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MILITARY HEALTH CARE

Factors Affecting Contractors' Ability to Schedule Appointments

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Contents

Abbreviations

DOD	Department of Defense
MTF	military treatment facility

GAO
Accountability * Integrity * Reliability

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The Honorable Steve Buyer
Chairman
The Honorable Neil Abercrombie
Ranking Minority Member
Subcommittee on Military Personnel
Committee on Armed Services
House of Representatives

For most people, the initial contact with a health care system occurs when they call their physician's office to schedule an appointment. For years, Department of Defense (DOD) beneficiaries seeking to make appointments in military treatment facilities (MTF) gained access to care this way—by calling the clinic directly. Over the past several years, however, DOD has been moving toward a centralized appointment system. In some MTFs, an appointment center has been created, and beneficiaries call that center to schedule various types of appointments. In addition, in four areas of the country that DOD refers to as TRICARE regions, the TRICARE contractors have established regional appointment centers which beneficiaries call to schedule appointments with physicians in MTFs.[1] Centralized appointment scheduling is intended to provide beneficiaries with improved appointment services and increase efficiency by consolidating the appointment function such that MTF clinic staff will be less involved in the process. The contractors perform this function as part of their administrative tasks under their contracts with DOD.

As you requested, this report provides information on (1) the proportion of appointments scheduled by TRICARE contractors for beneficiaries in the four TRICARE regions with centralized systems, and (2) the factors that affect the contractors' ability to schedule appointments.

To determine the extent to which the contractors scheduled appointments, we obtained and analyzed data for appointments scheduled between

[1]DOD has organized its health care system into 11 geographic regions. In four of those regions—region 1 (the Northeast), region 2 (the mid-Atlantic), region 5 (the Midwest), and region 11 (the Northwest)—a regionwide centralized appointment system has been implemented.

November 1 and November 30, 1999, in each MTF in the four TRICARE regions.[2] We visited the contractors' appointment centers in three of the four regions to observe appointment scheduling and met with contractor officials and appointment staff to discuss the appointment process. We also discussed issues regarding the contractor's role and ability to schedule appointments with DOD officials, and with MTF physicians and medical staff at five MTFs. We did our work from September 1999 to June 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Our analysis of DOD data shows that contractors scheduled only about one-quarter of the appointments during November 1999 in the four regions where TRICARE contractors have appointment-making responsibility. The percentage of appointments scheduled by the contractors varied among the regions, ranging from about 17 percent to about 63 percent. In general, contractors scheduled a higher percentage of appointments for clinics that provide primary care services (42 percent) than for clinics providing specialty care, such as dermatology, cardiology, and orthopedics (17 percent).

In the four regions, DOD and its MTFs have restricted the types and number of appointments available to the contractors for scheduling. Some MTF physicians and other professional staff told us that they want to retain control over the appointing process because they do not trust contractors to accurately schedule appointments and to ensure that any medical instructions can be provided prior to the visit, such as instructions about fasting. When comparing like clinics within different MTFs the percentage of appointments scheduled by contractors varies substantially, suggesting that physicians' and other staff's desire to retain appointment control may be the driving factor, rather than the need to provide medical instructions. When contractors do not have access to appointments because of DOD and MTF restrictions, beneficiaries requesting appointments from contractors may be transferred from the appointment center to the MTF clinic, or told to call MTF clinics themselves. Thus, what was meant to be a simplified, more user-friendly appointment process is now a complex and confusing process in which beneficiaries are unsure whether to call the contractor or the MTF to schedule appointments.

[2]The November data were the most recent complete data available to us at the time we requested them.

To improve its appointment system, DOD is in the process of reducing and standardizing the number of appointment types and names used throughout the military health care system. Currently thousands of appointment types and names are used. Although reduction and standardization could simplify the appointment-making process, until DOD decides on and implements a more uniform process for making appointments, there will continue to be differences in how beneficiaries access the military health care system.

