Medical Home Port
Getting Enrollment Right

Clinic Management Course
FY14
Objectives

• Define enrollment in primary care
• Compare and contrast enrollment scenarios
• Explore the impact on quality and cost
• Describe how to align enrollment in order to improve access and performance
Enrollment in Primary Care

- BUMED Memo Ser M3B7/140M0032 dtd 12 Mar 14 Primary Care Enrollment Staffing Target
- HA policy 99-033 (December 1999) PCM by name
- HA policy 09-015 (September 2009) Patient Centered Medical Home (PCMH) policy
- Dr. Woodson’s letter – 1100 per assigned for eMSMs
- Medical Operation Group (MOG) approved Tri-Service Primary Care enrollment at 1100 per primary care provider assigned to primary care
For FY13 enrollment is trending up (mostly due to MCMH) and is currently above the FY11 yearly average.

This represents a 3% increase in enrollment for FY13.

FY13 average is below all previous years averages.
Optimizing the MTF: “Are you open?”

Navy Medicine East Prime Market Population

- Since 2007 there has been a 6% loss of Prime enrollees from Navy MTFs to the Network
  - 80% of the loss is the Active Duty Family Members

- Is your MTF taking advantage of opportune enrollment periods (i.e., PCS season)?
V2C: Patient Enrollment and Staffing

Top 3 Performers: NHC Quantico (1,482), NHC Charleston (1,210), NHC Patuxent River (1,174)
Bottom 3 Performers: NH Sigonella (402), NH Naples (491), NH Rota (567)

Trend Over Time: Enrollment per Assigned by Region

Target = 1,100 – 1,300 enrolled per assigned FTE

Comparison of MTFs: Enrollment per Assigned Provider in July 2013

Target = 1,100 – 1,300 enrolled per assigned FTE

Source: M2 and MTF self-reported must-see numbers, data pulled in OCT-13; data lag is approximately 3 months

FHCC Great Lakes data removed because of challenges gaining access to Navy data following the merger with VA
Why 1100?

- Typically ~2000-2500 civilian practice
- Allows for leave, TAD, training, military unique activities, average deductions
- Accounts for avg. primary care utilization rate of 4 visits per enrollee per year
- Tri-Service Benchmark goal 1100 per assigned provider on average per command
Tri-Service Enrollment Methodology

• Current Target: 1,100 – 1,300 per Assigned
  – Deductions for Ward and OB duty and post duty rest
    • 10 FTE for MEDCEN
    • 5 FTE for Teacher
    • 2.5 FTE for Small Hospital
  – 0.5 FTE deductions for IDC, UMO and FS
  – Residents and interns are excluded
• Future Target: 1,300 -1,500 per Assigned
• This defines the enrollment target for the Parent
The Enrollment Imperative

BLUF: Navy Medicine must quickly increase DC enrollment

- $3,094/Enrollee in network
  - Recapturing 100=$185K. Huge potential savings.
  - We manage the health of our population well
    - Preventive services
    - ↓ admissions (↓ 1 admission =$8K savings)

- Primary Care Realignment: Move providers to CMDs that can grow enrollment.
  - If you can’t grow enrollment, decrease provider staff either by ↓ contract or military providers
Understanding Cost Trends
Drivers of Navy Medicine Purchased Care Spending from FY07 to FY12

Increase Spending
- Outpatient Utilization: 19%
- Inpatient Cost: 67%
- Pharmacy Cost: 7%
- Pharmacy Utilization: 5%
- Inpatient Utilization: 2%

Decrease Spending
- Outpatient Cost: 58%
- Enrollment: 42%

- An increase in outpatient utilization accounts for 67% of the increase in spending
- Decrease in outpatient cost (OPPS) accounts for 58% of the reduction in spending
Managing Demand: “Are you managing your population?”

- Outpatient utilization is up
  - 2.5 visits in the network and 1 visit in military MTFs
Managing Demand:
“Are you managing your population?”

