive Services* and TRICARE minimal clinical preventive services (enhanced benefits) requirements. Submit all supplements to this Air Force Pamphlet (AFPAM) to AFMOA/SGOP for approval. Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMOA/SGOP, 110 Luke Avenue, Suite 405, Bolling AFB DC 20332-7050.

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Chapter 1

PROGRAM OVERVIEW

1.1. Overview.

1.1.1. Put Prevention Into Practice (PPIP) is a national initiative developed by the US Public Health Service's Office of Disease Prevention and Health Promotion (ODPHP). Its purpose is to enhance the delivery of preventive care in primary practice, and to achieve the national health promotion and disease prevention objectives 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 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 System (MHS). On 31 March 1998, the Acting Assistant Secretary of Defense for Health Affairs signed HA Policy 9800027, *Policy for Put Prevention into Practice (PPIP)*. The policy prescribes the staged implementation of PPIP IAW the MHS Strategic Plan.

1.1.2. The PPIP program supports the AF Medical Service (AFMS) strategic plan. The program links individual education and responsibility in attaining a state of good health, with direct access to base-level preventive services. For PPIP to succeed, the effort must be based on both the population and the individual. This "two-pronged" approach is best accomplished by a network of Health and Wellness Centers (HAWC), open to eligible beneficiaries at each Air Force Base, that complements and augments clinical preventive services (CPS) authorized by fully privileged health care providers. Examples of CPS include screening for health risks, providing intervention counseling, administering immunizations, and establishing smoking cessation protocols.

1.1.3. The Air Force has demonstrated its commitment to prevention by establishing the HAWCs. While line commanders provide fiscal resources, the physical facility, and personnel support for the HAWC, local medical treatment facility (MTF) commanders provide professional expertise and medical program oversight to ensure that top-quality health promotion and education services are offered.

1.1.4. PPIP principles must be integrated into the everyday operations of the AFMS. Each member of the AFMS, regardless of Corps affiliation, must understand and support PPIP, and appreciate their role in achieving the program's goals. Air Force training programs for technicians, nurses, public health officers, and medical residencies and fellowships must incorporate the principles of health promotion and preventive care.

1.2. Purpose . This pamphlet provides guidance to each AF MTF on fully implementing PPIP and incorporating program principles into the daily culture of health care.

1.3. Goal . The goal of PPIP is to improve the overall health and well being of the AF community by:

1.3.1. Improving the delivery of CPS.

1.3.2. Enhancing the health and fitness of active duty members, in support of mission readiness requirements.

1.3.3. Enhancing the productivity of the active duty force.

1.3.4. Decreasing preventable disease and death.

1.3.5. Reducing attrition among active duty members.

1.4. Strategic Planning . Prevention must be included in strategic planning at the AFMS and MAJCOM/SG levels and in tactical planning and execution at the MTF level. The key to success is identifying prevention program requirements and executing those requirements. To build and sustain defensible prevention programs, the MTF's executive staff and Prevention Committee must understand the complex links within DoD, AF, and MAJCOM strategic planning. The more we understand DoD and AF planning and programming processes, the more likely we are to secure necessary resources.

1.4.1. DoD Strategic Planning . Strategic planning starts with the DoD Health Affairs Defense Planning Guidance (DPG). The DPG emphasizes prevention by stating that programs will be funded to facilitate a transition from interventional medicine to a focus on preventive services. The DoD Environmental Security DPG directs the Services to fund programs that improve readiness, reduce costs, and enhance quality of life—all results of an integrated prevention program.

1.4.2. Air Force Strategic Planning .

1.4.2.1. Headquarters Air Force has identified six core competencies (found on Internet website: http://www.xp.hq.af.mil/xpx/3frame.htm) that will enable the AF to sustain superior military capabilities for the nation. To align medical operations with AF operations, the AF Surgeon General developed the pillars of Strategic Initiatives. PPIP is a key component of the "Building Healthy Communities" (BHC) pillar and supports others, such as "Medical Readiness."

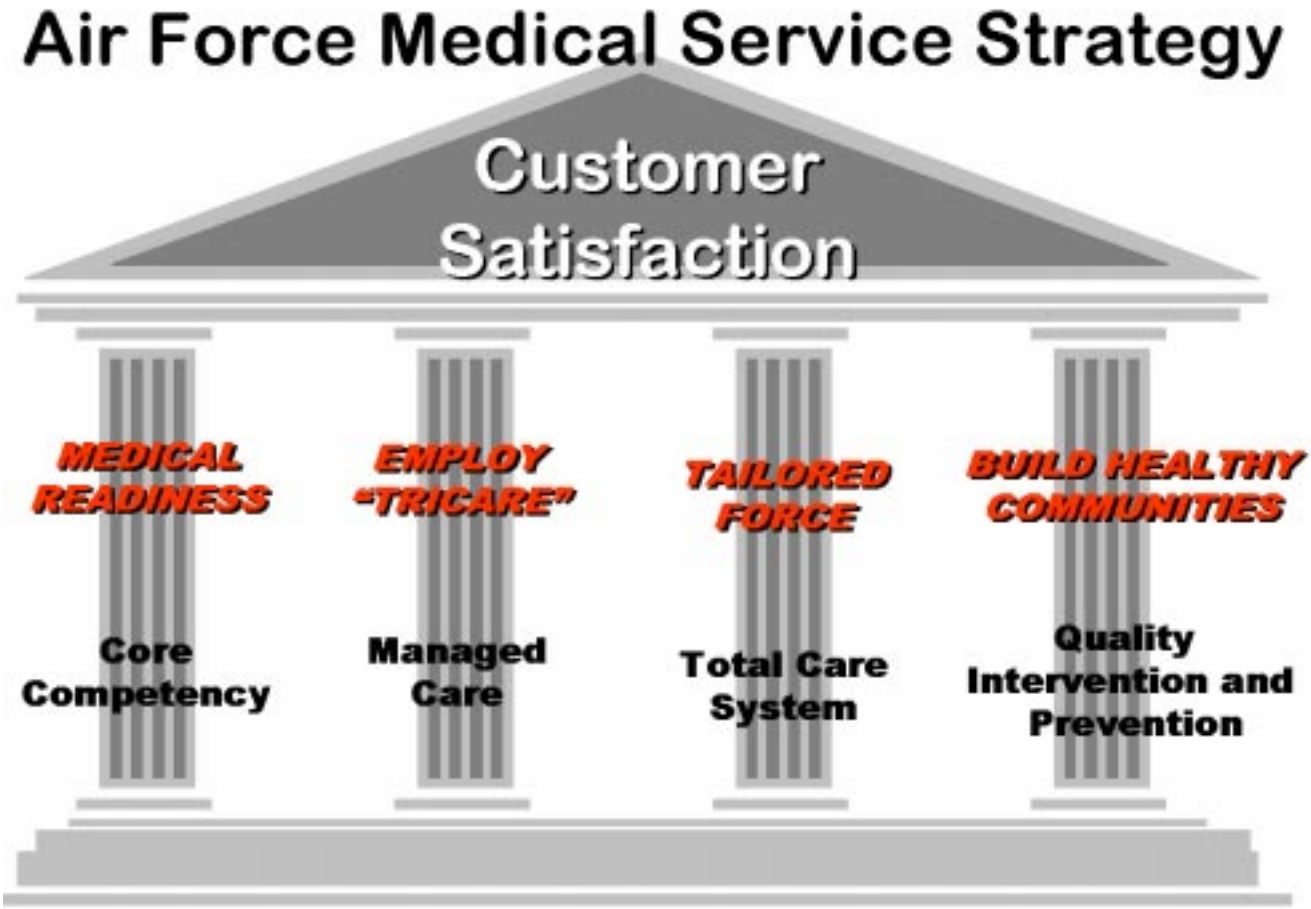
1.4.2.2. There are two operational tasks driving the BHC strategic initiative: *Prevent Disease, Promote Health, and Enhance Performance*; and *Promote a Safe and Healthful Environment*. These operational tasks set the stage for identifying requirements and allocating resources for a prevention program.

1.4.2.3. For each of these operational tasks, there are desired end-states for FY08, current deficiencies that impact their completion, and AF-level initiatives for meeting them. Both tasks provide the Prevention Committee with planning direction for the MTF's prevention program. Specifically, each task identifies deficiencies that must be corrected. Each MTF Prevention Committee should determine whether a deficiency exists and develop corrective actions, as appropriate. Additional details on each operational task are documented in the AFMS Mission Support Plan (MSP).

1.4.3. MAJCOM Strategic Planning . Each MAJCOM should develop a strategic plan that aligns with DoD, AF, and AF Surgeon General strategic plans.

1.4.4. Medical Treatment Facility Strategic Planning .

Figure 1.1. Air Force Medical Service Strategic Initiatives.



1.4.4.1. Given the significant potential for overlap in providing prevention programs to a base population, each MTF must work closely with their installation's Human Services Integrated Delivery System in developing a plan for a healthier community. PPIP affects clinical outcomes for the population by emphasizing prevention by clinical providers and medical support staff. HAWCs are a primary source of assessment, awareness, and intervention programs to improve overall health and fitness. Occupational medicine, flight medicine, public health, and bioenvironmental engineering work together to identify, evaluate, and control health hazards in the occupational environment, thus improving community health, operational capabilities, and human performance.

1.4.4.1.1. The Prevention Committee should be the primary source for the prevention strategic and tactical plans. The Prevention Committee should use real data to prioritize, implement, and evaluate prevention activities. To ensure that the entire spectrum of prevention is addressed in the strategic plan, the MTF Prevention Committee must include members from a broad range of activities and communities.

1.4.4.2. Planning establishes the direction for the program over an extended period (10 years for a strategic plan). Key areas that should be addressed in the plan are:

1.4.4.2.1. Mission of the base

1.4.4.2.1.1. Anticipated operational losses or gains

1.4.4.2.1.2. Increases or decreases in civilian or active duty work force

1.4.4.2.2. Population served by the prevention program

1.4.4.2.2.1. Demographics (catchment area, deployed location, etc.) can be obtained from RMO

1.4.4.2.2.2. Specific causes of illness, injury, medical retirement, death (prioritized list)

1.4.4.2.2.3. Specific causes of preventable illness, injury, medical retirement, death (prioritized list)

1.4.4.2.3. Material and non-material resources available and required

1.4.4.2.3.1. Financial requirements (baseline, initiatives, and method of tracking)

1.4.4.2.3.2. Manpower requirements (PPIP coordinator, certified health educator, providers and support staff, administrative staff, etc.)

1.4.4.2.3.3. Facilities, equipment, and supplies

1.4.4.2.3.4. Information systems (connectivity and interactivity with existing systems)

1.4.4.2.3.5. Easy access to web sites and e-mail capabilities

1.4.4.2.3.6. Partnering opportunities with local communities (expertise pool)

1.4.4.2.3.7. Daycare centers

1.4.4.2.3.8. Commissaries

1.4.4.2.3.9. Schools

1.4.4.2.3.10. Health departments

1.4.4.2.3.11. Lead agents and TRICARE contractors

1.4.4.2.4. Education requirements (recurring training of MTF staff, residency and technical training, patient/work force training, etc.)

