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The Purpose of this Graduate Management Project is to identify the OB/GYN resource requirements to meet the needs of all DoD employees and their family members on the Korean Peninsula. The unique environment in Korea presents several challenges to the Military Health System for providing OB/GYN care. The study uses both quantitative and qualitative analysis. The quantitative analysis measured staffing, productivity, and access to care. Results of the quantitative analysis indicated the need for additional support staff. The qualitative study was used to verify and/or identify any additional requirements. Results of the qualitative analysis indicated that there was a need to increase the availability for prenatal care, increase the amount of appropriate support staff, and to provide a more robust Storknest program.

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RUNNING HEAD: The resources needed to provide OB/GYN care in Korea

What resources are required to provide full service obstetric and gynecologic care to DoD employees and their families on the Korean Peninsula?

A Graduate Management Project in partial fulfillment of the requirements for a Master Degree in Health Administration

By
CPT Alan A. Jones

Seoul, Republic of Korea
10 June 2007

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Abstract

The Purpose of this Graduate Management Project is to identify the OB/GYN resource requirements to meet the needs of all DoD employees and their family members on the Korean Peninsula. The unique environment in Korea presents several challenges to the Military Health System for providing OB/GYN care. The study uses both quantitative and qualitative analysis. The quantitative analysis measured staffing, productivity, and access to care. Results of the quantitative analysis indicated the need for additional support staff. The qualitative study was used to verify and/or identify any additional requirements. Results of the qualitative analysis indicated that there was a need to increase the availability for prenatal care, increase the amount of appropriate support staff, and to provide a more robust Storknest program.

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What resources are required to provide full service obstetric and gynecologic care to DoD employees and their families on the Korean Peninsula?

The armed forces of the United States have had a significant presence on the Korean peninsula for over 55 years. The American military's mission has been to support deterrence of North Korean aggression against the Republic of Korea (ROK), and if needed, conduct combat operations (EUSA, 2006a). This mission requires a considerable force; the current Department of Defense (DoD) population, including their families, in the Republic of Korea (ROK) is 64, 967 members who are spread over 98,480 sq km (DBIDS[1], 2007; CIA World Factbook, 2006).

The medical support for the United States Forces Korea (USFK) and their families is provided by 13 small primary care clinics geographically dispersed across the Korean peninsula and a single Level III facility,[2] the 121st Combat Support Hospital (CSH), located in the capital city of Seoul. The 121st CSH has 61 inpatient beds and extensive out-patient facilities which provide an array of clinical and ancillary services (Table 1). The hospital's mission is two fold: during hostilities it is "to provide stabilization and hospitalization for patients who require further evacuation out of the theater of operations"; during armistice it is "to provide primary care, inpatient and outpatient specialty care, and ancillary care to authorized beneficiaries" (121st GH, 2006a).

Table 1.

121st CSH clinical and ancillary services

Primary Care Services	**Inpatient Units**
Ambulance and Emergency Medical Services	Inpatient Psychiatry
Primary Care Clinic	Intensive Care Unit
Internal Medicine Clinic	Multi Care Unit
Pediatric Clinic	Post Anesthesia Care Unit
Well Baby Clinic	Women and Infant Care Unit
Specialty Clinics – Behavioral Medicine	**Specialty Clinics – Medical**
Alcohol and Treatment Center	Dermatology Clinic
	Pharmacy Clinic
Mental Health Clinic	Neurology Clinic
Army Substance Abuse Program	Immunization Clinic
Specialty Clinics – Support	**Specialty Clinics – Surgical**
Chaplain Services	Eye, Ear, Nose, Throat Clinic
Exceptional Family Member Program	Obstetrics and Gynecology Clinic
Laboratory Services	Ophthalmology Clinic
Nutrition Care Clinic	Optometry Clinic
Occupational Therapy Clinic	Oral and Maxillofacial Surgery Clinic
Pharmacy Services	Orthopedic Clinic
Physical Therapy Clinic	General Surgery Clinic
Pre-Admission Unit	
Educational and Developmental Intervention Services	
Radiology Services	

The medical health plan for the DoD is TRICARE. TRICARE was first introduced to the military health system (MHS) in the early 1990's. The purpose behind the TRICARE program was to ensure the MHS remained competitive with health care programs in the civilian sector (Roark, 1997). In order to remain competitive, TRICARE had to both increase patient choice and

control costs. This particularly impacted obstetrical and gynecological (OB/GYN) care within the MHS because of recent advancements in care.

Although TRICARE covers the entire DoD, the priority for care at the military treatment facility (MTF) varies according to beneficiary status. Authorized beneficiaries of medical care in the military are determined by their enrollment status in the Defense Enrollment Eligibility Reporting System (DEERS[3]). Although there are many types of plans offered under TRICARE, most beneficiaries in Korea fall under two TRICARE programs; TRICARE Overseas Program (TOP) Prime and TOP Standard.

TRICARE Overseas Program (TOP) Prime is offered in three overseas areas: Europe, Pacific, Latin America/Canada (TRICARE, 2006b). TOP Prime is set up very similar to a civilian health maintenance organization (HMO) where beneficiaries are assigned a Primary Care Manager (PCM) and receive most of their care at the MTF. Prime beneficiaries must receive a referral and authorization from their PCM for routine, specialty or inpatient care provided by someone other than their PCM. If necessary, a PCM may refer medical care to a host nation facility. In Korea each recommended host nation facility has a Memorandum of Understanding (MOU) with the MTF, ensuring that the host nation facility meets or exceeds the established standard of care. All active duty members are automatically enrolled in TOP Prime. The TOP Prime managed care option is offered to authorized active duty family members residing with their active duty sponsor, but it is not available to retired service members and their families (TRICARE, 2005). Although retired service members and their families have the option to enroll in TRICARE Prime in the United States, MTFs in Korea are not allowed to enroll those beneficiaries because there is no managed care support contract with host nation medical facilities.

TOP Standard is the only available TRICARE option in Korea for beneficiaries who do not qualify for TOP Prime. TOP Standard is a fee-for-service plan that allows the greatest flexibility for a beneficiary. Beneficiaries are not assigned a PCM and are allowed to seek care at any authorized host nation facility. Although Standard offers the most flexibility, it is the most expensive. According to TRICARE policy, Standard patients must "satisfy a yearly deductible before cost sharing begins" (2006a, ¶ 3). In addition, beneficiaries are required to pay co-payments or cost shares for outpatient care, medications, and inpatient care (TRICARE, 2006a).

Conditions that Prompted the Study

On 1 October 2005, a DoD policy changed the eligibility requirements for TRICARE Overseas Program Prime (Winkenwerder, 2005). The new policy limits TOP Prime eligibility to active duty service members and active duty command-sponsored family members (Appendix A). Command-sponsored family members are dependents of active duty members entitled to travel to overseas commands at the government's expense and must be endorsed by the appropriate military commander. The determination for command-sponsorship eligibility is a human resources decision. The impact of this policy is twofold. First, non-command sponsored family members are only authorized to use TOP Standard and can only be seen at the MTF on a space available[4] basis. Second, the Automated Staffing Assessment Model[5] (ASAM) does not capture those family members as part of the beneficiary population unless they have three or more visits a year. Because the MTF staffing is based on its beneficiary population, the MTF may be providing care for a significant number of patients for which it is not staffed.

In his Commander's Intent, General B.B. Bell, the USFK Commander, describes the integral role that families play in supporting service members and the USFK organization (2006). He notes that while assignments to Korea have historically been a one year unaccompanied tour,

he has implemented several initiatives in an effort to make Korea a three year "assignment of choice" (2006). General Bell's initiatives include increasing the number of command sponsored positions and offering Assignment Incentive Pay. Assignment Incentive Pay authorizes service members to collect an additional amount of money for extending their tour of duty in Korea. There are currently about 5,400 Army family members on the Korean peninsula and 2,700 of those are non-command sponsored (EUSA, 2006b).

Statement of the Problem

The OB/GYN clinic at the 121st CSH provides the only military OB/GYN physicians on the peninsula. The 121st CSH is currently staffed by four OB/GYN physicians, plus a Nurse Practitioner, and includes two divisions for women's health: the Women and Infant Care Unit (WICU) and the OB/GYN clinic. The WICU averages approximately 35 deliveries a month. The OB/GYN clinic serves as a referral center for the hospital and the primary care clinics on the peninsula, averaging approximately 900 visits per month.

The 121st CSH does not have the necessary resources to guarantee access to full service obstetric and gynecological care to all DoD employees and their families on the Korean peninsula. Currently, non-command sponsored dependents receive care on a space available basis. The current eligible population is approximately 55,000 (121st GH, 2006b). The desire among the USFK leadership is to provide medical care for all active duty military and their family members, retirees and their family members, and DoD employees, which is an additional population of 9,967. This disparate application has had a significant impact on the 121st CSH and those individuals not covered under TOP Prime. The most significant impacts are the lack of available appointments for non-command sponsored dependents at the MTF, financial barriers for Host Nation medical care, and staffing issues within the MTF.

There are two reasons why patients in Korea are referred to Host Nation facilities for care: lack of space available within the MTF (e.g., no appointments or all inpatient beds full) or lack of services available within the MTF (e.g., advanced genetic counseling or advanced infertility care). According to the TRICARE-Korea database, the 121st CSH sent 542 OB and 403 GYN referrals to Korean hospitals in the fiscal year 2006. These referrals included patients who received both inpatient and outpatient care, some of whom were covered under TOP Prime and some under TOP Standard. This represented a significant cost for private sector care.

The 2005 TRICARE policy change has created significant financial barriers for non-command sponsored family members. According to TRICARE policy, patients covered under TOP Standard while living overseas are "responsible for paying annual deductibles and cost shares, just as they are in the U.S." and may be required to pay up front for care, possibly in the host nation currency (2006b, ¶ 9). The financial burden is further magnified by the fact that a majority of the non-command sponsored family members are dependents of junior military members who have much smaller incomes than most command sponsored dependents. Junior military members (E-6 and below; 0-2 and below) in Korea earn an annual salary between $14, 136 and $33, 396; while senior military members (E-7 and above; O-3 thru O-6) in Korea earn between $51, 564 and $106,105.

