Report to Congressional Armed Services Committees

Section 744 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328)

Report on the Pilot Program on the Display of Wait Times at Urgent Care Clinics and Pharmacies of Military Medical Treatment Facilities

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $8,100 for the 2019 Fiscal Year. This includes $100 in expenses and $8,000 in DoD labor.

Executive Summary

Pursuant to section 744 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114-328), this submission provides a report to the Congressional Armed Services Committees on the pilot program to display wait times at Urgent Care (UC) clinics and pharmacies in at least 12 military medical treatment facilities (MTFs). As required by the NDAA for FY 2017, this report identifies: selected pilot site MTFs; the cost of displaying the wait times at MTF UC clinics and pharmacies; any changes in patient satisfaction; any changes in patient behavior with respect to using UC and pharmacy services; any changes in pharmacy operations and productivity; a cost-benefit analysis of posting such wait times; and the feasibility of expanding the posting of wait times in Emergency Rooms (ERs) in MTFs. This report is organized along the major categories, as described above.

The Military Health System (MHS) began displaying wait times in public areas at selected pilot MTFs in FY 2018 and concluded the pilot in early FY 2020. The MHS modified an existing enterprise-wide patient queuing and notification system to support the wait time pilot requirements at a cost of $796,890. Based on pilot results, the MHS did not identify any trends in changes of patient satisfaction, patient behavior, pharmacy operations, or pharmacy productivity among pilot sites. The MHS also was not able to calculate and directly associate the benefit of posting wait times to the cost of posting wait times for a cost-benefit analysis because there was no meaningful change in utilization or patient behavior and also because changes in utilization or satisfaction could not be attributed solely to the posted wait time pilot. Confounding variables affecting utilization and patient satisfaction included, but were not limited to: satisfaction with other components of the UC or pharmacy visit; benefit changes to allow unlimited self-referred network UC visits; and shifts in overall MTF primary care empanelment from direct care to the network.

The MHS was able to identify a significant financial benefit of issuing a single, enterprise-wide license for the patient queuing and notification system, which includes the avoided costs of maintaining legacy software and of managing multiple contracts. Through this pilot, the MHS also identified the potential to change patient behavior and enhance patient experience by posting accurate wait times using other convenient modes besides an electronic screen in a pharmacy or UC. Specifically, also posting current wait times on-line on the MTF webpage and/or mobile application would allow beneficiaries to make a choice on when to seek care or services at the MTF at times of shorter rather than peak times, which would improve the MTF's ability to optimize operations and enhance patient experience.

Based on an assessment of the feasibility of posting wait times in ERs, the MHS would follow procedures different from the specifications applicable to the pilot. The wait time should be calculated based on an average of the last 30 minutes compared to the 4 hours applicable to the pilot to calculate wait times over- and under-estimates wait times due to a high variance in patient demand by hour. The wait time calculation also should measure the time from when the patient checks into the ER until the patient is triaged by a provider or Registered Nurse (RN), which is the civilian standard. Use of the civilian standard will provide a comparable wait time for all beneficiaries, regardless of acuity, and will allow beneficiaries to accurately compare wait times in a MTF ER compared to a civilian ER.

Finally, posting wait times in ERs and on MTF websites should be implemented as MTFs transition to the new MHS GENESIS electronic health record (EHR), because the new EHR includes the capability to calculate wait times in ERs. Waiting until MHS GENESIS implementation will avoid defense health program costs to purchase additional Q-flow software licenses, which will become obsolete once MHS GENESIS is implemented. All MTFs are expected to implement MHS GENESIS by FY 2024.

Section A: Participating MTF UC Clinics and Pharmacies and Program Implementation

Section 744 of the NDAA for FY 2017 required the MHS to select at least four MTFs each from medical center, hospital, and ambulatory care center categories. The NDAA for FY 2017 also required that at least one MTF from each of the three categories above be located outside the continental United States (OCONUS). In selecting MTFs, the MHS identified participating MTFs under the authority of all military Medical Departments and the Defense Health Agency (DHA). Because the MHS did not have enough independent UC clinics to meet the requirements in section 744 of the NDAA for FY 2017, the MHS substituted MTF ERs with internal UC fast-track clinics as pilot sites. Finally, the MHS selected MTFs using the same queuing software, referred to as Q-flow.

