

TOOLS FOR CLINIC MANAGEMENT: HEADS-UP DISPLAY (HUD) & PATIENT ACUITY SCORING TOOL (PAST)

Introduction:

The Mike O'Callaghan Federal Hospital (MOFH) Executive Staff directed the Group Practice Management (GPM) Office to create a comprehensive solution for improving the management of clinics and to enhance patient access. Five initiatives were executed to provide a comprehensive MTF-wide solution.

Methods:

Several key areas throughout the patient experience were analyzed and optimized to improve patient access. Initial focus was to ensure proper resourcing and execution of programs to care for the enrolled population. The five initiatives are listed below.

1. Unwieldy large composite Family Medicine clinic containing two separate missions with sometimes conflicting goals between traditional primary care access and graduate medical education: The Family Health Clinic (FHC) and the Family Medicine Residency (FMR) had been structured as a single clinic with one MEPRS code (BGAA). There was no distinction between leadership, resources, and empanelment allocated for each program, thus patient access suffered as a result. Following extensive planning and consultation between MDG leadership and the family medicine consultant to the AF/SG, leadership approved a reorganization plan and the clinic was split into two separate flights with distinct MEPRS codes starting 1 Oct 2010 allowing each to focus on their specific missions.
2. Optimize the templates of each clinic to meet the intent of the AFMS Access To Care Guide: The GPMs worked with the primary care clinics to optimize clinic templates and to create capacity in Pediatrics and Internal Medicine. Opportunities were identified to re-empanel patients to Pediatrics and Internal Medicine, as appropriate, relieving access pressures from the Family Health Clinic.
3. Balance the enrollment across the MTF: The GPMs, in conjunction with several primary care providers, developed a tool called the Patient Acuity Scoring Tool (PAST). This tool groups patients based on historical primary care utilization and medical conditions and also provided a framework to quickly correct the imbalance of empanelment between the clinics and providers.
4. Closely monitor projected patient access: The GPMs instituted the Heads-Up Display (HUD) at the MOFH in 2010, originally developed at David Grant Medical Center in 2007. In addition, enhancements were made to improve its data analysis and reporting capabilities. With this enhanced tool, the GPMs provided weekly briefings to leadership indicating projected patient access over the next 6 weeks. This allows leadership to proactively focus attention on upcoming access issues.
5. Direct oversight over the Appointment Center: The GPMs were tasked to manage the appointment center and to work on fixing the staffing and performance issues. This change was validated to be the right choice as a recommendation in the AFMS Access to Care Guide. Two efforts were initiated. The first effort was to solicit assistance across the MDG to staff the

appointment center during peak call periods to revolve the call center issue immediately. A second effort was to place an Unfunded Request (UFR) to request resources to properly staff the appointment center.

Results:

Since these efforts were initiated in late 2010, the MOFH primary care clinics are now structured to take on an additional 7,000 patients to reach our goal of 50,000 total enrolled patients by end of FY12.

With the FHC and FMR programs separated, the clinics were resourced and held accountable for taking care of their enrolled patients. The GPMs worked with each clinic to project the appointment needs of their enrolled patient population. Average provider templates increased across the board (see Business Plan Execution and Monthly RVU Report).

Using the PAST, the GPM staff successfully re-empanelled over 1,200 patients in several phases from the FHC to Internal Medicine and Pediatrics. This effort brought the FHC empanelment from 108% to 97% capacity and ensured clinical staff was resourced to meet access to care standards for their empanelled patients. At the same time, the 1,200 patients with more specialized needs are now under the care of specialized primary care providers, a win-win for patient access and clinical currency.

Using the HUD, the GPMs, along with Flight and Squadron Commanders, monitor patient access continuously and prospectively. This tool is continually being improved and newer versions are published on the Air Force Knowledge Exchange. This tool has been instituted by the Air Force's largest four MTFs (Wilford Hall Ambulatory Surgical Center (Lackland), Mike O'Callaghan Federal Hospital (Nellis), David Grant Medical Center (Travis), and Elmendorf Hospital (Elmendorf)) and also several other small hospitals and clinics. In addition, the updated HUD and PAST tools are presented at the Air Force Medical Service Group Practice Management course curriculum at Ft Sam Houston, TX. The HUD had also been presented at the AFSPC Surgeon General's Conference in March 2011 as the AFSPC SG's highly recommended tool for MTF Commanders and briefed to the ACC/SG in June 2011 for deployment command-wide.

Our call center metrics improved significantly, greatly improving the patient experience with a drastic reduction of the average speed of answer from 7 minutes to less than 1 minute. The longest wait time dropped from over 50 minutes to under 5 minutes during our highest peak period today. Daily call abandonment rate dropped from over 70% previously to between 2-15% today.

Conclusion:

From 2010 to 2011, the MOFH achieved outstanding results in improving patient access and clinical productivity by leveraging information. The firm commitment from leadership at all levels and our clinic staff is the key to our continuous improvement in access to care.