[Numerical Listing] [Categorical Listing]

HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

6 March 2000

MEMORANDUM FOR: ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA))
ASSISTANT SECRETARY OF THE AIR FORCE (M,RA,I&E)

SUBJECT: Policy to Improve Military Treatment Facility (MTF) Primary Care Manager Enrollment Capacity

At our recent TRICARE Access Summit, one of the policy imperatives agreed to by participants was the development of a plan to improve provider availability and MTF enrollment capacity. The military treatment facility's capacity to enroll its beneficiaries is affected by the number of Primary Care Managers (PCM) at the MTF, their availability to see patients, readiness considerations, patient demand for visits, and productivity of providers which is determined by availability of sufficient clinic support personnel, facility redesign and management actions that emphasize improved access.

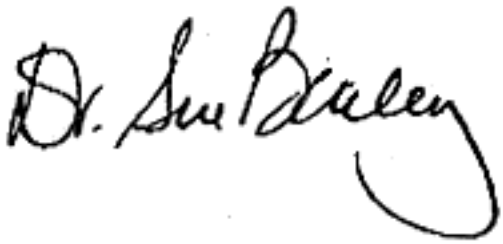
This policy memorandum puts forth a triservice developed uniform enrollment capacity planning model. This policy also identifies a framework for program improvement as well. The goal is to optimize MTFs and recapture appropriate network workload. A review of civilian literature and work done within the Services suggest that within the Military Health System (MHS), approximately 1,500 members could be enrolled to each PCM if necessary support staff and other resources are made available. For some PCMs it is not reasonable to expect 1,500 enrollees, particularly where the alignment of assets in support of mobilization commitments takes priority over realignment of assets in support of primary care or the average patient severity index is high. The 1,500 enrollees per provider is an overall goal. A review of the number of currently authorized PCMs does suggest that with appropriate reengineering inside the MTFs and across the MHS, we have enough providers to enroll all MHS current users in the MTF catchment areas to providers in the direct care system. However, to accomplish this goal will take considerable refocusing of our primary care clinics operations to include all of the above identified variables.

Using the model provided, each MTF should identify its baseline enrollment capacity and develop a plan to move toward an enrollment objective of 1,500 enrollees per PCM. This is a critical component of meeting our MTF baseline optimization objectives. The Services will conduct an initial assessment of each MTF's present enrollment, availability of examination
rooms and support staff by 14 April 2000. A phased comprehensive capacity plan for achievable enrollment targets should be completed by 30 June 2000. This plan should address all the significant determinants of

enrollee/provider ratio and have projected completion dates for each item. MTF enrollment plans should be provided to their respective Services' point of contact with an information copy provided to the regional Lead Agent in support of MHS Optimization and TRICARE 3.0 managed care support contract implementation. Monthly enrollment status reporting will continue to be provided by the regional Lead Agents to the MHS Operations Directorate, TMA to monitor program progress with increasing MTF enrollment.

The PCM ratio of enrollees to provider depends primarily on four factors: demand, productivity, availability, and readiness considerations. Each of these factors needs to be managed to produce optimum results in terms of cost, quality, and access. To reach 1,500 enrollees per PCM will require significant reductions in the average number of primary care visits per enrollee by increasing their health and appropriate utilization of resources through demand management, e.g., the use of nurse advice lines and nurse triage systems, self-help pamphlets, and prevention measures. It will require greater productivity through the use of appropriate support staff, examination rooms, scheduling techniques and practice patterns. It will also require the availability of assigned PCMs to staff primary care clinics. Our beneficiaries will also have to believe that we are serious about providing continuity of care and committed to meeting their expectations if we are to entice them back to the MTF. Finally we will have to continue balancing the unique demands that are incurred by the MHS readiness mission.

Attached at **TAB A** is a more detailed discussion of an equation that quantifies the effects of each of these enrollment capacity factors. Resource managers within the services will be provided a spreadsheet model that can estimate the current capacity of each MTF based on their assigned PCMs and other local factors. Increasing enrollment is an important competitive strategy to recapture workload into the MTF. Achieving increased productivity must be accomplished through improved business processes and support systems, and not by simply laying an increased burden on our providers. A target goal of 1,500 enrollees per PCM is ambitious, but by managing the demand and increasing productivity, this goal could be achievable over the next few years with proper resourcing and other necessary support to our MTF commanders.



Dr. Sue Bailey

Attachment:
As stated

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force

HA Control No: N/A
HB&FP Control No: Suspense Date:

February 7, 2000

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

THROUGH: DASD (HEALTH BUDGETS AND FINANCIAL POLICY)

FROM: COL Blum, PD(HB&FP)/RCT

SUBJECT: Policy to Improve MTF Primary Care Manager Enrollment Capacity

DISCUSSION: The Policy memorandum puts forth a Triservice developed uniform enrollment capacity planning model proposed by the RCT. There is currently no uniform Triservice goal for a Primary Care Manager (PCM) Enrollment Rate. While there are many obstacles to overcome, a goal of 1,500 enrollees per PCM is achievable and has been targeted as a key objective in support of MHS Optimization by the Reengineering Coordination Team (RCT). This is the second policy memorandum recommendation forwarded by the RCT. The first policy memorandum forwarded by the RCT addressing Primary Care Managers (by Name) was signed on 3 December 1999.

