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Foreword

This appendix of the *Commander's Guide to Access Success* describes the Open Access appointing methodology. Open Access is not a coding or workload management process. This appendix covers the methods to use to book appointments using a standard methodology. The objective is for MTFs that elect to implement Open Access to be able to measure patient access consistently and accurately and to timely monitor performance in achieving "Doing today's work, today." **This section is not an endorsement of Open Access.** Sites have had both good and marginal experiences implementing this model. But an attempt has been made here to openly present the experiences and feedback from the Open Access sites to help other MTFs as they contemplate whether this model will work in their environment.

I. What is Open Access Appointing?

Open Access is a process of developing schedules and booking medical appointments for patients. The rule, "Do today's work today" is the foundation of Open Access appointing. Today means today, not within 24 hours. The MHS goal in utilizing Open Access is that a patient will see a provider on the same day that they request an appointment. This does not mean that the clinic is opening itself as a full walk-in service. The underlying premise behind Open Access is one of prevention and that both patients and providers are better off if everyone in the clinic is able to do today's work today. This includes both seeing patients today, as well as completing all related administration and paperwork that flows into the clinic. Assurance of continuity of care, i.e., the patient will see their own physician/provider, is an additional objective and a by-product when the model is properly executed.

Open Access is primarily used to book Primary Care appointments but may also be applied in Specialty Care clinics. It is patient-centered, with all preferences for appointment times being chosen by the patient. It is non-intuitive and cannot be adopted suddenly and without extensive study and research of utilization patterns and history on the part of the clinic/MTF that wishes to undertake this model. It requires continuous day-to-day, and at times, hour-by-hour management of provider schedules. Additionally, due to its non-intuitive nature, regular and consistent training, re-training and, re-emphasis of Open Access concepts and practices are necessary for clinical staff and providers. Otherwise backsliding into previous undesirable patterns and practices will most certainly occur.

In order to successfully implement the Open Access model, the physician's "bad" appointment backlog must be eliminated. "Bad backlog" represents appointments that have been made into the future and were built into an inventory as a result of common "carve-out" techniques used in many MTF clinics' appointment schedules. Many of these appointments are routine or follow-up and could be seen sooner rather than later. It is called "backlog" because this inventory of

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appointments results in a longer and more frustrating waiting time for the appointment. "Good backlog" is generally acceptable and consists of appointments made by patients who request an appointment other than today because of convenience or preference.

Templates need to be arranged to ensure that a clinician is in the clinic at least some time each day. Alternatively, a clinician pair can split days and a panel. If possible, the same clinician should complete all the work needed to care for a patient, including follow-up work. Open Access may allow MTFs to re-examine the role of demand management programs.

II. Advantages/Disadvantages of Open Access Appointing.

The advantages of Open Access are the following:

- Reduces the time-consuming need to prioritize or triage care
- Enhances the patient's satisfaction and compliance by guaranteeing timely access to care
- Improves quality by providing care close to the onset of the problem
- Enhances the patient's trust of the system
- Reduces the need for a patient to "game" the system by booking multiple appointments in an attempt to obtain a convenient appointment
- Patients who are confident that they have ready access are much more willing to do home-care for minor illnesses
- Patient no-show and cancellation rates are decreased
- Management of schedules is simplified in some ways due to decreased numbers of appointment types, but must be closely monitored and coordinated; often easier to modify schedules on short-notice
- May enhance continuity of care
- On days with decreased demand, clinical staff will have greater flexibility to accomplish other tasks other than direct patient care

Disadvantages include:

- Surges in demand may require that providers and support staff work extended hours
- Staff burn out is possible
- Requires frequent, possibly daily or hourly, schedule review and adjustment
- Requires provider and staff buy-in
- Frequent or seasonal staff turnover, deployments, etc., can cause disruption to the Open Access method and access problems for patients during these periods and significantly increase the workload for remaining staff
- Significant and on-going training and planning required
- Providers must be available to meet patients' needs in order to maintain continuity of care and "do today's work today"

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- Requires more frequent monitoring of appointment supply and demand
- May encourage over-utilization of appointments.
- Clinics must be optimized to provide the necessary support staff.

III. Prior Research is Key.

The Open Access model is based on research indicating that demand can be predicted and consistent over time for a practice or clinic. A clinic should begin by determining its true population and patient historical demand, and determining the level of effort required to eliminate the patient backlog and sustain Open Access. True demand is defined as a request for an appointment made either during or after normal business hours. This includes patients who were trying to be seen in the clinic, but had to settle for an emergency room visit, or an appointment in the network, because the clinic was closed. It also includes those patients whose request for an appointment was pushed back to a future date or deferred/handed off to another clinic or facility. Many clinics that utilize Open Access found that about 60% of appointments should be available for same-day demand. This may vary based on the population served, mobility activities, and other local conditions that must be factored into the equation.

IV. References. Post to TAI website

Sites contemplating the move to Open Access should inquire with MTFs already performing OA or with their Service Headquarters to determine best practices or policy guidance. Other sources of information, available on the TRICARE Access Imperatives website (<http://www.tricare.osd.mil/tai/pm.htm>), include:

- TRICARE Europe Open Access Implementation Manual dated 2 May 03
- Open Access Review and Recommendations, Final Report dated August 2002.AFMS Open Access Implementation and Sustainment Guide (attachment 1) dated 1 October 2004.
- Air Force Policy On Open Access Appointing For Primary Care, with Implementation and Sustainment Guide, dated 19 October 2005

IV. Leadership, Provider and Staff Commitment.

Implementing Open Access requires a firm commitment from leadership and staff, to eliminate any existing backlog of patients. This often requires a “surge” effort involving overtime/extended hours clinics until the backlog is eliminated or, at the very least, to the point where providers are noticing on their own metrics that they are seeing their patients within a single day of the patient’s request for an appointment. The presence of a “Physician champion” in the clinic or Primary Care Team that is implementing Open Access appointing is optimal for

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implementing and sustaining a successful program. The longer this “Physician champion” has left in his current assignment the better, as it will allow the OA appointing process to mature.