The participating medical centers were: 60th Medical Group at Travis Air Force Base; Darnall Army Medical Center at Ft Hood; Regional Medical Center (RMC) Landstuhl; Naval Medical Center (NMC) Camp Lejeune; and NMC Portsmouth. Participating hospitals were: Weed Army Community Hospital (ACH) at Ft Irwin; the 673rd Medical Group at Joint Base Elmendorf Richardson; the Fort Belvoir Community Hospital (FBCH); and Naval Hospital (NH) Pensacola. Participating ambulatory care centers were: 11th Medical Group at Joint Base Andrews; Schofield Barracks Army Health Clinic (AHC); Premier Community Base Medical Home (CBMH) at Ft Carson; and Naval Health Clinic (NHC) Annapolis. The medical center, hospital, and ambulatory care facility category MTFs located OCONUS were RMC Landstuhl in Germany, 673rd Medical Group in Alaska, and Scofield Barracks AHC in Hawaii, respectively. Figure 1 depicts UC and pharmacy pilot site locations by MTF.

Figure 1: Pilot Site Locations by MTF

Service	MTF	UC Clinic Pilot Location	Pharmacy Pilot Location
Air Force	11th Medical Group	Yes - In ER	Yes
Air Force	60th Medical Group	Yes - In ER	Yes
Air Force	673rd Medical Group	Yes - In ER	Yes
Army	Darnall AMC	Yes - In ER	Yes
Army	Landstuhl RMC	Yes - In ER	Yes
Army	Premier CBMH	Yes *	Yes
Army	Schofield Barracks AHC	Yes	Yes
Army	Weed ACH	Yes - In ER	Yes
Navy	NH Pensacola	Yes	Yes
Navy	NHC Annapolis	No	Yes
Navy	NMC Camp Lejeune	Yes - In ER	Yes
Navy	NMC Portsmouth	Yes - In ER	Yes
DHA	FBCH	Yes - In ER	No

* The MHS initiated the posted UC wait times pilot in the Premier CBMH; however, the CBMH had transitioned to proiding urgent care services by appointment, only. As a result, posting wait times was not relevant and the pilot was terminated at the Premier CBMH.

The MHS implemented the section 744 pilot at participating MTFs in stages from October 2017 through October 2018. Because Q-flow technology was already in use at pharmacies, MTF pharmacies began implementation earlier than at MTF UC clinics and ERs. While most participating MTFs implemented both the UC and pharmacy portions of the pilot, Premier CBMH and NH Annapolis implemented the pilot in the pharmacy, only, and FBCH implemented the UC pilot program, only.

Section B: Costs for Displaying the Wait Times at MTF UC Clinics and Pharmacies

In early FY 2018, the MHS awarded a contract to ACT Technologies for an enterprise-wide patient queuing and notification system. To support the section 744 of the NDAA for FY 2017 pilot to display wait times, the MHS modified the contract at one-year cost of $796,890, which funded hardware, software and service support. The MHS subsequently included sustainment costs beyond one year to support the pilot in the first option year of the enterprise-wide contract.

Section C: Changes in Patient Satisfaction

The MHS assessed changes in patient satisfaction in two ways: through a pilot-specific Interactive Customer Evaluation (ICE) survey; and using existing questions on the Joint Outpatient Experience Survey (JOES).

ICE Survey and Results

The MHS developed and implemented an ICE survey specifically to assess patient satisfaction with the display of wait times in MTF UC clinics and pharmacies. The approved survey consisted of 18 questions; 17 questions' included multiple-choice answers on a five-point Likert scale and one question allowed for open-ended responses.

MTFs made the ICE survey available through paper copies of the survey; through signage with a Quick Response code for use with smartphones to direct responses to the survey; and through a widget on participating pilot MTF webpages. The MHS received 915 ICE surveys from December 2017 to July 2019. The number of responses varied by MTF and is identified in Appendix A.

