

Military Health System (MHS) Section 703 Workgroup Use Case Decision Package

Clark Health Clinic Joel
Health Clinic
Robinson Health Clinic Volume
I

Disclaimer: This Use Case provides information relevant to decisions to change capacity and capability of a military treatment facility. A detailed implementation plan is needed to accomplish a transition of clinical services.

Executive Summary

Site	Womack Bragg Clinics (Clark Health Clinic, Joel Health Clinic, Robinson Health Clinic)
Decision	Clark Clinic should remain an outpatient facility predominately for Active Duty family members (ADFM) and serve as a referral source for workload to Womack Hospital. The 703 Workgroup recognizes the Clark Clinic may take on additional space available beneficiaries in order to maintain appropriate empanelment and currency for providers in accordance with established policy and metrics. Transition Joel Health Clinic outpatient facility and Robinson Health Clinic outpatient facility to an Active Duty only with Occupational Health clinic (AD/OH). All base support functions and pharmacy workload supporting all beneficiaries will be maintained.

Background and Context

The table below summarizes the findings and data informing the decision on the future of the Military Medical Treatment Facility (MTF). Information in the Use Case Package could include but is not limited to: Base and MTF mission briefs, a site-visit trip report, and two network assessments (TRICARE Health Plan Network Review and an independent government network assessment). When determining the decision for each site, the mission impact and network impact were considered in conjunction with Service and MTF input.

Base Mission Summary

Fort Bragg, which encompasses Cumberland, Hoke, Harnett, and Moore counties in North Carolina, is located approximately 12 miles from Fayetteville. It equips, trains, rapidly deploys, and sustains full spectrum forces supporting combatant commanders from a community of excellence where Soldiers, families, and civilians thrive. Fort Bragg supports a community of approximately 261,000 service members and their Families, and retirees and their Families, and Department of Army civilians and contractors. Today, Fort Bragg, "the Home of the Airborne and Special Operations," with approximately 57,000 military personnel, 11,000 civilian employees, and 23,000 family members is one (1) of the largest military complexes in the world, 10% of the Army's active component forces. Fort Bragg has 38 Controlled facilities, seven (7) Occupied Installation Management Command facilities, and four (4) leased facilities off post support the enrolled population across 44 specialty services.

Criteria Matrix

Criteria	Rating or Value ¹	Key Takeaways or Findings	Use Case Package
Mission Impact	M	<ul style="list-style-type: none"> The Army military system needs to be able to expand and contract depending on the wartime need, which could be impacted based on decisions Womack Army Medical Center (WAMC) and Fort Bragg clinics must maintain appropriate patient population mix to support the existing Graduate Medical Education. This is true especially for the retiree population where the clinical complexity of the patients helps support readiness of medical staff As an integrated and federated system of Readiness and Health, Womack enables the Operational Force to achieve overmatch by ensuring that every Soldier is physically and cognitively Ready to Fight Tonight and proficient in their respective critical medical wartime skills. A change in the systems capabilities could add strain to the other system's parts in their ability to deliver care 	Section 1.0
Network Assessment	H	<ul style="list-style-type: none"> Clark, Robinson, and Joel Health Clinics are no more than a 15-minute drive apart and any change to their capabilities will impact each other as well as the surrounding commercial Primary Care network Both the TRICARE Health Plan (THP) and independent government assessments found that the Primary Care market would be challenged to absorb the impacted beneficiary population if all three clinics were to transition to Service Member Only care. The TRICARE network would have to expand to accommodate the additional demand 	Section 2.0

¹ See Appendix B for Criteria Ratings Definitions

	<ul style="list-style-type: none"> • Because of the size of Fort Bragg, family members in some zip codes are already testing the network where the care is especially good. Other locations will have to be more closely studied to understand the specific network capabilities. 94% of non-AD MTF Prime and Plus beneficiaries are living within the 30-minute drive-time boundary for Primary Care, and 95% of MTF Prime, Reliant, and Medicare Eligible beneficiaries are living within the 60-minute drive-time boundary for Specialty Care, concentrated around the MTF location • The MHS impacted population for Primary Care is more than 28,000 which represents less than 10% of the general Primary Care population in the market, and thus will not materially impact the supply of, and demand for, care. However, Pediatric services will be a particularly important consideration as 43% of beneficiaries are below the age of 18 and the population growth is projected at 3.8% over the next five years (2019 to 2023) • Overall, there is a shortage of Primary Care physicians. However, surplus observed in Cumberland County, where the MTF is located, covers approximately 64% of impacted beneficiaries • There is currently no effective way to share data between the military system and the network. There is a safety and quality issue to not having access to this information during transition of patients to the network 	
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Risk / Concerns and Mitigating Strategies

The Risk / Concerns and Mitigation table below, represents a high-level summary of the risks identified throughout the process as well as the main concerns of the Base and MTF Commanders identified on the site visit. Though not exhaustive, the mitigation strategies / potential courses of action will be used to help develop a final implementation plan.

