
APPENDIX F

ACCESS TO CARE METRICS AND MEASURES

1. METRICS AND MEASURES SOURCES

1.1. The four metrics and sixteen measures described in this appendix are recommended, so that MTFs can track their progress in the implementation and sustainment of access improvement initiatives. MTF Access Managers are able to collect the data for these metrics and measures either from their local appointing information systems in the form of canned or ad-hoc reports or they can use MHS or Service level sources. The TRICARE Operations Center (TOC), and some Service and intermediate command level sources provide web based tools and reports that measure various components of access to care and appointing processes. Please check with your MTF chain command of command for the availability of these reports and tools. These tools and reports from the TOC and from other higher level sources update their tools and reports on regular basis daily, weekly, or monthly. The goal of these centralized tools and reports is to save the access manager time in locally gathering the same data and provides them the information they need to make timely and informed decisions about monitoring and improving access.

1.2. A good rule of thumb is that if the data for a particular performance measurement cannot be routinely gathered due to system or resource limitations, a 10 percent random sampling of available data may be used. These metrics and measures may be used to document relevant information that may have affected performance such as special cause variations, i.e. unexpected deployment of physicians that hindered the ability to meet access standards. The MTF commander may designate more frequent analyses (i.e., weekly) or more detailed analysis (i.e., measurement by individual provider). The goal is to analyze both process and special cause variations to provide as much feedback as needed to those who have the capability to make improvements in the system.

2. METRICS OVERVIEW: The goal of access improvement is to implement and sustain a systematic, proactive, and responsive MTF access management plan for all clinics and services that meets or exceeds the mandate that healthcare services will be provided within the Access To Care (ATC) standards as stated in 32 Code of Federal Regulations 199.17. These are that the wait time for an appointment for Active Duty and TRICARE Prime personnel for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours. With the concurrence of access management personnel from the Army Medical Department, Navy Bureau of Medicine and Surgery and the Air Force Surgeon General's Office headquarters, this appendix establishes four metrics that will be utilized to measure if these standards are being met. The following chart below briefly summarized these Access to Care metrics:

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ATC Measurements	Data Source
Metric #1. Acute appointments made and not made within 24 hours	CHCS ATC Summary Report
Metric #2. Routine appointments made and not made within 7 days	CHCS ATC Summary Report
Metric #3. Wellness appointments made and not made within 28 days	CHCS ATC Summary Report
Metric #4. Specialty appointments made and not made within 28 days	CHCS ATC Summary Report

Below is a detailed description of each metric:

2.1. Metric #1: Wait time for urgent (acute) care appointments less than twenty four hours

Rationale: This metric measures how well TRICARE access standards are being met when scheduling urgent (acute) care appointments for Active Duty and TRICARE Prime enrollees. The measure indicates the number and percentage of urgent (acute) care appointments scheduled within 24 hours and the number and percentage of urgent (acute) care appointments scheduled greater than 24 hours from the time the need for this appointment is determined.

Users: Providers, clinic managers, appointing staffs (MCSC and MTF), MTF executive staff, TMA, Service Headquarters

Definition: The appointment types for urgent (acute) care are ACUT, ACUT\$, OPAC, and OPAC\$. An urgent (acute) care appointment is reserved for non-emergent, urgent care that is typically delivered by an MTF or network Primary Care Manager (PCM). Acute care services for Active Duty and TRICARE Prime enrollees shall be scheduled no greater than 24 hours from the time the need for this appointment is determined.

Exceptions: If a beneficiary waives the 24-hour access standard and the waiver is documented using the CHCS Patient Refusal Option, or the facility cancels an appointment and reschedules immediately using the CNOT cancel option, the appointment will not be included in the total # not scheduled within 24 hours. If the provider or clinic cancels the appointment and does not reschedule within the original 24-hour window, the appointment shall be counted as not meeting the access standard. An appointment still meets the access standard if the scheduled visit is within the 24-hour window to the minute but the beneficiary is no-show, patient cancel, or leave without being seen. For those MTFs that use Open Access appointing, see Appendix J of this guide for additional measures.

