MHS Section 703 Workgroup Use Case Decision Package

Kenner Army Health Clinic (KAHC) 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	**Kenner Army Health Clinic (KAHC)**
Decision	Transition Kenner Army Health Clinic outpatient facility to an Active Duty only and Occupational Health clinic (AD/OH). Kenner AHC should maintain extended care hours to include weekend and holiday half-hours. 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 Lee and the KAHC are in Fort Lee, VA, approximately 30 miles south of Richmond, VA. Fort Lee's key mission elements include the Combined Arms Support Command (CASCOM) and the Army's Sustainment Center of Excellence. The population of Fort Lee averages more than 27,000 and includes members from all branches of the military service, their families, government civilians, and contractors. As many as 50,000 troops will pass through Fort Lee's classrooms each year, making it the third largest training site in the Army.

Criteria Matrix

Decision Criteria	Rating or Value[1]	Key Takeaways or Findings	Use Case Package
Mission Impact	L	• KAHC supports soldier and medical force readiness by maintaining multiple facilities to deliver care directly to the trainees on base. Trainees do not have cars so by distributing medical services to Troop Medical Clinics (TMCs) near training sites, KAHC is able to improve access • All trainees need to have green Periodic Health Assessments (PHAs) before they arrive at their first duty station. This means that approximately 12,000 PHAs are conducted at KAHC annually • Readiness issues may arise if family member care is sent to the network as active duty may need to spend time away from training and jobs to support family members receiving care	Section 1.0
Network Assessment	M	• The Garrison Directorate of Emergency Services (DES) has an in-house ambulance at the fire department because leadership believes that the community response times are not fast enough o Some neighborhoods have experienced where Emergency Medical Services (EMS) are challenged to make the timeliness standards for arrival times (7 minutes for first arriving company and 12 minutes for transport unit and Advanced Life Support (ALS) capability),[2] even with the two (2) fire/ambulance stations on Fort Lee o The MTF Commander believes it would be even more challenging for an off-post ambulance to provide the same or better response to Fort Lee and that going from a 3-5 minute response time to anything greater could potentially cause bad outcomes if emergency care is needed. Not all Fort Lee gates are open past duty hours and weekends which could further delay entrance/egress times • TRICARE Health Plan's assessment shows that Fort Lee currently has an 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 • The independent government network assessment shows that within the KAHC market, there is adequate supply of Primary Care physicians to cover the increased demand from the impacted TRICARE beneficiaries, concentrated in Richmond, Chesterfield, and Henrico counties.	Section 2.0

[1] See Appendix B for Criteria Ratings Definitions
[2] DODI 6055.06 DoD Fire and Emergency Services Program

		Given the forecasted population growth and existing supply of Primary Care providers in the market, the commercial Primary Care network within the 30-minute drive-time standard is expected to have the capability of accepting the incremental demand from MHS beneficiaries • While capacity for care exists in Richmond, it may take up to half a day for someone to receive care and not all of Richmond medical facilities fall within a 30-minute drive-time from Fort Lee. KAHC can provide most care in under 1-2 hours, saving time for AD and family members • KAHC leadership does not have visibility into the quality of network care and is concerned about the ability for dissatisfactions with network care to be shared with leadership in an effective manner o Fort Lee recently experienced a tragedy when a trainee went to an Urgent Care Center (UCC) in the network with flu-like symptoms and received an oral antibiotic before returning to the barracks. Later that night the trainee passed away o After reporting the case to DHA Clinical Quality Management and being told the case was completed, the MTF is still unaware of how the case was resolved or what the findings were. The lack of transparency concerns the MTF Commander and reduces their trust that potential issues in the network are being addressed	

