Medical Treatment Facility Data Call[1] for the Congressional Report on the Elimination of the National Health Care Information Line (HCIL)

Index

[1] TRICARE Management Activity/C&CS, RCS DD-HA(AR)2194

Executive Summary

This study was undertaken at the direction of the Deputy Director of TMA to examine beneficiary access to health care information and nurse triage services following the November 2004 conclusion of regional Health Care Information Line (HCIL) contracts. In particular, the survey looked at after-hours access to Primary Care Managers (PCMs) and also gathered feedback on mitigating self-help implementation efforts.

Of the 114 U.S. MTFs surveyed, 112 (98%) responded to this data call:

- 48 (43%) of the responding MTFs provide hands-on ambulatory care 24X7. These are generally larger MTFs, serving 60% of the TRICARE Prime enrolled beneficiaries in this study.

Of the 64 responding MTFs without 24-hour ambulatory care:

- 57 (89%) provide 24-hour access to a privileged provider, either directly or on-call.
- 7 provide neither after-hours ambulatory care, nor access to a privilege provider via phone, though alternative arrangements may be in place.
- 56 (88%) are confident their after-hours telephone consult number has been communicated to their enrollees. Phone numbers were provided in the survey as a validation of this service.
- 50 (78%) have the capability to arrange for patients to promptly see a provider. The remaining 22% of MTFs care for approximately 193K Prime enrollees.
- 53 (83% of MTFs without after-hours care and 47% of all responding MTFs) cannot book urgent care appointments after-hours, impacting 781K Prime enrollees.
- MTFs reported an average of 16 after-hours phone consultations per thousand enrollees per month, but there was a 100-fold range in MTF estimates (0.5 to56 per thousand per month).
- The percentage of calls referred for medical attention ranged from 2 to 100 percent, with no apparent correlation between the proportion referred and MTF size.
- 47 (73%) of MTFs provide phone consultation service with in-house staff, and 35% have contracted for this service (some MTFs do both).

Recommendations are made for policy clarification or operational guidance to ensure a more uniform approach to the provision of these services.

Introduction

Background: In September 2002, MHS leadership determined to exclude HCIL services from new TRICARE regional health care contracts based on cost-benefit analysis and the service was phased out during the transition to new contracts between 1 June and 1 November 2004. The Senate and House Armed Services Committees have expressed concern that this could adversely affect beneficiary access to health care services.

Purpose: This study was undertaken at the direction of the Deputy Director, TRICARE Management Activity as a collaborative effort of TMA's Communications and Customer Services, Health Program Analysis and Evaluation, and Operations directorates to do the following:

- Determine whether Military Treatment Facilities (MTFs) are providing or arranging for access to primary health care services on a 24-hour basis.
- Assess whether alternative arrangements to HCIL have been made consistent with HA Policy 96-060, A*fter-Hours Care for TRICARE Prime Enrollees, 26 Sep 1996.*
- Solicit local insight on the provision of after-hours care for TRICARE Prime enrollees
- Provide analytic support for policy development in order to optimally align MTF operational activities and financial responsibilities.
- Use measurement to support a report to the Senate and House Armed Services Committees on whether elimination of the national HCIL service has adversely affected beneficiary access to health care services.

Methodology

Survey Administration: Commanders of 114 U.S. MTFs that previously participated in contract transition metrics were asked to complete a 13-question Web enabled questionnaire. Survey questions were reviewed and approved by the Defense Manpower Data Center, and the Washington Headquarters Service assigned Report Control Symbol (RCS) DD-HA(AR)2194 in accordance with DoD 8910.1-M, *DoD Procedures for Management of Information Requirements*. A tasker was transmitted from TMA to MTFs via their respective Service Deputy Surgeons General on 18 February 2005, with a requested response no later than 15 March. Due to the unexpected closure of TMA offices due to a suspected anthrax attack on 15 and 16 March, the data call was not concluded until 18 March.

Response Rate: Responses were submitted by 112 of the 114 U.S. MTFs polled for a response rate of 98%.

Sample Characteristics: Responding MTFs constitute the largest of the MHS' 142 major U.S. hospitals and outpatient clinics, and have approximately 2.4 million TRICARE Prime enrolled beneficiaries. Enrollment to these facilities constitutes approximately 56% of Prime enrolled beneficiaries residing within the U.S, and about 70% of enrollees to direct care MTFs. Approximately 1.0 million beneficiaries are enrolled to U.S. contract providers and another 4.1 million TRICARE eligible beneficiaries residing in the U.S. are not enrolled in Prime.[2] MTF Service affiliations and TRICARE Prime enrollment of the responding MTFs are summarized in the table below.