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Recommended Frequency: Monthly

Source Data System/File/Report: CHCS Patient Appointment File/ATC Summary Report

Target/Threshold/Benchmark: On-going compliance is expected to be not less than 90 percent of booked urgent care (acute) appointments.

2.2. Metric #2: Wait time for routine care appointments shall not exceed seven calendar days.

Rationale: This metric measures how well TRICARE access standards are being met when scheduling routine care appointments for Active Duty and TRICARE Prime enrollees. The measure indicates the number and percentage of routine care appointments scheduled within seven days and the number and percentage of routine care appointments scheduled greater than seven calendar days from the time the need for this appointment is determined.

User: Providers, clinic managers, appointments staffs (MCSC and MTF), MTF executive staff, TMA, Services Headquarters

Definition: The appointment types for routine care are ROUT, ROUT\$. A routine care appointment is designated for patients who require a visit with their PCM for a new healthcare problem that is not considered urgent. Routine care for Active Duty and TRICARE Prime enrollees shall be scheduled within seven calendar days from the time the need for this appointment is determined.

Exceptions: If a beneficiary waives the seven calendar day access standard and the waiver is documented using the CHCS Patient Refusal Option, or the facility cancels an appointment and reschedules immediately using the CNOT cancel option, the appointment will not be included in the total number not scheduled within seven calendar days. If the provider or clinic cancels the appointment and does not reschedule within the original seven calendar day window, the appointment shall be counted as not meeting the access standard. An appointment still meets the access standard if the scheduled visit is within the seven day window to the minute but the beneficiary is no-show, patient cancel, or leave without being seen.

Recommended Frequency: Monthly

Source Data System/File/Report: CHCS Patient Appointment File/ATC Summary Report

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Target/Threshold/Benchmark: On-going compliance is expected to be not less than 90 percent of booked routine appointments.

2.3. Metric #3: Wait time for wellness care appointment shall not exceed 28 calendar days.

Rationale: This metric measures how well TRICARE access standards are being met when scheduling wellness care appointments for Active Duty and TRICARE Prime enrollees. The measure indicates the number and percentage of wellness care appointments scheduled within 28 days and the number and percentage of wellness care appointments scheduled greater than 28 calendar days from the time the need for this appointment is determined.

Users: Providers, clinic managers, appointments staffs (MCSC and MTF), MTF executive staff, TMA, Service Headquarters

Definition: The appointment types for wellness care are WELL, WELL\$, and PCM, PCM\$. A wellness care appointment is designated for patients who require a visit for a wellness/or preventive health concern or with their PCM for an initial visit. This wellness care for Active Duty and TRICARE Prime enrollees shall be scheduled within 28 calendar days from the time the need for this appointment is determined.

Exceptions: If a beneficiary waives the 28 calendar day access standard and the waiver is documented using the CHCS Patient Refusal Option, or the facility cancels an appointment and reschedules immediately using the CNOT cancel option, the appointment will not be included in the total number not scheduled within 28 calendar days. If the provider or clinic cancels the appointment and does not reschedule within the original 28 calendar day window, the appointment shall be counted as not meeting the access standard. An appointment still meets the access standard if the scheduled visit is within the 28 day window to the minute but the beneficiary is a no-show, patient cancel, or leave without being seen.

Recommended Frequency: Monthly

Source Data System/File/Report: CHCS Patient Appointment File/ATC Summary Report

Target/Threshold/Benchmark: On-going compliance is expected to be not less than 90 percent of booked wellness appointments.

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2.4. Metric #4: Wait time for specialty care appointment shall not exceed 28 calendar days.

Rationale: This metric measures how well TRICARE access standards are being met when scheduling specialty care appointments for Active Duty and TRICARE Prime enrollees. The measure indicates the number and percentage of specialty care appointments scheduled within 28 calendar days and the number and percentage of specialty care appointments scheduled greater than 28 calendar days from the time the need for this appointment is determined.