Template and real-time active schedule management are essential for Open Access success. If necessary, additional appointments may need to be added to meet demand, or unused follow-up appointments may need to be changed to Open Access appointments. Use of automatic reconfiguration of schedules may assist in maintaining the appropriate mix of appointment types.

V. Specific Templating and Scheduling Guidance.

Overview. Managing an Open Access clinic requires significant up-front training for staff who schedule appointments. In its purest form, under Open Access appointing, patients calling for an appointment today – whether for acute, routine, wellness, specialty, and/or follow-up health care needs – may be booked into the Open Access (OPAC) appointment type. To manage an open access clinic, no distinction is made between these health care needs/ATC Categories for patients who call in today, unless the visit requires resources that are not present every day (e.g. specific personnel, equipment, etc). The provider should attempt to address all patient concerns in a single visit in order to eliminate the need to add future appointments/repeat visits for the same patient. This may necessitate combining appointment slots. Required follow-up care should be anticipated and schedules should contain sufficient open appointments in the future to meet the need for follow-up visits. MTFs should also anticipate patients who desire an appointment in the future for personal reasons. A recommended appointment mix for starting Open Access is 60 % OPAC, 40% all other appointment types. Check with your individual Service headquarters for guidance on schedule management. As a general rule, patients should have the option of scheduling known follow-up visits prior to leaving the clinic in order to reduce telephone workload in the future.

1. Use of the Open Access (OPAC) Appointment Type.

- The OPAC standard appointment type will be used to offer patients same day acute, routine, wellness, or follow-up primary care services. Every effort will be made to allow patients to see their Primary Care Manager (PCM) on the same day that they request an appointment by using the OPAC appointment type.
- It is recommended that no less than 60 percent of appointment slots on a Clinic’s or Primary Care Team’s schedule engaged in OA appointing will be the OPAC standard appointment type. However, this practice does not open the clinic into a full "walk-in" type service.

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- To the greatest extent possible, all of the patient's issues are addressed in a single visit to minimize the need for unnecessary future appointments/repeat visits This may necessitate combining appointment slots.
- To search for the OPAC appointment type, appointing personnel must use the ACUTE Access To Care (ATC) Category in the Composite Health Care System (CHCS) Managed Care Program (MCP) that is mapped to the 24-hour ATC Standard.
- **OPAC Appointment Type Scenario.** Mrs. Jones has been experiencing a pain in her shoulder for a couple of days and calls the MTFs appointment line on Monday morning to schedule a visit with her PCM. The appointment clerk at the MTF, using the appropriate script, determines that she is a TRICARE Prime beneficiary enrolled to Dr. Smith and using the Acute ATC Category in CHCS, searches for OPAC appointments with Dr. Smith, offering a specific appointment at 1400 on Monday afternoon; Mrs. Jones accepts. The clerk books the appointment and provides Mrs. Jones with the appropriate instructions for her appointment.

2. Appointment Types Used For OA appointing.

- The standard appointment types available for OA appointing are OPAC, PCM, WELL, SPEC, PROC, EST, GRP.
 - If the other available appointment types (other than OPAC) are utilized, they will be used in accordance with the operational definitions described in Appendix H of this guide.
 - These other available appointment types will assist clinic staffs in setting aside times to book patients for specific services.
 - Acute, Wellness, Specialty and Future ATC Categories/CHCS Searches may have to be employed to search for and book these available appointment types.
 - OA clinics and/or Primary Care Teams appointment types other than OPAC may see these same ATC Categories on their ATC Summary Reports.
 - It is at the discretion of the clinic to use one or all of the appointment types from this available standard appointment type group.

3. Appointment Types Not Used For OA appointing.

- The standard appointment types that will not be used for OA appointing are ACUT and ROUT. OA appointing by its definition does not permit Clinics to use the ACUT or ROUT appointment types on their templates or schedules.

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4. Good Backlog Appointment Slot Definition. A Good Backlog appointment slot will be used for patients who decline an offer for a same day OPAC appointment in favor of an appointment on a future date or for provider directed appointments to be scheduled at a future time, e.g. follow-ups, specialty visits, procedures, group appointments.

- **Good Backlog Appointing Scenario.** Mrs. Brown has a son that needs a sports physical and calls the Appointment Line on Tuesday morning to schedule a visit with his PCM. The appointment clerk, using the appropriate script, determines that he is a TRICARE Prime beneficiary enrolled to Dr. Hart. Using the Acute ATC Category in CHCS, the clerk searches for OPAC appointments with Dr. Hart and offers a specific appointment at 1500 on Tuesday afternoon. Mrs. Brown declines this appointment, as her son will still be in school and the clerk offers a later appointment at 1530. Mrs. Brown declines again and asks if he can be seen on Thursday. The clerk then offers an appointment at 0730 on Thursday with Dr. Hart and Mrs. Brown accepts. The clerk documents the waiver of access standards using the prompts in CHCS, books the Good Backlog appointment and gives Mrs. Brown the appropriate instructions.

5. Good Backlog Templating and Scheduling Methods Guidance. This appendix recommends 4 methods to template and schedule Good Backlog appointment slots. So that consistency of process is maintained, it is recommended that OA MTFs use only one of the four methods described below. It is recommended that all Clinics at the same MTF use the same method of booking Good Backlog appointments.

Method One. Use OPAC appointment type only (OPAC) without GDBL detail code. In this method MTFs will only use the OPAC appointment type without the GDBL detail code to template and schedule Good Backlog appointments. Using the Acute ATC Category/CHCS search, clerks will first search for and offer the patient an OPAC appointment on the same day. If a patient refuses a same day OPAC appointment, clerks will remain with the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an OPAC appointment not on the same day. If the OPAC appointment selected to be booked is not on the same day but is within the 24 hour, 1,440 minute, Acute ATC Standard, CHCS will annotate this booking as a Met on the ATC Summary Report. If an appointment is chosen outside the 24 hour, 1,440 minute, Acute ATC Standard, and there are available slots inside this standard, the clerk will document the waiver of access standard due to patient preference. CHCS will annotate this booked appointment as a Patient Refusal on the ATC Summary Report.

Advantages of Method One:

- Simple to template, only one appointment type for clerks to learn.

