MILITARY HEALTH SYSTEM'S GUIDE TO ACCESS SUCCESS

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

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MILITARY HEALTH SYSTEM'S GUIDE TO ACCESS SUCCESS

1. Purpose. This document establishes roles, responsibilities, definitions and guidance for implementing, sustaining and managing Military Treatment Facility (MTF) Access to Care (ATC) in the Military Health System (MHS).

1.1. Definition of ATC. ATC encompasses all of the necessary activities that will ensure our beneficiaries get to the right provider at the right time at the right place.

1.2. Scope of ATC. In the MHS, Access to Care/Access Management encompasses many MTF functions to include:

1.2.1 The day-to-day management of the clinic's templating, scheduling, appointing functions including those made by telephone and the internet

1.2.2. Information system management that supports ATC to include provider network file and table building, and clinic and provider profile management

1.2.3. Enrollment, panel and demand management and analysis

1.2.4. Referral management activities

1.2.5. Appointing telephony management

1.2.6. Effective and efficient personnel management in support of the MTFs ATC program.

1.3. Goals of ATC. The goal of access management is to implement and sustain a systematic, proactive, and responsive MTF access plan for all clinics and services that meets or exceeds the ATC standards stated in 32 Code of Federal Regulations (CFR) 199.17.

1.4. Objectives of MHS ATC. The key to a successful ATC program is for the MTF Commander to oversee the development and deployment of a well researched, efficient and effective plan supporting his/her beneficiary population's mission requirements and health care needs. To achieve these results MTFs will make as their top ATC objectives the following:

1.4.1. Make the appointment system customer friendly.

1.4.2. Provide access to health care services within access standards.

1.4.3. Resolve the patient's request for health care services within their first contact/telephone call.

1.4.4. Resolve patient issues with as few visits/interactions as possible.

1.4.5. Strive for the highest in patient satisfaction.

1.4.6. Open schedules on time and with sufficient supply.

2. Roles and Responsibilities.

2.1. MTF Commander.

2.1.1. Is responsible for the health care needs of his/her supported beneficiary population. Healthcare services will be provided within Access to Care (ATC) standards.[1].

2.1.2. Will ensure that MTF senior leadership monitors ATC program compliance.

2.1.3. Designates an access manager and a multi-disciplinary team to oversee and integrate the implementation of access to care improvements into all applicable processes across the MTF.

2.1.4 Ensures enrollment and PCM assignment IAW with current MHS policy.

2.1.5 Ensures efficient and effective management of appointment templates.

2.2. Access Manager.

2.2.1. Access Managers will perform their duties IAW applicable job descriptions as listed in Appendix B of this guide.

2.2.2. Supports the multi-disciplinary team which includes, but is not limited to, Population Health personnel, Primary Care Clinic Leaders, Specialty Care Clinic Leaders, ancillary personnel, and support personnel.

2.2.3. Ensures that periodic review and updating of templates is performed to maximize access.

[1] The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks (28 calendar days); for a routine visit, the wait time for an appointment shall not exceed one week (7 calendar days); and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

2.2.4. When developing a responsive access management strategy, MTF access managers/teams will consider, at a minimum, the following processes that impact access to care:

2.2.4.1. Health care demands of the MTFs supported population with its seasonal fluctuations

2.2.4.2. Quality of patient care and safety

2.2.4.3. Patient and staff satisfaction

2.2.4.4. Number of enrollees and trends

2.2.4.5. Business planning targets

2.2.4.6. Multi-market service obligations

2.2.4.7. Templating, scheduling, and appointing systems

2.2.4.8. Referral management operations

2.2.4.9. Telephone system capabilities and operations

2.2.4.10. Provider and staff availability and stability to include:

2.2.4.10.1. Permanent Change of Station (PCS) rotation schedules

2.2.4.10.2. Impact of post/base exercises and deployment commitments

2.2.4.10.3. Graduate Medical Education (GME) programs and requirements

2.2.4.10.4. Patient acuity and disease burden

2.2.4.10.5. Provider inpatient responsibilities

2.2.4.16. Data analysis support availability/capability

2.2.4.17. Access Manager/Population Health personnel capabilities and knowledge

2.2.4.18. Experience and education of clinical and administrative staff

2.2.4.19. Centralized versus decentralized appointing methodology

2.2.4.20. Contractor or Government appointing staff

2.2.4.21. Medical records availability

2.2.4.22. Pharmacy, laboratory, and radiology support

2.2.4.23. Normal and after hours support the MTF provides to its supported population

2.2.4.24. Infrastructure limitations (e.g. facility, technology, equipment)

2.2.4.25. Availability/quality of care in network

2.2.4.26. Staff familiarity and experience with information systems

2.2.5. The access manager and/or team should conduct an ongoing demand analysis of the seasonal health care needs of the MTF's enrolled patient population and its applicable non-enrolled beneficiaries.

2.3. Clinic Leaders Responsibilities:

2.3.1. Should work closely with Access Managers to:

2.3.1.1. Determine the appropriate mix of appointment types and quantity of appointment slots for any given day of the week and time of year.

2.3.1.2. Regularly review performance of access improvement initiatives and appointing operations in order to make timely adjustments to meet MTF ATC and business planning objectives.

2.3.1.3. Receive regular feedback on ATC performance and disseminate this feedback to their staff.

2.3.1.4. Provide senior MTF leaders with regular feedback on clinic operations and ATC performance.

3. Scheduling and Appointing Responsibilities.

3.1. Overview of Templating and Scheduling.

3.1.1. Appointment Template Planning and Administration.

3.1.1.1. Definition of Template: A template is a predefined schedule outline for a day of the week or for an entire week used to build appointment schedules for a specific time period. They assist access managers in planning the correct supply and type to meet the demand of the supported beneficiary population or target of the business plan.

3.1.1.2. The standard appointment type operational definitions and applicable guidance will be used to build templates and schedules IAW Appendix H of this guide.

3.1.1.3. A number of factors need to be considered when developing templates. The factors include but are not limited to:

3.1.1.3.1. Acuity and number of enrollees

3.1.1.3.2. Number of non-enrolled "Must See" patients each provider is expected to treat

3.1.1.3.3. Information system provider files and table processing parameters

3.1.1.3.4. Clinic available space and equipment

3.1.1.3.5. Special procedures the clinic performs

3.1.1.3.6. Availability of providers, support and ancillary staff

3.1.1.3.7. Accurate alignment of clinical capability to population demand

3.1.1.3.8. Actual numbers of appointments required in schedules to meet ATC standards, seasonal demand, and business plan targets

3.1.1.3.9. Availability of non-empanelled providers borrowed for use as back-ups

3.1.1.3.10. Graduate Medical Education requirements

3.1.1.3.11. Provider inpatient responsibilities

3.1.1.4. When developing individual provider templates, the Access Manager/ clinical staff should consider the following factors:

3.1.1.4.1. Number of appointments of each type required by day of the week, time of day, and accounting for seasonal trends

3.1.1.4.2. Number of minutes required for each appointment type

3.1.1.4.3. Number of patients per appointment slot

3.1.1.4.4. Options and recommendations for auto reconfiguration of appointment types

3.1.1.4.5. Appointments that could be web-enabled

3.1.1.4.6. Appointments that are count and non-count

3.1.1.4.7. The number and types of detail codes assigned to appointment slots, i.e., patient access type, age, and gender detail codes, especially to ensure that Prime patients get access

3.1.1.4.8. Instructions to the patient to include clinical instructions as well as available facilities such as parking and wheelchair access, etc.

3.1.1.4.9. Instructions to the booking clerk on booking the appointment

3.1.2. Appointment Schedule Management and Administration Guidance:

3.1.2.1. To ensure that the provider's time is used effectively, the appointment schedule should be derived from a template that is well planned and coordinated with the provider. Primarily the appointment schedule defines the bookable/available appointments in a provider's schedule for a particular time period

3.1.2.2. Schedules will be released to allow a continuous supply of appointment at least 30 days into the future.

3.1.2.3**.** Schedules should be coordinated with providers prior to final release. In this process, several factors impact the availability of the numbers of appointments and of providers and clinic support staff's time to support the schedule. These factors include, but are not limited to:

3.1.2.3.1. Unplanned/unscheduled provider and support staff absences

3.1.2. 3.2. Availability of ancillary support (lab, radiology and pharmacy) and medical records

3.1.2. 3.3. Replacement or back-up providers, i.e. Non-empanelled providers, etc.

3.1.2.3.4. Availability of like clinical services in the MTF, e.g., booking pediatric patients into Family Practice.

3.1.3. Guidance on identifying provider absences and schedule change requests.

3.1.3.1. Ensure there is a process is in place that manages provider and support staff availability, i.e. leave and TDYs/TADs.

3.1.3.2. Monitor appointment schedule change requests with the goal of minimizing:

3.1.3.2.1. changes to opened schedules

3.1.3.2.2. facility cancellations

3.1.3.2.2. rescheduling patients

3.1.4. Freezing appointment slots is a local MTF decision. Ensure timely release of frozen appointments to avoid negatively impacting access. Reconfiguration can be used to release frozen slots.

3.2. Appointing Guidance.

3.2.1. Appointing is the business process of booking a patient to see a provider at a specific time in a specific location.

3.2.2. Appointing processes should support booking the appointment during the first patient request/contact.

3.2.3 Primary Care Appointing Guidance.

3.2.3.1. Establish and maintain appointing processes which maximize continuity/patients being appointed first to their assigned PCM. If this is not achievable, MTFs will optimize direct care resources so appropriate care is coordinated during the first telephone call or request for care.

3.2.3.2. In Multi-Service markets, coordination should occur among member MTFs to appoint the patient within the direct care system if possible.

3.2.3.3. If direct care resources are not available, MTFs will work with the MCSCs/network resources to appoint the patient with an appropriate downtown provider.

3.2.3.4. Division, clinic, group and provider profiles should be built and maintained to support the principles of continuity and appointing within the direct care system.

3.2.4. Specialty Care Appointing.

3.2.4.1. Specialty appointments can be booked through provider initiated referral, self referral by the patient, or right of first refusal (ROFR) processes IAW MTF business rules.

3.2.4.2. A referral is the act or an instance of referring a TRICARE beneficiary to another authorized provider to obtain necessary medical treatment for a specific medical issue. The treatment may entail an admission, procedure, or a specialty consultation."

3.2.4.3. A self referral is the ability by a patient to gain access to specialty care services without a provider referral/consult/request IAW MTF business rules.

3.2.4.4 The Right of First Refusal (ROFR) is the process of providing the MTF with an opportunity to review referrals from civilian providers for specialties designated in the MTF MOU to determine if the MTF has the capability and capacity to provide the treatment within the ATC standards.

3.2.5. MTFs will establish and maintain appointing processes which support referral management and maximize patients being appointed within the MTF to the appropriate MTF specialty care per the referring provider's priority for care.

3.2.6. In Multi-Service markets, coordination should occur among the member MTFs to appoint the patient within the direct care system if possible.

3.2.7. If direct care resources are not available, MTFs will work with the MCSCs/ network resources to appoint the patient with an appropriate downtown provider.

3.2.8. Division, clinic, group and provider profiles should be built and maintained to support this process.

3.2.9. Appointing personnel will choose one of the ATC categories with the appropriate ATC standard based on the timeline requested by the patient or on locally based protocols.

3.2.10. MTFs should develop processes and training programs to ensure appointing personnel comply with all applicable MHS and Service Level ATC policies and procedures. MTFs, in multi-service markets or with shared appointing service personnel should ensure required training is IAW MHS and Service ATC policies.

3.2.11. Use of Standard Appointment Types. Use of standard appointment types are governed by definitions and business rules set forth in Appendix H of this guide. Only those appointment types listed in Appendix H will be used.

3.2.12. General Guidance on choosing ATC Categories/search options and appointment types with corresponding ATC Standards. Appointing personnel will use the chart below as a quick reference in booking appointments. Access is tracked in minutes, not days as shown in the chart.

ATC Category/ Search Option	Standard Appointment Type That Should Be Chosen/Booked	ATC Standard (Time In Which The Appointment Type Needs To Be Booked)
Acute	ACUT and ACUT$	24 Continuous Hours/1440 minutes
	OPAC and OPAC$	Same Calendar Day
Routine	ROUT and ROUT$	7 Calendar Days/10,080 minutes
Wellness	WELL and WELL$ PCM and PCM$	28 Calendar Days/40,320 minutes
Specialty	SPEC and SPEC$ PROC and PROC$	28 Calendar Days/40,320 minutes, or per Provider Designation not to exceed 28 Calendar days
Future	EST or EST$ GRP or GRP$ APV	No Standard or per Provider Designation
Dental Routine	DROUT or DROUT$	21 Calendar Days/30,240 minutes

3.3. Use of dollar sign ($) suffix on appointment types.

3.3.1. Appointment types using the ($) as the last character on a slot may be used but should be used sparingly. The $ greatly limits access as it is primarily used by the MTF

or specific clinics inside the MTF to restrict booking by appointing agents assigned to multi-market/regional central appointing offices external to the MTF.

3.3.2. MTFs will not use the $ suffix to prevent MTF personnel from booking these appointments or to make it a provider book only slot.

3.3.3. MTFs cannot use the ($) suffix in conjunction with the WEA detail code as this prevents these appointments from being booked via the TRICARE Online (TOL) appointing capability. Refer to Appendix U for a complete summary of TOL appointing business rules.

3.4. Patients Who Refuse Appointments Offered Within ATC Standards.

3.4.1. A patient may waive ATC standards and request appointments outside of ATC Standards for convenience reasons or to maintain continuity with their provider, even though an appointment was offered within ATC standards.

3.4.2. Appointing personnel will document patient refusals IAW information system processes to ensure these booking transactions result in a patient refusal as opposed to not meeting access standards.

3.5. Patients Who Refuse All Appointments Offered. Appointing personnel will document the patient's reason for refusal IAW information system processes to ensure this patient refusal is accurately documented and to prevent the request from being documented as not meeting access standards.

3.6. Booking Transactions Not Meeting ATC Standards.

3.6.1. MTFs will use the ATC categories and/or information system searches that best represent the patient's needs, even if they do not find available appointments within the ATC standard.

3.6.2. Initial ATC searches may not meet access standards. Not meeting standards can be an indication of many factors to include increased demand, lack of capacity, wrong provider mix, wrong appointment type mix, increased operations tempo, under-resourcing, or incorrectly determining the needs of the patient. One of the goals of the booking process is to accurately record the results of meeting/not meeting the ATC Standards.

3.7. Requests for Appointments Not Resulting in a Booked Appointment.

3.7.1. Appointing personnel will be trained to accurately use the Unbooked Appointment

Request and Reporting functionality of Composite Health Care System/Enterprise Wide Registration system (CHCS/EWSR). This functionality allows for the tracking and reporting of patients who requested an appointment, a search was performed, but the appointment request did not result in an appointment being booked.

3.7.2. Appointing personnel will choose the most accurate Unbooked Appointment Request reason matching why the search attempt did not result in a booked appointment. Appointing personnel will become familiar with the operational definitions of Unbooked Appointment Request reasons and this functionality's reports per definitions listed below and use them IAW current MTF business processes.

3.7.2.1. Added to Waitlist: Patient was added to the MTF waitlist and patient preferences for the direct care appointment were documented.

3.7.2.2. All Appointments Refused: The patient refused all offered MTF/direct care appointments inside and/or outside the ATC standard.

3.7.2.3. Appointed to Network: Patient was instructed that care was not available in the MTF/direct care system and was appointed to the network.

3.7.2.4. No Appointments Available: No appropriate appointments were available in the MTF/direct care system for the clerk to book.

3.7.2.5. No Appointments Available to Contractor: No appropriate appointments were available in the MTF/direct care system for the appointing contractor to book.

3.7.2.6. Patient Requested To Call Back: The patient was requested to call back later to get an MTF appointment. Clerk should document in the free text field the reason why.

3.7.2.7. Request Referred to MCSC: The patient was referred to the MCSC (or contractor) for issue resolution.

3.7.2.8. Request Referred to MTF Clinic: The patient was referred (usually by the contractor or appointing contractor) to the MTF clinic for issue resolution.

3.7.2.9. Self-Care Recommended: Clerk referred the patient to a clinician to answer the patient's questions and to provide a self-care plan if appropriate.

3.7.2.10. Unsuccessful Telephone Transfer: Clerk attempted to transfer the patient but the telephone system dropped the call.

3.7.2.11. Just Looking: The clerk was entering test data into the system, checking availability of appointments, or performing other administrative tasks not related to booking an actual patient request. This reason will never be used for actual patient requests for clinical care.

3.7.2.11.1. Appointing personnel are strongly discouraged from using the "Just Looking" unbooked appointment reason for all searches that did not result in a booked appointment. A high rate of these reasons minimizes the usability and benefits of this report.

3.7.2.12. Other (Free Text): This reason may be used for patient requests whose disposition is not covered by any of the above reasons. Use the free text field to document the actual disposition of the patient request. Sites should develop standards for data entry into this reason field.

3.7.3. Appointing staff can use the Unbooked Appointment Request Report to manage patient call-backs. This report provides all the necessary information to facilitate this process to include the patient's name, phone number, need for care, requested clinic, etc.

3.8. No-Shows.

3.8.1. Definition. An appointment is designated a No-Show when a patient does not keep a scheduled appointment or cancels an appointment without sufficient notice, according to local MTF policies. A patient who fails to provide notification as specified above is considered a No-Show.

3.8.2. MTFs will strive for a no show rate of less than five percent (5%) of all booked appointments. To achieve this standard, MTFs will educate patient populations on medical no show appointment procedures and may incorporate measures such as, briefing installation leadership on the cost of no shows by organization, and publishing articles in the installation newspaper or electronic news-bulletin, etc.

3.8.3. MTFs may utilize manual (mail) or automated appointment reminder processes/systems and should maintain a convenient means for patients to cancel appointments to minimize no-show rates. MTFs may also mail letters to patients that have been identified as a No-Show.

3.8.4. Line commanders may be notified of No Shows of Active Duty members under their command. The MTF is not required to record these as disclosures under HIPAA, as this falls under the definition of treatment.

3.8.5. MTF Commanders will ensure that only one no-show policy is administered and applied consistently throughout the MTF so as to not confuse staff and patients with differing policies between clinics/ departments.

3.8.6. Providers/staff will document and follow-up on no-show patients to ensure patient wellness and to comply with Joint Commission and/or AAAHC guidelines.

3.9. Late Patient Arrival for Scheduled Appointment (Late Show).

3.9.1. Definition: A late show is any patient who arrives at the clinic after their scheduled appointment time as defined by local MTF policies, e.g.

3.9.2. Depending on the judgment of the clinic staff, the patient's health status, and/or individual circumstances as to why the patient was late, the MTF leadership can take actions to 1) place another patient in the late show patient's scheduled appointment; time, 2) offer the late show patient the opportunity to reschedule their appointment, or 3) allow the patient to wait for the provider to see them that day if the provider is available. For purposes of this policy, clinic staff refers to privileged providers and nurses.

3.9.3. MTF Commanders will ensure that only one late-show policy is administered and applied consistently throughout the MTF so as to not confuse staff and patients with differing policies between clinics/ departments.

3.9.4. The MTF will educate its patient population on late show appointment processes.

3.10. Patient Cancellations.

3.10.1. Definition: A patient cancellation is when a patient with a scheduled appointment notifies the MTF in sufficient time for the MTF to schedule another patient into the appointment slot according to local MTF policies.

3.10.2. MTFs will develop patient centered processes to allow for easy cancellation of appointments such as a patient appointment cancellation telephone number or clearly defined appointment cancellation menu options.

3.10.3. The MTF will educate its patient population on appointment cancellation procedures.

3.11. Facility Cancellations.

3.11.1. Definition: A facility cancellation occurs when the facility cancels an available/open appointment or cancels a patient's scheduled appointment. The intent of

this action is to permanently remove the affected appointment slot(s) from the schedule. MTFs will take all necessary actions to minimize facility cancellations.

3.11.2. MTFs will ensure that clear schedule management procedures are in place to govern all parts of the facility cancellation process to include who has authority; when this practice is authorized, and what feedback/reports are generated.

3.11.3. The MTF will inform affected patients of their appointment cancellation as soon as possible.

3.11.4. All patients who had facility cancelled appointments should be offered a new appointment at the time they are informed of the cancellation. When possible, the patient should be rescheduled to meet the ATC Standards of their original appointment request. The ATC Standard is not met if the patient is rescheduled outside the access standard assigned to the original appointment.

3.11.5. If a patient was not informed of a facility cancelled appointment and presents at the MTF for care, the MTF will take reasonable actions to arrange care that same day.

3.12. Walk-in and Sick Call Appointing.

3.12.1. Definitions: A Walk-in is a patient who seeks care without a scheduled appointment, arrives at the clinic, and is assigned a time to see the provider the same day. There is no ATC Standard for a walk-in appointment. Sick Call is reserved for an Active Duty member who arrives at a clinic that uses Sick Call as a regular, common time to receive healthcare. There is no access standard for sick call appointments.

3.12.2. Walk-ins are not designed for use as a schedulable event. High utilization of walk-ins can create data quality challenges for the MTF and make the process of measuring/explaining access, and assessing demand more complex. High rates of Walk-ins may also make business plan targeting difficult since they are unplanned events. Excessive walk-in activity can reduce the appointments available to patients requesting care on the telephone. However, if clinics utilize the Walk-in function to get patients seen in a manner that is more timely/convenient for the patients, this is recognized as good customer service from the patient's perspective. The MTF should make an informed decision as to the challenges and benefits of using Walk-in care and Sick Call to treat its patients.

3.12.3. The practice of seeing high volumes of Walk-ins can complicate the MTF/Clinic patient flow process if MTF leadership does not ensure its clinic staff is properly trained/educated in its use. Use of Walk-ins should not be a substitute for active review and management of appointment schedules and telephone access to appointments.

3.12.4. If MTFs choose to offer Walk-in care and/or Sick Call appointments, MTF leadership will provide guidance for clinic staff on the following:

3.12.4.1. How to coordinate walk-in care with PCM/PCM teams or clinics

3.12.4.2. How to respond to patients requesting Walk-in services (either over the phone or in-person at the reception desk);

3.12.4.3. How to balance customer service at the reception desk for pre-scheduled versus Walk-in patients (queue and priority awareness)

3.12.4.4. How to manage patients waiting for extended periods of time in reception;
3.12.4.5. Processes to ensure records availability

3.12.5. The MTF will educate its patient population on walk-in and/or sick call processes as applicable.

3.12.6. At End of Day processing, Walk-in and Sick Call appointments **will not** have their appointment statuses changed to any other appointment status. This will ensure data quality on Walk-in care and Sick Call care is maintained.

3.13. Splitting and Joining Appointments.

3.13.1. MTFs are encouraged to split or join appointment slots to improve patient access. These booking functions allow MTFs to easily tailor lengths of appointment time and to create additional appointments so the provider's time is used efficiently and the patient is scheduled for the appropriate time needed to provide their care.

3.13.2. Access Managers/clinic staff will work with providers to coordinate the development of protocols for splitting and joining appointments.

3.13.3. The Split function must be used to subdivide appointments of greater than 30 minutes.

3.14. Cross Booking.

3.14.1. Definition: Booking a patient with a PCM group/clinic to whom they are not enrolled when their enrolled provider's or group's appointment availability, or lack of appointment availability, does not meet their needs.

3.14.2. Cross booking appointing processes will be established to maximize patients being appointed within the MTF. Cross booking should not exceed the 30 minute drive time access standard for Primary Care.

3.15. Automatic Schedule Reconfiguration.

3.15.1. MTF appointing and template managers are strongly urged to use the automatic schedule reconfiguration functionality of the appointing information system to improve access while decreasing the amount of time spent on manually managing/changing schedules.

3.15.2. MTF appointing personnel can use this function to allow for a systematic changing of appointment types and detail codes and releasing of frozen appointments to maintain the correct mix of appointment types at the right time.

3.15.3. This function is not used to split and join appointments. Detailed instructions on how to use this functionality is provided by Service specific training modules.

4. Detail Codes.

4.1. Purpose of Detail Codes. Detail codes assist appointing personnel to rapidly identify and search for requested slots on appointment schedules, to indicate the care available at that time (procedures, classes, etc.), or to reserve slots for Prime or other categories of patient. The appointment information system enables clerks to search by detail code.

4.2. Use of Detail Codes. MTFs can use detail codes to further define appointment type definitions on templates and schedules. Appendices M and N of this document contain guidance on the use of select detail codes and the approved list and definitions of all standard detail codes for the Appointment Detail Fields to be used in appointment slots.

5. Open Access (OA) Appointing Guidance. OA Appointing will be conducted IAW Appendix J of this guide.

6. Verifying and Updating Patient Information and Eligibility.

6.1. For Active-duty and retired service members, registration in the Defense Enrollment Eligibility Reporting System (DEERS) is normally automatic; however, this is not true for family members. It is incumbent on the beneficiary to ensure they and their family members are registered and their accounts are updated in DEERS.

6.2. When DEERS verification cannot be validated for any beneficiary, a DEERS eligibility check must be performed. It is the beneficiary's responsibility to keep DEERS records

updated when personal eligibility information changes. This includes changes in military career status; addresses; and family status (marriage, divorce, birth, and adoption) etc.

6.3. Registering children in DEERS: Parents and legal guardians must register their newborn or newly adopted child in DEERS as soon as possible after birth or legal adoption. Sponsors must take action to register their family members and ensure they are correctly entered into the DEERS database.

6.4. Updating DEERS information: Beneficiaries should visit the DEERS Web site to update their address. Call 1-800-538-9552 or 1-866-363-2883 (TTY/TDD for the deaf), or Fax address changes to 1-831-655-8317, or Visit the local ID card facility, or Mail the new information to:

Defense Manpower Data Center Support Office
Attn: COA
400 Gigling Road
Seaside, California 93955-6771

7. Referring Questions Related to Patient Eligibility. Appointing personnel will refer questions related to the patient's eligibility for care and/or enrollment status to the MTFs eligibility office responsible for enrollment. Other Health Insurance questions should be referred to the MTF's office responsible for Third Party Collection program.

8. Assigning Appointing Statuses.

8.1. MTF staff will determine the status for each appointment as accurately as possible. Appointment statuses will be consistently applied according to the following definitions:

8.1.1. Kept: The patient has a booked appointment, arrives at the MTF/clinic, and is treated by the provider.

8.1.2. Patient Cancellation: A patient with a scheduled appointment notifies the MTF in accordance with (IAW) local procedures that they will not keep the appointment.

8.1.3. Walk-in: The patient does not have a scheduled appointment, arrives at the clinic, and is assigned a time to see the provider the same day. This status will not be changed at End of Day (EOD) processing.

8.1.4. Sick Call: An Active Duty member arrives at a clinic for a pre-arranged block of time for care. This status will not be changed at EOD processing.

8.1.5. No-Show**:** A scheduled appointment that the patient does not keep. Determination of no-shows will be IAW local procedures.

8.1.6. Facility Cancellation: The MTF cancels an available/open appointment or cancels a patient's scheduled appointment. The intent of this action is to permanently remove the affected appointment slot(s) from the schedule.

8.1.7. Left Without Being Seen (LWOBS): The patient has a booked appointment, arrives at the clinic, and is checked in, but decides to leave without seeing the provider.

8.1.8. Pending: The MTF appointment information system assigns this initial status for an appointment that has been booked for a patient for a future date or time. All Pending appointments must be changed to one of the final encounter statuses in order to complete EOD Processing.

8.1.9. Admin (ADMIN): The Admin status is used on appointments or telephone consults that do not represent actual contact with a patient. The status must be assigned in End of Day Processing. A transaction with this status will not be passed to ADM or AHLTA and therefore will not be coded or included in the SADR.

8.1.10. Occasions of Service (OCC-SVC): The OCC-SVC status on a patient appointment indicates no medical decision was made by a privileged provider who is directly responsible for the management of care for the patient. Per Service policy, the OCC-SVC status will no longer be used on telephone consults. The OCC-SVC transaction will pass from CHCS/EWSR to the Ambulatory Data Module (ADM), is always non-count, and may be used to assess level of effort. ADM and AHLTA do not recognize OCC-SVC as an appointment for encounter completion. Therefore this status will NOT prompt the provider to code the encounter and will avoid generating a Standard Ambulatory Data Record (SADR). Examples of OCC-SVC are provider to provider consultation, and pharmacy refills, etc.

8.1.11. Telephone Consultation (TEL-CON): When a provider answers a telephone consult in AHLTA, the provider will be asked by the system, "Does this meet the outpatient visit criteria?" If the provider is a technician, nurse, or other non-count provider or the clinic is a non-count clinic (per the Clinic Profile), the workload type response will be defaulted to No (non-count) and cannot be changed in AHLTA. If the provider is a privileged provider and the clinic is a count clinic, the default will be Yes (count). The provider should change the response to No if it does not meet the visit criteria. The telephone consult data will be sent to CHCS/EWSR with the workload type set according to the criteria above. The appointment status on the telephone consult record is defaulted by the system to TEL-CON if count and to ADMIN if non-count. Clinic staff may correct the workload type and appointment status in ADM to reflect actual workload as follows: correct to non-count and a status of ADMIN if the consult

has not been sent on the SADR; correct to non-count and CANCEL if the consult has been sent on the SADR (this will cancel the transaction on the SADR).

9. End of Day (EOD) Processing. EOD processing will be correctly completed at the end of each business day. All workload types (count/non-count) on appointment slots will accurately match the care provided.

10. Appointing Information System Operations.

10.1. Division, Clinic, Group, and Provider Profiles.

10.1.1. MTF leadership will clearly identify those individuals with the responsibility to establish and maintain division, clinic, group, and provider profiles in the MTF information system(s).

10.1.2. MTF leadership will ensure these individuals are adequately trained for this responsibility. Training courses and information on division, clinic, group, and provider profiles can be found at https://kx.afms.mil/healthbenefits.

10.1.3. MTF division, clinic, group, and provider profiles will be established and maintained to support MHS and Service policies and to support DEERS enrollment. Addition guidance on set up and management of these can be found in Appendix O, Access Improvement Education. These functions would include but are not limited to:

10.1.3.1. Development of Primary Care Groups

10.1.3.2. Assignment of clinic/Primary Care Group MEPRS codes

10.1.3.3 Assigning hospital locations and providers

10.1.3.4 Establishing appointment types and durations

10.1.3.5 Setting up and changing detail codes

10.1.3.6 Assignment of workload type (count and non-count appointments)

10.1.3.7 Assigning the maximum number of patients per slot

10.1.3.8 Setting up the maximum number of overbooks per day, per slot

10.1.3.9 MTF and clinic addresses and phone numbers

10.1.3.10 Referral management settings/requirements.

10.1.4. MTF leadership will ensure the ATC Reporting Flag is set to "Yes" in each of their primary and specialty care (B-MEPRS accounts) clinic profiles.

10.1.5. Limited Self-Referrals by patients are allowed for certain preventive services/care based on the MTF service model. The Self-Referral flag will be set to "Yes" in the clinic profile for participating clinics. Self-Referral flags also impact the MTF's ability to offer self-referral care to TOL users.

10.2. Appointing Information System Booking Authority and Security Key Administration.

10.2.1. MTF leadership will establish who will have authority to book and cancel appointments in the appointing information system(s). Leadership should ensure regular review and update of security keys for all MTF appointing information system users.

10.2.2. MTF leadership will identify appropriate personnel to use various appointment information system security keys. These may need to be reviewed at the clinic level and include:

10.2.2.1. Changing appointment types

10.2.2.2.Changing and/or adding detail codes

10.2.2.3.Changing gender, age designations on appointment slots

10.2.2.4.Booking appointments outside ATC standards

10.2.2.5. Instantaneously creating and booking appointments

10.2.2.6. Deleting appointment slots

10.2.2.7. Freezing and unfreezing appointments slots

11. Referrals /Consults.

11.1. All specialty care and Right of First Refusal (ROFR) referrals/consults will be managed IAW current referral management policy and guidance. Specialty care referrals/consults will be appointed to the MTF/Direct Care System (DCS) within prescribed ATC Standards or referred to the local network.

11.2. Referral/consult appointments will be booked in Appointment Order Processing (AOP) as per the following table in order to link the appointment with the referral/ consult:

Consult/ Referral Priority Entered by Provider	ATC Category/ assigned by MTF information system	ATC Standard assigned by MTF information system	Standard appointment type that can be booked
STAT, ASAP, Today, 24 HRS	Acute	within 24 Hours or 1440 minutes	All Types
48 HRS, 72 HRS	Routine	within 7 calendar days or 10,080 minutes	All Types
Routine	Specialty	within 28 calendar days or 40,320 minutes	All Types
For 2nd, 3rd, etc. appointment on a consult, user selects ATC	Any ATC Category including the Future ATC Category	No Standard	All Types

12. Telephone Administration and Support to Appointing.

12.1. MTF leadership will ensure telephone appointment personnel are adequately trained and appointment lines are adequately staffed to accept incoming telephone requests for appointments and achieve first call resolution.

12.2 Use of Standardized Automated Call Distribution (ACD) Systems will be operated IAW Service Policy.

13. Nurse and Medical Technician Run Clinics/Nurse Role in Support of ATC. MTFs which desire to establish Nurse and Medical Technician run clinics will follow guidance as established by their parent Service.

14. After Hours Care. MTF leadership will develop guidelines and procedures to ensure after hours care is provided IAW with current MHS policy that states "After normal duty hours, a Primary Care Manager (PCM) should be available to triage Prime beneficiaries, either directly or

to provide back-up consultation to an advice nurse." Patients will be educated on these policies and subsequent local supporting procedures.

15. Health Care Access for TRICARE Prime Beneficiaries Not Enrolled to the MTF or in a Transition Status.

15.1. TRICARE Prime beneficiaries are eligible for care in any MTF, regardless of enrollment site. MTF leadership will establish guidelines to ensure appointment access to TRICARE Prime enrolled members that may be in a student status, travel status, transitioning enrollment between MTFs, transferring enrollment between regional support contractors, or in a terminal/appellate leave status.

15.2. Leaders of MTFs located in multi-market areas will develop guidelines to ensure that clear lines of responsibility are delineated in delivering care to TRICARE Prime beneficiaries enrolled to other multi-market MTFs in their area. The goal is to maximize continuity of care.

15.3. If the MTF cannot provide care for these enrolled elsewhere beneficiaries within its direct care system, either because these beneficiaries or the MTF cannot contact the assigned PCM for consultation or to gain care from the MTF to which they are enrolled, the MTF should ensure that a referral is input authorizing care to be provided by network/contract resources for these beneficiaries.

15.4. MTF Eligibility Determination function personnel shall ensure Active Duty Service Members (ADSMs) departing their final duty stations are briefed about how they should access health care services while in terminal or appellate leave status. MTF Eligibility Determination function personnel should proactively provide options and instructions on accessing care and enrollment procedures to TRICARE Prime beneficiaries identified to be in transition status due to out-processing, changing enrollment sites, or spending greater than 30 days away from the MTF where the beneficiaries are enrolled. These may be beneficiaries geographically separated from their sponsors, to include spouses and children of deployed Active Duty, fulltime college students attending school away from their enrolled MTF, and retirees on extended vacations.

16. Management of Mental Health Access.

16.1. The management of mental health access will be IAW Health Affairs Policy 07-022, TRICARE Prime Access Standards for Mental Health Care, dated 9 October 2007.

16.2. MTFs will establish processes to ensure that initial requests for emergent care will be provided on an immediate basis, as dictated by the threat.

16.3. Urgent mental healthcare will be provided within 24 hours or less.

16.4. Routine mental healthcare is defined as an initial request for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent.

16.4.1. Routine mental healthcare will be provided within one week/7 calendar days of the patient's request. Beneficiaries will retain the option of deferring this routine mental health assessment past this 7-day standard.

16.4.2. Appointing staffs need to be aware that these routine mental healthcare requests need to be appointed within 7 days from the patient's request, and can be appointed to the patient's Primary Care, Behavioral Health, or Mental Health Clinics.

16.4.3. Mental Health Clinics should use the ROUT or ROUT$ appointment type in their templates and schedules and use the Routine ATC Category to book these initial mental health self-referral requests.

16.5. Specialty care mental health referrals will be managed IAW with current Service and MHS referral management policy and guidance.

16.6. Active Duty Service Members must still have preauthorization prior to obtaining non-emergent mental healthcare outside the Direct Care System. All other Prime beneficiaries may still use their unmanaged eight mental health visits in the TRICARE network before obtaining preauthorization.

REFERENCES AND SUPPORTING INFORMATION

References:

32 Code of Federal Regulations, 199.17, Parts I and II.

ASD (HA) Policy Guidance for Referral Management, dated 5 May 2004 and 29 July 2004 (references (c) and (d))

ASD (HA) 06-007, TRICARE Policy for Access to Care and Prime Service Area Standards, 21 February 2006

ASD (HA) 07-022, TRICARE Prime Access Standards for Mental Health Care, 9 October 2007

DOD TMA Medical Management Guide, January 2006

Commander's Guide for Access Success, 15 August 2003

AFI 41-210, Patient Administration Functions, 22 March 2006

Air Force Policy on Open Access (OA) Appointing for Primary Care, 6 January 2007

AFMS Open Access Implementation and Sustainment Guide and Checklist, 6 January 2007

AFMS Primary Care Element (PCE) Policy Guidance, dated March 2004

Air Force Referral Management User's Guide 4.0, June 2006

Group Practice Manager (GPM) Position Description, 15 December 2006

Health Care Integrator (HCI) Position Description, 15 December 2006

Standardization of Automatic Call Distribution Systems, 17 August 2006

Ten Percent for Primary Care Appointments Booked on TOL, 12 July 2006

Revised Flight Surgeon MEPRS Codes and Mission Essential Tasks/Activities for Line Support, 23 May 2005

Policy Letter on the Implementation of DoDI 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, 22 June 2006

AFMS ATC Bulletin Number 6, Appointment Schedule Automatic Reconfiguration, 14 January 2005

AF Policy on Providing Network/Contractor Furnished Urgent/Routine Medical Care Services

Websites:

AFMS Knowledge Exchange (AFKX) Health Benefits page: https://kx.afms.mil/healthbenefits

Access Improvement Module website: https://aim.afmoa.af.mil/

Biometric Data Quality Assurance Service (BDQAS) website: http://www.pdhealth.mil/guidelines/downloads/AFBehavioralHealthCodingHandbook05.pdf

CHCS Training Materials: https://kx.afms.mil/healthbenefits

AFMS ATC Bulletins: https://kx.afms.mil/healthbenefits

AFMS Referral Management: https://kx.afms.mil/referralmanagement

AFMS Group Practice Management: https://www.afms.mil/gpm

Medical Management website: http://www.mhsophsc.org/public/home.cfm

P2R2 website: https://p2r2.afmoa.af.mil/chartview.cfm

Population Health Portal: http://www.mhsophsc.org/public/home.cfm

TOL Education Materials: https://kx.afms.mil/healthbenefits

TRICARE Operations Center (TOC) website: http://mytoc.tma.osd.mil/

TRICARE Operations Manual (TOM): http://manuals.tricare.osd.mil/

TRICARE website: http://www.tricare.mil/

TRICARE Online: http://www.tricare.mil/

AHLTA issues related to ATC: http://citpo.ha.osd.mil/index.html

APPENDIX A

MHS ACCESS IMPROVEMENT PLAN TEMPLATE

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MHS ACCESS IMPROVEMENT PLAN TEMPLATE

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APPENDIX A

MHS ACCESS IMPROVEMENT PLAN TEMPLATE

Understanding the Mission: Access management encompasses a myriad of MTF functions to include: templating, scheduling, appointing to include those made by telephone and thru the web; file and table building, clinic and provider profile management; enrollment management, panel management; demand management and analysis; referral management; population health promotion and management; information system's management to include impact of changes on functional business processes; appointing telephony; and personnel management to include providers, nurses and support staff. The goal of access improvement is to implement and sustain a systematic, proactive, and responsive MTF access management plan for all clinics and services that meets or exceeds the mandate that healthcare services will be provided within the Access To Care (ATC) standards as stated in 32 Code of Federal Regulations 199.17. This regulation defines wait times for a well-patient visit or a specialty care referral as not exceeding 28 calendar days; for a routine visit, the wait time for an appointment shall not exceed 7 calendar days; and for an urgent care visit the wait time for an appointment shall not exceed 24 hours. The key to Access Success is for MTF Commander to oversee the development of a well researched and proactive plan that can implement and sustain improved access for their beneficiaries.

Quantitative Decision Making to Improve Access: The MHS and the Services have developed many quantitative performance measurement tools that can assist the MTF Commander and Access Manager to identify if a particular provider, clinic or if an entire MTF has an access problem. Indicators of a problem using these quantitative measures as compared to MHS, Service or MTF established thresholds serves as an indicator a possible arising or long-term problem. Coupled with direct discussions with patients, appointing and provider staffs, Commanders and Access Managers can use this information to develop and implement successful access management/improvement plans.

MHS Goal of Improving Access. In the MHS, access improvement is a process of developing schedules and booking medical appointments, designed to offer each enrolled patient requesting health care services an appointment or health care service within the standards as set forth by 32 CFR 199.17. Schedules will be made available for booking at least 30 days in advance, to allow patients and appointing personnel sufficient numbers and choices of times to fulfill patients' expectations. All efforts will be made to ensure that enrolled beneficiaries requests for services are resolved during their initial request or first telephone call. The end result of access management planning is that the right patient is provided the right health care service at the right time at the right place with the right provider.

A Commitment to Improving Access. MTF Commanders must make the commitment to ensure that the goals of MHS Access Improvement are obtained and sustained. To do so, adequate planning by qualified, knowledgeable personnel must take place. All MTF staff should fully understand the goals of improving access and make the commitment to providing this level of service. Staff members are strongly encouraged to complete this MHS Access Improvement Plan Template.

APPENDIX A

MHS ACCESS IMPROVEMENT PLAN TEMPLATE

Directions for Completing this Plan.

The MHS Access Improvement Plan Development Template was developed to assist sites in their pursuit of improving, implementing and sustaining a successful access management program.

It is recommended that all parts of this plan be considered and completed. Space for note taking on this document has been provided. The level of detail is at the discretion of the local command. This template will allow MTFs to consider a wide range of factors that impact access improvement. By completing all parts of this plan template, the MTF will be able to fully analyze present processes and then decide what actions to take to develop successful access improvement plans.

1. Background for Access Improvement. In this first section the MTF will describe its goals, expectations, and support for the improvements.

1.1. Describe your MTFs Expectations and Goals.
Discuss your MTF's understanding of the advantages, disadvantages and anticipated benefits improving access will offer your MTF patients and staff. Identify your overall goals in the areas of quality, access and cost and how your MTF will measure success, i.e. how will your MTF know if it is doing a good job at providing superior access to care.

1.2. Discuss Purpose and Senior Leadership Support.
Describe the reason(s) your facility is planning to make access improvements. Describe how this decision was made and what roles senior leadership played to include adjusting staff, tailoring policies and providing resources to successfully implement and sustain access improvements at your MTF.

1.3. Identify your Physician Champion.
Describe his/her role to the success of making access improvements. Provide how long he/she will be remaining in his/her present duty assignment. It is recommended the Physician Champion identified have at least 12 months remaining at the MTF.

1.4. Discuss your MTF's previous performance with Access to Care (ATC). Accuracy of this data is solely dependent on adherence to APS III Booking.

1.4.1. Discuss your Booked to Acute ATC Summary Report Scores.
1.4.2. Discuss your Booked to Routine ATC Summary Report Scores.
1.4.3. Discuss your Booked to Future ATC Summary Report Scores.
1.4.4. Discuss your patient refusal scores for Booked to Acute, and Routine on the ATC Summary Report.
1.4.5 MTF Patient Satisfaction Survey Data
1.4.6 Defer to Network Patient Satisfaction Survey Data
1.4.7 Review the MTF Business Plan

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1.5. Describe the membership of your Access Improvement Implementation team.
Provide names and positions of each team member. Your team at a minimum should include personnel from the following areas:

1.5.1. Team leader if not the Physician Champion _____
1.5.2. Physician Champion; see above _____
1.5.3. Nursing and/or Nurse Managers _____
1.5.4. Administration (Chief, Managed Care, Group Practice Manager, Chief, Clinical Support, etc) _____
1.5.5. Template manager if assigned _____
1.5.5. Administrative Technicians, Records Management _____
1.5.6. Medical Technicians _____
1.5.7. Appointing Staff Member(s) _____
1.5.8. Ancillary Staff Member(s) _____
1.5.9. Specialty Care _____

1.6. Identify the scope of the project and your MTF's "Go Live" and "Get Well" date.
You will identify the "Go Live" and "Get Well" date for each of your targeted Primary Care and Specialty Care Clinics that will take on access improvements. Provide clinic's names and its MEPRS code(s).

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_____

1.7. Present appointing practices.
In the paragraphs below describe the appointing practices of these targeted areas identified above:

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

_____
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_____
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2. Define Access Improvement Commitments by Analyzing Data.
In the paragraphs below describe population demographics, PCM enrollment and distribution, patient demand, backlog, waiting times, and supply patterns, and staffing. Identify all data sources next to each item (i.e. TRICARE Operations Center, CHCS/AHLTA, MCFAS, MEPRS EASIV, MDR, M2 Reports, etc.).

_____
_____
_____
_____

2.1. Determine Population Demographics.

2.1.1. Enrolled Population. Identify your Active Duty, Prime and Plus beneficiaries for the access improvement implementation. The objective of this analysis is to define the enrolled beneficiary population so demand can be predicted. An enrolled population is definable and their demand for care reasonably predictable.

2.1.2. Non-Enrolled Population. If a facility provides care to non-enrolled patients, defining this population and the extent to which their needs are currently being met by the facility is required. If the facility does not currently supply all the potential demand for care by eligible non-enrolled patients, then some procedure to regulate non-enrollee care must be used so that demand is predictable and manageable. You should consider the following groups of non-enrolled beneficiaries: 1) Reserve/Guard; 2) Transient eligible's; 3) Prime Remote; 4) Foreign eligible's; 5) DoD employees (teachers); 5) Accession patients; 6) ROTC encampment; 7) Students; 8) Secretarial Designees; 9) Civilian pay patients (state hired, etc).

You may reflect your population similar to the example table below:

TABLE 1: SAMPLE MTF PATIENT POPULATION *			
ACTIVE DUTY PRIME	974	2225 TRICARE PRIME/PLUS	2815 TOTAL ELIGIBLE PATIENT POPULATION
NON-ACTIVE DUTY PRIME	1235		
TRICARE PLUS	16		
TRICARE STANDARD	15	590 OTHER ELIGIBLE'S	
CIVILIAN ELIGIBLE	240		
OTHER (OCC HEALTH)	335		

2.2. Determine PCM and Clinic enrollment and distribution.
This analysis is important to ensure your targeted PCMs and Clinic(s) provide both daily access and continuity. Each Primary Care Clinic/Group must have the capacity to provide for the daily demand of the enrolled panel. It must be possible to distribute enrollees among providers so that each PCM/Primary Care Clinic/Group's panel size is proportional to that provider's capacity. If there are a substantial number of non-enrollees and other demand, their impact on the capacity of PCMs must be clarified. At a minimum you consider:

2.2.1. Enrollees/empanellees per PCM
2.2.2. Enrollees/empanellees per Clinic
2.2.3. Estimated volume of other visits (non-enrolled) per month per PCM
2.2.4. Estimated volume of other visits per month per Clinic

Table 2: Example of how this information should be displayed:

PCM Provider	# Enrollees (Firm)	#Non-Enrollees Visits (Estimated)
Jones	1,200	25
Smith	1,200	25
Brown	1,200	25
Harper	1200	
Family Practice Clinic	Clinic Total of 4800	25 per month average

Note: The numbers in Table 2 above do not reflect HA Policy. Panel sizes are at the discretion of the MTF/Service.

2.3 Determine Patient Demand for Care.

Conduct a demand analysis. A demand analysis is vital step to ensure you provide adequate appointments to meet the needs of your patient population. Three suggested methods to follow are listed below:

2.3.1. Civilian Benchmark

Use of civilian benchmark is probably the quickest method to estimate demand. Mark Murray, the father of Open Access, states 0 .75% of an enrolled population will seek care on a given day. To use this method, simply multiply your MTF's enrollment by .0075. That will provide you an estimated number of appointments needed per day. This rate may be lower than your actual utilization rates for your facility, because Dr. Murray is using rates for civilian healthcare institutions were demographics and barriers to care may be different than those in the military.

2.3.2. Clinic Utilization Rate

A historical clinic annual utilization rate can be used to make better estimates of primary care utilization and mission requirements for the MTF. You will need to know your MTF's annual utilization rate. You can obtain this rate using your clinic's visit data from MEPRS. Ideally you would want to obtain both monthly and annual utilization rates per enrollee. To estimate the number of visits each clinic will need during a 12-month period, multiply each clinic's annual utilization rate by the number of it's enrollees. For a monthly rate, multiply each clinic's monthly utilization rate by the number of monthly clinic enrollees it has registered. This estimate assumes the clinic has essentially the same number of providers as it did in the years previous and has no loss of any present year primary care services, e.g., Clinic had a pediatrician in CY2003, but lost to PCS in CY2004 with no replacement. Then you need to divide the annual count by 12 for a monthly count and 18 for a daily count of appointment slots that your primary care clinic requires.

$$\frac{\text{Annual Utilization Rate x \# Enrollees}}{12} = \text{Monthly}$$

$$\frac{\text{Monthly}}{18} = \text{Daily}$$

As a broad planning factor, the MHS Access Manager's have stated that a good general planning factor for a primary care utilization rate is 3.5 visits per enrollee per year. For smaller clinics and/or those in less populated areas, the rate may be greater than 5.5 visits/year. These methods provide you a historical view of those patients that received care, but do not provide you a picture of those patients that were deflected, or had unmet demand.

2.3.3. Total Demand Analysis Process.

Conducting a complete demand analysis should provide a more accurate demand estimate; however it will take additional time and effort to complete. The foundation of a demand analysis starts with capturing historical demand. Because historical demand does not necessarily depict all the actual demand, it is necessary to consider the following factors and make necessary adjustments. (This list is not an inclusive listing of data sources):

- Telephone system capability (call volume, abandonment rates)
- Emergency Room/Acute Care Clinic visits
- Care deferred to network
- No-show rates
- Clinical Preventive Service Backlog
- Un-booked appointment report numbers and rates
- Waitlist numbers and rates

By capturing met and the unmet demand, your MTF can better plan for the actual demand needed to care for your population.

2.3.4 Describe your final demand analysis conclusions.

From the analysis above, report your findings and conclusions. How much demand does your clinic have?

_____

_____

_____

_____

2.4. Determine Waiting Times.
Identify the waiting times. Determining the baseline waiting time will give an indication of current access deficiencies and the value to be obtained by improving access. It also provides the starting point to which improvements can be compared. Waiting times can be calculated in several ways. Two examples are:

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

2.4.2. Average Waiting Time Method. In this approach one monitors when appointments are booked in relation to when they are requested. An average waiting time for appointments can be determined by looking at every booking. An appointment booked for today counts as "0", tomorrow as "1", 2 days out as "2", etc. The waiting time for every booked appointment on a given day is summed and divided by the total number of appointments booked to give an average waiting time for appointments. Clearly the more appointments that are booked for today (day "0"), the lower the average waiting time for an appointment will be. If all appointments were booked for the current day, then the average waiting time would be "0". This data can be extracted from the CHCS Access to Care Summary Report.

2.5. Assess Primary Care Manager Continuity.
Determine your present PCM continuity and describe your business plan for booking patients to their own PCM to the greatest extent possible. The patient decides between access standards and PCM continuity. The main goal is to maintain PCM continuity. You should describe use of personnel, appointing procedures, the handling of provider absences and use of information systems and measures/metrics in maintaining continuity.

3. Staffing.
Discuss your full range of staffing to support the Access Improvements in your clinic. Base your staffing on your mission requirements and MTF business plan.

3.1. Perform efficiency analysis to determine proper use of provider and support staff.
Analyze if your clinic has adequate staffing to initiate and sustain access improvements in the following paragraphs in this section.

3.1.1. Clinic Optimization. Discuss your clinic's optimization effort as it relates to the potential access improvement areas. Discuss team development, knowledge and their buy-in.

3.1.2. Provider staffing. Discuss how providers will ensure that access improvements are met, to include number of appointments per provider, summer rotations, coverage for provider absences, and control of leaves/TDYs/TADs. Discuss the roles of both PCM and non-PCM providers to include use of Physician Assistants, Nurse Practitioners, residents and providers serving in command and leadership positions. Provide a subjective gauge of this group's "buy-in" to access improvements. Is it supportive?

3.1.3. Support Staffing. Address the use of medical clerks and technicians, resource sharing, contractors, nurse run clinics and nurse triage to make operations more efficient. Provide a subjective gauge of this group's "buy-in" to access improvements.

3.1.4 Contingencies.
Describe contingency plans for deployments, staff shortages, information system downtime, readiness exercises, excessive patient demand, etc.

4. Additional Support Requirements.
Discuss the impact of access improvement activities on appointing services, medical records, ancillary support services, and others as applicable.

4.1. Assess appointment system's capabilities.
Discuss call-handling protocols, to include: phone capabilities to handle daily/hourly call volumes, nurse triage support (if applicable), unmet demand (unbooked appointments report) and staff training on how to handle patients.

4.2. Assess your MTF's medical records processing functions.
Discuss medical records staffing, location, availability, filing backlog, ambulatory data record completion rates, coding processes, third party collection efforts.

4.3. Assess your MTF's ancillary services.
Discuss laboratory, radiology, and pharmacy's role and ability to support access improvements in your clinics.