Attached is a policy memorandum establishing the goal of 1,500 enrollees per PCM. It also has an attachment that elaborates on the model that was used to arrive at this goal and which identifies the major factors that affect the enrollment rate.

- Input from the three Surgeons General has been incorporated into this policy memorandum.
- RCT members have reviewed with their DSGs.
- Enrollment capacity is a critical component for improving access and is supported by the Chairman, JCS.
- Policy established an initial assessment by 15 March 2000 and the time phased comprehensive plan to achievable enrollment targets by 15 May 2000.
- MTF enrollment plans will be provided through their Services to the regional Lead Agents
- An electronic spreadsheet will be provided to the resource managers within the services so that they can estimate the current capacity of each MTF based on their authorized PCMs and other local factors.

RECOMMENDATION: That ASD(HA) approve and sign attached policy.

COORDINATION:
COS _____
XO _____
SGs _____ See attached. Concerns and recommendations addressed.
ASD APPROVAL:
Approved _____
Disapproved _____
Other _____

MHS Enrollment Capacity Planning Model

This MHS **enrollment capacity planning model** will help facilities predict their capacity to provide primary care, standardize enrollment projections for resource allocation and will be used as a basis for managed care support contract bids. This model will allow facilities to:

- Predict the portion of the catchment area population which can be effectively enrolled
- Develop realistic targets for enrollment of specific populations to individual providers
- Identify factors which could be improved to increase enrollment capacity
- Receive financial resources commensurate with enrollment capacity and predicted workload
- Monitor performance and improve key determinants of enrollment capacity

The Model

The number of beneficiaries who can be enrolled to a single primary care provider can be estimated using the determinants in the following formula. Altering any of these variables or preferably, all of the variables in combination, will produce significant increases in the enrollee/provider ratio.

$$\text{Enrollees/Provider} = \frac{\textbf{Weeks Worked/Year} \times \textbf{Clinical Hours/Week} \times \textbf{Visits/Hour}}{\textbf{Annual Visits/Enrollee}}$$

Numerous factors will determine enrollment capacity and must be addressed to optimize clinic productivity, decrease inappropriate or excessive utilization and produce better patient outcomes:

- Scope and complexity of practice
- Direct clinical support staff
- Number and availability of exam rooms per provider
- Clinical support tools
- Business support tools
- Information management
- Demand management tools
- Demographic factors (contributes to calculation of visits per beneficiary per year)
- Reserve integration
- Community support
- Operational unit organic medical support

The specific determinants of the number of enrollees per provider are as follows:

Weeks Worked/Year and Clinical Hours/Week. The number of hours a provider can dedicate to clinical activities is predicated on the number of hours the provider is available to perform clinical duties. Military providers generally take 4 weeks of leave per year and use an additional 2 weeks for continuing education and readiness training – leaving 46 weeks for clinical duties. Civilian providers employed by DoD also take leave and participate in a week of continuing education – conservatively yielding between 44-47 weeks of clinical availability.

Civilian general and family practice clinicians spend an average of 47 hours per week in direct patient care. This includes office or clinic visits, hospital rounds, surgery, and other direct patient care activities. Thus, all 47 hours are not spent seeing clinic patients. Conservatively, 35 to 40 hours per week (7 to 8 hours per day) should be allocated for direct patient care. For military providers, this estimate must be further reduced by a "Military Unique Factor" (approximately 8%) which reflects time when military providers are not available due to unique military training (including readiness) and other requirements. For civilian providers, clinical hours will depend on the provisions of their contracts or other terms of employment.

Clinical availability is also dependent on facility and provider commitments for direct support of operational requirements. Many of our facilities provide personnel for base training as well as to augment deployments, which are not part of the regularly planned command mission. Careful review of all non-clinical activities and requirements is necessary to increase provider and support staff availability for direct patient care. The number and timing of staff meetings, optional duty requirements, and non-patient care responsibilities etc., should all be reviewed and reorganized to prioritize patient care duties.

Graduate medical education training programs impose special staffing requirements that mitigate staff's normal clinical availability. However, the trainees add some measure of clinical throughput that must be included when calculating the effect of the teaching demands on overall availability of the staff.

Full integration of Reserve providers and support staff can substantially add to staffing levels without increasing personnel costs. Reserve readiness will be enhanced by their experience.

Likewise, the availability of community support must be considered. Facilities in relatively mature managed care areas may be able to contract for services at more cost effective rates than other facilities. Business case analyses should drive contracting and other outsourcing decisions.

