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Army Medical Treatment Facilities often have to refer patients to civilian health care providers for services which are beyond the capabilities of the Army facility. These referrals fall into two categories: 1. CHAMPUS referrals and 2. Supplemental Care referrals. Supplemental care referrals, used whenever non-elective specialized treatment procedures, consultations, diagnostic tests (like CT scans, EEGs, or others unavailable at the Army MTF), and supplies are required to augment the overall course of care being provided by the Army facility, are the focus of this study. It examines the problems with Cutlers's existing system in 1982 and sets forth the optimal feasible system for handling and monitoring that hospital's supplemental care referrals. A draft MEDDAC Regulation is also prepared.

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A STUDY OF THE HANDLING OF REFERRALS FOR SUPPLEMENTAL CARE BY MILITARY MEDICAL TREATMENT FACILITIES WITH PROPOSED CHANGES TO IMPROVE THE HANDLING OF SUCH REFERRALS AT CUTLER ARMY COMMUNITY HOSPITAL FORT DEVENS, MASSACHUSETTS

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In Partial Fulfillment of the

Requirements for the Degree

of

Master of Health Administration

by

Jay H. Anderson MD
Lieutenant Colonel, Medical Corps

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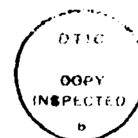

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I. INTRODUCTION

Conditions Which Prompted this Study

Army medical treatment facilities often have to refer patients to civilian health care providers for services which are beyond the capabilities of the Army facility. Such referrals fall into two general categories:[1]

(1) Those patients who are referred under the provisions of CHAMPUS. In the case of these referrals, the patient pays a portion of the cost and the remainder comes from the Department of Defense. The referring Army medical treatment facility does not have to use any of its budgeted operating funds to pay for this care. CHAMPUS referrals may be for either total care (the civilian health care providers are totally responsible for the management of the patient) or cooperative care (the patient is referred to the civilian provider for a specific treatment or service and a military physician retains responsibility for the overall management of the patient's care).

Patients eligible for care under CHAMPUS are the dependents of active duty military personnel, military retirees and their dependents.

(2) Supplemental care is those non-elective specialized treatment procedures, consultations or tests (such as CT scans or radiation therapy) and supplies which are required to augment the overall course of care being pro-

vided by an Army medical treatment facility to a patient eligible for such services or supplies, except CHAMPUS eligible beneficiaries. The costs of supplemental care are paid for by the referring Army facility directly out of its operating funds.

The handling of patients under the provisions of supplemental care directly impacts both the internal management and operating budgets of Army medical treatment facilities. This study then will be limited to the management of those referrals from Army facilities to civilian health care providers that come under the provisions of supplemental care.

Good management practice necessitates that these referrals be monitored from both the professional (medical) and administrative standpoints in order to obtain the best trade-offs between quality, service, and cost.

Professional monitoring must address: (1) The clinical appropriateness of the referral--is it really indicated? and (2) The quality, both technical and professional, of the service provided.

Administratively, both costs and numbers of referrals have to be monitored. Information as to the numbers of each specific type of study referred must be easily captured and recallable for planning purposes. Such information is also necessary for decisions concerning the implementation of services into Army medical treatment facilities. There must also be an easy effective means of verifying that the requested service has been rendered prior to authorizing payment.

Investigation of the area of supplemental care was prompted by a request from the Commander of Cutler Army Community Hospital to the writer to "find out if there were more orthopedic radiographic procedures referred to civilian providers in 1981 than in 1980." While the hospital comptroller's office did have records of payments to vendors for such procedures under supplemental care, it was essentially impossible to answer this question with any degree of certainty for several reasons.

Specific records of radiographic procedures referred to civilian providers were not maintained in the Department of Radiology. All referrals for outside radiographic procedures originated from, and the reports were returned to, the various clinical departments and nursing units. In the majority of instances the Radiology Department was not aware that a study had been sent out. The individual clinical departments and nursing units did not maintain records as to the number of specific radiographic studies which were being sent out.

The records in the Comptroller's office were filed only under the general category of radiology and were not segregated by specific study. They were filed in the sequence in which claims were processed rather than in the sequence in which the referrals were made. These records were further complicated by the fact that most radiology referrals generate two bills. One bill is from the civilian facility (usually a hospital) which performed the study. The second is for the professional services of the radiologist who interprets the study. These separate bills usually came to the

comptrollor's office at different times and, thus, were not filed together. This made it almost impossible to avoid duplicate counting, even when a concerted effort was made to match patient names and dates. In addition, the terminology employed to name the studies was not consistent from one time to the next from the same vendor or even between the bills received from the hospital and the radiologist for the same study. It was also observed that charges varied widely between civilian providers for the same procedure.

Discussion of the problems of easy accurate information retrival concerning these procedures with the Comptroller of Cutler Army Community Hospital revealed another area of needed management information. There was no effective means for his office to obtain verification that the requested service he received a bill for had, in fact, been rendered by the civilian provider. He further pointed out that in the case of referrals for obstetrical care of pregnant soldiers under supplemental care, the civilian practitioners were following their usual practices of using civilian laboratories near their offices. This resulted in the Army being billed for a number of laboratory tests that could be performed at Cutler Army Hospital with a resulting significant savings in costs. He raised the question of exploring contracting for supplemental obstetrical care with a panel of local civilian practitioners including the use of the Cutler Army Hospital laboratory whenever possible.

Further inquiry showed that while the Chief of Professional Services approved all requests for referrals under supplemental care and determined that they were clinically appropriate, his office did not maintain a log of such referrals nor any totals of the specific studies sent out. There was no single central control point or log for supplemental care referrals anywhere within the hospital.

A brief survey of three other Army medical treatment facilities indicated considerable variation as to how different facilities handle and monitor supplemental care referrals.[2]

The Problem

The problem addressed by this study is to determine the optimal feasible system for handling and monitoring supplemental care referrals for Cutler Army Community Hospital. CHAMPUS referrals, while having less of an impact on the internal management and administration of an Army medical treatment facility, are an extension of the same process. This study addresses the professional and administrative management information needs at Cutler Army Hospital as they relate to the referral of patients to civilian health care providers for supplemental care. In addition, certain general principles are developed that should have applicability to all Army medical treatment facilities.

The Objectives of This Study Were

1. To analyze, in depth, the existing system at Cutler Army Community Hospital for handling and monitoring the referral of patients to civilian health care providers for supplemental care.

2. To obtain and analyze similar systems from several other military medical treatment facilities.

3. To compare the several systems analyzed and use them to develop feasible alternatives for the handling of supplemental care referrals.

4. To systematically evaluate the alternatives developed in terms of:

a. Arriving at the optimal feasible system for handling and monitoring supplemental care referrals at Cutler Army Hospital.

b. Evolving general principles for the handling of supplemental care that have a potential applicability to all Army medical treatment facilities.

5. To develop a plan for implementing the recommended solution at Cutler Army Community Hospital.

Feasible Solutions Must Meet the Following Criteria

1. Provide for effective monitoring of both the clinical appropriateness and professional quality of the referrals made, while insuring timely responsiveness to both requests and the return of information to the patient's attending physician.

2. Allow for easy capture and recall of referral workload

by specific study or type of patient.

3. Provide a means of verifying that the requested service has been rendered prior to the Comptrollor's authorizing payment for the service. Such verification must be accomplished with a minimum of additional effort on the part of existing personnel or systems. Additionally, such verification must be done on a timely basis so as not to delay the processing of payment authorizations.

4. Provide a means for monitoring the costs of such referals and provide information to assist in decisions concerning the most economical means of such referrals, without imparing either quality or service.

5. Be consistent with current Army and Health Services Command policies and regulations.

Assumptions

1. No additional administrative personnel were available to implement proposed changes.

2. No electronic data processing support was available at Cutler Army Hospital to support any proposed changes.

Limitations

1. Literature in this area was quite limited. Research was, of necessity, directed primarily toward models from other military medical treatment facilities and general management writings.

2. Queried military medical treatment facilities were limited to ones in the continental United States plus Hawaii.

3. Not all of the military medical treatment facilities queried responded.

4. Because of their immediate concern to Cutler Army Hospital, diagnostic radiology procedures and obstetrical care for pregnant soldiers have been the major areas of concentration. The principles evolved, however, should have applicability for all referrals to civilian facilities for services under supplemental care.

Research Methodology

Forty-two military medical treatment facilities were queried by letter (Appendix A). These consisted of thirty-five Army, four Navy, and three Air Force facilities. The selection critera for the facilities were all Army Medical Centers and Medical Department Activities in the continental United States and Hawaii plus those Navy and Air Force facilities which had assigned administrative residents who were members of the 1982 U. S. Army-Baylor University Class in Health Care Administration.

In the case of facilities with an assigned administrative resident, the letters were addressed to the resident. In the case of those Army facilities which did not have a resident the letters were addressed to the executive officer.

The data gathered from these responses was analyzed and used to develop models which then served as alternatives which were tested against the above criteria. Feasible alternatives were then used to arrive at the solution for Cutler Army Hospital.

Footnotes

1. See: United States Department of the Army Regulations:

AR 40-3 (Change 3), Medical, Dental and Veterinary Care, Janurary 15, 1982

AR 40-121, Uniformed Services Health Benefits Program, September 15, 1970

AR 40-122, Fiscal Policies, Uniformed Services Health Benefits Program, Feburary 13, 1967

AR 40-400, Patient Administration, August 1, 1978

2. See: United States Department of the Army:

Dwight David Eisenhower Army Medical Center, Fort Gordorn, Georgia, DDEAMC REGULATION 40-3, Utilization of Supplemental Care, September 29, 1980

United States Army Medical Department Activity, Fort Bragg, North Carolina, MEDDAC SOP 40-10, Supplemental Medical Care, May 11,1 1981

United States Army Medical Department Activity, Fort Jackson, South Carolina, MEDDAC REGULATION 40-3-1 Referral to Civilian Sources for Supplemental Tests or Examination, March 7, 1980

II. DISCUSSION

Existing Systems for the Handling of Referrals for Supplemental Care at Cutler Army Hospital

There are at the present time two different systems for handling referrals to civilian health care providers under the provisions of supplemental care at Cutler Army Community Hospital. One system is used for radiographic procedures and other diagnostic tests which are beyond Cutler's capability. Another system is used for the referral of pregnant soldiers for obstetrical care. The second of these, the one for obstetrical care, provides better administrative control than does the one used for radiographic procedures. Each system will be discussed separately.

Outside Referral of Radiographic Procedures

These referrals consist primarily of computed tomography (CT) scans, nuclear medicine scans, mammograms, and, until recently, ultrasound scans plus small numbers of other diagnostic procedures. Several different civilian sources are utilized; however, the majority are sent to one of three nearby civilian hospitals.

Referrals of patients for outside radiographic procedures are handled by the individual clinics and nursing units. There are six clinics and two nursing units making a total of eight separate points of origin for these referrals. Figure 1 is a flow diagram of the handling and processing of referrals under supplemental care for outside radiographic procedures.