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	Quality care for retirees and family members must be maintained. There may not currently be enough regular oversight of patient satisfaction and quality of care for the network. Transition of beneficiaries to the network must be carefully planned and monitored to ensure availability of Primary Care providers	• The MTF and Managed Care Support Contract (MCSC) will monitor the transition and performance of private-sector hospitals to identify and address quality and access issues
2	Families with single cars (i.e., one mode of transportation) could lead to extended time away from duty for Active Duty Service Members (ADSM)	• The installation and MTF should coordinate to develop alternative modes of transportation for ADSM dependents. This will likely require additional policy decisions and dedicated resources beyond what is currently provided to the MTF
3	Access to care for orthopedics and mental health are priorities for the population of trainees on base	• Required mission support will be continued and monitored to ensure the MTF is meeting mission requirements
4	Community ambulance response time may not be fast enough to meet the needs of the Fort Lee population	• Update MOUs/MOAs between KAHC and Garrison DES to support Solider Readiness
5	Taking into account traffic patterns and the location of the most advanced Emergency Room (ER) service will require further analysis to assess any un-mitigatable risk to the health and safety of the Soldiers, Sailors, Marines and Airmen population residing on Fort Lee	• TriCities Emergency Center is a free-standing ER which is open 24/7, located 3 – 4 miles away from KAHC. Southside Regional Medical Center has an ER located 7 – 8 miles away from KAHC. The Installation/MTF and MCSC should develop relationships with the ERs to better understand how to mitigate risks to the health and safety of the Soldiers, Sailors, Marines and Airmen population

Next Steps:

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.

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1.0. Installation and Military Medical Treatment Facility (MTF) Description

Fort Lee is in Fort Lee, VA and is the home of KAHC, as well as several other tenant organizations and units. Fort Lee is home to the Combined Arms Support Command (CASCOM) and the Army's Sustainment Center of Excellence. CASCOM trains, educates and grows adaptive sustainment professionals and develops and integrates innovative Army and Joint sustainment capabilities, concepts, and doctrine to sustain Large Scale Ground Combat Operations. With as many as 50,000 troops passing through its classrooms each year, Fort Lee is the third largest training site in the Army.

1.1. Installation Description

Name	Fort Lee
Location	Fort Lee, VA; approximately 30 miles south of Richmond, VA
Mission Elements	• KAHC • CASCOM • Army Sustainment Center of Excellence • Defense Contract Management Agency • Quartermaster Center and School & 23rd QM BDE • Ordnance Center & 59th BDE • Transportation Center and School • Army Logistics University • Defense Commissary Agency • Marine Corps Detachment • 345th Air Force Training Squadron • 54th & 111th QM Companies (Mortuary Affairs)
Mission Description	Integrate and deliver Base Operations that enable Training in support of readiness
Regional Readiness / Emergency Management	Far forward MSK care PHAs for trainees (~12,000 per year) Acute care on weekends and evenings
Base Active or Proposed Facility Projects	No Information
Medical Capabilities and Base Mission Requirements	According to United Stated Army Training and Doctrine Command (TRADOC), the ideal medical support includes: • Delivered within unit areas as appropriate to minimize time away from training • Heavy emphasis on Primary Care, Musculoskeletal (MSK) Care, and Behavioral Health (BH) • Surgeon and BH officer support at BDE and Center of Excellence (CoE) level • Human performance support aligned with Army's Holistic Health and Fitness (H2F) plan • Ability to perform consultation for potential orthopedic surgery on post at MTF • Extended access to care hours The installation and MTF currently support 731 unique individuals enrolled in the Exceptional Family Member Program (EFMP).

1.2. MTF Description

Name	Kenner Army Health Clinic
Location	Fort Lee, VA; approximately 30 miles south of Richmond, VA
Market[3]	Central Virginia – Small Market

[3] Defined by FY17 NDAA Section 702 Transition

Mission Description	We are committed to enhancing Soldier and Medical Force readiness through the delivery of exceptional and compassionate patient-centered care
Vision Description	Aspiring to exceed expectations as the DoD's premier system for health and readiness
Goals	No Information
Facility Type	Outpatient facility
Square Footage	154,526 Square Feet
Deployable Medical Teams	• PROFIS • MTOE Assigned Personnel
FY18 Annual Budget	No Information
MTF Active or Proposed Facility Projects	No information
Performance Metrics	See Volume II Part D and E for Partnership 4 Improvement (P4I) measures and Joint Outpatient Experience Survey - Consumer Assessment of Health Providers and Systems (JOES-C) data

Projected Workforce Impact

Active Duty	Civilian	Total
48	101	**149**

FY18 Assigned Full Time Equivalents (FTEs)[4]

