OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 08 2010

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is submitted in response to Section 721 (e)(1) of the National Defense Authorization Act for Fiscal Year 2010, which requires a report on actions taken to enhance the capability of the Military Health System (MHS) and improve the TRICARE program. The report describes progress made and future plans for improvement of Military health care. The information reveals areas of excellence, as well as opportunities for improvement.

We are dedicated to improving the health care provided to all Department of Defense beneficiaries, in the United States and abroad. Thank you for your continued support of the MHS.

Sincerely,

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 08 2010

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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The Honorable Lindsey O. Graham
Ranking Member

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 08 2010

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 08 2010

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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The Honorable Joe Wilson
Ranking Member

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HEALTH AFFAIRS

JUL 08 2010

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

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The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

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Ranking Member

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HEALTH AFFAIRS

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

JUL 08 2010

HEALTH AFFAIRS

The Honorable Norm Dicks
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

Report to Congress

Study and Plan to Improve Military Health Care

Table of Contents

Background

Section 721of the National Defense Authorization Act for Fiscal Year 2010 directs that the Secretary of Defense, in consultation with the other administering Secretaries, undertake actions to enhance the capability of the Military Health System (MHS) and improve the TRICARE program. This report annotates actions considered by the Secretary and progress made in the undertaking of such actions to enhance the capability of the MHS and improve the TRICARE program.

Actions to Guarantee Care within Established Standards

We were asked to consider actions to guarantee the availability of care within established access standards for eligible beneficiaries based on a study of the ten most common medical conditions for which active duty family members (ADFMs) seek care. We were also asked to consider the availability and access in both the direct care and purchased care system of providers to treat these medical conditions.[1]

For a more thorough review, we analyzed the number of visits by place of service for the 14 most common conditions in Fiscal Year 2009 (FY09) for both military treatment facility (MTF) and civilian TRICARE Prime enrollees as well as ADFMs not enrolled in TRICARE Prime. The findings are at attachment 1 (tables 1-3).

For each of the three beneficiary groups, we examined the number of visits in each of the following six settings:

- MTF Emergency Room
- MTF "Other" (non-emergency room)
- Civilian Emergency Room
- Civilian physician office
- Civilian Hospital Outpatient Department (HOPD)
- Civilian "Other"

Findings

In FY09, approximately 53 percent of ADFMs were MTF Prime enrollees, 28 percent were civilian Prime enrollees, and 19 percent were non-enrolled. Most of the top 14 conditions can be considered acute. For these top 14 conditions, we found that MTF enrollees had a total of 2.3 million visits, civilian enrollees had 1.2 million visits and non-enrollees had 0.6 million visits. As a percentage of the total number of ADFM visits for

[1] 32 Code of Federal Regulations, Section 199.17(p) (5). The standards include a beneficiary being seen by a health care provider for an acute issue within 24 hours, for routine care within 7 days, and for specialty and wellness care within 28 days

these 14 conditions, the MTF enrollees had 56 percent of the visits, the civilian enrollees had 29 percent of the visits, and the non-enrolled ADFMs had 15 percent of the visits. Thus, the percentage of total visits was slightly higher for the enrolled populations and lower for the non-enrolled beneficiaries. We expect this relationship because some of the non-enrolled ADFMs are not users of the MHS.

We also found that there were different sources of care by type of beneficiary. For example, Table 1 shows that for otitis media (PDX 382), MTF Prime enrollees received 76 percent of their care from the MTF (12 percent from the MTF emergency room (ER) and 64 percent from other parts of the MTF). For this same condition, civilian Prime enrollees received only three percent of their care from the MTF and 97 percent from civilian sources. Non-Prime enrollees received about five percent of their visits at the MTF and 95 percent from purchased care (see Table 3). For some other conditions, a lower percentage of care is delivered at the MTF. For example, for MTF Prime enrollees with acute bronchitis (PDX 466), 62 percent of the MTF Prime enrollee visits were received at the MTF and 38 percent from purchased care. For civilian Prime and non-Prime enrollees, about two to five percent of the visits were received at the MTF for this condition.

For some of these 14 conditions, most of the care is provided by civilian providers. For example, for adjustment reaction (PDX 309, a mental health condition which includes Post-Traumatic Stress Disorder (PTSD)), about 80 percent of the care for MTF-enrolled ADFMs was provided by civilian providers. Similarly, for disorders of refraction (PDX 367, eye care), about 80 percent of the visits for MTF Prime enrollees were provided in the purchased care sector. On the other hand, only 16 percent of the care for normal pregnancy (PDX V22) for MTF Prime enrollees was provided in purchased care.

The access standard for acute care is being seen within 24 hours. Our access metrics do not measure items in the same manner for Prime and non-Prime patients, so our proxy has been to evaluate access by measuring the level of emergency room use for treatment of these conditions.

We examined the degree to which the three different types of ADFMs used emergency rooms for these 14 conditions. ADFM MTF enrollees received about seven percent of their visits from emergency rooms while civilian Prime enrollees received four percent of their care from emergency rooms and non-enrolled beneficiaries received five percent of their care from emergency rooms.

The importance of enrollment to and establishing a relationship with a Primary Care Manager ("Primary Care Manager by Name" or PCM BN) has been targeted as an important Military Health System goal since TRICARE's inception. The Medical Home model for providing primary care further develops this concept. The Medical Home is a

patient-centered, comprehensive and holistic model which focuses on such principles as team-based health care, population health, improved access and patient involvement with targeted outcomes in satisfaction, quality and efficiency/cost. Medical Homes could potentially save money as better primary care substitutes for lower utilization of avoidable inpatient and emergency services and other services resulting from poor care coordination. The Army, Navy, and Air Force have embraced the Medical Home approach in many of their MTFs. In September 2009, Assistant Secretary of Defense (HA), signed a policy memorandum instructing the Services to implement the Medical Home model MHS-wide.

The Medical Home includes seven core principles:

- Personal Primary Care Provider
- Primary Care Provider Directed Medical Practice (PCM is team leader)
- Whole Person Orientation (respectful, patient centered not disease or provider centered)
- Care is Coordinated and/or Integrated (across all levels of care)
- Quality and Safety (evidence-based, safe medical care)
- Enhanced Access (meet access standards from the patient perspective)
- Payment Reform (incentivize the development and maintenance of the medical home)

Overall, for ADFM Prime beneficiaries enrolled in either the direct care or the purchased care system, in regard to the 14 most common conditions, the MTF is providing the care roughly 75 percent of the time. Through the Medical Home model, we expect the level of care provided in MTFs for MTF enrollees to rise in FY 2010.

Alternatives

We are also exploring how to better provide access for these acute conditions. Some of our health care support contractors are developing networks of convenience, urgent, or "minute" clinics to enhance access. Our regulations allow the use of a health care finder for after-hours and out-of-area care, thus we are looking to leverage this authority with the new network urgent care clinics to provide better access for these acute conditions.

Sharing of Health Care Resources among Federal Health Care Programs

We were asked to consider actions to expand and enhance sharing of health care resources among Federal health care programs, including designated providers (as that term is defined in section 721(5) of the National Defense Authorization Act for Fiscal Year 1997 (Public Law 104-201; 110 Stat. 2593; 10 U.S.C. 1073 note)).

The Department of Defense (DoD) and Department of Veterans Affairs (VA) have a highly developed partnership under the oversight of the joint Health Executive Council (HEC). The HEC mandates resource sharing to promote cost effective use of Federal health care resources, improve access, and maintain high levels of clinical capability. Each year, the Departments submit a joint Report to Congress on the activities and accomplishments of DoD/VA health care resource sharing over the past fiscal year (FY), as mandated by Title 38, § 8111, Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources. The FY09 Annual Report to Congress captures several key joint programs which are symbolic of the nature of the current activities.

Mental Health/Traumatic Brain Injury

One of the main focuses to expand and enhance health care resource sharing between DoD and VA is the prevention, identification, treatment, recovery, and reintegration for Service members and veterans who are at risk for, or are experiencing mental health (MH) conditions or Traumatic Brain Injury (TBI). Both DoD and VA have significantly increased MH staffing levels in their respective facilities. While each Department has separate processes for measuring access to care standards for MH specialty visits, meeting its standards is a high priority for both Departments. In FY 2009, DoD met 90 percent of its standards and VA met 95 percent of its standards. In November, 2007, the Defense Centers of Excellence (DCoE) for Psychological Health (PH) and TBI was stood up to help meet current wartime challenges, and includes an embedded VA mental health leader. In October, 2009, the Departments held a joint conference on mental health issues critical in providing Service members, veterans and their families the best coordinated care and resources possible. The Departments will be implementing a number of recommendations that resulted from the conference in 2010.

On October 1, 2009, the National Center for Health Statistics (NCHS) released the first phase of a series of improvements to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, an initiative championed by DoD and VA. These improvements allow health care practitioners to identify more accurately the TBI conditions of Service members, and further assist in the collection of data on those who have been diagnosed and treated for this injury. DoD and VA are currently working with NCHS on the second phase of code improvements, including new symptoms codes for cognitive and memory deficits associated with TBI.

The Departments have also collaborated extensively in the area of suicide prevention and risk reduction programming, including cross-participation of key staff in each Department's suicide prevention activities, development of standard operating procedures for collaboration between the DCoE help line and the VA suicide prevention lifeline, and shared participation in the suicide prevention work group of the Federal partnership on MH.

Foundational DoD/VA Health Data Sharing Initiatives

DoD and VA continue their strong partnership in interagency health data sharing activities, delivering Health Information Technology solutions that significantly improve the secure sharing of appropriate electronic health information. In the last decade, health data sharing and interoperability activities between the Departments have increased substantially, with the primary benefit being that providers have access to more complete and accurate health records for Service members and veterans.

The first exchange of electronic health care information between the Departments occurred in 2001. Since that time, the Departments have incrementally expanded the type of information that is shared, and improved the manner in which the information is shared. The following initiatives are currently responsible for the majority of health care data that is exchanged between the Departments.

