

# 2010 Military Health System Conference

## Using LSS/CPI to Improve Healthcare Operations

Army Medicine's Commitment to Strategic Performance Improvement

Sharing Knowledge: Achieving Breakthrough Performance

Gaston M. Randolph, Jr.

26 January 2001



Headquarters, Department of the Army  
Office of The Surgeon General/US Army Medical Command

# Today's Agenda



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- Strategic Focus
  - Aligned with the MHS Quadruple Aim
  - Using the Balanced Scorecard in Army Medicine

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- **Continuous Performance Improvement**
  - **Our Lean Six Sigma Initiative**

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  - Using the Balanced Scorecard in Army Medicine
- Continuous Performance Improvement
  - Our Lean Six Sigma Initiative
- Knowledge Management
  - And Best Practice Transfer



# Strategy



# Strategy

***It's all about taking the Right Road!***



- **Alice: Which way should I go?**





- **Alice: Which way should I go?**
- **Cat: That depends on where you are going.**





- **Alice: Which way should I go?**
- **Cat: That depends on where you are going.**
- **Alice: I don't know where I'm going!**





- Alice: Which way should I go?
- Cat: That depends on where you are going.
- Alice: I don't know where I'm going!
- ***Cat: Then it doesn't matter which way you go!!***

Lewis Carroll - 1872  
*Through the Looking Glass*





Alice: Which way should I go?

Cat: That depends on where you are going.

Alice: I don't know where I'm going!

Cat: Then it doesn't matter which way you go!!

Lewis

Carroll - 1872

*Through the Looking Glass*

**Bottom Line: If you don't know  
where you're going...**



***...then you'll never get there!***



You need to know where you're going...

**(A Vision of the Future)**

and have a roadmap to get there...

**(A Strategy)**

and performance engines to help you get  
down the road...

**(Lean Six Sigma &  
Knowledge Management)**



Alice: Which way should I go?

Cat: That depends on where you are going.

Alice: I don't know where I'm going.

Cat: Then it doesn't matter which way you go!!

Carroll 1872

**...and you need**  
**methodologies and**  
**business processes that**  
**tie it all together!**

*Bottom Line: If you don't know  
where you're going...*

*...then you'll never get there!*

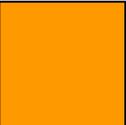


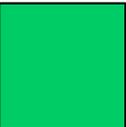
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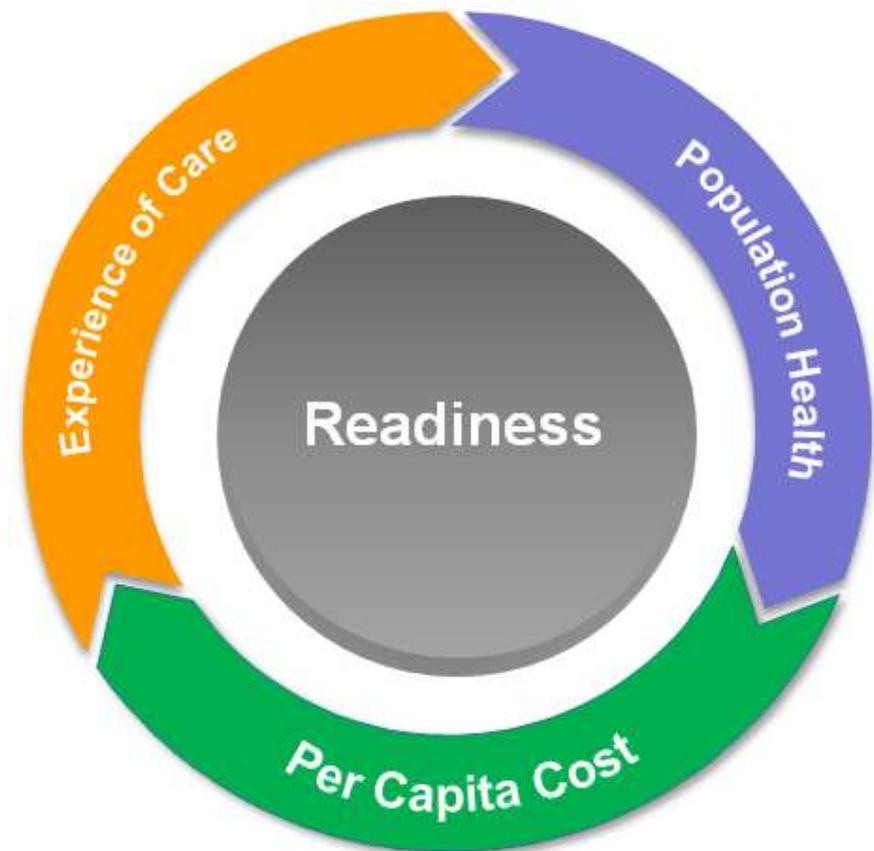


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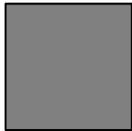
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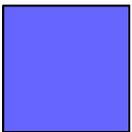


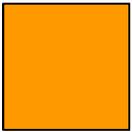
***Let's examine our alignment...***

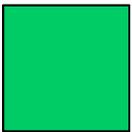
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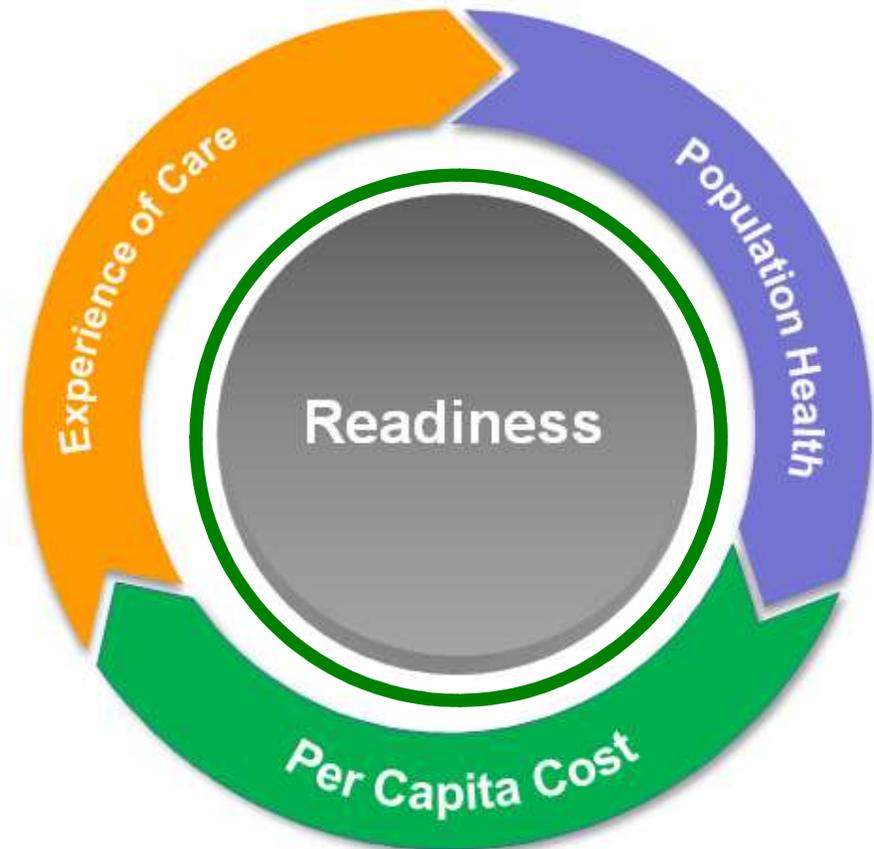


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# Navy Medicine & Q-AIM's "Readiness"



MHS Quadruple Aim	Strategic Goal	Strategic Objective	CPI/LSS Based Initiative	Project POC
<b>Medical Readiness</b> Enabling a medically ready force, a ready medical force, and resiliency of all MH personnel.	<b>Deployment Readiness</b>	Improve BSO-18 IMR Status/Reporting	1. Medical Screening Timeliness Improvement of Reservists at Navy Mobilization Processing Site at San Diego.	• CAPT Comer
		Improve Accuracy of Readiness Info by Medical Platforms	2. Improving Individual Medical Readiness at Naval Hospital Camp Pendleton	• CDR Grush
<b>Population Health</b> Improving quality and health outcomes for a defined population. Advocating and incentivizing healthy behaviors	<b>Quality of Care</b>	Policies and Practices are rooted in evidence	1. Surgical Care Improvement Project 3a - Infection Control - at Naval Medical Center San Diego	• CAPT Greenwood
		Patient safety is maximized	2. Specialty Referral Reporting Improvement Program	• LCDR Cook
<b>Experience of Care</b> Patient and family centered care that is seamless and integrated. Providing patients the care they need, exactly when and where they need it.	<b>Patient and Family Centered Care</b>	Ensure patient satisfaction with the health care experience in: access, coordination, and safety	1. Improving VA.DoD Disability Evaluation System Processing at Naval Medical San Diego	• CAPT Comer
		Develop a comprehensive management program to integrate resource allocation, workload production, and quality to increase alignment of accountability and fiscal responsibility for efficient and effective mission accomplishment,	2. Improved Access to Outpatient OB Care at Naval Medical Center San Diego	• CAPT Comer
<b>Per Capita Cost</b> Managing the cost of providing care for the population. Eliminate waste and reduce unwarranted variation; reward outcomes, not outputs.	<b>Performance Based Budgeting</b>	Develop a comprehensive management program to integrate resource allocation, workload production, and quality to increase alignment of accountability and fiscal responsibility for efficient and effective mission accomplishment,	1. Timely Coding Completion of Outpatient Records at NNMC	• LCDR Dunbar-Reid
		2010 MHS Conference	2. Improving Supply Chain Inventory Management of Immunizations in Navy Medicine West	• CAPT Comer