Risk/Concerns		Mitigating Strategy
1	<ul style="list-style-type: none"> • Changing the focus of three (3) clinics will require substantial planning prior to implementation 	<ul style="list-style-type: none"> • An implementation plan will need to be developed to address any major issues related to the three clinics (including Robinson)
2	<ul style="list-style-type: none"> • The impact of transitioning Active Duty Family Members and their medical records back and forth between a civilian provider and the MTF (e.g. network Primary Care providers not using Armed Forces Health Longitudinal Technology Application (AHLTA) to MTFs that use AHLTA) 	<ul style="list-style-type: none"> • Adequate Administrative support staff will need to be maintained/returned to cover the administrative load or the workload to be realigned to other MTFs
3	<ul style="list-style-type: none"> • The Managed Care Support Contractor network and Clark Health Clinic may not be able to accommodate beneficiaries shifting from Robinson and Joel Health Clinics 	<ul style="list-style-type: none"> • The MTF should conduct the transition in a measured way incorporating a phased recapitalization plan tailoring to the beneficiary specific needs and minimizing the risk of disrupted services or capabilities. The MTF and Defense Health Agency (DHA) will monitor progress and address access issues by slowing down the transition
4	<ul style="list-style-type: none"> • The network may experience challenges sustaining adequacy until there are new Primary Care market entrants 	<ul style="list-style-type: none"> • The MCSC/TRICARE Health Plan and MTF will monitor the Primary Care network adequacy and address supply issues by slowing down the transition as necessary. Additionally, the conversion of Clark Health Clinic's capabilities to Active Duty Family Member Primary Care only clinic will mitigate issues in the supply of care

Next Step

Develop the implementation plan for the above decision, with a focus on deliberately shifting enrollees to an expanded civilian network one (1) panel at a time while developing a plan to transfer additional staff to Womack Bragg Army Medical Center. DHA and Service leadership will develop a plan to ensure GME programs are more organized so that programs such as the sports medicine fellowship is relocated to MTFs where most of the relevant soldier population are located.

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1.0. Installation and MTF Description

Fort Bragg which encompasses Cumberland, Hoke, Harnett, and Moore counties, North Carolina is located approximately 12 miles from Fayetteville, and it equips, trains, rapidly deploys, and sustains full spectrum forces supporting combatant commanders from a community of excellence where Soldiers, families, and civilians thrive. Fort Bragg supports a community of approximately 261,000 service members and their Families, retirees, and their Families, and Department of Army civilians and contractors. Today Fort Bragg, "the Home of the Airborne and Special Operations," with approximately 57,000 military personnel, 11,000 civilian employees, and 23,000 family members is one of the largest military complexes in the world, 10 percent of the Army's active component forces. Fort Bragg has 38 Controlled facilities, seven (7) Occupied Installation Management Command facilities, and four (4) leased facilities off post support the enrolled population across 44 specialty services.

