3. ACCESS TO CARE IN THE MILITARY HEALTH SYSTEM

Introduction

Access to care is defined as "the timely use of personal health services to achieve the best health outcomes."[24] Access to care is influenced by many factors, including community health care resources, insurance coverage, financial status, proximity to care, and technology. Timely access to health care is a universal concept applicable to all health systems; however, the definitions and measures of timeliness are not standardized nationally.

Unique to the MHS, access standards are identified in Section 199.17(p)(5) of 32 Code of Federal Regulations (32 C.F.R. § 199.17(p)(5)); see Appendix 3.1). These standards include:

- 30-minute drive time for primary care
- Specialty care appointments within four weeks
- Routine appointments within one week
- Urgent care appointments generally not to exceed 24 hours
- Emergency room access available 24hrs/7 days per week
- 60-minute drive time for specialty care
- Office wait times should not exceed 30 minutes unless emergency care is being rendered to another patient

MHS enrollees to Medical Treatment Facilities (MTFs) have options for accessing care, including MTF appointments, Secure Messaging, TRICARE Online booking, or referrals to the private sector if the MTF does not have capability or cannot meet the MHS access standards. The Nurse Advice Line enhances access for all MHS beneficiaries within the continental United States.

In the MHS, the direct care and purchased care components operate in tandem to meet the 32 C.F.R. § 199.17 standards for the 5.3 million enrolled TRICARE Prime beneficiaries. The purchased care component is a safety net to ensure that Prime beneficiaries have an avenue for care when the direct care component cannot provide it. Annually, direct care provides an average of 43.4 million office visits while the MHS spends more than $15 billion annually in purchased care.

The following summary was compiled by subject matter experts from each of the Services and from the Defense Health Agency (DHA), which also represents the National Capital Regional Medical Directorate (NCR MD). It includes a review of access governance in the MHS, an

---

[24] Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services (1993). *Access to Health Care in America.* Washington, D.C.: National Academies Press.

examination of policy gaps, a review of current access performance, analysis of seven site visits, and findings and recommendations.

Access to Care Governance

DHA is responsible for oversight of the purchased care component and regularly reviews contract performance for care delivered in the purchased care component, including available access data. In the direct care component, Service- and DHA-level guidance sets the conditions for MTF leadership to build and sustain a culture of continuous process improvement to ensure their access to care program is meeting standards set by DoD policy. Site visitors noted minor variation in governance on this issue among the seven MTFs. The Air Force has specific Group Practice Managers who are responsible for monitoring and managing access. The Army, Navy, and DHA generally have assigned MTF Access Managers.[25] MTF and clinic leaders are aware of their access performance and challenges, primarily through excellent communication with the access managers. Two of the seven sites had a multidisciplinary access to care group or committee for collaborative discussion and sharing of best practices to facilitate an organizational and strategic approach to access.

Ultimately, the commanding officer or director of each facility is responsible for access within the MTF, which is accomplished through performance monitoring reviews. Across Services and DHA, the total number of metrics used in access reviews varies; however, all review acute access in primary care, primary care manager (PCM) continuity, secure messaging enrollment, Nurse Advice Line calls/dispositions, and emergency department utilization. Information on access flows between the MTF commander, intermediate commands, headquarters, and the Service Surgeon General; however, access data are not consistently transmitted above the level of the Surgeons General across the Services.

Primary care access for all three Services and DHA is reviewed by the Medical Operations Group (MOG) through the Tri-Service Patient Centered Medical Home (PCMH) Advisory Board's quarterly update. The update includes data on PCM continuity, access metrics for same day and routine appointing, emergency department utilization, patient satisfaction, staff satisfaction, and quality metrics. Best practices are identified and shared across the Services and DHA. The MOG also receives monthly performance metrics on the recently launched Nurse Advice Line for CONUS beneficiaries.

In 2014, the MOG approved the formation of the MHS Access Improvement Work Group (MHS AIWG) to facilitate access standardization in primary and specialty care across the Services. The MHS AIWG is currently drafting a DoD Instruction to standardize access business rules at all MTFs (see AIWG charter in Appendix 3.2). The MOG also approved the formation of the Tri-Service Specialty Care Advisory Board to standardize specialty care product lines including

---

[25] One small multidisciplinary clinic had someone from each department managing that department's access.

business rules for access, templates, secure messaging, operating rooms, and performance review metrics.

Policy Review and Identification of Gaps

The overarching guidance on access to care is set by 32 C.F.R. § 199.17, which has been in place since 1995. Critical supporting guidance includes Office of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) instruction, "TRICARE Policy 11-005, TRICARE Policy for Access to Care" (HA Policy 11-005) and the TRICARE program manuals. The policy review includes assessment of vertical gaps between higher and lower echelons and horizontal gaps between the Services and the NCR MD.

ASD(HA) – Overarching Guidelines

HA Policy 11-005 implements 32 C.F.R. § 199.17 and confirms the applicability of the guidance to overseas locations and to TRICARE Overseas Program (TOP) contractors. The policy also encourages the Services to use the *MHS Guide to Access Success* (2008) as guidance. Although not "policy" explicitly, the *Guide* remains central to the management of access within the MHS. HA Policy 09-15 directs each Service to implement the PCMH model of primary care, which includes enhanced access to care.

Military – Service-Level Instructions

Each of the Services and DHA has established policy letters, instructions, and directives for Service-specific guidance on meeting the access standards. (Summaries of DoD and Service-level policies and orders can be found in Appendix 3.3.)

TRICARE – Purchased Care Guidelines

The purchased care component is expected to meet access standards, administered through the TRICARE program manuals. Although evaluation of compliance is defined in the contract, it does not require the same level of detail required in the direct care component. For example, patient satisfaction with length of time to appointment is used as a surrogate measure of primary care access in lieu of detailed access to care compliance data.

External Reviews

A 10-year retrospective review of DoD Inspector General (IG) and Government Accountability Office (GAO) reports identified 34 potentially relevant documents, seven of which were related to access but only two of which were relevant to access for TRICARE Prime beneficiaries; however, neither addressed the 32 C.F.R. § 199.17 access standards. The remaining GAO reports focused on access to civilian providers for TRICARE Standard beneficiaries, for whom access standards are not defined by DoD regulation since beneficiaries are free to use any authorized provider. (Information on the GAO reports is found in Appendix 3.4.)

Vertical gaps are defined as inconsistencies between higher- and lower-level policies. One such gap was identified—neither the Services nor NCR MD have established a standardized methodology to assess the 30-minute office waiting times. This gap was also noted in the purchased care component. Review of Service and NCR MD policies found no significant horizontal gaps.

Education and Training

The Services have invested in access to care training for relevant personnel at a variety of levels. Currently, 12 distinct educational opportunities provide training on access management. This training is designed to develop expertise among all roles and levels of MTF staff and facilitates common goals to:

1. Implement and sustain a systematic, proactive, programmatic, and responsive access management program
2. Ensure all clinics/services meet or exceed the access standards
3. Create an access curriculum for all levels of the organization

Each of the Services has a course on access management. In addition, the MHS has implemented a Tri-Service Access Improvement Seminar. Given the redundancy of these courses, there is opportunity to standardize training across the Services. (Summaries of Service-level access courses are found in Appendix 3.5.)

The site visit team found that appointing staff members receive formal training on the Composite Health Care System (CHCS), which serves as the foundation for DoD's electronic health record. Medical appointments in MTFs are scheduled in CHCS, based on locally developed appointment templates. In addition, some MTFs have clinic-specific orientation to train new staff on standard operating procedures, along with on-the-job training. CHCS training appears to be standardized across the seven MTFs visited by the MHS Review Group, but clinic-level training ranges from formal and documented training to undocumented, informal on-the-job training. While all seven facilities provide training for call center booking agents and front desk clerks, some MTFs have organization-wide customer relations training during initial orientation and only a few require annual customer service training. Clinic leadership at all sites expressed a desire to learn more about clinic operations, including effective management of access and demand forecasting. Given that customer service at every contact point in a health care facility can have a direct effect on the patient experience, there is an opportunity to standardize customer service training.

Methodology

The MHS Review Group evaluated multiple data sources to explore access performance for the purposes of this review. Chosen metrics met the following criteria:

1. Established, readily available, and understood across the organization to the highest degree possible
2. Sufficient to assess compliance with 32 C.F.R. § 199.17

3. Relevant to access to care performance throughout the entire MHS, to include both the direct care and purchased care components
4. Include modes of enhanced access to virtual services provided to patients such as secure messaging or use of an online portal
5. Include patients' perception of and satisfaction with MHS access to care
6. Limited to primary care and specialty care as a whole, rather than by product line, due to time constraints for the review
7. Include on-site observations and interviews in order to validate other data sources

Measures to assess the direct care component were chosen based on ready availability through standard access reports housed at the TRICARE Operations Center (TOC) website. The TOC electronically collects appointment process details for all MTFs and provides MTF clinical staff and decision makers at all levels meaningful current and historical access reports using a DoD Common Access Card. Appointment processing and scheduling business rules built into CHCS are directly aligned with 32 C.F.R. § 199.17 and HA Policy 11-005.

The following TOC data were reviewed at the MHS and Service levels, by facility type (Medical Center, Hospital, and Clinic), by location (Overseas or United States), and by facility name:

1. Average number of days to acute appointments
2. Average number of days to third next available acute appointment (primary care)
3. Average number of days to third next available routine appointment (primary care)
4. Average number of days to specialty appointments
5. Average number of days to third next available specialty appointment
6. Percent of acute appointments meeting MHS access standards
7. Percent of specialty appointments meeting MHS access standards

The following metrics were used to assess enhanced access to care and satisfaction:

1. Percent appointments web-enabled for TRICARE Online (TOL) booking
2. Number of direct care enrollees in secure messaging
3. Percent of direct care enrollees registered in secure messaging who initiated contact with their PCM
4. Number of calls to the Nurse Advice Line
5. Percent of calls to the Nurse Advice Line by disposition
6. Satisfaction with Getting Care When Needed (Service Surveys)
7. Satisfaction with Access to Care (TROSS)
8. Satisfaction with Seeing a Provider When Needed (TROSS)
9. Satisfaction with Getting Care Quickly (HCSDB)
10. Satisfaction with Getting Care when Needed (HCSDB)

TRICARE regional contractors submit data on the purchased care component as part of the contract requirements. The current TRICARE contracts do not require the contractors to collect and report the same level of detail on access to care as is available in the direct care component. The contractors do not collect the same measures in the same way as the MHS direct care

components, and do not use the same information systems. Moreover, the overseas contract does not collect the same data as the U.S. contractors. Although comparisons between the direct and purchased care components are difficult, data were collected on the following metrics:

1. Number of enrollees per network provider - United States
2. Specialty care percentage within a 60-minute drive time - United States
3. Percent of appointments within 28 days - United States
4. Access to care composite (TRICARE Outpatient Satisfaction Survey [TROSS]) - United States
5. Seeing a provider when needed (TROSS) - United States
6. Getting care quickly composite (Health Care Survey for DoD Beneficiaries [HCSDB]) - United States
7. Getting needed care composite (HCSDB) -United States
8. Overseas network satisfaction data

The analysis also incorporated a review of external benchmarks, site visit information, town hall meetings, and regional reviews. Given that there are no national benchmarks for access, the MHS Review Group assessed national health plan standards, which vary widely. The California State Department of Managed Health Care set specific timelines for non-emergent access in 2002, which are used to benchmark the current MHS performance. (See access standards comparison in Appendix 3.6)

Direct Care Component Analysis

The following section presents performance in access metrics for the direct care component. (See Appendix 3.7 for FY 2014 access measures displayed by facility, and Appendix 3.8 for the analysis of percent of appointments meeting MHS standards). The data apply only to the care delivered in the MTFs and has been split to show access within primary care and specialty care across the MHS and the Services by facility type and geographic location. The 32 C.F.R. § 199.17 and California (CA) standards are displayed in Table 3.1.

Table 3.1 MHS vs. CA Standards Comparison

MHS Appointment Type	MHS Standard	CA Appointment Type	CA Standard
Acute	Generally within 24 hours	Urgent	48 hours
Routine	7 calendar days	Non-urgent primary care	10 business days
Specialty	28 calendar days	Non-urgent specialist	15 business days

2014 MHS Review Group
Source: California Department of Managed Care, June 2014

Acute Care

Average Number of Days to an Acute Appointment

Overall: As of April 2014, 88 percent of acute appointments planned in CHCS were delivered in primary care and 12 percent in specialty care. Thus, this metric is most applicable to primary

care for the direct care component, but it does include both primary and specialty care acute appointments. In Fiscal Year 2014 to date, the average number of days to an acute appointment is 0.97 days overall, outperforming both the MHS and CA access standards (see Figure 3.1).

The median was 0.46 days and there were four minor outliers and seven major outliers.[26] The four outliers with average days to acute care appointments greater than 1.18 days were 99th MDG- Federal O'Callaghan, 633rd Medical Group, NMC Portsmouth, and Ft. Belvoir Community Hospital. The seven major outliers with average days of 1.69 days or greater were 35th Medical Group, Leonard Wood ACH, Irwin ACH, Darnall AMC, NH Guantanamo Bay, NHC Hawaii, and Walter Reed National Military Medical Center. (See Appendix Table 3.10-1 and Appendix Figure 3.10-1.)

**Figure 3.1 Average Number of Days to Acute Appointment –
Overall: MHS Access Standard ≤ 1 Day**
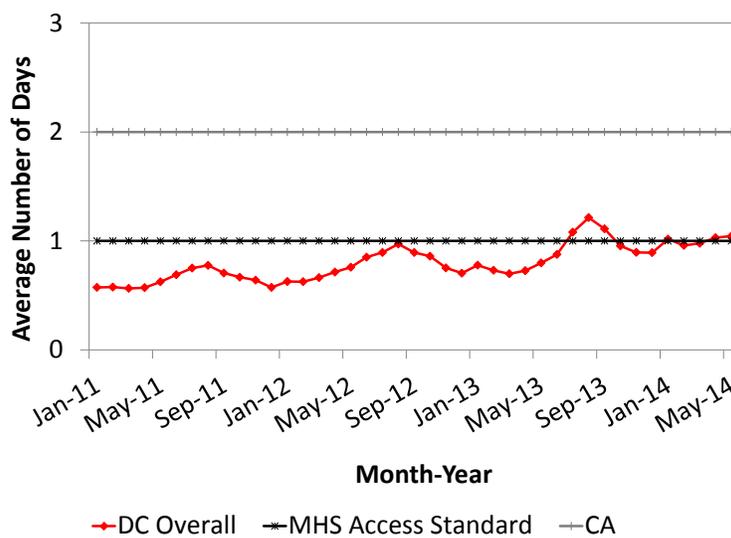
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

In general, the upward trend in the number of days to an acute care appointment reflects an increase in demand associated with the direct care component's transition to the PCMH model of care and the move to enhanced access. Previously, 24-hour appointments were reserved for acute health issues; now, more same day appointments allow health issues previously seen on a routine (7-day) basis to be seen on a 24-hour basis. By standardizing appointment templates, the direct care component increased total primary care appointments by five percent between FY 2011 and FY 2014. The direct care component also simplified appointment templates and

---

[26] Outliers for MHS-level data were calculated based on the interquartile range (IQR), which is the difference between the first and third quartiles of observed data. Minor and major outliers were defined as 1.5 times beyond IQR and 3 times beyond the IQR, respectively.

reduced the number of appointment types, which increased the number of acute appointments by 35 percent.