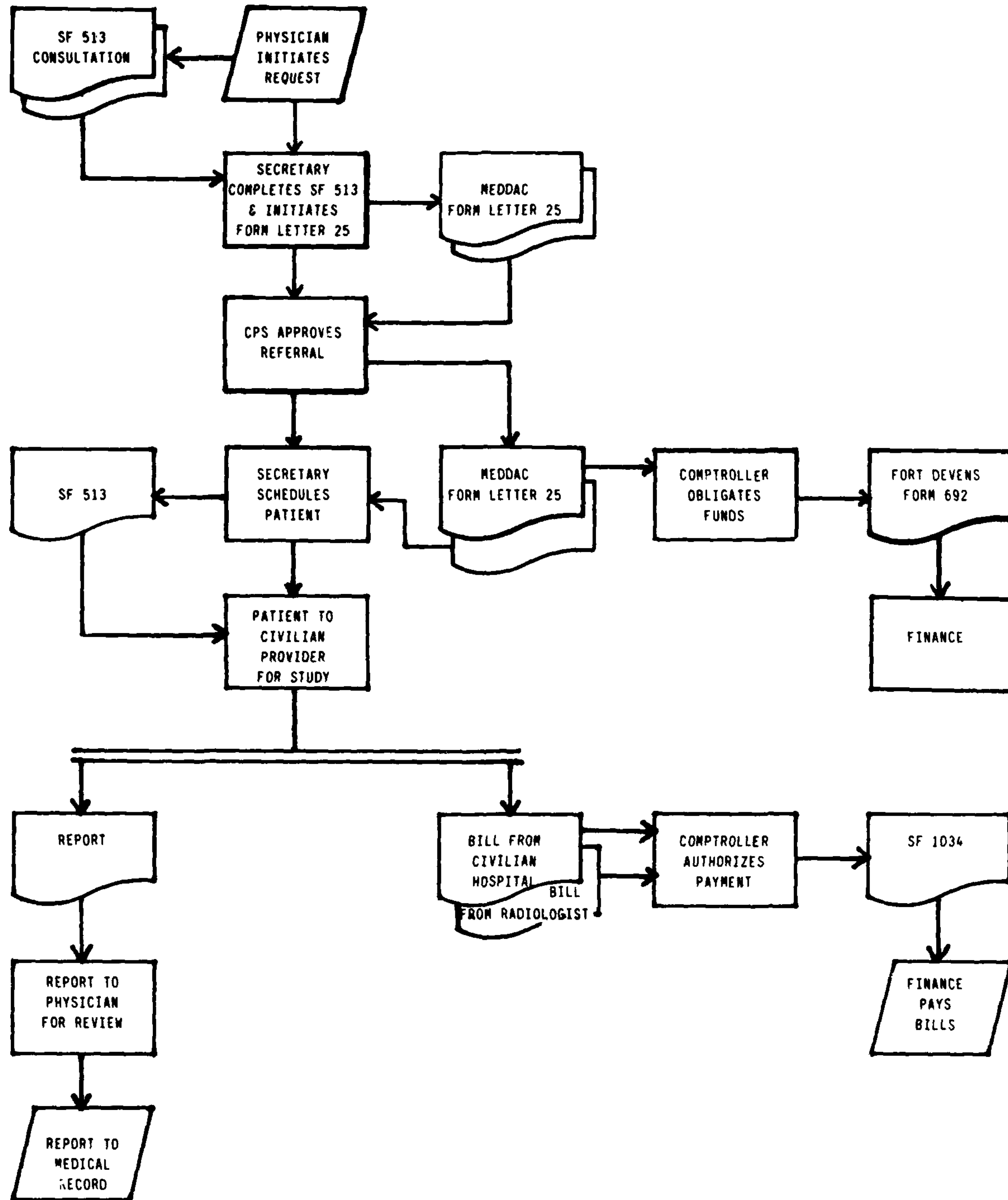


Figure 1, Flow Chart of the existing system for handling referrals for radiographic procedures under supplemental care at Cutler Army Community Hospital

The patient's attending physician initiates a request for an outside radiographic procedure by filling out a Standard Form (SF) 513, "Consultation Sheet." This SF 513 then goes to clinic secretary or ward clerk who completes the form and initiates a MEDDAC Form Letter 25 "Request for Care Beyond the Capabilities [of the MEDDAC]." The Form Letter 25 is sent to the Chief of Professional Services (CPS) who has been delegated approval authority by the MEDDAC Commander. After approval has been received, the secretary schedules an appointment for the study with a civilian facility. The patient then takes the SF 513 to the civilian facility and the study is performed. A report of the study is returned to the patient's physician for review and then is included in the patient's medical record. In the case of emergency requests the referral is made immediately and the approval is generated the next working day.

Administrative processing of the payment for such studies begins with a copy of the Form Letter 25 being sent to the comptroller who then obligates the necessary funds. This obligation is entered on a Fort Devens Form 692 which is sent to the post finance officer. When bills are received for the procedure (one from the civilian hospital and another from the civilian radiologist) the comptroller authorizes payment using a SF 1034 "Public Voucher for Purchases and Services Other than Personal." This SF 1034 is sent to the finance officer who then pays the bill. The two separate bills for each procedure are usually received and processed at different times.

Referral of Pregnant Soldiers for Obstetrical Care

The system for these referrals is similar to that used for radiographic procedures but differs in a number of ways and thus, provides for better administrative control. A flow diagram of this system is depicted in figure 2.

After a physician confirms the diagnosis of pregnancy, the patient is referred to the Head Nurse of the Surgical/GYN clinic. The nurse then counsels the patient as to her various options concerning the pregnancy. If the pregnant soldier chooses to have the child a MEDDAC Form Letter 25 is initiated by the nurse. The patient then goes to the Health Benefits (CHAMPUS) Advisor in the Patient Administration Division. Here the patient is further counseled as to how payment will be made for her care. The Health Benefits Advisor (HBA) then obtains approval on the Form Letter 25 from the CPS. The patient takes one copy of the Form Letter 25 with her and makes her own arrangements for obstetrical care with a civilian obstetrician. The HBA enters the patient's name in a log maintained in the HBA's office and sends the second copy of the Form Letter 25 to the comptroller. The comptroller obligates the necessary funds, transmitts a Fort Devens Form 692 to post finance and maintains an internal log of obstetric patients.

After the care has been provided the patient returns to full duty six weeks post partum. When the bills come in, the comptroller authorizes payment on a SF 1034 which is sent to finance for payment. Actually, several bills come in during the course of the care and each are processed separately. The comproller's

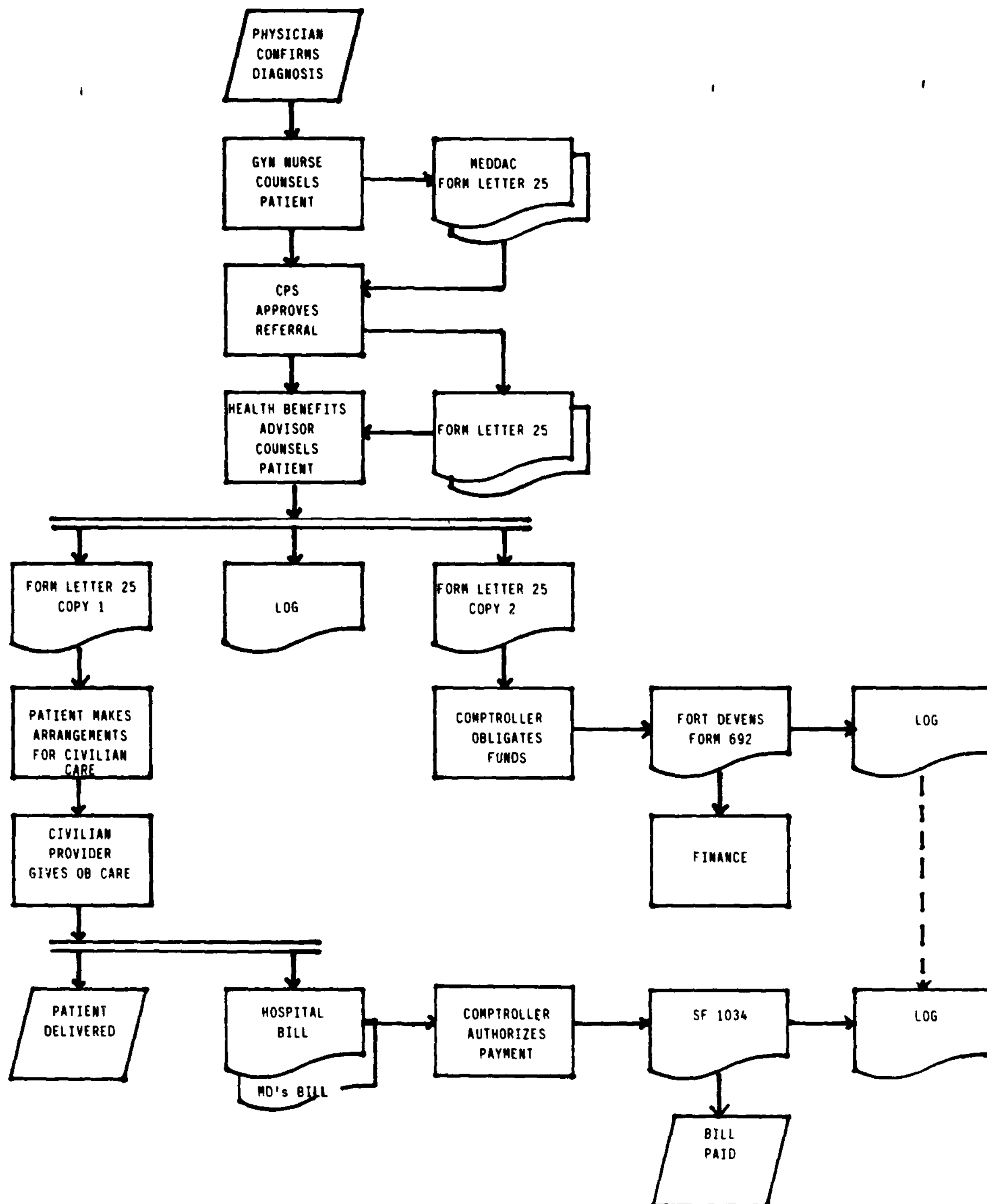


Figure 2, Flow chart of the existing system for handling the obstetrical care of pregnant soldiers under supplemental care at Cutler Army Community Hospital

log is used to maintain an ongoing record of the payments made for each individual obstetric case.

Problems with the Current Systems

The problems with the existing supplemental care referral systems at Cutler Army Hospital are more administrative than professional in nature. However, there are weaknesses in both areas, particularly in the case of referrals for radiographic procedures.

The way radiographic referrals are now handled provides for an effective timely flow of diagnostic information. However, the bypassing of the radiologist greatly reduces the role of this member of the medical staff as a consultant. This consulting role should be employed both in the selection of the most appropriate radiographic procedure for the patient's problem and in correlating outside radiographic procedures with those which are performed at Cutler Army Hospital.

Administratively, the system for outside radiological referrals fails to either capture specific workload data or to provide a means of verification that the study was performed prior to the authorization of payment. The lack of specific workload data has an impact on professional as well as administrative operations. The decision to institute or reintroduce procedures inhouse must, of necessity, be a joint effort on the part of both the medical and administrative staffs. Such data is essential to the Chief of the Department of Radiology for future planning.