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_____

5. Plan for Extended Hours.
In this section you will need to discuss your clinic's procedures if hours will need to be extended to cover increased fluctuations in demand. Discuss the extended hours plan for clinics to include provider and support team staff extension of hours, compensatory time resolution and triggers for extending hours. Discuss the extended hours plan for support and ancillary areas.
Describe who makes this decision and necessary coordination to be made for support personnel and facilities.

_____
_____
_____
_____

6. Clinic Goals for Improving Access
Provide a short explanation of the goals your clinic wants to achieve in the areas of access, backlog control, waiting times, meeting or exceeding access to care standards, PCM continuity, and provider, staff, and patient satisfaction.

Example responses for Paragraph 6:

- Acute Access To Care Met Standard: 95 percent
- Overall clinic average waiting time of 3.5 days
- Constant supply of appointments for 30 days into the future

_____
_____
_____
_____

7. Discuss Strategies For Implementing Access Improvements.
Discuss plans for matching supply and demand, increasing continuity, increasing supply, decreasing demand, and maximizing office efficiencies.

7.1. Plan for matching supply and demand.
Discuss plan to right size clinic enrollment; how you will manage templates and schedules; what appointing guidelines will be used.

7.1.1. Panel Size. Discuss issues such as the number, age, acuity, and gender of empanelled beneficiaries and the provider's experience.

7.1.2. Template/Schedule Management. Briefly discuss/answer the following questions:

- What appointment types are going to be used? e.g. ACUT, ROUT, EST, PROC.
- What guidance is provided to clerks booking patients into the future, either outside ATC standards or as patient refusals?
- With the appointment types mentioned above, for what services are these appointment types going to be used?
- What detail codes are going to be used?
- What is your plan for controlling the development, and opening of templates and schedules? Who, When, How?
- What is the number of slots required per day for each day of the week?
- What are the necessary number of days /weeks of available appointment slots needed to be open?
- How will your clinics schedule wellness services such as pap smears, physical exams, preventive health assessments, etc?
- How will the clinic schedule procedures?
- What are the rules on splitting and joining appointment slots?
- How will the clinics and providers' CHCS file and tables be constructed?
- What is the plan for TRICARE Online appointing?
- What is the plan for Nurse - Tech run clinic scheduling?
- What is the process for modifying open schedules?

7.1.3. Appointing Process Guidelines. Discuss the following:

- Use of clinic's appointing scripts/ algorithms for the appointing agents
- Training program for appointment agents and others who book appointments
- Guidelines for first call resolution
- Guidelines for booking patients whose PCMs are on leave or absent
- Guidelines on facility cancellations
- Guidelines on ending the clinic day
- Guidelines on extending the clinic day
- Guidelines on overbooking patients
- Guidelines on walk-in/sick call patients
- Guidelines on changing appointment types and detail codes
- Guidelines on patients not wanting to take appointments offered
- Guidelines on booking follow-ups prior to patient leaving the clinic
- Guidelines on provider book only, MTF book only, and booking authority, and detail codes security keys (to set up appropriate access rights)
- Guidelines on planned down days, restricted days, training days
- Guidelines on "no shows", "late shows," and "left without being seen"

- Guidelines on appointment searches that did not result in a booked appointment
- Guidelines for initiating and replying to telephone consults
- Guidelines for administering security keys (to set up appropriate access rights)

7.2. Plan For Increasing Clinic Continuity.
Discuss strategies on how clinic will increase continuity.

7.3. Plan for Increasing Supply of Appointments.
Discuss strategies for increasing the supply of appointments. Strategies may include limiting or changing days of meeting times; planned expansion of clinic workday and ancillary support services; use of reservists; use of contract providers; use of medical technicians and/or nurses; use of network providers etc.

7.4. Plan for Managing Demand.
Discuss strategies for managing demand for appointments. Topics such as the proper booking of follow-ups; conditions that can be handled by technicians or nurse run clinics; the handling of prescription refills; use of telephone consults to provide good service without an appointment; preventive health services; providing immunizations; daily monitoring of schedules; self-care; etc.

7.5. Plan for Maximizing Efficiencies.
Discuss strategies such as:

- Office layout and capacity
- Exam room standardization
- Elimination of bottlenecks
- Results of cycle time measurements
- Commitment to starting each morning on time
- Team Building
- Use of population driven reporting data, e.g. IMR, MRRS, HEDIS, MHS Portal, M2 Reports
- Appointing and records layout (centralized or decentralized)
- Familiarity/Training of MHS systems

8. Discuss Measurement and Metrics.
State how your MTF will measure, track, and trend your access improvements. Measures may include continuity of care, demand for appointments, waiting time, percent of searches resulting in meeting ATC standards, PCM enrollment, appointing waiting time, decrease in unused appointments, no-show percentages, etc.

9. Marketing Plan.
Discuss whether or not internal and/or external marketing plan for access improvements will be initiated, who, what, where, when, how?

10. Discuss any other pertinent issues not covered in the above paragraphs.

11. Coordination with Intermediate Command, MCSCs, Multi-market office and/or Other Agencies (e.g. VA/DoD, etc.).

Date:
Prepared By:

Provider Champion's Signature Block:

MTF Commander's Signature Block:

Listing of Attachments, or Reports

APPENDIX B

JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

JOB DESCRIPTION/RESPONSIBILITIES OF ACCESS MANAGER

Access Manager/Appointment Officer Responsibilities/Position Description

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

- Functions as the Commander's agent for access improvement, management and sustainment activities, appointment standardization, provider and table builds, access measurement and schedule management at the MTF

- Chairs the MTFs Access Management Team

- Consults with and assists clinic heads in formulating clinic goals in terms of meeting access standards to include but not limited to access management functions, schedule management, capacity management, patient demand analysis, staffing, and other applicable Access Management areas seen fit by the local command.

- Assesses clinic operations and appointment utilization patterns to identify bottlenecks and to maximize use of available resources

- Ensures that , standardized appointment types, , and standardized detail codes are implemented and properly used 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, and Service specific access management tools and reports, etc.

- Ensures personnel are designated at the clinic level who are responsible and accountable for access management, 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 Access Improvement directives

- Functions as the MTFs point of contact for ATC operations and represents the MTF at related functions, meetings and conferences

- Identifies need for changes in access management processes and or for functional changes to appointing information systems

- Interfaces with Intermediate Command, Service level counterparts to facilitate access improvement 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 Appointment Information System/CHCS provider 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 ATC improvement initiatives and the policies that govern them.

- Demonstrates a thorough knowledge of the functionality of MHS/Service Appointing Information Systems.

- Demonstrates a working knowledge of the correct usage of MEPRS Codes, CPT and ICD codes for the various clinics within the MTF as it applies to developing appointment templates and schedules and booking patient appointments.

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

- Skilled in identifying problems, developing solutions 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.

- Demonstrates an awareness and appreciation for the duties and responsibilities of the MTFs providers and access management and appointing personnel.

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

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APPENDIX C

APPOINTMENT STANDARDIZATION METHODOLOGY

This appendix 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 Time requirement Access Standard Location Clinical need	Provider linked to right location	Place linked to right clinical services	Provider defining availability (scheduling)

2. Assumptions.

2.1. The appointment system will not be developed as a tool for workload or workforce accounting but will be consistent with workload requirements.
2.2. Appointment names are standardized.
2.3. Appointments may be reserved to ensure access to care by specific types of patient.
2.4. Military Treatment Facility (MTF) and Appointing Contractors including Managed Care Support Contractors (MCSCs) may share the ability to appoint.
2.5. MTFs are permitted to designate certain appointments as "MTF Book Only". One of the goal s of the appointing process is to maximize the utilization of MTF capacity.
2.6. MTFs will ensure beneficiaries are aware that one telephone number will function as the point of access for appointing and referrals.
2.7. The appointing system is demand focused, not supply focused, and will strive to match supply to demand.
2.8. Leadership supports standardization and Access to Care and the efforts to implement both.
2.9. TRICARE Prime patients seeking care are properly enrolled
2.10. The patient will be seen at the appropriate level of care.

3. Appointment Process Objectives.

3.1. Identify visit type
3.2. Assign the authority to arrange visits
3.3. Identify visit duration
3.4. Identify procedures
3.5. Match patient to provider skills
3.6. Match patient needs to resources
3.7. Allow for performance measurement
3.8. Demonstrate effectiveness, efficiency, and customer satisfaction

4. Standardized Data Elements.

4.1. Appointing Types
4.2. Booking Authority
4.3. Time (appointment duration)
4.4. Patient Access based on policy
4.5. Appointment Detail fields
4.6. Age delineation
4.7. Gender delineation

5. The Ten MHS Standard Appointment Types and Access Criteria.

5.1. PCM Initial primary care only (4 weeks in calendar days)
5.2. ACUT Acute (24 hours to the minute or 1,440 minutes)
5.3. OPAC Open Access (same day patient calls for appointment)
5.4. ROUT Routine appointment (7 calendar days to the minute or 10,080 minutes)
5.5. WELL Wellness, health promotion (4 weeks in calendar days or 40,320 minutes)
5.6. SPEC Initial specialty care only (4 weeks in calendar days or 40,320 minutes)
5.7. PROC Procedure (28 calendar days or provider designated duration within 28 calendar days or 40,320 minutes)
5.8. EST Established patient follow-up (provider designated duration)
5.9. GRP Group/class (provider designated duration)
5.10. DROUT Dental Routine care (21 calendar days to the minute or 30,240 minutes)

6. Booking Authority.

6.1. MTFs can use appointment types with the dollar sign ($) as the last character on all ten standard appointment types to indicate that these slots are to be booked by MTF staff only, e.g. PCM$, ROUT$. Through arrangements with local appointing contractors or in a multi-market service area with a regional, centralized appointing function, standard appointment types with the dollar sign ($) will not be booked unless they have MTF approval. MTFs should minimize the use of the dollar sign ($) on appointment types to 10% or less of their available appointment slots to allow supporting organizations the ability to book as many appointments as possible, since this is their contracted function.

6.2. MTFs will not use the dollar sign ($) suffix to prevent MTF personnel from booking these appointments or to make it a provider book only slot. The Provider Book Only (PBO) detail code can be used to accomplish this function. Appropriate business rules should be utilized to minimize the usage of dollar signs ($) since it restricts access to care for patients.

6.3. MTFs wanting to maximize the number of web-enabled appointments should not use the dollar sign ($) as this prevents these appointments from being booked via the TRICARE Online appointing capability.

7. Patient Access Types. All MTFs will have the capability to reserve appointment slots in accordance with the TRICARE Policy for Access to Care and Prime Service Area Standards,

dated 21 Feb 2006. Patient access types may be used for this as follows. Refer to Appendix N for definitions of the Patient Access Types:

7.1. Active Duty
7.2. Prime Enrollees Only; No Active Duty, no TRICARE Plus
7.3. Active Duty and Prime, no TRICARE Plus
7.4. Active Duty, Prime, TRICARE Plus, and Special Programs Patients
7.5. No Active Duty
7.6. No Prime
7.7. No Active Duty, No Prime
7.8. Graduate Medical Education
7.9. Special Programs Patients
7.10. TRICARE Standard/CHAMPUS

8. MHS Enterprise Appointments and Referral Business Rules. The Access to Care 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 by the Location of the Appointment:

For 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 assigned 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.	For Non-Prime Patients seeking primary care: 1. Primary Care physician—civilian or MTF 2. Next available MTF 3. Network physician 4. Non-network physician
For 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	For Non-Prime patients seeking specialty care: 1. Closest MTF 2. Next available MTF 3. Network physician 4. Non-network physician

8.2. Specialty Care and Referral Process.

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

8.2.2. All referral requests will be electronic via CHCS or AHLTA (or other approved system e.g. Fax from MCSC).

8.3. Patient's Rights.

8.3.1. The patient may elect to use the Point of Service Option.
8.3.2. Beneficiaries may waive the distance access standard for specialty care.
8.3.3. 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.
8.3.4. The patient's refusals and waivers will be documented electronically in CHCS (or other approved system). Stopped work on 09/25/08

8.4. Booking

8.4.1. Clinic appointment templates, will be open for booking at least 30-45 days ahead at all times. Reference Appendix J for Open Access process.
8.4.2. Basic CHCS Patient Demographic information, at a minimum, name, address, and telephone number will be updated at the time of appointment booking.
8.4.3. Delinquent and non-count appointments are to be resolved daily by CHCS end-of-day processing.

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

8.5.1. Refer to Appendix N for detailed definitions and usage of Patient Access Types

8.6. Associated Appointment Process Business Rules

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8.6.1. Contractor and MTF appointment clerks will be able to view all available appointments in CHCS or any other approved system.
8.6.2. Patients will be able to book allowed appointments on TRICARE On-Line.
8.6.3. One telephone number will function as the beneficiaries' point of access for all appointing needs 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.
8.6.4. The appointing process will work under the assumption of "PCM by Name" enrollment where applicable so that continuity of care is maximized for the beneficiary.

9. Associated Appointing System Requirements.

9.1. Scheduling.

9.1.1. Scheduling supervisors will have the ability to define up to 4 detail codes for each appointment slot to indicate resources or restrictions for the appointment. Detail codes are optional.
9.1.2. The patient access type is a type of detail code and is optional.
9.1.3. Scheduling supervisors will be able to assign a patient access type to each appointment slot on a provider schedule.
9.1.4. Patient Access Types will be five alphanumeric characters.
9.1.5. 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.

9.2.1. Managed Care Program (MCP) users will be able to search for appointment slots within the user selected Access standard (the Access to Care Category)
9.2.2. Managed Care Program (MCP) users will be able to search for appointment slots based on Patient Access Types.
9.2.3. Users with appropriate authority may override the Patient Access Type, appointment types, detail codes, gender, or age restrictions on a slot and book the appointment for a patient with a different appointment type, patient access type, gender, or age.
9.2.4. The split and join features have been integrated with appointment booking screens for ease of use and allow booking clerks to change appointment durations as they book appointments.
9.2.5. The clinic has the responsibility to define access on a continuous basis, i.e., the types of appointments, how many appointments, and for which types of beneficiary.
9.2.6. Each MTF has the ability to designate when an appointment will be released for booking and what the appointment definition will be.
9.2.7. CHCS will highlight appointments that meet the patient's beneficiary type, age, gender, and Access to Care requirements (e.g. exact match booking).

9.3. Age and Gender Delineation.

9.3.1. 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.
9.3.2. When searching for available appointments for a patient, CHCS will highlight appointments with providers who treat patients of that gender, based on the gender 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.

9.5.1. The Appointment Detail Fields are permanent and searchable.
9.5.2. Scheduling supervisors will be able to assign up to four appointment detail values to each appointment slot on a provider schedule.
9.5.3. Valid detail entries will be those in a common file having the same controls as the appointment type file.
9.5.4. Patient Access Types are detail codes and will be included in the Detail code file.
9.5.5. These entries will be from two (2) to eight (8) characters in length.
9.5.6. MCP users will be able to search for appointment slots based on appointment detail entries.
9.5.7. The system will allow additional locally defined age detail codes only. Sites may recommend detail codes as a standard.
9.5.8. 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., Red Team, Orthopedic Hand or Orthopedic Foot.
9.5.9. All detail codes will be upper case. 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

EDUCATION AND TRAINING

APPENDIX D

EDUCATION AND TRAINING

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1. Access 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 and training are ongoing efforts for users at all levels to successfully implement and sustain Appointment Standardization and Access Improvement.

2. Education and Training Resources.

- The TRICARE Access Imperatives Web site is provided to assist Military Treatment Facilities (MTFs) and Managed Care Support (MCS) Contractors with managing Access to Care. This web site contains the supporting documentation for the policies, methodology, business rules, software changes, and training.

- Local MTF training should incorporate aspects of the Access to Care business rules, the relationships of the ATC standards as they apply to appointment types and detail codes. This training should be integrated with the functionality of the MCP Booking module to ensure staff have a comprehensive understanding of the information systems and the ATC business rules.

3. Distance Learning.

In order to assist MTFs with their training needs, the MHS developed Web Based Training (WBT) covering aspects of the MHS Information Systems that are available in two formats.

- WBT – This training is self paced and role specific. Modules are available in separate sections to allow for specific training that is required at that time. Additionally the student can participate with the WBT from the home computer providing them with a flexible venue to increase their knowledge and skill level. Available courses cover numerous aspects of MTF Operations.

- Virtual Classroom – This training is presented via the individual's computer system and teleconference. This allows a live instructor to provide comprehensive instruction and a platform for the student to ask questions as the training progresses.

Students who wish to utilize this training must first request an account. Once they have been granted access to the MHS Learn web site all that is necessary is to enroll in courses. **Other**

4. Training Resources.

- **Navy Resources** – Navy Knowledge Online NAVY Clinic Management Course

Clinic Management Course

URL to Web Site - http://navmedmpte.med.navy.mil/courses/CMC.htm

The Clinic Management Course trains Clinic Teams in the skills and tools necessary to provide quality health care, in a fiscally responsible manner, in alignment with BUMED strategic initiatives.

Eligibility: Primary, specialty, and dental outpatient clinic teams.

Continuing Education Credits: Medical- 24.75
Dental- 24.75
Nursing- 19.55

Funding/Billeting: NAVMED MPT&E provides full funding for clinic teams. The team will be authorized one rental car for commuting to and from the airport and daily to the course. It is your responsibility to work with your command's TAD office to book your flights and lodging. Accounting data is sent to the TAD representative that is noted on the nomination form and to the students. NAVMED MPT&E is not authorized to fund individuals who are auditing the course.

Course data: Length: 4 days - Classes/yr: 8/yr - Seats available: 30 per class. 5-member teams from 6 clinics are selected for each class (Note: 5-members is the "ideal" team size, if there were limitations in sending staff a smaller team may attend). Selection of teams: Parent Commands identify the clinics of focus for improvement efforts and identifies members of that clinic team to attend the course. (Note: personnel should have 1 year remaining in current clinical position) The 5-member team should be drawn from the same clinic - preferably one of each of the following positions:

- Credentialed Provider (usually MD or DO)
- Business Manager / Clinic or Template Manager
- Nurse
- Corpsman / LPN
- Department Head

Student Support C: (301) 295-2355 LCPO :(301) 319-4507 Fax: (301) 295-1292

SELRES POC: (301)-319-4740

- **Army Resources** – Army Knowledge Online via Access Knowledge Center

- **Air Force Resources** – Listed below are websites and courses offered by the Air Force that provide information and instruction in the areas of access improvement:

  - The Air Force Medical Service (AFMS) Knowledge Exchange (Kx) is the website where most of the AFMS information on improving access is posted. To access the AFMS Kx, personnel will need an account and permissions to join and use this website. For instructions on how to apply for an account, please go to https://kx.afms.mil/kxweb/join.do.

  - The AFMS Kx Health Benefits page has a comprehensive listing of education and training courses, policies, best practices, Computer Based Training Modules, and periodic reports that can assist AFMS access management personnel. Specific areas of interest include Open Access appointing, demand management, enrollment management, TRICARE Online appointing, appointing contracting, appointing information systems operations, listings of all AFMS Access Improvement Seminars and Appointing Information Systems Training Courses, referral management, appointing telephony, minutes of AFMS Access Improvement Working Groups and more. To access this information, personnel will need an AFMS Kx account and then go to: https://kx.afms.mil/healthbenefits and then look under Access and Appointing.

  - The AFMS Kx Group Practice Management page at https://kx.afms.mil/gpm has a comprehensive set of materials posted that are particularly helpful to AFMS personnel that are serving in the position of Group Practice Manager.

  - The AFMS Kx Referral Management page located at: https://kx.afms.mil/referralmanagement contains a comprehensive set of posted materials to support AFMS personnel in the operations of Referral Management Centers.

  - AFMS Medical Management website located at: http://www.mhsophsc.org/public/home.cfm contains materials to assist AFMS personnel in medical management responsibilities.

  - The Air Force (AF) Surgeon General (SG's) office maintains the Executive Global Look (EGL) website that measures many aspects of MTF operations to include access and appointing, patient satisfaction and more. The URL for this website is: https://egl.afms.mil.

- The AF SG's office operates the EGL Virtual Analyst website that provides in-depth background data, analysis tools, online and push reports on various measures and metrics associated with MTF operations and/or listed on the Executive Global Look at:
- https://eglva.afms.mil. To access this site, users will need to obtain a log-on and password. To do so prospective users will need to click on the "Join" verbiage on the front page of the site and following the instructions contained there.

- The AF SG's office maintains a tactical management tool with several reports to assist access managers in the day-to-day operations of appointing and access processes at the MTF. To use the AFMS Access Improvement Module website go to: https://aim.afms.mil. Prospective users of this tool will have to apply for a user name and password by going to the website and clicking on the "New User" verbiage on the front page and follow the instruction contained there.

- The AFMS specifically offers three courses that educate and/or train Access Managers in various positions and levels of responsibilities. They are:

  - **AFMS Access Improvement Seminar.** These seminars provide access managers with comprehensive instruction in the most up-to-date access improvement information in the areas of access policy, access data analysis, and access to care (ATC) performance measurement, demand management, population/enrollment management clinic, appointing management, appointing information systems management and referral management. For more information on these seminars and to register, prospective AFMS students need to go to: https://kx.afms.mil/atceducation.

  - **AFMS Appointing Information Systems Hands-on Training Course**. This course provides detailed instruction on various appointing functions, the operations and the management of MHS appointing information systems, i.e., the Composite Health Care System, (CHCS)/CACHE/Enterprise Wide Scheduling and Registration System; and the TRICARE Online appointing functions. Specifically, hands-on training classes are provided on template, schedule, file and table building and management; appointing system functions operations; consult tracking; ad-hoc building and reporting. For more information on this course and to register, prospective AFMS students can go to: https://kx.afms.mil/atceducation.

- **AFMS Group Practice Manager's (GPM) Course.** This course provides training for those personnel being assigned to Group Practice Manager positions. Emphasis is placed on the skills required to prepare the health services administrator to effectively manage and support the clinics assigned to ensure that beneficiaries receive access to medical care within standards. The curriculum consists of practice management concepts, to include roles and responsibilities, population health overview, data management, templating/scheduling skills in MHS appointing information systems, and training for electronic hands-on web-based tools. For more information on this course prospective AFMS personnel will need to go to the AFMS Kx GPM website at: https://kx.afms.mil/gpm.

APPENDIX E

STANDARD SYSTEM BUSINESS RULES

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APPENDIX E

STANDARD SYSTEM BUSINESS RULES

The business rules for appointing under the Access to Care guidelines are presented below. The rules are organized by function to allow easier reference.

1. File and Table.
The following business rules apply to the processes required to successfully build files and tables for Managed Care Program (MCP) Booking.

1.1. Clinic Profiles.

1.1.1. MTFs should coordinate clinic location name changes with the MEPRS staff at the MTF.

1.1.2. 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 the entire clinic's workload as count.

1.1.3. 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. Count appointments are not allowed.

1.1.4. For a clinic with MIXED COUNT AND NON-COUNT workload, set the Workload Indicator in the Clinic Profile to count. Non-count appointments are allowed.

1.1.5. MTFs will use the Workload Type field in templates, schedules, and on booked appointments to determine the count/non-count value of the appointment.

1.1.6. CHCS/EWSR will accommodate clinic specific detail code help lists. MTFs 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 to indicate the detail codes that are used by the clinic. 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.

1.1.7. If a clinic will be able to enter self-referrals, the Self-Referrals Allowed field in the Clinic Profile must be set to YES. The Clinic Specialty field in the Clinic Profile should be populated with the self-referral specialty to authorize that type of care in that clinic. Multiple specialties are allowed and all are considered self-referral for that clinic.

1.1.8. MTFs should identify those clinics that support self-referrals. Examples of self-referral care are: Allergy, Alcohol & Drug, Audiology, Community Health, Family

Advocacy, Mental Health, Nutrition, Occupational Health, Orthopedics, Optometry, Otolaryngology (EENT), Physical Therapy, Psychology, Psychiatry, Social Work, and Substance Abuse.

1.2. Appointment Types.

1.2.1. For Medical Appointment types, CHCS and EWSR will support only the ten standard Appointment types in templates, schedules, and on help lists. 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.

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

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

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

1.2.4.1. For Primary Care Only

1.2.4.1.1. PCM 28 calendar day access

1.2.4.1.2. ROUT 7 calendar day access

1.2.4.2. For Specialty Care Only

1.2.4.2.1. SPEC 28 calendar days/provider designated

1.2.4.2.2. ROUT 7 calendar days for Mental Health self referral only

1.2.4.3. For Both Primary and Specialty Care

1.2.4.3.1. ACUT 24 hour access

1.2.4.3.2. OPAC Same Day (requested and booked the same calendar day)

1.2.4.3.3. WELL 28 calendar day access

1.2.4.3.4. PROC 28 calendar days/provider designated

1.2.4.3.5. EST provider designated

1.2.4.3.6. GRP provider designated

1.2.4.4. Only five standard appointment types are recommended for Dental appointments.

1.2.4.4.1. ACUT Acute (24 hours)

1.2.4.4.2. DROUT Dental Routine (21 calendar days)

1.2.4.4.3. SPEC Specialty (28 calendar days)

1.2.4.4.4. WELL Wellness (28 calendar days)

1.2.4.4.5. PROC Procedure (28 calendar days or provider designated)

1.3 Detail Codes.

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

1.3.2. Multi-Service platforms should coordinate age detail code builds with all MTFs serviced by the platform.

1.3.3. MTFs 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 (days); a W (weeks); or an M (months). The lower age precedes the upper age limit and must be separated by a hyphen.

1.3.4. 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 or MEPRS codes for sub-specialty care.

1.3.5. The Workload Type Field (count or non-count) must be assigned to each appointment slot in templates and schedules to indicate appropriate workload for that care and provider combination.

1.4. Security Keys.

1.4.1. 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 Appointment Types and Detail Codes linked to a specified clinic in the MCP module on CHCS and EWSR.

1.4.2. Booking clerks tasked to correct detail codes and appointment types when booking appointments must have the SD APPT STAND security key. This security key will also control the ability of a clerk to book appointments that are outside the access standard.

1.4.3. The SD APPT STAND security key will control splitting and joining of appointments by allowing or disallowing a user to override the appointment type and detail codes during booking to make the new appointment(s) fit the patient demographics and access standard.

1.4.4. 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.

1.4.5. Clerks will require the SD CHG AGE GNDR security key to book a patient who does not match the age and gender criteria for an appointment as indicated by age and gender detail codes. This security key is activated across all clinic and MTFs on the host.

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.

2.1.1. MTFs may create their own age detail codes. However it is critical that these codes be coordinated and standardized across the MTFs on the host.

2.1.2. MTFs may propose new standard detail codes. Refer to Appendix M for new detail code proposal and approval processes.

2.1.3. MTFs should review the use of the ten standard Patient Access Types (see Appendix N).

2.1.4. MTFs are able to modify their templates and schedules to include the appropriate detail codes on each slot. The detail codes appear on the Appointments Display screen when selecting and booking an appointment.

2.1.5. Access to the slot comment field during booking is inconvenient but available. In CHCS, if the slot comment contains a comment, a tilde (~) will appear in front of the appointment on the list of available appointments during booking. The slot comment is viewable on a secondary window when the user selects a specific appointment and presses F9. In EWSR, a column will indicate Yes or No if there are comments and the user clicks on the underlined Clinic Name to view the comments. Reporting will be inconsistent if slot comments are used improperly.

2.1.6. Detail codes are optional on the schedules, templates, and in booking searches. However the slot comment field should not be used in place of detail codes for the purpose that detail codes are designed. TOL will require that all detail codes be stored in one of the four detail code fields.

2.2. Batch Assigning Slot Characteristics.

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

2.2.2. When slots are modified, CHCS deletes the reconfiguration data for only the modified slots. In CHCS, if reconfiguration is needed, the user should rebuild the reconfiguration criteria from scratch on the modified appointments only. EWSR will rebuild reconfiguration data from the appointment type in the Provider Profile for the appointment(s) modified.

2.2.3. The appointment duration will be initially defaulted from the appointment type in the Clinic Profile for non-count clinics and from the appointment type in the Provider Profile for count clinics. Users may override the default duration for the appointment slots being created in templates and schedules and specify the actual minutes required by the provider for the appointments.

2.3. Template Creation.

2.3.1. 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

2.3.2. Modify templates instead of creating new templates

2.3.3. MTFs should establish standard naming conventions for templates

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

2.3.5. In templates, each slot may define appointment types, the appointment duration, the authorized beneficiary categories, the workload type, and up to 4 detail codes for the visit. The detail codes include a Patient Access Type as follows: Active Duty only; Prime only; Active Duty and Prime only; GME only; no Active Duty; No Prime; no Active Duty and no Prime; Special Programs Patients and TRICARE Plus; TRICARE Standard; and Active Duty, Prime, TRICARE Plus, and Special Programs Patients.

2.3.6. The appointment duration is defaulted for each appointment type from the Clinic Profile to the Provider Profile and then to the appointment slot in the template with that appointment type. The duration may be overridden by the provider or schedule clerk.

2.3.7. 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 who are assigned the SD WK LOAD security key.

2.4. Schedule Creation.

2.4.1. Schedules should be released a minimum of 30-45 days ahead. Slots should be OPEN.

2.4.2. Determine who should enter age restrictions on schedules.

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

2.4.4. Each schedule slot may define the new appointment types, the appointment duration, the authorized beneficiary categories, the workload type, and up to 4 detail codes for the visit (including a Patient Access Type as follows: Active Duty only; Prime only; Active Duty and Prime; GME only; no Active Duty; No Prime; no Active Duty and no Prime; Special Programs Patients and TRICARE Plus; TRICARE Standard; and Active Duty, Prime, TRICARE Plus, and Special Programs Patients.

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

2.4.6. 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 who is assigned the SD WK LOAD security key.

2.5. Identification of Self-Referral Specialties.

2.5.1. The following specialties may be provider referred Specialty clinics, candidates for Self-Referral clinics, or included in Primary Care. Generally use the SPEC as the primary appointment type for these clinics. The ROUT appointment type may be used for Mental Health.

2.5.1.1. Allergy

2.5.1.2. Alcohol & Drug

2.5.1.3. Audiology

2.5.1.4. Community Health

2.5.1.5. Family Advocacy

2.5.1.6. Mental Health

2.5.1.7. Nutrition

2.5.1.8. Occupational Health

2.5.1.9. Occupational Therapy

2.5.1.10. Orthopedics

2.5.1.11. Optometry

2.5.1.12. Otolaryngology (EENT)

2.5.1.13. Physical Therapy

2.5.1.14. Psychology

2.5.1.15. Psychiatry

2.5.1.16. Social Work

2.5.1.17. Substance Abuse

2.5.2. The following clinics may be considered Primary Care clinics however, they would not normally have an enrolled population.

2.5.2.1. Preventive Medicine

2.5.2.2. Communicable Diseases

3. Managed Care Program (MCP) Health Care Finder Booking. The following business rules apply to the processes required to successfully book appointments using the CHCS or EWSR MCP module.

3.1. Patient Identification and Registration.

3.1.1. Identify the patient and verify eligibility for care according to DEERS. Failure to do so can result in the patient being booked incorrectly, i.e., an enrollee is not booked to their PCM.

3.1.2. The booking clerk shall verify and correct the patient phone number and address at each encounter.

3.1.3. Verify the TRICARE Prime status according to DEERS. If not current, the patient will be booked incorrectly in CHCS and EWSR since CHCS and EWSR determine the correct booking module from the HCDP code.

3.1.4. Verify and ensure the priority for care in the MTF, i.e., Active Duty, Prime, TRICARE Plus, Non-Prime, NATO, Foreign Nationals, ineligibles, etc.

3.1.5. Examples of acceptable DEERS eligibility overrides are:

3.1.5.1. Newborns

3.1.5.2. Patient has a valid ID card but registration is not yet recorded in DEERS

3.1.5.3. Secretarial Designees

3.1.6. If a user overrides the ineligibility and enters the override reason, the patient may be booked using the MCP Non-Enrollee Booking function.

01 Care denied. - Not Treated

02 Patient presented a valid DD Form 1172 and a valid ID card.
03 Patient recently became eligible for benefits (less than 120 days) and presents card issued within 120 days (Patient not on DEERS).
04 Sponsor recently entered Active Duty for a period of greater than 30 days.
05 Newborn infant less than 1 year old.
06 Patient has valid ID card issued within 120 days (Patient on DEERS but shown ineligible).
07 Emergency Care – Eligibility and billing determination still required. MTF to maintain audit trail.
08 Sponsor's Duty Station Outside the 50 United States or within APO/FPO Address.
09 Survivors of Deceased Sponsors. One time exception.
10 DEERS enrollment exception. Billing determination required.
99 SSN erroneously keyed. Disregard ineligible response.

3.2. Access Management.

3.2.1. Identify the appropriate ATC category/search function and the corresponding appointment type based on the type of care requested by the patient.

3.2.2. A patient may choose PCM continuity over the access standards. It is recommended that the patient be encouraged to choose PCM continuity.

3.2.3. If a patient prefers access standards over continuity of care every effort must be made to provide an appointment within the access standards.

3.2.4. If a patient waives the access standard, the clerk MUST document the appointment refusal in CHCS or EWSR.

3.2.5. MTFs should conduct a periodic review of all templates and schedules. Delete all templates that are no longer needed.

3.2.6. Referrals should be tracked to ensure that the patient receives an appropriate appointment within the access standard defined by the provider.

3.3. Searching for an Appointment.

3.3.1. 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.

3.3.2. Select the ATC category/search function based on the patient's requested urgency for care. 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 (1,440 minutes)
ROUTINE	7 calendar days (10,080 minutes)
WELLNESS	28 calendar days (40,320 minutes)
SPECIALTY	28 calendar days (40,320 minutes)
FUTURE	No standard or provider designated
DROUTINE	21 calendar days (Dental only, Oct 2003)

3.3.3. Booking clerks should be familiar with the appointing system process on the order of precedence for an appointment search for PCM booking . Refer to Appendix C, Appointment Standardization Methodology, page C-3, para 8.1, the order of search precedence for appointments.

3.3.4. CHCS or EWSR will display available appointments based on the following criteria: ATC category, clinic specialty, provider, place of care, and requested date range. Searching by appointment type or specific detail codes is also supported.

3.3.5. If the clerk selects the location as search criteria, then the user must also select a specialty type.

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

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

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

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

3.3.9. Select EST to find an appointment for follow-up primary care or specialty care.

3.3.10. Select MCP Booking for care available in the MTF to search for an MTF appointment before referring to the network. Non-MTF appointment booking is a self referral option not a PCM clinic option.

3.3.11. The fastest search is the selection of the exact place of care. and EWSR will display all available appointments for that clinic. However this search will result in

fewer appointment options for the patient. This search option requires the clerk to know the MTF clinics well in order to find the appropriate care wherever it is available.

3.3.12. 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 shown.

3.3.13. 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.

3.3.14. 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 MTFMCP File and Table points of contact.

3.3.15. The Booking Authority security key is assigned to a provider and appointment type. If a clerk does not have that security key the clerk will not be able to view or book the appointments with that provider. Use this security key carefully. Make sure TOL users are included as valid users or patients booking on TOL will never see the appointments regulated by this security key.

3.3.16. Detail Codes (including patient access types) and duration are included in the list of searchable criteria.

3.3.17. The system will first display the appointments that exactly match the Access to Care Category and search criteria as well as the patient demographics. If the Exact Match appointments do not meet the patient's needs, the clerk may press return to select the All Appointments option to view appointments of all types out 28 days. The user may be required to modify the appointment type and/or detail codes on appointments in the All Appointments list in order to book them.

3.4. Booking an Appointment (General).

3.4.1. 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 calendar days
WELLNESS	→	WELL, PCM	28 calendar days
SPECIALTY	→	SPEC	28 calendar days

SPECIALTY	→ PROC	28 calendar days or provider designated within 28 days
FUTURE	→ EST, GRP	Provider designated
DROUTINE	→ DROUT	21 calendar days (Dental only, Oct 2003)

3.4.2. Book the appointment and, if necessary, 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.

3.4.3. It is recommended that appointments be joined or split (See Browse option below) 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.

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

3.4.5. If the detail fields do not contain a Patient Access Type and the slot comment does not restrict who can use the appointment, then the appointment is available to be booked to anyone.

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

3.4.7. 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.

3.5. PCM Booking.

3.5.1. 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.

3.5.2. 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

3.5.3. When booking to PCM team members in the enrollee's assigned place of care, identify the appropriate ATC category and appointment type based on the patient's request.

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

3.5.5. The AOP option will display on the PCM Booking action bar for each patient who has a consult order. If AOP appears, it is very important to use AOP to book the appointment for the referral. If a walk-in is entered instead, it is very difficult to close out the corresponding referral.

3.5.6 A Primary Care referral is required when booking an appointment for a Prime patient who belongs to the enrolling MTF but not the PCM Group they are not enrolled to. Referral Booking or self-Referral Booking may be used in this instance. .

3.6. Non-Enrolled Booking.

3.6.1. The following patients are examples of non-enrollees who should be booked through the Non-Enrollee Booking function: all ineligibles or patients whose DEERS check is incomplete, NATO, Secretarial Designees, over 65 and non-TRICARE Plus, non-enrolled retirees, non-enrolled family members (Space available), GME patients, Special Programs patients, dependant parents/in-laws, reservists on active duty less than 180 days and not deployed, foreign nationals, midshipmen, Specialized Treatment Services (all eligible beneficiaries), and Department of Defense Dependent School (DODDS) teachers.

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

3.6.3. In EWSR Foreign Nationals will match to appointments reserved for Active Duty and AD Family Members as appropriate.

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

3.6.5. All non-enrollee appointment refusals will be documented.

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

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

3.6.8. 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.

3.7. Referral Booking.

3.7.1. Referral booking contains two separate functions: Booking a referral that has an associated Consult, and creating a referral for Primary Care.

3.7.2. Specialty appointments will usually be booked by a HCF (the Consult Tracking option).

3.7.3. Before creating a referral for care, ensure that no existing Consult Order exists for the care.

3.7.4. The CHCS and EWSR default start time to stop time for a consult order is currently 28 days from the date and time the consult is entered into the system by the provider. The DoD policy is that the default should be 28 days.

3.7.5. 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.

3.7.6. When a new Consult Order is incomplete, inadequate, or unacceptable, train the staff in alternative procedures.

3.7.7. When modifying an existing referral, develop local policy and train the clerks on the data elements that may be changed.

3.7.8. Train the provider on the importance of entering the number of authorized visits on the referral and the Advice Only flag (for Evaluation vs. Evaluation and Treat).

3.7.9. Providers should be trained on the use of the start and stop dates on the referral.

3.7.10. The Reason for Referral field should always be completed and should include all clinical information provided by the referring provider.
3.7.11. The MTF and Region should develop guidelines on when to enter or modify the review status and the review comment on a Consult Order.

3.7.12. In Consult Tracking, when performing the consult review, the reviewing official should enter the clinic name in the comments if they know where the patient should get the care or the clinic specialty if the care is to go downtown.
3.7.13. Use of the CPT and ICD codes is optional per local determination but if mandated, the clerk should make sure the values are correct.

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

3.8. Operational Forces Booking.

3.8. 1. 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.

3.8. 2. 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.

3.9. Appointments Refusal.

3.9.1. If a patient refuses an appointment that is within the access standards, CHCS and EWSR require that the refusal be documented in the Appointment Refusal option with the reason “ATC Declined - Patient Preference”. 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.

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

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

3.9.3.1. Requested Provider not available

3.9.3.2. Appointment date/time unacceptable

3.9.3.3. Unhappy with MTF service/provider(s)

3.9.3.4. Unhappy with Group/Provider

3.9.3.5. Distance too great to travel

3.9.3.6. Wanted a civilian appointment

3.9.3.7. Cost share too high

3.9.3.8. ATC Declined - Patient Preference

3.9.3.9. ATC Request Late - Patient called late for appointment

3.10. Self-Referral Booking.

3.10.1. 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.

3.10.2. Refer to paragraph 2.5 in this Appendix for a lit of the specialties that may be considered for self-referral:

3.11. Wait List Requests.

3.11.1. When matching a Wait List Request that includes detail codes to a clinic appointment slot that has no detail codes, CHCS and EWSR 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.

3.12. Enrolled Elsewhere Booking.

3.12.1. The Enrolled Elsewhere Booking allows the following types of patient to be booked to any PCM and/or to any specialist in the MTF without a referral.

3.12.1.1. Active Duty who are not enrolled to any MTF will be booked in this option.

3.12.1.2. Prime 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.

3.12.1.3. Prime patients enrolled to a Civilian PCM.

3.12.1.4. Patients who are temporary Active Duty.

APPENDIX F

ACCESS TO CARE METRICS AND MEASURES

APPENDIX F

ACCESS TO CARE METRICS AND MEASURES

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1. METRICS AND MEASURES SOURCES.

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

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

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

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

Below is a detailed description of each metric:

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

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

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

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

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

Recommended Frequency: Monthly

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

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

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

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

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

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

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

Recommended Frequency: Monthly

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

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

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

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

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

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

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

Recommended Frequency: Monthly

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

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

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

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

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

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

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

Recommended Frequency: Monthly

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

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

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

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

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

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

3.1. Measure #1: Number of Beneficiaries Enrolled Per PCM

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

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

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

Exceptions: None

Recommended Frequency: Monthly

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

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

3.2. Measure #2: Number of Primary Care Visits Per Enrollee Per Year

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

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

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

Exceptions: Unmet demand may be a factor.

Recommended Frequency: Yearly

Source Data System: CHCS, M2

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

3.3. Measure #3: Number Of Total Appointments Made Available To Appointing Entities: Percentage Of MTF Book Only Appointments ($)

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

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

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

Exceptions: None

Recommended Frequency: Monthly

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

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

3.4. Measure #4: Number of Open Access Appointments Requested and Booked for the Same Day

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

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

Definition: Metric is computed as follows:

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

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

DMIS ID: 123, Sample MTF, Gold Team, Clinic: Family Practice MEPRS Code: BGAA
Report Period: 1-31 May 08

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

SAME DAY PERCENTAGE: 72.5% STATUS: Green $\geq$ 60%

Exceptions: None

Recommended Frequency: Monthly

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

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

3.5. Measure #5: Unbooked Appointment Slots

Rationale: This measure relates to all unbooked appointments including those appointments with the status of open, cancel, frozen, and wait. Unbooked appointments may reflect unused CHCS provider time made available for patient care or scheduling inaccuracies that need to be corrected or adjusted so all available appointment slots are all fully utilized.

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

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

Exceptions: None

Recommended frequency: Monthly

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

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

3.6. Measure #6: # Unbooked Appointment Requests (UAR)

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

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

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

Exceptions: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Locally determined

3.7. Measure #7: # and % of MTF Enrolled Patients Sent to MCS Contractor Network for Specialty Care

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

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

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

Frequency: Monthly/Weekly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

3.8. Measure #8; Number of Emergency Room (ER) Visits in the MTF and the Network

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

User: Clinic Management, MTF executive staff and Services.

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

Exceptions: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Locally determined.

3.9. Measure #9: Number of Unscheduled Visits (Walk-in, Sick Call)

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

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

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

Frequency: Monthly - Drill down to Clinic

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

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

3.10. Measure #10: # and % of MTF Enrolled Beneficiaries Referred to the MCS Contractor Network (Deferred to Network) for Primary Care

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

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

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

Frequency: Monthly/Weekly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

3.11. Measure #11: Percentage of No Show Appointments

Rationale: This measure is designed to capture the ratio of scheduled appointments for which the scheduled patient fails to appear compared to the number of appointments booked for that clinic for the month. Some reasons for no shows include the following; patients forgetting appointment dates; appointment times not convenient, no responsive appointment cancellation process, last minute installation

exercises, or a lack of patient education on the clinic consequences of no shows. Strategies to decrease high no-show rates include: having a responsive appointment cancellation process; using the MTFs automated appointment reminder system; increased command emphasis on no-show policies, informing line commanders on active duty no shows and; template managers being allowed to double book appointments slots. No show rates may adversely affect ADSM readiness.

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

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

Exceptions: None

Frequency: Monthly - Drill down to Clinic

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

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

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

Rationale: This measure allows access managers to determine the number of patients that waived access standards for a particular category of care. The patient’s reason for doing so may include many reasons. Access managers need to carefully analyze there meaning. Conclusions may be drawn if there are increased numbers for a particular clinic or provider. These trends may indicate that schedules need to be reviewed to determine if they are meeting the scheduling needs of patients and that the appropriate mix of appointment types and times are available. Some of the reasons that patients wave access standards may indicate that the times that were offered to patients during the ATC standard were not convenient to meet their needs; patients wanted to continue seeing their own PCMBN and elected continuity over being treated in a more timely manner; may indicate that appointment types of correct variety were not available to the appointing agents, or that the appointing agents were not allowed to change appointment types that satisfied the patient’s need.

Definition: Number of patients scheduling appointments who were offered an available appointment within access standards for a particular ATC category (Acute,

Routine, Wellness and Specialty), but for whatever reason elected to waive the access standards of 24 hours, 7 days or 28 days and take an appointment outside of these standards.

Qualifiers: None

Frequency: Monthly - Drill down to Clinic

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

Target/Threshold/Benchmark: Local policy

3.13. Measure #13: Appointment Schedules Opened 30 Calendar Days or More in Advance

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

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

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

Exceptions: None

Recommended Frequency: At a minimum, weekly

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

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

3.14. Measure #14: Appointment Mix Meeting the Needs of Beneficiary Population

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

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

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

Exceptions: None.

Recommended Frequency: Weekly

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

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

3.15. Measure #15: Number of Appointments Booked Using the Future Access To Care Category

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

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

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

Exceptions: None.

Recommended Frequency: Monthly

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

Target/Threshold/Benchmark: Service or locally defined

3.16. Measure #16: Patient Satisfaction with Access to Care

Rationale: MTFs can use locally, Service Headquarter or MHS developed tools that monitor patient satisfaction with Access to Care. Many of these tools can drill down to clinic, provider satisfaction measures and individual patient comments. Trends in a MTFs patient's attitudes about their satisfaction with areas such as ease of making an appointment, first call resolution, courtesy of appointing staff, etc, though subjective, can alert access managers to possible issues/problems with their appointing processes. When satisfaction measures are used with the other access measures, this combination provides a more complete picture of a MTFs/clinic's access performance.

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

Definitions: Various tools use varying measures to gather patient satisfaction data. These data can range from the collection paper, telephonic or web-based survey data using rating scales, to that of gathering free text comments. These data are generally

expressed as a rate/level of satisfaction with some dimension access that was surveyed.

Exceptions: None

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

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

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

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

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

4. Business Planning Critical Initiatives:

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

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

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

4.3. Other key components affecting Access to Care are as follows:

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

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

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

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

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

- Minimum access to care standards for all appt types at least 90% of the time
- TOL Registration 20% to 50%
- TOL Appointing 10% to 20%
- WEA Appointments 50% to 80%
- MTF Book Only < 5% to 10%
- Facility Cancel < 3%
- Patient Cancel < 5% to 10%
- Leave without being seen < .05% to 1%
- Provider schedules (primary/specialty) 45 days out < 10% gap
- NED discrepancies < .05%
- No show < 5%
- Unbooked < 5%
- Increase Primary care (MC/PC) appointments > 5%

4.6. Critical Initiative Components: Consists of:

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

APPENDIX G

ACCESS TO CARE OPTIMIZATION

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ACCESS TO CARE OPTIMIZATION

This appendix is a guide for the MTF to analyze key aspects and processes of a facility's access to care operations to support annual business planning. MTFs need to review the entire appointment booking process from enrollment through receiving patient calls, booking appointments, and tracking the patient up to but not including the encounter with the provider. There are six activities MTFs should utilize in whole or part to optimize access. MTFs should implement these activities as a complement to their Business Plan Critical Initiatives and improvements. The tables below provide an outline of critical access improvement points in the outpatient care setting. The MTF should use these tables as part of an access to care optimization program.

ATC Optimization Activities

1. Optimize Enrollment /Empanelment

1.1 Balance distribution of patients to panels in accordance with patient clinical needs and the skill/experience of the provider.

1.2 Balance distribution of patients to panels in accordance with Graduate Medical Education (GME) and Provider/Patient Readiness Requirements.

1.3 Maximize the average weighted patient encounter.

1.4 Minimize the movement of patients from one panel to another.

1.5 Enrollment/PIT errors < 0.5%. (How many assignment errors does the MTF have between DEERS and CHCS?)

1.6 The National Enrollment Database (NED) discrepancy report should be reviewed regularly. MTF should promptly correct Patient Information Transfer (PIT) errors.

1.7 Ensure Managed Care Support Contractor (MCSC) establishes sufficient enrollment capacity within the Network TRICARE Prime Service Area (PSA) to directly augment Direct Care System enrollment.

1.8 Perform regular demand management studies that best suit the needs of the patient population and the capabilities of the MTF providers.

2. Access Manager Responsibilities

2.1. Promotes the provision of high quality, accessible, cost effective healthcare services.

2.2. Assist providers, professional, support, and administrative staff in optimizing patient care and clinical processes.
2.3. Maintaining processes that optimize template management.

2.4. Facilitates and coordinates healthcare resources to ensure optimal Access Standards are met > 90% of the time IAW MHS/Service specific Business Planning guidance.

2.5. Facilitates and coordinates clinical oversight for empanelment decisions.

2.6. Ensure providers' schedules reflect at least 30- 45 days of full appointment availability.

2.7. < 5% of appointments unused (does not apply to Open Access environment or clinics with excess capacity).

2.8. Minimize the use of detail codes that restrict the use of appointments.

2.9 Minimize the use of provider book only, MTF book, and freezing of appointments.

2.10. Minimize the use of facility cancelled appointments.

2.11. Develop and facilitate processes that reduce no show, patient cancel, left with out being seen (LWOBS), and unbooked appointment rates.

2.12. Implement processes encouraging TRICARE Online (TOL) registration and the use of TOL for appointing.

3. Implement adequate Telephone/Web-Enabled Network

3.1. Maximize use of MTF automatic call distribution system and monitor telephone calls everywhere appointments are made.

3.2. Maintain a simple call tree with minimal use of call tree layers.

3.3. Reduced Call abandonment rates to 2% or below.

3.4. Respond to callers in less than 90 seconds, 90% of the time.

3.5. Provide one local and toll free number for beneficiaries to call for appointments.
3.6. Implement processes that support 1st call resolution.

3.7. Implement a 24 hour centralized appointment cancellation line.

3.8. Maintain telephone metrics (wait time and caller abandon rate) and incorporate into command level monitoring and reporting.

3.9. Survey beneficiaries on telephone appointing services.

3.10. Utilize the appointment reminder system to minimize no-show rates.

3.11. Decrease rate of calls that don't result in an appointment being booked by providing appropriate alternatives to unavailable appointment requests, i.e. network appointment, clinic triage, PCM consultation, etc.

4. Optimizing Primary Care

4.1. Implement processes that result in patient/provider satisfaction with access greater than or equal to 90% of the time.

4.2. Increase capacity and available appointments.

4.3. Decrease patient throughput times.

4.4. Decrease the number of primary care appointments made outside the primary care clinic - Decrease by 90%.

4.5. Decrease the number of preventable Emergency Department (ED) visits.

4.6. Ensure that provider and support staff ratios are optimized.

4.7. Ensure continuity of care and coordination of care.

4.8. Implement processes that monitor outcomes.

4.9. Utilize physician assistants, nurse practitioners, and nurses for care to optimize physicians, physician assistant, nurse practitioner and nurses' time for appropriate care.

4.10. Implement patient education programs for self care.

4.11. Decrease Reliance on ED/Acute Care Clinics.

4.12. Decrease Leakage to the Network.

4.13. Ensure 24/7 Access to a Primary Care Manager.

4.14. Meet Health Plan Employer Data and Information Set (HEDIS) Targets – at or above 90%

4.15. Clinical Practice Guideline (CPG) compliance - – at or above meet 90% baseline.

4.16. Practice Early Detection of Disease (EDD).

4.17. Improve coding accuracy.

5. Implement Open Access Model where appropriate

5.1. Implement processes that ensure Appointment is with the PCM Team 90% of the time.

5.2. Implement processes that ensure patient satisfaction with access to care > 90%.

5.3. Implement processes that ensure 60% of appointments are requested and seen within the same day.

6. Business Planning Access to Care Critical Initiatives

6.1. Effectively manage resources/processes to improve access.

6.2. Effectively document utilization of healthcare manpower.

6.3. Based on individual Service guidance, select access to care critical initiatives that help support and increase access to health care.

6.4. Develop action plans that will achieve Access to Care critical initiative objectives.

APPENDIX H

STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

APPENDIX H

STANDARD APPOINTMENT TYPES OPERATIONAL DEFINITIONS WITH ACCESS STANDARDS

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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 templates and schedules and booking appointments. The appointment type definitions and scenarios are followed by a table documenting the access standards and booking directions for each appointment type.

1. PCM (Initial Primary Care Appointment):

1.1. Definition: The PCM appointment type is designed for the initial primary care visit with the PCM to collect health data, family history, readiness data, etc. A PCM visit may or may not be the patient's first visit to the PCM since an acute or routine appointment may precede a PCM visit. Sites can use this appointment type to track whether the PCM has completed this initial visit as defined by the TRICARE benefit. This appointment type is not designed to meet acute or routine health care needs.

1.2. Where used: Only in primary care clinics.

1.3. ATC Category and Standard: For all appointing information system booking methods except Referral Booking, appointing agents will use the Wellness ATC Category or information system search function to book PCM appointments. To meet the Wellness ATC Standard, the PCM appointment type needs to be booked within 28 calendar days or 40,320 minutes from the patient’s request.