1.4.4.3. The Prevention Committee should use a one-year tactical plan to guide its work throughout the execution year. Minimum requirements of the tactical plan are:

1.4.4.3.1. Planning cycle

1.4.4.3.1.1. Review of MTF Strategic Plan (compare to AFMS and MAJCOM)

1.4.4.3.1.2. Generation of the following year’s tactical plan

1.4.4.3.1.3. Inclusion of prevention topics in the facility MSP

1.4.4.3.2. Financial cycle

1.4.4.3.2.1. Quarterly review and reporting of baseline and initiative prevention expenditures and metrics

1.4.4.3.2.2. Quarterly review of Lead Agent-sponsored prevention programs and metrics

1.4.4.3.3. Manpower cycle

1.4.4.3.3.1. Input to Strategic Resourcing Portfolio Tool

1.4.4.3.3.2. Review of stability and resourcing of key prevention positions

1.4.4.3.4. Prevention initiatives cycle

1.4.4.3.4.1. Submitting unfunded initiatives (to MAJCOM through the MTF Executive Committee)

1.4.4.3.4.2. Processing prevention initiative grant proposals

1.4.4.3.5. Submit unfunded research or grant initiatives through established protocols (e.g., MTF Executive Committee, MAJCOM, Lead Agent)

1.5. Summary of the PPIP Framework.

1.5.1. Establish an overall structural concept for PPIP and other prevention efforts.

1.5.2. Designate ownership and responsibility for the program.

1.5.3. Designate a full-time PPIP coordinator.

1.5.4. Designate a PPIP Provider Champion.

1.5.5. Obtain adequate resources for implementing PPIP through annual budget, in-house prevention grant process, etc.

1.5.6. Provide ongoing and targeted PPIP education and skills training.

1.5.7. Implement the PPIP office materials/systems.

1.5.8. Perform a needs assessment of the work force and TRICARE Prime beneficiaries.

1.5.9. Develop a marketing plan for prevention programs.

1.5.10. Develop intervention programs for high-risk/multiple-risk patients.

1.5.11. Provide required clinical and occupational preventive services.

1.5.12. Develop an effective referral process to ensure that appropriate prevention services are provided.

1.5.13. Integrate PPIP into quality assurance activities and provide feedback to all.

Chapter 2

STAFFING AND RESPONSIBILITIES

2.1. Staffing Support

2.1.1. Medical staffing requirements are based on the size of the beneficiary population and the work force.

2.1.2. Requirements have been approved, effective FY 98, to increase support staff for family practice/primary care clinics.

2.1.2.1. The AF Surgeon General has recommended that these requirements be in the ambulatory care setting, to increase provider support, and for such services as patient education and health maintenance.

2.1.2.2. Support staffing requirements will be based on the number of assigned providers in the family practice/primary care clinic, as of 30 April 1996. The staffing ratios are 0.5 46N3 per provider and 2.0 4N0X1 per provider.

2.1.3. The MTF commander, in collaboration with the MAJCOM, determines staffing support at the MTF level.

2.1.4.The MTF commander must ensure that each member of the health care team understands his or her role in providing health care and enhancing the health, wellness, and fitness of the entire military community.

2.2. Responsibilities

2.2.1. MAJCOM Surgeon General

2.2.1.1. Implements prevention policy.

2.2.1.2. Directs and funds prevention programs.

2.2.1.3. Provides support to installation personnel by identifying MAJCOM points of contact for prevention issues, dissemination of information, guidance, and directives.

2.2.1.4. Establishes a Prevention Committee:

2.2.1.4.1. Appoints a MAJCOM Prevention Committee chairperson.

2.2.1.4.2. Establishes a Prevention Committee to provide oversight for integrating clinical and occupational prevention and health promotion activities.

2.2.1.4.3. Recommended committee membership:

2.2.1.4.3.1. Chief, Professional Services Division

2.2.1.4.3.2. Command Dental Surgeon

2.2.1.4.3.3. Command Nurse

2.2.1.4.3.4. Chief, Aerospace Medicine

2.2.1.4.3.5. Chief, Clinical Services

2.2.1.4.3.6. Manager, Family Advocacy Program

2.2.1.4.3.7. Chief, Occupational Health Engineering

2.2.1.4.3.8. Chief, Biomedical Sciences

2.2.1.4.3.9. Chief, Health Promotion And Fitness

2.2.1.4.3.10. Chief, Human Resources

2.2.1.4.3.11. Chief, Strategic Planning

2.2.1.4.3.12. Chief, Managed Care

2.2.1.4.3.13. Chief, Financial Management

2.2.1.4.3.14. Enlisted personnel

2.2.1.5. Stimulates group interaction among MTF PPIP coordinators through quarterly videotelephone or telephone conferences. Conferences should include the AF PPIP Program Manager and the AF Health Enrollment Assessment Review (HEAR) Program Manager.

2.2.1.6. Communicates quarterly to the PPIP Program Office, the current MAJCOM PPIP coordinator, MTF PPIP coordinators, and MTF PPIP Provider Champions. The following information is requested:

2.2.1.6.1. Rank

2.2.1.6.2. Full name

2.2.1.6.3. Position (i.e., PPIP coordinator, PPIP Provider Champion, etc.)

2.2.1.6.4. Corps affiliation

2.2.1.6.5. Organization

2.2.1.6.6. Office symbol

2.2.1.6.7. Mailing address

2.2.1.6.8. DSN and commercial duty phone

2.2.1.6.9. DSN and commercial fax number

2.2.1.6.10. E-mail address

2.2.2. MTF Commander

2.2.2.1. Ensures the integration of PPIP throughout the facility.

2.2.2.2. Oversees the overall prevention program and initiatives that ensure beneficiaries are provided annual clinical preventive services.

2.2.2.3. Maintains a letter of appointment for the PPIP coordinator, PPIP Provider Champion, and members of the Prevention Committee.

2.2.2.4. Appoints a full-time PPIP coordinator.

2.2.2.4.1. The PPIP coordinator should be a health care professional (or senior NCO, with direct support from a health care professional, at smaller facilities) trained or experienced in disease prevention and health promotion.

2.2.2.4.2. The PPIP coordinator should not serve as either the health promotion manager or the Prevention Committee chairperson.

2.2.2.5. Appoints a PPIP Provider Champion.

2.2.2.5.1. The PPIP Provider Champion should be a primary care physician or preventive medicine physician.

2.2.2.5.2. The PPIP Provider Champion should be able to devote 25 percent of his or her time (e.g., one full day or two half-days, as needed) to PPIP activities such as training other providers, community education, working with PPIP coordinator, etc.

2.2.2.6. Establishes an MTF Prevention Committee

2.2.2.6.1. Appoints a Prevention Committee chairperson from the MTF senior leadership (i.e., MDOS/CC, AMDS/CC, etc.).

2.2.2.6.2. Ensures establishment of a Prevention Committee charter.

2.2.2.6.3. Selects Prevention Committee members from key medical-group personnel, to provide oversight for integration of clinical prevention activities.

2.2.2.6.4. Recommended committee membership:

2.2.2.6.4.1. PPIP Coordinator

2.2.2.6.4.2. PPIP Provider Champion

2.2.2.6.4.3. Chief, Medical Staff

2.2.2.6.4.4. Commander, Medical Operations Squadron/Flight

2.2.2.6.4.5. Commander, Aerospace Medicine Squadron/Flight

2.2.2.6.4.6. Chief Nurse Executive

2.2.2.6.4.7. Commander, Dental Squadron/Flight

2.2.2.6.4.8. Primary Care Provider

2.2.2.6.4.9. Medical Technician

2.2.2.6.4.10. Bioenvironmental Engineer

2.2.2.6.4.11. Director, Resource Management Office

2.2.2.6.4.12. Public Health Officer

2.2.2.6.4.13. Manager, Health Promotion

2.2.2.6.4.14. Managed Care Representative

2.2.2.6.4.15. Coordinator, Health Care/UM

2.2.2.6.4.16. Mental health personnel (social worker and/or family advocacy program manager)

2.2.2.6.4.17. Senior NCO

2.2.2.7. Provides appropriate medical staff, facilities, equipment, and funds to conduct the program.

2.2.2.8. Ensures an organization-wide mechanism for verifying MTF personnel compliance with program requirements.

2.2.2.9. Ensures that the MTF Executive Committee reviews Prevention Committee minutes.

2.2.2.10. Ensures that the MTF Executive Committee reviews relevant prevention information on the MTF-specific performance measurement tool, DoD Report Card, Health Plan Employer Data Information Set (HEDIS), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) inspection, Health Services Inspection (HSI) and Prevention Committee minutes.

2.2.2.11. Communicates to MAJCOM the following information on the current PPIP coordinator and PPIP Provider Champion:

2.2.2.11.1. Rank

2.2.2.11.2. Full name

2.2.2.11.3. Position (i.e., PPIP coordinator, PPIP Provider Champion, etc.)

2.2.2.11.4. Corps affiliation

2.2.2.11.5. Organization

2.2.2.11.6. Office symbol

2.2.2.11.7. Mailing address

2.2.2.11.8. DSN and commercial duty phone

2.2.2.11.9. DSN and commercial fax number

2.2.2.11.10. E-mail address

2.2.3. MTF Prevention Committee

2.2.3.1. The Prevention Committee Chairperson

2.2.3.1.1. Oversees activities of the PPIP program and other prevention activities such as PHA, Breast Cancer Initiative, Health and Wellness Center, Healthcare Integration, etc.

2.2.3.1.2. Ensures the development and maintenance of an MTF PPIP operating instruction.

2.2.3.1.3. Designates a prevention marketing team.

2.2.3.1.4. Provides leadership and consultative services to departments and agencies or sections within the organization, to achieve regulatory, accreditation, and organizational compliance, and performance improvement in prevention activities.

2.2.3.1.5. Directs the prevention training and education of organizational leaders.

2.2.3.1.6. Coordinates the dissemination of prevention performance-improvement information within the organization, including basic statistical analysis and comparative processes.

2.2.3.1.7. Oversees the prevention investment-plan process.

2.2.3.1.8. Participates in problem assessment, solution recommendations, implementation, and follow-up activities regarding the quality of preventive services, including tracking abnormal results.

2.2.3.1.9. Submits minutes of the Prevention Committee and results of performance-measurement tools to the MTF Executive Committee for review.

2.2.3.1.10. Attends quarterly MAJCOM PPIP video/telephone conferences.

2.2.3.2. Prevention Committee Members

2.2.3.2.1. Participate in developing prevention policies for the health care system, considering especially the integration and collaboration of internal administrative, clinical, and occupational health policies.

2.2.3.2.2. Uses local prevention data (HEAR, CHCS, ADS, PHA, immunizations, etc.) to plan, program, implement and evaluate prevention initiatives.

2.2.3.2.3. Review and approve prevention proposals.

2.2.3.2.4. Advocate prevention programs to subordinates and co-workers.

2.2.3.2.5. Make recommendations to the Executive Committee for the use of prevention funds.

2.2.4. Prevention Marketing Team

2.2.4.1. Advocates prevention and wellness.

2.2.4.2. Should consist of energetic individuals from internal and external sources.

2.2.4.3. As its main goal, promotes prevention and PPIP as a tool.

2.2.4.4. Each MTF is unique in its delivery of health care and the population it serves. The team should design marketing strategies to capitalize on this uniqueness. Areas for consideration are:

2.2.4.4.1. Conducting a media campaign (video, TV, buttons, stickers, radio, computers, T-shirts, posters, etc.)

2.2.4.4.2. Using “Meet one, teach one” (word of mouth)

2.2.4.4.3. Using discharge teaching (inpatient)

2.2.4.4.4. Using PPIP materials routinely

2.2.4.4.5. Becoming part of newcomers’ orientation

2.2.4.4.6. Initiating catchy phrases or slogans (“Have you been PPIPed?”)

2.2.4.4.7. Talking with specialty committees (Top 3, Middle Managers, etc.)

2.2.4.4.8. Standardizing terminology (everyone using the same terms)

2.2.4.4.9. Focusing on the cost of care vs. the cost of prevention

2.2.4.4.10. Promoting the benefits of staying healthy

2.2.4.5. The Air Force PPIP Program Office has a collection of base prevention articles on the PPIP homepage (www.ophsa.brooks.af.mil) that other bases may use.

