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SECRETARY OF THE AIR FORCE**



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**ACCESS TO CARE CONTINUUM**

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**AFMS Access to Care Policy and Procedures**

This publication implements AFPD 44-1, *Medical Operations*. It provides guidance and procedures for Access to Care (ATC) operations within the Air Force Medical Service (AFMS). It establishes the roles, responsibilities, definitions and requirements for implementing, sustaining and managing ATC for AFMS Military Treatment Facilities (MTFs). Organizational alignment of these functions may vary between MTFs. It applies to individuals at all levels including the Air Force Reserve and Air National Guard (ANG), contract personnel and volunteers who are working in military treatment facilities except where noted otherwise. This publication may be supplemented at any level, but all supplements are routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the AF Form 847, Recommendation for Change of Publication; route AF Forms 847 from the field through the appropriate chain of command. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, and T-3”) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of IAW the Air Force Records Disposition Schedule (RDS) in the Air Force Records Information Management System (AFRIMS). Program Managers have a legally approved records disposition per the eGovernment Act and National Archives and Records Administration (NARA) Bulletin 2010-02 that governs

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### ***SUMMARY OF CHANGES***

This document has been substantially revised. This rewrite of AFI 44-176 includes: more detailed roles and responsibilities to include GPM and TOPA Flight Commander; more closely aligned with AFI 44-171, *Patient Centered Medical Home Operations*; addition of distinct schedule, template and appointment management sections; inclusion of MHS GENESIS Electronic Health Record (EHR) system; expansion of available schedules to 180 days in sync with proposed MHS guidance; schedule guidance for Graduate Medical Education (GME) residents and their preceptors; demand management and analysis guidance; changes in schedule management and timeframes (to include the elimination of the use of dollar signs in appointment types); inclusion of simplified appointing; first call resolution guidance; referral management; changes in no-show guidance, changes in self-referral appointing instructions; inclusion of consolidated specialty care management guidance; guidance for telephone administration; detailed Nurse Advice Line (NAL) instructions; inclusion of TRICARE Online roles and responsibilities. It is not directed toward dental clinics within the AFMS.

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## Chapter 1

### PROGRAM OVERVIEW

**1.1. Definition of Access To Care (ATC) Management.** ATC management encompasses a myriad of MTF functions and is an integral part of inpatient and outpatient, primary and specialty healthcare delivery. ATC management includes, but is not limited to: day-to-day management of templating, scheduling, and appointing functions, including appointments made by telephone, in-person, electronic secure messaging, and web-based capabilities; information systems management, including provider file and table building, and clinic/provider profile management; empanelment, demand management and analysis; referral management activities; appointing telephony management; and effective and efficient personnel management in support of this mission. ATC also includes the concept of Enhanced Access which encompasses healthcare management of the patient by the entire healthcare team through the use of clinical support staff and non-traditional face-to-face physician/provider visits. Under Enhanced Access, the healthcare team is expanded to include Clinical Pharmacists, Behavioral Health Optimization Program (BHOP) providers, the Base Operational Medical Cell (BOMC), and Medical Management (MM) personnel. Enhanced Access includes the use of Secure Messaging (SM), the Nurse Advice Line (NAL), telemedicine, and direct access Physical Therapy (PT). Enhanced Access will be incorporated into the MTF ATC strategy.

**1.2. Goal of ATC Management.** The goal of ATC management is to implement and sustain a systematic, proactive, programmatic, and responsive access program for all clinics and services across the MTF. MTFs must ensure appointment access meets the standards as stated in Title 32 Code of Federal Regulations 199.17, implemented by the Office of the Secretary of Defense (OSD) in Department of Defense Instruction (DoDI) 6025.20 (Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas). The desired outcome is the patient is provided the right healthcare service, at the right time, in the right setting within a patient centric, not staff centric focus. The right setting may include over the phone, in the office, or virtually, and it may be with a provider other than a physician. (T-0)

**1.3. Objectives of ATC Management.** The objectives of ATC management are to deliver patient-centric access to services, meet mission requirements, and satisfy the wellness needs of beneficiaries. Specifically, the AFMS' access objectives are to:

- 1.3.1. Provide access to healthcare services/appointments within access standards.
- 1.3.2. Achieve patient and staff satisfaction.
- 1.3.3. Provide a patient-centered, first call resolution appointment system.
- 1.3.4. Implement Enhanced Access strategies.
- 1.3.5. Maximize patient-provider continuity.
- 1.3.6. Meet the healthcare needs of beneficiaries.

**1.4. Health Insurance Portability and Accountability Act (HIPAA) Compliance.** MTFs must ensure ATC Management functions comply with the HIPAA privacy and security programs and national standards, including compliance with DOD 6025.18-R, DOD *Health Information Privacy Regulation*, DOD 8580.02-R, DOD *Health Information Security Regulation*, or as superseded by new or revised HIPAA privacy or security regulations and instructions. (T-0)

## Chapter 2

### ROLES AND RESPONSIBILITIES

#### 2.1. The Military Treatment Facility (MTF) Commander will:

- 2.1.1. Provide a supply of primary and specialty care appointments that meet patients' total demand for healthcare within ATC standards; mission and currency requirements; the AFMS' Strategy objectives and performance measures; and contain purchased care costs for services available at the MTF. (T-1)
- 2.1.2. Set standards and procedures to maintain patient continuity with their Primary Care Manager (PCM) in accordance with (IAW) AFI 44-171, Patient Centered Medical Home Operations. (T-2)
- 2.1.3. Establish processes that enable follow up care and initial specialty care appointments for new referrals to be appointed to the direct care system before the patient leaves the MTF. Appointed means the patient has been booked with a time and place for future care. (T-1)
- 2.1.4. Ensure the MTF's Capability and Capacity report is as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs. Retain authority for or assign an Executive Staff member as the approval authority for changes to the MTF's Capability and Capacity report. (T-1)
- 2.1.5. Provide "first call resolution" IAW paragraph 5.7 of this AFI at all central appointment centers, RMCs and clinics that book primary care and initial specialty appointments. (T-0)
- 2.1.6. Appoint the Group Practice Manager (GPM) as the Access Manager. (T-2)
- 2.1.7. Charter a multidisciplinary Access Management Team (AMT) to continuously optimize the MTF's patient-centric ATC strategy. (T-2)
- 2.1.8. Ensure ATC performance measures are briefed monthly at the Executive Committee meeting. (T-2)
- 2.1.9. Publish and market the AFMS no-show standard, IAW paragraph 5.8 of this AFI, to all MTF staff and beneficiaries and ensure it is applied throughout the MTF to enable a consistent patient experience. (T-2)
- 2.1.10. Impress on their staff that the NAL is a DHA-run but Service-led operation which enhances beneficiaries' access to care while giving the MTFs the opportunity to reduce leakage to the network. The MTF will support the NAL in these efforts and will utilize all available staff and resources to develop processes to support and promote NAL usage. (T-1)
- 2.1.11. Ensure MDG personnel are adequately trained to implement NAL processes and initiatives IAW TRICARE NAL Operational Guidance. (T-1)
- 2.1.12. Establish processes to enhance and market the use of Secure Messaging, as well as assign responsibility for Secure Messaging management.
- 2.1.13. Establish processes for the pre-approval of clinical staff to nonclinical positions, as this will impact clinical capacity and capability. Ensure matrixing of clinical staff to



nonclinical positions is kept to a minimum, except for where an adverse action exists per AFI 44-119, *Medical Quality Operations*.

## **2.2. The Access Manager/Access Management Team (AMT) will:**

2.2.1. Be chaired by the GPM. The Chief of the Medical Staff (SGH) will be the alternate chair. The AMT will follow the agenda outlined in Attachment 3 of AFI 44-176. (T-2)

2.2.2. Include at a minimum: the Access Manager, all GPMs, SGH, Chief Nurse (SGN); Administrator (SGA); Health Care Integrator (HCI); Health Service Management 4A Functional or representative; Aerospace Medicine Chief (SGP) or representative; Flight Commanders of all clinics, TRICARE Operations and Patient Administration (TOPA) Flight Commander, the Quality Manager, and the lead appointment agent. (T-2)

2.2.2.1. The Medical Operations Squadron (MDOS), Medical Support Squadron (MDSS) and Aerospace Medicine Squadron (AMDS), and Surgical Operations Squadron (SGCS) Commanders are highly encouraged to participate and/or be members of the AMT.

2.2.3. Meet in-person with AMT members listed in para 2.2.2 above at least monthly to review/coordinate templating, scheduling, appointing, clinic/appointment staffing, provider coverage, supply shortfalls and surpluses, and other clinical operational issues with the goal of optimizing ATC at the MTF. The AMT will discuss process improvement efforts. (T-2)

2.2.4. Review performance measures for all clinics monthly, to include but not limited to: Third Next available appointment (24HR, FTR, SPEC), appointment utilization, demand management purchased care leakage, patient satisfaction, telephony metrics, no-show metrics, first call resolution results, PCM continuity measures, and NAL metrics. (T-2) See Attachment 3 for full list of measures to be reviewed at the AMT.

2.2.5. Document evidence of meeting occurrence (i.e. slides and sign-in roster). Formal meeting minutes are encouraged but not required. (T-2)

2.2.6. The AMT will review the Nurse Advice Line (NAL) sustainment plan annually. (T-2)

## **2.3. The Group Practice Manager (GPM) will:**

2.3.1. Chair the AMT. (T-2)

2.3.2. Recommend access improvement strategies and at minimum report deficient access-related performance measures/results to the Executive Committee at least monthly through the AMT in accordance with paragraph 2.2.4 above. (T-2)

2.3.3. Monitor/analyze NAL appointment booking, usage and performance metrics. (T-2)

2.3.4. Perform continuous demand management forecasting. (T-2)

2.3.5. Develop and modify provider templates. (T-3) This should be done in conjunction with providers and clinic leadership (e.g. Flight Commander/Flight Chief, etc.).

2.3.6. Collaborate with providers and clinic leadership to provide an adequate supply of appointments through management of templates, schedules, appointing procedures and utilization of access enhancing tools. (T-2)

- 2.3.7. Develop processes to ensure that appointment templates and appointing protocols are reviewed and approved no less than semi-annually by providers, Flight Commanders, SGH and appropriate SQ/CC. (T-3)
- 2.3.8. Provide current booking protocols to appointing staff and review protocols quarterly. (T-3)
- 2.3.9. Be involved in MTF business plan development and execution. (T-3)
- 2.3.10. Provide the number of administratively closed (ADMIN) appointments performed in Composite Health Care System (CHCS) or MHS GENESIS to the Data Quality Team. (T-3)
- 2.3.11. Coordinate with the Health Care Integrator (HCI) and SGH to determine appropriate provider empanelments. (T-3)
- 2.3.12. The GPM will analyze unfilled appointments to determine the root causes of non-use through the use of available ATC Tools such as the TRICARE Operations Center (TOC) and Direct Access Reporting Tool (DART). (T-2) The MTF should consider factors such as type of appointment, time appointment offered, purchased care leakage for the same services, detail codes restrictions, etc.
- 2.3.13. The GPM will analyze published schedules to determine the effectiveness of meeting patient demand relative to the quantity of appointments: time of available appointments, over/under supply of appointment mix, seasonality impacts, cancellations, no-shows, schedule changes, etc. (T-3)
- 2.3.14. The GPM will follow responsibilities as outlined in [Chapter 7](#) and [Chapter 11](#) of this document. (T-3)
- 2.3.15. The GPM will attend required events as outlined in [Chapter 12](#) of this document. (T-3)

#### **2.4. The TOPA Flight Commander will:**

- 2.4.1. Manage the Referral Management Center (RMC) to ensure the requirements as outlined in [Chapter 8](#) and Appendix 2 of this document are met. (T-3)
- 2.4.2. Complete Referral Management (RM) related Management Internal Control Toolset (MICT) checklist IAW MICT guidance criteria pertaining to this AFI. This can also be completed by TOPA personnel appointed by the TOPA Flight Commander. (T-3)
- 2.4.3. Be the primary Functional Requirements Evaluator Designee (FRED) for the Air Force Medical Support Agency (AFMSA) RMC central contract (only for participating MTFs). The TOPA Flight Commander will assign an alternate FRED in writing. (T-3)
- 2.4.4. Manage the processing of patient enrollment and PCM empanelment/reassignment within the electronic scheduling system (CHCS or MHS GENESIS). (T-3)

## Chapter 3

### SCHEDULE MANAGEMENT

#### 3.1. Schedule Management.

3.1.1. Schedule management encompasses continuous planning, forecasting, implementation, management and analysis of provider and clinical staff schedules to meet patient demand.

#### 3.2. Planning and Forecasting.

3.2.1. The MTF will maintain a rolling 180-day schedule to ensure adequate provider and clinic staff availability to meet patient demand within access standards. (T-0) Consider the following in schedule development: historical patient utilization patterns, leave, TDY, base exercises, down days, etc.

3.2.2. The AMT will analyze patient demand utilizing the measures listed in para 2.2.4 above and others as needed. (T-2) Effective management of appointments will maximize patient access to the MTF and avoid purchased care leakage.

#### 3.3. Implementation and Management.

3.3.1. Primary and specialty care clinics will provide a minimum of 180-calendar days of available appointments for booking at all times. (T-0)

3.3.1.1. Graduate Medical Education (GME) residents and their preceptors will provide a minimum of 60-calendar days of available appointments for booking at all times. (T-0)

3.3.1.2. Primary and specialty clinics shall not use the dollar sign appointment types. (T-1) Use of dollar sign appointment types prevents the appointment from being booked, thus limiting patient access to care.

3.3.2. The Template Manager (TM) will have written processes for appointment schedule change requests with the goal of minimizing frequent/repeated changes to opened schedules, changes causing facility cancellations, rescheduling of patients, etc. (T-3) This process should be automated, as functionality to auto-reconfigure appointments exists in CHCS.

3.3.3. Primary Care clinics will convert unbooked FTR appointments to 24HR appointments no later than (NLT) 24 hours prior to the scheduled appointment time. (T-2)

3.3.4. The TM will release/delete unbookable appointments (FROZ, WAIT, HOLD, etc.) NLT 48 hours prior to the clinic day in which the unbookable appointments were scheduled. (T-2) Appointments will be set up to auto-reconfigure.