1.4. Scenario: Mrs. Jones, spouse of Lieutenant Jones, who has recently made a Permanent Change of Station move, is enrolled in TRICARE Prime at the local MTF to PCM Dr. Brown. She is not experiencing any acute health problems. Mrs. Jones wishes to set up an appointment with her PCM, Dr. Brown to tell her about her longstanding medical conditions. Mrs. Jones calls the 1-800 MTF appointment line. Mrs. Jones asks the appointment clerk for an appointment at the clinic. The appointment clerk asks Mrs. Jones for the appropriate demographic information to establish her identity. Upon seeing the appropriate demographic information (Health Care Delivery Program Code, Enrolled Clinic, PCM, etc) the appointment clerk confirms that Mrs. Jones is a TRICARE Prime Enrollee at the MTF with Dr. Brown. The appointment clerk (1) Asks Mrs. Jones if this is the first time she has asked for an appointment with her PCM or (2) Notices by viewing previous appointments that Mrs. Jones has not had an appointment with the PCM before. The appointment clerk asks Mrs. Jones if she has any acute health conditions that require that she see a doctor within 24 hours. Mrs. Jones replies that she does not, so the appointment clerk schedules her for a PCM appointment.

2. ROUT (Routine Appointment):

2.1. Definition: The ROUT appointment type is designated for patients who require an office visit with their PCM or mental health provider for a new healthcare problem that is not considered urgent. Routine mental healthcare is defined as an initial request for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent.

2.2. In the case of healthcare that is not characterized as mental health, appropriate clinical personnel can offer other appropriate alternatives for care, such as self-care. In locations where Nurse Triage is not in place, the concept of "prudent lay-person terminology" will be used to determine whether a patient should be given a routine or acute appointment. Appointing staffs need to be aware that these routine mental healthcare requests need to be appointed within 7 calendar days, and can be appointed to the patient's Primary Care, Behavioral Health, or Mental Health Clinics.

2.3. Where used: Only in primary care and mental health clinics.

2.4. ATC Category and Standard: Appointing agents will use the Routine ATC Category or information system search function to book ROUT appointments. To meet the Routine ATC Standard, the appointment needs to be booked within 7 calendar days or 10,800 minutes.

2.5. Scenario 1: Mrs. Jones has been experiencing a pain in her shoulder joint area for a couple of days and decides to call the 1-800 MTF 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. Jones' call to the Triage Nurse. The Triage Nurse, using approved protocols, rules out self-care and determines that an acute appointment is not necessary, but that a routine (ROUT) appointment should be scheduled with her provider within 7 calendar days. Using the Order of Search Precedence for Appointments Business Rule, the Triage Nurse books the appointment and gives the patient appropriate instruction.

2.6. Scenario 2: Sergeant Jones, recently redeployed from a combat area, is experiencing first time problems with sleeping, and is feeling anxious. He does not need to see someone immediately. He calls the Mental Health Clinic to ask for an appointment. The mental health technician determines that Sergeant Jones has an initial request for a new mental health condition for which intervention is required but is not urgent. The technician books Sergeant Jones into a routine (ROUT) appointment with a mental health professional within 7 calendar days.

3. SPEC (Initial Specialty Care Appointment)

3.1. Definition: The SPEC appointment type is designed for the initial consult or referral appointment to a specialist or an initial self referral for specialty care by a patient to a specialist. Generally speaking, the appointing information system will assign the ATC Standard and Category that matches the referral priority entered by the requesting provider. A SPEC appointment may be booked for a consult or referral with any priority.

3.2. Where used: Only for specialty clinics and primary care clinics with specialty care, e.g. Family Practice Clinics that also provide Gynecology and Obstetrical Care.

3.3. ATC Category and Standard:

3.3.1. In Referral Booking: The Composite Health Care System (CHCS) will automatically assign the correct ATC Category to the priority designated by the requesting provider, e.g. ASAP, Today, STAT, 48 Hrs, 72 Hrs, and Routine priorities. To meet the Specialty ATC Standard, the appointment needs to be booked within 28 calendar days or 40,320 minutes. The appointment type booked is not required to match the ATC Standard. Any appointment type may be booked. If the Routine referral priority request is for a stated time period such as, “Patient to be seen in 14 calendar days” the appointment is required to be booked in that time frame.

3.3.2. Self Referral Booking. In a Specialty Clinic that allows itself to be a self-referral clinic, “regular” booking functions are used by appointing personnel. In this instance appointing personnel will use the Specialty ATC Category/ information system search function to book the SPEC appointment. To meet the Specialty ATC Standard, the appointment needs to be booked within 28 calendar days or 40,320 minutes from the patient’s request.

3.4. Scenario: Mrs. Jones’ PCM (Dr. Brown) notices some abnormalities in a routine examination during her office visit. Dr. Smith is concerned about Mrs. Jones's examination and judges that an examination by a specialist is required. Her condition is such that it can wait 4 weeks to be seen. Dr. Brown orders a specific scheduled consult order and sends it to the Referral Management Center using the Routine referral priority. Mrs. Jones is instructed to go to the Referral Management Center on her way out of the hospital to allow them to book her initial specialty appointment in the requested specialty clinic. The clerk at the Referral Management Center clerk, who has access to Dr. Specialist Bone’s schedule, pulls up the consult order on Mrs. Jones, understands the instructions in the consult order, and books Mrs. Jones an

initial specialty care appointment with Dr. Bones within the 28 calendar day timeframe specified.

4. ACUT (Acute Appointment)

4.1. Definition: The ACUT appointment type is designed for scheduling appointments for beneficiaries who have a need for non-emergent, urgent care that require treatment within 24 consecutive hours.

4.2. Where used: For both primary and specialty care clinics.

4.3. ATC Category and Standard: For all information system booking methods except Referral Booking, appointing agents will use the Acute ATC Category or information system search function to book ACUT appointments. To meet the Acute ATC Standard, the appointment needs to be booked within 24 consecutive hours or 1,440 minutes from the patient's request.

4.4. Scenario**:** Mrs. Jones is experiencing flu-like symptoms and feels that she is in need of prescription medication. She calls the 1-800 MTF 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. Jones, as a TRICARE Prime enrollee, reasonably feels, as a prudent lay person, that her condition needs attention within 24 consecutive 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. Jones' demographic information and verifies her identity and TRICARE enrollment status. The clerk verifies that Mrs. Jones is seeking an immediate visit with her PCM to get treatment for flu-like symptoms. The clerk transfers Mrs. Jones' call to a triage nurse who, using appropriately approved protocols and algorithms, determines whether (1) Mrs. Jones 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. Jones 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.

5. WELL (Wellness or Health Promotion Appointment)

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

5.2. Where used: both primary and specialty care clinics.

5.3. ATC Category and Standard: In all information system booking methods except Referral Booking, appointing agents will use the Wellness ATC Category or information system search functions to book WELL appointments. The WELL appointment type will map to the 28-day Wellness ATC standard. To meet the Wellness ATC Standard, the appointment needs to be booked within 28 calendar days or 40,320 minutes from the patient's request.

5.4. Scenario**:** Mrs. Jones calls the 1-800 MTF 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. Jones. The clerk does a search keyed on WELL appointment types (other appropriate identifiers may also be used for the search; e.g., by time, detail code 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. EST (Established Patient Follow-up with Designated Time Allotment)

6.1. Definition: The EST appointment will be used when a patient is 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 care, or to have a procedure performed. The EST appointment type and Future Search will not be a substitute booking practice for patients requiring anything other than the described EST appointment needs. 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 time designation.

6.2. Where used: For both primary and special care clinics.

6.3. ATC Category and Standard: There is no ATC Standard. In all information system booking methods except Referral Booking, appointment agents will use the Future Search to book EST appointments.

6.4. Scenario. Mrs. Jones 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. Jones' follow-up appointment.

6.4.1. One Alternative: The patient could call central appointments giving the clerk the appropriate information for accessing Appointment Order Processing (AOP) in order to find the reviewed order and book the appointment.

6.4.2. Better Alternative: The simpler, patient centered 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.

7. PROC (Procedure Appointment)

7.1. Definition: The PROC appointment type is designated for patients in need of medical procedures other than those 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 ambulatory same day procedure appointing subsystem. A procedure appointment will be scheduled with a provider within 28 calendar days or per the referring provider's designation. The provider's designation must not exceed 28 calendar days. CHCS will assign the appointment the ATC Standard and Category that matches the referral priority entered by the requesting provider. The appointment type that is booked, is not required to match the ATC Category or Standard.

7.2. Where used: For both primary and specialty care clinics.

7.3. ATC Category and Standard: To book a PROC appointment, personnel will use the Specialty ATC Category. To meet the Specialty Care ATC Standard, the PROC appointment needs to be booked within 28 calendar days or 40,320 minutes from the patient's request.

7.4. Scenario: SGT Jones had been referred to Gastroenterology. The Gastroenterologist decides that Jones needs to come back in one week for an Upper GI examination that will be performed in the clinic.

7.4.1. Alternative 1 – The Call Back: The physician enters a consult order into the system for the procedure to be performed. Instructions to be given to SGT Jones are included on the consult order. SGT Jones 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 Sergeant Jones). 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 Jones to have the procedure performed. The appointment clerk uses the information on the consult

order to remind SGT Jones of the physician's instructions on how to be prepared for the procedure.

7.4.2. Alternative 2 – PROC Booked Before the Patient Leaves the Clinic: Sergeant Jones is able to stop by the front desk of the clinic and get his PROC appointment scheduled before he leaves the clinic.

8. GRP (Group Appointments with Multiple Patients)

8.1. Definition: The GRP (Group) appointment type will be used for patients who require therapy, counseling, or teaching sessions where a provider will perform the service in a group setting. The detail code fields can be used to provide further information about the care to be provided in the group appointment, (e.g., TOBCES, a Tobacco Cessation Class). A group appointment should be scheduled per self referral of the patient, or the clinic's or referring provider's policy or designation.

8.1.1. The GRP appointment type will NOT be used to book multiple patients into a single time slot for wellness (WELL), routine, (ROUT), acute (ACUT), established (EST), specialty (SPEC) care, procedures (PROC) or for open access (OPAC) appointments. These specific appointment types should be used with multiple overbooks to accommodate multiple patients being booked into one slot for these types of health care services.

8.2. Where used: For both primary and special care clinics.

8.3. ATC Category and Standard: There is no ATC Standard for the GRP appointment type. For all appointing information system booking functions or methods except Referral Booking, appointment agents will use the Future ATC Category search to book GRP appointments.

8.4. A group appointment should be scheduled per the referring provider's recommended time that the patient needs the care.

9. OPAC (Open Access (OA))

9.1. Definition: The OPAC appointment type will be used by those sites that offer patients same day acute, routine, wellness, or follow-up primary care services. Every effort will be made to allow patients to see their PCM on the same day they request an appointment. However, this practice does not open the clinic into a full "walk-in" type service. To the greatest extent possible, all of the patient’s issues are addressed in a single visit to minimize the need for unnecessary future appointments or repeat

visits. Guidance on performing Open Access appointment methodology is contained in Appendix J, Open Access Appointing of this document.

9.2. Where used: Primary and Specialty Care Clinics.

9.3. ATC Category and Standard:

9.3.1. For all information system booking methods except Referral Booking, appointing agents will use the Acute ATC Category or information system search function to book OPAC appointments. To meet the Acute ATC Standard, the appointment needs to be booked within 24 hours or 1,440 minutes from the patient's request.

9.3.2. Other Services may apply specific ATC standards for booking OPAC appointments.

9.3.2.1. In the Air Force Medical Service (AFMS), appointments booked in designated Open Access clinics must be booked and the patient seen on the same calendar day. ATC standards for AFMS Open Access appointing for AFMS Open Access sites are computed by the Air Force Surgeon's General Office using an Ad-hoc report.

10. DROUT (Dental Routine)

10.1. Definition: The DROUT appointment type is designated for patients who require preventive or routine dental care (e.g., dental examinations, periodic examinations, check-ups, screenings, etc.)

10.2. Where used: dental treatment clinics and facilities that book appointments using the Composite Health Care System (CHCS).

10.3. ATC Category and Standard: In all information system booking methods except Referral Booking, appointing agents will use the Dental Routine ATC Category or information system search functions to book DROUT appointments. The DROUT appointment type will map to the 21 calendar day Dental Routine ATC standard. To meet the Dental Routine ATC Standard, the appointment needs to be booked within 21 calendar days or 30,240 minutes from the patient's request.

10.4. Scenario: Sergeant Jones calls the dental clinic needing his periodic screening. The appointing clerk at the dental clinic, searches CHCS using the Dental Routine ATC Category and finds SGT Jones and DROUT appointment in 2 ½ weeks and books the appointment.

11. Use of dollar sign ($) suffix on appointment types:

11.1. MTFs can use appointment types with the dollar sign ($) as the last character on all ten standard appointment types to indicate that these slots are to be booked by MTF staff only, e.g. PCM$, ROUT$. Through arrangements with local appointing contractors or in a multi-market service area with a regional, centralized appointing function, standard appointment types with the dollar sign ($) will not be booked unless they have MTF approval. MTFs should minimize the use of the dollar sign ($) on appointment types to 10% or less of their available appointment slots to allow supporting organizations the ability to book as many appointments as possible, since this is their contracted function.

11.2. MTFs will not use the dollar sign ($) suffix to prevent MTF personnel from booking these appointments or to make it a provider book only slot. The Provider Book Only (PBO) detail code can be used to accomplish this function. Appropriate business rules should be utilized to minimize the usage of dollar signs ($) since it restricts access to care for patients.

11.3. MTFs wanting to maximize the number of web-enabled appointments should not use the dollar sign ($) as this prevents these appointments from being booked via the TRICARE Online appointing capability.

12. Other Embedded Appointment Types:

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

12.1.1. 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.

12.1.2. EROOM. The Emergency Room may use EROOM or any standard appointment type.

12.1.3. 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.

12.1.4. T-CON*. A telephone consultation 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.

12.1.5. RNDS. Used by providers to account for inpatient rounding. Cannot be placed in outpatient appointment schedules.

13. Appointment Booking.

13.1. Appointing information system booking options other than Referral Booking or Appointment Order Processing (AOP) require booking clerks to match the ATC Category to the appointment type, per the business rules built into the appointment information system.

13.2. Appointment personnel are required to book the appointment within the appropriate time to meet the ATC Standard in which the care should be provided. These ATC Standards have been established by law in 32 CFR 199.17. The appointment information system automatically tracks if the booked appointment was provided within the ATC Standard. All time standards are in consecutive hours or consecutive calendar days. The appointing personnel establish the ATC Standard by choosing the ATC Category to begin the searching for appointments that matches the patient's request/need for health care services. These ATC Categories with ATC Standards are as follows:

TABLE: ATC Categories with Corresponding ATC Standards:

ATC Category/Search Option	ATC Standard (to the minute)
Acute	within 24 consecutive hours or 1,440 minutes
Routine	within 7 calendar days or 10,080 minutes
Wellness	within 28 calendar days or 40,320 minutes
Specialty	within 28 calendar days or 40,320 minutes
Future	No Standard
Dental Routine	within 21 calendar days or 30,240 minutes

13.3. Appointment personnel may select any appointment type, but must correct the appointment type to match the ATC Category, per appointment information system business rules, or the appointment cannot be booked. The appointment must also be booked within the appropriate time (ATC Standard) to meet the time standard

requirements for the care requested by the patient. Appointment personnel will follow the chart below to book appointments.

TABLE: ATC Categories, and Related Appointment Types and ATC Standards

ATC Category/ Search Option	Standard appointment type that should be chosen/booked	ATC Standard (time in which the appointment type needs to be booked
Acute	ACUT and ACUT$	24 consecutive hours/1,440 minutes
	OPAC and OPAC$	Same Calendar Day
Routine	ROUT and ROUT$	7 calendar days/10,080 minutes
Wellness	WELL and WELL$ PCM and PCM$	28 calendar days/40,320 minutes
Specialty	SPEC and SPEC$ PROC and PROC$	28 calendar days/40,320 minutes, or per Provider Designation not to exceed 28 calendar days
Future	EST or EST$ GRP or GRP$ APV	No Standard or per Provider Designation
Dental Routine	DROUT or DROUT$	21 calendar days/30,240 minutes

13.4. In Consult (AOP) and Referral Booking appointment personnel are not required to choose a certain appointment type to match the ATC Category. They can choose any appointment type to book the appointment. However, they should change the appointment type to the care that best describes the care provided to the patient. The appointing information system automatically assigns the ATC Category and applicable ATC Standard to the referral priority assigned by the provider's referral request. Appointment personnel will select appointment types that are in the Clinic and Provider Profile and within ATC Standards. Appointment personnel will use the below chart for guidance in booking appointments requiring a referral.

TABLE: Referral Priorities and What Corresponding Appointment Types Can be Booked with Applicable ATC Standard

Consult/ Referral Priority Entered by Provider	ATC Category/ assigned by MTF information system	ATC Standard assigned by MTF information system	Standard appointment type that can be booked
STAT, ASAP, Today, 24 HRS	**Acute**	within 24 Hours or 1440 minutes	All Types
48 HRS, 72 HRS	**Routine**	within 7 calendar days or 10,080 minutes	All Types
Routine	**Specialty**	within 28 calendar days or 40,320 minutes	All Types
For 2nd, 3rd, etc. appointment on a consult, user selects ATC	**Any ATC Category including the Future ATC Category**	No Standard	All Types

13.5. MTFs will ensure all MTF appointing personnel are trained and understand the procedures for booking appointments in appointing information systems.

APPENDIX I

ACCESS TO CARE MEASUREMENT AND REPORTING FUNDAMENTALS

APPENDIX I

ACCESS TO CARE MEASUREMENT AND REPORTING FUNDAMENTALS

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APPENDIX I

ACCESS TO CARE MEASUREMENT AND REPORTING FUNDAMENTALS

This appendix provides an overview of the fundamentals of how access to care measurement and reporting works in the Composite Health Care System/Enterprise Wide Scheduling and Registration system. The objective of this appendix is to provide MTF Access Managers an in-depth understanding of this process to more accurately measure and improve ATC performance.

1. Explanation of Access to Care (ATC):

1.1. Background. With the establishment of the TRICARE Program, Congress through the implementation of 32 CFR 199.17 mandated that enrolled/TRICARE Prime beneficiaries be provided access to acute, routine, wellness, and specialty care services within establish ATC time standards of 24 hours, 7 calendar days, or four weeks/28 calendar days. The ATC functionality of the Composite Health Care System (CHCS)/Enterprise Wide Scheduling and Registration (EWSR) was developed to measure if a provider/clinic/MTF are meeting these mandated ATC standards.

1.2. Access to Care Categories, Appointment Types and Standards. The ATC categories, the standard patient appointment types and ATC time standards all work together to assist Access Managers to measure if their MTF's teams or clinics are meeting the health care needs of its enrolled beneficiaries within these acceptable time standards. It also permits authorized users/appointing agents at the MTF to search for standard appointment types in schedules using a corresponding ATC Category. An ATC Category is a system function that allows the appointing agent to narrow their search to look for a service that is categorized as either acute, routine, wellness, specialty, dental routine or can be provided in the future. Each ATC Category chosen establishes a time range used by CHCS/EWSR to search the provider schedules and display available standard appointment types that meet (are inside this time range) or do not meet (outside this time range) of the ATC standard that corresponds to the care needed by the patient. The Access time range is calculated in minutes with five of the six CHCS/EWSR searches having an ATC Standard. Appointing template managers are permitted to use 10 Standard Appointment Types with suffixes in their schedules. Each Standard Appointment Type has a standard operational definition and must be booked using one of the five ATC Categories/search options in Managed Care Program of CHCS/EWSR to complete the booking episode transaction. Per the business rules built into the CHCS/EWSR system, each Standard Appointment Type has been mapped to a specific ATC Category and ATC Standard.

1.3. Accuracy of Booking Appointments Using the ATC Functionality. The most important principle to accurately measure access to care is matching the ATC search to the patient's need. Using the chart below, appointment agents completing the booking episode are required to choose the Standard Appointment Type that corresponds with the beneficiary's need and ATC Category and Standard.

Table 1.

ATC Category/ Search Option	Standard Appointment Type That Must Be Booked to complete the transaction	ATC Standard (Time In Which The Appointment Type Needs To Be Booked)
Acute	ACUT and ACUT$ OPAC and OPAC$	24 consecutive hours/1440 minutes
Routine	ROUT and ROUT$	7 calendar days /10,080 minutes
Wellness	WELL and WELL$ PCM and PCM$	28 calendar days/40,320 minutes
Specialty	SPEC and SPEC$ PROC and PROC$	28 calendar days/40,320 minutes, or per Provider Designation not to exceed 28 days
Future	EST or EST$ GRP or GRP$ APV	No Standard or per Provider Designation
Dental Routine	DROUT or DROUT$	21 calendar days/30,240 minutes

1.4. Implementing the Measurement of ATC.

The Access to Care (ATC) functionality of CHCS/EWSR measures whether these categories with applicable time standards are met. As listed in the table below, access is measured in each of the following modules of CHCS/EWSR and is calculated from the specified start dates only for booked appointments:

Table 2. Starting Points for Measuring Access.

CHCS/EWSR Module	Start Dates of Measurement
Order Entry:	Date/time a specialty care order is entered into the system for a consult (CON), Ambulatory Procedure (APR), or Ancillary (ANC) order
Managed Care Program (MCP) Booking:	Date/time a referral is entered in the system, or Date/time a PCM, Non-enrolled, enrolled elsewhere or Self-referral appointment is entered into the system
Waitlist:	Date/time a wait list request is entered into the system

1.5. Access To Care Information Gathered.

1.5.1. Access to Care Reporting Functionality. The Access to Care Summary Report (ATCSR) measures if an applicable standard is met each time an appointment is booked in CHCS/EWSR. This information has been gathered and may be available since July, 2000 on the CHCS host and is accessible by the local database administrator. Additionally, the ATCSR captures the following information:

1.5.1.1. The number of appointments booked and the percentage of booked appointments which meet and do not meet the ATC standard for the ATC category chosen.

1.5.1.2. At the CHCS Division/ MTF, Department, Clinic, and Provider level.

1.5.1.3. By Beneficiary Program Category, and ATC category.

1.5.1.4. Computes the average days of waiting time for appointments booked by ATC category by full days and by tenths of a day.

1.5.1.5. Captures number of appointments booked within the ATC standard, outside ATC standard or refused by the patient for personal preferences.

1.5.2. Obtaining ATC Report Information.

1.5.2.1. MTFs must turn the ATC Summary Report flag in the applicable CHCS clinic profile to “yes” to allow for the printing of this report for the measured clinic.

1.5.2.2. If the reporting flag is turned to “no” ATCSR information is still gathered and stored, but cannot be reported or printed.

1.5.2.3. This information may be obtained from your local CHCS host, the TRICARE Operations Center (TOC) or Service Level Reports.

1.5.3. Notional View of the Access to Care Summary Report. Figure 1 is an example of the ATCSR obtained from a local CHCS host.

Figure 1. Notional View of the Access to Care Summary Report in CHCS.

```
Notional Access to Care Detailed Report
==========================  Screen # A-1 =======================================
SAMPLE AFMEDCEN SAMPLE AFB                                  04 Aug 2007@1325    Page 1
                ACCESS TO CARE REPORT
              Detail by Clinic Specialty
                Jul 1 2007 to Jul 31 2007
DIRECT CARE:
MTF: MTF Name
Clinic Specialty: FAMILY PRACTICE CLINIC/BGAA
==========================================================================================
ATC Category
 Provider
  Program Category          % Met     # Met    # Not Met  # Appts     Avg Days  #Refused
==========================================================================================
ACUTE ATC Category
------------------
 WALKER,JAMES
  ENROLLED ACTIVE DUTY         80%      80        20        100         1.1           0
  NON ENROLLED ACTIVE DUTY     78%      70        20         90         1.3          10
  PRIME FOR AD FAM MBR         75%      60        20         80         1.3          20
  PRIME FOR RETIRED            80%      80        20        100         1.3           0
  PRIME RET FAM MRR            80%      80        20        100         2.0           0
  TRICARE STANDARD             80%      80        20        100         1.3           0
  DIRECT CARE ONLY             80%      80        20        100         1.3           0
  OTHER                        80%      80        20        100         1.3           0
  TRICARE SENIOR PRIME         80%      80        20        100         2.0           0
  TRICARE PLUS                 80%      80        20        100         1.3           0
  NOT ELIGIBLE                 80%      80        20        100         1.3           0
Provider Total                 80%     850       220       1070         1.2          30
 WILSON,LAUREL
  ENROLLED ACTIVE DUTY         80%      80        20        100         1.1           0
  PRIME FOR AD FAM MBR         80%      80        20        100         1.3           0
 Provider Total                80%     160        40        200         1.2           0
Acute Total                    80%    1010       260       1270         1.2          30

ROUTINE ATC Category
---------------------
 SMITH,FRED
  ENROLLED ACTIVE DUTY         80%      80        20        100         1.1           0
  PRIME FOR AD FAM MBR         80%      80        20        100         1.3           0
 Provider Total                80%     160        40        200         1.2           0
Routine Total                  80%     160        40        200         1.2           0
WELLNESS ATC Category
---------------------
 BAKER,LORI
  PRIME FOR ACTIVE DUTY        80%      80        20        100         1.1           0
  PRIME FOR AD FAM MBR         80%      80        20        100         1.3           0
 Provider Total                80%     160        40        200         1.2           0

Wellness Total                 80%     160        40        200         1.2           0
SPECIALTY ATC Category
----------------------
 BAKER,LORI
  ENROLLED ACTIVE DUTY         80%      80        20        100         1.1           0
  PRIME FOR AD FAM MBR         80%      80        20        100         1.3           0
 Provider Total                80%     160        40        200         1.2           0
Specialty Total                80%     160        40        200         1.2           0
Clinic Total
    Total                      80%    1490       380       1870         1.2          30
FUTURE appointments
---------------------
 BROWN, RICHARD
  PRIME FOR ACTIVE DUTY                                    100        21.1
  PRIME FOR AD FAM MBR                                     100        21.3
 Provider Total                                            200        21.2

Future Total                                               200        21.2           0
*  Only clinics which are identified for Access to Care reporting are included on this
   report. *
```

2. Exact Match and All Appointments Search Options of CHCS/EWSR and ATC measurement. Access to care measurement takes place each time a booking agent searches for

and books an appointment. To start this process the booking agent must use a booking function. to include 1) Referral Booking; 2) PCM Booking; 3) Non-Enrollee Booking; 4) Self-Referral; 5) Enrolled Elsewhere; 6) Wait List; 7) Enrolled Booking; 8) Appointment Order Booking for Consults. The MCP booking function of CHCS/EWSR provides the appointing agent with the flexibility of choosing two types of search options, Exact Match and All Appointments. The MCP booking functions support these two search options and ATC measurements.

2.1. Exact Match Search Option Defined. Any authorized user granted access to the booking functions of CHCS/EWSR can use the Exact Match Search option to book appointments. CHCS/EWSR will display highlighted appointment slots as Exact Match if they meet the following criteria:

2.1.1. Matches all the user-entered search criteria that can include but not be limited to the following:

2.1.1.1. Place of Care

2.1.1.2. Specialty Type

2.1.1.3. Location

2.1.1.4. Date Range

2.1.1.5. Appointment Type

2.1.1.6. Detail Codes

2.1.2 The appointment slot is within the ATC time standard of the selected ATC category AND

2.1.3. The ATC category chosen maps to the correct Appointment Type(s) listed on the schedule, (e.g. the Wellness ATC Category is chosen and all WELL and PCM appointment types will display) AND

2.1.4. Match the patient's demographics, to include age detail codes, patient access type detail codes, gender detail codes, or no detail codes listed on the appointment slot.

2.2. All Appointments Search Option Defined. Appointing agents will require appointing security keys to book appointments using this search option since the appointments that display may require alteration. The following are characteristics of the All Appointments Search Option:

2.2.1. If no Exact Match appointments are available or if the Exact Match appointment Search Option is not selected, the All Appointments Search is the default.

2.2.2. The All Appointments Search Option will display all appointments available on the schedule from the current date/time.

2.2.3. Appointment slots not highlighted in the All Appointments Search Option are not exact match and may require modifications to the appointment type or detail codes as prompted by CHCS/EWSR.

2.2.4. Appointments preceded by a hyphen are displayed to all appointing agents, but may only be booked by an appointment clerk with appropriate security keys.

2.2.5. If the appointing agent has the appropriate security keys he/she can change the appointment type to match the parameters of the search. For example, if the Routine ATC Category is chosen and the All Appointments Search Option shows WELL appointments that are available within 7 days, the appointing agent can change the WELL to a ROUT appointment type. In this instance the ATC Standard is now met.

3. MCP Booking Functions and ATC Measurement. Appointing agents may use the Exact Match or the All Appointments search options in all MCP booking functions. The business rules of searching for, finding appointments that are within ATC standards and matching patient needs to appointment types are different in Primary Care and Consult/Referral Booking.

3.1. Primary Care Appointment Booking. In CHCS/EWSR Primary Care Booking, the default automatically searches for appointments with the patient's assigned Primary Care Manager (PCM) and PCM group.

3.1.1. This search has three steps. They are:

3.1.1.1. Search for appointments with the patient's PCM in the enrolled Place of Care.

3.1.1.2. If no appointments are found, search for appointments with the patient's PCM in alternate Places of Care where the PCM has schedules.

3.1.1.3. If appointments are still not found, search for appointments with PCM Group members in the enrolled Place of Care or other Places of Care where members have schedules.

3.1.2. The chart below illustrates the four steps needed to search for and accurately book appointments in PCM Booking.

Table 3. Primary Care Booking Steps:

Step One: Identify the Patient's Need	**Step Two: Pick the Correct ATC Category**	**Step Three: Choose the Correct Standard Appointment Type**	**Step Four: Try to Make Appt Within the Appropriate ATC Standard**
For Acute care or for MTFs with OPAC appointing	Acute	ACUT and ACUT$ OPAC and OPAC$	Within 24 Consecutive Hours or 1,440 minutes
For Routine care with a PCM	Routine	ROUT and ROUT$	Within 7 Calendar Days or 10,080 minutes
For wellness care/self referral care	Wellness	WELL and WELL$ PCM and PCM$	Within 4 Weeks/28 Calendar Days or 40,320 minutes
For initial Specialty care or a procedure	Specialty	SPEC and SPEC$ PROC and PROC$	Provider Directed or Within 4 Weeks/28 Calendar Days or 40,320 minutes
For a follow-up or a group appointment	Future	EST or EST$ GRP or GRP$	No Time Standard or Provider Directed, up to 28 day display

3.2. Consult and Referral Booking. Consult/referral booking differs markedly from primary care booking. The system automatically searches for appointments that meet the criteria established in the provider's consult or referral request. The characteristics of consult/referral booking are as follows:

3.2.1. CHCS/EWSR automatically assigns an ATC category to the consult/referral based on its priority (usually entered by the provider). The appointing agent does not have to choose an ATC category to book an appointment.

3.2.2. Exact Match: The system will display all appointments of any type that fall within the ATC time standard that match the consult/referral priority AND the patient's demographics (age, gender, patient access type detail codes).

3.2.3. All Appointment Search: Displays all appointments of any type within 28 days for initial appointment and within 180 days for 2nd, 3rd, 4th follow-ups.

3.2.4. The user is not required to correct the appointment type to match the ATC Category.

3.2.5. In the All Appointment Search the user is still required to correct any detail codes that are inconsistent with patient demographics.

3.2.6. For follow-up appointments, the ATC Category can be changed to Future, or any other category.

Table 4. Consult/Referral Booking Steps. The following table shows the four steps required to search for appointments in consult/referral booking. The appointing agent will perform only steps three and four.

Step One: Provider Entered Referral/Consult Priority	**Step Two: CHCS/EWSR Assigns ATC Category**	**Step Three: User Chooses the Correct Appt Type**	**Step Four: User Tries to Make Appt Within the Appropriate ATC Standard**
STAT, ASAP, Today, 24 HRS	Acute	All	Within 24 consecutive hrs or 1,440 minutes
48 HRS, 72 HRS	Routine	All	Within 7 calendar days or 10,080 minutes
Routine	Specialty	All	Provider Directed or Within 4 Weeks/ 28 Calendar Days or 40,320 minutes.
Pre-op	Specialty	All	Provider Directed or Within 4 Weeks/28 Calendar Days or 40,320 minutes.
Any ATC category for 2nd, 3rd, 4th, etc., appointment	Future	All	Provider designated/ No Standard

4. Guidance for Access to Care Searches in CHCS/EWSR. This next section gives access managers and appointing personnel a very detailed description of how the ATC measurement function interfaces with the booking of appointments in CHCS/EWSR. ATC Categories are synonymous with the term CHCS/EWSR searches AND with the term booked to acute, routine, wellness, specialty, or future. For clarity within this section the following terms and definitions apply:

- A patient refusal included on the ATCSR is defined as a patient refusing an appointment offered within the ATC standard and decided due to their preference to accept an appointment outside the standard. This definition applies to all patient refusals referenced in this section.
- A patient refusing all offered appointments because the MTF could not meet the patient's preference and did not book an appointment is an example of a patient refusal not included on the ATCSR. This information is included the CHCS/EWSR Appointment Refusal Option.

4.1. Choosing the Acute ATC Category/Performing an Acute ATC Search in CHCS/EWSR.

4.1.1. The Acute ATC appointment search is designed for scheduling appointments for beneficiaries who have a need for non-emergent, acute care within 24 hours.

4.1.2. For EXACT MATCH searches, the system will display all ACUT or ACUT$ and OPAC or OPAC$ appointment types meeting Acute ATC Standards from the date/time of the patient request or the date/time the referral was entered.

4.1.3. During ALL APPOINTMENT searches, CHCS/EWSR will display all appointments of any type and all detail codes. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Acute ATC standard and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected. In this case, the appointing agent must change the appointment type to ACUT or ACUT$ or OPAC or OPAC$ appointment types in order to complete booking the appointment.

4.1.4. All appointments booked using the Acute ATC search are mapped to the Acute ATC Category on the ATC Summary Report.

4.1.5. MTF's using the Open Access appointing methodology will use the Acute ATC search to book Open Access (OPAC) appointments. These appointments are measured against the Acute ATC Standard.

4.1.6. A "Not Met" count on the ATC Summary Report only occurs in the All Appointments Search Option. Choosing any appointment, of any type, that is greater than the Acute ATC standard, will get a "Not Met" count if there were no appointments available in the clinic/group with any of the providers that are part of the clinic within the access standard.

4.1.7. A patient refusal will be registered on the ATC Summary Report only in the All Appointment Search option. The system counts that appointment as a patient refusal if a patient:

- is offered an available appointment within the Acute ATC Standard, AND
- if the system finds that there are available appointments of any type with any providers with schedules in the clinic/group member. network that are within the Acute ATC standard, AND
- the patient refuses, but agrees to a later appointment outside 24 hours/1,440 minutes.

4.2 Choosing the Routine ATC Category/Performing a Routine ATC Search in CHCS/EWSR.

4.2.1. The Routine ATC appointment search is designated for patients who require an office visit with their PCM or mental health provider for a new healthcare problem that is not considered urgent. Routine mental healthcare is defined as an initial request for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent. Appointing agents need to be aware that these routine mental healthcare requests need to be appointed within seven days. The Routine search will be conducted so that the patient can be appointed to Primary Care, Behavioral Health, or a Mental Health Clinic and measurement of Routine ATC Standard can take place.

4.2.2. For EXACT MATCH searches, the system will display all ROUT or ROUT$ appointment types meeting Routine ATC Standards from the date/time of the patient request.

4.2.3. During ALL APPOINTMENT searches, CHCS/EWSR displays all appointments of any type with all detail codes available within 28 days. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Routine ATC standard and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected. In this case, the appointing agent must change the appointment type to ROUT or ROUT$ appointment types in order to complete booking the appointment.

4.2.4. All appointments booked using the Routine ATC search are mapped to the Routine ATC Category on the ATC Summary Report in CHCS/EWSR.

4.2.5. MTF's using the Open Access appointing methodology cannot use the routine search to book appointments.

4.2.6. A "Not Met" count on the ATC Summary Report only occurs in the All Appointments Search Option. Choosing any appointment, of any type, that is greater than the Routine ATC standard, will get a "Not Met" count if there were no appointments available in the clinic/group with any of the providers that are part of the clinic within the Routine ATC Standard.

4.2.7. A patient refusal will be registered on the ATC Summary Report only in the All Appointment Search option. The system counts that appointment as a patient refusal if a patient:

- is offered an available appointment within the Routine ATC Standard, AND

- if the system finds that there are available appointments of any type with any providers with schedules in the clinic/group that are within the Routine ATC standard, AND
- the patient refuses, but agrees to a later appointment not within the Routine ATC Standard.

4.3. Choosing the Wellness ATC Category/Performing a Wellness ATC Search in CHCS/EWSR.

4.3.1. The Wellness appointment search is designated for patients who require preventive health maintenance care or an initial appointment with their PCM. Examples include periodic examinations, check-ups, screenings, physical exams, pap smears, eye exams, preventive health assessments, school physicals.

4.3.2. For EXACT MATCH searches, the system will display all WELL, WELL$, PCM, or PCM$ appointment types meeting Wellness ATC Standards from the date/time of the patient request.

4.3.3. During ALL APPOINTMENT searches, CHCS/EWSR displays all appointments of any type with all detail codes available within 28 days. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Wellness ATC standard and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected. In this case, the appointing agent must change the appointment type to WELL, WELL$, PCM, or PCM$ appointment types in order to complete booking the appointment.

4.3.4. All appointments booked using the Wellness ATC search are mapped to the Wellness ATC Category on the ATC Summary Report in CHCS/EWSR.

4.3.5. A "Not Met" count on the ATC Summary Report only occurs in the All Appointments Search Option. Choosing any appointment, of any type, that is greater than the Wellness ATC standard, will get a "Not Met" count if there were no appointments available in the clinic/group with any of the providers that are part of the clinic within the Wellness ATC Standard.

4.3.6. A patient refusal will be registered on the ATC Summary Report only in the All Appointment Search option. The system counts that appointment as a patient refusal if a patient:

- is offered an available appointment within the Wellness ATC Standard, AND
- if the system finds that there are available appointments of any type with any provider assigned to the clinic/group that are within the Wellness ATC Standard, AND

- the patient refuses, but agrees to a later appointment outside the Wellness ATC Standard.

4.4. Choosing the Specialty ATC Category/Performing a Specialty ATC Search in CHCS/EWSR.

4.4.1. The Specialty ATC category is used to book appointments for patients requiring an initial visit with a Specialist. The Specialty Search is also used to book Procedure Appointments.

4.4.2. CHCS/EWSR will automatically assign the Specialty ATC category to Routine Priority Consult/Referrals when booking a consult or referral. When you have a Routine Priority Consult, CHCS/EWSR automatically assigns the Specialty ATC category.

4.4.3. For EXACT MATCH searches, the system will display all SPEC, SPEC$, PROC, or PROC$ appointment types meeting Specialty ATC Standards from the date/time of the patient self referral or the date/time the referral is entered.

4.4.4. During ALL APPOINTMENT searches for self referral or consults, CHCS/EWSR displays all appointments of any type with all detail codes available within 28 days. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Specialty ATC standard and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected. In this case,
the appointing agent must change the appointment type to SPEC, SPEC$, PROC, or PROC$ appointment types in order to complete booking the appointment.

4.4.5. In referral/consult booking the appointment type does not have to be changed to match the referral priority. But in self-referral booking the appointment type does have to match the Specialty ATC standard to the SPEC, SPEC$, PROC, or PROC$ standard appointment type in order to complete the booking transaction.

4.4.6. In both self-referral and referral/consult booking the detail codes that do not match the patient's demographics (age, gender, patient access type) must be corrected by a booking agent with the appropriate security key.

4.4.7. All appointments booked using the Specialty ATC search are mapped to the Specialty ATC Category on the ATC Summary Report.

4.4.8. A "Not Met" count on the ATC Summary Report only occurs in the All Appointments Search Option. Choosing any appointment, of any type, that is greater than the Specialty ATC standard, will get a "Not Met" count if there were no

appointments available in the clinic with any of the providers that are part of the clinic within the Specialty ATC Standard.

4.4.9. A patient refusal will be registered on the ATC Summary Report only in the All Appointment Search option. The system counts that appointment as a patient refusal if a patient:

- is offered an available appointment within the Specialty ATC Standard, AND
- if the system finds that there are any available appointments of any type with any providers with schedules in the clinic that are within the Specialty ATC standard, AND
- the patient refuses, but agrees to a later appointment outside the Specialty ATC Standard.

4.5. Choosing the Future Search in CHCS/EWSR.

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

4.5.2. For EXACT MATCH searches, the system will display all EST, EST$ or GRP, GRP$ appointment types on the schedule within 28 days of the date/time the patient request or the date/time the referral is entered.

4.5.3. During ALL APPOINTMENT searches, CHCS/EWSR displays all appointments of any type with all detail codes available within 28 days. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Future Search Option and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected.

4.5.4 For primary care booking, the appointing agent must change the appointment type to EST, EST$, GRP, or GRP$ appointment types in order to complete booking the appointment. For referral/consult booking, the appointment type need not be changed.

4.5.5. All appointments booked using the Future CHCS/EWSR search option are mapped to the Future section displayed on the ATC Summary Report in CHCS/EWSR.

4.5.6. MTFs using the Open Access appointing methodology cannot use the Future search option in CHCS/EWSR to book OPAC appointments.

4.5.7. There will be no counts for "Not Met", "Met", or Patient Refusals when conducting Future searches. Appointments booked using the Future Search option and the Average Days waiting time computations are computed and displayed in the ATC Summary Report.

4.6. Choosing the Dental Routine ATC Category/Performing a Dental Routine ATC Search in CHCS/EWSR.

4.6.1. The Dental Routine appointment search is designated for patients who require preventive or routine dental care (e.g., dental examinations, periodic examinations, check-ups, screenings, etc.). This search will be used only when dental treatment clinics set up templates and schedule and book dental appointments using CHCS/EWSR.

4.6.2. For EXACT MATCH searches, the system will display all DROUT or DROUT$ appointment types meeting Dental Routine ATC Standards of 21 days from the date/time of the patient request.

4.6.3. During ALL APPOINTMENT searches, CHCS/EWSR displays all appointments of any type with all detail codes available within 28 days. An appointing agent can choose any appointment type to book, but may require a security key to correct/change the appointment type or detail codes (age, gender, patient access types). Appointment types that do not match the Dental Routine ATC standard and detail codes that do not match the patient's demographics (age/gender/patient access type) must be corrected. In this case, the appointing agent must change the appointment type to DROUT or DROUT$ appointment types in order to complete booking the appointment.

4.6.4. All appointments booked using the Dental Routine ATC search are mapped to the Dental Routine ATC Category on the ATC Summary Report in CHCS/EWSR.

4.6.5. A "Not Met" count on the ATC Summary Report only occurs in the All Appointments Search Option. Choosing any appointment, of any type, that is greater than the Dental Routine ATC standard, will get a "Not Met" count if there were no appointments available in the clinic/group with any of the providers that are part of the clinic within the Dental Routine ATC Standard.

4.6.6. A patient refusal will be registered on the ATC Summary Report only in the All Appointment Search option. The system counts that appointment as a patient refusal if a patient:

- is offered an available appointment within the Dental Routine ATC Standard, AND
- if the system finds that there are any available appointments of any type with any provider with schedules in the clinic that are within the Dental Routine ATC standard, AND
- the patient refuses, but agrees to a later appointment.

5. **Guidance on Meeting Standards Of Initial ATC Searches with Scenario.**

5.1. Met counts on the ATC Summary Report are registered either in the EXACT MATCH search option or when the ALL APPOINTMENT SEARCH option is used and there are available appointments of any type either on the enrolled patients provider's schedule if selected or on the schedules of any of the providers that are part of the clinic network and these appointments of are within the access standard.

5.1.1. Scenario: The Red Team of Family Practice consists of Dr. A, Dr. B, Dr. C and Dr. D. The appointing agent performs a Routine search in CHCS/EWSR for an enrolled patient that is empanelled to Dr. A in the Red Team of Family Practice. Once executing an EXACT MATCH and ALL APPOINTMENTS search she finds that there is a PCM$ appointment type available within the 7 day/10,080 minute standard in Dr. C's schedule. The appointing agent selects this PCM$ appointment, being allowed the security key, she is able to change this appointment to a ROUT appointment type and books the appointment. Even though the Routine Search was initiated and a PCM$ was initially chosen the appointment was not with the patient's PCM, but since it could be changed to a ROUT to match the ATC Category this booking episode generated a Met count on the ATC Summary Report.

5.2. Before initiating a search, appointment personnel should understand the patient's request. This enables choosing the most appropriate ATC category during the first call.

5.3. To ensure the ATC standard is met, the appointing agent, should find and BOOK an available appointment slot of any type (ACUT/$, ROUT/$, WELL$, SPEC/$, PCM/$, EST/$, PROC/$, GRP/$, OPAC/$) within the standard that corresponds to the chosen ATC Category. This could be in the EXACT MATCH or the ALL APPOINTMENT search options.

5.4. A count of Met on the ATC Summary Report is not dependant upon the appointment type booked. The appointment booked must be within the ATC standard to get a count of met.

6. **Guidance on Not Meeting Standards Of Initial ATC Searches with Scenario.**

6.1. Not met counts on the ATC Summary Report are registered only when the ALL APPOINTMENT SEARCH is used and there are no appointments available of ANY TYPE, within the access standard for any of the available providers within the group/clinic.

6.1.1. Scenario: The Red Team of Family Practice consists of Dr. A, Dr. B, Dr. C and Dr. D. The appointing agent performs a Routine search in CHCS/EWSR for an enrolled patient that is empanelled to Dr. A in the Red Team of Family Practice. Once executing an EXACT MATCH and ALL APPOINTMENTS search she finds no appointment of

ANY TYPE (meaning there are no ACUT/$, ROUT/$, WELL$, SPEC/$, PCM/$, EST/$, PROC/$, GRP/$, OPAC/$ within 7 days FOR ANY OF THE PROVIDERS IN THE RED TEAM and finally finds a ROUT appointment type on the 9th day and books the appointment. This booking episode just generated a Not Met count on the ATC Summary Report.

6.2. Appointment personnel should use the ATC searches that best represent the patient's request, even if they do not find available appointments within the ATC standard.

6.3. Not meeting ATC standards may be an indication of many factors to include but not limited to enrollment issues, increased demand, lack of capacity, provider mix issues, operations tempo, or not correctly determining the patient's request.

6.4. When booking an appointment that does not meet the ATC Standard, the CHCS/EWSR system will provide the following warning:

This appointment is outside the Access to Care Standard.
There are no appointments within the Access to Care Standard.

7. Guidance on Patient Refusals and Scenario.

7.1. A Patient Refusal is registered in the system when there ARE appointments of ANY TYPE available to the patient within the ATC standard for any of the available providers within the group/clinic and the patient is offered this appointment but prefers an appointment that is OUTSIDE the ATC standard. When this happens, a patient refusal count is generated on the ATC Summary Report.

7.1.1. Scenario: The Red Team of Family Practice consists of four Providers. The appointing agent performs a Routine search in CHCS/EWSR for an enrolled patient that is empanelled to the Red Team. Once executing an EXACT MATCH and ALL APPOINTMENTS search she finds that there are several appointments available within 7 days with the Red Team, but no appointments with the patient's PCM. The appointing agent offers appointments to the patient that are within the ATC Standard with other providers of the Red Team, but the patient prefers to be seen by their PCM and elects to take an appointment on the 9th day, which is outside the 7 day/10,080 minute ATC Standard. The appointing agent books this ROUT appointment type that is available on the 9th day. This booking episode generates a Patient Refusal on the ATC Summary Report.

7.2. The system will register a patient refusal even if other providers in the group or clinic were not searched and appointments were available of any type inside the ATC standard.

When this happens, the system displays the following warning when this occurs:

> ***This appointment is outside the Access to Care Standard.***
> ***Earlier appointments are available that meet the Access to Care Standard.***

7.3. Score Computation for the ATC Summary Report for Patient Refusals Example:

MET rate for an ATC category = # MET booked for that category/ (total # booked for that category - # patient refusals for that category).

8. Facility and Patient Cancellation Impact on the ATC Summary Report.

8.1. Facility Cancellations:

8.1.1. An appointment cancelled by the facility will be counted as NOT MET on the ATC Summary Report unless immediately rescheduled within the original access standard. Appointment agents may cancel an appointment by accessing existing Cancel by Facility functionality using CHCS menu path (CA>PAS>S>M>CMSC).

8.1.2. The Facility Cancellation (CA>PAS>S>M>CMSC) menu path or Notify option (Menu Path of CA>PAS>S>NOT>CNOT) should be used to reschedule the appointment within the ATC Standard of the initial appointment request. To avoid the Not Met count, appointing agents must cancel the appointment in CMSC (Cancel by Facility) and immediately answer 'Yes' to the prompt to process the patient's new appointment. Mission may dictate MTFs accepting "Not MET" appointments.

8.1.3. The agent will select the CNOT or Facility Cancellation function and should reschedule the patient in CNOT immediately. Provided the agent does not change patients, the Not Met count will convert to a Met count if the patient is appointed within the access standards, calculated from the original appointment request date.

8.2. Patient Cancellations:

8.2.1. Each appointment cancelled by a patient will be included in the Access to Care Summary report. An appointment cancelled by a patient will retain the Access to Care characteristics associated with the initial booked appointment, including the met, not met, or appointment refusal status.

8.2.2. If a single appointment slot is patient canceled multiple times, each cancellation is included in the ATC summary report, e.g. if a single appointment slot is patient cancelled

5 times, there will be five appointments with five Met, or Not Met or Patient Refusals counted on the ATC Summary Report.

9. Miscellaneous factors impacting counts on the ATC Summary Report:

9.1. Appointments with final Status of Left Without Being Seen (LWOBS) and No Show will be included in the Access to Care Summary report. LWOBS and No-show appointments will retain the Access to Care standard associated with the initial, booked appointment, i.e., the Met, Not Met, or appointment refusal status.

9.2. Appointments with the final status of Walk-in and Sick call are unscheduled visits and will not be included in the Access to Care Summary Report. An appointment\visit must have an associated Access to Care category to be captured in the Access to Care Summary Report. ATC measurement functionality screens out Unscheduled Visits since Unscheduled Visits do not have an associated ATC category and are assumed to have met ATC standards.

9.3. Access to Care Summary Report information is captured for all booked workload status count and non-count booked appointments.

9.4. Appointments for both privileged and non-privileged providers are counted on the ATC Summary Report.

10. Program Categories on the ATC Summary Report:

10.1. Each time an ATC Category is chosen and an appointment is booked, the ATC functionality in CHCS/EWSR categorizes the patient receiving the booked appointment into one of 11 Program Categories on the ATC Summary Report. These categories are derived from groupings of related Health Care Delivery Program (HCDP) Codes. They are:

10.1.1. Non-Enrolled Active Duty

10.1.2. Enrolled Active Duty

10.1.3. Prime for AD Family Members

10.1.4. Prime for Retirees and Family Members

10.1.5. TRICARE Plus

10.1.6. TRICARE Senior Prime

10.1.7. TRICARE Standard

10.1.8. Direct Care Only

10.1.9. Not Eligible

10.1.10. Other

10.1.11. Status Unknown

10.2. It is recommended that Access Managers use this information to determine if appropriate access is being provided for the beneficiaries in the program categories listed above.

APPENDIX J

OPEN ACCESS APPOINTING

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OPEN ACCESS APPOINTING

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Foreword

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

1. What is Open Access Appointing?

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

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

In order to successfully implement the Open Access model, the physician's "bad" appointment backlog must be eliminated. "Bad backlog" represents appointments that have been made into the future and were built into an inventory as a result of common "carve-out" techniques used in many MTF clinics' appointment schedules. Many of these appointments are routine or follow-up and could be seen sooner rather than later. It is called "backlog" because this inventory of appointments results in a longer and more frustrating waiting time for the appointment. "Good backlog" is generally acceptable and consists of appointments made by patients who request an appointment other than today because of convenience or preference.

Templates need to be arranged to ensure that a clinician is in the clinic at least some time each day. Alternatively, a clinician pair can split days and a panel. If possible, the same clinician

should complete all the work needed to care for a patient, including follow-up work. Open Access may allow MTFs to re-examine the role of demand management programs.

2. Advantages/Disadvantages of Open Access Appointing.

The advantages of Open Access are the following:

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

Disadvantages include:

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

3. Prior Research is Key.

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

4. References. Post to TAI website

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

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

5. Leadership, Provider and Staff Commitment.

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

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

6. Specific Templating and Scheduling Guidance.

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

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

- The OPAC standard appointment type will be used to offer patients same day acute, routine, wellness, or follow-up primary care services. Every effort will be made to allow patients to see their Primary Care Manager (PCM) on the same day that they request an appointment by using the OPAC appointment type.

- It is recommended that no less than 60 percent of appointment slots on a Clinic's or Primary Care Team's schedule engaged in OA appointing will be the OPAC standard appointment type. However, this practice does not open the clinic into a full "walk-in" type service.

- To the greatest extent possible, all of the patient's issues are addressed in a single visit to minimize the need for unnecessary future appointments/repeat visits This may necessitate combining appointment slots.

- To search for the OPAC appointment type, appointing personnel must use the ACUTE Access To Care (ATC) Category in the Composite Health Care System (CHCS) Managed Care Program (MCP) that is mapped to the 24-hour ATC Standard.