1.1. Installation Description

Name	Fort Bragg
Location	Cumberland, Hoke, Harnett, and Moore counties, North Carolina; approximately 12 miles from Fayetteville
Mission Elements²	82 nd Airborne Division, the XVIII Airborne Corps, the United States (U.S.) Army Special Operations Command, U.S. Army Forces Command, U.S. Army Reserve Command, and the U.S. Army Parachute Team, the Golden Knights, and 18 other tenant commands
Mission Description	Fort Bragg equips, trains, rapidly deploys, and sustains full spectrum forces supporting combatant commanders from a community of excellence where Soldiers, families and civilians thrive.
Regional Readiness/ Emergency Management	Fort Bragg is the Home of the Airborne and Special Operations Forces and the Army's Flagship Power Projection Platform with various mission sets and demand signals. Ready Bragg is a community awareness campaign to increase the knowledge and awareness of disaster preparedness among all Soldiers, Family members, Department of Army Civilians, and contractors who live and work on the installation. The campaign provides the community with the basic tools needed to recognize and respond to all hazards.
Base Active or Proposed Facility Projects	Unknown
Medical Capabilities and Base Mission Requirements	<p>The Fort Bragg Military Health System is a federated system that is centralized around Womack Army Medical Center with multiple tenant unit organic medical assets and off post community health partners.</p> <p>Womack is an Army Generating Force Unit in Direct Support to the Fort Bragg Senior Commander and all Fort Bragg activities, executing Joint Health Service Functions (ROLE 4).</p> <p>As an integrated system of Readiness and Health, Womack enables the Operational Force to achieve overmatch by ensuring that every Soldier (Army Total Force and Joint Force) is physically and cognitively Ready to Fight Tonight and proficient in their respective critical medical wartime skills.</p>

1.2. Clark Health Clinic Description

Name	Clark Health Clinic
Location	Fort Bragg, North Carolina; approximately 12 miles from Fayetteville
Market²	Central North Carolina – Large Market
Mission Description	Provide the highest quality health care, maximize the medical readiness of the force, and sustain exceptional education and training programs
Vision Description	One Team - Quality Care - Quality Caring
Goals	Unknown
Facility Type	Outpatient Facility

² Defined by FY17 NDAA Section 702 Transition

Square Footage	51,771 Square Feet			
Deployable Medical Teams	N/A			
Fiscal Year (FY) 2017 Annual Budget	Unknown			
MTF Active or Proposed Facility Projects	Converting Clark Health Clinic to a Bencat Clinic			
Performance Metrics	See Volume II Part E for performance measures (Partnership for Improvement) (P4I) measures. For Joint Outpatient Experience Survey (JOES-C) data please see Section 2.1 TRICARE Health Plan Network Assessment Summary ³			
FY18 Assigned Full-time Equivalents (FTEs)⁴		Active Duty	Civilian	Contractor
Healthcare Services	Medical	17.6	71.9	0.0
				89.5
	Medical Adult Primary Care Pediatrics Behavioral Health GYN Internal Medicine Clinical Pharmacy Immunizations Ancillary Laboratory Radiology Pharmacy Minor Procedures Audiology Social Work Services			
Projected Workforce Impact		Active Duty	Civilian	Total
		0	0	0

1.3. Robinson Health Clinic Description

Name	Robinson Health Clinic
Location	Fort Bragg, North Carolina; approximately 12 miles from Fayetteville
Market⁵	Central North Carolina – Large Market
Mission Description	Provide the highest quality health care, maximize the medical readiness of the force, and sustain exceptional education and training programs
Vision Description	One Team - Quality Care - Quality Caring
Goals	Unknown
Facility Type	Outpatient Facility
Square Footage	44,884 Square Feet
Deployable Medical Teams	N/A
FY17 Annual Budget	Unknown

³ TRICARE Health Plan Network Assessment Summary references JOES-C Question #31 "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?"

⁴ Source: MTF Portfolio: Parent 0089 Womack AMC-Ft Bragg

⁵ Defined by FY17 NDAA Section 702 Transition

MTF Active or Proposed Facility Projects	Unknown				
Performance Metrics	See Volume II Part F for performance measures (Partnership for Improvement) (P4I) measures. For Joint Outpatient Experience Survey (JOES-C) data please see Section 2.1 TRICARE Health Plan Network Assessment Summary ⁶				
FY18 Assigned FTEs⁷		Active Duty	Civilian	Contractor	Total
	Medical	18.4	75.2	0.0	93.6
Healthcare Services	Medical Adult Primary Care Pediatrics Behavioral Health Ancillary Laboratory Radiology Pharmacy Optometry Physical Therapy Immunizations				
Projected Workforce Impact		Active Duty	Civilian	Total	
		0	0	0	

