U.S. Army - Baylor University Graduate Degree Program in Health Care Administration

The True Costs of No-Shows

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By

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ABSTRACT

In recent years Winn Army Community Hospital (WACH) has been commended on several occasions for its cost-savings efforts. Recent legislative actions to decrease funding to federal agencies and the 1 July 1996 implementation of TRICARE in Region 3 by the Military Health Services have developed into significant changes for Region 3's Winn Army Community Hospital (WACH).

Financial budget constraints have greatly limited the scope and accessibility of services WACH can provide. Increased cost-saving efforts are required in order for WACH to survive in the future. Inefficiencies in the existing appointment system may be root cause of the loss of substantial financial and personnel resources.

This study examined 5 outpatient clinics and identifies the potential loss of over $4.5K in 1st Quarter, FY97 due to loss utilization of fixed costs associated with patient appointments. $4.5K loss each quarter equates to $18K of wasted financial resources that could have been otherwise allocated that fiscal year. The study also provides a potential death spiral cycle that links the rise in no-shows with the rise in patient complaints, patient and employee turnover, and lost 3rd party funds.

WACH will require significant effort to break the cycle of no-shows and, thus, create a more efficient, well managed facility. WACH has faced many challenges to remain within the limits established by reducing financial resources. As our financial resources continue to decrease so will our cost-saving opportunities. WACH must concentrate on breaking the no-show cycle by proactively eliminating the causes as opposed to reacting to the after-effects.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

> *True costs...there are no true costs. Cost means value. Value is subjective. Cost is a perception based upon subjective variables assigned by the inquirer. If the costs are not perceived, they are not valued; if they are not valued, they are not managed and, therefore, remain uncontrolled.*

The Military Health Service System (MHSS) has traditionally programmed and budgeted for programs on the basis of historical resources consumption and workload trends. This practice encouraged facilities to produces more output services then may be medically necessary. In fact, it rewarded inefficient practices with additional funding while decreasing funds to facilities that performed similar services more efficiently (Health Affairs, 1997).

The MHSS is undergoing the most dramatic changes in its history. The forces accelerating change are economic and political. The reform issues are *value*—service received for dollar spent, and *access*—who can count on and who can be denied care (Griffith, 1995).

In 1992, President Clinton spearheaded an initiative to control the exploding rate of health care costs. His administration proposed using managed competition as a major tool to reform the health care industry. Insurers, health care institutions, and individual health care providers would be given strong incentives to develop local group care models referred to as "Health Networks." These networks would operate under a global budget based on capitated fees. Each network would negotiate fees with participating practitioners and institutions, and the

fees would be on a capitated or fee-for-service basis. Politically, his initiatives failed to receive acceptance by the legislative bodies; however, many of his initiatives became the foundation of MHSS's conversion into a Managed Care Organization (MCO).

MCOs are entities that offer one or more products that integrate financing and management with the delivery of health services to an enrolled population; either share financial risk and/or have some incentive to deliver efficient service; and use an information system capable of monitoring and evaluating patterns of utilization and financial outlays (Hale, 1988). DoD pursued a variety of initiatives to discover how it could best transition into a MCO while still accomplishing its unique mission as a *military* health care organization. As a result, it enhanced the existing Civilian Health And Medical Program of the Uniformed Services (CHAMPUS) for beneficiaries who do not live near or have limited access to medical treatment facilities. TRICARE became the official name of the new DoD managed care program. "It is DoD's managed care program that joins the military and the private sectors' health care industries to better serve the beneficiary population." (Health Affairs Tricare Pamphlet, 1997)

TRICARE in essence is a tool to transition the MHSS from a disease-based, workload measure to a modified capitation-based methodology. It provides each military treatment facility (MTF) commander the responsibility for providing all health care to a defined population. In response, each MTF will receive a predetermined fixed amount of finances per beneficiary enrolled in TRICARE, regardless of what services are used. Each MTF is discouraged from allowing inappropriate hospital admissions, excessive lengths of stay, and unnecessary services. The MTFs are encouraged to ensure that care is provided in the most

cost-efficient setting, to utilize preventive services, to effectively deliver each episode of care, and to carefully monitor the volume of services provided. (Health Affairs Policy Paper, 1997).

The current health care industry is measured by the factors of cost, quality and access. Access has traditionally been a highly criticized element within the MHSS. Current TRICARE initiatives have sought to improve access by establishing specific access standards for the fully-enrolled (Prime) beneficiaries: 1 week for routine; 1 day for acute illness; and 4 weeks for well visits (Health Affairs TRICARE Access, 1997).

The longer patients have to wait for an appointment, the more likely they will forget about it or decide to live with the problem (Bean, 1995). Their condition may improve during the wait, or worsen, forcing them to seek emergency care. This paper will focus on the associated costs of beneficiaries who have access to the system but do not to present for their appointments.

CONDITIONS THAT PROMPTED THE STUDY

Winn Army Community Hospital's (WACH) fiscal year 1997 (FY97) programmed budget was reduced by $3.2 million. WACH was forced to increase its efforts to seek every opportunity to save financial resources.

On 12 September 1996, an internal No-Show Multidisciplinary Quality Improvement Team (MQIT) published a report stating that within 9 months, January-September 1996, 7,619 no-show appointments accounted for an estimated loss of over $1 million of WACH resources. Appendix A.

WACH has attained the highest percentage of TRICARE Prime enrollment (74%) for Region 3. The large number of TRICARE Prime enrollees has placed greater emphasis on the efficiency of the appointment system. Each Prime enrollee who requests an appointment and cannot receive that appointment within the allotted period of time will receive authorization to seek care outside of WACH. Each authorization will incur additional expenditures for WACH.

In 1996, DoD conducted a survey of beneficiary satisfaction with the MHSS. The survey indicated that the beneficiaries within the WACH catchment area were most dissatisfied with the access to the facility. In fact, WACH had the lowest satisfaction scores of all facilities in Region 3.

The No-Show MQIT reported WACH has between 10,000 and 11,000 patient appointments available per month (includes specialty appointments) with an existing no-show

rate of 13.8%. This means approximately 1,518 beneficiaries could not access care because the appointments were reserved for people who did not show up for their appointments.

Clinic chiefs have attempted to increase beneficiaries' accessibility to appropriate care by implementing evening walk-in clinics, extended clinic hours, increased same-day surgery procedures, weekend clinics, and scheduled walk-in clinics for beneficiaries with chronic conditions (asthma, diabetes, etcetera).

The MHSS is rapidly becoming very similar to existing civilian service industries. Civilian industries like hotels, airlines and restaurants have been known to conduct studies to resolve issues associated with no-shows. These industries have decreased their no-show rates by placing penalties on no-show consumers, calling or mailing appointment reminders, and increasing the consumer's awareness of the significance of no-shows. The increasing similarity between the MHSS and civilian industries makes it very feasible that the MHSS will eventually use the same tactics and policies to reduce no-shows within its system.

In FY 98, the MHSS will implement a capitation-based methodology to determine the funding for each medical treatment facility. The methodology is known as Enrollment-Based Capitation (ECB). ECB is main purpose is to ensure that the capitation method used to allocate resources to each MTF provides the proper incentives to encourage each commander, provider, and decision maker to be fully accountable for delivering high-quality, cost efficient health care to all enrolled beneficiaries. EBC empowers each MTF commander with full accountability for all required resources to provide health care for a given enrolled population and each MTF will be funded according to the number of enrolled beneficiaries (Health Affairs Policy 97-043,

1997). The significant factor is that each facility's annual budget will be directly linked to the number of beneficiaries that voluntarily choose to remain within its health care network.

Each condition expresses an urgent need to identify all potential cost saving areas. As it stands, all financial resources are forecast for continued decline. To find the optimum solution to a problem, it helps to know the costs of the problem. Without this knowledge, a facility suffers a high risk of spending more on the solution than on the problem.

PROBLEM STATEMENT

What are the true costs of broken appointments (no-shows) in the Military Health Service System TRICARE environment for Region 3, Winn Army Community Hospital? The purpose of appointment scheduling is to achieve the most efficient use of physician and support staff time. "Unused appointments (those never booked) are at least as significant as no-shows. Somehow no-shows seem more offensive and tend to get more attention, but 'opportunity foregone' is opportunity foregone – unbooked or no-show, provider and support personnel time are wasted." (Kerr, 1996) Because anticipated idle time for the providers is virtually unrecoverable, the problem of the patient who does not keep an appointment is of considerable interest. The increasing pressure for reduced costs in providing health care makes the potential problems created by broken appointments very serious.

LITERATURE REVIEW

The term "no-show" is not new to the health care industry. There have been hundreds of articles on appointment breaking published in medical, dental, and public health journals over the past 20 years (Bean, 1995). But few empirical studies have been published. Most research articles were produced between 1980 and 1990 during the rapid growth of health maintenance organizations (HMOs) which increased from 236 HMOs servicing 9 million members in 1980, to 591 HMOs servicing more than 34 million enrollees in 1989. (Langwell, 1990).