Because most staff rotations occur in the summer months, the average number of days to an acute care appointment is higher from May to August each year. This trend may have been further exacerbated in July and August 2013, which coincided with civilian employee furloughs.

Civilian Comparison: Health System 3 reported an average days to acute care appointments of "less than one" day, which is consistent with the direct care component FY 2014 average performance of 0.97 days. Health System 3 reports that patients who have acute medical needs are able to be seen on a walk-in basis or are given an appointment for the same day. A recent Merritt Hawkins survey of 15 major U.S. metropolitan areas reported the time to see a family medicine provider of 18.5 days (the study did not specify acute or routine.)[27]

Service Level: There is variation in performance. All Services currently perform better than the CA access standard with the Air Force (0.55 days) outperforming the MHS access standard. Army (1.07 days), Navy (1.17 days), and NCR MD (1.64 days) did not meet the MHS access standard in FY 2014 (see Figure 3.2).

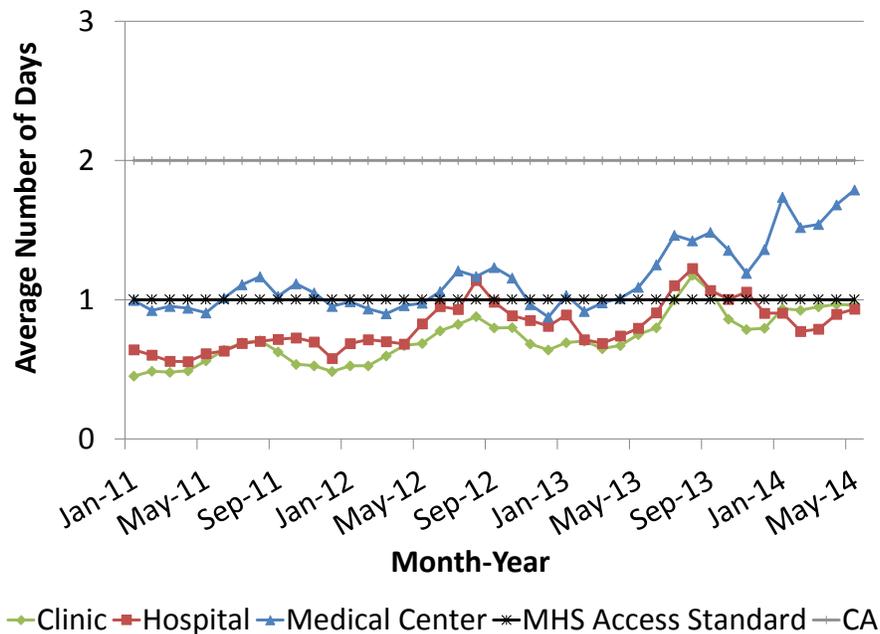Figure 3.2 Average Number of Days to Acute Appointment – By Service: MHS Access Standard ≤ 1 Day
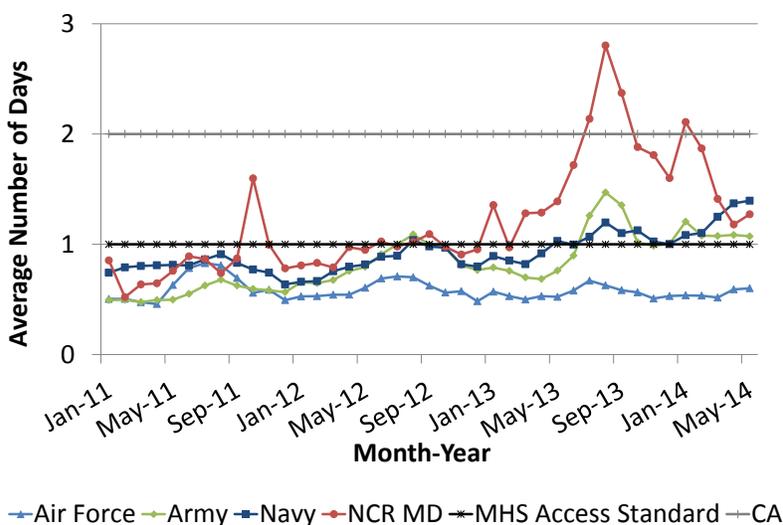
2014 MHS Review Group
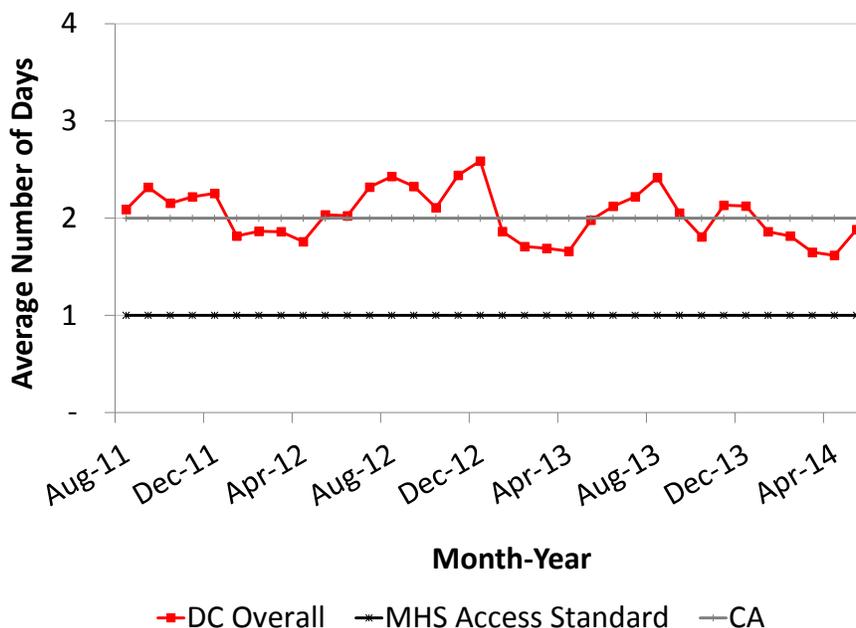Source: TRICARE Operations Center (TOC), June 2014

---

[27] Merritt Hawkins 2014 Survey of Physician Appointment Wait Times and Medicaid and Medicare Acceptance Rates. (2014). Available at:
http://www.merritthawkins.com/uploadedFiles/MerrittHawkings/Surveys/mha2014waitsurvPDF.pdf.

Facility Type: There is variation in average days to acute appointments when data are broken out by facility type. The larger facility types show a higher average number of days to acute care appointments than hospitals and clinics. All three facility types performed better than the CA acute access standards (see Figure 3.3).

Figure 3.3 Average Number of Days to Acute Appointment – By Facility Type: MHS Access Standard ≤ 1 Day

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: Facilities located overseas performed better on average days to an acute care appointment than facilities located in the United States: 0.61 days in FY 2014 compared to 1.03 days. Both groups performed better than the CA access standard. Overseas locations may perform better as a result of having a pre-screened population and higher staffing levels. (See Appendix Figure 3.9-1.)

Average Number of Days to Third Next Acute Appointment in Primary Care

MHS Level: The average number of days to third next appointment is a *prospective* health care industry standard measure and is considered an excellent measure of overall appointment availability. The Agency for Healthcare Research and Quality (AHRQ) and the Institute for Healthcare Improvement recommend measurement of average number of days to third next acute and routine appointments in primary care settings as a more sensitive measure of ATC. In FY 2014 to date, the average number of days to the third next acute appointment is 1.86 days, down 11 percent from 2.09 days in FY 2012 (see Figure 3.4). The MHS and CA acute access standards are included as goals to work toward, as there is no standard for average number of days to third next appointment. The overall range of observations is 0.44 days to 5.62 days with 64 percent of MTFs performing better than the overall overage of 1.86 days. The median was

1.4 days and there were 6 minor outliers with average number of days to third next acute greater than 1.72 days (99th MDG- Federal O'Callaghan, 633rd Medical Group, 81st Medical Group, Darnall AMC, William Beaumont AMC, Walter Reed National Military Medical Center) and one major outlier with average number of days to third next acute greater than 3.44 days (60th Medical Group).[28] (See Appendix Table 3.10-2 and Appendix Figure 3.10-2.).

Figure 3.4 Average Number of Days to Third Next Acute Appointment (Primary Care) – Direct Care Component Overall

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Civilian Comparison: The average number of days to the third next acute appointment of 1.86 days in direct care is better than Health System 2 and Health System 3, which averaged 9.02 days and 11.63 days, respectively.

---

[28] Outliers for MHS-level data were calculated based on the interquartile range (IQR), which is the difference between the first and third quartiles of observed data. Minor and major outliers were defined as 1.5 times beyond IQR and 3 times beyond the IQR, respectively. See Appendix 3.10 for Outlier Analysis.

Service Level: There is variation among the Services in the average number of days to the third next acute appointment (see Table 3.2 and Figure 3.5). To better understand these differences, the percent of 24-hour appointments was reviewed and appears to have an inverse correlation to third next acute measure. All of the Services have improved performance since FY 2012.

Table 3.2 Average Number of Days to Third Next Acute Appointment (Primary Care) by Service and Percent of 24-Hour Care Appointments

	Navy	Army	Air Force	NCR MD
Average Number of Days to Third Next Acute Appointment	1.00	1.91	2.24	2.53
% Primary Care Appointments Available for 24-Hour Care	54%	46%	36%	30%

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Figure 3.5 Average Number of Days to Third Next Acute Appointment (Primary Care) – By Service
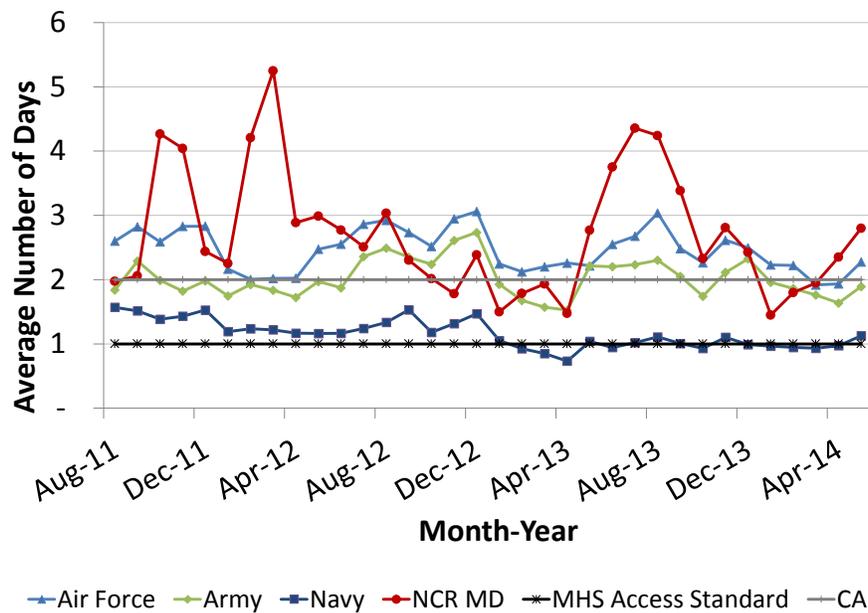
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: In general, the average number of days to third next acute appointment is higher in medical centers (2.6 days), compared to hospitals (1.5 days), and clinics (1.7 days) in FY 2014 (see Figure 3.6).

Figure 3.6 Average Number of Days to Third Next Acute Appointment (Primary Care) – By Type of MTF
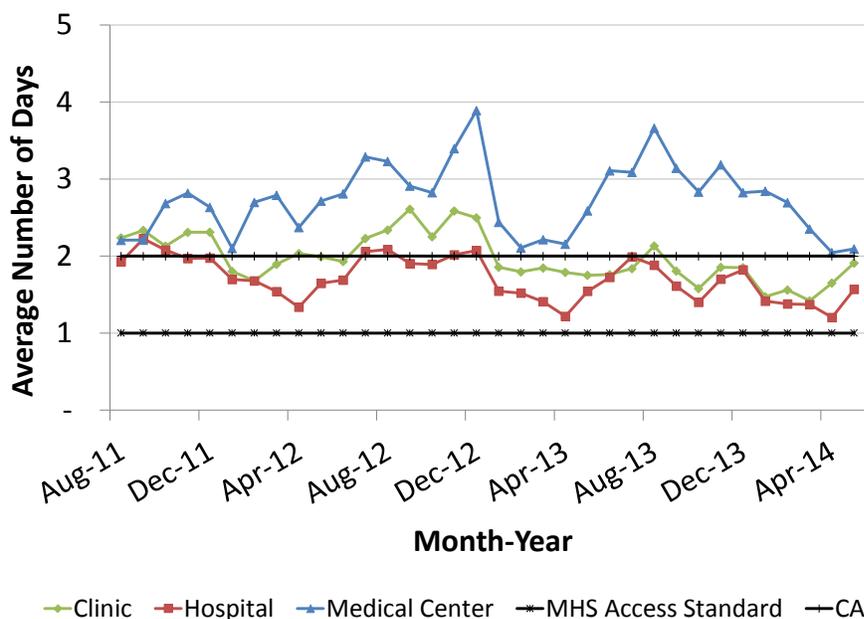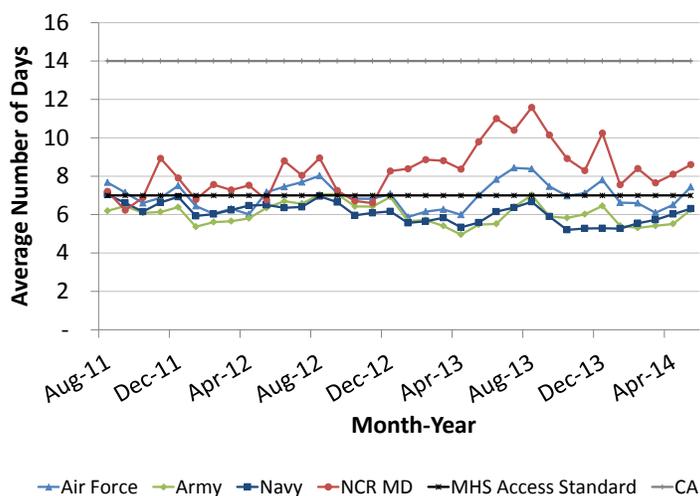

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: The average number of days to third next acute appointment is lower in overseas facilities compared to those in the United States in FY 2014: 0.8 days compared to 1.9 days. (See Appendix Figure 3.9-2.)