1.4. Joel Health Clinic Description

Name	Joel Health Clinic				
Location	Fort Bragg, North Carolina; approximately 12 miles from Fayetteville Central				
Market⁸	North Carolina – Large Market				
Mission Description	Provide the highest quality health care, maximize the medical readiness of the force, and sustain exceptional education and training programs				
Vision Description	One Team - Quality Care - Quality Caring				
Goals	Unknown				
Facility Type	Outpatient Facility				
Square Footage	58,271 Square Feet N/A				
Deployable Medical Teams	Unknown				
FY17 Annual Budget	Unknown				
MTF Active or Proposed Facility Projects	See Volume II Part G for performance measures (Partnership for Improvement) (P4I) measures. For Joint Outpatient Experience Survey (JOES-C) data please see Section 2.1 TRICARE Health Plan Network Assessment Summary ⁹				
Performance Metrics		15.5	55.6	0.0	71.0
FY18 Assigned FTEs¹⁰					

⁶ TRICARE Health Plan Network Assessment Summary references JOES-C Question #31 "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?"

⁷ Source: MTF Portfolio: Parent 0089 Womack AMC-Ft Bragg

⁸ Defined by FY17 NDAA Section 702 Transition

⁹ TRICARE Health Plan Network Assessment Summary references JOES-C Question #31 "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?"

¹⁰ Source: MTF Portfolio: Parent 0089 Womack AMC-Ft Bragg

Healthcare Services

Medical

Adult Primary Care
Pediatrics
Behavioral Health
OB/GYN

Ancillary Laboratory

Radiology
Pharmacy
Minor Procedures

**Projected Workforce
Impact**

Active Duty	Civilian	Total
94	89	183

2.0. Healthcare Market Surrounding the MTF

Description	The 15-mile radius (30-minute drive-time) around Fort Bragg encompasses 34 zip codes and eight (8) partial counties (Bladen, Cumberland, Harnett, Hoke, Lee, Moore, Robeson, Sampson) and in it there are 113 Primary Care practice sites, with 168 physicians overall (not limited to TRICARE). While ability and willingness to accept TRICARE patients must be confirmed, the vast majority of providers in the Womack-Bragg market are accepting government-sponsored insurance, and many are already contracted to provide services to TRICARE beneficiaries																				
Top Hospital Alignment	<ul style="list-style-type: none"> • Cape Fear Valley Medical Center (Fayetteville, North Carolina) • Womack Army Medical Center (Fort Bragg North Carolina) • Central Carolina Hospital (Sanford, North Carolina) • Firsthealth of the Carolinas Moore Region (Pinehurst, North Carolina) • Highsmith-Rainey Specialty Hospital (Fayetteville, North Carolina) • New Hanover Regional Medical Center (Wilmington, North Carolina) • Southeastern Regional Medical Center (Lumberton, North Carolina) 																				
Likelihood of Offering Primary Care Services to TRICARE Members¹¹	<table border="1"> <thead> <tr> <th></th> <th>Number of Practices</th> <th>Number of Physicians</th> </tr> </thead> <tbody> <tr> <td>Contracted with TRICARE</td> <td>87</td> <td>129</td> </tr> <tr> <td>High Likelihood</td> <td>1</td> <td>1</td> </tr> <tr> <td>Medium Likelihood</td> <td>25</td> <td>38</td> </tr> <tr> <td>Low Likelihood</td> <td>0</td> <td>0</td> </tr> <tr> <td>Total</td> <td>113</td> <td>168</td> </tr> </tbody> </table>		Number of Practices	Number of Physicians	Contracted with TRICARE	87	129	High Likelihood	1	1	Medium Likelihood	25	38	Low Likelihood	0	0	Total	113	168		
	Number of Practices	Number of Physicians																			
Contracted with TRICARE	87	129																			
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Medium Likelihood	25	38																			
Low Likelihood	0	0																			
Total	113	168																			

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Fort Bragg, North Carolina (Fayetteville) has a market area population of approximately 1.4M¹²
- Robinson, Joel, and Clark Clinics offer Primary Care and optometry services
 - Robinson Clinic has 13,749¹³ non-AD enrollees who could enroll to the network
 - Joel Clinic has 8,529 non-AD enrollees who could enroll to the network
 - Clark Clinic has 6,995 non-AD enrollees who could enroll to the network
- Total non-AD enrollees are 29,273
- Managed Care Support Contractor (MCSC) has contracted 150¹⁴ of 168¹⁵ (89%) Primary Care providers (PCP) within a 15-mile radius of the MTF. Only 137 of the 150 are accepting new patients
- Rolling 12-month JOES-C scores ending October 2018 with a “health care rating” scored as a nine (9) or 10 on a scale of 0-10:
 - Robinson patients: 54.0% (28 respondents)
 - Joel patients: 86.5% (25 respondents)
 - Clark patients: 31.6% (18 respondents)
 - Network patients: 71.4% (733 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members¹⁶
 - Preventive Care Visit: \$0
 - Primary Care Outpatient Visit: \$20
 - Specialty Care Outpatient or Urgent Care Center Visit: \$30
 - Emergency Room Visit: \$61