Most respondents reported they saw the wait times posted in the UC clinic or pharmacy; results were 69 percent and 75 percent, respectively. Only 19 percent of beneficiaries using MTF UC clinics and 29 percent using MTF pharmacies strongly agreed that the posted wait times were accurate. Approximately a third of respondents reported the posted wait times influenced their decision to wait, 20 percent strongly agreed the posted wait times improved their overall experience and 21 percent strongly agreed that posted wait times would make them more likely to refer someone to the facility. Figure 2 below provides responses to each ICE survey question.

Figure 2: Beneficiary ICE Survey Responses

ICE Survey Questions	Response Choice	Percent Responding
Did you see the wait time posted in Urgent Care?	Percent "Yes"	69%
Seeing the posted wait time in Urgent Care influenced my decision to wait.	Percent "Strongly Agree"	30%
The posted wait time in Urgent Care was accurate.	Percent "Strongly Agree"	19%
The posted wait time in Urgent Care was reasonable given the time of day and number of patients.	Percent "Strongly Agree"	24%
Did you see the wait time posted in the Pharmacy?	Percent "Yes"	75%
Seeing the posted wait time in the Pharmacy influenced my decision to wait.	Percent "Strongly Agree"	38%
The posted wait time in the Pharmacy was accurate.	Percent "Strongly Agree"	29%
The posted wait time in the Pharmacy was reasonable given the time of day and number of patients.	Percent "Strongly Agree"	35%
Posted wait times improved my overall experience today.	Percent "Strongly Agree"	20%
Posted wait times will make me more likely to refer someone to this facility.	Percent "Strongly Agree"	21%
Did the product or service meet your needs?	Percent "Yes"	61%

The MHS also evaluated open-ended survey question responses to identify comments specific to the display of wait times, which included comments about the inaccuracy of posted wait times, difficulty in using the queuing technology kiosks, dissatisfaction and confusion with the multi-step process in the pharmacy and a perception of other beneficiaries being seen sooner, regardless of check-in time. The last type of comment is related to priority given to prescriptions for Active Duty Service members and to a lack of awareness of triage priority given to beneficiaries based on health condition acuity in UC fast-track clinics co-located in ERs. Examples of relevant comments are provided in Figure 3.

Figure 3: Sample of Open-Ended ICE Survey Responses

Sample of Open-Ended ICE Survey Responses
"The new automated software at [a pilot facility's pharmacy] is confusing, takes more time, and does not appear to add value to decreasing the wait time or helping the customer. The ID scan is quirky, and difficult to use. The questions asked do not contribute to speed of service. Personal observation is the majority of older customers have trouble with the new software."
"The posted wait times are completely inaccurate. When I got my ticket, the time to check in was 35 min. It took 65 min to check in."
"Waited 2+ hours to be seen. Wait time posted in urgent care said 10 minutes."
"The [pilot facility's pharmacy] is not using their system to its full potential. There should be a window dedicated to patients who called in Rx refills and those who are returning to pick up an Rx after being checked in as someone who elected the drop-off and return option. If there aren't any of those categories in the queue, then that window would pick up ticket numbers from the other categories in queue until a refill checked in or drop-off and return rescanned their ticket for pick-up."
"There were 9 A tickets numbers called all of which arrived after me. Only one of those members were actually in uniform as required and nothing was said to any of them. I am all for head of the line for active duty, but if you are not in uniform you should be turned away to pull the proper ticket."
"I utilized [the] exchange pharmacy. The reader on the kiosk is somewhat awkward to use, recommend a picture showing how the card must be placed. Overall this device enhanced my experience."
"While waiting the wait time changed three times starting at 75 minutes and ending at 180 minutes. We still weren't seen after 3 hours and 30 minutes. Patients who arrived up to one hour after us were called in before us.

The JOES and Results

The JOES is the MHS' standard survey sent to beneficiaries who receive care in MTFs. Between December 2017 and May 2019, 750,000 JOES surveys were sent to beneficiaries at pilot site MTFs; response rates ranged from 7 percent to 23 percent.

The JOES does not include questions specific to satisfaction with wait times. As a result, the MHS utilized the results from the most comparable question as a proxy; however, the limitation of using the JOES survey results to assess changes in patient satisfaction include the presence of many variables affecting patient satisfaction.