Barron (1980), Deyo and Inui (1980), and Oppenheim, Bergman, and English (1979) published research reviews for studies conducted prior to 1980. Deyo and Inui identified 87 separate studies pertaining to the issue of no-show appointments. Surprisingly, there still remains very limited empirical study consolidating the large variety of outcomes.

The private sector is currently in the maturity stage of the product life cycle. (Goldsmith, 1995). Pre-1990 literature addresses the issues faced by the private sector's managed care industry during its introduction and growth stages. DoD's managed care industry is currently in its introduction and growth stages. The absence of DoD-specific literature, the relative newness of its industry, and the growing similarity between the private sector and the MHSS strengthen the importance and relevance of pre-1990 literature. In fact, the more the MHSS continues to mirror the private sector's health care industry, the more likely it will face the very same issues. In response, this study will concentrate on research that has been developed from the period of 1980 to the present time.

Most of the existing research addresses the causes and predictors of no-shows, considering such factors as demographics and patient lifestyles and behaviors. The outcomes were not always the same due to the variables and differently perceived values. However, several significant outcomes were identified in the areas of length of time to appointment, use of appointment reminders, and scheduling procedures.

Length of time to appointment—6 of 12 research studies indicated that the more time a patient must wait for an appointment the more likely the appointment would be missed. An experimental study by Benjamin-Bauman, Reiss, and Baily (1984) found that patients given a 1 week waiting time for an annual gynecological examination had a no-show rate of 25% while those that were given a 3 week wait time had a no-show rate of 43% (Bean, 1992).

Bean (1995) states that the most significant predictor of a no-show appointment is the number of days to the appointment. Bean's research found that patients having same-day or next-day appointments had a 25.9% appointment failure rate; patients with a 2 to 6 day wait missed 34.3% of their appointments; and the appointment failure rate for patients with a wait longer than a week rose to 47.7%. (Table 1-1)

Broken Appointments by Specialty Group and Appointment Lead Time

Predictor	Number	Number Broken	% Broken
Specialty Group			
Family Practice	390	126	32.3
Internal Medicine	135	52	38.5
Obstetrics-Gynecology	294	92	45.1
Orthopedics	55	28	50.9
Pediatrics	36	13	36.1
Other Specialties	59	24	40.7
Appointment Lead Time			
Same Day	145	35	24.1
1 day	87	25	28.7
2-3 days	119	38	31.9
4-6 days	123	45	36.6
7-13 days	192	83	43.2
14-20 days	77	39	50.9
21-27 days	54	31	57.4
28 or more	82	39	47.6
Total Cases	879	335	38.1

TABLE 1-1 Andrew Bean, *Predicting appointment breaking*, 1995.

Appointment Reminders—all studies indicate that mail and telephone appointment reminders are both beneficial and cost effective. The current structure of the MHSS cannot accommodate a preponderance of same-day and next-day appointments. Large demands for services require an estimated appointment wait time of at least 1 week. The longer the time interval before a patient can access the system, the more important are appointment reminders. Morse (1981) noted that mailed reminders lose their effectiveness over time and telephone reminders are becoming less effective with the increased use of answering machines.

Ho and Lau's "Minimizing total cost in scheduling outpatient appointments" was one of the few studies that addressed the associated costs of no-shows. The article examined various rules for scheduling appointments for medical clinic outpatients and their ability to minimize a weighted sum of medical personnel's and patients' idle-time costs. The article stated that the idle times costs incurred by any given rule are affected by three environmental factors: 1) the probability of no-show, 2) the coefficient of variation of service times, and 3) the number of patients per clinical session.

Dickey and Morrow (1991) discussed the potential for high no-show rates in ambulatory care centers to promote the inefficient use of outpatient facilities and waste diminishing resources. Macharia, Leon, Rowe, Stephenson, and Hayes (1992) pointed out that the potential loss of revenues generated from high no-shows is compounded when a patient's visit involves several professional health care providers. The missed appointment causes disruptions in patient-provider relationships, decreases the opportunity for other patients to

receive timely care, and directly contributes to rising health care costs (Koren, Bartel, and Corliss, 1994).

Hard (1991) discussed management practices that can improve patient flow and facility productivity. Some of the significant statements made by the article were: "patient flow is disrupted in outpatient magnetic resonance imaging (MRI) centers, for instance, because patients miss appointments or cannot tolerate the MRI procedure; an average of 20 to 30 percent of MRI business is lost to "no-shows" and patient intolerance of MRI exams...; and a quote by Kenneth Johnson, President of Kenneth Johnson and Associates Inc., Columbus, OH.: "Fluctuation of one patient exam per day means a gain or loss of an additional $125,000 per year."

Gombeski's (1993) article provided several reasons for pursuing better appointment utilization and ultimately shorter access time. Gombeski surveyed 2,028 patients to determine the effectiveness of a patient callback program. The survey found that about 14% had an unmet clinical, appointment scheduling, or service need. Six percent had a clinical need that was directed to a physician's office. Examples of concerns included: post-operative bleeding, fever, numbness, swelling, pain, headache, nausea, continuous vomiting, bruised ribs, dizziness, sore throat, seizures, inflammation, blurred vision, or cramps. Two percent of the patients or their families required help in scheduling appointments. The article addresses the need and benefit of an efficient appointment system. Without an efficient system these unmet clinical needs would essentially go untreated until the patient advances to a higher acuity status.

Another resource was the Survey Analysis and Reporting for the 1994-95 Health Care Survey of DoD Beneficiaries which focused on the question: How do military beneficiaries

living in Region 3 - Eisenhower view their health care? It provided the responses of 8,785 individuals to questions about their access to care, use and source of care, and level of satisfaction with care received. The survey indicated that limited access is a major concern of all beneficiaries within the catchment area.

Another significant resource is the Office of the Assistant Secretary of Defense, Health Affairs Internet site. The site contains the most current policies, regulations and news articles concerning TRICARE access issues.

Last, but just as important as the previously mentioned literature sources, is the articles published within the local media portraying the feelings and opinions of the community we serve. Each article portrays a somewhat distorted view of facts after an event or unfortunate incident. However, the message of the articles is that consumers are not satisfied with the current procedures, policies or personnel within the system. Each article addresses an opportunity to improve our current system or, at a very minimum, better educate our serviced population.

Ultimately, the literature review revealed one fact of particular importance: there is a need for research pertaining to no-shows within the DoD structure. This lack of literature and the relative newness of DoD's managed care industry requires the development of empirical research.

PURPOSE OF THE STUDY

The purpose of this study is to determine if the rate of no-shows has a significant impact on WACH's available resources. The working hypothesis is there are substantial wasted resources associated with unmonitored no-show appointments.

The study considered the following variables: the number of maximum available appointments, man-hours to complete visit, backlog in scheduling system, third party service costs, no-show rate of each clinic, stated reasons for no-shows, number of patients referred to TRICARE Service Center due to inability to meet time restraints, expended resources to prepare for appointment, and resources saved from patient not presenting.

The study's objectives were to identify specific clinics which display higher rates of no-shows; identify clinics' definition for no-shows, where and why no-shows are occurring, and the associated costs of no-shows.

CHAPTER 2

METHODS AND PROCEDURES

The study consisted of two methods of data collection. The first method was retrospective and consisted of retrieving data from established management information systems for three consecutive fiscal year Quarters: 4th Quarter, FY96 (July through September 1996), 1st Quarter, FY97 (October through December 1996), and 2nd Quarter, FY97 (January through March 1997). The second method was prospective and required personal interviews of staff, telephone survey of patients, and direct observation of appointment processes.

The current information management systems were fielded to provide the ability to pool clinical and administrative data from different sources and to analyze the relevant data for trends, comparisons and forecasts of specific events. (Health Affairs, IM Initiatives). However, different management information systems contained different sets of similar data. For example, one system, CHCS, lists the orthopedic clinic's September 1996 number of outpatient appointments as 719, while MED302 lists it as 874. Each system was fielded to meet a specific need and, therefore, has inherent strengths and weaknesses. This study compensated for the variety of data by using the most valid system as perceived by the organization and end-users.

The outpatient visit was used as the unit of measure to determine workload and potential opportunity costs. MED302 data was used to determine each outpatient clinic's actual total number of visits. The number of no-show appointments was attained through CHCS. The data was then consolidated and manipulated within a Microsoft Excel spreadsheet to determine the appointment efficiency for each clinic for the three sequential fiscal Quarters. The raw data is shown in Appendix B.

Appointment efficiency (AE) was defined as 1 minus the average percentage of no-shows (%ANS) for the three consecutive Quarters [AE=1-%ANS]. The %ANS was defined as the total number of no-show appointments (NS) divided by the total number of visits(V) [$AE=(NS_1+NS_2+NS)/(V_1+V_2+V_3)$]. The higher the percentage of no-shows, the lower the appointment efficiency. For no-show percentages, lower means better.

All associated financial costs per visit were derived from the Step-Down Allocation function of the MEPRS information system; MEPRS data was chosen over ADS and CHCS because it provides the most reliable source for all expense allocations. The most recent data available for release was the 1st Quarter FY 97 (October-December 1996).