	Active Duty	Civilian	Contractor	Total
Medical	80.8	283.7	0	**364.5**

Healthcare Services

Primary Care
- Family Medicine Clinic
- Pediatrics Clinic
- Internal Medicine
- Women's Health
- Active Duty Clinic

Specialty Services
- Behavioral Health
- Optometry
- Orthopedics
- Physical Therapy
- Dermatology

Ancillary Services
- Pharmacy
- Laboratory
- Radiology (x-ray, mammography, ultrasound)

Preventive Medicine
- Occupational Health
- Public Health
- Army Wellness Center
- Industrial Hygiene
- Environmental Health

[5] Source: Kenner AHC MTF Portfolio

2.0. Healthcare Market Surrounding the MTF

Description	Within the KAHC drive time standard, there are currently 61 Primary Care practice sites comprised of 112 physicians. Within KAHC's Specialty Care drive time standard, there are currently 117 Specialty Care practice sites comprised of 310 providers. The potential impact of new MHS beneficiaries on the total population is well below the 10% threshold for both population groups and thus will not materially impact supply and demand of services in the market.
Top Hospital Alignment	• Southside Regional Medical Center, Petersburg, VA • Bon Secours St Mary's Hospital, Richmond, VA • John Randolph Medical Center, Hopewell, VA • Johnston-Willis Hospital, Richmond, VA • Chippenham Medical Center, Richmond, VA • Bon Secours St Francis Medical Center, Richmond, VA • Bon Secours Richmond Community Hospital, Richmond, VA • UVA Healthsouth Rehabilitation Hospital, Charlottesville, VA • Piedmont Medical Center, Warrenton, VA • Medical College of Virginia Hospitals, Richmond, VA
Likelihood of Offering Primary Care Services to TRICARE Members[5]	

	Number of Practices	Number of Physicians
Contracted with TRICARE	24	58
High Likelihood	28	42
Medium Likelihood	9	12
Low Likelihood	0	0
Total	**61**	**112**

2.1. TRICARE Health Plan Network Assessment Summary

Facts:

- Fort Lee (Petersburg, VA) has a market area population of approximately 1.5M[6]
- KAHC has 15,701[7] non-AD enrollees who could enroll to the network
- KAHC offers Primary Care, dermatology, mental health, orthopedics, and physical therapy
- Managed Care Support Contractor (MCSC) has contracted 46[8] of 112[9] (41%) Primary Care providers (PCP) within a 30-mile radius of the MTF. All 46 are accepting new patients
- Rolling 12-month JOES-C scores ending October 2018 with a "health care rating" scored as a 9 or 10 on a scale of 0-10:
    - KAHC patients: 41.2% (147 respondents)
    - Network patients: 74.3% (464 respondents)
- TRICARE Prime Out-of-Pocket Costs for Retirees and their family members[10]
    - Preventive Care Visit: $0
    - Primary Care Outpatient Visit: $20
    - Specialty Care Outpatient or Urgent Care Center Visit: $30
    - Emergency Room Visit: $61
- TRICARE Prime enrollees should expect to drive no more than:
    - 30 minutes to a PCM for Primary Care
    - 60 minutes for Specialty Care

[5] 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

[6] Network Insight Assessment Summary (Independent Government Assessment)

[7] M2

[8] MCSC

[9] Network Insight Assessment Summary (Independent Government Assessment)

[10] http://www.tricare.mil/costs

Assumptions:

- MCSC could contract an additional 50% of the existing non-network PCPs
- The average PCP panel is approximately 2000[11]
- 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 Lee is in a rural area 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 79 PCPs accepting new patients
- Each PCP would have to enroll 199 new patients to accommodate the 15,701 KAHC enrollees
- Based on the assumptions above, the MCSC network could not likely expand rapidly to meet the new demand
- Beneficiaries rate network health care 33% higher than KAHC 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 KAHC
- MCSC may be unable to contract enough PCPs within the 30-minute drive time
-
- Retirees working at Lee may miss more work time, reducing trainee throughput
- 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 Military Health System (MHS) impacted population for Primary Care is just greater than 14,000, which represents 3.8% of the impacted population within a 30-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Population growth has been strong over the last five years (2014 to 2018) averaging 7-8%, and is projected to level out over the next five years at 3-4%