Users: Providers, clinic managers, appointments staffs (MCSC and MTF), MTF executive staff, TMA, Service Headquarters

Definition: The appointment types for specialty care are SPEC, SPEC\$, PROC, PROC\$. A specialty care appointment (SPEC or SPEC\$) is designated for patients who require an initial consult, referral, or initial self-referral. Specialty care for Active Duty and TRICARE Prime enrollees shall be scheduled within 28 calendar days from the time the need for this appointment is determined. A specialty care appointment also includes procedures (PROC, PROC\$) designated for patients in need of medical procedures other than those performed in the Ambulatory Procedure Unit (APU B**5-MEPRS clinics).

Exceptions: If a beneficiary waives the 28 calendar day access standard and the waiver is documented using the CHCS Patient Refusal Option, or the facility cancels an appointment and reschedules immediately using the CNOT cancel option, the appointment will not be included in the total number not scheduled within 28 calendar days. If the provider or clinic cancels the appointment and does not reschedule within the original 28 calendar day window, the appointment shall be counted as not meeting the access standard. An appointment still meets the access standard if the scheduled visit is within the 28 day window to the minute but the beneficiary is no-show, patient cancel, or leave without being seen.

Recommended Frequency: Monthly

Source Data System/File/Report: CHCS Patient Appointment File/ATC Summary Report

Target/Threshold/Benchmark: On-going compliance is expected to be not less than 90 percent of booked specialty care appointments.

3. MEASURES OVERVIEW. Access management personnel from the Army Medical Department, Navy Bureau of Medicine and Surgery and the Air Force Surgeon General's Office, also recommend the measures listed below that MTF and intermediate command

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access managers may want to use to assist them to improve and sustain access to care processes in their organizations. The following chart summarizes these recommended measures.

Recommended ATC Measures	Data Source
1. Number of beneficiaries enrolled per PCM	M2, CHCS, TOC PCM enrollment report
2. Number of Primary Care visits per enrollee per year	CHCS, M2
3. Number of total appointments made available to appointing entities: Percentage of MTF Book Only appointments (\$)	TOC/MTF ATC Management Report and appointment activity tool (Appointment listed by status/type)
4. Number of Open Access appointments requested and booked for the same day	Appointment records from the Patient Appointment File of CHCS
5. Unbooked Appointment Slots	CHCS Schedule Entity File, TOC ATC Management Report
6. # Unbooked Appointment Requests (UAR)	CHCS Unbooked Appointment Report data
7. # and % of MTF Enrolled Patients Sent to MCS Contractor Network for Specialty Care	CHCS Ad-Hoc Deferral Report produced by the MCSC
8. Number of Emergency Room (ER) Visits in the MTF and the Network	MCS Contractor Systems, CHCS MCP and M2
9. Number of Unscheduled Visits (Walk-in, Sick Call)	CHCS/PAS Files/ Appointment Utilization Report/TOC Access Management Report
10. # and % of MTF Enrolled Beneficiaries Referred to the MCS Contractor Network (Deferred to Network) for Primary Care	MCSC Referral Management Ad Hoc Report
11. Percentage of No Show Appointments	CHCS/ PAS Files/ CHCS Appt Utilization Rpt, TRICARE Ops Center Access Mgmt Report; TRICARE Ops Center Appt Activity Tool
12. Number Of Patients Waiving Access Standards By Access To Care Category	CHCS Access to Care Summary Report
13. Appointment Schedules Opened 30 Calendar Days or More in Advance	CHCS/ CHCS Schedulable Entity File/CHCS Managers Reports/ TRICARE Ops Cen Template Analysis Tool
14. Appointment Mix Meeting the Needs of Beneficiary Population	CHCS Schedulable Entity File, CHCS Managers Reports TRICARE Ops Cen Template Analysis Tool
15. Number of Appointments Booked Using the Future Access To Care Category	CHCS Patient Appointment File /ATC Summary Report/TOC
16. Patient Satisfaction with Access to Care	MHS Satisfaction Survey or Service Developed Tools

Each measure is described in more detail starting in paragraph 3.1 below.