The primary design of the study was a quantitative analysis to identify the opportunity and financial costs associated with no-shows. The critical variables were 1) workload of physicians; 2) workload of ancillary staff; 3) utilization of essential equipment; 4) utilization of services; 5) the associated costs of patients referred to the TRICARE Service Center to meet access standard requirements, and 6) the cost of the same services provided within WACH.

Please note that this study's initial proposal was to determine appointment efficiency by calculating each clinic's number of no-show appointments as opposed to percentage of no-shows. The initial data review revealed that basing the measurement on the number of no-shows would be inappropriate because of the large variance in appointment scheduling between clinics.

IDENTIFICATION OF NO-SHOW

In December 1996, the facility established a standard definition for no-shows. "No cancellation for primary care 2 hours in advance or 24 hours in advance for specialty appointments would be considered a no-show. The patient must be annotated as a no-show if they have not presented after 15 minutes of the appointment's start time."

Each clinic was asked, "what is the trigger for designating a patient as a no-show for an appointment?" Each clinic stated that a patient is designated a no-show after 15 minutes has elapsed since the beginning of their appointment. However, each clinic also stated designating a patient as a no-show is very subjective. Typically, if the patients eventually did present to the clinic, the staff would make an effort to fit the patient into the doctor's schedule and, if successful, would not list the patient as a no-show.

A CHCS ad hoc query report, Appendix C, was created to first identify all no-shows for a given clinic and period of time; then report each patient's name, phone number, scheduled appointment date and time, and date the appointment was made. This report was used to conduct the telephone survey for beneficiaries' reasons for no-shows.

CHAPTER 3

RESULTS

CLINIC WITH HIGHEST NO-SHOWS

The data analysis identified the top three percentages of no-show appointments occurring in Audiology (15%), Occupational Therapy (11%), and Mental Health (8%). The study includes the services provided by the Outpatient Psychiatry clinics (7%) because of current cost-saving efforts in discussion.

REASONS FOR NO-SHOWS

The reasons for no-shows are not significant factors in the scope of this research. However, they are very significant in determining whether the primary source is internal to the organization (systemic or administrative); or external (patient's behavior, misunderstanding, lack of transportation, or unavailability); and, most important, if the source is controllable or avoidable.

The population of no-show appointments for the month of April 1997 was chosen for the telephone survey. The group was chosen because the period does not contain any extensive holidays or training exercises; patients were recently designated as no-shows; and, most of all, patients have most likelihood of recalling reasons for no-shows.

A sample size of each clinic's identified no-show population was calculated with the equation n=(N*Z^2*.25)/((d^2*(N-1)) +(Z^2*.25)). A 95% confidence interval would require contacting 199 patients.

Each patient was asked:

- Are you aware that you missed an appointment at the _____ clinic in April?
- Have you been seen for the initial complaint?
- Have you been seen at a military or civilian facility?
- And why exactly did you miss your first appointment?
- If evening appointment hours were available, what time would you prefer?

Formula: n=(N*Z^2*.25)/((d^2*(N-1)) +(Z^2*.25))				
		95% Confidence Level		Required Sample
Clinic	Population (N)	Precision Level (d)	Std Dev (Z)	Size (n)
Audiology	30	0.05	1.96	28
Mental Health	39	0.05	1.96	35
Occupational Therapy	39	0.05	1.96	35
Psychiatry (O/P)	90	0.05	1.96	73
Well Baby	30	0.05	1.96	28
TOTALS	228			199

TABLE 3-1

The population (N) in TABLE 3-1 is the total number of recorded no-shows for a specific clinic. The required sample size (n) is the number of beneficiaries within each subgroup that must be contacted to obtain 95 % confidence level that the responses accurately reflect the opinion of the whole population. A total of 199 successful calls was needed to attain a 95%

confidence level for the whole population and 98 successful calls for all clinics minus mental health and psychiatry outpatient clinics. Several attempts were made to contact the target populations for audiology, occupational therapy and well baby clinic. Unfortunately, only 54 patients were able to be contacted. The limited number of successful calls rendered this survey to be non-conclusive. The next intention was to make up the difference in required calls by contacting additional psychiatric and mental health beneficiaries. However, additional guidance was sought to ensure mental health and psychiatry outpatient patients' rights of privacy would not be jeopardized by the survey. This resulted in numerous opinions by medical staff, Judge Advocate General, and, ultimately, the discovery of the Health Affairs Policy 97-012, *Policy for Surveys within the Military Health Service System*, (Appendix D), which forbids conducting any form of survey without prior approval by the Under Secretary of Defense (Personnel and Readiness). After contacting the identified approval source, the no-show reasons for patients within psychiatry outpatient clinic and mental health clinic were not collected for this research.

OPPORTUNITY COST

Opportunity cost—a measure of cost based on the value of the alternatives that are given up in order to use the resource as the organization has chosen. (Finkler, 1994).

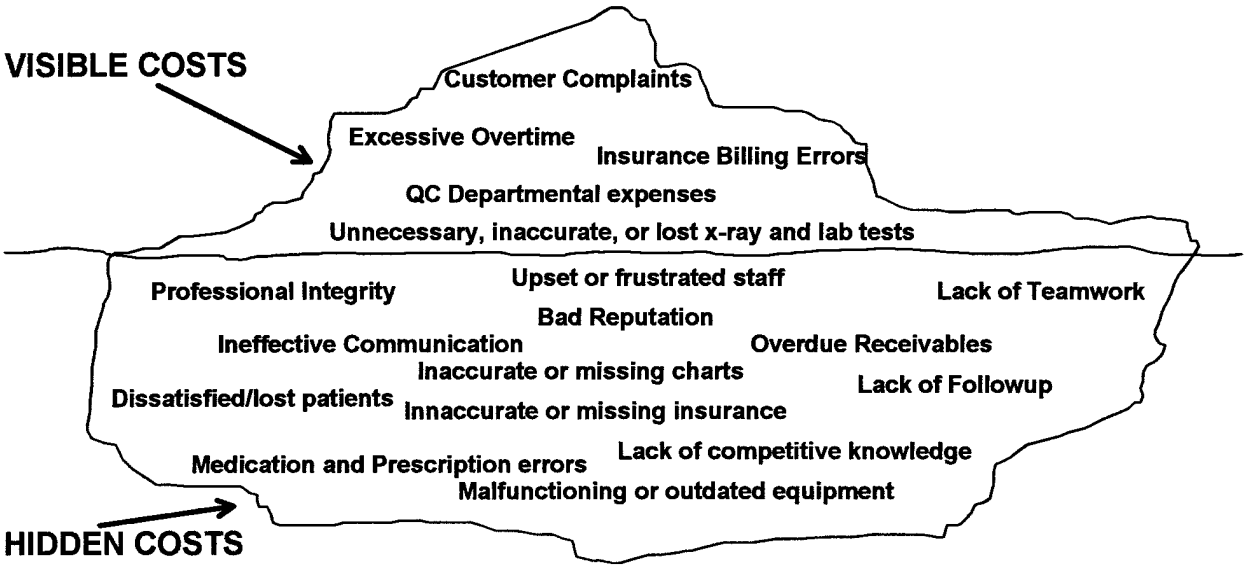

FIGURE 3-1

Crosby (1989) emphasizes that organizations should recognize the hidden (opportunity) costs associated with not doing the job right the first time. He points out that quality and productivity improvement within a Health Service Organization will have both visible and hidden costs (FIGURE 2-1). He presents his perception of costs in the shape of an iceberg. Those on the top of the iceberg are more readily seen, measured and monitored within an organization; the costs at the bottom are harder to perceive and, thus, manage.

Crosby's iceberg is a brilliant representation of the rising issues within WACH. For example, the Patient Relations Office received 110 complaints for the month of April 1997 compared to 57 complaints in April 1996. Since the beginning of TRICARE, 11 months ago, there have been 135 complaints about access to care out of a total of 406 complaints (33%). In July 1997, WACH enters its first reenrollment period for TRICARE, this process will be a critical signpost for whether or not disenrollment (lost patients) will be the critical factor determining the sustainability of WACH.

Strasser and Davis (1991) created a model that depicts the potential opportunity costs associated with patient leaving a civilian health care network because of dissatisfaction. The scenario was an urban hospital of about 450 beds with 14,500 discharges annually. The authors derived the following results after various calculations of previous research and personal interviews with existing health care providers:

- $164,293 was the direct dollar lost from dissatisfied patients.
- $119,797 was the estimated dollar losses from negative word-of-mouth advertising.
- $284,089 was the grand total loss by one facility in one fiscal year due to dissatisfied patients.

The chart poses great significance to the MHSS because under the realms of TRICARE and EBC the losses associated with individual patients may prove to be very similar to the individual patient costs for the civilian market.

FINANCIAL COST

Cost allocation is the best method to associate costs as closely as possible with patients who caused them to be incurred (Finkler, 1994). The step-down method requires the organization to allocate all of the costs of a nonrevenue cost center to all other cost centers (Finkler, 1994). An analysis of this magnitude would require extensive man power and time. Fortunately, the MEPRS information system was fielded with the capability to track and produce step-down allocation reports (Appendix E). The pertinent information has been extracted in Tables 3-2 through 3-6.