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- Customer focused, as there is no differentiation between OPAC same day and OPAC Good Backlog appointment slots. OPAC is used for same day or Good Backlog appointments.
- Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care Category/CHCS search. Most times when booked, a Met or a patient refusal will be documented.

Can be displayed on TRICARE Online (TOL) appointing schedules.

Disadvantages of Method One:

- There is no upfront template and schedule planning to identify the proper number or mix of Good Backlog appointments and same day appointments.
- There is no clear identification on the schedule of Good Backlog appointments for clerks or providers.
- There is a potential that there will be no preservation of same day access, meaning all appointments on future days will be booked.
- TOL appointment display does not differentiate between same day and Good Backlog appointments.
- Clerks cannot perform an appointment search by detail code.
- There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC) as they are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool of the TRICARE Operations Center URL:
<http://www.tricare.osd.mil/tools>.

Method Two. Use OPAC appointment type with and without the Good Backlog (GDBL) detail code (OPAC-GDBL). In this method MTFs identify Good Backlog appointments on their templates and schedules by using the OPAC appointment type in conjunction with the GDBL detail code. Using the Acute ATC Category/CHCS search, clerks first search for and offer the patient an OPAC appointment on the same day.

If a patient refuses a same day OPAC appointment, clerks will remain in the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an OPAC-GDBL slot not on the same day. If the OPAC-GDBL appointment slot is booked and is not on the same day of the current search, but is within the 24 hour, 1,440

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minute, Acute ATC Standard, CHCS will annotate this booking as a Met on the ATC Summary Report. If an OPAC-GDBL appointment slot is chosen outside the 24 hour, 1,440 minute, Acute ATC Standard, and there are available slots inside this standard, the clerk will document a patient waiver of access standards due to patient preference. CHCS will annotate this booking as a Patient Refusal on the ATC Summary Report. . Using the automatic re-configuration function in CHCS to remove the GDBL detail code is encouraged to open appointments within 24 hours, which also enables them in TOL.

Advantages of Method Two:

- Allows upfront template and schedule planning, e.g. a 60 percent sameday/40 percent Good Backlog appointment ratio can be maintained.
- Easy for clerks and providers to identify slots on templates and schedules.
- Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care/CHCS search. Most times when such appointments are booked, a met or a patient waiver of access standards will be documented.
- Appointment booking is faster since appointment types do not have to be changed.
- An appointment search by detail code can be performed to find Good Backlog appointments.

Disadvantages of OPAC-GDBL Booking Good Backlog (Method Two):

- There is less patient choice of Good Backlog appointments with this method.
- There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC-GDBL) are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool.
- More templating and scheduling work is required to add the detail code GDBL to the OPAC appointment type.
- OPAC-GDBL appointments are not available on TOL.

Method Three. Use of OPAC and the Established appointment type (EST) with the GDBL detail code (EST-GDBL). In this method MTFs will identify Good Backlog appointments on their templates and schedules by using the EST appointment type in

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conjunction with the GDBL detail code. Using the Acute ATC Category/CHCS search, clerks will first search for and offer the patient an OPAC appointment on the same day. If a patient waives the access standard, clerks will remain with the same search, meaning that they will not back out of the current Acute ATC Category/CHCS search, and select an EST-GDBL slot not on the same day. If the EST-GDBL appointment slot is booked and is not on same day as the search, but is within the 24 hour, 1,440 minute, Acute ATC Standard, CHCS will prompt the user to change the appointment type from EST to OPAC and will annotate this booking as a Met on the ATC Summary Report. If an EST-GDBL appointment slot is chosen outside the 24 hour, 1,440 minute, Acute ATC Standard, the clerk will be prompted to change the appointment type from EST to OPAC and will document a patient waiver of access standards due to patient preference. CHCS will annotate this booking as a Patient Refusal on the ATC Summary Report. . Using the automatic re-configuration function in CHCS to remove the GDBL detail code is encouraged to open appointments within 24 hours, which also enables them in TOL.

Advantages of EST-GDBL Good Back Log Booking (Method Three):

- Allows upfront template and schedule planning, e.g. a 60 percent sameday/40 percent Good Backlog appointment ratio can be maintained.
- Easy for clerks and providers to identify slots on templates and schedules.
- Separates provider directed follow-up (EST) slots from patient wanting a Good Backlog appointment (EST-GDBL).
- EST-GDBL allows for an easier measure of usage. These appointment slots are a different standard appointment type from the same day OPAC appointment type and can be differentiated on various canned CHCS reports or on the Template Analysis Tool.

Disadvantages of EST-GDBL Good Back Booking (Method Three):

- There is less patient choice of Good Backlog appointments.
- More templating work is required to add the detail code GDBL to the EST appointment type.
- TOL will not display EST appointments with the GDBL detail code.
- Clerks are required to change the EST appointment type to OPAC in order to book the appointment. CHCS requires the appointment type to correspond with an initial

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Acute Access To Care Category/CHCS search. There is a need to issue security keys for this activity.

Common Elements of Methods 1-3 for booking Good Backlog

- If Clinics opt for either method 1, 2, or 3, these methods may only be used to template and schedule good backlog services such as initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. Only OPAC and/or EST appointment types are used.
- There will be no differentiation made on the schedule for good backlog services by appointment types when using either method 1, 2, or 3. However, schedulers could create slots with longer or shorter time periods or use detail codes to assist clerks with discerning those slots that could be used for different types of services. Clerks will have to be trained to understand the difference, e.g., an OPAC-GDBL slot that is 45 minutes long may be used for a procedure or an initial specialty visit. Or an OPAC appointment that has 10 available slots at the top of the hour, and is one hour long and is coded with education detail codes could be used for a group service appointment. Clerks could be trained to split and/or join these appointments to allow for more patients to be booked depending on how far out into the future slots are available on the schedule.
- A risk of only using either method 1, 2, or 3 for templating and scheduling good backlog appointments is that there will be no appointments slots available to patients requiring the following types of services: initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. It is a risk because these slots are not readily identifiable to the clerk.
- Use of other detail codes is addressed in Paragraph 6 below.

