



# **Efficiency Strategies in Primary Care**

Achieving the Promise of Value-based Medicine through  
Strict Adherence to the Incentives Engendered by  
Capitation

**COL Richard Malish**  
Chief of Staff and Military Deputy  
Assistant Secretary of Defense for Health Affairs

June 23, 2022  
1130-1230 ET

# Purpose

---

**To inform Clinical Communities  
teammates on the results of The Central  
Texas Market's conversion to QUiC  
clinics as a primary care methodology**

UNCLASSIFIED



*Medically Ready Force... Ready Medical Force*



# Presenter

---

**Army Col. Richard G. Malish, M.D.,  
M.B.A., F.A.C.P., F.A.C.C.**

Chief of Staff and Military Deputy

Assistant Secretary of Defense for Health Affairs

UNCLASSIFIED



*Medically Ready Force... Ready Medical Force*



# Army Col Richard G. Malish, M.D., M.B.A., F.A.C.P., F.A.C.C.



COL Rich Malish graduated from Johns Hopkins University with a B.S. Biology. He then earned his Doctor of Medicine degree from the Uniformed Services University of the Health Sciences.

After graduation, he completed a transitional internship at Madigan Army Medical Center before embarking on a career that mixed academic and operational experiences.

COL Malish graduated from Brooke Army Medical Center's Internal Medicine Residency, earning honors as the "Most Outstanding Senior Resident." He then trained in Cardiology at Walter Reed Army Medical Center.

Other academic highlights include earning Master's degrees in Military Arts and Sciences and in Business Administration from the Command and General Staff College. Additionally, he was awarded the General George C. Marshall (White Briefcase) Award identifying him as the Distinguished Graduate. He then attended the Army War College where he was a Distinguished Graduate and winner of the Army War College Foundation Award for Outstanding Program Research Project.

In operational endeavors, COL Malish was the Battalion Surgeon for 3rd Battalion, 5th Special Forces Group (Airborne). He served as Brigade Surgeon for the 173rd Airborne Brigade and accompanied his unit on its combat deployment to Iraq.

After his deployment, COL Malish was assigned to Womack Army Medical Center where he served as the Chief of Cardiology Testing. He deployed to Honduras as a flight surgeon. COL Malish's next operational assignment was with the 3rd Infantry Division Surgeon where he returned to Iraq for a second deployment.

Prior to accepting command at Carl R. Darnall Army Medical Center, he served as the Army Surgeon General's Deputy Chief of Staff for Quality and Safety.

COL Malish is board certified in Internal Medicine and Cardiology. He is the lead author of several articles in operational medicine, and he has received numerous awards and badges throughout the years.

UNCLASSIFIED



*Medically Ready Force... Ready Medical Force*



# Disclosures

- COL Richard Malish has no relevant financial or non-financial relationships to disclose relating to the content of this activity.
- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of Defense, nor the U.S. Government.
- This continuing education activity is managed and accredited by the Defense Health Agency, J-7, Continuing Education Program Office (DHA, J-7, CEPO). DHA, J-7, CEPO and all accrediting organizations do not support or endorse any product or service mentioned in this activity.
- DHA, J-7, CEPO staff, as well as activity planners and reviewers have no relevant financial or non-financial interest to disclose.
- Commercial support was not received for this activity.

UNCLASSIFIED



*Medically Ready Force... Ready Medical Force*



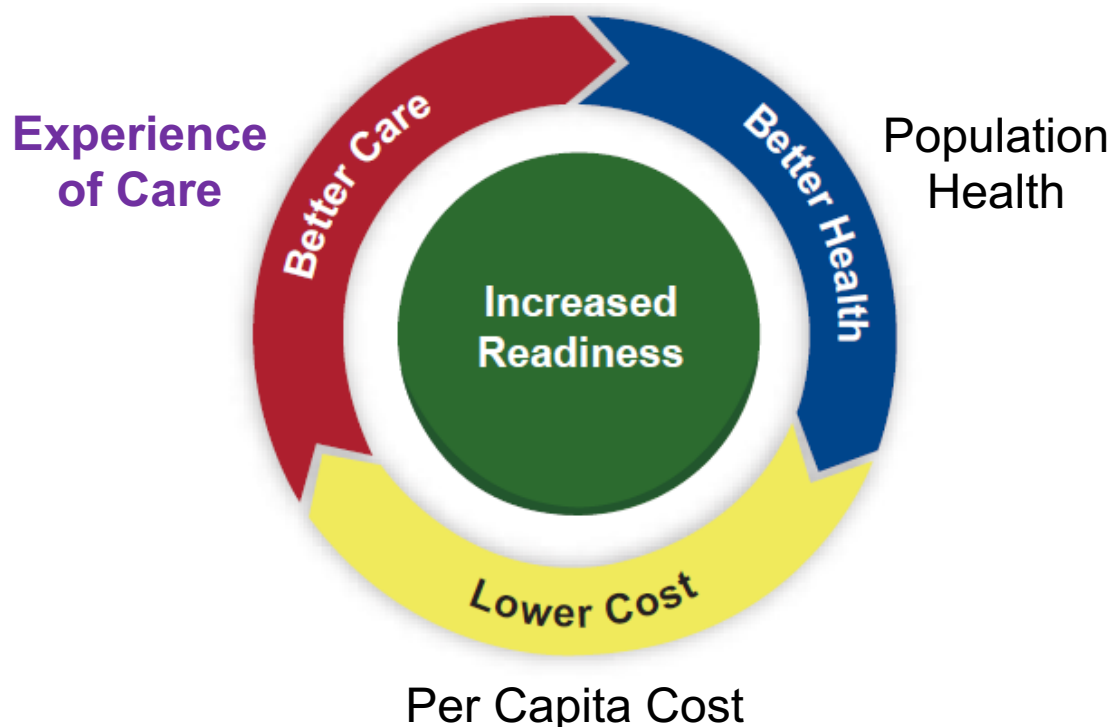
## ACRONYMS

- RVU – Relative Value Units
- R&A – Review and Analysis
- EHR – Electronic Health Record
- AHLTA – Armed Forces Health Longitudinal Technology Application
- PCMH – Patient-Centered Medical Home
- FFS – Fee for service
- UCC – Urgent Care Center
- HEDIS – Healthcare Effectiveness Data and Information Set
- SMS – Short Message Service
- TCON – Teleconference
- PI – Performance Improvement
- ATC – Access to Care
- VH – Virtual Health
- PCM – Patient Care Management
- SOUTHCOM – United States Southern Command
- OPOD – Operations Order
- WKMH – West Killeen Medical Health
- MEDCEN – United States Army Medical Center
- SCMH – Army Soldier Centered Medical Home
- CBMH – Community Based Medical Home
- ED – Emergency Department
- ICU – Intensive Care Unit
- L&D – Labor and Delivery
- SRU – Soldier Readiness Unit
- EMS – Emergency Medical Services
- OR – Operating Room
- BH – Behavioral Health
- MOE – Measure of Effectiveness
- MPT – Meaningful Patient Touches
- MOP – Measure of Performance
- EOD – End of Day
- CRDAMC – Carl R. Darnall Army Medical Center
- CCMH – Copperas Cove Medical Health
- KMH – Killeen Medical Health
- HHMH – Harker Heights Medical Health
- RCHC - Russell Collier Health Clinic
- FTR – Future Appointment

At the end of the activity, the learners will be able to:

1. Recognize how the Quadruple Aim is best achieved, in primary care, by fully embracing the behaviors encouraged by the capitation reimbursement model.
2. Explain how primary care clinics can optimize value-based metrics by adopting the QUiC Clinic model (Quality, Urgent, internet & phone Care).
3. Describe how providing urgent care at primary care clinics can offload a hospital's Emergency Department and ancillary services.

1. **QUiC Tenants**
2. The Central Texas Market QUiC experience
3. Tracking QUiC
4. Secondary QUiC benefits



- **Population Health:** Improving the health of a population by encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience.
- **Experience of Care:** Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe and always of the highest quality.
- **Per Capita Cost:** Creating value by focusing on quality, eliminating waste, and reducing unwarranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

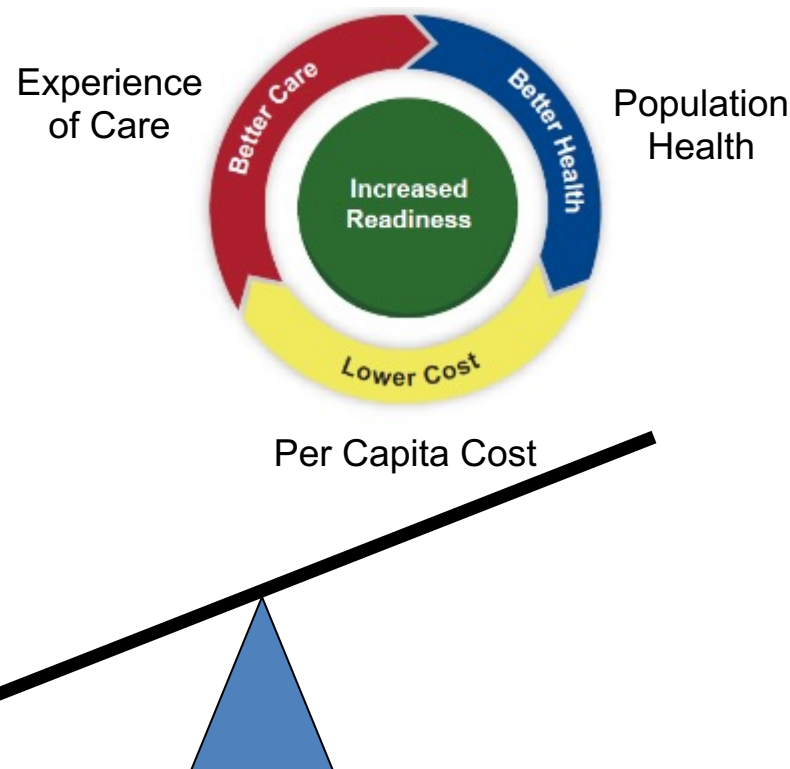
# The Problem that QUiC Solves

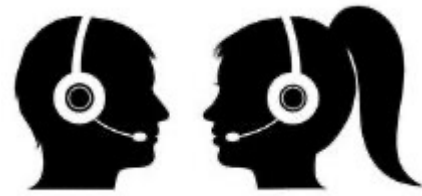
**We 'balance' the Quad Aim with Productivity.**

**Our system has been built to  
incentivize Productivity primarily.**

## **Productivity**

1. RVUs encouraged. (R&As, etc.)
2. EHR (AHLTA) built to encourage coding & productivity.
3. Classes on coding for max value.
4. Templates: Mostly Face to Face (F2F) Appointments (High RVUs)
5. All appointments filled (High RVUs).
6. No-shows are 'bad' because they reduce productivity





Selective  
flow

Easy Flow





















































































## Max RVUS

### PROBLEM

Our system values the use of provider time for use in face-to-face visits (**maximum RVUs**). This is manifested by a rigid templating system that directs the vast majority of provider time to seeing patients. Little time is provided for **HEDIS, SMS, TCONs, or availability of providers for WALK-INS**. Because these items are all emphasized **secondarily**, they are inconsistently attained. Providers become exhausted and turn-over is high.

day  
start

Mon	Tue	Wed	Thu	Fri
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	 20
 20	 20	 20	 20	
 20	 20	 20	 20	ADMIN  PI meetings training
 20	 20	 20	 20	
 20	 20	 20	 20	
 20	 20	 20	 20	
 20	 20	 20	 20	
 20	 20	 20	 20	
 20	 20	 20	 20	

day  
end

Legend



Acute




Routine



Virtual  
Care

**PCMH: We are Built**  
(in terms of templates)  
For FFS

X  Walk-ins?

**UCC (Urgent Care Center)**

**Keep Happy ?**

**See Rarely ?**

X  HEDIS?  
SMS?  
X  TCONS?

Burn-out



Victim of the 'cage'



1. Our goal is to create clinics that **embrace** Quality (Better Health)...
2. ...& have Urgent care features so that they can **always see the sick.** (Better Care)
3. We achieve this goal by shifting routine appointments into the **virtual space** (internet & phones). (Lower cost)

**Q**  
**U**  
**i**  
**C**are

3.  
2.  
1.

Quality Care



+

Urgent Care



+

internet & phone Care



We're  
TURNING



~Because we're Obsessed with your health~

## How QUiC is Different

A daily template.