- **OPAC Appointment Type Scenario.** Mrs. Jones has been experiencing a pain in her shoulder for a couple of days and calls the MTFs appointment line on Monday morning to schedule a visit with her PCM. The appointment clerk at the MTF, using the appropriate script, determines that she is a TRICARE Prime beneficiary enrolled

to Dr. Smith and using the Acute ATC Category in CHCS, searches for OPAC appointments with Dr. Smith, offering a specific appointment at 1400 on Monday afternoon; Mrs. Jones accepts. The clerk books the appointment and provides Mrs. Jones with the appropriate instructions for her appointment.

6.2. Appointment Types Used For OA appointing.

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

6.3. Appointment Types Not Used For OA appointing.

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

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

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

clerk documents the waiver of access standards using the prompts in CHCS, books the Good Backlog appointment and gives Mrs. Brown the appropriate instructions.

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

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

Advantages of Method One:

- Simple to template, only one appointment type for clerks to learn.
- Customer focused, as there is no differentiation between OPAC same day and OPAC Good Backlog appointment slots. OPAC is used for same day or Good Backlog appointments.
- Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care Category/CHCS search. Most times when booked, a Met or a patient refusal will be documented.
- Can be displayed on TRICARE Online (TOL) appointing schedules.

Disadvantages of Method One:

- There is no upfront template and schedule planning to identify the proper number or mix of Good Backlog appointments and same day appointments.

- There is no clear identification on the schedule of Good Backlog appointments for clerks or providers.

- There is a potential that there will be no preservation of same day access, meaning all appointments on future days will be booked.

- TOL appointment display does not differentiate between same day and Good Backlog appointments.

- Clerks cannot perform an appointment search by detail code.

- There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC) as they are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool of the TRICARE Operations Center URL: http://www.tricare.osd.mil/tools.

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

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

Advantages of Method Two:

- Allows upfront template and schedule planning, e.g. a 60 percent sameday/40 percent Good Backlog appointment ratio can be maintained.

- Easy for clerks and providers to identify slots on templates and schedules.

- Clerks are not required to change the appointment type to correspond with an initial Acute Access To Care/CHCS search. Most times when such appointments are booked, a met or a patient waiver of access standards will be documented.

- Appointment booking is faster since appointment types do not have to be changed.

- An appointment search by detail code can be performed to find Good Backlog appointments.

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

- There is less patient choice of Good Backlog appointments with this method.

- There is no easy way to measure usage as the appointment slots designated for Good Backlog (OPAC-GDBL) are the same standard appointment type as for same day (OPAC) and cannot be differentiated on various canned CHCS reports or on the Template Analysis Tool.

- More templating and scheduling work is required to add the detail code GDBL to the OPAC appointment type.

- OPAC-GDBL appointments are not available on TOL.

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

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

- Allows upfront template and schedule planning, e.g. a 60 percent sameday/40 percent Good Backlog appointment ratio can be maintained.

- Easy for clerks and providers to identify slots on templates and schedules.

- Separates provider directed follow-up (EST) slots from patient wanting a Good Backlog appointment (EST-GDBL).

- EST-GDBL allows for an easier measure of usage. These appointment slots are a different standard appointment type from the same day OPAC appointment type and can be differentiated on various canned CHCS reports or on the Template Analysis Tool.

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

- There is less patient choice of Good Backlog appointments.

- More templating work is required to add the detail code GDBL to the EST appointment type.

- TOL will not display EST appointments with the GDBL detail code.

- Clerks are required to change the EST appointment type to OPAC in order to book the appointment. CHCS requires the appointment type to correspond with an initial Acute Access To Care Category/CHCS search. There is a need to issue security keys for this activity.

Common Elements of Methods 1-3 for booking Good Backlog

- If Clinics opt for either method 1, 2, or 3, these methods may only be used to template and schedule good backlog services such as initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. Only OPAC and/or EST appointment types are used.

- There will be no differentiation made on the schedule for good backlog services by appointment types when using either method 1, 2, or 3. However, schedulers could create slots with longer or shorter time periods or use detail codes to assist clerks with discerning those slots that could be used for different types of services. Clerks will have to be trained to understand the difference, e.g., an OPAC-GDBL slot that is 45 minutes long may be used for a procedure or an initial specialty visit. Or an OPAC appointment that has 10 available slots at the top of the hour, and is one hour long and is coded with education detail codes could be used for a group service appointment. Clerks could be trained to split and/or join these appointments to allow for more patients to be booked depending on how far out into the future slots are available on the schedule.

- A risk of only using either method 1, 2, or 3 for templating and scheduling good backlog appointments is that there will be no appointments slots available to patients

requiring the following types of services: initial provider PCM visits, wellness visits, initial specialty care visits, procedures, provider directed follow-ups or group appointments. It is a risk because these slots are not readily identifiable to the clerk.

- Use of other detail codes is addressed in Paragraph 6 below.

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

- If using method 4, schedulers will use the standard appointment types of, PCM, WELL, SPEC, PROC, EST or GRP in accordance with the definitions as listed in Appendix H of the Commander's Guide for Access Success.

- The advantages of using one or all of the appointment types to include, PCM, WELL, SPEC, PROC, EST or GRP allows for their immediate recognition by appointment clerks to schedule various services that the clinic offers other than OA or good backlog appointments. Templates and schedules can be easily apportioned to allow for advanced planning of services.

- Allows upfront template and schedule planning, e.g. a 60 percent OPAC/40 percent other appointment types.

- If using method 4, clerks can use two methods to search for and book, PCM, WELL, SPEC, EST and GRP appointments. They are:

    - Use the Acute ATC Category to search for and book these appointments. By using the Acute ATC Category/CHCS search, the clerk will be required to change the appointment type of, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type. If there are no appointments of any of these types available on the same day, a patient refusal will be documented. When using this searching method, Clinics may want to additionally code the slot with a GDBL detail code, to tell the clerk that these, PCM, WELL, SPEC, PROC, EST, or GRP appointment slots can be searched for and booked using the Acute ATC Category/CHCS search instead of their traditional appointing ATC Category.

    - Use the appropriate/traditional ATC Category/CHCS Search. If the clerk learns at the beginning of the patient request for service a need for a specialty care consult request, or for a provider directed follow-up after an initial visit with the PCM, or if the clinic conducts a program such as "Right Start," or for a provider directed Group visit or class, the clerk can conduct the appropriate traditional search to book the needed appointment. The clerk can use the

appropriate Routine, Wellness, Specialty, or Future ATC Category/CHCS Search. By doing so, there is no need for the clerk to change the appointment type from, PCM, WELL, SPEC, PROC, EST, or GRP to the OPAC appointment type.

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

- In accordance with CHCS functionality, up to 4 detail codes can be used on each appointment slot. Clinics are encouraged to use detail codes sparingly. Detail codes are used to restrict access to the appointment slot for a particular need such as designating that slot for a particular procedure, reserving a slot for a specific class, or to permit only a certain group of beneficiary to be booked into the slot, such as Active Duty or TRICARE Prime.
- Use of detail codes will be in accordance with Appendix M.

- The GDBL/Good Backlog Detail Code is meant to facilitate OA appointing.

    - GDBL/Good Backlog Detail Code. This detail code will be used to code a Good Backlog appointment slot. This slot will be used for patients who decline an offered same day OPAC appointment in favor of an appointment on a future date other than the same day of the request, or provider directed future appointments, e.g. follow-ups, initial specialty visits, procedures, group appointments. The GDBL detail code can be used in combination with the, PCM, WELL, SPEC, PROC, EST or GRP standard appointment types available for OA appointing.

6.7. Bad Backlog in Open Access Appointing.

- **Definition of Bad Backlog.** Bad Backlog in the open access model refers to a situation in which an MTF can not reasonably accommodate a beneficiary's request for a same day appointment. Bad backlog in the ATC Summary Report refers to the Access to Care standard of providing an acute appointment within 24 hours (1440 minutes) of the request. .NOTE: "book an appointment on a future date" is an expression of time and does not refer to the booked to future ATC Category/function in CHCS.

- **Bad Backlog Scenario:** SSgt Powell needs to be seen for an earache and calls the appointment line at 0830 on Thursday morning to schedule a visit with his Primary Care Manager. The appointment clerk, using the appropriate script, determines that he is TRICARE Prime and enrolled to Dr. Sharp. Knowing that Dr. Sharp is unavailable, the clerk asks SSgt Powell if he would like to be seen by another provider and SSgt Powell accepts. Using the Acute ATC Category in CHCS, the clerk searches for OPAC appointments with the other PCMs in the clinic and finds no

available appointments. The clerk then communicates this lack of appointments to the nurse who tries to work SSgt Powell into an appointment on the same day schedule, but cannot. The clerk then tells SSgt Powell there is nothing available on Thursday and offers an appointment at 0800 on Friday with Dr. Blocker. SSgt Powell accepts the appointment and the clerk provides the appropriate instructions. NOTE: In this scenario, the MTF met the acute ATC standard of 24 hours, however, it did not meet the same day standard of Open Access. Therefore this situation constitutes bad backlog under the OA model, however will not be reflected as bad backlog on the ATC Summary Report.

7. Identifying Capacity and Demand.

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

8. Planning Supply of Appointments in Open Access Appointing.

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

9. Enrollment Aspects of Open Access Appointing.

Maintenance of provider panel sizes to manageable levels is critical. OASD/HA policy suggests a maximum of 1,500 enrollees per Primary Care Manager (PCM). Under Open Access, civilian guidelines suggest a capacity as low as 800 and as high as 2500 enrollees per PCM . There is no absolute numerical key to the proper PCM to panel ratio. Open Access success has less to do

with empirical figures than with the assurance that PCM and support staffs are consistently available to handle the patient demand. Most failures occur when demand for appointments is undermined by the loss of a patient provider for extended periods of time, the burden of the panel has to be taken up unexpectedly by another provider, and nursing and support staff becomes unduly stressed. Proper coordination and planning for provider absences allows for flexibility and response to the patient's requirements.

10. PCMBN and Continuity Aspects of Open Access Appointing.

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

11. 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.

11.1. Appointment Availability.

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

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

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.

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

11.3. Continuity (appointment is with PCM).
Examine continuity from the perspective of how often a patient sees his or her assigned PCM when seeking care.

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

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

11.6. **No-Shows**.
In sites that have implemented Open Access, the percentage of patients who fail to show up for scheduled appointments dropped significantly. The metric is of interest because no-shows represent a waste of appointment supply.

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

11.8. Satisfaction Measures

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

a. **Patient Satisfaction** – Using trend analysis, what effect did implementing Open Access have on patient satisfaction? MTFs may develop survey methods that provide statistically significant results. How do patients feel about having the option of an appointment on the same day they call the office? Do they feel that they are getting better quality, more timely care? MTFs may utilize existing patient satisfaction surveys collected by the MTF or the parent Service.

b. **Staff Satisfaction** – What effect did Open Access have on staff and provider satisfaction? Do providers get to see their own patients more often? Do providers feel their patients are getting more timely treatment? Do providers and staff feel that patients are more satisfied? Do they have adequate administrative time?

12. Open Access Implementation and Sustainment Analysis.

- This OA implementation and sustainment analysis is available to assist sites with implementing and sustaining OA appointing.

- MTFs may need to check with their respective higher headquarters, to ensure all requirements are met before moving to OA appointing.

This analysis is most effective if all parts are addressed. The level of detail is at the discretion of the MTF/clinic/Primary Care Team implementing OA appointing. This analysis plan should identify the Primary Care Clinics and Primary Care Teams contemplating a move to OA appointing..,. Completing this plan enables the MTF to fully analyze its present and future business processes and make an informed decision. regarding the feasibility of OA appointing.

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

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

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

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

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

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

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

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

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

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

- What process for searching for and booking appointments is used?
- What appointment types and detail codes are used?
- Are there scripts or algorithms on hand for appointing agents to use?
- How are provider absences covered?
- What is the training level and competency of appointing agents to include contract, active duty, and/or civilian appointing personnel?

- How far in advance are schedules available for booking?
- How are templates and schedules developed and controlled?
- Is your system for appointing centralized or decentralized?
- What are your medical records location(s) and rate their availability?
- What is your clinical and support staff availability?
- What is your customer satisfaction with present services?
- Do you have any achievements with present appointing practices?
- Do you have any problems with present appointing practices?

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

12.2.1. Determine Population Demographics.

- Enrolled Population. Identify the Active Duty and Non Active Duty Prime. beneficiaries. The objective of this analysis is to define the beneficiary population and predict demand.

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

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

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

Stopped work on 07/11/07

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

- Civilian Benchmark. Civilian benchmarks are probably the quickest method to estimate demand. Mark Murray, MD, MPA Healthcare Consultant, a pioneer of Open Access appointment, states .75% of an enrolled population will seek care on a given day. To use this method, simply multiply your MTFs enrollment by .0075. That will provide you an estimated number of appointments needed per day. This rate may be lower than your actual utilization rates for your facility, since Dr. Murray is using rates for civilian healthcare institutions where demographics and barriers to care may be different than those in the military

- MTF Utilization rate. Historical MTF annual utilization rates are more accurate estimates of primary care utilization. You can obtain these rates using your MTFs visit data from MEPRS, or MHS or parent Service's tools and/or reports. Obtain both monthly and annual utilization rates per enrollee. To estimate the number of primary care visits your facility will need to deliver during a 12-month period. Multiply your MTFs annual utilization rate by the number of MTF enrollees. For a monthly rate, multiply your MTFs monthly utilization rate by the number of monthly MTF enrollees it has enrolled. This analysis assumes the MTF has essentially the same number of providers as it did in the years previous and has no loss of any present year primary care services, e.g., MTF had a pediatrician in CY2005, but lost to PCS in CY2006 with no replacement. Then you need to divide the annual count by 12 for a monthly count and (utilize 18 workdays for Air Force and 21 workdays for Army and Navy) for a daily count of appointment slots that your primary care clinic requires. MHS Policy recommends that a good general planning factor for a primary care utilization rate is 3.5 visits per enrollee per year These methods provide a historical view of those patients that received care, but did not provide a picture of those patients that were deflected, or had unmet demand.

- Demand Analysis Process. Conducting a full-blown demand analysis provides the most accurate demand analysis. This will take additional time and effort to complete. The foundation of a demand analysis starts with capturing historical demand. Historical demand does not necessarily depict all the actual demand. It is necessary to consider the following factors and make necessary adjustments. (This list is not an inclusive listing of data sources):

- Telephone statistics (call volume, abandonment rates)
- Emergency Room/Urgent Care/ Fast Track/Acute Care Clinic visits
- Care deferred to network (Pop Off or Self Initiated ER/Urgent Care)
- No-show rates/LWOBS/Patient Cancellations
- Clinical Preventive Service Backlog
- Un-booked appointment report numbers and rates
- Waitlist numbers and rates

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

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

- This is obtained by counting all of the booked into the future appointments to obtain the total number.

- Appointments booked into the future can be divided into two groups, "good" backlog, and "bad" backlog. Good backlog consists of patients who were offered but declined an appointment for today, and also patients instructed to book a follow up appointment in the future. All other future booking is considered bad backlog, because it represents work that could have been done today.

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

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

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

- Average Waiting Time Method. This approach monitors appointments booked in relation to when they are requested. This average waiting time is determined by counting every requested appointment based on the time it was booked. For example, an appointment booked today counts as "0", tomorrow as "1", 2 days out as "2", etc. The waiting time for every booked appointment on a given day is summed and divided by the total number of appointments booked. This gives an average waiting time for appointments. The more appointments booked today (day "0"), the lower the average waiting time for appointments. If all appointments were booked for the current day, then the average waiting time would be "0". This data should be obtained from the "canned" Access To Care Summary Report contained on the local CHCS host.

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

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

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

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

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

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

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

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

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

12.4.3. Assess your MTFs ancillary services capability to handle the increase in same-day appointing. Identify laboratory, radiology, and pharmacy's role and ability to adequately support OA in your potential OA clinics/PCM teams during normal and contingency operations.

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

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

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

12.6. MTF Goals for Open Access Appointing.
Identify the goals your MTF wants to achieve in the areas of access, controlling backlog, reducing waiting times, keeping percent of same day work completed high, increasing provider/Clinic continuity, and provider, staff, and patient satisfaction.
Goal examples would be:

- 60 percent of requests for care treated on the same day
- Acute Access To Care Met Standard: 90 percent

- Backlog of 150 appointments on the books at any given time
- Overall OA Clinic average waiting time less than 1 days

12.7. Discuss Strategies For Implementing OA Appointing.
Develop plan for working down bad backlog, increasing continuity, optimizing supply to meet demand, and maximizing office efficiencies.

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

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

12.7.2.1. Panel Size. Develop panel sizes based on number, age, acuity, and gender of empanelled beneficiaries and the provider's experience, other local requirements to include mission and GME.

12.7.2.2. Template/Schedule Management. For the potential OA areas, the MTF needs to have processes in place to answer the following questions:

- What appointment types are going to be used? e.g. OPAC, EST, PROC.
- What method of Good Backlog appointing is going to be used?
- With the appointment types mentioned above, for what services are these appointment types going to be used?
- What detail codes are going to be used? e.g. GDBL, WEA.
- What is your plan for creating, controlling, opening templates and schedules? What, Who, When, Why?
- What is going to be the number of slots required per day for each day of the week?
- How will your potential areas schedule wellness services such as pap smears, physical exams, preventive health assessments, and procedures, etc?
- What are the rules for splitting and joining appointment slots?
- How will the potential OA Clinic(s)/Primary Care Team(s) network (CHCS file and table) be constructed?
- What is the TRICARE Online OA appointing plan?

12.7.2.3. Appointing Process Guidelines. OA implementation plans should contain guidance on the following:

- Use of OA appointing scripts/ algorithms for the appointing personnel
- Training of appointment personnel who book appointments under OA
- Guidelines to ensure that patients are not directed to call back if appointments are full
- Guidelines on use of appointing automatic reconfiguration function
- Guidelines for booking patients whose PCMs are on leave or absent
- Guidelines on facility cancellations
- Guidelines on ending the clinic day
- Guidelines on extending the clinic day
- Guidelines on overbooking patients
- Guidelines on "walk-in/sick call" patients
- Guidelines on changing appointment types
- Guidelines on patients not wanting to take appointment offered
- Guidelines on booking follow-up appointments prior to patient leaving the clinic
- Guidelines on provider book only, MTF book only
- Guidelines on the administration of appointing security keys
- Guidelines on planned down days, restricted days, training days, lunch time coverage
- Guidelines on "no shows", "late shows," and "left without being seen"
- Guidelines on "un-booked" searches
- Guidelines for telephone consults

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

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

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

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

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

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

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

12.8. Develop Open Access Measures and Metrics.

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

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

12.9. Clinics and Primary Care Teams combining traditional and Open Access Appointing. Define and analyze the appointing method relationships of

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

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

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

13. Open Access Appointing Marketing.

13.1. General Marketing Guidance.

- The decision to market open access directly to the patient and/or to local command leadership will be the choice of the MTF commander. Experience has shown that marketing OA in this manner has advantages and disadvantages.

- Regardless of what marketing strategy that is employed, all MTFs employing OA must continue to deliver care that is within the 32 CFR 199.17 ATC standards.

- Each MTF must employ a marketing strategy that is tailored to the population it serves and allows for success of its OA program.

13.2. "No Marketing" Strategy Considerations.

- For this no marketing strategy the MTF has two choices:
  - Market the 1-7-28 day access promise and keep the appointing strategy transparent
  - Market only when the new OA practices has had a reasonable success rate and the transition period had been established and proven

- MTFs that employed a no marketing strategy should make all activities during the OA transition period invisible to the beneficiary. The only thing that the patient should recognize is their increased ability to get an appointment on the same day.

13.3. Partial or Total Marketing Strategy Considerations.

- MTFs will need to be cautious as to how they label their OA program, as it influences patient behavior and/or expectations. Recommended labels are Open Access or Same Day appointing.

- If marketing OA directly to patients, MTFs should use the OA appointing definitions as stated in appendix.

- MTFs may want to request support from the local command leadership as the clinic/PCM team works down bad backlog during the transition from traditional to OA appointing by minimizing base/post taskings for support.

- A possible way to market OA is to let patients know that the MTF is transitioning to a new appointing method to improve its ability to deliver on the 24 hour, 7 day, and 28 day access standards.

APPENDIX K

IMPROVING ACCURACY IN ATC MEASUREMENTS

1. Improving Accuracy in ATC Measurement.

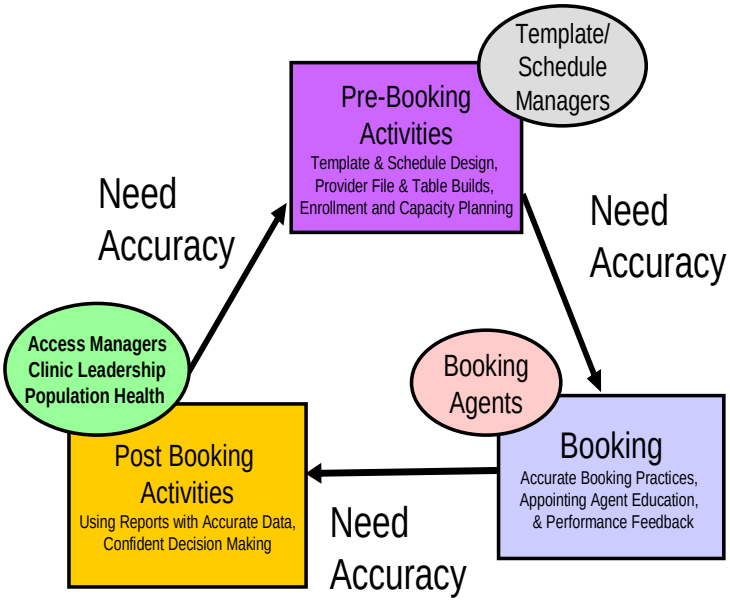
1.1. There are three important activities that greatly impact the accuracy of access to care measurement. They include:

1.1.1. Managers forecasting the demands of the supported/enrolled population and designing templates that best meet those needs of the enrolled population.

1.1.2. Appointing agents using the schedule generated from these templates book appointments, the goal of which is to accurately match patients' needs and access requirements as efficiently as possible.

1.1.3. Reports generated in the booking process allow Access Managers to confidently evaluate and manage the performance of this cycle. See Figure 1.

Figure 1. Cycle of Access to Care Accuracy and Improvement



1.2. Pre-Booking Activities The way templates, schedules, provider files and tables and enrollment/capacity in CHCS are set up can greatly impact on the accuracy of ATC measures. If done properly it can lead to a more efficient use of a provider's

time, their increased satisfaction with their day-to-day work, make it easier for the appointing agents to find and book appointments and can improve customer service.

1.2.1. Recommended Template and Schedule Design Actions.

Template/Schedule managers should:

1.2.1.1. Ensure that standard appointment types are used on each slot and match the Standard Appointment Type definitions listed in Appendix H of the MHS Guide for Access Success.

1.2.1.2. Discuss with MTF/Clinic/Team providers the types of services they want or need to provide based on their capabilities, experience level and the demand patterns of the population served/enrolled.

1.2.1.3. Consider the demographic make up of the patients that the MTF/clinic/team/ provider serves and how much access these entities can provide based on the following:

1.2.1.3.1. Enrollment status of the patients

1.2.1.3.2. The ages of the patients

1.2.1.3.3. Patient gender

1.2.1.3.4. Number of TRICARE Online (TOL) web-enabled appointments to be offered

1.2.1.3.5. The mission of active duty units

1.2.1.3.6. The disease entities of the population

1.2.1.4. Decide whether to use or not to use patient access, age, or gender detail codes to identify/set aside slots in the templates.

1.2.1.5. Establish appointment type durations for each provider to assist them to efficiently execute their schedules, based on their practice patterns, abilities, and provider experience levels, etc.

1.2.1.6. Establish workload count flags on appointment types to support proper workload accounting for the providers, nurses, and technicians on the schedules.

1.2.2. Provider File and Table Builds. Provider File and table builds/structure in CHCS have great impact on ATC measurement results and in supporting effective/efficient booking of patients to their providers. Template/schedule managers need to:

1.2.2.1. Confer with their medical staffs and leadership to define the File and Table information needed to complete the CHCS Provider Group, to include numbers of providers, places of care, MEPRS codes and support personnel. **Note: Ensure place of care matches the MEPRS code.**

1.2.2.2. Ensure that File and Table builds balance continuity of care with access to care standards.

1.2.2.3. Decide with group, team and clinic leadership, the search parameters appointing agents will use when searching for appointments. Depending on how the CHCS Provider Groups are established for an MTF, the appointing agents may search for available appointments using a wide range of search combinations to include:

1.2.2.3.1. With the PCM only

1.2.2.3.2. With the PCM in multiple places of care

1.2.2.3.3. With a provider as a member of multiple Provider Groups with consideration for cross booking.

1.2.2.3.4. With a provider as a PCM in one, multiple, or all MCP Provider Groups with consideration for cross booking.

1.2.2.3.5. With nurses, technicians, or part-time providers with schedules in the group

1.2.2.4. CHCS ATC functionality searches for available appointments across the entire group, and will indicate if there are available appointments inside or outside the standard, even though the appointing agent did not search other group providers' schedules.

1.2.3. PCM Enrollment, Capacity Planning**.** Schedule/template managers should work with providers, clinic managers and enrollment managers to establish enrollment panels/capacities. Factors such as numbers of enrollees, ages, genders, unit mission, a population's epidemiology/acuity level, etc. have great impact on access, and the level at which customer service is delivered. Other factors include:

1.2.3.1. PCM flags in CHCS need to be correctly set for each PCM allowing the system to automatically match the patient to their provider.

1.2.3.2. Panels/capacities for PCMs need to match their abilities and experience and mission requirements.

1.2.3.3. Effective enrollment management at the MTF enhances the Managed Care Support Contractor's (MCSC) ability to enroll patients.

1.2.3.4. Properly coordinated enrollment management gets the right patient to the right provider. This improves the appointing agent's chances of booking the patient faster with the right provider.

1.2.3.5. Provider absences should be identified before schedules are opened, e.g. meetings, leaves, TDYs, Admin time, Comp time need to identified so that part-time providers can be used, or cross booking can be arranged to enhance continuity of care.

1.3. Booking Activities.

Appointing agents play a critical role in ensuring access measurements are accurate. Management needs to ensure appointing agents are trained and routinely receive feedback on their performance in booking appointments. The booking of appointments provides data to reports. These reports impact management decisions on the development of templates, schedules, files, tables and ultimately the MTF's ATC performance.

1.3.1. Steps to take to Accurately Book Appointments**.**

1.3.1.1. Appointing agents need to identify the patient, their provider and clinic/group in order to book the appointment. If the templates, schedules, files, tables, enrollment panels/capacities are properly identified as in paragraph 1.2 above, this makes the booking activity easier, faster for appointing agents.

1.3.1.2. Instructions and protocols need to be in place to assist the appointing agent to accurately match the request of the patient to the correct ATC Category in CHCS.

1.3.1.3. Appointing agents need to categorize the patient's request in terms of either being Acute, Routine, Wellness, Specialty, or Future as accurately as possible before booking the appointment.

1.3.1.4. Appointment agent searches for and selects the appropriate appointment slots, at the time, with the provider that match the patient's needs and his/her age, enrollment status and gender.

1.3.2. Managing Booking Personnel to Enhance Accuracy.

1.3.2.1. Take care of "your people". Access managers must understand that appointing agents at all levels of the MTF are the ones that are responsible to accurately book appointments. Their activities control the daily schedules of providers, and have impact on access and customer satisfaction.

1.3.2.2. Staff education and re-education is required to ensure that ATC searches are appropriate for the care required.

1.3.3.3. Appointing personnel need to understand the business rules of PCM and Referral Booking tables outlined in Appendix R of this guide.

1.3.3.4. Access managers must provide appointing agents with feedback on their performance on a recurring basis. MTFs may develop reports demonstrating appointing agent performance in accurately booking appointments within ATC standards.

1.4. Post Booking Activities. Access Managers must realize that if appointing agents accurately book appointments the data generated from these activities feed CHCS, TRICARE Operations Center and Service level tools and reports that produce information that better reflects what is actually happening in the MTF. Use of these data enables managers at all levels to be more confident in developing templates and schedules and managing access. Some actions available to access managers are:

1.4.1. Using appointing activity reports to better match the supply of appointments (the plan) with the expected demand for appointments (reality) for the <u>mix</u> and <u>quantity</u> required to meet patients' needs and ATC standards. These are defined as follows:

1.4.1.1. The mix is defined as having enough appointments of each type to provide appointing agents a sufficient supply to meet various patients' requests for service when using the Exact Match search option. Example: When using the Routine Search option, there are ROUT appointments displayed. A well forecasted appointment mix reduces the likelihood of having to change appointment types during the All Appointment search option, reducing steps and expediting service to customers.

1.4.1.2. Quantity is defined as having a sufficient number of appointments, of any type, within ATC standards, to meet demand when using the All Appointment search.

1.4.2. Use historical appointment data reports when building future schedules and templates. For example, identify the demographics of patients and the historical demand for care, to include various wellness services such as pap smears, school physicals, well baby exams, etc. when building templates and schedules for wellness care.

1.4.3. Use the Access to Care Summary Reports (ATCSR) to forecast future appointment needs.

1.4.4. Use the ATCSR counts and percentages of Met, Not Met appointments, and patient refusals by provider, to forecast future schedules and verify accuracy of that forecast.

1.4.5. Use the various CHCS Management Reports to identify appointment type usage and non usage, beneficiary type usage, and multiple others types/categories of data.

1.4.6. Use the Unbooked Appointment Report in CHCS to determine numbers of patients who requested an appointment but for whom none was booked. This allows for the determination of unmet demand and if there is a need for more appointments to be added on the schedule.

1.4.7. Use the Planned versus Final Booked Appointment Report in CHCS to assess the types and volume of modifications made to appointments in order to complete the booking function. This allows the manager to adjust templates and schedules to minimize modifications during booking.

1.4.8. Use un-booked (unused) appointment data to identify appointments that are targets for auto-reconfiguration.

APPENDIX L

REFERRAL MANAGEMENT

APPENDIX L

REFERRAL MANAGEMENT

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APPENDIX L

REFERRAL MANAGEMENT

This appendix provides general guidance for all services in the management of referrals and requests for Right of First Refusals (ROFR):

1. Referral management processes in the Military Health System (MHS) will be accomplished at a minimum as follows:

1.1. All MTFs should have one centralized referral management Point of Contact (POC).

1.2. Referrals will be entered into Composite Health Care System (CHCS)/AHLTA on the CHCS Referral Ad Hoc.

1.3. Direct Care initial routine priority specialty care referral appointments will be booked via Appointment Order Processing (AOP) in CHCS within 28 calendar days or per provider direction not to exceed 28 calendar days. The Access to Care measurement clock starts at the time the referral is entered into CHCS/AHLTA.

1.4. Direct Care initial specialty care referral appointments will be booked via AOP prior to the patient leaving the MTF when feasible.

1.5. Direct Care initial specialty care referral results will be rendered by specialty providers in CHCS/AHLTA within 72 hours of the initial direct care specialty encounter. in accordance with (IAW) OASD HA Policy 98-007

1.6. Direct Care Initial specialty care referrals will be closed out in CHCS automatically once results are rendered and reviewed by the referring provider.

1.7. To meet The Joint Commission (TJC), American Accreditation Association for Health Care (AAAHC), and Service Inspection Agency requirements, referring providers are required to review and sign-off on referral results in CHCS/AHLTA.

1.8. All Initial specialty care referrals refused by patients will be closed out in CHCS with appropriate clinical documentation as to the reason of their refusal.

1.9. Direct Care Initial routine priority specialty care referrals appointed outside the 28 day standard will reflect the reason why the standard was not met.

1.10. The use of “Paper” referrals is strongly discouraged, if CHCS/AHLTA is available. If paper referral is used, initial specialty care referral results will be rendered by the specialty care provider, forwarded to the referring provider via the Referral Management Center (RMC) for signature and appropriate clinical annotation, and then filed in the patient’s medical record.

1.11. All initial specialty care referrals will be tracked and accounted for to conclusion (from referral generation to results received by referring provider and signed-off).

2. Administration of request for Right of First Refusals (ROFRs):

2.1. Within Prime Service Areas, MTFs have the Right of First Refusal (ROFR) for all referrals. MTFs will determine which referral requests they want to receive based upon specialty capability and capacity. The Managed Care Support Contractor, (MCSC) will provide ROFR requests prior to medical necessity and covered benefit review to provide MTFs the opportunity to accept ROFR requests.

2.2. MTFs will accept or decline ROFRs and respond back to the MCSC within one business day for routine ROFRs and within 30 minutes for 72 hour ROFRs. When no response is received from the MTF in response to the ROFR request within one business day (30 minutes for 72-hour ROFRs), the MCSC shall process the referral request as if the MTF declined to see the patient. For greater clarity refer to the TRICARE Operations Manual (TOM) or your local MTF Memorandum of Understanding (MOU) between MTF and/or MCSC.

2.3. Initial specialty care ROFR appointments should be booked via Appointment Order Processing (AOP) within 28 calendar days or per provider direction not to exceed 28 calendar days. The clock starts at the time referrals are entered into CHCS/AHLTA.

2.4. MTFs which accept ROFR referrals should provide Clear and Legible Results (CLR) directly to the referring purchased care system provider within 10 calendar days of the initial specialty ROFR encounter.

3. Definitions:

3.1. Referral. The act or an instance of referring a TRICARE beneficiary to another authorized provider to obtain necessary medical treatment for a specific medical issue. The treatment may entail an admission, procedure, or a specialty referral/consult.

3.2. Referral Management Center (RMC). A central MTF office identified for the management of specialty care referrals. The RMC is responsible for accounting for and tracking all referrals.

3.3. Right of First Refusal. Specialty care referrals written by a provider in the civilian network providing care for an eligible beneficiary that are sent to the MTF by the MCSC for consideration of whether the MTF has the capability and capacity to

provide care as defined in the MTF's capability list. It is the method for determining if an MTF has the specialty capability as reflected in the capability list, has an available specialty care appointment, and can make that appointment within the Access to Care standards which state that specialty care must be appointed within 28 calendar days or sooner if so requested by the referring provider.

4. References:

4.1. TRICARE Operations Manual (TOM) 6010-51M, updated 20 Mar 08, Change 62,

4.2. Assistant Secretary of Defense, Health Affairs Policy 98-007, Policy for Specialty Care Consultants, dated 7 January 1998,

4.3. Assistant Secretary of Defense, Health Affairs Policy 98-036, Policy for Specialty Care Standards and Authorizations, dated 11 May 1998,

4.4. Assistant Secretary of Defense, Health Affairs Policy 03-026, Personnel on Medical Hold, dated 29 October 2003,

4.5. Assistant Secretary of Defense, Health Affairs Policy 06-007, TRICARE Policy for Access to Care and Prime Service Areas, dated 21 February 2006,

4.6. Assistant Secretary of Defense, Health Affairs Policy 7-022, TRICARE Prime Access Standards for Mental Health Care, dated 9 October 2007,

4.7. AFMS MTF Referral Management Center (RMC) Users Guide, current edition located at the AFMS Knowledge Exchange.

APPENDIX M

DETAIL CODES

APPENDIX M

DETAIL CODES

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APPENDIX M

DETAIL CODES

DETAIL CODE INSTRUCTIONS

The following is the current list of standard codes for the four Appointment Detail Fields. Up to four of these codes may be used for any one appointment slot. MTFs should attempt to keep detail code use to a minimum. Extensive use of detail codes can decrease overall access. Patient Access Types, Age codes, and Gender codes can increase access for pre-defined categories of patients. Detail codes may help clerks search for appointments with specific attributes.

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

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

USE OF DETAIL CODES

1. General Principles

1.1. Detail codes may assist appointing personnel in rapidly identifying and searching for appointment slots with special requirements. The appointment system enables clerks to search by detail code.

1.2. Detail codes are utilized to further define appointment type definitions on templates and schedules. This appendix and Appendix N contain the approved list with definitions of standard detail codes for the Appointment Detail Fields. There are approximately 240 Standard Detail Codes with over 60 that describe procedures.

1.3. Detail codes are descriptors of the following:

1.3.1. Equipment, personnel and/or facility resources needed for the appointment

1.3.2. Patient enrollment status (patient access types) for the category of patient for whom the appointment is designated.

1.3.3. Patient age ranges for which the appointment is designated.

1.3.4. Detail code to web enabled appointment slots

1.3.5. Patient education, counseling classes

1.3.6. Readiness care slots

1.3.7. Specifying the gender of patient for whom the appointment is designated

1.3.8. Classification of provider designated for the appointment slot.

1.3.9. Dental care

1.3.10. In addition to the web enabling detail code, other specific detail codes must be used to web enable appointment slots for TOL.

1.3.9. Up to four detail codes may be assigned to any appointment slot. The sequence of these detail codes is irrelevant.

1.4. If standard appointment types, e.g. ROUT, SPEC, adequately define the requirements of an appointment slot, detail codes should not be needed. Any patient may be booked into this appointment slot.

1.5. Use of detail codes is optional. MTF access managers should work with the Clinic Leaders and providers to decide which detail codes, if any, are required on various appointment slots.

1.6. The automatic reconfiguration function can be used to transform un-booked appointment slots by changing/removing detail codes. This allows unrestricted booking of that appointment slot.

2. Guidance on the Use of Age Detail Codes.

2.1. Age detail codes are the only detail codes that may be created by MTFs without approval by the TRICARE Management Activity (TMA) or Service's Headquarters.

2.2. MTFs can tailor appointment slots to allow patients of certain ages into these slots, by adding MTF defined age codes to the detail code field. The appointing and web appointing systems (TOL) automatically permit a patient in the age range defined by the MTF to be booked into that appointment slot. MTFs can use age detail codes to schedule various pediatric, adolescent, or geriatric care for their beneficiaries.2.3. Age codes must adhere to the following formatting standards and include a time buffer so patients can book early or late:

2.3.1. Correct formats include an age range with a lower and upper limit and a hyphen.

2.3.2. M indicates age in months plus or minus 60 days. Example: 3M-6M represents a patient between 3 and 6 months of age.

2.3.3. D indicates age in days plus or minus 14 days. Example: 3D-21D represents a patient between 3 days and 21 days of age.

2.3.4. W indicates age in weeks plus or minus 14 days. Example: 1W-6W represents a patient between 1 and 6 weeks of age.

2.3.5. a number alone indicates age in years plus or minus 30 days. Example: 0-12 represents a patient between 0 and 12 years of age.

2.3.6. a hyphen is the only allowable separator between the upper and lower age range

2.3.6. The low and high numbers are inclusive and the low age precedes the upper age limit.

2.3.7. Sites must add age detail codes to the Detail Code Table so that the system will recognize them.

2.4. Age defined detail codes can be used on appointments in conjunction with TRICARE Online appointing to match patients by age to the correct web based appointments.

2.5. The appointing information system and the web appointing system match the patient's actual age to the age detail code on the appointment slot to automatically permit or deny services to specific ages of patients, e.g. Grandpa, age 80 cannot be booked into a pediatrics appointment slot templated with a 1-18 age detail code.

3. Guidance on the Use of Gender Detail Codes.

3.1. MTFs can use gender detail codes. Patient gender detail codes ensure that the appointing information system matches the correct gender patient to the correct gender detail code on the appointment slot. Gender detail codes are as follows:

3.1.1. FE-Female

3.1.2. MA-Male

3.2. Gender detail codes can be used in conjunction with TRICARE Online appointing to identify correct genders of patients booking web based appointments e.g. appointments with FE will only display to female patients.

3.3. The appointing information system and the web appointing system match the patient's gender status to the gender detail code on the appointment slot and will automatically permit or deny services to a beneficiary with a different gender, e.g. A male patient cannot be booked into a PAP appointment slot templated with a FE detail code.

4. Web Enabled (WEA) Detail Codes.

4.1. MTFs will use the WEA detail code to identify all the appointments slots the MTF wants to make available for display and booking via the TRICARE Online (TOL) appointing functionality. For more specific information on setting up TOL appointing see Appendix U.

4.1.1. Appointments without the WEA detail code cannot be displayed to the patient for booking on TOL.

4.1.2. Appointment slots with WEA detail codes are available both to MTF appointing personnel and to TOL users on a first come, first serve basis for booking. The presence of a WEA detail code on an appointment slot does not prevent appointing personnel from booking these appointments through telephone or walk-up requests.

4.1.3 Appointment slots with a WEA detail code plus other detail codes that are not the permitted detail codes (e.g., other than Patient Access Types, Gender Codes, and Age Codes) will not display on TOL for web booking. The system cannot ensure that the patient will be booked appropriately in this case

5. Guidance on the Use of the Provider Book Only (PBO) Detail Code.

5.1. Definition: The PBO detail code is used if an individual provider needs to have control over booking a particular appointment slot. The use of the PBO detail code restricts booking by other members of the clinic, MTF staff, central appointing function staff, and/or within the multi-market office.

5.2. MTFs should develop and publish instructions as needed on the use of the PBO detail code to define appropriate providers, services and patients for appointment slots with PBO detail codes.

5.3. It is strongly recommended that the PBO detail code should be limited to appointment types (PROC, GROUP, SPEC) where provider designation or patient screening protocols need to be completed. It is also strongly recommended that the

PBO detail code NOT be used on appointment types designated for urgent, same day or routine access to care.

6. Guidance on the Use of the Cross Book (CB) Detail Code.

6.1. The CB detail can be used to designate appointment slots in other clinics/primary care team's/group's and/or clinic provider's schedules for patients who are unable to get care with their own provider or group, e.g. patient enrolled to PCM A in Team A is cross booked to a provider in Team B.

6.2. The CB detail code appointment slots can be added to schedules for "floater/fill-in" providers, or regular enrolled PCMs or providers and/or clinic staff to equal the same number of daily slots that would have been made available if a missing provider(s) slots were on the schedule. For example, if the missing provider(s) daily available slots were 25, then 25 CB detail coded slots could be added to "floater" or staff provider's schedules to maintain the same number of slots in the clinic for the cared for population.

7. Detail Code Approval Process

7.1. 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. 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. 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. A standard definition for the detail code should accompany the request explaining how the detail code should be used across the MHS. The detail code must fit into one of the following categories: (1) patient access types, (2) procedure or test, (3) evaluation or education, (4) provider classification, and (5) multi-use/miscellaneous.

Step 2. The MTF then forwards its request to the appropriate office as defined by their Service. The service will analyze the need for the new detail code(s), review them against existing detail codes, eliminate duplicates, and refine the definition as necessary, coordinating with the appropriate consultant in their region. The goal of the Access Manager review is to have a commitment to the proposed detail code's necessity and either concur or not concur for its need. If the detail code is not approved, the action stops for the code and the submitting MTF will

be notified. If approved, the code will be submitted to TMA for coordination with all Services.

Step 3. TMA will then review with the Services one final time for necessity and duplication and consistency with policy. If all Services and TMA agree on necessity and lack of duplication and adherence to policy, then the Access Manager for the originating Service shall forward the System Change Request (SCR) to the TMA Access to Care Information Manager for appropriate action. Once approved the new detail code will be published in the *MHS Access to Care Guide.* If an issue is identified, the Service Access Manager will consult with the Chief, Medical Officer/Clinical Director of TMA for clarification or further action.

7.2. To ensure continuity, each Service will publish their process to their tenant commands.

8.0. Figures and Tables of Appendix M. Listed in the remaining pages of this appendix are figures and tables of categorized detail codes. Below listed is the name of the figure and table:

8.1. Figure M-1, Instructions on the completion of the Military Health System/Information Management Information Management Submissions Form.

8.2. Figure M-2, Example of a completed IM Submission Form.

8.3. Table M-1, Alphabetical definition listing of all Detail Codes.

8.4. Table M-2, Patient Access Type Detail Codes.

8.5. Table M-3, Procedure and Test Detail Codes.

8.6. Table M-4, Education and Evaluation Detail Codes.

8.7. Table M-5, Provider Classification Detail Codes.

8.8. Table M-6, Multi-Use, Miscellaneous Detail Codes.

Figure M-1: Instructions on the completion of the Military Health System/Information Management Information Management Submissions Form

** Services will utilize the attached format and refer to sample for Detail Codes Submissions.

MILITARY HEALTH SYSTEM/INFORMATION MANAGEMENT INSTRUCTIONS FOR COMPLETING THE IM SUBMISSIONS FORM

Purpose: To provide the form and instructions for submitting new requirements or changes to Military Health System (MHS) automated information systems (AISs).

Who Should Use This Form: Any member of the MHS who would like to recommend:

- A change to an existing MHS AIS
- A new capability that a MHS AIS should support.

How To Complete This Form: Refer to the form instructions on the following pages. Please complete as many of the fields as possible.

Where to Send This Form: Once completed, this form may be sent to TRICARE Management Activity, Information Management (IM) Division by email to: IMIT_Reqs@tma.osd.mil.

IM Response: A member of the IM Division will:

- Send you an email confirming receipt of your submission
- Provide you with a submission number.

Questions: Contact IM at IMIT_Reqs@tma.osd.mil

IM Submissions Form Instructions

The following instructions apply to completing the IM Submissions Form. The form can be found on the following page.

1. Date: Enter the date on which you are submitting your recommendation.

2. Short Descriptive Title of Change or New Capability: Enter a one sentence explanation of the MHS AIS change or new capability that you are recommending and its standard use

3. Outside Tracking Number (used by Originator, if any): Enter your tracking number (if any) that may already be associated with your recommendation (e.g., tracking number from a help desk).

4. Urgency (High, Medium, Low): Use the table below to determine the urgency of your request.

5. **Justification for High (for High priorities only): Specific details on how the request meets the criteria as defined in the table below **MUST** be provided to have this request considered as a High Urgency.

Urgency	*Definition*
High (Justification must be provided)**	Jeopardizes patient safety, information security, or accomplishment of a mission essential capability **AND NO FEASIBLE WORK-AROUND EXISTS**.
	Adversely affects technical, cost, or schedule risks to the project or to the life-cycle support of the system **AND NO FEASIBLE WORK-AROUND EXISTS**.
Medium	Adversely affects the accomplishment of an operational or mission essential capability; *however* a feasible work-around solution is known.
	Adversely affects technical, cost, or schedule risks to the project or to life-cycle support of the system; *however* a feasible work-around solution is known.
Low	Results in user and operational inconvenience or annoyance but does not affect a required operational or mission essential capability.
	Other changes or features considered "nice to have."

6. Potential System(s) Impacted: Identify Information Systems (MHS, Service or other, if applicable) that may be affected if your recommendation is implemented

7. Description of Change/New Capability: Briefly describe (1 – 4 sentences) the change or new capability that you would like to see implemented.

8. Projected Benefit: Describe the benefit that MHS AIS users will realize should your recommended change or new capability be implemented. What is the impact if this submission is not implemented? Include any references to regulations/guidance upon which this request is based. (*A copy of the exact citation/regulation is required.*)

9. Policy Change/Addition: Identify any change to known policy (TMA, MHS, DoD, other) or if new policy decisions will be necessary to implement this recommendation.

10. Functional Proponent: Identify the key stakeholders for this recommendation.

11. Originator's Name/Title: Enter your name and title, as the Originator. The originator must be government civilian or military personnel.

12. Originator's Agency/Address: Enter your organization and its complete mailing address.

13. Originator's Phone/Fax/Email: Enter your phone (including DSN, if available), Fax number, and Email address

14. External Funding Source: If this change is being funded by a source other than Central MHS, e.g. Services.

15. Existing MHS Requirements Repository Requirement IDs affected by this Submission (if known):

16. Existing MHS Operational Architecture/Health Data Management products affected by this Submission (If available or known, attach copies of products or provide the URL of where these products may be found.)

Figure M-2: Sample IM Submissions Form
for:
MHS Automated Information Systems
Changes or New Capabilities

1. Date: Oct 8, 2007

2. Short Descriptive Title of Change or New Capability: Patient Categories (PATCAT)s do not update to match beneficiary status in DEERS, i.e. Active Duty sponsor converts to RET in DEERS and displays as SPONSOR RETIRED. However doesn't update CHCS PATCAT. and by means of accidentally identifying an individual then the families are manually updated????. Need to also add a new PATCAT to identify those family members that are dependents of RES/NG units so reports that are being requested by the BG can be provided.

3. Outside Tracking Number (if any): MHS TICKET 1116994 OCT 8, 2007

(Help Desk Ticket #, SIR #, SCR #, Requirement Number, etc)

4. Urgency (Select one): High☒ **Medium**☐ **Low** ☐
(*See table on instruction page*)

5. **Justification for High Urgency: The change is required to provide a more accurate reporting on beneficiaries enrolled to sites for data pulls/DQ and to calculate enrollment to a PCM By Name (PCMBN) by PATCAT available assignment. Causes more time in assigning PCMBN when PATCAT is assumed one thing and is another. A PCMBN can't be assigned till the PATCAT manually corrected. Patient may be sent downtown in error and incur charges.

6. Potential System(s) Impacted: M2, CHCS Enrollment, AdHoc, Cam Rpt, etc

7. Description of Change/New Capability: Cause an impact when running reports to capture accurate number of patients by PATCAT. Causes problems in Enrollment in terms of payment/PITs. These have to be updated as identified manually. Will impact the APS III load when utilizing the patient's demographic information to map to an appropriate booking logic.

8. Projected Benefit: Improve accuracy of reporting.

9. Policy Change/Addition: This will affect **No** known policies, however it will enable better M2, CHCS AdHoc/Cam reporting data.

10. Functional Proponent: CHCS, MCP/PAS

11. Originator's Name/Title: John Smith, Health System Specialist

12. Originator's Agency/Address: Kimbrough Amb Care Ctr, Managed Care Division, Ft Meade, MD 20755-5800

13a. Originator's Phone: 301-677-8481

13b. Originator's Fax: 301-677-8603

13c. Originator's Email: John.Smith@na.amedd.army.mil

14. External Funding Source (if known):

15. Existing MHSRR Requirement IDs affected by this Submission (if known):

16. Existing MHS Operational Architecture\Health Data Management products affected by this Submission (If available, attach copies of products or provide the URL of where these products may be found.):

TABLE M-1: DETAIL CODES WITH DEFINITIONS

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	Acupuncture	Acupuncture: Used to identify patients who are seeking acupuncture 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.	

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.	

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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
38a	CB	Cross Book	This appointment is reserved for a patient who is not empanelled to this PCM. Should be used to restrict the slots that are available to patients that are not empanelled 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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
50	COUNS	Counseling Only	Counseling Only: A universal detail code that precedes other STANDARD comments (e.g. BTL, Gene, and 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.	
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	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
53	DEXA	DEXA Bone Scan	Dual Energy X-ray 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	
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	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
64	EDU	Education or Class	Education or classes: A universal detail code proceeded 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.
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

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.	

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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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 that make visits at individual homes.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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
120	MOBEX	Mobilization Intervention & Exercise Therapy, Sports Medicine Only	Mobilization Intervention & Exercise Therapy: Requires technician assistance and equipment monitoring.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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 evaluation 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 that 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.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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).	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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. (i.e. Plast Surg, Ophth, ENT). Procedure requires specific equipment.	
146	PLASMA	Plasma	Plasma: Procedure requires specific equipment.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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).	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
160I	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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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 ultrasound.	
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.

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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.	

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.
187a	VAERS	Vaccine Adverse Event Reporting	Vaccine Adverse Event Reporting: Reserved for patients treated under the Vaccine Adverse Event Reporting System.	

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
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.	
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

ITEM NBR	STANDARD ABBR	DESCRIPTION	DEFINITION	Additional Instructions/ Comments
196	WOUND	Wound Care	Wound Care: Appointments must be reserved to accommodate the variable number of patients who require same-day wound care.	
198	WT	Warrior in Transition	Designates care for warriors in transition	

APPENDIX M

DETAIL CODES

The following five tables show the standard detail codes grouped by one of the following detail code categories: (Table M-2) patient access types, (Table M-3) procedure or test, (Table M-4) evaluation or education, (Table M-5) provider classification, and (Table M-6) multi-use/miscellaneous.

Table M-2	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

Table M-3	Procedure and Test Codes	
ACUP	Acupuncture	
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	
CIRC	Circumcision	May use with EDU or other comments that may apply
COLON	Colonoscopy	
COLPO	Colposcopy, abnormal pap required	
CORSCR	Cornea Scrape/Rescrape	

Table M-3	Procedure and Test Codes	
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	
DEXA	DEXA Bone Scan	
DEXPR	Dental Exam/Prophylactic Cleaning	
DIL	Dilation	
DOMFS	Oral Maxillofacial Surgery	
DOPER	Operative Dentistry	
DORTHO	Orthodontics	
DOSIM	Methocholine & CPEX	
DPEDO	Pediatric Dentistry	
DPERIO	Periodontics	
DPRO	Dental Prophylactic Cleaning	
DPROS	Prosthodontics	
DSGCH	Dressing/Bandage Change	
DTMD	Temporomandibular Disorders	
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	
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	

Table M-3	Procedure and Test Codes	
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	
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	
NPSYC	Neuropsychological Testing Only - No ADHD	
NST	Non Stress Test (fetal monitoring during pregnancy)	
OAE	Newborn Hearing Screening	
PACE	Pacemaker	
PAP	Pap Smear	
PARA	Abdominal Paracentesis	
PEG	Percutaneous Endoscopic Gastrostomy	
PFT	Pulmonary Function Test/Spirometry	
PHOTO	Photos	
PLASMA	Plasma	

Table M-3	Procedure and Test Codes	
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	
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	

Table M-4	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	

Table M-4	Education and Evaluation Codes	
BF	*Breast Feeding*	Use with EDU. *New Oct 2003*
BEPC	Birth and Early Parenting Class	
BFC	Breast Feeding Class	
CARD	Cardiac Counseling/Care	
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	
DEVAL	Dental Evaluation	
DEXAM	Dental Examination	
DPO	Dental Post-Operative Visit	
DSC	Dental Sick Call	
DVIOL	Domestic Violence Class	
EAR	Ear Recheck	
EDU	Education or Class	Combine with other detail codes.
ER	Emergency Room Follow-Up Appointment	
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	
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	

Table M-4	Education and Evaluation Codes	
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	
RP2	Research Protocol 2	
RP3	Research Protocol 3	
RP4	Research Protocol 4	
RP5	Research Protocol 5	
RP6	Research Protocol 6	
RP7	Research Protocol 7	
RP8	Research Protocol 8	
RP9	Research Protocol 9	
RP10	Research Protocol 10	
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.
TOUR	Hospital Orientation	
VAERS	Vaccine Adverse Event Reporting	
WCE	Work Capacity Evaluation	

Table M-5	Provider Classification Codes	
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.