Routine Care

Average Number of Days to Routine Appointment

This review does not include average days to routine appointments because the direct care component's ability to schedule a routine appointment under different appointment categories makes data aggregation difficult. Due to the direct care component's transformation to the PCMH model of primary care, 86 percent of routine appointments are classified as established (EST) appointments with the remaining 14 percent classified as routine (ROUT). As a result, routine access to care is evaluated through the Average Days to Third Next Routine Appointment in Primary Care measure, which includes both ROUT and EST appointment types.

Average Number of Days to Third Next Routine Appointment in Primary Care

MHS Level: In FY 2014 to date, the average number of days to the third next routine appointment is 6.22 days, down 6 percent from 6.62 days in FY 2012 (see Figure 3.7). The CA access standard is 10 business days, which converts to 14 calendar days for comparison to the MHS access standard. The overall range of observations is 0.7 days to 12.5 days with 64 percent of MTFs performing better than the overall overage of 6.2 days. The median is 5.3 days and there were 3 minor outliers with average number of days to third next routine greater than 11.3 days (72nd Medical Group, 45th Medical Group, 99th MDG Federal O'Callaghan) and no major outliers beyond 15.5 days. (See Appendix Table 3.10-3 and Appendix Figure 3.10-3.)

Figure 3.7 Average Number of Days to Third Next Routine Appointment (Primary Care) Overall
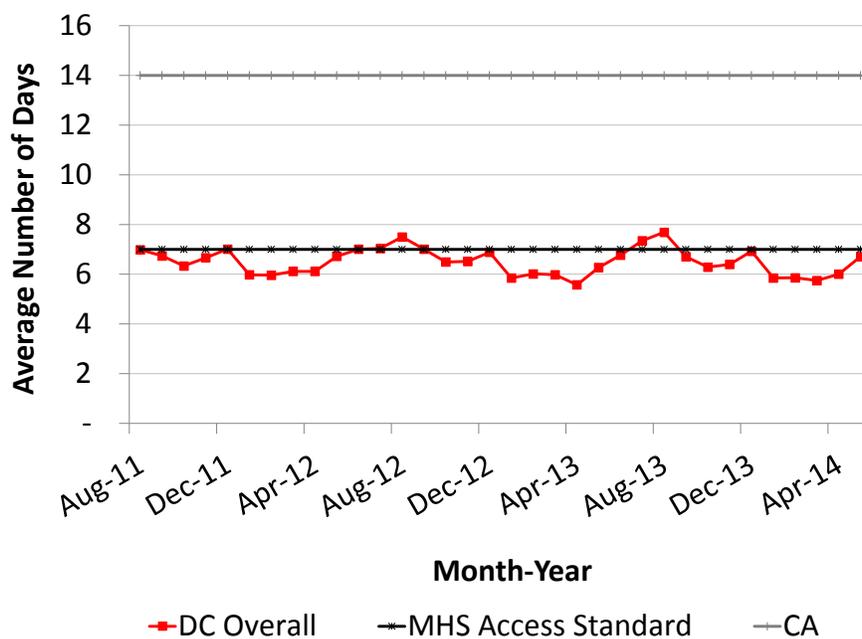
2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Civilian Comparison: The average number of days to the third next routine appointment of 6.2 days in direct care is better than Health System 2 and Health System 3, which averaged 9.0 days and 14.2 days, respectively.

Service Level: The FY 2014 average number of days to the third next routine appointment is 5.6 days for the Navy, 5.8 days for the Army, 6.9 days for the Air Force and 9.2 days for the NCR MD (see Figure 3.8).
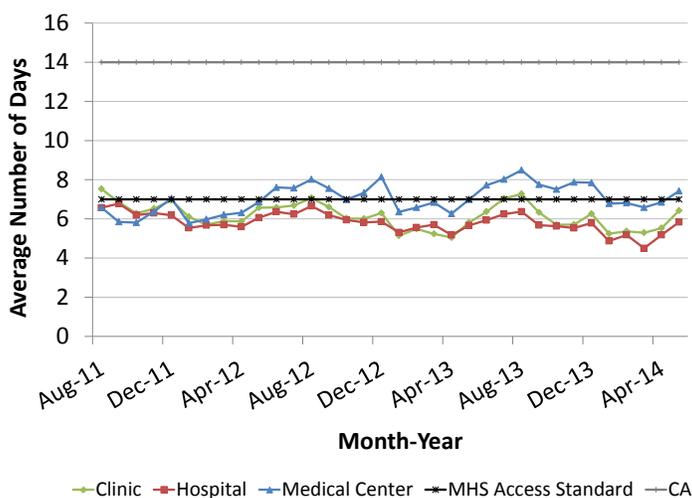
Figure 3.8 Average Number of Days to Third Next Routine Appointment (Primary Care) – By Service

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: The average number of days to third next routine appointment is higher in medical centers (7.2 days), compared to hospitals (5.3 days) and clinics (5.7 days) in FY 2014 (see Figure 3.9).

Figure 3.9 Average Number of Days to Third Next Routine Appointment (Primary Care) – By Type of MTF

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

46

Location: The FY 2014 average days to the third next routine appointment at overseas facilities is 5.2 days compared to facilities in the United States at 6.3 days. (See Appendix Figure 3.9-3.)

Specialty Care

Average Number of Days to Specialty Appointment

MHS: The FY 2014 average number of days to specialty appointment is 12.4 days, which outperforms the MHS access standard of 28 days and the CA specialty access standard of 15 business days (21 calendar days) (see Figure 3.10). The overall range of observations is 6.5 days to 18.0 days with 67 percent of MTFs outperforming the overall overage of 12.4 days. The median is 11.6 days and there was one minor outlier with average number of days to specialty appointment greater than 15.7 days (52nd Medical Group) and no major outliers beyond 22.8 days.[29] (See Appendix Table 3.10-4 and Appendix Figure 3.10-4.)

Figure 3.10 Average Number of Days to Specialty Appointment – Overall: MHS Access Standard ≤ 28 Day
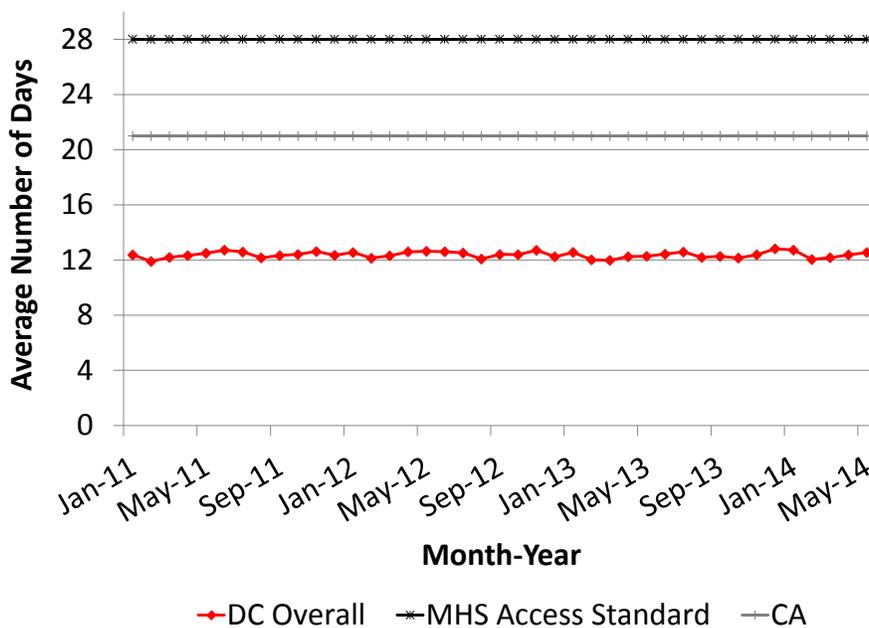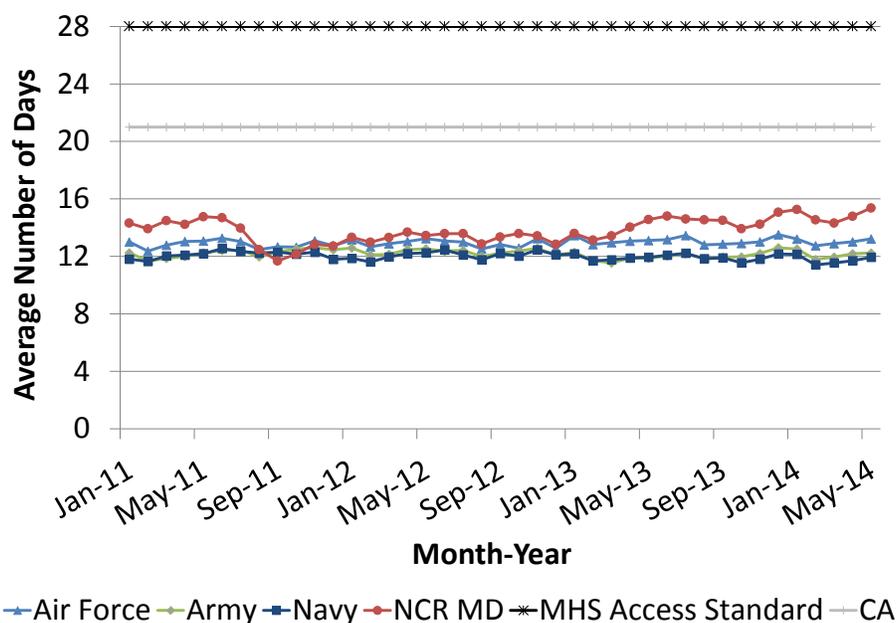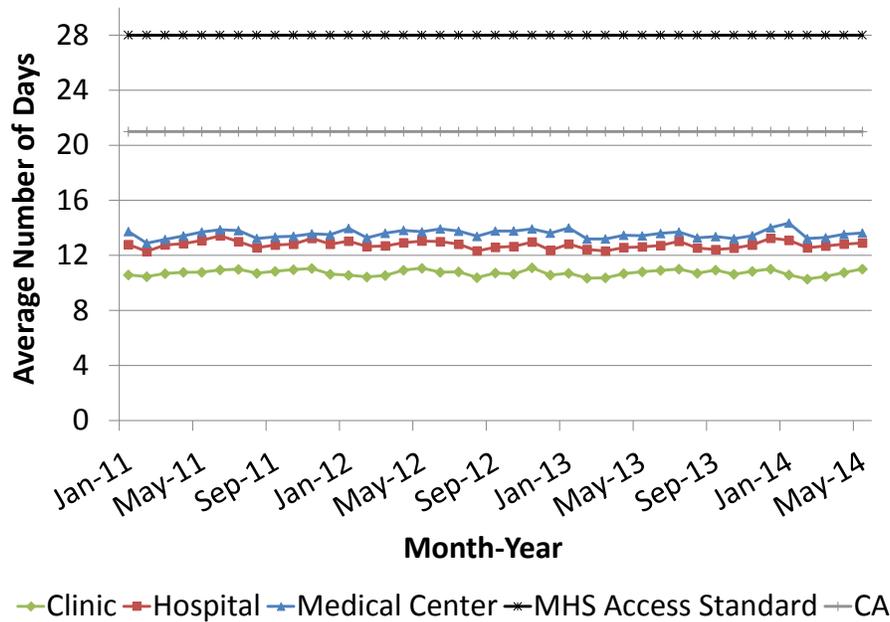

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

---

[29] Outliers for MHS-level data were calculated based on the interquartile range (IQR), which is the difference between the first and third quartiles of observed data. Minor and major outliers were defined as 1.5 times beyond IQR and 3 times beyond the IQR, respectively. See Appendix 3.10 for Outlier Analysis.

Civilian Comparison: The average of 12.4 days to a specialty appointment in direct care is better than Health System 3, which reported an average days to specialty care appointments of 22.3 days. The recent Merritt Hawkins survey of 15 major U.S. metropolitan areas reported a wait time to see a specialty provider of 18.5 days.

Service-Level: The FY 2014 average number of days to a specialty appointment is 11.8 days for the Navy, 12.2 days for the Army, 13.1 days for the Air Force, and 14.7 days for NCR MD (see Figure 3.11).

Figure 3.11 Average Number of Days to Specialty Appointment – By Service: MHS Access Standard ≤ 28 Day

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: In FY 2014, the average number of days to specialty appointments in clinics, hospitals, and medical centers is 10.7 days, 12.8 days, and 13.6 days, respectively (see Figure 3.12). All three facility types meet both the MHS access standard of 28 days and the CA specialty access standard of 15 business days (21 calendar days).

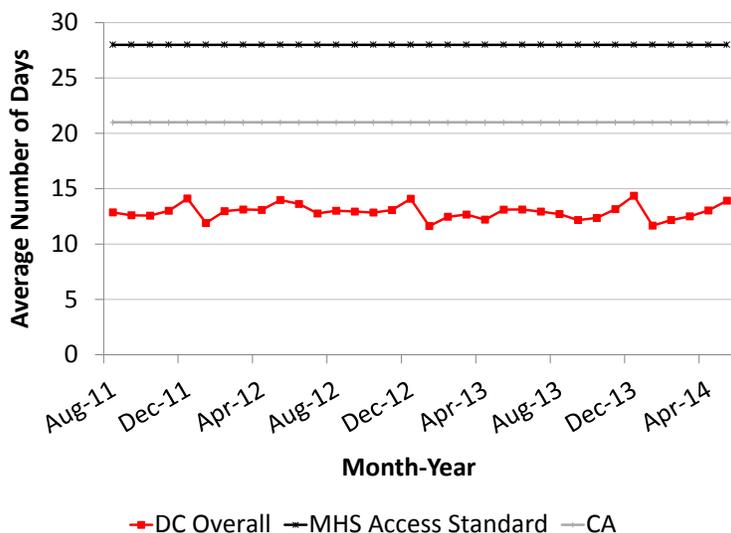**Figure 3.12 Average Number of Days to Specialty Appointment – By Facility Type: MHS Access Standard ≤ 28 Day**

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: MTFs located overseas had only slightly better performance compared to facilities located in the United States. The FY 2014 average number of days to specialty appointment overseas is 11.5 days compared to 12.5 days in facilities located in the United States. Both groups performed better than the MHS access standard of 28 days and the CA specialty access standard of 15 business days or 21 days. (See appendix Figure 3.9-4.)