¹¹ Contracted with TRICARE: Providers are currently contracted to provide services to TRICARE beneficiaries; High Likelihood: Providers are connected to organizations currently providing services to TRICARE beneficiaries; Medium Likelihood: Providers are accepting Medicare and/or Medicaid; Low Likelihood: Providers are neither providing Medicare nor Medicaid

¹² Network Insight Assessment Summary (Independent Government Assessment)

¹³ M2

¹⁴ MCSC

¹⁵ Network Insight Assessment Summary (Independent Government Assessment)

¹⁶ <http://www.TRICARE.mil/costs>

- TRICARE Prime enrollees should expect to drive no more than:
 - 30 minutes to a PCP for Primary Care
 - 60 minutes for Specialty Care

Assumptions:

- MCSC could contract an additional 50% of the existing non-network PCPs
- The average PCP panel is approximately 2000¹⁷
- PCPs generally have relatively full panels, able to immediately enroll:
 - Up to 2.5% more enrollees (49) easily
 - 2.5% - 5% (50-99) with moderate difficulty
 - > 5% (100+) with great difficulty
- Rural networks will grow more slowly than metropolitan networks to accommodate demand

Analysis:

- Fort Bragg is in a small metropolitan area (Fayetteville) with a currently adequate Primary Care network
- Enrollment of additional beneficiaries to the network would depend on MCSC network expansion and potentially the entry of additional physicians into the market
- If MCSC contracts 50% of the non-network PCPs, they would have a total of 146 PCPs accepting new patients
- Each PCP would have to enroll 201 new patients to accommodate the 29,273 Womack satellite clinic enrollees
- Based on the assumptions above, the MCSC network could not likely expand rapidly to meet the new demand
- Beneficiaries rate network health care about the same as the Womack clinic healthcare, so beneficiary satisfaction is not likely to suffer with network enrollment
- Network enrolled Retirees and their family members will have higher out-of-pocket costs than MTF enrollees
- On base non-AD residents will have to travel farther for Primary Care if enrolled to the network

Implementation Risks:

- MCSC network may not grow fast enough to accommodate beneficiaries shifted from Womack
- MCSC may be unable to contract enough PCPs within the 30-minute drive time
- Retirees and their family members may seek less Primary Care due to out-of-pocket costs (+/-)

2.2. Network Insight Assessment Summary (Independent Government Assessment)

Facts:

- **Primary Care:** The MHS impacted population for Primary Care living within a 30-minute drive-time radius is approximately 28,000 (approximately 6,700 of which are from Clark Clinic) and represents about 5% of the population. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Of note, Pediatric services will be a particularly important consideration as 43% of Clark Health Clinic beneficiaries are below the age of 18 and 15.3% of the combined

¹⁷ MGMA

Clinics' beneficiaries are below the age of 5. Population growth over the last five (5) years (2014 to 2018) has averaged ~7.2%, and the projected growth for this area is 3.8% over the next five (5) years (2019 to 2023)

Assumptions:

- Assumptions can be found in Section 4.3.2 of the NDAA Section 703 Report

Analysis:

- **Primary Care:** The commercial Primary Care network within the 30-minute drive-time standard *may not be capable of accepting the specific demand* from the more than 28,000 impacted beneficiaries (more than 6,700 of which are from Clark Clinic). Overall, there is a shortage of Primary Care physicians. However, surplus observed in Cumberland County, where the MTF is located, covers ~64% of impacted beneficiaries. The network may be challenged to sustain the ability to service incremental demand, particularly due to the shift to value based care and resulting increased Primary Care provider usage

3.0. Appendices

Appendix A	Use Case Assumptions
Appendix B	Criteria Ratings Definition Glossary
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Appendix A: Use Case Assumptions