The 121st CSH is staffed using a combination of Army staffing models, and is based in combination with the Modified Table of Organization and Equipment (MTOE[6]), the Augmentation Table of Distribution and Allowances (TDA[7]), the Officer Distribution Plan (ODP[8]), and the Automated Staffing Assessment Model (ASAM). These individual staffing systems are based on measures that balance the necessary personnel requirements with the available personnel inventory and resources. Army Medical Centers (MEDCEN) and Army

Medical Activities (MEDDAC) are based on a TDA, the ODP, and the ASAM. The main difference between the MEDDAC/MEDCEN and the 121st CSH is the MTOE manning document. The MTOE manning document is determined based on a wartime requirement, while the TDA document is based on patient care requirements in a non-deployable peacetime setting. The ASAM and ODP are used to identify and prioritize personnel resources for the MTOE and the TDA. The effectiveness of these systems is determined by how well the staffing models accurately reflect the organization's requirements.

Literature Review

There is an emphasis on wellness and disease prevention in both gynecological and obstetrical care with the goal being to address the cause of disease rather than just managing illness. According to Olden and Newbold, "Women's health issues are currently receiving a renewed focus of research interest nationwide..." (2000, p.767). The intent among health care providers is for women in the 21st century to enjoy longer, healthier lives as well as deliver healthy babies.

Nearly two decades ago, a movement known as preconceptional health promotion began. This movement sought to have a positive impact on reproductive outcomes by promoting prepregnancy wellness (Moos, 2004). In 1985, the Institute of Medicine wrote "Only casual attention has been given to the proposition that one of the best protections available against low birth weight and other [negative] pregnancy outcomes is to have a woman actively plan for pregnancy, enter pregnancy in good health with as few risk factors as possible, and be fully informed about her reproductive and general health" (p. 119). Despite recognition by leading professional organizations such as the American College of Obstetricians and Gynecologists (ACOG); the American Academy of Pediatrics; and the Association of Women's Health,

Obstetrical, and Neonatal Nurses; there is little evidence that the paradigm shift necessary to reframe the clinical care of women has occurred (Moos, 2004). The MHS has also been very slow to embrace preconceptional health promotion. There are several explanations for the lack of attention to proven prevention strategies including poor appreciation of the incidence of unintended pregnancies, lack of confidence that preconceptional counseling is effective, inadequate education of clinicians about preconceptional health, belief that women will seek the care appropriate to their needs, and lack of reimbursement coverage (Moos, 2004). In order for preconceptional health promotion to be effective, OB/GYN and other health care providers must approach women's reproductive health as a continuum of care rather than a series of episodic encounters which are unrelated to each other.

Obstetric and Gynecologic care within the military health care system has experienced significant changes over the past decade. Following the implementation of TRICARE in the early 1990s, many women requested to receive their care at civilian facilities, which offered more services and amenities such as ease in scheduling appointments, individualized prenatal education, allowance of children to attend OB visits, private postpartum rooms, lactation support programs, and admission/discharge done at the bedside (Pueschel, 2003). Many MTFs were challenged with trying to convince women to stay at the MTF to receive OB care. In order to prevent rising cost and recapture beneficiaries, the Military Health System (MHS) developed a focused marketing campaign.

As part of her 1999 Graduate Management Project (GMP), Captain Kelly Soh studied the impact of TRICARE on OB/GYN services. She developed a marketing campaign to attract female beneficiaries back into the MTF. As a result of her research and simultaneous research conducted at several MTFs, the Army Medical Department (AMEDD) implemented the OB

initiative (Table 2). The initiative was based in part on the variation in the number of recommended prenatal visits for women having uncomplicated pregnancies (Partridge & Holman, 2005). It was recognized that a reduction in unnecessary prenatal visits with no adverse impact on perinatal outcomes or maternal satisfaction would provide a significant cost savings for providers of maternity care. According to recent research, "prenatal and labor and delivery care is a large portion of care delivered at military hospitals, and maintaining the highest standard of care using evidenced-based medicine when available is of the utmost importance" (Partridge & Holman, 2005, p. 556). The OB initiative implemented a new set of standards for obstetrical care across the AMEDD. These new standards have been instrumental in providing more patient focused care as well as reducing the number of unnecessary appointments.

Table 2.

DoD OB initiatives

ACCESS	LABOR AND DELIVERY
Needs assessment for MTF to offer OB visits during evenings and weekends	Generic MTF Birth Plan at orientation or on website
Needs assessment for access to remote/ off-site clinic	Siblings allowed to attend birth
Allow children to attend clinic visits or offer daycare at MTF	24/7 anesthesia support
Eliminate requirement for MTF to confirm pregnancy before scheduling 1st visit.	Private post-partum rooms
Offers special parking for pregnant women, mothers w/infants at every MTF	Private bath in room
PRENATAL CARE	**CUSTOMER SATISFACTION**
Individualized OB education	Lactation support staff
75% of Prenatal visits with same provider (OB Clinic)	Admission PAD at bedside
Implement continuity clinic (OB) (individual or team)	Newborn enrollment for TRICARE/DEERS at bedside
75% of Prenatal Visits with same provider (FP Clinic)	Follow-up appointment for mother scheduled prior to discharge
Implement continuity clinic (FP) (individual or team)	Follow-up appointment for newborn scheduled prior to discharge
Capability to schedule clinic follow-up appointments	Patient satisfaction assessment
Implement the Clinical Practice Guideline (for the Management of Uncomplicated Pregnancy	Implement local marketing
Referral for genetic counseling available	Dedicated OB/GYN website page at each MTF
Offer every woman an anatomic ultrasound between 16 and 20 weeks.	OB Staff photos or binder in waiting area

Note. The OB initiative is a set of OB standards established in 2002 for all Military Treatment Facilities in the Military Health Care System

Perhaps the most important aspect of the OB initiative is the VA/DoD Clinical Practice Guideline for Management of Uncomplicated Pregnancy. This clinical practice guideline (CPG) incorporates recommendations for prenatal care from ACOG, and strives to use evidence-based medicine to provide prenatal care with specific gestational age visits, each having well-defined

goals and objectives (DoD, 2002). The key elements of the CPG are: (1) standardized prenatal care for lower risk patients to minimize variation in care, (2) standardized care plan to improve overall patient satisfaction with prenatal care, (3) explicit, evidenced-based interventions for screening and management, (4) standardized education of patients and providers, (5) standardized counseling for antenatal diagnostic screening, (6) standardized prenatal screening to identify women with high-risk pregnancies, and (7) a tool kit for patients and providers to empower implementation.

Researchers at the US Naval Hospital Camp Pendleton (NHCP) studied the effect of the guideline by comparing the number of prenatal visits and perinatal outcomes for patients delivering at NHCP for one year before and after the introduction of the CPG. They found that the change from the delivery of traditional prenatal care to a reduced visit, goal-oriented practice was associated with a reduction in prenatal visits, a small increase in L&D visits, and no increase in adverse perinatal outcomes. A further analysis of outpatient visits to L&D from 2001-2004 showed fewer visits than the preguideline year (Partridge et al., 2005).

Research continues to explore new ways to improve women's health care. The emphasis on wellness and disease prevention is vital in ensuring the health of future generations. As evidenced by the introduction of the OB initiatives and the CPG, the DoD is committed to not only providing the highest standard of OB care but also being the preferred provider for these services.

Purpose

The purpose of this study is to identify the resources that are required to provide full service OB/GYN care (Table 3) to the current number of DoD employees and their families

(Table 4) on the Korean Peninsula in order to ensure the highest quality OB/GYN care.

Table 3.

Obstetric and gynecologic care available at the 121st CSH

GYNECOLOGY	OBSTETRICS
Uterine Fibroids	Low risk; limited high risk OB care
Pelvic Pain	Routine anatomy scan
Polycystic Ovarian Syndrome (PCOS)	Screening for cystic fibrosis/triple screen
Incontinence	Amniocentesis
Abnormal Uterine Bleeding	Gestational diabetes
Dysplasia (colposcopy/LEEP/cone biopsy)	Preeclampsia
Endometriosis	Fetal anomalies (some may be referred to MOU)
STDs	Multiples (twins only)
Pelvic Inflammatory Disease (PID)	> 36 weeks gestation labor and delivery
Ovarian Cysts	Cesarean sections
Uterine prolapse/cystocele/rectocele	Vaginal Delivery After Cesarean Section (VBAC)
REPRODUCTIVE ENDOCRINOLOGY & INFERTILITY	**MATERNAL FETAL MEDICINE**
Coital infertility treatment	High Risk OB encompassing available area of specialty
Reproductive endocrinology on a generalist level	**GYNECOLOGY ONCOLOGY**
UROGYNECOLOGY	Gynecology Oncology on a generalist level
Urogynecology on a generalist level	

Note: This list is not all inclusive. Source – Chief, OB/GYN Clinic

Table 4.

DoD employees and their family members

Active Duty	Command Sponsored Family Members	Non Command Sponsored Family Members
Government Service (GS) Civilians	Department of Defense Dependent Schools employees (DODDS)	Contractors
Non-Appropriated Funds employees (NAF)	US Embassy personnel	Retirees

Note: N = 64,967

Methods and Procedures

Study Design

This study is an exploratory study using non-experimental research. Exploratory studies intend to clearly define concepts and develop operational definitions in an effort to identify requirements (Cooper & Schindler, 2003). Non-experimental research includes the review and study of a research question without the manipulation of data or variables. Similar to the study by Thompson (1999), this study examines events as they occur in the present without attempting to influence any of the variables inherent in the description.

Type of Analysis / Methods

This study uses both quantitative and qualitative analyses. A quantitative analysis based on MEDCOM and ASAM staffing models was employed to determine the staffing requirements. The ASAM model was chosen because it is a Department of the Army (DA) model used to identify baseline staffing requirements. It is also used to establish the priorities for the ODP. The ASAM is periodically applied at MTFs to determine personnel requirements and to ensure that MTFs can meet their beneficiary population's evolving needs.

In order to account for the entire population defined in Table 3, data pulls were done from two separate databases, DBIDS and CHCS. The data were discussed with the Chief of the OB/GYN clinic to ensure the data had face validity. Face validity is the extent to which data is subjectively measured by a knowledgably person on the subject (Sirkin, 1999). The new staffing recommendations provided by the ASAM study were compared with the current staffing and the previous ASAM recommendations (which calculated staffing based on TOP Prime members and the reliant population). Further quantitative analyses were conducted using the current staffing to analyze whether access to care standards were being met and to determine provider productivity.