Additionally, the system for the referral of radiographic procedures in unnecessarily complicated by the use of two forms (SF 513 and Form Letter 25). This extra paperwork load could be obivated by the use of Department of Defense Form, DD 2161 "Referral for Civilian Medical Care" which is prescribed by Army Regulation 40-3.[2]

The system for the handling of obstetrical referrals has relatively few problems whiich are primarily in the professional area. Since these patients are referred out for their total obstetrical care the management of the patient is lost in this area. This at times presents problems in relating the care of the patients for nonobstetrical problems with their obstetrical care. In some instances these patients do not make arrangements for obstetrical care as soon as is desirable. They then come into Cutler with a problem and their is no attending obstetrician to contact. The performance of prenatal laboratory work by civilian laboratories increases costs and the results are often not available to the pediatricians at Cutler who provide care for the infants after they have been released from the delivering civilian hospitals.

Except for the need to substitute DD Form 2161 for Form Letter 25, the handling of supplemental obstetrical care does not have the administrative problems associated with the handling of radiographic referrals.

The major problems in the existing systems are need for better administrative controls and information retreival in regard to outside radiographic referrals.

Comparison of Existing Systems with the Criteria for Feasible Solutions

Both the system for handling radiographic referrals and supplemental obstetrical care currently provide for professional monitoring in regard to clinical appropriateness, professional quality, and timeliness of response. The inclusion of the radiologist in the referral process can potentially further improve professional monitoring in regard to radiographic procedures.

There is no effective means for the easy capture of the number of each specific radiographic procedure which is being referred to civilian sources. The log maintained by the Health Benefits Advisor does readily provide such information for obstetric referrals.

Neither system provides for verification that the service has been provided prior to authorizing payment. In the case of obstetrical care many of the providers do certify that their bills are correct and that they have provided the described services.

Although there is a means of monitoring the total cost of all radiographic proceures sent out under supplemental care there is no easy means of monitoring this by each specific type of study sent out. The log in the comptroller's office does provide a means of monitoring the costs of obstetrical care.

Excepting for the need to use DD Form 2161, both current systems are consistent with Army and Health Services Command policies and regulations. Most of the problems identified are not specifically addressed by such regulations which provide overall guidance rather than specific operational details.

Areas of Needed Improvement in the Existing Systems

These needs center mainly in the system for handling and monitoring referrals for radiographic procedures. All such referrals need to go through a centralized control point rather than to originate from eight separate areas. Only by such centralization will it be possible to provide for the necessary data capture and subsequent information retrieval. Similarly, such centralization will make the implementation of a means of verifying that the service has been performed prior to authorizing payment easier and allow for cost monitoring of each specific type of radiographic study sent out.

The system for obstetrical referrals needs to address those few patients who bypass the Health Benifits Advisor or who do not make arrangements for care on a timely basis. The system also needs to address the lack of availability of laboratory results to the pediatricians at Cutler Army Hospital.

In the long run the problems associated with radiologic referrals have a greater overall impact. Because of the size of the facility it is unlikely that Cutler Army Hospital will ever be able to justify the inhouse performance of either CT or nuclear medicine scans. On the other hand, it is quite probable that as the Army gains additional obstetricians deliveries will be reinstituted at Cutler. This hopefully will be in the next few years.

Survey of Other Military Medical Treatment Facilities

Summary of Responses

Letters inquiring as to how they handled supplemental care referrals were sent to forty-two military medical treatment facilities (Appendix A). Replies were received from thirty-three of these facilities (Appendix B). This was a response rate of seventy-eight percent. Responding facilities included six Army Medical Centers, twenty-one Army Community Hospitals, three Navy Regional Medical Centers, and three Air Force medical facilities.

In all instances the routing of supplemental care referrals for approval was similar. However, there were a number of variations which can be grouped into four general patterns (table 1).

TABLE 1

ROUTING PATTERNS OF APPROVAL FOR SUPPLEMENTAL CARE REFERRALS

Routing pattern	Number (%)
1. Physician → Dept Chmn → CPS/CDR → Civ Source	7 (21%)
2. Physician → Dept Chmn → Civ Source	4 (12%)
3. Physician → CPS/CDR → Civ Source	14 (43%)
4. Physician → PAD → CPS/CDR → Civ Source	8 (24%)

CPS = Chief of Professional Services; CDR = Commander
PAD = Patient Administration Division

Patterns 1 and 2, which include the department chairman, are more common in the larger medical centers. Patterns 3 and 4 are usually found in the community hospitals. Twelve of the respondents route referrals for, and reports of, outside radiographic procedures through their radiology departments.

The control points for the administrative handling of referrals, receiving of reports, and processing of payments vary from one facility to another (table 2).

TABLE 2

ADMINISTRATIVE CONTROL POINTS

Control Point	Number (%)
Referrals	
Patient Administration Divsion/Health Benefits Advisor	27 (82%)
Originating Department or Clinic	4 (12%)
Clinical Support Division	2 (6%)
Reports*	
Originating Department or Clinic	23 (70%)
Patient Administration Division	6 (18%)
Comptroller Division	4 (12%)
Payment Authorizations	
Patient Administration Division	17 (52%)
Comptroller Division	12 (36%)
Originating Department or Clinic	3 (9%)
Clinical Support Division	1 (3%)

* All reports eventually go through the Patient Administration Division to be filed in the patient's medical record.

The most common location of the control point for the administrative processing of supplemental care referrals is in the Patient Administration Division, usually the Health Benefits Advisor. Most of the time reports are returned from the civilian provider directly to the originating department or clinic. After review by the attending physician they are filed in the patient's medical record. The control point for receipt of bills and the preparation of SF 1034s, to authorize payment, is usually either in the Patient Administration Division or the Comptroller Division.

The appointments with the civilian providers are scheduled by the originating clinic in approximately three-fourths (24/33) of the responses. Six schedule these appointments through the Patient Administration Division. In two smaller community hospitals this scheduling is done by the Clinical Support Division.

Nineteen respondents keep logs in either the office of the Chief of Professional Services, Patient Administration Division, or the Comptroller's office which allow retrieval of workload information. All of these logs are manual. The remaining fourteen can only retrieve workload data by review of the file of SF 1034s.

A General Model for Supplemental Care

Each of the thirty-three responses presents a slightly different model for handling supplemental care. These differences are the result of variations in how a relatively small number of basic building blocks are combined. In order to provide a framework for discussing these several combinations a general model

for handling supplemental care is presented. This model is consistent with the criteria presented in chapter one and is designed to allow for the discussion of alternatives in terms of necessary clinical and administrative controls.

Viewed from an abstract conceptual basis the referral of patients for supplemental care is a dual channel management information system. One channel handles the flow of clinical information used in the patient's medical management. The other channel is devoted to the flow of information necessary for the administrative management of the referring medical treatment facility.

These two channels are not independent of each other. They overlap in a number of areas. These areas of overlap form nodes in the two networks where controls points can be implemented.

The clinical channel's main function is the exchange of diagnostic or theraputic information between the patient's attending physician and the civilian health care provider. This exchange of clinical information must provide for effective and timely integration of the required supplemental care into the management of the patient.

The administative channel is concerned with the documentation, funding, and payment of the services received from civilian sources.

Patient scheduling, monitoring of costs, selection of civilian sources of services, the quality of services provided, and future planning in regard to supplemental care are of concern to both information channels.

The supplemental care program exists solely to augment the clinical information channel in military medical treatment facilities. The clinical channel must be the central focus of any model which is developed. The facility's administrative apparatus and the administrative information channel exists only to support the clinical information channel.

In the simplest of terms the clinical information channel is a two way exchange between the patient's attending physician and the civilian consultant (provider). However, this exchange requires certain professional controls. These include an evaluation of the appropriateness of the referral and an assessment of the quality and timeliness of the response from the civilian source of service (figure 3).

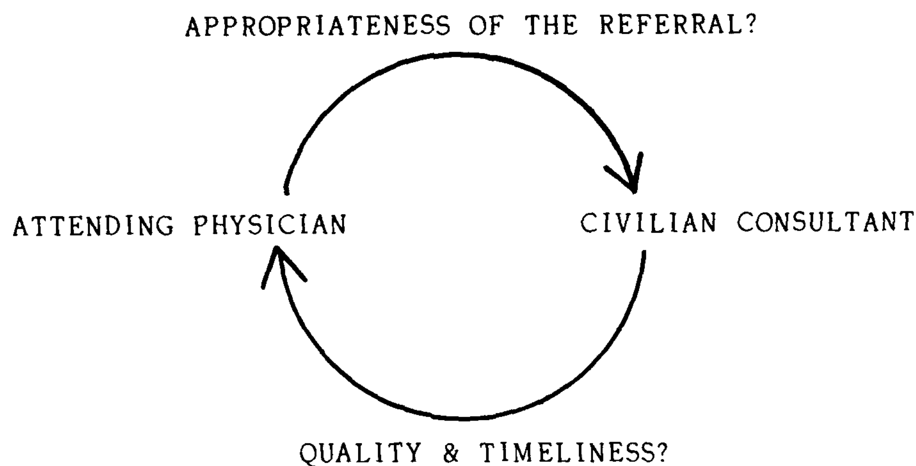


Figure 3, Schematic depiction of the clinical information channel showing areas of necessary professional control

The administrative channel, in order to support the clinical channel, must address several functional areas and is more complex. The functional areas of the administrative channel are: (1) The scheduling of appointments for, and counseling patients in regard to, supplemental care. (2) The payment of civilian health care providers for their services. (3) The incorporation of the results of supplemental care services into the patient's medical record. (4) Planning and budgeting for supplemental care augmentation of the military medical treatment facility. Thus, the administrative channel involves a number of information loops (figure 4).

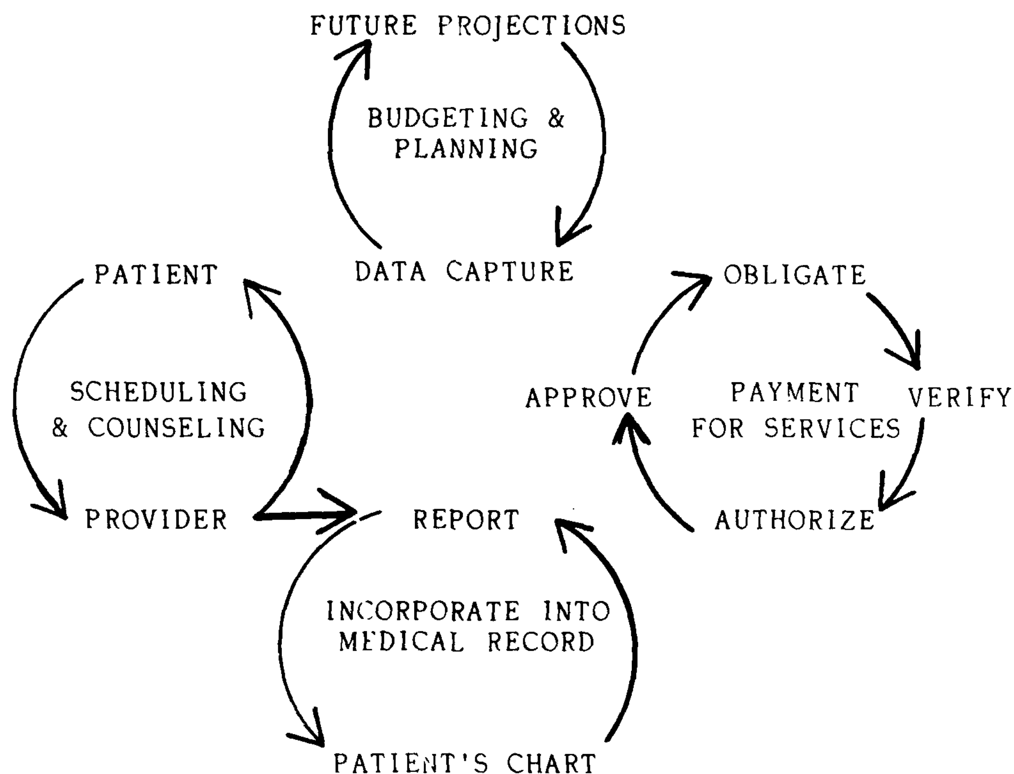


Figure 4, Schematic depiction of the information loops found in the administrative information channel

Two of these information loops--scheduling and counseling along with the incorporation into the medical record--are actually only clerical extensions of the clinical information channel. The other two administrative loops are involved with providing resource support for the clinical information channel. The two channels combine to form three basic information loops (figure 5).

