Practical Implementation of Patient Centered Medical Home
Success Stories from Over 120 MTF Clinics

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Vice President, Health Plan Design and Management
TriWest Healthcare Alliance

Disclosures

- Neither I nor any member of my immediate family has a financial relationship or interest with any proprietary entity producing health care goods or services related to the content of this CME activity.
- I have no relevant financial relationships with manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services.
- My content will not include any discussion or reference of any commercial products or services.
- I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

What Would You Change In Your Clinic?
Learning Objectives

- Discuss practical implementation of PCMH following Services’ and HA/TMA policies
- Establish “As Is” clinic capacity
- Discuss how to develop a demand forecast
- Determine demand/capacity gap and develop mitigation strategies to close the gap
- Discuss approach to capacity management
- Discuss approach to demand management
- Provide blueprint for efficient clinic operations with all staff members working at the top of their license
- Make the clinic more enjoyable for patients and staff

Joint Strategic Optimization Planning Process
Consultative Support Services

1. Demand and Capacity Forecasting
   - Population Based Demand Forecasting
   - Locality Based Capacity Projections
2. Project Development - Recapture / Avoidance
   - Clinical Operations and Direct Care Experience
   - MHSSI, JIF, Service Funds Application Support
3. Clinic and Executive Management
   - Demand / Capacity, Productivity and Access
4. CSAs and ERSAs
5. Decision Support
   - Direct and Purchased Care Data Reports & Analysis
6. Whatever It Takes

TRICARE
Safe from PPACA But………. 

- PPACA; no effect on TRICARE
- $50 Billion 2010 expenditures
- $51 Billion in 2011, 2% increase, 9.3% of DOD budget
- $52.5 Billion 2012, 300% increase from $19 B in 2001
- 10 years of war contributed
- The Budget Control Act of 2011 cut $350 billion from Defense budgets over the next decade, and charged the Congressional “Super Committee” with finding an additional $1.2 trillion in savings. If not, half from Defense and half from entitlements like Medicare.
- Under 10 U.S.C. 1079(h) and 1079(j)(2), TRICARE was mandated to adopt Medicare’s reimbursement rules
MHS PCMH Initiatives to Increase Quality and Decrease Costs, PCMH

- The model replaces episodic care based on illness and patient complaints with coordinated care and long-term healing relationships
- There are 6 NCQA standards in 2011 which align with the core components of Primary Care
  - Enhance access and continuity
  - Identify and manage patient populations
  - Plan and manage care
  - Provide self-care and community support
  - Track and coordinate care
  - Measure and improve performance

MHS Initiatives
PCMH Increases Quality and Decreases Costs

- 36.3% Drop in hospital days
- 32.2% Drop in ER use
- 15.0% Outpatient specialty down
- 10.5% Decrease in inpatient specialty costs
- 18.9% Ancillary costs down
- 9.6% Decrease in total PMPM cost

JSOPP Practical Optimization Approach
Policy, Execution, Measurement & Monitoring

- JSOPP Clinic Optimization follows Principles of:
  - BUMED Instruction 6300.19 - Primary Care Services in Navy Medicine, 26 May 2010
  - Patient Centered Medical Home and Family Health Operations 16 Jan 2011 (AFI 44-171)
  - Operation Order 11-20, Army Patient-Centered Medical Home, 250715R January 2011
- Provide practical approach to execute these principles:
  - Data and analysis presented as information for decision making and management
  - Practical tools for demand, demand forecasting, demand management, and capacity management
  - Gap analysis and mitigation planning
TRICARE West Region Consultations

- Over 120 Primary Care (Family Medicine, Pediatrics, Internal Medicine) Clinic Optimization Consultations
  - Assisted in rollout of Air Force FHI/PCMH 2010
  - Assisting in rollout of Air Force Pediatric PCMH 2011-2012
  - Assisting in rollout of Navy PCMH 2011-2012
  - Integrated with Army OIP assist visits and PCMH 2011-2012
- Mental Health Clinic Consultations
  - 6 Army Mental Health consultations completed
  - 6 AF Mental Health consultations completed
  - 1 Navy Behavioral Health consultation completed
- Multiple Specialty and Service Line Consultations
  - ER, Surgical Services, O.R., RMC, PT, OB/GYN, Nursery II

Pediatric Clinics

- 2 Teaching Programs
  - Ft Lewis
  - NMCSD
- 1 Mid-size Hospital Based
  - Ft Leonard Wood
- 4 Clinic Based
  - Fairchild AFB
  - Peterson AFB
  - NHC, Hawaii, Kaneohe Bay
  - NHC, Hawaii, Pearl Harbor
- 1 Mixed Specialty Clinic
  - Ft Irwin
- 4 Consultative Support
  - Cannon AFB
  - Holloman AFB
  - Ft Bliss
  - NMCSD

Clinic Operations

Practical Approach and Tools

- Enrollment Analysis and Modification
- Capacity/Enrollment
- Demand Forecasting
- Demand Management
- Capacity Management
  - Templates and Scheduling
  - Clinic Efficiency and Flow
- Demand/Capacity Gap Mitigation Strategies
What is the Capacity of Your Clinic?
If Demand > Capacity Where Do Your Patients Go?