### Current

1. High RVUs. System is built for productivity. Max billing.
2. Clinic time is fully 'caged' by templates (17/4 or 21)
3. Clinics are fully booked because F2F appointments are the predominant way to get care
4. Appointment slots dictate time used per patient (a 5 min problem costs 20 mins)
5. All PCM time is used for F2F appointments; little incentive to direct patients to virtual appointments
6. Sick patients cannot get in.
7. 'Routine' patients get care in the clinic.
8. Backlogged patients put into the template cage perpetuates the problem

Time is  
'caged' by  
the  
Template  
Cage

UCC



X

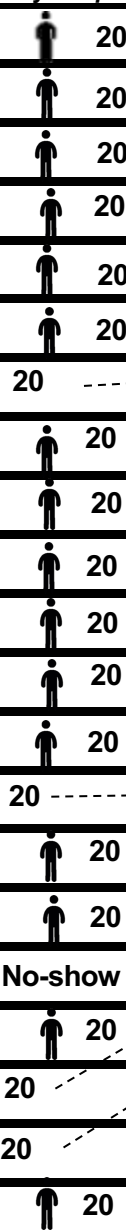


X

ED



X



20 patients seen  
0 Sick patients  
seen

### Virtual + Urgent Care

1. Lower RVUs. System is built for value (ATC, satisfaction, quality).
2. Clinic time is 'protected' to manage virtual visits and to see acute care visits.
3. Clinics don't require 21/17 F2F appointments because patient needs dictate how problems are managed (VH vs. F2F).
4. Patient needs dictate time used per patient (a 5 min problem costs 5 mins)
5. Because very little PCM time is 'saved' for F2F appointments, there is a lot of incentive to direct patients to virtual appointments
6. Priority is seeing sick patients
7. 'Routine' patients get care at home or at work. Prevention.
8. Backlogs don't develop because more patients are 'touched.' Trade RVUs for 'touches!'

Time is  
protected  
HEDIS

White  
Space  
Win!  
Win!

White  
Space  
Win!

HEDIS

### Legend



Unscheduled  
Sick patient

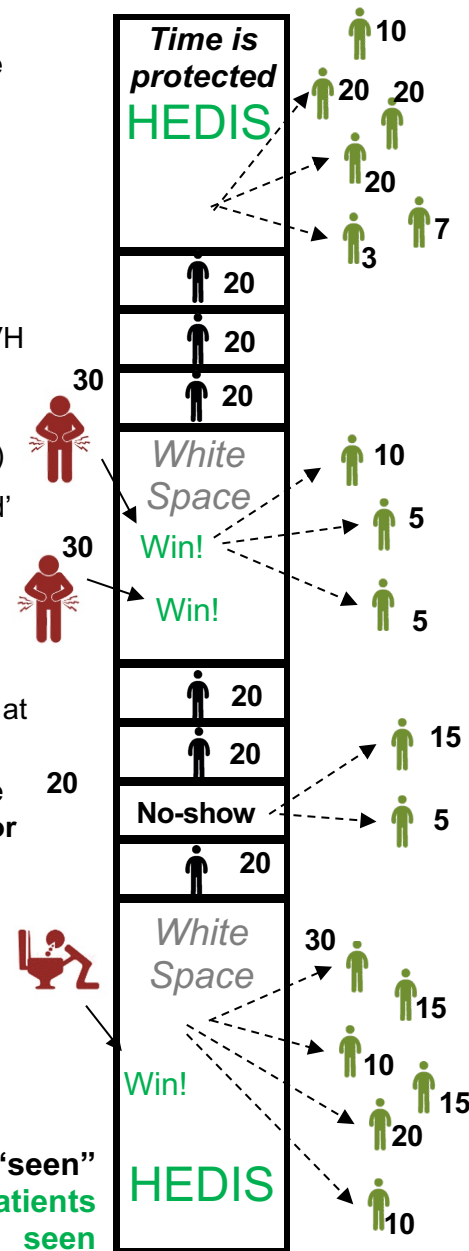


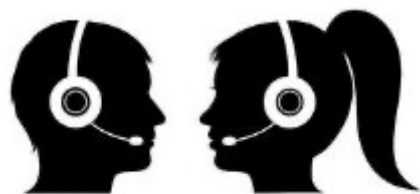
Scheduled  
visit



Virtual  
Care

26 patients "seen"  
3 Sick patients  
seen





Easy Flow

Selective flow



White Space

Mon	Tue	Wed	Thu	Fri
20	20	20	20	White Space
20	White Space	20	20	SMS
20	HEDIS SMS	20	20	
20		20	20	
20		20	20	
20		20	20	
20		White Space	20	20
20		VH	20	20
20			20	20
20			20	20
20			20	20
20			20	20
White Space	20	TCONS	20	White Space
TCONS	20		20	20
	20		20	20
	20		20	20
	20		20	20
	20	20	White Space	20
HEDIS SMS	20	20	TCONS	20
	20	20		20
	20	20		20
	20	20		20
	20	20		White Space
HEDIS SMS	20	20		HEDIS
	20	20	TCONS	White Space
	20	20		
	20	20		
	20	20		

## SOLUTION

### Urgent Care Non-F2F Care Quality Care

We must create a system that protects provider time and allocates it to the things that are valued in a capitated system (**access, satisfaction, and quality**). This is achieved by directing all information-exchange appointments to TCONS and SMS, adapting templates, and using the freed time to seeing sick patients and getting after quality metrics.



PCMs actually manage their populations



See Rarely  
Keep Happy

Capacity for walk-ins,  
acutes, urgent care visits

Keep Happy

TCONS

HEDIS  
SMS

White Space

VH

TCONS

SMS

White Space

HEDIS

A Pilot was already completed at SOUTHCOM

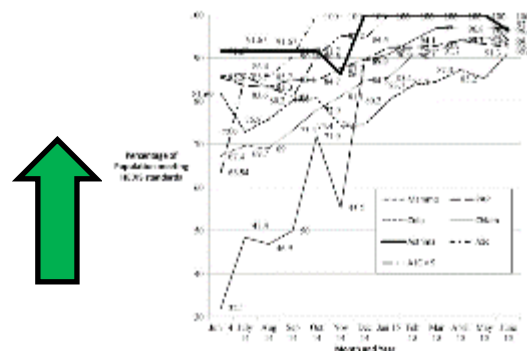
MILITARY MEDICINE, 181, 10:1228, 2016

## Capitation as an Incentive for Transitioning to Patient-Centered Medical Homes in the United States Army: A Brief Report

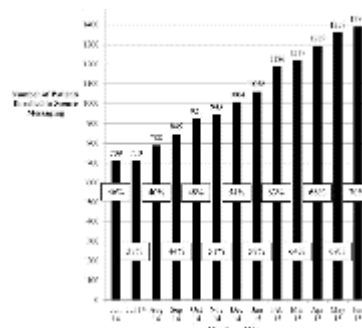
COL Richard G. Malish, MC USA

**ABSTRACT** The Army transitioned to a Patient-Centered Medical Home concept for primary care beginning in 2011. In spite of organizational commitment to the paradigm, the transition has not been without pitfalls. This performance improvement project operated under the hypothesis that focusing on the market-based incentives of a capitated system would result in a quantum leap toward the Patient-Centered Medical Home ideal. Utilizing a simple teaching device to repetitively highlight clinic and provider behaviors incentivized in a value-based payment system, a single clinic achieved significant improvements in enrollment, patient satisfaction, and measures associated with prevention while assuming an identity as a "virtual clinic". We recommend that the military consider a similar philosophy in educating clinics across the enterprise.

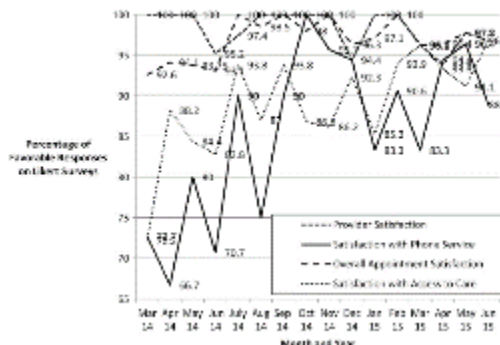
### HEDIS Measures\*



### Secure Messaging\*



### Patient Satisfaction\*



*\*Please remember these patterns!*

### 1. Enroll Many

### 2. Keep Happy

### 3. See Rarely

Goals		Imperatives		Tasks	
1	Enroll Many	1	Build the facility and process to work at the highest efficiency	1	Convert administrative space into clinical space. Create workflow so that providers can see many patients sequentially.
				2	Use technology to maximize provider output (WI-FI, tablets, rolling workstations, etc.). Remove provider "anchors" (offices, desktop computers, individualized exam rooms). Displace providers and ancillary staff to team rooms.
				3	Adopt team-based care. Empower clinical teammates to screen patients, chart, use computer systems, enter orders, and handle routine patient issues. <b>Engender in the team an identity as a busy call center, automated information exchange hub, and traditional clinic.</b> Teach communication techniques that allow multi-tasking.
				4	Offload providers by ensuring that teammates work at the top of their credentials.
2	Keep them happy	2	Always see the sick	5	<b>Never turn a sick patient away.</b> Create templates to contain enough flexibility to ensure that patients can be seen when acutely ill or injured.
		3	Empower the front desk to provide great customer service	6	Understand that the front desk is the clinic's interface with patients. Resource it to manage their needs quickly and efficiently. <b>A responsive, empowered, and courteous front desk creates a brand and is a game-changer for patient satisfaction.</b>
				7	Create phone trees that route calls to administrative leaders. Leaders must be actively involved with the front desk. Failure to do so permits a blind spot in a function vital to the clinic's success.
				8	Deliberately assign a clinical subject matter expert to reside at the front desk. This allows the front desk to identify which patients must be seen acutely.
3	See them rarely	4	Commit to a virtual environment for information exchange	9	Free up space in templates by managing all information-sharing requirements and communications by telephone and secure messaging.
				10	<b>Budget adequate time in providers templates to handle virtual communication (2-4 hours).</b> Virtual communication is not an 'add-on' to be completed at the end of the day - but a regularly scheduled process.
				11	Create processes and products that direct patients to virtual resources. Enroll patients into internet-based resources (secure messaging, online appointment scheduling, finding lab values and referral results) while in clinic. Demonstrate use. Provide instructions for home use.
		5	Adopt "prevention!" as the clinic's rallying cry	12	Understand that patients who lead healthy lifestyles will not be high utilizers of health care.
				13	Dedicate time to educate patients on the benefits of sleep, activity, and nutrition.
				14	Prevent long term morbidity and mortality. <b>Obsess about metrics that indicate quality in health screening and management of chronic disorders.</b>



## #4 Simple Actions

1. Shift routine appointments into the virtual space (**internet & phones**).
2. Use extra time for **urgent care** visits
3. Use extra time to obsess about **HEDIS**
4. (Provide **GREAT customer service**)

### 100% MUST-DOs

Teams must achieve these MUST-DOs before all else



#### 100% MUST-DOs

1. Always see the sick
2. Empower the front desk to provide GREAT customer service
3. Commit to a virtual environment for information exchange
4. Obsess about HEDIS (Top 10%)



#### We're Turning QUIC



Same Day  
Appointments



Urgent Care  
Services



Maximized  
Virtual Care

**Q** = *Quality*

**U** = *Urgent*

**i** = *internet & phone*

**C** = *Care*

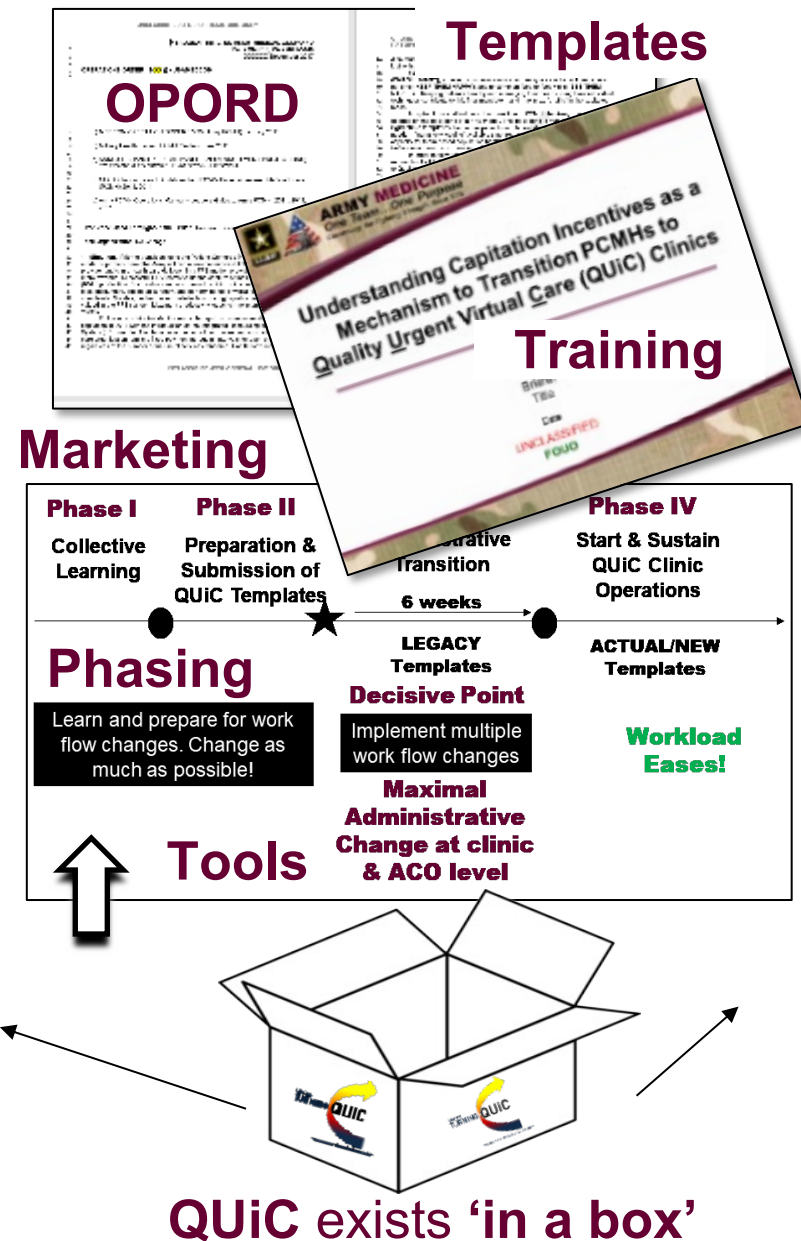
Because We're Obsessed  
with Your Health