Background

DOD health care, referred to as TRICARE, is provided in military-operated hospitals and clinics worldwide, supplemented by civilian providers. TRICARE is organized geographically into 11 health care regions administered by five contractors. In TRICARE regions 1, 2, 5, and 11, the contractors' administrative tasks include scheduling appointments for the MTFs within their region. In each of these four regions, the contractor has established a central appointment center. Centralized appointment-making is intended to provide beneficiaries with improved appointment services, including the ability to make multiple appointments during a single phone call, and increased access to appointment clerks, because the appointment centers typically are open before, during, and after MTF clinic hours. To schedule an appointment at any of the MTFs in the region, beneficiaries call a regionwide toll-free number. In November 1999, contractor staff in the four regions answered more than 393,000 calls and scheduled about 211,000 appointments.

In regions 2 and 5, beneficiaries calling the toll-free number may be routed first to contractor staff located in the TRICARE service center closest to where the call originated. If that line is not available, the call is automatically routed back to the contractor's central appointment center. This rerouting is invisible to the caller, occurring in a few seconds. In regions 1 and 11, calls to the toll-free number are answered in the contractors' regional appointment center. Regardless of where the contractors' appointment clerks are located, the process for making appointments is the same: the contractors' clerks view computer screens showing schedules developed by the MTFs that include information on appointment availability and other descriptive information, such as the type of patient or procedure that should be scheduled into a particular appointment slot.

Although the TRICARE contracts require the contractors to schedule appointments, they do not specify the appointment workload. Each of the

contractors we met with stated that they schedule all the appointments provided to them by the MTFs and that this service was included in the administrative fees paid under the contract. Some of the contracts also include standards related to telephone responsiveness, such as a maximum number of rings before which incoming calls should be answered, or a maximum time callers should be placed on hold.

Proportion of Appointments Scheduled by Contractors

Our analysis of appointment data from the TRICARE regions reviewed indicates that only about one-quarter of the appointments in the MTFs were scheduled by contractor staff. As shown in table 1, the percentage of appointments scheduled by contractor staff varied among the regions. Regions 1, 2, and 5 have less experience than region 11 with central appointment scheduling, and the percentage scheduled by the contractors in those regions—17, 29, and 22 percent, respectively—is notably lower than the 63 percent of appointments scheduled by the contractor in region 11.[3]

Table 1: Percentage of Appointments Scheduled by Contractor Staff

Region	Contractor	Percentage scheduled by contractor[a]
1	Sierra Military Health Services, Inc.	17
2	Anthem Alliance Health Insurance Co.	29
5	Anthem Alliance Health Insurance Co.	22
11	Foundation Health Federal Services, Inc.	63
	Weighted average for all four regions[b]	26[c]

Note: Data are for appointments scheduled between November 1 and November 30, 1999.

[a]Percentage is calculated by dividing the number of appointments scheduled by the contractor by the total number of appointments scheduled by the contractor and MTF staff.

[b]The average is based on the total appointments for all four regions combined.

[c]The 26 percent represents about 211,000 appointments.

[3]Region 11 began performing the appointment function in March 1995, regions 2 and 5 began in May 1998, and region 1 in June 1998.

We also found that, in general, contractors scheduled a higher percent of appointments for primary care clinics than for specialty clinics.[4] Overall, about 42 percent of the appointments for primary care clinics were scheduled by contractor staff, as compared to about 17 percent of the appointments for specialty care clinics. These percentages also varied among the regions, as shown in table 2.

Table 2: Percentage of Primary and Specialty Clinic Appointments Scheduled by Contractor Staff

Region	Contractor	Percentage of primary clinic appointments scheduled by contractor[a]	Percentage of specialty clinic appointments scheduled by contractor[a,b]
1	Sierra Military Health Services, Inc.	33	9
2	Anthem Alliance Health Insurance Co.	44	19
5	Anthem Alliance Health Insurance Co.	37	11
11	Foundation Health Federal Services, Inc.	76	54
	Weighted average for all four regions[c]	42	17

Note: Data are for appointments scheduled between November 1 and November 30, 1999.

[a]Percentage is calculated by dividing the number of appointments scheduled by the contractor by the total number of appointments scheduled by the contractor and MTF staff.

[b]We defined specialty care clinics as all clinics not identified by the MTFs as primary care clinics. These include the full range of specialty medicine, such as cardiology, dermatology, and orthopedics; and some ancillary services that required an appointment, such as radiology.

[c]The average is based on the total appointments for all four regions combined.