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3.1. Measure One: Number of Beneficiaries Enrolled Per PCM

Rationale: MTFs should monitor the number of enrolled beneficiaries for each PCM to ensure the provider is able to meet the healthcare demands for his/her enrolled population. An over enrolled PCM may be unable to meet the demand. The population may seek care through alternate military or civilian PCMs or ERs. An under enrolled PCM may appear less productive and less efficient on business models.

User: Primary Care Clinic Managers, Access Managers, Enrollment Managers

Definition: Number of enrolled beneficiaries include Prime, Plus, and non-enrolled Active Duty. MTFs with GME programs may also include space available beneficiaries in order to meet the needs of its education programs. Patient Acuity should be considered when developing PCM Panels.

Exceptions: None

Recommended Frequency: Monthly

Source Data System: M2, CHCS, TOC PCM enrollment report

Target/Threshold/Benchmark: Full time equivalent PCMs traditionally maintain an enrolled population of 1,200-1,500 beneficiaries. This number may fluctuate based on the PCMs specialty and case mix and acuity of the enrolled population.

3.2. Measure Two: Number of Primary Care Visits Per Enrollee Per Year

Rationale: MTFs will need to review and understand their population's demand for primary care services. Beneficiary categories will require different healthcare services at different rates. MTFs should understand how each beneficiary group consumes Primary Care services in order to apportion appointments to meet this demand.

Users: Primary care clinic managers, access managers, enrollment managers

Definition: The total number of MTF, clinic, or PCM Primary Care visits divided by the total number of enrollees for the designated MTF, clinic, or PCM.

Exceptions: Unmet demand may be a factor.

Recommended Frequency: Yearly

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Source Data System: CHCS, M2

Target/Threshold/Benchmark: MHS beneficiaries average 3.5 Primary Care visits per enrollee per year. This number may fluctuate based on the case mix of the enrolled population.

3.3. Measure Three: Number Of Total Appointments Made Available To Appointing Entities: Percentage Of MTF Book Only Appointments (\$)

Rationale: This measure determines the number of appointments the MTF has designated as MTF book only (\$). Appointments designated with a dollar sign (\$) are limited to clinic or MTF booking only. MTF book only designated appointments cannot be booked by appointment staff outside the clinic due to CHCS security key restrictions. These appointment types are not made available on TRICARE Online.

Users: Providers, clinic managers, and appointment staffs (centralized/non-centralized),

Definition: This measure is calculated by dividing the total number MTF book only designated appointments by the total number of planned appointments

Exceptions: None

Recommended Frequency: Monthly

Source Data System: TOC/MTF ATC Management Report and appointment activity tool (Appointment listed by status/type)

Target/Threshold/Benchmark: On-going compliance for MTF book only appointments is expected to be less than 10 percent of all planned appointment types

3.4. Measure Four: Number of Open Access Appointments Requested and Booked for the Same Day

Rationale: This measure relates to available open access appointments (same day) and the demand for this appointment type. Open access appointing means seeing today's work today and not shifting it beyond the same day request. This measure counts the number of open access appointments made available and the number of unfilled open access that were requested. The Open Access metric does not use any of the measures reflected on the ATC Summary Report. It is a measure of same day access in open access clinics engaged in open access appointing.

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Users: Providers, clinic managers, and appointment entities, MTF executive staff, Service Headquarters.

Definition: Metric is computed as follows:

Numerator: Number of appointment records where appointment requested date is the same calendar date as its final booked status to include kept, sick call, walk in, no show, left without being seen (LWOBS), patient cancel, facility cancel or pending, for the monthly reporting period.

Denominator: All appointment records requested and booked with a final booked status of kept, sick call, walk in, no show, LWOBS, patient cancellation, facility cancellation and pending for the same monthly reporting period. This includes all appointments requested and booked on the same day AND requested on one calendar day and booked on a later day.