Step-down allocation of the Audiology Clinic			
Ambulatory Work Unit (AWU) Visits: 247	Weight : .0166 AWU: 4.1002	Appointment Total Cost	Appointment Fixed Costs
	Direct Expense:	449	449
	Expense received from Ancillary Staff	0	N/A
	Expense received from Service Staff	10,397.92	10,397.92
	Expense received from cost pools during purification	11150.88	11150.88
	Total Expenses	21,997.80	21,997.80
	Workload	247	247
	Unit Costs (Total Expenses) / Workload	$89.06	$89.06

TABLE 3-2

Step-down allocation of the Mental Health Clinic			
Ambulatory Work Unit (AWU) Visits: 1233	Weight : .0372 AWU: 45.8676	Appointment Total Cost	Appointment Fixed Cost
	Direct Expense:	000	000
	Expense received from Ancillary Staff	568.04	N/A
	Expense received from Service Staff	3326.36	3326.36
	Expense received from cost pools during purification	24993.38	24993.38
	Total Expenses	28,887.78	28,319.74
	Workload	1233	1233
	Unit Costs (Total Expenses) / Workload	$ 23.43	$ 22.97

TABLE 3-3

Step-down allocation of the Occupational Therapy Clinic			
Ambulatory Work Unit (AWU) Visits: 748	Weight : .0146 AWU: 10.9208	Appointment Total Cost	Appointment Fixed Cost
	Direct Expense:	48,261.00	48,261.00
	Expense received from Ancillary Staff	1,465.71	N/A
	Expense received from Service Staff	14,865.05	14,865.05
	Expense received from cost pools during purification	0.00	0.00
	Total Expenses	64,591.76	63,126.05
	Workload	748	748
	Unit Costs (Total Expenses) / Workload	$ 86.35	$ 84.39

TABLE 3-4

Step-down allocation of the Psychiatry Clinic			
Ambulatory Work Unit (AWU) Visits: 422	Weight : .0146 AWU: 10.9208	Appointment Total Cost	Appointment Fixed Cost
	Direct Expense:	27,623.00	27,623.00
	Expense received from Ancillary Staff	18,964.70	18,964.70
	Expense received from Service Staff	4,471.02	4,471.02
	Expense received from cost pools during purification	8,371.67	8,371.67
	Total Expenses	59,430.39	40,465.69
	Workload	422	422
	Unit Costs (Total Expenses) / Workload	$ 140.83	$ 95.89

TABLE 3-5

The charts identify the specific financial costs associated with individual clinics for 1st Quarter, FY 97 (October-December 1996). The Appointment Total Cost column lists all associated costs for all outpatient visits for the quarter. The Appointment Fixed Cost column subtracts all ancillary staff expenses to determine the dollar value of resources not used. Each clinic has a different value for individual appointments. Fixed costs per visit range from $23.43 to $140.83. These fixed costs are essential in determining the overall costs per patient visit.

The following table, Table 3-6, displays the productivity of the central appointments system for 2nd Quarter, FY 97. Calls offered is the number of callers who have been able to reach the patient automated appointment system. Calls answered is self-explanatory. No significant findings were uncovered in this area.

Month	CALLS OFFERED	CALLS ANSWERED	WAIT AVG	TALK AVG	HOLD #/AVG	CONNECT AVG	WORK AVG
Jan-97	21563	20738	2:09	1:34	2295 / 01:31	3:53	0:10
Feb-97	17482	16667	0:57	1:31	1927 / 00:57	2:35	0:07
Mar-97	19684	17110	2:10	1:31	2599 / 00:55	3:49	0:08
Apr-97	17655	15664	2:05	1:40	1969 / 01:11	3:54	0:09

TABLE 3-6

IMPLICATIONS

Service	# Visit	# No Shows	% No-Shows	Cost at WACH	Cost at 3rd Party	Difference in Cost	Total Cost to WACH
Audiology	247	125	0.50607	$89.06	$52.00	$37.06	$4,632.50
Mental Health	1233	216	0.17518	$23.43	$138.00	-$114.57	-$24,747.12
Occupational Therapy	748	60	0.08021	$86.35	$98.00	-$11.65	-$699.00
Psychiatry (O/P)	422	123	0.29147	$140.83	$154.00	-$13.17	-$1,619.91
Well Baby	1238	154	0.12439	$26.77	$58.00	-$31.23	-$4,809.42
TOTALS/AVERAGE:	3888	678	0.23547	$73.29	$100.00	-$26.71	-$4,540.49

TABLE 3-7

Table 3-7 is the data from 1st Quarter, FY97 (October-December 1996). The table represents the potential costs given a scenario in which maximum enrollment has been achieved, all available appointments are continually filled, and all excess demands for appointments are appropriately forwarded to the TRICARE Service Center (TSC). The major assumption is that every no-show equates to an additional request for TSC service.

The last column of Table 3-7 indicates potential financial cost to WACH per clinic per Quarter. The total Quarterly costs to WACH range +$4,633 in our favor to -$24,747. Total cost was derived by multiplying the number of no-shows by the difference in cost. Audiology represents the only clinic that may actually be beneficial to send to the TSC or other third party provider. As depicted by the table, WACH will lose an average of $4.5K in financial resources for each fiscal Quarter.

CHAPTER 4

DISCUSSION

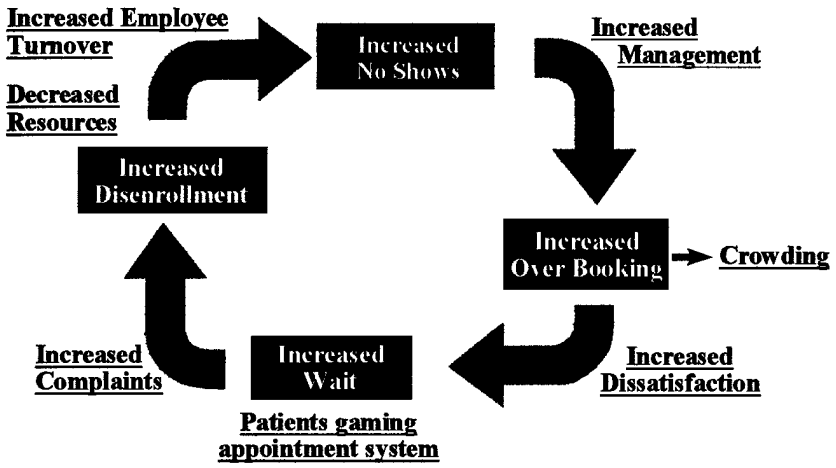

FIGURE 4-1

The figure above will not be found in any textbook or article. It is a perception of a potential death spiral that exists in WACH. Traditionally, beneficiaries' primary cost to access military health facilities was *time*. The financial cost for medical resources was relatively insignificant to civilian sources. Today, TRICARE has placed higher financial costs on the beneficiaries with the promise of decreasing time costs. However, the current reality seems to be that more enrollees in TRICARE equals higher time costs. The increased time costs are a direct cause of increased dissatisfaction and possibly increased disenrollment. Appointment

efficiency becomes an essential component in reducing time costs. An increase in no-shows can greatly damage a facility's abilities to manage time costs. As no-shows increase in WACH, a cycle becomes very apparent.

The cycle begins with no-show appointments. No-show appointments disrupt patient flow and decrease the ability to forecast required levels of personnel and supply resources. Increased levels of no-shows creates a haphazard patient flow with sporadic periods of overcrowded waiting rooms and other periods with little or no patients. A direct result of overbooking is longer wait times for patients. The longer wait times create an environment in which patients begin to "game" the appointment system. Patients intentionally come in late because they expect the provider to be behind schedule; patients only accept appointments during periods of expected low patient census, for example, Friday afternoon; other patients sign in for appointment at the correct time, leave to do other activities or medical appointments, and attempt to return just in time to see the provider.

Initially, no-shows consisted of patients who could not/would not come in for a scheduled appointment. At this stage, you have to add in the patients who come late as well as the patients who leave the waiting area and do not return in time to see the doctor. This stage intensifies the effects of no-shows. A direct result is increased complaints by both the patients and the staff.

A patient's level of (dis)satisfaction is an indicator of how likely they will remain with the same provider. (Marquis, Davies, and Ware 1983; Strasser and Schweikhart, 1992). As a patient experiences increased time costs, their level of dissatisfaction increases. (Dansky, 1997). Employee dissatisfaction skyrockets as they become the target of beneficiaries' frustrations.

The end result is a hostile environment for both the patient and worker. The following stage in the cycle is increased disenrollment. Disenrollment is an option for the patient to switch their medical care needs to a different health care network. WACH's current environment seems to provide most beneficiaries higher time costs, higher financial costs, and lower customer service. These factors encourage patients to pursue their option to disenroll. Another potential outcome of the cycle is increased employee turnover. Employees experience increased stress from dissatisfied patients and management attempting to react to a variety of issues directly attributable to patient dissatisfaction. Soon, the facility's public image and confidence become at risk. Turnover of both patients and employees comes at higher rates. Employee inefficiencies increase as their commitment/concern for quality decreases. Higher rates of patients and employees opt out of the system. And, ultimately, the cycle begins to repeat itself as no-shows increase due to inefficient data processing by employees and patients with appointments opt out of the system.

