

Family Health Initiative/Access-Compassion-Excellence (FHI/ACE)

Introduction: Family Health Initiative (FHI) focuses on a “Patient Centered Medical Home,” with personalized care and continuity achieving value-added patient encounters. Current clinic appointment template allows 15-20 minutes per encounter. Recurrent patient complaints include: an inability to address multiple medical issues in a single visit, feeling rushed during visits, and frustration having to recount care history to multiple team members. Scheduled appointment time is frequently consumed by patient arrival delays, intake form completion and the medical technician initial assessment; leaving less than 10 minutes for the provider to render care. The ideal primary care appointment has sufficient time to address acute care issues, disease management, disease prevention and patient education. We hypothesize that maximizing support staff skill sets and face-to-face time with the provider will translate into improved patient outcome metrics and staff satisfaction.

Methods: A working group was formed in June 2011 to operationalize the concept of an enhanced appointment template. Obstacles to the ideal primary care appointment identified by the working group and validated by provider surveys administered in Sept 2011 included:

- Insufficient long term staff continuity
- Limited duration of encounters
- Suboptimal medical technician data collection skills
- Lack of standardized comprehensive patient education products
- Inflexible and non-portable medical information systems

To overcome these challenges, several initiatives were implemented including:

- Clinic leadership lessened non-FHI tasks and duties to enable support staff availability 75% of duty days
- The appointment time was expanded to 40 minutes and relabeled as a “team appointment” divided into 20 minute segments for the technician and provider respectively
- Appointments were staggered between two medical technicians assigned to the credentialed provider to meet FHI provider appointment goals
- Nurse corps staff conducted technician training on focused assessment skills, data collection and analysis, population health management, and EMR documentation.
- Standardized patient education products were purchased with AF/SG MHPI incentive funds. Portable and flexible computer options were discussed and a functioning wireless EMR was defined as the goal
- Access to EMR systems by multiple team members during the encounter was streamlined

Project team members included FHI Medical Director, NCOIC Medical Services Flight, Medical Services Flight Commander, SGH, SGN, and MDOS/CC. Organizational support for this initiative included 579 MDG/CC and 79 MDW/CC. A nine-question survey administered to all FHI PCMs focused on job satisfaction and patient workflow perceptions. Outcome measures reported by team and generated by centralized AFMS and/or MHS data systems. These include patient

satisfaction, HEDIS scores, UCC/ED utilization, continuity of patient encounters with their FHI team and number of closed referrals. Data collection and monitoring for this project began 19 Sept 2011.

Results: All FHI providers completed questionnaires prior to implementation of the initiative; 80% were neutral and/or somewhat dissatisfied with their job. Of all providers, none routinely had 20 minutes per encounter and 100% were dissatisfied with time available for face to face interaction with the patient. Administrative tasks frequently trumped direct patient care. Providers felt that lack of continuity and underutilization of support staff negatively impacted the achievement of PCMH goals. During preliminary interviews with the pilot team, 100% of technicians voiced improved team dynamics, communication, and use of skill sets. The provider was able to address all patient needs in one visit, including screening exams and minor procedures on several occasions. Unsolicited feedback from patients was 100% positive. Sequential EMR logon by provider and technicians in the exam room eliminated prior data loss caused by simultaneous EMR logon at separate locations. Improvements were realized within one week of implementation despite lack of a functioning wireless network. All staff received Carepoint access and training on disease management concepts, data retrieval and analysis resulting in actionable items. Compliance with medication reconciliation improved from 33% pre to 80% post implementation. Population outcome metrics will be available in early 2012.

Conclusion: The goals of Patient Centered Medical Home are to improve patient outcomes and staff satisfaction. FHI/ACE restores ownership of patient care to the FHI team. Preliminary data is suggestive that the goals of PCMH including movement from healthcare to health can be achieved within 3-6 months. Of note, wireless computer system upgrade costs and additional manpower requests were not essential to FHI/ACE. Irrespective of new technology and manpower, improvements in FHI can be realized by applying a systems approach. This innovative primary care appointment template maximizes technician support and is low cost, sustainable and reproducible in both military and civilian settings. Additionally, this process has the potential to be translated to pediatric FHI. Future efforts include creation of a "tool kit" for medical technicians during phase II training and for local implementation at individual MTFs.