Carl R. Darnall Army Medical Center Public Affairs Office CRDAMC HO ??? (11 Nov 19)

## QIiC-in-a-Box

1. Operationalize and Articulate Value-based incentives. ✔ Done!
2. Complete a pilot of value-based incentives (SOUTHCOM Clinic). ✔ Done!
3. Document success or failure. ✔ Done!
4. Learn from the pilot ✔ Done!
5. Create an OPORD to scale the process ✔ Done!
  - DRAFT OPORD '**box**' includes methodology, training, template tools, etc.
  - QIiC transition occurs in deliberate **phases (I-IV)**
6. Validate by testing in a new market (WKMh) ✔ Done!
7. Learn and move forward.



### Primary Care (12 homes)


(Referrals Generated)

**Monroe SCMH**  
(9730)  
1/1 ABCT 2/1 ABCT  
1 CD

**Copperas Cove CBMH**  
(6150)

**Bennett SCMH**  
(10041)

**Russell Collier CBMH**  
(11003)


**TMC 12 SCMH**  
(2859)  
1 CD CAB

**West Killeen CBMH**  
(7207)

**Thomas Moore SCMH**  
(10597)  
1 CD SB

**Killeen CBMH**  
(6226)

**Harker Heights CBMH**  
(7523)

**Internal Medicine PCMH**


**Pediatrics PCMH**

**Family Medicine Residency PCMH**


**Embedded Behavioral Health**

### Tertiary Care (MEDCEN)

(Referrals Seen)



- Level III Trauma ED
- 8 Operating Rooms
- 6 ICU beds
- 32 Medical / Surgical beds
- 18 Behavioral Health beds
- Robust L&D capability
- Specialty Services



### Readiness Generators

**Soldier Readiness Unit**

**Integrated Disability and Evaluation System (IDES)**

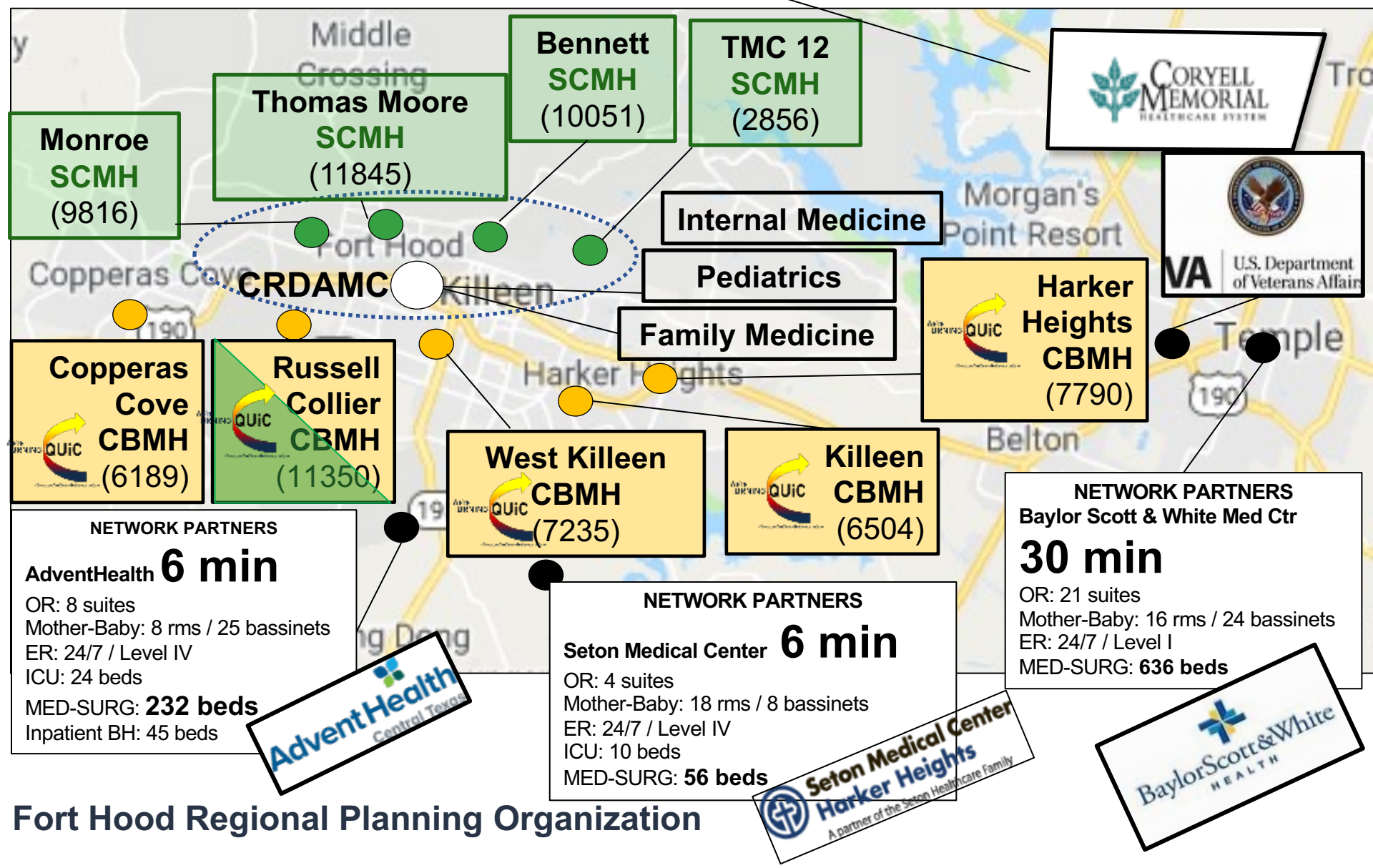
**Medical Support Unit**

Total Personnel 3,411

- 683 Military
- 128 SRU
- 2,200 Civilian
- 400 Contractors

**Prehospital EMS**





# Agenda

1. QUiC Tenants
2. The Central Texas Market QUiC experience
- 3. Tracking QUiC**
4. Secondary COVID benefits

Leading Measure of Performance:

1

Meaningful Patient Touches (MPTs) per day (MOP1)

7

Staff Satisfaction (MOP2)

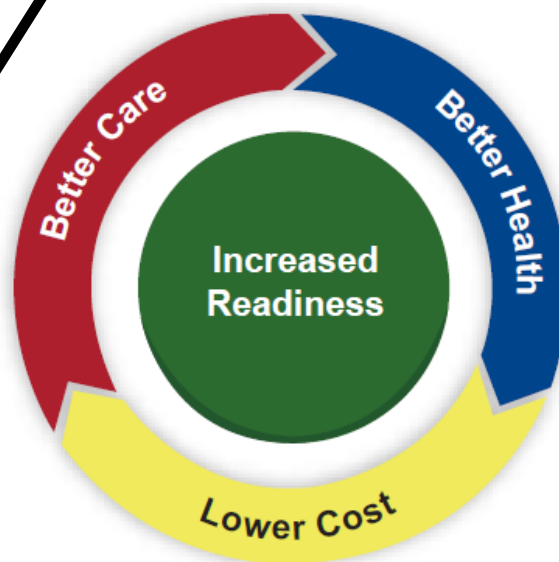
Experience of Care

2

Access to Care (MOE1)

3

Patient Satisfaction (MOE2)



Population Health

6

HEDIS (MOE5)

Per Capita Cost

4

Leakage (MOE3)

5

Enrollment (MOE4)

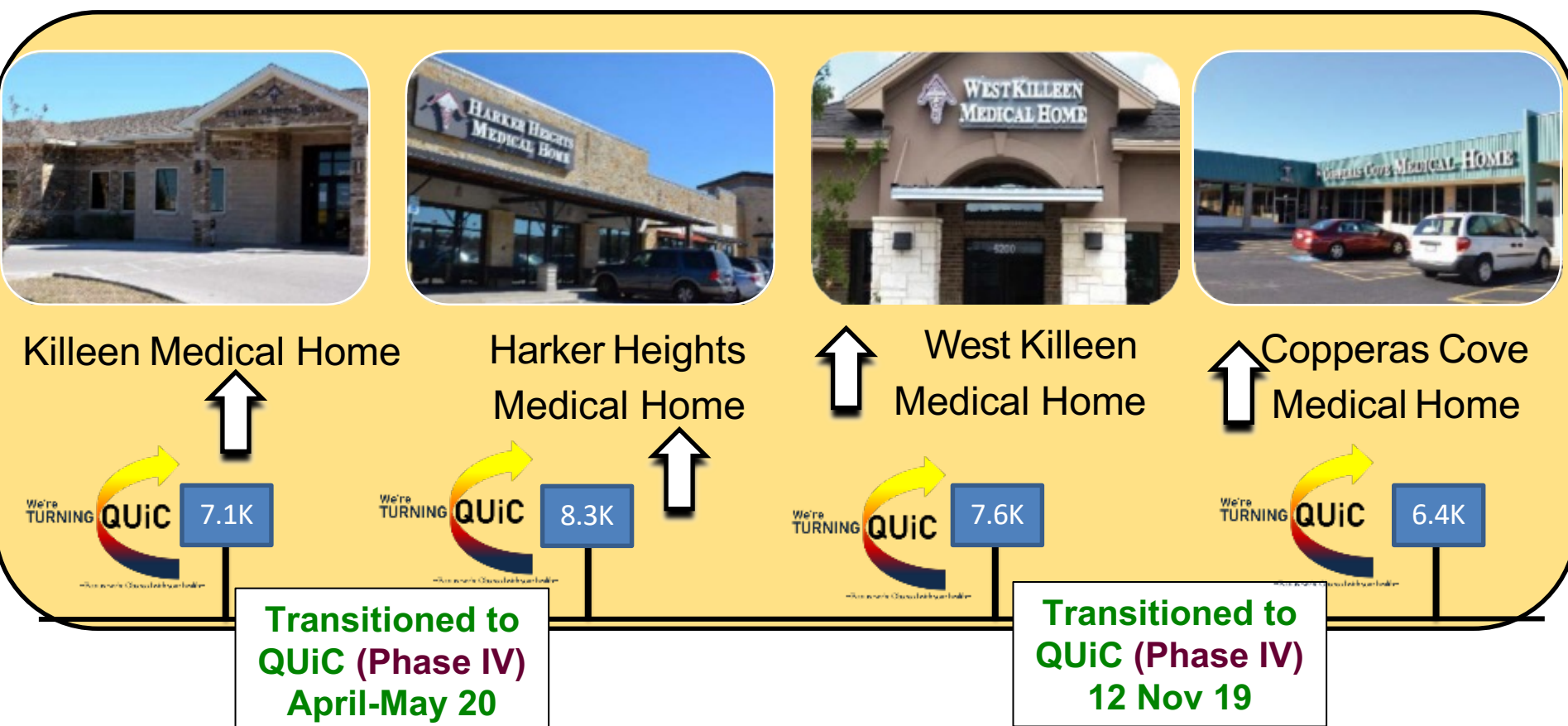
\*Note: **RVUs are not important.** QUiC strives to achieve the QUAD AIM – not to bill insurance. Our values determine our goals/metrics. Our care is value-based.

<https://health.mil/Reference-Center/Glossary-Terms/2013/04/09/MHS-Quadruple-Aim>, n.d.)