DMIS ID: 123, Sample MTF, Gold Team, Clinic: Family Practice MEPRS Code: BGAA
Report Period: 1-31 May 05

NUMERATOR: 1115 appointments requested and booked on the same calendar day
DENOMINATOR: 1537 total appointments requested and booked for the month

SAME DAY PERCENTAGE: 72.5%

STATUS: Green \geq 60%

Exceptions: None

Recommended Frequency: Monthly

Source Data System/File/Report: Data for this metric will be derived from extracting appointment records from the patient appointment files of CHCS.

Target/Threshold/Benchmark: 60 percent of all primary care appointment requests are appointed for that calendar day.

3.5. Measure Five: Unbooked Appointment Slots

Rationale: This measure relates to all unbooked appointments including those appointments with the status of open, cancel, frozen, and wait. Unbooked appointments

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may reflect unused CHCS provider time made available for patient care or scheduling inaccuracies that need to be corrected or adjusted so all available appointment slots are all fully utilized.

Users: Providers, clinic managers, and appointment entities, MTF executive staff, Service Headquarters

Definition: this measure is calculated by dividing the total number unbooked appointments (open, cancel, frozen & wait) by the total number total planned clinic appointments

Exceptions: None

Recommended frequency: Monthly

Source data system: CHCS Schedule Entity File, TOC ATC Management Report

Target/threshold/benchmark: On-going compliance for unbooked appointment is expected to be less than 10 percent of all planned appointment types

3.6. Measure Six: # Unbooked Appointment Requests (UAR)

Rationale: This measurement relates to the number and percentage of beneficiary appointment requests that did not result in a booked appointment. This will potentially assist MTFs in managing unmet demand.

Users: Clinic managers, appointing staff/central appointing and MTF executive staff.

Definition: When appointing personnel do not book an appointment for a beneficiary they are required to document a reason. This data point provides assistance in managing the appointing process related to demand management.

Exceptions: None

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: CHCS/PAS/Unbooked Appointment Report.

Target/Threshold/Benchmark: Locally determined

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3.7. Measure Seven: # and % of MTF Enrolled Patients Sent to MCS Contractor Network for Specialty Care

Rationale: This measure is used to identify direct care specialty care capacity concerns.

Definition: Number of MTF Enrolled patients requesting specialty care that could not be accommodated by the MTF. This will assist the service in identifying access and or capacity issues.

Exceptions: This may include those specialty services that are not available at the MTF.

Frequency: Monthly/Weekly - Drill down to Clinic

Source Data System/File/Report: CHCS Ad-Hoc Deferral Report produced by the MCSC

Target/Threshold/Benchmark: Local policy

3.8. Measure Eight; Number of Emergency Room (ER) Visits in the MTF and the Network

Rationale: This measurement relates to the number and percentage of non –emergent patients seen in the MTF ER and in the network ER. Enables Clinic Management staff to see if non-emergent clinic workload is “leaking” to other areas within the MTF and network. Analysis will provide insight into overall access.

User: Clinic Management, MTF executive staff and Services.

Definition: The number and percentage of non –emergent patients actually seen in the MTF ER or in MCS contractor ER facilities. Increases in both factors may indicate a non-availability of desired MTF appointments by patients in Primary Care.

Exceptions: None

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: MCS Contractor Systems, CHCS MCP and M2

Target/Threshold/Benchmark: Locally determined

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3.9. Measure Nine: Number of Unscheduled Visits (Walk-in, Sick Call)

Rationale: This metric will analyze whether capacity meets demand, whether appointments are available at convenient times for the beneficiaries.

Definition: This measurement is utilized primarily to identify deficiencies in primary care availability. A high percentage of unscheduled visits may indicate insufficient demand planning and or resource allocation.

Exceptions: This will not apply to MTFs that utilize Military Sick Call, or have an after hour Urgent Care clinic.

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: CHCS/PAS Files/ Appointment Utilization Report/TOC Access Management Report

Target/Threshold/Benchmark: MHS Business Planning guidance recommends less than 10%.