Table M-6	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.
CHOL	Cholesterol	
CM	Case Management	
COB	Complicated OB Patient Only	
DERM	Dermatology	Perform as primary care or specialty care in a multi-specialty clinic.
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	
GENE	Genetics Consult	
GYN	Gynecology Appointments Only	
HC	House Calls	

Table M-6	Multi-Use/Miscellaneous	
HCDC	Hearing Conservation Patient	
HTN	Hypertension Patient	
INF	Infant Care	
MA	Male Patient Only	
MH	Mental Health	Perform as primary care or specialty care in a multi-specialty clinic.
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	
PBO	Provider Book Only	
PDS	Pathfinding/Drill Sergeant Test	Candidate for cancellation
PP	Post-Partum Patient Only	
PRENAT	Prenatal	
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	
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

1. Use of Patient Access Types.

1.1. Patient Access Type detail codes allow an appointment slot to be reserved and booked to a patient with a specific enrollment/eligibility status.

1.2. All Patient Access Type detail codes are defined in this appendix for reference.

1.3. The MHS's primary mission is to provide care to Active Duty and Prime patients, so Patient Access Type detail codes used on template and scheduled appointment slot can ensure that TRICARE Prime and Active Duty receive priority for care.

1.4. MTFs can limit non-enrollee access to appointments or tailor schedules to allow quotas of slots to be booked for Space Available or TRICARE Standard patients, e.g., for specialty care or for non-enrollees requiring care overseas.

1.5. The appointing information system and the web appointing system match the patient's enrollment/eligibility status to the Patient Access Type on the appointment slot to automatically permit or deny services to specific kinds of beneficiaries, e.g. Active Duty only, TRICARE Plus patient, or can be booked into appointments with BPNAP but not BPAD or BPAP.

1.6. MTFs should use only one Patient Access Type detail code per appointment slot. The information systems only recognize the first Patient Access Type on the slot.

1.7. Patient Access Type detail codes can be used in conjunction with TOL appointing to identify the appropriate enrollment status of patients booking web-based appointments.

1.8. The Patient Access Codes should be used to reserve appointments for beneficiaries to meet TRICARE contract quotients.

The Patient Access Type codes are special detail codes in the Detail Code table and are defined below.

2. Patient Access Types

Code	Description
BPAD	Active Duty, DoD CONUS Affiliates
BPPR	Prime Enrollees Only, No Active Duty, DoD CONUS Family Member Affiliates, No TRICARE Plus
BPAP	Active Duty and Prime, DoD CONUS Affiliates and Family

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

3. 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.

3.1. Active Duty *(BPAD)* — Uniformed Services Personnel (regardless of where or whether they are enrolled), guard and reserve on active duty, NATO, CONUS DoD Sponsor Affiliates, 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.

3.2. Prime *(BPPR)* — Family members of Uniformed Services Personnel, retirees, and retiree family members, who are enrolled in TRICARE to any local or remote MTF, plus CONUS DoD Family Member Affiliates 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.

3.3. 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.

3.4. 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.

3.5. 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, CONUS DoD Sponsor Affiliates, 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.

3.6. No Prime *(BPNPR)* — Non-active duty Prime enrollees from the local MTF or remote MTFs, contractor enrollees, CONUS DoD Family Member Affiliates 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 providers whose contracts specify that they may not treat Prime patients.

3.7. No Active Duty, No Prime *(BPNAP)* — TRICARE Standard, TRICARE Reserve Select, 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 Available.

3.9. 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.

3.10. 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.

3.11. TRICARE Standard *(BPTS)* — Active Duty family members, retirees, and retiree family members who are entitled to TRICARE reimbursement for civilian care rendered, and TRICARE Reserve Select. This type supports the contract revised financing requirement to capture TRICARE eligible non-enrollees who would otherwise go downtown.

APPENDIX O

BUILDING PROVIDER FILES AND TABLES IN CHCS FOR ACCESS TO CARE

APPENDIX O

BUILDING PROVIDER FILES AND TABLES IN CHCS FOR ACCESS TO CARE

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APPENDIX O

BUILDING PROVIDER FILES AND TABLES IN CHCS FOR ACCESS TO CARE

1. INTRODUCTION

1.1. Appendix D, Building Provider Files and Tables in Composite Health Care System (CHCS) for Access to Care is included in the MHS Guide for Access Success to provide a reference for all Access Managers and CHCS users on solutions for the correct definition of the Provider Direct Care Structure. The objective of this appendix is to optimize access to care in the outpatient setting and ensure that a provider's appointments will display during booking.

1.2. The Provider Structure is defined in CHCS and/or Enterprise Wide Scheduling and Registration (EWSR) system. This appendix explains how to build provider files and tables both from a functional and technical perspective. A broad overview is provided initially followed by an explanation with sufficient technical detail to guide users through the complex file and table building process. This appendix provides four stand-alone sections that include complete instructions on how to build profiles for Provider Groups, Places of Care, and Providers and how to link them. Alerts describe the data elements that must be completed or appointments will not display. The design of a Civilian group is also covered in Section 2since MTFs may employ civilian providers or wish to document direct care or civilian care in civilian facilities. Building a civilian group within the MTF is strictly for referral/consult purposes. NOTE: Consult is for Evaluate Only; Referral is for Evaluate and Treat.

1.3. The three critical objectives of this appendix are:

1.3.1. Understand the impact of the Provider File and Table Structure on a clinic's ability to meet or not meet access standards.

1.3.2. Learn how to build the Provider File and Table Structure so appointments display to appointing agents within and across clinics and MTFs.

1.3.3. Ensure appropriate access for an enrollee to his/her PCM first, and, if the PCM is not available, to the PCM's Group Members wherever they practice within the enrolling MTF.

2. TERMS AND DEFINITIONS

2.1. The following definitions clarify the unique usage of terms in the CHCS Managed Care Program (MCP) module on screens and reports.

2.1.1. **Division** – an MTF at the child level that provides health care to Military beneficiaries as an accountable unit**.**

2.1.2. **Provider** – any person (MTF and civilian, physician, nurse, physician assistant, technician, etc.) who provides clinical care to patients seen in MTFs.

2.1.3. **Provider Group –** one or more providers who collectively provide health care to TRICARE enrollees or non-enrolled beneficiaries and cover each others' patients. The group is usually a Primary Care group with Primary Care Managers (PCM) but may also be a Specialty group.

2.1.4. **Network** – the total set of health care providers (direct care and civilian) who are designated to provide care to TRICARE beneficiaries at specified Places of Care in the MTF or in the civilian community. Sometimes refers only to civilian locations and providers.

2.1.5. **Managed Care Program (MCP) –** a module of the Patient Appointing System (PAS) that defines and supports the TRICARE Managed Care Provider Structure build. This module guides appointing functions in CHCS and EWSR, including appointing for Prime patients to their Provider Groups.

2.1.6. **Managed Care Support Contractor (MCSC)** – one of the TRICARE contractors assigned to perform claims processing, enrollment, Medical Management, and other TRICARE functions for their TRICARE region.

2.1.7. **Core Files** – basic files shared by all modules of CHCS that contain data common to most of those modules, e.g., Hospital Location file, Patient file, Provider file.

2.1.8. The **Hospital Location** record contains core data about any Direct Care or Civilian location where MHS health care may be provided, including inpatient, outpatient, dental, surgical, ancillary, etc.

2.1.9. The **Place of Care** record is stored in the Hospital Location file as the Clinic Profile and contains core data describing and controlling processing specific to the outpatient clinic. This profile carries the MEPRS code for workload reporting; this MEPRS code is assigned to every appointment booked to this location.

3. PROVIDER FILE AND TABLE FUNCTIONAL DESCRIPTION

3.1. The Provider File and Table Structure is a composite of three sets of data: Provider Groups, Places of Care, and Providers. The Provider File and Table Structure identifies the relationships and organization of providers, provider groups, and the places of care where the providers practice as well as the type of clinical care provided by each provider at each location. Individual providers must be assigned to at least one group and may be assigned to multiple Provider Groups and/or multiple Places of Care and/or multiple MTFs on a CHCS

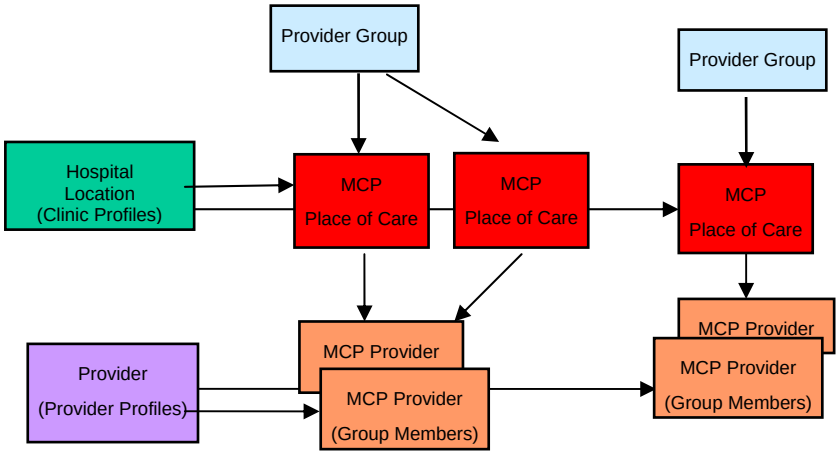
host. For example, a provider may practice at two locations, National Naval Medical Center in Bethesda, Maryland and at Walter Reed Army Medical Center in Washington DC, and belong to different groups in each location. CHCS uses this information to find and present appointments to appointing staff when booking patients.

3.2. The following chart displays two sample designs for the relationships between the five CHCS files used to define the Provider Structure. The Provider File and Table Structure integrates profile data from two CHCS core files into appointment processing:

3.2.1. Provider profile data is integrated into the Provider Appointing data.

3.2.2. Hospital Location profile data is integrated into the Place of Care data.

MCP PROVIDER FILE AND TABLE RELATIONSHIPS



The Provider File and Table Structures above show the elements used by CHCS to search for, display, and book appointments. CHCS searches user selected Places of Care in Provider Groups for the providers and specialties practiced in those Places of Care. Place of Care and Provider Profiles are used to control processing, build schedules, and display appointments.

3.3. **Provider Groups**: The Provider File and Table Structure defines Provider Groups as sets of primary and specialty providers. Direct Care Providers may be a mix of individual Uniformed Service, Government Civilian, or Contract Civilian providers and are generally grouped by clinic specialty and/or practice location. Every provider must belong to a group, even if they are the only provider in the group. Groups are defined in the MCP Provider

Group file. Every enrollee is enrolled to a Provider Group as well as a PCM and Place of Care. The data that must be entered/updated to create a Group include:

3.3.1. The Group name.

3.3.2. All Places of Care where Group Members practice.

3.3.3. All providers with their specialties practicing in the Group's Places of Care.

3.3.4. A total group enrollment capacity that restricts the overall number of enrollees assigned to individual providers.

3.4. **Places of Care**: The Provider File and Table Structure defines Places of Care **as** the locations (clinic or branch clinic) where health care will be provided. These are records in the Hospital Location File and are either an MTF clinic/location or a non-MTF (civilian) location. Locations may be logical or physical and may support outpatient, ambulatory surgery, dental, or ancillary care. A Provider can practice at multiple Places of Care in the MTF, in civilian network practice locations, and/or civilian out of network clinics. The important data that must be updated for a Place of Care (referred to in CHCS as the Clinic Profile) include:

3.4.1. All the providers that practice in this Place of Care and have appointment schedules.

3.4.2. The clinic specialties supported.

3.4.3. The workload indicators for the work performed (Medical Expense Performance and Reporting System (MEPRS) and count/non-count).

3.4.4. If applicable, enrollment capacity and age limitations by beneficiary category to limit and balance the panel of enrollees assigned to the Place of Care within the Group.

3.4.5. Valid appointment types and appointment type characteristics shared by providers practicing in the Place of Care.

3.4.6. Access to Care and Self-Referral activation flags.

3.4.7. Record processing and patient notification indicators.

3.5. **Providers**: The Provider File and Table structure must define any provider who will care for a beneficiary if that care is to be documented in CHCS or AHLTA. Local Credentialing Offices are responsible for verifying credentials and overseeing provider

privileges. CHCS System Administrators/Clinic Access Managers are responsible for creating the role-based security initial provider data; the Managed Care office updates the Provider's Appointing Profile. Providers include MTF providers, civilian providers (signs an agreement with the MHS to provide care at a discount), and non-network providers (no agreement with the MHS to provide care and bills according to their practice's rate schedule). The data that must be updated include:

3.5.1. Provider demographics.

3.5.2. The provider's credentialed specialties.

3.5.3. Valid appointment types for the provider's schedules each with durations, workload data, etc.

3.5.4. Places of Care where the provider practices.

3.5.5. For a PCM, the enrollment capacity and age limitations by beneficiary category for the individual providers within the Place of Care to limit the numbers and types of enrollees assigned to the PCM.

3.5.6. For a PCM, the PCM flag to identify a provider within the group as a PCM for a specific provider specialty, e.g. Pediatrician who is a PCM, but also has an Allergist Specialty.

3.5.7. The specialty referral flag indicates whether this provider (either physician or technician) can treat patients for a specified provider specialty when requested in a consult. **This flag MUST ALWAYS BE SET TO 'YES' OR SCHEDULES WILL NOT DISPLAY FOR BOOKING. Also if not set to 'Yes', referrals cannot be booked for this Specialty to this Place of Care.**

3.6. The following business rules apply to the design of the CHCS Provider Structure.

3.6.1. Defining a Group.

3.6.1.1. A Group must have at least one Place of Care and one provider.

3.6.1.2. A Group may have multiple Places of Care with multiple providers in each Place of Care.

3.6.2. Defining Places of Care.

3.6.2.1. Must be assigned to a Provider Group in order to participate in appointing.

3.6.2.2. May be assigned to multiple Groups.

3.6.2.3. A Place of Care must have been assigned providers with schedules in order for appointments to display for booking.

3.6.3. Defining Providers.

3.6.3.1. Each provider must be a member of at least one group and at least one Place of Care.

3.6.3.2. A provider may be a member of multiple Groups simultaneously.

3.6.3.3. Any provider may practice at multiple Places of Care.

3.6.4. Defining PCMs.

3.6.4.1. A PCM must be assigned to at least one Group and one Place of Care in order to participate in appointing.

3.6.4.2. A PCM may be in multiple Provider Groups and multiple Places of Care within each Group simultaneously.

3.6.4.3. In order for an enrollee to be assigned to a PCM, six data elements must be defined for the PCM in CHCS. This data is sent to DEERS where it is accessed by the MCSC during enrollment. A PCM must have the PCM flag set as follows. Select the following in order:

3.6.4.3.1. A Division (MTF), **then**

3.6.4.3.2. A Provider Group at the MTF, **then**

3.6.4.3.3. One of the Group's Places of Care, **then** the provider, **then**

3.6.4.3.4. A provider's specialty supported by the provider at that Place of Care, and finally

3.6.4.3.5. Set the PCM flag to Yes.

3.6.4.4. Once a PCM is defined, Enrollment Capacities must be assigned to the Provider Group, Place of Care, and the PCM to allow the MCSC to enroll patients to the PCM. Enrollment levels by beneficiary category are optional but recommended

to balance the panel and match the clinician's capabilities, i.e., active duty, active duty family members, retirees, retiree family members, and TRICARE Plus patients this PCM will accommodate

3.7. **Planning the Provider File and Table Structure.**

3.7.1. Before entering data into CHCS, clinics must evaluate and select a model for their Provider Files and Tables. CHCS supports a very flexible application tool for defining the Provider Structures. Provider Groups, Places of Care, and Providers 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.

3.7.2. Some considerations include:

3.7.2.1. File and Table builds have great impact on Access to Care (ATC) measurement results, especially WAM and RVU values.

3.7.2.2. Appointment personnel need to confer with their medical staffs to determine the best design.

3.7.2.3. Appointment personnel need to confer with the AHLTA experts. It now takes at least six weeks to create a CHCS clinic in AHLTA.

3.7.2.4. File and table builds need to balance:

3.7.2.4.1. Health care access - making sure that the enrolled beneficiary is seen by his/her PCM or Group member.

3.7.2.4.2. Health care timeliness - making sure that the beneficiary receives an appointment within the ATC Standard of 24 hours, 7 calendar days, and/or 4 weeks (28 calendar days).

3.7.3. Sample design alternatives have been provided by actual MTFs on the following pages and explain how relationships are established between the three files. The benefits and limitations of each design are described under each chart. The following business rules apply to booking to and among Provider Groups in CHCS and will be referenced in the designs shown below. **Note**: Referral as shown below denotes a referral to a Primary Care Provider Group for care not available with an enrollee's PCM Group, not a specialty care referral.

3.7.3.1. **Requires a Referral.**

3.7.3.1.1. An enrollee booked to a Primary Care Provider who is in the enrolling MTF but not in the enrolling Group.

3.7.3.1.2. An enrollee booked to their PCM in a place of care not in the enrolling MTF.

3.7.3.1.3. An enrollee booked to another PCM who is not in the enrolling MTF.

3.7.3.1.4. The exceptions to this rule are Operational Forces members. The Provider File and Table may be defined to allow operational forces appointments to a PCM in a place of care that belongs to a different enrolling division.

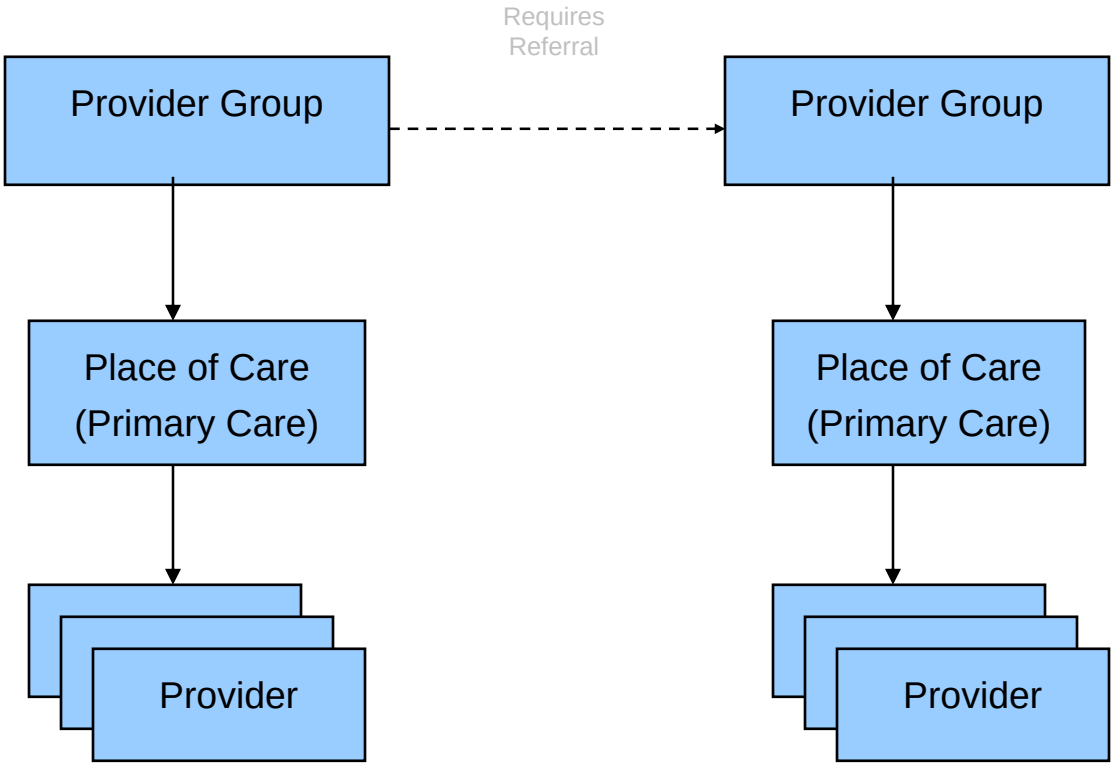
3.7.3.2. **Does Not Require a Referral.**

3.7.3.2.1. Enrollees booked to their PCM in the Place of Care, Group, and MTF they are enrolled to. This is the default appointing option for Primary Care in CHCS.

3.7.3.2.2. Enrollees booked to their PCM in another Place of Care in the enrolling MTF that is not their enrollment Place of Care and/or Provider Group.

3.7.3.2.3. Enrollees booked to a member of the enrollee's PCM Group in any place of care within the enrolling MTF where a Group member has schedules, e.g., a provider who floats or substitutes in multiple Primary Care clinics.

MCP File and Table Design
Single Group - Single Place of Care

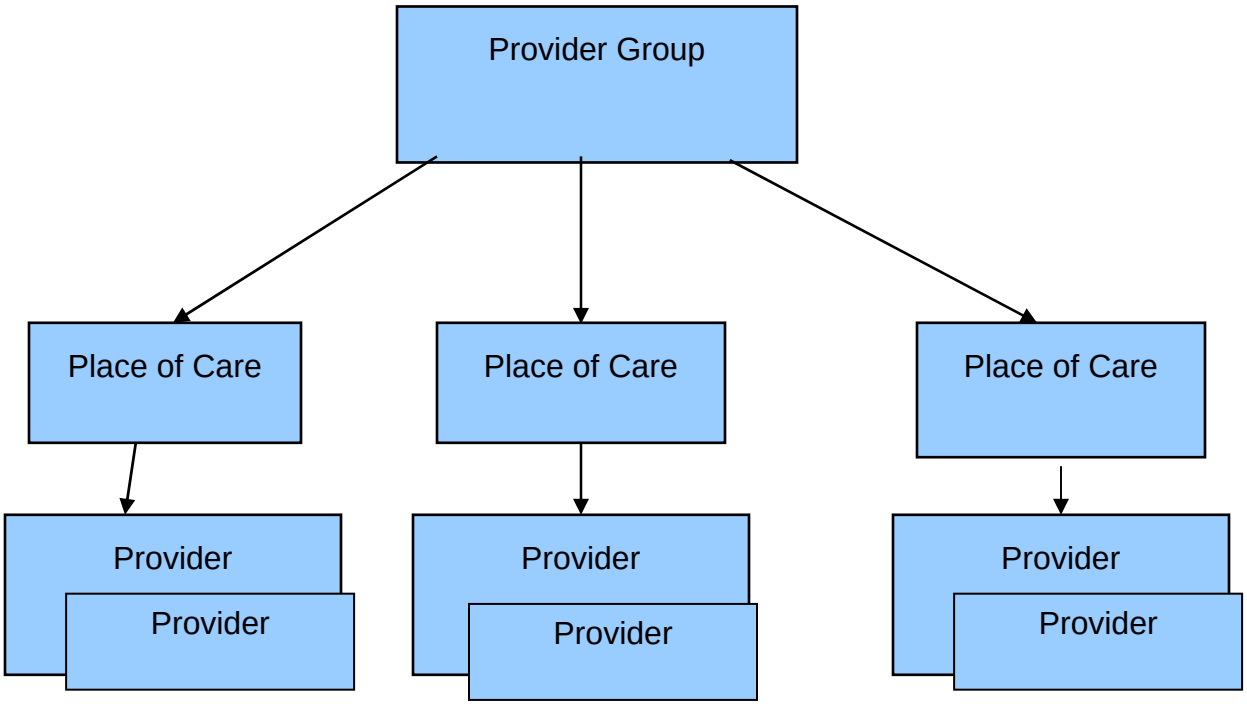


Single Group - Single Place of Care

This design defines separate Primary Care provider groups each with a single Place of Care supporting multiple providers. Enrollees are assigned to the PCMs in the single Group and Place of Care.

This design promotes continuity of care within the group. However cross booking among Primary Care provider groups and Places of Care requires a referral or a self-referral. The workload of each group of providers is easily measured.

MCP File and Table Design
One Group – Multiple Places of Care

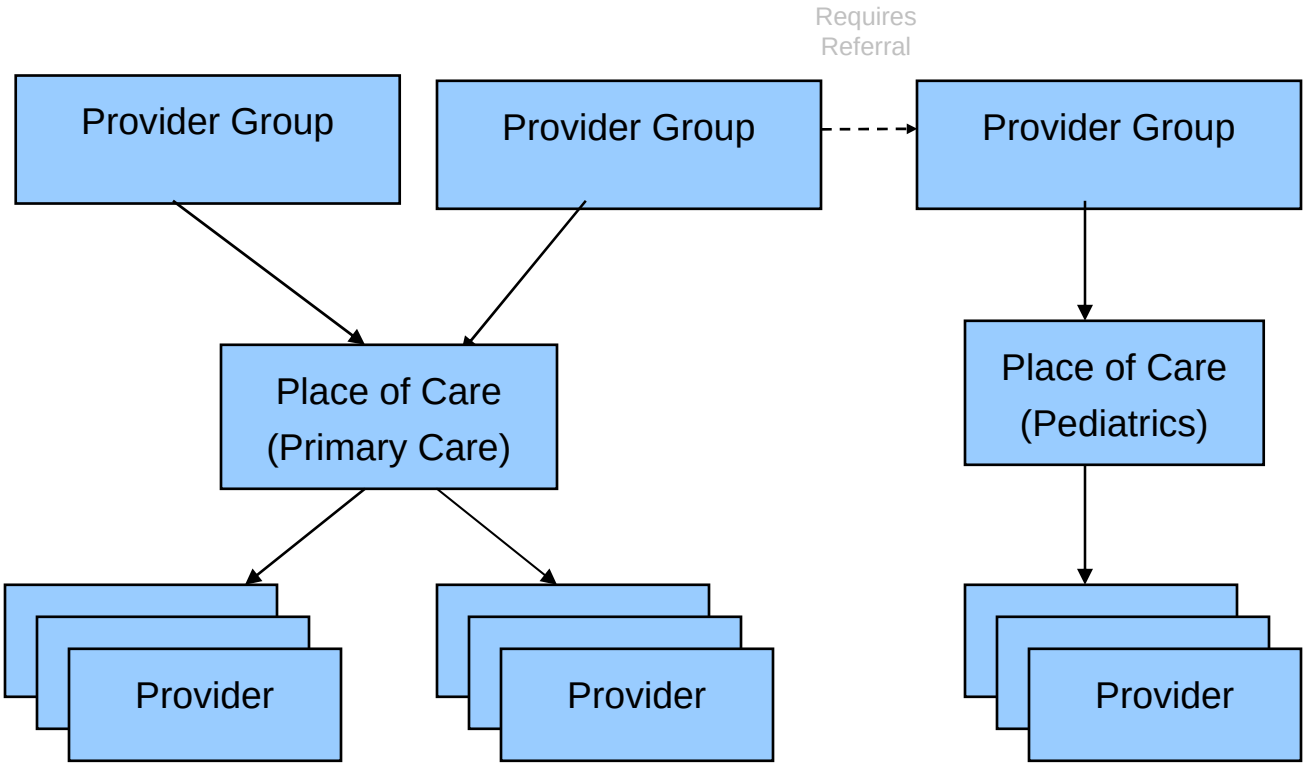


One Group – Multiple Places of Care

This design represents a single Primary Care Group Provider Structure at a large Medical Center. In order to have maximum flexibility to book an enrollee to any PCM in the MTF, the facility created a single Provider Group that contains all PCMs. Individual providers are grouped into their own place(s) of care. When the PCM is not available, primary care appointments can be booked across multiple places of care in the enrolling MTF without a referral (but not across MTFs).

This example maximizes access to Primary Care and reduces the requirement to enter referrals. It does not promote continuity of care. Workload of the Group is difficult to measure.

MCP File and Table Design
Multiple Groups - One Place of Care

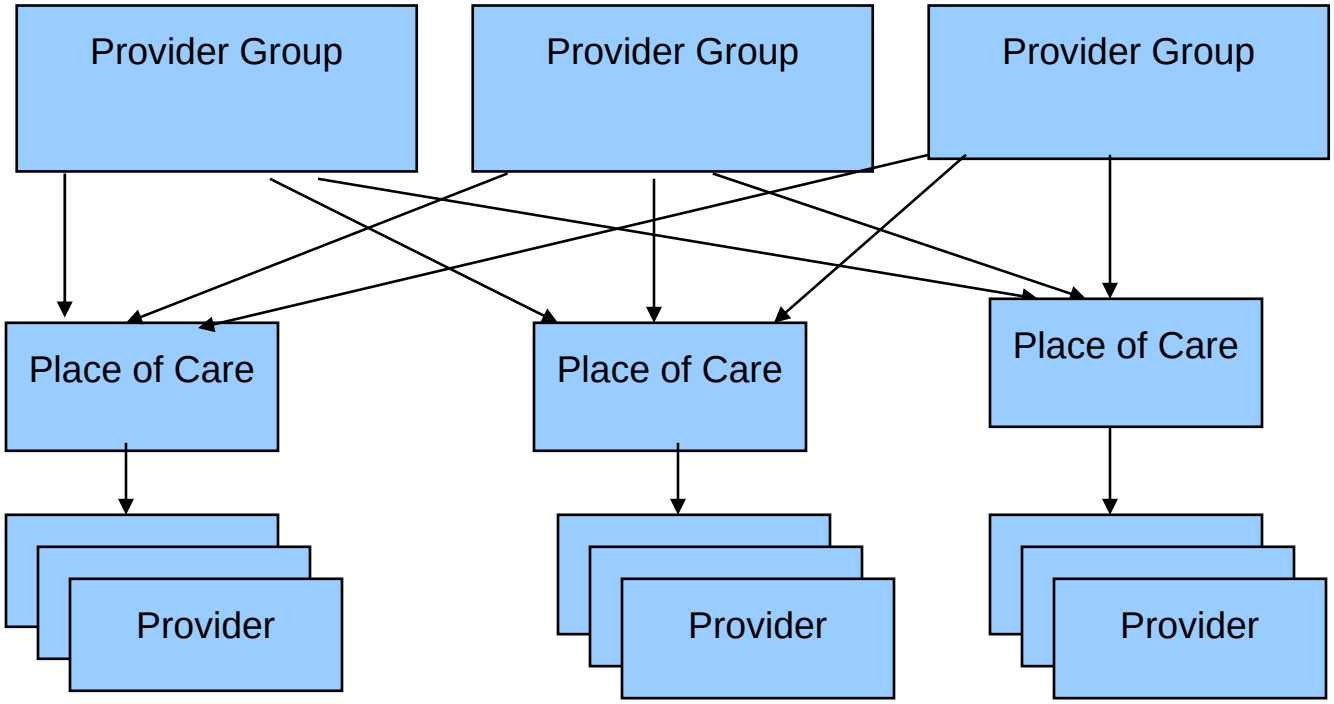


Multiple Groups – One Place of Care

This design defines separate Primary Care Provider Groups each supporting their own providers but sharing one Place of Care. Enrollees are assigned to the providers in the Place of Care and to their own Group.

This is useful in a large facility when a single group would be too large and the provider help lists too long when selecting providers for appointing. However it will require referrals or self-referrals to cross-book among Provider Groups. It does not promote continuity of care. The workload of each group is difficult to measure.

MCP File and Table Design
Multiple Groups with Shared Providers

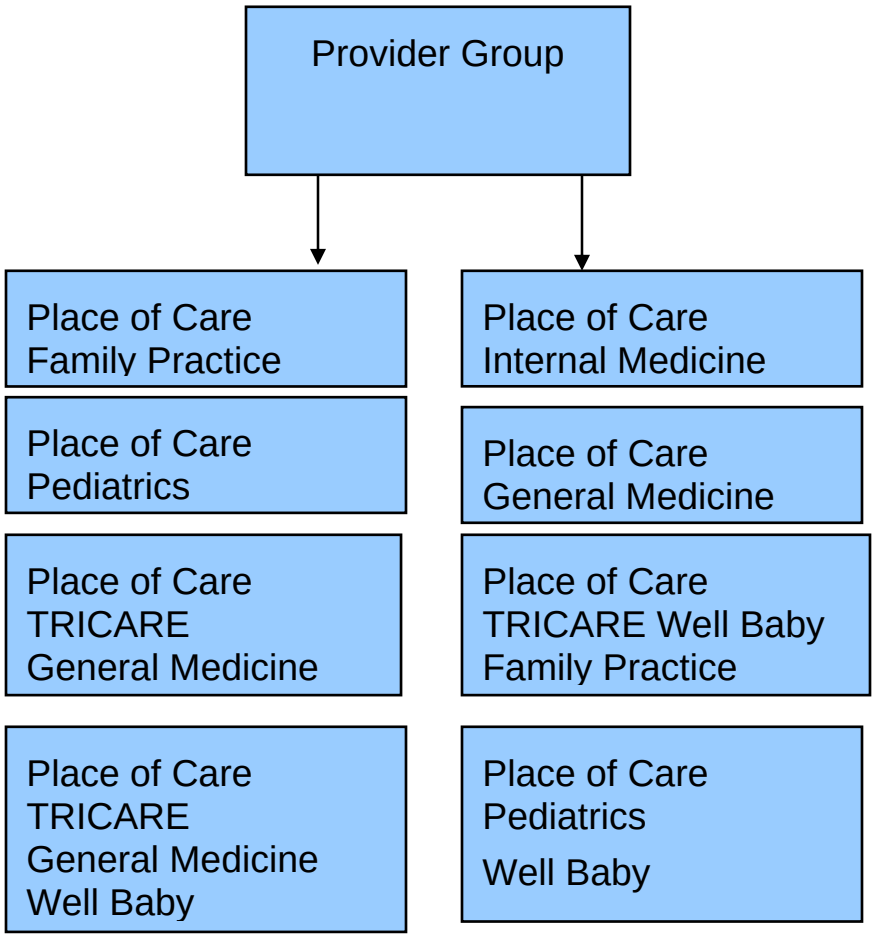


Multiple Groups with Shared Providers

This design creates multiple Primary Care groups but maximizes PCM access between the groups by sharing providers and their places of care across groups. When the PCM is not available in one place of care/group combination, primary care appointments can be booked to any provider assigned to the provider in another Place of Care where they also practice (but only within the enrolling MTF). A referral is not required to cross book between PCMs.

This model maximizes the ability to book appointments to Group Members across other groups and places of care provided the other group members in other Places of Care are also assigned to the enrollee's place of care. This increases access but has a negative impact on continuity of care. The workload of each group is very difficult to measure.

MCP File and Table Design – Multi-Specialty Model



Multi-Specialty Model

This model defines a multi-specialty primary care group with multiple places of care. Each Place of Care has its own clinical specialty and own providers.

In this design referrals are not required to book patients to any of the Places of Care and specialties in the group. A referral must be created only if a patient is booked to a provider in another group. This may negatively impact continuity of care.

3.7.4. In summary, the CHCS Provider Structure supports different provider 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 are encouraged to select the model/architecture that works best for them. Regional Commanders may require architecture standards on MTFs in the region.

3.8. The following table lists those File and Table data elements that must be completed in order for appointments to display during booking. The menu path to the function in CHCS is also displayed.

FILE AND TABLE REQUIRED DATA ELEMENTS

DATA ELEMENT	MENU PATH
Location Type = "Clinic"	DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location
Service is completed	DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location
Division is completed and links to the Service	DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location
MEPRS is completed	DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location
Clinic Specialt(ies) are correct and complete	DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location
Clinic Type = Count or Non-Count.	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
DMIS ID of the MTF is completed	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Activation Status = Activated	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Appointment Types used by all member providers are correct and complete in the Clinic's Profile list.	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care

DATA ELEMENT	MENU PATH
Type of Facility is completed, usually MSC or SSC	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Place of Care Enrollment Capacities are completed for each PCM Place of Care	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Available Schedule = set to 30 to 45 days	PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Access to Care Reporting = Yes	PAS → MAN Managed Care Program →>FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Self-Referral Allowed = Yes if self-referral to be supported in TOL	PAS → MAN Managed Care Program -→ FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care
Capacities completed for all Places of Care.	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → GROU Group Enter/Edit then Select Place of Care.
Provider Flag = 1 (Provider)	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit
Provider Class = Physician, Nurse Practitioner, etc.	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit
Location = the provider's primary location (required)	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit
Clinic ID = the name of the clinic the provider is associated with Provider Specialties are completed	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit

DATA ELEMENT	MENU PATH
DOB - must be complete or certain processing will not work	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit
Gender - completed to ensure successful appointment searches per patient preferences.	DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit
In the Specialties option, each Provider Specialty for a PCM **MUST** have the *Accepts PCM Assignments* set to **Yes** or the provider will not be considered a PCM.	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit → (S)pecialties
In the Specialties option, each Provider Specialty **MUST** have the *Accepts Specialty Referrals* indicator set to **Yes for any and all providers**. **If this indicator is No, schedules will not display. Creates all the appointing indexes.**	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit
Professional Category – not used in appointing but is required	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit
Max # of Patients Per Day must have a value or schedules will not display	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit
PCM Capacities completed for all PCMs	PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit

4. PROVIDER FILE AND TABLE TECHNICAL DESIGN

4.1. The Provider File and Table Structure is comprised of **Profiles**. Profiles are records that contain data that drive processing, implement data processing standards, and may be shared by multiple organizations at different levels, e.g., profile parameters may be passed top down from a MTF's Division Profile to its member Place of Care (Clinic) Profiles to their Provider Profiles. CHCS supports 5 types of profiles: Host, Division, Group, Place of Care, and Provider.

NOTE: CHCS allows users to build schedules for providers when critical data is missing that will cause the schedules not to display correctly for booking. In order to prevent this, the following paragraphs will explain critical/applicable data elements for appointment booking that MUST be completed correctly for schedules to display.

4.1.1. **Setting Up Host and Division Profiles.** Prior to building the Groups, Places of Care, and Providers, the Host and Division Profiles must be created and set up for appointing as explained below.

4.1.1.1. **Host Profile.** One of the MTFs in the Division Profile is designated as the Host Profile. The Host Profile is used infrequently and contains data and flags describing processing options that are applied by CHCS to all MTFs and Places of Care sharing the host system. Contact your Host's System Administrator for help with this profile.

4.1.1.1.1. **Host Profile Menu Path and Data Elements.** Below listed is the menu path that gets the user to the Host Profile and the data elements that can be edited to control processing at the host level. They are**:**

4.1.1.1.1.1. **Menu Path***: PAS → PROF Profiles → HPR Host Platform Profile*

4.1.1.1.1.2. **Schedule Deletion -** the number of days a schedule must be inactivated before the system will automatically delete it. Maximum is 120 days. If left blank, deletion is not performed. Impacts data available of the Appointment Utilization

4.1.1.1.1.3. **Appointment Overlap Interval -** the minimum number of minutes allowed for a patient between appointments on the same day.

4.1.1.1.1.4. **Inactivity Period -** the number of days after a provider is inactivated that the provider's schedule and profile data will be deleted. A

bulletin will be sent to the supervisor's mail group one week prior to deletion. The suggested inactivity period is 60 – 90 days, but may go to 365 days.

4.1.1.2. **Division Profile.** Each MTF (whether a parent or child) that performs processing on a CHCS host must have a Division Profile. A Division Profile contains data and flags that control processing options defaulted for all Places of Care in that MTF. Processing defaults may be overridden by a user in the Place of Care Profile for the Place of Care. The Division Profile may be used to establish standard appointing processes within the MTF and/or to save many keystrokes when building Place of Care Profiles.

4.1.1.2.1. **Division Profile Menu Path and Data Elements.** Below listed is the menu path that gets the user to the Division Profile and the data elements that can be edited to control processing at the CHCS Division level. They are**:**

4.1.1.2.1.1. **Menu Path:** *PAS → PROF Profiles → DPRO Division Profile*

4.1.1.2.1.2. **Facility and Division names:** This field indicates the name of the MTF on the CHCS host. MTFs that are children of other MTFs must have their own Division.

4.1.1.2.1.3. **Group and DMIS ID Codes:** This is field is used for the Defense Management Information System (DMIS) standard identification code for the parent or child MTF.

4.1.1.2.1.4. **MTF Address:** This field provides the MTF's physical address, shared by all CHCS processes.

4.1.1.2.1.5. **Patient Record Pull.** This field indicates the default number of days prior to a patient's appointment that the patient's health/medical record is to be pulled. The default days are 0 – 7; zero means do not pull the record. The default will be applied in the Clinic Profile.

4.1.1.2.1.6. **Radiology Record Pull.** This field indicates the default number of days prior to a patient appointment that the patient's radiology record is to be pulled. The default number of days are 0 – 7; zero means do not pull the record. The default will be applied in the Clinic Profile.

4.1.1.2.1.7. **Schedule Hold Duration:** If the Auto Release function is turned on, frozen slots will be automatically opened (released) by CHCS by the number of days indicated in this field from the date they are frozen.

4.1.1.2.1.8. **PAS Mail Group:** This field defines a mail group to receive appointing messages and activity bulletins for the Division.

4.1.1.2.1.9. **MCP Division:** This flag must be set to Yes for one but only for ONE primary Division on the host. The element turns MCP processing on.

4.1.1.2.1.10. **Beneficiary PCM Contact Number**: This is the default phone number sent to DEERS unless overridden in the Place of Care phone number. DEERS will print this phone number on all PCM Change Letters for the Place of Care.

4.1.1.2.1.11. **Automatic Appointment Reconfiguration**: This flag can be set to Yes/No. For this Division (MTF) to use the Automatic Appointment Reconfiguration function, this flag may be turned on (Yes) or off (No)

4.1.1.2.1.12. **Time to Run Reconfiguration**: If Automatic Reconfiguration is on (Yes), this field indicates the time that can be set to run the reconfiguration processing job at night for this MTF. The time reconfiguration will execute is limited to a range of times that are from 00:00 (midnight) to 06:00.

4.1.1.2.1.13. **Default to Remind Patient of Other Appointments/ Wait List Requests**: This flag can be set to Yes/No and indicates the default value of Yes or No for the following prompt displayed during booking: *Remind patient of other appointments/wait list requests? No//*

4.1.1.2.1.14. **Cross Division Record Pulling.** Enter other Divisions that may pull records for their clinics from Record Rooms in this Division. No entries means *Pull Records for this Division only*.

4.1.2. **Summary of the Steps to Build a Provider Group.** The following is a summary of the **four** steps required to build a **successful** Provider Group to correctly support Access to Care. Each step has two tasks. **Provider schedules may not display if certain data elements and steps are not completed.**

4.1.2.1. **Create the Place of Care Profile:**

4.1.2.1.1. In the Data Administration option (DAA) in the Hospital Location option (HOS), create core data for the Place of Care.

4.1.2.1.2. In the Managed Care Program option (MAN), update the profile for the Place of Care with appointing parameters. Appointing parameters may be applied later to all providers belonging to the Place of Care.

4.1.2.2. **Create the Provider Group Profile:**

4.1.2.2.1. In the Managed Care Program option (MAN), create the Group, entering the Group's name, capacity, and other group data.

4.1.2.2.2. Add the applicable Places of Care to the Group. Do not add providers at this time.

4.1.2.3. **Create the individual provider**:

4.1.2.3.1. In the Data Administration option (DAA), create core data for the Provider. Synchronize with DEERS. Credentialing usually is responsible for this task.

4.1.2.3.2. In the Managed Care Program option (MAN), update the profile for the Provider with the Places of Care and appointing parameters including appointment types and reconfiguration. Appointing parameters including reconfiguration criteria may be defaulted from the Place of Care Profile.

4.1.2.4. **Assembling the Provider Group:**

4.1.2.4.1. In the Managed Care Program, assign providers to the group and to the group's places of care.

4.1.2.4.2. Set up provider appointing and enrollment profiles in the Place of Care for the group in particular the PCM data if not already done. Appointment types and reconfiguration may be entered or updated here.

4.1.3. **Detailed Description of the Four Steps to Build a Provider Group**

4.1.3.1. **STEP 1: CREATE THE PLACE OF CARE PROFILE.** Each Place of Care that provides outpatient appointments must be defined in CHCS and have a complete Place of Care Profile (also referred to as a Clinic Profile). The Place of Care Profile contains data that control and standardize appointment processing applied to all providers in that Place of Care. Clinic Supervisors should be familiar with the parameters for their assigned Places of Care and its impact on their Access to Care measures. The Division parameters are also important since the Division settings default into the Place of Care Profile when it is created. Users may override the default settings.

4.1.3.1.1. **Place of Care Rules:**

4.1.3.1.1.1. Locations (also referred to as Place of Care) are the primary building blocks in the system and may be either MTF or Non-MTF (Civilian).

4.1.3.1.1.2. A Place of Care must be assigned to the Provider's Group before the provider can be assigned to the Group.

4.1.3.1.1.3. Each Direct Care Place of Care is assigned one and only one MEPRS code at the 4th level. Each booked appointment in that Place of Care is assigned that MEPRS code for workload reporting.

4.1.3.1.1.3.1. **MEPRS codes may be shared among Places of Care. MTFs should coordinate clinic location name changes with the MEPRS staff at the MTF.**

4.1.3.1.1.3.2. MEPRS codes are descriptive of a physical location (place of service) i.e., the Internal Medicine clinic. The location Tri-Service wide is identified with the MEPRS code BAA*.

4.1.3.1.1.3.3. Within a MEPRS Code (physical location) labor is reported and the labor generates inputs which produce outputs such as visits, RVUs from SADR, Raps from SIRs.

4.1.3.1.1.3.4. The costs for the MEPRS code physical location are reported via the Service's Accounting Systems (i.e., the labor, the supplies, travel, equipment, etc). These costs are accumulated to the physical location. A supply item purchased for the Internal Medicine clinic would be charged in the line of accounting to the MEPRS code BAA*. MEPRS then uses workload that is common across all similar physical locations (i.e., all outpatient clinics) such as visits, RVUs, etc to produce a unit cost.

4.1.3.1.2. **Benefits of Place of Care Profiles.** File and Table Build done correctly can decrease the appointment search time, enhance search results, and ensure that appointments display properly. In a single search, MCP can find appointments for:

4.1.3.1.2.1. A single provider in a place of care.

4.1.3.1.2.2. All providers in a single place of care.

4.1.3.1.2.3. All providers across multiple places of care or MTFs by searching on clinic or provider specialties common to those places of care or MTFs.

4.1.3.1.2.4. In PCM Booking functions by searching all group members in all their places of care in the enrolling MTF.

4.1.3.1.3. Two Tasks are required to create a Place of Care Profile.

4.1.3.1.4. **Task 1: Add Place of Care to Hospital Locations.** The Hospital Location record contains core data about any Direct Care or Civilian location where MHS health care may be provided, including inpatient, outpatient, dental, surgical, ancillary, etc. The Place of Care record is stored in the **Hospital Location** file as the Clinic Profile and contains core data describing and controlling processing specific to the outpatient clinic. This profile carries the MEPRS code for workload reporting; this MEPRS code is assigned to every appointment booked to this location.

4.1.3.1.4.1. **Hospital Location Business Rules**

4.1.3.1.4.1.1. An outpatient Place of Care is a subset of all the locations in this file.

4.1.3.1.4.1.2. The Place of Care may represent a physical or a logical outpatient clinic.

4.1.3.1.4.2 Hospital Location Menu Path and Data Elements that Apply to Appointing. The menu path is shown below that gets the user to the Hospital Location file and the data elements that can be edited to create the processing elements of the Hospital Location. They are**:**

4.1.3.1.4.2.1. **Menu Path:** *PAS → Scheduling Supervisor → FILE File/Table Maintenance → CFIL Create a New Clinic (Quick Method – selects division and facility)* **Or** *DAA → CFT Common Files and Tables → CFM Common File and Table Maintenance → HOS Hospital Location (Long Method)*

4.1.3.1.4.2.2. **Clinic Name/Abbreviation/Description/Address**: The clinic name is site definable and is used to identify the care available in that location. This may be a logical or physical clinic location. The MHS has no standard clinic naming conventions. Thus similar clinics can seldom be matched by name in order to compare services provided. Since the Clinic Specialty code is sometimes inadequate to accurately describe all the care provided in a Place of Care, clinics may decide to create

special logical locations with names that identify the care provided. A descriptive Clinic Name helps the booking clerk find correct appointments for that type of care, e.g., general orthopedics vs. hand surgery vs. back pain. The MEPRS code is used for this.

4.1.3.1.4.2.3. **Clinic Abbreviation:** Data entry s required and must be unique on the host.

4.1.3.1.4.2.4. **Clinic Description/Address**: This field is needed for mailing notices and on forms but not required.

4.1.3.1.4.2.5. **Location Type**: Appointing and Referral Processing use this flag to identify direct care versus downtown locations. The appointing function also uses this flag to distinguish medical versus dental clinics in order to apply correct appointment types. Location types are required and indicate whether the Hospital Location is one of the following:

- outpatient clinic (“C”)
- dental clinic (“D”)
- Non-MTF civilian location (“O”)

4.1.3.1.4.2.6. **Service:** This field indicates the clinical service provided at one or more Divisions on the host. Completion of this field is required for appointments to display. Service is defined in the Department and Service file. The Service restricts the Divisions that can be selected.

4.1.3.1.4.2.7. **Division**: This is a required field and indicates the Division that the Place of Care belongs to. The application only allows Divisions supporting the selected Service (see above).

4.1.3.1.4.2.8. **Facility**: Is automatically populated by CHCS based on the Service and Division entered. Indicates the MTF that the Place of Care belongs to.

4.1.3.1.4.2.9. **Telephone**: If a telephone number is NEVER entered in this field, the phone number defaults from the Beneficiary PCM Contact Number in the Division Profile but may be overridden in this profile.

4.1.3.1.4.2.10. **Default Device**: This field indicates the printer where all the appointing messages and notices will be printed for this Place of Care.

4.1.3.1.4.2.11. **MEPRS Code:** the code used as a consistent indicator of the Place of Care within and across MTFs and the MHS and also to measure workload. Logical clinics are usually distinguished from each other by a MEPRS code at the 4th level, e.g., BGAA, BGAB, and BGAC. MEPRS is included on the SADR for each appointment and for workload reporting. **Note: MTFs should coordinate clinic location name changes with the MEPRS staff at the MTF.**

4.1.3.1.4.2.12. **Prompt for Requesting Service**: This flag can be set to Yes or No. It tracks the source of specialty referrals to this clinic. If set to Yes, during booking, CHCS will request the MEPRS code of the Place of Care that referred the patient to this Place of Care.

4.1.3.1.4.2.13. **Enrollee Lockout**: This flag can be set to Yes or No. It can be used in a Primary Care Clinic. If set to Yes, it will block a non-enrollee patient from being booked to this Place of Care. Appointing agents may override the lockout and enter a reason code and book the patient.

4.1.3.1.4.2.14. **Type of Care**: If Enrollee Lockout is set to Yes, this field indicates Primary Care ("P"), Specialty Care ("S"), or Both ("B"). This field is used to identify Primary Care clinics for Enrollee Lockout. Many clinics are both.

4.1.3.1.4.2.15. **Clinic Specialty (multiple):** This field indicates the authorized type(s) of health care services provided at the Place of Care, e.g., cardiology, family practice, allergy, pediatrics, etc. This field is required. Providers assigned to this Place of Care may only provide the services/appointments that are included in this list of Clinic Specialties or in the Specialty Table of Provider Specialties related to these specialties. The 900 Series codes are used.

4.1.3.1.4.2.16. **Duplicate Checking Order Type**: This field indicates for each order type specified (e.g., CON, ANC, RAD, LAB, NRS, BLD, etc), CHCS will check a patient's record for active orders that have the same Consult Procedure name as the order being entered. If found, CHCS will block entry of this duplicate order. ***NOTE*****:** *Will check across all MTFs on the host and will check all open, active orders. If set to On, may cause problems in AHLTA when writing a similar referral for the same patient*

4.1.3.1.5. **Task 2: Update Managed Care Program Place Of Care Profile.** Add, change, or delete Hospital Location data and appointing parameters for the Place of Care. Setting up appointment processing for the Place of Care involves entry of:

4.1.3.1.5.1. The appointing parameters, e.g., wait listing, patient notifications, workload designation, medical records requests, access to care reporting, self-referral booking, etc.

4.1.3.1.5.2. Standard Appointment Types that will be allowed in provider schedules in this Place of Care. Data includes the unique processing characteristics for each appointment type for this Place of Care.

4.1.3.1.5.3. **MCP Place of Care Business Rules:**

4.1.3.1.5.3.1. A Place of Care must be assigned to a Provider Group in order for appointments to display.

4.1.3.1.5.3.2. A Place of Care must have assigned providers in order for appointments to display.

4.1.3.1.5.3.3. CHCS Direct Care Place of Care enrollment capacities are sent to DEERS.

4.1.3.1.5.4. **Managed Care Place of Care Profile Menu Path and Data Elements.** Below listed are the menu path that gets the user to the Managed Care Place of Care Profile and the data elements that can be edited to control processing in the Managed Care Place of Care Profile. They are**:**

4.1.3.1.5.4.1. **Menu Path:** *PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care, then*

Or PAS → SCH Scheduling Supervisor → PROF Profiles → CPRO Clinic Profile then:

- Select the Place of Care.