TMA Deloitte/Zogsby Survey of ER Patients
Why Patients Prefer the ER

7,566 ER Users from 7 MTF Clinics and 1 MEDCEN

- Why they chose ER
  - 44% serious or sent to ER by PCM, Poison Control, etc.
  - 50% mentioned lack of PCM availability, after hours, distance
  - 55% no appointment necessary
  - 51% faster than PCM

TMA Deloitte/Zogsby Survey of ER Patients
Why Patients Prefer the ER

- Patterns / Preference
  - 66% knew their PCM by Name
  - 67% DID NOT try calling their PCM first
  - 74% said they would go to Urgent Care instead, if available
  - 84% preferred Urgent Care without appointments vs. with appointments

- Frequent Users of ER
  - ~37-46% use ER 1 / year (all groups)
  - ~40% use ER 2-3 / year (all groups)
  - ~16% use ER 4-6 / year (AD / ADFM)
  - ~6-7% use ER ≥7 / year (AD / ADFM)
West Region MTF Enrollees ER Utilization
TriWest Methodology

Primary Care Enrollees
Purchased ER Visits Analysis ≤17 Years Old

Pediatric Enrollees
Sample MTF ER Visits Analysis
Important Changes in Mind Set

- A PCM and the PCM Team should be concerned about how best to provide care for their 1250 patients, not how many visits/RVUs they generate. Done well, PMCH will decrease the visits.
- For acute care, the PCMH team will address how best to give care to the team’s patients
- The emphasis should be on access to the PCMH Team/RN not just access to physical appointments
- PCMH is “Patient Centered”
- Healthcare Delivery should be about a Team that is “Provider Focused”. All team members must work at the “top of their license” for PCMH to succeed.

Define the Population
Sample AFB Pediatric PCM Enrollment

<table>
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<tr>
<th>Provider</th>
<th>AD - MD</th>
<th>AD - PNP</th>
<th>BDAB</th>
<th>BDAC</th>
<th>BDAD</th>
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<td>1,453</td>
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<td>1,360</td>
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<td>1,360</td>
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<td>1,535</td>
<td>1,535</td>
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Average Enrollment per Pediatric Provider 1,294

Source: TOC as of September 9, 2011

Patient to PCM Annual Continuity
Family Health and Pediatric Clinic Visits Only

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<thead>
<tr>
<th>Provider</th>
<th>AD - MD</th>
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<th>BDAB</th>
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<tr>
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<td>16,256</td>
<td>15,978</td>
<td>94%</td>
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<td>BDAC</td>
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<td>15,978</td>
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<td>15,978</td>
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<tr>
<td>BDAD</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Average Enrollment per Pediatric Provider 1,294

Source: TRO-W Data Year: FY2011 Q1 - FY2011 Q4

Clinic MEPRS: BDAA – BDAD, and BDAA
PCM to Patient Annual Continuity
Family Health and Pediatric Clinic Visits Only

Continuity of Care Using In-Catchment Visits
Pediatric Clinic Enrollees

% of Family Medicine Care Delivered in Clinic
Using In-Catchment Visits - MTF Comparison
Appointment Type Analysis
Pediatric Clinic

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>eRVU</th>
<th>eRVU / Visit</th>
<th>Visits</th>
<th>Percentage by Type</th>
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<tr>
<td>WELL</td>
<td>27,412</td>
<td>3.38</td>
<td>8,109</td>
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<tr>
<td>ACUT</td>
<td>12,507</td>
<td>2.17</td>
<td>5,768</td>
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<td>ROUT</td>
<td>6,613</td>
<td>2.40</td>
<td>2,752</td>
<td>14%</td>
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<tr>
<td>EST</td>
<td>3,633</td>
<td>2.32</td>
<td>1,569</td>
<td>8%</td>
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<tr>
<td>EST$</td>
<td>986</td>
<td>0.71</td>
<td>1,381</td>
<td>7%</td>
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<tr>
<td>ACUT$</td>
<td>556</td>
<td>1.65</td>
<td>336</td>
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<td>PROC</td>
<td>224</td>
<td>5.89</td>
<td>38</td>
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<tr>
<td>SPEC</td>
<td>31</td>
<td>10.27</td>
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<tr>
<td>#EMPTY</td>
<td>6</td>
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<td>2</td>
<td>0%</td>
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<tr>
<td>T-CON</td>
<td>0</td>
<td>0.00</td>
<td>1</td>
<td>0%</td>
</tr>
</tbody>
</table>

Monday | Tuesday | Wednesday | Thursday | Friday | Total Visits / Day | Percentage / Day |
-- | -- | -- | -- | -- | -- | -- |
1,622 | 1,605 | 1,269 | 743 | 846 | 6,085 | 36% |
2,851 | 2,910 | 2,916 | 2,292 | 2,596 | 13,565 | 64% |
4,473 | 4,515 | 4,185 | 3,035 | 3,442 | 19,650 | 69% |

Future Appointments by Type
Pediatric Clinic Providers

Future Continuity Appointments
Pediatric Clinic Providers
Past Appointments – Unused Pediatric Clinic Providers

Time of Day Clinic Runs Out of Same Day Acute Appointments – Monday and Thursdays

Principal Provider Appointment Analysis
Provider Appointment Loss Rate 14.9 > 13.0
Pediatric Clinic Principal Providers Only

Principal Provider Appointments & Visits
Air Force WR Family Health Clinic Comparison

Appointments and Visits Comparison
Pediatric Clinic – Principal Providers
### Diagnosis Codes 1 and 2