A final qualitative analysis was conducted to validate and/or identify any additional resources required to provide full service OB/GYN care to the entire beneficiary population in Korea. Using both techniques was essential to best answer the research question. Data gathering techniques included but were not limited to: M2[9] data pulls, AHLTA[10] data pulls, PASBA[11] data pulls, the ASAM, information briefings, ACOG recommendations, and interviews from several departments within the 121st CSH. The purpose of using several sources was to determine the best solution for the research question and to give validity and reliability to the findings.

Operational Definitions

The foundation to the research question lies in operationally defining both OB/GYN care and DoD employees and their families. The operational definition of OB/GYN care at the 121st CSH is determined by the MTF (Table 3). The 121st CSH currently provides a full spectrum of OB/GYN service. However, some patients who require high risk or specialty care (e.g., preterm labor, severe fetal anomalies, advanced gynecology oncology care, etc.) may be referred to an MOU hospital due to a the lack of specialty personnel, services, and equipment at the MTF. The purview of OB/GYN care is established by the ACOG standards of care. The definition for DoD

employees and their family members is provided in Table 4. The DBIDS database was used to obtain an accurate number of DoD employees and their family members on the Korean peninsula.

Validity and Reliability

Several methods for acquiring data in the study were used to ensure valid and reliable results. Both construct and content validity were employed to ensure that the research question was valid. The operational definitions define the constructs of the research. Only MEDCOM accepted staffing tools and the VA/DoD accepted standard of care guidelines were used to ensure content validity.

The research uses a parallel form of reliability, using prior studies and replicating study designs, to ensure that the results replicated similar findings in the literature.

Results

Quantitative Analysis

The quantitative study used the ASAM methodology. The author ran the ASAM, capturing the entire population of eligible DoD employees and their family members living on the Korean peninsula, in order to calculate staffing recommendations for OB/GYN services at 121st CSH (Appendix B). Table 5 depicts the staffing output of the quantitative study, the current OB/GYN staff, and the difference.

Table 5.

OB/GYN staffing at the 121 CSH

OB/GYN staffing	CAT 1 and 2	CAT 3, 4, and 5	Total
Quantitative study (Feb 07)	5	36	41
Current staff (Feb 07)	5	29	34
Difference	0	7	7

Note: Source ASAM database POC Chief, Manpower MEPRS

The ASAM calculates the recommended number of staff by grouping them into two categories: professional staff (CAT 1, 2) and support staff (CAT 3, 4, 5). The five categories represent: CAT 1 = Doctor of Medicine (MD) and Doctor of Osteopathy (DO); CAT 2 = Nurse Practitioner (NP), Physician Assistant (PA), and Certified Nurse Midwife (CNM); CAT 3 = Registered Nurse (RN); CAT 4 = Licensed Practical Nurse (LPN); CAT 5 = Health Care Specialists and Administrative Clerks.

When compared to the current staffing, the new study demonstrated a need for seven additional support staff (CAT 3, 4, and 5). The ASAM study determined that the current support staff did not meet the minimum requirements to support the current population and workload. Additional quantitative analyses examined access to care and provider productivity in order to further investigate whether current staffing was adequate.

Access to care standards for each appointment type are determined by TRICARE and aim to measure whether patients are gaining access to health care in a timely manner. The types of

appointments used to schedule obstetric and gynecological patients and their access to care standards are defined in Table 6.

Table 6.

OB/GYN appointment types at the 121 CSH

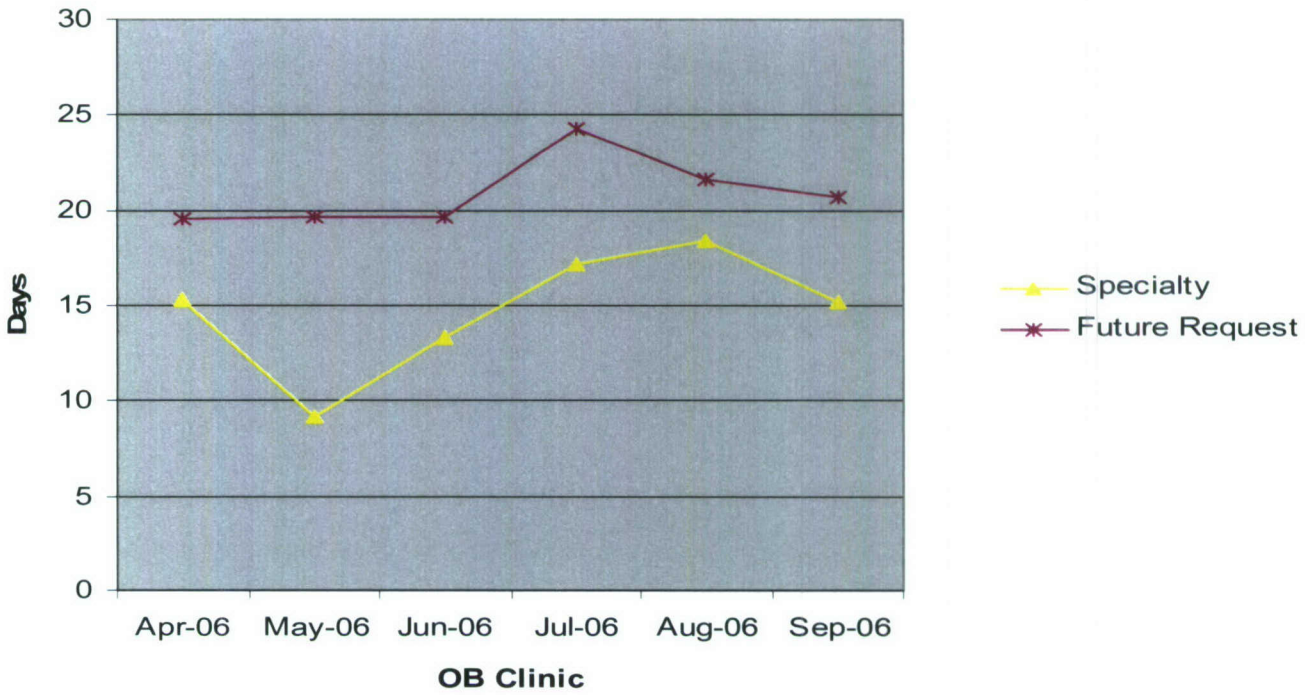
Obstetric Clinic		
Appointment Type	**Description**	**Access to Care standard**
"OBA" GRP (group appointment)	Group orientation class for OB patients between 6-8 weeks gestation	28 days
"OBB" SPEC (specialty appointment)	A complete physical exam; first appointment with an OB provider, conducted between 10-12 weeks gestation	28 days
"OBC" EST (established)	Routine OB follow-up appointments for every 4-6 weeks throughout pregnancy	28 days
"OBC" ACUTE	Acute appointment for issues that do not require evaluation in the ED or L&D	24 hours
"OBC" ROUT (fit to fly)	Routine appointment needed to ensure that it is safe for an OB patient to fly/travel	7 days
Gynecology Clinic		
SPEC (specialty)	Initial or follow-up GYN appointment	28 days
ACUTE	Acute appointment; usually referred from the ED	24 hours
PRE-OP SPEC (specialty)	Appointment required prior to GYN surgery	28 days
POST-OP SPEC (specialty)	Appointment to check patient's status following GYN surgery	28 days

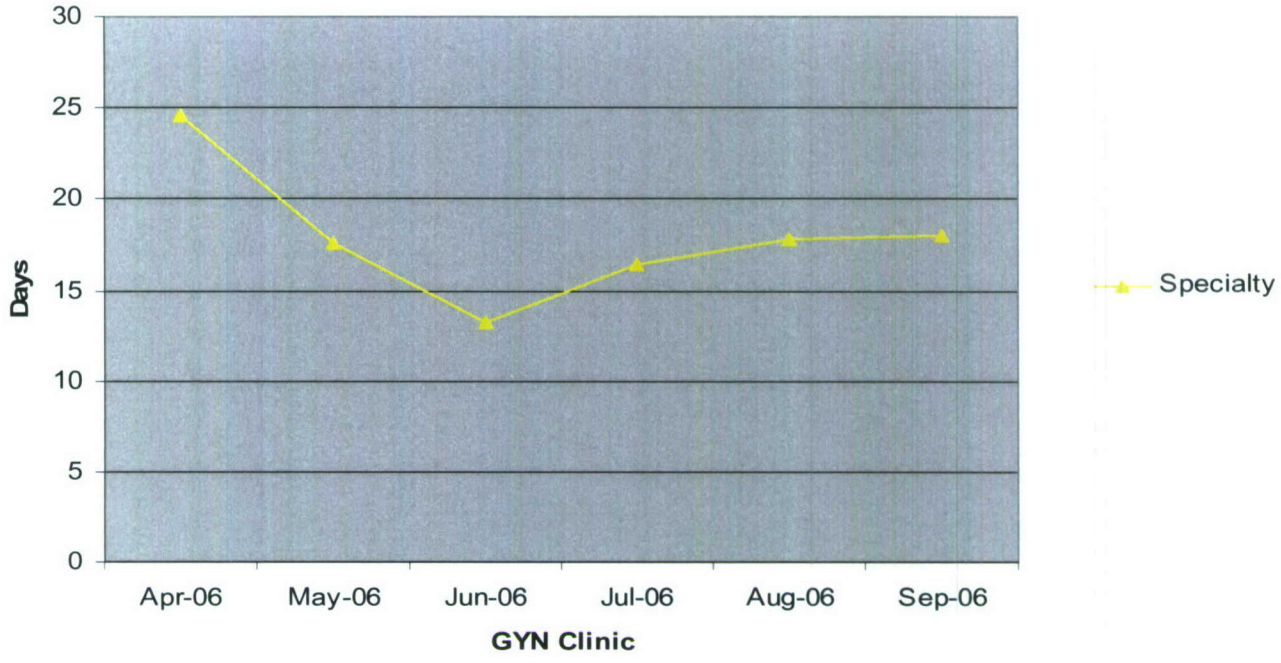
Note. Group and established appointment types can be categorized together as future requests in CHCS

Access to care was analyzed for the OB and GYN clinics by pulling 6 months of data from CHCS and placing it in line graphs in order to identify trends (Figure 1). The data represented both TOP Prime patients and TOP Standard patients. The results indicated that both clinics met the access to care standards. The graphical display shows that both clinics met the access to care standard, averaging under the 28 day established guideline. The data for the OB clinic are broken down into two categories: specialty and future request. The specialty appointment represents the first encounter that a patient has with an OB provider. The appointment should be conducted between 10 to 12 weeks gestation. The future request appointments represent group and established encounters. The group appointment is an orientation class for OB patients conducted by a RN. The established appointments are routine follow-up appointments for every 4 to 6 weeks, following the specialty appointment, throughout the pregnancy. The access to care study in the OB clinic was limited because it did not take into account whether appointments were being scheduled within the appropriate timeframe as determined by the OB CPG. The graphic display also fails to show acute visits because they are not available on the appointment template; rather, the on-call provider cares for those patients on a same day basis or the patients are deferred to a MOU facility.