CHAPTER 5

CONCLUSION

The purpose of this work was to identify the potential costs of no-show appointments in the Winn Army Community Hospital (WACH). The MHSS environment is undergoing its most dramatic changes in history. In July 1997, WACH transitioned from a fee-for-service to a managed care based facility with the implementation of TRICARE. In FY 98, the DoD will implement the Enrollment-Based Capitation (ECB). ECB's most significant impact will be its incentive for MTF commanders to maximize enrollment while minimizing costs.

Current DoD and health care reform initiatives have greatly reduced the number of personnel and financial resources available to the MHSS. Every military health facility has undergone drastic cuts in both personnel and financial resources. Each facility has been forced to increase their efforts to function as a "most-efficient organization" (MEO) in order to maintain their mission and remain financially viable. The journey to become a MEO requires the critical look at the necessity of all services and taking advantage of every available cost-saving opportunity.

This study examined 5 outpatient clinics and identified the potential loss of over $4.5K during the 1st quarter FY 97. $4.5K loss each quarter equates to $18K of financial resources that

could have been otherwise allocated. These potential financial losses are often compensated through various scheduling techniques such as overbooking. The dollar cost of no-shows is different from clinic to clinic and may have little significance in the overall expenditures of most military medical facilities. However, The opportunity costs from either high no-shows or overbooking practices can have grave ramifications on the survival of the organization.

The significance of opportunity costs will be magnified as WACH reaches higher enrollment rates. Opportunity costs such as customer complaints, bad public image, dissatisfied patients, lack of teamwork, frustrated staff and a hostile work environment may be key determinants in whether a serviced population chooses to stay or leave the network. As noted by Strasser and Schweikhart (1992), a patient's level of satisfaction is an indicator of how likely they will remain with the same provider (or network).

As of today, WACH appears to be within a death spiral cycle that continually increases beneficiaries' time and financial costs and, ultimately, forces beneficiaries to consider seeking enrollment in other health care networks. WACH will require significant effort to break the cycle of no-shows and, thus, create a more efficient, well managed facility. WACH has faced many challenges to remain within the limits established by reducing financial resources. As our financial resources continue to decrease so will our cost saving opportunities. WACH must concentrate on breaking the no-show cycle by proactively eliminating the causes as opposed to reacting to the after-effects. The true costs of no-shows is a disenrolled population.

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Appe-B7

WINN ARMY COMMUNITY HOSPITAL
FORT STEWART, GEORGIA 31314

MULTIDISCIPLINARY QUALITY IMPROVEMENT TEAM (MQIT 96-03)
TEAM CHARTER NO SHOW POLICY
21 May 1996

PROBLEM: Clinics at WACH consistently report "No-Show" rates of 10-35%, at a loss of $183.70 per no-show. Not only does this appear to be significant on the surface, it also translates to obligated supplementary payments to civilian providers due to patients being denied access to military care. Currently, there is no mechanism in place to address the number of patient appointments that are wasted because of patient no shows.

MISSION: Due to the misuses and unnecessary wast of time , money and frequent inconvenience to our patients, the WACH appointment process must be reengineered into a cost effective, centralized appointment, business process that stops the needless waste of money and satisfy patient needs. Written progress reports are to be presented to the QMB within one week of the first meeting and at least monthly thereafter.

OBJECTIVES:
1. To review current trends, data, theory and develop a working definition for no show patients at WACH.
2. Define a trigger for no show appointments.
3. Identify mechanisms that can be used to improve the no show rate at WACH.
4. Define roles and responsibilities of the staff, patient, sponsor's unit and command in dealing with the improvement.
5. Develop an educational process that can increase the patients' awareness of the impact on the organization and other patients' access to care when an appointment is not utilized.
6. Evaluate the patient appointment process to identify opportunities to improve.
7. Methods to fill cancelled appointments and no-shows.

TEAM LEADER:
CPT Harrington, MS, C, CSD

TEAM FACILITATOR:
Ms. Peggy McRae, MCD

CORE MEMBERS:
CPT Diane Paulson, AN, HN, Family Practice Clinic
CPT Michael Burton, MC, Soldier Family Health Clinic No. 3
2LT Laura Schrum, MS, Health Systems Assistant, Dep of Primary Care
SSG Smith, NCOIC, Physical Therapy Service

MCUB-CSD 16 Dec 96

INFORMATION PAPER

SUBJECT: Access to Care at Winn Army Community Hospital

1. Purpose. To inform beneficiaries on access to care issues at Winn Army Community Hospital (WACH), Fort Stewart, Georgia.

2. Facts.

a. WACH can enroll 60,000 beneficiaries into TRICARE Prime. We currently have 37,200 beneficiaries enrolled in TRICARE Prime.

b. TRICARE Prime enrollees have priority to care at WACH. All others receive care at WACH on a space available basis only.

c. As enrollment into TRICARE Prime increase, space availability for primary care appointments decreases.

d. From 1 Jan 96 to 31 Aug 96, WACH had 7,619 people not show up for their appointments. They did not cancel these appointments, therefore these appointments were not known to be available to give to someone else.

e. WACH has developed a no show policy that will allow us to better utilize the available appointments. Patients who have not called to cancel a primary care appointment within 2 hours of the appointed time or 24 hours prior to a specialty appointment will be considered a no show. Patients who are more than 10 minutes late will be considered a no show.

f. Most times, the first way for beneficiaries to access care at WACH is through the central appointments line 767-6MED (6633). For those calling long distance, the number is 1-800-6633. Alternate numbers to 767-6MED are 767-6877 and 767-6886. Central Appointments is open Monday through Friday 7:30 a.m. to 4:30 p.m. (closed for lunch from 11:30 a.m. to 12:45 p.m.)/

g. The appointments line is restricted to TRICARE Prime enrollees until 10:30 a.m.

h. Beneficiaries in the Savannah are may access care at the Tuttle Army Health Clinic (TAHC). Care is given at TAHC by appointment only. The walk-in clinic formerly known as PRIMUS is no longer open.

i. Appointments for non-TRICARE Prime patients can only be made by calling after 10:30 a.m. Appointments are made for the remainder of that day or the next day only.

j. TRICARE Prime access standards are (not for non-TRICARE

Prime enrollees):

(1) An acute care appointment must be made within 24 hours. Acute care is defined as anything that will not become an emergency within 24 hours. An emergency is defined as a direct threat of life, limb or sight.

(2) Routine appointments must be made within one week.

(3) Wellness visits must be made within four weeks.

k. TRICARE Prime enrollees are assigned to Team Colors; red, white, blue, green and yellow. These teams are their Primary Care Manager (PCM), and are responsible for the oversight of the beneficiaries health care needs.

l. TRICARE Prime patients can access their PCM 24 hours per day. During duty hours, PCM contact can be made by dialing the central appointments number and choosing the 3d option. Upon reaching the clinic menu, select the appropriate clinic. The clinic will take your message, if an urgent situation exists, tell the clinic personnel what it is. The clinic will get the telephone message to the PCM. If the situation is acute, the PCM/clinic will call you back that day. If it is not, the PCM/clinic will call you back within 72 hours.

m. WACH's central appointments line is arranged on a "hunt group". The "hunt group" is a number of lines that will answer for 767-6MED. If all the numbers in the "hunt group" are busy, 767-6MED will continue to ring instead of offering a busy signal. This is so the next available line will answer the call. If the line were to ring busy, then you would have to continually redial 767-6MED.

n. While our computerized pharmacy system creates the perception of prescriptions being available for immediate pick up upon leaving the clinic, WACH has over 20 clinics with multiple providers writing prescriptions for patients during any hour of the day. There is an approximate wait of 30 minutes from the tie you leave the physician's office to the prescription being available for pick up. Also adding to the pharmacy wait is the fact WACH has only one window to service customers. WACH currently has a plan to expand the pharmacy to four service windows and is awaiting funding for this project.

o. While non-availability statements are no longer necessary for our TRICARE PRIME patients, authorization for care must be obtained prior to any care being delivered. The PCM is the approval for any care not provided at WACH.

p. Care for TRICARE Prime enrollees that has not authorized in advance falls under the point of service option.