Average Days to Third Next Specialty Care Appointment

MHS Level: In FY 2014 to date, the average number of days to the third next specialty care appointment is 12.4 days (see Figure 3.13). The median is 11.5 with a range from 3.1 days to 37.1 days. There is one minor outlier with average days to third next specialty appointments greater than 21.5 days but still within access standard (27th Special Operations Medical Group) and one major outlier beyond 28.5 days (423 MDS-RAD Alconbury). (See Appendix Table 3.10-5 and Appendix Figure 3.10-5.)

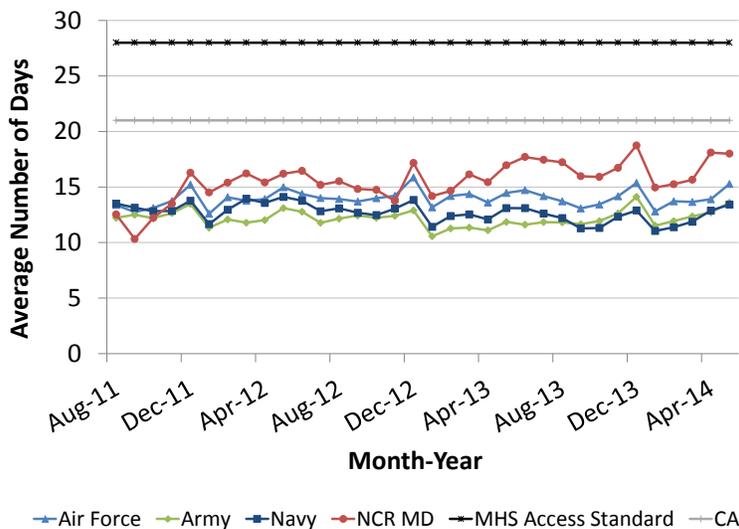**Figure 3.13 Average Number of Days to Third Next Specialty Care Appointment – Overall**

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Civilian Comparison: The average number of days to the third next specialty appointment of 12.9 days in direct care is better than Health System 2, which averaged 16.7 days.

Service Level: The FY 2014 average number of days to the third next specialty care appointment averages 12.1 days for the Navy, 12.6 days, for the Army, 14.0 days for the Air Force, and 16.7 days for the NCR MD (see Figure 3.14).
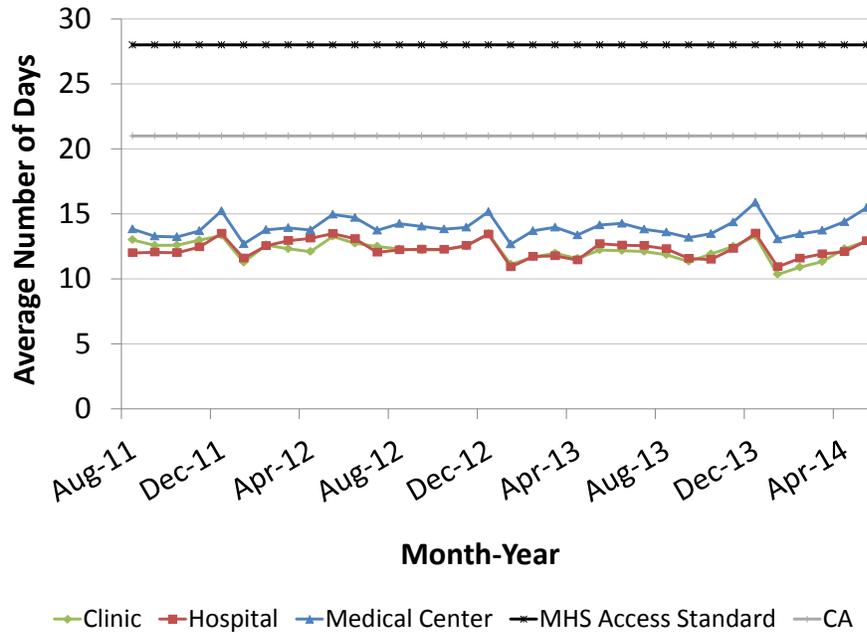
Figure 3.14 Average Number of Days to Third Next Specialty Care Appointment – By Service

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Facility Type: In general, the average number of days to third next specialty care appointment is higher in medical centers (14.2 days), compared to hospitals (12.1 days), and clinics (11.9 days) in FY 2014 (see Figure 3.15).

Figure 3.15 Average Number of Days to Third Next Specialty Care Appointment – By Facility Type
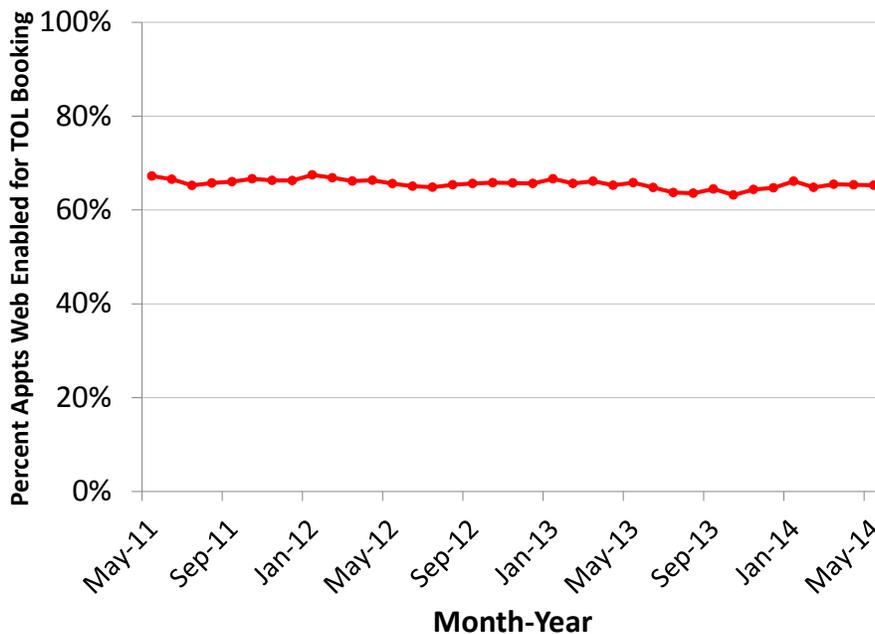

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Location: The FY 2014 average number of days to third next specialty care appointment at overseas facilities is 11.5 days compared to facilities in the United States at 13.2 days. (See Appendix Figure 3.9-5 showing performance from August 2011 to May 2014.)

TRICARE OnLine (TOL) Booking: Web-Enabled Appointments

TOL is a web portal available to MTF enrollees for making appointments and for viewing personal health information 24 hours a day. Each month, more than 700,000 appointments, approximately 65 percent of available appointments, are web-enabled for TOL booking. This overall percentage of TOL web-enabled appointments has been stable over the past three years (see Figure 3.16). In the direct care component, nearly three percent of appointments are booked using TOL. This rate has not changed in three years.

Figure 3.16 TRICARE On-Line (TOL) Web-Enabled Appointments: MHS Overall
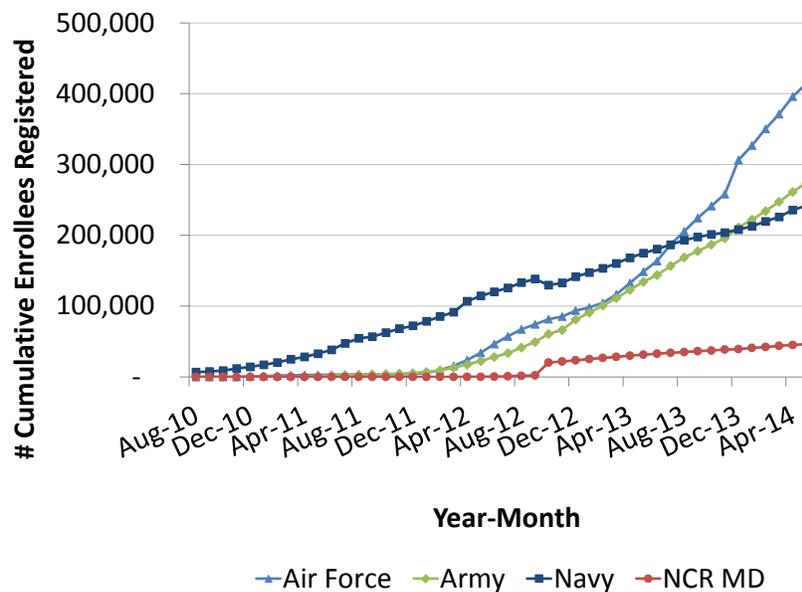

2014 MHS Review Group
Source: TRICARE Operations Center (TOC), June 2014

Secure Messaging (SM): Number of MTF Enrollees Registered

The direct care component has enhanced access through SM, which broadens the relationship between the patient and their PCM. Patient satisfaction with SM is 97 percent and more than 86 percent of SM satisfaction survey respondents agreed that using SM interaction allowed them to avoid an unnecessary trip to the clinic, emergency department, or urgent care facility. SM was fully implemented across primary care clinics in January 2014; specialty care implementation began in February 2014. As of June 2014, more than 1 million MTF enrollees were registered in SM, a growth of 53 percent in FY 2014 compared to FY 2013 (see Figure 3.17).

Figure 3.17 Number of MTF Enrollees Registered in Secure Messaging – By Service,

August 2010 – May 2014

2014 MHS Review Group
Source: Relay Health Reports, June 2014

Percent of Enrollees Registered in Secure Messaging Who Initiated Contact with PCM

Percentages-to-date by type of patient-initiated clinical messages are reported in Table 3.3.

Table 3.3 Type of Patient-Initiated Clinical Message

Type of Patient-Initiated Message	Percent of Total
Question for PCM	56%
Appointment Requests	17%
Rx Refill Requests	16%
Laboratory Result Requests	7%
Referrals	4%

2014 MHS Review Group
Source: Relay Health reports, June 2014

The current direct care component policy is for patient-initiated messages to be answered within 72 hours. The FY 2014 average response time is 35 hours. In FY 2014, 17 percent of users have initiated a clinical message to request an appointment (see Table 3.4).

Table 3.4 Registered Users Initiating a Secure Message to PCM, FY14

| MHS Group	Percent of Total
MHS Overall	17%
Army	21%
Navy	15%
Air Force	14%
NCR MD	26%

2014 MHS Review Group
Source: Relay Health reports, June 2014

Nurse Advice Line (NAL)

In March 2014, the MHS began the phased rollout of a 24-hour a day, 7-day a week NAL to enhance access to care for beneficiaries. All beneficiaries calling the NAL receive advice, health care finder assistance, and, if indicated, direct MTF primary care appointing. If an appointment cannot be obtained within the time recommended based on the triage end point and the clinical judgment of the NAL's professional registered nurses, the patient will be advised to seek care in the network. A formal survey process will begin after full implementation; however, initial informal feedback from patients and staff has been overwhelmingly positive. Call volume is steadily increasing to an average of over 1,000 calls per day currently (see Figure 3.18).

On average to date, 12 percent of NAL callers were referred to private sector emergency departments, 25 percent to private sector urgent care facilities, 23 percent to the MTF (PCMH, urgent care [UC] or emergency department [ED]), and 40 percent to self-care (the patient did not need an appointment, just advice). If the MTF is unavailable, the NAL refers the patient to the private sector for urgent care. Notably, 1.3 percent of all calls to date have resulted in a decision to activate the emergency medical system (EMS) response. The most common reasons for activating EMS are chest pain, neurological problems, and breathing problems.

**Figure 3.18 Nurse Advice Line (NAL) Calls Triaged 28 March to 25 July 2014**
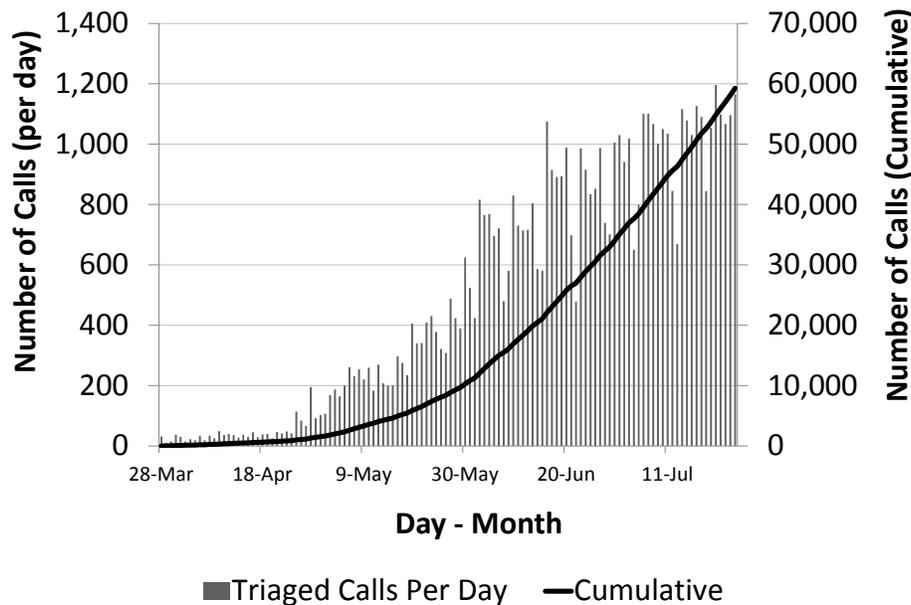
2014 MHS Review Group
Source: NAL Live Web Repository, June 2014

Emergency Department and Urgent Care Center Utilization by MTF Enrollees in the Purchased Care Network

If primary care cannot be delivered in the MTF within MHS access standards, HA Policy 11-05 states that patients are to be offered an appointment in the purchased care network. To assess access in the direct care component, the percent of care offered in both components for MTF enrollees was reviewed. In FY 2014, 79 percent of MTF enrollee primary care was delivered in the PCMH and 10 percent elsewhere in the MTF (direct care Emergency Department [ED] or Urgent Care [UC] resources). Approximately 11 percent of MTF enrollee primary care was delivered in the purchased care network: 4 percent was delivered in purchased care EDs and 7 percent in purchased care UC. Since FY 2011, the percentage of MTF enrollee primary care delivered in the PCMH has increased from 73.5 percent to 78.6 percent while the percent of primary care delivered in the purchased care network (ED and UC) has decreased from 14 percent to 11.1 percent (see Figure 3.19).