[11] MGMA

- **Specialty Care:** The MHS impacted population for Specialty Care is around 35,000, which represents 2.3% of the impacted population within a 60-minute drive-time radius. This is well below the 10% threshold, and thus will not materially impact the supply of, and demand for, care. Population growth in this area has been strong over the last five years (2014 to 2018) averaging 6.1% and is projected to level out over the next five years at 3%

Assumptions:

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

Analysis:

- **Primary Care:** There is an adequate supply of Primary Care physicians to cover the increased demand for the impacted TRICARE beneficiaries, concentrated in Richmond, Chesterfield, and Henrico counties. A large surplus of providers in Richmond and Chesterfield counties could potentially accommodate excess demand from impacted TRICARE beneficiaries. While ability and willingness to accept TRICARE patients must be confirmed, the majority of Primary Care providers in the KAHC market already accept TRICARE or other government-sponsored insurance
- Given the forecasted population growth and existing supply of Primary Care providers in the market, we expect the commercial Primary Care network within the 30-minute drive-time standard to have the capability of accepting the incremental demand from the approximately 14,000 impacted beneficiaries
- **Specialty Care:** There is an adequate supply of physicians in the key specialties to cover the increased demand for the impacted TRICARE beneficiaries. Although we expect to see an overall shortage of Psychiatry and Orthopedic Surgery providers, large surpluses in Richmond county can potentially cover demand from impacted TRICARE beneficiaries

3.0. Appendices

Appendix A	Use Case Assumptions
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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 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 2000[12]

[12] 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

Term (alphabetical)	*Definition*
Ambulatory Care	**Ambulatory care** or outpatient **care** is medical **care** provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services (Source: Wikipedia)
Beneficiary	Individuals who have been determined to be entitled to or eligible for medical benefits and therefore authorized treatment in a military treatment facility or under Department of Defense auspices (Source: health.mil)
Critical Access Designation	**Critical Access** Hospital is a **designation** given to eligible rural hospitals by the Centers for Medicare and Medicaid Services (CMS). ... The CAH **designation** is designed to reduce the financial vulnerability of rural hospitals and improve **access** to healthcare by keeping essential services in rural communities (Source: Ruralhealthinfo.org)
Direct Care	Hospitals and clinics that are operated by military medical personnel (Source: health.mil)
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: Military.com)
Enrollee	An eligible MHS beneficiary that is currently participating in one of the TRICARE plans
JOES	Joint Outpatient Experience Survey
JOES-C	Joint Outpatient Experience Survey – Consumer Assessment of Health Providers and Systems
Managed Care Support Contractor	Managed Care Support Contractors. Each TRICARE region has its own managed care support contractor (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 assessment and intervention to develop, recover, or maintain the meaningful activities, or occupations, of individuals, groups, or communities. It is an allied health profession performed by occupational therapists and Occupational Therapy Assistants
Overseas Remote	TRICARE Prime Remote Overseas is a managed care option in designated remote overseas locations: Eurasia-Africa, Latin America and Canada, Pacific
P4I	A set of MHS clinical, quality, safety and readiness performance measures (Partnership for Improvement)
Panel	"Provider panel" means the participating providers (Primary Care physician) or referral providers who have a contract, agreement or arrangement with a health maintenance organization or other carrier, either directly or through an intermediary, and who have agreed to provide items or services to enrollees of the health plan (Source: Definedterm.com)
Physical Medicine	The branch of medicine concerned with the treatment of disease by physical means such as manipulation, heat, electricity, or radiation, rather than by medication or surgery. the branch of medicine that treats biomechanical disorders and injuries (Source: Dictionary.com)
Plus	With TRICARE Plus, you get free Primary Care at your military hospital or clinic. The beneficiary does not pay nothing out-of- pocket. TRICARE Plus doesn't cover Specialty Care (Source: health.mil)
Prime	TRICARE Prime is a health insurance program offered to active duty members, retirees, activated guard & reserve members, and families. If you're on active duty, you have to enroll in TRICARE Prime, all others can 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	Supplementing the direct care component, the purchased care component of TRICARE is composed of TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers who have generally entered into a network participation agreement with a TRICARE regional contractor.
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	DHA TRICARE Health Plan Network Review
Part C	Network Insight Assessment Summary (Independent Government Assessment) P4I
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Part F	Base Mission Brief
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Appendix E: MTF Trip Report

MHS Section 703 Workgroup Site Visit Trip Report

AHC Kenner-Lee

02 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 options and decisions to be included in a report to Congress.