- Data Transferred from DoD to VA at the Point of Separation
- Data Accessible on Shared Patients
- Sharing Computable Data
- Medical Image Sharing
- NDAA FY 2008, Section 1635, Interoperability Milestone
- Virtual Lifetime Electronic Record (VLER)

Joint DoD/VA Facilities and Markets

The Joint Market Opportunities (JMO) Work Group, under the auspices of the HEC Joint Facility Utilization and Resource Sharing Work Group, continues to identify opportunities for improving the delivery of health care through existing joint venture relationships and other market-based partnerships. In Phase I, the Work Group focused on improving the efficiency and relationships at eight VA/DoD joint venture sites: Albuquerque, NM; Anchorage, AK; El Paso, TX; Fairfield, CA; Honolulu, HI; Key West, FL; Las Vegas, NV; and North Chicago, IL; while working with Biloxi, MS; and Denver, CO; to develop a concept of operations leading to joint venture status.

Phase II focused on establishing or improving a collaborative relationship at sites with funded construction projects and/or market areas with increased political interest in federal resource sharing, utilizing lessons learned from the Phase I joint venture sites. In Phase III, the Work Group is looking to further the VA/DoD health care resource sharing relationship by focusing on sites with close proximity and high purchased care activity. The benefits that have been and can be realized from a joint venture relationship include increasing access to care, reducing infrastructure, improving efficiency, strengthening provider practices and quality, and mitigating the impact of deployment. These benefits

are sufficient to export these joint venture arrangements to other sites and multi-market areas.

The North Chicago Veterans Affairs Medical Center and the Naval Health Clinic Great Lakes will merge into one Federal Health Care Center (FHCC) on October 1, 2010, serving both DoD and VA populations. It will be the first integrated facility of its kind, encompassing all medical and dental care in Great Lakes and North Chicago. The FHCC will have an integrated single chain of command with a merged budget including both DoD and VA missions with VA as the lead partner. This will result in the FHCC being the only VA-associated system in the country with an Operational Readiness mission in support of wartime requirements and the pipeline to the Fleet. The Executive Agreement that will serve as the formal agreement between the Departments regarding the standup and operation of the FHCC was signed on April 23, 2010.

Medical Technology to Speed and Simplify Referrals

We were asked to consider actions using medical technology to speed and simplify referrals for specialty care. The health care industry has long been aware and made use of electronic data transactions for administering referrals from an organization's internal care system and out into the purchased care networks. This practice enables the controlling organization (i.e., the one that serves as the patient's primary care manager) to make best use of its internal resources in the overall care provided to the patient.

In the next generation of TRICARE contracts, the MHS will use the Air Force's Integrated Clinical Database on an interim basis to streamline referral processing operations using the Referral Management System (RMS). RMS is a software application that supports an electronic fax capability from all CONUS, Alaska, and Hawaii MTFs to the three MCSCs for all MTF referrals to MCSC "Defer to Network" referrals and all incoming Right of First Refusal (ROFR) determinations. It creates a referral request document with information from CHCS/AHLTA of sufficient clinical, administrative, and authorization information to allow a consulting provider to appropriately evaluate the patient, contact the referring provider, and complete the appropriate claims/billing paperwork. In order to use the RMS capability, the MTF must use the CHCS/AHLTA Consult Order functionality to input and review consult orders and ROFR requests. RMS also supports the capability to override the default MCSC fax numbers and fax consults to Network providers or other POCs as required. A companion software application, Referral Management System Tracking and Reports (RMSTR) allows tracking and accounting for referrals and referral results.

In the long-term, the MHS plans to develop the Enterprise-wide Referral and Authorization Management application using lessons learned from prior work on the Enterprise-wide Referral and Authorization Systems. The goal is to simplify, integrate

and standardize the referral and authorizations functions to better support MHS operations.

Plan to Improve Regional or National Staffing Capabilities

A number of initiatives are ongoing or being implemented to address staff shortages at military medical treatment facilities. The MHS Human Capital Office (HCO) was created in the summer of 2008 with the primary objective being to focus on helping DoD attract and retain an increased number of health care professionals needed to care for its wounded warriors. Additionally, the HCO was established to create and implement adaptable human capital solutions to address changes in mission requirements, healthcare delivery trends, and emerging healthcare needs. The Chief Human Capital Officer (CHCO) serves as an advocate for the Services and serves as the coordinator and facilitator of all current and future military and civilian personnel initiatives necessary to support a recognized case for change in the MHS. As a policy office, the CHCO works with the Services to initiate human capital policy and proposed legislation where needed.

The HCO supports and implements the goals and objectives in the Human Capital Strategic plan. This plan was developed to identify long-term human capital goals and objectives to include; reducing competition for the same limited hiring resources, benefiting from shared best medical recruitment practices, and providing a coordinated effort to address human capital issues across all Services. Working towards these objectives has resulted in improved staffing capabilities DoD-wide. However, there is still a need for more aggressive recruitment strategies to meet the future demand for DoD mental healthcare practitioners.

Although medical recruitment is a challenge across DoD, the Department is using a variety of recruitment and compensation approaches to meet this challenge as aggressively as possible. Innovative recruitment approaches continue to be developed and leveraged enterprise-wide to further enable recruitment of the numbers and quality of candidates needed. The Department extensively utilizes recruitment incentives as a means of attracting civilians to its healthcare occupations, to include recruitment, retention, and relocation incentives, as well as student loan repayments. Additionally, medical workforce planning efforts throughout DoD have streamlined the hiring process of health care providers. Available appointing flexibilities, as well as compensation incentives are also being utilized. As a result, DoD has been able to increase recruitment and hiring of many of its healthcare positions.

Military Staffing:

We currently have sufficient authority for incentives to deal with retention and recruitment of our military health professionals. While the active-duty numbers remain relatively flat, and in total, close to our authorizations, we are short in some specific specialties. We expect the recently implemented Consolidation of Special Pay (CSP), 37 US code §335, to have a significant effect on retention and recruitment. The new consolidated authority specific to Health Professions officers provides flexibility for the Department to address Health Provider manning and retention issues that could not previously be addressed under the legacy authorities

Civilian Staffing:

Several initiatives have been launched which provide additional tools to aid in recruiting and retention efforts to meet staffing shortages and to ensure the MHS remains competitive in recruiting from the civilian labor market.

As a method of succession planning, and to answer the DEPSECDEF's challenge to "grow our own", legislation has been proposed for development of a scholarship program, with a focus initially on mental health professionals. This legislation is entitled Health Professions Financial Assistance Program for Civilians, and is designed to provide tuition for graduate education in a medical profession in exchange for a period of service. This program would provide a direct link to civilian succession planning for our civilian workforce by recruiting young talent, paying for their education in exchange for commitment to serve in areas where there are DoD beneficiaries, and develop loyalty to DoD as they "grow" in our workforce. This authority would be available as a tool for the Services to use as needed.

Many partnering efforts are ongoing to facilitate recruitment efforts. As a result of a Memorandum of Agreement signed in 2008 between ASD (HA) and the Assistant Secretary for Health (DHHS), the Public Health Service has committed to detailing 200 behavioral health providers to MTFs to backfill deploying military mental health providers. Full funding for the detailing of these officers to the Services is provided centrally by ASD (HA).

Additionally, as a result of the Senior Oversight Committee for the Wounded Ill and Injured, and as directed by Congress, VHA and DoD have committed to working together to implement strategies to attract, hire and retain qualified medical health

professionals. Joint efforts include visiting joint DoD/VA locations to capture successful recruitment initiatives and best practices; develop communication/outreach strategies, participate in joint job fairs, etc. The Army Medical Department (AMEDD) DoD/VA Healthcare Resources Sharing Program identifies and facilitates enhanced collaborative partnerships with the VA which has led to mutually beneficial coordination, use, and exchange of healthcare resources, thereby improving quality, efficiency, and effectiveness of healthcare delivery operations.

A key part of improving staffing capabilities is knowledge of the staffing "requirements." Mental health has been a medical area of considerable concern for the past four years. The Office of the Deputy Assistant Secretary of Defense (DASD) for Clinical & Program Policy has spearheaded an initiative to develop a tri-Service staffing model for mental health staffing. This model, Psychological Health Risk-Adjusted Model for Staffing (PHRAMS), represents the culmination of a collaborative manpower requirements effort which started in May 2006. The ASD/HA asked the Center for Naval Analysis (CNA) to develop a user application version of the model designed for use by medical department personnel within the Army, Air Force, and Navy, and by staff within the ASD/HA and TMA as a flexible planning tool. The PHRAMS application can be used by the Services for program planning and projection and ASD/HA is looking forward to feedback on PHRAMS as it is field tested. Future work on PHRAMS will look to refine the model by incorporating Service feedback into future versions.

The HCO has a dedicated recruiter who works cooperatively with recruiters and other representatives from each of the Services, as well as with the Public Health Service and the Veterans Administration, and provides nationwide recruiting support. Recruitment efforts include participation in joint job affairs as well as exchanging of recruiting tools and best practices. There is also commitment from the MHS HCO and the Components to develop partnerships with a number of colleges and universities and other professional organizations to market DoD's medical occupations, as well as to fully engage in automated processes in the form of websites, blogs, etc. specific to the healthcare community. Focused recruiting and marketing has enhanced the ability to attract applicants.

Appointing Authorities:

Congress has provided many authorities to assist in DoD healthcare recruitment efforts and improve market competitiveness. The components utilize a variety of existing incentives to recruit at the entry level, to include SCEP and STEP, intern programs, targeted recruiting and direct and expedited hiring authorities. The Expedited Hiring Authority (EHA) and Direct Hiring Authority (DHA), assist with the hiring difficulties in

order to enable the Department and the Services to recruit and retain critical shortage mental health providers. Both EHA and DHA are tools being utilized to shorten the hiring process.

The DHA has been provided in several past DoD Appropriations Acts for critical shortage skill medical positions. The DHA has been and continues to be used extensively by all the Military Departments. It provides the ability to extend an "on the spot" tentative job offers thereby enabling us to hire quickly, putting more professionals in our MTFs and deployment locations. Through this authority, DoD has been able to compete more readily with its private sector counterparts and more expeditiously hire the critical care givers it so urgently needs. The current direct hire authority expires annually and must be re-delegated every year. An expansion of direct hire authority for additional healthcare occupations is being sought, as well as making the authority permanent.

The EHA was granted under NDAA FY09 and can be used to identify any category of medical or health professional occupations within the DoD as shortage category positions. The EHA authorizes the appointment of "highly" qualified individuals to these designated positions. Under current regulations, appointments under this authority may not be made after September 30, 2012.

Compensation Authorities:

The Department has instituted a number of compensation flexibilities to facilitate recruitment and retention of health care practitioners. Many special salary rates (SSR's) have been established for DoD healthcare occupations at various locations, and where feasible match the VA rates. The Department has established more than 100 special salary rates for healthcare occupations.

