

TRICARE Consumer Watch

South ♦ Quarter 3 CY 2004

HEALTH PROGRAM ANALYSIS & EVALUATION DIRECTORATE

South: Sample size-14,038 Response rate-32.3%

MHS: Sample size-50,000 Response rate-28.7%

Inside Consumer Watch

TRICARE Consumer Watch is a brief summary of what TRICARE Prime enrollees in your region say about their healthcare. Data are taken from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB includes questions from the Consumer Assessment of Health Plans Survey (CAHPS). Every quarter, a representative sample of TRICARE beneficiaries are asked about their care in the last 12 months and the results are adjusted for age and health status and reported in this publication. In 2004, a new version of CAHPS (3.0) is used. Some new questions cannot be compared with the old ones.

Scores are compared with averages taken from the 2003 National CAHPS Benchmarking Database (NCBD), which contains results from surveys given to beneficiaries by civilian health plans.

Health Care

Prime enrollees were asked to rate their healthcare from 0 to 10, where 0 is worst and 10 is best.

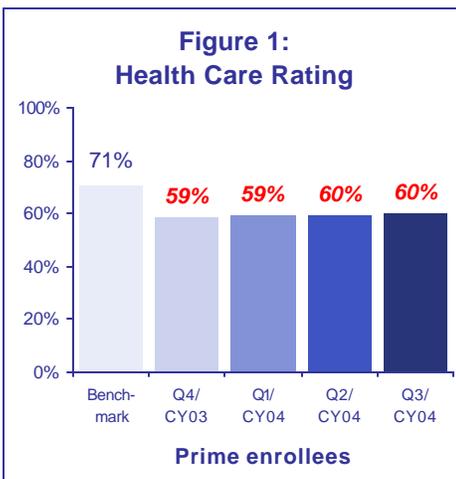
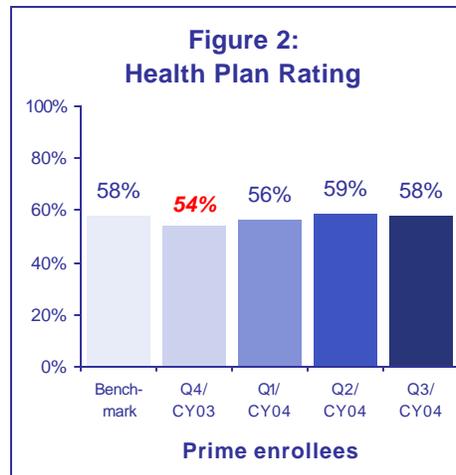


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 3rd quarter of

2004, describing the period July 2003 to June 2004, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark ($p < .05$). Health care ratings depend on things like access to care, and how patients get along with the doctors, nurses, and other care providers who treat them.

Health Plan

Prime enrollees were asked to rate their health plan from 0 to 10, where 0 is worst and 10 is best. Figure 2 shows the percentage who rated their plan 8 or above for each reporting period.

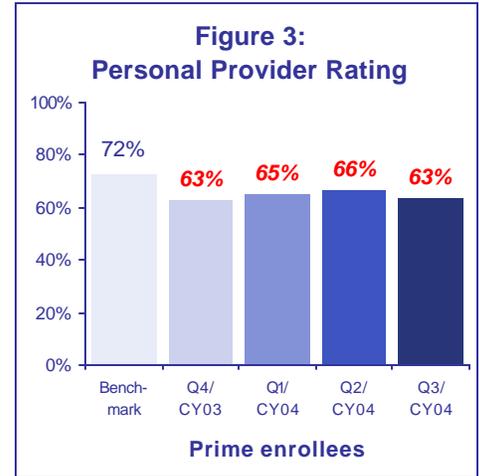


Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

Personal Provider

Prime enrollees who have a personal provider were asked to rate their personal provider from 0 to 10, where 0 is worst and 10 is best.

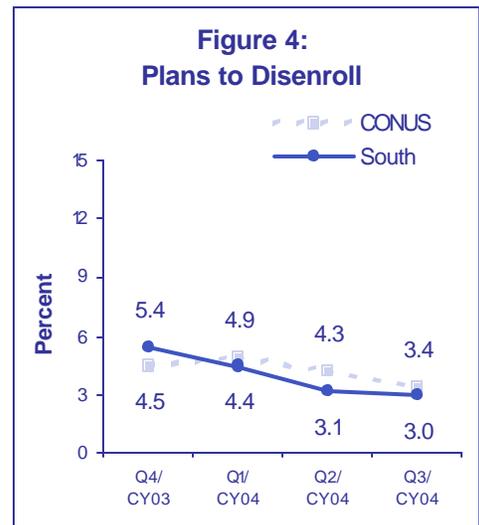
Figure 3 shows the percentage who rated their doctor 8 or above for each reporting period. Personal doctor ratings depend on how the patient gets along with the one doctor responsible for their basic care.