**Pediatrician**

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
<th>Diagnosis Description</th>
<th>Avg eRVU / Visit</th>
<th>Visits</th>
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<tr>
<td>V202</td>
<td>ROUTIN CHILD HEALTH EXAM</td>
<td>2.99</td>
<td>4,246</td>
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<tr>
<td>V2031</td>
<td>No Diagnosis Desc</td>
<td>0.69</td>
<td>628</td>
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<tr>
<td>V6549</td>
<td>OTHER SPECFD COUNSELING</td>
<td>0.89</td>
<td>269</td>
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<tr>
<td>4659</td>
<td>ACUTE URI NOS</td>
<td>2.28</td>
<td>558</td>
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<tr>
<td>6929</td>
<td>DERMATITIS NOS</td>
<td>3.30</td>
<td>159</td>
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<tr>
<td>V2032</td>
<td>No Diagnosis Desc</td>
<td>1.52</td>
<td>513</td>
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<tr>
<td>4659</td>
<td>ACUTE URI NOS</td>
<td>3.15</td>
<td>146</td>
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<tr>
<td>31401</td>
<td>ATTN DEFIC W HYPERACT</td>
<td>2.62</td>
<td>394</td>
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<tr>
<td>4779</td>
<td>ALLERGIC RHINITIS NOS</td>
<td>2.81</td>
<td>128</td>
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<tr>
<td>49390 2</td>
<td>No Diagnosis Desc</td>
<td>2.76</td>
<td>117</td>
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<tr>
<td>6910</td>
<td>DIAPER OR NAPKIN RASH</td>
<td>3.09</td>
<td>61</td>
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<tr>
<td>V679</td>
<td>FOLLOW-UP EXAM NOS</td>
<td>2.18</td>
<td>114</td>
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<tr>
<td>38101</td>
<td>AC SEROUS OTITIS MEDIA</td>
<td>2.74</td>
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<td>7824</td>
<td>JAUNDICE NOS</td>
<td>0.72</td>
<td>51</td>
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<td>ATTN DEFIC NONHYPERACT</td>
<td>2.63</td>
<td>100</td>
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<tr>
<td>V059</td>
<td>VACCIN FOR SINGL DIS NOS</td>
<td>4.83</td>
<td>51</td>
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<tr>
<td>4779</td>
<td>ALLERGIC RHINITIS NOS</td>
<td>2.34</td>
<td>81</td>
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<tr>
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<td>OBESITY NOS</td>
<td>2.68</td>
<td>47</td>
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<tr>
<td>37200</td>
<td>ACUTE CONJUNCTIVITIS NOS</td>
<td>2.10</td>
<td>79</td>
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<tr>
<td>7746</td>
<td>FETAL/NEONATAL JAUND NOS</td>
<td>1.01</td>
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<tr>
<td>56400</td>
<td>CONSTIPATION NOS</td>
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<tr>
<td>493901</td>
<td>BRONCHITIS</td>
<td>2.93</td>
<td>32</td>
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<tr>
<td>486</td>
<td>PNEUMONIA, ORGANISM NOS</td>
<td>2.60</td>
<td>68</td>
</tr>
<tr>
<td>462</td>
<td>ACUTE PHARYNGITIS</td>
<td>2.06</td>
<td>68</td>
</tr>
<tr>
<td>7862</td>
<td>COUGH</td>
<td>2.25</td>
<td>72</td>
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### Primary Care & ER Utilization Rates

**Pediatric Clinic Enrollees**

<table>
<thead>
<tr>
<th></th>
<th>Rate</th>
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<tbody>
<tr>
<td>Total Visits</td>
<td>30,430</td>
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<tr>
<td>Outside Sample AFB</td>
<td>4,355 (14%)</td>
</tr>
<tr>
<td>Other MTF ER</td>
<td>146</td>
</tr>
<tr>
<td>Other MTF Pediatrics</td>
<td>77</td>
</tr>
<tr>
<td>Purchased Urgent Care</td>
<td>455</td>
</tr>
<tr>
<td>Purchased ER</td>
<td>1,605</td>
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<tr>
<td>Total Visits Outside Sample AFB</td>
<td>4,355</td>
</tr>
<tr>
<td>Total Visits At Elmendorf AFB</td>
<td>26,075 (86%)</td>
</tr>
<tr>
<td>Total Visits At Sample AFB</td>
<td>19,096</td>
</tr>
<tr>
<td>Total Visits At Family Medicine (BGAx)</td>
<td>616</td>
</tr>
<tr>
<td>Total Visits At Emergency Room Clinic (BIAA)</td>
<td>6,363</td>
</tr>
</tbody>
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### What is the Demand on Your Clinic?

Joint Strategic and Optimization Planning Process
TriWest and TRO-West
March 12, 2012
Confidential and Proprietary
Air Force Pediatrics Utilization Rates
ER, Urgent Care and Primary Care ≤ 17

<table>
<thead>
<tr>
<th>MTF</th>
<th>Visits</th>
<th>Visits %</th>
<th>ER Visits</th>
<th>ER Visits %</th>
<th>PC Visits</th>
<th>PC Visits %</th>
<th>Total Visits</th>
<th>Total Visits %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill AFB</td>
<td>22,997</td>
<td>100%</td>
<td>2,616</td>
<td>11.7%</td>
<td>20,381</td>
<td>90.4%</td>
<td>23,003</td>
<td>100%</td>
</tr>
<tr>
<td>Eielson AFB</td>
<td>2,770</td>
<td>100%</td>
<td>192</td>
<td>7.0%</td>
<td>2,578</td>
<td>93.0%</td>
<td>2,770</td>
<td>100%</td>
</tr>
<tr>
<td>Travis AFB</td>
<td>2,330</td>
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<td>153</td>
<td>6.6%</td>
<td>2,177</td>
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<td>2,295</td>
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<tr>
<td>Luke AFB</td>
<td>17,123</td>
<td>100%</td>
<td>1,678</td>
<td>9.8%</td>
<td>15,445</td>
<td>89.7%</td>
<td>17,123</td>
<td>100%</td>
</tr>
<tr>
<td>Ellsworth AFB</td>
<td>3,160</td>
<td>100%</td>
<td>445</td>
<td>14.1%</td>
<td>2,715</td>
<td>85.9%</td>
<td>3,205</td>
<td>100%</td>
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<tr>
<td>Edwards AFB</td>
<td>1,640</td>
<td>100%</td>
<td>1,197</td>
<td>73.1%</td>
<td>443</td>
<td>26.9%</td>
<td>1,640</td>
<td>100%</td>
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<tr>
<td>Hickam AFB</td>
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<td>1,070</td>
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<td>1,640</td>
<td>100%</td>
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<tr>
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<td>100%</td>
<td>1,070</td>
<td>100%</td>
<td>0</td>
<td>0</td>
<td>1,070</td>
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Source: WPS Data Warehouse
Calendar Year 2010