Method Four. Allows schedulers to use a combination of either method 1, 2, or 3 for booking good backlog and using one or all of the available standard appointment types on the schedule to include PCM, WELL, SPEC, PROC, EST or GRP.

- If using method 4, schedulers will use the standard appointment types of, PCM, WELL, SPEC, PROC, EST or GRP in accordance with the definitions as listed in Appendix H of the Commander's Guide for Access Success.
- The advantages of using one or all of the appointment types to include, PCM, WELL, SPEC, PROC, EST or GRP allows for their immediate recognition by appointment

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clerks to schedule various services that the clinic offers other than OA or good backlog appointments. Templates and schedules can be easily apportioned to allow for advanced planning of services.

- Allows upfront template and schedule planning, e.g. a 60 percent OPAC/40 percent other appointment types.
- If using method 4, clerks can use two methods to search for and book, PCM, WELL, SPEC, EST and GRP appointments. They are:
 - Use the Acute ATC Category to search for and book these appointments. By using the Acute ATC Category/CHCS search, the clerk will be required to change the appointment type of, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type. If there are no appointments of any of these types available on the same day, a patient refusal will be documented. When using this searching method, Clinics may want to additionally code the slot with a GDBL detail code, to tell the clerk that these, PCM, WELL, SPEC, PROC, EST, or GRP appointment slots can be searched for and booked using the Acute ATC Category/CHCS search instead of their traditional appointing ATC Category.
 - Use the appropriate/traditional ATC Category/CHCS Search. If the clerk learns at the beginning of the patient request for service a need for a specialty care consult request, or for a provider directed follow-up after an initial visit with the PCM, or if the clinic conducts a program such as "Right Start," or for a provider directed Group visit or class, the clerk can conduct the appropriate traditional search to book the needed appointment. The clerk can use the appropriate Routine, Wellness, Specialty, or Future ATC Category/CHCS Search. By doing so, there is no need for the clerk to change the appointment type from, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type.

6. Guidance on Use of Detail Codes in Open Access Booking.

- In accordance with CHCS functionality, up to 4 detail codes can be used on each appointment slot. Clinics are encouraged to use detail codes sparingly. Detail codes are used to restrict access to the appointment slot for a particular need such as designating that slot for a particular procedure, reserving a slot for a specific class, or

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- to permit only a certain group of beneficiary to be booked into the slot, such as Active Duty or TRICARE Prime.
- Use of detail codes will be in accordance with Appendix M.
 - The GDBL/Good Backlog Detail Code is meant to facilitate OA appointing.
 - GDBL/Good Backlog Detail Code. This detail code will be used to code a Good Backlog appointment slot. This slot will be used for patients who decline an offered same day OPAC appointment in favor of an appointment on a future date other than the same day of the request, or provider directed future appointments, e.g. follow-ups, initial specialty visits, procedures, group appointments. The GDBL detail code can be used in combination with the, PCM, WELL, SPEC, PROC, EST or GRP standard appointment types available for OA appointing.

7. Bad Backlog in Open Access Appointing.

- **Definition of Bad Backlog.** Bad Backlog in the open access model refers to a situation in which an MTF can not reasonably accommodate a beneficiary's request for a same day appointment. Bad backlog in the ATC Summary Report refers to the Access to Care standard of providing an acute appointment within 24 hours (1440 minutes) of the request. .NOTE: "book an appointment on a future date" is an expression of time and does not refer to the booked to future ATC Category/function in CHCS.
- **Bad Backlog Scenario:** SSgt Powell needs to be seen for an earache and calls the appointment line at 0830 on Thursday morning to schedule a visit with his Primary Care Manager. The appointment clerk, using the appropriate script, determines that he is TRICARE Prime and enrolled to Dr. Sharp. Knowing that Dr. Sharp is unavailable, the clerk asks SSgt Powell if he would like to be seen by another provider and SSgt Powell accepts. Using the Acute ATC Category in CHCS, the clerk searches for OPAC appointments with the other PCMs in the clinic and finds no available appointments. The clerk then communicates this lack of appointments to the nurse who tries to work SSgt Powell into an appointment on the same day schedule, but cannot. The clerk then tells SSgt Powell there is nothing available on Thursday and offers an appointment at 0800 on Friday with Dr. Blocker. SSgt Powell accepts the appointment and the clerk provides the appropriate instructions. NOTE: In this scenario, the MTF met the acute ATC standard of 24 hours, however, it did not meet the same day standard of Open Access. Therefore this situation constitutes bad backlog under the OA model, however will not be reflected as bad backlog on the ATC Summary Report.

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VI. Identifying Capacity and Demand.

Schedules should be carefully monitored to ensure that booked appointments are not overtaking the number of appointments designated as open. An available tool for capacity management is the TMA Template Analysis Tool (TAT). The TAT shows both appointment availability in the future and past utilization. This tool also shows the number of unused appointments on a daily basis. The MTF can use this data as a forecasting tool to determine and manage its capacity for open appointments and whether or not they will be filled for any given day. Demand Management is discussed in Para 2.3 below.

VII. Planning Supply of Appointments in Open Access Appointing.

Since demand is not always consistent, the clinic must have a contingency plan that will kick-in when demand surges on specific days and under unpredictable conditions. A contingency plan may mean that the staff work later hours that day, staff members help other staff members, and roles of support staff are expanded to reduce non-care tasks for physicians. The rules must be clearly defined to the staff and management. A plan for “weaning” providers on and off their schedules during leave and temporary absence/duty periods is essential as is providing a plan for providers to agree on how their individual panel loads will be handled when the primary PCM is unavailable. Each clinic or team must establish criteria for provider absence from patient care duties, determine minimum number of providers on duty, and assign executive agent to control templates. Plans must be in place to increase supply capacity at select times (school physicals, etc) and time-off policy based on demand. The average number of appointment requests may vary daily or seasonally. The number of requests is usually greater on Mondays and Fridays, after a three-day holiday, and in the winter. Morning huddles are a good idea to review the day and develop coordinated tactics.