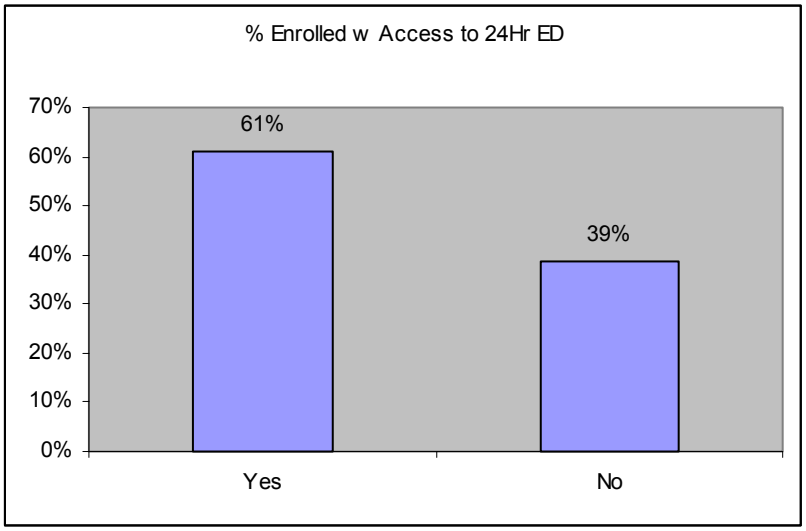
Service	Army	Navy	USAF	Total
# of MTFs	30	20	62	112
% of MTFs	27%	18%	55%	100%
Enrolled Beneficiaries	739,470	471,828	1,153,739	2,365,037
% of Enrollment	31%	20%	49%	100%

[2] TRICARE enrollment and eligibility data from M2 DEERS Sponsor file, March 2005

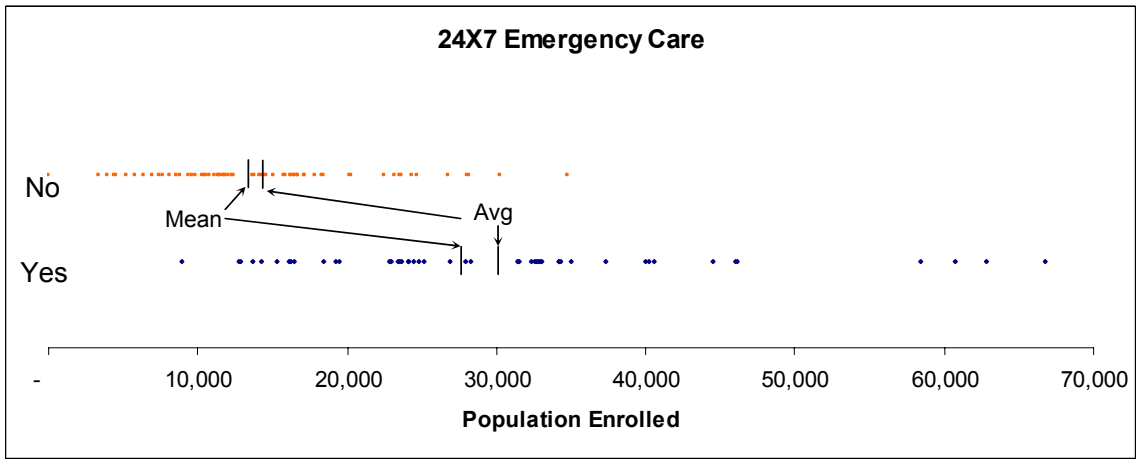
Results

Question #3. Is emergent, hands-on ambulatory care available at your MTF on a 24-hour per day, 7-day per week basis?

	# of MTFs	% of MTFs	# Enrolled	% of Enrolled
Yes	48	43%	1,446,004	61%
No	64	57%	919,033	39%
Total	112	100%	2,365,037	100%