## Central Texas Market Community Based Medical Homes

**All clinics began Phase I: (Collective Learning) in Aug 19**

ENROLLED ADFM/RETIREE/RETIREE FM ONLY



**Note: Changes in metrics manifest before official launch (Phase IV)**

1

Meaningful Patient Touches  
(MPTs) per day (MOP1)

Before

**136.6 MPTs/day**

74.7 Kept/day

67.4 i/day

0 Walk-in/day

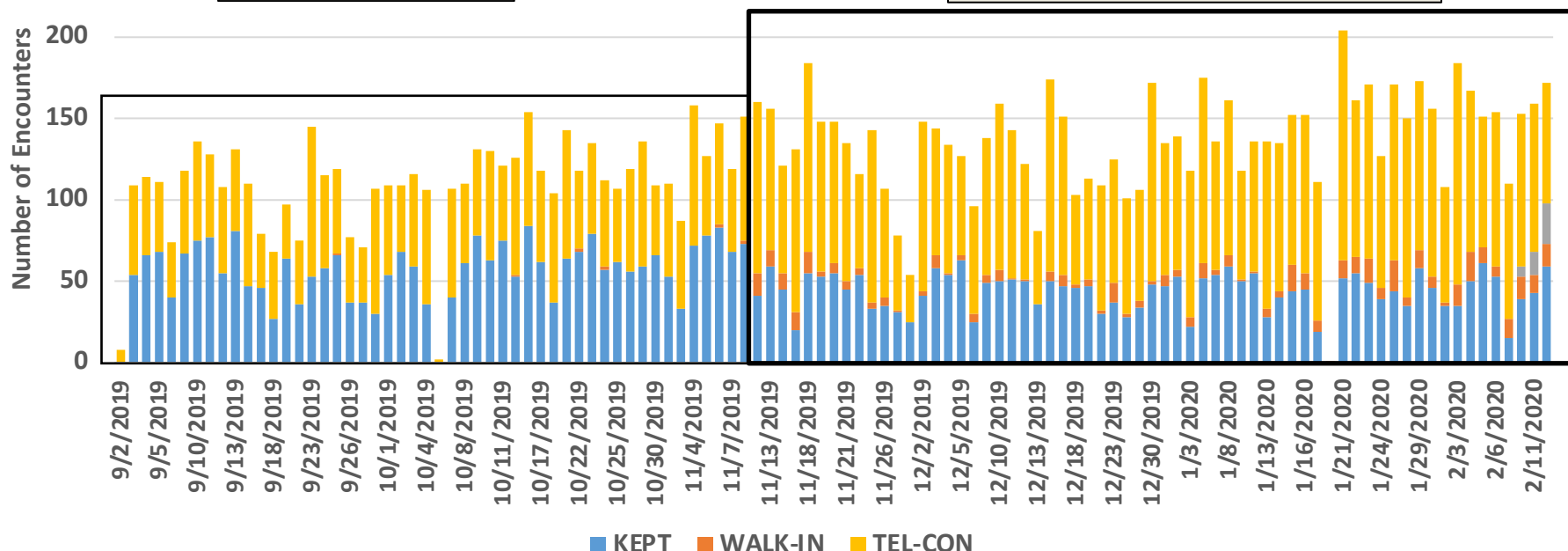
After

**159.2 MPTs/day**

53.1 Kept/day

98.6 i/day

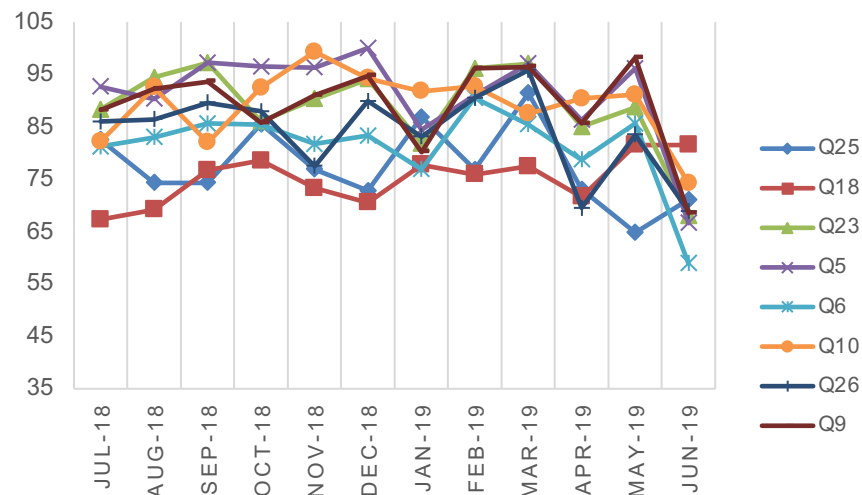
**8 Walk-in/day = urgent care**



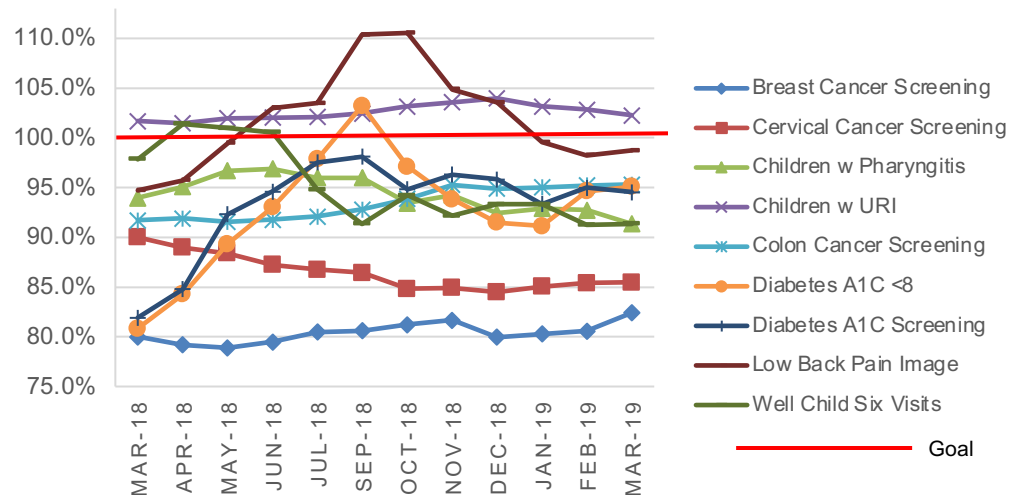
**Analysis** (*'This is what QUIC looks like in EOD reporting'*)

- Enabled the clinic to "meaningfully touch" 23 more patients per day.**
  - Reduced routine Face-to-Face appointments by 22/day
  - Increased internet and phone appointments by 31/day
  - Changed i/K ratio from 0.9 to 1.86
- Created a walk-in capacity that previously did not exist (8 patients per day).**

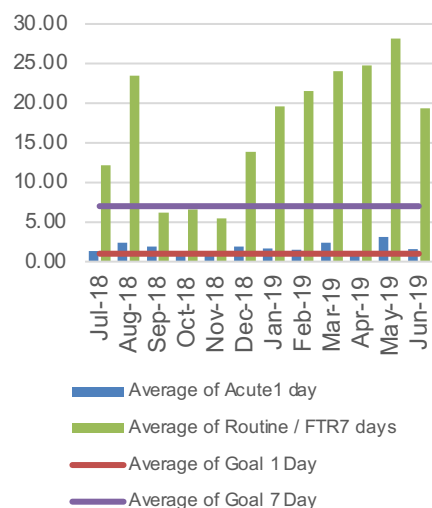
JOES



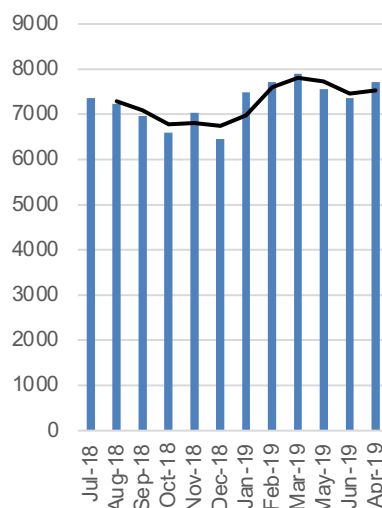
WKMh HEDIS



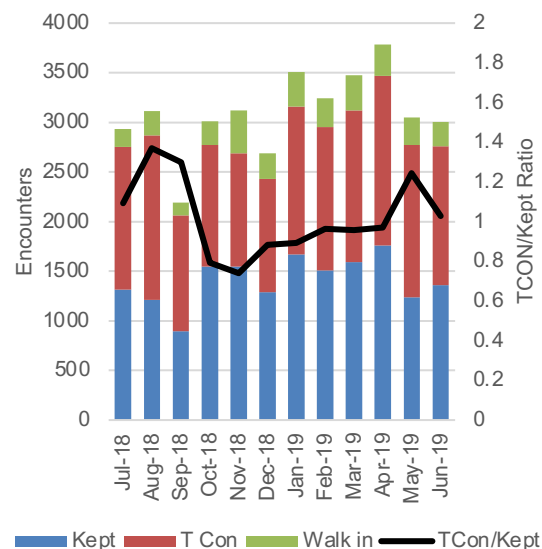
ATC



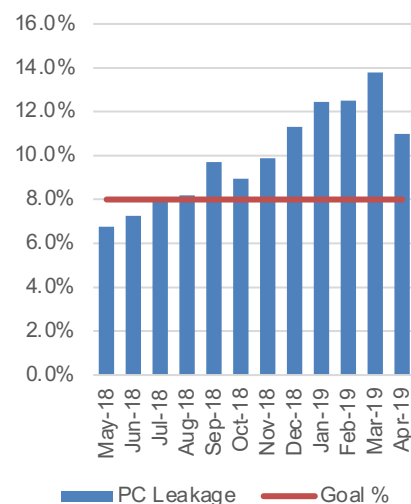
Enrollment



Appointment Data



Leakage



## **All CRDAMC Community Based Medical Homes**

1. West Killeen CBMH: transitioned Nov 2019
2. Harker Heights CBMH: transitioned April 2020
3. Killeen CBMH: transitioned April 2020
4. Copperas Cove CBMH: transitioned May 2020
5. Russell Collier CBMH: transitioned May 2020