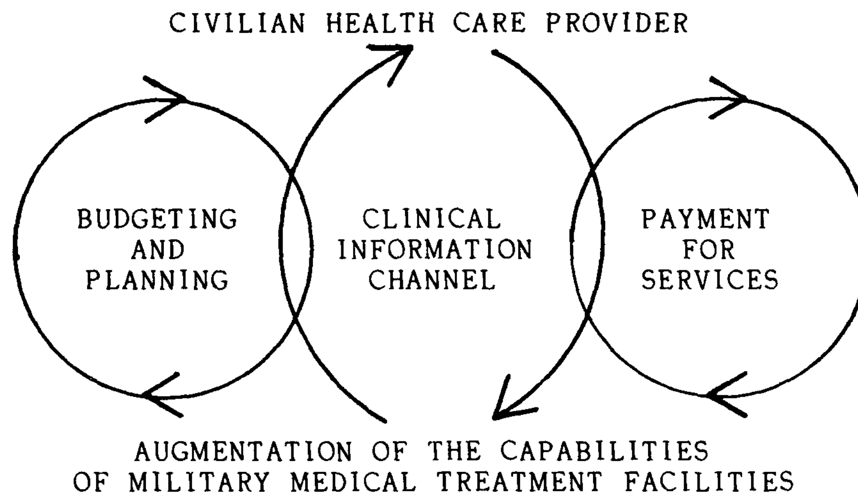


Figure 5, Basic information loops related to supplemental care

The clinical information channel along with its clerical extensions drive the supportive administrative information loops. The interface of these administrative loops and their necessary controls must not impair the timely flow of clinical information. Thus, such interfaces need to be at points in the clerical extensions of the clinical channel where the administrative information needs can be derived easily as a byproduct. In order to minimize effort,

all required administrative requirements should interface at a single point. This point should provide for centralization of both clinical and administrative controls.

Figure 6 is a simplified flow chart of the general model for handling supplemental care referrals. Control points are indicated by the letters A, B, C, D, and E contained in the ovals. The several models which can be derived from the survey differ primarily in where these control points are located within the hospital's organizational structure.

Control point A is where the clinical appropriateness of the referral is determined. This is the primary clinical control point and usually concurrent with the approval process. This is a responsibility of the medical treatment facility commander. The authority to make this determination is usually delegated to the Chief of Professional Services or the chairmen of the various medical staff departments. In large centers approval authority rests with the department chairmen or is routed through both the appropriate department chairman and the Chief of Professional Services. Three respondents indicate that such approval rests with the Patient Administration Division. Since this determination is a clinical one and requires professional medical expertise these facilities must also have a physician somewhere in the approval process. In the smaller hospitals the Chief of Professional Services is the approving authority.

Control point B is where specific workload data is captured. This provides input into the planning and budgeting ad-

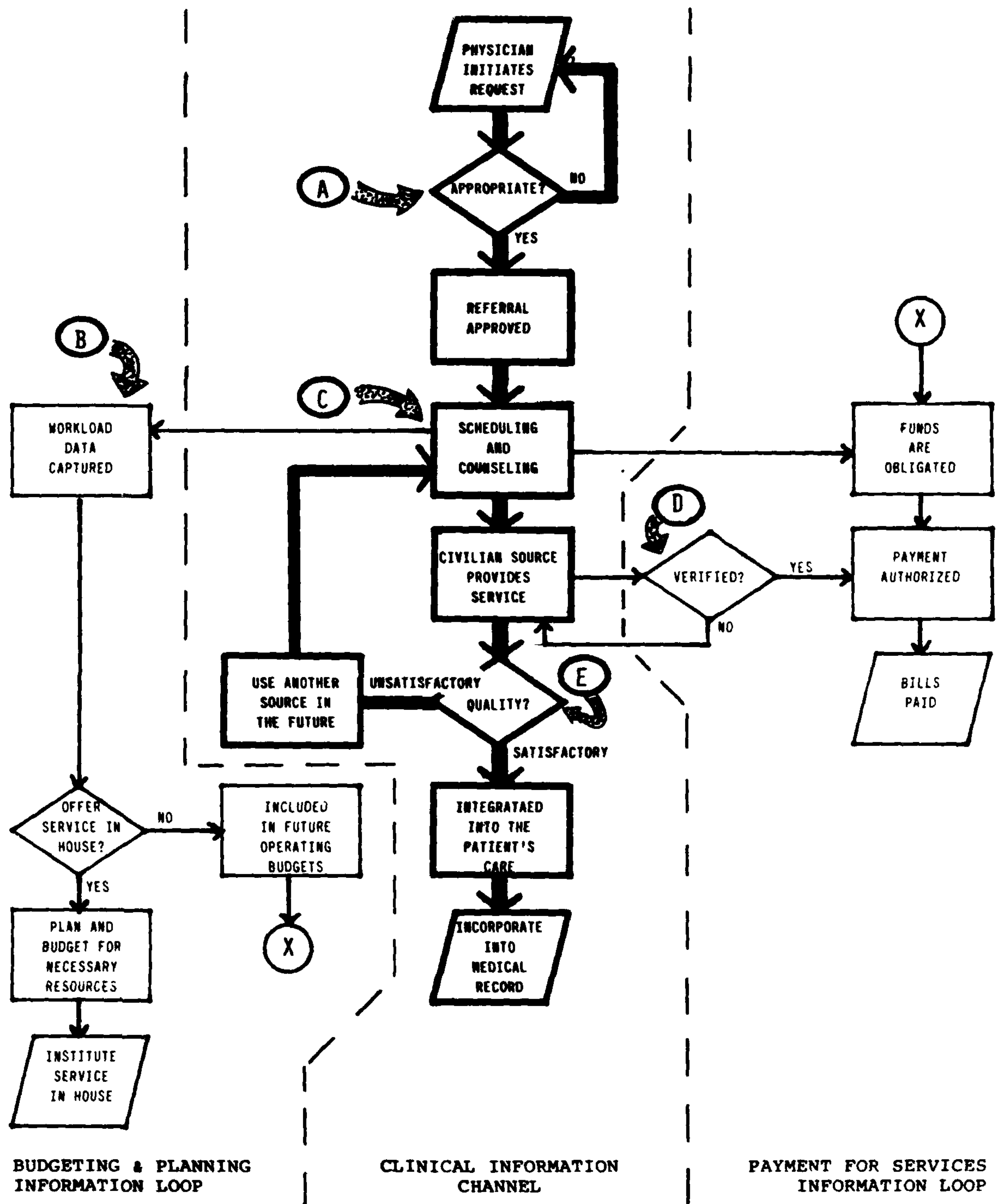


Figure 6, Simplified flow chart of the general model for supplemental care depicted as an information system. The main (clinical) information channel is shown in bold face. Sites for control points are shown by the letters: A, B, C, D, E in the ovals.

ministrative information loop. Less than sixty percent (19/33) of the hospitals surveyed have a defined mechanism for capturing this data. Those who do capture the data do so by the use of manually kept logs. As can be seen from the flow chart control this data can easily be captured as a by-product of the scheduling and counseling functions. Thus, control points B and C are easily combined.

Control point C is where patients are scheduled to receive services from civilian providers. This is also where patients receive any necessary instructions and are counseled concerning payment mechanisms, etc. This point is where the administrative information loop for payment of bills is initiated by notifying the Comptroller to obligate funds. It is at control point C that choices between different civilian providers for the same service are made. These choices are dependent upon feedback from control point E in regard to quality, service, and costs for the available sources. Although represented as a single point on the flow chart, the functions performed at control point C are often done by different offices in many of the hospitals surveyed.

Control point D is where verification that a requested service was actually provided prior to authorizing payment. Only twenty of the surveyed hospitals describe a definite means for obtaining such verification. In many instances certification by the provider that the service was rendered is used in lieu of verification.

Control point E is where the quality and timeliness of the service obtained from the civilian provider is evaluated. This

evaluation is primarily a clinical decision. In all instances this function has been delegated to the medical staff.

Costs can and need to be monitored at all of the indicated control points. However, detailed cost data can best be kept at the point where workload is captured. The determination of the best trade-offs between quality, service, and cost needs to be a joint effort on the part of both the medical and administrative staffs.

Specific Models: Combinations of Building Blocks

Two different feasible alternatives are available for controlpoint A and three each for control points B, C, and D. Only one feasible alternative exists for control point E. This then generates a total of fifty-four possible models. Even when control points B and C are combined there are eighteen possible models. Rather than discuss all possible models the available alternatives (building blocks) for each of the control points will be discussed. Since controls points B and C should be combined, the discussion will be limited to four major control points: (1) Appropriateness review and approval, (2) Patient scheduling and counseling plus workload data capture, (3) Verification that services have been performed, and (4) Evaluation of quality and timeliness. The possible alternatives for each of these are listed in table 3.

Clinical appropriateness evaluation is a clincal function and must be done within the framework of the medical staff structure. The control is incorporated into the approval process for the referral. Whether this is the Chief of Professional Services or the clinical

department chairmen is dependent on the size and operational policies of a particular facility. The Patient Administration Division does not have the necessary clinical medical expertise and, thus, is not a viable alternative for this clincal control. However, the resources in the Patient Administration Division devoted to the support of quality assurance programs can assist the clinical staff in retrospective evaluation of the effectiveness of this control.

TABLE 3

ALTERNATIVES FOR CONTROL POINTS

Appropriateness Review and Approval

1. Chief of Professional Services
2. Medical Staff Department Chairmen

Patient Scheduling and Counseling plus Workload Data Capture

1. The Originating Department or Clinic
2. Patient Administration Division/Health Benefits Advisor
3. Clinical Support Division/Chief of Professional Services

Verification of Services

1. Originating Department or Clinic
2. Patient Administration Division/Health Benefits Advisor
3. Comptroller Division

Evaluation of Quality and Timeliness of the Services Received

1. Medical Staff through the Chief of Professional Services

In community hospitals with a relatively small medical staff appropriateness review is easily accomplished by the Chief

of Professional Services. In larger community hospitals and medical centers it may be preferable to delegate this review and its associated approval authority to the department chairmen. This may be particularly appropriate in facilities with graduate medical education programs. The proper use of referrals, including those for supplemental care procedures, is a part of the learning process for resident physicians and is perhaps best controlled by their teaching chief.

