DEFENSE HEALTH AGENCY
7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VIRGINIA 22042-5101

DHA-IPM 18-001
February 4, 2020

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER
        AND RESERVE AFFAIRS)
        ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND
        RESERVE AFFAIRS)
        ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER
        AND RESERVE AFFAIRS)
        DIRECTOR OF THE JOINT STAFF
        DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH
        SERVICES POLICY AND OVERSIGHT)

SUBJECT: Interim Procedures Memorandum 18-001, "Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)"

References: See Attachment 1.

    Purpose. This Defense Health Agency-Interim Procedures Memorandum (DHA-IPM), based on the authority of References (a) through (c), and in accordance with the guidance of References (d) through (j) and Reference (l):

- Establishes the Defense Health Agency's (DHA) procedures to describe standard appointing processes, procedures, and appointment types in primary, specialty, and behavioral healthcare in Defense Health Program (DHP)-funded Department of Defense (DoD) MTFs.

- This DHA-IPM is effective immediately and cancels Reference (k); it must be incorporated into a future DHA-Procedural Instruction. This DHA-IPM will expire June 3, 2020.

    Applicability. This DHA-IPM applies to DHP–funded DoD MTFs, and DoD health care practitioners who are involved in the delivery of health care services to eligible beneficiaries and all other organizational entities within the DoD (referred to collectively in this DHA-IPM as the "DoD Components").

    Policy Implementation. It is DHA's instruction, pursuant to Reference (e), and in accordance with References (f) through (j), and References (l) through (p), to:

- Establish uniform accountability and standard processes, procedures, appointment types, and other business rules for primary, specialty, and behavioral health care appointing in MTFs.
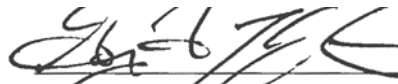
- Support high reliability organization principles and uniform business rules, which establish standard appointing processes, procedures, productivity standards to optimize readiness, appointment capacity, and appointment types in primary, specialty, and behavioral health care in all MTFs. Standard processes and procedures in all MTFs improve medical readiness, reduce unwarranted variation, enhance the patient experience, increase access to care, minimize fragmentation, and support the principles of a highly reliable organization.

Responsibilities. See Attachment 2.

Procedures. See Attachment 3.

Releasability. **Cleared for public release**. This DHA-IPM is available on the Internet from the Health.mil site at: www.health.mil/DHAPublications.

For, RONALD J. PLACE
LTG, MC USA
Director

Attachments:
As stated,

cc:
Acting Assistant Secretary of Defense for Health Affairs
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Medical Officer of the Marine Corps
Joint Staff Surgeon
Director of Health, Safety, and Work-Life, U.S. Coast Guard
Surgeon General of the National Guard Bureau
Director, National Capital Region Medical Directorate

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ATTACHMENT 1

REFERENCES

(a) United States Code, Title 10, as amended
(b) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(c) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(d) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015
(e) National Defense Authorization Act for Fiscal Year 2017
(f) Health Affairs Policy 11-005, "TRICARE Policy for Access to Care," February 23, 2011
(g) Health Affairs Policy 09-015, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs," March 18, 2009
(h) TRICARE Operations Manual 6010.59-M, April 1, 2015
(i) TRICARE Policy Manual 6010.60-M, April 1, 2015, as amended
(j) DHA-Interim Procedures Memorandum 17-001, "Use of Tri-Service Workflow (TSWF) Core Adult and Pediatric Forms for Screening and Documentation of Primary Care Outpatient Face-to-Face Encounters with Providers," January 6, 2017
(k) DHA-Interim Procedures Memorandum 17-002, "Specialty Care Referral Accountability and Business Rules," January 19, 2017 (hereby cancelled)
(l) DHA-Interim Procedures Memorandum 17-003, "Accounting for Defense Health Program (DHP) Primary Care Managers (PCMs)," June 27, 2017
(m) Health Affairs Memorandum, "Guidance for Implementation of Simplified Appointing," July 29, 2015[1]
(n) DHA-Procedural Instruction 6025.03, "Standard Processes and Criteria for Establishing Urgent Care (UC) Services and Expanded Hours and Appointment Availability in Primary Care in Medical Treatment Facilities (MTFs) to Support an Integrated Health Care System (IHCS)," January 30, 2018
(o) Department of Defense Manual 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management In The Military Health System (MHS)" October 29, 2013
(p) Assistant Secretary of Defense (Health Affairs) Policy Memo, "Provision of Telemedicine at a Patient's Location," February 3, 2016

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[1] This reference can be found at:
https://info.health.mil/hco/clinicsup/hsd/pcpcmh/Documents/Forms/AllItems.aspx?RootFolder=%2Fhco%2Fclinics up%2Fhsd%2Fpcpcmh%2FDocuments%2FPolicies%2FHA%20Policies%2FPolicy%20for%20Implementation%20 of%20Simplified%20Appointing&FolderCTID=0x012000D3E68956761537418E935D5AC018689D&View=%7B 87C81850%2DB4EC%2D489C%2D8C7D%2DE4CFB4B60A0D%7D

ATTACHMENT 2

RESPONSIBILITIES

1. <u>DIRECTOR, DHA</u>. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs, and in accordance with References (e) through (n), the Director, DHA, will:

   a. Assign responsibility for tracking compliance with the standard processes, procedures, and appointment types outlined in this DHA-IPM to the Deputy Assistant Director, Healthcare Operations (DAD, HCO).

   b. Support the Military Medical Departments by ensuring standard appointing and workload systems are in place to collect data and measure compliance with this DHA-IPM.

   c. Exercise Reference (c) authority over the National Capital Region Medical Directorate.

2. <u>DAD, HCO</u>. The DAD, HCO, will:

   a. Oversee the development of data collection, analysis, and accountability monitoring of standard processes, procedures, and appointment types by DHA, HCO.

   b. Monitor compliance with the guidance outlined in this DHA-IPM via the Tri-Service Patient Centered Care Operations Board (PCCOB) to the Medical Operations Group (MOG).

   c. Recommend and track measures to assess access to care, capacity and appointing performance, and compliance with the business rules and processes outlined in this DHA-IPM.

   d. Update this guidance with additional standard appointing processes and procedures in support of continuous improvement, as recommended by the PCCOB.

3. <u>REGIONAL COMMANDS</u>. The Regional Commands will:

   a. Ensure MTFs implement the standard appointing processes, procedures, and appointment types outlined in this DHA-IPM.

   b. Ensure MTF Commanders, Directors, and/or Senior Market Managers comply with the guidance in this DHA-IPM and implement corrective actions or provide additional resources and training, if required.

    c. Ensure MTF Commanders and Directors provide the same access to care to all Prime beneficiaries who are traveling, are on leave, and/or who are in temporary duty status, as Prime beneficiaries empaneled to the MTF to which they are seeking care, in accordance with the Military Health System (MHS) access to care policy.

    d. Ensure MTFs establish a process to ensure patients who receive a referral for specialty or behavioral health care are offered the opportunity to book a specialty or behavioral health care appointment before the patient departs the MTF if the MTF can provide those services.

    e. Monitor, recommend, and track measures to assess access to care, capacity and appointing performance, and compliance with the business rules and processes outlined in this DHA-IPM.

    f. Ensure processes are standardized in any single service or multi-service market.

4. <u>MTF COMMANDERS AND DIRECTORS</u>. The MTF Commanders and Directors will:

    a. Implement the standard appointing processes, procedures, and appointment types outlined in this DHA-IPM.

    b. Comply with the guidance in this DHA-IPM and implement corrective actions or provide additional resources and training, if required.

    c. Ensure MTF staff provide all Prime beneficiaries who are traveling, are on leave, and/or who are in temporary duty status, the same access as Prime beneficiaries empaneled to the MTF to which they are seeking care, in accordance with the MHS access to care policy.

    d. Monitor and track measures to assess MTF access to care, capacity and appointing performance, and compliance with the business rules and processes outlined in this DHA-IPM.

    e. Grant exceptions, in writing, to booking the first specialty or behavioral health appointment before the patient departs the MTF after receiving the referral only when there are compelling medical or mission interests.

5. <u>PCCOB</u>. The PCCOB will:

    a. Monitor access to care, supply and demand, and compliance with standard appointing processes, procedures, and appointment types outlined in this DHA-IPM to ensure a reliable, standardized appointing process and a single medical appointment system, available via telephone or virtually, to provide patient-friendly access to primary, specialty, and behavioral health care.

    b. Recommend additional standard processes and procedures related to appointing to governance for approval and inclusion in updates to this DHA-IPM in support of continuous improvement and high reliability principles.

c. Report to the MOG in compliance with this DHA-IPM at least quarterly.

ATTACHMENT 3

PROCEDURES

1. OVERVIEW. This DHA-IPM establishes standard processes, procedures, and business rules for primary, specialty and behavioral health care appointing and productivity standards. Implementation of the standard processes, procedures, business rules and productivity standards in this DHA-IPM apply to MTFs using either Legacy or MHS GENESIS appointing systems. The goals of this instruction are to eliminate unwarranted variance in appointing processes in MTFs, increase MTF capacity and improve patient experience and access to care.

2. TIMELINE. Full compliance with this guidance is required within 6 months from signature for all MTFs, including those in Enhanced Multi-Service Markets (eMSMs). Within 6 months, the DHA will establish the process for oversight of MTFs by the Services and eMSMs via the MOG.

3. GOVERNANCE. The PCCOB will report to the MOG on all related responsibilities outlined in Attachment 2.

4. MANUAL APPOINTING SYSTEM

    a. The direct care system will continue using the Composite Health Care System (CHCS) as the sole appointment system to build templates and schedule appointments in MTFs.

    b. Upon transition to the new electronic health record (EHR), MTFs will use MHS GENESIS as the sole appointment system to build templates and schedule appointments.

5. STANDARD APPOINTMENT TYPES AND LENGTH

    a. Patients will be able to schedule follow-up and wellness appointments 180 days in the future at all MTFs.

    b. Primary Care. Most appointment types used in primary care will be within 24 hours (24HR) or in the future (FTR), in accordance with Reference (m). MTFs will actively balance 24HR and FTR appointments to maximize the MTF's ability to meet access standards. Future appointments for follow-up care, wellness needs or when the patient requests to be seen beyond 24 hours in the future will be a combination of FTR and virtual appointment types. Virtual appointment types and use cases are identified below. The suggested appointment mix for face-to-face appointments is 60 percent 24HR and 40 percent FTR; however, MTFs may adjust the appointment mix based on local demand, as needed. The MTF will ensure all providers template all approved appointment types 180 days in the future or until the provider's projected rotation

date. Primary care is authorized to use only the following standard appointment types in CHCS and in MHS GENESIS:

(1) <u>24HR</u>. 24HR appointments are used for when the patient wants to be seen within 24 hours. The MTF will ensure a minimum of three appointments are available within 24 hours per primary care team to meet access goals. Three appointment time lengths are authorized: 1) 20 minutes; 2) 40 minutes for complex patients; and 3) 60 minutes for training purposes and in accordance with American Council for Graduate Medical Education (ACGME) requirements or other formal healthcare provider training program requirements (Physician Assistant [PA], Nurse Practitioners [NP]). Embedded specialists in primary care are authorized 30-minute appointments.