**Earlier Homes are more 'QUiC' Advanced**



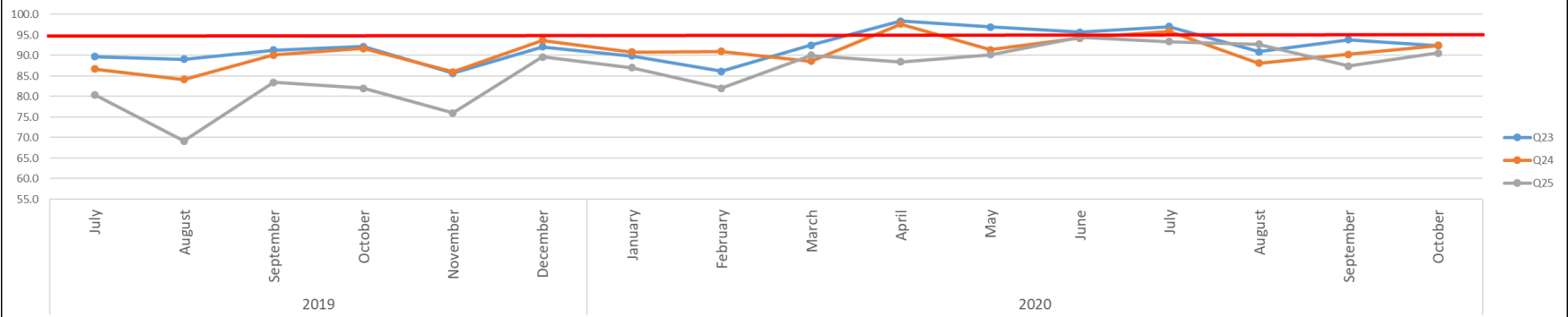


# ARMY MEDICINE

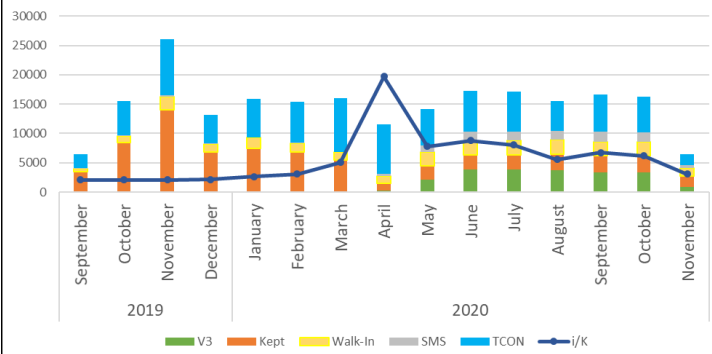
## Army Medicine... Army Strong

UNCLASSIFIED// FOUO  
CCMH, KMH, HHMH, WKMH,  
and RCHC

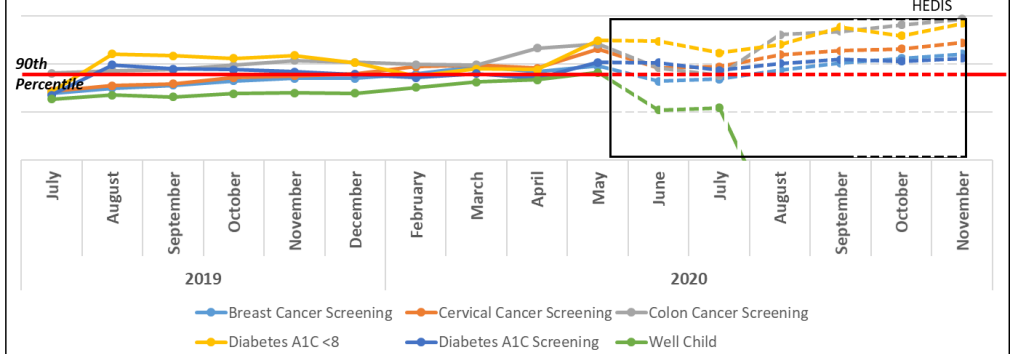
### JOES



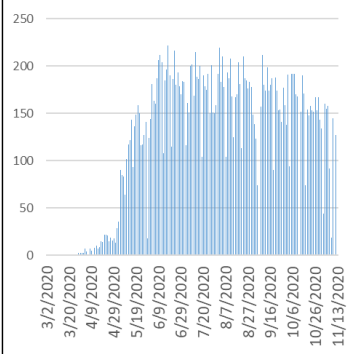
### Meaningful Touches



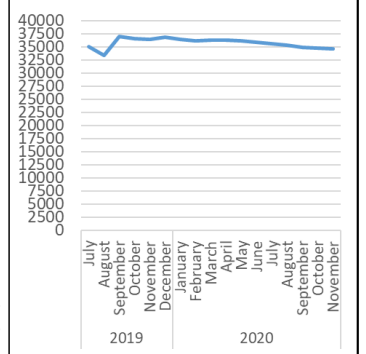
### HEDIS Trend



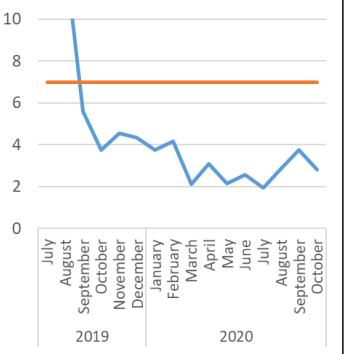
### Virtual Video Visits



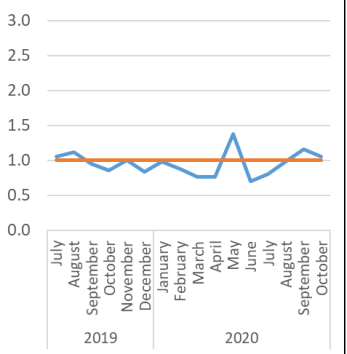
### Enrollment



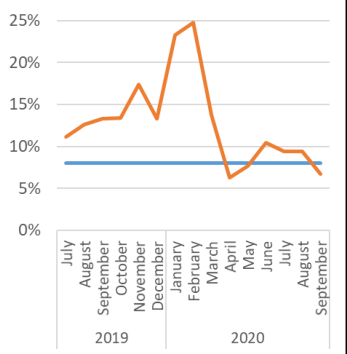
### FTR ATC



### 24HR ATC



### Leakage



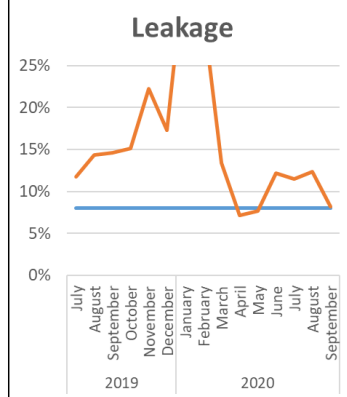
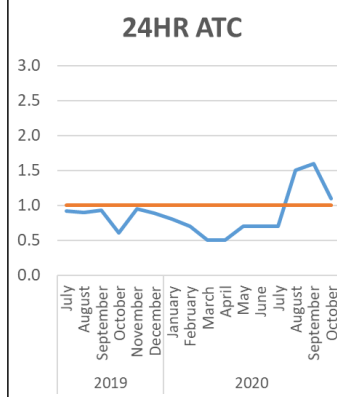
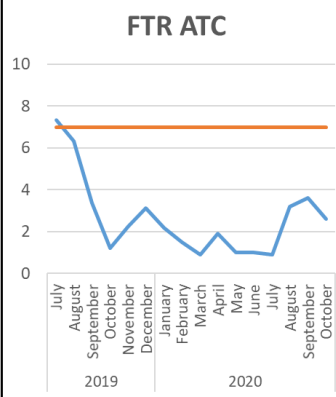
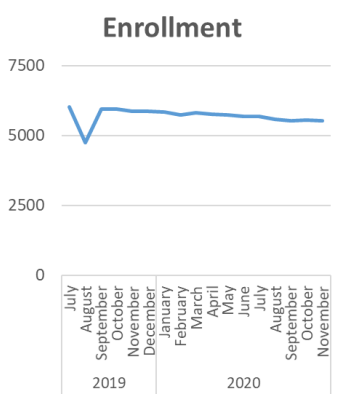
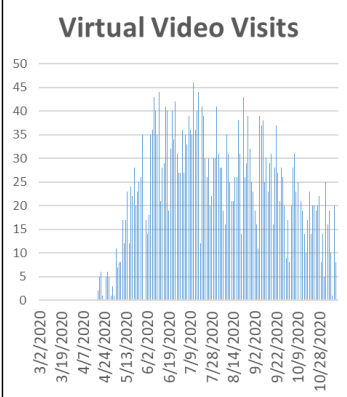
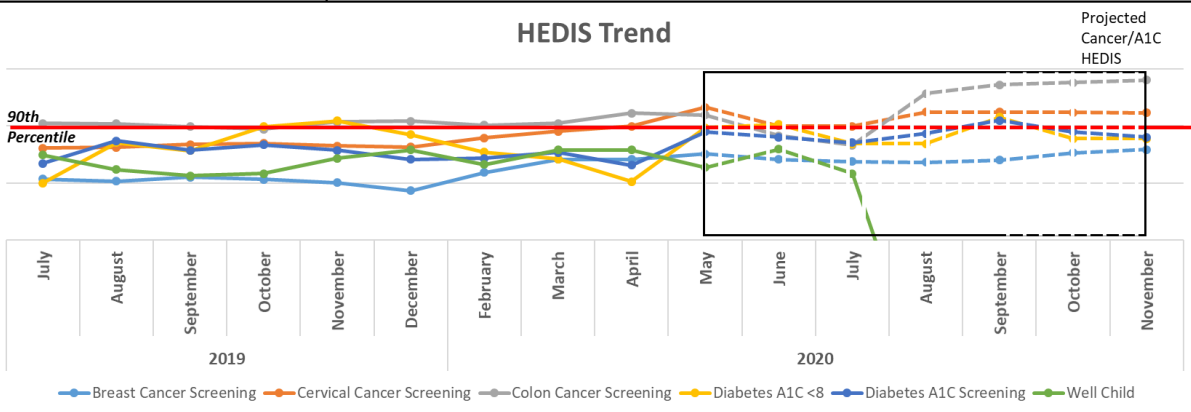
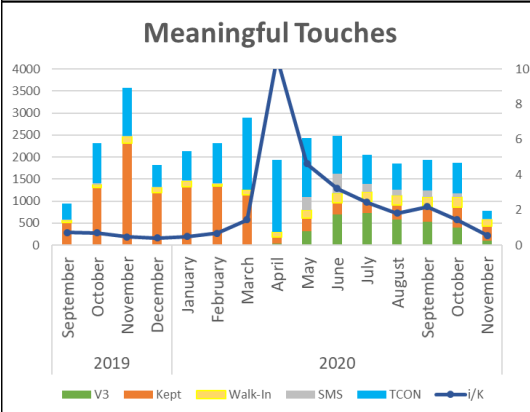
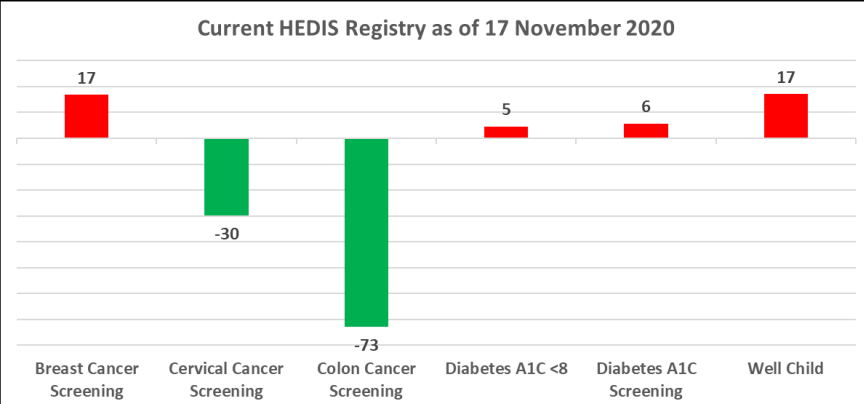
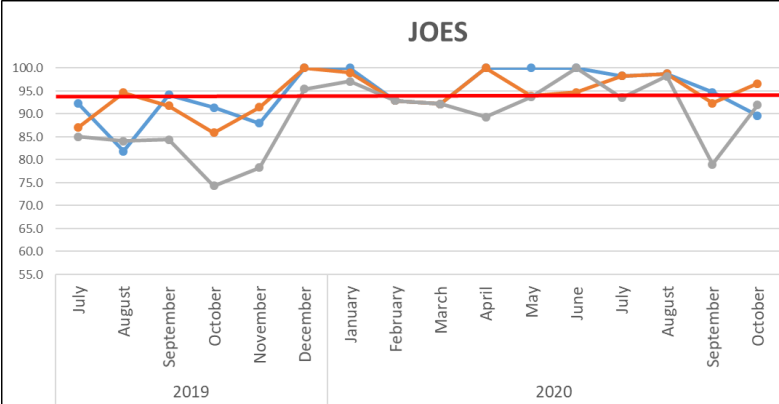