3.3.5. The TM will not delete unbooked or unused appointment slots from the appointing system. (T-1)

3.3.6. The TM will review the next clinic day's appointment availability and mix daily to ensure schedules meet patient demand and are adjusted as needed. (T-2)

### 3.4. Analysis.

3.4.1. The GPM will analyze unfilled appointments to determine the root causes of non-use through the use of available ATC Tools such as the TRICARE Operations Center (TOC) and Direct Access Reporting Tool (DART). (T-3) The MTF should consider factors such as type of appointment, time appointment offered, purchased care leakage for the same services, detail codes restrictions, etc.

3.4.2. The GPM will analyze published schedules to determine the effectiveness of meeting patient demand relative to the quantity of appointments: time of available appointments, over/under supply of appointment mix, seasonality impacts, cancellations, no-shows, schedule changes, etc. (T-3) This includes those clinics that offer sick call appointments.

## Chapter 4

### TEMPLATE MANAGEMENT

#### 4.1. Template Management.

4.1.1. MTFs will construct templates and schedules using the MHS Standard Appointment types (see Table 5.1). Definitions can be found on the AFMS Knowledge Exchange (Kx) ATC page. MTFs using MHS GENESIS will follow appointing procedures for MHS GENESIS.

4.1.2. Primary care provider templates will be created IAW AFI 44-171 and will meet forecasted patient demand for healthcare access. (T-2)

#### 4.2. Use of Detail Codes.

4.2.1. MTFs may use detail codes to further define appointment types on templates and schedules, IAW approved detail code list in MHS Guide for Access Success.

4.2.2. MTFs will use the tri-service approved operational definitions of detail codes. (T-2)

#### 4.3. TRICARE Online (TOL) Web Enabled Detail Code.

4.3.1. Appointments, by default, are web enabled. MTFs will ensure at least 80 percent of appointments in Family Health, Pediatrics, Internal Medicine, Flight Medicine Primary Care clinics and Optometry clinics are web enabled. (T-0)

#### 4.4. Provider Book Only (PBO) Detail Code.

4.4.1. In Primary Care clinics, the MTF will limit the use of the PBO detail code to those appointments in excess of required centrally bookable appointment levels for AFMH, IAW AFI 44-171. (T-2)

4.4.2. For initial specialty care referral appointments, the MTF will not use the PBO detail code. (T-2)

#### 4.5. Patient Access Type Detail Codes.

4.5.1. MTFs will use no more than two patient access type detail codes per appointment slot. (T-3) This ensures appointing personnel correctly identify the eligible beneficiary category of patient per TRICARE policy to be booked into a particular slot. (T-1)

## Chapter 5

### APPOINTING

#### 5.1. Appointment Management.

5.1.1. The MTF medical clinics will use the MHS electronic patient scheduling appointment system to schedule patient appointments. (T-1)

5.1.2. MTF will provide equal priority access for TRICARE Prime beneficiaries not enrolled to the MTF as for those enrolled to the MTF, US Family Health Plan enrollees may be seen on a space available basis, IAW 32 CFR Sec. 199.17. (T-0) Prioritize according to Title 32 CFR 199.17 (d)(1) and Health Affairs Policy 11-005: Active Duty Family Members (ADFM) in Prime have priority access, followed by Retirees, etc.

5.1.3. The MTF staff who book patient appointments will match the patient's request for care with the appropriate ATC category. (T-0)

#### 5.2. Defense Enrollment Eligibility Reporting System (DEERS) Checks.

5.2.1. The MTF staff will complete a DEERS eligibility check and patient demographic information verification (current address and current telephone number) at each patient interface (e.g., booking via telephone or in person, telephone consultation requests, and check-in by a patient for any appointments, etc.). The only exception is for telephone contacts made by/to providers. (T-0)

5.2.2. Patient eligibility for care and enrollment status should be addressed by TOPA IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*.

#### 5.3. ATC Categories.

5.3.1. Appointing personnel will select one of the ATC categories (see Table 5.1) in the CHCS appointing search function in order to book scheduled appointments. (T-1) The appropriate ATC standard is based on the timeline of the patient's request for care or provider directive. MTFs using MHS GENESIS will follow appointing procedures for MHS GENESIS.

**Table 5.1. Military Health System (MHS) Standard Appointment Types.**

MHS Standard Appointment Type	Timeline of Patient's Request for Care (ATC Standard)	ATC Category/CHCS Search Options
24HR	24 Continuous Hours/1440 minutes	Acute
WELL	28 Calendar Days/40,320 minutes	Wellness
SPEC PROC	28 Calendar Days/40,320 minutes, or per Provider Designation not to exceed 28 Calendar days	Specialty
FTR GRP	No Standard or per Provider Designation	Future

**5.4. Simplified Appointing.**

5.4.1. All Primary Care clinics using the BAA, BDA, BDB, BGA and BJA Medical Expense and Performance Reporting System (MEPRS) codes will utilize the Simplified Appointing model in provider schedules. The 24HR, FTR, SPEC, PROC and GRP appointment types will be used as described below. (T-0)

5.4.2. For most MTFs, a Primary Care schedule with a minimum of 50/50 mix of 24HR and FTR appointments provides optimal access to meet patient demand. MTFs should utilize demand management forecasting and available demand forecasting tools such as the Direct Access Reporting Tool (DART) to determine the appropriate mix of appointments and to adjust schedules as needed to provide a patient-centric supply of appointments.

5.4.3. Group Practice Managers will maximize the use of the 24HR and FTR appointment types in Primary Care templates and schedules. (T-0) Only SPEC, PROC and GRP appointment types may be added to the schedule to support provider practice patterns. However, use of these appointment types should be consistent with AFI 44-171 bookable appointments requirements and be complementary to maximize 24HR and FTR access to care.

**5.4.4. Definitions of Simplified Appointing Appointment Types.**

5.4.4.1. 24HR: primarily used for patient care conditions requiring care within 24 hours of the request. It may also be used for non-urgent patient conditions, but must be balanced with urgency and availability; this process will be described in the MTF appointing protocols. To the greatest extent possible, appointing staff will fill all open 24HR slots on a daily basis. Appointments will not be limited to "one complaint" or medical issue, but rather will address all patient concerns that can be adequately covered in the time allotted to minimize the need for unnecessary future appointments or repeat visits.

5.4.4.2. FTR: used for patients requesting non-urgent services beyond 24 hours (such as for routine, wellness and follow-up care). The FTR appointment type will not be used for initial specialty (SPEC) appointments. To the greatest extent possible, appointments will not be limited to “one complaint” or medical issue, but rather will address all patient concerns that can be adequately covered in the time allotted to minimize the need for unnecessary future appointments or repeat visits.

5.4.4.3. SPEC: used for an initial consult/referral appointment. It may also be used for a patient initiated self-referral appointment. The CHCS appointing system will automatically assign the ATC Standard and Category that matches the referral’s clinical priority entered by the requesting provider.

5.4.4.4. PROC: used for patients in need of medical procedures. A procedure appointment will be booked and seen with a provider within 28 calendar days or per the provider's designation. Within Primary Care clinics, a referral is generally not required. If the PROC appointment is not performed within the patient’s medical home, a referral will be required.

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

5.4.5. Measurement. The following strategic measures will be utilized to measure the success of Simplified Appointing (T-1):

**Table 5.2. Appointment Measures.**

Measure	Target	Report Location
<b>Prospective Measures</b>		
3 <sup>RD</sup> Available 24HR Appointment	≤ 1.0 days	TRICARE Operations Center (TOC), Third Available Report Monthly
3 <sup>RD</sup> Available FTR Appointment	≤ 7.0 days	TOC, Third Available Report Monthly
3 <sup>RD</sup> Available SPEC Appointment	≤ 28.0 days	TOC, Third Available Report Monthly
3 <sup>RD</sup> Available WELL Appointment	≤ 28.0 days	TOC, Third Available Report Monthly



<b>Retrospective Measures</b>		
Average Days to Be Seen (Acute search)	≤ 1.0 days	TOC, Access to Care Summary Report
Average Days to Be Seen (Future search)	≤ 14.0 days	TOC, Access to Care Summary Report

### **5.5. Booking Transactions.**

5.5.1. MTFs will use the access category search that best represents the patient's request. (T-0)

5.5.2. MTFs will waive ATC standards should patients request appointments outside of ATC standards for provider continuity/convenience/personal reasons, even though the MTF may have appointments available inside ATC Standards with their PCM or other providers in the team/clinic. (T-1) MTFs will not use 'Just Looking' feature in CHCS to search for appointments.

5.5.3. Patients Refusing All Appointment Times Offered. Appointing personnel will document patient refusals in CHCS, IAW current CHCS information system processes to ensure it reflects the reason a patient refused all appointment times offered as opposed to accepting an appointment within ATC standards. (T-3)

5.5.4. Unbooked Appointment Request Functionality. Appointing personnel will choose the most accurate Unbooked Appointment Request as defined in the current MHS access to care guide. (T-3)

### **5.6. Continuity List Patients.**

5.6.1. Continuity List (CL) patients are those high-acuity patients who must be seen by their provider due to the risk in both outcome, and/or unnecessary deferral to the network.

5.6.2. PCM Teams in Primary Care will develop and maintain a current list of their continuity patients IAW AFI 44-171.

5.6.3. Patients identified as CL patients will be identified by [CL] in the remarks field of CHCS. These patients will be offered a continuity appointment as outlined in AFI 44-171.

### **5.7. First Call Resolution.**

5.7.1. MTFs will not divert patients to the NAL during business hours as a means to complete first call resolution. (T-1)

5.7.2. Appointing agents will:

5.7.2.1. Search for appointments with the patient's PCM. If no appointments are available, the agent will search within the PCM Team, then PCM Clinic, then across all Primary Care clinics (this includes cross-booking into the following MEPRS: BAA - Internal Medicine, BDA - Pediatrics, BGA- Family Health, BJA – Flight Medicine). (T-1)

5.7.2.2. If unable to find an appropriate appointment for the patient, transfer the call to the patient's PCM team nurse or a designated clinic triage nurse, via warm hand-off, for triage and appropriate disposition. (T-1)

5.7.2.3. If unable to warm-handoff the patient to the PCM team nurse, enter a high priority T-CON (red in AHLTA) to the team indicating the need for a two-hour response. (T-1)

5.7.3. PCM Team nurses will:

5.7.3.1. Take warm hand-off calls from appointing agents and determine the most appropriate disposition. (T-1)

5.7.3.2. When warm hand-offs are not possible, reply to RED TCONs within two hours. (T-1)

5.7.3.3. Ensure Active Duty patients are deferred to the network only as a last resort. (T-1)

5.7.3.4. MTFs will use the Un-booked Appointment Request/Reporting functionality in CHCS to allow for the tracking and reporting of patients who requested an appointment, a search was performed by an appointing agent, but the appointment request did not result in a booked appointment. (T-3)

**5.8. Left Without Being Seen (LWOBS).**

5.8.1. A patient who has a booked appointment, arrives at the clinic, and is checked in, but leaves without seeing the provider.

**5.9. No-Shows.**

5.9.1. The MTF will designate an appointment a no-show when a patient does not keep a scheduled appointment or cancels within 2 business hours of the appointment. Commanders will publish and market the AFMS no-show standard to all MTF staff and beneficiaries and ensure it is applied throughout the MTF to enable a consistent patient experience. (T-3) If a patient is designated a no-show by cancelling within 2 business hours of the appointment, every effort will be made to utilize the now unfilled appointment.

5.9.1.1. An individual clinic's no-show rate will not exceed five (5) percent of all booked appointments. (T-1) Specialty care clinics no-show rates will be IAW [Chapter 11](#), Specialty Care.

5.9.1.2. The MTF will use the following formula to calculate the no-show percentage (T-1):

$$\frac{\# \text{ No-Shows}}{(\text{LWOBS} + \text{Kept} + \text{No Show} + \text{Pending})^*} - (\text{Facility Cancelled} + \text{Patient Cancelled})$$

*\*all booked appointments*

5.9.1.3. Providers, clinical staff and appointment line staff will attempt to contact (e.g. voicemail, secure messaging, written letters, etc.) no-show and Left Without Being Seen (LWOBS) patients at least once to ensure patient wellness/safety. All attempts will be documented in the Electronic Health Record (EHR). (T-3)

### 5.10. Late Patient Arrival for Scheduled Appointment (Late-Show) .

5.10.1. MTF Commanders will publish and market a single late-show policy to all MTF staff and beneficiaries, and will ensure it is applied throughout the MTF to enable a consistent patient experience. (T-3) Patients who arrive at the clinic greater than 10 minutes after their scheduled appointment time are considered late. Every effort will be made to accommodate late showed patients.

### 5.11. Patient Cancellations.

5.11.1. MTFs will establish a separate cancellation telephone number/call tree option that is available/open 24 hours a day, seven days a week to capture patients' appointment cancellation requests. (T-3) The phone number will be clearly published on MTF websites, appointment line messages, phone books and other communications. TRICARE Online (TOL), Secure Messaging, and e-mail appointment cancellation notifications do not fulfill this requirement.