The delegation of appropriateness review and approval to the chairmen of technical diagnostic departments such as pathology and radiology has advantages even in smaller hospitals. Outside laboratory tests, which involve only the transport of a specimen, always go through the laboratory and are controlled by the chairman of the pathology department. This provides for input from the pathologist both in the selection of tests and the integration of the returning results into the care of the patient. The radiologist as a physician with particular expertise in diagnostic imaging should serve as a consultant both in the selection of outside radiographic procedures and in correlating them with procedures which have been done in-house. Many of the surveyed hospitals do channel radiologic referrals through the radiology department.

Scheduling of appointments, instruction of patients, and workload data capture all are a part of the administrative support required for supplemental care referrals. In order to avoid unnecessary duplication of effort and to minimize the number of offices

a patient must contact in the process of going out for supplemental care these functions are best centralized at one location. The first alternative for such centralization is in the originating department or clinic. This has the advantage of good communication between the patient's attending physician and the civilian health care provider. In addition the necessary clerical work is accomplished next to the physician's office and makes it easy for the patient to stop off and see the clinic secretary on the way out. However, in many hospitals counseling is done by the Health Benefits Advisor even when scheduling is done by the originating clinic. This then causes the patient to have to go to two places.

Scheduling from the clinics has the disadvantage that referrals originate from several different areas in a hospital. This duplicates effort and complicates both data capture and the verification process. This approach also bypasses the radiologist for radiographic referrals and thus reduces his or her role as a consultant.

Since the Health Benefits Advisor is commonly the place where patients are counseled this is an attractive alternative for centralizing scheduling, counseling, and workload data capture. This choice risks reducing communication between the attending physician and the civilian provider. The radiologist is also bypassed with this choice.

Centralization of these functions in the Clinical Support Division, which provides administrative support for the Chief of Professional Services, has similar advantages and disadvantages

to those of using the Health Benefits Advisor, with the exception of patient counseling. The Health Benefits advisor is already counseling CHAMPUS patients and it is easy to extend this counseling role to all outside referrals.

Verification that requested services have been performed is best accomplished by comparing the output of the service (a consultation report) with the bills received. Alternative sites for this control are the originating clinic, the Patient Administration Division, or the Comptroller's office. In any event the comparison will have to occur at a place where the flow of returning reports and bills can be merged. Such mergers can be achieved by either forwarding copies of reports or logs, in which returned reports are checked off against requests, to the place where bills are received. Other options are to route all bills and reports through the same location or to require that duplicate reports be sent with all bills. Perhaps the easiest approach is to return the reports to the place where the referral was scheduled and the log is kept. This will allow the log to be checked off and a copy periodically forwarded to the office responsible for authorizing payments. This then makes verification a by-product of the receipt and distribution of returning reports.

Use of the originating clinic would require that this take place at several locations, but provide for more rapid dissemination of information to the patient's attending physician. Centralization reduces sites, but has the potential of delaying dissemination of reports.

The evaluation of the quality and timeliness of the service provided is primarily a clinical decision. The patient's attending physician is in the best position to make this determination. The experiences of all of the medical staff with specific civilian providers need to be considered by the Chief of Professional Services when choosing future sources of supplemental care.

Cost monitoring and comparisons are a joint clinical and administrative decision. Any potential cost saving which might be realized by choosing a particular provider must be balanced against the level of service and quality that is expected by the medical staff.

While there are eighteen possible different models that can be developed for the handling of supplemental care which are combinations of the building blocks that have been discussed, there are three basic approaches. The first is to decentralize supplemental care referrals to each individual department and clinic. The second is to centralize the handling of all referrals through a single control point. The third is a mixture of centralization and decentralization.

Alternatives for Cutler Army Hospital

There are three alternatives for resolving the problems in handling supplemental care referrals at Cutler Army Hospital. These alternatives follow along the lines of the three basic approaches that can be derived from the survey.

The first alternative is to continue the existing system

for supplemental care at Cutler and to add the necessary workload data capture and verification of services. As will be recalled from figures 1 and 2 the existing system is centralized for obstetrical referrals and decentralized for all other referrals.

Institution of workload data capture in the existing system at Cutler would require that all of the eight originating clinics and nursing units maintain logs of supplemental care referrals. Since reports are returned to the originating units they could be checked off against these logs and the necessary verification obtained. Since the clinical controls for both appropriateness and evaluation of quality and timeliness are now effective at Cutler the system would be complete with the addition of the above logs.

To institute logs in each originating clinic or nursing unit would result in a great deal of duplicate effort throughout the hospital. The several logs still will all have to be aggregated. This aggregation of data not only adds an extra step, it also adds a chance that some data may not be captured. In the case of some of the clinics the addition of the necessary log will have only a minor impact on workload; in others the increased clerical work will be more substantial. In the case of the nursing units where a large number of people rotate in and out a great deal of continuous staff education will be required.

Retaining the existing system with the necessary additions has the advantages of maintaining the existing communication between the patient's physician and the civilian consultant. It also has the advantage of minimal change in current operating procedure.

In addition to increasing the clerical workload in a number of areas, retaining the existing system does not take advantage of the radiologist in the referral of radiographic procedures.

The second alternative for Cutler Army Hospital is to centralize all supplemental care referrals through one single office. Since the Health Benefits Advisor is currently handling obstetrical referrals and is experienced in counseling patients this office would appear to be the logical choice. However, the office of the Health Benefits Advisor is staffed by only one person. The current workload, primarily CHAMPUS, in this office already has the occupant occupied full time. It is quite unlikely that the additional work could be taken on without extra clerical help. There are no additional clerical resources available for the implementation of any changes in the handling of supplemental care.

Another potential site for centralization of supplemental care referrals is the Clinical Support Division. While this division has more resources than the Health Benefits Advisor they are currently undergoing a transition from having provided support only for the Department of Primary Care to one of providing support for all of the clinical departments and the office of the Chief of Professional Services. Once this transition is complete their close relationship with all of the clinical areas would be an advantage in their handling of supplemental care referrals. Even with their greater resources once the transition is complete they will also be fully occupied and, thus, would also need more personnel in order to handle supplemental care referrals.

Complete centralization of all supplemental care referrals at Cutler Army Hospital will not only require additional clerical personnel, which are not available at the present time, it will also require considerable changes in existing operating procedures. Additionally, just as with the retention of the existing system this alternative does not make use of the radiologist in the referral process for radiographic procedures.

The third alternative for Cutler is to centralize all radiographic referrals through the radiology department and all other supplemental care referrals through the Health Benefits Advisor. This takes advantage of the radiologist's expertise in the case of radiographic referrals. It reduces the number of locations where logs will have to be maintained from nine to two. This will result in a very small additional workload for the Health Benefits Advisor. It will be recalled that the Health Benefits Advisor is already handling obstetrical referrals, which are the largest volume of referrals after radiology. Non-radiographic referrals other than obstetrics total only four or five a month. This small additional workload can be absorbed by the Health Benefits Advisor.

This alternative will, however, increase the clerical workload in the radiology department. The radiology department did handle all such referrals in the past with their existing clerical resources. When this function was decentralized to the several nursing units and clinics the radiology staff was not reduced. Thus, they have some slack time and should be able to resume this function.

While routing all radiographic referrals through the radiology department will also require a change in current operating procedures, this change is not that great. All in-house radiographic procedures are sent to the radiology department. The sending of all requests for radiographic procedures to the radiology department is a logical extension of the same procedure. Additionally, the inclusion of the radiologist in the referral process with its clinical as well as administrative advantages should improve communication between the attending physician and the civilian provider. This is in contrast to the other potential procedural changes which risk reducing this communication.

Centralizing all radiologic referrals through the radiology department will require that approval authority for these referrals be delegated to the radiologist. The radiology department will then schedule all supplemental care referrals for radiographic procedures and have all reports returned back to them. This will allow for a log which can be used both for workload data capture and to verify that the procedure was performed. This will also allow for the inclusion of a report of the outside procedure in the patient's radiology file at Cutler. In the case of certain procedures, such as CT and nuclear medicine scans, a duplicate film should be requested and incorporated in the patient's in-house radiology file. This augmentation of the in-house files will allow the radiologist to better correlate outside procedures with those performed at Cutler and to readily review them with the patient's attending physician.

The third alternative for Cutler Army Hospital is also consistent with the anticipated future. It is highly probable that obstetrical services will be reinstituted at Cutler in the next two to three years. This will then reduce the supplemental care referrals handled by the Health Benefits Advisor to a bare minimum. On the other hand, it is quite unlikely that Cutler will ever have a large enough volume to justify either in-house CT or nuclear medicine scanning. Thus, supplemental care referrals will constitute almost all supplemental care referrals after obstetrics have returned. At this point in time the system will for all practical purposes be centralized. This centralization will provide the necessary administrative controls as well as an enhanced clinical information channel.

Recommended Solution for Cutler Army Hospital

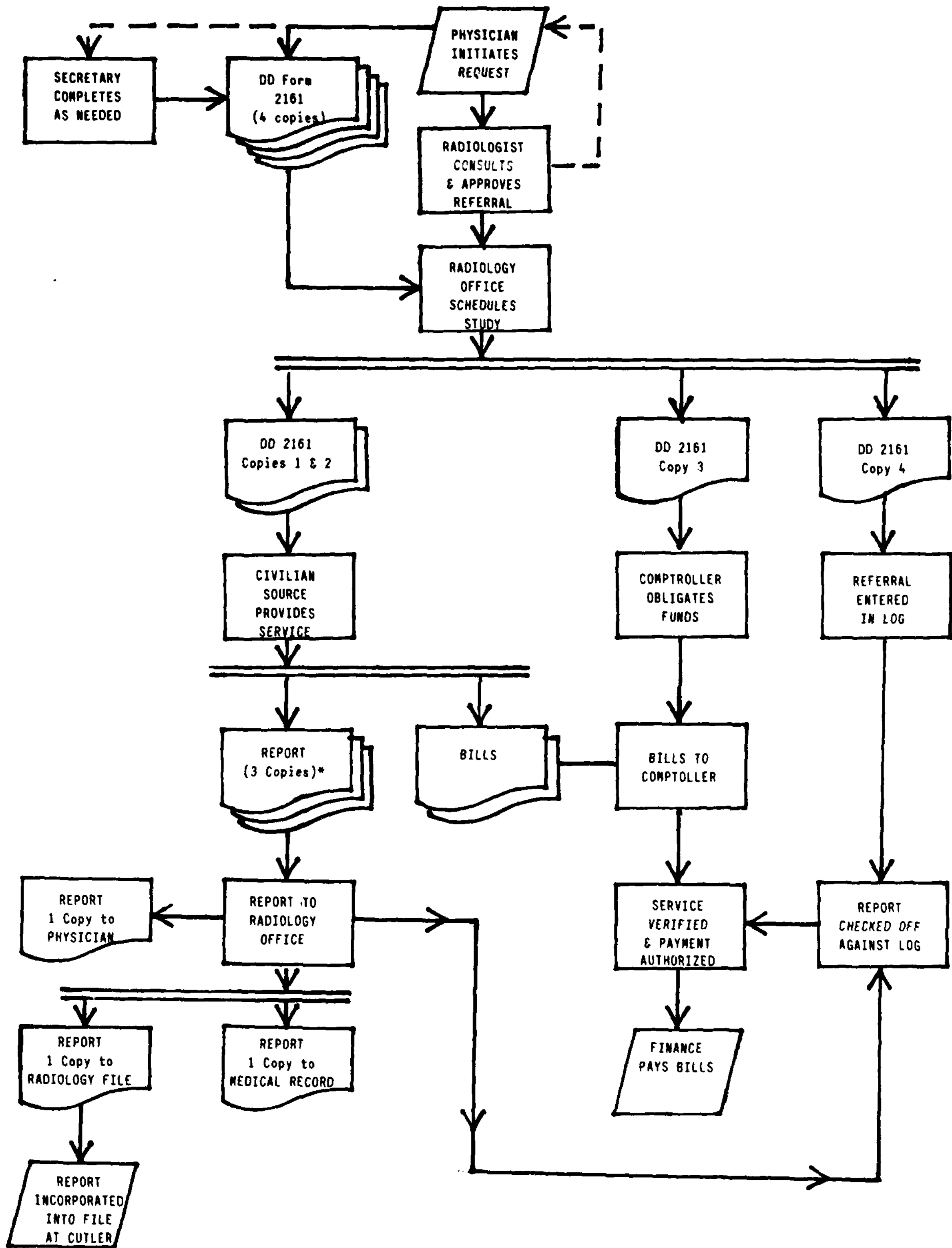
Three feasible models have been presented for addressing the problems related to the handling and monitoring of supplemental care referrals at Cutler Army Community Hospital. Each of these require some degree of procedural change and result in some additional clerical workload at some point in the system. However, only the third alternative discussed will improve the clinical information channel--the reason for supplemental care in the first place--while also incorporating the necessary administrative controls. Because of this additional clinical advantage the third alternative of routing all radiographic referrals through the radiology department and all other supplemental care referrals through the Health

Benefits Advisor is the recommended solution. This recommendation is also the one which is most readily achieved with the existing clerical personnel resources.