- Select the active profile.

-Select **(A)ctive**, (I)nactive, (R)econfigure, or (Q)uit appointment types: **A// Active**

4.1.3.1.5.4.2. **Clinic Location**: This is a free text field indicating the room number, building, or area where the clinic is located.

4.1.3.1.5.4.3. **Clinic Availability**: This is a free text field explaining the days of the week and hours of operation, e.g., Mon – Fri 0800-1600

4.1.3.1.5.4.4. **Department**: This field states the name of the department to which the Place of Care belongs.

4.1.3.1.5.4.5. **Wait List Activated**: This flag turns on waitlist processing for the Place of Care. It has a Yes/No flag. If No, waitlist prompts are not displayed for this Place of Care.

4.1.3.1.5.4.6. **Maximum Wait List Days**: Indicates the maximum number of days into the future from today that a patient may be kept on the waitlist.

4.1.3.1.5.4.7. **Wait List Provider Mandatory**: This Yes/No flag will require that the user will be required to enter a provider when putting a patient on the waitlist.

4.1.3.1.5.4.8. **Wait List Hold Duration**: This is the number of days AFTER creation of the schedule that the system will automatically change schedule slot(s) held for Wait List Processing to an Open status so they can be booked.

4.1.3.1.5.4.9. **Auto Wait List Processing**: If this field is set to Yes and the user elects to perform automatic assignment of waitlisted patients, the system will assign the patients at night to slots assigned a “Wait” status.

4.1.3.1.5.4.10. **Schedule Hold Duration**: This field indicates the number of days after being frozen that the frozen appointment will be released to an Open status either automatically by the system or manually by a user, (0 – 30 days). The user selects manual or automatic at the time the appointment is frozen.

4.1.3.1.5.4.11. **Prompt for Requesting Service**: If this flag is set to Yes, the system will track the source of referrals to this Place of Care. During booking of the patient, CHCS will request the MEPRS code of the Place of Care that referred the patient to clinic to which the patient is being booked.

4.1.3.1.5.4.12. **Clinic Type**: This field describes whether work performed in this clinic counts or does not count in workload reporting, e.g. physician versus technician/nurse workload. Completion of this field is required. Its values can be 'Count' or 'Non-Count'. If set to Non-Count, all workload for the Place of Care will be Non-Count; if set to Count, all appointment slot will default to Count workload, unless changed to Non-Count at the count indicator on the appointment slot.

4.1.3.1.5.4.13. **Patient Record Pull**: This field indicates the number of days prior to the patient's appointment that the patient's health/medical record is pulled. The default number of days (0 – 7) is used to indicate the days prior to the patient's appointment to pull the medical record. Zero is the same day as the appointment. This field requires an entry.

4.1.3.1.5.4.14. **Radiology Record Pull**: This field indicates the number of days prior to the patient's scheduled appointment that the patient's radiology record is pulled. The default number of days (0 – 7) is used to indicate the number of days prior to the patient's appointment to pull the patient's radiology record. This field requires an entry.

4.1.3.1.5.4.15. **Check Holiday File**: If this flag is set to Yes, the system will exclude holidays (defined in the MTF Holiday file) from the provider schedules; if No, holidays are included in schedules. The MTF Holiday file may be updated to include Service specific holidays.
Holiday Update Path: DAA → CFT → CFM → CFS → HOL

4.1.3.1.5.4.16. **Roster Production**: This field identifies the number of days prior to an appointment date that a Provider's Patient Roster will be automatically printed. The values for this field can be between 1 – 7 days.

4.1.3.1.5.4.17. **Prepare Reminder Notice**: This data element indicates the number of days prior to the appointment to print the patient appointment reminder notices. The values can be between 4 – 30 days. It is a required data field.

4.1.3.1.5.4.18. **Activation Status**: If this data field is **not set to 'Activated', appointments on the schedule will not display. This is a required data field.**

4.1.3.1.5.4.19. **Available Schedule**: This data element indicates the minimum number of days a schedule should be open in the future so appointments can be booked in the Place of Care. This is a required data field. If a provider's schedule does not have Open appointments the number of days into the future as indicated in this field, CHCS will send a warning message to the clinic. Values in the data field can be set between 30 – 45 days.

4.1.3.1.5.4.20. **Access to Care Reporting**: This Yes/No flag indicates whether this Place of Care is included in and can be printed on the Access to Care Summary Report. This flag is required to be set to Yes for MEPRS B clinics.

4.1.3.1.5.4.21. **Self-Referrals Allowed**: This is a Yes/No flag. If set to Yes, patients may be booked to this Place of Care for specialty care appointments without a referral. This field needs to be set to Yes if the clinic wants to set up TRICARE Online Appointing for Self-Referral Visit Reasons.

4.1.3.1.5.4.22. **Clinic Appt Instructions**: This free text comments field provides canned instructions to booking agents to read to the patient when an appointment is booked.

4.1.3.1.5.4.23. **Clinic Specialty** (multiple entries): This field indicates the type(s) of health care services provided at the Place of Care (900 Series), e.g., cardiology, family practice/primary care, allergy, pediatrics, etc. Providers assigned to the Place of Care may only provide services that are either included in this specialty list or in the Specialty Table of provider specialties related to these clinic specialties.

4.1.3.1.5.4.24. **Detail Codes** (multiple entries): Detail Codes entered into these fields will display on the Appointment Search Help Lists to indicate to the booking agent the detail codes used by this Place of Care. If accurate, saves the clerk time searching for care/explanations of detail codes not provided in the Place of Care.

4.1.3.1.5.4.25. **Appointment Types (multiple)**: Appointment types entered in the Clinic Profile work as a permission list to determine the appointment types Providers in this Place of Care may use in their schedules. Each appointment type entered in these data fields has its own profile for this Place of Care. For each appointment type entered, the following four data elements must be defined.

4.1.3.1.5.4.25.1. **Duration**: This is the default length of time in minutes for this appointment type. This data field is required.

4.1.3.1.5.4.25.2. **Status**: This data field indicates whether the appointment type is active or inactive. This data field must be activated for these appointments to display to scheduling and booking agents. Appointment types cannot be deleted once added, just inactivated. This is a required data field.

4.1.3.1.5.4.25.3. **Workload Type**: The values for this data field are Count/Non-Count. This field indicates whether the appointment type is a count or non count visit for MEPRS workload purposes. This is a required data field. This flag/setting overrides the Clinic Type value only if Place of Care is a "Count" Clinic Type.

4.1.3.1.5.4.25.4. **Referral Required**: If set to Yes, patient care in this clinic will require a referral to be entered into CHCS first to get an appointment in this Place of Care.

4.1.3.1.5.4.25.5. **Pull Patient Record and Pull Radiology Record**: These Yes/No flags indicate whether the patient records are to be pulled for this appointment type in this Place of Care. This is a required data field.

4.1.3.1.5.4.25.6 **Send Reminder Notice**: This Yes/No flag will allow CHCS to create an appointment reminder notice (letter to be sent thru the mail) to the patient. This flag will be No if the site is using the automated telephonic reminder notification system (Audio Care Reminder). This is a required data field.

4.1.3.1.5.4.25.7. **Total # of Overbooks**: This data field indicates the maximum number of appointment overbooks allowed per day for this Provider and appointment type in this Place of Care.

4.1.3.1.5.4.25.8. **Max # of Overbooks Per Slot**: This data field is used to indicate the maximum number of overbooks allowed for each slot each day for this appointment type in this Place of Care.

4.1.3.1.5.4.25.9. **Instructions**: This free text field is used to provide appointing instructions for appointments with this appointment type.

The booking agent will read these instructions to the patient booked to that appointment in that Place of Care.

4.1.3.1.5.4.25.10. **Booking Authority**: This field, if used, defines a set of up to 3 security keys that can be assigned to selected booking clerks and TOL users (if applicable) to allow only these users access to this appointment type in this Place of Care. Users without this security key will not see these appointments during booking. Clinic managers must keep these keys up to date. Your System Administrator must create these key. Your System Administrator must create these keys before the clinic can use them.

4.1.3.1.5.4.25.11. **Appointment Change Authority**: This field, if used, defines up to 3 security keys that permit users to change this appointment type to another value when booking to this Place of Care. The Place of Care profile as listed above can define several of these security keys. Your System Administrator must create these keys before the clinic can use them.

4.1.3.1.5.4.25.12. **Overbook Authority**: This field if used defines up to 3 security keys that can be assigned to selected users to allow only that user to overbook this appointment type in this Place of Care. Your System Administrator must create these keys before the clinic can use them.

4.1.3.1.5.4.26. **Type of Facility**: This data element is usually set to either Multi-Service Clinic or Single Service Clinic for the Place of Care. Other values are supported.

4.1.3.1.5.4.27. **Appt Contact**: This free text field provides information on the person or organization to contact if someone has questions about appointments in that Place of Care.

4.1.3.1.5.4.28. **DMIS ID #:** This data field indicates the Defense Management Information System (DMIS) number assigned to the MTF where this Place of Care is located.

4.1.3.1.5.4.29. **OPS Forces Place of Care (PLOC)**: This Yes/No field can be used by the Services to identify PCM locations for ship-based patients. If set to Yes, will allow the user to book a PCM appointment for an Active Duty patient whose enrolling MTF (DMIS ID) is defined as OPS Forces. The system will search for any provider in any Place of Care

in any MCP Provider Group to which the patient's assigned PCM is a member.

4.1.3.1.5.4.30. **Beneficiary PCM Contact Number**: This data element contains the telephone number that is sent to DEERS to be printed on the PCM Change letters. If the MTF uses only one phone number for these contact letters for the entire Division, it is recommended that the user enter only one phone number in the Division Profile. That phone number will then be copied to PCM Contact Number fields in Places of Care if those fields have **never** been populated. If a Place of Care uses its own phone number, enter that phone number in this field. *Once the PCM Contact Number is modified at the Place of Care level, the number must always be corrected at the Place of Care level.*

4.1.3.1.5.4.31. **Place of Care Hours of Service**: This data field provides a detailed display of the hours the clinic is operational.
4.1.3.1.5.4.32. **Directions to Place of Care**: This free text field provides driving/walking directions to the clinic for the appointing agent to give to the patient.

4.1.3.1.5.4.33. **Comments on Place of Care**: This free text field provides supplemental information for the patient on parking, wheelchair access, and other helpful information related to that Place of Care.

4.1.3.1.5.4.34. **Maximum Place of Care Capacities.** These data fields indicate the maximum number of enrollees that may be assigned to the Place of Care collectively across all the Primary Care Managers (PCM) practicing in the Place of Care. These capacities are sent to DEERS where they limit the maximum number of enrollees permitted to be enrolled to this Place of Care. Capacity limits may be broken out by age restrictions and Beneficiary Categories to support balance in the panels in the clinic. Enrollment capacities on the Place of Care will supersede the capacities set for any PCM. For example, if the Place of Care capacity is 500 Active Duty, then when the total Active Duty assignments to all PCMs in the Place of Care reaches 500, no more enrollees may be assigned to any PCMs in that Place of Care.

4.1.3.1.5.5. **Reconfiguration of Appointments.** This feature allows instructions to be set up in advance for a Place of Care that tells the appointing system when and how to change the characteristics of an Open or Frozen appointment slot. Booked appointments are never reconfigured. The change should make the appointment more likely to be booked, e.g., reconfigure an

EST to a WELL 28 days prior to the appointment; reconfigure a ROUT to an ACUT slot 24 hours prior to the appointment; add or remove the WEA or PBO detail code, or change a $ appointment type to an appointment type without the $. The benefits of reconfiguration are as follows:

4.1.3.1.5.5.1. Saves scheduling supervisors hours each day manually fine tuning schedules to transform unused appointments into more bookable appointments.

4.1.3.1.5.5.2. Reduces the numbers of unused appointments.

4.1.3.1.5.5.3. Improves access to care since appointing agents will have more available appointments of the right type at the right time.

4.1.3.1.5.5.4. The appointment reconfiguration function supports the change of appointment criteria at 3 levels in CHCS. They are:

4.1.3.1.5.5.4.1. Place of Care Profile: At this level it creates default reconfiguration data for each appointment type that can be copied only to the profiles of providers assigned to the Place of Care. This action is recommended as it saves time.

4.1.3.1.5.5.4.2. Provider Profile: Reconfiguration sets can be copied to the Provider Profile from the Place of Care Profile by appointment type, or be created manually provider by provider. Provider Profile reconfiguration can be copied to the Provider's templates and from the templates to the schedules as they are created. Including reconfiguration in Provider templates is r**ecommended as it saves time.** If not copied to templates and schedules, the user must build reconfiguration from scratch on each appointment schedule slot or reconfiguration will not execute.

4.1.3.1.5.5.4.3. Schedule slots: At this level reconfiguration data must be defined on each slot that is to be reconfigured in order to execute the function**. If the schedule is created from a template, all reconfiguration data in the template will copy to the same slots in the schedule**.

4.1.3.1.5.5.5. **Reconfiguration Menu Path and Data Elements.** Reconfiguration changes are made to the provider's schedule on the specified number of days before the appointment. All reconfiguration fields are optional except for the number of days. Blank fields leave the

value in the appointment slot unchanged. The menu paths are indicated below with the associated data elements that the user can edit to affect changes to the clinic profile reconfiguration functions:

4.1.3.1.5.5.5.1. **Menu Path:** *PAS → Scheduling Supervisor Menu → PROF Profiles Menu → CPRO Clinic Profile Edit*
Or
PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PLAC Place of Care

Select CLINIC: <**Place of Care Name**>

Select (A)ctive, (I)nactive, **(R)econfigure**, or (Q)uit: A// **R**

Transfer newly entered/edited reconfigured appointment type(s) to Provider Profile(s)? No// Choose **Y (***always answer Yes to save keystrokes)*
4.1.3.1.5.5.5.2. **Reconfigured Appointment Type:** In this data element, the user indicates the new appointment type for the appointment and is required.

4.1.3.1.5.5.5.3. **Number of days before the Appt:** This data element indicates the number of days before the actual appointment date to apply the reconfiguration criteria. The values in this data element can be from 0 – 99 days. The value of 0 indicates that the reconfiguration change would be performed after midnight on the day of the scheduled appointment. This is a required data element.

4.1.3.1.5.5.5.4. **Workload Type:** This field permits the user the option to change the workload type from count to non-count or vice-versa during reconfiguration.

4.1.3.1.5.5.5.5. **Slot duration:** This data field allows the user to change the duration of the appointment slot (in minutes) during reconfiguration to the desired value.

4.1.3.1.5.5.5.6. **Max # of Patients per Slot:** This data field allows the user to change the maximum number of patients allowed to share the appointment slot.

4.1.3.1.5.5.5.7. **Unfreeze:** This Yes/No data field allows the user to Unfreeze the appointment during reconfiguration if the value is Yes.

4.1.3.1.5.5.6.8. **Change Detail Codes.** This Yes/No data element allows for the changing of detail codes on subject slots. It works as follows:

- If set to "No" indicates that the existing Detail Codes on the appointment remain unchanged.
- If set to "Yes" with new Detail Codes, indicates that all existing Detail Codes will be replaced by the new detail codes specified in the reconfiguration.
- If set to "Yes" with no Detail Codes entered, this entry will remove all the detail codes from the appointment.

4.1.3.1.5.5.6.9. **Detail codes:** The user may specify up to 4 detail codes to replace all the detail codes currently on the appointment slot. Or the user may leave all detail codes blank to remove all detail codes from the appointment.

4.1.3.2 STEP 2. CREATE THE PROVIDER GROUP PROFILE. The primary function of the Provider Group Profile is to identify its member Places of Care, and the providers who practice in those Places of Care and cover for each other's schedules, The Provider Group Profile contains very few data elements.

4.1.3.2.1. **Business Rules for Provider Group Profiles:**

4.1.3.2.1.1. Every Group must have at least one provider and one Place of Care.

4.1.3.2.1.2. Group providers must be assigned to at least one Place of Care in the Group.

4.1.3.2.1.3. CHCS will not find appointments in a Place of Care unless the above relationships are correctly defined.

4.1.3.2.2. **Benefits of Provider Group Profiles**

4.1.3.2.2.1. Supports TRICARE Prime appointing to a Provider Group to improve the chances that the patient is booked to their PCM which in turn increases the continuity of care for that group.

4.1.3.2.3. **Group Profile Menu Path and the Data Elements.** Below listed are the menu path that gets the user to the Group Profile and the data elements that can be edited to control processing in the Group Profile. They are**:**

4.1.3.2.3.1. ***Menu Path:*** PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → GROU Group Enter/Edit Or
Type **^GROU** on any menu

4.1.3.2.3.2. ***Group Address, phone, and contact information:*** *This data element indicates the group address, phone number and contact information that can be given to patients booking appointments in the group.*

4.1.3.2.3.3. ***Will this Group allow PCM Assignments to the "Group Provider"?*** *This is a Yes/No flag and should always be set to NO since enrollment to Groups is no longer supported.*

4.1.3.2.3.4. ***Group Capacity****: This data field indicates the maximum number of enrollees that can be assigned collectively to all the providers in the group. Values are whole numbers starting at 0.*

4.1.3.2.3.5. **Total Enrollees Assigned**: This field is a display only data element and is computed real-time by the system as enrollees are assigned to or disenrolled from the group.

4.1.3.3. STEP 3. CREATE THE INDIVIDUAL PROVIDER. Each provider has an appointing profile containing data fields with flags and data used to manage the building of the provider's templates and schedules. The Provider Profile guides appointment booking in accordance with the provider's skills and his/her schedule. The Provider Profile documents valid appointment types, appointment durations, and the workload type for that provider.

4.1.3.3.1. **Provider Profile Business Rules.**

4.1.3.3.1.1. Supports both Direct Care and civilian providers.

4.1.3.3.1.2. Supports both PCMs and Specialty providers.

4.1.3.3.1.3. Each Direct Care and civilian provider must be entered into CHCS if the provider's care for a patient is to be documented in CHCS.

4.1.3.3.1.4. A provider must have at least one provider specialty and be assigned to at least one Place of Care in a Direct Care or civilian Provider Group.

4.1.3.3.2. **Provider Profile, *Shared Provider* Business Rules.**

4.1.3.3.2.1. Providers may practice in more than one MTF.

4.1.3.3.2.2. Providers may practice in more than one Place of Care or in both a direct care and a civilian clinic.

4.1.3.3.2.3. Providers may practice in more than one Provider Group.

4.1.3.3.2.4. A provider may practice in multiple groups and, for each group, in multiple Places of Care on the same day but not at the same time.

4.1.3.3.3. **Benefits of Place of Care Profiles.**

4.1.3.3.3.1. File and table builds that are done correctly can decrease the appointment search time and improve patient satisfaction by matching the right patient to the right provider, for the right service, at the right time.

4.1.3.3.3.2. Prevent incorrect schedules from being built for the provider and reduces the probability of mis-booked appointments.

4.1.3.3.3.3. Allow the Place of Care to control appointment processing by appointment type.

4.1.3.3.4. **Summary of Tasks to Create a Provider Profile.** Creating a Provider Profile requires two tasks:

Task 1: Create the Provider in CHCS and define the provider's authorized clinical capabilities and identifiers after review and verification by the Credentialing Office.

Task 2: The MTF creates the Provider's Appointing Profile.

4.1.3.3.5. **Task 1: Define the Provider and Clinical Capabilities.**

4.1.3.3.5.1. **Provider Profile Menu Path and Data Elements.** Below listed are the menu path that gets the user to the Provider Profile Menu Path and the data elements that can be edited to control processing for the provider.

They are**:**

4.1.3.3.5.1.1. **Menu Path:** *CA → DAA Data Administration → CFS Common Files → CFM Common Files → PRO Provider File Enter/Edit*

4.1.3.3.5.1.2. **Name:** This data element indicates the provider's name, Last Name, First Name, MI spaced exactly as follows: SMITH,JOHN P

4.1.3.3.5.1.3. **Provider Flag:** This data element indicates whether a provider is a Provider, an MCP Provider Group, a lab provider, or none of these. This data element is required to distinguish a provider from the Group record during booking. Appointments are only booked to individual providers who are members of a Provider Group.

4.1.3.3.5.1.4. **Provider ID:** This data element indicates the numerical number that identifies the provider. Generally speaking this Provider ID number is generated by and for the Provider Credentialing system.

4.1.3.3.5.1.5. **Provider Class:** This data field identifies the type of license that the provider possesses. A provider class could be physician, intern, clinical nurse, nurse practitioner, dentist, physician assistant, flight surgeon, audiologist, etc. MTFs are permitted to add their own values to the Provider Class table.

4.1.3.3.5.1.6. **Person Identifier:** This data field indicates the provider's SSN or Foreign Identification Number (FIN) or Temporary Identification Number (TIN).

4.1.3.3.5.1.7. **Person ID Type Code:** This data element identifies the type of provider identifier, e.g., Social Security Number, FIN, TIN, etc.

4.1.3.3.5.1.8. **Provider Specialties:** This data field designates each of the provider's credentialed specialties, e.g., SURGEON, PATHOLOGIST, etc. CHCS will search for appointments based on these specialties. Provider Specialties are not always definitive enough to describe the exact care to be provided during the appointment. The Place of Care name may be used for that purpose. **NOTE:** *This data element is very important in booking when searching for a specific type of care for a patient.*

4.1.3.3.5.1.9. **Location:** This field indicates the primary location where the provider practices in the Division. ***NOTE***: *Appointing personnel will not find appointments if this field is not completed correctly*.

4.1.3.3.5.1.10. **HCP SIDR-ID: The system generates this unique identifier for the Standard Ambulatory Data Record (SADR).** Patient Data Records generated by the provider. It is a system generated ID number.

4.1.3.3.5.1.11. **Branch of Service:** Data element indicates the provider's Military Branch of Service, e.g., Army, Navy, Air Force, etc. This is a required data element.

4.1.3.3.5.1.12. **Rank:** This field provides the military rank of the provider if military.

4.1.3.3.5.1.13. **Home Phone, Work Phone:** These data elements indicate the provider's home and work telephone numbers.

4.1.3.3.5.1.14. **Clinic ID:** This field indicates the name of the primary clinic (in the Hospital Location file) with which the provider is associated. *Appointing will not find appointments if this is not completed correctly*.
4.1.3.3.5.1.15. **Department ID:** Indicates the name of the provider's department within the provider's Division.

4.1.3.3.5.1.16. **Sex:** This data element indicates if the provider is male or female. This element is important in appointment searches to match patient preferences for a specific gender of provider.

4.1.3.3.5.1.17. **Military Status:** This field indicates the current status of the provider within the military, e.g., active duty, civilian, Reserve, National Guard, etc.

4.1.3.3.5.1.18. **Provider Type:** This field identifies the type of service provided by the provider, e.g., full time, part time, house staff, partner, fee basis, etc.

4.1.3.3.5.1.19. **Flying Status:** This Yes/No/Null data field indicates whether the provider has a flying status. If Null, the fly status is unknown.

4.1.3.3.5.1.20. **DOB:** This field indicates the provider's date of birth. This is not a required field but will cause problems in other functions if not completed.

4.1.3.3.5.1.21. **Languages:** This field indicates the foreign language(s) the provider can speak. This information is used in appointment searches to meet patient communication requirements. The field has multiple entries.

4.1.3.3.5.1.22. **Requirement for Supervising Provider:** This field indicates whether this provider is in the General Medical Education training program and requires a supervising provider, e.g., is an intern or a resident and requires house staff oversight.

4.1.3.3.6. **Task 2: Define the Provider's Appointing Profile.** The MCP Appointing module has its own data elements that support the creation of provider schedules and the appointing of patients to those schedule slots. This function also allows the user to update some of the core data elements entered when creating a new Provider. All MCP Provider Profile data is associated with both a provider and a place of care in order to document appointing practices unique to that combination. There are four steps required to update the Provider's Appointing Profile.

-Step One: Defining demographics in the Provider Profile Managed Care Program Menu.
-Step Two: Editing provider appointing practice parameters.

-Step Three: Editing provider appointment type data elements.

-Step Four: Defining/editing the appointing reconfiguration data elements.

The user should execute the multiple options shown on the Action Bar under the CHCS Menu Paths listed below to make sure all the data is updated.

4.1.3.3.6.1. **Step One: Defining the Provider Profile Managed Care Menu Path and Data Elements.** Below listed are the menu path that gets the user to the Provider Profile Managed Care Program and the data elements that can be edited to control processing in this area. They are**:**

4.1.3.3.6.1.1. **Menu Path:** *CA → PAS → MAN Managed Care → FMCP File and Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit*

- *To edit Provider demographics and identifiers:*

- Select the Provider.

- Select (P)rovider Profile enter/edit: On this menu one will see Pro(V)ider Capacity, (G)roup add/delete, P(R)actice Parameters, (D)elete Provider from all Groups, or (Q)uit: Choose the letter **P.**

4.1.3.3.6.1.2. **NED PCM ID Type Code:** This data element indicates the type of ID for the PCM, e.g., S for SSN, C for MCSC Internal Provider Identifier, E for DoD EDIPN, H or HIPAA provider identifier, L for Legacy value, N for NPI, T for Tax identifier, D for Drug Enforcement identifier, etc.

4.1.3.3.6.1.3. **NED PCM ID:** This data element requires the entry of a unique MCP Primary Care Manager (PCM) identifier.

4.1.3.3.6.1.4. **Network Provider Type Code:** This data element indicates type of care of the provider as direct care, civilian, resource sharing, etc.

4.1.3.3.6.1.5. **Professional Category:** This data element allows for the identification of the provider's professional category such as Audiologist, Dental Surgeon, Licensed Practical Nurse, Physician Assistant. Completion of this data element is required.

4.1.3.3.6.1.6. **Gender:** This field indicates the provider's gender as either male or female. This information can be used in appointment searches to meet patient preferences for provider gender.

4.1.3.3.6.1.7. **CHAMPUS Number, Unique Provider Identification Number (UPIN #):** This data element indicates another provider identification number. ***NOTE****: These numbers may be obsolete so check with credentialing or claims office if needed.*

4.1.3.3.6.1.8. **Language(s)**: This field indicates the foreign language(s) the provider can speak. This information is used in appointment searches to meet patient communication requirements. The field has multiple entries.

4.1.3.3.6.1.9. **Receive e-mail notification of new or terminated PCM Assignments:** This data field indicates whether PCM Assignment or Reassignment notifications will be generated and e-mailed to the patient.

This code is obsolete now that enrollment is the responsibility of the MCSC.

4.1.3.3.6.2. **Step Two: Editing the Provider Appointing Practice Parameters.** Below listed is the menu path that gets the user to the edit Appointing Practice Parameters and the data elements that can be edited to control processing in this area. They are**:**

4.1.3.3.6.2.1. **Menu Path:** In the following action bar:
Select (P)rovider Profile enter/edit, Pro(V)ider Capacity, (G)roup add/delete, ***P(R)actice Parameters****, (D)elete Provider from all Groups, or (Q)uit: Q//,* the user is requested to select the letter **R** to start the process of editing the Appointing Practice Parameters.

- Select the Group and Place of Care.

- Select **(A)dd Place of Care**, (D)elete Place of Care, (V)iew Place of Care, (S)pecialties, (H)ours of Service, (P)AS Provider Profile enter/edit, or (Q)uit: **A**

- "Place of Care has not been profiled at the group level. Assigning the selected provider to this Place of Care will automatically add this Place of Care to the group profile. Do you still want to assign the provider to this Place of Care? Yes//**Y"**

4.1.3.3.6.2.2. **Hours of Service:** This data element provides a detailed display of the working hours of the clinic.
4.1.3.3.6.2.3. **Clinic Hours:** This free text field displays the clinic start and stop times, e.g. 0800 – 1600.

4.1.3.3.6.2.4. **Location:** This free text data field indicates the office/room location of the subject provider.

4.1.3.3.6.2.5. **Maximum # of Patient Appointments Per Day:** This required data field indicates the maximum number of patients that may be scheduled on any day for this provider. ***NOTE***: *A value must be entered in this field or appointments will not display for this provider. The user should select the Provider Profile option in order to update this field but is not required to do so and therefore this field is easy to miss.*

4.1.3.3.6.2.6. **Appointment Arrival Advance Time:** This field indicates the number of minutes that the patient should arrive at the Place of Care prior to the appointment.

4.1.3.3.6.2.7. **Provider Instructions:** This data field provides the provider's instructions to the patient for the visit.
4.1.3.3.6.2.8. **Print Roster with Open Appointments:** This is a Yes/No data field. If set to Yes, the printed Provider Patient Roster will show open appointments in addition to booked appointments. This is a required data element.

4.1.3.3.6.2.9. **Inactivation Date:** This data element, if populated, allows for the provider's schedules to be deleted from all clinics based on the Host Profile Inactivity Date which determines the number of days after inactivity that all of a provider's schedules will be purged. A Discrepancy Avoidance Report will be available.

4.1.3.3.6.2.10. **Appointment Types:** This data field sets up all of the appointment types that are valid and can be used on schedules for the provider in the Place of Care.

4.1.3.3.6.3. **Step Three: Editing Provider Appointment Type Data Elements.** The following data elements are defined for each appointment type in the Provider Profile. These data elements are the identical data elements supported in the Clinic Profile for each appointment type. They may be copied from the Clinic Profile to save keystrokes and then be overridden in the Provider Profile if required.

4.1.3.3.6.3.1. **Duration**: This data element provides the length of the appointment type in minutes. It is used to build the daily templates and schedules.
4.1.3.3.6.3.2. **Status**: This field indicates whether the appointment type is active or inactive. Completion of the data element is required. Appointment types cannot be deleted just inactivated.

4.1.3.3.6.3.3. **Workload Type**: This data element has two values. These values are Count or Non-Count. This field indicates whether the appointment type is considered a count or non count visit as it pertains to MEPRS workload processing. Completion of this data element is required. The appointment types in a Place of Care that have been designated as Non-Count, ALWAYS default all appointments in that Place of Care to Non-Count and they cannot be changed.

4.1.3.3.6.3.4. **Referral Required**: This data element indicates if the patient requires a referral in order to be booked to this clinic.

4.1.3.3.6.3.5. **Pull Patient Record and Pull Radiology Record**: These are Yes/No data elements and indicate whether the subject record will be pulled for that appointment type. These data elements can default to the Clinic Profile value or the user may override the clinic parameter. These are required data elements.

4.1.3.3.6.3.6. **Send Reminder Notice**: This Yes/No data field indicates if an appointment reminder notice will be sent to the patient. If Yes, CHCS will create an appointment reminder notice to be mailed to the patient. A mailed reminder notice may not be needed with the use of automated appointment reminder systems. This is a required data element.

4.1.3.3.6.3.7. **Total # of Overbooks**: This data field identifies the total number of patients to overbook per day for this appointment type and provider in this clinic.

4.1.3.3.6.3.8. **Max # of Overbooks Per Slot**: This field identifies the maximum number of patients that can be overbooked per slot per day for this appointment type and provider in this clinic.

4.1.3.3.6.3.9. **Instructions**: This data field provides any special instructions associated with an appointment type.

4.1.3.3.6.3.10. **Security Keys:** This data field allows for the setting of optional site-defined CHCS Security Keys for each appointment type. There are three security categories that can be set up and each may have multiple keys defined.

4.1.3.3.6.3.10.1. **Booking Authority**: A user must have at least one of these CHCS Security Keys in order to book an appointment with this provider and appointment type. If the user does not have this security key he/she will not see these appointments. If this security key is used, be sure to include the standard TOL user name or TOL users will not be able to access/book these appointments.

4.1.3.3.6.3.10.2. **Appointment Change Authority**: A user must have at least one of these Security Keys in order to change appointment types to new values for this provider, particularly when splitting or joining appointments.

4.1.3.3.6.3.10.3. **Overbook Authority**: A user must have at least one of these Security Keys in order to overbook an appointment for this provider in this Place of Care with this appointment type.

4.1.3.3.6.4. **Step Four: Defining/Editing the Reconfiguration Data Elements.** Reconfiguration changes are made automatically to the provider's schedule after midnight on the specified number of days before the appointment. All reconfiguration fields are optional except for the number of days. Blank reconfiguration fields leave that value in the appointment slot unchanged. The menu path below gets the user to the reconfiguration function and the data elements that can be edited to control processing during reconfiguration. They are**:**

4.1.3.3.6.4.1. **Menu Path***: PAS → MAN Managed Care Program → FMCP File and Table for MCP → PTAB Provider Network → PROV Provider Enter/Edit*

- Select Provider: <enter Provider Name>

- Select the Group and then the Place of Care.

- Select (A)dd Place of Care, (D)elete Place of Care, (V)iew Place of Care, (S)pecialties, (H)ours of Service, **(P)AS Provider Profile** enter/edit, or (Q)uit: **P**

- Select (A)ctive, (I)nactive, **(R)econfigure**, or (Q)uit: A// **R**
- For each appointment type, the data elements that can be reconfigured (changed) include the following. These can also be copied from the Clinic Profile and overridden.

4.1.3.3.6.4.2. **Reconfigured Appointment Type:** This field indicates if a change will be made to the appointment to this value.

4.1.3.3.6.4.3. **Number of days before the Appt:** This data element indicates the number of days before the appointment date to perform the reconfiguration. Values for this field can be between 0 – 99 days. Zero will execute reconfiguration after midnight the day of the appointment. Completion of this data element is required.

4.1.3.3.6.4.4. **Workload Type.** The work load type for this element can be changed to either count or non-count.

4.1.3.3.6.4.5. **Slot duration.** This field allows for changing of the duration of the appointment slot in minutes.

4.1.3.3.6.4.6. **Max # of Patients per Slot.** This field can be edited to allow for changes in the maximum # patients to be seen in this appointment slot. Values are whole numbers.

4.1.3.3.6.4.7. **Unfreeze:** This is a Yes/No field. If set to Yes, the system reconfiguration process unfreezes the appointment if frozen; and if set to No, leaves the appointment frozen.

4.1.3.3.6.4.8. **Change Detail Codes.** This flag prompts the user if they want to change the detail codes during reconfiguration. It is a Yes/No field. The flags work as follows for each of the designated appointment slots the user wants to reconfigure:

4.1.3.3.6.4.8.1. If set to "No" indicates that the existing Detail Codes remain unchanged.

4.1.3.3.6.4.8.2. If set to "Yes" with new Detail Codes, indicates that all existing Detail Codes will be replaced by the system with the new detail codes specified below.

4.1.3.3.6.4.8.3. If set to "Yes" with no Detail Codes entered, the system will remove all the detail codes from the appointment.

4.1.3.3.6.4.9. **Detail codes** – Up to 4 new detail codes will replace all existing detail codes on the appointment slot.

4.1.3.4. STEP 4: ASSEMBLING THE PROVIDER GROUP. Once the Places of Care (Step 1), Group (Step 2), and Provider Profiles (Step 3) are all input/set-up into CHCS, the final step is to link them to the Group according to CHCS rules. This is to ensure that the appointing system has the data to search for appointments with Group members in their Places of Care.

4.1.3.4.1. **Business Rules for Assembling Groups:**

4.1.3.4.1.1. Providers must be assigned to the Group and to one of the Group's Places of Care in order for the provider's appointments in that Place of Care to display when booking an appointment.

4.1.3.4.1.2. The Provider Specialties must be defined for the provider in the Place of Care in the Group or appointments will not display.

4.1.3.4.1.3. PCMs and PCM Capacities cannot be defined until the two steps above are complete.

4.1.3.4.1.4. Sites must keep capacities up to date in DEERS so that the MCSC can enroll beneficiaries to a PCM.

4.1.3.4.1.5. Some sites will pad their capacities to allow enrollment to continue when disenrollments are delayed.

4.1.3.4.2. **Select the Menu Path for Assembling Groups.** Below listed is the menu path that allows the user to edit the Assembling of Groups. It is**:**

- PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → GROU Group Enter/Edit
Or ^GROU

- Select (A)dd Place of Care, **(P)roviders**, (D)elete Place of Care, (V)iew Place of Care Profile, or (Q)uit: Select the letter **P.**

- Select the provider or PCM **in their Place of Care** to add to the Group. The Place of Care must have been assigned to the Group or can be assigned at this point.

4.1.3.4.3. **Business Rules Identifying PCMs and Their Attributes.** Primary Care Providers may be designated as PCMs by setting a flag in CHCS. The following are the business rules for identifying PCMs and their attributes:

4.1.3.4.3.1. A provider must be designated in CHCS as a PCM for the MTF, Provider Group, Place of Care, and Provider Specialty combination indicating how they will provide care to their enrollees.
4.1.3.4.3.2. PCMs may have enrollees in multiple Places of Care and/or multiple MTFs provided they are defined for each combination.

4.1.3.4.3.3. Direct Care PCMs in CHCS must be on DEERS and have a DoD EDIPN as their identifier (PCMBN requirement) in order to accept enrollees.

4.1.3.4.3.4. CHCS will send all CHCS Direct Care PCM data and capacities to DEERS.

4.1.3.4.4. **Identify PCMs and Their Attributes.** The menu path is shown below with the data elements that govern the processes related to identification of PCMs and their attributes. They are**:**

4.1.3.4.4.1. **Menu Path***: PAS → MAN Managed Care Program → FMCP File/Table for MCP → PTAB Provider Network → GROU Group Enter/Edit*

- Select the Place of Care and provider.

- Select (A)dd Place of Care, (D)elete Place of Care, (V)iew Place of Care, **(S)pecialties**, (H)ours of Service, (P)AS Provider Profile enter/edit, or (Q)uit: **S**

- Select the Provider Specialty for enrollment.

4.1.3.4.4.2. **Accepts Specialty Referrals:** This is a Yes/No data element**. The user must always set this flag to Yes or appointments will not display to the booking agent**. If set to No, appointments for this specialist will not display when booking including consults and referrals.

4.1.3.4.4.3. **Accepts PCM Assignments:** This Yes/No data element indicates that a provider is a PCM in the designated MTF, Place of Care and Group for the designated Provider Specialty and can be assigned enrollees at that place of care. This data field is important to identify in DEERS actual PCMs who can accept enrollments and their enrollment capacities and locations.

4.1.3.4.4.4. **Setting Up Maximum Provider Capacities:** Users will need to set up the maximum numbers of enrollees that a PCM can be assigned. To do so the following steps are required:

4.1.3.4.4.4.1. **Menu Path:** Select (A)dd Place of Care, (D)elete Place of Care, (V)iew Place of Care, (S)pecialties, **(C)apacities**, (H)ours of Service, (P)AS Provider Profile enter/edit, or (Q)uit: Pick the letter **C.**

4.1.3.4.4.4.2. **Maximum Provider Capacities:** Once the PCM flag is turned on for a provider in the Place of Care, Group, and Provider Specialty, the maximum number of enrollees that may be assigned to

the PCM for that combination must be defined. Capacity limits may be broken out by age limits and by Beneficiary Categories to balance the PCM's panel. Capacities are sent to DEERS where they limit the number of enrollees permitted to be enrolled to this PCM in this Provider Group and Place of Care.

4.1.3.4.5. **Business Rule for Appointing to the PCM.** Additional business rules are listed below governing appointing to PCMs in a group:

4.1.3.4.5.1. A patient may see any member of the PCM's Group if the PCM is not available. If the visit is within access standards, the clinic meets the standard. However this does not support PCM by Name continuity.

4.1.3.4.5.2. Members of a PCM Group may be scheduled with appointments with the Group's Prime patients even though they are not designated as PCMs.

4.1.3.4.5.3. Members of a PCM Group who have schedules in multiple Places of Care/Groups may see a PCM's Prime patients in those other Places of Care provided those Places of Care are in the enrollee's MTF. The other Place of Care gets the workload credit.

4.1.3.4.6. **Inactivation Processes For Providers And Places Of Care.** Some basic inactivation lessons are listed below. explaining the processes to follow when inactivating providers and places of care.

4.1.3.4.6.1. Consult the Enrollment experts at your MTF. **NOTE:** This is a complicated process.

4.1.3.4.6.2. Providers and Places of Care with assigned enrollees must be done very carefully. Enrollees must be reassigned to another Place of Care and/or provider before the Place of Care can be inactivated.

4.1.3.4.6.3. Open appointments for schedules for inactivated providers should be facility canceled. If another provider is covering for the inactivated provider, then the schedules may be transferred to that provider.

4.1.3.4.6.4. Booked appointments for inactivated providers should be transferred to other providers.

4.1.3.4.6.5. It is recommend that users usually back out all the assignments for the Group in reverse order prior to inactivation, i.e., remove the enrollees,

then the providers, then the Places of Care, then turn off the Group. But check the details first.

4.1.4. UPDATING THE PROVIDER SPECIALTY TYPES TABLE

4.1.4.1. When searching for appointments, CHCS uses the links in the Specialty Table to find providers with clinical skills related to and qualifying for the care requested, i.e., CHCS will display appointments with providers that have any provider specialty linked to the requested clinic specialty and/or vice versa. This table is maintained by the MTF.

4.1.4.2. The provider specialty table links the following and expands the appointments that the search finds by linking specialties that will match the search results as follows:

4.1.4.2.1. By provider specialties to clinic specialties and vice versa.

4.1.4.2.2. By provider specialties to provider specialties.

4.1.4.2.3. By clinic specialties to clinic specialties.

4.1.4.3. **Specialty Type Table Business Rules.**

4.1.4.3.1. An appointment search for a specific clinic or provider specialty will also find any appointments with a clinic or provider specialty that is linked in the table to the requested specialty.

4.1.4.3.2. Provider specialties can include professions such as Nurse Practitioner, General Medical Officer, etc. in order to find Primary Care appointments with these types of provider,

4.1.4.4. **Specialty Type Table Menu Path.** Users can get to this function as follows:

PAS → MAN Managed Care → FMCP File and Table → PTAB Provider Network File → SPEC Specialty Type Enter/Edit

4.1.5. VALIDATING THE PROVIDER GROUP BUILD. The Provider Group Report can help validate that the group was correctly defined. It lists the following information so the user can determine if the Places of Care are all defined, the clinic specialties are complete, and all the PCMs are defined and have capacities in the Group and have the

correct Places of Care. It does not report Non-PCMs in the Place of Care. It does not list non-PCMs assigned to the group. As follows are the menu path and the output of the Provider Group Report:

4.1.5.1. **Menu Path**: *PAS → MAN Managed Care Program → OMCP Outputs and Management Reports → NPRM Network Provider Reports → GMRM Group Management Reports → 2 Provider Group Report*

4.1.5.2. Lists Provider Groups and their Places of Care with the MEPRS and Clinic Specialties for each Place of Care.

4.1.5.3. Lists valid appointment types and their attributes for each Place of Care.

4.1.5.4. Lists the enrollment capacities for Places of Care with PCMs.

4.1.5.5. Lists the PCMs who are assigned to the Group.

5. CLINIC PROFILING RECOMMENDATIONS.

5.1. Make sure that the Access to Care Reporting flag is set to Yes. This action supports the measurement of Access To Care for the measured clinic/group. It allows for the printing of the Access To Care Summary Report.

5.2. If a clinic supports self-referrals, set the clinic Self-Referrals Allowed flag to Yes.

5.3. Build the correct hospital locations for all the clinics where schedules will be created.

5.4. Assign the correct set of clinic specialties to all the outpatient clinics so that care can be found when searching for appointments by clinic specialty.

5.5. Make sure the correct appointment types that will be booked by any provider in the clinic are entered in the Clinic Profile.

5.6. Beware of using the Booking Authority security keys. If using security keys, make sure system users privileges and names are up to date and include TOL user. Perform regular updates/purges of authorized booking agents.

6. PROVIDER PROFILING RECOMMENDATIONS.

6.1. Assign each provider to all the Provider Groups and Places of Care where they will treat patients and where schedules will be created.

6.2. Assign the correct set of Provider Specialties to the providers so that CHCS will find their appointments when a user searches for appointments for that care.

6.3. Make sure the correct appointment types that will be booked for any provider in the clinic are entered in both the Clinic and Provider Profiles.

6.4. Make sure, if security keys are required, that the correct security keys are assigned to the appointment types in the Provider Profiles. These would include:

6.4.1. Booking Authority.

6.4.2. Appointment Change Authority.

6.4.3. Overbook Authority.

6.5. If a provider is a PCM, set the PCM flag to Yes under the Group, Place of Care, and Provider Specialty that the PCM care will be provided.

6.6. Make sure Provider Specialties and the Provider Type support the Provider Availability metrics to identify residents and faculty. These specialty codes must be correct or appointments may not be found.

6.7. Make sure the Clinic Specialties and Provider Specialties are properly linked. If they are not, searches may not find any appointments. See section 4.1.4.

APPENDIX P

TRICARE ONLINE (TOL)

APPENDIX P

TRICARE ONLINE (TOL)

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APPENDIX P

TRICARE ONLINE (TOL)

1. Foreword.

1.1. This appendix of the *Military Health System Guide to Access Success* describes TRICARE Online (TOL). TOL is the enterprise-wide, secure, Internet portal for use by DoD beneficiaries, providers, managers, external support contractors, and medical support staff worldwide. TOL is utilized to access healthcare services, benefits and information. TOL is a scalable, cutting-edge application that supplies a secure infrastructure for eHealth initiatives.

1.2. Although the Automated Web Appointing is a key interactive function of TOL designed to improve beneficiary experiences with access to care, reduce costs, and has demonstrated the potential for a significant Return on Investment (ROI), this is only one of many TOL functions.

1.3. Private sector research has indicated that consumers are more drawn to, and more likely to return to healthcare websites that offer a variety of integrated functions and capabilities. Furthermore, they found consumers were not drawn to health websites for administrative functions alone. Civilian organizations have demonstrated that when consumer priorities were integrated into one website, usage increased dramatically. Increased utilization rates can result in increased use of the administrative functions (e.g., Pharmacy Refill, Web appointing), which in turn, ROI.

1.4. Military Treatment Facility (MTF) continued support and visibility is the key to successful implementation and maintenance of TOL. Personnel training, marketing and awareness at all levels of the MTF and beneficiary population is paramount to continued success. The information provided in this appendix is a guide to assist MTFs with implementation and sustainment. Information within this guide is up to date as of the posting of this appendix; however, is subject to revision as new capabilities are brought online.

2. TOL Web-based Appointing Functions.

2.1. Authorized users of TOL appointing functions

2.1.1. Must be a DoD beneficiary who is registered in the Defense Enrollment Eligibility Reporting System (DEERS) or be granted access to the system by those with the appropriate security roles.

2.1.2. Must be validly registered on TOL with a password and a Personal Identification Number (PIN).

2.1.3. Must be enrolled to an MTF that has web enabled schedules on TOL

2.1.4. Beneficiaries who are enrolled to a PCM by name at the MTF **may** book:

2.1.4.1. TOL PCM Visit Reasons with their PCM/PCM Group

2.1.4.2. or may book into any self referral specialty clinics for appointments that are categorized as TOL Self Referral Visit Reasons.

2.1.5. Beneficiaries that are not enrolled to the MTF (space available patients) but have registered in TOL to the MTF may book to self referral clinics for TOL Self Referral Visit Reasons if not restricted by MTF self-referral clinics.

2.2. TOL Authorized User Appointing Function Restrictions:

2.2.1. Authorized TOL users can only have up to 2 active appointments at any one time booked via TOL. NOTE: Beneficiaries may have 2 active appointments booked via TOL on the same day and even in the same clinic.

2.2.2. Each member of the same family must be separately registered in TOL and possess a separate TOL account. These separate accounts need to have different user names for each family member. All family members may share the same password.

2.2.3. TOL authorized users must renew their accounts and passwords every 150 days. Problems with re-setting passwords should be addressed to the MHS Helpdesk.

2.3. General TOL Appointing Business Rules:

2.3.1. To web enable TOL PCM and Self Referral Visit Reasons, there are specific steps that the MTF must take with appointing templates and schedules in the Composite Health Care System (CHCS).

2.3.2. TOL Systems Administrators (SAs) should work with CHCS template managers to determine which appointments in CHCS schedules they are web-enabling in TOL.

2.3.3. To make appointment types visible (web-enabled) on TOL, combinations of particular appointment types and detail codes must be set-up in CHCS appointing templates and/or schedules to correspond to various TOL PCM and Self-Referral Visit Reasons. (See Tables 1 and 2).

2.3.4. CHCS Appointment types ACUT, OPAC, ROUT, WELL, SPEC, PCM, and EST can be web-enabled for booking on TOL.

2.3.5. CHCS appointments types with the (dollar sign) $ suffix cannot be web-enabled, even if they are paired with a WEA detail code.

2.3.6. CHCS appointment types, GRP, PROC, Ambulatory Patient Visits (APV) or Emergency Room (E-room) cannot be web-enabled for appointing on TOL.

2.3.7. Appointments slots in CHCS that require a referral cannot be web-enabled.

2.4. PCM Visit Reasons:

2.4.1. All 11 PCM Visit Reasons display on the *TOL Appointing Visit Reason dropdown menu* (See Table 1). These reasons display even if not populated (or web-enabled) from CHCS to TOL.

2.4.2. TOL PCM Visit Reason booking mirrors the functions of PCM booking in CHCS. Beneficiaries who are enrolled to a PCM at the MTF **c**an search for and book TOL PCM Visit Reasons. Non-enrolled (space available) beneficiaries cannot search for or book TOL PCM Visit Reasons.

2.4.3. If allowed by the MTF TOL SA, enrolled beneficiaries can search for PCM Visit Reasons with:

2.4.3.1. Their own PCM.

2.4.3.2. Their own PCM in a different clinic location

2.4.3.3. The other PCMs on their own PCM's team/group only

2.4.3.4. The PCMs on their own PCM's team/group in different clinic locations

2.4.3.5. Non PCM providers which are other Doctors, Physician Assistants, Nurse Practitioners (NPs), part-time provider/floaters/back-ups), registered nurses and technicians who are members of the PCM Group that DO NOT have assigned/enrolled patients

2.4.4. The search and booking function of PCM Visit Reasons does not permit an enrolled TOL user to cross-book to other PCM teams, e.g. Patients assigned to the Red Family Practice Group cannot book appointments to the Blue Family Practice Group in the same MTF on TOL.

2.4.5. To display TOL PCM Visit Reasons to enrolled beneficiaries, CHCS template managers must set up appointments types and detail codes per the guidance listed in Table 1.

Table 1: Business Rules to Web-Enable CHCS appointments into PCM Visit Reasons, showing corresponding CHCS Appointment Types, and mandatory Detail Codes needed on CHCS templates and schedules.

Primary Care Manager Visit Reasons	CHCS Appt Type(s)	Mandatory Detail Code(s)
New Problem/Urgent with PCM/PCM Group	ACUT, OPAC	WEA
Follow-up PCM Visit with PCM/PCM Group	EST, OPAC	WEA
First Visit with PCM	PCM	WEA
New Problem/Not Urgent with PCM/PCM Group	ROUT, OPAC	WEA
Pap Smear with PCM /PCM Group	WELL, OPAC	WEA and PAP
Return to Duty with PCM/PCM Group	WELL, OPAC	WEA and WCE
Return to Flight Status with PCM/PCM Group	WELL, OPAC	WEA and WCE and FLT
School Physical with PCM/PCM Group	WELL, OPAC	WEA and SCH
Well Baby Exam with PCM/PCM Group	WELL, OPAC	WEA and WB
Diabetes Maintenance with PCM/PCM Group	WELL	WEA and DM
Diabetes Follow-up with PCM/PCM Group	EST	WEA and DM
Active Duty PHA with PCM/PCM Group	WELL	WEA and PHA

2.5. Self-Referral Visit Reasons.

2.5.1. To ensure that TOL Self-Referral Visit Reasons become web-enabled, CHCS Template Managers, TOL SAs and others as appropriate need to work together to decide which appointments in CHCS will be web-enabled.

2.5.2. CHCS Template Managers/CHCS Systems Administrators with the appropriate access will set the “Self-Referrals Allowed” flag in the CHCS Clinic profile to “Yes” for clinics wanting to web-enable Self-Referral Visit Reasons.

2.5.3. Clinic Managers must understand that setting this flag to “Yes” not only allows the clinic to web-enable TOL Self-Referral Visit Reasons, it also opens up the clinic to allow booking of non-enrolled/enrolled elsewhere patients into its schedules by appointing agents of the MTF and of MTFs on a shared CHCS host.

2.5.4. Both enrolled and non-enrolled (space available) TOL users can search for and book TOL Self-Referral Visit Reasons.

2.5.5. Clinics can allow only enrolled TOL users to book TOL Self-Referral Visit Reasons by using Patient Access Type Detail Codes BPAD, BPAP, BPAPS, and BPPR. Using these detail codes prevents Non-Enrolled (Space Available) beneficiaries from booking these appointments.

2.5.5.1. Example: A space available patient that has registered to Fort Sample is prevented from booking the Self-Referral Visit Reason, Physical Exam, which was web-enabled by this MTF's Wellness Clinic because the BPAPS (Active Duty/Prime/TRICARE Plus Only) detail code was used on its CHCS schedules.

2.5.6. Clinics cannot restrict enrollees registered to other MTFs that share the CHCS host from searching for and booking Self-Referral Visit Reasons that they web-enabled.

2.5.6.1. Example: Sample AFB Optometry Clinic that shares a CHCS host with Fort Example cannot restrict Fort Example's enrollees from searching for and booking Annual Eye Exam Self-Referral Visit Reasons at the Sample AFB's Optometry Clinic.