To measure patient experience with the display of wait times in UC clinics or UC fast-track clinics located in MTF ERs, the MHS evaluated the results of Question 20, which asks: "Overall, I am satisfied with the healthcare I received on this visit." Average satisfaction increased at the 60th Medical Group and NMC Camp Lejeune; there was no change at Darnall AMC. The remaining MTFs saw average satisfaction decrease during the post-implementation period. Figure 4 provides the average percent satisfaction pre- and post-implementation of the pilot wait time on Question 20 from respondents seen in the MTF UC clinic or UC fast-track clinic in the MTF ER.

Figure 4: Average Satisfaction on Question 20 Pre- and Post-Wait Time Pilot Implementation

Question 20: Percent Satisfaction from Respondents Seen in MTF UC Clinic or UC Fast-Track in ER				
Service	**MTF**	**Pre-Implementation Average Percent Satisfied**	**Post-Implementation Average Percent Satisfied**	**Percentage Point Change**
Air Force	11th Medical Group	81%	80%	-1%
Air Force	60th Medical Group	83%	88%	5%
Air Force	673rd Medical Group	92%	82%	-10%
Army	Darnall AMC	90%	90%	0%
Army	Landstuhl RMC	89%	87%	-2%
Army	Schofield Barracks AHC	83%	79%	-4%
Army	Weed ACH	91%	79%	-12%
DHA	FBCH	91%	87%	-4%
Navy	NH Pensacola	93%	86%	-7%
Navy	NMC Camp Lejeune	83%	84%	1%
Navy	NMC Portsmouth	87%	81%	-6%

To measure patient experience with the display of wait times in pharmacies, the MHS evaluated the results of question 23, which asks: "If you also went to the Pharmacy, Laboratory or Radiology Department in conjunction with THIS visit, please rate your experience with these services." Average satisfaction increased at the 60th Medical Group, 673rd Medial Group, Premier CBMH, Schofield Barracks AHC and NHC Annapolis; satisfaction was unchanged at FBCH and Darnall AMC. Average satisfaction decreased during the post-implementation period at the remaining MTFs. Figure 5 provides the average percent satisfaction pre- and post-implementation by MTF of the pilot wait time from respondents using the MTF Pharmacy.

Figure 5: Average Satisfaction on Question 23 Pre- and Post-Wait Time Pilot Implementation

Question 23: Percent Satisfaction from Respondents Using the MTF Pharmacy				
Service	**MTF**	**Pre-Implementation Average Percent Satisfied**	**Post-Implementation Average Percent Satisfied**	**Percentage Point Change**
Air Force	11th Medical Group	74%	73%	-1%
Air Force	60th Medical Group	56%	58%	2%
Air Force	673rd Medical Group	69%	70%	1%
Army	Darnall AMC	73%	73%	0%
Army	Landstuhl RMC	85%	75%	-10%
Army	Premier CBMH	70%	74%	4%
Army	Schofield Barracks AHC	82%	88%	6%
Army	Weed ACH	77%	75%	-2%
DHA	FBCH	61%	61%	0%
Navy	NH Pensacola	67%	50%	-17%
Navy	NHC Annapolis	57%	76%	19%
Navy	NMC Camp Lejeune	63%	61%	-2%
Navy	NMC Portsmouth	63%	48%	-15%

Section D: Changes in Patient Behavior with Respect to Using UC Services

The MHS assessed changes in patient behavior in MTF UC clinics or UC fast-track clinics in MTF ERs by evaluating the average number of monthly encounters pre- and post-wait time pilot implementation. The MHS did not include network leakage of UC workload by beneficiaries empaneled to the MTF in its assessment of patient behavior related to the wait time pilot because of the confounding effects of the benefit change allowing unlimited self-referred network UC clinic visits, which have resulted in a 135 percent increase in FY 2019 compared to FY 2017. Overall, beneficiaries are using network UC clinics in addition to and not in lieu of care in MTFs. Changes in patient behavior by beneficiaries using pharmacy services was evaluated by comparing the average number of prescriptions filled pre- and post-wait time pilot implementation. Pharmacy data is reported in Section E of this report.