5.11.2. MTFs will develop an ongoing process in which cancellations (via automated appointment reminder, secure message, etc) are translated back into the appointing information system thus, making cancelled appointments available for booking. (T-3)

### 5.12. Facility Cancellations.

5.12.1. MTFs will establish processes to minimize facility cancellations. (T-3)

5.12.2. MTFs will establish schedule management processes to govern the facility cancellation process to include: approval authority; conditions when facility cancellation is allowed (e.g., emergency weather conditions); and reporting and tracking of occurrences to the MTF AMT. (T-3) Mental Health patients who are on the High Interest List (and are therefore at elevated risk for harm or behavioral issues) are required to speak with a provider prior to cancelling an appointment IAW AFI 44-172, *Mental Health*. (T-1)

5.12.3. MTFs shall notify affected patients of their facility cancelled appointment within one business day of the facility cancellation. One business day includes the facility cancellation date plus the end of the next business day. (T-3)

5.12.4. MTFs' facility cancellation rate shall not exceed three percent of all booked appointments. MTFs will use the below formula to calculate the facility cancellation rate: (T-2)

# Facility Cancelled

---

(LWOBS + Kept + Facility Cancelled + No shows + Pending)\*

\*number of patients who were booked appointments

### 5.13. Appointing Data Quality/End of Day Processing.

5.13.1. At the end of each business day, clinics will complete CHCS end of day processing. (T-3)

5.13.2. Clinic staff will:

5.13.2.1. Determine and assign a patient appointment status for each appointment. (T-3)

5.13.2.2. Process and apply workload types (count/non-count) on appointment slots to match the actual care provided. (T-3)

5.13.2.3. Match the provider who actually saw the patient to the final appointment status. (T-3)

5.13.2.4. Preserve Walk-in and Sick Call appointment statuses and will not change them to any other appointment status. (T-3)

5.13.2.5. Preserve open/unused appointment slots and will not delete them from the schedule. (T-3)

## Chapter 6

### APPOINTING INFORMATION SYSTEM OPERATIONS

#### 6.1. Division, Clinic, and Provider Profiles.

6.1.1. Executive staff will identify staff responsible to establish and maintain division, clinic and provider profiles in CHCS. MTFs using MHS GENESIS will follow procedures for MHS GENESIS. (T-3)

6.1.2. Executive staff will ensure the following settings in CHCS: (T-1)

6.1.2.1. Set the ATC Reporting Flag to "Yes" in each of its primary and specialty/surgical care clinic profiles that have active schedules.

6.1.2.2. Set the Self-Referral flag to "Yes" in the clinic profile of primary care clinics to accommodate cross-booking per AFI 44-171.

6.1.2.3. Set the Self-Referral flag to "Yes" in the clinic profile of the following specialty care clinics: women's health, nutritional medicine, optometry and mental health.

#### 6.2. Appointing Information System Booking Authority and Security Key Administration.

6.2.1. Executive staff and GPM will establish who will have authority to book and cancel appointments in the appointing information system which will be reviewed annually. (T-3)

6.2.2. Executive staff and GPM will identify positions and what appointment information systems security keys are needed to perform required duties (T-3). These appointment information system security keys include:

6.2.2.1. Changing appointment types.

6.2.2.2. Changing and/or adding detail codes.

6.2.2.3. Changing gender and age designations on appointment slots.

6.2.2.4. Booking appointments outside ATC standards.

6.2.2.5. Instantaneously creating/booking appointments while appointing the patient.

6.2.2.6. Deleting appointment slots.

6.2.2.7. Freezing and unfreezing appointment slots.

6.2.2.8. Facility canceling appointments.

#### 6.3. Telephonic/Text/Email Appointment Reminder Systems.

6.3.1. Executive staff will identify at least two MTF personnel who are responsible and trained to set up and maintain the appointment reminder systems (e.g., Audiocare, TOL, Televox). (T-3) The executive staff will ensure that a local contingency plan is developed and in place in the case there is a phone outage or other event that challenges communications to and from the MTF.

6.3.1.1. MTF leadership will ensure that a local MTF marketing campaign is developed to enroll patients in TOL or the current web-based telephonic/text/email reminder system. (T-3)

## Chapter 7

### TELEPHONE ADMINISTRATION AND SUPPORT TO APPOINTING

#### 7.1. Appointing Telephony Functional Responsibilities.

7.1.1. The GPM will have primary functional control, and whenever possible, administrative control of appointing personnel (telephone as well as front desk appointing). (T-2)

7.1.2. The GPM will monitor four (4) calls per month, per agent, and provide feedback on at least two of those calls using the AFMSA/SG3S recommended quality monitoring scorecard. (T-3)

7.1.3. Calls routed through the Automatic Call Distribution (ACD) may be recorded IAW local labor laws, and may be retained for up to 30 days.

7.1.4. MTFs will select their ACD system after receiving approval from AFMSA/SG3S. (T-1)

#### 7.2. Telephonic Access Management Duties.

7.2.1. Key Performance Indicator (KPIs) targets that Telephonic Access Management personnel will review are:

7.2.1.1. Percent of Abandoned Calls - Less than or Equal to 8%. (T-2)

7.2.1.2. Service Level – 90% of Calls Answered within 90 seconds. (T-2)

7.2.1.3. Average Speed of Answer – Less than or Equal to 45 seconds. (T-2)

7.2.1.4. Average Talk Time – Less than or equal to 180 seconds. (T-2)

7.2.2. The GPM is responsible for reporting KPI measurement outcomes to the Executive Committee on a monthly basis and recommends improvement strategies through the AMT as needed. (T-2)

#### 7.3. Automatic Call Distribution (ACD) Call Tree Considerations.

7.3.1. The GPM and Telephonic Access Management personnel will ensure call trees will not exceed five options in any given menu. (T-1) Not included in the five options are cancelling an appointment, an option to return a caller to Option #1 on the menu, and an option to repeat a menu.

7.3.2. The GPM and Telephonic Access Management personnel will ensure call menus do not exceed six layers. (T-1)

7.3.3. Option #1 from the opening or main menu is to access the appointment desk/call center function to book appointments at the MTF only. The GPM will ensure the Nurse Advice Line (NAL) will not be made any part or sub-menus of Option #1. (T-1)

7.3.3.1. The GPM will ensure the NAL will be placed on the call tree as an option other than Option #1 when the appointment line/call center is open for normal business hours (i.e. Option #2 or #3 behind primary care, specialty care and dental appointments for the MTF). (T-1) When the appointment line is closed, the NAL will be moved to Option #1. (T-1)

7.3.4. Each system will ensure any on-hold music represents a professional atmosphere and is legally obtained for rebroadcast. (T-2)

7.3.5. The GPM will ensure skill set naming conventions start with the MEPRS code, to ensure consistent data collection across the AFMS. (T-3)

7.3.6. All MTF PCM booked appointments are routed through the ACD to capture workload. While the use of skill sets is encouraged for high volume clinics, the calls may be routed by the ACD to a direct clinic line.

7.3.7. All changes to the call tree that impact the collection of ACD metrics must be approved by the AFMSA/SG3S, Access To Care Program Office prior to implementation. (T-1)

## Chapter 8

### NURSE ADVICE LINE

#### 8.1. General.

8.1.1. Military Treatment Facilities (MTF) will establish a written Nurse Advice Line (NAL) plan; developed by collaborative efforts of all designated points-of-contact (POCs) to ensure program sustainability and reduce variation in standards of practice among various work-centers. (T-2)

8.1.2. On-going marketing efforts, details of work-centers' roles and responsibilities, training, warm handoff processes, information sharing, performance metric reporting, and process improvement methodologies will be included in the plan.

8.1.3. The plan will be reviewed by the Access Management Team (AMT), forwarded to Executive Committee of the Medical Staff (ECOMS) for approval and annotated in the ECOMS meeting minutes. (T-2) The plan will accompany the minutes as an attachment.

8.1.4. Annual review will be conducted to ensure significant changes are incorporated. (T-2)

#### 8.2. NAL Metrics.

8.2.1. NAL updates, booking analysis metric, warm-handoff metric, beneficiaries pre-intent and NAL recommended disposition metrics, and process improvement efforts will be reported to the AMT monthly. (T-2) MTFs can report additional metrics if desired.

8.2.2. NAL clinical quality assurance (QA) concerns will be forwarded to Air Force Medical Operations Agency NAL to determine the need for a formal quality review from NAL Program Management Office (PMO). QA submissions for Air Force MTFs in enhanced Multi-Service Markets (eMSM) should be forwarded to the appropriate NAL Leads.

8.2.3. All clinical quality assurance concerns resulting in an unwarranted patient outcome will be forwarded to AFMOA/SGNE via [AFMOA.NAL@us.af.mil](mailto:AFMOA.NAL@us.af.mil) or eMSM NAL Leads immediately.

#### 8.3. Roles and Responsibilities.

8.3.1. SGN, SGH and SGA will:

8.3.1.1. Collaboratively determine expectations from NAL utilization that will support MTF's access to care strategic goals.

8.3.1.2. Collaboratively determine the MTF NAL lead and alternate POCs.

8.3.1.3. The MTF NAL process responsibilities will be shared between clinical and administrative functions to include the SGN, Family Health Flight Commander, 4A Functional, GPM, and HCI. An individual in one of these functional areas will be designated as the lead by the SGN/SGA/SGH.

8.3.1.4. This group will forward all quality assurance submissions, POC updates, clinic instructions, warm handoff updates, and all other inquires to AFMOA via [AFMOA.NAL@us.af.mil](mailto:AFMOA.NAL@us.af.mil) or eMSM NAL leads.

8.3.1.5. Ensure the selected work-center POCs listed below follows guidance:



- 8.3.2. The Flight Commander or clinical nurse designee from each AFMH clinic will:
- 8.3.2.1. Provide guidance and oversight for beneficiary follow-up protocols post Urgent Care Center (UCC) or Emergency Department (ED) visit.
  - 8.3.2.2. Review clinic instructions and warm-handoff contact numbers to ensure accuracy.
  - 8.3.2.3. Address warm-handoff deficits related to gaps in internal processes.
  - 8.3.2.4. Ensure all personnel designated to respond to warm handoffs are aware of rules of engagement and daily access capabilities/expectations.
- 8.3.3. The Appointing Center Supervisor will:
- 8.3.3.1. Ensure personnel are aware of NAL rules of engagement and daily access capability/expectations.
  - 8.3.3.2. Address warm-handoff deficits related to gaps in internal processes/workflows immediately to the MTF NAL POC.
- 8.3.4. Utilization Managers (UM) will:
- 8.3.4.1. Track, trend, and analyze the population's utilization patterns.
    - 8.3.4.1.1. Provide recommendations related to conditions, demographic factors, outcomes and formulate process improvements accordingly.
    - 8.3.4.1.2. Report trends and metrics to the Executive Committee accordingly.
- 8.3.5. The Health Care Integrator (HCI) will:
- 8.3.5.1. Provide population education via appropriate forums such as mandatory briefs, newcomers briefings, Commanders Calls, community outreach forums and marketing tools.
  - 8.3.5.2. In absence of an assigned UM, assume the UM's responsibilities as indicated above.
- 8.3.6. TRICARE Operations and Patient Administration (TOPA) will:
- 8.3.6.1. Assist with population education by facilitating availability of NAL marketing tools.
  - 8.3.6.2. Forward UCC/ED network provider updates to NAL when discrepancies are identified.
- 8.3.7. Education and Training Officer (ETO) or representative will:
- 8.3.7.1. Provide expertise to enable MTF to meet all training criteria stated in this guidance.
- 8.3.8. Information Management (IM) (i.e. Composite Health Care System (CHCS) administrator and/or Chief Information Officer (CIO)) will:
- 8.3.8.1. Ensure CHCS accounts are activated or deactivated per guidance of the Defense Health Agency (DHA) NAL PMO.

8.3.8.2. Ensure scheduled and unscheduled CHCS and Application Virtualization Hosting Environment (AVHE) outages are reported to the NAL.

8.3.8.3. Be prepared to receive account activation and deactivation notifications from the DHA NAL PMO to facilitate access of NAL staff.

#### **8.4. NAL Sustainment Guidance.**

8.4.1. The NAL may be used as a PCM designee to respond to patient urgent care needs 24 hours a day, 7 days a week. Facilities that use the NAL do not need to identify an on-call provider for this purpose.

#### **8.5. Training.**

8.5.1. To ensure continuity within the MTF, NAL should be included in all orientation checklists for executive leadership and work-centers (i.e. AFMH clinics, appointing centers, TOPA, Information Management-CHCS administrator, medical management team, etc.) involved in decision making, workflow and training processes.

8.5.2. Refresher training should be conducted at least once a year to ensure key personnel are fully aware of all changes to NAL strategic goals, program dynamics, and workflow processes.

#### **8.6. Guidance on Beneficiary Initiated Contact with MTF.**

8.6.1. During normal operations, MTF personnel will not redirect beneficiaries to the NAL as a substitute for their ability to access their AFMH teams. (T-1)

8.6.2. If the patient states they want to speak to a nurse, the NAL should not be chosen by MTF staff as the primary option over the beneficiary's PCM team's nurse.

8.6.3. If resources are available to provide walk-ins, MTFs will not redirect beneficiaries to the NAL.

8.6.4. It is appropriate for patients to be transferred to the NAL upon the patient's request; however, MTF personnel cannot transfer or tell the beneficiaries to call the NAL if the individual prefers to seek care with their AFMH team.

8.6.5. Beneficiaries have the option to utilize NAL services 24 hours a day, seven days a week.

#### **8.7. Guidance on Warm Handoffs.**

8.7.1. The MTF will designate phone line(s) and develop workflows (how the MTF routes calls and provides support staff for maximum effectiveness) to receive NAL warm handoffs. Per the AFMS NAL Operational Guidance, signed June 2016, a warm handoff is when one party telephonically connects the beneficiary with another party and both parties verbally accept the exchange of the beneficiary via the phone line.

8.7.2. The workflow and telephonic resources must support personnel's capability to answer the NAL call within 45 seconds.

8.7.3. When the NAL RN triages the patient and if an appointment is needed, the NAL clerk first attempts to book the patient in CHCS, and if not successful, there is an attempt by the NAL to make a warm-handoff to the MTF.

8.7.4. Personnel assigned to answer the designated warm handoff phone line must be aware of MTF's access goals and current access capacity, i.e. providers available, ability to cross book within the team or across teams; hours of the UCC/ED (if available) and other applicable access to care protocols during the time of the call.

8.7.5. It is suggested that weekly telephonic technical quality assurance inspections be performed to ensure full functionality of designated line(s).

## **8.8. CHCS and Application Virtualization Hosting Environment (AVHE) Guidance.**

8.8.1.1. The MTF must provide CHCS account access to NAL nursing staff/clerks. This provides the NAL appointment booking capability into the MTF's CHCS platform.

8.8.1.2. The NAL clerks must be given booking access to all AFMH clinics, to include Family Medicine, Pediatric, Internal Medicine, Flight Medicine, and Personnel Reliability Program.

8.8.1.3. The MTF staff must ensure NAL profiles are developed to support cross booking capability, first to the PCM, then to the PCM Team, then to the PCM clinic in order to recapture the greatest amount of care possible.