(2) <u>FTR</u>. FTR appointments are used for follow-up care, wellness care, or when the patient requests care beyond 24 hours in the future. MTFs will ensure a minimum of three appointments in each clinic per day are available within 7 days per primary care team to meet access goals. Three appointment time lengths are authorized: 1) 20 minutes; and 2) 40 minutes for complex patients; and 3) 60 minutes for training purposes and in accordance with ACGME or other formal healthcare provider training program requirements (PA, NP). Follow-up appointments will be made based on patient preference and the patient's diagnosis, condition, care plan, and the clinical judgment of the provider. Embedded specialists in primary care are authorized 30-minute appointments.

(3) <u>Specialty (SPEC)</u>. SPEC appointments are used for specialty care delivered in a primary care setting. Three appointment time lengths are authorized: 1) 20 minutes; and 2) 40 minutes for complex patients; and 3) 60 minutes for training purposes and in accordance with ACGME or other formal healthcare provider training program requirements (PA, NP). Longer appointment lengths are also used for complex patients requiring additional time.

(4) <u>Group (GRP)</u>. GRP appointments are 40 or 60 minutes in length.

(5) <u>Virtual (VIRT) or Telephone Visits</u>. Virtual appointments are used when clinically appropriate based on the judgement of the provider. VIRT or telephone visits will use a SPEC appointment type with a House Call (HC) detail code. The SPEC HC appointment length is 10 minutes. In MHS GENESIS, the VIRT appointment type will be used in lieu of the SPEC HC appointment type. VIRT appointments may be 10 or 20 minutes in length.

(6) <u>Procedures (PROC)</u>. PROC appointment types are used for procedures delivered in a primary care setting. Authorized appointment lengths are 30 minutes for minor procedures, and 60 minutes for complex procedures warranting additional time.

c. <u>Non-behavioral/Mental Health Specialty Care</u>. Most appointment types used in specialty care templates will be SPEC or FTR, in accordance with Reference (m). Specialty care templates will comply with product line-specific guidance provided in Appendix 1 and 60-minute appointments are authorized for training purposes and in accordance with ACGME requirements. Overall, MTFs will actively balance SPEC and FTR appointment types to maximize the MTFs' ability to meet access standards, reduce network deferrals, and capture specialty care to the MTF. The MTF will ensure all providers template all approved appointment types 180 days in the future or until the provider's projected rotation date. Specialty care is authorized to use only the following standard appointment types in CHCS and in MHS GENESIS.

(1) <u>24HR</u>. 24HR appointments are for urgent specialty referrals from other clinics in the MTF or when acutely distressed patients present to the clinic as walk-ins. Specialty care 24HR appointment lengths are identified in Appendix 1.

(2) <u>FTR</u>. FTR appointments are used for routine or follow-up care for established patients after the first specialty care appointment. MTFs will ensure at least three FTR appointments in each clinic are available every duty day. Specialty Care FTR appointment lengths are identified in Appendix 1.

(3) <u>SPEC</u>. SPEC appointments are reserved for a patient's first non-urgent Specialty care appointment. The MTF will ensure at least a minimum of three appointments per each duty day are available within 28 days. SPEC appointment lengths are identified in Appendix 1.

(4) <u>GRP</u>. GRP appointment lengths for these specialties are identified in Appendix 1.

(5) <u>VIRT or Telephone Visits</u>. VIRT or telephone visits will use a SPEC appointment type with a HC detail code. The SPEC HC appointment length is 10 minutes. In MHS GENESIS, the VIRT appointment type will be used in lieu of the SPEC HC appointment type. Authorized VIRT appointment lengths are 10 or 20 minutes in length. VIRT specialty care appointment lengths are identified in Appendix 1.

(6) <u>PROC</u>. Authorized PROC appointment lengths are 30 minutes for minor procedures and 60 minutes for complex procedures warranting additional time. SPEC appointment lengths are identified in Appendix 1.

d. <u>Behavioral/Mental Health Care</u>. Most appointment types will be SPEC or FTR, in accordance with Reference (m). Behavioral health appointment templates will comply with product line-specific guidance; however, MTFs will actively balance routine (ROUT), SPEC, and FTR appointment types to maximize the MTF's ability to meet access standards, reduce network deferrals, and capture behavioral care to the MTF. The MTF will template and make appointments available for booking 180 days in the future. Specialty behavioral health care is authorized to use only the following standard appointment types in CHCS and in MHS GENESIS

(1) <u>24HR</u>. 24HR appointments are for urgent behavioral health care referrals from other clinics in the MTF or when acutely distressed patients present to the clinic as walk-ins. 24HR appointments are 60 minutes in length.

(2) <u>FTR</u>. FTR appointments are used for follow-up care for established patients after the first specialty appointment. MTFs will ensure at least three FTR appointments in each clinic are available within 7 days. The authorized behavioral health care FTR appointment lengths are 30, 60, and 90 minutes, based on patient complexity or Graduate Medical Education (GME) program requirements. Behavioral health will ensure an adequate supply of FTR appointments are available to meet local demand for mandatory 7-day post-behavioral health hospitalization follow-up. The MTF will template and make appointments available for booking 180 days in the future.

(3) <u>SPEC</u>. SPEC appointments are for the patient's first non-urgent specialty appointment in behavioral health. The MTF will ensure at least a minimum of three appointments each duty day are available within 28 days. The authorized SPEC care appointment lengths are 60 and 90 minutes, based on patient complexity or training purposes and in accordance with ACGME or other formal healthcare provider training program requirements (PA, NP). To support readiness, reduce deferrals to the private sector network and to increase capture of specialty care to the MTF, the MTF will template and maintain availability for SPEC appointments at least 60 days in the future.

(4) <u>ROUT</u>. ROUT appointments may be used for self-referred, non-urgent behavioral health care needs. ROUT appointments are 60 minutes in length. The MTF will ensure at least three ROUT appointments each duty day are available within 7 days.

(5) <u>GRP</u>. GRP appointments are 60 and 90 minutes in length.

(6) <u>VIRT or Telephone Visits</u>. VIRT or telephone visits will use a SPEC appointment type with an HC detail code. Patients may be booked into VIRT or any other appointment type. The SPEC HC appointment length is 10 minutes. In MHS GENESIS, the VIRT appointment type will be used in lieu of the SPEC HC appointment type. Authorized VIRT appointment lengths are 10 or 20 minutes in length.

(7) <u>PROC</u>. Authorized PROC appointment lengths are 20, 40, 60, 90, and 240 minutes, based on the procedure and time required.

6. <u>UNIVERSAL STANDARD OPERATING HOURS, APPOINTING PROCESSES AND PROCEDURES</u>. The following standard processes and procedures are applicable to primary, specialty, and behavioral health care.

a. <u>MTF Operating Hours/Days</u>. MTFs will offer additional extended operating hours Monday–Friday beyond 9 hours a day or on weekends where sufficient demand exists to result in a positive business case or when urgent primary care is not available in the local network, if approved by the Service or the DHA, based on DHA guidance on extended hours in MTFs (n). Data on patient demand will include both appointment data in the Direct Access Reporting Tool (DART) demand dashboard and visits to direct and private sector Urgent Care Clinics (UCCs) and emergency rooms (ERs).

(1) MTFs will ensure adjustments to core hours will align with the hours the majority of beneficiaries prefer to be seen. MTFs will monitor supply and demand by day of week and hour of day. MTFs will adjust templates to ensure sufficient numbers and types of appointments are available to meet at least 90 percent of forecasted demand based on retrospective data.

(2) MTFs and clinics with operational training missions will match core operating hours to line readiness requirements.

b. <u>Consecutive Days Closed</u>. No MTF may close in excess of 3 days or any additional day beyond federally declared holidays as identified by the Office of Personnel Management or the President of the United States or officially recognized federal office closures or local weather or contingency events.

(1) The direct care system does not consider Service or installation-specific days to be authorized federal holidays; therefore, MTFs are required to be minimally staffed for some portion of the day on unit, installation morale, or training days at a level required to meet patient demand for acute medical issues.

(2) MTFs may schedule medical training days adjacent to a weekend or a federally declared national holiday; however, the MTF must ensure sufficient staff are available to meet demand for acute health care needs.

c. <u>First Call Resolution</u>

(1) <u>Primary Care Acute/Urgent Needs</u>. Patients will be scheduled for primary care appointments in the MTF to which the patient is empaneled; however, Prime beneficiaries on leave or on official business away from the MTF to which he/she is empaneled may request a 24HR appointment at the nearest MTF. If a patient calls for a primary care acute/urgent need, the authorized procedures are, in order, as follows:

(a) Book the patient an appointment.

(b) If no 24HR appointment is available within 24 hours, offer to book outside the booking window.

(c) If the patient refuses the appointments, direct transfer to primary care for walk-in care or deferral to the network at the discretion of the primary care provider.

(d) If the primary care direct transfer fails, the MTF will offer the patient a 2-hour window for a telephone consult (T-Con), if the MTF is open.

(e) If the MTF has an UCC or ER with a low-acuity fast track clinic, the MTF will offer the patient care in the MTF UCC or ER.

(f) If the patient refuses all options for care, the MTF will inform non active-duty beneficiaries of ability to utilize preauthorized UCC visit and provide recommendations on and locator assistance for network urgent care.

(2) Primary Care Routine Medical or Follow-up Needs. Patients will be scheduled for primary care appointments in the MTF to which the patient is empaneled; however, Prime beneficiaries on leave or on official business away from the MTF to which he/she is empaneled may request an FTR appointment at the nearest MTF. If a patient calls for an FTR appointment and only 24HR appointments are available on the requested day, appointing clerks (ACs) will:

(a) Change the 24HR appointment on the requested day to an FTR and book the patient (preferred).

(b) Book the patient into an available 24HR appointment on the requested date with a note in CHCS that the appointment was booked based on patient preference.

(c) If no appointments are available for the patient within 7 days, the MTF will offer to defer the patient to the network.

(d) Not ask any patient to call back on a preferred day to see if appointments are available.

(3) Specialty or Behavioral Health Care Follow-up Needs. Specialty appointments will be booked by centralized specialty care appointing. If a patient calls for an FTR appointment and only SPEC appointments are available on the requested day or if the patient calls for a SPEC appointment and only FTR appointments are available, ACs will:

(a) Change any other available appointment type on the requested day to the type of appointment requested by the patient and book the patient (preferred).

(b) Book the patient into any other available appointment type on the requested date with a note in CHCS that the appointment was booked based on patient preference.

(c) If no appointments are available for the patient within 28 days, the MTF will offer to defer the patient to the network.