The Department projects implementation of a new compensation system for physicians and dentists in the near future. Policy for the new hybrid title 38 pay system has been formally coordinated and salary surveys have been purchased and analyzed and are ready for use in making local pay decisions. This authority will provide the pay comparability needed to recruit and retain civilian physicians and dentists in DoD.

On May 27, 2010, the Director of the NSPS Transition Office published a final decision memo on the healthcare positions that are exempt from conversion during the NSPS Transition. Physicians, dentists, therapists and most health care technicians will not convert to the General Schedule on September 26 during TMA's NSPS Transition.

The Department remains committed to improving staffing capabilities across the medical specialties and shares Congress's concern for a quality medical force by providing the necessary recruiting and retention tools.

Plan to Improve Access to Health Care for Reservists

We were asked to improve health care access for members of the Reserve components and their families, including such access with respect to mental health care and consideration of access issues for members and their families located in rural areas. The Department has taken many steps to improve access to health care for all eligible beneficiaries in rural areas. While many of the Reserve component (RC)[2] members and their families live in rural areas, our approach is to improve or enhance access to care for all eligible MHS beneficiaries living in rural areas.

RC members and family members are eligible for military health care benefits through a variety of TRICARE plans. While the RC member is on active duty, they and their family members receive all AD/ADFM benefits. After demobilization, they get TAMP which allows them to enroll in Prime or use the Standard/Extra coverage for 180 days. Additionally, when not mobilized the RC members and their families are eligible to purchase a standard like benefit under the TRICARE Reserve Select (TRS) program. TRS gives them the ability to choose their providers and to get the benefit of reduced cost-shares if they choose a network provider. See Table 1 for a list of TRICARE plans that are available to RC members and family members.

Table 1 – TRICARE Plans Available to Reserve Components

TRICARE Plan available to RC (on active duty)
TRICARE Prime
TRICARE Prime Remote
TRICARE Prime Remote for Active Duty Family Members
Uniformed Services Family Health Plan
TRICARE Standard
TRICARE Extra
TRICARE Plan available to RC (demobilized)
Transitional Assistance Management Program
TRICARE Reserve Select

[2] Members of the Air National Guard, Air Force Reserve, Army National Guard, Army Reserve, Coast Guard Reserve, Marine Corps Reserve, and Navy Reserve

Enrolled Beneficiaries

Depending on health plan eligibility standards, geography, and personal choice, RC members on active duty and their families can elect to enroll with a network provider. As enrolled beneficiaries, care must be rendered within the access to care standards established by regulation. The managed care support contractors (MCSCs) are required to report any instance when an enrolled beneficiary is not being provided care within the standards.

Non-Enrolled Beneficiaries

Non-enrolled beneficiaries have the greatest degree of flexibility to seek any TRICARE-authorized provider. Unlike those beneficiaries enrolled to a network provider, non-enrolled beneficiaries do not have a statutorily defined access to care (ATC) standard that must be met. Rather, for non-enrolled beneficiaries, the goal is to provide health care as close to the beneficiary's home as possible, and in a timely manner. Through online provider directories, toll-free lines, and, if nearby, TRICARE Service Centers, the MCSCs assist non-enrolled beneficiaries in locating a TRICARE-authorized provider to meet their health care needs in a timely manner.

ATC Improvements in Rural Areas

DoD has taken specific actions to improve health care access for all eligible beneficiaries, including RC members and family members, and, in particular, for those who live in rural areas.

The TRICARE Management Activity (TMA) conducts both provider and beneficiary satisfaction surveys that include questions about access to care. Some of these surveys are directed by Congress. TMA conducted a Congressionally directed three-year provider survey of TRICARE Standard providers [3], concluding that 80 percent of civilian physicians accepted TRICARE Standard if they accept any new patients at all. This indicated a high understanding of the TRICARE program as well as high acceptance of new TRICARE patients, with the exception of psychiatrists.

In 2008, TMA started another round of surveys to assess ATC, among other things.[4] The four-year round of provider surveys included non-physician behavioral health providers as well. Most ratings of access and satisfaction were similar between TRICARE Standard beneficiaries living in Prime Service Areas (PSAs), where there are provider networks typically providing a full range of health care services, and TRICARE

[3] National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2004, Section 723, and NDAA for FY 2006, Section 711.

[4] NDAA for FY2008, Section 711

Standard beneficiaries living in Prime non-PSAs where there are few network providers and sometimes scarce TRICARE-authorized providers. In fact, access to care was statistically better in non-PSAs than in PSAs. Overall, we found that 69 percent of civilian providers who accepted new patients would accept new TRICARE patients.

Survey results are analyzed by TMA and the three TRICARE Regional Offices (TROs) that oversee the delivery of health care in the United States. The TROs, working in conjunction with their MCSC partners, identify areas for improvement and to determine whether or not there are available providers in the local area that can be asked to become TRICARE-authorized. In some cases, there may not be any providers in that town, or the nearest providers could be miles away. However, we recognize that there may be areas where access to health care is inadequate and, when we encounter them, we work to provide or arrange for this needed care.

Each TRO has an assigned TRICARE Standard Manager to oversee the TRICARE Standard program in each region and to ensure their contractor provides assistance to beneficiaries, including RC families, to find TRICARE-authorized providers in their local area.

Since there are typically no networks in many rural areas of the country, beneficiaries are often the provider's first contact with TRICARE if the provider is not already associated with TRICARE as a network or TRICARE-authorized provider. We developed a simple tear-out page describing to the provider how they might become a network or non-network provider. Beneficiaries should find it easier to inform providers about TRICARE and how to sign up to be a TRICARE-authorized provider. This tear-out page, initially placed in the TRICARE Reserve Select handbook, will be placed in all TRICARE beneficiary handbooks during 2010.

We have streamlined the processes by which a provider can become either a TRICARE network provider or become authorized as a TRICARE provider. Most providers can simply submit an industry standard health care claim to start the process, or can find information and forms on each of the managed care support contractor's websites.

The TROs and their contractor partners perform outreach services to RC units, members, and families. They support the DoD Yellow Ribbon Reintegration Program, which is a DoD-directed program to deliver benefit information to soldiers of the Army Reserve and their families through all phases of the deployment cycle. At these events, they provide TRICARE information to the RC members and their families and assist them with any issues regarding their health care benefits through pre-deployment, during deployment, and post-deployment. They also provide information about availability of providers and how RC members and their families can find a provider in their local area.

If access to specific health care services is severely impaired in a rural area, DoD uses its locality waiver authority to raise payments to providers for all similar services performed in that area. Payment rates can be established through addition of a percentage factor to an otherwise-applicable payment amount, or by calculating a prevailing charge, or by using another Government payment rate. Higher payments will be paid on a claim-by-claim basis.

Access to Mental Health Care

The Department has taken many steps to ensure that access to mental health providers is adequate. It has added 1,952 new mental health providers to the direct care system from May, 2007, to May, 2009, and added 10,220 additional mental health providers to the TRICARE civilian network during the same time frame. We recognize that there may be areas where access to mental health care is inadequate and, when we encounter them, we work to provide the needed care.

In addition to strengthening the TRICARE network with mental health care providers, the Department has fielded two new mental health initiatives. The first is offering the TRICARE Assistance Program which provides video chat-based short-term professional counseling, similar to employee assistance counseling, 24 hours a day, seven days a week. It provides unlimited access for ADSMs, their families, those enrolled in TRICARE Reserve Select, and those in the Transitional Assistance Management Program in the continental United States. It is a demonstration project and outcomes and satisfaction levels will help determine if it will become a permanent benefit.

The Department has also established a network of telemedicine mental health care for all beneficiaries by requiring the MCSCs to establish civilian "originating sites" where beneficiaries go to obtain care and a network of distant providers who provide telemedical mental health care. The requirement is for one civilian originating site in each Prime Service Area (PSA) since that is where the majority of ADSMs and their families live and work. In addition, we are requiring one originating site per region to be developed where there are significant numbers of TRICARE Prime Remote and/or TRICARE Reserve Select enrollees.

Future Plans to Improve Access to Care

While we are proud of our efforts so far to enhance access to care for RC members and their families, we are continuing to develop ways to improve access to care for beneficiaries in rural areas.

Our future plans include the development of an analytical model that determines where TRICARE Standard beneficiaries live in rural areas and where health care has been provided in that area in the past. The process should identify whether there is potential scarcity of health care providers in that area. The TROs and their MCSC partners will then follow up in those targeted areas to see if there are opportunities to recruit additional TRICARE-authorized providers.

TRICARE beneficiaries are often savvy Internet users. While the MCSC websites have look-up capability to find a network provider, there is no automated tool to look up TRICARE-authorized providers. The tool will be modeled after the Medicare provider look-up tool. A link to the TRICARE website will be added to the Medicare website, as most Medicare providers accept TRICARE patients.

There have been a few complaints lodged with the MCSCs about access to care. However, at this time, the Health Care Finder reports coming from the MCSCs do not contain sufficient detail to determine the type of beneficiary category. We plan to modify the new TRICARE managed care support contracts to provide this level of detail, so we can determine if Standard beneficiaries are registering complaints.

We will continue to survey both providers and beneficiaries to assess access to care and patient satisfaction issues. We will use the results to identify geographical areas that may not have sufficient numbers of TRICARE-authorized providers to satisfy the demand for health care in a particular area.

If access to care is severely impaired and additional providers cannot be persuaded to accept the prevailing TRICARE reimbursement rates, the Department will continue to evaluate the area for special locality based reimbursement rates.

Actions to Ensure Access to Care Standards

We were asked to consider actions to ensure consistency throughout the TRICARE program to comply with access standards which are applicable to both the commanders of military treatment facilities and our managed care support contractors.

Access to care standards have been in place since the beginning of TRICARE in 1995, and the standards have always applied to both the direct care and purchased care systems. Throughout these past 15 years of TRICARE operations, numerous policies have consistently sent this message. This year, to highlight further our access to care standards, we have consolidated eight access to care policy memorandums and are reissuing this consolidated memorandum to the Services for their further dissemination to the field.

In addition, each Service reviews their access to care metrics on a periodic basis. Service-specific oversight is included in attachment 2.