VIII. Enrollment Aspects Of Open Access Appointing.

Maintenance of provider panel sizes to manageable levels is critical. OASD/HA policy suggests a maximum of 1,500 enrollees per Primary Care Manager (PCM). Under Open Access, civilian guidelines suggest a capacity as low as 800 and as high as 2500 enrollees per PCM . There is no absolute numerical key to the proper PCM to panel ratio. Open Access success has less to do with empirical figures than with the assurance that a PCM and support staff are consistently available to handle the patient demand. Most failures occur when demand for appointments is undermined by the loss of a patient provider for extended periods of time, the burden of the panel has to be taken up unexpectedly by another provider, and nursing and support staff becomes unduly stressed. Proper coordination and planning for provider absences allows for flexibility and response to the patient’s requirements.

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IX. PCMBN And Continuity Aspects Of Open Access Appointing.

Primary Care Manager By Name (PCMBN) is the most essential ingredient to the success of an Open Access method of appointing. A patient-provider relationship that is developed through PCMBN cultivates trust and long-term knowledge and familiarity with each individual patient. Many unnecessary repeat and follow up visits that clog access and add to multiple-provider backlog are avoided when the PCM is regularly seeing his or her own enrollees.

X. Performance Measures for Open Access

The following reports are required to establish baseline performance and then track the progress of all of these measures. CHCS provides useful data that can be used.

1. Appointment Availability

There must be an adequate number of providers and support staff to provide health services. Open Access seeks to remove the delay to the next available appointment. Appointment availability may be checked on a regular basis in CHCS for the next available and/or the third next available appointment for each clinician participating in Open Access. The view of future appointment availability provided by the TMA Template Analysis Tool indicates how much future capacity is available each day to accommodate new patients. The more un-booked capacity the clinic has, the easier it will be to offer same-day services to patients who call that day. Second available appointments do not provide as accurate a picture of availability as the third available.

The way of measuring this waiting time is to pick an appointment type that is normally delayed into the future, such as the Wellness appointment and to search for the third available appointment. The reason for looking at the third appointment is that there are often cancellations that may open up an appointment or two for today, but this does not accurately reflect the real waiting time, which may be 2 or 3 weeks. By plotting the 3rd available over time, reductions in delays can be monitored.

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Based on data extracted from CHCS, reports can show the average delay between the date of booking and the date of the appointment. Although some appointments booked are “good backlog” as they meet a patient's needs with other than a same-day appointment, the average over time is a good indicator of progress toward Open Access.

2. Demand

True demand is the sum of met and unmet demand. Met demand is those patients requesting and receiving an appointment. Unmet demand is patients requesting, but not receiving appointments with their PCM or PCM Team. Measuring demand requires examining booked appointments, unmet appointment requests, and patient services delivered each day, to show what work would look like if done today. This measurement should include those patients who tried to access the system but failed in some way (e.g., telephone access problems, un-booked appointment requests, no available appointments with PCM/ Team, etc.). However, many facilities do not have the capabilities to monitor telephone calls for missed access, so measuring demand can be determined by using the following measures in CHCS. CHCS captures appointment booking activity each day and non-appointed or overflow work (walk-ins/sick call, Urgent Care, possibly ED visits), making it relatively easy to obtain these totals. The sum of these totals is the true demand for the day. Examine demand by the patients for each provider, for each day over two weeks to get a baseline, and then each month to detect changes (ideally reductions).

3. Continuity (appointment is with PCM)

Examine continuity from the perspective of how often a patient sees his or her assigned PCM when seeking care.

4. Panel Size

An important element of managing supply and demand is balancing provider panels for size and acuity.

5. Productivity

A combination of improved office efficiency to include available provider and support staff, the proactive management of clinic schedules, and reduced no-shows can improve productivity

6. No-Shows

In sites that have implemented Open Access, the percentage of patients who fail to show up for scheduled appointments dropped significantly. The metric is of

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interest because no-shows represent a waste of appointment supply. .

7. Cycle Time

Cycle time measures the elapsed time from a patient's arrival in the clinic to the patient's departure from the clinic. Shortening of cycle times is a good indicator of improvements in office efficiency, both patient flow and workflow, which in turn improve capacity. .

8. Satisfaction Measures

Measuring satisfaction of patients and staff before , during and after implementation of any new process is key to showing success or failure of the process. The underlying premise behind Open Access is that both patients and providers are better off if everyone in the clinic is able to do today's work today.

- a. Patient Satisfaction – Using trend analysis, what effect did implementing Open Access have on patient satisfaction? MTFs may develop survey methods that provide statistically significant results. How do patients feel about having the option of an appointment on the same day they call the office? Do they feel that they are getting better quality, more timely care? MTFs may utilize existing patient satisfaction surveys collected by the MTF or the parent Service.
- b. Staff Satisfaction – What effect did Open Access have on staff and provider satisfaction? Do providers get to see their own patients more often? Do providers feel their patients are getting more timely treatment? Do providers and staff feel that patients are more satisfied? Do they have adequate administrative time?

XII. Open Access Implementation and Sustainment Analysis.

- This OA implementation and sustainment analysis is available to assist sites with implementing and sustaining OA appointing.
- MTFs may need to check with their respective higher headquarters, to ensure all requirements are met before moving to OA appointing.

This analysis is most effective if all parts are addressed. The level of detail is at the discretion of the MTF/clinic/Primary Care Team implementing OA appointing. This analysis plan should identify the Primary Care Clinics and Primary Care Teams contemplating a move to OA

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appointing... Completing this plan enables the MTF to fully analyze its present and future business processes and make an informed decision. regarding the feasibility of OA appointing.

1. Identify goals, expectations, and support for OA appointing.

1.1. Discuss Purpose and Senior Leadership Support. Identify the reason(s) for implementing OA appointing. Describe how the decision to explore OA appointing was made and the roles senior leadership played. Senior level leadership support for successful Open Access appointing is essential.

1.2. Describe Expectations and Goals. Identify the advantages, disadvantages and anticipated benefits of OA appointing for patients and staff. Identify overall goals in the areas of quality, access and cost and how success will be measured.