Air Force West Region
Average Annual West Region Pediatric Rates

<table>
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<tr>
<th>Age Category</th>
<th>Enrollment</th>
<th>Visits</th>
<th>Visits %</th>
<th>ER Visits</th>
<th>ER Visits %</th>
<th>PC Visits</th>
<th>PC Visits %</th>
<th>Total Visits</th>
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<td>15,856</td>
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<td>0</td>
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<td>15,856</td>
<td>100%</td>
<td>15,856</td>
<td>100%</td>
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<tr>
<td>3-7</td>
<td>12,951</td>
<td>23,217</td>
<td>100%</td>
<td>9,081</td>
<td>39.0%</td>
<td>14,136</td>
<td>60.0%</td>
<td>23,217</td>
<td>100%</td>
</tr>
<tr>
<td>8-13</td>
<td>17,952</td>
<td>37,635</td>
<td>100%</td>
<td>14,719</td>
<td>39.0%</td>
<td>22,916</td>
<td>61.0%</td>
<td>37,635</td>
<td>100%</td>
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<tr>
<td>14-17</td>
<td>9,662</td>
<td>18,169</td>
<td>100%</td>
<td>6,488</td>
<td>35.8%</td>
<td>11,681</td>
<td>64.2%</td>
<td>18,169</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>42,565</td>
<td>88,801</td>
<td>100%</td>
<td>30,377</td>
<td>34.2%</td>
<td>58,454</td>
<td>65.8%</td>
<td>88,801</td>
<td>100%</td>
</tr>
</tbody>
</table>

0-2 Age Group, 20% of population require 6.58 visits/year

Pediatric Enrollees
Sample AFB Pediatric Visits By Age Category

40% (Age 0-4) of Enrollees utilize 48% of visits delivered in Clinic (BDAA)

Source: TRO-W
Date Range: FY2010 Q4 - FY2011 Q3

Confidential and Proprietary
Air Force Pediatrics Utilization Rates
Urgent Care and Primary Care ≤ 17 Years Old

Source: WPS Data Warehouse
Calendar Year 2010 – Direct and Purchased Care

Air Force Pediatrics Utilization Rates
ER ≤ 17 Years Old

Source: WPS Data Warehouse
Calendar Year 2010 – Direct and Purchased Care

Primary Care & ER Utilization Rates
Pediatric Clinic Comparison

<table>
<thead>
<tr>
<th>MTF</th>
<th>Inside MTF</th>
<th>Outside MTF</th>
<th>Total</th>
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<tbody>
<tr>
<td>Elmendorf AFB</td>
<td>2.52</td>
<td>0.42</td>
<td>2.94</td>
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<tr>
<td>Fairchild AFB</td>
<td>2.27</td>
<td>1.13</td>
<td>3.40</td>
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<tr>
<td>Peterson AFB</td>
<td>2.30</td>
<td>1.14</td>
<td>3.44</td>
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<tr>
<td>FE Warren</td>
<td>2.72</td>
<td>0.82</td>
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<tr>
<td>Ft. Leonard Wood</td>
<td>3.44</td>
<td>0.39</td>
<td>3.83</td>
</tr>
<tr>
<td>Ft. Lewis</td>
<td>3.06</td>
<td>0.5</td>
<td>3.56</td>
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<tr>
<td>Kaneohe Bay</td>
<td>3.12</td>
<td>2.05</td>
<td>5.17</td>
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<tr>
<td>NHC Hawaii (Makalapa)</td>
<td>3.58</td>
<td>0.57</td>
<td>4.15</td>
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<tr>
<td>Average Pediatric Utilization Rate</td>
<td>2.93</td>
<td>0.94</td>
<td>3.87</td>
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</table>

Source: TRO-W
Confidential and Proprietary
Pediatric Clinic Enrollee Demand
Demand Pressure and Gap

<table>
<thead>
<tr>
<th>Pediatric Clinic Visits</th>
<th>Annual Visits</th>
<th>% of Demand</th>
<th>% of catchment visits</th>
<th>% of Total Visits</th>
<th>% of total catchment visits</th>
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</thead>
<tbody>
<tr>
<td>Total Visits</td>
<td>19,096</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Family Medicine (BGAx)</td>
<td>616</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Emergency Room (BIAA)</td>
<td>6,363</td>
<td>100%</td>
<td>100%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>Other MTF Pediatrics</td>
<td>77</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Purchased Pediatric (≤17 Years Old)</td>
<td>2,519</td>
<td>82%</td>
<td>66%</td>
<td>75%</td>
<td>75%</td>
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<tr>
<td>Purchased Urgent Care (≤17 Years Old)</td>
<td>553</td>
<td>82%</td>
<td>72%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Purchased ER (≤17 Years Old)</td>
<td>1,951</td>
<td>82%</td>
<td>61%</td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>Totals</td>
<td>30,430</td>
<td>28,751</td>
<td>26,491</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Non-Enrollee Clinic Pressure