2.2.5. Resource Manager

2.2.5.1. Works with the PPIP coordinator to establish and maintain the prevention budget.

2.2.5.2. Responds to inquiries on budget status.

2.2.6. PPIP Coordinator

2.2.6.1. Advocates prevention and wellness.

2.2.6.2. Serves as a point of contact for local PPIP activities. Ensures that the organization-wide prevention program is continuously evolving.

2.2.6.3. Coordinates prevention education and skills training sessions for staff and beneficiaries.

2.2.6.4. Oversees ordering PPIP office materials; DD Form 2766, **Adult Preventive and Chronic Care Flowsheet**; educational materials; etc.

2.2.6.5. Submits an annual budget IAW MTF requirements. Establishes and maintains the prevention budget. Oversees the prevention initiative and grant proposal process. Works with the resource manager to respond to budget-status inquiries.

2.2.6.6. Is a resource to the MTF in developing evaluation criteria for clinical and occupational preventive initiatives, meeting accreditation standards for health care documentation, etc.

2.2.6.7. Implements both process and outcome evaluation activities.

2.2.6.8. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.

2.2.6.9. Attends quarterly MAJCOM PPIP video/telephone conferences.

2.2.6.10. Has continuous access to the Internet, to use as a prevention research tool and to review the PPIP homepage (www.ophsa.brooks.af.mil) for program updates.

2.2.7. PPIP Provider Champion

2.2.7.1. Advocates prevention and wellness.

2.2.7.2. Works with providers to ensure that patients receive required prevention measures.

2.2.7.3. Provides an initial orientation and recurring in-service to providers.

2.2.7.4. Works with the PPIP coordinator in coordinating prevention-education and skills-training sessions for staff and beneficiaries.

2.2.7.5. Provides community education.

2.2.7.6. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.

2.2.7.7. Reviews the PPIP homepage (www.ophsa.brooks.af.mil).

2.2.7.8. Attends quarterly MAJCOM PPIP video/telephone conferences.

2.2.8. Providers

2.2.8.1. Advocate prevention and wellness.

2.2.8.2. Incorporate preventive interventions into each patient encounter, using the *Clinician's Handbook of Clinical Preventive Services* or the US Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services* as a reference.

2.2.8.2.1. Counsel patients (including providing printed media) on health and wellness/preventive medicine topics, based on identified health and occupational risks, and the patient's desire to change associated beliefs and behaviors.

2.2.8.2.2. Document health and wellness/preventive counseling, referrals, and prescriptions on SF 600, **Chronological Record of Medical Care**, using the "SOAPP" note format (where the second "P" indicates prevention).

2.2.8.2.3. Document the identification and review of patient risk behaviors on DD Form 2766. This documentation is based on a review of the patient's record, HEAR (or other health risk assessment, if HEAR is not available), clinical findings, occupational risks, and interviews.

2.2.8.2.4. Ensure that patients receive appropriate screenings or exams at the frequencies specified on the DD Form 2766.

2.2.8.2.5. Refer patients with documented health risks to appropriate health-education programs (HAWC, public health, nutritional medicine, family advocacy, etc.) for counseling, support, and follow-up.

2.2.8.3. Assess and improve the quality of preventive services by using process/outcome evaluation measurements.

2.2.8.4. Develop and advocate prevention initiative programs.

2.2.9. Health Educator. Note: A full-time health educator in the primary care clinics (i.e., family practice, flight surgery, OB-GYN, primary care) is critical to providing clinical and occupational preventive services to beneficiaries and members of the work force.

2.2.9.1. Advocates prevention and wellness.

2.2.9.2. Provides briefings and literature to patients, based on specific issues identified by providers.

2.2.9.3. Incorporates preventive interventions into each patient encounter, using the *Clinician's Handbook of Clinical Preventive Services* or the *Guide to Clinical Preventive Services* as a reference.

2.2.9.3.1. Counsels patients (including providing printed media) on health and wellness/preventive medicine topics, based on identified health and occupational risks, and the patient's desire to change associated beliefs and behaviors.

2.2.9.3.2. Documents health and wellness/preventive counseling and referrals on SF 600, using the "SOAPP" note format (where the second "P" indicates prevention).

2.2.9.3.3. Documents the identification and review of patient risk behaviors on DD Form 2766. This documentation is based on a review of the patient's record, HEAR (or other health risk assessment, if HEAR is not available), clinical findings, occupational risks, and interviews.

2.2.9.3.4. Ensures that patients receive appropriate screenings or exams at the frequencies specified on the DD Form 2766.

2.2.9.3.5. Refers patients with documented health risks to appropriate health education programs (HAWC, public health, nutritional medicine, family advocacy, etc.) for counseling, support, and follow-up.

2.2.9.4. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.

2.2.9.5. Develops and advocates prevention initiative programs.

2.2.10. Team Aerospace

2.2.10.1. Advocates prevention and wellness.

2.2.10.2. Provides occupational-health expertise to the Prevention Committee.

2.2.10.3. Ensures that Wing operational requirements are integrated into prevention goals and programs.

2.2.10.4. Identifies, evaluates, and controls health hazards in the occupational environment. Performs occupational illness/injury tracking and trend analysis to target prevention activities. Provides health, wellness, and preventive services to the military and civilian work force.

2.2.10.5. Assesses and improves the quality of preventive services through process/outcome evaluation measurements.

2.2.10.6. Develops, advocates, and manages prevention initiative programs. Moves successful initiative programs to fully funded operating and maintenance (O&M) programs.

2.2.10.7. Ensures Aerospace Medicine Council activities support Prevention Committee activities, if applicable.

2.3. MTF Staff Collaborative . Note: A coordinated, facility-wide approach to improving community health requires an intensive, integrated, and collaborative systems approach by all disciplines. Although not all disciplines may be centrally located, every effort must be made to communicate and collaborate in planning and carrying out prevention programs and activities.

2.3.1. Advocates prevention and wellness.

2.3.2. Orders and maintains sufficient quantities of health and wellness/preventive pamphlets in exam rooms and reception areas

2.3.3. Ensures that each credentialed provider has and understands how to use the *Clinician's Handbook of Preventive Services*.

2.3.4. Prior to each patient visit, ensures a DD Form 2766 is present in the patient's medical record. See Chapter 4, Documentation, for specific instructions.

2.3.5. Reviews and updates the DD Form 2766, based on information obtained from the health record.

2.3.6. Ensures that patients receive appropriate counseling and/or screenings and exams at the frequencies specified on the DD Form 2766.

2.3.7. Provides health and wellness/preventive support to patients, as self-referred, directed, or recommended.

2.3.8. Documentation on DD Form 2766 may be accomplished by any medical personnel providing the counseling or screening service. Transcription from AF Form 1480 and /or AF Form 3922 may be accomplished by any medical/administrative personnel. If clinical judgment is required in the transcription process then a licensed professional will be required to make the clinical interpretation.

2.3.9. Assesses and improves the quality of preventive services by using process/outcome evaluation measurements.

2.3.10. Develops, advocates, and manages prevention initiative programs. Moves successful initiative programs to fully funded O&M programs.

2.4. Logistical Support

2.4.1. Office Materials. Maintains PPIP supplies appropriate to each clinic (i.e., prevention posters and preventive care timeline charts, *Clinician's Handbook of Preventive Services,* DD Form 2766, etc.).

2.4.2. Systems Support

2.4.2.1. The systems officer can write ad hoc reports using the Ambulatory Data System (ADS) and Composite Health Care System (CHCS). These reports can provide valuable information about the types of illness, diseases, and injuries seen in the MTF or the services it provided.

2.4.2.2. Trains staff on how to query systems for the targeted populations.

Chapter 3

EDUCATION

3.1. Medical Staff Training

3.1.1. Training and support are essential for everyone who works with patients, from the person who answers the telephone for an appointment, to the person who fills prescriptions. All medical staff members need education and a "prevention" attitude.

3.1.2. PPIP represents a paradigm shift within the Military Health System (MHS). All health care providers need preventive medicine training in order to understand this new way of doing business.

3.1.3. The *Guide to Clinical Preventive Services* provides a comprehensive review of screening, counseling, and other preventive services, with uniform recommendations for screening interventions. Providers should examine the appropriate data and determine whether to use a particular intervention in a specific situation.

3.1.4. PPIP must be integrated into the system, so that it is rewarding and reinforcing. Providers should want to practice prevention. Everyone in the AFMS must promote prevention, not just providers.

3.1.5. Concerted efforts will be required to change provider behavior toward improving CPS delivery. Multiple concurrent methods will be the most effective in producing behavior change. These methods include:

3.1.5.1. Financial incentives and penalties (unlikely to be used in the military direct-care system, but are a possibility through TRICARE contracts)

3.1.5.2. Provider education and skills training (especially for counseling techniques and behavior modification strategies) through clinical guidelines, continuing medical education, modeling by leadership, and academic detailing

3.1.5.3. Ongoing performance feedback (compare provider delivery of CPS with peers and internal/external standards)

3.1.5.4. Prompting to provide CPS at the time of every patient visit (e.g., chart flowsheets, reminder stickers, and computerized records)

3.1.5.5. Administrative rules that decrease barriers to delivering CPS, or provide incentives (positive and/or negative) to increase patient demand for CPS (generated by patient education efforts)

3.1.6. Providers should be heavily involved in developing appropriate clinical guidelines, administrative rules, and quality-improvement efforts for improving CPS delivery. Providers are more likely to become actively involved in prevention activities if they are also active participants in the change process.

3.2. Formal Training Programs

3.2.1. Medical personnel in training programs at MTFs (e.g., residents, phase II, physician assistants, etc.) should be trained in:

3.2.1.1. TRICARE and MHS

3.2.1.2. PPIP

3.2.1.3. HEAR

3.2.1.4. Primary care manager role and its impact on resource utilization

3.2.1.5. Prevention aspects of the AFMS Performance Measurement Tool (AFMSPMT), MAJCOM-specific performance measurement tools, DoD report card, HEDIS, JCAHO, and HIS

3.2.1.6. Quality approach and fact-based practice management

3.2.1.7. Patient education and counseling skills

3.2.1.8. Marketing and customer satisfaction

3.2.2. Specific medical/technical training should include Air Force Service Code (AFSC)-appropriate prevention training, as identified in Section 3.1.

3.3. MTF Staff Training

3.3.1. Focused skills training on the PPIP program and using PPIP materials should be locally developed and targeted to providers, nurses, technicians, clerical staff, medical records personnel, volunteers, and others who have contact with patients. All training should be AFSC specific. Three training programs, specifically aimed at decreasing barriers to an effective program, are available on the PPIP homepage (www.ophsa.brooks.af.mil):

3.3.1.1. "Patient Education and Counseling for Prevention"

3.3.1.2. "Clinical Practice Guidelines: PPIP"

3.3.1.3. "Prevention Outcomes Alphabet: MMD, BRFSS, QMR"

3.3.2. In-depth training for providers and support staff in clinical and occupational preventive strategies and tactical applications should be continuous. This training can be accomplished in grand rounds, professional staff meetings, journal clubs, and local CME/CEU meetings. Personnel should have a working knowledge of the *Clinician's Handbook of Clinical Preventive Services*, the *Guide to Clinical Preventive Services*, and the TRICARE region self-care book.