Plans to Disenroll

Enrollees were asked whether they plan to disenroll from Prime. Figure 4 shows the percentage of retirees and family members of active duty or retirees who plan to disenroll. Regional values differing significantly from CONUS ($p < .05$) are shown by red italics.

These groups have the option to disenroll if they choose, so their planned disenrollment rate is an overall measure of satisfaction with Prime.

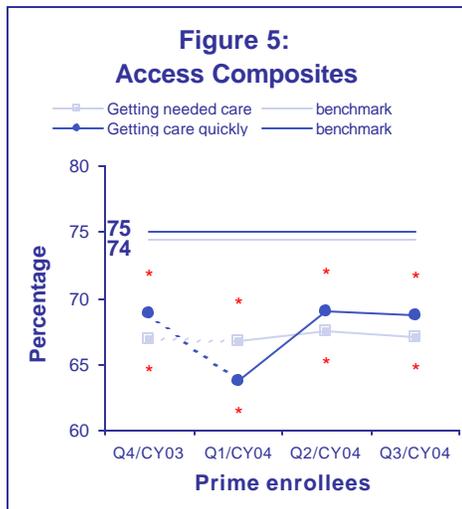


Health Care Topics

Health Care Topics scores average together results for related questions. Each score represents the percentage who “usually” or “always” got treatment they wanted or had “no problem” getting a desired service. Asterisks show values significantly different from the NCBD benchmark ($p < .05$). Hatched lines show where CAHPS 3.0 scores cannot be compared to CAHPS 2.0.

Figure 5 (Access Composites) includes the composites “Getting needed care” and “Getting care quickly.”

Scores in “Getting needed care” are based on patients’ problems getting referrals and approvals and finding a good doctor.



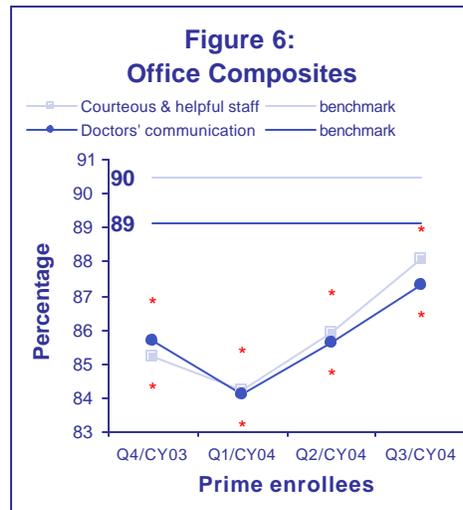
“Getting care quickly” scores concern how long patients wait for an appointment or wait in the doctor’s office.

Figure 6 (Office Composites) includes the composites “Courteous and helpful office staff” and “How well doctors communicate.”

Scores in “How well doctors communicate” are based on whether the doctor spends enough time with patients, treats them respectfully and answers their questions. “Courteous and helpful staff” scores measure both the courtesy and helpfulness of doctor’s office staff.

Figure 7 (Claims/Service Composites) includes composite scores for “Customer service” and “Claims processing.”

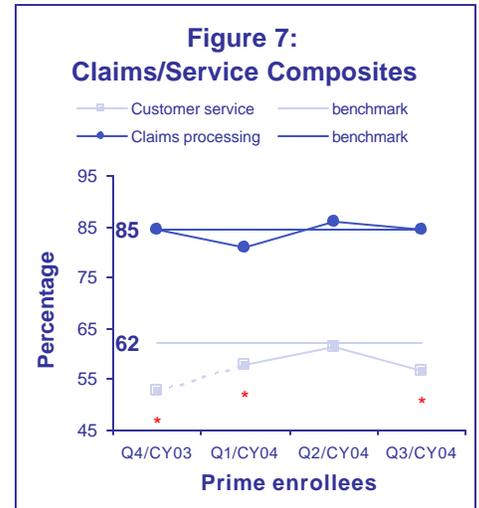
Scores in the “Customer service” composite concern patients’ ability to get information from phone lines and written materials, and the manageability of the health plan’s paperwork. “Claims processing” scores are based on both the timeliness and correctness of plan’s claims handling.



Preventive Care

The preventive care table compares Prime enrollees’ rates for several types of preventive care with goals from Health People 2010, a government initiative to improve Americans’ health by preventing illness. The table shows the most recent four quarters of data for five

measures of preventive care.



Mammography is the proportion of women over age 40 who received a mammogram in the past two years. Pap smear is the proportion of women over 18 who received a Pap smear for cervical cancer screening in the past three years. Hypertension indicates the proportion of all beneficiaries whose blood pressure was checked in the past two years and who know whether their blood pressure is too high. Prenatal care shows the proportion of women pregnant in the past 12 months who received prenatal care in the first trimester. Cholesterol screen is the proportion of all adults whose cholesterol was tested in the previous 5 years.