## **8.9. Guidance on Clinic & MTF Closures.**

8.9.1. All Clinic and/or MTF closures due to training, weather, etc. must be reported to the NAL.

8.9.1.1. This enables the NAL to appropriately support and/or route calls from MTF beneficiaries during closure. Additionally, it helps to reduce skewed data related to the unsuccessful warm handoff performance metrics. If the NAL is aware of the closure, they won't unnecessarily attempt a warm handoff.

## **8.10. Marketing Guidance.**

8.10.1. An effective MTF marketing campaign will enable beneficiaries to establish realistic expectations of NAL services and enhance comprehension of rules of engagement contributing to customer satisfaction.

8.10.2. Marketing tools and examples are located on the NAL Kx page.

## Chapter 9

### REFERRAL MANAGEMENT

#### 9.1. General.

9.1.1. All specialty/surgical care and Right of First Refusal (ROFR) referrals/consults will be managed IAW current AFMS Referral Management Business Rules (BRs), (see attachment two), and Assistant Secretary of Defense for Health Affairs (ASD (HA)) referral management (RM) guidance.

9.1.2. The TOPA Flight Commander is responsible for executing the referral management (RM) process and the Referral Management Center (RMC); GPMs must be familiar with the referral process. (T-3)

9.1.3. The MTF's RMC is accountable for managing and tracking referrals generated by the MTF and ROFR referrals until closure. The referral is considered closed when: the referral is cancelled/denied; the patient has cancelled/not used the referral; or the referring provider has received the Clear and Legible Report (CLR). (T-1)

9.1.4. Carepoint Referral Management Suite (RMS) is the only interim electronic RM application approved by the Military Health System for use by the MTF to transmit and track all referrals until the MHS GENESIS Electronic Health Record (EHR) is deployed at the MTF. (T-0)

9.1.5. The MTF Executive staff or designee (not a workgroup) is the approval authority for the MTF's Capability and Capacity report (T-1). The MTF's Capability and ROFR reports should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs. These reports should be updated as needed for accuracy. (T-3) All referral requests will be routed to the RMC or multiservice market referral center for administrative review, appointing to the MTF, and processing to the Managed Care Support Contractor (MCSC). Exceptions to this process shall be approved by the Executive Staff or designee in writing. MTF specialty clinics exempted by the Executive Staff are responsible for referral review, booking, & tracking of those referrals. (T-3)

9.1.6. The MTF Executive Staff will provide appointment booking keys to trained, front line support staff (e.g. in primary care, central appointing, RMC, etc.) in order to support patient-centered booking into specialty clinics before the patient leaves the MTF. (T-3)

9.1.7. Clinic, RMC and appointing personnel will use the CHCS Appointment Order Processing function to book initial MTF specialty appointments. (T-1). This CHCS function links the appointment to the referral and ensures correct tracking through CHCS and RMS.

9.1.8. The MTF Executive Staff will empower appointing agents to book the patient's specialty appointment anytime the referral has an "Appoint to MTF" review. If the referral lacks a review disposition when the patient calls, then the appointment center agent shall provide the patient a "warm hand-off" to the RMC or specialty clinic to immediately review the referral and appoint or defer it. If "clinic-book only" appointments are authorized, and a patient calls the central appointment center for a "clinic book only" appointment, then the

appointing agent shall provide a “warm hand-off” directly to the specialty clinic to assist the patient. (T-0)

9.1.9. The MTF Executive Staff will ensure patients are offered three different specialty appointment times within the 28 calendar day access to care standard. When the MTF cannot offer three different specialty appointment times within the access standard, patients may be offered MTF appointments outside the standard if they choose to waive their ATC standard. If the patient does not waive their ATC standard, the patient’s referral will be deferred to the purchased care. (T-0)

9.1.10. The MTF Executive Staff will ensure specialty clinic and RMC personnel return patient messages within one business day of message receipt. One business day includes the message received date plus the end of the next business day. (T-0)

9.1.11. The MTF Executive Staff will ensure the MTF’s consult/referral auto-closure function in CHCS is turned off. (T-0)

## **9.2. Referring Provider Responsibilities.**

9.2.1. The referring provider will:

9.2.2. Promptly enter all initial specialty referrals into the EHR, preferably before the patient leaves the encounter or immediately after the virtual visit. (T-1)

9.2.3. Review referral results within three business days of notification that the results have been received. (T-1)

9.2.4. Communicate to the patient within one business day when a referral is denied or cancelled, and whether or not a new referral will be ordered. This communication may be delegated to the clinical team. (T-3)

## **9.3. Specialist Responsibilities.**

9.3.1. The specialist will communicate to the referring provider the reasons for a referral cancellation or if more information is needed on the referral. This communication may be delegated to the clinical team. (T-3)

## **9.4. Referral Management Center (RMC) Responsibilities.**

9.4.1. The RMC will:

9.4.1.1. Ensure all initial specialty care referrals are either accepted for appointing to the direct care system or deferred to the network within one business day from the order date. One business day includes the order date plus the end of the next business day. (T-0)

9.4.1.1.1. For referrals requiring specialty clinic review, if the specialty clinic does not review the referral within one business day, the RMC will book the patient to the specialty clinic based on the MTF’s capability/capacity report or defer the patient to the network. (T-0)

9.4.1.2. Defer TRICARE eligible patient referrals to the network regardless of beneficiary category or specialty service line if the patient cannot be booked to the MTF specialty clinic within the appropriate ATC standard as indicated by the referral priority and the patient does not waive the ATC standard. (T-0)

9.4.1.3. Notify patients that their referral was deferred to the network or accepted for appointing to the MTF within one business day from the time the review decision (e.g., Appoint to MTF or Defer to Network) was entered into the EHR. (T-0)

9.4.1.3.1. This communication can occur before the patient leaves the MTF, by live phone call or secure messaging after the patient leaves the MTF, or through automated methods (e.g. Audio-Communicator, etc.). The communication will inform the patient about how to make the direct care appointment, how to cancel the referral, and/or when to expect the network authorization letter or e-mail. (T-0)

9.4.1.4. Notify the referring provider of all routine priority referrals not used or activated by their patients IAW local MTF policy, but no less than monthly. (T-1)

## Chapter 10

### AIR RESERVE COMPONENT (ARC) ACCESS TO CARE

#### 10.1. Introduction.

10.1.1. The following DoD and Air Force publications provide guidance for determining ARC eligibility: AFI 41-210, *TRICARE Operations and Patient Administration Functions*; AFI 36-2910, *Line of Duty (LOD) Determination, Medical Continuation (MEDCON), and Incapacitation (INCAP) Pay*; AFI 44-170 *Preventive Health Assessment*; DoDI 1332.18, *Disability Evaluation System (DES)*, and the Air Force Reserve Command (AFRC) PHA Guide. In addition, Title 10 USC Section 1074 and Title 37 United States Code, Section 204 as well as AFRC/SG and Air National Guard (ANG)/SG can be used for references.

10.1.2. ARC members who incur or aggravate an injury, illness or disease in the line of duty while performing active duty, active duty for training or inactive duty for training or while traveling directly to or from such duty, shall be provided the medical or dental care appropriate for the condition until the member is found returned to duty, or the injury, illness or disease cannot be materially improved by further hospitalization or treatment and the member has been separated as a result of a Disability Evaluation System (DES) determination. To enter into the DES for a duty-related determination, the member must have received an In Line of Duty (ILOD) determination for his/her potentially unfitting condition(s). (T-0)

#### 10.2. ARC Health Care Benefits for Air Force Required Evaluations.

10.2.1. ARC members assigned to ARC Units with sufficient medical assets will receive their required evaluations (e.g., Periodic Health Assessment (PHA), annual Dental exam, etc.) from their respective servicing Reserve Medical Unit or Guard Medical Unit or other approved source. (T-2)

10.2.2. AFRC members attached to Regular Air Force (RegAF) units or assigned to ARC Units without a servicing AFRC Medical Unit will receive their required AFRC PHA evaluations from a RegAF MTF or other approved source. (T-2)

10.2.3. Many ARC members travel considerable distances from their home to their unit of assignment or have limited time to complete these appointments on duty days. When an ARC member is seen in the MTF, clinic/ancillary services personnel must complete all physical and ancillary services on the same day as the provider appointment. (T-3) This does not include the completion of the paperwork, only the actual testing and evaluation.

10.2.4. ARC members residing outside the MTF catchment area or more than 40 miles from their units' servicing MTF may also obtain these evaluations from the nearest MTF.

10.2.5. ARC members not on orders normally show as ineligible in DEERS (Defense Enrollment Eligibility Reporting System); however, this does not preclude the booking of an appointment for the ARC member by appointing agents. Should further verification of eligibility be required, appointing agents should contact the ARC member's unit administrator/medical representative or consult the MTF access manager.

10.2.6. ARC members are not required to be in “military status” to schedule an appointment; however, they must be in a military status at the time of the examination and must provide documentation to clinic staff that they are in a military status. Military status is defined as active or inactive duty status. ARC members with an approved LOD do not need to be in a military status for examination or treatment. (T-2)

10.2.7. ARC members will have the same level of access for these required evaluations as RegAF members. (T-0)

### **10.3. ARC Access to Care for Line of Duty (LOD) Determinations.**

10.3.1. Access to care is allowed only for the condition identified for LOD determination, during the determination of the LOD. In accordance with AFI 36-2910, *Line of Duty Determination, Medical Continuation and Incapacitation Pay*, ARC member must provide documentation of LOD(s) that are in process or have been determined LOD in order to receive follow-up care (e.g., AF Form 348). (T-3)

10.3.2. Eligibility for continued medical/dental care will be determined by line of duty findings as specified in AFI 36-2910. According to AFI 41-210, entitlement exists only for the medical condition determined to be In the Line of Duty (ILOD). An AF Form 348 (-R), or DD Form 261, Report of Investigation Line of Duty and Misconduct Status, or Interim LOD with all signature blocks complete, is needed to establish eligibility. The LOD is valid for care only until the service member is found fit and returned to duty or separated by the Disability Evaluation System (DES) for the documented medical condition.

10.3.2.1. ARC members will have the same level of access to care as RegAF members for treatment of those conditions identified in a positive finding for ILOD determination. (T-0)

10.3.3. ARC members will not be eligible for care when the determination is Not in Line of Duty (NILOD). (T-0) Care received at this point is at the member’s expense.

10.3.4. According to AFI 36-2910, paragraph 2.3.3., the immediate commander may issue an Interim LOD determination to establish initial care and treatment pending the final LOD determination. The Interim LOD determination is comprised of the completed medical portion of AF Form 348, in accordance with guidance listed in AFI 36-2910, paragraph 2.3.3.3.

**10.4. ARC Referrals.** ARC members who require follow-up care not in the area where the initial treatment was rendered are referred to the closest MTF near their home. Appropriate medical authority from the referring MTF contacts the appropriate medical authority at the receiving MTF to ensure care is delivered. The referring MTF will notify the member’s supporting ARC medical unit of the referral action for tracking purposes. (T-1)

10.4.1. Refer ARC members who are serving under Title 10 Contingency, Title 10, or Title 32 orders who are identified with potential duty-related illness or injury in an urgent manner (72 hour consult), to include maximum utilization of both RegAF and off-base referral sites. This practice ensures timely identification and access to entitled healthcare prior to the end of mobilization or contingency orders and without a break in service that can result in loss of medical benefits.



10.4.2. Any care referred outside the MTF is only paid for if the LOD process has been initiated or completed. In addition, the referral must be coordinated with the Reserve and Service Member Support Office Great Lakes (R&SMSO-GL) (formerly MMSO) by MTF staff. (T-1) Coordination with the R&SMSO-GL ensures services are rendered without a denial of claim.

## Chapter 11

### SPECIALTY CARE

#### 11.1. Overview.

11.1.1. Specialty clinics include but are not limited to: Optometry, Mental Health, Physical Therapy, Women's Health, Surgery, Internal Medicine and Pediatric Specialties, etc.

#### 11.2. Schedule Planning and Forecasting.

11.2.1. Unless otherwise noted in this chapter, specialty care clinics will maintain a rolling 180-day calendar (e.g., historical patient utilization patterns, leave, TDY, base exercises, down days, etc.) to ensure adequate provider and clinic staff availability to meet patient demand within access standards. (T-0)

11.2.2. The AMT will analyze patient demand utilizing the measures listed in para 2.2.4. (T-2) Effective management of appointments will maximize patient access to MTF and avoid purchasing private sector medical care.

#### 11.3. Schedule Implementation and Management.

11.3.1. Clinic leadership will ensure that schedules are released to allow, at a minimum, a continuous/rolling 180-calendar day supply of available appointments for booking, unless otherwise noted in this chapter. (T-0)

11.3.2. Clinic leadership will have written processes for appointment schedule change requests with the goal of minimizing frequent/repeated changes to opened schedules, changes causing facility cancellations, and rescheduling of patients. (T-3) Appointments will be set up to auto-reconfigure as applicable, IAW with [Chapter 3](#), Schedule Management, of this AFI.

11.3.3. In coordination with the clinic, unbooked FTR appointments will be converted or auto reconfigured to SPEC no later than (NLT) 7 days prior to the scheduled appointment time. (T-1)

11.3.4. Frozen appointments will be released/deleted NLT 72 hours prior to the clinic day. Appointments will be set up to auto-reconfigure. (T-1)

11.3.5. GPM will provide a daily review of the next clinic day's appointment availability and mix to ensure schedules meet patient demand and are adjusted as needed. (T-2)

#### 11.4. Analysis.

11.4.1. Unfilled appointments will be analyzed to determine the root causes: for example, type of appointment; time appointment offered; in contrast to purchase care leakage for the same services; detail codes restrictions, etc. (T-2)

11.4.2. Published schedules will be analyzed to determine the effectiveness relative to the quantity of appointments, over/under supply, seasonality impacts, cancellations, no-shows, schedule changes, etc. (T-2)

11.4.3. The GPM and RMC will develop a business case analysis to determine effectiveness of retaining referred care. (T-2)

#### 11.5. Mental Health ATC Management.

11.5.1. The GPM will provide at least a monthly consultation on the management of templates and schedules and the measurement of the Mental Health clinic's performance in meeting ATC standards to the leadership and templating/scheduling staff of the Mental Health clinic. (T-3)

11.5.2. The GPM will ensure overall management of Mental Health access will be IAW AFI 44-172, *Mental Health*, to include appointment cancellation guidance for Mental Health patients. (T-0)

11.5.3. MTFs will establish processes to ensure that requests for emergent mental healthcare are provided on an immediate basis as dictated by the threat. (T-0)

11.5.4. Urgent mental healthcare is provided within 24 hours or less. (T-0) Urgent mental healthcare includes manifest behavior and/or cut-off scores on the Patient Health Questionnaire-9 (PHQ-9). Clinics can book these patients into 24HR appointments or walk them in. Mental Health clinics should utilize CHCS as much as possible for creating appointments.

