

Empanelment: A Novel Healthcare Initiative - A Viewpoint

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INTRODUCTION

Military Hospital management in Nepal is evolving to balance the growing demand of healthcare to active members of the military, veterans and dependents. Management has to continuously explore measures to enhance productivity and improve patient care. Multiple challenges constitute providing cost-effective quality healthcare while maintaining a workforce capable of meeting both peace and wartime needs. Military health services in countries facing similar challenges are known to respond by expanding the role of the medical professionals;¹ restructuring following benchmarking practices with civilian healthcare providers;² partnering with civilian healthcare providers³ amongst others. In this context, a novel empanelment was implemented at Military Hospital Itahari (MHI), the third and most recent upgraded Military Regional Command Hospital at Itahari, Nepal with two already functioning at Pokhara and Nepalgunj, mid west and western regions of Nepal.

Empanelment in healthcare has multiple arrangements despite its centrality in many effective primary healthcare systems. On one end of the continuum, it means implementation of iterative processes to

identify and assign populations to facilities, care teams, or providers who have a responsibility to know their assigned population – panel – and to proactively deliver coordinated primary healthcare towards achieving universal health coverage. For this type of empanelment to drive improvements in health outcomes, the services delivered must be of sufficient quality to be effective and include promotive, preventive, curative, rehabilitative, and palliative health services, aligning with the WHO vision of universal health coverage.⁴ On the other hand, it can mean a contractual arrangement whereby a provider, fulfilling qualification and subsequent selection process, to perform procedures and services on eligible patients for predetermined charges. MHI has the latter arrangement with Birat Medical College and Teaching Hospital (BMCTH), a civilian tertiary care provider in Biratnagar, Nepal.⁵

DISCUSSION

MHI was upgraded from 25-bedded field hospital to provide the right care at the right place and the right

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Table 1. Patients at MHI (Per Nepali Month) (First 6 Months)

Department/Month	Baisakh (Mid Mar - Mid Apr)	Jesth (Mid Apr - Mid May)	Asar (Mid May - Mid Jun)	Shrawan (Mid Jun - Mid Jul)	Bhadra (Mid Jul - Mid Aug)	Aswin (Mid Aug - Mid Sep)	Total
MOPD	106		40	37	15	0	198
SOPD	107		3	33	37	0	180
ORTHO	194		66	67	14	0	341
USG	106		76	85	52	0	319
GOPD / Emergency	1,133	1,007	1,361	1,390	1,487	555	6,933
GYNAE	40			3	101	51	195
PAEDIATRIC	56			2	20	10	88
DENTAL	99		5	31	16	3	154
Lab test	380	105	175	313	390	75	1,438
ENT	99	37	59	100	130	50	475
In patient	32	22	28		51	35	168
Total	2,352	1,171	1,813	2,061	2,313	779	10,489

Table 2. Referred Patients at BMC (Per Nepali Month)
(First 6 Months)

Department/Month	Baisakh (Mid Mar - Mid Apr)	Jesth (Mid Apr - Mid May)	Asar (Mid May - Mid Jun)	Shrawan (Mid Jun - Mid Jul)	Bhadra (Mid Jul - Mid Aug)	Aswin (Mid Aug - Mid Sep)	Total
MOPD	16	2	4	1	2	2	27
SOPD	20	5	3	4	7	1	40
ORTHO		3	3	2	4	2	14
USG	22	17	5	7	19	13	83
Emergency	22	21	15	9	33	20	120
GYNAE				2	3	0	5
ECHO	5	4	3	3	3	0	18
DENTAL	2					2	4
Lab test	58	20	24	22	22	0	146
SKIN	7			1		0	8
Eye	10	2	1			0	13
UGIE	6	1				8	15
In Patient	30	22	17		20	22	111
Total	198	97	75	51	113	70	604

time thereby reducing referrals and medevac to tertiary level Shree Birendra Hospital in Kathmandu, Nepal. The 50-bedded hospital serves the Eastern Division. It was brought into operation by a team comprising the hospital Commandant, Gynecologist, Paediatrician, Dentist and two Medical Officers. One civilian Medical Officer initially hired on contract was later followed by three more. At full capacity, it is planned to have 170 personnel comprising a Surgeon, Physician, Anesthetist, Radiologist, Pathologist, Ophthalmologist,

Otolaryngologist, Dentist and two Medical Officers for advanced dressing station. Its management committee, chaired by the Eastern Division Commander, has three officer members with hospital Commandant serving as member secretary.⁶

The empanelment became effective from the date of commissioning, inaugural day, of the hospital coinciding the Army Day on 20 February 2020. It started providing 24/7 A&E; OPDs for General,

Gynaecology, Paediatric, and Dental; Pharmacy, Physiotherapy; basic Pathology and Radiology services; and non-complicated inpatients. It started treating patients while the construction was in progress for support services like CSSD, oxygen plant, laundry, waste management, RO water treatment plant, mortuary, etc. Similarly, equipment for ICU ventilators, X-ray and suction machines; hematocrit and sodium potassium analyzers; and OT accessories were being installed.

Empanelment with BMCTH comprised:

- i) Contracting consultants for on-site OPDs for medicine, surgery, orthopedic and radiology (USG) four days per week (10:00 to 13:00) and an anesthesiologist for three days per week
- ii) IPD/OPD referrals at BMCTH for emergencies and services not available at MHI like trauma, critical care, ICU/NICU/maternity, post-surgery admissions, diagnostic tests, advanced investigations, major surgeries, CT/MRI/Mammogram, endoscopy/colonoscopy/bronchoscopy, histopathology, Na, K, TFT, HbA1c, etc. to be compensated at rates specified in the Government's health insurance scheme.⁷

The empaneled OPDs consistently served more patients than military doctors' (Table 1). Though it was disrupted during COVID-19 pandemic, the empaneled Consultants provided consultations via telephonic and virtual conferencing tools. OPD numbers fell in the

latter two months as MHI members were infected by COVID-19, limiting services only for emergency. Despite further complications due to supply chain disruptions and COVID-19 infection amongst BMCTH members also, empanelment ensured continued treatment of MHI beneficiaries at BMCTH (Table 2).

Effective empanelment implementation comprised instituting procedures clarifying treatment cost ceilings and co-payments for OPD tickets as well as reimbursement mechanisms for CT / MRI contrast and implants; centrally integrating patient records and treatment costs; clarifying provisions of bed types, medicine, food during treatment, entitlement for consumables and supplies; harmonizing dispensary facilities for cost effectiveness; monitoring treatment of admitted patients and costs to-date; settling claims; and assessing patient satisfaction for continuous improvement.

CONCLUSIONS

Despite differences of organizational cultures and practices between a military and a civilian hospital, while gaining operational capacity, MHI was able to provide acute and equitable healthcare with economy of time, cost, and convenience through empanelment even during the COVID-19 pandemic. Lessons from this pilot initiative can be adapted to enhance healthcare management systems.

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