| Other MTF AFB Enrollee Clinic Pressure (Other than BDAA) | 74 |

Total Clinic Pressure

| Total Clinic Pressure | 27,372 |

Gap

| Gap | 7,395 |

Pediatric Clinic Gap Analysis – Historical

<table>
<thead>
<tr>
<th>Providers</th>
<th>Average Awaiting Days</th>
<th>Average Appts</th>
<th>% Occupied</th>
<th>% Booked</th>
<th>Average Awaiting Days</th>
<th>Average Appts</th>
<th>% Occupied</th>
<th>% Booked</th>
<th>% Reduction</th>
<th>Demand</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT - PNP</td>
<td>224</td>
<td>16.5</td>
<td>3,695</td>
<td>100%</td>
<td>19,096</td>
<td>18.5</td>
<td>3,695</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
<tr>
<td>AD - PNP</td>
<td>155</td>
<td>15.8</td>
<td>2,445</td>
<td>100%</td>
<td>19,096</td>
<td>15.8</td>
<td>2,445</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
<tr>
<td>CT - MD</td>
<td>142</td>
<td>17.2</td>
<td>2,438</td>
<td>100%</td>
<td>19,096</td>
<td>17.2</td>
<td>2,438</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
<tr>
<td>AD - MD</td>
<td>186</td>
<td>10.9</td>
<td>2,022</td>
<td>100%</td>
<td>19,096</td>
<td>10.9</td>
<td>2,022</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
<tr>
<td>AD - PNP</td>
<td>167</td>
<td>10.9</td>
<td>1,828</td>
<td>100%</td>
<td>19,096</td>
<td>10.9</td>
<td>1,828</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
<tr>
<td>AD - MD</td>
<td>151</td>
<td>9.8</td>
<td>1,483</td>
<td>100%</td>
<td>19,096</td>
<td>9.8</td>
<td>1,483</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Totals | 1,510 | 13.0 | 19,601 | 376 | 19,977 | 0% | 27,372 | 7,395 | 73% |
Demand Forecasts and Production Plan  
Pediatric Clinic Gap Analysis – Status Quo

**Gaps and Capacity Management Strategies:**

- With patients < 4 yr old, demand may be > optimal capacity
- Emphasis may be to decrease demand

Confidential and Proprietary
**Enrollment**

**Managing Temporary Orphaned Patients**
- Identify patients on the panel needing continuity of care between providers
  - Chronic Disease
  - Children 0 – 4 years of age
  - Frequent Users > 3 visits in last 6 months
  - Patients identified by PCM and PCM Team as needing continuity between providers
- Reassign those unique patients to a PCMH team provider until the provider returns from deployment or contract or GS position is filled.
  - This may require sending acute patients to UCC
- Other patients can be seen by PCMH team PCMs for infrequent acute needs

**Enrollment Management**

**Frequent Users and Complex Patients**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Enrollment</th>
<th>Direct Care Users</th>
<th>Total</th>
<th>Direct Care Users</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>PNP - AD</td>
<td>1,550</td>
<td>1,004</td>
<td>594</td>
<td>816</td>
<td></td>
</tr>
<tr>
<td>MD - AD</td>
<td>1,521</td>
<td>956</td>
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<td>MD - AD</td>
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<td>518</td>
<td>766</td>
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</tr>
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<td>MD - AD</td>
<td>1,518</td>
<td>877</td>
<td>518</td>
<td>766</td>
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</tr>
<tr>
<td>MD - AD</td>
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<td>518</td>
<td>766</td>
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</tr>
<tr>
<td>PNP - CT</td>
<td>1,533</td>
<td>998</td>
<td>95</td>
<td>734</td>
<td></td>
</tr>
</tbody>
</table>

**Communication Strategies**

**Voice of the Customer**
- Reach Out to the Customer
  - Survey patients and ask them what is important to them and how well you are doing in those areas. This allows work on issues important to patients.
  - Ask open ended questions in waiting room
    - What are the 5 most important things to you about your care and visit?
    - How are we doing in those areas?
  - Proactively Reach out to Base Commanders and Senior Enlisted and attend their meetings
  - Make Commander/Flag/G.O. and Senior Enlisted Spouses your partners. Invite them to the MTF.
    - Go over what you are improving and invite them back for progress updates
Demand Management
Web Site/Face Book/Brochures/Handbooks

- Web Site/Face Book/Brochures/Handbooks
  - Good Web Site/Facebook Page and Handbook can decrease calls to the clinic. Enhance sites with useful information and market (include Refrigerator magnets)
  - Make positive and market the new features of the PCMH
  - Include information patients want to know
  - How to make an Appointment (Acute/Continuity)
  - Rx Renewals/Refills
  - Communicating with PCM team
    - Tests and Consult results, Advice, Follow Up, etc
  - Referral process
  - Phone numbers, directions, etc.
  - Involve patients in design and content
  - One person accountable for content, accuracy, and updates

Demand Management
Refrigerator Magnet (20th Century App)

<table>
<thead>
<tr>
<th>EVANS ARMY COMMUNITY HOSPITAL INFORMATION NUMBER, (719) 526-7000</th>
</tr>
</thead>
<tbody>
<tr>
<td>To make an appointment call: (719) 467-273</td>
</tr>
<tr>
<td>Internet Appointment Service: <a href="https://www.tricareonline.com">https://www.tricareonline.com</a></td>
</tr>
<tr>
<td>Referral Questions: (800) 877-6378</td>
</tr>
<tr>
<td>Refill Pharmacy: (719) 524-4081</td>
</tr>
<tr>
<td>YOUR PRIMARY REFERRAL TEAM</td>
</tr>
</tbody>
</table>

Patient Access/Demand Management
Phone Tree

- The phone system is still the major entry to health care
- Phone tree should be based on why patients are calling.
  - In general there should be no more than 5 main trunks. After 911 instruction for emergencies and the URL for TOL, Relay, and the Clinic’s Website/Facebook, suggested choices include:
  1. Appointments / Rx Renewals / Message for PCM Team
  2. Cancellations
  3. Refills or to speak to a pharmacist
  4. Referral questions to RMC or MCSC/TriWest
  5. Directory for all other clinics and services
- Use layman’s terms and keep messages short and simple. Provide TOL and Relay information while on hold.
Patient Access/Demand Management
Phone Access to PCMH and Monitoring

- The following metrics should be monitored and tracked:

**Industry Benchmarks**

- Abandonment rate: < 4%
- Speed of Answer: < 45 seconds
- Talk time: < 2 minutes