3.3.3. Sample training recommendations are outlined in **Attachment 4**, Staff Education Requirements.

3.3.4. Documentation

3.3.4.1. Document prevention education and training on AF Form 1098, **Special Task Certification and Recurring Training**, for all staff members, except physicians and other credentialed providers.

3.3.4.2. Document prevention education and training for physicians and other credentialed providers in their credentials folders.

3.3.5. Additional Training Opportunities. Additional PPIP continuing education can be accomplished during hospital newcomers' orientation, department in-service, staff meetings, etc.

3.4. Patient Education.

3.4.1. Education Needs.

3.4.1.1. Implementing PPIP requires patient education. Preventive care is medical care. Patients must expect wellness care as part of their medical appointments.

3.4.1.2. Some reasons patients do not expect wellness care:

3.4.1.2.1. They do not necessarily understand preventive medicine.

3.4.1.2.2. Many do not want to hear about preventive medicine because they already have heard it many times.

3.4.1.2.3. Often they do not follow preventive service recommendations, so preventive approaches may meet a dead end.

3.4.1.3. Patients must be educated to seek out preventive services. These services can be provided through either the medical system or the HAWCs. If they want and request them, patients are more likely to receive these services and become active participants in their care. They should be encouraged to seek preventive services before they become ill. A team or primary care provider approach is necessary, so that the patient knows who is responsible for various aspects of preventive care. Preventive care must also be tracked for each patient.

3.4.1.4. Patient perceptions and needs for preventive interventions must also be addressed. Specific behavioral interventions can then be tailored to the specific stage of acceptance. For example, if the provider assesses a smoker's readiness for change with a few questions, he or she can determine the appropriate intervention: a tobacco cessation program, a discussion about quitting, or simply giving the patient a pamphlet on cessation.

3.4.1.5. Many different approaches to patient education are available. Several MTFs and clinics have kiosks available in their main lobbies. By touching the kiosk's computer screen, patients can find health promotion or education information. This educational method has proven to be very valuable.

3.4.1.6. The lack of communication and continuity between systems is an education problem. If prevention programs were standardized, a person could travel from base to base and receive the same types of information. They would not get conflicting messages. However, because this is not yet a reality, ongoing patient education at each contact point is necessary.

3.4.2. Program Elements. In conjunction with the health-promotion program, community and/or beneficiary education programs should address, as a minimum:

3.4.2.1. Self-care

3.4.2.2. Personal health practices (proper nutrition, fitness, tobacco use, mental health, alcohol and drug use, heart disease and cancer prevention)

3.4.2.3. Youth and family violence

3.4.2.4. Substance abuse

3.4.2.5. Sexual behaviors

3.4.2.6. Injury prevention

3.4.2.7. Home safety

3.4.3. Other Educational Opportunities

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

3.4.3.2. Additional opportunities exist for community education by using established orientation programs, such as the base newcomers' orientation.

Chapter 4

DOCUMENTATION

4.1. DD Form 2766, Adult Preventive and Chronic Care Flowsheet

4.1.1. Introduction

4.1.1.1. DD Form 2766 was developed as a tri-Service form and will be used by all DoD military personnel and TRICARE Prime beneficiaries to ensure continuity of care in the TRICARE system and during deployment.

4.1.1.2. DD Form 2766 replaces AF Form 1480A, **Adult Preventive and Chronic Care Flowsheet**. Any reference in this pamphlet to DD Form 2766 also applies to AF Form 1480A. All AF Form 1480As are grandfathered and do not require reaccomplishment to the DD Form 2766 except when the six-year life expectancy is completed or there is a need to reaccomplish it due to loss or mutilation.

4.1.1.3. Use of DD Form 2766 by active duty personnel. All active duty, reserve, and Air National Guard personnel will use the non-electronic, folder-style form. The folder-style DD Form 2766 is NOT authorized for local reproduction and is available through the AF PDC.

4.1.1.4. Use of DD Form 2766 by non-active duty TRICARE Prime beneficiaries .

4.1.1.4.1. All non-active duty TRICARE Prime beneficiaries should use pages 1 of 4 and 2 of 4. Pages 3 of 4 and 4 of 4 are not required, since they pertain to readiness issues. The automated printout from the immunization tracking system should be used to document the patient's immunizations. All other non-active duty beneficiaries not enrolled in TRICARE Prime may use DD Form 2766 at the discretion of the provider or individual Services. The folder-style DD Form 2766 is not authorized for use in non-active duty records.

4.1.1.4.2. The electronic version used by non-active duty beneficiaries is authorized for local reproduction and will not be available through the AF PDC. The recommended printing specifications for DD Form 2766 are 8¾" X 12" 32 lb paper, printed head to foot, scored or perforated one-inch from the bottom providing a one inch lip, with the lip punched with two holes. When placed in the medical record, this will allow the medical staff to easily flip the page and document on the back of the form.

4.1.1.5. DD Form 2766 is an interim measure until the Preventive Health Care Application (PHCA) is deployed and the form is automated. The life expectancy of this form is six years.

4.1.1.6. A pediatric version of DD Form 2766 is currently under development.

4.1.2. General Guidelines

4.1.2.1. DD Form 2766 replaces and consolidates medical information from the current AF Form 1480, **Summary of Care**, and AF Form 3922, **Adult Preventive Care Flow Sheet**.

4.1.2.2. The priority populations to receive the DD Form 2766 in their medical records are:

4.1.2.2.1. Mobility personnel

4.1.2.2.2. Active duty

4.1.2.2.3. Adult beneficiaries.

4.1.2.3. DD Form 2766 is designed to track those CPS reported in the *Guide to Clinical Preventive Services* (2nd ed.); the TRICARE Prime Benefit package; the Advisory Committee on Immunization Practices; and AF Joint Instruction 48-110, *Immunizations and Chemoprophylaxis*.

4.1.2.4. The additional blank boxes in specific prevention areas should be reserved for future AF or DoD requirements. MTF-specific prevention items should be documented on DD Form 2766c, **Adult Prevention and Chronic Care Flowsheet – Continuation Sheet**.

4.1.2.5. Information documented on the medical record is considered part of the legal document, and is not to be discarded from the medical record at any time.

4.1.2.6. All documentation will be completed in ink, except in Section 1, "Allergies"; Section 3, "Medications"; Section 7, "Screening Exams"; and glasses prescription in Section 10 "Readiness." See Sections 1, 3, 7, and 10 for an explanation.

4.1.2.7. Transcribing information from AF Form 1480 onto DD Form 2766:

4.1.2.7.1. After transcribing data, draw a line diagonally across the form and write the word "Transcribed" along the line.

4.1.2.7.2. Write the date, full name, rank, and AFSC of the transcribing individual. A stamp may be used for this purpose.

4.1.2.7.3. The AF Form 1480 will remain with the medical record. Place the form behind the current DD Form 2766 and the HEAR Primary Care Manager's (HEAR PCM) Report.

4.1.2.8. Transcribing information from AF Form 3922 onto DD Form 2766:

4.1.2.8.1. AF Form 3922 does not have to be transcribed immediately onto DD Form 2766. Temporarily attach AF Form 3922 to the bracket on the right side of the inner section of DD Form 2766, until the next (or initial) prevention screening (including the HEAR), during the Preventive Health Assessment (PHA), or enrollment in TRICARE Prime.

4.1.2.8.2. After the patient receives their first full documentation of preventive services, place the AF Form 3922 behind the "transcribed" DD Form 2766.

4.1.2.8.3. Transcribe AF Form 3922 information the same way as the AF Form 1480.

4.1.2.9. The approved order of forms on the left, inside cover of the medical record for AF Form 2100 Series (two-part folder), or in Section 1 for AF Form 2100A Series (four-part folder):

4.1.2.9.1. DD Form 2766

4.1.2.9.2. DD Form 2766c (for non-active duty beneficiaries)

4.1.2.9.3. HEAR PCM Report

4.1.2.9.4. AF Form 1480

4.1.2.9.5. AF Form 3922

4.1.2.10. DD Form 2766c, Adult Preventive and Chronic Care Flowsheet - Continuation Sheet

4.1.2.10.1. DD Form 2766c replaces AF Form 1480B, **Adult Preventive and Chronic Care Flowsheet – Continuation Sheet**. Any reference in this pamphlet to DD Form 2766c also

applies to AF Form 1480B. All AF Form 1480Bs are grandfathered and do not require reaccomplishment to the DD Form 2766c.

4.1.2.10.2. DD Form 2766c is a continuation form for DD Form 2766, or it may be used for local requirements. For active duty personnel, attach it to the bracket on page 2 of 4 of DD Form 2766 when it is completed. For TRICARE Prime beneficiaries, place it behind DD Form 2766.

4.1.2.10.3. The immunization tracking system (ITS) uses an automated version of DD Form 2766c. Each time a member receives an immunization, ITS will print an updated DD Form 2766c. The previous DD Form 2766c is to be destroyed.

4.1.2.10.4. The ITS automated DD Form 2766c is only for immunizations. Use an additional DD Form 2766c for documenting other information for DD Form 2766.

4.1.2.10.5. DD Form 2766c is authorized for local reproduction.

4.1.2.10.6. DD Form 2766c may be attached to AF Form 1480A.

4.1.3. Implementing DD Form 2766 in the MTF

4.1.3.1. Every MTF has unique organizational challenges (staffing, space, flow, etc.) in completing DD Form 2766. Each MTF should establish protocols indicating which individuals or departments are responsible for specific sections of the DD Form 2766. Suggested ways of completing the form:

4.1.3.1.1. Active duty personnel: during the PHA process, as outlined in the PHA implementation plan. The PPIP coordinator and the health educator can assist with patient counseling.

4.1.3.1.2. Sections 1, 2, and 3 (“Allergies,” “Chronic Illness,” and “Medications”): by the provider

4.1.3.1.3. Section 4 (“Hospitalizations/Surgeries”): by medical personnel during the screening process, as the patient checks into the clinic

4.1.3.1.4. Section 5 (“Counseling”): by the medical personnel who provide the counseling

4.1.3.1.5. Section 6 (“Family History”): by those medical personnel responsible for discussing family medical history

4.1.3.1.6. Section 7 (“Screening Exams”): by those medical personnel ordering the exam or reviewing the results. Qualified administrative personnel may document results in the DD Form 2766 prior to review by medical personnel.

4.1.3.1.7. Section 9 (“Immunizations”): by the immunization clinic attaching the automated DD Form 2766c immunization form (or other automated immunization form) to the DD Form 2766 for active duty personnel, and behind the electronic DD Form 2766 for non-active duty beneficiaries

4.1.3.1.8. Sections 8, 10, and 11 (“Occupational History/Risk,” “Readiness,” and “Pre/Post Deployment History”): during the PHA process, or before and after deployment

4.1.4. Documentation

4.1.4.1. Section 1, “Allergies”:

4.1.4.1.1. Write the medication and other types of allergies within the area noted.

4.1.4.1.2. If patient does not have any allergies, write "N/A" in pencil.

4.1.4.2. Section 2, "Chronic Illness": List chronic illnesses.

4.1.4.3. Section 3, "Medications":

4.1.4.3.1. You may complete this section in pencil.

4.1.4.3.2. List current medications, including dosage, frequency, and purpose (e.g., "Inderal LA - hypertension versus migraine control").