# Army Medicine's BSC "Readiness"



## Army Medicine Strategy Map January 2009

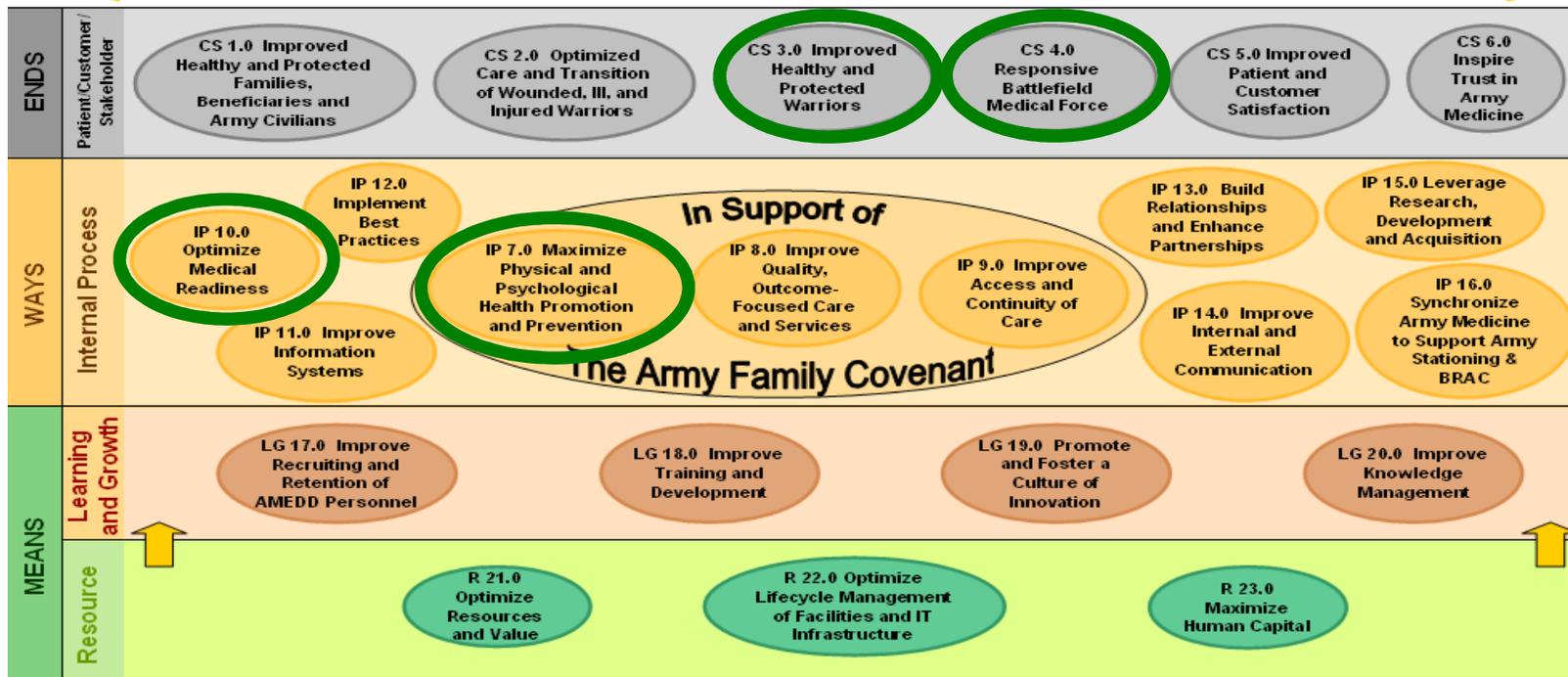
**Mission** - Promote, Sustain and Enhance Soldier Health  
 - Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations  
 - Deliver Leading Edge Health Care to the Army Family to Optimize Outcomes

**Vision** America's Premier Medical Team Saving Lives and Fostering Healthy and Resilient People  
 Army Medicine...Army Strong!

**Strategic Themes**

Maximize Value in Health Services	Provide Global Operational Forces	Build the Team	Balance Innovation with Standardization	Optimize Communication and Knowledge Management
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**SUSTAIN PREPARE RESET TRANSFORM**



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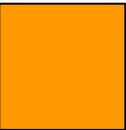
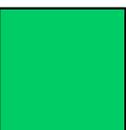
# Air Force Medical Futures: "Readiness"

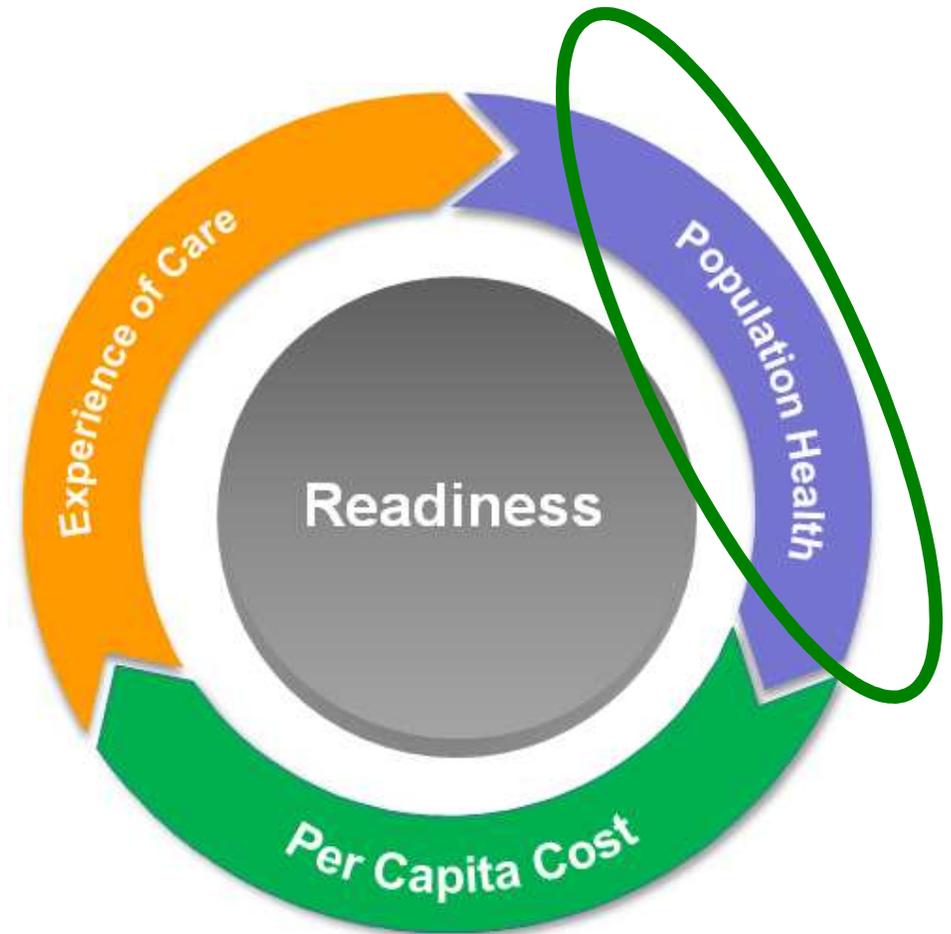


AFMS IMPERATIVES						
		Patient-Centered Care	Technology Integration	Synergy - Joint, Coalition, Interagency	Precision Health Care	Light/Lean Health Care Platforms
AFMS PRIORITIES	Medically Reliable Nuclear Mission					
	Enhance Full Spectrum Medical Capabilities					
	Sustain Healthy/Resilient Airmen					
	Advance Research and Recapitalization					
	Build Acquisition Expertise					

# The MHS' Quadruple Aim



-  Enabling a medically ready force, a ready medical force, and resiliency of all MHS personnel.
-  Improving quality and health outcomes for a defined population. Advocating and incentivizing healthy behaviors.
-  Patient and family centered care that is seamless and integrated. Providing patients the care they need, exactly when and where they need it.
-  Managing the cost of providing care for the population. Eliminate waste and reduce unwarranted variation; reward outcomes, not outputs.