- Contract should be performance based
- Appointment/Messaging Center
  - Contract should also include message center functions so appointment clerks can take messages and generate T-Cons to PCMH teams to enhance access to PCMH
  - Contract should allow for proactive ("Reverse") appointing

Access to PCMH Team
Committing to PCMH Panel of Patients

- Accessible
- Responsive
- Reliable
- Consistent
- Familiar
- Trusted

Access to PCMH Team
Most Common Reasons for Calls to PCM RNs

- Rx Renewals
- Results: Lab, Imaging, Consult
- Advice/Appointment Issues
- Referral Process Issues
- Consult Renewals
- Administrative Requests
Patient Access/Demand Management

Access to PCMH Team

- Meeting needs without a physical visit to the clinic
- 95% of T-Cons can be managed by PCM RN
- Flag T-Cons about acute symptom based calls. Clerk takes number (preferably cell) and tells patient to keep the line open. Allow Caller ID from MTF on patient’s phone.
- Patient requires Responsiveness, Accessibility, Familiarity, Trust, Reliability, and Consistency from their PCM team
  - Committing to a window of time will decrease phone tag substantially. Can use text message to arrange call time.
  - When leaving a message for acute issues, RN commits to call patient back within a 1 hour window. If done, 90% will be reached on the first attempt vs. > 3 phone tags
  - For non acute issues RN commits to within 4 hours and always before the close of business

Patient Access/Demand Management

Appointment Clerk Role; Access to PCM Team

- Acute Symptom Based Call
  - Appoint to PCM > PCMH Team PCM > Urgent Care
    - As an OPTION, offer for PCM Nurse (by name) to return call within 1 hour window
  - Non Acute Call to PCM Team
    - RN will call back within 4 hours but no later than COB

Patient Access/Demand Management

Rx Renewal / Pharmacy Support

- Rx Renewal
  - Develop and use standard protocol for process including same day provider signature and RN role in Rx renewals
  - Make drug renewal an option (with PCM Team) on the phone tree
  - Assign fair share of renewals to PharmD
  - Synchronize renewal time for drugs
  - Provide up to 1 year supply to compliant patients
  - Reminder in clerk’s tickler file for lab tests, visits, renewals
  - Adopt Vandenberg model for appointment/message clerk informing patients they can pick up meds in 72 hours if they don’t hear from Team RN
Patient Access/Demand Management
Phones and Messaging, Accurate Phone Number

- Communication with the PCM team requires accurate phone numbers
- Recommendations for Accurate Phone Numbers
  - Appointing Clerks at each call and Clinic Clerks at each check-in must validate the correct number (preferably Cell by having patient tell them the number) and must be placed in the CHCS field so number is not changed by DEERS
  - This is an efficiency issue for the PCM RNs and Providers and required to use the CHCS AudioCare reminder function to decrease No-Shows and the Audio Communicator broadcast function to send out messages to the population about closures and late opening etc.
  - Most importantly, it is a safety and quality issue if the patient must be contacted for medical reasons

Patient Access/Demand Management
Access to PCM Team

- Other
  - Market TOL and “Blue Button” for lab results retrieval
  - Direct referral process questions to the RMC and TriWest. Direct consult result questions to the PCM RN.
- Secure Messaging (Relay/MiCare)
  - In the very near future, all MTFs will have secure messaging allowing communication between the patient and PCM team over the web in a secure environment
  - An execution plan will have to be developed for Relay to be successful
  - Eventually virtual visits can be conducted when appropriate. In Denmark, 70% of the visits are now virtual.

Capacity Management
Simplify Appointing

- Move to 3 Appointment Types
  - Acute
    - Today when there is a symptom that needs to be seen today (today not 24 hours) as determined by the patient
  - Continuity
    - All other appointments (EST) should be seen by the PCM. New non acute problems should be booked within 7 days. This can be monitored with 3<sup>rd</sup> Available appointment.
  - Procedures
    - Booked from clinic
Capacity Management
Simplify Appointing

- Appointment Guidelines
  - Simplify and standardize appointment guidelines
  - Eliminate 1 problem per appointment guideline
  - Eliminate provider specific guidelines, standardize and simplify
  - Simplify Appointing continued
  - Make Continuity a high priority in appointing especially for follow up and non acute appointments
  - Continuity and Access (3rd Available) are the most important measures and should be emphasized, measured, and monitored as per MHS Guide to Access to Care http://www.tricare.mil/tma/tai/cguide.aspx
  - Access To Care (ATC) standards should also be measured and monitored but should not trump Continuity and Access (MHS Guide to Access to Care)

Capacity Management
Simplify Appointing

- Simplify Appointing continued
  - Start Times
    - Treat appointment time as Start Times, not rigid appointment lengths and types. Make all appointments 20 minutes (15 minutes for some providers but all should be the same for a provider). Some visits will be longer and some shorter. AHLTA entry part of appointment, no interruptions.
    - Goals for provider, staff and patients are to start on time, have good patient flow with minimal to no waiting by patient or provider, and end clinic session on time.
  - Modified Wave Appointing
    - In order to compensate for late patients or to give the provider a “head start”, consider checking in the first 2 patients of the session at the same time so the session starts with 2 patients in exam rooms when the provider starts the session

Capacity Management
Simplify Appointing

- Simplify Appointing continued
  - Wait Function
    - Appointments can be protected using the “Wait” function in CHCS i.e. certain number of Acute/Today appointments or appointments within 7 days to meet patient demand. As per Service Instructions, do not use $, PBO, or Frozen appointments
Capacity Management
Simplify Appointing, Reverse Appointing