4.1.4.4. Section 4, "Hospitalizations/Surgeries": List hospitalizations and all surgeries, including dates.

4.1.4.5. Section 5, "Counseling":

4.1.4.5.1. Fill in "Date," "Age," and "Topic" at the annual prevention assessment (e.g., TRICARE Prime enrollment, Preventive Health Assessment, or when the HEAR is evaluated and the patient is counseled). Counseling is listed from the general to the specific. Write the letter associated with the type of counseling in the corresponding box (e.g., "F" for fitness). When all preventive health topics are addressed, you may write "all areas addressed" in the block. Circle the letter that corresponds to the individual's high-risk profile. There are extra boxes for documenting "outstanding" high-risk preventive counseling (e.g. alcohol abuse, mental health concerns, etc.) accomplished at times other than the annual assessment.

4.1.4.5.2. Document preventive counseling on SF 600, **Chronological Record of Medical Care**, at every visit using the SOAPP format (where the second "P" is for prevention counseling). The counseling block on DD Form 2766 does not take the place of quality counseling documentation on SF 600, nor is it assumed to be an official referral for further education from community-based services.

4.1.4.5.3. "Advanced Directives" (Living Will) – Place Advanced Directives (Self-Determination Act forms) in an envelope and file them in section 4 of the folder, as the last document. Annotate the DD Form 2766 to indicate that a living will is filed and the date it was filed.

4.1.4.6. Section 6, "Family History":

4.1.4.6.1. In the larger block, fill in the family member's designation with the corresponding disease, using the key provided.

4.1.4.6.2. Specify the types of illness or disease.

4.1.4.6.3. Document the age of the family member at the time of death, particularly if there is a correlation between the illness or disease process.

4.1.4.7. Section 7, "Screening Exams":

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

4.1.4.7.2. Fill in the circles under the "Date" and "Age" fields to denote the next time the screening exam is due.

4.1.4.7.3. Documenting screening exams:

4.1.4.7.3.1. Use pencil for the date the exam is ordered.

4.1.4.7.3.2. Use ink when the exam is completed, and the results have been received and reviewed.

4.1.4.7.3.3. Use the proper key code, or write in the actual results in the blocks.

4.1.4.7.3.4. Update each flowsheet every time preventive care is ordered, performed, or results are returned.

4.1.4.8. Section 8, “Occupational History”: Check the appropriate box and list the exposure hazards, as needed.

4.1.4.9. Section 9, “Immunizations”:

4.1.4.9.1. Immunization documentation on DD Form 2766 is not required if the automated DD Form 2766c from ITS or an equivalent is used. Attach the automated immunization form to the DD Form 2766 bracket line through Section IX, “Immunizations,” and annotate on the line “See automated document.” For non-active duty beneficiaries, place it behind the electronic DD Form 2766.

4.1.4.9.2. You must record the date and type of immunization. You will document titers with the date and result, using the corresponding date block.

4.1.4.9.3. Additional blank data blocks allow for flexibility, in case an injection or titer is required that is not presently listed.

4.1.4.9.4. You must document lot numbers in the medical record. You may fill in the date block by hand, stamp, sticker, or automation, to comply with national regulations.

4.1.4.9.5. If you document the date and lot number in the medical record, it does not have to be duplicated on DD Form 2766.

4.1.4.9.6. Additional resources should be considered to accomplish this labor-intensive task. MTFs may also use bar-coding to log the lot information into their automated system.

4.1.4.10. Section 10, “Readiness”:

4.1.4.10.1. Enter date and required information in the appropriate spaces.

4.1.4.10.2. Write the optometry prescription directly below the “Glasses/Gas Mask” block description. You may document changes in the prescription within the date block, as needed. Pencil may be used in this section to document the prescription.

4.1.4.11. Section 11, “Deployment”:

4.1.4.11.1. Document deployment location and completion dates of pre- and post-deployment evaluations here. If needed, continue the deployment-history documentation on DD Form 2766c.

4.1.4.11.2. Until DD Form 2766 is initiated, documenting deployments is not required.

4.1.4.11.3. Place documentation of pre- and post-deployment evaluations for classified operations in the individual’s personnel folder.

4.1.5. Deployment Instructions

4.1.5.1. It is recommended that each MTF photocopy DD Form 2766 prior to deployment and keep the copy in the medical record. The original DD Form 2766 folder will accompany the individual to the field. If the deployed member receives medical care, all medical documentation will be placed in the bracket inside the folder (e.g., SF 600, AF Form 422, lab reports, radiology reports, etc.). Upon return to the MTF (after deployment), remove the medical documentation (except the DD Form 2766c) from the DD Form 2766 folder and place it in the proper order within the patient's medical record. Remove and shred the photocopied DD Form 2766 when the original is returned to the medical record.

4.1.5.2. It is recommended the MTFs have an arrangement with a copying service (or base reproduction services) to rapidly reproduce DD Form 2766 onto 17"x 11 1/2" paper when deployment is imminent. The extra name and Social Security Number lip of the form will not be needed for the photocopied document.

4.1.6. Chart Audit. This action is reserved for official JCAHO and military inspections. MTFs may use this area for test surveys in preparation for official inspections. Place the date in the designated square.

4.2. SF 600, Health Record: Chronological Record of Medical Care

4.2.1. Every patient encounter using SF 600 should contain prevention documentation. The DD Form 2766 counseling block does not take the place of quality counseling documentation on the SF 600.

4.2.2. Document health and wellness, preventive counseling, referrals, and prescriptions on SF 600, using the "SOAPP" note format (where the second "P" indicates prevention documentation).

Chapter 5

MARKETING

5.1. Overview. Marketing increases the beneficiary population's knowledge of the specific processes and programs available to them for enhancing their health and well being. Marketing is necessary to compete in the new environment of changed requirements and reduced resource consumption, the environment in which PPIP plays a prime role.

5.2. Marketing . HEAR, the DoD health risk assessment, assists in identifying patient needs. It creates an extensive database for developing effective programs. Use it to develop an annual marketing plan and design programs based on patient needs. PPIP coordinators should work with those personnel responsible for maintaining the HEAR database.

5.3. Promotion . The PPIP coordinator must ensure that programs and activities are effectively promoted. Promotion is part of the marketing mix and has five elements: Advertising, publicity, personal contact, incentives, and internalizing.

5.3.1. Advertising

5.3.1.1. Advertising is any non-personal promotion, usually for a fee, that identifies you as the originator. It includes prevention articles, ads, posters, flyers, and radio and television spots. Working with the HAWC, place ads in the base newspaper and various bulletins. The MTF public relations office can produce professional-looking flyers. Display items in all patient-access areas of the MTF, as well as frequently visited base activities, such as the exchange, commissary, post office, etc.

5.3.1.2. Some installations in United States Air Forces in Europe (USAFE) and Pacific Air Forces (PACAF) have access to Armed Forces Radio and Television Service (AFRTS), which offers excellent advertising opportunities. Stateside, many local cable operators have a community access channel run by the base communication squadron, another excellent opportunity to advertise PPIP.

5.3.1.3. Waiting Room/Timeline Posters

5.3.1.3.1. Waiting Room Posters should be placed in every waiting room and lobby in the MTF. You can display them in the commissary, post office, childcare centers, gyms, and other areas, as determined by the Prevention Committee.

5.3.1.3.2. Display the Adult and Child Timeline Posters in all examination rooms of the family practice clinic or the primary care clinic. You can place them in other areas of the MTF as determined by the Prevention Committee.

5.3.1.3.3. Display the Child Timeline Posters in all examination rooms of the pediatric clinic. You can place it in other areas of the MTF determined by the Prevention Committee.

5.3.1.4. The *Personal Health Guide* and *Child Health Guide*. Patients play a critical role in tracking and prompting their own preventive care. Studies have shown that both clinicians and patients appreciate patient-held (or parent-held) records, such as those promoting childhood immunization programs.

5.3.1.4.1. The *Personal Health Guide* and the *Child Heath Guide* inform patients of a range of preventive services, facilitate a structured dialogue with providers, and assist patients in tracking their own care.

5.3.1.4.2. When explaining how to use the *Personal Health Guide* and the *Child Heath Guide*, let the patient know that you think the guidelines are important. Discuss topics that apply to the patient's personal health behavior, as well as areas in which he or she desires to make changes. Instruct patients to bring the guides to each visit for review and updating. Advise patients to read or review the information at the top of each page identified on their individualized records, reinforce health messages and assist patients in setting realistic goals for changing health behaviors, and reinforce positive behavior changes.

5.3.1.4.3. Give a *Personal Health Guide* to every adult patient (17 and older) and a *Child Health Guide* to the parent of every pediatric patient. For the guides to be effective tools, an explanation of their importance is critical.

5.3.2. Publicity. Publicity differs from advertising in that it does not identify you as the originator. A paid ad in the base newspaper is a form of advertising. A staff reporter writing a review of a program is a form of publicity. Advertising is better for informing the public about upcoming events, while favorable publicity helps to generate a good image because the endorsement comes from a third party. Work with your MTF public affairs representative to use both techniques. Prevention articles are available through the PPIP homepage (www.ophsa.brooks.af.mil) that can be modified for use in local base newspapers.

5.3.3. Personal Contact. Personal contact is the most effective promotion method, although it reaches fewer people. A personal presentation about a program carries more impact than an article in the paper. Use this method to brief first sergeants, commanders, and attendees at commander's call.

5.3.4. Incentives. Promotional and advertising efforts are results-oriented. Each effort is designed to achieve a specific goal or a combination of goals, such as increased awareness, participation, membership, demand, or sales. Successfully accomplishing marketing and promotional goals will contribute significantly to overall program success. We recommend that the PPIP coordinator work with the HAWC in using incentives to promote prevention and wellness.

5.3.5. Internalizing.

5.3.5.1. One of the most overlooked roles of effective promotion is to inform and support our own MTF personnel. Direct your promotion efforts toward other MTF personnel, as well, and ensure that all medical staff members are fully briefed on upcoming programs.

5.3.5.2. Methods of promoting the PPIP program among medical staff members include:

5.3.5.2.1. E-mails

5.3.5.2.2. Electronic bulletin boards

5.3.5.2.3. Newsletters

5.3.5.2.4. Staff meetings

5.3.5.2.5. In-services

Chapter 6

RESOURCES

6.1. PPIP Materials

6.1.1. Reference Materials

6.1.1.1. The *Clinician's Handbook of Preventives Services* provides the recommendations of major authorities, emphasizing age and periodicity for preventive screening, at the beginning of each chapter. By reviewing these recommendations, clinicians can decide which guidelines to select, or can set their own standards based on current recommendations. A set of standards, even if minimal, must be identified and adopted as policy. Concentrate your efforts on those preventive services that can actually be provided under time, staff, and other resource limitations. Periodically examine the selected standards, updating them as needed, based on current research and the changing needs of the patient population. The Virtual Hospital, developed by the University of Iowa, offers an on-line version of the 1994 edition of the *Clinician's Handbook* at http://vh.radiology.uiowa.edu/Providers/ClinGuide/CGType.html. This site features the full text of the publication, including all sixty chapters and graphs/charts.

