APPOINTMENT STANDARDIZATION

COMMANDER'S GUIDE TO ACCESS SUCCESS

The Right Patient, to the Right Provider At the Right Time, at the Right Place

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EXECUTIVE SUMMARY

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1. PURPOSE

This guide provides you, the Medical Treatment Facility (MTF) Commander, and your staff a methodology, step-by-step guidance, and the tools required to improve beneficiary access, to simplify MTF and Managed Care Support Contractor's (MCSCs) appointment processes and to smoothly implement and sustain one of the most important optimization programs in the Military Health System today, Appointment Standardization (APS) and Access to Care improvement. The regulations in the Defense Authorization Act, Code of Federal Regulations Title 32, Section 199.17, are law. The changes outlined in this guide are many and your performance in implementing and sustaining these changes will be measured. Sound leadership will be the key to successful implementation and ongoing maintenance of APS. As you know, change is never easy but it is hoped that this guide and the assistance that it provides will make your leadership of this transformation easier.

2. OBJECTIVES

The Government Accounting Office (GAO) at the request of Congress has found that there are many areas of our appointing processes where we as a system can improve. GAO found that we use up to 10,000 different appointment types to make appointments. GAO also found that in some TRICARE Regions, the contractor support that is strictly dedicated to the making of appointments is used very little or not at all. Principally the GAO found that our appointment process were confusing to our beneficiaries, hard to use by appointments personnel, and that our system's efforts to meet Congressionally mandated access standards were not measured. The primary objective of APS is simple, "Match the right patient to the right provider, at the right place, and at the right time." Secondary objectives are to improve beneficiaries' access to care, maximize utilization of MTF capacity, standardize and normalize appointment data elements and clinic names for better performance measurement and management, and implement one standard, simplified appointment booking model across the DoD Military Health System. You as the MTF Commander and your staff working as a team can achieve all of these.

3. CONTENTS OF THIS GUIDE

This guide provides a road map for MTF Commanders to fully implement and maintain Appointment Standardization, to understand the processes, and to improve overall beneficiary access and access measurement. The first chapter includes a recommended ten step process modeled after the familiar FOCUS Plan, Do, Check, and Act (PDCA) methodology to get your MTF to full APS implementation and Access Improvement and to sustain performance. All other appendices support this endeavor and provide instructions on the methodology and

performance measures; guidance on how to reconfigure your CHCS files and tables; directions on the initial education approach; instructions on where to obtain assistance; and most important, full explanations of the APS methodology, business rules and operational definitions.

4. COMMANDER'S RESPONSIBILITIES IN IMPLEMENTING AND SUSTAINING APS, AND IMPROVING ACCESS

Commanders must understand that their leadership and support for APS implementation and Access Improvement are the most important factors for its *success.*

Commanders should appoint an Access Manager to lead the efforts to implement and sustain APS and Access Improvement.

Commanders must understand that APS implementation and Access Improvement will greatly support the successful on-going sustainment of Primary Care Manager By Name, the National Enrollment Data Base, Tri-Service Health Care (TRICARE) for Life, TRICARE Plus, web-based appointing, and web-based Referral and Authorization. All programs together will radically change the way we do things, and end in great overall improvement in the services we provide.

Support full utilization of the Managed Care Program (MCP) Appointment Booking module of the CHCS.

Support the ongoing education/training of MTF personnel needed to implement APS and improve access.

Allow the TRICARE Operations Center (TOC) to access their CHCS host to download data to support schedule and appointments analyses. Periodic on-line Appointment Management and Access to Care reports on the results are currently available on the entire MHS.

Support the formation of an Access Management Team to manage and monitor the smooth implementation of APS practices and methodologies at the MTF and to ensure adherence to the data element standards and accurate access to care measurement.

5. HOW WILL PERFORMANCE BE MONITORED

The plan to monitor performance in implementing APS and improving access has two measures.

- APS Implementation. The primary goal of APS is for all MTFs to use the standardized appointment methodology as directed in the Assistant Secretary of Defense for Health Affairs policy. The standard for success for full implementation of APS will be that 100 percent of total appointments made in each MTF will use the designated standard appointment types. We are currently at the 99.9 percent level. Dental appointment types remain non-standard but will be migrated to the standard appointment types in October 2003. The TRICARE Management Activity (TMA) will publish reports on the status of each MTF and pass them to the Service headquarters and TRICARE Lead Agents Offices for action and coordination with the MTF Commanders.

- Access Improvement. Access To Care (ATC) functionality in CHCS is a quantitative measure designed to calculate the time elapsed between a beneficiary's request (or in the case of a consult/referral, the provider's request) for a medical appointment and the actual date/time of the scheduled appointment with a health care provider. A report then can be generated that calculates the number of appointments that did or did not meet the access to care standard and demonstrates compliance with TRICARE access standards for acute, routine, wellness and specialty care. TMA and the Services are in the process of testing this system and will use this data to monitor the MTF's performance in meeting these standards.

CHAPTER I

RECOMMENDED PROCESS TO IMPLEMENT APPOINTMENT STANDARDIZATION AND IMPROVE ACCESS

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This guide does not have all the answers to implementing APS or improving access at your facility. It is only a start. There is no "cookie cutter" approach to successfully completing the implementation or to developing/sustaining improved access to care for your beneficiaries. Each facility will be different. However the following steps are recommended to help initiate and sustain this project on an ongoing basis. The steps are a modified FOCUS-PDCA process for continuous improvement. Any other model may work but this one has been selected as it offers a familiar approach.

Each step identifies appendices or references that will assist in that step's completion.

STEP ONE: (F) Find a Process to Improve Appointments and Access

Per the findings of the GAO and of the TRICARE Management Activity's Operation Center data pulls from CHCS hosts, there have been as many as 3000 appointment types used in the MHS. MTF appointments personnel were faced daily with the daunting task of choosing among too many appointment types. MCSC personnel hired to support the appointing function were often not fully or not at all utilized because MTFs were afraid to give up control of the appointments, professing the entire process to be too difficult for contractor personnel to understand. In the mean time beneficiaries were switched from operator to operator or clinic to clinic looking for appointments. Satisfaction was low. Appointment systems differed from clinic to clinic in MTFs, from MTF to MTF in TRICARE Health Service Regions, and from TRICARE Region to TRICARE Region. Leadership at all levels was unable to quantitatively measure whether TRICARE access standards for acute, routine, specialty and wellness care services were being met. The implementation of an MHS wide standardization of the appointment process combined with reliable quantitative measures is the solution to these problems. The MTF Commander is the focal point of the solution.

For a full discussion of the background and the problems with the appointment processes refer to the following appendix.

APPENDIX A: Background/GAO Findings and APS Solutions.

STEP TWO: (O) Organize a Team that Knows the Process

MTF Commanders and Services should first appoint an Access Management/APS Implementation and Sustainment Team Leader. The commander must appoint a team leader with the skills to lead and the knowledge of the appointment system. This individual will

oversee the successful implementation and sustainment of Appointment Standardization and Access to Care Improvement throughout the facility. This Access Management Team Leader will guide the actions of a group of personnel that thoroughly know the appointment process. No two facilities will have the same personnel. Team members may include providers, appointments supervisors, appointments schedulers, personnel that build appointments templates, personnel knowledgeable in MCP, MEPRS/resource management personnel, MCSC appointments personnel (if the MTF utilizes their services), triage nurse personnel, managed care/clinical support personnel, frontline appointments clerks, information systems personnel and others as applicable. To understand the skill sets that are required refer to the following appendix.

APPENDIX B: Job Description of Access Manager.

STEP THREE: (C) Clarify Current Knowledge of the Appointment Process

The Access Management Team needs to review or analyze the current appointment process on an ongoing basis. Flowcharting the present process may be the best way of identifying the "as is" way of booking appointments and providing access to care for beneficiaries. The following questions should be answered by flowcharting:

- What are the purpose, place, sequence, people, and methods that are used to book appointments?
- Is the system designed to fulfill the needs of the patients?
- How does the MTF book its appointments?
- What are the current appointment types used to book appointments?
- What are all the clinics that book appointments?
- What are the wait times for these appointment types by clinic?
- What appointment types are used to book Acute, Routine, Specialty, Wellness services and how do they translate to the Access To Care Category searches in CHCS?
- How long does it take appointment personnel to make an appointment?
- What appointment personnel make the appointments? MTF or Contractor?
- Who builds the files and tables in the MCP? Do they eliminate the need for extra searches by appointment personnel?
- Do the current file and table builds support the Primary Care Manager by Name (PCMBN) initiative at the MTF/Network?
- What appointments consistently go unfilled?
- How are slot comments used in appointment records?

- What is the current on hand inventory of appointments available to patients? Thirty days? Sixty days?
- What percentage of available appointments represents frozen appointments? Why?
- How often does the wrong patient get a wrong appointment slot?
- How does the clinic manage Open Access appointments to make sure slots are available in the future?
- What referrals do not have an initial appointment?

To assist your staff to answer these questions refer to the following appendices. These appendices provide explanations of current and future performance measures.

APPENDIX D: TRICARE Operations Center Description and Services including the Template Analysis Tool
APPENDIX G: Standardized Appointment Types and MCP Utilization Reports on the TRICARE Operations Center
APPENDIX I: Access to Care Optimization Program

STEP FOUR: (U) Uncover the Differences Between The Present System and APS

The goal of this step is to identify the differences between the "as is" process and the "to be" APS model. This will lay the foundation for the move towards and maintenance of appointment standardization, access improvement, and accurate measurement of this process. During this step, MTF Access Improvement/APS Implementation Teams will have to make sure they understand the "to be" APS model. The APS model requires on-going sweeping changes to MTF day-to-day appointment business practices and the way CHCS is used.

The team should review and become familiar with the following appendices in this guide. Careful analysis of these guidelines will help the team to understand how to sustain Appointment Standardization and Access to Care Improvement.

APPENDIX C: Appointment Standardization Methodology
APPENDIX D: TRICARE Operations Center Description and Services including the Template Analysis Tool and Access Management Reports
APPENDIX E: Appointment Standardization Business Rules
APPENDIX F: Appointment Standardization Recommended Metrics
APPENDIX G: Standardized Appointment Types and MCP Utilization Reports on the TRICARE Operations Center
APPENDIX H: Standard Appointment Types Operational Definitions with Access Standards
APPENDIX I: Access to Care Optimization Program

APPENDIX M: Standard Detail Codes
APPENDIX N: Patient Access Types

STEP FIVE: (S) Start the Plan, Do, Check, Act Cycle (PDCA)

In this step the team will start then maintain the change to APS and the measurement of access to care. The Plan, Do, Check, Act cycle will follow the guidelines in Steps Six through Nine below.

STEP SIX: (P) Plan the Change

Once the Access Management Team understands all of the facts about the present system and the "to be" APS model, the group will establish timelines and plans to implement/maintain APS and improve access. Each MTF's plans will not be the same due to different clinic and provider mixes. Small MTF's may have more Primary Care clinics; larger MTFs or Medical Centers may have more Specialty clinics. Careful ongoing mapping of the current processes to the APS model will have to be performed. Decisions on appropriate standardized clinic location names, appointment types and detail codes will have to be made. Clinics may decide to migrate to the Open Access model. File and table changes in CHCS will have to be considered. MTFs must have personnel who are knowledgeable in the use of the CHCS MCP module. The scope of the change will have to be considered. MTFs may want to first test changes in selected clinics and develop some lessons learned to help with full APS implementation and Access Improvement throughout their facility. Others may want to start in Primary Care clinics and then move to Specialty clinics. Issues such as education of staff and marketing to providers are important and will have to be addressed in the planning process. The staff must be well educated in APS. Personnel at all levels of the MTF must know the reasons for APS and Access Improvement, be aware of its benefits, and be committed to its implementation and sustainment.

The following appendices provide guidance on education, marketing and APS benefits.

APPENDIX I: Access to Care Optimization Program
APPENDIX J: Open Access Appointing
APPENDIX O: APS Education
APPENDIX P: APS Marketing and Benefits

STEP SEVEN: (D) Do the Change

With the entire process planned, the MTF is now ready to begin the changes. A step by step process to complete the implementation of APS and continue to improve the processes and accurately measure access will have to be undertaken. In this step the plans of the Access Management Team will affect the actual operations of the appointing process. A recommended checklist that will guide MTF staff in this endeavor is included in this manual as are instructions on the proper use of the access to care search functionality in CHCS. Access Management Teams may also want to consult with other MTFs that have changed their appointment systems and have made the jump to APS including Open Access.

Refer to the following appendices for guidelines related to performing the change. Access Management Teams may modify the implementation/sustainment checklist to accommodate plans and operations specific to their facilities. No TMA point of contact information is available at this time. Consult your Service Access Manager for information on Access Management.

CHAPTER II: General Appointment Standardization Implementation And Access Improvement Guidance
APPENDIX I: Access to Care Optimization Program
APPENDIX Q: MTF Master Check List for Appointment Standardization and Access Improvement Sustainment
APPENDIX R: Recommended Guidance To Appointment Personnel On Accurate Access To Care Searches
APPENDIX S: Appointment Standardization Point of Contact (POC) Information

STEP EIGHT: (C) Check the Results of Changes

In this step feedback is important to see whether the changes are properly taking effect. The Access Management Team should review data from the Template Analysis Tool (TAT), the Standardized Appointment Types, the Appointment Utilization Report and the local Access to Care Summary Report. To help a site assess its access to care performance, four new reports will be available on the TRICARE Operations Center web page in early 2003: the Appointment Management Report, Access to Care Summary Report, Detail Code Report, and Detail Code Summary Report. Appointment personnel and providers should be questioned as to problems or breakthroughs arising out of the changes. Results may indicate that further changes in the process are required.

- The standard for success for full implementation of APS is 100 percent of total patient appointments made in clinics will use one of the ten standard appointment types.

- The standard for success for improved access to care is that waiting times should decrease

The following appendices will familiarize staff with the understanding and implementation of available feedback tools.

APPENDIX D: TRICARE Operations Center Description and Services including the Template Analysis Tool and Access Management Reports
APPENDIX F: Appointment Standardization Recommended Metrics
APPENDIX G: Standard Appointment Types Utilization Reports on the TRICARE Operations Center

STEP NINE: (A) Act to Hold, Gain or Improve APS and Access

Once the Access Management Team determines that alterations in the appointing processes are making positive changes in the clinics, the team will use lessons learned to expand to all clinics throughout the MTF. Frequent two-way feedback should be encouraged to define the positive and negative aspects of process changes between the managers and the front line appointment personnel, and the administrative, nursing and provider functions. When changes have taken hold at the MTF and best practices have been developed, the Access Management Team can draft permanent procedures for APS processes.

Once the MTF is comfortably operating with these procedures the MTF Commander can downsize the Access Management Team. The Access Management Team should record their findings for communications with higher headquarters and with MTF beneficiaries. It is strongly recommended that personnel in each facility be assigned either sole or additional duties of ongoing management of access.

APPENDIX L: Appointment Standardization Phase III (APS III)

STEP TEN: Make Recommendations To Higher Headquarters/Market Results To Your Beneficiaries

As success is achieved it is important to share these with your higher headquarters at all levels. Your lessons learned can assist other MTFs. It is also important as your access improves that you communicate the improvement to your beneficiaries.

CHAPTER II

GENERAL APPOINTMENT STANDARDIZATION IMPLEMENTATION AND ACCESS IMPROVEMENT GUIDANCE

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GENERAL APPOINTMENT STANDARDIZATION IMPLEMENTATION AND ACCESS IMPROVEMENT GUIDANCE

This section is a compilation of TMA and Appointments Standardization IPT (ASIPT) guidance on recommended implementation and sustainment activities for Appointment Standardization (APS). The history of the APS activities will be covered from pre-implementation through post-implementation: establish the authority, establish the environment, resource the key functions, implement an action plan, and improve the business rules. These processes are also applicable to on-going sustainment activities, particularly the process of access reengineering.

Standardization is designed to be MHS-wide. In order to achieve this objective, each site must ensure that their staff understand and apply the standards as designed. The following table is a summary of the implementation/sustainment objectives for APS and Access Improvement reengineering and contains a summary of the points made in each section in this chapter.

TABLE 1

APS AND ACCESS GOALS AND OBJECTIVES

Goals/Objectives	**Action Authority**
I. Establish Authority	
A. Disseminate policies	TMA, ASIPT
B. Draw on established HA authority	MTF
C. Obtain SG policy approval	TMA, LA
D. Commander commitment and motivation	MTF CDR
E. Create and authorize Access Management Team	MTF CDR
F. Maintain TRICARE contract updates for APS changes	TMA, MTF
II. Establish Environment	
A. Continue iterative development of APS plan	CDR, MTF
B. Conduct iterative APS education and training	TMA, LA, MTF
C. Facilitate APS marketing and communication	MTF
D. Establish APS metrics and feedback mechanisms	TMA, LA, MTF
E. Develop and train APS business rules	TMA, ASIPT, MTF
F. Develop concept for APS implementation	LA, MTF
G. Develop concept for APS sustainment	LA, MTF

III. Commit Needed Resources	
A. Designate APS Points of Contact (POC)	LAs
B. Assign Tri-Service representatives to ASIPT	SGs
C. Designate MTF Access Management Team	MTF Commanders
D. Receive MCP and APS training	LA, MTFs
E. Receive connectivity for ATC	IM
F. Participate in Template Analysis Tool	MTFs
IV. Improve Business Rules	
A. Provide Lessons Learned	LA, MTFs
B. Feedback incorporated into APS model	TMA, ASIPT
C. Update Business Rules	TMA, ASIPT
D. Train Business Rules	TMA, LA, MTF
V. Implement Appointment Standardization (Completed)	
A. Provide User Assistance through Multi-Tiered Customer Support Capability	CSD
B. Identify the functional and information requirements of Appointment Standardization and Access Improvement	TMA, ASIPT
C. Implement Ten Standard Appointment Types	MTF
D. Implement MCP Booking	MTF
E. Establish and coordinate new standards	MTF, LA, TMA, ASIPT
F. Update and republish Commander's Guide to Access Success	TMA
VI. Implement Access Improvement	
A. Perform Access Improvement process	TMA, ASIPT, LA, MTF
B. Perform analysis on data variations across MTFs	TMA, TOC

CHAPTER II

GENERAL APPOINTMENT STANDARDIZATION IMPLEMENTATION AND ACCESS IMPROVEMENT GUIDANCE

1. ESTABLISH AUTHORITY

Two policy letters related to Appointment Standardization have been issued by the Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA)) to provide the Commanders with the authority to implement APS. The first letter mandates the use of the nine standard appointment types to book 90 percent of appointments by 1 October 2001; the second mandates the use of CHCS MCP to book appointments by 15 January 2001. In May 0f 2002, a policy letter was issued to authorize a tenth appointment type was added to support the Open Access booking model. These policies have been approved by the Deputy Surgeons General (SG) for all the Services and a copy is available in the Policies topic on the TRICARE Access Imperatives (*TAI*) Web Site, at *http://www.tricare.osd.mil/tai.*

The ASIPT was chartered by TMA in May 1999 to perform the analysis and recommendations for APS, Access Improvement, and the resolution of GAO appointing concerns. The ASIPT developed the Appointment Standardization Methodology which is now available on the TAI Web Site.

The Appointment Standardization Program Manager at TMA Health Services and Operational Support Directorate (HSOSD) will monitor the progress of each MTF as they transition to the use of MCP Appointment Booking, APS, and Access Improvement. The TMA Appointment Standardization Program Manager worked closely with designated representatives from each MTF and the LAs to implement the program, track success, and address concerns. Responsibility for the program has now transitioned to the Services. Close coordination and integrated support will facilitate a successful transition, implementation, and standard solution.

The Surgeons General and the Service Major Commands are the ultimate decision point and issue the directive to implement the new policies.

Commander support and involvement will be the most defining factor in the success of APS and Access Improvement. The Commander will be requested to support implementation of MCP Booking, the *ten* standard appointment types, and training for their staff.

The Commander will designate an Access Manager and Access Management Team at the MTF to oversee and integrate the implementation of APS and Access Improvement across all MTF activities. The Access Management Team will be directed by the Access Manager.

Appendix W, Appointment Standardization and Access Improvement Responsibilities of DoD Entities, describes in detail the roles and responsibilities of involved DoD and MTF organizations in the establishment and ongoing support for APS and Access Improvement.

CHAPTER II

GENERAL APPOINTMENT STANDARDIZATION IMPLEMENTATION AND ACCESS IMPROVEMENT GUIDANCE

2. ESTABLISH THE ENVIRONMENT

The LAs in each Region and the MTF Commander will have the responsibility to establish an environment that fully supports and monitors on an on-going basis APS, MCP Appointment Booking, and access to care standards. Establishing and maintaining the environment involves planning, education and training, marketing and communication, committing needed resources, and improving and implementing the business rules listed in Appendix E. Strategies for these processes are explained below.

2.1 Changing the Culture

Commanders will have the responsibility to motivate their staff and set expectations for provider performance. It is suggested that Commanders designate an Access Manager and Access Management Team to initiate and sustain the program processes and to assist and monitor successful implementation and execution of the APS and Access Improvement programs. This team should be multi-disciplinary. Marketing and feedback processes must be tasked. The objective is a positive perception change among all those involved in the appointing processes. The team must also integrate the technical aspects of the changes into the marketing and operations. Refer to Appendix B for the Access Manager's job description/responsibilities and knowledge, skills, and abilities.

2.2 Pre-Implementation Strategy

The following sections on planning, commitment of resources, and business rules training address *the historical* pre-implementation processes defined to prepare the environment for APS. Education and training, marketing and communications are addressed in Appendices O and P respectively.

2.2.1 Planning

Commanders are encouraged to develop an Action Plan to implement and sustain APS. The plan will address needed preparation steps, MTF and Command points of contact for assistance, management, and coordination, and how assistance will be provided on an ongoing basis. Appendix Q, MTF Master Implementation/Sustainment Tasks and Check List for Appointment Standardization and Access Improvement, suggests a list of tasks that will support planning, implementation, and sustainment of the two programs.

Planning is critical to a successful implementation. Sites have designed the local implementation and training plans using Access Management Teams. The Access Management Team is multi-disciplinary, comprised of appointment and scheduling, clinical, providers, information

technology, and professional staff. Each Access Management Team will provide guidance and assistance to clinics, providers, and appointment personnel as the programs roll out and ensures a standard solution and a common understanding. In the Policies, Documents, and Presentations topic under Presentations, the TAI Web Site contains the descriptions of the implementation methods used by some sites. TMA point of contact information is no longer available on-line. Consult your Service Access Manager for information on Access Management.

TMA has developed this Commander's Guide to Access Success, which also will be included on the TAI Web Site for easy access to Commanders and their staff. The guide will support the successful planning, transition, implementation, and sustainment for APS and Access Improvement.

2.2.2 Commit Needed Resources

Resources must be made available across many centers such as manpower, time, cost, training, equipment, and information management. Proper staffing will be a key factor in the success of the project.

To ensure effective management of data in the MHS and of Access Improvement and APS initiatives, additional fine-tuning of resources may be required. The actions below are recommended:

- SG and LAs designate an Access Manager Steering Committee to serve as facilitators and advisors on standardization and Access improvement and policy issues.

- MTFs designate an Access Management Team to serve as a local facilitator to the clinics and to represent the MTF for the identification and management of appointments and schedule management issues within the command. This team will need the backing and personal interest of the MTF Commander to make APS and Access Improvement a reality for the patients. MTFs that have done this have found that these positions have helped to perpetuate better schedule management, provider productivity, make more appointments available, and fit the right patient to the appropriate appointment.

- The TMA APS Program Manager, working with the LAs, facilitates implementation and sustainment of APS and Access Improvement initiatives.

- Tri-Service personnel will be available at the TMA Operations Center (TOC) for data and report services. The level of funding for this service will be determined

from existing funding resources within the command and or Region. Regardless of funding implications, access standards are to be met by every MTF; MCP is to be used to book appointments; and **100** percent of all appointments booked at the MTF must be booked utilizing the **ten** standard appointment types.

2.2.3 Improve Business Rules

APS business rules have been developed by the ASIPT and are documented in Appendix E. These rules are grouped by CHCS function so that they may be easily separated for distribution to the appropriate organizations or staff members. Implementation of the complete set of rules is important in order to maintain standardization and consistency across the MHS.

2.2.4 Miscellaneous Pre-Implementation Procedures

The ASIPT suggested some local pre-implementation objectives and steps:

- Encourage preventive medicine, i.e., structure schedules to see patients under preventive rather than acute conditions

- Develop written appointing criteria and provide to booking clerks; explain how to use the slot comment field

- Revise Government Services (GS) Booking Clerk Position Descriptions for APS

- Map old appointment types to new standard appointment types. Use the $ extender ($ for MTF Book Only) where appropriate. The X non-count appointment types were inactivated in the APS II release in November 2001. Now count/non-count values are determined by the new Workload Type field on each appointment in a template or schedule. The Workload Type field still defaults from the Clinic or Provider Profile as it always has but scheduling staff may change the default to a corrected value. The only 'X' appointment type that is currently available is TCONX which in conjunction with TCON and TCON$ will be used temporarily to identify patient calls for appointments that did not result in an appointment. *TCON, TCON$, and TCONX will inactivated in APS Phase III due out in October 2003.* These appointment types will be replaced by a new feature in APS III that will enhance CHCS to allow an MTF to track patient calls that do not result in an appointment.
- Coordinate new appointment types with Ambulatory Data Module (ADM) overlays

- Open schedules 30 to 60 days in the future
- Expand working hours
- Implement local policy for appointment duration and schedule planning
- Coordinate clinic names and count/non-count designations with site MEPRS representatives
- Complete MCP File and Table Build correctly for Primary and Specialty care
- Mandate MCP Booking. MCP is the only booking module supported by CHCS and also may be used to book self-referral appointments. In APS III due out October 2003, a new booking module, Enrolled Elsewhere, will book beneficiaries who are enrolled to other facilities.
- Plan training required for use of MCP to book appointments
- Plan methods to book dental appointments, e.g., use referral booking or use PAS as a secondary menu option
- Simplify MCP Referral booking
- Recommend and establish an ATC Measurement plan
- Conduct clinic assistance visits
- Develop progress reports on the change over

CHAPTER II

GENERAL APPOINTMENT STANDARDIZATION IMPLEMENTATION AND ACCESS IMPROVEMENT GUIDANCE

2.3 History of the Implementation Strategy

The APS system enhancements *were* rolled out in *three* releases, CHCS APS I (November 2000), CHCS APS II (November 2001), and an upgrade (APS II + in June 2002) to turn off non-standard appointment types and non-standard detail codes. However, the APS II system enhancements were not needed to begin the conversion to the *ten* standard appointment types. Once the APS I change package was loaded, sites began using the *ten* standard appointment types for Primary Care and, as appropriate, for Specialty Care. Detail codes were implemented prior to APS II by entering one or several detail codes as free text in the slot comment field where they would display to the booking clerk on the available appointments list.

Implementation of the *ten* standard appointment types will make the transition to CHCS II easier.

A conversion program was developed to help sites move easily and quickly into APS without the need to extensively rebuild templates and schedules.

A future release, APS III, is planned for October 2003. Refer to Appendix L for a list of the System Change Requests that will be included in that release.

Appendix Q, MTF Master Implementation/Sustainment Tasks and Check List for Appointment Standardization and Access Improvement, provides suggested steps for each MTF. Sites may tailor this list to suit their needs.

Some suggested local implementation objectives are listed below.

- Provide MCP experts to perform hand holding during implementation and sustainment
- Book appointments correctly at the start, not at end of day processing
- Perform a pilot test of Appointment Standardization in a clinic, particularly for Primary Care
- Monitor patient waiting time at the clinic and remedy
- Ensure patient demand is met

Refer to the Appointment Standardization Business Rules in Appendix E for the complete set of MCP Health Care Finder booking rules that cover data entry into MCP.

2.4 Post-Implementation Strategy

APS was rolled out in phases and is currently deployed. MTFs continue to provide lessons learned from APS implementation so that the processes can be refined as the program moves into sustainment mode. Feedback will continue to play an important factor in the assessment of the success of the Appointment Standardization and Access Improvement solution and to ensure compliance across the command and clinics.

2.4.1 Feedback

The MTF Access Managers have responsibility for the assessment of the APS and Access Improvement effort and for coordinating the feedback solicitation and analysis internally. The feedback procedures and results will be communicated to the LA. The LAs will provide feedback to TMA on the successes and concerns with the program. Important feedback sources include patients, providers, clinics, MCSCs, and performance measurement of appointment data.

TMA continues to monitor progress on conversion to the *ten* standard appointment types using the TRICARE Operations Center home page to view the Standard Appointment Type Utilization Reports. TMA, the Services, and the LAs will provide any needed guidance and assistance to sites.

2.4.2 Feedback Strategy

Measurement of the success of APS and Access Improvement will provide important feedback to the MTF staff to help them understand the on-going adjustments that must be made to schedules to meet ATC criteria. The MTF Access Management Team members will be responsible for the analysis of the TOC Template Analysis Tool (TAT) data, Standard Appointment Type Utilization Reports, and Access Management Reports and will provide guidance and oversight to clinics to correct clinic schedules that are not meeting demand. Guidance will include the following.

- schedule planning
- balancing the available appointment types to meet patient demand
- balancing the types of beneficiaries receiving appointments (to meet DoD access standards)
- use of detail codes to ensure appropriate appointing
- monitoring frozen appointments to ensure a timely release
- projecting demand based on usage
- changing appointment types on the fly to open up access

- other techniques that improve access to patients

When sites need to add new standard appointment types, or detail codes, they will submit their recommendation to the LA. The LA will work with the Clinical/Medical Director and TMA to ensure that an MHS-wide standard is maintained. Once approved, sites must wait to use the new appointment type and detail codes until they are released in a quarterly CHCS table update.

Several feedback options will be available to sites to track their progress with APS and Access Improvement initiatives.

2.4.3 Performance Measures and Tools

The following tools are currently available to assist the commander and staff in monitoring performance for APS and Access Improvement. Commanders need to be familiar with the use of these tools so that the staff members are aware that the Commander takes a personal interest in each clinic's performance. These tools provide directorates and clinics with detailed performance analysis, measuring compliance to the access standards.

- The Template Analysis Tool (TAT) is designed to inform directorates and clinics of the availability of appointments in each clinic. The tool collects schedule data for 30 days in the future and prospectively identifies the clinics that are not releasing schedules in time for booking. Data for the past 30 days is kept on file for comparison. This tool allows management to correct bottleneck problems before the problems restrict access for patients. The tool will also indicate by MTF and clinic the current status of the use of the ten standard appointment types in the schedules.

- In the future, TMA is developing four new Access Management reports on the TRICARE Operations Center web page: Detail Code Usage Report, Detail Code Summary Report, Access Management Report, and Access to Care Summary Report. The Access Management Report will include walk-in appointments as a separate measure in the access measurements. When walk-in appointment measures are combined with measures of booked appointments and number of providers in the clinic, a site will be able to have an high-level indicator of provider productivity within a clinic based on the number of visits accommodated per provider each day. This will simply be an indicator that further investigation is required. The Access to Care (ATC) Summary Report on the TOC will measure access using different criteria than the CHCS ATC Summary Report. However the CHCS ATC Summary Report will be modified in August 2003 to

measure access to appointments using the same criteria as the TOC ATC Summary Report.

These TAT and TOC Reports are available on the Web and all sites have access to their own reports. The reports are updated daily with current data. The Web address is http://www.tricare.osd.mil/tools. The reports can be displayed by downloading the Snapshot Viewer to your computer.

- The MCP Utilization Summary Report was formerly available on the TAT Web Site and provides a snapshot of MCP booking usage in CHCS. The goal that all MTFs should be using MCP Booking was achieved in the APS II release in November 2001 and therefore the report was inactivated..

- The CHCS ATC Summary Report provides counts of appointments by access category, division (MTF), department, clinic, provider, and beneficiary category (i.e., TRICARE PRIME (AD) or TRICARE PRIME (CHAMPUS) or TRICARE Plus). The appointment counts indicate the degree to which each clinic/provider in the MTF is meeting or not meeting Access Standards and the average number of days to get an appointment for that access category and type of beneficiary. The data for this report may be exported in a flat ASCII file for download and analysis. ED/IS will receive and store all reports from the submitting sites. TMA is also pursuing a process to display these reports on the TOC web site.

- The MTF Standardized Appointment Types Utilization Report provides a monthly snapshot to all TRICARE Health Service Regions (HSR) and Uniform Services as to their progress in implementing/using standardized appointment types at their facilities. The TRICARE Operations Center has developed this report. The report can be accessed on the TRICARE Operations Website at this URL: http://www.tricare.osd.mil/tools/.

- The MHS Appointment Type Utilization Report provides a monthly snapshot of all appointment types used in the Military Health System. It rank orders by number of appointment slots used in each appointment type from the highest to lowest of all of the different varieties of appointment types used in the MHS. The report can be accessed on the TRICARE Operations Web site at this URL: http://www.tricare.osd.mil/tools/

- The CHCS Refused Appointment Report will help sites measure the frequency that a patient or all patients refuse available appointments within access standards. Patient refusal of an available appointment will not be counted against the clinic's

performance in meeting access standards. This data is also captured in the Access to Care Summary Report when a patient refuses an appointment within the access standard.

2.5 Access Improvement Reengineering

Access to Care initiatives will continue to be developed over the next several years to optimize access for patients. These initiatives will include the methods used by the MHS to make and track appointments. Improvements such as E-Health technology (e.g., Web-based appointing), provider productivity, and patient Call Response reporting are being looked at to improve the use of existing resources. Phone systems will be improved and standardized including monitoring of dropped calls, and faster phone responses. The CHCS II technology will impact the future direction of appointing.

The groundwork for improvement is being positioned now. It is hoped that before the end of the year 2001, APS will have a standard utilization report that provides tracking of individual provider productivity. Some MTFs such as Tripler Army Medical Center and others have developed home grown reporting mechanisms to monitor and report this data using Uniform Chart of Accounts Personnel Reporting System (UCAPERS) and the Ambulatory Data System (ADS) data. TMA and the SG together are looking at "frequent flyer" reports to understand how single beneficiaries can consume more than an average share of PCM resources and measure that impact on overall access, i.e., not just assess how many visits are conducted but how many patients are being seen.

Access to Care at the MTF

Local guidance should be developed in the following areas to improve beneficiary access to care, and improve access measurement.

- The MTF and LA Office must have personnel identified who are responsible and accountable for the management and success of APS and Access Improvement.

- Personnel should be assigned at the clinic level to be accountable for access improvement and to ensure that provider schedule responsibilities are fulfilled.

- Assign a standard percentage of total appointments to each beneficiary type to ensure access, e.g., to ensure that Prime patients receive care in an appropriate ratio.

- Assign a standard percentage of total appointments to each appointment type to ensure that specific types of care are available to patients and not consumed by other appointment types, e.g., acute appointments don't push out wellness or routine appointments.

- Monitor adherence to TRICARE access standards to make sure patients are seen within the time period that they perceive they need care.

- Use standard detail codes to ensure patients are matched correctly to special resources or restrictions applied to the time slot.

- Decide the allocation of walk-ins versus booked appointments in the appropriate ratio. Decide whether to code all walk-ins as schedule slots so the TAT can track and reflect them in provider productivity assessments.

- Apply existing commercial standards where they are useful, e.g., from Kaiser or the MCSC.

- Coordinate APS changes with the MCSC booking clerks.

- Standards should be developed and applied to address the amount of time required per call, the number of calls processed per month, and the number of calls where the patient did not obtain h. The MCSC should be required to adhere to these standards.

- Review, correct, and follow-up on appointing procedures and schedule design. Correct the appointments mix and perform demand management.

- Access to care measurement reporting and tracking is the key to success.

Best Business Practices

There are a number of best business practices that will be mentioned here. More information on Best Business Practices can be found on the TRICARE Access Imperatives Web site.

- Nurse Triage has been started in a number of MTF Call Centers. Triage is an effective way of increasing access to care, making sure the patient gets the right type of appointment for their problem, and is believed to bring better quality of care to patients that sometimes do not understand the seriousness of their symptoms.

- Commanders must ensure that Department and Clinics Chiefs have their schedule/provider input submitted in a timely manner so that schedules are released with a minimum of 30 days into the future.

- The MHS is moving to a paradigm shift in appointing. Web-based appointing for patients to book their own appointments is being rolled out MHS-wide. Initially Web appointing will be offered for routine (ROUT) and established (EST) PCM Primary Care appointments only, then in early 2003 ACUT, OPAC, PCM, WELL, and self-referral appointments will also be offered.

- Some MTFs have chosen to experiment with the Open Access Model. The premise of this model is that today you see those patients who need an appointment today. The site has no appointments backlog. Information on Open Access can be found on the TRICARE Access Imperatives Web site (http://www.tricare.osd.mil/tai) and on the Family Practice Management Web site (http://www.aafp.org/fpm/20000900/45same.html), Same Day Appointments: Exploding the Access Paradigm, September 2000. Initially, modifications in provider schedules, increased staffing, and increased hours of operation are required to eliminate the appointments backlog.

2.6 Key Issues

The following key issues need to be clear when discussing and implementing APS.

- APS requires ongoing leadership support from the top.

- Communication and feedback are critical.

- Commanders and staff need to understand that problems may occur in implementing some of the changes. Test clinics may have to be identified so that problems can be resolved before implementation to the entire MTF.

- Problems that surface after implementation will need to be identified and reported to the LA and conveyed to the TMA Program Manager for APS.
- Provide a comfort level for the change.

At the MTF level, additional issues will be:

- Matching the ATC category in CHCS to the standard appointment type. Correct appointments to ensure a match
- Identification and correction of duplicate appointments
- Rescheduling no-show and canceled appointments
- Rescheduling patients who called and did not get an appointment.
- Resolution of refused appointments and their impact on patient care within access standards
- With fewer appointment types, the Current Procedural Terminology (CPT) code may not marry up with the ADS encounter record
- Clerk training, accurate appointing, and access measurement
- Provider productivity analysis and adjustment
- Difficulty in the standard application of appointment types, detail codes, and clinic names in accordance with the TMA guidance.
- Avoid Wellness and Future access to care categories except where appropriate
- Forward department/clinic memos to Managed Care and Appointments Centers
- CHCS platforms are shared; sites must coordinate among MTFs sharing the platform
- Train clerks on MCP

- Train clerks on the *ten* standard appointment types (including extenders), access categories, and proper use of both

- Make sure MCP file and table build is correctly completed

  All medical appointments must use the ten standard appointment types. If using detail codes, all medical and dental appointments must use only the standard values except age codes. Currently CHCS allows Dental to use their own appointment types. Dental is being encouraged to migrate to the use the Standard Appointment Types now including a new Dental DROUT appointment type. DROUT has a 21 day access standard. In October 2003, CHCS will lock out all Dental non-standard appointment types, add DROUT as a new standard appointment type for Dental use only, include a 21 day Access to Care Category, DROUTINE, require the use of standard appointment types, and inactivate all non-standard dental appointment types.

- No access standards are applied on follow-up appointments when a referral requires multiple appointments

- Conversion of existing ad hoc reports

- Compliance with the processes to recommend new appointment types, detail code, and other standard codes. Refer to Appendix M for instructions on proposing new appointment types and detail codes.

3. SUMMARY

Finally, APS will realize benefits for all participants in the appointing process. Standardized appointing processes will be more efficient, and more user friendly to patients, providers, appointment personnel, and managed care support contractors.

Our patients will be better served in obtaining timely appointments in accordance with their perceived needs. Patients should leave the facility with required specialty care appointments already booked. Patients should be more accurately booked using the detail codes. Providers should realize better schedule management and utilization of their time with patients appropriately booked to their care. Schedule managers will have better tools to develop and define accurate schedules. With fewer appointment types, appointing staff should experience simplified appointing with more appointments available to be booked and easier to find. Resource requirements should be easier to assess using the detail codes.

APS is clearly a team effort. It requires that each responsible agency, organization, clinic, and staff member know their role and take positive actions to ensure that the process works successfully. As in every large undertaking, open lines of communication at all levels are essential. The orchestration of APS across the MHS is an intricate, yet complex set of processes that requires constant and continuous dialogue, at all levels. Everyone has an important role to play and every role is key to ensuring that we get the right patient, to the right provider, at the right place, and at the right time.

APPENDICES

APPENDIX A

BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

APPENDIX A

BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

The Government Accounting Office (GAO), by direction of the Congress, conducted and published three studies on appointing in the Department of Defense (DoD) Military Health System (MHS) environment: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (26 February 1998), Appointment Timeliness Goals Not Met; Measurement Tools Need Improvement (September 1999), and Factors Affecting Contractor's Ability to Schedule Appointments (July 2000).

In response to the GAO studies and to the TRICARE 3.0 initiative to standardize appointing practices across all DoD health care regions, the TMA created the APS Integrated Product Team (ASIPT) to study and solve problems with appointing at the MTFs. The ASIPT consists of representatives from the three Surgeons General's Offices, from TMA, and from Lead Agent (LA) offices in each region.

The ASIPT first met in June 1999 and began to formulate the model for APS. The model was modified as each new GAO report was released. By December 1999, the primary methodologies for the Access Improvement and APS project were developed and ready to roll out. A critical decision was made to use the Composite Health Care System (CHCS) Managed Care Program (MCP) module exclusively to book appointments and to include APS in that module.

Two policy changes were implemented by the TMA. Dr. Sue Bailey signed a policy on 25 May 1999 mandating that the nine standard appointment types be implemented across the MHS by 1 October 2001. A second policy letter was signed by Admiral Cowan for Dr. Sears on 27 October 2000, mandating that appointments be booked MHS-wide using the CHCS MCP Health Care Finder Booking module by 15 January 2001.

The CHCS MCP module was updated with APS changes and the rollout of the system changes began in November 2000 with APS I. APS II was released on 7 November 2001 as a Change Package. APS II+ was released in June 2002 to lock down the standard appointment types and detail codes. APS III will be rolled out in October 2003 to track patient requests that do not result in appointments and to always display at least 28 days of appointments when searching for appointments.

APPENDIX A

BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

The following chart lists the GAO concerns and the APS Solution for each concern. The Vehicle and Release column documents the system and software release or the business process that will be changed to solve the access problem. The Delivery Date column shows the target date for the fix to be implemented.

Nbr	GAO Concern	APS Solution	Vehicle & Release	Current Projects Under Way
1	DoD lacks the capability to adequately assess TRICARE's effects on MHS access, quality, and cost	Access to Care (ATC) measurement implements access categories to track the lapse between the patient request for care and the date of the appointment booked for that care. The time lapse is compared to the DoD access standard to identify those clinics that do not meet the standard. Quality is addressed by the annual Military Health System (MHS) Patient Satisfaction Survey and the monthly MTF Patient Satisfaction Survey. Cost is not addressed in this solution.	CHCS SMMR2 (Jul 2000)	Display ATC Summary Report on TOC Website. Issue policy that ATC data will be tracked.

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BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

Nbr	GAO Concern	APS Solution	Vehicle & Release	Current Projects Under Way
2	Lack of program-wide goals and performance measures to track DoD progress on a regional and system-wide basis to meet TRICARE access and quality program goals for care provided	MHS-wide APS and Access Improvement initiatives include *ten* standard appointment types, standard clinical resource coding, standard codes for slot reservations by beneficiary type, and Access to Care measurement tools. Standardization of CHCS appointing data will allow appointment processes to be measured and compared consistently across the entire MHS. Access will be measured prior to and after Appointment Standardization is implemented and the delta measured. Quality is addressed by the annual MHS Patient Satisfaction Survey and the monthly MTF Patient Satisfaction Survey. In APS III track patients who called for an appointment but were not scheduled to see a provider.	CHCS APS I (Nov 2000) & CHCS APS II (Nov 2001) & APS III (2003)	Display ATC Summary Report on TOC Website. Issue policy that ATC data will be tracked. Report available in Jan 2003.
3	Lack of enforcement of the access to care priorities by type of beneficiary (Active Duty, Prime, and non-Prime beneficiaries)	Development of Patient Access Types to allow sites to reserve appointments for a type of beneficiary in advance to ensure access to Active Duty, Prime, and to meet contract requirements. The Access to Care Summary report shows, by clinic, the average number of days to get an appointment and the percent of total appointments that met or did not meet DoD access standards.	CHCS APS I (Nov 2000)	Display ATC Summary Report on TOC Website. Issue policy that ATC data will be tracked.

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BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

Nbr	GAO Concern	APS Solution	Vehicle & Release	Current Projects Under Way
4	Appointment names do not relate to the standards for the visit	Ten standard appointment types, each related to an ATC standard, are being implemented. An Open Access (OPAC) appointment type has been added.	CHCS APS I (Nov 2000) CHCS APS II + (June 2002)	Open Access is being implemented at clinics on a voluntary basis.
5	Lack of standard appointment names across the MHS	Ten standard appointment types are being implemented across the MHS for 100 percent of the appointments in each clinic. An Open Access (OPAC) appointment type has recently been added.	CHCS APS I (Nov 2000) CHCS APS II + (June 2002) was released to lock down the standard appointment types and detail codes.	Open Access is being implemented at clinics on a voluntary basis.
6	Lack of documentation on patients who elect to book appointments outside the access standards	An appointment refusal must be entered into CHCS when a patient refuses an available appointment within access standards and elects an appointment outside access standards. The Access to Care Summary Report shows the volume of appointment refusals.	CHCS SMMR2 (Jul 2000)	Display ATC Summary Report on TOC Website.

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BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

Nbr	GAO Concern	APS Solution	Vehicle & Release	Current Projects Under Way
7	Enforce CHCS system as the data source for the determination of MTF compliance in lieu of reliance on the Customer Satisfaction Survey	Appointment Standardization and Access Improvement features are implemented and. integrated into the Managed Care Program (MCP) module of CHCS. Sites may only use MCP to book appointments.	CHCS SMMR2 (Jul 2000), CHCS APS I (Nov 2000), & CHCS APS II (Nov 2001)	Display ATC Summary Report on TOC Website. Issue policy that ATC data will be tracked.
8	Limited number of appointments allocated to the contractor to book	"MTF Book Only" and "Provider Book Only" appointments will be supported but will be measurable so that they can be tracked and managed at the MHS level. Procedural appointments may continue to be booked as "MTF Book Only" at many sites.	CHCS APS II (Nov 2001)	Set standards for "MTF Book Only" appointments. Review use of all detail codes, especially PBO detail code on TOC reports.
9	Lack of standardization in clinic names and appointment names made appointing difficult for the contractors	Ten standard appointment types will be implemented. Standardization of clinic will be an MTF and Region responsibility initially. The Enterprise Wide Scheduler will address standard clinic names.	CHCS APS I (Nov 2000) CHCS APS II + (June 2002) was released to lock down the standard appointment types and detail codes.	

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BACKGROUND
GAO FINDINGS AND APS SOLUTIONS

Nbr	GAO Concern	APS Solution	Vehicle & Release	Current Projects Under Way
10	Longer time required to book an appointment because appointments cannot be found or may only be booked by MTF staff	Ten standard appointment types and standard detail codes will simplify and standardize booking and make appointments more readily available. Clerks will be able to reconfigure any appointment to meet the patient needs. In 2003 CHCS will be able to automatically reconfigure open appointments about to expire so that they are more likely to be booked. Open Access is being implemented by clinics on a voluntary basis. Open Access will guarantee a patient an initial appointment on the day they call.	CHCS APS I (Nov 2000) & CHCS APS II (Nov 2001) & CHCS APS II + (June 2002) & APS III (2003)	Set standards for "MTF Book Only" appointments. Review use of all detail codes, especially PBO detail code on TOC reports.
11	Inability to assess beneficiary over-utilization of MTF care services	CHCS Ad-Hoc report instructions to identify frequent users are printed on the TRICARE Access Imperatives web page for download to any site. The address is: http://www.tricare.osd.mil/tai.	CHCS AdHoc	
12	Inability to determine the patients who are booked inappropriately	CHCS II will provide the solution to this concern.	CHCS II	Fund SCR 1089. EWS will fund the requirement. Enforce a policy that documents the issues.
13	Inability to measure the number of patients who are unable to obtain appointments	Ability to track patient calls that do not result in a booked appointment. SCR submitted and funded for CHCS APS III to cover this. Contractor must have a call tracking system to monitor dropped calls due to long wait period. MTF needs the same.	CHCS APS III (Oct 2003)	SCR 1085, 1091 currently funded and under development.. Track patient calls that did not result in an appointment.

APPENDIX B

JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

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JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

Access Manager/Appointment Officer Responsibilities/Position Description

The job description of the MTF's Access Manager/Appointment Officer will include, but not be limited to, the following responsibilities:

- Functions as the Commander's agent for appointment standardization, provider and table builds, access measurement and schedule management at the MTF
- Chairs the MTF's Access Management Team
- Assists clinic heads in formulating clinic goals in terms of access, volume, patient demand, staffing, and GME
- Assesses clinic operations and appointment utilization patterns to identify bottlenecks and to maximize use of available resources
- Ensures that MCP booking, standardized appointment types, standardized places of care, and standardized detail codes are implemented within the MTF
- Ensures appointment personnel are appropriately trained on appointment standardization and access improvement initiatives and procedures
- Ensures clinic leadership is trained on the value and use of performance measurement tools such as canned CHCS reports, Template Analysis Tool, Access to Care Summary Reports, etc.
- Ensures personnel are designated at the clinic level who are responsible and accountable for appointment standardization, patient access, and provider schedule management
- Monitors appointment standardization compliance, referral processing compliance, and access metrics for all clinics within the MTF
- Ensures the MTF-wide dissemination of pertinent MTF and higher headquarters APS and Access Improvement directives
- Maintains a standardized environment for all APS and ATC data at the MTF and forwards new APS and ATC issues to the Lead Agent for review and assistance

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JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

- Functions as the MTF's point of contact for APS and ATC issues and represents the MTF at related conferences

- Identifies need for any additional standardized codes (including detail codes), appointment types and elevates this need to the Lead Agent for approval prior to use at the MTF

- Interfaces with Lead Agent, Intermediate Command, Service level counterparts to facilitate access improvement and appointment standardization programs

Access Manager/Appointments Officer Knowledge, Skills, and Abilities (KSA)

The knowledge, skills and abilities of the MTF Access Manager/Appointment Officer should include, but not be limited to the following:

- Knowledge of MTF and clinic procedures for scheduling appointments, building CHCS files and tables, and managing provider templates and schedules.

- Knowledge of clinical operating procedures of the various clinics within the MTF.