Outpatient Utilization by Diagnostic Grouping
Direct and Purchased Care for Navy MTF Prime Enrollees

- Supplementary Classifications*
- Musculoskeletal
- Mental
- Ill-defined
- Nerves & Senses
- Injury & Poisoning
- Respiratory System
- Pregnancy and Childbirth
- Skin
- Neoplasm’s
- Endocrine & Metabolism
- Genitourinary
- Digestive System
- Infection & Parasites
- Blood
- Congenital Anomalies
- Prenatal
- Circulatory System

**RVUs (Millions)**

- 2012
- 2007

*Immunizations have been removed.

• Over 80% of the increased utilization is in the top 5 diagnostic groupings.
Impact on Quadruple Aim

- Enrollment correlates with continuity and patient satisfaction
- Sustained continuity of care has been shown to improve health outcomes:
  - Increasing provision of preventive services
  - Proactively managing chronic diseases such as diabetes and asthma
  - Decreasing hospitalizations and emergency room utilization
- Patient satisfaction with care predicts:
  - Choice of healthcare plan (purchased care vs. direct care)
  - Compliance with prescribed regimens

Enrollment Considerations

• Setting the number isn’t the entire solution
• Establishing accountability and business rules is equally important
  o Enforcing the PCM relationship whenever possible
  o Incentives for providers to demand manage practice
  o Asynchronous messaging / T-cons
  o E-visits
  o Utilization of Nurse protocols and team based care
• Measuring performance and providing feedback to providers is critical
Building a Successful Enrollment Capacity Model in Order to Define Individual Enrollment Targets
Begin by Gathering Information

- What is the current enrollment?
- Provider staffing and skill type mix?
- What will micro-practices (teams) look like?
- What major duties interrupt continuity of practice?
- Examine clinic templates; available time?
- Historical patient demand for services?
- Case mix of patients?
- Chronic disease burden?
- Special populations (OB, infant, must-sees)?
Step 1: Determine the C-FTE

- Determine each provider's clinical full time equivalent (c - FTE)
- Enrollment for 1.0 FTE in Navy = 1100-1300
- 1.0 FTE is full time provider seeing clinic each day no other duties (includes administrative time)
- Others will need deductions based on actual time away from clinic for major collaterals
- Graduate Medical Education enrollment capacity models include added complexities
Standardized Deductions

- Inpatient duties
- Mandatory in-house call
- Procedure clinics
- Consults
- Director or Department Head
- ECOMS Chair
- Specialty Leader
- CMIO
- ACGME regulated residency deductions
- Other duties: actual time away—significant?
Provider Example –
Step 1: Determine Deductions

• Doctor Smith
  o Family Physician
  o 1 of 10 providers that covers inpatient
  o Call 1:10 nights (phone)
  o Procedures one half day week
  o Department Head with 3 teams

<table>
<thead>
<tr>
<th>Deduction</th>
<th>1.0 FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department Head</td>
<td>- 0.3</td>
</tr>
<tr>
<td>Inpatient</td>
<td>- 0.1</td>
</tr>
<tr>
<td>Call</td>
<td>- 0.0</td>
</tr>
<tr>
<td>Procedures</td>
<td>- 0.1</td>
</tr>
<tr>
<td>c - FTE =</td>
<td>0.5</td>
</tr>
</tbody>
</table>

c - FTE should correlate to enrollment
Step 2: Determine Panel Size/Demand

Panel Size

0.5 c - FTE x 1,100 / FTE = 550 patients

Capacity / Demand

Average demand = 4 visits per year

550 X 4 visits = 2,200 visits

How do we determine whether Dr. Smith will be able to support his patients’ demands?
Step 3: Check Availability vs. Demand

**Availability**
- 5 half-days of clinic per week on average (0.5 c - FTE)
- 3 appointments / hour
- 10 appointments/ half day
- 44 weeks available
  - 4 weeks vacation
  - 2 weeks TAD/CME
  - 2 weeks Holidays/Other

**Anticipated Capacity**
- 44 weeks
  - x 5 half days
  - x 10 appointment slots = 2,200 slots

*Dr. Smith should be able to handle a panel of 550, perhaps more as utilization decreases!*
But What If.....

• Only 2 appointments per hour?
  o Capacity then 1,760 slots!

• Historical demand is 6 visits per year?
  o Demand then 3,300 visits!