Summary of Site Visit

Base/Mission Impact:

- Ft. Lee is home to the Combined Arms Support Command (CASCOM) and the Army's Sustainment Center of Excellence. Time in the classroom is the most important part of the training-mission space. Having medical services that support keeping cadre and trainees in the classroom (e.g., flexible clinic hours, UCCs, local Troop Medical Clinics) will support the readiness of the trainees

MTF Impact:

- AHC Kenner supports an enrolled population of 20,643, of which 23.5% (4,852) are Active Duty, 33.7% (6,961) are AD Family Members, 16.1% (3,317) are Retirees, and 25.2% (5,211) are Retired Family Members/Other. Because of the training schools on base, there is an average of approximately 10,500 trainees on ground at Ft. Lee who are not enrolled to the MTF
- According to the MTF leadership, the ideal TRADOC (U.S. Army Training and Doctrine Command) Medical Support would be delivered within the unit area to minimize time away from training and sustain the ability to perform consultation for potential orthopedic surgery on post at MTF. There would be a heavy emphasis on Primary Care, Musculoskeletal care, and Behavioral health with performance support aligned to the Army's Holistic Health and Fitness (H2F) plan. In addition to these unit-associated medical services, there is a need for 24/7 UCC or at least acute/urgent care expanded into evening and weekend hours. Currently, urgent care capabilities are only available off-base

Network Impact:

- Leadership recognizes that the network has strengths because they are already sending specialty care to the network. They want to be sure Retirees and Family Members receive quality care, even if that is not MTF care. The MTF leadership is concerned that there is not enough regular oversight of patient satisfaction and quality of care for the network, and that they will not have a way of knowing if patients are receiving quality care if they don't have an opportunity to see the patients themselves

Summary of MTF Leadership Discussion

List of Attendees

The following were in attendance during the MTF Leadership discussion:

Name	Title	Affiliation
LTC Paul J. Kassebaum	Commander, AHC Kenner	MTF
LTC Nichelle Johnson	Incoming Commander	MTF
SGM Joanne S. Rollocks	Sergeant Major	MTF
LTC Tameka Bowser	Deputy Commander for Nursing	MTF
LTC David Glad	Deputy Commander for Administration	MTF
Mr. Matthew Dias	Deputy to the Commander for Quality & Safety	MTF
LTC Dentonio Worrell	Ft. Lee Dental Clinic Commander	MTF
Mr. Jeff Schend	RHC-A Health Systems Specialist	MTF
LTC Brent Clark	RHC-A Dental	MTF
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
COL Gary Hughes	Optometry Consultant and Program Manager Office of the Surgeon General	703 Workgroup
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	703 Workgroup
Mr. Nate Leach	Deloitte Support	703 Workgroup

Summary of MTF Leadership Discussion

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

Voice of the Customer Summary:

- MTF Mission Overview:
  - Ft. Lee is home to the Combined Arms Support Command (CASCOM) and the Army's Sustainment Center of Excellence. CASCOM trains, educates and grows adaptive sustainment professionals and develops and integrates innovative Army and Joint sustainment capabilities, concepts, and doctrine to sustain Large Scale Ground Combat Operations. With as many as 50,000 troops passing through its classrooms each year, Fort Lee is the third largest training site in the Army
  - Medical services at AHC Kenner-Lee include:
    - **Primary Care (Patient Centered Medical Home)**: Family Medicine, Pediatrics, Internal Medicine, Women's Health and AD Clinic. There are approximately 731 EFMP participants, and the pediatric services at AHC Kenner are very important to the AD and ADFMs in the program
    - **Specialty Care**: Behavioral Health, Optometry, Orthopedics (outpatient), Physical Therapy and Dermatology. AHC Kenner provides 90% of optometry for the enrolled population. This is especially important when taking care of the retirees and family members. PT and Ortho clinics help keep the trainees in the classroom instead of sending them to the network. The Ortho clinic is already 90% Active Duty so moving to AD only clinic would not change the service much. They provide acute and chronic injury management, pain management, and joint injections but no

procedures. For Dermatology and Dietitian clinics, the patient population is currently approximately 50% Active Duty which saves classroom time.