3.10. Measure Ten: # and % of MTF Enrolled Beneficiaries Referred to the MCS Contractor Network (Deferred to Network) for Primary Care

Rationale: This measure is used to determine primary care capacity concerns. This may allow the MTF to review how care is provided and potentially re-capture workload.

Definition: Number of MTF Enrolled **beneficiaries** requesting primary care that could not be accommodated by the MTF. This will assist the service in identifying access and or capacity issues.

Exceptions: This would include those primary care services that are not available at the MTF.

Frequency: Monthly/Weekly - Drill down to Clinic

Source Data System/File/Report: CHCS MCSC Referral Management Ad Hoc Report

Target/Threshold/Benchmark: Local policy

3.11. Measure Eleven: Percentage of No Show Appointments

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Rationale: This measure is designed to capture the ratio of scheduled appointments for which the scheduled patient fails to appear compared to the number of appointments booked for that clinic for the month. Some reasons for no shows include the following; patients forgetting appointment dates; appointment times not convenient, no responsive appointment cancellation process, last minute installation exercises, or a lack of patient education on the clinic consequences of no shows. Strategies to decrease high no-show rates include: having a responsive appointment cancellation process; using the MTFs automated appointment reminder system; increased command emphasis on no-show policies, informing line commanders on active duty no shows and; template managers being allowed to double book appointments slots. No show rates may adversely affect ADSM readiness.

Users: Access managers, clinic managers, appointment staffs, MTF executive staff, and Service Headquarters.

Definition: Number of appointment "no shows" as marked by end of day status, divided by the number of booked appointments.

Exceptions: None

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: CHCS/ PAS Files/ CHCS Appointment Utilization Report, TRICARE Operations Center Access Management Report; TRICARE Operations Center Appointing Activity Tool.

Target/Threshold/Benchmark: Not more than 5 percent of all appointments booked during the month should be a "no show".

3.12. Measure Twelve 12: Number Of Patients Waiving Access Standards By Access To Care Category

Rationale: This measure allows access managers to determine the number of patients that waived access standards for a particular category of care. The patient's reason for doing so may include many reasons. Access managers need to carefully analyze there meaning. Conclusions may be drawn if there are increased numbers for a particular clinic or provider. These trends may indicate that schedules need to be reviewed to determine if they are meeting the scheduling needs of patients and that the appropriate mix of appointment types and times are available. Some of the reasons that patients wave access standards may indicate that the times that were offered to patients during the ATC

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standard were not convenient to meet their needs; patients wanted to continue seeing their own PCMBN and elected continuity over being treated in a more timely manner; may indicate that appointment types of correct variety were not available to the appointing agents, or that the appointing agents were not allowed to change appointment types that satisfied the patient's need.

Definition: Number of patients scheduling appointments who were offered an available appointment within access standards for a particular ATC category (Acute, Routine, Wellness and Specialty), but for whatever reason elected to waive the access standards of 24 hours, 7 days or 28 days and take an appointment outside of these standards.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: CHCS/ PAS Files/ ATC Summary Report

Target/Threshold/Benchmark: Local policy

3.13. Measure Thirteen: Appointment Schedules Opened 30 Calendar Days or More in Advance

Rationale: In accordance with Service level policies, clinic schedules are to be opened allowing for a continuous supply of appointments at least 30 calendar days into the future. Access managers should monitor that clinic schedules are opened and appointments are made available for booking at least 30 days into the future to ensure that appointing agents find it more easily to search for and book appointments for patients. Increasing the numbers of appointments allows patients to have ample choices to satisfy their needs on their first request. It minimizes the possibility of patients calling back because the schedules are not opened. It speeds telephonic response times and reduces the interaction between appointing agents and nurses and the use of telephone consults due to the lack of appointments being available on schedules. A continuous supply of at least 30 days of appointments opened into the future improves the probability of allowing for the scheduling of follow-up appointments prior to the patient leaving the clinic from their initial primary care or specialty care evaluation. Maintaining 30 days of open schedules also allows for the booking of specialty care and wellness appointments which both have 28 day ATC standards.