2.5.7. TOL Self-Referral booking mirrors Self-referral, Non-enrollee and Enrolled Elsewhere booking functions in CHCS appointing.

2.5.8. To display TOL Self-Referral Visit Reasons to enrolled and/or non-enrolled beneficiaries, CHCS template managers must set up appointment types and detail codes per the guidance listed in Table 2.

Table 2: Business Rules to Web-Enable CHCS appointments into Self-Referral Visit Reasons, showing corresponding CHCS Appointment Types, and mandatory Detail Codes needed on CHCS templates and schedules.

Self-Referral Visit Reasons	CHCS Appt Type(s)	Mandatory Detail Code(s)
PAP Smear	WELL	WEA and PAP
Preventive Health Assessment (PHA)	WELL	WEA and PHA
Annual Eye Exam	WELL	WEA and EYEEX
Hearing Screening	WELL	WEA and AUENT
Well Baby Exam	WELL	WEA and WB
Routine Physical	WELL	WEA and PE

Self-Referral Visit Reasons	CHCS Appt Type(s)	Mandatory Detail Code(s)
School Physical	WELL	WEA and SCH
Flight Physical	WELL	WEA and FLT
Dietary Counseling	WELL	WEA and NUTR
Mental Health	SPEC, WELL, OPAC	WEA and MH
Return To Duty	EST, OPAC	WEA and WCE
Return To Flight Status	EST, OPAC	WEA and FLT
Dental Exam/ Cleaning	DROUT	WEA and DEXPR
Dental Cleaning	WELL	WEA and DPRO
Dental Exam	DROUT	WEA
Sports Medicine Same Day	OPAC	WEA
Sports Medicine Follow-up	OPAC, EST	WEA
Diabetes Maintenance any Provider	WELL	WEA and DM
Diabetes Maintenance Follow-up any Provider	EST	WEA and DM
Eye Exam Follow-up	EST	WEA and EYEEX
PRK Follow-up	EST	WEA and EYEEX and PRK

2.6. Use of Detail Codes for TOL Appointing Functions. The TOL appointing function works with 5 categories of detail codes. These categories are web-enabling, patient access types, age, gender and the mandatory detail codes listed in Tables 1 and 2.

2.6.1. Use of WEA Detail Codes:

2.6.1.1. Template managers must use the “Web-Enabled Appointment” (or WEA) detail code to designate those appointment slots in CHCS that they want to web-enable on TOL. Without using the WEA detail code, appointments in CHCS WILL NOT display for booking on TOL

2.6.1.2. This detail code must be used to web-enable both TOL PCM and Self-Referral Visit Reasons. When entered into an appointment slot in CHCS, it allows TOL to display these “WEA” slots on the web.

2.6.1.3. The WEA detail code may be added into any of the four detail code fields on the CHCS template or schedule and can be used on both count and non-count appointment slots.

2.6.1.4. The use of the WEA detail code does not preclude booking by other means in CHCS such as by phone or walk-up appointment requests by patients.

2.6.1.5. WEA appointments will be booked on a first come first serve basis by either TOL users or CHCS appointing agents.

2.6.2. Using Patient Access Type or "BP" Detail Codes.

2.6.2.1. The functionality of TOL appointing permits MTF CHCS template mangers to use Patient Access Type detail codes to allow or restrict certain categories/groups of TOL users from searching for and booking appointments on TOL. Full definitions and information on the use of Patient Access Type Detail codes are listed in Appendix N of this guide. These Patient Access Type detail codes with an abbreviated definition of the group of beneficiaries it permits to book appointments on TOL are listed as follows:

2.6.2.1.1. BPAD: Active Duty only

2.6.2.1.2. BPAP: Active Duty and Prime only

2.6.2.1.3. BPPR: TRICARE Prime only

2.6.2.1.4. BPNAD: No Active Duty

2.6.2.1.5. BPNPR: No Prime

2.6.2.1.6. BPNAP: No Active Duty, No Prime

2.6.2.1.7. BPSP: TRICARE Plus Only

2.6.2.1.8. BPAPS: Active Duty, Prime, and TRICARE Plus Only

2.6.2.1.9. BPTS: TRICARE Standard Only

2.6.2.2. Use of the patient access type detail code, BPGME-Graduate Medical Education, does not work with the TOL appointing function.

2.6.2.3. TOL and CHCS system functionality dictates that <u>ONLY ONE</u> Patient Access Type (BP) Detail code can be used on a template or schedule appointment slot. CHCS will not recognize the second listed BP detail code if used.

2.6.2.4. If no Patient Access Type detail code is listed on a Web enabled appointment slot, any category/group of beneficiary can search for and book appointments according to the booking rules of PCM and Self-Referral Visit Reasons stated above.

2.6.3. Using Age Detail Codes.

2.6.3.1. MTFs can tailor their CHCS appointment slots to allow patients of certain ages to be booked into these slots by adding MTF defined age codes to the detail code fields. Once age detail codes are added in CHCS, TOL will automatically permit only a patient in the age range defined by the MTF to be booked into that web enabled appointment slot. MTFs can use age detail codes to schedule various pediatric, adolescent, or geriatric care for their TOL users.

2.6.3.2. Age codes must adhere to the following formatting standards and include a time buffer so patients can book early or late in relation to their present age:

2.6.3.2.1. Correct formats include an age range with a lower and upper limit and a hyphen.

2.6.3.2.2. The letter M indicates age in months plus or minus 60 days. Example: 3M-6M represents a patient between 3 and 6 months of age.

2.6.3.2.3. The letter D indicates age in days plus or minus 14 days. Example: 3D-21D represents a patient between 3 days and 21 days of age.

2.6.3.2.4. The letter W indicates age in weeks plus or minus 14 days. Example: 1W-6W represents a patient between 1 and 6 weeks of age.

2.6.3.2.5. A number alone indicates age in years plus or minus 30 days. Example: 0-12 represents a patient between 0 and 12 years of age.

2.6.3.2.6. A hyphen is the only allowed separator between the upper and lower age range.

2.6.3.2.7. The low and high numbers are inclusive and the low age precedes the upper age limit.

2.6.3.2.3. Individual MTFs/sites must add age detail codes to the Detail Code Table in CHCS so that the system will recognize them.

2.6.3.2.4. CHCS and TOL match the patient's actual age to the age detail code on the appointment slot to automatically permit or deny the appointment slot to be booked by specific ages of patients, e.g. Grandpa, age 80 cannot be booked into a pediatrics appointment slot templated with a "1-18" age detail code.

2.6.4. Guidance on the Use of Gender Detail Codes.

2.6.4.1. MTF template managers can use gender detail codes to ensure that CHCS matches the correct gender TOL user to the correct gender detail code on the web-enabled appointment slot.

2.6.4.2. Gender detail codes are as follows:

2.6.4.2.1. FE-Female

2.6.4.2.2. MA-Male

2.6.4.3. Once used on CHCS template and schedule appointment slots, the TOL appointing function can also use these detail codes to identify the correct gender of TOL users booking web based appointments. Example: Web enabled appointments with FE detail codes will only display to female TOL users.

2.6.5. Using Disallowed Detail Codes. If detail codes other than WEA, Patient Access Types, Gender Codes, Age Codes and those mandatory detail codes listed in tables 1 and 2 are used on CHCS templates or schedules, these appointment slots will not display on TOL appointing. Those detail codes are listed in Table 3.

Table 3: Disallowed Detail Codes on TRICARE Online. If any of the detail codes listed in this table are used in CHCS appointing templates or schedule appointment slots, those slots in CHCS will not display on TOL, even if one of the other detail codes is WEA.

1TT	2TT	3TT	ACG
ACUP	AD	ADEI	ADHD
ADSC	ADTX	ANGER	ANPST
ANRD	AQUA	ASTHMA	ASTIG
BCP	BEESN	BEPC	BF
BF>	BFC	BIO	BK
BOTOX	BPGME	BRON	BTL
CARD	CATH	CAVH	CB
CCEP	CHOL	CIRC	CLEFT
CM	CMDPSY	CNM	COB
COLON	COLPO	CORSCR	COSMETIC
COUNS	CPAP	CYSTO	DCONS
DENDO	DERM	DEVAL	DEXA
DEXAM	DIL	DOMFS	DOPER
DORTHO	DOSIM	DPEDO	DPERIO
DPO	DPROS	DSC	DSGCH
DTMD	DVIOL	DXE	E&I
EAR	ECG	ECHO	EDU
EEG	EFMP	EGD	EMGM
ENG	EP	ERCP	EVAL
EXERC	EYEDZ	FAM	FCC
FLAP	FLEXS	FNA	FOOT
GAST	GDB	GDBL	GENE
GYN	HAE	HAND	HBT
HC	HCATH	HCDC	HEAD
HOLT	HSG	HTN	IDC
IMDEF	INF	INJECT	INS
ISOK	IUD	IVP	KNEE
LASER	LASEYE	LASIK	LBX

Table 3-Disallowed Detail Code Listing Continued:

LEEP	LES	LP	MANO
MANO/PH	MC	MEB	MEDEX
MH	MINOR	MOBEX	MOHS
MOVDIS	NBO	PFT	PHOTO
PLASMA	PNB	POAE	POP
PP	PPD+	PRENAT	PREOP
PRT	PULM	PVA	PVR
REHAB	RET	RMV	RP1
RP2	RP3	RP4	RP5
RP6	RP7	RP8	RP9
RPD	RPG	RPRE	RTM
RUG	RX	SCOLI	SCS
SEA	SKT	SLEEP	SPD
SPE	SPRINT	STRESS	STROKE
TECH	TEE	TELMED	THAL
TILT	TOBCES	TOUR	TRACTION
TRPLT	TRUS	URODY	UROGYN
US	VAERS	VAS	VF
VIP	VT	WOUND	WT

2.6. TOL Appointing Availability Business Rules:

2.6.1. For CHCS appointments to be available on TOL, CHCS template managers and TOL SAs need to decide on which appointments will be web enabled.

2.6.2. Appointments that are made available to TOL will generally be but are not limited to the schedules of Family Practice, Primary Care, Flight Medicine, Pediatrics, Internal Medicine, Optometry, Nutrition Care, Audiology, Women's Health, Dental and Mental Health Clinics.

2.6.3. Appointments are generally not available to the web in clinics requiring a referral for an appointment.

2.6.4. CHCS template managers and TOL SAs can use the following templating rules to maximize the availability of CHCS appointments to the web. They are:

2.6.4.1. Rule 1: The appointment slot can be the ACUT, ROUT, PCM, EST, OPAC, WELL, SPEC, DROUT standard appointment type. Corollary: Appointment slots cannot be GRP, PROC or appointment types with the $ suffix.

2.6.4.2. Rule 2: Rule 1 must be satisfied plus the appointment slot must contain a WEA detail code in any one of the four detail code fields. .

2.6.4.3. Rule 3: Rules 1 and 2 must be satisfied and the appointment slot may also contain age, and/or gender and/or patient access type detail codes (e.g. BPAP) in any of the four detail code fields.

2.6.4.4. Rule 4: If the appointment slot contains the WELL appointment type and it only has a WEA in detail code fields 1-4, it is NOT available to the web.

2.6.4.5. Rule 5: For appointment slots that have the WELL standard appointment type to be available to the web, they must have a WEA detail code AND one of the following detail codes: PAP or PHA or EYEEX or AUENT or WB or PE or SCH or FLT or NUTR or MH or DEPRO or DEXPR in one of the other 3 detail code fields, per the guidance on Tables 1 and 2 above.

2.6.4.6. Rule 6. If Rule 5 is met, an appointment slot with the WELL standard appointment type MAY also contain age, and/or gender and/or patient access type detail codes (e.g. BPAP) in any of the 3 other detail code fields. The WELL standard appointment type cannot stand alone with WEA, age, gender or patient access type detail codes. It must also have the detail codes listed in rule 5.

2.6.4.7. Rule 7: If Rules 1 – 6 are satisfied, the appointment slot may not contain more than 1 patient access type detail code, e.g. BPAD and BPAPS.

2.6.4.8. Rule 8: If there is a disallowed detail code in combination with ANY of the first 7 rules, it makes that slot unavailable to web booking. See table 3.

2.7. Potential Target Clinics and Visit Reasons for Web Based Appointing. The following clinics are listed as potential targets for web based appointments. The TOL Visit Reasons with the corresponding CHCS Appointment type and required detail codes are listed under each potential clinic. Self-referral Visit Reasons are annotated with a asterisk (*). This section should be used to assist CHCS template managers and TOL SAs to decide what appointment slots to web enable.

2.7.1. Family Practice or Primary Care Clinics.

2.7.1.1. All acute or New Problem Urgent slots (ACUT, WEA)

2.7.1.2. All routine or New Problem Not Urgent slots (ROUT, WEA)

2.7.1.3. All follow-up slots or Follow-up with PCM slots (EST, WEA)

2.7.1.4. All return to duty slots with PCM (WELL, WEA, WCE)

2.7.1.5. All Pap smear slots (WELL, PAP, WEA).

2.7.1.6. All well baby visits (WELL, WB)

2.7.1.7. All school physicals (WELL, SCH)

2.7.1.8. All first visits with PCM (PCM, WEA)

2.7.1.9. All designated diabetes maintenance and f/u slots (WELL, WEA, DM**)**

2.7.1.10. All routine physicals slots (WELL, PE)

2.7.1.11. All Preventive Health Assessments (WELL, WEA, PHA). Identify both PCM and Self-Referral Visit Reasons.

2.7.2. Pediatric Clinics.

2.7.2.1. All acute or New Problem Urgent slots (ACUT, WEA)

2.7.2.2. All routine or New Problem Not Urgent slots (ROUT, WEA)

2.7.2.3. All follow-up slots with PCM (EST, WEA)

2.7.2.4. All Well Baby visits with PCM (WELL, WB)

2.7.2.5. All School Physicals (WELL, SCH)

2.7.2.6. Specific Well Baby and School Physical visits can be set up for infants and children from age 2 weeks to 18 years old using age detail codes.

2.7.2.7. During school physical time advertise that TOL can be used to book these slots.

2.7.2.8. All First Visits with PCM (PCM, WEA)

2.7.3. Flight Medicine Clinics.

2.7.3.1. All Acute or New Problem Urgent slots (ACUT, WEA)

2.7.3.2. All Routine or New Problem Not Urgent slots (ROUT, WEA)

2.7.3.3. All Follow-up slots with PCM (EST, WEA)

2.7.3.4. All return to duty slots (WELL, WEA, WCE)

2.7.3.5. All return to flight status slots (WELL, WEA, FLT, WCE)

2.7.3.6. All PAP smear slots (WELL, PAP, WEA)

2.7.3.7. All well baby visits (WELL, WB)

2.7.3.8. All school physicals (WELL, SCH)

2.7.3.9. All first visits with PCM (PCM, WEA)

2.7.3.10. *All routine physicals slots (WELL, PE)

2.7.3.11. *All Preventive Health Assessments (WELL, WEA, PHA) either PCM or Self Referral Visit Reasons

2.7.4. Internal Medicine Clinic.

2.7.4.1. All acute slots (ACUT, WEA)

2.7.4.2. All routine slots (ROUT, WEA)

2.7.4.3. All follow-up slots (EST, WEA)

2.7.4.4. All first visits with PCM (PCM, WEA)

2.7.4.5. All designated diabetes maintenance and follow-up slots (WELL, WEA, DM)

2.7.4.6. *All routine physicals slots (WELL, PE, BPAP)

2.7.5. Open Access Clinics.

2.7.5.1. All acute slots (OPAC, WEA)

2.7.5.2. All routine slots (OPAC, WEA)

2.7.5.3. All follow-up slots (OPAC, WEA)

2.7.5.4. All return to duty slots (OPAC, WEA, and WCE)

2.7.5.5. All return to flight status slots (OPAC, WEA, FLT, and WCE)

2.7.5.6. All pap smear slots (OPAC, PAP, WEA)

2.7.5.7. All well baby visits (OPAC, WB)

2.7.5.8. All school physicals (OPAC, SCH)

2.7.5.9. All first visits with PCM (PCM, WEA)

2.7.5.10. All designated diabetes maintenance and follow-up slots (WELL, WEA, DM)

2.7.5.11. *All routine physicals slots (WELL, PE)

2.7.5.12. *All Preventive Health Assessments (WELL, WEA, PHA), either PCM or self-referral visit reason

2.7.6. Optometry Clinics.

2.7.6.1. All annual eye exam slots (WELL, EYEEX).

2.7.6.2. All follow-up eye exam slots (EST, EYEEX)

2.7.6.3. Optometry Clinics on shared hosts will have to work with other MTFs on the host to coordinate how patients are seen. Two Examples:

2.7.6.3.1. Patients enrolled to San Antonio CHCS Host can be seen for Optometry at Randolph AFB, Lackland AFB, or Brooke Army Medical Center.

2.7.6.3.2. Patients enrolled to National Capital Region CHCS Host, may only be seen for Optometry at the MTF where they are enrolled for primary care.

2.7.7. Women's Health Clinics.

2.7.7.1. *All routine pap smears (WELL appointment type with WEA, PAP, FE, BPAPS or BPAP or BPAD detail codes)

2.7.8. Mental Health Clinics.

2.7.4.10.1. Self referral mental health counseling requests (WELL appointment slots, with WEA and MH detail codes)

2.7.9. Preventative Health/Force Protection Clinics.

2.7.4.11.1. For Preventive Health Assessments (WELL, WEA, PHA)

2.7.10. Audiology Clinics.

2.7.10.1. All hearing screenings/exams (WELL appt slot with AUENT detail code)

2.8. Summary of Steps to Ensure that Appointments from CHCS are Available to the Web.

2.8.1. Step 1: Decide what appointments to display on TOL with the CHCS Template Manager and TOL SAs. Review the potential clinics listed in paragraph 2.8. above to decide which clinics and visit reasons to web enable.

2.8.2. Step 2: Code appointments in CHCS.

2.8.2.1. Set up the correct combinations of appointment types and detail codes to ensure availability of TOL visit reasons.

2.8.2.2. Use the appropriate detail codes to include Gender, Patient Access Types, Age detail codes (correctly coded), WEA and the allowed/sanctioned detail codes per Tables 1 and 2.

2.8.2.3. Do not use any of the disallowed detail codes listed in Table 3.

2.8.2.4. CHCS PCM files and tables should be configured appropriately to optimize numbers of appointments.

2.8.2.5. Turn clinic self referral flag to yes in the CHCS clinic profile if self-referral visit reasons need to be web-enabled and available to the web.

2.8.3. Step 3: Set up the TOL side of the appointing process as listed in Figures 1 thru 9 below.

2.8.3.1. Set up OPAC parameters, search ranges, assistance text, etc. in the Manage Appointment Parameters in TOL. Note: See Figure

2.8.3.2. Identify and map self referral clinics to self-referral visit reasons. Note: See Figure 8.

2.8.4. Step 4: Go to the TOL appointment booking site and check to see if appointment slots in CHCS are visible on TOL schedules.

2.8.4.1. It may be necessary to ask other TOL users to search for web-enabled appointments. This search indicates if appointments in various clinics for TOL users with various demographics are available.

2.8.4.2. If personnel do not see slots that were thought to be web-enabled, TOL SAs will need to repeat steps 1-3.

2.8.5. Step 5: TOL SAs should ask their Clinic Managers if inappropriate patients are getting in via TOL, then make corrections if needed. Example: Is Grandpa getting an appointment in Pediatrics?

2.9. Managing Appointing Parameters. A series of TOL managing appointing screen shots are displayed below with instructions that will assist TOL SAs in obtaining the correct settings to successfully administer TOL appointing functions. The list of figures is as follows:

2.9.1. Figure 1: Finding the Managing Appointment Parameters on TOL

2.9.2. Figure 2: Defining Open Access Parameters

2.9.3. Figure 3: Defining TOL Appointing Search Parameters

2.9.4. Figure 4: Setting Up TOL Assistance Text

2.9.5. Figure 5: Setting Up MTF Specific Appointing Text

2.9.6. Figure 6: Setting Up MTF Specific Appointing Text continued

2.9.7. Figure 7: Managing Division and Clinic Display Names

2.9.8. Figure 8: Managing Self-Referral Visit Reasons

2.9.9. Figure 9: Managing Self-Referral Visit Reasons

2.9.10. Figure 10: Managing Self-Referral Visit Reasons on a Shared Host

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Figure 1: Finding the Managing Appointment Parameters on TOL

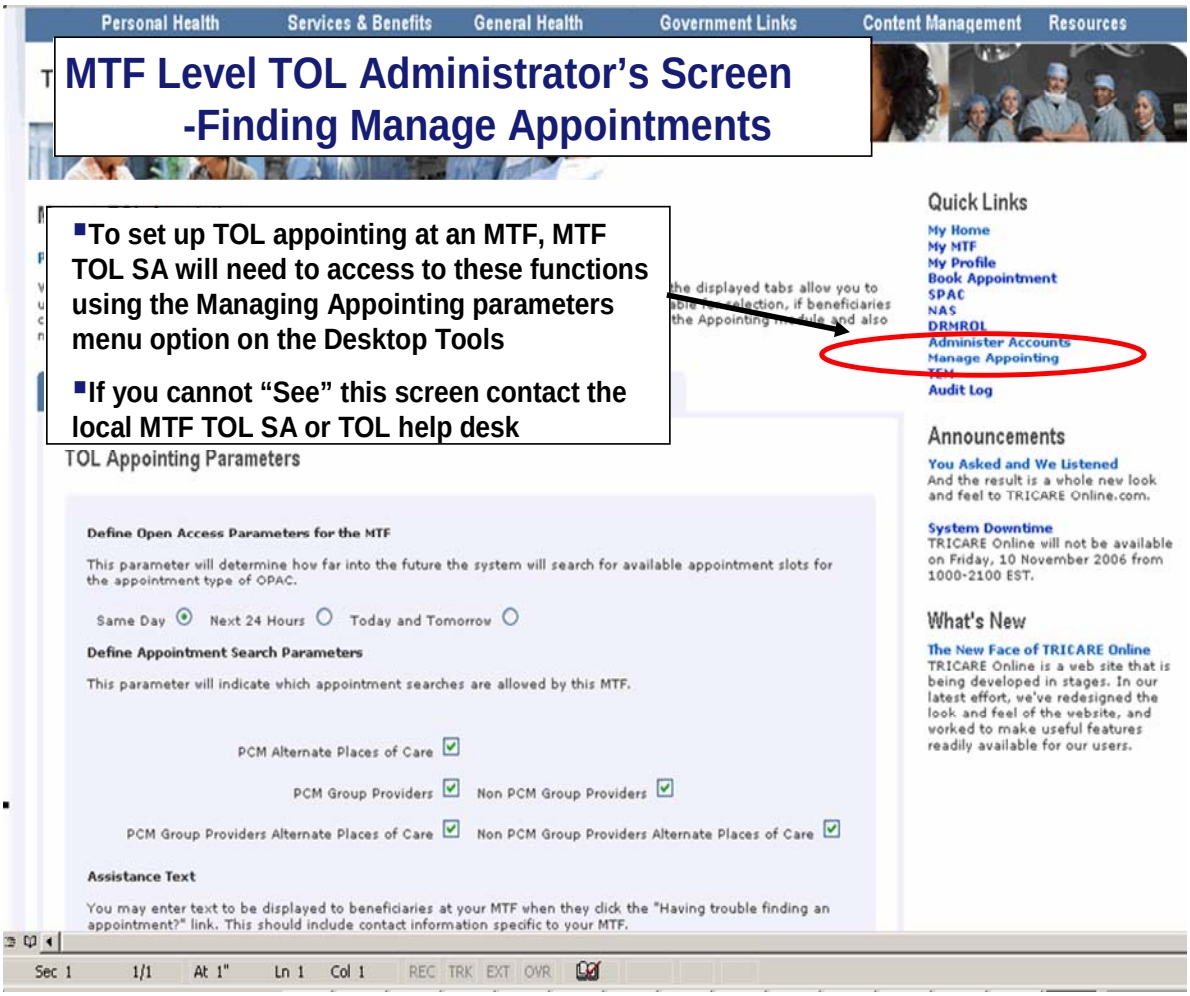


Figure 2: Defining Open Access Parameters

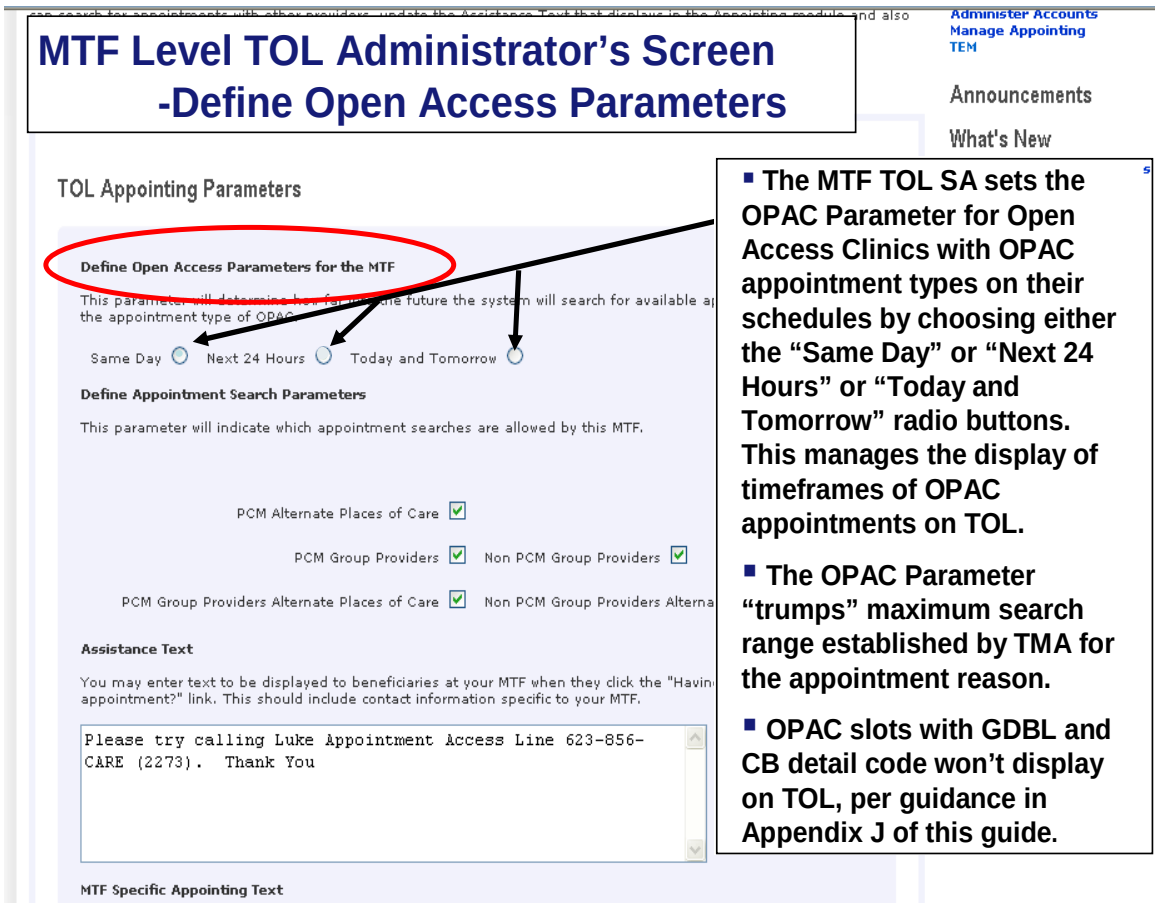
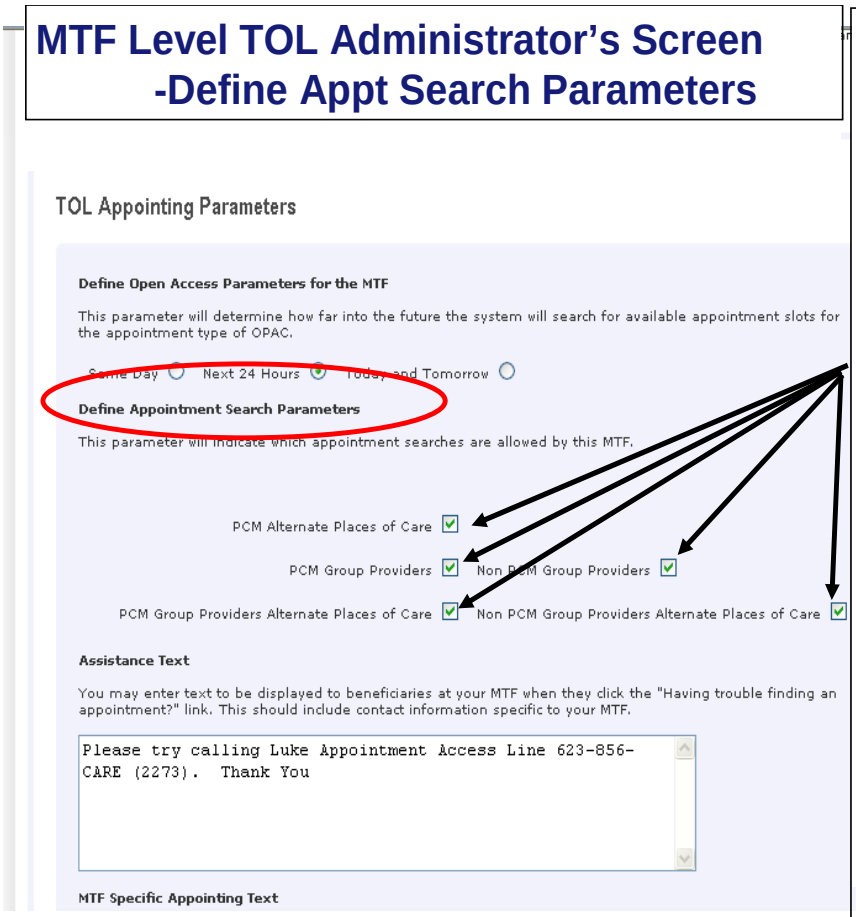


Figure 3: Defining TOL Appointing Search Parameters



- **The MTF TOL SA has the ability to set up the PCM/Provider Search Parameters that allows the TOL users to search for PCMs and Providers in various clinics and/or in various locations.**
- **When all 5 boxes are checked, this allows for the widest search by TOL users to the primary care clinic**

  - Allows for the booking with non-enrolled providers, techs and nurses who have TOL schedules
- **If none of the boxes in the "Define Appointment Search Parameters" are checked, TOL users can only search for and book appointments with their assigned PCM and not with other PCMs/ Providers in the clinic.**

Figure 4: Setting Up TOL Assistance Text

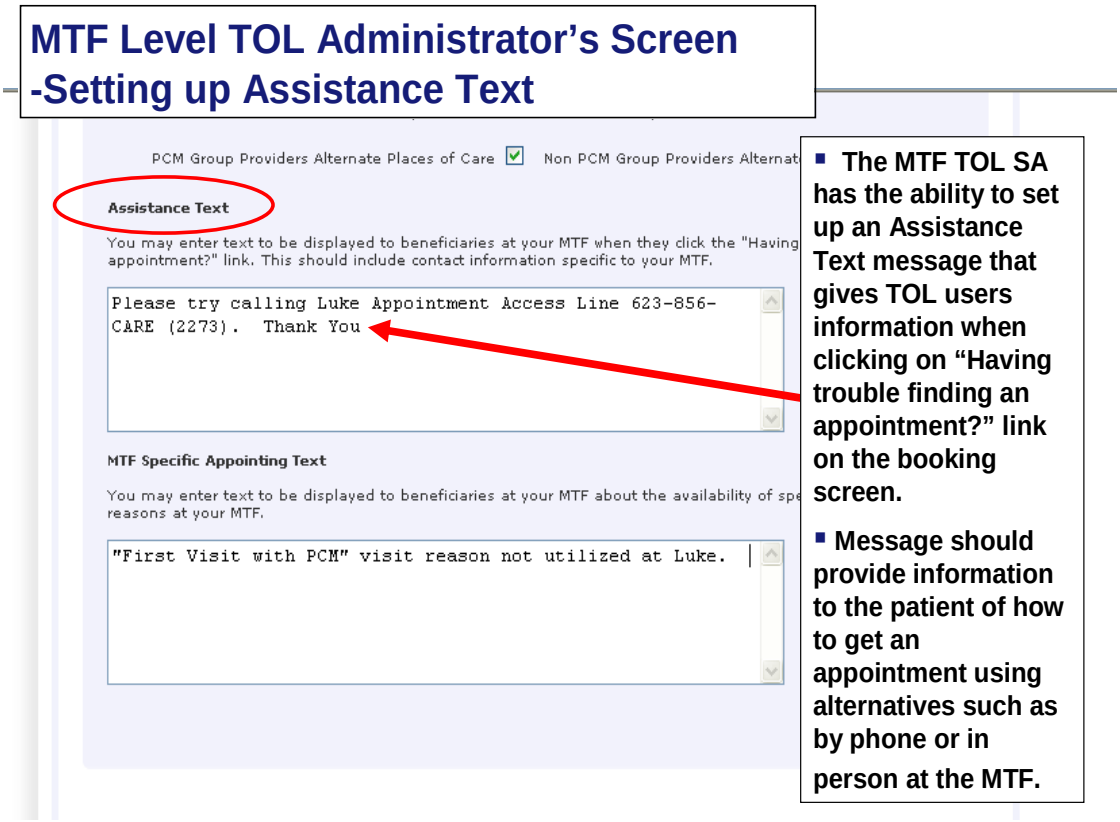


Figure 5: Setting Up MTF Specific Appointing Text

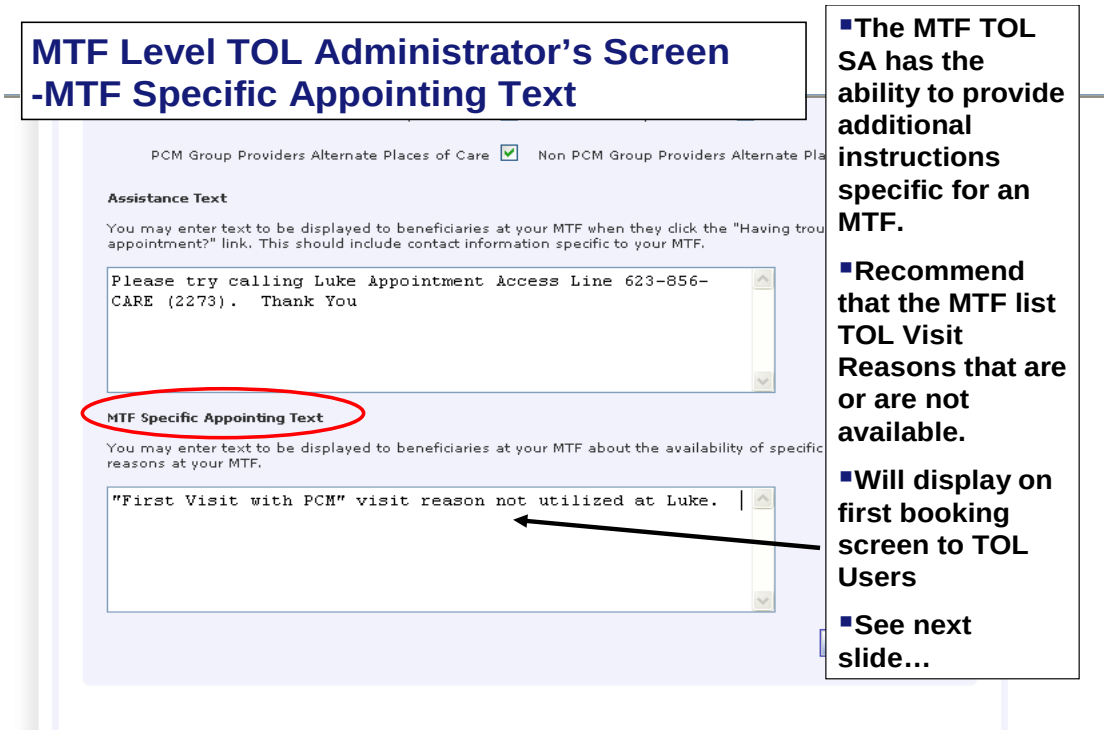


Figure 6: Setting Up MTF Specific Appointing Text continued

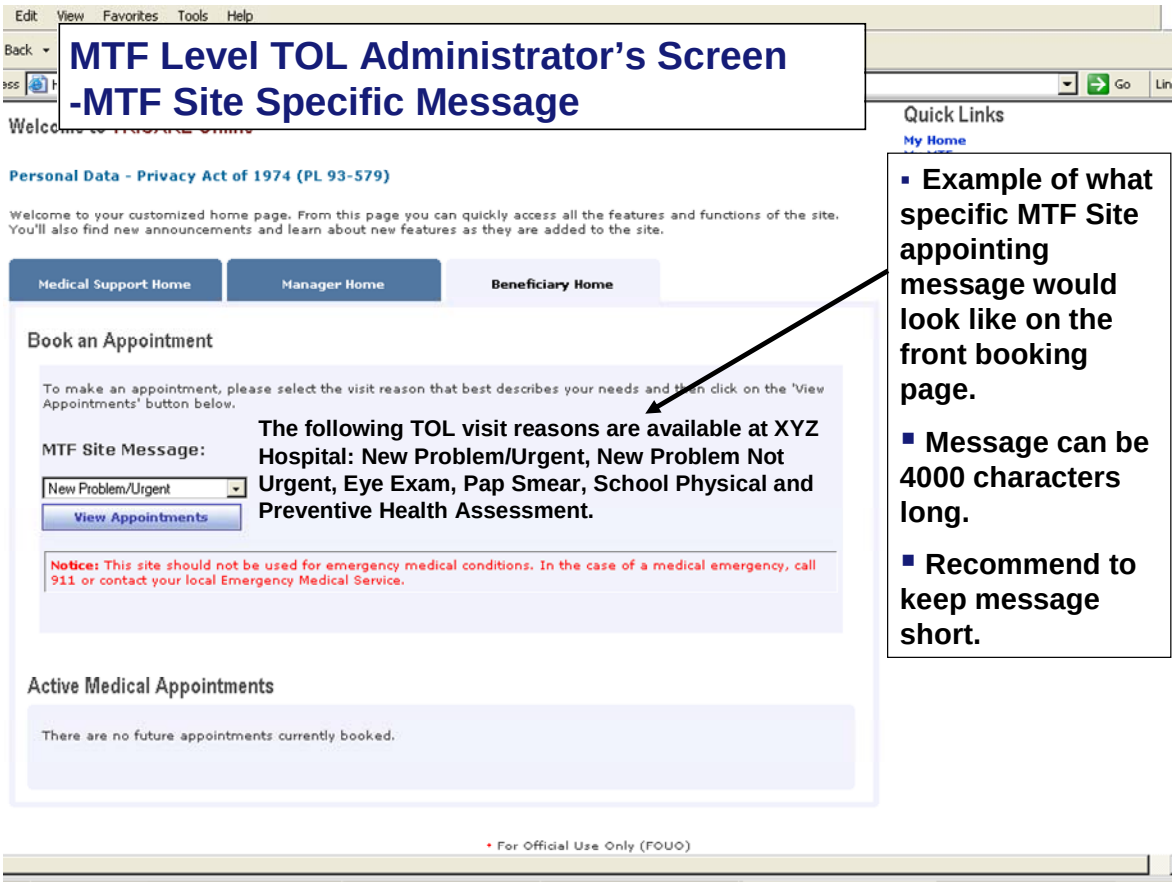


Figure 7: Managing Division and Clinic Display Names

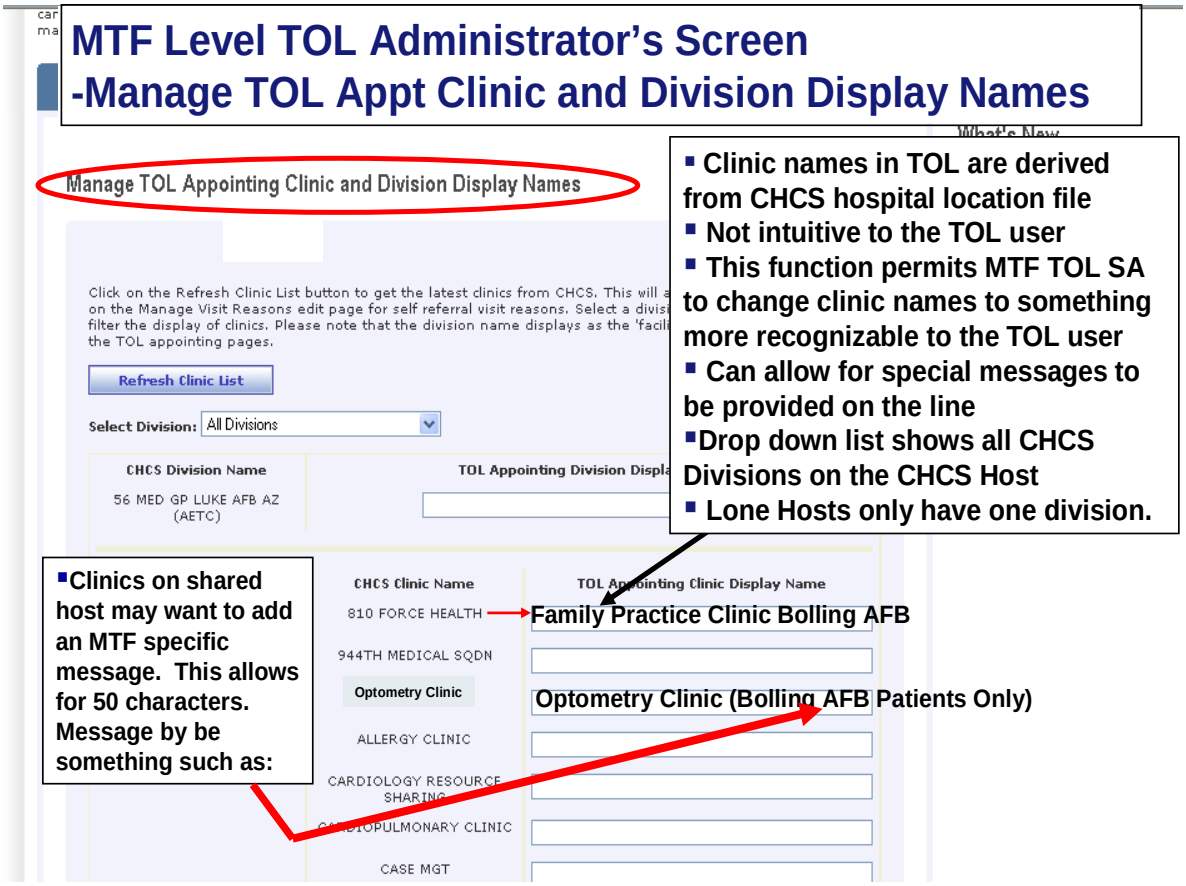


Figure 8: Managing Self-Referral Visit Reasons

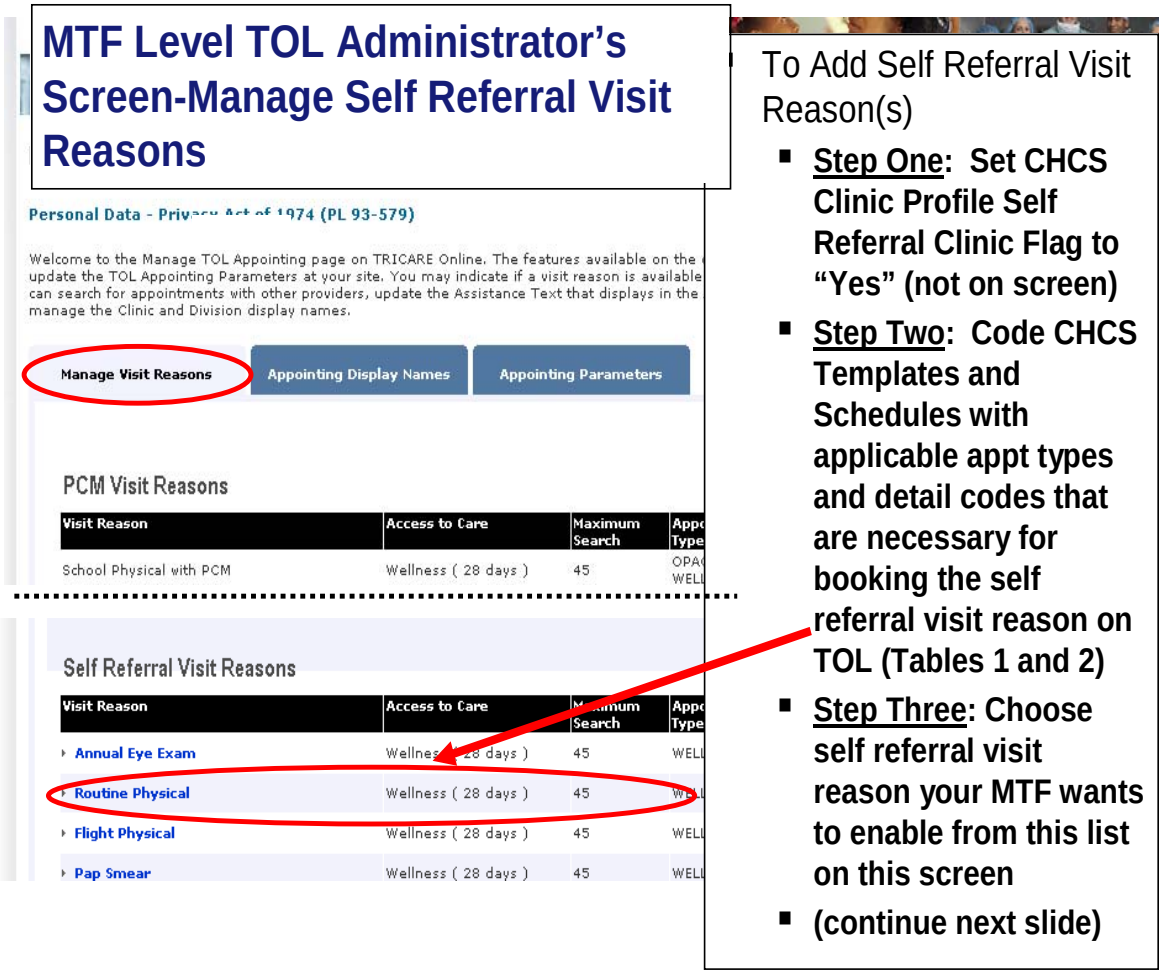


Figure 9: Managing Self-Referral Visit Reasons (Continued)

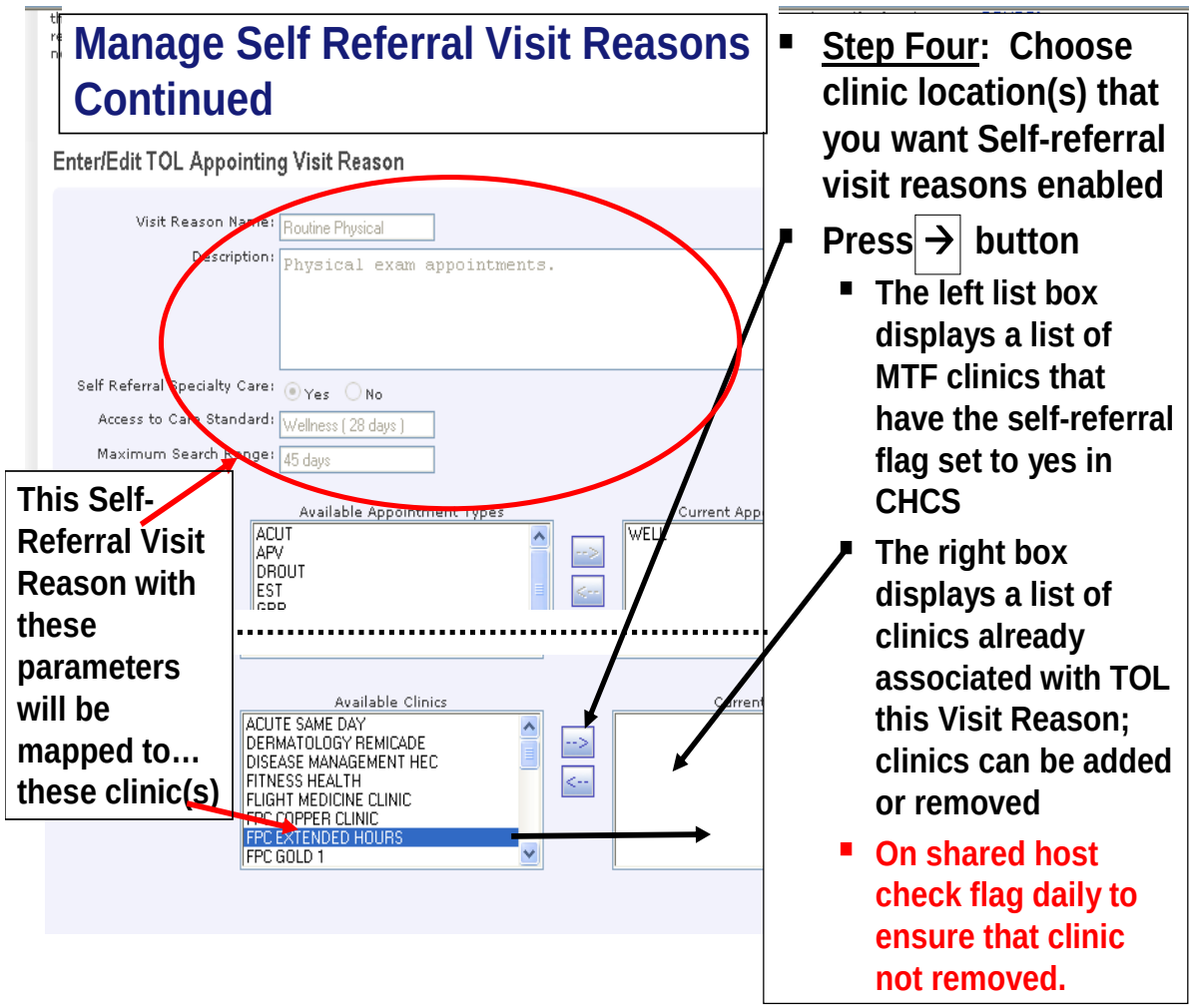
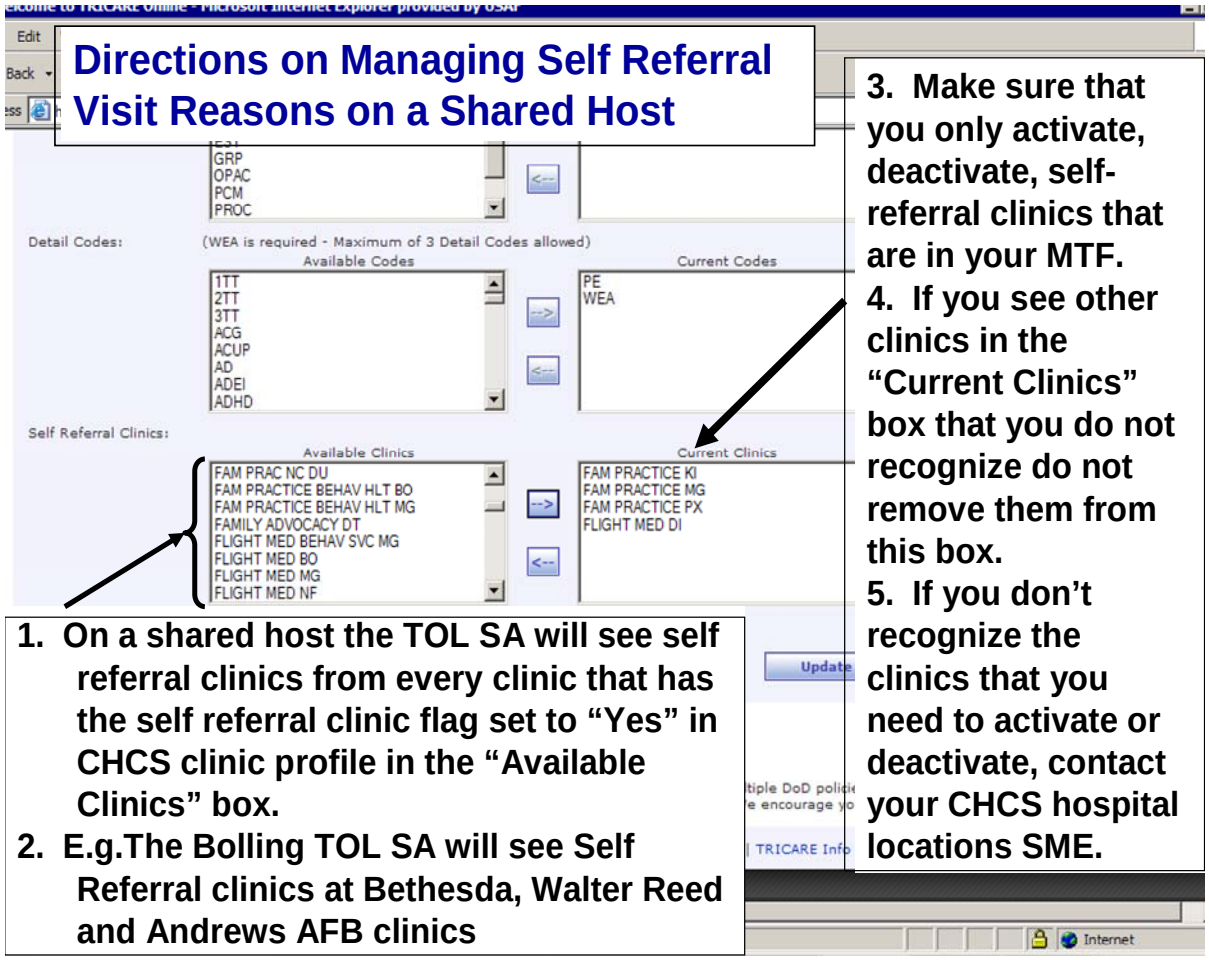


Figure 10: Managing Self-Referral Visit Reasons on a Shared Host



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3. Keys to Successful Use of TOL Appointing.