- Working knowledge of on-going APS and ATC improvement initiatives and the policies that govern them.

- Demonstrates a thorough knowledge of the functionality of CHCS MCP and PAS appointment systems.

- Demonstrates a working knowledge of the correct usage of MEPRS, CPT and ICD codes for the various clinics within the MTF.

- Demonstrates the ability to research, collect and analyze data from multiple sources and provide appropriate managerial recommendations to MTF leadership.

- Skilled in identifying problems, solution to problems and implementing those solutions to bring resolution to those problems in accordance with accepted guidance.

- Demonstrates experience of effectively communicating orally and in writing to higher headquarters, MTF leadership, and clinic heads.

APPENDIX B

JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

- Demonstrates an awareness and appreciation for the duties and responsibilities of the MTF's appointing personnel.

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

TRICARE Management Activity
Appointment Type Standardization

This document represents the methodology for standardization of the clinical appointments data fields for use throughout the Military Health System. This product evolved from the DoD-wide standardization effort of the Composite Health Care System (CHCS) data elements for appointment types and other data values as necessary to support standardized business practices in the clinical outpatient appointment process.

1. Requirements of the Process

Right Patient	**Right Provider**	**Right Place**	**Right Time**
Enrollment status Patient Type Age Sex	Provider linked to right location	Place linked to right clinical services	Provider defining availability (templating)
Time requirement (and access standard) Location Clinical need	Information Technology (IT) requirement	IT requirement	Management Responsibility

2. Assumptions

- The appointment system will not be developed as a tool for workload or workforce accounting but will be consistent with workload requirements.
- Appointment names are standardized.
- Clinic names will not be standardized at the MHS level at this time.
- Appointments may be reserved to ensure access to care by specific types of patient.
- Military Treatment Facility (MTF) and Managed Care Support Contractors (MCSCs) share the ability to appoint.
- At present, certain appointments will remain designated as "MTF Book Only". Eventually the contractor will be able to book a larger share of the appointments.
- Triage occurs before appointing.
- One of the goals of the appointing process is to maximize the utilization of MTF capacity.
- One telephone number will function as the point of access for appointing and referrals.
- The appointing system is demand focused, not supply focused, and will strive to match supply to demand.
- Leadership supports standardization and the efforts to implement the standardization.
- TRICARE Prime patients seeking care are properly enrolled using the DEERS On-line Enrollment System (DOES).
- The patient will be seen at the appropriate level of care.

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

3. Appointment Process Usage Objectives

- Differentiate visit type
- Assign the authority to arrange visits
- Differentiate time expectations
- Differentiate visit duration
- Identify procedures
- Match patient to provider skill
- Match patient needs to resources
- Allow for performance measurement
- Demonstrate effectiveness, efficiency, and customer satisfaction

4. Data Elements Requiring Standardization

Existing Field	Existing Field	Modified Field	New Field	New Field	New Field
1 Appointment Types	2 Booking Authority	3 Time (appt duration)	4 Patient Access Type	5 Appointment Detail Field	6 Age Delineation

5. The Ten MHS Standard Appointment Types and Access Criteria

- PCM initial primary care only (4 weeks in calendar days)
- ACUT acute (24 hours)
- OPAC Open Access (same day patient calls for appointment)
- ROUT routine appointment (7 days)
- WELL wellness, health promotion (4 weeks in calendar days)
- SPEC initial specialty care only (4 weeks in calendar days)
- PROC procedure (28 days or provider designated duration within 28 days)
- EST established patient follow-up (provider designated duration)
- TCON telephone consult
- GRP group/class (provider designated duration)

6. Booking Authority

- The dollar ($) sign will be used as the last character in the appointment type field to indicate MTF Book Only, e.g. PCM$, ROUT$.
- The $ extender is a permanent solution. However, the MTF and the MCSC will have a partnership to allow the MCSC to book a larger share of the appointments.

7. Patient Access Types

All MTFs will have the capability to reserve appointment slots according to a patient access type as follows. Refer to Appendix N for definitions of the patient access types**:**

- Active Duty
- Prime Enrollees Only; No Active Duty
- Active Duty and Prime
- Active Duty, Prime, and Special Programs Patients
- No Active Duty
- No Prime
- No Active Duty, No Prime
- Graduate Medical Education
- Special Programs Patients
- TRICARE Standard/CHAMPUS

8. MHS Enterprise Appointments and Referral Business Rules

The APS business rules will be applied across the MHS. MTFs will support and coordinate appointment standardization. Refer to Appendix E for documentation of the business rules.

8.1 Order of Search Precedence for Appointments (non Specialized Treatment Service [STS]) by the Location of the Appointment:

For Prime patients seeking primary care:	For Non-Prime Patients seeking primary care:
1. PCM – physician based in the enrolled place of care 2. PCM – physician based in any **other** place of care where the PCM practices 3. PCM – any PCM group member providing service in the enrollee's place of care or in a group member's place of care. 4. PCM – for OPS forces only, any provider in any place of care in any MCP Provider Group to which the patient's assigned PCM is a member.	1. Primary Care physician—civilian or MTF 2. Next available MTF 3. Network physician 4. Non-network physician

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

For Prime patients seeking specialty care:	For Non-Prime patients seeking specialty care:
1. MTF based physician or clinic requested by PCM 2. Next available MTF (based physician) within access standards 3. Network physician within access standards 4. Non-network physician within access standards	1. Closest MTF 2. Next available MTF 3. Network physician 4. Non-network physician

8.2 Specialty Care and Referral Process

- All TRICARE Prime patients seeking specialty care will have a referral from their PCM except in the case of a medical emergency. Limited Self-Referral will be permitted for certain known and predictable conditions based on the MTF service model. Optometry, physical exams, immunizations, dental, psychiatry, audiology, and pap smears are possible self-referral services at the MTF.

- All referral requests will be electronic via CHCS (or other approved system).

8.3 Patient's Rights

- The patient may elect to use the Point of Service Option.
- Beneficiaries may waive the distance access standard for specialty care.
- The patient may waive the time access standard and request appointments outside of access standards for convenience or continuity of care reasons even though appointments are available within access standards.
- The patient's refusals and waivers will be documented electronically in CHCS (or other approved system).

8.4 Booking

- Clinic appointment templates, other than acute, will be open for booking at least 30 days ahead at all times.
- Basic CHCS Patient Demographic information, at a minimum, name, address, and telephone number will be updated at the time of appointment booking.
- Delinquent and non-count appointments may be resolved daily by CHCS end-of-day processing.

8.5 An appointment slot may be reserved using one of the Patient Access Types:

- Active Duty
- Prime Enrollees Only; No Active Duty
- Active Duty and Prime
- Active Duty, Prime, and Special Programs
- No Active Duty

- No Prime
- No Active Duty, No Prime
- Graduate Medical Education
- Special Programs Patients
- TRICARE Standard/CHAMPUS

8.6 Associated Appointment Process Business Rules

- MCSC and MTF appointment clerks will be able to view all available appointments in CHCS or any other approved system.
- One telephone number will function as the beneficiaries' point of access for all appointing and referral needs. The beneficiary's call will be appropriately routed to the right telephone extension if the first point of contact is unable to serve the beneficiary's health care information or appointment needs. The routing will occur without requiring the patient to make an additional telephone call.
- The appointing process will work under the assumption of "PCM by Name" enrollment where applicable IAW ASD/HA Policy Memorandum - Individual Assignments to Primary Care Managers by Name (3 Dec 1999).

9. Associated CHCS (or other approved system) Requirements

9.1 Scheduling

- Scheduling supervisors will have the ability to define *up to 4 detail codes* effective October 2003 for each appointment slot to indicate resources or restrictions for the appointment. Detail codes are optional.

- The patient access type is a type of detail code and is optional.

- Scheduling supervisors will be able to assign a patient access type to each appointment slot on a provider schedule.

- Patient Access Types will be five alphanumeric characters.

- Future "No Active Duty" and "No Active Duty, No Prime" patient access types will indicate slots reserved for patients to be seen through resource sharing agreements.

- Appointment durations will default from the clinic profile appointment type for non-count clinics and from the provider profile appointment type for count clinics, but the scheduling clerk may change the duration on the specific slot per provider instructions.

9.2 Booking

- Managed Care Program (MCP) users will be able to search for appointment slots based on Patient Access Types.
- Users with appropriate authority may override the Patient Access Type, appointment types, detail codes or age restrictions on a slot and book the appointment for a patient with a different patient access type or age.
- The browse function will continue to be used to modify the appointment duration. In APS III, *the split and join features of* the browse function will be integrated with appointment booking screens for ease of use.
- The clinic has the responsibility to define access on a continuous basis (how many appointments are designated by which enrollment status).
- Each MTF has the ability to designate when the appointment will be released and what the new appointment definition will be.
- In the future (APS III) CHCS will highlight appointments that meet the patient's beneficiary type, age, and access to care requirements.

9.3 Age Delineation

- When searching for available appointments for a patient, CHCS will highlight appointments with providers who treat patients of that age, based on the age specifications in the detail codes.

9.4 Time

- Providers are able to define the amount of time required (duration) per appointment or procedure**.**

9.5 Appointment Detail Field

- The Appointment Detail Field is permanent and searchable.
- Scheduling supervisors will be able to assign up to three appointment detail values to each appointment slot on a provider schedule.
- Valid detail entries will be those in a common file having the same controls as the appointment type file.
- Patient Access Types will be included in the Detail code file.

- These entries will be from two (2) to eight (8) characters in length.
- MCP users will be able to search for appointment slots based on appointment detail entries.
- The system will allow additional locally defined age detail codes only. Sites may recommend detail codes as a standard. Site defined detail codes should be standardized across the Region by the LA, and coordinated with TMA..
- Detail codes will not be used by sites to indicate specialty care at the MEPRS 4 level. Specialty care at the fourth MEPRS level should be designated by the creation of a clinic name (hospital location) to indicate the care, e.g., Orthopedic Hand or Orthopedic Foot.
- All detail codes will be upper case.

Note: A current list of approved detail codes, their definitions, and an explanation of the detail code approval process are located at Appendix M.

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

1. TRICARE OPERATIONS CENTER DESCRIPTION

The TRICARE Operations Center (TOC) is an organization whose work is funded by TMA. One of the functions of the TOC is to extract data from CHCS hosts, store the data in a central database, use standard, validated, consistent measures, and provide on-line reports to each site on the results of the analysis of their data. The TOC offers voluntary access to the MTF Template Analysis Tool (TAT) to interested MTFs, Intermediate Commands, Services and Lead Agents. The TOC also provides miscellaneous Appointment Standardization Reports such as the Standard Appointment Type Utilization Reports (also referred to as the MEPRS 3 Appointing Reports) and four new reports released in February 2003 and summarized below: Detail Code Report, Detail Code Summary Report, Access Management Report, and Access to Care Summary Report. Refer to Appendix G of this document for the technical specifications describing the content and format of these four reports.

2. TEMPLATE ANALYSIS TOOL (TAT)

The TAT is a data gathering application that has been developed to assist leaders to manage the appointment process.

Before a site implements the new APS process, it must measure performance using the same measures and same measurement process (as closely as possible) in order to establish a valid baseline for comparison. The TAT is a reporting capability developed and maintained by the TRICARE Operations Center that performs standard measurement of CHCS appointments schedule status and efficiencies.

PURPOSE: Provide background information on an automated tool available to MTF leadership and managers for day-to-day management of appointments templates.

BACKGROUND: The TAT was developed in Europe in 1998 and expanded to numerous CONUS MTFs in 1999. The TAT was developed to help MTFs meet established TRICARE Prime access standards. Implementation of this tool led to development and evaluation of "Best Practices" in clinic scheduling and template design.

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

DISCUSSION: The MTF Template Analysis Tool is an automated, Microsoft Access based program, which downloads data from CHCS hosts then graphs results in an easy-to-access, easy-to-read format.

- Data Source: CHCS Schedulable Entity File
- Update Frequency: Daily, database updated overnight and reports generated by 0700 hrs
- Report Focus: Includes primarily provider scheduled workload. Walk-ins are captured only when schedule time is blocked for them.
- Report Format: 1 page per MEPRS 4 level clinic per 4 week time period, for both the past month and future month
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TAT has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

POINT OF CONTACT: *TMA Regional Operations, TRICARE Operations Center*

3. STANDARD APPOINTMENT TYPE UTILIZATION REPORTS

PURPOSE: Provide the percentage of clinic patient appointments using standard appointment types. Display percentages by region, Service, MTF, and MEPRS3 code. In addition provides an overall status for all facilities in the MHS.

BACKGROUND: The Appointment Standardization program mandated the reduction of appointment types from 10,000 to 10 appointment types for all facilities in the MHS. In order to track progress on the conversion to the new appointment types, the TOC developed this report as an overview of the progress on Appointment Standardization of each clinic and each MTF.

DISCUSSION: This report is presented in downloadable spreadsheet format. The metrics on the usage of standard appointment types are updated monthly and are available aggregated by Region, Service, MTF, and by MEPRS3 code.

- Data Source: CHCS Schedulable Entity File
- Update Frequency: Daily, database updated monthly

- Report Focus: Includes counts of scheduled appointments by appointment type and MEPRS3 code
- Report Format: 1 page per MEPRS 3 level clinic per 1 month time period, for the past month in spreadsheet format
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TOC has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

POINT OF CONTACT: TMA Regional Operations, TRICARE Operations Center

4. ACCESS MANAGEMENT REPORTS

Four new Access to Care performance reports are available on the TRICARE Operations Center Web Page as of February 2003. These reports will ensure that appointing performance and access to care at all MTFs are measured consistently and accurately. The detailed specifications for each of the four reports are included in Appendix G for your information.

I. Detail Code Usage Report

PURPOSE: This report will give clinic level managers the ability to compare the degree of change among detail codes in their clinic, comparing provider scheduled appointments to what was actually booked for those appointments for the report time period.

VALUE ADDED: Clinic managers should be able to more accurately establish schedules and predict demand for particular services ahead of time and decrease the need to change detail codes when the appointment is actually booked. This report shows the level of usage and degree of change of individual detail codes for a facility (Division) at the clinic level. It allows a site to compare the scheduled appointments in the CHCS Schedule Entity file to the actual booked appointment in the Patient Appointment file for the same schedule period. One of the guiding principles of appointment standardization is to encourage appointment personnel to use detail codes to track what the appointment slot was actually used for. In other words, if the appointment in the provider's schedule has detail codes that do not match what the appointment

is actually going to be used for then, on a regular basis, appointment personnel should change that booked appointment's detail codes to reflect the actual usage.

BACKGROUND: The Appointment Standardization program mandated the use of standard detail codes to ensure the reservation of special equipment or resources for an appointment, or to indicate special restrictions on the appointment. An analysis of the use of standard detail codes will help the MTFs develop better provider schedules to meet patient care needs.

DISCUSSION: This report is presented in downloadable spreadsheet format. The metrics on the usage of standard detail codes are updated monthly and are available aggregated by Region, Service, MTF, and by MEPRS3 code.

- Data Source: CHCS Schedulable Entity File
- Update Frequency: Weekly
- Report Focus: Includes counts of detail codes used on appointments by individual detail code and MEPRS3 code by Service, Region, and/or MTF.
- Report Format: 1 page per MEPRS 3 level clinic per 1 month time period, for the past month in spreadsheet format
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TOC has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

POINT OF CONTACT: TMA Regional Operations, TRICARE Operations Center

II. Detail Code Usage Summary Report

PURPOSE: This report will give MTF and Major Command level managers the ability to compare the degree of change among detail codes at a facility, comparing scheduled appointments at a facility to what was actually booked for the same time period.

VALUE ADDED: MTF and Major Command managers should be able to more accurately establish schedules and predict demand for particular services ahead of time and decrease the need to change detail codes when the appointment is actually booked. This report shows the

level of usage and degree of change of individual detail codes for a facility (Division) and allows for a comparison of the scheduled appointment in the CHCS Schedule Entity file and the actual booked appointment in the Patient Appointment file for the same time period. One of the guiding principles of appointment standardization is to encourage appointment personnel to use detail codes to track what the appointment slot was actually used for. In other words, if the scheduled appointment has detail codes that do not match what the appointment is actually going to be used for, then appointment personnel should on a regular basis change the booked appointment's detail codes to reflect the actual usage.

BACKGROUND: The Appointment Standardization program mandated the use of standard detail codes to ensure the reservation of special equipment or resources for an appointment, or to indicate special restrictions an appointment. An analysis of the use of standard detail codes will help the MTFs develop better provider schedules to meet patient care needs.

DISCUSSION: This report is presented in downloadable spreadsheet format. The metrics on the usage of standard detail codes are updated monthly and are available aggregated by Region, Service, MTF, and by MEPRS3 code.

- Data Source: CHCS Schedulable Entity File
- Update Frequency: Weekly
- Report Focus: Includes counts of detail codes used on appointments by individual detail code, by MTF, and by Service or Region
- Report Format: 1 page per Service or Region per 1 month time period, for the past month in spreadsheet format
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TOC has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

POINT OF CONTACT: TMA Regional Operations, TRICARE Operations Center

III. Access Management Report

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

PURPOSE: This report will allow sites to assess patient access to a clinic's services for each type of beneficiary and, if care was not given, the number of appointments involved and the reason. The report shows the distribution of booked appointments to each beneficiary category, i.e., Active Duty (TRICARE Prime and non-enrolled), TRICARE Prime (CHAMPUS), TRICARE Plus, Non Prime, and Other.

VALUE ADDED: MTF and Major Command managers should be able to:

- more accurately predict demand for particular services ahead of time
- predict the frequency of appointments that are booked yet do not result in encounters with the provider
- decrease the need to correct appointment data when the appointment is actually booked.
- identify problem areas in the booking process and take appropriate corrective action based on the metrics in this report

BACKGROUND: One of the objectives of the Appointment Standardization program is to help sites analyze their scheduling and appointing processes in order to make corrections to improve patient access. This report integrates data from scheduling and from appointment booking to provide an integrated view of both schedule planning and appointment booking at the clinic level with an overall view of the workload performed.

DISCUSSION: This report is presented in downloadable spreadsheet format. The metrics on the status of the appointments are updated weekly and are available aggregated by Region, Service, MTF, and by MEPRS3 code.

- Data Source: CHCS Patient Appointment File and the Schedulable Entity File.
- Update Frequency: Weekly with a Monthly Summary
- Report Focus: Includes counts of appointments by MEPRS3 clinic codes, by beneficiary category, by Service, Region, or MTF
- Report Format: 1 page per MEPRS 3 level clinic per 1 month time period, for the past month in spreadsheet format
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TOC has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

POINT OF CONTACT: TMA Regional Operations, TRICARE Operations Center

IV. Access To Care Summary Report

PURPOSE: This report will allow MTFs to assess patient access to each clinic's services overall and by type of beneficiary (Program Category) for the date range and MTF(s) selected for the report. This report measures how well the clinic is meeting the DoD Access to Care standards for patient requests, including appointments for primary care, appointments for primary care consults/referrals, and appointments for specialty care consults/referrals. Every booked appointment is counted to assess the clinic's total booking activity and patient access, including kept, patient cancellations, facility cancellations, leave without being seen, and no-show appointments.

VALUE ADDED: MTF and Major Command managers should be able to:

- more accurately predict patient access to specific clinic services ahead of time
- assess access by type of beneficiary
- plan more effectively
- identify problem areas in booking, and take appropriate corrective action

BACKGROUND: This report meets the government requirement to measure access to military health care for TRICARE Prime enrollees. Access is measured for MTF care across the five government standard access categories: acute (24 hours), routine (7 calendar days), wellness (28 calendar days), specialty (28 calendar days) in addition to a future category to measure all other care.

DISCUSSION: This report is presented in downloadable spreadsheet format. The metrics on the access to care categories are updated weekly and are available aggregated by Region, Service, MTF, MEPRS3 code, and beneficiary category (TRICARE Active Duty, TRICARE Prime (Non-Active Duty), TRICARE Plus, Medicare, and Direct Care). The beneficiary categories are derived from the Alternate Care Value (ACV) in DEERS.

- Data Source: CHCS Patient Appointment File and GP Consult Tracking file
- Update Frequency: Weekly with a Monthly Summary
- Report Focus: Includes counts of booked appointments by access to care category, beneficiary category, and MEPRS3 code and by MTF, Service, or Region. All booked appointments are counted even if the patient elected not to keep the appointment, e.g. patient was no-show, leave without being seen, or cancelled the appointment.

APPENDIX D

TRICARE OPERATIONS CENTER DESCRIPTION AND SERVICES INCLUDING THE TEMPLATE ANALYSIS TOOL (TAT) AND ACCESS MANAGEMENT REPORTS

- Report Format: 1 page per MEPRS3 clinic per 1 month time period, for the past month in spreadsheet format
- Availability: Reports are posted to the TMA WWW site (http://www.tricare.osd.mil/tools)
- MTF Cost: Zero - Once the TOC has access to a local CHCS host, the MTF has no additional work. Processing of the data and WWW posting are automated from a central TMA location.

DAILY STATISTICS: 104 CHCS Hosts; 397 MTFs; 4500 Clinics; ~4.5M Appointments

POINT OF CONTACT: TMA Regional Operations, TRICARE Operations Center

APPENDIX E

APPOINTMENT STANDARDIZATION BUSINESS RULES

APPENDIX E

APPOINTMENT STANDARDIZATION BUSINESS RULES

The business rules for appointing under the new APS guidelines are presented below. The rules are organized by function to allow easier reference by those directly affected. Please take careful note of these.

1. FILE AND TABLE

The following business rules apply to the processes required to successfully build files and tables for MCP Booking.

1.1 Clinic Profiles

- Sites should coordinate clinic location name changes with the MEPRS staff at the MTF.
- For a clinic whose workload is ALL COUNT workload, create a separate clinic location for the clinic (if not already done). Set the Workload Indicator in the Clinic Profile to count and all the Workload Indicators for the clinic's appointment types to count. The system will treat all the clinic's workload as count.
- For a clinic whose workload is ALL NON-COUNT, create a separate clinic location for the clinic (if not already done). Set the Workload Indicator in the Clinic Profile to non-count. The system will treat all workload for the clinic as non-count by default.
- For a clinic with MIXED COUNT AND NON-COUNT workload, set the Workload Indicator in the Clinic Profile to count.
- Sites will now use the Workload Type field in templates, schedules, and on booked appointments to determine the count/non-count value of the appointment.
- Create a separate clinic for outside providers who provide a unique specialty and assign its own cost pool code.
- Use the clinic name to identify a fourth level specialty that is the total workload of the clinic.
- CHCS will accommodate clinic specific detail help lists. Sites may associate specific detail codes with each clinic. This capability is solely for the purpose of defining a smaller Detail Code help list for the clinic to be used when building schedules and templates. This capability does not restrict in any way the detail codes that may be

assigned to appointment slots for the clinic in the Template and Schedule Build options. All detail codes are allowed.

- If a clinic will be able to enter self-referrals, the Self-Referrals Allowed field in the Clinic Profile, must be set to YES and the Clinic Specialty field should be populated .

- Sites should identify those clinics that support self-referrals. Some examples are Mammography, Psychiatry, PAP smears, Audiology, Dental, Immunization, Physical Exams, and Optometry clinics.

1.2 Appointment Types

- For Medical Appointment types, CHCS will support only the ten standard Appointment types. Dental clinics will now also be restricted to the ten standard medical appointment types plus one dental appointment type, DROUT. Ancillary clinics will continue to be able to create and use their own appointment types for provider templates, schedules, and booking.

- Only the appointment types with the Medical Appointment Type flag set to YES may be used for templates, schedules, and on help lists when booking medical appointments.

- Only the appointment types with the Dental Appointment Type flag set to YES or the Medical Appointment Type flag set to YES may be used for templates, schedules, and on help lists when booking dental appointments.

- Ancillary clinics will set the Medical and Dental Appointment flags to NO.

- The Standard Appointment Type flag will be set to YES by the system for each medical appointment type that is designated by the IPT as standard. Sites will not be able to modify this flag.

- Wait List appointments will also use only the standard appointment types.

- Ten standard appointment types are allowed (for schedulable medical appointments only). Patient access standards are indicated. Appointments types will be used as follows.

  –For Primary Care Only
  - »PCM 28 day access
  - »ROUT 7 day access

–For Specialty Care Only

»SPEC	28 days/provider designated

–For Both Primary and Specialty Care

»ACUT	24 hour access
»OPAC	Same Day
»WELL	28 day access
»PROC	28 days/provider designated
»EST	provider designated
»GRP	provider designated
»TCON	N/A

- Only five standard appointment types are recommended for Dental appointments.
  - ACUT - Acute (24 hours)
  - DROUT - Dental Routine (21 days)
  - SPEC - Specialty (28 days)
  - WELL - Wellness (28 days)
  - PROC - Procedure (28 days or provider designated)

1.3 Detail Codes

- **Sites may only add site defined age codes to the Detail Code file. This applies to all clinics, including Dental and Ancillary.**

- Regions should develop their own age codes and include them in the Detail Code Table. Age codes indicate the appropriate age of the patient. The standard format for the age code is an age range, e.g. 0-12, 17-65, 0-3D, 1W-4W, 0-6M, 3M-6M, 65-120. The age is in years unless otherwise indicated with a D, which indicates days; a W, which indicates weeks; or a M which indicates months. The lower age precedes the upper age limit and must be separated by a hyphen.

- Detail codes for clinical care should only be used to identify sub-specialty care when a clinic performs that care intermittently, not as their sole mission. Detail codes are not intended to replace the clinic hospital location names for sub-specialty care.

- The new Workload Type Field has been initiated on each appointment slot in templates and schedules.

1.4 Security Keys

- Scheduling Supervisors tasked to create and maintain medical clinic profiles must have the new SD APPT STAND security key. This security key will allow the Scheduling Supervisor to enter/edit Detail Codes linked to a specified clinic in the MCP module on CHCS.

- Booking clerks tasked to correct detail codes and appointment types when booking appointments must have the SD APPT STAND security key.

- Existing security keys that control splitting and joining of appointments will allow a user to override the appointment type and detail codes during booking to make the appointment fit the patient.

- A clerk with the responsibility for maintaining workload data must be assigned the new SD WK LOAD security key. This security key will allow a user to correct the Workload Type information on an appointment in templates, schedules, on booked appointments, and at end-of-day processing.

2. SCHEDULES AND TEMPLATES

The following business rules apply to the processes required to successfully build provider templates and schedules.

2.1 Assigning Detail Codes

- Sites may create their own age detail codes. However it is critical that these codes be coordinated and standardized across the region. Sites may propose new standard detail codes. Refer to Appendix M for new detail code proposal and approval processes.

- Sites should review the use of the ten standard Patient Access Types (see Appendix N) in the slot comment field.

- Sites will be able to modify their templates and schedules to include the appropriate detail codes on each slot. The detail codes will now appear on the Appointments Display screen when booking an appointment. The slot comment will now be viewable only on a secondary screen when the user selects a specific appointment and presses F9 to view additional data about the appointment. If the slot comment for an appointment contains

data, a tilde (~) will appear in front of the appointment on the list of available appointments during booking.

- Detail codes are optional on the schedules, templates, and in booking searches. However the slot comment field should not be used for the purpose that the detail codes are designed. A fourth detail code will be implemented in the upcoming CHCS APS III release in October 2003. Detail codes in the slot comment field should be transferred to the new fourth detail code. TOL will require that all detail codes be stored in one of the four detail code fields. Access to the slot comment field during booking will be inconvenient but available. Reporting will also be inconsistent if slot comments are used improperly.

2.2 Batch Assigning Slot Characteristics

- Appointment detail codes, appointment duration, and appointment type may be batch assigned to multiple appointment slots when creating the slots. If modifying the slots, a user must select slots that have identical characteristics in order to batch assign a change to them.

- The appointment duration will no longer be derived exclusively from the appointment type. The appointment duration will still be initially defaulted as follows: from the appointment type in the clinic profile for non-count clinics and from the appointment type in the provider profile for count clinics. However users may now override the default duration for the appointment slot and specify the actual minutes required by the provider for the appointment.

2.3 Template Creation

- Recommend the maximum use of templates when a provider or clinic regularly replicates standard schedules. This assumes the clinic or provider knows the mix of patients seen over each time period

- Modify templates instead of creating new templates

- Establish naming conventions for templates

- The appointment duration will continue to be set in the Clinic Profile and Provider Profile based on the appointment type.

- Templates will have new flexibility. Each slot may define the new appointment types, the appointment duration, the booking authority, the workload type, and up to 4 detail codes for the visit. The detail codes include a Patient Access Type: Active Duty only; Prime only; GME only; no Active Duty; No Prime; no Active Duty or Prime; Special Programs Patients and TRICARE Plus; Active Duty and Prime; TRICARE Standard; and Active Duty, Prime, TRICARE Plus, and Special Programs Patients.

- The appointment duration will be defaulted from the Clinic Profile to the Provider Profile and then to the appointment slot for each appointment type and may be overridden by the provider or schedule clerk.

- The workload type will be defaulted by appointment type from the Clinic Profile for non-count clinics and from the Provider Profile for count clinics and may be overridden by a provider or schedule clerk with the SD WK LOAD security key.

2.4 Schedule Creation

- Schedules should be released a minimum of 30-45 days ahead or per TRICARE contract requirements. Slots should be OPEN.

- Modify existing schedules instead of creating new schedules.

- Determine who should enter age restrictions on schedules.

- The appointment duration will continue to be set in the Clinic Profile *and Provider Profile* based on the appointment type.

- Schedules will have new flexibility. Each slot may define the new appointment types, the appointment duration, the booking authority, the workload type, and up to 4 detail codes for the visit (including a Patient Access Type: Active Duty only; Prime only; GME only; no Active Duty; No Prime; no Active Duty or Prime; Special Programs Patients and TRICARE Plus; Active Duty and Prime; TRICARE Standard; and Active Duty, Prime, TRICARE Plus, and Special Programs Patients.

- The appointment duration will be defaulted from the Clinic Profile to the Provider Profile and then to the appointment slot for each appointment type and may be overridden by the provider or schedule clerk.

- The workload type will be defaulted by appointment type from the Clinic Profile for non-count clinics and from the Provider Profile for count clinics and may be overridden by a provider or schedule clerk with the SD WK LOAD security key.

2.5 Identification of Specialty Clinics

The following clinics are recommended as Specialty clinics, either self-referral or provider referred. Generally use the SPEC appointment type for these. However these clinics may also support Primary Care.

–Allergy
–Alcohol & Drug
–Audiology
–Community Health
–Family Advocacy
–Mental Health
–Nutrition
–Occupational Health
–Occupational Therapy
–Orthopedics
–Optometry
–Otolaryngology (EENT)
–Physical Therapy
–Psychology
–Psychiatry
–Social Work
–Substance Abuse

The following clinics are Primary Care clinics.

–Preventive Medicine
–Communicable Diseases

3. MCP HEALTH CARE FINDER BOOKING

The following business rules apply to the processes required to successfully book appointments using the CHCS MCP module.

3.1 Patient Identification and Registration

- Identify the patient and verify eligibility for care according to DEERS.
- The booking clerk shall verify and correct the patient phone number and address at each encounter.
- Verify the TRICARE Prime status according to DEERS.
- Verify the priority for care in the MTF, i.e., Active Duty, Prime, TRICARE Plus, Non-Prime, NATO, ineligibles, etc.
- Examples of acceptable DEERS eligibility overrides are:
  - Newborns
  - Patient has a valid ID card but registration is not yet recorded in DEERS
  - Secretarial Designees
- If a user overrides the ineligibility and enters the override reason, the patient may be booked using the MCP Non-Enrollee Booking function.

3.2 Enrollment

- If the patient is not enrolled to the local MTF but is living in the catchment area and wants to enroll, work with the patient to enroll them according to local policy and procedure.
- If enrolled in DEERS to the MTF but the enrollment is not recorded in CHCS, the clerk will contact the appropriate enrollment office to correct the CHCS enrollment. The TRICARE contract determines who enters the enrollments.

3.3 Access Management

- Identify the appropriate ATC category and the corresponding appointment type based on the type of care requested by the patient or based on nurse triage.
- Patient may choose PCM continuity over access standards conformance. The patient should be encouraged to choose PCM continuity.
- Per local or regional policy, a patient who prefers access standards over continuity of care must be provided an appointment within the access standards.
- If a patient waives the access standard, the appointment refusal must be documented in CHCS to protect the MTF.
- Sites should conduct an annual review of all templates and schedules.
- Referrals should be tracked to ensure that the patient receives an appropriate appointment within the access standard defined by the provider.

3.4 Searching for an Appointment

- Ask the patient if they need to see the physician or just talk to the physician (a telephone consultation) to solve their problem. This is an MTF option for demand management.
- Select the ATC category based on the patient's requested urgency for care or based on nurse triage. The following table reflects the ATC standards for patients to receive care. These standards are applied to the minute, e.g. 24 hours from an acute request made at 10 AM must be booked by 10AM the next day to meet the access standard.

ATC Category	ATC Standard
ACUTE	24 hours (1440 minutes)
ROUTINE	7 days (10,080 minutes)
WELLNESS	28 days (40,320 minutes)
SPECIALTY	28 days (40,320 minutes)
FUTURE	provider designated
DROUTINE	21 days (Dental only, Oct 2003)

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APPOINTMENT STANDARDIZATION BUSINESS RULES

- Booking clerks should be familiar with the MTF policy on the order of precedence for an appointment search. Refer to Appendix C, page C-4, for a discussion of the order of search precedence for appointments.

- CHCS will display available appointments based on the following criteria: ATC category, specialty, provider, place of care, appointment type, and date range.

- If the user selects the location criteria, then the user must also select a specialty.

- If a specialty is selected, a provider must also be selected and the provider must support the specialty in order to obtain a list of appointments.

- Selecting the specialty type will result in a broader search than using the clinic specialty.

- Select the PCM appointment type for a Prime initial PCM visit only.

- Select the SPEC appointment type for a Specialty initial visit only.

- Select EST to find a follow-up appointment for either follow-up or specialty care.

- Select MTF Booking to search for an MTF appointment before booking to the external network or non-network.

- The fastest search is the selection of the exact place of care. CHCS will display all available appointments for that clinic. This search is similar to current PAS functionality but will result in fewer appointment options for the patient.

- Searches will take longer if too many search criteria are selected. Booking clerks should limit the search criteria to only those fields needed to find an appropriate appointment. Selecting many fields can result in no appointments.

- Selecting the location (zip code combinations) may take longer. Zip code combinations should have only the zip codes of the facilities you want to search. The more zip codes included, the longer the search will take.

- If the search consistently fails to find appointments in a clinic that has appointments, it may be a File and Table Build deficiency. Refer the problem to your site MCP File and Table points of contact.

- Detail codes (including patient access types) and duration are now included in the list of searchable criteria.

3.5 Booking an Appointment (General)

- Select an appointment that has an appointment type that is consistent with the ATC category and matches the access standard. as follows:

ATC Category		Appointment Type	ATC Standard
ACUTE	→	ACUT	24 hours
ACUTE	→	OPAC	Same Day
ROUTINE	→	ROUT	7 days
WELLNESS	→	WELL, PCM	28 days
SPECIALTY	→	SPEC	28 days
SPECIALTY	→	PROC	28 days or provider designated within 28 days
FUTURE	→	EST, GRP	provider designated
DROUTINE	→	DROUT	21 days (Dental only, Oct 2003)

- Where possible, select an appointment type that is consistent with the ATC category as documented in Select an Appointment above.

- Book the appointment and correct the appointment type to match the ATC category, e.g., correct the appointment type from WELL to ACUT for an ACUTE category. If you don't have the security key to do this, refer it to a clerk who has this privilege.

- Appointments should be joined or split (See Browse option) to offer flexibility and reflect reality. Always correct the appointment type and appointment duration to accurately reflect the planned visit. Control of the security key to permit a clerk to join or split an appointment is the responsibility of the MTF.

- Consult local definitions of appointing rules to determine when to change an appointment type.

- If the slot comment or detail field do not contain a Patient Access Type, then the appointment is available to be booked to anyone.

- When the slot comment field or a detail code contains a Patient Access Type (Active Duty; Prime; Active Duty and Prime; GME; No Active Duty; No Prime; No Active Duty or Prime; Special Programs Patients or TRICARE Plus; TRICARE Standard; or Active Duty, Prime, TRICARE Plus, and Special Program Patients), the clerk should only allow patients who qualify for that patient access type to be booked to the appointment unless instructed to override the access type.

- If an appropriate detail code is not available and an inconsistent detail code is available, refer the appointment to a clerk who has the security key to correct the detail code. Consult local definitions of appointing rules to determine when to change a detail code. Book the appointment and correct the detail code to match the care scheduled for the patient.

3.6 PCM Booking

- The accurate build of the PCM files and tables is very important to the success of PCM booking. For PCM By Name, the organization of the PCM group is critical to successful booking when the PCM is not available. One technique is to create smaller groups but have each group share one or several providers and places of care from another group. This will result in an expanded list of providers during PCM appointment searches.

- When booking to a PCM in an alternate place of care, identify the correct ATC category <u>and</u> corresponding appointment type based on the patient request or nurse triage.

- When booking to PCM team members in the enrollee's assigned place of care or to their alternate places of care in the enrollment MTF, identify the appropriate ATC category <u>and</u> appointment type based on the patient's request or nurse triage.

- When booking to a provider who does not belong to both the enrolling MTF and the PCM Group, a referral is required, except for Operational Forces (refer to paragraph 3.9 below).

- The AOP option will display on the PCM Booking action bar for each patient who has a consult.

3.7 Non-Enrolled Booking

- The following patients are examples of non-enrollees who should be booked through the Non-Enrollee Booking function: non-enrolled active duty service members, active duty in training, NATO, Secretarial Designees, over 65 and non-TRICARE Senior Prime, non-enrolled retirees, non-enrolled family members (Space available), GME patients, Special Programs patients, dependant parents/in-laws, Prime patients from other regions or MTFs, reservists on active duty, foreign nationals, midshipmen, Specialized Treatment Services (all eligible beneficiaries), and Department of Defense Dependent School (DODDS) teachers. In the future (APS III), a new booking option, Enrolled Elsewhere, will be available to book Prime patients who are enrolled to remote facilities.

- FEHBP and USTF enrollees should not be seen in the MTF except by special signed agreement.

- For specialty care, make sure the patient is booked to the correct specialty clinic.

- All non-enrollee appointment refusals will be documented.

- The decision to offer telephone consults versus future appointments to non-enrollees is a local or regional responsibility.

- Booking of non-enrollees to external providers is a regional and demonstration project issue related to the TRICARE contracts and other contracts in the region. The rules for booking non-enrollees to external providers should be developed by the Contracting Officer. Training should be coordinated by the Region.

- Prime beneficiar*ies* who are not locally enrolled can be booked to a PCM or specialty (SPEC) appointment, etc.

- TRICARE Standard and TRICARE Extra beneficiaries should not be booked to PCM appointment types.

- Clinics may be required to reserve a fixed percentage of their available appointments for the "at risk" population, i.e., those patients who receive care that the TRICARE contractor has financial responsibility for, including TRICARE Standard, TRICARE Extra, and space available patients.

3.8 Referral Booking

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APPOINTMENT STANDARDIZATION BUSINESS RULES

- A referral is required when booking a Prime patient to a provider who does not belong to both the enrolling MTF and the PCM Group.
- Referral booking contains two separate functions: Booking a referral that has an associated Consult and creating a referral for Primary Care.
- Specialty appointments will usually be booked by a HCF (the Consult Tracking option).
- Before creating a referral for care, ensure that no existing Consult Order exists for the care.
- The CHCS default start time to stop time for a consult order is currently 28 days from the patient request. The DoD policy is that the default should be 28 days.
- Before changing start/stop dates for Consult Orders, regional issues should be considered as well as the impact on ATC measures and performance for each clinic.
- When a new Consult Order is incomplete, inadequate, or unacceptable, train the staff in alternative procedures.
- If entering a referral for Primary Care, the PCM appointment type should be used for an initial visit. Otherwise never use the PCM appointment type in Referral booking, particularly for specialty care.
- When modifying an existing referral, develop local policy and train the clerks on the data elements that may be changed.
- Train the provider on the importance of entering the number of authorized visits on the referral.
- Providers should be trained on the use of the start and stop dates on the referral.
- The Reason for Referral field should always be completed and should include all clinical information provided by the referring provider.
- The MTF and Region should develop guidelines on when to enter or modify the review status and the review comment on a Consult Order.

- In Consult Tracking, when performing the consult review, the clerk should enter the clinic name in the comments if they know where the patient should get the care.

- Use of the CPT and ICD codes is optional per local determination but if mandated, the clerk should make sure the values are correct.

- After the initial appointment for a referral or consult order, the time elapsed for the remaining visits is provider designated.

3.9 Operational Forces Booking

- When an operational forces member (enrolled to their ship or mobile unit) returns to home base, this feature allows these forces to be booked to their unit/ship PCM or to any provider in any place of care in any MCP Provider Group that the patient's PCM is assigned to, even though the patient is enrolled to a different DMIS ID from the home base MTF.

- In order for this feature to work correctly, sites must ensure that the enrollee's MCP enrollment place of care is defined and the new Ops Forces Booking Allowed flag is set to YES on that MCP place of care record.

3.10 Appointments Refusal

- If a patient refuses an appointment that is within the access standards, CHCS requires that the refusal be documented in the Appointment Refusal option with the reason "ATC Declined - Patient Preference" to protect the MTF. This documentation will prevent the appointment from being counted as outside the clinic's access standards. This refusal reason is only available under the above conditions and cannot be entered otherwise.

- All patient refusals must be documented with appropriate standard refusal codes. Sites may not add new refusal reasons to this list.

- The current standard refusal codes when a patient is offered several appointments and refuses all offered appointments are:

  — Requested Provider not available
  — Appointment date/time unacceptable
  — Unhappy with MTF service/provider(s)
  — Unhappy with Group/Provider

- — Distance too great to travel
- — Wanted a civilian appointment
- — Cost share too high
- — ATC Declined - Patient Preference
- — ATC Request Late - Patient called late for appointment

- Proposed New Refusal Codes not yet implemented

  - — PCM Preference or Continuity of Care
  - — ATC Deferred
  - — Patient TDY/TAD/Deployed

3.11 Self-Referral Booking

- The Self-Referral Allowed indicator must be set to YES in the clinic's Profile in order for the clinic to use the self-referral function to book appointments.

3.12 Wait List Requests

- When matching a Wait List Request that includes detail codes to a clinic appointment slot that has no detail codes, CHCS will book the Wait List request to the appointment slot provided each of the Wait List Request detail codes match a detail code defined on the Clinic Profile.

3.13 Enrolled Elsewhere Booking (Available October 2003)

- This new booking option will display automatically for patients who are not enrolled to any MTF on the CHCS host.

- Patients who are enrolled to an MTF on another CHCS host will be able to be booked as an enrollee without a PCM on this CHCS host.

APPENDIX F

APPOINTMENT STANDARDIZATION RECOMMENDED METRICS

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APPOINTMENT STANDARDIZATION RECOMMENDED METRICS

1. BACKGROUND INFORMATION OF APS/ACCESS IMPROVEMENT METRICS

The GAO stated in recent studies that the patient appointment system used for TRICARE is confusing for beneficiaries due to the numerous types and ways appointments are made. Active Duty and TRICARE Prime beneficiaries are not receiving priority for scheduled appointments; and thus TRICARE access standards are not being met. Other deficiencies cited that Managed Care Support Contractors and MTF appointment staffs are not working efficiently to properly appoint patients. So an ASIPT was chartered to measure performance and the Appointment Standardization project was initiated. After its inception the ASIPT formed a Performance Measurement Sub-Team to develop performance measurements to track access to MTF care. The proposed tracking method analyzes appointment data at clinic and MTF-levels. Measurements are to be reported by beneficiary categories as defined below.

1.1. PROPOSED DATA COLLECTION/ANALYSIS METHODOLOGY

The measures described below are recommended for MTFs to track their progress in Appointment Standardization and Access Improvement. The MTF will have the primary responsibility for collecting appointment data to support these measures. The TRICARE Operations Center provides web based reports to consistently measure Access Improvement and Appointment Standardization successes across the MHS.

If a particular performance measurement cannot be routinely accomplished due to system or resource limitations, a 10 percent random sampling of available data may be used. These 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 possible to those who have the capability to make improvements in the system.

It is recommended that this information be discussed at MTF Catchment Area Executive Committee (CAEC) meetings to continually monitor and improve appointments processes. This same information can be forwarded to Service intermediate command and Surgeon General headquarters if so directed.

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APPOINTMENT STANDARDIZATION RECOMMENDED METRICS

1.2 PERFORMANCE MEASURES OVERVIEW

The following chart summarizes the IPT recommended measures that MTFs may want to initiate prior to and during their APS implementation and Access Improvement efforts. These measures will assist MTF staffs to determine the degree of success that their programs are having. Each measure is described in more detail in paragraph 1.3 in this appendix.

There are two main categories of measures: effectiveness measures and efficiency measures. They are not separate reports but different views of the same data. All metrics will be stratified by the six beneficiary categories listed in the explanation of APS Metric #1 in paragraph 1.3.1. The following measures should be instituted prior to the changes in the business processes and analyzed afterward to see if the program changes are effective, create efficiencies and satisfy all users.

A. Effectiveness Measures: Yes/No Does the process work?	**Data Source**
Each measure stratified by beneficiary status	
1. # of beneficiaries served	CHCS
2. # acute seen and # not seen within 24 hours	CHCS
3. # routine seen and # not seen within 7 days	CHCS
4. # wellness seen and # not seen within 28 days	CHCS
5. # specialty seen and # not seen within 28 days (unless specified differently by specialist)	CHCS
6. # Open Access appointments seen the same day	CHCS
7. # total appointments available: # available to Contractor, # available to MTF	CHCS
8. # unused appointments	CHCS
9. # of patients sent to MCS Contractor network	CHCS, MCSC
10. # ER visits in MTF, # ER visits in the MCS Contractor network	CHCS, MCSC
11. # unscheduled visits	CHCS

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APPOINTMENT STANDARDIZATION RECOMMENDED METRICS

B. Efficiency Measures: How well does the process work?	Data Source
1. % of beneficiaries served compared to planned appointments	CHCS
2. % of acute seen within 24 hours	CHCS
3. % of Open Access seen on the day the patient called for the appointment	CHCS
4. % routine seen within 7 days	CHCS
5. % wellness seen within 28 days	CHCS
6. % specialty seen within 28 days (unless specified differently by specialist)	CHCS
7. % treated by the MCS Contractor network compared to seen "in-house"	CHCS, MCSC
8. % total appointments used compared to total appointments available	CHCS
9. # mis-booked appointments (1. wrong appointment, 2. incomplete information to book the appointment, 3. wrong place or provider, 4. other)	Future
10. # no shows	CHCS
11. # patients waiving access standards	CHCS

C. ATC Measurements	Data Source
1. Acute appointments made and not made within 24 hours	CHCS ATC
2. Routine appointments made and not made within 7 days	CHCS ATC
3. Wellness appointments made and not made within 28 days	CHCS ATC
4. Specialty appointments made and not made within 28 days	CHCS ATC
5. Future appointments made	CHCS ATC

D. MTF Compliance on Appointment Standardization and Access Improvement	Data Source
1. # of appointments by appointment type and appointment status used in clinics in an MTF	TOC
2. Schedule oversight - distribution of appointments by type, status, and volume over time	TOC

1.3 EXPLANATION OF EACH PROPOSED METRIC

The following paragraphs describe in detail the functions and features of each metric. The following 12 metrics will be stratified using the *four* beneficiary categories listed in APS Metric #1.

1.3.1 APS Metric #1 — Number and percentage of beneficiaries served compared to planned appointments

Definition: This metric will allow the measuring of the actual number and the percentage of appointments booked that had planned appointments reserved for the same. Totals are provided for each of the beneficiary categories listed below:

- Active Duty
- Prime
- TRICARE Plus
- Non-Prime
- Special Programs Patients

Rationale: Comparison will show if MTFs are setting aside enough appointments for each of the beneficiary categories.

User: Providers, Clinic Chiefs, Appointments Staffs, MTF executive staff, LAs, TMA, and Services

Frequency: Monthly - Drill down to clinic level and beneficiary category level.

Source Data System/File/Report: CHCS I/Schedule Entity & Patient Appointment

1.3.2 APS Metric #2 — Number and percentage of acute appointments scheduled within 24 hours

Rationale: This metric will measure how well TRICARE access standards are being met when scheduling acute appointments for TRICARE Prime enrollees. The measure will capture the number of acute appointments that were scheduled within 24 hours and the number and percentage of acute appointments scheduled greater than 24 hours from the time of the beneficiary's call and/or triage for acute care.

User: Providers, Clinic Chiefs, Appointments Staffs (MCSC and MTF), MTF executive staff, LAs, TMA, Services

Definition: The appointment types for acute care are ACUT, ACUT$, OPAC, and OPAC$ (Acute MTF Book Only). An acute appointment is reserved for non-emergent, urgent care that is typically delivered by an MTF or network Primary Care Manager (PCM). Acute care for a TRICARE Prime Beneficiary must be appointed within 24 hours from the time of the beneficiary's appointment request and/or triage. Open Access appointments are to be booked the same day that the patient calls for an appointment.

Qualifiers: If a triage mechanism is in place, triage personnel must determine that acute care is necessary before the appointment is booked. 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..

Frequency: Monthly - Drill down to clinic level.

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

Target/Threshold/Benchmark: Compliance to acute access standards will be represented as a percentage for each clinic: 0-69 is red; 70-84 is yellow; and 85-100 is green. On-going compliance is expected to be not less than 90 percent of booked acute appointments for the clinic.

1.3.3 APS Metric #3 — Number and percentage of routine appointments scheduled within 7 days

Rationale: This metric measures how well TRICARE access standards are being met when scheduling routine appointments for TRICARE Prime enrollees. This measure will capture the number and percentage of routine appointments scheduled within seven days and the number and percentage of routine appointments scheduled greater than seven days from the date of the beneficiary's call and/or triage.

User: Providers, Clinic Chiefs, Appointments Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The appointment types for routine care are ROUT and ROUT$ (routine MTF Book Only). A routine appointment is reserved for routine primary care. Routine care for TRICARE Prime beneficiaries must be appointed within 7 calendar days from the date of the beneficiary's appointment request and/or triage.

Qualifiers: If a beneficiary waives the 7-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, these appointments will not be included in the total # not scheduled within 7 days. If the provider or clinic cancels the appointment and does not reschedule within the original 7-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 7-day window to the minute but the beneficiary is no-show, patient cancel, or leave without being seen.