# ARMY MEDICINE

## Army Medicine... Army Strong

UNCLASSIFIED// FOUO

### Copperas Cove Medical Home



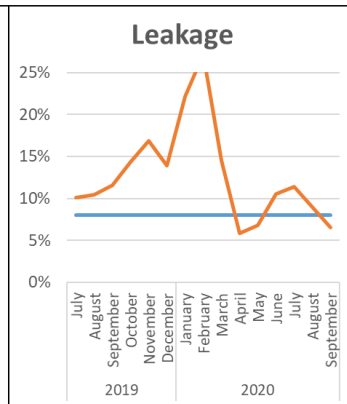
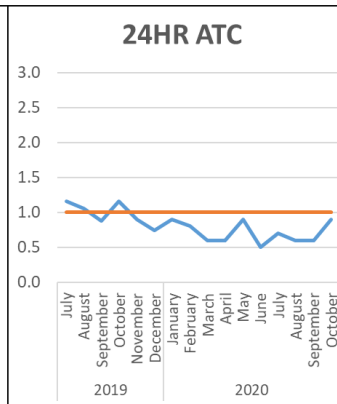
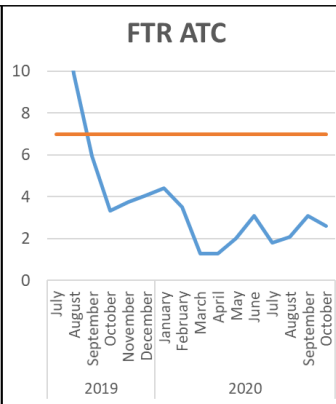
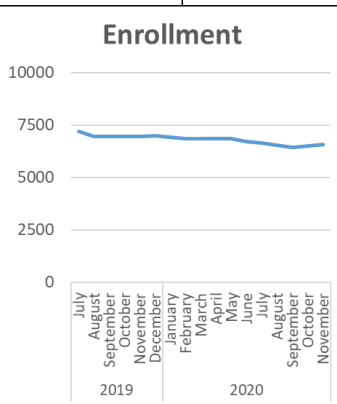
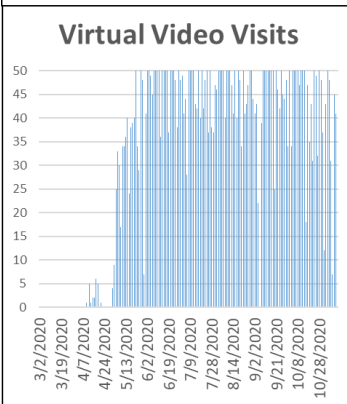
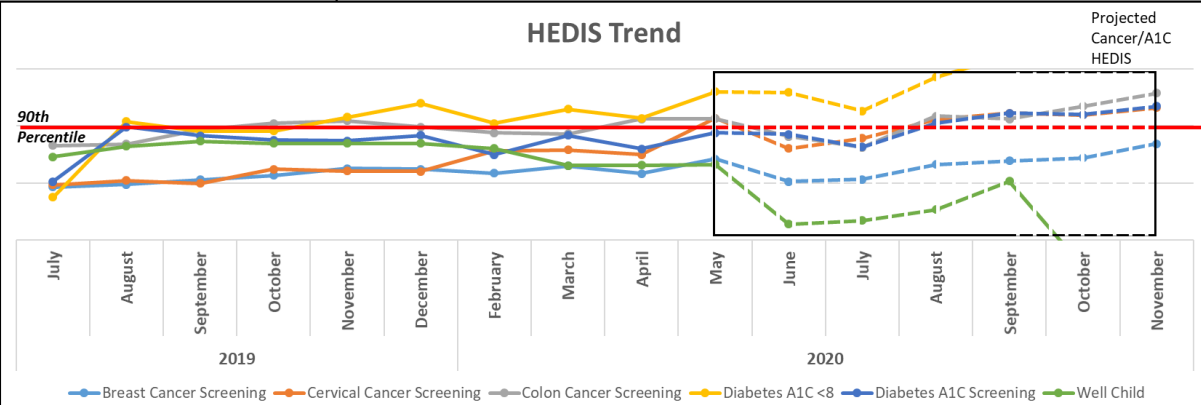
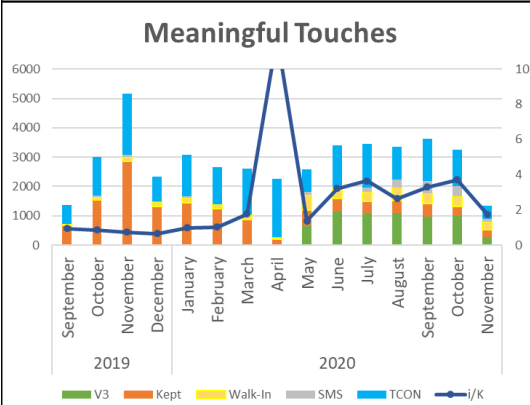
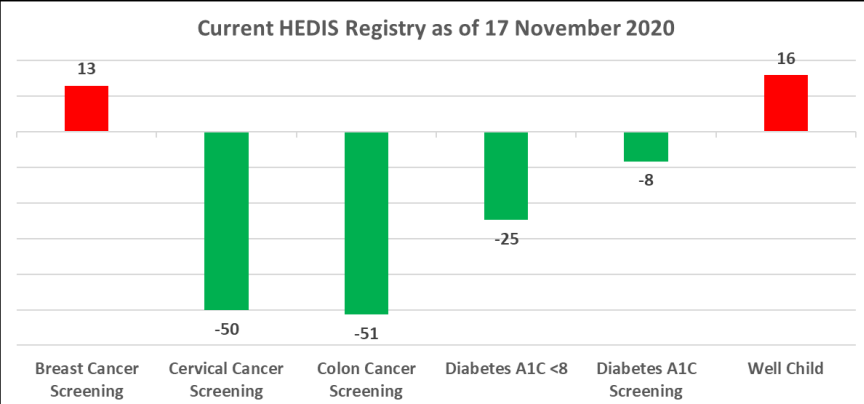
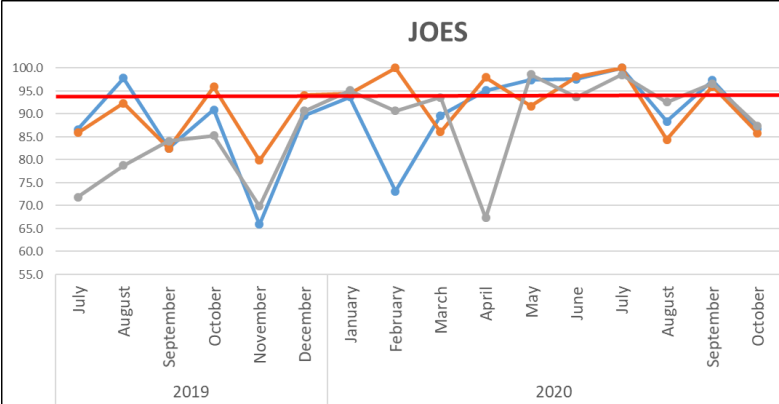


# ARMY MEDICINE

## Army Medicine... Army Strong

UNCLASSIFIED// FOUO

### Harker Heights Medical Home



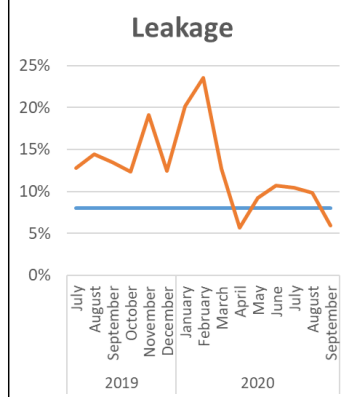
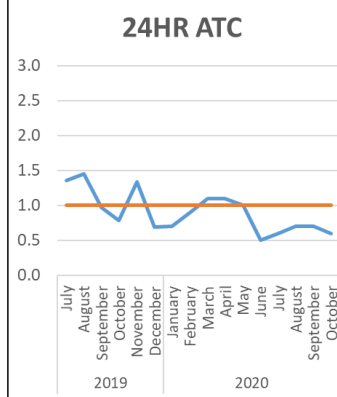
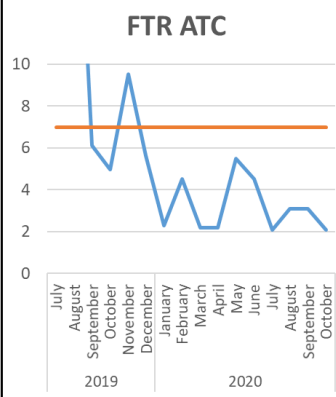
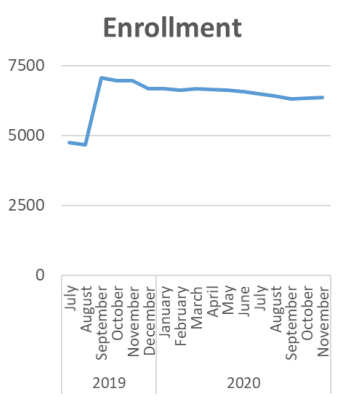
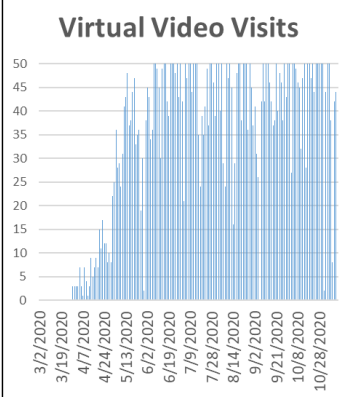
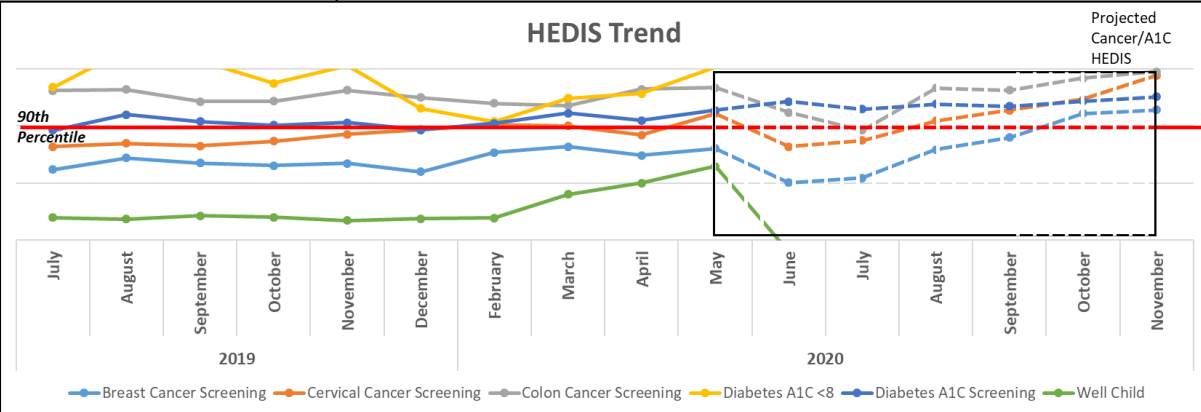
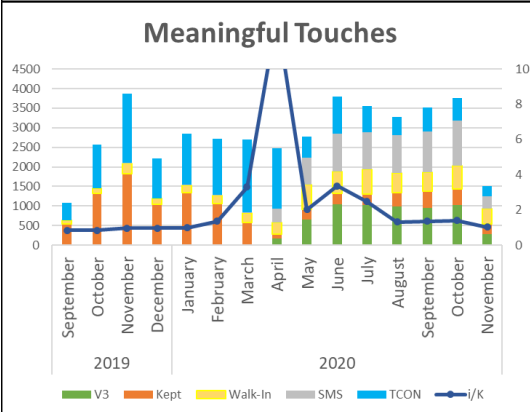
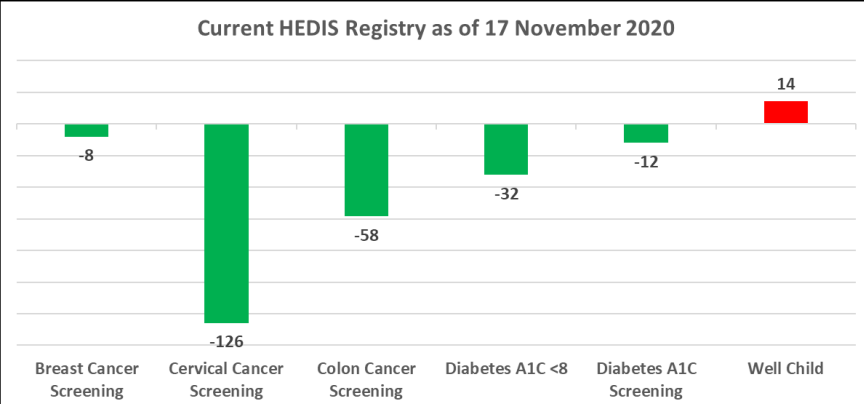
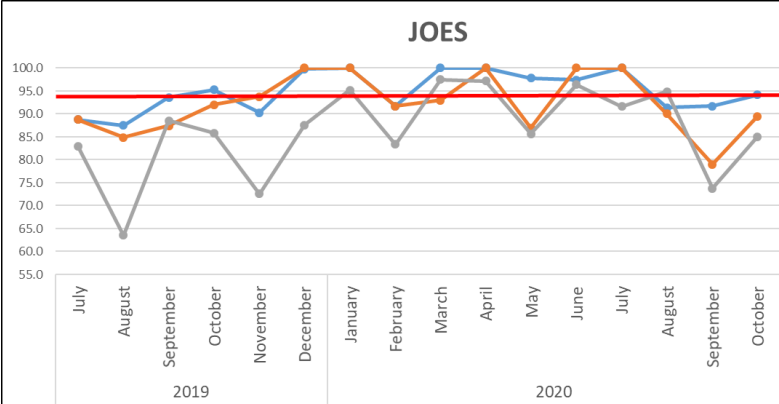