(d) Do not ask any patient to call back on a preferred day to see if a specialty or behavioral health care appointment is unused.

d. Appointment Template/Schedule Management and Control

(1) Template Control and Authority. All MTFs and clinics within MTFs are required to have an obligated or shared professional Template Schedule Manager, Clinic Manager, or a Group Practice Manager. Only Template Schedule Managers, Clinic Managers, and Group Practice Managers, or other responsible personnel designated in writing by the MTF Commander or director are authorized to create, edit, modify or delete templates and open, block, adjust, cancel, or freeze appointment slots on schedules, however, ACs can change appointment types or book into appointment types available to meet patients' needs and prevent them from having to call back as outlined in paragraph 6.c. above.

(2) Appointment Auto Configuration to Maximize Supply and Access

(a) Primary Care. MTFs will auto reconfigure unused FTR, SPEC, and PROC appointments to 20-minute 24HR appointments 48 hours in advance to ensure an appointment is fully bookable by ACs, TRICARE OnLine (TOL), and the Nurse Advice Line (NAL). MTFs will set the auto reconfigure value at "2" or 2 days in advance of midnight on the day of the appointment. Schedules should be reviewed manually 48 hours in advance to ensure all unused appointments are converted to 24HR.

(b) Specialty and Behavioral Health Care. MTFs will convert any unused appointments to the requested appointment type based on patient demand. Practice managers will monitor the supply and mix of SPEC and FTR appointments to meet patient demand for both first specialty appointments and follow-up appointments.

(3) Demand-based Appointment Templating and Unused Appointments

(a) MTFs will balance appointment types in primary, specialty, and behavioral health care to ensure patients are offered choices on the days and time they prefer to be seen. The MTF will also ensure access to care and network primary care leakage rates meet MHS goals. The MTF will target a range of 10-15% unused appointments to provide convenience times for patients booking appointments.

(b) If appointments are routinely unused, templates will be adjusted to provide appropriate appointments at days and times convenient to patients (i.e., late in the afternoons to accommodate requests for care after work or school).

(4) Schedule Review for Supply and Patient Experience Optimization

(a) Primary and specialty care clinics will review and scrub appointment schedules at least 2 business days in advance to identify patient needs which can be appropriately met through Clinical Standard Staff Protocol (CSSP) team-based care, including embedded behavioral health specialists, clinical pharmacists and direct access physical therapy, T-Con or via a 10 minute telephone call for established patients.

(b) Primary and specialty care clinics will convert appointments freed up by use of T-Cons, VIRT visits, or CSSPs to 24HR appointments in primary care and SPEC appointments in specialty care.

(5) Detail Codes. Primary and specialty care clinics may not use detail codes or slot comments to restrict booking on more than five percent of appointments, excluding those used to designate appointments for active duty beneficiaries and HC detail codes for VIRT appointments in CHCS.

(6) Appointment Cancelling and Freezing

(a) Primary and specialty care clinics will not cancel more than three percent of appointments each month with the exception of cancellations due to weather, operational or ACGME compliance contingencies. The MHS will monitor the three percent freezing limit and adjust if necessary due to the requirement to book FTR appointments 180 days in advance.

(b) Primary and specialty care clinics are discouraged from freezing appointments; however, if required due to operational uncertainty, frozen appointments will either be cancelled or released 48 hours in advance for booking. Prior to releasing appointments, template managers must coordinate with the clinic to confirm provider availability.

e. Walk-In Care. Primary and specialty care clinics will accept walk-in care for urgent reasons to the greatest extent possible.

(1) Primary Care. Primary care will accept Prime enrollees empaneled to the MTFs who are referred by the NAL or re-directed by the MTF ER or MTF UCCs to an authorized/qualified MTF representative and it has been determined, based on that communication, that the receiving clinic is the optimal recommendation for care. The handoff could incorporate the utilization of established Clinical Support Staff Protocols (CCSPs) for Primary Care to meet patient needs.

(2) Specialty and Behavioral Health Care. Specialty and behavioral health care will discuss potentially emergent referrals with the referring provider in real-time; emergent referrals accepted by specialty or behavioral health care must be addressed the same day.

f. Follow-up and Specialty Booking at Appointment Check-Out

(1) If a follow-up appointment is clinically indicated in the professional judgment of the provider, the MTF health care team will offer to schedule the patient a follow-up FTR appointment prior to the patient departing the MTF. MTFs will not direct patients who want to schedule a follow-up appointment before departing the MTF to call the MTF appointment center. The healthcare team will accommodate the patient at appointment check-out.

(2) If a patient does not choose to book a follow-up appointment during appointment check-out, the MTF will instruct the patient on how to schedule an appointment later by calling the MTF appointment center or by using the TOL patient portal or secure messaging.

g. <u>Missed, Late or Wrong Day Appointments</u>. The direct care system defines a missed appointment as an appointment for which the patient is not present or when the patient is more than 10 minutes late for the scheduled appointment time.

(1) If the patient arrives more than 10 minutes late, the MTF will offer to work the patient in with the same or a different provider before the end of day. If the patient chooses to reschedule, the patient status will be marked No-Show. If the patient chooses to wait, the visit will be documented in the current encounter.

(2) If the patient prefers, the MTF will offer to reschedule the patient at a day and time of the patient's preference.

(3) If the patient presents to the MTF for an appointment on the wrong day, the MTF will offer to work the patient in with the same or a different provider before the end of the day.

h. <u>Telephone and In-Person Appointing Standard Processes</u>. MTFs will use standard customer service scripts provided by the Tri-Service Access Improvement Working Group for all appointing staff to optimize patient experience, and to ensure patients' needs are met on the first call. Standard AC script guidelines for common scenarios are provided in Appendix 2. MTF personnel can request reasonable proof of the individual's identify prior to making a disclosure of a patient's protected health information to the caller.

(1) <u>Primary Care</u>

(a) Primary care appointing staff will adhere to standard processes, regardless of whether MTF appointing is centralized or decentralized.

(b) Patients will be scheduled for primary care appointments at the MTF to which they are empaneled. Appointing staff will first attempt to make an appointment with the patient's Primary Care Manager (PCM). If no appointments with the PCM are available, the following options will be offered to the patient in order:

<u>1</u>. Another provider on the same team as the PCM;

<u>2</u>. Cross-booking to a provider on another team on a limited basis; see paragraph 7.d.2(b) 2;

<u>3</u>. MTF UCC, MTF after-hours clinic, MTF ER/ER Fast track if available; and

<u>4</u>. Network UCC.

(c) To facilitate patient-centered appointing, MTF primary care staff will include appointing supervisors in clinic huddles and staff meetings at least monthly to enhance understanding and synchronization of booking protocols and procedures. In eMSMs, appointing supervisors will coordinate in person or via telephone at least monthly with clinics at eMSM MTFs.

(2) Specialty and Behavioral Health Care

(a) MTFs will centralize specialty and behavioral health referral review and appointing for the first specialty care appointment. If the MTF is in a market, then referral review and appointing will be centralized at the market level.

(b) Patients will be booked for the first SPEC appointment after the first referral review by centralized appointing. If approved by the PLL, some specialties may not require referral review.

(c) Follow-up specialty and behavioral health care appointments may be booked by the MTF centralized appointing system or by the specialty or behavioral health clinic during the appointment check-out process.

(d) To facilitate patient-centered appointing, MTF specialty and behavioral staff will include appointing supervisors in clinic huddles and staff meetings at least monthly to enhance understanding and synchronization of booking protocols and procedures. In eMSMs, appointing supervisors will coordinate in person or via telephone at least monthly with clinics at eMSM MTFs.

i. Post-Discharge Appointment Booking. MTFs will schedule all patients enrolled to the direct care system and who are discharged from an MTF or private sector inpatient setting for an MTF follow-up in-person or virtual appointment with the patient's PCM. In addition to the appointment with the patient's PCM, the patient may also be scheduled for a follow-up appointment in specialty or behavioral health care, if clinically appropriate.

(1) Patients enrolled to the direct care system who are discharged from an MTF will be scheduled for the post-discharge follow-up appointment prior to the patient being discharged from the MTF.

(2) Patients enrolled to the direct care system who are discharged from private sector inpatient facilities also will be scheduled for a follow-up appointment. The MTF will contact patients discharged from private sector inpatient facilities to schedule a post-discharge follow-up appointment with the patient's PCM.

(3) Follow-up appointments for patients enrolled to the direct care system who are discharged from direct care or private sector inpatient facilities may be either in-person or via telephone using the VIRT visit appointment type.

(4) MTF discharge planners, ward clerks, social workers or other assigned personnel will arrange a follow-up appointment in private sector primary care for non-enrolled patients discharged from the MTF. MTF staff will coordinate with the patient or patient's family/caregivers to identify and obtain contact information for the patient's private sector primary care provider.

j. Care Coordination. MTFs will ensure patients' care is coordinated and received in the MTF. MTFs will provide care coordination for all patients who receive care in MTFs regardless of enrollment category or whether the patient is a TRICARE-eligible beneficiary.

k. Secure Messaging. The direct care system will use secure messaging capabilities in all primary, specialty and behavioral health clinics in MTFs and optimize secure messaging workflows to minimize provider workload while improving patient experience and response times.

    (1) All MTF enrollees will have access to secure messaging.

    (2) Providers and staff MTF-wide will encourage patient use of secure messaging.

    (3) MTF staff members will not message patients using any e-mail platform other than the approved secure messaging service.

    (4) MTFs will oversee the update and management of secure messaging by all clinics.

    (5) MTF staff will respond to patient-initiated messages within one business day.

l. TOL Patient Portal. MTFs will implement the following standard processes to maximize the number of appointments available for automated booking on the TOL patient portal.

    (1) Primary Care. MTFs will ensure at least 90 percent of face-to-face 24HR and FTR primary care appointments are available for online booking. MTFs may consider making embedded behavioral health care specialist appointments available for online booking. 24HR appointments will be available for on-line booking 24 hours in advance of the appointment.

    (2) Specialty and Behavioral Health Care. MTFs will make at least 50 percent of appointments in self-referred clinics including physical therapy, optometry and specialty behavioral health for active duty routine care available for online booking.

m. Prime Enrollees and Active Duty Personnel Traveling or on Temporary Duty Status. Prime beneficiaries who are traveling or who on temporary duty status, are authorized care in any MTF and will receive the same priority for care as Prime beneficiaries empaneled to the MTF, in accordance with the MHS access to care policy.

    (1) Primary Care. Prime beneficiaries traveling or on temporary duty status will be offered 24HR and FTR appointments for medical and wellness needs.

        (a) Prime beneficiaries will be offered 24HR appointments within 24 hours and FTR appointments within 7 days. Prime beneficiaries may be offered appointments beyond 24 hours or 7 days based on patient preference.

(b) The MTF will offer FTR appointments for wellness needs and preventive screens within 28 days. Prime beneficiaries may be offered appointments beyond 28 days based on patient preference.