# Navy Medicine & Q-AIM's "Population Health"



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# Army Medicine's BSC "Population Health"



## Army Medicine Strategy Map

January 2009

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### Strategic Themes

Maximize Value in Health Services

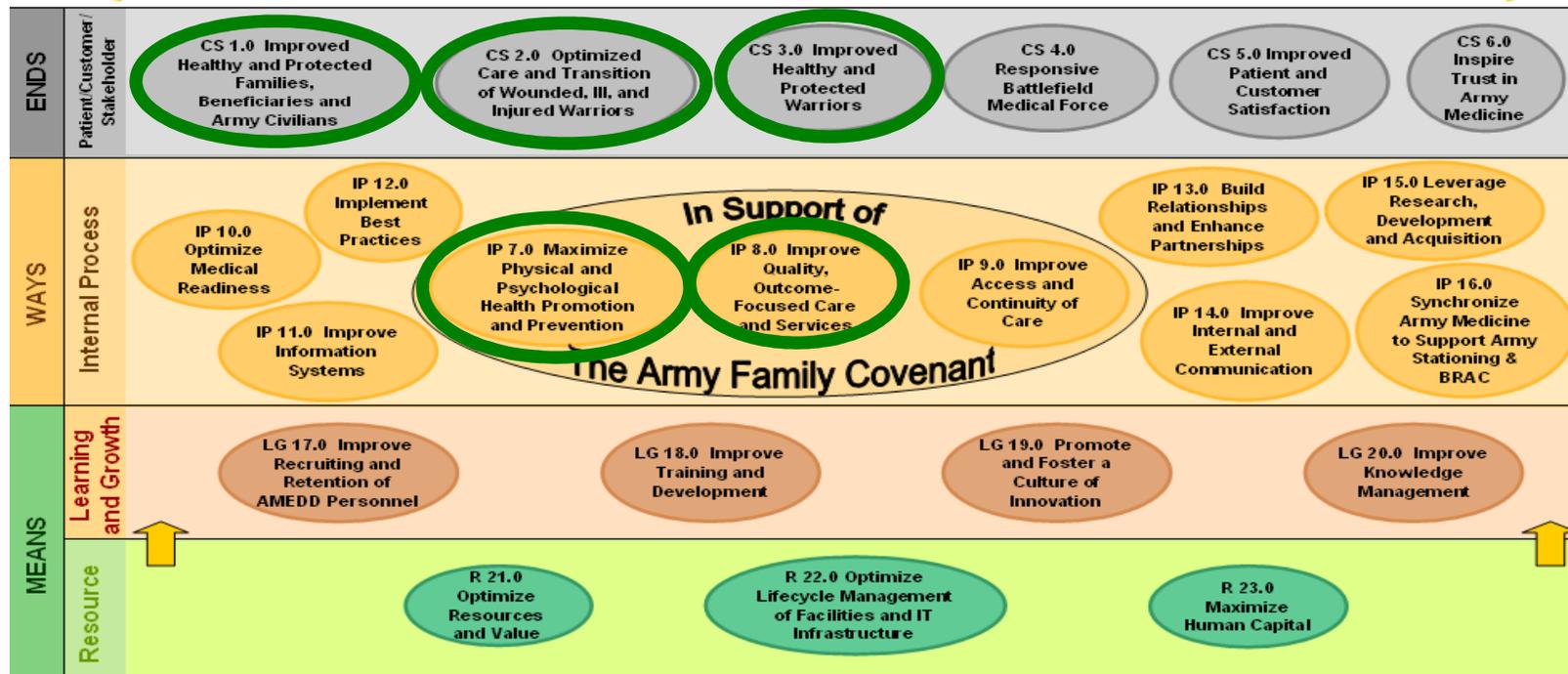
Provide Global Operational Forces

Build the Team

Balance Innovation with Standardization

Optimize Communication and Knowledge Management

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AFMS PRIORITIES	Medically Reliable Nuclear Mission	✓				
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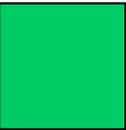
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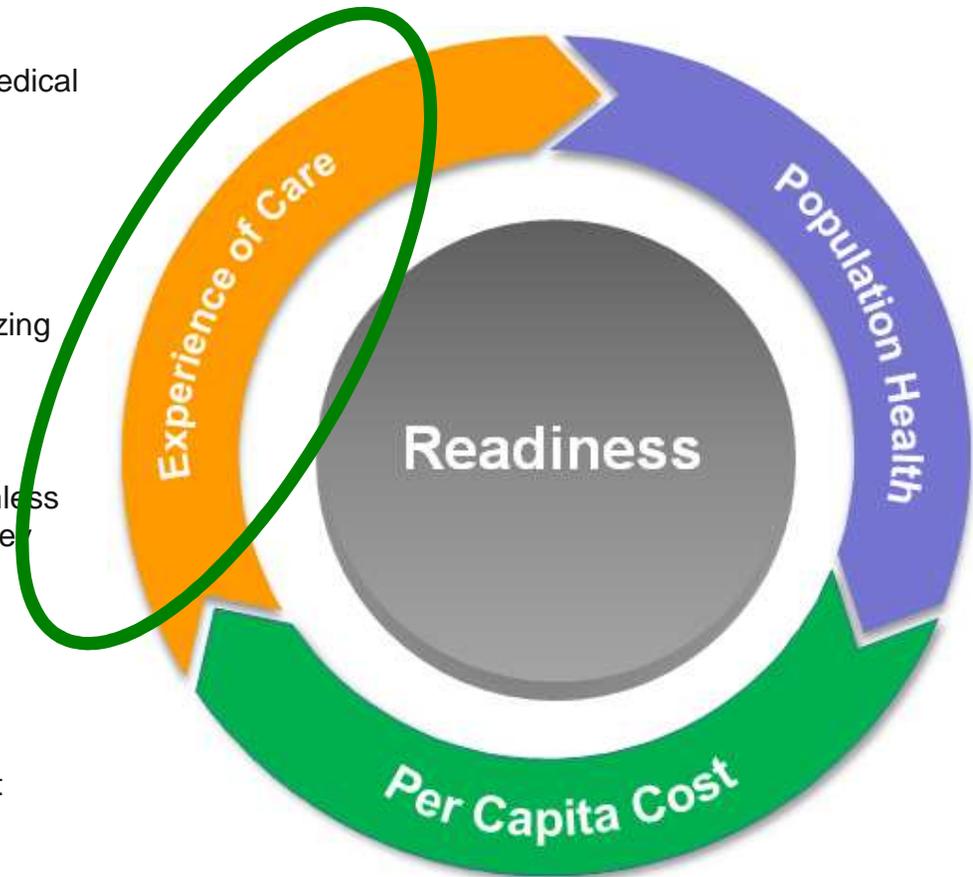


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# Navy Medicine & Q-AIM's *“Experience of Care”*



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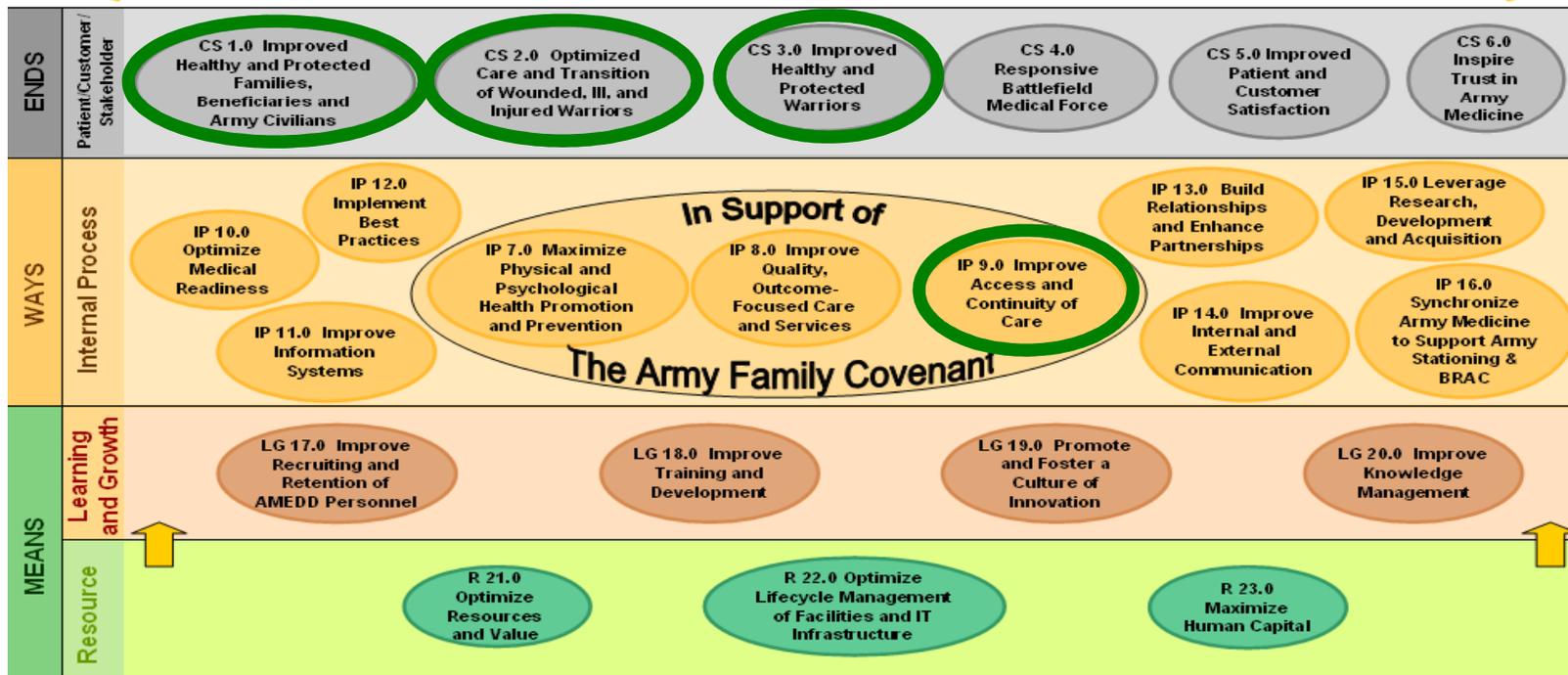
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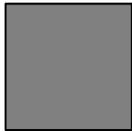
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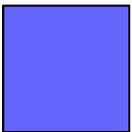