Figure 7 is a flow chart of the proposed system for handling radiographic referrals under supplemental care at Cutler Army Community Hospital. This maintains an effective flow of clincal information and utilizes the expertise of the radiologist as both a consultant (dashed line returning from the radiologist to the attending physician) and the approving authority. The radiology office schedules the studies and maintains a log of all referrals by patient name and type of study. Reports and, when appropriate, duplicate films are returned to the radiology office. Receipt of the reports are checked off in the log against the referrals to verify that the service was actually performed. A copy of this log will be forwarded weekly to the comptroller to complete the verification loop prior to authorizing payment. The log maintained in radiology also captures workload data and will be the primary source of such information when it is needed.

Three copies of the report will be requested from the civilian providers. These copies will be distributed as shown after the appropriate log entries have been made.

Evaluation of the quality and timeliness of the service provided will be done jointly by the radiologist and the rest of the medical staff. The choice of civilian providers will also be similar joint decisions.



* Reports to be accompanied by duplicate films in the case of CT scans and other studies when appropriate. These duplicates will then be incorporated into the patient's radiology file at Cutler Army Hospital.

Figure 7, Flow chart of the proposed system for handling supplemental care referrals for radiographic procedures at Cutler Army Community Hospital

The existing system for obstetrical referrals (figure 2) will be retained with only minor modifications. These changes are not separately illustrated. The MEDDAC Form Letter 25 will be replaced by the use of DD Form 2161. In addition, an accompaning letter (Appendix C) will be attached to the DD 2161 which the patients takes to her initial appointment with the civilian obstetrician. This letter requests cooperation in the use of the laboratory at Cutler and the return of a clinical summary after delivery to the Health Benefits Advisor. These summaries will be used to verify that the service was performed and then incorporated into the patient's military health record. This will enhance the clinical information channel at the same time an administrative gap is closed.

The few supplemental care referrals which are not for either radiographic procedures or obstetrical care will be handled much like obstetrical referrals, with some exceptions. There is no need for the counseling step by the surgical/gynecology clinic nurse. The originating clinic secretaries will schedule the appointments with the civilian providers after the referral has been approved. The Health Benefits Advisor will counsel patients regarding modes of payment and maintain a log of these supplemental care referrals. Two copies of reports will be requested. The copy destined for the medical record will be routed through the Health Benefits Advisor to be checked off against the log before going to the patient's chart. Copies of the log will be forwarded to the comptroller to provide the necessary verification.

Implementation Plan for the Recommended Solution for Cutler Army Hospital

Once the recommendations have been accepted by the Commander, Cutler Army Hospital and his staff, an educational program will have to be conducted to acquaint the rest of the hospital with the changes in operating procedures. This program will be twofold. Initial educational efforts will consist of a general explanation to both the medical and administrative staffs, including the clerical employees who will be involved, of the reasons for changing the existing system. The necessity for incorporating the additional administrative controls without imparing the flow of clinical information will be emphasized as will the clinical advantages of including the radiologist in the referral process for radiographic referrals.

The second aspect of the educational program will consist of appointing an action officer to coordinate the implementation of the proposed changes. This action officer will become thoroughly familiar with the recommended system for handling supplemental care referrals and then work with each of the individuals (eg., radiology department secretary) on a one on one basis until the new system is working as planned.

In addition to the educational program a new MEDDAC regulation (Appendix D) will be published. This regulation is designed to serve as detailed written procedural instructions for the handling of referrals for care beyond the capabilities of Cutler Army Community Hospital.

Comments on Clinical Laboratory Tests As Supplemental Care

Although clinical laboratory tests which cannot be performed by a medical treatment facility are often sent out to civilian laboratories under the supplemental care program, these referrals are handled in essentially the same manner by all facilities. The existing system for laboratory tests, based on recommendations of the College of American Pathologists, provide for both the effective flow of clinical information and the necessary administrative controls. Therefore, since there is already a standardized system for the referral of clinical laboratory tests which meet the criteria established in chapter one, detailed analysis and discussion of this aspect of supplemental care was unnecessary. The referral of these tests is easier than are other supplemental care referrals since only a specimen, which is collected by the referring facility, is sent out rather than the patient.

The writer who is a clinical pathologist and former laboratory director is quite familiar with the laboratory referral system. The model developed for the referral of radiologic procedures is based on this experience and is in many ways analogous to the laboratory referral system. The pathologist as the medical director of a hospital's clinical laboratory plays a consulting clinical as well as administrative role in laboratory referrals. This same combined clinical consulting and administrative role is envisioned for the radiologist in the radiologic supplemental care referral process.

Contracts and Supplemental Care

In the survey letter (Appendix A) a specific question was asked concerning the use of contracts for procedures commonly sent out under supplemental care. Only two of the responding facilities indicated that they had such contracts. Only one of the two indicated that their contract effected any cost saving for these referrals.

Contracts are probably not more widely used for supplemental care referrals for two reasons. The first is a perceived reduction in the choice of civilian providers and consequent flexibility in care available to the attending medical staff. The second, and probably more significant, is the cumbersome and bureaucratic system for negotiating contracts for military facilities. Since contracts for military facilities are negotiated by a contracting officer, who often does not even work for the facility and who in any event does not fully understand the clinical information needs involved, it is often questionable whether the possible savings to be realized are worth the effort required of the medical staff in such contract negotiations.

There are, however, potential savings to be realized by contracting for certain supplemental care services, particularly in the area of radiologic referrals. This will require further research into the many ramifications of contracts for military facilities and a means of simplifying and expediting the entire contracting process.

General Principles Related to the Handling of Supplemental Care

Supplemental care is one of the ways in which military medical treatment facilities can obtain care for patients which is beyond their own intrinsic capabilities. Supplemental care referrals are an extension of the clinical information channel directed toward the care of patients. Any system for handling supplemental care referrals must give priority to the effective and timely flow of clinical information. Administrative steps and controls, while necessary, must support this flow of clinical information with a minimum of encumbrance. Such encumbrance is minimized when system design starts with the clinical information channel and administrative steps and controls are developed as a by-product of this channel.

The centralization of all supplemental care referrals through one single control point is administratively appealing. The variety of such referrals is so great that such centralization potentially encumbers the flow of clinical information. On the other hand complete decentralization results in unnecessary duplication of clerical and administrative efforts. Therefore, a system of partial decentralization is the best approach. The particular level of decentralization needs to be tailored to each individual facility.

However, regardless of the size of the facility supplemental care referrals for clinical laboratory and radiologic procedures should be decentralized to the departments of pathology and radiology respectively. This is to include the pathologist and radi-

ologist in the clinical information channel and gain their expertise as consultants. In smaller community hospitals all other supplemental care referrals are easily centralized through one area. In larger teaching medical centers the decentralization of such referrals to each major clinical department has potential advantages.

Contracts, while only minimally utilized at the present time, do offer the potential of reducing costs for some procedures which are obtained through supplemental care. All facilities should explore the use of contracts for diagnostic procedures which they commonly refer out under supplemental care.

Basic principles to be kept in mind in the design of systems for handling of supplemental care referrals are: (1) Maintaining the priority of the flow of clinical information and deriving administrative steps and controls as a byproduct of clinical information flow. (2) The routing of laboratory and radiographic referrals through the pathology and radiology departments. (3) Partial decentralization of each individual system tailored to the resources and needs of the facility involved. (4) Increased exploration and possible use of contracts for commonly requested supplemental care services as a potential means of reducing costs.

III. SUMMARY AND CONCLUSIONS

The initial impetus for this study was a request by the Commander of Cutler Army Hospital as to whether the number of civilian referrals for orthopedic radiographic procedures was greater in 1981 than in 1980. The search for this information revealed that there was no mechanism for readily capturing and recovering this data at Cutler Army Hospital. Further inquiry into the handling of referrals to civilian health care providers for procedures which were beyond Cutler's capability found other, primarily administrative, problems with the existing system. The major administrative problem was a lack of a means for verifying that a requested service had been performed prior to authorizing payment. A brief survey of three other Army hospitals found that each handled supplemental care referrals differently.

In order to redesign the system for the handling of supplemental care referrals at Cutler Army Hospital, research was conducted regarding how a number of military medical treatment facilities handled supplemental care. This research consisted of a survey of forty-two military medical treatment facilities. The responses to the survey, which consisted of answers to specific questions and copies of SOPs etc., were analyzed and used to develop models for the handling of supplemental care. At the same time the existing system at Cutler was analyzed in depth. Both of these analyses compared current systems against the criteria for feasible alternatives, enumerated in chapter one, which were

established before conducting the research. The analyses viewed supplemental care as a multichannel management information system. This information system consists of a clinical information channel and an administrative information channel. The administrative information channel has four separate information loops. Two of these administrative loops are also part of the clinical information channel and two are purely administrative. The administrative information channel exists to support the clinical information channel, which must have priority in any system design.

The analysis of the survey responses was done in terms of a number of control points in this complex information system. Several possible organizational locations were being used for each control point. This resulted in a large number of possible models. However, only three general alternatives emerged for the handling of supplemental care: (1) Total centralization through a single control point. (2) Complete decentralization of all referrals to each originating clinic or department. (3) Partial decentralization of supplemental care referrals to only a few organizational locations.

Alternatives for Cutler were developed and discussed in terms of these three general alternatives. The existing system at Cutler is almost totally decentralized. In addition to lacking some necessary administrative controls, which could be superimposed, it fails to effectively employ the radiologist as a consultant in radiologic referrals. Complete centralization of all referrals at Cutler would require additional clerical personnel in areas where they are not available and still not effectively utilize

the radiologist. The third general alternative of partial decentralization is the optimal solution for Cutler Army Hospital. This directs all radiology referrals through the radiology department and all clinical laboratory procedures through the laboratory (this is a universal practice for laboratories and, thus, is not discussed in detail). All other supplemental care referrals are centralized through the Health Benefits Advisor at Cutler with some special provisions made for the unique aspects of obstetric referrals.