(2) <u>Specialty Care</u>. Prime beneficiaries traveling or on temporary duty status are required to obtain a referral for specialty care from their own PCM, from a primary care provider at the MTF or from the medical duty officer at their home station in order to obtain specialty care in the MTF if available at that MTF.

n. Members of the Reserve Components are entitled to emergent or urgent medical care while in duty status for injuries or illnesses. They may seek that care at an MTF. Once the member of the Reserve component on duty status is seen and the emergent/urgent medical need is addressed, they will be referred back to their regular source of civilian care for follow-up.

7. <u>PRIMARY CARE SPECIFIC STANDARD PROCESSES AND PROCEDURES</u>. MTFs will implement the following primary care-specific standard processes and procedures. Primary care clinics include all family medicine, pediatrics, internal medicine, general primary care and operational medicine, including flight medicine, and any other clinic types providing primary care services.

a. <u>Pre-Visit and Pre-Appointment Screening</u>

(1) <u>Pre-Visit Screening</u>. The primary care team will conduct pre-visit screening for all FTR appointments at least 2 business days in advance. The MTF will proactively identify any prevention/wellness needs and required annual screenings, and plan to accommodate these needs during the appointment.

(2) <u>Appointment Screening</u>. From the patient's perspective, all standard 24HR and FTR appointments will begin with 20 minutes pre-appointment screening. Patients will be notified of appointment start time to begin with pre-appointment screening.

(a) Ancillary staff will conduct and document all required screenings to include behavioral health screening in the appropriate Tri-Service Workflow (TSWF) form. The primary care ancillary staff will conduct medication reconciliation, identify and schedule wellness visits, offer embedded specialist services, as appropriate, and identify issues to be addressed by the PCM.

(b) Primary Care teams will ensure ACs notify each patient of the appointment time, which begins with pre-appointment screening.

b. <u>No "One Visit/One Problem" Policy</u>. No MTF, clinic, or individual provider will be permitted to implement a "One Visit/One Problem" policy by either verbally making statements to this effect to patients or by posting signage in public areas within the MTF.

(1) MTF primary care clinics will conduct pre-visit planning and triage presenting issues to maximize the value of the visit if the patient's visit was scheduled at least 48 hours in advance. The problems most clinically urgent in the judgement of the provider will be addressed during the scheduled appointment time. If the provider determines another medical issue is more clinically urgent than the issue for which the patient sought care, the provider will explain clearly to the patient why the issue is more clinically urgent. As time permits, the provider will also address the less clinically urgent issues the patient wishes to address, while balancing the impact of extending the visit beyond the allotted time with the impact on the remaining scheduled patients' care and satisfaction.

(2) The patient will be offered a second appointment for any non-urgent issues that cannot be addressed during the scheduled appointment time.

c. Primary Care Productivity Standards

(1) MTF primary care clinics will template a total of 100 appointments per week per full-time provider with a suggested eighty face-to-face appointments and some combination of face-to-face or VIRT/telephone appointments to add up to twenty additional appointments. MTFs may adjust the proportion of virtual appointments as demand for virtual appointments increases. Waivers to these standards for additional duties (such as clinic leadership, medical directors, clinical practice guideline champions and precepting physicians) will be approved in writing by the MTF Commander or Director. DHA may adjust targets based on readiness and other considerations.

(2) Productivity standards may be adjusted for overall clinic acuity based on the John Hopkins Adjusted Clinical Groups available on the MHS Carepoint Platform.[2]

(a) Primary care clinics with average acuity of less than 2.0 will meet 100 percent of the expected number of available appointments.

(b) Primary care clinics with average acuity of greater than 2.0 but less than or equal to 2.5 will meet 80 percent of expected number of available appointments; the recommended appointment distribution per full-time equivalent (FTE) provider per week is 65 face-to-face and 15 virtual or telephone visits.

(c) Primary care clinics with average acuity of greater than 2.5 will meet 65 percent of the expected number of available appointments; the recommended appointment distribution per FTE provider per week is 50 face-to-face and 15 virtual or telephone visits.

(d) Provider empanelment will be calculated based on the expected number of appointments per year and the utilization rate.

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[2] https://carepoint.health.mil/SitePages/Detail.aspx?detailId=244

(3) VIRT/telephone appointments must meet the standard for a coded encounter with Subjective, Objective, Assessment, and Plan (SOAP) note documented in the patient's medical record. The Objective component may be deferred since no physical exam will be completed. As additional virtual health capabilities are available in direct care, the MTF may use such technologies as video conferencing to complete virtual encounters. If such technologies are used, telemedicine procedures, as discussed in references (o) and (p) need to be followed.

(4) Primary care clinics engaged in GME and other accredited healthcare provider training platforms (i.e., PA, Nurse Practitioner) will establish a weekly number of bookable face-to-face and virtual appointments locally via collaboration between the Program Director, consultant/specialty leader and the MTF/CC in accordance with ACGME or other formal healthcare provider training program requirements (PA, NP) in order to meet educational requirements and to maintain access of empaneled beneficiaries.

d. Balancing and Maximizing Supply and Demand. MTFs will actively manage appointment supply and capacity in order to meet patient demand for primary care. MTFs will use approved standard data sources, including TRICARE Operations Center, the DART, and authorized data sources on the DHA Patient-Centered Medical Home (PCMH)/Access SharePoint site https://info.health.mil/hco/clinicsup/hsd/pcpcmh/SitePages/Home.aspx. The PCMH/Access SharePoint site provides actionable information that includes, but is not limited to, appointments by day/hour, predictive no-show data, enrollee ER/UC utilization, and NAL outcomes and booking performance data.

(1) Demand. Patient demand is defined as the sum of met and unmet demand. MTFs will monitor MTF ability to meet primary care demand using:

(a) Met Demand by MTF. Met demand by the MTF is defined as maintained face-to-face, telephone, sick call, and walk-in appointments, as well as patients whose needs were met through the use of secure messaging, T-Cons and CSSPs.

1. Met demand also includes MTF appointments booked through the.

2. The NAL also meets patient demand by offering self-care advice, if clinically appropriate; however, patients' needs met through NAL self-care advice are considered met demand through external means rather than by the MTF.

(b) Unmet Demand. Unmet demand includes those patients who tried to access the system but failed, including those who were not given an appointment and leaked to direct and private sector ER and UCCs for non-emergent, urgent needs, as well as NAL calls by MTF enrollees who required an appointment and were not able to be appointed to the MTF. The DART Demand Dashboard will be used to monitor a sub-set of unmet demand in MTFs using CHCS. The DART Demand Dashboard compares demand met with appointments scheduled in CHCS and T-Cons to the percent of beneficiaries who received neither appointments nor T-Cons.

(2) Supply. The direct care system defines the supply of primary care appointments as the sum of face-to-face primary care appointments, VIRT telephone encounters, and other team-based methods to address patient demand such as, secure messages, CSSPs and T-Cons.

(a) Team-based care options fully leverage the primary care team, maximize appointment efficiency, and enhance patient experience.

(b) PCM continuity is a key tenet of the PCMH model of care. Effective management of supply and demand and ensuring a sufficient number of 24HR and FTR appointments are available supports the ability of the MTF to ensure PCM continuity for care within 24 hours and beyond for those patients empaneled to the MTF.

1. PCMHs will ensure adequate numbers of appointments are available to maximize PCM continuity by optimizing provider availability, ensuring providers are scheduling the appropriate number of appointments per day and ensuring appointments are scheduled at times convenient to patients based on retrospective analysis of demand.

2. Cross-booking refers to scheduling a patient with a provider on another team. MTFs may use cross-booking on a limited basis, only. The patient may be offered an appointment when clinically appropriate with a provider on another team if no appointments are available with the patient's PCM or another provider on the patient's PCMH team. MTF leadership will monitor cross-booking to identify persistent appointment supply problems in PCMH teams. In the case of persistent supply problems, PCMHs ensure that the team workload is distributed evenly and performance requirements of each primary care provider are met as identified above.

e. Managing/Adjusting Templates to Maximize Access to Care

(1) Templates and Appointment Mix. Primary care clinics will actively manage and balance available primary care appointments to maximize each clinic's ability to meet MHS access standards and MHS performance goals for all appointment types utilized for patients empaneled to the MTF. The MHS default face-to- face appointment mix standard is 60 percent 24HR and 40 percent FTR appointments to be adjusted and balanced locally to meet demand. Virtual appointments may be used to supplement face-to-face appointments to achieve the expected number of templated appointments per full-time provider as discussed in paragraph 7.c.(1).

(2) Demand-Based Appointment Balancing by Hour of Day. MTFs will ensure primary care appointments are available every operating hour, based on patient demand for preferred times.

(a) The availability of appointments by type, per hour, will be adjusted locally to minimize unfilled appointments and maximize access to care.

(b) If the MTF uses a generic 9-hour operating day, at least 10 percent of total planned primary care appointments will be available each hour.

(c) MTFs should minimize scheduling 24HR appointments before 0900 hours if they are routinely unfilled. MTFs also will ensure sufficient 24HR appointments are available through the end of the day to meet demand after patient work or school hours.

(d) If an MTF expands/extends operating hours, the MTF will distribute planned appointments proportionally. MTFs may adjust these standards in collaboration with Service-level access representatives based on post-implementation analysis of local demand.

(3) <u>24HR Appointment Type Supply for Urgent Health Needs for Holidays and by Season</u>. The MTF will maintain the maximum number of required 24HR appointments during high demand, based on analysis of historical met and unmet demand.

(a) MTFs are required to adjust templates to accommodate higher historical demand for 24HR appointments above normal levels to accommodate an increased demand for appointments for urgent reasons before and after weekends and holidays, as well as during the cold and flu season.

(b) MTFs also will actively manage increased demand for school physicals in July and August through planned events where multiple physicals are accomplished with a series of sequential steps, increased FTR appointments, and use of team-based care.

(c) During summer rotation season or any other period when the MTF is experiencing longer-term gaps in primary care provider staffing, the urgent needs of less high acuity patients may be shifted temporarily to the network using the MTF Integrated Healthcare System (IHCS) operating model. MTF IHCS plans will leverage the NAL and the MHS' TRICARE contracts to provide medical care to beneficiaries in the private sector network, if required.

f. <u>Team-Based Care and CSSPs</u>. MTFs will offer alternative access to primary care team members to maximize the MTF's ability to meet patient needs. All MTF primary care providers must utilize available team-based care.

(1) Primary care providers, practice managers, and senior enlisted staff will ensure primary care support staff members are available and trained to support the PCM.

(2) PCMHs will fully utilize embedded specialists including behavioral health specialists, clinical pharmacists and physical therapists. Direct booking to embedded specialists is encouraged. PCMs will coordinate with embedded specialists to develop and monitor care plans for patients, as clinically appropriate.