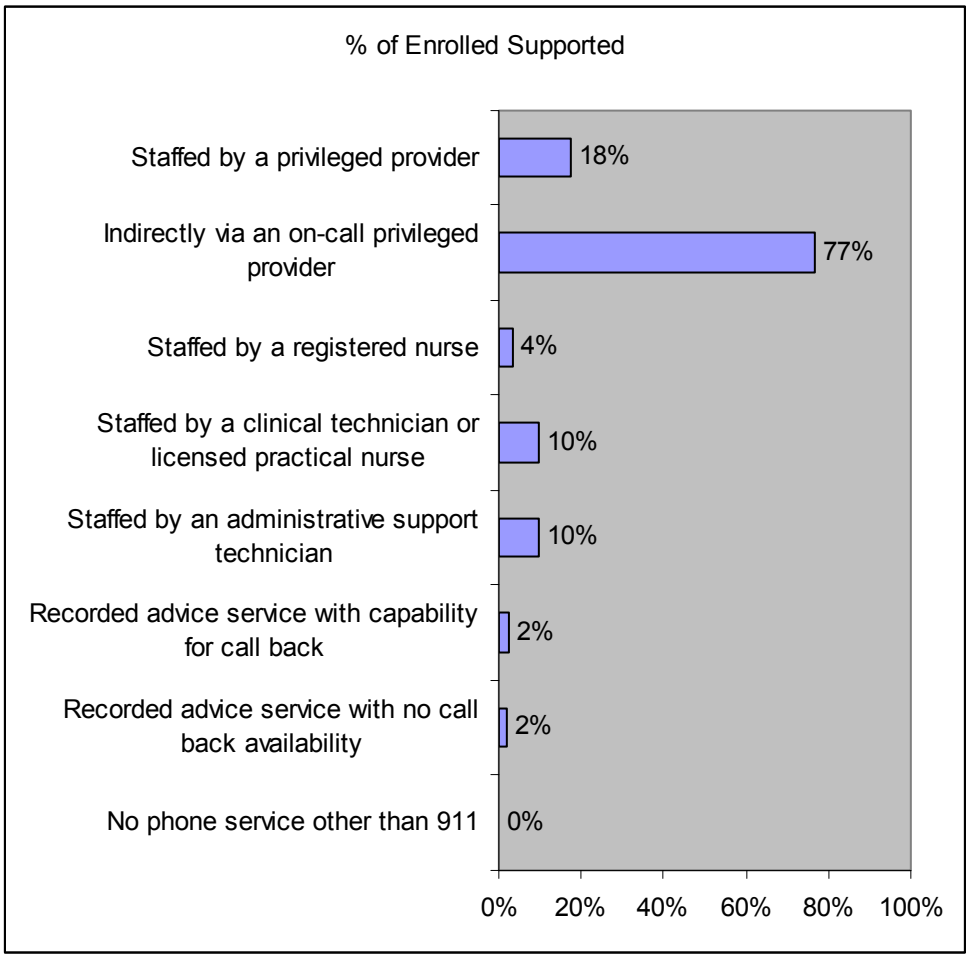
As shown below, enrolled population for MTFs responding "yes" averaged 30,125 with a median of 28,068, while for those MTFs responding "no" the average was 14,360 with a median of 13,730. Although larger MTFs were more likely to have 24X7 hands-on ambulatory care, due to other local options, even MTFs as large as the 72nd Medical Group, Tinker (24,760 enrolled) and McDonald ACH-Ft. Eustis (26,751 enrolled) did not provide this service. Conversely, due to local mission Keller ACH-West Point (8,866 enrolled) and due to lack of other local options, 366th Medical Group-Mountain Home (12,806) and Weed ACH-Ft. Irwin (12,852) did provide this service.



(Note: MTFs responding "yes" to question #3 were instructed to skip to question #12.)

Question #4. Please describe any after-hours phone consultation services provided to patients by your MTF. ***(Mark all entries that apply.)***

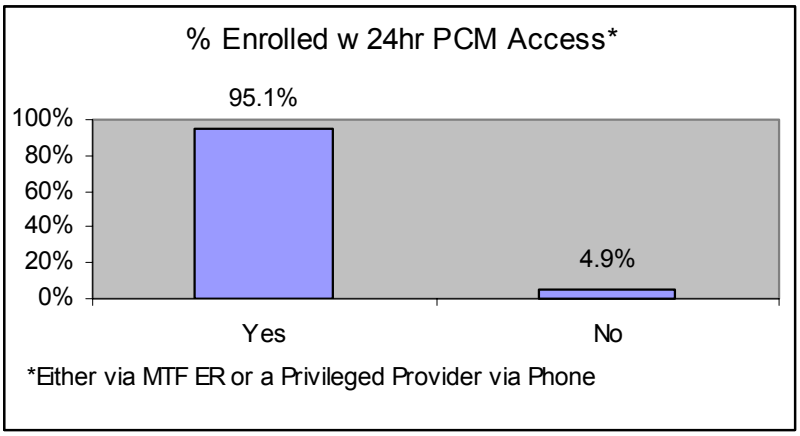
	# MTFs	% of MTFs
Staffed by a privileged provider	14	22%
Indirectly via an on-call privileged provider	48	75%
Staffed by a registered nurse	3	5%
Staffed by a clinical technician or licensed practical nurse	7	11%
Staffed by an administrative support technician	6	9%
Recorded advice service with capability for call back	2	3%
Recorded advice service with no call back availability	1	2%
No phone service other than 911	0	0%



NOTE: The total of all responses exceeds 100% since respondents were asked to "mark all that apply."

Six MTFs marked both the first response (staffed by a privileged provider) and the second response (indirectly via an on-call privileged provider). One MTF marked neither response, but in remarks (shown below) noted, "*Calls are taken by our ambulance staff and then referred to the PCM on call."* Thus, 57 (89%) of the 64 MTFs without 24-hour emergency room support indicated they had PCM coverage either directly or indirectly.