Frequency: Monthly - Drill down to clinic level.

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

Target/Threshold/Benchmark: Compliance to routine access standards will be represented as a percentage for each clinic: 0-69 is red; 70-84 is yellow; and 85-100 is green. On-going compliance is expected to be not less than 90 percent of booked routine appointments for the clinic.

1.3.4 APS Metric #4 — Number and percentage of wellness appointments scheduled within 28 days

Rationale: This metric will facilitate measuring how well the TRICARE access standards are being met when scheduling wellness appointments for TRICARE Prime enrollees. This measure will capture the number and percentage of wellness appointments that were scheduled within 28 days and the number and percentage of wellness appointments that were scheduled greater than 28 days from the date of the beneficiary's call and/or triage.

User: Providers, Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The appointment types for wellness care are designated as WELL or WELL$ (wellness or preventive health visit MTF Book Only), and PCM or PCM$ (initial primary care visit, MTF Book Only). A wellness appointment is reserved for wellness or preventive health primary care. For TRICARE Prime beneficiaries wellness care must be appointed within 28 calendar days from the date of the beneficiary's appointment request and/or triage.

Qualifiers: If a beneficiary waives the 28-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, these appointments will not be included in the total # not scheduled within 28 days. If the provider or clinic cancels the appointment and does not reschedule within the original 28-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.

Frequency: Monthly - Drill down to clinic level.

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

Target/Threshold/Benchmark: Compliance to wellness access standards will be represented as a percentage for each clinic: 0-69 is red; 70-84 is yellow; and 85-100 is green. On-going compliance is expected to be not less than 90 percent of booked wellness appointments for the clinic.

1.3.5 Metric #5 — Number and percentage of specialty care appointments scheduled within 28 days

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APPOINTMENT STANDARDIZATION RECOMMENDED METRICS

Rationale: This metric will facilitate measuring how well the TRICARE access standards are being met when scheduling specialty appointments for TRICARE Prime enrollees. This measure will capture the number of specialty appointments that were scheduled within 28 days (or the time period determined medically appropriate between referring and accepting providers) and the number of specialty appointments scheduled outside of 28 days (or the time period specified by the referring provider).

User: Providers, Clinic Chiefs, Appointments Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The appointment types for an initial specialty care visit are SPEC and SPEC$ (initial specialty visit, MTF Book Only). A specialty appointment is reserved for care to be delivered by a network or MTF specialist. Specialty care must be appointed no later than 28 calendar days from the date of the PCM or provider referral. In some cases it may be determined between referring and accepting providers that an appointment sooner than 28 days is more medically appropriate. Although the official access standard for a specialty appointment is 28 days medical appropriateness will take priority for obtaining an appointment, whether it be in the direct care system or with a network provider.

Qualifiers: If a beneficiary waives the 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,, these appointments will not be included in the total # not scheduled within 28 days or the time frame specified by the referring provider. If the provider or clinic cancels the appointment and does not reschedule within the original access window, the appointment shall be counted as not meeting the access standard. An appointment still meets the access standard if the scheduled visit is either within the 28-day window to the minute or within the referring provider priority but the beneficiary is no-show, patient cancel, or leave without being seen.

Frequency: Monthly - Drill down to clinic level.

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

Target/Threshold/Benchmark: Not less than 90 percent of booked specialty appointments met the access standard

1.3.6 APS Metric #6 — Number of appointments available to the MCS Contractor and the MTF and number of visits booked by the MTF and MCS Contractor

Rationale: This metric will reflect the percentage and number of appointments available and booked by the MCS Contractor and the MTF. This will allow analysis of level of effort of both and compliance with contract requirements.

User: Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The number of appointments available will be an aggregate sum of appointments available/booked for patients to the MCS Contractor and the MTF. Percentages will be a ratio of the two. The measure will assist leaders at all levels to determine if the level of effort is appropriate for the MCS Contractor and/or the MTF appointment staff.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic and MCS Contractor clinic schedule

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

Target/Threshold/Benchmark: Based on local policy and or contractor requirements

1.3.7 APS Metric #7 — Number and percentage of unused appointments compared to available appointments

Rationale: This metric will reflect the percentage and number of unused appointments compared to available appointments. This will allow analysis of level of effort of both providers and clinics; and allow for corrections in appointment templates and tailoring of demand management strategies.

User: Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The number of unused appointments will be compared to available appointments. Percentages will be a ratio of the two. The measure will assist leaders at all levels to determine if the staffing levels, appointment type variety, and availability is appropriate.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: 95 percent

1.3.8 APS Metric #8 — Number of patients sent to the MCS Contractor network.

Rationale: This metric will reflect the number of patients sent to network resources. It allows for analysis to see if appointments become more available in the MTF.

User: Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The number of patients referred to the MCS Contractor network due to MTF not meeting access standards.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Locally determined

1.3.9 APS Metric # 9 — Number of Emergency Room visits in the MTF and the network.

Rationale: This metric will reflect the number and percentage of patients seen in the MTF ER and in the network ER. Allows analysis of availability of appointments for patients at the MTF.

User: Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The number and percentage of patients actually seen in the MTF ER or in MCS contractor ER facilities. Increases in both factors would indicate an unavailability of desired MTF appointments by patients.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Locally determined

1.3.10 APS Metric #10 — Number of unscheduled visits

Rationale: This metric will analyze whether capacity meets demand or appointments are available at convenient times for patients or if appointment slots are over-coded.

Definition: Number of unscheduled visits will be counted from CHCS I.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

1.3.11 APS Metric #11 — Number and percentage of misbooked appointments

Rationale: This metric will reflect the number and percentage of booking errors compared to total appointments scheduled. The booking errors considered critical are those which result in inconvenience to the patient, disruption of clinic effectiveness/efficiency, and failure to appropriately match TRICARE Prime beneficiaries to appointment slots reserved for Prime.

User: Providers, Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: The number of misbooked appointments divided by total available appointments will constitute percentage of misbooked appointments. The measure will also be broken down to reflect "contractor booking errors" and "MTF booking errors". Misbooked appointments occur when (1) a patient is given the wrong appointment type for the level and type of care needed, (2) the appointment clerk does not correctly complete the data elements, (3) the patient is sent to the wrong location or the wrong provider, or (4) any other booking error that results in inconvenience to the patient, disruption of clinic effectiveness/efficiency, and failure to appropriately match TRICARE Prime beneficiaries to appointment slots reserved for Prime. Feedback regarding misbooked appointments may be collected from patients, providers, clinic support staff, booking clerks and appointment supervisors.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

Source Data System/File/Report: Future

Target/Threshold/Benchmark: Not more than 5 percent of all appointments booked during the month

1.3.12 APS Metric #12 — Number and percentage of no shows

Rationale: Capacity is not efficiently used when patients fail to show up for scheduled appointments. This measure is designed to capture the percentage of scheduled appointments for which the scheduled patient fails to appear. If there are high no-show rates in a particular clinic, template changes could be made to allow for double booking.

User: Clinic Chiefs, Appointment Staffs, MTF executive staff, LAs, TMA, and Services.

Definition: Number of booked appointments divided by the number of available appointments where the disposition status is marked "no show".

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Not more than 5 percent of all appointments booked during the month

1.3.13 APS Metric #13 — Number of patients waiving access standards by appointment type

Rationale: This measure will allow data collection to refine information reported on access standards compliance for the acute, routine, wellness and specialty type appointments offered by MTFs and MCS contractors.

Definition: Number of patients scheduling appointments who were offered an available appointment within access standards but for whatever reason elected to waive the access standards and take another appointment.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

1.3.14 APS Metric #14 — Number of patients requesting appointments but not scheduled for an appointment (Available October 2003)

Rationale: This measure will allow data collection to refine information reported on access standards compliance for the acute, routine, wellness and specialty type appointments offered by MTFs and MCS contractors.

Definition: Number of patients requesting an appointment by Access to Care Category who did not receive an appointment.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

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STANDARD APPOINTMENT TYPES
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STANDARD APPOINTMENT TYPES UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

1. MTF Standard Appointment Type Utilization Report

Purpose. As of 15 January 2001 the TRICARE Operations Center (TOC) in coordination with TMA and the Appointment Standardization Integrated Program Team developed the MTF Standardized Appointment Types Utilization Report. This report provides a weekly snapshot to all TRICARE Health Service Regions (HSR) and Uniformed Services as to their progress in implementing/using standardized appointment types at their facilities.

How the Report is Produced. The report is produced weekly and takes a forward looking snapshot of the appointment types listed in the schedule entity file of the Composite Health Care System. It reviews appointment types listed in this file approximately 35 days forward from the date that the report is produced. The report then compares the coding of the appointment types found during this 35 day window and compares them to the standard appointment types.

What the Report Measures. The results of this report are arrived at by dividing the number of appointments available at the time of the report using the *ten* standard appointment types and 18 suffixes, E-ROOM, APV, T-CON* and N-MTF appointment types by the total number of appointments available/booked using all appointment types to include standard and non-standard types. The initial goal for this report is that all MTFs will achieve *100 percent usage* of standard appointment types for all appointments available/booked. The data is available at the Service, Command, HSR, and MTF levels.

How to Get This Report. The report can be accessed on the TRICARE Operations Website at this URL: http://www.tricare.osd.mil/tools/. First time users will have to download a Microsoft Snapshot Viewer. Once this down load of software is completed users can click on **the Access to Care Reports** and then on the **Standard Appointment Type Utilization Report**. The report is in MS Excel spreadsheet format. Once entering the report the user can then view Service, Command, HSR, and MTF (Parent/Child) level views of appointment standardization performance. The goal of this report is to see standard appointment type usage move *to 100 percent.*

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2. MHS Standard Appointment Type Utilization Report.

Purpose. As of 15 January 2001 the TRICARE Operations Center in coordination with the TMA and the Appointment Standardization Integrated Program Team has developed the MHS Standard Appointment Type Utilization Report. This report provides a weekly snapshot of all appointment types used in the Military Health System.

How the Report is Produced. The report is produced weekly and takes a snapshot of the appointment types listed in the schedule entity file of the Composite Health Care System. It reviews appointment types listed in this file approximately 35 days forward from the date that the report is produced. The report then rank orders by number of appointment slots used in each appointment type from highest to lowest of all of the different varieties of appointment types.

What the Report Measures. Once entering the report, the user will see six columns.

- The first column is the coded appointment as it appears in the CHCS schedule entity file.
- The second column is the text description of the appointment type.
- The third column is the appointment type's relation to one of the five Access to Care categories either acute, routine, wellness, specialty or other.
- The fourth column is the appointment type's occurrence in appointment slot counts across the MHS.
- The fifth column is the number of facilities that use this appointment type
- The sixth column shows whether the appointment type is a TMA standard appointment type, i.e. True = is a TMA standard appointment type, false = is not a TMA standard appointment type.

How to Get the Report. The report can be accessed on the TRICARE Operations Website at this URL: http://www.tricare.osd.mil/tools/. First time users will have to download a Microsoft Snapshot Viewer. Once this down load of software is completed users can click on **Access to Care Reports** then on **MHS Std Appt Type Report**. The goal of this report is to see a reduction of the appointment types used in the MHS and a rise in the number of appointments available using the standard appointment types.

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ACCESS MANAGEMENT REPORTS

Four new Access to Care performance reports have been designed and appear on the TRICARE Operations Center Web Page at **http://www.tricare.osd.mil/tools**. *The specifications for each of the four reports are included below in this chapter for your information. These reports will ensure that appointing performance and access to care at all MTFs are measured consistently and accurately.*

In the report specifications below, the following terms will be used:

- ***Scheduled or Planned= an appointment slot in the provider schedule that has not yet had a patient booked for it.***
- ***Booked = an appointment slot in the provider's schedule that has a patient booked to see the provider at the defined time.***

Al l four reports described in these specifications are retrospective, i.e., they report data from the past for the report date range, not into the future.

3. Detail Code Usage Report

Purpose: This report will give clinic level managers the ability to compare the degree of change among detail codes in their clinic, comparing provider scheduled appointments to what was actually booked for those appointments for the report time period.

Value Added: Clinic managers should be able to more accurately establish schedules and predict demand for particular services ahead of time and decrease the need to change detail codes when the appointment is actually booked. This report shows the level of usage and degree of change of individual detail codes for a facility (Division) at the clinic level and allows for a comparison of the scheduled appointments in the CHCS Schedulable Entity file and the actual booked appointment in the Patient Appointment file for the same schedule period. One of the guiding principles of appointment standardization is to encourage appointment personnel to use detail codes to track what the appointment slot was actually used for. In other words, if the appointment in the provider's schedule has detail codes that do not match what the appointment is actually going to be used for then, on a regular basis, appointment personnel should change that booked appointment's detail codes to reflect the actual usage.

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Special Technical Requirements:

Each appointment with no detail codes should be counted one time in the report for each clinic. Show blanks in the detail code column for these appointments and "None" in the detail code description by clinic. Many clinics use no detail codes to keep appointments unrestricted.

The use of each detail code will be counted for a scheduled appointment and separately for a booked appointment. In most cases since each appointment has up to 3 detail codes, the sum of the count of appointments within a clinic with a specific detail code will not match the total count of all appointments for the clinic. However, the total count of the 'no detail code' or a single detail code cannot exceed the number of appointments scheduled or booked. In addition the sum total of all detail codes and no detail codes cannot exceed 3 times the total count of schedule appointments or 3 times the total count of booked appointments in the clinic for the reporting period. When CHCS is changed to support 4 possible detail codes in October 2003, the limit will be 4 times the total count of booked appointments in the clinic.

DETAIL CODE USAGE REPORT
Report Specifications

Frequency	Weekly
Sort Criteria	Service or Region (option), Division, Clinic Name, MEPRS 3, and detail code in the Schedulable Entity file. Note: All sorts are in ascending order unless otherwise specified.
Detail Level	By MTF (Division), By Clinic Name, by Detail Code
Roll Up Totals	By Region or Service, by MTF (Division), by Detail Code
Report Subtotals	By MTF (Division), by Clinic, by Detail Code
Selection Criteria	Select all clinic appointment schedule slots (Schedulable Entity file) and booked appointments slots (Patient Appointment file) that have Medical Appointment Types. Exclude telephone consults, dental, radiology, other ancillary, walk-in, sick call, and civilian appointments. Include both count and non-count appointments.

DETAIL CODE USAGE REPORT
Report Specifications

	Select a reporting period, service or region, and division (optional).
Primary Source Files	Schedulable Entity File and Patient Appointment File. *Data Pull Level*: Appointment data at the appointment level to capture accurate data.
Header	Detail Code Usage Report
Format	Excel Spreadsheet with auto filter on

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DETAIL CODE USAGE REPORT **Report Columns (left to right)**	
BRANCH OF SERVICE	the Military Armed Forces Service affiliation of the Division
REGION	the Military Armed Forces geographical region where the division is located
DIVISION	the facility name
DMIS ID	the Defense Medical Information System (DMIS) code for the facility
CLINIC NAME	the name of the clinic at the facility. **Note:** The TOC does not currently capture the CHCS clinic name, only the standard specialty name associated with the MEPRS3 code. This change is being looked at by the TOC for correction for this report.
MEPRS 3	Medical Expense Performance Reporting System code at the third level for the corresponding clinic name above
DETAIL CODE	one of the detail codes assigned to the appointment, or blanks if no detail code is assigned to the appointment
DETAIL DESCRIPTION	the standard description of the detail code or "None" for appointments with no detail code

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DETAIL CODE USAGE REPORT **Report Columns (left to right)**	
TOTAL PLANNED CLINIC APPTS	the total number of appointments in all the clinic's provider schedules (for all providers and all appointment types), e.g. the Primary Care clinic of Walter Reed scheduled appointments for all providers for the month of January. Shows the usage of detail codes in clinic schedules. Includes all statuses: open, booked, canceled, frozen, and wait. *Source*: Schedulable Entity File
# OF DETAIL CODES IN PLANNED CLINIC APPTS	the number of appointments in the clinic's schedules with this detail code or with no detail codes. Keep separate totals for appointments with no detail codes, i.e., the "None" description. Each slot may have up to 3 detail codes and will be counted once for each detail code. The number should not be greater than 3 times the TOTAL PLANNED CLINIC APPTS. *Source*: Schedulable Entity File
% DETAIL CODES IN PLANNED CLINIC APPTS	for this clinic and detail code, DETAIL CODES IN PLANNED CLINIC APPTS divided by TOTAL PLANNED CLINIC APPTS *Source*: Schedulable Entity File
TOTAL BOOKED CLINIC APPTS	the total number of booked appointments in all the clinic's schedules (for all providers and all appointment types including statuses of pending, kept, patient cancel, clinic cancel, no-show, and leave without being seen). The goal is to allow clinic managers to compare the scheduled to the booked appointments for the report period. *Source*: Patient Appointment File

DETAIL CODE USAGE REPORT Report Columns (left to right)	
# OF DETAIL CODES IN BOOKED CLINIC APPTS	the number of the clinic's booked appointments that are assigned this detail code or that have no detail codes. The totals for appointments with no detail codes (i.e., the "None" description) should be counted separately. Includes all appointments booked for the patient regardless of the outcome (including kept, pending, leave without being seen, no-show, patient cancel, and clinic cancel). Each slot may have up to 3 detail codes and will be counted once for each detail code. The number should not be greater than 3 times the TOTAL BOOKED CLINIC APPTS. *Source*: Patient Appointment File
% DETAIL CODES IN BOOKED CLINIC APPTS	for this clinic and detail code, # OF DETAIL CODES IN BOOKED CLINIC APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
# DETAIL CODES DIFFERENCE OF PLANNED VS BOOKED APPTS	For this clinic and detail code, # OF DETAIL CODES IN PLANNED CLINIC APPTS minus # OF DETAIL CODES IN BOOKED CLINIC APPTS for the reporting period. Could be a positive or negative number. A positive number indicates more appointments were planned than booked. A negative number indicates that additional appointments are needed. *Source*: Schedulable Entity File & Patient Appointment File

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DETAIL CODE USAGE REPORT Report Columns (left to right)	
TOTAL APPTS BOOKED BY TOL (Future)	For this clinic, the number of the clinic's booked appointments that were booked in TRICARE On-Line by a patient (future column) *Source*: Patient Appointment File

4. Detail Code Usage Summary Report

Purpose: This report will give MTF and Major Command level managers the ability to compare the degree of change among detail codes at a facility, comparing scheduled appointments at a facility to what was actually booked for the same time period.

Value Added: MTF and Major Command managers should be able to more accurately establish schedules and predict demand for particular services ahead of time and decrease the need to change detail codes when the appointment is actually booked. This report shows the level of usage and degree of change of individual detail codes for a facility (Division) and allows for a comparison of the scheduled appointments in the CHCS Schedulable Entity file to the actual booked appointments in the Patient Appointment file for the same time period. One of the guiding principles of appointment standardization is to encourage appointment personnel to use detail codes to track what the appointment slot was actually used for. In other words, if the scheduled appointment has detail codes that do not match what the appointment is actually going to be used for, then appointment personnel should on a regular basis change the booked appointment's detail codes to reflect the actual usage.

Special Technical Requirements

The use of each detail code will be counted for a scheduled appointment and for a booked appointment. In most cases since each appointment has up to 3 detail codes, the sum of the count of appointments for an MTF with a specific detail code will not match the total count of all appointments for the MTF. However, the total count of the 'no detail code' or a single detail code cannot exceed the number of appointments scheduled or booked at the MTF in all clinics. The sum total of all detail codes plus no detail codes cannot exceed 3 times the total count of scheduled or 3 times the total count of booked appointments in all clinics in the MTF for the reporting period. When CHCS is changed to support 4 possible detail codes in October 2003, the limit will be 4 times the total count of booked appointments in the clinic.

Appointments with no detail codes should also be counted one time in the report. Show blanks in the detail code column for these appointments and "None" in the detail code description column by clinic. Many clinics use no detail codes to keep appointments unrestricted.

DETAIL CODE USAGE SUMMARY REPORT
Report Specifications

Frequency	Weekly
Sort Criteria	Service or Region (option), Division, and detail code. Note: All sorts are in ascending order unless otherwise specified.
Detail Level	By MTF Name, by Detail Code
Selection Criteria	Select all clinic schedule slots and appointments at the MTF that have Medical Appointment Types. Exclude telephone consults, dental, radiology, other ancillary, walk-in, sick call, and civilian appointments. Include both count and non-count appointments. Select a reporting period, service or region, and division (optional).
Primary Source Files	Schedulable Entity File and Patient Appointment File. *Data Pull Level*: Appointment data at the appointment level to capture accurate data.
Roll Up Totals	By Region or Service, by MTF (Division), by Detail Code
Report Subtotals	By MTF (Division), By Detail Code
Header	Detail Code Usage Summary Report
Format	Excel Spreadsheet with auto filter on

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DETAIL CODE USAGE SUMMARY REPORT **Report Columns (left to right)**	
BRANCH OF SERVICE	the Military Armed Forces Service affiliation of the Division
REGION	the Military Armed Forces geographical region where the Division is located
DIVISION	the facility name
DMIS ID	the Defense Medical Information System (DMIS) code for the facility
DETAIL CODE	one of the detail codes assigned to the appointment, or blanks if no detail code is assigned to the appointment
DETAIL DESCRIPTION	the standard description of the detail code or "None" if no detail code is assigned to the appointment
TOTAL PLANNED CLINIC APPTS	the total number of appointments in all the clinic's provider schedules (for all providers and all appointment types) for the report date range. Includes all statuses: open, booked, canceled, frozen, and wait. *Source*: Schedulable Entity File
# OF DETAIL CODES IN PLANNED CLINIC APPTS	the number of appointments in the clinic's schedules with this detail code or with no detail codes. Keep separate totals for appointments with no detail codes, i.e., the "None" description. Shows the usage of detail codes in clinic schedules. Each slot may have up to 3 detail codes and will be counted once for each detail code. The number should not be greater than 3 times the TOTAL PLANNED CLINIC APPTS. *Source*: Schedulable Entity File

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DETAIL CODE USAGE SUMMARY REPORT **Report Columns (left to right)**	
% DETAIL CODES IN PLANNED CLINIC APPTS	for this clinic and detail code, DETAIL CODES IN PLANNED CLINIC APPTS divided by TOTAL PLANNED CLINIC APPTS *Source*: Schedulable Entity File
TOTAL BOOKED CLINIC APPTS	the total number of booked appointments in all the clinic's schedules (for all providers and all appointment types including pending, kept, patient cancel, clinic cancel, no-show, and leave without being seen. The goal is to allow clinic managers to compare the planned to the booked appointments for the report period. *Source*: Patient Appointment File
# OF DETAIL CODES IN BOOKED CLINIC APPTS	the number of the clinic's booked appointments that are assigned this detail code or that have no detail codes. The totals for appointments with no detail codes (i.e., the "None" description) should be counted separately. Includes all appointments booked for the patient regardless of the outcome (including pending, kept, patient cancel, clinic cancel, no-show, and leave without being seen). Each slot may have up to 3 detail codes and will be counted once for each detail code. The number should not be greater than 3 times the TOTAL BOOKED CLINIC APPTS. *Source*: Patient Appointment File
% DETAIL CODES IN BOOKED CLINIC APPTS	for this clinic and detail code, # OF DETAIL CODES IN BOOKED CLINIC APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File

DETAIL CODE USAGE SUMMARY REPORT Report Columns (left to right)	
# DETAIL CODES DIFFERENCE OF PLANNED VS BOOKED CLINIC APPTS	For this clinic and detail code, # OF DETAIL CODES IN PLANNED CLINIC APPTS minus # OF DETAIL CODES IN BOOKED CLINIC APPTS for the reporting period. Could be a positive or negative number. A positive number indicates more appointments were planned than booked. A negative number indicates that additional appointments are needed. *Source*: Schedulable Entity File & Patient Appointment File
TOTAL APPTS BOOKED BY TOL (Future)	For this clinic, the number of the clinic's booked appointments that were booked in TRICARE On-Line by a patient (future column) *Source*: Patient Appointment File

5. Access Management Report

Purpose: This report will allow sites to assess patient access to a clinic's services for each type of beneficiary and, if care was not given, the number of appointments involved and the reason. The report shows the distribution of booked appointments to each Program Category, i.e., Active Duty (TRICARE Prime and non-enrolled), Prime (TRICARE Prime - CHAMPUS), TRICARE Plus (ACVs of "L" and "G"), Non Prime (CHAMPUS), and Other (Direct Care Only, etc.).

Value Added: MTF and Major Command managers should be able to:

- more accurately predict demand for particular services ahead of time
- predict the frequency of appointments that are booked yet do not result in encounters with the provider
- decrease the need to correct appointment data when the appointment is actually booked.
- identify problem areas in the booking process and take appropriate corrective action based on the metrics in this report

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Special Technical Requirements:

The report will show for each clinic and program category (with subtotals by clinic):

(1) the total number of planned appointments
(2) the total number of booked appointments for each of the following statuses: pending, kept, canceled by the clinic, canceled by the patient, no show, leave without being seen, walk-in, sick call, and a total of all encounters (including scheduled and unscheduled visits)
(3) the total encounters including all kept, walk-in, and sick call appointments.

The Program Categories are Active Duty (TRICARE Prime and non-enrolled), Prime (TRICARE Prime - CHAMPUS), TRICARE Plus (ACVs of "G" and "L"), Non Prime (CHAMPUS), and Other (Direct Care Only, etc.). Active Duty includes all patient categories with 11, 12, 13, 14, 15, and 21 in the last two characters, i.e., Active Duty, Reserve, National Guard, Cadet, AD Recruit, both enrolled and non-enrolled.

The report includes all booking activity even if the provider has no SSN and is a generic provider.

The total Unbooked Appointments is the sum of the number of Open, Canceled, Frozen, and Wait appointments for the clinic occurring during the report period but remaining unbooked on the last day of the report period.

ACCESS MANAGEMENT REPORT
Report Specifications

Frequency	Weekly with a Monthly Summary
Sort Criteria	Region or Service, Division, MEPRS 4, Clinic Name, Program Category Note: All sorts are in ascending order unless otherwise specified.
Detail Level	By Division, by MEPRS 4, by Clinic Name, by Program Category
Selection Criteria	Select all clinic booked appointments (Patient Appointment file) that have medical Appointment Types. Exclude telephone consults, dental, radiology, other ancillary, and civilian appointments. Include both count and non-count appointments. Include appointments booked as a

ACCESS MANAGEMENT REPORT
Report Specifications

	result of either a primary care or specialty care consult/referral. Pull data from the Schedulable Entity file for scheduled appointments that were unused (Open, Frozen, Canceled, and Wait). Select a reporting period, service or region, and division (optional).
Roll Up Totals	By Region or Service, by MTF (Division), by Program Category
Report Subtotals	By MTF (Division), By MEPRS 4, By Clinic Name, by Program Category
Primary Source Files	Patient Appointment File and the Schedulable Entity File. *Data Pull Level*: Appointment data at the appointment level to capture accurate data.
Header	Access Management Report
Format	Excel Spreadsheet with auto filter on

ACCESS MANAGEMENT REPORT Report Columns (left to right)	
SERVICE	the Military Armed Forces Service affiliation of the Division
REGION	the Military Armed Forces geographical region where the division is located
DIVISION	the facility name also referred to as the Military Treatment Facility
DMIS ID	the four character Defense Medical Information System (DMIS) code for the facility

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ACCESS MANAGEMENT REPORT Report Columns (left to right)	
CLINIC	the name of the clinic at the facility. **Note:** The TOC does not currently capture the CHCS clinic name, only the specialty name associated with the MEPRS3 code. This change is being looked at by the TOC for correction for this report.
MEPRS	Medical Expense Performance Reporting System 4TH level code for the corresponding clinic name above
PROGRAM CATEGORY	the type of beneficiary seen during this visit, e.g. Active Duty (includes TRICARE Prime, Reserve, National Guard, Cadet, AD Recruit, both enrolled and non-enrolled), Prime (TRICARE Prime - CHAMPUS), TRICARE Plus (includes both the "G" and the "L" ACVs), Non Prime (CHAMPUS), and Other (Direct Care Only, etc.). Active Duty will be identified by a patient category with 11, 12, 13,14,15, and 21 in the last two characters. All Active Duty are reported together.
TOTAL PLANNED CLINIC APPTS	the number of appointments in the clinic's provider schedules that are available to patients to be booked including Open, Booked, Canceled, Frozen, and Wait statuses. This column is duplicated later in this spreadsheet for readability. The Program Category is unknown for this data so the count includes all Program Categories and is reported in the clinic total line. *Source*: Schedulable Entity File
TOTAL BOOKED CLINIC APPTS	the number of appointments booked for the clinic to include pending, kept, clinic cancel, patient cancel, no-show, and LWOBS appointments. *Source*: Patient Appointment File

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ACCESS MANAGEMENT REPORT **Report Columns (left to right)**	
TOTAL ENCTRS	the sum of all workload to include PENDING APPTS, KEPT APPTS, WALK-IN APPTS, and SICK CALL APPTS. This column is duplicated later in this spreadsheet for readability. *Source*: Patient Appointment File
BOOKED APPTS AS % OF TOTAL ENCTRS	equals TOTAL BOOKED CLINIC APPTS divided by TOTAL ENCTRS *Source*: Patient Appointment File
LWOBS APPTS	the number of booked appointments for patients that Left Without Being Seen (LWOBS). *Source*: Patient Appointment File
LWOBS % OF BOOKED APPTS	equals LWOBS APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
CLINIC CANCEL APPTS	the number of booked appointments that were canceled by the clinic. If the appointment is rescheduled using the CHCS CNOT or CMSC options, the initial canceled appointment is not counted. The start date/time on the new appointment is the date/time the appointment was initially entered for the patient. If the appointment is canceled then rescheduled without using CNOT or CMSC, the canceled appointment is counted as a 'NOT MET' and the clock is restarted for the rescheduled appointment. *Source*: Patient Appointment File

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ACCESS MANAGEMENT REPORT **Report Columns (left to right)**	
CLINIC CANCEL % OF BOOKED APPTS	equals CLINIC CANCEL APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
PATIENT CANCEL APPTS	the number of booked appointments that were canceled by the patient. If an appointment is canceled multiple times, it is counted each time it is canceled. If the appointment is rescheduled, the new start date/time is the date/time it is rescheduled. *Source*: Patient Appointment File
PATIENT CANCEL % OF BOOKED APPTS	equals PATIENT CANCEL APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
NO SHOW APPTS	the number of booked appointments for patients that were No-Show. *Source*: Patient Appointment File
NO SHOW % OF BOOKED APPTS	equals NO SHOW APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
PENDING APPTS	the number of booked appointments that the patient has not yet kept or that have not been assigned a final status. *Source*: Patient Appointment File

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ACCESS MANAGEMENT REPORT Report Columns (left to right)	
PENDING % OF BOOKED APPTS	equals PENDING APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
KEPT APPTS	the number of booked appointments where the patient showed up and was treated, i.e. the patient is not a cancellation, no-show, LWOBS, walk-in, or sick call. *Source*: Patient Appointment File
KEPT % OF BOOKED APPTS	equals KEPT APPTS divided by TOTAL BOOKED CLINIC APPTS *Source*: Patient Appointment File
WALK-IN APPTS	the number of walk-in appointments indicates that a patient is "walked-into" the clinic for treatment using the Unscheduled Visits functionality of CHCS *Source*: Patient Appointment File
WALK-IN % OF TOTAL ENCTRS	equals WALK IN APPTS divided by TOTAL ENCTRS *Source*: Patient Appointment File
SICK CALL APPTS	the number of Sick Call appointments indicates that a patient is seen in sick call and entered into the Unscheduled Visits functionality of CHCS *Source*: Patient Appointment File

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ACCESS MANAGEMENT REPORT Report Columns (left to right)	
SICK CALL % OF TOTAL ENCTRS	equals SICK CALL APPTS divided by TOTAL ENCTRS *Source*: Patient Appointment File
TOTAL ENCTRS	The Total Encounters is the sum of all workload to include PENDING APPTS, KEPT APPTS, WALK-IN APPTS, and SICK CALL APPTS. This column is duplicated here in the spreadsheet for readability. *Source*: Patient Appointment File
TOTAL PLANNED CLINIC APPTS	the number of appointments in the clinic's provider schedules that are available to patients to be booked including Open, Booked, Canceled, Frozen, and Wait statuses. This column is duplicated in this spreadsheet for readability. The Program Category is unknown for this data so count includes all Program Categories and is reported on the clinic total line only. *Source*: Schedulable Entity File
UNBOOKED APPTS	the number of planned appointment slots that did not have a patient booked for a clinical service, to include Open, Frozen, Canceled, and Wait appointments. The count is the total occurring during the report period that remain unbooked on the report end date. *Source*: Schedulable Entity File
UNBOOKED APPTS AS % OF PLANNED APPTS	equals UNBOOKED APPTS divided by TOTAL PLANNED CLINIC APPTS *Source*: Schedulable Entity File

6. Access To Care Summary Report

Purpose: This report will allow MTFs to assess patient access to each clinic's services overall and by type of beneficiary (Program Category) for the date range and MTF(s) selected for the report. This report measures the ability of the clinic to manage schedules to meet demand and how well the clinic is meeting the DoD Access to Care standards for patient requests, including appointments for Primary Care and Self-Referred Care, appointments for Primary Care consults/referrals, and appointments for Specialty Care consults/referrals. Every booked appointment is counted to assess the clinic's total booking activity and patient access, including kept, patient cancellations, facility cancellations, no-show, and leave without being seen appointments.

Value Added: MTF and Major Command managers should be able to:

- more accurately predict patient access to specific clinic services ahead of time
- assess access by type of beneficiary
- plan more effectively
- identify problem areas in booking, and take appropriate corrective action

Special Technical Requirements

This report is a retrospective report that will print the total number of appointments that were booked for patients to include the following appointment statuses: pending, kept canceled by the patient, canceled by the clinic, no show, snf leave without being seen (LWOBS). The totals will be reported by access standard (acute, routine, wellness, specialty, and future) calculated from the date the patient called for the appointment or the date a provider entered the referral/consult into CHCS. Appointments booked outside the access standard per patient preference or because the patient called in late will be reported separately as an appointment refusal.

This report also shows the distribution and types of appointments booked for each Program Category, i.e., Active Duty (includes TRICARE Prime and non-enrolled), Prime (TRICARE Prime - CHAMPUS), TRICARE Plus (ACVs of "L" and "G"), Non Prime, and Other.

Appointments without an Access to Care Category will be counted as a separate metric. Also all providers with or without identification data, such as an SSN, will be counted.

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For appointments without a referral/consult, compute the time (in minutes) elapsed from the date/time the appointment is entered into CHCS until the date/time the patient is scheduled to see the provider. The standard is met if this time difference is not greater than the Access to Care standard to the minute (derived from the Access to Care (ATC) Category), e.g., for a ROUTINE ATC category the appointment must be booked within 7 days x 24 hours X 60 minutes = 10080 minutes or is a 'not met'.

Appointments booked as a result of a consult or referral are reported under the 'Referred To' clinic and include only initial (not canceled) appointments. At this time second, third, fourth, etc. appointments for a consult/referral will not be counted since the referral start date in CHCS currently is incorrectly set to the date the provider first put the referral into the system. Primary care and Specialty Care consults/referrals will each be counted separately under the appropriate ATC Category. Access to Care is computed in minutes elapsed from the date/time the referral/consult is entered into CHCS until the date/time of the initial appointment with the provider. The standard is met if this time difference is not greater than the Access to Care period defined by the appointment's Access to Care Category.

Patient cancellations: An appointment that is canceled multiple times by a patient will be counted each time it is canceled and reported according to the appointment's ATC Category, start date/time, and refusal category if any. If a patient cancellation is rescheduled, a new appointment is created with the start date/time set to the reschedule date/time. This appointment will be met or not met based on the Access to Care Category and start date/time for the rescheduled appointment.

Clinic cancellations: Clinic cancellations that are not rescheduled will be counted as 'not met'. Clinic cancellations that are rescheduled (provided the CNOT or CMSC options are used *immediately* to reschedule) will be counted as either met or not met based on the data in the initial request, i.e., the start date/time and ATC Category.

For waitlist requests, compute the number of patient requests on the Waitlist as of the last day of the report. (future requirement).

ACCESS TO CARE SUMMARY REPORT
Report Specifications

Frequency	Monthly
Sort Criteria	Region or Service, Division, MEPRS 4, Clinic Name, Program Category Note: All sorts are in ascending order unless otherwise specified.
Detail Level	By Division, by MEPRS 4, by Clinic Name, by Program Category
Selection Criteria	Select by division all clinic booked appointments (Patient Appointment file) during the report period that have Medical Appointment Types. Include kept, no-show, leave without being seen, pending, clinic canceled, and patient canceled appointments. For Primary Care or Specialty Care consult/referral counts, include only initial appointments booked as a result of the consult/referral. Include both count and non-count appointments. Exclude telephone consults, dental, radiology, other ancillary, walk-in, sick call, civilian appointments, and occasions of service. Select all consults or referrals entered or having appointments during the reporting period. Omit "Deferred to Network" consults. Second, third, fourth appointments for a consult/referral will be excluded from access to care measures but will be included in the total booked appointments count.
Roll Up Totals	By Region or Service, by MTF (Division), by MEPRS 4, by Clinic Name
Report Subtotals	By MTF (Division), By MEPRS 4, By Clinic Name, by Program Category
Primary Source Files	Patient Appointment File and GP Consult Tracking file *Data Pull Level*: at the patient level for greater accuracy

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ACCESS TO CARE SUMMARY REPORT
Report Specifications

Header Access to Care Summary Report

Format Excel Spreadsheet with auto filter on

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
SERVICE	the Military Armed Forces Service affiliation of the Division
REGION	the Military Armed Forces geographical region where the division is located
DIVISION	the facility name, also referred to as the Military Treatment Facility
DMIS ID	The four character Defense Medical Information System (DMIS) code for the facility
CLINIC	the name of the clinic at the facility **Note:** The TOC does not currently capture the CHCS clinic name, only the specialty name associated with the MEPRS 3 code. This change is being looked at by the TOC for correction for this report.
MEPRS	Medical Expense Performance Reporting System code at the fourth level for the corresponding clinic name

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STANDARD APPOINTMENT TYPES
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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
PROGRAM CATEGORY	the type of beneficiary seen during this visit, e.g. Active Duty (includes Active Duty, Reserve, National Guard, Cadet, AD Recruit, both enrolled and non-enrolled), Prime (TRICARE Prime - CHAMPUS), TRICARE Plus (includes both the "G" and the "L" ACVs), Non Prime (CHAMPUS), and Other. Active Duty will be identified by a patient category with 11, 12, 13,14,15, and 21 in the last two characters. All Active Duty are reported together.
TOTAL # OF BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for this Program Category to include ACUTE, ROUTINE, SPECIALTY, WELLNESS, and FUTURE ATC Categories. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes all appointments booked with or without a referral (including 2nd, 3rd, etc appointments), booked with or without an ATC Category, booked from the waitlist, and booked with an appointment refusal.
TOTAL # BOOKED CLINIC APPTS W/O ATC	the total number of booked appointments for the clinic for this Program Category without an ATC Category. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes all appointments booked with or without a referral (including 2nd, 3rd, etc appointments). Excludes appointment refusals as they do apply here..

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ACUTE -TOTAL MET & NOT MET ACUTE BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for the Program Category and Acute Access to Care Category including all met and not met. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ACUTE - # NOT MET OF ACUTE BOOKED CLINIC APPTS	the number of booked appointments with an Acute ATC Category that did not meet the Acute Access to Care Standard for the specified date range (24 hours). Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ACUTE- # MET APPTS W/O REF	the number of appointments booked without a referral/consult that have an Acute ATC Category and that met the Acute Access to Care Standard for the specified date range. An acute appointment meets the Acute ATC standard if the appointment is scheduled with the provider within 24 hours to the minute of the time the request is entered into CHCS. Excludes appointment refusals.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ACUTE - # MET APPTS W/PC REF	the number of initial (not canceled) appointments booked for a Primary Care referral/consult that have an Acute ATC Category and that met the Acute Access to Care Standard for the specified date range. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ACUTE - # MET APPTS W/SPEC REF	the number of initial (not canceled) appointments booked for a Specialty Care referral/consult that have an Acute ATC Category and that met the Acute Access to Care Standard for the specified date range. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ACUTE - TOTAL # REFUSALS WITH ATC DECLINED	the number of booked appointments with an Acute ATC Category that were booked outside the ATC standard per patient preference or when the patient called in late (reasons 11 and 12). The appointment is not measured as either met or not met and is thus excluded from all ATC Standard measures. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a Primary Care or Specialty Care consult/referral. Excludes "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ACUTE - % MET OF TOTAL MET & NOT MET ACUTE BOOKED CLINIC APPTS	the percentage of all booked appointments with an Acute ATC Category that have met the Acute Access to Care Standard for the specified date range. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral. Computation: ACUTE (# MET APPTS W/O REF + # MET APPTS W/PC REF + # MET APPTS W/SPEC REF) divided by TOTAL MET AND NOT MET ACUTE BOOKED CLINIC APPTS.
ACUTE - AVG DAYS TO BE SEEN	the average number of days for Acute met and not met appointment requests to be booked, from the date of the request to the date of the appointment with the provider for the report date range. Includes appointments booked without a referral and only (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ROUTINE - TOTAL MET & NOT MET ROUTINE BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for the Program Category and Routine Access to Care Category including all met and not met. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ROUTINE - # NOT MET OF ROUTINE BOOKED CLINIC APPTS	the number of booked appointments with a Routine ATC Category that did not meet the Routine Access to Care Standard for the specified date range (7 day). Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ROUTINE- # MET APPTS W/O REF	the number of appointments booked without a referral/consult that have a Routine ATC Category and that met the Routine Access to Care Standard for the specified date range. A Routine appointment meets the Routine ATC standard if the appointment is scheduled with the provider within 7 days to the minute of the date/time the request is entered into CHCS. Excludes appointment refusals.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ROUTINE - # MET APPTS W/PC REF	the number of initial (not canceled) appointments booked for a Primary Care referral/consult that have a Routine ATC Category and that met the Routine Access to Care Standard for the specified date range. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ROUTINE - # MET APPTS W/SPEC REF	the number of initial (not canceled) appointments booked for a Specialty Care referral/consult that have a Routine ATC Category and that met the Routine Access to Care Standard for the specified date range. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
ROUTINE - TOTAL # REFUSALS WITH ATC DECLINED	the number of booked appointments with an Routine ATC Category that were booked outside the ATC standard per patient preference or when the patient called in late (reasons 11 and 12). The appointment is not measured as either met or not met and is thus excluded from all ATC Standard measures. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a Primary Care or Specialty Care consult/referral. Excludes "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
ROUTINE - % MET OF TOTAL MET & NOT MET ROUTINE BOOKED CLINIC APPTS	the percentage of all booked appointments with a Routine ATC Category that have met the Routine Access to Care Standard for the specified date range. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral. Computation: ROUTINE (# MET APPTS W/O REF + # MET APPTS W/PC REF + # MET APPTS W/SPEC REF) divided by TOTAL MET AND NOT MET ROUTINE BOOKED CLINIC APPTS
ROUTINE - AVG DAYS TO BE SEEN	the average number of days for Routine appointment requests to be booked, from the date of the request to the date of the appointment with the provider for the report date range. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
SPECIALTY TOTAL MET & NOT MET SPECIALTY BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for the Program Category and Specialty Access to Care Category including all met and not met. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
SPECIALTY - # NOT MET OF SPECIALTY BOOKED CLINIC APPTS	the number of booked appointments with a Specialty ATC Category that did not meet the Specialty Access to Care Standard for the specified date range (28 days). Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
SPECIALTY- # MET APPTS W/O REF	the number of appointments booked without a referral/consult that have a Specialty ATC Category and that met the Specialty Access to Care Standard for the specified date range. A Specialty appointment meets the Specialty ATC standard if the appointment is scheduled with the provider within 28 days to the minute of the date/time the request is entered into CHCS. Excludes appointment refusals.

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
SPECIALTY - # MET APPTS W/PC REF	the number of initial (not canceled) appointments booked for a Primary Care referral/consult that have a Specialty ATC Category and that met the Specialty Access to Care Standard for the specified date range to the minute. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
SPECIALTY - # MET APPTS W/SPEC REF	the number of initial (not canceled) appointments booked for a Specialty Care referral/consult that have a Specialty ATC Category and that met the Specialty Access to Care Standard for the specified date range to the minute. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
SPECIALTY - TOTAL # REFUSALS WITH ATC DECLINED	the number of booked appointments with an Specialty ATC Category that were booked outside the ATC standard per patient preference or when the patient called in late (reasons 11 and 12). The appointment is not measured as either met or not met and is thus excluded from all ATC Standard measures. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a Primary Care or Specialty Care consult/referral. Excludes "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
SPECIALTY - % MET OF TOTAL MET & NOT MET SPECIALTY BOOKED CLINIC APPTS	the percentage of all booked appointments with a Specialty ATC Category that have met the Specialty Access to Care Standard for the specified date range. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral. Computation: SPECIALTY (# MET APPTS W/O REF + # MET APPTS W/PC REF + # MET APPTS W/SPEC REF) divided by TOTAL MET AND NOT MET SPECIALTY BOOKED CLINIC APPTS
SPECIALTY - AVG DAYS TO BE SEEN	the average number of days for Specialty met and not met appointment requests to be booked, from the date of the request to the date of the appointment with the provider for the report date range. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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STANDARD APPOINTMENT TYPES
UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
WELLNESS – TOTAL MET & NOT MET WELLNESS BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for the Program Category and Wellness Access to Care Category including all met and not met. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
WELLNESS - # NOT MET OF WELLNESS BOOKED CLINIC APPTS	the number of booked appointments with a Wellness ATC Category that did not meet the Wellness Access to Care Standard for the specified date range. (28 days) Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
WELLNESS- # MET APPTS W/O REF	the number of appointments booked without a referral/consult that have a Wellness ATC Category and that met the Wellness Access to Care Standard for the specified date range. A Wellness appointment meets the Wellness ATC standard if the appointment is scheduled with the provider within 28 days to the minute of the date/time the request is entered into CHCS. Excludes appointment refusals.

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
WELLNESS - # MET APPTS W/PC REF	the number of initial (not canceled) appointments booked for a Primary Care referral/consult that have a Wellness ATC Category and that met the Wellness Access to Care Standard for the specified date range to the minute. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
WELLNESS - # MET APPTS W/SPEC REF	the number of initial (not canceled) appointments booked for a Specialty Care referral/consult that have a Wellness ATC Category and that met the Wellness Access to Care Standard for the specified date range to the minute. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
WELLNESS - TOTAL # REFUSALS WITH ATC DECLINED	the number of booked appointments with an Wellness ATC Category that were booked outside the ATC standard per patient preference or when the patient called in late (reasons 11 and 12). The appointment is not measured as either met or not met and is thus excluded from all ATC Standard measures. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a Primary Care or Specialty Care consult/referral. Excludes "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
WELLNESS - % MET OF TOTAL MET & NOT MET WELLNESS BOOKED CLINIC APPTS	the percentage of all booked appointments with a Wellness ATC Category that have met the Wellness Access to Care Standard for the specified date range. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral. Computation: WELLNESS (# MET APPTS W/O REF + # MET APPTS W/PC REF + # MET APPTS W/SPEC REF) divided by TOTAL MET AND NOT MET WELLNESS BOOKED CLINIC APPTS
WELLNESS - AVG DAYS TO BE SEEN	the average number of days for Wellness met and not met appointment requests to be booked, from the date of the request to the date of the appointment with the provider for the report date range. Includes appointments booked without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals and second, third, etc. appointments booked for a consult/referral.

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UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
FUTURE - TOTAL # OF FUTURE BOOKED CLINIC APPTS	the total number of booked appointments for the clinic for the Program Category and Future Access to Care Category. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
FUTURE - % OF TOTAL BOOKED CLINIC APPTS	TOTAL # FUTURE BOOKED CLINIC APPTS divided by TOTAL # OF BOOKED CLINIC APPTS Includes appointments booked with or without a referral and only initial (not canceled) appointments booked as a result of a consult/referral. Excludes appointment refusals, "Defer to Network" consults/referrals, and second, third, etc. appointments booked for a consult/referral.
CONSULT/REFERRALS - # NEW CONSULTS OPENED	the number of new Primary Care and Specialty Care consults/referrals referred to this clinic during the report date range. Excludes "Defer to Network" consults/referrals and appointment refusals.
CONSULT/REFERRALS - # APPTS FROM CONSULTS	The number of Primary Care or Specialty Care consults/referrals referred to this clinic that have appointments during the report date range.

APPENDIX G

STANDARD APPOINTMENT TYPES
UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
CONSULT/REFERRALS - # APPTS BOOKED FROM CONSULTS WHICH MET ATC	The number of Primary Care or Specialty Care consults/referrals whose initial(not canceled) appointment was booked to this clinic, occurred during the report date range, and met the access to care standard defined by the referring provider. Booked appointments include pending, kept, patient cancel, clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Compute number met as follows: Compute the number of minutes from the date/time the provider entered the consult into CHCS until the date/time of the first appointment (not canceled) with the referred to provider. The access standard is met if this number of minutes is not greater than the access standard defined in the priority converted to minutes. **Priority** — **Access Standard** Emergency, Urgent, STAT, ASAP — 24 hours 24 HOURS, TODAY — 24 hours 48 Hours — 48 hours 72 Hours — 72 hours. Routine — 28 days Excludes consults that are administratively closed without an appointment, "Defer to Network" consults, and appointment refusals.
WAITLIST - # ON WAITLIST AS OF RUN DATE (Future)	the number of waitlist requests still on file for the clinic on the end date of the report (future requirement)

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STANDARD APPOINTMENT TYPES
UTILIZATION REPORTS ON THE TRICARE OPERATIONS CENTER

ACCESS TO CARE SUMMARY REPORT Report Columns (left to right)	
TOTAL # OF BOOKED CLINIC APPTS	The total number of booked appointments for the clinic for this Program Category to include ACUTE, ROUTINE, SPECIALTY, WELLNESS, and FUTURE ATC Categories. Booked appointments include pending, kept, patient cancel, and clinic cancel (if not rescheduled for the same patient), no-show, and LWOBS. Includes all appointments booked with or without a referral (including 2nd, 3rd, etc appointments), booked with or without an ATC Category, booked from the waitlist, and booked with an appointment refusal.