(3) MTFs will, at a minimum, implement CSSPs for: adult cold, adult sore throat, urinary tract infection, pregnancy test, pediatric cold, and pediatric sore throat in those clinics with high incidence of these conditions. Standard CSSP guidelines will be provided by the DHA for approval at the local level. The direct care system will develop CSSP protocols based on industry-standard algorithms and embed the protocols in TSWF.

(4) MTFs will leverage and appoint patients to PCMH-embedded behavioral health care, Clinical Pharmacists, and Physical Therapy specialists, if available.

(5) MTFs will employ available case, disease, and utilization management to improve outcomes, patient experience, and reduce unnecessary utilization.

g. Evidence-Based Follow-up Care

(1) PCMHs will schedule follow-up care based on the clinical judgement of the provider and medical evidence, diagnosis and the patient's care plan progress.

(2) PCMHs will use secure messaging or VIRT/telephone "check-in" visits for follow-up care with established patients, if clinically appropriate.

h. Enterprise Referral Guidelines. The direct care system has made evidence-based standard specialty referral guidelines available in TSWF. Primary care providers will:

(1) Collaborate with MTF and eMSM specialty care leaders to enhance the referral guidelines in TSWF based on local capabilities in order to maximize direct care system bookings of the first specialty or behavioral health care appointment.

(2) Use specialty referral guidelines in TSWF when referring a patient for a specialty or behavioral health care appointment.

i. Patient Engagement/Activation/Education. MTFs will conduct on-boarding for patients enrolled to the direct care system.

(1) On-boarding information will include options for accessing care, including the NAL, secure messaging, TOL patient portal, MTF appointing center, CSSPs, and T-Cons with a team of Registered Nurses (RN).

(2) On-boarding education will include information on the concept of evidence-based principles of quality care to educate patients that the MTF will not provide or recommend unnecessary procedures, specialty care visits and medications that are not supported by medical evidence.

(3) The MTF will provide instruction on self-care for low acuity self-limiting conditions and the availability of CSSPs to reduce unnecessary primary care utilization and provide the patient with options for dealing with common acute conditions. Strategies may include an MTF program to teach beneficiaries how to obtain an appointment, advice through the NAL or secure messaging, and/or how they can take care of their own needs for self-limiting illnesses (e.g., colds).

j. <u>Group Appointments</u>. MTFs will increase the use of group appointments to improve patient engagement, outcomes, and patient experience. MTFs will consider group appointments for the following conditions: fibromyalgia, diabetes, and hypertension. MTFs will offer group appointments for additional health care conditions where industry evidence demonstrates patient collaboration and communication through group appointments have improved outcomes and satisfaction, while reducing unnecessary primary care appointment utilization. If used, MTF leadership will need to develop standard group appointment protocols and rules of engagement to, at a minimum, ensure patient privacy.

k. <u>NAL</u>. MTFs will actively encourage and endorse the use of the NAL and distribute NAL stakeholder education materials, which are located on the NAL SharePoint site https://info.health.mil/hco/clinicsup/hsd/pcpcmh/nal/SitePages/Home.aspx.

(1) MTFs are also responsible for ensuring their MTF-specific NAL instructions (e.g., hours of operation, warm hand-off telephone number) are up to date and CHCS accounts for NAL Customer Service Representatives and NAL ACs are activated and completed within 30 days of notification.

(2) MTFs are responsible for submitting civilian UC referrals in CHCS or MHS GENESIS for Active Duty beneficiaries.

(3) If a patient initially contacts the MTF during duty hours, the MTF will not direct patients to call the NAL, but will either meet the patient's need(s) or defer the patient to the network. MTF staff members may respond to patient-initiated messages using other means preferred by the patient.

(4) Detailed NAL business rules and instructions are published separately in a DHA NAL Interim Procedures Memorandum.

8. <u>SPECIALTY AND BEHAVIORAL HEALTH CARE-SPECIFIC PROCESSES AND PROCEDURES</u>. The direct care system has established the following standard processes, procedures, and appointment types for specialty and behavioral health care clinics in MTFs.

a. <u>Specialty and Behavioral Health Care Appointment Performance Monitoring</u>. The MTF will actively monitor and implement performance improvement activities to meet the MHS goals of providing timely access for all covered beneficiaries and maintaining the readiness of the medical force. The following core performance measures will be measured on the MHS Dashboard.

(1) Number of Days from Referral to Booking.

(2) Number of Days from Booking to an Appointment.

(3) Specialty Care Leakage to Private sector.

b. <u>Specialty Product Line Leaders (PLLs)</u>. Each MTF will designate an MTF PLL for each specialty available in the MTF. eMSMs will designate one leader in each product line to develop a market approach. PLLs will:

(1) Collaborate with centralized specialty and behavioral health care Group Practice Managers (Air Force), Template Schedule Managers (Army), or a Clinic Managers (Navy) who will be responsible for developing the daily schedule as well as shaping the schedule to meet local demand.

(2) Implement the standard processes and procedures in this DHA-IPM, optimize appointment templates and associated clinical activities to maximize specialty care capacity, improve access to care, decrease the number of deferrals to the network, and increase the care captured from the network.

(3) Collaborate with primary care to enhance the referral guidelines in TSWF based on local capabilities to maximize direct care system booking of specialty appointments.

c. <u>Specialty and Behavioral Health Care Productivity</u>. While maximizing access and minimizing leakage of specialty care to the network are the primary measures of effectiveness for the specialty and behavioral health clinics, the number of encounters per provider will also be utilized as a measure of performance. The median number of Medical Group Management Association (MGMA) encounters by specialty and behavioral health care product line will be multiplied by an FTE rate based on whether the provider is active duty, government civilian, or a contractor. DHA may adjust targets based on readiness and other considerations including leadership and other additional duties. The MHS will use the most recent available MGMA information which will be distributed to MTFs through the Regional Commands.

(1) Active Duty: 0.55 FTE x MGMA median number of encounters by product line.

(2) Government Civilian: 0.71 FTE x MGMA median number of encounters by product line.

(3) Contractor: 0.83 FTE x MGMA median number of encounters by product line.

(4) Specialty care clinics engaged in GME will establish a weekly number of bookable face-to-face and virtual appointments locally in collaboration with the Program Director and the MTF Commander or Director in accordance with ACGME guidance in order to meet educational requirements and to maintain access of empaneled patients.

d. <u>Specialty and Behavioral Health Care Appointment Performance Monitoring</u>. PLLs, Group Practice Managers, Template Schedule Managers, Clinic Managers, and other personnel designated in writing by the MTF Commander or Director are authorized to build, block, freeze, adjust, and cancel appointment templates. Specialty and behavioral health care templates will be managed and appointed centrally to standardize the appointing and capacity process.

e. <u>Pre-Visit Planning to Maximize Supply and Value</u>. MTF specialty and behavioral health care clinic staff will actively manage and review appointment schedules beginning 72 hours in advance but no later than 24 hours in advance to identify patient needs, which can be met virtually with a T-Con with a provider or the clinic RN.

(1) If pre-visit planning reveals the patient is more or less complex than anticipated, the MTF may adjust the scheduled appointment length to accommodate the patient's clinical needs.

(2) If pre-visit screening reveals that the patient needs additional testing or test results, the specialty or behavioral health care team will contact the patient to ensure required information is available at the time of the appointment to maximize the appointment value.

(3) The MTFs will convert appointments made available through the demand management processes identified above to SPEC appointments in specialty and behavioral health care.

f. <u>Balancing and Maximizing Supply and Demand</u>. MTFs will actively manage appointment supply in order to meet patient demand for specialty and behavioral health care. MTFs will use approved standard data sources, including TRICARE Operations Center, the DART and other authorized data sources.

(1) <u>Demand</u>. Patient demand is defined as the sum of met and unmet demand. MTFs will monitor MTF ability to meet specialty and behavioral health care demand using:

(a) <u>Met Demand by MTF</u>. Met patient demand includes maintained face-to-face, telephone, sick call, and walk-in appointments, as well as patients whose needs were met through the use of secure messaging, T-Cons and CSSPs.

(b) <u>Unmet Demand</u>. Unmet demand includes demand from patients who tried to access the system but failed, including those who were not given an appointment and leaked to network specialty and behavioral health care. The DART Demand Dashboard will be used to monitor a sub-set of unmet demand. The DART Demand Dashboard compares demand met with appointments scheduled in CHCS and T-Cons to the percent of beneficiaries who received neither appointments nor T-Cons.

(2) <u>Supply</u>. The direct care system defines the supply of specialty and behavioral health care appointments as the sum of face-to-face specialty and behavioral health care appointments, VIRT telephone encounters, and other team-based methods to address patient demand such as, secure messages, CSSPs and T-Cons.

g. <u>Specialty and Behavioral Health Care Follow-up Appointments</u>. Follow-up appointments will be available at least 180 days in the future in specialty and behavioral health care.

(1) All direct care system specialty and behavioral health care clinics will offer to schedule a follow-up appointment at check-out, if follow-up care is clinically indicated after the first specialty or behavioral health care appointment.

(2) If a patient chooses not to schedule a follow-up appointment at check-out, the patient will be instructed to call the MTF or eMSM central appointing number. The MTF or eMSM central appointing centers are authorized to book follow-up appointments for established beneficiaries up to 180 days in the future.

h. <u>Centralized Specialty Care and Behavioral Health Appointing</u>. All MTFs and eMSMs will implement centralized specialty care appointing.

(1) Centralized specialty and behavioral health care Group Practice Managers (Air Force), Template Schedule Managers (Army), or a Clinic Managers (Navy) are responsible for advising on the development of the daily schedules as well as adjusting the schedules to meet local demand.

(2) Patients will be booked for the first SPEC appointment after the first referral review by centralized appointing. If approved by the PLL, some specialties may not require referral review.

(3) The MTF will proactively contact the patient until the specialty or behavioral health care appointment is booked.

(4) The MTF also will provide the patient with a central telephone number to call to book the specialty or behavioral health care appointment; however, the MTF is required to proactively contact the patient rather than waiting for the patient to call the MTF.

(5) Where applicable, MTF specialty clinics will make a decision on whether an internal referral will be accepted within 24 business hours. If the specialty clinic has not made a decision on whether to accept the referral within 24 business hours, the referral will immediately be sent to the private sector network for disposition.

(6) The MTF will inform patients when a deferral to the network may result in a longer wait time for care than the direct care system using current TRICARE data showing network access to care performance by specialty care type. Each Managed Care Support Contractor (MCSC) provides this data in a monthly report to the TRICARE Regional Offices (TROs) and the data is available to the MTFs for download on the respective MCSC portals in the 50 United States. Overseas MTFs may obtain data from the MCSC MTFs outside the 50 United States.

(7) Additional procedures for booking the first specialty or behavioral health care appointment when a referral is generated are provided in Section 9 of this DHA-IPM.

i. <u>Referral Review</u>. Review of specialty referrals prior to appointing will be the exception since this unnecessarily delays beneficiary appointing and is not the standard in civilian medical organizations. MTFs will eliminate "clinic-book only" appointments for initial SPEC care referrals, and only grant exceptions to guidance in writing when there are compelling medical or mission interests.