Conversely seven MTFs indicated they do not have 24-hour emergency room support and they also do not provide direct or indirect PCM access.[3] These MTFs constituted 6% of MTFs participating in the survey and support 116,998 enrolled beneficiaries (4.9% of Prime enrollees in this sample).



Question #5. Please enter the telephone number of the after hours phone consultation service for your MTF.

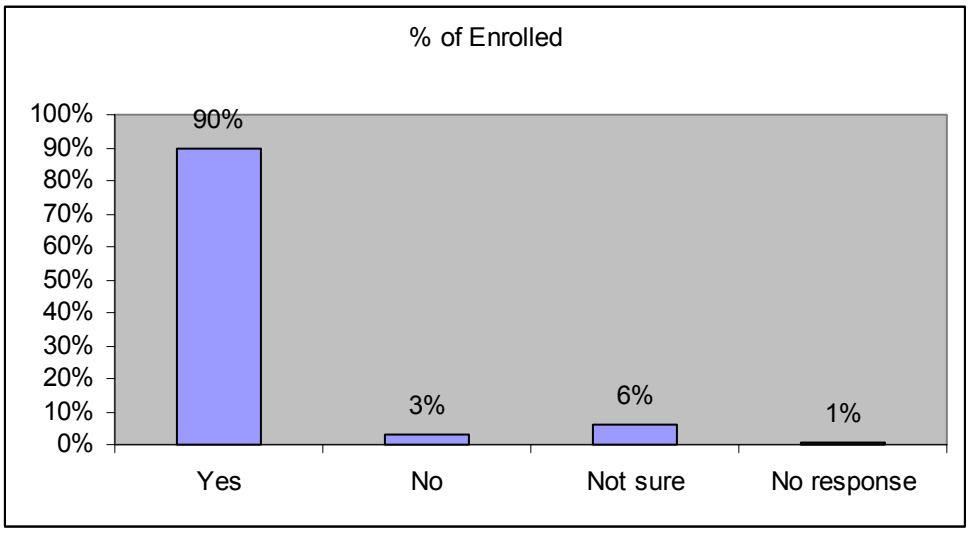
334-953-3368
623-856-2273 or 623-935-1444
(520) 570-7080
501 987-8811
(530) 634-4444
606-CARE
(661) 277-2330
302-736-2802
850-283-7591
321 494-8241 888 PAT-CURE
229-257-2778
478-327-7850
1-800-425-4620
318-456-6555
no entry
660 687-2188
406 731 4MED (Same number as day time appts.)
402-232-9891
505-846-3200
505-572-3260
(505) 784-2778
919 580 4184
701-775-1466
(701) 723-5633 option 4
(405) 631 5700
580-481-5235
803-895-2273

[3] It's also possible alternate arrangements exist via contract support or a nearby MTF.

605-385-3430
325-696-2334/1-800-481-0931
830-703-6199
801-777-5285
247-5661
307-773-3461
907-377-1847
719-556-CARE
808-448-6000 Appointment line after hours has a selection to speak to the provider on call; automatically dials the contracted service that takes the information and calls the on call provider
1-888-628-9633
1-888-223-2448
(910) 273-2746 / Pager-825-8890
580-249-4471
843-963-6880
(210) 215-5750
325-654-3159
(210)871-4027
253-982-CARE
202-841-1688
850-883-8600
720-847-9355
301-342-1506
843-743-7000
361-961-2688
(808) 473-0247
410-293-2273
(703) 784-1725 or (888) 784-1802
1-888-NAVYMED/1-888-628-9633
913-684-6000
(804) 734-9000
315-772-2778
1-800-884-8452
520-533-2433
757-314-7680
732-383-1116
301-677-8392
(256) 955-8888

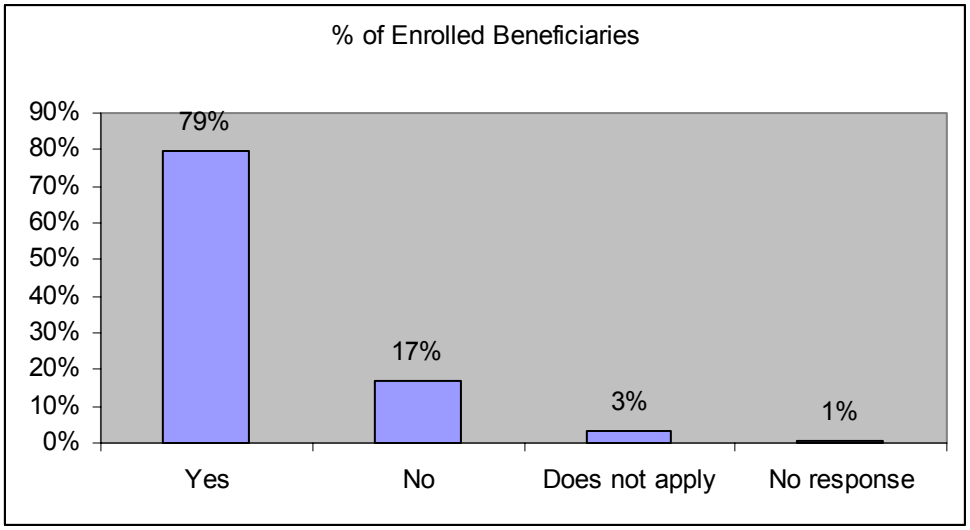
Question #6. Has this number been communicated to all beneficiaries enrolled to this MTF?