APPENDIX H

STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

APPENDIX H

STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

This appendix documents the appropriate usage of each of the *ten* standard appointment types. Sites should adhere to these guidelines when creating and using these appointment types. The appointment type definitions and scenarios are followed by a table documenting the access standards for each appointment type.

The MTF Book Only ($ extender) versions of the standard appointment types are permanent, e.g., PCM$, ROUT$, etc.. To indicate count or non-count workload on appointments, sites should now use the new feature (the permanent solution) to enter/correct the Workload Type directly on the appointment slot.

1. PCM (Initial Primary Care Appointment)

The PCM appointment type is designed for the initial primary care visit with the PCM to collect health data, family history, readiness data, and possibly HEAR data. A PCM visit may not be the patient's first visit to the PCM since an acute or routine appointment may precede a PCM visit. This appointment type will be used by sites to track whether the PCM has completed this initial visit as a TRICARE benefit. This appointment type is not designed for use for acute or routine health care. The WELL appointment type should be used for the annual exam.

The initial PCM appointment will map to the 28-day Wellness ATC category.

Scenario—Mrs. Snuffy, spouse of Lieutenant Snuffy, enrolled in TRICARE Prime (MTF) yesterday. She is not experiencing any acute health problems but wishes to "get established" with the MTF so she calls the 1-800 TRICARE appointments line. Mrs. Snuffy asks the appointment clerk for an appointment at the hospital. The appointment clerk asks Mrs. Snuffy for the appropriate demographic information to establish her identity. Upon seeing the appropriate demographic information (ACV, Enrolled Clinic, PCM, etc) the appointment clerk confirms that Mrs. Snuffy is a TRICARE Prime Enrollee. The appointment clerk (1) Asks Mrs. Snuffy if this is the first time she has asked for an appointment with her PCM or (2) Notices by viewing previous appointments that Mrs. Snuffy has not had an appointment with the PCM before. The appointment clerk asks Mrs. Snuffy if she has any acute health conditions that require that she see a doctor within 24 hours. Mrs. Snuffy replies that she does not, so the appointment clerk schedules her for a PCM appointment.

2. SPEC (Initial Specialty Care Appointment)

The SPEC appointment type is designed for the initial appointment (by consult or referral) to a specialist. A specialty appointment is reserved for care to be delivered by a network or MTF specialist for a specific disease process.

The initial specialty care appointment will map to the 28 day Specialty ATC category by default, unless a consultation between the referring provider and the specialist specifies that the visit to the specialist must occur sooner. The requirement for a specialist visit to occur sooner than 28 days will be documented on the electronic CHCS Consult Order, on a referral, or other applicable automated consult system.

Scenario—Mrs. Snuffy's PCM (Dr. Smith) notices some abnormalities in a routine examination during her office visit. Dr. Smith is extremely concerned about Mrs. Snuffy's examination and judges that examination beyond the capability of a PCM is necessary to ensure that Mrs. Snuffy does not have a serious health problem. Dr. Smith sends a specific scheduled consult order to the Health Care Finder using the STAT priority. Dr. Smith also calls Dr. Bones, the Specialist, and discusses Mrs. Snuffy's case and the two agree that Mrs. Snuffy needs to be seen *soon*. The CHCS Consult Order is reviewed and designated for an appointment specifically with Dr. Bones. As a result of the consultation between Dr. Bones and Dr. Smith the referral priority is changed to a *72*HRS priority, i.e., a referral within *3* days. Mrs. Snuffy is instructed to stop and see the front desk clerk on the way out to schedule the appointment. The clerk, who has access to Dr. Bones' schedule, pulls up the consult order on Mrs. Snuffy, understands the instructions in the consult order, and books Mrs. Snuffy an initial specialty care appointment with Dr. Bones within the *3* day timeframe specified.

3. ACUT (Acute Appointment)

The ACUT appointment type is designed for scheduling appointments for beneficiaries who have a need for non-emergent, urgent care typically delivered by an MTF or network provider. ACUT is synonymous with the intent of "Same Day " appointments. Before an ACUT appointment is scheduled appropriate nurse triage may occur to determine the most appropriate level of treatment for the patient's medical problem.

The acute appointment will map to the 24-hour Acute ATC category.

Scenario—Mrs. Snuffy is experiencing flu-like symptoms and feels that she is in need of prescription medication. She calls the 1-800 TRICARE Appointments line and explains that she needs an appointment to see a health care provider right away. She will be referred to nurse triage as appropriate. If Mrs.Snuffy, as a TRICARE Prime enrollee, reasonably feels, as a prudent lay person, that her condition needs attention within 24 hours every effort will be made to ensure she receives an appointment consistent with the order of search priority business rule or with local policy. If not an emergency, the appointment clerk pulls up Mrs. Snuffy's demographic information and verifies her identity and TRICARE enrollment status. The clerk verifies that Mrs. Snuffy is seeking an immediate visit with her PCM to get treatment for flu-like symptoms. The clerk transfers Mrs. Snuffy's call to a triage nurse who, using appropriately approved protocols and algorithms, determines whether (1) Mrs. Snuffy needs to have an office visit within 24 hours, (2) can wait for a "Routine" or "Established" patient appointment, or (3) can benefit from health care information or self-help instruction from the nurse. If the triage nurse determines that Mrs. Snuffy does need to be seen by a health care provider within 24 hours she will have access to the PCM clinic appointment schedule and can book an appointment immediately.

4. ROUT (Routine Appointment)

The ROUT appointment type is designated for patients who require an office visit with the PCM for a new health care problem that is not considered urgent. Patients may be routed through Nurse Triage, if available, before the routine appointment is booked. The Nurse Triage can offer other appropriate alternatives for care such as self-care. Based on the approved Nurse Triage protocols, the determination may be made to book an acute appointment. In those locations where Nurse Triage is not in place the concept of "prudent lay-person terminology" will be used in determining whether the patient should be given a routine or acute appointment. If the patient insists on an acute appointment, every effort will be made to book one within access standards using the Order of Precedence for Appointments Search business rule. **ROUT appointment types should be used for Primary Care only.**

The ROUT appointments type will map to the 7-day Routine ATC category.

Scenario—Mrs. Snuffy has been experiencing a pain in her shoulder joint area for a couple of days and decides to call the 1-800 TRICARE Appointment Line to schedule a visit with her provider. The appointment clerk, in accordance with local guidelines or scripts determines the patient's needs and reaches the decision point to transfer Mrs. Snuffy's call to the Triage Nurse. The Triage Nurse, using approved protocols, rules out self-care and determines that an acute appointment isn't necessary, but that a routine appointment should be scheduled with her

provider within 7 days. Using the Order of Precedence for Appointments Search business rule, the Triage Nurse books the appointment and gives the patient appropriate instruction.

5. WELL (Wellness or Health Promotion appointment)

The WELL appointment type is designated for patients who require preventive, health maintenance care (e.g., physical examinations, periodic examinations, check-ups, screenings, PAP, PPIP).

The WELL appointment type will map to the 28-day Wellness Access-To-Care standard.

Scenario—Mrs. Snuffy calls the 1-800 TRICARE appointment line to ask for an appointment for her periodic physical examination. The appointment clerk pulls up the appropriate screen with demographic information and enrollment status for Mrs. Snuffy. The clerk does a search keyed on WELL appointment types (other appropriate identifiers may also be used for the search; e.g., PCM, detail field information, Wellness Access-To-Care category, etc.) and finds the next available WELL appointment slot. The clerk books the appointments for the patient.

6. PROC (Procedure Appointment)

The PROC appointment type is designated for patients who are determined to be in need of medical procedures other than those that are performed in the Ambulatory Procedure Unit (APU - B**5 MEPRS Clinics). Procedures performed in APUs will be considered Ambulatory Procedure Visits (APVs) and will be scheduled using the CHCS MCP VAP subsystem.

A procedure appointment should be scheduled with a provider within 28 days or per the referring provider's designation. The provider's designation must not exceed 28 days.

Scenario—SGT Snuffy had been referred to Gastroenterology. The Gastroenterologist decides that Snuffy needs to come back in one week for an Upper GI examination which will be performed in the clinic. Alternative 1 - (No scheduling personnel within clinic) The physician enters a consult order into the system for the procedure to be performed. Instructions to be given to SGT Snuffy are included on the consult order. SGT Snuffy is instructed to call the central appointment line and inform them he has a consult for a procedure to be scheduled (or the appointment clerk calls SGT Snuffy). The appointment clerk is able to open the CHCS AOP option and select the consult order (review marked - "appoint to MTF") to schedule an appointment for SGT Snuffy to have the procedure performed. The appointment clerk uses the information on the consult order to remind SGT Snuffy of the physician's instructions on how to

be prepared for the procedure. Alternative 2 (more desirable) - SGT Snuffy is able to stop by the front desk of the clinic and get his appointment scheduled before he leaves the clinic.

7. EST (Established Patient Follow-up with Designated Time Allotment)

The EST appointment will be used when a patient is being scheduled for follow-up care per direction of a PCM or a Specialist. The EST appointment type is designated for patients who request a follow-up appointment with the PCM that is not for acute health care, routine primary care, initial PCM appointments, wellness or to have a procedure performed. The EST is also designed for a patient who requests a follow-up appointment with a Specialist for other than initial specialty care, acute health care, wellness, or to have a procedure performed.

An established appointment should be scheduled with a provider per the initial provider's designation. There is no access to care category. The access to care search will be Future.

Scenario—Mrs. Snuffy had been seen as an acute patient (using the ACUT) appointment type last week for a severe upper respiratory infection. She is instructed to get a follow-up appointment one week later to ensure that the antibiotics prescribed work effectively. The PCM may use a Consult Order to provide instructions. The instructions will be available for the appointment clerk to properly book Mrs. Snuffy's follow-up appointment. One Alternative: The patient could call central appointments giving the clerk the appropriate information for accessing AOP in order to find the reviewed order and book the appointment. Better Alternative: The simple, user friendly method would be for the patient to simply relay the physicians instructions for a follow-up appointment next week to the front desk clerk who will book the patient's appointment using the EST appointment type before the patient leaves the clinic.

8. TCON (Telephone consults between provider and patient)

The TCON, TCON$, and TCONX appointment types are currently reserved for temporary use to track patient calls that did not result in an appointment. The appointment type defines the access to care standard requested by the patient, e.g., TCON for acute, TCON$ for wellness, and TCONX for specialty care. These 3 appointment types will be inactivated in APS III in October 2003.

All telephone consults should use the T-CON* appointment type in the Provider Profiles for telephone consults. Refer to the definition of T-CON* below.

9. GRP (Group Appointments with Multiple Patients)

The GRP (Group) appointment type will be used for patients who must be scheduled for therapy, counseling, or teaching sessions where a provider will perform the intervention in a group setting. The detail field can be used to provide further information on the type of care scheduled for the group appointment (e.g., NPCL for New Prenatal Class).

A group appointment should be scheduled per the referring provider's designation.

10. *OPAC (Open Access Appointments)*

The OPAC appointment type is designated for acute, routine, or follow-up appointments that will be scheduled for patients the day they call for a visit with their Primary Care Manager (PCM) or a specialist. Some sites may wish to book wellness appointments as OPAC appointments. Every effort will be made to allow patients to see their own physician on the same day that they request an appointment, but the clinic does not open itself into a full walk-in type service. Follow-up care should be avoided if possible so that ALL the patient's issues are addressed in a single visit so as to eliminate the need to add future appointments/repeat visits for the same patient. Patients may be routed through Nurse Triage, if available, before the OPAC appointment is booked. The Nurse Triage can offer other appropriate alternatives for care such as self-care. In those locations where Nurse Triage is not in place, the concept of "prudent lay-person terminology" will be used in determining whether the patient can wait for a scheduled OPAC appointment or be told to report immediately for acute service. OPAC appointment types will only be used in clinics at MTFs that have coordinated their use prior to establishing an open/advanced access appointing process with their Lead Agent and Service Commands. If the patient refuses all appointments offered today, the booking clerk should record a patient refusal for the call to avoid getting a 'not met' count against the clinic.

The OPAC appointment type will use a 24-hour Access To Care standard and map to the Acute ATC category. However the appointment should be booked the day of the patient request.

Scenario: Mrs. Snuffy has been experiencing a pain in her shoulder joint area for a couple of days and calls the 1-800 TRICARE Appointment Line on Monday morning to schedule a visit with her Primary Care Manager. The appointment clerk, at an Open Access MTF, in accordance with local guidelines or scripts determines the patient's needs and reaches the decision point to transfer Mrs. Snuffy's call to the Triage Nurse. The Triage Nurse, using approved protocols, rules out self-care and determines that an open access appointment is necessary and Mrs. Snuffy is told that there are appointments available at several times Monday afternoon. Mrs. Snuffy chooses an appointment time of 1400 and, using the Order of Precedence for Appointments Search business rule, the Triage Nurse books the OPAC appointment and gives Mrs. Snuffy appropriate instruction.

11. Other

Four fixed appointment types, used for processing by CHCS, will continue to be supported as follows.

- APV Ambulatory Procedure Visit. This appointment type is used for outpatient same day surgery visits. Same Day Surgery clinics may have a location type of C (Clinic) or S (Same Day Surgery). If the clinic location type is S, then all ambulatory visits (APV appointments) for the clinic will be picked up in the VAP (Ambulatory Visits) option in order to record minutes of service.
- EROOM The Emergency Room may use EROOM or any standard appointment type.
- N-MTF A downtown appointment logged into CHCS. This appointment type must be added to the Non-MTF Place of Care's (Clinic) profile and to the individual provider profiles for each provider linked to that non-MTF place of care. When a HCF logs a non-MTF appointment, the system will automatically populate the appointment type field with the N-MTF appointment type.
- T-CON* a TCON that needs to be answered. This non-searchable appointment type must be added to an individual provider's Provider Profile and the provider must be a User in the User file before telephone consults may be entered for the specified provider.

APPENDIX H

STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

STANDARDIZED APPOINTMENTS TYPES WITH ACCESS STANDARDS

The following table lists the standard appointment types with their access standards.
The second column shows the MTF Book Only version of the standard appointment types.
The third column shows additional temporary versions of the standard appointment types and explains their use.

The fifth column indicates the Access to Care Category that applies to the appointment types. The sixth column shows the standard number of days within which patients may expect to be seen.

STANDARD CODE (1)	(permanent) MTF BOOK ONLY (2)	(temporary) OTHER APPT (3)	DESCRIPTION (4)	ACCESS TO CARE CATEGORY (5)	ACCESS STANDARD (6)
ACUT	ACUT$		non-emergent, urgent care	ACUTE	24 hours
OPAC	OPAC$		open access appointment	ACUTE	Same day patient calls
ROUT	ROUT$		new non-urgent health care problem	ROUTINE	7 days
PCM	PCM$		initial primary care visit only	WELLNESS	28 days
WELL	WELL$		health maintenance, preventive care	WELLNESS	28 days
SPEC	SPEC$		initial appointment to a Specialist	SPECIALTY	28 days

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STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

STANDARD CODE (1)	(permanent) MTF BOOK ONLY (2)	(temporary) OTHER APPT (3)	DESCRIPTION (4)	ACCESS TO CARE CATEGORY (5)	ACCESS STANDARD (6)
PROC	PROC$		Appointments for medical procedures that are not Ambulatory Visits	SPECIALTY	Provider designated, but not more than 28 days
EST	EST$		PCM appointments that are provider designated, follow-up, or other than acute, wellness, or initial PCM visit	FUTURE	Provider designated
GRP	GRP$		care provided in a group setting for therapy counseling, or teaching sessions	FUTURE	Provider designated
APV	N/A		ambulatory procedure visit – used for outpatient same day surgery visit	N/A	N/A
EROOM	N/A		default value for an emergency room visit	N/A	N/A
N-MTF	N/A		an appointment with a civilian provider that is recorded in CHCS for analysis	N/A	N/A

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STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

STANDARD CODE (1)	(permanent) MTF BOOK ONLY (2)	(temporary) OTHER APPT (3)	DESCRIPTION (4)	ACCESS TO CARE CATEGORY (5)	ACCESS STANDARD (6)
TCON	TCON$	TCONX (still active)	Telephone consults - used to track patient calls that did not result in appointments. TCON indicates an acute call; TCON$ indicates a wellness call, and TCONX indicates a specialty care call. All will be inactivated in APS III in Oct 2003.	N/A	N/A
T-CON*	N/A		a telephone consult that needs to be answered by the provider	N/A	N/A

APPENDIX I

ACCESS TO CARE OPTIMIZATION PROGRAM

APPENDIX I

ACCESS TO CARE OPTIMIZATION PROGRAM

In 2002, TMA was tasked to perform analysis, identification, testing, implementation, and measurement of processes to improve Access to Care in the outpatient setting at MTFs MHS wide. In response to the tasking, an Access to Care Optimization WIPT was created to assess the critical improvement points in the outpatient care processes. The WIPT was comprised of representatives from each Service and experts in outpatient care.

The consensus of the WIPT was that the entire appointment booking process needed careful review from enrollment through receiving patient calls, booking appointments, and tracking the patient up to but not including the encounter with the provider. As a result of the analysis, eight activities were identified as candidates for improvement. These options were offered to each of the Services with instructions to select one or more to implement at selected facilities that would benefit from that improvement. Funding was planned to be provided to each Service pending submission of costing for each of the selected activities to implement

The charts and tables developed by the WIPT are included below on the objectives, the plan, and the results of the WIPT analysis.

I. Purpose of the Access to Care (ATC) Optimization model

- Identify and plan ATC optimization activities
- Provide a standard method for implementing a generic ATC optimization plan in the MHS
- Define benchmarks and measure performance
- Review progress and act on results

II. WIPT Tasks

Step 1. Plan

1.1 Assess needs
1.2 Determine possible action items
1.3 Determine costs and timelines
1.4 Assess the change risk management
1.5 Determine priorities
1.6 Determine dependent activities
1.7 Rank action plan based on priorities

Step 2. Do

Step 3. Check
Measure performance (outcomes)

Step 4. Act
Review progress and act on results, make it better

III. Key Messages from the ATC Optimization WIPT

- **Fix Enrollment/Empanelment processes and enforce PCMBN**
- **Need Access Managers and more available appointments**
- **Inadequate telephony systems are a huge issue**
- **Primary Care Optimization (PCO) is critical**
- **The Open Access model works well only if PCO occurs first**
- **Referral Management still slow, fragmented, and not universally implemented**
- **Network referral results feedback to direct-care PCM's is still problematic**
- **Follow-up with patients needs to be improved**

IV. Analysis: ATC Optimization activities have points of overlap and integration

1. Fix Enrollment /Empanelment

- Balance distribution of patients to panels in accordance with patient clinical needs and the skill/experience of the provider
- Enrollment errors < 2%

[Note: This is a one time event meant to address current unbalanced panels. It is not meant to optimize panel size nor address day to day provider productivity]

2. Assign Access Managers

- Optimal template management
- Ensure that Access Standards are met > 95%
- Clinical oversight to empanelment decisions
- Ensure providers' schedules reflect at least 45 days out
- < 5% of unused appointments (does not apply to Open Access environment)

3. Implement adequate Telephony Network

- Reduced Call abandonment rates to 5% or below
- Call response time (on hold not more than 30 seconds 95% of the time)
- Beneficiary has one number to call for access to care services (per market)

4. Implement Primary Care Optimization (PCO)

- Patient satisfaction with access is "satisfactory" or above at least 85% of the time
- Provider satisfaction with PCO process is "satisfactory" or above at least 85% of the time
- Increased capacity
- Decreased throughput times
- Provider and support staff ratios are optimized
- Ability to move to Open Access model where applicable

5. Implement Open Access Model where appropriate

- Appointment is with PCM Team 90% of the time
- Patient satisfaction with access to care > 90%
- 100% of appointments kept within 32 hours

6. Fix Referral Management

- Turnaround time for referral appointment booking < 72 hours
- Reduced number of specialty referrals needing consult / review
- Increase Specialist capacity – refer appropriate care back to the PCM (track 100% of completed consults)
- Elimination of authorization requirements for primary preventative services (mammo's, etc.)

7. Fix network referral results

- Improved referral results turnaround. 24 hours for emergent, 5 days for non-emergent and Op reports.

8. Fix patient follow-up processes

- Decreased telephone call volumes for appointment requests
- Decreased rate of calls that don't result in an appointment

Metrics Charts

The charts on the following pages describe the activities selected by the Access to Care Optimization WIPT to offer to the Services as options to improve patient access to outpatient care. Each option has the following defined for clarification and standardization:

- metric definition
- metrics to measure successful implementation
- criteria for successful implementation (or benchmark) of the activity.

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ACCESS TO CARE OPTIMIZATION PROGRAM

Activity	Metric(s)	Metric Definition	Metric Calculations	Activity Benchmarks
Fix Enrollment/ Empanelment	Average weighted patient encounters per PCM	Average number of estimated weighted patient encounters per MEPRS available PCM FTE's per year	(Estimated summation of weighted pt encounters per year x RVU) / PCM MEPRS Available FTE's	5400 [AFMS P_2R_2 standard of 25 equivalent Out-patient Visits/PCM/Day * 216 annual duty days]
Assign Access Managers	Meet Access Standards	Percentage of time that access standards are met	Total appointments booked within Access Standards / total booked appointments x 100	Meets access standards > 90% of the time [TRICARE Access Imperatives]]
	Unused appointments (capacity)	Percentage of appointment slots left unused	Total unused appointment / Total slots available appointment slots x 100	< 5% [TRICARE Access Imperatives]
Implement adequate Telephony Network	Call abandonment rate	Percentage of callers who hang up before they are assisted by a live contact/service representative	(Number of calls abandoned / total number of calls received) x 100	< 5% [The Benchmarking Exchange - Call Center Performance Standard Survey 7-25-02]]
	Call response time	Percentage of calls that are answered within 30 seconds from the time the call enters the queue to the point that the beneficiary is provided assistance from a live person	(Total number of calls answered within 30 seconds / Total number of calls) x 100	100% < 30 seconds [TRICARE Access Benchmark, 24-July-02]

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ACCESS TO CARE OPTIMIZATION PROGRAM

Activity	Metric(s)	**Metric Definition**	**Metric Calculations**	**Activity Benchmarks**
Implement Primary Care Optimization	Patient satisfaction	Overall patient satisfaction with primary access to care processes	Percentage of patients rating primary access to care process as "Satisfactory" or above	85% [FCG research]
	Provider satisfaction	Overall provider satisfaction with primary care processes	Percentage of providers rating primary care processes "Satisfactory" or above	85% [MHS experience]
	PCM Continuity of Care	Percentage of appointments made and kept with the patients PCM	Appointments kept with PCM / Appointments made with PCM x 100	None [FCG recommends 40-50%]
	PCM Team Continuity of Care	Percentage of appointments made and kept with the patients PCM Team	Appointments kept with PCM Team/ Appointments made with PCM Team x 100	None [FCG recommends 90%]
	Equivalent Out-Patient Visits/PCM/Day	Average weighted patient encounters that a PCM performs per available duty day	(Summation of weighted pt encounters per month [CPT-4] x RVU) / (PCM FTE's x duty days [18])	25 [AFMS P_2R_2]
	Support staff ratio	Number of support staff per provider	Support Staff* (RN, LPN/MA, clerk) / Provider Staff * Does not include Access Manager / clinic administrator	2.5 [AMEDD & AFMS standard]

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ACCESS TO CARE OPTIMIZATION PROGRAM

Activity	Metric	Metric Definition	Metric Calculations	Activity Benchmarks
Implement Open Access Model where appropriate	Continuity of Care	Rate of appointments made and kept with the patients PCM Team	Appointments kept with PCM Team/ Appointments made with PCM Team x 100	TBD
	Patient satisfaction	Overall patient satisfaction with primary access to care processes	Percentage of patients rating primary access to care process as "Satisfactory" or above	85% [FCG research]
	Appointments seen within target window	Acute and routine appointments seen within 32 hours	(Acute and Routine appointments seen within 32 hours / acute and routine appointments) x 100	TBD [AFMS standard]

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ACCESS TO CARE OPTIMIZATION PROGRAM

Activity	Metric	Metric Definition	Metric Calculations	Activity Benchmarks
Fix Referral Management	Referral Turnaround time	Time required to request a referral until scheduling SC visit	Amount of time (hours) passed from time of referral submission into the health care system to the time appointment was booked	72 hours [TRICARE standard]
	Specialty referrals needing consult / review	Percentage of referrals needing consult review	Referrals needing consult or review / total referrals x 100	5% [FCG Experience]
	Specialty capacity	Percentage of patient care referred back to PCM	(Referrals closed out by PCM / total referrals to Specialty care providers) x 100	None
	Self-referrals	Percentage of self referrals for primary preventative services	(Number of self-referrals for primary preventative services / total referrals) x 100	None

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ACCESS TO CARE OPTIMIZATION PROGRAM

Activity	Metric	Metric Definition	Metric Calculations	Activity Benchmarks
Fix network referral results	Referral Results Turnaround	Turnaround time from the time of the specialist consult until results are received by the PCM	Amount of time (hours/days) passed from the time a consult is performed until the results are received by the PCM	24 hours for emergent 5 days for non-emergent 5 days for Op reports, etc.
Fix patient follow-up processes	Number of calls that don't result in an appointment	The rate of occurrences that a beneficiary contacts the health system but ends the contact without completing an appointment	Total calls that did not result in an appointment / Total calls requesting appointments	None
	Decreased telephone call volumes for follow-up appointment requests	Decrease in the telephone calls for follow-up appointment requests	(1 – (Current period requests / previous period requests)) x 100	None

APPENDIX I

ACCESS TO CARE OPTIMIZATION PROGRAM

The table on the following pages describes in detail the criteria for measuring successful implementation for each activity offered as an option to the Services as a potential improvement project. Each Service was instructed to select one or more of these options to be implemented to improve access at Service selected facilities.

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ACCESS TO CARE OPTIMIZATION PROGRAM

Option #	Recommendation for ATC Improvement	Metrics to Measure Success
1	Redesign process of scheduling follow-up, procedures, primary care, and specialty appointments prior to leaving facility	• **Centrally Measured** - *ATC Summary Report* analysis on TOC for specialty and primary care clinics broken out by type of patient, i.e., Prime, Standard, etc.: a. Avg. days from request until patient sees the provider may decrease b. # and % appointments that met the access standard increases in the target clinics. c. # of consults booked, whether they met or did not meet the access standard, increase overall d. # appts with a Future Access To Care category increase e. # appts with a Specialty ATC increase - *Access Management Report* analysis on TOC a. Unused appointments decrease for both primary and specialty care b. # encounters increase - Military Healthcare Survey - Customer Satisfaction Survey - may need to include questions that more closely address relevant access to care issues in detail.

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Option #	Recommendation for ATC Improvement	Metrics to Measure Success
2	Establish Access to Care Manager	• **Centrally Measured** - *ATC Summary Report* analysis on TOC for specialty and primary care clinics: a. Avg. days from request until patient sees the provider may decrease b. # and % appointments and consults that met the access standard increases - *Access Management Report* analysis on TOC a. Unused appointments decrease b. # encounters increase - *TAT Reports* a. Appointments are open further into the future, i.e. 30 – 45 days out - *PCMBN Report* a. % patients booked with their PCM increase - Military Healthcare Survey - Customer Satisfaction Survey

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Option #	Recommendation for ATC Improvement	Metrics to Measure Success
3	Train MTF and MCSC staff (if applicable) on and implement use of standard ATC measures and tools	• **Centrally Measured** • *ATC Summary Report* analysis on TOC for specialty and primary care clinics: a. Avg. days from request until patient sees the provider may decrease b. # and % appointments that meet the access standard increases in the target clinics c. # met and not met Consults increase d. Future searches decrease e. Facility cancellations decrease • *MEPRS3 Report* analysis on the TOC a. Proper use of appointment types for primary versus specialty care - *Access Management Report* analysis on TOC a. Unused appointments decrease b. # encounters increase - Military Healthcare Survey - Customer Satisfaction Survey • **MTF Measured (optional)** Currently unable to reliably identify MTF staff versus MCSC staff consistently across the MHS in order to measure performance of each group. Sites can develop a local ad hoc to measure this.
4	Train MTF and MCSC staff (if applicable) on appointment process, access standards, and appointing guidelines	Same as Option 3.

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ACCESS TO CARE OPTIMIZATION PROGRAM

Option #	Recommendation for ATC Improvement	Metrics to Measure Success
5	Simplify access for primary care appointing (800# for each MTF)	• **Centrally Measured** • Analyze *ATC Summary Report* from TOC for specialty and primary care clinics by type of patient, i.e., Prime, standard, etc.: a. # appointment searches increase - *PCMBN Report* Analysis on the TOC b. % patients booked with PCM increases - *Access Management Report* Analysis on TOC a. Unused appointments decrease in primary care clinics c. # encounters increase in primary care d. # walk-ins decrease in primary care - Military Healthcare Survey - Customer Satisfaction Survey
6	Upgrade each MTF's Telephony capability	• **Centrally Measured** - *Access Management Report* analysis on TOC b. Unused appointments decrease c. # encounters increase - Military Healthcare Survey: Adult - Customer Satisfaction Survey a. Include a specific question on satisfaction with telephone access and service. • **MTF Measured (optional)** a. Volume of calls increase b. Analyze call times using telephone statistics (Report from Services) c. Dropped calls decrease d. # minutes before contacting a human e. length of phone calls decrease

APPENDIX I

ACCESS TO CARE OPTIMIZATION PROGRAM

Option #	Recommendation for ATC Improvement	Metrics to Measure Success
7	Hire personnel to increase access or clinic hours	• **Centrally Measured** • *ATC Summary Report* analysis on TOC for specialty and primary care clinics: a. Avg. days from request until patient sees the provider may decrease - *PCMBN Report* analysis on the TOC b. % patients booked with PCM increases - *Access Management Report* analysis on TOC a. # available appointments will increase c. # encounters increase d. # walk-ins may decrease • *TAT Reports* a. Appointments are open further into the future, i.e. 45 days - Military Healthcare Survey: Adult - Customer Satisfaction Survey
8	Hire Nurse Triage personnel and implement best practices at local facilities	• **Centrally Measured** a. Customer Satisfaction Survey improve b. Consider adding question that specifically addresses Nurse Triage ▪ **MTF Measured – Report to TMA** - Use AF Model/Tool Kit • ACD Volume/details improve • # calls redirected to Triage increase • Caller Demograhics/Reason for Call • Clinical Outcomes a. Appropriate Decisions (peer review) b. Self-care increases by ca. 30% • Financial Outcomes a. Disposition vs. Original Inclination b. Cost/Risk Avoidance • Identify Protocol Used

APPENDIX I

ACCESS TO CARE OPTIMIZATION PROGRAM

Option #	Recommendation for ATC Improvement	Metrics to Measure Success
9	Implement Open Access at local facilities	• **Centrally Measured** • *ATC Summary Report* analysis on TOC for specialty and primary care clinics: a. Avg. days from request until patient sees the provider should decrease and be less than 24 hours b. # and % appointments scheduled within 24 hours increase c. # future searches decrease d. # facility cancellations decrease e. # no-shows decrease • *MEPRS3 Report* analysis on the TOC a. Clinic only uses OPAC and EST appointment types in schedules b. # OPAC appointments greater than sum of acute and routine before change to Open Access - *Access Management Report* analysis on TOC a. Unused appointments decrease b. # encounters increase • Military Healthcare Survey • Customer Satisfaction Survey
10	Improve transportation to increase access to care	• **Centrally Measured** • *ATC Summary Report* analysis on TOC for specialty and primary care clinics: a. # no-shows decrease • Military Healthcare Survey • Customer Satisfaction Survey

APPENDIX J

OPEN ACCESS APPOINTING

APPENDIX J

OPEN ACCESS APPOINTING

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ACTIVITY

MAY 7 2002

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Open Access Appointing

Open access (also known as advanced access) appointing is viewed by many as a revolution in the process of developing schedules and booking medical appointments. The basic premise of open access appointing is that beneficiaries will see providers on the same day that they request an appointment. Many Military Treatment Facilities (MTFs) in the Military Health System are contemplating adopting this appointing strategy. It must be understood that implementing open access requires a firm commitment from leadership, a great deal of planning, and significant up-front training for staff who schedule appointments. In an effort to ensure that this process remains standard, the TRICARE Management Activity's (TMA's) Appointment Standardization Integrated Program Team has published the attached guidance for MTFs to follow when implementing open access appointing. This information will also be included in the *Appointment Standardization Commander's Guide to Access Success.*

It is strongly recommended that facilities that are considering implementation of an open access appointing methodology perform extensive research and develop a sound business plan. MTFs will coordinate their intentions with their respective Lead Agent, Service Intermediate and Service Level Commands, and TMA's Regional Operations Directorate at least 60 days in advance of opening open access schedules. This advance notice and prior planning is to ensure that contractual, customer expectation, staffing and service integrity issues can be avoided and improve the chances of success for open access appointing at given sites.

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Thomas F. Carrato
Executive Director

Attachment:
As stated

cc: Lead Agents

APPENDIX J

OPEN ACCESS APPOINTING

Foreword

This section of the *Commander's Guide to Access Success* will describe a new booking model titled Open Access (or Advanced Access). The section will cover the methods to use to book these appointments using a standard methodology. The objective is for Military Treatment Facilities (MTF) who elect to implement Open Access to be able to measure patient access consistently and accurately and monitor success or failure up front. 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. Case studies from facilities at Hill AFB, Utah and Ramstein AB, Germany, are included in Section VII of this appendix.

I. What is Open Access?

Open Access (also referred to as Advanced Access Appointing) is viewed by many as a revolution in the 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 basic principle and 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 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, 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-driven, with all preferences for appointment time 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 that wishes to undertake this model. Due to its non-intuitive nature, regular and consistent training and 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. Open Access appears to improve staff and patient satisfaction in many but not all settings; its impact on improving physician/provider retention in the military is unknown.

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In order to successfully implement the Open Access model, the physician's "bad" appointment backlog must first 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 military treatment appointment schedules. Many of these types of appointments are of a routine or follow-up nature and could or should be seen sooner rather than later. It is called "backlog" because this inventory of appointments results in a longer and more frustrating waiting time for the appointment on the part of the patient. "Good backlog" is generally acceptable and consists of appointments made by patients who request an appointment other than today because of convenience or preference expressed by the patient. An additional critical requirement and potential failure point is that clinics must be optimized to provide the necessary support staff to prevent burn out.

Open Access works best when it provides incentive to the system to do today's work today. 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 a provider sees his/her own patients, the incentive is to do everything possible to complete all the work needed to care for that patient, including follow-up work. This only occurs when the provider is seeing their own patients i.e., ownership. If providers take care of all their own work today, on average each provider will see 20 patients a day, but a few days (on the far end of the bell shaped curve) some providers will see 30 patients and others will see 10 patients.

Open Access may allow Military Treatment Facilities (MTF) to re-examine the role of demand management programs. For example, nurse triage may become more valuable in determining WHO the patient should see (e.g., their PCM, a nurse, or a technician) rather than WHEN the patient should be seen.

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 know 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 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/leave early

Disadvantages include:

- surges in demand may require that providers and support staff work extended hours
- staff and support staff burn out is possible
- requires frequent, possibly daily, schedule review and adjustment
- requires provider and staff buy-in
- frequent or seasonal staff turnover, deployments, etc., can cause access problems 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"

II. How is Open Access Administered?

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 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. This is a misleading simple measure as it can take quite some time to collect this kind of data. Without question, the clinic must ensure that they are appropriately staffed so they can see today's calls today most of the time. Many clinics that utilize Open Access have found that about 75% 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.

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Implementing Open Access requires a firm commitment from leadership, clinical and administrative staff, etc. 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 likelihood of success is significantly diminished without strong buy-in from the clinic staff. In addition, implementation during periods of high demand (e.g., when there has been frequent staff turnover or during the flu season) has proven to be problematic.

Managing an Open Access clinic requires significant up-front training for staff who schedule appointments. Under Open Access, patients calling for an appointment today – whether for a routine or an acute problem – will be booked into the Open Access appointment type (OPAC), but will be classified differently in the Access To Care module of MCP. To manage an Open Access clinic, no distinction is made between routine and acute care for patients who call in today, unless the visit requires resources that are not present every day (e.g. specific personnel, equipment, etc). Follow-up care should be avoided if possible so that ALL the patient's issues are addressed in a single visit in order to eliminate the need to add future appointments/repeat visits for the same patient. These booked repeat visits are what add stress to the system and backlogs of appointments. Required follow-up care should be estimated and schedules should contain sufficient open appointments in the future to meet the need for follow-up visits or patients who desire to schedule an appointment in the future for personal reasons. The clinic at Hill AFB has implemented a split of 70% open access and 30% follow-up appointments in the Primary Care schedules. Alternatively, in Region 2 all appointments for an Open Access clinic are OPAC including follow-up and wellness appointments and all care is delivered the same day. Good backlog is indicated by the recording of appointment refusals when patients elect care on a future day. In any case 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.

Template and real-time schedule management are essential. If necessary, additional appointments may need to be added to meet demand, or unused follow-up appointments may need to be transitioned to an Open Access appointment. Open Access appointment schedules will use only one standard appointment type: the new Open Access (OPAC) appointment. The objective is to see any patient for any care the day the patient calls for an appointment. If the patient refuses an appointment offered today and is booked another day, then an appointment refusal is logged for the patient and the appointment is only counted as a refusal, not as a 'not met' for the clinic. If there is no appointment available today and the patient is booked on another day, then the

appointment is counted as a 'not met' for the clinic's access measurement Until clinics have worked out the open access schedules and booking procedures, appointments for Established (EST), Procedures (PROC), and Wellness (WELL) for annual GYN exams may be needed. A new detail code will be included in APS III (due out October 2003) to help sites manage and schedule appointments for good backlog, GDBL..

Schedules should be carefully monitored to ensure that booked appointments are not overtaking the number of appointments designated as open. An excellent instrument is the MTF Template Analysis Tool that can easily show how the MTF is utilizing its capacity for appointments. This tool will also show the number of unused appointments on a daily basis. The MTF clinic 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. In addition, in the event that the patient's PCM is not available when they call or when the patient wishes to be seen, sites may use the Cross Book (CB) detail code to reserve appointments for the PCM for TRICARE Prime patients who are enrolled to another PCM. All other appointments are for the PCM's TRICARE Prime enrollees in support of continuity of care. Appointments other than the Open Access appointments (OPAC) should be corrected when booking the appointment to reflect the type of care scheduled for the patient so that sites can assess access to care. Some sites are freezing all future Open Access appointments (other than today's appointments) to prevent these appointments from being booked in advance of today.

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. Define the meaning of "Today", i.e., today, not within 24 hours. Morning huddles are a good idea to review the day and develop coordinated tactics.

Maintenance of provider panel sizes to manageable levels is critical. The military 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 (refer to authors Murray and Tantau on Open Access). 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 is consistently available to handle the patient demand. Most failures occur when demand for appointments is undermined by the loss of a 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 allow for flexibility and response to the patient's requirements.

Lastly, 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's case. While this may be self-evident, it works with Open Access. 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 and is not absent for extended periods of time. This phenomenon is known as "Percentage of Continuity" and must also be regularly measured.

These concepts are interlocking and must be equally considered and implemented. It must also be stressed that there is no "cookie-cutter" approach and that each clinic must adapt and customize practices based on the clinic's own features and services.

III. Appointment Standardization Business Rules for Open Access

MTFs that elect to implement Open Access should adhere to the following business rules.

- Each site that is contemplating a move to the Open Access appointing methodology will perform extensive research and should develop a business plan. Sites will assess their capacities, provider availability, true demand, provider-patient continuity, wait times for appointments tracked over time, and office flow patterns with any predictable surges and troughs.
- Sites will coordinate their intentions with their respective Lead Agent and Service Intermediate and Service Level Command at least 60 days in advance of opening Open Access schedules. Sites should be prepared to brief their capacity and ability to successfully undertake Open Access. This coordination will give these organizations time to provide needed funding, resources, support, and oversight. Contractual, customer expectation, staffing

and service integrity problems can be avoided with advance notice and prior planning. This will improve the chances of success for Open Access appointing at given sites.

- Beneficiaries should not be informed of the new practices until a reasonable success rate and transition period have been established and proven. Historical evidence has shown that premature marketing and advertising serves only to confuse beneficiaries or engender high and unreasonable expectations. All activities during the transition period should be invisible to the beneficiary who should only notice that their ability to get an appointment has greatly improved.
- Upon notification from the candidate site, the Lead Agent will inform the TMA Access Project Manager. The Lead Agent will address any necessary changes to existing Regional Agreements/Memorandums of Understanding before implementation can proceed.
- The Lead Agent, in collaboration with TMA, will coordinate Managed Care Support Contract changes and other administrative changes to ensure smooth implementation and a coordinated schedule.
- Open Access appointments will be indicated in schedules and templates with a new appointment type, OPAC. The access standard will be 24 hours, but is actually today. The Access to Care Category will be Acute. The definition of this appointment type and a scenario are listed in Section IV below. Schedules may use the GDBL detail code to manage appointing for 'good backlog'.
- If clinics elect to use other appointment types, they should use the appropriate standard appointment types and the applicable Access To Care categories for each appointment type as defined in the standard appointment type definitions in the *Commander's Guide to Access Success*, i.e., ACUT, EST, SPEC, WELL, PROC, and GRP. The current *Commander's Guide to Access Success* is found on the TMA Access Imperatives web page at http://www.tma.osd.mil/tai.
- Sites have a new optional feature to help with Open Access continuity of care, a new Detail Code titled Cross Book (CB). Use of the CB detail code is not mandatory but, when used, will limit the appointments in a PCM or PCM Group schedule for TRICARE enrollees who could not obtain care with their own PCM or MTF. If a candidate site wishes to use the CB detail code, its use will be discussed in their business plans prior to opening schedules for open access booking and they will inform the Services, Lead Agents, and MCSC. This is to ensure there are no contract issues. CB may be used for other than Open Access appointments.

- Inform patients that they are being booked into Open Access and how it works. It has been recommended that the term Open Access not be used in marketing to patients as they may interpret this term as walk-in access without an appointment. Sites may want to come up with their own catch phrases such as advanced or enhanced access.
- TMA is working on several reports that will appear on the TRICARE Operations Center (TOC) web page to measure access to care for Open Access and other types of appointments. Refer to Appendix G, Standard Appointment Types Utilization Reports, for a detailed description of these reports.
- MTFs will develop and share ad hoc reports to assess the performance of Open Access.

IV. OPAC - Open Access Appointment Type Definition and Scenario

Definition: The OPAC appointment type is designated for patients who call in today and require an office visit with their Primary Care Manger (PCM) or a specialist. All types of appointment are included under the OPAC appointment type, e.g. acute, routine, wellness, and follow-up. Every effort will be made to allow patients to see their own physician on the same day that they request an appointment, but the clinic does not open itself into a full walk-in type service. Follow-up care should be avoided if possible so that ALL the patient's issues are addressed in a single visit so as to eliminate the need to add future appointments/repeat visits for the same patient. Patients may be routed through Nurse Triage, if available, before the OPAC appointment is booked. The Nurse Triage can offer other appropriate alternatives for care such as self-care. In those locations where Nurse Triage is not in place, the concept of "prudent lay-person terminology" will be used in determining whether the patient can wait for a scheduled OPAC appointment or told to report immediately for acute service. OPAC appointment types will only be used in clinics at MTFs that have coordinated their use prior to establishing an open/advanced access appointing process with their Lead Agent and Service Commands.

The OPAC appointment type will use a 24-hour Access To Care standard and map to the Acute ATC category. However the appointment should always be booked the day of the patient request.

Scenario: Mrs. Snuffy has been experiencing a pain in her shoulder joint area for a couple of days and calls the 1-800 TRICARE Appointment Line on Monday morning to

schedule a visit with her Primary Care Manager. The appointment clerk, at an Open Access MTF, in accordance with local guidelines or scripts determines the patient's needs and reaches the decision point to transfer Mrs. Snuffy's call to the Triage Nurse. The Triage Nurse, using approved protocols, rules out self-care and determines that an open access appointment is necessary. Mrs. Snuffy is told that appointments are available at several times Monday afternoon. Mrs. Snuffy chooses an appointment time of 1400 and, using the Order of Precedence for Appointments Search business rule, the Triage Nurse books the OPAC appointment and gives Mrs. Snuffy appropriate instruction.

V. 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. The fundamental delay that Open Access seeks to remove from clinic operations is the delay to the next available appointment. This is the single most important measure of progress and success. Check on a regular basis in CHCS for the third next available appointment for each clinician participating in Open Access. Pick a routine appointment type, with a reasonable volume of services that tends to be the least available, i.e., a well-baby or a routine physical appointment. Use the third available appointment for each PCM and for the clinic as a whole. Better to measure from the patient perspective, including weekends. This means counting Saturday and Sunday in the delay.

Data tracked by TMA (http://www.tricare.osd.mil/tools/Tat/TOC/TAT.htm) provide a different view of appointment availability. For purposes of Open Access, the view of future appointment availability provided by the MTF 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.

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 total number of patients seeking services—patients who call the clinic for advice, those who unsuccessfully seek service, and patients who obtained appointments (the sum of all requests to your MTF for care). To measure demand requires examining booked appointments, patient calls for care, and patient services delivered each day, to obtain a reflection of what our work would look like if we did today's work today. This measurement should include those patients that tried to access the system but failed in some way (e.g., hung up, disconnected, left without being seen, could not get an appointment, 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, Urgent Care, possibly emergency department 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 patient perspective (how often patients assigned to PCMs actually see their PCM when they come in for care) rather than from the provider perspective (how many of the patients each provider sees are on the provider's panel).

4. *Panel Size*
An important element of keeping supply and demand in balance is equalizing panel sizes, combined with other efforts to make providers accountable for managing their panel.

5. *Productivity*
A combination of improved office efficiency, changes in clinic schedules, and reduced no-shows can improve provider productivity. This metric is also of interest to Open Access to see the potential impact of improved operations on this important indicator of capacity.

6. No-Shows
In sites that have implemented Open Access, the percentage of patients who

fail to show up ("No-Shows") for scheduled appointments dropped significantly. The metric is of interest because no-shows represent a misuse of supply. No-show metrics are obtained fairly easily from the CHCS.

7. *Cycle Times*
Cycle times measure the amount of time a patient spends receiving care from arrival to departure. Shortening of cycle times is a good indicator of improvements in office efficiency, both patient flow and workflow, which in turn improve capacity. CHCS does not currently collect this data so these metrics will have to be determined locally.

8. *Satisfaction Measures*
Measuring satisfaction of patients and staff before 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. This includes both seeing patients today, as well as completing all related administration and paperwork that flows into the clinic.

   a. *Patient Satisfaction* - Has patient satisfaction increased? 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? Ask patients the above questions when they call to schedule an appointment, or give them a quick survey to complete in the reception area. Refer to existing patient satisfaction surveys collected by the MTF. These are either by episode or annual overall collected by TRICARE.
   b. *Staff Satisfaction* - Are the staff and physicians more satisfied? 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 providers and staff get time-off when they request it? Do they get to go home when the clinic closes, or do they have to stay late to do paper work?

VI. Some Recommended Steps to Implement Open Access

Step Nbr	Open Access Implementation Step	Completion Date	POC
1	Define MTF Commitments		

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Step Nbr	Open Access Implementation Step	Completion Date	POC
1a	Determine patient population		
1b	Determine patient demand for care (See Section II, paragraph one, and Section III above for guidelines)		
1c	Perform optimization/efficiency analysis to determine proper use of clinical staff such as the use of non-physician staff in place of providers for work that is neither related to patient care nor administrative in nature.		
1d	Plan and implement above efficiencies		
1e	Develop a business plan to book patients to meet the continuity of care goal that patients will be booked to their own PCM as close to 70% of the time as possible.		
1f	Assess appointment system capability for increase in same day appointing and medical records processing		
2	Determine staffing required		
2a	Implement new staffing responsibilities		
2b	Assure adequate staffing to support open access		
2c	Determine impact on medical records and appointments services		
3	Sixty days prior to implementation, sites will coordinate Open Access implementation with the Lead Agent and their Service Intermediate Command.		
4	The Lead Agent will coordinate implementation with the Managed Care Support Contractor (MCSC) (if they book appointments for the site) and ensure Regional Agreements/MOUs are updated as needed.		
5	The Service representative and Lead Agent will inform the Service Access Project Manager that the site is implementing Open Access.		

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Step Nbr	Open Access Implementation Step	Completion Date	POC
6	The Lead Agent in collaboration with TMA will coordinate contract changes and other administrative changes to ensure smooth implementation and a coordinated schedule.		
7	Sites must inform the Services, Lead Agents, and MCSC if they plan to implement the Cross Book (CB) detail code to support continuity of care and to ensure that PCM appointments are available to enrollees when the patient's PCM is not available.		
8	If using the Cross Book detail code (CB), booking staff must be trained to understand that the CB detail code may be used to set aside appointments for patients who are unable to get care with their own PCM or at their MTF. By default (and this is a training issue), PCM or PCM Group enrollees will have priority for appointments without the CB detail code.		
9	The TRICARE Contractor will be instructed to book into the first available appointment.		
10	Develop a plan to reduce patient appointment backlog.		
11	Publish instructions to the staff documenting procedures, responsibilities, and schedules to reduce the backlog.		
12	Set up templates and schedules for Primary Care using only the OPAC appointment type to indicate Open Access appointments. This is the only appointment type that should be used for Open Access appointments and will cover at a minimum routine and acute appointments booked the same day.		

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Step Nbr	Open Access Implementation Step	Completion Date	POC
13	Sites may freeze OPAC appointments so those appointments cannot be booked in advance, then release them within 24 hours of the appointment. However, sites must be careful to coordinate any template management programs with existing guidance if participating in other appointing initiatives such as TRICARE On-Line patient web booking.		
14	In clinics that are not Open Access, use the standard appointment types per Appointment Standardization guidelines. These appointment types will be used to track access to care (ATC) at the clinic and should match the ATC category.		
15	Arrange for delivery of medical records to the clinic.		
16	PCM or provider directed follow-up appointments should be arranged before the patient leaves the clinic.		
17	Monitor schedules daily. If EST or WELL appointments will expire soon without being booked, change the appointment to an Open Access appointment in the schedule only if needed.		
18	Sites will define and implement metrics to measure the ongoing progress and status of Open Access including:		
19	Develop Ad hoc reports to track Open Access Appointments and the average days for patients to get an appointment for the OPAC appointment type.		
20	After a careful transition period, the site will declare itself an Open Access site and inform the patients. Sites may want to use a different project title than “Open Access” as the patient may interpret Open Access as open walk-in .		