The findings of the survey served as the basis for developing the general model of supplemental care as an information system (shown in figure 7). From this general model certain general principles can be derived which are applicable to all systems for handling supplemental care. The first and most important is that supplemental care is an extension or augmentation of the patient care process within the medical treatment facility. Supplemental care programs exist solely to increase the clinical information available to the patient's attending physician. This priority must be maintained in the design of any system. Administrative steps and controls, while essential, must be subordinate to and not encumber the flow of clinical information. Secondly, the expertise of the radiologist and pathologist must be utilized in the referral system. Thirdly, partially decentralized systems tailored to the circumstances in each individual hospital are probably the best approach to design of supplemental care referral systems.

The survey made a specific inquiry as to the use of contracts for supplemental care and any cost savings that were realized.

Only two of the thirty-two respondents indicated that they had such contracts. Only one of these two indicated that a cost savings was realized. The use of contracts would appear to offer a potential for cost savings in some areas and should be a subject of further research. Although not definitely stated by the respondents, the writer's experience with the military contracting system would suggest that its cumbersome bureaucratic nature is a major impediment which precludes the more widespread use of contracts.

The proposed solution for Cutler Army hospial for the handling of supplemental care referrals incorporates the administrative controls which were found missing when the problem was defined. At the same time the proposed changes not only maintain the effectiveness of the clinical information channel, they actually enhance this channel. An implementation plan for instituting these changes is discussed. This implementation plan includes a proposed MEDDAC regulation to effect the necessary procedural changes.

APPENDIX A

LETTER USED TO SURVEY HOW SUPPLEMENTAL CARE IS HANDLED IN MILITARY MEDICAL TREATMENT FACILITIES

DEPARTMENT OF THE ARMY

US ARMY MEDICAL DEPARTMENT ACTIVITY

FORT DEVENS, MASSACHUSETTS 01433

REPLY TO
ATTENTION OF

HSXF-X

v

Dear

As a part of an administrative residency, I am conducting a research project related to the referral of patients from military medical treatment facilities to civilian sources for services which are beyond their capability (supplemental care).

Specific areas of interest for the research relate to the following:

1. What is the procedure that is followed from the time a staff physician requests a referral until the information is returned and is integrated into the patient's care?
2. Are all referrals handled through a centralized control point or are they delegated to the individual clinical departments and services for their specialty areas?
3. How are the clinical appropriateness of the referral requests and the quality of the services received controlled and monitored?
4. Do you have a mechanism for capturing and recalling referral workload data by specific type of study or patient? If so, how does this mechanism operate?
5. Do you have a mechanism for verifying that the requested service was performed prior to authorizing payment? If so, how does this mechanism operate?
6. How are diagnostic test results, etc. returned to your facility? In the case of studies such as CT scans do you receive a copy of the actual study? If so, where and how are they filed?
7. How are specific civilian sources for referral selected? What is done to minimize costs? Are contracts negotiated with specific civilian facilities for referrals that are commonly sent out (ie. CT scans)? If so, how are these contracts negotiated? Have any cost savings been realized over the usual fee shedules from these sources?

HSXF-X

It is anticipated that most of these questions can be answered by the applicable policy statements, SOPs, or regulations from your facility. Will you forward copies of the appropriate SOPs etc. to me at the address given below. In the case of questions that are not specifically addressed by SOP etc. will you forward a brief narrative comment.

Your assistance and cooperation in this research project will be greatly appreciated. I want to thank you in advance for your help. Please feel free to contact me by either letter or telephone if you have any questions.

Sincerely yours,

Jay H. Anderson MD, LTC MC
Administrative Resident
USA MEDDAC
Fort Devens, MA 01433

Autovon 256-3083/2728
Commerical 617-796-3088/2728
Home 617-772-6288

APPENDIX B

LIST OF MILITARY MEDICAL TREATMENT FACILITIES SURVEYED

MILITARY MEDICAL TREATMENT FACILITIES
WHICH RESPONDED TO THE SURVEY

1. Dwight David Eisenhower Army Medical Center, Fort Gordon, GA
2. Fitzsimmons Army Medical Center, Denver, CO
3. Madigan Army Medical Center, Tacoma, WA
4. Tripler Army Medical Center, Honolulu, HI
5. Walter Reed Army Medical Center, Washington, DC
6. William Beaumont Army Medical Center, El Paso, TX
7. USAMEDDAC, Fort Belvoir, VA
8. USAMEDDAC, Fort Benning, GA
9. USAMEDDAC, Fort Bragg, NC
10. USAMEDDAC, Fort Campbell, KY
11. USAMEDDAC, Fort Carson, CO
12. USAMEDDAC, Fort Dix, NJ
13. USAMEDDAC, Fort Jackson, SC
14. USAMEDDAC, Fort Leonard Wood, MO
15. USAMEDDAC, Fort Ord, CA
16. USAMEDDAC, Fort Polk, LA
17. USAMEDDAC, Fort Riley, KS
18. USAMEDDAC, Fort Sill, OK
19. USAMEDDAC, Fort Huachuca, AZ
20. USAMEDDAC, Fort Leavenworth, KS
21. USAMEDDAC, Fort Lee, VA
22. USAMEDDAC, Fort McClellan, AL

23. USAMEDDAC, Fort Meade, MD
24. USAMEDDAC, Redstone Arsenel, AL
25. USAMEDDAC, Fort Rucker, AL
26. USAMEDDAC, Fort Stewart, GA
27. USAMEDDAC, United States Military Academy, West Point, NY
28. Naval Regional Medical Center, Camp Pendelton, CA
29. Naval Regional Medical Center, Great Lakes, IL
30. Naval Regional Medical Center, Orlando, FL
31. USAF Academy Hospital, USAF Academy, CO
32. USAF Medical Center, Scott (MAC) Scott AFB, IL
33. Wilford Hall USAF Medical Center (AFSC), Lackland AFB, TX

QUERIED FACILITIES WHICH DID NOT RESPOND

1. Brooke Army Medical Center, Fort Sam Houston, TX
2. Letterman Army Medical Center, Presidio of San Francisco, CA
3. USAMEDDAC, Fort Hood, TX
4. USAMEDDAC, Fort Knox, KY
5. USAMEDDAC, Fort Eustis, VA
6. USAMEDDAC, Fort Irwin, CA
7. USAMEDDAC, Fort Monmouth, NJ
8. USAMEDDAC, Fort Sheridan, IL
9. National Naval Medical Center, Bethesda, MD

APPENDIX C

PROPOSED LETTER TO CIVILIAN OBSTETRICIANS TO ACCOMPANY SUPPLEMENTAL CARE REFERRALS FOR OBSTETRIC CARE OF ACTIVE DUTY MILITARY PERSONNEL

DEPARTMENT OF THE ARMY
US ARMY MEDICAL DEPARTMENT ACTIVITY
FORT DEVENS, MASSACHUSETTS 01433

REPLY TO
ATTENTION OF

20 April 1982

Reference: Sp4 Suzanne Queue
123-45-6789

Dear Doctor,

The above patient is a member of the U S Army serving on active duty. She is making her own arrangements with you for her obstetrical care. She will be entirely under your management for her prenatal course, labor and delivery. You are to use the hospital of your choice. The cost of her care will be paid by Cutler Army Hospital.

I do wish to solicit your cooperation in a number of areas related to her care. The first is that whenever possible, without compromising her care, you utilize the clinical laboratory here at Cutler for outpatient laboratory work. This then will allow us to incorporate the data in her military health record. The data will be available to our staff if it is needed in providing the patient care for non-obstetrical conditions or for her infant after delivery. Since Cutler has a pediatric service civilian pediatric care is not authorized after the infant is discharged from the hospital. The use of our laboratory will help to reduce our operating costs. This will allow us to provide service for a greater number of patients within the limitations of our budget. A prenatal package as defined by our laboratory is attached. You may order this as "Prenatal Lab Work". The results will be sent to your office. If you desire any tests which are not included, please specify them separately at the time of your request.

I also solicit your cooperation in encouraging this patients to come to Cutler for non-obstetrical medical problems. We have asked her to provide us with your name and telephone number. These are included in her military health record. In the event she comes to us with any problem which may affect her pregnancy, our staff will contact you. After she has delivered we will contact the hospital where she delivered for a clincal summary. This summary will be incorporated into her military health record. Your cooperation in the timely preparation of this summary will be greatly appreciated.

I want to thank you in advance for your assistance in the provision of quality obstetrical care for our patient. Please feel free to contact me or my staff if you have any questions.

Sincerely,

Frank V. Benincaso MD
Colonel Medical Corps
Commander Cutler Army Hospital

APPENDIX D

PROPOSED MEDDAC REGULATION FOR IMPLEMENTING RECOMMENDED CHANGES IN HANDLING SUPPLEMENTAL CARE REFERRALS AT CUTLER ARMY COMMUNITY HOSPITAL

DEPARTMENT OF THE ARMY
UNITED STATES ARMY MEDICAL DEPARTMENT ACTIVITY
FORT DEVENS, MASSACHUSETTS 01433

MEDDAC REGULATION 40-36 20 April 1982

REFERRALS TO CIVILIAN HEALTH CARE PROVIDERS FOR CARE BEYOND THE CAPABILITIES OF CUTLER ARMY HOSPITAL

1. PURPOSE: The purpose of this regulation is to establish procedures for referring patients from Cutler Army Hospital to other medical treatment facilities for care which is beyond the capability of Cutler Army Hospital (CAH).

2. GENERAL: Referrals for care beyond the capabillities of CAH are accomplished in one of three general ways: The first, particularly in the case of active duty military personnel, is to use another Federal medical treatment facility which has the necessary capability. The second is to refer CHAMPUS eligible patients to civilian health providers. CHAMPUS referrals can be for either total care or cooperative care (see para 4, definitions). The third is to refer patients to civilian providers under the provisions of supplemental care. The costs of CHAMPUS referrals are paid by the Department of Defense, but do not come out of CAH operating funds. The costs of supplemental care referrals are paid out of CAH operating funds. Referrals to other Federal treatment facilities generate the least cost to the government.

3. APPLICABILITY: This regulation applies to all referrals to civilian sources for care beyond the capabilities of CAH which originate from CAH or the two troop medical clinics located on Fort Devens. The outlying health clinics which are a part of the MEDDAC will establish their own procedures handling referrals to civilian providers and submit them to this headquarters for approval.

4. DEFINITIONS:

a. CHAMPUS care:

(1) CHAMPUS, Total Care: Those instances in which the civilian health care provider is totally responsible for the management of the patient.

(2) CHAMPUS, Cooperative Care: Those instances in which the patient is referred to a civilian health care provider for a specific treatment or service and the staff physician at CAH retains responsibility for the overall management of the patient's care.

b. Supplemental care: Those non-elective specialized treatment procedures, consultations or tests (eg. CT scans and radiation therapy) and supplies which are required to augment the overall course of care being provided by CAH to a patient eligible for such services, except CHAMPUS eligible beneficaries. The staff physician at CAH retains responsibility for the medical management of the patient.