- Reverse Appointing
  - Follow Up Appointments
    - Follow up appointments within 6 weeks should be booked in the clinic by their PCM Tech before they leave.
  - Reverse Appointing (Fairchild method)
    - If greater than 6 weeks i.e., Follow up, Well Child, etc., give appointment time to clinic clerk to be placed in tickler file (physical or electronic) to call the patient and make the appointment and order any tests needed as the date approaches.
  - Assign Clinic Clerks to teams for this function
  - Appointment Clerks can be used for making the actual call
  - Assign last available EST appointment leaving first available for patient initiated new problems

Future Continuity Appointments
Pediatric Clinic Providers

Capacity Management
Template/Scheduling Management

- Template management and scheduling should be done by the GPM/Clinic Manager/Administrator with input from the Providers and Clinic Leadership
- Keys should be held only by the GPM/Clinic Manager/Administrator and Flight Commander/Clinic Chief
- Ensure enough appointments to meet enrolled demand, usually 18/day, 90/week
- Facility Cancellations should be avoided at all costs
- Appointments should be opened out a minimum of 6 weeks
- Everyone including Providers must plan 6 weeks out
Capacity Management
Template Management

Unbooked Appointments
Common Causes

Demand and Capacity Management
Continuity
Clinic Operations
Check In Policies

- Check In Time (Show Time) is Appointment Time
- Do not ask patients to come in early
- Make this uniform across the command
- Appointment Components
  - Screening, vital signs, AHLTA entry, Medication reconciliation etc. should be completed before the provider arrives to see the patient i.e. 10 minutes 0800 - 0810
  - Provider, 20 minutes must be totally with the patient i.e. 0810 – 0830. The encounter ends after the provider finishes the AHLTA note. Do not disturb providers until finished. Some set aside 5 minutes at the top and/or bottom of the hour for questions.
- Post appointment: After 0830, PCM RN education, Pharmacy, Lab, Imaging

Clinic Operations
Late Policies

- Late Policy
  - 10 – 15 min after appointment time (uniform across command). MUST receive clinical screen by RN before turned away or delayed.
  - Goal is to see the patient if at all possible. Wasted appointment if not seen. Give them choices:
    - Wait until there is a no show or the provider gets ahead of schedule
    - Wait until the end of the session
    - Reschedule
  - Enforce with compassion and common sense
  - Measure to determine size of “problem” vs. irritant

Clinic Operations
Deployment and Unfilled Contracts and GS

- PCMH in a Military Environment
  - Absent providers cause orphaned panels and patients
  - Have mitigation plan for deployed providers and for unfilled contracts and GS positions
  - Once position is unfilled for 2 months, look for another vehicle, i.e. Locums, CSAs, etc.
  - When possible assign AG providers with permanent civilian providers
  - Avoid part time PCMs if at all possible. Patients are full time.
  - Review last 2-3 years and determine average number of deployed providers and unfilled contract and GS positions.
  - Consider maintaining one provider as float PCM to avoid a floating orphaned panel
Clinic Operations
Team Approach, Roles and Responsibilities

- The Provider should have at least 2 permanent Techs and 1 permanent RN. One Tech should ideally be a civilian LPN, MA, or CNA.
- The RN will be the “Anchor” and the face of the team to the enrolled patients.
- In a Military setting, this will offer stability to the patients when Providers are deployed or contracts unfilled.
- Team Continuity and Patient/PCM Continuity may be the 2 most important actions to decrease demand and increase productivity.

Clinic Operations
PCMH Team Stability

- The PCM Team must be intact and in the clinic together to function efficiently. 2 year assignments ideal.
- If team members must be pulled, it must be planned 6 weeks in advance.
- If Providers, Nurses, Techs*, and Patients commit to 6 weeks, everyone (Group, Wing, Directorate, Command, and CMC/CSM/CCM) must commit to 6 weeks for planning meetings, training, ceremonies, etc.
- Recommend Clinic Chief/Flight Commander approval for cancelling any appointments and for pulling personnel from the clinic and then only if done 6 weeks out.
  * Corpsman, 4N, Medic, CNA, MA, LVN

Clinic Operations
Team Approach, Roles and Responsibilities

- Critical Recommendations
  - Permanent PCM teams for all providers to include Techs and RN
  - Patient/PCM and PCM/Patient Continuity
  - Daily 1/7 Huddles of team to discuss patients coming to clinic or requiring follow up or proactive care
  - Written standardized roles for and expectations of RNs, Techs, Clerks, and Providers to eliminate variability*
  - Develop training program including TSWF for Techs and Clerks. Functional 4N/Senior Enlisted Leader/NCOIC is responsible for training and monitoring performance
  - Develop orientation program and roles and responsibilities for new RNs and Providers. Clinic Chief/Flight Commander and Medical Chief are responsible for these programs.

* Template provided by TriWest
Clinic Operations
Team Approach, Roles and Responsibilities

- RN Roles for PCM Team(s)
  - The RN will be the “Anchor” and the face of the team to the enrolled patients
  - In a military setting, this will offer stability to the patients when Providers are deployed or contracts unfilled
  - New patient orientation to clinic; how to use clinic and be part of the Medical Home team
  - Huddle to review upcoming patients with PCM and Tech
  - Screen Tel-Cons from patients and resolve any problems possible i.e. test results, symptom based calls, prescription renewals, unavailability of appointments, etc.
  - Chronic disease education and care coordination

- RN roles for PCM Team(s)
  - RN augmented clinics; UTI, Rash, URI, etc.
  - Lead contact for complicated patient including pain management patients
  - Call patients before the visit to discuss any issues that can be handled in advance
  - Use patient tools such as on line forms for organizing patient concerns for visit
  - Review medications they are on including drugs from other providers (MTF and Network) in CHCS
  - Guaranteed booking for follow up if more time needed
  - Lead for interventions to decrease ER visits