VII. Examples of Open Access Implementation in the Military Health System

The following two MTFs have implemented their own version of the Open Access appointing model in a Primary Care setting: Hill Air Force Base in Utah (a clinic) and Luke AFB in Arizona (a bedded facility). The processes and lessons learned from each model are described below. As many as 15 or 16 sites have tried and many have succeeded in implementing Open Access.

Open Access at Hill Air Force Base, Utah (a clinic, not a bedded facility) (as of Aug 8, 2003)

Analysis: Hill introduced open access (OA) appointing in June 2001. Hill determined that 75% of its Primary Care calls are same day demand and up to 1.5% of all enrollees request appointments each day. Based on data two and a half years ago, a Primary Care patient seeks care on average of four times per year, Hill graphed the monthly demand for appointments. The graph showed that the patient population fluctuated up and down by 100 to 200 patients from month to month and increased 621 over a year from 16,200 to 17,500. Present patient population is now 19,910. Hill also consulted and used the civilian utilization rates of 800-2,500 patients per Primary Care Manager (PCM). Present Family Practice (FPC) PCM enrollment is approximately 1,395 per PCM. Pediatrics (Peds) is also 1,395 per PCM.

Enrollee demand for Primary Care fluctuated up and down by 100 to 400 appointments per month and actually dropped approximately 800 appointments per month when Open Access was implemented in June 2001. Under Open Access, the reduced level was sustained partially throughout 2001. The following reflects the average monthly patient visits:

	Pre-Open Access	Post-Open Access
FPC =	2549	3419
Peds =	854	1083

This increase in patient visits reflects increased enrollments, better productivity, and recapture of patients due to Same-Day access appointing.

Staffing: Hill created two pods with five PCM/Primary Care Element (PCE) teams in Family Practice and three PCM/PCE teams in Pediatrics. Each team consists of one provider (either a physician assistant, nurse practitioner, or physician), one administrative technician (the Air Force provided an additional authorization of .5 FTEs (administrative

technician) per PCM Team, as part of an Air Force Primary Care Optimization project in mid Sep 02), two medical technicians, and one nurse. Support staff members are used to provide extended care. One provider (Family Practice/Pediatrics, and Flight Medicine) is on-call during off-duty hours to authorize emergency room and urgent care visits.

Templates and Schedules: Hill implemented template and schedule management for Open Access. Appointments were booked as either same day (an ACUT appointment type – now using OPAC) or not same day (EST appointment type). All appointment lengths are 15 minutes. Appointments are double booked every half hour (total of 4/hour) to increase efficiency. For the majority of the providers, the last appointment of the day is at 1530-1545, but the clinic remains open until 1900, with late provider booking until 1830. Another lesson learned to improve Front Desk Check-ins was to stagger provider schedules. Half of the providers' first appointments begin at 0730, the other half begin at 0745. This prevents an initial surge of patients checking in at the same time and allows staff to keep exam rooms consistently full. PCMs are scheduled to spend an average of 70% (and as high as 76%) of their time physically in the clinic. Hill created schedules for technicians in order to manage their time and is in the process of linking technician and provider schedules in order to enhance team efficiency.

Hill worked with the Appointment Standardization IPT to define the Hill templates and schedules to conform to the new Appointment Standardization guidelines. Hill established the OPAC appointment for use with all MTFs utilizing Open Access – as the replacement for ACUTE and same day appointments.

Booking: Open Access is implemented in Primary Care, Flight Medicine, and Pediatrics. OPAC appointments are bookable only on the day of the appointment. Urgent care for the next day must be booked into EST appointments. PCM$ appointment type is used for Right Start (newly arrived personnel) appointments. OPAC$ is used for active duty sick call appointments and are frozen then released (as are OPAC appointments). The majority of walk-in appointments are assigned when demand exceeds capacity. Patients may cross book to another PCM Clinic team only if their PCM or that PCM Clinic team is unavailable. We tested a reengineered schedule in which patients are double booked on the half-hour so one patient can be prepped while the other is being treated. This has been very successful and is now a part of our standard schedule templating.

Successes: Pre-Open Access, the average total wait time for all Access to Care (ATC) categories at Hill was 7 days; the Post-Open Access wait time is now 4 days. Hill meets and often exceeds the access standard for 90% of all access to care categories, for the entire Medical Treatment Facility. For Primary Care Open Access ATC:

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OPEN ACCESS APPOINTING

Pre-Open Access	*Post-Open Access*
Acute = 92%	99%
Routine = 68%	95%
Specialty = 90%	96%
Wellness = 93%	95%

Waiting times have also been well under the MHS standards at Hill:

Pre-Open Access	*Post-Open Access*
Acute = 0.58	0.19
Routine = 8.1	2.36
Specialty = 12.6	7.05
Wellness = 11.8	**8.7**

PCM and PCM Team (PCE) Patient Continuity at Hill:

	Pre-Open Access	*Post-Open Access*
MTF	**= 44%**	**68%**
MTF PCM Team/PCE	**= 60%**	**93%**
FPC PCM	**= 36%**	**68%**
FPC PCM Team/PCE	**= 55%**	**95%**
Peds PCM	**= 52%**	**68%**
Peds PCM Team/PCE	**= 65%**	**99%**

Additional 0.5FTE, 4A, Administrative Support per PCM Team, Record Availability:

Pre 4A Contract	*Post 4A Contract*
70%	92.3%

No-Show rates:	**Pre-Open Access: 6.9%**	**Post-Open Access: 3.6%**
Cancellation rates:	**Pre-Open Access: 11.8%**	**Post-Open Access: 8.9%**
Walk-In rates:	**Pre-Open Access: 12%**	**Post-Open Access: 7.1%**

Network and Emergency Room Utilization have decreased. Hill continues to book some appointments in the future ATC category (3 to 5 %) and implemented a patient reminder system in February 2002. In October 2001 Hill had 28.6 Relative Value Units (RVU) per PCM per day, up from 18.3. These are weighted average workload tied to Evaluation and Management (E&M) codes. Hill seems to be recapturing the civilian work.

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OPEN ACCESS APPOINTING

***Lessons Learned*: Doing "Today's Business Today" is realistic and achievable, maximizes patient visit and staff efficiency, increases patient access and satisfaction, and results in less cancelled/rescheduled appointments since 75% of provider appointments are frozen until the day they are required.**

Key Success Factors: Executive leadership and staff buy-in, dedicated data quality and data analyst to manage the business data to support accurate, current data driven decision metrics, thorough Business Case Analysis, a dedicated full time group practice manager and support (at least a template manager), support staff for each PCM trained to their full job descriptions and capabilities, management oversight and support, contract of access to only the enrolled population, a commitment from the staff to make it successful, and the resources to dedicate to the pre- and post-maintenance in starting and sustaining Open Access.

Successful Implementation of Open Access at Hill AFB resulted in increased patient and staff satisfaction, increased access and reduced waiting times, reduced patient cancellations and no-shows, a manageable PCM enrollment ratio, increased PCM and primary care team continuity, reduction of unnecessary visits, and financial improvement through the reduction of MTF staff non-productive time from cancellations and no-shows.

Problems Encountered by the Hill staff doing Open Access appointing included constant attention to the appointing process, a full FTE requirement for template management, increased patient education to call when appointments are needed ("Trust us, we will be able to see you the day you call"), staff education and support to do "Today's Work Today" until it is finished, lack of contractor support to correctly book into Open Access appointments, provider and staff buy-in to minimize nay sayers, and maintaining the approach during periods of short staff to avoid staff burn out. Until the additional .5 FTE for administrative support was funded, poor record accountability and availability resulted in numerous patient visits without records. Authorized Vs assigned PCM/PCE staffing is an ongoing problem, concern, and challenge. Usual staffing of 4N's is 50%, 4A's is 50%, and RN is 70%. A few of the constant challenges and limitations include: Readiness/UTC training and deployments, Base Ready Teams (SP augmentees, Search and Recovery Teams), TCN Escort Deployments, Drug Demand Reduction Support, and unfilled position authorizations, beyond the control of the MTF/CC.

Summary: Maintaining Open Access, once implemented, is the most challenging part. However, the rewards from its successes far outweigh the effort for the amount of maintenance needed compared to running a traditional appointing process.

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The pressure to revert back to the "Old System" of limiting supply to a comfortable level is significant and challenging. This is the main challenge for leadership to maintain Open Access appointing. The ultimate success or failure depends on resisting this pressure and changing the paradigms of military medical care.

Updated: 8 Aug 03
Data and information provided by Richard C. Umpleby, GS-11, Data Quality Manager, Hill AFB, UT

Additional review and input by:
Maj Mark Devoe, GPM
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Reviewed and Approved by:
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Col Larry H. Isakson, Commander, Medical Operations Squadron
Col Stephen G. Reinhart, Commander 75th Medical Group

Red Dragon Open Access at 56 MDG: Luke AFB, AZ (*bedded facility*)
(as of 4 Feb 2003)

Analysis: Luke has total enrollment of approximately 31,000; 21000 are enrolled to the three family practice teams. After researching lessons learned from industry and other bases, we began by considering several critical measures that were considered imperative to implementing an open access model.

- Patient population/panel – Who are they? What resources do they use/need? When do they use them? The Health Care Integrator looked at all 21,000 enrollees to ensure patients were divided evenly among teams. We used 7,500 enrollees per team to allow for continued growth.

- Continuity - One of the primary concerns of the providers was being able to see his/her own provider when s/he seeks care.

- Demand – By looking at historical appointment and patient usage data, it was determined that Luke beneficiaries use primary care an average of 3-4 times per year, which drives 26,250 visits per team annually (7,500 x 3.5 = 26,250).

- Access –26,250 appointments per team translates to 122 appointments per day per team. (26,250/216 duty days per year = 122)

- Appointment Mix – It was determined that the proper mix between same day appointments and future booked appointments was 70% same day and 30% future. It is critical however, that the templates be actively managed daily in order to ensure the proper balance.

- No-show – Luke was averaging somewhere around 100 no-shows per week which equates to one PCO team sitting idle one day a week.

- Backlog reduction – Luke calculated its backlog at 6.3 days for all of Family Practice. That means that if we would have stopped booking new patients all together it would have taken us 6.2 days to clear all the future booked appointments.

Staffing: Staffing for each Red Dragon team includes 3 Family Practice Providers and 2 Physician Assistance (PA). One PA is unempanelled and the entire 7,500 is considered his/her family. The unempanelled PA's templates are full of open access (OPAC) appointments and this PA is considered the workhorse of the team. The PA functions as an acute care clinic in the event the primary PCMs schedule becomes filled and is able to provide flexibility in the event one of the other providers on the team is out. The other PA and the three physicians each have approximately 1900 patients enrolled to them. Support staff for the team includes 5 nurses, 10 medical technicians, and 3 administration techs. The additional 2 administration technicians were sent to Central Medical Records (Patient Admin) so the intent of PCO is met with this design.

Templates and Schedules: The primary appointment types used are Same Day Open Access (OPAC) and Established (EST; not booked same day). The Routine appointment type (ROU) is not used. Appointment lengths are 15 or 20 minutes; some batch appointing is used (appoint multiple patients to same time slot, i.e. 2 patients every half hour). Group appointments are infrequently used.

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The Executive staff strongly supported the transition to the Red Dragon concept and implemented policies to limit the amount of meetings and appointments scheduled during clinic time. Meetings and appointments are scheduled first thing in the morning or at the end of the day. Roles were also defined throughout the MTF to ensure ancillary service departments' hours coincide with provider start times.

Booking: The theory is that patient gets an appointment, without regard to perceived need or urgency. The patient decides when he or she needs to be seen. Templates were built to create a total capacity of 128 appointments when all providers were in clinic. Appointments are opened at 1200 each day and all acute appointments are booked within 24 hours. If no appointments are available, Central Appointments will T-Con the clinic nurse and a walk-in appointment will be made.

Successes:

- The percent of Acute appointments which meet access standards is up from 96% in Jan 03 to 98% in Jun 03. The percent of Routine appointments which meet access standards is up from 84% in Jan 03 to 95% in Jun 03. Access standards have been maintained during the summer "underlap."

- Patients see their PCM by name 92% of the time, which is up from 66% in Jan 03. Patients see a member of their PCM team over 98% of the time.

- Demand for appointments has dropped over the past 6 months while emergency room visits have remained unchanged. This indicates that demand is dropping as the patients begin to trust that they can get an appointment when they call.

- Of note, enrollment has also increased by over 1000 patients with no increase in staffing.

- No-show rates have decreased significantly because patients get appointments the day they call.

Lessons Learned:

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OPEN ACCESS APPOINTING

- Provider buy-in is extremely important to implementing an open access. Providers should be included in the development of the model.

- Provider availability is key.

- Red Dragon support staff (nurses and technicians) *must* be available.

- Whole facility concept must be reviewed before implementation (medical records, ancillary service, etc.)

- A plan must be in place to reduce backlog before the model is implemented. Teams that did not have as long to reduce backlog had a much harder time transitioning to the new model.

- Clear guidance needs to be in place for those patients that choose not to have a same day appointment. This plan needs to briefed to the Central Appointments staff so that no patient is told to call back on the day they want an appointment.

- The Red Dragon model does a great job of providing flexibility when one provider is out, but contingency plans need to made for when more that one provider is out. The model calls for appointments to be added to the remaining providers schedules but if that does not happen access will suffer.

- Executive staff support and attention is critical to success.

APPENDIX K

TBD

APPENDIX K

TBD

APPENDIX L

APPOINTMENT STANDARDIZATION PHASE III (APS III)

APPENDIX L

APPOINTMENT STANDARDIZATION PHASE III (APS III)

In October 2003, six new CHCS System Change Requests (SCR) and one System Incident Report (SIR) # 32107 will be released in Appointment Standardization Phase III. These enhancements will help MTFs with access to care management and improvement. The System Change Request documents and the System Incident Request are included below with a description of the new functionality and the justification for the change.

I. Change Requested: Highlight Appointments that Match Both Access to Care Standards and Detail Codes that Match the Patient's Demographics

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

In all MCP Booking functions, during appointment selection, the system shall display ALL available appointments that meet the primary selection criteria and are scheduled for today through and including 28 calendar days in the future with one exception. When booking a referral with a Future ATC Category, the system will display appointments out 180 days. Within this list, the system shall highlight those available appointment slots that match all of the following criteria:

(1) the appointment is within the associated ATC Category access period (at the 24 hour mark)
(2) the appointment type is appropriate for the ATC Category (see rules below)
(3) the patient's demographics match any detail code criteria specified on the appointment slot including patient age range, patient gender (FE and MA), and patient access type (BP detail codes).
(4) If possible, place all the highlighted appointments at the beginning of the list.

Appointments that are not highlighted will still be able to be selected. Only clerks with the SD APPT STAND security key will be allowed to select and book these non-highlighted appointments. If a clerk selects one of the non-highlighted appointments, the system will warn the clerk that the appointment is not a match to the patient's needs. The warning will display at the time the appointment is selected, not when filing the appointment.

Clerks with the SD APPT STAND security key will be required to correct the appointment type and detail codes to match the Access to Care Category and the patient demographics. The clerk may then book the appointment.

If the clerk attempts to book an appointment with a gender detail code or age detail code that is inappropriate for the patient, then CHCS will warn the clerk and explain the exact data element

that is the problem. A special security key (not SD APPT STAND) is required for a clerk to override age and gender. If the clerk has this security key, CHCS will allow the clerk to change the age or gender detail codes, enter an override reason, and book the appointment. If the clerk does not have the security key, CHCS will not allow the clerk to book the appointment.

If the user changes the search criteria, the system shall again highlight the matching appointments that meet the new search criteria. The functionality described in the paragraphs above will be applied to the selection of an appointment.

The system will calculate whether the final appointment with all corrections meets the access to care and detail code criteria as per criteria 1 through 3 above and ensure that the user makes the appropriate corrections.

The rules to map Appointment Types to Access to Care Categories follow. The appointment type should always be consistent with the ATC Category even though the appointment is booked outside the access standard, i.e., an ACUT booked out 48 hours with an Acute ATC Category.

ATC Category	Appointment Type
Acute	ACUT
Acute	OPAC
Routine	ROUT
Wellness	PCM
Wellness	WELL
Specialty	SPEC
Specialty	PROC
Future	EST
Future	GRP
DRoutine	DROUT (Dental only)

FUNCTIONS IMPACTED: Health Care Finder - all booking functions

Justification for Change Request:

In CHCS, when the clerk requests available appointments for a patient, CHCS displays a list of all available appointments that are open for booking within the access to care standard time period selected by the clerk (ATC Category). Many of the appointments presented may not be appropriate for the patient and/or may not be the best to book to meet the clinic's scheduling objectives. This does not promote correct booking for the patient or clinic. A clerk who is not alert may misbook appointments, assuming that the list tendered by CHCS contains only

appointments which are appropriate for the patient (which may not be the case). CHCS also limits the appointment list according to the ATC Category selected by the clerk. This encourages the clerk to select an incorrect ATC category to search further into the future in order to find care quickly. An incorrect ATC Category will cause Access to Care performance measurements to be incorrect and will not document the patient's real needs. CHCS should give the clerks as many appointments as possible in a single search to make sure an appointment is found.

This SCR will encourage the clerk to select the correct appointment to ensure that
(1) appointments are correctly assigned to patients based on the clinic access standards and
(2) the patient conforms to the detail code criteria that specifies the patient demographics for the appointment.

This solution mirrors the E-Health Web solution.

Policy Change/Addition: N/A

Functional Proponent: Appointment Standardization

Originator's Name/Title: Appointment Standardization Integrated Program Team (ASIPT)

2. Change Requested: Automatic Reconfiguration of Unbooked Appointments

Outside Tracking Number (used by Originator, if any): 2 (DOORS 1071)

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

During Template Build and Schedule Build/Maintenance, the system shall allow the user to enter the following appointment reconfiguration data multiple times for each appointment slot: (1) a release date and time *or* a number of hours prior to the appointment, (2) the new appointment type, (3) the new appointment duration, (4) the new workload count, and (5) *up to 4 new detail codes*. This reconfiguration data may also be entered for multiple appointment slots at the same time (batch assignment). Each entry should be in chronological order. Entry of reconfiguration data is optional. Based on this data, an **unbooked** appointment slot may be reconfigured as described below in order to make it more bookable.

In the clinic and provider profiles, a clerk will be permitted to enter multiple sets of the default reconfiguration data (see above) for each appointment type defined in the profile. These

reconfiguration sets will be used as the default set when creating Templates and Schedules for that provider and the provider's appointment types. Clinic reconfiguration defaults will populate provider reconfiguration defaults and provider reconfiguration defaults will populate the reconfiguration sets in templates and schedules on each appointment slot according to the appointment type. The workload type for non-count clinics will always be non-count for all the clinic and provider appointment slots and reconfiguration data.

The system will support a continual update process to automatically reconfigure/release **unbooked** appointment slots based on the date/time specified in the reconfiguration multiple for each appointment slot. The system will select and release/reconfigure only unbooked appointments that are scheduled to be reconfigured at that date/time. During the release, the system will replace the current appointment type, duration, workload type, and detail fields in the Schedule Entity File with the new appointment type, duration, workload type, and up to 4 detail codes, if any, specified in the reconfiguration multiple being processed. Schedule data including appointment type, workload type, duration, detail codes, and frozen statuses will be deleted/overlayed when the appointment is reconfigured.

For example, a wellness slot is unbooked and is scheduled per the release date/time to be released tonight at midnight and become a routine appointment with a duration of 15 minutes instead of 30 minutes. The system will release the slot at midnight and replace the data elements as indicated in the multiple. Tomorrow, if the appointment is still not booked, and the next set of release data indicates the appointment will become an acute appointment tomorrow at noon, the system will change the appointment data a second time at noon.

Frozen appointments will be set and released using the reconfiguration data, and the appointment status will be automatically changed to open. The reconfiguration data, not the slot comment field, will be used when freezing and unfreezing appointments.

Some examples of categories of appointments that might be automatically released are: frozen to open, Active Duty only or Prime only to the general population, MTF Book Only to general booking, acute to routine, routine to acute, wellness to routine, wellness to acute, etc.

FUNCTIONS IMPACTED: Continual update process running in the background in CHCS

APPENDIX L

APPOINTMENT STANDARDIZATION PHASE III (APS III)

Justification for Change Request:

Currently sites must manually track unused appointments daily in provider schedules and reconfigure the appointment when an unbooked appointment is approaching and may expire without being booked. This is very time consuming.

A more efficient technique would be to allow sites to set up the appointments as needed then program one or more reconfigurations to be executed automatically by CHCS in the background based on a release date/time or a number of hours before the appointment. These reconfigurations would make the appointment more likely to be booked, e.g., change from a wellness to a routine and then, if still not booked, to an acute appointment. This requires the scheduling clerk to be able to identify multiple changes for each appointment slot, or, in batch, multiple reconfigurations for a selected set of appointment slots.

Policy Change/Addition: N/A

Functional Proponent: Appointment Standardization

Originator's Name/Title: Appointment Standardization Integrated Program Team (ASIPT), Dec 1999

3. Change Requested: Track patient appointment telephone calls that did not result in a booked appointment.

Outside Tracking Number (used by Originator, if any): 85 (DOORS # 1091)

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

When a clerk searches for an appointment, either an appointment will be booked or the clerk will attempt to exit without any action. This SCR will require that some action be taken to log the call despite the fact that no appointment is booked. The key strokes required should be kept to a minimum and should include default of the current phone number with the ability to correct the number and entry of a reason that the call was not booked.

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When a clerk searches for an available appointment and selects an appointment to book, there will be two options available to the clerk: Book and Modify. This is current functionality and should be supported without change for these two functions.

If the clerk searches for an appointment and does not select an appointment to book, three options will be available to the clerk: No Appointments; Appointment Refusal; and Just Looking. If the clerk selects No Appointments or Appointment Refusal, then CHCS will create a record in a "Calls with No Appointment" file that will record the patient's name, Patient SSN, Sponsor FMP/SSN, PCM name (if available), PCM Group, Patient Category, Division, initial requested clinic, clinic specialty requested, eligibility status, ACV, enrolling DMIS, referral number if applicable, Access to Care category, a free text field, and the date/time the call is entered into CHCS. Appointment Refusal will work as per current functionality but will post a record to the Calls with No Appointment file. Just Looking will exit without logging any information in the Calls with No Appointment file. Before exiting the appointing function, the booking clerk will enter only the reason the call was not booked and the most current phone number (if not already available in Registration).

Close the call record once the patient is finally scheduled or waitlisted for an appointment for the selected specialty.

Create reason code table explaining why the call could not be booked or what follow-up action will be taken, i.e., no appointments available, self care recommended, call referred to MTF clinic, call referred to MCSC, sent downtown, referral not entered, timely care not available for deployed active duty, not an appointment request, request for benefits, unsuccessful transfer, CHCS downtime, asked patient to call back, other, etc. The default reason will be No Appointments available. The Reason code table will permit the MTF to add its own reasons.

The No Appointments function will be released turned on but may be turned off at the MTF level.

Justification for Change Request:

Clinics have requested a TRAC 1, 2, and 3 appointment type in order to track calls that did not result in an appointment. Access to Care needs a way to track calls by the Access to Care Category that did not result in an appointment and to require a booking clerk to log these calls for analysis. Appointment Standardization does not want to create additional appointment types for this purpose.

Policy Change/Addition: N/A

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Functional Proponent: Appointment Standardization - LTC David Corey

Originator's Name/Title: Region 6, Region 11

4. Change Requested: Create a Patient Request Outcomes Report

Outside Tracking Number (used by Originator, if any): 64.1 (DOORS # 1085)

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

Create Patient Request reports to measure Access to Care Data.

Report 1: Compare Planned Schedule Data to Final Booked Appointments and identify change patterns

- Compare planned appointment types, durations, and detail codes between the Schedule Entity File and the Patient Appointment File to show changes from the planned to the execution of appointments.

Report 2: Report lists calls that do not result in a booked appointment.

- Sort calls by division, and by initial requested clinic or by clinic specialty
- User selects a division, clinic or clinic specialty, a date/time range, and one, multiple, or all reasons
- Print line will include the following fields: Patient name, Sponsor FMP/SSN, beneficiary category, DMIS ID, ACV, PCM name, phone number, ATC Category, date/time call logged, clinic specialty, and 'no appointment' reason.
- Include subtotals with counts of calls at the division, clinic, and reason levels.

See SCR # 85 for the functionality that creates the Calls with No Appointments file.

Justification for Change Request:

CHCS does not provide any reports to assess clinic appointment demand and to compare it to the planned access.

Policy Change/Addition: N/A

Functional Proponent: Appointment Standardization

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APPOINTMENT STANDARDIZATION PHASE III (APS III)

Originator's Name/Title: Appointment Standardization Integrated Program Team (ASIPT), Region 11

5. Change Requested: Convenient Access to Split and Join Appointments

Outside Tracking Number (used by Originator, if any): 10 (DOORS # 1072)

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

During the appointment booking processes (PCM Booking, Non-Enrollee Booking, Referral Booking, Consult Order Processing and Booking, Self-Referral Booking, etc.), the system shall allow a more convenient access to the appointment split and join and overbook functions as described below. Providers and appointment clerks should be able to easily create an appointment of the appropriate length or adjust the number of patients to be booked to the appointment without exiting the function.

The new Modify function implemented in APS II can be enhanced to allow the following features. The clerk should be able to select either one or multiple appointments on the available appointment display list.

- If one appointment is selected, the Appointment Split and Overbook functions should be available on the action bar. The clerk should be able to directly access the appointment split function (without going through Browse) and enter the split slot data for each new appointment. The duration of the second appointment should default to the difference between the length of the original appointment less the duration of the first split appointment. The clerk may change this duration.

- If two or more appointments are selected, CHCS should determine whether they are contiguous and belong to the same provider. If these multiple appointments do not meet these criteria, CHCS should ask the clerk to try again. If the multiple appointments meet the criteria, the clerk should be automatically put into an Appointment Join function and the length of the new appointment should be the sum of the lengths of the selected appointments. The clerk should be able to enter the data for the new appointment in accordance with current functionality. The clerk may change the duration.

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FUNCTIONS IMPACTED: Health Care Finder - all booking functions including Consult Tracking

Justification for Change Request:

Currently, in order to join or split or overbook appointments, booking clerks are required to access the Browse function and select a single provider then select their appointments. An available appointment can be lost to another patient due to the time required by this process. The clerk is required to re-enter selection criteria when the appointments they wanted to join or split were already displayed on the available appointment screen. Many additional keystrokes are required to use this functionality. This SCR will reduce the time required to join or split an appointment. This will be consistent with the Access to Care Guidance to make the appointment fit the patient's needs.

In addition the Join or Split function is not easily available when booking an appointment for a Consult. This SCR would simplify training and save clerks a substantial amount of data entry time when changing the duration of an appointment.

Policy Change/Addition: N/A

Functional Proponent: Appointment Standardization

Originator's Name/Title: Appointment Standardization Integrated Program Team (ASIPT)

6. Change Requested: Include a New Booking Option: Enrolled Elsewhere

Outside Tracking Number (used by Originator, if any): 54 (DOORS # 1079)

MHS System(s) Impacted: Composite Health Care System (CHCS) I

Description of Change/Current Problem:

The system shall implement a new single booking option (ENROLLED ELSEWHERE) that will support booking for traveling Prime beneficiaries in MCP Booking.

A Traveling Prime Beneficiary is a beneficiary who is enrolled to a remote MTF and has no Primary Care Manager (PCM) at the facility where care is requested

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APPOINTMENT STANDARDIZATION PHASE III (APS III)

The terms "Enrolled" or "TRICARE Prime" should be interpreted as "enrolled in DEERS".

Non-Enrolled Booking will be offered from now on only to non-enrollees, including TRICARE Standard/Extra patients, Medicare, Space Available, and Active Duty who are not enrolled in DEERS.

When a patient calls for an appointment, CHCS will perform existing functionality to identify and register the patient, and to determine/validate eligibility and the enrollment status of the patient.

Requirements for: Traveling Prime Beneficiary with no PCM at the facility where care is requested

The *Enrolled Elsewhere* booking option will book appointments for TRICARE Prime beneficiaries (enrolled Active Duty and CHAMPUS) who are traveling and/or reassigned away from their enrolling MTF and PCM, and who are requesting care at a facility on this CHCS host.

FUNCTIONS IMPACTED: Health Care Finder Booking

Justification for Change Request:

Traveling TRICARE Prime Enrollees: This requirement proposes a system solution to support the implementation of the National Enrollment Database (NED) and the existing policy concerning the reciprocity of TRICARE Prime benefits when enrollees are traveling away from their Primary Care Manager (PCM) and need an outpatient appointment. Under MCP, MTFs must currently go to "Non-Enrolled Booking" as the work around to appoint TRICARE Prime enrollees not enrolled to the local MTF. Clerks mistake these patients for non-Prime and refuse care. This causes problems for active duty members on temporary duty, traveling beneficiaries, and newly assigned/relocated families.

CHCS will identify traveling beneficiaries and provide a booking option that will be appropriate for them.

Policy Change/Addition: Supports National Enrollment Database (NED) functionality

Functional Proponent: Enrollment

Originator's Name/Title: TRICARE Management Activity, Enrollment, Col Loretta Bailey

7. System Incidence Report (SIR) # 32107 - System does not offer an appointment refusal to the user when the user selects an appointment just outside the 24 hours to the minute but prior to the end of the day.

Problem: Currently when a user selects an Access to Care Category, CHCS will display available appointments up to the last hour of the last business day that meets the access standard. However the access to care standard is exactly 24 hours, 7 days, etc. to the minute from the time the patient calls. Appointments are displayed outside the standard and give the user the false impression that these appointments are within the access standard. This causes two problems.

1. If the user selects one of these appointments outside the standard, CHCS does not display a warning that the appointment is outside the standard and the clinic will be given a "not met" access status for the appointment
2. If there are available appointments within the access standard and the patient prefers an appointment outside the standard, CHCS is not offering the appointment refusal option to document that this was the patient's preference. The clinic is again being given a "not met" access status for the appointment

Solution: When a user selects an appointment occurring from the end of the access standard to the end of the day, CHCS will warn the user that the clinic is about to get a "not met" access status. In addition if there are available appointments within the access standard and the patient selects an appointment outside the standard, the user will be offered the option to enter an appointment refusal so the clinic will avoid the "not met" status.

APPENDIX M

STANDARD DETAIL CODES

APPENDIX M

STANDARD DETAIL CODES

DETAIL CODE INSTRUCTIONS

The following is the final list of standard codes for the Appointment Detail Fields. MTFs should attempt to keep detail code usage to a minimum. Extensive use of detail codes will lessen access.
However detail codes do help clerks search for appointments with specific attributes.

Sites may add only one type of detail code to the Detail Code Table: site defined age codes. Age detail codes are the only detail codes that may be created by the sites without approvalat the TMA and regional level. Age codes should be standard across the region as much as possible. Age codes must adhere to the following formatting standards in the form of an age range with a lower and upper limit: 0-12, 65-120, 3M-6M, 3D-21D, 1W-6W, etc. where M indicates age in months, D indicates age in days, and W indicates age in weeks. The number alone indicates age in years. **A hyphen is the only allowable separator between the upper and lower age range.** The low and high numbers are inclusive and the low age precedes the upper age limit. Sites must add age detail codes to the Detail Code Table n so that the system will recognize them. It is recommended that sites not assign an age code as the first detail code since it appears on the CHCS Available Appointment List immediately after the duration and is confusing to booking clerks.

Detail codes may be one of the following: procedures, equipment, evaluations, readiness care, education/classes, counseling, care requiring an unusual duration, and temporarily a provider professional category.

Detail codes will not be any of the following: diagnosis, place of care, appointment type, provider group, provider specialty, or any standard care that can be rendered in a normal setting.

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STANDARD DETAIL CODES

DETAIL CODE APPROVAL PROCESS

The following approval process for detail codes is effective immediately.

Step 1. The MTF comes up with a "need" for a new detail code. The MTF defines the circumstance, or service for which it is to be used. Normally the detail code should not be a place of care or a diagnosis. A detail code should be used to define an appointment slot that needs a special room, a specialized piece of equipment, a special skill of a technician or health care professional that makes sure that the right patient gets with the right provider at the right time at the right place. MTFs should attempt to keep detail code usage to a minimum. Extensive use of detail codes will lessen access.

Step 2. The MTF then forwards its request to the Lead Agent Appointment Standardization Integrated Program Team (IPT) member. This member will analyze the need for the new detail code, review them against existing detail codes and eliminate duplicates, and staff the request with the appropriate consultants in their region. The goal of the Lead Agent review is to have a commitment to the proposed detail code's necessity and either concur or not concur for its need. This review will include a documented review and concurrence or non-concurrence of necessity by the Lead Agent Clinical/Medical director. If the detail code is not approved, the action stops for the code and the submitting MTF will be notified. If concurred by the IPT member and the Lead Agent Clinical/Medical Director, the code will be submitted to TMA.

Step 3. TMA will then review one final time for necessity and duplication, and will forward to the Clinical Information Technology Program Office (CITPO) to include in the next detail code table update. Once approved the new detail code will be published in the *Commander's Guide to Access Success*. If an issue is identified, the Appointment Standardization Program Manager will consult with the Chief, Medical Officer/Clinical Director of TMA for clarification or further action.

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
1	1TT	First Trimester	First Trimester: Reserved for an Obstetrics patient in her first trimester of pregnancy after attending the OB enrollment course; not to be defined by the number of weeks pregnant.	May combine with EDU for education.
2	2TT	Second Trimester	Second Trimester: Reserved for an Obstetrics appointment after the first trimester up to 36 weeks pregnant. For patients who are not considered complicated OB patients.	May combine with EDU for education.
3	3TT	Third Trimester	Third Trimester: Reserved for an Obstetrics patient in her third trimester of pregnancy. Patient may not be scheduled before third trimester (6 - 9 months of the pregnancy). For patients who are not considered complicated OB patients.	May combine with EDU for education.
4	ACG	After Care Group	After Care Group: Reserved for patients who require evaluation and treatment before and after admission to a substance abuse treatment facility. The admission is directed by the military command.	
4a	ACUP	Accupuncture	Accupuncture: Used to identify patients who are seeking accupuncture treatment that requires special equipment and skills.	
5	AD	Alcohol and Drug	Alcohol and Drug: Used to identify patients who are being seen for an alcohol and/or drug problem. Some counselors do not see patients with chemical dependencies.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
6	ADEI	Alcohol and Drug Early Intervention	Alcohol and Drug Early Intervention: Used to identify patients who are being seen for an alcohol and/or drug problem. Some counselors do not see patients with chemical dependencies. Early intervention appointments take more time than regular follow-up appointments for alcohol and drug patients.	
7	ADHD	Attention Deficit and Hyperactivity Disorder or Attention Deficit Disorder	Attention Deficit & Hyperactivity Disorder or Attention Deficit Disorder: These patients are seen by specific providers within the clinic.	Evaluation
8	ADSC	Alcohol and Drug Screening Only	Alcohol and Drug Screenings only: Reserved for initial screening, evaluation and plan of care development for substance abuse case needing immediate intervention.	Special resources
9	ADTX	Alcohol and Drug Treatment 2 week Program Only	Alcohol and Drug Treatment 2 week Program Only: Must have initial screening by certified counselor prior to attending.	Special resources
10	ANGER	Anger Management Education	Anger Management Education: This is a group appointment and a referral may or may not be required. The appointment is a longer duration and the duration is determined by the individual clinic/provider.	
11	ANPST	Anergy Panel (stick)	Anergy Panel (stick): Used to check for a false positive on a PPD test with a strong reaction. Procedure requires a specific sequence of occurrence.	
12	ANRD	Anergy Panel Reading	Anergy Panel Reading: Should be performed 48 hours after an ANPST (PPD stick). Procedure requires a specific sequence of occurrence.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
13	AQUA	AQUA Pool	AQUA Pool: Reserved for patients referred by credentialed Physical Therapist for therapeutic rehabilitation in a specialized pool. The number of appointments is limited by time, facility space, and staffing.	
14	ASTHMA	Asthma Evaluation or Education Appointments	Asthma Evaluation or Education Appointments: This appointment is of longer duration for patients who have been identified with a probable diagnosis of asthma.	
15	ASTIG	Treatment of Astigmatism	Treatment of Astigmatism: Optical defect in which refractive power is not uniform in all directions (meridians). Because of the high command interest of laser eye surgery, this specialized patient care service warrants special identification for planning, management and tracking purposes.	
16	AUENT	Audiometric Diagnostic	Audiometric Diagnostic: Procedure requires a specific sequence of occurrence.	
17	BCP	Birth Control	Birth Control: Reserved appointment for birth control instruction which requires more time due to the education component.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
18	BEESN	Bee Sting	Bee sting: Reserved for a specialized, once a month appointment type for all patients presenting with a chief complaint of anaphylaxis: mostly due to bee sting or fire ant allergy (also latex, idiopathic, etc.). Advance preparation based on the number of slots filled is an absolute requirement to alleviate the possibility of wasted bee venom dilutions and the extensive man-hours involved in their preparation.	
19	BEPC	Birth and Early Parenting Class	Birth and Early Parenting Class: Reserved for a group appointment of longer duration. The beneficiary may self-refer to this appointment. If there are two parents in the family, it is recommended that the parents attend the class together. The class is for beneficiaries with children who are 3 years of age or younger.	
20	BF>	Weight Exceeding Body Fat Standards	Weight exceeding body fat standards: Appointment reserved for active duty personnel who have been identified as having a possible weight problem. It is important that these patients are given appointments as soon as possible; there is a limited amount of time for these personnel to show progress.	
21a	BF	Breast Feeding	Breast Feeding: Appointment reserved for mothers to see a Certified Lactation Consultant on breast or breastfeeding related issues or conditions.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
21	BFC	Breast Feeding Class	Breast Feeding Class: Reserved for a group appointment to educate mothers on the methods of providing milk to a newborn or infant.	
22	BIO	Biopsy	Biopsy: Reserved appointment for obtaining a representative tissue sample for microscopic examination. This procedure requires specific equipment.	
23	BK	Back Pain or Problem	Back Pain or Problem: Reserved for the initial evaluation of patients with a chief complaint of back pain or condition. A referral is required. Evaluation is required prior to implementing treatment or a therapeutic exercise program. Only certain providers see patients with a complaint of back pain or problem.	
24	BOTOX	Botulinum Toxin Type A Injections	Botulinum Toxin Type A Injections: Appointment of very short duration. Ensures patient will be seen with appropriate clinic personnel available when the procedure is requested.	
25	BPAD	Active Duty Only	Active Duty: Uniformed Services Personnel (regardless of where or whether they are enrolled), guard and reserve on active duty, NATO, and other status of forces agreement active duty members are the only patients permitted to be booked for appointments reserved for this access type. The intent of this type is to allow sites to ensure access for any Active Duty member to the MTF for care that is appropriate for that type of beneficiary.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
26	BPAP	Active Duty and Prime Enrollees	Active Duty and Prime: This category includes Active Duty and Prime patients. Refer to BPAD and BPPR operational definitions for each category.	
27	BPAPS	Active Duty, Prime Enrollees, TRICARE Plus, and Special Programs Patients	Active Duty, Prime, TRICARE Plus, and Special Programs Patients: This category includes Active Duty, Prime, TRICARE Plus, and Special Programs Patients. Refer to BPAD, BPPR, and BPSP operational definitions for each category.	
28	BPGME	Graduate Medical Education	Graduate Medical Education: Any interesting case designated by local directive as reserved for the training of Graduate Medical Education staff. The clinic will usually book appointments for these patients.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
29	BPNAD	No Active Duty	No Active Duty: Uniformed Services Personnel (regardless of where or whether they are enrolled), Federal Employees Health Benefit Program (FEHBP), guard and reserve on active duty, NATO family members, USFHP enrollees (except by specific authorization), Secretarial Designees, and other status of forces agreement active duty members may not be booked into this slot. Anyone else may be booked into this slot, including TRICARE Standard, TRICARE Extra, and Uniformed Services family members, retirees, retiree family members and TRICARE Senior Prime *and* TRICARE Plus enrollees. This access type is intended to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Active Duty.	
30	BPNAP	TRICARE Standard, Space Available, and Other Patients - No AD or Prime	TRICARE Standard, Space Available, and Other Patients - No Active Duty or Prime: TRICARE Standard, TRICARE Extra, Medicare, and other direct care only (Space A) beneficiaries may be booked to these appointments. This access type is primarily designed to reserve appointments for "at risk" patients who are contractor reliant. Secondarily, this type also supports the contract revised financing requirement to capture non-enrollees who would otherwise go downtown, i.e. Medicare and Space A.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
31	BPNPR	No Prime Enrollees	No Prime Enrollees: Non-Active Duty Prime enrollees from the local MTF or remote MTFs, contractor enrollees, TRICARE Senior Prime, and TRICARE Plus may not be booked into this slot. Active Duty may be booked to these appointments. All other beneficiaries, including Medicare patients, TRICARE Standard, NATO, NATO family members, Secretarial Designees, etc. may be booked to these appointments. The intent of this access type is to reserve appointments for Medicare, Space A, and other special needs patients and to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Prime patients.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
32	BPPR	Prime Enrollees Only, No Active Duty	Prime Enrollees Only; No Active Duty: Family members of Uniformed Services Personnel, retirees, and retiree family members, who are enrolled in TRICARE to any local or remote MTF, are the only patients permitted to be booked for appointments reserved by this access type. This group also includes enrollees with contractor PCMs. This group does not include TRICARE Plus, NATO family members and enrollees to the Uniformed Services Family Health Plan (USFHP), or Federal Employees Health Benefit Plan (FEHBP) except by specific authorization. The intent of this type is to allow sites to ensure access for any Non-Active Duty TRICARE Prime enrollee to care that is appropriate for that type of beneficiary.	
33	BPSP	Special Programs Patients *and TRICARE Plus*	Special Programs Patients and TRICARE Plus: Beneficiaries enrolled in special local programs and in TRICARE Plus may be booked to these appointments. This access type is designed to ensure that a site's special program access requirements can be met by appointing.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
34	BPTS	TRICARE Standard Patient Only	TRICARE Standard Patients: Active Duty family members, retirees, and retiree family members who are entitled to CHAMPUS reimbursement for civilian care rendered. This type supports the contract revised financing requirement to capture CHAMPUS non-enrollees who would otherwise go downtown.	
35	BRON	Bronchoscopy	Bronchoscopy: Reserved for fiber-optic examination of the lungs. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
36	BTL	Bilateral Tubal Ligation	Bilateral Tubal Ligation: Reserved as a group appointment for female patients desiring to undergo a bilateral tubal ligation procedure.	Can be used with EDU or other comments that may apply.
36a	CARD	Cardiac Counseling/Care	Cardiac Counseling/Care	
37	CATH	Catheter	Catheter: Removal or insertion of a catheter. Procedure requires specific sequence of occurrence and equipment.	Combine with RMV for removal of Catheter or INS for insertion.
38	CAVH	24 hour Dialysis Treatment	Continuous Arterio-Venous Hemofiltration: 24 hour hemodialysis treatment. Procedure requires specialized skills and specific equipment.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
38a	CB	Cross Book	This appointment is reserved for a patient who is not empaneled to this PCM. Should be used to restrict the slots that are available to patients that are not empaneled to this PCM. If this code is used, then by default, all other slots are for empanelees only.	
39	CCEP	Comprehensive Clinical Evaluation Program for Persian Gulf Illnesses	Comprehensive Clinical Evaluation Program for Persian Gulf Illnesses: A DoD mandated program reserved for specialized one-time evaluation of veterans of the Persian Gulf War.	
40	CHOL	Cholesterol	Cholesterol: Reserved as a group appointment for patients referred for either hypertension or high cholesterol level counseling.	
41	CIRC	Circumcision	Circumcision: Reserved appointment for the surgical removal of the end of the prepuce of the penis. Procedure requires specialized equipment, trained staff, scheduling of a room and provider specified timeframe.	Can be used with EDU or other comments that may apply
42	CLEFT	Cleft Lip and Palate	Cleft Lip and Palate: Reserved appointment for patients who have a vertical cleft or clefts in the upper lip or congenital fissure in the roof of the mouth. This procedure requires specialized skills and specific equipment.	
42a	*CM*	*Case Management*	Case Management: Reserved for an individual appointment to evaluate, counsel, or assist in patient-specific health care needs or coordination of care.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
43	CMDPSY	Command Directed Psychological Evaluations	Command Directed Psychological Evaluations: Reserved appointment slots required to be set aside in order to meet the access standards of a command-directed psychological evaluation.	
44	CNM	Certified Nurse Midwife	Certified Nurse Midwife: Identifies the professional qualifications of the provider. This is a temporary detail code.	In a future release, will display the provider professional category.
45	COB	Complicated OB Patient Only	Complicated OB Patients Only: Reserved for Obstetrical patients who require management and follow-up with a provider appropriately trained to manage their complex care requirements.	
46	COLON	Colonoscopy	Colonoscopy: Reserved for fiber-optic examination of the colon. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
47	COLPO	Colposcopy, abnormal pap required	Colposcopy, abnormal pap required: Reserved for the examination of vaginal and cervical tissues by means of a colposcope. This procedure requires specialized skills and specific equipment, scheduling of room and provider.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
48	CORSCR	Cornea Scrape/Rescrape	Cornea Scrape/Rescrape: Reserved for patients who require a rescraping of the cornea after post-operative photo refractive keratectomy (PRK). Command interest requires unique identifier for planning, management and tracking purposes.	
49	COSMETIC	Referrals for Non-Covered Cosmetic Procedures	Referrals for Non-Covered Cosmetic Procedures: Reserved for patients who are referred for a medically necessary or pre-arranged (active duty) plastic surgery procedure. Availability is very limited.	When preceded by "No", restricts appointing of patients who are seeking cosmetic surgery that is not medically necessary or is pre-arranged.
50	COUNS	Counseling Only	Counseling Only: A universal detail code that precedes other STANDARD comments (e.g. BTL, Gene, Vas). These appointments require coordination of resources, counselors, providers, and information materials to support the needs of the patient and family.	
51	CPAP	Continuous Positive Airway Pressure	Continuous Positive Airway Pressure: Procedure requires specialized skills and specific equipment.	
52	CYSTO	Cystoscopy	Cystoscopy: Reserved for a patient who requires fiber-optic examination of the urinary tract. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
52a	DCONS	Dental Consultation	Dental Consultation: Reserved for a patient who requires a dental consultation.	
52b	DENDO	Endodontics	Endodontics: Reserved for a patient who …	
52c	DERM	Dermatology Evaluation	Perform evaluation as primary care. Otherwise write a referral.	
52d	DEVAL	Dental Evaluation	Dental Evaluation: Reserved for a patient who	
53	DEXA	DEXA Bone Scan	Dual Energy Xray Absorptiometry (DEXA): Reserved for a bone densitometry study used for the management of osteoporosis. This study requires special equipment, trained staff, and scheduling of the room.	
53a	DEXAM	Dental Examination	Dental Examination: Reserved for a patient who	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
53b	DEXPR	Dental Exam/Prophylactic Cleaning	Dental Exam/Prophylactic Cleaning: Reserved for a patient who …	
54	DIL	Dilation	Dilation: Esophageal dilation is used (accompanying the EGD code) for a procedure that includes the esophagogastroduodenoscopy along with a dilation of esophagus. This is a specialized procedure, which requires a detail code for the purpose of planning and ordering specialized supplies.	
55	DM	Diabetes	Diabetes: Identified appointments for diabetic patients. Due to the education component and involvement of other staff members, the appointment will be of a longer duration.	
55a	DOMFS	Oral Maxillofacial Surgery	Oral Maxillofacial Surgery: Reserved for a patient who	
55b	DOPER	Operative Dentistry	Operative Dentistry: Reserved for a patient who	
55c	DORTHO	Orthodontics	Orthodontics: Reserved for a patient who	
56	DOSIM	Methocholine & CPEX	Methocholine & CPEX: Procedure requires specialized skills and specific equipment.	
56a	DPEDO	Pediatric Dentistry	Pediatric Dentistry: Reserved for patients who	
56b	DPERIO	Periodontics	Periodontics: Reserved for patients who	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
56c	DPO	Dental Post-Operative Visit	Dental Post-Operative Visit: Reserved for patients who	
56d	DPRO	Dental Prophylactic Cleaning	Dental Prophylactic Cleaning: Reserved for patients who	
56e	DPROS	Prosthodontics	Prosthodontics: Reserved for patients who	
56f	DSC	Dental Sick Call	Dental Sick Call: Reserved for patients who	
57	DSGCH	Dressing/Bandage Change	Dressing/Bandage Change: Reserved appointment for changing the covering (protective or supportive) for diseased or injured parts. Requires special supplies and trained staff.	
57a	DTMD	Temporomandibular Disorders	Temporomandibular Disorders: Reserved for patients who	
58	DVIOL	Domestic Violence Class	Domestic Violence Class: This is a specialized counseling class for cases of spousal and/or child abuse occurrence or risk of occurrence.	
59	DXE	Dobutamine Stress Test	Dobutamine Stress test: Pts are administered Dobutamine Intravenously to raise heart to simulate exercise/stress. Echocardiogram is recorded simultaneously. Procedure requires specialized skills and specific equipment.	
60	E&I	Female Endocrine and Infertility Patient Only	Female Endocrine and Infertility Patient Only: Room setup is required.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
61	EAR	Ear Recheck	Ear Recheck: Is a 5-minute follow-up appointment of a previously diagnosed ear infection to ensure it has cleared. The child should be asymptomatic as these are not ill child appointments. The appointment is generally scheduled one month after treatment for the ear infection was started. This appointment if appropriately booked will increase availability of appointments.	
62	ECG	Electrocardiogram	Electrocardiogram: Reserved for patients who require a graphic tracing of heart function. Requires coordination of specialized equipment, space and trained staff.	
63	ECHO	Echocardiogram	Echocardiogram: A graphic recording of the position and motion of the heart walls and internal structures of the heart. Requires coordination of specialized equipment, space and trained staff.	
64	EDU	Education or Class	Education or classes: A universal detail code preceded by other STANDARD comments (e.g. Chol, DM, HTN) clarifying that this appointment is for patient education. Identifies as an education class so resources can be coordinated and managed.	Combine with other detail codes.