Factors Limiting Contractors' Ability to Schedule Appointments

The primary factor limiting contractors' ability to schedule appointments is the limited number of appointments that are allocated to them for scheduling. DOD has given the region 1, 2, 5, and 11 contractors authority to schedule only certain types of appointments, and MTFs have further reduced the number of appointments available to contractors for

[4]It is reasonable to expect some portion of specialty appointments to be scheduled by MTF staff. Visits to specialists normally occur as a result of a referral from a primary care provider, and the clinic staff may call the specialty clinic within the MTF directly on behalf of the patient at the time the referral is made. Also, follow-up visits to specialists may be booked directly with clinic staff as patients leave the clinic.

scheduling. For example, in region 1, the contractor is authorized to schedule eight appointment types, including those for initial primary and specialty care, physical exams, and well-baby care. For the month of November 1999, these eight appointment types represented about two-thirds of all the appointments, with the remaining one-third not available for contractor scheduling. In regions 2 and 5, the contractor can schedule 9 and 12 appointment types, respectively.[5] At one MTF in region 5, the 12 authorized appointment types represented about 60 percent of total, and thus about 40 percent of the appointments were unavailable to the contractor for scheduling.

The number of appointments available for contractor scheduling has been further reduced because of MTF-imposed restrictions. For example, in region 1, of the 314 appointment openings in one MTF's optometry clinic in the month of November 1999, 222 were of the type that the contractor was authorized to schedule. However, the MTF further limited the contractors' scheduling ability by designating 300 of the 314 appointments as appointments that should be scheduled only by MTF staff. Therefore, only 14 appointments were available to the contractor's staff to schedule.

In region 11, each MTF has identified specific appointment types that should be scheduled by the contractor, and developed guidance for the contractor's appointment staff to follow when scheduling appointments. This guidance provides detailed descriptions of the various appointments, including the types of patients that should be scheduled in the different appointment slots, and whether the appointment can be scheduled by the contractor or by MTF clinic staff. The contractor told us that this guidance is cumbersome and confusing for the clerks to follow. The original appointment guidance totaled almost 900 pages for all the MTFs combined, and although the contractor and DOD have worked to reduce the number of pages, it is still about 300 pages long, providing appointment requirements for more than 100 clinics in the region's MTFs. Adding to the cumbersome nature of the long and prescriptive guidance is the fact that the appointment guidance and appointment names are not uniform among the MTFs. For example, at one MTF, contractor staff can schedule appointments for new patients in the ophthalmology clinic; however, in another MTF, appointments for new ophthalmology patients cannot be

[5]DOD has identified 12 appointment types that the contractor can schedule in region 5. However, each MTF determines which of the 12 types the contractor will schedule for each clinic.

scheduled by the contractor. Additionally, over 100 different appointment names are used by the MTFs in region 11. For example, 10 different appointment names are used to designate well-care visits—2-, 4-, 6-, 9-, and 12-month-old well-baby checkups; well-child checkups; well visits; 15- or 30-minute well visits; and follow-up well visits.

In September 1999, we reported on the lack of standardized appointment names throughout the military health care system, and recommended that DOD standardize appointment types across the system.[6] DOD established a group to undertake this task, and it has recommended using nine standard appointment types across the military health care system—a significant reduction from the thousands currently used. DOD has accepted the group's recommendation and expects to begin standardizing the appointment names used in the appointment system in the fall of 2000. Standardizing and reducing the number of appointment types will simplify the appointment process not only in the MTFs but also for contractors who are responsible for scheduling appointments in regions 1, 2, 5, and 11.

Beneficiaries can encounter unnecessary burdens and delays when the contractor's staff is restricted from scheduling certain appointments. For example, if the contractor's appointment clerk cannot schedule an appointment requested by a beneficiary because the MTF has not made the appointment type available to the contractor, the clerk might transfer the call to the MTF, put the caller on hold while he or she contacts the MTF to determine if the appointment can be scheduled, call the patient back after contacting the MTF, or tell the beneficiary to call the MTF directly. Thus what was intended to be a relatively straightforward procedure becomes a complicated process for beneficiaries seeking medical care in the military health care system.