(1) The MTF will focus efforts on appointing the patient as soon as possible, preferably before the patient departs the MTF after receiving the referral to SPEC or behavioral health care.

(2) MTFs will ensure specialty and behavioral health care providers' review of referrals is not required prior to scheduling the patient for an appointment. All referrals generated from Primary Care will be directed to the centralized Referral Management (RM) location at the MTF or the Multi-Service Market (MSM). For referrals requiring a review prior to appointing, the RMC/O staff will either review or send to the appropriate MTF staff for review (e.g., Case Management RN/LPN, Utilization Management RN, or designated MTF second review provider).

(3) Specialty and behavioral health care clinics are required to collaborate with primary care and the RMC/O on an on-going basis to minimize the number of appointments requiring review prior to booking through development of simplified specialty and behavioral health care booking protocols.

(4) MTFs also will ensure all pre-visit care and testing have been accomplished to maximize the value of the first specialty or behavioral health care visit.

9. SPECIALTY CARE REFERRAL ACCOUNTABILITY AND BUSINESS RULES

   a. Overview

(1) MTFs in the 50 United States will designate a single RMC/O at each MTF, which will be accountable for managing and tracking and trending all referrals generated by the MTF, capturing all Clear and Legible Reports (CLRs), and managing Right of First Refusal (ROFR) referrals.

(2) All eMSMs will use the same, single standard process. In eMSMs, the Senior Market Manager will centrally designate a single RMC/O that is similarly accountable for all referrals generated by MTFs within the market, capturing all CLRs, and managing ROFRs. Furthermore, MTFs within eMSMs will retain referral management staffing onsite to accommodate standardized market-level processes, and coordinate referral operations with the market's designated RMC/O to reduce fragmentation and enhance accountability.

(3) The referral management business processes described in this DHA-IPM apply in both legacy and MHS GENESIS systems. While some specific references to the legacy EHR in use may not be applicable in MHS GENESIS, the requirement to comply with the overarching referral management business processes in this DHA-IPM remains in effect. In most instances, processing functions within MHS GENESIS will remain very similar or duplicates of current processes in use.

(4) All referrals generated from primary care will be directed to the centralized Referral Management (RM) location at the MTF or the eMSM. All referrals will be reviewed and either appointed to the MTF or deferred to the MCSC within one business day of referral generation. Each designated RMC/O, including the market's centrally designated RMC/O, should be empowered to defer referrals to the network regardless of patient/beneficiary category, SPEC service line, or referring MTF in cases when the direct care system is unable to provide services within the standards set forth in this DHA-IPM and Reference (f). However, MTF Commanders and/or Senior Market Managers will first make every effort to maximize use of the direct care system within access-to-care standards.

(5) Each designated RMC/O, both in MTFs and eMSMs is accountable for ensuring all initial specialty care referrals are either accepted for appointing to the direct care system or deferred to the network within 1 business day from the order date. One business day includes the order date plus the entire following day, excluding weekends and holidays. To facilitate meeting this standard, MTFs and eMSMs should collaborate to minimize the number of specialty referral queues within the CHCS or applicable health record system and centrally manage referral queues.

(6) Specialty and Behavioral Health Clinic leadership and the designated RMC/O should track and trend at the MTF specialty level, the number and percent of initial specialty or behavioral health referrals that were successfully dispositioned within 1 business day as: Appoint to MTF, Defer to Network, or No Appointment Required.

(7) All initial specialty or behavioral health referrals should be entered into the EHR before the patient leaves the encounter or by Close of Business on the day of the encounter.

(8) The denial/cancellation of a referral, and the reason, should be communicated to the referring provider within 1 business day of the referral denial/cancellation and will be annotated in the EHR with a telephone. The referring provider/clinical team is then responsible for communicating to the patient within 1 business day that the referral was denied/cancelled, and whether or not a new referral will be ordered.

(9) Patients must be notified when a referral is deferred to the network or accepted for appointing to an MTF. This communication can occur face-to-face before the patient leaves the MTF or by live telephone call, secure messaging or automated methods (e.g., Audio-Communicator-Disease Management module) after the patient leaves the MTF. This contact attempt should occur within 1 business day from the time the review decision was entered into the EHR. The communication should inform the patient about how to make the direct care appointment, how to cancel the referral, and/or when to expect the network authorization letter or e-mail. For referrals accepted for MTF appointing, the communication should be repeated until the appointment is booked, the patient cancels the referral, or the message has been delivered three times (first message NLT day 3 and final message not earlier than day 14). This process may be supplemented by letters to patients as needed. For referrals deferred to the network, a follow-up automated message should be sent 14 calendar days after the referral's order date to remind the patient to make an appointment with the civilian provider indicated in the authorization letter (if the patient has not done so already).

(10) The CarePoint Referral Management Suite (RMS) is the only interim electronic referral management application approved for MTF or eMSM use to transmit and track all MTF-generated referrals, until MHS GENESIS is deployed at the MTF. The auto-closure function in CHCS must be turned off.

    b. <u>Direct Care Referral Business Rules</u>

       (1) The MTF Commander, Director and/or Senior Market Manager will:

         (a) Establish processes that enable initial specialty and behavioral health care referrals to be appointed to the direct care system before the patient leaves the MTF, to the greatest extent possible. Appointed means the patient has been booked with a time and place for health care.

         (b) Track the average number of days from when the initial specialty referral was ordered until it was booked, as well as from the date it is booked until the actual appointment occurs for MTF referrals.

         (c) Ensure appointment booking keys in CHCS or applicable EHR are available to trained front line support staff (e.g., in primary care, central appointing) to support patient-centered booking into specialty clinics before the patient leaves the MTF.

         (d) Ensure appropriate functionalities are used to link MTF specialty appointments in CHCS to the referral, and thereby ensure correct tracking through CHCS and CarePoint RMS.

         (e) Eliminate "clinic-book only" appointments for initial specialty or behavioral health care referrals, and only grant exceptions to policy in writing when there are compelling medical or mission reasons to do so. MTF Commanders or Directors must grant exceptions to this guidance to the RMO/C in writing.

         (f) Ensure processes are in place to contact the patient proactively for booking an appointment within 1 business day after accepting a referral if an exception in writing has been given to real-time booking before the patient leaves the MTF or when the patient does not prefer to book a specialty or behavioral health care appointment before departing the MTF.

         (g) Ensure "first call resolution" is utilized at all central appointment centers, RMC/Os, and clinics that are authorized in writing to book initial specialty appointments.

         (h) Ensure specialty and behavioral health care clinics and RMC/Os adequately staff phone lines to accept calls from the appointment center and return messages on the same business day messages are received.

         (i) Ensure patients are offered three different specialty or behavioral health care SPEC appointments within the 28-calendar day access to care standard.

(j) Ensure patients in eMSM catchment areas are offered the first available MTF SPEC care appointment that meets access to care standards within the market, regardless of referring MTF. Patient preference for MTF location should be considered and accommodated within access to care standards, when possible.

(k) Ensure processes are in place to confirm that all CLRs have been reviewed by the referring provider within 3 business days of notification that the CLR has been received.

(l) Ensure processes are in place to confirm that MTF Providers send preliminary reports for urgent and emergency specialty care referrals to the referring provider within 24 hours.

(2) The designated RMC/O/MSM will:

(a) Use RMS or applicable EHR to ensure all referrals are dispositioned within 1 business day as Appoint to MTF, Defer to Network, or No Appointment Required.

(b) Use RMS/CHCS or applicable EHR to identify referrals generated in the EHR that are pending action (e.g., Review, Appoint to MTF, Info Needed, Defer to Network, Refer to Subspecialty, and/or Space Available) and, when appropriate, notify reviewing SPEC clinics of pending referrals requiring action. The RMC/O or specialty clinic will accept the referral for appointing, defer it to the network, or request more information. This process does not preclude specialty care clinics, medical management entities, or other stakeholders from reviewing referrals, but it does aim to streamline the number of reviewers to ensure the appointment is booked within 1 business day.

(c) Establish and maintain routine command level reporting of trends by specialty.

(d) Administratively close all un-appointed referrals accepted by an MTF no later than 180 days beyond the order date. The RMC/O will notify the referring provider when the patient cancels a referral or when referrals are administratively closed.

(e) Maintain current TRICARE data showing network access to care performance by specialty care type and inform patients when a deferral to the network may result in a longer wait time for care than the direct care system. Each MCSC provides this data in a monthly report to the TROs and the data is available to the MTFs for download on the respective MCSC portals in the 50 United States.

(f) Central appointments or the clinic authorized in writing to book its own appointments will attempt contact no less than three times on three separate days (first message NLT day 3 and final message not earlier than day14), after order date, or until the appointment is booked, whichever effort concludes first. Each attempt to contact the patient should be documented in the EHR. If the patient has taken no action to schedule the initial specialty care appointment after 120 days, the referral shall be closed as Not Used and annotate {NU} in CHCS or applicable EHR.

(g) When a patient calls for a specialty care appointment, appointing clerks will be empowered to book the patient's appointment anytime the referral has an "Appoint to MTF" review. If the referral lacks a review disposition when the patient calls, then the appointment center agent will provide a "warm hand-off" to the RMC/O or SPEC clinic to immediately review the referral and appoint or defer it. If "clinic-book only" appointments are authorized locally and a patient calls the central appointment center for a "clinic book only" appointment, then the appointment center will provide a "warm hand-off" directly to the SPEC clinic to assist the patient.

(h) When the MTF or eMSM cannot offer three different SPEC appointments within the access standard, then patients may be offered MTF appointments outside the standard, but only after being informed they are authorized network care.

(i) In most instances referrals ordered for inpatients as part of discharge planning are the same as outpatient referrals. RMC/Os should assist the Inpatient Unit RN, the patient and provider by routing a referral to the appropriate Specialty Clinic and can assist with future scheduling of the outpatient specialty care Appointment.

c. Private Sector Referral Business Rules. The designated RMC/O will:

(1) Ensure all defer to network referrals are transmitted and tracked in RMS or the applicable EHR.

(2) Verify that Reserve Component Line-of-Duty (LOD) documentation is on file and scanned into the patient's record at the MTF for any LOD conditions requiring care in the network. The referral must additionally include a statement relating the LOD to the referral so it can be processed under the Supplemental Health Care Program.

(3) The RMC/O shall ensure that active duty operational forces receive priority with appointing, referrals, and authorizations when identified as a mission related access priority in accordance with Reference (f).

(4) Ensure that referral reviewers document a reason code in the CHCS Review Comment field for any referrals deferred to the network. The reason code should be encased in hard brackets [xx]. Use of at least one authorized reason code is required. Multiple codes may be used; however, each code must be in its own brackets. The following nine reason codes are authorized:

(a) [2nd] indicates a request for a second opinion.

(b) [CB] indicates lack of MTF capability for the SPEC/services requested.