Figure 1.

OB/GYN access to care at the 121 CSH





Note. The data represents monthly average wait time for each appointment type.
Source: The access to care data was pulled from CHCS.
N = 2644 for 121 CSH OB clinic
N = 287 for 121 CSH GYN clinic
Future Request = group and established appointment types

In an effort to provide care for patients within the MTF, clinic policy dictates that when the demand for OB/GYN appointments exceeds the current available appointment slots the on-call provider will see the patients on a standby basis (Appendix B). If the on-call provider is unable to see those patients or does not have the resources to provide them with complete care, they are referred to an MOU facility. According to a TRICARE-Korea data pull, the OB/GYN clinic referred 268 outpatients to MOU hospitals during the examined six month time frame.

The final quantitative analysis examined provider productivity in the OB/GYN clinic. Six months of data were pulled from the M2, WTS[12], and UCAPERS[13] databases to calculate provider productivity. The data were measured by RVUs (relative value units) per provider per

day. The RVU is based on the volume and the intensity of the patient encounter. The provider productivity table illustrates that the OB/GYN providers meet or exceed the DoD standard for obstetric productivity (Table 7/Appendix D.).

Table 7.

Provider productivity for OB/GYN at the 121 CSH

Clinic	RVU Per Provider Per Day PPS FY '08 Goal	RVU Per Provider Per Day Actual
121 CSH OB Clinic	17.7	20.79
121 CSH GYN Clinic	20.45	20.21

Note. The provider productivity data was pulled from the M2 database and the WTC/UCAPERS database. The time frame is 1 April 2006 to 30 September 2006. PPS – Prospective Payment System/the PPS is used by the MHS to assist in reimbursement and budgeting.

The quantitative analyses conducted in this study demonstrated a need for some additional staff. The author's ASAM study did not identify a need for an additional provider, but a need for seven additional support staff, above the current staffing, were identified in order to extend care to the entire population of DoD employees and their family members on the Korean peninsula. The quantitative study also showed that current staffing was meeting or exceeding access to care standards and provider productivity goals.

Qualitative Analysis

Qualitative analyses were done to further examine staffing issues and to validate and/or identify other resources needed to answer the research question.

The author identified three requirements from qualitative interviews needed to answer the research question: increase the availability of prenatal care, increase the amount of nursing and support staff, and provide a more robust Storknest program.

Prenatal care is paramount for expecting mothers and is required in order for a woman to deliver at the 121st CSH. Women who have not received prenatal care are automatically categorized as "high risk." The 121st CSH does not have the resources to safely deliver a patient who has not had prenatal care because of the potential negative outcomes due to undiagnosed complications. The resources needed to provide these types of services require a Neonatal Intensive Care Unit (NICU), which the 121st CSH does not have. The 121st CSH does not have the demand to establish a NICU, so these patients are referred to MOU facilities where they have the resources to respond to any complications that may arise before, during, or after delivery.

One unique challenge for the 121st CSH OB/GYN staff is to manage prenatal care for expecting mothers who are geographically dispersed across the Korean peninsula. In many instances, beneficiaries must travel long distances to receive care if they want to be seen at the MTF. For example, beneficiaries located in Chinhae are 250 miles south of the 121st CSH. While MOU facilities are an available option they are not required to follow the CPG mandated for DoD treatment facilities. Additionally, unless the beneficiary travels for each prenatal appointment there is an interruption in the continuity of care. The OB/GYN staff has implemented a program which rotates an OB/GYN provider every other week to two outlying Army Health Clinics where these women normally receive their health care, to alleviate some of the challenges for pregnant mothers. Although this program does not solve the entire challenge of caring for geographically dispersed beneficiaries, it has allowed for significant strides in ensuring that patients are afforded the opportunity to see military OB providers for prenatal care.

The crux for continuing this service is ensuring that an adequate OB/GYN staff is maintained at the 121st CSH. If the current OB/GYN provider staff dips below five, the program would have to discontinue. The current ASAM does not have a formula that accounts for the rotating provider which means that some workload is unaccounted for in the staffing model.

The qualitative study identified a need for four additional nursing and support staff in the WICU and the OB/GYN clinic, compared to the seven identified in the ASAM (Table 8). One difference between the ASAM and the qualitative study is the facility limitations. The author noted that the ASAM model does not account for facility or equipment resources. The current OB/GYN clinic has four treatment rooms, but current AMEDD guidance recommends two to three treatment rooms for each provider; thus, additional providers would be under utilized if they had to share four treatment rooms.

Table 8.

Recommended OB/GYN nursing and support staffing for the 121 CSH

	RN	LPN	Health Care Specialist	Administrative Clerk	Total
WICU	14(13)	8(4)	0(3)	0(0)	
OB/GYN clinic	2(2)	0(0)	8(6)	1(1)	
Total	16(15)	8(4)	8(9)	1(1)	33(29)

Note: The current staff is in parenthesis
The addition of one RN and four LPNs on the WICU would give the head nurse and the ward master more time for administrative duties.

The author believes that a new combination to the staffing mix would alleviate unnecessary duplication of work, or three less support staff than the seven recommended in the quantitative ASAM study. His recommendation would give a new aggregate of 33 support

personnel to the current OB/GYN service line. The author believes that the WICU should have one additional RN, four additional LPNs, and three less health care specialists. Further, the OB/GYN clinic should have two additional health care specialists. Currently, at the 121st CSH, 70% of the WICU nursing staff is Korean Government Service (KGS) nurses. According to Korean law, KGS nurses can work a maximum of eight hours per day. This requires much of the WICU staff to work eight hour nursing shifts, each of which must maintain a minimum of two RNs and one LPN. Thus, more nurses are required to staff the unit on a daily basis than if the entire unit were on 12 hour shifts. In addition, the ASAM weighs health care specialists equally with licensed nursing staff when it calculates staffing needs; however, health care specialists are not privileged to perform nursing duties that are vital to caring for OB patients in the WICU (e.g., performing assessments, giving medication, fetal monitoring, etc.). Thus, they are very limited in the duties they can perform. The WICU staff is responsible for two labor and delivery beds, eight postpartum /antepartum beds, and two Non-Stress tests beds. The WICU is currently staffed with 13 RNs; with one head nurse, two "in training" to become OB/GYN qualified, and seven Korean Government Civilians who are limited to eight hours work days. The WICU currently has four LPNs including the NCOIC. There are three health care specialists but they can only be used to supplement the nursing staff because of their limited scope of practice. Finally, the WICU does not have any clerks to support the administrative responsibilities of the ward. The administrative duties are currently maintained by the staff providing patient care. As a result of the staffing mix, the nurses can become quickly overwhelmed when the census or the acuity of the patients is high. In some instances, patients are diverted to MOU hospitals because of the lack of appropriate nursing staff (Stella, personnel communication, April 23, 2007).

The OB/GYN clinic currently has two RNs and five health care specialists. The five health care specialists are each assigned to a provider but any time they are tasked, in training, on leave, or are sick, the nursing staff or another health care specialist must "double-up" to cover those duties. The end result of inadequate nursing and administrative support can result in reduced patient satisfaction, reduced provider productivity, and reduced access to care.

The lack of appropriate nursing and support staff can be partially explained by limitations in the ASAM and UCAPERS. The ASAM does not take into consideration the differences in the scope of practice among providers or among nursing staff, medical technicians, or administrative staff. Thus, it alone cannot be used to determine the appropriate mix of staffing to meet the workload requirements of the ward or clinic.

The final resource needed to provide full service obstetric and gynecological care to DoD employees and their families on the Korean peninsula is a more robust Storknest program. The Storknest program was developed in an effort to help geographically separated expectant mothers gain closer access to the 121st CSH for delivery (Appendix E). The program strives to offer rooms for expectant mothers at 38 weeks gestation. Unfortunately the facilities that support the Storknest program are not always available because they maintain 98% capacity (Im, personnel communication, April 23, 2007). According to the Family Care Center database, during the first four months of 2007, 53 expectant mothers have been unable to get a room at the Storknest.

Limitations

The limitations identified in this study include gathering accurate population data from the M2 database, measuring obstetrical access to care, and analyzing purchased care data.

The M2 database created challenges when gathering population data with the predetermined query definitions. The typical MEDDAC is able to use the 40-mile *Catchment Area* definition to determine their beneficiary population. The 121st CSH is responsible for all U.S. forces in Korea, many of whom fall outside of the defined 40-mile radius. Although the M2 database is used as the MHS standard for gathering population data, it was a limiting factor in this study. DBIDS was used instead to ensure that all DoD employees and their family members on the Korean peninsula were included in the population data.

Another limitation in this study was applying the access to care metric for the OB clinic. The access to care standards defined by TRICARE are independent from the OB CPG, which outlines very specific points throughout a woman's pregnancy when appointments are needed (Appendix F). While the OB clinic was found to meet TRICARE's access to care standards, there is currently not a system in place to measure whether patients are able to get appointments that coincide with the OB CPG recommendations.

The final limitation in this study was the usefulness of the purchased care data. Obstetric and gynecological care in Korean hospitals is not governed by DoD initiatives or ACOG. Although patients are routinely sent to MOU hospitals due to the lack of availability, specialty personnel, services, and equipment at the 121st CSH, the health care system in Korea is designed differently, specifically insurance and reimbursement, than the health care system in the United States; therefore, data beyond dollars spent and patients seen cannot be compared because the two countries use different methodologies for productivity and reimbursement.