New Budgeting and Resource Allocation Methodologies for MTFs

We were asked to consider actions to create new budgeting and resource allocation methodologies to support and incentivize care provided by military treatment facilities. The Military Health System currently utilizes a Prospective Payment System (PPS) for adjusting funding levels for patient care workload on a fee-for-service (FFS) basis. Medicare pre-defined resource intensity rates for discrete inpatient and outpatient services, with adjustments for outliers, serve as the foundation for the calculation. These resource intensity values are multiplied against a MHS-set financial amount per unit of resource to determine the funding adjustments for services (a fee paid for each service unit). Thus, as the volume of services increases, so does the funding provided to resource such care. Workload is projected for each fiscal year based on past performance and calculated population changes. One-time payments and funds for special programs are included. The amount is calculated to the MTF level, rolled up to the Service level, and provided directly to the Service medical headquarters. The Services calculate the money to allocate to their operational elements based on their own specific funding methodologies.

Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. Thus, the incentives for efficiencies in providing such care or outcomes of that care are not included. To begin addressing outcomes of care, in 2008, Health Affairs provided additional funds to the Services based on achievement of targets for specific quality indicators including patient outcomes, satisfaction, and access.

Each Service funds their MTFs by evaluating the previous year's financial execution, operational performance, and projected operational changes. The Army and Navy provide additional funds based on clinical and administrative outcomes as described below.

Throughout the year, the Army makes funding adjustments based on operational performance and quality outcomes through the Performance Based Adjustment Model (PBAM), which is the U.S. Army Medical Command's enabling tool that links resources to strategically focused objectives. PBAM calculates a value of an MTF's health care output (workload) and adjusts funding with changes in that value. It also provides financial incentives (positive and negative budget adjustments) for improvements in key performance areas including provider efficiency, inpatient length of stay, patient satisfaction, compliance with Healthcare Effectiveness Data and Information Set (HEDIS) quality standards, and timeliness and accuracy of administrative functions in

support of patient care. The funding for these incentives comes from their base funding. Use of PBAM has contributed to continuous growth in output and quality.

The Navy utilizes Performance Based Budgeting (PBB) to adjust/reallocate funds during the execution year based on workload, but additionally provides incentives to obtain specific clinical and administrative program outcomes. The targeted outcomes are associated with evidence-based health care, individual medical readiness, and public health and management processes associated with obstetrics. The funds available for PBB are identified as a withhold in each of their Region's annual planning figures. PBB then gives the Regions an opportunity to earn the money based on their performance. Each measure in PBB is given a weight based on leadership's decisions about relative importance.

The Air Force provides funds to their MTFs based on what was programmed during the Planning Programming and Budgeting process to build the Program Objective Memorandum (POM). Current year execution is adjusted for the factors reflected above, such as population and mission changes.

Studies are currently underway to investigate alternate funding mechanisms which incentivize efficiency and quality; provide increased capability for innovation based on local patient needs; and take a patient-centered, comprehensive and holistic approach to patient care. These include capitated or hybrid payments for primary care and prevention as well as bundled, episodic and carve-out payments (a single, comprehensive payment for a group of related services) for specific conditions. Standards of performance in areas focusing on clinical processes of care and health outcomes, patient experience with receiving care, access, and resource use (efficiency) are key elements to these approaches. Incentives for having attained relative or absolute performance thresholds, having improved over the prior year's performance, participating in specific initiatives, or participating in some combination thereof would be tied to the funding methodology.

Medicare's Acute Care Episode (ACE) demonstration for acute care episodes which provides a bundled payment for specific cardiac and orthopedic procedures with cost savings shared by the providers and patients is an example of one approach being evaluated by the Department. The PROMETHEUS (Provider payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction, Excellence, Understandability and Sustainability) model is one in which bundled or episodic payments are provided for a specific chronic, acute or inpatient condition. This additionally serves as an excellent example of options the Department is exploring in order to create a new budgeting and resource allocation methodology to fully support and incentivize care provided by MTFs.

The 2010 plan for addressing new budgeting and resource allocation includes developing programs at six sites which target prevention and primary care while

rewarding improvements in areas such as clinical processes and health outcomes, patient satisfaction, and readiness while achieving specific cost projections. Thus, incentives will be provided for total system management as well as individual patient care.

Also during 2010 more advanced models for funding currently being studied will be evaluated further. As appropriate, future years will include piloting, revising and subsequently implementing system-wide such alternative funding mechanisms.

The Medical Home concept could potentially save money as better primary care substitutes for lower utilization of avoidable inpatient and emergency services and other services resulting from poor care coordination.

The Department is evaluating the different operational implementation models of the Services as well as the Medical Homes' outcomes to determine potential future funding mechanisms which would be based not solely on the volume of services but also on the outcome of those services. This would be an additional funding mechanism to support and provide incentives for care provided by the MTFs.

Alternative funding mechanisms to support and incentivize care provided by the MTFs target managing the health of the population while allowing MTF Commanders flexibility to implement care processes most appropriate for their beneficiaries. Aspects of different funding approaches which include FFS for specific conditions, episodic, bundled, carve-out and capitated payments for others, and rewards for clinical processes and outcomes are being evaluated in 2010 with limited pilot sites testing specific aspects of such approaches. Future years include further evaluation, piloting, and, as appropriate, implementation in future years.

Financing Options for Civilian Providers

We were asked to consider actions regarding additional financing options for health care provided by civilian providers.

In considering possible new financing options for care provided by civilian providers, the Department is mindful of two key points. First, TRICARE's payment methods and rates generally follow Medicare's payment methods and rates when this is feasible. Second, TRICARE generally is not a dominant payer in most markets or for most providers.

For both of these reasons, the Department is carefully monitoring Medicare's various demonstrations and other research initiatives related to new financing options to assess which options might be feasible and appropriate for implementation in TRICARE.

Among the new Medicare approaches TRICARE is monitoring are:

- Paying an additional fee to network primary care managers (PCMs) who are willing and able to serve as a "medical home" for their Prime enrollees (based on a specified set of requirements and expectations for a medical home);
- Reducing the DRG payments to hospitals which have a high rate of re-admitted patients (within a specified time from the initial admission, and whether or not the re-admission occurs at the same hospital or a different hospital); and
- The feasibility of converting from fee-for-service to episode-based payments, at least for some conditions and some circumstances (e.g., perhaps in areas that are far from military treatment facilities, to avoid issues raised when the care for a given episode is partially delivered by MTF providers and partially by civilian providers).

Actions to Reduce Administrative Costs

We were asked to consider actions to reduce administrative costs. The Department makes great effort to reduce administrative costs wherever possible. For example, contract consolidation efforts combined two pharmacy contracts into one and combined six overseas contracts into one, both initiatives are estimated to reduce duplicate administrative costs.

Additionally, in the T-3 contracts, we have changed our electronic claims processing requirements from having network providers submit claims electronically to requiring a percentage of all claims to be processed electronically. Another example is our T-3 requirement for the contractors to use TRICARE's suite of educational materials rather than just requiring it for provider educational materials.

Our new overseas contract consolidates the requirements of the previous six individual contracts, thereby streamlining contract administration. However, our ability to process overseas claims that are over one year from the date of service is problematic and requires an individual review and approval for each claim received. We believe the new TRICARE Overseas Program Contractor should eliminate problems for the network provider claims. However, we are considering submitting a proposed amendment to Title 10 U.S. Code § 1106 (b) that currently requires all claims to be submitted no later than one year after the date of service, to eliminate the requirement for overseas out-of-network provider claims. We believe this will speed and ease the overseas claims process. This will require a legislative proposal.

Plan to Control the Cost of Health Care and Pharmaceuticals

We were asked to consider and take actions to control the cost of health care and pharmaceuticals. Actions taken by the Department to control the cost of health care and pharmaceuticals include:

- Ongoing implementation of federal pricing refunds for retail pharmacy prescriptions;
- Implementation of the hospital outpatient prospective payment system (OPPS);
- Reducing the MS-DRG payments to hospitals for patients with hospital-acquired conditions;
- Incorporating incentive payments related to quality of care in the next generation of the Managed Care Support contracts (the "T3" contracts); and
- Reducing MCS contractor risk for issues outside the contractor's control in the T3 contracts, which is expected to result in lower underwriting fees.

In the future, the Department is considering payment reform for sole community hospitals, which currently are paid based on billed charges. In addition, as recommended by multiple studies and commissions (including the Congressionally mandated Task Force on the Future of Military Health Care), the Department continues to believe that an overall update of the TRICARE fee structure is an important element to control the costs of health care and pharmaceuticals. The Department will continue to work with Congress and other stakeholders to develop the way ahead on this important issue.

Audit DEERS to Improve Eligibility Determinations

We were asked to consider actions to audit the Defense Enrollment Eligibility Reporting System (DEERS) to improve system checks on the eligibility of TRICARE beneficiaries. The Defense Manpower Data Center (DMDC) is the agency that operates DEERS. DEERS is the central system responsible for determining and reporting the eligibility of all persons for TRICARE medical benefits.

The TRICARE Management Activity arranges through the DoD Inspector General for an annual audit of the Medicare Eligible Retiree Healthcare Fund (MERHCF) and Contract Resource Management (CRM). The MERHCF/CRM audit team visits the Defense Finance and Accounting Service (DFAS), the Defense Information Systems Agency (DISA), the DoD Office of the Actuary, TMA offices, and the Defense Manpower Data Center (DMDC).

The MERHCF audit looks primarily at retirees. They reconcile the DEERS eligibility to the DFAS retiree file as well as look at the Centers for Medicare and

Medicaid Services (CMS) information to verify Medicare status. The CRM portion of the audit looks at the full population of all TRICARE-eligible beneficiaries, the source of the information and the authentication of the beneficiary's eligibility.

Since this audit covers all eligibles, we believe this audit satisfies the primary requirement for system checks to improve the eligibility of TRICARE beneficiaries. Although the formal report from the latest audit has not been released yet, DMDC did verify with the auditors that no erroneous data was used in the audit.

In the last two years, DMDC created an internal Data Quality Initiative (DQI) with rotating teams of functional and technical experts who review the internal business processes within DMDC for improvement. The DQI reviews trace the date from receipt from the Services, the edit and extract process and the update to DEERS. Working with the DQI teams, the Uniformed Service liaisons at DMDC have helped improve the accuracy and timeliness of the data.

As part of the annual legislative cycle which creates or adjusts benefits programs, DEERS is always coordinating internal quality testing and checks and external quality testing and checks with data partners. These are additional opportunities where processes are refined and improved in addition to the annual audit and DQI reviews.