Rates that are significantly different ($p < .05$) from the Healthy People 2010 goal are shown by red italics.

Preventive Care					
Type of Care	Qtr 4 CY 2003	Qtr 1 CY 2004	Qtr 2 CY 2004	Qtr 3 CY 2004	Healthy People 2010 Goal
Mammography (women ≥ 40)	<i>81</i>	<i>84</i>	<i>83</i>	<i>79</i>	70 (550)
Pap Smear (women ≥ 18)	<i>93</i>	<i>94</i>	<i>93</i>	<i>92</i>	90 (1172)
Hypertension Screen (adults)	<i>89</i>	<i>90</i>	<i>90</i>	<i>90</i>	95 (2404)
Prenatal Care (in 1st trimester)	82	<i>93</i>	90	92	90 (140)
Cholesterol Screen (adults)	<i>79</i>	<i>79</i>	<i>77</i>	<i>77</i>	90 (2361)

Issue Brief: Referrals to Specialists

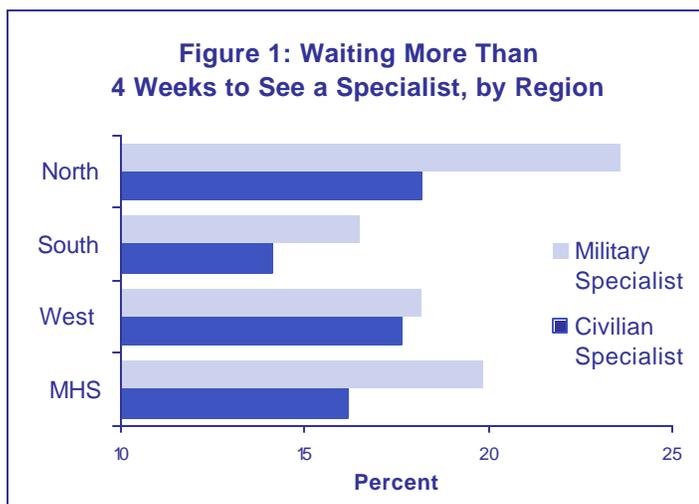
Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries. This quarter, the issue brief concerns problems with specialty referrals under TRICARE.

Under TRICARE Prime, military and civilian physician networks both provide care to enrolled patients. By permitting patients to get care from both sources, Prime increases patients' access to health care resources. However, combining the two networks creates challenges in care coordination and management. HPA&E recently conducted focus groups with physicians and patients to learn about problems with referrals to specialists under Prime¹. Both doctors and patients described barriers affecting access to specialists and communication between primary care managers (PCMs) and specialists. Questions were added to the HCSDB to learn more about these barriers.

Access to specialists

Before obtaining an appointment with a specialist, TRICARE enrollees must consult their PCM for a referral. Referrals from the PCM may be directed to a particular specialist or clinic, or to a particular specialty. In either case, TRICARE Access to Care standards require that the enrollee be provided an appointment within four weeks².

Figure 1 shows the proportion of enrolled patients who obtained appointments with civilian and MTF specialists within 4 weeks, by region. In spite of access standards, many enrollees report long waits for both direct care and civilian appointments. One sixth of those seeing civilian specialists and one fifth of those seeing military specialists report a wait of longer than 4 weeks. In the north, waits for military specialists are particularly long.



Twenty-four percent in the north report waiting more than 4 weeks to see a military specialist compared to 17 percent in the south and 18 percent in the west. There is less regional variation in waiting times for civilian specialists. In both the north and west region, 18 percent report waits of more than 4 weeks, compared to 15 percent in the south.

Patients who are referred to specialists may see a civilian specialist who is convenient to them or consult a direct care specialist. However, patients are referred to direct care specialists in preference to purchased care specialists if direct care specialists are available. In some regions, the civilian network may contain few members in the desired specialty. In regions where PCMs are reluctant to make referrals to civilian specialists or where the civilian network is weak, patients may be forced to travel long distances if their local MTF does not staff many specialists.