(c) [CP] indicates lack of MTF capacity (available appointments).

(d) [CC] indicates deferral for continuity of care operationally defined as follow on care from a specific specialist as part of a specific procedure or service that was performed within the previous 6 months.

(e) [DS] indicates deferral for travel distance exceeding access to care standards.

(f) [NAR] indicates no pre-authorization required.

(g) [OHI] indicates other health insurance or Medicare coverage.

(h) [POS] indicates point of service or self-referred care.

(i) [CMD] indicates a command directed deferral by the Chief of Medical Staff.

(5) Track until closure all MTF generated initial specialty, behavioral health and urgent care referrals that were deferred to the network. Closure occurs when the referring provider is notified that either a CLR is available for review, or notified the referral is closed in CHCS or applicable EHR. The RMC/O is not required to track follow-ups but should provide follow-up results to the referring provider if received. There is no requirement to track durable medical equipment, or referrals not requiring an authorization, nor hospice referrals.

(6) Once CLRs are received, the following process should be followed:

(a) Upload all CLRs into the Health Artifact and Image Management Solution (HAIMS) within 3 working days of receipt, close the referral in CHCS as "Deferred Results Received," and notify the referring provider.

(b) Use the following standard naming convention for CLRs loaded into HAIMS or applicable EHR: "Network Results–SPEC Month/Day/Year (MM/DD/YY)" where the Month/Date/Year is the date the patient was seen, if available, or the date of the report. Use the same standard naming convention in the "Document Title" field in HAIMS for the associated CLR. Providers who generated the referrals will be notified the CLR is in HAIMS via a t-con. Clinics will close the referrals in CHCS or applicable EHR as "Deferred Results Received." MTF RMC/Os may enter additional data to the standard naming convention within title fields to accommodate ease of future search for CLRs.

(7) Initiate efforts to capture the CLR upon request by the referring provider or no later than 60 days from the date the referral was ordered or as soon as a claim is discovered, whichever occurs first. Consultants must send preliminary reports for urgent and emergency specialty care consultations to the referring provider within 24 hours. There is no requirement in the TRICARE Overseas contract to send preliminary reports for urgent and specialty care consultations.

(a) When a CLR has not been documented in the EHR, check the applicable claims database for a claim.

(b) If a claim is found, request the CLR from the rendering network provider. If there is no response from the provider within 10 calendar days, repeat the request. If the provider still does not provide the CLR, then initiate TRICARE contractor procedures as per the TRICARE Operations Manual and/or the Memorandum of Understanding with the TRICARE regional contractor. Additionally, forward a report to the TRO/TRICARE Area Office each month that lists all provider names, SPEC care rendered, and referral Unique Identifier Numbers (referring MTF Defense Medical Identification System number + date + CHCS Consult Order number) for which no CLR has been received after two attempts.

(c) After 180 days, if the CLR still has not been received, close the referral and annotate {CRNRR} in soft brackets in the CHCS or applicable EHR Review Comment Field indicating a claim was reported, but no results were received and notify the referring provider.

(d) After 180 days from the order date, if no claim or evidence is found indicating the patient utilized the referral in the network, then close the referral in CHCS or applicable EHR and annotate {NU} in soft brackets in the CHCS or applicable EHR Review Comment field indicating the patient did not use the referral, and notify the referring provider.

(e) If a patient cancels a referral, notify the referring provider.

(f) MTFs will notify their TRO if CLRs are not sent to the MTF within the required timeframe.

d. <u>ROFR Referral Business Rules</u>

(1) The designated RMC/O will:

(a) Record and track all ROFRs accepted by an MTF. In addition, in the 50 United States, the RMC/O will notify the referring network provider when a patient appointed under a ROFR fails to keep or book an MTF appointment.

(b) If electronic return of a CLR is not available, print the encounter information from the Armed Forces Health Longitudinal Technology Application, or other MTF sources, and send the referral report to the network physician within 10 days of the patient's kept appointment. This does not apply overseas.

(c) Track communications and results sent to a referring civilian provider in CarePoint RMS. Providers must send preliminary reports for urgent and emergency specialty care consultations to the referring provider within 24 hours. This does not apply overseas.

(d) Enter accepted ROFRs from their MTF CHCS ROFR clinic or applicable EHR, which must have a clinic profile of Hospital Location: "MANAGED CARE PROGRAM NON-MTF" to designate the referral as a ROFR in RMS or MHS GENESIS.

(e) Reconcile the tracking record for all accepted ROFRs no later than 60 days from receipt of the accepted ROFR. If any reports are outstanding, the RMC/O will attempt to locate the report. If the patient did not utilize the referral or keep the appointment, the RMC/O will close the referral in CHCS or applicable EHR NLT 180 days from the date of acceptance and annotate {NU} in the CHCS or applicable EHR Review Comment field to indicate the patient did not use the referral, and then notify the referring network provider.

(f) Coordinate with specialty clinics about the ROFR capability and capacity and ensure the information provided to the TRICARE contractor in the 50 United States is updated as often as needed but no less than monthly.

10. <u>OVERSIGHT OF STANDARD APPOINTING PROCESSES AND PRODUCTIVITY GOALS</u>

a. The PCCOB will report at least quarterly to the MOG on MTF compliance with the standards and processes identified in this policy and identify MTFs not in compliance with standards for Service and eMSM resolution. The following measures will be evaluated:

(1) Universal Measures for Primary, Specialty and Behavioral Health.

(a) Percent Demand Met.

(b) Percent MTFs with Closure Days in Excess of Weekends/Federal Holidays.

(c) Percent of Appointments of Authorized Types.

(d) Percent Provider Book Only Appointments.

(e) Percent Satisfaction with Getting Care When Needed.

(2) Primary Care Measures:

(a) Percent of providers meeting the expected number of bookable encounters per week.

(b) Average Days to Third Next 24 HR Appointments.

(c) Average Days to Third Next FTR Appointments.

(d) Percent of scheduled appointments available after 1500 hours.

(e) Percent Primary Care Leakage to Network.

(f) Percent of appointments scheduled on TOL.

(3) Specialty/Behavioral Health Measures:

      (a) Total number of encounters per FTE compared to MGMA Median performance by specialty.

      (b) Average Days from Referral to Booking.

      (c) Average Days from Booking to Appointment.

      (d) Percent Specialty Care Leakage to Network.

   b. The MOG will re-evaluate standard processes and productivity goals at least semi-annually to optimize access, capacity and patient experience in MTFs to inform annual changes to standards/goals if required.

APPENDIX 1

SPECIFIED SPECIALTY CARE PRODUCT LINE APPOINTMENT LENGTHS

APPOINTMENT LENGTHS (IN MINUTES)

	24 HR	FTR	SPEC	GRP ROUT	VIRT/ T-CON	PROC
ALLERGY/IMMUNOLOGY	15	30/40	30/45/60	180	15/30	15/30/60/90/240
ANESTHESIOLOGY	30	20/30/60	20/30/60	60/90	10/15	15/30/60
AUDIOLOGY	20/30	20/30/60	20/30/60	60/90	10/20	15/30/60
BEHAVIORAL HEALTH*	60	30/60/90	60/90	60/90 60*	10	20/40/60/90/240
CARDIOLOGY	20/30	15/30/45	30/40/60	60	10	15/30/40/60/120/180/240
CARDIOTHORACIC SURGERY	30	20/30/60	20/30/40/60	60	10	15/30/60
COLON AND RECTAL SURGERY	30	20/30/60	20/30/60	60	10	15/30/60
CRITICAL CARE	30	15/30/60	10/30/60	60	10	30/60/90
DERMATOLOGY	20/30	15/20/30	10/20/30	30	10	20/30/40/60/90
ENDOCRINOLOGY	30	15/30/60	10/30/45/60	60	10/15	30/60/90
ENT	30	20	20/30	90	10	15/20/60/90
GASTROENTEROLOGY	30	30/45/60	30/45/60	60	10	45/60/90/120/150
GEN SURGERY	30	10/20/60	15/30/60	60/120	10	45/60/90
GENETICS	30	15/30/40/60	10/30/60	60	10	30/60/90
HEMATOLOGY/ONCOLOGY	30	15/30/60	10/30/60	60/140	10	30/60/90/120
INFECTIOUS DISEASES	30	15/30/60	10/30/60	60	10	30/60/90
INTEGRATIVE MEDICINE	30	15/30/60	10/30/60	60	10	30/60/90
INTERNAL MEDICINE	30	15/20/30	10/30/45/60	60	10/15	30/40/60/90
NEPHROLOGY	30	15/30/60	10/30/60	40/60	10	30/60/90/120
NEUROLOGY	30	15/30/60	10/30/60	60	10	30/60/90/120
NEUROSURGERY	30	20/30/60	20/30/60	60	10	15/30/60
OB/GYN	20/30	20/30/60	20/30/60	60/90/120	10	15/30/40/60

OCCUPATIONAL MEDICINE	20/30	15/20/30/60	10/20/30/60	30/60	10/20	30/40/60/90
OCCUPATIONAL THERAPY	20/30	20/30/60	20/30/45	60/90	10	15/30/40/60
OPHTHALMOLOGY	20/30	10/20/30/60	30/60	60	10	30/45/60
OPTOMETRY	20/30	20/30/60	20/30/60	20/30/60	10	15/30/60
ORTHOPEDICS	20	10/20	20/30/45	20/30/60	10/30	15/30/60
PAIN MANAGEMENT	30	20/30/60	20/30/45/60	60	10/30/60	15/30/40/60
PEDIATRIC SURGERY	30	20/30/60	20/30/60	60	10	15/30/40/60
PEDIATRICS: ADOLESCENT MEDICINE	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: CARDIOLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: CHILD DEVELOPMENT	30	15/30/60	10/30/60/90 / 120/240	60/120/240	10	30/60/90/120/240
PEDIATRICS: CRITICAL CARE/INTENSIVIST	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: ENDOCRINOLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: GASTROENTEROLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: GENETICS	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: HEMATOLOGY/ONCOLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: INFECTIOUS DISEASE	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: NEONATAL MEDICINE	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: NEPHROLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: NEUROLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: PULMONOLOGY	30	15/30/60	10/30/40/60	60/90	10	30/45/60/90
PEDIATRICS: RHEUMATOLOGY	30	15/30/60	10/30/60	60	10	30/60/90
PEDIATRICS: SPORTS	30	15/30/60	10/30/60	60	10	30/60/90

MEDICINE						
PHYSICAL MEDICINE & REHABILITATION	30	20/30/60	20/30/40/60	60	10	15/30/60
PHYSICAL THERAPY	30/40	20/30/60	20/30/45/60	60	10/15	15/30/40/60
PLASTIC SURGERY	30	20/30/60	20/30/60	60	10	15/30/60
PODIATRY	20/30	20/30/60	20/30/60	60	10	15/30/60
PREVENTATIVE MEDICINE	30	15/30/45	30/60	30	10	30
PULMONARY CLINIC	30	20/30	30/40/45	60/90	15	15/30/40/60/120
RADIATION ONCOLOGY	30	20/30	60	60	30	20/30/90/120
SLEEP CLINIC		15/20/30	30/40/45	60		480
TRAUMA/SURGICAL CRITICAL CARE	30	20/30/60/120	20/30/40/60	60	10	15/30/60
UROLOGY	20	15/20/60	30/60	60	10	15/30/60/90
VASCULAR SURGERY	30	20/30/60	20/30/60	60	10/15	15/30/60

For specialties not listed above, DHA will provide additional guidance to MTFs through the Regional Commands.