Visits/Hour. The number of patients which our providers can see each clinical hour is dependent on a wide variety of factors and is the single most fertile area for process improvement. A proper number of well-managed and trained direct clinical support staff is the most important factor to optimize a provider's patient contact time and productivity. "Direct clinical support staff" are those personnel who are immediately available to assist with clinic operations. Staffing varies widely in the Military Health System (MHS); productivity is maximized where more than 3 support personnel are assigned for each primary care provider. Experience from the civilian health care sector indicates that 3 to 3.5 support staff per provider who are directly in the clinic is optimal for a patient throughput of 3.5 to 4 visits per hour. MHS primary care providers would likewise be more productive if this level of support staff were available.

The number and availability of exam rooms per provider can be increased using many strategies. Optimizing the use of existing space can be achieved by modifying operating hours to spread clinical workload, altering provider schedules, and "reclaiming" clinical spaces.

Clinical and business support tools which improve information management can also dramatically improve productivity. Examples are: innovative and customized scheduling techniques, missed appointment tracking, and automated patient interaction. Near term IM/IT products will facilitate better utilization of resources and increased provider and system productivity.

Annual visits per enrollee. A variety of studies have demonstrated military beneficiary (non-Medicare eligible) primary care visits to range from 3.1 to 4.3 per year. The industry utilization rates of 3.5 visits per beneficiary per

year falls near the middle of this range. Our population also has some proscribed visits above those expected in the civilian sector – e.g.,overseas screening and mandated physical examinations.

Demographic factors play an important role in predicting the level of effort, which will be required to care for the catchment area population. Each catchment area is unique in its case severity index (CSI). For example, if the population is predominantly retirees or others who contribute to a high CSI, more assets will be required to provide care, fewer visits per hour will be possible, and the average number of visits per beneficiary may be higher.

In some areas, operational unit organic medical personnel will be serving as primary care providers and may deliver a significant portion of primary care to active duty beneficiaries. These medical assets are not normally included in fixed facilities' workload measurements and can substantially reduce the fixed facilities' 'annual visits/enrollee' for active duty.

There is a wide variety of demand management tools currently available and which will effectively reduce demand. Self-care books and Health Care Information Lines (HCIL) provide clinical information to improve beneficiary medical autonomy, decreasing reliance on unscheduled visits to acute care and expensive hospital portals. Case management is another tool for identifying high volume/cost users with illnesses or injuries which are amenable to early intervention. These and other methods will be described fully in an upcoming Population Health Improvement tool.

Concentration on preserving and improving the health of the beneficiary population is the single most important factor in reducing health services demand. A healthier population will, in composite, require fewer services. Eighty more beneficiaries could be enrolled to each primary care provider if demand were reduced by only one visit per year for every 10 enrollees.

Calculations. Using the formula and range of variables described above, the following calculations can be made:

$$\text{Enrollees/Provider} = \frac{\textbf{Weeks Worked/Year} \times \textbf{Clinical Hours/Week} \times \textbf{Visits/Hour}}{\textbf{Annual Visits/Enrollee}}$$

- Weeks worked/year vary from 46 weeks (military) to 47 weeks (civilian)
- Clinical hours may vary from 35 to 40 hours per week (reduced by 8% for active duty providers = Military Unique Factor)
- Visits per hour may vary from 3.5 to 4 patient visits per hour
- Annual primary care visits vary from 3.1 to 4.3 per non-Medicare eligible enrollee

$$\text{Enrollees/Provider} = \frac{\textbf{(46 to 47weeks)/Year} \times \textbf{(35 to 40 hrs)/ civilian (32 to 37 hrs)/ military*/week} \times \textbf{(3.5 to 4.0) visits/hour}}{\textbf{(3.1 to 4.3) visits/enrollee}}$$

* decreased by 8% Military Unique Factor for active duty

Enrollees/Provider	=	**1205 to 2230** **1310 to 2425**	for Military providers **for Civilian providers**

Conclusions. Enrollment capacity rates above 1300 beneficiaries per primary care provider may readily be accomplished by considering the factors described above and modifying those which hinder current productivity. The MHS expectation is that each primary care provider while in clinic seeing patients will be supported by 3 to 3.5 clinical support staff, have 2 examination rooms available, and nominally care for 3.5 patients per hour (25 patients per day). Realignment of existing staff, movement of staff between MTFs, retraining of staff and supplementation of existing staff are all actions which may be required to optimize provider/support staff ratios.

Each facility commander/commanding officer must examine all the above factors to determine their impact on enrollment capacity. Factors which reduce the clinicians' productivity should be identified and minimized.

Expectations: 1500 beneficiaries enrolled per primary care provider
3.5 support staff per primary care provider
2 examination rooms per primary care provider
25 patients seen per day per primary care provider

[Top]
Last update: 03/06/2000