Figure 3.19 MTF Enrollee Primary Care Workload, by Venue of Care, FY11 – FY14
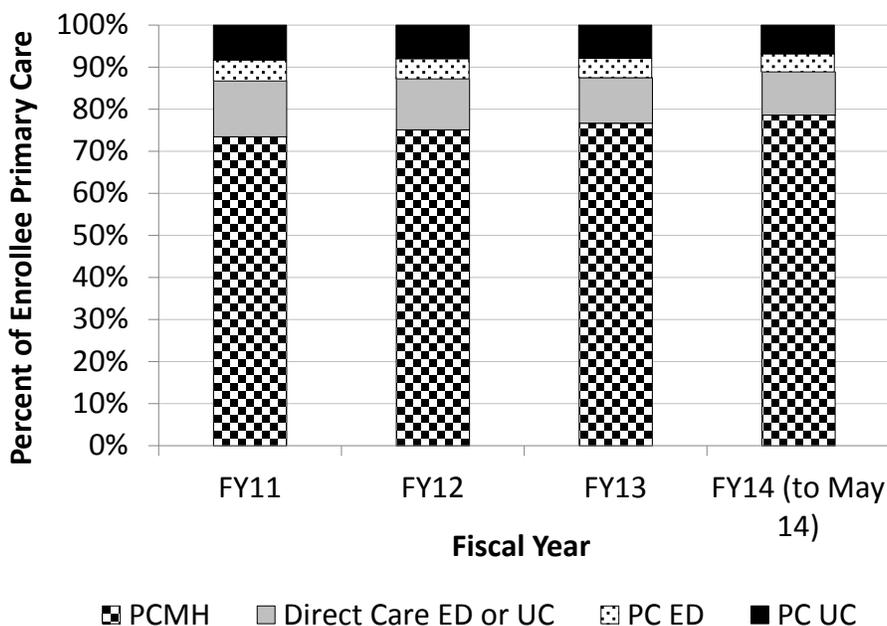
2014 MHS Review Group
Source: Military Health System Mart (M2), June 2014
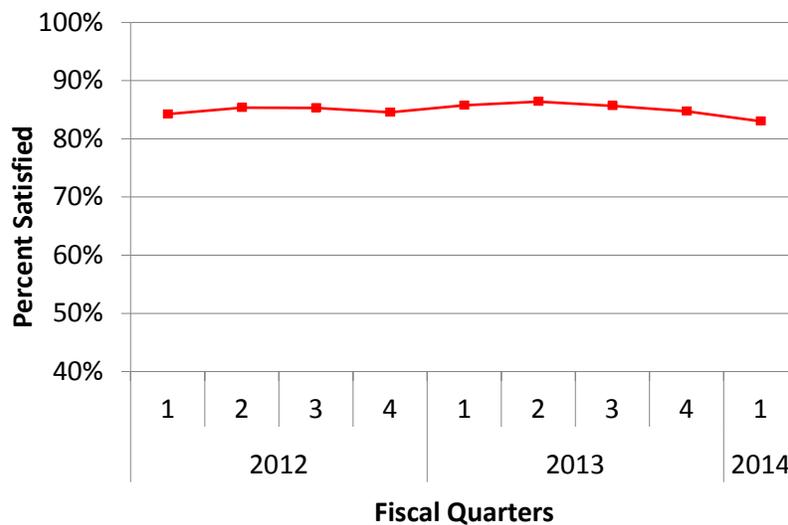
Patient Satisfaction Surveys

The Army, Navy and Air Force each measure patient satisfaction with access to care through Service-specific surveys. Additionally, the DoD evaluates patient satisfaction with access to care through the results of two surveys, TRICARE Outpatient Satisfaction Survey (TROSS) and Health Care Survey for DoD Beneficiaries (HCSDB).

Service-Specific Survey Results: Each Service has a patient satisfaction survey that asks about patient satisfaction with "getting care when needed." Service surveys have averaged 85 percent satisfaction with this question over the last two years. Service-specific surveys average 636,000 responses annually (25-percent response rate) (see Figures 3.20 and 3.21).

In the direct care component, analysis demonstrated a correlation between both lower average number of days to third next acute and third next routine appointments and higher PCM continuity. It also showed a lower average number of days to third next acute and third next routine each correlated with higher patient satisfaction. Finally, higher PCM continuity correlated with higher patient satisfaction. (See Appendix 3.11 for correlation analyses.)

Figure 3.20 Satisfaction with "Getting Care When Needed" (Service Surveys) Overall, FY12 Q1 – FY14 Q1

2014 MHS Review Group
Source: Air Force Service Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS);
Patient Satisfaction Survey (PSS), June 2014

Figure 3.21 Satisfaction with "Getting Care When Needed" (Service Surveys) – By Service*, FY12 Q1 – FY14 Q1
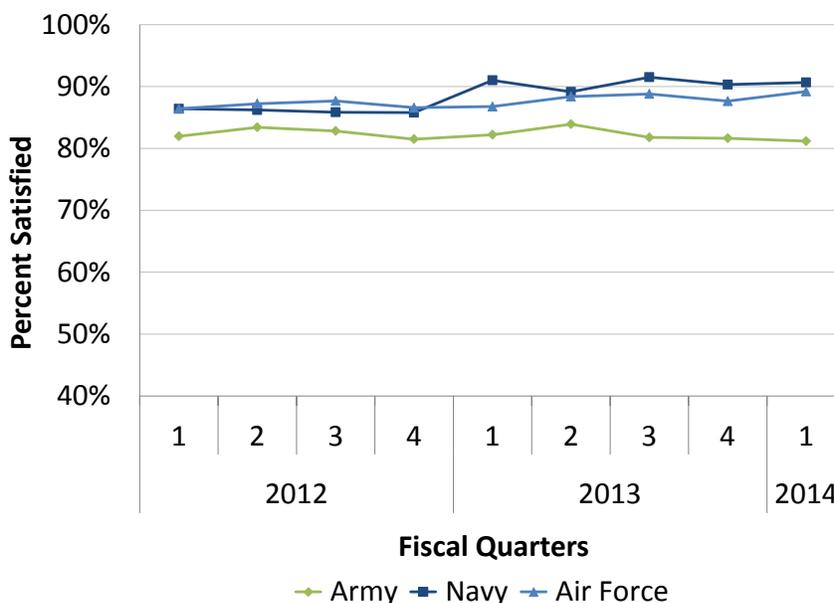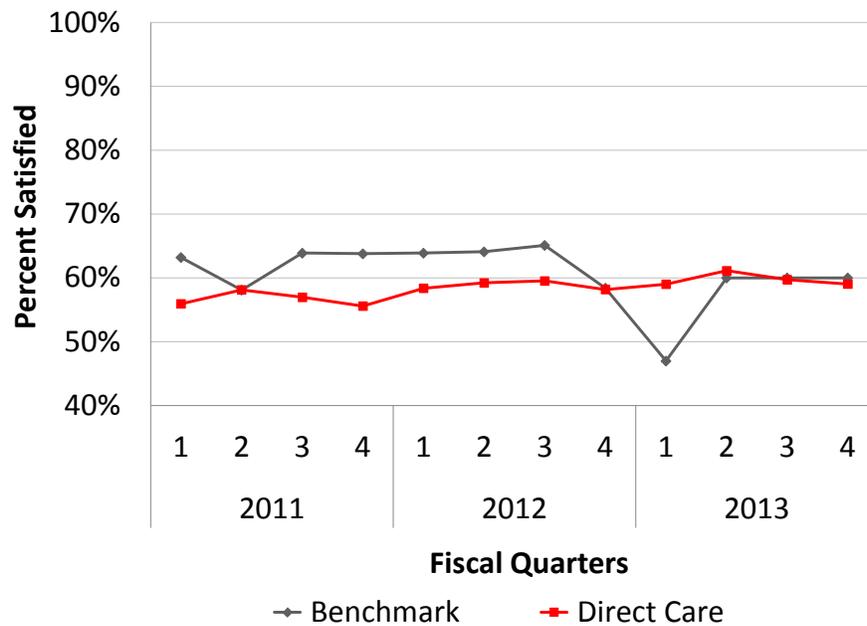

2014 MHS Review Group
Source: Air Force Service Delivery Assessment (SDA); Army Provider Level Satisfaction Survey (APLSS); Patient Satisfaction Survey (PSS), June 2014
*Each Services' patient satisfaction survey collects data using different modes. AHRQ reports that collection modes for patient satisfaction data produce significantly different response rates and satisfaction scores.

TROSS: The TROSS is sent randomly to MHS beneficiaries following outpatient encounters with a MTF (including DHA facilities) or civilian provider. Respondents include TRICARE Prime enrollees and those not enrolled but eligible for TRICARE through other plan options, such as TRICARE Standard or Extra. Responses are defined as direct care if the patient received the outpatient care at an MTF and purchased care if the care was received from a civilian provider, regardless of the patient's TRICARE plan. In this report, two TROSS questions are evaluated, one composite and one standalone question (Note: satisfaction with network access is analyzed in the purchased care section). TROSS metrics are compared to benchmarks established by AHRQ through the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The MHS compares to the CAHPS 75th percentile for its TROSS access to care composite. There is no benchmark for the TROSS question asking whether the patient gets care when needed. (See Appendix 3.11 for specific questions asked on the TROSS and HCSDB including the CAHPS percentiles.)

TROSS Overall Access to Care: Over three quarters of FY 2013, the average satisfaction ratings for direct care matched the contemporaneous CAHPS benchmark of 60 percent (see Figures 3.22 and 3.23). Only the NCR MD demonstrated substantial variation, falling below the CAHPS benchmark. TROSS surveys average 64,700 responses annually with a response rate of 19.2 percent for the direct care component.

Figure 3.22 TROSS – Satisfaction with Access to Care – Direct Care, FY11 Q1 – FY13 Q4

2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014
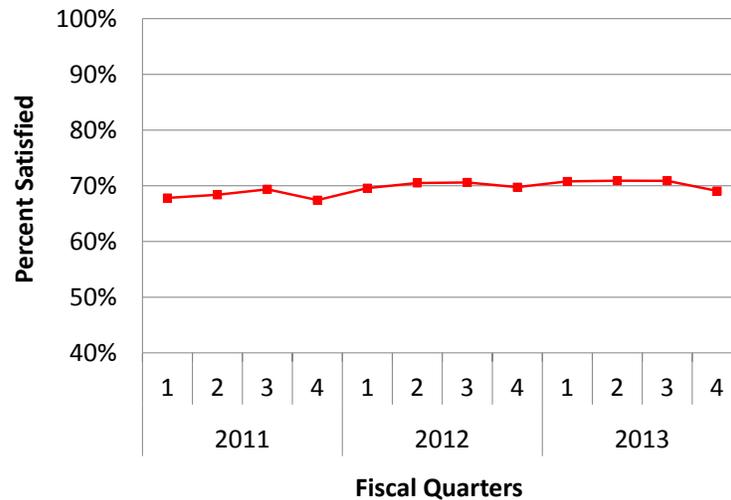*Benchmark changes quarterly

Figure 3.23 TROSS – Satisfaction with Access to Care – By Service, FY11 Q1 – FY13 Q4
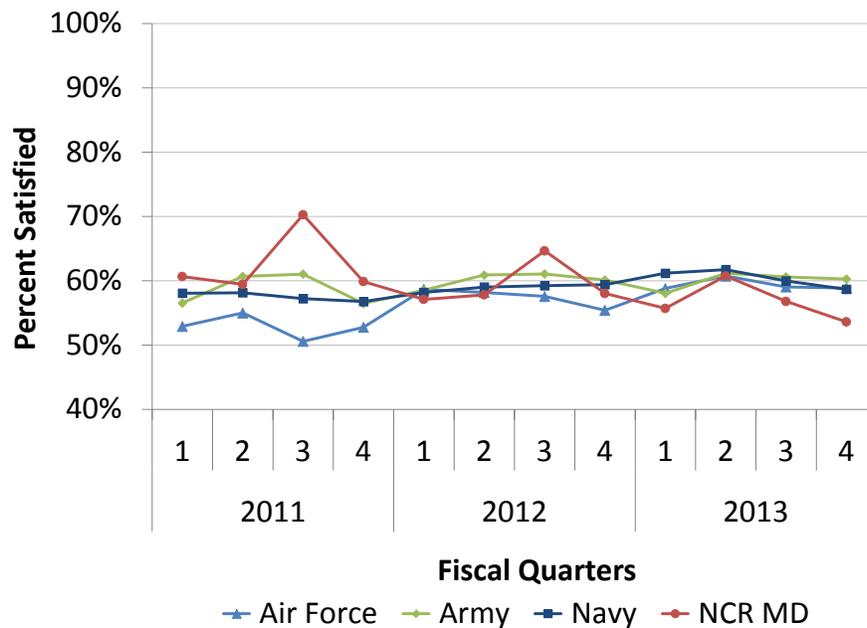
2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Seeing Provider When Needed. Figures 3.24 and 3.25 display patient satisfaction with "seeing provider when needed." Across the direct care component, beneficiaries report higher satisfaction with "seeing provider when needed" than with their overall access. There is no CAHPS benchmark for this measure of satisfaction.
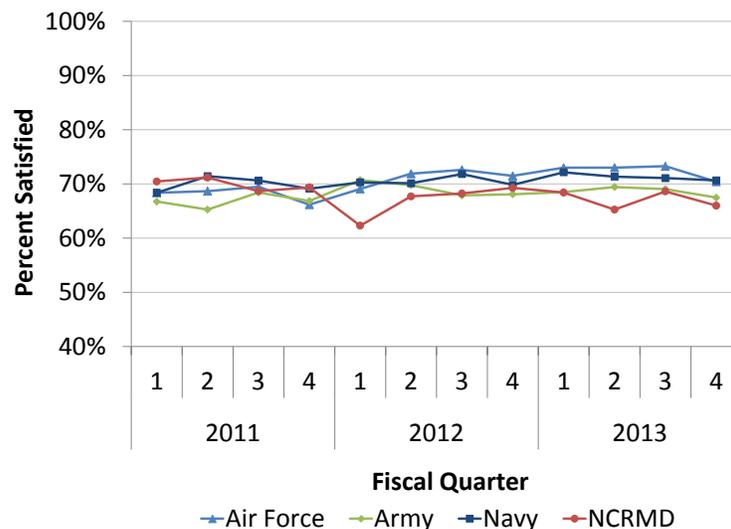
Figure 3.24 TROSS – Satisfaction with "Seeing Provider when Needed." Direct Care, FY11 Q1 – FY13 Q4