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
65	EEG	Electroencephalo-graphy	Electroencephalography: A graphic recording of the electric currents developed in the brain, by means of electrodes applied to the scalp. Requires coordination of specialized equipment, space and trained staff.	
66	EFMP	Exceptional Family Member Program	Exceptional Family Member Program: Reserved for the special needs family member who is affected by a physical, emotional, or educational condition. Requires ongoing mental or physical health care and/or special education services not generally available in isolated areas or overseas locations.	Can be used with EDU or other comments that may apply
67	EGD	Scope of Esophagus and Lower Stomach	Scope of Esophagus and Lower Stomach, Esophagogastroscopy: Reserved for patients who require fiber-optic or endoscopic examination of the esophagus and lower stomach. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
68	EMGM	Nerve Conduction Studies	Nerve Conduction Studies: Reserved for a patient who requires study of nerve function. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
69	ENG	Electronystagmo-graphy Testing	Electronystagmography Testing: Reserved for a patient who requires testing for vertigo. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
70	EP	Auditory Brainstem, Visual, Upper/Lower Somatosensory Evoked Potentials	Auditory Brainstem, Visual, Upper Somatosensory, Lower Somatosensory Evoked Potentials (nerve pathway tests): A series of procedures performed by the Neurology clinic to measure brain activity as to test for seizures. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
70a	ER	Emergency Room Follow-up Appointments	Emergency Room Follow-up Appointments:	
71	ERCP	Endoscopic Retrograde Cholangiopancreato-graphy	Endoscopic Retrograde Cholangiopancreatography: Reserved for a patient who requires fiber-optic or endoscopic examination of gallbladder and pancreas. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
72	EVAL	Evaluation - in depth	Evaluation - in depth: (Evaluation or Assessment): A specialized appointment for an initial evaluation for a patient referred with a chief complaint of neurological, muscular, joint, or skeletal injury or condition. Referrals from all primary care providers and specialty clinics *for evaluations*. All patients must be evaluated prior to implementation and scheduling of treatment or rehabilitation. All patients will undergo initial evaluations (EVAL) and then are scheduled at an appropriate time in the future for a re-check evaluation (EST appointment).	Combine with other detail codes.
73	EXERC	Exercise Therapy	Exercise Therapy: Therapy requiring specific equipment.	
74	EYEDZ	Eye Disease	Eye Disease: Utilized for continued follow-up appointments pertaining to disease related to the eye.	
75	EYEEX	Eye Exam	Eye Exam: Patients can be given an appointment with an optometrist or a technician. These exams are not routinely performed by ophthalmologists.	
76	FAM	Family Therapy or Meeting	Family Therapy or Meetings: Required to distinguish family therapy sessions versus individual therapy sessions.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
77	FCC	Child Care Provider Mental Health Screening	Child Care Provider Mental Health Screening: This is a specialized mental health screening required for all individuals seeking to become certified child care providers. This appointment type is a standard screen for non-patients designed to rule out history or current patterns which would contraindicate becoming a certified child care provider.	
78	FE	Female Patient Only	Female Patient Only: Reserved appointments for female patients only.	
79	FLAP	Flaplift	Flaplift: Reserved for a patient who requires follow-up or treatment after laser-in-situkeratomileusis (LASIK) procedures. Command interest requires unique identifier for planning, management and tracking purposes.	
80	FLEXS	Esophogastoduodeno-scopy/Flexible Sigmoidoscopy	Esophogastoduodenoscopy/Flexible Sigmoidoscopy: Reserved for a specialized appointment in a clinic with multiple procedures. Requires coordination of special equipment, technician, room and provider.	Can be used with EDU or other comments that may apply
81	FLT	Flight Physical Exam	Flight Physical Exam: Reserved for active duty members and other patients who require a medical status to ensure flight worthiness.	
82	FNA	Fine Needle Aspiration	Fine Needle Aspiration: Reserved for appointment which requires equipment and other necessary preparation.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
83	FOOT	Foot or Ankle Evaluation	Foot or Ankle Evaluation: Reserved for the initial evaluation of patients with a chief complaint of foot or ankle injury or condition. A referral is required. Evaluation is required prior to implementing treatment or a therapeutic exercise program.	
84	GAST	Gastric Bypass Surgery Psychological Evaluation	Gastric Bypass Surgery Psychological Evaluation: This is a specialized appointment for all patients being considered for gastric bypass surgery. It involves psychological evaluation and screening, as well as support group activities for patients both pre- and post-surgery. This specialized patient care service is part of a multi-disciplinary approach and warrants special identification by a separate detail code for planning, management and tracking purposes.	
85	GDB	Gestational Diabetes Patient	Gestational Diabetes Patient: Reserved for OB patients being followed for gestational diabetes.	
85a	GDBL	Good Backlog Appointments	Good Backlog Appointments: Reserved for patients who prefer an appointment on a future day in an Open Access clinic.	
86	GENE	Genetics Consult	Genetics Consult: Reserved for appointment for patients undergoing genetic counseling.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
87	GYN	Gynecology Appointments Only	Gynecology Appointments Only: Ensures the appropriate staff and equipment are available to perform the procedure. This code is to be used only in multi-specialty clinics to identify this type of care, e.g., Family Medicine clinic providing Gynecological care, or Obstetrics/Gynecology.	
88	HAE	Hearing Aid Evaluation	Hearing Aid Evaluation: Reserved for active duty military and retirees who participate in the retiree at cost hearing aid program (RACHAP). Patients require hearing aid evaluation, maintenance, and/or repair. A unique identifier is required for planning, management and tracking purposes.	
89	HAND	Hand Patient Only	Hand Patients Only: Reserved by the Orthopedic Clinic for patients who require evaluation and/or treatment by a hand surgeon (a subspecialty with limited availability). Conditions must be specific to the hand; general orthopedic conditions may not be booked into this appointment type.	
90	HBT	Hydrogen Breath Test	Hydrogen Breath test: This test is designed to measure the volume of hydrogen absorbed from the colon and expelled in the breath. This is a 4-hour, one-time procedure.	
91	HC	House Calls	House calls: Utilized to schedule appointments for the nursing outcomes staff who make visits at individual homes.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
92	HCATH	Cardiac Catherization	Cardiac Catherization: Procedure by which a catheter is passed through a blood vessel into the chambers of the heart as an aid in the diagnosis of various heart disorders and anomalies. This procedure is carried out under direct visualization with fluoroscopy. A coronary angiogram is usually part of this procedure.	Use with APV appointment type.
93	HCDC	Hearing Conservation Patient	Hearing Conservation patients: Ensures hearing conservation appointments are available for appropriate non-MHS-eligible patients, e.g., post/base civilian personnel.	
94	HEAD	Headache Education	Headache: Reserved for patients referred to group class after initial evaluation, for education and training on various methods of managing headaches.	
95	HOLT	Holter Monitor	Holter Monitor: Reserved for patients who require the application of a specific type of cardiac monitoring device. The provider must specify the application of this particular device. Procedure requires special equipment and trained staff.	
96	HSG	Hysterosalpingogram	Hysterosalpingogram: Roentgenography of the uterus and uterine tubes. Procedure requires specialized skills and specific equipment.	
97	HTN	Hypertension Patient	Hypertension Patient: Reserved for patients followed for hypertension control.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
98	IDC	Independent Duty Corpsman	Independent Duty Corpsman: Identifies the professional qualifications of the provider. It is a temporary detail code.	In a future release, will display the provider professional category.
99	IMDEF	Immunodeficiency	Immunodeficiency: Reserved for specialized patient care service and evaluations. It is unique among military treatment facilities and warrants special identification by a separate detail code for planning, management and tracking purposes.	Combine with other detail codes.
99a	INF	Infant Care	Infant Care: Reserved for appointments for care related to newborn development, healthcare, safety, and parenting.	
100	INJECT	Shot only	Shot only: Appointment of very short duration. Patient can be seen by clinic personnel other than a physician, physician assistant, or nurse practitioner.	
101	INS	Insertions	Insertions: Reserved for insertion of catheters, dressings, contraceptive devices, etc (established patients.)	Combine with other detail codes.
102	ISOK	Isolinetic Testing	Isolinetic Testing: Reserved for a patient who requires isokinetic testing to evaluate a specific joint's strength throughout a range of motion. A referral from Physical Therapy, Physical Medicine & Rehabilitation, Orthopedics, or Podiatry is required. Procedure requires specialized equipment, a scheduled room and trained staff.	

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STANDARD DETAIL CODES

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
103	IUD	Placement of IUD	Placement of IUD: Reserved for the insertion and removal of an intra-uterine device.	Combine with RMV for removal of IUD or INS for insertion.
104	IVP	Intravenous Pyelogram	Intravenous Pyelogram: Reserved for a patient who requires radiographic study of the urinary tract. Requires radiographic equipment, a scheduled room, and trained staff.	
105	KNEE	Knee School for Patient with Knee Pain	Knee School for Patient with Knee Pain: Consists of knee pain education and exercise instruction. Reserved by the Orthopedic Clinic for patients who experience chronic knee pain and will benefit from specific exercise instruction and education. Requires staff trained to educate and instruct class attendees.	May combine with EDU for education.
106	LASER	Laser	Laser: Requires the use of a LASER and is a surgical procedure. Requires special equipment, trained staff, and may require dressings to wounds.	
107	LASEYE	Laser Eye Surgery	Laser Eye Surgery: Reserved for laser procedure or possible follow-up procedure. Requires special equipment, scheduled room, and provider.	
108	LASIK	Laser-in-situkeratomileusis	Laser-in-situkeratomileusis: Reserved for a patient 21 years old and older for reduction or elimination of myopia and hyperopia, with or without astigmatism by use of keratome and laser treatment.	

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STANDARD DETAIL CODES

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
109	LBX	Liver Biopsy	Liver Biopsy: Liver biopsy is a needle aspiration of liver tissue for histological analysis. This is a specialized procedure, which necessitates individualized pre-procedure teaching, special order supplies, and coordination with other departments.	
109a	LEEP	Loop Electro-surgical Excision Procedure	Loop Electro-surgical Excision Procedure: Reserved for colposcopy patient that may require specialized surgical service in a clinic or a same day surgery setting.	
110	LES	Leishmaniasis Treatment	Leishmaniasis Treatment: This appointment is for a patient with Leishmaniasis, a disease caused by a protozoan organism. Procedure requires specialized skills and specific equipment.	
111	LIFE	Life Skills Group	Life Skills Group: Reserved for patients who would benefit from life skills training (goal planning, stress management, anger control, alcohol use, etc.). This class is for beginners. Requires staff trained to present on specific topics.	
112	LP	Lumbar Puncture	Lumbar Puncture: Procedure requires specialized skills and specific equipment.	
113	MA	Male Patient Only	Male Patient Only: Reserved appointments for male patients only.	
114	MANO	Manometry	Manometry: Esophageal manometry is a procedure used to diagnose and study esophageal motility disorders. This is a specialized on-time procedure. A separate detail code is necessary for planning and tracking purposes.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
115	MANO/PH	Manometry/24 Hr pH Study	Manometry/24 Hr pH Study: Esophageal manometry accompanied by a 24-hour continuous collection of esophageal pH readings obtained by passing a probe through a nostril and securing it 5cm above the proximal border of the LES. This procedure requires appointments on two consecutive days. Therefore a separate detail code is necessary for planning, management and tracking.	
116	MC	Medicare Eligible	Medicare Eligible	
117	MEB	Evaluation Board Physical Exam	Evaluation Board Physical Exam: Reserved for an active duty military member who requires evaluation for possible separation from the military for health reasons. This appointment is a military requirement and requires a unique identifier for planning, management and tracking purposes. Can also be used for Physical Evaluation Board (PEB), Temporary Duty Retirement List (TDRL), etc.	
118	MEDEX	Lumbar Extension Machine, Sports Medicine Only	Lumbar Extension Machine, Sports Medicine Only: Requires technician assistance and equipment reservation.	
118a	MH	Mental Health	Mental Health Screening	
119	MINOR	Excision of Skin Tags, Moles, Warts, or Subcutaneous Nodules	Minor surgical procedure (excision of skin tags, moles, warts, or subcutaneous nodules, etc.) under conscious sedation. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	Is an ambulatory procedure visits - APV

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STANDARD DETAIL CODES

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
120	MOBEX	Mobilization Intervention & Exercise Therapy, Sports Medicine Only	Mobilization Intervention & Exercise Therapy*:* Requires technician assistance and equipment monitoring.	
121	MOHS	MOHS Surgery	MOHS Surgery: Micrographic Surgery to remove skin cancer. It is different than the other cancer skin surgery. In this case a patient stays in the clinic until all of the cancer cells are removed. A slide of the skin cancer cell is developed and viewed by the Dermatologist while the patient stays in the clinic. Minimal appointment time is 60 minutes but no other appointments are booked for the rest of the day, because this procedure may take an entire day.	
121a	MOVDIS	Movement Disorder	Movement Disorder: Reserved for a patient who requires evauation by a fellowship trained movement disorder specialist for a possible surgical procedure such as deep brain stimulation or botulina toxin injections.	
122	NBO	Newborn Physical Only (3-7 days after discharge)	Newborn Physicals Only (3-7 days after discharge): Reserved appointment for newborns who require a physical exam within a specified period.	
123	NECK	Neck Patient	Neck Patient: Only specific providers see patients whose chief complaint is a neck problem. Detail codes ensure the correct provider sees the patient.	

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STANDARD DETAIL CODES

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
124	NO	Universal Exclusion - used in front of other detail codes	Universal Exclusion - is used in front of other detail codes: Universal exclusion detail code precedes other STANDARD detail codes (i.e. No THAL, No WB, No GI, etc.). This identifier permits exclusion of a specific procedure or conditions within a clinic. Eliminates the listing of repetitive codes when excluding procedures or specific conditions.	Combine with other detail codes. "No" should precede each detail code to be excluded.
125	NOPAP	Gynecology Appointment Only, No Paps	Gynecology appointment only, No Pap Smears	
126	NP	Nurse Practitioner	Nurse Practitioner: Identifies the professional qualifications of the provider. It is a temporary detail code.	In a future release, will display the provider professional category.
127	NPCL	New Prenatal Class	New Prenatal Class: Initial class for pregnant patients. Pregnancy must be verified before the patient is given an appointment. Code for this class ensures that all pregnant patients will be given an opportunity to attend the class. Attendance by both parents is recommended.	
128	NPSYC	Neuropsychological Testing Only - No ADHD	Neuropsychological Testing Only - No ADHD: Reserved for patients requiring neuropsychological testing vice other types of psychological testing.	

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STANDARD DETAIL CODES

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
129	NST	Non Stress Test (fetal monitoring during pregnancy)	Non Stress Test (fetal monitoring during pregnancy): Reserved for Obstetrics patients requiring fetal monitoring during pregnancy. Requires special equipment and scheduling of room and trained staff.	
130	NUTR	Nutrition Education	Nutrition Education: Reserved as a group appointment for education concerning the intake and utilization of food substances.	
131	OAE	Newborn Hearing Screening	Newborn Hearing Screening: Appointment for infants who did not have a newborn hearing screen prior to hospital discharge. It is recommended that this screening be done before 3 months of age.	
132	OB	Pregnancy or Obstetrics	Pregnancy or Obstetrics: Reserved for routine, non-complicated Obstetrics patient appointments. This code is to be used only in multi-specialty clinics to identify this type of care, e.g., Family Medicine clinic providing Obstetrical care, or Obstetrics/Gynecology.	
133	ONC	Cancer Patient or Treatment Only	Cancer patient or treatment only: Reserved for patients undergoing cancer treatment.	Can be combined with EVAL and EDU.
133a	ORTHO	Orthopedics	Orthopedics - Reserved for patients who need to see an orthopedics specialist in a Primary Care clinic.	
134	OSS	Overseas Screening	Overseas Screening: Reserved as special physical examinations for patients in receipt of orders for overseas assignments.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
135	PA	Physician's Assistant	Physician's Assistant: Identifies the professional qualifications of the provider. It is a temporary detail code.	In a future release, will display the provider professional category.
136	PACE	Pacemaker	Pacemaker: Annual checkup for patients with pacemaker. The code ensures annual appointments will be available for these patients.	
137	PAP	Pap Smear	Pap Smear: Reserved for patients that require only a Pap Smear (annual Paps or acute GYN patients needing Paps).	
138	PARA	Abdominal Paracentesis	Abdominal Paracentesis: Paracentesis is withdrawal of peritoneal fluid for diagnostic and therapeutic purposes using a large-bore needle, syringe, suction and/or gravity. This is a specialized procedure that requires a separate detail code for planning and ordering specialized supplies.	
139	PARENT	Parenting Class	Parenting Class: This is specialized counseling for cases where child neglect has occurred or there is a risk of occurrence. These cases warrant special identification by a separate detail code for planning and management.	
139a	PBO	Provider Book Only	Provider Book Only Appointments	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
140	PDS	Pathfinding/Drill Sergeant Test	Pathfinding/Drill Sergeant Test: Appointment for service members who have been selected to attend pathfinding/drill sergeant school. Reserves an appointment slot for these soldiers.	
141	PE	Physical Exam	Physical Exam: Appointment for personnel who require a physical exam for schooling, age, or retirement. Can be combined with patient access types.	
142	PEG	Percutaneous Endoscopic Gastrostomy	Percutaneous Endoscopic Gastrostomy: A non-surgical technique for the percutaneous placement of a gastrostomy or jejunostomy tube using endoscopic technique. This is a specialized procedure that requires individualized teaching, special order equipment and coordination with other departments. A separate detail code is necessary for planning, management and tracking.	
143	PFT	Pulmonary Function Test/Spirometry	Pulmonary Function Tests/Spirometry: Reserved to determine the functional capability of the respiratory system. It is one of the basic procedures to check for numerous respiratory conditions such as asthma, COPD, and a restrictive versus obstructive disease process. It is also required for certain career fields (AFSCs) as part of the annual physical.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
144	PHA	Preventive Health Assessment	Preventive Health Assessment: Reserved for annual preventive/screening for active duty members for worldwide qualification and mobility readiness.	
145	PHOTO	Photos	Photos: Photography appointment to record the stages of a patient's treatment. (ie. Plast Surg, Ophth, ENT). Procedure requires specific equipment.	
146	PLASMA	Plasma	Plasma: Procedure requires specific equipment.	
147	PNB	Prostate Needle Biopsy	Prostate Needle Biopsy: Reserved for patients who require biopsy of the prostate. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
148	POAE	Pediatric Otoacoustic Emission Test	Pediatric Otoacoustic Emission Test: A hearing test for children. Procedure requires specialized skills and specific equipment.	
149	POP	Post Operative Follow-up	Post Operative Follow-up: Codes ensures that post-op patients are seen within the time period specified by the provider.	
150	PP	Post-Partum Patient Only	Post-Partum Patient Only: Reserved for women who are experiencing blues following childbirth.	
151	PPD+	Positive Purified Protein Derivative (PPD) or Other Tuberculosis Test Evals	Positive Purified Protein Derivative (PPD) or Other Tuberculosis Test Evaluations: Reserved for patients who have been tested for tuberculosis. Appointment should be given within 48-72 hours of the injection for optimal result examination.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
151a	PRENAT	Prenatal	Prenatal: Reserved for individual or group appointment for intake of new obstetrics patient that includes interview, assessments, lab work, prenatal vitamins, establishment of record, referral(s), and/or scheduling of physical.	
152	PREOP	Check-in for Surgery / Pre-operation Rounds	Check-in for Surgery / Pre-operation Rounds: Reserved for patients who are scheduled for surgical procedures. Appointment requires comprehensive, coordinated evaluation between multiple departments (anesthesia, lab, radiology, surgery).	
153	PRK	Photo Refractive Keratectomy	Photo Refractive Keratectomy: Reserved for a patient 18 years or older who is scheduled for reduction or elimination of myopia (nearsightedness) or hyperopia (farsightedness) with varying range of astigmatism by means of epithelium ablation and laser treatment. Command interest requires unique identifier for planning, management and tracking purposes.	
154	PRT	Physical Readiness Test Screens	Physical Readiness Test Screens: Mandated services (military only.). Reserves appointments for the screening that is conducted twice yearly prior to the physical readiness test.	
155	PULM	Pulmonary Patient Only	Pulmonary patients Only: Reserved for inhalation (IPPB) therapy (established patient). Requires special equipment.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
156	PVA	Psychological Vocational Assessment	Psychological Vocational Assessment: Appointment requiring specific documentation and time requirements.	
157	PVR	Post-Void Residual	Post Void Residual: Reserved for Urology patients undergoing urinalysis testing. Special equipment and scheduling of room and provider is required.	
158	REHAB	Rehabilitation Therapy	Rehabilitation Therapy: Therapy requiring specific equipment.	
159	RET	Retinal Screening	Retinal Screening: Reserved for general exam/new patients for determining disease or the potential for disease of the retina.	
160	RMV	Removals	Removals: Removal of catheters, dressings, contraceptive devices, etc (established patients.). Used in combination with other detail codes, e.g., RMV IUD.	Combine with other detail codes.
160a	RP1	Research Protocol 1	Research Protocol 1: Infectious disease research protocols that require specialized service by qualified providers.	
160b	RP2	Research Protocol 2	Research Protocol 2: Infectious disease research protocols that require specialized service by qualified providers.	
160c	RP3	Research Protocol 3	Research Protocol 3: Infectious disease research protocols that require specialized service by qualified providers.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
160d	RP4	Research Protocol 4	Research Protocol 4: Infectious disease research protocols that require specialized service by qualified providers.	
160e	RP5	Research Protocol 5	Research Protocol 5: Infectious disease research protocols that require specialized service by qualified providers.	
160f	RP6	Research Protocol 6	Research Protocol 6: Infectious disease research protocols that require specialized service by qualified providers.	
160g	RP7	Research Protocol 7	Research Protocol 7: Infectious disease research protocols that require specialized service by qualified providers.	
160h	RP8	Research Protocol 8	Research Protocol 8: Infectious disease research protocols that require specialized service by qualified providers.	
160l	RP9	Research Protocol 9	Research Protocol 9: Infectious disease research protocols that require specialized service by qualified providers.	
160j	RP10	Research Protocol 10	Research Protocol 10: Infectious disease research protocols that require specialized service by qualified providers.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
161	RPD	Readiness Post Deployment	Readiness Post-Deployment: Reserved for patients who are seeking care for potentially deployment related experiences or exposures and for patients who are experiencing health concerns which they relate to a deployment, e.g., family members of recently deployed personnel. Patients may be referred to care during screening for deployment or after deployment following a PCM evaluation. Should be a 30 minute appointment. May be booked as ACUT, ROUT, or WELL appointment types.	
162	RPG	Retrograde Pylelogram	Retrograde Pylelogram: Reserved for a patient who requires radiographic study of the kidneys. Requires radiographic equipment, a scheduled room and trained staff.	
163	RPRE	Readiness Pre-Deployment Health	Readiness Pre-Deployment Health: Appointments requiring specific documentation and time requirements.	
163a	RTM	Rehabilitation Team Meeting	Identify treatment plan appointments with the patient, the Behavioral Health counselor, and the patient's command. The appointments are greater in length than the standard treatment appointments and must be scheduled in advance to ensure command participation. Prep time is involved in for this meeting, so advance notice is required.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
164	RUG	Retrograde Urethrogram	Retrograde Urethrogram: Reserved for a patient who requires radiographic study of the urinary tract. Requires radiographic equipment, a scheduled room, and trained staff.	
164a	RX	Medication	Reserved for patients requiring a follow-up appointment to review their medication treatment plan with the provider, definitely essential in the Behavioral Health arena. This appointment differs from a medication refill in that a face to face interaction must occur to assess the patient. The patient not only sees the Behavioral Health Provider, but has interface with other health care providers, such as the psychiatric technician, social worker, and/or pharmacist.	
165	SCH	School Physical	School Physical: Reserved appointments for school and sports physicals required by schools.	
166	SCOLI	Scoliosis	Scoliosis: Initial examination for or not otherwise specified (NOS) curvatures of the spine.	
167	SCS	Skin Cancer Screening	Skin Cancer Screening: Reserved for patients who self-refer to the Dermatology Clinic during National Skin Cancer Screening Month. Availability is sporadic and targeted toward prevention. This annual promotion runs counter to the normal practice of seeing active duty and TRICARE Prime patients on a referral basis only.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
168	SEA	Sea Duty Screening	Sea Duty Screening: Reserved for determining disease or the potential for developing an illness, mandated services (military only).	
169	SKT	Skin Test	Skin test: Procedure requires specialized skills and specific equipment.	
170	SLEEP	Sleep	Sleep: Study Clinic (Attended or non-attended) reserved for sleep study evaluations that require an overnight stay.	
171	SPD	Special Duty Evaluation	Special Duty Evaluation: To reserve appointment slots for Active Duty personnel who need evaluations within a specified period of time.	
172	SPE	Separation or Retirement Physical Exam	Separation or Retirement Physical Exam: Reserved appointment for Active Duty personnel who require a physical exam for separation or retirement from the military.	
173	SPRINT	Sprint Test	Sprint Test (speech recognition in noise test): Reserved by audiology for Active Duty military to assess H-3 profiled soldiers to provide recommendations concerning a potential communication handicap. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
174	ST	Exercise Stress Test	Exercise Stress Test: Reserved for a patient who will be asked to exercise on a treadmill while attached to heart monitoring equipment for evaluation of a possible heart condition. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
175	STRESS	Stress Management Education Program	Stress Management Education Program: This is a group appointment and a referral may or may not be required. The appointment is of longer duration and the duration is determined by the clinic/provider.	Combine with other detail codes.
175a	STROKE	Stroke	Stroke: Reserved for patients who require special evaluation by a stroke fellowship doctor who may use special equipment such as a transcranial doppler untrasound.	
176	TECH	Provider is a Technician	Provider is a Technician: Identifies the professional qualifications of the provider. It is a temporary detail code.	In a future release, will display the provider professional category.
177	TEE	Trans-esophageal Echocardiogram	Trans-esophageal Echocardiogram: Reserved for a patient who is undergoing ultrasound evaluation of the heart walls and internal structures through insertion of an endoscope into the esophagus. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
178	TELMED	Tele-Medicine Conference	Tele-Medicine Conference: Sessions requiring specific equipment and location.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
179	THAL	Thallium Stress Test	Thallium Stress Test: Reserved for a patient who will be asked to exercise on a treadmill while attached to heart monitoring equipment and while undergoing injection of a radiographic tracing element (Thallium) to evaluate heart function. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
180	TILT	Tilt Test, Test for Syncope	Tilt Test, Test for Syncope: Tilt table/vagal response test, test for syncope. Procedure requires specialized skills and equipment.	
181	TOBCES	Tobacco Cessation	Tobacco Cessation: Counseling/risk factors assessment for tobacco users.	May combine with EDU for education.
181a	TOUR	Hospital Orientation	Hospital Orientation: Reserved for individual or group appointment orienting patient and significant others, e.g. Labor, Delivery, Mother-Baby Unit, Nursery, policies and procedures.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
182	TRACTION	Traction Physical Therapy	Traction Physical Therapy: A specialized treatment appointment for patients prescribed traction after an evaluation by a physical therapist, or a doctor from Orthopedics, Physical Medicine & Rehabilitation, or Neuro-Surgery. Traction treatment is limited to the number of traction tables available at each clinic. Traction is the therapeutic use of manual or mechanical tension created by a pulling force to produce a combination of distraction and gliding to relieve pain and to increase tissue flexibility.	
183	TRPLT	Transplant	Transplant: Utilized to distinguish established visits by transplant patients. Requires specific providers.	
184	TRUS	Transrectal Ultrasound	Transrectal Ultrasound: Reserved by the Urology Clinic for a patient who is being evaluated for a prostate condition. Procedure requires specialized equipment, trained staff, scheduling of a room, and provider specified timeframe.	
185	URODY	Urodynamics	Urodynamics: Procedure to study the hydrodynamics of the urinary tract. Procedure requires specialized skills and specific equipment.	
186	UROGYN	Urogynecology	Urogynecology: Reserved as initial exam for urology/gynecology patients.	
187	US	Ultrasound	Ultrasound: Procedure requires specialized skills and specific equipment.	Can be combined with EVAL and EDU.

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
187a	VAERS	Vaccine Adverse Event Reporting	Vaccine Adverse Event Reporting: Reserved for patients treated under the Vaccine Adverse Event Reporting System.	
188	VAS	Vasectomy	Vasectomy: Reserved for patients desiring a vasectomy. This detail code is used to designate GRP appointment slots where these patients must first undergo counseling.	
189	VF	Visual Field Exam	Visual Field Exam: Procedure requires specialized skills, specific equipment and location.	
190	VIP	Very Important Patient	Very Important Patient: Required to reserve slots for the numerous Senators, Governmental Officials and General Officers who frequent the clinics in the National Capital Area.	
191	VT	Venom Test	Venom Test: Reserved for contacting the patient and or the parent/guardian to inform them of the need to do venom testing and specifying the time of the appointment and special testing date.	
192	WB	Well Baby	Well Baby: Reserved for a routine pediatric appointment used with an age code.	Use in conjunction with an age code.
193	WCE	Work Capacity Evaluation	Work Capacity Evaluation: Appointment to assess a patient's work capacity to evaluate the potential to perform or return to competitive work. Appointment requires specific documentation and time requirements.	

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ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
194	WEA	Web and MCP Bookable	Web and MCP Bookable: An appointment that is shared and bookable by WEB appointing and simultaneously by MTF direct care appointing. For sites using the WEA detail code to mark Web appointments, all appointments without the WEA detail code will be excluded from the Web.	Web code
196	WOUND	Wound Care	Wound Care: Appointments must be reserved to accommodate the variable number of patients who require same-day wound care.	

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STANDARD DETAIL CODES

The following five tables show the standard detail codes grouped by one of the following detail code categories: (1) patient access types, (2) procedure or test, (3) evaluation or education, (4) provider classification, and (5) multi-use/miscellaneous. The provider classification codes will be supported only temporarily until HIPAA standard provider classification codes are implemented.

	Patient Access Types
BPAD	Active Duty Only
BPAP	Active Duty and Prime Enrollees
BPAPS	Active Duty, Prime Enrollees, TRICARE Plus, and Special Programs Patients
BPGME	Graduate Medical Education
MC	Medicare Eligible
BPNAD	No Active Duty
BPNAP	TRICARE Standard, Space Available, and Other Patients - No AD or Prime
BPNPR	No Prime Enrollees
BPPR	Prime Enrollees Only, No Active Duty
BPSP	Special Programs Patient and TRICARE Plus
BPTS	TRICARE Standard Patient Only

	Procedure and Test Codes	
ACUP	*Accupuncture*	*New Oct 2003*
ANPST	Anergy Panel (stick)	
ANRD	Anergy Panel Reading	
ASTIG	Treatment of Astigmatism	
AUENT	Audiometric Diagnostic	
BEESN	Bee Sting	
BIO	Biopsy	
BOTOX	Botulinum Toxin Type A Injections	
BRON	Bronchoscopy	
BTL	Bilateral Tubal Ligation	May use with EDU or other comments that may apply.
CATH	Catheter	Combine with RMV for removal of Catheter or INS for insertion.
CAVH	24 hour Dialysis Treatment	

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STANDARD DETAIL CODES

	Procedure and Test Codes	
CIRC	Circumcision	May use with EDU or other comments that may apply
COLON	Colonoscopy	
COLPO	Colposcopy, abnormal pap required	
CORSCR	Cornea Scrape/Rescrape	
COSMETIC	Referrals for Non-Covered Cosmetic Procedures	When preceded by "No", restricts appointing of patients who are seeking cosmetic surgery that is not medically necessary or is pre-arranged.
CPAP	Continuous Positive Airway Pressure	
CYSTO	Cystoscopy	
DENDO	Endodontics	New Oct 2003
DEXA	DEXA Bone Scan	
DEXPR	Dental Exam/Prophylactic Cleaning	New Oct 2003
DIL	Dilation	
DOMFS	Oral Maxillofacial Surgery	New Oct 2003
DOPER	Operative Dentistry	New Oct 2003
DORTHO	Orthodontics	New Oct 2003
DOSIM	Methocholine & CPEX	
DPEDO	Pediatric Dentistry	New Oct 2003
DPERIO	Periodontics	New Oct 2003
DPRO	Dental Prophylactic Cleaning	New Oct 2003
DPROS	Prosthodontics	New Oct 2003
DSGCH	Dressing/Bandage Change	
DTMD	Temporomandibular Disorders	New Oct 2003
DXE	Dobutamine Stress Test	
ECG	Electrocardiogram	
ECHO	Echocardiogram	
EEG	Electroencephalography	
EGD	Scope of Esophagus and Lower Stomach	
EMGM	Nerve Conduction Studies	
ENG	Electronystagmography Testing	
EP	Auditory Brainstem, Visual, Upper/Lower Somatosensory Evoked Potentials	

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	Procedure and Test Codes	
ERCP	Endoscopic Retrograde Cholangiopancreatography	
FLAP	Flaplift	
FLEXS	Esophogastoduodenoscopy/Flexible Sigmoidoscopy	May use with EDU or other comments that may apply
FNA	Fine Needle Aspiration	
HBT	Hydrogen Breath Test	
HCATH	Cardiac Catherization	Use with APV appointment type.
HOLT	Holter Monitor	
HSG	Hysterosalpingogram	
INJECT	Shot only	
INS	Insertions	Combine with other detail codes.
ISOK	Isolinetic Testing	
IUD	Placement of IUD	Combine with RMV for removal of IUD or INS for insertion.
IVP	Intravenous Pyelogram	
LASER	Laser	
LASEYE	Laser Eye Surgery	
LASIK	Laser-in-situkeratomileusis	
LBX	Liver Biopsy	
LEEP	Loop Electro-surgical Excision Procedure	New Oct 2003
LES	Leishmaniasis Treatment	
LP	Lumbar Puncture	
MANO	Manometry	
MANO/PH	Manometry/24 Hr pH Study	
MEDEX	Lumbar Extension Machine, Sports Medicine Only	
MINOR	Excision of Skin Tags, Moles, Warts, or Subcutaneous Nodules	Is an ambulatory procedure visit (APV)
MOHS	MOHS Surgery	
MOVDIS	Movement Disorder	New Oct 2003
NPSYC	Neuropsychological Testing Only - No ADHD	
NST	Non Stress Test (fetal monitoring during pregnancy)	
OAE	Newborn Hearing Screening	

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STANDARD DETAIL CODES

	Procedure and Test Codes	
PACE	Pacemaker	
PAP	Pap Smear	
PARA	Abdominal Paracentesis	
PEG	Percutaneous Endoscopic Gastrostomy	
PFT	Pulmonary Function Test/Spirometry	
PHOTO	Photos	
PLASMA	Plasma	
PNB	Prostate Needle Biopsy	
POAE	Pediatric Otoacoustic Emission Test	
PPD+	Positive Purified Protein Derivative (PPD) or Other Tuberculosis Test Evals	
PRK	Photo Refractive Keratectomy	
PVR	Post-Void Residual	
RET	Retinal Screening	
RMV	Removals	Combine with other detail codes.
RPG	Retrograde Pylelogram	
RUG	Retrograde Urethrogram	
SCS	Skin Cancer Screening	
SKT	Skin Test	
SPRINT	Sprint Test	
ST	Exercise Stress Test	
STROKE	Stroke	New Oct 2003
TEE	Transesophageal Echocardiogram	
THAL	Thallium Stress Test	
TILT	Tilt Test, Test for Syncope	
TRUS	Transrectal Ultrasound	
URODY	Urodynamics	
US	Ultrasound	May be combined with EVAL and EDU.
VAS	Vasectomy	
VF	Visual Field Exam	
VT	Venom Test	

APPENDIX M

STANDARD DETAIL CODES

	Education and Evaluation Codes	
ACG	After Care Group	
ADHD	Attention Deficit and Hyperactivity Disorder or Attention Deficit Disorder	Evaluation
ADSC	Alcohol and Drug Screening Only	Special resources
ANGER	Anger Management Education	
ASTHMA	Asthma Evaluation or Education Appointments	
BF	*Breast Feeding*	Use with EDU. *New Oct 2003*
BEPC	Birth and Early Parenting Class	
BFC	Breast Feeding Class	
CARD	Cardiac Counseling/Care	New Dec 2001.
CCEP	Comprehensive Clinical Evaluation Program for Persian Gulf Illnesses	
CLEFT	Cleft Lip and Palate	
CMDPSY	Command Directed Psychological Evaluations	
COUNS	Counseling Only	
DCONS	Dental Consultation	New Oct 2003
DEVAL	Dental Evaluation	New Oct 2003
DEXAM	Dental Examination	New Oct 2003
DPO	Dental Post-Operative Visit	New Oct 2003
DSC	Dental Sick Call	New Oct 2003
DVIOL	Domestic Violence Class	
EAR	Ear Recheck	
EDU	Education or Class	Combine with other detail codes.
ER	Emergency Room Follow-Up Appointment	New Oct 2003
EVAL	Evaluation - in depth	Combine with other detail codes.
FAM	Family Therapy or Meeting	
FCC	Child Care Provider Mental Health Screening	
FOOT	Foot or Ankle Evaluation	
GAST	Gastric Bypass Surgery Psychological Evaluation	
HAE	Hearing Aid Evaluation	
HAND	Hand Patient Only	

APPENDIX M

STANDARD DETAIL CODES

	Education and Evaluation Codes	
HEAD	Headache Education	
IMDEF	Immunodeficiency	Combine with other detail codes.
KNEE	Knee School for Patient with Knee Pain	May combine with EDU for education.
LIFE	Life Skills Group	
MEB	Evaluation Board Physical Exam	
NBO	Newborn Physical Only (3-7 days after discharge)	
NPCL	New Prenatal Class	
NUTR	Nutrition Education	
OSS	Overseas Screening	
PARENT	Parenting Class	
PE	Physical Exam	
PHA	Preventive Health Assessment	
POP	Post Operative Follow-up	
PRT	Physical Readiness Test Screens	
PVA	Psychological Vocational Assessment	
RP1	Research Protocol 1	New Oct 2003
RP2	Research Protocol 2	New Oct 2003
RP3	Research Protocol 3	New Oct 2003
RP4	Research Protocol 4	New Oct 2003
RP5	Research Protocol 5	New Oct 2003
RP6	Research Protocol 6	New Oct 2003
RP7	Research Protocol 7	New Oct 2003
RP8	Research Protocol 8	New Oct 2003
RP9	Research Protocol 9	New Oct 2003
RP10	Research Protocol 10	New Oct 2003
RTM	Rehabilitation Team Meeting	
RX	Medication	
SCH	School Physical	
SCOLI	Scoliosis	
SEA	Sea Duty Screening	
SLEEP	Sleep	
SPD	Special Duty Evaluation	
SPE	Separation or Retirement Physical Exam	
STRESS	Stress Management Education Program	Combine with other detail codes.
TOBCES	Tobacco Cessation	May combine with EDU for education.

APPENDIX M

STANDARD DETAIL CODES

	Education and Evaluation Codes	
TOUR	Hospital Orientation	
VAERS	Vaccine Adverse Event Reporting	
WCE	Work Capacity Evaluation	

	Provider Classification Codes (temporary)	
CNM	Certified Nurse Midwife	In a future release, will display the HIPAA provider professional category.
IDC	Independent Duty Corpsman	In a future release, will display the HIPAA provider professional category.
NP	Nurse Practitioner	In a future release, will display the HIPAA provider professional category.
PA	Physician's Assistant	In a future release, will display the HIPAA provider professional category.
TECH	Provider is a Technician	In a future release, will display the HIPAA provider professional category.

APPENDIX M

STANDARD DETAIL CODES

	Multi-Use/Miscellaneous	
1TT	First Trimester	May combine with EDU for education.
2TT	Second Trimester	May combine with EDU for education.
3TT	Third Trimester	May combine with EDU for education.
AD	Alcohol and Drug	May combine with EDU for education.
ADEI	Alcohol and Drug Early Intervention	
ADTX	Alcohol and Drug Treatment 2 week Program Only	Special resources
AQUA	AQUA Pool	
BCP	Birth Control	
BF>	Weight Exceeding Body Fat Standards	
BK	Back Pain or Problem	
CB	Cross Book	Reserve appointments for patients not enrolled to this MTF. New Dec 2001.
CHOL	Cholesterol	
CM	Case Management	New Oct 2003
COB	Complicated OB Patient Only	
DERM	Dermatology	Perform as primary care or specialty care in a multi-specialty clinic. New Dec 2001.
DM	Diabetes	
E&I	Female Endocrine and Infertility Patient Only	
EFMP	Exceptional Family Member Program	May use with EDU or other comments that apply
EXERC	Exercise Therapy	
EYEDZ	Eye Disease	
EYEEX	Eye Exam	
FE	Female Patient Only	
FLT	Flight Physical Exam	
GDB	Gestational Diabetes Patient	
GDBL	Good Backlog Appointments	New Oct 2003

APPENDIX M

STANDARD DETAIL CODES

	Multi-Use/Miscellaneous	
GENE	Genetics Consult	
GYN	Gynecology Appointments Only	
HC	House Calls	
HCDC	Hearing Conservation Patient	
HTN	Hypertension Patient	
INF	Infant Care	New Oct 2003
MA	Male Patient Only	
MH	Mental Health	Perform as primary care or specialty care in a multi-specialty clinic. New Feb 2002
MOBEX	Mobilization Intervention & Exercise Therapy, Sports Medicine Only	
NECK	Neck Patient	
NO	Universal Exclusion - used in front of other detail codes	Combine with other detail codes. "No" should precede each detail code to be excluded.
NOPAP	Gynecology Appointment Only, No Paps	
OB	Pregnancy or Obstetrics	
ONC	Cancer Patient or Treatment Only	May be combined with EVAL and EDU.
ORTHO	Orthopedics	New Oct 2003
PBO	Provider Book Only	New Oct 2001
PDS	Pathfinding/Drill Sergeant Test	Candidate for cancellation
PP	Post-Partum Patient Only	
PRENAT	Prenatal	New Oct 2003
PREOP	Check-in for Surgery / Pre-operation Rounds	
PULM	Pulmonary Patient Only	
REHAB	Rehabilitation Therapy	
RPD	Readiness Post Deployment	Readiness
RPRE	Readiness Pre-Deployment Health	Readiness
TELMED	Tele-Medicine Conference	
TRACTION	Traction Physical Therapy	
TRPLT	Transplant	
UROGYN	Urogynecology	

APPENDIX M

STANDARD DETAIL CODES

	Multi-Use/Miscellaneous	
VIP	Very Important Patient	
WB	Well Baby	Use with an age code.
WEA	Web and MCP Bookable	Web code for online appointing
WOUND	Wound Care	

APPENDIX N

PATIENT ACCESS TYPES

APPENDIX N

PATIENT ACCESS TYPES

The following Patient Access Type codes are special detail codes in the Detail Code table. **Several of the Patient Access Types have been redefined to remove TRICARE Prime as a Prime category. Also TRICARE Senior Prime has been removed from the definitions.** The standard patient access codes should be used to reserve appointments for beneficiaries to meet TRICARE or contract quotients.

1. Patient Access Types

Code	Description
BPAD	Active Duty
BPPR	Prime Enrollees Only, No Active Duty
BPAP	Active Duty and Prime
BPGME	Graduate Medical Education
BPNAD	No Active Duty
BPNPR	No Prime
BPNAP	No Active Duty, No Prime
BPSP	Special Programs Patients and TRICARE Plus
BPAPS	Active Duty, Prime, TRICARE Plus, and Special Programs
BPTS	TRICARE Standard/CHAMPUS

2. Operational Definitions

The Patient Access Types provide the capability to reserve an appointment for the specific group of beneficiaries indicated in the operational definition below.

- Active Duty *(BPAD)* — Uniformed Services Personnel (regardless of where or whether they are enrolled), guard and reserve on active duty, NATO, and other status of forces agreement active duty members are the only patients permitted to be booked for appointments reserved for this access type. The intent of this type is to allow sites to ensure access for any Active Duty member to the MTF for care that is appropriate for that type of beneficiary.

- Prime *(BPPR)* — Family members of Uniformed Services Personnel, retirees, and retiree family members, who are enrolled in TRICARE to any local or remote MTF, are the only patients permitted to be booked for appointments reserved by this access type. This group also includes enrollees with contractor PCMs. This group does not include NATO family members and enrollees to the Uniformed Services Family Health Plan (USFHP), TRICARE Plus, or Federal Employees Health Benefit Plan (FEHBP) except by specific authorization.

APPENDIX N

PATIENT ACCESS TYPES

The intent of this type is to allow sites to ensure access for any Non-Active Duty TRICARE Prime enrollee to care that is appropriate for that type of beneficiary.

- Active Duty and Prime (*BPAP*) — This category includes Active Duty and Prime patients. This group represents the combination of BPAD and BPPR groups. Refer to above operational definitions for each category.

- Graduate Medical Education *(BPGME)* — Any interesting case designated by local directive as reserved for the training of Graduate Medical Education staff. The clinic will usually book appointments for these patients.

- No Active Duty *(BPNAD)* — Uniformed Services Personnel (regardless of where or whether they are enrolled), FEHBP, guard and reserve on active duty, NATO family members, USFHP enrollees (except by specific authorization), Secretarial Designees, and other status of forces agreement active duty members may not be booked into this slot. Anyone else may be booked into this slot, including TRICARE Standard, TRICARE Extra, and Uniformed Services family members, retirees, retiree family members, and TRICARE Plus enrollees. This access type is intended to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Active Duty.

- No Prime *(BPNPR)* — Non-active duty Prime enrollees from the local MTF or remote MTFs, contractor enrollees, and TRICARE Plus may not be booked into this slot. Active Duty may be booked to these appointments. All other beneficiaries, including Medicare patients, TRICARE Standard, NATO, NATO family members, Secretarial Designees, etc. may be booked to these appointments. The intent of this access type is to reserve appointments for Medicare, Space A, and other special needs patients and to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Prime patients.

- No Active Duty, No Prime *(BPNAP)* — TRICARE Standard, TRICARE Extra, Medicare, and other direct care only (Space A) beneficiaries may be booked to these appointments. This access type is primarily designed to reserve appointments for "at risk" patients who are contractor reliant. Secondarily, this type also supports the contract revised financing requirement to capture non-enrollees who would otherwise go downtown, i.e. Medicare and Space A.

- Special Programs Patients (BPSP) — Beneficiaries enrolled in special local programs including TRICARE Plus may be booked to these appointments. This access type is designed to ensure that a site's special program access requirements can be met by appointing.

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PATIENT ACCESS TYPES

- Active Duty, Prime, *TRICARE Plus,* and Special Programs *(BPAPS)* — This category includes Active Duty, Prime, TRICARE Plus, and Special Programs Patients. Refer to above operational definitions for each category.

- TRICARE Standard/CHAMPUS *(BPTS)* — Active Duty family members, retirees, and retiree family members who are entitled to CHAMPUS reimbursement for civilian care rendered. This type supports the contract revised financing requirement to capture CHAMPUS non-enrollees who would otherwise go downtown.

APPENDIX O

APS EDUCATION

APPENDIX O

APS EDUCATION

1. Education and Training

The difference between education and training in this guide is that education focuses on providing knowledge and understanding while training focuses on providing capabilities to perform functions. Education is instruction performed by functional teams and includes executive briefings, management briefings, and staff business rule instruction. The objective of education is to migrate current business practices into a new business model and to assure data quality by applying correct business practices. Training is the instruction performed by technical teams and includes system demonstrations combined with general guidance on how to use the system application. The objective of training is to teach data entry staff the appropriate procedures to enter correct data into a system and to understand and use the system properly.

Both education and training will be required as an ongoing effort by users at all levels to successfully implement and sustain APS and Access Improvement. Refer to Appendix Q, MTF Master Implementation Tasks, for suggested education and training. Appointment Standardization training was performed in Spring 2001 in preparation for the release of Appointment Standardization. This section is included as documentation on the techniques and syllabus used to support Appointment Standardization training.

2. Education and Training Strategy

TMA funded education was developed and made available to sites as follows:

- The TRICARE Access Imperatives Web Site was implemented by TMA in August 2000. The site contains all documentation related to APS and provides support to the MTFs during transition to the APS and Access Improvement programs. Documents cover policies, related presentations, business rules, guidance on implementation of the APS program at the MTF level, site-specific implementation plans as examples, software enhancements, software requirements and design documents, tools to help sites obtain ATC performance measures, and studies on Best Business Practices in Appointing. This site will be kept current by TMA. The What's New section of the Web site will list each new update to materials on the Web site. The Web address is http://www.tricare.osd.mil/tai.

- Commanders received an executive briefing at the January 2001 TRICARE Conference that explained APS and Access Improvement and how these two programs will be implemented.

- TMA is available at any time via telephone to answer questions from the LAs or sites. The LAs may elect to be the conduit for questions so that answers are made available to all sites in the Region. *Refer to Appendix S for information on the Point of Contact.*

- Local MTF training should emphasize selection of appropriate access standards, use of the ten appointment types, use of detail codes, the relationship between the Access to Care Category and appointment types, identification of beneficiaries for priority booking, determination of enrollment eligibility, classification of a count versus non-count appointments, the appointments join/split function, a MEPRS visit definition, end-of-day processing, coordination of CHCS and Ambulatory Data Systems (ADS) under appointment standardization, access to care measurement, and the impact on enrollment based capitation when appointment types are changed.

3. APS Self Training

In order to aid sites with the transition to APS and use of MCP Booking, self-training materials have been developed and are available as follows.

A MCP Computer-based Training (CBT) Course for Novices (101), developed by the Clinical Information Technology Program Office (CITPO), has been distributed to all MTFs on CD-ROM. Sites should use this CBT to train new booking clerks. This CBT can be located at the URL: https://chcswebsrvr.spawar.navy.mil/. This is a secure website and you will be required to register and receive a user id and password to access the CBT. The website requires 128-bit encryption.

An Advanced MCP CBT course, developed by CITPO and TMA jointly, will cover data entry for both CHCS MCP Booking and Schedule/Template Build functions for APS II and APS II Plus. The CBT is available on CD-ROM and on the Web and allows testing for competency per Joint Commission on Accreditation of Healthcare Organizations (JCAHO) guidance. Feedback will be available to supervisors but only when the CBT tests are taken on the Web. This courseware became available in December 2000 and was updated for APS II Plus in 2001. This CBT does not cover all the details of the MCP exception processing which will be left to local experts. This CBT can be located at the URL: https://chcswebsrvr.spawar.navy.mil/. This is a secure website and you will be required to register and receive a user id and password to access the CBT. The website requires 128-bit encryption.