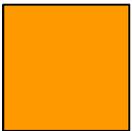
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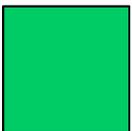
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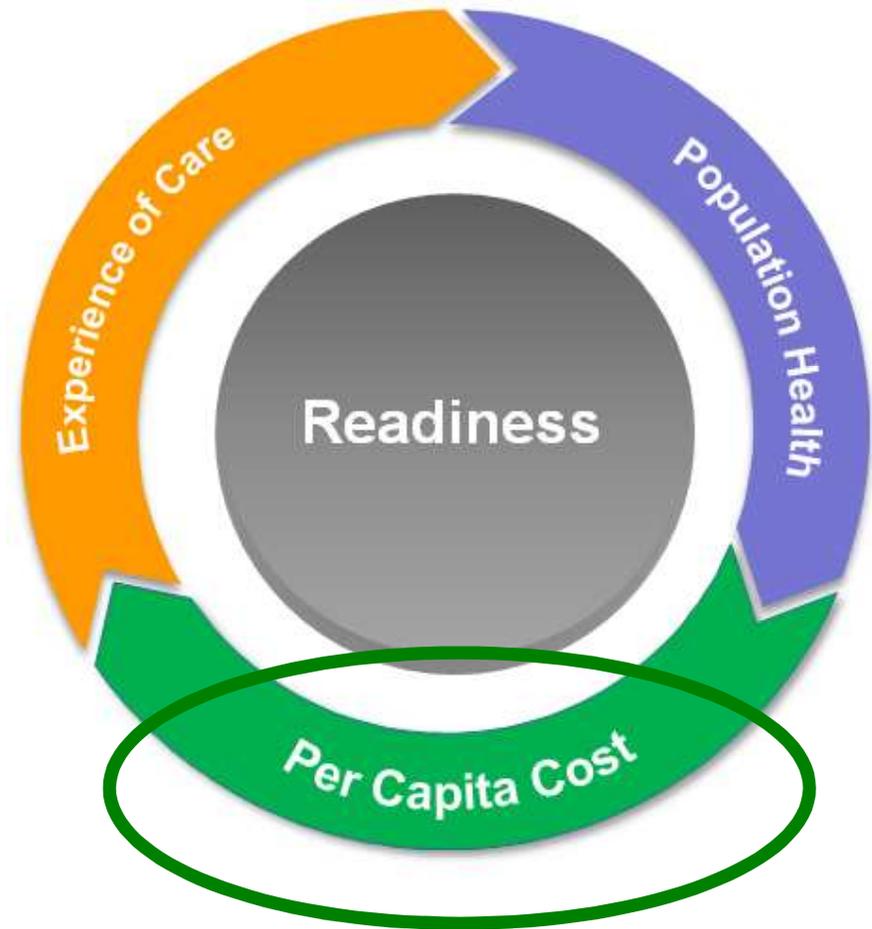


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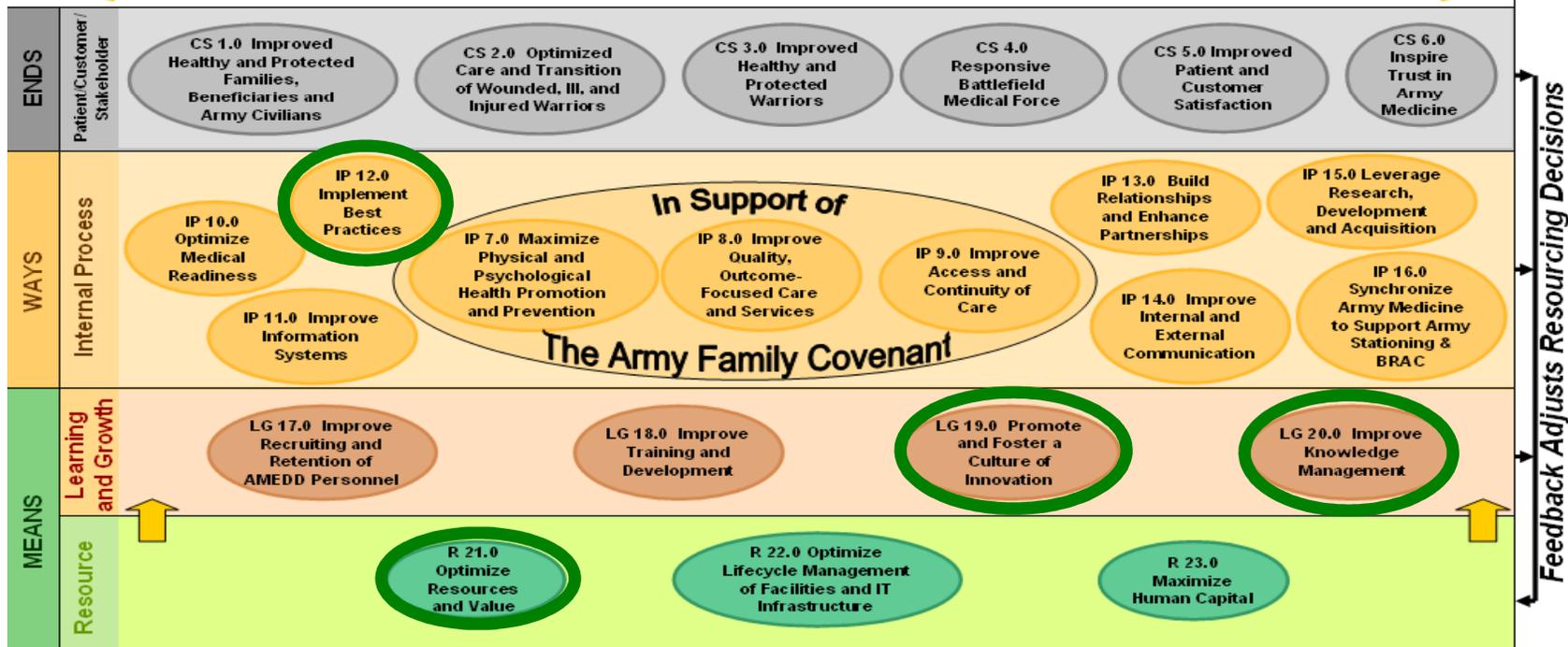
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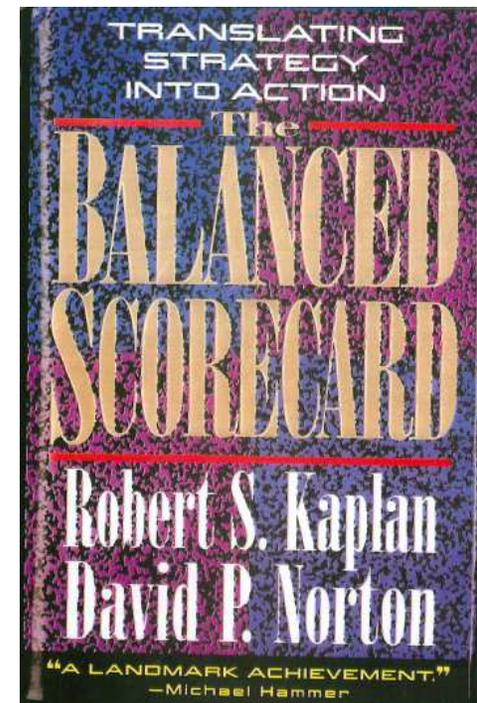
# Army Medicine Uses the Balanced Scorecard



# Army Medicine Uses the Balanced Scorecard



- A Kaplan and Norton Industry Best Practice strategic management system that enables organizations to *clarify* their *vision* and *strategy* and *translate them into action*.



- *The Balanced Scorecard*, Robert S. Kaplan & David P. Norton, 1996, Harvard Business School Press

# Army Medicine Uses the Balanced Scorecard



- A Kaplan and Norton Industry Best Practice strategic management system that enables organizations to *clarify* their *vision* and *strategy* and *translate them into action*.
- An organizational measurement-based guiding and monitoring tool **balancing** views in **4 critical performance areas** (*perspectives*):
  - Customer Service
  - Internal Processes
  - Learning & Growth
  - Resource Stewardship



There are two parts to a Balanced Scorecard:



There are two parts to a Balanced Scorecard:

*A Strategy Map*



There are two parts to a Balanced Scorecard:

*A Strategy Map*  
and a supporting  
*Scorecard*

# The Strategy Map...

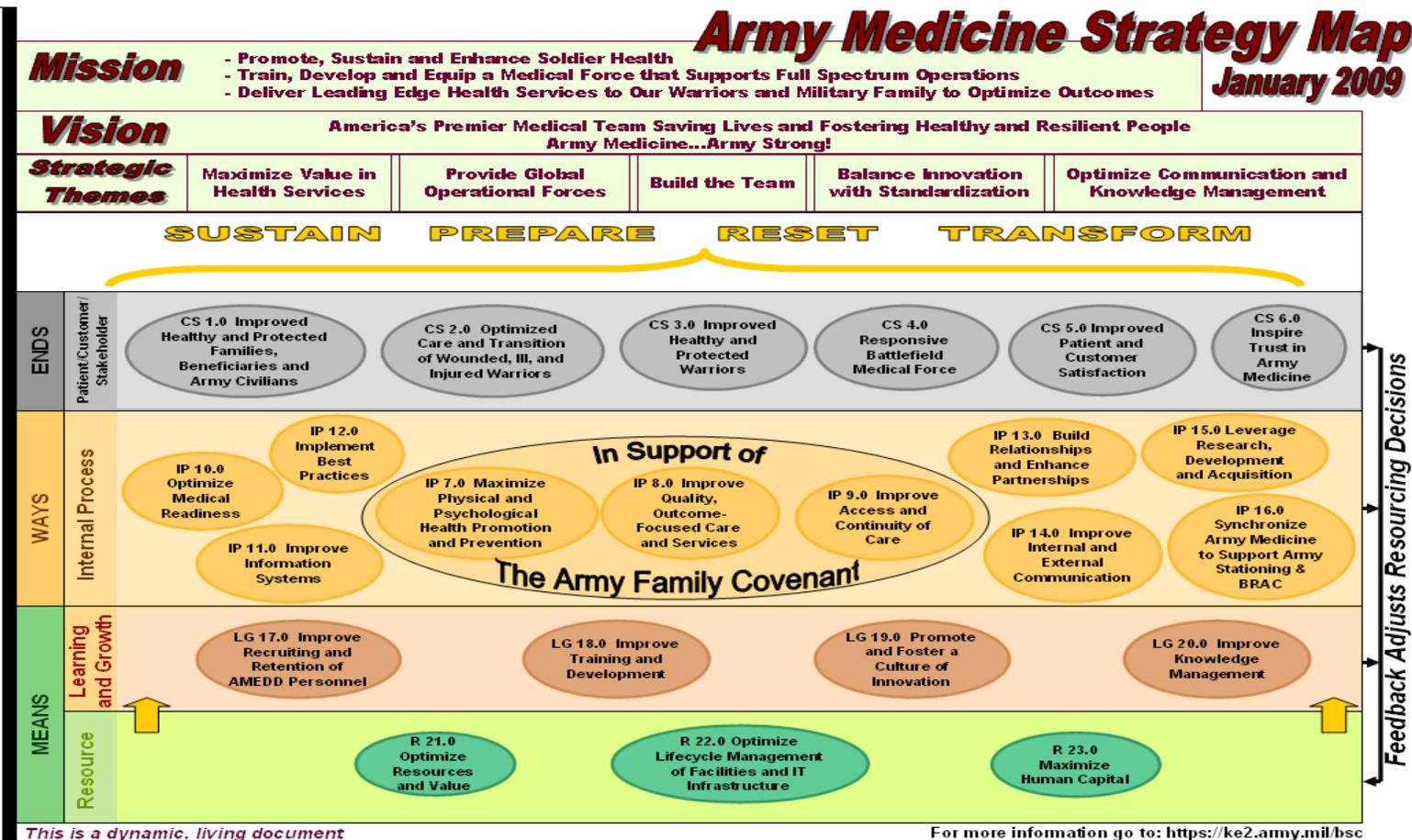


- A single-page, visual representation of an organization's strategy

# The Strategy Map...



- A single-page, visual representation of an organization's strategy



# The Strategy Map...



- A single-page, visual representation of the organization's strategy
- Communicates the organization's strategic priorities

**23 Strategic Objectives—the “linchpins” of our strategy...**

## Medicine Strategy Map January 2009



**Mission & Vision Statements**

**Strategic Themes: “Pillars of Excellence”**

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# The Scorecard...



- **Developed from the Strategy Map**

# The Scorecard...



- Developed from the Strategy Map
- Translates strategic objectives into performance measures, targets, initiatives

Strategic Objective	Objective Statement	Measure	Target	Initiatives	Remarks
<b>11.0 MAXIMIZE PHYSICAL &amp; EMOTIONAL HEALTH PROMOTION &amp; PREVENTION</b> CDR-CHPPM	Within the total Army (Soldiers, family members, civilians, and retirees) to enhance disease and injury prevention and promote physical and emotional well-being.	BMI (Body Mass Index) for family members and retirees / TRICARE Prime and TRICARE for Life (source is AHLTA)	% of overweight FM / retiree population should not exceed the U.S. national average (TBD)	1) Create a web-based community of interest on weight control best practices for practitioners, families, retirees and civilian employees 2) Develop a process w/ IMCOM to ensure that their master plans promote active lifestyles, i.e. bike/housing paths to service 3) Partner w/ DoDDs to find ways to improve opportunities for physical activity	
		E -% of PHAs for all Soldiers, all COMPOS	85% of all Soldiers (all COMPOS) assessments completed	1) Conduct a BCA to determine best investment strategy to achieve compliance w/ PHA for COMPO 2 & 3 2) Conduct a survey to determine insurance status of COMPO 2 & 3 and modify a system (MEDPROS) to capture information	
<b>12.0 IMPROVE INFORMATION SYSTEMS</b> CoFS	Provide an integrated and user-friendly family of information systems that is responsive and reliable to better and seamlessly support the continuum of health care, health care personnel and efficient practices across the full spectrum of operations.	% Provider satisfaction with AHLTA	Increase provider satisfaction by 10% in 6 months	Coordinate with responsible offices (MHS, Army, DCIM, MTF) to eliminate causes of downtime	
		% AHLTA downtime per month per MTF	Higher than 99.9% uptime per month per MTF	Enhance AHLTA usability by deploying integrated package of technology and new clinical practices	
<b>13.0 IMPROVE KNOWLEDGE MANAGEMENT</b> CDR, AMEDD C&S	The ability to capture, share, and reuse knowledge in order to improve the efficiency and speed of decision making.	% age of good ideas (Lessons Learned) = # implemented per quarter / # validated per quarter	TBD - Develop baseline NLT 1 May 08	Develop/refine the process to collect, analyze, validate, process and distribute Lessons Learned to validate the measure.	
<b>14.0 IMPROVE QUALITY, OUTCOME-FOCUSED CARE AND SERVICES</b> ASG-FP	Provide high quality, outcome-focused care and services through the use of evidence based practice, clinical practice guidelines, and proactive disease management.	HEDIS/ORIX measures (PAP smear, mammogram, cold CA, asthma, diabetes x 3, pneumonia)	90th percentile for each measure	1) policy 2) regular feedback to RMC / MTFs 3) Consider inset into PBAM	
		ORYX (CHF, pneumonia, surgical complication)	Meet or exceed national benchmarks	1) PBAM incentives 2) new policy 3) provider scorecard	

# The Scorecard...



- Developed from the Strategy Map
- Translates strategic objectives into performance measures, targets, initiatives

**...turns Strategy into Action!**

Strategic Objective	Objective Statement	Measure	Target	Initiatives	Remarks
11.0 MAXIMIZE PHYSICAL & EMOTIONAL HEALTH PROMOTION PREVENTION CDR-CHP	Within the total Army (Soldiers, family members, retirees) and their communities, enhance physical and emotional health and well-being.	BMI (Body Mass Index) for family members and retirees / TPSCARE, Pense and TPSCARE for Life (TPSCARE AHLTA)	% of overweight PM/retiree population should not exceed the U.S. national average (TBD)	1) Create a web-based community of interest on weight control best practices for practitioners, families, retirees, and civilian employees. 2) Develop a process w/ PMCCOP to ensure that their meal plans promote active lifestyles, i.e. bike/housing paths to service. 3) Partner w/ fitness to and provide incentives for active lifestyles. 4) Develop a weight management strategy to achieve compliance w/ PHA for COMPO 2 & 3. 5) Conduct a survey to determine insurance status of COMPO 2 & 3 and modify a system (MEDPROS) to capture information.	
12.0 IMPROVE INFORMATION SYSTEMS CoS	Provide an integrated and user-friendly family of information systems that is responsive and reliable to better and seamlessly support the continuum of health care, health care personnel and efficient practices across the full spectrum of operations.	% Provider satisfaction with AHLTA  % AHLTA downtime per month per MTF	Increase provider satisfaction by 10% in 6 months  Higher than 99.9% uptime per month per MTF	Coordinate with responsible offices (MHS, Army, CDIM, MTF) to eliminate causes of downtime.  Enhance AHLTA usability by deploying integrated package of technology and new clinical practices.	
13.0 IMPROVE KNOWLEDGE MANAGEMENT CDR, AMEDD C&S	The ability to capture, share, and reuse knowledge in order to improve the efficiency and speed of decision making.	% age of good ideas (Lessons Learned) = # implemented per quarter / # validated per quarter	TBD - Develop baseline NLT 1 May 08	Develop/refine the process to collect, analyze, validate, process and distribute Lessons Learned to validate the measure.	
14.0 IMPROVE QUALITY, OUTCOME-FOCUSED CARE AND SERVICES ASG-FP	Provide high quality, outcome-focused care and services through the use of evidence based practice, clinical practice guidelines, and proactive disease management.	HEDIS/ORX measures (PAP smear, mammogram, cold CA, asthma, diabetes x3, pneumonia)  OPVX (CHF, pneumonia, surgical complication)	90th percentile for each measure  Meet or exceed national benchmarks	1) policy 2) regular feedback to RMC / MTFs 3) Consider inseat into PBAM  1) PBAM incentives 2) new policy 3) provider scorecard	



**So MEDCOM uses the Balanced Scorecard...**

**...and MEDCOM Uses Lean Six Sigma!**

# *LSS “Fits” in MEDCOM’s Business Innovation Toolkit*



- **BSC defines our organizational strategy**

# *LSS “Fits” in MEDCOM’s Business Innovation Toolkit*



- BSC defines our organizational strategy
- **LSS fits as BSC Improvement Engine**