Recommendations and Conclusion

Recommendations for Further Studies

This study lays the foundation for further studies in determining the necessary resources for providing full service medical care in today's fluid environment. In particular, studies should be conducted to determine if resources meet current medical requirements and if current data measures accurately measure access to care.

A future study should be conducted in other service lines to determine if resources meet the needs of the population, specifically, if those resources meet the requirements of CPGs which have inadvertently established either additional requirements or involve the resources of additional services.

An additional future study should be conducted to establish a process that is a better measure of access to care for Obstetrical care. The development of the OB CPG standardized care within the military health system and established specific, goal oriented OB appointments. In order to measure compliance with the CPG, a tracking system could be established to ensure women are seen within the established timeframes. This information would provide administrators and clinicians with a more accurate picture of how accessible OB care is within the MHS. The new process could measure if patients are seen in accordance with the specific timeframes established in the CPG, in addition to, how long it took for a patient to be seen for a specific appointment type.

Enhancing 121st CSH OB/GYN Care

The 121st CSH can enhance the ability to provide full service OB/GYN care to all DoD employees and their family members on the Korean peninsula by having a full support staff and by enhancing the ability to care for the beneficiary population.

A full support staff is crucial for a well-run WICU and OB/GYN clinic. Registered nurses, licensed practical nurses, and administrative staff are instrumental in the delivery of quality care. It is essential to not only have an adequate number of staff but also the appropriate mix of staff. The ASAM alone cannot be used to determine appropriate staffing due to the limitations previously discussed. Additional staffing models such as the Labor and Delivery System (LADS[14]) would be an excellent input variable into the ASAM to help determine the proper amount of nursing staff.

Caring for a geographically diverse population and analyzing private sector care data is a unique challenge for the 121st CSH. The planned relocation of USFK forces in Korea to two major hubs will mitigate the challenge of caring for a geographically dispersed population. The relocation includes moving to a new facility which will be built to properly meet the current needs of the population as well as meet the facility requirements outlined in the OB initiative. The implementation of a three year, command-sponsored tour will allow for an accurate capture of population data which is vital for planning and providing care that meets established standards. In addition to the planned relocation of forces the planned establishment of a managed care support contract will provide the leadership with a better opportunity to do an in-depth analysis of private sector care. A managed care support contract will provide the framework for better continuity of care and reduce the financial burden for patients cared for by MOU facilities.

Conclusion

In conclusion, women's health care within the military health system has undergone major transformations over the past decade. The changes have sought to provide beneficiaries with the highest standard of care using evidenced-based medicine while offering amenities comparable to those found in the civilian sector. In an effort to identify resources needed to

provide full service OB/GYN care to all DoD employees and their family members on the Korean peninsula, this study conducted quantitative and qualitative analyses. There are three measures that will extend Obstetric and Gynecologic care on the Korean peninsula to better serve the population. The first is increasing the amount of nursing and support staff in the OB/GYN clinic and WICU which will enable the providers to see more patients. The second is rotating OB/GYN providers to the geographically dispersed primary care clinics to ensure that beneficiaries are provided the necessary prenatal care. The final measure is to provide the capability to offer a more robust storknesting service for all the women who would like to deliver their child(ren) at the 121st CSH.

References

121st General Hospital. (2006a). Mission statement. Retrieved August 15. 2006 from http://www.seoul.amedd.army.mil/level2/sub/mission.asp?pages=mission&types=121&from=2

121st General Hospital. (2006b, June). Command Brief. Presented at Newcomer's Orientation, Yongsan, South Korea.

CIA World Fact Book. (2006). South Korea. Retrieved September 17, 2006. https://www.cia.gov/cia/publications/factbook/geos/ks.html

Cooper, D.R., Schindler, P.S. (2003). Business research methods. (8th ed.). New York: McGraw-Hill Irwin.

Department of Defense. (2002). VA/DoD clinical practice guideline for the management of uncomplicated pregnancy. Retrieved September 28, 2006. http://www.cs.amedd.army.mil/Qmo

Eighth United States Army. (2006a). Mission statement. Retrieved September 17, 2006. http://8tharmy.korea.army.mil/

Eighth United States Army. (2006b, June). Command Sponsorship Future Assignments – Korea. Presentation presented at the Command Sponsorship Working Group, Yongsan, ROK.

Im, H.C. (2007, April). Discussion on the availability of Storknest rooms on Yongsan Garrison. 121st Combat Support Hospital, Yongsan, South Korea.

Institute of Medicine. (1985). Preventing low birthweight. Washington: National Academy Press.

Moos, M.K. (2004). Preconceptional health promotion progress in changing a prevention paradigm. Journal of Perinatal and Neonatal Nursing.18(1), 2-13.

Olden, K., Newbold, R.R. (2000). Women's health and the environment in the 21st century. Environmental Health Perspectives. 108(5), 767-768.

Partridge. C.A., Holman, J.R. (2005). Effects of a reduced-visit prenatal care clinical practice guideline. Journal of American Board Family Practitioners. 18, 555-60.

Pueschel, M. (2003). DoD begins effort to improve maternity care. U.S. Medicine The Voice of Federal Medicine. Retrieved 13 March 2007. http://www.usmedicine.com/article.cfm?articleID=748&issueID=55

Roark, A. (1997). Marketing: applications in a military health care setting. Military Medicine. 162, 543-546.

Sirkin, M.R. (1999). Statistics for the social sciences. (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Soh, K.E. (1999). A strategic marketing plan for women and infant services, Dewitt Army community hospital and the Dewitt health care system. Graduate Management Project (Unpublished Manuscript). Baylor University. Defense Technical Information Center Report # ADA420894.

Stella, C.A. (2007, April). Discussion on diverting WICU patients because of the lack of available nursing care. 121st Combat Support Hospital, Yongsan, South Korea.

Thompson, K. (1999). Health promotion and wellness staffing methods. Graduate Management Project (Unpublished Manuscript). Baylor University.

TRICARE. (2005) TRICARE Pacific beneficiary handbook: your guide to program benefits in the TRICARE pacific area. Japan: Department of Defense.

TRICARE. (2006a). TRICARE standard. Retrieved 11 October 2006. http://www.tricare.osd.mil/TRICAREStandard/default.cfm

TRICARE. (2006b). TRICARE overseas program (TOP) standard. Retrieved 22 September 2006. http://www.tricare.osd.mil/Factsheets/viewfactsheet.cfm?id=342

United States Forces Korea. (2006). Commander's Intent. Retrieved 18 September 2006. http://www.usfk.mil/usfk/index.html?/usfk/contents/cdrintent.html

Winkenwerder, W. (personal communication, April 4, 2005).

Footnotes

[1] DBIDS –The Defense Biometric Identification System is a fully configurable security and identification system that enhances safety against terrorism and conflict. DBIDS uses accurate personal identification for access onto military installations.

[2] Level III facility – A facility capable of providing resuscitation, initial surgery, definitive and re-constructive surgery, post-op care, intensive care and either return to duty in theater or stabilization for further evacuation.

[3] DEERS – The Defense Enrollment Eligibility Reporting System is a computerized database of military sponsors, families and family members worldwide. DEERS registration is required for TRICARE eligibility.

[4] Space Available – a term that is used to describe either; (A) priority based on beneficiary status (1) active duty service members; (2) family members of active duty service members enrolled in TRICARE Prime; (3) retirees, their family members and survivors enrolled in TRICARE Prime; (4) family members of active duty service members who are not enrolled in TRICARE Prime; and, (5) all other beneficiaries. (B) Available appointments or lodging space

[5] Automated Staffing Assessment Model – An Army system used to determine minimum essential staffing requirements for medical treatment facilities (MTF). It is an evolving population-based model to assist MTF commanders in decisions regarding operational staffing. ASAM uses mathematical formulas to determine manpower requirements for a specific mission or tasks based on population or projected workload.

[6] Modified Table of Organization and Equipment - Prescribes the normal mission, organizational structure, personnel, and equipment requirements for a military unit and is the basis for an authorization document.

[7] Table of Distribution and Allowances - TDA units are organized to perform specific missions for which there are no appropriate MTOEs. Unlike MTOE units, TDA organizations are considered non-deployable, even when organized overseas, as their missions are normally tied to a geographic location. The personnel of TDA organizations can be military, civilian, or a combination of both.

[8] Officer Distribution Plan - The distribution of officers to meet the Army Manning Requirements: accounts for authorizations, priorities, and available officer inventory. This system identifies unit shortages and overages of officers, and validates officer requirements to man units.

[9] M2 - The MHS Management Analysis and Reporting Tool is a powerful ad-hoc query tool used to obtain summary and detailed views of population, clinical, and financial data from all MHS regions.

[10] AHLTA – The Armed Forces Health Longitudinal Technology Application is the military's electronic health record (EHR); it is interoperable, globally-accessible, and protected, for Uniformed Services members, retirees and their families.

[11] PASBA – The Patient Administration Systems and Biostatistics Activity is a tool for medical treatment facility (MTF) patient administrators and other personnel. It is used for regulation updates, procedural guidelines, directives, diagnostic coding and procedure changes, data quality initiatives, and other patient administration-related activities.

[12] WTS – The Work Hour Tracking System is database for providers that accounts for their time. Providers enter the break out of their time spent in both patient care and non-patient care. The system provides the essential data to determine productivity.

[13] UCAPERS – The Uniform Chart of Accounts Personnel Utilization System is the standard Army automated system that collects and reports personnel hours which are converted to full-time equivalent (FTEs) for civilian, military, and contract personnel supporting military treatment facilities (MTFs).

[14] LADS – The Labor and Delivery System serves as the foundation for nursing manpower requirements determination in the labor and delivery unit.

Appendix A

TOP Prime Policy

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

APR 0 4 2005

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (SAF/MR)
DIRECTOR, RESERVE AND TRAINING (G-WT)
UNITED STATES COAST GUARD

SUBJECT: Clarification on Policy for Enrollment in TRICARE Prime in Overseas TRICARE Regions

References: ASD (HA) Policy 97-052, Policy for Enrollment in TRICARE Prime in Overseas TRICARE Regions, May 21, 1997
TRICARE Policy Manual, Chapter 12, Section 1.1 VII A and B JFTR Appendix A, page A-7 (Change 213 dated 09/01/04)

There are differing interpretations across overseas regions with respect to enrollment of active duty family members (ADFMs) into the TRICARE Overseas Program (TOP) Prime and the TRICARE Global Remote Overseas (TGRO) Program. To clarify Health Affairs Policy 97-052, only ADFMs who meet the Joint Federal Travel Regulation (JFTR) definition of Command Sponsored shall be eligible for enrollment into TOP Prime or TGRO, with the exception of those who meet one of the four criteria on the attached list.