Response	# of MTFs	% of MTFs
Yes	56	88%
No	2	3%
Not sure	5	8%
No response	1	2%
TOTAL	64	100%



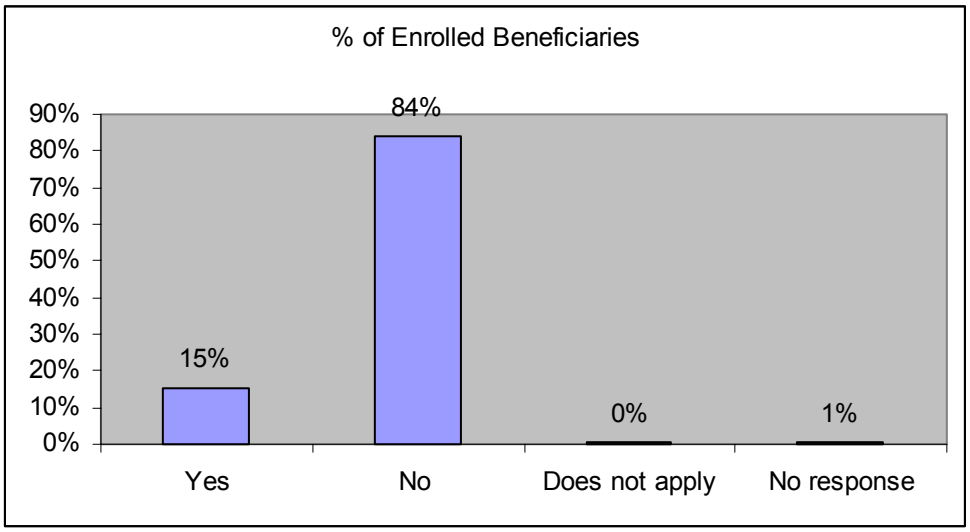
Question #7. Does the after-hours phone consultation service have the capability to arrange for those patients requiring urgent care to promptly see a provider (either military or civilian)?

	# of MTFs	% of MTFs
Yes	50	78%
No	10	16%
Does not apply	3	5%
No response	1	2%
Total	64	100%



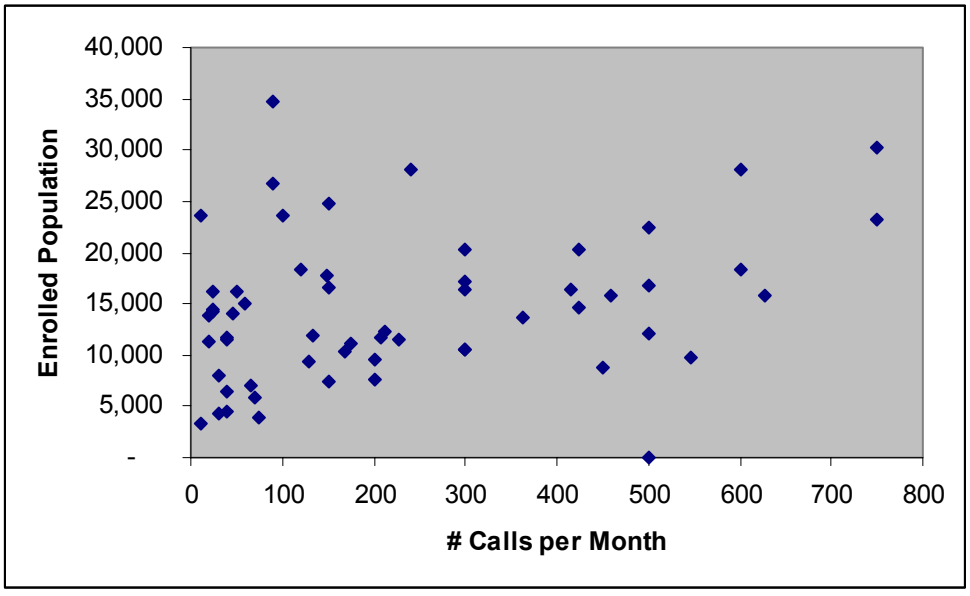
Question # 8. Does the after hours phone consultation service have the capability to book appointments?

	# of MTFs	% of MTFs
Yes	9	14%
No	53	83%
Does not apply	1	2%
No response	1	2%
Total	64	100%



Question #9. How many after hours phone consultation calls are received per month?