Users: Access managers, providers, clinic managers, appointments staffs, MTF executive staff, Services headquarters.

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Definition: Provider Schedules including nurses, and technicians, open allowing for at least a continuous 30 day supply of appointments available for booking.

Exceptions: None

Recommended Frequency: At a minimum, weekly

Source Data System/File/Report: CHCS/CHCS Schedulable Entity File/CHCS Managers Reports/TRICARE Operations Center Template Analysis Tool.

Target/Threshold/Benchmark: All providers', including nurses and technicians', appointing schedules will be opened and made available to appointing agents at least 30 days into the future.

3.14. Measure Fourteen: Appointment Mix Meeting the Needs of Beneficiary Population

Rationale: Access, template managers and clinic leaders need to periodically monitor the appointment mix of their schedules to ensure that the appointing mix matches the desired practice patterns of the clinic and the individual providers and meets the healthcare needs of the beneficiary population. In order to estimate the appointment mix that the clinic needs, access, template and clinic managers need to know their clinic's patient population and their healthcare needs. The appointment mix is expressed in appointment types and may include one or all of the appointments varieties listed in Appendix H. The types of appointment required on the schedule should consider supply factors such as the number of appointments required by each provider to service their enrolled panel, to include consideration of their patient's age, gender, disease entity, mission, occupational exposure, acuity; maintaining their provider's skill level, etc. A continued analysis of the needed mix, and numbers of appointments may indicate that tools such as the automatic appointment schedule reconfiguration function of CHCS may be needed to adjust numbers, types, slot durations and detail codes to be opened for appointing agents to book.

Users: Access managers, providers, clinic managers, appointments staffs, MTF executive staff, Service headquarters.

Definition: Schedules for Providers, including nurses, and technicians contain an adequate mix of appointments that meet the healthcare needs of the beneficiary population.

Exceptions: None.

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Recommended Frequency: Weekly

Source Data System/File/Report: CHCS/CHCS Schedulable Entity File/CHCS Managers Reports/TRICARE Operations Center Template Analysis Tool.

Target/Threshold/Benchmark: Clinic schedules will contain an adequate mix of appointments based on the need established by the beneficiary population.

3.15. Measure Fifteen: Number of Appointments Booked Using the Future Access To Care Category

Rationale: This measure allows access managers to determine the number of appointments that were searched for and booked using the Future ATC Category of the CHCS booking function. There is no time standard established by CHCS that has to be met when using the Future ATC Category. Large numbers of future searches may indicate a lack of Acute, Routine, Wellness and Specialty appointments as well as potential avoidance of ATC automated tracking features.

User: Access managers, providers, clinic managers, appointing staffs, MTF executive staffs, Services headquarters.

Definition: The ATC Future search is designated for patients that require follow-up appointments, group visits, or other services that are provider designated and do not have an associated access to care standard.

Exceptions: None.

Recommended Frequency: Monthly

Source Data System/File/Report: CHCS Patient Appointment File /ATC Summary Report/TOC

Target/Threshold/Benchmark: Service or locally defined

3.16. Measure Sixteen: Patient Satisfaction with Access to Care

Rationale: MTFs can use locally, Service Headquarter or MHS developed tools that monitor patient satisfaction with Access to Care. Many of these tools can drill down to clinic, provider satisfaction measures and individual patient comments. Trends in a MTFs patient's attitudes about their satisfaction with areas such as ease of making an

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appointment, first call resolution, courtesy of appointing staff, etc, though subjective, can alert access managers to possible issues/problems with their appointing processes. When satisfaction measures are used with the other access measures, this combination provides a more complete picture of a MTFs/clinic's access performance.

Users: Access managers, clinic managers, appointing staffs, MTF executive staff, and Services headquarters

Definitions: Various tools use varying measures to gather patient satisfaction data. These data can range from the collection paper, telephonic or web-based survey data using rating scales, to that of gathering free text comments. These data are generally expressed as a rate/level of satisfaction with some dimension access that was surveyed.