1.3. Identify your Physician Champion. A Physician champion is paramount to the successful implementation of OA appointing. Describe his/her role to the success of the program. Identify how long he/she will be remaining in his/her present duty assignment. Eighteen to 24 months left on station is optimal. Bottoms-up desire to implement OA appointing at an MTF is highly desirable.

1.4. Analyze and trend previous performance with Access To Care (ATC).

- Analyze and trend present Booked to Acute ATC Summary Report Scores.
- Analyze and trend present Booked to Routine ATC Summary Report Scores.
- Analyze and trend present Booked to Future ATC Summary Report Scores.
- Analyze and trend present patient refusal scores for Booked to Acute, and Routine on the ATC Summary Report.

1.5. Identify OA Implementation team membership. Your team at a minimum should include personnel from the following areas:

- Team leader if not the Physician Champion
- Provider (Physician Champion; see above)
- Nursing and/or Population Health Coordinator
- Access Manager
- Data Analyst
- Template manager if assigned
- Administrative Tech/Records Management
- Medical Technicians

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- Appointing Staff Member(s)
- Ancillary Staff Member(s)

1.6. Identify the scope of the project and “Go Live” date. Identify the “Go Live” date for each targeted Clinic/Team that will be converted to OA appointing.

1.7. Identify present appointing practices and resources. Identify your present state of doing business and determine changes required to perform OA Appointing by answering the following questions:

- What process for searching for and booking appointments is used?
- What appointment types and detail codes are used?
- Are there scripts or algorithms on hand for appointing agents to use?
- How are provider absences covered?
- What is the training level and competency of appointing agents to include contract, active duty, and/or civilian appointing personnel?
- How far in advance are schedules available for booking?
- How are templates and schedules developed and controlled?
- Is your system for appointing centralized or decentralized?
- What are your medical records location(s) and rate their availability?
- What is your clinical and support staff availability?
- What is your customer satisfaction with present services?
- Do you have any achievements with present appointing practices?
- Do you have any problems with present appointing practices?

2. Define OA Commitments by Analyzing Data. Identify the OA clinic’s/Primary Care Team’s population demographics, PCM enrollment and distribution, patient demand, backlog, waiting times, and supply patterns, and staffing. Identify data sources to be used next to each item, (i.e. Service Level Tools, TRICARE Operations Center, CHCS, AHLTA, MCFAS, M2, etc.). Doing so provides understanding of the level of service OA clinics and/or teams will have to provide to OA appointing.

2.1. Determine Population Demographics.

- **Enrolled Population.** Identify the Active Duty and Non Active Duty Prime beneficiaries. The objective of this analysis is to define the beneficiary population and predict demand.
- **Non-Enrolled Population.** When a facility provides care to non-enrolled patients, defining this population and the extent to which their needs are

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currently being met by the facility should be determined. A process to manage and predict non-enrollee care should be implemented. Examples of non-enrollees are: 1) Reserve/Guard; 2) Transient eligible's; 3) Prime Remote; 4) Foreign eligibles; 5) DoD employees (teachers); 5) Accession patients; 6) ROTC students; 7) Students; 8) Secretarial Designees; 9) Civilian pay patients (state hired, etc).

2.2. Determine PCM and/or Clinic enrollment. Ensure the targeted PCM/Clinic(s) provide both daily access and continuity. Each Clinic must have the capacity to provide for the daily demand of the enrolled panel. Distribute enrollees among providers so that each PCM/Clinic's panel size and acuity is proportional to that provider's capacity/capability. Medical proficiency and GME requirements must also be considered. The impact of Non-enrollee demand must be clarified. At a minimum provide:

- Enrollees per PCM
- Enrollees per Clinic/Primary Care Team
- Estimated volume of other visits (non-enrolled) per month per PCM
- Estimated volume of other visits per month per Clinic/Primary Care Team

Stopped work on 07/11/07

2.3. Determine Patient Demand for Care. Demand analysis helps ensure adequate appointments are provided to meet the needs of your patient population. Three suggested methods to follow are listed below:

- Civilian Benchmark. Civilian benchmarks are probably the quickest method to estimate demand. Mark Murray, MD, MPA Healthcare Consultant, a pioneer of Open Access appointment, states .75% of an enrolled population will seek care on a given day. To use this method, simply multiply your MTFs enrollment by .0075. That will provide you an estimated number of appointments needed per day. This rate may be lower than your actual utilization rates for your facility, since Dr. Murray is using rates for civilian healthcare institutions where demographics and barriers to care may be different than those in the military
- MTF Utilization rate: Historical MTF annual utilization rates are more accurate estimates of primary care utilization. You can obtain these rates using your MTFs visit data from MEPRS, or MHS or parent Service's tools and/or reports. Obtain both monthly and annual utilization rates per enrollee. To estimate the number of primary care visits your facility will need to deliver during a 12-month period. Multiply your MTFs annual utilization rate by the number of MTF enrollees. For a monthly rate, multiply your MTFs monthly utilization rate by the number of monthly MTF enrollees it has enrolled. This

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analysis assumes the MTF has essentially the same number of providers as it did in the years previous and has no loss of any present year primary care services, e.g., MTF had a pediatrician in CY2005, but lost to PCS in CY2006 with no replacement. Then you need to divide the annual count by 12 for a monthly count and (utilize 18 workdays for Air Force and 21 workdays for Army and Navy) for a daily count of appointment slots that your primary care clinic requires. MHS Policy recommends that a good general planning factor for a primary care utilization rate is 3.5 visits per enrollee per year. These methods provide a historical view of those patients that received care, but did not provide a picture of those patients that were deflected, or had unmet demand.

- Demand Analysis Process. Conducting a full-blown demand analysis provides the most accurate demand analysis. This will take additional time and effort to complete. The foundation of a demand analysis starts with capturing historical demand. Historical demand does not necessarily depict all the actual demand. It is necessary to consider the following factors and make necessary adjustments. (This list is not an inclusive listing of data sources):
 - Telephone statistics (call volume, abandonment rates)
 - Emergency Room/Urgent Care/ Fast Track/Acute Care Clinic visits
 - Care deferred to network (Pop Off or Self Initiated ER/Urgent Care)
 - No-show rates/LWOBS/Patient Cancellations
 - Clinical Preventive Service Backlog
 - Un-booked appointment report numbers and rates
 - Waitlist numbers and rates

By capturing this potential deflected demand, MTF/clinic/primary care team can better plan for the actual demand needed to care for its population.