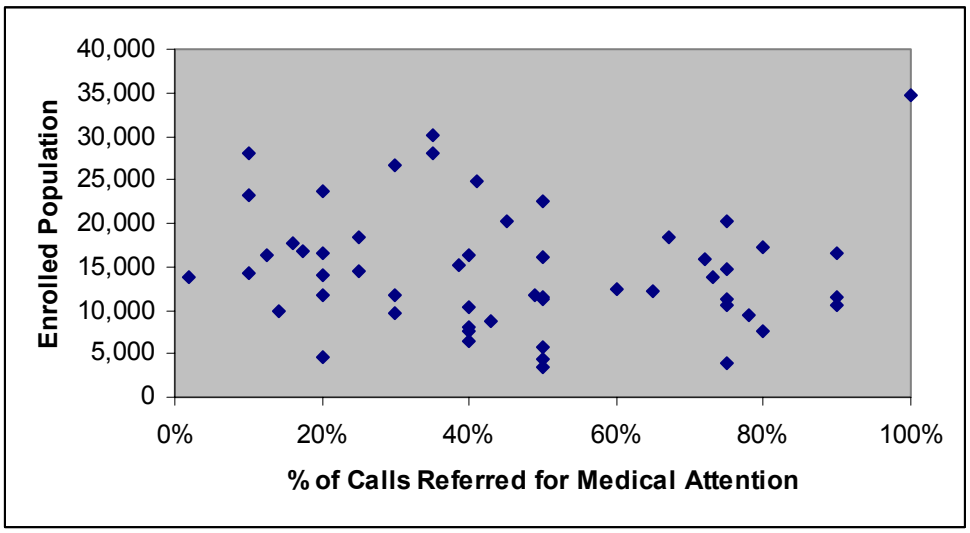
Five MTFs either were not tracking this or did not provide a quantitative response. 59 MTFs provided a response ranging from <10 calls per month to 750 calls per month. The average was 243, and the median 150 calls per month. (Note: Several MTFs provided an estimated range. In those cases the midpoint of the range was used in calculating this average.)



The estimated number of calls per month per enrolled beneficiary in this sample of MTFs without 24-hour emergency room support was 0.016 or 16 per thousand enrollees per month; however this ranged 100-fold from 0.5 to 56 per thousand per month. There appears to be a weak correlation of calls per month per enrollee (correlation coefficient = 0.29).

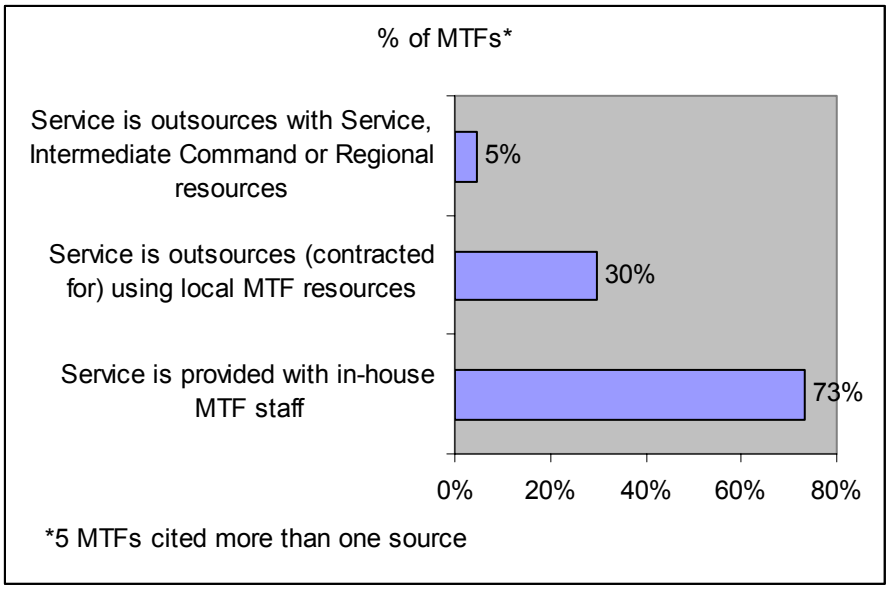
Question #10. What percentage of calls to the after hours phone consultation service result in advice to seek professional medical attention?

54 MTFs provided a quantitative response. Responses ranged from 2% to 100% with an average of 46%. The median was 41%. In other words, half the MTFs indicated 41% or more of calls required referral for further medical treatment. The percentage of calls referred does not appear to correlate to enrolled population (coefficient = -0.11).