q. WACH has two patient representatives, Ms. Nellie Nelson

	4TH QUARTER, FY 1996									1ST QUARTER, FY 1997									2ND QUARTER, FY 1997									Aver
Clinics	July			August			September			October			November			December			January*			February			March*			%NS
	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	Visits	NS	%NS	
Audiology	564	33	6%	313	63	20%	309	84	27%	375	72	19%	123	45	37%	109	8	7%	151		0%	126	29	23%	124		0%	15%
Cardiology	7	0	0%	8	0	0%	5	0	0%	7	0	0%	4	0	0%	8	0	0%	10		0%	7	1	14%	9		0%	2%
Cast	201	1	0%	241		0%	327		0%	326		0%	282		0%	253		0%	273		0%	264		0%	336		0%	0%
Dermatology	404	4	1%	871	23	3%	531	13	2%	641	22	3%	479	10	2%	630	15	2%	684		0%	701	32	5%	702		0%	2%
Family Practice	2111	85	4%	3508	219	6%	4142	309	7%	4412	306	7%	3878	274	7%	4212	334	8%	4973		0%	4681	364	8%	5805		0%	5%
General Surgery	306	16	5%	435	15	3%	406	25	6%	420	21	5%	320	13	4%	323	10	3%	385		0%	401	13	3%	406		0%	3%
Gynecology (Winn)	439	29	7%	453	42	9%	447	29	6%	378	31	8%	356	29	8%	440	21	5%	346		0%	460	25	5%	426		0%	5%
Internal Medicine	940	16	2%	805	25	3%	1154	23	2%	1224	30	2%	1024	23	2%	933	23	2%	1055		0%	1024	27	3%	1148		0%	2%
Medical Examination	183		0%	253		0%	263		0%	313		0%	224		0%	230		0%	325		0%	265		0%	302		0%	0%
Mental Health	788	49	6%	734	41	6%	755	36	5%	782	101	13%	544	115	21%	401	55	14%	494		0%	544	57	10%	618		0%	8%
Obstetrics	2221	165	7%	2255	119	5%	2153	136	6%	2006	124	6%	1865	140	8%	1854	150	8%	1892		0%	1715	127	7%	2008		0%	5%
Occ. Health Nursing	366		0%	337		0%	417		0%	1160		0%	1161		0%	929	34	4%	556		0%	505	34	7%	625		0%	1%
Occupational Therapy	598	7	1%	442	42	10%	305	31	10%	285	26	9%	266	15	6%	193	19	10%	174		0%	76	30	39%				11%
Ophthalmology	215	2	1%	231	10	4%	308	16	5%	292	10	3%	306	13	4%	281	6	2%	365		0%	369	18	5%	296		0%	3%
Optometry Winn	216	13	6%	226	23	10%	313	24	8%	188	39	21%	247	18	7%	124	7	6%	305		0%	263	26	10%	318		0%	7%
Orthopedic	692	32	5%	767	34	4%	877	48	5%	926	61	7%	705	42	6%	661	42	6%	782		0%	560	31	6%	843		0%	4%
Otorhinolaryngology (E	139	11	8%	236	13	6%	214	8	4%	125	5	4%	151	15	10%	223	8	4%	210		0%	319	20	6%	208		0%	5%
Pediatric	1258	39	3%	1332	49	4%	1661	47	3%	1926	64	3%	1575	62	4%	1578	56	4%	1850		0%	1763	66	4%	1848		0%	3%
Physical Therapy-Winn	2354	124	5%	2371	86	4%	2360	96	4%	2398	146	6%	2345	106	5%	2107	121	6%	1911		0%	1533	124	8%	1836		0%	4%
Podiatry	298	13	4%	311	11	4%	346	18	5%	260	24	9%	76	12	16%	151	12	8%	171		0%	116	16	14%	150		0%	7%
Psychiatry (Outpatient)	619	42	7%	612	47	8%	558	38	7%	679	57	8%	533	65	12%	388	35	9%	538		0%	512	51	10%	663		0%	7%
Psychology	323	27	8%	330	20	6%	256	24	9%	400	50	13%	375	30	8%	250	43	17%	330		0%	433	26	6%	422		0%	7%
Urology	1	0	0%	8	0	0%	1	0	0%	106	3	3%	198	7	4%	80	7	9%	166		0%	169	13	8%	195		0%	3%
Well Baby	390	37	9%	446	22	5%	366	34	9%	407	33	8%	391	62	16%	440	59	13%	424		0%	357	34	10%	291		0%	8%
Total	**21,816**	**786**	**4%**	**24,037**	**993**	**4%**	**24,999**	**1,146**	**5%**	**27,158**	**1,307**	**5%**	**23,538**	**1,180**	**5%**	**23,477**	**1,161**	**5%**	**24,296**	**0**	**0%**	**22,994**	**1,338**	**6%**	**25,500**	**0**	**0%**	**4%**

* --> Total number of no-show appointments unavailable

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' Sort Template? NO// y  (YES)
Name of SORT TEMPLATE: GS CLINIC NO SHOW//
DESCRIPTION:
  1>
READ ACCESS: #PpsDdL1HhFKkfMmAaNnOoQqRrYy&S  Replace
WRITE ACCESS: #PpsDdL1HhFKkfMmAaNnOoQqRrYy&S  Replace
USER #: 136//
Associated PRINT TEMPLATE: GS CLINIC NO SHOW//
Sort by: CLINIC@';1//   CLINIC
Select CLINIC: FAMILY PRACTICE//   FAMILY PRACTICE          FAMILY PRACTICE CLI
C     CLINIC     WINN ACH FT STEWART GA     BGAA
  Within CLINIC, Sort by: APPOINTMENT DATE/TIME@'  Replace   APPOINTMENT DATE/
ME
  Earliest APPOINTMENT DATE/TIME: 07 Mar 1997//   (07 Mar 1997)
  Latest APPOINTMENT DATE/TIME: 14 Mar 1997//   (14 Mar 1997)
    Within APPOINTMENT DATE/TIME, Sort by: APPOINTMENT STATUS@';1
  Replace   APPOINTMENT STATUS
Select APPOINTMENT STATUS: NO-SHOW//   NO-SHOW
      Within APPOINTMENT STATUS, Sort by: NAME@//   NAME
      Start with NAME: A//
      Go to NAME: Z~//
        Within NAME, Sort by:
Store Sort logic in Template: GS CLINIC NO SHOW//   GS CLINIC NO SHOW        (0
14/97)  USER #136
                                                                  FILE #44.2
DATA ALREADY STORED THERE ...OK TO PURGE? y  (YES)
Should Template user be asked to 'Select CLINIC',
                                  without special default? YES//   (YES)
Should Template user be asked 'FROM'-'TO' range for 'APPOINTMENT DATE/TIME',
                                  without special defaults? YES//   (YES)
Should Template user be asked to 'Select APPOINTMENT STATUS',
                                  without special default? NO//   (NO)
Should the precise 'Select' value you have entered
always be used in sorting by APPOINTMENT STATUS? YES//   (YES)

Should Template user be asked 'FROM'-'TO' range for 'NAME',
                                  without special defaults? NO//   (NO)
Should the precise 'FROM' value you have entered
always be used in sorting by NAME? YES//   (YES)

Should the precise 'TO' value you have entered
always be used in sorting by NAME? YES//   (YES)

First Print FIELD: [gs clinic no show  GS CLINIC NO SHOW        (03/14/97)  USE
#136
                                                                  FILE #44.2
Want to edit 'GS CLINIC NO SHOW' Template? NO// y  (YES)
NAME: GS CLINIC NO SHOW//
DESCRIPTION:
  1>
READ ACCESS: #PpsDdL1HhFKkfMmAaNnOoQqRrYy&S  Replace
WRITE ACCESS: #PpsDdL1HhFKkfMmAaNnOoQqRrYy&S  Replace
First Print FIELD: NAME;L18;C1!//   NAME
Then Print FIELD: NAME://
  Then Print PATIENT FIELD: FMP;L3//   FMP
  Then Print PATIENT FIELD: PHONE;L12//   PHONE
  Then Print PATIENT FIELD: //
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[Categorical Listing] [Numerical Listing]

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

NOV 18 1996

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Policy for Surveys within the Military Health Services System (MHSS)

Survey data are becoming a key component of MHSS Information Systems. They provide decision makers with the perspective of our various "customers" whether they are Prime enrollees, MTF patients or beneficiaries who do not look to the MHSS as their regular source of health care. However, surveys must protect our customers' privacy and not present an undue burden. This memorandum identifies five major surveys currently sponsored or under development by Health Affairs (HA) which all MHSS managers should be familiar with. The memorandum also outlines the procedures for obtaining approval of any survey designed to meet information needs not addressed in the five HA-sponsored surveys listed in paragraph 3.

The Under Secretary of Defense (Personnel and Readiness) (US D(P&R)) will soon reissue DoDI 1100.13 "Surveys of DoD Personnel". Surveys which require participation by personnel in a DoD component other than the sponsoring component must be approved by USD(P&R) and display a Reports Control Symbol (RCS). Surveys of MHSS beneficiaries or MTF patients -- whether by mail, telephone, or local questionnaires conducted in waiting rooms or base newspapers -- almost always cross service lines and therefore require RCS approval. (Surveys solely of personnel in the sponsoring component require Service level Reports Control approval and are not covered by this memorandum).