In meetings with MTF physicians and medical staff, they told us they withhold or restrict appointments due to their concern about the accuracy of the appointment-making performed by contractor staff. MTF physicians and medical staff provided anecdotal accounts of appointments incorrectly scheduled by contractor staff, such as scheduling patients with the wrong primary care manager, not scheduling enough time for certain appointment types, and scheduling the wrong type of patient into an appointment slot (such as an adult into a pediatrics slot). The physicians and medical staff

[6] *Defense Health Care: Appointment Timeliness Goals Not Met; Measurement Tools Need Improvement* (GAO/HEHS-99-168, Sept. 30, 1999).

could not quantify the number of times such errors occurred, however, and acknowledged that they usually did not report the errors to the contractor. The contractors told us that when they learn of such errors, the appointment clerks are counseled and provided additional instruction. While DOD does not require contractors to report the extent to which their clerks incorrectly schedule appointments, one contractor did monitor its clerks' errors and found appointment error rates of less than 1 percent.

MTF physicians also told us that some specialty and primary care appointments should only be scheduled by MTF clinic staff to ensure the availability of medical personnel to answer any questions the patient may have and to provide any medical instructions. We recognize these may be valid reasons for the MTF clinic to schedule some appointments. However, when comparing like clinics in different MTFs, we found considerable difference in the percentage of appointments scheduled by the contractors, suggesting that the appointing process could be strongly influenced by physician or medical staff preference to retain control over appointments rather than the need to provide medical instructions. For example, the percentage of dermatology appointments scheduled by contractors ranged from 88 percent in one MTF to 0 percent at six other MTFs. Similarly, the contractor scheduled 97 percent of the optometry appointments at one MTF, while 0 percent were scheduled at eight other MTFs.

Because of concerns raised about contractor performance, we also obtained information on the extent to which beneficiaries had difficulty getting through to the contractors' appointment clerks or were placed on hold for long periods of time. The data indicate that most beneficiaries do not encounter busy signals or unreasonable hold times when calling for appointments. In all four regions, the contractors' performance standard is that 90 percent of the callers will speak with the clerk within 120 seconds. In November 1999, contractors in two regions exceeded the standard, with 100 and 97 percent of the callers speaking to contractor staff within 120 seconds. In the other two regions, the contractors fell slightly short of the standard at 89 percent. The data also indicate that a small percentage of callers received busy signals or were put on hold. For example, one region reported that about 3 percent of the callers encountered busy signals, with the other three regions reporting 1 percent or less. In terms of hold times, one region reported that only 2 percent of the callers experienced a hold

time of more than 5 minutes, and two other regions reported average hold times of about 1 minute or less.[7]

Conclusions

Inconsistencies exist across the military health care system in terms of whom beneficiaries should call to make an appointment, resulting in a confusing process for beneficiaries. While improvements could be made in the central appointing process and the contractors' access to appointments increased, at this juncture a larger issue exists for DOD resolution—what type of appointment scheduling process best serves the needs of the military health care system and its beneficiaries.

DOD has not evaluated the appointment-making processes currently in place across the military health care system, including the advantages and disadvantages of using contractor versus MTF staff, nor developed criteria or guidance to be used uniformly across the military health care system. The appointment process should be transparent to all beneficiaries and based on solid evidence that it is providing beneficiaries with the best possible service. Congress is considering legislation that would authorize $20 million to support procurement of a local appointment-scheduling system and would direct that the planning and installation of such a system be coordinated with the contractors in order to integrate and synchronize the local systems with regional applications to the maximum extent possible. As a first step toward implementing such a requirement, DOD needs to assess and decide on the respective roles of contractors and MTF staff in the appointment process.

Recommendations

To clarify and standardize the appointment-making process to the extent practical, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to assess the effectiveness of the current appointment-scheduling process and determine how that process could be optimized, including a determination of the role contractors should play. The Assistant Secretary should then implement the selected appointment-scheduling process system-wide.

[7]One region does not collect data on caller hold times.

Agency Comments

We provided DOD with a draft of this report and discussed it with the Deputy Executive Director, TRICARE Management Activity. He agreed with the information presented and our recommendations, and said that DOD is in the process of determining the specific actions needed to implement the recommendations.

We will send copies of this report to the Honorable William S. Cohen, Secretary of Defense, and others who are interested.

If you have any questions or would like additional information, please call me on (202) 512-7101, or Michael T. Blair, Jr., on (404) 679-1944. Other major contributors to this report were Nancy T. Toolan and Lisa M. Moore.

Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

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