- **Ancillary Services**: Pharmacy, Laboratory, and Radiology are available at the AHC as well as the TMCs. AHC Kenner has both pharmacy (distributive function) and clinical pharmacy (advisory function as part of PCMH). Pharmacy is available at AHC as well as the TMCs. The workload may not be sufficient at each TMC to justify this, but the logistics and need for easy access make it hard to remove ancillary services from TMCs. There is some Laboratory and Radiology equipment at TMCs run by technicians, and more complete services as well as laboratory officers at AHC
- **Preventative Medicine**: Occupational Health, Public Health, Army Wellness Center, Industrial Hygiene, and Environmental Health. A large part of the preventative medicine work provides vaccines to troops. The occupational health staff are all civilian. Inspections are mostly at Ft. Lee, but occasionally they travel to other Bases and Worksites (including Fort A.P Hill, Rivanna Station, DLA Aviation, Fort Pickett, and Radford Army Ammunition Plant) for environmental health inspections (approximately 70 annually)
- **Dental**: Dental screenings, and CAD CAM and 3D printing for crowns and dental heads. Because of the trainee turnover, the dental clinic need to have these tools on site to provide crown/dental implant services to trainees in the 6-8 weeks on-base timeline. If they did not have that capability, it would take longer to get the services out in the network

- AHC Kenner supports an enrolled population of 20,643, of which 23.5% (4,852) are Active Duty, 33.7% (6,961) are AD Family Members, 16.1% (3,317) are Retirees, and 25.2% (5,211) are Retired Family Members/Other. Because of the training schools on base, there is an average of approximately 10,500 trainees on ground at Ft. Lee who are not enrolled to the MTF. While this is generally a healthy population, they do need access to care through the MTF while on base, especially for mental health and orthopedics

- Readiness:
  - AHC Kenner supports soldier and medical force readiness by maintaining a number of facilities to deliver care directly to trainees. Trainees don't have cars so by distributing medical services to TMCs near training sites, AHC Kenner is able to improve access. The MTF leadership report issues retaining civilian medical practitioners at the satellite clinics because there is not much appetite for the work needed to take care of trainees. As of March 2018, TRADOC Tasking Order IN163644 mandates that COMPO 1 Soldiers must remain "green" on PHA (Periodic Health Assessment) for 1 month following graduation and COMPO 2/3 Soldiers must remain "green" on PHA for 6 months following graduation before reporting to their permanent units. This means that approximately 11-12k PHAs are required at Kenner AHC annually. Currently resources are insufficient to complete this mission
  - According to the MTF leadership, the ideal TRADOC (U.S. Army Training and Doctrine Command) Medical Support would be delivered within the unit area to minimize time away from training. There would be a heavy emphasis on Primary Care, Musculoskeletal care, and Behavioral health with performance support aligned to the Army's Holistic Health and Fitness (H2F) plan. In addition to these unit-associated medical services, there would be a need for 24/7 UCC
  - Leadership feels that moving family member care into the network may cause readiness issues because it will create time away from training/jobs to help support family member care
- Network:
  - Fort Lee has ambulance services at two fire department locations because leadership believes community response times would not meet response times required in DODI 6055.06 Table E3.T1.