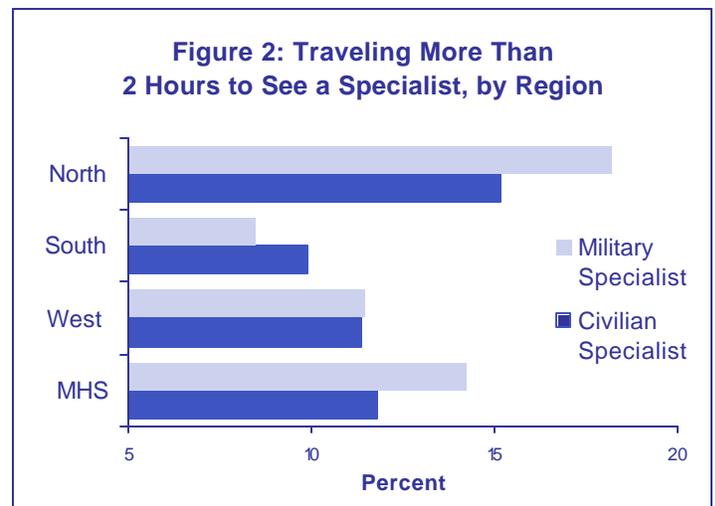


Figure 2 shows that travel times are longest in the north region. Eighteen percent report traveling over two hours to see a specialist at a MTF. Patients in that region are also likely to spend a long time traveling to see civilian specialists, with 15 percent reporting trips of more than two hours. Overall, Prime patients are only slightly more likely to make long trips for MTF specialty care (14 percent) than for civilian care (12 percent). The results indicate that preferences for MTF care do not greatly increase the patient's travel burden.

Issue Brief: Referrals to Specialists

Communication with specialists

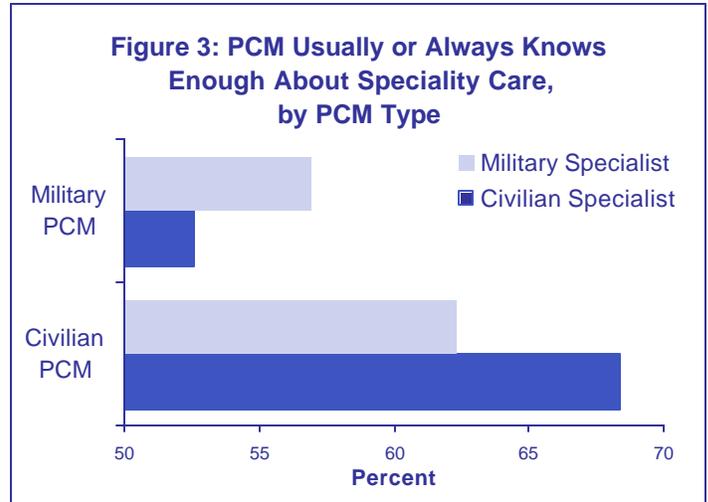
PCMs are responsible for managing the care the patient receives from all sources. By awareness of all the patient’s specialty care, the PCM can avoid unnecessary tests and treatments and manage all chronic and acute conditions. Focus groups revealed that both doctors and patients were concerned that communication between PCMs and specialists was poor. HCSDB results also indicate problems.

As shown by Table 1 information gets from specialists to PCMs by different routes depending on whether the referring PCM and specialist are military or civilian. PCMs learn about the patient’s treatment by talking to the specialist 37 percent of the time when both specialist and PCM are civilian and 20 percent of the time when the PCM is military and the specialist is a civilian. Military PCMs communicate with civilian specialists most often through the patient. Twenty-seven percent of patients with military PCMs report that they are responsible for keeping their PCM informed about their treatment from specialists. By contrast when the specialist is military, neither civilian nor military PCMs are likely to communicate directly with the specialist. Military PCMs are most likely to refer to the patient record (34 percent), while civilian PCMs most often refer to the patient record (24 percent) or the patient (23 percent).

PCM	Specialist	Communication Method*		
		By Patient Record	Through Patient	Doctor to Doctor
Percent				
Military	Military	34	19	11
	Civilian	15	27	20
Civilian	Military	24	23	14
	Civilian	11	20	37

*Omitted categories: Don't know, PCM does not keep track

As a result, many patients do not feel that their PCM gets enough information about their specialty care. As shown in Figure 3, only 52 percent of patients think their military PCM usually or always knows enough about their care from civilian specialists. Communication is rated best when both PCM and specialist are civilian. Sixty-eight percent with civilian PCMs think that their PCM usually or



always knows enough about their care from civilian specialists. Whether the specialist is from direct care or purchased care, patients with civilian PCMs feel that their PCM is better informed about their specialty care than do patients with military PCMs.

Conclusions

Long waits for appointments and long trips to see specialists vary by region, and appear to be most frequent in the north. These problems may be explained by weaknesses in the civilian network. Strengthening the civilian network may help to overcome them. Communication problems are greatest when civilian specialists provide care to patients of military PCMs. To ensure high quality care, more must be done to break down barriers between the military and civilian networks.

REFERENCES

¹ Cohen, R, Zeidman, E and Schone, E. *The TRICARE Referral and Authorization Process: Findings from Focus Groups with Providers and Beneficiaries*. Mathematica Policy Research, Washington DC. July, 2004.

² United States General Accounting Office. *Factors Affecting Contractors’ Ability to Schedule Appointments* (GAO-00-137). Washington, DC: July 2000.