Question #11. Please describe how the after-hours phone consultation service is funded/staffed. ***(Mark all entries that apply.)***

	# of MTFs	% of MTFs*
Service is provided with in-house MTF staff	47	73%
Service is outsourced (contracted for) using local MTF resources	19	30%
Service is outsourced with Service, Intermediate Command or Regional resources	3	5%

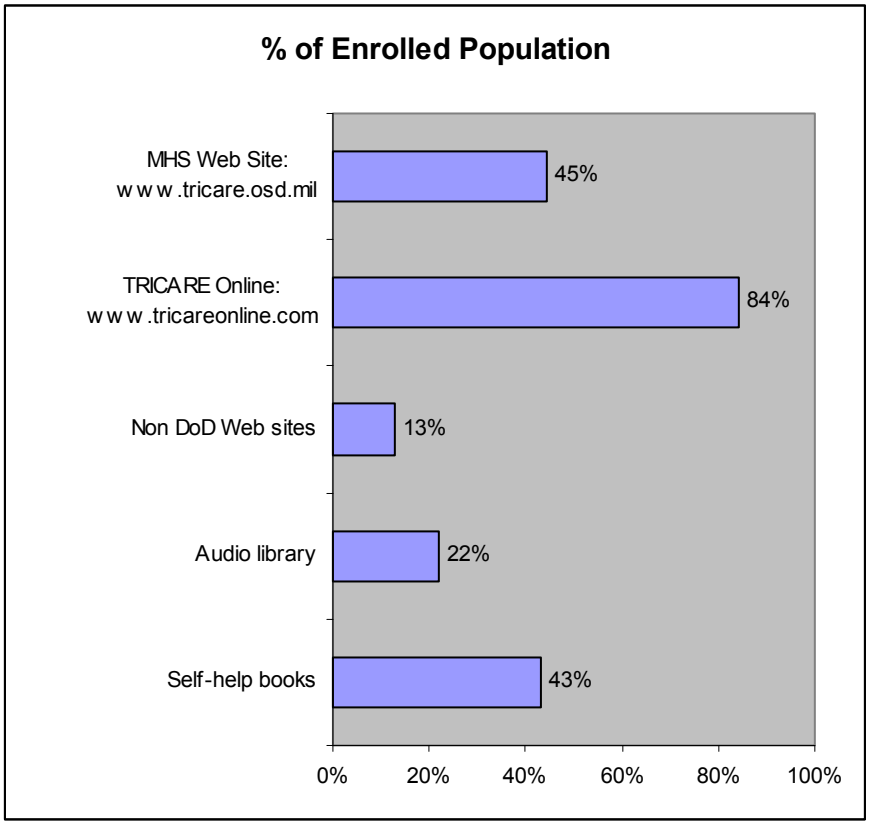


Response	Comment
MTF staffed	*MOD on call and Paramedic Ambulance Service*
MTF staffed	*Answering service (which connects pt with on-call provider)paid with local funds*
MTF staffed	*Providers rotate Medical Officer of Day duty*
MTF staffed	*Initially we used military providers only as the "on call" providers to cover this new requirement. But this is no longer a viable option since most of our FP providers were deployed. We did not have enough military providers left to rotate and cover the "on call" hours. We used TNEX $$ to add call hours to contract providers. In addition we added calls to civilian GS providers and ended up taking the $$ to pay for this out of our core budget.*
MTF staffed	*Line is answered by in-house Urgent Care Center staff from 1800 - 2200.*
MTF staffed & outsourced with local resources	*Contract answering service PCM on call*
MTF staffed & outsourced with local resources	*Answering service pages the nurse on call week nights, provider on call weekends.*
MTF staffed & outsourced with local resources	*We purchase answering service access for beneficiaries to our "On-call" PCM out of our O/M funds.*
MTF staffed & outsourced with local resources	*Contract answering service calls forwarded to MTF providers*
MTF staffed & outsourced with local resources	*Local MTF resources are used to fund an outside contractor which provides phone screening service with referral, as needed, to an MTF physician serving as on-call PCM.*
Outsourced with local funds	*On same contract with Eglin, part of appt system*
Centrally funded	*Funded with O&M funds from AFMC*

No response	*Contract for call service, but credentialed staff are MTF providers*
No response	*Answering service is contracted with MTF resources; PCM is provided with in-house staff*
No response	*Call service answers the calls*

Question #12. Until as late as October 2004, regional TRICARE contractors provided a toll free "ask a nurse" Health Care Information Line (HCIL) to TRICARE beneficiaries. Is your MTF promoting HCIL alternatives to your beneficiaries? ***(Please mark all responses that apply.)***

	# of MTFs	% of MTFs
MHS Web Site: www.tricare.osd.mil	46	41%
TRICARE Online: www.tricareonline.com	91	81%
Non DoD Web sites	14	13%
Audio library	12	11%
Self-help books	53	47%



Conclusions and Recommendations

After-Hours PCM Access: Approximately 60% of TRICARE Prime enrolled beneficiaries in this study have access to after-hours, hands-on ambulatory care, and an additional 35% have after-hours telephone access to a privileged provider. No more than 4.9% of the beneficiaries encompassed by this survey (those enrolled to the seven responding MTFs without these services) are limited in their access to either direct patient care or after-hours telephone consultation. There may be alternative local accommodations for these beneficiaries, such as the availability of a larger nearby MTF or the establishment of contract support.