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- BSC defines our organizational strategy
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  - Evaluate objective targets, gaps to reach them
  - ID initiatives to close gaps
  - Those initiatives become LSS projects

# LSS “Fits” in MEDCOM’s Business Innovation Toolkit



- BSC defines our organizational strategy
- LSS fits as BSC Improvement Engine
  - Evaluate objective targets, gaps to reach them
  - ID initiatives to close gaps
  - Those initiatives become LSS projects
- ***Aligns commitment, resources, and effort against strategically-focused projects!***

# Our Lean Six Sigma Program...



## Army Medicine BSC Performance Update Briefing



**Objective:** LG 19.0 Promote and Foster a Culture of Innovation  
**Measure:** ROI on LSS Projects

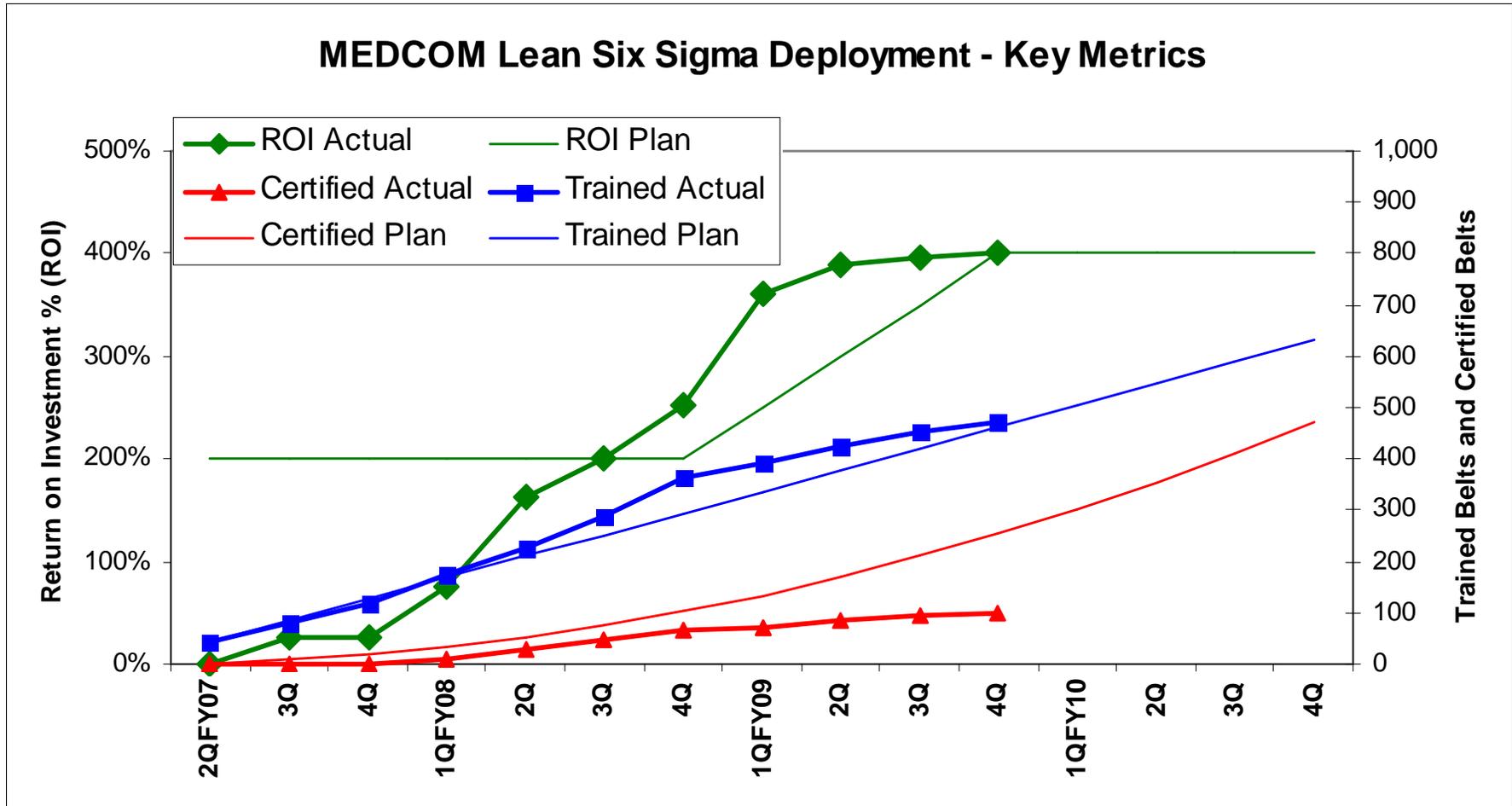
Measure											Performance History																										
Period:		Actual	Target	Variance																																	
<b>G</b>	Quarterly	402%	400%	+2%																																	
Data Dictionary											Source: PowerSteering 30 Sep 09																										
Measure Description	Measure Owner	Lead / Lag	Input / Output / Process / Outcome	Baseline	Target	Polarity	Data Source	How is data collected?	Who collects the data?	Frequency																											
Return on Investment (ROI) for Lean Six Sigma (LSS) projects in PowerSteering	DSI - Mr Randolph	Lag	Output	200%	400%	UP	PowerSteering	Data Pull	Mr Zook	Real Time																											
Comments/Decision Required											Initiatives																										
<b>Comments:</b> <ol style="list-style-type: none"> <li>HQDA-canceled FY09 LSS training adversely impacted MEDCOM's FY09 LSS Program.</li> <li>LSS ROI will improve when MEDCOM LSS resources are dedicated to LSS (incl TDA auth pos'ns) replacing contract support.</li> <li>LSS Project, "Improve Belt Certification" completed. Root Causes: poor initial project scoping &amp; insufficient dedicated time for belts to execute projects (aside from normal duties).</li> <li>Draft MEDCOM LSS FY10 Sustainment Plan complete; discussed at LSS Track, AUSA Med Symp. Est complete/published 1QFY10.</li> </ol> <b>Decision Required: None</b>											<table border="1"> <thead> <tr> <th></th> <th>\$</th> <th>Time</th> <th>%</th> <th>Status</th> </tr> </thead> <tbody> <tr> <td>• MEDCOM FY10 LSS Tng Plan pub/HQDA-resourced (1)</td> <td><b>G</b></td> <td><b>G</b></td> <td>100%</td> <td>C</td> </tr> <tr> <td>• Tng Plan executed (1)</td> <td></td> <td></td> <td>0%</td> <td>NS</td> </tr> <tr> <td>• Pub TSG-signed MEDCOM LSS Sustainment Plan (2)(3)(4)</td> <td><b>G</b></td> <td><b>A</b></td> <td>60%</td> <td>IP</td> </tr> <tr> <td>• MSC HQs DSI TDA Template developed/approved (2)</td> <td><b>G</b></td> <td><b>A</b></td> <td>75%</td> <td></td> </tr> </tbody> </table>			\$	Time	%	Status	• MEDCOM FY10 LSS Tng Plan pub/HQDA-resourced (1)	<b>G</b>	<b>G</b>	100%	C	• Tng Plan executed (1)			0%	NS	• Pub TSG-signed MEDCOM LSS Sustainment Plan (2)(3)(4)	<b>G</b>	<b>A</b>	60%	IP	• MSC HQs DSI TDA Template developed/approved (2)	<b>G</b>	<b>A</b>	75%	
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**Key - Measure:** G = Meeting Target; Y = between Goal & Warning; R = Below Warning Level

**Key - Initiatives (\$/Time):** G = On Budget/On Time; Y = At Risk; R = Over budget/Behind schedule

**Key - Initiative Status:** Not started (NS); In progress (IP); On hold (OH); Complete (C)

# Our Lean Six Sigma Program...



Source: PowerSteering 30 Sep 09



# ***Knowledge Management*** **(its Best Practice Transfer component)**

***our next big challenge...***



# ***Knowledge Management*** **(its Best Practice Transfer component)**

***and why it's important...***



# Think about it...



***“...cave dwellers froze to death on beds of coal.”***



***“Coal was right under them,”***  
***“but they couldn’t see it...  
mine it...  
or use it.”***



*“what you don’t know can  
and will hurt you.”*



**But it's happening all over  
again in the 21<sup>st</sup> Century!**



“...it’s not beds of coal...  
...but beds of ‘*knowledge*’”



they exist in all organizations!

*“relatively untapped...”*

*relatively “unmined...”*

*relatively unused...*

- Adapted from Carla O'Dell, *If Only We Knew What We Know*, p. ix.



...and it's *really hurting* us!