Since DEERS is the central data base for identity and beneficiary eligibility for TRICARE within DoD, a portion of the customer service process focuses on correcting information the beneficiary states is incorrect. The DMDC has created the "My DoD Benefits Portal" which allows beneficiary access and validates their benefits information. The portal not only displays the beneficiary information, it provides the proper points of contact if the beneficiary needs to correct the information. This ensures the beneficiary receives the proper support to correct or update any information.

All these steps are part of DMDC's holistic approach to improve the processes to collect the data and provide eligibility. We believe the annual audit and internal DQI will provide the Department thorough controls over the audit of beneficiary eligibility provided by DEERS.

Plan to Enhance Availability of Prevention and Wellness Care

We were asked to consider actions, including a comprehensive plan, for the enhanced availability of prevention and wellness care. TRICARE has long been committed to providing all recommended preventive services and wellness care to its beneficiaries. Starting with immunizations, a number of preventive and wellness services have been added to the TRICARE benefit over the years, without eliminating the overarching requirement of having to demonstrate medical necessity in treatment. We now have a TRICARE benefit that generally provides all currently recommended preventive and wellness services at no cost to beneficiaries. Otherwise, TRICARE continues working to identify aspects of preventive care that can enhance health and potentially save money.

PREVENTIVE HEALTH PLAN--CURRENT INITIATIVES

Smoking Cessation

The Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (FY09 NDAA), Public Law 110-417, Section 713, directed the Secretary of Defense to establish a smoking cessation benefit under the TRICARE program, to include cessation counseling and no-cost nicotine replacement therapy. Smoking cessation programs had previously been specifically excluded from the TRICARE benefit, per 32 CFR 199.4(g)(65). The Department is currently engaged in drafting the necessary regulations to allow coverage of over-the-counter nicotine replacement therapy at no cost for smokers, and now provides counseling for smoking cessation as a covered benefit.

Cancer Screening

The Department is currently pursuing final rulemaking to implement section 703 of the FY07 NDAA, Public Law 109–364. The rule will allow coverage for ‘‘breast cancer screening’’ and ‘‘cervical cancer screening’’ for female beneficiaries of the Military Health System, instead of constraining such testing to mammograms and Papanicolaou tests. This rule ensures new breast and cervical cancer screening procedures can be added to the TRICARE benefit as such procedures are proven to be a safe, effective, and nationally accepted medical practice. This amends the cancer-specific recommendations for breast and cervical cancer screenings to be aligned with the processes for updating other cancer screening recommendations.

Section 712 Military Health Risk Management Demonstration

Section 712 of the FY09 NDAA requires the Secretary of Defense to conduct a demonstration project and to develop and offer a wellness assessment to beneficiaries enrolled in the demonstration. The wellness assessment is to incorporate

nationally recognized standards for health and healthy behaviors and is to be used to determine a baseline assessment, and repeated at appropriate intervals as determined by the Secretary. A notice for this required demonstration was posted in the federal register October 1, 2009. The demonstration effective dates are October 1 2009, until February 28, 2012.

The Military Health Risk Management demonstration project is being conducted to evaluate whether monetary incentives in conjunction with wellness programs will encourage healthy behaviors among non-Medicare-eligible retired beneficiaries and their family members who are enrolled in TRICARE Prime and reside in the demonstration project service areas. The duration of the project will be approximately 3 years. There will be a monetary incentive award to enrollees for full participation in this project of an amount equivalent to 50 percent of the annual TRICARE Prime enrollment fee ($230/family or $115/individual). For the purpose of this study, at least one demonstration project service area will encompass a military treatment facility (MTF), and the others will encompass areas supported exclusively by purchased care. The National Naval Medical Center, Medical Homes Program, Bethesda, MD, has been selected as the MTF demonstration project service area; the Designated Provider Programs at Martin's Point, Portland, ME, and CHRISTUS Health, Houston, TX, have been selected as the purchased care demonstration project service areas.

Section 714 Preventive Health Allowance Demonstration

Studies have been performed in health organizations to assess the effectiveness of waiving co-pays for clinical preventive services, as well as financial incentives for healthy behavioral change. No studies to date have assessed the effects of providing financial incentives for increasing compliance with recommended and, in some instances, mandated clinical preventive services in an active duty military population. This demonstration project will be the first such effort among active duty military personnel and their family members. The results of this demonstration will have a direct impact on the future utility of this type of intervention.

Section 714 of the NDAA for FY09 authorizes the Department to conduct a demonstration project designed to evaluate the efficacy of providing an annual allowance to members of the armed forces to increase the use of preventive health services by such members and their dependents. To meet eligibility standards to receive this benefit, the member of the armed forces must be serving on active duty for a period of more than 30 days and meet the medical and dental readiness requirements for their branch of Service. Not more than 1,500 members of each of the Army, Navy, Air Force, and Marine Corps may receive a preventive health services allowance during any year, of which half in each Service shall be members without dependents and half shall be members with dependents. A notice for this required demonstration was posted in the federal register

November 27, 2009. The demonstration effective dates are December1, 2009, until December 31, 2011.

The Preventive Health Allowance demonstration project is being conducted to evaluate whether a preventive health services allowance will increase the utilization of clinical preventive services among active duty personnel and their family members. Clinical Preventive Services, with respect to age and gender-specific recommendations included in this study, are screening for colorectal cancer, breast cancer, cervical cancer, and prostate cancer; an annual physical exam; an annual dental exam; weight and body mass screening; and immunizations. There are approximately 1,500 active duty members enrolled from each Service, with half being single active duty members, and half having family members. The Secretary of the military department concerned is paying the preventive health allowance at the rate of $500 or $1,000 per year for single active duty members or for active duty with family members respectively for those in compliance with the appropriate clinical preventive services recommendations. The participants are provided information regarding the nature of the study, their obligations during the study, the incentive that can be achieved with compliance and a toll free telephone number for enrollment and/or questions.

An independent evaluation of the demonstration will be conducted. The evaluation will be designed to determine whether the provision of a preventive health allowance increased the utilization rate of clinical preventive services among TRICARE Active Duty personnel and their family members.

Population Health Initiatives

Population health focuses on maintaining and enhancing the health of the MHS population while ensuring the most efficient and effective possible use of resources. Population Health Improvement (PHI) is the balance of awareness, education, prevention and intervention activities required to improve the health of a specified population. This model connects self, MTF, worksite and community-based wellness and prevention activities with medical interventions that are centered on primary, secondary, and tertiary prevention to reduce morbidity and premature mortality and improve health.

The strategies and initiatives focus on modifying personal disease and injury risk, effectively changing behaviors to optimize health and enhance fitness, allowing health services providers to render necessary care while reducing unwarranted treatment variation, and achieving measurable improvements in performance and health status. MHS population health initiatives have recently included demonstration projects on healthy choices for life, which were designed to address tobacco, obesity, and alcohol.

Tobacco Cessation and Alcohol Education Campaigns

Social marketing campaigns to counter tobacco use and alcohol misuse/abuse have been developed. These projects are ongoing and are targeted toward young enlisted active duty members, who are the most likely Service members to use tobacco products and drink alcohol. They are operated by TMA with assistance from the military services, but are outside of the covered services benefit and are, therefore, separately funded.

Despite decades of efforts to reduce the use of tobacco in military populations, tobacco use remains firmly entrenched in a significant segment of the military population, with new smokers and chewers starting every day. As measured in 2005, the prevalence of smoking among 18 to 25-year-olds on active duty was 40 percent. Young enlisted soldiers and Marines smoke cigarettes at rates that exceed those of their civilian counterparts, and soldiers smoke cigarettes at a significantly higher rate than did members of any other Service. Also of concern is the fact that many personnel initiate tobacco use after entering the Service.

Responding to increased tobacco use among junior active duty military personnel, DoD implemented and evaluated a national marketing and education campaign: "Quit Tobacco. Make Everyone Proud." This campaign aimed at helping our active duty military personnel quit tobacco and lead healthier lives. The campaign targets 18- to 24-year-old active duty, junior, enlisted personnel, particularly those with an expressed intention to quit.

Similarly, the alcohol counter-marketing campaign was implemented to target high levels of binge and heavy drinking among junior personnel. According to a 2005 survey, binge drinking is roughly two times higher among the military population than the civilian population (about two-fifths and one-fifth, respectively). In particular, the incidence of heavy alcohol use and/or binge drinking is highest among younger, junior-level, enlisted male Service members. With the goal of ensuring the health and well-being of all military personnel, TMA is addressing this issue through an alcohol abuse prevention education campaign, themed "Don't Be That Guy," that draws attention to the current levels of excessive drinking, informs Service members about the negative consequences associated with such behavior, and encourages them to change their behaviors and reduce their consumption of alcohol.

Through education and outreach strategies that include leadership briefings, collateral materials distribution, and web and electronic marketing, the two campaigns encourage their respective audiences to visit either www.ucanquit2.org , a web-based cessation support and education tool that features a personalized quit plan, facts, games, multimedia features, and private chats with trained cessation counselors, or www.thatguy.com, a web-based alcohol education tool that features humorous anecdotes,

jokes, facts, games, multimedia features, and download materials directed at changing attitudes and behaviors that lead to excessive drinking.

Force Health Protection and Readiness

The Pre-Deployment Health Assessment is a force health protection process and form, which allows deploying military and DoD employees to record information about their general health and share any concerns about their health before they deploy. The assessment documents a member's self-reported health readiness status and helps to identify any needed clinical evaluations that may be needed prior to deploying and ultimately helps determine whether the individual is deployable.

The Post-Deployment Health Reassessment (PDHRA) is a force health protection process and form to enhance the deployment-related continuum of care. Targeted to be completed by Service members and DoD employees not earlier than 30 days before the expected return from deployment date and not later than 30 days after return from deployment, the PDHRA provides education, health screening, and a general health assessment to identify and facilitate access to care for deployment-related physical health, mental health and readjustment concerns.

The PDHRA is a force health protection targeted for completion by Service members and DoD employees at three to six months after returning from contingency operations. The PDHRA provides education, health screening, and a general health assessment to identify and facilitate access to care for deployment-related physical health, mental health, and readjustment concerns. Key elements of the PDHRA include outreach, education, screening, health assessment, referral for detailed evaluation and treatment, and any necessary medical follow-up. Screening is conducted to identify current conditions, while education is important for concerns and for issues that may emerge later.