Recommendations:

1) The availability of local alternative arrangements or plans to rectify noncompliance with HA Policy 96-060 should be further explored with local Commanders.
2) Since the MTFs in this study constituted most of the larger U.S. MTFs, and another 30% of U.S. Prime enrollees are enrolled to many other smaller MTFs, MHS leadership may want to further examine compliance with HA policy and urgent care access within other MTFs.

National HCIL:

- Although a question as to 'whether the Commander favors establishment of a national HCIL' was not asked, 25 MTFs provided solicited remarks (provided in the data call narrative) that could be interpreted as either pro-HCIL (12 MTFs) or anti-HCIL (13 MTFs). However, when examined in relation to enrolled population, these opinions were unevenly distributed.
    - 11 of 14 commenting smaller MTFs (those with fewer than 15,100 enrolled) indicated HCIL is not useful to them and the investment is not worth the return. The complaints are not focused upon the concept of the HCIL per se, but more on the execution by previous contractors. In particular it was noted that HCIL algorithms:
        - did not effectively direct beneficiaries to the appropriate care venue;
        - too often directed patients to the ER unnecessarily;
        - did not have the ability to appoint, so they eventually called back to the PCM anyway—often after receiving conflicting prescriptive advice.
    - 9 of 11 commenting larger MTFs had a much more positive opinion of HCIL:
        - HCIL is useful for directing self-care when appropriate;
        - HCIL reduces the number of unnecessary ER and acute care visits.
- A variety of alternative solutions have been implemented locally, to include MTF and multi-service market contracts for nurse advice or on-call services, and services which are not staffed by privileged providers.
- Several MTFs indicated they favored HCIL, but other resourcing needs had higher local priority.

Recommendations:

1) Further assessment of MTF practices may be necessary to determine if policy clarification or operational guidance is warranted to ensure a more uniform approach for the provision of these services.
2) Further cost benefit analysis is warranted since economies of scale could possibly be realized through either regional or national subscription to an existing national service or establishment of a TRICARE HCIL.

Ability to Provide or Arrange for After-Hours Urgent Care:

Approximately 95% of enrollees to MTFs in this study have after-hours access to either hands-on ambulatory care or telephone access to a PCM. However, even when an on-call service is available, the data suggests that 13% of MTFs in this study do not have the capability to arrange for a beneficiary with an urgent care condition to see a provider promptly. This affects approximately 193K beneficiaries enrolled to the MTFs surveyed. The current HA policy appropriately requires this practice to direct urgent care patients who must be seen immediately, but should not utilize the emergency room for their condition. While most MHS commanders and staff are aware of a 24-hour time-frame for urgent care, the responsibility for arranging this care may not be clearly understood; further, they may be allowing for passive reliance on civilian emergency services which would not be an optimal solution for either beneficiaries or the MHS.

Recommendation:

1) Conduct second-level analysis of the MTF Data Call to determine local practice and assess performance gaps. Policy clarification may be warranted.

Ability to Provide After-Hours Appointing:

54 of the 112 MTFs (48%) do not have the capability to book appointments after-hours. The chief criticism of the previously contracted HCIL service was the inability of the nurse advice line to either book an appointment directly or to transfer them to an appropriate point of service. This is a performance gap that was not resolved with the previously contracted HCIL, and apparently has continued in its absence. Several respondents commented that the on-call provider would have to have remote access to CHCS if this becomes a mandated policy expectation.

Recommendations:

1) Conduct second-level analysis of the MTF Data Call to determine local practice and policy that prevents more effective and immediate appointment capability for the MTF 24 hours-a-day, 7 days-a-week. Policy clarification may be warranted.
2) Successful deployment and adoption of this capability within TRICARE Online may facilitate improved efficiencies with this issue.

Call Volume:

The estimated number of calls per month per enrolled beneficiary in the sample of MTFs without 24-hour ambulatory care support was 0.016 or 16 per thousand per month; however this ranged 100-fold by MTF, from 0.5 to 56 per thousand per month. The extreme variability may be due to poor record keeping or variance in the respondent's interpretation of question #9 in this survey, for example, counting all calls for information, vice just calls for clinical advice.

Recommendations:

1) If a decision is made to implement either regional or national HCIL services, further data collection, to include feedback from MTFs with after-hours ambulatory care would be helpful.
2) Further analysis of current local practices that are proving successful need to be evaluated to determine if they are applicable in similar-sized facilities. MTFs may, in fact, be capable of implementing local solutions with minimal investment that would preclude a regional or national contracting solution.