4. APS Formal Training

- A 5-day CHCS Managed Care Program (MCP) Super Users regional training course was conducted in the late summer to early fall of 2000 by CITPO. This course includes training on MCP Booking and MCP File and Table builds. TMA, CITPO, and the LAs had been discussing whether and how to make this training available in the future.

- Multiple seminars were conducted by TMA in a central CONUS location and Europe during the months of March, April, and May 2001. Training dates for TRICARE Pacific were in September 2001. Each CONUS seminar required a day and a half and was comprised of eight courses covering the APS Business Rules and APS Implementation Guidance. Overseas seminars *were* modified to fit MTF needs. The optimum class size for CONUS was 30 - 50 participants for each course but as many as 60 attended one course though participants in the back were very far from the projection screens. Participants attended classes according to their job description or per site recommendation. The course syllabus for the TMA Appointment Standardization seminars is included below.

5. Training Schedule for the APS Seminars

The schedule for the Appointment Standardization seminars in 2001 are shown below.

LOCATION	DATES	NUMBER SEMINARS	NUMBER PARTICIPANTS	REGION
Europe	March 19 - 23	3	90	13
WASHINGTON DC #1	April 10-11	1	50-60	2/5/15
WASHINGTON DC #2	April 12-13	1	40-50	1
WASHINGTON DC #3	May 1-2	1	30-40	6
WASHINGTON DC #4	May 3-4	1	30-40	Central
WASHINGTON DC #5	May 15-16	1	40-50	9/10/11
WASHINGTON DC #6	May 17-18	1	50-60	3/4
Japan	September 13-14	Canceled	40-50	14
Hawaii	September 17-18	1	40-50	12

6. TMA CONUS Based Appointment Standardization Seminars

Seminar Description: TMA conducted "train the trainer" Appointment Standardization seminars, two seminars overseas and six seminars in a central CONUS location during the months of April and May. Each seminar required a day and a half and was comprised of the five courses described below. The optimum class size was determined to be 30 - 50 participants for each CONUS course. Overseas seminars were altered to accommodate MTF needs and travel schedules of presenters. Participants attended classes according to their job description or per site recommendation. Access Managers should attend.

1. Course: Appointment Standardization Executive Overview (60 minutes) (Day 1)

Target Audience: Commanders, Lead Agents, Administrators, Appointment Supervisors, Information Management Supervisors

Course Contents: A high-level briefing covering the Appointment Standardization objectives and benefits, the imperatives of access standards, a review of the "as-is" model, a description of the "to be" model, directions on how to prepare for and sustain Appointment Standardization, implementation/sustainment steps and considerations, and information on tools and techniques available to measure success. A discussion of MHS future initiatives such as Web Appointing will also be covered.

2. Course: Provider Overview (30 minutes) (Day 1)

Target Audience: Department Heads, Providers

Course Contents: A high-level briefing covering the Appointment Standardization objectives and benefits, the imperatives of access standards, the improvements to the appointment process, a review of the impact on providers in the areas of scheduling and booking, a summary of the new business rules, a discussion of the measurement capabilities and tools available to determine success and to allow more accurate schedule planning/analysis, and instructions on preparation for implementation of MCP and Appointment Standardization. Training tools and sources will also be presented.

3. Course: Access to Care Measurement Business Rules (45 Minutes) (Day 1)

Target Audience: Lead Agents, Decision Support Staff, Information Management Supervisors, Appointments Systems Supervisors

APPENDIX O

APS EDUCATION

Course Contents: A business process overview of the techniques to collect accurate Access to Care data. This block of instruction will enable leadership at all levels to be familiar with possible problem areas and solutions to these problems of collecting accurate Access To Care data. Appropriate education strategies of appointments personnel, schedule analysis and management techniques, reporting methods, data interpretation and measurement of MTF performance to meet access standards for acute, routine, wellness and specialty care will be discussed. Upon completion of instruction attendees will be able to train staff to accurately use ATC in CHCS, understand the importance of the type of data and recognize and correct scheduling problems arising from the collection of this type of data.

4. Course: Lessons Learned (45 minutes) (Day 1)

Target Audience: Lead Agents, Decision Support Staff, Information Management Representatives, Appointments Scheduling Supervisors, Appointments Booking Supervisors, and MCSC representatives.

Course Contents: A briefing by a representative from a site describing their implementation procedures, benefits, and issues with Appointment Standardization.

5. Course: Open Access (45 minutes) (Day 1)

Target Audience: Lead Agents, Decision Support Staff, Information Management Representatives, Appointment Scheduling Supervisors, Appointment Booking Supervisors, and MCSC representatives.

Course Contents: A briefing *on the* Open Access booking model. The presentation will explain the Open Access model, and the implementation procedures, benefits, and problems encountered.

6. Course: Appointment Standardization Operational Overview (4 hours) (Days 1 & 2)

Target Audience: Information Management Representatives, Appointment Scheduling Supervisors, Appointment Booking Supervisors, and MCSC representatives.

Course Contents: A detailed technical briefing covering the Appointment Standardization objectives and benefits, the imperatives of access standards, the improvements to the appointment process, a review of the impact on scheduling and booking clerks, guidance for dental and ancillary booking, a summary of the new business rules, a discussion of the measurement capabilities and tools available to determine success and to allow more accurate schedule planning/analysis, and direction

on preparation for the use of MCP and implementation of Appointment Standardization. Training tools, capabilities and help sources will also be presented.

7. Course: Access To Care Measurement Tools (45 minutes) (Day 2)

Target Audience: Lead Agents, Decision Support Staff, Information Management Supervisors, Appointment Systems Supervisors

Course Contents: A technical briefing covering appointment standardization measurement capabilities, including tools available to determine improved performance and to allow more accurate schedule planning/analysis. Discussion will include measurement at the executive, decision support, and MTF operational levels. External sources of information will also be provided.

8. Course: Regional Overview (30 minutes) (Day 2)

Target Audience: Lead Agents, Decision Support Staff, Information Management Representatives, Appointment Scheduling Supervisors, Managed Care Staff, Appointment Booking Supervisors, and MCSC representatives.

Course Content: An overview by the Region of the Region's specific plans for APS implementation.

APPENDIX P

APS MARKETING AND BENEFITS

APPENDIX P

APS MARKETING AND BENEFITS

1. MARKETING AND COMMUNICATION

Effective marketing and ongoing communications must convey the imperatives and benefits of APS and Access Improvement to the SG POCs, the Commander, and the MTF staff. **Communications must keep all those involved in booking and scheduling and those managing these efforts informed of correct interpretations of the standards and appropriate methods to implement them**. APS is a phased program and will require ongoing support from the MTF to achieve the total solution. All those involved must make an effort to keep up with the status and updates to the APS program as it rolls out over time.

Marketing objectives for the SG POCs, Commanders, and their staff include the following.

- Educate the SG POCs, Commanders, and their MTF staff on the policies, GAO mandates, and imperatives of APS and Access Improvement
- Motivate the SGs, Commanders and their MTF staff by explaining the objectives and benefits of APS and Access Improvement
- Educate the MTF staff on the APS methodology to ensure proper implementation and sustainment
- Explain the role of the Lead Agent (LA) in the establishment and maintenance of standards, including new appointments types, and new detail codes
- Explain that the LA must take the lead role in arranging education and training for the MTFs
- Explain the APS phases, program features, and the training options so that Commanders and their staff can plan appropriately. Presentations will be on the TAI Web Site to assist with training
- Explain the significance of using the *ATC Summary Report* to provide feedback on access standards compliance and how to use the information to improve patient access. Refer to four new Access Management Reports on the TRICARE Operations Center (TOC) web page for consistent access performance metrics on all MTFs: **http://www.tricare.osd.mil/tools.**

- Assign the Access Management Team to perform regular monitoring of each MTF's and clinic's access performance
- Establish communications with all involved departments and individuals, including Scheduling and Ambulatory Data Module (ADM) staff, so that they participate in the migration to the new booking model and are appraised of the current status of the project, any new policies, and the evaluation of the success of the project
- Coordinate marketing and implementation with the Managed Care Support Contractor (MCSC)

1.1 Marketing Strategy

APS marketing strategies will be accomplished by local presentations, distribution of materials, and the education initiatives described in Appendix O. Appropriate MTF staff must be motivated and educated. The program should be integrated across all affected functions.

TMA has made every effort to provide materials on the TAI Web site that will assist sites to promote these programs. TMA briefings to the SG and individual site presentations are also available on the Web site and may be extracted and modified to meet MTF needs.

1.2 Communication Strategy

Communication between TMA, the SG POCs, the LA, the MTF, and the TRICARE contractors will be critical if true standardization is to be accomplished *and maintained*. MTFs and contractors must not depart from the mandated standards, for example **by misusing the appointment types for functions not described in the operational definitions, by selecting ATC categories that do not reflect the patient's requested time frame for an appointment, or by using detail codes inappropriately.**

Regular communication among the following entities is also important: the clinics with the Access Management Team; the Access Management Team with the Appointment clinical information officers; the Access Management Team members and the LA with the MCSC; the MTFs with the LA Office; and the LAs with TMA. Regions that have done well have monthly telephone conferences with their MTF POCs for Appointments to share ideas, initiatives, and progress on APS.

TMA will establish the standards. The LA will be the conduit for site requests for additions or changes to the established standards. The MTFs will pass requests for new appointing standards, feedback, and questions to the LA for resolution. All proposed additions or changes to existing standards will be coordinated between the LA and TMA to ensure maintenance of an MHS-wide standard. TMA will publish all communications, policies, and standards on the TAI Web site.

MTFs must provide patients with better appointing services. MTFs must be able to communicate from the patient to the appointments scheduler, MCSC, MTF Clinic, front desk personnel, other MTFs, and providers. Use of standard appointment types, and detail codes will simplify and facilitate communication.

2. BENEFITS OF APPOINTMENT STANDARDIZATION

In summary, the four major technical initiatives with the benefits of each are described in the following paragraphs:

- The exclusive use of MCP to book appointments is required to perform booking in accordance with the TRICARE policy for access standards, PCM By Name guidelines, standard booking procedures, and health care referral policies. The MCP application will be modified to support APS functions.

- APS will ensure that the four military services and the Managed Care Contractor staff are using the same standardized appointment types. Each of the appointment types is tied to access standards as recommended by GAO. These appointment types will result in more efficient, simplified booking; provide better lists of available appointments; and support better appointments and ATC performance measures and management.

- Measurement of access to care evaluates each patient request for access against the time lapse from the date of the request until the patient is seen, based on the patient's declared need. ATC categories are used to identify the need and measure access results: acute (24 hours), routine (7 days), wellness (28 days), specialty (28 days), and future (no standard). CHCS MCP will use these timeframes to search for an appropriate appointment that meets the access standard. Refer to Appendix H for the list of appointment types with access standards, operational definitions, and scenarios for the use of these codes.

APPENDIX P

APS MARKETING AND BENEFITS

The benefits of APS for the MTF Commander and their staff are described below.

- The MTF Commander benefits from improvement in access to care as it provides optimization of existing resources and provides quicker and better customer service to patients.

- The Provider benefits because he can better plan and manage his schedule.

- The Patient benefits from improved customer service received in the appointment process as well as improved booking to appropriate resources.

- Management at the Executive, Department, and Clinic levels all benefit from the availability of performance measurement tools such as the Template Analysis Tool (TAT), the ATC Summary Report, Detail Code Usage Reports, and Access Management Reports by facility on the TRICARE Operations Center web page that assist them in improving patient service and utilization of resources at http://www.tricare.osd.mil/tools.

- Department Chiefs will be able to better manage appointment availability, provider productivity, and schedule management within their department or clinic.

- Resource Management, as well as the MTF Commander benefits from increasing the capacity of existing resources.

- File and Table Build Staff will find the tables much easier to build and maintain with the use of simplified, standardized appointment types, and detail codes.

- Appointment Booking Supervisors and Clerks benefit from being able to better serve patients to ensure they have access to the right provider, at the right place, and at the right time within access standards.

- Managed Care Support Contractors (MCSC) staff benefit from APS as the reengineering efforts for standardization reduce the variations of appointment types, and detail codes to standardized information among MTFs. Available appointments are easier to search for at an MTF or among several MTFs.

APPENDIX Q

MTF MASTER TASK CHECK LIST FOR APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT SUSTAINMENT

APPENDIX Q

MTF MASTER TASK CHECK LIST FOR APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT SUSTAINMENT

This list is designed as a checklist for your MTF for the sustainment of APS. Your MTF may tailor this list to the MTF's specific requirements. The information in the table's columns is described below.

Action List: Each activity that should be completed to ensure a smooth implementation of Appointment Standardization and Access Improvement.

Action Authority: The individual or organization responsible for execution or management of the activity. Where fields are left blank, the action authority is determined locally.

Recommended Due Date: The date that the activity must be completed so that your facility may complete Appointment Standardization prior to the 30 September 2001 deadline.

Date Action Completed: For MTF use: the actual date that the activity is completed at your MTF.

ACTION	ACTION AUTHORITY	RECOMMENDED DUE DATE	DATE ACTION COMPLETED
Implement recommendations in Commander's Guide to Access Success	Commander	Ongoing	
Appoint an Access Manager at the MTF	Commander	Training + 30 days	
Form an MTF *Access Management Team* with individuals representing each clinic and diverse roles to discuss issues and progress on APS and Access Improvement	Commander	Ongoing	
Schedule TMA business rule training	Lead Agent		

APPENDIX Q

MTF MASTER TASK CHECK LIST FOR APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT SUSTAINMENT

ACTION	ACTION AUTHORITY	RECOMMENDED DUE DATE	DATE ACTION COMPLETED
Select and schedule appropriate new booking clerks and scheduling staff to review and be tested on the Novice and Advanced MCP CBT		Ongoing	
Train booking clerks on new Clerk Front Desk Functions menu			
Work with File and Table Build staff to inactivate providers who no longer practice at the MTF. Make sure the Provider files and associated hospital locations are correct			
Distribute Appointment Types Operational Definitions to booking clerks as guidance on how to use each appointment type correctly			
Distribute detail code list with definitions			
Distribute Patient Access Type Operational Definitions to booking clerks as guidance on the use of patient access types to reserve appointments for patients			
Develop written appointing criteria and provide to appointing staff			
Coordinate with supervisor scheduling staff to ensure they understand what is required in APS			
Develop guidelines for each clinic with numbers of appointments to reserve for enrolled and for contract beneficiaries			

APPENDIX Q

MTF MASTER TASK CHECK LIST FOR APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT SUSTAINMENT

ACTION	ACTION AUTHORITY	RECOMMENDED DUE DATE	DATE ACTION COMPLETED
Develop referral processing guidelines for each clinic	Access Manager	Ongoing	
Review templates/schedules. Plot the needed changes to incorporate new detail codes (with patient access types), configuration of appointment durations, count and non-count indicators at the appointment slot level, and age restrictions.		Sept 2001	
(Future APS III) Define slot reconfiguration criteria to have CHCS help manage schedules and keep appropriate appointment types available.		*October 2003*	
Review and adjust templates and schedules to ensure that they meet patient needs and demand for care		Ongoing	
Schedule APS training	Lead Agent		
Select and schedule appropriate booking clerks and scheduling staff to review and be tested on the Advanced MCP CBT for APS II			
Review and adjust templates and schedules to ensure that they meet patient needs for care		Ongoing	

APPENDIX Q

MTF MASTER TASK CHECK LIST FOR APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT SUSTAINMENT

ACTION	ACTION AUTHORITY	DUE DATE	DATE ACTION COMPLETED
Measure Performance			
Train staff on ATC Summary Report, Access Management Report, and Detail Code Utilization Reports on the TOC			
Validate that all appropriate clinics are participating in and using the ATC report to monitor access improvement			
Monitor clerk selection of appropriate access category for each patient	ATC Report & TAT	Monthly	
Measure access improvement with the use of ten appointment types			
ATC Metric Assessment Process implemented		Ongoing	
Measure clinic adherence to access standards by printing the ATC Summary Report from the TOC		Monthly	
Develop and implement regional and corporate indicators of access success	LAs and PO	TBD	
Review provider productivity			
Review "frequent-flyer" report to identify patients who consume more than average resources			
Measure demand and compare to availability. Take action to correct differences.			

APPENDIX R

RECOMMENDED GUIDANCE TO APPOINTMENT PERSONNEL ON ACCURATE ACCESS TO CARE SEARCHES

APPENDIX R

RECOMMENDED GUIDANCE TO APPOINTMENT PERSONNEL ON ACCURATE ACCESS TO CARE SEARCHES

1. EXPLANATION OF ACCESS TO CARE (ATC):

BACKGROUND: With the establishment of the TRICARE Program, the Congress of the United States has mandated that TRICARE have the capability of adequately meeting the health care needs of enrolled beneficiaries. The mandate establishes specific standards which requires that enrolled beneficiaries have access to specific categories of health care services within certain wait times or standards. Congress also established that TRICARE should establish ways to measure its performance in meeting these standards.

ACCESS TO CARE CATEGORIES: The access categories listed below are the foundation of the Access to Care (ATC) project. The Access to Care (ATC) project provides enhancements in the Managed Care Program (MCP) and Patient Appointment and Scheduling (PAS) Functionality of the Composite Health Care System (CHCS) an permits TRICARE to measure its performance in meeting the health care needs of its beneficiaries. It permits authorized users/appointments clerks at the MTF to search for appointments using a corresponding ATC Category. When looking for an appointment using the CHCS ATC Functionality, the appointment clerk has five search options to choose from. When choosing from one of the five search options, it should correspond as closely as possible to the beneficiary's particular request/need for service. The five ATC Categories/search options are:

ATC Categories/CHCS Search Options

Acute
Routine
Wellness
Specialty
Future

ACCESS TO CARE STANDARDS: The ATC Category or search option in CHCS must be chosen first by the appointment agent prior to booking an appointment. Each ATC Category or search that is chosen searches the schedule and displays a time/date range of ALL types of available appointments from which an appointment clerk can book an appointment. The time/date range search of these appointments represents the acceptable time that our beneficiaries should wait for a particular ATC Category of service. It also represents the ATC Standard that Congress has mandated for that particular ATC Category. The ATC Category

with corresponding time/date range of appointments displayed in CHCS and ATC Standards are as follows:

ATC Category	Range of Appointments in CHCS	ATC Standard
Acute:	Displays 24 hours of available appts/all types	24 hours
Routine	Displays 7 days of available appts/all types	7 Days
Wellness	Displays 4 weeks of available appts/all types	4 Weeks/28 Days
Specialty	Displays 4 weeks of available appts/all types	4 Weeks/28 Days
Future	Displays 90 days of available appts/all types	Provider Directed/No Standard

STANDARD APPOINTMENT TYPES: Since June 2002, the TRICARE Management Activity and CHCS will only permit the use of 10 Standard Appointment Types with suffixes and four system specific types. Each Standard Appointment Type has a standard operational definition and should be booked using one of the five ATC Categories/search options in MCP or PAS. In other words, per the direction of the TRICARE Management Activity, each Standard Appointment Types has been mapped to a specific ATC Category and Standard. Using the chart below, appointment personnel should then choose the correct Standard Appointment Type that corresponds with the beneficiary's need and corresponding ATC Category and Standard. The ATC Category, ATC Standard and corresponding Standard Appointment Type chart is as follows:

ATC Category/ Search Option	ATC Standard/ CHCS Date Range Search	Standard Appointment Type That Should Be Chosen
Acute	24 Hours	ACUT and ACUT$
		OPAC and OPAC$
Routine	7 Days	ROUT and ROUT$
Wellness	4 Weeks/28 Days	WELL and WELL$
		PCM and PCM$
Specialty	Provider Directed or Not to Exceed 4 Weeks/28 Days	SPEC and SPEC$
		PROC and PROC$
Future	Provider Directed or 90 Days	EST or EST$
		GRP or GRP$
Not Linked to ATC Search	No Standard	T-CON, T-CON$, T-CONX (obsolete in APS III, October 2003)
		E-ROOM, N-MTF, APV, T-CON*

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When booking an appointment, the booking agent should choose the Standard Appointment Type that best reflects the service that is requested by the patient and according to the chart above. The CHCS ATC Functionality does not search and display the appointment type that matches the ATC Category and Standard. It only searches for the time/date range of appointments that matches the ATC Category and Standard. It is the clerk's responsibility to match the appointment type to the patient's need, ATC Category and ATC Standard.

ACCESS TO CARE MEASUREMENT: ATC functionality in CHCS calculates the time elapsed between a beneficiary request or provider referral for an appointment at the MTF or Network, and the actual date/time of the scheduled appointment with a health care provider or service. For referrals, the time elapsed is calculated from the date the referral is entered to the date that the appointment is booked. ATC generates reports that calculate the number of kept appointments, referrals, consults, or waitlisted patients that meet or do not meet ATC standards. The chart below provides an example of how ATC Functionality measures the MTF's ability to meet or not meet standards.

Search #	ATC Search Type Used	Time/Date Range of Search and Available Appointments. Displayed	Available Appts in the Date Range?	Appointment Selected	Met Standard ?
1	Acute	14:00, 22 Oct to 13:59, 23 Oct	Yes	ACUT, 16:30, 22 Oct	Yes
2	Acute	07:30, 25 Mar to 07:29, 26 Mar	No	OPAC, 07:45, 26 Mar	No
3	Routine	07:30, 25 Mar to 07:29, 1 Apr	Yes	ROUT, 0:830, 28 Mar	Yes
4	Wellness	08:00, 1 Apr to 07:59, 29 Apr	No	WELL, 09:00, 2 May	No
5	Specialty	08:00, 1 Apr to 07:59, 29 Apr	Yes	SPEC, 10:00 2 May	*N/A

*Even though the booked appointment falls outside the routine ATC search category, the appointment transaction will not count against the MTF as not meeting the access standard. CHCS will eliminate the appointment from the not met count for the clinic since the patient was originally offered an appointment within the access standard but refused and the refusal was documented in CHCS.

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STEPS IN PERFORMING ACCURATE ATC SEARCHES:

In order to book an appointment and to ensure that ATC Functionality accurately measures this process, the booking agent has to make the following decisions and perform the following steps:

Step 1: Decide what type of service the requesting patient needs.

Step 2. Decide and choose, based on the patient's input, what ATC Category best represents the need stated by the requesting patient.

Step 3: Perform an Acute, Routine, Wellness, Specialty or Future ATC search in CHCS.

Step 4: CHCS searches for either 24 hours, 7 days, 4 weeks/28 days or 90 days of all types of available appointments based on the corresponding ATC search chosen by the clerk that matches the patient's need.

Step 5: CHCS displays 24 hours, 7 days, 4 weeks/28 days or 90 days of all available appointments and types to the booking agent.

Step 6: The appointment clerk books the appointment.

Option 1. Two Outcomes. The Appointment clerk books appointment without changing the appointment type.

Outcome 1: If ample numbers of appointments of the correct types are available within the corresponding date range, the booking agent chooses the appointment type that most closely matches the patient's need, time desired and the ATC Category/search and books the appointment, e.g. an ACUT appointment slot is chosen within the next 24 hours for a patient needing an acute care service. In this example the ATC Standard is met.

Outcome 2: If ample numbers of appointments of the correct types are available within the corresponding date range, the booking agent offers these available appointments within the ATC Standard that most closely matches the patient's need and the ATC Category/search. If the patient refuses all appointments available during the ATC Standard date range and the appointment clerk has to extend the date range of

the search, the clerk will annotate in CHCS that the patient refused the appointment due patient preference and books the appointment outside the ATC Standard, e.g. Patient wants a routine appointment and after performing a Routine ATC Search the clerk find several ROUT appointments are available inside 7 days. However, none of the available times are convenient to the patient. The clerk, per the patient's request then extends the date range of the search and books a ROUT appointment on day 9 that is outside the ATC standard. In this circumstance, the ATC Functionality of CHCS reports this as a Patient Refusal due to Patient's Preference.

Option 2: Two Outcomes. The Appointment clerk books appointment and changes the appointment type.

Outcome 1: If the clerk finds available slots, but none are Standard Appointment Types that match the service needed by the patient, the clerk IAW supervisor authorization and/or clinic protocol, can and should change the appointment type to match the requested service, e.g. the clerk searches using the Routine ATC Category, however none are Standard Appointment Type ROUT, the clerk changes a WELL Standard Appointment Type to a ROUT and books the appointment within seven days. In this circumstance the ATC Standard is met.

Outcome 2: If the clerk finds available slots, but none are Standard Appointment Types that match the service needed or times desired by the patient within the ATC Standard, the appointment clerk may extend the date range of the search, changes the Standard Appointment Type to match the patient's need and books the appointment outside the ATC Standard. The clerk will annotate in CHCS that the patient refused the appointment due patient preference. In this circumstance, the ATC Functionality of CHCS reports this as a Patient Refusal due to Patient's Preference.

Option 3: The Appointment Clerk books the appointment outside the standard.

The ATC search does not find any available appointment slots of any type within the ATC Standard. In order to book the appointment the clerk extends the date range of the search and books the appointment outside the ATC Standard, e.g. the clerk performs a Routine ATC search and does not find any slots of any appointment type available within

7 days. In order to find available appointments, the clerk extends the date range finds available slots and books the appointment. In this option the ATC Standard is not met.

2. THE ROLE OF APPOINTMENTS PERSONNEL:

The success of Access to Care measurement rests primarily on you, the appointment personnel, triage nurses, and others who make the patient appointments. You are the personnel who perform these searches using ATC. Your thorough understanding and commitment is required to ensure that the appointment search process, using the functionality of Access to Care, reflects as closely as possible the desires of the beneficiaries you serve.

Using the appropriate searches in ATC may take a little longer. However the information gained by doing these searches accurately will pay big dividends. Accurate searches will provide improved information to leaders at all levels of your MTF, your Service, your TRICARE Region and the Department of Defense (DoD). Accurate Access To Care information will improve patient care services and satisfaction; support better scheduling practices; and make more efficient use of personnel, space, supplies and financial resources. Ultimately, accurate ATC information will show our beneficiaries that DoD medicine is truly committed to meeting and exceeding access standards for the acute, routine, specialty and wellness services it provides.

3. GUIDANCE FOR APPROPRIATE ACCESS TO CARE SEARCHES

The following scenarios are offered to provide examples and guidance to assist appointing personnel in performing accurate searches.

ACUTE ATC SEARCH - The Acute ATC search is designed for scheduling appointments for beneficiaries who have a need for non-emergent, acute care typically delivered by an MTF or network/resource sharing provider. Additionally, acute appointment searches can be directed by a provider or through use of local nurse triage or self-care protocols. An Acute appointment search will look for all appointments available of any type in the CHCS schedule for the next 24 hours. The Acute ATC search will map to the 24-hour Access to Care category. MTF's using the Open Access appointing methodology will use the Acute ATC search to book Open Access (OPAC) appointments. Based on the date/time of the appointment request, the appointment must be booked within 24 hours, to the hour, to meet the standard. Personnel will search for and try to book the ACUT or OPAC Standard Appointment Types available in the schedule.

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Scenario – The patient calls requesting an appointment today or tomorrow, the appointment clerk will perform an Acute ATC search and book the appointment. If the MTF has nurse triage support, the patient, per local guidance, may be referred to the triage nurse to determine the appropriate ATC search category or self-care protocol. If the patient is found by triage nurse personnel to have a need that is not acute but routine in nature, the patient should be asked if a later appointment time meets their needs, if so the Routine ATC search will be performed. If the patient does not agree with the routine appointment time recommendation, the appointing staff will conduct the Acute ATC search based on the patient's desire. The appointment staff then reviews the schedules for available ACUT or OPAC appointment types to provide this service. Upon reviewing the schedule the appointment staff ascertains that there are no available ACUT or OPAC appointments available and changes an available WELL to ACUT to provide the appointment to the patient. In this instance the standard is met even though the Standard Appointment Type was changed from WELL to ACUT.

Second Scenario – In the above scenario, after talking to the triage nurse, the patient still desires to be seen today or tomorrow. Therefore, at 15:30, the triage nurse performs an Acute ATC search for available ACUT or OPAC appointments. He finds only two ACUT appointments slots. Both acute appointments are for the next day, one at 14:00 and the other at 14:30. The triage nurse advises the patient of both appointments. If the 14:00 appointment is booked, then the acute access standard is met (within the 24 hour range of the 15:30 ATC search). If on the other hand, if there were no appointments available within the 24 hour period using the Acute ATC search, and the first available appointment was not found until 16:00 the next day, then the acute access standard would not be met (more than 24 hours from the 15:30 start of the Acute ATC search).

Third Scenario - If there were available appointments during the 24 hour period of the original Acute ATC Search, however the patient, due to what ever reason, did not accept these times and was given an appointment at 16:00 the next day, the triage nurse must now document the desire of the patient to refuse that appointment and accept the one outside of the ATC standard. The triage nurse will annotate in the Appointment Refusal module with the refusal reason of "ATC Declined-Patient Preference". The refusal will be captured in the refusal totals and not in the met or not met summary of the ATC reporting function. CHCS will eliminate the appointment from the met - not met counts for the clinic since the patient was originally offered an appointment within the access standard but refused and the refusal was documented in CHCS.

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ROUTINE ATC SEARCH - The Routine ATC search is designated for patients who require an office visit with their PCM for a health care problem that is considered non-emergent or non-acute. The patient feels or has been instructed by his/her provider that waiting seven days is acceptable. The Routine search will map to the 7 day Access-To-Care Category. An appointment must be booked within 7 days, to the hour, to meet the standard. Personnel will search for and try to book the ROUT Standard Appointment Types available in the schedule.

> **Scenario** – The patient calls requesting an appointment that is neither specialty nor wellness and is not required within 24 hours. The clerk will perform a Routine ATC search. Routine searches are normally performed if the patient answers **"No"** to needing an appointment within 24 hours. In reviewing the available appointments on the schedule, the clerk finds several available ROUT and WELL appointment slots. The patient is first offered the ROUT appointment slots but declines because the offered schedule times are not convenient. Then per clinic guidance, the clerk offers the WELL slots to the patient and the patient accepts. The clerk books the patient into the original WELL slot but forgets the change the Standard Appointment Types to ROUT. Even though the Standard Appointment Type was not changed to ROUT, the ATC Standard of 7 days is met because the patient was provided a routine service and the Routine ATC search was used. Two weeks later, after reviewing a CHCS Ad Hoc Report, the clerk's supervisor saw that a WELL appointment was booked using the Routine ATC search. The clerk was reminded that the appointment should have been changed to ROUT in order to match the patient's need to the ATC search with the appointment provided.

WELLNESS ATC SEARCH - The Wellness search is designated for patients who require preventive health maintenance care or an initial appointment with their PCM. Some examples are periodic examinations, check-ups, and screenings (e.g. physical exam, Pap smear, eye exam). The Wellness ATC search will map to the 4 weeks/28 day Access-To-Care category. Be aware that the selection of a Routine priority on a referral will result in an ATC category of Wellness in CHCS for the referral and this cannot be changed. The MTF will have to establish business rules to differentiate between wellness and specialty care searches. Based on the date/time of the request, an appointment must be booked within 4 weeks/28 days, to the hour, to meet the standard. Personnel will search for and try to book WELL and PCM Standard Appointment Types available in the schedule.

> **Scenario** – The patient calls requesting an appointment for their preventive health maintenance examination or an initial appointment with their PCM. The appointment clerk will conduct a wellness search and book the appointments for the patient.

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SPECIALTY ATC SEARCH - The Specialty search is designated for patients referred to a specialist by a PCM/provider for an initial visit to a MTF or network specialist or for a procedure. The Specialty ATC search will map to what time stated by the provider or in all other cased to the 4 week/28 day Access-To-Care category. Based on the date/time of the request, an appointment must be booked per the direction of the provider or within the 4 weeks/28 days, to the hour, to meet the standard. Personnel will search for and try to book SPEC or PROC Standard Appointment Types available in the schedule.

> **Scenario** – The patient requests a Specialty appointment or procedure based on the existence of a referral from a provider. The MTF may have local procedures by which requests for specialty services are managed via hard copy or electronically and are forwarded to an appointment center for coordination with the patient. The clerk conducts a Specialty search for SPEC or PROC appointment types and books the appointment first to the MTF and if none are available, then to a network specialist. If the patient calls for a specialty clinic appointment without a referral the clerk may or may not be able to book the appointment based on local MTF capability or TRICARE regional policy. The MTF will need to designate which specialty clinics are self-referral clinics such as physical exams, optometry, etc whereby the patient does not need a consult or referral from their PCM.

FUTURE ATC SEARCH – The ATC Future search is designated for patients that require follow-up appointments, group visits, or other services are not provider designed or do not have an access to care standard. Personnel will search for and try to book EST or GRP Standard Appointment Types available in the schedule.

Scenario – The patient requests an appointment as directed by his/her primary or specialty provider for either a follow-up or group type appointment within ninety (90) days. The clerk conducts the Future ATC search and books the appointment in accordance within the time lines as specified by the provider.

4. GUIDANCE ON NOT MEETING STANDARDS OF INITIAL ATC SEARCHES

Appointment personnel are strongly encouraged to use the ATC searches that best represent the patient's needs. If this is done, it is widely known that all initial ATC searches WILL NOT meet access standards. It is perfectly acceptable that some searches WILL NOT meet access standards.

> **Scenario:** In this example, a patient calls requesting a routine appointment. Appointment personnel perform a routine ATC Search that displays seven days worth of appointments. It is found that there are no appointments of any type available within seven days. Appointment personnel then perform a second search and find an available appointment within nine days. The patient accepts the appointment, however the appointment made does not meet the access to care standard for routine care.
>
> If not meeting access standards is a continuing trend, this information accurately collected can indicate a need to review and change templates/schedules and a need to shift or increase resources to take care of this unmet patient demand.
>
> **Alternative Scenario:** If the patient accepts the appointment that lies outside the access to care standard, it is booked. If not, then the appointment personnel and the MCSC staff/Health Care Finders need to coordinate with the clinic staff to see the beneficiary or an appointment should be made with a network provider that will meet access standards and be accepted by the patient.

5. GUIDANCE ON PATIENTS NOT ACCEPTING APPOINTMENTS OFFERED THAT ARE WITHIN THE ATC SEARCH CATEGORY'S STANDARD

The ATC program allows appointment personnel to annotate in the CHCS ATC application, a patient's desire of not accepting an appointment that was offered within the access to care standards.

> **Scenario:** A patient calls requesting a routine appointment. Appointment personnel perform a routine ATC search that calls up seven days worth of appointments. Appointment personnel find an appointment that is available within six days and it is offered to the patient. The patient considers the offered appointment but declines as they cannot make this day. Appointment personnel perform a second search and find an appointment available within 9 days. An available appointment slot is offered to the

patient and the patient accepts. At this time appointment personnel will annotate in the Appointment Refusal module the refusal reason of ATC Declined-Patient Preference. Even though the booked appointment falls outside the routine ATC search category, the appointment transaction will not count against the MTF as not meeting the access standard. CHCS will eliminate the appointment from the not met count for the clinic since the patient was originally offered an appointment within the access standard but refused and the refusal was documented in CHCS.

6. GENERAL GUIDANCE FOR ALL SEARCHES:

When using the search function, appointment personnel are cautioned not to initiate any of the five category searches until the type of appointment (acute, routine, specialty, wellness, or future) and wait period, search range (within 24 hours, 7 days, 4 weeks/28 days, or 90 days) acceptable to the patient are clearly understood. Due to software limitations the ATC category may not be changed during the search.

Appointment personnel are reminded to book appointments to the local MTF first. If there are no appointments in the MTF then an appointment should be booked with network providers.

7. PRESENT SEARCH VIEW:

The functionality of ATC allows appointment personnel to search for available appointments within the prescribed access standards for the TRICARE program, i.e. an Acute ATC search calls up 24 hours of available appointments. A Routine ATC search displays seven days of available appointments. Specialty and Wellness ATC searches displays 4 weeks or 28 days of available appointments of ALL types. Finally, a Future ATC search displays up to 90 days of available appointments.

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Presently, when performing searches using any of the ATC search functions, staff will find multiple varieties of appointment types being displayed. An example of a routine appointment search is in Figure 1 below. The Routine ATC search depicted below shows the clerk calling up seven days worth of available appointments. All appointment types are displayed and some may be inconsistent with the ATC category.

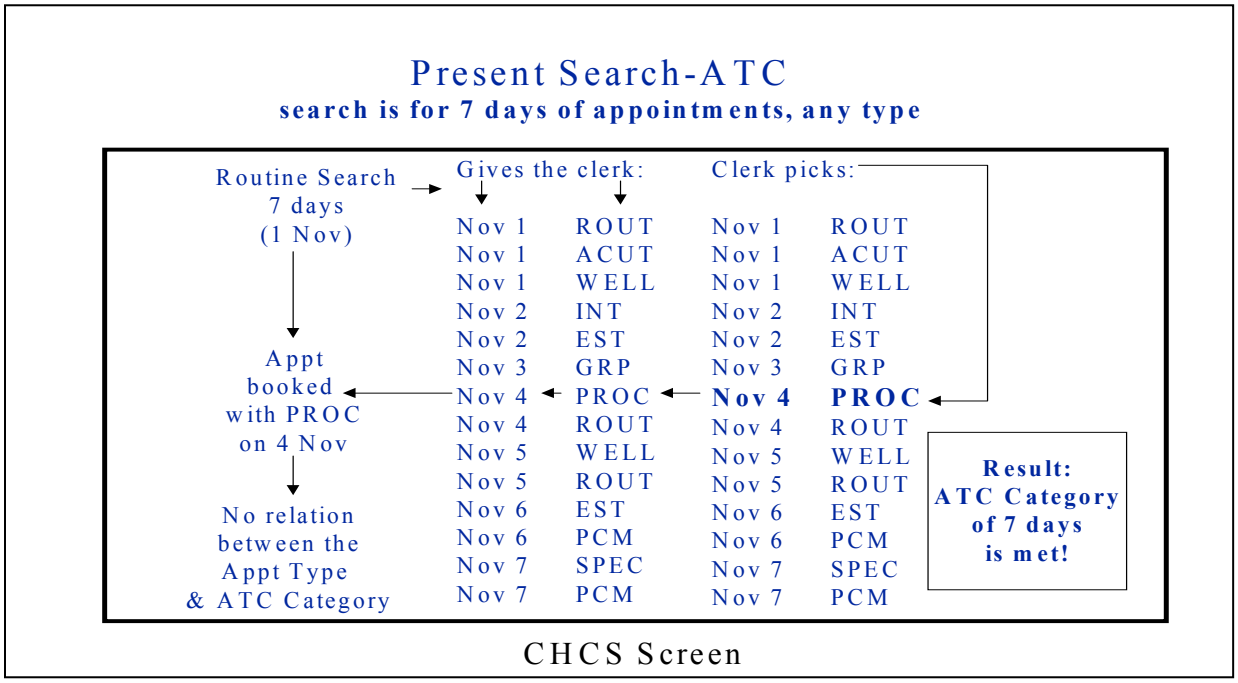

Figure 1: PRESENT SEARCH VIEW

Appointment personnel are faced with choices that do not integrate the appointment templating process with the access standards. As you can see in Figure 1, the appointment clerk chooses a PROC or procedure Standard Appointment Type because it satisfies the patient's time requirement and results in the access standard being met. However the appointment type has no logical relationship to the access to care standard and the Standard Appointment Types should be changed.

8. DESIRED ATC SEARCH VIEW

One of the goals will be to improve the accuracy of ATC data. It is hoped that increased accuracy will improve the template builds for provider's schedules to more closely resemble the appointments required by our patients. Figure 2 shows the desired or future view of what an ATC search should look like. As demonstrated in the following example, a Routine ATC search has been performed and seven days of available appointments have been retrieved.

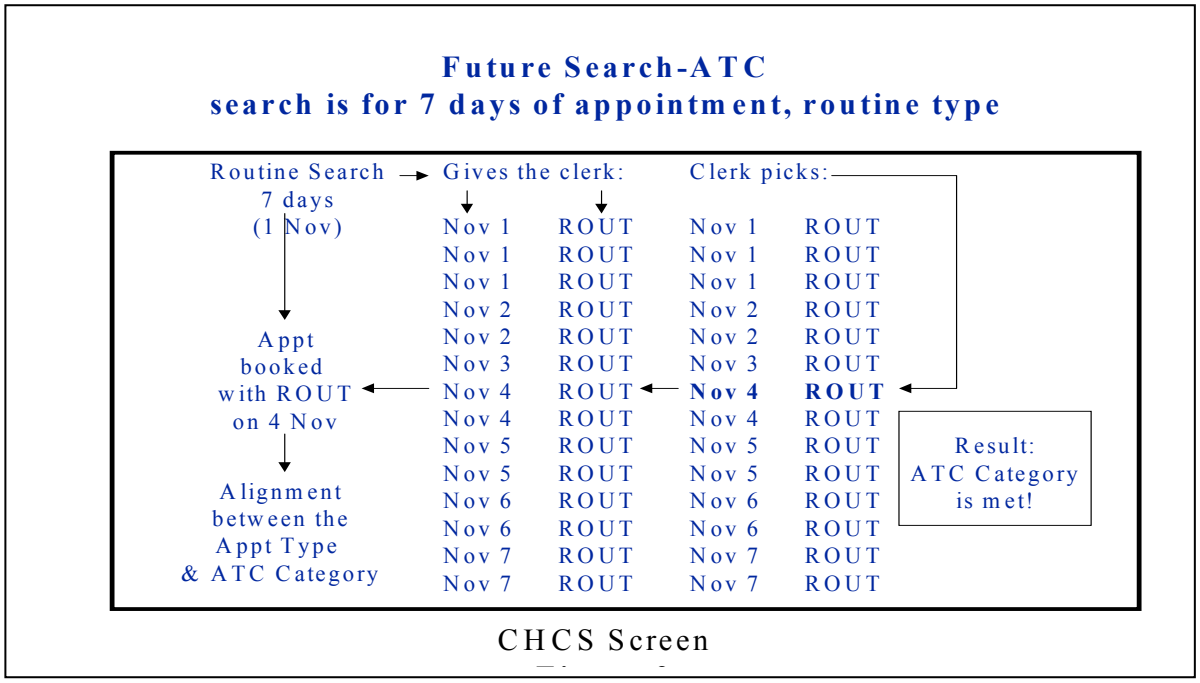

Figure 2: DESIRED ATC SEARCH VIEW

In this example the clerk has an easy task and chooses a routine appointment. Due to more accurate data gathered during the ATC search process, more accurate provider templates and schedules have been made available to appointment personnel. This desired view matches the access to care search with the appointment type with the patient's desire. It is easy to see in this example that these schedules better forecast patient demand and make for an easier selection by appointment personnel.

9. CHANGING APPOINTMENT TYPES

It is strongly encourage that appointment personnel booking appointments change the Standard Appointment Type to match the patient's need. By doing so, upon retrospective review of the patient schedules the appointment managers will have a more accurate view of the services that were actually provided. This will allow schedulers to build more accurate templates and have the correct number of the correct appointment types that will allow for more appointment system operations.

APPENDIX S

APPOINTMENT STANDARDIZATION POINT OF CONTACT (POC) INFORMATION

APPENDIX S

APPOINTMENT STANDARDIZATION POINT OF CONTACT (POC) INFORMATION

This section has been deleted in accordance with the policy on *Removal of Personally Identifying Information of DoD Personnel from Unclassified Web Sites, dated 28 December 2001*. At this time, no alternate point of contact is available. Consult your Service Access Managers *or Lead Agents* with any questions.

APPENDIX T

FREQUENTLY ASKED QUESTIONS

APPENDIX T

FREQUENTLY ASKED QUESTIONS

1. Test MTFs that are claiming success for using the standard appointments types are actually primary care sites.

TMA Response: Implementation of specialty clinics without the ability to use and search on detail codes will be difficult for some clinics. The detail code is designed to cover the information embedded in the thousands of former appointment types that will not be covered by the new APS standard appointment types. However detail codes will not be needed for every appointment.

2. Additional detail fields and complexity will significantly add to the amount of time required to develop and deploy provider schedules.

TMA Response: Formerly, the number and diversity of appointment types and the compound meanings included in each appointment type (e.g., combinations of duration, clinical resources, patient type, patient age, and MTF Book only information) were big problems with the CHCS appointing design. Clerks often could not find an appointment and booked patients inappropriately because they did not understand the meaning of an appointment type.

Under APS, the *203 (240 in October 2003)* approved standard detail are clearly defined and are much less complex than the hundreds of appointments types used in different variations on every CHCS host. Increased accuracy and better lists of appointments in the searches are providing improved patient access to care at the sites. Inclusion of a field to document the appointment duration has also helped to reduce the number of appointment types. The PBO (Provider Book Only) detail code has been approved as a new standard detail code.

3. Speed of appointing will be much slower due to additional searchable fields.

TMA Response: Problems with the former booking process were as follows: (1) some appointments may not be found due to the complexity and variations of the appointment types among clinics, (2) training is critical to prevent the selection of an inappropriate appointment type, and (3) if the clerk elects a broad appointment search in order to find appointments, the clerk must view multiple pages of appointments with various appointment types to find the correct appointment, and (4) the same appointment type may mean different care at different MTFs.

APS will not take away current functionality but will offer added flexibility when searching for appointments. In Non-Enrollee booking, for example, MCP still provides appointment lists similar to the PAS BOK module when clerks select both a single place of care and a specialty for

the search. Detail codes are not required but if special resources or restrictions are appropriate, APS will allow clerks to optionally select detail codes to help find the required care. The detail codes will be standard on all CHCS hosts so that searching for appointments should have fewer or no variations from host to host. The clerks will be educated and responsible for selecting the most efficient path to find the greatest number of appropriate available appointments.

4. Non-count appointment types have not been adequately addressed.

TMA Response: Per MTF request, non-count appointment types were addressed in the October 2000 WIPT conference. The solution was the modification of the CHCS template and schedule build functionality to allow scheduling clerks to set a new count/non-count indicator directly on each appointments slot. If a clinic is non-count, the new schedule indicator will default to non-count and may not be changed. If the clinic is count, the schedule indicator will default to the workload type on the provider profile appointment type and the schedule build clerk may change it to non-count where appropriate. With this technique, sites will have flexibility to define schedules appropriately up front.

5. Current software will be driving clinical practice.

TMA Response: The CHCS application should reinforce operational and clinical practices and ensure that the data makes sense. Many of the enhancements in APS are capabilities that will permit providers and scheduling clerks more flexibility to define accurate schedules, e.g., each appointment slot may be assigned its own duration as appropriate for the provider. The duration will still default from the clinic or provider profile but the scheduling clerk may change it to meet scheduling needs. There will be no need to gerry-rig schedules to make booking work, as has been required in the past.

6. Appointment Detail Fields lack flexibility.

TMA Response: The APS list of detail codes contains 203 detail codes (240 in APS II due out in October 2003) as printed in the Commander's Guide to Access Success, Appendix M. Sites may recommend additional new detail codes. Sites should review the detail codes in APS and forward recommendations for new codes to your Lead Agent for approval. The Lead Agent will coordinate the recommendation with the Clinic/Medical Director and then with TMA to ensure an MHS standard detail code with no duplicates.

7. Must be implemented as a Region.

TMA Response: The objective of APS is, at a minimum, a standard booking system across all MTFs in a Region. The ultimate objective is a single standard booking process across the entire

MHS using standard data elements with standard codes and performance that is measurable. This will simplify booking for the MCSC booking clerks and will keep the contract pricing down.

8. APS Business Rules have not been written.

TMA Response: The APS Business Rules have been completed and appear on the TRICARE Access Imperatives Web page and in *this Commander's Guide to Access Success*, in Appendix E.

9. Current Business Rules require Slot Comments to contain appointing directions for *MCSC Clerks*.

TMA Response: The slot comment is now free to be used for any needed comments. Currently the slot comment is also used for freezing and unfreezing an appointment and erases the data in the slot comment field. In October 2003, a fourth detail code will be added to CHCS to give sites more flexibility in their schedules. Also in APS III, the slot comment will no longer be used for freezing and unfreezing appointments. A new Reconfiguration capability will be used to unfreeze appointments and the unfreeze date will be stored on the appointment record for reference.

10. Utility in specialty appointing (Done by Clinics) has not been established.

TMA Response: Refer to Response #1 for instructions. The reduction of appointment types should simplify searches and result in a more complete and accurate list of appointments for specialty clinics. Detail codes will not be required on every appointment. The detail code is designed to cover the information embedded in the thousands of former appointment types that will not be covered by the new APS standard appointment types.

Booking clerks need to be educated on the appropriate use of detail codes. MCSC clerks should also be able to learn and use the detail codes more effectively than the current appointment types. Patients should be booked more accurately since the standard Detail Codes can be more specific and reliable than the former appointment types that were often MTF or even clinic specific or had different meanings in different clinics. Operational definitions for each detail code are now available in this *Commander's Guide to Access Success* in Appendix M.

11. *Ten* appointment types in other than Primary Care clinics are restrictive.

TMA Response: Refer to the response to issue 10.

APPENDIX U

E-HEALTH REQUIREMENTS AND INTERACTION WITH APS

APPENDIX U

E-HEALTH REQUIREMENTS AND INTERACTION WITH APS

A paradigm shift has occurred in the MHS for appointing. The MHS is rolling out patient web-based appointment booking. The E-Health Project under TMA is developing a web-based application, TRICARE On-Line that will allow TRICARE Prime beneficiaries to book their own appointments for Primary Care. TRICARE On-Line will also provide patient access to personalized provider web pages.

Appointment Standardization (APS) is working with E-Health to implement web-based appointing using standard APS appointment types and detail codes. Initially the web application will support two appointment types, routine and established (follow-up). The application will evaluate Patient Access Types, gender, and appropriate age codes, if present, to determine appropriateness of an appointment for a Prime enrollee. Refer to Appendices M and N for a list of valid patient access type detail codes, gender codes, and age code formats. Eligibility and enrollment verification will be performed. Patients will build their own accounts on-line. Multiple appointments may not be booked on the same day.

The Web-based requirements are summarized below.