2.3. Determine Backlog. Calculating the backlog for Clinic(s)/Primary Care Team(s), provides an indication of the amount of effort required to implement OA. Total backlog is the sum of all the patients booked into the future.

- This is obtained by counting all of the booked into the future appointments to obtain the total number.
- Appointments booked into the future can be divided into two groups, “good” backlog, and “bad” backlog. Good backlog consists of patients who were offered but declined an appointment for today, and also patients instructed to book a

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follow up appointment in the future. All other future booking is considered bad backlog, because it represents work that could have been done today.

- The point at which backlog can be reduced to “good” backlog will vary. For example, good backlog will range from 20-30 patients visits per 1000 beneficiaries. For a beneficiary population of 5000, the good backlog can range from 100 – 150 appointments booked into the future. For this example, if the bad backlog is 450, then to implement open access, the clinic/primary care team will require the reduction of at least 300 patient visits. Once good and bad backlog has been determined, provide a date that the MTF/clinic/primary care team can reduce this bad log to OA level. Note: Do not discuss your backlog reduction plan here, discuss in paragraph 7.

2.4. Determine Appointment Waiting Times. Waiting times and backlog are related measurements. Higher backlog results in longer waiting times for appointments. Determining the baseline waiting time will give an indication of current access to care deficiencies. Waiting times can be calculated in several ways. Two examples are:

- Third Available Appointment Method. The classic way of measuring waiting time is to pick an appointment type that is normally delayed into the future, such as the Wellness appointment and to search for the third available appointment. The reason for looking at the third appointment is that there are often cancellations that may open up an appointment or two for today, but this does not accurately reflect the real waiting time, which may be 2 or 3 weeks. By plotting the 3rd available over time, reductions in delays can be monitored.
- Average Waiting Time Method. This approach monitors appointments booked in relation to when they are requested. This average waiting time is determined by counting every requested appointment based on the time it was booked. For example, an appointment booked today counts as “0”, tomorrow as “1”, 2 days out as “2”, etc. The waiting time for every booked appointment on a given day is summed and divided by the total number of appointments booked. This gives an average waiting time for appointments. The more appointments booked today (day “0”), the lower the average waiting time for appointments. If all appointments were booked for the current day, then the average waiting time would be “0”. This data should be obtained from the “canned” Access To Care Summary Report contained on the local CHCS host.

2.5. Analyze Clinic/PCM Team Continuity. Analyze the use of personnel, appointing processes, the handling of provider/support staff absences, use of information systems and measures/metrics to maximize clinic/PCM team continuity.

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3. Staffing.

Analyze your available staffing to support the OA process. Base staffing estimates on authorized versus actual staffing, (use on hand strength levels compared to unit manning documents).

3.1. Optimization. Identify your MTFs optimization staffing levels as it relates to the potential OA areas.

3.2. Provider staffing. Identify how medical providers will ensure that open access imperatives are met, to include number of appointments per provider, summer rotations, coverage for provider absences, other duties, and control of leaves/TDYs/TADs. Analyze and discuss the roles of both PCM and non-PCM providers to include use of Physician Assistants, Nurse Practitioners, residents and providers serving in command and leadership positions. It is important to gauge this group's "buy-in" to the implementation of OA appointing.

3.3. Support Staffing. Identify and discuss the use of medics/medical technicians, appointing/administrative personnel, resource sharing, contractors, It is important to gauge this group's "buy-in" to the implementation of OA appointing.

3.4. Contingencies. Describe contingency plans for both planned and unplanned staff shortages, information system downtime, readiness exercises, excessive patient demand, etc and their impact on OA appointing.

4. Additional Support Requirements.

Define the impact of OA on appointing services, medical records, ancillary support services, and others as applicable.

4.1. Determine the appointment telephony capability to handle the increase in same-day appointing. Need to fully understand telephony capabilities to include: daily call volumes, abandonment rates, and call busy rates, etc.

4.2. Assess your MTFs medical records processing function's capability to handle the increase in same-day appointing. Define/understand MTFs paper/electronic medical records section/department's staffing, location, availability, filing backlog, ambulatory data record completion rates, coding processes, and third party collection efforts, during normal and contingency operations.

4.3. Assess your MTFs ancillary services capability to handle the increase in same-day appointing. Identify laboratory, radiology, and pharmacy's role and ability to

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adequately support OA in your potential OA clinics/PCM teams during normal and contingency operations.

5. Plan for Extended Hours. Define/understand MTFs procedure if additional clinic hours are required to cover increased fluctuations in demand. Determine who makes this decision and what necessary coordination has to be made for support personnel, facilities, etc.

5.1 MTF targeted area. Define the extended hours plan for your potential OA Clinics/Primary Care Teams. Include provider and support team staff extension of hours, compensatory time resolution and triggers for extending hours.

5.2 Support and Ancillary Areas. Define the extended hours plan for support and ancillary areas.

6. MTF Goals for Open Access Appointing.

Identify the goals your MTF wants to achieve in the areas of access, controlling backlog, reducing waiting times, keeping percent of same day work completed high, increasing provider/Clinic continuity, and provider, staff, and patient satisfaction.

Goal examples would be:

- 60 percent of requests for care treated on the same day
- Acute Access To Care Met Standard: 90 percent
- Backlog of 150 appointments on the books at any given time
- Overall OA Clinic average waiting time less than 1 days

7. Discuss Strategies For Implementing OA Appointing.

Develop plan for working down bad backlog, increasing continuity, optimizing supply to meet demand, and maximizing office efficiencies.

7.1. Plan for Working Down Backlog. Develop plan on how to work down bad backlog as identified in paragraph 2.3 above. This plan will incorporate how bad backlog is identified and what additional efforts are required to bring bad backlog under control prior to OA implementation. Discussion should focus on issues such as provider and support staff leave control; the possibility of extending clinic hours with ancillary support; optimizing administrative time, and the scheduling of meeting times.