Those ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions on the attached list, will remain eligible for TRICARE Standard, TRICARE Plus, or space-available care when and where it is available.

This policy clarification also serves as a reminder of the overseas screening and Exceptional Family Members Program requirements for assigning ADFMs overseas.

My point of contact on this matter is Commander Dave Walton, who may be reached at (703) 681-0039.

William Winkenwerder, Jr., MD

Attachment:
As stated

cc:
Service Surgeons General
Overseas Unified Commands

Exceptions to Policy for Enrollment in TRICARE Prime in Overseas Regions

1. If the active duty Service member and his/her Command Sponsored active duty family members (ADFM) are enrolled in TRICARE Overseas Program (TOP) Prime or TRICARE Global Remote Overseas (TGRO) and the sponsor is reassigned on unaccompanied orders to a location that does not permit Command Sponsored family members, the family member(s) can remain enrolled at their current TOP Prime or TGRO site, as long as they remain Command Sponsored. If the family member(s) do not relocate elsewhere during the sponsor's Permanent Change of Station (PCS) move, then the family may remain enrolled in TOP Prime or TGRO for a period based on the length of the sponsor's unaccompanied orders but not to exceed two years. The normal unaccompanied tour is 24 months or fewer.

2. If ADFMs are allowed to relocate under the sponsor's PCS orders, in accordance with JFTR U5222, or Noncombatant Evacuation Orders without the sponsor to an outside-of-the continental United States location supported by TOP Prime or TGRO, then the ADFMs will be eligible for enrollment in the overseas program consistent with their orders.

3. If ADFMs are currently enrolled in TOP Prime or TGRO and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the appropriate overseas program.

4. If the ADFM is a transitional survivor, that individual may remain enrolled in TOP Prime for the duration specified for transitional survivor benefits.

Appendix B

ASAM study results

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: 18TH MEDICAL COMMAND | WORK CENTER: SURGICAL CLINICS | DATE: FEB 07

OB / GYN - STATEMENT OF CONDITIONS RETURN TO TOP

TDA PARA(S)	OB / GYN CLINIC
9068	0
0	0

CURRENT MTF POPULATION SUPPORTED:

	64957		POPULATION (TRICARE Enrolled, Non-Prime Users, AD Trainees, Enrolled Elsewhere Users)
25%	16242		FEMALE POPULATION - >= 18 YRS OF AGE (TRICARE Enrolled, Non-Prime Users, AD Trainees, Enrolled Elsewhere Users)
	0	BCBS / BCB7	GYN ANNUAL NUMBER OF APVS REPORTED
X1	2335	BCBA / BCB9	GYN ANNUAL NUMBER OF CLINIC VISITS REPORTED
	6909	BCC_	OB ANNUAL NUMBER OF CLINIC VISITS REPORTED
	0	BCA5	FAMILY PLANNING ANNUAL NUMBER OF APVS REPORTED
	0	BCAA	FAMILY PLANNING ANNUAL NUMBER OF CLINIC VISITS REPORTED

FORECASTED POPULATION WORK CENTER DATA:

	64957	POPULATION (TRICARE Enrolled, Non-Prime Users, AD Trainees, Enrolled Elsewhere Users)
X2	16242	FEMALE POPULATION (>= 17 yrs) TO SUPPORT
X3	3600	OB-GYN: 1 PROVIDER PER APPLICABLE POPULATION (ROUND @ 0.67)
X4	0.100	FAMILY PRACTICE OB DELIVERY SUPPORT DEDUCTION

READINESS:

X5	0	BASELINE TDA AUTHORIZED MILITARY PROVIDERS
X6	0	BASELINE TDA AUTHORIZED MILITARY SUPPORT
X7	0	PROVIDER ADDITIONAL ANNUAL NON-AVAILABLE HOURS
X8	0	SUPPORT ADDITIONAL ANNUAL NON-AVAILABLE HOURS

EDUCATION:

X9	0	

MTF UNIQUE:

X10	0.0	OTHER PROFESSIONAL FTE(S) - If Applicable, Explained under Comment 1
X11	0.0	OTHER SUPPORT FTE(S) - If Applicable, Explained under Comment 1

MANAGEMENT / SUPERVISION:

X12	4.900	PROFESSIONAL STAFF EARNED FROM POPULATION, READINESS, MTF UNIQUE
X13	15.000	SUPPORT STAFF EARNED FROM POPULATION, READINESS, MTF UNIQUE

CORE FUNCTIONAL LIST

6	TDA PROVIDER (CAT 1 / CAT 2) BASELINE REQ(S)
4	TDA SUPPORT (CAT 3-4-5) BASELINE REQ(S)
9	TDA BASELINE AUTHORIZATION(S)
11	CURRENT WORKING STRENGTH

CURRENT WORKING STRENGTH (INCLUDE ALL FTEs)

CAT 1-2		CAT 3-4-5	
MIL/GS PROVIDERS	5.0	MIL/GS SUPPORT	6.0
CONTRACT PROV	0.0	CONTRACT SUP	0.0
BMM	0.0	KGS / KATUSA	9.0
	5.0	BMM	0.0
			6.0

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: 18TH MEDICAL COMMAND | WORK CENTER: SURGICAL CLINICS | DATE: FEB 07

OB-GYN MANPOWER EQUATION APPLICATION = 20.0

FORECASTED POPULATION:	BASIC FORMULA	COMMENT		PROF STAFF		SPT STAFF
Y1 = IF(X1 = 0,0, (X2 / X3))	4.512		OB / GYN	5.000		
Y2 = (X2 / X6) * 3.0					CAT 3-4-5	15.000
Y3 = (X4)			FAM PRAC DEDUCT	-0.100		
READINESS:						
Y4 = (X5 * 90) / 1740			READINESS	0.000		
Y5 = (X6 * 90) / 1740					READINESS	0.000
Y6 = (X7 / 1740)			ADD NV HRS	0.000		
Y7 = (X8 / 1740)					ADD NV HRS	0.000
EDUCATION:						
Y8 = (X9)						
MTF UNIQUE:						
Y9 = (X10)		1	OTHER PROF	0.000		
Y10 = (X11)		1			OTHER SUPPORT	0.000
			TOTAL(S)	4.900		15.000
MANAGEMENT / SUPERVISION:						
Y11 = (((POWER (X12) + (X13), 0.1251)) * 145) / 145) * %				0.436		0.436
				5.336		15.436
			GRAND TOT(S)	5.000		15.000

REQUIREMENTS SUMMARY

PROVIDER (CAT 1-2)

BASELINE	EARNED	DELTA
6	5	-1

SUPPORT (CAT 3-4-5)

BASELINE	EARNED	DELTA
4	15	11

TOTAL

BASELINE	EARNED	DELTA
10	20	10

COMMENTS

RETURN TO TOP

NOTE:	
1	RECOMMENDED BREAKOUT OF 3.0 SUPPORT STAFF EARNED PER PROVIDER BASED OFF OF POPULATION OR OTHER IS (0.7 RN, 1.8 LPN/NA, 0.5 MED CLK)
	0

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: 18TH MEDICAL COMMAND | WORK CENTER: WICU NURSING SUPERVISOR | DEPARTMENT OF NURSING | DATE:

RETURN TO TOP

TDA PARA(S): 0 / 0 = 0 / 0

0 TDA SUPPORT (CAT 3-4-5) BASELINE REQ(S)

0 TDA BASELINE AUTHORIZATION(S)

1 CURRENT WORKING STRENGTH

X1 20 # of Earned Subordinate Requirements

CORE FUNCTIONAL LIST

CURRENT WORKING STRENGTH (INCLUDE ALL FTEs)

MIL AN	1	MIL ENL	0
CIV RN	0	ADMIN	0
	1		0

MANPOWER EQUATION APPLICATION: 1.0

=((POWER (X1 , 0.1251) * 145) / 145

	COMMENT	STAFF
		1.455
	TOTAL(S)	1.000

RECOMMENDED BREAKOUT:

RN	NCO	ADMIN	*MAY ADJUST %*
50%	50%	0%	TOTAL
1	1	0	1

REQUIREMENTS SUMMARY

SUPPORT (CAT 3-4-5)

BASELINE	EARNED	DELTA
0	1	1

COMMENTS

1 0

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: 18TH MEDICAL COMMAND | WORK CENTER: LABOR & DELIVERY - STATEMENT OF CONDITIONS | DEPARTMENT OF NURSING | DATE:

RETURN TO TOP

TDA PARA(S): 0 / 0 / 0 = 0 / 0 / 0

0 TDA SUPPORT (CAT 3-4-5) BASELINE REQ(S)

0 TDA BASELINE AUTHORIZATION(S)

0 CURRENT WORKING STRENGTH

CORE FUNCTIONAL LIST

CURRENT WORKING STRENGTH (INCLUDE ALL FTEs)

MIL / GS RN	0	91WM5 / LPN	0	BMM ENL	0
CONT/RS RN	0	CONT/RS LPN	0	ADMIN	0
BMM AN	0	91W / CIV NA	0	CONT/RS ADM	0
		CONT/RS NA	0		
	0		0		0

			UTILIZATION RATE
	A. DIRECT NURSING CARE		
X1	886.0 Annual Number of Inpatients	X1A	0.013637693
	73.8 Average Monthly Number of Patients		
	2.4 Average Daily Number of Patients		
X2	274 Annual # of Vaginal Deliveries *(L&D)*	X2A	0.004217528
X3	59 Annual # of C-Section Deliveries (IF ONLY DONE BY L&D)	X3A	0.000908153
X4	315 Annual # of Outpatient Visits *(L&D)*	X4A	0.004848615
	B. INDIRECT NURSING CARE		
X5	0.000 Indirect Nursing Hour Factor		
	C. STAFF RELATED		
X6	0 Management / Admin (Insert up to 5220 Hours) Head Nurse , Wardmaster, Ward Clerk - If Stand-Alone Unit		
X7	0 (Preceptorship Prg) Annual Number of New 2nd LT's		
X8	0 Annual Number of Staff Orientees		
X9	0 Number of RN's / LPN's Assigned (CEU's)		