All MTF UC and ER data included information from October 2016 to June 2019 to ensure the pilot evaluation data included seasonable fluctuations in patient demand. The average was calculated for pre- and post-implementation, based on each MTF's wait time pilot implementation date. A slight increase in the number of encounters was observed at Weed ACH. Landstuhl RMC and 673rd Medical Group had less than a one percent change in encounters. All other MTFs had decreases in utilization, which may be due to a shift in workload to network UCCs but also to an increased number of available primary care appointments, secondary to productivity requirements per provider required in DHA policy on standardized appointing and provider productivity standards. Pre-implementation data was not available for FBCH because the UC clinic was implemented shortly before the pilot was initiated. The average number of encounters pre- and post-implementation by MTF are provided in Figure 6.

Figure 6: Average MTF Monthly Encounters UC Clinic or UC Fast-Track in the ER

Service	MTF	Pre-Implementation Average Monthly Encounters	Post-Implementation Average Monthly Encounters	Percent Change
Air Force	11th Medical Group	1,792	1,765	-2%
Air Force	60th Medical Group	1,920	1,743	-9%
Air Force	673rd Medical Group	2,015	2,014	0%
Army	Darnall AMC	3,846	3,668	-5%
Army	Landstuhl RMC	2,150	2,140	0%
Army	Schofield Barracks AHC	2,015	1,799	-11%
Army	Weed ACH	926	983	6%
DHA	FBCH	N/A (new UCC)	1,544	N/A
Navy	NH Pensacola	1,563	1,542	-1%
Navy	NMC Camp Lejeune	4,192	4,112	-2%
Navy	NMC Portsmouth	5,871	5,725	-2%
	Total (Less FBCH)	**26,290**	**25,491**	**-3%**

Section E: Changes in Patient Behavior with Respect to Using Pharmacy Services/Changes in Pharmacy Operations and Productivity

The MHS assessed changes in patient behavior as well as changes in pharmacy operations and productivity in MTF pharmacies by evaluating the average number of monthly prescriptions filled pre- and post-wait time pilot implementation.

To allow the evaluation to include seasonable fluctuations in patient demand, all MTF pharmacy data included information from October 2016 to June 2019. The average was calculated for pre- and post-implementation, based on each MTF's wait time pilot implementation date. Increases in the number of prescriptions filled was observed at NMC Portsmouth, Darnall AMC, Weed ACH and NHC Annapolis. The 60th Medical Group had less than a one percent change in the number of prescriptions filled. All other MTFs had decreases in the number of prescriptions filled. The largest decrease was seen at the Premier CBMH; however, this was due to the beneficiary empanelment being shifted to Evans ACH, secondary to the loss of the lease and subsequent closure of the CBMH. The average number of prescriptions filled pre- and post-implementation by MTF are provided in Figure 7.

Figure 7: Average MTF Monthly Encounters UC Clinic or UC Fast-Track in the ER

Service	MTF	Pre-Implementation Average Monthly Prescriptions Filled	Post-Implementation Average Monthly Prescriptions Filled	Percent Change
Air Force	11th Medical Group	12,470	11,625	-7%
Air Force	60th Medical Group	18,745	18,658	0%
Air Force	673rd Medical Group	21,738	18,389	-15%
Army	Darnall AMC	33,148	35,753	8%
Army	Landstuhl RMC	18,446	16,644	-10%
Army	Premier CBMH	3,259	2,004	-39%
Army	Schofield Barracks AHC	25,532	24,466	-4%
Army	Weed ACH	7,860	8,012	2%
Navy	NH Pensacola	50,026	49,439	-1%
Navy	NHC Annapolis	9,495	9,725	2%
Navy	NMC Camp Lejeune	33,369	30,438	-9%
Navy	NMC Portsmouth	3,121	3,418	10%
Total		**237,209**	**228,571**	**-4%**

Section F: Cost-Benefit Analysis of Posting Wait Times

The MHS was not able to assess cost-benefit analysis using traditional means for two reasons. First, there was no overall increase in utilization or patient behavior in MTF UC clinics, UC fast-track clinics in ERs or pharmacies at pilot sites; as a result, the MHS was not able to quantify a benefit based on utilization or changes in patient behavior. In addition, any changes in utilization or satisfaction cannot be attributed solely to the posted wait time pilot due to multiple confounding variables affecting satisfaction and utilization, which include, but are not limited to: satisfaction with other components of the UC or pharmacy visit; benefit changes to allow

unlimited self-referred network UC visits; and shifts in overall MTF primary care empanelment from direct care to the network. As a result, the MHS was not directly able to calculate and directly associate the benefit of posting wait times to the cost of posting wait time.