2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Figure 3.25 TROSS – Satisfaction with "Seeing Provider when Needed," by Service, Direct Care, FY11 Q1 – FY13 Q4
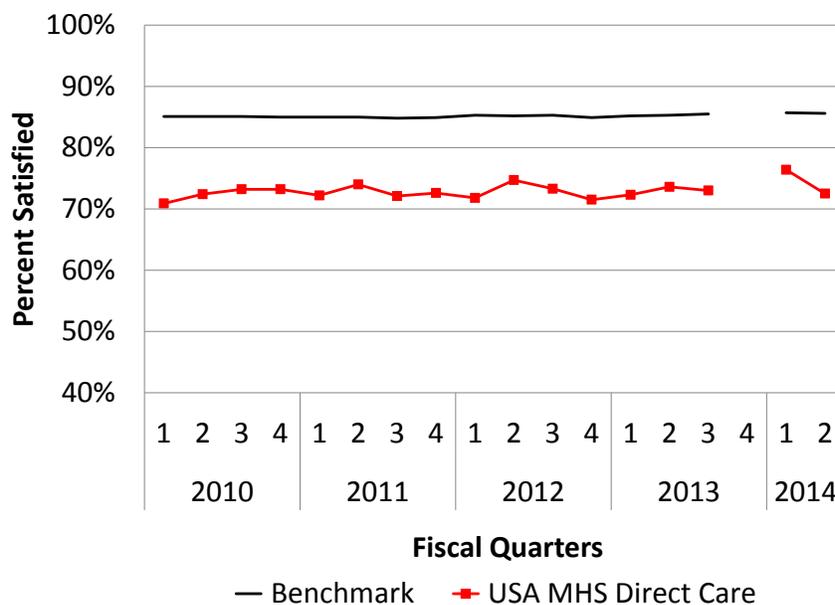

2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

TROSS Patient satisfaction with "seeing provider when needed" is higher than overall satisfaction with access. This indicates that satisfaction with supplemental ATC measures included in the overall access composite, such as time spent in the waiting room and communication with a provider, contribute substantially to the overall access to care score. The degree to which these factors contribute to a patient's perception of access should be further analyzed.

HCSDB: HCSDB is sent randomly to all MHS-eligible users and non-users, independent of whether they had a recent encounter. Respondents include those enrolled to TRICARE Prime (MTF and network enrollees) and non-enrolled beneficiaries who may receive care in MTFs or through the purchased care system. For this report, only the HCSDB results for Prime enrollees are presented (Note: Prime beneficiaries enrolled to the network are presented in the purchased care section). Beneficiary responses to two composite questions that address the beneficiary's ability to "get care quickly" and "get needed care" are evaluated. The HCSDB response rate is 18 percent. (See Appendix 3.12 for questions and CAHPS benchmarks.)
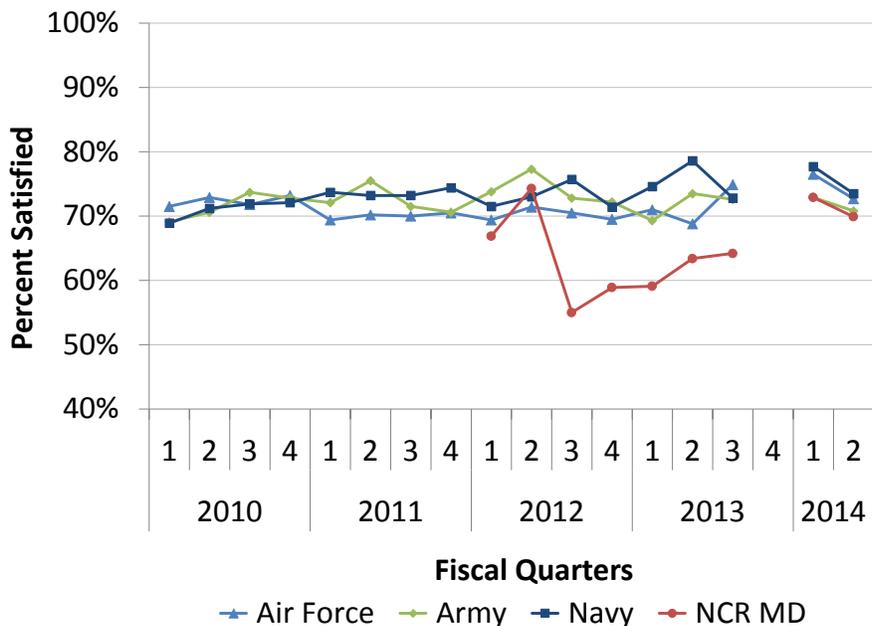
HCSDB Getting Care Quickly. Satisfaction with "getting care quickly" has remained relatively constant over time. Over the past four years MTF-enrollee satisfaction ranges from 71 to 74 percent and is below the CAHPS benchmark of 86 percent. Figures 3.26 and 3.27 display Service-level satisfaction with "getting care quickly". Three of the Services remained relatively constant over time, although the NCR MD demonstrates variation in satisfaction and has lower satisfaction with "getting care quickly" than the other Services. There were no HCSDB data available in FY 2013 Q4. No information was available on the number of HCSDB respondents or response rate.

Figure 3.26 HCSDB – Satisfaction with "Getting Care Quickly", FY10 Q1 – FY14 Q2

2014 MHS Review Group
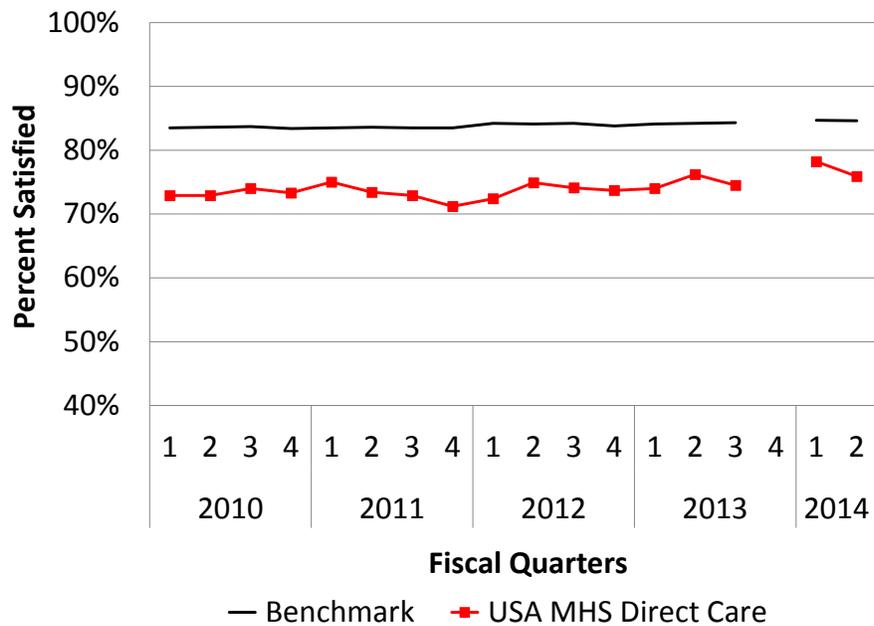Source: Health Care Survey of Department of Defense Beneficiaries (HCSDB), June 2014

Figure 3.27 HCSDB – Satisfaction with "Getting Care Quickly" – by Service, FY10 Q1 – FY14 Q2

2014 MHS Review Group
Source: Health Care Survey of Department of Defense Beneficiaries (HCSDB), June 2014

HCSDB Getting Care When Needed. Patient satisfaction with "getting care when needed" does not differ greatly from satisfaction with "getting care quickly." Over the past four years, MTF-enrolled patient satisfaction ranges from 71 to 76 percent and has remained below the CAHPS benchmark of 85 percent in each quarter. Figures 3.28 and 3.29 display Service-level satisfaction with 'getting care quickly". On average, the Services have remained at or above 70 percent satisfaction for the past four years while the NCR MD remained below 70 percent until the most recent survey quarter. No information was available on the number of HCSDB respondents or response rate.

Figure 3.28 HCSDB – Satisfaction with "Getting Care When Needed", FY10 Q1 – FY14 Q2

2014 MHS Review Group
Source: Health Care Survey of Department of Defense Beneficiaries (HCSDB), June 2014

Figure 3.29 HCSDB – Satisfaction with "Getting Care when Needed" – by Service, FY10 Q1 – FY14 Q2
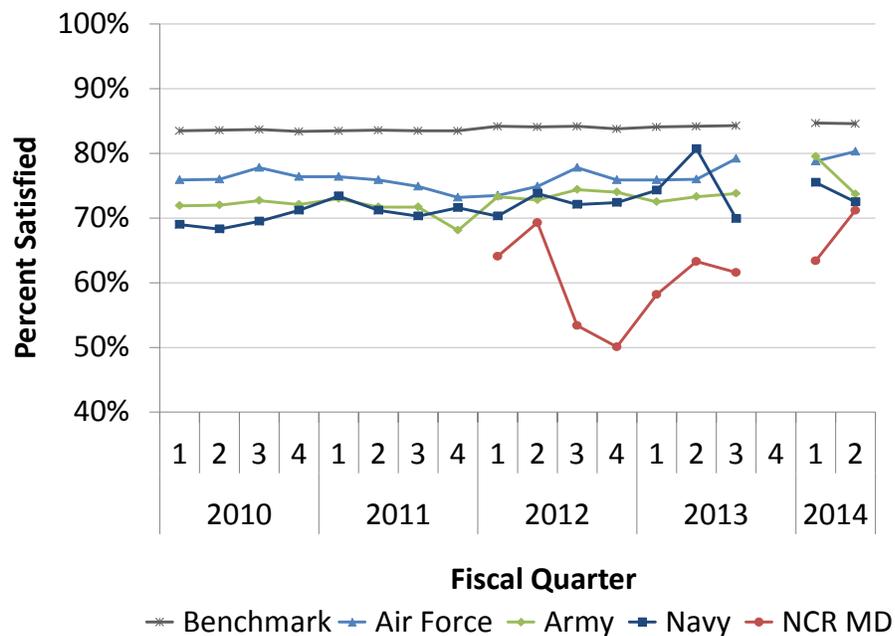
2014 MHS Review Group
Source: Health Care Survey of Department of Defense Beneficiaries (HCSDB), June 2014

Purchased Care

TRICARE Prime beneficiaries are entitled to seek medical care in the purchased care sector if that care is not available at the MTF. The current TRICARE contracts do not require TRICARE regional contractors to provide the same level of data on access to care as is available in the direct care component. The TRICARE regional contractors do not collect primary care access data; however, they do report the percent of specialty appointments meeting the MHS access standard. In addition, there is variation in reporting among the TRICARE regional contractors.

Each of the three regional contractors in the United States is required to develop a network of contract providers to serve Prime beneficiaries living within 40 miles of an MTF (Prime Service Areas [PSA]). This same network of providers also serves as the TRICARE Extra network for beneficiaries using TRICARE Standard. Although regional contractors are not required to contract with providers outside of PSAs, they are encouraged to do so to further expand the TRICARE Extra network. To evaluate whether patients receive a high degree of access to network providers in the United States, several measures are analyzed, including network adequacy (number of network providers and drive time to a provider), 28-day Access Standards Reports provided by the contractors, and patient satisfaction.

Overseas network care is managed by the TOP contractor, International SOS. Data indicating whether 28-day access standards are met are not available; however, the robustness of a network can be assessed based on the number of contracted providers and the percentage of claims paid to network providers. Survey data are also collected to determine whether patients are satisfied with network care overseas. Like in the United States, if a specialist is not available, the contractor is contractually responsible for locating a non-network provider.

### Network Adequacy (United States)

In the United States, the number of contract network providers within a PSA is based on the TRICARE-eligible beneficiary population within that PSA. Figures 3.30 and 3.31 show the number of providers per enrolled beneficiary within each region's PSAs. Most of the increase in the number of providers per enrolled beneficiaries is largely attributed to the change to the new contractor in the West region, which has a larger network of providers. It should be noted that these figures represent network providers. In cases where a contracted specialist is not available, the contractor has contractual responsibility to locate a non-network provider for Prime-enrolled beneficiaries. Since FY 2011, more than 97 percent of referrals were to a network provider or the MTF in each of the three regions, with only 3 percent to non-network providers.