This regulation supercedes MEDDAC SOP 2-24, 15 August 1978

5. PATIENTS ELIGIBLE FOR REFERRAL TO CIVILIAN PROVIDER:

a. Active duty members of the U S Armed services when the service cannot be readily obtained from another Federal medical treatment facility.

b. CHAMPUS beneficiaries:

(1) Under the provisions of supplemental care: The care which may be provided under this subparagraph is limited to that which isenumerated below. The control of the patient must remain with CAH. CAH will be considered to be retaining control when it provides primary support and retains management of the patient's overall course of care. Such management includes initial evaluation, prescribing or recommending the tests and other services to be performed, performing intermittent evaluations if required and directing the final disposition of the case.

(2) Supplemental care referrals authorized for CHAMPUS eligible beneficaries:

(a) All specialty consultations for the purpose of establishing/confirming diagnoses and/or recommending a course of treatment.

(b) All diagnostic tests, diagnostic examinations, and diagnostic procedures (including genetic tests and CT scans) ordered by qualified health care providers at CAH.

(c) Prescription drugs and medical supplies.

(d) Civilian ambulance service, when the service has been ordered by authorized CAH personnel. (Civilian ambulance service for CHAMPUS beneficiaries not ordered by CAH comes under the provisions of CHAMPUS).

(3) All other referrals of CHAMPUS eligible beneficaries, if so authorized, must be done under the provisions of CHAMPUS, either total or cooperative care. The CHAMPUS (Health Benefits) Advisor (HBA) in the Patient Administration Division should be contacted concerning specific benefits authorized etc.

c. Other patients whose eligibility has been established IAW AR 40-3 by the Patient Administration Division CAH.

6. PROCEDURES:

a. Supplemental care referrals: Supplemental care referrals are paid out of CAH operating funds and come under four categories.

(1) Radiographic procedures not available at CAH:

(a) The patient's attending physician initiates a request for the procedure using a DD Form 2161 (4 copies). This must include clinical information sufficient to establish the reason for the study.

(b) The secretary in the originating clinic or nursing unit will make sure the necessary patient identifying data is entered on the DD 2161 before it is forwarded to the Department of Radiology.

(c) The radiologist will review the request, consult with the patient's attending physician as necessary and approve the referral.

(d) The radiology department secretary will maintain a log of all referrals. This log will contain the following information:

-- Patient's Name
-- Patient or Sponsers Social Security Number
-- Attending Physician's Name
-- Procedure Requested
-- Date Requested

-- Name of civilian provider
-- Date of appointment
-- Date report was returned to radiology department

(e) The radiology department sectretary will schedule an appointment for the patient with the civilian provider and inform the patient that this referral is only for the specific procedure requested on the scheduled date. Any other services required will have to be authorized in advance by CAH before they can be obtained.

(f) The patient will be given two copies of the DD 2161 to take to the civilian provider. One copy of the DD 2161 will be sent to the supplemental care clerk in the comptroller division. One copy will be retained in the radiology department.

(g) All civilian providers of radiographic services will be requested to return three (3) copies of a report to the radiology department CAH. When these reports are returned the date will be entered in the log and the reports distributed as follows: The original will go to medical records for inclusion in the patient's chart. One copy will be incorporated into the patient's radiology file at CAH. One copy will go to the patient's physician.

(h) In the case of CT and nuclear medicine scans the civilian provider will be requested to send a duplicate film with the report. These duplicate films, when received, will be given to the radiologist for review and then incorporated into the patient's CAH radiology file.

(i) A photocopy of the log showing patients for whom reports have been returned will be forwarded weekly to the comptroller.

(j) When the comptroller receives the copy of the DD2161 funds will be obligated to pay for the study. When the copy of the log is received is will be used to verify that the service was performed andthe comptroller will initiate an SF 1034 to authorize payment for the service.

(k) The logs will be retained in the radiology department. They will serve as a data source for referral workload and future planning.

(2) Clinical laboratory tests:

(a) Clinical laboratory tests which are provided under supplemental care are ordered by the attending physician like all other clinical laboratory procedures.

(b) The pathologist will review such requests, consult with the attending physician, as necessary, and approve the referral.

(c) The proper specimen will be collected and sent to the reference lab.

(d) A log of all outside laboratory referrals will be maintained by the clinical laboratory.

(e) When results are returned from the reference laboratory they will be recorded in the log. Copies of the report will be sent to the patient's physician and to medical records for inclusion in the patient's chart.

(f) The log will be permanently retained in the clinical laboratory. The log will serve to provide the comptroller verficiation that the service was rendered and as a workload data source.

(3) Obstetrical care for active duty military personnel:

(a) This type of referral applies only to active duty female military personnel who are pregnant. All obstetrical care for

CHAMPUS eligible beneficaries will be under the provisions of CHAMPUS.

(b) After the diagnosis of pregnancy has been established by a staff physician the patient will be counseled by GYN clinic personnel as to the options she may pursue in regard to her pregnancy.

(c) If the patient elects to continue her pregnancy GYN clinc personnel will further counsel her that she will need to make her own arrangements for care with a civilian obstetrician and that after she has had her initial appointment with this obstetrician that she is to inform CAH of his name and telephone number (this information will be included in her military health record so that if she is seen at CAH with a problem related to her pregnancy her civilian obstetrician can be notified). She is also to be counseled that after her infant is released from the hospital she is to come to CAH for pediatric care. Civilian pediatric care is not authorized for these infants. She is also to be informed that she is to come to CAH for any medical problems not directly related to her pregnancy.

(e) A DD 2161 (4 copies) will be prepared and sent to the Chief of Professional Services for approval. The patient will go to the Health Benefits Advisor with approved DD 2161.

(f) The HBA will counsel the patient regarding the the mechanism of payment and authorized benefits. She will be told that she is to have the hospital where she is admitted for delivery notify CAH of the admission at once.

(g) The HBA will maintain a log of supplemental care obstetrical referrals.

(h) One copy of the DD 2161 will be forwarded to the comptroller who will obligate the necessary funds.

(i) The patient will be given two copies of the DD2161 along with a cover letter to take with her to the civilian obstetrician.

(j) After the patient has delivered the patient administration division will request a clinical summary from the delivering hospital. Receipt of this summary will be recorded in the log maintained by the HBA. The log will be used by the comptroller to verify that the service was provided prior to authorizing payment.

(4) Other supplemental care referrals: This includes all referrals under the supplemental care program which are not covered under the above three categories.

(a) The attending physician will intitiate the request for the referral using DD 2161 (4 copies). In addition to the usual clinical information, this request must specify that the referral is for a one time consultation and is not for continuing management of the patient.

(b) The clinic secretary will make sure the DD2161 has the necessary patient identification data.

(c) The referral will be routed to the C, Professional Services for approval.

(d) The clinic will then schedule an appointment for the service. The patient will be referred to the Health Benefits Advisor with the approved DD 2161.

(e) The HBA will counsel the patient concerning the mechanism of payment and the benefits which are authorized.

(f) The HBA will maintain a log of these referrals.

(g) The patient will be given two copies of the DD 2161 to take to the civilian provider. One copy will be sent to the comptroller so that the necessary funds can be obligated. One copy will be retained by the HBA.

(h) Civilian providers will be requested to send two copies of reports back to the health benefits advisor.

(i) When the reports are received this will be recorded in the log. The original will be sent to medical records to be incorporated into the patient's chart. The other copy of the report will be sent to the patient's physican.

(j) The log will be used by the comptroller division to verify that the service was provided and as a workload data source.

(5) Off-hour emergency referrals:

(a) When radiographic procedures or other services from civilian sources on an emergency basis during other than normal duty hours, the attending physican assisted by the nursing staff will arrange for the service with the usual civilian provider. The above approval and clerical activities, including entry into the appropriate log will be accomplished the next duty day.

(b) The attending physician is expected to use clinical judgement in the use of emergency referrals so that there will be no problem with there being sufficient justification to approve them after the fact.

b. CHAMPUS referrals:

(1) CHAMPUS beneficiaries who do not come under the provisions of the above, will have to receive care beyond the capabilities of CAH under the provisions of CHAMPUS. The Health Benefits Advisor should be consulted as to the benefits which can be provided. Cooperative care referrals are initiated utilizing DD Form 2161 in a manner similar to supplemental care referrals

(2) Nonavailability statements are required only for elective care for CHAMPUS beneficaries who will be hospitalized for 24 hours or longer and who live within 40 miles of a Uniformed Services medical treatment facility. They are not required for emergency or outpatient care for CHAMPUS beneficiaries. If the patient requires a statement of non-avaiilability this will be provided by the Health Benefits Advisor.

7. RESPONSIBILITIES:

a. MEDDAC Commander: IAW AR 40-3 the MEDDAC Commander is the approving authority for all supplemental care referrals. This authority is delegated as described below.

b. Chief of Professional Services: The delegated approving authority for all referrals for care beyond the capabilities of CAH which are not further delegated. The CPS is responsible. in conjunction with the rest of the medical staff, for evaluating the quality and timeliness of the services received from civilian sources and for the selection of the civilian sources which are used.

c. Chief Department of Pathology: The delegated approving authority for all referrals for clinical laboratory procedures beyond the capabilities of CAH. The C, Department of Pathology is the medical staff's consultant for laboratory procedures and recommends civilian sources of laboratory tests and consults with the medical staff in regard to the use of the laboratory tests. The Chief department of

pathology is responsible for maintaining the necessary files and logs as described.

d. Chief Department of Radiology: The delegated approving authority for all referrals for radiographic procedures beyond the capability of CAH. The medical staff expert responsible for recommending civilian sources for radiographic procdures to the rest of the medical staff and the consultant to the medical staff in the use of radiographic procedures. The Chief department of radiology is responsible for maintaining the necessary files and logs as described.

e. Other department and service chiefs. To ensure that the various members of their respective departments understand the process for referring patients for care beyond the capabilities of CAH and that such referrals are used appropriately by their staff.

f. Chief Patient Administration Division. To ensure that reports are incorporated into the medical record on a timely basis.

g. Chief Comptroller Division. To ensure that the necessary funds are obligated and bills are authorized for payment after the necessary verification of service has been accomplished.

h. Health Benefits Advisor. To provide assistance and counseling for all CHAMPUS referrals and for the non-radiologic and non-laboratory supplemental care referrals as described. To maintain the necessary logs as described.

8. REFERENCES:

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THE PROPONENTS OF THIS REGULATION ARE THE C, PROFESSIONAL SERVICES; C, COMPTROLLER DIVISION; AND C, PATIENT ADMINISTRATION DIVISION. USERS ARE INVITED TO SEND COMMENTS AND SUGGESTED CHANGES ON DA FORM 2028 (Recommended Changes to Publications) TO COMMANDER USA MEDDAC, ATTN HSXF-C, FORT DEVENS, MA 01433

FOR THE COMMANDER

KENNETH K. YAMANOUCHI
LTC (P), MSC
Executive Officer

OFFICIAL

DAVID W. CANNON
CPT, MSC
Adjutant

DISTRIBUTION
"B"

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COL George Baddour, MC, Chief of Professional Services

MAJ Ruby Baddour, MC, Chief Department of Pathology

CPT Ronald Ledford, MSC, Chief, PAD

CPT Susan Huggler, ANC, Head Nurse Gyn Clinic

Mrs Marge O'Donnell, Health Benefits Advisor

MAJ Brian Thiel, MSC, Chief Comptroller Division

SSG Ronald Wilson, NCOIC, Radiology Department

Mrs Theresa Wright, Secretary Department of Medicine

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