The MHS identified a significant financial benefit of issuing a single, enterprise-wide license for the patient queuing and notification system, which includes the avoided costs of maintaining legacy software and of managing multiple contracts. In addition, the MHS identified multiple methods of calculating wait times in MTFs prior to pilot implementation. After the implementation of the enterprise-wide license, a single methodology was adopted to measure wait times at the UC clinics and pharmacy, which supports DHA goals to standardize processes in MTFs to eliminate variance in patient experience.

Finally, this pilot demonstrated there is a potential to change patient behavior and enhance patient experience by posting accurate wait times using other convenient modes besides an electronic screen in a pharmacy or UC clinic. Specifically, posting current wait times on-line on the MTF webpage and/or mobile application would allow beneficiaries to make a choice on when to seek care or services at the MTF. If beneficiaries, when presented with information on wait times, preferentially would not visit the MTFs at peak times but instead at times of shorter wait times, workload compared to available resources would be spread out throughout the day and ultimately, will improve the MTF's ability to optimize operations and enhance patient experience.

Section G: Feasibility of Expanding the Posting of Wait Times in ERs

Because the MHS had a limited number of stand-alone UC clinics, the MHS implemented the wait time pilot in ERs with UC fast-track capability at the following MTFs: NMC Camp Lejeune, NMC Portsmouth, Darnall AMC, 60th Medical Group, Landstuhl RMC and the 673rd Medical Group, Winn ACH, FBCH and the 11th Medical Group. Therefore, the MHS is able to assess the feasibility of expanding the posting of wait times in ERs, based on the experience implementing the wait time pilot in MHS ERs.

In order to implement the posting of wait times in ERs, the MHS would change specifications applicable to the pilot; shorten the length of time preceding the calculation; and change the calculation to the civilian industry standard. Section 744 of the NDAA for FY 2017 required the wait time to be calculated for a four-hour period preceding the calculation of the average length of time beginning at the time of patient arrival at the UC clinic and ending at the time at which the patient is first seen by a qualified medical professional. Section 744 of the NDAA for FY 2017 further defines a ''qualified medical professional'' to mean a doctor of medicine, a doctor of osteopathy, a physician assistant, or an advanced registered nurse practitioner.

The MHS believes the wait time should be calculated based on an average of the last 30 minutes compared to the four hours required in the NDAA. In ERs, demand for care often varies greatly by hour. By including a full four-hour period preceding the calculation, the wait time is often under- or over-estimated, resulting in inaccurate posted wait times and patient dissatisfaction. The calculation also should measure the time from when the patient checks into the ER until the

patient is triaged by a provider or RN. In ERs, patient wait times are not based on arrival time; instead wait times are based on patient acuity, which can only be assessed through evidence-based triage by a provider or a RN. Wait times in ERs will vary greatly depending on whether the patient is seeking care for a self-limiting illness, such as a cold, or for a true emergency, such as trauma or a suspected heart attack. For this reason, the civilian industry standard is to measure from the time the patient checks into the ER until the patient is triaged by a provider or RN. In order to post a comparable wait time for all beneficiaries and also to allow beneficiaries to evaluate wait times in a MTF ER compared to a civilian ER, the MHS should follow the civilian industry standard for measurement of wait times in ERs.

Finally, posting wait times in ERs and on MTF websites should be implemented as MTFs transition to the new MHS GENESIS EHR because the new EHR already includes the capability to calculate wait times in ERs. Waiting until MHS GENESIS implementation will avoid defense health program costs to purchase additional Q-flow software licenses, which will become obsolete once MHS GENESIS is implemented. All MTFs are expected to implement MHS GENESIS by FY 2024.