APPENDIX 2

<u>STANDARD SCRIPT GUIDELINES FOR APPOINTING STAFF APPOINTMENTS</u>

<u>Offer an Appointment</u>

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

What would you [patient name] like to be seen for? I see [patient name]'s PCM is [provider name]. When would you like to be seen for [chief complaint]? (If available, book by request. If unavailable, see No appointment available script).

[Patient name]'s appointment is at the [clinic] with [Provider] on [date] at [time].

If you need to cancel this appointment for any reason please dial the cancellation line at xxx-xxx-xxxx or go to www.TRICAREonline.com to cancel your appointment.

Otherwise [patient name] your appointment is at the [clinic] with [Provider] on [date] at [time].

May I help you with anything else today? If no, [Organization's standard closing].

<u>Verify an Appointment</u>

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

Note: If the caller is not the patient and the patient has reached the age of majority or is over 18 years of age or (the age of majority as designated by state/local laws), refer to SOP for guidance on limited information release or inform of limited release of health care information.

Which appointment would you like to verify? (Verify, then offer appointment information). [Patient name] have/has an appointment at the [clinic] with [Provider] on [date] at [time].

May I help you with anything else today? If no, [Organization's standard closing].

<u>No Appointment Available</u>

Currently all appointments within 24 hours (or 7 days or 28 days) have been booked with your provider, if it would be all right with you, I will check other providers within your team for an appointment. (If no appointments with PCM are available, the following options will be offered to the patient in order:

    1. Another provider on the same team as the PCM.

2. Cross-booking to a provider on another team.

3. MTF UCC, MTF after-hours clinic, MTF ER/ER Fast track, if available.

4. Network UCC.

I have checked all providers and contacted the Primary Care Department (xxx-xxx-xxxx), and currently there is no available appointment within 24 hours (or 7 days or 28 days). I can offer you a list of local options for urgent care as outlined in our First Call Resolution policy (Be sure to offer care in designated partner UCCs in the MTF IHCS).

May I help you with anything else today? If no, [Organization's standard closing].

Note: Appointment clerk is not required to put a referral in CHCS

Cancelling an Appointment

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

Which appointment would you like to cancel? Would you like to reschedule that appointment? Verify the appointment to be cancelled or rescheduled. [Patient's name] the [clinic] with [Provider] on [date] at [time] has been cancelled. Offer, book and verify the new appointment.

Note: Family members are able to cancel appointments for minor children in accordance with local and state guidelines only.

Facility Cancellations:

Due to unforeseen scheduling conflicts it is necessary for us to reschedule your appointment, the next available appointment is (give earliest date and time) or is there another time and date that would work better with your schedule? If a facility cancellation, the patient must be offered an appointment within the original Access standard or will offer to defer the patient to the network.

Select/Space-Available

Sir/Ma'am, our system shows that you are TRICARE (give the HCDP Category if it is other than PRIME). Is that information correct? (If no, please refer to your SOP. If yes, advise). Beneficiaries who have elected the TRICARE Select option are able to call any provider within the civilian sector who accepts TRICARE for an appointment. Currently there are no space available appointments at this facility.

Which would be more convenient for you today?

Note: In areas where space available appointments are available clerks would book the appointment accordingly (Offer directions to office or contact information as requested). May I help you with anything else today? If no, [Organization's standard closing].

Dental

Sir/Ma'am, the Dental clinic manages its own appointments, but I would be happy to transfer you to xxx-xxxx (give clinic number). I will transfer your call please hold. Offer contact information and/or transfer.

May I help you with anything else today? If no, [Organization's standard closing].

Emergent; Medical

Sir/Ma'am, I am concerned that the symptoms you are describing may require immediate care. I would like to transfer you to someone with clinical expertise (a health professional).

<div align="center">

REFERRALS

</div>

Check Referral Status

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

Which referral may I verify for you? Verify, and then advise in accordance with SOP.

If referral should be complete and is not, offer a <u>transfer </u>to referral management for further assistance. If referral is not due to be complete (patient calling before 72 hours): Sir/Ma'am, I do see patient name]'s referral in the system, it has not yet been reviewed. It should be available by [date]. If the clinic hasn't contacted you by then, please don't hesitate to contact us for assistance (patients calling after 72 hours, book referral according to review status).

May I help you with anything else today? If no, [Organization's standard closing].

Check status:

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

I see that a note to your care team in [clinic] was placed for you on [date]. Verify, then advise in accordance with SOP. If T-Con should be complete and is not, offer a <u>transfer </u>to the clinic of care.

May I help you with anything else today? If no, [Organization's standard closing].

PRIVACY

Release of Healthcare Information (PHI or HIPAA): Adult or Emancipated Minor Patient

Sir/Ma'am, adult patients' confidentiality is protected by law. Health care information can only be shared with the adult patient. Is he/she available? If yes, verify name, last 4 OR DoD ID, and date of birth.

If no: I will be happy to provide that information to (state patient name) upon his/her request. If verification is questionable, or if customer is dissatisfied, transfer to supervisor.

May I help you with anything else today? If no, [Organization's standard closing].

For Minors who Have Consented to Their Own Care

Please refer the caller to Patient Administration or the patient's clinic.

TELECONS (T-Con)

Offer a T-Con

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth. Thank you.

What message would you like to leave? What phone number would you like your care team to use to call you back? I'm entering a note to your care team at [state clinic] for [summarize main points]. Someone from your care team will be calling you back as soon as possible; however, if circumstances change, or you miss the call, please don't hesitate to call us again.

May I help you with anything else today? If no, [Organization's standard closing].

Check T-Con Status

May I have the patient's last name and sponsor's last four/DoD ID? Please verify your/the patient's name and date of birth? Thank you.

If T-Con is not due to be complete: Sir/Ma'am, I do see [patient name]'s note to your care team at [state clinic's name] in the system. We do our best to return patient calls the same day, but it can take up to 3 business days. Has there been a change in your condition? (If there has been a change in the patient condition): I will update your note with this change as well as alert your care team that you are requesting assistance as soon as possible. (If no change to the patient's condition): I will update your note to alert your care team that you are requesting assistance as soon as possible.

May I help you with anything else today? If no, [Organization's standard closing].

GENERAL

Greeting

Good morning/afternoon you have reached the (state clinic /office name). I am (state your name) how may I help you?

Completing the call:

May I help you with anything else today? If no, [Organization's standard closing].

Transferring a Call

Note: Always provide information as opposed to transferring a customer (except in the case of sensitive information involving OPSEC/PHI/HIPAA).

Sir/Ma'am, May I ask what this is regarding? I'd like to be sure I get you to the right destination. Offer contact information and/or underline transfer.

May I place you on a brief hold while I contact clinic/ [person's name] for your transfer? If the destination for the call is available, advise the answering party with the information you've received from the caller (i.e., "I have a patient on the line for you that would like to book a follow-up appointment"), acknowledge reply and complete the transfer.

If the destination is not available but has a voicemail or a phone number that can be released to the caller, advise: Sir/ Ma'am, it appears that clinic [person's name] is not available at this time. I would be happy to connect you to their voicemail and give you their direct line. Offer contact information and/or transfer.

May I help you with anything else today? If no, [Organization's standard closing].

Transfer to a supervisor

Note: If a caller calls in with an immediate complaint, a call becomes escalated, or the caller is clearly not completely satisfied, attempt to seek advice on behalf of the patient. If the patient is belligerent or abusive, offer an immediate transfer.

Mr./Ms. [Patient Name] I understand your concern, I'd like to see what I can do for you. May I place you on a brief hold while I check with a supervisor? Seek guidance from immediate supervisor, and present to caller.

Thank you so much for your patience. May I forward your contact information and situation to a supervisor? I think he/she is the best qualified to resolve this for you. Be transparent about your actions; let the patient know what you are submitting (this also verifies that you are submitting

the issue the way the caller views it), and what to expect (with respect to a return call (from [Name], call center lead/supervisor by [time]).

May I help you with anything else today? If no, [Organization's standard closing].

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AC	Appointing clerk
ACGME	Accreditation Council for Graduate Medical Education
CHCS	Composite Health Care System
CLR	Clear and Legible Report
CSSP	Clinical Standard Staff Protocol
DART	Direct Access Reporting Tool
DHA	Defense Health Agency
DHA-IPM	Defense Health Agency-Interim Procedures Memorandum
DHP	Defense Health Program
EHR	Electronic health record
eMSM	Enhanced Multi-Service Market
ER	Emergency room
FTE	Full-time equivalent
FTR	future appointment type
GME	Graduate Medical Education
GRP	Group appointment type
HAIMS	Health Artifact and Image Management Solution
HC	House Call
IHCS	Integrated Healthcare System
LOD	Line-of-Duty
MCSC	Managed Care Support Contractor
MGMA	Medical Group Management Association
MHS	Military Health System
MOG	Medical Operations Group
MTF	Medical Treatment Facility
NAL	Nurse Advice Line
NP	Nurse Practitioner
PCCOB	Patient Centered Care Operations Board

PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PA	Physician Assistant
PLL	Product Line Leader
PROC	procedures appointment type
RMC/O	Referral Management Center/Office
RMS	Referral Management Suite
RN	Registered Nurse
ROFR	Right of First Refusal
SPEC	First non-urgent specialty appointment type
T-Con	Telephone consult
TOL	TRICARE OnLine
TRO	TRICARE Regional Office
TSWF	Tri-Service Workflow
UCC	Urgent Care Clinic
VIRT	Virtual appointment type
24HR	24-hour appointment type

PART II. DEFINITIONS

Active Duty. Refers to Service members who are on active duty or members of the Reserve components who are in duty status.

Direct care. Describes DHP-funded DoD MTFs.

MOG. A flag-level governance group with voting members from DHA and the Services with oversight for medical operations.

PCCOB. A DHA-led board with Service lead voting representatives for primary and specialty care. The PCCOB is supported by Service representatives from access, medical management/population health, telehealth, referral management, coding/medical records, and other key working groups.

PCMH. The MHS's model of primary care, which includes family medicine, pediatrics, internal medicine, operational medicine, and multi-disciplinary primary care clinics. PCMHs' operations are guided by Tri-Service standard processes and procedures with warranted variance in the type of additional care available based on the needs of the patient population.

<u>Private sector</u>. Health care delivered in the civilian private sector system through TRICARE contracts.