General Use Case Assumptions

1. Population impact that is greater than 10% of total population will impact the supply and demand of the provider network market
2. There will be no change in the TRICARE benefit to accommodate decisions
3. Readiness requirements for the final decision will be addressed in the Service Quadruple Aim Performance Plan (QPP)
4. There will be no changes to the existing Managed Care Support Contract (MCSC)
5. The MCSC could contract an additional 50% of the existing non-network Primary Care Providers (PCPs)
6. The average PCP panel is approximately 2000¹⁸

¹⁸ MGMA

Appendix B: Criteria Ratings Definition

Criteria Ratings Definition

Mission Impact	High: High probability of impacting the mission or readiness with the impacted population receiving network care Medium: Moderate probability of impacting the mission or readiness with the impacted population receiving network care Low: Low probability of impacting the mission or readiness with the impacted population receiving network care
Network Assessment	High: Both network assessments confirm inadequate network for primary and Specialty Care. Low probability of network growth or MCSC recruitment in the future Medium: Mixed findings from both network assessments for primary and Specialty Care. Moderate probability of network growth in the future Low: Both network assessments confirm adequate network for Primary Care and Specialty Care

Appendix C: Glossary

<i>Term (alphabetical)</i>	<i>Definition</i>
Ambulatory Care	Ambulatory care is care provided by health care professionals in outpatient settings. These settings include medical offices and clinics, ambulatory surgery centers, hospital outpatient departments, and dialysis centers (AHRQ.gov)
Beneficiary	Individuals who have been determined to be entitled to or eligible for medical benefits and therefore are authorized to receive treatment in a military treatment facility or under Department of Defense auspices (Source: health.mil)
Critical Access Hospital Designation	Critical Access Hospitals (CAHs) is a designation given to eligible hospitals by the Centers for Medicare and Medicaid Services (CMS)..... (CAHs) represent a separate provider type with their own Medicare Conditions of Participation (CoP) as well as a separate payment method. CoPs for CAHs are listed in the Code of Federal Regulations (CFR) at 42 CFR 485.601–647 (Source: CMS.gov)
Direct Care	Care provided to eligible beneficiaries throughout the Military Health System at DoD hospitals, clinics, and pharmacies (usually MTFs) (Direct Care); (Source: McEvoy, L. N., 2Lt, USAF. (2018). A Study of Military Health Care Costs: Direct Versus Purchased Care in a Geographical Region. Defense Technical Information Center, 1-6. Retrieved from https://apps.dtic.mil/dtic/tr/fulltext/u2/1056374.pdf .)
Eligible	To use TRICARE, you must be listed in DEERS as being eligible for military health care benefits. TRICARE-eligible persons include the following: Military members and their families, National Guard/Reserve members and their families, Survivors, Some former spouses, Medal of Honor recipients and their families (Source: TRICARE.mil)
Enrollee	The Cambridge Dictionary defines Enrollee as “someone who is on the official list of members of a group, course, or college.” For the purposes of this Use Case, Enrollee is defined as an eligible Military Health System beneficiary that is currently participating in one of the TRICARE Health plans
JOES	Joint Outpatient Experience Survey (Source: health.mil)
JOES-C	Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems (Source: health.mil)
Managed Care Support Contractor (MCSC)	Each TRICARE region has its own MCSC who is responsible for administering the TRICARE program in each region. The MCSCs establish the provider networks and conduct provider education. Humana is the MCSC in the East, and HealthNet is the MCSC in the West (Source: health.mil)
Network	A provider network is a list of the doctors, other health care providers, and hospitals that a plan has contracted with to provide medical care to its members. These providers are called “network providers” or “in-network providers.” (Source: cms.org)
Occupational Therapy	Occupational therapy is the use of individualized evaluations, customized intervention strategies, and outcome evaluations to help people across their lifespan participate in activities they want and need through the therapeutic use of everyday activities (occupations) (Source: The American Occupational Therapy Association)
Remote Overseas	TRICARE Prime Remote Overseas is a managed care option in designated remote overseas locations: Eurasia-Africa, Latin America and Canada, Pacific (Source: TRICARE.mil)
P4I	A set of MHS clinical, quality, safety and readiness performance measures (Partnership for Improvement)
Panel	A panel is a list of patients assigned to each care team in the practice. The care team (e.g., a physician, a medical assistant, and a health educator) is responsible for preventive care, disease management, and acute care for all the patients on its panel. This means that a patient will have the opportunity to receive care from the same clinician and his or her care team. The panel's population are the patients associated with a provider or care team, the physician care team is concerned with the health of the entire population of its patient (Source: AHRQ.gov)
Plus	With TRICARE Plus patients receive free Primary Care at their respective military hospital or clinic. The beneficiary is not required to pay anything out-of-pocket. TRICARE Plus does not cover Specialty Care (Source: health.mil)
Prime	TRICARE Prime is a health insurance program offered to active duty members, retirees, activated guard and reserve members, and families. Active Duty members are required to enroll in TRICARE Prime, while all others may choose to enroll or use TRICARE Select. TRICARE Prime offers fewer out-of-pocket costs than TRICARE Select, but less freedom of choice for providers (Source: health.mil)
Purchased Care	TRICARE provides care to its eligible beneficiaries in two broad settings: a system of DoD hospitals, clinics, and pharmacies (usually MTFs) (Direct Care); and a supplemental network of participating civilian health care professionals, institutions, pharmacies, and suppliers (Purchased Care) (Source: McEvoy, L. N., 2Lt, USAF. (2018). A Study of Military Health Care Costs: Direct Versus Purchased Care in a Geographical Region. Defense Technical Information Center, 1-6. Retrieved from https://apps.dtic.mil/dtic/tr/fulltext/u2/1056374.pdf .)
Reliant	Active Duty Service Members who are not enrolled to TRICARE Prime (e.g. students and recruits) (Source: MHS Modernization Study, Feb 2016)
Value Based Payment	Value Based Payment (VBP) is a concept by which purchasers of health care (government, employers, and consumers) and payers (public and private) hold the health care delivery system at large (physicians and other providers, hospitals, etc.) accountable for both quality and cost of care (Source: AAFP)