AHC Kenner funds ambulance services which are under the direction of Fort Lee's Department of Emergency Services

- Leadership feels the capacity exists in Richmond, but that takes half a day whereas delivering the same care at AHC Kenner can be done in 1-2 hours. This time difference affects the family members seeking care, as well as the active duty who may need to take time away to support family members
- From the MTF leadership perspective, there is not enough visibility on the quality of network care. When family members and retirees are getting care on base, it is easy to know that they are receiving quality, timely care. While TRICARE and Humana may be evaluating these metrics for the network physicians, the data is not clear to the MTF leadership. There is concern that this may create the same conditions as family housing privatization 15 years ago that led to the current family housing crisis which involve Soldier and Family Member dissatisfaction and frustration while leadership was unaware because the feedback mechanisms weren't in place to share these dissatisfactions. MTF leadership are concerned that they won't know if patients are receiving quality care if they do not have an opportunity to see the patients themselves

- Additional Concerns with Movement to AD Only:
  - In response to the assertion that retiree care should be transitioned to the network and resources realigned to active duty care to meet readiness needs, AHC Kenner reports that 2 providers are needed for the trainee PHA mission. Taking 2 provider FTEs from retiree care would result in 2600 retirees moving to the network and a $1.3 million reduction in capitation. Subsequently these 2 providers would only generate $950,000 in revenue by completing PHAs full time. There are also concerns with an enterprise outsourcing model or shared resourcing model because of previous experience with limited reduction in administrative burden at the MTF (facilities, coding, IMD). Care at AHC Kenner is accredited by the Joint Commission. Primary care in the network generally does not have this assurance of quality and safety provided by independent accreditation
  - As mentioned above, there are concerns with the visibility and oversight of quality care when it is being delivered by network providers. Additionally, there are a number of logistical concerns with families as they PCS being able to transfer their medical records from one network provider to another. This may be especially burdensome for EFMP families who are already having issues with specialty referrals and CLRs
  - Leadership noted that general health of the family member population may be at risk. Moving Primary Care out into the network may result in people seeking care later in illness (i.e. A1C compliance declined when renovations on laboratory facilities started)
  - The need for a robust customer service/network transition cell was identified in order to provide retirees and family members with face-to-face support to ensure a smooth transition to network care and ongoing oversight of network care meeting their needs

Summary of Base Leadership Discussion

List of Attendees

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

Name	Title	Affiliation
MG Rodney Fogg	Commanding General U.S. Army CASCOM and Fort Lee, Virginia	Base
SGM Joanne Rollocks		Base
LTC Nichelle Johnson		Base
Dr. Mark Hamilton	Program Analyst, Office of the Assistant Secretary of Defense (Health Affairs)	703 Workgroup
COL Gary Hughes	Optometry Consultant and Program Manager Office of the Surgeon General	703 Workgroup
Mr. Ricky Allen	Business Operations Specialist, TRICARE Health Plan	703 Workgroup
Mr. Nate Leech	Deloitte Support	703 Workgroup

Summary of Fort Lee Leadership Discussion

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

Voice of the Customer Summary:

- Readiness Factors:
  - Sustainment is responsible for 35% of the training load across TRADOC and most of that comes through Ft. Lee. Time in the classroom is the most important part of the training-mission space. Classroom time needs to be a priority, and the medical capabilities that would support this would be special hours. Having providers available from 9-5 does not support the training mission because that is when classroom sessions are scheduled. To support readiness and safeguard Program of Instruction (POI) time, they need healthcare to be available in the early morning, evenings and on weekends
  - Instructors are often retiree contractors who expect to receive care on base. This has become an unintentional benefit of becoming an instructor and if the policy changes so that retirees and family members have to go to the network for care, the second-order effect may make the instructor position less desirable
  - There are medical services that are important to the mission especially the ortho clinic. Trainees often come from basic training with injuries that they need Physical Therapy to help them manage while at Ft. Lee
- Network:
  - Leadership want to be sure that the transition includes proper oversight of the network to ensure they are optimizing the existing commercial network and that the actual network availability and quality of care match the expectations
  - Leadership recognize that the network has strengths because they are already sending specialty care to the network. The want to be sure Retirees and Family Members receive quality care, even if that is not MTF care
  - Concerns include the transfer of medical records both between Army and DHA as that transition continues, and between the network and the MTF. The military is a transient system as AD and their family members PCS
- Culture:
  - The retiree population are an engrained part of the culture at Ft. Lee. Any changes in the environment will change the culture and could be detrimental if not rolled out properly**.** AHC Kenner enrollment includes approximately 8,500 retirees and 7,000 family members. This culture drives desire to work on the base, and provides high demand for good retiree instructors