11.5.5. Mental Health Clinic Appointment Types. Clinics will use appointment types IAW the definitions of **Chapter 5**. Only the following standard appointment types are permitted to be used: (T-1)

11.5.5.1. Clinics will use 24HR slots to book urgent mental healthcare requests within 24 hours, to include walk-in appointments that need to be seen the same day.

11.5.5.2. Clinics will use SPEC slots to book any initial mental health patients referred by another provider or clinic, not to exceed 28 days. All new appointments referred by the BHOP should be SPECS.

11.5.5.3. Clinics will use FTR slots to book follow-up appointments for additional mental healthcare/course of therapy. Clinics will book these appointments within the time frame requested by the mental health provider.

11.5.5.4. Clinics will use GRP slots for patients who require group therapies, counseling, or teaching sessions where a mental health provider will perform the service in a group setting. The detail code fields can be used to provide further information about the care to be provided in the group appointment, (e.g., STRESS for a Stress Management Class). A group appointment should be scheduled per self-referral of the patient, the clinic's or referring provider's policy or designation.

11.5.5.4.1. Automated Neuropsychological Assessment Metrics (ANAM) GRP appointment slots can also be used for ANAM assessments for 1 to 50 personnel being scheduled during the same time slot. To clarify the care being provided in this group appointment, it is recommended that two additional detail codes be used in combination with the GRP standard appointment type. This alerts appointing agents to book the proper individuals into these slots. This coding also provides a mechanism to monitor the number of ANAM assessments being performed. They are:

11.5.5.4.1.1. For Pre-deployment Assessments: Use MH detail code (for Mental Health) combined with the RPRE detail code (for Readiness Pre-Deployment).

11.5.5.4.1.2. For Post-deployment Assessments: Use the MH detail combined

with the RPD (Readiness Post-deployment) detail code.

11.5.5.5. Clinics will use ROUTINE slots to book new self-referrals and not just for those patients discharged from an inpatient facility.

11.5.6. Behavioral Health Optimization Program (BHOP) Appointing. Military Treatment Facilities should attempt to utilize BHOP services as entry point for Mental Health services.

11.5.6.1. Appointment types for BHOP: Family Health Clinic embedded service BHOP clinics are permitted to use three standard appointment types:

11.5.6.1.1. Clinics will use 24HR slots to book urgent behavioral healthcare requests within 24 hours, to include walk-in appointments that need to be seen the same day. (T-1)

11.5.6.1.2. Clinics will use the FTR appointment type for patients requesting non-urgent follow up services, beyond 24 hours only. Follow-up appointments will be booked within the time frame requested by the BHOP provider. (T-1)

11.5.6.1.3. Clinics will use the GRP appointment type for patients who require therapy, counseling, or teaching sessions where a provider performs the service in a group setting. (T-1)

11.5.6.1.4. Clinics will use the SPEC appointment type for all new appointments. (T-1)

11.5.6.2. WALK-IN visits are also allowed and clinics will use when a patient urgently needs to be seen and there is no appointment available. (T-1)

11.5.7. Mental Health should have a no-show rate of no more than five (5) percent for new SPEC appointments and no more than ten percent for all other appointment types. (T-1)

## **11.6. Physical Therapy (PT) Direct Access Management.**

11.6.1. Appointment Types Used in PT Templates and Schedules. Appointment types will be used as outlined below: (T-3)

11.6.1.1. Clinics will only use 24HR slots to schedule direct access (i.e., no referral needed) evaluations and for acute conditions that should be seen within 24 hours.

11.6.1.2. Clinics will use SPEC slots to schedule/book any Routine priority referral/consult requests for initial physical therapy care evaluations by a physical therapist (officer or civilian/contract equivalent) within the time frame requested by the referring provider or not to exceed 28 days. (T-3)

11.6.1.3. Clinics will use FTR slots to schedule/book appointments to the physical therapist for the purpose of reevaluation or treatment. Clinics will book these appointments within the time frame requested by the physical therapist. (T-3)

11.6.1.4. Clinics will use PROC slots to schedule PT care appointments to enlisted, civilian, or contract PT technicians or equivalent providers as approved/directed by the physical therapist. The majority of appointments scheduled for PT technicians will use the PROC appointment type. If multiple patients are to be seen at the same time by the PT Technician in a group setting for PT care/courses of therapy, the PROC appointment

type with multiple appointment slots during the same time will be used. Clinics will book all PROC appointments within 28 days to meet the Specialty Care ATC standard. (T-3)

11.6.1.5. Clinics will use GRP slots for patients who require group teaching/education classes/sessions by any physical therapist or PT technician. (T-3)

11.6.2. Guidance if Physical Therapist and PT Technician treat patient during same visit:

11.6.2.1. If both the physical therapist and the PT technician see a patient during a visit, the appointment type used will default to the one that was originally chosen when booking the appointment. For example, if a PROC appointment is booked for the PT tech, but during the visit the physical therapist sees the patient, then the appointment type for the visit remains PROC.

11.6.3. Physical Therapy should have a no-show rate of no more than five (5) percent for new SPEC appointments and no more than ten percent for all other appointment types. (T-3)

### **11.7. Audiology/Hearing Conservation ATC Management.**

11.7.1. Audiology/Hearing Conservation scheduling must adhere to all of the operational definitions. (T-3)

11.7.2. Clinics will schedule Hearing Conservation (Audiology) encounters in the FBNA MEPRS clinic regardless of appointment type booked. (T-3)

11.7.3. Clinics will schedule Clinical Audiology encounters in the BHDA (Primary Medical Care - Audiology) MEPRS clinic regardless of appointment type booked. (T-3)

## Chapter 12

### ACCESS TEAM TRAINING, MANAGEMENT AND TRAINING RESOURCES

#### 12.1. Management and Training of GPMs:

12.1.1. To ensure that the GPM is optimally trained for the position, GPMs must attend the resident AFMS GPM Orientation Course conducted at the Medical Education and Training Campus (METC) within two to four months of assuming the GPM position. (T-2)

12.1.2. The GPM will attend an Access Improvement Seminar during the first year of each assignment as a GPM. (T-2)

12.1.3. GPMs will attend the Air Force Medical Home Operations (AFMHO) Course within 6 months of assignment as a GPM. (T-2)

12.1.4. GPMs will attend the Appointing Information Systems Hands-on Training Course during their first assignment as a GPM. (T-2)

12.1.5. GPMs will remain in the position no less than 2 years. (T-3)

12.1.6. GPMs will attend the annual GPM symposium or as scheduled. (T-3)

#### 12.2. Training of Appointing Agents:

12.2.1. MTFs will establish and require initial and annual refresher appointing training for all personnel who have CHCS booking keys. (T-3)

12.2.2. Evidence of required training will be documented and tracked within the MTF. (T-3)

## Chapter 13

### TRICARE ONLINE

#### 13.1. TRICARE Online (TOL) Overview.

13.1.1. TRICARE Online is an enterprise-wide, secure, internet portal for use by all DoD beneficiaries, providers, managers, managed care support contractors, and worldwide medical support staff to access available healthcare services, benefits, and information. TOL is a scalable, open standards platform upon which other applications can be integrated.

13.1.2. MTF leadership and commitment are vital to the success of TOL adoption, implementation and sustainment. MTF Commanders should appoint experienced, empowered, and motivated personnel to serve in key TOL team leadership positions.

#### 13.2. TRICARE Online Roles and Responsibilities.

13.2.1. Air Force TOL Functional Program Manager. The Air Force TOL functional program manager is located at AFMSA/SG3S and provides program policy direction and functional requirements expertise to the AFMSA/AFMOA Information Management offices to help them manage and sustain the technical aspects of the TOL system. Responsibilities include:

13.2.1.1. Provide support to Defense Health Agency (DHA) TOL Program Management as the AFMS Functional Service Program Manager/ Stakeholder.

13.2.1.2. Support/coordinate technical maintenance efforts with AFMS Information Management Office in accordance with service guidelines.

13.2.1.3. Coordinate processes needed to receive, develop and approve systems change requests and new requirements received from AFMSA, AFMOA, MAJCOM and/or MTF level functional personnel.

13.2.1.4. Submit/coordinate new TOL system change requests/requirements on behalf of the AFMS to DHA and coordinate on new requirements submitted by the other Services.

13.2.1.5. Coordinate the final development of necessary metrics/measures of appointing operations performance with applicable AF and DHA organizations.

13.2.1.6. Maintain an MTF TOL Appointing Subject Matter Expert (SME) list that is updated at least semi-annually.

13.2.1.7. Coordinate with the DHA Program Office to grant TOL System Administrator rights to those designated/listed as an SME.

13.2.1.8. Attend TOL related meetings (e.g., Program Management meeting, sustainment meeting, and various joint-service configuration management working groups).

13.2.1.9. Provide guidance to Air Force Inspection Agency (AFIA), AFMOA, MAJCOM Command Surgeons, and/or MTFs in the area of TOL functions.

13.2.1.10. Review marketing, training, and support materials for release to AFMS organizations and MTFs.

13.2.1.11. Coordinate training with AFMSA and/or MTFs.

13.2.1.12. Coordinate upgrades of new TOL capabilities with DHA TOL Program Office, AFMOA, MAJCOMs and MTFs.

13.2.1.13. Coordinate applicable system security, information assurance certifications with DHA, AFMSA and/or necessary AFMOA offices as needed to ensure that applicable documents such as Authority to Connect, Authority to Operate and other system security certifications are approved to support secure TOL system operations.

13.2.2. AFMSA Access to Care Program. AFMSA Access to Care Program has the role of maintaining the policy pertaining to the TOL roles and responsibilities for the AFMS.

13.2.3. AFMOA Health Benefits Division (AFMOA/SGAT). The AFMOA Office coordinates with the AFMSA/SG3S TOL functional program management office regarding program and system implementation and sustainment requirements. Responsibilities of this office include:

13.2.3.1. Serves as AFMSA TOL program implementation and sustainment point of contact (POC).

13.2.3.2. Maintains an MTF identified TOL System Administrator listing that is updated at least semi-annually.

13.2.3.3. Forwards the updated/completed listing to AFMSA/SG3S, Operations Element, who will coordinate with the DHA Program Office to grant TOL System Administration (SA) rights.

13.2.4. MTF Responsibilities. The MTF leadership appoints and empowers personnel to fill the TOL sustainment team positions, to include a TOL Program Manager, MTF TOL System Administrator (SA), MTF TOL Appointing Subject Matter Expert (SME) and TOL Marketing POC. (T-3)

13.2.4.1. MTF TOL Program Manager. Personnel fulfilling this role are assigned to the TOPA function at the MTF. Responsibilities include:

13.2.4.1.1. Coordinate TOL account permissions and facilitate account activation/changes for TOL users. (T-3) Partner with pharmacy to ensure that TOL pharmacy features are reviewed regularly and are enabled for patient use.

13.2.4.1.2. Establish business practices to incorporate TOL registration into venues such as the newcomer orientation or Right Start process for newly assigned base personnel. (T-3)

13.2.4.1.3. Attend Medical Group (MDG) staff meetings as appropriate to disseminate new TOL information. Examples include TOL system updates, system downtimes, new tools, etc. (T-3)

13.2.4.1.4. Complete all applicable training pertaining to the TOL System, functionality, and user accounts. Initial and annual training will be provided by AFMSA/SG3S. (T-1)

13.2.4.1.5. Ensure appointment letter/MDG POC listings are updated for MDG staff to be aware of the individual(s) fulfilling the MTF TOL SA role. (T-3)



13.2.4.1.6. Work with MTF TOL Marketing POC to ensure successful marketing to the base populace. (T-3)

13.2.4.2. MTF TOL System Administrator. Personnel fulfilling this role are assigned to the Information Systems Flight at the MTF. Responsibilities include:

13.2.4.2.1. Review/understand the MTF Server Installation and Configuration Guide and basic TOL features that can be obtained from the Science Applications International Corporation (SAIC®) personnel at the MTF to ensure the proper operations of the TOL system. (T-3)

13.2.4.2.2. Coordinate with the MTF TOL Program Manager and the AFMOA Health Benefits Division to assist/provide oversight with TOL hardware and software installation activities. (T-1)

13.2.4.2.3. Resolve TOL system/technical issues at the MTF level as needed. (T-3)

13.2.4.2.4. Serve as coordinator when changes/maintenance to CHCS, or any other network, impacts the overall operation of TOL. (T-3)

13.2.4.2.5. Coordinate with the MTF TOL Program Manager to ensure MTF is ready for new capability interfaces. (T-3)

13.2.4.2.6. Ensure the maintenance of the MTF TOL system to include all aspects except appointing functions.

13.2.4.3. MTF TOL Appointing SME. Personnel fulfilling this role are assigned to the GPM office. Responsibilities for this role include:

13.2.4.3.1. Understand how to prepare, monitor, and maintain CHCS appointing schedules to maximize TOL's web-enabled appointing functionality. (T-3)

13.2.4.3.2. Work with MTF appointing staff, the MTF TOL Program Manager and SA and the AFMSA/SG3S TOL Functional Program Office, to maximize the MTF's TOL appointing functions. (T-1)

13.2.4.3.3. Serve as the MTF POC when changes to the CHCS appointing templates impact TOL, appointing functionality, or when new appointment functionality is added to TOL. (T-3)

13.2.4.3.4. Ensure the MTF clinic personnel understand the TOL appointing business rules. (T-3)

13.2.4.3.5. Ensure that at least 80 percent of all CHCS appointment slots in primary care clinics, to include Family Health, Pediatrics, Internal Medicine, Flight Medicine and Optometry clinics schedules, are available/viewable for booking in TOL appointment schedules IAW [Chapter 3](#) and [Chapter 5](#) of this AFI. (T-1)

13.2.4.3.6. Management of TOL Scheduling and Appointment Management will be governed IAW [Chapter 3](#) and [Chapter 5](#) of this AFI. (T-1)

13.2.4.4. TOL Marketing POC. The Marketing POC performs one of the most critical functions for TOL sustainment. MTF staff and beneficiary knowledge about TOL is crucial to the success of the program and/or any new application releases on TOL. Responsibilities of this role include:

13.2.4.4.1. Develop and organize a marketing strategy that targets the MTF's various patient groups. (T-3) This strategy includes: having providers and clinic staff act as informal promoters of TOL, utilizing available resources (e.g., newsletters, on-hold telephone messages, installation newspapers) to market TOL, coordinating with MTF TOL Appointing SME to develop marketing strategies specific to clinic (e.g., pediatric vs. adult medicine clinic), and/or supplying marketing materials to clinics throughout the MTF, and across the base. (T-3) The MTF TOL usage goal is no less than 5%.