Urgent Care Needs are Delivered Somewhere

- Important as to where we drive Urgent Care
- Producing barrier to PCM or UCC can drive care to ER
- During clinic hours, if the patient needs to be seen, goal is to see patient in the PCMH by their PCM or team.
- Ideally some care can be handled by a Accessible, Responsive, Reliable, Consistent, Familiar, and Trusted PCMH Team

<table>
<thead>
<tr>
<th>PCM Clinic</th>
<th>PCMH Team/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care</td>
<td>RN for Advice</td>
</tr>
<tr>
<td>ER</td>
<td>and Guidance</td>
</tr>
</tbody>
</table>
**Recommendations**

**ER Intervention**

- ER Intervention
  - See all acute care enrollees in clinic during clinic hours
  - Take MTF ER enrollees in clinic during clinic hours
  - PCMH RN calls patients seen in MTF or Network ER or UCC the next morning
  - Check on status which may avoid "follow up" visit with PCM
  - Advise on other options next time, i.e. call PCMH RN
  - Educate on PCMH
  - Proactively call the patients who use the ER 2-6 times/year
  - New enrollee visit to include ER orientation
  - Prenatal visit and/or newborn well visit ER orientation to target 0-4 age group

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**Ellsworth AFB Enrollee**

**ER Visits / 100 Trend**

![Bar chart showing ER visits per 100 - Active Duty and MTF Prime Enrollees Ellsworth AFB (2005-2011).](chart1.png)

Source: WPS Data Warehouse
Processed through November 30, 2011

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**Bangor Sub Base Enrollee**

**ER Visits / 100 Trend**

![Bar chart showing ER visits per 100 - Active Duty and MTF Prime Enrollees NBHC SUBASE Bangor (2005-2011).](chart2.png)

Source: WPS Data Warehouse
Processed through November 30, 2011
**PCMH Progress**

- Persistence and Patience
  - Optimizing the clinic will not generate immediate results
  - Afterhours and weekend care will still be needed
  - Demand will change with seasons and patient needs
  - Patients bring expectations from past commands
  - Patient behavior will change but it will take time

---

**Execution**

**Most Important Requirements for Success**

- Goals
- Timelines
- Responsible Individual
- Track Progress
- Measurement
- Trend
- Monitor Measure/Progress Weekly at MTF Leadership Meetings
- Give Feedback to Responsible Individual Weekly
The above graphs are tabular summary data from the Air Force Medical Service’s ‘Service Delivery Assessment’ question which asks how much you agree with the statement:

“In general, I am able to see my provider when needed”

WHAT WE ARE DOING TO IMPROVE THE AVAILABILITY OF APPOINTMENTS FOR YOU

1. Quarterly Saturday Training Days all training and Commander’s Call days on this additional duty day for the entire Medical Group
2. Quarterly Saturday Training Days for Air Force Medical Service’s ‘Service Delivery Assessment’ question which asks how much you agree with the statement:
3. Expanded appointment schedules in Flight Medicine clinic. Reserve appointments open for acute needs for on-duty day at weekends
4. Expanded appointment schedules in Flight Medicine clinic. Reserve appointments open for acute needs for on-duty day at weekends
5. Agreement with McAfee Army Medical Clinic at White Sands Missile Range to use their excess appointments when we run short
6. Group appointments (when appropriate) and non-physician protocols to get the care you need and maximize clinical efficiency
7. Medical Group Physical Training sessions completed as a group twice each week at 0545, so clinic can open on time
8. Effective work with Air Force Medical Operations Agency to add more providers and to fill the slots that we do have

TRIWEST’s Strategic Planning Visit (January 2011) declared that 49 MDG is “Best in the West” on clinical efficiency

9.3% of provider time lost to non-clinical activities

Top Recommendations

- Revamp phone tree. Simplify ability to access PCMH team. Consider ACD system and monitoring.
- Assess reasons for unused appointments
- Assess clinic lost time and eliminate unneeded time away from clinic or adjust enrollment
- Ensure demand forecasting method in place and enough clinic capacity (usually 18 appt/day/provider)
- Implement appointment show time and late policies
- PCM RN call back for acute issues within 1 hour, all others within 4 hours or COB
- PCM RN next day call to ER and UCC patients
- Implement “Vandenberg” RX renewal process
- Implement “Fairchild Reverse Appointing” for Follow Up

Top Recommendations (continued)

- Assign permanent Corpsman/4N/Medic/CNA/LVN with Providers and prohibit pulling from clinic without planning and approval of Clinic Department Head
- Implement “1/7” daily Huddles
- Establish written Roles and Responsibilities and appoint individuals in charge and accountable for training and performance
- Appoint Senior Officer to oversee improvement in AHLTA performance. Establish measures of performance and monitor at Commander level.
- Appoint Senior Officer to oversee performance of Contract and GS fills. Establish measures of performance and monitor at Commander level.
- Appoint Senior Officer to oversee the consult reporting process. Establish measures of performance and monitor at Commander level.
Summary of Actions for Practical Implementation of PCMH

- Know demand of patients
- Optimize capacity, 18/day, 90/week
- Know time/appointments lost to non clinic and adjust time or enrollment
- Written and enforced roles and responsibilities of all staff including TSWF
- Stable PCM team who huddles 1/7 every day
- Implement continuity PT/PCM and PCM/PT. No cross booking.
- See enrolled patients for all acute care during clinic hours
- Access to PCMH team via phone and Relay
- PCM RN who is accessible, responsive, reliable, consistent, familiar, trusted and coordinates care including prevention
- Strategy to decrease ER use with targeted education to patients

Recommended Reading


Recommended Reading

- Yu C. The role of the pediatrician in military medicine. Pediatrics 2012: Volume 129, Number 2, February 2012: Supplement
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Practical Implementation of Patient Centered Medical Home
Success Stories from Over 120 MTF Clinics

USPS, Seattle Washington, March 10-13, 2012
W. Mitch Heroman, MD, MBA, FAAP, CPE

Bibliography