D. READINESS

X10 0 Baseline TDA Authorized Military Officers

X11 0 Baseline TDA Authorized Military Enlisted

E. POPULATION

X12 64967 Current

X13 64967 Forecasted

F. OTHER ANNUAL HOURS

X14 0

X15 0

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: **WORK CENTER:** **DEPARTMENT OF NURSING** **DATE:**

18TH MEDICAL COMMAND

L&D MANPOWER EQUATION APPLICATION 9.0

	COMMENT	STAFF
A. = ((X1 * 13) + (X2 * 8.1) + (X3 * 22.38) + (X4 * 0.85)) / 1740		8.808 Direct Nursing Care
B. = (X1 * X5) / 1740		0.000 Indirect Nursing Care
C. = (X6 / 1740)		0.000 Management / Admin
= (((X7 * 19.333) + (X8 * 4) + (X9 * 1.75)) * 12) / 1740		0.000 Staff Related Work Center Adjustment
D. = ((X10 * 90) + (X11 * 90)) / 1740		0.000 Readiness
E. = IF (X1=0,0,(((X13-X12)*X1A)+((X13-X12)*X2A)+((X13-X12)*X3A)+((X13-X12)*X4A)) *8.0))/1740		0.000 Forecasted Population
F. = (X14 + X15) / 1740		0.000 Other Annual Hours
		8.808
	TOTAL(S)	9.000

RECOMMENDED BREAKOUT: *MAY ADJUST %*

RN	LPN	NA	ADMIN	TOTAL
65%	20%	10%	5%	
6	2	1	0	9

REQUIREMENTS SUMMARY

SUPPORT (CAT 3-4-5)

BASELINE	EARNED	DELTA
0	9	9

COMMENTS

1 0

AUTOMATED STAFFING ASSESSMENT MODEL (ASAM)

MTF: **WORK CENTER:** **DEPARTMENT OF NURSING** **DATE:**

18TH MEDICAL COMMAND

MOTHER-BABY - STATEMENT OF CONDITIONS RETURN TO TOP **CORE FUNCTIONAL LIST**

TDA PARA(S)

8088	WOMEN INFANT CARE UNIT
0	0
0	0
24	TDA SUPPORT (CAT 3-4-5) BASELINE REQ(S)
10	TDA BASELINE AUTHORIZATION(S)
22	CURRENT WORKING STRENGTH

CURRENT WORKING STRENGTH (INCLUDE ALL FTEs)

MIL / QS RN	12	91WM6 / LPN	7	BMM ENL	0
CONT/RS RN	0	CONT/RS LPN	0	ADMIN	2
BMM AN	1	91W / CIV NA	0	CONT/RS ADM	0
		CONT/RS NA	0		
	13		7		2

A. WMNS DIRECT / INDIRECT NURSING CARE

3.0	Annual # of CAT I Patients	4,667	X1	
857.0	Annual # of CAT II Patients	4190.302	X2	
725.0	Annual # of CAT III Patients	7734.300	X3	
6.0	Annual # of CAT IV Patients	106.686	X4	
12.0	Annual # of CAT V Patients	322.707	X5	
0.0	Annual # of CAT VI Patients	0.000	X6	
X14 1603.0	Annual # of Occupied Beds	12356.658		TOT ANL NCH
133.6	Average Monthly Occupied Bed Days	1029.888		AVG MO NCH
4.4	Average Daily Occupied Beds	33.833		AVG DAILY NCH
1.778	INDIRECT FACTOR			

B. ADDITIONAL NURSING CARE ADDITIVES (If Appropriate)

X7 0.0 Annual Minutes of Service for Observation Patients

C. STAFF RELATED

X8 5220 Management / Admin **(Insert up to 5220 Hours)** Head Nurse , Wardmaster, Ward Clerk - **If Stand-Alone Unit**

X9 0 (Preceptorship Prg) Annual Number of New 2nd LT's

X10 6 Annual Number of Staff Orientees

X11 20 Number of RN's / LPN's Assigned (CEU's)

D. READINESS

X12 6 Baseline TDA Authorized Military Officers

X13 7 Baseline TDA Authorized Military Enlisted

E. POPULATION

X15 64967 Current

X16 64967 Forecasted

F. OTHER ANNUAL HOURS

X17 0

X18 0

MTF: **WORK CENTER:** **DEPARTMENT OF NURSING** **DATE:**

18TH MEDICAL COMMAND

MOTHER BABY MANPOWER EQUATION APPLICATION 11:0

	COMMENT	STAFF
A. = (X1 + X2 + X3 + X4 + X5 + X6) / 1740		7.103 WMNS Direct / Indirect Nursing Care
B. = (X7 / 60) / 1740		0.000 Patient Observation
C. = (X8 / 1740)		3.000 Management / Admin
= (((X9 * 19.333) + (X10 * 4) + (X11 * 1.75)) * 12) / 1740		0.407 Staff Related Work Center Adjustment
D. = ((X12 * 90) + (X13 * 90)) / 1740		0.672 Readiness
E. = IF (X14 = 0, 0, ((X16 - X15) * (X14 / X15) * 7.4)) / 1740		0.000 Forecasted Population
F. = (X17 + X18) / 1740		0.000 Other Annual Hours
		11.182
	TOTAL(S)	11.000

RECOMMENDED BREAKOUT:

RN	LPN	NA	*MAY ADJUST %* ADMIN	
50%	15%	30%	5%	TOTAL
6	2	3	1	11

REQUIREMENTS SUMMARY

SUPPORT (CAT 3-4-5)

BASELINE	EARNED	DELTA
24	9	15

COMMENTS

1 0

Appendix C

OB/GYN on-call information hand-out

OB/GYN
"Walk-In" Appointments

Your walk-in appointment is scheduled for _____

Please arrive 15 minutes early to allow time for check in.

An OB/GYN physician is assigned as the "walk-in" doctor daily to provide care for women with acute / emergent problems and to see pregnant women who could not be scheduled in a routine appointment for prenatal care.

This physician is also responsible for the care of laboring patients, emergency room consults, and emergent surgeries.

For this reason, the wait time to see the walk-in doctor may be variable (long or short) depending on the status of other patients. We will do our best to update you the status of your wait time if you are being seen today on a walk-in basis.

If you have any concerns regarding your status or wait time, please see our head nurse, CPT Hyatt.

We appreciate your patience!

Appendix D

OB/GYN Provider Productivity

Provider	Month/2006	RVU per provider per day	Δ	PPS FY 08 Goal
121st CSH GYN Clinic				
Provider 1	April	21.88	1.43	20.45
Provider 2	April	13.60	6.86	20.45
Provider 3	April	11.78	8.67	20.45
Provider 1	May	13.11	7.35	20.45
Provider 2	May	6.15	14.30	20.45
Provider 3	May	8.31	12.14	20.45
Provider 1	June	19.42	1.03	20.45
Provider 2	June	17.19	3.26	20.45
Provider 3	June	79.80	59.35	20.45
Provider 1	July	17.30	3.15	20.45
Provider 2	July	9.71	10.74	20.45
Provider 3	July	21.86	1.41	20.45
Provider 4	August	18.49	1.96	20.45
Provider 2	August	8.47	11.98	20.45
Provider 3	August	23.84	3.39	20.45
Provider 5	August	1.59	18.86	20.45
Provider 4	September	58.93	38.48	20.45
Provider 2	September	18.44	2.01	20.45
Provider 3	September	14.20	6.25	20.45
Clinic Average		**20.21**	**.24**	**20.45**
121st CSH OB Clinic				
Provider 1	April	18.66	0.96	17.7
Provider 2	April	14.32	3.38	17.7
Provider 3	April	16.89	0.81	17.7
Provider 6	April	16.66	1.04	17.7
Provider 1	May	25.51	7.81	17.7
Provider 2	May	14.81	2.89	17.7
Provider 3	May	20.05	2.35	17.7
Provider 6	May	12.66	5.04	17.7
Provider 1	June	23.72	6.02	17.7
Provider 2	June	18.72	1.02	17.7
Provider 3	June	16.11	1.59	17.7
Provider 6	June	12.82	4.88	17.7
Provider 1	July	31.79	14.09	17.7

Provider 2	July	13.13	4.57	17.7
Provider 3	July	23.65	5.95	17.7
Provider 6	July	7.94	9.76	17.7
Provider 4	August	23.37	5.67	17.7
Provider 2	August	22.24	4.54	17.7
Provider 3	August	23.63	5.93	17.7
Provider 5	August	15.16	2.54	17.7
Provider 4	September	45.53	27.83	17.7
Provider 2	September	32.74	15.04	17.7
Provider 3	September	29.10	11.40	17.7
Provider 5	September	19.72	2.02	17.7
Clinic Average		**20.79**	**3.09**	**17.7**

Appendix E

Family Care Center Memorandum

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Family Care Center (FCC)

1. **PURPOSE:** To define the process and personnel involved in the management of the Family Care Center for patients enrolled in the Storknest Program and family members of patients of the Intensive Care Unit (ICU).

2. **APPLICABILITY:** Written in collaboration with Family Support Division, this policy applies to all personnel assigned, attached, volunteering or working at the 18th MEDCOM Integrated Healthcare Organization (IHO) Medical Treatment Facilities (MTFs).

3. **RESPONSIBILITIES:**

a. OB/GYN Department

1. The OB/GYN Physician, Nurse Midwife and/or Nurse Practitioner initiates the eligibility for FCC reservations of obstetrical patients at 38 weeks gestation by completing and signing the FCC Letter of Eligibility (Encl 1).
2. The OB/GYN clinic front desk clerk maintains the FCC reservation log (Encl 2) on the OB/GYN J-drive and verifies patient eligibility for a FCC room. If a room is available, the patient reports to the Army Community Service (ACS) Building #4106, Room 205 for a FCC room. If no availability, the reception staff provides the patient with a list of eligible housing accommodations located on and off post (Encl 3).
3. The OB/GYN clinic headnurse/NCOIC ensures the FCC reservation log remains updated on the OB/GYN J-drive & maintains the Microsoft Outlook FCC reservation calendar. Also communicates daily with Family Support Division and Women Infant & Child Unit (WICU) staff on reservation logs and Microsoft Outlook FCC reservation calendar. Picks up the FCC room reservation daily from Patient Administration Division (PAD), 121 General Hospital.
4. Provides patient education on Storknest Program at initial OB appointment and at 36 weeks gestation.

b. WICU

1. The WICU headnurse/NCOIC has responsibility for updating patient deliveries on the Microsoft Outlook FCC reservation calendar.
2. Communicates daily with Family Support Division and OB/GYN Clinic staff on deliveries that change the Microsoft Outlook FCC reservation calendar.
3. Responsible for providing the FCC Letter of Eligibility (Encl 1) to OB patients during after duty hours (1630 hrs to 0800 hrs) and sending to Patient Administration Division for FCC keys.