# ARMY MEDICINE

Army Medicine... Army Strong

UNCLASSIFIED// FOUO

## Killeen Medical Home



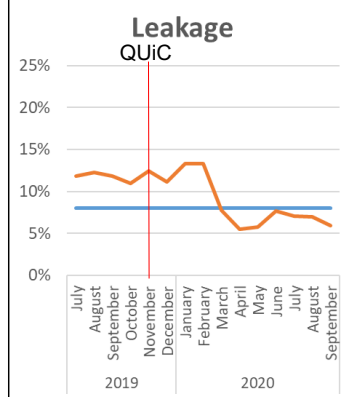
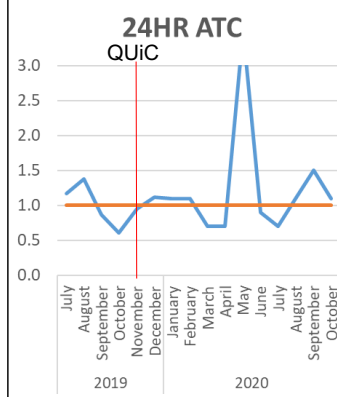
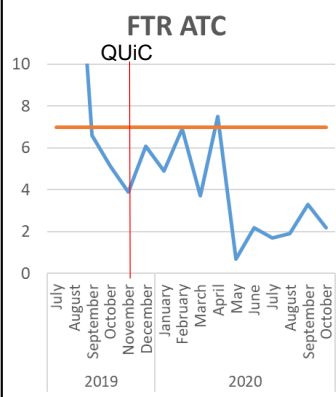
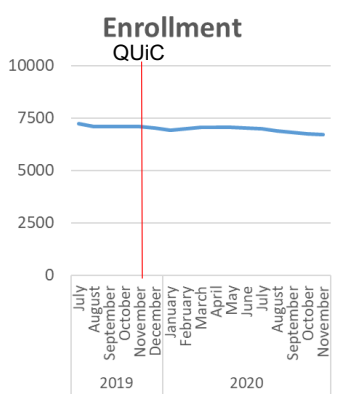
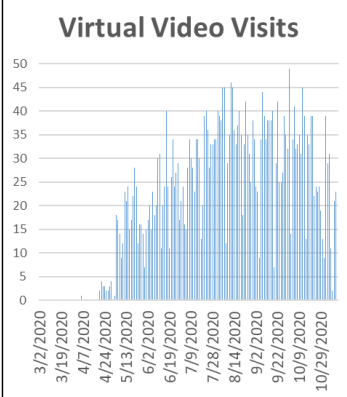
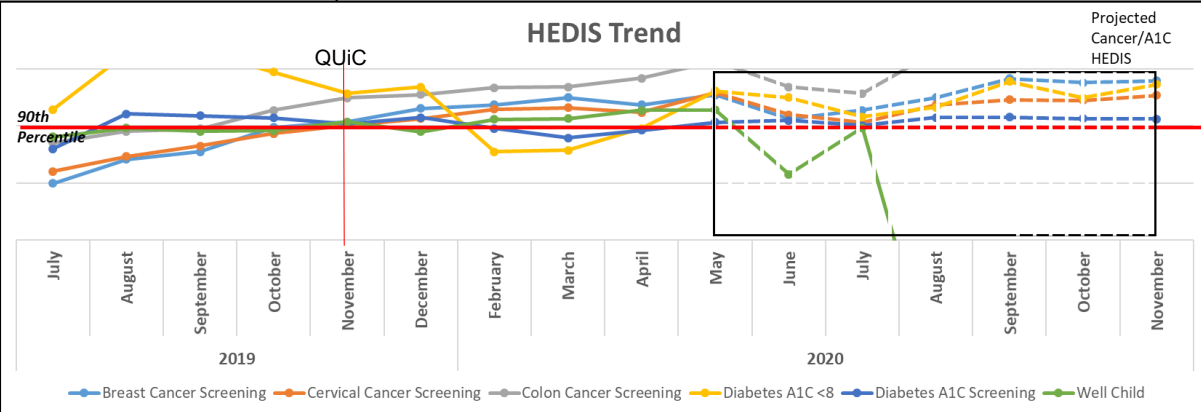
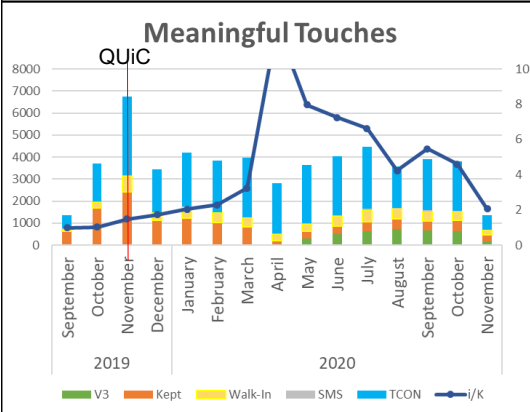
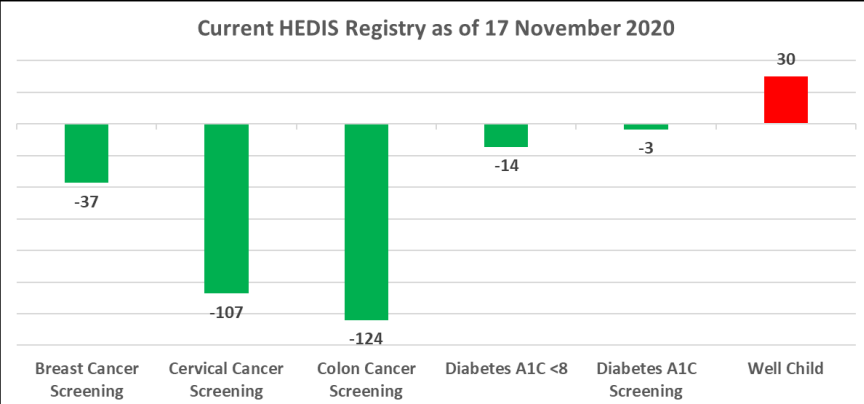
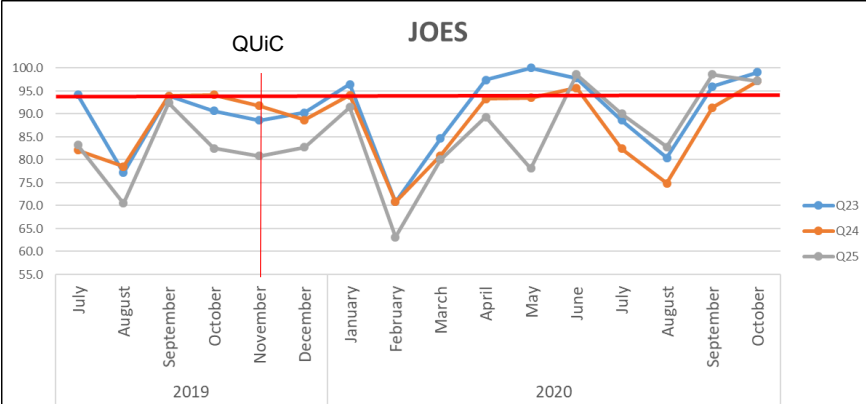


# ARMY MEDICINE

Army Medicine... Army Strong

UNCLASSIFIED// FOUO

## West Killeen Medical Home



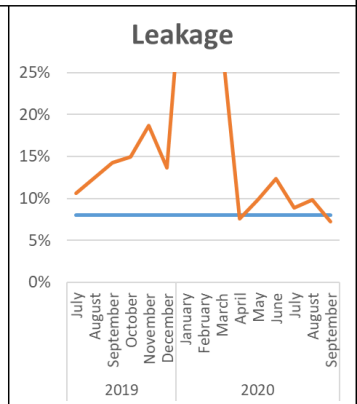
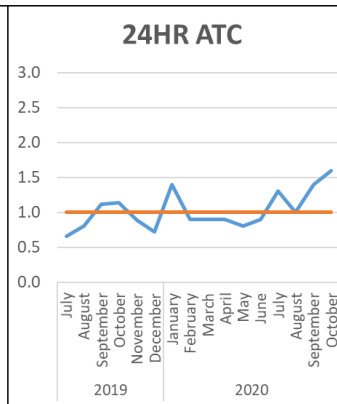
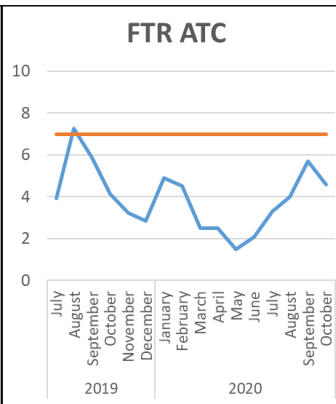
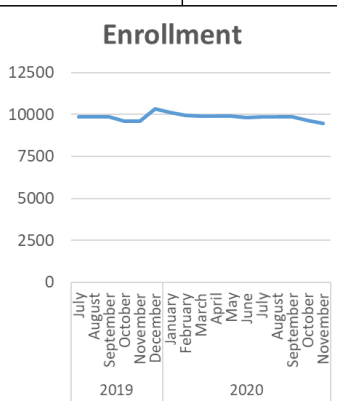
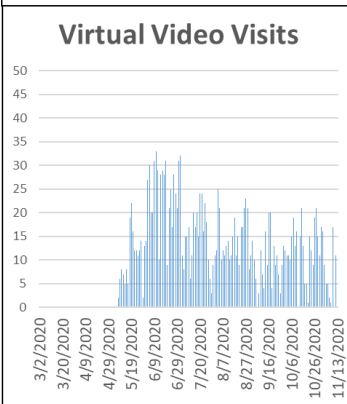
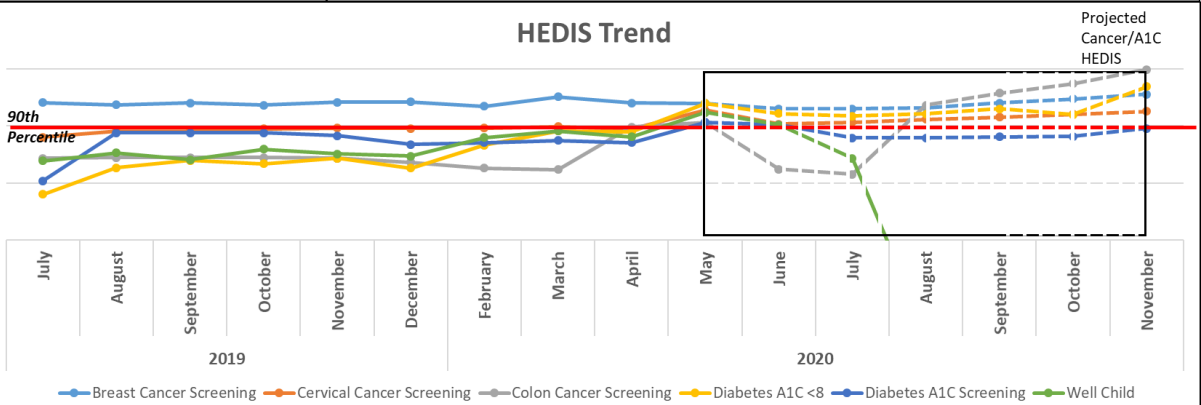
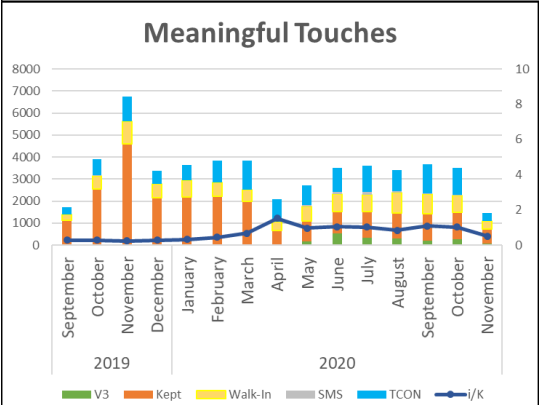
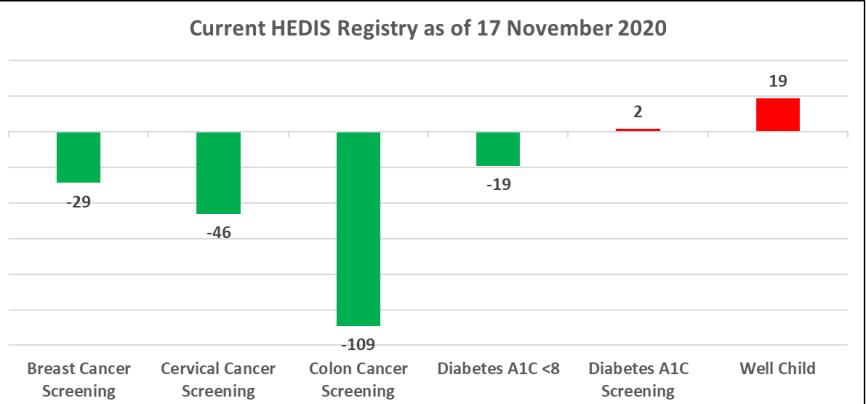
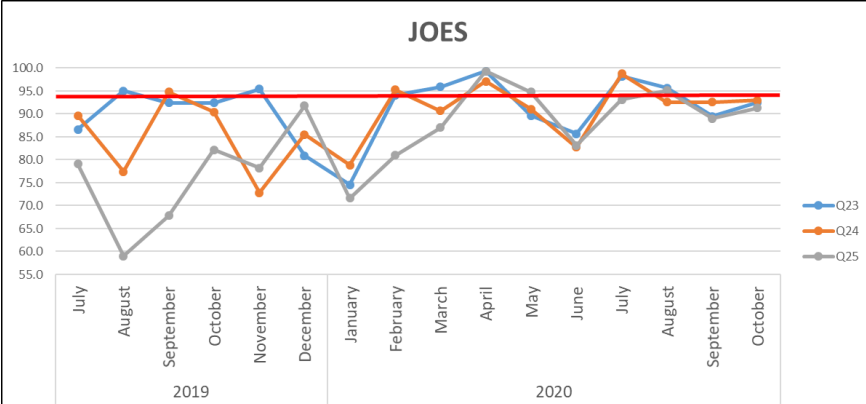