13.2.4.4.2. Redefine marketing strategies for specific clinics as needed as well as when new TOL capabilities and changes develop. (T-3)

13.2.4.4.3. Attend marketing meetings with the TOL Program Office, MAJCOM and/or AFMOA TOL POC, and AFMSA/SG3S. (T-1)

MARK A. EDIGER, Lieutenant General, USAF,  
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## Attachment 1

## GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

*References*

10 USC Sections 1074, 1078

Title 32 Code of Federal Regulations, 199.17

37 USC §204

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***Prescribed Forms***

None

***Adopted Forms***

AF Form 847, Recommendation for a Change of Publication

***Abbreviations and Acronyms***

**AAAHC**—Accreditation Association for Ambulatory Health Care

**ACD**—Automated Call Distribution

**ADSM**—Active Duty Service Member

**AF**—Air Force

**AFI**—Air Force Instruction

**AFMSA**—Air Force Medical Support Agency

**AFMH**—Air Force Medical Home

**AFMS**—Air Force Medical Service

**AFRC**—Air Force Reserve Command

**AHLTA**—Armed Forces Health Longitudinal Technological Application

**AMDS**—Aerospace Medical Squadron

**ANG**—Air National Guard

**ARC**—Air Reserve Component ATC—Access to Care

**AVHE**—Application Virtualization Hosting Environment

**BHOP**—Behavioral Health Optimization Program

**BR**—Business Rules

**CHCS**—Composite Health Care System

**CSSP**—Clinical Support Staff Protocol

**DART**—Direct Access Reporting Tool

**DEERS**—Defense Enrollment Eligibility Reporting Systems

**DoDD**—Department of Defense Directive

**DoDI**—Department of Defense Instruction

**EOD**—End-Of-Day Processing

**GPM**—Group Practice Manager

**HA**—Health Affairs

**HCI**—Health Care Integrator

**IMA**—Individual Mobilization Augmentee

**Kx**—Knowledge Exchange

**LOD**—Line of Duty

**LWOBS**—Left Without Being Seen

**MCSC**—Managed Care Support Contractor

**MDOS**—Medical Operations Squadron

**MDSS**—Medical Support Squadron

**MEPRS**—Medical Expense Reporting and Performance System

**MHS**—Military Health System

**MTF**—Military Treatment Facility

**NAL**—Nurse Advice Line

**OSD**—Office of the Secretary of Defense

**PCM**—Primary Care Manager

**PHA**—Preventive Health Assessment

**PT**—Physical Therapy

**RC**—Reserve Component

**RMC**—Referral Management Center

**RM**—Referral Management

**RMS**—Referral Management Suite

**ROFR**—Right of First Refusal

**SGA**—Administrator

**SGH**—Chief, Medical Staff

**SGN**—Chief Nurse

**TJC**—The Joint Commission

**TM**—Template Manager

**TOL**—TRICARE On-Line

**TOC**—TRICARE Operations Center

**TOM**—TRICARE Operations Manual

**TOPA**—TRICARE Operations and Patient Administration

**TRC**—TRICARE Regional Contractor

## Attachment 2

## AFMS REFERRAL MANAGEMENT (RM) BUSINESS RULES (BRS)

Table A2.1. Numbered Decision Points.

No.	Decision Point	Description	Tier
1.	<b>RMC Staff Training</b>	<p>At a minimum, the Referral Management Center (RMC) staff will:</p> <p>Read and refer to AFI 44-176, RM guidance/policies, other AFIs impacting referrals; TRICARE Operations Manual (TOM) chapters related to referrals; TRICARE Policy Manual (TPM) on the TRICARE benefit.</p> <p>Complete Referral Management Suite (RMS) and Electronic Health Record (EHR) training (CHCS or MHS GENESIS); Managed Care Support Contractor (MCSC) website/tools training; other MTF training.</p>	T-2
2.	<b>Locate RMC w/Patient In Mind</b>	The RMC should be located within the MTF (exception: Enhanced Multi-Service Markets (eMSM)) and in close proximity to the primary care clinics to promote patient convenience and staff communication. The RMC location will be configured to accommodate queues and patient privacy.	
3.	<b>Educate MTF Providers &amp; Clinical Staff</b>	The MTF will train providers/clinical staff during orientation/in-processing and on a recurring basis as needed on the following: roles and responsibilities for ordering referrals/consult; specialty capability within the MTF/eMSM; non-covered benefits to avoid writing referrals that will be denied; use of network specialists; and avoidance of MTF directed referrals and use of non-network specialists without written clinical justification.	T-3
4.	<b>Consult and Referral Definitions and Priority Types</b>	<p>Definition of a consult: a request for an opinion on the best course of treatment for a patient; the referring provider continues care for patient based on the advice of the consulted provider. Example: Evaluate Only</p> <p>Definition of a referral: a request to evaluate and treat and assume care for the patient for the condition. The terms referrals and consults are used interchangeably in this document. Example: Evaluate and Treat</p>	T-3
4.1.	Other than Routine Priority Specialty Care Referrals	For other than routine priority referrals, the provider/clinical team will contact the specialist directly and arrange an appointment (hand-off communications). The accepting provider's name, appointment date, phone number (if	T-1

No.	Decision Point	Description	Tier
		available) and location/facility will be annotated within the referral. Urgent Care is defined in the TOM as “medically necessary treatment that is required for illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.”	
4.2.		For urgent priority referrals, the provider/clinical team will contact the specialist directly and arrange for an urgent specialty care appointment (hand-off communication). Alternatively, the MTF’s MCSC can assign a specialist. The RMC will process the referral immediately and transmit it to the MCSC. The RMC/clinical team will ensure the patient clearly understands when and where his/her urgent priority referral appointment will occur per the MCSC authorization, before leaving the MTF.	T-1
4.3.	Routine Priority Referrals	The DoD access to care (ATC) standard for routine referrals is 28 days from date the referral was written. See BR 10, “Appoint Referral to MTF Specialty Clinic”, for waiving ATC standards.	
4.4.	Urgent Primary Care Referrals	The MTF will manage and track consults for urgent primary care. Urgent primary care consults requested during or after duty hours will be entered into the EHR NLT the next duty day. With documented training and written algorithms, other staff members (e.g., appointing agents, etc.) may enter consults for urgent primary care into the EHR. The RMC will transmit the consult to the MCSC and obtain the urgent primary care consult results.	T-1
4.5.	Urgent Primary Care Pilot	For the allowed number of urgent primary care visits without a referral for eligible beneficiary categories per TRICARE policy, refer to TOM, Chapter 18, Section 19, Pilot Program On Urgent Care For TRICARE Prime/TPR Beneficiaries. Urgent care (UC) sought under this program is considered a “self-referral” episode of care; there is no requirement to chase the UC report. However, MTFs should encourage Urgent Care Clinics (UCCs) to send results to the MTF. UCC Reports to be obtained by the MTF through means such as the NAL.	

No.	Decision Point	Description	Tier
5.	<b>Order Referral</b>	Credentialed providers will order consults in the EHR before the end of the patient encounter so the patient can go to the RMC for appointing, guidance/counseling before he/she leaves the MTF. At a minimum, providers should include on the referral: a provisional diagnosis; reason for referral to include treatments attempted and outcome(s); care or service requested; and whether the specialist is to evaluate or evaluate and treat the patient.	T-1
5.1.	Referral Renewals, Retroactive Referrals	The RMC staff will not enter new, renewal, or retroactive referrals/consults (excludes ROFRs). For requests by network specialists for additional visits, per TOM Chapter 8, Section 5, "For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional service to authorize. The MCSC shall not request a referral from the MTF..." This applies for non-ADSM patients. ADSM patients require MTF approval and referral renewal.	T-1
5.2.	Provider By Name, Directed, and Non-Network Referrals	The MTF will not direct referrals to specific network or non-network providers (Provider by Name) without written clinical justification. The MTF will not direct referrals to providers greater than 100 miles from the MTF (Directed Referrals) and coordination with the TRO (See TOM, Chapter 8, Section 5). Patients requesting specific non-network providers may exercise their point of service option or contact the MCSC.	T-0
5.3.	Non-Covered Benefits	If a referral is ordered for a non-covered benefit, the MTF will submit to the MCSC the Defense Health Agency (DHA) waiver approval with the referral. If the waiver approval is not included when the referral is sent, the MCSC will deny the referral. Resources: The MCSC will use the No Government Pay List (NGPL) and TRICARE Policy for included/excluded services to administer the TRICARE benefit for ADSMs (See TOM, Chapter 17, Section 3, Contractor Responsibilities, for complete policy <a href="http://manuals.tricare.osd.mil/">http://manuals.tricare.osd.mil/</a> ). The NGPL is available on the <a href="http://www.health.mil">www.health.mil</a> site.	T-0
5.4.	Waiver for Non-Covered Benefit	Waiver forms, DHA policy, and AF waiver process can be downloaded from the AFMS Knowledge Exchange. Contact the AFMOA/SGAT region POC for questions. In general, the requesting provider and the MTF SGH will initiate the waiver process and complete required documents. Forward waiver to the AF Consultant that provides guidance for the	



No.	Decision Point	Description	Tier
		specialty requested. If the AF Consultant does not support the waiver, do not forward to AFMOA SGAT. If the AF Consultant approves the waiver, forward package to the respective AFMOA SGAT Regional Rep. Once the waiver is approved by DHA, the RMC will fax the approved waiver with the referral to the MCSC.	
6.	<b>Route Referrals to RMC</b>	The MTF will route all specialty care referrals through the EHR to the RMC or eMSM RMC for administrative review, appointing to the MTF, and processing. The Executive Staff will approve in writing exceptions to this routing. MTF specialty clinics (exempted by the Executive Staff) that perform their own reviews will be responsible for referral review, booking, and tracking of referrals.	T-1
6.1.	RMC CHCS "Clinic"	MTFs will configure the RMC as a "Clinic" location Hospital Location file, use ELAA MEPRS code and populate the "Clinic Specialty" field with all clinic specialties available in the MTF and purchased care.	T-1
6.2.	CHCS Ancillary Procedures	The MTF will ensure that each Ancillary Procedure contains the name of the specialty in the "Clinic Specialty" field and the RMC in the "Consulting Clinic" field. Applies only for specialty care referrals as defined in BR 4.	T-1
6.3.	Orders Entered as "Referrals"	For orders or requests for care that use the EHR as means to track orders performed in the purchased care and do not require a MCSC authorization (e.g, mammograms for Non-ADSMs, case management, laboratory requests, etc.), the MTF will route the "referral" to the appropriate MTF accountable tracking owner. See BR 13.5	T-1
7.	<b>Send Patients to the RMC</b>	Referring providers/clinical teams will instruct patients with referrals to go to the RMC prior to leaving the MTF (Exception: eMSM RMCs located at a distance from the referring MTF). The MTF should provide patients a brochure which explains, at a minimum, the RM process, contact information of MCSC for authorization questions, and RMC's contact information for questions.	T-3
8.	<b>Customer Service</b>	RMC staff will confirm patient's TRICARE eligibility and contact information (in CHCS, ensure preferred phone number is entered in the "home phone number" field); appoint the patient's MTF specialty appointment prior to leaving the MTF or explain how they will be notified of their appointment; and explain the purchased care referral process. Refer the patient to the MCSC or Beneficiary Counseling and	T-3

No.	Decision Point	Description	Tier
		Assistance Coordinator for health plan coverage information as needed.	
9.	<b>Referral Review</b>	The RMC will review all specialty care referrals (except self-referrals and “referrals” for administrative tracking) within one business day from the date the referral was ordered. One business day includes the order date plus the entire following day, excluding weekends and holidays. The review process includes checking the MTF’s capability/capacity report and appointing guidelines to determine if the referral can be appointed to the MTF. The RMC staff should consult with subspecialty clinics or send the referral to the specialist for review as needed. If the MTF has no capability/capacity for the requested specialty, the RMC will defer the referral to the purchased care. The RMC will ensure the referral includes the required data elements as defined in TOM Chapter 8 Section 5.	T-0
9.1.	Specialty Clinic Review	If the referral requires a review by the specialty clinic, the specialty clinic will review the referral within one business day from the date the referral was ordered. One business day includes the order date plus the entire following day, excluding weekends and holidays. If the specialty clinic does not review the referral within one BD, the RMC will book the patient to the specialty clinic based on the MTF’s capability/capacity report and appointing guidelines or defer the patient to the network.	T-1
9.2.	Incomplete referrals	The RMC may complete missing information or over-ride incorrect fields in RMS or MHS GENESIS, if permitted; otherwise, the RMC should return the referral to the ordering provider for correction and/or completion.	
10.	<b>Appoint Referral to MTF</b>	To the greatest extent possible, the MTF will book patients to the MTF’s specialty care clinic before the patient leaves the MTF.	T-0
10.1.	Specialty Clinic Appointing Guidelines	Specialty clinics will provide the RMC and eMSM RMC with current appointing guidelines. The appointing guidelines should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals within the MTF.	T-3