4. Provides education to patient/family members that room key must be turned into ACS same day of discharge from 121 General Hospital. If patient is discharged on the weekend, the keys are turned in at Patient Administration Division.

c. Ambulatory Care Clinic (ACC)
   1. The Family Practice Physician/Provider initiates the eligibility for FCC reservations of obstetrical patients at 38 weeks gestation by completing and signing the FCC Letter of Eligibility (Encl 1).
   2. The ACC designated staff maintains the FCC reservation log (Encl 2) and verifies patient eligibility for a FCC room. If a room is available, the patient reports to the Army Community Service (ACS) Building #4106, Room 205 for a FCC room. If no availability, the reception staff provides the patient with a list of eligible housing accommodations (Encl 3) located on and off post.
   3. The ACC designated staff ensures the FCC reservation log remains updated and maintains the Microsoft Outlook FCC reservation calendar. Also communicates daily with Family Support Division, Women Infant & Child Unit (WICU) and OB/GYN clinic staff on reservation logs and Microsoft Outlook FCC reservation calendar. Picks up the FCC room reservation daily from 121 General Patient Administration Division.

d. VSI/ICU Patient Family Members
   1. The ICU Headnurse/Charge Nurse needing a room at FCC for a VSI patient should communicate with OB/GYN Clinic/WICU Headnurse/NCOICs for eligibility for FCC room.
   2. The ICU Headnurse/Charge Nurse provides family member name to OB/GYN staff for update on the Microsoft Outlook FCC reservation calendar.
   3. Obtains the appropriate Medical Staff signature to initiate the FCC Letter of Eligibility.
   4. If a room is available, the patient reports to the Army Community Service (ACS) Building #4106, Room 205 for a FCC room. If no availability, the reception staff provides the patient with a list of eligible housing accommodations (Encl 3) located on and off post.
   5. If a room is needed after hours (1630 hrs to 0800 hrs), ICU staff should contact WICU staff on duty for eligibility of FCC rooms. If a room is available, send patient to Patient Administration Division.
   6. Notifies OB/GYN/WICU staff of pending patient discharges.
   7. Provides education to family members about room check out same day of discharge from 121 General Hospital. If patient is discharged on the weekend, the keys are turned in at Patient Administration Division.

e. Patient Administration Division (PAD)
   1. The assigned PAD staff member signs for the FCC keys daily at 1600 hrs from Family Support Division staff and signs over the keys to Family

Support Division staff daily at 0800 hrs daily. On weekends the keys will be maintained in PAD until 0800hrs the following Monday.

2. Maintains accountability of the FCC keys.
3. Provides patients, who present with a signed (letter signed by healthcare provider or nursing staff on duty) FCC Letter of Eligibility (Encl 1), a FCC room assignment and key. Assists patient in completing the Family Care Center Reservation Request (Encl 4) and updates patient name on the FCC log (Encl 2).
4. Directs patient to Building #5214 for rooms 102, 103, 104, 105 and to Building #5212 for rooms 301, 302, 303. See directions.
5. If no room availability, the PAD staff member provides the patient with a list of eligible housing accommodations (Encl 3) located on and off post.

f. Family Support Division
   1. Maintains the official FCC occupancy list.
   2. Updates daily the FCC occupancy to 121 General Patient Administration Division.
   3. Signs FCC keys to 121 General Patient Administration staff at 1600 hrs daily and picks up keys daily at 0800 hrs. On weekends signs keys to 121 General Hospital Patient Administration staff at 1600 hrs and picks up the following Monday at 0800 hrs.

4. **PROCEDURES:**

g. The OB/GYN/ACC staff provides education on the Storknest Program (FCC room reservations) at the initial OB appointment (OBA), 36 weeks gestation, and 38 weeks gestation.

h. The healthcare professional gives the OB patient a signed FCC Letter of Eligibility (Encl 1) at 38 weeks gestation.

i. The patient presents the FCC Letter of Eligibility to the OB/GYN Clinic front desk clerk. The front desk clerk logs the patient name on the FCC reservation list (Encl 2) located on the OB/GYN J-drive and verifies patient eligibility for a FCC room.

j. If a room is available, the patient reports to the ACS Building #4106, Room 205 for a room assignment. If no room availability, the OB/GYN front desk clerk provides the patient with a list of eligible housing accommodations (Encl 3) located on and off post.

k. The OB/GYN Clinic Headnurse/NCOIC verifies the FCC reservation list daily and transfers updates to the Microsoft Outlook FCC reservation calendar. The Microsoft Outlook FCC reservation calendar will only include patient initials, FCC room number and estimated date of departure (due date).

l. Provides education to patient about checking out of room the same day of discharge from 121 General Hospital.

m. After Duty Hours (1630 hrs to 0800 hrs)
   1. Family Support Division will sign the FCC keys to the 121General Patient Administration Division staff each day at 1600 hours and pick up keys

daily at 0800 hours. The Family Support Division also provides to staff duty a FCC log sheet with room availability status.

2. Provides patients, who present with a signed (letter signed by healthcare provider or nursing staff on duty) FCC Letter of Eligibility (Encl 1), a FCC room assignment and key. Updates patient name on the FCC log (Encl 2) and assists patient in completing the Family Care Center Reservation Request (Encl 4).
3. Directs patient to Building #5214 for rooms 102, 103, 104, 105 and to Building #5212 for rooms 301, 302, 303. See directions.
4. If no room availability, the PAD duty provides the patient with a list of eligible housing accommodations located on and off post (Encl 3).
5. Ensure completion of the updated FCC log, Reservation Request Forms and keys for next day at 0800 hrs by the Family Support Division staff.

5. GENERAL

a. All FCC rooms are free and available on a first –come, first- service basis.
b. Patients are required to check out same day of discharge from 121 General Hospital to make accommodations for other patients with pending reservations.
c. Family Support Division will give patients/family members the Family Care Center Reservation Request Form as an agreement of understanding to sign explaining accommodations at FCC (i.e. mandatory checkout times, etc.). Staff duty will complete the Family Care Center Reservation Request Form89 for after hours room assignments.
d. Occupancy Eligibility in order of priority
    a. 38 week pregnant active duty service members have first priority of available FCC rooms
    b. 38 week pregnant Prime family members
    c. 38 week pregnant Standard family members
    d. Family members of ICU patients
    e. Others
e. ACS Family Care Center Point of Contact: Ms. Hui Chae Im, DSN: 738-7169, Cell: 010-2304-6831 and email: imhc@korea.army.mil

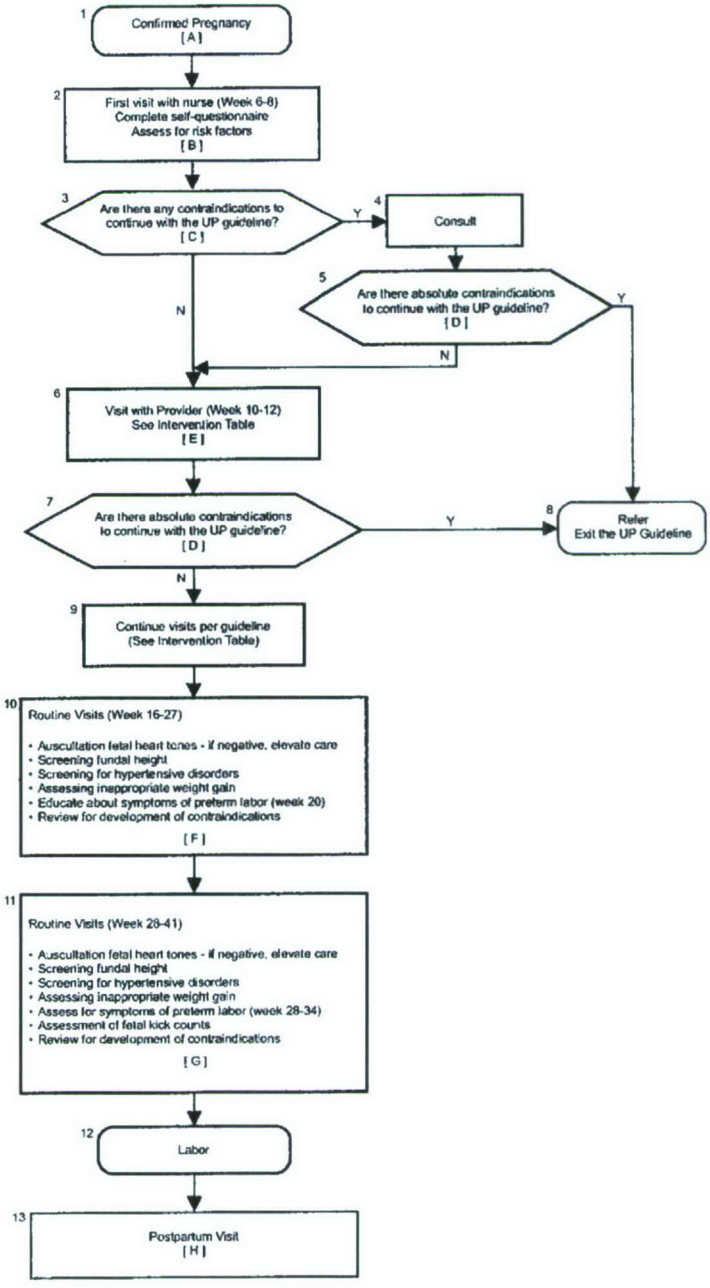
DISTRIBUTION:

EAMC-H-ACC
EAMC-H-ICU
EAMC-H-OBGYN

Appendix F

CPG Algorithm

DoD/VA Clinical Practice Guideline for Management of Uncomplicated Pregnancy



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