Health Assessment Review Tool (HART)

The Health Assessment Review Tool (HART) is an automated self-reported health information survey that was developed specifically for Military Health System beneficiary health assessments. The HART survey lies at the core of the MHS self-reporting strategy and is the only tool currently available for systematically identifying preventive health care needs and high-risk health behavior for the MHS. This mechanism helps to identify patients who may utilize high levels of health care services, and allows them to be matched to appropriate Primary Care Managers. HART is only available to authorized TRICARE Online (TOL) beneficiaries. Beneficiaries must be registered on TOL and logged into TOL to access the health information survey links.

Currently, there are three versions of the HART form available to beneficiaries. The Health Assessment Review Tool-Accession (HART-A) tool asks questions about Service members' health and life experiences prior to joining the military. The information provides a baseline for future comparisons and helps them monitor their health throughout their military career. The Health Assessment Review Tool-Readiness (HART-R) tool asks questions about health and personal behaviors to guide medical providers in helping to protect health, encourage fitness, and maximize job performance of Service members. All active duty, National Guard, and Reserve service members can complete a HART-R as part of their annual periodic health assessment (PHA). Finally, a new Health Assessment Review Tool (HART) Full questionnaire is now available on TRICARE Online. TRICARE beneficiaries who have enrolled in the Military Health Risk Management Demonstration Project and have been asked to complete the HART-F can access the tool and follow the instructions they have been given. All other TRICARE beneficiaries are welcome to complete the HART-F survey in support of the Military Health System's goal to increase health risk awareness.

Disease Management (DM)

In September 2006, TMA established a consistent approach to identifying and evaluating disease management (DM) services for TRICARE beneficiaries less than 65 years old, to include both TRICARE Prime and Standard beneficiaries residing in the West, South, and North regions. The initial DM demonstration program roll-out included beneficiaries with a diagnosis of chronic asthma and/or congestive heart failure. TMA later added beneficiaries with diabetes (in June 2007) and chronic obstructive pulmonary disease (COPD; in September 2009) to the program. TMA is currently in the process of further expanding the demonstration to include beneficiaries with chronic depression and specific anxiety disorders. Existing cancer screening programs will also shortly be placed within the DM program, and evaluation of cancer screening services will be expanded. The purpose of the demonstration is to evaluate DM program applicability for Standard beneficiaries, in terms of the same clinical, utilization, satisfaction, and financial outcomes as for Prime beneficiaries. Once the evaluation results are obtained, the Department will undertake the rulemaking process in order to specify the DM benefit to be provided.

Behavioral Health

Prevention and wellness in behavioral health are centered on two basic tenets: 1) that preventing the onset of stress and ameliorating its intensity and duration promotes emotional well-being and in part defines psychological resilience, and 2) identification and early treatment of mental disorders and their precursors are key to ameliorating the duration and severity of disabling psychological symptoms. The approaches taken by DoD are varied and reflect both common practice and innovation.

Resilience is generally thought of as the ability to effectively cope with, adapt to, and overcome adversity, stress, and challenging experiences. Training programs such as the Army's Battlemind Training https://www.battlemind.army.mil/, Comprehensive Soldier Fitness Program and the Navy-funded FOCUS project seek to teach skills that will lessen the impact of moderate and severe stressors on individual and family health. The Comprehensive Soldier Fitness Program http://www.army.mil/csf/ focuses on optimizing five dimensions of strength: physical, emotional, social, spiritual and family and uses individual assessments, tailored virtual training, classroom training and embedded resilience experts to provide skills to soldiers and family members. The FOCUS project http://www.focusproject.org, is a resiliency-building program designed for military families and children facing the multiple challenges of combat operational stress during wartime. It seeks to help families identify and build upon their existing strengths and positive coping strategies, to communicate and better understand how each was affected by deployment, assist couples to work more effectively as a team in parenting their children before, during, and after deployment and increase parents' skills in dealing more effectively with some of the emotional and behavioral reactions that children can have when experiencing stress.

Since 2007 DoD has created several on-line mental health self-assessment and self-care resources (realwarriors.net, militarymentalhealth.org, and afterdeployment.org).

Afterdeployment.org is a comprehensive web resource, developed under the direction of the DoD. It deploys state-of-the-art internet-based education, assessment, skill-building and treatment tools that can be used by Service members alone; used in conjunction with primary care manager support; or used in conjunction with mental health care providers. Users have access to on-line assessments, learning tools, and proven self-help strategies to help participants understand their adjustment concerns and engage in self-initiated help for their behavioral health problems, including symptoms related to post-traumatic stress. The site is designed to attract and serve Reserve, National Guard and active duty Service members and their family members who have not yet sought medical care and are not receiving treatment, though it is expected that the resources offered at the site will be extremely useful to those persons who are already in treatment. Problem-focused programs (sleep, anger, depression, stress, etc.) are tailored to meet the needs of SMs and their families. (See http://www.afterdeployment.org).

The Mental Health Self-Assessment Program (MHSAP) at https://www.militarymentalhealth.org is a voluntary, anonymous mental health and alcohol screening and referral program offered to families and Service members affected by deployment or mobilization. It is offered online 24/7, as well as through in-person events. The MHSAP is funded by the DoD Office of Health Affairs.

The Real Warriors Campaign http://www.realwarriors.net is an initiative launched by the Defense Centers of Excellence for Psychological Health and Traumatic Brain

Injury (DCoE) to promote the processes of building resilience, facilitating recovery and supporting reintegration of returning Service members, veterans and their families.

While resilience programs remain largely unproven, there is considerable activity in their evaluation both within and outside of DoD. Most importantly, efforts are underway to determine how to best:

- Implement to the most effective and efficient state practicable the measures that are already in place, ensuring that implementation adheres to the evidence base existing for those activities.
- Fully implement integrated behavioral health in primary care to the extent supported by available evidence.
- Focus resilience program implementation and evaluation efforts on a few initiatives rather than diluting resources over a large number of activities.

Technology to Improve Health and Preventive Care Communications

We were asked to consider actions using technology to improve direct communication with beneficiaries regarding health and preventive care. The Defense Manpower Data Center (DMDC) is working with the Uniformed Services, the TRICARE Management Activity (TMA) and the Department of Veterans Affairs to capture permission-based e-mail data for use in benefits correspondence and notification to the beneficiary.

The permission-based e-mail capture is being implemented in several business areas with DMDC and TMA to reduce the cost of benefit change correspondence and to provide more timely notification to the beneficiary of benefit changes. DMDC expects to implement the first phase of this process through DEERS with the implementation of the next generation of TRICARE managed care support contracts by March, 2011.

Performance Metrics

We were asked to consider performance metrics to better evaluate access to care. In addition to the performance metrics captured by the TRICARE Operations Center and used by the Services which we addressed earlier in this report, we are developing metrics to analyze the effectiveness of the patient centered medical home. We will more fully address these metrics in the next update required with our FY 2012 budget submission.

Quality Assurance — Ensuring No Adverse Impact to Cost, Access, or Care

On May 28, 2010, the TRICARE Quality Monitoring Contract (TQMC) as a follow-on to the National Quality Monitoring Contract was awarded Keystone Peer Review Organization (KePRO). The contract is due to start April 01, 2011.

The purpose of this contract is to assist Health Affairs, TRICARE Management Activity (TMA), the TRICARE Regional Offices (TRO), the Uniformed Services Family Health Plan (USFHP), the TRICARE Overseas (TAO) Europe, Pacific and Latin America/Canada Program Offices, the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC), the Pharmacy and Dental Program Offices, by providing the Government with an independent, impartial evaluation of the care provided to Military Health System beneficiaries.

The TRICARE Quality Monitoring Contractor (TQMC) shall review care provided by the Designated Providers (DP) under the USFHP, the managed care support contracts (MCSCs) and the TDEFIC contractor. In addition, the TQMC will review records from other TRICARE contractors (e.g., TRICARE pharmacy and dental contractors) to satisfy requirements to validate the quality of care delivered under the TRICARE benefit.

The objectives under this contract are:

- To provide an independent, impartial evaluation of the health care provided to MHS beneficiaries.
- To evaluate "best value health care" as defined in the TRICARE Operations Manual.
- To measure, evaluate, and identify superior quality health care services and recommend means to transfer successes.
- To provide comprehensive and timely reviews that are consistent with all TRICARE requirements, to ensure receipt of appropriate levels of health care for all beneficiaries.

Conclusion

In conclusion, we are undertaking a wide array of actions to enhance the capability of the Military Health System and improve the TRICARE program. Subsequent reports will highlight the progress made in the undertaking of such actions to enhance the capability of the Military Health System and improve the TRICARE program.

Attachment 1

Table 1

ADD MTF Prime Enrollees: Number of Visits by Place of Service for 14 Common Conditions in FY09

	Number of Visits	MTF Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	12,913	46,632	4,701	4,814	224	3,070	72,354
309	Adjustment reaction	388	49,207	194	208,315	1,075	6,031	265,210
367	Disorders of refraction and accommodation	2	41,486	1	197,925	311	7,174	246,899
372	Disorders of conjunctiva	8,703	45,672	3,126	10,201	336	4,031	72,069
382	Suppurative and unspecified otitis media	23,652	128,967	11,630	25,443	1,574	10,765	202,031
461	Acute sinustitis	2,839	28,097	1,610	12,257	357	4,694	49,854
462	Acute pharyngitis	14,861	96,084	6,735	13,733	463	7,150	139,026
465	Acute upper respiratory infections of multiple or unspecified si	31,297	196,531	11,050	23,171	1,044	12,558	275,651
466	Acute bronchitis and bronchiolitis	5,606	28,630	5,122	9,114	472	6,330	55,274
477	Allergic rhinitis	1,453	97,383	372	52,953	415	1,513	154,089
493	Asthma	6,388	82,747	4,988	20,942	2,166	3,625	120,856
692	Contact dermatitis and other eczema	3,726	61,223	1,601	10,414	255	1,890	79,109
719	Other and unspecified disorders of joint	4,131	80,888	2,230	196,769	1,746	6,042	291,806
V22	Normal pregnancy	271	250,796	88	39,865	629	7,571	299,220