7.2. Plan for optimizing supply to meet demand. Develop plan to optimize the clinic/Primary Care Team's operations making the move to OA appointing. Address panel size, management of templates and schedules and what appointing guidelines will be utilized.

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- a. Panel Size. Develop panel sizes based on number, age, acuity, and gender of empanelled beneficiaries and the provider's experience, other local requirements to include mission and GME.
- b. Template/Schedule Management. For the potential OA areas, the MTF needs to have processes in place to answer the following questions:
 - What appointment types are going to be used? e.g. OPAC, EST, PROC.
 - What method of Good Backlog appointing is going to be used?
 - With the appointment types mentioned above, for what services are these appointment types going to be used?
 - What detail codes are going to be used? e.g. GDBL, WEA.
 - What is your plan for creating, controlling, opening templates and schedules? What, Who, When, Why?
 - What is going to be the number of slots required per day for each day of the week?
 - How will your potential areas schedule wellness services such as pap smears, physical exams, preventive health assessments, and procedures, etc?
 - What are the rules for splitting and joining appointment slots?
 - How will the potential OA Clinic(s)/Primary Care Team(s) network (CHCS file and table) be constructed?
 - What is the TRICARE Online OA appointing plan?
- c. Appointing Process Guidelines. OA implementation plans should contain guidance on the following:
 - Use of OA appointing scripts/ algorithms for the appointing personnel
 - Training of appointment personnel who book appointments under OA
 - Guidelines to ensure that patients are not directed to call back if appointments are full
 - Guidelines on use of appointing automatic reconfiguration function
 - Guidelines for booking patients whose PCMs are on leave or absent
 - Guidelines on facility cancellations
 - Guidelines on ending the clinic day
 - Guidelines on extending the clinic day
 - Guidelines on overbooking patients
 - Guidelines on "walk-in/sick call" patients
 - Guidelines on changing appointment types
 - Guidelines on patients not wanting to take appointment offered

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- Guidelines on booking follow-up appointments prior to patient leaving the clinic
- Guidelines on provider book only, MTF book only
- Guidelines on the administration of appointing security keys
- Guidelines on planned down days, restricted days, training days, lunch time coverage
- Guidelines on “no shows”, “late shows,” and “left without being seen”
- Guidelines on “un-booked” searches
- Guidelines for telephone consults

7.3. Plan For Increasing PCM Continuity. Develop strategies on how clinic/PCM team will increase continuity.

7.4. Plan for Optimizing Supply of Appointments. Discuss strategies for optimizing the supply of appointments. Strategies may include:

- Use of non empanelled providers
- Reservists
- Limiting or changing days of meeting times
- Planned expansions
- Use of resource sharing providers
- Use of nurses/pharmacists/technicians;
- Use of other clinics within the MTF
- Other multi-market/local MTFs as feasible
- Use of network providers, etc.

7.5. Plan for Decreasing Demand. Develop strategies for decreasing demand for appointments. These processes could include:

- The proper booking of follow-ups to prolong the need for a patient’s return to the clinic
- Conditions that can be handled by technicians, pharmacists, nurse run clinics
- The handling of prescription refills
- Use of telephone consults to provide appropriate service without an appointment
- Providing immunizations
- Daily monitoring/changing of schedules
- Self-care
- Population health strategies
- Use of wellness/health promotion strategies, etc.

7.6. Plan for Maximizing Efficiencies. Develop strategies such as:

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- Optimizing office layout and capacity
- Exam room standardization
- Elimination of bottlenecks
- Shortening cycle times
- Commitment to starting each morning on time
- Huddles/team meetings/clinic morale to support OA
- Use of most current/timely population driven data/guidance, e.g. Clinical Practice Guidelines, IMR, HEDIS, MHS Portal, M2 to optimize the management of the population

8. Develop Open Access Measures and Metrics.

Define measures and metrics to track and trend OA performance. Measures may include:

- Telephony measures
- Continuity of care
- Demand for appointments
- Appointment and clinic waiting time
- Percent of same-day booked appointments
- PCM empanelment
- Bad backlog
- Percent same-day open appointments
- No-show percentages
- Etc

9. Clinics and Primary Care Teams combining traditional and Open Access

Appointing. Define and analyze the appointing method relationships of Clinics/Primary Care Team's engaged and not engaged in OA appointing in the MTF. Address possible positive and negative effects on staff, providers, and patients.

10. Marketing Plan. Develop a strategy of whether or not internal and/or external marketing will be done and how, when, who, where, and why.

11. Identify any other pertinent issues not covered in the above paragraphs.

XIII. Open Access Appointing Marketing.

1. General Marketing Guidance.

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- The decision to market open access directly to the patient and/or to local command leadership will be the choice of the MTF commander. Experience has shown that marketing OA in this manner has advantages and disadvantages.
- Regardless of what marketing strategy that is employed, all MTFs employing OA must continue to deliver care that is within the 32 CFR 199.17 ATC standards.
- Each MTF must employ a marketing strategy that is tailored to the population it serves and allows for success of its OA program.

2. “No Marketing” Strategy Considerations.

- For this no marketing strategy the MTF has two choices:
 - Market the 1-7-28 day access promise and keep the appointing strategy transparent
 - Market only when the new OA practices has had a reasonable success rate and the transition period had been established and proven
- MTFs that employed a no marketing strategy should make all activities during the OA transition period invisible to the beneficiary. The only thing that the patient should recognize is their increased ability to get an appointment on the same day.

3. Partial or Total Marketing Strategy Considerations.

- MTFs will need to be cautious as to how they label their OA program, as it influences patient behavior and/or expectations. Recommended labels are Open Access or Same Day appointing.
- If marketing OA directly to patients, MTFs should use the OA appointing definitions as stated in appendix.
- MTFs may want to request support from the local command leadership as the clinic/PCM team works down bad backlog during the transition from traditional to OA appointing by minimizing base/post taskings for support.
- A possible way to market OA is to let patients know that the MTF is transitioning to a new appointing method to improve its ability to deliver on the 24 hour, 7 day, and 28 day access standards.