3.1. MTFs that book many appointments on TOL have leaders who made TOL appointing a priority for their MTFs

3.2. MTF leadership needs awareness of the advantages of how online appointing can support their business objectives:

3.2.1. Very few beneficiary web appointing errors/abuses occur

3.2.2. MTFs find that beneficiaries are very good at entering "reason for visit" (This is a mandatory field) - easier to tell the web application than a human being.

3.2.3. Reduces appointment no-show rates

3.2.4. Reduces appointment telephone calls

3.2.5. Reduces patient telephone wait time - less calls overall

3.2.6. Allows appointing staff to perform other duties

3.2.7. Increases customer satisfaction - patient centric-24 hours a day, 7 days a week access

3.2.8. Reduces numbers of un-booked appointments

3.3. Clinics must ensure sufficient numbers of appointments are available when a beneficiary attempts to use TOL to book an appointment.

3.4. To maximize TOL appointing, clinics should not be using appointing triage activities to screen care provided for same-day or acute requests for care

3.4.1. MTF/Clinic leadership should realize that 50% -70% of demand for Primary Care appointments are same-day or acute requests and should web-enable those appointments to optimize web appointing.

3.4.2. MTFs with high Web appointment usage rates do not screen (triage) requests for same-day appointments to determine appropriateness of requests

3.4.3. TOL appointing works with or without clinics using the Open Access appointing methodology.

3.5. There needs to be proactive template management both in CHCS and TOL to ensure that there is a constant supply of web-available appointments

3.5.1. Proactive Template Management allows for the building of templates to maximize the number of appointment slots available to web appointing

3.5.2. Reactive Template Management has clinics creating new appointments or “getting the patient in” which does not support Web appointing

3.5.3. Schedule review may be needed hourly, daily or weekly and is dependent upon clinic demand and its resources or supply

3.6. The Automatic Schedule Reconfiguration function of CHCS is helpful to web-enabling appointments at the right time, with the right type, for the right patients.

3.7. Beneficiaries will not use Web appointing if they do not believe they have the same or better access to appointments than they do by phone.

3.8. Develop a Robust TOL Appointment Marketing Program.

3.8.1. Highlight the benefits of Web appointing at the MTF. This may include focusing on advantages such as greater selection of appointments early in the morning hours or prior to the Call Center opening for the day.

3.8.2. MTFs can brief the benefits of TOL appointing at in-processing sessions.

3.8.3. Successful marketing includes actively pursuing all briefing opportunities, to include Base or Post functions, newcomer's orientations, retiree days, spouses meetings, etc.

3.8.4. Have providers and clinic staff act as informal promoters of TOL. They can perform this role face-to-face with patients during office visits.

3.8.5. Utilize available resources (e.g. MTF newsletters, on-hold telephone messages, installation newspapers,) to market TOL.

3.8.6. MTF leadership may coordinate with clinic managers to develop marketing strategies specific to a clinic (i.e., pediatric vs. adult medicine clinic), and/or supply marketing materials (e.g., trifolds, flyers, posters) to clinics and throughout the MTF.

3.9. Develop a Responsive TOL User Registration Process.

3.9.1. High usage rates of TOL appointing functionality are a direct result of making as many appointment slots in CHCS available to the web, combined with a strong marketing program AND developing a responsive and sustained effort to register as many users of TOL as possible. MTFs may have greater than 90% of their appointments available to the web, have an excellent TOL appointing marketing program, but if its beneficiaries are not registered as TOL users, appointments will not be booked on the web.

3.9.2. MTFs need to develop ongoing processes to register beneficiaries on TOL. Venues to concentrate on TOL registration activities may include personnel in-processing meetings, retiree meetings, health fairs, military unit activities, or during the patient's first visit to the MTF.

3.9.3. During these registration activities, computers need to be available to allow potential TOL users the opportunity to go online to register.

3.9.3. TOL customer service representatives should be available to demonstrate TOL features, answer questions, or assist with registration actions.

3.9.4. Assisting with TOL registration alone does not ensure beneficiary use or return use, but does provide excellent opportunity to showcase and answer questions about TOL and online appointing.

3.9.5. Patients experiencing difficulty with TOL registration should be directed to the MHS Helpdesk for assistance.

4. Other Functionality of TOL. The following is a partial list of TOL modules.

4.1. Health Assessment Reporting Tool (HART) Link.

4.1.1. There is a link on TOL to the personal Health Assessment Reporting Tool (HART). It is currently for service members only such as Active Duty, National Guard or Reserve. This link will take these beneficiaries directly to:

4.1.1.1. HART-A. The Health Assessment Review Tool - Accession asks questions about the patient's health and life experiences prior to joining the military. The information provides a baseline for future comparisons and helps the doctor monitor the patient's health throughout their military career. All individuals, both enlisted and officer, complete the HART-A one time as they enter the military.

4.1.1.2. HART-R. The Health Assessment Review Tool - Readiness asks questions about the patient's current health and personal behaviors so that the doctor can help protect their health, encourage fitness, and maximize job performance. All Active Duty, National Guard, and Reserve service members must complete a HART-R as part of their annual periodic health assessment (PHA).

4.2. Link to My Health*e*Vet

4.2.1. This link is the gateway to veteran health benefits and services. It is a powerful tool to help Veterans better understand and manage their health. It provides access to trusted health information.

4.2.2. This function links to Federal and Veterans Administration (VA) benefits and resources, the VA's Personal Health Journal and online VA prescription refill functions.

4.3. TOL Self-Assessment Tools.

4.3.1. This interactive tools page on TOL provides access to helpful self-assessment tools that calculate information related to diet, exercise, and general health.

4.3.2. This page also has the Health Risk Assessors tool that measures risk factors for common health problems.

4.4. Beneficiary Web Enrollment (BWE).

4.4.1. The BWE is a Defense Eligibility Enrollment Reporting System (DEERS) web application developed by Defense Manpower Data Center (DMDC). This application allows active duty service members, active duty family members, retirees and their families an online self-service capability to manage their TRICARE Prime enrollments without visiting a TRICARE Service Center or mailing a paper form. NOTE: BWE is currently not available OCONUS.

4.4.2. This function is linked to the DEERS, allowing beneficiaries to update their personal contact information (home address, phone number, email) for both TRICARE and DEERS at the same time.

4.4.3. BWE allows users to:

4.4.3.1. Enroll/dis-enroll eligible beneficiaries

4.4.3.2. Make their initial payment (ongoing payments will be billed separately)

4.4.3.3. Transfer enrollment

4.4.3.4. Update contact information

4.4.3.5. Select a new primary care manager (not available to Active Duty Service Members)

4.4.3.6. Add other health insurance information

4.4.3.7. Request a new enrollment card

4.5. TRICARE Online Medication Information.

4.5.1. This function provides a complete guide that covers everything that a TOL user needs to know about over-the-counter and prescription medications.

4.5.2. Beneficiaries can look up drug related information such as:

4.5.2.1. Indications for use

4.5.2.2. Dosage and frequency

4.5.2.3. Drug precautions

4.5.2.4. Common side effects

4.5.2.5. Newly approved FDA drugs

4.6. TRICARE Online Rx Checker. This function permits TOL users to search for drugs by name, add drugs to their own virtual medicine cabinet, and check for possible harmful drug/food interactions.

4.7. TRICARE Online (TOL) Pharmacy Refill.

4.7.1. This function allows authorized beneficiaries to securely request prescription refills from the TOL website (www.tricare.mil).

4.7.2. Authorized beneficiaries have the ability to:

4.7.2.1. Request refills

4.7.2.2. Check the status of current prescription refill requests

4.7.2.3. Obtain a link to the TRICARE Mail Order Pharmacy (TMOP) web page to order prescriptions there

4.7.2.4. At participating MTFs , request that refills be mailed from the VA Consolidated Mail-Out Pharmacy (CMOP)

4.8. Personal Health Record (PHR).

4.8.1. The PHR application within TOL is comprised of features providing authorized beneficiaries with access to view portions of their personal electronic health record (EHR) information within a secure architecture.

4.8.2. TOL users are authorized to access the PHR data after first going through a Military Health System (MHS) defined authentication process to verify their identity.

4.8.3. Once authenticated, TOL users are authorized TOL to access all of their PHR using a Common Access Card (CAC) and a CAC reader.

4.8.4. The TOL PHR application is comprised of four primary modules that allow PHR users to retrieve and display their portions of electronic health record. Those include:

4.8.4.1. Demographic Profile/Personal Information

4.8.4.2. Medication Profile

4.8.4.3. Allergy Profile

4.8.4.4. Personal Health Summary

4.9. Secure Provider Access To CHCS (SPAC).

4.9.1. The SPAC feature of TOL gives providers greater flexibility in managing their workloads by allowing remote access to their CHCS schedules, patient histories, and resources.

4.9.2. SPAC allows registered and properly authenticated TOL Users who are assigned the Provider Role to have direct access to CHCS host environments in which they are registered users. This allows Providers the ability to perform CHCS application functions securely from a remote location. Providers will be able to access all functional aspects of the CHCS environment as defined by their individual CHCS account privileges.

4.9.3. This access is in the form of a secure link from TRICARE Online to the CHCS login screen. A new CHCS account cannot be established from TRICARE Online, only a link to an existing account or accounts. CHCS users with accounts on multiple MHS hosts will have access to all authorized accounts, given that SPAC is currently available at that host site.

4.9.4. The use of the SPAC feature requires the TOL user with the Provider role to download a Java Plug-in on any desktop or laptop computer used for remote access.

4.10. Non-Availability Statement (NAS) Module.

4.10.1. The NAS application of TOL is used to track the creation and approval of Non-Availability Statements. The NAS application is also used to communicate referral information with the Fiscal Intermediary at overseas locations.

4.10.2. For CONUS locations, the NAS application is only required to be used for the Major Diagnostic Category or MDC of Mental Diseases and Disorders. All other MDCs do not require a NAS.

4.10.3. The NAS is initiated by the NAS Originator on behalf of a patient request for care outside of the MTF on TOL.

4.10.4. Upon initiation of the request, the NAS application communicates with DEERS to obtain TRICARE eligibility information for the selected patient.

4.10.5. The NAS application uses and stores the DEERS information for use in the NAS referral and transmissions to the Managed Care Support Contractor.

5. TRICARE Online Training.

5.1. The MHS leadership developed a set of Web Based Training (WBT) Modules to allow MTF TOL personnel to educate themselves online on the operations of various functions of TOL.

5.2. These WBT modules address the needs of users in the following roles: MHS Help Desk Staff, MTF Appointing Clerks/Supervisors, Providers, System Administrative Assistants, MTF System Administrators (SAs)/Subject Matter Experts (SMEs), TOL MTF Site Support Staff, Non-Availability Statement (NAS) Originators, NAS Reviewers, and NAS Rules Managers.

5.3. There are several WBT modules that were developed. Course titles and descriptions are:

5.3.1. Course Title: MHS Help Desk Staff. The "MHS Help Desk Staff" course enables the Help Desk personnel to be valued resources when users have TRICARE Online (or TOL) questions. The course may also be a reference resource when such questions arise. This course provides an overall description

of the TRICARE Online TOL website and the various tools and information areas that are available. In addition, this course teaches the skills needed to set up the Appointing process on TOL, check the Web Server status, and administer User Accounts. It also familiarizes the Help Desk Staff with the functionality and resources that TOL offers for providers and beneficiaries.

5.3.2. Course Title: Provider. The "Providers" course teaches MHS Providers to use the TRICARE Online (or TOL) website. This course provides an overall description of the TOL website and the various tools and information areas that are available. In addition, it shows providers how to access SPAC, which is Secure Provider Access to the Composite Health Care System (or CHCS) and Deployment-Related Medical Records Online (or DRMROL).

5.3.3. Course Title: MTF System Administrator/Appointing Supervisor. This course provides an overall description of the TOL website and the various tools and information areas that are available and necessary to those who use it, as well as the roles and capabilities of those who make up the TOL team. This course also covers TOL appointing and web site metrics. In addition, it teaches the skills needed to administer user accounts, administer clinics, access the Data Server, develop web content, and build or approve web pages.

5.3.4. Course Title: NAS Originator and Reviewer. This course provides instruction on how to use the NAS (Non-Availability Statement) application in your role as an NAS Originator or NAS Reviewer. The course is a comprehensive overview of the daily activities for these two user roles.

5.3.5. Course Title: NAS Rules Manager. This course is designed to enable you to run the NAS application smoothly by creating the rules and queues that route NAS requests within the system.

5.4. WBT Module Course Access Methods.

5.4.1. Via TOL. Potential students can access these modules via TOL. The user logs in to TOL, clicks on Resources and clicks on My Training to launch the TOL page containing the URL to the MHS Learn web site.

5.4.2. Directly via MHS Learn site. Users need to go to the following MHS Learn website at: https://mhslearn.satx.disa.mil. Once the user logs into this MHS Learn site they type in the key word “TOL” in the Catalog Search field to get to the 3 TOL courses. Then they type in the key word “NAS” in the Catalog Search field to get to the 2 NAS Courses.

5.5. Service Component TOL training. TOL users should check with their TOL Program POC on any service specific training events or courses.

APPENDIX Q

REFERENCES AND ACRONYMS

APPENDIX Q

REFERENCES AND ACRONYMS

The following are reference documents for the MHS Guide to Access Success and Access Improvement projects. Many of these documents appear on the TRICARE Access Imperatives Web page at http://tricare.osd.mil/tai.

References:

32 Code of Federal Regulations, 199.17

ASD (HA) Policy 00-005, Policy for Standardized Appointment Types

ASD (HA) Policy 01-015, Policy Memorandum to Refine Policy for Access to Care in Medical Treatment Facilities and Establish the TRICARE Plus Program

ASD (HA) Policy 03-026, Personnel on Medical Hold

ASD (HA) Policy 05-014, Policy Guidance for Active Duty Service Member Enrollment to TRICARE Prime

ASD (HA) Policy 06-007, TRICARE Policy for Access to Care and Prime Service Area Standards, 21 February 2006

ASD (HA) Policy 06-015 Facilitating the Transition of Beneficiaries going from TRICARE Prime Coverage under the Transitional Assistance Management Program to TRICARE Prime Coverage as Active Duty Service Members and Active Duty Family Members

ASD (HA) Policy 07-002 TRICARE Prime Enrollment Policy for Reserve Component Members and their Families

ASD (HA) Policy 07-022: TRICARE Prime Access Standards for Mental Health Care dated Oct 9, 2007

ASD (HA) Policy Guidance for Referral Management, dated 5 May 2004 and 29 July 2004 (references (c) and (d))

ASD (HA) Memorandum: Enrollment of Active Duty Service Members in Appellate Leave Status dated Nov 8, 2006

ASD (HA) Memorandum: Enrollment of Active Duty Service Members in Terminal Leave Status dated Nov 8, 2006

DOD TMA Medical Management Guide, January 2006

DoDI 6025.20, Medical Management Programs in the Direct Care System and Remote Areas, 22 June 2006

Websites:

MHS Population Health & Medical Management.
http://www.dodpopulationhealth.info/public/spd.cfm?spi=mmguide

TRICARE Operations Center (TOC) website: http://mytoc.tma.osd.mil

TRICARE Operations Manual (TOM): http://manuals.tricare.osd.mil/

TRICARE website: http://www.tricare.mil/

Service specific websites:

Air Force Medical Service (AFMS) Executive Global Look (EGL) website:
https://sgegl.afmoa.af.mil

AFMS Knowledge Exchange (AFKX) Health Benefits page:
https://kx.afms.mil/healthbenefits

TOL Education Materials: https://kx.afms.mil/healthbenefits

AFMS Access Improvement Module website: https://aim.afmoa.af.mil/

CHCS Training Materials: https://kx.afms.mil/healthbenefits

AFMS ATC Bulletins: https://kx.afms.mil/healthbenefits

AFMS Referral Management: https://kx.afms.mil/referralmanagement

AFMS Group Practice Management: https://www.afms.mil/gpm

Biometric Data Quality Assurance Service (BDQAS) website:
http://www.pdhealth.mil/guidelines/downloads/AFBehavioralHealthCodingHandbook05.pdf

AMEDD Patient Administration Systems and Biostatistics Activity (PASBA):
https://pasba3.amedd.army.mil/ Requires Password

AMEDD Access Knowledge Center (AKC): https://www.us.army.mil/suite/page/336433
Requires Password

Each acronym, abbreviation, or term is followed by its definition, using upper or lower case as appropriate, and sometimes by additional information in parentheses, such as the agency, program, or field in which it is used. Uncertain or conflicting information is shown in brackets; we would especially appreciate confirmation or correction for those items. Alphabetization of terms is strictly letter by letter, ignoring spaces or punctuation (e.g., PADSTARS, PA&E, PAF).

AAPCC—adjusted average per capita cost (managed care)
AAPPO—American Association of Preferred Provider Organizations
A(ASD)—Acting Assistant Secretary of Defense
ACAT—Acquisition Category
ACPERS—Army Civilian Personnel System
ACR—adjusted community rating (managed care)
ACV—Ambulatory Care Visit
AD—Active Duty
ADFM—Active Duty Family Member
ADSM—Active Duty Service Member
AFIP—Armed Forces Institute of Pathology
AGR—Active Guard Reserve
AMDF—Army Master Data File
AMDL—Air Force Master Data List
AMEDD—Army Medical Department
ANSI—American National Standards Institute
APP—Annual Performance Plan
AQCESS—Automated Quality of Care Evaluation Support System (DoD)
A/R—Accounts Receivable
AR—Army Regulation
AR—Army Reserve
ASC—Ambulatory Surgery Center
ASD(C3I)—Assistant Secretary of Defense (Command, Control, Communications, and Intelligence)
ASD(C4I)—ASD (Command, Control, Computers, Communications, and Intelligence)
ASD(HA)—Assistant Secretary of Defense (Health Affairs)
ASH—Assistant Secretary for Health (DHHS)
ASHA—American Speech and Hearing Association
ATEC—Army Test and Evaluation Command
ATIC—Advanced Technology Integration Center
AVG—Ambulatory Visit GroupBCAC—Beneficiary Counseling and Assistance Coordinator
BCF—Basic Core Formulary
BRAC—Base Realignment and Closure
BUMED—Bureau of Medicine and Surgery (DoD/Navy)

BUMEDINST—BUMED Instruction
BUMIS—BUMED Manpower Information System
BUPERS—BUMED Personnel System [Bureau of Naval Personnel?]
C4—Command, Control, Communications, and Computers
C4I—Command, Control, Communications, Computers, and Intelligence
CAC—Catchment Area Commander [initial caps?] (DoD)
CAC—Common Access Card
CAE—Component Acquisition Executive
CAMP—Consolidated Acquisition Management Program
CARES—CHAMPUS Administrative, Reporting, and Eligibility System
CBA—Clinical Business Area (CHCS)
CBA—Cost Benefit Analysis
CBHCO—Community-Based Health Care Organizations
CCA—Clinger-Cohen Act
CCB—Configuration Control Board
CCDD—Catastrophic Cap & Deductible Database
CDC—Centers for Disease Control and Prevention
CDCF—Centralized Deductible And Catastrophic Cap File (DoD)
CDR—Clinical Data Repository
CDR—Commander
CDR—Critical Design Review
CHAMPEUR—CHAMPUS Europe
CHAMPUS—Civilian Health and Medical Program of the Uniformed Services
CHAMPUS AVE—CHAMPUS Ambulatory Visit Encounter
CHAMPVA—Civilian Health and Medical Program of the Department of Veterans Affairs
CHC—Community Health Center
CHCBP—Continued Health Care Benefit Program
CHCS—Composite Health Care System (DoD)
CITPO—Clinical Information Technology Program Office
CMAC—CHAMPUS Maximum Allowable Charge
CMS—Centers For Medicare and Medicaid Services
COC—Certificate Of Coverage (managed care)
CoCC—Certificate of Creditable Coverage
COE—Centers of Excellence
CONOPS—Concept Of Operations
COO—Chief Operating Officer
COTS—Commercial Off-The-Shelf
CPR—Computer-Based Patient Record
CPRI—Computer-based Patient Record Institute
CPRS—Computer-based Patient Record System
CPT—(Physician's) Common Procedural Terminology (codes)
CPU—Central Processing Unit

CQI—Continuous Quality Improvement
CQL—Clinical Query Language
CQM—Clinical Quality Management
CRI—CHAMPUS Reform Initiative
CSR—Change System Request
DASD—Deputy Assistant Secretary of Defense
DASD—Direct Access Storage Device
DBMIS—Data Base Management Information System
DBMIS—Defense Blood Management Information System
DBMS—Database Management System
DBSS—Defense Blood Standard System
DBTC—DEERS Beneficiary Telephone Center
DCAO—Debt Collection Assistance Officer
DDS—DEERS Dependent Suffix
DEERS—Defense Enrollment Eligibility Reporting System
DEERS–ACTUR—DEERS Automated Central Tumor Registry
DEERS–Panograph—DEERS Panoral Radiographs
DEERS–RDDB—DEERS Reportable Diseases Data Base
DFAS—Defense Financial & Accounting Service
DHCP—Decentralized Hospital Computer Program (VA)
DHHS—Department of Health and Human Services
DHP—Defense Health Program
DICOM—Digital Imaging and Communications in Medicine
DII—Defense Information Infrastructure
DIMHRS—Defense Integrated Manpower and Human Resources System
DIN–PACS—Digital Imaging Network–Picture Archiving and Communications System
DISA—Data Interchange Standards Association, Inc.
DISA—Defense Information Systems Agency
DITSCAP—DoD Information Technology Security Certification and Accreditation Process (DoD 5200.40)
DMDC—Defense Manpower Data Center
DME—Durable Medical Equipment
DMHRS—Defense Medical Human Resources System
DMIS—Defense Medical Information System
DMISID—DMIS Identification
DMLSS—Defense Medical Logistics Standard Support
DOB—Date of Birth
DoD—Department of Defense
DoDI—Department of Defense Instruction (followed by a number)
DOES—Defense Online Enrollment System
DOEHRS—Defense Occupational and Environmental Health Readiness System
DOORS—Dynamic Object-Oriented Requirements System
DOS—Date of Service

DP—Designated Providers
DRG—Diagnosis Related Group (no hyphen, per Webster's Medical Desk Dictionary)
DRG—Diagnosis-Related Group (with hyphen, per Dorland's Illustrated Medical Dictionary)
DSO—Defense Manpower Data Center (DEERS) Support Office (DoD)
DT&E—Developmental Test And Evaluation
DTF—Dental Treatment Facility
EAS–III—Expense Assignment System, Version III (DoD)
ECHO—Extended Care Health Option
EDI—Electronic Data Interchange
EDIPN—Electronic Data Interchange Person Identification Number
EFT—Electronic Funds Transfer
EID—Enrollment Information Dental [message]
EI/DS—Executive Information/Decision Support
EIN—Employee Identification Number
EIT—Encounter Information Transfer
EMC—Electronic Media Claims
EOB—Explanation of Benefits
EOI—Evidence Of Insurability (managed care)
EOMB—Explanation of Medicare Benefits/or Medicaid Benefits/or Medical Benefits
ERA—Electronic Remittance Advice
ESA—Enterprise System Architecture
EWR—Enterprise Wide Registration
EWRAS—Enterprise Wide Referral and Authorization System
EWS-R—Enterprise Wide Scheduling and Registration
FEA—Functional Economic Analysis
FEAA—Functional Economic Analysis Agent
FIN—Foreign Identification Number
FM—Family Member
FM—Functional Manager
FMP—Family Member Prefix
FOIA—Freedom of Information Act
FP—Functional Proponent
FPWG—Functional Proponent Working Group
FRE—Fiscally Responsbile Entity
FST—Formal System Test
FY—Fiscal Year (capitalized when followed by the year: Fiscal Year 1997, FY 1997, FY97)
GAO—General Accounting Office
GAT—Government Acceptance Test
GATES—Government Automated Time Entry System
GB—Gigabyte (computers)
Gbps—Gigabits Per Second

GCPR—Government Computer-Based Patient Record
GFE—Government-Furnished Equipment
GFE&S—Government-Furnished Equipment and Services
GFI—Government-Furnished Information
GFP—Government-Furnished Property
GFPTS—Government-Furnished Property Tracking System
GIAT—Government Installation Acceptance Test
GIQD—General Inquiry of DEERS(an inquiry database)
GIS—Generic Interface System
GMRA—Government Management Reform Act
GMT—Greenwich Mean Time
GOTS—Government Off-The-Shelf
GPIAT—Government Pre-Installation Acceptance Test
GPRA—Government Performance and Results Act (of 1993)
GRDS—Guard/Reserve Deceased Sponsors
GSA—General Services Administration
GWOT—Global War On Terrorism
HA—Health Affairs (OASD)
HA/OA—Health Affairs/Office Automation
HBA—Health Benefits Advisor (DoD/CHAMPUS)
HB&P—Health Budgets and Programs (OASD(HA))
HC—Health Care
HCCR—Health Care Cost Recovery (use initial caps if the name of a program)
HCDP—Health Care Delivery Program
HCF—Health Care Finder
HCFA—Health Care Financing Administration (DHHS)
HCFA 1500—(a universal fee billing claim form developed by HCFA)
HCIN—Health Care Information Network
HCP—Health Care Provider
HCPCS—Health Care Procedural Coding System
HCPR—Health Care Provider Record
HCSR—Health Care Service Record (DoD/CHAMPUS)
HEAR—Health Enrollment/Evaluation Assessment Review
HEDIS—Health Plan Employer Data and Information Set (HCFA; version 2.0=NCQA, 3.0=Medicaid/Medicare)
HFMT—Healthcare Financial Management Tool
HFO—Health Facilities Office
HFPA—Health Facilities Planning Agency
HFS—Hospital Formulary System
HHA—Home Health Agency
HHA—Home Health Aide
HHC—Home Health Care
HHS (also DHHS)—Department of Health and Human Services

HIAA—Health Insurance Association of America
HIBCC—Health Industry Business Communications Council
HIC—Healthcare Industry Council
HIFAC—Health Industry Functional Advisory Council
HII—Health Information Infrastructure
HIDA—Health Industry Distributors Association
HIISC—Healthcare Information Integration Support Committee
HIMA—Health Information Manufacturing Association
HIMSS—Healthcare Information Management Systems Society
HIN—Health Industry Number
HIO—Health Insuring Organization
HIPAA—Health Insurance Portability and Accountability Act
HIS—Hospital Information System
HITS—Health Integration Tracking System
HITSG—Health Information Technology Standards Guidance
HIV—Human Immunodeficiency Virus
HL7—Health Level 7
HMHS—Humana Military Healthcare Services
HMIS—Health Manpower Information System
HMO—Health Maintenance Organization
HMS—Health Management System
HMSPO—Health Management System Program Office (DMSSC)
HNFS—Health Net Federal Services
HQ—Headquarters
HQ ACC—Headquarters, Air Combat Command
HQAF—Headquarters, Air Force
HQAFOMS—Headquarters, Air Force Office of Medical Systems
HQDA—Headquarters, Department of the Army
HQMAC/SG—Headquarters, Military Airlift Command/Surgeon General
HRA—Health Resources Administration
HRA—Health Risk Appraisal (Army)
HRSA—Health Resources and Services Administration (DHHS)
HSA—Health Service Agreement (managed care)
HSAM—Health Services Analysis And Measurement
HSC—Health Services Command (DoD)
HSF—Health Service Finder
HSF—Health Services Financing
HSP—Health Service Plan (managed care)
HSPMO—Health Systems Procurement Management Office
HSPO—Health Systems Program Office
HSQB—Health Standards and Quality Bureau (HCFA)
HSRA—Health Services and Resources Administration
HSR&D—Health System Research and Development

HSRS—Health Standard Resources System
HSS—Health Service Support
HSS—Health Support System
HSSPO—Health Support Systems Program Office (DMSSC)
HTML—Hypertext Markup Language
HTTP—Hypertext Transfer Protocol
IAIMS—Integrated Advanced Information Management System
IATO—Interim Authority To Operate
IAW—In Accordance With
IBNR—Incurred But Not Reported
IBPA—Investment Baseline/Performance Agreement
IC3—Integrated Command, Control, and Communications System
ICA—Independent Cost Analysis
ICD—Interface Control Diagram
ICD—Interface Control Document
ICD—International Classification of Diseases (World Health Organization)
ICD–9—International Classification of Diseases, 9th Revision
ICD–9–CM—International Classification of Diseases, 9th Revision, Clinical Modification
ICD–10—International Classification of Diseases, 10th Revision
ICD–O—International Classification of Diseases for Oncology
ICE—Independent Cost Estimate
ICF—Intermediate Care Facility (managed care)
ICF/MR—Intermediate Care Facility For The Mentally Retarded
ICWG—Interface Configuration Working Group
ID—Identification, Identifier
IDEA—Individuals With Disabilities Education Act
IDEF—Integrated Computer-Aided Manufacturing Definition language
IDEF0—Integrated Definition Language, Functional
IDEF1X—Integrated Computer-Aided Manufacturing Definition Extended 1
IE—Information Engineering
IEN—Internal Entry Number
IEP—Individual Education Plan
IES—Integrated Eligibility System (Medicaid)
IFD—Interface Functional Description
IFWG—Interface Functional Working Group
IG—Inspector General
IGCE—Independent Government Cost Estimate
IHS—Indian Health Service (PHS)
IHS—Integrated Health System
IICWG—Internal Interface Control Working Group
IIFEA—Integrated Inpatient Functional Economic Analysis
IM—Information Management

IMD—Information Management Division
IMIA—International Medical Informatics Association
I&M IPT—Integration and Migration Integrated Product Team
IM/IT—Information Management/Information Technology
IMO—Information Management Office
IMO—Integrated Multiple Option (Managed Care)
IMT&R—Information Management, Technology and Reengineering (no comma after technology) ING—Inactive National Guard
IOC—Initial Operating Capability
IOM—Institute of Medicine (National Academy of Sciences)
IP—Implementation Plan
IP—Implementation Procedures
IP—Information Processing
IP—Internet protocol
IPA—Independent Physician Association
IPA—Individual Practice Association (HMO Act of 1973)
IPA—Individual Provider Association
IPOE—Inpatient Order Entry
IPR—In-Process Review
IPR—Interim Progress Review
IPSC—Information Processing Standards Committee
IPT—Integrated Product Team
IRMD— Information Resource Management Department
IRR—Individual Ready Reserve
IRS—Interface Requirements Specification
IS—Information System
IS—International Standard
ISA—industry standard architecture
ISA—information system architecture
ISD—Information Service Division
ISDN—Integrated Services Digital Network
ISMP—Information System Management Plan
ISN—Integrated Service Network (Bureau of Primary Care, HHS)
ISO—International Standards Organization
ISQL—Informix Structural Query Language
ISSA—Inter-Service Support Agreement
ISSAA—Information Systems Selection and Acquisition Agency
IT—Information Technology
IT OIPT—Information Technology Overarching Integrated Product Team
ITS—Immunization Tracking System
IV&V—Independent Verification And Validation
IWG—Interface Working Group
JAD—Joint Application Development

JADWG—Joint Application Development Work Group
JAD/RAD—Joint Application Development/Rapid Application Development
JAG—Judge Advocate General (military services)
JAMA—Journal of the American Medical Association
JCAHO—Joint Commission on Accreditation of Healthcare Organizations
JCALS—Joint Computer-aided Acquisition Logistics System
JCCB—Joint Configuration Control Board
JCL—Job Control Language (computers)
JCS—Joint Chiefs of Staff
JHMS—Joint Healthcare Manpower Standards
JHPC—Joint Health Plan Coordination
JHSS—Joint Health Services Support
JIEO—Joint Integration and Engineering Organization
JIEO—Joint Interoperability Engineering Organization (in DISA)
JINTACCS—Joint Interoperability of Tactical Command and Control Systems
JITC—Joint Interoperability Test Command
JITPO—Joint Imaging Technology Project Office
JLC—Joint Logistics Center
JPEG—Joint Photographic Experts Group
JTA—Joint Technical Architecture
JTA–A—Joint Technical Architecture–Army
JTC—Joint Technical Committee
KB—Kilobyte
KB—Knowledge Base (computers)
kbps—Kilobits Per Second, Kilobytes Per Second
LA—Lead Agent
LAN—Local Area Network (computers)
LOD—Line Of Duty
LOE—Level Of Effort
LOINC—Laboratory Observation Identifier Names and Codes
LOS—Length Of Stay
LOS—Level Of Security
LPC—Licensed Professional Counselor
LPN—Licensed Practical Nurse
LTC—Long-Term Care
M2— Military Health System Management Analyses and Reporting Tool
MA—Medical Assistance (a program in many States)
MAC—Maximum Allowable Cost (managed care)
MB—Megabyte
MBP—Military Blood Program (2004)
mbps— Megabits Per Second
mbps—Megabytes Per Second
MBTS—Medical Boards Tracking System

MCFAS—Managed Care Financial Analysis System
MCFAS—Managed Care Forecasting Analysis System
MCO—Managed Care Organization
MCP—Managed Care Program
MCQA—Managed Care Query Application
MCR—Modified Community Rating (managed care)
MCS—Managed Care Support
MCSC—Managed Care Support Contractor
MDA—Milestone Decision Authority (for CHCS II PO it is ASD(C3I)
MDC—Major Diagnostic Category
MDRTS—Medical and Dental Records Tracking System
MEB—Medical Evaluation Board
MEPM—Medical Expense Performance Module
MEPR—Medical Expense and Performance Report
MEPRS—Medical Expense and Performance Reporting System (DoD)
MEPRS–EAS II—MEPRS Expense Assignment System, version II
MEPRS–EAS III—MEPRS Expense Assignment System, version III
MEPRS–EAS IV—MEPRS Expense Assignment System, version IV
MEQS—MEPRS Executive Query System
MH—Mental Health
MH/CD—Mental Health/Chemical Dependency
MHS—Military Health System (formerly Military Health Services System)
MHSA—Military Health Services Area
MILDEP—Military Department (DoD)
MIME—Multipurpose Internet Mail Extensions
MIPR—Military Interdepartmental Purchase Request
MIPS—Millions of Instructions per Second
MIS—Management Information System
MMSO—Military Medical Support Office
MNS—Mission Needs Statement (DoD)
MOA—Memorandum of Agreement
MOAA—Military Officers Association of America
MOU—Memorandum of Understanding
MPI—Master Patient Index
MQAS—Medical Quality Assurance System
MRSP—Medical Readiness Strategic Plan
MRT—Medical Record Tracking
MSA—Metropolitan Statistical Area
MSAM—Manpower Staffing Assessment Model
MS–DOS—Microsoft Disk Operating System
MUMPS—Massachusetts General Hospital Utility Multi-Programming System
NAIC—National Association of Insurance Carriers
NAS—Non-Availability Statement (DoD)

NCA—National Capital Area
NDAA—National Defense Authorization Act
NED/NEDB—National Enrollment Database (managed care)
NG—National Guard
NIC—Network Interface Card
NIH—National Institutes of Health
NMOP—National Mail Order Pharmacy program
NQMC—National Quality Monitoring Contractor
OA—Office Automation
OA—Open Architecture (computers)
OA—Operational Architecture
OBD—Occupied Bed Day
OBRA—Omnibus Budget Reconciliation Act
OCHAMPUS—Office of the Civilian Health and Medical Program of the Uniformed Services
OCHAMPUSEUR—OCHAMPUS Europe
OCONUS—Outside the Continental United States (DoD)
OCR—Optical Character Recognition
ODTF—Overseas Dental Treatment Facility
OE/RR—Order Entry/Results Retrieval
OHI—Other Health Insurance
OHIMS—Occupational Health Information Management System [? see also OHMIS]
OHMIS—Occupational Health Management Information System [? see also OHIMS]
OLE—Object Linking And Embedding
OLTP—On-Line Transaction Processing (computers)
OMB—Office of Management and Budget (Federal Government)
OO—object-oriented
OOTW—operations other than war
OPV—Outpatient Visit
ORD—Operational Requirements Document (for acquisition of major AIS)
OSF—Open Software Foundation
OSG—Office of the Surgeon General
OSHA—Occupational Safety and Health Administration (Department of Labor)
OTC—Over-The-Counter
OT&E—Operational Test And Evaluation (computers)
OTR—Outpatient Treatment Request
OTS—Off-The-Shelf
OTSG—Office of the Surgeon General
PAC—Preadmission Certification (managed care)
PACS—Picture Archiving and Communication System
PAD—Patient Administration Division
PAS—Patient Appointing and Scheduling (a module of CHCS)
PASARR—Preadmission Screening And Annual Resident Review

PASBA—Patient Administration System and Biostatistical Activity
P&T—Pharmacy and Therapeutics
PCM—Primary Care Manager (esp. in TRICARE)
PCP—Primary Care Physician
PCMBN—Primary Care Manager By Name
PCR—Problem Change Request
PDASD—Principal Deputy Assistant Secretary of Defense
PDASD(HA)—PDASD (Health Affairs)
PDM—Program Decision Memorandum
PDR—Physician's Desk Reference
PDR—preliminary design review
PDTS—Pharmacy Data Transaction Service
PEC—Preexisting Condition (managed care)
PEER—Physical External Evaluation Review
PEO—Program Executive Officer
PFPWD—Program for Persons with Disabilities
PGBA—Palmetto Group Benefits Administration
PHCA—Preventive Health Care Application
PHCS—Preventive Health Care System
PHO—Physician Hospital Organization
PHP—Partial Hospitalization Program
PHS—Public Health Service (DHHS)
PIC—Personal Identification Card; Personal Identification carrier
PIDS—Person Identification Service
PIN—Personal Identification Number
PIT—PCM Information Transaction
PIT—Primary Care Manager (PCM) Information Transfer
PITE—Point In Time Extract
PKI—Public Key Infrastructure
PL—Public Law
PM—Preventive Medicine
PM—Program Management, Program Manager
PM—Project Management, Project Manager
PM–DRG—Pediatric-Modified DRG
PMO—Program Management Office
PMP—Performance Management Plan
PMP—Performance Management Program
PMPM—Per Member Per Month (managed care)
PMPY—Per Member Per Year (managed care)
PMSA—Primary Metropolitan Statistical Area (formerly SMSA)
PO—Program Office
PO—Project Officer (Federal Government)
PO—Purchase Order

POC—Point Of Contact
POM—Program Objective Memorandum
P.O.M.R.—Problem-Oriented Medical Record
POP—Period Of Performance
POS—Point Of Service
PPN—Preferred Provider Network (managed care)
PPO—Preferred Provider Organization (managed care)
PPS—Prospective Payment System
PRB—Project Review Board; Program Review Board
PRC—Program Review Committee
PRD—Presidential Review Directive
PRO—Peer Review Organization
PRP—Peer Review Panel (VA)
PSRO—Professional Standards Review Organization
PTSD—Post-Traumatic Stress Disorder
QA—Quality Assurance
QALY—Quality Adjusted Life Year
QAP—Quality Assurance Program [Plan?]
QA/RM—Quality Assurance/Risk Management
QAS—Quality Assessment Specialist (VA contract)
QC—Quality Control
QI—Quality Improvement
QIC—quarter-inch cartridge
QIS—QUEST information system
QM—Quality Management
QMB—Qualified Medical Beneficiary (Medicaid)
QMB—Qualified Medicare Beneficiary
QMB—Quality Management Board
QMP—Quality Management Program
QPMP—Quality Project Management Process
QPMR—Quarterly Program Management Review (B&D)
RA—Requirements Analysis
RAD—Radiology (a module of CHCS)
RAD—Rapid Application Development
RADCF—Risk-Adjusted Discounted Cash Flow
R–ADT—Registration–Admission, Discharge, Transfer
RAM—Random Access Memory (computers)
RAPIDS—Real-Time Automated Personnel Identification System
RBRVS—Resource-Based Relative Value Scale (managed care)
RBUC—Received But Unpaid Claim
R&C—Reasonable and Customary (managed care)
RC—Reserve Component
RCCPDS—Reserve Component Common Personnel Data System

RCCS—Radiological Controls Computer System
RCFM—Reserve Component Family Member
RCM—Representative Category of MTF
RCMAS—Retrospective Case-Mix Analysis System
RCMAS–G—RCMAS–Government version
RCMAS–OSE—RCMAS–Open Systems Environment
RCMAS–P—RCMAS–Proprietary
RCMI—Relative Case Mix Index
RCMS—Retrospective Case Management System
RCT—Randomized Clinical Trial (CHCDP)
R&D—Research and Development
RDA—Recommended Daily Allowance
RDA—Registered Dental Assistant
RDA—Relational Database Access
RDA—Relational Database Architecture
RDA—Relational Distributed Architecture
RDA—Remote Database Access
RDB—Requirements Data Bank
RDBMS—Relational Data Base Management system
RDC—Regional Data Center
RDP—Remote Dental Program
REA—Request for Equitable Adjustment
Retro—Retrospective Rate Derivation (managed care)
RF—Radio Frequency
RFA—Request For Applications
RFA—Request For Assistance
RFC—Request For Comment
RFDO—Request For Delivery Order
RFI—Radio Frequency Interference
RFI—Request For Information (government procurement)
RFP—Request For Proposal; request for proposals (government procurement)
RFQ—Request For Quotation (government procurement)
RISC—Reduced Instruction Set Computing
RITPO—Resource Information Technology Program Office
RM—Resource Management
RM—Risk Manager
RMA—Registered Medical Assistant
RMC—Rating Method Code (managed care)
RMC—Records Management Center
RMC—Regional Medical Center; Regional Medical Command (Army)
RMC—Remote Modem Control
RMF—Radiology Master File
RMP—Risk Management Plan

RMS—Requirements Management System
RMS—Resource Management System
RN—Registered Nurse
RNA—Registered Nurse Anesthetist
RN,C—Registered Nurse, Certified
RN,CNA—Registered Nurse, Certified In Nursing Administration
RN, CNNA—Registered Nurse, Certified In Nursing Administration, Advanced
RN, CS—Registered Nurse, Certified Specialist
RO—Regional Office
ROM—Range Of Motion
ROM—Read-Only Memory (computers)
ROM—Rough Order Of Magnitude
ROTC—Reserve Officers' Training Corps
RPC—Remote Procedure Call
RPG—Report Program Generator
RPN—Retail Pharmacy Network
RPO—RAPIDS Program Office
RPO—Regional Processing Office
RPT—registered physical therapist
RR—Results Retrieval
RRA—Registered Record Administrator
RRC—Regional Review Center (CHAMPUS)
RRC—Residency Review Committee
RRL—Registered Record Librarian
RRS—Readiness Reporting System
RRT—Registered Respiratory Therapist
RS–232, RS–422, RS–423—(ANSI serial telecommunication standards)
RSCE—RAPIDS Support Center Europe
RT—Requirements Traceability
RT—Respiratory Therapist
RTC—Residential Treatment Center
RTDB—Requirements Traceability Database
RTE—Remote Terminal Emulator
RTI—run-time improvement
RTM—Requirements Traceability Matrix
RT(N)—nuclear medicine technologist
RTR—Registered Recreational Therapist
RT(R)—Technologist In Diagnostic Radiology
RTS—Regional TRICARE Server
RT(T)—Radiation Therapy Technologist
RUMR—Redistributed Uniform Management Report
RUMRS—Reports of Unavailable Medically Related Services
Rx—treatment, therapy, prescription

SA—systems analyst
SA—system administrator
SAA—Systems Application Architecture
SAAABB—Subcommittee on Accreditation of the American Association of Blood Banks
SADR—Standard Ambulatory Data Record (CHAMPUS)
SAF—SAS Accumulator File
SAIC—Science Applications International Corporation (CHCS contractor)
SAMS—SNAP Automated Medical System
SASC—Senate Armed Services Committee
SASS—Standard Appointing and Scheduling System
SASSY—Standard Automated Supply System
SBB(ASCP)—Specialist In Blood Banking Certified By The American Society Of Clinical Pathologists
SBHCS—sustaining base health care services
SBIS—Sustaining Base Information Services
SCM—Software Configuration management
SCM—system control monitor
SCOPCE—Select Committee on Psychiatric Care Evaluation (CHAMPUS)
SCP—session control protocol (DEC)
SCP—system change package
SCR—standard class rate (managed care)
SCR—system change request (computers)
SCRD—system change request description
SCT(ASCP)—Specialist In Cytotechnology Certified By The American Society Of Clinical Pathologists
SDD—system design document
SDE—Secure Data Exchange (IEEE)
SDN—Secure Data Network
SE—Systems Engineer
SEC—Securities and Exchange Commission
SECDEF—Secretary of Defense
SECNAV—Secretary of the Navy
SECNAVINST—Secretary of the Navy Instruction
SELRES—Selected Reserve
SF—Standard Form
SFDD—Software Functional Design Document
SGLI—Serviceman's Group Life Insurance
SGML—Standard Generalized Markup Language
SHCP—Supplemental Health Care Program
SHIP—State Health Insurance Program (Hawaii)
S/HMO—Social Health Maintenance Organization
S–HTTP—Secure Hypertext Transfer Protocol

SIA—System Interface Agreement
SIC—Standard Industry Code (of types of employers) (managed care)
SIDR—Standard Inpatient Data Record (CHAMPUS)
SIR—System Incident Report
SIT—Standard Insurance Table (a database of insurance company addresses)
SIT—System Integration Test
SIT—Systems Integration Testing
SLA—Service Level Agreement
SLC—Systems Life Cycle
SM—software maintenance
SMI—supplemental medical insurance (SSI)
SMI—supplementary medical insurance (managed care)
S/MIME—Secure/Multipurpose Internet Mail Extensions
SMSA—Standard Metropolitan Statistical Area (superseded by PMSA)
SMTP—Simple Mail Transport Protocol
SNA—System Network Architecture (computers)
SNF—Skilled Nursing Facility
SNOMED—Systemized Nomenclature of Medicine
SNP—Special Needs Program
SNPMIS—Special Needs Program Management Information System
SOAP—Subjective, Objective, Assessment Plan
SOBRA—Supplemental Omnibus Reconciliation Act [Medicaid?]
SON—Submitting Office Number
SOW—Statement Of Work (government procurement)
SPOC—Service Point of Contact
SPOC—Site Point Of Contact
SPSSN—Sponsor's Social Security Number
SQL—Structured Query Language (a type of computer language)
SQL2—NIST Standard Query Language Level 2 Standard
SQL*NET—(ORACLE's distributed network protocol)
SR/NG—Selected Reserves/National Guard
SRR—system requirements review
SRS—system requirements specification
SSAA—System Security Authorization Agreement
SSAC—Source Selection Advisory Council
SSAN—social security account number
SSB—Special Separation Benefit
SSC—small-scale contingency
SSDI—social security disability income (SSA)
SSEB—Source Selection Evaluation Board
SSI—supplemental security income
SSI—surgical site infection (superseded SWI in 1992)
SSI—System Services Integration (Team)

SSL—Secure Sockets Level
SSL—standard security label
SSN—social security number
SSP—Source Selection Plan (mandatory for dollar acquisitions over $40m)
SSP—System Security Plan
SSP—System Support Program
S&SX—signs and symptoms
STD—sexually transmitted disease
STD—standard
ST&E—security test and evaluation
STF—specialized treatment facility (DoD)
STLDD—Software Top-Level Design Document
STM—synchronous transfer mode
SURS—Surveillance and Utilization Review System or Subsystem (Medicaid)
SVGA—super video graphics adapter; super video graphics array
TACCMIS—Theater Automated Command and Control Management Information System
TAFIM—Technical Architecture Framework for Information Management (DoD)
TAMMIS—Theater Army Medical Management Information System
TAMMIS–D—Theater Army Medical Management Information System–Division
TAMP—Transitional Assistance Management Program
TAMP—Transitional Assistance Management Plan
TAO—TRICARE Accounting Office
TATRC—Telemedicine and Advanced Technology Research Center
TCP/IP—Transmission Control Protocol/Internet Protocol
TCPR—Transportable Computer-based Patient Record
TCSDB—Tri-Service CHAMPUS Statistical Data Base
TDA—Table of Distribution and Allowances
TDD—Technical Development Division
TDD—telecommunications device for the deaf
TDEFIC —TRICARE Dual Eligible Fiscal Intermediary Contract
TDP—TRICARE Dental Program
TEC—TRICARE Executive Committee
TED—TRICARE Encounter Data
TEFRA—Tax Equity and Fiscal Responsibility Act of 1982 (Medicare)
TELNET—telecommunications network
TEMP—Test and Evaluation Master Plan
TEPRV—TRICARE Provider File Records
T&E—test and evaluation
TF—task force
TFL—TRICARE for Life
TGRO—TRICARE Global Remote Overseas
THCB—Transitional Health Care Benefit

THCDP—Transitional Health Care Demonstration Project
TIMPO—Tri-Service Infrastructure Management Program Office
TIN—Tax Identification Number
TIN—Temporary Identification Number
TIWG—Technical Integration Working Group; Technical Integrated Working Group
TLAC—TRICARE Latin America and Canada
TMA—TRICARE Management Activity
TMA-RM—TRICARE Management Activity-Resource Management
TMII—Theater Medical Information Infrastructure
TMIP—Theater Medical Information Program
TMIS—Theater Medical Information System[2]
TMOP—TRICARE Mail Order Pharmacy (TMOP)
TMP—Technical Management Plan
TNEX—TRICARE Next [Generation of Contacts]
TOL—TRICARE Online
TOP—TRICARE Overseas Program
TPA—Third-Party Administrator (managed care)
TPC—Third-Party Collection
TPC/AR—Third Party Collection/Accounts Receivable
TPCP—Third-Party Collection Program (DoD)
TPL—Third-Party Liability (managed care)
TPLA—TRICARE Pacific Lead Agent
TPO—Telemedicine Project Office
TPOCS—Third-Party Outpatient Collection System (DoD)
TPR—TRICARE Prime Remote
TPR—Third-Party Resource (managed care)
TPRADFM—TRICARE Prime Remote for Active Duty Family Members
TPRRM—TRICARE Program for Ready Reserve Members
TPS—Tri-Service Pharmacy System
TRAC—TRICARE Regional Appointment Center
TRAC2ES—TRANSCOM Regulating and Command & Control Evacuation System
TRDP—TRICARE Retiree Dental Program
TRICARE—Tri-Service Care (Army, Navy, Air Force health care delivery system)
TRIFOOD—Tri-Service Food Service System
TRILAB—Tri-Service Laboratory Information System
TRIMEP—Tri-Service Medical Evaluation Program
TRIMIS—Tri-Service Medical Information System
TRIPAD—Tri-Service Patient Administration System
TRIPAS—Tri-Service Patient Appointment and Scheduling System
TRIPHARM—Tri-Service Pharmacy Information System
TRIPS—Treatment Referral, Information, and Placement Services

TRIRAD—Tri-Service Radiology Information System
TRISARF—Tri-Service Alcoholism Recovery Facility
TRISLPR—(selected Tri-Service database of NSN consumption)
TRI–TAC—Tri-Service Tactical Communications System
TRITS—TRICARE Immunization Tracking System
TRRx—TRICARE Retail Pharmacy Program
TPRADFM—TRICARE Prime Remote for Active Duty Family Members (TPRADFM)
TSC—TRICARE Service Center
TSC—TRICARE Support Contractor
TSG—The Surgeon General
TSM—technical system manager
TSO—TRICARE Support Office
TSP—TRICARE Senior Prime
UAT —User Acceptance Test
UB–82—Uniform Billing Claim Form of 1982 (HCFA)
UB–92—Revised Universal Billing Claim Form of 1992 (HCFA)
UBO—Uniform Business Operations
UBO—Uniformed Business Office
UBU—Unified Biostatistical Utility
UC—Use Case
UCA—uniform chart of accounts
UCAPERS—Uniform Chart of Accounts Personnel System (DoD)
UCCI—United Concordia Companies, Inc. (TRICARE Dental Plan Carrier)
UFR—unfunded requirement
UI—user interface
UIC—Unit Identification Code
UID—unique identifier
UM—utilization management (managed care)
UML—Unified Modeling Language
UMLS—Unified Medical Language System
UP3—Universal Pharmacy Patient Profile
UPIN—Unique Physician Identification Number
UPMR—Unit Personnel Management Roster
UPS—uninterruptible power supply
UR—utilization review (managed care)
URDB—User Requirements Database
URL—uniform resource locator
UR/QA—utilization review/quality assurance
User–ID—user identification number
USFHP—Uniformed Services Family Health PlanVA—Department of Veterans Affairs (formerly Veterans Administration)
USPHS—United States Public Health Service
VACO—Veterans Affairs Central Office

VA/DHCP—Department of Veterans Affairs Decentralized Hospital Computer Program
VISN—Veterans Integrated Service Network
VISTA—Veterans Health Information Systems and Technology Architecture
VSI—Voluntary Separation Initiative
WAM—Workload Assignment Module
WAN—wide area network (computers)
WEDI—Workgroup for Electronic Data Interchange
WG—working group
WHO—World Health Organization
WIC—Women, Infants, and Children (a program of the Department of Agriculture)
WIPT—Working Integrated Product Team
WPS—Wisconsin Physicians Service
X.25—(a protocol for electronic data transmission)
XML—Extensible Markup Language
YHLS—years of healthy life saved
YTD—year-to-date
ZIP Code—Zone Improvement Plan Code