Appendix A: Number of ICE Survey Responses by MTF

Service	MTF	Total ICE Responses
Navy	NMC Portsmouth	225
Army	Schofield Barracks AHC	124
Navy	NHC Annapolis	106
Air Force	11th Medical Group	64
DHA	FBCH	61
Air Force	673rd Medical Group	60
Army	Premier CBMH	59
Navy	NMC Camp Lejeune	55
Army	Darnall AMC	50
N/A	Did Not Identify MTF	44
Air Force	60th Medical Group	30
Navy	NH Pensacola	27
Army	Landstuhl RMC	7
Army	Weed ACH	3
Total		**915**

Appendix B: Section 744 of the NDAA for FY 2017 Language

SEC. 744. PILOT PROGRAM ON DISPLAY OF WAIT TIMES AT URGENT CARE CLINICS AND PHARMACIES OF MILITARY MEDICAL TREATMENT FACILITIES.

(a) PILOT PROGRAM AUTHORIZED.—Beginning not later than one year after the date of the enactment of this Act, the Secretary of Defense shall carry out a pilot program for the display of wait times in urgent care clinics and pharmacies of military medical treatment facilities selected under subsection (b).

(b) SELECTION OF FACILITIES.—

(1) CATEGORIES.—The Secretary shall select not fewer than four military medical treatment facilities from each of the following categories to participate in the pilot program:

(A) Medical centers.

(B) Hospitals.

(C) Ambulatory care centers.

(2) OCONUS LOCATIONS.—Of the military medical treatment facilities selected under each category described in subparagraphs (A) through (C) of paragraph (1), not fewer than one shall be located outside of the continental United States.

(3) CONTRACTOR-OPERATED FACILITIES.—The Secretary may select Government-owned, contractor operated facilities among those military medical treatment facilities selected under paragraph (1).

(c) URGENT CARE CLINICS.—

(1) PLACEMENT.—With respect to each military medical treatment facility participating in the pilot program with an urgent care clinic, the Secretary shall place in a conspicuous location at the urgent care clinic an electronic sign that displays the current average wait time determined under paragraph (2) for a patient to be seen by a qualified medical professional.

(2) DETERMINATION.—In carrying out paragraph (1), every 30 minutes, the Secretary shall determine the average wait time to display under such paragraph by calculating, for the four-hour period preceding the calculation, the average length of time beginning at the time of the arrival of a patient at the urgent care clinic and ending at the time at which the patient is first seen by a qualified medical professional.

(d) PHARMACIES.—

(1) PLACEMENT.—With respect to each military medical treatment facility participating in the pilot program with a pharmacy, the Secretary shall place in a conspicuous location at the pharmacy an electronic sign that displays the current average wait time to receive a filled prescription for a pharmaceutical agent.

(2) DETERMINATION.—In carrying out paragraph (1), every 30 minutes, the Secretary shall determine the average wait time to display under such paragraph by calculating, for the four-hour period preceding the calculation, the average length of time beginning at the time of submission by a patient of a prescription for a pharmaceutical agent and ending at the time at which the pharmacy dispenses the pharmaceutical agent to the patient.

(e) DURATION.—The Secretary shall carry out the pilot program for a period that is not more than two years.

(f) REPORT.—

(1) SUBMISSION.—Not later than 90 days after the completion of the pilot program, the Secretary shall submit to the Committees on Armed Services of the House of Representatives and the Senate a report on the pilot program.

(2) ELEMENTS.—The report under paragraph (1) shall include—

(A) the costs for displaying the wait times under subsections (c) and (d);

(B) any changes in patient satisfaction;

(C) any changes in patient behavior with respect to using urgent care and pharmacy services;

(D) any changes in pharmacy operations and productivity;

(E) a cost-benefit analysis of posting such wait times; and

(F) the feasibility of expanding the posting of wait times in emergency departments in military medical treatment facilities.

(g) QUALIFIED MEDICAL PROFESSIONAL DEFINED.—In this section, the term ''qualified medical professional'' means a doctor of medicine, a doctor of osteopathy, a physician assistant, or an advanced registered nurse practitioner.