# ARMY MEDICINE

## Army Medicine... Army Strong

UNCLASSIFIED// FOUO

### Russell Collier Health Clinic





# ARMY MEDICINE

*One Team... One Purpose!*  
Conserving the Fighting Strength Since 1775



## Clinic Satisfaction (MOP2)

Patients  
Like QUiC

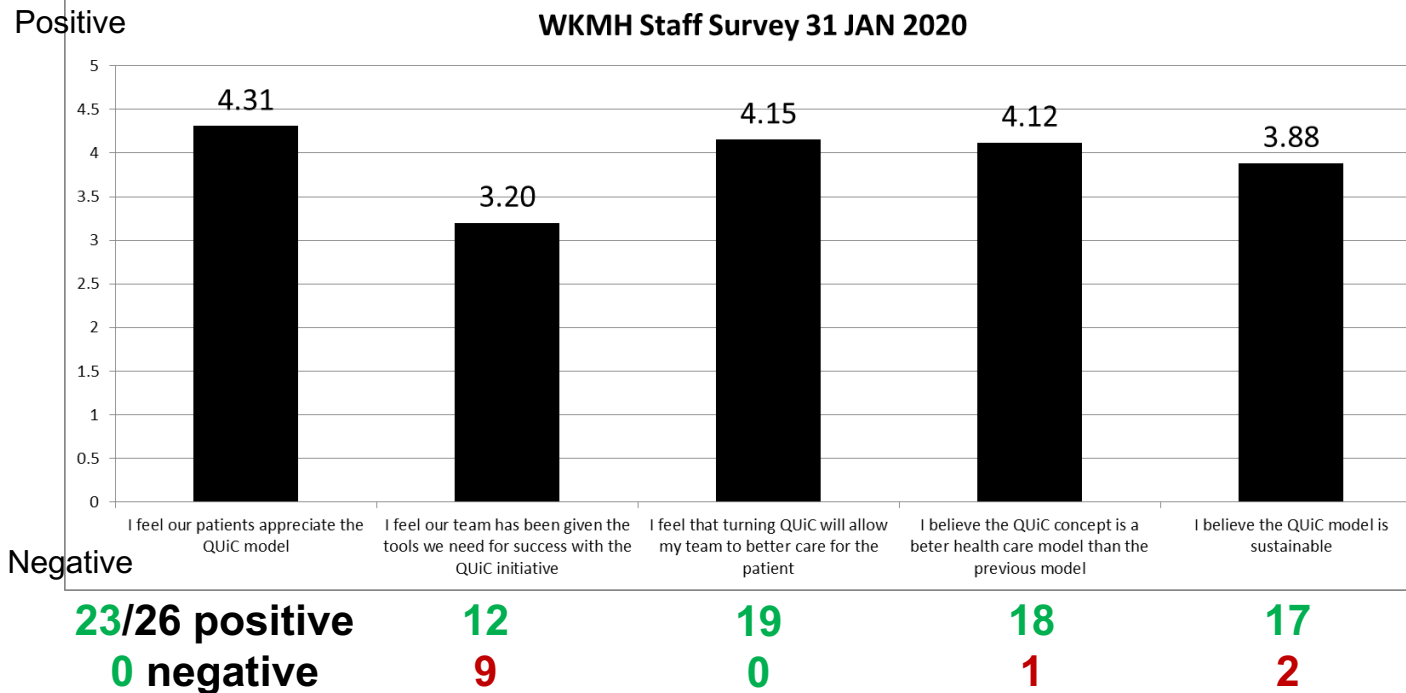
Clinic given the  
tools to  
transition

QUiC  
enables  
better care

QUiC methodology  
is better than  
previous

QUiC is  
sustainable

West Killeen Medical Home  
Staff Survey 31 JAN 2020



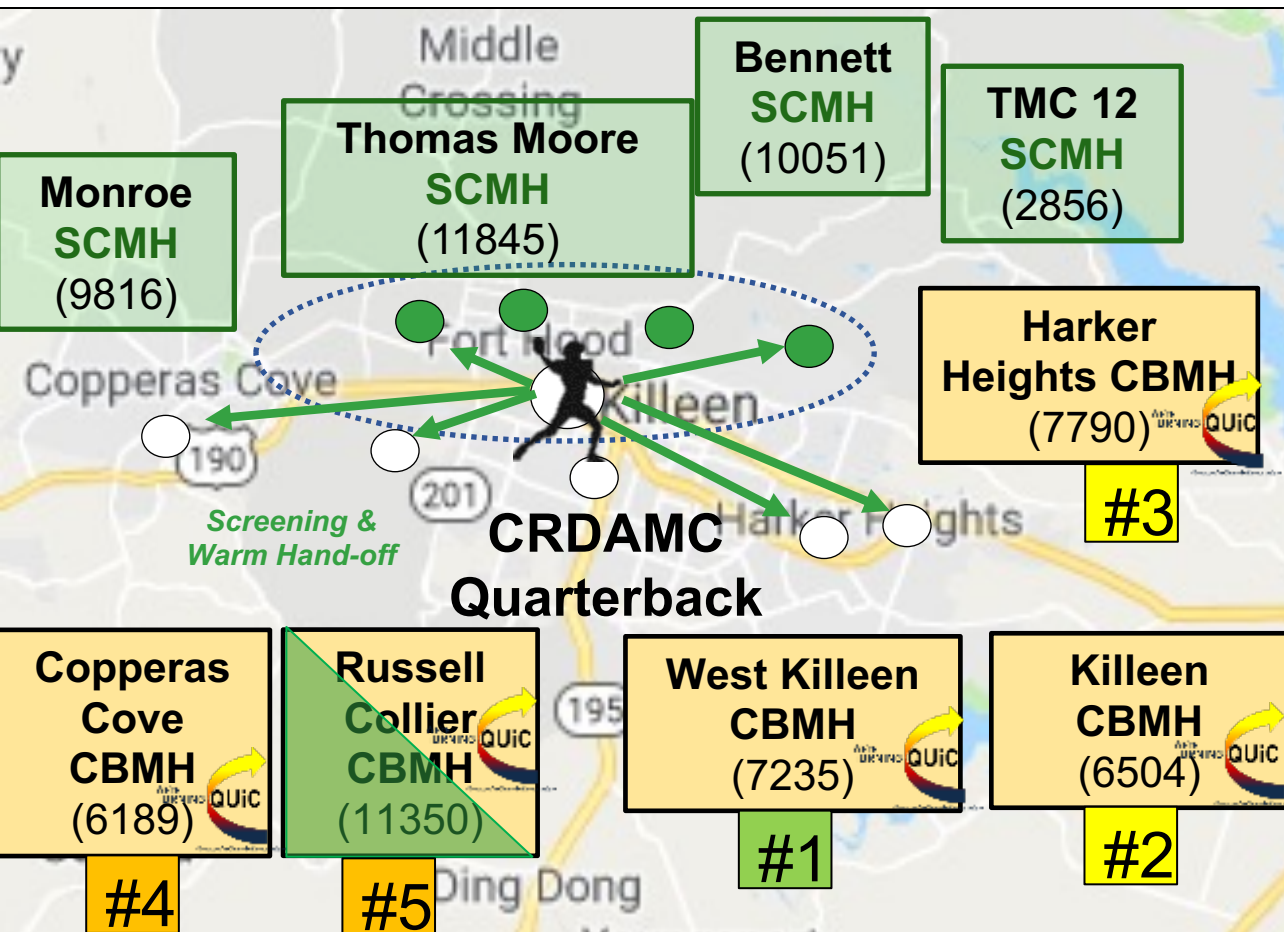
I feel our patients appreciate the QUiC model  
I feel our team has been given the tools we need for success with the QUiC initiative  
I feel that turning QUiC will allow my team to better care for the patient  
I believe the QUiC concept is a better health care model than the previous model  
I believe the QUiC model is sustainable

Eval #	1	2	3	4	5
1	4	2	3	3	2
2	4	4	5	5	4
3	4	4	4	4	4
4	4	2	5	5	4
5	4	3	3	3	3
6	4	4	4	4	4
7	5	4	4	5	4
8	5	5	5	5	5
9	4	4	4	4	4
10	3	2	3	1	3
11	5	2	4	3	3
12	5	4	5	5	4
13	5	2	3	3	4
14	4		4	4	3
15	5	4	5	5	5
16	3	3	3	3	3
17	4	4	3		2
18	4	4	4	4	3
19	5	2	5	5	5
20	4	3	5	5	5
21	5	4	5	5	5
22	3	2	3	3	3
23	5	5	5	4	4
24	5	2	5	5	5
25	5	2	5	5	5
26	4	3	4	5	5
Avg Score	4.308	3.2	4.154	4.12	3.885
Std Dev	0.679	1.041	0.834	1.054	0.952

## Analysis

- WKMh personnel support the QUiC methodology **almost unanimously** (only 3 of 26 personnel were not predominantly positive)
- Only question indicating need for improvement was **clinic preparation**
  - A sensing session revealed that transition could have been improved by: better phone system, team-co-location, better wi-fi, a better printer/fax machine, headsets.
- This lesson has been spread to all PCMHs and all have benefited from the solutions applied to WKMh**

QIiC clinics and an “ED Quarterback” enable a  
Reversal of Flow for low acuity care  
(from ED & UCCs to QIiC clinics) improving ED/hospital ops



## Benefits

### ED:

- Lower Wait Times
- Higher Acuity
- More time for Virtual MEDCEN consultation

### QIiC Clinic:

- Continuity of Care
- Less work on case management
- More HEDIS touchpoints
- Better patient experience

## Risks

- Mis-triage & return to ED
- Patient dissatisfaction
- Provider dissatisfaction
- Poor hand-offs



# References

- Army Medical Center Darnall-Hood. (n.d.) QUiC Clinics. <https://darnall.tricare.mil/Getting-Care/QUiC-Clinics>
- Malish, R., Allen, S., Arroyo-Cazzuro, M.A., Geslak, K.M., Hacker, J.B., Hall, B.T., Ingram, J.C., Whiddon, M.S. (2021). Pivoting to the QUAD AIM—Lessons learned from the Central Texas Market. *Military Medicine*, usab336. <https://doi.org/10.1093/milmed/usab336>
- Malish, R., Flannery, B.J., Meyers, G., Hall, B.T. (2021). QUiC Clinics in the Central Texas Market: Value-based Primary Care in Military Medicine. *Military Medicine*, usab321.  
<https://doi.org/10.1093/milmed/usab321>
- Malish, R.G. (2016). Capitation as an incentive for transitioning to Patient Centered Medical Homes in the United States Army. *Military Medicine*, 181(10): 1228-34. <https://doi.org/10.7205/MILMED-D-15-00541>
- Malish, R.G. (2020). Market observations, lessons, and recommendations for the Defense Health Agency. *Military Medicine*. <https://doi.org/10.1093/milmed/usaa107>
- Military Health System. (2013). MHS Quadruple Aim. <https://health.mil/Reference-Center/Glossary-Terms/2013/04/09/MHS-Quadruple-Aim>



## **Efficiency Strategies in Primary Care**

Achieving the Promise of Value-based Medicine through  
Strict Adherence to the Incentives engendered by  
Capitation

**Discussion,  
Guidance,  
Questions**

We're  
**TURNING QUiC**

~Because we're Obsessed with your health~

# How to Obtain CE/CME Credits

To receive CE/CME credit, you must register by 0745 ET on 24 June 2022 to qualify for the receipt of CE/CME credit or certificate of attendance. You must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through 7 July 2022 at 2359 ET. Please complete the following steps to obtain CE/CME credit:

1. Go to URL: <https://www.dhaj7-cepo.com/content/jun-2022-ccss>
2. Search for your course using the Catalog, Calendar, or Find a course search tool.
3. Click on the REGISTER/TAKE COURSE tab.
  - a. If you have previously used the CEPO CMS, click login.
  - b. If you have not previously used the CEPO CMS click register to create a new account.
4. Follow the onscreen prompts to complete the post-activity assessments:
  - a. Read the Accreditation Statement
  - b. Complete the Evaluation
  - c. Take the Posttest
5. After completing the posttest at 80% or above, your certificate will be available for print or download.
6. You can return to the site at any time in the future to print your certificate and transcripts at: <https://www.dhaj7-cepo.com/>
7. If you require further support, please contact us at: [dha.ncr.j7.mbx.cepo-cms-support@mail.mil](mailto:dha.ncr.j7.mbx.cepo-cms-support@mail.mil)