Exceptions: None

Frequency: Weekly, Monthly - Drill down to Clinic, Provider.

Source Data System/File/Report: Locally developed surveys may be used when available and Service authorized. If MTFs have Service patient satisfaction level surveys, they should be used as the primary source for monitoring patient satisfaction. These Survey Tools include:

- Army Medical Department-Army Provider Level Satisfaction Survey (APLSS)
- Air Force Medical Service-AFMS Service Delivery Assessment (SDA)
- Navy Medicine-Online Patient Satisfaction Survey at Navy Medicine Monitor via <https://navymedicinemonitor.msgovt.com>
- MHS-DoD Patient Satisfaction Survey

Results from these Service level satisfaction processes can be obtained by using procedures established by each Service. MHS level data is available on M2 via the Medical Data Repository.

Target/Threshold/Benchmark: Refer to the local or Service level tool for targets or benchmarks. The DoD Satisfaction Survey has a benchmark of 90 percent.

4. BUSINESS PLANNING CRITICAL INITIATIVES:

Commanders should consider reviewing additional access to care measures consistent with business planning initiatives. These critical initiatives are based upon the 2006 Quadrennial Defense Review, MHS Mission, Vision, and Balanced Score Card. Refer to your most recent business plan to determine those measures that support your critical initiatives.

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The purpose for critical initiatives is to manage and improve access and patient satisfaction. When eligible beneficiaries access the MTF, they should expect to:

- be seen on time
- be satisfied with their overall healthcare experience
- be satisfied with the care they received from the provider
- be satisfied with the overall quality of care

Other key components affecting Access to Care are as follows:

MTF Enrollment Areas: MTF Enrollment Areas (previously identified as “catchment areas”) are the areas within 30 minutes drive time of an MTF in which a commander may require TRICARE Prime beneficiaries to enroll with the MTF. In certain circumstances, ADSM may be required to drive one hour for primary or specialty care services in accordance with TRICARE Prime Remote (TPR) regulations and policy. Refer to TMA Policy 06-007 for additional guidance.

Prime Service Areas (PSA): Minimum Government standards for MTF PSAs and BRAC PSAs are geographically defined by zip codes that create an approximate 40 mile radius from the MTF or BRAC installation. MTF Commanders are authorized, through the use of the Memorandum of Understanding (MOU) between the MCSC and the MTF, to recommend revisions to the direct care zip-codes that facilitate their MTF enrollment and referral business rules. MOU enrollment guidelines should follow the access to care guidelines in accordance with 32 CFR 199.17 (p)(5)(i) which requires under normal circumstances, that TRICARE Prime beneficiaries should not be required to travel more than 30 minutes for access to a primary care services, or more than one hour for access to specialty care services.

MHS Balance Score Card Performance Objectives & Monitoring: MTFs will be measured at the MHS level for:

- Number of primary care appointments per enrollee per year - 3.5 appts per enrollee
- Patient satisfaction with appointing

Operational Performance Objectives (Service Level Monitoring): MTFs are required to maintain at least the following based on the initiatives selected:

- Minimum access to care standards for all appointment types at least 90% of the time
- TOL Registration 20% to 50%

APPENDIX F

ACCESS TO CARE METRICS AND MEASURES

- TOL Appointing 10% to 20%
- WEA Appointments 50% to 80%
- MTF Book Only < 5% to 10%
- Facility Cancel < 3%
- Patient Cancel < 5% to 10%
- Leave without being seen < .05% to 1%
- Provider schedules (primary/specialty) 45 days out < 10% gap
- NED discrepancies < .05%
- No show < 5%
- Unbooked < 5%
- Increase Primary care (MC/PC) appointments > 5%

Critical Initiative Components: Consists of:

- MTF Self Assessment (Multi-Service Market MTFs only)
- Initiative Criteria
- Initiative Selection
- Initiative Plan of Action
- Initiative implementation and performance monitoring