- Prime Enrollees Only (includes TRICARE Plus*)* and Special Programs Patients (SPP)
- Supports Primary Care Appointments for Prime, and Non-Enrollee Appointments for Special Projects Patients
- Prime Booking Adheres to MCP PCM Booking Processes and Rules
- Special Projects Patients will be able to book appointments with their Primary Physician only.
- SPP Patient Booking Adheres to Non-Enrollee Booking Process and Rules
- First iteration only selects ROUT and EST Appointment Types
- The next iteration of TOL due to be released in 2003 will add OPAC, PCM, WELL, and ACUT appointment types.
- Sites may use Patient Access Types, particularly to reserve appointments for Active Duty, Prime, TRICARE Plus, or Special Programs Patients (SPP),
- Book Count Appointments Only
- Patient Access Types, gender codes, and age codes will be included in the detail code fields.
- Minimum Requirement: 50% of all ROUT and 50% of all EST appointments must be made available on the Web for patients to book.
- Detail code WEA must be used to indicate appointments made available to the patient.

The table on the following page documents the business rules applied in the TRICARE On-Line Web Appointing application. The left column identifies the data element, code, or subject of the rule; the right column documents the processing rule for the data element, code, or subject.

APPENDIX U

E-HEALTH REQUIREMENTS AND INTERACTION WITH APS

The following business rules will govern the types and uses of appointment types and detail codes for the E-Health application for web based appointing. These rules are all inclusive and there will be no substitutions. The goal of this test is to keep coding of appointments to a minimum to allow for maximum participation of beneficiaries to select appointments from the web.

Prime Only

In order to book an appointment on the Web, a patient must be either a TRICARE Prime patient with a PCM assigned on the CHCS host or may be a Special Program patient.

Special Program Patients

Special Program Patients will be identified with the character string, "SPP:" anywhere in the registration comment and the PCM's name in the Primary Physician field on the Registration screen.

Web appointing will book to either an individual PCM or a group PCM.

Booking Module to Use

If the patient is a TRICARE Prime or TRICARE Plus patient with a PCM assigned on the CHCS host, then TRICARE On-Line (TOL) web appointing will use the PCM Booking Module to book appointments.

If the patient is a Special Programs patient indicated by an "SPP:" anywhere in the Registration Comment, then TRICARE On-Line web appointing will book the appointment in the Non-Enrollee Booking module. The appointment will be booked to the provider whose name appears in the Primary Physician field on the Registration screen.

If the patient is a TRICARE Prime patient with no PCM assigned on the CHCS host, then TRICARE On-Line web appointing will instruct the patient that web appointing is unable to book the appointment until a PCM is selected.

TRICARE Prime Enrollee Booking adheres to MCP PCM Booking processes and rules. SPP Patient Booking adheres to Non-Enrollee Booking process and rules.

APPENDIX U

E-HEALTH REQUIREMENTS AND INTERACTION WITH APS

Appointment Types

Initially, web appointing should display/offer only appointments with a ROUT or EST appointment type. Refer to additional restrictions below. Only Primary Care EST appointments should be offered to the patient.

In a future release in 2003, TOL will also offer OPAC, PCM, WELL, and ACUT appointments to the patient to book.

ATC Category and Appointment Display

Initially, if the patient requests a Routine (ROUT) appointment, then Web appointing will select the Future ATC Category. If the patient requests an Established (EST) appointment, then Web appointing will select the Future ATC Category. Up to 45 days of appointments will display.

In the future, if the patient requests an ACUT or OPAC appointment, then the Web appointing will select the Acute ATC Category with a 24 hour standard. If the patient requests a ROUT appointment, then the Web appointing will select the Routine ATC Category with a 7 day standard. If the patient requests a PCM appointment, then the Web appointing will select a Wellness ATC category with a 28 day standard. If the patient requests an established (EST) appointment, then the Web appointing will select a Future ATC Category with no access standard.

Count Appointments

Only Count appointments will be booked by Web appointing. Non-count appointments may be excluded from Web appointing by putting WEA on count appointments only.

General

Format of the Detail Code

Detail codes indicate restrictions or special resources available for the appointment and further define the appointment type affixed to the appointment slot.

Location of Detail Codes

Up to three (3) detail codes can be used for each appointment slot. By October 2003, 4 detail codes will be available.

Detail Code Order

Detail codes are not required to appear in any predefined order in the available detail code fields. However it would help the booking clerks if sites select the order for the types of detail codes, e.g., patient access type, age, patient gender, web code.

APPENDIX U

E-HEALTH REQUIREMENTS AND INTERACTION WITH APS

Match Patient to Appointment

The Web appointing application will match patients to an appointment based only on the following four types of Detail Codes: Patient Access Types, age codes, patient gender, and web appointing codes (WEA-Refer to rules below). Only the values listed below for the Patient Access Type will be supported for a Web appointment. If one or more patient access types are specified on the appointment and the patient does not match at least one of the patient access types, the appointment will not display for booking.

If there are any detail codes in any of the three available detail code fields other than the four listed above, sites should not use WEA on the appointment. TOL will automatically screen out appointments with detail codes that are not recognized by the application.

No Detail Codes

If the appointment slot has no detail codes, the web application will allow any enrolled patient of any age, gender, and any type of beneficiary to select this appointment.

TOL Recognized Detail Codes

The TRICARE-On-Line web-appointing application will ONLY recognize the following four categories of detail codes: They are Patient Access Types, Web Codes, Age and Gender. If any other detail codes are used, the appointment will not be available to the web for booking even if WEA is on the appointment.

TYPE One*:*

Patient Access Types

The following detail codes are the valid Patient Access Types for Web appointing and are a subset of the total list of Detail Codes. TRICARE Senior Prime is no longer active and has been removed from these definitions. When used in the appointment detail codes, the Patient Access Type designates the type of beneficiary that may be booked in the appointment slot. Refer to the screening criteria below for each of the authorized codes. **Note:** If Patient Access Types are specified in one of the three detail code fields and more than one Patient Access Type is included, then the patient must meet either criteria to view and be booked to that slot. If no Patient Access Type is recorded in a detail code field, any type of beneficiary may be booked in the appointment.

BPAD

Active Duty - Uniformed Services Personnel (regardless of where or whether they are enrolled), guard and reserve on active duty, NATO, and other status of forces agreement active duty members are the only patients permitted to be booked for appointments reserved for this access type. The intent of this type is to allow sites to ensure access for any Active Duty member to the MTF for care that is appropriate for that type of beneficiary.

BPPR

Prime, No Active Duty - Family members of Uniformed Services Personnel, retirees, and retiree family members who are enrolled in TRICARE to any local or remote MTF, are the only patients

permitted to be booked for appointments reserved by this access type. This group also includes enrollees with contractor PCMs. This group does not include NATO family members and enrollees to the Uniformed Services Family Health Plan (USFHP), TRICARE Plus, or Federal Employees Health Benefit Plan (FEHBP) except by specific authorization. The intent of this type is to allow sites to ensure access for any Non-Active Duty TRICARE Prime enrollee to care that is appropriate for that type of beneficiary.

BPAP

Active Duty and Prime - This category includes Active Duty and Prime patients. Refer to the operational definitions above of each category, BPAD and BPPR, for a list of types of patient included in this category.

BPNAD

No Active Duty - Uniformed Services Personnel (regardless of where or whether they are enrolled), FEHBP, guard and reserve on active duty, NATO family members, USFHP enrollees (except by specific authorization), Secretarial Designees, and other status of forces agreement active duty members may not be booked into this slot. Anyone else may be booked into this slot, including TRICARE Standard, TRICARE Extra, and Uniformed Services family members, retirees, retiree family members, and TRICARE Plus enrollees. This access type is intended to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Active Duty.

BPSP

Special Programs Patients and TRICARE Plus - Beneficiaries enrolled in special local programs or TRICARE Plus may be booked to these appointments. This access type is designed to ensure that a site's special program access requirements can be met by appointing.

BPAPS

Active Duty, Prime, TRICARE Plus, and Special Programs - This category includes Active Duty, Prime, TRICARE Plus, and Special Programs Patients. Refer to above operational definitions for each category.

BPGME

Graduate Medical Education - Any interesting case designated by local directive as reserved for the training of Graduate Medical Education staff. The clinic will usually book appointments for these patients.

BPNPR

No Prime - Non-active duty Prime enrollees from the local MTF or remote MTFs, contractor enrollees, and TRICARE Plus may not be booked into this slot. Active Duty may be booked to these appointments. All other beneficiaries, including Medicare patients, TRICARE Standard, NATO, NATO family members, Secretarial Designees, etc. may be booked to these appointments.

The intent of this access type is to reserve appointments for Medicare, Space A, and other special needs patients and to support the region's need to reserve slots for resource sharing providers whose contracts specify that they may not treat Prime patients.

BPNAP

No Active Duty, No Prime - TRICARE Standard, TRICARE Extra, Medicare, and other direct care only (Space A) beneficiaries may be booked to these appointments. This access type is primarily designed to reserve appointments for "at risk" patients who are contractor reliant. Secondarily, this type also supports the contract revised financing requirement to capture non-enrollees who would otherwise go downtown, i.e. Medicare and Space A.

BPTS

TRICARE Standard/CHAMPUS - Active Duty family members, retirees, and retiree family members who are entitled to CHAMPUS reimbursement for civilian care rendered. This type supports the contract revised financing requirement to capture CHAMPUS non-enrollees who would otherwise go downtown.

TYPE Two:

Web Detail Code

WEA

The sites must use the code WEA in one of the three detail code fields. This will be used for all the Primary Care Clinic appointment slots that sites want to be booked on the web. WEA should only be used for count appointment types. WEA will not be used for non-count appointments. For sites using the WEA detail code, the application will display and book on the web only those Primary Care Clinic appointments that use a WEA detail code and have an ACUT, OPAC, ROUT, PCM, WELL, or EST appointment type. The WEA can appear in any order of the three detail codes. The patient must meet all four of the Detail Code criteria to display and book the appointment (patient access type, age, gender, and web appointing code). Appointments with a WEA in the detail code will also be available to the Managed Care Support Contractor and patients phoning in for appointments.

TYPE Three:

Age Codes

Sites must create their own detail codes to indicate age restrictions. These codes must be added to the Appointment Detail Code file by the system administrator. Sites must use the standard format

for age codes as follows. CHCS will not allow any other format.

A number alone indicates the number of years.
A number with the letter M indicates number of months.
A number with the letter W indicates number of weeks.
A number with the letter D indicates number of days

All age codes will be in the form of an age range, with a hyphen, indicating the allowable range of patient ages in number of years, months, etc., lower age first, e.g., 0-12, 17-64, 3M-6M, 0-6M, 1W-3W, 1D-7D, or 5D-3W (combed age codes are permitted).

TYPE Four*:*
Patient Gender

Sites can use one of two detail codes to specify patient gender: MA (Male) and FE (Female). If no patient gender is specified in the detail codes, then any patient of any gender may be booked to the appointment.

APPENDIX V

REFERENCES

APPENDIX V

REFERENCES

The following are reference documents for the APS and Access Improvement projects. Many of these documents appear on the TRICARE Access Imperatives Web page at http://tricare.osd.mil/tai.

The Government Accounting Office by direction of the Congress conducted and published three studies on patient appointing in the DoD MHS environment.

- *Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE* (26 Feb 1998)
- *Appointments Timeliness Goals Not Met; Measurement Tools Need Improvement* (September 1999)
- *Factors Affecting Contractor's Ability to Schedule Appointments* (July 2000)

The APS WIPT developed an Appointments Standardization Methodology document defining the principles of the standardization initiative. This document resides on the TRICARE Access Imperative Web site at http://tricare.osd.mil/tai.

A policy letter, *Policy for Specialty Care Timeliness* was signed by Dr. Edward D. Martin on 15 Januray 1997 establishes the 28 days access standard for procedures.

An *Appointments Type Standardization Policy letter* was signed by Dr. Sue Bailey on 25 May 2000 mandating the MTF transition to the nine standard appointments types by 1 October 2001. This policy letter resides on the TRICARE Access Imperative Web site at http://tricare.osd.mil/tai.

A second policy letter, *Activation of the Composite Health Care System (CHCS) Managed Care Program Module*, signed by Admiral Cowan for Dr. Sears on 27 October 2000 mandates exclusive use of the CHCS MCP module to book outpatient appointments. The deadline for all sites to convert to MCP is 15 January 2001.

The *Independent Government Cost Estimates* for the changes to the use of CHCS MCP and the new appointing functionality are also included on the TRICARE Access Imperatives Web site

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REFERENCES

An *Advanced User MCP Computer-based Training (CBT*) module is available on the Web site at the URL: https://chcswebsrvr.spawar.navy.mil/. *This is a secure website and you will be required to register and receive a user id and password to access the CBT. The website requires 128-bit encryption.* This CBT provides step-by-step instructions on building schedules and templates and booking in MCP. The CBT supports testing of users on competency in MCP booking. The CBT was made available to all sites on CD Rom in December 2000.

The *APS I Cookbook Guide* is available on the TRICARE Access Imperatives Web site at http://tricare.osd.mil/tai. The cookbook provides guidance and business rules on the installation of APS I change package and the transition into APS.

The *APS I Project Requirements and Design Document* is available on the TRICARE Access Imperatives Web site at http://tricare.osd.mil/tai. This document describes the technical solution for the APS I change package, including menu changes and screen changes/additions.

The *APS II Project Requirements and Design Document* is available on the TRICARE Access Imperatives Web site at http://tricare.osd.mil/tai. This document describes the technical solution for the APS II change package, including menu changes, screen changes and additions, and report changes.

The *ATC Project Requirements and Design Document* is available on the TRICARE Access Imperatives Web site at http://tricare.osd.mil/tai. This document describes the setup, data collection, and reporting functions for ATC measurement at the clinic and provider level for the MTF.

The *Memorandum of Agreement* (MOA) for Alpha testing of the ATC functionality of the CHCS has been signed by Keesler and is pending signature by Ft. Riley and Jacksonville. The MOA describes the relationships and responsibilities of the commanders at these sites to support Alpha testing of CHCS ATC functionality.

The primary documents developed to support APS and Access Improvement implementation are listed below.

- The APS WIPT developed an *Appointments Standardization Methodology* document defining the principles of the standardization initiative. This document resides on the TRICARE Access Imperatives Web site at: http://tricare.osd.mil/tai.

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REFERENCES

- Dr. Sue Bailey signed an Appointments Type Standardization Policy letter on 25 May 2000, mandating the MTF transition to the nine standard appointments types by 1 October 2001.

- A second policy letter*, Activation of the Composite Health Care System (CHCS) Managed Care Program Module,* signed by Admiral Cowan for Dr. Sears on 27 October 2000, mandates exclusive use of the CHCS MCP module to book outpatient appointments. The deadline for all sites to convert to MCP is 15 January 2001.

- *Commander's Guide to Access Success, 31 October* 2001, describes the background, solution, benefits, and implementation guidance for the successful implementation of APS. The newest updated Guide will be posted as of 15 May 2003.

- Office of the Assistant Secretary of Defense, Health Affairs, Memorandum, *Appointment Standardization Program (APS) Guidance*, signed by Dr. Sears on 26 March 2001, explains what initiatives are underway and what actions are required to fully support the implementation of APS business practices.

- United States Air Force Surgeon General's Memorandum, *Improving Appointing and Access Business Practices*, signed by LtGen Carlton on 28 March 2001, directs timely implementation of the appointment/access management initiatives outlined in the above references.

- Headquarters, United States Army Medical Command Memorandum*, Improving Appointing and Access Business Practices,* signed by LTG Peake on 5 April 25, 2001, reiterates the fact that full implementation of APS initiatives require the leadership and support of each MTF Commander.

APPENDIX W

APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT RESPONSIBILITIES OF DOD ENTITIES

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APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT RESPONSIBILITIES OF DOD ENTITIES

The following bullets define the responsibilities of the DoD and MHS entities that support APS and Access Improvement:

- Office of the Assistant Secretary of Defense (OASD) (Command, Control, Communications, and Intelligence) establishes overall APS and access assessment procedures, standards, and guidance for DoD.

- Office of the Assistant Secretary of Defense (Health Affairs) (OASD (HA)) sets policy and provides general oversight of the MHS, its information management technology resources, and related health care information management activities.

- TMA, through the APS Integrated Product Team (ASIPT), provides TRICARE corporate guidance, direction, and performance measurement tools for APS and Access Improvement.

- TMA Health Services and Operational Support Division (HSOSD) Office of OASD (HA) oversees the APS Program and Access Improvement measurement. This organization ensures interoperability, compatibility, and compliance with architecture and standards/guidance. TMA HSOSD develops and maintains data standards for MHS. HSOSD also develops guidance and tools to assist program managers and MTF Commanders in their planning for implementation of data standards and monitors compliance with these standards at the MTF level.

- Service Surgeons General (SG) establish an environment that recognizes the importance of APS and Access Improvement and encourage compliance to standards. They designate qualified officers who are responsible for implementing APS and maintaining and improving access standards within their medical departments.

- TRICARE Lead Agents oversee and coordinate the MTFs in the Region to ensure that:

  — The standardized appointments types and standardized detail codes are implemented within their Region

— Proposed new standard detail codes are coordinated with the Lead Agent Clinic/Medical Director and TMA

— MTFs within their Region move towards and convert to MCP by 15 January 2001 per Health Affairs (HA) policy directive

— MTFs within the Region comply with all higher headquarters directives pertaining to APS and Access Improvement. Refer to the TRICARE Access Imperatives Web site to review the applicable policy letters at http://www.tricare.osd.mil/tai

— Monthly meetings or telephone conferences are held with a representative from each MTF to discuss the clinics that are not meeting access standards and to receive MTF reports on the progress or corrective actions taken. Discussion will center on the performance indicators from the Template Analysis Tool (TAT), ATC Summary report, etc. LAs are also responsible to ensure that communication, ideas, and initiatives concerning APS and Access Improvement are shared with or distributed to all MTFs within their Region.

— LAs will each designate an individual who will be responsible for Access issues within the region and who will be the point of contact for Access Improvement and APS on the ASIPT. They will be responsible for the coordination and communication required with MTFs to facilitate and maintain appointments data standards across the region.

- MTF Commanders will "own" and are responsible for access improvement and standardization of appointments within their facilities and will manage the following:

  — Agree via an MOA to *100* percent participation by their MTF clinics in the use of the *ten* standard appointments types

  — Support education and training needed to implement APS

  — Allow the TOC to access their CHCS host to download data to support schedule and appointments analysis. The analysis will be made available to their site daily on-line

- — Designate command oversight and responsibility for clinic schedule management, APS, provider and table build, provider schedule performance measurement analysis (using the Template Analysis Tool), ATC measurement, etc., to a responsible individual. This Access Manager will monitor APS and Access metrics. This person will also be the point of contact with the LA and the Customer Service Division for Access and APS issues

- — Establish an environment that recognizes the importance of Access and encourages Total Data Quality Management (TDQM)

- The MTF Access Manager monitors and manages the MTF's transition to APS including booking with MCP, the ten standard appointment types, the standard detail codes, provider schedule management, and measurement of access to care. This individual will ensure that the following are completed at their MTF:

  - — Standardized appointment types, and standardized detail codes are implemented within their MTFs

  - — Additional MTF clinic names and detail codes needed by a site are requested from and approved by the Region LA Office and TMA prior to implementing them

  - — Clinics within the MTF convert to MCP Booking by 15 January 2001

  - — Clinics within the MTF comply with higher headquarters directives pertaining to APS and Access Improvement. Refer to the TRICARE Imperatives Web site to review the applicable policy letters at http://www.tricare.osd.mil/tai

  - — Personnel are designated at the clinic level who will be responsible and accountable for APS, patient access, and provider schedule management within the facility and command. They will monitor access metrics and establish an environment that recognizes the importance of access and encourages TDQM. They will be the point of contact with the LA and the Customer Service Division for Access Improvement and APS issues

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APPOINTMENT STANDARDIZATION AND ACCESS IMPROVEMENT RESPONSIBILITIES OF DOD ENTITIES

- The APS Program Manager (PM) is a member of the TMA HSOSD and is the operational arm of TMA in the Access Improvement and APS processes. Specifically, the Program Manager develops and executes the APS plan.

- The ASIPT was chartered in May 1999 to establish the functional and information requirements for the APS program and for Access Improvement. The ASIPT provides the TMA Program Office with recommendations for program direction and actions for improving access and standardization of the MTF appointing process. This group, composed of representatives from each branch of the Services and from every organizational level within the MHS, including LAs, represents all Service interests during the life of the project. The team provides a venue for determining access issues having corporate and MTF impact. It identifies and prioritizes both near- and far-term requirements for APS and Access Improvement projects. It defines and communicates functional requirements to the TMA PO for design, development, operations, and maintenance of the appointing functions in CHCS. The IPT was closed out in June 2002.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

Appendix X, Provider Network Architecture in CHCS, is included in the Commander's Guide as a reference for all sites on possible solutions to the definition and implementation of a comprehensive Provider Network using the CHCS MCP application. The Provider Network supports Primary Care Manager by Name (PCMBN) objectives.

The Provider Network models documented in this section are solutions currently implemented at sites. The most complicated issue for the Provider Network design is building a Network that can ensure appropriate access by booking an enrollee to their PCM first and, if the PCM is not available, to the PCM's group members within the enrolling MTF.

Functional Perspective

The MCP Provider Network defines a network of primary and specialty providers who may be MTF and /or civilian providers, and identifies the locations where they provide care. An MTF provider is a direct care provider employed by the MHS to provide health care to their beneficiaries. A civilian network provider is a provider who has signed an agreement with the government to deliver health care to MHS beneficiaries at the MTF and/or at their own practice location, usually at discounted rates. A non-network provider has no agreement with the MHS to provide care and bills according to their practice's rate schedule.

Prior to MCP, CHCS could not define a provider group. In 1994 the CHCS MCP Provider Network application was developed to allow sites to define and build provider groups within an MTF or in a civilian practice to support a Health Care Management Organization (HMO) model for the military. Each MCP Provider Group is comprised of individual provider members who practice at one or several places of care in the MTF and/or in civilian practice location(s). The places of care are usually clinics where the care is delivered. Clinics may be outpatient, ambulatory surgery, dental, ancillary, or civilian.

The following business rules apply to the CHCS Provider Network.

- A provider may be a PCM in multiple places of care.
- A provider may be a member of multiple Provider Groups.
- A provider may be a PCM in one, multiple, or all MCP Provider Groups.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

The following business rules apply to booking to the Provider Network in CHCS.

- An enrollee may not be booked to their PCM in a place of care that is not in the enrolling DMIS ID without a referral. The exceptions to this rule are Operational Forces members. The provider network file and table may be defined to allow operational forces appointments to a PCM in a place of care within a different enrolling division.
- An enrollee may not be booked to another PCM in another DMIS ID without a referral.
- Enrollees may be booked to their PCM in another Place of Care other than the Place of Care in which they are enrolled provided the different Place of Care belongs to the enrolling DMIS.
- Enrollees may be booked to a different PCM who is a member of the same group as the enrollee's PCM but the appointment must be in a place of care in the enrolling DMIS ID.

MCP Provider Network Technical Features

MTF staff define the Provider Network by entering Provider group and individual provider data into the MCP Provider files in CHCS. The Provider files define the Provider Network and are comprised of individual and group profiles for MTF (internal) providers, and for civilian providers.

The MCP Provider Network application integrates data from five CHCS files to define the Network. The files include two core CHCS files (the Provider file and the Hospital Location file), and three MCP specific files: MCP Provider File, NED Provider Group file, and MCP Place of Care file. The MCP specific files contain data directly related to the HMO care model and requirements; these files were designed to complement the Provider and Hospital Location files to define the Network.

The Provider file contains the Provider Profile data including system processing parameters for an individual provider or group. Examples of Provider file data are provider demographics, provider specialties, various provider identification codes (e.g., DEA# and UPIN), military data including status, professional category, appointment types used by the provider, languages, and other data used as default values during data entry or to control processing for the provider.

The Hospital Location file (also referred to as the Place of Care) contains data describing inpatient and outpatient locations/clinics in the MTF or in the civilian network, wherever MHS beneficiaries receive health care. The Clinic Profile is part of the data in this file.

The MEPRS code is assigned to each place of care and is used for workload reporting across the MHS. The location type drives CHCS processing based on the type of location being processed in CHCS. Examples of hospital location data are location type (clinic, same day surgery, Non-MTF), division (the DMIS ID of the MTF), department, MEPRS code, location/clinic name, name of the MTF that the location belongs to, address, telephone number, clinic specialties, and clinic availability. The file also records various processing parameters that drive CHCS data entry. Some examples of these parameters are: (1) patient record management parameters including patient record pull days and radiology record pull days and (2) other booking management parameters such as schedule hold duration, roster production, prepare reminder notice days, maximum wait list days, wait list activation, wait list hold duration, and auto wait list processing activation. CHCS provides the capability to restrict, by appointment type, which users are permitted to book a slot (Booking Availability), overbook (Overbook Authority), or change(Split/Join – Appointment Change Authority) an appointment by assigning a security key to the appointment in the clinic provider profile.

The NED Provider Group File contains data describing the group. This data includes all places of care where group provider members practice; the group capacities that restrict the number of enrollees the group may care for overall; group capacities by beneficiary category that establish a maximum number of enrollees that may be assigned to the combined providers for a given beneficiary category; capacity limitations for the enrollees assigned to the places of care within the group; and the capacity limitations for the individual providers within the group. The NED Provider Group file also contains the specialties supported cumulatively by the group, as well as PCM assignment age limitations. The definition of a provider within the group as a PCM or specialty provider is also stored in the NED Provider Group file with the individual specialties practiced by the provider within the group.

The MCP Provider File contains data about each individual provider in the Network. The data applies primarily to their participation in the HMO model, including provider name, a link to the data in the Provider file, professional category, CHAMPUS number, UPIN, the NED PCM ID, and the PCM ID Type code.

The MCP Place of Care file contains data that is unique to the HMO model, including a link to the Hospital Location file, the division DMIS ID, the facility type, days and hours of operation, directions and comments.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

Defining PCMs

CHCS supports the identification and definition of those providers who will be Primary Care Managers in the Provider Network application. A group may be assigned multiple providers and some may be designated as PCMs and some may not. If the Provider Group is designated as a Primary Care Manager, then all the providers in the group will be considered PCMs, even though none are designated as individual PCMs. When CHCS searches for PCM appointments for an enrollee assigned to a Group Provider PCM, appointments with all members of the group will be presented.

To designate a provider within a group as a PCM, a user need only access the specialty screen and indicate 'Yes' in the column "Accepts PCM Assignments associated with the Specialty at this place of care".

When an individual provider is identified as a PCM, enrollment capacity limitations may be defined to limit the number of enrollees that may be assigned to the provider. This prevents over-assignment and reduced access to care. The capacity limitations may be defined by beneficiary category (Active Duty, Active Duty Family Member, Retiree, Retiree Family Member, Medicare, and Other) and serve to reserve PCM assignment slots for specific types of enrollee, improving access to care.

Unique CHCS MCP Technical Rules

CHCS requires that each MCP provider be assigned to an MCP Provider Group, even if a provider practices alone. Therefore MCP supports groups with a single provider.

The MCP provider group file and table will support a provider in multiple groups and/or hospital locations.

A MCP provider group must be defined with places of care in order to support appointing and/or PCM assignment to providers within the group. A provider within a group can be associated with a single or multiple places of care but only for those places of care defined for the group.

Provider specialties are associated with PCM assignments and can be used as search criteria within Health Care Finder Booking. In order to support these uses, the specialties of providers must be defined/associated with the provider within any MCP provider group the provider is assigned to.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

MCP Provider Group Models

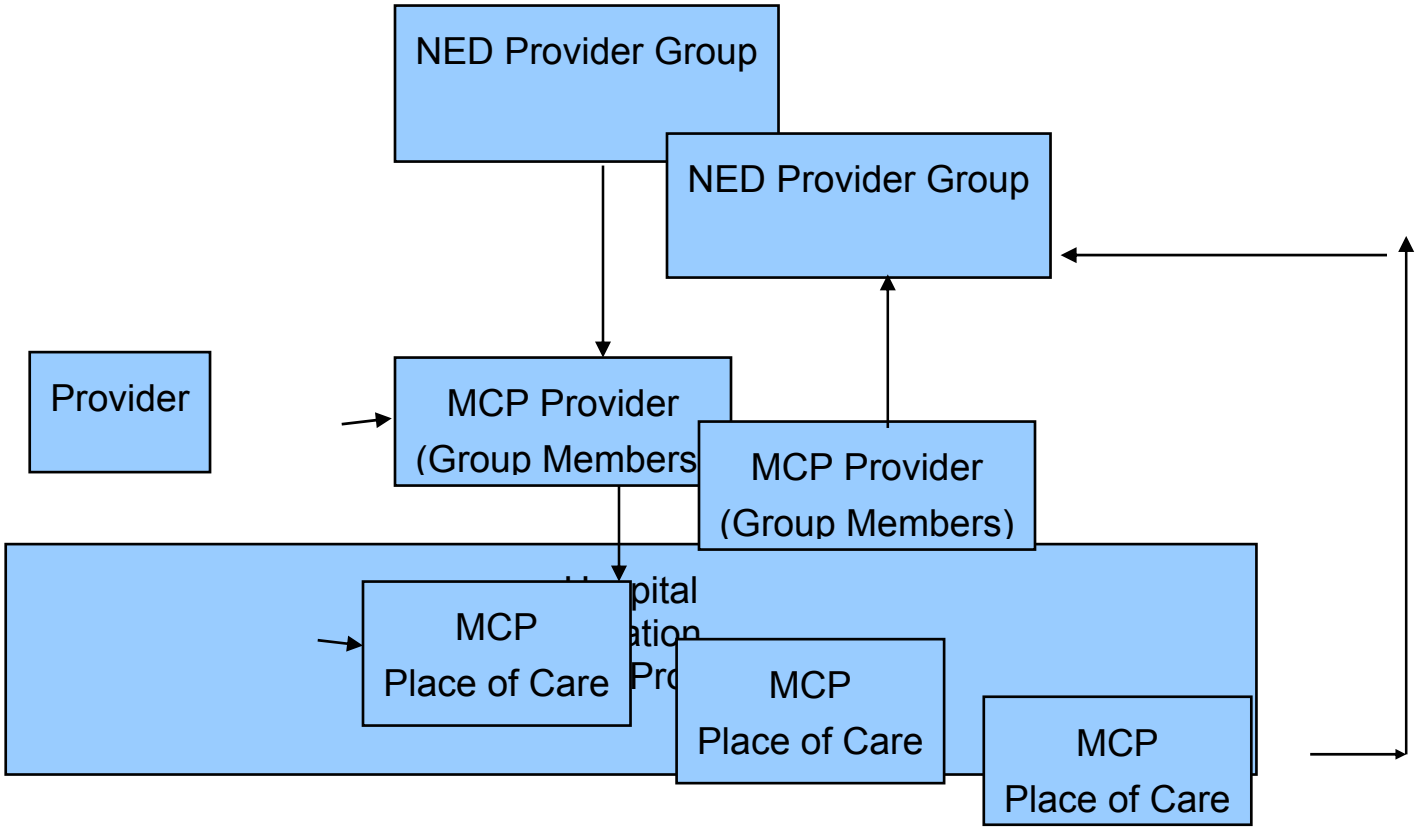
MCP supports a very flexible application tool for defining the Provider Network. Providers, Provider Groups, and Places of Care may be defined to reflect the actual organization of any MTF provider group. Sites have frequently found it necessary to develop creative models in order to be able to book enrollees to their PCM and PCM group members according to local policy or PCM By Name.

The following pages contain various MCP Provider Group models and explain how relationships are established between the three files: Provider Group, Individual Provider, and Place of Care.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

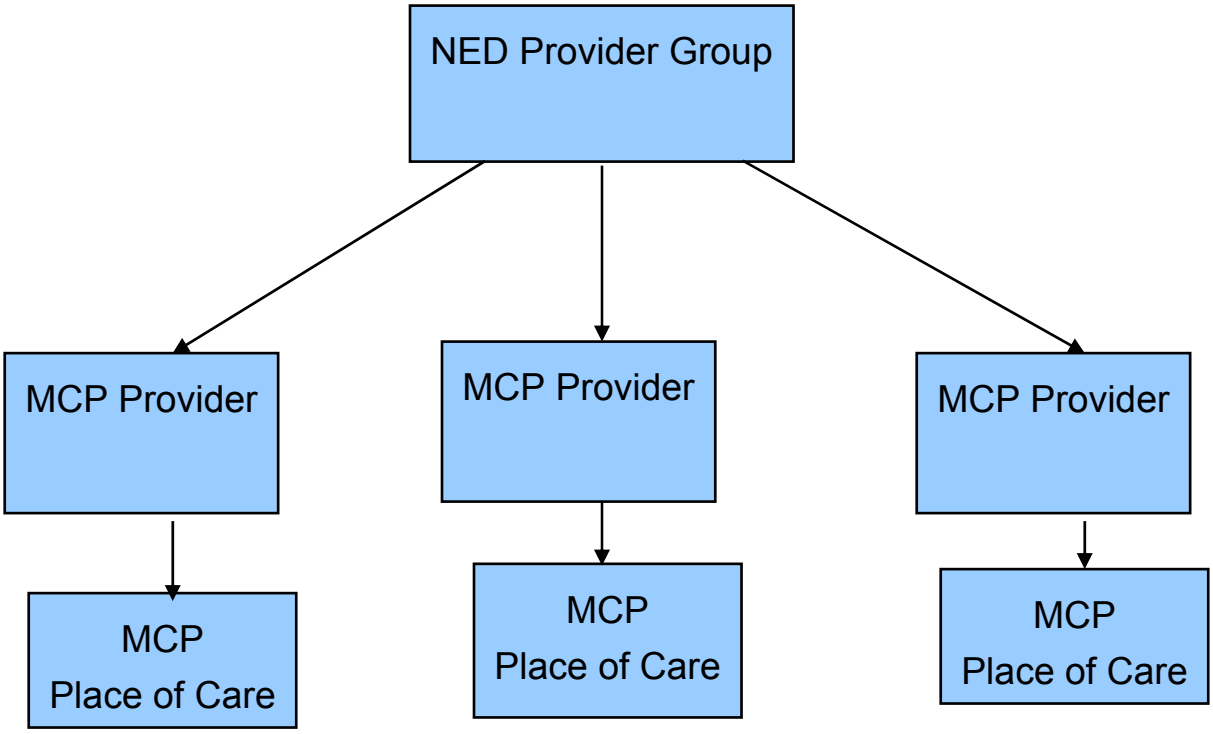
MCP File and Table Design



This chart shows the relationships between the five CHCS files used to define the Provider Network. MCP Provider Network files incorporate data from two CHCS core files: the Provider file and the Hospital Location file. Data from the Provider file is integrated into the MCP Provider file. Data from the Hospital Location file is integrated into the MCP Place of Care file.

Individual providers must be assigned to at least one group and may be assigned to multiple Provider Groups and/or multiple Places of Care. For example, a provider may practice at three locations, Maryland, Virginia, and DC, and belong to a different group in each location.

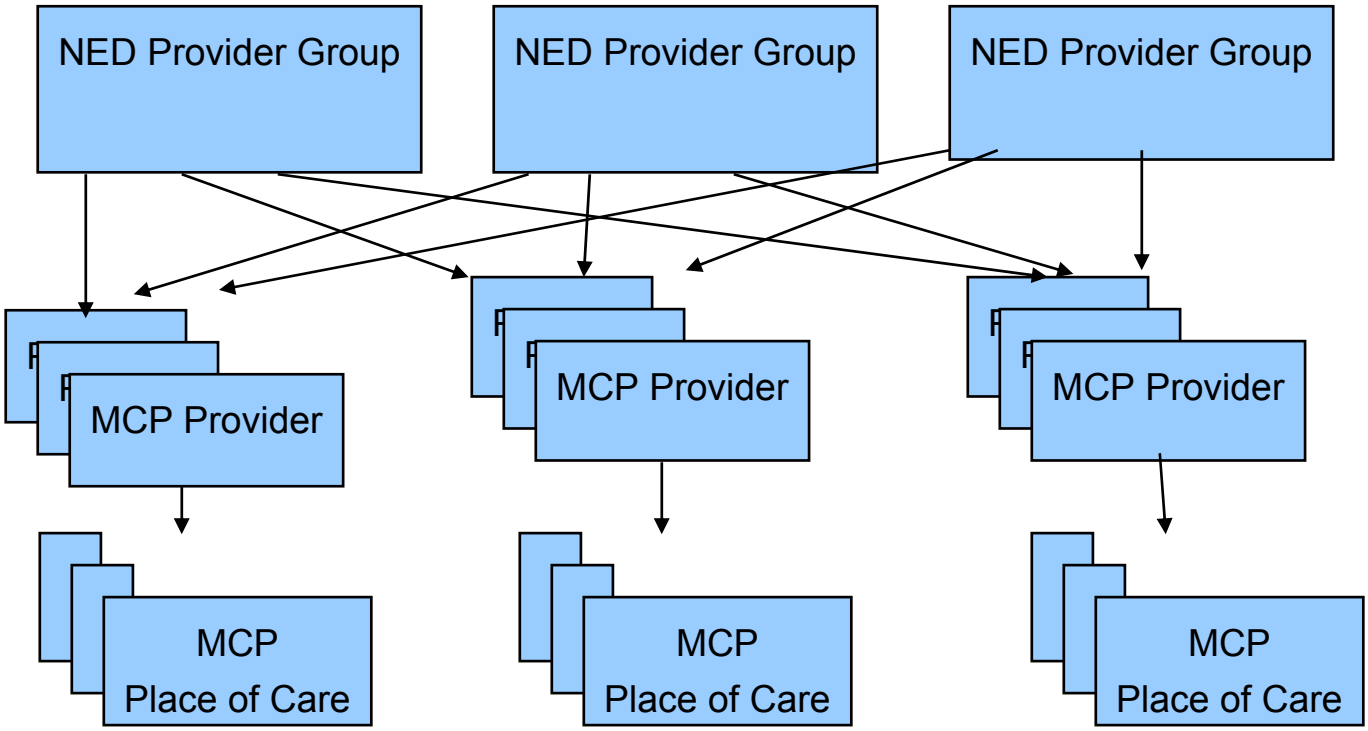
MCP File and Table Design One Group



This chart shows the design of the Provider Network at Keesler, a large Medical Center. In order to have maximum flexibility to book an enrollee to any PCM in the MTF; Keesler created a single Provider Group that contains all PCMs. Each PCM has his or her own places of care. This is an example of a creative solution to maximize access to primary care.

When the PCM is not available, primary care appointments can be booked across multiple places of care in the MTF without a referral but not across DMIS IDs, depending on the Network design.

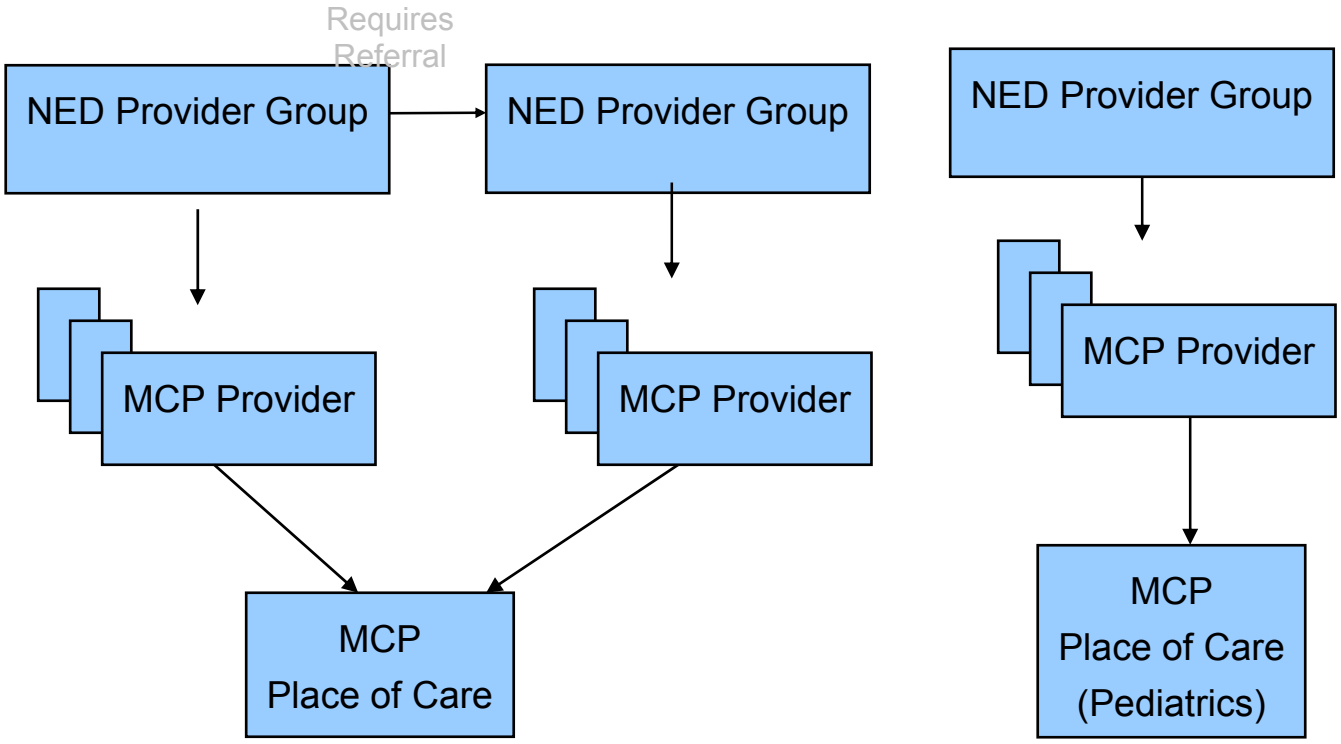
MCP File and Table Design
Multiple Groups with Shared Providers



This chart shows a Provider Network design from Region 5. Region 5 has created multiple groups but maximizes PCM access between the groups by sharing providers, and therefore their places of care, across groups. This is an example of a creative solution that maximizes the ability in CHCS to book to other PCMs in other groups and places of care provided the other PCM is a member of the enrollee's assigned place of care.

When the PCM is not available in one place of care/group combination, primary care appointments can be booked to that PCM in another group/place of care combination without a referral (assuming that the place of care is within the beneficiaries enrolling DMIS ID).

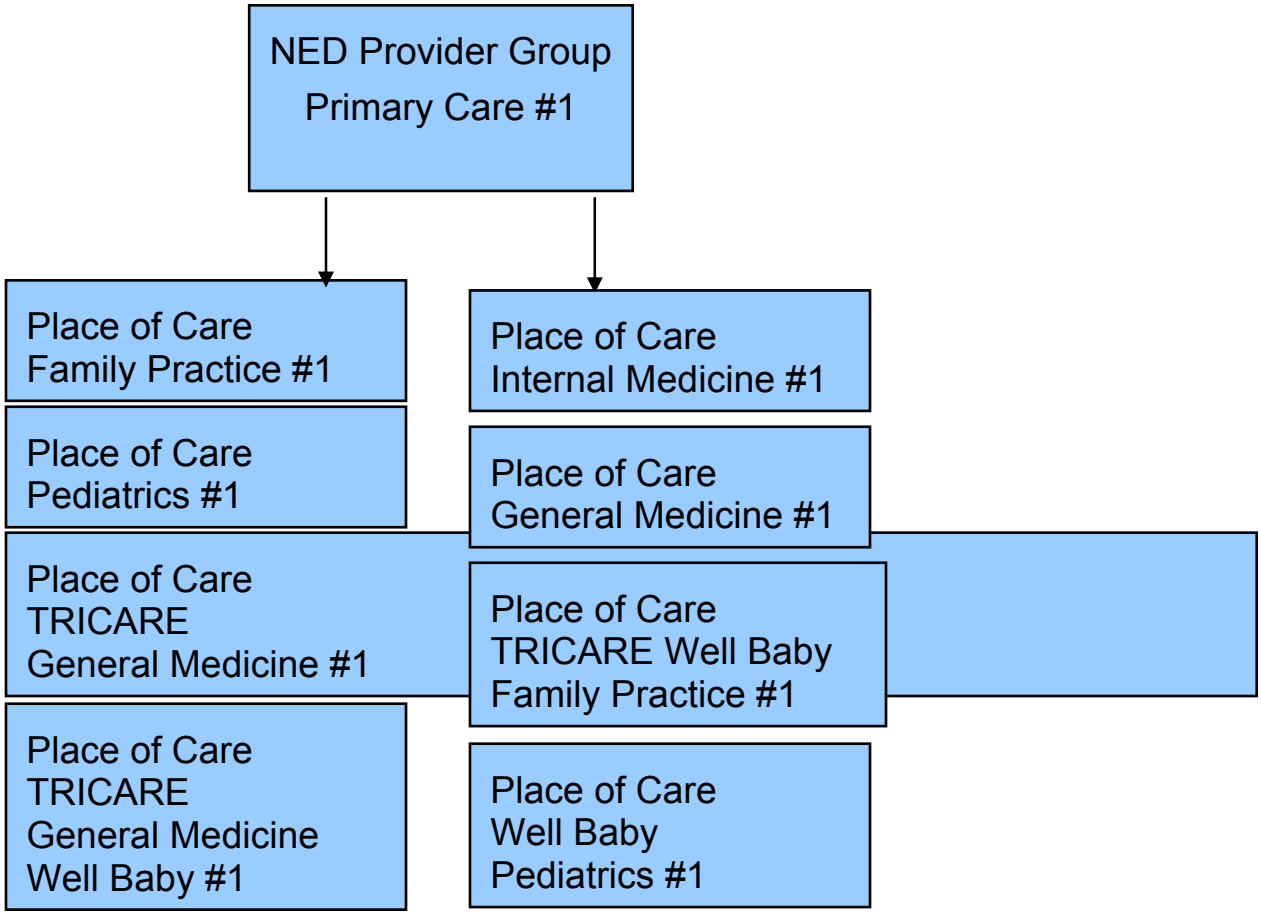
MCP File and Table Design
Large Facility Model - Single Clinic



This model depicts the Provider Network design at Walter Reed. Walter Reed chose to define separate Primary Care provider groups supporting multiple places of care and assign enrollees to them. Multiple groups are required since a single group would be too large and the provider help lists would be too long to reference.

In this design a referral must be created if the enrollee's PCM and PCM group members are not available and the patient is booked to a provider in another group.

MCP File and Table Design
Ft Riley - Multi-Specialty Model



This chart shows the Primary Care Provider Network model at Ft Riley with multi-specialty clinics. A single group contains multiple places of care each with its own specialty.

In this design a referral must be created if the enrollee's PCM and PCM group members are not available and the patient is booked to a provider in another group.

APPENDIX X

PROVIDER NETWORK ARCHITECTURE

In summary, the CHCS Provider Network supports different Provider Network models that are each relevant according to the size and organization of the MTF clinics that use them. Selection of a specific model is also based on the combination and distribution of specialties to individual clinics. MTFs have had complete freedom to select the Network model/architecture that works best for them. Regional commanders may impose Network architecture standards on MTFs in the region.

APPENDIX Y

ACRONYMS

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
ACUT	Acute Care Appointment Type
AD	Active Duty
ADS	Ambulatory Data System
AOP	Appointment Order Process
APS	Appointments Standardization
APV	Ambulatory Patient Visit
ASIPT	Appointments Standardization Integrated Product Team
ASD	Assistant Secretary of Defense
ATC	Access to Care
BPAD	Active Duty Access Type
BPAP	Active Duty and Prime Access Type
BPAPS	Active Duty, Prime, TRICARE Plus, and Special Programs Access Type
BPGME	Graduate Medical Education Access Type
BPPR	Prime Access Type
BPNAD	No Active Duty Access Type
BPNAP	No Active Duty, No Prime Access Type
BPNPR	No Prime
BPSP	Special Program Patients and TRICARE Plus Access Type

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
BPTS	TRICARE Standard/CHAMPUS Access Type
CAEC	Catchment Area Executive Committee
CBT	Computer-based Training
CHCS	Composite Health Care System
CITPO	Clinical Information Technology Program Office
CONOPS	Concept of Operations
CPET	Change Package Except Training
CPT	Current Procedural Terminology
DEERS	Defense Eligibility Enrollment Reporting System
DMIS	Defense Medical Information System
DoD	Department of Defense
DOES	DEERS On-Line Enrollment System
ER	Emergency Room
EROOM	Emergency Room Fixed Appointment Type
EST	Established (Follow-up) Appointment Type
FEHBP	Federal Employee Health Benefit Plan
FOCUS-PDCA	Find, Organize, Clarify, Uncover, Start – Plan, Do, Check, Act
FPC	Family Practice
GAO	General Accounting Office

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
GME	Graduate Medical Education
GRP	Group/Class Appointment Type
GS	Government Services
HA	Health Affairs
HCF	Health Care Finder
HEAR	Health Enrollment/Evaluation Assessment Review
HSOSD	Health Services and Operational Support Division
HSR	Health Services Region
IAW	In Accordance With
ICD	International Classification of Diseases
IGCE	Independent Government Cost Estimate
IPT	Integrated Program Team
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LA	Lead Agent
MCP	Managed Care Program
MCSC	Managed Care Support Contractors
MEPRS	Medical Expense and Performance Reporting System

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
MHS	Military Health System
MOA	Memorandum of Agreement
MTF	Medical Treatment Facility
NATO	North Atlantic Treaty Organization
NED	National Enrollment Database
OA	Open Access
OASD	Office of the Assistant Secretary of Defense
OASD (HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OPAC	*Open Access appointment type*
OPEN ACCESS	*Scheduling patients to see the provider on the day they call for an appointment.*
OPS	Operations
PA	Physician Assistant
PAS BOK	Patient Appointing and Scheduling Booking
PAT	Process Action Team
PCM	Primary Care Manager
PCMBN	Primary Care Manager By Name
PDCA	Plan, Do, Check, and Act Process
PM	Program Manager

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
PO	Program Office
POC	Point of Contact
PROC	Procedure Appointment Type
RMC	Regional Medical Command
ROUT	Routine Appointment Type
SG	Surgeon General
SPEC	Specialty Appointment Type
STS	Specialized Treatment Service
SPP	Special Program Patients
TAI	TRICARE Access Imperatives Web Site
TAT	Template Analysis Tool
TBD	To Be Determined
TCON	Telephone Consult Fixed Appointment Type
TDQM	Total Data Quality Management
TMA	TRICARE Management Activity
TOL	TRICARE On-Line
TOC	TRICARE Operations Center
TRICARE	Tri-Service Health Care
UCAPERS	Uniform Chart of Accounts Personnel Reporting System

APPENDIX Y

ACRONYMS

ACRONYM	DESCRIPTION
USFHP	Uniformed Services Family Health Plan
USTF	Uniformed Services Treatment Facility
WELL	Wellness Appointment Type