• Provider practices vary?
  o Unnecessary follow ups
  o Use or non-use of secure messaging
  o Use of non-use of team based practice and demand management
  o Is their schedule consistent with calculated c - FTE
Utilization and Capacity

- Decreasing average utilization per enrollee allows for increased capacity/enrollment.

<table>
<thead>
<tr>
<th>UTILIZATION RATE</th>
<th>ENROLLMENT PER PCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0</td>
<td>880</td>
</tr>
<tr>
<td>4.0</td>
<td>1,100</td>
</tr>
<tr>
<td>3.38</td>
<td>1,300</td>
</tr>
<tr>
<td>2.9</td>
<td>1,500</td>
</tr>
<tr>
<td>2.7</td>
<td>1,630</td>
</tr>
<tr>
<td>2.2</td>
<td>2,000</td>
</tr>
</tbody>
</table>

Mature Medical Home Ports have observed consistent utilization rates of 2.9-3.1

- 44 Weeks Per Year = 220 clinical days (Includes Leave/TAD/GME/Wknds & Holidays
- 16 minimum appointments per day + 4 add-on/Virtual appointments per day
- 4,400 appointments available per year
  - 4,400 / Utilization Rate of 4 = 1,100
# Capacity Model: Building the Team

<table>
<thead>
<tr>
<th>Provider</th>
<th>Prov Type / Occ Code (MD, NP, PA, IDC)</th>
<th>Pers Type (AD, CIV, CONT)</th>
<th>Skill Type (1 or 2)</th>
<th>Deduction Justification</th>
<th>FTE Reduction</th>
<th>Available Clinical FTEs (c-FTEs)</th>
<th>Current Enrollment Sep 13</th>
<th>Future Capacity (c-FTE * 1100)</th>
<th>Delta Today</th>
<th>Capacity at cFTE*1200</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH</td>
<td>MD</td>
<td>AD</td>
<td>1</td>
<td>DH 0.1, INPT 0.05</td>
<td>0.15</td>
<td>0.85</td>
<td>980</td>
<td>935</td>
<td>-45</td>
<td>1020</td>
</tr>
<tr>
<td>JONES</td>
<td>MD</td>
<td>AD</td>
<td>1</td>
<td>INPT 0.05, CONS 0.2</td>
<td>0.25</td>
<td>0.75</td>
<td>763</td>
<td>825</td>
<td>62</td>
<td>900</td>
</tr>
<tr>
<td>MILLER</td>
<td>FNP</td>
<td>CIV</td>
<td>2</td>
<td>PROC 0.1</td>
<td>0.1</td>
<td>0.9</td>
<td>832</td>
<td>990</td>
<td>158</td>
<td>1080</td>
</tr>
<tr>
<td>BAKER</td>
<td>PA</td>
<td>CON</td>
<td>2</td>
<td></td>
<td>0</td>
<td>1</td>
<td>962</td>
<td>1,100</td>
<td>138</td>
<td>1200</td>
</tr>
<tr>
<td><strong>TOTAL TEAM ONE CAPACITY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>0.5</strong></td>
<td><strong>3.5</strong></td>
<td><strong>3,537</strong></td>
<td><strong>3,850</strong></td>
<td><strong>313</strong></td>
<td><strong>4200</strong></td>
</tr>
</tbody>
</table>
Effect of Increasing cFTE Benchmark

<table>
<thead>
<tr>
<th>Available Clinical FTEs (c-FTEs)</th>
<th>Future Capacity cFTE * 1100</th>
<th>Future Capacity cFTE * 1200</th>
<th>Future Capacity cFTE * 1300</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.85</td>
<td>935</td>
<td>1020</td>
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<td>825</td>
<td>900</td>
<td>975</td>
</tr>
<tr>
<td>0.90</td>
<td>990</td>
<td>1080</td>
<td>1170</td>
</tr>
<tr>
<td>1.00</td>
<td>1100</td>
<td>1200</td>
<td>1300</td>
</tr>
<tr>
<td>3.50</td>
<td><strong>3850</strong></td>
<td><strong>4200</strong></td>
<td><strong>4550</strong></td>
</tr>
</tbody>
</table>

To accommodate the goal of an average of 1100 per assigned FTE, commands will need to increase providers panels to accommodate providers with significant deductions.
Enrollment Adjustments