6.1.1.2. The *Guide to Clinical Preventive Services* presents a systematic approach to evaluating the effectiveness of clinical preventive services. The recommendations, and the review of evidence from published clinical research on which they are based, are the product of a methodology established at the outset of the project. The intent of this analytic process has been to provide clinicians with current and scientifically defensible information about the effectiveness of different preventive services, as well as the quality of the evidence on which these conclusions are based. It is intended to help clinicians, whose time is limited, select the most appropriate services to offer in a periodic health examination, for patients of different ages and risk categories. The critical appraisal of evidence is also intended to identify services of uncertain effectiveness, as well as those that could result in more harm than good, if performed routinely by clinicians.

6.1.2. Office Materials

6.1.2.1. DD Form 2766, **Adult Preventive and Chronic Care Flowsheet**, and AF Form 3923, **Child Preventive Care Flowsheet**. The most basic tool for tracking and prompting preventive services is a flowsheet. For flowsheets to be useful, you must enter data on them promptly. Staff assistance in updating and maintaining chart flowsheets is very important. The entire staff must be familiar with their format and how to use them. Over time, flowsheets are useful for tracking and auditing the performance and results of preventive care, encouraging increased compliance with preventive care standards, and detecting and treating preventable conditions early. There are three patient chart flowsheets (for adults, children, and childhood immunizations) to track and prompt preventive services.

6.1.2.1.1. Maintain DD Form 2766 for every adult TRICARE Prime patient assigned to a MTF PCM.

6.1.2.1.2. Maintain AF Form 3923 and AF Form 1480 for every child TRICARE Prime patient.

6.1.2.2. The *Personal Health Guide* and the *Child Health Guide*. Patients play a critical role in tracking and prompting their own preventive care. Studies have shown that both clinicians and

patients appreciate patient-held (or parent-held) records, such as those promoting childhood immunization programs. These guides:

6.1.2.2.1. Provide patients with information on a range of preventive services.

6.1.2.2.2. Facilitate a structured dialogue between patients and providers.

6.1.2.2.3. Assist patients in tracking their own care.

6.1.2.2.4. When explaining how to use the *Personal Health Guide* and *Child Health Guide*:

6.1.2.2.5. Let patients know that you think the guidelines are important.

6.1.2.2.6. Discuss topics that apply to the patient's personal health behavior, as well as those areas in which they desire to make changes; instruct patients to bring the guides to each visit for review and updating.

6.1.2.2.7. Advise patients to read or review the information at the top of each page identified on their individualized records.

6.1.2.2.8. Reinforce health messages and assist patients in setting realistic goals for changing health behaviors.

6.1.2.2.9. Reinforce positive behavior changes.

6.1.2.3. Prescription Pad for Prevention. Prevention prescriptions and behavioral-change contracts facilitate change by clearly defining expectations of the patient and the clinician. In addition, a written plan of action, based on an agreement between the patient and the clinician, emphasizes the patient's ability and responsibility to contribute to their own disease prevention and health promotion. Follow-up telephone calls to determine progress are also helpful in encouraging compliance with health-related recommendations, but they are less cost-effective than mailed prompts.

6.1.2.4. Reminder Postcards (Adult and Child). Postcards or letters can be useful in reminding patients to come in for needed preventive care. You can reproduce reminder postcards (one for adults, one for parents) locally. Organizations can easily create such reminders, or they can obtain preprinted cards from outside sources. Computerized systems can generate mailed prompts. Patient reminders can greatly increase the rate at which clients return for services. Templates are available through the Internet at http://www.ahcpr.gov/ppip/.

6.1.2.5. Post-itô Note Pads. These provide temporary reminders for providers to deliver needed preventive services, even if a visit is scheduled for other reasons.

6.1.2.6. Chart Stickers. Permanent alert stickers for patient charts remind providers to address needed preventive services, such as smoking cessation or diet counseling, at every encounter.

6.1.2.7. Waiting Room Poster, Adult Examination Room Timeline, and Child Examination Room Timeline. These visual prompts in the office and all examination rooms remind both office staff and patients of the need for continuing preventive care services.

6.1.2.7.1. Preventive care timelines (one for children through age 18 and one for adults) show the ages at which preventive care should be given. They are colorful wall charts for use in the office and clinic examination rooms.

6.1.2.7.2. They serve two functions:

6.1.2.7.2.1. Guides for clinicians in determining which services to provide to which individuals.

6.1.2.7.2.2. Prompts for individual consumers to ask for services, and thereby promote service delivery, as recommended by major authorities.

6.1.2.8. Refer to the PPIP Home Page (http://www.ophsa.brooks.af.mil) for information on ordering PPIP Material.

6.2. Preventive Health Assessment (PHA)

6.2.1. The PHA is an improved method of applying physical standards to the active duty force, and is a significant link in the PPIP initiative. It has evolved from the periodic physical examination program, focused physical examination, and Preventive Health Physical (PHP) initiatives.

6.2.2. Preventive services based on the PPIP concept will be incorporated into the PHA process with the completion of DD Form 2766 on all active duty members.

6.2.3. The MTF PPIP coordinator and the health educator can assist by providing counseling services on self-identified risk factors obtained from the HEAR or the 16-question Health History Questionnaire.

6.2.4. You can find information about how the PHA and PPIP relate to each other in the Preventive Health Assessment Implementation Document located at the AF School of Aerospace Medicine homepage (wwwsam.brooks.af.mil/af/chief.htm).

6.3. Health Enrollment Assessment Review (HEAR)

6.3.1. HEAR is a self-reporting health assessment tool that indicates:

6.3.1.1. An individual's health risk factors and preventive care needs, which are reported to both the individual and their primary care manager (PCM).

6.3.1.2. Those individuals who are likely to use high levels of medical resources.

6.3.1.3. The appropriate training and expertise level required for the effective management of an individual's health care.

6.3.1.4. Risk factors, demographics, care levels, and utilization for strategic planning in population health management and resource utilization at the Regional, MAJCOM, or MTF level.

6.3.2. HEAR Questionnaire. The survey is administered to those 17 years old and older who enroll in TRICARE Prime. It takes about 20 minutes to complete. The survey questions cover demographics, physical activity, men's health, cholesterol status, alcohol use, mental health, activity limitations, life satisfaction/family conflict, blood pressure status, women's health, tobacco use, preventive issues, stress, absenteeism, medical care history, and chronic conditions.

6.3.3. HEAR Software. Elements from the HEAR survey are entered into a database, generally by scanning. Algorithms are run against the data and several reports are generated:

6.3.3.1. Patient Report Card

6.3.3.2. Primary Care Manager (PCM) Report

6.3.3.3. PCM Panel Report

6.3.3.4. Ad Hoc Custom Reports

6.3.3.5. Patient Report Card . A concise report addressing the individual's health risk factors, currency for recommended preventive services, and chronic disease history.

6.3.3.6. Primary Care Manager (PCM) Report. Provides the same information as the Patient Report Card, plus an assessment of the selected risk factors, predictions for resource utilization, suggested care level, and any missing or incomplete information from the HEAR survey.

6.3.3.6.1. Within 30 days of receipt, the PCM team should review the PCM Report IAW set clinical triage protocols that match acuity.

6.3.3.6.1.1. Reports reflecting high resource utilization and high primary care level (i.e., 3-3) should be reviewed by the PCM to determine the need for further follow-up.

6.3.3.6.1.2. Reports reflecting moderate resource utilization and moderate primary care level (i.e., 2-2) should be reviewed by a nurse to determine additional follow-up, per MTF protocol.

6.3.3.6.1.3. Reports reflecting low resource utilization and low primary care level (i.e., 1-1) can be reviewed by qualified medical personnel to determine additional follow-up, per MTF protocol.

6.3.3.6.2. PCM Reports may have SOAPP notes placed directly on them, stating outcomes and follow-ups completed.

6.3.3.6.3. PCM Reports will become a permanent part of the patient's medical record, filed behind the DD Form 2766.

6.3.3.7. PCM Panel Report. Gives a comprehensive picture of the individuals on each PCM's panel. It identifies the number of smokers, hypertensive individuals, diabetics, individuals needing tetanus immunization, etc., by PCM.

6.3.3.8. Ad Hoc Custom Reports. Ad hoc custom reports can be generated for health promoters, PCMs, commanders, and health care planners at all levels, to support the unique objectives of an organization. Medical personnel should be trained to gather data from the ad hoc custom reports and how to personalize MTF reports using MK Query Builder (included in HEAR software), or another database report-writing program (e.g., MS Access, Crystal Reports) selected by the MTF.

6.3.4. HEAR Information/Resources. The HEAR program has a site on the Office for Prevention and Health Services Assessment (OPHSA) homepage (www.ophsa.brooks.af.mil). It contains software downloads, documentation downloads, information packets, a bulletin board information exchange, briefing materials, and direct e-mail access to managerial and technical resources.

Chapter 7

EVALUATION

7.1. Purpose. Evaluation is a primary function of all management levels. Evaluating the MTF prevention program is a joint function of the Prevention Committee, the MTF executive staff, and the MAJCOM Surgeon's staff.

7.1.1. Evaluation is a spectrum of activities that includes:

7.1.1.1. Metrics

7.1.1.2. Inspection

7.1.1.3. Benchmarking

7.1.1.4. Quality improvement

7.1.2. Prevention evaluation studies should address several basic questions.

7.1.2.1. Magnitude: What is the size of the problem addressed by the prevention strategy?

7.1.2.2. Efficacy: Can the prevention strategy work?

7.1.2.3. Effectiveness: Does the prevention strategy work?

7.1.2.4. Societal perspective: What are the benefits and harms of the prevention strategy?

7.1.2.5. Cost analysis: What does the prevention strategy cost?

7.1.2.6. Cost-effectiveness, cost-benefit, and cost-utility analysis: How do the benefits compare with the costs?

7.1.3. The effectiveness of prevention program initiatives is the product of its efficacy, compliance, and penetration.

7.2. Metrics

7.2.1. Using metrics, or some form of measurement, is critical to achieving goals. Good metrics will gauge progress in reaching desired outcomes. The purpose of collecting and tracking data is to help improve the system or process. Data are a means to an end, not an end itself.

7.2.2. Health Plan Employer Data and Information Set (HEDIS) 3.0

7.2.2.1. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have information to reliably compare the performance of managed health care plans. The performance measures in HEDIS are related to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes. HEDIS 3.0 also includes a standardized member-satisfaction survey. It is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA).

7.2.2.2. Combining information from NCQA's accreditation program (a rigorous and expert evaluation of managed-care plan organization and operation) with HEDIS data provides the most complete view of health-plan quality available. HEDIS 3.0 provides consumers with an unprecedented ability both to evaluate the quality of different health plans along a variety of important dimensions, and to make decisions based on demonstrated value, rather than simply on cost.

7.2.3. Air Force Medical Service Performance Measurement Tool (AFMSPMT)

7.2.3.1. In February 1997, the AFMS roundtable discussed the lack of standardized performance measurements and the incentives to achieve them. It was concluded that these deficiencies create significant barriers to improving AFMS quality, service, and cost efficiency. It was agreed that future evaluations of MTF performance and resource allocation should be based on standardized performance measures. The JCAHO/HSI accreditation process will continue. However, creating an AFMSPMT that uses standardized metrics and automates data collection (particularly for the AFMS as an accountable health care plan with an enrolled population) will be a crucial first step in meeting AFMS goals.