	Percent of Total	MTF Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	18%	64%	6%	7%	0%	4%	100%
309	Adjustment reaction	0%	19%	0%	79%	0%	2%	100%
367	Disorders of refraction and accommodation	0%	17%	0%	80%	0%	3%	100%
372	Disorders of conjunctiva	12%	63%	4%	14%	0%	6%	100%
382	Suppurative and unspecified otitis media	12%	64%	6%	13%	1%	5%	100%
461	Acute sinustitis	6%	56%	3%	25%	1%	9%	100%
462	Acute pharyngitis	11%	69%	5%	10%	0%	5%	100%
465	Acute upper respiratory infections of multiple or unspecified si	11%	71%	4%	8%	0%	5%	100%
466	Acute bronchitis and bronchiolitis	10%	52%	9%	16%	1%	11%	100%
477	Allergic rhinitis	1%	63%	0%	34%	0%	1%	100%
493	Asthma	5%	68%	4%	17%	2%	3%	100%
692	Contact dermatitis and other eczema	5%	77%	2%	13%	0%	2%	100%
719	Other and unspecified disorders of joint	1%	28%	1%	67%	1%	2%	100%
V22	Normal pregnancy	0%	84%	0%	13%	0%	3%	100%

Attachment 1

Table 2

ADD Civilian Prime Enrollees: Number of Visits by Place of Service for 14 Common Conditions in FY09

	Number of Visits	Civilian Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	1,395	535	3,051	27,849	817	1,758	35,405
309	Adjustment reaction	56	1,674	110	118,360	952	2,743	123,895
367	Disorders of refraction and accommodation	-	1,505	-	99,313	691	309	101,818
372	Disorders of conjunctiva	910	557	2,144	31,046	651	1,705	37,013
382	Suppurative and unspecified otitis media	2,800	1,572	8,300	114,709	2,599	5,483	135,463
461	Acute sinustitis	359	233	1,146	59,594	866	3,135	65,333
462	Acute pharyngitis	1,898	730	5,418	69,153	1,067	4,567	82,833
465	Acute upper respiratory infections of multiple or unspecified si	3,553	1,697	7,705	116,794	2,033	6,033	137,815
466	Acute bronchitis and bronchiolitis	690	274	3,783	42,475	793	3,898	51,913
477	Allergic rhinitis	160	1,280	287	102,390	1,218	1,151	106,486
493	Asthma	805	1,292	3,609	61,043	2,197	3,010	71,956
692	Contact dermatitis and other eczema	490	699	1,261	31,888	669	1,013	36,020
719	Other and unspecified disorders of joint	529	1,207	1,931	131,801	2,036	2,428	139,932
V22	Normal pregnancy	24	27,765	81	31,645	1,243	5,987	66,745

	Percent of Total	Civilian Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	4%	2%	9%	79%	2%	5%	100%
309	Adjustment reaction	0%	1%	0%	96%	1%	2%	100%
367	Disorders of refraction and accommodation	0%	1%	0%	98%	1%	0%	100%
372	Disorders of conjunctiva	2%	2%	6%	84%	2%	5%	100%
382	Suppurative and unspecified otitis media	2%	1%	6%	85%	2%	4%	100%
461	Acute sinustitis	1%	0%	2%	91%	1%	5%	100%
462	Acute pharyngitis	2%	1%	7%	83%	1%	6%	100%
465	Acute upper respiratory infections of multiple or unspecified si	3%	1%	6%	85%	1%	4%	100%
466	Acute bronchitis and bronchiolitis	1%	1%	7%	82%	2%	8%	100%
477	Allergic rhinitis	0%	1%	0%	96%	1%	1%	100%
493	Asthma	1%	2%	5%	85%	3%	4%	100%
692	Contact dermatitis and other eczema	1%	2%	4%	89%	2%	3%	100%
719	Other and unspecified disorders of joint	0%	1%	1%	94%	1%	2%	100%
V22	Normal pregnancy	0%	42%	0%	47%	2%	9%	100%

Attachment 1

Table 3

ADD Non-Prime Enrollees: Number of Visits by Place of Service for 14 Common Conditions in FY09

	Number of Visits	Non-Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	994	1,156	1,767	13,143	320	1,096	18,476
309	Adjustment reaction	31	1,631	76	52,731	547	2,094	57,110
367	Disorders of refraction and accommodation	-	1,429	2	32,190	198	94	33,913
372	Disorders of conjunctiva	704	1,280	1,087	14,686	266	967	18,990
382	Suppurative and unspecified otitis media	1,449	2,210	3,819	53,208	1,268	3,222	65,176
461	Acute sinustitis	283	433	612	31,886	419	2,138	35,771
462	Acute pharyngitis	1,105	1,278	2,599	33,400	456	2,812	41,650
465	Acute upper respiratory infections of multiple or unspecified si	2,859	5,114	4,358	56,936	1,058	3,688	74,013
466	Acute bronchitis and bronchiolitis	557	999	2,293	21,904	538	3,551	29,842
477	Allergic rhinitis	129	1,394	138	44,244	352	551	46,808
493	Asthma	412	1,482	1,916	26,668	1,102	2,001	33,581
692	Contact dermatitis and other eczema	378	1,551	715	15,773	251	701	19,369
719	Other and unspecified disorders of joint	375	2,069	1,304	77,973	2,471	1,987	86,179
V22	Normal pregnancy	37	11,901	75	21,773	962	4,541	39,289

	Percent of Total	Non-Prime Enrollees						
PDX	Description	MTF ER	MTF NonER	Civ ER	Civ Off	Civ HOPD	Civ Oth	Total
079	Viral and chlamydial infection in conditions classified elsewhe	5%	6%	10%	71%	2%	6%	100%
309	Adjustment reaction	0%	3%	0%	92%	1%	4%	100%
367	Disorders of refraction and accommodation	0%	4%	0%	95%	1%	0%	100%
372	Disorders of conjunctiva	4%	7%	6%	77%	1%	5%	100%
382	Suppurative and unspecified otitis media	2%	3%	6%	82%	2%	5%	100%
461	Acute sinustitis	1%	1%	2%	89%	1%	6%	100%
462	Acute pharyngitis	3%	3%	6%	80%	1%	7%	100%
465	Acute upper respiratory infections of multiple or unspecified si	4%	7%	6%	77%	1%	5%	100%
466	Acute bronchitis and bronchiolitis	2%	3%	8%	73%	2%	12%	100%
477	Allergic rhinitis	0%	3%	0%	95%	1%	1%	100%
493	Asthma	1%	4%	6%	79%	3%	6%	100%
692	Contact dermatitis and other eczema	2%	8%	4%	81%	1%	4%	100%
719	Other and unspecified disorders of joint	0%	2%	2%	90%	3%	2%	100%
V22	Normal pregnancy	0%	30%	0%	55%	2%	12%	100%

Attachment 2

Air Force Efforts to Improve Access to Care-
The Family Health Initiative (FHI), Access to Care (ATC), and Monitorability

- FHI and one of its elements, ATC, address Overall Satisfaction with Health Care and DoD's assessment of Prime survey data

- FHI goal is to create an enjoyable and productive practice environment that promotes and delivers quality, evidence-based care to our patient populations

-- Improved patient continuity to ensure the patient sees their assigned provider

-- Improved support staff ratios and periods of assignment to foster comprehensive care delivery teams

-- Maintaining high appointment levels to ensure appointment availability with that provider/team

-- Monitoring established civilian and evidence-based metrics to ensure desired outcomes are realized with respect to utilization and prevention

-- Inviting patient and provider/staff feedback to achieve and maintain high levels of satisfaction, and to maintain stakeholder trust and loyalty

- ATC is a tenet of FHI to ensure all available resources are optimized, to include appointment utilization

-- Educate and train all care delivery roles on how to optimize appointments, supporting staff and technologies, and to employ evidence-based techniques

--- Conferences held for all roles multiple times annually, supported by SMEs and additionally accessible via the Surgeon General's Knowledge Exchange

-- Monitor appointment usage to ensure availability to care is not wasted

-- Monitor purchased care that could have been provided at the MTF to ensure appointment optimization

-- Monitor and develop evidence-based metrics to support actions needed to achieve FHI/MHS goals

-- Site, descriptions and links have been provided and serve as baseline for discussions at all levels within the AFMS

Examples of current Metrics:

Access Improvement Module	- Drillable and roll-up capable ATC statistics for MTF. Daily analysis/ comparison - Appointment demand and supply by provider, by appointment type	https://aim.afms.mil/
AF/SG Balanced Scorecard	- Access (Routine, Acute, Wellness) - Ambulatory Data Module (ADM) - PCM Schedule Availability	https://egl.afms.mil/
AFMS Knowledge Exchange (Health Benefits Section)	**Access & Appointing** - APS Phase III - ATC Seminar Presentations - Policies & Directives - Reports - T-Nex Appointing	https://kx.afms.mil/healthbenefits
Appointing Information System Hands On Training Course	To register for this course go to the following website and then click on the Appointing Info Systems Icon on the front page	https://kx.afms.mil/atceducation
Appointment Equalizer	What if scenario to tool to assist Access Managers determine the right supply of appointments	https://aimae.afms.mil
BP Radar	Tool to assist business plan managers to make targets at their MTFs	https://bpradar.afms.mil
	Business Planning - Business Plan Enrollment Analysis - Business Plan RVU Analysis - Business Plan RWU Analysis	
Executive Information & Decision Support (EI/DS)	- Basic M2 Training - Customer Satisfaction Survey Data - DEERS Point-in-Time Extract (PITE) – Eligible Beneficiaries - Expense Assignment System	https://eids.ha.osd.mil

	IV (EAS IV) - Health Care Provider Record (HCPR) - Health Care Service Record (HCSR) Institutional Claims - Health Level 7 (HL-7) - Non-Availability Statements (NAS) - Pharmacy Data Transaction Service (PDTS) - Standard Ambulatory Data Record (SADR) - Standard Inpatient Data Record (SIDR) - TRICARE Encounter Data (TED) Claims - TRICARE Enrollment File - Worldwide Workload Report	
Executive Global Look (EGL)	**Resources** - Access to Care - ADM Accuracy - ADM Completeness - PCM Schedule Availability - Prime Containment **Customer Satisfaction: Service Delivery Assessment (SDA)**	https://egl.afms.mil/
EGL Virtual Analyst & Push Reports	Drill down reports to various EGL metrics and more	https://eglva.afms.mil/
MHS Guide to Access Success	Joint service comprehensive guide of appointing and scheduling business rules	http://www.tricare.mil/tma/tai/cguide.aspx
MHS Insight Tool	MHS designed Access To Care Metrics. Must have applied for access. There are 3 metrics - PCM Continuity Metric - Booking Success Metric - Third Available Routine Metric	https://eids.ha.osd.mil
NPI HA Policies		http://www.tricare.mil/hipaa/identifiers.html
Population Health	- Population Health Definition - Pop Health Improvement Plan	http://www.mhsophsc.org/public/home.cfm

	& Guide - Conferences & Training - Resources	
TRICARE Access Imperatives Website	- Best Business Practices - **MHS Guide For Access Success** o Education & Training o Performance Measures/Metrics - Policies, Documents, and Presentations - What Can Sites Implement Now?	http://www.tricare.mil/tai/
TRICARE Management and Measurement Tools	- Data Quality Metrics and Reports - Executive Metrics (TOPS) - Military Health System Performance Measures - TRICARE Access Imperatives - TRICARE Operations Center	http://www.ha.osd.mil/hbfp/resources.cfm

Attachment 2

Army Medical Department's Access to Care Efforts

The Army Medical Department (AMEDD) and its Military Treatment Facilities (MTFs) are decisively engaged in improving access to care (ATC) for Soldiers and their Families. Our ultimate goal is to have the right provider, providing care at the right time, using the right venue that's best for the beneficiary.