Appendix D: Volume II Contents

Part A	Data Call
Part B	Relevant Section 703 Report Detail Glossary DHA
Part C	TRICARE Health Plan Network Review
Part D	Network Insight Assessment Summary (Independent Government Assessment) P4I
Part E	Measures
Part F	JOES-C 12-month Rolling Data
Part G	Base Mission Brief
Part H	MTF Mission Brief
Part I	MTF Portfolio (Full)

Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

Clark Clinics – Fort Bragg, NC
05 April 2019

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Purpose of the Visit

This was a fact-finding visit to assist the MHS Section 703 Workgroup in understanding unique mission aspects, as well as base and MTF's leadership perspective of the capacity of the current civilian network market. This information will be used for making MTF specific capability and capacity decisions options and decisions to be included in a report to Congress.

Summary of Site Visit

Base/Mission Impact:

- Soldier and medical force readiness are the central to the training missions at Fort Bragg. Base leadership desires a military medical system that will support 1) healthcare and readiness of soldiers 2) readiness of medics 3) optimized troops as athletes 4) Integration between line soldiers and medics

MTF Impact:

- Army medicine is focused on integrating with the Army's vision of optimization of soldier's health and readiness to fight. This means optimizing health prior to injury through metabolic development and training as elite athletes
 - **Robinson Clinic** will become an AD only, sports medicine center of excellence. The clinic is located across the street from the gym, and will have PT, sports medicine and OT to support Army total force care
 - **Joel Clinic** is becoming an AD only aviation medicine center of excellence which will include dental services
 - **Clark Clinic** will become a Benefit Category (Bencat) clinic because of the proximity to Special Warfare Center and School (SWCS) schoolhouse, this will enable them to consolidate child and family behavioral health and family advocacy into one building

Network Impact:

- Because of the size of Fort Bragg, family members in some zip codes are already testing the network where the care is especially good. Other locations will have to be more closely studied to understand the specific network capabilities

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
COL John Melton	WAMC Commander	MTF
SGM Wendell Mullen II	WAMC Command Sergeant Major	MTF
COL Hall		MTF
COL Ochoa	Chief of Primary Care	MTF
Ms. Horton	Deputy Chief of Primary Care	MTF
COL Hamilton		MTF
LTC Johnson	WAMC Chief of Nutrition	MTF
Joan Sanders		MTF
MAJ Clark Cave	WAMC Executive Officer	MTF
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	703 Workgroup
Mr. Nate Leach	Contract Support	703 Workgroup

Summary of MTF Leadership Discussion Agenda

Below is the summary of the topics that were discussed during the MTF Leadership Discussion:

Voice of the Customer Summary:

- **MTF Mission Overview:** The Fort Bragg Military Health System is a federated system that is centralized around Womack with multiple tenant unit organic medical assets and off post community health partners. As an integrated system of Readiness and Health, Womack enables the Operational Force to achieve overmatch by ensuring that every Soldier (Army Total Force and Joint Force) is physically and cognitively Ready to Fight Tonight and proficient in their respective critical medical wartime skills. Womack has 38 Controlled facilities, seven Occupied IMCOM facilities, and four leased facilities off post. They support an enrolled population of 116,865 across 44 specialty services
- **Soldier Readiness:** The army is moving towards optimization of soldier's health and readiness to fight. This means optimizing soldier health prior to injury through metabolic development and training. Womack is optimizing their medical facilities and resources to further support the readiness mission. They are expanding UCCs and Medical One-Stop as well as realigning services at Fort Bragg clinics to deliver specific care in proximity to the relevant populations
 - **Robinson Clinic** will become an AD only, sports medicine center of excellence. The clinic is located across the street from the gym, and will have PT, sports medicine and OT to support Army total force care
 - **Joel Clinic** is becoming an AD only aviation medicine center of excellence which will include dental services
 - **Clark Clinic** will become a Benefit Category (Bencat) clinic because of the proximity to Special Warfare Center and School (SWCS) schoolhouse, this will enable them to consolidate child and family behavioral health and family advocacy into one building
- **GME Platform (Readiness of medical personnel):** WAMC and Fort Bragg clinics must maintain appropriate patient population mix to support the existing GME. This is true especially for the retiree population where the clinical complexity of the patients help support readiness of medical staff

- Existing partnerships could become more seamless to provide training experiences. WAMC currently sends physicians to network facilities (i.e. Emory) to integrate locally, and to get experiences to prepare the medical force
- Additionally, with DHA oversight of logistics, GME could be more organized so that programs like a sports medicine fellowship is relocated to MTFs where most of the relevant soldier population are located
- Network:
 - Because of the size of Fort Bragg, family members in some zip codes are already testing the network where the care is especially good. Other locations will have to be more closely studied to understand the specific network capabilities
 - WAMC is honoring family member choice by advising them of the care they can receive in the network. They support “hot handoffs” as families PCS, and they aim to target another 10,000 family member beneficiaries by the end of 2019. There are logistical challenges, as Humana requires approval for patients to get released from on-base primary care (i.e. for active management of cardiac issues through network care)
 - Working in partnership with network facilities (utilizing MOUs) the MTF can optimize workflows so that they do initial workup on base, and then transfer patients to the network in exchange for training experiences for the medical force. The biggest barrier for this is an effective way to share data between the military system and the network. There is a safety and quality issue to not having access to this information
 - TRICARE reimbursements to commercial providers are low compared to non-government payers. WAMC has to be sure that the network will accommodate their patients

Summary of Base Leadership Discussion

List of Attendees

The following were in attendance during the Fort Bragg Leadership discussion:

Name	Title	Affiliation
MG McKiernan	Commander, 18 th Airborne	Base
COL John Melton	WAMC Commander	MTF
SGM Wendell Mullen II	WAMC Command Sergeant Major	MTF
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	703 Workgroup
Mr. Nate Leach	Contract Support	703 Workgroup

Summary of Fort Bragg Leadership Discussion

Below is the summary of the topics that were discussed during the Base Commander Discussion:

Voice of the Customer Summary:

- **Readiness:** Soldier and medical force readiness are the central to the training missions at Fort Bragg. Base leadership desires a military medical system that will support 1) healthcare and readiness of soldiers 2) readiness of medics 3) optimized troops as athletes 4) Integration between line soldiers and medics
 - Previous changes to running the MTFs focused too much on metrics and statistics, and that became more important than taking care of soldiers at the combat support hospitals. Ideally, medical care would be delivered at battalion aid stations so that PAs and medics can take care of daily readiness requirements. By attempting to match metrics that civilian hospitals record, the MTF is missing the element of maintaining readiness. This is not the same in the civilian network where keeping, or making people healthy is the mission
 - Base leadership expressed interest in focusing more on battlefield readiness so that medical forces get the medical care experience daily, not just during special trainings. Military medicine should focus more on combat medicine
 - Additionally, the Army military system needs to be able to expand and contract depending on the wartime need