***Unwarranted variation***

***Sub-optimized  
transactional outcomes***

***Unpredictability for patients***

***here's how...***

***Best Practice Transfer  
measured in years vs months***

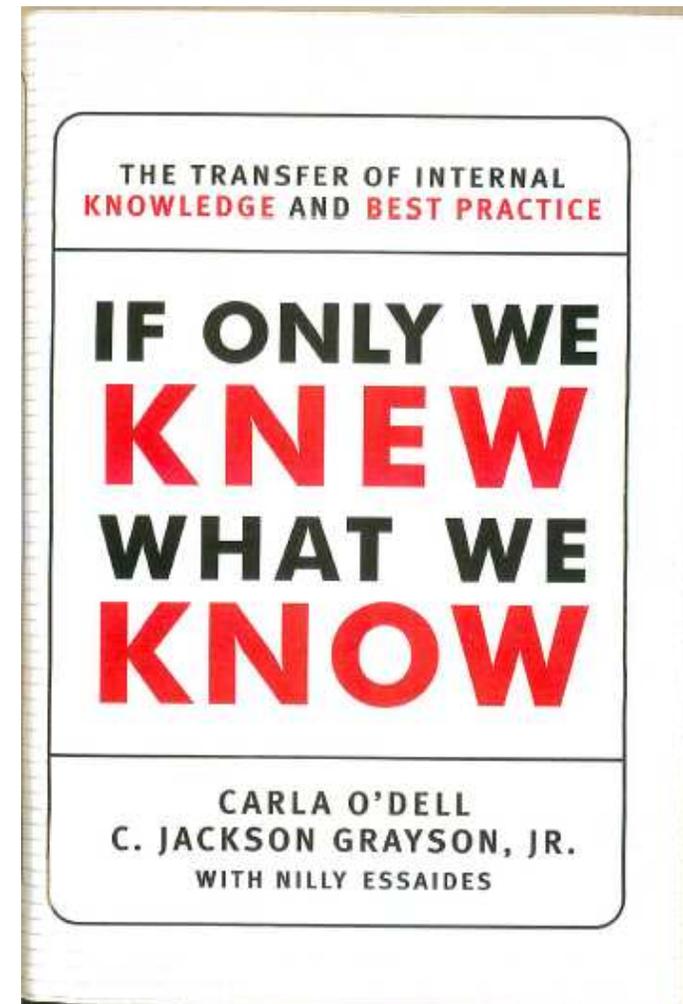
***Sub-optimized  
clinical outcomes***

***Misdirected (wasted) resources***

***Incremental improvement vs  
enterprise-wide improvement***



# Why Don't Best Practices Get Transferred?



# Why Don't Best Practices Get Transferred?



- **Reason #1: Ignorance...**

- People with knowledge don't realize others may find it useful
- People who could benefit from knowledge don't know others have it

...from If Only We Knew What We Know: The Transfer of Internal Knowledge and Best Practice, Carla O'Dell, author

# Why Don't Best Practices Get Transferred?



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- Reason #4: **Lack of motivation...**
  - People may not perceive a clear reason for pursuing the transfer

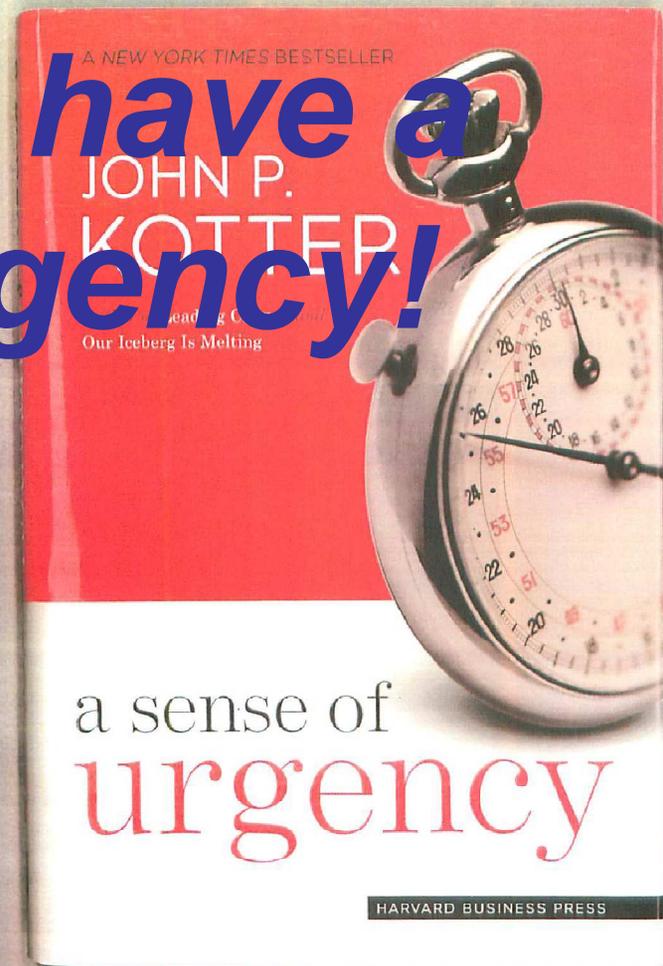
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# Why Don't Best Practices Get Transferred?



- Reason #1: Ignorance...
  - People who don't know what they don't know
  - People who could benefit from knowledge
- Reason #2: Inadequate resources
  - People lack the money, time, resources
- Reason #3: The lack of practice
  - People use knowledge & practice from other settings
- Reason #4: Lack of motivation
  - People may not perceive a clear reason to change

**People must have a sense of urgency!**





***An Army Medicine example:  
at a high level...***

***linking Organizational Strategy  
to Performance Improvement  
using  
Lean Six Sigma  
and  
Best Practice Transfer!***

# Army Medicine Strategy Map

April 2008

## Mission

- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes

## Vision

America's Premier Medical Team Saving Lives and Fostering Healthy and Resilient People  
Army Medicine...Army Strong!

## Strategic Themes

Maximize Value in Health Services

Provide Global Operational Forces

Build the Team

Balance Innovation with Standardization

Optimize Communication and Knowledge Management

**SUSTAIN PREPARE RESET TRANSFORM**



This is a dynamic, living document

For more information go to: <https://ke2.army.mil/bsc>

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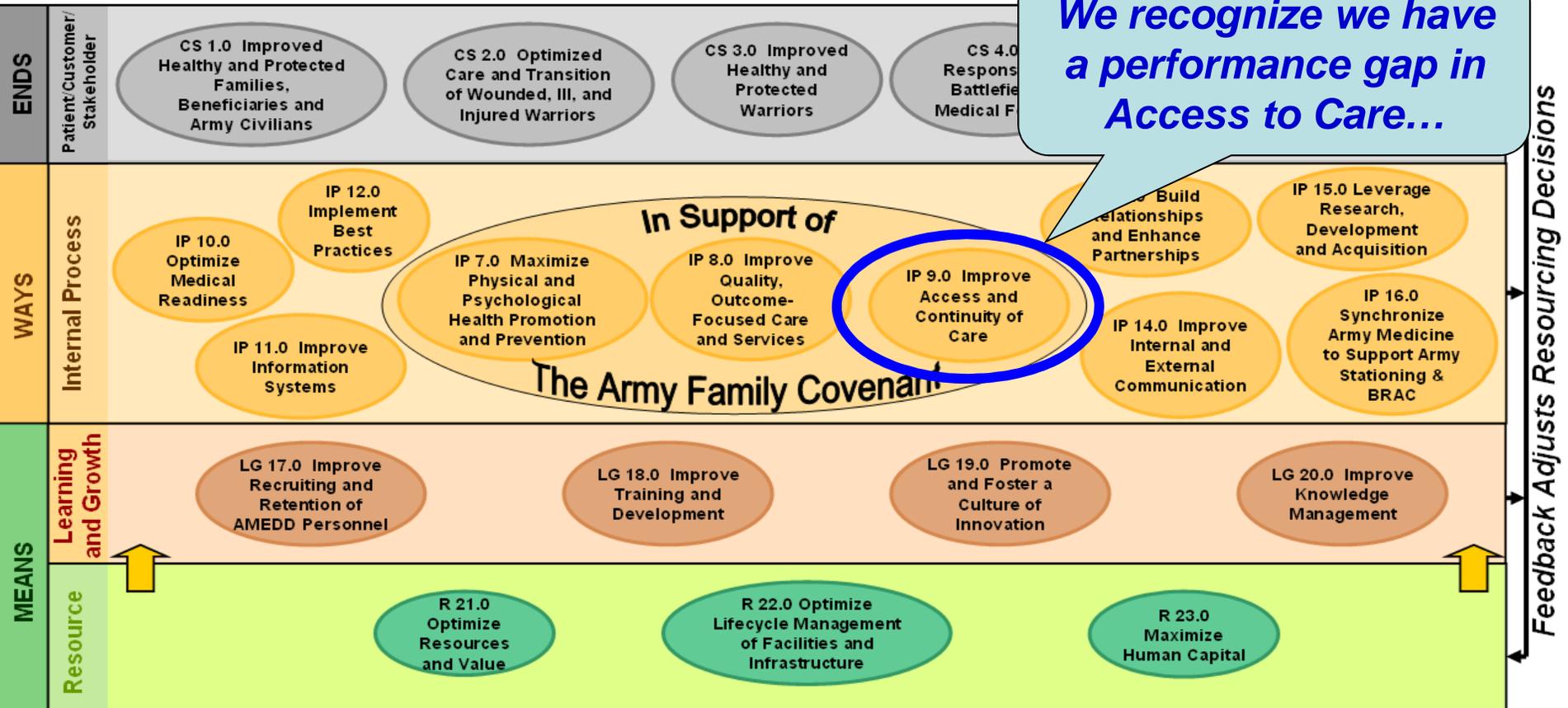
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# Value Stream #9: Improve Access and Continuity of Care