In January 2009, The Army Surgeon General briefed the Chief of Staff of the Army on the AMEDD's plan to "fix ATC". One of the first steps to improve ATC was the US Army Medical Command (MEDCOM) Chief of Staff's approval and distribution of $6.2M in Jan 2009 to support the purchase of additional primary care teams to improve access at 12 installations. A total of $12M is authorized to support a total of 28 additional primary care teams at the 12 installations.

In March, 2009, Operation Order (OPORD) 09-36 (ATC Campaign) was published. This OPORD contains 11 specific focus areas with specified tasks. The focus areas are as follows:

- Ensuring valid and appropriate MTF enrollment
- Improving the patient appointing and access process
- Increasing use of TRICARE Online appointing
- Standardizing schedule/template management
- Ensuring timely and appropriate referral management
- Improving Primary Care Manager (PCM)/Team continuity of care with beneficiaries
- Improving customer service and beneficiary education
- Increasing patient satisfaction
- Optimizing use of TRICARE network when demand exceeds MTF capability
- Ensuring command oversight
- Maintaining visibility of all primary care provider assignments

The MEDCOM is also providing incentives for MTFs to increase/improve primary care and behavioral health access by increasing reimbursement rates within the AMEDD Performance Based Adjustment Model (PBAM). Furthermore, patient satisfaction metrics were also incorporated into the FY09/10 PBAM. In FY09, the AMEDD distributed $8.7M to the MTFs that had the best performance towards improved access and patient satisfaction. Currently the MEDCOM is analyzing potential metrics and methodology for financial withholds from MTFs that do not achieve certain ATC standards. The Army Surgeon General approved financial awards recognizing MTFs that greatly improve access to care as measured by eight key metrics. Those awards will be distributed every six months at the MHS Conference and the Army Medical Symposium.

In the August/September 2009 timeframe, each MEDCOM Regional Medical Command (RMC) commander conducted ATC back-briefs to The Surgeon General (TSG) to assess their compliance in meeting ATC standards.

Additionally, efforts to improve access by hiring the remaining authorized PCM teams and planning for implementation of new Off-Post Community-Based Primary Care Clinics (CBPCC) occurred. Implementation of 22 CBPCCs in 14 markets will offer convenience, continuity and enhanced access for potentially more than 160,000 Active Duty Family Members. Continued vigilance on proper alignment of enrollment with MTF capacity, increased primary care appointments to meet demand, and a well designed Patient-Centered Medical Home (PCMH) model to increase the percentage of patients seeing their PCM (primary goal) or PCM-Team are the cornerstones of success in access to care. The Army Surgeon General/MEDCOM Commander will hold these RMC Commander back-briefs on a quarterly basis, at a minimum.

ATC was a major Department of Army focus and a critical element of the AMEDD's support of the Army Family Covenant in FY09 and will continue to be in the coming years. Primary care is the center of gravity at our MTFs and applies to both the Direct Care System (our MTFs) as well as beneficiaries referred to the Purchased Care System (TRICARE civilian network).

Joint Collaboration efforts to support Improved ATC within the entire Military Health System.

Military Health System Patient-Centered Medical Home

The AMEDD's Concept of Operations for the MHS PCMH is being finalized with the MEDCOM Clinical Service Division as lead. The PCMH concepts are to be applied to our CBPCC, but will have broader application to MTF based care. Alterations of the concept must be evaluated based on the care site and provider-mix (uniform providers versus civilian/contractor).

Some key MHS support elements required are improvements to AHLTA and creation of secure provider to patient communication modalities (e.g., secure email).

- AMEDD endorses for the positive beneficiary focused attributes and improved out-comes.
- PCM By Name (PCMBN) at the center, within a provider group (3-5 PCMs) to ensure greater continuity.
- Appropriate support staff and improved MHS IM/IT are critical to the concept.

Enterprise Efforts for Access to Care Measures

Under the Strategy Management Work Group – weekly meetings w/ CAPT Maureen Padden (Navy, Jacksonville) as Chair. Key metrics are:

- PCM Continuity.
- Booking Success Rate
- 3rd Available Appt.

Standardized Efforts for Referral Management/Clear & Legible Reporting (CLR)

Rear Admiral Hunter directed formation of a Tiger Team composed of representatives from TRICARE Management Activity, their TRICARE Regional Offices, and the three Services. AMEDD is pushing the Tiger Team to standardize 'front-end' referral management business processes between MTF and their supporting TRICARE contractor; after this, a standardized 'back-end' CLR process can be crafted. IM/IT solutions are possible, but AMEDD's focus is on fixing and standardizing business processes first. Highlights:

- CLR requirement not in the T3 contracts, MHS Tiger Team formed.
- Team will develop/implement standard business rules/tools that support MTFs and identify resource requirements.
- The Joint Healthcare Oversight Council approved placing CLR responsibility under MTF.
- Tri-Service efforts to revitalize an active Health Care Finder program as defined by Title 32 Code of Federal Regulations.

Enterprise Efforts to Improve Greater Standardization within the MHS

The AMEDD is engaged in many Enterprise-level Councils, WGs, and Integrated Process/Project Teams (IPTs). The focus of the AMEDD is for the MHS to have complete standardization of core business design elements, both within the MTFs and by the TRICARE contractors, that support MTF operations and our MTF-enrolled beneficiaries worldwide. The Military Health System endorses a portable Prime benefit, and our Prime beneficiaries deserve the same benefit execution anywhere in the world where they access TRICARE Prime healthcare. Highlights:

- MHS Guide to Access Success, published 15 Dec 08.
- Enterprise-Wide Scheduling and Registration (EWS-R).
- TRICARE On-Line.
- Tri-Service initiative for standardized MTF to TRICARE Contractor Memorandum of Understandings.
- TMA Tasker to consolidate ASD(HA) Policy Memos effecting ATC.
- Tri-Service efforts to revitalize an active Health Care Finder (HCF) program as defined by Title 32 Code of Federal Regulations.

- DoD Innovation Investment Process (IIP) Nurse Advice Line (NAL) program discovery; has similarities with HCF.
- Enterprise-level TRICARE Enrollment Liaison WG.
- Enterprise-level T-3 DEERS IPT.
- Enterprise-level OCONUS Contract Transition WG.
- Enterprise CLR Tiger Team.

Attachment 2

Navy Medicine Efforts to Improve Access to Care- Memo dated 22 Jan 2010

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY 2300 E STREET NW
WASHINGTON DC 20372-7300

IN REPLY
REFER TO

JAN 22 2010

MEMORANDUM FOR THE HEALTH AFFAIRS-SPONSORED NATIONAL DEFENSE AUTHORIZATION ACT FISCAL YEAR 2010, SECTION 721, ENTERPRISE WORKING GROUP

SUBJECT: Navy Medicine Efforts to Improve Access to Care (ATC)

Ensuring beneficiaries' timely access to needed care is at the heart of Navy Medicine's strategic goal of patient and family-centered care. To minimize variability in medical treatment facility (MTF) and clinic business processes that support ATC, Navy Medicine issued NAVMED Policy 09-004, "Access to Care Management Policy for Navy Medicine Military Treatment Facilities" of 12 March 2009.

This policy articulates roles, responsibilities, and expectations for Navy Medicine Regional Commands and MTF Commanding Officers (COs), as they relate to ATC. It also provides clinics and MTFs with a framework to implement a well-researched, efficient and effective access plan that supports their beneficiary population's mission requirements and health care needs. The policy reinforces the use of the Assistant Secretary of Defense, Health Affairs' "Military Health System Guide to Access Success" to standardize and improve ATC business processes.

As Navy Medicine Regions have begun implementing NAVMED Policy 09-004, they have identified ATC improvement opportunities at their respective facilities and are actively involved in education and communication efforts to implement best business practices at each facility.

Successful implementation of the Navy Medicine ATC Policy is supported by the active engagement of leadership at the enterprise, Regional, and MTF level. The Navy Medicine ATC Policy/MHS Guide to Access Success requires that MTF COs formally appoint an access manager, whose primary responsibility is to assist in developing an access to care improvement plan, and engaging MTF staff in its successful execution. To this end, MTF COs are required to establish a multidisciplinary team that oversees and

integrates ATC improvements into all applicable processes across the MTF. Navy Medicine Regions provide oversight and guidance by reviewing and approving MTF ATC improvement plans, while providing ongoing support and education to MTFs.

To date, ATC performance monitoring has typically focused on a single or number of metrics (e.g., third next available appointment or patient satisfaction with ATC). ATC performance is multidimensional, however, as many factors and business processes impact ATC. Focusing on a single or small number of ATC metrics could potentially create a false sense of how an MTF is performing on ATC

To address the shortcomings associated with looking at a single metric and to support active monitoring of ATC, Navy Medicine has recently developed an ATC management panel within MHS Insight. The management panel consolidates 31 key A TC metrics from a variety of sources, organizing fragmented data and one-dimensional metrics into overarching composite scores that provide a more holistic view of ATC performance. The management panel provides the ability to monitor ATC performance at the enterprise, Regional, and MTF level. Once fully deployed, the management panel will be utilized to actively monitor and report on ATC throughout the Navy Medicine enterprise. ATC performance is also reviewed quarterly by the Navy Medicine Corporate Executive Board, which is comprised of senior medical leadership.

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