No.	Decision Point	Description	Tier
10.2.	Access To Care (ATC)	The MTF will book the initial specialty appointment IAW DoD ATC standards (32 CFR Section 199.17). If the MTF cannot meet the ATC standard, the appointing staff should ask patients if they would like to waive their ATC standard and opt for a later appointment. MTFs cannot mandate patients to waive their ATC standard. If the patient does not waive his/her ATC standard, then the MTF will defer the patient to purchased care.	T-0
10.3.	Appointing in the EHR	The MTF will book the initial MTF specialty appointment in CHCS using the Appointment Order Processing (AOP) function in order to link the appointment with the referral and ensure correct tracking through CHCS/RMS. Follow MHS GENESIS procedures to appoint patients.	T-0
10.4.	Contact Patients	The MTF will notify patients of their MTF referral appointment before they leave the MTF or within one business day from the date the review decision to appoint the referral to the MTF was made. The notification can be done by live phone call, secure messaging, or through automated methods (e.g. Audio-Communicator, etc.). The notification will be repeated until the appointment is booked, the patient cancels the referral, or the message has been delivered three times on separate days.	T-0
11.	<b>Referrals to Another MTF (CHCS)</b>	<p>MTFs that refer patients to other MTFs should follow the following processes:</p> <ol style="list-style-type: none"> <li>a. If the referring MTF (e.g., Bolling AFB) is on the same CHCS host as the consulting MTF (e.g., Andrews AFB), the referring MTF (Bolling) should select the consulting clinic (e.g., Andrews RMC) and enter a review status of “Refer to Subspecialty” (code 14).</li> <li>b. If the referring MTF (e.g., Laughlin AFB) is not on the same CHCS host as the consulting MTF (e.g., SAMMC Consult &amp; Appointing Office (CAMO)), the referring MTF (Laughlin) should enter a review status of “Defer to Network” (code #10) and in the first line of the “Review Comment” field will type “To MTF/” plus the DMIS of the consulting MTF, e.g. TO MTF/0066. Complete the Clinic specialty field, indicating the specialty requested. Transmit the referral to the consulting MTF. The consulting MTF’s RMC (e.g., CAMO) should enter the referral in CHCS/AHLTA as a consult and in the first line of the</li> </ol>	

No.	Decision Point	Description	Tier
		Review Comment field will type "From MTF/" plus the DMIS of the referring MTF, e.g., FROM MTF/0114. Follow MHS GENESIS procedures.	
12.	<b>MTF Capability and Capacity Report</b>	The MTF Executive Staff will approve the MTF's Capability and Capacity report. The MTF's Capability and Capacity report should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs. The MTF will ensure the report is current and provided to the RMC, MCSC, and eMSM (if applicable).	T-1
13.	<b>Defer Referral to Purchased Care</b>	When there is no specialty care available in the MTF, the RMC or eMSM will defer and transmit the referral to the MCSC. The RMC will assist patients with specialty care referrals not requiring MCSC authorization and advise them of their options based on their TRICARE health plan and eligibility.	T-0
13.2.	Patient Contact	The MTF will notify patients of their defer to network referral before they leave the MTF or within one business day from the date the review decision to send the referral to the purchased care was made. The notification can be done by live phone call, secure messaging, or through automated methods (e.g. Audio-Communicator, etc.). Repeat the call 14 calendar days after the referral's order date to remind the patient to make an appointment with the civilian provider indicated in the authorization letter.	T-0
13.3.	Document Reasons for Deferring a Referral to the Purchased Care	The RMC will document at least one of the below codes in the referral's CHCS Review Comment field using the hard brackets [xx]. Use of at least one code is mandatory. Multiple codes may be used; however, each code must be in its own bracket. MTFs should utilize the RMS "Referral Summary" or "Referral Trends" reports to analyze reasons referrals were sent to the purchased care. MTFs on MHS GENESIS will follow MHS GENESIS processes.	T-1
13.3.1.	[2nd]	Second opinion requested. Patient or provider requested a second opinion	
13.3.2.	[CB]	Capability. MTF did not have specialty or services requested	
13.3.3.	[CC]	Continuity of Care: Continuity of care is operationally defined as follow on care from a specific specialist as part of a specific procedure or service that was performed within the	

No.	Decision Point	Description	Tier
		previous six months (TOM, Chapter 8, Section 5)	
13.3.4.	[CMD]	Command Directed. Referrals requiring approval from Chief of the Medical Staff or designee	
13.3.5.	[CP]	Capacity. MTF did not have appointments available within the access to care standards	
13.3.6.	[DS]	Distance. Exceeds TRICARE distance/travel requirements	
13.3.7.	[NAR]	No Pre-authorization required	
13.3.8.	[OHI]	Other Health Insurance. Patient has OHI or is Medicare eligible	
13.3.9.	[POS]	Point of Service or Self-Referred care	
13.4.	Laboratory and Radiology Orders, DME Which Require MCSC Authorization	The RMC will process and track laboratory and radiologic orders and Durable Medical Equipment (DME) referrals that require MCSC authorizations. DME invoices are considered a “clear and legible report (CLR).”	T-1
13.5.	Laboratory and, Radiology Orders, DME Which <u>Do Not</u> Require MCSC Authorization	If the MTF enters referrals for ancillary services not requiring MCSC authorizations for electronic tracking purposes, the MTF will designate the appropriate department (e.g., radiology, laboratory, medical management, etc.) to track these “referrals.” This function is not within the scope of the central RM contract. DME that do not require authorization is optional.	T-1
13.6.	Disease Management, HEDIS Screening	Preventive care testing does not require TRICARE authorization; therefore, the RMC will not process, manage, or track orders/referrals for screening exams. The RMC will not enter cancer screenings (breast, cervical and colorectal cancer screenings), HgbA1c results, and LDL HEDIS results in the TSWF MHSPHP AIM form. This function is not within the scope of the central RM contract.	T-1
13.7.	Patient Travel	For authorized care outside of the 100 mile MTF-radius, the TOPA travel section will assist patients with travel arrangements (Refer to AFI 41-210).	T-1
<b>14.</b>	<b>Right of First Refusal Referrals (ROFRs)</b>	A ROFR is a referral from a beneficiary enrolled to a network civilian PCM sent to the MTF by the MCSC for appointing consideration. MTFs should ensure the fullest extent of ROFR acceptance to sustain clinical currency.	

No.	Decision Point	Description	Tier
14.1.	Accept or Decline ROFRs	The MTF will accept/decline urgent priority ROFRs received within 90 minutes of receipt or as updated in TOM 8.5. The MTF will accept/decline routine priority ROFRs received within two business day of receipt or as updated in TOM 8.5. Failure to respond to ROFR requests within the prescribed time is an implied MTF declination and the MCSC will send the patient to the network.	T-0
14.2.	Enter ROFRs in the EHR	If the ROFR is accepted, the RMC will enter the ROFR into the EHR as a consult. If the ROFR is entered in CHCS Referral Booking, convert the referral to a consult in CHCS in order to track results. In both cases, use the CHCS downtown provider or generic downtown provider as the referring provider. Follow MHS GENESIS processes for entering referrals.	T-0
14.3.	Appoint ROFRs	The RMC or specialty clinic will contact the patients and schedule their MTF specialty care appointments. See BR 10.	T-0
14.4.	Send ROFR Referral Reports to Civilian PCM	The RMC will forward the specialty care report via a HIPAA-compliant method to the referring civilian PCM within 10-business days of the patient's kept appointment.	T-0
<b>15.</b>	<b>Referrals for Certain Patient Categories and Situations</b>	The MTF shall have processes to address the below patient situations:	T-1
15.1.	ADSM on Medical Hold	Health Affairs policy 03-026, requires MTFs to ensure specialty care services are available for ADSMs on "medical hold" within two weeks of identifying the need for an appointment. Consult AFI 41-210, <i>TRICARE Operations and Patient Administration Functions</i> , for specific medical hold requirements. MTFs should collaborate with their MCSCs to ensure that ADSMs receive their referral authorizations and appointments expeditiously. Referring MTF providers will specify in the body of the referral when the ADSM should be seen (e.g., 72 hours, 7 days, 14 days, etc.) rather than using the default 28-day ATC standard for "Routine" priority referrals.	T-0
15.2.	ADSMs on Terminal Leave	During the terminal leave period, an ADSM in need of urgent private sector care must receive a referral and authorization from his or her MTF Primary Care Manager (PCM) located at the ADSM's final duty station. Routine private sector medical care is authorized only as part of the ADSM's active healthcare needs and should be pre-planned	T-0

No.	Decision Point	Description	Tier
		<p>and pre-authorized collaboratively by ADSM with his or her PCM. ADSMs on terminal leave may receive routine or urgent care at a VA medical facility. If an ADSM intends, while in terminal leave status, to reside outside of the Prime Service Area of the MTF where the ADSM is enrolled, utilizing procedures specified in TOM Chapter 17, Section 1, the MTF shall issue to the MCSC a single preauthorization for the ADSM to obtain from VA any necessary routine or urgent outpatient medical care. The period covered by this preauthorization shall be the entire anticipated span of the terminal leave period. This preauthorization shall be sent to MCSC before the ADSM departs his or her final duty station to commence terminal leave. It shall not include authorization for any private sector care or specialty care. ADSMs enrolled overseas traveling or returning stateside while on terminal leave should contact the OCONUS MCSC for private sector care authorizations.</p> <p>Refer to HA Policy “Enrollment of Active Duty Service Members in Terminal Leave Status” 20120514; HA Policy, “Policy Memorandum for Preauthorization of Routine and Urgent Medical Care Provided by the Department of Veterans Affairs to Active Duty Service Members in Terminal Leave Status” 20090116.</p>	
15.3.	ADSMs and the Integrated Disability Evaluation System (IDES)	The Physical Evaluation Board Liaison Officer shall work with the RMC to process referrals for Compensation and Pension (C&P) examinations at the DVA. The RMC will ensure the administrative documentation required for C&P referrals per TOM, Chapter 8.5 are completed prior to transmitting to the MCSC.	T-0
15.4	ADSM to an Advanced Rehabilitation Center (ARC)	ADSM amputee patients will be referred to DoD ARCs for assessment before authorizing care in the purchased care. See ASD(HA) memorandum, 14 Dec 16, Referral of ADSMs to an ARC.	T-0
15.4.	Prime Patients with OHI	Other health insurance (OHI) is insurance acquired through an employer, entitlement program or other source. The RMC will instruct Prime beneficiaries with OHI to submit referral requests to their primary health insurer and follow the guidance provided by their primary health insurer for referral appointments. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service or other programs or plans as identified by the Defense	T-0

No.	Decision Point	Description	Tier
		Health Agency. Request patients to contact the RMC with the specialist contact information to obtain the CLR.	
15.5.	OCONUS Pay Patients	"Pay Patients" are prioritized for care after ADSMs, Prime AD Family Members, Prime Retirees/Family members, AF Family Members not enrolled in TRICARE Prime, and T-Plus enrollees. "Pay Patients" are eligible to be seen within the MTF if capacity exists.	
15.6.	TRICARE Plus, TRICARE For Life (TFL), Medicare Beneficiaries	If MTFs have specialty capability and capacity, MTFs are highly encouraged to accept self-referral specialty care requests from TFL/Medicare beneficiaries with or without a referral/request from their civilian PCMs. These beneficiaries should be afforded the opportunity to be seen in the MTF based on the MTF's capability and capacity and currency case needs. Depending on where the patient presents, the specialty clinic or the RMC will enter a consult in CHCS. Obtain civilian physician information from patient and notate it on the referral. Note: specialty access for TFL/T Plus patients cannot be at the expense of access for Prime patients seeking the same specialty care. Prime patients cannot be deferred to network due to lack of access used by TFL/T-Plus patients. The RMC will provide the referring civilian provider/PCM the results within 10 business days from the kept appointment.	
16.	<b>Referral Tracking</b>	The RMC will track all initial specialty care referral results generated by the MTF, regardless of beneficiary status or enrollment, from the time the referral is written until the results are available to the referring provider or cancelled/not used by the patient. Referrals generated for tracking purposes (e.g., labs, radiology, case management, HEDIS, etc.) do not meet the definition of a specialty care referral/consult and will not be tracked by the RMC (BRs 4, 13.5).	T-1
17.	<b>Direct Care Referral Results</b>	If there is a kept MTF appointment associated with the direct care referral, the referral is considered "closed" and no further action by the RMC is required. (Note: The referring	



No.	Decision Point	Description	Tier
		provider should use AHLTA Consult Log to identify which direct care referrals have a specialist report available for review.)	
18.	<b>ROFR Referral Results</b>	The RMC will check the status of all accepted ROFRs no later than 60 days from receipt of the accepted ROFR. If there is a kept appointment associated with the ROFR, the RMC will provide the specialty care referral report to the referring purchased care provider within 10 business days of the kept specialty encounter. If the patient did not utilize the referral or keep the appointment, the RMC will close the referral in CHCS no later than 180 days from the date of acceptance and annotate {NU} in soft brackets in the CHCS Review Comment field to indicate the patient did not use the referral. Notify the referring network provider.	T-0
19.	<b>Purchased Care Referral Results</b>	The RMC will be the MTF's single POC to receive all purchased care CLRs. The RMC will obtain the initial CLR. Although the RMC does not actively seek CLRs for follow-up visit, the RMC will provide follow-up CLRs, if received, to the referring provider. If follow-up visit results are received from the specialist, the RMC will upload results into the Health Artifact and Image Management Solution (HAIMS) and notify the referring provider with a T-CON per BR 31.	T-1
20.	<b>CLR Received</b>	The RMC/MTF will import CLRs into HAIMS (see BR 32) and will close the referral in CHCS with a "Deferred Results Received" (Code #23) status. The RMC will notify the referring provider of CLRs via T-Con per BR 31.	T-1
21.	<b>When to Start "Chasing" CLRs</b>	The RMC will initiate efforts to obtain the CLR as soon as a claim is discovered, upon request by the referring provider or no later than 60 days from the date the referral was ordered, whichever occurs first.	T-0
21.1.	<b>60-Day Mark</b>	When a CLR has not been received or documented in the EHR, the RMC will check the applicable claims database for a claim.	T-0
21.2.	Claim	If a claim is found, the RMC will request the CLR from the rendering purchased care provider. If there is no response from the provider within 10 calendar days, repeat. If the provider still does not provide the CLR, the RMC will close the referral in CHCS using the status of "Deferred results received" and annotate {CRNRR} in soft brackets in the CHCS Review Comment Field indicating a claim was	T-0