7.2.3.2. The AFMSPMT Workbook Appendix outlines the tool. You can find it at the OPHSA homepage (www.ophsa.brooks.af.mil). Performance is assessed in the three major quality areas of health care: technical outcomes (readiness and managed care), customer service, and financial performance. The current benchmark for health care plans is HEDIS 3.0. The AFMSPMT establishes the foundation upon which future performance-assessment enhancements will be built. These "foundation-building metrics" in the tool include promoting data integrity, to ensure that enrollment data is correct and, thus, correct funding of our MTFs, as DoD moves to enrollment based capitation. Data integrity will help identify functional and technical deficiencies early, and address them quickly through standardized, "bridge" automated solutions. This effort does not replace, but rather complements and is consistent with, the broader MHS automation plan ("Emerald City"). The goal is to make data collection, analysis, and utilization as easy and as automated as possible, so AFMS personnel can support continued quality improvement.

7.2.3.3. The performance measures identified in the AFMSPMT Workbook, and their automated solutions, represent a first, critically important step toward incorporating the principles of utilization management/quality management (UM/QM) into AFMS practice. Data is being drawn from existing systems (DEERS, ADS, CHCS, and Alpha Rosters), using standardized definitions and programmed technical solutions. Deployment and implementation of ADS 2.0 will greatly facilitate this effort.

7.2.3.4. Many experts in the field say, "what gets measured, gets managed." The AFMSPMT represents what is achievable in the near term, as opposed to the ideal. The desired result is an accountable health plan, with data-driven quality improvement built in, not added on. These performance measures are a major step toward improved information for better resource allocation, quality, and demand/disease management decisions at all levels. The AFMSPMT will continue to be refined and improved. As the AFMS center for health-services research, OPHSA and related work groups will be aggressively attacking the metrics that do not have ad hoc solutions specified, or that are labor intensive. In addition, other clinical quality improvement efforts, such as the development and implementation of clinical practice parameters, PPIP, the HEAR and PPIP support offices, the PHCS, etc., will be coordinated through OPHSA for maximum impact and accessibility.

7.2.3.5. The metrics and ad hoc solutions already specified should be used NOW to help AFMS learn the principles and practices of integrating existing systems and processes to improve the quality of care.

7.2.4. MAJCOM Prevention Metrics. MAJCOM prevention goals provide metrics that should require data collection, tracking, and reporting to MAJCOM Surgeons' Prevention Committees.

7.2.5. MTF Planning and Management. Metrics are primarily useful for making course changes in project management. Examples of management metrics include the percent of providers trained in prevention, the percent of records with completed DD Form 2766 or SOAPP notes, etc.

7.2.6. MTF Metrics. MTF metrics should look at three areas – structure, process, and outcome. These metrics provide a measure of a prevention program's effectiveness. Frequently, they reflect behavior change.

7.2.6.1. A structural metric provides a measure of how well the infrastructure is designed. An example of a structural metric might be "the percent of providers having a copy of the *Clinician's Handbook of Preventive Services"*.

7.2.6.2. A process metric provides a measure of how well a process works. An example of a process metric might include "the percent of patients that have an up-to-date DD Form 2766".

7.2.6.3. An outcome metric provides a measure of a prevention program's effectiveness. An example of an outcome metric might be "the real reduction in late stage breast cancer diagnoses due to earlier screening".

7.2.6.4. Examples of good outcome metrics:

7.2.6.4.1. Decrease in base smoking rate, as a measure of a tobacco cessation program.

7.2.6.4.2. Decrease in pediatric head injury statistics, as a measure of a bicycle safety and helmet distribution program.

7.2.6.5. Examples of poor outcome metrics:

7.2.6.5.1. Graduation rate from tobacco cessation program

7.2.6.5.2. Number of bicycle helmets distributed

7.2.6.6. The emphasis is to measure health outcomes, not completion of a process.

7.2.6.7. Attachments 5 and 6 contain sample administrative and clinical objectives/checklists developed by the preventive services working group of the DoD PPIP Model Project for the MHS. Use these sample objectives/checklists as guides for developing the MTF objectives/checklists.

7.2.7. Provider and Staff Performance Feedback.

7.2.7.1. Medical managers review individual performance measures with providers.

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

7.2.7.3. Performance feedback should be completed monthly, briefed in departmental staff meetings, and reported to the Prevention Committee and the MTF Executive Committee.

Chapter 8

INSPECTIONS

8.1. Self-Inspections . Self-inspection is a critical component of quality improvement and is required for all prevention programs. Discrepancies found in self-inspections must be identified, corrected, and documented. Deficiencies not acted on or improved for three months should be examined by the MTF Executive Committee. Deficiencies that cannot be resolved locally should be reported, through the Executive Committee, to the MAJCOM Prevention Committee.

8.2. Joint Commission for Accreditation for Health Organizations (JCAHO). Current JCAHO inspection criteria do not address the PPIP Program directly.

8.3. Health Services Inspections (HSI) . HSI inspections measure an MTF's prevention program against specific criteria, as well as other MTFs. It is in the MTF Prevention Committee's best interest to actively seek lessons learned from other inspection programs. Discrepancies identified should be tracked to resolution. Any item that continues without action for three months should be reported, through the Executive Committee, to the MAJCOM Prevention Committee.

8.4. Staff Assistance Visits (SAV) . MAJCOMs should make a timely response to SAV requests. The requesting MTF is financially responsible for SAVs, but they should be a high priority in the MAJCOM's list of responsibilities. MAJCOM SAV recommendations should be briefed to the local Prevention and Executive Committees, as well as the MAJCOM Prevention Committee.

8.5. Benchmarking . Benchmarking can help improve the overall prevention program. By purposefully comparing the local program with other prevention programs, inside and outside the military, ideas can be generated and problems corrected. There is no need to reinvent the wheel. Several programs worthy of benchmarking are listed on the PPIP homepage (www.ophsa.brooks.af.mil). You may find others at the USAF Inspector General Medical Operations Directorate's "best practices" homepage: http://www-afia.saia.af.mil/sg/sg_restrict/sg_best.html.

8.6. Quality Improvement . A quality improvement program will incorporate measures to ensure movement toward a personal commitment by individual providers in the prevention arena (using SOAPP format, where the last "P" stands for prevention, etc.). Quality improvement involves process and outcome improvements, in both small and large increments, but always moving toward the prevention program goals.

8.7. Forms Prescribed. This pamphlet prescribes the following forms: AF Form 422, **Physical Profile Serial Report**; AF Form 1098, **Special Task Certification and Recurring Training**; AF Form 1480, **Summary of Care**; AF Form 1480A, **Adult Preventive and Chronic Care Flowsheet**; AF Form 1480B, **Adult Preventive and Chronic Care Flowsheet – Continuation Sheet**; AF Form 2100 Series, **Health Record – Outpatient**; AF Form 2100A Series, **Health Record – Outpatient**; AF Form 3922, **Adult Preventive Care Flow Sheet**; AF Form 3923, **Child Preventive Care Flowsheet**; DD Form 2766, **Adult Preventive and Chronic Care Flowsheet**; DD Form 2766c, **Adult Preventive and Chronic Care**

Flowsheet – Continuation Sheet; and SF 600, **Health Record – Chronological Record of Medical Care**.

CHARLES H. ROADMAN II, Lt General, USAF, MC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

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AFI 41-210, *Patient Administration Functions*

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USAF/SGM Memorandum, *Directed Requirements for Family Practice/Primary Care Clinics*, 5 September 1996

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Abbreviations and Acronyms

ADS—Ambulatory Data System

AF—Air Force

AFJI—Air Force Joint Instruction

AFMS—Air Force Medical Service

AFMSPMT—Air Force Medical Service Performance Measurement Tool

AFRTS—Armed Forces Radio and Television Service

AMDS—Aeromedical Squadron

BHC—Building Health Communities

BRFSS—Behavioral Risk Factor Surveillance Survey

CC—Commander

CEU—Continuing Education Units

CHCS—Composite Health Care System

CME—Continuing Medical Education

CPS—Clinical Preventive Services

DEERS—Defense Enrollment Eligibility Reporting System

DoD—Department of Defense

DPG—Defense Planning Guidance

HAWC—Health and Wellness Center

HEAR—Health Enrollment Assessment Review

HEDIS—Health Plan Employer Data Information Set

HSI—Health Service Inspection

ITS—Immunization Tracking System

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

MAJCOM—Major Command

MDOS—Medical Operations Squadron

MHS—Military Health System

MMD—Morbidity, Mortality, and Disability Study

MSP—Mission Support Plan

MTF—Medical Treatment Facility

NCO—Noncommissioned Officer

NCQA—National Committee for Quality Assurance

OASD/HA—Office of the Assistant Secretary of Defense for Health Affairs

OB/GYN—Obstetrics/Gynecology

ODPHP—US Public Health Service Office of Disease Prevention and Health Promotion

OPHSA—Office for Prevention and Health Services Administration

O&M—Operation and Maintenance

PACAF—Pacific Air Forces

PCM—Primary Care Manager

PDC—Publication Distribution Center

PHA—Preventive Health Assessment

PHCA—Preventive Health Care Application

PHP—Preventive Health Physical

PPIP—Put Prevention into Practice

QM—Quality Management

QMR—Quality Management Review

SAV—Staff Assistance Visit

SG—Surgeon General

SOAPP—Subjective, Objective, Assessment, Plan, Prevention

UM—Utilization Management

USAFE—United States Air Forces Europe

USPSTF—United States Preventive Services Task Force

WWW—World Wide Web

Terms

Clinical Preventive Services (CPS)—Preventive care (counseling, immunizations, chemophrophylaxis, and screening tests) provided during outpatient clinic visits for enhancing readiness and improving the health of all beneficiaries.

Disease Prevention

Primary prevention—Measures designed to target risk factors to prevent occurrence of disease or injury (pneumococcal vaccine, sunscreen, hearing protection, etc.).

Secondary prevention—Measures provided to identify and treat asymptomatic persons who have already developed risk factors or preclinical disease but in whom the condition has not become clinically apparent (mammography, etc.).

Tertiary prevention—Measures provided as a part of the treatment and management of persons with established illnesses or injury (lipid lowering medications, insulin, etc.).

Health Promotion—Disease and injury prevention strategies that depend on behavioral change in individuals.

Health Risk Appraisal—Survey instrument designed to assess patient cognitions and behaviors related to health. Provides information for targeting and evaluating the efficacy of CPS for the individual.

Occupational Preventive Services—Activities designed to prevent or mitigate occupationally related illnesses and injuries, so that community health, operational capabilities, and human performance are increased.

Put Prevention into Practice—Outpatient clinic tools and strategies for improving CPS. Includes, but not limited to, PPIP reception area posters; adult and child preventive care timeline posters; personal health guides for adult and child; DD Form 2766, Adult Preventive and Chronic Care Flowsheet; AF Form 3922, Adult Preventive Care Flowsheet; preventive medicine/health and wellness pamphlets; and preventive medicine prescriptions.