• For LOWER than calculated capacity:
  o Amortize proportionally across panels
  o Keep panels open but incrementally open so they fill equally

• For HIGHER than calculated capacity (typically a temporary issue):
  o Potentially close enrollment for over-enrolled provider
  o Allow drift down/attrition
  o Use Overseas Contingency Operations (OCO), temp/term civ, borrowed labor, reservist
  o Transfer patients to another Medical Home with capacity
Common Pitfalls Affecting Success
Pitfall #1: “Must-sees”

• MHP defn: recruits, students, foreign nationals, OCONUS DoDDS, etc – those without inherent medical assets

• Different from Tricare Business Plan definition – all Ops Forces

• Obtain numbers from units OR obtain “non-enrolled” primary care visits from M2 (face-to-face visits, excluding tcons, specs, procs, imms) in last year / 4 = swag # must sees
Account for Must-Sees in Enrollment

• MTF in question has following patients:
  o 5,000 TRICARE enrollees
  o 3,500 must-sees (DoD school teachers)
  o Total population caring for = 8,500
  o Ratio of 60% enrollees and 40% must-sees

• Staffing:
  o 6 Physicians; 2 Nurse Practitioners; 2 Physician Assistants

• Given size and staffing, 2 Medical Home Port teams is appropriate
## Medical Home Port Teams 1000/FTE

<table>
<thead>
<tr>
<th>Provider</th>
<th>c - FTE</th>
<th>Enrollees</th>
<th>Must-Sees</th>
<th>Total Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>0.6</td>
<td></td>
<td></td>
<td>600</td>
</tr>
<tr>
<td>Physician</td>
<td>0.9</td>
<td></td>
<td></td>
<td>900</td>
</tr>
<tr>
<td>Physician</td>
<td>0.8</td>
<td></td>
<td></td>
<td>800</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>1.0</td>
<td></td>
<td></td>
<td>1,000</td>
</tr>
<tr>
<td>Physician Asst</td>
<td>1.0</td>
<td></td>
<td></td>
<td>1,000</td>
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<tr>
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<td>1.0</td>
<td></td>
<td></td>
<td>1,000</td>
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<tr>
<td>Physician Asst</td>
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### Medical Home Port Teams 1,000/FTE

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<th>Total Panel</th>
</tr>
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<tbody>
<tr>
<td>Physician</td>
<td>0.6</td>
<td>360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>0.9</td>
<td>540</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician</td>
<td>0.8</td>
<td>480</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>1.0</td>
<td>600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Asst</td>
<td>1.0</td>
<td>600</td>
<td>400</td>
<td>1,000</td>
</tr>
</tbody>
</table>

Think about how you could queue must-sees to provider in pseudo-PCM relationship.

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<td>540</td>
<td>360</td>
<td>900</td>
</tr>
<tr>
<td>Physician</td>
<td>0.8</td>
<td>480</td>
<td>320</td>
<td>800</td>
</tr>
<tr>
<td>Physician</td>
<td>0.9</td>
<td>540</td>
<td>360</td>
<td>900</td>
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<td>1.0</td>
<td>600</td>
<td>400</td>
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<td>1.0</td>
<td>600</td>
<td>400</td>
<td>1,000</td>
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</table>

**Totals**

5,440 | 3,460 | 8,900
Pitfall #2

• Analyze how many non-enrolled patients you are seeing that you should not be (std, network) and if significant numbers, invite for enrollment.
• Does practice have room for Space-A patients?
• Command policy for Space A patients?
Pitfall #3

• Hiring Overseas Contingency Operations (OCO) backfills and enrolling a panel to them in addition to covering the deployed person’s panel.

• Consider transferring enrollment if > 6 months coverage
Pitfall #4

• Enrolling PCMs at one site to their maximum availability then using them at multiple clinics
• Alters their availability to continuity practice
Final Step: Execute!

- Confounding variables to be addressed:
  - Age and gender mix
  - Chronic Disease burden
  - Special populations (OB, infants)
  - Business rules
  - Does actual practice = model assumptions?
  - Team-based practice?
  - Provider behaviors?
Questions?