Figure 3.30 Primary Care Providers per 1,000 Enrolled Beneficiaries (Restricted to beneficiaries living in Prime Service Areas), FY11 Q1 – FY13 Q3
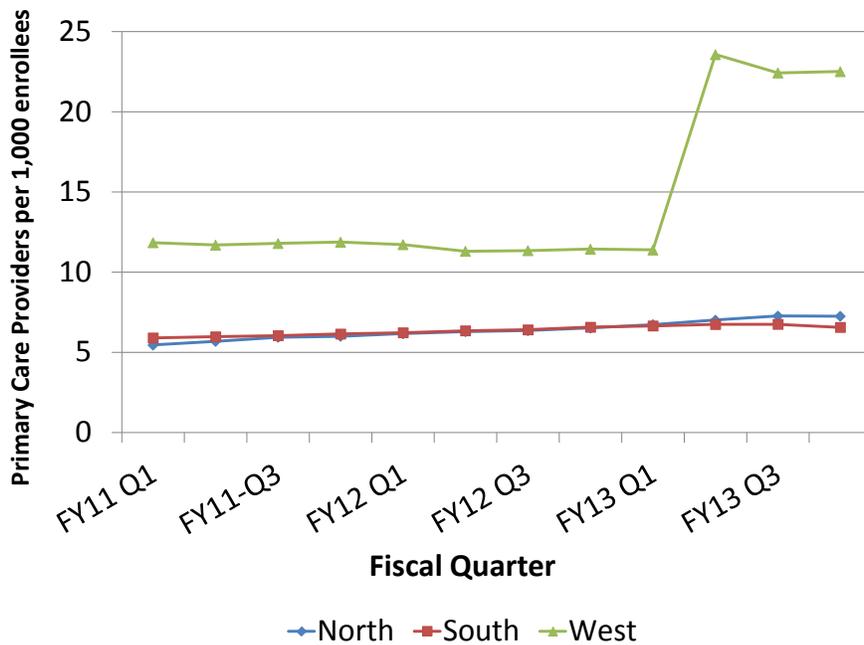
2014 MHS Review Group
Source: Regional Managed Care Support Contractors Data System, June 2014

**Figure 3.31 Specialty Care Providers per 1,000 Enrolled Beneficiaries (Restricted to beneficiaries living in Prime Service Areas), FY11 Q1 – FY13 Q3**
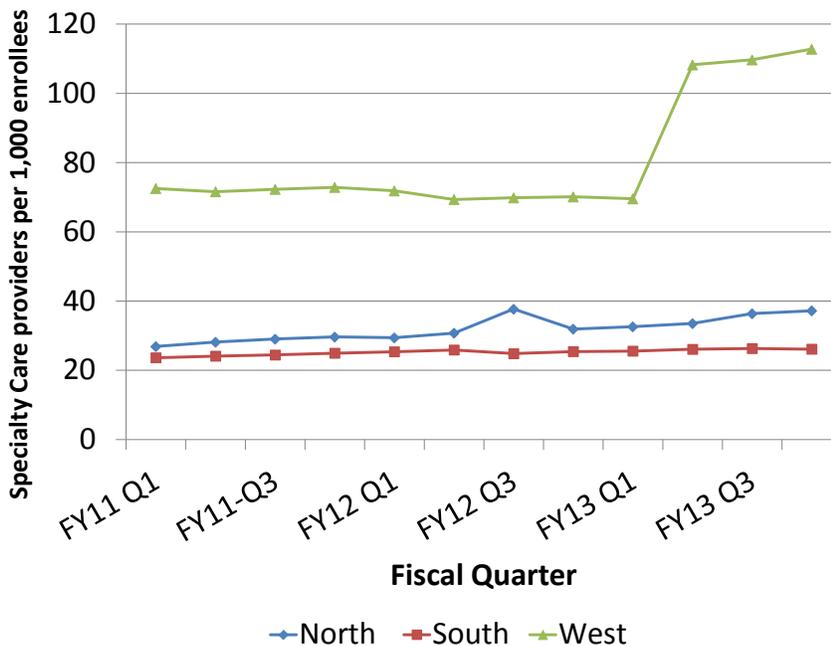
2014 MHS Review Group
Source: Regional Managed Care Support Contractors Data System, June 2014

The percentage of patients driving greater than 60 minutes for a specialist appointment is another measure to evaluate network adequacy. Contractors are required to refer patients to non-network providers before requiring the patient to drive greater than 60 minutes. If a specialist is not available within 100 miles of the patient's PCM, the Prime Travel Benefit provides reimbursement for travel expenses. Figure 3.32 indicates that in 81 of the 102 PSAs, patients are able to see a specialist within 60 minutes of their home over 90 percent of the time. In six PSAs, patients must drive more than 60 minutes over 25 percent of the time.

Figure 3.32 Percent of Patients in a PSA Required to Drive More than 60 Minutes to see a Specialist
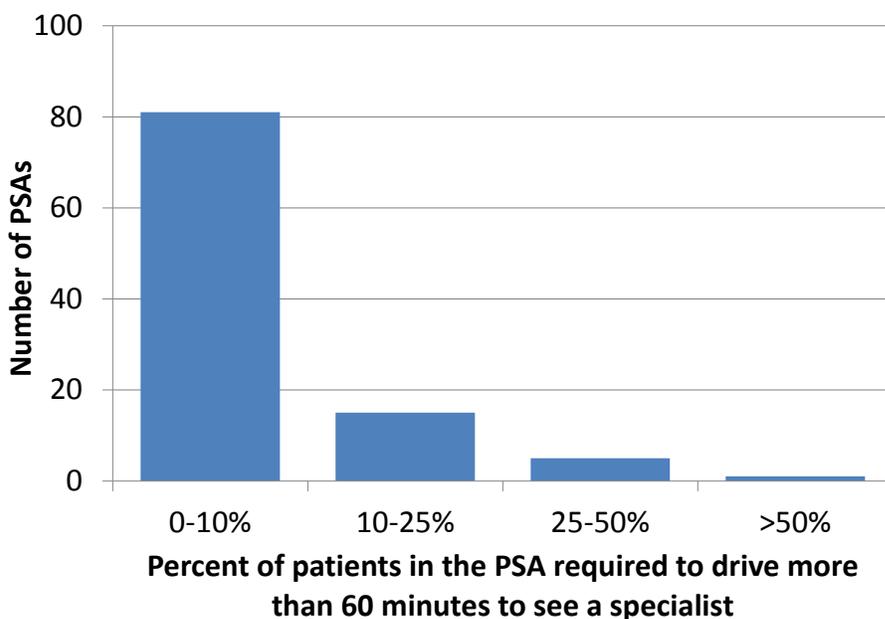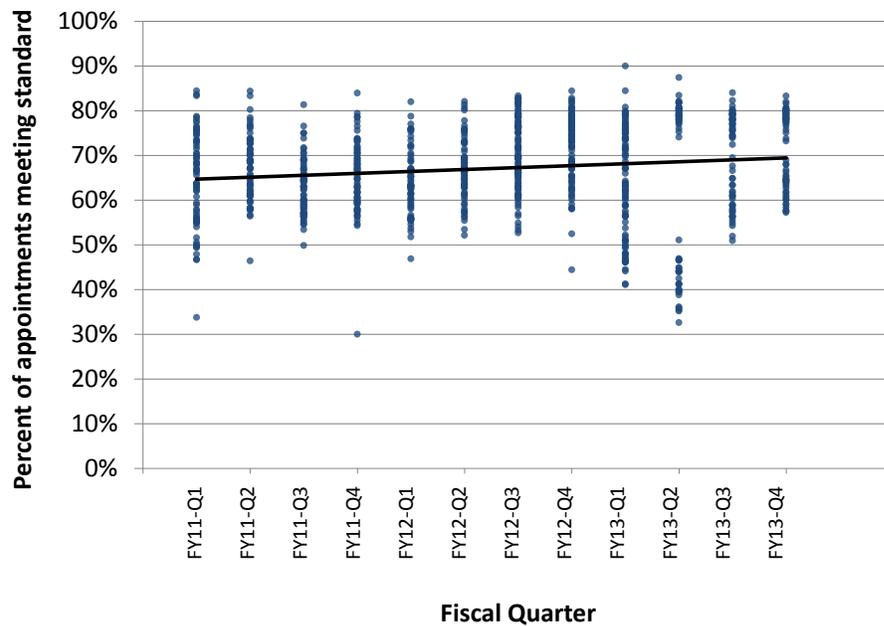

2014 MHS Review Group
Source: Regional Managed Care Support Contractors Data System, June 2014

28-Day Access to Network Care (United States)

Network compliance with specialty care access standards is measured by the percentage of specialty referrals with an appointment within 28 days. This measure includes all referrals originating within an MTF and sent to a network provider, as well as those referred from within the network. This metric does not take into account the administrative time to process the referral and is based on when the patient made the appointment; these two factors may contribute to the appointment being outside the 28-day standard. The 28-day access standard is tracked within the 102 PSAs. Figure 3.33 plots the percentage of referrals meeting the 28-day access standard for each PSA. In FY 2013, an average of 68 percent of specialty appointments met the MHS access standard and there is an upward trend in the number of specialty appointments meeting the 28-day standard. There is variation across PSAs with averages ranging from 53 percent to 84 percent.

Figure 3.33 Percentage of Network Referrals Meeting 28 Day Access Standard, by PSA (Each point represents one PSA), FY11 Q1 – FY14 Q4

2014 MHS Review Group
Source: Regional Managed Care Support Contractors Data System, June 2014

Patient Satisfaction with Network Access to Care (United States)

Satisfaction with access to care in the network is measured by TROSS and HCSDB. The results in Figure 3.34 and Table 3.5 demonstrate that patient satisfaction with access to care in the network is consistently close to CAHPS benchmarks. Note that HCSDB results are available through Q2 of FY 2014, but TROSS results are only available through FY 2013. The break present in the HCSDB results is because the survey was not fielded in Q4 of FY 2013.

Figure 3.34 U.S. Network Satisfaction: Four Satisfaction Measures, FY10 Q1 – FY14 Q1
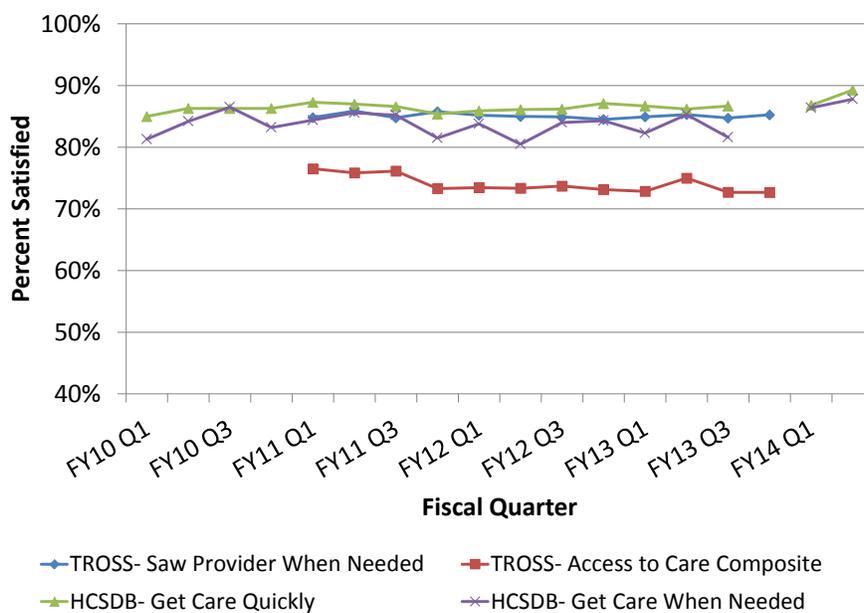
2014 MHS Review Group
Source: Department of Defense TRICARE Outpatient Satisfaction Survey (TROSS), June 2014

Table 3.5 CAHPS Benchmarks

Benchmark	Percent
TROSS-Access to Care Composite (FY 2013)	60%
HCSDB-Get Care Quickly (FY 2014)	86%
HCSDB-Get Care When Needed (FY 2014)	85%

2014 MHS Review Group
Source: Consumer Assessment of Healthcare Providers and Systems, June 2014

Access to Network Care (Overseas)

Network adequacy overseas is measured by the number of providers and the percent of referrals seen by a network provider. The total number of network providers has remained stable since 2012 at approximately 9,300, and more than 83 percent of the claims processed were from TOP network providers. Any TOP-enrolled beneficiary who cannot be appointed to a network provider is referred to a non-network provider.

Overseas network satisfaction is also evaluated through patient survey data. The two questions are:

1) If you were referred to a specialist in the last 60 days, how satisfied were you with International SOS' coordination of the referral?

2) If you received services from a civilian network provider, how satisfied were you with the service you received?

Figures 3.35 and 3.36 display quarterly results for these two questions. Responses are measured on a 1-6 scale, with 6 being "completely satisfied." The mean satisfaction score for civilian network providers and specialists is close to 5, increasing slightly over 3 years. Since this is a unique military contract, the data can only be compared with previous satisfaction surveys.

Figure 3.35 Satisfaction with International SOS Coordination of Specialty Care, FY11 Q2 – FY13 Q4
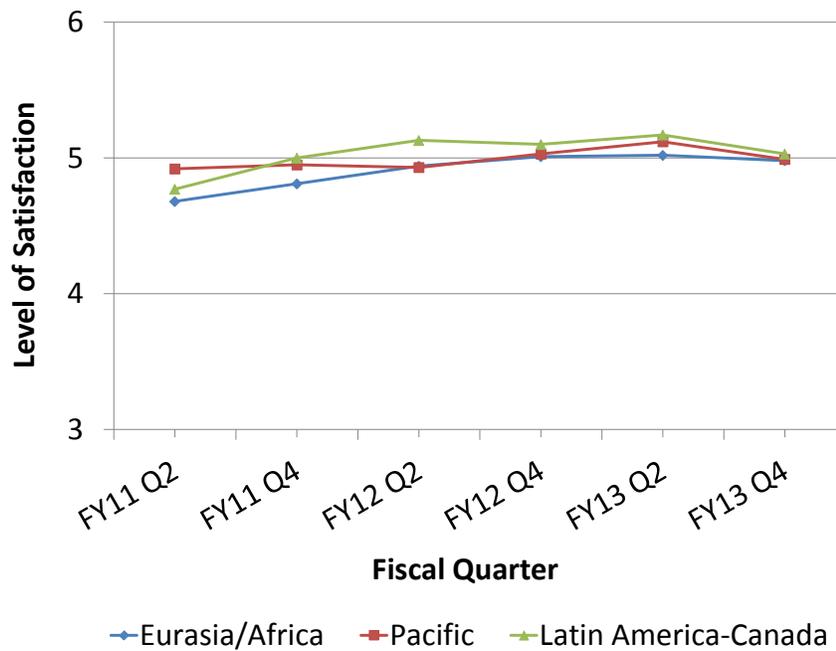
2014 MHS Review Group
Source: TRICARE Overseas Program Contractor Data Systems, June 2014

Figure 3.36 Satisfaction with Civilian Network Care, FY11 Q2 – FY13 Q4
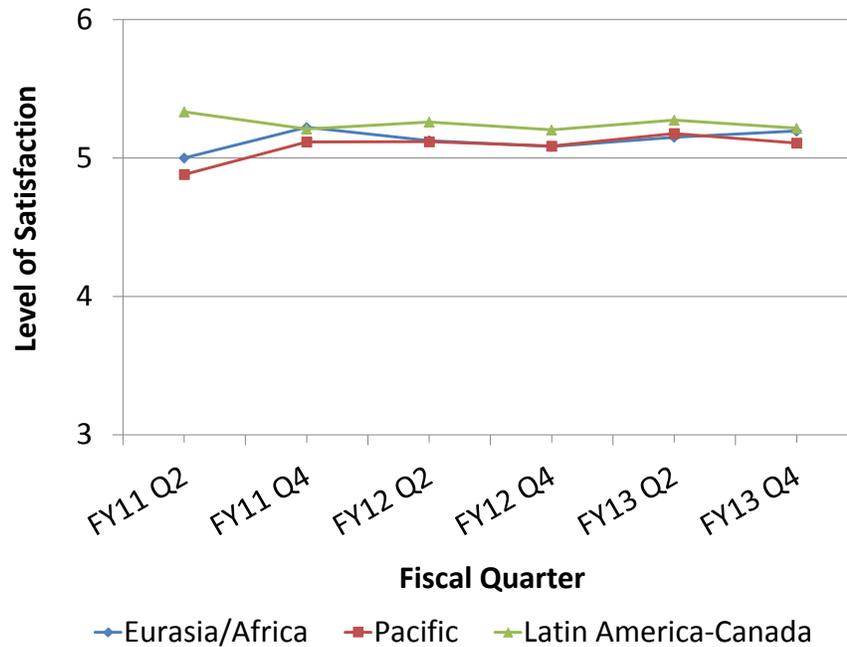
2014 MHS Review Group
Source: TRICARE Overseas Program Contractor Data Systems, June 2014

Site Visit Information

Introduction

The site visits were conducted to validate if the access to care data correlated with execution of policy, performance measures, and patient experiences. The site visits demonstrated that MTF executive leadership, as well as clinic leadership and staff, are aware of their patients' experiences and perceptions of access at the majority of sites. It was also apparent that there is a patient-centered culture driven by the leadership of every facility, as witnessed during the executive leadership sessions.