## PVC #1: Maximize Value in Health Services



Suppliers	Inputs	Process	Outputs	Customer
<ul style="list-style-type: none"> <li>• Patients</li> <li>• DOD Healthcare Professionals</li> <li>• IMCOM</li> </ul>	<ul style="list-style-type: none"> <li>• Need for Care (preventive, acute)</li> <li>• Healthcare staff</li> <li>• Facilities and infrastructure</li> </ul>	<ul style="list-style-type: none"> <li>• Customer Service</li> <li>• Telephone Services</li> <li>• Provider Support Staff Utilization</li> <li>• Primary Care Exam Room Utilization</li> <li>• Patient Appointing, Referral Mgt.</li> <li>• TRICARE Online Appointment</li> </ul>	<ul style="list-style-type: none"> <li>• Satisfied beneficiary</li> <li>• Accessible appointments</li> <li>• Standardized, utilized support staff</li> <li>• Optimized provider productivity</li> <li>• Optimized referral execution, delivery</li> <li>• Increased utilization of on-line appointment system</li> </ul>	<ul style="list-style-type: none"> <li>• DOD Title 10 patients (e.g., Soldiers, retirees, families)</li> <li>• Non-Title 10 patients (e.g., civilian emergencies, contractors, foreign officers and families, etc.)</li> </ul>

**High level process maps (SIPOCs) help us better focus on the problem/s in our work...**

Output Metrics
<ul style="list-style-type: none"> <li>• Patient Satisfaction</li> <li>• Access to Care Standards (e.g., achieve acute care appt. within 24 hours)</li> <li>• Support Staff to Primary Care Provider Utilization ratio</li> </ul>

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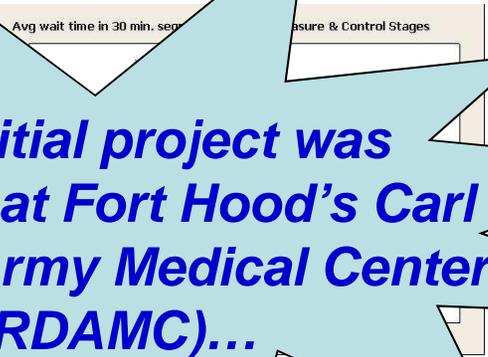
*...and we decided to start by improving the Telephone Appointing Process*

Customer	Input Metrics	Process Metrics	Output Metrics
<ul style="list-style-type: none"> <li>• DOD Title 10 patients</li> <li>• Non-Title 10 patients</li> </ul>	<ul style="list-style-type: none"> <li>• Call Volume</li> <li>• # of Appts. Requested</li> <li>• Type of Care Requested</li> <li>• Staff Availability</li> <li>• Facility Scheduling</li> </ul>	<ul style="list-style-type: none"> <li>• Call Hold and Handle Times, Call Abandon Rate</li> <li>• Care Appointment Availability</li> <li>• Schedule Availability</li> <li>• Facility Availability</li> </ul>	<ul style="list-style-type: none"> <li>• Patient Satisfaction</li> <li>• Access to Care Standards (e.g., achieve acute care appt. within 24 hours)</li> <li>• Support Staff to Primary Care Provider Utilization ratio</li> </ul>

# Project Summary: Carl R. Darnall AMC Telephone Appointing

## Mark Hernandez – Black Belt



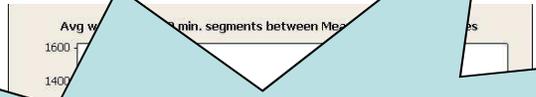
<b>PROBLEM / BASELINE / GOAL</b>	<b>IMPROVEMENTS</b>
<p><b>PROBLEM STATEMENT</b></p> <p>The telephone appointing process at CRDAMC has observed low patient satisfaction scores and long process hold times. Over the last six months, it takes an average of 3:14 minutes to answer customer calls to make an appointment. This has led to numerous customer complaints which have led to lower patient satisfaction scores for telephone appointing services.</p> <p><b>BASELINE</b></p> <ul style="list-style-type: none"> <li>▪ Army's largest call center: 10,000+ calls a week</li> <li>▪ Low customer satisfaction: 68%</li> <li>▪ Average wait time: 3:14 minutes</li> <li>▪ Calls answered under 90 seconds: 65%</li> <li>▪ Overall call abandon rate: 26%; Peak time: 49%</li> </ul> <p><b>GOAL</b></p> <ul style="list-style-type: none"> <li>▪ Decrease process hold time to less than 90 seconds/ call</li> <li>▪ Decrease overall abandoned call rate to less than 10%</li> <li>▪ Decrease peak time call abandon rate to less than 25%</li> </ul>	<ul style="list-style-type: none"> <li>▪ Agent scheduling changes to handle peak times</li> <li>▪ Agent training, area setup, shift change by SOP</li> <li>▪ Phone menu tree and call handling improved</li> <li>▪ Future ACD design requirements specified</li> </ul> 
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**...the initial project was conducted at Fort Hood's Carl R. Darnall Army Medical Center (CRDAMC)...**

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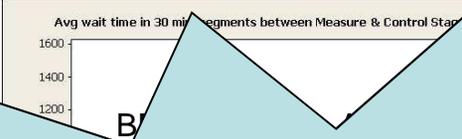
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*...high call volume, low patient satisfaction, long process cycle time, high variation...*

# Project Summary: Carl R. Darnall AMC Telephone Appointing

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### PROBLEM / BASELINE / GOAL

#### PROBLEM STATEMENT

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#### BASELINE

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#### GOAL

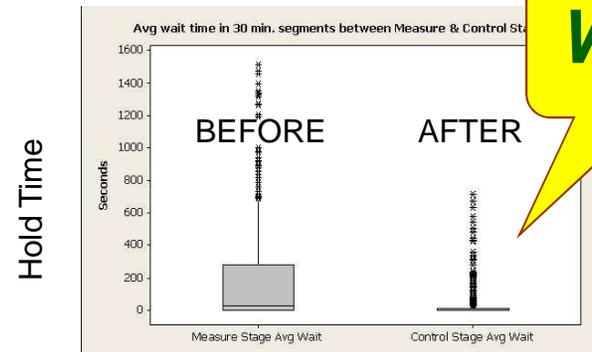
- Decrease process hold time to less than 90 seconds per call
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### RESULTS / BENEFITS

- Overall average hold time reduced to 33 seconds
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### IMPROVEMENTS

- Agent scheduling changes to handle peak times
- Agent training, area setup, shift change by SOP
- Phone menu tree and call handling improved
- Future ACD design requirements specified



Hold Time

**WOW!**

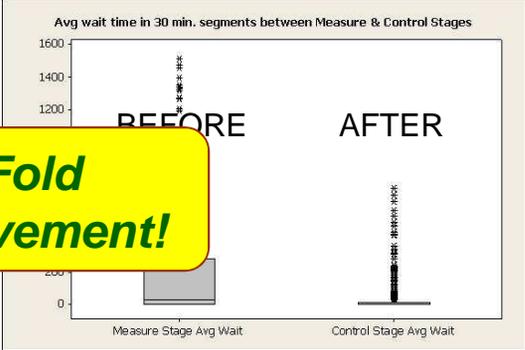
### REPLICATION / WAY-AHEAD

- Performance Action Plan Completed; Access to Care Initiative 17.2
- Adjust MEDCOM BSC telephone appting standards NLT 20 Apr 07
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- Replicate LSS projects across MEDCOM MTFs NLT Dec 08

# Project Summary: Carl R. Darnall AMC Telephone Appointing

## Mark Hernandez – Black Belt



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<p><b>PROBLEM STATEMENT</b></p> <p>The telephone appointing process at CRDAMC has observed low patient satisfaction scores and long process hold times. Over the last six months, it takes an average of 3:14 minutes to answer customer calls to make an appointment. This has led to numerous customer complaints which have led to lower patient satisfaction scores for telephone appointing services.</p> <p><b>BASELINE</b></p> <ul style="list-style-type: none"> <li>▪ Army's largest call center: 10,000+ calls a week</li> <li>▪ Low customer satisfaction: 68%</li> <li>▪ <b>Average wait time: 3:14 minutes</b></li> <li>▪ Calls answered under 90 seconds: 65%</li> <li>▪ Overall call abandon rate: 26%; Peak time: 49%</li> </ul> <p><b>GOAL</b></p> <ul style="list-style-type: none"> <li>▪ <b>Decrease process hold time to less than 90 seconds/call</b></li> <li>▪ Decrease overall abandoned call rate to less than 10%</li> <li>▪ Decrease peak time call abandon rate to less than 25%</li> </ul>	<ul style="list-style-type: none"> <li>▪ Agent scheduling changes to handle peak times</li> <li>▪ Agent training, area setup, shift change by SOP</li> <li>▪ Phone menu tree and call handling improved</li> <li>▪ Future ACD design requirements specified</li> </ul> 
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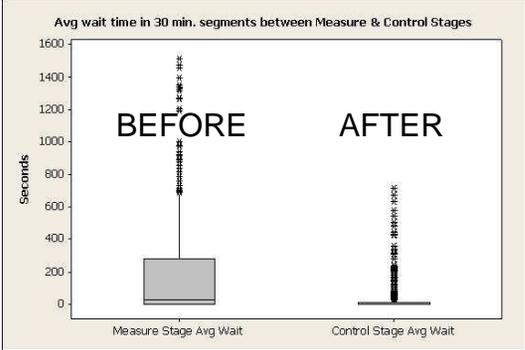


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**Disciplined,  
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Transfer Best-  
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# For additional information on these topics in the US Army Medical Command, Contact

Directorate of Strategy and Innovation

703.681.5000



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