The OASD(HA) is sponsoring the following five surveys that are designed to meet the majority of our needs for patient level information:

a. **DoD Survey of Health Related Behaviors Among Military Personnel** conducted every three years by OASD(HA) Clinical Services. This survey collects worldwide data from active duty personnel on drug & alcohol abuse and other health related behaviors. (POC: Ms. Terry Zolock, OASD(HA) CS, DSN 225-2640)

b. **Annual Health Care Survey of DoD Beneficiaries** conducted by OASD(HA) Health Budgets and Programs in response to Congressional mandate. This survey collects worldwide data from all beneficiaries eligible for military health care on access, satisfaction, health status and use of services. (POC: Dr. Amy Graham, OASD(HA) HB&P, DSN 761-7895, Ext 246)

c. **Health Enrollment/Evaluation Assessment Review** is a clinically oriented questionnaire completed by patients as they enroll in TRICARE Prime. It identifies high utilizers and chronic conditions, assesses need for preventive services and motivates behavioral change. (POC: Ms. Terry Zolock, OASD(HA) CS, DSN 225-2640)

d. **Customer Satisfaction Survey** conducted centrally under the supervision of OASD(HA) Health Budgets and Programs. This survey, currently under development, will focus on patient satisfaction with care at military MTFs. See attached for more information. (POC: Dr. Robert J. Opsut, OASD(HA) HB&P, DSN *761-7895*, Ext 259)

e. **Bi-annual MHSS User Survey** conducted twice per year by OASD(HA) Health Budgets and Programs on source of health services by U.S. beneficiaries (including Alaska and Hawaii). Data from this survey are used to develop capitation budgets. When enrollment is completed and ADS is operational in all sites, this survey will be discontinued. (POC: Mr. Edmund Chan, OASD(HA) HB&P, DSN 761-8448)

The depth and breadth of these efforts are sufficient to answer most questions we can pose, and there will be an opportunity for tri-service workgroups to assess and modify these instruments on a regular basis. Survey data will be provided to the Services/Lead Agents electronically and in hard copy and will be fully available to researchers to conduct independent analyses. If other patient and staff level information is necessary to meet management requirements, OASD(HA) will generally sponsor surveys (e.g., inpatient satisfaction surveys and surveys targeted to specific clinical groups such as pregnant women or diabetics) which meet the criteria in DODI 1100.13, especially paragraphs B, D and F.

Personnel at all levels of the MHSS conducting unauthorized surveys must either discontinue them immediately or begin the approval process by contacting Ms. Kim Frazier, Health Affairs Information Management Control Officer, at DSN 761-8876 or (703) 681-8876 or, via e-mail, *kfrazier@osd.ha.mil*. She will assist you in coordinating and approving the survey, including requesting the RCS, Office of Management and Budget clearance (if necessary), and any other requirements.

Other questions regarding this memorandum may be addressed to Dr. Amy Graham or LtCol Frank Rubino at DSN 761-7895 or (703) 681-7895 or *agraham@osd.ha.mil* or *frubino@osd.ha.mil*.

Edward D. Martin

Edward D. Martin, M.D.
Principal Deputy Assistant Secretary

Attachment:
Quarterly MTF-level Outpatient Satisfaction Survey

HA POLICY 97-012

Quarterly MTF-level Outpatient Satisfaction Survey

PURPOSE: To directly question beneficiaries who had appointments regarding their satisfaction with a specific appointment. Survey will permit direct comparisons among MTFs, of the same MTF over time, against civilian benchmarks.

DESCRIPTION: MTFs will be required to forward selected appointment data from CHCS or ADS monthly to the DISIDDOMS contractor managing the program. The contractor will mail a questionnaire direct to the patients' homes 30-50 days after the appointment. The questionnaire will be customized to the date, time and clinic of the appointment, ask 20-25 multiple choice questions and allow space for patient's written comments. The questions will be returned to the contractor which will produce descriptive and trending reports based on the multiple choice questions. The contractor will forward all written comments directly to the MTF, without analysis. The contractor will report to the MTF, Lead Agent, Service and Health Affairs within 45-60 days of the end of each quarter.

TIMING: Draft questionnaire and sampling procedures will be reviewed by the Surgeons General as soon as they are prepared by the contractor Initial "pilot" questionnaires are expected to be mailed to patients in mid-February based upon January 1997 appointments. MTFs will therefore be required to forward patient information to the contractor in early February. The survey should enter its "routine" stage by May 1997 when questionnaires are mailed to patients who have had April 1997 appointments.

FURTHER INFORMATION: Is available from Dr. Robert Opsut or Lt Col Frank Rubino at DSN 761-7895.

[Top]

Last update: 1/30/1997

COMPUTATION EXPENSE SUMMARY FOR ACCOUNT CODE: BHDA AUDIOLOGY CLINIC

AMBULATORY WORK UNIT (AWU) WEIGHT: .0166 VISITS: 247 AWU: 4.1002

DIRECT EXPENSE:	449.00	CLIN SAL:	0.00	DIRECT MINUS CLIN SAL: 449.00
EXPENSE RECEIVED FROM 'D' ACCOUNTS DURING STEPDOWN:	0.00			
EXPENSE RECEIVED FROM 'E' ACCOUNTS DURING STEPDOWN:	10,397.92			
EXPENSE RECEIVED FROM COST POOLS DURING PURIFICATION:	11,150.88			
TOTAL EXPENSES:	21,997.80			
WORKLOAD:	247			
UNIT COST (TOTAL EXPENSES / WORKLOAD):	89.06			

DIRECT EXPENSE SCHEDULE (DES) (Expenses from the Personnel, Financial, and Manual DES)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
26.20	OTHER SUPPLIES	87700	OPMA	449
			TOTAL:	449

PERSONNEL DIRECT EXPENSE BY SKILL TYPE (DESP)

SKILL TYPE	CATEGORY	SEEC	SEEC DESCRIPTION	PEC	APPR	EXPENSE

NO DATA THIS REPORT

PRE-STEPDOWN PURIFIED EXPENSE (Direct Expense plus expense received from Cost Pools PRIOR TO Stepdown)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	2,942
11.72	MILITARY COMPENSATION	87700	MILP	2,765
26.20	OTHER SUPPLIES	87700	OPMA	449
			TOTAL:	6,156

***** END OF EXPENSE ANALYSIS FOR BHDA *****

COMPUTATION EXPENSE SUMMARY FOR ACCOUNT CODE: BFDA MENTAL HEALTH CLINIC

AMBULATORY WORK UNIT (AWU) WEIGHT: .0372 VISITS: 1233 AWU: 45.8676

DIRECT EXPENSE:	0.00	CLIN SAL: 0.00	DIRECT MINUS CLIN SAL:	0.00
EXPENSE RECEIVED FROM 'D' ACCOUNTS DURING STEPDOWN:	568.04			
EXPENSE RECEIVED FROM 'E' ACCOUNTS DURING STEPDOWN:	3,326.36			
EXPENSE RECEIVED FROM COST POOLS DURING PURIFICATION:	24,993.38			
TOTAL EXPENSES:	28,887.78			
WORKLOAD:	1,233			
UNIT COST (TOTAL EXPENSES / WORKLOAD):	23.43			

DIRECT EXPENSE SCHEDULE (DES) (Expenses from the Personnel, Financial, and Manual DES)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE

NO DATA THIS REPORT

PERSONNEL DIRECT EXPENSE BY SKILL TYPE (DESP)

SKILL TYPE	CATEGORY	SEEC	SEEC DESCRIPTION	PEC	APPR	EXPENSE

NO DATA THIS REPORT

PRE-STEPDOWN PURIFIED EXPENSE (Direct Expense plus expense received from Cost Pools PRIOR TO Stepdown)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	2,237
11.72	MILITARY COMPENSATION	87700	MILP	14,227
			TOTAL:	16,464

***** END OF EXPENSE ANALYSIS FOR BFDA *****

COMPUTATION EXPENSE SUMMARY FOR ACCOUNT CODE: BLBA OCCUPATIONAL THERAPY

AMBULATORY WORK UNIT (AWU) WEIGHT: .0146 VISITS: 748 AWU: 10.9208

DIRECT EXPENSE:	48,261.00	CLIN SAL:	0.00	DIRECT MINUS CLIN SAL: 48261.00
EXPENSE RECEIVED FROM 'D' ACCOUNTS DURING STEPDOWN:	1,465.71			
EXPENSE RECEIVED FROM 'E' ACCOUNTS DURING STEPDOWN:	14,865.05			
EXPENSE RECEIVED FROM COST POOLS DURING PURIFICATION:	0.00			
TOTAL EXPENSES:	64,591.76			
WORKLOAD:	748			
UNIT COST (TOTAL EXPENSES / WORKLOAD):	86.35			

DIRECT EXPENSE SCHEDULE (DES) (Expenses from the Personnel, Financial, and Manual DES)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	5,906
11.72	MILITARY COMPENSATION	87700	MILP	39,449
26.15	MEDICAL/DENTAL SUPPLIES	87700	OPMA	2,625
26.20	OTHER SUPPLIES	87700	OPMA	281
			TOTAL:	48,261

PERSONNEL DIRECT EXPENSE BY SKILL TYPE (DESP)

SKILL TYPE	CATEGORY	SEEC	SEEC DESCRIPTION	PEC	APPR	EXPENSE
2	DIR C PROF	11.72	MILITARY COMPENSATION	87700	MILP	20,909
4	DC PARA-PRO	11.72	MILITARY COMPENSATION	87700	MILP	18,540
5	ADM/CLERICL	11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	5,906
					TOTAL:	45,355