The patient-centered culture was repeatedly observed when clinics found a way to get a patient the care they needed despite there being limited or no appointments available. Rather than ask the patient to call back at a later time or date, scheduling clerks, nurses, and providers would collaborate to identify options for the patient to obtain care. As an example of patient-centeredness, one MTF provides patients with historical average wait times for network care to assist the patient in making an informed decision about where they would like to be seen. It is standard practice across all seven MTFs to schedule any patient follow-up visit at the clinic checkout desk before the patient departs. If this was not possible (e.g., the requested follow-up appointment date was beyond the published schedule), a reminder list was employed by several clinics. Though these lists were not used by all MTFs, those that were used were managed appropriately, allowing the MTF to effectively facilitate future appointments.

Most sites had a centralized access management group that monitored all clinics and provided regular access analysis and training down to the clinic leadership level. Staffing of these functions varied among sites. Although leadership was keenly aware of the information the access to care management group provided, most of the frontline staff was unaware of clinic performance.

Regional and Headquarters Leadership Survey

The Regional Headquarters leadership completed a survey to capture its perspectives on subordinate facility performance and processes. The survey included eight questions on access, five scored on an objective Likert scale and three with a narrative. The Likert scale responses from worst to best: Not at all, partially, neutral, effective, and very effective. On the five objective questions, the headquarters indicated an 83-percent level of confidence that subordinate MTFs performance relative to access is "effective" or "very effective." On the narrative questions, the regional level reported focused efforts on regular performance reviews with initiatives to improve access.

On-site: Leadership, Staff, Patients

MTF leadership demonstrated several initiatives focused on improving access to care, including informing executive and other MTF staff members on performance to drive improvement. These initiatives included presentations to the executive leadership by clinic managers, provider scorecards based on performance metrics, and updates at weekly clinical business forums. Other initiatives focused on changing daily operations to be more patient-centered, including modification of operating hours and provider duty hours as well as employing providers dedicated to seeing walk-ins.

MTF leadership and staff across the majority of facilities were aware of specific access issues, which appeared to be aligned with their patients' perceptions of access. Most of the MTFs relied on the purchased care network to meet patients' same day primary care needs when appointments were no longer available. While all sites had processes for referring to either an UC center or neighboring MTF, the majority of patients expressed that they prefer to be seen in the MTF and are more satisfied with the care they receive when seen by their PCM. Same day access is also limited due to staff members converting same day appointments to accommodate follow-up needs. In a few clinics, same day appointments are only opened first thing in the morning, so patients are told to call back to get a same day appointment. While staff usually followed the UC referral processes when unable to offer an appointment during the initial contact, staff and patients acknowledged that patients are asked to call back on occasion. Additionally, the move to a simplified appointment system in primary care has caused confusion in the use of specific appointment types related to appointment time frames (routine versus follow-up care). This confusion was not apparent in specialty clinics; however it was noted that there are no standards for the time to procedure.

The greatest challenge faced by the smaller facilities visited is staffing shortages, some of which are brought on by the annual permanent change of station season, but also by other unavoidable events, including resignations, furloughs, retirements, illness/injury, and deployments. Same day

appointment availability is most heavily affected by these shortages. Additionally, the civilian employee hiring process is lengthy and cumbersome, which is a key factor in access degradation in some of these facilities.

Patients at a few sites stated that access to specialty care within the network or other direct care facilities in the area was inconvenient. While the complaint was related to the driving distance involved either in highly congested areas or very remote areas, it was still within the 60-minute drive time standard. One active duty member from an operational platform expressed frustration at navigating the system to see a specialist.

TOL and SM are demand management tools that can be used to reduce face-to-face appointments and access demand, in addition to increasing patient convenience. There was variance in prioritizing web-enabled appointing and education of TOL. On the other hand, SM is becoming increasingly useful to MTFs and the majority of sites are aggressively marketing its functionality for patients. MTFs have increased enrollment in SM by 38 percent in the last year. All MTFs would benefit from increased marketing and utilization of both the TOL appointing function and the use of SM for enhanced patient access to primary care; increased TOL appointing allows patients to book 24 hours a day, seven days a week, rather than just when the appointment desk is open during duty hours and allows patients to communicate and have virtual visits with their PCM in lieu of face-to-face visits.

Site Visit Survey Results

In reviewing the data from the site visit surveys, it is evident that regional headquarters and MTF leadership are aligned in their understanding of access within the MTF (Figure 3.37). At most MTFs, there was equal knowledge of access practices and performance between MTF mid-level managers and the clinic staff interviewed. At all but two sites, the perspectives of the subject matter experts (SMEs) and staff are in line with the patients' perspectives. Of note, at one of these two sites, patients and staff had a more positive view of access than did the SMEs.

Figure 3.37 Access: Perceptions Among Regional Headquarters, MTF Leaders, Subject Matter Experts (SMEs), Staff Members and Patients During Seven MHS Site Visits, 2014
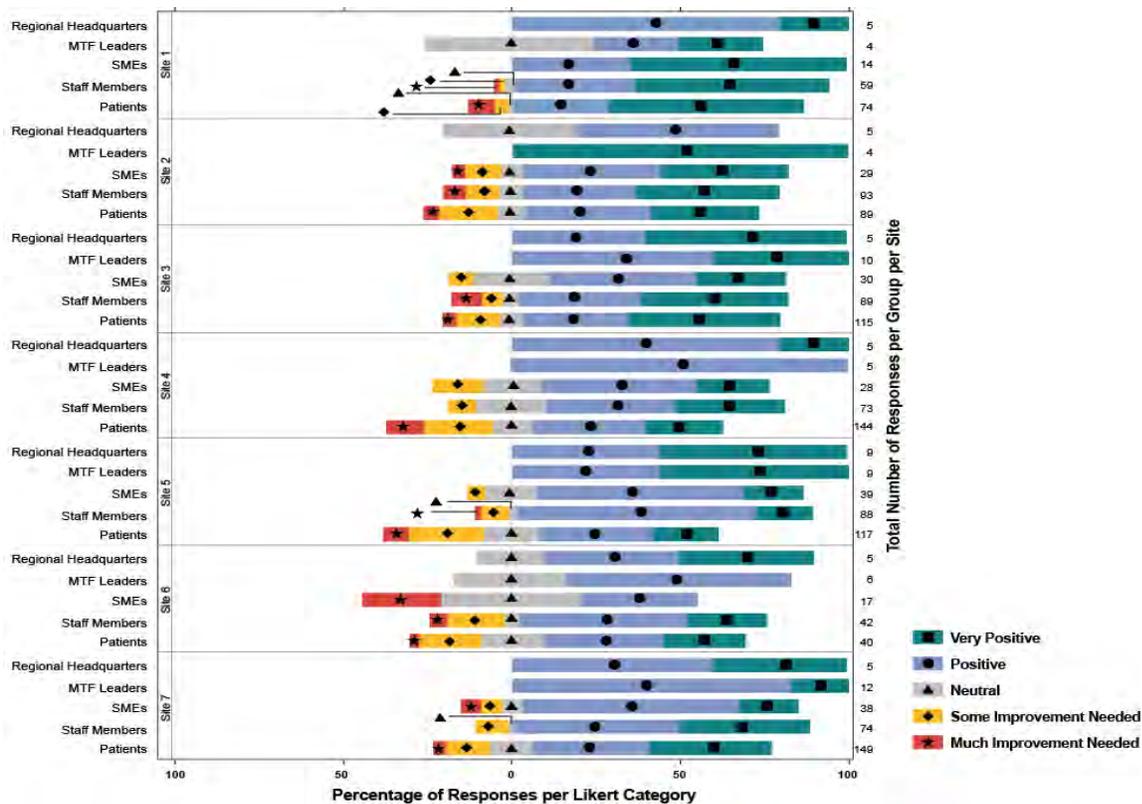
2014 MHS Review Group
Source: MHS Site Visit Survey, June - July 2014

Staff Town Halls

Staff town halls were conducted to assess staff knowledge and experience with access policies and procedures. The theme across all sites indicated there are various levels of success and challenges in meeting access standards. Staffing shortages (seasonal and persisting) and variations in schedule management practices among clinics were most often cited as challenges to meeting demand. Several comments indicated that schedules fill up very quickly after being released. Staff in primary care and specialty care often had different perspectives and challenges. Staff demonstrated good understanding of access issues within their areas and is doing everything within their control to take care of the beneficiary.

Beneficiary Town Halls

Beneficiary town halls included a mix of beneficiary categories and were conducted to assess experience with access to care at the MTF and in the purchased care component. An identified theme at the site visits was that patients expressed difficulty in obtaining appointments. Of the 100 comments about access, 29 percent of responses were positive and 71 percent were negative. Identified problem areas included difficulty in getting an appointment when wanted, being told

to call back for an appointment, or difficulty in obtaining a specialty appointment. A variety of primary and specialty care clinic types were identified at town halls as presenting access challenges; no single clinic type was consistently identified. Some beneficiaries expressed challenges when they called the MTF appointment line and were more successful in obtaining an appointment when they went to the clinic in person. In addition, beneficiaries at several sites reported they were referred to an ED or UC center to obtain care when acute appointments were not available at the MTF. Beneficiaries reported SM is a welcome addition and a useful option for contacting their provider. They also expressed a wish that more providers would use SM. Overall, the participating beneficiaries expressed a range of experiences that identified areas of MTF performance that should be sustained and others that should be improved.

Access to Care: Overall Findings and Recommendations

Based on the analysis of MHS access data, the MHS provides ready access to medical care as defined by access standards in policies and guidance of HA, the military medical departments, and in TRICARE contract specifications. In accordance with DoD's access standards, MTFs have made significant progress in the last three years to increase MTF access to care capacity within the direct care component. The majority of patients in the direct care component receive medical care within MHS access standards. In addition to face-to-face encounters, the direct care component has multiple modalities for accessing care and assistance, including Secure Messaging, TRICARE On-Line, and a purchased care safety net. Satisfaction surveys demonstrate that the majority of patients reported being satisfied with access to care. There is variance between satisfaction scores in the direct care and purchased care components, depending on which survey tool is used. In addition, the town hall respondents reported instances of access challenges, which present opportunities for further exploration and improvement. Access policy has achieved significant standardization in primary care over the past four years. Vertical alignment in access policy is noted, and site visits revealed a strong patient-centered culture across all levels of staff.

Specific findings are provided below:

1. The MHS provides ready access to medical care as defined by access standards in the policies and guidance of HA, the military medical departments, and in TRICARE contract specifications.
2. The review looked at specialty care as a whole, not individual product lines. Variance in specialty care business practices was noted on site visits.
3. There is variation in business process standardization, as evidenced in town hall meetings where some patients reported difficulty in getting an appointment or were asked to call back for an appointment.
4. 32 C.F.R. § 199.17 requires a level of detail not available for the purchased care component under current TRICARE contracts. While data are limited, the surrogate access measure is patient satisfaction. There are no access data available for non-Prime enrolled beneficiaries (TRICARE Standard / Extra). In the review, it was noted that the GAO and DoD IG reports focused on access for non-enrolled beneficiaries in the

74

purchased care component; however, none focused on access for TRICARE Prime enrollees.

5. There are multiple patient satisfaction survey tools (Service-specific surveys, TROSS, HCSDB) used across the MHS with varying response rates and results.
6. There is variation in reporting of purchased care access data from each of the TROs to the Services.
7. There is no standardized MHS measure for evaluating office waiting times, as required by 32 C.F.R. § 199.17.
8. There is variation in the promotion of SM and TOL as methods for enhanced access to care in the direct care component.
9. Each Service has developed its own training courses for access, clinic, and group practice management. The Services' customer service training is not standardized.

Recommendations to Improve Access to Care

1. **MHS governance should increase the focus on the standardization of specialty care in the direct care component through the following: a) create the Tri-Service Specialty Care Advisory Board, b) fund requirements to standardize specialty product lines, c) establish business rules for access, and d) define performance review metrics for specialty care product lines.**
2. **MHS governance should standardize MHS direct care component access to care business practices by replacing the MHS Guide to Access Success with a MHS policy memorandum and subsequent DoD Instruction.**
3. **MHS governance should commission an external study to evaluate purchased care access for TRICARE Prime enrollees as it relates to 32 C.F.R. § 199.17. This study should include a review of all available data and recommend metrics for incorporation into current and future TRICARE contracts.**
4. **MHS governance should continue implementation of the Joint Service survey tool, refining access satisfaction questions to include satisfaction with office wait times.**
5. **MHS governance should standardize reporting on access from the TRICARE Regional Offices to the Services.**
6. **MHS governance should promote Secure Messaging and TRICARE On-Line through direct care component standardized business processes and a strategic marketing approach.**
7. **MHS governance should standardize both access to care and customer service training across the direct care component.**

This page left intentionally blank.