Attachment 2

EDUCATION/TRAINING

Job Title	Tasks	Task Examples	Required Education
Appointment Clerk	Counsels	1. Reminds to bring shot record 2. Reminds to bring Service-specific health risk assessment printout	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 2766 template is in medical record 4. Counsels	3. Provides PPIP Health Habits Questionnaire 4. Communicates 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	5. Performs vital signs 6. Educates about Personal Health Guides 7. Reviews health habits questionnaire 8. Counsels 9. Completes flowchart on DD Form 2766 template	5. Provides reminders for providers about specific risk factors 6. Distributes *Personal Health Guides* 7. Communicates 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 8. QI process

Job Title	Tasks	Task Examples	Required Education
Provider	10. Performs history and physical 11. Addresses highlighted items on Health Habits Questionnaire 12. Completes flowchart DD Form 2766 template 13. Makes preventive medicine and other appropriate referrals and consultations	8. Checks boxes next to preprinted comments to indicate preventive health issues 9. Checks 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 preventive services
Health Educator or Nurse Educator	1. Provides health education literature 2. Counsels 3. Initiates referrals per local procedures	Addresses issues represented by boxes checked by provider	Module Four
Case Manager	4. Provides clinical case management (e.g., diabetes) to move from tertiary prevention to secondary prevention 5. Consults/is clinic resource for staff education		Module Four plus: Case management skills
PPIP Coordinator	6. Tracks/studies patient flow patterns in clinics 7. Interfaces with UM/QM committees 8. Interfaces with case managers 9. Coordinates/provides staff education on PPIP 10. Consults on PPIP resources 11. Performs/monitors QI 12. Complements provider champion in staff education efforts		Module Five: 1. Contents of Modules One, Two, Three, and Four, plus: 2. CHCS training for customized reports 3. PHCA training 4. Health Promotion Director Training Certification Course

Job Title	Tasks	Task Examples	Required Education
PPIP Provider Champion	13. Participates at all levels of staff education 14. Advocates prevention by word and deed 15. Consults on PPIP throughout system		Module Six: 1. Contents of Module Five, plus 2. Automation systems training (CHCS, PHCA) for outcomes reports 3. Population-based medical practices 4. Health outcomes
Commander, Executive Officer, MTF Executive Committee, Prevention Oversight Committee	16. Reviews Service-specific health risk assessment and region specific morbidity data 17. Assesses and prioritizes community needs 18. Directs priorities for preventive services		Module Seven (Executive Module) 1. Overview of PPIP 2. Overview of systems thinking 3. USPSTF Guidelines 4. Stages of Change 5. Population-based medical practices 6. Health outcomes

Attachment 3

ADMINISTRATIVE OBJECTIVES

General Objective	Element	Indicators	Data Sources
Administration/ Oversight	Prevention Committee	1. Composed of management, providers, nursing, quality assurance, administration, health promotion, public health, enlisted personnel, dental, and PPIP 2. Oversight for PPIP with a clearly defined charter 3. Involved in continual assessment, implementation, and evaluation of PPIP initiatives	Survey
	PPIP Coordinator	Full-time coordinator/program manager who coordinates all local PPIP activities	Survey
	Provider Prevention Champion	Available with at least 25 percent of duty time dedicated to PPIP	Survey
	"Policy for Put Prevention into Practice (PPIP)" Memorandum	Office of the Assistant Secretary of Defense for Health Affairs (OASD/ HA) memorandum available	Survey
	Processes/MTF Plan	Process/MTF plan available, documenting how PPIP is instituted	Survey
	PPIP Flowsheet	DD Form 2766 used consistently and contains accurate data (either manual or electronic)	Medical records and PHCA
	SF 600	PPIP counseling documented on SF 600 using the SOAPP format; the additional "P" = prevention counseling documentation (manual or electronic)	Medical records

General Objective	Element	Indicators	Data Sources
	Performance Feedback	Performance feedback to providers and staff 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, participating medical personnel in PPIP concept, office materials, documentation, tools for discussing prevention with patients, and outcome measurements	Focused skills training (initial and recurring) 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/prevention concepts incorporated into basic curricula in facilities with provider, nursing, technician, and ancillary health training programs 2. Principles/practice of prevention interventions included in all educational forums in medical facility (grand rounds, journal clubs, local CME/ CEU meetings, etc.)	Survey
	Provide prevention educational opportunities to TRICARE Prime patients and other beneficiaries	Education for TRICARE Prime patients accomplished via informational handouts/video presentations in waiting areas, articles in base/local newspapers, presentations at installation/ community meetings, radio/TV spots, and referrals to health educators. Standardized material will be provided by MHS Working Group.	Survey
Resources/Systems	Staffing	Staffing structure for primary care sufficient to provide acute care, chronic care, and clinical preventive services	Survey
	Computer and Internet Support	PPIP coordinator has dedicated computer with Internet access	Survey

General Objective	Element	Indicators	Data Sources
	PPIP Publications	Publications available in clinic areas. 1. At least 90 percent of primary care providers have a current *Clinician's Handbook of Preventive Services* 2. At least 90 percent of exam rooms and waiting areas have timelines and PPIP posters	Survey
	PPIP Forms	At least 90 percent of TRICARE Prime patients seen by PCM within the last year have prevention flow-sheet in their medical record. Flow-sheets used consistently and contain accurate data.	Survey
	Reminder System	Adequate reminder system/follow-up in place to provide ongoing motivation to clients (specific implementation determined by Service)	Survey
	Health Enrollment Assessment Review (HEAR)	In place to ensure indicated testing and/or counseling is accomplished	Survey
Marketing	Increase awareness by executive staff	Executive staff understands preventive services	Survey
	Increase awareness by medical staff	Medical staff understands preventive services	Survey
	Increase awareness by patients	TRICARE Prime patients understand preventive services	Survey

Attachment 4

CLINICAL OBJECTIVES

NOTE:

Recommended screening guidelines are in accordance with the United States Preventive Services Task Force recommendations found in the 1997 Guide to Clinical Preventive Services. Recommendations do not necessarily reflect current requirements by TRICARE contract or the United States Air Force. The data sources for all objectives are CHCS, Service-specific health risk assessments, and a records review.

Criteria	Target Population
ALCOHOL Queried regarding alcohol use during 5-year period	TRICARE Prime patients continuously enrolled during reporting year
ALCOHOL Indicated potential heavy use	TRICARE Prime patients continuously enrolled during reporting year, AND Indicated alcohol use during past 5 years
ALCOHOL Follow-up: counseling	TRICARE Prime patients continuously enrolled during reporting year and preceding year, AND Indicated heavy alcohol use during the past 5-year period or Treated in MTF for accident or injury, AND Indicated heavy use of alcohol
ALCOHOL Accident/injury: visits	Treated in MTF for accident or injury during reporting year and preceding year
ALCOHOL If accident/injury: queried regarding alcohol use	Treated in MTF for accident or injury during reporting year and preceding year
ALCOHOL If accident/injury: visits with heavy use indicated	Treated in MTF for accident or injury, AND Indicated heavy alcohol use during reporting year and preceding year
ALCOHOL Follow-up: program referral	TRICARE Prime patients continuously enrolled during reporting year and preceding year, AND Indicated heavy alcohol use during past 5-year period or Treated in MTF for accident or injury, AND Indicated heavy alcohol use
CHOLESTEROL Any screening during 5-year period	TRICARE Prime males at least 35 years old, AND TRICARE Prime females at least 45 years old, AND Continuously enrolled during reporting year and preceding year

Criteria	Target Population
CHOLESTEROL Follow-up: repeat test	TRICARE Prime males at least 35 years old, AND TRICARE Prime females at least 45 years old, AND Continuously enrolled during reporting year and preceding year, AND Had abnormal cholesterol result
CHOLESTEROL Follow-up: lipoprotein	TRICARE Prime males at least 35 years old, AND TRICARE Prime females at least 45 years old, AND Continuously enrolled during reporting year and preceding year, AND Had abnormal cholesterol result
CHOLESTEROL Follow-up: counseling	TRICARE Prime males at least 35 years old, AND TRICARE Prime females at least 45 years old, AND Continuously enrolled during reporting year and preceding year, AND Had abnormal cholesterol result
CHOLESTEROL Follow-up: medication	TRICARE Prime males at least 35 years old, AND TRICARE Prime females at least 45 years old, AND Continuously enrolled during reporting year and preceding year, AND Had abnormal cholesterol result
IMMUNIZATIONS 2 year olds: diphtheria, tetanus, and pertussis immunization; oral or inactivated polio vaccine; and measles, mumps, and rubella vaccine series	TRICARE Prime children who turned two years old during reporting year, AND Continuously enrolled for 12 months immediately preceding second birthday
IMMUNIZATIONS 2 year olds: hepatitis B vaccine, hemophilus influenza B vaccine, and varicella	TRICARE Prime children who turned two years old during reporting year, AND Continuously enrolled for 12 months immediately preceding second birthday
IMMUNIZATIONS Active Duty: influenza	All active duty members continuously enrolled during reporting year
IMMUNIZATIONS Active Duty: hepatitis A	All active duty members continuously enrolled during reporting year with at least one hepatitis A vaccine
MAMMOGRAMS Breast cancer screening	Women aged 50 through 69 at test time, AND Continuously enrolled during reporting year and preceding year, AND Had mammogram during reporting year or preceding year

Criteria	Target Population
MAMMOGRAMS Follow-up: days to notification of abnormal	Women aged 50 through 69 at time of testing, AND Continuously enrolled during reporting year and preceding year, AND Had mammogram during reporting year or preceding year, AND Had abnormal mammogram
MAMMOGRAMS Follow-up: days from notification to follow-up	Women aged 50 through 69 at time of testing, AND Continuously enrolled during reporting year and preceding year, AND Had mammogram during reporting year or preceding year, AND Had abnormal mammogram
MAMMOGRAMS Follow-up: days from mammogram to follow-up	Women aged 50 through 69 at time of testing, AND Continuously enrolled during reporting year and preceding year, AND Had mammogram during reporting year or preceding year, AND Had abnormal mammogram
PAP SMEAR Cervical cancer screening	Women aged 21 through 64, AND Continuously enrolled during reporting year, AND Received one or more Pap tests during reporting year or two years prior to reporting year
PAP SMEAR Follow-up: abnormal Pap smear	Women aged 21 through 64 years, AND Continuously enrolled during reporting year, AND Received one or more Pap tests during reporting year or two years prior to reporting year, AND Had abnormal Pap smear
PAP SMEAR Follow-up: days from notification to follow-up	Women aged 21 through 64 years, AND Continuously enrolled during reporting year, AND Received one or more Pap tests during reporting year or two years prior to reporting year, AND Had abnormal Pap smear
PAP SMEAR Follow-up: days from Pap smear to follow-up	Women aged 21 through 64 years, AND Continuously enrolled during reporting year, AND Received one or more Pap tests during reporting year or two years prior to reporting year, AND Had abnormal Pap smear
REPRODUCTIVE COUNSELING Ever queried/advised regarding STDs during 5-year period	Adults aged 17 years and older as of December 31 of reporting year, AND Continuously enrolled during reporting year, AND Seen by plan provider during the reporting year

Criteria	Target Population
REPRODUCTIVE COUNSELING Follow-up: counseling	Adults aged 17 years and older as of December 31 of reporting year, AND Continuously enrolled during reporting year, AND Had one or more sex partners, AND Seen by plan provider during reporting year
STD Follow-up: hepatitis B vaccine	Adults aged 17 years and older as of December 31 of reporting year, AND Continuously enrolled during reporting year, AND Had one or more sex partners, AND Seen by plan provider during reporting year
TOBACCO Screening for use	Adults aged 17 years and older as of December 31 of reporting year, AND Continuously enrolled during reporting year, AND Seen by plan provider during reporting year
TOBACCO Advising smoker to quit	Adults aged 17 years and older as of December 31 of reporting year, AND Continuously enrolled during reporting year, AND Either current smokers or recent quitters, AND Seen by plan provider during reporting year