No.	Decision Point	Description	Tier
		reported but no results were received. Notify the referring provider. Initiate TRICARE contractor procedures as per the TOM and/or the Memorandum of Understanding (MOU) with the TRICARE regional contractor. Additionally, forward a report to the TRICARE Regional Office each month that lists all provider names, specialty care rendered, and referral Unique Identifier Numbers for which no CLR has been received after two attempts or per MOU.	
21.3.	No Claim	If no claim is found, the MTF should allow the patient more time to use referral. MTFs should understand their purchased care market's ATC environment.	
<b>22.</b>	<b>NLT 180 days</b>	NLT 180 days from the date referral was ordered, if the CLR has not been received, the RMC will recheck the applicable claims database for a claim. If there is a claim, follow BR 21.2).	T-0
22.1.	Claim	Follow BR 21.2 above.	T-0
22.2.	No Claim	If there is no claim and the MTF has reminded the patient to use the referral per BRs 10.4 and 13.2 above, the RMC will close the referral in CHCS. The MTF will use the below mandatory closed reason codes in CHCS; use of the other codes is optional. MTFs on MHS GENESIS will follow MHS GENESIS processes. The RMC will use only one code per referral.	T-1
22.2.1.	{NU}	The RMC will close the referral in CHCS with the status of "No appointment required" (code #13) and will type '{NU}' for "Not Utilized" in the "Review Comment" field (Mandatory).	T-1
22.2.2.	{CRNRR}	RMC will close the referral in CHCS with the status of "Deferred Results Received (code #23) and will type [CRNRR] for "Claim Received No Results Received" in the "Review Comment" field (Mandatory).	T-1
22.2.3.	{ACPC}	Patient Cancelled via Audio Communicator Referral Reminder	
22.2.4.	{PCRMO}	Patient called the RMC/RMO to cancel the referral (not via AudioCommunicator Referral Reminder)	

No.	Decision Point	Description	Tier
23.	<b>Patient “No Shows”</b>	The RMC should follow the MTF’s No Show Policy. Define process when to close the referral (e.g., after 1, 2, or 3 ‘No Shows” and who will close the referral in CHCS (e.g., the specialty clinic who documented the “No Show,” the RMC, or the referring provider/clinical team).	
24.	<b>Notify Providers of Unused, Cancelled, Denied Referrals</b>	The RMC will notify the referring provider of all routine priority referrals not used or cancelled by their patients IAW local MTF policy, but no less than monthly. (Note: the RMC should utilize RMS to generate a report by referring provider for the desired date range and provide it to leadership IAW local MTF policy.)	T-1
25.	<b>STAT / Urgent Referral Results</b>	If immediate results for STAT and urgent priority specialty care referrals are clinically required, then the PCM/clinical team should request them from the purchased care specialist. The clinic should provide the purchased care provider the RMC fax number. If the PCM/clinical team need the referral results for a future scheduled patient appointment regarding the CLR results, and the CLR results are not in AHLTA, HAIMS or the medical records, then the PCM/clinical team should provide the RMC as much prior notice as possible for the RMC to obtain the needed CLR.	
26.	<b>Automatic CHCS Closure of Referrals</b>	MTFs will disable the automatic closure function in CHCS for referrals/consults.	T-1
27.	<b>Import CLRS into the EHR</b>	The RMC shall import the following documents into the EHR within three working days from receipt of results: the initial specialty care CLR; follow-up CLRs; urgent primary care results; and laboratory results and radiology reports that require an authorization. All other loose documents shall be imported into HAIMS by Medical Records per AFI 41-210. MTFs using MHS GENESIS will upload the CLR into MHS GENESIS. Non-MHS GENESIS MTFs will upload the CLR into HAIMS.	T-1
28.	<b>MHS GENESIS MTFs</b>	The RMC should follow procedures for importing documents into MHS GENESIS and provider notification.	
29.	<b>Non-MHS GENESIS MTFs</b>	The MTF will create a T-Con and HAIMS entry for each CLR/result.  The MTF will associate the T-Con with the HAIMS entry so that the reviewing provider clearly understands which T-Con is for which HAIMS entry.	T-1

No.	Decision Point	Description	Tier
		<p>For both parts, the MTF will use the following mandatory standard naming convention: Network Results – Specialty MM/DD/YY where the MM/DD/YY is the date the patient was seen. For example, Network Results – Cardiology 2/10/14.</p> <p>If the local HAIMS is down, the MTF will select alternative Healthcare Artifact and Image Repository (HAIR) to upload CLRs and include the link to the alternative HAIR in the provider notification T-Con.</p>	
29.1.	Shared Folders in Shared Drives	The MTF shall not maintain any existing shared folders used for the purpose of storing temporary results or other Protected Health Information longer than 30 calendar days following the date of the original image upload. Thereafter, the electronic folder and documents must be deleted (AFI 41-210)	T-1
29.2.	Original and Translated CLRs (OCONUS)	The MTF shall import both the original foreign language and the English translated CLR into HAIMS. The untranslated result/CLR does not have to be signed by the referring provider if the translated result/CLR was already signed.	T-1
29.3.	Wet Signatures; Hard Copy of Referral	<p>Once loaded into HAIMS, the reviewing provider is not required to handwrite or “wet” sign the hard copy result/report. The paper copy of the result/report is not required to be filed into the paper outpatient medical record. However wet signatures and filing of paper copy may be required for special programs (e.g. PRP) or payment issues). Before destroying the original hard copy or electronic result/report, ensure that the scanned document is legible by the provider. Ensure you have a quality check process in place to ensure right patient, right CLR and right record.</p> <p>Correcting errors: The MTF will have a quality check process to minimize PHI/PII errors.</p>	
30.	<b>Create HAIMS Encounter</b>	The MTF will create a HAIMS encounter for the CLR. See HAIMS RM Workflow Training slides_Nov 2013_Colorado MSMO found at AFMS Knowledge Exchange.	T-1
31.	<b>Create AHLTA T-Con</b>	<p>The MTF will follow the below process:</p> <p>Under the Folder List, select “Telephone Consults.”</p> <p>From the Toolbar/Action bar, click “New Telcon” icon; click “Yes” in the pop-up.</p> <p>In the “Clinic” field, select the clinic location of the provider</p>	T-1

No.	Decision Point	Description	Tier
		<p>receiving the T-Con. AHLTA automatically defaults this field to the creator’s location. You must change it. Once you click “OK,” you cannot make changes. If you chose the wrong clinic and clicked “OK”, you must cancel the T-Con and start over.</p> <p>In the “Assigned Owner” field, select the provider receiving the T- Con.</p> <p>In the “Reason for Telephone Consult” field, enter the following mandatory naming convention: “Network Results – Specialty MM/DD/YY”.</p> <p>For example, “Network Results – Orthopedics 02/13/14” or “Network Results – Lab 02/13/14”; or “Network Results – Radiology 02/04/14”.</p> <p><u>The entry should match the name of the corresponding HAIMS entry</u></p> <p>Click “OK” when done. Your T-Con will automatically display.</p> <p>If sending a courtesy copy notification of a result/report, use the following naming convention: “Network Results - Specialty MM/DD/YY—CC” (CC=courtesy copy).</p> <p>In the “Note” field, reference the HAIMS entry in the T-Con. For example, “Please review the results in HAIMS titled Network Results – Orthopedics 02/13/14”. For T-Con:</p> <p>In the “Note” field, enter text. For example, “Please review the results in HAIMS titled Network Results – Orthopedics 2/13/14”.</p> <p>In the “Urgency” field, AHLTA defaults to “Medium.” Change as appropriate.</p> <p>In the “Diagnosis” box, select “Z76.89 - Persons encountering health services in other specified circumstances”.</p> <p>In the “Admin” box:</p> <p>In the “Meets Output Visit Criteria (Workload)?” field, change the default “Yes” to “No”.</p> <p>In the “E &amp; M” field, ensure “99499” is selected.</p> <p>From the Toolbar/Action bar, click “Save” and “Close” icons. Do not sign the T-Con. The receiving provider will</p>	

No.	Decision Point	Description	Tier
		sign the T-Con. The T-Con is automatically sent to the selected provider.	
32.	<b>Upload CLR in HAIMS and Associate T-CON</b>	<p>The MTF will follow the below process:</p> <p>From the Folder List, select Artifacts and Images. (Note: Telecon Tab is still open).</p> <p>Select Import Asset icon</p> <p>In the “Acquire Asset Import New” box, ensure “Browse and upload a file” and “Associate with Selected Encounter” boxes are checked.</p> <p>Select “Browse” and locate CLR. Click “Upload”</p> <p>Fill in Metadata fields as instructed in BR 33.5.</p> <p>Select “Save and Close”</p> <p>Close Artifacts and Images screen. Select “Close” button on toolbar. CLR is now available in HAIMS and is associated with the T-CON created, which makes it easier for the provider to find the HAIMS CLR.</p>	T-1
32.1.	Mandatory HAIMS Metadata Fields	<p>The MTF will fill out the below mandatory HAIMS metadata fields for CLRs:</p> <p>Author Name: The author name is the purchased care provider or group that provided the CLR.</p> <p>Date Document Created: The date that the patient visit occurred or the date of the CLR. (For mental health CLRs, check box titled, “Mark as Sensitive.”)</p> <p>Document Type: Use the dropdown menu: for CLRs, select: Encounter Note—Consultation. Others, Radiologic report, Procedure Note, etc.</p> <p>Document Title: Network Results – Specialty MM/DD/YY where the date is the date in #2 above.</p> <p>Save and Close</p>	T-1
32.2.	Optional Metadata Fields	<p>Practice Setting: Outpatient</p> <p>Specialty: Type a few characters and choose (e.g. orthopedics)</p> <p>Procedure or Service: type a few characters and choose (e.g., MRI)</p>	

No.	Decision Point	Description	Tier
		Save and Close	
33.	<b>Provider Review</b>	<p>At a minimum, providers will document their review of the HAIMS CLR in the corresponding T-Con. Ensure T-Con is non-count workload. Change T-Con medical coding as appropriate. Sign and close.</p> <p>Providers will review T-Cons notifying them of scanned results/reports within three business days from the receipt of the T-Con. Providers will have current surrogates in CHCS/AHLTA to review T-Cons in their absence.</p> <p>Completed T-Cons are assumed to mean that the provider has reviewed the result/report in HAIMS/AHLTA.</p>	T-1
34.	<b>CHCS Ad Hoc to Monitor Provider Review of Scanned CLRs</b>	<p>When the T-Con naming convention is used per policy instructions, MTFs may use the CHCS Provider Review Ad Hoc that displays which CLRs had been scanned into HAIMS and whether or not they have been reviewed. These can be identified by patient or by provider.</p> <p>On the printed ad hoc report, if the T-Con has been reviewed, a status of “Tel-Con status” will show next to the T-Con. If the T-Con has NOT been reviewed, a status of “Occ-Svc status” will show next to the T-Con.</p>	
35.	<b>Measures</b>	<p>The MTF will report the below measures to MTF Executive leadership at least quarterly. Items 1-5 can be obtained from Referral Mgt Performance Mgt Tool (RMPMT). Items 8-9 can be obtained in RMS.</p> <ol style="list-style-type: none"> <li>1. Number of specialty care referrals/consults</li> <li>2. Number of urgent primary care referrals</li> <li>3. Number of referrals seen in the MTF or to other MTFs</li> <li>4. Number of referrals deferred to the purchased care</li> <li>5. Number and percentage of ROFRs accepted from the MCSC (Note: if the MTF has no ROFR capability, then items 5 and 6 are N/A)</li> <li>6. Percent ROFR referral results sent to requesting civilian PCM within 10 days of the kept appointment</li> <li>7. Number and percent of initial specialty referrals that were dispositioned within one business day as “Appoint to the MTF” or “Defer to Network.</li> </ol> <p>CLR Percent Received Report</p>	T-2

<b>No.</b>	<b>Decision Point</b>	<b>Description</b>	<b>Tier</b>
<b>36.</b>	<b>Secure Messaging (SM), MiCare</b>	The RMC should check their assigned SM box several times a day for new messages. The RMC should use SM to answer patient questions on referrals, obtain results from purchased care providers who are using the same SM vendor, and communicate with providers/clinical teams. Using SM to communicate with patients and purchased care providers about referrals saves the RMC time by decreasing unnecessary phone calls and eliminating telephone tag.	



**Attachment 3 (Added)****ACCESS MANAGEMENT TEAM (AMT) AGENDA**

**Chair:** Group Practice Manager (GPM)

**Alternate Chair:** Chief of the Medical Staff (SGH)

**Required Attendees:** Access Manager, all GPMs, Chief of Medical Staff (SGH), Chief Nurse (SGN), Chief Administrator (SGA); Health Care Integrator (HCI); Health Service Management 4A0 Functional representative; Aerospace Medicine Chief (SGP) or Representative; Flight Commanders of all clinics, TRICARE Operations and Patient Administration (TOPA) Flight Commander, the Quality Manager, and the lead appointment agent.

**Frequency:** Meet in-person with AMT members listed above (IAW AFI 44-176 para 2.2.2) at least monthly.

**Standard Agenda items will include but are not limited to:**

- 1) Review and coordination of: templating, scheduling, appointing, clinic/appointment staffing, provider coverage, supply shortfalls and surpluses, clinical operational issues with the goal of optimizing ATC at the MTF, process improvement efforts.
- 2) Review performance measures for all clinics monthly, to include, but not limited to:
  - a) Third Next available appointment (24HR, FTR, SPEC)
  - b) Appointment Utilization
  - c) Demand Management
  - d) Purchased care leakage
  - e) Patient satisfaction
  - f) Telephony metrics
  - g) No-show metrics
  - h) First call resolution results
  - i) PCM Continuity measures
  - j) NAL metrics (e.g., updates, NAL booking analysis metric, warm-handoff metric, beneficiaries pre-intent versus NAL recommended disposition metrics)
  - k) Minimum of 180-calendar days of available appointments for booking at all times for specialty and primary care clinics.

**AMT Meeting Documentation:** Evidence of AMT meeting occurrence (i.e. slides and sign-in roster) must be documented. Formal meeting minutes are encouraged but not required.