***** END OF EXPENSE ANALYSIS FOR BLBA *****

COMPUTATION EXPENSE SUMMARY FOR ACCOUNT CODE: BFAA PSYCHIATRY CLINIC

AMBULATORY WORK UNIT (AWU) WEIGHT: .0401 VISITS: 422 AWU: 16.9222

DIRECT EXPENSE:	27,623.00	CLIN SAL:	27405.00	DIRECT MINUS CLIN SAL: 218.00
EXPENSE RECEIVED FROM 'D' ACCOUNTS DURING STEPDOWN:	18,964.70			
EXPENSE RECEIVED FROM 'E' ACCOUNTS DURING STEPDOWN:	4,471.02			
EXPENSE RECEIVED FROM COST POOLS DURING PURIFICATION:	8,371.67			
TOTAL EXPENSES:	59,430.39			
WORKLOAD:	422			
UNIT COST (TOTAL EXPENSES / WORKLOAD):	140.83			

DIRECT EXPENSE SCHEDULE (DES) (Expenses from the Personnel, Financial, and Manual DES)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.72	MILITARY COMPENSATION	87700	MILP	27,405
25.65	OTHER MISC CONTRACTS	87700	OPMA	218
			TOTAL:	27,623

PERSONNEL DIRECT EXPENSE BY SKILL TYPE (DESP)

SKILL TYPE	CATEGORY	SEEC	SEEC DESCRIPTION	PEC	APPR	EXPENSE
1P	CLINICIAN	11.72	MILITARY COMPENSATION	87700	MILP	27,405
					TOTAL:	27,405

PRE-STEPDOWN PURIFIED EXPENSE (Direct Expense plus expense received from Cost Pools PRIOR TO Stepdown)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	749
11.72	MILITARY COMPENSATION	87700	MILP	32,170
25.65	OTHER MISC CONTRACTS	87700	OPMA	218
			TOTAL:	33,137

***** END OF EXPENSE ANALYSIS FOR BFAA *****

COMPUTATION EXPENSE SUMMARY FOR ACCOUNT CODE: BDCA WELL BABY CLINIC

AMBULATORY WORK UNIT (AWU) WEIGHT: .0136 VISITS: 1238 AWU: 16.8368

DIRECT EXPENSE:	6,825.00	CLIN SAL:	0.00	DIRECT MINUS CLIN SAL: 6825.00
EXPENSE RECEIVED FROM 'D' ACCOUNTS DURING STEPDOWN:	8.39			
EXPENSE RECEIVED FROM 'E' ACCOUNTS DURING STEPDOWN:	3,240.28			
EXPENSE RECEIVED FROM COST POOLS DURING PURIFICATION:	23,063.42			
TOTAL EXPENSES:	33,137.09			
WORKLOAD:	1,238			
UNIT COST (TOTAL EXPENSES / WORKLOAD):	26.77			

DIRECT EXPENSE SCHEDULE (DES) (Expenses from the Personnel, Financial, and Manual DES)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
25.65	OTHER MISC CONTRACTS	87700	OPMA	6,825
			TOTAL:	6,825

PERSONNEL DIRECT EXPENSE BY SKILL TYPE (DESP)

SKILL TYPE	CATEGORY	SEEC	SEEC DESCRIPTION	PEC	APPR	EXPENSE

NO DATA THIS REPORT

PRE-STEPDOWN PURIFIED EXPENSE (Direct Expense plus expense received from Cost Pools PRIOR TO Stepdown)

SEEC	DESCRIPTION	PEC	APPROP	EXPENSE
11.00	PERSONNEL COMP & BENEFITS	87700	OPMA	9,263
11.72	MILITARY COMPENSATION	87700	MILP	3,089
25.50	CONTRACT HEALTH CARE	87700	OPMA	714
25.65	OTHER MISC CONTRACTS	87700	OPMA	6,825
26.15	MEDICAL/DENTAL SUPPLIES	87700	OPMA	714
26.20	OTHER SUPPLIES	87700	OPMA	222
			TOTAL:	20,827

***** END OF EXPENSE ANALYSIS FOR BDCA *****

U.S. ARMY-BAYLOR UNIVERSITY GRADUATE PROGRAM
CLASS 95-97
RESIDENCY WRITTEN REQUIREMENTS

Will send Replacement

DID NOT RECEIVE ANY FURTHER DOCUMENT

RESIDENT: SLADE DARIUS J **PHONE:** (541)826-2111 EXT 3346

HOSPITAL: VA HOSPITAL 8495 CRATER LAKE HWY, WHITE CITY, OR 97503-1088

FACULTY READER: DR. FINSTUEN **S:** COB 30 Aug 96

Each reviewer has 10 working days to read research papers and 7 working days to read reports.

EVALUATION:

RESIDENCY ROTATION PLAN

Approved DF (File) recommend approval
Not Approved_____

PROGRAM PROGRESS REPORT I

Approved_____
Not Approved_____

PROGRAM PROGRESS REPORT II

Approved_____
Not Approved_____

PROGRAM PROGRESS REPORT III

Approved_____
Not Approved_____

PROGRAM PROGRESS REPORT IV

Approved_____
Not Approved_____

GRADUATE MGMT PROJECT PROPOSAL

Approved_____
Approved w/Minor Modifications_____
(no resubmission)
Approved w/Major Modifications_____
(resubmission)
Not Acceptable_____

GRADUATE MANAGEMENT PROJECT

Approved_____
Approved w/Modifications_____
(major/resubmission or minor)
Not Acceptable_____

COMMENTS TO FACULTY READER(S):

RESIDENCY STATEMENT: YES OR NO

AMEDD C&S Form 421 (Rev)
1 JUL 96

ED. TECH.: Levi **DATE:** 8/22

DEPARTMENT OF VETERANS AFFAIRS
Domiciliary
White City OR 97503

August 9, 1996

In Reply Refer To: 692/00

MS. Rene L. Pryor
U.S. AMEDD Center and School
Building 2841 MCCS-HRA
3151 Scott Road
Fort Sam Houston, Texas 78234

Subject: Preceptor's Endorsement of Mr. Slade's Residency Training Plan

I have reviewed, and endorse, the enclosed summary of Mr. Slade's goals and objectives for his training plan. However, a more specific rotational plan will be submitted upon the completion of coordination and scheduling.

Should you have any question please contact Mr. Slade or me.

George H. Andries, Jr. FACHE
Director

Enclosure

ADMINISTRATIVE RESIDENCY TRAINING PLAN
(31 Jul 96 to 1 Aug 97)

for

Mr. Darius J. Slade, CHE

I. GOALS AND OBJECTIVES:

My residency is to prepare me for middle management or staff positions within the Department of Veterans Affairs (VA). My past clinical experience in health care within the VA and the Department of the Army, coupled with the VA's current organizational redesign efforts, supports balancing my prior experiences and my goal with rotations through primarily non-clinical departments, holding key managerial positions, and participating in and completing key managerial assignments within the VA.

II. SUMMARY OF TIME AND EFFORT DISTRIBUTION FOR THE RESIDENCY:

Central Office Administration		1 weeks
VISN Administration		1 weeks
Veteran Benefits Administration		2 weeks
Tertiary/Domiciliary Administration:		
Puget Sound Health Care	(5)	
White City	(9)	14 weeks
Community Healthcare:		
Rogue Valley Medical Ctr	(3)	
Providence Medford Medical Ctr	(3)	6 weeks
Managed Care Administration:		
Medford Clinic		2 weeks
Healthcare Insurance:		
BlueCross & BlueShield		2 weeks
Research		6 weeks
Community Affiliations		2 weeks
National and Regional Meetings		4 weeks
Leave		6 weeks
Preceptor directed projects		6 weeks
		52 weeks

REPORT DOCUMENTATION PAGE

Form Approved
OMB No. 0704-0188

1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE	3. REPORT TYPE AND DATES COVERED
	June 1997	Graduate Management Project June 96-97

4. TITLE AND SUBTITLE

The True Costs of No-Shows

5. FUNDING NUMBERS

6. AUTHOR(S)

Ivan D. Speights, Sr., CPT, MS, U.S. Army

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Winn Army Community Hospital
Fort Stewart, GA 31314

8. PERFORMING ORGANIZATION REPORT NUMBER

25-97

9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)

Winn Army Community Hospital
Fort Stewart, GA 31314

10. SPONSORING/MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION/AVAILABILITY STATEMENT

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 words)

This study examined 5 outpatient clinics and identified the potential loss of $4.5K in 1st quarter, FY97, due to loss utilization of fixed costs associated with patient appointments. $4.5K equates to a potential $18K of wasted resources that could have been otherwise allocated during the fiscal year. The study also provides a potential death spiral existing within the appointment system of Winn Army Community hospital that links the rise in no-shows to the rise in patient complaints, patient and employee turnover, and loss 3rd party funds.

14. SUBJECT TERMS	15. NUMBER OF PAGES
Appointment Scheduling, Opportunity costs, Office Management, Missed Appointments, No-show appointments, Patient Satisfaction, Demand Management, TRICARE, Managed Care scheduling	40
	16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT
UNCLASSIFIED	UNCLASSIFIED	UNCLASSIFIED	